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2 NEW YORK STATE DEPARTMENT OF HEALTH

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EMERGENCY MEDICAL SERVICES FOR CHILDREN
6 ADVISORY COMMITTEE MEETING

7

DATE: June 12, 2012
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1 EMSC - 6-12-12 - Conference Call

2 IN ATTENDANCE:
Sharon Chiumento
3 Rita Molloy
Sarah Sperry
4 Debra Sottalano
Surgey Kunkov, M.D.
5 Arthur Cooper, M.D.
Linda Tripoli.
6 Lee Burns
Sandra Haff
7 Martha Gohlke
Lisa McMurdo
8 Jan Rogers
Elise van der Jagt, M.D.
9 Robert Kanter, M.D.
Pam Lawrence
10 Danielle LaRaque, M.D.

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1 EMSC - 6-12-12 - Conference Call
2 CHAIRMAN COOPER: You didn't miss a lot. Don't
3 worry about it. It was just sort of, Bobby, it was just
4 sort of, you know, table talk about, you know, getting
5 this to the Codes Committee and getting a draft buffed
6 up by, you know -- you know, soon, okay.
7 DR. KANTER: All right.
8 MS. GOHLKE: Actually, one thing that you --
9 that you did miss is that since we don't have -- we got
10 to start the other meeting at this point. If you have
11 any additional comments on the rest -- rest of the
12 document.
13 DR. KANTER: Yes.
14 MS. GOHLKE: If you can get them to us
15 sooner -- as soon as possible, that would be good.
16 DR. KANTER: Well, I -- I do have one. And if
17 you want to do it another time, we can do that.
18 MS. GOHLKE: Yeah. I don't know who else is on
19 the line at this point and I'd like to --
20 MS. BURNS: I think we're all on the line and
21 some people from, you know, the rest of the Committee as
22 well, Martha.
23 MS. GOHLKE: Right. So --.
24 MS. BURNS: All those who were on before are
25 still on.

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2 MS. GOHLKE: If you just hold on to it, Dr.
3 Kanter, and do it later.
4 DR. KANTER: Okay.
5 CHAIRMAN COOPER: Bob and Deb? Who else?
6 MS. CHIUMENTO: Sharon.
7 CHAIRMAN COOPER: Hey, Sharon.
8 MR. MOLLOY: Rita.
9 CHAIRMAN COOPER: Hey, Rita.
10 MR. MOLLOY: Hi.
11 MS. SARA: Sara's here, too.
12 CHAIRMAN COOPER: Who?
13 MS. SARA: Sara, from Injury.
14 CHAIRMAN COOPER: I'm sorry, Sara. Thank you.
15 MS. SARA: That's okay.
16 DR. KUNKOV: And -- and Sergey Kunkov is here
17 from -- doctor from Stony Brook.
18 CHAIRMAN COOPER: Oh, great. Great. Welcome.
19 DR. KUNKOV: Thank you.
20 MS. GOHLKE: We'll just give a couple minutes
21 for other people to join us.
22 DR. KANTER: Can -- can I -- Dr. Cooper, I
23 agree with you. I think that we -- we want to start low
24 for folks like, you know, E.M.T.s, paramedics or someone
25 who may wish to join.

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2 MS. ROGERS: Good morning.
3 MS. GOHLKE: Hi, who's that?
4 MS. ROGERS: This is Jan Rogers.
5 MS. GOHLKE: Hi, Jan, it's Martha.
6 CHAIRMAN COOPER: Hey, Jan. Jan --
7 MS. ROGERS: Hi.
8 CHAIRMAN COOPER: -- are you --? Okay. It's
9 ten-thirty-five. We wanted to give people five minutes
10 to sort of, you know, join on. So let's ask Martha to
11 do a quick roll call here. Here in Albany, we have me.
12 This is Art Cooper and, of course, to my immediate left
13 is Martha Gohlke. We have -- also have with us Lee
14 Burns, Director of the Bureau. Linda Tripoli, Trauma
15 Program Manager and Sandy Haff, our regulatory guru
16 from -- from Bureau of Hospital Services. That's who's
17 in the room. And Martha would -- would you just call
18 the attendance of people --.
19 MS. GOHLKE: And Lisa McMurdo's here, too.
20 CHAIRMAN COOPER: Oh, Lisa's here, too.
21 Excellent. Okay.
22 MS. GOHLKE: Sharon Chiumento, Rita Molloy --.
23 UNKNOWN SPEAKER: Hello, Alexandria. Hello.
24 MS. GOHLKE: Hi. Lisa's on the line. Deb
25 Sotolotto's (phonetic spelling) on the line. Dr.

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2 Kunkov's on the line. And Jan --
3 DR. KANTER: Bob Kanter is.
4 MS. GOHLKE: Bob Kanter. Thank you. And Jan
5 Rogers. And anyone else I didn't catch?
6 MS. LAWRENCE: And I'm here, Martha.
7 MS. GOHLKE: I'm sorry, who's that?
8 MS. LAWRENCE: Pam Lawrence.
9 MS. GOHLKE: Oh, hi Pam.
10 MS. LAWRENCE: Hi.
11 CHAIRMAN COOPER: Hey, Pam.
12 MS. BURNS: Hey, Pam.
13 DR. LaROCK: Hi, this is Danielle. I joined as
14 well.
15 CHAIRMAN COOPER: Hi, Danielle.
16 MS. GOHLKE: LaRock. Dr. LaRock.
17 DR. LaROCK: Yes.
18 MS. GOHLKE: Okay.
19 CHAIRMAN COOPER: Okay. Well, welcome
20 everyone. Very briefly, as you know, we have relatively
21 few items on the agenda this time. So we felt that it
22 made sense to save everyone a -- a trip and save the
23 State a little bit of money. Lee is smiling. So, we're
24 briefly going to hear from Lee in terms of a Bureau
25 report. Martha's then going to tell us about the E.M.S.

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2 for Children Grant report. We're then going to have an
3 update from myself and Bob on the 405 Codes issues, as
4 well as the task force on Life and the Law with Respect
5 to Pediatric Ventilators. And then we're going to speak
6 a little bit about an age-old problem. Who is a
7 pediatric patient. Because SEMAC has recently chosen to
8 get -- wade in these waters. And we'll talk a little
9 bit about the National Pediatric Readiness Survey and
10 before getting updates from our sister committees,
11 SEMSCO, SEMA and STAC. I -- I don't think any of this
12 is going to take a terribly long time. We -- we're
13 scheduled from ten-thirty to twelve-thirty, but we may
14 not need anywhere near that amount of time. So, Lee,
15 please take it away. And if anyone joins into -- to the
16 call along the way, please identify yourself so we can
17 make sure that you're properly recognized in the, you
18 know, in the minutes.
19 MS. CHIUMENTO: Somebody joined while you were
20 speaking.
21 CHAIRMAN COOPER: Did someone join -- who
22 joined while I was speaking? And someone else just
23 joined. Hello?
24 MS. GOHLKE: Anybody new on the line?
25 CHAIRMAN COOPER: We have Sharon, Rita --

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2 MS. GOHLKE: Sara.
3 CHAIRMAN COOPER: -- Sara, Deb Sotolotto, Bob
4 Kanter, myself, Linda, Lee, Sandy, Martha, Lisa, Jan,
5 Elise --
6 MS. GOHLKE: Dr. Kunkov.
7 CHAIRMAN COOPER: -- Dr. Kunkov, Pam Lawrence
8 and Danielle LaRock. Anybody else? Okay. All right.
9 Lee, go -- go for it.
10 MS. BURNS: Just in case you did not know, the
11 Bureau and the Division and many -- and the Hospital
12 Services people have relocated to a lovely spot in
13 Albany. Actually, just outside of downtown. 875
14 Central Ave. So the move actually occurred on May 22nd.
15 We're still working out some infrastructure and
16 logistical issues. Our current crisis is our -- our --
17 our fax number is not up and running. So we -- we've
18 conjoined with the Division and we're using a singular
19 fax number. We're working with the -- the phone people
20 to get that straightened out and we're wondering whether
21 that'll ever get straightened out. However, we are in
22 flux and we -- we're living in a -- a canyon of file
23 cabinets with a little bit of chaos. So we're in the
24 process of getting organized and -- although Martha's
25 pretty well organized. But, generally speaking, if you

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2 need something, give us -- give us a little patience.
3 We should be in a dead run by the summer. I smiled when
4 Art was talking about not traveling because of, you
5 know, saving the State a couple of bucks. The travel
6 reimbursement process, statewide, has -- has changed.
7 The State has instituted something it calls the
8 Statewide Fiscal System. The acronyms -- we have
9 assigned other things to. It's very, very difficult.
10 The Department staff are having, you know, some
11 technical challenges with it. But part of that is that
12 the Bureau has to -- has had to completely change its
13 re -- its reimbursement process for the council members.
14 You all are -- are one committee of four. We have about
15 a hundred and twenty council members. Actually, Art
16 represents many seats, so there's a few left. But,
17 we -- we're in the process of working with our council
18 ops and the fiscal people to get that process up and
19 running and it's -- it's card-based and every time we
20 ask questions, no one seems to have the answers. So,
21 for myself, just because I am me, I would not identify
22 anybody to be -- in my Bureau to be the holder of those
23 cards until somebody could explain to me what it was
24 that they do. And then they threatened me. So right
25 now one of our clerks is the holder of the council net

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2 cards. I hate to use the word credit. So, we're in the
3 process of getting all that straightened out so that by
4 the next time you do actually have to travel, we will
5 have a method for reimbursing you. On the, you know,
6 just to share the misery, though, all of us are on the
7 same system and not very many people have seen money.
8 You have gotten a check, have you not?
9 MS. GOHLKE: No.
10 MS. BURNS: No? Okay. Staff -- we've had some
11 staff changes. Jim Soto, our long-time Associate
12 Director for Prepared -- E.M.S. Preparedness left the
13 Bureau after being with us for twenty-five years. He
14 took a position with State Emergency Management and he
15 is the Regional Director in the Easter Hudson Valley
16 Region, so Poughkeepsie. We do have -- we do have
17 contact with him, luckily, because he packed his boxes
18 before he left and we're still unearthing tons and tons
19 of stuff. Just to let you know -- and we're -- we
20 thought things were going too smoothly, but it is our
21 lot in life. In collaboration with the SEMSCO, the
22 Department is in the process of updating all of its
23 E.M.S. education curricula to be in line with the
24 national E.M.S. education guidelines. And with the
25 exception of our E.M.T. critical care or E.M.T.T --

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2 E.M.T.C.C. level, most of our training programs will be
3 longer in terms of training hours. Some of you may be
4 familiar with the national guidelines. It's a -- it's
5 actually a better curricula than it has been in probably
6 the last fifteen to twenty years. It reverts back to a
7 great deal of assessment-based treating, which the
8 current curricula or the 1994 curricula was not
9 assessment-based, particularly. So, one of -- among the
10 things we're working on in order to get up and running,
11 updating the practical skills and written examinations,
12 which is not only a didactic issue, but also a
13 contractual one. We're in the process of examination
14 our E.M.S. training money and reallocating it so that we
15 can better fund longer training programs. We're
16 developing transition training programs for both C.M.E.
17 and conventional E.M.T., all levels of E.M.T. refresher
18 courses. And, thanks to our office website expert, the
19 transitional information is up on the website and the --
20 the development process continues so that our training
21 course sponsors have access to both resources from
22 publishers, from experts and they can plan accordingly.
23 So that's -- that's a big project. We were surprised
24 when the State Council came to the conclusion with it
25 that we really weren't hearing a lot of push back. Now

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2 we're hearing push back. And it's not really
3 educational push back, as much as it is dollars. The --
4 the courses sponsors are hanging on by a thread at our
5 current funding rate at our current class levels and
6 they -- and we have a very fixed pool of money. So
7 we're -- we're -- we're just beginning the process to
8 work with the Department and State Council to really
9 examine how we fund our training programs given,
10 basically, the -- the pool of funds we have now. In
11 May, Martha dragged me kicking and screaming to the
12 National E.M.S. for Children meeting that was coupled
13 with the National State E.M.S. Officers gathering.
14 The -- not that you as the Pediatric Committee care all
15 that much, but the Feds have turned over the
16 construction of ambulance standards to the National
17 Fire -- whatever they are -- N.F.P.A. --
18 CHAIRMAN COOPER: N.F.P.A. -- National Fire
19 Protection Association.
20 MS. BURNS: -- Protection Association. It is
21 not without a huge amount of controversy. The -- the
22 new design has a potential to cost -- to cause an
23 ambu -- a new ambulance to cost between eight and twenty
24 thousand dollars more than the current very expensive
25 ambulances on the road. New York has been pretty silent

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2 with regard to the N.F.P.A. standards. One of -- we
3 have a New Yorker is rep -- represents us, such as it
4 is, on one of the sub-committees. But, what I've asked
5 the State E.M.S. Council to do is put together a -- a
6 tag to really look -- examine the standards and do a
7 couple things. One is determine what the effect of the
8 new standard will have on New York State from a
9 regulatory and policy perspective. And also look at how
10 best to educate our pre-hospital agencies so that they
11 really know what they're walking into. Because twenty
12 thousand dollars is a huge amount of money right now or
13 ever. The other thing we had endless conversations
14 about were medication shortages. Much to my surprise,
15 New York State is oddly ahead of the curve in terms of
16 dealing with pre-hospital medication shortages. The --
17 the Department, with a group of SEMAC docs, have a
18 process for looking at alternatives to the short
19 medications and a streamline process for approving them
20 to get them trained and on the road. So that's worked
21 out very, very well. And no, you know, actually, thanks
22 entirely to this tag and Andy Johnson and a couple of
23 really smart pharmacists. The other thing that we did
24 in New York, and we did it by accident, I say it's
25 because we're not very bright and that's a advantage,

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2 but many of the states are having controlled substance
3 license issues and cost issues. And in working with our
4 Bureau of Narcotics Enforcement, we decided that what
5 harm would it be to expand the pre-hospital license so
6 that it accurately could address appropriate licensure
7 for these medication alterations. So pre-hospital
8 licenses now actually have four schedules listed on
9 them. We don't -- we didn't charge for that. Who knew?
10 We don't tell the Governor. The other thing is that
11 they -- the -- NHTSA has contracted with ASEP to develop
12 a strategy and guidance document for E.M.S. on the
13 culture of safety which our State can --.
14 UNKNOWN SPEAKER: We lost them again. I'll get
15 a -- I'll get their secretary to call them back again.
16 Hold on, everybody. Hi, they're going over to notify
17 them. So, hopefully, just a few minutes, guys.
18 MS. GOHLKE: Okay, sorry. We lost you. My
19 fault. Is everybody still there? All right. At least
20 we caught it before we went too far.
21 CHAIRMAN COOPER: Okay. So -- so what was the
22 last thing you guys heard from us?
23 MS. BURNS: Did you hear the ASEP part?
24 UNKNOWN SPEAKER: You were talking about the
25 nar -- what we've been doing with the narcotics and how

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2 we're ahead of the curve.
3 MS. BURNS: Yeah, the -- anyway, the last --
4 the last thing with regard to that is ASEP -- ASEP has a
5 contract with the National Highway Traffic Safety
6 Administration -- NHTSA -- to develop a strategy and
7 guidance document for E.M.S. on the culture of safety,
8 which I think, you know, Sharon would enjoy that mostly.
9 So that's kind of interesting. Two other -- we -- just
10 for your own infor -- ah, you don't care. I'm sitting
11 next to Linda Tripoli, who is our Trauma Coordinator.
12 And we, as you -- we probably told you -- and this may
13 be repetitive from your last meeting -- made the
14 decision to move trauma -- trauma hospitals to the
15 American College of Surgeons' Committee on Trauma
16 Verification Process. And so we've -- we've notified
17 the hospitals. We've received an -- a surprisingly
18 positive response to it and every time I answer the
19 phone I'm waiting for someone to yell at me and they --
20 they just haven't -- haven't.
21 CHAIRMAN COOPER: You might call it a
22 surprisingly resigned response to it.
23 MS. BURNS: Well, no. I -- I -- I -- I guess
24 I -- on the more -- on the glass half empty side of
25 things, yeah. Although, in talking with the people I've

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2 talked to, they don't seem resigned. They seem
3 interested. So many of the hospitals have reached out
4 to schedule their consultative visits. We've asked them
5 to give us a timeline to be where -- you know, what they
6 think it will take them. We're working with the STAC to
7 work on deadlines and that kind of stuff. So we'll keep
8 you posted if you're out of the loop locally. But if --
9 from my perspective, it's been amazingly interesting.
10 I'm sure, you know, Linda's still able to breathe, sit
11 up and take nourishment. So it hasn't killed her yet.
12 But it might.
13 MS. TRIPOLI: It might.
14 MS. BURNS: She -- she managed and I'm afraid
15 to really look at the details of this, but they're --
16 the college is conducting training in the next -- next
17 week.
18 MS. TRIPOLI: Friday? It's this Friday?
19 MS. BURNS: Yeah. In Syracuse on -- on the --
20 the verification process. And many, many of the
21 hospitals are going to Syracuse. Some of them were not
22 really not sure where Syracuse is until this point.
23 So --. And the last is that, just to let you know, I
24 actually am appointed as the Dir -- Bureau Director
25 of -- of E.M.S. So --

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2 UNKNOWN SPEAKER: Congratulations.
3 MS. TRIPOLI: Yay.
4 MS. BURNS: -- you're stuck with me for real,
5 in case you didn't figure that out before. So that's my
6 report, Doctor Chairman.
7 CHAIRMAN COOPER: That's comes with a massive
8 increase in salary, correct?
9 MS. BURNS: Oh, yeah, massive.
10 CHAIRMAN COOPER: That's what I thought.
11 MS. GOHLKE: And although she's been doing the
12 job for two and a half years --
13 MS. BURNS: Right.
14 MS. GOHLKE: -- she got retroactive pay of one
15 week. And I'm serious. That's not a joke.
16 MS. BURNS: Actually, and I -- and one of the
17 women -- the woman that takes care of this in our office
18 looked at me and said, and if you think you can get new
19 business cards, think again. I have not gotten business
20 cards yet. Valerie, she -- no new business cards. So
21 Linda and I don't have business cards.
22 CHAIRMAN COOPER: Ah, you just give us the
23 business, right?
24 MS. BURNS: Yeah, who needs cards for that?
25 CHAIRMAN COOPER: Precisely. All right.

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2 Moving right along. Thank you. Thank you, Lee. Any
3 questions for Lee? Hearing none, Martha.
4 MS. GOHLKE: Okay. So, as Lee mentioned, I
5 dragged her down to my annual meeting that the E.M.S.
6 for Children folks have. That includes funding for
7 P-CARN (phonetic spelling) and targeted issue grantees
8 as well.
9 MS. BURNS: It is now a flat, Martha, by the
10 way.
11 MS. GOHLKE: Anyways, so I brought this up the
12 last meeting they had. They asked me to speak -- a
13 number of grantees to speak about what they're doing in
14 their states with -- in regards to the performance
15 measures and they asked me to speak on what we're doing
16 with the minimum standards for hospitals in regards to
17 pediatrics and the guidance document. So, you know,
18 every state handles it a little differently and the
19 reason that the Feds wanted me to speak is because
20 nobody's done in their minimum standards for hospitals
21 like we're doing it here in New York. So they wanted me
22 to present that little twist to the nation. So they got
23 to hear from me on that. I also recently heard back
24 from -- I have to, you know, give documentation every
25 few years on the performance measures. I mean, every

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2 year, I do. But every other year they -- they want more
3 than the regular report. But, so we -- we just got word
4 back. I submitted the doc -- documentation in September
5 and I just heard a couple days ago that we've now met
6 five of the eight performance measures of the grant in
7 four and a half years. So we're moving right along.
8 And, of course, they're developing new ones for states
9 like ourselves that are completing all performance
10 measures. One of which is the big one, which is the
11 pediatric hospitals, which, like I said, we're doing
12 through the codes and the guidance document. But we --
13 and so that's -- that's a big one. And that's going to
14 be awhile before we meet that one. But we're moving
15 right along in New York State. So -- and I will give a
16 more formal presentation on the performance measures and
17 what it is that we have to meet and -- and our status at
18 our next meeting when we meet in person, which we need
19 to talk about dates and set them.
20 CHAIRMAN COOPER: Yeah. I think we're in
21 pretty good shape, though, with respect to moving along
22 toward the pediatric regionalization piece. You know,
23 it's --
24 MS. GOHLKE: We are.
25 CHAIRMAN COOPER: -- as we'll -- as we'll hear

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2 a little bit later.
3 MS. GOHLKE: Yup. So, let's see. Money --
4 money. Every year I mention this about this time.
5 There is -- with the other grants that the Bureau gets
6 frees up a little bit of money on the E.M.S. for
7 Children grant. It's about twenty thousand dollars each
8 year. And we're going to have about that amount this
9 year, as well. I bring it to the Committee every year
10 to ask for suggestions in how we can utilize those
11 funds. And, generally, every year what I do is I -- I
12 offer it to the regions and the hospitals to do
13 pediatric training for providers. And that's,
14 generally, how it's been utilized in the past. But,
15 again, I'm letting the Committee know. So if there is
16 ideas on how to utilize these funds, you know, we should
17 talk about it, if we want to do something other than the
18 pediatric provider training statewide. We have to
19 expend the funds by the end of February 2013. So we
20 have to decide soon and get the information out there or
21 just -- you know, figure what we want to do with the
22 funds, if we want to do something different this year.
23 One of the things that we are using some of the funds
24 for is to pay for this A.C.S. verification of trauma
25 centered trainings that Linda's setting up. I've

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2 offered some of the grant funds to do that, since it
3 does meet our grant performance measures of trauma
4 centers for pediatrics. So some of the -- a small
5 portion of the funds -- the trainings aren't that
6 expensive -- are going towards funding that. The -- I
7 just want to briefly mention the other grant that I
8 normally do at this time, the -- our Electronic Records
9 grant for lack of a better term. You know, we're making
10 our pre-hospital reporting -- well, it is electronic.
11 It's been electronic, but we're just changing the
12 repository where we collect that electronic information.
13 And that's what that grant has been utilized for the
14 last several years. This is the last year of the grant.
15 We tried to apply for a new -- new funding, but they
16 turned us down. But this -- it's starting to -- we're
17 actually starting to get our data into this new
18 repository statewide. We haven't gotten New York City
19 submitting quite yet. But they're -- they're working
20 towards it. And, of course, they're the bulk of our --
21 of our pre-hospital calls. But we do have another --
22 the other vendors up and running, putting their data
23 into this repository. And one of the recent uses, for
24 example, that is so great about this new online
25 repository of data is that a region can look up the

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2 medications that are being used in real -- real time.
3 And if there's a shortage in their area, they can say,
4 well, we really need to make sure we can cover this
5 shortage or we're not really using that medication in
6 our region, so we don't really need to worry about that
7 shortage in their area. So it's a great -- we've gotten
8 good positive feedback from our providers in our regions
9 in New York State saying they can access the date, they
10 can look quickly to see, for example, what medications
11 are being used in their region and they're able to bring
12 that to their REMACs and apply that information to care
13 to the patient. So it's -- it's turning out to be a
14 positive system after all these years of work. So
15 that's moving along. And just the other piece of this
16 is we're still working diligently on our new data
17 repository for our trauma registry. And we've hit a
18 couple bumps in the road, but we are, like I said, very
19 diligent and working out those problems and trying to
20 get that repository up and running for our trauma
21 centers. But that's pretty much all I know. We do need
22 to talk about dates for next year. We're working with
23 the contract with the hotel and the contract with the
24 same hotel in Troy -- the Hilton Garden. I'd like to
25 have a September meeting at the Hilton Garden -- an

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2 in-person meeting. We normally have it in September and
3 then we normally have one in the beginning of December.
4 We're still required by the grant and our statute to
5 meet four times a year. Neither the grant or the
6 statute stipulates whether or not it -- it needs to be
7 in person or electronic. So, my proposal is that we
8 have an in-person meeting in September and then we do an
9 electronic meeting early in December just because with
10 the holidays everybody has a real hard time getting the
11 time to travel. But I'd like to keep -- normally we do
12 a September meeting, a December meeting, then a March
13 meeting and then a June meeting. And I'm -- what I want
14 to ask the group is Tuesdays -- are Tuesdays still a
15 good day for me to look forward to get dates with? I've
16 kind of -- yeah, I can't necessarily choose the date
17 with the hotel, but I can at least give them a day of
18 the week that we want to work with. So I guess I'd like
19 to hear if Tuesdays are -- are an issue now. They have
20 been okay for several -- ever since I've been on board
21 you folks have liked Tuesdays.
22 OTHER MEMBERS: Fine to meet on Tuesdays.
23 MS. GOHLKE: That you meet on Tuesdays. Okay.
24 MS. ROGERS: Now, SEMSCO was pushed to -- to
25 October.

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2 MS. GOHLKE: Uh-huh. Yeah.
3 MS. ROGERS: Is it because they needed two
4 days?
5 MS. GOHLKE: I think it's because they're down
6 to three meetings a year.
7 MS. ROGERS: No, no. It had to do with
8 availability.
9 MS. TRIPOLI: Yeah, it did. Because Yom Kippur
10 was available and then it was October.
11 MS. GOHLKE: Okay. Well, so the bottom line is
12 I'll still shoot for Tuesdays and I'm going to work out
13 the dates in the near future and I will push them out to
14 the Committee e-mail and you can let me know if there's
15 conflicts, you know, national meetings that you need to
16 go to or something else that I didn't consider when
17 picking a date. And I'll get those dates to you as soon
18 possible so you can block your calendars. And that's it
19 for me.
20 CHAIRMAN COOPER: Okay. Any questions for
21 Martha? We're hearing none. We're up to unfinished
22 business, otherwise known as old business. And just to
23 give a very brief update on the 405 Hospital Codes
24 issue, we had the pleasure and great fortune of meeting
25 this morning -- great good fortune of meeting this

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2 morning with Departmental staff prior to our meeting.
3 Ruth Leslie was here from O.H.S.M. Lisa, of course, is
4 here from O.H.S.M. -- Lisa McMurdo. Sandy Haff from
5 Bureau of Hospital Services, and we had a -- an
6 individual from the Division of Legal Affairs on --
7 online with us as well. And we had the opportunity to
8 go over the latest draft of the -- of -- of the minimum
9 standards for pediatric care that are being prepared for
10 presentation to the -- I'm sorry, Lisa, I can't do
11 this -- State Hospital Review and Planning Council
12 successor --
13 MS. MCMURDO: Yes.
14 CHAIRMAN COOPER: -- it's Public Health and
15 Health Policy. Is that right?
16 MS. MCMURDO: Public Health and Health Planning
17 ---
18 CHAIRMAN COOPER: -- Public Health and Health
19 Planning Council. Okay.
20 MS. MCMURDO: PHHPC is the new acronym.
21 CHAIRMAN COOPER: PIP --
22 MS. MCMURDO: PHHPC --
23 CHAIRMAN COOPER: -- PHHPC --
24 MS. MCMURDO: -- like Philadelphia.
25 CHAIRMAN COOPER: -- PHHPC like Philadelphia.

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2 Public Health and Health Planning Council. Sorry, I've
3 got SHRPC on the brain.
4 MS. MCMURDO: Yes.
5 CHAIRMAN COOPER: Anyway -- anyway, we're
6 actually looking at a date for the Codes Committee of
7 the PHHPC on July 26 of this year. Isn't that
8 incredible? And so we -- we -- we spent quite a bit of
9 time this morning focusing mostly on the pediatric
10 intensive care regs and I think we came to some pretty
11 solid agreements. Most of the -- of the agreements, I
12 think, were -- were pretty straightforward in terms of
13 having quality improvement program and, you know,
14 appropriate medical oversight of transfers in and
15 ability to provide, you know, direct medical control to
16 outside physicians and E.M.S. personnel so on and so on.
17 The controversial issues from last time, as many of you
18 may recall, were the -- some of the volume issues and --
19 and staffing issues. And we did come to conceptual
20 agreement that in -- in -- in accordance with the
21 currently existing scientific literature, we would
22 support a minimum annual admission volume of two hundred
23 per year. That we would support a minimum of two R.N.s,
24 no matter how many admissions you had. And a ratio -- a
25 minimum ratio of one to two critical care nurses per

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2 patient, depending upon the size of the -- of the unit.
3 And we supported Board certification in appropriate
4 disciplines for the -- the -- the Director of the unit
5 at this point. And so I think those were the major
6 issues that -- that we were -- that we -- that were
7 still open for discussion. I think we got most of
8 them -- we got all of them accomplished this morning and
9 I -- I think it was an incredibly productive meeting and
10 really want to thank Sandy and Lisa for, you know, Ruth
11 of course, and -- and Holly from the D.L.A. for
12 supporting this process. Bob, do you have anything to
13 add at this point to that?
14 DR. KANTER: No, I think you got it.
15 CHAIRMAN COOPER: Sandy?
16 MS. HAFF: No.
17 CHAIRMAN COOPER: Okay.
18 MS. HAFF: It's going to be on discussion for
19 July 26th.
20 CHAIRMAN COOPER: Okay. All right. Very good.
21 MS. MCMURDO: Well, we did discuss whether the
22 Committee would want to do a letter in support.
23 CHAIRMAN COOPER: Oh, yes. Of -- oh, yes. Oh,
24 thank you, Lisa.
25 MS. MCMURDO: And --

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2 CHAIRMAN COOPER: Yes.
3 MS. MCMURDO: -- you know, they probably would
4 want to see the draft.
5 CHAIRMAN COOPER: Yes. So, what we will do in
6 this regard is we will, once we get this draft
7 finalized, okay, we will prepare a letter in support.
8 We'll send the draft and the letter around well in
9 advance. We have to -- we have to get it out well in
10 advance for the Codes Committee of the PHHPC as well.
11 So we'll get this out to you so you can take a look at
12 it and make sure that, you know, you're okay with --
13 with what we're sending forward.
14 DR. VAN DER JAGT: Hey, Art?
15 CHAIRMAN COOPER: Yes, Elise.
16 DR. VAN DER JAGT: I just -- I just want to
17 make sure I heard this correctly. Did I hear correctly
18 you just said one to two R.N.s critical care nurses per
19 patient or did you mean to say one to two patients per
20 nurse?
21 CHAIRMAN COOPER: A nursing ratio of one to two
22 nurses -- sorry, one to two patients per nurse. Thank
23 you very much, Elise.
24 DR. VAN DER JAGT: Yup, thank you.
25 CHAIRMAN COOPER: Yeah. I -- I think it's only

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2 in Rochester where it's two patients -- two nurses per
3 patient, Elise.
4 DR. VAN DER JAGT: Well, as long as we have one
5 nurse per patient. But I thought you probably meant the
6 other, so.
7 CHAIRMAN COOPER: Okay. All right. So, any --
8 any questions about that? I can't give you specific
9 dates to be looking at your e-mail because the draft
10 isn't quite finalized yet. But -- but it'll -- but
11 it'll be soon. That I can tell you. Okay. Bob, would
12 you like to give an update on the -- on the taskforce on
13 Life and the Law?
14 DR. KANTER: Yeah. This is a taskforce that's
15 been meeting for quite some time trying to write a set
16 of guidelines for disaster management of very large
17 surges of patients when the needs greatly outnumber the
18 existing resources and where some efforts would -- might
19 need to be made to make difficult triage allocation
20 choices, otherwise known as rationing choices in
21 deciding who gets treatment when there is not enough
22 critical care treatment to go around. Now, everyone --
23 everyone gets at least palliative care treatment under
24 any circumstances -- comfort care and such. But when
25 you don't have enough ventilators, specifically, to go

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2 around, who would be the priority group for selecting
3 for treatment and -- and who would not. This is all
4 still a work in progress. The -- the general approach
5 is to say at some point in a -- in a disaster -- in a
6 public health emergency, not a normal every day ordinary
7 surge situations but, you know, when -- when your
8 hospitals may be ten percent over capacity. That would
9 be normal standards of care -- conventional standards of
10 care would pertain then. But in a true massive public
11 health emergency, usually with some declaration of
12 emergency status at a -- at a high public health
13 decision-maker level with a -- with a true massive
14 emergency status, rules would apply -- would -- would
15 shift -- goals would shift in which you'd be aiming to
16 improve population outcomes rather than maximizing the
17 outcome likelihood for every individual patient. And
18 included in that would be trying to identify or define
19 criteria for which patients are likely to benefit from
20 intensive care, from a ventilator, with a relatively
21 limited period of time on the ventilator. Those would
22 be the patients selected as high priority to get
23 ventilator treatment. Since all of the details are a
24 work in progress, I'm not sure -- unless, Art, if you
25 want to go into more detail, we could -- but suffice it

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2 to say this is an attempt to write some
3 pediatric-specific guidance that would build upon the
4 foundation of the very good guidance that they've
5 already done for adults and published several years ago.
6 And that was -- Tia Powell was the lead author on that
7 report and -- and this is trying to build on that
8 foundation.
9 CHAIRMAN COOPER: Okay. Thank you, Bob. Any
10 questions for Bob? Hearing none, we will move forward.
11 I think Bob did mention that that group is going to be
12 meeting again on July 17th and we are hoping that that
13 will be the last meeting but it may not be. The
14 discussions that have been held so far have been quite
15 provocative and, you know, not -- in a good way and, you
16 know, and have led to more questions than answers, hence
17 the need for additional meetings. But we will let you
18 know when we know more. Moving on to new business.
19 A -- an issue that arose at the -- at the last SEMAC
20 meeting, raised by one of our emergency medicine
21 colleagues, regarded the age of pediatric patients. The
22 SEMAC wanted to make all pediatric protocols in effect
23 end at about eight years of age. Because the Heart
24 Association resuscitation protocols, you know, basically
25 begin at about eight years of age to treat -- to treat

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2 children according to adult resuscitation protocols.
3 Sharon and I were at that meeting and I don't believe
4 that either of us thought that that was a particularly
5 wise idea. But the -- the -- the -- at the Medical
6 Standards Committee of -- of SEMAC, the -- the group did
7 vote to have the pediatric protocol or the -- the
8 statewide A.L.S. protocols apply -- adult protocols
9 apply to patients eight years of age and above.
10 MS. CHIUMENTO: Can't --.
11 CHAIRMAN COOPER: Now -- hang on -- that --
12 that vote did not go forward at the SEMAC. When -- when
13 that -- when that vote went forward at the SEMAC, the --
14 the vote was -- did -- didn't explicitly mention an age.
15 It just spoke about -- about the -- the -- the pediatric
16 A.L.S. protocols. So, you know, I had argued pretty
17 strenuously at -- at the meeting that we needed to get
18 the E.M.S.C. Advisory Committee's input as to what the
19 appropriate age to, you know, begin and end pediatric
20 protocols should be. So, that's -- that's my take on
21 it. Sharon, I -- I think you had a comment to make.
22 MS. CHIUMENTO: Yes. I didn't think it was age
23 eight. I thought it was that they were going -- they
24 wanted to use the same guidelines as we use for the
25 resuscitation, which is basically the onset of puberty.

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2 That was my recollection.
3 MS. ROGERS: Physiological findings.
4 CHAIRMAN COOPER: Okay. You know, as -- as --
5 it -- that was not entirely clear to me because, as we
6 all know, some of the resuscitation protocols begin to
7 speak about, you know, about -- about age -- about age
8 eight, but for the sake of the argument, let's go with
9 onset of puberty which, as we all know, in -- in -- in
10 this day and age, you know, is getting down to, you
11 know, close to eight years of age, you know, in some of
12 our larger children. But -- but -- but the point is
13 that I think in the past we have -- we have made the
14 argument that -- that the pediatric protocol should
15 probably apply to kids in the peri-pubertal age range,
16 as opposed to, you know, the -- just the -- just the
17 kids, you know, that -- prior to the onset of puberty.
18 You know, I -- I think that we all know that there's
19 pretty good, you know, anatomic physiologic reason for
20 doing that. There's also a concern on the part of some
21 of the officials in the State Health Department that,
22 you know, that if -- that if E.M.T.s and paramedics are
23 basing their decisions on whether someone, you know, has
24 the start of puberty or not that, you know, that there
25 might be sort of at least an invitation for some

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2 individuals to inappropriately exam children for signs
3 of, you know, of -- you know, of sexual, you know,
4 maturation. And, in fact, the -- the Chief Medical
5 Officer of the Health Department for the Western Region
6 has already had to field a few calls on, you know, from,
7 you know, complaining individuals on that very issue.
8 And I think his presence at the meeting actually was
9 part of what allowed the -- the vote to go forward with
10 a little bit less specificity on the age than the
11 Medical Standards Group adopted. But I'm interested in
12 what others think about this and what, perhaps, we
13 should recommend to SEMAC regarding a -- an age cutoff
14 for -- for -- for pediatric protocols.
15 DR. VAN DER JAGT: Art, I have some --
16 DR. HALPERT: Quick question for Elise. Elise
17 is probably the most up to date on this. Elise, when
18 I've looked through the 2010 guidelines -- documents, I
19 can't find anything that addresses age anymore. It used
20 to --
21 DR. VAN DER JAGT: Yes.
22 DR. HALPERT: -- but I don't see it anymore.
23 DR. VAN DER JAGT: Right. And that -- well,
24 let me tell you about that I had actually spoken to Art
25 about a month ago about this. But, first of all, the

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2 American Heart Association does not define pediatrics by
3 age at all. It really does not. So if that -- if that
4 is the -- one of the premises, it is absolutely false.
5 It is not the Heart Association -- that's what you've
6 picked up in the books, too, when you looked at them.
7 There is no definition of pediatric by age. There --
8 the only two things that are related to age -- and this
9 is -- this is actually what was discussed at, I should
10 say, over the Peds Committee over the last few years,
11 how do we define pediatrics? It was decided to leave
12 the age out of the proto -- out of the general flavor of
13 what is pediatric versus adult. The only places where
14 age is mentioned is that the A.E.D.s, the, you know,
15 there is a age relationship there with A.E.D.s that have
16 adult cables versus pediatric cables that has a resistor
17 in it. That is weight-based, actually even more so than
18 age-based. That's one. That's only one thing -- that's
19 the use of the A.E.D. Second place is that for
20 resuscitation protocols only that when patients get to
21 the age of puberty, then one should consider the adult
22 resuscitation guidelines. And I'm talking specifically
23 defib, detac, S.V.T., that kind of thing. Other than
24 that, there is nothing in any of the American Heart
25 Association educational documents that defines

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2 pediatrics by age or by puberty. So -- so --.
3 DR. HALPERT: Elise, I can't even find -- I
4 can't even find that indication about onset of puberty
5 in the 2010 --.
6 DR. VAN DER JAGT: The onset of puberty is in
7 the areas regarding Basic Life Support. So when you
8 come across a patient -- and this has to be strictly --
9 this is really laypersons. So a layperson who comes
10 across a patient and they have to decide whether
11 two-person Basic Life Support should maintain the ratio
12 of thirty-to-two versus two persons for fifteen-to-two.
13 That is based on puberty. That's all of it.
14 DR. HALPERT: In the B.L.S. And it's in the
15 B.L.S.
16 DR. VAN DER JAGT: In the B.L.S. That -- that
17 is correct.
18 CHAIRMAN COOPER: And so, to summarize, then
19 Elise, the only stipulations from the Heart Association
20 are that -- that you go from fifteen-to-two to
21 thirty-to-two at -- at onset of puberty or that that's a
22 reasonable begin -- place to make that change and
23 that -- and that A.E.D. use is -- with the pediatric
24 pads and cables -- is approximately eight years of age
25 slash twenty-five kilograms or above. Correct?

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2 DR. VAN DER JAGT: That is correct. And that
3 is the only places where either is valid. There's
4 nothing else that defines -- and we -- again, we had a
5 very specific conversation and it was felt that it --
6 because there was variation across the country and
7 across the world about what pediatric meant, it was
8 specifically decided not to take a position on age-based
9 defi -- defining pediatric.
10 DR. LaROCK: So -- this is Danielle jumping in.
11 So, I'm listening, but I'm not clear on what the process
12 is. Meaning, is it the expectation that somebody's
13 going to do an assessment of Tanner staging?
14 DR. VAN DER JAGT: No. And we had a discussion
15 about that, as well, okay. So, because of that -- you
16 can imagine -- a fairly amusing discussion.
17 DR. LaROCK: As practical.
18 DR. VAN DER JAGT: Hello?
19 DR. LaROCK: Hello?
20 DR. VAN DER JAGT: Hello. Are we there?
21 CHAIRMAN COOPER: Yup, we're all still here.
22 Sounds like something went by --.
23 DR. VAN DER JAGT: So -- so the discussion
24 was -- it was -- in fact, the discussion became -- even
25 in our Pediatric Heart Association Committee was well,

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2 this is really very interesting. Laypeople know what,
3 you know, onset of puberty, adolescence is. How come
4 doctors don't know that, you know? So it was really
5 related to a pretty obvious -- sort of the obvious, you
6 know, big kid, you know, likely some facial hair, you
7 know, likely just some suggestion that this is probably
8 a child who was in puberty. It was not to -- meant to
9 be an accurate kind of thing. It was not meant to be
10 specifically age-based. But it was basically that your
11 common things -- we talked about this is not intended to
12 undress people, looking at Tanner stages, it's none of
13 that stuff. It was basically what a layperson would be
14 able to look at -- at a patient and say, no, probably a
15 teenager.
16 DR. LaROCK: It's still -- are there data to
17 show that lay folks can do that to some degree of
18 accuracy? Because this is a useful thing. Meaning,
19 just looking --.
20 DR. VAN DER JAGT: There is probably no data on
21 that. I think it was -- again, it was left very vague
22 because it was very -- people were very hesitant,
23 especially in the lay area, to give various specifics
24 about, you know, you have to look for this, this and
25 this and this. There are some -- and I can pull this up

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2 probably -- there are some descriptive of what you might
3 consider looking for. You know, kid's got a beard. You
4 know, pretty obvious, right?
5 DR. LaROCK: A kid's got a beard, he's
6 obviously more than eight.
7 DR. VAN DER JAGT: It's about -- all I'm saying
8 is -- no, that's a good point, actually. However, you
9 have to remember that this is very vague. This is what
10 the general layperson would typically say this is, you
11 know, this is likely a kid who's, you know, in puberty.
12 It is not meant to be specifically Tanner staging like
13 you would do with a healthcare provider. It's not --
14 that was not intended. But if it is recognized --.
15 CHAIRMAN COOPER: You know, if it gets to be --
16 it needs to be a matter of common sense. But --
17 DR. VAN DER JAGT: Common sense is what the
18 word is, yes.
19 DR. HALPERT: -- but part of the -- the
20 ambiguity here is -- I -- I -- I've pulled this thing up
21 on my computer here. I don't see anywhere in that 2010
22 document on B.L.S. where it addresses the issue of age
23 class or pediatric classification at all.
24 DR. LaROCK: Yeah.
25 DR. VAN DER JAGT: Correct. And that is

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2 correct.
3 DR. HALPERT: I mean, do we --?
4 CHAIRMAN COOPER: Elise, perhaps you could
5 provide the specific reference where it speaks about
6 going from fifteen-to-two to thirty-to-two.
7 DR. HALPERT: It just says for a child you do
8 this. For an infant you do that. It does not --
9 DR. VAN DER JAGT: That's exactly right.
10 DR. HALPERT: -- say exactly how you decide.
11 DR. LaROCK: Right.
12 DR. VAN DER JAGT: So I think that the bigger
13 picture is here is the -- the American Heart Association
14 does not -- specifically does not define pediatrics by
15 age. It does not do it, you know, because of the
16 concern -- of the various concerns that are -- are
17 addressed there. So that's -- that's about the one
18 point. Second thing is I'd like to also -- I'm
19 concerned about here is -- is that that the converse of
20 that -- let's say it is eight, okay, or even twelve or
21 eleven -- the converse of that is that adult protocols
22 will be applied to pediat -- what we think might be
23 pediatric patients. And that is just as concerning.
24 Because now the kid who is nine comes in with chest
25 pain, now what? The kid who comes in with potential

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2 stroke, you know, now what? Are they going to use the
3 adult protocol? The kid who comes in who is now
4 post-arrest automatically gets ice-lavage, you know,
5 I.V. I am very concerned about that. And I think that
6 that might be something that we need to also point out.
7 That just like it's not as simple as pediatrics goes to
8 adults but that also means adult protocols apply to what
9 are we, typically, the pediatric community would
10 consider pediatric patients who have very different
11 etiologies and pathophysiologies.
12 DR. LaROCK: Right.
13 CHAIRMAN COOPER: Well, hence -- hence the -- I
14 mean, hence the -- the -- the issue being brought to
15 this Committee. I -- I don't think anybody believes
16 that, you know, that -- you know, that children, you
17 know, who are -- who have not begun puberty should be
18 subject to adult protocols. Traditionally, in the
19 E.M.S. world, when it -- when the E.M.S. world started
20 out, people were -- people were sort of saying ten years
21 of age and above, in effect, onset of puberty. But over
22 the years the E.M.S. protocols have sort of matured to a
23 point where, in most regions, I think -- Sharon, you
24 might know better than I on this one -- you know,
25 they're using a fourteen-fifteen cutoff, roughly

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2 speaking, sort of as end of puberty rather than
3 beginning of puberty. You know, which to me, has always
4 made more sense in terms of A) the physiology --
5 anatomy, physiology and developmental issues, and B) the
6 epidemiological issues because that's kind of when, you
7 know, C.D.C. splits it and so on. But -- but, you know,
8 the -- the SEMAC wants to -- wants to go with onset of
9 puberty and it's basing it on the Heart Association or
10 their understanding of the Heart Association direction.
11 I think we can successfully refute that and we can cite
12 some examples that Elise has cited in terms of kids with
13 chest pain, stroke, you know, and so on. Should the,
14 you know, do we -- do we mean that a kid who's
15 peri-pubertal, you know, should be, you know, and is
16 having some chest pain should be treated the same way,
17 you know, as a -- as a -- as a forty-five-year-old adult
18 who we think may be having an M.I.? You know, etcetera,
19 etcetera. But I -- but they're looking for an age
20 because the, you know, or at least some clear --
21 reasonably clear marker of when the protocols begin and
22 end, you know. And -- and I think that, absent our
23 giving them advice, you know -- and, frankly, perhaps
24 even, you know, expert professional organizations that
25 deal with children, you know, might feel a need to weigh

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2 on -- weigh in on this, too. I don't know. But, you
3 know, I -- I certainly think that we need to take a
4 position on this and say what we think.
5 MS. CHIUMENTO: Right. Art, if I can jump in?
6 I strongly agree with you. And I think this is one
7 where the appropriate committees at the national
8 level -- the A.A.P. --
9 DR. HALPERT: Right.
10 MS. CHIUMENTO: -- might lend some expert, you
11 know, advice on this. And I think it would be a bad
12 step for them to take to -- to do this in the absence of
13 other considerations -- epidemiologic you -- you talked
14 about and a number of other things. So, I think it
15 would make sense to bring this to the A.A.P., for
16 example.
17 DR. KANTER: I concur with that.
18 DR. KUNKOV: I think if -- I -- I'm sorry. If
19 I can butt in. This is Sergey Kunkov. I think --
20 CHAIRMAN COOPER: Never mind that. You're a
21 member of the Committee. Speak up.
22 DR. KUNKOV: -- I think A.A.P. defines
23 pediatric age group is up to twenty-one years of age, if
24 I am not mistaken.
25 DR. HALPERT: That's correct.

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2 MS. CHIUMENTO: Right. But the A.A.P. is very
3 used to -- so certainly, UNICEF defines under
4 eighteen -- that's what most of the world does. We
5 define twenty-one in the A.A.P. and, actually, extended.
6 But for this discussion, I think we can have very
7 specific discussions with respect to the expertise
8 that's needed around resuscitation is what I think it
9 is. And I think the A.A.P., while you're correct, for
10 sort of developmental perspectives, etcetera. But I
11 think what's being addressed is what makes the most
12 sense with respect to epidemiology of disease. No,
13 you're not going to treat a fifteen-year-old with chest
14 pain the same way you're going to treat a
15 forty-five-year-old with chest pain. Just doesn't make
16 sense.
17 DR. KUNKOV: Right.
18 MS. CHIUMENTO: So I think I'm speaking more to
19 that than, you know, the broad definition of child,
20 which is both globally and internationally much broader
21 than, you know, up to age eight of course.
22 DR. KANTER: The real issue here is we're
23 talking about experienced generalists in the
24 pre-hospital setting --
25 MS. CHIUMENTO: Exactly.

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2 DR. KANTER: -- and how can we be sure they do
3 the best possible job. And the fact is that these
4 experienced generalists -- providers in the pre-hospital
5 setting -- have an enormous amount of experience in the
6 care of adults and, if you just say, here's someone,
7 resuscitate them per normal routines, they will, on
8 average, do a terrific job. If you start getting them
9 thinking about the -- the -- the -- the nuances and
10 contingencies about maybe it's pediatrics, maybe I need
11 to modify for this and that, then they slow down. They
12 start thinking too much and it -- they're not using
13 normal -- they're not using their normal judgment and
14 experience. I think you want to be -- have a common
15 sense approach to this. The American Academy of
16 Pediatrics, if truth be told, talks about twenty-one as
17 a business position. Who are we going to admit to the
18 kids' hospital? Who are the pediatricians going to take
19 care of? It's different in the pre-hospital setting.
20 You've got E.M.S. providers who can do the job. And if
21 you take the -- the adolescent, the post-pubertal or
22 in -- in-puberty adolescent, the adult providers are
23 going to do a good job. And I don't think you want to
24 do anything to stand in their way.
25 DR. VAN DER JAGT: I think --

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2 DR. LaROCK: No, I'm not --.
3 DR. VAN DER JAGT: -- that the other thing is
4 that --.
5 DR. LaROCK: -- commonality that you don't do
6 that. But let's review carefully -- and I don't think
7 we can do it over the -- over the -- the phone here --
8 as to dosing of medication, protocols, likelihood of --
9 of -- you know, a pathophysiology of disease, those are
10 relevant, as opposed to, you know, whatever the business
11 case or how childhood is defined. I don't think -- I
12 think we're agreeing there. But I think there's some
13 specific pediatric knowledge with respect to likelihood
14 of disease presentation that's relevant to this. And I
15 would agree with you. The simpler the better. If you
16 have less deviation from the protocol, but it's not at
17 risk of just lumping all kids age eight and above with
18 an adult protocol. I think that's what we're saying
19 needs to be reviewed. And, again, I don't think we can
20 do that effectively on the phone. And thoughtfully on
21 the phone.
22 DR. HALPERT: I don't think --
23 DR. VAN DER JAGT: I think all --.
24 DR. HALPERT: -- anyone is using age -- the age
25 eight anymore. I think they're talking about pubertal.

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2 And, frankly, in the resuscitation phase and the
3 pre-hospital phase, I have a hard time thinking about
4 what is really pediatric unique in a pubertal patient
5 that's different than someone who's over whatever your
6 adult cutoff really is -- twenty-one or whatever.
7 DR. VAN DER JAGT: I think --
8 DR. KUNKOV: I would think resuscitation --
9 DR. VAN DER JAGT: -- I think that one of the
10 things -- I -- I -- I just think that we want to use a
11 common sense approach. And it -- I don't think anyone
12 would say that we would adopt the A.A.P. position up to
13 age twenty-one. We don't even do that in the hospital.
14 I mean, so this really a different venue.
15 DR. KUNKOV: Jo, I -- I think --
16 DR. VAN DER JAGT: But I --
17 DR. KUNKOV: -- I second that, absolutely.
18 Because I think it's a charity for us to -- to call
19 this -- these people between eighteen and twenty-one a
20 pediatric age group. Although they already, you know,
21 like serve in the Armed Forces and -- and have their own
22 family in view -- there's nothing about this age group
23 that is really pediatric in nature, I think. So I
24 absolutely agree. I think the UNICEF position is much
25 more understandable and straightforward. And I sort of

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2 agree with everyone that, you know, in the field when
3 E.M.S. arrives and someone is, you know, under real dire
4 straits, they -- the last thing we want to know -- we
5 want to make them to do is to think what to do. We just
6 have to give them a common sense approach whom to call a
7 kid, you know, and take it from there.
8 CHAIRMAN COOPER: Well, guys and gals --
9 DR. VAN DER JAGT: I think also --.
10 CHAIRMAN COOPER: -- guys and gals, if common
11 sense were common, we wouldn't be in the trouble that
12 we're in, right? I mean, and that's the -- that's --
13 that's part of the problem here, okay? That common
14 sense isn't as common as we might think. And -- and
15 many of our pre-hospital colleagues are really very much
16 literalists, you know, in -- in, you know, in -- in a
17 good way -- in the sense that, you know -- you know,
18 many of our pre-hospital -- I mean, some of our
19 pre-hospital colleagues, you know, go a little bit
20 overboard at times. But, most of our pre-hospital
21 colleagues really, you know, really want to stick very,
22 very much to the line because they don't to -- they
23 don't want to do -- do any harm to anybody. And so they
24 want pretty explicit careful direction as to the -- as
25 to which way we should go. So just in terms of trying

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2 to focus the discussion and -- and bracket the
3 discussion, I think we're kind of looking at either sort
4 of, you know, beginning of puberty -- roughly ten-ish,
5 okay or end of puberty -- roughly fourteen, fifteen-ish,
6 okay -- as sort of the limits of our discussion. I
7 think everybody agrees that we're not talking about, you
8 know, the older ado -- or the older adolescent who is
9 serving in the military capable of having his or her own
10 family, etcetera, etcetera. But I think, at the same
11 time, you know -- you know -- I mean, Bob has made some
12 very good points that, you know, that we want our
13 pre-hospital colleagues to do what they're most
14 comfortable with. You know, what they do every way to
15 keep -- every day to keep it simple. But, at the same
16 time, I think Elise and Danielle have made some
17 excellent points that, you know -- you know, a -- a -- a
18 fourteen, fifteen-year-old kid with chest pain, you
19 know, shouldn't be treated the same way we treat a
20 forty-five-year-old with chest pain. So how do we --
21 how do you suggest we resolve that -- resolve this?
22 Because I -- I don't think in -- in the middle of
23 puberty it's -- it's reasonable to kind of help our
24 pre-hospital colleagues figure out, you know, sort of,
25 you know, anything other than the beginning of puberty

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2 or the end of puberty, you know. And, again, using just
3 gross sort of estimates of, ah, you look like you've
4 kind of finished your puberty or you -- you look like
5 you're -- you're just kind of starting it.
6 DR. VAN DER JAGT: I think -- there's a couple
7 of other things here that I think need to be noted here.
8 One is I would specifically steer away the in -- the
9 sort of global discussion from we are re -- that E.M.S.
10 resuscitate in the field. Because I think that that
11 immediately puts it into an algorithm of some sort --
12 could it be the A.E.D. algorithm, which is twenty-five
13 kilograms. So I think that's a mistake. Because a
14 large majority of patients who are picked up by E.M.S.
15 for pediatrics are not resuscitating in that sense.
16 CHAIRMAN COOPER: Absolutely correct.
17 DR. VAN DER JAGT: You know, so that's a real
18 important thing and then that gets you away from
19 adopting A.H.A. standards, even though they were false
20 standards as they have been portrayed, you know. But it
21 gets it away from that part of it. Second thing is --.
22 CHAIRMAN COOPER: That point was made at SEMAC
23 but didn't carry a lot of weight.
24 DR. VAN DER JAGT: Right. That's what it
25 sounded like, yeah. So the second thing is, I do think

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2 it's important to get input from other ones including
3 ASEP. You know, I think that there needs to be -- the
4 pediatric emergency medicine community needs to also be
5 part of this discussion because we als -- always want
6 continuity across different spheres of medicine. You
7 know, outpatient versus inpatient. We think that's
8 important. The third thing is, I think the general
9 practitioner needs to be involved, he's probably A.A.P.
10 And then the -- the other thing is is that the -- what
11 was the other -- I have another point here. Too many
12 points here, I guess. The -- oh, I see -- is the first
13 do no harm. I would be concerned about setting the age,
14 whatever it is, too low because, as it is, you don't
15 want people to make a mistake, you know. And if there
16 is an issue that's particularly pediatric and they had
17 to apply adult principles to a patient that really is
18 actually -- you think the kid's ten but the kid's really
19 eight or seven -- now you have a real issue. So I'd
20 rather stay away from that younger early pubertal age
21 and move it up to a more late puberty kind of age,
22 which -- of course, puberty doesn't end really,
23 typically, seventeen or eighteen, but at least put it in
24 the fourteen, fifteen range, which we have used for many
25 years in many places for trauma issues, you know. So

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2 there needs to be some careful in that we don't go too
3 low on this because for fear that people actually, you
4 know, will make a mistake in this area.
5 CHAIRMAN COOPER: Of note, I just might add
6 that -- that -- that the -- that the A.C.S. Trauma
7 Center standards, you know, do use the fourteen, fifteen
8 cutoff for, you know, for -- for what can -- how you
9 count your pediatric -- how you count your pediatric
10 patients.
11 DR. VAN DER JAGT: So -- so -- so that may be
12 helpful, Art. Because if that's the A.C.S. and now the
13 State is going to A.C.S. in terms of accreditation, then
14 maybe that should be a similar one I think most of us
15 would feel relatively comfortable with.
16 DR. LaROCK: Yeah, that's reasonable.
17 DR. VAN DER JAGT: And then it's consistent
18 across both medical and trauma, you know.
19 CHAIRMAN COOPER: Yeah, all right. What --
20 what I'm hearing, then, is -- what I'm hearing -- what
21 I'm -- I'm hearing a consensus emerge that we should --
22 that we should go with a more of a fourteen, fifteen
23 split for several reasons. A.C.S. is using it. The
24 Heart Association does not define age and, in any event,
25 is focused on resuscitation per se, you know. Whereas

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2 most of the kids who -- who E.M.S. transports, you know,
3 do not require resuscitation. All the, you know, the
4 anatomic issues, etcetera, physiologic issues,
5 epidemiologic issues. I'm hearing kind of an emerging
6 consensus for fourteen, fifteen. Let me just -- do --
7 do I hear correctly?
8 DR. LaROCK: Yes.
9 DR. VAN DER JAGT: Yes.
10 CHAIRMAN COOPER: Others?
11 DR. HALPERT: That sounds reasonable, yup.
12 DR. KANTER: I -- I -- it's Bob. I try to stay
13 as consistent with the American Heart Association as
14 possible, since most of the protocols are coming from
15 them.
16 DR. VAN DER JAGT: But what -- what would you
17 do then? The Heart Association doesn't have anything
18 for most --
19 DR. KANTER: Well --.
20 DR. VAN DER JAGT: -- most kids that E.M.S.
21 transports?
22 DR. KANTER: Again, if it's -- if the American
23 Heart Association statements are good enough for
24 everybody else, I don't know why we can't somehow make
25 that clear to providers in the pre-hospital setting in

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2 New York State.
3 DR. VAN DER JAGT: Which, basically, leaves
4 them in the middle. There's no age.
5 DR. HALPERT: I think that's correct.
6 DR. VAN DER JAGT: Uh-huh.
7 DR. KANTER: Because in the pre-hospital
8 setting you don't know the age.
9 DR. VAN DER JAGT: Exactly.
10 DR. HALPERT: Uh-huh.
11 CHAIRMAN COOPER: Well, given that, I'm -- I
12 mean, given that -- that the Heart Association is not
13 recommending any specific age, except, you know, from
14 what I'm hearing, only with respect to the A.E.D., okay,
15 which is not really even age-based but more
16 weight-based, and given that, Bob, we can't seem to find
17 any reference in the B.L.S. section about -- about age,
18 you know, I'm having a -- I guess I'm having a bit of
19 difficult time understanding how we could say we should
20 be consistent with the age recommended by the Heart
21 Association if they don't recommend one.
22 DR. KANTER: Not the age. The definition of a
23 child versus adolescent.
24 DR. LaROCK: Can you say it again? What is
25 their definition?

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2 DR. KANTER: I -- I would -- I don't know what
3 the defi -- I can't find it --
4 DR. VAN DER JAGT: There is none.
5 DR. KANTER: -- in the document.
6 DR. VAN DER JAGT: There is -- there is no
7 definition.
8 CHAIRMAN COOPER: That's why --
9 DR. KANTER: But what --
10 CHAIRMAN COOPER: -- that's why we're having
11 the conversation.
12 DR. KANTER: -- well, Elise, with -- with all
13 respect to the Heart Association, we look to them for
14 guidance. Somewhere in their deliberations there must
15 be some kind of clarification on this.
16 DR. VAN DER JAGT: There is none, Bob. I've
17 been there for those discussions.
18 DR. KANTER: Well --.
19 DR. VAN DER JAGT: There is -- it -- and it was
20 specifically discussed that there would be no age set.
21 DR. KANTER: No, no, no. I agree -- I agree
22 with no age. There needs to be some kind of definition
23 of what's a child.
24 MS. CHIUMENTO: May I say --
25 DR. KANTER: Some kind of guidance for the

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2 providers.
3 MS. CHIUMENTO: -- may I interject something
4 here? And that is that, in reality, the E.M.S.
5 providers don't realize that there's nothing in the new
6 protocols. They're still basing it on onset of puberty.
7 That's still what's being taught in the classrooms.
8 That's -- that's what they were taught. And they have
9 not seen any change. They don't go in detail into the
10 documents of the A.H.A. So they don't know anything
11 different. So, as of right now, what most people in
12 E.M.S. are using is still the onset of puberty for
13 resuscitation purposes.
14 CHAIRMAN COOPER: I -- well --.
15 MS. CHIUMENTO: So that's the reality of things
16 right now.
17 CHAIRMAN COOPER: I -- I'm not sure that I'd
18 agree with you, Sharon. I think that may be true
19 Upstate. It's not true in the City, where the -- the
20 City has adopted a pretty clearly a fourteen, fifteen
21 split.
22 MS. CHIUMENTO: Well, you know, as I say, I
23 don't know -- many of the areas are still using the old
24 materials. They're using PALS because they don't really
25 specify anything in PALS right now. It's probably not

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2 even being mentioned. So people are going by their
3 previous memories in many cases --
4 CHAIRMAN COOPER: Well --
5 MS. CHIUMENTO: -- unless they're specifically
6 being taught something. If you look at the protocols
7 across the board, they're variable. Some -- and that
8 was the whole reason why this came up was because some
9 areas use twelve, some use - some use the onset of
10 puberty, some use eighteen and some use sixteen.
11 There's a huge variation across the state in -- in -- in
12 the protocols themselves. And in the teaching, many
13 people are still thinking -- in the E.M.S. society --
14 are still thinking about the previous guidelines of the
15 American Heart Association because they don't realize
16 that there's nothing changed -- that it's changed.
17 CHAIRMAN COOPER: -- well, you -- we -- we've
18 got to come to some kind of resolution on this, guys and
19 gals, okay. Otherwise, it's going to stay at onset of
20 puberty and we're going to be treating, you know,
21 ten-year-olds with chest pain like adults.
22 DR. VAN DER JAGT: Well, I would make a motion
23 that I -- that we would go with the, you know, fourteen,
24 fifteen age group consistent with the American College
25 of Surgeons, the Trauma, in the absence, particularly,

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2 of no specific guidance about age from the Heart
3 Association. And I think that's a reasonable ground
4 between the A.A.P. and this, you know, down to eight.
5 MS. CHIUMENTO: I would agree.
6 CHAIRMAN COOPER: Is there a second to that?
7 DR. LaROCK: Yes.
8 MS. CHIUMENTO: Yeah.
9 UNKNOWN SPEAKER: Yes.
10 CHAIRMAN COOPER: In a motion by Dr. Van Der
11 Jagt, seconded by Dr. LaRock. Discussion?
12 MS. LAROCK: Just -- just a clarifying point
13 because you -- you contrasted A.A.P. position. This is
14 a very specific discussion and I don't think there would
15 be disagreement at the A.A.P. The definition of a
16 child -- not to rehash this -- but has some -- is not
17 with respect to this kind of very focused discussion.
18 So I don't think there's disagreement.
19 CHAIRMAN COOPER: Okay.
20 DR. KANTER: I just -- I just think you want to
21 consider what's going to make for the best care in the
22 pre-hospital setting --
23 DR. LaROCK: Correct. And that's what we're --
24 DR. KANTER: -- and with all respect, saying
25 fifteen is not going to further better care, it's going

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2 to introduce as much, if not more, ambiguity and
3 uncertainty as any wording about puberty.
4 CHAIRMAN COOPER: Okay.
5 DR. LaROCK: I just think it's --.
6 CHAIRMAN COOPER: Any other --
7 DR. VAN DER JAGT: That's not been our
8 experience here.
9 CHAIRMAN COOPER: -- any other --?
10 DR. VAN DER JAGT: Our experience here, having
11 been involved with the A.L.S. stuff and trying to figure
12 out what age group, we have done that in
13 Monroe-Livingston County and we have set ages and it has
14 not been a particular problem.
15 DR. KANTER: Well, I -- I don't know. Maybe --
16 I mean, I don't know how come the ages are -- I mean the
17 patients don't come with age labels in my region or your
18 region. And, you know, here people just say it looks
19 like a teenager. We're going to resuscitate him as a
20 teenager and they don't worry about it too much. If you
21 give them reason to worry about it, it ends up being an
22 obstacle.
23 MS. CHIUMENTO: Right. So we --
24 DR. LaROCK: So, what happens if --
25 MS. CHIUMENTO: -- can they go by size and

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2 poundage?
3 DR. LaROCK: -- are you -- I -- I think I'm
4 hearing consensus that saying teenager is similar to
5 saying -- definitely a teenager, which is about
6 fourteen, fifteen --
7 DR. KANTER: Right.
8 DR. LaROCK: -- as opposed to a ten-year-old
9 who -- or eight-year-old who may not be a teena --
10 you -- I'm hearing consensus with what you're saying.
11 Are you hearing the same thing?
12 DR. VAN DER JAGT: Yes. And I think, you know,
13 that's really important, Danielle because now that we're
14 having the obesity epidemic, you know, an eight-year-old
15 can look like this sometimes and it's a problem.
16 DR. LaROCK: Uh-huh.
17 DR. VAN DER JAGT: But when you have both of
18 those parameters -- roughly fourteen, fifteen clearly
19 a -- clearly a teenager -- you don't want to be down to
20 the young -- younger age group, even when they're obese.
21 DR. LaROCK: Correct.
22 DR. VAN DER JAGT: And that -- just staying
23 away from the resuscitation issues, you know.
24 CHAIRMAN COOPER: All right. That sounds --
25 that sounds like -- that sounds like a point on which we

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2 can all agree. That we're saying we want the adult
3 protocols to apply to someone who's clearly a teenager.
4 DR. LaROCK: Yeah, clearly a teenager.
5 DR. VAN DER JAGT: Clearly.
6 CHAIRMAN COOPER: That make sense, Bob? Are
7 you okay with that?
8 DR. KANTER: Yeah, that's sort of back to -- I
9 mean, what's the difference between a teenager and
10 puberty?
11 DR. LaROCK: Well, puberty implies that you've
12 done an assessment of puberty. And here we're agreeing
13 that there is no assessment of puberty, really. I mean,
14 what we --.
15 DR. KANTER: Well, I -- we're all sort of
16 repeating ourselves. I, you know, I -- I -- I think --
17 I think, in the end, generalist pre-hospital providers
18 need to get the job done. And the -- our responsibility
19 is to try to make that easier, not more complicated for
20 them.
21 CHAIRMAN COOPER: Well, I -- I think we're -- I
22 think we're all trying to do that, Bob.
23 DR. LaROCK: And minimize adverse impact of our
24 intervention may be something to add.
25 CHAIRMAN COOPER: All right. So, I -- I - I'm

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2 hearing -- I -- Elise, I'm hearing that while originally
3 you suggested fourteen, fifteen, I'm sort of hearing
4 that you accepted what might be Danielle's friendly
5 amendment that we say, definitely a teenager, which we
6 all recognize as, you know, as sort of, you know, sort
7 of late puberty, end of puberty kind of -- kind of time
8 period. Correct?
9 DR. VAN DER JAGT: I think that's -- I could
10 live with that, sure.
11 CHAIRMAN COOPER: Danielle, you're the
12 seconder?
13 DR. LaROCK: Yes. Yes.
14 CHAIRMAN COOPER: Yes? Any -- so that -- so we
15 have a motion on the table that we're going to -- we're
16 going to -- we're going to recommend back to SEMAC that
17 we're looking for, you know, adult protocols to apply to
18 somebody who's definitely a teenager. And if they're,
19 you know, words to that effect. And if they're not,
20 then they should be treated according to the pediatric
21 protocols. Is that right?
22 DR. VAN DER JAGT: Are you going to put in
23 there, age? Like approximately fourteen, fifteen?
24 CHAIRMAN COOPER: I -- if that's the will of
25 the Committee, yeah.

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2 DR. VAN DER JAGT: I would prefer to do that.
3 DR. LaROCK: Uh-huh.
4 DR. KANTER: I'd prefer not to.
5 DR. VAN DER JAGT: Because that would be
6 consistent with A.C.S., uh-huh.
7 CHAIRMAN COOPER: Okay.
8 MS. CHIUMENTO: You're making a recommendation
9 to the SEMAC --
10 CHAIRMAN COOPER: Yes.
11 MS. CHIUMENTO: -- on their behalf?
12 CHAIRMAN COOPER: Well, I understand. But --
13 MS. CHIUMENTO: I know.
14 CHAIRMAN COOPER: -- I -- I -- I -- I -- I --
15 MS. CHIUMENTO: For the record.
16 CHAIRMAN COOPER: -- yes. I understand. For
17 the record, we are making a recommendation to SEMAC,
18 which we do hope that, as the pediatric experts here,
19 they will strongly consider, correct?
20 MS. CHIUMENTO: Correct. But, you --
21 DR. KANTER: Well, perhaps -- perhaps -- you
22 know, I -- I think the other thing you might represent
23 is the diversity of opinion within the group.
24 CHAIRMAN COOPER: I -- is there a diversity of
25 opinion in the group? Are there other folks that agree

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2 with Bob on this one? Okay. We'll -- I will -- I -- I
3 will reflect that there was some diversity of opinion,
4 but the -- but the -- a clear majority favored the
5 clearly a teenager approach, you know, roughly fourteen,
6 fifteen. Is there -- okay. So that's the motion on the
7 table con -- and again, consistent with A.C.S.
8 standards. Okay. Is there -- is there further
9 discussion? All in favor, please signify by saying aye.
10 MANY IN THE GROUP: Aye.
11 CHAIRMAN COOPER: Opposed?
12 DR. KANTER: No.
13 CHAIRMAN COOPER: Okay. So it sounds like the
14 ayes have it and it sounds like there is a single
15 dissenting vote. Okay. All right. So that's that.
16 Martha, can you tell us about the National Pediatric
17 Resi -- Readiness Assessment Survey?
18 MS. GOHLKE: Yup. I'll be brief. I just want
19 to give you a heads up. There'll be more about this
20 because I think New York is due to roll this out, well,
21 in the fall or winter. I haven't been told yet. But so
22 at the national level they're benchmarking E.D.'s
23 readiness to pediatrics and they've been hammering away
24 at the E.M.S. for Children grantees to help out with
25 getting these surveys answered. I sent it -- one of our

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2 secretaries, Rhonda -- sent it out electronically just
3 so you can have reference to it. We're not going to go
4 through it. But I -- like I said, I just want to give
5 you a heads up that later this year they're going to ask
6 all hospitals with E.D.s to complete this survey, which
7 is very lengthy so that they can benchmark New York and
8 all the states against one another to see how we're
9 doing nationally. I guess -- you know, we're not
10 mandated, meaning E.M.S. for Children grantees to
11 spearhead the answering of this surgey -- survey in the
12 state, but, like I said, they're really encouraging us
13 to take it on because we do so well with getting our
14 surveys answered in general. And because of our
15 connections that many states -- people like in my -- my
16 position have with the hospitals and want to be involved
17 because they, you know, for many reasons. So, my only
18 concern -- and I need to do some work with this on the
19 D.O.H. level here -- is they're hammering away at this
20 at all levels -- the Feds are -- in order to get this
21 answered. And I'm already seeing webinars pop up from
22 other people in New York State about this survey. So
23 we've got to make sure we have one cohesive way to roll
24 this out in the state and to get this answered and
25 collect the information rather than ten people in New

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2 York State rolling out the same survey over and over
3 and -- and irritating all the hospitals for answering
4 the same survey. So --.
5 CHAIRMAN COOPER: Do you have a suggestion,
6 Martha?
7 MS. SOTOLOTTO: This is Deb. I just -- I'm
8 sorry. I just -- I did want to just make sure that we
9 coordinate on it as well because, you know, we just did
10 that survey and if there's a way of not asking the same
11 questions to the hospitals that just answered it, you
12 know.
13 MS. GOHLKE: Yeah, probably not. Because they
14 have their own survey instrument and the way they're
15 going to --
16 MS. SOTOLOTTO: Yeah.
17 MS. GOHLKE: -- collect the data is through
18 that survey instrument.
19 MS. SOTOLOTTO: Okay.
20 MS. GOHLKE: I mean, you know, my -- my initial
21 thought process, again, like Deb says, we haven't
22 coordinated this at a State level yet. But, you know,
23 they have their own survey instrument that they've
24 developed and basically may be sending a link through
25 her to the survey instrument that the Feds have created.

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2 Maybe the most efficient way but, like I said, we need
3 to talk about that and figure out how to get that link.
4 Because ideally it is to use their survey instrument.
5 Because I have used -- had to use it in the past and it
6 is very well done and easy for people to read and
7 answer. But, again, I think I'm more concerned about
8 who's going to reach out to the hospitals and how are we
9 going to get them that survey link so that they answer
10 it one and only one time. So I just wanted to make
11 people aware of this. And we may, once it's rolled out
12 in New York State, ask you to go to your E.D. and make
13 sure that it's getting answered. If we're having
14 trouble getting an answer from your hospitals, we may
15 ask you to do like that part.
16 CHAIRMAN COOPER: Okay, so Martha, sort of sum
17 up -- staff is going to sort of work internally to
18 figure out how to minimize, you know -- you know, shall
19 we say double-dipping so to speak with respect to
20 filling out the questionnaire. And -- and we're going
21 to help you, you know, do this to the best of our
22 ability when the decision is made. Is that -- is that
23 correct?
24 MS. GOHLKE: Yes.
25 CHAIRMAN COOPER: Okay. That work for

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2 everybody?
3 DR. VAN DER JAGT: Uh-huh.
4 MS. SOTOLOTTO: Uh-huh.
5 CHAIRMAN COOPER: Okay.
6 DR. KANTER: Yup.
7 CHAIRMAN COOPER: Good. All right. Well, then
8 let's move on to --
9 DR. KUNKOV: Well, I just --
10 CHAIRMAN COOPER: -- go ahead, Bob, I'm sorry.
11 DR. KUNKOV: -- no, this is Sergey Kunkov.
12 Who -- who will be responsible to --
13 CHAIRMAN COOPER: Oh, Sergey, I'm sorry.
14 DR. KUNKOV: -- I'm sorry. Who will be
15 responsible within the hospital to fill out those
16 questionnaires?
17 MS. GOHLKE: Well, I think, depending on how we
18 roll it out in New York, somebody in the emergency
19 department. And we can define roles, I guess, on who
20 would be best to target the --.
21 DR. KUNKOV: Right. Yeah. Because I think it
22 will be a -- useful to think about specifying who -- who
23 should be in charge of it. Because if -- it will be on
24 the level of like administrators filling this out, they
25 might or might not know all the specifics. So it should

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2 be like a task of, you know, if they do have it, a
3 pediatric emergency director. If they don't have it,
4 then the next certified -- the next -- next higher up,
5 you know, as a surrogate. Because I went -- I looked
6 through the questions in there.
7 MS. GOHLKE: Yeah.
8 DR. KUNKOV: And, obviously, you know, some --
9 some hospitals will not have any sort of coordinators
10 who are like sufficient coordinators -- the nurse
11 practitioners coordinators. So it -- it should be
12 like -- we should think about the hierarchy of who this
13 questionnaire should go. The last thing we want is see
14 some administrative office filling this out and sending
15 it back and then it will not be true. The presentation
16 was going to actually in a clinical area.
17 MS. GOHLKE: Right. Right.
18 CHAIRMAN COOPER: I think that's really a good
19 point. Most of the surveys do go out to the -- sort of
20 dear hospital administrator kind of -- kind of -- kind
21 of linkages without explicitly saying here's the person
22 that should be filling it out.
23 MS. GOHLKE: Yeah.
24 CHAIRMAN COOPER: I think that's a great point
25 and I can see Martha nodding her head yes. And so I'm

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2 sure that whatever guidance is that she develops in
3 collaboration with her colleagues in the Health
4 Department will reflect that -- that advice.
5 MS. GOHLKE: And just so you know, they pilot
6 tested this survey out in California so, you know,
7 California has all their recommendations on how it went
8 in their state. And they're doing focus groups now.
9 They did it at our national meeting in each region of
10 the country to see how this could best get answered. So
11 they're -- they're really doing their homework ahead of
12 time, I should say, in trying to give us guidance on how
13 best get the best answers, especially since this is a
14 self-reporting survey.
15 DR. KUNKOV: Absolutely. Because, you know,
16 it's an ex -- an excellent way of, you know, coming up
17 with, you know, the -- the focus groups, you know, they
18 have already that in the State of California. That's
19 excellent. Because I can totally see how administrators
20 will be tempted to answer yes to everything.
21 MS. GOHLKE: Right. And then --.
22 DR. KUNKOV: And then --
23 MS. GOHLKE: Yup.
24 DR. KUNKOV: -- and then we'll end up with like
25 wonderful representation or wonderful --

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2 MS. GOHLKE: Right. Yup.
3 DR. KUNKOV: -- you know, preparedness. And
4 then, you know, when in actuality it's far from that.
5 MS. GOHLKE: Yup. Exactly. So they are trying
6 to figure out guidance in that -- in that area before
7 they roll it out nationally. But --
8 DR. KUNKOV: Yup. Very well.
9 MS. GOHLKE: -- yup.
10 CHAIRMAN COOPER: Okay. All right. Great.
11 Let's move on to the updates from our sister advisory
12 committees. Sharon, would you like to -- in addition to
13 the fact that we got the A.L.S. protocols passed, which
14 we've already mentioned, and that the -- and that we
15 have just talked about the age issue. Sharon, is there
16 anything else that you think we should be mentioning
17 from SEMAC?
18 MS. CHIUMENTO: Yes, just a couple things. The
19 one of the things as was mentioned earlier is that we
20 are changing to the national standard for training. And
21 one of the big issues that did come up was that the --
22 at the -- we are going to be adopting the national
23 A.E.M.T. module and replacement of the current I.L.S.
24 certification in New York State -- the intermediate
25 certification. That's going to take a few years to, you

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2 know, to roll over -- everybody over and everything, but
3 we're moving in that direction. So one of the things
4 that, when we discuss the cardiac arrest epi, they --
5 it -- at the E.M.T. that was not -- a epi was not and
6 cardiac arrest was not listed in the standards. And it
7 was never trained -- they were not trained at that. The
8 national standard also do not have epis for cardiac
9 arrest in the standards. So although we're adopting
10 everything else in the curriculum, there was a question
11 about whether or not we should add epi and cardiac
12 arrest for it -- just into the training for the moment
13 for the new A.E.M.T. level training in New York State.
14 So at the moment, they said well let's just train them
15 how to do it. We're not going to change the protocols
16 currently. We want to at least look at the training and
17 adding epi in their training just for cardiac arrest.
18 So that's something that's in future discussion, but at
19 least I think you need to be aware of that. Another
20 thing is is that the -- you may want to be aware of the
21 fact that the way the training is going to work is
22 there's not going to be a standard curriculum across New
23 York State, as there has been in past years for any of
24 the levels. Instead, the people will be using what
25 is -- the -- each instructor -- each educator -- each

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2 E.M.S. educator will base what their teaching on the
3 textbook that they're using and the Federal standards.
4 So there's not going to be a standardized curriculum any
5 longer. But the -- the standards, as far as
6 protocol-type standards, will be standardized. But the
7 training itself will no longer be standardized across
8 New York State. So, just so you are aware of that as
9 well.
10 CHAIRMAN COOPER: Well, Sharon, our instructors
11 are going to be encouraged to use the instructional
12 guidelines, though, are they not?
13 MS. ROGERS: Yeah, I'm --.
14 MS. CHIUMENTO: No, the instructional -- there
15 won't be instructional guidelines the way there have
16 been in the past, no.
17 MS. ROGERS: Yeah. Plus they were going to
18 provide them with objectives because in order to test
19 them, they have to be tested against objectives. So
20 we've been working on developing objectives for these
21 courses, as have a number of -- of other states around
22 us -- Massachusetts most notably. So we're working on
23 that. So while an instructor won't have a word-by-word
24 curriculum like we've provided in the past, there'll
25 certainly be teaching materials, both commercially

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2 prepared and provided.
3 CHAIRMAN COOPER: Yeah, the instructional
4 guidelines are still pretty detailed. They'll -- they
5 look -- they look, you know, pretty similar to the old
6 national standard curricula.
7 MS. ROGERS: Some areas they're very detailed.
8 And in some areas --
9 CHAIRMAN COOPER: Less detailed. Yeah,
10 that's --.
11 MS. ROGERS: -- well, almost nothing. So --.
12 MS. CHIUMENTO: Specifically in the treatment
13 area. There's very little in the treatment areas.
14 There's a lot in the assessment and a lot about various
15 past physiologies now that there has not been in past
16 years. But -- but there's not a lot in the treatment
17 area in the national standards.
18 MS. ROGERS: That's -- that's because they
19 wanted to be politically correct.
20 MS. CHIUMENTO: Exactly.
21 CHAIRMAN COOPER: Thank God. All right. Okay,
22 anything else from SEMAC, Sharon?
23 MS. CHIUMENTO: Yes. Just a couple of things
24 of -- of things that they're working on. One of the
25 things is looking at the possibility of having E.M.S.

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2 providers administer flu vaccine in the future. Also
3 looking at developing community paramedics programs in
4 the State. Looking at what's being done in other
5 states. Also looking at intranasal Naloxone. There's
6 demonstration projects going on with that in a few areas
7 and C-PAP by basics also for patients over the age of
8 ten years. I couldn't find an age group on the other
9 two. I just didn't have the documentation here. But
10 the C-PAP for age over ten years at the basic level
11 rather than waiting until the A.L.S. level. So those
12 are all things that are either being demonstration
13 projects or are being looked at for future projects.
14 That's all I've got.
15 CHAIRMAN COOPER: Very good. Okay. Any
16 questions for Sharon? Okay, hearing none. STAC -- we've
17 commented, I think, on the big issue that was discussed,
18 which was sort of preparation for the A.C.S.
19 verification process. The STAC voted to, in effect, say
20 that -- and I may be not quite accurate about the dates
21 but people have to sign up for a consultation visit
22 within a year. And then -- and then -- and then with
23 it -- and then they have to follow the college timeline
24 in terms of the veri -- the subsequent verification
25 visit. A dear administrator letter did go out to the

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2 trauma center dir -- trauma center hospital
3 administrators saying if you want to be a trauma center,
4 you're going to have to, you know, follow the A.C.S.
5 standards and -- and, you know, and get ready to do so
6 and here's the -- here's the date by which you've got to
7 contact the college. And, oh by the way, be sure to let
8 the Department know and so on. So that took up a great
9 deal of discussion at the meeting. There was a
10 presentation by two individuals who've recently
11 undergone consultative site visit, which I think was
12 very helpful to the -- the great majority of
13 coordinators in the -- in the room. The Department has
14 worked with the Society of Trauma Nurses to bring the
15 Optimal Resources Course -- the course that sort of
16 helps trauma program managers and coordinators prepare
17 for, you know, site visit. There are going to be two --
18 two iterations of that course. One is going to be held
19 at the Upstate Medical Center in -- in Syracuse on
20 Friday, June 15th. And there is another version of the
21 course or another session of the course, which is going
22 to be held in the downstate area, at New York Hospital
23 of Queens on August 17th. The latter having been sort
24 of independently procured. The State has graciously
25 agreed to support the first training --

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2 MS. GOHLKE: The grant --
3 CHAIRMAN COOPER: -- the --
4 MS. GOHLKE: -- not the State.
5 CHAIRMAN COOPER: -- the grant, excuse me.
6 Okay.
7 MS. GOHLKE: Just to be clear.
8 CHAIRMAN COOPER: Okay. Martha' being clear,
9 okay. It was a grant, okay. So - so that will, I
10 think, help us all. There was some discussion of
11 course, as always, about -- about, you know, the -- some
12 of the registry issues as we move toward, you know,
13 the -- the new trauma registry. Sharon comm -- I'm --
14 I'm sorry, Martha commented on this a little bit earlier
15 in her -- in her remarks under the E.M.S.C. Grant
16 Report. And I believe those were the major issues that
17 we covered. I'll ask Linda Tripoli to see if she has
18 anything that she needs to add at this point or anything
19 that I've missed.
20 MS. TRIPOLI: Nope, that's it, pretty much. We
21 did meet with Rick Cook, the Director of O.H.S.M., who
22 accepted all of STAC's recommendations. A letter by him
23 has been signed yesterday. Shook that loose, so,
24 hopefully, it'll be going out, which will iterate the
25 timeframe, as recommended by STAC. And the fact that if

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2 a facility chooses not to adopt the standards or go
3 through the consultative process, they will be
4 de-desig -- de-designated. The goal is to have all
5 trauma patients be transported to trauma centers of some
6 level of designation.
7 CHAIRMAN COOPER: Now, this is going to be a
8 little bit interesting, as we go forward. I think
9 everyone expects that most of the currently existing
10 trauma centers -- most, but perhaps not all -- will
11 decide to retain their trauma center status. However,
12 the American College of Surgeons has pretty strict
13 volume criteria. The State has never enforced its
14 strict volume cri -- volume criteria, which in fact,
15 were quite a bit more stringent than the College's.
16 The -- you remember that the old trauma regs were
17 written back in the late '80s during the height of the
18 crack epidemic when there was a whole lot more trauma
19 everywhere.
20 MS. GOHLKE: I thought you were going to say
21 when you were all on crack.
22 CHAIRMAN COOPER: Well, that -- that's --
23 that's but we're still all, you know -- you know,
24 smoking something, right. So, anyway, what's the
25 interesting part is that, of course, many trauma centers

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2 will be able to retain their Level One trauma center
3 status. Some will not because they don't meet the
4 twelve hundred volume threshold. The -- now, of course,
5 it will be up to the State in -- in the fullness of time
6 how it wishes to designate, okay. Because what the
7 College does is verify and the -- and the State will
8 then take that information and do a designation. It is
9 presumed that the State's designation process will --
10 will mirror the College's verification process. But
11 that has not yet been actually formally decided, either
12 by -- certainly by the Department. And the STAC has not
13 weighed in on that. I presume the STAC would probably
14 say that if we're verifying at Level One, Two, Three,
15 Four, that the State should designate it One, Two,
16 Three, Four. Although that -- that specifically has not
17 been determined. That having been said, our current
18 status -- our current system has regional and area
19 trauma centers, okay. Which sort of roughly correspond
20 with Level One-and-a-half, Level Two-and-a-half by the
21 College standards, okay. We're now going to be using
22 Level One, Two for the College standards. But there
23 will also be Level Threes and Level Fours. Level Threes
24 are -- well, let -- let me go back. Regionals and areas
25 in New York State are required to have virtually all the

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2 specialists that you need to care for trauma patients.
3 But -- and we -- we don't have any lower levels. In the
4 College standards, that same, you know, system sort of
5 is in place, as all of us know. Although you have to
6 have higher volume at a Level One and you got to have
7 research and teaching at a Level One. But the College
8 additionally has Level Three and Level Four. Level
9 Threes, in effect, are community hospitals and really
10 only have a General Surgeon and maybe an Orthopod. They
11 don't have to have Neurosurgical coverage. And Level
12 Fours are, in effect, trauma stations in rural areas
13 which are meant as way stations to stabilize before
14 patients get to other -- other centers. Now many, many,
15 many years ago, the Department was very afraid of
16 having, you know, rural hospitals -- small community
17 hospitals and rural hospitals, you know, becoming part
18 of the trauma system because it was -- there was a deep
19 level of concern that patients would be held in
20 community hospitals for economic reasons, you know, to
21 keep those hospitals viable when, in fact, they should
22 be moved on for a better quality of care. But now that
23 we've adopted the College standards, you know, the
24 Commissioner, in his wisdom, has made the decision that,
25 you know, we're going to, you know, go in a new

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2 direction and it remains to be seen at this point
3 whether anybody out -- out there is going to ask for
4 Level Three or Level Four status. I don't know that
5 Linda has received any applications yet.
6 MS. TRIPOLI: Actually, I have.
7 CHAIRMAN COOPER: Actually, she has. And if
8 you could comment on that.
9 MS. TRIPOLI: Actually, we've had a -- we've
10 had a really good response to the Level Four
11 designation. The College has produced guidelines for
12 Level Four designation that are set to be released in
13 October. Certainly, I've had conversation with them as
14 to what that kind of process -- verification process
15 will look like for a Level Four center. But we have a
16 fair number of upstate facilities that are looking at
17 Level Four designation in some underserved areas. So it
18 will be interesting to see how this plays out.
19 CHAIRMAN COOPER: Well, certainly, inclusivity
20 in terms of the trauma system has always been a goal.
21 And perhaps this -- perhaps this will help us accomplish
22 it. Perhaps -- perhaps, you know, not with the -- it
23 does remain to be seen. But anyway, so any other -- any
24 other thoughts or questions regarding the STAC report?
25 Well, hearing none, is there any other unfinished

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2 business we should touch upon? Any new business we
3 should touch upon? Well, then, hearing none, it is
4 twelve-twelve. We're finishing fifteen minutes early.
5 This is sort of a new indoor record for us, I think.
6 Martha will scour the calendar and hotel availability
7 for a Tuesday in -- in the early fall.
8 MS. GOHLKE: You could -- if you want to pencil
9 in either September 11th or 18th, those are the first
10 two dates I'm going to propose to the --
11 MS. CHIUMENTO: September 11th, really?
12 MS. GOHLKE: Or the 18th.
13 CHAIRMAN COOPER: That -- I may need to get
14 back to you on that, Martha. The American Association
15 for the Surgery of Trauma is meeting somewhere in that
16 timeframe in a faraway place.
17 MS. GOHLKE: You wouldn't -- you wouldn't
18 rather be in Albany than Troy?
19 CHAIRMAN COOPER: No, I'd much rather be in
20 Albany. Of course.
21 DR. KANTER: It's -- it's Bob. I know I'm not
22 available on the 11th.
23 MS. GOHLKE: Okay. So I'll shoot for the 18th.
24 CHAIRMAN COOPER: 18th or the 25th, okay.
25 We'll shoot --.

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2 MS. GOHLKE: Not the 25th.
3 CHAIRMAN COOPER: Not the 25th?
4 MS. GOHLKE: Nope.
5 CHAIRMAN COOPER: It's got to be the 18th, huh?
6 MS. ROGERS: Rita and I will be across -- we'll
7 be in Idaho.
8 MR. MOLLOY: We will?
9 MS. ROGERS: Yes.
10 CHAIRMAN COOPER: All right. Well, we will --
11 we will scout -- scout that out, okay, and figure
12 out --.
13 MS. GOHLKE: So pencil in the 18th.
14 CHAIRMAN COOPER: Okay.
15 MS. GOHLKE: Well, we'll talk about it. I'll
16 e-mail you as soon as I get confirmation from the hotel.
17 CHAIRMAN COOPER: Okay. So then we're looking,
18 hopefully, at the 18th, if that works with the -- the
19 fall meeting schedule with the big national
20 organizations. And there we are. So I guess it's time
21 for a motion for adjournment and wish everybody a good
22 summer. Okay. May I have a motion to adjourn?
23 DR. KUNKOV: So moved.
24 MS. ROGERS: So moved.
25 CHAIRMAN COOPER: Thank you so much. Thanks so

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2 much for coming on everybody. I think we made a lot of
3 progress and I'm really excited about the forward
4 movement on the 405s. Okay. Thanks again for coming.
5 DR. KUNKOV: Thanks.
6 DR. KANTER: Martha?
7 MS. GOHLKE: Yes.
8 DR. KANTER: Martha, are you there?
9 MS. GOHLKE: Yeah, I'm here.
10 DR. KANTER: I wonder if you have a couple of
11 minutes just to go back to the prior discussion?
12 MS. GOHLKE: Well, some -- not everybody is
13 still here.
14 DR. KANTER: All right.
15 MS. GOHLKE: I don't know if Sandy is here.
16 MS. HAFF: I can stay.
17 CHAIRMAN COOPER: You need a 405 discussion,
18 Bob?
19 DR. KANTER: Yeah.
20 MS. GOHLKE: Can you give us a couple minutes,
21 Dr. Kanter?
22 DR. KANTER: Sure.
23 MS. GOHLKE: Dr. Cooper just kicked the phone
24 and I need to use the ladies room.
25 DR. KANTER: Yup.

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2 MS. ROGERS: I can sing to you the Jeopardy
3 song, if you want.
4 DR. KANTER: Good.
5 MS. ROGERS: I'm guessing you don't.
6 CHAIRMAN COOPER: I'm hoping this isn't going
7 to be too long because I've got another meeting I got to
8 rush --
9 DR. KANTER: Two minutes.
10 CHAIRMAN COOPER: -- oh, two minutes. Okay.
11 DR. KANTER: Two minutes.
12 MS. ROGERS: He's running out, too. You may be
13 stuck with me.
14 CHAIRMAN COOPER: We're all going to the same
15 place -- only two halves of the same place, I think.
16 MS. GOHLKE: Are you there, Dr. Kanter?
17 DR. KANTER: Hi.
18 MS. GOHLKE: Hi. Is -- what section did you
19 want to talk about?
20 DR. KANTER: Radiology.
21 MS. GOHLKE: Okay. That would have been
22 fifteen.
23 CHAIRMAN COOPER: Ah, I know what Dr. Kanter
24 wants to talk about.
25 DR. KANTER: All right. The issue is simply

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2 that I think that there needs to be some wording -- and
3 I'm not the one to decide on the wording because I don't
4 know the proper technical terminology -- but there needs
5 to be some sort of guidance or requirement about size
6 appropriate radiation dosing for diagnostic studies.
7 This is a matter of huge national attention. I don't
8 know if any of you saw the article just came in the
9 Medical Journal called "The Lancet" which talks about
10 excess risk of brain tumors and leukemia in people and
11 children who have been exposed to C.T. scans. This is
12 one of several comparable studies that are showing very
13 serious adverse affects of excessive radiation dose.
14 And the fact is there's still a -- a complete absence or
15 lack of any kind of clarity about what's the right way
16 to approach this. I can tell you in my own hospital we
17 have a new pediatric radiologist just came on board and
18 he can't figure out what they're doing. There needs to
19 be --
20 MS. HAFF: You know what --
21 CHAIRMAN COOPER: They, meaning -- they,
22 meaning your Department.
23 DR. KANTER: The radiol -- our radiologist.
24 MS. HAFF: -- you know, this -- this particular
25 section we worked with our radiology people. And I

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2 think what I would do is I'll send an e-mail, include
3 all of you and them and maybe you can send an e-mail
4 with your specific concerns and then we'll work out the
5 language. Because they're the ones that really
6 developed this piece.
7 CHAIRMAN COOPER: Yeah, and I'll also say,
8 Bob -- I think -- and I think I mentioned this to you in
9 a prior conversation - that when Morley was here with
10 the Department, you know, discussions were really hot
11 and heavy on this very issue in terms of image widely
12 for adults and image gently for kids protocols. And,
13 you know, the -- the image gently protocols are out
14 there from the American, you know, Rankin Society and we
15 should -- we should probably either reference them, you
16 know, indirectly or directly in the regs, you know --
17 you know, as you suggest.
18 MS. HAFF: Okay. Why don't I have you send an
19 e-mail that we will share with them and we'll work out
20 what it is you're concerned about and how they want
21 to --.
22 DR. KANTER: It -- it -- it's really -- it's
23 really -- I mean, it -- I mean, I'm not the one who's
24 qualified to address this. It's simply the dose. It's
25 sort of like you wouldn't give drug doses to children

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2 without considering their size. Likewise --.
3 MS. HAFF: Is there a particular piece in the
4 regs -- is there a particular subdivision or paragraph
5 that you're focusing on?
6 DR. KANTER: I'm con -- I'm concerned that it's
7 not there.
8 MS. HAFF: Okay.
9 CHAIRMAN COOPER: We'll make sure that it's
10 there, Bob.
11 DR. KANTER: Okay. That's all. Thank you.
12 MS. GOHLKE: Don't hang up. Don't hang up.
13 Just F.Y.I., when we talked to Rick Cook about the plan
14 with the 405s, I pitched the idea about Arizona and
15 their model of pediatric designation and the process to
16 do that outside of the Health Department structure and
17 possibly looking at the State chapter of the A.A.P. and
18 approaching them and -- and see if they would be
19 interested in taking this on in New York State and he --
20 he thought that was the way of the future and he gave us
21 thumbs up and the green light to do that.
22 CHAIRMAN COOPER: You're kidding me.
23 DR. KANTER: Good.
24 CHAIRMAN COOPER: Knock me over with a feather.
25 Wow. Okay.

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2 DR. KANTER: Now you have to see if the A.A.P.
3 wants anything to do with it.
4 CHAIRMAN COOPER: We did mention this on a very
5 preliminary basis to the A.A.P. and they're not --
6 they're not -- they're not, on the face of it, opposed
7 to it, okay. But I think that, you know, a lot of work
8 would have to be done --
9 MS. GOHLKE: Right.
10 CHAIRMAN COOPER: -- to figure out how it
11 might -- how it might happen.
12 MS. GOHLKE: Well, I'd love to have my
13 counterpart from Arizona come out -- and my grant can
14 pay for that -- to do some sort of a presentation to the
15 A.A.P. or our Committee or both to talk about --.
16 CHAIRMAN COOPER: All right. Let's -- we'll
17 talk more about that. With -- the A.A.P. district
18 meeting is going to be held in August --
19 MS. GOHLKE: Yeah.
20 CHAIRMAN COOPER: -- 23rd through the 26th. So
21 we can -- we can work on that.
22 MS. GOHLKE: Okay.
23 CHAIRMAN COOPER: All right. Okay, Bob. Thank
24 you so much.
25 DR. KANTER: Thank you guys. See you.

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2 (The proceeding concluded)
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3 transcript from the electronic sound recording of the
4 proceedings in the above-entitled matter.
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