

1 10/12/2022 - STAC Meeting - Albany, N.Y.

2 NEW YORK STATE

3 DEPARTMENT OF HEALTH

4 STATE TRAUMA ADVISORY COMMITTEE MEETING

5

6 DATE: October 12, 2022

7 TIME: 1:34 p.m.

8 CHAIR: Patricia O'Neill, M.D.

9 LOCATION: 40 Lodge Street

10 Albany, New York

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2 APPEARANCES:

3 Patricia O'Neill, M.D., STAC VICE CHAIR (ACTING CHAIR)

Matthew Bank, M.D., Nassau RTAC

4 Daniel Clayton, Executive Secretary

Jose Prince, M.D., N.Y.C. RTAC

5 Arthur Cooper, M.D.

Steve Dziura, Deputy Director, BEMSATS

6 Sheldon Teperman, M.D., N.Y.S. RTAC

William Hallinan, R.N., Finger Lakes RTAC

7 Mark Gestring, M.D., Finger Lakes RTAC

Cristy Meyer, R.N. STAC Sub-Committee Chair

8

Robert Winchell, M.D., STAC Sub-Committee Chair

Ronald Simon, N.Y.C. RTAC

9

Peter Brody, D.O.H.

10 Kim Wallenstein, M.D., Central RTAC

Kerrie Snyder, R.N., Northeaster RTAC

11 Sloan Yoselowitz, D.P.T., NuHealth

Jerry Morrison, President N.Y.S. Chapter Trauma Society

12 Donald Doynow, M.D., SEMAC Chair

Jane McCormack

13 Abenamar Arrillaga, M.D., Suffolk RTAC

James Vosswinkel, M.D., Suffolk RTAC

14 Jamie Ullman, M.D.

Tammy Sykes, R.N.

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2 (The meeting commenced at 1:34 p.m.)
3 DR. O'NEILL: Remember to try to
4 identify your name for the recorder. Can we have the
5 roll call?
6 MR. CLAYTON: Dr. O'Neill?
7 DR. O'NEILL: Here. Oh. Dr. O'Neill
8 is here.
9 MR. CLAYTON: Dr. Wallenstein?
10 MS. WALLENSTEIN: Dr. Wallenstein's
11 here.
12 MR. CLAYTON: Dr. Gestring?
13 DR. GESTRING: Here.
14 MR. CLAYTON: William Hallinan?
15 MR. HALLINAN: Here.
16 MR. CLAYTON: Dr. Bank?
17 DR. BANK: Here.
18 MR. CLAYTON: Dr. Angus?
19 Dr. Simon?
20 DR. SIMON: Here.
21 MR. CLAYTON: Dr. Agriantonis?
22 Dr. Prince?
23 DR. PRINCE: Here.
24 MR. CLAYTON: Dr. Teperman?
25 DR. TEPERMAN: Here.

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2 MR. CLAYTON: Kerrie Snyder?

3 MS. SNYDER: Here.

4 MR. CLAYTON: Dr. Arrillaga?

5 DR. ARRILLAGA: Present.

6 MR. CLAYTON: Dr. Vosswinkel?

7 DR. VOSSWINKEL: Here.

8 MR. CLAYTON: Dr. Flynn is excused.

9 Dr. Ullman?

10 DR. ULLMAN: Here.

11 MR. CLAYTON: Dr. Winchell?

12 DR. WINCHELL: Here.

13 MR. CLAYTON: Tammy Sykes?

14 MS. SYKES: Here.

15 MR. CLAYTON: Dr. Dailey?

16 Dr. Doynow?

17 DR. DOYNOW: Here.

18 MR. CLAYTON: Dr. Goldman?

19 Dr. Cooper.

20 DR. COOPER: Here.

21 MR. CLAYTON: Roll call complete. We

22 have better than quorum.

23 DR. O'NEILL: Great. So Dan sent out

24 a copy of the minutes from our previous meeting.

25 Does anyone have any corrections, comments, or edits

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2 that they want to bring forward? Hearing none, can I
3 have a -- a motion to approve the minutes?

4 DR. PRINCE: So moved.

5 DR. O'NEILL: Name.

6 DR. PRINCE: Prince, so moved.

7 DR. COOPER: Cooper, second.

8 DR. O'NEILL: All in favor?

9 DR. COOPER: Aye.

10 DR. PRINCE: Aye.

11 DR. O'NEILL: The minutes are
12 approved. With that, we'll move forward with our
13 bureau update.

14 MR. DZIURA: Good afternoon. Steve
15 Dziura, Deputy Director of the Bureau of E.M.S.
16 standing in for Ryan this week to hear this meeting.
17 He's in Florida, so everybody feel bad for him.

18 So lots going on in the department.
19 First of all, first and foremost, really glad to be
20 back here in person with everybody. The
21 conversations that have been occurring and the -- the
22 networking that we've had the opportunity to do just
23 today has been phenomenal and something we -- we all
24 haven't been able to experience in a couple of years,
25 so very happy to be back.

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2 Most importantly too, of new news to
3 the department or the bureau rather is a lot of new
4 stuff coming in. So we've got two new district
5 chiefs. I'm sorry, one new district chief in the
6 western regional office and one who is returning from
7 a -- nearly a year and a half COVID deployment with
8 the National Guard, which is why I slipped and said
9 two. So Lisa and Dawn from the west of -- western
10 regional office will likely -- you'll see their faces
11 a little more maybe in our tech meetings or -- or
12 different meetings in the regions.

13 We have two postings that are going up
14 now, or I believe are out right now, in our New York
15 City region. We have one position in our Syracuse
16 office that is just pending appointment at this
17 point. We have a new appointment in the capital
18 district office which is kind of a shuffling of the
19 seats. Alex, who used to be with Peter, is now Alex
20 from capital district regional office as a district
21 chief. And Peter and some additions to his team, the
22 Alex's, Alex 1 and Alex 2, were both over there. So
23 we welcome all this, you know, great support and --
24 and it's nice to have the ability to replenish our
25 bench a little bit.

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2 From the administration side, our
3 program agency and REMSCO contracts are being
4 finalized now and we're waiting on a couple of
5 budgets to get those in place. The E.M.S.C. grant
6 application is fine -- being finalized. The new
7 grant, I should mention, requires the only new change
8 I guess to the Syracuse grant, is the requirement
9 that the state identify an emergency department TAC
10 (phonetic spelling), which I believe will come up in
11 conversation later.

12 From -- from the data and informatics
13 perspective, our biospatial program, which we talked
14 a little about -- a little bit about big committees
15 today, is beginning to roll out to the local health
16 departments and program agencies. Right now it has -
17 - and Peter correct if I'm wrong, but right now it
18 has the -- the E.M.S. data set. It does have and is
19 ready for the trauma data set. We just need to make
20 some technical fixes on our side to get that data
21 uploaded at some point in the near future.

22 A bunch of questions, there were some
23 -- some reports that I saw today during the -- the
24 meeting, the different committee meetings that, you
25 know, biospatial would be perfect for and I believe

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2 will really help this group. So I've asked that
3 Peter prepare a presentation, a brief presentation,
4 for the next STAC meeting so that everybody here can
5 understand what biospatial is, how it works, how it
6 can be used to help everybody better understand what
7 we're doing, faster.

8 We -- we have a lot of this data now
9 but the system does it in -- in a few clicks as
10 opposed to weeks and weeks of -- of data mining. So
11 we'll get a presentation up and ready for you in the
12 next meeting.

13 From an operation standpoint, we held
14 the New York State E.M.S. Memorial on September 20th.
15 It's the first time in -- in -- at least as long as I
16 can remember that it actually got rained out. So we
17 had to move the memorial indoors, but it worked out
18 really well, had a great attendance, and -- and the
19 unfortunate part is our memorial is out of space,
20 which is something we -- we hope would never happen.
21 So we're having to work with O.G.A. to expand the
22 existing memorial, and we were hoping that would be
23 done. The reason we normally have the memorial in
24 May, the reason we moved it to September is because
25 the expansion was supposed to be done, but like

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2 everything else, there are supply chain issues and we
3 couldn't get granted. So hopefully this will be done
4 in the spring and we'll have the new memorial while
5 in place.

6 Some other operational issues, we
7 continue to have community paramedicine through
8 executive order happening throughout the state. And
9 a recent new edition was the ability -- in add -- in
10 addition to the ability to provide COVID vaccinations
11 is now the ability to provide Polio vaccinations.
12 And there's some new guidance material and training
13 requirements up on our website that walk different
14 community paramedicine agencies through how that
15 works.

16 These programs have been, you know,
17 although not -- not established in law yet, we are
18 seeing over the past two years that community
19 paramedicine programs can really help drive the right
20 resources to the right patients at the right time.
21 And so, you know, we saw during COVID the ability to
22 treat in place instead of having to overwhelm
23 emergency departments. We saw the ability to do
24 telemedicine from the scene and take patients to
25 alternative loc -- destinations, provide vaccinations

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2 to people that were unable to leave their homes.

3 So, you know, a lot of the stuff we
4 talked about as -- as a pie-in-the-sky vision of how
5 it could work. And over the past two years, we've
6 definitely proven that it's a valuable addition to
7 our toolbox. And we work to promote that, hopefully
8 bringing it to a more permanent status in New York
9 State going forward. Although right now, it is under
10 executive order. The unfortunate part is if at any
11 point those executive orders go away, so do all the
12 community paramedicine programs. So just wanted to
13 give you the update on where those stand.

14 We are monitoring very carefully a
15 trend in increasing emergency department delays.
16 We're seeing delays in emergency departments for
17 E.M.S. transfer of patient care that can be an
18 upwards of, I've seen up to three and a half hours,
19 five hours routinely running over an hour across the
20 states. So we're monitoring that data closely.
21 We're -- we're seeing that impact, both the emergency
22 department, we -- we understand, we're running the
23 surge operation center, so we see both sides of the
24 house. We can see that there's a lot of patients
25 being boarded in the emergency department, which is

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2 backing up the E.D.s. And that is trickling down to
3 the E.M.S. services who are unable to offload their
4 patients coupled with just a -- an increase in
5 patient volume coming through the emergency
6 departments and -- and a recent spike in certain
7 areas in pediatric patients in their emergency
8 department.

9 What it's doing is it's causing a -- a
10 system, an E.M.S. system that is designed to bring a
11 patient to the hospital, offload, and get back in
12 service for the next nine one one call, and it's now
13 tying them up at the emergency department for hours.
14 And this is now impacting the nine one one system.
15 So we've been asked to look at that and -- and try
16 and develop recommendations or solutions to the
17 commissioner for potential -- the ability to reduce
18 those offload times at least a little bit.

19 DR. TEPERMAN: So Steve, it's
20 obviously a -- a great concern of New York City
21 Health Department.

22 DR. O'NEILL: Your name. Your name.

23 MR. CLAYTON: Could you introduce
24 yourself?

25 DR. TEPERMAN: Yeah. Sorry. Dr.

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2 Teperman, New York City Health and Hospitals. So --
3 but it's obviously a great concern to us in the city.
4 I see it all the time in my trauma center. But
5 there's no mystery as to why it's happening, right?

6 The state made decisions a decade and
7 two decades ago to close hospital beds, close I.C.U.
8 beds, and to -- and to narrow the operating
9 certificates for hospitals in New York State. And --
10 and this is the consequence. So it's not -- it's not
11 that we're not trying really, really hard to, you
12 know, for turnover. And then the other thing is that
13 -- that relates to it is the turnover ... The New
14 York City RTAC this week took a little poll. And on
15 the average, sixty percent of our nurses have been
16 there -- our E.R. nurses have been less than a year.
17 So you have these two things that are on a collision
18 -- collision course. There are no beds. We're -- we
19 are a lot busier and nurses are brand new. All of
20 that is, you know, when you -- when you take your
21 recommendations back, you got to think about that.
22 We need more hospital beds. We need more I.C.U.
23 beds. We got to figure out something about this
24 turnover of nurses.

25 MR. DZIURA: So while I'll definitely

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2 agree with you on the staffing side, I respectfully
3 disagree on the -- the number of beds and we have --
4 we have plenty of data to support that -- that the
5 number of licensed beds is not being fully staffed by
6 hospitals, mostly because of staffing issues. We
7 totally understand the recruitment of -- of new
8 staff, especially nurses. But from the data we can
9 see, there are -- there are -- if all the hospital
10 beds that were physically available had staff to go
11 along with them, we wouldn't have as much of a
12 problem right now as -- as we do. So this is a
13 staffing issue, not so much a space -- a space issue
14 right now. I wouldn't say that's always been the
15 case, but today that is what we're seeing.

16 So, you know, we're being asked to --
17 to look at different avenues of this. We -- we
18 recognize it's not just a finger-pointing game. And
19 it -- it -- it's an entire ecosystem, and we have to
20 look at every piece of it. Is there alternative
21 destinations we can get patients to use of -- of
22 urgent care or -- or alternate primary care
23 facilities connecting people with primary care
24 providers so they're not using the emergency
25 department as primary care, more access to mental

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2 health services. All the things that -- that we've
3 seen and read about in -- in, you know, publications
4 and newspapers. We're taking a look at that on the
5 New York State basis. But I welcome any, you know,
6 any suggestions you may have of things that we might
7 look at that could help alleviate some of this --
8 this trickle-down problem throughout the hospitals.

9 As I said, we're running the -- the
10 Bureau of Emergency Medical Services continues to run
11 these state surge operation center. It has given us
12 a very unique perspective to -- to really focus our
13 attention, not only on just the E.M.S. side where we
14 normally focus a lot of attention, but also on the
15 hospital side and how those intersect. I can tell
16 you personally that I've gotten a much better
17 appreciation of -- of -- and I mentioned earlier, the
18 fact that our healthcare system is an ecosystem.
19 None of us operates in -- in silo and anything anyone
20 of us does affects the other.

21 And we see that when -- when, you
22 know, when a nursing home can't staff and -- and
23 can't accept a new patient, it backs up the hospital.
24 When the hospital backs up, it backs up the emergency
25 department which backs up E.M.S. And -- and I'm just

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2 using the example of the nursing home, not -- not
3 calling them out. But we see that everywhere. And -
4 - and so we're looking from a Department of Health
5 aspect and -- and working very closely with our
6 hospital division partners at the -- the ecosystem as
7 a whole.

8 We continue to work towards -- with
9 the surge operation center in helping to identify
10 patient transfer locations which are -- are occurring
11 both locally and still quite far distances to find
12 the right resources for patients, helping to identify
13 transportation options for patients, and up -- we
14 just launched within the past two months the
15 statewide hospital diversion system. So we're --
16 we've got a good chunk of upstate New York on board.
17 We're going to be working with F.D.M.Y. to try and
18 get those hospitals connected to our system, and then
19 last but not least, we're working with NASA on
20 Suffolk County so that we have one statewide control
21 board, if you will, identifying the resources of a
22 hospital emergency department at the first step,
23 either as open or -- or on diversion. And then
24 hopefully in the future additional things like what
25 types of services are available there, you know, if

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2 your CAT scan is down, the ability to publish that.
3 So all the resources know, all the E.M.S. services
4 know, there's one place to go to figure out what's
5 available at different hospitals, so.

6 We are also working on what's called
7 the hospital capacity direct access project, which
8 brings continuous every two-hour recording of full
9 hospital capacity data into the New York State
10 system. So we can have a -- instead of a once-a-day
11 snapshot of what our hospitals' capacity looks like,
12 a more ongoing routine data set that will help us,
13 especially in times of emergency or catastrophe,
14 identify beds throughout the state that could be
15 available to help those situations.

16 So we've got about sixty give or take
17 hospitals on board now. We're launching another
18 couple -- a hundred and twenty, I believe over the
19 next couple of weeks. And we hope to have the whole
20 state onboarded by the end of the year.

21 The last two things, the SEMSCO and
22 SEMAC met right after the memorial, so the 21st and
23 the 22nd. Their next scheduled meetings are December
24 6th and 7th, again, at Hilton Garden Inn in Troy.

25 And finally, I saved the best for

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2 last, our New York State Vital Signs conference will
3 be held here in Albany, October 27th through the
4 30th. And we're still accepting registrations.
5 There's a lot of good programs. Attendance is
6 increasing daily. We've got both of the in-person
7 and a virtual option available. And so we're --
8 we're really looking forward to launching that
9 program and getting through that. Thank you.

10 MR. HALLINAN: Steve, I wonder if you
11 can field the question about the SEMSCO meeting?

12 MR. DZIURA: I sure can.

13 MR. HALLINAN: All Right. It -- it
14 appears that Dr. Dailey made a motion regarding
15 Allied Health Professionals practicing in the pre-
16 hospital environment. So this is Bill Hallinan from
17 the Finger Lakes. We see a lot of crossover across
18 our Pennsylvania border. And I believe this
19 specifically refers to the Pennsylvania's pre-
20 hospital registered nurses. It appears Dr. Dailey's
21 motion fell un-seconded and the conversation ended.
22 Could you just maybe tell us what that conversation
23 was?

24 MR. DZIURA: No, mostly because I
25 don't fully recall it. So I -- I -- separately from

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2 -- I -- I honestly don't recall that piece of -- any
3 conversation with Dr. Dailey. But interestingly have
4 been digging into that because there's a couple of
5 questions out of the Western New York area is -- so
6 we are looking at the way Pennsylvania does the
7 P.H.R.N. and the P.H.M.D. program. We've got some
8 folks that are checking to see how that certification
9 works, what type of requirements they have, and --
10 and at some point, once we have gathered all that
11 information, we'll bring it back to the state council
12 to make a determination as to whether, first, we
13 create a similar type of certification in New York
14 State. And second, if we did, would we take the
15 reciprocity from other states who already have it?

16 So we are working on that, and I have
17 a meeting today at four o'clock to also discuss the
18 crossover of paramedics in emergency departments to
19 see if that's something they can continue. It's
20 allowed today through executive order. But we're
21 trying to make a final determination as to whether or
22 not that can continue without an executive order.

23 MR. HALLINAN: Thank you.

24 MR. DZIURA: You're welcome. Sorry I
25 couldn't be more specific. I just don't recall that

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2 piece of the conversation.

3 DR. O'NEILL: Does anyone else -- else
4 have any questions for Steve? Okay. So we'll move
5 forward on the agenda. Dan, do you have anything to
6 report as to the trauma program update?

7 MR. CLAYTON: So thank you Dr.
8 O'Neill. Dan Clayton, executive secretary of the --
9 the STAC, also department staff. I just have a
10 couple of things to -- to note. Patty and I -- Patty
11 Riley, and my staff and I have been very busy over
12 the last -- since the last meeting and even prior to
13 that. Earlier this year since the verification
14 review committee has been doing visits, we have been
15 involved and we continue to be involved with the
16 verification, re-verification review process with the
17 A.C.S. So we are participating in the visits. At
18 least one of us is -- is on ninety-nine percent of
19 the visits, and we look to do that in the future as
20 well.

21 We also are very involved. We've --
22 we've seen a couple of applications come in for
23 trauma center designations. So we're in the process
24 of reviewing those and collaborating with staff, with
25 trauma needs assessment to -- to look at those under

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2 the new policy that I think Dr. Winchell is going to
3 ask me to put up a little bit later. It's been
4 through the approval process.

5 So outside of our, you know, visits
6 there, Patty also is working, I would say full time
7 on the surge operation center. So in addition to her
8 trauma duty, she's working the surge operation center
9 leading that along with a couple of other department
10 staff including Steve. So she's been busy and is it
11 -- it is definitely a valuable resource to not only
12 to the trauma section but to the whole bureau as --
13 as a whole.

14 So I think other than that, I'm going
15 to leave it -- I think most of what I would want to
16 bring up is going to come out at the subcommittee
17 report outs so I'm -- I'm going to leave at that, Dr.
18 O'Neill. Thank you.

19 DR. O'NEILL: But just maybe a comment
20 on the status of all the vetting?

21 MR. CLAYTON: Yeah. Sure. So thank
22 you for that question. Obviously, since the COVID
23 pandemic took over everything back in early 2020, we
24 had some vetting that Cathy Burns as prior executive
25 secretary had started but was unable to complete nor

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2 was I -- nor was I able to complete over the last
3 year and a half since I've been in the executive
4 secretary position because of COVID operations.
5 Patty has stepped up to the plate. And I am happy to
6 report today that everybody that needs to be re-
7 vetted because their term has -- has expired. Of
8 course, you remain seated until, you know, you're re-
9 vetted or, you know, replaced so to speak. But
10 everybody is in process and above the bureau level.

11 In other words, we -- the bureau has
12 signed off on the vetting process. And it has gone
13 up through the -- the center, to the office, to the
14 commissioner's office, et cetera, for reappointment.
15 And I would also want to mention and I don't know if
16 this is the time to do it or maybe later, but we do
17 have some vacant open seats on STAC as well that we
18 should discuss at some point. But I leave that to
19 you --

20 DR. O'NEILL: Maybe you can just list
21 them for now.

22 MR. CLAYTON: Sure.

23 DR. O'NEILL: So that we will make a
24 point of it, because I don't think we'll be able to
25 ex -- have a more extensive discussion, and what we

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2 can do is then discuss further at the upcoming
3 meetings.

4 MR. CLAYTON: So according to my
5 records --

6 DR. O'NEILL: We have a burn position?

7 MR. CLAYTON: Yes. There's definitely
8 a burn -- oh, I'm seeing now where -- how she did
9 this. Patty did the roll call vote. I'm -- I'm
10 reading it and understanding it now. So Northeastern
11 RTAC, I think we are -- we have an open seat there,
12 which is being worked on for Dr. Kirk Edwards, I
13 believe. We also have an opening in Western RTAC.
14 And again, some of these may be actually, we're in
15 the vetting process for individuals. I'm just
16 telling you that currently there's nobody in the
17 seat, okay?

18 Hudson Valley RTAC with two seats. An
19 area trauma center representative opening, a
20 community hospital professional opening, and a public
21 health professional seat in addition to the burn
22 surgeon that Dr. O'Neill just mentioned that, you
23 know, Dr. Summers held until her untimely death last
24 -- last summer. So those are the open slots
25 currently.

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2 And Dr. O'Neill, have we discussed a -
3 - a process for applications to be received and a --
4 a deadline? I think we had.

5 DR. O'NEILL: So we -- we actually did
6 receive a -- a burn surgeon application. One
7 individual did show interest in applying for the burn
8 position. But it's been our practice in the past
9 that a small group would be put together as a tag to
10 review any nominations. And so what we're -- I'm
11 going to do now is to open up to the STAC members, if
12 you know any burn surgeon within your region that you
13 want to propose as a -- to be considered to fill the
14 burn position, please send their name to Patty and
15 Dan. And then we will accept any nominations, review
16 them, and then at that point, we will put forward
17 someone to fill the position.

18 So far, we do have a very excellent
19 candidate. I'm not -- for the sake of time, because
20 it'd be premature, but that one candidate that we
21 have is actually very -- comes in with very good
22 credentials. But because we haven't actually opened
23 it up for nominations, we're just putting it open
24 now. And so just forward any -- any names or
25 recommendations to Dan and Patty, and then we will

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2 work on a small group to vet them and then come up
3 with a decision.

4 Regarding the area, I think we need to
5 change that name. We no longer use the word area.
6 And I believe we have several level three trauma
7 center directors who may be of interest. So can --
8 can I put out to the group that we officially changed
9 this position for a level three? Would -- would
10 everyone agree to that?

11 Dr. BANK: Yes.

12 DR. O'NEILL: Okay. So do you want to
13 make a motion?

14 DR. BANK: So we're going to make a
15 motion that the seat on STAC, instead of coming from
16 an area or trauma center or trauma med director,
17 which the terminology that we do not use anymore, it
18 comes from a level three, a A.C.S. verified New York
19 State Level Three Trauma Center.

20 DR. O'NEILL: Okay. And with that,
21 what I will then do is I'll recommend to the members
22 of the committee to forward any interest, any trauma
23 medical directors from a level three trauma center
24 who would be interested in serving in that position
25 can send their name also to Dan and Patty. And then

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2 we will have a vetting process for that as well. Oh,
3 I'm sorry.

4 DR. GESTRING: I just want to second
5 his --

6 DR. O'NEILL: Forgive me. I just had
7 a brief T.I.A.

8 DR. GESTRING: So I'll second Dr.
9 Bank's comment.

10 DR. O'NEILL: Thank you. So we have a
11 seconded motion.

12 MR. CLAYTON: Dr. O'Neill, seconded
13 motion by Dr. Gestring?

14 DR. O'NEILL: Yes.

15 MR. CLAYTON: Test with the audio.

16 DR. O'NEILL: Thank you. And can we
17 have -- can we have a vote? Everyone in favor of the
18 change?

19 MR. CLAYTON: Aye.

20 DR. GESTRING: Aye.

21 DR. O'NEILL: All right. The aye's
22 have it. Any nays? Any abstentions? Okay. So the
23 aye's carry.

24 MR. CLAYTON: Dr. O'Neill, could I
25 just -- just add something. I -- I'm not confident

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2 it is. I have to pull up the bylaws to make sure
3 that it -- what it says, but I'm pretty sure that it
4 defines it in the bylaws --

5 DR. O'NEILL: Oh.

6 MR. CLAYTON: -- not statute of
7 regulation, but in the bylaws that its -- that we use
8 the term area. So let's, you know, we need to look
9 into that, just to be aware. It doesn't mean we
10 can't, you know, move this right now. But I wanted
11 to make sure I bring that up to be transparent.

12 DR. TEPERMAN: And Dr. Simon is saying
13 that -- that in the new bylaws they think they fixed
14 it. But that's the new bylaws.

15 DR. O'NEILL: Okay. So the -- but the
16 intent of the motion is that the open position will
17 be open for a level three trauma medical director to
18 apply to fill the position regardless of whether we
19 call it an area center versus a level three center.
20 We agree?

21 MR. CLAYTON: Yes.

22 DR. O'NEILL: Okay.

23 DR. TEPERMAN: Trish?

24 MR. CLAYTON: Yes.

25 DR. TEPERMAN: Just have a -- a

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2 comment about the vetting and we're addressing to our
3 -- this is Sheldon Teperman, to our state colleagues,
4 which is that we owe a -- a great debt of gratitude
5 to Dr. O'Neill for having stepped in and -- and being
6 the caretaker of the Chair of STAC. But it's been
7 quite a number of months since we voted Dr. Bank into
8 this body. And again, Trish has done a great job.
9 But I think for the STAC to move forward in new
10 directions and -- and take on, you know, new things,
11 it's only reasonable to expect -- to expect Trish to
12 help us tread water. So I want to encourage the
13 department to have a bunch of people need to be
14 vetted. But, you know, talk to whoever it is that's
15 above and say, let's seat our Chair.

16 DR. O'NEILL: So --

17 DR. TEPERMAN: That -- the -- the
18 comments were directed towards the state.

19 DR. O'NEILL: Yeah.

20 MR. DEIURA: So I appreciate your
21 comments, and I can actually appreciate the sentiment
22 behind them. The department is not delaying any
23 vetting process. And -- and works diligently to vet
24 members of all sixty councils of the Department of
25 Health. Unfortunately, that takes time. There's

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2 background checks. There's required steps that that
3 must go through that are all -- that just take time
4 to process. And -- and -- but I can assure you there
5 is no delay on the part of the Department of Health
6 to work towards obtaining vetted status.

7 DR. O'NEILL: And Sheldon, although we
8 can't guarantee it, we are anticipating that for the
9 next meeting that will be in the Chair position.

10 DR. TEPERMAN: Yeah, but the problem
11 there is, right, so that's four or five months from
12 now. And that's for -- for -- four or five months of
13 -- of work. So that's too late. That's too late.
14 It needs to happen now-ish, but I appreciate your
15 comments upstate.

16 DR. O'NEILL: Okay. So is that your
17 report, Dan?

18 MR. CLAYTON: Yes. Thank you.

19 DR. O'NEILL: Okay. So for the
20 executive report, I just have two items to -- to
21 bring forward or to report on. And the first one is
22 that with Matt Banks' help, we've actually looked at
23 the upcoming date for the 2023 meetings, which we've
24 final -- finalized this morning.

25 Matt, do you want to just --

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2 DR. BANK: So we're going to have
3 three meetings on STAC in 2023. They're all on a
4 Wednesday. It's going to be January 25th, May 3rd,
5 and October 11th. And we plan so far to have them
6 all at the Hilton Garden Inn in Troy.

7 MR. CLAYTON: Can you say those dates
8 one more time?

9 DR. BANK: It is January 25th, May
10 3rd.

11 DR. O'NEILL: On a Wednesday.

12 DR. BANK: These are all Wednesdays.
13 January 25th, May 3rd, and October 11th.

14 DR. TEPERMAN: Just a comment, May 3rd
15 is the New York City Jacobi Trauma Symposium. And
16 with speakers -- with speakers coming from various
17 national posts.

18 DR. BANK: One trauma symposium we did
19 not count on. We did look at everything on the
20 internet. We -- we can discuss.

21 DR. O'NEILL: We can. The only thing
22 that -- Matt, there's a lot of background work
23 looking at all the other national meetings and
24 symposia that were already in existence. And there
25 was an alternate date for May that conflicted with

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2 the national pediatric surgery meeting. And so
3 that's why the May 3rd date came abrupt. But we were
4 unaware that you are having your -- your symposium on
5 May 3rd.

6 DR. PRINCE: If -- if I -- if I may,
7 Jose Prince from -- you know, I think that the impact
8 probably to the New York State trauma community are
9 probably larger for the -- in the downstate region
10 than the national meeting that is -- spans over
11 several days and only begins on the 10th. So we
12 would be open to reconsidering it with the group if
13 that if ultimately that's better.

14 DR. BANK: So -- so we can reconsider.
15 We just -- we just have to do another search on the
16 internet to make sure that --

17 DR. PRINCE: I have to validate the
18 new date.

19 DR. BANK: Right.

20 DR. PRINCE: So we'll have to maybe
21 come back to the committee. I'll -- I'll defer to
22 the Chair obviously for final selection.

23 DR. BANK: Okay.

24 DR. O'NEILL: So the May date might be
25 changed. But we did want to just point out again

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2 that these were all Wednesday dates, which is
3 different from this meeting. And the other
4 announcement is that -- and I -- this has come up at
5 the -- some of the subcommittee meetings. But the
6 bureau has started the paperwork to submit to -- for
7 the changes related to the 405 regulations regarding
8 the nurse reviewer and regarding the updates to the
9 reference to the gray book, the 2022 A.C.S. Standards
10 for Trauma Centers. So we are anticipating that that
11 will -- change would be made and in -- in place by
12 September 2023. But the bureau has a backup plan to
13 move forward in the event that it's not com -- been
14 completely accepted to change.

15 And with that, does anyone have any
16 further questions regarding either of those
17 announcements?

18 Okay. So we'll move forward then with
19 the rest of our reports. And Cristy, can you give us
20 our -- the registry report?

21 MS. MEYER: Sure. So Cristy Meyer,
22 the subcommittee chair for registry. Once again,
23 thank you for allowing us to hold this meeting. To
24 report from the committee, one of the biggest areas
25 of opportunity or discussion was related to non-

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2 trauma center data collection. We'd like to refer
3 this issue back to our Department of Health partners
4 to try to develop and -- and assess the feasibility
5 of getting this regional data back to the RTAC areas.
6 This is part of the regulations to support regional
7 trauma centers in their P.I. work but also in that
8 non-trauma center data collection that's part of the
9 regulation. Another area of opportunity is to kind
10 of finalize and quantify the changes for 2023 New
11 York State Trauma Data Dictionary. We've had a
12 couple of discussions about what those changes are.
13 We'll be making the final edits to the New York State
14 Trauma Registry Data Dictionary and get that out to
15 members as soon as possible. In addition, we would
16 need the X.S.D. file to get out to our vendors. We
17 had good vendor participation in today's meeting and
18 at last night's meeting at A.T.S., good interface,
19 and some discussion to hold more routine meetings
20 between our image trend vendor and some of the state
21 vendors. So we're looking forward to troubleshooting
22 some of the data collection throughout the state.

23 And just one word for the work group.
24 Jane McCormack has volunteered to develop a work
25 group to discuss the development of a resource for e-

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2 code data collection on micro bikes and motorbike e-
3 code collection. There are new I.C.D. ten codes in
4 this area. It would also feature a visual to use at
5 the bedside to help patients identify what motorbike
6 they were riding when they had the accident. And
7 that concludes my report.

8 DR. O'NEILL: Okay. Thank you,
9 Cristy.

10 Any questions for Cristy? So we'll
11 move forward with the trauma center needs assessment.
12 Dr. Winchell --

13 DR. WINCHELL: Sure.

14 DR. O'NEILL: -- do you have the
15 slides?

16 DR. WINCHELL: No. Thank you. Robert
17 Winchell, Chair of the Trauma -- Trauma Center Needs
18 Assessment Subcommittee. All good? All right. We
19 had essentially three elements of discussion and one
20 motion to talk about the first. In the last set of
21 STAC meetings, we have developed and then had fully
22 vetted, I guess is the right word, a policy for a
23 trauma center needs assessment step that will be
24 inserted whenever a new center applies for
25 provisional trauma center status, and I don't know,

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2 can you put that up, Dan?

3 MR. CLAYTON: Yes, So we're trying.

4 Yeah.

5 DR. WINCHELL: So that has now been
6 through all of the legal and various portions of --
7 of the department. So this is how we'll be doing the
8 applications for new trauma center provisional status
9 going forward. And we can mail out the full
10 document. It'll be on the website pretty soon. But
11 basically it contains a population coverage, or
12 basically a geospatial metric by which we will either
13 be strongly supporting -- supporting or weekly
14 supporting a trauma center depending -- depending on
15 the timeframe and degree of population coverage they
16 have.

17 There's a second way that -- that
18 people will get in based -- if they do have an
19 overlap and don't get in by the population coverage
20 metrics alone, then other -- if you scroll down a
21 little bit. The other things around capacity
22 included the other trauma center spending more than
23 two percent of their time on diversion or more than
24 twenty percent of patients meeting New York State
25 criteria for transport being taken to a non-

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2 designated facility because of transport issues. And
3 those were other metrics that we suggested for need
4 or that we've approved for need.

5 And then there's a final catch-all on
6 the next page that if a center doesn't meet either of
7 these two criteria, which would mean you're within
8 the catch mid area of one or more other facilities
9 that aren't on bypass and that aren't having a lot of
10 patients wind up at non-trauma centers, it would then
11 be up to the trauma center to provide us with their -
12 - the perspective trauma center to provide us with
13 data as to what need their filling with respect to
14 either access to a subpopulation of trauma patients
15 or to demonstrate that there is significant or
16 sufficient volume that the other centers would not be
17 adversely affected.

18 MR. SIMON: Ron -- Ron Simon. I'm --
19 I'm -- I'm just trying to remember the -- the last
20 state report that we had. But I -- I'm pretty sure
21 that in this state between twenty-five and thirty
22 percent of patients who were -- met the definition of
23 trauma patients were not going to trauma centers. So
24 if -- if you're going to use that number as a cutoff,
25 then there should be an -- additional trauma centers

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2 all over the state.

3 DR. WINCHELL: But that number is
4 specifically within the catchment district that's
5 being contested. So that if I wanted to come and set
6 up a trauma center across the street from you guys,
7 if I can show that within your catchment area,
8 there's already twenty percent of the patients who
9 meet field criteria going somewhere else, which we
10 use that as a proxy for E.M.S. not being able to
11 access the trauma center that's there. And, you
12 know, we -- we can adjust or see how it goes as we
13 put it into practice. But it was intended as a
14 metric of under capacity of the designated center in
15 the region. And again, I doubt that it will be met,
16 and I doubt that twenty percent of patients meeting
17 criteria are bypassing your facility for a non-trauma
18 center.

19 MR. SIMON: If you look at the New
20 York City data, again, this is from --

21 DR. WINCHELL: Okay.

22 MR. SIMON: -- 2015 or '17, but it --
23 it was in the New York City area where there are lots
24 and lots of trauma centers, still twenty-five percent
25 of people were not going to a trauma center, so.

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2 DR. WINCHELL: But then, you know,
3 then we'll have to look and see if -- if that metric
4 doesn't work in New York where you could argue that
5 the culture is still drive to the nearest hospital,
6 which is probably different than the rest of the
7 state where it's not -- you know, where the driving
8 distance are different, but we can see. And -- and
9 certainly this is a first cut at -- at the policy,
10 which we certainly anticipate improving and modifying
11 with time.

12 DR. O'NEILL: And Dr. Winchell, just
13 for clarification, this is just the application
14 process to achieve provisional status?

15 DR. WINCHELL: Yes.

16 DR. O'NEILL: And then they would be
17 required to have a consultation visit because they
18 obviously need trauma patients to be able to go for a
19 consultation and an eventual verification visit?

20 DR. WINCHELL: So there is already a
21 policy in place that states what it takes to be --
22 what you have to have in place to be designated or
23 named as a provisional center. I would tell you that
24 falls in the category of what it takes for you to say
25 that you can be a trauma center. That existing 2018

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2 policy does not address any of that should you be a
3 trauma center questions.

4 DR. O'NEILL: Right.

5 DR. WINCHELL: This add-on was an
6 attempt to try in an advisory way, answer the should
7 question also. And so its additive to the policy
8 that's -- that's already on the website from 2018.

9 DR. TEPERMAN: Just a question -- a
10 comment first, which I would say, Dr. Winchell, we --
11 we owe a debt of gratitude to you and Charice
12 (phonetic spelling) because this is very good work
13 and you brought your expertise from the college to
14 this. And, you know, to me it hits me as -- as, you
15 know, you're doing what you should be doing. You're
16 looking at reasonable metrics. Its, you know, it's a
17 very reasonable process, just -- just a question as
18 to process. Will this be an internal deliberation of
19 the subcommittee and which will then go straight to
20 the Department of Health, or will there be, you know,
21 then a second conversation at the larger STAC to say
22 these are the -- the subcommittees recommendations on
23 X, Y, and Z trauma center STAC?

24 DR. WINCHELL: So -- so the intent is
25 that we would have a small working subgroup of the

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2 needs assessment subcommittee aiming to get people
3 who are not in the area immediately involved. So to
4 be as objective and disconnected as we can within the
5 state, to initially look through this provider
6 recommendation to the executive committee of the STAC
7 with the anticipation that would eventually come
8 forward to the STAC though realizing there may be a -
9 - depending on how quickly we move, whether we'll
10 ever have these happen in between full STAC meetings
11 or not. But that -- that's the workflow we
12 anticipate.

13 DR. TEPERMAN: Thank you.

14 DR. O'NEILL: And for the recorder,
15 that was Dr. Teperman who asked the question.

16 Anyone have any other questions for --
17 or asking for clarification from Dr. Winchell?

18 DR. WINCHELL: Our second brief topic
19 is at the last virtual STAC meeting, we voted and
20 approved that the state or -- or the Department of
21 Health would seek funding for an official trauma
22 systems consultation from the trauma systems
23 evaluation and planning committee of the C.O.T. And
24 we just discussed progress. We think that the state
25 thinks that they have identified funding and are

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2 beginning the process of contract negotiations with
3 the A.C.S. trauma systems committee. So more to
4 follow on that one.

5 And then finally, a third piece of
6 work that we've been undertaking has to do with
7 gaining access to our E.M.S. registry and trauma
8 registry data for internal Q.I. purposes around needs
9 assessment and system Q.I. And so we've -- now,
10 there's a data use agreement in play that's been
11 developed to potentially allow outside or other --
12 other participants beside the state to assist in the
13 data analysis which has typically been the hold up
14 for us on this data.

15 And so we are at a place I think to --
16 to try this out. That we've got all the pieces in
17 place to -- to work through the process. And so our
18 formal motion brought forward by the subcommittee is
19 that -- I guess you can put that one up, if you want,
20 Dan, the motion, do you want to put it up for -- oh,
21 you're faster than I am. All right. Sorry about
22 that.

23 MR. CLAYTON: No, Steve is.

24 DR. WINCHELL: Anyway, it says that the
25 needs assessment subcommittee will proceed with a

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2 formal request to obtain raw data from both the
3 E.M.S. and trauma registries for the purposes of
4 internal analysis to perform objective needs
5 assessment based on regional metrics of E.M.S. access
6 and hospital capacity. The analysis of this raw data
7 will be undertaken by the subcommittee and may
8 potentially utilize outside resources under the newly
9 developed STAC data use agreement to try and add some
10 of the horsepower from some of our academic
11 institutions to try and move this process forward.
12 So then that's our formal -- formal motion we bring
13 forward for a vote here.

14 DR. O'NEILL: Okay, so --

15 DR. WINCHELL: And otherwise that
16 concludes my report.

17 DR. O'NEILL: So this comes to us
18 already as a seconded motion from a subcommittee so
19 we don't need to second it. Is there any further
20 discussion that anyone wants to -- okay. So we will
21 move --

22 MR. BRODY: Dr. O'Neill, may I?

23 DR. O'NEILL: Yes.

24 MR. BRODY: Sorry. Oh, sorry. This
25 is Peter Brody from the Department of Health, Bureaus

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2 of E.M.S. The only question I have for you, Dr.
3 Winchell, is which member of the trauma needs
4 assessment committee will be responsible for housing
5 the data outside the Department of Health. Has the
6 trauma needs assessment committee identified that
7 individual or that organization to be able to manage
8 that and the confidentiality of the data?

9 DR. WINCHELL: So I don't know that we
10 have settled on even the fact that we need to do
11 that. I would certainly put myself forward as one
12 potential person. I have no doubt Dr. Berry would do
13 the same. I think at the time that when we've come
14 down to actually looking into it and filling out the
15 data use agreement, we'll obviously have to have that
16 nailed down.

17 MR. BRODY: So then the -- the motion
18 then would leave that to the discretion of the Chair
19 and the committee to determine the outside
20 organization that will assume responsibility for the
21 legal and confidentiality requirements of the data
22 provided by the Department once the D.O.A. process is
23 complete, correct?

24 DR. WINCHELL: Okay. Yes. Whatever -
25 - whatever --

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2 MR. BRODY: Just making sure the time
3 it would take for --

4 DR. WINCHELL: -- additional language
5 you think is necessary there would be great.

6 MR. BRODY: If I went in two meetings
7 at the same time, I get a ...

8 DR. WINCHELL: Yep. Yep. No. I
9 appreciate it.

10 DR. O'NEILL: So Peter, I think what
11 you were saying is that we would follow the process
12 as it's outlined on the -- on the form, on the
13 standard data request form.

14 MR. BRODY: That's correct.

15 DR. O'NEILL: For our housing and --

16 MR. BRODY: For housing.

17 DR. O'NEILL: And responsibility of
18 maintaining confidentiality --

19 DR. WINCHELL: Yes.

20 MR. BRODY: Right.

21 DR. O'NEILL: -- and what we do with
22 it.

23 MR. BRODY: Correct.

24 DR. O'NEILL: And I think that was
25 implicit in the motion, but I'm glad you clarified

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2 it.

3 MR. BRODY: Yeah. I hope you don't
4 mind, Madam Chair.

5 DR. O'NEILL: Not at all. Not at all.
6 Any other further questions?

7 So we have a motion on the floor. All
8 in favor? Okay. Any nays? Anyone abstaining? So
9 carried.

10 Okay. Anything else, Dr. Winchell?

11 DR. WINCHELL: No, that -- that's
12 everything. Thank you.

13 DR. O'NEILL: Okay. With that, I'm
14 going to go a little bit out of order. Dr. Cooper
15 has an appointment in the city that he has to make.
16 So Art, do you want to move forward and give the
17 report of the emergency medical services for
18 children?

19 DR. COOPER: Thank you -- thank you,
20 Dr. O'Neill, and I appreciate the indulgence of the
21 Chair in allowing me to speak out of order. The
22 emergency medical services for children advisory
23 committee met about three weeks ago virtually. And
24 there were several important topics of discussion.
25 But I'll limit them to three. And perhaps the first

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2 and the most important to this group of those issues
3 has to do with the new requirement in the -- in the
4 gray book that all emergency departments and trauma
5 centers have pediatric emergency care coordinators.
6 Amy Eisenhower, our E.M.S.C. program manager who
7 could not be with us today, prepared a -- a brief
8 slide presentation focusing on the -- the role of the
9 pediatric emergency care coordinator, and she's been
10 kind enough to share her slides with Peter Brody.
11 And Peter will very briefly run through these slides
12 for you so you all understand what a pediatric
13 emergency care coordinator is in case you couldn't
14 guess and how we plan to, you know, go forward in
15 implanting it here locally with all of your support.

16 Peter?

17 MR. BRODY: Thank you, Dr. Cooper.
18 This is Peter Brody from the Department of Health,
19 Bureau of E.M.S. Amy had put together this
20 incredible slide show, and I am sorry that she's not
21 here to do this because she's much better at this
22 than I am. But a hospital pediatric emergency care
23 coordinator is a pediatric champion, someone who
24 advocates quite effectively, and vocally,
25 administratively, and structurally for equipment,

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2 supplies, training, continuing education, and
3 practice that are necessary to helping maintain an
4 effective pediatric care program in an emergency
5 department. As we discussed earlier in this
6 morning's pediatrics meeting, the med student
7 facilities in this room already have an effective
8 person for this role. However, the point is to get
9 this out into the smaller hospitals who may -- may
10 not be part of the trauma system. But you'd be
11 looking for a physician who's a specialist in
12 emergency medicine or pediatric emergency medicine
13 and a registered nurse with interest in training in
14 emergency care of children, you know. And in some
15 cases especially in smaller hospitals with fewer
16 resources, these individuals may well have this as an
17 add-on task or an administrative task, something
18 you're all quite used to. So quickly moving through
19 this, some of the points are the same between the
20 physician and the R.N., is participating in E.D. --
21 E.D. pediatric Q.I. and P.I., patient safety injury
22 and almost prevention in clinical care, and promote -
23 - promoting and verifying adequate skill and
24 knowledge of E.D. physicians and other E.D.
25 healthcare providers, and assisting with development

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2 and periodic review of E.D. policies, procedures
3 related to medications equivalent supplies to ensure
4 that the emergency department is prepared for this.
5 And serving as liaison to have in hospital and out of
6 hospital Pediatric Care Committees and facilitating
7 pediatric emergency education for E.D. healthcare
8 providers and out of hospital providers as well.

9 So -- and -- and collaborating with
10 the nursing coordinator to ensure adequate staffing,
11 medications, the ... supplies another resources are
12 well maintained for children in the emergency
13 department. Some of those are about the same for the
14 nursing coordinator as far as liaison -- liaising and
15 facilitating education for nursing and other care
16 provider staff and making sure that these tasks are
17 included in orientation for nursing, ensuring initial
18 and annual competency evaluations are completed,
19 promoting pediatric disaster preparedness for the
20 E.D., and participating in hospital disaster
21 preparedness activities. You know, these challenges
22 and disasters could happen anywhere in the state. So
23 the intent is to have an advocate in emergency
24 departments across the state. And then promoting
25 patient family education and illness and injury

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2 prevention.

3 Moving forward, providing assistance
4 and support for our pediatric education working with
5 clinical leadership to ensure the availability of
6 pediatric equipment and developing periodic review of
7 the availability of the equipment.

8 And I'm moving through this fairly
9 quickly. We did this earlier and the slides are
10 available. Looking to improve, you know, the
11 benefits of having a PEC in the emergency department
12 will hopefully improve pediatric readiness for
13 increasing staff awareness and competency and
14 pediatric best practices, having safer, better
15 equipped E.D. for pediatric emergencies, and
16 establishing sustainable pediatric education
17 improvement program that will ensure that kids always
18 present to a safe E.R. receiving the best care
19 possibly we can provide. Their guidance and tools
20 are available listed here and they'll be available.
21 If anybody has any questions, they can email Amy
22 Eisenhower.

23 So we'll be looking for the -- working
24 with E.M.S. for children advisory committee and the
25 state's run advisory committee, work group to review

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2 E.M.S.C. and hospital research and recommendations.
3 And work group to build New York State and Hospital
4 PEC program, you know, and provide some resources for
5 that.

6 This morning, Dr. Prince and his co-
7 chair led a -- a spirited discussion of this as -- as
8 we said many of the individuals in the room are --
9 are already pretty well pediatric prepared. It's a
10 matter of helping those hospitals that may not be.

11 And then rolling up program to the
12 hospital. There's Amy's contact information for
13 anybody who would like to reach her. She is watching
14 from home today. She wishes she was able to be here.
15 She'd rather be here than home. Although her office
16 assistant, the kitty loves having her at home, so.

17 DR. O'NEILL: Sheldon?

18 DR. TEPERMAN: Thank you. Just --
19 just a -- just a question, Art

20 MR. COOPER: Sure.

21 DR. TEPERMAN: This is a knowledge gap
22 and I -- I regret that I -- couldn't be at the
23 pediatric meetings. So I'm trying to understand,
24 this is just a knowledge gap that I have. So if
25 you're a pediatric trauma center or you have a

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2 pediatric emergency room, you -- you obviously are
3 pediatric facing and you're doing this all the time.
4 And there's twenty nurses that are trained at your
5 place in -- in this capacity. So this is for general
6 hospitals that have an emergency room that aren't
7 specializing in kids that should have one of these
8 folks. So how do you -- so -- so how -- how do you
9 do that? How do you operationalize this? You just
10 take -- take the bucket of -- of hospitals that are
11 pediatric places and pediatric specialization,
12 pediatric trauma centers and you say, you're good to
13 go and then you go to the other folks and say you
14 need this. I'm trying to understand.

15 MR. COOPER: Sure, a very good
16 question. Thank you, Sheldon. So as we discussed
17 this morning in our pediatric trauma subcommittee,
18 which Dr. Prince will focus on a little bit later, we
19 recognize that pediatric trauma centers will already
20 meet all the criteria that a pediatric emergency care
21 coordinator would fulfill as part of the routine
22 duties of the administration of that emergency
23 department. Certainly someone like a pediatric
24 emergency department director, pediatric emergency
25 department nurse in charge might be the named

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2 coordinator, if you will. But these individuals are
3 already performing the tasks that one would expect a
4 pediatric emergency care coordinator to perform. And
5 it would simply be question of designating the person
6 on paper and make -- and -- and making sure that that
7 person has access to the records that demonstrate
8 that work is being done, that it has been done.

9 So the focus of the pediatric
10 emergency care coordinator role is really designed to
11 improve the quality of pediatric care at institutions
12 that do not have extensive pediatric expertise.
13 Numerous studies both within our own department as
14 well as elsewhere have demonstrated that -- you know
15 that -- that having a focus on pediatric expertise in
16 an emergency department does make a huge difference
17 in terms of outcome. Quality improvement project
18 that we performed here in this department about five
19 years ago clearly show that -- that -- that, you
20 know, mortality or case fatality rate in the
21 emergency department actually was considerably lower
22 in -- in hospitals that had a focus on pediatric
23 emergency care via some sort of pediatric expertise
24 in terms of resources and -- and staffing, mostly
25 education.

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2 But the -- the trick is to make sure
3 that the system works at the local level. And so
4 part of the discussion that we had this morning in
5 terms of oper -- operationalizing the concept is that
6 these sorts of things really become best
7 operationalized when they're a regional coalition
8 that support hospitals that don't have the
9 specialized pediatric expertise, particularly with
10 respect to issues like disaster preparedness. So --
11 so that would -- that's the -- the role and goal is
12 to, you know, improve the quality of pediatric care
13 by ensuring that adequate resources and adequate
14 education are in place for the staff, you know, at
15 every hospital. But, of course, that is already in
16 place for places like pediatric trauma centers. I
17 hope that answers your question. Any other questions
18 regarding -- regarding Amy -- Amy's and Peter's
19 presentation?

20 Well, hearing none, I just want to
21 comment very briefly on two other items that E.M.S.C.
22 focused on. First, many of you are already aware
23 that there's a new set of field triage guidelines
24 that's been promulgated by the college. It looks
25 very different in format, but is quite similar in

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2 content with the exception of the E.M.S. provider
3 judgment section, which is quite a bit more explicit
4 than has been the case in past versions. I think the
5 sense among -- among all participants, SEMAC, STAC,
6 E.M.S.C. is that, you know, embracing these new
7 guidelines as our own in New York State makes good
8 sense. But it also seem to make good sense to
9 E.M.S.C. and SEMAC agreed, I believe, Dr. Doynow,
10 that getting together a small group to look -- to
11 look at these and -- and look at these new field
12 triage guidelines and see if there was anything that
13 we felt needed perhaps more explication to our peers
14 before they were adopted. And I know Amy is getting
15 this small group together.

16 The other major issue has to do with
17 the adoption of -- of a new pediatric agitation
18 protocol. As many of you are aware, you know,
19 agitated adolescence can be quite a handful as can
20 agitated younger children. The focus in -- in
21 pediatric agitation management is much, much more on
22 de-escalation than it is on the use of drugs. And in
23 particular, you know, most -- most pediatric
24 psychiatrists or child psychiatrists and most
25 pediatric emergency medicine physicians tend to shy

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2 away from use of Ketamine, you know, except in
3 extreme cases where you're dealing with a very large
4 -- very large adolescent who's really acting like a,
5 you know, an adult. And what used to be called
6 excited delirium, but now there's a new name which
7 I'm blocking on at the moment.

8 But that -- a preliminary version of
9 that protocol was adapted by SEMAC as part of the
10 global embrace of the so-called collaborative
11 protocols that were put into place or -- or that were
12 -- I should -- I should say created by the
13 collaborative protocol group. They were recently
14 enacted by the SEMAC.

15 Another small group is getting
16 together to look at the -- the -- the actual protocol
17 that was recommended by E.M.S.C. and to see if there
18 are any additional changes that may need to be made
19 to the -- the collaborative -- the recently adopted
20 collaborative protocol to really refine it a little
21 more fully. Both of these subgroups are expected to
22 meet before the December SEMAC meeting so that these
23 issues can be finalized in time for rollout of -- of
24 protocol changes by the New Year.

25 That's all I have. I'll be happy to

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2 answer any questions, but I want first to ask Dr.

3 Doynow if I told any lies?

4 DR. GESTRING: Well, I think you're on
5 base there, Art.

6 DR. COOPER: Thank you. Shell?

7 DR. O'NEILL: All right. I'll just --
8 I just have a quick question. Wat you're referring
9 to, those protocols are for our pre-hospital only?

10 DR. COOPER: That's correct. Yes.
11 So, but, of course, they may be useful for anyone,
12 you know, who recent -- yes. I think there's two
13 questions, Mark Gestring had a question and Shell had
14 a question.

15 DR. GESTRING: I just wanted to
16 encourage anyone who's looking at the field triage
17 guidelines to make sure they include looking at the
18 manuscript, which is open access, available to
19 everybody, and lists in great painful detail every
20 decision that was made regarding what's included,
21 what's excluded, and why along with current
22 references, so make sure that gets looked at the same
23 time.

24 DR. COOPER: Thank you. Thank you,
25 Mark, a very important contribution. Sheldon?

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2 DR. O'NEILL: Mark, do you want to
3 comment on any of the other educational materials
4 that go with the recommendations in case some of our
5 members want to investigate it further?

6 DR. GESTRING: Sure. Thank you. Mark
7 Gestring, Finger Lakes RTAC. I -- I would mention
8 that as Dr. Cooper said, the field triage guidelines,
9 which originally lived within the C.D.C. were revised
10 within NHTSA, the National Highway Traffic Safety
11 Administration. In 2021, that process was led by the
12 committee on trauma, the American College Resurgence
13 Committee on Trauma but include -- I don't remember
14 the number, but a very large number of collaborating
15 authors from all of the E.M.S. agencies, the E.M.S.
16 for children, anybody related to emergency, Madison
17 E.M.S., paramedicine, any -- any of the first
18 responder communities along with the E.M.S. educators
19 as well. So this -- this work was completed last
20 year. It is now available and fully completed on --
21 on the website. And it's fieldtriageguidelines.org,
22 I think. But if you type in field triage guidelines,
23 it'll automatically come up. What's on the website
24 includes not just the new guidelines, but like I just
25 referred to, a manuscript which was written to

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2 describe the entire process. There are also
3 educational materials written for a number of
4 different consumers. So there are slide decks for
5 brand new E.M.S. providers who have never used
6 guidelines like this before. There's another set for
7 experienced providers who need to understand why
8 they're different now. There's a different set
9 written in the A.B.C. kind of teaching methodology.
10 There's a different set using MARCH which is the
11 Massive Hemorrhage -- there's a -- kind of different
12 teaching modalities across the country. So the
13 materials are all available online and they're also
14 customizable. So if you want to download the
15 equipment and call it Dr. Cooper's Education on Field
16 Triage Guidelines, you can do that, and then still
17 the core material is still included. So -- so that
18 stuff's all available for people who are interested
19 in looking at it.

20 DR. O'NEILL: Sheldon --

21 DR. GESTRING: The -- the last piece
22 that people should be aware of, there was some --
23 there was some national questions regarding the host
24 organization because many states have included a
25 C.D.C. triage guidelines in their regulations and the

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2 C.D.C. no longer does this. The work got shifted
3 over to NHTSA. So the C.D.C. recently published an
4 explanatory paragraph on their -- attached to their
5 guidelines saying they no longer do guidelines and
6 they have re -- basically sub -- turned that over to
7 NHTSA, so that should not be a problem for anybody in
8 terms of wording or anything like that.

9 DR. O'NEILL: Okay. Sheldon?

10 DR. TEPERMAN: Teperman, New York.

11 I'm -- I'm just wondering out loud, Dr. O'Neill and
12 Dr. Bank. We clearly have in our midst a subject
13 matter expert on this. And I'm just wondering, you
14 know, if Mark would agree and if you, the leadership
15 thought it was a good idea that we have a brief or a
16 detailed presentation on the new trauma triage
17 criteria as it would affect trauma centers at the
18 next STAC?

19 DR. O'NEILL: I think that's great
20 idea. We can put it under new business or you can do
21 it -- well, actually you won't have a report, so we
22 can put it under new business.

23 DR. TEPERMAN: Sorry Mark for --

24 DR. BANK: As long as Mark and Dr.
25 Gestring agrees.

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2 DR. GESTRING: I'm -- I'm happy to
3 share it with the group. There's a standard --
4 several -- excuse me, several of the -- of the author
5 group have a slide set that we use so that we're
6 consistent in the message we deliver, so I'm -- I'm
7 happy to share that with the group. I can do it in a
8 -- in a subcommittee in the morning, if you want, or
9 we can do it at the main STAC. And, you know, it
10 takes a little bit of time so maybe you want to do it
11 in the morning?

12 DR. BANK: We'll -- we'll figure out
13 the logistics with you before --.

14 DR. GESTRING: Happy to do it.

15 DR. COOPER: One just final very brief
16 comment in terms of the pediatric agitation protocol.
17 There are now excellent, you know, video
18 presentations on pediatric de-escalation, you know,
19 in the e -- the E.M.S.-C.E.I.I.C. website, that's the
20 E.M.S.C. innovation and implementation center website
21 hosted at the Texas Children's Hospital. And with
22 that I'll conclude my report unless there are any
23 other questions that are -- are outstanding. Hearing
24 none, thank you, Dr. O'Neill, appreciate it.

25 DR. O'NEILL: You're welcome. I'm

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2 going to take the prerogative of the Chair to change
3 the order of the reports again, because I think this
4 would be a very timely time to have Dr. Prince give
5 the pediatric report just rather than to come back to
6 pediatrics later on in the meeting.

7 DR. PRINCE: Thank you, Dr. O'Neill.
8 Jose Prince for the Pediatric Subcommittee with Kim
9 Wallenstein, who's my co-chair, but who's got a bit
10 of a sore throat. So I'll do most of the speaking,
11 but Kim, please jump in at -- at any point. And I --
12 I'm glad, thank you, because I had the thought, but I
13 thought everyone else would just think I wanted to
14 leave early by asking to go sooner. So I -- this is
15 -- there was no text message exchange making this
16 request. I -- I think probably the most natural
17 place then for me to give the report for the
18 pediatric subcommittee is to begin with a motion that
19 was -- we'd like to bring forward with regards PEC.

20 And thank you, Peter, for the
21 presentation this morning and again now. What -- and
22 I don't know if you have it to show, or if not,
23 that's okay. I can try to remember the language.

24 MR. CLAYTON: It was -- it was part of
25 the email I sent you.

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2 DR. PRINCE: I'm sorry. Was this from
3 executive subcommittee?

4 MR. CLAYTON: Yeah. It was.

5 DR. PRINCE: I didn't see it typed up.

6 MR. CLAYTON: I think it's part of the
7 email that I --

8 DR. PRINCE: Oh. So I'll begin to
9 speak while we -- while we generate it, and I can
10 move to another topic and come back. But -- but it
11 essentially in -- in -- as a follow-up to try to
12 operationalize as -- as I think Dr. Teperman's
13 question raised, a process for how we do this. One
14 of the first state -- step was to just get an
15 inventory of what -- who and at what facilities would
16 have this responsibility currently or where the gaps
17 are that a facility does not have an identified
18 individual. So we would like to have the STAC
19 through this motion request that the department
20 require that -- that an individual be identified in
21 any emergency hospital or any emergency services
22 providing facility in New York State with an
23 identified individual who will serve as the pediatric
24 emergency care coordinator.

25 And that would allow us then to have

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2 the ability to identify an individual in each
3 location, and then from there work within a RTAC
4 regional approach, at least initially, so that each
5 RTAC might identify at least a lead site that would
6 be the pediatric -- let's go with the disaster
7 component of this work that would naturally be the --
8 the lead site or lead sites if in the region for a
9 pediatric mass casualty or disaster event. As -- as
10 we all know, the -- well, just to emphasize that the
11 number one killer of children in this -- in this
12 country now is gun violence. And we -- we suffer
13 from that in New York State, so. And that is
14 throughout the state and can happen at any location.
15 So making sure that we have a pediatric emergency
16 readiness to handle those kinds of events and then
17 help to provide structure in that chaos. So -- and
18 the from there within the regions to begin to help
19 facilitate whatever resources we can help provide
20 from the facilities that are well resourced, in terms
21 of even sometimes just helping to point out the
22 resources that already very much exist to do this.
23 So that -- that is the -- the motion that we would
24 like to bring forward to the staff.

25 DR. O'NEILL: We need something a

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2 little more succinct to be able to vote on.

3 DR. PRINCE: Yeah. I'm sorry. I
4 thought -- I think we have it. I just was waiting
5 for the --

6 DR. BANK: This is -- this is Dr.
7 Bank, and I -- I would propose from the executive
8 subcommittee a motion to the full STAC. The STAC
9 asked the Department of Health to require New York
10 State hospitals to providing emergency services to
11 designate a pediatric emergency care coordinator.

12 DR. TEPERMAN: A comment. So I
13 obviously am in favor of this. But just because in
14 one of my facilities, there's already been -- been
15 some confusion about it. And just because I was
16 confused, as I mentioned. Might I suggest that there
17 be some language that lets people know that for
18 trauma centers or pediatric emergency room, This is
19 not a new requirement, right? So the confusion at
20 one my facilities, which was a pediatric center was
21 that somehow there needed to be someone new doing
22 this work. So I don't know how you do that in the
23 wording. But, you know, something like, you know, it
24 is understood At a pediatric trauma center that
25 someone is doing this work, We just need their name.

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2 I -- I -- you know, --

3 DR. PRINCE: Yeah. I -- I -- my
4 thought --

5 DR. TEPERMAN: Because the confusion
6 could -- could undermine the -- your entire purpose.

7 DR. PRINCE: Yeah. I think that
8 that's the follow up of -- of we -- we just really
9 want the facilities to catalogue and identify
10 individuals. The follow up will be us helping to
11 provide what those individuals should do, or need to
12 do, and then a discussion amongst the facilities to
13 do that. I don't -- I'm -- I'm open to thinking
14 about it. I think the plan was to make this as
15 simple as possible in just -- in our request. And in
16 the way that a hospital has to identify to the state
17 who their infection control individual is or who
18 their tissue manager -- all -- there's a lot of
19 mandated reporting for facilities for -- for point
20 people. That's essentially just what we're starting
21 with at this point.

22 DR. O'NEILL: Jose, I have a question.
23 Because I am not a pediatric trauma center, I've been
24 looking at the gray book specifically for adults.

25 DR. PRINCE: Um-hum.

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2 DR. O'NEILL: So all adult trauma
3 centers now are required to have a defined PEC with
4 the appropriate job responsibilities. Does the gray
5 book specify what the pediatric trauma centers need
6 even though the -- the responsibilities to find in
7 the PEC are -- are expected to be done by a
8 designated pediatric center already? Do they require
9 a name to pick in a pediatric trauma center? Because
10 I didn't look at the review -- at the book to
11 determine that. And I think that's what the
12 confusion was that Dr. Teperman was speaking to.

13 DR. PRINCE: I don't think so. I'm
14 not going to be in -- in the C.O.T. meeting this week
15 as a reviewer. I -- I can certainly ask the group
16 that's there to clarify it, at least for me or for us
17 if that is -- if there's any understanding that would
18 be there.

19 Again, I think for a -- for a
20 children's hospital or pediatric trauma center, it
21 probably is just a matter of putting a name on a
22 piece of paper. There's really no other requirement
23 because it's all done. It would just because the
24 point of contact that we would -- we would utilize
25 within the state. And I think the A.C.S. would want

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2 to understand who -- who is in theory the person
3 collating or organizing that information. But I can
4 double-check to -- to make sure. I don't --

5 DR. O'NEILL: Any --

6 DR. PRINCE: The gray book reads very
7 differently. And maybe I'll ask Kim.

8 Kim, do you want to add or do you know
9 more clearly than me?

10 DR. WALLANSTEIN: Hi, Kim Wallanstein.
11 I don't. That is a question that we have also had
12 because like we have all talked about, we're already
13 fulfilling all of those criteria. I believe they do
14 want one name just to check off the box of a
15 designated person but that is a good question to ask.

16 DR. PRINCE: So -- so for someone like
17 ourselves, just to be clear as we're talking about
18 two different systems between the state and the
19 A.C.S., I -- for someone like us, it would be my
20 pediatric emergency medicine liaison to my peer
21 review committee would be my PEC, right, if their --
22 if they have the expertise, they're in the role and
23 they're already functioning in it. And there's no
24 really added ask for them at that point. They're
25 already are participating in the trauma, peer review,

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2 and quality and disaster management, and everything
3 else that comes along with it, so. So I -- I don't
4 know, to get back to the motion. I -- I think just
5 from a streamlining point of view, it's a very simple
6 ask that we're just asking for the state to require a
7 -- a designation of an individual. It has to happen
8 for all the trauma centers. And again, I -- I don't
9 think -- the spirit of this is, I think the trauma
10 centers, we're all going to be fine. We have a lot
11 of resources in this space. The concern is much more
12 around the smaller rural facilities that have no one
13 identified potentially in this space. And starting
14 to help them have this conversation so that we can
15 make sure that we help them as we elaborate the plan
16 going down the line.

17 MR. DEIURA: So just for process to
18 clarify, if -- if this motion moves forward, we will
19 work to co-author a dear administrator letter with
20 the division of hospitals and diagnostic treatment
21 centers. In that letter to your point, and I think
22 it's a good one, we can specifically call out that it
23 does not need to be a newly created position. If
24 somebody is already designated or fulfilling those
25 job duties or responsibilities, that person can be

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2 used as the point of contact. And -- and any other
3 suggestions you may have to clear up any confusion
4 before we send the letter out to avoid having to
5 respond to it after we send the letter out would be
6 great.

7 DR. PRINCE: Yeah. Thank you.

8 DR. O'NEILL: Okay. So this did not
9 come to the committee as a subcommittee seconded
10 motion, so we have to go through the full process.
11 We kind of jumped ahead before seconding the motion
12 to the discussion.

13 DR. PRINCE: Sure.

14 DR. O'NEILL: So Matt, do you mind
15 reading the motion one more time.

16 DR. BANK: So the motion from the
17 executive subcommittee would be STAC asks the
18 Department of Health to require New York State
19 hospitals providing emergency services to designate a
20 pediatric emergency care coordinator.

21 MS. SNYDER: I'll second that.

22 Does anyone want to second that?

23 MS. SNYDER: Kerrie Snyder will second
24 it.

25 DR. O'NEILL: Okay. All in favor?

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2 Anyone opposed? No oppositions. Anyone abstaining?

3 Okay. The motion carries.

4 (Off-the-record)

5 DR. PRINCE: Just to be clear for the
6 group, we discussed this morning and the pediatric
7 subcommittee for quite some time. We just didn't
8 frame it as a motion. We didn't -- we didn't
9 appreciate the best process to bring it forward to
10 this group. So I appreciate Steve and -- and the
11 state helping us to -- to think about the most
12 effective way to accomplish the goal. And then I'll
13 be very brief for the rest of it. We -- we have our
14 pediatric New York State tea quip ... collaborative.
15 We will have a -- a group meeting at the national
16 meeting in December. That continues to be a larger
17 support structure for the pediatric research
18 consortium, which has already successfully published
19 two papers and has two other projects taking place in
20 the state looking at dog bite injuries and cataloging
21 them, for example, is one of the successful ones
22 that's been completed. And looking at bone to
23 abdominal trauma. They're the current ones that are
24 ongoing have to do with the social determinants of
25 health and child abuse, and as well as long-term

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2 impact of trauma on children.

3 We spoke about the injury prevention
4 component and raised the discussion around firearm
5 safety and gun violence in children given as I -- I
6 mentioned earlier that it is the leading cause of
7 death of children in the United States. And -- and
8 gathering a discussion for our next pediatric
9 subcommittee that would discuss firearm safety and
10 gun violence reduction efforts focused on, within our
11 space, the pediatric component of it.

12 We also discussed the C.D.C. triage,
13 which I will not go into again as Dr. Cooper very
14 much discussed it already in his report and pediatric
15 transport. The one issue that was raised was
16 discussed to some degree already but has to do with a
17 -- I -- I might have missed it but just to emphasize
18 in -- especially in the upstate region and the more
19 rural parts of New York State, difficulty in inter-
20 facility transfers and delays based on E.M.S.
21 availability based on their staffing models. And
22 that there are children who are sometimes taking over
23 a day to be able to move from one facility to another
24 to receive definitive trauma care. And I think that
25 -- that covers my review of the pediatric sub --

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2 subcommittee.

3 Dr. Wallenstein, would you like to add
4 anything?

5 DR. WALLENSTEIN: Kim Wallenstein, no,
6 that covered it.

7 DR. TEPERMAN: Just a com -- a
8 comment. So roughly this statistic is accurate. At
9 some point during the year, my center had triage to
10 it, fifty percent or greater than fifty percent of
11 the children that were shot in New York City. So I
12 want -- I -- I -- I rise to praise the activity of
13 the subcommittee with drawing focus on what is just
14 an epidemic of gun violence against children in this
15 country.

16 DR. PRINCE: Yeah. Thank you, Dr.
17 Teperman. Yeah. I think at our facility, we've seen
18 triple the volume of gunshot victims this year
19 compared to -- and we're not done with the year, but
20 already it's tripled the volume of our historic
21 annual penetrating pediatric trauma with -- with
22 firearm injuries. So it's clearly a -- an injury
23 prevention aspect, and all aspects that we can
24 participate in, that is important. Thank you. All
25 right.

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2 DR. O'NEILL: So we will move forward
3 with the injury prevention report and Christy
4 Ladowski (phonetic spelling), unfortunately, could
5 not make a report so she is going to have Sloan.

6 MR. YOSELOWITZ: My name is Sloan
7 Yoselowitz. I'm the injury prevention coordinator of
8 Roc --

9 DR. O'NEILL: We have to spell your
10 last name because --

11 MR. YOSELOWITZ: I'll -- I'll give you
12 my card before I leave, that's fine.

13 DR. O'NEILL: For the rec -- okay.
14 I'll give it to you.

15 MR. YOSELOWITZ: I'm the injury
16 Prevention Coordinator of ... University Medical
17 Center, and being here in person is so much better
18 than looking at a box. It was nice to meet a whole
19 bunch of people and really enjoyed the past day and a
20 half.

21 So for the subcommittee meeting for
22 injury prevention, the University of Rochester is now
23 a group site for disaster management and emergency
24 planning. They're going to be offering these courses
25 virtual and in person going forward.

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2 As far as the E.T.S. and Safe States,
3 they have a bunch of educational opportunities. One
4 of them is -- there's going to be an upcoming
5 information about all the injury prevention, things
6 in the gray book, and they also have past webinars
7 online. They're going to be offering mentorship
8 programs for new and experienced injury prevention
9 coordinators, which I think is wonderful to bridge an
10 ice gap to really have us to be able offer many more
11 programs in the community.

12 Safe States is also preparing to
13 partner resources to prequel to the roadmaps and
14 partnerships. In November, they have new seed
15 grants. It's going to be twenty to twenty-five
16 thousand dollars for injury prevention programs for
17 organizations to partner with businesses. We spoke
18 about micro mobility and Eric Marten (phonetic
19 spelling) had a sheet in which, Your Honor, I guess
20 Cristy Meyers spoke about recently before which is
21 going to show different types of E-mobilities which
22 will help first responders, police officers, and
23 emergency care identify exactly what type of mobility
24 vehicle it -- it will be. As far as the older adult
25 fall prevention grant funding, we are funded until

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2 2025. Christina Agee (phonetic spelling) spoke from
3 OHIP. She gave an overview -- overview of all the
4 new injury prevention educational and outreach
5 resources, which were available on the website. And
6 we can order physical copies. We also had a lively
7 discussion about data sources and data analysis. And
8 we'll try to connect with the State Department of
9 Health to inform our trial -- trauma colleagues from
10 making a request and accessing data.

11 I'm not sure if anyone has questions.

12 DR. O'NEILL: Any questions for Sloan?
13 Okay. Thank you very much, and I appreciate your
14 patience in being put down to the end of the list.
15 Just leave me your card so I could give it --

16 MR. YOSELOWITZ: Yeah. I'll give it
17 right now. It was wonderful meeting everybody.

18 DR. O'NEILL: Okay. That brings us to
19 regional P.I. Dr. Bank?

20 DR. BANK: Okay, really a great
21 meeting. We had two really nice presentations, one
22 from the center from Nassau Emergency Medical Center
23 talking about a real interesting injury prevention
24 program she put together using geolocated data on --
25 on mechanisms of injury in Nassau County. From that

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2 presentation, from the discussion came the first
3 motion from the P.I. subcommittee to the STAC, and
4 that first motion is that we recommend that the
5 Department of Health works with STAC and uses its
6 resources to help with the geolocation of fall
7 patients.

8 In addition, this data will be
9 reported to the appropriate RTEC.

10 DR. O'NEILL: Okay. So the motion has
11 already been seconded at the subcommittee level. So
12 I open it up for discussion. Is there anyone who has
13 any questions or further comments regarding the
14 motion? Okay. So moving forward then, we'll just
15 proceed with a vote. All in favor of supporting the
16 motion? Any nays? Any abstain -- abs --
17 abstentions? Okay, the motion carries.

18 DR. BANK: So our second presentation
19 was from Cristy Meyer from Northwell who discussed
20 how to use video review. She further performs
21 improvement at her institution. This generated a
22 large amount of discussion among the committee and
23 generated our second motion. The second motion is
24 that we will recommend that the Department of Health
25 endorses the use of video review of trauma

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2 activations at trauma centers for the purposes of
3 performance improvement and patient safety.

4 DR. O'NEILL: So this motion is also
5 coming to the committee having already been seconded.
6 So I open it for discussion. Any questions or
7 comments? So we'll move forward with the vote. All
8 in favor of supporting the motion? Any nays? Any
9 abstentions? The motion carries.

10 DR. BANK: And that completes my
11 report. Thank you.

12 DR. O'NEILL: Okay. And then Dr.
13 Simon (sic), systems?

14 MR. SIMON: Okay.

15 DR. O'NEILL: We're getting a lot of
16 work done today.

17 DR. SIMON: Yeah. So Ron Simon. So
18 we've already had an update on the -- on the bylaws
19 and on the four zero five updates, so I'm not going
20 to bother with that. The -- there was a request from
21 SEMAC for us by -- well, it was from SEMAC but it was
22 led by Dr. Doynow about requesting support from the
23 STAC for allowing ground ambulances to continue blood
24 transfusions during transport. And there was a
25 discussion at the systems, and we came up with the

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2 following support.

3 DR. BANK: So you -- do you want --
4 this is Matthew Bank. Do you want me to read the
5 motion?

6 MR. SIMON: Well, okay, I thought we
7 had it up, but okay.

8 DR. BANK: So --

9 MALE VOICE: I think we have it.

10 FEMALE VOICE: There we go. Well, as
11 you can see --

12 MALE VOICE: No. This is -- this is -
13 - this is separate motion and should be taken out.

14 DR. BANK: Okay.

15 MALE VOICE: Yep.

16 DR. BANK: This is Matthew Bank. So
17 the motion from the system subcommittee is that STAC
18 recommends a modification to the existing regulation
19 to allow New York State paramedics and E.M.T.
20 critical care providers to transport patients via
21 ground ambulances with ongoing blood and blood
22 product infusions without the need for a preexisting
23 transfusion agreement from their transferring
24 hospital.

25 MR. SIMON: So -- so apparently, while

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2 this has nothing to do with E.M.S. starting blood in
3 the field, which gets some people a little upset, it
4 has more to do with once a patient has blood already
5 in one facility and they're being transported to
6 another facility that they can continue the blood
7 transfusion during transport. This is apparently
8 allowed in the aeromedical space, but not allowed on
9 the ground ambulance space. So SEMAC was just asking
10 us to support them to allow it to happen in ground
11 ambulances also.

12 DR. TEPERMAN: Could you -- could you
13 read it one more time? Teperman.

14 DR. BANK: STAC recommends a
15 modification to the existing regulations to allow New
16 York State paramedics and E.M.T. critical care
17 providers to transport patients via ground ambulances
18 with ongoing blood and blood product infusions
19 without the need for a preexisting hospital
20 transfusion agreement from the transferring hospital.

21 MR. CLAYTON: And also we're -- we're
22 in the process of putting it into -- something we can
23 project on the screen, the motion.

24 DR. O'NEILL: Any other discussion
25 points, clarification? Okay. So this came to the

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2 committee also already being seconded at the sub --
3 as a recommendation from a subcommittee. So seeing
4 that there's no further discussion, we'll move
5 forward with the vote. All in favor of accepting the
6 motion? Any nays? Any abstentions? The motion
7 carries.

8 MR. SIMON: And the -- the last thing
9 which I was asked, I -- I was asked to -- we didn't
10 get to it in the subcommittee. But most of the
11 people probably have heard that the new state report
12 should be coming out in the next couple of months
13 which will incorporate data up to 2021, which is
14 pretty exciting. But being the forward-thinking
15 people that we are, I'm thinking about the next
16 report and how we can make it a better report. So we
17 will discuss this somewhat at the next systems
18 committee.

19 But to jump start it, if anyone is
20 interested in giving some thoughts on how we could
21 make the state report better for the next round, then
22 please send them to me, and I will bring them up at
23 next STAC committee. And -- because there -- we are
24 going to have a meeting with the state data people to
25 start already figuring out how the next report will

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2 look.

3 DR. O'NEILL: Yeah. So sometime, I
4 think, we are hoping in November that we will have a
5 virtual meeting with the DMAR representatives to
6 discuss aspects of the report and then potential
7 changes. So we don't want to necessarily wait for
8 the next STAC meeting. So if you have any specific
9 ideas about what should be included in the report
10 that haven't been included in prior reports, you can
11 send those ideas to Dr. Simon. Thank you for
12 volunteering to be the repository for that.

13 MR. SIMON: Sure.

14 DR. O'NEILL: And then the -- this
15 Chairs of the different subcommittees who are members
16 of the executive committee will participate in that
17 virtual meeting, and I'm sure it's not going to be
18 the end -- the final meeting as well. I'm sure
19 there'll be an ongoing discussion. But this is an
20 opportunity for us to actually look at data that
21 might be really much more specific or of interest to
22 us on STAC. Any comments or questions about that?
23 Okay. Are you -- anything else?

24 MR. SIMON: That's the end to my
25 report.

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2 DR. O'NEILL: Great. So we will move
3 forward then to the other reports. We will get an
4 update from the New York State Chapter of the
5 American Trauma Society. Jerry, welcome.

6 MR. MORRISON: Thank you. Good
7 afternoon. I'm Jerry Morrison. I'm the president of
8 the New York State Chapter of the American Trauma
9 Society. We had our meeting last night. We had more
10 than a hundred attendees. It was really great to be
11 able to see and interact in person. Reporting from
12 our education committee, a -- an educational needs
13 assessment was conducted, and the top five needs for
14 programming that were identified were the A.I.S.
15 course, TCAR registry course, A.T.L.S. and DMAP.
16 Information was also shared about the registry and
17 registry staff. In regards to injury prevention and
18 outreach, we had updates, and they're updating their
19 program directory currently and seeking information
20 from existing structures and injury prevention
21 coordinators. From national updates, there's been a
22 significant number of webinars conducted on injury
23 prevention as it relates to the new guideline
24 standards. Injury Prevention Awareness Day is
25 November 18th with a Go Green theme. And they also

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2 are soliciting information regarding articles and
3 events to put in their next newsletter publication.

4 And from the legislative committee,
5 new legislation includes the Safer Communities Act
6 aimed at reducing firearm violence, Nine Eight Eight
7 National Suicide Prevention, and Mental Health
8 Hotline, and new Narcan laws, which require the
9 prescription of Narcan with narcotic prescriptions.

10 In regards to Stop the Bleed, there's
11 been a focus on grassroots advocacy. We are
12 currently looking at options for a combination
13 advocacy and Stop the Bleed Program for legislature
14 and their staff with the upcoming January meeting.

15 And also talked about collaboration
16 with New York State A.C.S. Governmental Affairs
17 liaison, Babette Grey, for A.T.S. and STAC to
18 increase public awareness of training and
19 availability of equipment for Stop the Bleed.

20 E.N.A. is working on a new addition of
21 the T.N.C.C. program which is -- will be released in
22 the near future. S.T.N. has Trauma Con, which will
23 be March 29th through 31st in Denver, Colorado.

24 T.C.A.A.s National Conference will be in Albuquerque,
25 April 30th through May 5th. E.S.O. presented

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2 information regarding a new registry and support of
3 its existing products. We had updates from the
4 Department of Health and from the New York State TQIP
5 Collaborative. And our -- our final action was we
6 approved grant fund -- or funding for grant. So
7 annual grants are gone through and distributed
8 through the New York State A.T.S. and a budget of
9 fifteen thousand dollars was approved for 2023. So
10 that's my report. Are there any questions?

11 DR. O'NEILL: Jerry, do you have a
12 deadline for the request for the grant money?

13 MR. MORRISON: So typically, we'll
14 start going through and dispersing the grant
15 information applications typically in November, and
16 presentation at the January meeting.

17 DR. O'NEILL: Any other questions for
18 Jerry? Thank you.

19 MR. MORRISON: Thank you.

20 DR. O'NEILL: And so Dr. Doynow?

21 DR. DOYNOW: Thank you, Dr. O'Neil.
22 This is Don Doynow, SEMAC Chair. We met in
23 September. There were a number of collaborative
24 protocol changes of which Dr. Cooper mentioned, two
25 of them, one that I was asked to bring this group,

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2 T.X.A. was approved for pre-hospital care. And the
3 question that came up was whether we would go with
4 the standard dose of one gram or escalate that to two
5 grams, and it was thought that we should get input
6 from your expertise as to what this group would
7 suggest.

8 DR. TEPERMAN: Well, I have just
9 comment. T.X. -- you know, this is like, are you
10 still beating your wife, right? So I -- I think that
11 it would've been nice to have had the ability to
12 comment on whether this should be done at all. I --
13 I think that the trauma surgeons have a difference of
14 opinion about this. I -- but I -- I would say that
15 certainly lots of folks think that the second -- the
16 second gram and certainly the infusion shouldn't be
17 done. So notwithstanding the fact that I'm not a big
18 T.X.A. person, you definitely don't want to give more
19 than a gram. And I would point out that it -- it's
20 not clear -- it's not clear that we're not seeing a
21 whole bunch of extra thromboses down the road from
22 altering the fibrinolysis pathway. And, you know, I
23 -- I would say that just as a general comment that
24 I'd like to see some medical control. That this be
25 decision not at the level of the operator on the

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2 street, but that -- that there be some level of
3 medical control brought to the decision of whether or
4 not to give T.X.A. either on in the street or on
5 route.

6 DR. DOYNOW: Okay. Not to contradict
7 Dr. Teperman, but in the Finger Lakes Region, we --
8 we discussed this at our RTAC and we had an advisory
9 ahead of the collaborative protocol changes and our
10 recommendation was two.

11 DR. TEPERMAN: So I -- I really -- I --
12 - I think that before the STAC could -- this would
13 just be my thought. Before the STAC could make a
14 cogent recommendation there would need to be
15 convened, you know, an expert panel of -- of -- of
16 trauma surgeons who knows something about this. And
17 the -- the dose is critical, right? So, I mean, you
18 know, if you're -- if you're me and you believe that
19 we are altering the fibrinolysis pathway in an
20 inappropriate way, and you're going to spread a lot
21 of T.X.A. into the world, you're going to spread a
22 lot of trouble into the world.

23 So my recommendation would be that
24 there be a, you know, whatever subcommittee is -- is
25 relevant, that some experts be brought to bear on it.

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2 This is a -- this is, you know, almost exclusively a
3 trauma-related issue, and that those experts look at
4 it and decide on the -- on whether or not there
5 should be a recommendation and what the dose should
6 be, would be my thought.

7 DR. O'NEILL: Well, I would say as a
8 trauma surgeon myself, I am not one that believes
9 that T.X.A. should be given to everyone in the field
10 either. I'm a little surprised that this did go
11 forward and was accepted at the SEMAC without any
12 input from us. So I do not have an opinion about the
13 dose.

14 Dr. Prince, do you have a comment?

15 DR. PRINCE: Yeah. Jose Prince. I
16 just have a question. Is -- is the pediatric dosing
17 or use in pediatrics discussed at the SEMAC level and
18 is that dose also information being sought from the
19 group?

20 DR. DOYNOW: No, that wasn't, and
21 actually, this was brought to the local surgeons
22 before it came up for collaborative protocols at our
23 local, in Albany district.

24 DR. O'NEILL: And -- and admittedly,
25 Dr. Teperman and I are, you know, from downstate in

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2 an urban environment and transport times and things
3 are quite different. But I would agree that I don't
4 think there's a consensus across the country and
5 within the trauma circles as to the role of T.X.A.
6 There's no hundred percent consensus about its use in
7 the pre-hospital setting.

8 That being said, are you putting a
9 motion on the floor? I wasn't quite sure.

10 DR. DOYNOW: Well, that wasn't a
11 motion, it was just for expertise. But I can
12 certainly bring it back to SEMAC.

13 DR. PRINCE: Sorry. I -- I -- I'm
14 sorry I didn't catch that. The -- the --

15 DR. DOYNOW: There -- there was not a
16 motion.

17 DR. PRINCE: It will be under -- no,
18 for it will be used in under eighteen transports or
19 it would be only in adults?

20 DR. DOYNOW: At this point, it would
21 be adults.

22 DR. PRINCE: Okay. So there's no
23 question about pediatric dosing?

24 DR. DOYNOW: Not as of yet.

25 DR. PRINCE: Okay.

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2 MR. SIMON: I -- I just have to say,
3 I'm -- I -- I -- I had to be quiet for a minute
4 because I was so stunned by your request that the
5 fact that the -- the fact that you -- you came to us
6 to ask us about the dosing. But you didn't ask us
7 about whether or not we agreed with the utility. I'm
8 -- I -- I just don't understand that. But that's,
9 you know, that's what you did and that's fine. I
10 would just ask the SEMAC, when you're going to be
11 doing things that are affecting our patients that we
12 will be taking care of for the long term, and we deal
13 with the consequences and you don't, it would've been
14 nicer that you had come to us and asked us our
15 opinion first.

16 DR. DOYNOW: Well, I can certainly
17 bring that back to the group. Okay. And I will
18 bring that back.

19 DR. TEPERMAN: Right. So the -- so
20 the concern is that interfering with the fibrinolysis
21 pathway -- just, you know, the specific -- and, you
22 know, these are reasonable things I think to discuss
23 amongst colleagues. And then -- and the issue of
24 medical control, right? So, you know, I -- I think
25 a, you know, an emergency medicine physician getting

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2 a request from the field, right? Because this -- the
3 problem is, you know, when you have lemons, you make
4 lemonades. And -- and, you know, I think that the --
5 the field folks would be anxious to try to help the
6 bleeding patient. But I do think just one little
7 element of medical control even if we're not
8 successful at these efforts here, you know, would
9 give a -- you know, let's pause for a second, and
10 let's think about whether or not we need to interfere
11 with a fibrinolysis pathway. An M.D., you know,
12 sitting in a -- in a controlled operations area,
13 weighing in on the decision, I -- I -- I think at a
14 minimum if you're going to go forward with this.

15 DR. DOYNOW: So --

16 DR. TEPERMAN: My idea. My idea.

17 DR. DOYNOW: So my -- my
18 understanding, would this group prefer to put
19 together a -- a subcommittee group to look at this to
20 respond back to SEMAC before we put this
21 collaborative protocol into effect, which would not
22 occur until January? We can certainly --

23 DR. WINCHELL: I -- I think that that
24 would be a great idea because, you know, I think the
25 state's very different, right? And it may or may not

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2 make sense in Manhattan where I've got a ten-minute
3 transport time.

4 DR. DOYNOW: Right.

5 DR. WINCHELL: It may make a ton of
6 sense where I'm looking at a four-hour transport
7 time. Equally as you note, there's substantial
8 controversy about what the right dose should be and
9 how it should be given.

10 DR. DOYNOW: Exactly.

11 DR. WINCHELL: So I think the idea, if
12 we could put together a group to offer refinements
13 additions, hey, did you think about this kind of
14 stuff back to the policy would be great.

15 MR. SIMON: And -- and it would be
16 nice to actually see the policy.

17 DR. DOYNOW: Okay.

18 DR. O'NEILL: So Dr. Doynow, first,
19 please don't take any of these comments personally.
20 We welcome and really appreciate your being here. We
21 were just all taken by surprise. But we will then
22 try to put this maybe -- would you want to put this
23 on the agenda for the subcommittee for the systems?

24 DR. DOYNOW: Sure.

25 DR. O'NEILL: And -- but would you be

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2 able to have some of your colleagues come in to -- in
3 the morning?

4 DR. DOYNOW: Sure. No problem. I'd
5 be more than happy to do so.

6 DR. O'NEILL: They would want to make
7 that, because I think it would be important to have
8 some representation from your -- from SEMAC to be
9 able to hear that side of it so that we're not making
10 unilateral decisions, because as Dr. Winchell said,
11 you know, we do practice in different environments.

12 DR. DOYNOW: That's very true.

13 DR. BANK: Could we, maybe, Ron, and
14 figure out a -- a sub - a few -- a few people to
15 interact with SEMAC so maybe you could come with
16 collaborative effort to present.

17 MR. SIMON: Okay. Can we -- can we
18 ask Dan -- Dan, can you do that? Can you put us
19 together with SEMAC or the -- or I can --

20 MR. CLAYTON: Yes.

21 DR. O'NEILL: Do a virtual?

22 MR. CLAYTON: Yes. Yes, we can do
23 that.

24 MR. SIMON: A virtual thing and we can
25 have a -- an educated discussion.

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2 MR. CLAYTON: Sure thing.

3 DR. O'NEILL: Jane? Yeah.

4 MS. MCCORMACK: Thank you. I'm Jane
5 McCormack. Could you also involve the RTACs in this
6 because this topic has been discussed and voted on in
7 Suffolk RTAC? I directly realize that there are so
8 many different agents in the state to Dr. Winchell's
9 point. So I know that in Suffolk we voted on it and
10 began to hear that nobody considered that is
11 disheartening. Thank you.

12 MR. CLAYTON: If -- if I -- if I may.
13 Thank you, Jane, for that comment. It's a good
14 point. STAC is made up of, among others, RTAC
15 representatives. So you do have RTAC representatives
16 at the table here at STAC. So I would say that would
17 be the mechanism is working up through your Regional
18 Trauma Advisory Committee to STAC and, you know, that
19 would be the process, I would say.

20 DR. O'NEILL: Well, what I think we
21 can do, Dan, is when you set up the virtual meeting
22 that you have the Chair of the RTACs on that virtual
23 meeting because that would be more important to have
24 that balanced representation since there are regional
25 differences.

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2 MR. CLAYTON: We can do that.

3 DR. O'NEILL: And Dr. Bank, do --

4 DR. BANK: I agree. I think it would
5 be better rather than bringing some members of SEMAC
6 and having this discussion, which could take several
7 hours looking at -- looking at studies, that we
8 actually do this offline, and then maybe come back to
9 January with a collaborative effort that's a little
10 bit more mature.

11 DR. O'NEILL: All right. And Dr.
12 Doynow, maybe in preparation before the virtual, any
13 documents or pol -- protocols you could share so that
14 people can see them before the meeting in order to go
15 in and keep the discussion as focused as possible?

16 DR. DOYNOW: Sure. I can get those to
17 Dan. That -- that's fine. No problem. When do you
18 propose that we have this meeting? Our -- our next
19 SEMAC meeting is coming up December?

20 MR. SIMON: I think we should have --
21 I think we should have a couple of virtual meetings,
22 and then we can have the -- at the next STAC, we can
23 have -- this is what we all came an agreement to.

24 DR. DOYNOW: Okay. I'll bring that
25 back to SEMAC and see if we can postpone the release

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2 of that particular protocol until the decision by
3 this group.

4 MR. SIMON: That'd be great. Thank
5 you.

6 DR. O'NEILL: I mean, ideally we can
7 try to do that obviously before the January meeting.
8 But I will admit that's quite a few individuals that
9 you have to coordinate calendars for. So that is a
10 little bit of a challenge even with the virtual
11 meeting. But I'm sure we can try to do it sooner
12 than later.

13 MR. CLAYTON: Okay. Just -- just to
14 be clear, does it exist in the collaborative
15 protocols today?

16 DR. DOYNOW: It will exist in the
17 collaborative protocol as of January when they would
18 be released in training. Is it something that can be
19 held? Yes, because it hasn't been released, but it's
20 there.

21 MALE VOICE: It's there today.

22 FEMALE VOICE: It's there today.

23 MALE VOICE: It's being used today.

24 One gram dose is being used today.

25 FEMALE VOICE: (unintelligible)

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2 DR. O'NEILL: Well, it's my
3 understanding that T.X.A. has been used in some
4 regions in the prehospital setting even before this
5 protocol, correct? So practice isn't necessarily
6 changing because of this proposal. The practice of
7 using T.X.A. has been sporadic in many regions
8 already.

9 DR. DOYNOW: That probably is true.
10 And one question I do have for Dan or Steve, those
11 particular changes need to be approved by the health
12 commissioner, and has that been done?

13 MR. CLAYTON: So Steve, go ahead.

14 MR. DZIURA: I'm just thinking. I
15 don't believe they have been transmitted up to the
16 Commissioner's office yet. I'd have to double check
17 on that, but likely not yet.

18 DR. DOYNOW: Okay.

19 DR. O'NEILL: Okay. So I think we
20 have a plan to address that.

21 Dr. Doynow, do you have anything else,
22 Dr. Doynow?

23 DR. DOYNOW: No. Other than that,
24 just thank the group for the support for transfusions
25 and ground ambulances. Appreciate it.

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2 DR. O'NEILL: You're very welcome.

3 Okay. So --

4 MR. CLAYTON: Dr. Chair, I -- I -- to
5 try to prevent discussion after the meeting and --
6 and further delay this whole process, tranexamic acid
7 is in the advanced E.M.T. protocol. It was approved
8 sometime during 2021 and it was put into the
9 protocols earlier this year up through the executive
10 Deputy Commissioner. And the protocols that are on
11 the website, the collaborative A.L.S. protocols do
12 have T.X.A. in them.

13 MR. SIMON: At what dose?

14 MALE VOICE: One gram.

15 FEMALE VOICE: One gram.

16 MR. CLAYTON: I just sent the link to
17 Theresa here.

18 MR. SIMON: Folks are saying one --
19 one gram.

20 MALE VOICE: It's one gram.

21 FEMALE VOICE: One gram.

22 DR. O'NEILL: And what are the
23 criteria for twos at this point? Is it a standard
24 for certain patients? Do all patients to get it
25 meeting certain requirements or is it --

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2 DR. TEPERMAN: Is there medical

3 control?

4 DR. DOYNOW: Yes.

5 DR. TEPERMAN: There is medical

6 control.

7 MALE VOICE: There is no medical

8 control.

9 FEMALE VOICE: No, there's not.

10 MALE VOICE: No? We're hearing none.

11 MALE VOICE: I'm sorry, the what?

12 MALE VOICE: It's under the adult

13 shock hypoperfusion protocol.

14 MALE VOICE: Can we turn on the

15 screen?

16 FEMALE VOICE: Can you turn on the

17 screen?

18 MALE VOICE: It's for decompensated

19 hypovolemic shock patients. So it's a very small

20 subset of issues.

21 MALE VOICE: Oh, I disagree with that.

22 MALE VOICE: At -- at my -- at my

23 center, this is just a sunny Tuesday decompensated

24 hypovolemic shock.

25 MALE VOICE: Dan, what version is

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2 that? Is that two zero two two ...

3 MR. SIMON: Transfusion? One unit of
4 O-negative blood. I mean, who -- who is this?

5 DR. O'NEILL: This is region.

6 MR. SIMON: Who -- who is this?
7 Because this is certainly not a New York --

8 MR. CLAYTON: And a lot of it, there
9 are two liters of saline, I'm loving that. So to
10 answer the question from the audience, this is
11 version two -- two zero two two point one, which is
12 effective 4-15-2022. It is for advanced life support
13 so anything above E.M.T. level. Now granted,
14 A.E.M.T.s are not doing this, okay? But it is in the
15 Advanced Life Support Protocol.

16 MR. DZIURA: And to be clear, which
17 does not cover New York City. New York City is under
18 the unified protocols. And I don't recall off the
19 top of my head if it mirrors this. I believe,
20 actually, if I'm recalling correctly, part of the
21 discussion was that they want to edit into the
22 unified protocol. And there was a discussion around
23 standardizing the dose between the two protocols so
24 it was consistent.

25 DR. TEPERMAN: But also with a

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2 transport time of -- in New York City of on the
3 average of eight minutes to a trauma center, the idea
4 that you would give two liters of -- of fluid to
5 anybody is -- is shocking. And then what doesn't --
6 what's hard to understand is we -- the Department of
7 Health has not authorized any E.M.S. service to
8 initiate a transfusion of blood as far as I can tell,
9 to the conversation all day. So why would that --
10 unless we got that wrong, right? E.M.S. services
11 cannot initiate a transfusion by New York State Law.

12 MR. DZIURA: Air Ambulance Services
13 may.

14 DR. TEPERMAN: Air Ambulance Services
15 may, so this -- so that part only relates to the Air
16 Ambulance Service, the part that says transfuse what.

17 DR. O'NEILL: I'm going to take the
18 prerogative of the Chair. I think we're going to
19 stop this discussion. And we will have to address
20 this through the virtual meetings. There's clearly a
21 lot more here than we can even address in this
22 meeting. But thank you for sharing that. So at
23 least now we know what we -- the issues that we have
24 to latch on.

25 MALE VOICE: Bring the patient.

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2 DR. TEPERMAN: We may know what we
3 don't know.

4 DR. O'NEILL: So in -- just so for old
5 business, just an update, maybe Steve or Dan, maybe
6 you want to report on this trauma system funding for
7 the report, if it's good news?

8 MR. CLAYTON: Yeah, so I'll just share
9 a briefly because I don't have a lot of information
10 on it. But I know that this committee had brought up
11 to this body publicly before the -- the want, the
12 need, the desire for a statewide system assessment to
13 be completed of our trauma system. And over the
14 summer months, Director Greenberg came to me in -- in
15 a meeting and said that he believed that he had
16 identified some funding. I don't know where from. I
17 can't go into detail about that. But some funding
18 that might be available to help us do this. And if
19 it ended up being, and it sounds like it might, you
20 know, a sole source per contract like the American
21 College of Surgeons, we would have to go through
22 that. As you know, when you're dealing with
23 government, we -- we have a contracting process. So
24 if it ends up being the American College of Surgeons
25 that does this, we would obviously have to develop a

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2 contract in order to have them come here and do a
3 statewide system assessment of our trauma system.

4 But the -- the -- the bureau is in
5 support of it and Director Greenberg says that he's
6 identified some funding. We did have a meeting
7 scheduled with the A.C.S., the Department did, a
8 couple of months ago that unfortunately had to be
9 postponed. But it is our intention to meet with them
10 in the -- the coming month, in -- in November for
11 sure to discuss this program, find out about steps,
12 policies, procedures, and how to move forward.

13 Do you have anything to add, Deputy
14 Director?

15 DR. O'NEILL: Okay. That's great
16 news. And then I know we're all getting tired. So
17 under new business, just sort of an announcement of
18 what's to come. Many of you who've been on the
19 committee for many years know that the size of the
20 STAC has grown exponentially in the last few years.
21 In our prior years, believe it or not, committee
22 members were officially named into the different
23 subcommittees. By no means are we looking to exclude
24 anyone from the subcommittees they're participating
25 in. But what came to our attention over the last

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2 year or so is that at any one point we have no
3 listing of individuals who are actively members of
4 those subcommittees. So -- nor have we had sign-in
5 sheets so that as motions were proposed at
6 subcommittee member -- activities, we didn't really
7 have a documentation of who was there to actually
8 vote on it.

9 So for process purposes, et cetera,
10 moving forward, we're going to have to do a little
11 housekeeping for that. So you may have noticed that
12 today at the subcommittee meetings, we actually did
13 have sign-in sheets. And so we are going to start
14 first with the sign-in sheets, and then most likely
15 one of the charges of the new Chair will be to
16 formally identify the official members of the
17 subcommittees. So most of people have pretty much
18 assigned themselves. And so the intent will be that
19 you can still continue to be an official member of
20 those subcommittees, we just need to have an
21 accounting of who's on those subcommittees. And we
22 do have a responsibility as well to make sure that
23 there's equal regional representation on those
24 subcommittees, which I would be shocked if we don't
25 already have that just by the size of our

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2 subcommittees.

3 Any questions?

4 MR. CLAYTON: Dr. O'Neill, if I could
5 just add to that, everything she said is correct.
6 But I would just add to that to make sure that it's
7 understood that this, of course, will include STAC-
8 vetted voting members. But we also welcome
9 participation on these subcommittees from those who
10 are not STAC-vetted floating members. And, you know,
11 it -- it -- obviously at the full body of the STAC,
12 like we're meeting right now, it has to be STAC
13 members only that are voting and everything. But we
14 want to -- we want to encourage participation from
15 the trauma community statewide at our subcommittee
16 levels.

17 DR. O'NEILL: Yes. And that's what I
18 meant by telling individuals that -- and for those
19 who are not here, if you -- you know, can clarify if
20 they should hear about this, we're welcoming them.
21 They will still be active members of those
22 subcommittees. Remember, we do have a term of
23 associate members. So everyone who participates in
24 those commit -- subcommittees will be members of the
25 subcommittee. We do have to make sure there -- by

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2 process that there are vetted mem -- voting members
3 on these committees as well, and I don't anticipate
4 that to be a problem. Any questions?

5 Okay. So the next STAC meeting.

6 DR. PRINCE: May I -- one --

7 DR. O'NEILL: Yes.

8 DR. PRINCE: May I bring up one other
9 item for new business? Is that okay?

10 DR. O'NEILL: Yes, you can.

11 DR. PRINCE: It'd be brief. I -- I --
12 we've discussed it in executive committee meeting
13 last week and I -- we ran out of time earlier.

14 I just wanted to ask for the support
15 of the STAC to -- for a letter to be issued again as
16 has been issued in the past in support of the
17 E.M.S.C. proposal for grant support for ongoing
18 support for the E.M.S.C. So if I could just have a
19 sent from the -- from the group for that.

20 DR. O'NEILL: Oh, thank you for
21 remembering that.

22 DR. PRINCE: Well, actually, others
23 reminded me, so I -- Peter.

24 DR. O'NEILL: Do you want to just give
25 the background for that, that this is not a new

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2 grant, this is something that we're -- we'll be
3 continuing to support?

4 DR. PRINCE: Yeah, Dr. Cooper's the
5 best one describe this obviously. But for a long
6 time there has been multiple Federal grants that have
7 ongoing -- an ongoing manner have supported E.M.S.C.
8 across the country. It currently lives out of Texas,
9 I think the central grant holding component. And
10 every three to five years we need to submit a new
11 grant proposal to remain funded and a part of this
12 E.M.S.C. protocol, and that's been partly what
13 supports some of the efforts that we've all discussed
14 today.

15 DR. O'NEILL: So the motion is simple,
16 that the STAC will write a letter in support of
17 continued funding to the -- to -- to the committee --
18 to the council.

19 DR. PRINCE: Correct. It is something
20 we have done a number of times over many years and is
21 done by other organizations as well. I think SEMAC
22 and others also provide letters of support that then
23 get submitted with the grant to show that we as a --
24 as a state support that the E.M.S.C. continue it's
25 work.

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2 DR. O'NEILL: Can I have a second?

3 MALE VOICE: Second.

4 DR. O'NEILL: All in favor? Any nays?

5 Any abstentions? The ayes have it. We will give you
6 that letter.

7 DR. PRINCE: Great. Thank you so much
8 everyone.

9 DR. O'NEILL: And so final
10 announcement, now that we have defined our dates for
11 2023, the next STAC meeting will be January 25th,
12 2023, and the meeting is adjourned.

13 (The meeting concluded at 3:33 p.m.)

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2 STATE OF NEW YORK

3 I, MONIQUE HINES, do hereby certify that the foregoing was
4 reported by me, in the cause, at the time and place, as
5 stated in the caption hereto, at Page 1 hereof; that the
6 foregoing typewritten transcription consisting of pages 1
7 through 106, is a true record of all proceedings had at
8 the hearing.

9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 25th day of October, 2022.

11

12

13 MONIQUE HINES, Reporter

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