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NEW YORK STATE DEPARTMENT OF HEALTH

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4 EMERGENCY MEDICAL SERVICES
FOR CHILDREN

5 ADVISORY COMMITTEE MEETING

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7 LOCATION: Troy, New York

8 DATE: September 20, 2011

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2 APPEARANCES:

3 Arthur Cooper, M.D., Chair
Robert Kanter
4 Marilyn Kacica
Edward Conway, Jr., M.D.
5 Sharon Chiumento
Sarah Macinski Sperry, M.S.
6 Linda Tripoli, R.N.
Rita Molloy, R.N.
7 George Foltin, M.D.
Tim Czapranski EMT-P
8 Martha Gohlke
Susan Brillhart, M.S. R.N., CPN-P
9 Kathryn Bass
Lisa McMurdo, R.N. M.Ph.
10 Sandra Haff. BSN, MPA

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2 (The meeting commenced at 1:11 p.m.)

3 DR. COOPER: I'd like to welcome everyone to

4 the September meeting of the New York State Emergency

5 Medical Services for Children Advisory Committee. My

6 name's Art Cooper. I have the honor of chairing this

7 group, and we have a full agenda today.

8 But before we get to that agenda, I am pleased to

9 introduce some new faces to our number. Ed Conway is a

10 pediatric critical care physician from New York City.

11 He's chief of pediatrics -- chairman of pediatrics,

12 actually, at Beth Israel Hospital in New York City. He

13 is a past chair of the -- of the Pediatric Fundamentals

14 of Critical Care Support Working Group for the Society

15 of Critical Care Medicine. Most recently a coauthor on

16 the revised pediatric brain death guidelines published

17 jointly by the A.A.P. and the -- and the Society of

18 Critical Care Medicine, and an all around great guy, and

19 so we're very happy to have him with us.

20 George Foltin, immediately to his left, I think

21 needs no introduction to anyone. George has been -- has

22 been a significant contributor, leader, player in

23 emergency medical services for children locally,

24 regionally, nationally for years. George was one of the

25 investigators on the original E.M.S.C. grant here in New

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2 York City back in 1985. George, of course, is -- is
3 director of pediatric emergency services at Bellevue and
4 a past winner of the E.M.S.C. Lifetime Achievement Award
5 from the federal E.M.S.C. program. So it's really great
6 to have George with us after all these years.
7 And last, but not least, is another new face
8 and that of Kathryn Bass. And Kathryn is a colleague of
9 mine, a fellow pediatric surgeon. I'm not exactly sure
10 why she traded, you know, the heat of Texas for the cold
11 and snow of Buffalo, but she did, and she's director of
12 trauma at -- at the Women and Children's Hospital of
13 Buffalo. She's very, very well published. A -- you
14 know, a rising star in -- in pediatric trauma surgery,
15 and she's going to be another terrific addition to
16 our -- our committee. And so welcome to Ed, George,
17 and -- and -- and Kathryn.
18 I don't believe that -- oh, there's one other
19 new face actually since we last met, and that's that of
20 Linda Tripoli. Linda is a critical care nurse,
21 emergency nurse by background, and we are extremely
22 fortunate that she has been able to succeed Mike Tayler
23 as the trauma program manager for the New York State
24 Department of Health. I have no doubt that Lee Burns
25 has her performing multiple other tasks as well, but --

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2 but she's really hit the ground running, as we learned
3 at the State Trauma Advisory Committee meeting earlier
4 this month. And we're really, really pleased that she's
5 been able to join us as well.
6 So I think that about wraps up our new faces.
7 But I'm not sure that our new faces necessarily know all
8 of our old faces, so I'm going to -- I'm going to have
9 everyone starting with Lisa, just -- if they could just
10 go around the room and just say just a word about who
11 you are and what you do so that our -- our new friends
12 will get to know you just a bit better.
13 MS. MCMURDO: Hi. Lisa McMurdo. I'm the
14 Director of the Division of Quality and Patient Safety
15 which is over E.M.S. that houses the council that you're
16 sitting on. Very glad to have you here today and -- and
17 hope you find it enjoyable.
18 DR. COOPER: Lisa's been a tremendous friend of
19 E.M.S.C. for as long as I've known her, which is far
20 longer than either one of us cares to admit.
21 MS. SPERRY: Hi. I'm Sarah Sperry. I am a
22 guest here. I come from the Bureau of -- well, it's no
23 longer -- it used to be the Bureau of Injury Prevention.
24 Now we are in the Bureau of Occupational Health and are
25 the Injury Prevention Program. And I come here and try

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2 to do my best to offer whatever services it is that we
3 do that we can to help you all in your great mission.
4 MR. CZAPRANSKI: Tim Czapranski. I'm a
5 paramedic. I'm the E.M.S. administrator in Monroe
6 County, New York. I also am the current chair of the
7 state E.M.S. Council, and I also sit on child fatality
8 review teams and other committees.
9 MS. HAFF: I'm Sandy Haff. I'm with the
10 Department, and I'm with Division of Certification and
11 Surveillance, and I'll be involved in developing the
12 regulations.
13 MS. TRIPOLI: Hi, I'm Linda Tripoli. I'm the
14 new Trauma Program Coordinator for the Bureau of E.M.S.
15 MS. GOHLKE: You may be wondering why we have
16 to use microphones in such a small room, but the
17 stenographer over there is taking down every word that
18 you say, so keep that in mind. So you have to use the
19 microphones, and we appreciate if it's only one at a
20 time. Most people have name cards here. If you don't
21 have a name card, if you speak, please say your name so
22 the stenographer can make sure it's -- unless you have
23 something bad to say, then you can use your colleague's
24 name next to you. But otherwise, we'd prefer you to use
25 your own name. And by the way, I'm Martha Gohlke. I'm

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2 the E.M.S.C. Coordinator for New York State.
3 DR. COOPER: I'm professor of surgery at
4 Columbia and Director of Trauma and Pediatric Surgical
5 Services at Harlem Hospital, and I will turn the
6 microphone to my partner to the right.
7 DR. KANTER: Bob Kanter, pediatric critical
8 care in Syracuse.
9 MS. CHIUMENTO: Sharon Chiumento, a retired
10 pediatric nurse and also retired Q.A./Q.I. coordinator.
11 DR. BASS: Kathryn Bass. I'm the Pediatric
12 Trauma Director at Women and Children's Hospital in
13 Buffalo.
14 MR. FOLTIN: George Foltin, Director of
15 Pediatric Emergency Services and Division of Pediatric
16 Emergency Medicine at Bellevue Hospital.
17 DR. CONWAY: Hi, I'm Ed Conway. I'm Chairman
18 of Pediatrics at Beth Israel Medical Center in New York
19 and the chief of peds critical care.
20 MS. MOLLOY: My name is Rita Molloy. I'm a
21 school nurse, and I am the past president of the New
22 York State Association of School Nurses and a past
23 critical care nurse.
24 DR. KACICA: Hi, I'm Marilyn Kacica. I'm the
25 medical director in the Division of Family Health, and

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2 I'm a pediatric infectious disease specialist.
3 DR. COOPER: Great. And we have our final new
4 face, who is Surgey Kunkov from Stony Brook. Surgey,
5 perhaps you could tell us a little bit about yourself
6 because I think you're about the only person here I
7 don't know.
8 MR. KUNKOV: Surgey Kunkov --.
9 DR. COOPER: You would press the -- the button?
10 Thank you.
11 MR. KUNKOV: Surgey Kunkov. I'm Director of
12 Pediatric Emergency Department at Stony Brook Children's
13 Hospital, newly found. And I'm not a member of this
14 committee as of yet. I've not been vetted. I was just
15 invited to attend this meeting.
16 DR. COOPER: We're very pleased to have you
17 with us.
18 MR. KUNKOV: Thank you. Thank you very much.
19 DR. COOPER: Okay. Our next task is to just
20 quickly review the agenda. We are going to receive a
21 report from Lisa McMurdo on the current state of life in
22 the Bureau of E.M.S. in the Department of Health from --
23 as I said, from Lisa in the absence of Lee Burns, who
24 can't be with us today. Lee Burns, for those of you who
25 do not know her, is the Acting Director of the Division.

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2 Martha Gohlke will then give us our E.M.S. for Children
3 grant report.
4 We're then going to move in to talking about
5 some old but very current business, 405 codes, A.L.S.
6 protocol template, and a New York State pediatric trauma
7 center update.
8 We then wanted to speak a little bit about a
9 national effort of the National Quality Forum that is
10 proceeding at pace at this point as well as an update on
11 emergency preparedness activities before we hear some
12 updates from our sister committees.
13 Martha, I don't see review of the minutes on
14 the agenda. Should we do that? I think we should,
15 should we not?
16 MS. GOHLKE: Yes.
17 DR. COOPER: They were mailed. They were
18 mailed to everyone.
19 MS. GOHLKE: E-mailed.
20 DR. COOPER: E-mailed, yes, exactly. So did
21 everybody have a chance to look at those minutes, I
22 pray? Yes. Okay. Well, in that case, I'll entertain a
23 motion for approval. Sharon, thank you. Second? Thank
24 you, Rita. Discussion? All in favor, please signify by
25 saying aye. Opposed? It carries without dissent.

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2 Thank you so much.
3 And for those of you who are new, we have
4 our -- our last arriving member today, who got stuck in
5 a little bit of rain -- more than a little bit of rain
6 is my understanding -- Susan Brillhart. So if you'd
7 introduce yourself, please.
8 MS. BRILLHART: Susan Brillhart, nursing, City
9 University of New York. Hello.
10 DR. COOPER: Susan's a professor of nursing
11 there. She never gives herself enough credit, so --
12 okay. So let's move right in to the Bureau report.
13 Lisa?
14 MS. MCMURDO: Yes. Thank you for letting me
15 sit in for Lee. Lee is Lake Placid at the Rural Health
16 Conference with Dr. Shah. Both of them are speaking
17 today, so she asked me if I could update you on some of
18 the activities of the Bureau as well as the Division of
19 Quality and Patient Safety.
20 First of all, just let me say Linda was
21 introduced, and we're really happy to have Linda Tripoli
22 working with us on these various committees. I think
23 when Lee had the ability to have Linda have a transfer,
24 it was -- really says a lot to what Lee sees are the
25 priorities of the Bureau that she immediately thought

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2 that she needed to put her into this committee and to
3 the trauma work. So we welcome Linda, and we're hoping
4 that she enjoys her time with us.
5 UNIDENTIFIED FEMALE: Hoping she stays.
6 MS. MCMURDO: Yeah. It won't be boring.
7 That -- that's for sure. The other announcement that --
8 I don't know if many of you are aware of this, but Dr.
9 John Morley who is our medical director, left the
10 Department about two and a half weeks ago. And our loss
11 is H.H.C.'s gain for those of you at H.H.C. John is the
12 Senior Assistant V.P. for Medical Affairs and Health
13 Care Improvement and the Deputy Medical Officer --
14 Deputy Chief Medical Officer at H.H.C. So it's beyond
15 words to explain the loss of the clinical expertise
16 and -- and his knowledge for us in O.H.S.M., Office of
17 Health Systems Management. We wish him luck, and I'm
18 sure you'll have lots of fun working with him, Dr.
19 Foltin and Dr. Cooper.
20 DR. COOPER: Lisa, is -- is it anticipated that
21 his position will be backfilled?
22 MS. MCMURDO: It is anticipated it will not be
23 backfilled. I think that's the safest thing to say
24 for -- for the immediate future, so -- unfortunately.
25 So to move on, just -- I just want to hit some of the

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2 highlights of what's been going on with the bureau.
3 The -- the main thing the Bureau has been involved in
4 for the last month has been emergency response for the
5 continuing rain that we have suffered in the northeast.
6 From August 23rd to September 19th, the Bureau basically
7 was what we call activated mobilized. They helped
8 evacuate, which I know those of you who were in the city
9 were particularly aware of this. Seven to ten thousand
10 patients were moved out of hospitals then repatriated
11 back. The E.M.S. Unit was involved in handling the --
12 the FEMA contract. We did that E.M.S. ambulance
13 mobilization through a FEMA contract for the first time,
14 which was very interesting for the -- for the unit,
15 challenging, and -- and it worked out quite well. There
16 were two hundred and twenty-five ambulances under that
17 contract that were moved in and out to do that during
18 the storm.
19 The -- the other parts of the Bureau's
20 responsibility in this were -- we also -- once we had --
21 we got through the first storm, we had the second storm
22 that really affected a lot of the upstate areas much
23 more severely, and we were staffing the emergency
24 operations centers in the City, the staffing emergency
25 operation centers in Schoharie and Greene County. It

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2 was very, very taxing on the Bureau as well as the state
3 bunker that we call.
4 And in the midst of that, I do have to commend
5 the Bureau because they also have the regular work that
6 has to get done. E.M.T.'s still have to get certified.
7 We have complaints that have to get done. It's not like
8 the regular work does not stop. So I do have to, you
9 know, pat the back on the staff that do all the bulk of
10 this work. It really was a really trying, protracted
11 time similar to 9/11, except we have a lot less staff
12 than we did when we went through 9/11. We have more
13 experience in how to deal with these things. That's for
14 sure. But we -- the resources are much more limited for
15 us. Let's see.
16 The -- the -- actually, the main thing that I
17 did want to mention to you is with -- with those floods
18 and with that -- those disasters, we aren't sure what
19 that's going to mean budget-wise for the state in the
20 future. So the governor has been -- I've heard make
21 some statements about that the state will be picking up
22 the extra costs that FEMA doesn't cover. So I -- I
23 think it's pretty safe to assume we're going to go into
24 another difficult budget cycle given that we were in
25 tough times to begin with, and the -- and the rains and

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2 the aftermath of reconstruction I think is going to tax
3 us further. So again, just preparing folks that it
4 doesn't look like it's going to be a really good budget
5 year again.
6 And then the -- the last thing I want to
7 mention is the Vital Signs Conference. We gave you
8 brochures at your -- at your seats. For those of you
9 who are -- are not that familiar with the conference, it
10 really is a stellar state of the art E.M.S. conference,
11 one of the best in the country from what folks will tell
12 us. And it's in Syracuse this year, and we'd love to
13 have you. If you could pass on to the emergency medical
14 community that you work with, we'd love to see them
15 there. So are there any questions?
16 DR. COOPER: The evacuation, were there acute
17 care hospitals evacuated?
18 MS. MCMURDO: Yes. And I think people around
19 the table were probably intimately involved in that.
20 Yes, I believe N.Y.U. evacuated?
21 MR. FOLTIN: N.Y.U. Tisch Hospital was
22 evacuated. It was considered to be in the primary flood
23 zone. Interestingly enough, Bellevue, just four blocks
24 away, was not evacuated. It's ten feet higher. It's
25 really amazing to me how they parsed that. However, the

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2 neonatal I.C.U.'s were both evacuated from both sites.
3 At Bellevue, they just decided to do that proactively.
4 So they managed to empty out the entire hospital, get
5 them all to other institutions, sent home who they
6 could, and then they brought them all back afterwards.
7 They did leave about six patients in the hospital who
8 were too sick to move, along with nursing staff to take
9 care of them.
10 MS. MCMURDO: And I don't know what your
11 experiences were, but from what we've heard, considering
12 the volume of patients we're talking about in the middle
13 of the rain -- and it went fairly smoothly. It went --.
14 MR. FOLTIN: Yeah. I was surprised at how long
15 they waited to make the decision because it seemed to me
16 it would take much longer, but they were very efficient.
17 And Coney Island also evacuated, I believe. And --.
18 MS. BRILLHART: On Staten Island, two on Long
19 Island. Yeah, Staten Island -- I think two on Staten
20 Island, two on Long Island. Did -- what we used to call
21 Beekman Downtown, I think also, down near World Trade,
22 which is all flood zone.
23 MS. MCMURDO: It was interesting looking at the
24 maps. You know, they actually had maps of zone A.
25 Anybody in zone A -- you don't want to be in zone A

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2 because you had to evacuate. But you were absolutely
3 right. It was really interesting because you were
4 looking at this going -- intuitively, it doesn't make
5 sense to you, but when you look at a little bit of sea
6 level, it made a difference in who got evacuated and who
7 didn't.
8 MS. BRILLHART: Yeah, I -- I was unlucky enough
9 to work and live in zone A.
10 MR. FOLTIN: Double A.
11 MS. BRILLHART: Double A.
12 MR. FOLTIN: There was no damage though,
13 really. There was -- actually, it's not true there was
14 no damage. There was no damage to the functioning of
15 the hospital, but the Rusk Institute, which is very old,
16 a lot of the windows were damaged, and that needs some
17 repair.
18 MS. MCMURDO: Yeah, I'd say the upstate
19 counties. And we -- we had staff affected. We had -- a
20 lot of employees were affected in Schoharie, Greene,
21 Montgomery Counties. Then we had that tornado in
22 Amsterdam, and it was really a kind of a nutty ten day
23 period with an earthquake, two tropical storms,
24 hurricane, and a -- yeah, it was just unbelievable.
25 UNIDENTIFIED MALE: Can't wait for the snow,

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2 huh?
3 MS. MCMURDO: Well, you know, it's funny
4 because I think a lot of us did say that, that we can't
5 believe we're looking forward to a nor'easter. I mean,
6 this was --.
7 UNIDENTIFIED FEMALE: It was pretty bizarre.
8 MS. MCMURDO: Vermont affected by a hurricane?
9 I mean, intuitively, that just doesn't make any sense.
10 I mean -- I -- I mean, one of the things I don't like
11 about living upstate is I'm not near the ocean. But we
12 managed to get all the bad parts of it that go with it.
13 DR. COOPER: Any other questions for Lisa?
14 Okay. Martha?
15 MS. GOHLKE: I wanted to start with the vetting
16 for -- for our guests and for everybody else. So every
17 four years, the terms of the seats for this committee
18 come due, and -- and we were all vetted together four
19 years ago. So it -- it's time to re-vet those
20 individuals sitting around the table that have decided
21 to continue on. It's kind of like a life sentence.
22 And -- and then there's some interested parties, the
23 guests, some of which -- some of whom came today who
24 have voiced an interest in being on this committee. And
25 my understanding, it has the vetting package -- the

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2 recommendations have left the Health Department, and
3 they're sitting at the governor's appointment office.
4 And there's no movement there, which I'm sure is not
5 surprise to you, so I -- I can't give you an idea when
6 the vetting will be complete. It might be a while.
7 Because it's been known, obviously, that the -- these
8 committees are not a favorite of the -- the governor for
9 expense reasons.
10 So anyways, as a result, the nice part, though,
11 is that I have this grant. And when you're a vetted
12 member, your travel for this committee is -- is taken
13 out of state funds. But I have this grant to fall back
14 on, so our guests are welcome to come and get travel
15 reimbursement through the grant process, and that --
16 that will continue for a while. So if you -- if you
17 like today and you want to come back for more, our next
18 meeting is December 6th, so you can put it on your
19 calendar and make plans accordingly.
20 One of the issues with the vetting of this
21 committee is that, you know, there's a seat per
22 profession or specialty, however you want to say it, and
23 then we have, you know, a couple E.D. docs here, a
24 couple surgeons, you know, and so there's more people
25 than there is seats. That's not a -- our -- our

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2 committee is also in statute as well, a New York State
3 statute, which is a good thing. It's not only a mandate
4 as part of the grant -- the federal grant that the
5 E.M.S. for Children is, but it's also a state statute.
6 So the good thing is is that we're not limited to the
7 number of members in the statute. So we can have as
8 many as we want, which is why I don't want to turn
9 anybody away who's interested in -- in sitting on this
10 committee for -- for many reasons.
11 However, the reality is that the state budget
12 and reimbursement -- I don't know if they're going to
13 allow two surgeons or two E.D. docs on this committee
14 because of expense reasons, so it remains to be seen.
15 Everybody's names will be put forward. My understanding
16 is it made it through D.O.H. and it is sitting at the
17 governor's office. So nobody got cut at the D.O.H.
18 level. So I'm hopeful that everybody will be vetted,
19 hopefully in the somewhat near future. But it could --
20 it could be that they only allow one person per seat.
21 We may need to look in the future of writing in our
22 bylaws alternates or something because one of the
23 issues -- and this is one of the justifications I
24 gave -- I put forward to vetting everybody is we often
25 don't meet a quorum. And today we don't meet a quorum

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2 as well because people have lives, and they can't make
3 necessarily every single meeting. So we do need in some
4 cases, you know, two people per seat kind of thing in
5 order to make quorum to do business. So like I said,
6 I'm hoping that that argument, you know, goes all the
7 way through to the governor's office and -- and
8 everyone's vetted. But I just want to give everyone a
9 heads up that we are in the process and what the
10 possible outcome could be.
11 MR. FOLTIN: I'm just glad that the long delay
12 was not due to the background check.
13 MS. GOHLKE: Well, that leads me to -- has
14 anybody had any state police knock on their door?
15 MR. FOLTIN: No, and I didn't see anyone
16 skulking around either.
17 MS. GOHLKE: Okay. That's probably not a good
18 sign because it means that nothing's moving.
19 MR. FOLTIN: Oh.
20 MS. GOHLKE: So I'd be interested if -- if you
21 do have somebody knock on your door can you let me know?
22 Because that means things are moving along, and that's
23 actually a good sign, so --.
24 MR. FOLTIN: Do we have to give them milk and
25 cookies?

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2 MS. GOHLKE: You do need to be nice. I would
3 suggest you be nice.
4 MS. MCMURDO: Chocolate. Chocolate usually
5 works better.
6 MS. GOHLKE: And -- and my other suggestion is
7 be nice to your neighbors because my understanding is if
8 you're not home, they will knock on your neighbor's door
9 and ask about you. So if you don't like your neighbor,
10 I think it's time to make amends.
11 MS. MCMURDO: Are you sure they still do -- I
12 thought they do it by phone. They don't -- had anybody
13 gone through this recently? My understanding was they
14 do a --.
15 MS. GOHLKE: I hadn't heard that.
16 MR. CZAPRANSKI: Last time I heard, they --
17 they knocked on doors.
18 MS. GOHLKE: Okay.
19 MR. FOLTIN: Did they tell you when they were
20 coming or they just showed up?
21 MR. CZAPRANSKI: No, they just showed up --
22 showed up at my work.
23 MS. TRIPOLI: Yeah, and the council operations
24 person that I spoke with regarding my committee's
25 vetting said to prepare people for people knocking on

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2 their door.
3 MS. GOHLKE: So be nice. Be nice and be nice
4 to your neighbors, so -- unless you don't want on the
5 committee. All right. So that's it about the vetting.
6 In relation to the grant specifically, this grant,
7 again, as a F.Y.I. to our guests, is a hundred and
8 thirty thousand dollars that was recently up from a
9 hundred fifteen a year or two ago, which isn't a lot of
10 money when you talk about staffing a position and trying
11 to do activities in relation to the money, especially
12 when you're trying to change hospital codes and
13 standards, and everybody wants to know what the
14 reimbursement is behind it and things like that, so --
15 but it is something, and it's -- it's been longstanding.
16 It's been around since the pilot project in '84 is when
17 I believe it started, and New York State was one of
18 those pilot states to get that funding.
19 Recently, they put out a notice that there was
20 an extra thirteen thousand dollars additional funding to
21 grantees. It wasn't a competitive big process. It was
22 available monies. You did have to write a mini grant
23 justification for it, but I didn't have to compete
24 for -- with other states for it or -- or with the
25 general public, so we were awarded the funding. What we

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2 decided to do -- unfortunately, it was a quick
3 turnaround period. If you remember I sent a quick
4 e-mail to folks. We get -- there's -- this money is
5 available, and I have about two weeks to -- to write up
6 how we're going to use it to the committee. And I got a
7 couple of suggestions, but it was felt -- and -- and
8 this was kind of my feeling that since I've been in this
9 position for almost four years, one of the things that
10 keeps popping up from an E.M.S. perspective is
11 transporting of children in ambulances and how we have
12 no policy around it. And there's reasons for that.
13 Basically, the quick and dirty is that there's no crash
14 testing of child car seats in ambulances, so there's no
15 efficacy data to go with to say you should do this or
16 not do this. But there's some, you know -- you know,
17 street smarts or, you know, good things to do and bad
18 things to do type of information that's out there. And
19 so we may not write a policy statement until we have
20 some crash test data, but what we propose to do is do an
21 online continuing education program for E.M.T.'s that
22 basically gives them some guidance on -- on the best way
23 to transport with car seats or no car seats and what
24 information is out there. And NHTSA has draft
25 recommendations of guidance. They're not finalized yet.

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2 There's some question whether or not they'll ever be
3 finalized, but we're going to use those draft
4 recommendations in the online C.M.E. program and it will
5 be available nationally.
6 So all my counterparts are thrilled that
7 there's something -- some consistent information that's
8 going to be out there and not necessarily New York State
9 specific. And the program's going to be available to
10 any E.M.T. nationwide to take on a C.M.E. basis as long
11 as their state accepts it on that level. So me and a
12 few of my counterparts in my NHTSA connection will be
13 working on this online C.M.E. program with those monies.
14 MR. FOLTIN: All right. Nadine Levick
15 presented her work at national meetings. She never
16 published it.
17 DR. COOPER: No, she's published fairly
18 extensive.
19 MR. FOLTIN: So that was the information about
20 what happens to children in the back of an ambulance,
21 and they made some recommendations out of that, those
22 articles.
23 DR. COOPER: Yeah, some -- the -- some, yeah,
24 right. The -- the -- the NHTSA recommendations that do
25 exist are based at least in part on her work.

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2 MS. GOHLKE: The other project I work on
3 besides E.M.S. for Children is we also have a governor's
4 traffic safety grant which is also NHTSA money. And
5 this is to -- we submitted, I don't know, three and a
6 half years ago, four years ago, to make the patient
7 record reports on ambulances electronic -- at least the
8 state repository make it electronic. So that grant
9 is -- that's the -- the original purpose for it, so
10 we've been slowly getting vendors throughout New York
11 State online with this new state repository so that we
12 can upload their data electronically and quickly. And
13 as a result of this online repository, the E.M.S.
14 agencies and the regions can have access to their data
15 on a regional level and a state level through this
16 process.
17 It's -- like I said, it's taken us about three
18 and a half years to get to this point, and it's
19 finally -- we're finally starting to get some data in at
20 the state level. We did this before. An electronic
21 P.C.R. reporting was there before, but it was more of a
22 manual system where it was sent to a person in our
23 office, and then he put it into his own electronic
24 program. But the turnaround time to produce reports was
25 several years. So with the online system, it'll be

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2 hopefully much quicker and much more user friendly to
3 the people out in the -- in the field to access their
4 data.
5 The other piece to that is that we've now added
6 the trauma portion of it. And again, we had a trauma
7 registry, a patient registry, electronic one that was
8 handled in a -- in a more humanlike format, but now
9 we're adding it to this contract, and it's going to be
10 on this online repository as well. So that -- we just
11 now found out we got a fourth year of funding on that,
12 so that's great. We weren't sure we were going to get a
13 fourth year, and it's been awarded. It'll be the final
14 year, though, and then the state has to assume that --
15 those costs, but it's actually a lot cheaper the way
16 we're setting up now than with the existing system. So
17 we're hoping it shouldn't be an issue to move it over to
18 state funds.
19 The reason I bring that up is just because --
20 because we got a fourth year funding on that project, it
21 frees up money on this grant to do some more pediatric
22 training in the regions like we've done the last couple
23 years. I've offered small pockets of money to anybody
24 in New York State to do -- usually, PEP and PALS courses
25 generally is what people use it for in the regions to

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2 train their E.M.S. providers on pediatric topics. So
3 I'm going to put out a notice shortly letting people
4 know that those small pockets of money -- and it has to
5 be under three thousand dollars to be specific that can
6 be used for pediatric training. So if you know of
7 somebody that would like to utilize those funds to do
8 some sort of pediatric related training, let me know and
9 we'll get you set up. The -- it has to be -- the monies
10 have to be used by February 28th of 2012, so it's kind
11 of a short turnaround time. But we've been able to do
12 it for the last two years, and I wasn't sure if we could
13 do it this year until we found out about our other grand
14 funding, but we can do it again this year.
15 And then the other thing that I just wanted to
16 talk about was something a colleague did in New
17 Hampshire. And it got some real positive feedback from
18 my other colleagues at the national level, and I just
19 thought I would send it around and let you folks look at
20 it. And if we wanted to do something similar in New
21 York State, we can talk about it. But they have this
22 quick reference guide, and it's really geared towards
23 hospital staff to look at what types of training the
24 basic -- the basic E.M.T. has, the intermediate E.M.T.
25 has, the critical care E.M.T., and the paramedic level

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2 E.M.T. So it lists what their training is involved,
3 what meds they can give, what procedures they can do.
4 So for example, for transferring of patients, it lets
5 them know what the ambulance staff can and cannot do.
6 So I'll just pass it around.
7 I think New Hampshire said it was about two
8 dollars a copy for them to produce it. And we do have
9 some funds available in this year's grant if we wanted
10 to do something similar, if we thought it was
11 worthwhile. I'll pass that around. But we can think
12 about it, and -- and we could talk about it via e-mail
13 afterwards or even at our next meeting. There's
14 probably time to -- to get it done.
15 And that's it. That's what I have for my --
16 for my report. And there's a sign-in sheet, so make you
17 sign it. I think everybody did. If you didn't, that
18 just shows that you were here and that you get travel
19 reimbursement. Thank you.
20 DR. COOPER: Thank you, Martha. Any questions
21 for Martha?
22 DR. CONWAY: I just have one on those grants.
23 Maybe I misunderstood. Who -- who would be the audience
24 for the -- for the education?
25 MS. GOHLKE: The -- it can be -- it can be

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2 physicians. It's supposed to be -- I can justify it for
3 anybody who's -- who's giving care to peds. I can
4 justify it. Generally it's been for pre-hospital, but I
5 could justify it for hospital staff as well.
6 DR. CONWAY: The reason I bring it up is my
7 involvement with the P.F.C.C.S. course, which is a two
8 day course --
9 MS. GOHLKE: Uh-huh.
10 DR. CONWAY: -- you know, under the -- the
11 sanction of the Society of Critical Care. We -- we did
12 a few of them in New York City to train hospitalists for
13 surge capacity --
14 MS. GOHLKE: Uh-huh.
15 DR. CONWAY: -- and it's basically for people
16 who don't do critical care on a daily basis, how to
17 really take care of a kid for twenty-four hours, to just
18 set up the ventilator. We do it with simulators and
19 things. I was just wondering if that would be something
20 that would be --.
21 MS. GOHLKE: You know, this is -- I -- I
22 probably could justify that as far as the -- the grant
23 sponsor is concerned. My own feeling about that is
24 there's a lot of money -- money out there for emergency
25 preparedness, and there's not a lot of money for other

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2 training for E.M.S. and hospital staff. And I -- the
3 little money that we have with this grant, you know, the
4 emergency preparedness items I guess I feel like really
5 should -- they have a much bigger purse than we do, you
6 know? I can -- I can talk to you about maybe other ways
7 to fund some sort of a project like that. But I guess
8 I'm kind of sensitive to that because we get so little
9 money, and I'd like to see it go towards other training
10 that emergency preparedness might not cover.
11 DR. CONWAY: Okay.
12 MS. GOHLKE: Yeah.
13 DR. COOPER: Okay. Thank you, Martha, very
14 much for that comprehensive report.
15 We're going to now move into our unfinished
16 business. And as many of you know, a major initiative
17 of this committee for the past really couple of years
18 has been regionalization of critical pediatric care. We
19 do know that the trauma system was regionalized many,
20 many years ago in New York State for children as well as
21 adults, but that's not true for other conditions
22 affecting childhood. And Bob Kanter has been leading a
23 workgroup on regionalization for the last couple of
24 years. Bob's work -- Bob's work and that of his
25 committee culminated about fifteen months ago in a large

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2 statewide E.M.S.C. forum in which many of you
3 participated, at which time our late commissioner,
4 Richard Danes, authorized our going forward with
5 developing the first steps toward regionalization of --
6 of pediatric care. And of course, Bob has ably led that
7 effort.
8 Today, we had an opportunity to meet with some
9 of the senior department folks about -- about where we
10 stand with respect to this issue, and I'll let Bob take
11 it from here.
12 DR. KANTER: Just a word about the history.
13 I -- I actually think the -- the effort goes back about
14 ten years, certainly longer than I've been on this
15 committee. And there've actually been two separate
16 statewide stakeholder meetings where everyone
17 contributing was interested in seeing better definition
18 of pediatric skills, equipment for pre-hospital,
19 emergency, inpatient, as well as critical care phases of
20 care. Interest in identifying hospitals with particular
21 capabilities and interest in identifying criteria for
22 obtaining consultation or transfer of kids who may be
23 too sick or too badly injured for a non-pediatric
24 hospital.
25 So the discussion today was a reaction by

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2 senior Department of Health staff to the draft that we
3 submitted almost a year ago. I think the draft was
4 submitted in November of last year. And the gist of the
5 discussion was a question whether the pediatric
6 regulations, as we finally write them, should be in a
7 separate section dedicated to pediatrics, somewhat akin
8 to the way emergency services, surgical services,
9 anesthesia services are handled in the regulations. And
10 by the way, these regulations are those that describe
11 minimum standards of care, the so called 405 Section of
12 the codes and regulations. Whether they should be in a
13 single section for pediatrics or should be disbursed
14 among the existing regulations in a long document.
15 We -- we spent a good deal of time reviewing the merits
16 of each position, and I think it looks like the
17 Department intends to address these pediatric items
18 disbursed among existing sections, although we continue
19 to point out some advantages of putting them in a
20 separate section. Is that a fair --?
21 The other issue that we discussed at some
22 length was reacting to the draft items that we had
23 submitted. And by the way, many of you here have seen
24 the draft. We -- we circulated it and discussed it
25 extensively about a year ago, and the current reply from

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2 the Health Department has been circulated. Did
3 everybody get that document that you sent around?
4 UNIDENTIFIED FEMALE: No. That's --.
5 DR. KANTER: Okay. Okay. Fine. In any case,
6 it -- it -- it summarizes all the items that we
7 suggested in the draft and proposes in the Department's
8 reply whether to handle each of the items as a
9 regulation or to handle them in a guidance document that
10 doesn't carry the force of regulation, but -- but
11 nevertheless specifies some suggestions of how to handle
12 things. Our conclusion was we continued to -- we will
13 continue to work on identifying those things that should
14 be regulation versus guidance. We will submit our
15 suggestions for those things that we believe are
16 important enough that they should be regulations. Those
17 will be circulated to the members of this committee
18 who -- who want to look at that and give us your
19 suggestions.
20 There was also a general consensus from the
21 Department that it may be time to address in more detail
22 those criteria for pediatric intensive care that ought
23 to be written into regulations, whether it's minimal
24 standards or perhaps an elaboration above minimum
25 standards. We don't have a lot of detail yet on exactly

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2 how or when that's going to proceed, but we also feel
3 that it would be worth putting together some draft items
4 for inclusion in that future discussion. And of course,
5 that would be based not only on our experience, but also
6 on a huge body of existing professional opinion and
7 recommendations. American Academy of Pediatrics,
8 Society of Critical Care Medicine, and other groups have
9 addressed pediatric I.C.U. characteristics at higher or
10 lower levels of accreditation. So those -- those are
11 our assignments for the next couple months.
12 MS. GOHLKE: I just want to add that for the
13 individuals that aren't vetted yet, if you have an
14 interest in participating in ongoing discussion as we
15 develop these documents, we welcome your participation.
16 And we'll -- we'll -- we'll -- you can send me a note
17 that you'd like to be on this working group, and -- and
18 we'll make sure that you're included on it. Okay.
19 DR. COOPER: Yeah. In particular, there's a
20 group that'll -- that -- that will be looking at
21 high-end pediatric emergency department standards. I
22 think George had expressed an interest in that. And
23 Surgey, you may -- you may want to participate in that
24 as well.
25 MR. KUNKOV: If I'm ever vetted.

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2 MS. GOHLKE: Well, you don't have to be.
3 That's my point. If you -- if you want to contribute to
4 it until the process goes through, then you're welcome
5 to.
6 DR. CONWAY: I have a question.
7 DR. KANTER: Sure.
8 DR. CONWAY: Just a comment first. Just to
9 update. We -- the A.A.P. and the S.C.C.M. has been
10 struggling for probably the last four years -- because I
11 had chaired the committee for two of those four years --
12 trying to reissue the statements on the minimum
13 guidelines. Because what's happened, besides having a
14 primary and a secondary unit, now there are tertiary and
15 quaternary units, so it's become very difficult. And
16 that leads to my question, which may be naove, but at
17 the state level, do we have a definition of pediatric
18 age?
19 And I'll give you an example. As a chairman,
20 we go up to twenty-one. We have a bear of a time that
21 all of our adult consultants refuse to see our kids
22 because they quote -- the always say they haven't taken
23 the child abuse course. Whereas the opposite is true, I
24 find a hundred and fifty kids a year under twenty-one
25 who are admitted to various surgical services. So

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2 I'm -- I -- I -- I'm coming into this late, so I was
3 just curious if this discussion has come up. Because
4 the A.A.P., at least everyone I've spoke to -- I sit on
5 the Executive Committee for the Critical Care section --
6 doesn't want to sort of define the age. They leave it
7 kind of vague. And I'm just -- I always find that as a
8 stumbling block, and we've argued for a year. That's
9 why we're having such difficulty updating these
10 documents. So I'm just sharing that with you.
11 MS. GOHLKE: Looking at when we went through
12 the code, there's some different ages in there, but
13 generally it was eighteen and younger for the most part.
14 But it is -- there is some areas where it's left open to
15 interpretation. But you know, the feds -- on the
16 federal side, they've been very clear that it's eighteen
17 and -- or under the age of eighteen. So as far as my
18 grant's concerned, they want all documents really
19 addressed as far as under the age of eighteen for
20 children.
21 On a pre-hospital level, just as a F.Y.I.,
22 you're a child for fourteen and under, right, Tim? Yes.
23 So -- so you know, it varies on the pre-hospital side in
24 New York State and -- and then within the hospital side
25 as well.

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2 DR. CONWAY: Yeah, I -- because one of my
3 colleagues sitting to my left, they go up to age
4 twenty-five, I believe.
5 MR. FOLTIN: Yeah, so in the emergency
6 department, we have put up a new sign that says
7 pediatric and young adult. And that's because of the --
8 where we're located, you know, has gentrified so much
9 that our pediatric population at Bellevue has -- has
10 gone down, and so in order to keep the flow good in all
11 the parts who have gone up in age. However, what we
12 have done with that is that we have educated our
13 hospital to respond to us as part -- when they're over
14 eighteen or over twenty-one, that we'll consult the
15 adult providers. So it's been a matter of just
16 formatting ourselves to that -- that process.
17 DR. COOPER: This has been a vexing issue
18 forever, of course. The position that has historically
19 been taken is that individual facilities are free to
20 make a distinction as they see fit. In the trauma
21 world, for the most part in terms of definition,
22 although not necessarily in terms of -- of action,
23 fifteen or above is considered adult, and fourteen or
24 below is considered pediatric. Why that split? Most
25 kids have completed puberty at that particular point in

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2 time, and that's also the age cutoff that the C.D.C.
3 uses for epidemiologic purposes. It's -- it's -- the
4 next age group is fifteen to twenty-four. And so in
5 terms of, you know, looking at the epidemiology of what
6 we do, that seemed to be a -- you know, a useful cutoff.
7 But in terms of taking patients in one's own facility,
8 really it's -- it's all over the map in terms of what
9 the individual practice patterns may be. And I don't
10 think anybody's going to solve that at least in our
11 lifetimes, but maybe -- maybe someone will someday. Who
12 knows? Okay.
13 Any other questions for Bob? I must say that
14 this has been a really exciting project, and I -- I --
15 you know, Bob has -- has really taken the lead on this
16 as you all know, and he's done really a yeoman's job in
17 terms of getting this whole thing off the ground and
18 organized and -- and writing a whitepaper for the
19 Department that I think raised a lot of eyebrows, got a
20 lot of people thinking about it, and actually led to
21 our -- as I indicated earlier, having a statewide forum
22 which Commissioner Danes authorized our proceeding in
23 developing these pediatric regs. It's been a -- you
24 know, so it's been a real opportunity for us and for
25 those of us who will continue working on this either

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2 with the P.I.C.U. group or the pediatric E.D. group
3 or -- or the pediatric inpatient group. I think this is
4 really a vital legacy that this committee can -- can
5 leave for the children of New York State, so it's really
6 pretty exciting.
7 Speaking of exciting, Sharon Chiumento, many of
8 you know, but some of you do not know of the
9 extraordinary things she does for so many of us in terms
10 of the committee work and so on. And -- and Sharon has
11 taken on the task of completely, in effect, rewriting
12 all the advanced life support protocols for the entire
13 state. You know, some people have scratched their heads
14 and wondered why Sharon would ever take on such a task
15 given all that it entails, but she has done it and done
16 it extraordinarily well.
17 And one little part of that -- of that task
18 that she's taken on involves us looking at the
19 pre-hospital pediatric protocols for New York State.
20 And the SEMAC meeting that was to have been held on
21 September 13th would have been Sharon's moment in the
22 sun to present all the work of the -- the group that
23 looked at the pediatric statewide A.L.S. protocols.
24 Alas, the flooding in the -- in the Schoharie area tied
25 up most of the E.M.S. staff -- E.M.S. state staff so

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2 they were unable to actually staff the meeting of the
3 State Emergency Medical Advisory Committee and -- and
4 State Emergency Medical Services Council, so those
5 meetings were postponed. But that will give Sharon even
6 more time to create an even more perfect document, but
7 I'll let her take it away from this point because I
8 think it's important that we, as a committee, know --
9 know what she and her working group have been up to, so
10 you'll be fully up to speed with where we are with
11 A.L.S. protocols for kids in New York State.
12 MS. CHIUMENTO: Thank you, Art. For those of
13 you who are new to the Committee, many of you probably
14 do not know that the way that E.M.S. through regulations
15 in Article 30 work is that at the B.L.S. levels, basic
16 E.M.T. and the critical -- the certified first
17 responders, they work off of state protocols. The state
18 writes the protocols for the entire state, and if a
19 region wants to make any variation from that, they can
20 request a variation, but there is -- there -- for the
21 most part, everybody is on one page.
22 At the A.L.S. level, however, the law is
23 different. The law says that the state sets a standard,
24 and then the regions write their own protocols based on
25 the state standard. Unfortunately, the last state

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2 standard was written in 1993, so it is extremely
3 outdated. Three quarters of the drugs we now use in the
4 field were not on that document. Some of the things
5 that were on that document are no longer being utilized.
6 So that -- there is -- there is huge discrepancies.
7 What happens is that each region, when they do their own
8 protocols, they then bring it back to the Medical
9 Standards Committee of SEMAC, and then that group then
10 looks at the protocols and says yea or nay. And so I
11 have been on that committee for many years and -- and
12 kind of a person who was the editor type, you know, kind
13 of reads everything in detail and very often would bring
14 back to the regions things that needed to be changed
15 that -- that did not meet H.A. standards or other
16 standards or did not meet state curricula.
17 Some of the things went through anyways because
18 the feeling that was that in certain areas of the state,
19 they needed those particular things. But my concern has
20 always been -- and the reason why I have been doing
21 this -- is because my concern is is that that we have
22 many E.M.S. providers who practice across lines. They
23 may live in one county and volunteer in that county, and
24 then they work in another county and then may even
25 volunteer in a third county. One of the people that I

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2 work with works in three different -- three different
3 regions, and so each of those regions has different
4 protocols. And I think that puts the E.M.S. provider in
5 a huge safety risk because they -- what they may think
6 is right in one county is not in another. They then do
7 it and then could be sued if there's a bad outcome. So
8 you know, there's -- there's a lot of issues, and so I
9 have kind of taken this on as a pet project for the
10 last -- at least five years that I've been working on
11 that.
12 One of the things that I've done that I -- that
13 started this project is I actually went and looked at
14 all the protocols in the state. There are eighteen
15 regions, eighteen sets of protocols, most of which are
16 online. So I was able to go through, and I developed a
17 whole grid of what procedures were done in each region
18 and who could do it. So in some areas, there's a
19 critical care tech that could do it. Other areas, only
20 paramedics could do it. Other areas, E.M.T.
21 intermediates could do it. So I -- I collected all of
22 that information. I then tabulated it and tried to come
23 up with some type of a forum for us to start from.
24 What we found was there was huge variations in who could
25 do what where. For instance, pain medications, there

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2 was about fourteen different pain medications that were
3 being utilized, some by critical care, some by paramedic
4 only, some even by -- by -- by E.M.T. intermediates.
5 And so there's such a huge variation, and we felt that
6 we needed to get some handle on that. So the next step
7 that I went to was that I actually took them and put
8 them all together in a standard of care document. This
9 one, you don't have. This is the one that we worked on
10 all -- over all the summer. We used this as our working
11 document over the summer. So I took and I listed all
12 the things were done any place in the state. The things
13 above the double lines were things that everybody does,
14 and so we felt those were not things that needed to be
15 looked at. Things below the double lines were -- was --
16 there was huge variations across the state, so we felt
17 those were the items that needed to be looked at.
18 In your red folders there, you have a draft New York
19 State A.L.S. standard document -- standards of care
20 document. That document is the -- a revised format of
21 what we worked on over the summer. And basically what
22 we did -- what I did here was that -- well, Art and --
23 and Bob and Tim all worked on this committee with me,
24 and Elise van der Jagt, who's not here. And one of the
25 things is that they -- they -- there was a lot of

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2 asterisk points and things like that, so we actually
3 have divided it out step by step, who can do it, whether
4 it's a regional variation that's accepted, you know,
5 that's in state protocol or -- or in state -- not state
6 protocol, but in state curriculum, or whether there's
7 things that are not.
8 So if you look under pediatric airway
9 management, for instance, you'll see that there's
10 regional variations for the E.M.T.P.C.C. Those are
11 things that are pretty much standard, but who -- whether
12 they need medical control or not varies from place to
13 place. The regional variations for E.M.T.P., same
14 thing, they may -- that's -- it's within their
15 curriculum, but it may not be something that's used --
16 utilized in every single region.
17 Then we get into the next step, which is the
18 E.M.T.C.C. This is the critical care tech. They have
19 much less training than the paramedic, and so there are
20 many things that are not in their curricula. And so
21 these are the things that are being utilized across the
22 state, but they're not in the curricula, so they're not
23 being trained. Up until this point, what they've said
24 is okay, the region can actually do some training
25 locally to cover this -- this particular item. Well,

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2 now I guess some -- some of the legal department's
3 feedback is that we probably should not be doing it that
4 way. So the -- and so all this stuff is going to be
5 looked at. I did it for both the adult and for
6 pediatrics. And then over the summer, I -- there was
7 small a working group that worked on the phone to look
8 at each of the A.L.S. recommendations. So what you have
9 here is the -- is the pediatric recommendations only.
10 The other thing that's in your document is a grid.
11 These are the recommendations, because I couldn't go
12 back and -- and change this yet until it's discussed at
13 SEMAC because we do not have the ability to change these
14 protocol -- these standards here. That has to be
15 changed at SEMAC. We can only make recommendations. So
16 the grid that looks like this has the recommendations
17 that were made through the course of the two phone calls
18 over the summer as to whether or not certain things
19 should be removed totally -- that we don't think that
20 those are safe procedures in kids and they should be
21 removed totally across the board or whether the things
22 where there's doses that there's a huge variation in
23 doses, we recommended some standard doses so that each
24 region would be using the same drug. If they're going
25 to use that drug, they're going to use the same dose so

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2 that this way, much less chance for error.
3 And then there's other things that we made some
4 other suggestions of various kinds about recommending
5 whether or not they have strict medical control, that
6 type of thing. So I won't go through all of this right
7 now unless there's a question about something in
8 particular because it would take quite a while to go
9 through all of this, so I will leave it to all of you to
10 read in your spare time, and you can all, you know,
11 contact me. My address is on your -- the -- also in the
12 red folder here. So you can contact me if you have
13 anything that you feel really very strongly about one
14 way or the other.
15 These will be -- they were supposed to have
16 been brought back to SEMAC last week. Unfortunately,
17 because that meeting was cancelled, I don't know when
18 these are going to get to go back for. They'll be at
19 the next meeting, but we have no set meeting as of yet.
20 So I don't know how soon we will actually be able to
21 move forward with this. The step there will be that
22 they will look at the adult protocols first, and then
23 once they finish that, they will look at the pediatric
24 protocols -- or standards, I should say -- with the
25 E.M.S.C. recommendations. And hopefully, we will then

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2 have quite a bit of input into -- into that particular
3 set of standards.
4 DR. COOPER: For the new members of the
5 committee, as Martha mentioned, we -- we do exist in
6 statute under Article 30(c) of the Public Health Law.
7 And our role is a little bit different from that of our
8 sister councils that the -- the State E.M.S. Council has
9 the right to propose regulations regarding E.M.S.
10 operations and education. The SEMAC, the State
11 Emergency Medical Advisory Committee, has the right to
12 propose advisory guidelines regarding drugs and medical
13 devices. And the -- the STAC or the State Trauma
14 Advisory Committee has the right to propose regulations
15 regarding appropriateness of use standards for trauma
16 centers to the -- what used to be called the State
17 Hospital Review and Planning Council and is now called
18 something else. Lisa will know SHRPC's new name.
19 MS. MCMURDO: The Public Health and -- and
20 Planning Council. The Public Health and Health Planning
21 Council.
22 DR. COOPER: Public Health and Health Planning
23 Council. It's a combination of the old Public Health
24 Council and the State Hospital Review and Planning
25 Council, Public Health and Health Planning Council.

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2 Okay.
3 Our committee, however, has a unique role, and
4 we are, in effect, advisory to the Department, but also
5 advisory to our sister committees. So you know, we
6 basically propose, you know, the pediatric content for
7 each of the tasks that our sister committees are faced
8 with handling. And you know, a recommendation from our
9 committee is generally taken quite seriously and usually
10 adopted pretty much as we -- as we propose it because we
11 are clearly recognized pediatric experts. So I mention
12 that because, of course, we do have some folks like
13 George and Ed and Kathryn who have considerable
14 experience in -- in pediatric pre-hospital care over the
15 years and -- and may want to take a look at the -- you
16 know, and of course, Dr. -- Surgey, I'm --.
17 UNIDENTIFIED FEMALE: Kunkov.
18 DR. COOPER: I'm sorry?
19 UNIDENTIFIED FEMALE: Kunkov.
20 DR. COOPER: Kunkov, yes -- I'm sorry -- also.
21 So you may wish to take a look at these -- at these
22 protocols and get any thoughts that you might have back
23 to Sharon. Fortunately, we have time now because, as
24 she said, we don't know when the next meeting of the
25 SEMAC is going to be. And SEMAC has the right to set

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2 the protocols for the -- or the minimum standard
3 protocols for the state. So we propose to SEMAC, SEMAC
4 adopts formally -- they have to be approved by the state
5 E.M.S. Council, but then they're forwarded to the
6 commissioner, who actually signs off. So if you have
7 any thoughts, please get them to Sharon pretty quick.
8 MS. GOHLKE: I just want to add that the
9 challenge for the -- the newbies here to learn all these
10 acronyms by the next meeting.
11 DR. COOPER: Exactly.
12 MS. GOHLKE: And then another challenge, you
13 know, the impetus for this group was the HRSA E.M.S. for
14 Children grant back in '84. And since then, you know,
15 the deliverables for the grant keep evolving and
16 improving. So one of the challenges -- and I can send
17 this out. I sent it out a long time ago when I first
18 approached you about being on this committee -- is what
19 the deliverables on this grant is. And I think one of
20 the challenges or one of the ways it has evolved is that
21 even though it's in the E.M.S. or pre-hospital
22 perspective or usually the unit of the Health
23 Department, the deliverables cross over into the
24 hospital environment because we have to -- about the
25 standardization of care of children for medical

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2 emergencies and for traumatic injuries in the hospital.
3 So it's been a challenge, so to speak, coming from the
4 E.M.S. side of the world and Health Department to make
5 that bridge to that other silo in the Health Department
6 of the hospital services.
7 It's been a good -- it's actually been a good
8 thing. It's been very challenging, but it's been a good
9 thing that the deliverables have this cross reference,
10 for obvious reasons. But that's why you have E.M.S.
11 providers here and hospital providers here because we
12 have both of those types of deliverables here. But
13 that's just to give you a little bit of background.
14 But we are in statute, and that's a good thing. So we
15 are taken more seriously, obviously, on a state level
16 than just a federal grant that's a hundred and thirty
17 thousand dollars, which is a drop in the bucket to the
18 state. But so -- so headway has been made over the
19 years to -- to cross bridges, I guess.
20 MR. FOLTIN: We shouldn't underestimate,
21 though, how wonderful it is that that grant has allowed
22 New York State to continuously have an E.M.S.C. presence
23 because we have done so much work, and it's been so
24 effective. What you were talking about with --
25 obviously, we all agree that it should be a seamless

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2 ride from the field to the -- to the hospital. I was
3 fortunate enough to be on the Institute of Medicine
4 committee, which was the future of emergency health care
5 in America, and that was one of the things that they
6 recommended -- that we recommended was that there needed
7 to be more communication. A lot of stuff was dropped
8 between these different levels, so I'm -- I'm happy to
9 hear that.
10 Now I know in New York City -- the way New York
11 City E.M.S. works is they're allowed to get outcome data
12 from hospitals to do their Q.I. Is that a state reg or
13 is that a city?
14 UNIDENTIFIED FEMALE: Is it a state?
15 MR. FOLTIN: Because that's one way -- so
16 that's -- because that's one way to do it is to get
17 the -- and it's much harder out of New York City,
18 obviously, because New York City has this very large
19 standing E.M.S. agency that's its own entity. It's in
20 the Fire Department, but they -- you know, it's a
21 hundred percent professional. And so they -- they have
22 a large group for that. If we were to say to the
23 upstate E.M.S. --
24 MS. GOHLKE: Uh-huh.
25 MR. FOLTIN: -- agencies to do this Q.I.,

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2 they'd say well, where are we going to get the --
3 MS. GOHLKE: Right.
4 MR. FOLTIN: -- the funding from? So it might
5 be an idea maybe to have a partnership between the
6 hospitals and E.M.S. to do some kind of cross Q.I.
7 MS. GOHLKE: Absolutely.
8 DR. COOPER: I think that's a terrific project
9 for us to look at as we move toward the future. Okay.
10 Any further questions for Sharon or discussion about the
11 A.L.S. protocols? Tim?
12 MR. CZAPRANSKI: Just briefly, Sharon, if you
13 could put the version date on the bottom of the latest
14 versions, it would be helpful because we've gone through
15 many iterations. And just as a point of fact, the next
16 council meetings are scheduled for January 24th and
17 25th, barring having one sooner than that.
18 DR. COOPER: Great, Tim. Thank you.
19 Okay. Now we move on to Linda Tripoli and an
20 update on the status of pediatric trauma centers in New
21 York State, although it is primarily a New York City
22 issue at the present time. That said, there are plans
23 to move this -- this -- this whole process to upstate
24 and the island. So Linda, please take it away.
25 MS. TRIPOLI: Hi. It's a pleasure to be here

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2 this afternoon. I'm going to give you just an overview.
3 For some, it's a rehash of what you've already known.
4 For me, it's a reaffirmation of what my program did.
5 I've only been in the position a month. Some of this,
6 I've certainly been actively involved in. Other
7 information is anecdotal for me.
8 In March of 2009, at the direction of the STAC,
9 the Department sent letters to all seventeen trauma
10 centers serving New York City only, asking whether they
11 considered themselves to be a pediatric trauma center.
12 Eleven responded they were. One center, Jamaica
13 Hospital, subsequently advised the Department it was
14 withdrawing its pediatric trauma center standing. The
15 remaining ten centers were sent a paper survey to assess
16 their compliance with 708 guidelines which regulate
17 trauma care, and I've included that in your packet --
18 what the survey that was compiled by members of the STAC
19 created.
20 In the interim, the chair of the New York City
21 Regional Emergency Medical Advisory Committee, the
22 REMAC, was advised in writing of the centers that were
23 and were not pediatric trauma centers as a result of
24 that initial survey. Following receipt of the ten
25 completed surveys, a review was conducted by the Systems

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2 Committee of the STAC. And I have included a grid in
3 your packet as well that gives you the results of those
4 centers that were identified to have some level of
5 deficiencies.
6 Three centers were found to have -- what were
7 felt to be severe deficiencies. And severe deficiencies
8 were defined as either not having a pediatric trauma
9 surgeon as director of their service or in not having a
10 PICU. In those three instances, the facilities were
11 advised in writing of their deficiencies and were
12 advised that they had to submit a plan of correction
13 within thirty days with complete resolution of the
14 problem within six months.
15 Five centers were found to have what was felt
16 to be lesser deficiencies, defined as either not having
17 PALS certifications or not having transfer agreements.
18 And in those circumstances, they were also issued a
19 letter advising them to submit a plan of correction
20 within thirty days, with complete resolution of the
21 problem within twelve months.
22 As you can see from the grid, we have received
23 all plans of correction. We do have one center whose
24 plan of correction was not accepted. They do not have a
25 pediatric trauma surgeon as director of their trauma

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2 service, nor do they have the intent to at this point in
3 time. They did have transfer agreements, and they said
4 they did have a PICU. However, the transfer agreements
5 clearly indicated that their PICU was not capable of
6 caring for critically ill children. They were sent a
7 letter advising them that they did not meet 708
8 guidelines to be considered a pediatric trauma center.
9 They certainly could continue to serve as such, but they
10 had to meet the requirements. And -- and they were also
11 were advised that New York -- New York City REMAC would
12 be advised of the change in their standing. To date --
13 so this was Lincoln Medical Center that was taken off
14 the list.
15 Our next steps, we have canvassed upstate
16 hospitals asking the same question. Did they consider
17 themselves capable of handling pediatric trauma
18 patients? And I've also included a listing which now
19 includes upstate. As it currently stands, those
20 institutions that said yes, they did consider themselves
21 as such. And the plan, which has to be voted on at the
22 next STAC, is to now send out paper surveys to those
23 institutions as well. Another step that the STAC had
24 requested is to request SPARCS data to see where
25 critically ill pediatric patients in New York State are

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2 actually receiving care. Any questions?
3 MS. BASS: Just to add a point of
4 clarification.
5 MS. TRIPOLI: Certainly.
6 UNIDENTIFIED MALE: Please.
7 MS. GOHLKE: Yeah. And that -- that would be
8 the case. Yeah.
9 MS. BASS: And then we have services -- we have
10 agreements and arrangements with P.C.M.C. for
11 neonatologists --
12 MS. GOHLKE: Right. Oh. It should say, yeah,
13 "pediatric only." Thank you.
14 MS. TRIPOLI: Thank you.
15 DR. COOPER: Thank you for that clarification.
16 DR. CONWAY: Just one point of correction, just
17 on the first -- on the facility list, the second
18 hospital, it's -- Cohen's Children at LIJ is the new
19 name.
20 DR. COOPER: Yeah, Steven and Alexandra Cohen
21 Medical Center for Children, I believe.
22 DR. CONWAY: I have a question. As far as the
23 transfer agreements, is there a definition of what needs
24 to be in there? Of course, I don't want to take up the
25 committee's time with something I could just look at.

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2 DR. COOPER: Actually, there is no specific
3 definition of what has to be in the transfer agreement.
4 MS. GOHLKE: It's state code, but as far as the
5 feds are concerned, yes, there is. And that would be
6 going into our guidance document that we're going to be
7 developing of recommendations for what should be
8 involved in that transfer document.
9 DR. COOPER: What the state code says is
10 that -- is that --
11 MS. GOHLKE: You just have to have one.
12 DR. COOPER: -- you have to -- right.
13 DR. CONWAY: It has to be written with another
14 institution? And then that --.
15 MS. GOHLKE: Yes.
16 DR. CONWAY: Do you have to show -- the other
17 institution has to show that they meet all the
18 requirements? If I sign up with hospital B that my
19 children would go there, then hospital B is responsible?
20 MS. GOHLKE: It just says you have to have --
21 the language is that you have to have a transfer
22 agreement, yes.
23 MS. TRIPOLI: And interestingly, to your
24 question, most transfer agreements said that in the
25 event that a child needs such and such a service, we

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2 have a transfer agreement and there are signatures. In
3 Lincoln -- Lincoln's case, their transfer agreement
4 clearly spelled out the children that they would keep
5 and the children that they would transfer out. The
6 children their PICU would keep was comprised of a
7 paragraph. The children they would transfer out was
8 pages defining really -- that was the one and only
9 transfer agreement I've really ever seen in all my days
10 in the Health Department that spelled it out so
11 specifically.
12 UNIDENTIFIED MALE: I'm sorry. And you have to
13 list the specific institution they were sent to?
14 MS. TRIPOLI: Yes.
15 MR. FOLTIN: They could send to more than one
16 institution, though, right?
17 MS. GOHLKE: Uh-huh.
18 MS. TRIPOLI: Yes.
19 MR. FOLTIN: Yeah, okay.
20 MS. GOHLKE: And just as another F.Y.I., this
21 is one of the deliverables on this grant that the state
22 has a system for traumatic injuries treating children,
23 and that there's -- it's either regionalized or
24 standardized. They use both words in there. And we did
25 meet the fed's definition for that deliverable on the

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2 grant a few years back before they -- they put a number
3 to it. When they put a number to it a few years ago,
4 they said that twenty-five percent of the hospitals had
5 to be pediatric trauma centers in order to meet the --
6 the grant deliverable. We don't have -- twenty-five
7 percent of our hospitals are not pediatric trauma
8 centers. So according to the new definition in the
9 grant, the performance measure, we don't meet it. And
10 that's one of the arguments from the larger states like
11 California, Texas, and all of us that twenty-five
12 percent's ridiculous when you're talking about a state
13 this size. And we've yet to get good feedback from the
14 feds on that about whether or not they might change or
15 revise that percentage of hospitals. But I've asked for
16 clarification. I actually had to write up supporting
17 documentation about whether or not we still meet that
18 deliverable on the grant due to the fact that they've
19 added that twenty-five percent.
20 MR. FOLTIN: A couple of things. It's
21 interesting about what you're saying because if you want
22 to do good regionalization training --
23 MS. GOHLKE: Right.
24 MR. FOLTIN: -- planning, we usually find in
25 many places there's too many centers doing something.

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2 MS. GOHLKE: Right.
3 MR. FOLTIN: So we want it to be based on
4 population and geography. So I'm wondering whether you
5 serve twenty-five percent of the children with this set
6 up.
7 MS. GOHLKE: Well, this -- this is where I'm
8 going to bump it to Dr. Foltin and Dr. Cooper, who are
9 involved at the federal E.M.S.C. level, to give this
10 feedback to them and you know, see if they can get them
11 to change this percentage. That's why it's Greek that
12 you guys are involved here at the state level.
13 DR. COOPER: No comment at this particular
14 point in time. The -- no, the E.M.S.C. stakeholder
15 group has not met in about eighteen months, so there has
16 not been an opportunity to provide formal comment to the
17 federal program.
18 DR. BASS: Can you clarify for me? I'm -- I'm
19 looking at a list in this folder, and it looks like half
20 of the centers --.
21 MS. TRIPOLI: That's -- on first blush, that's
22 what we have from upstate. We've confirmed for New York
23 City through the survey process who is and who is not
24 serving as pediatric trauma centers. We have not
25 touched upstate yet except to get feedback from them

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2 asking whether they feel they're pediatric trauma
3 capable.
4 DR. BASS: Outside of New York City.
5 MS. GOHLKE: Are you talking self-designated or
6 state recognized? There's a difference. So this is
7 state recognized, okay, as far as they meet the 708
8 regulations for a trauma center. So as Linda said, we
9 recently tried to reaffirm people's initial commitment
10 when they signed up to be put on our website as a
11 pediatric trauma center. "Do you still, in fact, meet
12 the 708 regs?" And we actually lost, probably, I want
13 to say eight or ten institutions when they went back
14 through and looked at the regs again and said no, we
15 actually don't meet it. So as a result, we've -- we've
16 sent them letters saying basically you don't meet it,
17 and now we're going to tell ambulances not to deliver
18 their pediatric trauma patients to your facility. Does
19 that clarify anything?
20 DR. BASS: It does.
21 MS. GOHLKE: Okay. Of total hospitals in all
22 of New York State, not just -- these are just recognized
23 trauma centers, whether they're level ones or level
24 twos. Yeah. Yes.
25 UNIDENTIFIED MALE: Two hundred and fifty some

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2 odd --.
3 MS. GOHLKE: Well, there's about a hundred and
4 ninety-nine now. We keep going down. Actually, it's a
5 little less than that. Well, with an E.D. With an
6 E.D., okay? So that's the -- actually, it's less than
7 one ninety-nine. That's the last time I wanted to
8 count, but it keeps going down. It's probably in the
9 low one nineties now.
10 DR. COOPER: Lisa, do you know the number of
11 hospitals we have?
12 MS. MCMURDO: I thought it was in the two
13 hundreds you know, it's been going down.
14 DR. COOPER: Interesting.
15 MS. GOHLKE: A few years ago, the last count I
16 had -- the last time I had to do the supporting
17 documentation, so that was in -- three years ago, I
18 guess it was. We had two hundred and five. And now a
19 year or so ago, we were down to one ninety-nine. We've
20 gone down since then.
21 MS. BRILLHART: Yeah. There's more hospitals.
22 MS. GOHLKE: Right, right. Correct.
23 MS. BRILLHART: And so you're doing the --
24 MS. GOHLKE: E.D.
25 MS. BRILLHART: -- the twenty-five percent of

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2 E.D.'s.
3 MS. GOHLKE: E.D.'s, right.
4 DR. FOLTIN: Twenty-five percent of the E.D.'s
5 are supposed to accept level one trauma -- pediatric
6 trauma patients?
7 MS. GOHLKE: To be recognized by the state as a
8 pediatric trauma center.
9 DR. FOLTIN: That doesn't seem -- it seems --
10 it just seems odd that any group of planners would sit
11 down and come up with that number.
12 UNIDENTIFIED FEMALE: Level one or anybody?
13 MS. GOHLKE: Any level. Any level. They're
14 recognized within the pediatric trauma system and the
15 state level.
16 DR. BASS: How many levels?
17 MS. GOHLKE: Currently two.
18 DR. COOPER: This is a very complicated issue.
19 I'll give you what I believe to be the short version.
20 The -- the history of the trauma system in New
21 York State goes back in to the early 1980s when New York
22 City created a trauma system with one level of trauma
23 center, which was a general trauma center that handled
24 all comers. Building off that experience, the state
25 decided to designate trauma centers in 1989. And that

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2 same year, efforts were made to develop additional
3 pediatric standards for trauma centers, both in the city
4 and the state.
5 The -- the -- the climate at the time among
6 adult trauma providers and most hospitals and hospital
7 associations was that it would be too confusing to try
8 to separate adults and pediatric trauma care, so an
9 additional set of regs was developed at the city and
10 state level, which basically said if you are going to
11 receive pediatric trauma patients, you have to meet the
12 following additional requirements. Those regulations
13 were enacted in -- in -- in the summer of 1990, and the
14 first trauma centers were designated as adult -- adult
15 and pediatric or pediatric only in March of 1991.
16 Beginning with the creation of the -- or the enactment
17 of Article 30(b) of the Public Health Law, which
18 established a trauma system in New York State in --
19 in -- in law as opposed to merely regulation, the -- the
20 STAC, as I indicated, was given the responsibility to
21 develop what are called appropriateness of use standards
22 for trauma centers, which, in effect, are -- are trauma
23 center standards. And there's been a group that's been
24 meeting for the last few years to work these out. And
25 at the last meeting of the STAC, the group voted to move

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2 those regs forward or to recommend to the Department
3 that those regs be moved forward or those draft regs be
4 moved forward. They do contain quite a bit more in the
5 way of what you might think of as -- as level one or
6 level two A.S.C. equivalent types of standards for
7 pediatric trauma centers. So it -- it is possible that
8 the size of this pediatric list will decrease, you know,
9 once those regs make it through the process.
10 But this has been, you know, a system in
11 evolution, you know, for some time. And everyone sort
12 of looks at us and raises their eyebrows and thinks
13 we're crazy here in New York State, but the fact is that
14 we have one of the lowest pediatric injury -- injury
15 mortality rates of any state in the nation. It -- it --
16 it averages around twenty pediatric deaths per hundred
17 thousand pediatric population for pediatric injury
18 mortality nationwide. New York State consistently comes
19 in around eleven, which is quite a bit lower than almost
20 any other state.
21 So while our system isn't perfect and is in a
22 state of evolution, something is happening here in New
23 York State that isn't so bad. So it's our hope that
24 these changes in the regulations that the STAC voted to
25 recommend to the Department that it move forward will

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2 now move forward with at least some deliberate speed,
3 and we can -- we can, you know, have a set of
4 regulations that is much more contemporaneous and
5 reflects the -- you know, the reality of the times.
6 In terms of the actual, if you will, structure of
7 pediatric trauma centers in -- in New York State, most
8 of the trauma centers at the big upstate academic
9 medical centers easily meet A.C.S. level one standards
10 in terms of volume and in terms of the breadth of
11 their -- their capabilities. And of course, A.S.C.
12 defines a children's hospital really as either a
13 freestanding children's hospital, a separate pavilion,
14 or a children's hospital within a hospital. So you
15 don't have to actually have a separate building to be
16 considered a children's hospital under the A.C.S.
17 guidelines. So -- but the -- the new regulations, when
18 they move forward, will look very, very much like the
19 A.C.S. standards in terms of their content.
20 DR. BASS: I'm just curious about the
21 timetable.
22 DR. COOPER: You know, I -- I think we're all
23 curious about that timetable, and it's -- at this point,
24 it's -- I think it's kind of in the Department's -- the
25 ball's in the Department's court as to, you know,

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2 whether it wants to move this -- move them forward.
3 MS. GOHLKE: We're trying not to scare Linda
4 away, remember?
5 DR. COOPER: Yeah, I know. I -- I think --
6 I -- I -- I think that they -- they can -- the budget
7 crisis here in New York State deflected the Health
8 Department's attention from many, many, many things, and
9 the -- I think the trauma center standards were one of
10 them. We last got a good look at them probably about
11 fifteen months ago. And -- but -- but people were
12 reasonably happy with them at that point in terms of the
13 level one and level two adult standards and the
14 pediatric trauma center standards. What they were stuck
15 on was whether there might be a level three, perhaps
16 even level four, and discussions were -- or beginning on
17 that, but I think at this point, the -- the thought is
18 just to move forward with the -- the one, two, and the
19 peds standards. And -- you know, and if we want to
20 revisit the three and four, that can be done.
21 MS. GOHLKE: And we're happy to say that
22 Linda's got the backbone and the thick skin for this
23 job, and she's thrilled, right?
24 MS. TRIPOLI: I'm thrilled.
25 DR. COOPER: Okay. Moving right along. Yeah?

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2 Oh, do people want to take a break or you just
3 want to keep going? Okay. Let's take five minutes.
4 (Off the record)
5 DR. COOPER: We are now going to move on to new
6 business. Elise van der Jagt, who is not with us today
7 because he is attending a meeting of the Heart
8 Association Subcommittee on Pediatric Resuscitation,
9 and -- which is very sad for us, of course, because
10 Elise is a -- you know, such a thoughtful and involved
11 and dedicated member of our group. And I just mentioned
12 his name in that way because it was Elise who suggested
13 that we bring to your attention the National Quality
14 Forum Regionalized Emergency Care Framework. I had the
15 honor to serve on this -- on this group.
16 The National Quality Forum is an interesting
17 organization. It's really gotten going just in the last
18 five to ten years. And they're in the business of, if
19 you will, developing -- or not developing, but endorsing
20 metrics for the -- the measurement of quality in a
21 variety of health related disciplines and processes.
22 The -- their process is also a very interesting one.
23 They begin by performing what is known as an
24 environmental scan, which ends up as a document on their
25 website, which basically looks at all the quality

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2 metrics that are scanned regarding a particular subject
3 at a -- at a given point in time. And based upon
4 that -- that -- that document, they form a steering
5 committee whose job it is to vet a framework document,
6 which really looks at the direction in which metrics
7 should go in the future. Thank you. I think Ed noted
8 that my eyes were drifting from time to time during the
9 meeting because of my operative activities last evening.
10 The -- the -- the -- the -- the framework for the
11 Regionalized Emergency Medical Care Systems program,
12 however, took a little bit of a departure from the --
13 the recent past in the N.Q.F. history. Typically, the
14 framework document prepared by N.Q.F. actually really
15 looks at specific metrics as they relate to specific
16 quality of care standards regarding individual patients.
17 What they did for this particular document was looked
18 sort of more globally, a thirty thousand foot view, if
19 you will, of -- of the kinds of metrics that -- that
20 might be developed as opposed to, you know, looking at
21 specific metrics for processes of care in individual
22 patients, looking more at the kinds of metrics that
23 might be developed looking at an entire system rather
24 than individual outcome quality metrics for individual
25 patients. It's a much more theoretical document than

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2 documents that it's produced in the past.
3 But as you can see from the abbreviated handout
4 in your packet, the -- the focus of the document is to
5 follow a patient through an episode of care,
6 quote/unquote, from beginning to end with respect not to
7 the patient himself or herself, but the system supports
8 necessary to get the patient through that episode. I
9 don't want to say a whole lot more about it because if
10 you haven't read it, it won't make a whole lot of sense.
11 But I do very strongly urge you to visit the -- the --
12 the N.Q.F. website. Or failing that, just check your
13 own e-mail from Martha Gohlke from a few days ago
14 because Martha mailed out the latest draft of the -- of
15 this document. Yes, a few days ago. Yeah, that's
16 right.
17 So it's a very interesting document, and I just
18 commend it to you for your -- your -- your reading
19 because as folks who are concerned with emergency
20 medical services, particularly as they relate to
21 children, you know, it -- it's interesting to see how,
22 you know, system thinkers are approaching the whole
23 problem of emergency medical services systems. This
24 project was funded by Health and Human Services or
25 the -- you know, the N.Q.F. received money from Health

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2 and Human Services to put the framework together. And
3 the way the process works is after the steering
4 committee is formed, they look at a very preliminary
5 draft of the framework. They then go through one or two
6 rounds of additional comments on the framework before it
7 goes out for public comment. And then based upon the
8 public comment and comment from members of the steering
9 committee, it goes through one final review by the
10 committee before it goes to the members of the National
11 Quality Forum for endorsement.
12 The members of the National Quality Forum are
13 basically very large organizations or groups of
14 organizations that -- you know, that have an interest in
15 quality patient care. But for those of you who have
16 been following the quality movement, the National
17 Quality Forum is kind of where it's at. They are sort
18 of setting the tone and the -- and the direction for
19 how -- how quality metrics are going to be applied
20 throughout the healthcare system. C.M.S. pays intense
21 attention to what is going on at the N.Q.F. So for all
22 those reasons, it's worth looking at this document.
23 A final -- final vote is going to be held probably by
24 the end of October, at which time the -- the -- the
25 document will either get thumbs up or thumbs down by the

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2 N.Q.F. membership. No one expects that it will get
3 anything but a thumbs up at this particular point. And
4 the final document will have -- will be -- will probably
5 have been approved by the end of November or -- or you
6 know, officially approved by the end of November. And
7 then see where it goes.
8 The -- again, N.Q.F. does not itself develop
9 metrics, but it -- it either endorses metrics that have
10 been developed by others or it suggests directions for
11 the development of metrics, and that's what this
12 particular document has done with respect to the systems
13 components of care. So I'll stop there. I kind of
14 rambled on a little bit longer than I hoped to about
15 that, but it is -- it -- it's important for us all to
16 know about this and understand what's going on in this
17 larger world. So take a -- take a few moments and --
18 and read it if you have the opportunity. Questions?
19 Okay.
20 Well, we now have from Bob Kanter an emergency
21 preparedness activities update. And Bob had the
22 opportunity to study the integration of pediatric
23 disaster services into regional systems of care in -- in
24 Tuscaloosa earlier this year. As you may remember, we
25 discussed the New York City experience with our

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2 pediatric disaster coalition in -- in June. And while
3 this is not quite on as large a scale, obviously, as
4 what took place in New York City, I think you'll find
5 very interesting some of the parallels between what took
6 place there and is taking place in New York City. And
7 we hope at least in part with the assistance of this
8 committee, it will take place throughout upstate New
9 York. Thank you, Bob, please.
10 DR. KANTER: Thanks, Art. So many of us have
11 an interest in disaster preparedness, public health
12 emergency preparedness for children. And for those of
13 us who have any role in it, whether it's as decision
14 makers for an organization or as leaders or as
15 researchers, we all have this uncomfortable feeling that
16 a lot of our work is a little abstract. It's a little
17 theoretical. It's even speculative some of these
18 disasters, stuff happens, you know? And in every single
19 disaster, you know, something new happens that I've
20 never heard of before, you know? Some -- some strange
21 little quirk that, you know, usually works, but didn't,
22 you know?
23 But you know, it's -- it's -- it just
24 completely underscores, not to mention, you know, our
25 recent experiences here in New York State with the

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2 flooding and upstate and the torrential rains in New
3 York and the need to evacuate. We have to be much
4 better prepared than we really are. I was particularly
5 struck at hearing Bob's talk about, you know, how
6 everyone seemed to kind of come together even though
7 there wasn't a lot of prior training or experience in
8 dealing with disasters. And I was also struck by the
9 fact that the E.M.S. providers that shipped the kids
10 from Tuscaloosa to Birmingham did so without a single,
11 you know, untoward event.
12 As many of you -- many of you may know that Bob
13 is like one of the leading world gurus in -- in bad
14 stuff that happens in ambulances. He's studied --
15 he's -- he's -- he's -- he's studied that as one of --
16 he's now into disasters, but that was a huge theme of
17 his previous academic life. And you know, to see that
18 this kind of experience took place, you know, one
19 wonders, you know, what could be done, you know, to
20 better support ambulance providers in disasters. And
21 you know, Martha's heard me talk about this before, but
22 you know -- you know, we've had a really successful run
23 with our ambulance cars, you know what I mean? The --
24 we did the resuscitation card, and we did the children's
25 special healthcare needs card. It might be interesting,

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2 particularly given the -- the recent need, if in a
3 future project, Martha right now, of course, you know,
4 if we put together an ambulance card for, you know,
5 basic disaster preparedness for some of our -- some of
6 our ambulances, because I don't know if that would be --
7 you know, for pediatric ambulance preparedness. I don't
8 know if that would be worthwhile. But I just, you know,
9 throw that out there as an idea that somebody might want
10 to, you know, think about in the future.
11 MS. GOHLKE: Are you writing this up?
12 DR. KANTER: Huh?
13 MS. GOHLKE: Are you writing it up?
14 DR. COOPER: Yes. Yeah, and submit it to
15 pediatrics.
16 DR. KANTER: Really?
17 DR. COOPER: Yeah.
18 MS. MOLLOY: You know, Art --
19 DR. COOPER: Yeah?
20 MS. MOLLOY: -- one of the things was yes, the
21 schools were closed, so that changed the dynamic. But
22 as you were saying, if those children were housed in
23 those school buildings, that could be a whole another
24 picture. So in New York State, we have these, you know,
25 fifteen minute drills because of the roof collapsing in

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2 on a building somewhere, you know, so usually the --
3 the -- the day before Thanksgiving, at least on Long
4 Island, we have a fifteen minute early dismissal drill,
5 and it's the most ludicrous exercise because it's
6 preplanned. Everybody knows it. It's the way the day
7 goes. It's every year.
8 So in my particular building, we do actually
9 try to do a mock disaster evacuation of our building to
10 our site. Every year, we redo our disaster -- but it's
11 still got to be a fluid plan that can change all the
12 time. So then Martha mentioned that little grant, and
13 it could be used for something. I was talking --
14 talking to Dr. Kunkov, who has already left, about how
15 nice it would be if there was a small grant or some
16 program that took the kind of skills that the ambulance
17 providers do have for, you know, because they are --
18 they are -- I have over six hundred and twenty young
19 people in my care and my whole school community. And --
20 and so if something truly happens, really, I might be
21 the one with all those supplies people are looking at.
22 And it's been a while since I've been in the hospital.
23 So we were thinking that it might be nice to
24 try to make a program where there was a refresher or
25 shared skills that could cross over in a -- in a

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2 disaster for the body of people that we have in the
3 community, like school nurses, to seamlessly interface
4 with the E.M.S. providers that will be coming.
5 MS. GOHLKE: Plus, you may also be a shelter.
6 MS. MOLLOY: Yes, exactly. And that's the
7 other thing they forget to talk about is I can tell
8 you -- I would think people would be talking to me as --
9 as a leader in my professional position about that
10 emergency planning and what's in a pod and what's there
11 and what's going to be coming to my school. They don't.
12 I had one Red Cross person from Nassau County -- I'm
13 Suffolk County -- come and speak to me at one point to
14 talk about planning and stuff like that. And not even
15 in his county because he just was able to find me. And
16 so that's a disconnect, too, because we do need the
17 people who are going to be called upon to be in the know
18 and to be part of the plan. So I think that could be
19 something, you know, to consider for -- to enhance the
20 response.
21 DR. COOPER: Any other questions for Bob?
22 Okay. Well, I guess that's takes us up to our last two
23 items on the agenda which are the SEMAC report and the
24 STAC report. There is no SEMAC report. And STAC, the
25 STAC report will be very brief. The -- the main issue

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2 that was discussed at STAC was whether the STAC wished
3 to advise the Department to adopt the American College
4 of Surgeons system for verification, i.e., onsite
5 reviews or whether it wished to continue to pursue its
6 own system. And about two thirds, I would think, felt
7 that it would be most appropriate at this time, since so
8 much work had already gone into the continuation of the
9 New York State system, to continue to do that.
10 There were -- there was significant discussion
11 in and around this issue. There were a lot of cross
12 issues involved on both sides. A lot of arguments made
13 on both sides, but in the end, you know, the -- the --
14 the direction that people took was to move the -- or to
15 advise the Department to -- to move the New York State
16 regs forward and develop some kind of system, or -- or
17 at least explore developing some kind of internal
18 verification system within the state whereby the --
19 perhaps, you know, visit each other's centers and so on
20 and that sort of thing. And that's kind of under
21 discussion at the present time.
22 The other major issue -- and Linda and Martha,
23 you can correct me if I'm wrong about this. But the --
24 the contract with the School of Public Health is ending.
25 The School of Public Health had previously been

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2 responsible for accepting and cleaning all the data from
3 the -- the -- from the submissions of case records from
4 all the various trauma hospitals in New York State, you
5 know, in -- in effect, to -- to sustain the New York
6 State trauma registry. And with the contract with this
7 web-based stuff that Martha was discussing earlier, the
8 move is to -- on the part of the Department is to move
9 into a much more real-time kind of system where data can
10 be uploaded much more promptly, you know, into a
11 web-based system. That hasn't happened yet with respect
12 to the trauma component. It's not entirely clear when
13 that's going to happen, is my understanding. Although I
14 gather that you're making moves to have that happen
15 relatively soon.
16 There will no doubt be, you know, growing pains
17 involved as that -- as that switch is made, but ideally,
18 without any question, it ought to be a lot easier for
19 the trauma centers to directly upload their data into --
20 you know, into a web-based system. The issue, of
21 course, is going to be one of cleaning the data. I
22 don't think that's an issue that's been solved yet,
23 although I know that discussions are ongoing as to how
24 that might be accomplished.
25 And the final issue has to do with -- in that

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2 regard has to do with the production of, you know,
3 trauma periodic reports. Who will actually analyze that
4 data? And the School of Public Health, which, you know,
5 has taken on that task ever since the beginnings of the
6 trauma registries some eighteen years ago may have the
7 opportunity, as may others, to actually develop and
8 produce those reports in the future. That has not been
9 decided. To my knowledge, there is no R.F.P. at this
10 particular point. So we just don't know.
11 That having been said, Dr. Hannan, who leads
12 the Department of Health Policy and Management at the
13 School of Public Health in Albany, and who has always
14 been the principal investigator on the -- the Department
15 contract, you know, with the School of Public Health,
16 did produce a -- in effect, a verbal and PowerPoint
17 draft of the 2007 through 2009 data as it has been
18 submitted to the Department thus far, which would
19 represent the final report that's been filed under the
20 quote/unquote old system. Hospital specific data will
21 be available in that final report, but was not presented
22 to the STAC two weeks ago.
23 So in short, the trauma system is in a good
24 deal of flux at this particular point. There are --
25 there are, you know, I think several major issues that

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2 are outstanding at this point, which we're all hoping
3 maybe we'll have something by next month.
4 UNIDENTIFIED FEMALE: Next week.
5 DR. COOPER: Next week. But -- but -- but you
6 know, it is a time of change. And -- and you know, we
7 all recognize that you know that times do change, and we
8 have entered a new age in terms of, you know, data
9 collection and submission. And -- and you know, it --
10 it doesn't make sense to really utilize a -- you know --
11 you know, a merely -- a merely paper-based system in an
12 electronic age. And -- and you know, I think most of us
13 recognize that fact.
14 At the same time, we're all deeply concerned
15 that the baby might get thrown out with the bathwater,
16 you know, because we have, you know, in New York State
17 set the gold standard in terms of risk adjusted
18 mortality outcome analysis, and that is something we do
19 not want to lose. So I think that pretty much sums up
20 the key issues that were discussed at the STAC meeting.
21 Would you agree Linda? Okay.
22 So that will conclude the STAC report. So any
23 questions regarding that? Okay. Hearing, none, it is
24 four o'clock or very nearly four o'clock. It's four oh
25 one. Are there any new issues people want to bring

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2 before the group before we say sayonara until December
3 6th? Hearing none, I wish you all a very pleasant trip
4 home. And no doubt, we'll be in touch through Martha
5 if -- if no other way. And once again, we're very, very
6 happy to have so many new faces among us, and -- and we
7 look forward to an extremely productive next few years.
8 So thank you all so much for coming, and we will see you
9 on December 6th.
10 (The meeting concluded at 4:01 p.m.)
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2 STATE OF NEW YORK
I, Howard Hubbard, do hereby certify that
3 the foregoing was reported by me, in the cause, at the
time and place,, as stated in the caption hereto, at
4 Page 1 hereof; that the foregoing typewritten
transcription pages 1 through 82, is a true record of
5 all proceedings had at the hearing.
IN WITNESS WHEREOF, I have hereunto
6 subscribed my name, this the 30th day of September,
2011.
7

8 _____
Howard Hubbard, Reporter

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