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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APPEARANCES:

Alexa Cappola
Allison Lynch
Amy Eisenhauer
Benjamin Kasper
Beth McGown
Brielle Phillips
Colby Rowe
Cristine Lannoti
Daniel Clayton
David Violante
Deanna Ratigan
Dr. Elise Van Der Jagt
Dr. Matthew Harris
Drew Fried
George Stathidis
Helen Fries
Jacob DeMay
James Downey
Jennifer Goldman
Jessica Falgiatone
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 Stegtch
Suzanne Swan
Tiffany Bombard

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Tom Bonfiglio
Vera Feuer
Vince Calleo
Vincent Quimette

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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.

MS. EISENHAUER: Excellent. Dr. Kim Wallenstein.

DR. WALLENSTEIN: Present.

COURT REPORTER: I'm sorry --

MS. EISENHAUER: Dr. Vince Calleo.

COURT REPORTER: -- there's some background noise. I don't know if it's -- because it's making it hard for me to hear when you're calling the roll. It's like an echo or something.

MS. EISENHAUER: Can everybody, unless you're talking, go on mute? Dr. Vincent Calleo.

DR. CALLEO: Present.

MS. EISENHAUER: Douglas Hexle.

MS. CHIUMENTO: Hi ya.

MS. EISENHAUER: Oh, hey -- hey, Sharon.

MS. CHIUMENTO: Okay.

MS. EISENHAUER: Just doing the roll.

MS. CHIUMENTO: Yeah, I was having trouble getting in. So -- okay, we're good.

MS. EISENHAUER: Okay. We're good now. So Sharon Chiumento is present. Nicole O'Toole. I saw her.

MS. O'TOOLE: I'm here. Can you hear

me?

MS. EISENHAUER: There you go. Now I can hear you.

MS. O'TOOLE: Okay.

MS. EISENHAUER: Dr. Tiffany Bombard. Dr. Matthew Harris.

DR. HARRIS: Hi. Good afternoon.

MS. EISENHAUER: Hey. Chief Joseph Pataki said that he would not be able to be here. Jason Hague, he also said that the system at his agency was busy today. He may not be able to make it. Ben Kasper.

MR. KASPER: Present.

MS. EISENHAUER: Hey. Dr. Vera Feuer.

DR. VERA: Present.

MS. EISENHAUER: Thank you. Kelly-Ann McDonald. Jessica Falgiatano.

MS. FALGIATANO: Present.

MS. EISENHAUER: Dr. Mark Hannah. Okay. And I see, not vetted yet. Just one more -- one more probably meeting because your letter is in the process. I saw that Dr. Dorsett was here.

DR. DORSETT: I am.

MS. EISENHAUER: Okay. So we have a

quorum.

MR. COOPER: Thank you, Amy. So the next item on the agenda is approval of the minutes from our November 20 -- 2024 meetings. Those were distributed to everyone electronically. I ask now if there are any additions, deletions, or corrections to those minutes? Hearing none, I'll ask for a motion to approve.

MR. KASPER: Approved.

MS. CHIUMENTO: Motion made.

DR. HARRIS: Second.

MR. COOPER: Thank you.

COURT REPORTER: I'm sorry. Can I get who --

MR. COOPER: (unintelligible)

COURT REPORTER: -- who made the motion and who made the second? I didn't -- I don't know who that was.

MS. CHIUMENTO: Sharon Chiumento, motioned.

DR. HARRIS: Matt Harris, second.

MR. COOPER: Thank you. All in favor please signify by saying, aye.

MS. CHIUMENTO: Aye.

MR. KASPER: Aye.

DR. HARRIS: Aye.

MR. ALBERT: Aye.

MS. O'TOOLE: Aye.

MR. COOPER: Any -- any -- any no's or abstention? Hearing none, then the minutes are approved. All right. Amy, tell us all about the E.M.S. for children grant report.

VOICE ASSISTANT: This meeting is being recorded.

MS. EISENHAUER: Thank you, Ryan. So for everybody else, we're recording now. So the E.M.S. for children grant report. The Always Ready for Children Pediatric Recognition Program, I believe, we are at thirty five hospitals right now. There's one that we're reviewing, everybody else should be on the website. We also sent out welcome packets. We got everything together and much thanks to Ally for doing that -- the actual putting together of the packets and making everything look really great. So that would include a certificate, the Pediatric Assessment Triangle document that Dr. Van der Jagt and Sharon have kept up-to-date and done the heavy lift on that, some badge buddies and

information on where they can find more resources for pediatric preparedness in their hospital.

So those went out about a month ago, maybe a little longer than that, just around Christmas. And I've heard back from several hospitals that they got it, they were very excited and we're very excited for that as well. It's our hope that once we hire somebody -- which I'll cover in a moment. Once we hire somebody that late summer, early fall depending on how things go, we'll be able to have like a one day or even a half-day symposia to introduce the pre-hospital PECs to the hospital PECs and do some PEC learning workshops. Very recently there were three PEC Modules released by the E.I.I.C. And I'm going to send out an email to everybody with all of those as soon as I make sure that they are available and on the website.

As you may know, the Federal government has issued a -- a pause on some communications from healthcare -- from the healthcare groups and E.M.S., HRSA, and then E.M.S. for children was a part of that. So we're just on a pause until everything gets reviewed. So I just want to make -- I, you know, commit to it because there may be a

delay in getting it out. I think that's everything that's going on with Always Ready for Children. Ever moving forward, which is awesome and wonderful. We did remove --.

MR. COOPER: Amy.

MS. EISENHAUER: Yes.

MR. COOPER: Amy -- Amy, may I?

MS. EISENHAUER: Sure.

MR. COOPER: Stop and -- stop you here for a moment and ask a question. It's my understanding that there are about -- tell me if I'm wrong. Amy and Ryan. There are about a hundred and eighty hospitals in the state. We've only heard from thirty five of them. Is that -- is that what I'm hearing from you?

MS. EISENHAUER: I want to say it's a hundred eighty -- eighty eight hospitals, of course we --

MR. GREENBERG: Yeah, of course.

MS. EISENHAUER: -- we've only heard back from -- from thirty-five.

MR. COOPER: Is there something we can do to, you know, push some of these hospitals to participate in the program? Do you think?

MS. EISENHAUER: Right, so --.

MR. GREENBERG: So I think right now -- Amy, let me take this one.

MS. EISENHAUER: Go ahead.

MR. GREENBERG: So I think right now, you know, to be honest, the number of thirty-five is -- is pretty strong. You know, we haven't been doing this that long. We have not been pushing too hard. And I think part of what's going on right now too is also we're learning from the first adapters what's working, what's not working that -- that -- I wouldn't want to push too hard at the moment. I think this is a kind of a nice growth spurt in part because of Northwell. There's no question about that one. They are definitely champions in this, so thank you Northwell. But they have done it as a system approach, and we're really looking at that approach to see how we can take that model and bring it to other places. So I -- I think a little bit more of -- of pacing along and then we would gear it up a little bit more, would be my recommendation.

MR. COOPER: Okay. All right. Thank you, Ryan.

MR. GREENBERG: Amy, I don't know if -

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MR. COOPER: Thank you, Amy.

MR. GREENBERG: -- you feel the same way or not, but hundred percent.

MS. EISENHAUER: I -- well, I do. There is -- also there's been some discussion, and I think that's probably why Dr. Harris was raising his hand. There's been some discussion on promoting the program and how can we do that? And looking at different avenues. And I know Dr. Wallenstein has been a part of that conversation as well -- as well as Dr. Van der Jagt and some other members from PedsDoc. So there -- there has been discussion on -- on how to move forward getting more interest. But Ryan is right, we are learning a lot by the early adopters. Our early plan of having all the trauma hospitals jump in and join first kind of naturally what happened was systems jumped in and joined first. As Ryan mentioned Northwell, their whole system is now a part of Always Ready for Children. And I know University of Rochester, Lauren Whitman over there has really kind of been reaching out to her system hospitals and getting everybody prepared and -- and signing in. So right, as we go that's great

information to know and learn and see maybe if that's a more appropriate direction.

MR. COOPER: Okay. I just wanted to see if there's anything the committee could do to help, you know, push this out. You know, this is a really important initiative and -- for us and -- and so we will await your guidance and that of Ryan as to when the appropriate time might be to push a little bit harder.

MS. EISENHAUER: Yeah. I would say --

MR. COOPER: Thank you.

MS. EISENHAUER: -- maybe one thing that would not be overreaching would be just go to your hospitals and say, hey, there's a program. And just say, you know, I'm on this committee, I work with this endeavor, how can I help you be prepared and sign up?

MR. COOPER: Sure. Absolutely.

DR. HARRIS: Dr. -- Dr. Cooper --.

MR. COOPER: I -- I -- I'm sure that everyone on this -- I'm sure that everyone on this call has reached out to their own hospitals. I know, I certainly have. Matt, did you have a comment?

DR. HARRIS: Thanks for the few

moments. I wonder to both Ryan, with everyone's point, if a good middle ground is -- you know, I think there's some opportunities that we're going to discuss later today about some of the outreach efforts we're doing and could be doing. With other work that E.M.S.C. is doing that, there's likely representation from this group at all the REMSCOs and the REMAC. So rather than go right to the hospitals, but to learn the lessons we've had from Northwell, from other places, they should just be part of our elevator pitch maybe when we have our regional representation as part of our normal work at the REMSCOS and the REMAC to remind people that this is -- and that can be done, it's not time specific.

I think there was a lot of information that came out over the summer about the pre-hospital readiness program, which had a very defined end because it was still on that initial whatever. I think this would be a good opportunity for us to just say, this is an ongoing enrollment and that there's no calendar date for it. So maybe that's the middle ground and just urging all of our members here who engage in the REMAC and REMSCOs to bring it there. Just food for thought. Thanks for the time, Dr.

Cooper.

MR. COOPER: Not a bad idea. We'll discuss that further off line. Thank you, Matt. Amy, do you want to get into the grant sponsor visit issue?

MS. EISENHAUER: Yes. Well, not an issue at all. So representatives from HRSA came to visit us here in New York just to see kind of what we're doing, what we've been up to, projects that we've been working on, and just sharing information. I feel it was really great and productive. They had questions about our system and about the projects that we've been doing, how they've impacted -- impacted E.M.S. in hospitals. Also Dr. Cooper and Dr. Van der Jagt visited with us. Nicole represented the Family Action Network. So -- so we had a bunch of different meetings covering all the -- all the E.M.S. umbrella, and I thought it was really productive.

And so we're just waiting on feedback from them. Just, you know, Hey, this is great. Hey, have you thought about this? We also had the program manager, so my role, but from Utah. They have recently upgraded their PEC program. And we talked

about different things that they've been doing and how they've been tying in their PECs with other initiatives in the state. So that was great to hear from -- from other states that may have similar -- similar endeavors. So it was really great to hear other -- other thoughts, other processes, how other people are doing things. Do you have any comments on the visit, Ryan?

MR. GREENBERG: I -- you know, I will say we -- we didn't know what to expect with this visit. So that -- that was, you know, just -- I just want to echo that one. You know, they said they were coming and just wanted to learn more about us and stuff like that. I've been here seven years and they haven't had a visit in the time that I've been here. So it was -- we didn't know fully what to expect, but it was really nice. I think we had a really nice couple of days together. We got to learn from -- from some other states. We got to learn from the PEDS. We got to express some of our concerns with the program too. I think, you know, they were really good listeners too, which was nice. You know, things about funding and programs and stuff we would love to do, but just, you know, the -- the bandwidth isn't

there.

And so it -- it was nice to get the FaceTime and -- and to get to have those discussions with T and, you know, the rest of the team. So -- and I think, you know, we did a pretty good job of relaying and, you know, thank you to Art and some of the others who joined us on, you know, some of the different discussions to talk about the work that we're doing. And we did, you know, one of the big things I think that we emphasized for them is just the reminder of, you know, our numbers may not always be as high as we would want them to be when it comes to a percentage, but our numbers of those that participate normally exceed what most other states do by double. And so, you know, just recognizing the lift in what we can do and what we're able to do.

And -- and just to give an example, you know, when we have thirty five percent of our hospitals respond to a survey, you know, that is, you know, fifty or sixty hospitals. Well, for most states, that's more hospitals than what they have. So, you know, the data that we bring in and what we provide is, you know, pretty significant even when we're not able to capture, you know, a hundred

percent of what we would like to capture of everything else. When we have, you know, two hundred and fifty PEC agencies, you know, that's significant compared to most states that don't have that many E.M.S. agencies or don't have that many PEC agencies. So I think that, you know, having that time to talk about that and discuss it was, you know, just really nice. And -- and again, and getting them out and to see some of our PECs in our hospitals, I really enjoyed it. So --.

MS. EISENHAUER: Dave.

MR. VIOLANTE: Hey. Sorry about being offline -- off video there for a little bit. One of the -- the suggestion that came up is maybe create a one pager for some of the other hospitals. I know that you wanted to sort of temper some of the growth a little bit to be able to make sure we're doing what we're doing and -- and follow it along. But maybe that could be helpful as well, at least, for some -- some ideas for them as to -- to what this is about and how it could be helpful for them.

MR. COOPER: I think that's not -- I think that's not a bad idea. You're getting out of, you know, a very brief one pager sort of annual

report of what's been accomplished, I think would be, you know, very helpful. Thank you, David, for that suggestion. That's a really great idea. Thank you. 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,

okay, we'll take you guys out because you don't see PEDS. Although apparently, sporadically that seems that that's not really the case. So they've been -- your hospital has been added back in and they will be able to do the electronic version of the survey.

MR. KASPER: Awesome. Yeah. Thank you very much. Yeah.

MS. EISENHAUER: Yeah.

MR. KASPER: It's just one of those -- yeah, it's a kind of a reactive response after -- as soon as they say they don't get them, that's when they start getting some.

MS. EISENHAUER: Well, we're happy to have them.

MR. KASPER: Awesome. Thank you so much.

MS. EISENHAUER: Yeah, thank you.

MR. GREENBERG: And that was related to the V.A.? Is that what you said, Amy?

MS. EISENHAUER: Yes. Yes.

MR. GREENBERG: So for those of you who don't know, I feel like this is just a -- a fun bit of trivia for -- for this group that I think you'd find interesting. As many of you probably

know, our commissioner of health is a pediatrician by training. What some people may not know is that his role in the Navy was a pediatrician in the Navy, which most people don't think of the Navy needing many pediatricians. But as he has told me, they -- there are lots of babies that are made when shoreside and so on the bases there are lots of kids. And he was a pediatrician in the Navy. And so a lot of good stories from him when I've spoken to him on that one. So not only the V.A. --

MR. COOPER: Thank you, Ryan.

MR. GREENBERG: -- but also on the bases.

MR. COOPER: Thank you. Okay. There being no other questions for Amy, we can move right on to Nicole O'Toole. Please tell us about the E.M.S. for Children family act -- action network activities for the last couple of months. Nicole?

MS. O'TOOLE: Hi, can you hear me?

MR. COOPER: We can.

MS. O'TOOLE: Okay, great. I don't have much of a report, unfortunately, since the fans are under a pause as well under the E.I.I.C. But they did meet in January. And there is a fan from

Colorado and they're working on a readiness program for disasters and how to help children. And then there was another fan who is trying to get E.M.S.C. advisory committee meetings happening in her state, and I believe that was Delaware. But that's about it. Unfortunately, we're just kind of on a pause. No more meetings at the time during the pause. We can make phone calls to them, but they can't put out any emails or anything like that. So we're kind of on hold.

MR. GREENBERG: You said you can make phone calls or you can't make phone calls?

MS. O'TOOLE: I'm sorry, Brian, can you say that again?

MR. GREENBERG: You said you can make phone calls or you can't make phone calls?

MS. O'TOOLE: I can make a phone call to the fans, one-on-one phone calls. But they said no general meetings until they're off of pause.

MR. COOPER: I presume that applies to the entire E.I.I.C.; is that correct?

MS. O'TOOLE: That is correct. Yep.

MS. EISENHAUER: Yeah, all of our -- so the -- the E.I.I.C. does write educational

webinars for program managers and other E.M.S. for children stakeholders, though some have been paused for now as well as -- for example, the E.M.S. for Children Data Center does like a thirty minute tech talk once a month. Those have been paused, any information coming out about the survey data has been paused until all of that can be reviewed.

MS. O'TOOLE: Including social media too. There's nothing.

MS. EISENHAUER: Yeah.

MR. COOPER: Have we had, Amy, a formal directive from -- from Washington on -- on this? Have they told us what we can or cannot do, other than no meetings and so on?

MS. EISENHAUER: So it's no meetings from them. They cannot have meetings.

MR. COOPER: Yeah.

MS. EISENHAUER: Yes. So --.

MR. COOPER: That's all right. Yeah.

MS. EISENHAUER: So the last directive I got was about a week ago, and they called me on the phone just to tell me that, you know, everything had been taken off our calendars and explained why and that they would know more in -- in the short future.

So no -- no real directive because I think they're still figuring it out as well.

MR. COOPER: Okay. Well, fortunately, we have our activities in the statute, so we are obligated to continue, which is a good thing for the children of New York. So anyway, let's pray that things get sorted out in Washington and this program is back up and running as quickly as possible. Okay. Ryan, I hope you have some better news for us than Washington has for us.

MR. GREENBERG: Well, you know, let me just start off by saying, you know, I think it's important to recognize what you just said, which is, you know, this isn't statute now. The E.M.S. Advisory Council is -- is not a federal program. The -- I'm sorry, the E.M.S. for Children Advisory Council is not a federal program. That is a state program through our statute that has support by our E.M.S. for children partners at the federal level. So you know, should something change, it would not, you know, directly change this because it is in New York State statute that this committee would convene and discuss pediatric issues and things like that. Might affect some of the other things that happen,

you know, our PEC programs and things of that nature. But you know, for this group, I think that's important to -- to understand the importance of your work and everything as well.

So from our side, you know, we are -- we are busy. No question about that one. You know, we continue to, you know, be out there doing our outreach, you know, from the operations investigation side. We're excited to see the equipment regulations moving forward. So we had our -- they were out for public comment, they came back. We had a response to many public comments related to new equipment standards. And then we are putting them back out for public comment again because the number of changes that were made. Why do I bring it up to this group? Because there are significant things related to pediatric equipment that will become part of -- part of the eight hundred.

Now, a lot of ambulances had that anyway prior to, but this really codifies it including pediatric transport devices and things of that nature that were not required to before be carried on ambulance that post this will be required to be carried. So excited to see that happen. Yes,

thank you. So moving that forward. We also have a number of regulatory packets that are in the process including some system and agency performance standards as well as blood is in the process. So, you know, pre-hospital E.M.S., both air and ground being able to carry pre-hospital blood and what does that mean, and how does that work, and things of that nature. So a number of different things. You're going to see a lot of regulatory things come forward in -- in the future, and -- and we're excited to see that and move those things forward.

The -- sorry, there's something beeping in my house and I'm not sure what it is. So the out -- outside of that, you know, some of the bigger changes just on our side. You know, we are moving from a bureau to a division or we have made the move from bureau to a division. What does that mean? It means we're going to become the division of state E.M.S. and then we'll have three bureaus underneath us, the Bureau of E.M.S. Administration, the Bureau of E.M.S. Surveillance and Compliance, and the Bureau of Emergency -- E.M.S. Emergency Management. We're excited to continue to grow as -- as a division, to hire more staff, to do more things,

and hopefully, again, do more things on the pediatric side as well.

And, you know, with that, we are continuing to hire. Like Amy said, we're in interview process right now still for our E.M.S. for children's position. We're hiring a number of data positions. We're hiring a number of other positions to move forward. And so, again, lots of growth going on. Excited to see that growth and, you know, more to come and more information to come at, you know, the February meeting for SEMAC and SEMSCO. And then we also did make it into the budget this year, so E.M.S. was in the budget. There's some, you know, pretty significant things that are in there, including making E.M.S. an essential service which was proposed by the governor. And some other things that will, again, align with, you know, our desires on pediatric care and -- and, you know, bringing forth, you know, some more innovation related to pediatric care throughout the state. So happy to take any comments or questions, but I think I'll leave it at that for right now. All right. You're on mute, Ryan.

MR. COOPER: Do you think it would be

-- do think it would be possible to, you know, share with the group the sections of the budget that -- that specifically, you know, address pediatrics?

MR. GREENBERG: Absolutely.

MR. COOPER: So -- now, but via some sort of, you know -- you know, electronic communication.

MR. GREENBERG: Yeah. And you won't find anything in there that says the word pediatrics. It's more just as it strengthens the system, it will strengthen the pediatric care that we provide as well. But it is part R as in rain or -- or Ryan. Part R, is the part of the budget this year that is for EVAC.

MR. COOPER: It's definitely R for -- definitely R for Ryan, no question.

MR. GREENBERG: There you go. So that is -- that's out there and yeah, we're absolutely happy to share that. There's two other sections in there too that have some smaller stuff. We'll share that with everybody just so you have the awareness for it.

MR. COOPER: Thank you so much, Ryan.

MR. GREENBERG: Thank you.

MR. COOPER: Any questions for Ryan? All right. Well, thank you so much. We are rocketing along on this agenda today and I'd note that we have probably the best attendance we've had in quite a while, and we're very grateful for that to all of you who are attending. And we will be respectful of your time. So let's move on to old business. And next up is, of course, our dear friend and business partner, Sharon Chiumento, who has an update for us on the Pediatric Agitation Protocol Education work group. I hope we will learn that there's been a little bit more video activity, but Sharon, take it away.

MS. CHIUMENTO: Well, unfortunately, we've not been able to have a meeting. I've tried to do that a couple of times, but we're not able to get people together to -- to have a -- a meeting. But I have had some communications with Chief Pataki. The -- I -- he was not aware of any additional videos having been done. I know that he had offered to work with Vera Feuer and Matt Harris at the last meeting, but I don't know whether anything along those lines has occurred and -- and whether anything was done in that area. Amy, do we have the video that was done

to show today?

MS. EISENHAUER: We do not. It was my understanding that we were going to wait until they were all kind of --

MS. CHIUMENTO: Okay.

MS. EISENHAUER: -- ready, so that we only had to put them through once.

MS. CHIUMENTO: Okay. No problem. I just -- I just didn't -- wasn't sure what -- which way we had gone with that. The other thing I have done is I take -- took the outline that I had developed a while back and I've started to develop the PowerPoint. So as the videos are done, they are -- they will be incorporated within the PowerPoint as well as hopefully, some directly related -- maybe a slide or two directly related to the -- to each PowerPoint with points that were made in the PowerPoint or with additional concepts that should be considered. So -- so we're -- we're at least moving forward on that component, as they say. I don't have any further information about the videos reduction themselves.

MR. COOPER: Sharon, what can we do to help you and your committee move this along? It's --

it's -- you know, we were very heartened that last time that the video was -- for the first video was completed. But as you've noted, there are two more that need to -- need to be produced and we're sort of on hold with getting approval through the E.V.C. process, you know, until all three are done. Is there anything we can do to help you with this? I don't know if Chief Pataki is online today or not.

MS. CHIUMENTO: He's out of -- out of the country, so he's not -- he was not going to be available for today.

MR. COOPER: Got it.

MS. CHIUMENTO: I don't know Matt -- Matt or Vera, do you have any -- any progress that you can report on?

DR. HARRIS: No. I don't think -- Vera, I can't speak for you, but I -- I haven't heard from the Chief. I think that there --

MS. VERA: No, I haven't either.

DR. HARRIS: -- there -- there is a studio that we have access to that can help do the physical taping and editing, and they've agreed to do that. And the turn around very -- is very, very quick on those, usually within a couple of weeks. I

think if the content's done and we have the people to do it. I think we can definitely facilitate it.

MS. CHIUMENTO: Great. Yeah, I think --

MR. COOPER: Sure thing.

MS. CHIUMENTO: -- you could just, you know, maybe reach out to Chief Pataki because I think he was waiting to hear from you, so I think it might just be a communication issue here. And, of course, with the holidays and everything, it's kind of -- I am sure it slowed things down.

DR. HARRIS: I'll reach out to him now.

MS. CHIUMENTO: Thank you.

MR. COOPER: Yes, thank you. Let's -- let's get this back on track because we really need to get this finished up. It's been too long. Okay. Any questions for Sharon? Hearing none. Well, sadly, I learned just a few days ago that Dr. Van der Jagt was not going to be with us and just before the meeting that Dr. Conway would not be able to be with us. So we have no reports on procedural sedation work group, nor on the pediatric care standards work group. So we will have to wait until May for those.

So we are now one hour ahead of time, believe it or not. And Marilyn Kacica, are you in a position to be able to present the Title Five stuff that you wanted to bring forward?

MS. KACICA: I think actually Dr. Siegenthaler wanted to have that opportunity.

MR. COOPER: Okay.

MS. KACICA: I think we had given her the time of two, but I'll message her. But may- -- maybe we could like move on and then we could track back to it.

MR. COOPER: Sure. Sure, of course. Amy, go ahead.

MS. EISENHAUER: Dr. Cooper, so Dr. Harris had something that he wanted to discuss under new business. But this was already in process, so I told him just to bring it up under this stitch --

MR. COOPER: That would be fine, sure.

MS. EISENHAUER: -- and maybe we could do that. Yeah.

MR. COOPER: That would be fine, sure.

DR. HARRIS: Thank you, both. Thanks Dr. Cooper. Happy to be a space filler – while we find the report that's -- that's pending. I don't

know if Ryan wants to speak to this or -- or Amy, but I think there's a couple of opportunities that are coming up with some data that's going to be presented at SEMAC that I think has some relevance. And this is very much fed by some data that was presented at the National Association of the E.M.S. physicians related to pediatric airway management, pediatric cardiac arrest. So I wanted to put a feeler out to this group on two topics, and then I will submit for our next meeting, Amy, a formal -- this document for formal review to come out of this group with the intent of making recommendations for collaborative changes to the collaborative protocols on both of these topics.

So the first of which -- and -- and those who are more knowledgeable about this, please keep me honest here, is that I believe there is going to be some presentation at the upcoming SEMAC meeting on the B.L.S. i-gel program, which has been predominantly an adult i-gel program in the Hudson Valley and in Long Island and other places. Which looks -- for those who are not aware, is a supraglottic airway device in the hands of B.L.S. providers with the idea that there's a body of

evidence certainly in the adult literature and -- and also on previous pediatric literature for higher rates of first pass success rate and lower rates of complication. And again, those are who more knowledgeable than I can speak to this, but my understanding is that the B.L.S. data coming out of Hudson Valley -- Hudson region rather and from Long Island, are going to end up showing a very successful pilot program for B.L.S.

I know there's been some discussion from our colleagues on the adult side to make this a proposal for statewide B.L.S. implementation of i-gels. So I wanted to -- to bring this up in the context that, you know, there are two things that I think will feed airway management guidelines in the state. And, obviously, those guidelines will feed any education that comes out of this group, and that is two things. One is for those who are not aware, there is an active enrollment in this study called P.D. part which Buffalo and others are participating in. Northwell will be participating in moving forward, as well as some other agencies in the city. P.D. part is a -- a two-phased PECARN trial which is pairing supraglottic airway devices in the hands of

A.L.S. providers against bag-valve mask ventilation in the goal of getting somewhere in the ballpark of three thousand patients in their prospective study.

The winner of that outcome, meaning those with better out -- in clinical outcomes, will then be paired against a cohort of patients who are, again, whether it's i-gel, which is the likely winner, or B.V.M. versus endotracheal intubations. The goal is somewhere in the ballpark of six thousand enrolled patients over five years. My understanding is that this started in July and they already have about four hundred patients enrolled, so it does look like public demand. It is very, very likely based on prior data that i-gel will be or supraglottic devices in general i-gel will be -- be the definitive winner, if you will, for airway devices. Certainly, in the hands of A.L.S. providers and likely in the hands of B.L.S. providers for pediatric airway management. I'm going to guess for all comers, pediatric, cardiac arrest, seizure, asthma, et cetera, for kids.

So on the one hand, if we want to wait five more years, I think we'll have robust data to support, you know, in -- in the largest prospective study the use of supraglottic airway devices in kids.

I think that there is sufficient data based on prior studies by weighing in others by data as presented at N.A.S.P., which I'll submit for Amy's consideration for the next meeting so people can review on their own through our formal process. That when the i-gel comes up for the collaborative protocols in New York at the next SEMAC meeting, I think it is a reasonable thing for us to advocate that it'd be extended to pediatric patients. I think with appropriate education. This is something that is a muscle memory that does not require a unique knowledge of pediatrics. It is a -- it is a -- I think well-vetted both in the pre-hospital and in the in-hospital setting. So I would just like to solicit feedback from those on this call. There's general gestalt on putting together an -- an amendment to what I know is coming on the B.L.S. i-gel side for the adult airway management program. So with that, I'll pause before diving into the next topic, but I would appreciate the feedback of those on this call.

MR. COOPER: Matt, I think it would be helpful if you were able to circulate among the -- the membership of the committee any scientific literature that's available in terms of use of

pediatric i-gel. I think as we all recognize, there are various sizes of the -- of the device that -- that, you know, will need to be employed and, you know, the -- the ages for which they are available and how to size them and so on. It sounds like a simple thing but, you know, it may not be quite so simple as -- you know, as -- as we would -- we might at first think. You know, and so I think some pretty good data on that from -- you know, from various appropriate sources, most likely the Prehospital Emergency Care Journal, would be very helpful. Some of it may not be available yet in print. It may be available only in abstract form. I don't -- I -- I was unable to make the meeting this year at the last minute. So I'm not in a position to know quite as much of the latest and greatest as I'm sure you do. But I think any -- any -- any of that information that you have, I think would be very good to share with the committee. So, you know, we're in a position to offer, you know, an educated view --

DR. HARRIS: Happy to do so.

MR. COOPER: -- and -- and that's a response to your question.

DR. HARRIS: Happy to do so.

MR. COOPER: Any other questions for Matt?

MS. DORSETT: I just have that --?

MR. COOPER: Is that --

MS. DORSETT: Hi, Matt.

MR. COOPER: -- is that -- is that Maia? Yeah, Maia, please. Yeah, go ahead.

MS. DORSETT: I just have a comment which is I totally agree with Matt. And I think that somehow separating children out from the expanded scope of practice around i-gel continues -- sorry, got a phone call all of a sudden. Somehow separates children out from everything else. And I think that there is a lot of data to support that i-gel is easier than bag mask ventilation in particular, actually in everybody. I think that thinking about how you integrate it, the one thing that's really different for pediatrics is not the sizes because there's lots of things that are different, right? They have to size a mask in a pediatric patient. It's fixation of the i-gel with downward pressure and how to do that properly. But that's been well-developed in numerous systems who have implemented the i-gel in pediatrics in an A.L.S. system, and I

think would be easy to teach people at the B.L.S. level on how to do that. And so I would wholeheartedly support expanding the scope of practice for B.L.S. to use a pediatric i-gel because the technique of placement is not different. It's the -- or the verification, it's the securing of the device.

DR. HARRIS: Well, I think, Maia, you did point out just as C.P.M. scans up, but you did point out an important component of the B.L.S. side of this. Is that -- there a requirement in the pilot for end-tidal CO2 which would be the same for PEDS. I think that, you know, where we'd have to just kind of terse this out. Again, I don't know this off the top of my head as whether they're same and in line end-tidal CO2 would apply for neonatal supraglottic. So I think take Art's point into Maia's expertise here, there's a little bit more digging that has to be done and I'll include some of that information. And Amy, if it's okay, I'll circulate some of the studies in one pages through you to this committee for feedback.

MS. DORSETT: And -- and when I think about like neonatal --

MR. COOPER: Thank you. Go ahead, Maia.

MS. DORSETT: -- yeah, when I think about this neonatal supraglottic issue --

MR. COOPER: Go ahead, Maia.

MS. DORSETT: -- it's just -- just because N.R.P. doesn't rapidly, like regularly incorporate waveform capnography does not mean that it's not the right thing to do. And thinking about how do we expand use of waveform capnography for the verification of effective ventilation for all patients, I think is a -- is a much bigger deal. One of the places where we have fallouts, one of the measures we track regionally is the use of waveform capnography with all B.L.S. ventilation. And we like preload capnography on all our bags, and one of our fallouts is pediatric patients. And I see that as pediatric patients getting less good care. And so I think around like equity and care for pediatric patients. I think expanding waveform capnography, the expectations of its use can only make care safer.

DR. HARRIS: Great.

MS. DORSETT: Thank you.

MR. COOPER: Thank you, Maia. Pam?

MS. FEUER: Hi. Thanks, Maia. I fully support the expansion of waveform capnography. Anyone who sits with me on any E.R., I.C.U. meetings, that's kind of my number one discussion. What I wanted to ask you guys, so you've explained some of the downsides or difficulties in securing this device. I've never had my hands on it or anything. Have either of you experienced placing it? I'm looking forward to getting more information from you. So, you know, I'd like to know how you compare these devices to either if you have put in an L.M.A. or, you know, bag-valve mask. Uh-huh.

DR. HARRIS: Yeah. I mean, I could say here our group is now -- if you're -- if you come in and cardiac arrest with a B.L.S. crew, we exclusively put in supraglottic devices. And so we've sort of gone to two or three rounds of C.P.R. here unless we have, you know, anesthesiologist at the bedside who can do endotracheal intubation without interruption to C.P.R. So that's something that Pam, we've recently adopted. I think Josh, again, our numbers are real -- thankfully very, very low.

MS. FEUER: Yeah, they're low. Uh-

huh.

DR. HARRIS: Well, what -- what I'll tell you is that it -- it -- you know, and I grew up as a medic using L.M.A.s and, you know, I -- I -- I interestingly, Maia, like I find that yes, the i-gel get -- has a little pop. But the L.M.A.s were just so much less reliable back in the day. And I think that the i-gels have become -- I hate using the term standard of care, but considering how ubiquitous that I feel that everyone has become much more comfortable with them, Pam. So, yeah, I mean, I think Maia's point is that with the old L.M.A.s, you'd insert them, you'd inflate them, you knew they were going to pop up. With the i-gels as they would ease and they start to get bigger, they can get displaced.

I've never actually had one displaced, but again, the end of our experience is relatively low. But when you look at the greater experience in the adult population, I think, again, to Maia's point, this has been so well educated out there that whatever we put out there as a recommendation from this group and certainly into a collaborative protocol -- I'm going to hone on my colleagues Paul here. Paul -- Pam is very well. Guidelines --

guidelines must be coupled with education not be education of themselves. I think whatever review will have to come with robust education and this would be a great body for that to arise out of especially given that we have several intensivists on this call on a regular basis. So between, you know, Doug and Pam and Elise and others, I think we can really put out some robust education.

MR. COOPER: Maia, did you have more to say? Your hand is still up.

MS. DORSETT: Yes, I did. I was -- I was going to say that we implemented it. It's actually easy to teach. We don't have a huge end but in places and the ones that it's actually been used, it's been successful. And if we compare that even though a very small N, we have fail -- have had, when I look at the capnography waveform of failed mask ventilation in pediatric patients who had bad outcomes. And so I think that the N is not large, but the opportunity is great. As far as education, because we've implemented it across multiple agencies in our region, we have education that's available that we would be happy to share.

DR. HARRIS: Yeah.

MR. COOPER: Thank you, Maia. And Matt just one -- one comment from, you know -- oh, I'm sorry. Mark, did you have a comment?

DR. HARRIS: I -- I just want to echo everything that's being said. Different -- different E.M.S. agencies up in like the Westchester, Washington Heights area where we service, have also been migrating towards the i-gel. And the education and implementation -- and -- and it's exactly the same as everybody else. Our N is low, but we're seeing like an increased use of frequency and success rate here, just anecdotally. We're evaluating this data right now, and we hope to put it out once we reach a number that makes sense. But I -- I just want to champion this effort and say that I -- I think that for pre-hospital, out of hospital cardiac arrest, like it -- this, I think my personal opinion is that this is a viable option for airway placement.

MR. COOPER: Thank you, Mark. I just want to also note that Ms. Bombard commented in the chat her wholehearted support for waveform techno -- capnography as the appropriate technique to -- to confirm airway placement. As -- speaking as, you know, as a dinosaur here, I -- I just want to remark

that -- that while i-gel will -- will certainly improve our ability to manage pediatric airways, I think on some level it does reflect the fact that our teaching of bag-valve mask ventilation has not been perhaps as good as it could be. And, you know, that's a -- a fundamentally basic skill that -- that I have never felt as strongly enough emphasized. You know, i-gel may -- may improve the ability to ventilate, you know, a child, but certainly, you know, we need not, you know, as they say, throw the baby out with the bath water and ignore a B.V.M. ventilation entirely. So let's focus on that piece of it as well. And if -- if an educational program is developed, I would hope that it would include an emphasis on -- on B.V.M. as well as on i-gel placement and ventilation via that device. Any other comments on this? Okay. Matt, onto -- onto issue two.

MR. GREENBERG: Sorry, Dr. Cooper, just one thing on this one. And I--

MR. COOPER: Oh, Ryan, go ahead. Sorry.

MR. GREENBERG: It's come up in some discussions but Maia particularly hearing from you,

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

MR. COOPER: Yeah. I -- you know,

those are all good points, Ryan. Again, I -- I'm hopeful that Matt and perhaps Maia will be able to get together the -- you know, the scientific literature and support of this. That will help us a lot at the SEMAC level as well as, you know, statewide and in getting our colleagues on board with this. Okay. Any other points, questions? Was your hand up, Maia, or no? No. Okay. Any other points about -- about this issue? Okay. Matt, issue number two.

DR. HARRIS: Well, actually, Ryan -- Ryan's comment really dovetails really nicely with this. So the other big topic and, obviously, around PEDS was actually pediatric out of hospital cardiac arrest. And, you know, there was some great presentations that I actually -- are out of Washington State, and that when you talked to their A.L.S. leadership who was there, and they had a great paramedic who presented with their medical director. I think our friends who are north of the -- you know, the -- the -- the New York City Westchester region, their -- their experience is probably very -- likely very similar to this group in Seattle. That's sort of like sixty miles north of Seattle and really, you

know, does not have fifteen children's hospitals to spit into every once in a while.

And so there have been some modifications that I want to -- and again, I'll submit to Amy, that are already publicly available. So in the -- in the New York City REMAC, as Art knows, we modified the guidance around pediatric out of hospital cardiac arrests, oh, I'd say about a year ago. And with some specific language actually saying that i-gels or bag-valve masks are a reasonable alternative to endotracheal intubation for first line airway management. And so that is another point of -- that I think is worth bringing to the state level now. There's, again, I think we -- we are never going to have a randomized control trial in pediatric out of hospital cardiac arrests. So see, I observe (unintelligible) your comment. Thank you.

So I think that the next point is talking about making modifications, again, at the SEMAC level to guidance in the collaboratives around pediatric out of hospital cardiac arrest. There's a couple of points which, again, I'll -- I think Art, I'm going to hone you here. And I think you're going to say the same comment as before as I'll present

some of the data both from N.M.S.P. and from some recent publications in pediatric as -- as out of hospital cardiac arrest. But there's a couple of things that I'll bring to note. I don't think Susie Burnett is part of this call, but I think we're all very familiar with Susie through the CARES work that she does. She's an active paramedic, and I think like always fifteen minutes away from finishing her PhD. And -- and -- and I think, and I say this in the most complimentary way possible as sort of like the next book learner and I think she would feel very proud -- very proud to hear that.

So in New York State -- so out of hospital cardiac arrest survival with meaningful neurologic outcome nationally is eight percent, right? And that's obviously well below the adult numbers. For good reason, the adult's going into ventricular arrhythmias, kids have lower rates of recognition, everything that this call -- folks on this call know. In New York State with only forty eight percent of the state participating in CARES, we're at five percent. So we are substantially below even the national data which is obviously sort of sobering to begin with. Susie and I, one of my

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

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

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

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

what the role, if any, moving forward of epinephrine will be. And there's some -- I think the new PALS guidelines are going to deemphasize. Though Pam, I certainly would appreciate your guidance here. Are going to deemphasize epinephrine and add -- and witness out of hospital cardiac arrest because there's really no data to support that's coming. But I think the early non-controversial or minimally controversial things that I think will have a very meaningful outcome will be the guidance that comes from our airway recommendations and guidance for more on -- more on scene resuscitation prior to transport. So I just want to again bring that up for the consideration of this group with the plan of providing the guidance to Amy for distribution and some wording for modifications to the SEMAC protocols. I'll stop there.

MR. COOPER: Thank you, Matt. I -- you know, I --I think without the literature and without the support of this committee getting any change in the collaborative protocols is going to be a pretty heavy lift. Maia?

MS. DORSETT: One of the -- I wholeheartedly support, right? Like staying on scene

and one of the things we've been working on for pediatric cardiac arrest in our region. But my question is, do we think it belongs as a protocol recommendation or as some other -- I don't know what the alternative format is because it doesn't -- I have to double check. But I don't think the adult protocols say like, you will stay on scene for twenty minutes.

MR. COOPER: Yeah.

MS. DORSETT: And then so I feel a little bit strange sort of protocolizing where the care is delivered. I mean, it might be like in -- you know, at the end they have some suggestions and recommendations. But I agree, if I think about like the big picture of how do we get people empowered to stay on scene and provide good care for children? What is the best mechanism to do that? I'm just not sure a protocol -- recommend protocol change the way to do that --.

DR. HARRIS: I -- I get that, yeah. I -- I think you've hit the nail on the head. Like, I think that like, you know -- and the -- the -- this is -- and, you know, you and -- I think I had this conversation of like, you know, what is going to

reach more people? And that's going to be education, right? So like, I think -- I think I'd emailed you a couple of weeks ago about this and my failure to follow-up. And I think one of the things that -- and maybe this is -- and I'll defer to Art and Amy, but I think one of the things that we can decide as a committee to move forward is that if -- if we -- if we agree on the body of evidence, which we can discuss in the next meeting after it's attributed -- and even in the absence of any formal changes to guidelines, but maybe in those bullets at the bottom, I do think a -- a large scale educational effort supported by this group through webinars, through meetings at the REMCO, the REMAC, et cetera, in a purely educational fashion is warranted.

I mean, we are -- you know, there are children not surviving in New York State because of bad care. And care that could be optimized and I think is ultimately not bad because of provider, but because of the discomfort around these incredibly high acuity, low frequency events and a lot of mythology around it. And so I think that whether it ends up in a protocol or to your point maybe more appropriately in those pearls at the bottom, I do

think that this might -- this should be the year of the -- the E.M.S. committee -- E.M.S. for children committee to say we recognize that we are -- we have an obligation to educate to help New York City meet the mark and we can use the CARES data or another repository to help get there. So I think your point is very well taken there.

MS. DORSETT: And I think as far as the repository of data, I think you have to take a few different stabs at it because agencies who are enrolled in CARES are already going to be more engaged in sort of quality management around cardiac arrest. So it's a relatively biased sample. I think that there are ways, though imperfect, you can use the state data around this to actually look at the relative time from on scene to transport for pediatric cardiac arrest --

DR. HARRIS: Agreed. Yeah.

MS. DORSETT: -- and time determination of resuscitation. And I think that's data that would be actually relatively easy to write a state report around because it's not something that people have to put in a free text and --.

DR. HARRIS: Yeah, agreed, yeah.

MS. DORSETT: -- times. But I think maybe -- I don't know. I don't think E.M.S.C. does position statements or clinical guidelines or something. But I think a group of people who are representing E.M.S.C. making a recommendation to stay on scene and why, I think that's actually the first step because it sort of officializes it. There's lots of things that we've done where people are like, well, nobody gave me a policy or a guideline that said that, that said it was okay. And I think people are uncomfortable with this for a multitude of reasons. But the first step is them actually not knowing. It's not just okay. It's better and now we need to empower you with the tools to actually take care of these patients and manage families on scene and the rest of it.

DR. HARRIS: Yeah. And I -- I -- I'll defer to Art, but I do think -- and Art, correct me if I'm wrong. I don't -- I think there is precedence within this group but I think it's before my time for like a position statement like effort. I mean, I don't know if we for -- formally called them a position statement or we just issued guidance. But that guidance -- but I'll defer to Amy, Ryan or Art,

you know, from historical perspective about what -- like what the -- we have --.

MR. COOPER: And we have -- we have issued guidance in the past, few and far between. I think it's actually before Ryan's and Amy's time, so, you know. But there's no barrier to our doing that. We might want to do it in conjunction with SEMAC. We might want to do it another way. But -- but you know, I don't -- I don't think -- I don't see a barrier. This is all good stuff. We need to, you know, move deliberately based upon the available science and so on. I -- I would just caution however that, you know, we don't kind of get into panic mode because our numbers don't look so good. You know, there are -- there are -- there are innumerable reasons why -- why those numbers might not look so good. It may be that we work much harder to get patients to the hospital, okay? Whereas in other venues, people may declare on the scene and the patient never makes it to the hospital, you know. You know, there are confounding factors like that.

You know, I find it hard to believe, you know, that -- that the -- you know, that the training of our -- of our -- of our pre-hospital

providers, you know, is -- is so super deficient, you know, compared to others that, you know, that -- that our numbers are -- are, you know, not -- not where we would like them to be. I'm not saying that -- that the numbers are -- are not correct, don't get me wrong. And I'm not saying that -- you know, that -- that there's not vast room for improvement. And I'm also not saying that -- that the look isn't very good, the optics are not good. But, you know, it's not entirely clear to me that -- you know, that -- that the issue is that our -- that our pre-hospital personnel are doing a worse job than anyone else is. What we do need to do is make sure that they're doing as good a job as this possible, you know, given that -- given the circumstances that we have. Maia?

DR. HARRIS: Yeah, I think -- yeah.

MS. DORSETT: Yeah, I was going to say that I -- I think that's true. So the CARES data though, right? Takes into account all the patients who have a pre-hospital cardiac arrest. So whether or not they're transported to the hospital, we have that outcome and we also know that termination of resuscitation rates in the field for pediatric patients are exceedingly low compared to other --

other populations that we take care of. I think the biggest thing is that we can look and we -- if we look sort of where we are nationally, I don't think we're bad nationally. But we know that nationally pediatric cardiac arrest care pre-hospital is extraordinarily poor compared to the care that we give adult patients, which is in part because people are sort of more nervous and so it's complicated.

But there are systems that have -- it's actually not that much more complicated other than that, right? Like we've made it more complicated but there's ways to simplify it. But I think also because we have not -- we sort of somehow said that children are special and different in some way when they're not, act like if we just treated them like we treated our adult patients. We do have good examples of systems that have been able to turn this around. So there's systems in Florida that went from saying, we transport all kids and had two percent survival to saying we're going to stay on scene and resuscitate children and having like twenty to thirty percent survival, which is similar to what they reproduce for adults.

So and these types of changes in

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

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

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

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

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

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

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

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

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

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

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

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

into the issue of, you know, when cardiac arrest actually occurs. We all -- we all know that the kids generally get there from respiratory deterioration rather than cardiac deterioration, you know, and spending more time on scene with, you know, with good ventilation and CPR. But for that reason, you know, may -- may provide a -- you know, a -- a -- a leg up in terms of the resuscitation. But let's get that literature shared with everybody and -- and we'll have a more robust discussion about this next time. Perhaps, you know, Amy maybe we could organize a -- you know, a -- a call to look at that literature before the next meeting? I would imagine that -- that Matt and Maia and Tiff would be particularly interested in being involved with this. Pam Feuer, perhaps you too. I don't know if you have time. But let's -- let's get a look at this literature so we can -- can have a -- have a robust discussion about this at the next meeting. Okay. Matt, is that it for you at the moment?

DR. HARRIS: Yeah, I think I've used my time. Thanks, Art.

MR. COOPER: Okay. Okay. All right, no problem. So I -- I note at this point that Dr.

Siegenthaler has joined us and Marilyn Kacica had indicated that Kirsten would be doing the -- would -- would be doing the -- the presentation on the Title Five stuff. So please take it away.

MS. SIEGENTHALER: Good afternoon and thank you for inviting us to join. My name's Kirsten Siegenthaler. I am with the New York State Department of Health and our Office of Public Health, and I'm the director of the Division of Family Health. And I'm joined today -- I just want to give a moment for them to say hello, by Dr. Marilyn Kacica if she wants to say hello.

MS. KACICA: Hi everybody.

MR. COOPER: Hi Marilyn.

MS. SIEGENTHALER: And Suzanne Swan. Sue Swan is our director for our Bureau of Child Health. Sue, do you want to say hello?

MS. SWAN: I'm trying to.

MS. SIEGENTHALER: Okay. We heard you.

MS. SWAN: Hello.

MS. SIEGENTHALER: So we appreciate you giving us a few moments of your time. It'll be a -- a little bit of a turn from your prior discussion

which was, you know, fascinating to listen to. So appreciate the opportunity to talk more about some of the public health side of the maternal and child health work that the Department of Health does. And I am going to -- oh, thank you, Amy. I'm going to attempt to share. Are you able to see my PowerPoint and can you verbally tell --

MR. COOPER: We can.

MS. SIEGENTHALER: -- because I can't -- okay.

MR. COOPER: Yes.

MS. SIEGENTHALER: I can't see -- I can't see now that I have the PowerPoint on. So please just sort of ask questions. I'll try to pause as I go through this. But I just wanted to take this opportunity to share broadly a little bit more about what the Department of Health does to support what we really think of as birth through reproductive age here at the Department. So the Division of Family Health is quite large and we have have a pretty broad portfolio that does span the age group from birth through reproductive age and sort of cycles right back through again. I'm not going to go into each and every single area, but you can see that we have

child health. And I'll talk a little bit more about our programming for child's health as well as children and youth with special healthcare needs. And for our youngest, newborn hearing and early intervention. And for our adolescents, we do a lot to focus on interpersonal relationships preventing or mitigating sexual violence as well as addressing issues of mental health. And we have health equity really that crosses and is embedded in all of the work that we do. So we're a fairly good-sized division. We have a total budget that we are responsible stewards for around nine hundred and seventy-three million. Of that, we get a hundred and thirty-three million dollars in federal funding. The department --

MS. EISENHAUER: Siegenthaler.

MS. SIEGENTHALER: Yep.

MS. EISENHAUER: Sorry to interrupt you. Your slides are not advancing on the screen. You just --.

MS. SIEGENTHALER: Sorry. Thank you for letting me know .

MS. EISENHAUER: You just still have the title slide.

MS. SIEGENTHALER: Let me see if I can change that. I stopped sharing, so you should -- trying to see how to redo the entire screen.

DR. COOPER: Amy, do you have the slides?

MS. SIEGENTHALER: It's not -- it's not --.

MS. EISENHAUER: It's not -- I can -- I can share the slides and then --.

MS. SIEGENTHALER: Okay. If you wouldn't mind, yeah. So we don't waste time. We don't lose time.

MS. EISENHAUER: Not at all. Let me just grab them.

MS. SIEGENTHALER: Oh, it says we can't display your shared content. Make sure you've allowed permissions and then try again.

MS. EISENHAUER: Okay. That helps.

MS. SIEGENTHALER: Okay. If you can share them, I'll start.

MS. EISENHAUER: Sure.

MS. SIEGENTHALER: It does help if you can actually see what I'm talking about.

MS. EISENHAUER: Well, at first, I --

I was like, oh, okay. She's just going over things -- -.

MS. SIEGENTHALER: No, I was advancing.

MS. EISENHAUER: Oh. All right. Give me one second and I will share --.

MS. SIEGENTHALER: Sure. Technology, it's our friend.

MS. EISENHAUER: Yes. All right. And then we will do --

MS. SIEGENTHALER: Perfect. Yeah, this is it.

MS. EISENHAUER: There we go.

MS. SIEGENTHALER: All right. If you'll go to the first slide.

MS. EISENHAUER: Sure.

MS. SIEGENTHALER: Great. So here is a picture that would be much more interesting to look at, but our -- our portfolio really spans a broad range from birth through reproductive age. And, you know, health equity is both overlaid and also embedded in everything we do. You can see here, as I was saying earlier, that we have a focus on child health as well as children and youth with special

healthcare needs. And for the youngest, we have early intervention and newborn hearing screening. And then for our adolescents, we really focus on interpersonal relationships, sexual health, reducing or mitigating sexual violence, as well as addressing mental health concerns. So we can go to the next.

So we're a large division. We're responsible for nine hundred seventy-three million dollars total funding. We receive a hundred and thirty-three million dollars of federal funding of which the Department of Health manages eighty million. And then we work with an affiliate that is called Health Research Incorporated. They're a 501(c)3 that has a memorandum of understanding with the Department of Health to act as a bonafide agent. And so among that, federal money is the Title V Block Grant that I'll actually be spending my time on. But it is really actually important to understand that the Title V Block Grant is never meant to be a standalone. It's actually meant to be embedded with and to leverage broader funding both at the Federal and at the state level. And so we do receive appropriations through the state budget with grants of about a hundred and thirty million dollars.

And then we're responsible for a very large program for infants birth through three called the Early Intervention Program. And this provides habilitative services for infants and toddlers who are -- who are identified as having delays. And these services include physical therapy, occupational therapy, speech-language pathology, and special instruction. And so the -- in addition, we manage money through Medicaid and through the counties that collectively result in the full reimbursement for the program. So you can go to the next slide.

So specifically, among this funding is something we call the Title V Block Grant. And why it -- it matters to this group is it actually comes from the same area of the Federal government where this children -- Pediatric Emergency Medical Services funding comes. So we're -- we're funded under the Maternal and Child Health Bureau in the Health Resources and Services Administration. And so we have the same sort of federal oversight, and we have had it indicated to us at recent events, you know, that it would be important to reach out to our Pediatric Emergency Medical Services counterparts and really try to first share who we are, introduce

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

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

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of dictate, you know, what is needed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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is a pediatric group, we'll -- we'll -- we'll go to the next slide. And so we have perinatal and infant health really focus work with our newborn screening and addressing infant mortality. You can go to the next slide. We have some broad strategies that we use that are related to surveillance, social determinants and then some domain specific strategies typically as our pattern. If you go to the next one.

So for perinatal and infant health, we really focus a lot on clinical areas that we can support such as working with our hospitals to improve their perinatal care. We have newborn hearing screening -- newborn blood spot screening. We support environmental health and lead poison prevention. We have our early intervention program, and we work very closely with our colleagues who support vaccines as well as our Medicaid colleagues. So you can go to the next slide. For child health, we really -- because of the priority areas around healthy foods, you know, being able to get out into the environment and social cohesion, we focused our childhood -- child health area on physical activity and addressing childhood healthiness.

You know, it -- I -- I don't want I --

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we have many debates about B.M.I. and the challenges of B.M.I. We are very limited in the amount of -- of federally available data that they'll allow us to look at. And so B.M.I. is one of the areas that they have federally available data. It is not our priority in the sense that we are much more focused on creating healthy environments and getting activities -- you know, opportunities for children both to have access to healthy foods, which is great for both, you know, their wellbeing and their physical, you know, wellbeing as well as their mental health and oral health. So we'll go to the next slide.

So we have some strategies. We'll go to the next slide where we actually -- so our big areas that we work on are school-based health centers. And so we work with about two hundred and fifty schools that have clinics in them. And they're served by about fifty article twenty-eight operators. And they receive a combination of state and federal funding for these centers and then for the visits themselves they billed Medicaid. But we work very closely with these school-based health centers. And it's an excellent avenue for providing primary care

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to children in underserved areas where that might be a real challenge. We also really focus on oral health and the importance of oral health. We've seen a lot of children who go now to the emergency room, for example, for oral healthcare because they're really lacking from primary care and they -- you know, the -- the tooth decay advances.

Again, we work with -- to -- and support vaccines for children both through our school-based health centers are all vaccine -- vaccination sites, as well as we work with our local health departments and our partners to really promote vaccination for children. And then we work closely with our Medicaid. And so some of the things that Medicaid has done and is working on, you know, includes continuous coverage from birth through six years old, working with them on adverse childhood experience, screening and trauma-informed care work that we do as well as, you know, other areas that I'll get into for children and youth with special healthcare needs. So we'll go to the next slide.

So for adolescent health, we really do think about adolescents, both their sort of sexual health, but also their transition to adulthood

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because that's an area we know is a big challenge for our adolescents. You can go to the next slide. We have some strategies, and then our programs is the next slide. And so here we really work with our family planning programs. Our school-based health centers, again, are important areas for reproductive and development. We have sexual health grants that really focus on healthy relationship, financial literacy, and other work to support our adolescents. We have a center of excellence, and we are developing a youth advisory group. You can go to the next slide.

So our children and youth with special healthcare needs, again, these crossover the age groups. But children and youth with special healthcare needs has a really broad definition. So it's anyone -- any childbirth through twenty-one who really requires supports beyond what would be considered typical. So that's it. That's the definition but, you know, typically we think of everything from children with asthma, which would be a much more common sort of special healthcare need to some of the more significant -- significant medical issues or developmental delays or including

intellectual disabilities. And go to the next one. We have some strategies, and then we have the next slide as our programs.

So we work with our local health departments. We give them quite a bit of money to really serve as our local sort of boots on the ground, really engaging with their community members. We'd love to get them more engaged with, you know, all of the partners, including emergency rooms and emergency medical services. Because we would, you know, anticipate children with special healthcare needs might interact more frequently with -- with these places. We also fund a center of excellence because the broad range of children with special healthcare needs. It is so broad that we need really to have a resource for our local health departments so that they can get their questions answered as well as identify resources to help them when -- if -- when and if some conditions are relatively rare.

We work with lead poison prevention as well as treatment if high lead rates are found. We have a sickle cell navigation program for adolescents. We work with our -- with five hemoglobin apathy centers who help individuals with

sickle cell as they transition from pediatric medicine into adult care. And then again, Medicaid initiatives really supporting children and youth with special healthcare needs. So our children's health home, for example, we've worked on them on changing their sickle cell requirements to making it a single qualifying diagnosis for health home. Again, we've worked on a number of other initiatives with Medicaid. So we can go to the next slide, and that's it.

So that's -- that's in a very high level what your state Title V program is working on. You know, I -- I think it would be, you know, interesting to hear more if there are any opportunities you thought we could do to help. I know Dr. Kacica works closely with you on the toolkit that you've been working on. And we are here too to facilitate, you know, any emergency response we're supposed to have. You know, we're a part and Dr. Kacica has been part of a broader department team for, you know, health emergency preparedness. But I just wanted to share with you some of the higher -- kind of at a higher level what we are doing in the public health arm to support children. So thank you

again for letting me get on and -- and share rather rapidly, you know, overview of our portfolio.

DR. COOPER: Thank you, Dr. Siegenthaler. Marilyn Kacica, do you have anything you want to add at this point to Dr. Siegenthaler's presentation?

MS. KACICA: No, I think she did a great job. And as she said, you know, we're -- we're here to be partners. So if you have things that you want to discuss with us, you think are good ideas, you want more information about our priorities, how to get involved, you know, please let us know.

DR. COOPER: Okay. Any questions for Dr. Siegenthaler or Dr. Kacica? I think this is something we're going to have to take offline and think about a little bit there. I think there are, you know, several opportunities for collaboration here, you know. But, you know, your -- your portfolio is so vast and so broad, you know, that -- you know, that I think, you know, our part of it would, you know, be not -- not large. But I guess the one thing that strikes me, you know, is -- in hearing your presentation is that -- is that the -- the future plans call for, you know, metrics -- it --

you know, that -- you know, that -- that are suggestive of improvement in various health categories. You know, what I didn't hear, and I'm not -- this is not a criticism -- what I didn't hear is how successful you've been in the past in terms of -- you know, of meeting the metrics you set five years ago.

MS. SIEGENTHALER: Sure, yeah.

DR. COOPER: And -- and so on.

MS. SIEGENTHALER: Yeah, we'd be welcome to come -- we'd be welcome to, you know, come back and talk even a little bit more specifically say about the child health domain and the work that we've done. I just -- I kept it, like I said, at a very high level, knowing that I only had about fifteen minutes. So but --.

DR. COOPER: Yeah, no, that's fine.

MS. SIEGENTHALER: Yeah, yeah.

DR. COOPER: I'm just -- you -- I'm just -- you know, my -- my thought process is really, you know, not -- not meeting any criticism here, but basically to sort of see the areas in which, you know, you've been potentially more successful than others in terms of -- you know, in terms of meeting

the metrics that you set for yourself or yourselves, you know, and -- and so on. And, you know, whether -- whether the -- the therefore the -- the metrics you're putting forth for the next round are, you know, frankly, reasonably doable. Right? You know.

MS. SIEGENTHALER: Yeah.

DR. COOPER: I mean, we live in a -- we live in a -- in an era of, you know, people wanting to see results and you know, the performance measures and -- and so on. And -- and you know, I think, you know, our -- our goal would be to, you know -- you know, as you say, work mutually to ensure that metrics on both sides are -- are improving, right? And -- and the direction we want to see them go and, you know -- and fast enough too. So --.

MS. SIEGENTHALER: Yeah, for sure. I'll -- I mean, I'll just share, we -- you know, we struggle in the sense that this is one funding stream, and we're talking about typically our data, our population health data, and they're usually delayed --

DR. COOPER: Yeah.

MS. SIEGENTHALER: -- by three years. So it's always a bit of a give and take in relying

too heavily on some of those outcome measures to kind of understand where we are. We do like to look at them. I actually think more importantly, for strategic reasons, to figure out what are the big issues that are --

DR. COOPER: Sure.

MS. SIEGENTHALER: -- are addressing -- you know, that we need to address that are really affecting our children, right? And so the issues of mental health, you know, seeing that as so important. And so given the intersection of emergency medicine with mental health and specifically the pediatric population, that is not an area we are seeing improving. We're seeing quite the opposite. And so if we wanted to go from such a broad portfolio to maybe even thinking about some more specific topic areas, you know, I -- I think it -- we could certainly dig in in a number of locations and data might be a good way to start that conversation.

DR. COOPER: I was thinking also about, you know, the challenge of trying to reduce childhood obesity, right? You know, I -- I don't -- it seems to me, if anything, it's increasing rather than decreasing. And -- and, you know, that's

certainly true in -- in our practice here in the city. And just wondering if, you know, that's something that -- you know, that -- that the -- that the targets that you set for yourselves may be, you know, pretty optimistic. I don't know. You know, you would know better than I. But you know, these are thoughts that -- you know, that -- that I had as I was listening to your presentation.

But we really do appreciate your coming and, you know, sharing that the -- the work that you do. I was stunned, you know, to see the vastness, you know, and the degree of funding that you -- that -- that your division has compared with our own little, you know, project here and the -- you know, the relative, you know, shall we say, pittance of funding that we receive from the federal government, even though it's all part of the same, you know section of -- of you know, the federal initiative. I don't know, just scratching my head on that one. So maybe there -- there are areas in which we could work together and maybe potentially sort of broaden our own reach at E.M.S.C. in collaboration with family health. So --

MS. SIEGENTHALER: Yeah.

DR. COOPER: -- any other questions, comments?

MS. SIEGENTHALER: Well, we would welcome it. We're not far from -- we're -- we're right here at the Department. Amy knows how to get in touch with us, so we're happy to join at any point.

DR. COOPER: Great. Thank you so much. Okay. Thanks for coming and Marilyn, we'll see you next time of course. And let's move on to the next item, which is updates from our Department of Health partners and sister advisory committees, Bureau of Crisis Emergency Stabilization Initiatives. Jen Goldman and Alex Cappola, are you with us today? I don't see Alexa and I don't see Jennifer, so I guess we will have to wait till next time for a report from now. Amy, do have any information on --

MS. EISENHAUER: Hey.

DR. COOPER: -- pardon me?

MS. EISENHAUER: Sorry I had to step away for a moment. So Alexa and Dr. Goldman will be on after three because I was going by -- yes.

DR. COOPER: Okay. So --

MS. EISENHAUER: So -- so they will be

on just after three. Dr. --.

DR. COOPER: -- so we'll come back to them.

MS. EISENHAUER: Yes, Dr. Osnaga and Dr. Efflen reached out and said they don't have a report for this meeting.

DR. COOPER: Okay.

MS. EISENHAUER: Yep.

DR. COOPER: All right.

MS. EISENHAUER: So I think that brings us down to --

DR. COOPER: Peter Diane (phonetic spelling), or Brian Clemency or Susan -- I thought I saw Suzanne Burnett on. Is that -- or am I not -- am I mistaken? I do not see Suzanne Burnett. I don't see Peter Diane, and I don't see Brian Clemency. Okay. So no report from them unless you know differently Amy?

MS. EISENHAUER: I do not, but they may also just be --

DR. COOPER: Yeah. Okay.

MS. EISENHAUER: We wait.

DR. COOPER: Suzanne Stegich, and if I'm saying that correctly, I apologize if I

mispronounced. And Krista Alfonso from Bohi (phonetic spelling), are you there?

MS. STEGICH: It's Suzanne and I'm here, yep.

DR. COOPER: Great.

MS. STEGICH: So I'll -- I'll start and then Chris will follow me with the continuation of the report.

DR. COOPER: No problem.

MS. STEGICH: But it's pronounced Stegich and however you pronounce it is just fine.

DR. COOPER: Got you, okay. Thank you.

MS. STEGICH: All right. So under our child passenger safety the past year we had produced a video illustrating car seat installation instructions for limited English speaking and reading populations using the step one for the Four Steps for Kids Publication. This year we are in the process of a new script to produce the next video, which is step two in the Four Steps for Kids, which is forward facing car seat install -- installations in that series. Under our counterfeit car seat, we created a publication last year on the dangers of purchasing

and using counterfeit car seats. That publication will be available online and in print.

This fiscal year, we will have two safe transportation for all children trainings. The first of the trainings was already completed, and that was done November 8th and 9th in Schenectady County. We will collaborate with subject matter experts to create a resource on crash dynamics -- crash dynamics, which will include the misuse of car seats among families, caregivers and family service providers with special attention on proper installation and the use of car seats. Doesn't seem like we can ever get enough of that. There will be a child restraint system on school buses training February 19th at the Albany Marriott. And that training is developed for pupil transportation, administrators and supervisors along with school bus drivers and school bus monitors. And for what I understand, that class is full, which is great.

And then under our Younger Driver Safety Program, our Driver Education Research and Innovation Center, which is the free standardized curriculum for driver education instructors. This fiscal year, we're planning to hold up to four of

those training workshops throughout New York State. These trainings are taught by the members of the New York State Driver Traffic Safety Education Association. And finally new, we are working with the Think Fast Interactive Program to hold five program sessions throughout New York State high schools to increase younger driver safety awareness and behaviors. The program is offered and focused on high schools that have been recognized in the vulnerable roadway user areas. Targeted schools were sent out an invitation, and those invitations went out to the Rochester, Yonkers, Ramapo, Brownsville and Albany areas. And five have already been scheduled, so we are booked for those. And they will be in -- two of them will be in Yonkers, two will be in Spring Valley, and one will be -- be in Sovereign. So we're excited about that new program. And Chris will follow-up with the rest of our programs.

MS. ALFONSO: Thanks.

MS. STEGICH: Uh-huh.

MS. ALFONSO: Just one quick addition for myself. So actually was able to meet this morning with Amy Eisenhauer and other members of -- of the Emergency Medical services and -- and Trauma

Systems Bureau to discuss what we will be doing to create a micro mobility publication. And that is going to be specifically for folks in E.M.S. to familiarize them with this emerging issue of micro mobility safety and to discuss things such as helmet use, force when folks are involved in a crash with a micro mobility device, and we're going to emphasize the -- the kinetics of that. And that's all for us.

MR. ALBERT: Can I ask a question?

DR. COOPER: All right. Thank you so much. Any questions? Any que- -- I'm sorry. Go ahead.

MR. ALBERT: Out of my ignorance, what is micro mobility?

MS. ALFONSO: That is actually a great question. So micro mobility is -- is a broader term that's used for things like e-bikes and e-scooters. And we've -- we've seen a -- an emerging issue with that specifically in New York State.

DR. COOPER: Yeah. There's a pretty robust program in micro mobility here in the city, Kev -- Kevin. You know, the -- we see so many electric scooter and -- you know, and electric bicycle injuries here. It's probably -- in the kids

anyway -- it's probably more than half of our serious injuries now are coming from these toys, shall we say. And some of these injuries are pretty serious so, you know, it's -- it's -- it's a -- it's a problem. But micro mobility is the term of art, I -- I don't know. If you're hit by one of these things, it's really not micro mobility, it's macro mobility, you know. And certain number of our adult counterparts are suffering with this issue as well, not just the kids. Any other questions for our intervention colleagues, that's Ms. Stegich and Ms. Alfonso?

MS. EISENHAUER: I do.

DR. COOPER: Okay.

MS. EISENHAUER: This is Amy.

DR. COOPER: Go ahead.

MS. EISENHAUER: First, that might be interesting to add to the pamphlet some statistics on how many patients both pediatric and adults, right? We're seeing, and again, I know that may take some work because of how things are being documented, and we'd have to figure that out. But like Dr. Huber said, they're seeing a large amount of these patients. If we could qualify how many, that may

impress upon the people reading the brochures.

MS. ALFONSO: Yeah, absolutely. We can work with our data and epidemiology team for that for sure.

MS. EISENHAUER: Yeah.

MS. ALFONSO: Thanks.

DR. COOPER: Sounds -- sounds good. Thank you, Amy. Great point. Marilyn, do you have anything to add to the -- you know, the -- the Title V presentation that was done earlier with respect to your -- your division's activities? I would guess not, but you are listed on the agenda separately. Are you still with us? No, you are not still with us. Okay. So I guess the answer to that is no. Let's move to Kate Butler as a party and Brielle Phillips from the Health Emergency Preparedness Central Office. Guys anything new from you?

MS. RATIGAN: Hi, good afternoon. This is Deanna Ratigan on behalf of the Office of Health Emergency Preparedness. Just a couple quick updates that we have. We have -- continues to track and monitor any grant or funding updates associated with the current administration change. As others mentioned earlier, we too have had some standing

meetings and other contact points with the federal partners paused. However, the hospital preparedness program deliverable review and development will proceed for budget period two recognizing that continuation guidance will likely be delayed. So any changes in that, we will share with the group as that continues.

Additionally, OHEP continues to facilitate the previously discussed updates and revisions of the pediatric and obstetric emergency preparedness toolkit. The current goal is to be completed in June of this year and sent up the chain for final approvals. So we will continue to keep, again, this group updated on that as well. And then finally, we have recently filled the healthcare facilities preparedness manager position within OHEP. That was previously held by Kate Butler as a party and we filled that with Brielle Phillips, who is on the line. And I'm going to hand it over to her to give a brief intro of herself today. Brielle?

DR. COOPER: Please, Brielle.

MS. PHILLIPS: Hi. My voice is a little cracky because I have a respiratory illness, but I am so glad to be here. Some of you may know

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

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

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

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

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

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

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

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

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

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

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

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

So we met recently at the State Trauma Advisory Committee, just recent -- very recently. And in the pediatric subcommittee, we talked about a -- a few different things. One being some collaboratives that we're doing, including on imaging guidelines and either standardizing them following tracking compliance through each center. The things that are more interesting that were sort of new business for us are two things. One was we had a presentation from the program manager from Rochester talking about proposing a motion to require stop the bleed kits and teaching in public schools. And we're forming a small group in our interim meeting to draft a motion to that effect. We talked a little bit about the main STAC about how that would work and who would undergo that teaching because some people were concerned that we were going to propose having the children taught and stop the bleed. And I think that we're focusing mainly on teachers.

We talked a little bit about how currently nurses are not permitted to use some of the medical parts of those kits, including quick clot. So I think that we are sort of focusing on teachers at this point. And so we'll be bringing that motion

forward at the -- hopefully the next meeting. The other thing we talked about briefly is tourniquets. The -- the trauma medical director from Rochester has seen several patients recently that had negative outcomes from tourniquets that were left on too long in transport. We are from Upstate New York where transport times are -- are very long at times and not as potentially fast as more down in the city. And so talking about what E.M.S. needs in terms of guidance for tourniquets and tourniquet conversions, we're going to be talking more about that next time and also involving the other groups. And that was the main thing.

DR. COOPER: Thank you. Thank -- thank you, Kim. For all -- for all of you who don't know, Kim is chair of the Pediatric Trauma Subcommittee at -- at the STAC at the moment. I -- I -- I'm just a loyal member so --.

MS. WALLENSTEIN: And always -- always value you.

DR. COOPER: Thank you. Any questions for Kim? Okay. Well, hearing none. I did see that -- that Alexa Cappola had joined us, and so I think we can jump back up to the Bureau of Crisis Emergency

and Stabilization Initiatives. I did not see that Jennifer had been able -- oh, there she is. She did join us wonderful. So --

MS. GOLDMAN: Yeah, I think she's able to hop on.

DR. COOPER: Okay. So Jennifer and Alexa, please tell us what's going on in -- in your bureau.

MS. GOLDMAN: Sounds great. Well, thank you so much for having us here today to provide this brief update. And I can talk a little bit about the work that I have been doing, but -- but also others at O.M.H., myself, Alexa, as well as representatives from Oasis. Dr. Grace Hennessy, and others have been doing with the SEMSCO E.M.S. Innovations and Research Subcommittee. We've been working on developing -- the first step of our collaboration was to develop a roadmap for the potential for E.M.S. to drop off to the new crisis stabilization centers. And I think we were here at a meeting. Alexa and I at an earlier meeting with this group to give you a brief overview of what those crisis stabilization centers are all about or will be all about.

And Alexa, after I'm done providing this -- my portion of the update, Alexa will share just a little bit more detail about where we're at with the development of those centers across the state. But just to say a little bit more about our collaboration. So we're working with SEMSCO representatives on the development of this roadmap to really outline our goal for how to integrate E.M.S. drop off for these centers and the next step. And so that -- that document, that roadmap document, you may have some familiarity with because it was brought before SEMAC and SEMSCO for review and feedback, and ultimately approved as an outline of the work we would plan to do in the year ahead. And so now here we are getting into the details of it. And we're working on the development of a model clinical guidelines document that would outline specifically we're starting with the intensive crisis stabilization centers.

And so just for those of you who either might not have been there for our first update or certainly it was a while back, there are two -- there are two types of -- of these crisis stabilization centers. They are community based 24/7

open access centers that provide mental health and substance use care to individuals that are seeking it voluntarily. And there are two different types, there's the supportive model and the intensive model. And the -- so the intensive model has more onsite clinical services. They all -- all centers are equipped with the knowledge and resources to link individuals to community-based care. But the intensive centers have, for example, a -- a prescriber that's available 24/7 to write medications. And so we are starting with the intensive centers in terms of the -- the E.M.S. drop off guidelines and going through some just general considerations for E.M.S. when thinking about the decision of making -- bringing an individual to a C.S.C. as opposed to -- to an emergency room.

Because that's ultimately the goal. The goal is really to have another option available for patients. But certainly, and also for E.M.S. that can help to support individuals in crisis that does not necess -- necessitate hospital level care. And so the mono -- model clinical guidelines that we're developing are somewhat broad, but will include some -- some specifics such as the importance that

the individual is seeking the care voluntarily, certainly that they are medically stable, you know, within certain parameters. We really want this and we want these centers to be low barrier. So we're not trying to create a bunch of exclusionary criteria here. We're just trying to provide E.M.S. in the field some guidance for what to consider, who would be the most appropriate recipient to go to one of these centers.

And the -- the most important thing I think about this document is that, ultimately, it's -- it's just a guideline and that we're understanding that there's such variability across the state in terms of resources, in terms of how E.M.S. might operate, in terms of how the crisis stabilization -- the crisis stabilization centers might be designed. That ultimately these are guidelines that we hope then each region or each local -- you know, local E.M.S. provider and C.S.C. provider can take and then collaborate together on a shared process for how they would make referrals or how they'll do drop offs. So that's just a very brief overview and certainly as we get closer to having a document, I'd be happy to share that here for feedback.

DR. COOPER: Great. Thank you. Thank you, Jen. Is that shareable in draft form at this time or do you need to do more work on it?

MS. GOLDMAN: We need to do a little bit more work. Our -- our hope was to have some kind of shareable draft in the next, I would say, month or two. As -- as can be the case with certainly O.M.H., Oasis, government entities, we always need to have like our council weigh in and things like that. But --

DR. COOPER: Sure.

MS. GOLDMAN: -- I think the good news is there's a lot of alignment in where -- you know, from -- from the SEMSCO side, from O.M.H. and Oasis. I think we're all pretty aligned in what's important to have in there. And so now it's, you know, just going to get these extra looks and then we can open it up for additional feedback.

MS. CAPPOLA: I'll also add that --.

DR. COOPER: Yeah. Let me -- let me just say if I might. I'm sorry, Alexa, just let me just ask Jen a little bit more about that. I -- you know, I think as we've discussed in the past two things, I mean, as a -- as a group, our -- our

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

MS. GOLDMAN: Yes.

DR. COOPER: -- pretty clear guidance as to, you know, who shouldn't be going to one of your centers and should rather be going to an E.P.

MS. GOLDMAN: Yes. Thank you. Actually, I'm so glad you mentioned that because actually what I -- what -- what I did want to add in was that, well, I don't -- we certainly this guideline would not -- does not get into much into agitation management or medications because essentially -- because there is this voluntary requirement around individuals only being able to --

DR. COOPER: Right.

MS. GOLDMAN: -- go there, if they're voluntary -- voluntarily seeking the treatment. It automatically ends up discerning between individuals that would go to the hospital for that kind of, you know, agitation depending on what intervention happens in the field. But where we would really like your partnership, I mean, not only to have eyes in that regard, but also around -- we have no familiarity with some of the considerations for the children and adolescent populations around consent and voluntary -- and the voluntary nature of them

choosing to go. And so that is something actually that before -- before this even would go before any council's review or anything that we had wanted to be reaching out to all of our partner child, you know, experts to be able to give us that feedback and -- and to put language --

DR. COOPER: Yeah.

MS. GOLDMAN: -- in there around, you know -- because I think someone that is -- that was on the E.M.S. Innovations and Research Committee mentioned that, for example, unaccompanied minors. There -- there are certain considerations there around consent and voluntarily choosing. And so that's definitely an area that we want your input on and expertise. So I think as you're saying it, I do think we should probably share an early, you know, early, early, early draft, which would probably be in the next couple weeks, with -- with you and your team, so that we can have you consider all of those factors.

DR. COOPER: Sure. Yeah. I'm also thinking about the parent who -- you know, who has an agitated child who does not want to go to the E.P., but is willing to go to a crisis center. You know,

fearing stigma and all the rest of that sort of thing, you know, but they're in a position to voluntarily give consent for the child, but the child may not like it. I -- you know?

MS. GOLDMAN: That's right. Yes.

DR. COOPER: You know.

MS. GOLDMAN: Yeah. These are --

DR. COOPER: So --.

MS. GOLDMAN: -- the complexities that I think we definitely need to think through for that child adolescent population.

DR. COOPER: Yeah. Okay. Maybe we should -- we should -- once you get your draft together, Amy, maybe we should set up a call, you know, with those of us interested in this subject from our side and with Jen's team.

MS. GOLDMAN: We would like -- we would really like that.

DR. COOPER: Yeah.

MS. GOLDMAN: That would be great.

MS. CAPPOLA: And we're also collaborating --.

DR. COOPER: Alexa, I didn't mean to cut you off.

MS. CAPPOLA: No, no, absolutely not.

DR. COOPER: I didn't mean cut you off before, I -- please tell us what you've got.

MS. CAPPOLA: Well, I was also just going to add that we are also collaborating with our O.M.H. division of Integrated Community Services for child -- children and families. I know that's a mouthful. So added into our mix between O.M.H. and Oasis, we'll be collaborating with Matthew Perkins, who's the medical director of that division as well as another program individual from the kid's side. So once we're ready to have -- we're -- we're in communication with them now but when we're also ready to meet with this group, we'll -- we will absolutely invite them in to have more experts in this -- in this field.

DR. COOPER: Okay, great. So, wow, a lot of food for thought here, for sure. Any questions for either Jen or Alexa on this very interesting and very timely and very, very challenging subject?

Okay. Hearing -- hearing none. We are very lucky and honored to -- to have Elise Van der Jagt join us a little bit later in the day that I

-- I know he would've liked. But Elise we were unfortunately finding ourselves having to pass over your procedural sedation work group report earlier because you weren't with us yet. But if you have time to give us a brief, you know, statement of where you are, where your work group is with that and now would be the time.

MR. VANDERJAGT: Okay. Arthur, can you hear me okay?

DR. COOPER: We can hear you just fine. Thank you.

MR. VANDERJAGT: Okay. Thanks, I am sitting on --.

DR. COOPER: And thanks for joining us.

MR. VANDERJAGT: Yeah, I'm on vacation actually, as I -- I had told Arthur and Amy. I'm sitting here in the sunshine in Houston in the seventies, so it's kind of nice. But I didn't get a chance --.

DR. COOPER: Now, why was that necessary? It was not necessary to get into that level of detail, Elise.

MR. VANDERJAGT: Well, I just wanted

to make you all jealous, right? So --.

DR. COOPER: And you succeeded -- you succeeded.

MR. VANDERJAGT: Yeah. Thank you. And I am sorry I had to miss most of it because I wasn't able to be here for this. But anyway, the procedural sedation. We have not made any progress at this point because we had all had vacations since Dec -- in December, the holidays going on there. Our next steps really is -- was to create a survey for emergency departments. For those of you who don't know this -- this project, this project committee is looking at how pain and anxiety are -- are taken care of in emergency departments around the state, particularly with an emphasis on community hospitals not tertiary care centers, children's hospitals and looking predominantly right now, at least, at those procedures that are most common, which are basically around I.V. insertions, catheter insertions, things like that.

So our next step is to create a very brief survey that we would be able to send out to E.D. directors and nursing directors of -- of E.D.s, so that we can get some sense of one, what -- how

great this issue might be. And then secondly what could be some easy steps for us to help in those things. Things like making sure that kids have topical anesthetics to some of these kinds of things that they have opportunity for intranasal meds if necessary for them and how that would go about doing it. We -- we plan to also use the material that is on the I.I.C. website or the E.M.S.C. website. Basically, where there are resources which are -- they get in to pay attention to this as well. But anyway, right now there's no -- been no further progress in the last month and a half since we've really had our last meeting or two -- maybe almost two months now our -- our last meeting. But our plan is to move forward with -- with that project in the next few months and it will be definitely before the next meeting.

DR. COOPER: Thank you so much, Elise. Any questions for, for Dr. Van der Jagt? For those of you interested in this subject, I just want to call everyone's attention to the Society for Pediatric Sedation Program. There is an online version of their pediatric sedation course and, you know, so that those of us who are interested in this subject

and participate especially meaningfully in this subject. I invite you to take a look at the website and think about signing on to the course.

MR. VANDERJAGT: And are -- maybe I could --

DR. COOPER: Go ahead, Elise.

MR. VANDERJAGT: -- maybe I could just -- yeah. First of all, thank you for bringing that up again. Of course, I had spoken to that some -- to some degree in our last meeting. But the -- the big picture here also is to really partner, have the S.P.S., society for pediatric sedation, partner with E.M.S.C. since both organizations are very interested in the management of pain and anxiety across the spectrum of E.M.S.C. And so New York State, it seems to me, could be developing a prototype for that kind of partnership, which currently does not exist nationally, although there are also now efforts done that are being looked at.

I am on the S.P.S. quality committee and there are a number of pediatric emergency physicians who were also on that who were involved with E.M.S.C. So the idea was that this kind of a project could be a big quality assurance or not

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

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

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

MR. GREENBERG: Yeah, that sounds about right.

MS. EISENHAUER: May 5th. Yes --

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

MS. EISENHAUER: -- it's Monday, May 5th, and it will be in Saratoga, more information will be coming.

DR. COOPER: Right, right, right. Wonderful. Okay. Well, thank you so much, everyone. Does anybody have anything else that they want to raise for the -- for the good of the emergency care of children in New York State? Okay. Well, thank you all for your attendance and we hope you have a great rest of your day. Amy, as usual we've got a couple of things to follow-up on in terms of setting up a couple of additional calls.

MS. EISENHAUER: Yeah.

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

MS. EISENHAUER: Thank you, everyone.

DR. COOPER: -- and --.

MS. EISENHAUER: We can go off the record.

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

STATE OF NEW YORK

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

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

DANIELLE CHRISTIAN, Reporter

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