
NEW YORK STATE DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES FOR CHILDREN

ADVISORY COMMITTEE

Tuesday, March 17, 2009
11:00 a.m.
The Crowne Plaza
30 Lodge Street
Albany, New York

APPEARANCES:

Susan Brillhart
Lee Burns
Sharon Chiumento
Arthur Cooper, M.D.
Tim Czapranski
Louise Farrell
Brian Gallagher
Marjorie Geiger
Martha Gohlke
Jonathan Halpert, M.D.
Robert Kanter, M.D.
Kathleen Lillis, M.D.
Janice Rogers
Sarah Macinski Sperry
Ruth Walden
Edward Wronski

OTHERS PRESENT:

Deborah Brown
Nancy Ginsberg
Susan Stred, M.D.
Gary Tuthill

DR. COOPER: Good morning, everyone. I'd like to welcome you to the first meeting of the Emergency Medical Services for Children advisory committee for calendar year 2009. My name is Art Cooper and at your request, I have the honor of chairing this group today. And we have a rather full agenda, so I'll begin by asking Martha if she will call roll.

COURT REPORTER: I don't think the microphones are working.

MS. GOHLKE: Is this on? There we go. Hello. Hello.

What I prefer to do is maybe go around and let you guys introduce yourself, if you wouldn't mind, because actually Dr. Amler was supposed to be here and I thought it would be helpful for him, but I guess he hasn't arrived yet. So Lee, why don't we start with you.

MS. BURNS: Lee Burns. I'm with the EMS Bureau at the state health department.

MS. GOHLKE: Martha Gohlke, EMS coordinator.

MR. WRONSKI: Ed Wronski, the director of the EMSC group.

DR. COOPER: Art Cooper, pediatric surgeon on the committee.

MS. FARRELL: Louise Farrell, private practice manager at the School of Public Health.

DR. HALPERT: Jonathan Halpert, New York ACEP.

DR. STRED: I'm Sue Stred. I'm the associate professor of pediatric endocrinology at Upstate for about the last nineteen years.

MS. WALDEN: I'm Ruth Walden. I'm a family specialist with the children with special healthcare needs program.

MR. GALLAGHER: Brian Gallagher with the School of Public Health.

DR. KANTER: Bob Kanter, pediatric critical care, Syracuse.

MS. CHIUMENTO: Sharon Chiumento. I'm a nurse and a paramedic, as well as an EMS provider.

MR. CZAPRANSKI: Tim Czapranski, SEMSCO liaison. Also a paramedic and EMS coordinator for Monroe County.

MS. ROGERS: I'm Jan Rogers. I'm a pediatric nurse practitioner in the emergency department at Strong in Rochester.

MS. BRILLHART: Susan Brillhart, pediatric critical care nurse. I'm teaching for the City University of New York.

MS. SPERRY: Sarah Sperry. I'm a research scientist for the bureau of injury prevention.

DR. COOPER: Great. I'd

like to welcome you all and hope you had a pleasant holiday season and that your new year's off to a roaring start, as we are well into it at this point.

MS. GOHLKE: You've got to speak into the microphone.

DR. COOPER: So I hope it's not merely a roaring start but a roaring continuation.

The next item on the agenda is approval of the minutes. So if you could all take a look at your minutes. I don't believe they're in your packet. I think you needed to review them online before coming. I trust that there were no major problems upon review of the minutes. I personally did not find any.

DR. HALPERT: Motion to accept the minutes.

DR. COOPER: Thank you,

Jon.

MS. CHIUMENTO: Second.

DR. COOPER: Thank you, Sharon. Discussion? All if favor.

SPEAKERS: Aye.

DR. COOPER: Opposed? It carries unanimously. Okay. The minutes are approved.

Martha, would you review the agenda for us, please?

MS. GOHLKE: Sure. Here it is. Okay. We have folks here from the CARES Foundation who are going to talk about adrenal insufficiency. That's the first thing that we'll do. And then Mr. Wronski will give his EMS report from the bureau. I'll talk a little bit about the EMSC grant and do my latest presentation on the results of the medical direction study that I did -- the microphones aren't

working -- and medical direction and pediatric equipment survey that Brian helped me out with, Brian from the School of Public Health. We'll go through that. We'll just have a quick update on the progress of the different committees.

And we will have a working lunch today. They're going to provide -- they're going to put lunch here in the room here for us. Just so you know, it's only going to be up for a little over a hour. So, you know, bring all your food here. Don't expect to nibble throughout the day, because they will take it away. So get everything and bring it here. We will have to work through lunch, so we'll take a few minutes, you know, take a break, but then we will work through lunch so we can get out

on time. It's a beautiful day outside today.

And then we'll go to -- we'll do the new business of the committee, the old business, the new business, and hopefully we'll have time to get to the updates from the sister committees, if we can pack it all in.

Ann Fitton couldn't be here today with the festivities of St. Patrick's Day down in the City. She couldn't really excuse herself. FDNY is needed today. And who's the other person? I know Elise, but there is another person who couldn't be here today. Rita Molloy. Kathy Lillis is on her way. She's flying in and her flight gets in a little after ten. So this is a longer commute, unfortunately, from the airport

so she's hopefully going to be here any second. And Rita Molloy, our nurse from Long Island -- today is the kindergarten screening day at her school, so she also had to excuse herself for today. She couldn't make it up here.

And then Dr. Van der Jagt e-mailed me yesterday. His mother passed away unexpectedly yesterday. And we send our condolences to him on the passing of his mother.

DR. COOPER: Absolutely. Thank you, Martha. Okay. So as you can see, we do have a fairly full agenda.

So I'd like to begin by introducing Deborah Brown from the CARES Foundation and Sue Stred from Upstate Medical Center in Syracuse, who I believe have a presentation for

us about adrenal insufficiency as it applies to emergency medical services and the potential need for us to consider adding administration of glucocorticoids for patients with adrenal insufficiencies to the prehospital treatment protocols and formularies.

So Miss Brown, Dr. Stred, either one, both?

MS. BROWN: We have a parent here. Her name is Nancy Ginsberg.

DR. COOPER: Okay. A pleasure to have you with us.

MS. GOHLKE: Just a quick refresher -- reminder. The microphones aren't so much for our listening pleasure, but it's for Nora's assistance to make sure she catches everything. So just try to be cognizant of speaking into the microphones.

And you can pull them forward if you need to. They do have long cords.

MS. BROWN: The blue folders on the table -- the blue folders on the table have all of our presentation materials.

Well, first I want to thank you all for giving us the opportunity to speak to you today. Again, my name is Debbie Brown and I'm the parent of a two year old with congenital adrenal hyperplasia, a member of the board at the CARES Foundation and a registered nurse.

We are asking for this committee's support and urging the medical advisory board to include injectable glucocorticoid treatments of individuals affected by adrenal insufficiency in New York

State's statewide emergency response protocol.

What if I told you I had a miracle drug that could prevent shock, heart failure, cardiac arrest and help save the life of trauma victims during transport? Well, I do have that miracle drug and it's called Solu-Cortef.

Injectable glucocorticoids are not new. They've been around since first used by Addison's patient John F. Kennedy to save his life during back surgery in the 1950s. But among individuals affected with adrenal insufficiency, it is our miracle drug.

Upon injecting Solu-Cortef in an adult or a child in adrenal crisis, something miraculous does happen. The child that looks

ashen and unresponsive suddenly begins to have color and talk. The mother who is vomiting and feels as though she might faint suddenly feels better. It's on now -- the teen with the bone fracture may be kept from shock and the patient in cardiac arrest begins to respond to intervention. Yes, this is our miracle drug.

And for a cost factor of $4.65 a vial and a shelf life of four years, Solu-Cortef is not only lifesaving, but cost-effective, easy to administer and safe.

You must understand that when adrenal crisis comes on, it comes fast. I have seen this with my own daughter. She has gone from responsive and alert to barely responsive and blueish-gray in fifteen minutes.

With no time to spare, just a half of milliliter of Solu-Cortef IM did the trick. Within minutes, Isabelle's color began to improve as well as her responsiveness. She was able to arrive at the hospital in a much more stable condition due to Solu-Cortef administration prior to arriving at the emergency room. Shock and cardiac arrest were averted as well as a hospital admission, and today I'm here to tell you that she is fine.

This is just my story, though. There are many others that have not been as fortunate. Others have endured long hospital stays, permanent disability or death due to lack of prompt treatment with Solu-Cortef.

You all, as the medical

advisory -- you all as the Emergency Medical Services for Children can help change that. You have the ability to advocate for change of current protocols so that when someone is found unconscious due to adrenal crisis, EMS can save them. When EMS arrives at a scene with frantic parents and a child who is already blue from adrenal crisis, EMS can help.

I have been constantly reminded that where I live on Long Island, a hospital is only five minutes away. I agree, but five minutes may be five minutes too long when an adult or a child is severely ill from adrenal crisis. And as you are well aware, children and adults living in upstate New York have much longer response to transport times. At the time of

adrenal crisis, there simply is no time to waste.

We are not in unchartered territory as far as protocols go. Rhode Island has, for several years, had a simple protocol to treat adrenal insufficiency. Here in New York, we can too. And by the way, this protocol would not only assist 2,000 people in New York who share the same diagnosis as my daughter. This is just the tip of the iceberg. A protocol for adrenal insufficiency would also help patients who have had adrenalectomies, Addison's patients, and an even larger number with pituitary disorders. These conditions leave patients at risk for adrenal crisis. There are over 12,000 people living in New York who are at

risk and would benefit from protocol implementation.

My daughter wears a medic-alert bracelet, something a recent CARES Foundation survey found that seventy-five percent of our members do. This measure, however, will do nothing to save her life if she becomes ill or injured and we, her parents, are not there with her or have become incapacitated in the same accident. And current EMS protocols in New York simply do not address those with adrenal insufficiencies.

Finally, I want to mention we have a willing community of endocrinologists eager to provide training in this, as well as policy development. While I realize there are costs associated with change, looking at the whole

picture, I think it's fair to say that one hospital admission for an adrenal insufficient patient who has developed shock, heart failure or cardiac arrest will likely exceed the cost of implementing these changes.

On behalf of New York's children and families, I urge you to help keep the adrenal insufficient safe by advocating the inclusion of injectable glucocorticoids in New York's EMS prehospital and transfer protocols statewide. The power to save lives is in your hands. I thank you for your time today.

DR. COOPER: Thank you, Ms. Brown. Dr. Stred, did you want to speak now?

DR. STRED: I don't have much formal to add to that, but from a medical perspective and an ED perspective, this is one

of the safest medications on the planet. It is a one-time injection. You cannot hurt anyone with an injectable glucocorticoid, as long as you administer it into a correct site, either a muscle or a vein. And I would be happy to stand in front of this body or the main SEMAC body and accept an injection of an entire vial into my arm and stand there and talk to you, for $4.00. For $4.00. You cannot possibly hurt anyone with this and you can save their lives.

In upstate New York where we've got response times of twenty minutes and transport times of up to forty minutes, that's an hour for someone who isn't getting the specific medication that could save their lives that they really need.

IVs are wonderful; fluid resuscitation is invaluable. But if your body cannot make glucocorticoids and you need it, the only way for you to get it at a time of crisis is through an injection. It's safe. It's cheap. It cannot hurt anyone. And the peds/endo community would be happy to help out with instruction that would benefit even our adult endocrin community, who I would point out are a little less good about wearing their medic-alert tags. But we can work on that if we get a policy in place. It will add to the momentum of the snowball rolling of being much more comprehensive about wearing medic-alert tags. It's really pretty -- that we push our patients to wear medic-alert tags that ends up being of no

utility to them in the State of New York. Thank you.

DR. COOPER: Miss Ginsberg, would you like to say a word or two?

MS. GINSBERG: Hi. My name is Nancy Ginsberg. I am the parent of a three year old girl with congenital adrenal hyperplasia. CAH is a disease of the adrenal which is easily managed on a day-to-day basis with steroid supplements. However, physical trauma, excessive vomiting or diarrhea and fever are emergency, life-threatening situations for the adrenal insufficient. The key here is emergency. If any of these emergency situations occur, there is a very short window of time in which intervention for the adrenal insufficient can mean the

difference between life and death.

My daughter's life and safety is my responsibility. My husband and I go to great lengths to insure her safety. Wherever we go, we carry an emergency medical kit which contains extra oral doses of Lilly's daily steroids, a letter from her doctor detailing emergency protocols and the fact that time in a waiting room is not appropriate, and a Solu-Cortef injectable and syringes. She wears a medical ID bracelet which states "adrenal insufficiency, hydrocortisone required." We know that we are fully prepared should an emergency situation arise.

Although there is no nurse at Lilly's preschool, her

teacher keeps a duplicate emergency kit on hand as well. With my instructions and materials, Lilly's teacher is as prepared as she can be to respond appropriately if needed.

Although we as parents and caregivers take all these precautions, what happens when we fail? If I, her parent, am not close by, if something happens at school and Lilly's teacher is not available or able to provide Lilly with her injection, or what if one day she is out riding her bike or on a field trip. There will be times when she will be out in the community and regardless of the precautions I have taken, she will not be safe or able to be helped by an emergency response team that is not equipped with a life-saving

Solu-Cortef or equivalent glucocorticoid.

There is a gap here which you have the power to fill. Allow my daughter and other children the safety you can provide by equipping your teams with this low cost, easily administered, completely safe, life-saving vial.

I thank you so much for your time today. Please help us keep our children safe in the community. Allow them and others with adrenal insufficiency the comfort to function freely and safely in our community by adding glucocorticoids to New York's EMS prehospital protocols. Thank you.

DR. COOPER: Thank you. Does -- Dr. Stred, do you have any summarizing comments for the

group or pretty much --

DR. STRED: No.

DR. COOPER: Do any of our members have any questions for Ms. Brown, Ms. Ginsberg or Dr. Stred?

DR. HALPERT: I'm just curious about what the --

COURT REPORTER: I can't hear you. I'm sorry.

DR. HALPERT: I'm just curious about what the incidence might be regarding presentation of this population to the EMS community?

DR. STRED: It's only anecdotal data at the moment. It's been a real challenge, especially now with HIPAA, to try to get those kind of data and coding. If someone comes in in shock, the discharge code may well be shock and not adrenal insufficiency. We need a more

robust reporting system to get that.

But we estimate based on published population-based estimates, there are over 12,000 New Yorkers with either pituitary adrenal insufficiency or primary adrenal insufficiency.

MS. GOHLKE: Is this something they grow out of?

DR. STRED: No.

MS. GOHLKE: Okay.

DR. COOPER: Dr. Kanter.

DR. KANTER: My concern would be that in a major adrenal crisis, the issues are life-threatening hypoglycemia and hypobulemia, and giving hydrocortisone may not preclude the need for IV fluid resuscitation and IV glucose.

And I think the bigger issue is education about this

general disorder or set of disorders and education about the full spectrum of life-saving measures.

If I had a patient in my ICU with all of these problems, my priorities in the first fifteen minutes would be glucose, fluids and I'd be happy to give the hydrocortisone in the next fifteen minutes when we get to it. Fluids and glucose are a far more urgent need.

DR. STRED: I have no argument with that, but cardiac motility cardiac function is dramatically improved in adrenal insufficiency with glucocorticoid. So administering the appropriate fluid resuscitation is incredibly important, but if you can't get it moving around in the bloodstream, it could with

one additional simple maneuver. It would be a tremendous advantage.

One injection lasts about six hours, so by doing that quick maneuver either at the same time or in one sequence or the other, buys you six hours of resuscitation without having to spend -- without having to think about the glucocorticoid injections.

DR. HALPERT: Many of our prehospital providers in New York State are very loose regarding the use of injectable glucocorticoids because of the prevalence of Medrol. I'm not sure statewide; it may be greater. Ed is more familiar with that. But I'm suspecting it's pretty popular and well embraced.

I think the real issue is

going to be recognition. And certainly if there's a patient population out there that's got a bracelet or a tag on or for care providers or relatives who are familiar with their situation and the paramedic provider may not be specifically up to speed on the nature of adrenal insufficiency, but perhaps knows enough to say, Will you call my medical oversight doc or medical control doc? And say this patient was poorly profused and they're wearing this bracelet. Do I need to do anything additional with this? I have the Solu-Medrol out of my box already.

DR. STRED: That would be spectacular. And we have individual permission from individual medical control

officers to do that when that recognition is made.

Part of our push will also be to assist you in the inservices that will be required for increased recognition of the importance of this disorder and its ease in treatment. We're happy to do that.

We'd also like to ask that it be publicized more fully that an individual team can call their medical control and say this individual has this ID bracelet. Can we please give their own medication, which they have in their hand right now?

DR. COOPER: Any other questions from any other members of the committee?

MR. WRONSKI: Just first some comments. I absolutely appreciate all of you coming up today to speak for this group of

children, and adults too. Is the breakdown known of the 12,000 in New York, how that breaks out?

DR. STRED: Pituitary issues are more common in adults who had trauma or pituitary adenomas -- pituitary surgery, but we have an increasing number of children who are now making it to young adulthood with disorders that used to be fatal. So I can't give you a precise breakdown right now by age. I can only give it to you by diagnosis.

MR. WRONSKI: In New York State, we have a fairly robust EMS system, but it does vary a lot depending on where you are and it's composed of basic life support in conjunction with advanced life support providers.

And I would estimate or I

would guess that there's no good way to identify one of these patients through the 9-1-1 system dispatch unless someone's calling and knows the patient's suffering a problem and they tell the 9-1-1 dispatcher.

But barring that, I don't think it would necessarily be easy for EMS to identify the patient through medical symptoms. It would be more of the bracelet or some -- am I wrong on that?

DR. STRED: No. That's exactly right.

MR. WRONSKI: The -- our advanced life support system certainly has, in many areas, the capabilities of treating this and to identify it. The issue and the question is, do we promote universal carrying of this particular drug, the

Solu-Medrol, and how do we -- is that needed? Is the current ALS system and what it carries -- because Lee, remind me. It's not always Solu-Medrol, is it?

MS. BURNS: If it's going to be anything, it would be Solu-Medrol. As we had discussed, it's not -- one of the issues that I think -- most of you are aware of this, but ALS protocols are written, really, at the regional level and that's permissible under the statute. And many of them include Solu-Medrol in the asthma protocols that Dr. Halpert indicated.

In speaking with one of the medical directors in the central New York area, they removed it from their prehospital protocol because what they found was that by the

time -- it takes so long for it to actually be effective in the protocol, then why not give it at the hospital. But Tim, do your protocols include course --

MR. CZAPRANSKI: No.

MS. BURNS: Okay. I have sent an e-mail to Andy to see what the numbers are.

DR. STRED: I will point out that the anti-inflammatory action of the glucocorticoids is used slower than the cardiac contractility and is supported for memory function.

MS. BURNS: Is there -- I mean, I'm sure there is, but from a prehospital perspective, what would the difference between Solu-Cortef and Solu-Medrol be?

DR. HALPERT: I would order that equivalent. I keep both plus a variety of others

stored in my office and change them fairly frequently.

MR. WRONSKI: The last comment, just from the Bureau's perspective, is that we've done a lot of things over the years where special groups come up of interest. And a lot of it has been resolved through more robust education to the EMS community. This is what you might run into. And here's -- here's how you deal with that.

I think, first off, we would have absolutely no objection to doing that type of a program. The question is, what should that contain? What should our direction be at EMS? That's why it's here at this body, to get some advice from the EMSC committee. And then later when we meet with SEMAC, get the final recommendations

for what to do.

But I think at the very least, certainly the Department will support an education program so that our EMS providers know these children exist. And if you do have a call -- not just children, but adults as well -- what will you do. So I think that's a very reasonable thing to do. Exactly how it will be composed and what else do we recommend, I leave that to the EMSC committee and the SEMAC to recommend. Thank you.

DR. COOPER: Thank you. There is one issue that I think is infrequently understood by the public at large. I know you understand this as health professionals and parents of children with congenital adrenal hyperplasia.

But EMS is a funny system in many ways. We have the plethora of resources in the urban areas where they're least needed and the girth of the resources in the rural areas where they're most needed. The transport time to a hospital in the urban areas is usually no more than ten to fifteen minutes, urban and suburban areas, usually where the parents, docs and critical care techs are based. And again, of course, it takes a little bit of time to get control of the airway, get an IV established and so on. And do you spend the time moving the patient expeditiously to the hospital where -- where definitive treatment can be initiated quickly or immediately upon arrival, or do you take the

time, pull over to the side of the road on the way to the hospital to start the IV? You know, these are all questions that have to be factored in in terms of -- in terms of making a recommendation about -- about a drug like this.

The other comment that I might make is that while there is no specific protocol for the use of injectable glucocorticoids for treatment of CAH and other adrenally insufficient conditions, nowhere on the protocol does that proscribe. So it's not prescribed but it's also not proscribed.

And we have a long tradition in EMS of so-called discretionary decisions, where a medical director can be involved in a decision to use a drug that

-- that is contained within the prehospital formulary although not necessarily normally utilized as part of the protocol.

You might ask, well, why wouldn't you just include it as part of the protocol? Well, you know, the answer to that is if you include it as part of the protocol, you have to spend a great deal of time teaching it, drilling it and so on. And many of our -- of our prehospital colleagues are volunteers and the amount of time that we have available and the curriculum to teach them about a very, very wide variety of things is extremely limited.

So I'm meaning by these comments to sort of give you a flavor of some of the -- some of the issues that we face as an

EMS system in terms of insuring that the right patient gets the right treatment at the right time for the right reason. And yes, in one way it is as simple as this is a miracle drug that will save the life of a child, but in other ways it's far more can complicated than that.

So I think probably at this point, we as a committee need to think about this and come up with a recommendation.

I should note for the record and for you that we as a committee do not have the authority to make a recommendation to the Commissioner specifically regarding protocol. We do have the authority to make a recommendation to the SEMAC, which can then make a decision as to how it's included in the

protocol, which has to be signed off on by the Commissioner.

But there are opportunities, as Mr. Wronski has indicated. Education, certainly. There are other opportunities available to us, as well, advisory guidelines and, of course, inclusion of the drug in protocols for use under the circumstances, you know, that you mentioned this morning. I think the information that you presented is great. I know we're deeply appreciative as a committee for your taking time to come before us. And meaning no disrespect to you, Dr. Stred, but especially Ms. Brown and Ms. Ginsberg for the very moving, you know, testimony which you gave about your own children. This is something that, you know, I know must be a

most, you know, of heart-wrenching importance to you. So we will, I assure you, keep that in mind as we deliberate this really important issue. So thanks so much for coming.

DR. STRED: May I make two quick comments about the scientific content about what you said?

DR. COOPER: Sure.

DR. STRED: And they are brief. The first is that I think the recognition factor is actually easier for adrenal insufficiency if the medic-alert bracelet is there. So for instance, if a person is in imminent shock, has poor color and has a bracelet on, I think the recognition factor would be pretty rapid.

The second is appropriate

and we've heard it raised when we spoke in other kinds of venues, is everyone appropriately has in their mind the potential danger benefit, malice, of any medication. And I want to go back to the fact that this is incredibly safe. Any of us in this room, adrenally insufficient or not, could take that medication in an error in judgment and have zero effect that day. Long term, that's a whole another matter. That's a real dangerous drug in big doses and long term, but a single shot on a single day cannot hurt anyone.

DR. COOPER: I don't think anybody disagrees with the points you just made.

DR. STRED: Thank you.

MR. WRONSKI: Can I just ask the committee for a sense of

-- I know we have to think about protocol and what we might say to the SEMAC -- to the regional trauma advisory committees that exist across the state and what we want to say there and that will take a little bit more discussion. But an educational program, a program that we would, at least in concept, support -- that this committee supports the idea of increasing the education, and I don't mean in the -- necessarily the basic life support curriculum or the advanced life support curriculum, but just a standalone CME which we would -- the Bureau would support getting information out to EMS providers about this issue. Is that generally supported by this committee, that --

DR. KANTER: And in

particular, I think the education must include the importance of volume resuscitation and hypoglycemia. And giving the glucocorticoid alone is a little bit like giving antibiotics for septic shock without the other --

DR. COOPER: Sharon?

MS. CHIUMENTO: I would just suggest that one of the things we can do is include it as one of the considerations under our regular shock protocol. And just not -- I would not write a specific protocol just for this. I would include it as an option, a medical control option if you want or whether -- under our regular shock protocol. This way, as they're considering epileptic shock, that would be something that would be

considered then. They would then say, okay, I've got the medic-alert bracelet, I've got shock symptoms, this is what I need to do.

DR. STRED: That's where it is in the Rhode Island protocol.

DR. HALPERT: I would echo that sentiment, Sharon. I mean, that's really, in the emergency department -- in the emergency department, that's a standard operating procedure. A patient comes in in shock. You know, if you add at least one dose of glucocorticoid, you're -- it's imminently safe and imminently lifesaving in the right patient. And often times, it doesn't change things. But in that case, it's very useful.

I think from an academic perspective, though -- it's a

natural topic for a Vital Signs presentation. I mean, maybe you want to, say, involve a GEMS type of program, which is rather comprehensive and large and it's been out there for a while, but at least as an introduction, you've got a willing group of people right now who want to get this on track. You've got a mechanism that exists. It's a good topic. It's timely in many different ways. You know, it intertwines with a lot of things that go on. It's a typical Vital Signs conference. So, I mean, it's a perfect topic.

DR. COOPER: Personally, I think the last few comments have really summed it up very nicely. What's needed here is a contextual approach rather than a -- rather than a standalone approach. Certainly, a

standalone document, whether it's an advisory guideline or simply a letter to ambulance services indicating that it's easy to recognize patients with adrenal insufficiency if they're wearing a medic-alert bracelet and that calls for a particular response. That part's easy to do.

In terms of creating an entire CME program, I would far rather, as I think Bob and Sharon and Jon suggested, include this in some ways as part of the broad categorization of -- of kids in shock and kids with congenital adrenal hyperplasia. I'm a pediatric surgeon, so I'm a little off my best here, but, of course, you know, we do see very, very young infants that will present with shock and there is an entire

differential, independent lesions and CAH and -- but primarily overwhelming sepsis, as you know. And unless they're wearing that tag, the recognition can be -- can be difficult even in the hospital. So it's really within the context of shock, you know, as more broadly defined that I think we need to approach this in whatever way we think will reach the most people.

So unless there are any other comments, I think we'll once again thank you so much for your time and your effort for coming here today.

DR. STRED: Thank you for allowing us to be here.

DR. COOPER: Sure. It's really great you came. Thanks. And Ms. Brown and Ms. Ginsberg, thank you so much for

your -- again, your stories. They are very, very important to us and everyone. Okay. Good.

What I will do is defer ongoing discussion on this until a little bit later in the meeting to allow people to sort of cogitate about it just a little bit. And since I see that they're loading up the table over there, I want to move pretty quickly to the Bureau of EMS report, and if there's time, Martha, your presentation before we actually get into lunch hour.

MS. GOHLKE: We can actually take a quick break after the Bureau's report and then get our lunches and I can do my presentation during lunch.

DR. COOPER: Sounds good to me. Okay. So Mr. Wronski, we're looking forward to hearing the good news from all of you.

MR. WRONSKI: Yes. Thank you. I appreciate being here. And just for the record, Marjorie Geiger says hello to all of you.

DR. COOPER: Please say hello back.

MR. WRONSKI: We will. I will. Obviously on everybody's mind is budget. All right. So what's the budget look like right now? The answer is it's anybody's guess. What I would -- and the reason I say that is that with the expectation of federal funding, which is going to be put into many states, including a significant amount of money into New York State, this will affect how the budget is viewed.

From my personal perspective, and I will say personal because the Governor

doesn't talk to me about these things, the New York State budget is still in a very problematic area and that is that we've overspent and we haven't brought in enough money to pay the bills. That was very clear. There is a big hole. And even with the federal funding, which certainly will help things and move things in a more positive fashion along, we're going to have to adjust as a state and as government, as well, on how we use the money so that we don't, when that federal money has run out in assist to us, wind up in the same kind of fix. So I believe that is really what's on the table at the -- in the state negotiations that are going on as to how to revisit the state budget.

For a more specific

comment on the EMS Bureau's budget, that hasn't changed. It's 20.8 million dollars. That was the recommendation by the Governor. It's a match to last year's funding. I have not heard any suggestion that that will change either up or down. So we'll be able to pay as we have to continue our efforts to support EMS training and our regional efforts.

And some money is used within the Bureau's budget, state funding, to help support EMSC efforts. But again, there is no suggestion that the money will go up or down. It will pretty much remain flat line from last year.

The other big ticket item is the argument over Medicaid funding and that is, again, something that's going to be

revisited, I believe, because of the federal monies that are coming in, but I have no answers for you. All I can tell you is pay attention and see what comes out of these negotiations that are ongoing right now at the state level.

A good piece of news -- I don't know if this was mentioned by Martha. The Governor's traffic safety committee did award the Department a grant, approximately $250,000 a year, which is preliminarily for three years to help us develop and implement a platform to change our New York State PCR system so that we're able to efficiently collect and also analyze PCR data electronically, PCR data in the coming years. Some of you know or some of you may not that, at present, we're getting

about, volume perspective, close to half of our New York State data electronically, and this is because we have a couple regions, what we normally term non-New York City regions, who are submitting data electronically. And now New York City, while not a hundred percent, is close to a hundred percent of the 9-1-1 system calls that we receive from the City electronically. We also know that Suffolk County, as an example, is going to electronic data collection probably within the next twelve months to full online. And there are a couple of other regions who are exploring that, as well.

The advantage or the benefits to this committee is that hopefully by next year, you'll be seeing more and more

data coming in on a contemporary basis. The other big advantage, and I put this on the table here, is that we'll be moving towards a NEMSIS compliant database. And that means we'll be changing our data collection, we'll be educating our EMS providers once we decide exactly what data elements to -- to move to from the NEMSIS database and hopefully having a richer and stronger database so we can evaluate our prehospital care system.

What I would ask the EMSC committee to do, just as we've asked the state council and the SEMAC, is to make sure you've looked at the NEMSIS database and make recommendations to your committee as to what you think from a pediatric standpoint should be collected in that

database. And that's ongoing in our QI committee or our evaluation committee of the state EMS council. But if you do have comments you'd like to make at some point before this process is done, please do so.

The 2008 protocols are online now. And what does that mean? Did we rewrite the New York State protocols? No, we did not. What we've been doing is rewriting them for the last several years. But what finally happened is we put them into a finalized state protocol book again so that all of the revised protocols that have been revised since 2003 -- each year we did one or two revisions -- are now all collected as a sole document, a single document, and termed the 2008 BLS adult and pediatric protocols. And that's

online. We are printing hard copies which are going to go to our training sponsors later this year.

I do want to bring up a sad case, but I think it's an object lesson to learn from. There are some things we think are basic and that everyone knows, but apparently that's not always true. We had a case in the public access defibrillation program in one of the schools in Suffolk County in which a six year old boy had complained of rapid heartbeat and chest pain and was taken to the nurse's office and was defibrillated while awake and talking to the nurse. And we're looking into how this could have occurred, how the AED unit could have recommended shock. And it did, it recommended shock. And the

boy was shocked and luckily is fine. But what this issue brought us -- brought to our attention on a statewide basis is the constant need to re-educate and to remind people what the protocol says. And also to constantly look at our machinery and is it outdated, is it up-to-date or not. And so not only the Bureau, but the state education department is looking at the program and we're evaluating how this could have occurred.

But, you know, as fellow interested parties in the EMS system and our children, again, I take it as an education point that no matter how well trained you are, things can happen in an emergency or suddenly and you might forget the rules for the moment.

DR. COOPER: Mr. Wronski, just a quick question about that particular case. This is the first I've heard of that. Is this recent?

MR. WRONSKI: It was March 4th.

DR. COOPER: Quite recent, March 4th. And has it been reported to the FDA?

MR. WRONSKI: The -- at this point, I don't know that that's formally happened, but we intend to do so from our Bureau. I believe that may have occurred through another source, but we'll be in touch with --

DR. COOPER: That's vitally important, because the decision by the FDA to approve the AED for pediatric use was predicated on the notion that -- because events like this had never been reported to happen.

And they -- very, very important to report it immediately if it has not been reported thus far, and that they need to make a decision about -- about this, at least in terms of sending out some kind of warning to the general medical community.

MR. WRONSKI: I don't disagree. I believe it has been, but we were going to follow up with them to insure that it was. And it is an older model machine and we believe it's one of the models which we had identified early on in our discussions on the automatic machines in pediatrics and it had to do with default settings for cardioversion and it may not have been on the off setting. So we think the machine was recommending shock for

cardioversion and that may have been the complicating factor here.

DR. HALPERT: So there may have been a tachy arrythmia, but whether or not the patient was under-profused enough to require cardioversion is another story.

MR. WRONSKI: Right.

DR. COOPER: Bob?

DR. KANTER: But all those potential errors are really not pediatric-specific. They may be just as important for an adult with the same arrythmia.

DR. HALPERT: Right. It's still the people factor and should I push the button or not.

MR. WRONSKI: Yeah. It is. We can't educate the machine. We can pull it off of the shelf. But we constantly have to remind each other, you know, what the basic rules are.

So re-education is critical.

DR. COOPER: Of course, we're all aware of the literature stating how well or how poorly both professional rescuers and lay rescuers are impulsive. If we're establishing the presence or absence of a profusing rhythm, it is not necessarily, you know, as straight forward as we would like it to be.

I'm sorry, Mr. Wronski. I didn't mean to interrupt.

MR. WRONSKI: It's okay.

DR. COOPER: But it was such a vitally important issue that I felt I needed to comment, as did the others.

MR. WRONSKI: Ryan White. And very briefly, we mentioned this at prior state EMS committees, the Ryan White Act back in 2006 was modified by the

federal government and dropped the coverage for prehospital care providers and other first responders for access to information regarding exposure to an HIV patient. This was done inadvertently. It was an error. But it's still not corrected and our understanding is the federal law might not be touched until next year.

But there is a state regulation that actually provides for the ability for EMS providers who may have had an exposure to get that information and we've been doing an education piece on this and sharing with our EMS community the state regulations which already exist which allows this to occur.

And I don't seem to have it with me, but there's an

algorithm for doing this. But if any of you are interested, we'll e-mail you that information. It is on our EMS website, so you can go to our website and see all the information about the modification -- not modification, the fact that Ryan White has changed. But there is a state regulation that covers providers if they are exposed.

I want to bring up another unfortunate thing. And some of you may personally know this and some of you may not, and that's the closure of the -- rather the stress that's going on with our hospitals.

The Berger Commission last year identified a number of hospitals and other facilities they felt needed to be closed in the system to make the system

overall healthier by closing these facilities or having them merge, etcetera. And that has been causing some stresses in the local community. But what we've also been seeing is stresses on hospitals in which two thing are occurring. One, they're not able to staff to the level that you want them to staff. It may be a trauma center. It may be a children's hospital. It may be a burn center. And it's more and more difficult these days, particularly in some of our non-New York City communities but even in New York City, to have 24/7 coverage of needed specialties. And we're seeing this in our trauma system tremendously. We now have in the southern tier no formal trauma coverage -- all right --

formal -- from Jamestown in western New York all the way to Binghamton, and that's because two area trauma centers had to give up their designations as trauma centers because they were unable to get the staffing coverage. And that varied from 24/7 anesthesia ability, neurosurgical capability and even general surgery, general trauma surgery. General surgeons are committed to trauma calls. And we know there are other facilities who are having difficulties with this.

We also have financial difficulties and we had two hospitals in Queens, New York which recently closed. I was involved in discussions on a day-to-day basis with these hospitals to arrange for coverage. The two hospitals,

St. John's and Mary Immaculate hospitals -- Mary Immaculate was a regional trauma center -- both have closed effective the first week of March. I don't remember the specific date.

But what they did is it then produced a movement of emergency department patients to remaining hospitals in the area that was quite a -- quite a change. And so 28,000 ED patients who had gone to these hospitals were now split and moving to other EDs in an already crowded system.

So the Department continues to work with existing hospitals that remain and with the EMS system to try to build a replacement structure to deal with both the patients going to the emergency departments but also build in place primary care

and clinical services that were also lost when these two hospitals closed.

And I think as providers and a committee that oversees children's issues, you need to be aware of these tremendous pressures that are going on in all our hospitals around the state and to look at your own region to see -- well, how healthy is my particular region and my particular hospitals. Sometimes you can focus on your particular area and not see the big picture until it's already on top of you. And I think, in fact, that happened in one of the Queens hospitals. Many of the providers didn't realize the stress, the financial stress, that their facility was under until the point that it closed its doors.

And so what I would ask you to do is just pay attention overall to your healthcare system and advise us as soon as you know that there might be issues that we should work with the local community on.

I know Martha, and I think it's on the agenda, and the school of public health representatives are here to answer questions.

We have a draft of a new pediatric -- pediatric report that you will be able to review and comment on. I'm very happy for that and I'm proud that we've gotten a new report that we'll be able to issue this year.

The two other quick points. We are going to ask you to look at trauma regs. Dr. Cooper has shared them with you,

and that is in tandem with our State Trauma Advisory Committee, that is revising trauma regulations for area regional centers. But we're also looking at a pediatric piece and blood regs.

If you don't know, we have mailed out to all of our advisory committees and they have commented on changes in blood regulations which would allow in interfacility transport the carrying and maintenance of blood products for a patient that may need them in an interfacility transport by EMS. Prior to this, you needed a nurse or a physician or a PA or other licensed provider. But these new regs, when they are finalized, will allow EMS to move a patient in between hospitals with blood products

running. If you haven't seen those regulations, let me know and we can send e-mail copies to you.

The last is May 20th and there is a flier here. Our EMS memorial dedication at the Empire Plaza this year will be honoring two providers who lost their lives in the line of duty. There is a third who lost his life up in the St. Lawrence Seaway area this year and it was a very unusual occurrence because he was shot by a patient and killed during a call. He was a young man, twenty-five years old. He was in school to become a paramedic. He had been an EMT for less than two years but was very much committed to EMS. And he was called to a chest pain case, went in with a crew and the patient was upset,

went into another room, found a rifle and shot this EMT as he was trying to leave because they were trained that in situations like this, try to back away from the patient. And the patient shot and killed him. It's really unfortunate. Again, serves underlying dangers of the system and also how aware we have to be in EMS to protect ourselves. So while he's not on the memorial this year, his name will be added to the memorial next year. I just wanted to mention that.

Unless there is any questions, my report is done.

MS. GOHLKE: I just want to update you on a couple things on the grant before we'll take a break and we'll get some lunch and then I'll do my little Power Point presentation.

DR. COOPER: Mr. Wronski, I did have one question regarding the report. You did touch on closure of a number of services across the state, focusing mainly on trauma centers, but you did touch briefly on pediatric capabilities, as well. And as you know, there has been some concern in the New York City region for some time that prehospital providers don't always know which trauma centers are -- that are said to be capable of caring for children actually are capable of caring for children and, therefore, ultimately requires secondary transport to another center. I know that the New York City regional trauma advisory committee has brought this issue to your attention. I just

wondered if there has been any progress the Department's been able to make in sorting this issue out?

MR. WRONSKI: Yes, they have, and I thank Martha for her help. She helped compose letters that are being prepared right now to go to all the trauma centers in the City, two different letters.

But one of the first things we did was we did a review of all of our inhouse information, files for the hospitals, to confirm that at least through documents, there are twelve of the regional trauma centers in New York City who have committed to the care of pediatrics and who, by documents and commitment, say they can care for the needs of the major pediatric trauma

patient.

There has been, you know, issues raised by the New York City -- some New York City facilities whether or not that's confident information, so we're sending letters to all the regional trauma centers asking for a recommitment and are you, in fact, capable of doing that and do you have in place all the components of pediatric regulations. And we'll be asking them to attest to that. Whether we do something after that once we get that response will depend on what the responses are and what information we may have.

DR. COOPER: Thank you, Mr. Wronski. It's really good to see some progress on that area. It has been a taxing problem for a long time.

Martha, do you want to take a break now?

MS. GOHLKE: Can I just say two things, comments?

DR. COOPER: Sure.

MS. GOHLKE: Then we'll take a break. The grant was refunded, so that's good news. It was a little bit -- it was a little bit of angst with the whole, you know, budgetary crisis on a national level and worldwide level, but actually supposedly Obama and his staff is looking at funding for next year in April. So I was a little more concerned about next year being that now he's had the time to sit down with a scalpel, I think is what he was referring to, about cutting programs going through.

But the good news is Dr. Wakefield is now going to be

the HRSA president, CEO, whatever --

DR. COOPER: Administrator.

MS. GOHLKE: -- administrator. Dr. Wakefield was the parent of the child that died many years ago that this act is named for, so I think we're okay -- at least I think I'm okay, at least as long as she stands over herself. So good news for the grant.

And then just what -- Ed, I think, touched upon a lot of the information. We have a periodic conference call through the national resource center who's the technical assistance contractor for HRSA for providers on this grant. And they do periodic conference calls with the grantees and they highlight each one of the

performance measures and then they have states who have accomplished or on their way to accomplishing performance measures and talk about their successes and how they went about it so the other grantees can listen in. And we have one. I mentioned that New York State was highlighted a while -- a couple months ago in one of these conference calls because of our white paper and moving steps towards regionalization. But New York is also going to be highlighted again in May. I'll be talking about -- we're the only state, come to find out, that is as far along with mandating the goals of the performance measures of this grant. We've accomplished the most in the mandate format than any other state. So I have to

give kudos to my predecessors, Gloria and of course Marjorie for the work that they did. I'm just, you know, getting the claim at this point. So it's nice to be sitting here and have all that great work behind me. But I just wanted to mention that, that we're getting highlighted again in May. So hats off to you guys, 'cause you did all the hard work.

And why don't we take a break for lunch. Take ten, fifteen minutes, you know, and get your lunch, bring it back to the table, and then I'll go through my slide presentation on the survey data that Brian and I worked on. Okay.

DR. COOPER: We are recessed until everyone gets a plate.

(Whereupon, a lunch recess

was taken.)

MS. GOHLKE: Okay. I'm going to start rolling my presentation here. Okay. So let's see. Last year sometime -- yeah, last year. It's almost a year now. I collected data on the interfacility transfer guidelines and agreements for hospitals and I also did a survey at the same time with EMS agencies on their medical direction and their pediatric equipment that they carry according to the grant. So thank you, Brian.

I was able to enlist Brian's help from the School of Public Health to help me crunch these numbers, which saved me a lot of headaches and complaints. I'm still complaining, and Brian took the brunt of it, but it's not nearly as bad as if I did it

all myself.

In your packet, I just want to draw your attention -- I'm not going to go through it unless you have questions, but the NEDARC, which is the data contractor for HRSA, put together these fact sheets, you know, formatted them, and states could just stick in their results from their surveys. And if you get a chance, peruse through it as some point. Eventually we're going to post this online on the EMSC website. But if you see anything glaring that doesn't make sense, let me know. So you can look at that at your leisure.

Okay. So these surveys -- this survey went out together. The EMS agencies had to answer both of these together about pediatric medical direction --

both online and offline medical direction and also they were inquired about their equipment that they had on scene, pediatric equipment.

We'll first talk about the medical direction survey. This goes for both. So in New York, we certify and regulate about 1,200 services. NEDARC did a random sample of who we needed to survey. Thank God, I didn't need to do all 1,200. They picked 467 services that we had to survey. And as you can see, the split out there, 219 BLS and 248 ALS. And you can see how they were -- the EMT basics and the EMT intermediates were cleared at a BLS level nationally. And then ALS, our EMT critical care techs and paramedics were at an ALS level. So when you see BLS and ALS, I

have national numbers in the presentation, too. You'll know how our groups compare to theirs.

You may have remembered I had a choice of doing a paper survey or an online survey, and we did both because we weren't sure about the accessibility of the internet with our services at a volunteer level, so we decided to do paper and online. Those that completed it on paper, a bunch of us, we offered to enter it online because the NEDARC software survey instrument that we utilized.

And again another lesson learned here was that most of the providers preferred to do it online. I sent them the paper copy and it got lost or it never got to the person it needed to. And I would followup with them

and they'd say, Is there any way I can do this on the computer somehow? So it was nice to have it done both ways. And the next time around, I'll probably just do it all online. And if a person requests it on paper, send out the paper, but primarily just give them the online link.

377 services completed the survey, so that was just over the eighty percent threshold that the feds required of all our surveys. And I enlisted a lot of people's help in getting this 80.7 percent.

So one of the things that the feds wanted -- that plays into the answers in the survey, who answered the survey. You know, obviously they wanted key personnel who were involved at an administrative level and at a

provider level who are actually answering calls to answer the survey. I can't say that was the case with our survey, because we didn't want to put somebody's name on the address of the envelope in case that person had moved on or was no longer captain or -- you know, we didn't want somebody to say, Oh, it's not addressed to me. I'm not answering it, type of thing. So we just addressed them to the agencies and whoever answered it, answered it.

And I have to be honest, sometimes when I followed up with agencies, somebody would say to me, Oh, you know, I answered the survey, but I'm really more involved at the fire level than I am with the EMS level. So I can't always say it was the best person that

answered the survey, but we got an 80.7 percent return rate so that's all we needed.

So this is just some national numbers. Thirty-nine states in six territories actually did this survey. Not everybody -- well, most everybody had to do the survey, but I'll get back to that later.

So that's the numbers there that nationally had put their number to NEDARC. Our numbers are not national numbers because they compiled their data early fall and my numbers weren't in yet. So keep that in mind when you see the national numbers.

So they had over 5,300 records that were reported on average. Per state, 158 agencies were answering the survey. Now, I really want to

be the EMSC coordinator in Guam, because they have one service there on the island. It would be great to be the coordinator there, I think. But anyway -- okay.

So we asked them, you know, some basic information about who they are. So thirty-four percent of our respondents were at an EMT BLS level nationally, EMT-Bs and EMT-Is. Nine percent were critical care techs or ILS on a national level and fifty-seven percent were at a paramedic level.

About nineteen percent of the services were paid -- completely paid services. Sixty percent of the services are still all volunteers and then twenty-one percent are a combination of paid and

volunteer staff. About fifty-five percent self-reported that they respond to mostly rural areas and that was pretty much the same as the national numbers. And 10.6 percent of New York State incidents are pediatric, meaning there were under -- eighteen and younger -- or under the age of eighteen -- actually under the age of eighteen, seventeen and younger. So we're a little higher than the national numbers as far as the number of calls being for children.

One of the questions that we asked them was at what age do you consider a pediatric patient. It starts at what age and ends at what age. So fifty-four percent of the providers said that it starts at age zero, forty-one percent said

it starts at age one, and then four percent had different numbers. And then ends at age eight years fifteen percent said, seventeen percent said -- or four percent said at seventeen years, forty-five percent at eighteen years and thirty-seven percent that had other ages, too.

So what's kind of interesting is that, you know, what I drew from this is that when you write protocols and you just use the term pediatric, what the provider interprets in terms of what age that is. Our ALS protocol say fifteen and our BLS say eighteen, even within the state. So it just varies widely. So you've got to wonder what the treatment implications are in this case.

The federal definition,

you know, in the survey was under the age of eighteen, but, you know, they say -- they split it out zero to twenty-eight days is a neonate, twenty-nine days to one year is an infant, one to eleven years is a child and twelve to eighteen is an adolescent. They would all be considered pediatric, though. So again, the mandate is important as far as how that plays out.

They were asked how many calls they answered on an annual basis, and we did have FDNY in there in the survey. So the high end was, you know, over a half million, 650,000 plus and the low was twelve.

And then pediatric goes -- some agencies said, We've never had a pediatric call. Lucky them. And then, of course, FDNY

was at the high end there. So the median number, if you look statewide, was about 525 calls a year and 50 below eighteen.

Probably one of the things I hear most in the year I've been doing this is people come up to me and say, you know, We so rarely have kids and we're so nervous when we finally do have a child that we need more training. It's so infrequently that we get to practice, so these numbers kind of support that.

Okay. So then we get to the survey questions about -- in this case we talked about online. And you do have a copy of the survey, if you're interested, in your packet. You can look at the actual -- how thick it is, at least. And I think I double-sided it. But it

is a hefty survey and it required a lot of reading.

So the first question when you have a pediatric call and they need pediatric-specific online medical direction at the scene of an emergency, is it always available to them? Eighty-five percent, always. Eight percent said usually and then you got the lower numbers. So again it's pediatric-specific. Not only can you get somebody on the phone, but do they know what they're talking about in regards to peds if you have a peds question.

DR. HALPERT: Are you characterizing in general like that or are you saying it is someone that has FAAP after their name?

MS. GOHLKE: That's a good

question. I mean, it's their perception, who is at the other end of the phone. And are they asking for credentials? I don't think so, but --

DR. HALPERT: That could be --

COURT REPORTER: Could you use the microphone, please? I can't hear you.

DR. HALPERT: I'm sorry. I apologize. If they're in Ogdensburg, it could be a PA that's answering the phone and they're probably a great PA but not necessarily have the credentials to do --

MS. GOHLKE: And whether or not the provider who's calling you to do that is asking what the credentials are.

DR. HALPERT: They're just comfortable because they happen to know that PA because they

live next door to him.

MS. GOHLKE: Right.

DR. HALPERT: That's not out of the question, necessarily.

MS. GOHLKE: Excellent point. So do you feel that the individuals answering the phone are able to provide the necessary pediatric medical direction? So eighty percent said always, fourteen percent said usually, and then you've got the lower numbers, sometimes, rarely and never. So again, pretty high. But the feds want to see over ninety percent. They want to see that, you know, over ninety percent of the time, providers are getting pediatric-specific online medical direction. That's the goal.

DR. COOPER: As I recall,

the feds does not specify either, correct? In other words, the performance measure doesn't necessarily require the online medical direction --

COURT REPORTER: I'm having a hard time hearing you.

MS. GOHLKE: Right. The feds take on it, at this point, is that as long as it's a person on the other end of the phone that has a higher level of pediatric training than the caller, they're okay with it.

MS. ROGERS: Oh my gosh.

MS. GOHLKE: This has been a discussion with SEMAC, as well, about how the state wants to deal with this. But, I mean, one of the comments, I should say, when I presented this to SEMAC medical -- I can't remember, Medical Standards -- thank you.

What one individual -- one physician made the point, that I don't agree, that a pediatrician is the person we want on the other end of the phone when somebody's calling for online medical direction at the scene. Pediatricians do not have the emergency medicine experience behind them to answer all the peds calls, so you know --

DR. HALPERT: It sounds like the performance measure is asking who has access to online medical control.

MR. WRONSKI: If I could just comment. One of the things to always keep in mind is when you have one of these national surveys, they water down typically the survey so that it can be somewhat responsive to the variety of what you find out there clinically. And medical

control is a TAG not available in some large areas in different states on any kind of regular basis. Even New York State has some difficulty in some areas getting reliable medical control at a given time. Usually it's only due to technology, though, in this state.

But pediatric-specific, my understanding of the real goal was whether or not the EMS provider felt that they had someone that they could call who knew more about pediatrics, and the feds weren't going to, at least at this stage, demand what that was.

But I think as you're going to see as this comes out and over the next couple of years, they're going to try to better define that push some. What that is is probably going

to be in discussion at the national and state levels and what can we do. What could you potentially do?

MS. GOHLKE: Okay. So BLS and ALS. We have national and state numbers on the slide. BLS we're at an -- eighty-three percent that feel they have online pediatric medical direction at the scene as compared to the national sixty-nine percent.

For ALS, we're again ahead of the national average -- the national number of seventy-one percent and New York State is at eighty-one percent. So as far as how we compare nationally, we look good. We have a higher percentage.

Again, the target is to have ninety percent of the agencies have pediatric-specific

online medical direction and that's at year 2011. We're above the numbers through 2010. We do have to resurvey again in 2010 for a challenge to see if we can bring it up to ninety percent, but let's go a little further in the survey.

So, at what level is the online medical direction defined at your EMS agency? Now again, as Ed said, this is a national federal survey, so the language has to be generic so that all states understand. So this is where it gets a little -- where you start looking at the numbers -- you get fuzzy numbers here.

So is online medical direction defined at the state level, the region level or local level? And they didn't have that defined as either local hospital or other medical

personnel or other.

So at the regional level, New York State feels that it is defined for them -- thirty-eight percent say it's defined for them at the regional level. Fifty-nine percent of New York is in blue. Fifty-nine percent feel that it's defined for them at a local level. And then you've got two percent saying it's done at a state level and then one percent saying other.

The question is, you know, again, what -- how are you defining regional and local. You know. Again, is it my regional REMAC that's defining for me or are they local -- are they considered local? So there is some confusion, I think, with the question and how the providers are answering it.

DR. HALPERT: Could that

be a function of agencies that maintain their own set of protocols or is that --

MS. GOHLKE: I don't know.

MR. WRONSKI: Well, the fifty-nine percent would be high for local. I think you have providers who saw their local protocols -- their regional protocols as their local protocols.

DR. HALPERT: But I'm talking about ambulance X has its own operating protocols.

MR. WRONSKI: Certainly with air med and some of the specialty ambulances, they'll have their own local protocols. And then yes, you're correct, even some BLS agencies may have something that they see as their protocol that was developed by the ambulance service. So, they could also be responding to

that.

MS. GOHLKE: Brian, correct me if I'm wrong, but air medical was taken out of the equation.

MR. GALLAGHER: Right.

MS. GOHLKE: They're not in there. I mean, they were surveyed -- there were a few that were surveyed, but they were taken -- the feds didn't want that information so they were taken out.

Okay. So in general what level of training of the individuals that provide your providers with pediatric-specific -- so what is your perception of their level of training?

So again, New York State's in blue. Ninety percent said that they were ED physicians that answered the phone. Eleven

percent were PAs. Nine percent were paramedics. Seven percent is nurses and it goes down from there. Don't know is pretty low at four percent. So they all pretty much felt that they were ED physicians, but they could check more than one, I should say. They could check they were ED or physician's assistant or paramedic that answered the phone.

DR. HALPERT: Do you think it's significant that people checked off basic EMTs were providing online medical direction, both nationally and statewide?

MR. WRONSKI: Nationally, I'm not surprised. Again, there is such a diversity out there and difference in the system. But in New York State, I'd like to know where that is, because I

don't know of any. I think that in New York, any way, when they answered EMT, they probably just meant an EMS -- some EMS certified provider generically, because I don't know of any system that does that. Not medical control. They may have thought -- saw that as the dispatcher who could be an EMT. That's a possibility, but they're not supposed to give medical direction.

Where you will find it is nurses. There are nurses, there are PAs in New York that do this and as I'm sure you know, this is a hot topic at the moment at SEMAC for discussion as to whether or not policy should be changed to comply actually with the statute, because the statute says in New York that online medical control shall be

provided by a physician or under the direction of a physician. And the argument is should there ever be a case where online medical control should be under the direction of a physician, not directly by a physician. And there are some systems that use heavily nurses and PAs in their system.

DR. KANTER: Every once in a while, you see a statistic that surprises me that is very reassuring. I think the proportion that are accessing emergency physicians is higher than I thought and is a terrific statistic.

MR. WRONSKI: Just so you know, New York State having either an ED physician or a physician in medical control. They say ninety percent. I think it's probably close to

that, if not -- is very, very good. The national picture is -- other than a handful of states, is very different. It's very different.

MS. GOHLKE: So the next question was if you answered -- if they answered physician in the emergency department, do you know if they were a emergency medicine physician, pediatric emergency medicine, pediatrician, family practice physician, don't know, other?

So again, look a little better than national as far as emergency medicine physicians. Twenty-six percent, here we go, we don't know, really, who it is that they are on the other end of the phone. Questions or comments on this?

Okay. Just some of the comments. I put in quite a few

because they were interesting. So they say, Explain why you answered never, rarely, sometimes, or usually. So if they didn't answer "always," they had to answer this question -- to why -- to the availability of pediatric-specific online medical direction.

So the most common answer was communications failure. They're in a rural service. They don't have cell phone service and that's what they use to call medical control or the radio interference or whatever. They couldn't access them for technological reasons.

Okay. So number two, "The doctors who answered the phone at online medical control are generalists and trauma MDs or PAs and not pediatricians."

Number three. "Our

regional system for online medical control does not always afford the opportunity to speak with a pediatric specialist."

These get less common as we go along. Number four. "Occasionally does take an unreasonable length of time to contact physician at the hospital due to a very busy ER. Sometimes a doctor can take several minutes to answer a call for a signal."

Number five. "BLS unit not affiliated with any hospital or New York City medical control, so therefore we don't have online medical direction."

Number six. "The person answering the phone is an EMT, usually advanced level, who may not have extensive pediatric experience."

Number seven. "We have

never had a pediatric call so we've never called for online medical control."

So number eight. "We've never had to contact medical control for a pediatric call."

Number nine. "When an online MD is requested on rare occasions, the ambulance is at the hospital before the contact is made."

Number ten. "In a rural setting such as ours, we don't have the 24/7 advantage as a large urban setting would have."

Number eleven. "In my opinion, most providers are not always comfortable with pediatrics and dosages and they are drastically different for pediatric patients. This includes your medical control operators, not necessarily the physicians."

DR. HALPERT: So for number ten, can you go back real quick?

MS. GOHLKE: Yes.

DR. HALPERT: Does that mean that there is not twenty-four hour access to an emergency department physician? It's a rural hospital that --

MR. WRONSKI: There's a couple of hospitals that are staffed in the evenings with PAs and they are hospitals and they may be the only available.

DR. HALPERT: No, but the prior survey question said they're rural and they don't have online medical control. Is there anybody out there closing their doors after --

MR. WRONSKI: You mean medical control?

DR. HALPERT: Hospitals.

MR. WRONSKI: No. There

are no -- to my knowledge, there is no part-time hospital. But the nature of the staffing will change from daytime to nighttime.

MS. GOHLKE: Number twelve. "There is only one physician working who has not only the medical control responsibility but also has responsibility for treating an ER full of other patients. He may not be available when we need online medical control."

Number thirteen. "I work in a local ER and I know that the majority of the time the unit clerk answers the phone and has no medical training."

Number fourteen. "Phones are never answered by a doctor. Sometimes you have to go through two or three people to get to one."

Fifteen. "Go through the emergency department and talk to either a nurse doing triage or a doctor should the nurse there request him to give the medical direction and sometimes when contact is made with medical control. The doctor is only receiving what the dispatcher is telling him and not always in the room where the dispatcher is."

Just some interesting comments. And we talked about looking at this at SEMAC and deciding what we're going to do in New York State.

But I think Dr. Kanter made a good point. At least it's ninety percent of ED physicians that are -- at least the perception of who's answering the phone. So that's a good case scenario.

DR. COOPER: I think that point does deserve some special comments. We are Emergency Medical Services for Children advisory committee and we are by definition construction and every other way broadly multi-disciplinary of all the providers and agencies that help support emergency medical services for children.

And all of our specialties are required to have specific pediatric training as part of the goals and objectives of their residency and none of us can do it without the other. And no one on this committee has or I pray ever will suggest that EMSC belongs to pediatrics. EMSC belongs to all of us together, because we're all here to support emergency medicine online for the critically ill or

injured child.

MS. GOHLKE: So the survey then continued about their written protocols or offline written medical direction. So again you got to think of the language of our providers reading these questions.

The next one is, has your EMS agency adopted for use written or electronic offline pediatric medical direction? And it says, See above. It did have a definition of what offline medical direction was. So again there was a lot of reading with this survey, a lot of definitions, but it was defined for them if they read it all.

So do they have written medical direction? So sixty-four percent said yes at the BLS level, thirty-six

percent said no at a BLS level when you do define it at a state level. So that's a little concerning.

ILS, sixty-nine. Still thirty-one percent of intermediate said no. And then ALS was a little bit better. Ninety-two percent said yes, we do have offline pediatric medical direction. Only eight percent said no. You know. I think it was -- my opinion, I think it was just interpretation of the question.

What does adoption mean? People were confused. Did my agency adopt specific pediatric protocol? No. Again, how they interpreted the question, I think, clearly played into how they were going to answer. No, thirty-six percent of the time, at least for BLS level, anyway.

So the next question. When they have a specific pediatric call and they need off-line medical direction at the scene, are the protocols available in the patient care unit with the terminology? We also had vehicle in there -- or carried by the EMS providers. The "always," eighty percent of BLS said yes, they're always either in the vehicles. BLS -- ILS was eighty-eight percent and ALS was ninety-two percent. The feds want to see over ninety percent again for this target.

Again, comparing nationally with our numbers, BLS was just slightly lower as far as having written protocols. ALS was a little bit -- one percent higher, eight-four percent. And again, like I said, the target was ninety

percent for 2011.

So at an ALS level, we're good through 2010, at least as far as how they answered the survey. For the BLS level, you have to do a little figuring out on how to make sure providers know -- first of all, I think there is a question whether or not pediatric protocols, once we know there is the statewide protocols -- or maybe the question could be tweaked a little bit at the national level so the interpretation's better. I don't know. There could be an issue, whether or not they know pediatric protocols are within the adult protocols. I don't know, you know, what our providers feel at a BLS level.

Off-line medical direction in general. At the scene of an emergency, do your EMS providers

access -- how do your EMS providers access pediatric protocols or guidelines? Are they available in the unit? Eighty-four percent said yes. Are they memorized? Thirty-four percent said yes. Do they carry them him or herself? Thirty-three percent said yes. And again, they could check more than one. You have the national numbers there to compare to.

We don't -- we don't mandate that they actually have to be carried, either on the vehicle or on him or herself. We recognize it, but it's not mandated, and that's a glitch on the federal level. They want to see it -- it's supposed to be written somewhere and accessible on the scene.

MR. WRONSKI: Is there any comment by the committee? I

mean, BLS, I would argue that you don't have to have that protocol physically available with you, yet it's good practice to carry one in your ambulance. And I know that from going to calls in the past, I would refer to it if I knew where I was heading and it was likely to be there. But typically, BLS isn't so complex that you would necessarily need the protocol. But ALS could be different, particularly with kids. You might want to remind yourself of the dosages.

DR. KANTER: The American Heart Association in most hospitals, certainly the hospital I work in, has all the resuscitation algorithms posted right on the emergency carts that you can refer to at all times. You might think you know

them, but in a crisis, it's nice to glance at the algorithms right there.

DR. COOPER: It's often said that adrenaline makes you stupid. And yes, so I agree with Dr. Kanter completely.

MS. GOHLKE: So some comments here. So if they answered anything other than "always," they were asked to elaborate.

Protocols are kept at the base, but not all EMTs are trained before they ride on the ambulance. Interesting.

We expect providers to know protocols, and if there's any doubt, contact medical control.

Well, we have online medical control, so that's the purpose of it.

And we carry a copy of all

our protocols in our ambulance and our BLS first response truck. However, we also have some of our EMTs first respond to emergencies in their personal vehicles, where I expect they don't carry protocols. So it depends on how they're answering for each vehicle.

And they did ask, especially when you get to the pediatric equipment, it's any vehicle that responds to the scene. So if they have a fire tuck that's doing BLS first response, that was considered in the survey. Do you have protocol on it? Maybe not on the fire truck.

DR. HALPERT: Is there any feeling by the SEMSCO folks to try to enforce that kind of a proposition whereby there is a mandate, if you will, that a

protocol of some sort, in some fashion, is on the vehicle and accessible? That should be a serious consideration. I have a feeling about that.

MR. WRONSKI: They haven't expressed it, to my knowledge, at the meetings I've been at or had a motion to discuss that. I think conceptually, they all support that. It would be good to have this available. Mandating it, I know there's not been a vote to suggest that. If you did, it would be probably the only mandate that would be very easy to meet because you can download it from the state's website. It's not -- a few pieces of paper is all it costs. But Lee, I'm not wrong on that, right?

DR. HALPERT: Just from the discussion we've already had

today, we know that poorly managing pediatric-related cases is caused by lack of experience. And their comfort level, therefore, is not built up satisfactorily.

Bob's already mentioned having access to protocols or templates -- or guidelines available at the time of the emergency makes the job so much easier. So why ignore that fact and say to our field providers, Listen, you might be great at managing adults and heart failure patients, but you need to have a much better sense of what you're dealing with on a crashing asthmatic or a febrile or a seizing child. And if you're not comfortable with that or whatever your protocol driver is, it's important --

DR. COOPER: We did a few

years ago provide all ambulances in New York State with a copy of the resuscitation card and the children's special healthcare needs cards. We presume they're, for the most part -- but you raise a good point.

MR. WRONSKI: Well, the committee, either now or later when it has final comments, can certainly make a recommendation to the SEMAC that they look at language that they might want to direct EMS services to have state or regional protocols available in some fashion at the scene of an emergency. You don't even have to say mandate. You can just say promote. But, I mean, this body can do that. That can go forward to the SEMAC for consideration.

MS. GOHLKE: Okay. So just a summary of this one

survey, the medical direction survey. So ALS says that eighty-one percent have access to online pediatric medical direction. BLS, eighty-three percent. That's wrong. That number is wrong there. Oh, yes. I was thinking of the protocol. Online, yes. Eighty-three percent BLS. So we exceed the targets through 2010. We'll have to resurvey again in 2010, and again, the goal is to be at ninety percent by 2011.

For offline written protocols, ALS said eighty-four percent have access to these written protocols on the scene. Fifty-five percent BLS have protocols on the scene. So for ALS, again, we exceed the 2010 federal target. For BLS, we only meet the 2008 target. On both -- we need to get them both

up to ninety percent by 2011.

Let's skip this for a second and move on to the rest of the survey. We can come back to this.

Pediatric equipment. So the survey continues and it asked them about what pediatric equipment they have on the scene. And again, this is any vehicle -- they wanted to know any vehicle that's responding to the scene, not just the transporting ambulance but fire trucks, first response, fly car, whatever. Those were all in the mix here.

So about thirty-three states and about six territories were surveyed. Again, New York State is not in the national numbers. Nationally, they had 4,100 records to look at. You can see how it's split out

nationally versus New York State. And again, New York State was above the average number of EMS agencies that were surveyed.

So they asked about the -- or the patient care units or vehicles that are responding, ALS or BLS. New York State is about a 50/50 split. Nationally there was more BLS vehicles responding than ALS.

They -- we used the 1996 ACEP/AAP equipment list. This included adult equipment and child -- adult and adolescent PSA data. All the ranges of equipment. So it wasn't just pediatric equipment. And they had to answer for each vehicle. Do you carry this piece of equipment on your fire truck or whatever it is they're talking about? So it wasn't like an

inventory as far as how many pieces of equipment they carry on each vehicle. It's just whether, yes or no, they carry it.

So the bottom line, of all the equipment on that list, what number -- what percentage of these do you carry every single piece of equipment? New York State came in a little higher than the national number. We came in at twenty-seven percent versus nationally only twenty percent of the vehicles carry all the recommended pediatric -- well, actually, it wasn't all the pediatric, it was all the recommended equipment. Like I said, it included adult equipment, too. And again, the national target needs to be over ninety percent by 2011.

It is split out here by

BLS and ALS. BLS was higher than ALS in New York State for carrying the recommended equipment. And again, you have to remember here that this is fire trucks responding, fly cars. If you didn't carry a backboard because you're a fly car and then the ambulance comes behind you, but you got dinged if your fly car didn't carry a backboard. So again, it's all the vehicles that are responding. A fire truck may not have a backboard on it, so you got dinged. You're off the list if you missed one of those pieces of equipment.

Now what's changing is the next time we do this survey, the feds have changed. They're only going to consider transporting vehicles, the patients being transported to the hospital. So

automatically the numbers are going to go up right there because they're taking out the fire trucks and they're taking out the fly cars. So that's a good thing as far as -- whether or not it's intentional, I don't know. But we'll just automatically do better the next time we survey just simply for that reason. And it makes sense. I don't know why they didn't do it the first go around.

So BLS equipment most often carried in New York State was like FYI. Why we're not at a hundred percent on some of this -- but like the NRB breather for the adults, the blood pressure cuff for the adults, the BVM for the adults. All these pieces of equipment, you would think that they would

also maybe have on the fire truck as well, but it's not all carried.

Just as an FYI, the BVM, they split out the mask for the BVM and the bag for the BVM. So you had the right size mask for the infant and the child and you had the right size bag for the BVM. But because it was split out, that confused people. And a lot of people said, Oh yeah, we have the infant size BVMs but we don't have the smaller size bags to go with it. In fact, a lot of people said, That's out of scope for us. So again, the way the question was asked, it was very confusing. It was defined, but again, it required a lot of reading. So I think that affects some of the numbers, too.

The least often carried

was the pediatric backboard. And then they had the different size suction catheters.

Pediatric splints was one of the things that was on the list. You had to have a specific pediatric splint. A lot of people said, well, I can modify an adult split. That's why we don't buy them or whatever.

Portable suction with a regulator. Portable suction with a regulator, a lot of different size suction catheters, and the pediatric backboard. When the new list comes out very shortly, they're all on an optional part of the list. So again, we'll look better because it's moving from a mandatory part of the list to an optional part. So that will help us.

ALS equipment most often carried. Again, very high but not a hundred percent or ninety-nine percent. NRB breather adult, blood pressure cuff. Again, the BVM issue there with resuscitation bags, oropharyngeal size four and the BVM child.

ALS least often carried equipment. Pediatric backboard, oxygen mask infant, ET tube size six -- you know, twenty-five gauge needle. A lot of these sizes -- you know, they required every single size of needles, suction catheters, before. And now, in the new list that's coming out, they're saying you only need two sizes of suction catheters. You don't need the zero through five or whatever the numbers were. So again, that's a good thing. You can

just compare the national numbers. You know.

Most often carried equipment, BLS were higher than the national average, on average. And for least often carried, again, we looked better than the rest. ALS most often carried were pretty much on average with what the national numbers are.

Least often carried, pediatric stethoscope. My little caveat there. A lot of people, when I called, you know, had to follow up with questions and answers. And they would say, Well, what's a pediatric stethoscope? So it's a double bell pediatric stethoscope. And the answer was yes, but that wasn't in the survey. So a lot of people obviously had that question. If you had a double

bell stethoscope, you were okay with this.

I'm currently taking my EMT course and I'm sitting in my lab portion of it and somebody says, What's -- to the lab instructor -- there was two certified lab instructors in my little station here. And somebody asked on a double bell stethoscope, What's the smaller size for? And one lab instructor looks at the other one and says, I don't know, do you? And the other lab instructor goes, No. So I said, I think you can use that for heart in peds. It's recommended. You know, it's a little more sensitive. Oh. So that just goes to show you the ones that are teaching aren't necessarily familiar with the equipment very well either, so

--

MR. WRONSKI: Martha is taking her course in Vermont.

MS. BURNS: All of these were done in Vermont because it's still regulatorily (sic) required.

MS. GOHLKE: But the good news is it's a pediatric stethoscope and it's now in the optional portion of the new list that's coming out. But it's still regulatorily (sic) required.

MS. BURNS: But New York State does require it. Good point.

MS. GOHLKE: So that's my little story there for that one.

Okay. So now we ask, what's the reason, why don't you carry this stuff? So the number one answer was, in New York State, that there is no state or

local requirement on a lot of this stuff. The same with the local fire departments. We don't have to carry it; we're not going to carry it.

Only eight percent -- again, New York State is in blue -- only eight percent said they had limited funded. So money wasn't an issue. Four percent said, well, the pediatric equipment wasn't necessary, at least the ones that they said they don't have. It's used too infrequently to justify the expense. And one percent said, well, it's not reusable.

So -- so that's kind of interesting, especially the funding issue. I would have thought it would have been higher. I would have thought you would have heard the cry, Well, we don't have the money,

but that didn't appear to be really the issue.

So I gleaned from it that if we mandate it, they'll do it, at least that's what eighteen percent feel. Looks very similar for ALS answers here, too.

So some of the comments. Well, they're not in responder cars due to the ambulance responding with the responder car. So obviously they have all the equipment on the ambulance, not necessarily in the fly cars. Other devices can be used for multiple tasks. Like it says -- for example. And the amount of equipment, medication, etcetera are very costly for the amount that is actually used. Most peds calls are fracture in nature. So they were all pretty similar in their comments like

that.

Just -- this was just a little interesting, who answered that the equipment was out of scope for them. So they could have answered, "we have it", "we don't have it" and "it's out of scope for us, we can't use it."

So six percent of the patient care units, when they responded, said it was out of scope for us to use an oxygen mask for an adult. It's out of scope for us to use a portable suction unit with a regulator and it's out of scope for us to use a one-size suction catheter. Just kind of interesting answers. Four percent said it is out of scope for them to use a BP cuff for an adult. And then here's the bag part of the BVM. A lot of people said, you know, that's out of scope for

us. Pediatric backboard's out, cervical collar for an adult, and bulb syringe. You know.

MS. CHIUMENTO: Martha, I wonder if a lot of those are CFRs, because CFR protocols are not specifically --

MS. GOHLKE: We didn't survey them.

MS. CHIUMENTO: That's what I'm thinking, particularly blood pressure cuff. And for a while we said that wasn't part of the curriculum and the backboard -- and you don't do backboard, you only do mobilization. So I suspect that's where a lot of those are.

MS. BURNS: They surveyed ambulance services, not the BLS first responders.

MS. GOHLKE: We didn't do the BLS first responders.

MR. CZPRANSKI: In many

parts of our area, you have the fire departments that run the ambulance service and the chief responds in the chief's vehicle, who is a CFR.

So again, if you're going back and saying to look at the responding vehicles, that's where I'd look a the gap in the ninety-five percent. A lot of time it was a vehicle that wasn't an ALS fly car.

MS. BURNS: Aren't you optimistic?

MS. GOHLKE: Okay. So twenty-seven percent -- as far as having to look at the feds, twenty-seven percent of the agencies report carrying the recommended equipment. We fall short of all the targets, but we look better than the national number, which is twenty percent. But we still have to reach

ninety percent by 2011.

MS. BURNS: Get to work.

MS. GOHLKE: The new list is coming out. They're presenting it to the grantees in three weeks, I think. I did get a peek at the new list, the language. I mentioned where some of the things were moved to optional.

DR. COOPER: Has not changed.

MS. GOHLKE: So they had more of the national committees signing off on it this time around, ACEP and ACS, but you got the national association of EMS physician and then the federal EMS stakeholder's group.

One of the questions I had, were there any paramedics involved in the new list? And the answer is yes. It wasn't all physicians who were making

up this equipment list number. There were EMS providers involved in the new equipment list.

So the piece of equipment that might be an issue for us. We don't say that the portable suction has to have a regulator and it's still not on the mandatory list. We say, well, the new list says you have to have two pharyngeal suction tips, one between each of these sizes. We don't necessarily say they have to be between those sizes.

The valveless oxygen masks for adult and child is still on the list. And we say that for adults you're to use the NRB breather. We're going to fall short there. The NPA sizes, eighteen to thirty-four is on the list. We don't even have

NPAs on our list.

Alternative airway devices is not on our list. The pulse ox with pediatric and adult probes, no, we don't have that on our list.

Tourniquets are on there. Thermometer with the low temperature capability in a hypothermia issue might be a problem for us if we don't have those low temp monitors there.

And believe it or not, umbilical tape is on the list there and we don't have it on our list for the OB kit. So those are some of the pieces of equipment for BLS that might be a problem next go around.

For ALS, they have laryngoscope blades. You have to have one between each of those sizes. Actually, all those sizes you have to have on

the list.

ET tubes, those sizes have to be there. We don't mandate this on our list. End tidal CO_2 capnography is on there. Tourniquets again. Now a 3.25 inch needle for chest decompressions there. And the transcutaneous cardiac pacemaker adult and peds pads is on there. It looks like it may cause a problem for us.

Optional equipment. Like I said, oxygen masks -- the infant size was moved to the optional side. The infant bag was moved to the optional side, size 00 NPA. Infant and neonatal BP cuff is moved to the optional. Pediatric stethoscope, infant CV collar and pediatric backboard were all moved to optional, so that will help us.

MS. CHIUMENTO: What happened to the NG tube, the nasogastric tube? Did they stay on?

MS. GOHLKE: They only stayed on if they -- if somebody marked it as out of scope, then they weren't included in there. So for a lot of our providers, it is out of scope for them. So they weren't included and they weren't dinged if it was out of scope.

MS. CHIUMENTO: Because I remember that was the one piece of all the pieces that was the most often for ALS.

MS. GOHLKE: Was that on there?

MS. CHIUMENTO: It was, but I didn't see it on your presentation.

MS. GOHLKE: Actually, I think I talked to Brian about

this at a later point after you saw the original presentation and we talked about pulling it out because they marked it out of scope. So that's probably changes you saw in the presentation.

MS. CHIUMENTO: I remember that before you did the original survey. That was the number one thing --

MS. GOHLKE: Could be. Honestly, I did not go back as far as Gloria's surveys, to be honest. I had enough number crunching to do with my own survey. I have not even looked at what Gloria --

MS. CHIUMENTO: That was the one thing, but most of the people did say it was out of scope.

MS. GOHLKE: And it's probably -- I don't know the

difference when they surveyed back then. They probably added that question about out of scope. They probably didn't ask that before. I'm just guessing. But they keep refining, obviously, the survey, so that could be one issue with that.

DR. HALPERT: So Martha, you keep referring to providers answering the survey questions. That's the provider's perception of their scope of practice?

MS. GOHLKE: I would assume so.

DR. HALPERT: Define "scope of practice."

MS. GOHLKE: Only NG tubes, as far as I know, are the only thing that would legitimately be out of scope according to the pediatric list. What else?

DR. HALPERT: They're not

out of scope.

MS. GOHLKE: Which ones?

DR. HALPERT: NG tubes are not out of scope.

MS. GOHLKE: For some of them, regionally, I believe they are.

MS. CHIUMENTO: Yes.

MS. BURNS: There is a difference between out of scope and what is not included in their regional protocol, because NG tubes are in the curriculum.

DR. HALPERT: Right. That's what I'm using in my scope.

MS. GOHLKE: Are they allowed to use it or not, would be a better question.

DR. HALPERT: Are they able to train docs? The answer is yes. Can they use it as a function of --

MS. GOHLKE: In many

cases, no.

DR. HALPERT: So I'm saying it's in the curriculum, it's not in the scope of practice.

MS. GOHLKE: Right. Again, it could be interpretation.

DR. HALPERT: It's providers' interpretation of the scope of practice.

MS. GOHLKE: Right.

MS. BURNS: It is their interpretation. They don't need NRB breather masks, too.

DR. HALPERT: Right.

MS. GOHLKE: Surveys are always interesting. So anyway -- so the new list is coming out, like I said, shortly. You know, at a state level, we have to decide how to -- what we're going to do with this list, you know, if and how we distribute

it.

Does It require any changes to our list, our regulation, our part 800? Like I said we do need to resurvey in 2010. We probably will do an online survey, although there were issues -- there was an issue, though, with the paper and online. I actually think, in this case, the paper worked a little better, because in the online if you answered that anything -- the default -- they first asked you, Was any of this equipment out of scope for you? And you had to click yes or no. And it was defaulted to no. So nothing was out of scope for them. They had to move to the yes column if it was out of scope. If you misread that, a lot of people said yes we use all of this equipment, which got

then marked as out of scope. So if you did that, they didn't ask you any of those equipment questions. You got to skip over the survey in the online one. But in the paper one, you still filled out the questions, so you could change your answer and go back.

So anyway, again, if we are going to do this online or not, how we can refine that for our needs. We also have the option of doing the ambulance -- you know, doing the pediatric equipment list survey by ambulance inspection or maybe through doing the survey when you recertify services every other year is another option on how to handle the survey. Just food for thought for how to do for 2010. Comments?

DR. COOPER: Well, I have

a comment.

MS. GOHLKE: Yes.

DR. COOPER: The EMSC stakeholders are meeting in Washington on Thursday and Friday, and unless something radical is done, no one is going to make this benchmark guideline by 2011.

And the way the survey is constructed, of course, if you miss one of those pieces of equipment, you become part of the seventy-three percent as opposed to twenty-three percent, even though you may have virtually everything you need to resuscitate ninety-nine percent of kids.

So I think there does need to be some additional thought at the federal level as to how the survey is going to be administered and scored. But

beyond that, as you say, it's very interesting.

Gloria had conducted a survey quite similar to this a few years ago. I think we're doing a little better this time are around, as I recall. The one area where we continue to be especially weak is with nasogastric tubes. But the --

COURT REPORTER: I'm having a hard time hearing you.

DR. COOPER: Nasogastric tubes. I'm sorry. For some reason, this microphone is not the healthiest.

The -- but there has always been a problem with the use of nasogastric tubes, mainly that the training models that are out there are essentially non-existent, and the teaching about gastric distention and when to be compressed is quite

important. And -- or, I'm sorry. Even though quite important is quite problematic.

I mention this because one of the least cited, yet most important in my judgment, findings of Marianne Gausche's study regarding intubation was the twenty-eight percent incident of gastric distention in the children who were bagged as opposed to tubed.

Now, we all know that excessive gastric distention can limit the efficacy -- well, I shouldn't say efficacy -- the effectiveness of bag and mask ventilation. And so it would seem that -- that having the ability to decompress a distended stomach would be an important issue and that training models would have been developed to deal with that

issue. But they have not as yet been, which is really, to my mind, very interesting.

DR. KANTER: I think the other thing that's missing is evidence about what the proper sequence is to do things in. But for what it's worth, the American Heart Association pediatric advanced life support guidelines acknowledges that it's not completely clearcut whether you should intubate first or decompress the stomach first.

And for those systems that are not going right to prehospital intubation, the other question is, what's the best way to bag them and ventilate them, with or without a nasal or oral gastric tube in. It's harder to get a seal with a tube in.

So I'm not sure that they ideally know, based on evidence, what's the best way to go.

DR. COOPER: I certainly agree with you in terms of the -- in terms of the timing. One thing upon which we can all agree, however, is that if you do, in the course of bag or mask ventilation, involve diffusing the distended stomach, that at some point whether the tube stays in or is replaced or removed, decompressing that stomach will certainly assist in adequate ventilation with bag or mask ventilation. So this is an unsolved problem for many different aspects, but one that I continue to feel is one that requires our continued thought.

MR. WRONSKI: Can I just ask, because I don't know, how do you reverse that, the

stomach, the distended stomach? How do you reverse the effects of the distended stomach?

DR. COOPER: You decompress it with a tube.

MR. WRONSKI: With a tube?

DR. COOPER: Yes. You pass a tube into the stomach.

MS. ROGERS: As far as the survey goes and resurveying, what measures other than the equipment list changing are there proposed to improve our responses in the state to these questions?

MS. GOHLKE: That's what we need to decide.

MS. ROGERS: Pardon?

MS. GOHLKE: That's a good question. That's what we need to talk about.

DR. COOPER: You know, I think it's a very hard question to answer -- in fact, almost

impossible question to answer, because with the institution of the new list, it is going to be very, very hard to have a baseline to really know where people are starting from. And I think this raises a very important question for us and I will plan to raise this in Washington on Thursday.

If we are instituting a new list, perhaps we need a baseline round before we, you know, ask people to meet new targets, because it's going to be very difficult, I think, to really know where we're going unless we know where we are.

MS. WALDEN: Martha, do you --

COURT REPORTER: Please use the microphone.

MS. WALDEN: I'm sorry. Do you have any proposals to add

new national questions?

MS. GOHLKE: I haven't seen the survey questions yet. We were allowed to tailor the questions to meet our needs in the state. We'll do a better job tailoring next time. I don't know the extent of how much we'll be able to change or change it a lot, more than one or two words.

I'll be honest. When I came on board, there was a real rush to get this done because New York was behind the eight ball and we did -- we did look at the questions and we did tweak a few things. But now that I'm more aware of this world and the issues behind it, it will be tailored a little bit better next go around and hopefully get the answers that we need as far as whether

they'll allow us to revise the questions without changing what the national question is. So those -- it could be better.

MR. WRONSKI: What I've asked Martha to do, too, is at the national meeting -- and stake out some of the issues we have about the survey and the perceptions of providers and etcetera and that -- you know, the people who put the survey together have to rethink how they phrase some of these questions or even what questions, but certainly to put that on the table there.

One other thing I'd like to mention is, you know, for us, Martha had said what's the way to do this. Do we do another survey? Do we do inspections? How do we do this? The best way and the most accurate way to

determine what equipment is being carried is through the inspection process. But that's a cumbersome process.

Right now, it takes us somewhere between four to five years before we had gone through every ambulance service at least once to determine their equipment. Now, could we do that quicker? We could, but it means stopping other things that we do. We could increase it probably without doing any severe damage to what we do in the region to something in the area of three years. But that's three years. And they don't usually want to wait three years for the survey results.

But keep that in mind. We would be able to do a survey of a few hundred services in any given year and have that

sampling. So if the sampling were accepted -- I think, actually, it was accepted even for the mailing, right? It wasn't all the ambulance services that were surveyed.

MS. GOHLKE: Correct. Right.

MR. WRONSKI: So if it was a reasonable number, say 300, 350, 400 ambulance services, we'd have a better possibility of doing the survey.

And the other possibility is we could go to our regions and ask them to assist in the survey if we wanted to have a more accurate survey and do it within a year's time.

MR. CZAPRANSKI: I have a couple questions. You had mentioned on the one slide that new questions were going to pertain to just

transport-capable ambulances.

MS. GOHLKE: Right.

MR. CZAPRANSKI: Is that going to be for all the equipment questions?

MS. GOHLKE: Yes.

MR. CZAPRANSKI: The only concern I have with that are the national standards for advanced life support are eight minutes and fifty-nine seconds, ninety percent of the time, and that's predicated upon a -- response system. And so if we're not measuring their capabilities to treat the patients when they get on the scene, it would be a concern.

MS. GOHLKE: You're the first person that has expressed that. Good point.

DR. COOPER: Okay. Well, first I think we owe a tremendous debt of gratitude to

Martha and her colleagues for doing this.

MS. GOHLKE: Brian.

DR. COOPER: And of course we're very happy for Martha, too, because this gave her sort of a baptism by fire coming on the job when she did with an undone project laid in her lap. But at the very least, we clarified the issue about the double bell stethoscope.

MS. GOHLKE: At least for me and about four other people.

DR. KANTER: I wonder -- just listening to all the information here, it strikes me that the one important inexpensive feasible improvement opportunity is the written protocols to be carried with the responders. I wonder if this committee could make some statement that would favor that.

DR. COOPER: Bob, I'm going to take that as a motion. Is there a second to that motion?

DR. HALPERT: Second.

MS. BRILLHART: Second.

DR. COOPER: Multiple seconds. Thank you Susan and Jon. Discussion?

DR. HALPERT: I think the real upside to this, frankly, is that by saying, you know, we're the EMSC committee. We require a mandate -- you all keep these protocols near and dear, tucked away someplace accessible in the unit. But the reality here is that the pediatric aspects of the protocols is a good deal more often, which means you're going to keep the entire protocol -- so you're going to get a better bang for your buck, which is important.

MR. CZAPRANSKI: The point of the question is that the protocols refer to both local and state issues.

DR. HALPERT: Well, because the local protocols are endorsed by the state, correct?

MR. WRONSKI: Yes. All regional protocols need to be approved by the state.

MR. CZAPRANSKI: Well, if I'm an ambulance, I download the state protocols but I don't download my local protocols -- regional protocols.

DR. COOPER: I think -- I take the sense of the motion to be that all relevant protocols should be available on the unit.

MS. BURNS: One of the things that -- I mean, I have these conversations with many of our local physicians. As a paramedic, it is getting -- I'm

not getting any younger, either, but it's getting increasingly more difficult to really memorize the protocols when the book shows up and it's an inch thick and tiny little print.

And what -- in conversations at the local level that I've had with providers, we are encouraging the providers to carry the protocol. They shouldn't -- it's impossible for them to memorize the protocols. And considering the numbers of pediatric patients that they're treating, it's even more frightening.

So to endorse downloading the state protocols and making them a smaller whatever so you can stick them in your pocket or saying that they should be on the vehicle is hugely constructive.

I think our environment -- as Dr. Cooper said, adrenaline makes you stupid. It does. And we're seeing an increasing number of protocol violation issues that have not -- the end result has not been patient harm, but it could be and we're dodging a bullet here.

DR. HALPERT: I would echo your sentiment entirely. In the old days -- back in the day, I was hardcore in terms of you must know your protocols inside out. It's your job. But the reality is as time goes on, it is hard to do that. Now whether or not that translates to less protocol violations, I don't know, because people who tend to have issues in following protocol will probably tend to do that whether or not the book is in the back of the truck or

not.

MS. BURNS: Perhaps, but when you add Solu-Cortef to the drug box -- and I saw in a catalog today you can now get a drug -- ALS drug boxes with wheels on it. You know. Again, as I'm not getting any younger, I'm thinking that's a really good idea.

DR. KANTER: It's really a question of what is the best practice. The best practice is you know your protocols and you also have a written reference.

DR. HALPERT: Absolutely.

MR. WRONSKI: I think the message is, it's not unreasonable to ask that this piece of material, these documents, be on the unit.

MS. BURNS: And supported by policy.

MR. WRONSKI: And we'll

support it by policy, as well, but I think it's good to bring it to a formal body and say this. Because all we're asking providers to do is -- your -- everyday you go to an EMS call being asked to do something in a fairly rapid situation. Often that materializes quickly, as you didn't really know what you were walking into in a percentage of these cases. So why not have a document available that might give you a hand to do the job better and remind providers that they shouldn't be ashamed to look at it.

You know, this isn't an ego thing, and they can get over that. So I think those messages need to be out there. Make it available if you need it and don't be ashamed to look at it,

'cause we all have to remind ourselves what it says sometimes.

MS. GOHLKE: The other thing that I forgot to mention from the online medical direction part was there are some BLS providers that, when I talked to them, didn't realize they could call medical control. They just thought it had to be an ALS provider. So that could be why they never called, because they don't think they can.

And even in my own service that I ride on, there was a comment made to me during one of the trainings that we would never call them. That's the ALS. When they come, they would call. And sometimes that would take quite a while for ALS to get there. So there is possibly

the perception that they can't -- they're not the ones to call. Hopefully that will change. But it was scary when my own service said that.

DR. HALPERT: You know, converse is they should not feel intimidated to the point that they don't do it. And we had it happen -- you know, you're right, where a basic EMT has gotten on the telephone and says, I'm not sure what to do regarding this patient. You know. That's reasonable.

MS. GOHLKE: Absolutely.

DR. HALPERT: And working from the ED side, you have to explain to your colleagues why the heck they're getting a call from someone who --

MS. GOHLKE: Right.

DR. HALPERT: But it will happen and we should grow with

it.

DR. COOPER: I sense that there's quite a bit of unanimity on this point, so since we have a full agenda ahead of us, I'll call for a vote. All in favor of the motion to recommend to the SEMAC that the pediatric protocols, together with the adult protocols, both state and regional, form, in effect, a key resource that should be physically available on every ambulance and fly car in the State of New York? Please raise your hand. All opposed? Okay. Without dissent, the motion is carried. Okay. Martha, thank you again for that terrific job. Okay.

We're going to move now into sub-committee progress reports. Sharon, do you want to give the report for your group.

MS. CHIUMENTO: Okay. We started off a couple of weeks ago -- I talked to Bob about getting together some resources for us to start looking at and planning for where we were going to go with the interfacility transport ideas. And we had a very productive conference call last week where we were able to come up with what our direction was.

Unfortunately, a lot of members were not able to be here today. We were going to advance a little bit more on those ideas today. However, Bob and I have had -- kind of had some discussion and come up with a plan of action.

Our primary thing is the stakeholder's meeting that was mentioned earlier. It kind of talked a little bit about some

of the goals we needed to meet and some of the general classifications because we won't have any insight into who might be invited directly into the stakeholder's meeting, but at least general classifications that we might recommend.

So, you know, not only the pediatric hospitals but the outlying hospitals and payers and a lot of other people that would really have some involvement in what we're talking about. So that was one thing we discussed.

The second thing we discussed was developing a set of draft guidelines to make recommendations to hospitals that are doing interfacility transports, the kind of things that they would need to have in place in order to do that. So

should they have a checkoff list and what would be on that checkoff list. There are fortunately several states that are ahead of us on this particular endeavor, so Bob is going to be working on drafting a set of guidelines for New York State. They'll be on what other states have done and then the committee will then look at that and say, Are there things that you may want to modify.

One of the things that Ruth came up with earlier today that we've not seen in other state guidelines is something related to the family component and what happens to the family and how does the family get to the hospital the child's being transported to. Information. What information do they need to have? So that's one of the

things we might add to ours that's not been in previous guidelines that are out there.

And then the last thing is that we wanted to discuss having a meeting with some Department of Health representatives -- and I know Martha did a little bit of work in relationship to this to discuss the importance of developing what some guidelines are and developing maybe some guidelines as to which hospitals are most capable of taking care of certain kinds of patients. And then some of that will go along with even the deliverable, which really has to have a written guideline.

So those are kind of the directions we're working towards and I don't know if you want to add a little bit more here.

DR. KANTER: Just a couple

of words. The issue is trying to get the right patients to the right hospital at the right time. And so we need some criteria for which types of patients should be sent to a pediatric-capable hospital, which hospitals are the pediatric-capable hospitals and which ones should be thinking about transferring a patient away to a higher level of care and how to do it in a timely way.

This involves all the details in the process. The good news is there's a lot of information out there based on experience, evidence and precedence in other states and precedence in New York State for other types of specialty high-risk services.

The real help that we need

is after we put together a draft guideline or draft set of guidelines is to have some help from the Department on how do we really take the next step to develop a consensus among the stakeholders. And the stakeholders are the usual list of providers at every level, institutions, hospitals, EMS agencies, payers, families, regulators, everyone who has to make this happen and has to make all the work that we all do with a major new set of regulations. How do we take the next step to work toward this?

DR. COOPER: I think that we did receive some encouragement from the Department in the past several months about the issue that Dr. Kanter is speaking of, specifically the statements made

by both Patsy Jones, when she was still with the department, and John Morley in subsequent meetings, who is, as all of you know, the medical director for the office of health systems management within the Department.

Now it came to my attention not too long ago that Ms. Jones left her position at the Department --and of course, I think, within the past few months. And, of course, as all know, the state has faced unprecedented challenges in terms of the economic situation that the state and nation finds itself in at the moment. And I suspect that many of these things that have conspired to put the issue of the view of the pediatric regulations that Ms. Jones and Dr. Morley were

championing a little bit toward the back burner.

But I think Dr. Kanter's point is right, that unless they are moved to the front burner at some point and in the relatively near future that our regionalization efforts will be difficult to accomplish.

So I guess the best thing to do is since we are an advisory committee to the Department is to ask Mr. Wronski if he could purse this issue internally and ask through the appropriate channels what our committee can do to facilitate this process.

We may not as a committee be ideally constituted to review all the regulations that are involved and assist the Department in that way, but there is at least a committee

that's in place and already meeting that could perhaps assist the Department in taking on some of that responsibility as a prelude to making a more formal recommendation to some other part of the Department in much the way that the working group on trauma regulations has proposed regulations or will be proposing regulations to the STAC in terms of the State Hospital Review and Planning Council.

Certainly our committee already has quite a bit of work product on its plate to be completed within the next couple months, but once again, it's difficult to imagine how we could get the regionalization agenda completed without some degree of, if not standardization, at least

categorization of what facilities are out there and what types of facilities might best suit the needs of critically ill and injured children.

MR. WRONSKI: It's my turn to respond. And I can't give you a complete response but what I can tell you is conversations I've had on two occasions, one just this morning with Dr. Morley. Because one thing that thirty-five years in state service has told me is get your facts straight before you say it at a public meeting, because you're stuck with whatever you say.

So, first, Dr. Morley, as I think you know, has had a meeting with the Commissioner previously and discussed the white paper that you worked on

and shared with the Department.

The -- what I've been told is that, one, the Commissioner sends his thanks and appreciates the paper and did discuss it with Dr. Morley. The -- more specifically, the Commissioner is very interested and I underline "very" because Dr. Morley did, very interested in understanding this issue better and getting more information as we move along about the issue of regionalization and requests items that you outlined in white paper. And so that's very positive because he's open-minded to this and does want to learn more.

Secondly, we did get a green light that if we feel that the best avenue to take the next step is a stakeholder's meeting that we can do that.

Now Martha and I had discussed -- there had been a previous stakeholder's meeting in 2006 -- or was it 2007 -- earlier, so sometime back, and whether or not we should move in a different direction from that. But a fair amount of time's gone by and the white paper has come on out in the interim. So my understanding is that the thinking was that we should have a stakeholder's meeting.

What we'll commit to is that we will work with you on identifying an appropriate stakeholder's meeting and bring together people who should be at the table for this type of discussion and exploration, because that's really still what we need to do. What is it we think we need to do, what does the information that we can put

our hands on say we should do in this state.

And so briefly some of the groups that we would certainly want at the table are the hospital association, as they're going to be the primary players in this. So we would invite HANYS, we would probably invite Greater New York Hospital Association from the City. It would be my thinking to invite physicians and physician specialty groups and possibly the nurse's association, as well, and groups that you might think should be at the table and advise us. And we would work with you to put that together.

The agenda, and again the Commissioner has not said to us go ahead and create a regionalized pediatric system. So I make that clear for the

record. But he did say, I'm very interested in all of this. I would like to see where we can go and what the stakeholders have to say about it, what their interest and support is and go to that step next.

From that, certainly we might -- that might lead us to a regionalized pediatric system, but it's too early to say until we have that meeting and have those discussions.

So I think it's positive but I think we have a little ways to go yet. It's been mentioned about regulations and what's going on in the Department right now with regulations. I actually am not up-to-date on where the Department might be in working on pediatric regs. I don't think they've moved anywhere at

this point because there's been so much going on in other areas that has -- such as the hospital overcrowding issue that has been really still at the top of the plate along with the Berger Commission and what its concentration, what hospitals, and then of course the couple of crises that came up that I mentioned earlier with hospitals closing precipitously. All of this has taken away some of the time.

But I'll talk to Dr. Morley and find out, is there currently an active group or do they plan to reconvene to talk about any specific pediatric regulations and the EMSC committee is interested in taking part with the Department in that regard.

So you might have

potentially some work that's done between the Department and EMSC assisting on just some regulatory matters. All right.

And secondarily, parallel of course, is to have this stakeholder's meeting to look at the big picture and maybe create something down the road if that's the way that everybody agrees. So any questions on this?

MS. ROGERS: I have a comment. When you talk about the issue of overcrowding --

MR. WRONSKI: Yeah, sure.

MS. ROGERS: -- because I think in some ways that duck tails with the regionalization issue because -- and we have -- we have conflicting opinions within our own hospital whether we accept a child in transfer from another institution when

maybe the ED is already boarding, we have no beds and yet somebody else from our institution will accept that patient, who could go to another outlying hospital.

And there -- you know, I think that is something that regionalization should address that there is other places and we have better relationships with each other so that we can place a child in a place where they're better cared for because they're less overcrowded at that moment.

MR. WRONSKI: Right. I absolutely agree with you. And I'll use this example, because it's the one I'm most familiar with, and that's the trauma system.

I had the pleasure of coming into the State of New

York EMS right about the same time that the trauma system was pushed by the state. There already existed a trauma system here. We didn't create it, it was there, but we formalized it, streamlined it, put some rules to it, and everybody was frightened about it because they said all of the trauma is going to go to this one hospital or two hospitals in the area and we're going to lose all that. Well, that really didn't happen. What really happened was, and I watched this carefully over the years and I didn't watch it consciously originally but then it came to my attention by a variety of people mentioning what they were seeing, and that is that the trauma system, the leaders in the regional centers, particularly and in the area

centers, assisted the community hospitals in understanding how to care for trauma, and pushed and created this regional system where people were looked at regionally. Care got better in some of those community hospitals. And so that was very useful.

I think the same thing would happen here if we did create a regionalized pediatric system where it's not simply where the child goes that's critical, because you know better than me, there's what percent of children really do need to go to the specialty center, but how many other children should stay in the community hospital and would be better served there, if not only because of overcrowding but because you assisted those

community hospitals in understanding how to take care of those children.

And so I see that -- that's how I see the benefit of a regionalized system. Yes, I think it would assist ED overcrowding, particularly if you set up communications along the different hospitals. I'll bring that back to Dr. Morley so he understands that, too. He may already understand that, but I'll talk to him about that.

DR. COOPER: I have two comments. First of all, I know I speak for the committee in thanking you for bringing us this information and expressing your willingness to move forward sort of dually, simultaneously, with a potential regulatory component if the Department feels we have a role in

assisting -- in assisting and developing that structure.

But also at the same time, moving ahead to the stakeholder's meeting, there's no better way to get buy-in for the proposed structure for regionalization than by looking simultaneously at the rules, you know, with stakeholders, you know, to vet them.

So I think that your statements are just right on the mark in terms of where we are all ultimately hoping that this might go.

I do think there is one part of the trauma experience, though, that we probably don't want to see repeated here, and as we move toward the brave new world of sixty hour work week residency training programs and practitioners who will be used

to working sixty hours a week and taking no night call, we're going to have to do a better job of really defining what conditions really need to stay at the local level and providing folks with the tools that they need to manage them safely.

We all know that, as Jan pointed out, part of the overcrowding issue has been moving a lot of the community toward the big centers. But while it has improved the care as you said, Ed, the system relationships, the fact that more cases go to the centers and fewer remain in the periphery also has increased the anxiety of local providers and has, in some cases, decreased local providers because they no longer have the responsibility for those patients and can transfer

that responsibility to someone else when the patient might be just as well served in the community.

So I think that as a trauma system, nationally, we have not done as good a job as we could have done in terms of defining what can and should be cared for locally and how the best practices should be in line to do that. And I think it's a mistake we don't want to make here.

DR. KANTER: And I think you're absolutely right that what has happened historically is that more children are being sent from community hospitals to pediatric hospitals. I think the intent of a good regionalization system might not further that trend at all. In fact, what you might really like

to do is keep more of the straight forward, simple cases in the community hospitals and reserve the pediatric hospitals for the more complex, high risk conditions. And it may be a diminishing number from what we're doing now.

MR. WRONSKI: One of the things I'd ask this committee to do today is to agree to put a subcommittee together that can meet and do some work over the next couple months on helping to define the agenda for the stakeholder's meeting with us.

And certainly one of the things that would be useful at the stakeholder's meeting, and I'll tell you would be paid attention to very clearly by the hospital associations, is what do you mean -- what kind of children need to go to the

specialty centers?

And so if they heard what you just said, Dr. Kanter, I think they'd be pleased because what they do is represent, yes, the best interests of the patients but the best interests of their membership, which is 220 or so hospitals in the State of New York. And so they'd like to be able to go back to their members and say, Listen, what they're building here is you're still going to care for children, but we're going to make sure that we help you identify those kids that you really can care for and move them on and that really is a small number of patients and here's what we were told at this meeting and here's how to look at it. I see that as a good agenda piece, the education of

the stakeholders, as well. Because HANYS won't walk into the room knowing this. They're going to need to have that discussion and have it on the table.

So it would be useful if the committee also worked in a small group and made recommendations on what this agenda should be.

DR. KANTER: As Sharon said, we're sort of operating on the assumption that that's part of our assignment here.

MS. CHIUMENTO: Some patients might just need consultation and nothing further, but at least they have some idea where to go.

DR. COOPER: I think Ed is speaking about a different issue, however. I think he's speaking about what the agenda

might be for a stakeholder's meeting. And I think the interfacility focus has been identification of a process for interfacility transfer and a way to identify the patients who should be transferred and should not and the resources that might be necessary to care for them.

So they're slightly different, I think, but I think that there's no question that the work that your committee is doing is really going to be essential to the stakeholder meeting. Okay.

Anything else from your group, Sharon and Bob? Okay.

MS. GOHLKE: We need to take a short break.

DR. COOPER: Okay. We'll take a short break. We're going to have to move fairly quickly when we get back, because it's

moving on in the day. It's 2:12 and we've still got quite a bit of work to get done.

(Whereupon, a brief recess was taken.)

DR. COOPER: Let's begin. I think we all -- to reiterate, we're very pleased --

MS. GOHLKE: The microphones are working, but you have to get on top of them. Okay.

DR. COOPER: We heard from Ed Wronski about his conversation with Dr. Morley and we look forward to putting together that stakeholder group. What I will do is ask that anybody who is interested in serving on that small work group to look at a potential agenda for the stakeholder meeting, contact Martha and let her know of your interest and we'll go

from there.

I will jump quickly to nominations/membership. Just to let you know that Kathy and I had planned to meet this morning on this issue, but of course, as you all know, her plane was detained and she was unable to be here until just a few moments ago. So we will have to defer that until our next meeting, but we will get together by conference call in between and share our thoughts with you at the appropriate time.

So I'll ask now if Jan Rogers would give a report from the education work group.

MS. ROGERS: I think I'm probably the least prepared to give this, because I feel the least knowledgeable, but I took notes so that was my mistake. Anyway, please hop in and make

your comments when I falter.

The main -- one of the main thrusts that we talked about, and this was a little last minute because Ann Fitton, unfortunately, was unable to come. She's celebrating St. Patrick's Day, at least in an official manner -- was the lack of pediatric information in the EMT intermediate refresher course. Apparently, there was a section that was inadvertently left out of that course and so there needs to be pediatric content addressed for that particular refresher. Is that correct? Okay.

And so we did not have available the old course because we would like to see, first of all, what the old course had in its pediatric, content-wise and

identify what would be appropriate for pediatric information for the refresher. So that was one of the issues, getting back in the information.

We did briefly look at the EMT-I original curriculum and we glanced at that to see what kind of pediatric content and we noticed it was very integrated with the adult content. And we kind of discussed it a little bit, at least, about the fact that if it's integrated with the adult content it may be taught by somebody who is more -- more knowledgeable about adult versus pediatric content. And that was just an issue that was raised. I don't think we were willing to go any place at this time with it, but I think it needs more investigation rather than having like a separate component that

was pediatric. Okay. Anything else about that particular issue? Okay.

We talked about maybe getting together for a telephone conference once we got more information about what was missing and what needed to be included. So that was one of the proposals as far as taking this matter further.

One philosophical issue -- I think we kind of got a little bit -- a little bit off the track, but I think it was a very good issue related to education -- was more of a philosophical issue that Tim raised about the amount of transport time it's taking to get a child to the hospital if the paramedic or the basic -- more the paramedic and the advanced EMTs are trying to implement their skills in the

field rather than getting the child to the hospital. And some of this has to do with transport time. But if you're very close to the hospital, wouldn't it be better to get the child to a more definitive place of care rather than staying out in the field and trying to start a line or trying to intubate or trying to do advanced skills. So I think that's a good philosophical thought to have in mind when you're looking at the education of paramedics, I think more so than basic that it may not be the best time to show off your skills. It may be better if you can get the child to the hospital faster. So more emphasis on what skills are most important to keep the child's airway open, to keep him breathing in a safe fashion and

get them to a hospital faster. What else did we talk about.

DR. HALPERT: I think the further clarification on that point -- you're correct in what you said, but the other part of that was the EMS provider feeling comfortable in utilizing those skills in the in-transit mode.

MS. ROGERS: Oh, yes.

DR. HALPERT: So not distinguishing on-scene care from in-transit care, but continuing care that integrates with the overall emergency care system so that one should be capable to provide their skills and abilities while in transit.

MS. ROGERS: We talked a little bit -- I think I brought it up because I know we are becoming more encouraged into identifying our competency

levels.

As a nurse practitioner in the emergency room, it's becoming more emphasized that we have to actually document our competency. And if we don't see a certain number or do enough procedures in a year's time, then what remedial training will we need to keep our skills up. And we talked about the fact that if we don't get a certain number of skills to prove that you are competent, then you have to go into extra remediation time or refreshing times. And so there is a tendency to feel like you have to get your skills in or you're going to have to spend time refreshing. So there's a little bit of edge there to actually do the skills rather than it may be better to just get the child into the

emergency department. So there's a lot of --

MR. CZAPRANSKI: To develop on that further -- to say you need five intubations in a year. You've got four. You've got a pediatric patient that qualifies for intubation with a hospital three minutes away and you spend fifteen minutes on scene. So are you making decisions clinically-based or to hit a number or what the case may be?

I sat on a child mortality review team in Monroe County, and when I got to the prehospital care reports, one of the things that surprised me is the amount of scene time for pediatric patients. Most of these are infants, and twenty minute scene times when they're three or four of five minutes

from a major facility. These are kids you can pick up and go. These are non-traumatic injuries. So it's one of the things we're looking at.

And in the training module, once you get on scene and you do your scene safety and you start working through your skills history and your ABCs, at what point in time do you treat pediatric patients or do you pick up and move quickly? I think that's something we probably should look at the national critical level or state critical level. Where does that transport decision come in? It's different for a certain subset of pediatric patients.

DR. COOPER: All very good points. Jan, since you did take the notes, if you'd be kind enough to summarize them in the

form of some kind of very brief dot point list of thoughts that your committee shared, that would be helpful. And Sharon will be doing, as well, I trust.

So are there any questions or comments at this point? Ed.

MR. WRONSKI: Just a quick comment. Brain and Martha have looked at data -- pediatric, and one of the things we have is the 2006 PCR data. 2007 will be ready by May.

One of the things we can do, too, is take a look at the break out of scene times, pediatrics versus adults. I don't know that we've ever done that. We've done scene times in adult but I don't know that we've broken it down into the age groups. And if we looked at that, what would the difference be? And I'm hearing it might be

different. So we have data that is not really that old. You know. The system isn't going to change next year or isn't going to be different this year to what it was two years ago. So we can take a look at that.

DR. HALPERT: And I meant to ask this before, so I apologize. But it is almost a little counterintuitive to look at the pediatric fatality rate. So the delay you're talking about is, I presume, the most critically ill patients. And I wonder why that is. There is a set-up on the scene for someone that probably needs more expertise -- so I'm not sure without really seeing a case by case basis. I'm still scratching my head about that.

MR. CZAPRANSKI: I mean, the cases that we looked at go

through a -- you know, a series of sort of checks and balance. Usually they have CBC involvement or some level of county or state involvement in the home already, social worker or some other or it's a complicated case, unexplained death or ME sent it to us to say, This didn't go in by EMS to the hospital so it wasn't reported that way to the -- MEs office was called to the scene.

Fewer number of cases -- by far, most of the cases had EMS transport responding, law enforcement as well as social worker component. All those are brought into play. They're kids that have sometimes been neglected or get too much medication or are in some sort of respiratory crisis because it hasn't been treated properly at

home. There are a lot of reasons for it and they are critical.

And one of the things that I think the whole group agrees with is if I've got an eleven month old infant and I'm 150 feet away from an ambulance and two and a half miles from a hospital that has a whole team that can treat this patient, why work with one person? Do what you can do and move that patient along.

And I don't think that transport decision, at least in our discussions, has entered into the education piece of that as it relates to that subset of patients. When I talked to the paramedics involved, it makes perfect sense to them -- A, B, C, D and then start thinking about transport. We should

probably think about transport much quicker.

MS. CHIUMENTO: I'm just wondering, do you have a copy of the '09 protocols, because I believe I do, so if you let me know what section you want, I can probably scan it and e-mail it to you.

DR. COOPER: Okay. Any other thoughts regarding the education sub-committee report?

Hearing none, we are very fortunate that Gary Tuttle was able to take some time out of his busy schedule today to show us the EMS website and where we and EMSC might have a home within that EMS website at some point in the future for those of us who are tech savvy or who have become tech savvy. So Gary, if you'd go ahead.

MS. GOHLKE: And I thought

it would be nice to see one of the faces behind the big curtain here. This is one of our faces, so rather than listen to me and Dr. Cooper drone on, we asked Gary to chime in with his voice.

MR. TUTHILL: Thank you very much for having me. For the purposes of the stenographer, it's Gary Tuthill, T-U-T-H-I-L-L. Okay. Can everybody hear me okay?

Our website, if you go to the main department website which is www.nyhealth.gov and then you scroll down you'll get to the Bureau of EMS website.

On the left-hand column here towards the bottom, you're going to see EMS/EMT. Click on that. That goes to the Bureau of EMS home page. From this section on, it's the part that I maintain and am fondly familiar

with it.

You go down to the section for Bureau of EMS. It's got that and our staff, if you're interested in who does what in the Bureau.

Regional offices -- who works at the regional offices and stuff. You know, as you scroll down, it has a section for each area office.

Our forms page, right below the regional offices, that's got pretty much every form that the Bureau uses. There are some sections that probably will be added in the coming months, whether I like it or not. But anyway, if you're looking for a particular form for EMS, which I'm not quite sure what the committee here would have a need for, but the forms are all located on this

one site. Every other spot on the web page here that discusses forms will have a link back to that forms page. So they all link back to that one.

EMS statistical information. Right now as of 2005, I will be putting updated stuff on there. I believe 2006 -- 2006 or 2007 --

MS. BURNS: Six.

MR. TUTHILL: Six. So 2006 will be going up soon with the data.

MS. BURNS: More data than you know, courtesy of Brian.

MR. TUTHILL: Thank you, Brian.

MR. GALLAGHER: Sure.

MR. TUTHILL: Information by counties might be -- I'm just going to click on one county because they're all -- they all have the same information. But

Albany County will have listed the EMS coordinator's name, his or her office phone numbers and e-mail, which regional EMS council and program agency is covered -- covers that county. The actual ambulance services, their address and level of care. Non-transporting, BLS first response services or ALS first response, either way, same thing, address and level of care. Hospital information for that particular county and then for EMS purposes the location codes for their documentation. Last thing at the bottom of the page is going to be the regional office for our bureau that covers that particular county and their contact information.

Updates and announcements. I put here any kind of important announcement that comes up.

Usually it's a manufacturer recall or some other recall, like the peanut butter incident. Most recently, Welch Allyn AED 10 just had a recall. That information is up. The FDA notice is up as of about an hour and a half ago, actually.

Public meetings, where your meeting schedules are. We have the SEMAC, SEMSCO, Trauma and EMSC on this page. Right in this section also, after the meeting is done and the minutes are completed, I'll be posting the minutes here so you can just obtain minutes from previous meetings here. And as the agenda gets formulated for upcoming meetings, I'll post that as well.

Webcasts. If you can't make it -- you can't make the SEMAC SEMSCO meetings and you

wish to view them, that's where you find them.

Education gets pretty involved. Where to obtain EMT courses. The curriculum is here as well, CIC, CLI, and the EMS curriculum. So if you want to research what's actually in the current curriculum, you can locate it on this page. Course locations and how to find courses. Exam schedule if you're interested in that. Frequently asked questions for certification, there's a page for that. That covers everything from certification, recertification, reciprocity, military leave, a wide gamut -- questions about CLI, CIC certification, as well. This isn't going to have a lot of interest for this particular committee, but applications for

a service to go operational. The BLS protocols for the state would be here.

MR. WRONSKI: And as I mentioned earlier, they were just changed, so is this the updated protocol?

MR. TUTHILL: Most recent, yes. And then actually, if I can go back to the protocols, it has a link to SEMAC advisory, which I'll get into a little bit --

CFR protocols. Right now it's very messy -- it's a messy page, I'll freely admit that, but it is being updated to look very much the same as the basic life support for EMT and A-EMT protocol. It is going to be one PDF and look a lot cleaner.

Stroke centers. As I get notified of the new stroke centers in the state or a

hospital has closed or dropped its designation as a stroke center, I'll add or remove it as needed. But they're listed by regional EMS councils. Central New York, for instance, has Crouse, SUNY Upstate and Tompkins County, Cayuga. So those are added, you know, as I get the information.

MR. WRONSKI: And if you know in your region that somebody has opened as a stroke center and you didn't see it on here, feel free to send Gary a note and we'll check it out.

What we have found most often is that the hospital has jumped the gun and actually hasn't received the final letter from the Commissioner but has told the EMS community, We're approved as a stroke center. But they can't actually do that

until they have a physical letter from the Commissioner.

MR. TUTHILL: Prehospital quality improvement page, quality improvement manual. It's relatively large, so --

MS. BURNS: If you do have a chance, do take a look at it. It was really written by -- under the lead of Bob Delagi and Brad Kaufman -- Dr. Kaufman from New York City. And it's very, very good and it has a really nice educational package with it.

MR. TUTHILL: This is the educational package that she was just discussing. It's a Power Point presentation that the agencies can use to educate their own people on --

MS. BURNS: We had Marjorie look at it to make sure there were no inappropriate

slides. Bob Delagi and I -- you've got to look at it.

MR. WRONSKI: She did half the presentation.

MS. BURNS: I was going to say, because what's appropriate to us --

MR. TUTHILL: Our disaster preparedness page. There is not a lot of direct information that we've added. Just borrowed from other states and government agencies.

DR. COOPER: Could you just scroll back up for just a second?

MR. TUTHILL: Absolutely.

DR. COOPER: Just one suggestion. I don't see the FEMA training website listed in that section, training.fema.gov. Is it there?

MR. TUTHILL: Yes.

MS. BURNS: Right under

New York State --

DR. COOPER: It might be worth mentioning that there is special training available on that website.

MR. TUTHILL: The meat and potatoes of our existence is the policies and laws and regulations. Policy statements are on this page here, starting most recently, going to oldest policy statements. And as they're updated or deleted, they're added or removed here as well.

Coming up to the main page is located in this section here. The second one will be article 30.

MR. WRONSKI: If I could just mention on the policies. What a lot of people don't realize is that we have, at present, somewhere in the area

of a hundred different policies. The oldest ones go back to about 1984, maybe '85.

But what we've been mandated to do, and not just EMS but all of the state agencies is we have to make sure that any policy that's more than five years old is in fact still valid and that means -- maybe it doesn't apply anymore because the statute has changed and maybe it's just old information that needs to be updated. So we're having the different units look at a variety of policies to -- over the next year or two years, potentially update all of the policies -- delete or update so that this list will get crunched/ and what you're eventually going to see is all the policies will be typically no older than five years. As we

update them, we'll issue -- even if we don't change anything, all we'll say is this has been reviewed on this date and is reissued. But it will take us a couple years to really do a good job on all of them.

But there are significant policies and the EMS agencies follow the policies in general almost as if it they were regulations, at least we find that when we go out. They tend to be useful documents. We try not to make a policy like a regulation. Policies are meant to be guidance documents, but they're often backed up by regulation or statue.

DR. COOPER: Ed, are all the policies that are currently active listed on the website or are there others?

MR. WRONSKI: All policies

are on here, correct Gary?

MR. TUTHILL: Yes.

MR. WRONSKI: They're all on here.

MR. TUTHILL: All the active policies are on this page here.

MR. WRONSKI: And also at the bottom is the SEMAC advisories.

MR. TUTHILL: Then we go to article 30, public health law. In the table of contents, it's sectioned off so you can just skip to the section. You don't have to scroll all the way through it and that's very helpful in getting -- cutting to the chase on what you're looking for in the law.

There is EMS for Children law 30(c). Part 800 would be under the rules and regulations, and this is a direct link also

to the sections so you can go to where you need to.

We have information here that the department's -- department-wide has put information up on the recent changes with the Ryan White Act and post-exposure incidents for potentially infectious materials and guidance documents. So I added the link to that -- actually, I added this and the Department has a link to their site.

Lastly, we have the supporting programs. We have the regional EMS councils, program agencies, EMS for Children's page. Martha is very good at getting on me about keeping this accurate, so if you find an error, talk to her.

MS. BURNS: You can add your youtube video links too, if

you have them.

MR. WRONSKI: Or facebook or whatever.

MR. TUTHILL: Honestly, the most common change I put on this particular page is your own personal information, titles change, sometimes addresses change. Feel free to contact me and let me know that something needs to be updated here and I'll be happy to make the change. That's generally the most common.

Some of the products that you created and distributed, training documents.

Trauma program. Very similar actually as far as what they have, links and education stuff.

Link to our Vital Signs conference, information on that. That's also at the very top of

our website. I thought I'd advertise that a little bit.

Council awards, just the criteria for that.

State EMS council. This is a challenge to keep up-to-date with who is actually a vetted member and who's not, but when I get information I change it as needed.

And lastly, children's camps and the epinephrine auto-injector device law.

MR. WRONSKI: If I could comment. Gary's -- Gary's been doing this now for two years or a year?

MR. TUTHILL: Two years.

MR. WRONSKI: Two years. And he's made a lot of updates to it, gone to a number of training sessions, because to get this on the web, he has to translate all the documents into

the HTML language.

And -- but what we are told is that this is the second busiest website in the state -- for the state. Of the DOH websites, this is the one that's the second most busiest. It's first --

MS. GOHLKE: What is first?

MR. WRONSKI: I used to know but I don't recall any more.

MS. BURNS: OPMC. They're searching on these doctor types.

MR. WRONSKI: Yeah, maybe. But it is a very useful tool to find something fairly quickly.

MR. TUTHILL: It's also important to know that I have very tight constraints to the way things look, what can go up and what can't. Many things I have to get approval to post.

You'll notice there's not a lot of images on this particular site, because I almost need congressional approval to get images on here. So there is a very short leash to what's allowed to go on here and what's not.

In general, if you see a typographical error, those are very easy to change or a title, names, addresses. But as far adding content, sometimes that's a little more challenging to get approval to put up here. So it's important. I can't just put anything I want to on here.

MS. CHIUMENTO: I just want to tell you, the last couple of years there's been a huge improvement in the timeliness of the information that's on there and -- I use it all the time. I'm constantly

referring to different things on that, particularly protocols but a lot of other things, as well.

But the one thing that I could not find the other day, and maybe it's on purpose, is the e-mail addresses. And I notice that's Martha's was up there, but there is no e-mail addresses for anybody else.

MS. GOHLKE: Nobody wants to give their's out.

MS. CHIUMENTO: I just wondered if you could put a generic --

MS. BURNS: I'll give you my e-mail address.

MS. CHIUMENTO: I have yours.

MS. BURNS: When the web page actually first got really recognized, the Department's web page, there was what the Department calls a BML, a bureau

mail log. And we -- it was EMS.state.ny.us. And we were deluged in e-mail from spam to the most unbelievable stuff.

And several of us, my colleague in education and I, went whining to Ed and begged him for permission to take that down. And we purposely did that because it ranged from graduate students wanting us to do their research, which is a full-time job based on just the number of requests that we get, to racy stuff I wouldn't even want to talk to you about.

And so the Department took it down. And there is a main mail log that the department uses. I think it's DOH.health.state. It is available and it goes through our public affairs group. And a lot of it, I have implored them

to screen. And the coordinator that we deal with directly is quite good at that.

And we get a lot of -- a lot of stuff that -- people have gotten very lazy about doing their own research, and so it's just easy to send a note to this mail log and someone from the Health Department will tell them how to do it. We don't have the time or inclination to do that. So we have quite purposely not provided individual e-mail addresses.

MS. CHIUMENTO: The one specific one was related to the EMSC group and people had some questions about that.

MS. GOHLKE: Then we put you through the exercise of the phone and if you're really doing this and have lots of endurance, you'll get through to someone.

MS. BURNS: We're really good about that.

DR. COOPER: The reason that Kathy and I felt that we should spend a little bit of time showing the web site is so you not only had a sense about what was up there but what was up there about us and the kinds of information that we as a committee could put out there, you know, to the public and to our providers if we felt that it was important to do so.

So I think we would both ask you all to think about stuff that you think might be there that isn't there.

There are two things that I can think of off the top of my head that we might want to put up there and those are the ambulance reference cards that we --

MS. GOHLKE: They're on there, under products.

DR. COOPER: Oh, it's under products. Okay. They're there. Excellent.

MS. BURNS: We got you covered.

MS. GOHLKE: Come on, throw us another one.

DR. COOPER: So as you can see, I don't visit this web site very often in my travels. But if there are other things that you think should be there, please let Martha know. And please, to the extent that you have the ability, please share with all of our colleagues that we are well represented on the website. There are nice work products up there and that the site is there for, you know, our colleagues and public's use.

MS. BURNS: Very quickly.

You might have noticed we just updated our public access defibrillation policy. One of the things -- I drive Gary nearly insane. He's a very good natured person.

The Department has a very tight forms approval process. It is bureaucracy versus bureaucracy. So he keeps me out of their hair. But the new policy which really does affect you as pediatric experts is we moved -- the SEMAC and State Council approved several new training curriculum for public access defibrillation. And in the effort to be more flexible and get them more quickly up and available to PAD sites, we moved them from the notification form to the actual policy. So if you are dealing with schools who should not necessarily be

defibrillating children but you have issues with this stuff, this is all available.

With regard to that, and we're going to work with the state EMS council and SEMAC as well, and the result of this circumstance on Long Island a couple week ago, we're looking at working with the Department and all of you as experts now that essentially ten years has passed since the public access enabling legislation was enacted -- we're kind of shooting for EMS week -- but to send out some sort of public relations type information that will essentially remind these public access defibrillation sites a couple of things, which we take for granted. One is how are your batteries? Have you had your machine program

updated? Are your pads in current date? Do you have pediatric pads? Do you have pediatric interface? Have you had your training updated? Because we discovered as a result of this -- we knew this, but it had never been tested. We don't have enforcement authority under article 30 when an event occurs, which actually is frankly good.

But I think the Department feels in talking with Dr. Morley and Ed that a public education type awareness, even if we sent out pamphlets to all of our PAD sites and our EMS community -- hey, you remember these machines you plunked on the wall? Ten years has passed. Are they up-to-date with programming? Because at issue with that -- this situation occurred because

the machine was not programmed in accordance with the SEMAC guidelines at the time and current defibrillation protocols.

So that's sort of what we're going to do. So we'll reach out to your group and share what we come up with for you to take a look at.

DR. COOPER: Okay. Outstanding. Any questions or comments for Gary?

MR. TUTHILL: Thank you for having me.

(Discussion off the record.)

DR. COOPER: Thank you. Okay. Let's now move on to old business. I think we've pretty well covered the regionalization white paper update. Ed, thank you very much for going over that with us a little bit

earlier.

Ed or Martha, can you give us an update on the status of the EMSC bylaws?

MS. GOHLKE: Just briefly, just to let you know where they're at. We had a couple meetings with Department counsel folk and DLA.

DLA is finally, like two days ago maybe, sent back their comments on the bylaws. And we didn't have time to send that out and have you look at them; we'll do that for the next meeting.

There wasn't a huge amount of changes. The biggest change was -- I don't know if you remember, but we were following the STAC bylaws and their guidance that they had gotten back from DLA a year or two ago on reducing the terms from four

years to three years. And we just changed ours in accordance because we thought that's what DLA wanted. But come to find out, our statute -- because our statute said four year terms, we're going to follow the statute. We have to follow the statute. So we're going to go back to the four year term for membership for the committee. That's probably the biggest change in there and maybe also staggering the terms was the other one, so we don't have a turnover of the whole membership, you know, all at once in four years. We can do it every two years with half the membership.

Other than that, just some quick reminder things. I'll get them ready for you and send them out before the next meeting. At

the next meeting, we'll have you review them and then hopefully maybe we can vote on them at the next meeting.

DR. COOPER: Very good. Thank you so much.

On the pediatric disaster card, I don't think there is a lot to report here. We've been, I think, focusing on education and interfacility transport for the last few months, but I would like to get a jump start on that for the next meeting.

Now a word to the wise, which includes everyone in the room, of course. Unfortunately on May 20, and I say unfortunately because it conflicts with the EMS memorial ceremony in Albany, the New York City Department of Health has organized an immovable conference on pediatric disaster

care.

The pediatric disaster coalition of New York City is holding a one-day conference on all the pediatric surge planning that's been going on in New York City both in respect to mass casualty triage and expanding the pediatric ICU bed capacity within New York City. So there may be some new information available in terms of disaster triage or mass casualty disaster triage and certain issues that come out of that meeting.

And, of course, I think while I have not been told explicitly that the meeting is open to the public, I'm sure any member of the state EMSC advisory committee that wish to attend may do so. It is going to be held on May 20th at Baruch College in Manhattan.

So once again, if you're interested in working on the disaster card, please contact Sharon -- I'm looking at Sharon -- Martha, but I'm hoping Sharon will want to participate.

MS. CHIUMENTO: I'm on a fixed income now.

DR. COOPER: I know. As we all are in this current economic climate, right? Okay.

I now want to turn to new business and I want to spend just a few moments going over the proposed pediatric trauma regulations. Clearly --

MS. GOHLKE: Right-hand side.

DR. COOPER: Right-hand side. Thank you. On the right-hand side of your packets, third from last. Okay.

We had some fairly specific instruction from the

group that was charged to go over the regulations and make pediatric recommendations, and I'll just cover some of the highlights with you before we go through this in a little bit greater detail.

The group felt that we should make a stab at coming up with, at the least, a bottom line definition of what constituted a pediatric trauma patient, not that there couldn't be regional or local variations, but it made sense that there be some kind of statewide standard.

The group felt that there should be emphasis on the multiple disciplinary management of pediatric trauma. The group did not want to follow the American College of Surgeons model which designates level one and two pediatric trauma

centers.

And right behind the state draft is the current chapter in the green book from the American College of Surgeons that -- that describes what the American College of Surgeons has put into place for you to read, digest and compare with what's on the printed page here.

And, in fact, the group felt pretty much as though it wanted the pediatric trauma centers to be, whenever possible, linked with the level one centers. They wanted a statement that everybody should be capable of resuscitating a pediatric patient, no matter what facility, that there should be written transfer agreements between facilities not designated as pediatric-capable and those that were and that

there ought to be some way to direct pediatric patients to the appropriate facilities with appropriate consultation and also to review the transfers at a later date. Those were the -- those were the main themes that emerged from the meeting.

So going through the document section by section, and again, hitting on the high points. On the first page, section five, change the wording from "services" to "centers" because that's what the group felt it wanted.

Section one describes what constitutes a pediatric patient. I think we thought in the past that using a fifteen/fourteen split, since that's consistent with pre-puberty, post-puberty as well as the CDC definitions that it uses for epidemiologic

research. That seems to make the most sense. But that locally the definition could be changed if there was reason to do so.

The next section talks about who can be a pediatric trauma center and basically you can be a pediatric trauma center if you're a general or specialty hospital, being a pediatric specialty hospital, but you've got to meet the standards for regional trauma centers or level one trauma centers and meet all the standards that are applicable for children as well as the additional standards listed below.

The next section referred to pediatric trauma in area trauma centers, because the group only wanted one level center. The comment about all

trauma centers and stations being capable of resuscitation is next. The statement about written transfer agreements is next. The next longest paragraph adapts language from the systems section of the current code that specifies a process for getting the patient to the right place if he or she meets major trauma criteria and -- but does provide an opportunity for a patient who would ordinarily meet major trauma criteria not to go to the center if a consultation with a trauma specialist at the center suggested for some reason it's not a wise idea.

The next three sections all focused on, again, language adapted from the systems section of the current document that expands on these principles,

talking about decisions to transfer being the responsibility of the physician in the initial receiving hospital but is expected to occur in a timely manner, that the transfer should be made as soon as possible and that the mode of transportation should involve pediatric critical care transport teams whenever possible.

It defines the minimum components of the pediatric trauma team, an emergency physician, emergency nurse and pediatric surgeon. It talks about the requirements of -- to be the pediatric surgeon on duty in the hospital, again mirroring language that is currently in the code as adapted for the proposed revisions.

Moving on. Most of the

rest of the document involves some technical matters, the addition of the word "care" to mirror language elsewhere in section eleven.

Reference to successful course completion in section twelve, together with a switch from the fifth to the fourth year, consistent with the revisions that are suggested for the main document.

And then moving on. The next two sections are minor technical corrections. Section fifteen refers to the pediatric ICU. It was the feeling, as you recall, that it should be a pediatric intensive care unit rather than a pediatric intensive care area and that the people directing the care should be appropriately trained and certified. The same with the

emergency department.

And then the last four sections focused on a pediatric PI program. That PI program has to include review of all transfers and that findings have to be shared with the regional PI process, that there be support for pediatric social services and child life programs and that there be affiliation with a child advocacy center or equivalent for potentially abused children.

So I think this covers most of the issues that came up in the January meeting as that had not already been addressed in the first draft of this document, mainly the social services and child life issues.

And I've done the best I could to try to cover the flavor of those discussions. Bob, I

think you and Ed and Martha -- I think you were all there for those discussions and you can tell me if I've missed the boat on any of this or if I exceeded what was asked.

MR. WRONSKI: Well, I did leave at one point and so I missed part of the discussions, but in general it looks like you covered what the committee wanted. Again, that's going to take another couple of read-throughs, just like you're reading through it to determine if we missed something.

DR. COOPER: Absolutely.

MR. WRONSKI: Martha had a couple of comments from a federal reviewer who brought up that you might want to build something in on pediatric rehab and how that would be available, on injury prevention

capabilities in the hospital, do they have any.

I guess the question will be as we look at this, because regional centers and area centers in the trauma regs have that in it, how does that apply to pediatric sections or do we need to build it in separately. I think we need to look at questions like this.

So what I'll ask Martha to do, too, is to share the comments from the federal officer just for consideration, not that we're saying they should go in there, but these were thoughts that they came up with, so we should look at it, think about it.

From my perspective, the simpler and smoother and less complex the reg is, the easier it is to explain and get through

the process.

But if you look at the original pediatric section of the trauma regs, they were simple to the point of not being able to accomplish what we should be able to accomplish now, which is to build a more robust pediatric service or center.

So there is a different purpose to the current rewrite. And so look at these from the perspective of if a trauma center is going to accept a major trauma child, this really addressed what needs to be in place and comment in that fashion.

DR. COOPER: One other comment that I neglected to mention in the beginning of my remarks was there was a pretty clear sense that the overriding

principle should be to get a major pediatric connotation to a pediatric trauma center via primary transport whenever possible without having to rely on secondary transport interfacility, if the time and circumstances permit.

We have for a very long time had circumstances in many parts of the state where kids are transported to a nearby facility and then essentially automatically transported on to a larger center when they were close enough to a larger center to get there safely. And I think all thought that was probably not the way we wanted to go in the future.

DR. KANTER: I think you've done a great job and I think item five deals nicely with the contingencies about

primary versus secondary transport. I wonder -- I can't remember the discussion and I wonder if you could just make a comment on number eight, the interhospital transport when that is necessary. Many centers deal with this by using a local non-pediatric specialized transport service that is readily available from a referring hospital, because to wait for the specialized pediatric service would add a good deal of delay time. You cover that by saying it depends on the individual circumstances, but I wonder if you could add any stronger emphasis on that?

DR. COOPER: Sure. Good point. Good suggestion.

DR. LILLIS: I had the same concern, particularly --

COURT REPORTER: Could you

speak into the microphone, please?

DR. LILLIS: I had the same concern, particularly the way it's worded that they should use specialized pediatric transport wherever and whenever available. The things before that take into account --

COURT REPORTER: I'm sorry. I can't hear you.

DR. LILLIS: It should be cleaned up a little -- lightened up a little bit.

DR. KANTER: This is one of the things where the more explicit you are in your guidelines, sometimes you tie people's hands. And to emphasize, a lot of these decisions are made on an individual case basis.

DR. COOPER: Absolutely. Obviously you're all seeing

these for the first time today and there is, you know, no intent, obviously, to do anything other than to look at them today for your thought and review and comments over the next few months. I don't suspect that we will be wrapping this up even with the STAC before we meet again, so I think we'll have an opportunity to -- to look at these in more detail next time and make the --

I will -- I will take it as the sense of the committee that the change that you and Kathy have recommended is the one that should be made and I'm seeing everyone nod "yes" so we'll make that change and that will become draft 2.1.

And with your permission, I'll also follow the advice relayed from Martha that we

might want to include something about burns, rehab, injury prevention and possibly disaster management, as well, but in a very general way so as to follow the advice of the federal context, but at the same time, not make these regs too burdensome.

DR. LILLIS: I've just got a question about pediatric sub-specialties -- was there any discussion about that?

DR. COOPER: There really wasn't extensive discussion about pediatric sub-specialists except to note that there are no more in the traditional sense for pediatric neurosurgery or pediatric orthopedic -- orthopedic surgery.

While the truth of the matter is that most pediatric neurosurgeons are far more

interested in tumors and shunts and most pediatric orthopedists are far more interested in complex congenital reconstructive work than they are in taking care of trauma patients. And a neurosurgeon who cares for a fair amount of trauma and an orthopedist who cares for a fair amount of musculoskeletal injury in adults as well as children probably can do as good as and perhaps a better job than a pediatric specialist who's really focused on congenital issues.

But other than -- other than that, there wasn't really extensive discussion and that's why I just suggested leaving the language more or less the way it was at the top of page three.

Although I think, Kathy, your point that this particular

wording refers only to the anesthesiologist who probably should refer to the neurosurgeon or the orthopedist and other specialists and you know -- and just say they should be experienced and really kind of highlight -- not that it really changes the meaning. It's an inclusive phrase, but by highlighting neurosurgery, orthopedics and anesthesia is the focus that we really need it to be. A good suggestion.

MR. WRONSKI: If I could just comment. In a separate discussion that occurred with our neurosurgical board member in trauma, the issue came up as a sideline about pediatric neurosurgery. The big issue was availability. There is simply not many and then there is simply not many who have enough

children to concentrate in that area.

And so the general thinking of the state trauma committee was we don't want to put something in that's so restrictive because it doesn't exist. You wouldn't find it in most regions. And so they were more comfortable with the idea that the neurosurgeon or whatever specialty it was had some experience with children and could show that and could treat children but they didn't want to necessarily mandate some things.

They're having a hard enough time getting neurosurgeons to be available for trauma without having -- putting in the pediatric neurosurgery. It just may not be there.

DR. COOPER: Thanks Ed for bringing that point up. That was another critical issue that was discussed, yes. Okay.

Obviously, this process will remain open until the regs are published in the state register. There is not only our internal comment period among ourselves before we refer this to STAC, but there is also their internal comments process as well as when it finally goes to the State Hospital Review and Planning Council, their process followed by a public comment period. So this is hardly the last time you will have an opportunity to look at this and comment on it. But obviously the sooner the comments come forward, the sooner we get them incorporated and the sooner we can move on to other issues that

are equally if not of more importance.

MS. GOHLKE: If you think this warrants a conference call, if you'd like to sit down one more time as a group and talk about it, we can do that too.

DR. COOPER: Sure. Why don't you do that. I will ask that if you have comments about the regs other than the ones we've already mentioned, that you e-mail them to me, obviously with a copy to Martha, and if you feel that there are -- there are -- there is a need for us to communicate via conference call, let us know and we'll be happy to --

MS. GOHLKE: I know a couple of people wanted to be at the January meeting but couldn't make it. So those folks that wanted to be a part of this, as

well.

DR. COOPER: All right. Before we move to the updates from our sister committees, I'd like now to return to the one item of new business that we deferred from earlier in the meeting and then ask Brian if he would just briefly comment on the status of the trauma report. In fact, why don't we ask him to do that first. Brian, if you could comment on that briefly, where we are with that.

MR. GALLAGHER: Sure. The committee -- sort of a sub-committee, which was formed to look at the question of updating what is now a little bit out of date stuff, pediatric trauma reports, which was produced a number of years ago.

The committee met and discussed a couple of different

approaches to putting together a pediatric trauma report. Originally, the thought was we might follow the same format as the previous report, but after some consideration by the sub-committee, it was decided that trying to use the format which is in place by the national trauma data bank would probably be the best approach, so that data which is available from New York State will be readily comparable to the national data.

So the NTBD data, which is not comprehensive -- not that every trauma case in the country is contained in that data set, but it is a representative sample of national data and that's the format that was used.

And based on the availability of New York State's

trauma data, it was decided that the 2002 to 2006 period would be appropriate for a report. So what I did, with conjunction with Martha, was basically take the NTBDs 2006 pediatric trauma report, which contains '02 to '06 national data, reproduced that and put New York State 2002 to 2006 data side by side with the national data so that we could see what type of differences there were between New York State and the nation.

And there is a variety of tables, distribution of cases, morality -- mortality, method of injury, different organ systems. And these were all broken up into two age categories, zero to fourteen and fifteen to nineteen.

So I think the product is a good starting point for a

discussion of how New York State pediatric trauma data, relatively contemporary data, compares to the nation. And hopefully it will be helpful for this body and others who are interested in the outcome.

DR. COOPER: Thank you, Brian. Any questions for Brian? Brian, do you have any kind of rough timetable for us?

MR. GALLAGHER: Yes. Martha has the products now.

DR. COOPER: Great.

MS. GOHLKE: I'm sorry. I missed the question.

DR. COOPER: A rough timetable on getting the reports.

MS. GOHLKE: Ed?

MR. WRONSKI: I got to see the report during the week and it is very interesting. It does show some differences with the

national data, but whether it does or not, some of the tables are interesting to look at for what we're seeing for children.

So we can share the draft -- that particular draft with you. We will send it out by e-mail. We'll send it out for the members to take a peek at it, give us some comments.

What we're going to be doing is coming up with some narrative to kind of surround it, say a couple things about the kids. There may be some things that we want to point out in the data set. There may be some things there that we really think you should take a look at.

But what I'd ask -- what we're looking to do is try to get this out as soon as possible. It doesn't mean we can't still work with data, but

what I'd like to do is have a report in a somewhat finalized form so that it's out and released sometime this summer, if possible. That's optimistic, but if we can get your comments, write our narrative, send it up the chain and get a letter from the Commissioner to support it, we can have this out as a report that would be a partnership -- and make it a very clear partnership between us, the Department, the School of Public Health and the EMSC committee and obviously the State Trauma Advisory Committee and the trauma centers, where much of this data can comes from. And I think that would be useful to just promote, you know, pediatric issues and kids issues in the state.

DR. COOPER: Terrific. So

we'll look for that in the e-mail. And we'll ask that any comments that are forthcoming be circulated back to Martha so she can collate that and then the group that got together to look at the report or the basic structure of the report will review that and consider what changes, if any, need to be made. Okay. Does that make sense? Good. Okay. Moving right along.

The last issue under new business that I have is to revisit the issue that we led the meeting off with earlier this morning and that is the issue of the addition of glucocorticoids in prehospital protocols.

I will just invite you, if you would, to look behind the agenda in your packet and you'll

see an e-mail from Rita Molloy, who couldn't be with us today, but has concerns about -- about the issue and wanted to bring this to our attention. I think you all have that. Yes.

So I'll just give you a moment to read it, but in short she is arguing that we need a systematic approach that involves those responsible in the schools as well as others.

MS. BRILLHART: When I read this, what I see is having been involved in developing some school plans, section 504(b) plans -- when I read the e-mail, I see you're saying that school nurses aren't actually mandated in New York State. So the only way to make sure that you can legally carry through the section 504 plan would be to make sure that if EMS is

involved they could carry though that plan. Because school nurses aren't mandated, then how can you make sure that can actually be administered if it's not in place in EMS?

I think she's saying, Hey, yeah -- you know, for this legally-mandated school plan that we have in place. For the kids who are very allergic, we have epi-pens on the ambulances now. We have never carried through on a 504 plan for a kid with adrenal insufficiency unless it's put in place with EMS.

DR. COOPER: That's what I meant by having a -- you know, a system approach, but you said it much better than I did, so thank you.

DR. KANTER: Well, when you think about emergency plans

and emergency medical services, it's a continuum which begins in the community, at home, in the school, wherever and includes responders at the scene at various levels. And then a very short time later involves a hospital.

The question is what needs to be done immediately at the scene and what needs to be done in the steps after that. And among countless needs, how do we realistically apply -- I don't want to restate too many things that we all said this morning, but I really believe that this particular one from all the scientific evidence I know, the real issues are what's the shock algorithm that takes care of it at the scene in the first minutes. And if you know, that part of the origin of the shock

is hypobulemia, hypoglycemia, and adrenal insufficiency, it seems to me that it's perfectly reasonable for the provider at the scene to give hydrocortisone or Solu-Medrol or whatever they've got. But it doesn't change the fact that the immediately life-threatening issue is hypobulemia hypoglycemia.

And with respect to some of the things we heard this morning, I'm not sure about the scientific evidence of myocardial function. I think hypobulemia affects myocardial function and turning somebody around with a dose of steroids alone, I don't think there's a lot of evidence to support that.

DR. HALPERT: I would chime in on your heels, too, in terms of more of a reality

check. You know, it's not a known person with adrenal insufficiency walking around who suddenly is flat out on the ground near death. It's a kid that's been sick with a significant stressor that's been imminent, dwindling, lingering, involved and haven't been properly cared for for whatever reason.

Typically, if they're known to have adrenal insufficiency and they're on medication for that based on their known -- they are told if you get sick, you develop a respiratory infection, you double your dose and you call us kind of a thing.

People with this kind of a problem really -- they're from out of area, they've lost access to medication, they don't speak

the language, things like that where they have not been able to get access to the proper care for a fairly protracted period. Maybe not weeks. Maybe -- it could be hours, it could be twelve hours, twenty-four hours, but it's not two minutes.

And that's why it's kind of like my point of -- Sharon brought up the point of shock protocol. You know. You give that medication as part of your evolutionary workup and treatment of the presenting problem, but it's probably not the first thing you're going to give.

It's going to be saying, well, this person's not getting better at the scene. Let's give them a course of glucocorticoids --

COURT REPORTER: Could you

use the microphone? I'm having a hard time hearing you.

DR. KANTER: I worry that if you have a standalone protocol for adrenal insufficiency, the implication is he's sick, we give him the hydrocortisone, he's all better now. When in effect, what he really has is a ruptured spleen or septic shock or, you know, anything else in the textbooks.

DR. COOPER: I haven't reviewed today's blue packet in detail. The same presentation, if not identical but close to the same presentation was given at SEMAC a couple weeks ago. And as I understand the Rhode Island protocol -- I read it at that time; I haven't read this one today -- if memory serves me correctly, the Rhode Island protocol is basically to give

glucocorticoid to people wearing a bracelet. It's not give it to anybody that presents in shock.

So my own personal view on that is that this could be handled by some kind of note or footnote or caution box -- we do like those caution boxes in protocols. You know, that said, Hey, if you've done everything else in terms of shock management and the person's wearing a bracelet that says they're adrenally insufficient, give glucose and glucocorticoids or considering giving glucose and glucocorticoids. The question, I think, is whether -- whether that would require medical control or not, and my thought would be yes, primarily because you have the extra time to -- the extra time in the sense that it takes a while for

you to get, you know, the fluids started and so on, which is far more important.

People don't normally think about giving glucose in a shock protocol, and in fact, you know, sugars are high enough in many trauma patients already. And as we all know, sugar would ordinarily not be given in shock protocol in part for that reason.

So I think that perhaps our best advice might be to add some kind of caution -- as I said, some kind of caution or note or something in that protocol that says if you got the silver bracelet give -- give resuscitation dose of glucose and resuscitation dose of glucocorticoid. And it doesn't matter to me which one it is. Most services are carrying

Solu-Medrol for asthma patients and in some cases COPD patients. But I don't think we should get into Solu-Medrol for shock -- septic shock in the field. That comes much, much later. This is really the only time that you really can give it and I happen to share your concerns about that -- your statement that the evidence about the overwhelming improvement in myocardial contractility perhaps is not quite as great as was stated this morning and does appear to be more volume related, or -- so those are my views. Kathy?

DR. LILLIS: I guess I'm -- I would disagree a little bit with Jon. In fact, I have seen patients who have quickly deteriorated, for example, patients with vomiting where they can't get their oral doses

at home.

DR. HALPERT: Yeah, but they're sick with vomiting.

DR. LILLIS: But I have seen some -- and who come in blue and in shock and have very quickly deteriorated before my eyes.

I think that there's a couple -- lots of different steps from having all paramedics carrying it. And I particularly don't think that we're there, but I think there are things that need to be put in place, particularly with the patients who are known -- who have, whether it's the ID bracelet or some kind of identifying protocol at home where the paramedic facility can assist with the distribution of their own medication, because I think most of these kids carry their

kits -- and right now -- or at least in a school setting or on a field trip or wherever where it's not easily administered and people who are trained well to administer.

I guess I would advocate that we do work with the EMS system to help these families that may be in situations, because I think it can be life-threatening. I think it can make a difference by administering this early and I would advocate trying to have the EMS system help deliver the patient's own meds.

DR. COOPER: You think it should be the patient's own meds?

DR. LILLIS: I think as a first step. I understand the ramifications of trying to implicate this statewide and

having all agencies carry this. An easy solution would be -- at least step-wise and we'll see how that goes, but training, educational programs.

But I think -- at least when I investigated it at my hospital with my pediatric endocrinology department, they felt that all patients that are followed by their division all have medication at home readily available. And I think EMS can be helpful in helping us --

DR. KANTER: Well, as an educational initiative or a statewide improvement initiative, there is no question that you want to treat adrenal insufficiency in an effective way. And I don't know what the rules are about using a family's own medications, if that is an authorized thing to do. Maybe

it would be a good idea to work on that. But as you said the responders do have some kind of glucocorticoid with them, typically, most especially for asthma and we ought to use that if it appears to be indicated. I think it's more important -- far more important for asthma than it is for --

DR. COOPER: Absolutely.

DR. KANTER: And by the way, adrenal insufficiency should be suspected in a whole lot of other patients that just --

DR. COOPER: Sure.

DR. KANTER: So it is important and an educational initiative probably could be beneficial.

But I just want to say, again, if you look at the presentation, you get the idea

that the doses of hydrocortisone is the only step in intervention and I don't believe that's true. I think the whole advanced life support algorithm pertains here.

MS. BURNS: Speaking as just a representative of the statewide system, I just -- there are about 1,200 EMS -- certified EMS services in the state. Just about -- just under 700 of them are advanced life support. There are 6,000 plus or minus a few paramedic level providers.

At the risk of sounding callous, or as one of my colleagues say, have hair on my heart, one of the things that I do in our office and with the state council is just to remind you that in our last data year there were 2.7 million EMS calls. While I appreciate

intensely this situation, we are routinely faced with these kinds of things.

We should be carrying factor five on our rural ambulances because we had an incident up in the Adirondack's where a patient didn't have time before he went on vacation to get his factor five and he was in a small watercraft crash.

We've had the Marfan's who contact us and demand that we do training on Marfan's and triple A situations.

So, you know, I think we have to appreciate the fact that -- and be sensitive to the needs of these people, but remember that the volume of EMS responses are such that I'm afraid we're not going to capture the imagination or interest of our EMS providers.

And I think starting with your group, not to mislead you in any way, you direct us and we will do it, but you need to understand the likelihood that we send out stuff from the hemophilia group -- they had a group at our conference and we've done a lot of this.

But when an ambulance service looks at their call volume, they're treating chest pain, chest pain, chest pain, chest pain. They're unfortunately -- much to their horror, they're not treating trauma, trauma, trauma, trauma and pediatric victims of adrenal insufficiency. So I think that you have to put it into perspective.

MR. CZAPRANSKI: Can I comment? It would be nice to have an AED on every ambulance

first.

DR. HALPERT: It would be nice to have an EMT on every ambulance first.

MR. CZAPRANSKI: This is an ALS protocol. Would it make sense to turf this to the SEMAC to say, Give this to the regional council's as a review and consideration for their regions, because I think those regional councils and those REMACs were made of physicians and EDs in various hospitals that can look at the frequency and utilization and then determine if this consideration is correct.

I like the way that Sharon mentioned it, it ought to be under the shock protocol, which it is in the State of Ohio, in their shock protocol, pediatric. One thing about the Rhode Island

thing, Providence plantations.

DR. HALPERT: It goes way back.

MS. CHIUMENTO: Interestingly enough, one of the things that the Medical Standards committee is looking at is having regional options. And I think this would fit perfectly into that segment. So at the bottom of the protocol, have things everybody does for shock. And down at the bottom, regional options might include this and it would give the regions the options.

DR. HALPERT: I don't want to over-simplify this, but, you know, paramedics are equipped to manage patients in shock. Paramedics are equipped to utilize injectable glucocorticoids. It's real simple.

MS. BRILLHART: Can I ask a completely naive question? If they respond and one of the kids has CAH and he's got a medical protocol there and he's got his meds, but the school nurse isn't on the premises so there's technically nobody else that can do that, what's the current standard? The paramedics just have to say no, we can't and scoop and go?

DR. HALPERT: Call medical control.

DR. COOPER: They could get a discretionary decision.

DR. HALPERT: Right.

MS. BRILLHART: Okay. Because I guess the feeling -- the first thing that Rita's talking about is there is a medical plan in place. It's signed off by the doc. It's signed off by the parents. It's

signed off by the school. The kid has their own meds. But the person that can do it isn't in today and they're calling for help.

MR. WRONSKI: There is always -- particularly an advanced life support provider can always call medical control and get authority to use these meds. In those areas where sometimes medical control isn't available, sometimes a provider -- an advanced life support provider will punt and decide to do that. But rather than have them punt, I think that what can happen here -- and what I'm hearing is that there's a consensus, including from my own staff, that there are things in place to deal with the broader spectrum of what's happening to these patients and they're

included within that broader spectrum.

But I don't think there's an argument that if you knew this patient, for instance, had a bracelet or you knew they were suffering from this, then that would be part of your decision scheme as to how to treat them. So if you knew they had adrenal insufficiency, you could build that into your thinking process.

And what I would ask is that we do develop some education that we can share with our REMACs, we develop local ALS protocols and provide them with that information.

I was just -- I was given a note, and I don't know how we got this so quick. I'm always impressed. The only four regions -- four regional REMACs, and there are sixteen REMACs

medical groups, have Solu-Medrol in their ALS protocols out of the sixteen. So it may be something to bring this up as -- should all the sixteen regions consider having that within their protocols, not simply for this but for other reasons and have a discussion with the SEMAC on that and give advice in that regard. I would also certainly include it in the education and outreach.

What we've done before, EMS should be in touch with both families and schools in their area for any specialty issues regarding children. Are there people in your community or even adults who have certain types of diseases or maladies that you should know about? So if you're going to a certain street and a certain house, you know what

you're walking into. So they should know the plans if possible.

MS. BRILLHART: I was just kind of leaning towards or thinking about if we have the section 504 plan and we can't back it up with EMS then who are the parents going to sue? The school? EMS? The pediatrician who signed off on that but it's not carry-outable (sic)?

I was thinking if the stuff falls through the cracks, who's in trouble? You know what I mean? Having been somebody who has been part of setting up a training process for a 504 plan. That's all. I was just thinking of keeping people out of trouble.

DR. COOPER: I guess my general sense is that -- I guess my general sense is that we can

finesse this. You know. This is one of those -- let me give an example from New York City.

There is some data from the fire department that suggests that if a case occurs frequently enough, that there are some folks in the office of medical affairs who are hellbent on having a protocol specifically for those kids as separate from pediatric shock protocol. This, to me, is sort of like that issue. You know. It's something that occurs with enough regularity in enough places and the treatment for it is standardized enough that the system ought to be able in some way if not to prescribe the treatment at least not obstruct it. And on some level perhaps facilitate it under the appropriate circumstances.

And that it's not clear to me that that means that we want to make every single region have to come to the SEMAC asking for a special exemption to be able to do this if they were to choose to do it.

To me, I think we can -- I think we can do this in a way through some kind of note or something along the lines as a medical control thing if you got the silver bracelet on and you're treated for shock, give glucose and consider glucocorticoids under medical control. Something along those lines that would, you know, not be encouraging people to rely on that as a primary treatment but it wouldn't really obstruct anybody from doing it if there was a legitimate need to do so.

So I think that's kind of

the approach we should take. We have a saying down in New York City about our pediatric protocols. Refer to them as conservative yet permissive. They're very conservative in terms of stressing BLS, but we don't block appropriate ALS treatments when the situation calls for them.

So to me this falls into that category very nicely. We want to be conservative but we do want to be permissive here and not obstructive.

So I'd like to suggest that we craft a letter to the SEMAC which I will circulate to everybody and see if we can capture that flavor. Sharon.

MS. CHIUMENTO: In some ways, it's very similar to what we did with epi-pens. Originally, when the epi-pens

became available, it was for BLS and then for ALS, but it is the same kind of things. First we said, well, if patients had their own epi-pen, we could administer. And then we said agencies or regions could then allow agencies within their region to carry epi-pens. So this is a very similar type of thing. It's step-wise. You're not forcing everyone to carry the epi-pens, but you're allowing them to use what's there in a patient's own possession and/or to carry it if their own region approve it. It's a very similar process.

DR. COOPER: It's permissive rather than --

MS. WALDEN: I'd just like to add one thing and that is that parents have a certain responsibility in this as well

as all patients do, also, and that is to wear a medic-alert bracelet or to notify their squad that they have this condition. And in that instance, they can sign a paper authorizing the squad to give the medication if the squad carries it or provide a sample or a vial that can be stored for that child.

They tell you this is the most important thing is communication, communication, communication, but I still think we have to put some responsibility back to the parents.

DR. COOPER: I do think that limiting this to patients that have a silver bracelet on their arms is -- I think in a way is the enforcer of gradual responsibility. I mean, you're

absolutely right. It isn't just the bracelet relying on the world to take care of the child. There is a whole lot more than that. In the very least, if there's a bracelet on -- I'm sure that in your experience, as in mine, if parents go to that length to protect their child, they usually go to other lengths, as well.

MS. BRILLHART: Dr. Cooper, if I can make a friendly amendment?

DR. COOPER: Sure.

MS. BRILLHART: Knowing children as we do, they leave the house in their nice conservative tops and get to school with something completely different on because they stored it at their friend's house.

I'd like to add a friendly amendment that they have a

silver bracelet or a signed section 504 plan in place.

DR. HALPERT: Or a tattoo on their body.

MS. BRILLHART: Yes.

MR. CZAPRANSKI: I think add, or other appropriate identification of their medical condition.

MS. CHIUMENTO: I'm thinking also of the forms that Ruth showed us -- the pocket fold-up forms -- any of those forms that would identify the patient has a problem.

MS. WALDEN: Those forms are now on our website, as well.

MR. WRONSKI: I congratulate the committee for figuring out a way to support President Obama's parental responsibility initiative.

DR. COOPER: Okay. Very good. So I take it then that I

will craft a letter that reflects the sense of the committee in this regard, which I will circulate to everyone before it goes out so that people can, you know, make comments, agree or disagree, what have you. And if there is not substantial agreement, we will bring it back next time. Is that fair? Okay. Good.

MS. GOHLKE: I just want to mention -- speaking from somebody who's having an allergy attack and I have to get to my next prednisone application here soon, it is four o'clock. But anyway --

MS. ROGERS: Sorry. We're not authorized to do that.

MS. GOHLKE: I want to make a suggestion. I know people benefit from the updates, but maybe we can provide it by

e-mail after the meeting.

MS. CHIUMENTO: All the things that I had to bring to the committee have been spoke about already.

MS. GOHLKE: Okay.

DR. COOPER: And likewise for STAC. The key issues were the regulatory issues.

MS. GOHLKE: I just want to draw your attention to -- the committee dates are in your folder. Hopefully you already have them and you already have them on your calendar, but the EMSC committee dates are on along with all our other committees for those of you who are on several.

And I just wanted to also point out, I sent this around by e-mail, but Dr. Kanter and Dr. Cooper's latest publication is also in hard copy and in your

folders, as well.

DR. COOPER: I need to publicly disclaim major responsibility for this. Dr. Kanter was clearly the leader on this project.

DR. KANTER: Team effort.

DR. COOPER: And I was proud to be a member of the team, but he really -- he really did the work on that.

MR. WRONSKI: I did a quick read and I'll read it more carefully, but it looks very good. Very nice.

MS. GOHLKE: Our next meeting is June 2.

MS. BRILLHART: I was just going to make a motion to adjourn so she can stop typing while we do our nice social stuff.

DR. COOPER: Okay. So the next meeting then is June 2nd,

right here at the Crowne Plaza Hotel. And hearing no other calls for new business, I'll ask for a motion to adjourn.

DR. HALPERT: Yes.

DR. COOPER: Thank you all and we will see you on June 2.

(Whereupon, the meeting adjourned at 4:06 p.m.)

C E R T I F I C A T E

I, Nora B. Lamica, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby certify that the foregoing record taken by me is a true and accurate transcript of the same, to the best of my ability and belief.

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Nora B. Lamica

DATE: March 24, 2009