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

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE MEETING

DATE: October 12, 2022

TIME: 1:34 p.m.

CHAIR: Patricia O'Neill, M.D.

LOCATION: 40 Lodge Street

Albany, New York

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APPEARANCES:

Patricia O'Neill, M.D., STAC VICE CHAIR (ACTING CHAIR)
Matthew Bank, M.D., Nassau RTAC
Daniel Clayton, Executive Secretary
Jose Prince, M.D., N.Y.C. RTAC
Arthur Cooper, M.D.
Steve Dziura, Deputy Director, BEMSATS
Sheldon Teperman, M.D., N.Y.S. RTAC
William Hallinan, R.N., Finger Lakes RTAC
Mark Gestring, M.D., Finger Lakes RTAC
Cristy Meyer, R.N. STAC Sub-Committee Chair

Robert Winchell, M.D., STAC Sub-Committee Chair
Ronald Simon, N.Y.C. RTAC

Peter Brody, D.O.H.
Kim Wallenstein, M.D., Central RTAC
Kerrie Snyder, R.N., Northeaster RTAC
Sloan Yoselowitz, D.P.T., NuHealth
Jerry Morrison, President N.Y.S. Chapter Trauma Society
Donald Doynow, M.D., SEMAC Chair
Jane McCormack
Abenamar Arrillaga, M.D., Suffolk RTAC
James Vosswinkel, M.D., Suffolk RTAC
Jamie Ullman, M.D.
Tammy Sykes, R.N.

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(The meeting commenced at 1:34 p.m.)

DR. O'NEILL: Remember to try to identify your name for the recorder. Can we have the roll call?

MR. CLAYTON: Dr. O'Neill?

DR. O'NEILL: Here. Oh. Dr. O'Neill is here.

MR. CLAYTON: Dr. Wallenstein?

MS. WALLENSTEIN: Dr. Wallenstein's here.

MR. CLAYTON: Dr. Gestring?

DR. GESTRING: Here.

MR. CLAYTON: William Hallinan?

MR. HALLINAN: Here.

MR. CLAYTON: Dr. Bank?

DR. BANK: Here.

MR. CLAYTON: Dr. Angus?

Dr. Simon?

DR. SIMON: Here.

MR. CLAYTON: Dr. Agriantonis?

Dr. Prince?

DR. PRINCE: Here.

MR. CLAYTON: Dr. Teperman?

DR. TEPERMAN: Here.

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MR. CLAYTON: Kerrie Snyder?

MS. SNYDER: Here.

MR. CLAYTON: Dr. Arrillaga?

DR. ARRILLAGA: Present.

MR. CLAYTON: Dr. Vosswinkel?

DR. VOSSWINKEL: Here.

MR. CLAYTON: Dr. Flynn is excused.

Dr. Ullman?

DR. ULLMAN: Here.

MR. CLAYTON: Dr. Winchell?

DR. WINCHELL: Here.

MR. CLAYTON: Tammy Sykes?

MS. SYKES: Here.

MR. CLAYTON: Dr. Dailey?

Dr. Doynow?

DR. DOYNOW: Here.

MR. CLAYTON: Dr. Goldman?

Dr. Cooper.

DR. COOPER: Here.

MR. CLAYTON: Roll call complete. We have better than quorum.

DR. O'NEILL: Great. So Dan sent out a copy of the minutes from our previous meeting. Does anyone have any corrections, comments, or edits

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

DR. PRINCE: So moved.

DR. O'NEILL: Name.

DR. PRINCE: Prince, so moved.

DR. COOPER: Cooper, second.

DR. O'NEILL: All in favor?

DR. COOPER: Aye.

DR. PRINCE: Aye.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to people that were unable to leave their homes.

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

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

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

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

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

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

MR. CLAYTON: Could you introduce yourself?

DR. TEPERMAN: Yeah. Sorry. Dr.

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

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

MR. DZIURA: So while I'll definitely

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

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

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

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

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

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

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

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

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

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

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

And finally, I saved the best for

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

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

MR. DZIURA: I sure can.

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

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

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

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

MR. HALLINAN: Thank you.

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

piece of the conversation.

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

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

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

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

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

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

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

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

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

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

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

MR. CLAYTON: Sure.

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

can do is then discuss further at the upcoming meetings.

MR. CLAYTON: So according to my records --

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

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

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

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

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

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

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

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

Dr. BANK: Yes.

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

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

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

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

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

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

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

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

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

DR. O'NEILL: Yes.

MR. CLAYTON: Test with the audio.

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

MR. CLAYTON: Aye.

DR. GESTRING: Aye.

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

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

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

DR. O'NEILL: Oh.

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

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

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

MR. CLAYTON: Yes.

DR. O'NEILL: Okay.

DR. TEPERMAN: Trish?

MR. CLAYTON: Yes.

DR. TEPERMAN: Just have a -- a

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

DR. O'NEILL: So --

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

DR. O'NEILL: Yeah.

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

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

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

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

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

MR. CLAYTON: Yes. Thank you.

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

Matt, do you want to just --

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

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

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

DR. O'NEILL: On a Wednesday.

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

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

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

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

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

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

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

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

DR. BANK: Right.

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

DR. BANK: Okay.

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

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

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

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

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

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

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

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

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

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

DR. WINCHELL: Sure.

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

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

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can you put that up, Dan?

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

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

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

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

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

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

all over the state.

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

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

DR. WINCHELL: Okay.

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

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

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

DR. WINCHELL: Yes.

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

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

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

DR. O'NEILL: Right.

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

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

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

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

DR. TEPERMAN: Thank you.

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

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

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

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

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

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

MR. CLAYTON: No, Steve is.

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

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

DR. O'NEILL: Okay, so --

DR. WINCHELL: And otherwise that concludes my report.

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

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

DR. O'NEILL: Yes.

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

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

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

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

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

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

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

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

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

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

MR. BRODY: That's correct.

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

MR. BRODY: For housing.

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

DR. WINCHELL: Yes.

MR. BRODY: Right.

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

MR. BRODY: Correct.

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

it.

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

DR. O'NEILL: Not at all. Not at all.

Any other further questions?

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

Okay. Anything else, Dr. Winchell?

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

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

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

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

Peter?

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

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

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

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

prevention.

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

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

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

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

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

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

DR. O'NEILL: Sheldon?

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

MR. COOPER: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

answer any questions, but I want first to ask Dr. Doynow if I told any lies?

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

DR. COOPER: Thank you. Shell?

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

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

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

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

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

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

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

DR. O'NEILL: Sheldon --

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

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

DR. O'NEILL: Okay. Sheldon?

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

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

DR. TEPERMAN: Sorry Mark for --

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

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

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

DR. GESTRING: Happy to do it.

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

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

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

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

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

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

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

MR. CLAYTON: Yeah. It was.

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

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

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

And that would allow us then to have

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

DR. O'NEILL: We need something a

little more succinct to be able to vote on.

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

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

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

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I -- I -- you know, --

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

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

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

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

DR. PRINCE: Um-hum.

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

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

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

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

DR. O'NEILL: Any --

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

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

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

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

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

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

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

DR. PRINCE: Yeah. Thank you.

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

DR. PRINCE: Sure.

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

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

MS. SNYDER: I'll second that.

Does anyone want to second that?

MS. SNYDER: Kerrie Snyder will second it.

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

Anyone opposed? No oppositions. Anyone abstaining? Okay. The motion carries.

(Off-the-record)

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

impact of trauma on children.

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

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

subcommittee.

Dr. Wallenstein, would you like to add anything?

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

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

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

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

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

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

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

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

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

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

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

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

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

I'm not sure if anyone has questions.

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

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

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

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

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

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

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

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

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

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

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

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

MR. SIMON: Okay.

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

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

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following support.

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

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

DR. BANK: So --

MALE VOICE: I think we have it.

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

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

DR. BANK: Okay.

MALE VOICE: Yep.

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

MR. SIMON: So -- so apparently, while

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

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

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

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

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

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

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

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

look.

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

MR. SIMON: Sure.

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

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

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

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

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

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

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

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

E.N.A. is working on a new addition of the T.N.C.C. program which is -- will be released in the near future. S.T.N. has Trauma Con, which will be March 29th through 31st in Denver, Colorado. T.C.A.A.s National Conference will be in Albuquerque, April 30th through May 5th. E.S.O. presented

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

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

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

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

MR. MORRISON: Thank you.

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

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

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

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

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

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

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

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

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

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

Dr. Prince, do you have a comment?

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

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

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

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

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

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

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

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

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

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

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

DR. DOYNOW: Not as of yet.

DR. PRINCE: Okay.

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

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

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

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

DR. DOYNOW: So --

DR. TEPERMAN: My idea. My idea.

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

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

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

DR. DOYNOW: Right.

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

DR. DOYNOW: Exactly.

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

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

DR. DOYNOW: Okay.

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

DR. DOYNOW: Sure.

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

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

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

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

DR. DOYNOW: That's very true.

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

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

MR. CLAYTON: Yes.

DR. O'NEILL: Do a virtual?

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

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

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MR. CLAYTON: Sure thing.

DR. O'NEILL: Jane? Yeah.

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

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

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

MR. CLAYTON: We can do that.

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

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

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

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

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

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

of that particular protocol until the decision by this group.

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

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

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

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

MALE VOICE: It's there today.

FEMALE VOICE: It's there today.

MALE VOICE: It's being used today. One gram dose is being used today.

FEMALE VOICE: (unintelligible)

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

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

MR. CLAYTON: So Steve, go ahead.

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

DR. DOYNOW: Okay.

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

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

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

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DR. O'NEILL: You're very welcome. Okay. So --

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

MR. SIMON: At what dose?

MALE VOICE: One gram.

FEMALE VOICE: One gram.

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

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

MALE VOICE: It's one gram.

FEMALE VOICE: One gram.

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

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DR. TEPERMAN: Is there medical control?

DR. DOYNOW: Yes.

DR. TEPERMAN: There is medical control.

MALE VOICE: There is no medical control.

FEMALE VOICE: No, there's not.

MALE VOICE: No? We're hearing none.

MALE VOICE: I'm sorry, the what?

MALE VOICE: It's under the adult shock hypoperfusion protocol.

MALE VOICE: Can we turn on the screen?

FEMALE VOICE: Can you turn on the screen?

MALE VOICE: It's for decompensated hypovolemic shock patients. So it's a very small subset of issues.

MALE VOICE: Oh, I disagree with that.

MALE VOICE: At -- at my -- at my center, this is just a sunny Tuesday decompensated hypovolemic shock.

MALE VOICE: Dan, what version is

that? Is that two zero two two ...

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

DR. O'NEILL: This is region.

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

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

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

DR. TEPERMAN: But also with a

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

MR. DZIURA: Air Ambulance Services may.

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

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

MALE VOICE: Bring the patient.

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

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

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

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

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

Do you have anything to add, Deputy Director?

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

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

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

subcommittees.

Any questions?

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

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

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

Okay. So the next STAC meeting.

DR. PRINCE: May I -- one --

DR. O'NEILL: Yes.

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

DR. O'NEILL: Yes, you can.

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

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

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

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

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

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

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

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

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

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

MALE VOICE: Second.

DR. O'NEILL: All in favor? Any nays? Any abstentions? The ayes have it. We will give you that letter.

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

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

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

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STATE OF NEW YORK

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

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

MONIQUE HINES, Reporter

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**M**

**Q**