NEW YORK STATE
DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES FOR CHILDREN
ADVISORY COMMITTEE

DATE: March 2, 2010
TIME: 11:13 a.m. to 12:37 p.m. and
1:00 p.m. to 3:37 p.m.

LOCATION: Crown Plaza, Capital Room
Albany, New York

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PRESENT:
Arthur Cooper, M.D., MS, Chair
Susan Brillhart, MS, RN, CPNP (Telephonically)
Lee Burns
Sharon Chiumento, BSN, EMT-P
Tim Czapranski, EMT-P
Ann Fitton, EMT-P
Marjorie Geiger, RN
Martha Gohlke
Ed Hannon, M.D.
Robert Kanter, M.D. (Telephonically)
Christopher Kus, M.D.
Kathleen Lillis, M.D.
Sarah Macinski Sperry
Mike Tayler
Jennifer Treacy
Wendy Weller, Ph.D.

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(The meeting commenced at 11:13 a.m.)

DR. COOPER: All right. Welcome everyone. This is the March 2, 2010 meeting of the State Emergency Medical Services for Children Advisory Committee. My name is Dr. Arthur Cooper, and as you know, I have the honor of serving as your chair.

And we have a rather full agenda today. And so, we well plan on proceeding with the agenda. I'll note that Dr. Robert Kanter of Upstate Medical University in Syracuse is joining us via conference call, so I'll ask the stenographer to make note of that. And we have, fortunately, our guests from the School of Public Health, Dr. Wendy Weller, and from the Bureau of Injury Prevention in the Department, Sarah Sperry.

Welcome and thank you for joining us as always.

And we do anticipate that a very dear old friend of ours, Marjorie Geiger, former Assistant Director for the Bureau of Emergency Medical Services, who now heads the Safety Center

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within the Department of Health, will be here this afternoon to give us a briefing on the very important activities of -- of that center. So, we do have a full agenda, and let's not tarry and let's move on and get through it.

I'd like first to call for approval of the -- of the minutes.

DR. LILLIS: So moved.

MS. CHIUMENTO: Second.

DR. COOPER: It's moved and seconded by Dr. Lillis and Ms. Chiumento. Any additions, deletions, or corrections to the minutes?

(No audible response)

DR. COOPER: Hearing none, all in favor, please signify by saying aye.

FROM THE FLOOR: Aye.

DR. COOPER: Opposed?

(No audible response)

(The motion carried.)

DR. COOPER: Carries unanimously. Thank you so much.

Martha, would you be kind enough

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to review the agenda for us, as per the agenda?

MS. GOHLKE: Yes. Thank you, Dr. Cooper. So, it follows pretty much normal format. Lee Burns, when she arrives will give her Bureau of E.M.S. report. I'll talk -- I have a brief report about the grant -- the status of the E.M.S. for Children grant. We'll have the subcommittee progress report -- report out, and then we'll get to old business.

One of the agenda items today was the bylaws, but we don't have a quorum today, so we'll have to put off voting on the bylaws for a time when we meet in person and we have a quorum.

As Dr. Cooper mentioned, Mike will give us an update on the pediatric trauma centers in New York City and what's been going on with them. The -- we had a brief subcommittee -- asthma subcommittee meeting on -- via phone that Dr. Lillis will update us on. And the School of Public Health, Dr. Wendy Weller, will talk about a summary of the pediatric report, which they're just about getting finished to publish or produce for us.

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We have -- for new business, we have protocol that the Health Department is looking -- is developing, and we -- they asked us to bring it to this committee for your feedback, as a type of focus-group feedback. So we'll get to that. And Dr. Cooper is going to talk about the American Heart meeting that he went to earlier this -- or last month. Marjorie Geiger will be coming to talk about the Patient Safety Center, and Dr. Lillis will be talking about her project that's funded under the Patient Safety Center as well.

And Marjorie Geiger also asked for feedback from this committee on the pharyngitis article that you were sent ahead of time. So, she'll be here at that point to actually hear your feedback on that article. And then if we have time -- which it looks like we will today, we'll have the updates from the other committee meetings.

And that's our full agenda.

DR. COOPER: Thank you, Martha. Since Lee has been unavoidably detained, perhaps you could proceed and give us the E.M.S.C. grant report.

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MS. GOHLKE: Sure. Well, as usual, the grant year ends February 28th, and it's March 2nd today, and I have not heard if we've been re-funded. But this is normal. They always are kind of late with these announcements. I -- I have no indication that we will not be funded. Everything looks very good. We just haven't gotten the official word. And I'm still here and nobody told me not to show up this morning for work, so -- but so, the other thing I just want to mention, and I don't have much to talk about the grant, is the only thing different -- and you have a sheet in your folder -- it has -- it says E.M.S.C. State Partnership performance measures, and I've highlighted in yellow a couple lines.

The only thing they've really changed around with this grant in the past year is they renumbered the grant performance measures. They used to be in the sixties, now they're in the seventies. And the reason they did this was because a lot of them were rolled in together. So -- so, like they used to be sixty-eight-A, -B, -C, and -D, and if you didn't accomplish -A, -B,

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-C, and -D, then you didn't accomplish performance measure sixty-eight. So they changed the numbering, and they basically separated out all the performance measures, so that if you meet one of them we can show growth with the program, and that we've done some, you know, measures of accomplishment on the grant. So it was really to our benefit that they renumbered the performance measures, so we can make baby steps to accomplishing the entire grant performance measures.

And then one of the things I just decided to highlight for you was performance measures seventy-four and seventy-five. This is kind of what we've been focusing more so lately on with these meetings, and this grant is trying to meet these performance measures. We actually -- performance measure seventy-five is recognizing pediatric trauma centers or a standardized system for traumatic injuries for children. We actually already, in the eyes of the federal government, meet that performance measure, because we do have a pediatric trauma system set up in New York State.

What we don't meet is the system to manage pediatric medical emergencies, which is what the subcommittee, the interfacility and -- what else do we call them -- regionalization subcommittee has been working diligently on, in order to try and move us forward to meet this performance measure. And this is where our stakeholder's meeting on May 13th comes into play, to bring people around the state to talk about standardizing or developing a system in New York State to address medical emergencies in a more coordinated standardized way in New York State.

So, I just -- you know, we don't really talk about the performance measures of this grant, but I just wanted to reiterate, this is why we're doing the stakeholder's meeting in May. One of the impetuses is that this is what the federal government, with this grant, is saying that each state should move towards doing.

Are there any questions about the grant or performance measures that I can answer for anybody?

(No audible response)

MS. GOHLKE: That's about it. I mean those are the major changes as far as the grant's concerned and hopefully we'll get our award for next year, and we'll be moving forward.

DR. COOPER: Martha, just one question. Where do we stand as far as the fed is concerned, with respect to the other performance measures, understanding that seventy-four we do not yet meet.

MS. GOHLKE: Okay. See if I can remember off the top of my head. Let's see. The first one, seventy-one, percent of prehospital providers in the state have online pediatric medical direction. You have to have -- you have to have at least ninety percent of the providers reporting that they have access to online pediatric medical direction and the survey that we did a few years ago did not show that we had ninety percent access to this, so we don't meet that performance measure.

Offline you also need ninety percent. When we did our survey we did not meet that. The providers did not say that -- over

ninety percent of providers did not say that they had access to offline medical direction. So according to the survey, and the data from that survey, we do not meet that performance measure, according to the feds.

DR. COOPER: I'd like to just stop briefly --

MS. GOHLKE: Yes.

DR. COOPER: -- and comment on that.

MS. GOHLKE: Yes.

DR. COOPER: Dr. Henry, who as you know is chair of the SSEMAC --

MS. GOHLKE: Yes.

DR. COOPER: -- is quite convinced that we do meet that --

MS. GOHLKE: Right.

DR. COOPER: -- because, of course, emergency medicine physicians who provide medical control both online and offline for prehospital providers do spend a significant amount of time during their residencies caring for children, and it's his view that if -- if there's a

board-certified emergency-medicine physician who is providing the online or -- or -- and/or offline medical control, that that performance measure has been met.

MS. GOHLKE: Yes.

DR. COOPER: Now, certainly, the intent of the federal government here is to make sure that there is access to explicit pediatric expertise --

MS. GOHLKE: Right.

DR. COOPER: -- but I do think there may be some wiggle room here --

MS. GOHLKE: Well --.

DR. COOPER: -- and perhaps we could get some assistance from the federal government in helping to sort out exactly what -- what this means.

MS. GOHLKE: Yeah, I -- I mean, I can -- I can get into that. I mean -- at a policy level one of the things that we did for offline medical direction is we didn't have a policy stipulating that offline protocols be on the ambulance or on the provider at the -- at the

scene, which is what's required is that they have to have the offline and online medical control at the scene. So, we did write a policy statement that now all rigs have to carry the -- the written protocols either on the person or on the rig. So policy-wise, you know, we've set that up so that it should be there.

But the issue that the feds have is that if the provider doesn't know about it or doesn't have access to it, for whatever the reason is, and they're reporting that they don't have access to the pediatric-specific protocols, that's the problem. And if they're in an area where there isn't cell coverage, and they don't have access to online medical control, that's a problem, the feds feel, even though we may have a policy statement or we may have the physical set up as such that they should have it. So there's the policy side of it and then there's the practical, whether or not they really do have it at the scene. So they're trying to --

MR. KANTER: All right. It's fine, but you know, I -- I agree with Art, I -- I

think it -- the -- the questions -- it's hard to know what the responders to the survey really mean when they say this --

MS. GOHLKE: Exactly.

MR. KANTER: -- but Art is correct --

MS. GOHLKE: Yes.

MR. KANTER: -- that a board certified emergency physician certainly is adequate online medical control. And furthermore, except in the biggest cities, it's unlikely you're ever going to get any better than that.

MS. GOHLKE: The --.

MR. KANTER: So if you can get that, that's a success.

MS. GOHLKE: Yeah. And -- but, you know, we do know that it's -- it's not always necessarily the medical controls being with an emergency-medicine physician. So -- so there is -- and we do know that that is the case in some areas. So we can't actually go to the feds and say we know for sure that it's a M.D. that's answering the phone, giving online medical control.

You know, part of it is the survey, obviously, and part of it is how -- people's perception when they're answering the survey. I honestly think that a lot of providers don't know that the pediatric protocols are in the adult -- with -- combined with the adult protocols, and they're thinking is there a separate document, and no there isn't. So maybe they answered no.

I mean, there's obviously problems with the survey, but we were way off in our numbers. I mean, if we were off five percent, that would be one thing, but when we're off forty percent, the providers are off by forty percent, it's kind of hard to argue to the feds that they do actually have this in the field. So we -- we have to resurvey. That was just a baseline survey that we did a couple years ago. We have to resurvey this year, which I'm dreading. And we will do our best to make sure that the survey language is very clear, and it -- the -- the -- I haven't seen it yet, but the survey, I've been told, is much better this year. So, hopefully our results will be much better as a result.

But the data is part of the supporting information that the feds need, to see whether or not we've accomplished the performance measures.

Tim?

MR. CZAPRANSKI: Just one comment on the cellular coverage piece. That doesn't mean they can't get medical control. There's been a lot of times when I've used a patients home landline to get medical control, where there is no cellular coverage. So some time during the call, I had the opportunity to do that from a landline, as opposed to --

MS. GOHLKE: But whether the provider --

MR. CZAPRANSKI: -- a cell tower.

MS. GOHLKE: -- does that and knows that, I mean, I know in my agency that we have A.L.S. respond to all our calls, and I've actually heard my B.L.S. counterparts say "I would never call medical control. I would never do that." I mean, it's like -- they have the perception that they -- they are not the ones to

call, that it's always the A.L.S. provider, and that the B.L.S. provider doesn't call. So we know that as a group. We know how the system's set up, but the provider, who is the one that needs to access pediatric medical control, for whatever reason feels that it's either not available, or they can't do it. And that's the problem is that they don't have it at the scene, and that's what the feds see.

We can set up all the policies we want, you know, it makes -- try and get that information out there, and maybe that's part of the problem is we haven't disseminated how they need to get medical control information at the scene, which this committee could work on. But the -- you know, if they -- if they don't feel they have access to it in the field, that's -- that's where the problem lies.

DR. COOPER: You know, I've always felt that this particular measure would be the one that would trip us up, if any -- if any one did, for precisely the reasons that both you and Mr. Czapranski mentioned, Martha. The -- the --

the -- more the custom than the reality, that basic life support providers don't feel that they should be calling medical control.

I'm wondering, as we think about this, if there might not be some way that we could begin to educate our basic life support colleagues, you know, in this -- in this area. And I think that what might help is a conversation with SEMAC as to how to begin this discussion, followed -- not this year, of course, because the program's already set -- but the following year, by -- by perhaps a special session at Vital Signs. What does pediatric -- what is pediatric medical control? What does it mean? How do you get it?

MS. GOHLKE: Right.

DR. COOPER: You know, particularly if you're a basic life support provider, you know, especially in a rural area. You know, in the -- in the city, of course, with a centralized nine-one-one response and -- and dispatch center, you know, we -- we can clearly provide that at a basic life support level, as well as an advanced life support level, and that's well

understood. And I -- I think that the same is probably true for most of the upstate cities. But I think we have a huge problem in -- in the less urban areas of the city, in terms of people knowing where they can access medical control, or even if they can. I mean, there are -- we may believe that they can, but maybe they can't. So, I think this is something we should -- we should look at.

So, Martha, I'm going to ask that you organize a conference call with a few members of -- of SEMAC, to be selected by Dr. Henry, as to how we might begin to, you know, focus a little bit more on this particular performance measure, and how we might meet it. And of course, since we have to do the survey this year, it would be very nice if we could, you know, make some progress on that before we actually do the survey, and maybe even develop some guidance for people that could be written up in the form of a policy or something along those lines, that would at least keep the -- you know, the issue front and center, would provide us with some, you know, support at a federal level, to indicate that this is a problem we're actively

engaged in -- in correcting, so that the next time we get around to doing this survey, which I presume will be two years after this, you know, we'll be in much, much better shape. And I think the combination of having some kind of written policy that can be distributed to all the regions, every single ambulance service, so on, coupled with an educational session at Vital Signs, not this year, but next, I think might be very, very useful in -- in helping us meet that -- meet that target.

MS. GOHLKE: And -- and just to reassure everybody, believe me, they hear from New York, and they know that we are working diligently and -- and that we're not just okay with the -- the data numbers, that there was a problem with the survey, and that means -- I've gone back and forth with them on this, and they're aware that we are doing better than we show on paper. That's just --.

DR. COOPER: I -- I -- I have no doubt that -- that we are letting them know that on a regular basis, but I am concerned that there are providers out there that believe they may not have

access, and that is a problem. Because those are the people who obviously need it the most.

Sharon?

MS. CHIUMENTO: Martha, I was going to say one of the things is do you have access -- do you have the ability to change your question? You may want to ask them how they get control -- medical control, if they have -- if they have to -- if they have patient refusal, or if they can --

MS. GOHLKE: I can't --

MS. CHIUMENTO: -- give an example.

MS. GOHLKE: -- I can't get to that depth of -- of tweaking questions.

MS. CHIUMENTO: Okay.

MS. GOHLKE: I can use, you know, language that we use in New York State, but the question's got to stay standardized for every state.

MS. CHIUMENTO: Okay.

MS. GOHLKE: So, I -- I can't ask subsequent questions like that. I think they have

a lot of open-ended areas for people to comment on, but I can only tweak so much, and the let us do that, and we will do that, but I can't go to the depths that you're --.

MS. CHIUMENTO: Right. Because I think people do use medical control, they just don't realize that that's what they're doing.

MS. GOHLKE: Right.

MS. CHIUMENTO: They -- they think medical control is for getting orders.

MS. GOHLKE: Yeah.

MS. CHIUMENTO: In some cases charcoal would be an -- be a basic order that they might get.

MS. GOHLKE: Yeah.

MS. CHIUMENTO: But many regions, if they're going to do a refusal, the patient is doing -- doing a refusal, they also have to contact medical control. They just may not recognize that as medical control.

MS. GOHLKE: Yeah.

MS. CHIUMENTO: So, it might be, if there's some way to give them that information

or --

MS. GOHLKE: Yeah.

MS. CHIUMENTO: -- you know, that -- that explanation --

MS. GOHLKE: Yeah.

MS. CHIUMENTO: -- when you send out the survey you may actually get a better response.

MS. GOHLKE: Yeah. I can't tweak it to that point, but I mean, if we were only five percent off, you know?

MS. CHIUMENTO: Yes.

MS. GOHLKE: We're not. We're way off, especially on the B.L.S. offline protocols. So -- but I hear what you're saying.

MS. CHIUMENTO: Yeah.

MS. GOHLKE: And we do -- we are able to tailor somewhat some of the -- some of the semantics.

DR. COOPER: Thank you, Martha.

Now, so I think that we have spent quite a bit of time during the last year addressing performance measure seventy-three. You

gave us an update on seventy-four and seventy-five. Seventy-six, I believe, is related to seventy-four and that's -- and that's part of what Dr. Kanter's subcommittee is working on. For those who are on the telephone, that is the percentage of hospitals in the state that have written interfacility transfer guidelines. That will be part and parcel, of course, of our regionalization project.

And performance measure seventy-seven, same, because that covers interfacility guidelines for pediatric patients.

Now, seventy-eight we do have some work to do, and I think that will come up under the Education Committee report. That has to do with adoption of requirements by the state for pediatric emergency education, for license renewal for B.L.S. and A.L.S. providers.

Seventy-nine we meet because we're in law. That's whether we have an E.M.S.C. subcommittee established in -- in law.

MS. GOHLKE: We don't actually meet seventy-nine.

DR. COOPER: We do not?

MS. GOHLKE: No. I'm -- I'm not full-time off the grant, so unfortunately we don't meet it. So --.

MS. BURNS: Neither do most states, because most of their (off-mic) full-time positions.

DR. COOPER: Well, you sure seem full time to me, Martha.

MS. GOHLKE: That -- yeah. I -- I actually split my time over this and our other Governor's Traffic Safety grant. So in the eyes of the feds, I'm not working a hundred percent of my time on this grant. So, for that reason we don't meet that -- that performance measure.

DR. COOPER: Oh.

MS. GOHLKE: Yeah.

DR. COOPER: Well, I -- I -- I know Lee Burns will come up with a creative way to solve that problem.

MS. BURNS: Yes. We're going to lay her off part time.

MS. GOHLKE: That's the only option, Dr. Cooper.

DR. COOPER: Yeah.

MS. GOHLKE: Thank you for your advice.

DR. COOPER: That wasn't exactly -- it wasn't exactly what I had in mind.

FROM THE FLOOR: Well, since Lee can do three jobs, is there a reason Martha can't?

MS. BURNS: I --.

MS. GOHLKE: That's what I'm telling the feds. I said I can do more than this one grant, you know, you should be happy that I, you know, can multi-task.

DR. COOPER: And performance measure eighty, again, more of the same. It's more about permanent.

MS. GOHLKE: Yeah.

DR. COOPER: So -- so with the exception of that one little glitch in our permanence issues, I think Marsha -- or Martha meets them, or we meet them. So the real issues we have to focus on are the -- are the med control piece, and the -- the specific pediatric educational requirement piece.

MS. GOHLKE: Well, the -- and the -- and -- and the pediatric equipment we still have a ways to go on too.

DR. COOPER: Well, what --.

MS. GOHLKE: We don't have it in regs, all the list of the pediatric equipment.

DR. COOPER: Yeah. I -- I'm aware of that, but I mean --

MS. GOHLKE: Yeah.

DR. COOPER: -- I'm talking about areas where we -- where we don't have a plan in place.

MS. GOHLKE: Right.

DR. COOPER: You know, for example, we -- we -- we -- we've made significant progress on the ambulance equipment guidelines. We've made significant progress on regionalization. We haven't made quite so much headway with respect to medical control and explicit iteration in regard in -- in our -- in our policies and procedures, regarding meeting the educational requirements.

MS. GOHLKE: I actually have more -- the least amount of confidence in

seventy-three with the equipment, than I do with seventy-one and seventy-two.

DR. COOPER: Really?

MS. GOHLKE: I think we've made more headway. I mean, there's issues about putting all the equipment in regs and then making sure that they're on the ambulances, but -- that are probably more difficult to overcome than what we've done on the -- on the medical-control side.

DR. COOPER: Well, you -- you know, correct me if I'm wrong, with respect to the regulatory piece, but my understanding, Lee, was that we had moved away from being quite so explicit in regulation per se, and that the regulations are meant to specify general categories of equipment that we need to have, and -- and the rest can be referred to in terms of policy.

MS. BURNS: We -- actually, we have looked at that as an overreaching philosophy, but in terms of actually enacting that, and working with our partners on the systems committee at the state council, it's been a -- it's been a slow process. Most recently, we did -- we put together

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some policies in order to address some requests for regulatory change, but -- but because of the whole regulatory approval process is so complicated and slow, we -- we sort of dealt with it by policy not so much by actual regulation change.

Though in -- in response to your comment, what we've been working with, both in -- in the bureau, as well as with the state council, is to modernize the equipment list, and make it so that it does -- it's not -- the -- it's not as prescriptive as it is -- because, frankly, stuff changes, and the regulations, by their nature are outdated almost as soon as you enact them. So, we're exploring the possibility of wording it in such a way that the regulations address, for example, the need for -- for communications. But our regulations specifically talk about radio communication -- duplex radio communications. And that -- that's really quite outdated. I mean, with cellular telephone, we're, obviously, you know, we're well in advance of duplex radio communications, or you know, radio telemetry. So, we're looking at -- at putting it together so that

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it's -- it's more rational, and it's -- and it's more malleable as technology improves.

DR. COOPER: I'm sure I speak for the entire committee in -- in supporting the Department in moving toward a much more streamlined, flexible approach to the regulatory process, insofar as equipment is concerned. I don't -- given the fact that these equipment guidelines are updated, usually about every three to five years, by -- by the -- by the fed, through either a contract or -- or a grant to some professional organization, if not the E.M.S.C. program itself, and given the fact that our regulations change far less often than that, I think that this is something that we could do now to help ease regulatory burden, and of course, easing regulatory burden is always easier than stiffening regulatory burden. And maybe the -- maybe this is something that could go through with a little bit more ease than some of the other regulations that are proposed.

So I -- unless I hear an objection, I -- I -- I think I do speak for the

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committee in saying that we would urge the Department to move forward along that line, and -- and setting general categories of equipment that must be present on ambulances within the regs, and handling the remainder by reference, in terms of -- in terms of policy.

So noted. Thank you, Lee.

I'd like to just acknowledge that Ms. Jennifer Treacy from the Health Department has joined us. She is the official within the Health Department who is responsible in part for oversight of the E.M.S. programs. She works -- she works very closely with Lee, and -- and with Lisa McMurdo. And we're delighted that she's been able to join us today.

Thank you, Jennifer for being here.

MS. TREACY: My pleasure.

DR. COOPER: Yeah. Yeah. Thank you.

Okay. Well, this is actually a perfect time for us to move into the -- the E.M.S. Bureau report, and since Ms. Treacy has just

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arrived, it will save -- it will save you and Lee the -- the -- the need to get together for a formal briefing at some point in the near future, and I'm sure both of you have many, many things to do on your calendars, and so we can do this publicly and -- and save you both a little bit of time.

Lee?

MS. BURNS: This should sound strangely familiar to those of you who attended the SEMSCO meeting, or watched the Webcast, because I know everybody tuned in. The report is -- is very similar.

In terms of budget issues, one of the things that we have been plagued with is a lack of prehospital patient care report forms. I'm pleased to tell you - though it doesn't affect most of you - we have them now. There was a lot of -- we got a lot of mail at every level in the Department, from legislators to fire chiefs, saying that they were horrified that the Department was no longer going to be printing these forms. And when I saw the first one, I was horrified that the Department was no longer going to be printing these

forms, but we never were not going to print them. We have printed them and we have been approved. We're in the -- we have gone through the approval process for a follow-up order. So, we -- we -- we have forms. So, that is important to most of the E.M.S. community.

Interestingly, and -- and of import is that the governor's budget includes two things that are of concern, or at least should be brought to the attention of the E.M.S. community and -- and E.M.S. for Children. One -- and they're in there because the governor's budget is specifically intended to reduce the effect of the -- of the financial situation on local government. So, one of -- the governor's budget includes an item that would change General Municipal Law 209(b) and allow fire departments or districts to bill for ambulance service. At this point, 209(b) prohibits fire departments and fire districts from billing for ambulance service. It exempts you guys. Actually it exempts municipalities. A municipality may bill for ambulance service. There are many, many

municipalities whose -- whose ambulance service is operated by its fire department, who are permitted under law to bill.

Dr. Kanter, I'm just looking at Ann Fitton, since you -- you miss the joy of the visual.

(Off-the-record discussion)

MS. BURNS: The other -- I -- I'd lie down on railroad tracks for Ann Fitton, I've got to tell you.

So, the other thing that does concern us is there is an indication, though it's not in the governor's budget, that there -- the governor's budget includes a portion of consolidation. And what it does is it creates something that is loosely called the Division of Homeland Security and Emergency Management, and there may be something else in there, I -- I'd have to look. But currently, the budget includes the consolidation of the Office of Fire Prevention and Control, State Emergency Management, and several other emergency-management type branches in state government, into this division. And just so you

know, the state police are called The Division of State Police. So this would be another division under the Executive Branch.

E.M.S. had originally, in the first version that I saw, had not been included. Most recently, there is an indication or a concern that E.M.S. would be included should this be approved. And speaking for myself selfishly, I kind of like working for the Health Department. So there is a real concern about that.

The other -- with regard to the budget issue, it is important that you know that with the approval and consultation of the governor's office, the State Health Department is combining the State Hospital Review and Planning Committee, SHRPC, and the Public Health Council. These -- these are two huge advisory councils to the Commissioner and the governor.

And the reason that that is going on, and the reason that I tell you this, is that the budget situation is so severe that, in an effort to make government more efficient, make the advisory councils more efficient, and

project-oriented as well as save money, they are consolidating these -- these very large boards. Both of them have -- have very big responsibilities in statute.

So with that said, keep your ears open, because it is not -- it is not beyond the Department's, you know, horizon, that we in the Bureau of E.M.S. staff four advisory councils. And the question really is the efficiencies of how -- you know, how best to manage the groups, and whether it would make sense to consolidate them as well. So, for your information.

Dr. Kanter, did you have a question?

MR. KANTER: No.

MS. BURNS: Okay. With that said, this is my -- my -- I -- I did this with the -- the SEMSCO committees, as well as the SEMAC and the SEMSCO Council. One of the things -- it's kind of my -- my routine nagging, if you will. Because the councils, by their nature, are being examined very closely, I think that it is hugely important that our councils really, really look at

work plans, attainable projects, tracking for the completion of them, bringing them to a close, and essentially producing a -- an item at the end of whatever the project may be.

We've also kind of stepped forward into looking at long-range planning possibilities, so that, using the SEMSCO as an example, the chair is elected for a one-year term and by the time he hit -- you know, he has to hit the ground running and by the time anything is able to even come close to looking like it could be considered to be done, it's time for the next chair. So one of the things that this year's chair and his -- his vice chairs -- who -- Tim Czapranski who's here is one of them, is really looking at attainable projects that will have a consistency and carryover so that -- and that they are brought to closure, so that the councils are -- they are productive, but there is evidence that they are productive. So nagging session complete.

St. Vincent's Medical Center is a continuing issue. It -- it is looking at -- at -- it's work -- has been working with lenders and the

state for ongoing funding. It is in a financial crisis, and it doesn't look good, according to Ann. She shakes her head. We're -- we're actually -- we know. They essentially will run out of money -- they've run out of money. They -- the -- the question really is what the next steps are, and the Department continues to work with them on next steps, particularly considering their outreach clinics, their community-based health organizations. Much to our -- we're very encouraged. The Department is extremely concerned about emergency department and trauma care issues, as well as the nine-one-one system impact, and the impact of the loss of their ambulances in the nine-one-one system. So, we've -- we -- we're on the radar scope with that, which is actually very encouraging. Not so much for St. Vincent's but that it's at least -- you know, it -- it's at least under consideration. FDNY has been gracious with a lot of local data, so we're -- we're working with that as well.

The Ryan White project to bring New York State regs and Ryan White -- the current

Federal Ryan White Act to consistent -- consistency, continues. Our partners in the AIDS Institute issued an advisory, just to -- to provide resources as the work continues. Tangential to that, one of the fire groups has been working with the legislature on a bill that would allow for source patient testing, I think with -- with Mr. Godfrey (phonetic spelling). We have -- had conversations with them and we have a meeting with -- with them again -- I want to say this week, but I think tomorrow or Thursday -- not to discuss the merits specifically of the bill, but the concerns that the Department has are that the current -- the way the current bill is written and it's been around a while also, is that it is specific to H.I.V./AIDS, and one of the -- what the feds are looking at is a way to include the ability to utilize the Ryan White Act, and source patient testing, for other blood-borne infectious diseases, as well as new and emerging diseases, so that it -- it doesn't -- because the reality is that exposure to H.I.V./AIDS is not as big a concern as it was ten or fifteen years ago, though it's a concern.

However, the likelihood of being exposed to one of the hepatitises is greater. So that -- that is ongoing.

The E.M.S. Memorial is May 19th. I would -- I would implore you all to come. We are inducting three line-of-duty-death E.M.S. providers this year, one of -- one of whom was the -- was outside of -- of September 11th, murdered on -- on the -- while treating a patient. So, this -- we believe this year's service is going to actually be a big one. Most of St. Lawrence and Jefferson County will be here, but -- but it's -- it's a very -- it's a very nice event. And I think -- you've come.

DR. COOPER: Oh, yeah.

MS. BURNS: So dust off your black suits and please feel -- please come.

On -- on a less morose note, Vital Signs, again, is in New York City this year. The plans are continuing. Our staff there has made cite visits and they're very -- they're --they're very excited. The cite visit went really well. They have a very good working relationship with

the -- the hotel and the contractors. The speaker schedule is complete and has been sent to print, and I -- I -- I'm doing the quotes in the air thing because we're not actually going to print the big brochure. We're going to print a small number of the big brochure we've always printed, but we're printing small cards to mail out, and put the whole brochure on the Web site, and people can actually register online. So that's going on.

And then the other thing is that there are a whole host of -- of this is -- I'm saying this. I wrote it down. But we have very cool preconferences. I'm -- I'm going to follow Ann Fitton. That's my job for the whole weekend. Ann facilitated a preconference with the FDNY Fire Training Academy, where -- where they're going to do a bus explosion scenario, and a tour of the academy. And we went and it was raining sideways. It was -- the weather was so bad. But -- oh, my God, it's going to be great. It's going to be way cool. So mark your calendars for the end of August.

H1N1. Interestingly, the --

things have stabilized to the point really where the Department has -- has reduced their H1N1 calls -- conference calls, which I think is good, personally.

DR. COOPER: Which is good.

MS. BURNS: The -- the folks that -- they continue to do surveillance on patients and facilities for H1N1. The numbers appear to be stabilizing or lowering. Their -- their -- their -- they believe that the vaccine is effective. The distribution continues to be ongoing.

The -- with regard to the executive order allowing advanced E.M.T.s to participate in PODs, give vaccinations during PODs actually expired at -- is -- expires at the end of March. However, the Commissioner is working on regulations to allow -- give him the power to approve prehospital-care providers to participate as the need may be necessary.

We're doing a respiratory train-the-trainer program, which is ongoing. So far, we've completed training in nineteen counties.

There are another ten or so counties on the queue to -- to participate in the training. What it is is basically respiratory disease protection, C.M.E. and fit-testing training, so that people can go back to their services and fit-test their providers, and train other providers to do fit-testing.

So, I think -- the last thing that is actually quite huge for us, is we were approved for year number two of our G.T.S.C. Electronic P.C.R. grant. We have entered into a contract with Image Trend, to be what they call the state bridge, to accept data from all the regions in the state. It's a huge project. And so, while Martha is working on E.M.S. for Children a hundred percent of her time, she is also working ninety-nine percent of her time on the G.T.S.C. grant, which is why she looks like she's going to kill me. So, stay tuned for that. Year number two started on the 1st of February, and we're preparing to do our application for year number three. But the results of it will be really huge.

And that, Doctor, is my report.

DR. COOPER: Lee, I do think there was one other issue of great impact that did transpire at the most recent meeting of the -- of -- of the council, that related explicitly to your report.

MS. BURNS: Okay.

DR. COOPER: And that has to do with the -- the NEMSIS data elements and so on. And I -- I wanted to give you an opportunity to comment on that, because it does directly impact upon our work here as well.

MS. BURNS: Actually, thank you, because that's true. With -- in -- with work from the bureau staff under -- really under the leadership of Mike and -- and Martha, as well as the evaluation committee of the state council, they have settled on the data elements that will bring us into compliance with the NEMSIS dataset, as well as build a New York State prehospital patient registry.

You should look way happier.

So, this actually -- the work -- I -- I -- I missed you, Sharon, because -- Sharon

was also instrumental in this and dogmatic, might I add, as she is with many of her projects. But -- but the -- this is -- this is absolutely a show-stopper. This is huge.

DR. COOPER: It is huge.

MS. BURNS: So it allows us to move forward. The -- on the -- you know, the -- it's -- it's so mind-bogglingly complicated, but simplistically, it will allow us to collect prehospital care data that we have really -- I say we, the Department, and our physician community, including Dr. Cooper, for years have -- have really sought after. So, this is -- this is a breathtaking step forward.

DR. COOPER: Thank you, Lee. I -- I can honestly say that, other than being a cheerleader, I had nothing to with making sure that this happened. But Sharon, as usual did a yeoman's job, as did Mike and Martha in bringing this to fruition. This is probably the most important thing we can do from a quality-improvement standpoint, because finding common ground with our sister E.M.S. services throughout the nation allows

us to benchmark our own data and our own results, versus -- versus outcomes elsewhere. We have never had the opportunity to do that before.

Jennifer, I'm going to just take a moment and editorialize one little bit. We have had, in E.M.S. over the years, a very, very difficult problem with timeliness of data, that is to say, an insoluble problem to this date. The -- the data when it becomes available, is generally three to four years old, has major holes in it, and has really made it impossible for us to conduct meaningful quality improvement, which is our charge under, you know, under the -- the statute. Anything the Department can do to facilitate the -- the -- the adoption of -- of these data elements, creation of electronic means of reporting, i.e., the registry that -- that Lee was speaking about, would be deeply appreciated, and of course, with respect to the Department's appropriate focus on patient safety, there's nothing that -- nothing that we can do in E.M.S. that would be more important than making sure we have timely, accurate data, submitted electronically, that could be

analyzed, you know, appropriately, to give feedback to our E.M.S. services. There's really, of course, no more important focus for the Health Department than patient safety and quality improvement, and -- and that's the tool that will allow it to happen. And we've been years and years and years without it. And we finally, finally, finally, due to the work of Sharon and -- and Mike and Martha and the evaluation committee, supported by Lee, of course, have -- have the -- have -- have some light at the end of the tunnel. So, please, anything you can do from your end would be deeply appreciated by the entire E.M.S. system, I can assure you. Not to mention, of course, the citizens of New York State.

Okay. Any questions for Lee Burns?

(No audible response)

DR. COOPER: Jennifer, on behalf of the leadership group in the Health Department, do you have anything you'd like to report on this morning?

MS. TREACY: Well, not really. I think Lee covered it all. Maybe if the budget

is -- trying to think of how to -- you know, I think we kind of hit on all the high points when we were being asked to, you know project costs, ways to save money (off-mic) I don't think -- I don't really have any good news, I'm sorry.

DR. COOPER: That's okay. That's okay. I just think that, you know, on behalf of everyone here, we need to put in our plea to the sister three councils, that to the extent that E.M.S. can be held harmless in the budget situation, that it is. We learned the hard way on September 11th, and have learned the hard way on subsequent -- during subsequent disaster events, be they biological disasters, SARS, Pan-Flu, and so on, that without a vigorous and robust E.M.S. service to deal with the public health emergencies when they arise - and of course we never know when they're going to arise. It could happen -- it could be happening right now as we speak, and without our -- without our knowledge - without emergency medical services there to -- you know, to begin sorting us out of the mess, we will be nowhere. And the amount of money that we spend on

E.M.S. in New York State is -- is laughably small. In -- in the parlance of the federal government, it's decimal dust in terms of the -- the dollars that -- that are -- that are used to support the activities here. Yet it's the one thing that everyone relies upon, you know, when the mud hits the fan. And -- and -- and if we don't have that robust E.M.S. service, the Commissioner is going to be red-faced in front of the -- you know, in front of the cameras explaining why -- why that was not the case.

So I'm happy to say that on the public record, and ask that you share that observation, and I'm sure I speak for the entire committee in -- in bringing that to you. We're not asking for any increases, you know, with -- although we all know we're terribly, terribly underfunded to do the work that we -- that we need to do. What we are asking is that what little we have, on behalf of the public that we serve, not be cut.

Okay. Any other questions or comments for either Lee or Jennifer?

(No audible response)

DR. COOPER: Okay. Hearing none, let's move into subcommittee progress reports. And I -- I will give a report on behalf of Dr. Kanter, who I believe is -- has taken a break from the call.

Bob, are you there?

DR. KANTER: Sorry, I'm now back on.

DR. COOPER: Oh, you are. Excellent. Okay. Well -- well, hang on, Bob, then let me -- let me get the volume back up here a little bit.

MS. BRILLHART: Mike?

DR. COOPER: Yeah. Oh, Susan. Hi.

MS. BRILLHART: Hi.

DR. COOPER: Hang on. Am I going the wrong way? This one?

DR. LILLIS: Yeah.

DR. COOPER: Oh. Okay. Oh, there we go. Okay. Thank you. Kathy had to help me. I'm electronically challenged.

Bob and Sue, are you there now?

MS. BRILLHART: Hi. I am. And I also wanted to interject when you were doing the St. Vincent's report, I don't know if people know, but St. Vincent's is closed to all pediatrics. There is no pediatric inpatient under age of thirteen at St. Vincent's anymore.

DR. COOPER: That is true. Do you know the -- the effective date of that, Susan?

MS. BRILLHART: Yes, that was the first Monday in February --

DR. COOPER: Okay.

MS. BRILLHART: -- if anybody has a calendar. Because we could --

DR. COOPER: February 1st.

MS. BRILLHART: -- the last Saturday in January and they closed on Monday.

DR. COOPER: February 1st.

MS. BRILLHART: Okay.

DR. COOPER: Ann Fitton has indicated that the emergency department, however, is still accepting pediatric patients as of this moment.

MS. BRILLHART: Yes, it is, but just understand that they -- then they'll need to be transferred, because they don't -- they have literally closed their unit. So, just an F.Y.I.

DR. COOPER: Okay. Thank you. Just for the record, joining us by conference call is -- is Susan Brillhart, professor of nursing at -- at CUNY B.M.C.C.

Okay. Bob, are -- are you ready to give the interfacility report?

DR. KANTER: Sure. I think -- now, Martha, please step in if you have any more recent information than I do, but in a general way, the Department is planning, in a number of respects, to organize and maximize a fruitful discussion among stakeholders at the May 13th meeting, regarding improving statewide pediatric emergency and critical care, and aspects of regionalizing pediatric emergency and critical care. The guest list is in preparation, and the Department is giving some consideration to how much the Department wants to define some objectives ahead of time, as opposed to just leaving an

open-ended discussion for the stakeholders. And -- and -- and along all those lines, the agenda is being finalized.

But, Martha, you may have some more recent information than I do.

MS. GOHLKE: No, that's -- that's the most recent. We -- we have ongoing monthly conference calls that you're welcome to call into if you want to participate. We're -- we are kind of moving right along with this. And if you want to come to the May 13th meeting down in New York City, you're welcome as part of this committee. You just need to let me know sooner rather than later, because I have to do a bunch of travel paperwork that you'd be traveling off the E.M.S. for Children grant. So, I guess that was the only thing I wanted to add.

DR. COOPER: Thank you, Martha.

Bob --

MR. KANTER: Yeah.

DR. COOPER: -- do you have any -- any specific personal thoughts about -- about where we're heading on this, in terms of the

agenda? Are there issues that you believe perhaps, given that Jennifer Treacy is with us, that we need to call to the attention of John Morley or the Commissioner, here on the public record?

DR. KANTER: Yes. Well, I -- I think first of all, I did have the opportunity to speak with Dr. Morley a couple of weeks ago about some of these things, and in a general way, think, my own recommendation is that, to whatever extent the Department can explore ahead of time the various methods that the Department could use to promote improvements, I think if the Department considers these things ahead of time, and at least sort of takes tentative positions on what regulatory objectives in the long run would be useful, before the stakeholder meeting, I believe the stakeholder discretion might be somewhat clearer and more fruitful. Certainly, we want good, open input from all the stakeholders, but I think if the State Department of Health begins thinking about objectives that are desirable and feasible from the Department's point of view, I think the discussion might be structured in a more

effective and fruitful way. And I -- and I talked to Dr. Morley about that. And we'll -- I'm sure we'll hear more about it.

DR. COOPER: Thanks, Bob. I -- I could not agree with your sentiments more. This will now be the third stakeholders meeting that we have held on the issue of regionalization over the years, and you know, every time we hold the meeting on regionalization, the literature has grown and supports regionalization even more than it did the last time, and at this -- yet there has been no progress except with respect to pediatric trauma regionalization, which was accomplished really in the late '80s. And so, I -- I think that the Department, as you suggest, will have -- or -- or be receiving a much greater value for the -- you know, the investment in the stakeholder meeting, if there is a -- if you will, if not an actual on-paper strawman, at least a -- at least an -- an in-our-head strawman, as to how far the Department is willing to go. And that will allow the people who are attending the stakeholder meeting to actually give the Department, really, some pretty

explicit advice as to how -- how the task can best be accomplished.

You know, we -- we -- we're in an era where we all know that -- that we can no longer afford to have every -- every hospital capable of doing everything, if that was ever the case. That's certainly true with respect to critical care pediatrics. And this is really, in many ways, the one unsolved piece of our -- of our pediatric-emergency-care puzzle. Neonatal regionalization occurred in the early '70s, pediatric trauma regionalization occurred in the last '80s and early '90s. Yet here we are, some twenty years later, and you know, while there is de facto regionalization in most areas of the state, in that the large -- the largest geographic areas of the state, simply outside the major cities, don't have the pediatric resources, and automatically send the patients into the big children's centers. In the downstate areas, that's not the case.

And as you know, Bob, and as you'll be covering at the stakeholder meeting,

there is some data to suggest that outcomes could be improved, patient safety could be improved, if regionalization did occur for medical patients, as well as trauma patients and neonatal patients. So, once again, I think, Bob, if I hear you correct, the -- hear you correctly, the message that we hope Lee and Jennifer can take the Department is that we really feel that it's really incumbent upon the Department to give us some guidance as to how far it's willing and able to go in terms of regionalization, so we can give them the best advice possible at the upcoming meeting.

MR. BURNS: And Dr. Cooper --.

DR. KANTER: Yes. And it -- you know, it may be worth just spending a moment on defining my terms more explicitly.

MS. BURNS: Yeah.

DR. KANTER: Regionalization means different things to different people. You know, I think at the simplest level, we would be -- we -- there might be some advances if pediatric facilities even identified themselves more clearly. But regionalization also means some statement from

the Department about what capabilities should be available at each level of pediatric hospital, for emergency and critical care services. And then after you've defined what should be available, accreditation would imply that you've independently verified that indeed a facility has those services. Then the state could also participate in publicly identifying those that are accredited, an even stronger mechanism of promoting the use of these hospital would be to designate them, not only say here they are, but certain hospitals should be used for services of certain kinds of patients, with a list of criteria. And then, an even stronger Department action might involve some incentives or requirements that would enforce the use of designated facilities.

And then, finally, it -- it's, I think, implied by everyone who's thought about regionalization, is pediatric centers have certain responsibilities to assist other services and other agencies in the region for preparation, coordination, education and such, as well as data collection and -- and -- and guiding quality

improvement.

So I think all of these things are elements of what could happen in a well-regionalized system. Again, these -- the full spectrum of these activities could be quite expensive. I'm not sure that anyone dreams that this could happen immediately, but I think the more the state sort of identifies some of these elements, and tries to decide what's feasible and desirable right away, and what would be on longer time line to achieve them, might help structure a more -- a better conversation at the stakeholder's meeting.

DR. COOPER: Martha Gohlke has -- has something to add to the conversation.

MS. GOHLKE: I just wanted to add that New York is being looked at very closely as we go through this process, because we're one of the few states that are going through the process. I mean, there's a bunch of states that have already gone through it and have already had their designation system set up, for lack of a more agreeable term. But -- but then there's a bunch of

states that haven't gone down this road.

Our white paper that the -- this committee wrote is now being highlighted by the Federal E.M.S.C. program as one of the recommended steps that -- that states take to go down this road. HRSA had designated two people to come to our meeting in May because they're watching our process very closely, and we're being held up as the Federal E.M.S.C. example at this point, to other states on how do you go through this process, what do you need to do, what's recommended. You know, what happened when New York went through it? So not only is it, you know, vitally important for the care of children in our state, but right now we are setting an example for the Federal E.M.S.C. program to shine on other states. So this is -- this is a big meeting not only for our state, but as far as the Federal E.M.S.C. program goes and -- and their recommendation to other states, so I just wanted to add that.

DR. COOPER: Thanks, Martha.

You know, Jennifer, as -- as everyone around this table knows, and you know, and

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the Department knows, you know, the process of accreditation of specialized centers really involves a three-step process, the first being categorization, where the facility reviews its -- its -- its own compliance with -- with standards that have been set by an appropriate body, in this case the Department, through regulation or what-have-you. The second step being an onsite verification, and the third being some type of designation based upon, you know, the findings of the verifying body, versus the, you know, the -- the standards that have been set. So categorization, verification, and designation are key elements of the process.

Article 30 of the Public Health Law does include -- excuse me -- Article 30B of the Public Health Law does includes an explicit obligation on the part of the SEMAC to develop appropriateness-review standards for emergency departments, and -- as well as trauma centers, which would include both adult and pediatric components.

What we don't have is -- is -- is

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a -- is statutory language explicitly doing the same thing for pediatric critical care areas. Now, there is the general language in Article 30(c) that indicates that the -- the Department of Health does have the obligation to regionalize pediatric care. That was part and parcel of the -- of the federal grant requirements, and -- and the -- and the E.M.S.C. legislature was built around the federal grant requirements. And the -- the legislature, in its infinite wisdom, determined that in order to continue to receive the federal support for emergency medical services for children, that it would enact the -- you know, the general categories of performance measures into law.

So, we -- there is an obligation under Public Health Law for the Department to establish a system of regionalization. And since, by precedent, we do that for adult and pediatric trauma, and adult and pediatric emergency services, through a process of categorization, verification, and designation, via appropriateness-review standards, it -- it makes sense that we follow the same process, you know, with respect to pediatric

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critical care on the medical side.

But I think there's one piece that -- that we often neglect, and that is the entry point into the system. And by that I do not mean, in this particular case, E.M.S., although E.M.S. is the access point for everyone. By this I mean actual standards for the -- the most basic level of emergency department that will receive, you know, sick patients, you know, adult/pediatric, across the board. And too often when we think about designation and regionalization of -- of critical care services, we think at the highest end and we forget the lowest end. There are specific obligations at the -- at the -- at the intake point, to be able to, you know, resuscitate, stabilize and transfer. And I know that Bob has not neglected this in the white paper, and this will be an important subject for discussion at the stakeholder meeting.

But -- but regionalization is about getting the right patient to the right place at the right time. It's not about getting the critical patient to the critical service at the

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right time. That's part of it. But it's also about making sure that at the -- at the intake points we've provided - excuse me - for the special needs of children as well.

Are there other -- any other comments on the interfacility report?

(No audible response)

DR. COOPER: Okay. Sharon, do you want to give the education report, together with Ann?

MS. CHIUMENTO: Actually, on the education components, today we finished working on the RIS (phonetic spelling), still open for anybody else who may want to comment on it. I sent it out in the -- in an e-mail, so if anybody else has any additional comments. We added a few things. We added technamatry (phonetic spelling) and oxymetry to the -- to the list of procedures that may be required on an ambulance for different types of transport. And so, hopefully that will -- that will -- the next step now will be to try to put this into some kind of a narrative format. Right now it's a very, very, very (off-mic) and so

hopefully, the next step will be put it into some type of a narrative - ooh, there we go - some type of narrative format that can then be put into a manual for the hospitals -- the outlying hospitals -- the hospitals that are going to be doing the transferring, so that they have some things to help them with their decision-making process, as well as the components that they're going to need before transport. So what kinds of -- what kind of -- of a vehicle are they going to need; what kind of crew are they going to need? Is it going to be A.L.S., B.L.S.? Is there going to need to be an interfacility transport team? That type of thing. What types of hospital should it be? Lots of different kinds of information that we will be putting together in a manual.

So this is kind of our first step. We're ready to now start putting into a narrative format, so that's where we are.

DR. COOPER: Ann, do you have any to add?

MS. FITTON: I'd just like to tell you what a pleasure it is to work with Sharon.

She thinks of things that I -- I -- I don't know how she does it. She has such a mind for detail. It's a very detailed report, and her thoroughness is a credit to all of us.

MS. CHIUMENTO: I have to tell you though, Ann came up with several things today that I had not thought of, so I was very pleased --

DR. COOPER: She always does.

MS. CHIUMENTO: -- to have her input.

DR. COOPER: Okay. I think that we all heard from Lee Burns a little bit earlier, that finding work to do and getting it done, and showing the Department and the public that we are, in fact, completing tasks that we assign ourselves, you know, in order to improve the public's health, you know, is -- is of the utmost import, you know, to us as a committee. So to that end, I -- I need to ask every single member of the committee to review the work that Ann and Sharon have done together with their colleagues on the Education Committee and get any comments to them, really rather promptly.

I'd like to ask if Sharon and Ann could plan toward having something ready for official adoption by the committee by the end of the year, so that we can -- we can provide that particular component of it, or get that particular task done, and -- and then perhaps, although we need to discuss this a little bit more, consider moving on toward how we educate our colleagues in -- in the E.M.S. world about where and how they can obtain medical control in an appropriate manner in the -- in the -- in the future, and that can be a major focus for the next year.

Speaking of getting work done, I have no doubt that once we have the stakeholder conference that Bob's group will be active in terms of producing perhaps some draft regulatory language that the Department might consider, adopting or at least a process, if not, a regulatory model at this particular point, in terms of moving toward a -- you know, a three-pronged categorization, verification, designation model for accreditation of pediatric critical care services, together with the appropriate interfacility transfer guidance

documents that would be needed to support that effort, and that we can have that done by the end of year.

And then, of course, it will be up to the Department, although we imagine we will continue to keep -- keep the pressure on to do something about it, to the extent that we have the ability to do that.

And now, of course, I want to recognize Kathy Lillis, who has been doing a great job and heading up the nominations group, to give us some indication of progress there, which I believe since the last meeting has been quite substantial.

Kathy.

DR. LILLIS: Thanks, Art. The nominating committee has identified individuals for all but -- I believe all but one of the open positions and have gotten individuals who have expressed an interest in being on the committee. So we're in the process of collecting their C.V.s, writing letters of support, and then they will be forwarded up to -- up to the Commissioner.

Art, are we going to bring the nomination to here for input or --?

DR. COOPER: That's a good question.

Martha and Lee, is it -- is it your advice, on behalf of the Department, that the nominations should come to -- before the committee for formal approval, or -- I believe these are direct commissioner appointments, so they don't explicitly need to come to the committee, but you know, they -- they could. It's really up to you as to what you think is the appropriate thing to do.

MS. BURNS: I -- I mean, I think if -- discussing them here would be appropriate, but the -- the vetting process is the Department's.

DR. LILLIS: Maybe I -- I have a suggestion or recommendation that the subcommittee gather them all together and then send out a copy of their -- their C.V.s as in one e-mail and ask the members of the committee to review their C.V.s and gather any additional input, if there's anyone has concerns or -- or any other items for recommendation that we can include in the letter

that would go up to the Commissioner, that would be helpful as well.

MR. TAYLER: Dr. Cooper?

DR. COOPER: Yes, sir.

MR. TAYLER: From the -- from the Trauma Advisory Committee's side, it -- the Commissioner's appointing-office people like to see endorsements along with the -- along with the nominees, they like to see endorsements. So on the trauma side, if it's from like, the Regional Trauma Advisory Committee representative, then it's the -- it's the RTAC that sends me the endorsement letter. If it's an outside entity like -- well, like yourself, it -- you will -- you are being vetted to the State Trauma Advisory Committee as the pediatric trauma surgeon, so your endorsement is looking to come from a pediatric surgical or trauma surgical group of some sort.

But there -- there are those on the STAC that technically, it -- it's an endorsement from the STAC it -- itself. So, it -- it -- it kind of goes back to what statute says, what bylaw says. It has been my experienced with

the State Trauma Advisory Committee as to where the endorsements comes from -- whether they come from an outside group or from a region, or from this state-level committee itself. But they -- again, they do like to see the endorsement letters, as well as the C.V.s and such.

And just to -- to Dr. Lillis' comment, keep in mind confidentiality issues with the -- with the C.V.s. Don't -- I -- I wouldn't send around C.V.s even to -- to the group here, that -- that has information that might be confidential on it and such. It just -- it -- someone might take that as -- as feeling intrusive, you know, so just -- just a -- just a thought is all.

DR. COOPER: Thank you, Mike. Good advice from someone who has obviously recently suffered through the process.

To that end, I -- I might just share with the group just a tiny bit of information on some of the individuals that have been identified. There's a -- to fill the -- the seat of the pediatric toxicologist, being vacated by Dr.

Amler, dean of -- of the School of Public Health at New York Medical College, but recently promoted to vice president for intergovernmental affairs, he no longer has time to be with us for that reason, an individual has been identified who is -- heads a large regional poison center in upstate New York.

For the pediatric E.M.S. physician we've identified an individual who has an -- a very, very extensive background in pediatric prehospital care, has been previously identified as one of the National E.M.S.C. Heroes, Lifetime Achievement Award. We have an individual who is a participant at a national level in the American Academy -- American Academy of Pediatrics, dealing with specialty-care issues, who actually functions at the present time in a rural environment, with -- with close ties with the military, which have special needs for their population. We've identified an individual who is also deeply involved with the National American Academy of Pediatrics, who has very, very special interests in pediatric behavioral health and their interface with primary care.

And there's one other, Kathy.

(Off-the-record discussion)

DR. COOPER: Oh, yes. Yes, yes, yes. And we've identified an emergency medicine physician who serves as medical director to a municipal hospital in New York City, that has a very, very large pediatric medical and surgical services affiliated with it.

And I'm happy to report that -- that we have been able to reach out to these candidates, and all of them have indicated that they might be willing to serve, depending, of course, upon the -- you know, the vetting process that takes place.

DR. LILLIS: Pediatric physiatrist --?

DR. COOPER: Oh, yes. And there is a pediatric physiatrist as well, a pediatric rehabilitation specialist, who had been previously identified, who heads a large pediatric rehabilitation group in one of our major children's hospitals.

So, I think we've got an

outstanding group of candidates that really represent geographically, gender-wise, and culturally a very, very diverse cross segment of -- or cross section of New York State's population. So, I think that that's all to the good.

MS. GOHLKE: Just one thing.

DR. COOPER: Martha.

MS. GOHLKE: I think the only seat that hasn't been identified yet is the -- we have one seat for another parent representative. There's two seats on the committee, one of which Ruth Walden, who's ill today, couldn't be here, she has the parent representative for children with special healthcare needs. The other seat that's still open is the parent of a ill or injured child that basically has gone through the nine-one-one system. And that's the other seat that we need to fill, and I don't think they've identified -- the committee has identified anyone yet. So we could, obviously utilize suggestions from the group as for a parent representative. It's not that they have to come from this area, but it's something to consider. When you're asking about a parent

representative to travel across the state, it might be wiser if we want somebody to actually be sitting in the seat, to think of somebody local here to these meetings, but obviously, it doesn't have to be, but that is one other seat that we need to fill.

DR. COOPER: Thank you, Martha.

As always, the nominations process is wide open, so if other folks have candidates that they have identified that -- or that they -- that they know of, that they want to bring to the committee's attention, please get in touch with either Kathy or -- or myself, and -- and we'll -- we'll review the -- the recommendation and make a suggestion to the committee when we bring it back in June. Okay?

Yeah, Chris.

MR. KUS: The Health Department.

DR. COOPER: Oh, yes. Yes. Thank you, Chris, for joining us -- Dr. Christopher Kus from the Health Department Division of Family Health.

DR. KUS: Just one suggestion

with the parent one is to maybe check with Ruth -- we actually have groups of parents that go through parents training, to -- to -- to sit on policy groups, and I'm not sure that one would fit that, but it's always helpful to have somebody who's gone through policy making, and gotten some -- some experience about what it takes to sit on an advisory group.

MS. GOHLKE: Absolutely.

DR. COOPER: Chris, that's great advice. Thank you.

And Martha, perhaps we could reach out to Chris and ask him about several of these advisory groups that -- or parents groups that he knows of.

DR. KUS: Yeah. I -- yeah. Definitely. I'll actually -- I'll -- I'll talk with Ruth. She works with us and we have parent champions and parents in the regents that might know, so that -- that might be a way to recruit somebody.

DR. COOPER: That would be great. And we -- we have -- we have stumbled in the dark

with respect to finding a way to identify a parent of an ill or injured child, and I -- I think you've just opened a major door for us here.

Okay. Well, it is now twelve thirty-seven. We are only a couple of minutes behind on our agenda, but at the same time we've also covered quite a bit of the subcommittee progress report issues, so we might actually even be ahead. So lunch is here. It is behind you. So why don't we take a few minutes for lunch, and plan on reconvening at one o'clock. That will give everyone a chance to do what they have to do and -- and we'll see you back at that time. Thank you.

DR. KANTER: Art?

DR. COOPER: Yes, Bob?

DR. KANTER: I have a couple things I need to take care of. Would it be all right if I checked back in with you at two-thirty?

DR. COOPER: Sure. That would be fine.

DR. KANTER: Okay.

DR. COOPER: Thanks, Bob.

DR. KANTER: Good.

MS. GOHLKE: Good. Okay.

(A luncheon recess was taken at 12:37 p.m.)

(The meeting resumed at 1:00 p.m.)

DR. COOPER: I'd like to welcome everybody back from that excellent lunch, and we'll proceed with old -- old business, according to the agenda.

As Martha has shared with you, even though we do have enough members to make a quorum, attending the meeting electronically and in person, apparently electronically doesn't count, so we can't officially have a quorum today. So we're -- as Martha announced earlier, we're not in a position to finalize the E.M.S.C. bylaws, so we'll have to defer that until next time.

So at this point, I'd like to ask Mike Tayler if he'd give us the update on the New York City Pediatric Trauma Center situation.

Mike.

(Off-the-record discussion)

DR. COOPER: No. Okay. No

problem. What I'll do then is I'll skip down to the -- the American Heart Association meeting update.

As all of you know, the American Heart Association holds a meeting to revise the -- its resuscitation guidelines every five years or so. And that meeting was held the first week in February in Dallas. I had the opportunity to attend, as did Elise van der Jagt. Elise is the official representative from this area to the Heart Association, and I had asked that he give us a short report. He's unable to be with us today, so he said, "Would you do it?" And I said, "Of course I will."

I -- I need to begin my remarks by saying that the Heart Association has a very, very strict conflict-of-interest and -- what's the word -- nondisclosure policies, and -- and the guidelines are officially embargoed until they're published in circulation, which will happen later this fall. But I certainly can share with you, you know, some of the major themes that were discussed, as opposed to the actual outcomes of those

discussions, and offer a personal opinion that it does not seem that there will be huge changes in -- in the pediatric resuscitation guidelines this time around.

Those of you who follow the literature on this could have guessed that, because there has not been a lot of new science that has emerged over the last few years, but I would -- I would have to say that probably the biggest controversy regarding the 2010 guidelines to be, you know, published in the fall, had to do with compression-only C.P.R. There's a fair amount of information on that, and it is possible that we will see -- it is possible. I -- I -- I do not know that the final outcome will be. I'm not on the committee that will make that decision. But it is possible that we will see a much more prominent role for compression-only C.P.R. among the lay community, not among professional rescuers. So at least that's what it seems at this particular point. I don't think I'm talking out of school sharing that global insight. Not because of anything the Heart Association has said or not

said, but because once again, the science that has emerged points us in -- in that general direction. What -- explicitly what the guidelines will say, I -- I can't tell you. But again, I can tell you that the committee has met, that the documents, the worksheets will all be submitted and published a little bit later this spring.

Actually -- excuse me, they will be published as part of the -- the -- the -- the guidelines process in the -- in the fall. They will probably be posted to a Web site some time this spring for everyone to comment upon. But that's where things -- we -- but again, we can expect new guidelines to be available in October.

And Martha, I -- I think we can plan that at the December meeting we might want to spend a fair amount of time looking at the new guidelines and how they might impact upon pediatric protocols, so we can make appropriate recommendations to the SEMAC, and so they can vote on them, potentially, as soon as their first meeting in 2011.

The -- I look to my left because

the mistress of protocols is sitting two seats to the left of me, and you know, I -- I know she will be --

MS. BURNS: That's why I'm waiting to find out what the changes are going to be.

DR. COOPER: -- I know she will be on top of it, and -- and advise us all and come up with her usual detailed presentation iterating all the changes, so that we'll -- we'll be the first to know. So --

MS. FITTON: Excuse me, Art.

DR. COOPER: Yeah, sure.

MS. FITTON: Is there any -- is there any discussion about the role of hyperthermia for children? I mean, I know there's no science out there, however, is there any discussion?

DR. COOPER: There was discussion, but as you say there is no science on it. So, there is one multi-center study that is -- that is -- has not yet been published. It's being conducted under the auspices of the PECARN Research Network, and until that study is published, I don't

think we're going to have any -- any guidance.

MS. FITTON: Several --?

DR. COOPER: Yeah. Yeah. There was -- that was --

MS. BURNS: Several.

DR. COOPER: -- several. There was an -- there was an extensive discussion about hypothermia at the conference, but it's not clear what -- again, what the recommendation is going to be. I think the Heart Association clearly recognizes that while it's a relatively simple straightforward treatment for patients in cardiac arrest, it's very, very difficult to establish hypothermia as a standard of care in the United States, because the -- the greatest majority of the land mass is, you know, covered by basic life support, you know, personnel, who will not have the ability to administer, you know, ice cold saline in -- in the field to their patients, and where there -- there may be relatively long distances, you know, to the closest E.D., and where most E.D.s in, you know, the more rural parts of the nation don't have I.C.U.s where therapeutic hypothermia

could be continued.

So I think while all recognize that there is science that is emerging that supports, you know, hypothermia as a -- you know, as a therapy for follow up -- excuse me, not follow up -- for follow on therapy of patients in cardiac arrest in adults, it's not clear where the Heart -- Heart -- Heart Association is going to be able to go with that. And it -- it probably will not be able to make it, you know, if you will, "the standard of care," quote, unquote, because simply nowhere near everyone in the country can meet that standard.

Any other questions?

(No audible response)

DR. COOPER: Okay. So, again, everything is, you know, embargoed in terms of the final discussions, until October. Elise will be participating in them. I will not. But Elise is not able to speak about any specifics either. So, those are the -- I think the -- the -- the general themes that emerged, and we'll all anxiously await what the Heart Association has to say.

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Okay. Mike, are you ready?

(Off-the-record discussion)

MR. TAYLER: Two seconds.

(Off-the-record discussion)

MS. GOHLKE: The system's slow.

MR. TAYLER: If you recall, when Ed Wronsky was still here, there came the question of -- the last time we surveyed the trauma centers throughout the five boroughs of New York City was in 2002-2003. The -- and at that time, we knew who was -- who was an adult-only trauma center, who was a pediatric-only trauma center, and who was both.

Now, the difference -- the difference is this: Every trauma center, regardless, has to be able to receive any patient, of any age, with any condition, into their emergency department. From there, they have to stabilize them and then decide whether they're going to ship them to an appropriate facility for I.C.U., further surgery, whatever, if they are going to ship them to another facility, or if they are going to admit them to that facility. So, keep in mind that when you talk pediatric trauma

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centers, we have three trauma centers in New York State that are pediatric-only, because they don't generally accept adult patients in their E.R. That would be Schneider's L.I.J., Women's and Children's in Buffalo, and -- what's the other one in New York City?

DR. COOPER: Morgan Stanley. Morgan Stanley Children's Hospital/New York Presbyterian.

MR. TAYLER: New York -- Children's Hospital/New York Presbyterian, yeah, are the three.

But just because they say that those are pediatric trauma centers does not mean that -- that they are the only pediatric trauma centers in the state. We have forty -- I think we have forty-one trauma centers now. All forty-one of them can accept pediatric trauma patients. They have to stabilize them and then decide whether they go -- whether they are going to admit them to that facility or ship them. So under that, we -- we did the surveys of New York City back in 2002-2003. From those surveys, we knew who was admitting, who

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was stabilizing and shipping, who was pediatric-only, who was adults-only, who was doing both.

Then -- let me see, this is 2010. Along about 2007, we started hearing thoughts that maybe some of the trauma centers who said that they were pediatric weren't quite capable anymore of doing pediatric. And sure enough we discovered that there was. So, under Mr. Wronsky, what we did was send a letter to all the trauma centers in the five boroughs. The -- well, there was nineteen at the time, Mary Immaculate Hospital has since closed. The -- we sent a letter to all the -- all nineteen trauma centers and asked them: Do you do pediatrics? Do you meet the 708 -- the -- the Part 708 regulations to be a pediatric trauma center? And they eventually all -- it was thought-invoking. I got a lot of phone calls from -- from hospital administrators saying, "We thought we were, but maybe we're not quite, so we'll get back to you." It wasn't so clear cut, and it took well over a year to get all those responses back from -- from just nineteen hospitals. So, it was

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thought-invoking on the part of the administration of these hospitals, whether they actually were pediatric trauma centers, wanted to be pediatric trauma centers, or not. The letters came back to Ed Wronsky from the chief administrative officer, chief executive officer, from the higher-ups in the hospital, so that -- that -- that this is a definitive word from the hospital administration of what they want to be.

In that, we then took that list and gave it to the New York City Regional Trauma Advisory Committee, and said give us your take on this. There were some surprises at the hospitals that said they were, and some surprises at the hospitals that said they weren't. The -- so the New York City RTAC looked at this, to see is this going to impact pediatric trauma care in the five boroughs? So from there, they went borough by borough, and they said "Okay. So -- so up on my map here, this is Staten Island. So, we have Staten Island University North and Richmond University Medical Center. Is there -- are either of those going to do pediatrics on Staten Island?

And sure enough, both of them came back and said yes, they -- they admit both adult and pediatric trauma. So, from the New York City RTAC perspective, the borough of Staten Island is okay. They cover both adult and pediatric.

The -- okay. Help me here, Dr. Cooper. I know this is Manhattan. What's this?

DR. COOPER: Brooklyn.

MR. TAYLER: I'm not a New York City boy. Help me out here.

DR. COOPER: Brooklyn.

MR. TAYLER: In Brooklyn --

MS. BURNS: Art, you're horrified; aren't you?

MR. TAYLER: Well, I'm not a New York City boy. I'm a country boy, way up north by Canada.

DR. COOPER: No, not horrified.

MR. TAYLER: I can tell you more about Canada --

DR. COOPER: Just frightened.

MR. TAYLER: -- than New York City.

DR. COOPER: Right.

MR. TAYLER: Thirteen o four is --

DR. COOPER: Lutheran.

MR. TAYLER: Lutheran. King's County.

DR. COOPER: Thirteen o one, and twelve eighty-five is Brookdale.

MR. TAYLER: Twelve eight-six is --.

DR. COOPER: Brookdale.

MR. TAYLER: Brookdale? How do you know this, Dr. Cooper?

Brookdale said they are adult only. Kings County said that they are adult and pede, and Lutheran said that they are adult only. So, again, New York City RTAC felt there's at least one pediatric center in Brooklyn, so Brooklyn's okay.

Even with the recent in Manhattan, all this, fourteen fifty-eight is --

DR. COOPER: The one on the left Vinny's, the one on your right is Bellevue.

MR. TAYLER: -- fourteen fifty-eight?

MS. BURNS: He doesn't even have to book to tell you where these are.

MR. TAYLER: Yeah. Yeah. Yeah. It's the Harvard grad in him. He just knows.

DR. COOPER: It's the --.

MR. TAYLER: St. Vincent's --

DR. COOPER: Right.

MR. TAYLER: -- is here?

DR. COOPER: That's Vincent's. Bellevue is on the other -- right. That's --.

MR. TAYLER: Okay. St. Vincent's is the one that is closing -- maybe closing, they're in trouble. They -- even with the loss of them, the --

MS. BURNS: She just learned that.

MR. TAYLER: -- there are still pediatric trauma centers in the five -- in the -- in the borough of Manhattan. So, that's the perspective that the New York City RTAC took on it, that -- how they looked at it. And they -- their

recommendation back to the State Trauma Advisory Committee was that, although some of the responses back from these hospitals, from these C.E.O.s were surprising, they do not feel that it will impact either adult or pediatric trauma care in the -- in the five boroughs of New York.

So at this point, where we go with it, we are -- that report was given by Dr. Ron Simon out of Bellevue, who chairs the New York City RTAC. He gave that report to the State Trauma Advisory Committee. We are waiting for him to put that in writing for us, the bureau, and then we can act upon that as far as contacting the New York City REMAC and REMSCO, to talk about where ambulances should be directed for what kind of patients in the -- in the city.

So -- so, Ann, if you could relate that back to -- back to your folks, because the -- the first time we put this out I did like, the next day, get a phone call from Chief McFarland saying --.

MS. FITTON: You got that what --?

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MR. TAYLER: What's that?

MS. FITTON: I'm just saying --

MR. TAYLER: And that's okay.

MS. FITTON: -- what its frequency was --.

MR. TAYLER: And that's okay. He was -- but he was -- he was concerned that -- that F.D.N.Y. needed to do something right now. The -- the standstill is that FDNY shouldn't change anything until we, the bureau, talk to New York City REMSCO and REMAC medical directors, and -- and go from there. So, he was rightfully concerned. But -- and he called me right away, and -- but -- and that's okay. But just a piece -- a piece to FDNY leadership if you would, that we're -- they'll be hearing more on this. Don't take --

MS. FITTON: Sure.

MR. TAYLER: -- don't take any immediate action right now to -- to rock the boat.

Okay. Questions?

(No audible response)

DR. COOPER: Martha, did you have anything?

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MS. GOHLKE: I just want to add so, we -- we started this because we had heard rumblings of goings-on in New York City. So we completed, so to speak, as Mike says, we -- we did our investigations, and -- and -- and it -- it occurred to us that, you know, this may not just be a New York City phenomenon, even though that's where we heard the rumors. And so, we're going to do similar with the upstate trauma centers, and send them the letter and verify whether or not they're doing pediatric -- they're admitting pediatric trauma or not. Especially since we're going down the road of the stakeholder's meeting of looking at care of children across the continuum, it would be good, obviously, to make sure that what we think is going on upstate really is, and maybe, in fact, it isn't -- and have it on paper. So that's our next step is to send out the same letter, asking hospitals to verify if they're -- they're admitting pediatric trauma.

DR. COOPER: Thank you, Martha.

Always an interesting subject, particularly as healthcare systems mature,

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downsize, right-size - whatever the word is - consolidate, which leads me to a new bit of information for the group.

There -- as many of you are aware, the governor's budget calls for an additional three-hundred-and-seventy-million-dollar cut from the reimbursements through the Health and Hospitals Corporation, which has already sustained close to a billion dollars worth of cuts over the last couple of years. The Health and Hospitals Corporation is very, very actively considering getting as many as half of -- well, I shouldn't say half, a good number of its facilities out of the trauma business. There is a sense on the part of the H.H.C. leadership, and the executive vice president of Health and Hospitals Corporation is, in fact, a trauma surgeon, that there may be too many trauma centers within the Health and Hospitals system. Well, let me rephrase that. Not that there are too many trauma centers, but that -- but that the system can no longer afford to sustain that many trauma centers. And so, it is certainly possible that at least one, and as many as two of

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the six trauma centers in New York City that are operated by Health and Hospitals may -- may disappear.

They're really looking at having no more than one per borough at this point, and -- as we know, they do not have any acute-care facilities in Staten Island, so they would be looking at cutting back one trauma center in Manhattan possibly, cutting back one in the Bronx possibly. They only have one each in -- in -- in Queens and in -- in Brooklyn. So, we'll be following that -- that story very closely. H.H.C. has retained -- this is not, of course, anything private, they have sustained -- they have -- they have retained Deloitte and Touche, a major national healthcare consulting firm, to help them plan for the future. They're anticipating as much as a one-point-five-billion - that's with a B - -dollar budget shortfall, out of a total budget of about six billion dollars. That's a twenty-five percent cut in their overall operating expenses, which for hospitals that run on -- in New York State, that run on a margin of about a half to one

percent, and -- and H.H.C. is not one of those fortunate hospitals -- hospital systems, you know, that kind of hole in the budget is devastating. So that's where it is.

They have apparently made a decision not to close any facilities, because they've determined that closing facilities will lose patients, and will end up in a revenue-neutral situation, and the job loss in the primarily poor communities that those hospitals serve would -- would so undercut the tax base that it would not be worth, you know, the hit to the system to close the facility. So, what they're looking to doing instead is dramatically cutting back on -- on high -end services, and consolidating wherever they can. And very clearly, trauma services is one of the services that's on the chopping block.

So we may be revisiting this, Mike, in a very short period of time.

Chris.

DR. KUS: Martha and -- and -- and Mike, so -- so you asked the hospitals about are they doing this. Is there a procedure that

say, they change their status that they're supposed to inform somebody? So, the idea is to -- I mean, can you have a real-time view of what it is? Is there -- how does that work?

MR. TAYLER: No --

DR. KUS: Okay.

MR. TAYLER: -- is the long and short of it. The -- the trauma regulations are the original regulations from 1990. They are in the process of being reviewed and -- and updated, but that is a long and arduous process that is taking us several years, and we still are a ways away from getting that done. The -- so, we're still on the 1990 regulations.

The -- the gentleman's agreement is that if you are going to change your status or stop providing a service, that -- that you, you know, let the Department of Health know, but truly there -- there isn't much of a regulatory statute to -- to -- to go on, that they have to notify us. For example, Arnot Ogden was a trauma center in Elmira. They -- they notified everyone that they were no longer going to be a trauma center by

sending a letter to all of the affected stakeholders, E.M.S. agencies, and such in the surrounding area. That same letter was cc'd to Ed Wronsky in my office, as a, you know, F.Y.I. we're -- we're -- we're closing our doors. There was no prenotification to the Department of it. We, in fact, kind of heard through the grapevine that they were closing, and -- and we made a phone call to Arnot and they said yeah, the letter's coming.

So, really, there -- there is no requirement for them to notify us. There will be in the new regulations, once they come out, because this is one of the problems that we've identified. But it -- it -- it -- unfortunately, it's -- for example, if a trauma center has a robust pediatric trauma service run by a group of -- of renowned pediatric surgeons, and the group decides to pullout of the hospital for whatever reason, the hospital could just stop admitting pediatric trauma, and -- and start shipping pediatric trauma, and that's -- that's what the fallback would be. But there -- there would be no notification to us

that that occurred.

DR. KUS: See, that's kind of -- I mean, in the area -- in the era of preparedness and knowing capacity, that's -- that's amazing to me.

MR. TAYLER: Uh-huh.

DR. KUS: I mean, because talk about preparedness capacity --.

MR. TAYLER: It's something that was not -- that was not thought of in 1990. You know, preparedness was just not --.

DR. KUS: But it's here now. I mean, I guess it's -- the -- the question is: Is there a way to do it -- do something in this -- in this area with regard --

MR. TAYLER: That's --

DR. KUS: -- to not going through regs and all that kind of -- I mean, it just seems like it's -- but anyways --

MR. TAYLER: Uh-huh.

DR. KUS: -- I -- I hear what you're saying.

MR. TAYLER: Yeah.

DR. COOPER: Okay. Any other questions for Mike?

(No audible response)

DR. COOPER: I do think that it -- it may be worth, Mike, as we move forward on this, again, as we discussed earlier, for pediatric services or pediatric critical care services, the process of -- of, you know, a special franchise to receive a certain kind of patient, you know, should be following general accreditation guidelines, you know, in that there ought to be a categorization, verification, and designation process in place.

You know, it strikes me that asking the C.E.O.s of the hospitals, you know, what capabilities they have is the categorization component, but before decisions are made consideration should be given to an onsite verification of that. It's not always been the case that what you're told you're going to get is, in fact, what you get. And you know, for that reason - hang on - for that reason, it may be worth considering a verification step in that process, prior to making any decisions. But that's

obviously something that the Department will have to take under advisement.

Okay. I'd like to move on to the pediatric trauma report.

Wendy, are you given that, or is Ed Hannan giving that?

DR. WELLER: I'm giving it, but probably --

DR. COOPER: Oh, I'm sorry. I'm sorry. I skipped over Kathy. I'm so sorry. The -- the ad hoc asthma subcommittee.

Kathy.

DR. LILLIS: Okay. Just very briefly, we -- we had a conference call a week or so ago, and discussed a little bit of where we were with things. The recommendation from that meeting was that we would have a conference call with the bureau's asthma subcommittee. I don't know - Martha, do you know the exact title of what it is -- what it was, but Marilyn Canseca (phonetic spelling) said that there's a very active asthma subcommittee within the Department of Health, and suggested that the asthma subcommittee from this

group have a conference call with -- with that group, so we're in the process of trying to coordinate that at -- at this point.

DR. COOPER: Okay.

DR. LILLIS: I think we can move on to the trauma report now.

DR. WELLER: Yeah.

(Off-the-record discussion)

DR. COOPER: All right. I'd like to thank Kathy for that report.

This is -- once again, I mean, as we discussed last time, this is a really important issue for us as, a -- as a Department, you know, advisory body, and of course, for the Department. The number of kids with asthma is phenomenal, and we need to pull all our resources together. But it starts in the -- in the field and in the emergency department, and you know, so Chris, any help, and Jennifer, any help you can give us in getting this conference call together, and getting the resources of the Department, you know, all together in one place, to -- to deal with the front-end issue here, that we -- that we face, would be greatly

appreciated.

DR. KUS: I -- I wasn't on the call, but Marilyn was on the call, who works in my -- we -- we both work together, and -- and I think the idea is that -- that the asthma program itself, which is -- actually has an advisory group, that we have a whole way of dealing with it, is to try to link this issue within the -- that structure, which think would be the -- the way to do it, because then it becomes part of the -- you know, whether there's amendments to state plans or -- or activities, that would be the way to go. So, yes, we'll get that call set up.

DR. COOPER: Thank you, Chris.

Wendy, are you ready?

DR. WELLER: Yes.

DR. COOPER: Thank you.

DR. WELLER: If I can remember how to work this.

I've been asked to give an update or an overview of the -- the second pediatric trauma report that we're currently finishing up right now. So, I'm just going to give a little bit

of an overview of that. If -- I'm going to start out just with very brief background that most of you are probably familiar with. We're going to talk a little bit about the data sources, because we use New York State Trauma Registry data, but also some date from other sources. And then I'll give you some of the select findings. You have to keep in mind that the report is about two hundred pages, so you don't want to be here all day, you know, looking at slides, so I just picked out a few kind of key findings to -- to show you. And then I'll just back up with some conclusions.

Just a little bit of background, as you -- most of you know, that the initial pediatric trauma report was -- in New York was released in 2002, and that was based on 1994 to 1998 New York State Trauma Registry data. And it basically provided a descriptive overview of pediatric trauma in New York.

Like I said, the second report is -- is currently being finalized. And the second report addresses a few things. It first compares more recent New York City Trauma Registry data,

from 2002-2006, to that first report -- findings from the --the first report. But it also compares pediatric trauma in New York State to national data, using data from the National Trauma Data Bank. And they actually produced a pediatric report that was released in -- in 2007. And so basically we've kind of reproduced that national report, using -- using New York data, and kind of compared the findings.

I just want to spend a few minutes talking about the data sources, and some of the caveats associated with the data sources, because it's important to keep in mind when you're -- you're looking at the -- the findings. In terms of the New York State Trauma Registry, it does include data from all area and regional trauma centers in New York State. In '94 to '98, there were forty-eight trauma centers. In 2002 to 2006 there were forty-four trauma centers.

When the report was first done, and when -- and when the trauma registry was first implemented, information from nontrauma centers was collected. It's no longer collected, so it was in

the first report. It's not in the second report. So, you know, we had to -- we are -- we're in the process actually of doing, you know -- looking at noncenter -- you know, excluding noncenter data, and what it looks like with and without.

It also includes all deaths in the emergency department, admissions with injuries that are considered, you know, severe, as defined by I.C.D.-9 diagnosis codes that were identified by the -- the -- the State Trauma Advisory Committee. And data are collected from the prehospital care report, the emergency department record, and the face sheet from SPARCS. And pediatric patients are defined as those nineteen years of age and under.

And you just have to keep in mind, there are some differences between the '94 and '98 data, and the 2002 and 2006 data. And some of the -- the most important one probably is the inclusion of, or exclusion of, nontrauma centers. So, nontrauma centers were included in the original report, but we don't really collect that information anymore, so we examined the data with and without noncenters in there.

Also, previously, patients who were dead on arrival were included in the registry, but they stopped collecting data when they -- they stopped including them in the registry as of 2006. So, the D.O.A. information for 2002 to 2006 is really incomplete. So, again, we've done some, kind of, looking at the data with and without the D.O.A.s, and -- and I've actually excluded some of those from -- from this presentation.

The National Trauma Data Bank is another data source that we use. It's -- it's national dataset, but it's a little bit different than New York. It's maintained by the American College of Surgeons, and data is voluntarily submitted to this -- to this databank from hospitals and trauma centers across the -- the United States. So, unlike New York that requires trauma centers to submit data, you know, hospitals can decide whether or not they want to submit data to the National Trauma Data Bank. And the inclusion criteria for the National Trauma Data Bank are a little bit different than New York's. So, again, you have to keep that in mind when

you're -- you're making comparisons between New York and the nation.

DR. COOPER: Just one caveat, Wendy. There -- there -- it is mandatory for level-one and level-two American-College-of-Surgeons-verified trauma centers to submit data to the -- to the National Trauma Data Bank.

DR. WELLER: Uh-huh.

DR. COOPER: It's voluntary for everyone else, but it is mandatory for them. There's also some crossover between trauma centers in New York State and the N.T.D.B. --

DR. WELLER: Uh-huh.

DR. COOPER: -- because there are -- there are many centers that submit data to the N.T.D.B. from New York State, although not all.

Ed.

DR. HANNAN: There's also no means of actually verifying the cases --.

DR. COOPER: That's correct. Correct.

DR. WELLER: Right. So they can

sense that it's not all, you know -- so it's -- it's a little bit different than -- than New York.

Also, the -- the inclusion criteria for defining a trauma case is a little bit different for the National Trauma Data Bank than New York. They have a little bit broader definition than New York State. And they do include deaths on arrival. They also include deaths in the emergency rooms. And they also use I.C.D.-9 Codes, the diagnosis codes to, you know, identify trauma patients, but the codes that they use are much broader than New York's. Those are the codes there, excluding a few that are minor things like bug bites and things like that. But generally, it -- it's broader, and includes more things, and maybe sometimes, you know, things of lesser severity than -- than New York does.

And like I said, basically we're using 2002 to 2006 National Trauma Data Bank data to actually, you know, reproduce that report and compare it to New York. And again, they do define, in terms of age, pediatric patients, again, under -- nineteen and under. So, again, there are

some differences, you know, and again, if we look at the issues of doing these comparisons, again, the most -- probably the most important line that we're talking about of the national data is that the New York State Trauma Registry probably, and it does, include trauma patients that are more severely injured than the National Trauma Data Bank, because New York tends to limit it to I.C.D.-9 Codes that are expected to result in higher severity scores. And that's not the case for the National Trauma Data Bank. So, you have to be very careful when you're looking at things like mortality rates, because it -- and if they're not adjusted for severity, because they can, you know, it can be a little bit misleading.

Also, again, we talked about, you know, whether or not they have to submit to it, whether that's mandatory. It may result in some biases, you know, if certain trauma centers don't submit, you know, all their data, or just, you know, partial -- part of their data. Also the national data set includes D.O.A. versus, you know, New York, which stopped requiring those to be

included in the registry.

Also, the National Trauma Data Bank kind of breaks things into more refined categories. It includes some of the mechanisms of injuries that aren't included in the New York dataset -- data registry, including things like burns, suffocations, and -- and poisoning, so you can't really make comparisons across the two and -- for those things.

So let me just report a few -- again, these are just a few key findings from the report that's being finalized. I'll start out with New York State data comparing the two time periods in New York State, because those are a little more straightforward than the national comparison. And here on this table - these slides are kind of hard to see; PowerPoint was giving me a very difficult time when I put this together.

But you see that most general characteristics of pediatric trauma patients in New York were similar between the two time periods. About one in five trauma patients were children in both time periods. The vast majority of pediatric

patients, trauma patients, were male almost, you know, three in four. The largest age group in both time periods was children between the ages of fifteen and nineteen. And of course, New York City accounted for the largest share of -- of trauma -- pediatric trauma patients, and it was -- it was -- it was similar in both periods.

There were some regional differences when you looked at the regions with the highest percentage of pediatric trauma patients outside of New York, between the two time periods. In -- in -- the earlier time period in Central New York, they kind -- were kind of the second largest percentage. In the more recent period, the Finger Lakes Region accounted for the most. And the regions with the lowest percentage of pediatric trauma patients were a little bit different in -- in both years. Nassau in the earlier time period, and northeastern New York in the -- in the second.

When you look at where these children are being treated, the vast majority of pediatric trauma patients are being seen at regional trauma centers. And these figures

exclude -- again these exclude noncenters, you know, so it's just looking at regional versus area centers. And you can see, you know, eighty percent in -- almost ninety percent in the most recent years, but the vast majority is children seen at regional trauma centers.

And in both years, both time periods, falls and motor-vehicle crashes were the leading mechanism of injury. Falls accounted for about twenty-two percent of pediatric trauma injuries in both time periods, motor-vehicle crashes, almost the same, you know, percentage, about twenty-one percent in -- in both time periods.

And if you look at children who died in the emergency room, first of all, there were a very small percentage of pediatric trauma patients who actually died in the emergency room, less than one percent in either, you know, the earlier time period or the later time period. But if you look a that small population, you see that the mechanism of injury, you know, was similar between the two time periods, in terms of

motor-vehicle crashes accounted for twenty-seven percent in the earlier time period, a little bit more in the most recent time period, at about thirty-three percent. And assaults accounted for, again, about twenty percent in the earlier time period, almost -- what is it? I can't see. Twenty-six percent more recently. So, of little bit higher percentage in -- in more recent years, but they were both the same, you know, leading causes of death during the times.

And probably not surprisingly, most pediatric trauma patients were transported to the hospital by ambulance. Again, it's a little bit smaller -- the percentage is a little bit smaller in the more recent time period. But again, you know, they both were -- in both time periods, the -- you know, the majority of children were transported this way.

So, those are just kind of very brief, you know, very few select findings from just the first chapter of the report, which compares, you know, New York data in the two time periods. I'm going to talk a little bit now about New York

State compared to the National Trauma Data Bank. These are a little more difficult, and the slides aren't particularly pretty, they're kind of hard to read.

But this first graph shows the number of pediatric trauma injuries by age and gender, and - I'm going to see if I can work the pointer and then get the slides to work again. This first graph on the left shows the -- it shows New York State basically. And the second graph over here on the right shows national data. And the X axis is age and the Y axis is the number of incidents. And of course, you can't compare New York directly to the nation in terms of number, just because of the sample sizes. It's so different. But this bottom line on each of the -- the bottom lines on each of these -- this dotted line -- it -- it's -- it represents females, and the solid line represents males. And -- although you can't compare the exact, you know, numbers, you can see that the patterns are similar for both New York and the nation, in terms of numbers at each age with, you know, a trauma, you know, incident.

In both cases, boys -- they're -- at each age, you know, boys have more trauma than -- represent more trauma cases than -- than girls. Also, you can kind of see that, you know, there's kind of this peak at the lower ages, and then it's relatively stable for a while, and then it increases again. And you -- it increases kind of a bit later for girls than -- than boys, and this is kind of getting into the teenage years here. And you see that the difference between girls and boys kind of -- it -- it gets larger, you know, as -- as children get older.

Oh, that wasn't supposed to do that. All of a sudden it changed the -- which goes which way. Oh, I know why. See. I knew I shouldn't have turned on the pointer.

Okay. This is showing -- it's similar to the first slide in that it's broken out by age and gender, and it's -- it's showing mortality rates, and each age for girls and boys, although the slides are set up a little bit different in terms of the left is females and the right are males. And again, fairly similar

patterns, you know, the national are -- again, there are these dotted lines. There's sort of like more variation in New York, and it's somewhat due to sample sizes; the sample sizes are much lower, you know. These curves are smoother for the -- the nation. But again, you see that, you know, New York tends to be higher at each age than the national data. Again, you know, these aren't adjusted for anything, and -- but you see that in both cases, kind of younger children, the mortality rates -- and mortality here is just defined as the number of children at a given age who die divided by the total number of children in that age group.

DR. COOPER: Now, Wendy, these are -- you're comparing a straight comparison between our dataset and the N.T.D.B.; correct?

DR. WELLER: Uh-huh.

DR. COOPER: It -- it is possible, I believe, to -- to subselect N.T.D.B. with only, you know, I.S.S.-8 or -9 and above.

DR. WELLER: Right. And I'll show some of those --

DR. COOPER: Little bit later?

DR. WELLER: -- a little bit later.

DR. COOPER: Okay.

DR. WELLER: And we're actually, you know -- I'm -- I'm breaking it out a little bit finer, in finer categories, but --

DR. COOPER: Thank you.

DR. WELLER: -- so you can see that -- you can see that, again, at kind of the lower ages, there's kind of a peak in terms of mortality. It kind of remains somewhat constant, and then there's a big peak again as -- as children get older.

The most common type of injury by far in, you know, both the nation and in New York was blunt trauma. And this is true for -- most of these slides break out children who are, again, you know, fourteen and younger, and fifteen and older, so that's what's on the left and the right. And you see that, you know, for both New York and -- and in the nation, you know, blunt trauma is by far the most common type of injury. And again, you know, it kind of ignore the burn bars, because New

York doesn't collect data on burns, but I couldn't get it off of here, because it's a -- an object -- embedded as an object.

This graph is just children between the ages of zero and fourteen, and it shows trauma cases by the most commonly involved organ systems, I -- is it organ systems? Yeah. And you can see, again, for -- for children who are zero to fourteen, the most commonly involved organ system was the brain and -- and/or skull. And you can see that, you know, for New York, the percentages are much larger. They're the first bars in each category, you know. But again, remember that inclusion criteria is a little bit different for New York trauma patients versus the nation. And also you see that in the nationwide data, there's a huge percentage that's kind of classified as other and unknown, so that doesn't particularly help things either.

For older children -- this is the same chart, but for older children. And you can see, again, you know, brain and/or skull injuries were pretty much the most common type of injuries

in terms of organ systems. But for older children, you know, it wasn't uncommon for other types of organ systems to -- to be involved.

And this -- this -- the rest of the slides actually get into looking at trauma by very -- you know, by injury severity score, which -- injury severity scale score, which is one way of measuring severity. And again, you have to be a little bit careful comparing these, because the categories of severity scores are -- are relatively crudely defined, you know, from one to eight, to nine to fifteen, fifteen to twenty-four, and greater than twenty-four. And remember that New York tries to get patients included in the trauma registry that have severity scores of at least eight or nine.

So, you can see that the majority of children in both New York and nationwide have severity scores less than or equal to -- less than fifteen, but again, you know, you see that -- that New York has a slightly -- has a larger percentage of children in the -- that nine-to-fifteen range compared to the nation. But again, you know, if

you work it out even finer, that one to eight category, you would probably see, you know, differences as well.

And this shows mortality rates by I.S.S. scores. And you can see that by far, you know, mortality rates were highest among children with the highest severity scores. So, it was with severity scores greater than twenty-four, both nationally and in New York.

And there are only two slides left, but both of them discuss length of stay. This is showing mean hospital length of stay. And -- and it shows that length of stay increased as severity scores increased. And this is, again, was true both in New York and nationally. We see that there are -- the length of stay is greater in New York than nationally, but again, these are only kind of crudely adjusted for severity. You know, if you looked at severity as either a kind of continuously or in more refined categories, that might change things a little bit, but you know, in the -- the greatest severity score, you know, category, those greater than twenty-four, the

length of stay are fairly similar between New York and the nation.

And this is a very similar slide except this is getting at intensive-care-unit lengths of stay rather than just hospital stays. And again, you know, a similar finding in that length of stay increases with severity score. And again, you know, this -- the similar caveats hold.

So, again, this is a very brief overview of what's in the report. The report is -- is long. But some of the things that we can conclude based on what we found is that the common measures of pediatric trauma in New York between that '94-98 time period and the 2002-2006 time period, were relatively similar. Things, you know, look about the same in both time periods. There were several similarities in pediatric trauma between New York and the nation, especially when you look at patterns, not so much if you look at actual rates, but again, it's a little bit of a challenge, because it's hard to make direct comparisons for -- for some of those things, especially when they were looking at things like

number of -- of cases and so forth.

And also the actual case fatality rates or mortality rates and lengths of stay tended to be longer in New York than across the nation, but again, you know, if you -- if we do more adjustments for severity, this may kind of even out a little bit, you know, so the take-home message is -- is there are a lot of similarities, but you do need to be a little bit cautious when you're interpreting differences between New York and -- and the nation in general.

Oh, one last thing. Acknowledgments. I just, you know, want to acknowledge the people who are on this slide, you know, including those from the Department of Health and the Bureau of Emergency Medical Services, the committee, and those at the -- the School of Public Health, especially Ian Kramer (phonetic spelling) was a student who worked with me on this, and he did an incredible amount of, you know, data analysis, of -- it was a lot of things.

That's it.

MS. MACINSKI SPERRY: When the

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report is finished, will it be available online or will you send out copies and --?

DR. WELLER: I -- I --

MS. GOHLKE: It will be available online.

DR. WELLER: -- it's going to be available online.

MS. SPERRY: Awesome. If -- got to be available online.

DR. WELLER: Right. You can see the last one is online as well.

DR. COOPER: Thank you, Wendy.

The -- this is really very, very interesting, and from my standpoint, very important and powerful data. We all recognize that, you know, that the law of large numbers, which is not really a law, doesn't necessarily really apply when, you know -- even though we have such a large dataset in the National Trauma Data Bank, it doesn't necessarily mean, you know, because it is voluntary, it is a contribution-based registry, it doesn't -- it is not necessarily truly reflective of the population of seriously injured children

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across the nation.

But it is reassuring to see that -- that the patterns and the case mortality rates at least appear to be in the same ballpark, if not exactly identical. And once again, recognizing that direct comparisons are -- are fraught with -- you know, with difficulty. We do have a population-based registry, at least insofar as the trauma centers are concerned. We don't have noncenters in the data anymore. But -- but it is a population-based, so long as -- or insofar as trauma centers are concerned.

Still and all, you know -- you know, comparison with the N.T.D.B. is the best we've got, in terms of national benchmarking at this particular point. We could compare ourselves with -- you know, directly with other states, such as Pennsylvania, which, you know, is -- is demographically and geographically not dissimilar from our own, and they --they also have a population-based registry insofar as trauma centers are concerned. But that would not give us anywhere near the numbers that the N.T.D.B. does.

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But with all the -- you know, the -- the -- you know, the -- the whereases and so on involved, it does make sense to me that -- that at least for a few defined categories of patients, it might make sense to run some comparisons between our dataset and the N. -- and the component of the N.T.B. that is eight or -- eight -- eight and above or nine and above, whichever we choose, so that we can at least run a more direct comparison in terms of, you know, similar severity of cases. And I -- I think that would be very helpful.

And I -- I think at least to the policymakers in New York State, to realize that trauma care here -- pediatric trauma care here in New York State is as good as, or hopefully perhaps even a little better than, elsewhere, I think would be, you know, tremendously important. So to the extent that that can be done, given the resources that you have available to you, recognizing of course, that they're slim, you know, I think that would be all to the good.

Ed, do you have any comments -- additional comments that you might want to make

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about this report?

DR. HANNAN: Pretty much what you said. I mean, I believe -- I've worked with the National Trauma Data Bank and polled the data before, and -- and let me just comment on that. I mean because there are many hospitals in the database with a considerable number of patients who have recorded zero percent mortality rate in the database, so -- there are two problems. It can be that the deaths are not reported among the patients who are reported, but I think another potential problem is -- is that, you know, there could be patients who died who were not reported at all, the case was not reported. So I suspect that the overall mortality rate, if it was truly representative of all the hospitals in the database, would be higher than it is.

I do agree that the best way of compare it -- comparing it to New York would be to look at the -- the set of N.T.D.B. patients who are -- as -- as equivalent as possible to the ones that are in the New York database, in terms of getting a true view of how they compare.

But I -- I think the -- the normal expectation would be that mortality rate would be higher in New York than in the N.T.D.B., because there is this verification using SPARCS in New York State, which is not done nationally, both with respect to completeness of data, but also with respect to whether or not the patient actually died.

DR. COOPER: A very good point, and I might also add that, as much as we gnash our teeth and tear our hair out at the problems with data collection in our own system, you know, we look like, you know, Mount Olympus compared with the National Trauma Data Bank. There are huge fields of data that are missing entirely, some very critical ones, as you indicate, such as mortality data.

DR. HANNAN: Yeah. Yeah, just one other thing I forgot to mention is that, you know, you can see from what Wendy presented is that there's a very large number of cases for which the mechanism of injury are still unknown.

DR. COOPER: Absolutely.

DR. HANNAN: And so for those cases, you know, who knows what mechanisms they were in, and then if you were trying to compare them -- you know, so I mean there's clearly a -- in -- in addition to miscommunications, and probably inaccurate reporting on death, there's also data in, you know -- with regard to things like mechanism of injury, that are not reported properly.

DR. COOPER: Absolutely. And -- and -- you know, as you know, Ed, because you were an invited guest of the committee on trauma last March, I believe, if not -- or maybe it was October, I don't remember -- the N.T.B. -- N.T.D.B. is spending far, far, far more time than -- than -- than makes me comfortable, as a member of the N.T.D.B. committee, discussing data imputation, whereas we spend our time, you know, corralling the people to actually submit the real data points, rather than trying to impute, you know, values into a -- into a -- you know, a system that looks like Swiss cheese at times, in terms of the -- you know, the -- the number of missing data elements.

And the missing data elements are far from random. It's not as thought it's, you know -- you know, something that imputation, as good as the techniques are becoming, could -- could ever easily fix. So that, you know, I think everyone recognizes the -- the problems with the -- with the voluntary contribution-based registry. We're not there yet nationally as -- you know, as far as we are in New York, and as we all know, even here in New York we took a major, and in my view, pardon me, tragic step back, you know, almost ten years ago, when we stopped collecting data from noncenters. And I do pray that by the time I'm done, you know, with this phase of my life's work, we will see, you know, the opportunity to get -- to get that rectified, either through inclusion of admitting vital signs in SPARCS, which would be a best first approximation, or the actual data itself from the noncenters, which would be ideal.

But you know, for those of you who don't know - I don't know that there is anybody in this room who doesn't know, but it should be said in the public record - that the work that Ed

Hannan and Louise Farrell and Wendy Weller and others in Ed's department have been doing over the years, has really set a national standard in terms of quality reporting. And we are so privileged and honored to have Ed and his -- his -- his unit working with us. It's -- it's -- it's really a Godsend in terms of, you know, the ability to analyze data.

So, Ed, as always, and Wendy, thank you so much for -- for all you do for us and the people of New York State. It's great.

Any other questions for Ed, Wendy.

Martha.

MS. GOHLKE: I just want to echo your -- your thanks to the School of Public Health for all this work, because it is a huge document and it's been a long process meeting our needs. Just so you know, at this point, you know, the -- the publication has to go all the way up the line through the Health Department for approval before it can be published. We just went through it with the trauma report. We'll try to speed the process

as much as we can, but it's going to take some time before it's actually available to the public.

DR. COOPER: Is the trauma report actually approved at this point?

MS. GOHLKE: Mike?

DR. HANNAN: No.

DR. WELLER: Actually though, it's --.

DR. HANNAN: My -- my understanding is that it -- it -- D.O.H. executive has cleared it. It is now with the governor's office, which is a step that we hadn't expected, but --.

DR. WELLER: They did.

DR. HANNAN: They did. It's now with the governor's office, and my understanding is that once the governor's office releases it, then it's off to Commissioner Daines.

DR. COOPER: Oh, it goes to the governor's office before it goes to Commissioner Daines?

DR. HANNAN: Yes.

DR. COOPER: Wow. Now, that's

interesting.

DR. HANNAN: That's --.

MS. GOHLKE: It's good to know that your work is not going unread.

DR. COOPER: That's -- that's a new twist.

DR. HANNAN: That's right. New twist.

DR. COOPER: Well, we'll be looking at the -- at the New York Post and the New York Daily News to see, you know, the latest revelation from the -- you know, from the governor's office regarding pediatric trauma.

So in any event, that's great. So, Ed and -- and Wendy, I hope that, you know, we can collaborate in terms of turning this potentially -- at least a subset of this into a -- in to a publication that will, you know, serve to educate the national trauma community as we, you know, have always educated our own here in New York State. It's -- it's -- it's important data, and nobody does the job that I know that we do with pediatric trauma, in terms of, you know, collecting

and analyzing the data, and that's something that I personally hope we can continue as we move forward. Okay.

Well, we are expecting Marjorie in the not too distant future, but in the meantime we have finished, I believe, the old business on the agenda. So we now are going to move into new business, and Martha is going to share with us some information about the unexplained child death protocol. And then --

MS. GOHLKE: I'm not going to share so much information as I'm going --

DR. COOPER: -- and --

MS. GOHLKE: -- to ask for feedback.

DR. COOPER: -- and then I will ask Sarah Sperry if she would give her report about the -- about the upcoming conference. So Martha and then Sarah.

Martha, go ahead.

MS. GOHLKE: You -- we want you guys to be a focus group so to speak on this document that is getting close to completion. It's

been a work in progress for a while. I don't want to give you too much background at this point, because we want your honest feedback from a provider who is going to be receiving this in the emergency department. This is a document that will be sent to the emergency departments of hospitals on how to handle hospital pediatric fatality protocol.

So, I'm hoping that you looked at this, this was sent out before the meeting, and I told my colleague who is in this group developing this, that I would get your feedback and thoughts on -- on this document. And I -- and I'll fill you in a little bit as I get your feedback, but I don't want to do that -- I don't want to slant your feedback right away. And if we haven't had a chance to look at this, we can always put it to a another meeting, if we need to.

DR. COOPER: Well, Martha, were -- were there specific points on which you wanted feedback?

MS. GOHLKE: No.

DR. COOPER: Just the whole

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document?

MS. GOHLKE: Yeah. It's only --

DR. COOPER: Okay.

MS. GOHLKE: -- it's only -- it's not very long. It's only about four pages --

DR. COOPER: Okay.

MS. GOHLKE: -- plus an algorithm.

DR. COOPER: Well --

MS. FITTON: Martha, I had a suggestion --

DR. COOPER: Oh.

MS. FITTON: -- for you.

MS. GOHLKE: Yeah.

MS. FITTON: They talk about, you know, the protocol guidelines.

MS. GOHLKE: Uh-huh.

MS. FITTON: And you talk about complete a full assessment --

MS. GOHLKE: UH-huh.

MS. FITTON: -- include a history and a physical of the patient, document the findings. I think they should specifically include

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any prehospital care records.

MS. GOHLKE: Okay.

MS. FITTON: And -- and I -- you know, again, just being a prehospital care provider, there is a wealth of information that may be really pertinent to a later investigation of what exactly happened that no one could know except for those people who were objectively involved at the scene. That's my only suggestion for you.

DR. COOPER: And it's actually an incredibly important suggestion, you know, that once the child reaches the hospital, you know, it -- it obviously focuses on treatment, and the -- the focus of child fatality review is on etiology rather than treatment, so that preventive strategies can be put into place that will, you know, reduce that burden to us -- to us all.

DR. KUS: How available is that information to hospital personnel?

MS. FITTON: What happens is the patient isn't actually signed over to the hospital until the receiving nurse, or occasionally the receiving physician -- always, really a nurse,

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signs for the patient. So it should become -- a copy goes to that --

DR. KUS: So they should get that when they --.

MS. FITTON: -- they get a copy of that. You know, sometimes it is discarded, and sometimes it's a valuable piece of information. But I think -- and -- and part of that, really, the value depends on -- the value really depends on how the prehospital-care folks have -- have made their documentation. But it's a link. It's the only link from the hospital back to scene of wherever this -- the call for nine-one-one occurred.

DR. KUS: I -- I -- I mean, I totally agree in -- in -- in the context we're doing, trying to develop a better child death review process across the state, that would -- it's a -- it's a retrospective review with team members, but in looking at deaths, the issue of death-scene investigation is critical, and so one of the questions is how much death-scene investigation is included in that report?

FROM THE FLOOR: Probably not

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very much.

MS. FITTON: Actually there should be no investigation included in that report, but there should be an observation of the findings -- or the -- excuse me. There should be observation of how the child presented, of where that child presented.

DR. KUS: It -- it could be the terms that we're using, because I --

MS. FITTON: Okay.

DR. KUS: -- what I -- what I'm saying is that --

MS. GOHLKE: Assessment.

DR. KUS: -- the assessment of what -- what you found --

MS. GOHLKE: Conditions.

DR. KUS: -- there.

MS. FITTON: Right. And just take the -- just take, for instance, one of -- one of the -- the sore topics in -- in my personal repertoire, co-sleeping.

DR. KUS: Yeah, oh, I'm -- keep going. Yes.

FROM THE FLOOR: What was that?

MS. FITTON: I -- you know, co-sleeping when --

DR. KUS: We'll -- we'll get into --.

MS. FITTON: -- when a big old adult --

FROM THE FLOOR: Oh, yeah.

MS. FITTON: -- is sleeping in the same bed with some little tiny baby, and surprise, surprise the baby ends up dead. Things of that nature are -- are certainly there. So there -- there can be some -- you know, some linkage. And -- and -- and so like, Dr. Cooper and I both -- both have served on a committee in New York City which explores some of these, you know -- some of these factors. Now, it may be that when the people come to the emergency room, the parents, they may have one story --

DR. KUS: Right.

MS. FITTON: -- yet in the excited moments when they first called nine-one-one --

DR. KUS: Right.

MS. FITTON: -- there's a story that's available also, looking at the nine-one-one tapes.

DR. KUS: Right.

MS. FITTON: The second story is what they told the E.M.T.s and the paramedics at the scene. The third story is really going to be what, when they're separated perhaps, the parents.

DR. KUS: Right.

MS. FITTON: What one of them may have told them in the back of the bus -- back of the ambulance, excuse me, on the way to the hospital. So -- so, it -- that's -- that's -- that's my point.

The -- the other thing is I think -- I think Tim wanted to talk about this too, I think he had a point to make.

MR. CZAPRANSKI: Yeah, just the inclusion of the -- all prehospital care documents, which to me includes the nine-one-one piece. I sit on the child fatality review team, and we do the retrospective studies, and sometimes the cops

automatically go to, "Well, the kid wasn't even in bed; it was found on the floor." And I have to tell them, "Well, when they called nine-one-one, the telecommunicator instructed them, 'Is the child breathing?' 'No.' 'Well, let's get it on the floor and start doing these things.'" But they were not realizing that those things happened.

So the location of the child as documented by even E.M.S. may be triggered by nine-one-one telecommunicators doing over-the-phone instructions. So, I think the review of all those documentation proceedings is important to come up with the right summary.

MS. GOHLKE: The other thing --

DR. COOPER: Yeah.

MS. GOHLKE: -- that this process outlined, Dr. Kus, is on the E.M.S. and the prehospital level, once we get down the road of actually implementing this, is on a policy level, that if there is a child that died, who's under the age of eighteen, that the law enforcement has to be called just for that reason, because E.M.S. is not doing that. It's the law enforcement. So, that's

something that we'll have to do policy-wise, to have the law enforcement called for -- for children that die under the age of eighteen.

DR. KUS: So -- so, I -- I -- and again, this doesn't completely, but -- but this is a big interest, because of what you mentioned in terms of co-sleeping, and -- and -- and there's a whole story on that, and even the language I tend to rather call it bed-sharing; some people think co-sleeping is the kid sleeps in the same room with the person, so there's a whole issue with that, and -- and one of the things that happens is -- is you intimate by what's -- by somebody sleeping together, that they may have rolled over. Well, if you don't have a lot of information to say that that's what happened, that the kid was suffocated, it's hard to make that kind of judgment. But that's the point.

So -- so, you're saying the -- the actual description of how the kid was found, it sounds like you -- your folks are getting some of that too; right?

MS. GOHLKE: Well, like

preservation of evidence, and interviewing the family, and all that --

DR. KUS: Right.

MS. GOHLKE: -- investigative, law enforcement needs to be --

DR. KUS: Right.

MS. GOHLKE: -- brought in for that information.

DR. KUS: Right.

MS. GOHLKE: And that needs to be their focus and not prehospital's, so the gap that we identified through doing this, was that law enforcement's not always there --

DR. KUS: Right.

MS. GOHLKE: -- for whatever reason --

DR. KUS: Right.

MS. GOHLKE: -- in each county.

DR. KUS: Right.

MS. GOHLKE: So, we just need to make sure the prehospital provider gets law enforcement there, if they've come upon a scene like that.

DR. KUS: Right. But I think the point of -- of making sure that whoever is doing this at the hospital has the information that's in the -- from the transport part, is critical. And your point about how -- did the child die in bed, did the child -- not having that information is -- if you don't have it, you're -- you're making a wrong judgment. Yeah. Thank you.

MS. FITTON: And -- and Dr. Kus, just another thing, not all of these deaths are going to happen from the home. You know, another thing which is right up there with co-sleeping is kids not belted into a safety seat --

DR. KUS: Right.

MS. FITTON: -- in the car.

DR. KUS: Right.

MS. FITTON: Unfortunately, you know, at the -- at the scene, it's pretty apparent when a -- when a child is ejected from a car that they were not --

DR. KUS: Right.

MS. FITTON: -- strapped into the car, so those -- those sorts of things may also

become -- but the -- the difference is here that as a -- as a prehospital care provider, we may -- we are supposed to be mandated reporters of child abuse.

DR. KUS: Right. Right.

MS. FITTON: I don't know that universally the first thing anyone would be thinking of, after -- after caring for this child with this extensive trauma, would be doing that suspected child abuse report. Although, again, that -- that may be something that we need to be more aggressive about in our policies.

DR. COOPER: You know, the -- the issue of child fatality review panels is -- is a huge one in the child-abuse world, as all of you know, you know, the -- for obvious reasons. There are many, many, many children who die, and whom the -- the information that is gleaned from the various health professionals that have cared for that child, up to and including the medical examiner, is never collated in one place, and never reviewed by a policy-making body that is in a position to say hey, we're seeing these particular

trends; we need to make these public health interventions to decrease this -- you know, the burden of -- of unnecessary child death.

But I -- I think, Chris, you heard a couple of really important points here today. I mean, the hospital-fatality protocol is wonderful, you know, as far as it goes. But the problem is that, as you heard from both Ann and Tim, you know, the dispatch tapes are not part of the E.M.S. record. And that's going to be the first glimpse, you know, at what's -- what's going on. And as Tim pointed out, things may have changed drastically by the time the E.M.S. crew gets there, and it may have changed, you know, epically by the time the child reaches the hospital.

So if, you know, in its discussions with the -- sorry -- in the Department's discussions with the legislature, honestly, this law really needs to be amended and expanded, to ensure that the child fatality review panels have access to the nine-one-one tapes to the extent that they can, and the other piece that's

vitally important is -- is the inclusion of the prehospital care report in the patient -- in -- in the patient record.

Now, we were doing better and better and better, not great. You know, when -- when I started in the system, lo these many moons ago, you know, we were lucky to get, you know, thirty to forty percent of the -- of the P.C.R.s included in the hospital record.

FROM THE FLOOR: Uh-huh.

DR. COOPER: We were up around sixty to seventy percent across the board, which still isn't great, but a -- but a vast improvement, you know, when we started making the shift over to electronic medical records. And now it has -- it has slid back considerably, because, you know, people don't know how -- don't know how to get the electronic medical record -- you -- you know, get that information included in the E.M.R.

FROM THE FLOOR: Uh-huh.

DR. COOPER: So, two stipulations that would be vitally important would be getting access to the nine-one-one tapes, and getting

included in this policy, you know, a mandate that the hospital scan the P.C.R. and include it as part of the hospital record. You know?

MS. GOHLKE: I just want to clarify what Dr. Kus is asking is different than what we have in front of us.

DR. KUS: Right.

MS. GOHLKE: Okay. They're not -- they're two separate issues, so --

DR. KUS: Well -- well, they're somewhat related.

MS. GOHLKE: Oh, I mean -- yeah.

DR. COOPER: Well, but -- but they are --

MS. GOHLKE: I mean, I --

DR. COOPER: -- they are --

DR. KUS: They're somewhat related.

DR. COOPER: -- they're --.

MS. GOHLKE: -- I got the feedback --

DR. KUS: Yeah.

DR. COOPER: Yeah.

MS. GOHLKE: -- that nine-one-one, you know, transcript --

DR. KUS: Right. Right.

MS. GOHLKE: -- and what goes on the P.C.R needs to be --

DR. KUS: Yes.

MS. GOHLKE: -- included.

DR. KUS: Yeah.

DR. COOPER: Right. But I -- I understand that, but Dr. Kus also does have some influence over the process, which is, obviously --

DR. KUS: Right.

DR. COOPER: -- why he's bringing it to us for our discussion --

DR. KUS: Right.

DR. COOPER: -- you know, and those two pieces of -- of information, I think, would be very useful.

The last piece that I want to mention is that child fatality review, even though it's mandated, okay, now in New York State, is not universally done the way it should be done. You know. It's done well -- very well in Rochester,

for example. It's done very well in Syracuse, because of the nature of those particular communities.

But in New York -- in New York City, for example, the child fatality review panel is -- is solely a public-health panel that exists under the New York City Department of Health. The medical examiner of New York City has steadfastly refused to participate, you know, in any and all such efforts. And the accountability review panel for the Administration for Children Services, you know, sees only the -- the -- the -- about half the cases, because only about half the cases are known to A.C.S., you know, prior to the child's death.

And somehow -- somehow in our collective lifetimes, we need to solve that problem, because without getting an opportunity to look at all the child deaths, you know, in one place at one time, we're in real trouble. All right.

DR. KUS: Martha, I'm going to say one more thing on this part --

MS. GOHLKE: Sure.

DR. KUS: -- because it specifically speaks to that. The -- the good news, and I'm hoping it will happen in our lifetime is, we've been, at the State Department -- I'm real interested in child death review, and part of it is because you -- when you review it, you realize what little information we have about how kids die. There is a -- now a national dataset to -- that you can report to, so that it's a form that the review panel should fill out, then it would be uploaded to the state, and it's uploaded to national, which includes a lot of these reviews. That's the first time I've seen standardized data. So we've wanted to do that.

The -- you mentioned about the idea about child fatality review, the way we -- we've been partnering with the Office of Children and Family Services, because they have been reviewing deaths that are submitted to their hotline, or are in their facilities. And the public health message is unless you're reviewing all of the deaths, you're missing some.

So, we've now got the agreement

to work together, and we actually have a grant to try to do this, to try to improve the amount of deaths that have a child death review, which is, again, it's a retrospective review involving all of the players that should be involved, so you look at systems. It's then going to be -- we -- we actually got -- and this is a plus, we got the Office of Children and Family Services, because they've got the money. We don't have the money to do some of these reviews, but they have the money to -- to do these teams, to adopt this national data form for their teams to follow up, so we will have -- maybe in my lifetime, the first time we actually get more data on this. So -- and -- and -- and we have a group working together to say that our -- that our goal is to review all children's deaths, and do it in this fashion, so that we're able to collect the data, and not -- and not miss something. And then hopefully, gradually regularly improve it by improving -- because -- because I think the message is that a child's death is really a local community response. And you've got to get that community to look at that death,

and then we need to aggregate those into the state level, then aggregate to the federal level, so that you can actually find some of those trends.

So we have a program working pretty well with the Office of Children and Family Services, which is amazing, in terms of cross-agency because their line is child abuse and neglect --

MS. GOHLKE: Right.

DR. KUS: -- and our line is saying you've got to review all deaths, otherwise you're going to miss some. So, that's -- that's --.

MS. GOHLKE: I -- and I just want to -- I need a clarification as well, that the child death review teams, and correct me if I'm wrong, are triggered by a report to the -- the S.C.R.; correct?

DR. KUS: The -- the --

DR. COOPER: Not always.

DR. KUS: -- there's two different -- it's a -- it's complicated, and that's why we're trying to simplify it. But they're --

they talk about two different types of reviews that -- there's the multi-disciplinary team --

DR. COOPER: Right.

DR. KUS: -- ones, which is where they're reviewed real-time, hopefully.

MS. GOHLKE: Right.

DR. KUS: Then there's the retrospective review.

MS. GOHLKE: Right.

DR. KUS: And the way the law is written now, is the teams that can do the retrospective review can review all deaths.

MS. GOHLKE: Okay. But normally speaking, one of the triggers to the system is child abuse, neglect report to the -- the report registry; correct? I mean, I know you say that they could broaden if they wanted to --.

DR. KUS: Well, it -- it depends on the -- and -- and as I think, Dr. Cooper -- Cooper mentioned, it depends on the child fatality team, what the --

MS. GOHLKE: Okay.

DR. KUS: -- goal is actually for

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that team to be knowledgeable about any deaths --

MS. GOHLKE: Right.

DR. KUS: -- and start the review process that way.

MS. GOHLKE: Okay.

DR. KUS: But you're right in the --

MS. GOHLKE: Okay.

DR. KUS: -- sense the way the system had been working is --

MS. GOHLKE: Okay.

DR. KUS: -- on the -- on the silo that it relates specifically to child abuse and neglect.

MS. GOHLKE: And I -- I didn't want to go talk about this until I got more of your feedback, but I think we need to go here, is the focus of this is for children that died that don't get called in, they aren't -- that aren't --

DR. KUS: Right.

MS. GOHLKE: -- looked at as a child abuse or neglect case, and that so to speak, slipped through the cracks.

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DR. KUS: Right.

DR. COOPER: That's right.

MS. GOHLKE: So --

DR. KUS: That's exactly right. Yeah.

MS. GOHLKE: -- that's -- that's the perspective of -- of this document -- one of the perspectives of this document, is the child that dies for no apparent reason, or so the provider thinks.

DR. KUS: Yeah.

DR. COOPER: Yeah.

DR. KUS: The unexpected, you know --

MS. GOHLKE: Right.

DR. KUS: -- unexpected death, yeah.

DR. COOPER: The only problem is that this only fills one of the cracks.

DR. KUS: Right.

DR. COOPER: And we're -- and what we've been speaking about, of course, is trying to fill a few more of them, and to make sure

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that the information, once it's all collected, all gets to one central place where we can review it and think about it.

DR. KUS: And -- and the group that's doing this is working with the Office of Children and Family Services, and we've been involved in it, so we're trying to make sure that this is integrated in a whole child-death-review system for the state.

MS. GOHLKE: Right.

DR. KUS: So we've got to put that together.

MS. GOHLKE: And -- and the other thing is that you the providers in the hospital, you've got policymakers about ready to send out this document to the hospital. We want to make sure that it's functional --

DR. KUS: Sure.

MS. GOHLKE: -- for use when it gets to the hospital --

DR. KUS: Right. Right.

MS. GOHLKE: -- and that's the purpose of having this committee --

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DR. KUS: Right.

MS. GOHLKE: -- look at it at this point.

DR. COOPER: Right. And when -- again, so I think that's why my personal specific suggestion is to make sure that some direction is included in the document to scan the P.C.R. into the hospital record, so that -- you know, so that it actually makes it there.

DR. HANNAN: Art?

DR. COOPER: Yes, Ed?

DR. HANNAN: When I first read this, I -- I was -- being more familiar with -- with adult trauma and adult hospitalizations, I was more expecting to see something along the lines of -- so when unexpected deaths are explored in the adult setting, what is being looked at is whether or not there was a problem that occurred in the hospital, that was the fault of the hospital. And so, I guess the question here is does that situation fall under this also --

DR. COOPER: Yes.

DR. HANNAN: -- or is this

limited to child abuse, to that part -- so, okay. Because when you read this -- in the beginning, when I was reading this I was thinking that -- that's all I'm going to see, and then all it did see, seemingly, was looking at situations of -- of child abuse and -- and --

MS. GOHLKE: You're saying --

DR. HANNAN: -- neglect or whatever.

MS. GOHLKE: -- you saw child abuse when you looked at this, or you didn't see it?

DR. HANNAN: I'm saying I was not expecting to see that, because I was naively looking at it from the standpoint --

MS. GOHLKE: Right.

DR. HANNAN: -- of adult -- adult explorations of unexpected deaths. But then when I started reading it --

MS. GOHLKE: Yeah.

DR. HANNAN: -- all I saw was child abuse. I didn't see anything about whether there should be an exploration of whether or not

there was a -- there was a problem, you know, of treatment in the hospital setting. And I'm just questioning whether it --

DR. COOPER: Yeah.

DR. HANNAN: -- that was meant to be in here or not. Because typically in the adult setting, that's what it would all be about.

DR. COOPER: Right.

DR. HANNAN: It would be oh, somebody died, it was an unexpected death. The person came in with a D.R.G. or a condition that -- that has a point one percent mortality, and they died. What happened --

MS. GOHLKE: Oh, you mean --

DR. HANNAN: -- during the time that -- that --

MS. GOHLKE: -- so you -- you see it from the perspective of the possible neglect of the hospital and treatment --.

DR. HANNAN: Well, I'm wondering if that -- if that is -- if --

MS. GOHLKE: Okay. That's --

DR. HANNAN: -- the intent is

to --

MS. GOHLKE: -- that's good feedback.

DR. HANNAN: -- add that as well or not.

MS. GOHLKE: That's good feedback.

DR. HANNAN: And -- and -- and maybe the answer is no, that's not what we're looking for.

DR. COOPER: No, the answer is --

DR. HANNAN: But --.

DR. COOPER: -- very clearly yes. I -- I -- I actually read it both ways.

DR. HANNAN: But I don't see -- when I started reading it --

DR. KUS: Correct. You're right.

DR. HANNAN: -- I see it all tilting toward the --

DR. KUS: Correct.

DR. HANNAN: -- the -- the -- the patient -- or child abuse, you know, that kind of thing. I don't see anything about what were --

what were the -- what was the nature of the treatment --

DR. KUS: You're right.

DR. HANNAN: -- was there anything that went wrong during the treatment process, that kind of thing.

DR. COOPER: You're absolutely right. And -- you know, and from my standpoint, reading the purpose, you know, it was all inclusive. My own thinking along the lines is that -- is that most of that stuff would be -- most of the in-hospital stuff would be picked up, you know, through NYPORTS, and so you'd have access to that database as well.

But your point, Ed, as always, is very well taken. The -- the -- this document should reflect, you know, also that any -- any appropriate, you know, documentation regarding NYPORTS type events that occur, you know, in the hospital, or potentially even in -- in E.M.S., ought to be, you know, included, you know, in -- in the -- in the overall look-see.

DR. KUS: This is a -- I mean,

Martha, note this one, because this is an important point to clarify, because as I understood, the intent was more the issue of transport and emergency room death, and -- and not in the hospital, and that's why it's written this way, but we need to clarify --

MS. GOHLKE: I have it so noted. I have it so noted.

DR. HANNAN: It says here up in the top in the --.

DR. COOPER: Yeah.

DR. KUS: I -- I -- I know that. I know that. But I'm -- I'm saying from -- had the -- the intent people had put for it.

MS. GOHLKE: Uh-huh. Uh-huh.

DR. KUS: So this is a critical point --

MS. GOHLKE: Yeah.

DR. KUS: -- to clarify.

MS. GOHLKE: Yeah.

DR. KUS: Absolutely.

MS. GOHLKE: Absolutely.

DR. COOPER: But it's also --

from the standpoint of the public-health-policy question, which is how are children dying, where, why, under what circumstances --

DR. KUS: Right.

DR. COOPER: -- you know, and what can we do to stop it, it's all important. Child abuse component is important; the E.M.S. part is important; the in-hospital part is important. You know, it's all important, and -- and it's important that they all be looked at, you know, by -- through the --

FROM THE FLOOR: Uh-huh.

DR. COOPER: -- same child fatality review process.

DR. KUS: Right. Correct. Correct. Absolutely.

MR. CZAPRANSKI: It's funny, the way --

DR. KUS: Absolutely.

MR. CZAPRANSKI: -- I looked at it was this fills a gap, because we're good at catching when they call nine-one-one and there's a child fatality. We're not good at catching when

the patients go to the hospital by their parents directly, and overt (sic) the nine-one-one system.

MS. GOHLKE: Uh-huh.

MR. CZAPRANSKI: And this sort of brings that piece back, because only sixty-eight percent of the patients that get to --

DR. COOPER: Correct.

MR. CZAPRANSKI: -- the hospitals come via E.M.S.

DR. COOPER: That's right.

MR. CZAPRANSKI: So --.

MS. FITTON: It also brings to mind the fact that the -- you know, just look at what happened with H1N1, where suddenly a large number of our children, who should not die from flu-like illnesses, were dying. So, it might actually have a -- the ability to see what our preventive measures are, you know -- you know, what additional --

DR. COOPER: Absolutely. Sure.

MS. FITTON: -- are there any early signs and symptoms that the parents or -- or whoever simply treated with Tylenol or Advil or

whatever, thinking that that was the right thing to do, only to have a disaster on their hands. Those sorts of things that -- that -- that actually --

DR. COOPER: That's the whole point. Absolutely.

MS. FITTON: -- if somebody looked a little --.

DR. KUS: See -- see, that's -- I mean, it -- it's an interesting thing, because, you know, the -- how does this -- and I think we have to clarify. I mean, way back when, when I -- when we trained, you go to morbidity/mortality conferences in the -- in the hospital where people look at that.

DR. COOPER: Uh-huh.

DR. KUS: This -- as I had seen it had not been that kind of intent, but we've got to clarify that, absolutely.

MS. GOHLKE: Sure.

DR. COOPER: Well, you know --

DR. HANNAN: You know, and -- and just as another example, I mean, so for instance with the -- you know, the problem in NYPORTS, the

problem in trying to find this in the adult setting, is -- you know, what it says is: Is this an unexpected or unexplained death? Well, you know, here I am, and I'm supposed to report, you know, an unexpected or an unexplained death on my watch, and unexpected and unexplained is very hard to define.

DR. COOPER: Yeah.

DR. HANNAN: And -- and so, you know, the temptation for us is that, you know, well, it -- it's probably not going to be -- it -- it's much more often not going to be reported than -- when it -- when it did occur, than reported when it did not occur. And so --

DR. COOPER: Right. Right.

DR. HANNAN: -- and so, I mean -- so, then the question is what is unexpected or unexplained? Can you give somebody any guidance as to what that means?

DR. COOPER: Another great point.

DR. HANNAN: And -- and people need more guidance when suddenly they're not talking about something that happened to the

patient in the home setting, but something that happened in the hospital setting, and the person who's reporting it is in the hospital setting. That's much more challenging, and much more a potential conflict of interest.

So, I mean, one of the ways that it would be done in -- in the adult setting, for -- to -- to make things less arbitrary, would be to -- to take a look at the -- at the D.R.G., the patient diagnosis, I.C.D.-9 Code, whatever, and define an unexpected or unexplained death as a set of patients with diagnosis codes that has -- has an extremely low mortality. And so, it's -- it's unexpected, if the patient dies and the mortality rate for patients who are supposedly look like that is less than whatever -- point one percent, point o five percent or something like that, and those cases are immediately -- are automatically reviewed, because, you know, there just was not the expectation.

DR. COOPER: Ed, another -- another very insightful comment. And this just points out why we have to have you at these

meetings every time.

DR. KUS: See -- see, this is a -- I mean, it really is very interesting, because I think, again, in -- in -- in a child death review situation, a lot of times when you get the death to review, people will look at it and say "It's a kid with leukemia who died from leukemia, so that's one where we've got a cause here, and it's -- and it's a death that seems to be explained." So on -- on -- at the outside point of view, the unexpected is, you know, somebody, you know, is with -- we -- we talked about kids -- specifically relates to kids under one. There's a lot of kids under one that die and we don't know exactly why -- that's where SIDS and -- and that part of it is.

But if you're talking in the hospital, you know, you can do via codes there, does -- or it could be a judgment to say jeez, this kid should -- shouldn't have died. And so, that -- and then it gets -- it's -- it's complicated.

DR. HANNAN: Yeah. I mean, I guess on the other side of the coin, and if you'd -- if -- again, if you're talking about an

unexpected or an unexplained death, I mean, typically it would be -- you know, given what I saw --

DR. COOPER: Right.

DR. HANNAN: -- when I looked at this patient, I didn't think that this patient should have died. But suppose the patient comes in with -- with a severe head injury, and so the death is expected, but the circumstances that caused it in the home --

DR. COOPER: Right.

DR. HANNAN: -- may have been an --

MS. GOHLKE: Right.

DR. HANNAN: -- abuse case. So, it's not flagged --

MS. GOHLKE: Yeah.

DR. HANNAN: -- you know, by those standards. It's not flagged as an unexpected death --

MS. GOHLKE: Right.

DR. HANNAN: -- but it is -- it is a child-abuse case --

MS. GOHLKE: Uh-huh.

DR. HANNAN: -- that's fallen through the cracks, if that's --

MS. GOHLKE: Right.

DR. HANNAN: -- how you're --.

MR. GOHLKE: Well, let me just also talk about the -- the how we got to this point and maybe just -- it may bring some more questions to the table. So, a child died in New York State, and it was unexplained, unexpected and -- but there was no evidence of neglect or abuse, so it didn't go through the child, you know, hotline reporting because of that.

And then afterwards, the sibling ended up dying, and then they realized that there was abuse and neglect in the home, which probably should have been picked up with the first child dying, but wasn't, and therefore, you get the right lawmakers involved, a law came about to New York States saying now you've got to develop a policy to deal with how you -- you know, picking up cases of neglect and child abuse in cases that you wouldn't think necessarily is there, for the prevention and

death of other children. So, that was the -- that was the narrow focus kind of what we were given with.

And you know, hospitals already have a policy in place for infant mortality and for, you know, suspected child abuse. But we didn't have something in place for the unexplained, unexpected, and the challenge I think with this document was not to have people see this and say, oh, this is a -- this is a child-abuse thing. We already know what we're doing on this. Why are we getting this document? We've -- we've already got these policies in place, because we have to draw it that this is something new that they don't have, and what they need to do. Basically, any -- any child that dies under -- under the age of eighteen, has to undergo an autopsy, is -- is basically what this says. And then you've got to rule out child abuse, basically for a situation that wasn't naturally triggered.

DR. KUS: Well, I -- well, I think, again, the idea that there's a well-defined group of about child -- about child death review

process, and the whole idea is to look at all the systems and realize that a kid that came into a hospital with head trauma, the hospital could have done their job and the kid died, but this kid shouldn't -- shouldn't -- why did this kid have head trauma, and that's where the other systems need to be involved.

DR. COOPER: Right.

DR. KUS: So I think that's -- that is -- that is the -- a critical part. But all this kind of discussion brings us back to try to make clear about how we're -- how we're going to use this -- how it integrates into the -- into the whole system.

DR. COOPER: So, to summarize --.

DR. KUS: And -- and -- and just to make a point, it might be useful -- there is a specific defined sudden unexpected infant death for kids under -- SUID for kids under one year of age. There is a definition of which kids those are; there's a criteria; there's a whole protocol about reviewing those things. And what we're trying to do is start using that in New York State in those

investigations. And it gets into the issue of did they die because there was overlaying and suffocation, or was it SIDS? I mean, there's -- that's the big -- one of the biggest ones.

DR. COOPER: So, to summarize, our task was to really focus on this document, which is an attempt on the part of the legislature and the executive, in follow up to the legislature's directive, to fill a crack in the reporting system, specifically with respect to hospitals.

I think we've reached consensus that we need to scan the P.C.R. into the hospital documents, that we need to define what we mean by unexpected, and some quantitative measurement of that, with respect to what Dr. Hannan had suggested, specific diagnostic codes, specific, you know, case-fatality rates associated therewith, and inclusion of appropriate, you know, NYPORTS data, you know, or -- or NYPORTS type reports into this -- into this database or into this report needs to be -- be -- needs to be made.

I think the goal here, as we've

all come to -- to think of it, to analogize to the trauma system, is that we're really looking at population-based child-fatality review. We're not really looking at hospital-specific child-fatality review, you know, child-protective-services-specific fatality review, we're looking at all childhood deaths. And they all have to come to the same place so that the -- so that all the outliers can be identified, and all the problems can be picked up at the get-go.

And then separately from that we need to ask the powers that be to be certain that they have access in the cases, were E.M.S. is involved, to the dispatch tapes so that they can, you know, get as much as possible about the circumstance at home as -- as -- as they can.

Does -- does that summarize pretty much where we came to in our discussion, as far as everyone's concerned?

(No audible response)

DR. COOPER: Great. Okay. Bob has rejoined us.

Welcome, Bob.

DR. KANTER: Thanks.

DR. COOPER: And I know Susan has been on the whole time. Thank you, Susan.

MR. BRILLHART: Yeah, thanks.

DR. COOPER: And Sarah, I know you wanted a word, and then we're going to ask an old friend of ours to give us a little presentation on what she's doing now.

MS. GEIGER: Since when do you call me old?

MS. MACINSKI SPERRY: Okay. Thanks.

DR. COOPER: Well, old friend. Not a friend who is old.

MS. MACINSKI SPERRY: I just wanted to throw out a quick reminder promotion. When I was at the last meeting, I presented our -- some of our injury data, and I had talked about how we were -- had a childhood unintentional-injury project, and part of that was an upcoming symposium on childhood -- unintentional childhood injuries.

I did give everyone's contact information to Stephanie, who's running the --

basically she's running our unintentional childhood injury program, and everyone should have received an invitation via e-mail. The -- there will -- it just is a quick -- whatever. It's going to be Injury -- it's called Injury-free Kids. It's a one-day symposium. It will be on March 31st at Glen Sanders, which is in Scotia, outside of Schenectady, and it's free. We don't -- we can't pay for your travel, but it is free. You are -- you're all welcome to come. I have -- I brought some information on it. If there's anybody who didn't get it, has misplaced it, is interested, I can share that.

And also, if you'd like to mark on calendars, on June 30th, there's going to be another symposium, which will be on childhood injury policy. So that's June 30th. And March 31st, is this one coming up.

If you are interested but can't make it to the March 31st symposium, I can give you Stephanie's e-mail address and she would be happy to e-mail you materials from the symposium. They will be handing out fancy toolkits for starting

injury-prevention programs in your community. She won't -- there may be some paper copies, but you won't get the fancy toolkit that apparently is amazing, but I haven't seen it yet. So, you may be able to get paper copies. Definitely you can get materials e-mailed to you if you're interested.

MS. BURNS: Who's the target audience?

MS. MACINSKI SPERRY: Target audience. That's local public health partners.

MS. GOHLKE: Okay.

MS. MACINSKI SPERRY: It's -- it's really, I think, reaching out as -- as broadly as possible, because it's -- it's such a broad topic and has so many different players.

MS. GOHLKE: Got you.

MS. MACINSKI SPERRY: But -- yeah. I'm -- again, not my baby, so I'm not totally full of details, but it -- it should be good, and we're very excited about it. There's a whole lot of fact sheets and materials and information that are -- are involved, and I -- I talked to Martha at lunchtime about having --

during the next E.M.S.C. meeting, the Webinar, having Stephanie come on and talk about the project. And hopefully by then our new Web site will be up and running with all of this material, and we're hoping to have -- and this is probably a better answer to your question.

We've been in this very long process working on what we want in our Web site and -- and on this project. And we're looking at having it really a very broad topic, given that it will have information for parents and for -- parents and caregivers, so not just like, parents, but you know, grandparents and daycares and what-have-you. And for professionals and -- oh, and there was a third one. But there -- there were -- I think -- I think they were working on -- at least at one point in the idea phase we wanted to have some information targeted straight to kids. I don't know if we'll be able to do that with D.O.H. Web site limitations, but it's -- there's -- well, it -- there will be information on -- on everything like, the developmental stages of children, and how that relates to the injuries that

are pertinent to them, what parents can do, and data that backs it up, and a much evidence-based practices as possible for prevention.

DR. COOPER: Thank you, Sarah, so much. It sounds like a really exciting conference, and as soon as you get the information about that childhood injury policy conference, that would be very, very useful for us as well. I --

MS. MACINSKI SPERRY:

DR. COOPER: -- I will mark on my calendar to try to make both conferences on behalf of the committee, but I think everybody, you know, who can come from the committee, you know, should -- should try -- should try to come. I know my injury prevention coordinator at my place will be coming to the -- to the March 31st conference, but this is --

MS. MACINSKI SPERRY: Wonderful.

DR. COOPER: -- the first I've heard about the -- the June 30th conference, so that's great.

MS. MACINSKI SPERRY: Yeah. It's -- it's still in the works. I had asked

before I left. I was like, "Well, what do I tell them it's called." And Stephanie is like, "We're having a meeting this afternoon to talk about names."

DR. COOPER: Okay.

MS. MACINSKI SPERRY: So, it -- it doesn't -- doesn't even have a name yet, but it's -- it's hopefully going to be at the same place, and --.

DR. COOPER: Okay. Great. All right. Thank you so much.

MS. MACINSKI SPERRY: Thank you.

DR. COOPER: Okay. Well, it's my distinct pleasure and honor to welcome back a dear friend. As all of you know, Marjorie Geiger was assistant director of the Bureau of E.M.S. for many, many years, did an outstanding job in that capacity, and was stolen away from us by the Department for other purposes -- I'm not going to say grander, but certainly more overarching purposes, namely creation of a patient safety center for the Department and the -- the citizens that we serve.

And I asked Marjorie if she might not come today to tell us a little bit about the work that the patient safety center is doing, to see if there might not be, you know -- first to educate us, and second to see if there might not be areas in which, you know, the work of her center and our committee might overlap, and to see how we could support the patient safety efforts of the Department. And so, without further adieu, we want to welcome Marjorie back among us, and really looking forward to your presentation.

MS. GEIGER: Thank you, Dr. Cooper. The patient safety center wants to thank Dr. Cooper and Martha for extending this opportunity to come and have conversation.

Forward. Oh, Michael taught me, but -- there we go.

We are governed by the Health Information and Quality Improvement Act of 2000, which is contained in the New York State Public Health Law. It gives us an ambitious charge. First of all, it established the patient safety center, reporting right now through, as Jennifer

would tell you, the Division of Healthcare, Quality and Patient Safety. We also serve at the pleasure of Dr. Morley, who's the medical director of the Office of Health Systems Management. So he partners with us quite a bit, helps us with our case reviews that I'll go into in a little while.

We have a very ambitious charge which is to maximize patient safety, reduce medical errors, and improve the quality of healthcare by improving the systems of data-collection, analysis, and dissemination to providers and the public. And I'll talk a little bit about the information systems that we currently have in place. One of the oldest is the physician profile, and that actually is a mandate in our governing statute. And I'll -- I'll go into a little more in depth on that. We also manage the hospital and other provider profiles. Consumers may go to the Department of Health Web site and look up extensive information on quality indicators, but as well as demographic information on all hospitals in New York State. So a simple click on the Department of Health's Web page hospital profile will get you

there, as well as nursing home, home healthcare agencies, and other long-term-care providers. Hospitals have access through the Health Provider Network to their own quality measures and benchmarking systems on potentially preventable complications, known fondly in the business as P.P.C.s, and I'll talk about that in a little while. And we are also charged specifically in Public Health Law for overseeing the office-based-surgery program.

Physician profile provides information to consumers, providers, and other interested parties on approximately eighty-two thousand licensed physicians. As I mentioned, it's accessible by the public on the Department of Health's Web page, provides extensive mandatory information on clinical training, expertise, hospital privileges, any actions taken by the Department of Health or the State Education Department against that licensee's medical record, and whether a hospital has eliminated or sanctioned privileges. We are also required to display for the public certain medical malpractice information

for as long as ten years.

Now, for you physicians in the room, Drs. Cooper and Kus, you may not know this, but every time you reregister with the State Education Department on your license, you are required to update your profile. So, Dr. Daines, Dr. Kus, has a list of those Department of Health physicians who have not done that yet, so --

DR. KUS: Just -- just as you know, we -- we have a regular meeting, and it came up at one of our --

MS. GEIGER: Right.

DR. KUS: -- full meetings.

MS. GEIGER: So --

DR. KUS: I didn't know about it before.

DR. COOPER: I -- I can tell you, having recently gone through the relicensure process, that -- that there is no mention of doing so in the S.E.D. --

DR. KUS: No.

DR. COOPER: -- materials.

MS. GEIGER: Yes, there is, Dr.

Cooper.

DR. COOPER: There is?

MS. GEIGER: It's not in large font, but certainly it's for the new physicians --.

MS. BURNS: You stabbed him in the aorta.

DR. KUS: I -- I agree that it -- it is not --.

MS. GEIGER: It -- that is an S.E.D. form. We are partnering with them to resolve that, but it is there.

DR. COOPER: I will go back -- I will go back -- I will go back and look. I --.

MS. GEIGER: And I'll show it to you.

DR. COOPER: That would be good. That would be good.

MS. GEIGER: Okay. But it is on the Department of Health's Web page. Ding, ding, ding. But any event, I just point it out, that -- that it's there.

DR. COOPER: Thank you for coming.

MS. GEIGER: Sorry, Dr. Cooper. I couldn't even find it, I have to admit, until I scrolled down and saw, in the world's smallest font, that it's -- that it is indeed there.

DR. COOPER: I will go back and look.

MS. GEIGER: It's at the bottom of a page, and literally -- you are correct, it is not the most critical piece of information.

DR. COOPER: I'll see if I can get my bifocals updated as well.

MS. GEIGER: Oh, likewise for me. You should have seen us in the room trying to find it. So, it is a little confusing to the community.

As I mentioned, we profile two hundred and -- approximately two hundred and thirty-five hospitals, six hundred and fifty nursing homes, a long -- many, many other long-term care providers. And again, this is accessible to the community on the Department of Health's Web page.

We partner with a lot of folks inside the Department of Health. Our good friends

at the School of Public Health, the SPARCS Program, to provide, from administrative data, information to hospitals on their Health Provider Network account for quality improvement. And we are in the process of working with 3M, which is a research firm, and our SPARCS counterparts, as well as the Medicaid program, to use and provide the potentially-preventable-readmissions benchmarking data.

You should know that the federal government has the -- what's known as P.P.R.s, or potentially preventable readmissions, as an indicator under healthcare reform, both versions, in the House and on the Senate. What ultimately will come out of that federal legislation remains to be seen. But it will have the potential to alter reimbursement at both the federal level and at the state level, for readmissions that were found to be totally preventable, so it's something to watch for all of us.

As I mentioned, a new program under our purview is the office-based surgery program. This is a interesting way, for the first

time ever, to control and manage office-based medical practices, something that in New York State had been uncharted territory up until this point. So, those practices performing what's known as office-based surgery, have to do two things: One they have to be accredited by one of our three designated accrediting bodies, and I'll show you who they are in a future slide, and the physician or physicians, in that practice must report to the Department, in one business day, an adverse event directly related to the performance of that office-based surgery.

So in Public Health Law, this is the definition of office-based surgery: It's a "procedure that requires general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where that procedure is performed by a licensee in a location other than a hospital. It excludes minor procedures and procedures requiring minimal sedation."

And these are the adverse events defined in Public Health Law: A patient death within thirty days of the procedure, an unplanned

transfer from that office to a hospital, an unscheduled admission to a hospital within seventy-two hours of the procedure. So a patient may be discharged from that practice and be -- self-report to a hospital later.

Yes?

MR. TAYLER: Just out of curiosity, does -- does this also include dental procedures?

MS. GEIGER: Dentists are excluded unless they're duly licensed and using their medical license for an office-based-surgery practice.

MR. TAYLER: For those crazy dental procedures where they have to knock you out?

MS. GEIGER: Right.

MR. TAYLER: Okay.

MS. GEIGER: But then -- and then any other serious or life-threatening event. What was newly added is compliance with the hospital infection acquired program. So that's a reportable event as well.

There are protections of

confidentiality. This program came about in part because the law guarantees no disclosure, other than within use by the Department, and so that the physician reporting does have some levels of confidentiality.

Accredited O.B.S. practices are displayed on the Web site as another profile. So families and patients who want to know if their surgeon-to-be is accredited, they can go to that Web site, and listed there, I'm sorry that it -- it comes out poorly, are the three designated accrediting bodies by the Department.

To date, we have approximately nine hundred accredited practices in New York State, and since the law went into effect requiring the reporting of adverse events, the Department of Health has received approximately eleven hundred such reports. The top three reports relate to colonoscopy, access vascular issues, and upper endoscopy. And that should be no -- no surprise, because most of those are the outpatient procedures.

We've received other reports

related to the issues -- T.O.P. stands for termination of pregnancy. Also other GYN and dermatology issues. Very few --

DR. COOPER: Marjorie?

MS. GEIGER: Yes?

DR. COOPER: Marjorie, what -- what -- I mean, across the board, what -- these would be the categories in which the events occurred, but what are the general types of adverse --

MS. GEIGER: Bleeding.

DR. COOPER: Bleeding.

MS. GEIGER: Bleeding.

DR. COOPER: Just bleeding.

MS. GEIGER: Or a reaction to the sedation or anesthesia.

DR. COOPER: Uh-huh.

MS. GEIGER: Or in the access vascular, issues relating to the comorbidity of the patient, the complexity. These --

DR. COOPER: Okay.

MS. GEIGER: -- access and vascular patients are very sick patients.

DR. COOPER: Yeah. Yeah. Of course. Yeah.

MS. GEIGER: And so, they may have other underlying conditions related to the reason that they need that, and that would prompt an unexplained transfer or admission later.

DR. COOPER: Thank you.

MS. GEIGER: We also have a partnership with a contract with the New York State Chapter of the American College of Physicians. We're one of the few states participating in a voluntary near-miss reporting system. Near misses are those of patient events that fortunately are caught or identified prior to causing serious harm or impact to the patient. But there's many lessons to be learned from these near-miss events. So the College of Physicians in New York State has created a very innovative collection tool, where internal-medicine residents may report these near misses in total confidentiality. And the goal of this three-year project is to drill down that data, and learn those lessons, and help identify for the State of New York, best practices.

Once we have their new contract approved, we will be expanding the scope of project to other primary-care residents, including those that are pediatric residents.

So, Dr. Cooper, we hope to work with your hospital in that endeavor.

DR. COOPER: Great. That would be terrific.

MS. GEIGER: Okay. We're pretty excited about that. And you know, I feel very much at home. We have two medical advisory committees that we're staff to. One is the patient safety enhancement project, and the other one deals -- initially started focusing primarily on antibiotic use in New York State, but has certainly expanded its scopes to reduce infections and identify infections that are resistant to antibiotics.

And before you go, I have some material for you on what these committees have produced on behalf of the Department.

DR. COOPER: Great. Thank you.

MS. GEIGER: The attorney general had an out-of-court settlement with an unnamed

pharmaceutical company, and that out-of-court settlement resulted in a several-million-dollar fine, if you will. The attorney general made that available to the Commissioner of Health, who accepted it, and Office of Health Systems Management was the recipient of some of the funds, to support medication-safety initiatives. Dr. Sturman (phonetic spelling) of the Wadsworths Labs in the Department, also received a share to improve pharmaceutical research that will ultimately lead to improved patient outcomes in New York State.

So the Office of Health Systems Management used these funds for a three-phase project. The first one we made an award to a company to analyze our NYPORTS medication errors, as mandatory reporting in this system. Our second contractor has surveyed all New York State hospitals, to obtain state-of-the-art information on their pharmaceutical-safety systems. And then they drilled down that data to go onsite visits of approximately fifty select hospitals. The end goal is to provide Dr. Daines with two to three case studies of what would constitute best practices in

hospital-based pharmaceutical-safety systems.

And then last but not least, we used the bulk of the funds to support nineteen hospitals, to study and implement small pharmaceutical-safety projects. And these range from the use of health-information technology, provider education, patient education, or a combination of all of those. And some of the physicians on this esteemed group actually are recipients of these small grants.

And then, it is our goal to have a public dissemination of the study findings in Albany on June 9th of this year, and we'll keep Martha apprised of that, and send an invitation to the members of this committee. And as I mentioned, other funds were used by the Department of Health's Wadsworth Laboratory, and they will also be sharing their findings at this June 9th meeting.

And last but not least, we have a part time Ph.D. epidemiologist in the patient safety center, who has done remarkable research. And I have for you reactivation of the quality newsletter that was last produced by the Department

about three years ago. It draws specifically on SPARCS and our NYPORTS data system. And our goal here, each issue - and we call it the Periodic Quality Newsletter, so we don't hem ourselves in on a date, but our goal is to get it out semi-quarterly - is to have one particular issue that we drill down from the NYPORTS data system. And we looked for hospitals, so those of you who are affiliated with hospitals, I -- I extend an invitation to you. If you think that you have a lesson learned from a NYPORTS issue, please contact us, and we would love to learn what your root-cause analysis showed you, how you used those findings and that root-cause analysis to improve your systems, your processes, et cetera. These are things that we can't drill down from a root-cause-analysis evaluation, but certainly our hospital partners can help us do that. So, I want to provide that to you.

We also take under special research initiatives and collaboration with other units in the Department of Health, and at the request, of course, of Dr. Morley, our medical

director.

There's our phone number. You can reach us, we have a special e-mail for the office-based surgery program that continues to generate a lot of questions, particularly when we migrated to the mandatory accreditation process. But a simple little e-mail to the Department of Health's Web page will find us as well. And my e-mail has not changed when I migrated over to the patient safety center, so everybody here in this room can still find me at that same e-mail. In fact, some of you have.

So, does that answer your questions, Dr. Cooper?

DR. COOPER: That is great. That's really great.

MS. GEIGER: And you know, there's more to come. The patient safety center came a long way under its previous director who took it from, really, the law until what it's evolved today. Our goal is to continue to build on the success of its previous director.

I didn't make a slide, but some

of our next steps are we did submit with our epidemiologist, and she received approval, to have access to very deep layers of the Department's administrative database known as SPARCS, so it's our goal to marry and integrate the various data systems that we have access to. Our office-based surgery, which is very case-specific on patients, SPARCS, the vital records, both at New York City and the rest of the state, and we also included E.M.S. in there too, because we want to follow our patients from prehospital care to, you know, unfortunately when they die.

And then to use those analyses over time to help generate, perhaps, patient guidelines for our office-based-surgery program, and certainly in partnership with our hospital program colleagues. So, that's a long-term goal.

And we're in the process of drafting a report, the first ever, on the office-based-surgery program, which will be more a demographic release of information, not the whys and the hows right now. But we hope that that release will generate some interest among the

practice community.

And as I mentioned, in June, we have a public dissemination of our pharmaceutical safety grant, which we certainly hope will generate interest and ideas on how to move those findings further.

And ultimately, we'll be working with our colleagues in the office of Medicaid on the use of the potentially preventable readmissions. Where that will go, we're not quite sure yet, but that's certainly under development.

And more newsletters, of course. These are available on the Web if people don't want to print, but I do have a few hard copies that our friends in public affairs made available to us.

Does anybody have any questions or comments?

DR. COOPER: Just -- Marjorie, how -- how do you perceive that -- you know, that the activities here might interface with yours?

MS. GEIGER: Well, it --

DR. COOPER: It sounds as though you've kind of evolved into some fairly specific

niches, of which this, at this point, is not necessary one.

MS. GEIGER: Pediatrics are reportable events in NYPORTS, including the one that you just mentioned in your previous conversation. It's not that we see a lot of those, but again, if you have an idea for the quality and safety newsletter, and certainly some partnerships with our two medical advisory bodies, if you -- if you want to -- I -- you know, we can certainly put you on future agendas. We don't meet as a body like these folks do. We have been -- historically, we've -- we do monthly telephone meetings, because we don't have the funds to support face to face. But we certainly could do that. There's not a lot of volume in the office-based-surgery world, of pediatric patients --

DR. COOPER: Right.

MS. GEIGER: -- simply because the procedures that are done are more targeted to the adult community. But you know, Dr. Morley did reach out to you, Dr. Cooper, and Dr. Kanter, when he wanted to ask a specific question about some

rare occurrences among the -- so I see, Dr. Morley doing that, you know, if those events occur in our office-based-surgery environment. And as the -- the reportable events increase, and it's not because there's poor care out there, it's just the community knows -- learns that it is a mandatory reporting system, so you just expect the volume to grow --

DR. COOPER: Uh-huh. Uh-huh.

MS. GEIGER: -- as that knowledge becomes more --

DR. COOPER: Sure.

MS. GEIGER: -- persuasive among the community, we may reach out to this committee again.

DR. COOPER: Okay.

MS. GEIGER: So, definitely a role. And if -- once we get our data analysis underway, and I don't see that happening quite yet this year, because we only have one part-time epidemiologist --

DR. COOPER: Uh-huh. Uh-huh.

MS. GEIGER: -- assigned to us.

But should we get more resources of that nature, and we start to do the linkages, I see us partnering with the Bureau of E.M.S. and our hospital colleagues, and maybe coming back to this community, even though the volume is small, it may --

DR. COOPER: Right.

MS. GEIGER: -- be of enough interest to engage this committee.

DR. COOPER: Well, we'd love to continue to support the activities of your -- of your center.

The -- the reaching out that Ms. Geiger is referring to is an issue related to sedation of children in nonhospital-affiliated imaging centers, and you know, the potential untoward effects of -- of sedation.

I have -- just for the record -- I have identified a couple of national standard policies on sedation --

MS. GEIGER: Oh, good.

DR. COOPER: -- in such centers, and I'm going to -- I just --

MS. GEIGER: Well --.

DR. COOPER: -- yes. I just -- I just got ahold of those the other day, and haven't been back in the office since I got them. And I'm going -- I'll be forwarding them to you and to John.

MS. GEIGER: Good.

DR. COOPER: You know --

MS. GEIGER: He'll appreciate that.

DR. COOPER: -- yeah. Yeah, as soon as I get back tonight, actually.

MS. GEIGER: Good.

DR. COOPER: So, that's -- so that's -- that's great news. If the -- Bob and Sue, you're still there, I hope?

DR. KANTER: Yeah.

MS. GEIGER: Oh, hi, Dr. Kanter. Hi --

DR. KANTER: Hi, Marjorie.

MS. GEIGER: -- hi, Susan, how are you?

DR. KANTER: Question, if I may?

MS. GEIGER: Sure.

DR. KANTER: On slide nine of your presentation, regarding potentially preventable medical complications --

MS. GEIGER: Yes?

DR. KANTER: -- it's -- you don't have the space to go into detail there, but I'm wondering if you could say a word more about the methodology of that surveillance from administrative data, because if it's the tool that I think it is, I have -- I do have some concerns about it.

MS. GEIGER: Can I get back to you on that? I'm little fuzzy on that one.

DR. KANTER: Yes.

MS. GEIGER: But I'll -- I'll -- I'll -- oops, I don't know what I just did. Sorry. My slides went a little haywire.

DR. COOPER: There's slide nine for you.

MS. GEIGER: Yeah. Can I get back to you on that, because -- because --

DR. KANTER: Certainly.

MS. GEIGER: -- yeah.

DR. KANTER: But just for -- for -- for your information, I forwarded an article to Martha and Art that talks about a sort of an evaluation and critique of the one tool that I'm familiar with. And although it's a tool -- it's from the A.H.R.Q. --

MS. GEIGER: Uh-huh.

DR. KANTER: -- and has a good deal of merit as a screening tool. But one group of investigators who wrote this paper really strongly suggest it's not ready for use in public comparisons of hospitals.

MS. GEIGER: Okay.

DR. KANTER: So, if it happens to be the same tool, you might just take that into consideration.

MS. GEIGER: Okay. I'll -- I'll look at that and we'll get back to you.

DR. COOPER: Bob, as you recall, Marjorie's e-mail address is mag05.

DR. KANTER: Yeah.

DR. COOPER: And so, perhaps you

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could forward that to her as well?

DR. KANTER: Sure.

DR. COOPER: Thank you so much.

MS. GEIGER: Thanks, Dr. Kanter.

DR. KANTER: I'm going to have to sign off now. Thank you all very much.

DR. COOPER: Bob, can you stick with us for just one more minute?

DR. KANTER: Oh, sure.

DR. COOPER: Thank you. Because the next item on the agenda is the issue that Marjorie specifically asked us to comment on, which is the Centor paper on expanding the pharyngitis paradigm for adolescents and young adults. This is the issue of the Fusobacterium necrophorum screening in the E.D. And I was hoping that Kathy and -- might be able to be with us for this. Informally, I have -- as I had e-mailed to Marjorie, discussed this issue with numerous colleagues in New York City. No one in pediatric emergency departments in New York City is regularly screening for this organism.

And Bob, I wanted to ask you your

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thoughts about it.

DR. KANTER: Well, I think -- I think it's a very important clinical disorder, but I also think that the full-blown illness, with Lemierre's Syndrome is quite rare. I don't have any idea whether bacteriological screening is going to substantially address the rare severe illnesses. I view this as a professional-education issue about a rare complication of pharyngitis. And I think the -- the clinical recognition of the kid who's not responding to standard management, develops a neck swelling, especially unilateral neck swelling, with pain and trismus and such. I think that is -- is -- should be urgently recognized as a life-threatening situation. I'm not aware of any evidence that screening for the organisms is -- is going to really address a rare, serious complication.

MS. GEIGER: Thank you, Dr. Kanter. I can bring that back to our medical advisory group.

DR. COOPER: Did you hear that, Bob?

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DR. KANTER: Yeah.

DR. COOPER: Okay.

DR. KANTER: That's great.

DR. COOPER: Yeah.

MS. GEIGER: Thank you very much. They'll appreciate that.

DR. KANTER: Thanks. And see you all later. Thank you very much.

DR. COOPER: Okay, Bob. Thank you.

MR. AKNTER: Bye-bye.

MS. BRILLHART: Bye, Bob.

DR. COOPER: Marjorie, I would -- I would, you know, have very little to add to what Bob said. It's -- you know, although pediatric surgery does not normally deal with Lemierre's, it's usually handled by E.N.T.

MS. GEIGER: Uh-huh.

DR. COOPER: In my place, I usually end up getting called, because our E.N.T. coverage is -- is not as deep and broad as I would like. And it -- it's -- I can't remember the last time I saw a case of the full-blown syndrome

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either, if ever. And so, this is, I think, an important issue, as Bob says, but it's primarily one of education.

MS. GEIGER: Okay.

DR. COOPER: And as I -- as I indicated, the -- none of my emergency-medicine colleagues felt that this was something that they would -- you know, or that they were currently screening for on a regular basis, or that the current epidemiology, at least to their knowledge, suggest it should be routinely screened for.

MS. GEIGER: All right. I really appreciate that.

DR. COOPER: Okay.

MS. GEIGER: Thank you.

DR. COOPER: You're welcome.

Okay. I think at this point we have completed the -- the -- the full agenda, except for the -- the updates, I see a lot of people jumping up at this point. And I think that -- that with respect to SEMSCO and SEMAC, Tim, I'll ask you to comment on -- on SEMSCO, but I think, with respect to SEMAC, really the big issues

had to do with approval of the New York City hypothermia protocol, and the modified disaster-triage algorithm, that included an urgent category for patients with medical illnesses that -- that did not -- did not, according to START, reach the red category, but were clearly far sicker than the normal yellow, which is more of an orthopedic category. I think that really those were the really the two major issues that were -- that came out of SEMAC last time. The others we've already commented on.

How about SEMSCO? Anything from SEMSCO --

MR. CZAPRANSKI: The only thing --

DR. COOPER: -- that's worth commenting on?

MR. CZAPRANSKI: -- the only thing is SEMSCO really dealt with a lot of C.O.N. appeals. The only other thing was you're familiar with, Dr. Cooper, was the five breaths for -- for pediatric patients.

DR. COOPER: I'm sorry?

MR. CZAPRANSKI: We dealt mostly with appeals, but the only thing really important, which you're aware of, was the five breaths for pediatric patients.

DR. COOPER: Right. Right. Exactly.

And Martha, we will -- I think it will be worthwhile if we share with the -- the -- the E.M.S.C. Committee, the approved, you know, triage algorithm from New York City, so that they have a -- they have an idea what -- that, I can actually forward that too you, if you don't have an electronic copy.

MS. GOHLKE: Could you? Because what they've provided us is very complicated, and -- and Brad Kaufman said that he had a simpler algorithm than Dr. Freese's slide.

DR. COOPER: You mean for the hypothermia or for the -- the triage algorithm?

MS. GOHLKE: Triage algorithm.

DR. COOPER: I have the one that Dr. Gonzalez presented.

MS. GOHLKE: Okay.

DR. COOPER: The -- the one -- the one main slide that he presented.

MS. GOHLKE: Is there a -- Ann, is there a simpler algorithm than -- than the slides the doctors are using for orange?

MS. FITTON: Yeah, actually, I will e-mail you the --

MS. GOHLKE: Yeah.

MS. FITTON: -- the drill that we did on this, or the journal article on it, that -- that really just fully explains. It's probably the easiest way to do it.

MS. GOHLKE: Yeah.

MS. FITTON: The algorithm simply is that somebody who has a complaint, or reason to believe that they're exposed to, but it's probably among people who are walking, identifies himself with a complaint and is assessed. Now, if you look at START criteria, they may not be breathing more than thirty times a minute.

MS. GOHLKE: Right.

MS. FITTON: They're walking, so they're essentially a green tag, yet they've got --

they -- they've got, you know, chest pain, difficulty breathing. They still don't meet the criteria for the yellow-tag patients, so this orange category is a little nebulous. What the design of it is, is to catch those patients that have the complaint of, particularly, illness following a -- during the midst of a -- an M.C.I. Consider the patient who may have asthma, who is standing outside their home watching it burn to the ground. Potentially, they don't have -- they may not even have been in the fire, but they may now simply have an asthma attack, exacerbated by the stress. Similar things with chest pain. We see, a lot of times, when we have major motor-vehicle accidents, say with a bus that's -- has elderly citizens going to Atlantic City.

MS. GOHLKE: Who would have thought?

MS. FITTON: And -- and actually patients are not complaining about any specific injury, but commonly their complaints are of chest pain, difficulty breathing, and when they get assessed we just have a reason to think that -- so

they're not red tag. They're not yellow tag. We don't want them to be a green-tag patient. We're treating them for medical -- medical conditions. And that's -- that's -- that's essentially how it -- how it evolves. Initially, they're probably green tag.

MS. GOHLKE: The --

MS. FITTON: But they get an assessment.

MS. GOHLKE: -- the algorithm that Dario Gonzales shared, though, is very -- it -- it's very complicated. I was just thinking there should be something simpler.

MS. FITTON: Actually, what we tried to do was to convince Dr. Gonzales that we need to separate out this -- this chart that they had, and we have something a little more simple for training purposes. I'd be more than happy to share that with you.

DR. COOPER: Okay. Is there any other -- oh, yes -- sorry. With respect to SEMSCO and SEMAC, one other issue that was discussed, that I think was of some interest and import, had to do

with the safety group that works with the State E.M.S. Council and SEMAC. Given the -- the fact that we know that the -- the design of most ambulances is inherently unsafe, particularly when a provider must free himself or herself up from seat-belt restraint in order to perform patient care tasks, you know, the safety group had been working to develop a listing of procedures that they felt it was, you know, permissible to release one's self from restraints in order to perform the patient-care activities, and those in which it was less permissible. This was intended not as a hard and fast, you know, ruling, but as a guideline to sort of give folks riding in the back of ambulances a sense of, you know, what -- what they ought to be, you know, doing while the ambulance is moving, what they ought to be doing -- or what -- or what they ought not to be doing while the ambulance is moving, and what they ought to ask the driver to pull over, you know. And you know, who presumably is a fellow E.M.T., you know, to say hey, I've got to -- I've got to, you know, do something here, would you please pull over and let me -- let me do

it, so it can be done safely in a -- in a nonmoving vehicle. You know, that -- that list was presented to the SEMAC, I believe also to the safety committee of SEMSCO, and that is, you know, an ongoing discussion point among the two groups and will be, I think, not finalized, but brought up as a -- as a prefinal draft at the -- at the next meeting of the council, if I'm not mistaken.

In terms of the State Trauma Advisory Committee, there's relatively little to report on that front. STAC did meet earlier this year. The -- the -- the regulations are still kind of in limbo. You already heard from Mike about the -- the pediatric trauma situation -- designation situation in New York City, and you heard from Wendy and Ed about the School of Public Health pediatric trauma report.

A lot of the meeting was taken up with discussion of a system that's being developed for review of trauma centers, you know, in between the formal onsite visits, sort of a paper survey tool that's -- that's being developed. And I believe that -- that those were the really critical

issues from the STAC

Mike, were -- was there anything else that needs to really be brought up, so far as you're concerned?

MR. TAYLER: No, that's it.

DR. COOPER: Okay. So that completes the reports from our sister committees.

Now, it is now almost three-thirty. I have one issue that I wanted to bring up to the group, and I -- and there are clearly we will have to put this off until another meeting. But since we last met, there have been two major events in this hemisphere, one in Haiti and one in Chile, that have, you know, caused us all a great deal of, you know, concern for our fellow human beings, and have reminded us that tragedy can strike anywhere at any time.

In the aftermath of the Haiti event, the National Disaster Life Support Foundation developed a PowerPoint, Just-In-Time training, for hurricane victim -- or for medical professionals who were -- who were entering the earthquake zone, and -- and what to expect, what

to -- what sorts of issues might be encountered and so on. And it struck me that -- that it might be worthwhile our considering developing a series of Just-In-Time trainings, you know, a few, for common types of issues that -- disaster issues we might face here in New York State, that might involve children.

You know, and I think of, you know, ice storms that occur pretty regularly. We do have floods from time to time, you know. It might be worth our considering developing something, so that, you know, if -- if anything were to happen, that we could get some information out there to our -- our peers very, very quickly, that would, you know, facilitate their being able to, you know, deal with children's issues. So I just put that on the table as a project that we might want to -- we might want to -- to consider in the, you know, over the next several months. It's -- it's a time-limited, doable project, keeping in mind that, you know, Lee has exhorted us to look for work projects that can be completed within a short period of time and finalized. And

so I was thinking that we might want to consider doing something like that, you know, for, you know, over the next several months. We have two more meetings this year. It's not out of the -- out of the range of possibility that we could at least get one done.

MS. GOHLKE: Three.

DR. COOPER: Three?

MS. GOHLKE: Yeah.

DR. COOPER: Oh, you're right. Of course. Yes. June, September, December. Yeah, so we definitely have been getting one done.

MS. GOHLKE: May, September, and December.

DR. COOPER: Sorry. I got the months wrong.

MR. GOHLKE: Yeah.

DR. COOPER: Listen to Martha about the months. I -- I -- I have trouble remembering my calendar for tomorrow. I have to look at it tonight.

MS. GOHLKE: Yeah.

MS. BURNS: Just with -- with

regard to that, perhaps when you -- you know, you flesh out your thoughts even more, we can involve the Department's disaster preparedness planning, I don't know what their unit is called, but they -- they have been building a -- what is being called a volunteer database for response to disasters and events. We've been working with them specifically, frankly, to exclude E.M.S. providers, not because we don't love them, but because E.M.S. -- the E.M.S. providers --

DR. COOPER: Absolutely.

MS. BURNS: -- are already encumbered. And they would volunteer, and -- and -- it's very difficult to track them, so what we've asked is that we not advertise the volunteer database to the E.M.S. community, mainly because they're going to be going anyway. And we need them to be responding as part of the statewide mobilization plan and all those things.

But I'll speak with Laurie Liptac (phonetic spelling), who is one of the associate directors, and she's in charge of it, and she could probably explain to you whether there is any

Just-In-Time training for health professionals, or you know, she may be -- they may be the venue to point, other than prehospital-care-provider training, but Just-In-Time training to nursing, physicians, mental-health professionals, and those kind of things, so it certainly would dovetail well into your thought, I think; wouldn't it?

DR. COOPER: Okay. Yeah. Absolutely. Sure.

MR. CZAPRANSKI: I -- I'll just add that I think the Department of Health has a great process already in place, or a platform in place to put that on. When in Monroe County we wanted paramedics to do vaccinations for H1N1, we worked with the State Department of Health's system, and within twenty-four hours we had it up and running, where someone would go on, register, take the course, it would spit out reports, a successful completion of the reports by their, you know, level of training, et cetera. It was a very robust, but simply and quickly put together, on the spot, to get it done. So it was -- it was a lot of work on their part, but it was very, very well

received.

DR. COOPER: Okay. Well, I think this is something that will occupy at least some of our attention over the next several months, and I'll -- I'll reach out -- I'll be reaching out to a few of you to begin to, you know, begin the process of putting this together. Ice storms came to my mind immediately, you know, because that's something we have almost every year somewhere. Floods, because that's something we have almost every year somewhere. You know, we could probably do something on, you know, a school bus, you know, that happens at least once a year somewhere. But if there are other ideas about -- about, you know, disasters involving children, that occur here within New York State with -- with -- with some regularity, you know, that would be --.

MS. GOHLKE: I'm horrified to tell you that school shootings occur with some degree of regularity.

DR. COOPER: Yeah, I know. They haven't in New York State, yet have -- have we?

MS. GOHLKE: We've had a couple.

DR. COOPER: Have they -- have we?

MS. FITTON: There was one in Columbia County.

MS. GOHLKE: Yeah. Luckily no kids were shot.

DR. COOPER: That's -- yeah. Yeah. Yeah.

MS. GOHLKE: But they're -- it's a -- it's unfortunately -- it's frighteningly commonplace in -- across the country, and we've had a couple of incidents in New York.

DR. COOPER: Well, yeah, this -- this idea comes from the mad scramble that took place after -- after --

FROM THE FLOOR: Haiti.

DR. COOPER: -- the Haiti earthquake, to put together a training program. A lot of us spent about forty-eight hours going through multiple drafts, you know, at all hours of the day and night, to put this -- this thing together, and hold a Webinar about two days after the, you know, after the event occurred, you know.

And it wasn't, you know, pretty, you know, the -- the final product was okay. But you know, it wasn't as -- as perfect as it could or should have been. And for events that occur here in New York State with some regularity, it would be nice for us to have a -- you know, a databank of -- of Just-In-Time trainings available, that we could, you know, get out to our providers in a -- in a hurry, to remind them of, you know, the issues that they might be facing.

You know, we all -- although we -- we do have floods from time to time in the upstate area, I think downstate we're obviously -- as Ann well knows, deeply worried about the category three hurricane that inevitably will -- you know, will befall the New York City area.

MS. FITTON: Plus all the potential manmade disasters.

DR. COOPER: Absolutely. Sure. Yeah.

So okay. Is there any other new business to come before the committee?

MR. BURNS: You're like -- you

are it of the committee. Oh.

DR. COOPER: Okay. Then our next meeting, Martha, is June --

MS. GOHLKE: May.

DR. COOPER: Sorry. May -- May what?

MS. GOHLKE: Our -- our next meeting is a Webinar, so we will not be meeting in person.

DR. COOPER: Oh, okay.

MS. GOHLKE: Is May 4th. My assistant here -- not really -- he's -- he's going to actually teach me how to use the -- the forum, the Webinar forum, WebEx. He'll be helping me getting notices out, and you will have to register in order to attend the Webinar, but -- so, that will be coming via e-mail eventually, when we get closer to that point.

And then the stakeholder's meeting in New York City, just as a reminder, is May 13th. Folks that want to be there, need to talk to me, so I can make sure you get reimbursed for your travel, sooner rather than later, because

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this process is long and arduous. So, those are the next two meetings in May.

DR. COOPER: Great. Okay. So May 4th and May 13th. Wonderful.

Well, that's -- we have, as always, a full agenda of tasks to accomplish, and I deeply appreciate everyone making the trip to Albany. And for those of you who could not attend today, but were able to attend by phone, thank you.

And last but not least, Marjorie, thank you so much for taking time to be with us here today.

MS. GEIGER: And likewise the patient safety center appreciates being here. We look forward to working together.

DR. COOPER: Thank you.

Okay. We stand adjourned.

(The meeting concluded at 3:37 p.m.)

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