1/24/2024 - STAC - Albany, New York

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: January 24, 2024

TIME: 1:32 p.m. to 2:43 p.m.

CHAIR: MATTHEW BANK

LOCATION: Hilton Garden Inn

235 Hoosick Street

Troy, New York

1/24/2024 - STAC - Albany, New York

APPEARANCES:

ABENAMAR ARRILLAYA
ARIEL GOLDMAN
ARTHUR COOPER
CARRIE GARCIA
CHERISSE BERRY
CRISTY MEYER
DANIEL CLAYTON
DEREK WAKEMAN
DONALD DOYNOW
ERIC COHEN

GEORGE AGRIANTONIS
GEORGE ANGUS

JAMIE ULLMAN
KARTIK PRABHAKARAN
KATE MAGUIRE
KERRIE SNYDER
KIM WALLENSTEIN
KURT EDWARDS
MARK GESTRING
MARY IVES
MATTHEW CONN
MEGHAN MULLEN
MICHAEL DAILEY

MICHAEL VELLA
PATRICIA RILEY

PETER BRODIE
ROBERT WINCHELL

RONALD SIMON
ROSEANNA GUZMAN-CURTIS
RYAN GREENBERG
SLOAN YOSELOWITZ
SRINIVAS REDDY

1/24/2024 - STAC - Albany, New York

(The meeting commenced at 1:32 p.m.)

CHAIRMAN BANK: Okay. I think we are supposed to start the meetings now with the Pledge of Allegiance. So if you'll stand, please. I pledge allegiance to the flag of the United States of America and to the Republic for which it stands, one nation, indivisible, visible, with liberty and justice for all.

Thank you. Okay. Hold on one second. So really quick, I want -- sorry -- so I wanted to do the attendance roll call.

SECRETARY CLAYTON: Dr. Bank?

CHAIRMAN BANK: Here.

SECRETARY CLAYTON: Dr. Wallenstein?

DR. WALLENSTEIN: Here.

SECRETARY CLAYTON: Please use your mics. Dr. Guzman-Curtis?

CHAIRMAN BANK: She's here.

DR. GUZMAN-Curtis: Here.

SECRETARY CLAYTON: Dr. Gestring?

DR. GESTRING: Here.

SECRETARY CLAYTON: Dr. Prabhakaran?

DR. PRABHAKARAN: Here.

SECRETARY CLAYTON: Kate Maguire?

1/24/2024 - STAC - Albany, New York

MS. MAGUIRE: Here.

SECRETARY CLAYTON: Dr. Angus?

DR. ANGUS: Here.

SECRETARY CLAYTON: Dr. Riley.

DR. RILEY: Here.

SECRETARY CLAYTON: Dr. Agriantonis?

DR. AGRIANTONIS: Here.

SECRETARY CLAYTON: Matt Conn?

MR. CONN: Here.

SECRETARY CLAYTON: Carrie Snyder.

MS. SNYDER: Here.

SECRETARY CLAYTON: Dr. Edwards?

DR. EDWARDS: Here.

SECRETARY CLAYTON: Sheldon Teperman is excused. Dr. Arrillaga?

DR. ARRILLAGA: Present.

SECRETARY CLAYTON: Dr. Vaswinkle is excused. Dr. Flynn is excused. Meghan Mullen?

MS. MULLEN: Here.

SECRETARY CLAYTON: Dr. Ullman?

DR. ULLMAN: Here.

SECRETARY CLAYTON: Dr. Winchell?

DR. WINCHELL: Here.

SECRETARY CLAYTON: Tammy Sykes. Dr.

Dailey?

DR. DAILEY: Here.

SECRETARY CLAYTON: Dr. Doynow.

MR. DOYNOW: Here.

SECRETARY CLAYTON: Dr. Goldman? And Dr. Cooper?

DR. COOPER: Here.

SECRETARY CLAYTON: We have nineteen. We're quorum plus four.

CHAIRMAN BANK: Okay. Thank you very much. Just a -- a -- a new regulatory issue that I have to read at the beginning of the meeting. I am Matthew Bank and I have the privilege to call to order the meeting of the New York State Trauma Advisory Committee and welcome all members, participants, and observers.

As a reminder, this meeting is subject to the Open Meeting Law, and it's being broadcast over the internet. For your information, these webcasts can be as -- accessed at the Department of Health's website at, www dot health dot ny dot gov. The webcast will be available no later than seven days after the meeting for a minimum of thirty days, and a copy will re -- will be retained by the

department for four months.

There are some ground rules. The first time you speak, please indicate who you are and identify yourself as a council member or DOH staff, or in the case of the public, please introduce yourself when you come up to the microphones. Microphones are hot, meaning they will pick up every sound, therefore, ask you to refrain from rough -- ruffling papers in your open microphones, and be sensitive to personal conversations. Thank you in advance for your cooperation and for helping us fulfill the duties as described by law. And that is it. Can I have a -- a motion to approve the minutes of the previous meeting?

DR. DAILEY: So moved.

CHAIRMAN BANK: Can we have a second?

SECRETARY CLAYTON: Second.

CHAIRMAN BANK: Okay. Thank you very much. We're going to go a little bit out of order, just to -- to help people have to go to other meetings. Dr. Cooper, do you -- can you please go out of order and give us your report for E.M.S.C.?

DR. COOPER: Thank you. Thank you, Mr. Chairman. The E.M.S.C. Committee met in

December. It's meeting again next week, and there are several items on its agenda at the moment that I want to bring to your attention.

First of course, the Always Ready for Children program is hot among us. Amy Eisenhower has been getting the word out to everyone. So far there are seven emergency departments that have participated or joined -- joined in participation in this -- in this project. And we look forward to every emergency department in the state to indicate their readiness for children. But particularly, we want all of those pediatric trauma emergency departments associated with pediatric trauma centers to -- to hop on board as quickly as possible. Please contact Amy if you need any further information on this.

The -- the National Association of State E.M.S. officials is working on testing standards for pediatric transport devices. Our very own, Amy Eisenhower is deeply involved in this project, and I'm sure she'll have more to come -- or -- or more information to come to us in the near future. The -- the Pediatric Agitation -- Edu -- Education Work Group of the E.M.S.C and SEMAC

1/24/2024 - STAC - Albany, New York

continues to work on development of scenario scripts prior to moving on to actual recording. The pediatric Emergency Care Applied Research -- Research Network project entitled Treating Respiratory Emergencies in Children, is studying bundles of care for asthma. The program is being coordinated in Buffalo by the Oishei Children's Hospital Group. So more to come on that as well.

Dr. Brooke Lerner sadly left us late last year after a long-standing battle with a terrible disease. I would ask for a moment of silence in her -- in her honor, reminding us, of course, that Dr. Brian Clemency is taking over the responsibilities as P.I. for that group. Matt, can we just do a brief moment of silence for Brooke?

CHAIRMAN BANK: Absolutely.

DR. COOPER: Thank you. And finally, the -- a letter from E.M.S.C. to the world at large here in New York State, regarding pediatric pads for pediatric defibrillators, will be going out. It turns out that there's an incompatibility between certain pads and certain defibrillators which we are concerned may not be common knowledge around the state. And so we are reaching out to all emergency

departments and ambulance agencies to remind them of this problem so that the appropriate pediatric pads are used with the appropriate defibrillators. And that concludes my report. I'll be happy to answer any questions.

CHAIRMAN BANK: Any questions for Dr. Cooper?

DR. DAILEY: Dr. Cooper, if I could suggest that that information goes out to the regions and then disseminated from the regions as such notifications usually do. So we make sure we don't miss any of those agencies because the mis-compatibility of the automatic defibrillation capabilities for pediatrics with the LIFEPAK 12 and LIFEPAK 15, did indeed greet most people who heard it, as a surprise.

THE REPORTER: And if I could just get your name, please?

DR. COOPER: I'm sure that's the way it will -- it will --

MR. DAILEY: Dr. Dailey.

DR. COOPER: -- be distributed, Dr. Dailey. As you point out, that's the usual mechanism for distribution, and I -- I know that Amy Eisenhower

will make -- see that that happens. Thank you.

CHAIRMAN BANK: Any other any other questions for Dr. Cooper?

DR. COOPER: Again, we're meeting again on February 1st of this year. Just about ten days. Thank you.

MS. MAGUIRE: WebEx?

DR. COOPER: WebEx, yes.

CHAIRMAN BANK: Okay. Again, going a little out of order. Eric, who was going to present for Ron Simon at the -- for the Systems Committee.

MR. COHEN: Hi. Thank you, Eric Cohen presenting for Ronald Simon on behalf of the Systems Subcommittee. So the Systems Subcommittee met this morning. We talked about three different items specifically. One was regarding the 405 Regulations and the current status of them right now. And Director Greenberg, and correct me if I'm wrong, but the 405s are under emergency status and are being reviewed, they'll be going out for public comment. And the other part of the 405 Regs regarding the nurse reviewer and the removal of that requirement for visits, is not under emergency status and is also out for current review. And both will eventually

come back to the department to go through the fifth process.

DIRECTOR GREENBERG: The fifth project -- process. Yes. So the related -- I was going to start singing -- the current, the -- the Orange Book to the Gray Book -- see, they really want me to sing. The Orange Book to the Gray Book that is out. So that's in emergency regs. It's in effect today. That's why we're able to go by the new book.

In that process, it did go out for public comment, actually, and that comment period was closed. It goes to FIPIC, I believe, either this month or next -- next month, for the February meeting for final sign off on it. And then it will go into permanent regulation. If for some reason there's a delay in that permanent regulation or something along with that, then they would extend that emergency regulation period for another ninety days.

The other regs related to nurse reviewer is going through the traditional process. That's the one that is in their discussion period right now. Then that will go out for public comment period. When it does, we will make sure to share that with this group so that they can make any

comments that they wish. And then once that's concluded, it goes out for a public comment for sixty days. Once that comes back, it determines if there's any significant changes that needs to occur. If there's no significant changes that needs to occur, then it will move forward to FIPIC for final adoption.

MR. COHEN: Thank you for the clarification. We also discussed the New York State Trauma Registry Report. This is something that we just started discussing at the last STAC, and what do we actually want to see coming out of the New York State Trauma Registry. And specifically what impacts Sparks Data is actually having on the New York State Trauma Registry and is Sparks Data necessary to get a quality report from the New York State Trauma Registry. So there's going to be a subgroup form to take a look at that between Dr. Simon and Christie Meyer, and will be addressed between both the systems committee as well as the registry committee. It's sort of going to overlap.

And then the third topic that we discussed was, how are we getting non-trauma center data back, so that we can utilize that as part of the

New York State Report? Dan Clayton advised us that the requirement is in the current regulations, but we have no mechanism for those centers to feed back the data to either the state or to another trauma center. So, again, that's another topic that the Systems subcommittee is going to undertake. In addition to those three topics, we had three presentations regarding the recent changes from Orange to Gray Book, and from three centers that have undergone reverifications already. And that was Jean Roxum, from New York Presbyterian Morgan Stanley Children's Hospital, myself from Maimonides and Chris Gaverno, and Esther Cohen from Staten Island University Hospital. And that concludes my report.

CHAIRMAN BANK: Thank you very much, Eric. So we're just going to go back into our normal order of things. First is the bureau update, right?

DIRECTOR GREENBERG: So I'm going to keep it short. The big thing is just the regs, again, the emergency regs that are in place right now, as well as the other regs and changes moving along. When the other regs do come out, so the -- the nurses -- nurse reviewer, when that does come out for public comment period, which happens on in the

registry, we'll share it as permitted. We -- we are aware of it, and it is equally as important to get positive or feedback about that one as if -- much as getting feedback that says, hey, you know, we think this should be changed, or something else.

So just keep that one in mind if you are there and have that opportunity to provide some positive feedback as well. If you believe that is the change that should occur, it's also your opportunity, if you believe that that change shouldn't occur or it should look differently, that's your opportunity to move that forward as well. So please keep that one in mind.

So the bureau is moving along and like I said, just keeping it short today, there's a lot of really good things going on, particularly in the E.M.S. world. The governor's budget has a number of initiatives in the world of E.M.S. and -- and we are working along with the governor's office to facilitate any assistance that we can provide to them related to the budget and the budget initiatives. And we continue to work with FIPIC and the E.M.S. community related to offload times. We know that that is an ongoing problem within the E.R.s, and that

is trickling into our Trauma communities as well in understanding, you know, to make sure there's the availability for our Trauma community to be able to do what they need to do on a regular basis.

So there's a working group between the SEMSCO and the -- the FIPIC committee, which handles the hospital regulations, to see what they can do to identify and work forward on that one, to help with offloading times. We absolutely have regions that have in regular occasions, two-to-three-hour offload times for patients when the E.R. arrives, when the ambulance arrives. And so we're trying to work through that one so we can do for solutions.

There's been a number of staff movements within the department. Really happy to see a lot of positions being filled in the Department of Health, including some new positions coming into the Bureau of E.M.S. I think by May, you'll see some of those new positions filled. We've filled a number of them in the past couple of weeks. But with that, we also are sad to say that our own Patty Riley has accepted a promotion with another part of the Department of Health. So we're happy that she's staying in the Department of Health. But -- so our

Trauma Program Manager will be leaving us and hopefully we'll go out for recruitment with that, you know, shortly after. But I just want to say and extend my extreme gratitude to Patty for her past two years as a Trauma Program Manager, the work she's done, the site visits we've done together with many of you and just everything you've done to help move Trauma forward. So, thank you, Patty.

With that, I'm going to end my report, but I'm just going to see if Patty wanted to say anything.

MS. RILEY: No, thank you.

DIRECTOR GREENBERG: You got to say something.

MS. RILEY: No. No.

DIRECTOR GREENBERG: Nope. All right. She says nothing. First time for everything.

CHAIRMAN BANK: Okay. Going to the promo program update, Dan?

SECRETARY CLAYTON: So that -- that was the largest update was that we're -- we're losing staff to a well-deserved promotion. We continue to receive applications for level III trauma centers. We're working with a couple right now to get

designations out. So particularly upstate, we're also hearing from some trauma centers more downstate that are looking to move from level III to level II. And that may be something that comes up during trauma needs assessment, perhaps a little bit later. But obviously the -- we're -- we have a lot on our plate, and with Patty leaving, fewer staff, but Director Greenberg and Deputy Director Dziura are trying to create some new positions that would be dedicated full-time equivalents, more than just one for full-time equivalent for the Trauma program. So -- and they would also additionally be in nursing titles. So applaud the department executives for making the decision to try to push forward some -- some new positions to support the Trauma program.

Other than that, you know, I'm -- I'm also working in agency licensure now, so I'm overseeing another bureau -- another section in the bureau. And we're hiring staff under that -- under me for that. We're also training a new staff member in that area, so it's just a lot on the plate, and we appreciate your patience. Please continue to stay in touch with me. If you have changes to your Trauma program, staffing changes, please keep me advised and

Patty, until she leaves, February 14th, of -- of changes to your Trauma program, staffing locally. I think with that in mind, unless there are any questions that completes my report. Thank you.

CHAIRMAN BANK: Thank you very much. So, moving into the Executive Committee, a few things. So first of all, the next STAC will be May 29th at this hotel. So the next STAC will be May 29th at the Hilton Garden Inn Troy. So number two, I want you to take a -- a quick just interest poll, as was discussed, at the Registry Committee. Every registry is going to have to start moving to a A.I.S.15. So we were thinking of trying to offer a A.I.S.15 training course with the next STAC. The next STAC is May 29th. That's a Wednesday. It A.I.S. is a two-day course. That Monday is Labor Day, it's a holiday. So it would be the Thursday and Friday after STAC. It would be May 30th and 31st. The course would be about nine hundred dollars per person for a two-day course. Just so you guys know, seven hundred and fifty dollars of that goes directly to the -- to the people who are teaching the course. And it'll be about hundred and fifty dollars for us to get the hotel for two days per person.

So, just real quick, is anyone interested or have their staff be interested in taking an A.I.S.15 course with, in conjunction with the next STAC?

So, bunch of people. We have to have a minimum of fifteen people to guarantee them. And George is going to come twice. Okay, very good. So, we'll -- we'll send that out. Again, it's going to be -- if -- if we can get the hotel, and it's a big, if it would be about nine hundred dollars per person, it would be the Thursday and Friday directly following the STAC.

Separately than that, there are seven STAC positions that are open. We talked about this, at the last STAC. Some of the delay in filling these positions has been -- we have old bylaws and we've actually submitted new bylaws to be -- to be vetted. Some of the positions are not the same. Out the seven positions, there are six of those seven positions are still on the STAC on the new bylaws. And three of those six are described differently than the old bylaws.

There are three positions that are the same, and they're new bylaws. The old bylaws, that's

the vice chair position, the burn surgeon position, and the Nassau County RTAC position. The Nassau County RTAC, their leadership resigned, so the Nassau County RTAC will have to figure out who to nominate for. They have two seats, and one of their seats are empty. So they will figure out who to nominate, hopefully by the May STAC.

We have several nominations and self-nominations, for the burn surgeon and the vice chair. As per our bylaws, what we have to do is they have to go through a nomination committee. The nomination committee will then vet them to make them -- to make sure that they are appropriate candidates as per our bylaws. So, for example, the vice chair has to be a physician, so they'll go through the different qualifications and make sure that the -- that the people all vet correctly.

So we actually had made up a -- the nomination committee has to be made up of vetted STAC members, can -- obviously cannot be any STAC member that is nominated for this position. So Roseanna Guzman, George Angus, Kerrie Snyder, all agree to serve on the committee. And they're just going to vet the -- anyone who wants to be considered for

these positions, they're just going to vet the -- that they meet the qualifications for the position. The vice chair will be a election at the next STAC in May.

Any questions about this? Okay. If we could then go to the Registry Committee, Cristy?

MS. MEYER: Cristy Meyer, co-chair of the Registry Committee. We had a robust meeting this morning and happy to share some updates. And then we do have some business to do. There are a few motions coming out of the subcommittee for us to discuss. So first -- first of all, we have a new data dictionary that comes out each January. We're a bit delayed this year because we had added collecting the first P.C.R. into the referring hospital as a whole new set of fields. So in addition to the P.C.R. coming into your building as the final trauma center, we want to collect the first P.C.R.

There are some limitations with that, but the vendor and mapping updates are quite significant. So that will be delayed until January 1st, 2025. It will also allow us a little extra time to help get that record, maybe coming more frequently to the referring -- the receiving hospitals.

In addition, we in following up on some action from STAC last year, the Sparks process for reconciliation and really getting the data ready for final report. The DMAR Team from the Department of Health did a formal review. We will review the report from them with the new DMAR Director and make some recommendations at the upcoming STAC meeting, of whether we need to continue that validation process, or we feel that we have good enough data to just go forward with the reports from the Department of Health.

The 2023 Trauma Registry work group proposed the following edits for 2025; dead-on-arrival and dead in the emergency department, definitions were not standardized throughout the state and certainly throughout the nation. There was a lot of variability. So we also looked at the E.D. discharge date and time to revise the data dictionary. So this is just the highlight of things that are coming in May when we make final formal recommendations on how to revise those definitions. We do have a motion about the D.O.A. and D.I.E. which we'll talk about in just a moment.

We also had a presentation by Carrie

Garcia, the trauma program director from H.H.C. Jacoby. She gave a nice presentation about validating TQIP data and really shared that with the team. One of the biggest things are certainly top of mind for many of us, is that in January 1st, 2025, we would be required to report A.I.S. codes throughout the state and the nation in version 2015.

There was a recent notification that some of the vendors have contacted end users in the state, potentially about maybe two thirds of vendors. End users in the state may be impacted by a vendor that is not going to upgrade to meet that standard, and will require a full transition to a new product or a transition to another product. So this really is a huge transition, takes a long time. And the Registry Committee suggests that we follow-up with a few actions, but certainly a potentially a vendor showcase and a town hall for Registry members and Trauma Program leadership, to see what's out there and to hear how the transition's going for other people so they can plan their transition.

At the current state, about seventeen Trauma centers potentially have a -- a timeline that's not clear to meet that standard in January,

which is required by the A.C.S. for data submission. In addition to that, we have just a call for volunteers for our next STAC meeting to do a presentation, but also the next data dictionary work group to look at where data's moving in the State. Which brings us to a few motions that are coming out of the subcommittee today. I know they'll bring them up on the screen so we can look at them and have some discussion.

So, motion one is a motion from the Registry Subcommittee to immediately implement and include the new standardization of Dead-on-arrival and Dead in the Emergency Department, definition to the 2024 New York State Trauma Registry Data Dictionary. I can read to you the definitions; the Dead-on-arrival will be standardized to be a patient who arrived without a pulse or vital signs, and despite any resuscitation, did not regain a pulse. That patient would be considered a D.O.A. D.I.E., would be a patient that arrived without a pulse, regained a pulse, and then ultimately lost a pulse to expire in the emergency room, or arrived with a pulse and -- and lost the pulse and never regained it. So that would be the standardization. It would go in

the forward of the dictionary to give some inclusion and some data use information to end users. That was motion number one.

CHAIRMAN BANK: So everybody, any questions about motion number one? Okay. Can we -- you want to vote on motion number one? Everybody who feels yes, on motion number one, please raise their hand. I apologize, who had a comment?

MR. DAILEY: Well, I'm trying, but my microphone won't work. Sorry. I just wanted to clarify. So if I've got a patient that comes into the Emergency Department without a pulse, but we do a full cord press, including massive transfusion on this person, crack their chest and then they remain pulseless, that person is a D.O.A.?

MS. MEYER: Correct. And that is a change from some practice. Any procedures, people would consider that died in the Emergency Department, but the patient came in without vital signs and a pulse, never regained vital signs and a pulse. So that is a person who is dead.

MR. DAILEY: Have we confirmed whether or not this will ultimately end up leading to any billing concerns, because if we define somebody as

dead-on-arrival, yet they get billed for an hour of critical care time, is that a potential conflict?

CHAIRMAN BANK: So the -- the definition goes to the Registry, the State Registry, but it's not going to go to Blue Cross, Blue Shield or Medicare or Medicaid or anything like that. So this is for our registry, the definition. And the New York State Registry does not line up with a lot of things with C.M.S. and Blue Cross, Blue Shield and G.H.I. So we're not saying that we're changing the definition for insurance or Medicare and Medicaid. We're saying we change the definition for the Trauma Registry in New York State.

MR. DAILEY: So, Matt, can I follow-up with a different question? I'm sorry.

CHAIRMAN BANK: Matt?

MR. CONN: So just for clarification for everybody, this was a standardization for years. Different facilities, different programs have been collecting things different ways. And this is to provide guidance on standardization on what the definition of dead-on-arrival arrival versus dead in the E.D. is. Some people used to thoracotomize, master transfusion, did all the things thirty, forty-

five minutes an hour, trying to get somebody back, came in without vital signs or signs of life. They did all those things. They never got them back no matter what. That patient did in fact show up dead-on-arrival, and they remained dead despite anything that you did.

We, each, over time, all the different programs have had different conversations about what does this look like for you? What does that look like for you? And even doing research online, there is no standard definition that is widely accepted amongst the Trauma community. So this is our attempt of standardizing what we're saying was a D.O.A. even though the -- the N.T.D.S. pick list for E.D. discharges deceased expired, we are further clarifying our registries going to N.T.D.S. the N.T.D.B. as a deceased expired. What type of a deceased expired does that look like for us?

MR. DAILEY: No, I certainly appreciate that. And -- and really like the idea of standardization, I'm just worried whether or not we're creating any additional exposure anywhere else down the line. And I -- I know the registry doesn't

and billing are -- are separate, but at some point, the billing folks are going to turn around and look at the way it was coded somewhere else, you know, just --

CHAIRMAN BANK: No they're not --

DIRECTOR GREENBERG: Let me -- let me ask a question here. Cristy, this will be to you. Does it have to be that short of a term or could it be longer? Meaning if we were to add a few words into that, that said, dead in the E.R. post care -- or dead-on-arrival, post critical care, and you mentioned some other things, Dr. Dailey or something else, but that would help to clarify it. Still giving what you're looking for, but also not possibly raising concern.

CHAIRMAN BANK: Just so -- so your hospital will handle this, however, they already handle it. If they admit these patients, they don't admit these patients. They send bills, they don't send bills. I -- I don't see your hospital at all, ever looking at the New York State Trauma Registry, and right now the definition of complications in New York State Trauma Registry are different than the definitions that your hospital uses for VAP and

1/24/2024 - STAC - Albany, New York

(unintelligible). And so -- so those -- so again, we -- we control the New York, lack of a better word, control the New York State Trauma Registry. We're trying to figure out our risk adjustment for mortality as fair as possible. So it will affect that, but it will not affect whether this patient is currently admitted or not admitted at your institution, whatever your institution does in terms of their -- their billing practices.

MS. MEYER: I just want to add one piece that this is what piqued the group's interest in talking about this, is that we had a longstanding include -- exclusion in New York State, that if you came in and you were pronounced dead within three minutes of arrival, you would be a D.O.A. Then if you did an I.V. it wouldn't count as a procedure or any of the resuscitative measures, but if you did a thoracotomy, it would be marked as a D.I.E. And what sets what -- one procedure aside from another one. And that -- that was what some of the confusion was. What we're trying to get to is -- is this person salvageable? If you never had vital signs and you never get any -- it's very different than someone who maybe came in with a pulse, lost the pulse, despite

maximum resuscitation, expired in the emergency room, and never really got out of the room.

So I think that's the intent here. It's certainly not to guide any of the billing, any of the documentation practice that anyone's doing. It's more on the kind of backend of P.I. that these patients should be included in the Trauma Registry to tell the story. This is why things like vital statistics are important, like who doesn't even make it to us. So I think that's the intent here. If there's a language revision, I'm -- I'm happy to bring it back if that's what we think.

MR. DAILEY: I just want to be perfectly clear. I -- I absolutely like the idea of clarification. I like the idea of -- of some -- some guide rails that really help make sure that the -- the data's the same. All I was worried about was the potential for exposure by having two very different things going on. That's all.

CHAIRMAN BANK: Mark?

DR. GESTRING: It's -- so, yeah. So I'm just representing a question, which I don't know if we have a chat, but this is Dr. Flynn texting, asking why is a pulse needed? P.E.A. can be

resuscitated. So a patient who has electrical activity, when they come in, they don't have a pulse, but we're going to do different things than for somebody who doesn't have electrical activity, would that fall under your D.O.A. category also because they didn't technically have a pulse?

MS. MEYER: Again, you never -- you never had any vital signs and never named any --

DR. GESTRING: Well, it's -- it's P.E.A. -- do we consider that? I mean, in a trauma center, we would -- we do procedures based on that. So it's not a palpable pulse, but it's a finding that we -- you know, we have electrical activity, we use an ultrasound, we see that the heart is trying to do something, we will go on and do procedures. So I -- you know, I'm just concerned that a -- a patient who comes in dead and stays dead is different than a patient who comes in dead and spends an hour getting procedures and certainly not an I.V. but like you said, revo -- thoracotomy, you know, bilateral chest tubes. I think the Registry would get awfully confused or confusing by figuring out which patients get all those things and which ones don't, I think. And that was my understanding of this earlier

definition, and I have no problem with clarifying the earlier definition, but you're making the term died in E.D. go away, right?

MS. MEYER: No, that's --

CHAIRMAN BANK: No -- no -- no --

MS. MEYER: -- actually going to s --

DR. GESTRING: So they're the same?

MS. MEYER: Yeah --

CHAIRMAN BANK: No. So if you -- that's if you come in with a -- with a pulse and you die before you get out of the E.D.?

DR. GESTRING: Right.

CHAIRMAN BANK: Or if you come in without a pulse, you're resuscitated, you gain a pulse, and then you die before you leave the E.D. then you'll be dead in the E.D.

DR. GESTRING: So I guess (unintelligible) never gets a pulse that's the question.

CHAIRMAN BANK: Because if you're -- if you're in P.A. and you never get a pulse back and the entire time or whatever you do, that will be D.O.A. The -- the issue here, which a lot of T.M.D.s, myself included, were uncomfortable with, is

that it felt like some people were making decisions affecting the medical judgment of -- of what this patient is going to be classified as. So if in your medical opinion, we should do a thoracotomy or (unintelligible) on every single patient that comes in without a pulse, that -- that -- that's up to you. But there's still in the same class, there's still the same risk for mortality for all the other patients who come in without a pulse that we don't do these procedures on.

MS. MEYER: You know, and if you look at TQIP and other measures where we standardize, P.E.A. is not a measure that they're recording or using as a sign of life. So although we have algorithms in our centers, this is -- the intent is not to record an algorithm. This is really an outcome measure, and we want to be looking at it the same way, I think is really the comment here. Rather than, you know, if you have that in your algorithm that P.E.A. will get, you know, these interventions, this is -- this is not intended to supplant that at all, if that makes sense.

MR. DAILEY: I guess the other thing, Mark, would be, you know, in -- in terms of how --

what you -- when you look at a P.E.A. right, a -- a sinus of a hundred and forty, is very, very different than a wide complex P.E.A. at twenty. And if I drop an ultrasound probe on somebody's chest and they've got a sinus rhythm, and I'm seeing squeeze at that rate, that means I'm not feeling a pulse, but there could very well be a pulse, you know, and that one is probably going to be someone who ultimately dies in the E.D. if -- if we do resuscitative measures rather than someone who came in as a D.O.A. Does it have to be a palpable pulse or can it be a dopplerable pulse or an ultrasound evidence of a pulse, right?

MS. MEYER: So it's -- it's very interesting you bring that up because that was in the literature. When we looked at probably, I want to say like ten resources, the cardiac echo, you know, that you're doing, that imaging that you're doing in the Trauma bay, was an endpoint for people to determine if there's some kind of vital sign or sign of life. So if that's a clarification that -- that we'd want to add, that that would be considered, you'd have to have that very clearly documented in the record that -- that was present. But I'm not sure that changes the answer. I don't -- you know,

whether that's perfusing or not. And --

CHAIRMAN BANK: So do you want just restate the motion and then we could -- we could vote unless there's any other discussion.

DR. WINCHELL: So I would argue that we are trying to find out how many angels can dance on the head of a pen, and that all we need to do is come up with a standard definition. It isn't perfect. There won't be perfect, and it's always something you can start a fight in the bar over.

THE REPORTER: And what's your name?

DIRECTOR GREENBERG: But if you do know the answer to that question, I would like to know it.

THE REPORTER: Name for the gentleman that was speaking prior to --

CHAIRMAN BANK: Yeah. Last -- lastly, Jamie, before we before we go to this. The -- the last -- the last gentleman was Dr. Robert Winchell.

THE REPORTER: Robert Winchell, yeah.

MS. ULLMAN: Yeah. Hi, it's s --

DR. WINCHELL: Sorry about that. I thought I had more notoriety than that.

MS. ULLMAN: Yeah. Hi, it's Jamie

Ullman from -- so I -- yeah, I would have to say that if you were to define concussion, it's like forty different definitions of a disease process. If you can define cardiac you know dead-on-arrival versus dead in the E.R. then it's -- it's going to be a lot of contention about those definitions as well. In fact, I was going to mention P.E.A and I should have -- I would've looked like a smart person, but I would say that if -- if we come to some agreement that if a person has -- I don't know if -- if electrical activity is really considered significant in this definition, but yeah, I mean, if we could come to some sort of definition, I think that would probably be better for the Registry.

CHAIRMAN BANK: So the -- the -- the point of all this was to standardize the definition. So everybody's risk adjusted mortality looks the same. If, you know -- if -- if you don't standardize it, and people using D.I.E. instead of D.O.A. will affect their risk adjusted mortality. Okay. Last comment, Dr. Cooper, before we have to move on.

DR. COOPER: The proposal is simple, it's reasonable. Let's approve that.

CHAIRMAN BANK: Okay. So, Cristy, can

you restate the motion one more time and then we'll just vote?

MS. MEYER: Okay. And the motion from the Registry Committee to immediately implement and include the new standardization of dead-on-arrival and dead in the emergency department definitions that the 2024 New York State Trauma Registry Data Dictionary.

MS. ULLMAN: I second the motion.

CHAIRMAN BANK: Okay. All in favor, please raise your hand. Okay. All opposed? Motion passes. Thank you.

MS. MEYER: That clarification will be added to the 2024 Data Dictionary that will be going through the approval process probably next week. Thank you. The second motion is a motion from the Registry Committee to immediately implement and include the removal of exclusion reason number five, related to D.O.A. or dead-on-arrival, in the 2024 New York State Trauma Registry Data Dictionary. So again, this is that kind of legacy feel where the dead-on-arrival, if you pronounce the patient within three minutes of arrival. We're removing that exclusion, it actually is contradictory to N.T.D.S.

inclusion criteria.

CHAIRMAN BANK: Anyone to second the motion? Second -- everybody who -- any -- any discussion? Good? Anybody -- everybody raise your hand for -- for yes. Okay. One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen. We have about twenty people raising their hands, so the motion carries.

DIRECTOR GREENBERG: So only the people who are vetted members, going one more time. Thank you.

CHAIRMAN BANK: One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen. Seventeen. So the motion carries. Next motion?

MS. MEYER: Okay. Two more action items. So, motion number three is a motion from the Registry Committee for the STAC and the Department of Health Bureau of E.M.S. to write a letter to the A.C.S. about the New York State impacts of gaps in vendor updates related to the A.I.S. 2015 data collection and submission.

CHAIRMAN BANK: Can anyone second the

motion? There you go. Discussion.

MS. SNYDER: No, I just want to state the importance of this, that we cannot just sit by. A week has gone by since E.S.O. has sent us a letter saying that we have eleven months to have two thirds of us transition to a new registry, and that's just in New York State. There are forty-nine other states that are impacted by this.

We -- I think we have to have a very -- very strongly worded letter to the college of the impact that this is going to have on our ability to remain compliant with the American College of Surgeons, because anybody who's going to be in a reporting year, is going to be trying to report out first out of two registries, but more importantly, there's just literally no way that it is possible for all of us to transition and remain compliant by December 31st.

THE REPORTER: And your name, please?

MS. SNYDER: Kerrie Snyder.

THE REPORTER: Thank you.

CHAIRMAN BANK: Any other discussion? Okay. So Cristy, to just restate one more time --

MR. CONN: Well, I -- I -- I'm sorry,

Matthew --

CHAIRMAN BANK: Oh, there's Matt, go ahead.

MR. CONN: New York City RTAC. Do we have a sign -- I -- I -- understand the spirit of the letter and I -- I agree that it -- it is necessary. Do we have a recommendation on what that language would look like?

MS. SYNDER: Four letter word.

CHAIRMAN BANK: No four little words.

MS. MEYER: Just -- so Cristy Meyer from the Registry Committee. we did a very small poll to understand that about seventeen Trauma centers have already suggested that this timeline is unclear for them. So, to meet the standard by January 1st, 2025, it really is very impactful to many centers across -- across the state. And I'm not sure where these timelines are going to be. So, just to give you a -- just a snapshot, that was -- I think there were over thirty responses is about seventeen centers that suggested, and then maybe a couple others that really weren't aware. In a typical fashion, the vendors will update to, you know, the incoming new fields and definitions and even, you know, larger

changes like this by the deadline of when you're collecting data.

This was a notification really about ten days ago, that many of us would be impacted by non-compliance because they would -- they did not intend to update the product we're currently on. So that was you know, a bit of short notice when you think about the timeline of executing this kind of transition.

MS. SNYDER: I -- I mean, you're -- Kerrie Snyder, again. You're looking at -- so anybody starting January next year, you can't enter charts, right? Because you can't do you're A.I.S. codes because you don't have the fifteen codes. So your registries are dead. After December 31st, your registries are dead. So if you don't transition until -- I mean, it took us going from Trauma I server base to web base, eighteen months with the same company, right? Similar fields. It took us eighteen months.

Starting January, 1 of next year, if it -- if you don't get your transition done for fifteen or sixteen months, you're going to literally have five or six months, you are not going to be

entering data. What are you going to do? You're going to have reporting periods come up. You're going to have requirements to submit to TQIP, which is now a standard in the Grey Book of compliant. You have to be compliant per quarter.

So there's a lot of impacts to one company deciding that we all had eleven months to transition to new registries, and none of it is going to benefit New York State. None of it's going to benefit any hospitals in the country, but people need to really understand, really think about what this means for you. Are you -- are your registrars able to be five or six months behind before they start catching up again? When's your next reporting period? How far behind are you going to be? Are you -- do you have a reporting period starting in July? You're going to have six months in, and then you're not going to be able to collect data. What's going to happen to your verification? So that's the kind of letter we need to send to the college. It's the kind of letter we need to send to E.S.O. which I think was our -- was that our second motion or --

MS. MEYER: That's the -- the fourth motion.

MS. SNYDER: That they need to really understand this. This is -- this is not a -- a sustainable situation for us to maintain A.C.S. verification status, giving eleven months to transition to a new registry.

MS. MEYER: I just want to add that there's a -- a New York statewide impact to this, because this transition will affect our upload to New York State. So it's taken us a -- a few years, certainly to get that back up and running, and we've been consistently submitting data. And again, this -- every time there's a transition like this, it impacts that upload also. So it's national and it's state upload and all the resources that go along with implementing a new registry and up training people. So it's -- it's -- it's pretty massive.

MR. AGRIANTONIS: So, this -- this George Agriantonis, New York City RTAC. So we consent -- I support sending a letter to the A.C.S. to inform them of the -- what is impending crisis here, but what are we even expecting them to do about it? Like, there's nothing they could really do. This is a -- a problem initiated by the vendor, and I don't know what the -- what we would even ask from

the A.C.S.

MS. SNYDER: So the E.S.O. had told us that they had spoken to the A.C.S. and the A.C.S. said that they would take it into consideration for verifications. Do we really believe that?

MR. AGRIANTONIS: Well, if you have no data in your registry, how are they going to take that into consideration?

MS. SNYDER: This is -- it's -- this is just a giant, giant, giant, massive problem. And it's not just -- it is every state. I don't -- they weren't -- they did not answer. I asked -- E.S.O. was actually -- they came this morning. He did not answer. We asked them like, how many Trauma centers they had, we did not get an answer to that because their workforce has to do this work as well. Right? Do they have enough people to transition the entire country in eleven months?

CHAIRMAN BANK: So, what -- so let's just restate the -- we have a representative from E.S.O. here, but let's just restate the motion and -- and we can just vote real quick. Cristy?

MS. MEYER: The motion from the Registry Subcommittee is for the STAC and the

1/24/2024 - STAC - Albany, New York

Department of Health Bureau of E.M.S. and Trauma Systems to write a letter to the A.C.S. about New York State impacts of gaps in vendor updates related to A.I.S. 2015 data collection and submission.

CHAIRMAN BANK: Okay. Anybody for the motion? Yay. Raise their hand. One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen. So sixteen, so the motion passes. Your next motion, Cristy?

MS. MEYER: The final motion from the Registry Subcommittee is for a motion from the Registry Subcommittee for the STAC and Department of Health, Bureau of E.M.S. and Trauma Systems to write a letter to the Trauma vendors requesting -- requesting end user contact, providing a clear timeline for conversion to A.I.S. 2015 and the resources available to each center.

The spirit of this is that some end users have not been contacted either way, whether their registry is impacted yet. And in addition to that, some of us who have been contacted, we don't have a clear vision of what resources will be available to us to make that upgrade in the expected

1/24/2024 - STAC - Albany, New York

timeline.

CHAIRMAN BANK: Any discussion? So everybody who is for the motion, please raise your hand. One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen. So seventeen for the motion. Any abstentions? Any noes? Motion passes. Cristy, is this the last motion?

MS. MEYER: This concludes the Registry Committee report. Thank you.

CHAIRMAN BANK: Thank you. So now we're going to move to the Trauma Center Needs Assessment, Dr. Winchell.

DR. WINCHELL: Good afternoon. Robert Winchell, Chair of the Trauma Center Needs Assessment Committee. So we have one action item from the committee. We were again, going through the process -- recently established process for a needs assessment for all new Trauma center verify -- or designation applications. As previously noted, we have three in the pipeline, which have not yet completed the paperwork. So we haven't actually started on the assessment, two of which are Level III applications, I think one of which is a Level II to

1/24/2024 - STAC - Albany, New York

Level II upgrade application.

In the process of that discussion, it was felt that the current regulatory framework may or may not be robust enough to actually allow the Department of Health to say no to a designation request, if that was the recommendation or the feeling of the STAC and the D.O.H. And so we plan to -- or we propose to use the document that we created for the current needs assessment as a framework to create a regulation, if that will work, or if we have to work up to a bigger statutory change. But to create the language that would enable the Department of Health to make the designation decision, regardless of whether or not the hospital passes verification by the college. So do we have the text of the motion that we're bringing forward to the committee?

CHAIRMAN BANK: So, Rob, can you just read the motion and then we'll --

DR. WINCHELL: I -- I can't read it from here. Somebody who's a little closer might be able to.

CHAIRMAN BANK: Dan -- Dan, can you please read the motion?

SECRETARY CLAYTON: The motion -- I'm trying to figure out how to increase the font. Propose that the Department of Health use the existing needs assessment tool be used as a -- as the groundwork for a regulation to make decision of Trauma Center Designation regardless of the American College of Surgeons, A.C.S. verification. A.C.S. verification is a necessary condition, but the final decision of designation will be determined by the Department of Health.

MR. WINCHELL: All right, thank you. So that -- that's the motion that we would put forward to the larger committee.

CHAIRMAN BANK: Any discussion on the motion? Everybody who's for the motion, please raise your hand. Ten, eleven, twelve, thirteen, fourteen, fifteen, yes. Any abstentions? Anyone voting, no? So the motion would carry. Dr. Winchell, any other --

DR. WINCHELL: No. I think the only other informational piece we had is that we are continuing discussions around how and where we might look to find funding for Trauma Systems Consultation from the American College of Surgeons. And that's an

ongoing -- ongoing process. Thanks very much.

CHAIRMAN BANK: I am being told that we only had fifteen votes, but we need -- can we do one more time? We need one more vote. Just to vote on Dr. Winchell's motion, which is still on the screen. Just raise your hand one more time. I apologize.

DIRECTOR GREENBERG: Just to -- just to understand, you need sixteen to pass a motion because that is the number for -- total number.

CHAIRMAN BANK: One, two, three, four, five, six, seven --nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen --

DR. WINCHELL: Did somebody disappear between our last --

CHAIRMAN BANK: Yeah. Seventeen people are yes.

DIRECTOR GREENBERG: Yes, but not that many.

CHAIRMAN BANK: Any abstentions, any noes? We have seventeen, so the motion does pass. I hate to go back in time, but Ryan's mentioned we have a representative from E.S.O. here. Any comments on the -- the previous motions?

DIRECTOR GREENBERG: Did you want to talk at all or speak? It's up to you.

CHAIRMAN BANK: Any additional questions for our E.S.O. representative that were not asked this morning in the Registry Subcommittee?

DIRECTOR GREENBERG: That works. That saves everybody some time. And I'm sure we can work on setting up some additional meetings or things in order to coordinate any other questions of people who weren't able to attend today. Would that work? Wonderful. Thank you so much.

CHAIRMAN BANK: So moving on to the injury prevention.

DIRECTOR GREENBERG: I apologize. The first motion that you have --

CHAIRMAN BANK: Okay. For the first motion from -- from Cristy, do you want to just state it again? Apparently, we did not get on the record of seventeen votes.

MS. MEYER: Cristy Meyer from the Registry Committee. Motion one is from the Registry Subcommittee to immediately implement and include dead-on-arrival and dead in the Emergency Department's standard def -- definitions to the New

1/24/2024 - STAC - Albany, New York

York -- 2024 New York State Trauma Registry Data Dictionary.

CHAIRMAN BANK: So, one more time, I apologize. Everybody who agrees with the emotion may please raise their hand. So, One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen. So we have sixteen people raising hand. Any abstentions? any noes? The motion carries with sixteen.

One more. So, Injury Prevention. Rob Karn is not here. So, Dr. Angus had agreed to give the Injury Prevention Report. Is that true?

DR. ANGUS: That is correct, Mr. Chairman. The Injury Prevention Education Committee met this morning. There was a guest speaker from Jamaica Hospital who gave a PowerPoint presentation on the success of their Violence Elimination and Trauma Outreach program, better known as VETO. And it was very well received by the subcommittee. The second issue that was discussed was the National Injury Prevention Day, which was on November 18th, 2023, where many landmarks and buildings were lit up in green to promote awareness for injury prevention. The subcommittee also wants to publicize -- publicize

the fact that there are two websites that exist to promote injury prevention initiatives for the state. They include the New York City, the trauma-nyc.com, and the longislandfallsfree.com, where any of those sites can be used. Any trauma center can advertise their upcoming injury programs. And that concludes my report.

CHAIRMAN BANK: Any questions for Dr. Angus? As there are no motions, we'll move on to next Regional Performance Improvement. That is me. So we had a really great presentation by the Nassau University Medical Center of Staff and Dr. Angus on a very powerful geospatial analysis of where trauma care is provided in New York State. It was very, very interesting. We also went over the risk adjusted mortality and complication data from the collaborative. Any questions for the P.I. Subcommittee? Okay, moving on. Pediatric Trauma, Dr. Wallenstein?

DR. WALLENSTEIN: Hi, Kim Wallenstein. The Pediatric Subcommittee met this morning. We have no motions to present to -- to STAC. We did talk about three main topics. The first was our Pediatric TQIP collaborative. There are twelve centers in our

collaborative right now. We tend to do very well in most of our metrics. The high outlier that we've identified recently has been the T.B.I. mortality in the ages fifteen to eighteen. In looking at that, we saw that while we're very high outliers in that one category, each of our individual centers seems to be of a reasonable index. So we were not sure how that mathematically correlates. We do understand that there -- it is calculated differently when you look at the collaborative versus individual institutions. We're just going to reach out to TQIP to clarify that data and see if we're truly high outliers for that.

We also talked about the Pediatric Readiness Initiative. The Always Ready For Children. Dr. Cooper spoke a little bit about that earlier. We're excited that, I believe there's somewhere like six or seven centers that have signed up on that site. Most of them are A.C.S. verified centers, but there's at least one that's not, which is exciting. Our goal, our quest is to make all of the centers in New York register and become more pediatric-ready because we know that that improves outcomes and we will work closely with them to help with this. We're also continuing to look at our transfer patterns of

children to our Pediatric Trauma centers to see if we can help with those processes.

And the last thing we discussed briefly was some E.M.S. apps that can be used for pediatric care including one that used to be supported by the Department of Health, but is rather expensive at this point, but there is a free one that's also available. And we discussed those options briefly. And that's all I have.

CHAIRMAN BANK: Any questions for Dr. Wallenstein? Okay. So moving right along the New York State Chapter of the A.T.S. Carrie Garcia?

MS. GARCIA: Hi, good afternoon. I'm Carrie Garcia, the President of the New York State American Trauma Society. So no major updates were reported at the committee report outs. Association updates were limited to our upcoming -- not our, but the upcoming events which have been announced for 2024 from E.N.A. S.T.N. T.N.C.C. -- oh, sorry, T.C.A.A. as well as in the Education Committee, there was a discussion, well short announcement about the updated edition of T.N.C.C. which is out now. The treasury report was reviewed with updated balances shared with the committee. We also had reviewed the

election of the new officers with myself moving into the president position, Kate Maguire as the president-elect. Melania, I'm totally forgetting your last name, I apologize, as secretary, and Julia remaining on as treasurer.

Grant recipients were announced. We were able to give out close to nine thousand in grant funding. And then finally the meeting was rounded out with distinction awards for all areas of the Trauma program. That is all.

CHAIRMAN BANK: Any questions for Carrie? Okay. Then lastly, we have Dr. Doynow from SEMAC and SEMSCO.

MR. DOYNOW: Actually SEMAC. Unfortunately, we did meet in December, but we did not have a quorum, so no business was discussed. So nothing to bring forward from that meeting. Our next meeting is in two weeks here. Same place probably right in this room. We are missing a surgeon to represent us at SEMAC, so I'm looking for volunteers. We need one volunteer to join the SEMAC Committee. I don't know if anybody's interested. My suggestion is if you're interested, remain seated. Excellent. So it looks like everybody's interested.

Anyway, see me -- see me afterwards or see Dr. Bank, and we'll try and get you vetted onto the committee. We meet four times a year. You'll have my company and, and Dr. Dailey's company. So it's a good time.

CHAIRMAN BANK: And the -- the requirements were to -- would be to come to the meeting in person in Albany four times a year.

MR. DOYNOW: That is correct.

CHAIRMAN BANK: Any questions for Dr. Doynow? Mark?

DR. GESTRING: Just -- Mark Gestring. Just a generic SEMAC question. I know that there -- at the P.I. committee this morning, and in the past we've talked about issues related to critical care transport in the state. I know that's kind of on the back burner with SEMAC. I know people are talking about that. But to be -- the ability to transport an intubated, ventilated patient getting a blood transfusion, for instance, in a ground ambulance. I don't -- I don't know where that stands, but I think the STAC would be very interested in -- in watching that progress.

MR. DOYNOW: All that is fine, except

for the blood transport at the moment, unfortunately. I don't know, Mike, if you want to add into that. We've certainly been working on it. As you all know, it's -- it's going through for helicopters, but not for ground transport.

DR. GESTRING: Well, it was less about the blood, more about, like on a ventilator. I think in order to transport a patient on a ventilator, you would have to disconnect the ventilator and squeeze a bag for the period of ground transport, no?

DR. DOYNOW: That's not true. Many ambulances do have ventilators now and they can transport patients on a ventilator.

DR. GESTRING: So I don't -- I wasn't sure if there's policy related to why we're having trouble in Upstate New York, finding that service --

DR. DOYNOW: That I don't know --

DR. GESTRING: Transporting, you know, those kind of patients from hospitals to Trauma centers.

DR. DOYNOW: It may be your transport agency per se.

DIRECTOR GREENBERG: A geographic area may have an issue where they -- the agency doesn't

feel like they have critical care, trained paramedics or they choose not to purchase that equipment because they're primarily a 911 operation that doesn't use the vent. But we have ground transport agencies throughout New York State that regulate transporting patients on -- on vents, both long-term vent patients, critical care patients. Anything of that -- that nature.

DR. DAILEY: Actually, I'll just bring -- bring blood into that. You -- you will see that there will be growing discussions about blood going through the SEMAC and other committees around -- around E.M.S. in -- in New York. There are two different scenarios that we've discussed here, certainly before. One is Dr. Gestring is talking about, is the interfacility transport of blood products which requires an agency to currently have an ambulance transfusion certificate. In spite of the fact that the regulations actually say that in an emergency, any agency can do that. We have policy statements that actually speak against that. So that's still something that we've talked about before that needs some clarification.

The second is whether or not New York

State will join what is a growing move across the country, including extremely successful programs in Connecticut as our closest example, of blood transfusions being initiated for acute trauma patients in the field. I visited some of these programs. The programs in San Antonio and Austin are profoundly different in terms of how they're structured. But both is -- both have been extremely successful at providing early whole blood transfusions to acutely injured trauma patients, with significant success at reduction of mortality. So hopefully those things will have the opportunity to grow in New York, now that we have the example of helicopter blood transfusions out there regularly.

DIRECTOR GREENBERG: Yeah, I would go as far as saying, I think the framework is there. It would just take a change in wording and statute, but the framework is now there for blood to -- to be on aircraft and so they -- they can carry now. The regulation is in development related to the statutes that are -- allow for air medical to carry it. And I would recreate the wheel, I guess you would say, that if it has the opportunity to expand from air to ground, that would be a positive change in a system

that's already created and running. For those agencies that choose to carry blood, I think that'd be a big one, if equipped and trained.

CHAIRMAN BANK: Any further discussion for Dr. Doynow? Okay. Moving down. I don't have any old business that we have not discussed already. Any new business anyone wants to bring in front of the committee that we have not discussed already? Okay. Just going over again the announcements. The next STAC will be here. We'll be at the Hilton Garden Inn, on May 29th. And hopefully with some interest from around the state, we'll see if we can arrange for a A.I.S.15 course, that Thursday and Friday directly following the STAC meeting.

MS. SNYDER: Matt? Kerrie Snyder. I just want to for the programs out there where their surgeons still need to take the A -- is it DMAP? Is that the course that the surgeons -- It is now available on -- online, that you can take it online so you don't have to go and take it in person anymore. It's on the E.C.S. website. So if anybody's looking for that course it's now available. And we did confirm with the college that it is valid for verification.

1/24/2024 - STAC - Albany, New York

CHAIRMAN BANK: So the DMAP course and the A.I.S.15 courses are both available online. If you want to do it in person, the A.I.S. course is two eight-hour days. If you want to do it online, it is four -- four-hour days. Okay. Any other discussion?

MS. SNYDER: Doesn't matter. A.I.S. is two days online. We just did them a -- a couple months ago.

CHAIRMAN BANK: Okay. Do I have a motion to adjourn? Motion to second? Okay. We're adjourned. Thank you very much.

(The meeting concluded at 2:43 p.m.)

1/24/2024 - STAC - Albany, New York

STATE OF NEW YORK

I, MONIQUE HINES, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 61, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 7th day of February, 2024.

MONIQUE HINES, Reporter

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