
NEW YORK STATE DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES FOR CHILDREN
ADVISORY COMMITTEE

Tuesday, March 17, 2009
11:00 a.m.
The Crowne Plaza
30 Lodge Street
Albany, New York

APPEARANCES:

Susan Brillhart
Lee Burns
Sharon Chiumento
Arthur Cooper, M.D.
Tim Czapranski
Louise Farrell
Brian Gallagher
Marjorie Geiger
Martha Gohlke
Jonathan Halpert, M.D.
Robert Kanter, M.D.
Kathleen Lillis, M.D.
Janice Rogers
Sarah Macinski Sperry
Ruth Walden

Edward Wronski

OTHERS PRESENT:

Deborah Brown

Nancy Ginsberg

Susan Stred, M.D.

Gary Tuthill

1 DR. COOPER: Good morning,
2 everyone. I'd like to welcome you to the
3 first meeting of the Emergency Medical
4 Services for Children advisory committee
5 for calendar year 2009. My name is Art
6 Cooper and at your request, I have the
7 honor of chairing this group today. And
8 we have a rather full agenda, so I'll
9 begin by asking Martha if she will call
10 roll.

11 COURT REPORTER: I don't think the
12 microphones are working.

13 MS. GOHLKE: Is this on? There we
14 go. Hello. Hello.

15 What I prefer to do is maybe go
16 around and let you guys introduce
17 yourself, if you wouldn't mind, because
18 actually Dr. Amler was supposed to be
19 here and I thought it would be helpful
20 for him, but I guess he hasn't arrived
21 yet. So Lee, why don't we start with
22 you.

23 MS. BURNS: Lee Burns. I'm with
24 the EMS Bureau at the state health
25 department.

26 MS. GOHLKE: Martha Gohlke, EMS
27 coordinator.

28 MR. WRONSKI: Ed Wronski, the
29 director of the EMSC group.

1 DR. COOPER: Art Cooper, pediatric
2 surgeon on the committee.

3 MS. FARRELL: Louise Farrell,
4 private practice manager at the School of
5 Public Health.

6 DR. HALPERT: Jonathan Halpert,
7 New York ACEP.

8 DR. STRED: I'm Sue Stred. I'm
9 the associate professor of pediatric
10 endocrinology at Upstate for about the
11 last nineteen years.

12 MS. WALDEN: I'm Ruth Walden. I'm
13 a family specialist with the children
14 with special healthcare needs program.

15 MR. GALLAGHER: Brian Gallagher
16 with the School of Public Health.

17 DR. KANTER: Bob Kanter, pediatric
18 critical care, Syracuse.

19 MS. CHIUMENTO: Sharon Chiumento.
20 I'm a nurse and a paramedic, as well as
21 an EMS provider.

22 MR. CZAPRANSKI: Tim Czapranski,
23 SEMSCO liaison. Also a paramedic and EMS
24 coordinator for Monroe County.

1 MS. ROGERS: I'm Jan Rogers. I'm
2 a pediatric nurse practitioner in the
3 emergency department at Strong in
4 Rochester.

5 MS. BRILLHART: Susan Brillhart,
6 pediatric critical care nurse. I'm
7 teaching for the City University of New
8 York.

9 MS. SPERRY: Sarah Sperry. I'm a
10 research scientist for the bureau of
11 injury prevention.

12 DR. COOPER: Great. I'd like to
13 welcome you all and hope you had a
14 pleasant holiday season and that your new
15 year's off to a roaring start, as we are
16 well into it at this point.

17 MS. GOHLKE: You've got to speak
18 into the microphone.

19 DR. COOPER: So I hope it's not
20 merely a roaring start but a roaring
21 continuation.

22 The next item on the agenda is
23 approval of the minutes. So if you could
24 all take a look at your minutes. I don't

1 believe they're in your packet. I think
2 you needed to review them online before
3 coming. I trust that there were no major
4 problems upon review of the minutes. I
5 personally did not find any.

6 DR. HALPERT: Motion to accept the
7 minutes.

8 DR. COOPER: Thank you, Jon.

9 MS. CHIUMENTO: Second.

10 DR. COOPER: Thank you, Sharon.
11 Discussion? All if favor.

12 SPEAKERS: Aye.

13 DR. COOPER: Opposed? It carries
14 unanimously. Okay. The minutes are
15 approved.

16 Martha, would you review the
17 agenda for us, please?

18 MS. GOHLKE: Sure. Here it is.
19 Okay. We have folks here from the CARES
20 Foundation who are going to talk about
21 adrenal insufficiency. That's the first
22 thing that we'll do. And then Mr.
23 Wronski will give his EMS report from the
24 bureau. I'll talk a little bit about the

1 EMSC grant and do my latest presentation
2 on the results of the medical direction
3 study that I did -- the microphones
4 aren't working -- and medical direction
5 and pediatric equipment survey that Brian
6 helped me out with, Brian from the School
7 of Public Health. We'll go through that.
8 We'll just have a quick update on the
9 progress of the different committees.

10 And we will have a working lunch
11 today. They're going to provide --
12 they're going to put lunch here in the
13 room here for us. Just so you know, it's
14 only going to be up for a little over a
15 hour. So, you know, bring all your food
16 here. Don't expect to nibble throughout
17 the day, because they will take it away.
18 So get everything and bring it here. We
19 will have to work through lunch, so we'll
20 take a few minutes, you know, take a
21 break, but then we will work through
22 lunch so we can get out on time. It's a
23 beautiful day outside today.

24 And then we'll go to -- we'll do

1 the new business of the committee, the
2 old business, the new business, and
3 hopefully we'll have time to get to the
4 updates from the sister committees, if we
5 can pack it all in.

6 Ann Fitton couldn't be here today
7 with the festivities of St. Patrick's Day
8 down in the City. She couldn't really
9 excuse herself. FDNY is needed today.
10 And who's the other person? I know
11 Elise, but there is another person who
12 couldn't be here today. Rita Molloy.
13 Kathy Lillis is on her way. She's flying
14 in and her flight gets in a little after
15 ten. So this is a longer commute,
16 unfortunately, from the airport so she's
17 hopefully going to be here any second.
18 And Rita Molloy, our nurse from Long
19 Island -- today is the kindergarten
20 screening day at her school, so she also
21 had to excuse herself for today. She
22 couldn't make it up here.

23 And then Dr. Van der Jagt e-mailed
24 me yesterday. His mother passed away

1 unexpectedly yesterday. And we send our
2 condolences to him on the passing of his
3 mother.

4 DR. COOPER: Absolutely. Thank
5 you, Martha. Okay. So as you can see,
6 we do have a fairly full agenda.

7 So I'd like to begin by
8 introducing Deborah Brown from the CARES
9 Foundation and Sue Stred from Upstate
10 Medical Center in Syracuse, who I believe
11 have a presentation for us about adrenal
12 insufficiency as it applies to emergency
13 medical services and the potential need
14 for us to consider adding administration
15 of glucocorticoids for patients with
16 adrenal insufficiencies to the
17 prehospital treatment protocols and
18 formularies.

19 So Miss Brown, Dr. Stred, either
20 one, both?

21 MS. BROWN: We have a parent here.
22 Her name is Nancy Ginsberg.

23 DR. COOPER: Okay. A pleasure to
24 have you with us.

1 MS. GOHLKE: Just a quick
2 refresher -- reminder. The microphones
3 aren't so much for our listening
4 pleasure, but it's for Nora's assistance
5 to make sure she catches everything. So
6 just try to be cognizant of speaking into
7 the microphones. And you can pull them
8 forward if you need to. They do have
9 long cords.

10 MS. BROWN: The blue folders on
11 the table -- the blue folders on the
12 table have all of our presentation
13 materials.

14 Well, first I want to thank you
15 all for giving us the opportunity to
16 speak to you today. Again, my name is
17 Debbie Brown and I'm the parent of a two
18 year old with congenital adrenal
19 hyperplasia, a member of the board at the
20 CARES Foundation and a registered nurse.

21 We are asking for this committee's
22 support and urging the medical advisory
23 board to include injectable
24 glucocorticoid treatments of individuals

1 affected by adrenal insufficiency in New
2 York State's statewide emergency response
3 protocol.

4 What if I told you I had a
5 miracle drug that could prevent shock,
6 heart failure, cardiac arrest and help
7 save the life of trauma victims during
8 transport? Well, I do have that miracle
9 drug and it's called Solu-Cortef.

10 Injectable glucocorticoids are not
11 new. They've been around since first
12 used by Addison's patient John F.
13 Kennedy to save his life during back
14 surgery in the 1950s. But among
15 individuals affected with adrenal
16 insufficiency, it is our miracle drug.

17 Upon injecting Solu-Cortef in
18 an adult or a child in adrenal crisis,
19 something miraculous does happen. The
20 child that looks ashen and unresponsive
21 suddenly begins to have color and talk.
22 The mother who is vomiting and feels as
23 though she might faint suddenly feels
24 better. It's on now -- the teen with the

1 bone fracture may be kept from shock and
2 the patient in cardiac arrest begins to
3 respond to intervention. Yes, this is
4 our miracle drug.

5 And for a cost factor of \$4.65
6 a vial and a shelf life of four years,
7 Solu-Cortef is not only lifesaving, but
8 cost-effective, easy to administer and
9 safe.

10 You must understand that when
11 adrenal crisis comes on, it comes fast.
12 I have seen this with my own daughter.
13 She has gone from responsive and alert to
14 barely responsive and blueish-gray in
15 fifteen minutes. With no time to spare,
16 just a half of milliliter of Solu-Cortef
17 IM did the trick. Within minutes,
18 Isabelle's color began to improve as well
19 as her responsiveness. She was able to
20 arrive at the hospital in a much more
21 stable condition due to Solu-Cortef
22 administration prior to arriving at the
23 emergency room. Shock and cardiac arrest
24 were averted as well as a hospital

1 admission, and today I'm here to tell you
2 that she is fine.

3 This is just my story, though.
4 There are many others that have not been
5 as fortunate. Others have endured long
6 hospital stays, permanent disability or
7 death due to lack of prompt treatment
8 with Solu-Cortef.

9 You all, as the medical
10 advisory -- you all as the Emergency
11 Medical Services for Children can help
12 change that. You have the ability to
13 advocate for change of current protocols
14 so that when someone is found unconscious
15 due to adrenal crisis, EMS can save them.
16 When EMS arrives at a scene with frantic
17 parents and a child who is already blue
18 from adrenal crisis, EMS can help.

19 I have been constantly reminded
20 that where I live on Long Island, a
21 hospital is only five minutes away. I
22 agree, but five minutes may be five
23 minutes too long when an adult or a child
24 is severely ill from adrenal crisis. And

1 as you are well aware, children and
2 adults living in upstate New York have
3 much longer response to transport times.
4 At the time of adrenal crisis, there
5 simply is no time to waste.

6 We are not in unchartered
7 territory as far as protocols go. Rhode
8 Island has, for several years, had a
9 simple protocol to treat adrenal
10 insufficiency. Here in New York, we can
11 too. And by the way, this protocol would
12 not only assist 2,000 people in New York
13 who share the same diagnosis as my
14 daughter. This is just the tip of the
15 iceberg. A protocol for adrenal
16 insufficiency would also help patients
17 who have had adrenalectomies, Addison's
18 patients, and an even larger number with
19 pituitary disorders. These conditions
20 leave patients at risk for adrenal
21 crisis. There are over 12,000 people
22 living in New York who are at risk and
23 would benefit from protocol
24 implementation.

1 My daughter wears a medic-alert
2 bracelet, something a recent CARES
3 Foundation survey found that seventy-five
4 percent of our members do. This measure,
5 however, will do nothing to save her life
6 if she becomes ill or injured and we, her
7 parents, are not there with her or have
8 become incapacitated in the same
9 accident. And current EMS protocols in
10 New York simply do not address those with
11 adrenal insufficiencies.

12 Finally, I want to mention we
13 have a willing community of
14 endocrinologists eager to provide
15 training in this, as well as policy
16 development. While I realize there are
17 costs associated with change, looking at
18 the whole picture, I think it's fair to
19 say that one hospital admission for an
20 adrenal insufficient patient who has
21 developed shock, heart failure or cardiac
22 arrest will likely exceed the cost of
23 implementing these changes.

24 On behalf of New York's

1 children and families, I urge you to help
2 keep the adrenal insufficient safe by
3 advocating the inclusion of injectable
4 glucocorticoids in New York's EMS
5 prehospital and transfer protocols
6 statewide. The power to save lives is in
7 your hands. I thank you for your time
8 today.

9 DR. COOPER: Thank you, Ms.
10 Brown. Dr. Stred, did you want to speak
11 now?

12 DR. STRED: I don't have much
13 formal to add to that, but from a medical
14 perspective and an ED perspective, this
15 is one of the safest medications on the
16 planet. It is a one-time injection. You
17 cannot hurt anyone with an injectable
18 glucocorticoid, as long as you administer
19 it into a correct site, either a muscle
20 or a vein. And I would be happy to stand
21 in front of this body or the main SEMAC
22 body and accept an injection of an entire
23 vial into my arm and stand there and talk
24 to you, for \$4.00. For \$4.00. You

1 cannot possibly hurt anyone with this and
2 you can save their lives.

3 In upstate New York where we've
4 got response times of twenty minutes and
5 transport times of up to forty minutes,
6 that's an hour for someone who isn't
7 getting the specific medication that
8 could save their lives that they really
9 need. IVs are wonderful; fluid
10 resuscitation is invaluable. But if your
11 body cannot make glucocorticoids and you
12 need it, the only way for you to get it
13 at a time of crisis is through an
14 injection. It's safe. It's cheap. It
15 cannot hurt anyone. And the peds/endo
16 community would be happy to help out with
17 instruction that would benefit even our
18 adult endocrin community, who I would
19 point out are a little less good about
20 wearing their medic-alert tags. But we
21 can work on that if we get a policy in
22 place. It will add to the momentum of
23 the snowball rolling of being much more
24 comprehensive about wearing medic-alert

1 tags. It's really pretty -- that we push
2 our patients to wear medic-alert tags
3 that ends up being of no utility to them
4 in the State of New York. Thank you.

5 DR. COOPER: Miss Ginsberg, would
6 you like to say a word or two?

7 MS. GINSBERG: Hi. My name is
8 Nancy Ginsberg. I am the parent of a
9 three year old girl with congenital
10 adrenal hyperplasia. CAH is a disease of
11 the adrenal which is easily managed on a
12 day-to-day basis with steroid
13 supplements. However, physical trauma,
14 excessive vomiting or diarrhea and fever
15 are emergency, life-threatening
16 situations for the adrenal insufficient.
17 The key here is emergency. If any of
18 these emergency situations occur, there
19 is a very short window of time in which
20 intervention for the adrenal insufficient
21 can mean the difference between life and
22 death.

23 My daughter's life and safety is
24 my responsibility. My husband and I go

1 to great lengths to insure her safety.
2 Wherever we go, we carry an emergency
3 medical kit which contains extra oral
4 doses of Lilly's daily steroids, a letter
5 from her doctor detailing emergency
6 protocols and the fact that time in a
7 waiting room is not appropriate, and a
8 Solu-Cortef injectable and syringes. She
9 wears a medical ID bracelet which states
10 "adrenal insufficiency, hydrocortisone
11 required." We know that we are fully
12 prepared should an emergency situation
13 arise.

14 Although there is no nurse at
15 Lilly's preschool, her teacher keeps a
16 duplicate emergency kit on hand as well.
17 With my instructions and materials,
18 Lilly's teacher is as prepared as she can
19 be to respond appropriately if needed.

20 Although we as parents and
21 caregivers take all these precautions,
22 what happens when we fail? If I, her
23 parent, am not close by, if something
24 happens at school and Lilly's teacher is

1 not available or able to provide Lilly
2 with her injection, or what if one day
3 she is out riding her bike or on a field
4 trip. There will be times when she will
5 be out in the community and regardless of
6 the precautions I have taken, she will
7 not be safe or able to be helped by an
8 emergency response team that is not
9 equipped with a life-saving Solu-Cortef
10 or equivalent glucocorticoid.

11 There is a gap here which you have
12 the power to fill. Allow my daughter and
13 other children the safety you can provide
14 by equipping your teams with this low
15 cost, easily administered, completely
16 safe, life-saving vial.

17 I thank you so much for your time
18 today. Please help us keep our children
19 safe in the community. Allow them and
20 others with adrenal insufficiency the
21 comfort to function freely and safely in
22 our community by adding glucocorticoids
23 to New York's EMS prehospital protocols.
24 Thank you.

1 DR. COOPER: Thank you. Does --
2 Dr. Stred, do you have any summarizing
3 comments for the group or pretty much --

4 DR. STRED: No.

5 DR. COOPER: Do any of our members
6 have any questions for Ms. Brown,
7 Ms. Ginsberg or Dr. Stred?

8 DR. HALPERT: I'm just curious
9 about what the --

10 COURT REPORTER: I can't hear you.
11 I'm sorry.

12 DR. HALPERT: I'm just curious
13 about what the incidence might be
14 regarding presentation of this population
15 to the EMS community?

16 DR. STRED: It's only anecdotal
17 data at the moment. It's been a real
18 challenge, especially now with HIPAA, to
19 try to get those kind of data and coding.
20 If someone comes in in shock, the
21 discharge code may well be shock and not
22 adrenal insufficiency. We need a more
23 robust reporting system to get that.

24 But we estimate based on published

1 population-based estimates, there are
2 over 12,000 New Yorkers with either
3 pituitary adrenal insufficiency or
4 primary adrenal insufficiency.

5 MS. GOHLKE: Is this something
6 they grow out of?

7 DR. STRED: No.

8 MS. GOHLKE: Okay.

9 DR. COOPER: Dr. Kanter.

10 DR. KANTER: My concern would be
11 that in a major adrenal crisis, the
12 issues are life-threatening hypoglycemia
13 and hypobulemia, and giving
14 hydrocortisone may not preclude the need
15 for IV fluid resuscitation and IV
16 glucose.

17 And I think the bigger issue is
18 education about this general disorder or
19 set of disorders and education about the
20 full spectrum of life-saving measures.

21 If I had a patient in my ICU with
22 all of these problems, my priorities in
23 the first fifteen minutes would be
24 glucose, fluids and I'd be happy to give

1 the hydrocortisone in the next fifteen
2 minutes when we get to it. Fluids and
3 glucose are a far more urgent need.

4 DR. STRED: I have no argument
5 with that, but cardiac motility cardiac
6 function is dramatically improved in
7 adrenal insufficiency with
8 glucocorticoid. So administering the
9 appropriate fluid resuscitation is
10 incredibly important, but if you can't
11 get it moving around in the bloodstream,
12 it could with one additional simple
13 maneuver. It would be a tremendous
14 advantage.

15 One injection lasts about six
16 hours, so by doing that quick maneuver
17 either at the same time or in one
18 sequence or the other, buys you six hours
19 of resuscitation without having to
20 spend -- without having to think about
21 the glucocorticoid injections.

22 DR. HALPERT: Many of our
23 prehospital providers in New York State
24 are very loose regarding the use of

1 injectable glucocorticoids because of the
2 prevalence of Medrol. I'm not sure
3 statewide; it may be greater. Ed is more
4 familiar with that. But I'm suspecting
5 it's pretty popular and well embraced.

6 I think the real issue is going to
7 be recognition. And certainly if there's
8 a patient population out there that's got
9 a bracelet or a tag on or for care
10 providers or relatives who are familiar
11 with their situation and the paramedic
12 provider may not be specifically up to
13 speed on the nature of adrenal
14 insufficiency, but perhaps knows enough
15 to say, Will you call my medical
16 oversight doc or medical control doc?
17 And say this patient was poorly profused
18 and they're wearing this bracelet. Do I
19 need to do anything additional with this?
20 I have the Solu-Medrol out of my box
21 already.

22 DR. STRED: That would be
23 spectacular. And we have individual
24 permission from individual medical

1 control officers to do that when that
2 recognition is made.

3 Part of our push will also be to
4 assist you in the inservices that will be
5 required for increased recognition of the
6 importance of this disorder and its ease
7 in treatment. We're happy to do that.

8 We'd also like to ask that it be
9 publicized more fully that an individual
10 team can call their medical control and
11 say this individual has this ID bracelet.
12 Can we please give their own medication,
13 which they have in their hand right now?

14 DR. COOPER: Any other questions
15 from any other members of the committee?

16 MR. WRONSKI: Just first some
17 comments. I absolutely appreciate all of
18 you coming up today to speak for this
19 group of children, and adults too. Is
20 the breakdown known of the 12,000 in New
21 York, how that breaks out?

22 DR. STRED: Pituitary issues are
23 more common in adults who had trauma or
24 pituitary adenomas -- pituitary surgery,

1 but we have an increasing number of
2 children who are now making it to young
3 adulthood with disorders that used to be
4 fatal. So I can't give you a precise
5 breakdown right now by age. I can only
6 give it to you by diagnosis.

7 MR. WRONSKI: In New York State,
8 we have a fairly robust EMS system, but
9 it does vary a lot depending on where you
10 are and it's composed of basic life
11 support in conjunction with advanced life
12 support providers.

13 And I would estimate or I would
14 guess that there's no good way to
15 identify one of these patients through
16 the 9-1-1 system dispatch unless
17 someone's calling and knows the patient's
18 suffering a problem and they tell the
19 9-1-1 dispatcher.

20 But barring that, I don't think it
21 would necessarily be easy for EMS to
22 identify the patient through medical
23 symptoms. It would be more of the
24 bracelet or some -- am I wrong on that?

1 DR. STRED: No. That's exactly
2 right.

3 MR. WRONSKI: The -- our advanced
4 life support system certainly has, in
5 many areas, the capabilities of treating
6 this and to identify it. The issue and
7 the question is, do we promote universal
8 carrying of this particular drug, the
9 Solu-Medrol, and how do we -- is that
10 needed? Is the current ALS system and
11 what it carries -- because Lee, remind
12 me. It's not always Solu-Medrol, is it?

13 MS. BURNS: If it's going to be
14 anything, it would be Solu-Medrol. As we
15 had discussed, it's not -- one of the
16 issues that I think -- most of you are
17 aware of this, but ALS protocols are
18 written, really, at the regional level
19 and that's permissible under the statute.
20 And many of them include Solu-Medrol in
21 the asthma protocols that Dr. Halpert
22 indicated.

23 In speaking with one of the
24 medical directors in the central New York

1 area, they removed it from their
2 prehospital protocol because what they
3 found was that by the time -- it takes so
4 long for it to actually be effective in
5 the protocol, then why not give it at the
6 hospital. But Tim, do your protocols
7 include course --

8 MR. CZAPRANSKI: No.

9 MS. BURNS: Okay. I have sent an
10 e-mail to Andy to see what the numbers
11 are.

12 DR. STRED: I will point out that
13 the anti-inflammatory action of the
14 glucocorticoids is used slower than the
15 cardiac contractility and is supported
16 for memory function.

17 MS. BURNS: Is there -- I mean,
18 I'm sure there is, but from a prehospital
19 perspective, what would the difference
20 between Solu-Cortef and Solu-Medrol be?

21 DR. HALPERT: I would order that
22 equivalent. I keep both plus a variety
23 of others stored in my office and change
24 them fairly frequently.

1 MR. WRONSKI: The last comment,
2 just from the Bureau's perspective, is
3 that we've done a lot of things over the
4 years where special groups come up of
5 interest. And a lot of it has been
6 resolved through more robust education to
7 the EMS community. This is what you
8 might run into. And here's -- here's how
9 you deal with that.

10 I think, first off, we would have
11 absolutely no objection to doing that
12 type of a program. The question is, what
13 should that contain? What should our
14 direction be at EMS? That's why it's
15 here at this body, to get some advice
16 from the EMSC committee. And then later
17 when we meet with SEMAC, get the final
18 recommendations for what to do.

19 But I think at the very least,
20 certainly the Department will support an
21 education program so that our EMS
22 providers know these children exist. And
23 if you do have a call -- not just
24 children, but adults as well -- what will

1 you do. So I think that's a very
2 reasonable thing to do. Exactly how it
3 will be composed and what else do we
4 recommend, I leave that to the EMSC
5 committee and the SEMAC to recommend.
6 Thank you.

7 DR. COOPER: Thank you. There is
8 one issue that I think is infrequently
9 understood by the public at large. I
10 know you understand this as health
11 professionals and parents of children
12 with congenital adrenal hyperplasia.

13 But EMS is a funny system in many
14 ways. We have the plethora of resources
15 in the urban areas where they're least
16 needed and the girth of the resources in
17 the rural areas where they're most
18 needed. The transport time to a hospital
19 in the urban areas is usually no more
20 than ten to fifteen minutes, urban and
21 suburban areas, usually where the
22 parents, docs and critical care techs are
23 based. And again, of course, it takes a
24 little bit of time to get control of the

1 airway, get an IV established and so on.
2 And do you spend the time moving the
3 patient expeditiously to the hospital
4 where -- where definitive treatment can
5 be initiated quickly or immediately upon
6 arrival, or do you take the time, pull
7 over to the side of the road on the way
8 to the hospital to start the IV? You
9 know, these are all questions that have
10 to be factored in in terms of -- in terms
11 of making a recommendation about -- about
12 a drug like this.

13 The other comment that I might
14 make is that while there is no specific
15 protocol for the use of injectable
16 glucocorticoids for treatment of CAH and
17 other adrenally insufficient conditions,
18 nowhere on the protocol does that
19 proscribe. So it's not prescribed but
20 it's also not proscribed.

21 And we have a long tradition in
22 EMS of so-called discretionary decisions,
23 where a medical director can be involved
24 in a decision to use a drug that -- that

1 is contained within the prehospital
2 formulary although not necessarily
3 normally utilized as part of the
4 protocol.

5 You might ask, well, why wouldn't
6 you just include it as part of the
7 protocol? Well, you know, the answer to
8 that is if you include it as part of the
9 protocol, you have to spend a great deal
10 of time teaching it, drilling it and so
11 on. And many of our -- of our
12 prehospital colleagues are volunteers and
13 the amount of time that we have available
14 and the curriculum to teach them about a
15 very, very wide variety of things is
16 extremely limited.

17 So I'm meaning by these comments
18 to sort of give you a flavor of some of
19 the -- some of the issues that we face as
20 an EMS system in terms of insuring that
21 the right patient gets the right
22 treatment at the right time for the right
23 reason. And yes, in one way it is as
24 simple as this is a miracle drug that

1 will save the life of a child, but in
2 other ways it's far more can complicated
3 than that.

4 So I think probably at this point,
5 we as a committee need to think about
6 this and come up with a recommendation.

7 I should note for the record and
8 for you that we as a committee do not
9 have the authority to make a
10 recommendation to the Commissioner
11 specifically regarding protocol. We do
12 have the authority to make a
13 recommendation to the SEMAC, which can
14 then make a decision as to how it's
15 included in the protocol, which has to be
16 signed off on by the Commissioner.

17 But there are opportunities, as
18 Mr. Wronski has indicated. Education,
19 certainly. There are other opportunities
20 available to us, as well, advisory
21 guidelines and, of course, inclusion of
22 the drug in protocols for use under the
23 circumstances, you know, that you
24 mentioned this morning. I think the

1 information that you presented is great.
2 I know we're deeply appreciative as a
3 committee for your taking time to come
4 before us. And meaning no disrespect to
5 you, Dr. Stred, but especially Ms.
6 Brown and Ms. Ginsberg for the very
7 moving, you know, testimony which you
8 gave about your own children. This is
9 something that, you know, I know must be
10 a most, you know, of heart-wrenching
11 importance to you. So we will, I assure
12 you, keep that in mind as we deliberate
13 this really important issue. So thanks
14 so much for coming.

15 DR. STRED: May I make two quick
16 comments about the scientific content
17 about what you said?

18 DR. COOPER: Sure.

19 DR. STRED: And they are brief.
20 The first is that I think the recognition
21 factor is actually easier for adrenal
22 insufficiency if the medic-alert bracelet
23 is there. So for instance, if a person
24 is in imminent shock, has poor color and

1 has a bracelet on, I think the
2 recognition factor would be pretty rapid.

3 The second is appropriate and
4 we've heard it raised when we spoke in
5 other kinds of venues, is everyone
6 appropriately has in their mind the
7 potential danger benefit, malice, of any
8 medication. And I want to go back to the
9 fact that this is incredibly safe. Any
10 of us in this room, adrenally
11 insufficient or not, could take that
12 medication in an error in judgment and
13 have zero effect that day. Long term,
14 that's a whole another matter. That's a
15 real dangerous drug in big doses and long
16 term, but a single shot on a single day
17 cannot hurt anyone.

18 DR. COOPER: I don't think anybody
19 disagrees with the points you just made.

20 DR. STRED: Thank you.

21 MR. WRONSKI: Can I just ask the
22 committee for a sense of -- I know we
23 have to think about protocol and what we
24 might say to the SEMAC -- to the regional

1 trauma advisory committees that exist
2 across the state and what we want to say
3 there and that will take a little bit
4 more discussion. But an educational
5 program, a program that we would, at
6 least in concept, support -- that this
7 committee supports the idea of increasing
8 the education, and I don't mean in the --
9 necessarily the basic life support
10 curriculum or the advanced life support
11 curriculum, but just a standalone CME
12 which we would -- the Bureau would
13 support getting information out to EMS
14 providers about this issue. Is that
15 generally supported by this committee,
16 that --

17 DR. KANTER: And in particular, I
18 think the education must include the
19 importance of volume resuscitation and
20 hypoglycemia. And giving the
21 glucocorticoid alone is a little bit like
22 giving antibiotics for septic shock
23 without the other --

24 DR. COOPER: Sharon?

1 MS. CHIUMENTO: I would just
2 suggest that one of the things we can do
3 is include it as one of the
4 considerations under our regular shock
5 protocol. And just not -- I would not
6 write a specific protocol just for this.
7 I would include it as an option, a
8 medical control option if you want or
9 whether -- under our regular shock
10 protocol. This way, as they're
11 considering epileptic shock, that would
12 be something that would be considered
13 then. They would then say, okay, I've
14 got the medic-alert bracelet, I've got
15 shock symptoms, this is what I need to
16 do.

17 DR. STRED: That's where it is in
18 the Rhode Island protocol.

19 DR. HALPERT: I would echo that
20 sentiment, Sharon. I mean, that's
21 really, in the emergency department -- in
22 the emergency department, that's a
23 standard operating procedure. A patient
24 comes in in shock. You know, if you add

1 at least one dose of glucocorticoid,
2 you're -- it's imminently safe and
3 imminently lifesaving in the right
4 patient. And often times, it doesn't
5 change things. But in that case, it's
6 very useful.

7 I think from an academic
8 perspective, though -- it's a natural
9 topic for a Vital Signs presentation. I
10 mean, maybe you want to, say, involve a
11 GEMS type of program, which is rather
12 comprehensive and large and it's been out
13 there for a while, but at least as an
14 introduction, you've got a willing group
15 of people right now who want to get this
16 on track. You've got a mechanism that
17 exists. It's a good topic. It's timely
18 in many different ways. You know, it
19 intertwines with a lot of things that go
20 on. It's a typical Vital Signs
21 conference. So, I mean, it's a perfect
22 topic.

23 DR. COOPER: Personally, I think
24 the last few comments have really summed

1 it up very nicely. What's needed here is
2 a contextual approach rather than a --
3 rather than a standalone approach.
4 Certainly, a standalone document, whether
5 it's an advisory guideline or simply a
6 letter to ambulance services indicating
7 that it's easy to recognize patients with
8 adrenal insufficiency if they're wearing
9 a medic-alert bracelet and that calls for
10 a particular response. That part's easy
11 to do.

12 In terms of creating an entire CME
13 program, I would far rather, as I think
14 Bob and Sharon and Jon suggested, include
15 this in some ways as part of the broad
16 categorization of -- of kids in shock and
17 kids with congenital adrenal hyperplasia.
18 I'm a pediatric surgeon, so I'm a little
19 off my best here, but, of course, you
20 know, we do see very, very young infants
21 that will present with shock and there is
22 an entire differential, independent
23 lesions and CAH and -- but primarily
24 overwhelming sepsis, as you know. And

1 unless they're wearing that tag, the
2 recognition can be -- can be difficult
3 even in the hospital. So it's really
4 within the context of shock, you know, as
5 more broadly defined that I think we need
6 to approach this in whatever way we think
7 will reach the most people.

8 So unless there are any other
9 comments, I think we'll once again thank
10 you so much for your time and your effort
11 for coming here today.

12 DR. STRED: Thank you for allowing
13 us to be here.

14 DR. COOPER: Sure. It's really
15 great you came. Thanks. And Ms.
16 Brown and Ms. Ginsberg, thank you so much
17 for your -- again, your stories. They
18 are very, very important to us and
19 everyone. Okay. Good.

20 What I will do is defer ongoing
21 discussion on this until a little bit
22 later in the meeting to allow people to
23 sort of cogitate about it just a little
24 bit. And since I see that they're

1 loading up the table over there, I want
2 to move pretty quickly to the Bureau of
3 EMS report, and if there's time, Martha,
4 your presentation before we actually get
5 into lunch hour.

6 MS. GOHLKE: We can actually take
7 a quick break after the Bureau's report
8 and then get our lunches and I can do my
9 presentation during lunch.

10 DR. COOPER: Sounds good to me.
11 Okay. So Mr. Wronski, we're looking
12 forward to hearing the good news from all
13 of you.

14 MR. WRONSKI: Yes. Thank you. I
15 appreciate being here. And just for the
16 record, Marjorie Geiger says hello to all
17 of you.

18 DR. COOPER: Please say hello
19 back.

20 MR. WRONSKI: We will. I will.
21 Obviously on everybody's mind is budget.
22 All right. So what's the budget look
23 like right now? The answer is it's
24 anybody's guess. What I would -- and the

1 reason I say that is that with the
2 expectation of federal funding, which is
3 going to be put into many states,
4 including a significant amount of money
5 into New York State, this will affect how
6 the budget is viewed.

7 From my personal perspective, and
8 I will say personal because the Governor
9 doesn't talk to me about these things,
10 the New York State budget is still in a
11 very problematic area and that is that
12 we've overspent and we haven't brought in
13 enough money to pay the bills. That was
14 very clear. There is a big hole. And
15 even with the federal funding, which
16 certainly will help things and move
17 things in a more positive fashion along,
18 we're going to have to adjust as a state
19 and as government, as well, on how we use
20 the money so that we don't, when that
21 federal money has run out in assist to
22 us, wind up in the same kind of fix. So
23 I believe that is really what's on the
24 table at the -- in the state negotiations

1 that are going on as to how to revisit
2 the state budget.

3 For a more specific comment on the
4 EMS Bureau's budget, that hasn't changed.
5 It's 20.8 million dollars. That was the
6 recommendation by the Governor. It's a
7 match to last year's funding. I have not
8 heard any suggestion that that will
9 change either up or down. So we'll be
10 able to pay as we have to continue our
11 efforts to support EMS training and our
12 regional efforts.

13 And some money is used within the
14 Bureau's budget, state funding, to help
15 support EMSC efforts. But again, there
16 is no suggestion that the money will go
17 up or down. It will pretty much remain
18 flat line from last year.

19 The other big ticket item is the
20 argument over Medicaid funding and that
21 is, again, something that's going to be
22 revisited, I believe, because of the
23 federal monies that are coming in, but I
24 have no answers for you. All I can tell

1 you is pay attention and see what comes
2 out of these negotiations that are
3 ongoing right now at the state level.

4 A good piece of news -- I don't
5 know if this was mentioned by Martha.
6 The Governor's traffic safety committee
7 did award the Department a grant,
8 approximately \$250,000 a year, which is
9 preliminarily for three years to help us
10 develop and implement a platform to
11 change our New York State PCR system so
12 that we're able to efficiently collect
13 and also analyze PCR data electronically,
14 PCR data in the coming years. Some of
15 you know or some of you may not that, at
16 present, we're getting about, volume
17 perspective, close to half of our New
18 York State data electronically, and this
19 is because we have a couple regions, what
20 we normally term non-New York City
21 regions, who are submitting data
22 electronically. And now New York City,
23 while not a hundred percent, is close to
24 a hundred percent of the 9-1-1 system

1 calls that we receive from the City
2 electronically. We also know that
3 Suffolk County, as an example, is going
4 to electronic data collection probably
5 within the next twelve months to full
6 online. And there are a couple of other
7 regions who are exploring that, as well.

8 The advantage or the benefits to
9 this committee is that hopefully by next
10 year, you'll be seeing more and more data
11 coming in on a contemporary basis. The
12 other big advantage, and I put this on
13 the table here, is that we'll be moving
14 towards a NEMSIS compliant database. And
15 that means we'll be changing our data
16 collection, we'll be educating our EMS
17 providers once we decide exactly what
18 data elements to -- to move to from the
19 NEMSIS database and hopefully having a
20 richer and stronger database so we can
21 evaluate our prehospital care system.

22 What I would ask the EMSC
23 committee to do, just as we've asked the
24 state council and the SEMAC, is to make

1 sure you've looked at the NEMSIS database
2 and make recommendations to your
3 committee as to what you think from a
4 pediatric standpoint should be collected
5 in that database. And that's ongoing in
6 our QI committee or our evaluation
7 committee of the state EMS council. But
8 if you do have comments you'd like to
9 make at some point before this process is
10 done, please do so.

11 The 2008 protocols are online now.
12 And what does that mean? Did we rewrite
13 the New York State protocols? No, we did
14 not. What we've been doing is rewriting
15 them for the last several years. But
16 what finally happened is we put them into
17 a finalized state protocol book again so
18 that all of the revised protocols that
19 have been revised since 2003 -- each year
20 we did one or two revisions -- are now
21 all collected as a sole document, a
22 single document, and termed the 2008 BLS
23 adult and pediatric protocols. And
24 that's online. We are printing hard

1 copies which are going to go to our
2 training sponsors later this year.

3 I do want to bring up a sad case,
4 but I think it's an object lesson to
5 learn from. There are some things we
6 think are basic and that everyone knows,
7 but apparently that's not always true.
8 We had a case in the public access
9 defibrillation program in one of the
10 schools in Suffolk County in which a six
11 year old boy had complained of rapid
12 heartbeat and chest pain and was taken to
13 the nurse's office and was defibrillated
14 while awake and talking to the nurse.
15 And we're looking into how this could
16 have occurred, how the AED unit could
17 have recommended shock. And it did, it
18 recommended shock. And the boy was
19 shocked and luckily is fine. But what
20 this issue brought us -- brought to our
21 attention on a statewide basis is the
22 constant need to re-educate and to remind
23 people what the protocol says. And also
24 to constantly look at our machinery and

1 is it outdated, is it up-to-date or not.
2 And so not only the Bureau, but the state
3 education department is looking at the
4 program and we're evaluating how this
5 could have occurred.

6 But, you know, as fellow
7 interested parties in the EMS system and
8 our children, again, I take it as an
9 education point that no matter how well
10 trained you are, things can happen in an
11 emergency or suddenly and you might
12 forget the rules for the moment.

13 DR. COOPER: Mr. Wronski, just a
14 quick question about that particular
15 case. This is the first I've heard of
16 that. Is this recent?

17 MR. WRONSKI: It was March 4th.

18 DR. COOPER: Quite recent, March
19 4th. And has it been reported to the
20 FDA?

21 MR. WRONSKI: The -- at this
22 point, I don't know that that's formally
23 happened, but we intend to do so from our
24 Bureau. I believe that may have occurred

1 through another source, but we'll be in
2 touch with --

3 DR. COOPER: That's vitally
4 important, because the decision by the
5 FDA to approve the AED for pediatric use
6 was predicated on the notion that --
7 because events like this had never been
8 reported to happen. And they -- very,
9 very important to report it immediately
10 if it has not been reported thus far, and
11 that they need to make a decision about
12 -- about this, at least in terms of
13 sending out some kind of warning to the
14 general medical community.

15 MR. WRONSKI: I don't disagree. I
16 believe it has been, but we were going to
17 follow up with them to insure that it
18 was. And it is an older model machine
19 and we believe it's one of the models
20 which we had identified early on in our
21 discussions on the automatic machines in
22 pediatrics and it had to do with default
23 settings for cardioversion and it may not
24 have been on the off setting. So we

1 think the machine was recommending shock
2 for cardioversion and that may have been
3 the complicating factor here.

4 DR. HALPERT: So there may have
5 been a tachy arrhythmia, but whether or
6 not the patient was under-perfused enough
7 to require cardioversion is another
8 story.

9 MR. WRONSKI: Right.

10 DR. COOPER: Bob?

11 DR. KANTER: But all those
12 potential errors are really not
13 pediatric-specific. They may be just as
14 important for an adult with the same
15 arrhythmia.

16 DR. HALPERT: Right. It's still
17 the people factor and should I push the
18 button or not.

19 MR. WRONSKI: Yeah. It is. We
20 can't educate the machine. We can pull
21 it off of the shelf. But we constantly
22 have to remind each other, you know, what
23 the basic rules are. So re-education is
24 critical.

1 DR. COOPER: Of course, we're all
2 aware of the literature stating how well
3 or how poorly both professional rescuers
4 and lay rescuers are impulsive. If we're
5 establishing the presence or absence of a
6 profusing rhythm, it is not necessarily,
7 you know, as straight forward as we would
8 like it to be.

9 I'm sorry, Mr. Wronski. I didn't
10 mean to interrupt.

11 MR. WRONSKI: It's okay.

12 DR. COOPER: But it was such a
13 vitally important issue that I felt I
14 needed to comment, as did the others.

15 MR. WRONSKI: Ryan White. And
16 very briefly, we mentioned this at prior
17 state EMS committees, the Ryan White Act
18 back in 2006 was modified by the federal
19 government and dropped the coverage for
20 prehospital care providers and other
21 first responders for access to
22 information regarding exposure to an HIV
23 patient. This was done inadvertently.
24 It was an error. But it's still not

1 corrected and our understanding is the
2 federal law might not be touched until
3 next year.

4 But there is a state regulation
5 that actually provides for the ability
6 for EMS providers who may have had an
7 exposure to get that information and
8 we've been doing an education piece on
9 this and sharing with our EMS community
10 the state regulations which already exist
11 which allows this to occur.

12 And I don't seem to have it with
13 me, but there's an algorithm for doing
14 this. But if any of you are interested,
15 we'll e-mail you that information. It is
16 on our EMS website, so you can go to our
17 website and see all the information about
18 the modification -- not modification, the
19 fact that Ryan White has changed. But
20 there is a state regulation that covers
21 providers if they are exposed.

22 I want to bring up another
23 unfortunate thing. And some of you may
24 personally know this and some of you may

1 not, and that's the closure of the --
2 rather the stress that's going on with
3 our hospitals.

4 The Berger Commission last year
5 identified a number of hospitals and
6 other facilities they felt needed to be
7 closed in the system to make the system
8 overall healthier by closing these
9 facilities or having them merge,
10 etcetera. And that has been causing some
11 stresses in the local community. But
12 what we've also been seeing is stresses
13 on hospitals in which two things are
14 occurring. One, they're not able to
15 staff to the level that you want them to
16 staff. It may be a trauma center. It
17 may be a children's hospital. It may be
18 a burn center. And it's more and more
19 difficult these days, particularly in
20 some of our non-New York City communities
21 but even in New York City, to have 24/7
22 coverage of needed specialties. And
23 we're seeing this in our trauma system
24 tremendously. We now have in the

1 southern tier no formal trauma coverage
2 -- all right -- formal -- from Jamestown
3 in western New York all the way to
4 Binghamton, and that's because two area
5 trauma centers had to give up their
6 designations as trauma centers because
7 they were unable to get the staffing
8 coverage. And that varied from 24/7
9 anesthesia ability, neurosurgical
10 capability and even general surgery,
11 general trauma surgery. General surgeons
12 are committed to trauma calls. And we
13 know there are other facilities who are
14 having difficulties with this.

15 We also have financial
16 difficulties and we had two hospitals in
17 Queens, New York which recently closed.
18 I was involved in discussions on a
19 day-to-day basis with these hospitals to
20 arrange for coverage. The two hospitals,
21 St. John's and Mary Immaculate hospitals
22 -- Mary Immaculate was a regional trauma
23 center -- both have closed effective the
24 first week of March. I don't remember

1 the specific date.

2 But what they did is it then
3 produced a movement of emergency
4 department patients to remaining
5 hospitals in the area that was quite a --
6 quite a change. And so 28,000 ED
7 patients who had gone to these hospitals
8 were now split and moving to other EDs in
9 an already crowded system.

10 So the Department continues to
11 work with existing hospitals that remain
12 and with the EMS system to try to build a
13 replacement structure to deal with both
14 the patients going to the emergency
15 departments but also build in place
16 primary care and clinical services that
17 were also lost when these two hospitals
18 closed.

19 And I think as providers and a
20 committee that oversees children's
21 issues, you need to be aware of these
22 tremendous pressures that are going on in
23 all our hospitals around the state and to
24 look at your own region to see -- well,

1 how healthy is my particular region and
2 my particular hospitals. Sometimes you
3 can focus on your particular area and not
4 see the big picture until it's already on
5 top of you. And I think, in fact, that
6 happened in one of the Queens hospitals.
7 Many of the providers didn't realize the
8 stress, the financial stress, that their
9 facility was under until the point that
10 it closed its doors.

11 And so what I would ask you to do
12 is just pay attention overall to your
13 healthcare system and advise us as soon
14 as you know that there might be issues
15 that we should work with the local
16 community on.

17 I know Martha, and I think it's on
18 the agenda, and the school of public
19 health representatives are here to answer
20 questions.

21 We have a draft of a new pediatric
22 -- pediatric report that you will be able
23 to review and comment on. I'm very happy
24 for that and I'm proud that we've gotten

1 a new report that we'll be able to issue
2 this year.

3 The two other quick points. We
4 are going to ask you to look at trauma
5 regs. Dr. Cooper has shared them with
6 you, and that is in tandem with our State
7 Trauma Advisory Committee, that is
8 revising trauma regulations for area
9 regional centers. But we're also looking
10 at a pediatric piece and blood regs.

11 If you don't know, we have mailed
12 out to all of our advisory committees and
13 they have commented on changes in blood
14 regulations which would allow in
15 interfacility transport the carrying and
16 maintenance of blood products for a
17 patient that may need them in an
18 interfacility transport by EMS. Prior to
19 this, you needed a nurse or a physician
20 or a PA or other licensed provider. But
21 these new regs, when they are finalized,
22 will allow EMS to move a patient in
23 between hospitals with blood products
24 running. If you haven't seen those

1 regulations, let me know and we can send
2 e-mail copies to you.

3 The last is May 20th and there is
4 a flier here. Our EMS memorial
5 dedication at the Empire Plaza this year
6 will be honoring two providers who lost
7 their lives in the line of duty. There
8 is a third who lost his life up in the
9 St. Lawrence Seaway area this year and it
10 was a very unusual occurrence because he
11 was shot by a patient and killed during a
12 call. He was a young man, twenty-five
13 years old. He was in school to become a
14 paramedic. He had been an EMT for less
15 than two years but was very much
16 committed to EMS. And he was called to a
17 chest pain case, went in with a crew and
18 the patient was upset, went into another
19 room, found a rifle and shot this EMT as
20 he was trying to leave because they were
21 trained that in situations like this, try
22 to back away from the patient. And the
23 patient shot and killed him. It's really
24 unfortunate. Again, serves underlying

1 dangers of the system and also how aware
2 we have to be in EMS to protect
3 ourselves. So while he's not on the
4 memorial this year, his name will be
5 added to the memorial next year. I just
6 wanted to mention that.

7 Unless there is any questions, my
8 report is done.

9 MS. GOHLKE: I just want to update
10 you on a couple things on the grant
11 before we'll take a break and we'll get
12 some lunch and then I'll do my little
13 Power Point presentation.

14 DR. COOPER: Mr. Wronski, I did
15 have one question regarding the report.
16 You did touch on closure of a number of
17 services across the state, focusing
18 mainly on trauma centers, but you did
19 touch briefly on pediatric capabilities,
20 as well. And as you know, there has been
21 some concern in the New York City region
22 for some time that prehospital providers
23 don't always know which trauma centers
24 are -- that are said to be capable of

1 caring for children actually are capable
2 of caring for children and, therefore,
3 ultimately requires secondary transport
4 to another center. I know that the New
5 York City regional trauma advisory
6 committee has brought this issue to your
7 attention. I just wondered if there has
8 been any progress the Department's been
9 able to make in sorting this issue out?

10 MR. WRONSKI: Yes, they have, and
11 I thank Martha for her help. She helped
12 compose letters that are being prepared
13 right now to go to all the trauma centers
14 in the City, two different letters.

15 But one of the first things we did
16 was we did a review of all of our inhouse
17 information, files for the hospitals, to
18 confirm that at least through documents,
19 there are twelve of the regional trauma
20 centers in New York City who have
21 committed to the care of pediatrics and
22 who, by documents and commitment, say
23 they can care for the needs of the major
24 pediatric trauma patient.

1 There has been, you know, issues
2 raised by the New York City -- some New
3 York City facilities whether or not
4 that's confident information, so we're
5 sending letters to all the regional
6 trauma centers asking for a recommitment
7 and are you, in fact, capable of doing
8 that and do you have in place all the
9 components of pediatric regulations. And
10 we'll be asking them to attest to that.
11 Whether we do something after that once
12 we get that response will depend on what
13 the responses are and what information we
14 may have.

15 DR. COOPER: Thank you, Mr.
16 Wronski. It's really good to see some
17 progress on that area. It has been a
18 taxing problem for a long time.

19 Martha, do you want to take a
20 break now?

21 MS. GOHLKE: Can I just say two
22 things, comments?

23 DR. COOPER: Sure.

24 MS. GOHLKE: Then we'll take a

1 break. The grant was refunded, so that's
2 good news. It was a little bit -- it was
3 a little bit of angst with the whole, you
4 know, budgetary crisis on a national
5 level and worldwide level, but actually
6 supposedly Obama and his staff is looking
7 at funding for next year in April. So I
8 was a little more concerned about next
9 year being that now he's had the time to
10 sit down with a scalpel, I think is what
11 he was referring to, about cutting
12 programs going through.

13 But the good news is Dr.
14 Wakefield is now going to be the HRSA
15 president, CEO, whatever --

16 DR. COOPER: Administrator.

17 MS. GOHLKE: -- administrator.

18 Dr. Wakefield was the parent of the child
19 that died many years ago that this act is
20 named for, so I think we're okay -- at
21 least I think I'm okay, at least as long
22 as she stands over herself. So good news
23 for the grant.

24 And then just what -- Ed, I think,

1 touched upon a lot of the information.
2 We have a periodic conference call
3 through the national resource center
4 who's the technical assistance contractor
5 for HRSA for providers on this grant.
6 And they do periodic conference calls
7 with the grantees and they highlight each
8 one of the performance measures and then
9 they have states who have accomplished or
10 on their way to accomplishing performance
11 measures and talk about their successes
12 and how they went about it so the other
13 grantees can listen in. And we have one.
14 I mentioned that New York State was
15 highlighted a while -- a couple months
16 ago in one of these conference calls
17 because of our white paper and moving
18 steps towards regionalization. But New
19 York is also going to be highlighted
20 again in May. I'll be talking about --
21 we're the only state, come to find out,
22 that is as far along with mandating the
23 goals of the performance measures of this
24 grant. We've accomplished the most in

1 the mandate format than any other state.
2 So I have to give kudos to my
3 predecessors, Gloria and of course
4 Marjorie for the work that they did. I'm
5 just, you know, getting the claim at this
6 point. So it's nice to be sitting here
7 and have all that great work behind me.
8 But I just wanted to mention that, that
9 we're getting highlighted again in May.
10 So hats off to you guys, 'cause you did
11 all the hard work.

12 And why don't we take a break for
13 lunch. Take ten, fifteen minutes, you
14 know, and get your lunch, bring it back
15 to the table, and then I'll go through my
16 slide presentation on the survey data
17 that Brian and I worked on. Okay.

18 DR. COOPER: We are recessed until
19 everyone gets a plate.

20 (Whereupon, a lunch recess was
21 taken.)

22 MS. GOHLKE: Okay. I'm going to
23 start rolling my presentation here.
24 Okay. So let's see. Last year sometime

1 -- yeah, last year. It's almost a year
2 now. I collected data on the
3 interfacility transfer guidelines and
4 agreements for hospitals and I also did a
5 survey at the same time with EMS agencies
6 on their medical direction and their
7 pediatric equipment that they carry
8 according to the grant. So thank you,
9 Brian.

10 I was able to enlist Brian's help
11 from the School of Public Health to help
12 me crunch these numbers, which saved me a
13 lot of headaches and complaints. I'm
14 still complaining, and Brian took the
15 brunt of it, but it's not nearly as bad
16 as if I did it all myself.

17 In your packet, I just want to
18 draw your attention -- I'm not going to
19 go through it unless you have questions,
20 but the NEDARC, which is the data
21 contractor for HRSA, put together these
22 fact sheets, you know, formatted them,
23 and states could just stick in their
24 results from their surveys. And if you

1 get a chance, peruse through it as some
2 point. Eventually we're going to post
3 this online on the EMSC website. But if
4 you see anything glaring that doesn't
5 make sense, let me know. So you can look
6 at that at your leisure.

7 Okay. So these surveys -- this
8 survey went out together. The EMS
9 agencies had to answer both of these
10 together about pediatric medical
11 direction -- both online and offline
12 medical direction and also they were
13 inquired about their equipment that they
14 had on scene, pediatric equipment.

15 We'll first talk about the medical
16 direction survey. This goes for both.
17 So in New York, we certify and regulate
18 about 1,200 services. NEDARC did a
19 random sample of who we needed to survey.
20 Thank God, I didn't need to do all 1,200.
21 They picked 467 services that we had to
22 survey. And as you can see, the split
23 out there, 219 BLS and 248 ALS. And you
24 can see how they were -- the EMT basics

1 and the EMT intermediates were cleared at
2 a BLS level nationally. And then ALS,
3 our EMT critical care techs and
4 paramedics were at an ALS level. So when
5 you see BLS and ALS, I have national
6 numbers in the presentation, too. You'll
7 know how our groups compare to theirs.

8 You may have remembered I had a
9 choice of doing a paper survey or an
10 online survey, and we did both because we
11 weren't sure about the accessibility of
12 the internet with our services at a
13 volunteer level, so we decided to do
14 paper and online. Those that completed
15 it on paper, a bunch of us, we offered to
16 enter it online because the NEDARC
17 software survey instrument that we
18 utilized.

19 And again another lesson learned
20 here was that most of the providers
21 preferred to do it online. I sent them
22 the paper copy and it got lost or it
23 never got to the person it needed to.
24 And I would followup with them and they'd

1 say, Is there any way I can do this on
2 the computer somehow? So it was nice to
3 have it done both ways. And the next
4 time around, I'll probably just do it all
5 online. And if a person requests it on
6 paper, send out the paper, but primarily
7 just give them the online link.

8 377 services completed the survey,
9 so that was just over the eighty percent
10 threshold that the feds required of all
11 our surveys. And I enlisted a lot of
12 people's help in getting this 80.7
13 percent.

14 So one of the things that the feds
15 wanted -- that plays into the answers in
16 the survey, who answered the survey. You
17 know, obviously they wanted key personnel
18 who were involved at an administrative
19 level and at a provider level who are
20 actually answering calls to answer the
21 survey. I can't say that was the case
22 with our survey, because we didn't want
23 to put somebody's name on the address of
24 the envelope in case that person had

1 moved on or was no longer captain or --
2 you know, we didn't want somebody to say,
3 Oh, it's not addressed to me. I'm not
4 answering it, type of thing. So we just
5 addressed them to the agencies and
6 whoever answered it, answered it.

7 And I have to be honest, sometimes
8 when I followed up with agencies,
9 somebody would say to me, Oh, you know, I
10 answered the survey, but I'm really more
11 involved at the fire level than I am with
12 the EMS level. So I can't always say it
13 was the best person that answered the
14 survey, but we got an 80.7 percent return
15 rate so that's all we needed.

16 So this is just some national
17 numbers. Thirty-nine states in six
18 territories actually did this survey.
19 Not everybody -- well, most everybody had
20 to do the survey, but I'll get back to
21 that later.

22 So that's the numbers there that
23 nationally had put their number to
24 NEDARC. Our numbers are not national

1 numbers because they compiled their data
2 early fall and my numbers weren't in yet.
3 So keep that in mind when you see the
4 national numbers.

5 So they had over 5,300 records
6 that were reported on average. Per
7 state, 158 agencies were answering the
8 survey. Now, I really want to be the
9 EMSC coordinator in Guam, because they
10 have one service there on the island. It
11 would be great to be the coordinator
12 there, I think. But anyway -- okay.

13 So we asked them, you know, some
14 basic information about who they are. So
15 thirty-four percent of our respondents
16 were at an EMT BLS level nationally,
17 EMT-Bs and EMT-Is. Nine percent were
18 critical care techs or ILS on a national
19 level and fifty-seven percent were at a
20 paramedic level.

21 About nineteen percent of the
22 services were paid -- completely paid
23 services. Sixty percent of the services
24 are still all volunteers and then

1 twenty-one percent are a combination of
2 paid and volunteer staff. About
3 fifty-five percent self-reported that
4 they respond to mostly rural areas and
5 that was pretty much the same as the
6 national numbers. And 10.6 percent of
7 New York State incidents are pediatric,
8 meaning there were under -- eighteen and
9 younger -- or under the age of eighteen
10 -- actually under the age of eighteen,
11 seventeen and younger. So we're a little
12 higher than the national numbers as far
13 as the number of calls being for
14 children.

15 One of the questions that we asked
16 them was at what age do you consider a
17 pediatric patient. It starts at what age
18 and ends at what age. So fifty-four
19 percent of the providers said that it
20 starts at age zero, forty-one percent
21 said it starts at age one, and then four
22 percent had different numbers. And then
23 ends at age eight years fifteen percent
24 said, seventeen percent said -- or four

1 percent said at seventeen years,
2 forty-five percent at eighteen years and
3 thirty-seven percent that had other ages,
4 too.

5 So what's kind of interesting is
6 that, you know, what I drew from this is
7 that when you write protocols and you
8 just use the term pediatric, what the
9 provider interprets in terms of what age
10 that is. Our ALS protocol say fifteen
11 and our BLS say eighteen, even within the
12 state. So it just varies widely. So
13 you've got to wonder what the treatment
14 implications are in this case.

15 The federal definition, you know,
16 in the survey was under the age of
17 eighteen, but, you know, they say -- they
18 split it out zero to twenty-eight days is
19 a neonate, twenty-nine days to one year
20 is an infant, one to eleven years is a
21 child and twelve to eighteen is an
22 adolescent. They would all be considered
23 pediatric, though. So again, the mandate
24 is important as far as how that plays

1 out.

2 They were asked how many calls
3 they answered on an annual basis, and we
4 did have FDNY in there in the survey. So
5 the high end was, you know, over a half
6 million, 650,000 plus and the low was
7 twelve.

8 And then pediatric goes -- some
9 agencies said, We've never had a
10 pediatric call. Lucky them. And then,
11 of course, FDNY was at the high end
12 there. So the median number, if you look
13 statewide, was about 525 calls a year and
14 50 below eighteen.

15 Probably one of the things I hear
16 most in the year I've been doing this is
17 people come up to me and say, you know,
18 We so rarely have kids and we're so
19 nervous when we finally do have a child
20 that we need more training. It's so
21 infrequently that we get to practice, so
22 these numbers kind of support that.

23 Okay. So then we get to the
24 survey questions about -- in this case we

1 talked about online. And you do have a
2 copy of the survey, if you're interested,
3 in your packet. You can look at the
4 actual -- how thick it is, at least. And
5 I think I double-sided it. But it is a
6 hefty survey and it required a lot of
7 reading.

8 So the first question when you
9 have a pediatric call and they need
10 pediatric-specific online medical
11 direction at the scene of an emergency,
12 is it always available to them?
13 Eighty-five percent, always. Eight
14 percent said usually and then you got the
15 lower numbers. So again it's
16 pediatric-specific. Not only can you get
17 somebody on the phone, but do they know
18 what they're talking about in regards to
19 peds if you have a peds question.

20 DR. HALPERT: Are you
21 characterizing in general like that or
22 are you saying it is someone that has
23 FAAP after their name?

24 MS. GOHLKE: That's a good

1 question. I mean, it's their perception,
2 who is at the other end of the phone.

3 And are they asking for credentials? I
4 don't think so, but --

5 DR. HALPERT: That could be --

6 COURT REPORTER: Could you use the
7 microphone, please? I can't hear you.

8 DR. HALPERT: I'm sorry. I
9 apologize. If they're in Ogdensburg, it
10 could be a PA that's answering the phone
11 and they're probably a great PA but not
12 necessarily have the credentials to do --

13 MS. GOHLKE: And whether or not
14 the provider who's calling you to do that
15 is asking what the credentials are.

16 DR. HALPERT: They're just
17 comfortable because they happen to know
18 that PA because they live next door to
19 him.

20 MS. GOHLKE: Right.

21 DR. HALPERT: That's not out of
22 the question, necessarily.

23 MS. GOHLKE: Excellent point. So
24 do you feel that the individuals

1 answering the phone are able to provide
2 the necessary pediatric medical
3 direction? So eighty percent said
4 always, fourteen percent said usually,
5 and then you've got the lower numbers,
6 sometimes, rarely and never. So again,
7 pretty high. But the feds want to see
8 over ninety percent. They want to see
9 that, you know, over ninety percent of
10 the time, providers are getting
11 pediatric-specific online medical
12 direction. That's the goal.

13 DR. COOPER: As I recall, the feds
14 does not specify either, correct? In
15 other words, the performance measure
16 doesn't necessarily require the online
17 medical direction --

18 COURT REPORTER: I'm having a hard
19 time hearing you.

20 MS. GOHLKE: Right. The feds take
21 on it, at this point, is that as long as
22 it's a person on the other end of the
23 phone that has a higher level of
24 pediatric training than the caller,

1 they're okay with it.

2 MS. ROGERS: Oh my gosh.

3 MS. GOHLKE: This has been a
4 discussion with SEMAC, as well, about how
5 the state wants to deal with this. But,
6 I mean, one of the comments, I should
7 say, when I presented this to SEMAC
8 medical -- I can't remember, Medical
9 Standards -- thank you.

10 What one individual -- one
11 physician made the point, that I don't
12 agree, that a pediatrician is the person
13 we want on the other end of the phone
14 when somebody's calling for online
15 medical direction at the scene.
16 Pediatricians do not have the emergency
17 medicine experience behind them to answer
18 all the peds calls, so you know --

19 DR. HALPERT: It sounds like the
20 performance measure is asking who has
21 access to online medical control.

22 MR. WRONSKI: If I could just
23 comment. One of the things to always
24 keep in mind is when you have one of

1 these national surveys, they water down
2 typically the survey so that it can be
3 somewhat responsive to the variety of
4 what you find out there clinically. And
5 medical control is a TAG not available in
6 some large areas in different states on
7 any kind of regular basis. Even New York
8 State has some difficulty in some areas
9 getting reliable medical control at a
10 given time. Usually it's only due to
11 technology, though, in this state.

12 But pediatric-specific, my
13 understanding of the real goal was
14 whether or not the EMS provider felt that
15 they had someone that they could call who
16 knew more about pediatrics, and the feds
17 weren't going to, at least at this stage,
18 demand what that was.

19 But I think as you're going to see
20 as this comes out and over the next
21 couple of years, they're going to try to
22 better define that push some. What that
23 is is probably going to be in discussion
24 at the national and state levels and what

1 can we do. What could you potentially
2 do?

3 MS. GOHLKE: Okay. So BLS and
4 ALS. We have national and state numbers
5 on the slide. BLS we're at an --
6 eighty-three percent that feel they have
7 online pediatric medical direction at the
8 scene as compared to the national
9 sixty-nine percent.

10 For ALS, we're again ahead of the
11 national average -- the national number
12 of seventy-one percent and New York State
13 is at eighty-one percent. So as far as
14 how we compare nationally, we look good.
15 We have a higher percentage.

16 Again, the target is to have
17 ninety percent of the agencies have
18 pediatric-specific online medical
19 direction and that's at year 2011. We're
20 above the numbers through 2010. We do
21 have to resurvey again in 2010 for a
22 challenge to see if we can bring it up to
23 ninety percent, but let's go a little
24 further in the survey.

1 So, at what level is the online
2 medical direction defined at your EMS
3 agency? Now again, as Ed said, this is a
4 national federal survey, so the language
5 has to be generic so that all states
6 understand. So this is where it gets a
7 little -- where you start looking at the
8 numbers -- you get fuzzy numbers here.

9 So is online medical direction
10 defined at the state level, the region
11 level or local level? And they didn't
12 have that defined as either local
13 hospital or other medical personnel or
14 other.

15 So at the regional level, New York
16 State feels that it is defined for
17 them -- thirty-eight percent say it's
18 defined for them at the regional level.
19 Fifty-nine percent of New York is in
20 blue. Fifty-nine percent feel that it's
21 defined for them at a local level. And
22 then you've got two percent saying it's
23 done at a state level and then one
24 percent saying other.

1 The question is, you know, again,
2 what -- how are you defining regional and
3 local. You know. Again, is it my
4 regional REMAC that's defining for me or
5 are they local -- are they considered
6 local? So there is some confusion, I
7 think, with the question and how the
8 providers are answering it.

9 DR. HALPERT: Could that be a
10 function of agencies that maintain their
11 own set of protocols or is that --

12 MS. GOHLKE: I don't know.

13 MR. WRONSKI: Well, the fifty-nine
14 percent would be high for local. I think
15 you have providers who saw their local
16 protocols -- their regional protocols as
17 their local protocols.

18 DR. HALPERT: But I'm talking
19 about ambulance X has its own operating
20 protocols.

21 MR. WRONSKI: Certainly with air
22 med and some of the specialty ambulances,
23 they'll have their own local protocols.
24 And then yes, you're correct, even some

1 BLS agencies may have something that they
2 see as their protocol that was developed
3 by the ambulance service. So, they could
4 also be responding to that.

5 MS. GOHLKE: Brian, correct me if
6 I'm wrong, but air medical was taken out
7 of the equation.

8 MR. GALLAGHER: Right.

9 MS. GOHLKE: They're not in there.
10 I mean, they were surveyed -- there were
11 a few that were surveyed, but they were
12 taken -- the feds didn't want that
13 information so they were taken out.

14 Okay. So in general what level of
15 training of the individuals that provide
16 your providers with pediatric-specific --
17 so what is your perception of their level
18 of training?

19 So again, New York State's in
20 blue. Ninety percent said that they were
21 ED physicians that answered the phone.
22 Eleven percent were PAs. Nine percent
23 were paramedics. Seven percent is nurses
24 and it goes down from there. Don't know

1 is pretty low at four percent. So they
2 all pretty much felt that they were ED
3 physicians, but they could check more
4 than one, I should say. They could check
5 they were ED or physician's assistant or
6 paramedic that answered the phone.

7 DR. HALPERT: Do you think it's
8 significant that people checked off basic
9 EMTs were providing online medical
10 direction, both nationally and statewide?

11 MR. WRONSKI: Nationally, I'm not
12 surprised. Again, there is such a
13 diversity out there and difference in the
14 system. But in New York State, I'd like
15 to know where that is, because I don't
16 know of any. I think that in New York,
17 any way, when they answered EMT, they
18 probably just meant an EMS -- some EMS
19 certified provider generically, because I
20 don't know of any system that does that.
21 Not medical control. They may have
22 thought -- saw that as the dispatcher who
23 could be an EMT. That's a possibility,
24 but they're not supposed to give medical

1 direction.

2 Where you will find it is nurses.
3 There are nurses, there are PAs in New
4 York that do this and as I'm sure you
5 know, this is a hot topic at the moment
6 at SEMAC for discussion as to whether or
7 not policy should be changed to comply
8 actually with the statute, because the
9 statute says in New York that online
10 medical control shall be provided by a
11 physician or under the direction of a
12 physician. And the argument is should
13 there ever be a case where online medical
14 control should be under the direction of
15 a physician, not directly by a physician.
16 And there are some systems that use
17 heavily nurses and PAs in their system.

18 DR. KANTER: Every once in a
19 while, you see a statistic that surprises
20 me that is very reassuring. I think the
21 proportion that are accessing emergency
22 physicians is higher than I thought and
23 is a terrific statistic.

24 MR. WRONSKI: Just so you know,

1 New York State having either an ED
2 physician or a physician in medical
3 control. They say ninety percent. I
4 think it's probably close to that, if not
5 -- is very, very good. The national
6 picture is -- other than a handful of
7 states, is very different. It's very
8 different.

9 MS. GOHLKE: So the next question
10 was if you answered -- if they answered
11 physician in the emergency department, do
12 you know if they were a emergency
13 medicine physician, pediatric emergency
14 medicine, pediatrician, family practice
15 physician, don't know, other?

16 So again, look a little better
17 than national as far as emergency
18 medicine physicians. Twenty-six percent,
19 here we go, we don't know, really, who it
20 is that they are on the other end of the
21 phone. Questions or comments on this?

22 Okay. Just some of the comments.
23 I put in quite a few because they were
24 interesting. So they say, Explain why

1 you answered never, rarely, sometimes, or
2 usually. So if they didn't answer
3 "always," they had to answer this
4 question -- to why -- to the availability
5 of pediatric-specific online medical
6 direction.

7 So the most common answer was
8 communications failure. They're in a
9 rural service. They don't have cell
10 phone service and that's what they use to
11 call medical control or the radio
12 interference or whatever. They couldn't
13 access them for technological reasons.

14 Okay. So number two, "The doctors
15 who answered the phone at online medical
16 control are generalists and trauma MDs or
17 PAs and not pediatricians."

18 Number three. "Our regional
19 system for online medical control does
20 not always afford the opportunity to
21 speak with a pediatric specialist."

22 These get less common as we go
23 along. Number four. "Occasionally does
24 take an unreasonable length of time to

1 contact physician at the hospital due to
2 a very busy ER. Sometimes a doctor can
3 take several minutes to answer a call for
4 a signal."

5 Number five. "BLS unit not
6 affiliated with any hospital or New York
7 City medical control, so therefore we
8 don't have online medical direction."

9 Number six. "The person answering
10 the phone is an EMT, usually advanced
11 level, who may not have extensive
12 pediatric experience."

13 Number seven. "We have never had
14 a pediatric call so we've never called
15 for online medical control."

16 So number eight. "We've never had
17 to contact medical control for a
18 pediatric call."

19 Number nine. "When an online MD
20 is requested on rare occasions, the
21 ambulance is at the hospital before the
22 contact is made."

23 Number ten. "In a rural setting
24 such as ours, we don't have the 24/7

1 advantage as a large urban setting would
2 have."

3 Number eleven. "In my opinion,
4 most providers are not always comfortable
5 with pediatrics and dosages and they are
6 drastically different for pediatric
7 patients. This includes your medical
8 control operators, not necessarily the
9 physicians."

10 DR. HALPERT: So for number ten,
11 can you go back real quick?

12 MS. GOHLKE: Yes.

13 DR. HALPERT: Does that mean that
14 there is not twenty-four hour access to
15 an emergency department physician? It's
16 a rural hospital that --

17 MR. WRONSKI: There's a couple of
18 hospitals that are staffed in the
19 evenings with PAs and they are hospitals
20 and they may be the only available.

21 DR. HALPERT: No, but the prior
22 survey question said they're rural and
23 they don't have online medical control.
24 Is there anybody out there closing their

1 doors after --

2 MR. WRONSKI: You mean medical
3 control?

4 DR. HALPERT: Hospitals.

5 MR. WRONSKI: No. There are no --
6 to my knowledge, there is no part-time
7 hospital. But the nature of the staffing
8 will change from daytime to nighttime.

9 MS. GOHLKE: Number twelve.
10 "There is only one physician working who
11 has not only the medical control
12 responsibility but also has
13 responsibility for treating an ER full of
14 other patients. He may not be available
15 when we need online medical control."

16 Number thirteen. "I work in a
17 local ER and I know that the majority of
18 the time the unit clerk answers the phone
19 and has no medical training."

20 Number fourteen. "Phones are
21 never answered by a doctor. Sometimes
22 you have to go through two or three
23 people to get to one."

24 Fifteen. "Go through the

1 emergency department and talk to either a
2 nurse doing triage or a doctor should the
3 nurse there request him to give the
4 medical direction and sometimes when
5 contact is made with medical control.
6 The doctor is only receiving what the
7 dispatcher is telling him and not always
8 in the room where the dispatcher is."

9 Just some interesting comments.
10 And we talked about looking at this at
11 SEMAC and deciding what we're going to do
12 in New York State.

13 But I think Dr. Kanter made a good
14 point. At least it's ninety percent of
15 ED physicians that are -- at least the
16 perception of who's answering the phone.
17 So that's a good case scenario.

18 DR. COOPER: I think that point
19 does deserve some special comments. We
20 are Emergency Medical Services for
21 Children advisory committee and we are by
22 definition construction and every other
23 way broadly multi-disciplinary of all the
24 providers and agencies that help support

1 emergency medical services for children.

2 And all of our specialties are
3 required to have specific pediatric
4 training as part of the goals and
5 objectives of their residency and none of
6 us can do it without the other. And no
7 one on this committee has or I pray ever
8 will suggest that EMSC belongs to
9 pediatrics. EMSC belongs to all of us
10 together, because we're all here to
11 support emergency medicine online for the
12 critically ill or injured child.

13 MS. GOHLKE: So the survey then
14 continued about their written protocols
15 or offline written medical direction. So
16 again you got to think of the language of
17 our providers reading these questions.

18 The next one is, has your EMS
19 agency adopted for use written or
20 electronic offline pediatric medical
21 direction? And it says, See above. It
22 did have a definition of what offline
23 medical direction was. So again there
24 was a lot of reading with this survey, a

1 lot of definitions, but it was defined
2 for them if they read it all.

3 So do they have written medical
4 direction? So sixty-four percent said
5 yes at the BLS level, thirty-six percent
6 said no at a BLS level when you do define
7 it at a state level. So that's a little
8 concerning.

9 ILS, sixty-nine. Still thirty-one
10 percent of intermediate said no. And
11 then ALS was a little bit better.
12 Ninety-two percent said yes, we do have
13 offline pediatric medical direction.
14 Only eight percent said no. You know. I
15 think it was -- my opinion, I think it
16 was just interpretation of the question.

17 What does adoption mean? People
18 were confused. Did my agency adopt
19 specific pediatric protocol? No. Again,
20 how they interpreted the question, I
21 think, clearly played into how they were
22 going to answer. No, thirty-six percent
23 of the time, at least for BLS level,
24 anyway.

1 So the next question. When they
2 have a specific pediatric call and they
3 need off-line medical direction at the
4 scene, are the protocols available in the
5 patient care unit with the terminology?
6 We also had vehicle in there -- or
7 carried by the EMS providers. The
8 "always," eighty percent of BLS said yes,
9 they're always either in the vehicles.
10 BLS -- ILS was eighty-eight percent and
11 ALS was ninety-two percent. The feds
12 want to see over ninety percent again for
13 this target.

14 Again, comparing nationally with
15 our numbers, BLS was just slightly lower
16 as far as having written protocols. ALS
17 was a little bit -- one percent higher,
18 eight-four percent. And again, like I
19 said, the target was ninety percent for
20 2011.

21 So at an ALS level, we're good
22 through 2010, at least as far as how they
23 answered the survey. For the BLS level,
24 you have to do a little figuring out on

1 how to make sure providers know -- first
2 of all, I think there is a question
3 whether or not pediatric protocols, once
4 we know there is the statewide
5 protocols -- or maybe the question could
6 be tweaked a little bit at the national
7 level so the interpretation's better. I
8 don't know. There could be an issue,
9 whether or not they know pediatric
10 protocols are within the adult protocols.
11 I don't know, you know, what our
12 providers feel at a BLS level.

13 Off-line medical direction in
14 general. At the scene of an emergency,
15 do your EMS providers access -- how do
16 your EMS providers access pediatric
17 protocols or guidelines? Are they
18 available in the unit? Eighty-four
19 percent said yes. Are they memorized?
20 Thirty-four percent said yes. Do they
21 carry them him or herself? Thirty-three
22 percent said yes. And again, they could
23 check more than one. You have the
24 national numbers there to compare to.

1 We don't -- we don't mandate that
2 they actually have to be carried, either
3 on the vehicle or on him or herself. We
4 recognize it, but it's not mandated, and
5 that's a glitch on the federal level.
6 They want to see it -- it's supposed to
7 be written somewhere and accessible on
8 the scene.

9 MR. WRONSKI: Is there any comment
10 by the committee? I mean, BLS, I would
11 argue that you don't have to have that
12 protocol physically available with you,
13 yet it's good practice to carry one in
14 your ambulance. And I know that from
15 going to calls in the past, I would refer
16 to it if I knew where I was heading and
17 it was likely to be there. But
18 typically, BLS isn't so complex that you
19 would necessarily need the protocol. But
20 ALS could be different, particularly with
21 kids. You might want to remind yourself
22 of the dosages.

23 DR. KANTER: The American Heart
24 Association in most hospitals, certainly

1 the hospital I work in, has all the
2 resuscitation algorithms posted right on
3 the emergency carts that you can refer to
4 at all times. You might think you know
5 them, but in a crisis, it's nice to
6 glance at the algorithms right there.

7 DR. COOPER: It's often said that
8 adrenaline makes you stupid. And yes, so
9 I agree with Dr. Kanter completely.

10 MS. GOHLKE: So some comments
11 here. So if they answered anything other
12 than "always," they were asked to
13 elaborate.

14 Protocols are kept at the base,
15 but not all EMTs are trained before they
16 ride on the ambulance. Interesting.

17 We expect providers to know
18 protocols, and if there's any doubt,
19 contact medical control.

20 Well, we have online medical
21 control, so that's the purpose of it.

22 And we carry a copy of all our
23 protocols in our ambulance and our BLS
24 first response truck. However, we also

1 have some of our EMTs first respond to
2 emergencies in their personal vehicles,
3 where I expect they don't carry
4 protocols. So it depends on how they're
5 answering for each vehicle.

6 And they did ask, especially when
7 you get to the pediatric equipment, it's
8 any vehicle that responds to the scene.
9 So if they have a fire tuck that's doing
10 BLS first response, that was considered
11 in the survey. Do you have protocol on
12 it? Maybe not on the fire truck.

13 DR. HALPERT: Is there any feeling
14 by the SEMSCO folks to try to enforce
15 that kind of a proposition whereby there
16 is a mandate, if you will, that a
17 protocol of some sort, in some fashion,
18 is on the vehicle and accessible? That
19 should be a serious consideration. I
20 have a feeling about that.

21 MR. WRONSKI: They haven't
22 expressed it, to my knowledge, at the
23 meetings I've been at or had a motion to
24 discuss that. I think conceptually, they

1 all support that. It would be good to
2 have this available. Mandating it, I
3 know there's not been a vote to suggest
4 that. If you did, it would be probably
5 the only mandate that would be very easy
6 to meet because you can download it from
7 the state's website. It's not -- a few
8 pieces of paper is all it costs. But
9 Lee, I'm not wrong on that, right?

10 DR. HALPERT: Just from the
11 discussion we've already had today, we
12 know that poorly managing
13 pediatric-related cases is caused by lack
14 of experience. And their comfort level,
15 therefore, is not built up
16 satisfactorily.

17 Bob's already mentioned having
18 access to protocols or templates -- or
19 guidelines available at the time of the
20 emergency makes the job so much easier.
21 So why ignore that fact and say to our
22 field providers, Listen, you might be
23 great at managing adults and heart
24 failure patients, but you need to have a

1 much better sense of what you're dealing
2 with on a crashing asthmatic or a febrile
3 or a seizing child. And if you're not
4 comfortable with that or whatever your
5 protocol driver is, it's important --

6 DR. COOPER: We did a few years
7 ago provide all ambulances in New York
8 State with a copy of the resuscitation
9 card and the children's special
10 healthcare needs cards. We presume
11 they're, for the most part -- but you
12 raise a good point.

13 MR. WRONSKI: Well, the committee,
14 either now or later when it has final
15 comments, can certainly make a
16 recommendation to the SEMAC that they
17 look at language that they might want to
18 direct EMS services to have state or
19 regional protocols available in some
20 fashion at the scene of an emergency.
21 You don't even have to say mandate. You
22 can just say promote. But, I mean, this
23 body can do that. That can go forward to
24 the SEMAC for consideration.

1 MS. GOHLKE: Okay. So just a
2 summary of this one survey, the medical
3 direction survey. So ALS says that
4 eighty-one percent have access to online
5 pediatric medical direction. BLS,
6 eighty-three percent. That's wrong.
7 That number is wrong there. Oh, yes. I
8 was thinking of the protocol. Online,
9 yes. Eighty-three percent BLS. So we
10 exceed the targets through 2010. We'll
11 have to resurvey again in 2010, and
12 again, the goal is to be at ninety
13 percent by 2011.

14 For offline written protocols, ALS
15 said eighty-four percent have access to
16 these written protocols on the scene.
17 Fifty-five percent BLS have protocols on
18 the scene. So for ALS, again, we exceed
19 the 2010 federal target. For BLS, we
20 only meet the 2008 target. On both -- we
21 need to get them both up to ninety
22 percent by 2011.

23 Let's skip this for a second and
24 move on to the rest of the survey. We

1 can come back to this.

2 Pediatric equipment. So the
3 survey continues and it asked them about
4 what pediatric equipment they have on the
5 scene. And again, this is any vehicle --
6 they wanted to know any vehicle that's
7 responding to the scene, not just the
8 transporting ambulance but fire trucks,
9 first response, fly car, whatever. Those
10 were all in the mix here.

11 So about thirty-three states and
12 about six territories were surveyed.
13 Again, New York State is not in the
14 national numbers. Nationally, they had
15 4,100 records to look at. You can see
16 how it's split out nationally versus New
17 York State. And again, New York State
18 was above the average number of EMS
19 agencies that were surveyed.

20 So they asked about the -- or the
21 patient care units or vehicles that are
22 responding, ALS or BLS. New York State
23 is about a 50/50 split. Nationally there
24 was more BLS vehicles responding than

1 ALS.

2 They -- we used the 1996 ACEP/AAP
3 equipment list. This included adult
4 equipment and child -- adult and
5 adolescent PSA data. All the ranges of
6 equipment. So it wasn't just pediatric
7 equipment. And they had to answer for
8 each vehicle. Do you carry this piece of
9 equipment on your fire truck or whatever
10 it is they're talking about? So it
11 wasn't like an inventory as far as how
12 many pieces of equipment they carry on
13 each vehicle. It's just whether, yes or
14 no, they carry it.

15 So the bottom line, of all the
16 equipment on that list, what number --
17 what percentage of these do you carry
18 every single piece of equipment? New
19 York State came in a little higher than
20 the national number. We came in at
21 twenty-seven percent versus nationally
22 only twenty percent of the vehicles carry
23 all the recommended pediatric -- well,
24 actually, it wasn't all the pediatric, it

1 was all the recommended equipment. Like
2 I said, it included adult equipment, too.
3 And again, the national target needs to
4 be over ninety percent by 2011.

5 It is split out here by BLS and
6 ALS. BLS was higher than ALS in New York
7 State for carrying the recommended
8 equipment. And again, you have to
9 remember here that this is fire trucks
10 responding, fly cars. If you didn't
11 carry a backboard because you're a fly
12 car and then the ambulance comes behind
13 you, but you got dinged if your fly car
14 didn't carry a backboard. So again, it's
15 all the vehicles that are responding. A
16 fire truck may not have a backboard on
17 it, so you got dinged. You're off the
18 list if you missed one of those pieces of
19 equipment.

20 Now what's changing is the next
21 time we do this survey, the feds have
22 changed. They're only going to consider
23 transporting vehicles, the patients being
24 transported to the hospital. So

1 automatically the numbers are going to go
2 up right there because they're taking out
3 the fire trucks and they're taking out
4 the fly cars. So that's a good thing as
5 far as -- whether or not it's
6 intentional, I don't know. But we'll
7 just automatically do better the next
8 time we survey just simply for that
9 reason. And it makes sense. I don't
10 know why they didn't do it the first go
11 around.

12 So BLS equipment most often
13 carried in New York State was like FYI.
14 Why we're not at a hundred percent on
15 some of this -- but like the NRB breather
16 for the adults, the blood pressure cuff
17 for the adults, the BVM for the adults.
18 All these pieces of equipment, you would
19 think that they would also maybe have on
20 the fire truck as well, but it's not all
21 carried.

22 Just as an FYI, the BVM, they
23 split out the mask for the BVM and the
24 bag for the BVM. So you had the right

1 size mask for the infant and the child
2 and you had the right size bag for the
3 BVM. But because it was split out, that
4 confused people. And a lot of people
5 said, Oh yeah, we have the infant size
6 BVMs but we don't have the smaller size
7 bags to go with it. In fact, a lot of
8 people said, That's out of scope for us.
9 So again, the way the question was asked,
10 it was very confusing. It was defined,
11 but again, it required a lot of reading.
12 So I think that affects some of the
13 numbers, too.

14 The least often carried was the
15 pediatric backboard. And then they had
16 the different size suction catheters.

17 Pediatric splints was one of the
18 things that was on the list. You had to
19 have a specific pediatric splint. A lot
20 of people said, well, I can modify an
21 adult split. That's why we don't buy
22 them or whatever.

23 Portable suction with a regulator.
24 Portable suction with a regulator, a lot

1 of different size suction catheters, and
2 the pediatric backboard. When the new
3 list comes out very shortly, they're all
4 on an optional part of the list. So
5 again, we'll look better because it's
6 moving from a mandatory part of the list
7 to an optional part. So that will help
8 us.

9 ALS equipment most often carried.
10 Again, very high but not a hundred
11 percent or ninety-nine percent. NRB
12 breather adult, blood pressure cuff.
13 Again, the BVM issue there with
14 resuscitation bags, oropharyngeal size
15 four and the BVM child.

16 ALS least often carried equipment.
17 Pediatric backboard, oxygen mask infant,
18 ET tube size six -- you know, twenty-five
19 gauge needle. A lot of these sizes --
20 you know, they required every single size
21 of needles, suction catheters, before.
22 And now, in the new list that's coming
23 out, they're saying you only need two
24 sizes of suction catheters. You don't

1 need the zero through five or whatever
2 the numbers were. So again, that's a
3 good thing. You can just compare the
4 national numbers. You know.

5 Most often carried equipment, BLS
6 were higher than the national average, on
7 average. And for least often carried,
8 again, we looked better than the rest.
9 ALS most often carried were pretty much
10 on average with what the national numbers
11 are.

12 Least often carried, pediatric
13 stethoscope. My little caveat there. A
14 lot of people, when I called, you know,
15 had to follow up with questions and
16 answers. And they would say, Well,
17 what's a pediatric stethoscope? So it's
18 a double bell pediatric stethoscope. And
19 the answer was yes, but that wasn't in
20 the survey. So a lot of people obviously
21 had that question. If you had a double
22 bell stethoscope, you were okay with
23 this.

24 I'm currently taking my EMT course

1 and I'm sitting in my lab portion of it
2 and somebody says, What's -- to the lab
3 instructor -- there was two certified lab
4 instructors in my little station here.
5 And somebody asked on a double bell
6 stethoscope, What's the smaller size for?
7 And one lab instructor looks at the other
8 one and says, I don't know, do you? And
9 the other lab instructor goes, No. So I
10 said, I think you can use that for heart
11 in peds. It's recommended. You know,
12 it's a little more sensitive. Oh. So
13 that just goes to show you the ones that
14 are teaching aren't necessarily familiar
15 with the equipment very well either, so
16 --

17 MR. WRONSKI: Martha is taking her
18 course in Vermont.

19 MS. BURNS: All of these were done
20 in Vermont because it's still
21 regulatorily (sic) required.

22 MS. GOHLKE: But the good news is
23 it's a pediatric stethoscope and it's now
24 in the optional portion of the new list

1 that's coming out. But it's still
2 regulatorily (sic) required.

3 MS. BURNS: But New York State
4 does require it. Good point.

5 MS. GOHLKE: So that's my little
6 story there for that one.

7 Okay. So now we ask, what's the
8 reason, why don't you carry this stuff?
9 So the number one answer was, in New York
10 State, that there is no state or local
11 requirement on a lot of this stuff. The
12 same with the local fire departments. We
13 don't have to carry it; we're not going
14 to carry it.

15 Only eight percent -- again, New
16 York State is in blue -- only eight
17 percent said they had limited funded. So
18 money wasn't an issue. Four percent
19 said, well, the pediatric equipment
20 wasn't necessary, at least the ones that
21 they said they don't have. It's used too
22 infrequently to justify the expense. And
23 one percent said, well, it's not
24 reusable.

1 So -- so that's kind of
2 interesting, especially the funding
3 issue. I would have thought it would
4 have been higher. I would have thought
5 you would have heard the cry, Well, we
6 don't have the money, but that didn't
7 appear to be really the issue.

8 So I gleaned from it that if we
9 mandate it, they'll do it, at least
10 that's what eighteen percent feel. Looks
11 very similar for ALS answers here, too.

12 So some of the comments. Well,
13 they're not in responder cars due to the
14 ambulance responding with the responder
15 car. So obviously they have all the
16 equipment on the ambulance, not
17 necessarily in the fly cars. Other
18 devices can be used for multiple tasks.
19 Like it says -- for example. And the
20 amount of equipment, medication, etcetera
21 are very costly for the amount that is
22 actually used. Most peds calls are
23 fracture in nature. So they were all
24 pretty similar in their comments like

1 that.

2 Just -- this was just a little
3 interesting, who answered that the
4 equipment was out of scope for them. So
5 they could have answered, "we have it",
6 "we don't have it" and "it's out of scope
7 for us, we can't use it."

8 So six percent of the patient care
9 units, when they responded, said it was
10 out of scope for us to use an oxygen mask
11 for an adult. It's out of scope for us
12 to use a portable suction unit with a
13 regulator and it's out of scope for us to
14 use a one-size suction catheter. Just
15 kind of interesting answers. Four
16 percent said it is out of scope for them
17 to use a BP cuff for an adult. And then
18 here's the bag part of the BVM. A lot of
19 people said, you know, that's out of
20 scope for us. Pediatric backboard's out,
21 cervical collar for an adult, and bulb
22 syringe. You know.

23 MS. CHIUMENTO: Martha, I wonder
24 if a lot of those are CFRs, because CFR

1 protocols are not specifically --

2 MS. GOHLKE: We didn't survey
3 them.

4 MS. CHIUMENTO: That's what I'm
5 thinking, particularly blood pressure
6 cuff. And for a while we said that
7 wasn't part of the curriculum and the
8 backboard -- and you don't do backboard,
9 you only do mobilization. So I suspect
10 that's where a lot of those are.

11 MS. BURNS: They surveyed
12 ambulance services, not the BLS first
13 responders.

14 MS. GOHLKE: We didn't do the BLS
15 first responders.

16 MR. CZPRANSKI: In many parts of
17 our area, you have the fire departments
18 that run the ambulance service and the
19 chief responds in the chief's vehicle,
20 who is a CFR.

21 So again, if you're going back and
22 saying to look at the responding
23 vehicles, that's where I'd look a the gap
24 in the ninety-five percent. A lot of

1 time it was a vehicle that wasn't an ALS
2 fly car.

3 MS. BURNS: Aren't you optimistic?

4 MS. GOHLKE: Okay. So
5 twenty-seven percent -- as far as having
6 to look at the feds, twenty-seven percent
7 of the agencies report carrying the
8 recommended equipment. We fall short of
9 all the targets, but we look better than
10 the national number, which is twenty
11 percent. But we still have to reach
12 ninety percent by 2011.

13 MS. BURNS: Get to work.

14 MS. GOHLKE: The new list is
15 coming out. They're presenting it to the
16 grantees in three weeks, I think. I did
17 get a peek at the new list, the language.
18 I mentioned where some of the things were
19 moved to optional.

20 DR. COOPER: Has not changed.

21 MS. GOHLKE: So they had more of
22 the national committees signing off on it
23 this time around, ACEP and ACS, but you
24 got the national association of EMS

1 physician and then the federal EMS
2 stakeholder's group.

3 One of the questions I had, were
4 there any paramedics involved in the new
5 list? And the answer is yes. It wasn't
6 all physicians who were making up this
7 equipment list number. There were EMS
8 providers involved in the new equipment
9 list.

10 So the piece of equipment that
11 might be an issue for us. We don't say
12 that the portable suction has to have a
13 regulator and it's still not on the
14 mandatory list. We say, well, the new
15 list says you have to have two pharyngeal
16 suction tips, one between each of these
17 sizes. We don't necessarily say they
18 have to be between those sizes.

19 The valveless oxygen masks for
20 adult and child is still on the list.
21 And we say that for adults you're to use
22 the NRB breather. We're going to fall
23 short there. The NPA sizes, eighteen to
24 thirty-four is on the list. We don't

1 even have NPAs on our list.

2 Alternative airway devices is not
3 on our list. The pulse ox with pediatric
4 and adult probes, no, we don't have that
5 on our list.

6 Tourniquets are on there.
7 Thermometer with the low temperature
8 capability in a hypothermia issue might
9 be a problem for us if we don't have
10 those low temp monitors there.

11 And believe it or not, umbilical
12 tape is on the list there and we don't
13 have it on our list for the OB kit. So
14 those are some of the pieces of equipment
15 for BLS that might be a problem next go
16 around.

17 For ALS, they have laryngoscope
18 blades. You have to have one between
19 each of those sizes. Actually, all those
20 sizes you have to have on the list.

21 ET tubes, those sizes have to be
22 there. We don't mandate this on our
23 list. End tidal CO₂ capnography is on
24 there. Tourniquets again. Now a 3.25

1 inch needle for chest decompressions
2 there. And the transcutaneous cardiac
3 pacemaker adult and peds pads is on
4 there. It looks like it may cause a
5 problem for us.

6 Optional equipment. Like I said,
7 oxygen masks -- the infant size was moved
8 to the optional side. The infant bag was
9 moved to the optional side, size 00 NPA.
10 Infant and neonatal BP cuff is moved to
11 the optional. Pediatric stethoscope,
12 infant CV collar and pediatric backboard
13 were all moved to optional, so that will
14 help us.

15 MS. CHIUMENTO: What happened to
16 the NG tube, the nasogastric tube? Did
17 they stay on?

18 MS. GOHLKE: They only stayed on
19 if they -- if somebody marked it as out
20 of scope, then they weren't included in
21 there. So for a lot of our providers, it
22 is out of scope for them. So they
23 weren't included and they weren't dinged
24 if it was out of scope.

1 MS. CHIUMENTO: Because I remember
2 that was the one piece of all the pieces
3 that was the most often for ALS.

4 MS. GOHLKE: Was that on there?

5 MS. CHIUMENTO: It was, but I
6 didn't see it on your presentation.

7 MS. GOHLKE: Actually, I think I
8 talked to Brian about this at a later
9 point after you saw the original
10 presentation and we talked about pulling
11 it out because they marked it out of
12 scope. So that's probably changes you
13 saw in the presentation.

14 MS. CHIUMENTO: I remember that
15 before you did the original survey. That
16 was the number one thing --

17 MS. GOHLKE: Could be. Honestly,
18 I did not go back as far as Gloria's
19 surveys, to be honest. I had enough
20 number crunching to do with my own
21 survey. I have not even looked at what
22 Gloria --

23 MS. CHIUMENTO: That was the one
24 thing, but most of the people did say it

1 was out of scope.

2 MS. GOHLKE: And it's probably --
3 I don't know the difference when they
4 surveyed back then. They probably added
5 that question about out of scope. They
6 probably didn't ask that before. I'm
7 just guessing. But they keep refining,
8 obviously, the survey, so that could be
9 one issue with that.

10 DR. HALPERT: So Martha, you keep
11 referring to providers answering the
12 survey questions. That's the provider's
13 perception of their scope of practice?

14 MS. GOHLKE: I would assume so.

15 DR. HALPERT: Define "scope of
16 practice."

17 MS. GOHLKE: Only NG tubes, as far
18 as I know, are the only thing that would
19 legitimately be out of scope according to
20 the pediatric list. What else?

21 DR. HALPERT: They're not out of
22 scope.

23 MS. GOHLKE: Which ones?

24 DR. HALPERT: NG tubes are not out

1 of scope.

2 MS. GOHLKE: For some of them,
3 regionally, I believe they are.

4 MS. CHIUMENTO: Yes.

5 MS. BURNS: There is a difference
6 between out of scope and what is not
7 included in their regional protocol,
8 because NG tubes are in the curriculum.

9 DR. HALPERT: Right. That's what
10 I'm using in my scope.

11 MS. GOHLKE: Are they allowed to
12 use it or not, would be a better
13 question.

14 DR. HALPERT: Are they able to
15 train docs? The answer is yes. Can they
16 use it as a function of --

17 MS. GOHLKE: In many cases, no.

18 DR. HALPERT: So I'm saying it's
19 in the curriculum, it's not in the scope
20 of practice.

21 MS. GOHLKE: Right. Again, it
22 could be interpretation.

23 DR. HALPERT: It's providers'
24 interpretation of the scope of practice.

1 MS. GOHLKE: Right.

2 MS. BURNS: It is their
3 interpretation. They don't need NRB
4 breather masks, too.

5 DR. HALPERT: Right.

6 MS. GOHLKE: Surveys are always
7 interesting. So anyway -- so the new
8 list is coming out, like I said, shortly.
9 You know, at a state level, we have to
10 decide how to -- what we're going to do
11 with this list, you know, if and how we
12 distribute it.

13 Does It require any changes to our
14 list, our regulation, our part 800? Like
15 I said we do need to resurvey in 2010.
16 We probably will do an online survey,
17 although there were issues -- there was
18 an issue, though, with the paper and
19 online. I actually think, in this case,
20 the paper worked a little better, because
21 in the online if you answered that
22 anything -- the default -- they first
23 asked you, Was any of this equipment out
24 of scope for you? And you had to click

1 yes or no. And it was defaulted to no.
2 So nothing was out of scope for them.
3 They had to move to the yes column if it
4 was out of scope. If you misread that, a
5 lot of people said yes we use all of this
6 equipment, which got then marked as out
7 of scope. So if you did that, they
8 didn't ask you any of those equipment
9 questions. You got to skip over the
10 survey in the online one. But in the
11 paper one, you still filled out the
12 questions, so you could change your
13 answer and go back.

14 So anyway, again, if we are going
15 to do this online or not, how we can
16 refine that for our needs. We also have
17 the option of doing the ambulance -- you
18 know, doing the pediatric equipment list
19 survey by ambulance inspection or maybe
20 through doing the survey when you
21 recertify services every other year is
22 another option on how to handle the
23 survey. Just food for thought for how to
24 do for 2010. Comments?

1 DR. COOPER: Well, I have a
2 comment.

3 MS. GOHLKE: Yes.

4 DR. COOPER: The EMSC stakeholders
5 are meeting in Washington on Thursday and
6 Friday, and unless something radical is
7 done, no one is going to make this
8 benchmark guideline by 2011.

9 And the way the survey is
10 constructed, of course, if you miss one
11 of those pieces of equipment, you become
12 part of the seventy-three percent as
13 opposed to twenty-three percent, even
14 though you may have virtually everything
15 you need to resuscitate ninety-nine
16 percent of kids.

17 So I think there does need to be
18 some additional thought at the federal
19 level as to how the survey is going to be
20 administered and scored. But beyond
21 that, as you say, it's very interesting.

22 Gloria had conducted a survey
23 quite similar to this a few years ago. I
24 think we're doing a little better this

1 time are around, as I recall. The one
2 area where we continue to be especially
3 weak is with nasogastric tubes. But the
4 --

5 COURT REPORTER: I'm having a hard
6 time hearing you.

7 DR. COOPER: Nasogastric tubes.
8 I'm sorry. For some reason, this
9 microphone is not the healthiest.

10 The -- but there has always been a
11 problem with the use of nasogastric
12 tubes, mainly that the training models
13 that are out there are essentially
14 non-existent, and the teaching about
15 gastric distention and when to be
16 compressed is quite important. And --
17 or, I'm sorry. Even though quite
18 important is quite problematic.

19 I mention this because one of the
20 least cited, yet most important in my
21 judgment, findings of Marianne
22 Gausche's study regarding intubation was
23 the twenty-eight percent incident of
24 gastric distention in the children who

1 were bagged as opposed to tubed.

2 Now, we all know that excessive
3 gastric distention can limit the efficacy
4 -- well, I shouldn't say efficacy -- the
5 effectiveness of bag and mask
6 ventilation. And so it would seem that
7 -- that having the ability to decompress
8 a distended stomach would be an important
9 issue and that training models would have
10 been developed to deal with that issue.
11 But they have not as yet been, which is
12 really, to my mind, very interesting.

13 DR. KANTER: I think the other
14 thing that's missing is evidence about
15 what the proper sequence is to do things
16 in. But for what it's worth, the
17 American Heart Association pediatric
18 advanced life support guidelines
19 acknowledges that it's not completely
20 clearcut whether you should intubate
21 first or decompress the stomach first.

22 And for those systems that are not
23 going right to prehospital intubation,
24 the other question is, what's the best

1 way to bag them and ventilate them, with
2 or without a nasal or oral gastric tube
3 in. It's harder to get a seal with a
4 tube in.

5 So I'm not sure that they ideally
6 know, based on evidence, what's the best
7 way to go.

8 DR. COOPER: I certainly agree
9 with you in terms of the -- in terms of
10 the timing. One thing upon which we can
11 all agree, however, is that if you do, in
12 the course of bag or mask ventilation,
13 involve diffusing the distended stomach,
14 that at some point whether the tube stays
15 in or is replaced or removed,
16 decompressing that stomach will certainly
17 assist in adequate ventilation with bag
18 or mask ventilation. So this is an
19 unsolved problem for many different
20 aspects, but one that I continue to feel
21 is one that requires our continued
22 thought.

23 MR. WRONSKI: Can I just ask,
24 because I don't know, how do you reverse

1 that, the stomach, the distended stomach?
2 How do you reverse the effects of the
3 distended stomach?

4 DR. COOPER: You decompress it
5 with a tube.

6 MR. WRONSKI: With a tube?

7 DR. COOPER: Yes. You pass a tube
8 into the stomach.

9 MS. ROGERS: As far as the survey
10 goes and resurveying, what measures other
11 than the equipment list changing are
12 there proposed to improve our responses
13 in the state to these questions?

14 MS. GOHLKE: That's what we need
15 to decide.

16 MS. ROGERS: Pardon?

17 MS. GOHLKE: That's a good
18 question. That's what we need to talk
19 about.

20 DR. COOPER: You know, I think
21 it's a very hard question to answer -- in
22 fact, almost impossible question to
23 answer, because with the institution of
24 the new list, it is going to be very,

1 very hard to have a baseline to really
2 know where people are starting from. And
3 I think this raises a very important
4 question for us and I will plan to raise
5 this in Washington on Thursday.

6 If we are instituting a new list,
7 perhaps we need a baseline round before
8 we, you know, ask people to meet new
9 targets, because it's going to be very
10 difficult, I think, to really know where
11 we're going unless we know where we are.

12 MS. WALDEN: Martha, do you --

13 COURT REPORTER: Please use the
14 microphone.

15 MS. WALDEN: I'm sorry. Do you
16 have any proposals to add new national
17 questions?

18 MS. GOHLKE: I haven't seen the
19 survey questions yet. We were allowed to
20 tailor the questions to meet our needs in
21 the state. We'll do a better job
22 tailoring next time. I don't know the
23 extent of how much we'll be able to
24 change or change it a lot, more than one

1 or two words.

2 I'll be honest. When I came on
3 board, there was a real rush to get this
4 done because New York was behind the
5 eight ball and we did -- we did look at
6 the questions and we did tweak a few
7 things. But now that I'm more aware of
8 this world and the issues behind it, it
9 will be tailored a little bit better next
10 go around and hopefully get the answers
11 that we need as far as whether they'll
12 allow us to revise the questions without
13 changing what the national question is.
14 So those -- it could be better.

15 MR. WRONSKI: What I've asked
16 Martha to do, too, is at the national
17 meeting -- and stake out some of the
18 issues we have about the survey and the
19 perceptions of providers and etcetera and
20 that -- you know, the people who put the
21 survey together have to rethink how they
22 phrase some of these questions or even
23 what questions, but certainly to put that
24 on the table there.

1 One other thing I'd like to
2 mention is, you know, for us, Martha had
3 said what's the way to do this. Do we do
4 another survey? Do we do inspections?
5 How do we do this? The best way and the
6 most accurate way to determine what
7 equipment is being carried is through the
8 inspection process. But that's a
9 cumbersome process.

10 Right now, it takes us somewhere
11 between four to five years before we had
12 gone through every ambulance service at
13 least once to determine their equipment.
14 Now, could we do that quicker? We could,
15 but it means stopping other things that
16 we do. We could increase it probably
17 without doing any severe damage to what
18 we do in the region to something in the
19 area of three years. But that's three
20 years. And they don't usually want to
21 wait three years for the survey results.

22 But keep that in mind. We would
23 be able to do a survey of a few hundred
24 services in any given year and have that

1 sampling. So if the sampling were
2 accepted -- I think, actually, it was
3 accepted even for the mailing, right? It
4 wasn't all the ambulance services that
5 were surveyed.

6 MS. GOHLKE: Correct. Right.

7 MR. WRONSKI: So if it was a
8 reasonable number, say 300, 350, 400
9 ambulance services, we'd have a better
10 possibility of doing the survey.

11 And the other possibility is we
12 could go to our regions and ask them to
13 assist in the survey if we wanted to have
14 a more accurate survey and do it within a
15 year's time.

16 MR. CZAPRANSKI: I have a couple
17 questions. You had mentioned on the one
18 slide that new questions were going to
19 pertain to just transport-capable
20 ambulances.

21 MS. GOHLKE: Right.

22 MR. CZAPRANSKI: Is that going to
23 be for all the equipment questions?

24 MS. GOHLKE: Yes.

1 MR. CZAPRANSKI: The only concern
2 I have with that are the national
3 standards for advanced life support are
4 eight minutes and fifty-nine seconds,
5 ninety percent of the time, and that's
6 predicated upon a -- response system.
7 And so if we're not measuring their
8 capabilities to treat the patients when
9 they get on the scene, it would be a
10 concern.

11 MS. GOHLKE: You're the first
12 person that has expressed that. Good
13 point.

14 DR. COOPER: Okay. Well, first I
15 think we owe a tremendous debt of
16 gratitude to Martha and her colleagues
17 for doing this.

18 MS. GOHLKE: Brian.

19 DR. COOPER: And of course we're
20 very happy for Martha, too, because this
21 gave her sort of a baptism by fire coming
22 on the job when she did with an undone
23 project laid in her lap. But at the very
24 least, we clarified the issue about the

1 double bell stethoscope.

2 MS. GOHLKE: At least for me and
3 about four other people.

4 DR. KANTER: I wonder -- just
5 listening to all the information here, it
6 strikes me that the one important
7 inexpensive feasible improvement
8 opportunity is the written protocols to
9 be carried with the responders. I wonder
10 if this committee could make some
11 statement that would favor that.

12 DR. COOPER: Bob, I'm going to
13 take that as a motion. Is there a second
14 to that motion?

15 DR. HALPERT: Second.

16 MS. BRILLHART: Second.

17 DR. COOPER: Multiple seconds.
18 Thank you Susan and Jon. Discussion?

19 DR. HALPERT: I think the real
20 upside to this, frankly, is that by
21 saying, you know, we're the EMSC
22 committee. We require a mandate -- you
23 all keep these protocols near and dear,
24 tucked away someplace accessible in the

1 unit. But the reality here is that the
2 pediatric aspects of the protocols is a
3 good deal more often, which means you're
4 going to keep the entire protocol -- so
5 you're going to get a better bang for
6 your buck, which is important.

7 MR. CZAPRANSKI: The point of the
8 question is that the protocols refer to
9 both local and state issues.

10 DR. HALPERT: Well, because the
11 local protocols are endorsed by the
12 state, correct?

13 MR. WRONSKI: Yes. All regional
14 protocols need to be approved by the
15 state.

16 MR. CZAPRANSKI: Well, if I'm an
17 ambulance, I download the state protocols
18 but I don't download my local protocols
19 -- regional protocols.

20 DR. COOPER: I think -- I take the
21 sense of the motion to be that all
22 relevant protocols should be available on
23 the unit.

24 MS. BURNS: One of the things that

1 -- I mean, I have these conversations
2 with many of our local physicians. As a
3 paramedic, it is getting -- I'm not
4 getting any younger, either, but it's
5 getting increasingly more difficult to
6 really memorize the protocols when the
7 book shows up and it's an inch thick and
8 tiny little print.

9 And what -- in conversations at
10 the local level that I've had with
11 providers, we are encouraging the
12 providers to carry the protocol. They
13 shouldn't -- it's impossible for them to
14 memorize the protocols. And considering
15 the numbers of pediatric patients that
16 they're treating, it's even more
17 frightening.

18 So to endorse downloading the
19 state protocols and making them a smaller
20 whatever so you can stick them in your
21 pocket or saying that they should be on
22 the vehicle is hugely constructive.

23 I think our environment -- as Dr.
24 Cooper said, adrenaline makes you stupid.

1 It does. And we're seeing an increasing
2 number of protocol violation issues that
3 have not -- the end result has not been
4 patient harm, but it could be and we're
5 dodging a bullet here.

6 DR. HALPERT: I would echo your
7 sentiment entirely. In the old days --
8 back in the day, I was hardcore in terms
9 of you must know your protocols inside
10 out. It's your job. But the reality is
11 as time goes on, it is hard to do that.
12 Now whether or not that translates to
13 less protocol violations, I don't know,
14 because people who tend to have issues in
15 following protocol will probably tend to
16 do that whether or not the book is in the
17 back of the truck or not.

18 MS. BURNS: Perhaps, but when you
19 add Solu-Cortef to the drug box -- and I
20 saw in a catalog today you can now get a
21 drug -- ALS drug boxes with wheels on it.
22 You know. Again, as I'm not getting any
23 younger, I'm thinking that's a really
24 good idea.

1 DR. KANTER: It's really a
2 question of what is the best practice.
3 The best practice is you know your
4 protocols and you also have a written
5 reference.

6 DR. HALPERT: Absolutely.

7 MR. WRONSKI: I think the message
8 is, it's not unreasonable to ask that
9 this piece of material, these documents,
10 be on the unit.

11 MS. BURNS: And supported by
12 policy.

13 MR. WRONSKI: And we'll support it
14 by policy, as well, but I think it's good
15 to bring it to a formal body and say
16 this. Because all we're asking providers
17 to do is -- your -- everyday you go to an
18 EMS call being asked to do something in a
19 fairly rapid situation. Often that
20 materializes quickly, as you didn't
21 really know what you were walking into in
22 a percentage of these cases. So why not
23 have a document available that might give
24 you a hand to do the job better and

1 remind providers that they shouldn't be
2 ashamed to look at it.

3 You know, this isn't an ego thing,
4 and they can get over that. So I think
5 those messages need to be out there.
6 Make it available if you need it and
7 don't be ashamed to look at it, 'cause we
8 all have to remind ourselves what it says
9 sometimes.

10 MS. GOHLKE: The other thing that
11 I forgot to mention from the online
12 medical direction part was there are some
13 BLS providers that, when I talked to
14 them, didn't realize they could call
15 medical control. They just thought it
16 had to be an ALS provider. So that could
17 be why they never called, because they
18 don't think they can.

19 And even in my own service that I
20 ride on, there was a comment made to me
21 during one of the trainings that we would
22 never call them. That's the ALS. When
23 they come, they would call. And
24 sometimes that would take quite a while

1 for ALS to get there. So there is
2 possibly the perception that they
3 can't -- they're not the ones to call.
4 Hopefully that will change. But it was
5 scary when my own service said that.

6 DR. HALPERT: You know, converse
7 is they should not feel intimidated to
8 the point that they don't do it. And we
9 had it happen -- you know, you're right,
10 where a basic EMT has gotten on the
11 telephone and says, I'm not sure what to
12 do regarding this patient. You know.
13 That's reasonable.

14 MS. GOHLKE: Absolutely.

15 DR. HALPERT: And working from the
16 ED side, you have to explain to your
17 colleagues why the heck they're getting a
18 call from someone who --

19 MS. GOHLKE: Right.

20 DR. HALPERT: But it will happen
21 and we should grow with it.

22 DR. COOPER: I sense that there's
23 quite a bit of unanimity on this point,
24 so since we have a full agenda ahead of

1 us, I'll call for a vote. All in favor
2 of the motion to recommend to the SEMAC
3 that the pediatric protocols, together
4 with the adult protocols, both state and
5 regional, form, in effect, a key resource
6 that should be physically available on
7 every ambulance and fly car in the State
8 of New York? Please raise your hand.
9 All opposed? Okay. Without dissent, the
10 motion is carried. Okay. Martha, thank
11 you again for that terrific job. Okay.

12 We're going to move now into
13 sub-committee progress reports. Sharon,
14 do you want to give the report for your
15 group.

16 MS. CHIUMENTO: Okay. We started
17 off a couple of weeks ago -- I talked to
18 Bob about getting together some resources
19 for us to start looking at and planning
20 for where we were going to go with the
21 interfacility transport ideas. And we
22 had a very productive conference call
23 last week where we were able to come up
24 with what our direction was.

1 Unfortunately, a lot of members
2 were not able to be here today. We were
3 going to advance a little bit more on
4 those ideas today. However, Bob and I
5 have had -- kind of had some discussion
6 and come up with a plan of action.

7 Our primary thing is the
8 stakeholder's meeting that was mentioned
9 earlier. It kind of talked a little bit
10 about some of the goals we needed to meet
11 and some of the general classifications
12 because we won't have any insight into
13 who might be invited directly into the
14 stakeholder's meeting, but at least
15 general classifications that we might
16 recommend.

17 So, you know, not only the
18 pediatric hospitals but the outlying
19 hospitals and payers and a lot of other
20 people that would really have some
21 involvement in what we're talking about.
22 So that was one thing we discussed.

23 The second thing we discussed was
24 developing a set of draft guidelines to

1 make recommendations to hospitals that
2 are doing interfacility transports, the
3 kind of things that they would need to
4 have in place in order to do that. So
5 should they have a checkoff list and what
6 would be on that checkoff list. There
7 are fortunately several states that are
8 ahead of us on this particular endeavor,
9 so Bob is going to be working on drafting
10 a set of guidelines for New York State.
11 They'll be on what other states have done
12 and then the committee will then look at
13 that and say, Are there things that you
14 may want to modify.

15 One of the things that Ruth came
16 up with earlier today that we've not seen
17 in other state guidelines is something
18 related to the family component and what
19 happens to the family and how does the
20 family get to the hospital the child's
21 being transported to. Information. What
22 information do they need to have? So
23 that's one of the things we might add to
24 ours that's not been in previous

1 guidelines that are out there.

2 And then the last thing is that we
3 wanted to discuss having a meeting with
4 some Department of Health representatives
5 -- and I know Martha did a little bit of
6 work in relationship to this to discuss
7 the importance of developing what some
8 guidelines are and developing maybe some
9 guidelines as to which hospitals are most
10 capable of taking care of certain kinds
11 of patients. And then some of that will
12 go along with even the deliverable, which
13 really has to have a written guideline.

14 So those are kind of the
15 directions we're working towards and I
16 don't know if you want to add a little
17 bit more here.

18 DR. KANTER: Just a couple of
19 words. The issue is trying to get the
20 right patients to the right hospital at
21 the right time. And so we need some
22 criteria for which types of patients
23 should be sent to a pediatric-capable
24 hospital, which hospitals are the

1 pediatric-capable hospitals and which
2 ones should be thinking about
3 transferring a patient away to a higher
4 level of care and how to do it in a
5 timely way.

6 This involves all the details in
7 the process. The good news is there's a
8 lot of information out there based on
9 experience, evidence and precedence in
10 other states and precedence in New York
11 State for other types of specialty
12 high-risk services.

13 The real help that we need is
14 after we put together a draft guideline
15 or draft set of guidelines is to have
16 some help from the Department on how do
17 we really take the next step to develop a
18 consensus among the stakeholders. And
19 the stakeholders are the usual list of
20 providers at every level, institutions,
21 hospitals, EMS agencies, payers,
22 families, regulators, everyone who has to
23 make this happen and has to make all the
24 work that we all do with a major new set

1 of regulations. How do we take the next
2 step to work toward this?

3 DR. COOPER: I think that we did
4 receive some encouragement from the
5 Department in the past several months
6 about the issue that Dr. Kanter is
7 speaking of, specifically the statements
8 made by both Patsy Jones, when she was
9 still with the department, and John
10 Morley in subsequent meetings, who is, as
11 all of you know, the medical director for
12 the office of health systems management
13 within the Department.

14 Now it came to my attention not
15 too long ago that Ms. Jones left her
16 position at the Department --and of
17 course, I think, within the past few
18 months. And, of course, as all know, the
19 state has faced unprecedented challenges
20 in terms of the economic situation that
21 the state and nation finds itself in at
22 the moment. And I suspect that many of
23 these things that have conspired to put
24 the issue of the view of the pediatric

1 regulations that Ms. Jones and Dr. Morley
2 were championing a little bit toward the
3 back burner.

4 But I think Dr. Kanter's point is
5 right, that unless they are moved to the
6 front burner at some point and in the
7 relatively near future that our
8 regionalization efforts will be difficult
9 to accomplish.

10 So I guess the best thing to do is
11 since we are an advisory committee to the
12 Department is to ask Mr. Wronski
13 if he could purse this issue internally
14 and ask through the appropriate channels
15 what our committee can do to facilitate
16 this process.

17 We may not as a committee be
18 ideally constituted to review all the
19 regulations that are involved and assist
20 the Department in that way, but there is
21 at least a committee that's in place and
22 already meeting that could perhaps assist
23 the Department in taking on some of that
24 responsibility as a prelude to making a

1 more formal recommendation to some other
2 part of the Department in much the way
3 that the working group on trauma
4 regulations has proposed regulations or
5 will be proposing regulations to the STAC
6 in terms of the State Hospital Review and
7 Planning Council.

8 Certainly our committee already
9 has quite a bit of work product on its
10 plate to be completed within the next
11 couple months, but once again, it's
12 difficult to imagine how we could get the
13 regionalization agenda completed without
14 some degree of, if not standardization,
15 at least categorization of what
16 facilities are out there and what types
17 of facilities might best suit the needs
18 of critically ill and injured children.

19 MR. WRONSKI: It's my turn to
20 respond. And I can't give you a complete
21 response but what I can tell you is
22 conversations I've had on two occasions,
23 one just this morning with Dr. Morley.
24 Because one thing that thirty-five years

1 in state service has told me is get your
2 facts straight before you say it at a
3 public meeting, because you're stuck with
4 whatever you say.

5 So, first, Dr. Morley, as I think
6 you know, has had a meeting with the
7 Commissioner previously and discussed the
8 white paper that you worked on and shared
9 with the Department.

10 The -- what I've been told is
11 that, one, the Commissioner sends his
12 thanks and appreciates the paper and did
13 discuss it with Dr. Morley. The -- more
14 specifically, the Commissioner is very
15 interested and I underline "very" because
16 Dr. Morley did, very interested in
17 understanding this issue better and
18 getting more information as we move along
19 about the issue of regionalization and
20 requests items that you outlined in white
21 paper. And so that's very positive
22 because he's open-minded to this and does
23 want to learn more.

24 Secondly, we did get a green light

1 that if we feel that the best avenue to
2 take the next step is a stakeholder's
3 meeting that we can do that.

4 Now Martha and I had discussed --
5 there had been a previous stakeholder's
6 meeting in 2006 -- or was it 2007 --
7 earlier, so sometime back, and whether or
8 not we should move in a different
9 direction from that. But a fair amount
10 of time's gone by and the white paper has
11 come on out in the interim. So my
12 understanding is that the thinking was
13 that we should have a stakeholder's
14 meeting.

15 What we'll commit to is that we
16 will work with you on identifying an
17 appropriate stakeholder's meeting and
18 bring together people who should be at
19 the table for this type of discussion and
20 exploration, because that's really still
21 what we need to do. What is it we think
22 we need to do, what does the information
23 that we can put our hands on say we
24 should do in this state.

1 And so briefly some of the groups
2 that we would certainly want at the table
3 are the hospital association, as they're
4 going to be the primary players in this.
5 So we would invite HANYS, we would
6 probably invite Greater New York Hospital
7 Association from the City. It would be
8 my thinking to invite physicians and
9 physician specialty groups and possibly
10 the nurse's association, as well, and
11 groups that you might think should be at
12 the table and advise us. And we would
13 work with you to put that together.

14 The agenda, and again the
15 Commissioner has not said to us go ahead
16 and create a regionalized pediatric
17 system. So I make that clear for the
18 record. But he did say, I'm very
19 interested in all of this. I would like
20 to see where we can go and what the
21 stakeholders have to say about it, what
22 their interest and support is and go to
23 that step next.

24 From that, certainly we might --

1 that might lead us to a regionalized
2 pediatric system, but it's too early to
3 say until we have that meeting and have
4 those discussions.

5 So I think it's positive but I
6 think we have a little ways to go yet.
7 It's been mentioned about regulations and
8 what's going on in the Department right
9 now with regulations. I actually am not
10 up-to-date on where the Department might
11 be in working on pediatric regs. I don't
12 think they've moved anywhere at this
13 point because there's been so much going
14 on in other areas that has -- such as the
15 hospital overcrowding issue that has been
16 really still at the top of the plate
17 along with the Berger Commission and what
18 its concentration, what hospitals, and
19 then of course the couple of crises that
20 came up that I mentioned earlier with
21 hospitals closing precipitously. All of
22 this has taken away some of the time.

23 But I'll talk to Dr. Morley and
24 find out, is there currently an active

1 group or do they plan to reconvene to
2 talk about any specific pediatric
3 regulations and the EMSC committee is
4 interested in taking part with the
5 Department in that regard.

6 So you might have potentially some
7 work that's done between the Department
8 and EMSC assisting on just some
9 regulatory matters. All right.

10 And secondarily, parallel of
11 course, is to have this stakeholder's
12 meeting to look at the big picture and
13 maybe create something down the road if
14 that's the way that everybody agrees. So
15 any questions on this?

16 MS. ROGERS: I have a comment.
17 When you talk about the issue of
18 overcrowding --

19 MR. WRONSKI: Yeah, sure.

20 MS. ROGERS: -- because I think in
21 some ways that duck tails with the
22 regionalization issue because -- and we
23 have -- we have conflicting opinions
24 within our own hospital whether we accept

1 a child in transfer from another
2 institution when maybe the ED is already
3 boarding, we have no beds and yet
4 somebody else from our institution will
5 accept that patient, who could go to
6 another outlying hospital.

7 And there -- you know, I think
8 that is something that regionalization
9 should address that there is other places
10 and we have better relationships with
11 each other so that we can place a child
12 in a place where they're better cared for
13 because they're less overcrowded at that
14 moment.

15 MR. WRONSKI: Right. I absolutely
16 agree with you. And I'll use this
17 example, because it's the one I'm most
18 familiar with, and that's the trauma
19 system.

20 I had the pleasure of coming into
21 the State of New York EMS right about the
22 same time that the trauma system was
23 pushed by the state. There already
24 existed a trauma system here. We didn't

1 create it, it was there, but we
2 formalized it, streamlined it, put some
3 rules to it, and everybody was frightened
4 about it because they said all of the
5 trauma is going to go to this one
6 hospital or two hospitals in the area and
7 we're going to lose all that. Well, that
8 really didn't happen. What really
9 happened was, and I watched this
10 carefully over the years and I didn't
11 watch it consciously originally but then
12 it came to my attention by a variety of
13 people mentioning what they were seeing,
14 and that is that the trauma system, the
15 leaders in the regional centers,
16 particularly and in the area centers,
17 assisted the community hospitals in
18 understanding how to care for trauma, and
19 pushed and created this regional system
20 where people were looked at regionally.
21 Care got better in some of those
22 community hospitals. And so that was
23 very useful.

24 I think the same thing would

1 happen here if we did create a
2 regionalized pediatric system where it's
3 not simply where the child goes that's
4 critical, because you know better than
5 me, there's what percent of children
6 really do need to go to the specialty
7 center, but how many other children
8 should stay in the community hospital and
9 would be better served there, if not only
10 because of overcrowding but because you
11 assisted those community hospitals in
12 understanding how to take care of those
13 children.

14 And so I see that -- that's how I
15 see the benefit of a regionalized system.
16 Yes, I think it would assist ED
17 overcrowding, particularly if you set up
18 communications along the different
19 hospitals. I'll bring that back to Dr.
20 Morley so he understands that, too. He
21 may already understand that, but I'll
22 talk to him about that.

23 DR. COOPER: I have two comments.
24 First of all, I know I speak for the

1 committee in thanking you for bringing us
2 this information and expressing your
3 willingness to move forward sort of
4 dually, simultaneously, with a potential
5 regulatory component if the Department
6 feels we have a role in assisting -- in
7 assisting and developing that structure.

8 But also at the same time, moving
9 ahead to the stakeholder's meeting,
10 there's no better way to get buy-in for
11 the proposed structure for
12 regionalization than by looking
13 simultaneously at the rules, you know,
14 with stakeholders, you know, to vet them.

15 So I think that your statements
16 are just right on the mark in terms of
17 where we are all ultimately hoping that
18 this might go.

19 I do think there is one part of
20 the trauma experience, though, that we
21 probably don't want to see repeated here,
22 and as we move toward the brave new world
23 of sixty hour work week residency
24 training programs and practitioners who

1 will be used to working sixty hours a
2 week and taking no night call, we're
3 going to have to do a better job of
4 really defining what conditions really
5 need to stay at the local level and
6 providing folks with the tools that they
7 need to manage them safely.

8 We all know that, as Jan pointed
9 out, part of the overcrowding issue has
10 been moving a lot of the community toward
11 the big centers. But while it has
12 improved the care as you said, Ed, the
13 system relationships, the fact that more
14 cases go to the centers and fewer remain
15 in the periphery also has increased the
16 anxiety of local providers and has, in
17 some cases, decreased local providers
18 because they no longer have the
19 responsibility for those patients and can
20 transfer that responsibility to someone
21 else when the patient might be just as
22 well served in the community.

23 So I think that as a trauma
24 system, nationally, we have not done as

1 good a job as we could have done in terms
2 of defining what can and should be cared
3 for locally and how the best practices
4 should be in line to do that. And I
5 think it's a mistake we don't want to
6 make here.

7 DR. KANTER: And I think you're
8 absolutely right that what has happened
9 historically is that more children are
10 being sent from community hospitals to
11 pediatric hospitals. I think the intent
12 of a good regionalization system might
13 not further that trend at all. In fact,
14 what you might really like to do is keep
15 more of the straight forward, simple
16 cases in the community hospitals and
17 reserve the pediatric hospitals for the
18 more complex, high risk conditions. And
19 it may be a diminishing number from what
20 we're doing now.

21 MR. WRONSKI: One of the things
22 I'd ask this committee to do today is to
23 agree to put a subcommittee together that
24 can meet and do some work over the next

1 couple months on helping to define the
2 agenda for the stakeholder's meeting with
3 us.

4 And certainly one of the things
5 that would be useful at the stakeholder's
6 meeting, and I'll tell you would be paid
7 attention to very clearly by the hospital
8 associations, is what do you mean -- what
9 kind of children need to go to the
10 specialty centers?

11 And so if they heard what you just
12 said, Dr. Kanter, I think they'd be
13 pleased because what they do is
14 represent, yes, the best interests of the
15 patients but the best interests of their
16 membership, which is 220 or so hospitals
17 in the State of New York. And so they'd
18 like to be able to go back to their
19 members and say, Listen, what they're
20 building here is you're still going to
21 care for children, but we're going to
22 make sure that we help you identify those
23 kids that you really can care for and
24 move them on and that really is a small

1 number of patients and here's what we
2 were told at this meeting and here's how
3 to look at it. I see that as a good
4 agenda piece, the education of the
5 stakeholders, as well. Because HANYS
6 won't walk into the room knowing this.
7 They're going to need to have that
8 discussion and have it on the table.

9 So it would be useful if the
10 committee also worked in a small group
11 and made recommendations on what this
12 agenda should be.

13 DR. KANTER: As Sharon said, we're
14 sort of operating on the assumption that
15 that's part of our assignment here.

16 MS. CHIUMENTO: Some patients
17 might just need consultation and nothing
18 further, but at least they have some idea
19 where to go.

20 DR. COOPER: I think Ed is
21 speaking about a different issue,
22 however. I think he's speaking about
23 what the agenda might be for a
24 stakeholder's meeting. And I think the

1 interfacility focus has been
2 identification of a process for
3 interfacility transfer and a way to
4 identify the patients who should be
5 transferred and should not and the
6 resources that might be necessary to care
7 for them.

8 So they're slightly different, I
9 think, but I think that there's no
10 question that the work that your
11 committee is doing is really going to be
12 essential to the stakeholder meeting.
13 Okay.

14 Anything else from your group,
15 Sharon and Bob? Okay.

16 MS. GOHLKE: We need to take a
17 short break.

18 DR. COOPER: Okay. We'll take a
19 short break. We're going to have to move
20 fairly quickly when we get back, because
21 it's moving on in the day. It's 2:12 and
22 we've still got quite a bit of work to
23 get done.

24 (Whereupon, a brief recess was

1 taken.)

2 DR. COOPER: Let's begin. I think
3 we all -- to reiterate, we're very
4 pleased --

5 MS. GOHLKE: The microphones are
6 working, but you have to get on top of
7 them. Okay.

8 DR. COOPER: We heard from Ed
9 Wronski about his conversation with Dr.
10 Morley and we look forward to putting
11 together that stakeholder group. What I
12 will do is ask that anybody who is
13 interested in serving on that small work
14 group to look at a potential agenda for
15 the stakeholder meeting, contact Martha
16 and let her know of your interest and
17 we'll go from there.

18 I will jump quickly to
19 nominations/membership. Just to let you
20 know that Kathy and I had planned to meet
21 this morning on this issue, but of
22 course, as you all know, her plane was
23 detained and she was unable to be here
24 until just a few moments ago. So we will

1 have to defer that until our next
2 meeting, but we will get together by
3 conference call in between and share our
4 thoughts with you at the appropriate
5 time.

6 So I'll ask now if Jan Rogers
7 would give a report from the education
8 work group.

9 MS. ROGERS: I think I'm probably
10 the least prepared to give this, because
11 I feel the least knowledgeable, but I
12 took notes so that was my mistake.
13 Anyway, please hop in and make your
14 comments when I falter.

15 The main -- one of the main
16 thrusts that we talked about, and this
17 was a little last minute because Ann
18 Fitton, unfortunately, was unable to
19 come. She's celebrating St. Patrick's
20 Day, at least in an official manner --
21 was the lack of pediatric information in
22 the EMT intermediate refresher course.
23 Apparently, there was a section that was
24 inadvertently left out of that course and

1 so there needs to be pediatric content
2 addressed for that particular refresher.
3 Is that correct? Okay.

4 And so we did not have available
5 the old course because we would like to
6 see, first of all, what the old course
7 had in its pediatric, content-wise and
8 identify what would be appropriate for
9 pediatric information for the refresher.
10 So that was one of the issues, getting
11 back in the information.

12 We did briefly look at the EMT-I
13 original curriculum and we glanced at
14 that to see what kind of pediatric
15 content and we noticed it was very
16 integrated with the adult content. And
17 we kind of discussed it a little bit, at
18 least, about the fact that if it's
19 integrated with the adult content it may
20 be taught by somebody who is more -- more
21 knowledgeable about adult versus
22 pediatric content. And that was just an
23 issue that was raised. I don't think we
24 were willing to go any place at this time

1 with it, but I think it needs more
2 investigation rather than having like a
3 separate component that was pediatric.
4 Okay. Anything else about that
5 particular issue? Okay.

6 We talked about maybe getting
7 together for a telephone conference once
8 we got more information about what was
9 missing and what needed to be included.
10 So that was one of the proposals as far
11 as taking this matter further.

12 One philosophical issue -- I think
13 we kind of got a little bit -- a little
14 bit off the track, but I think it was a
15 very good issue related to education --
16 was more of a philosophical issue that
17 Tim raised about the amount of transport
18 time it's taking to get a child to the
19 hospital if the paramedic or the basic --
20 more the paramedic and the advanced EMTs
21 are trying to implement their skills in
22 the field rather than getting the child
23 to the hospital. And some of this has to
24 do with transport time. But if you're

1 very close to the hospital, wouldn't it
2 be better to get the child to a more
3 definitive place of care rather than
4 staying out in the field and trying to
5 start a line or trying to intubate or
6 trying to do advanced skills. So I think
7 that's a good philosophical thought to
8 have in mind when you're looking at the
9 education of paramedics, I think more so
10 than basic that it may not be the best
11 time to show off your skills. It may be
12 better if you can get the child to the
13 hospital faster. So more emphasis on
14 what skills are most important to keep
15 the child's airway open, to keep him
16 breathing in a safe fashion and get them
17 to a hospital faster. What else did we
18 talk about.

19 DR. HALPERT: I think the further
20 clarification on that point -- you're
21 correct in what you said, but the other
22 part of that was the EMS provider feeling
23 comfortable in utilizing those skills in
24 the in-transit mode.

1 MS. ROGERS: Oh, yes.

2 DR. HALPERT: So not
3 distinguishing on-scene care from
4 in-transit care, but continuing care that
5 integrates with the overall emergency
6 care system so that one should be capable
7 to provide their skills and abilities
8 while in transit.

9 MS. ROGERS: We talked a little
10 bit -- I think I brought it up because I
11 know we are becoming more encouraged into
12 identifying our competency levels.

13 As a nurse practitioner in the
14 emergency room, it's becoming more
15 emphasized that we have to actually
16 document our competency. And if we don't
17 see a certain number or do enough
18 procedures in a year's time, then what
19 remedial training will we need to keep
20 our skills up. And we talked about the
21 fact that if we don't get a certain
22 number of skills to prove that you are
23 competent, then you have to go into extra
24 remediation time or refreshing times.

1 And so there is a tendency to feel like
2 you have to get your skills in or you're
3 going to have to spend time refreshing.
4 So there's a little bit of edge there to
5 actually do the skills rather than it may
6 be better to just get the child into the
7 emergency department. So there's a lot
8 of --

9 MR. CZAPRANSKI: To develop on
10 that further -- to say you need five
11 intubations in a year. You've got four.
12 You've got a pediatric patient that
13 qualifies for intubation with a hospital
14 three minutes away and you spend fifteen
15 minutes on scene. So are you making
16 decisions clinically-based or to hit a
17 number or what the case may be?

18 I sat on a child mortality review
19 team in Monroe County, and when I got to
20 the prehospital care reports, one of the
21 things that surprised me is the amount of
22 scene time for pediatric patients. Most
23 of these are infants, and twenty minute
24 scene times when they're three or four of

1 five minutes from a major facility.
2 These are kids you can pick up and go.
3 These are non-traumatic injuries. So
4 it's one of the things we're looking at.

5 And in the training module, once
6 you get on scene and you do your scene
7 safety and you start working through your
8 skills history and your ABCs, at what
9 point in time do you treat pediatric
10 patients or do you pick up and move
11 quickly? I think that's something we
12 probably should look at the national
13 critical level or state critical level.
14 Where does that transport decision come
15 in? It's different for a certain subset
16 of pediatric patients.

17 DR. COOPER: All very good points.
18 Jan, since you did take the notes, if
19 you'd be kind enough to summarize them in
20 the form of some kind of very brief dot
21 point list of thoughts that your
22 committee shared, that would be helpful.
23 And Sharon will be doing, as well, I
24 trust.

1 So are there any questions or
2 comments at this point? Ed.

3 MR. WRONSKI: Just a quick
4 comment. Brain and Martha have looked at
5 data -- pediatric, and one of the things
6 we have is the 2006 PCR data. 2007 will
7 be ready by May.

8 One of the things we can do, too,
9 is take a look at the break out of scene
10 times, pediatrics versus adults. I don't
11 know that we've ever done that. We've
12 done scene times in adult but I don't
13 know that we've broken it down into the
14 age groups. And if we looked at that,
15 what would the difference be? And I'm
16 hearing it might be different. So we
17 have data that is not really that old.
18 You know. The system isn't going to
19 change next year or isn't going to be
20 different this year to what it was two
21 years ago. So we can take a look at
22 that.

23 DR. HALPERT: And I meant to ask
24 this before, so I apologize. But it is

1 almost a little counterintuitive to look
2 at the pediatric fatality rate. So the
3 delay you're talking about is, I presume,
4 the most critically ill patients. And I
5 wonder why that is. There is a set-up on
6 the scene for someone that probably needs
7 more expertise -- so I'm not sure without
8 really seeing a case by case basis. I'm
9 still scratching my head about that.

10 MR. CZAPRANSKI: I mean, the cases
11 that we looked at go through a -- you
12 know, a series of sort of checks and
13 balance. Usually they have CBC
14 involvement or some level of county or
15 state involvement in the home already,
16 social worker or some other or it's a
17 complicated case, unexplained death or ME
18 sent it to us to say, This didn't go in
19 by EMS to the hospital so it wasn't
20 reported that way to the -- MEs office
21 was called to the scene.

22 Fewer number of cases -- by far,
23 most of the cases had EMS transport
24 responding, law enforcement as well as

1 social worker component. All those are
2 brought into play. They're kids that
3 have sometimes been neglected or get too
4 much medication or are in some sort of
5 respiratory crisis because it hasn't been
6 treated properly at home. There are a
7 lot of reasons for it and they are
8 critical.

9 And one of the things that I think
10 the whole group agrees with is if I've
11 got an eleven month old infant and I'm
12 150 feet away from an ambulance and two
13 and a half miles from a hospital that has
14 a whole team that can treat this patient,
15 why work with one person? Do what you
16 can do and move that patient along.

17 And I don't think that transport
18 decision, at least in our discussions,
19 has entered into the education piece of
20 that as it relates to that subset of
21 patients. When I talked to the
22 paramedics involved, it makes perfect
23 sense to them -- A, B, C, D and then
24 start thinking about transport. We

1 should probably think about transport
2 much quicker.

3 MS. CHIUMENTO: I'm just
4 wondering, do you have a copy of the '09
5 protocols, because I believe I do, so if
6 you let me know what section you want, I
7 can probably scan it and e-mail it to
8 you.

9 DR. COOPER: Okay. Any other
10 thoughts regarding the education
11 sub-committee report?

12 Hearing none, we are very
13 fortunate that Gary Tuttle was able to
14 take some time out of his busy schedule
15 today to show us the EMS website and
16 where we and EMSC might have a home
17 within that EMS website at some point in
18 the future for those of us who are tech
19 savvy or who have become tech savvy. So
20 Gary, if you'd go ahead.

21 MS. GOHLKE: And I thought it
22 would be nice to see one of the faces
23 behind the big curtain here. This is one
24 of our faces, so rather than listen to me

1 and Dr. Cooper drone on, we asked Gary to
2 chime in with his voice.

3 MR. TUTHILL: Thank you very much
4 for having me. For the purposes of the
5 stenographer, it's Gary Tuthill,
6 T-U-T-H-I-L-L. Okay. Can everybody hear
7 me okay?

8 Our website, if you go to the main
9 department website which is
10 www.nyhealth.gov and then you scroll down
11 you'll get to the Bureau of EMS website.

12 On the left-hand column here
13 towards the bottom, you're going to see
14 EMS/EMT. Click on that. That goes to
15 the Bureau of EMS home page. From this
16 section on, it's the part that I maintain
17 and am fondly familiar with it.

18 You go down to the section for
19 Bureau of EMS. It's got that and our
20 staff, if you're interested in who does
21 what in the Bureau.

22 Regional offices -- who works at
23 the regional offices and stuff. You
24 know, as you scroll down, it has a

1 section for each area office.

2 Our forms page, right below the
3 regional offices, that's got pretty much
4 every form that the Bureau uses. There
5 are some sections that probably will be
6 added in the coming months, whether I
7 like it or not. But anyway, if you're
8 looking for a particular form for EMS,
9 which I'm not quite sure what the
10 committee here would have a need for, but
11 the forms are all located on this one
12 site. Every other spot on the web page
13 here that discusses forms will have a
14 link back to that forms page. So they
15 all link back to that one.

16 EMS statistical information.
17 Right now as of 2005, I will be putting
18 updated stuff on there. I believe 2006
19 -- 2006 or 2007 --

20 MS. BURNS: Six.

21 MR. TUTHILL: Six. So 2006 will
22 be going up soon with the data.

23 MS. BURNS: More data than you
24 know, courtesy of Brian.

1 MR. TUTHILL: Thank you, Brian.

2 MR. GALLAGHER: Sure.

3 MR. TUTHILL: Information by
4 counties might be -- I'm just going to
5 click on one county because they're all
6 -- they all have the same information.
7 But Albany County will have listed the
8 EMS coordinator's name, his or her office
9 phone numbers and e-mail, which regional
10 EMS council and program agency is covered
11 -- covers that county. The actual
12 ambulance services, their address and
13 level of care. Non-transporting, BLS
14 first response services or ALS first
15 response, either way, same thing, address
16 and level of care. Hospital information
17 for that particular county and then for
18 EMS purposes the location codes for their
19 documentation. Last thing at the bottom
20 of the page is going to be the regional
21 office for our bureau that covers that
22 particular county and their contact
23 information.

24 Updates and announcements. I put

1 here any kind of important announcement
2 that comes up. Usually it's a
3 manufacturer recall or some other recall,
4 like the peanut butter incident. Most
5 recently, Welch Allyn AED 10 just had a
6 recall. That information is up. The FDA
7 notice is up as of about an hour and a
8 half ago, actually.

9 Public meetings, where your
10 meeting schedules are. We have the
11 SEMAC, SEMSCO, Trauma and EMSC on this
12 page. Right in this section also, after
13 the meeting is done and the minutes are
14 completed, I'll be posting the minutes
15 here so you can just obtain minutes from
16 previous meetings here. And as the
17 agenda gets formulated for upcoming
18 meetings, I'll post that as well.

19 Webcasts. If you can't make it --
20 you can't make the SEMAC SEMSCO meetings
21 and you wish to view them, that's where
22 you find them.

23 Education gets pretty involved.
24 Where to obtain EMT courses. The

1 curriculum is here as well, CIC, CLI, and
2 the EMS curriculum. So if you want to
3 research what's actually in the current
4 curriculum, you can locate it on this
5 page. Course locations and how to find
6 courses. Exam schedule if you're
7 interested in that. Frequently asked
8 questions for certification, there's a
9 page for that. That covers everything
10 from certification, recertification,
11 reciprocity, military leave, a wide gamut
12 -- questions about CLI, CIC
13 certification, as well. This isn't going
14 to have a lot of interest for this
15 particular committee, but applications
16 for a service to go operational. The BLS
17 protocols for the state would be here.

18 MR. WRONSKI: And as I mentioned
19 earlier, they were just changed, so is
20 this the updated protocol?

21 MR. TUTHILL: Most recent, yes.
22 And then actually, if I can go back to
23 the protocols, it has a link to SEMAC
24 advisory, which I'll get into a little

1 bit --

2 CFR protocols. Right now it's
3 very messy -- it's a messy page, I'll
4 freely admit that, but it is being
5 updated to look very much the same as the
6 basic life support for EMT and A-EMT
7 protocol. It is going to be one PDF and
8 look a lot cleaner.

9 Stroke centers. As I get notified
10 of the new stroke centers in the state or
11 a hospital has closed or dropped its
12 designation as a stroke center, I'll add
13 or remove it as needed. But they're
14 listed by regional EMS councils. Central
15 New York, for instance, has Crouse, SUNY
16 Upstate and Tompkins County, Cayuga. So
17 those are added, you know, as I get the
18 information.

19 MR. WRONSKI: And if you know in
20 your region that somebody has opened as a
21 stroke center and you didn't see it on
22 here, feel free to send Gary a note and
23 we'll check it out.

24 What we have found most often is

1 that the hospital has jumped the gun and
2 actually hasn't received the final letter
3 from the Commissioner but has told the
4 EMS community, We're approved as a stroke
5 center. But they can't actually do that
6 until they have a physical letter from
7 the Commissioner.

8 MR. TUTHILL: Prehospital quality
9 improvement page, quality improvement
10 manual. It's relatively large, so --

11 MS. BURNS: If you do have a
12 chance, do take a look at it. It was
13 really written by -- under the lead of
14 Bob Delagi and Brad Kaufman -- Dr.
15 Kaufman from New York City. And it's
16 very, very good and it has a really nice
17 educational package with it.

18 MR. TUTHILL: This is the
19 educational package that she was just
20 discussing. It's a Power Point
21 presentation that the agencies can use to
22 educate their own people on --

23 MS. BURNS: We had Marjorie look
24 at it to make sure there were no

1 inappropriate slides. Bob Delagi and I
2 -- you've got to look at it.

3 MR. WRONSKI: She did half the
4 presentation.

5 MS. BURNS: I was going to say,
6 because what's appropriate to us --

7 MR. TUTHILL: Our disaster
8 preparedness page. There is not a lot of
9 direct information that we've added.
10 Just borrowed from other states and
11 government agencies.

12 DR. COOPER: Could you just scroll
13 back up for just a second?

14 MR. TUTHILL: Absolutely.

15 DR. COOPER: Just one suggestion.
16 I don't see the FEMA training website
17 listed in that section,
18 training.fema.gov. Is it there?

19 MR. TUTHILL: Yes.

20 MS. BURNS: Right under New York
21 State --

22 DR. COOPER: It might be worth
23 mentioning that there is special training
24 available on that website.

1 MR. TUTHILL: The meat and
2 potatoes of our existence is the policies
3 and laws and regulations. Policy
4 statements are on this page here,
5 starting most recently, going to oldest
6 policy statements. And as they're
7 updated or deleted, they're added or
8 removed here as well.

9 Coming up to the main page is
10 located in this section here. The second
11 one will be article 30.

12 MR. WRONSKI: If I could just
13 mention on the policies. What a lot of
14 people don't realize is that we have, at
15 present, somewhere in the area of a
16 hundred different policies. The oldest
17 ones go back to about 1984, maybe '85.

18 But what we've been mandated to
19 do, and not just EMS but all of the state
20 agencies is we have to make sure that any
21 policy that's more than five years old is
22 in fact still valid and that means --
23 maybe it doesn't apply anymore because
24 the statute has changed and maybe it's

1 just old information that needs to be
2 updated. So we're having the different
3 units look at a variety of policies to --
4 over the next year or two years,
5 potentially update all of the policies --
6 delete or update so that this list will
7 get crunched/ and what you're eventually
8 going to see is all the policies will be
9 typically no older than five years. As
10 we update them, we'll issue -- even if we
11 don't change anything, all we'll say is
12 this has been reviewed on this date and
13 is reissued. But it will take us a
14 couple years to really do a good job on
15 all of them.

16 But there are significant policies
17 and the EMS agencies follow the policies
18 in general almost as if it they were
19 regulations, at least we find that when
20 we go out. They tend to be useful
21 documents. We try not to make a policy
22 like a regulation. Policies are meant to
23 be guidance documents, but they're often
24 backed up by regulation or statute.

1 DR. COOPER: Ed, are all the
2 policies that are currently active listed
3 on the website or are there others?

4 MR. WRONSKI: All policies are on
5 here, correct Gary?

6 MR. TUTHILL: Yes.

7 MR. WRONSKI: They're all on here.

8 MR. TUTHILL: All the active
9 policies are on this page here.

10 MR. WRONSKI: And also at the
11 bottom is the SEMAC advisories.

12 MR. TUTHILL: Then we go to
13 article 30, public health law. In the
14 table of contents, it's sectioned off so
15 you can just skip to the section. You
16 don't have to scroll all the way through
17 it and that's very helpful in getting --
18 cutting to the chase on what you're
19 looking for in the law.

20 There is EMS for Children law
21 30(c). Part 800 would be under the rules
22 and regulations, and this is a direct
23 link also to the sections so you can go
24 to where you need to.

1 We have information here that the
2 department's -- department-wide has put
3 information up on the recent changes with
4 the Ryan White Act and post-exposure
5 incidents for potentially infectious
6 materials and guidance documents. So I
7 added the link to that -- actually, I
8 added this and the Department has a link
9 to their site.

10 Lastly, we have the supporting
11 programs. We have the regional EMS
12 councils, program agencies, EMS for
13 Children's page. Martha is very good at
14 getting on me about keeping this
15 accurate, so if you find an error, talk
16 to her.

17 MS. BURNS: You can add your
18 youtube video links too, if you have
19 them.

20 MR. WRONSKI: Or facebook or
21 whatever.

22 MR. TUTHILL: Honestly, the most
23 common change I put on this particular
24 page is your own personal information,

1 titles change, sometimes addresses
2 change. Feel free to contact me and let
3 me know that something needs to be
4 updated here and I'll be happy to make
5 the change. That's generally the most
6 common.

7 Some of the products that you
8 created and distributed, training
9 documents.

10 Trauma program. Very similar
11 actually as far as what they have, links
12 and education stuff.

13 Link to our Vital Signs
14 conference, information on that. That's
15 also at the very top of our website. I
16 thought I'd advertise that a little bit.

17 Council awards, just the criteria
18 for that.

19 State EMS council. This is a
20 challenge to keep up-to-date with who is
21 actually a vetted member and who's not,
22 but when I get information I change it as
23 needed.

24 And lastly, children's camps and

1 the epinephrine auto-injector device law.

2 MR. WRONSKI: If I could comment.

3 Gary's -- Gary's been doing this now for

4 two years or a year?

5 MR. TUTHILL: Two years.

6 MR. WRONSKI: Two years. And he's

7 made a lot of updates to it, gone to a

8 number of training sessions, because to

9 get this on the web, he has to translate

10 all the documents into the HTML language.

11 And -- but what we are told is

12 that this is the second busiest website

13 in the state -- for the state. Of the

14 DOH websites, this is the one that's the

15 second most busiest. It's first --

16 MS. GOHLKE: What is first?

17 MR. WRONSKI: I used to know but I

18 don't recall any more.

19 MS. BURNS: OPMC. They're

20 searching on these doctor types.

21 MR. WRONSKI: Yeah, maybe. But it

22 is a very useful tool to find something

23 fairly quickly.

24 MR. TUTHILL: It's also important

1 to know that I have very tight
2 constraints to the way things look, what
3 can go up and what can't. Many things I
4 have to get approval to post. You'll
5 notice there's not a lot of images on
6 this particular site, because I almost
7 need congressional approval to get images
8 on here. So there is a very short leash
9 to what's allowed to go on here and
10 what's not.

11 In general, if you see a
12 typographical error, those are very easy
13 to change or a title, names, addresses.
14 But as far adding content, sometimes
15 that's a little more challenging to get
16 approval to put up here. So it's
17 important. I can't just put anything I
18 want to on here.

19 MS. CHIUMENTO: I just want to
20 tell you, the last couple of years
21 there's been a huge improvement in the
22 timeliness of the information that's on
23 there and -- I use it all the time. I'm
24 constantly referring to different things

1 on that, particularly protocols but a lot
2 of other things, as well.

3 But the one thing that I could not
4 find the other day, and maybe it's on
5 purpose, is the e-mail addresses. And I
6 notice that's Martha's was up there, but
7 there is no e-mail addresses for anybody
8 else.

9 MS. GOHLKE: Nobody wants to give
10 their's out.

11 MS. CHIUMENTO: I just wondered if
12 you could put a generic --

13 MS. BURNS: I'll give you my
14 e-mail address.

15 MS. CHIUMENTO: I have yours.

16 MS. BURNS: When the web page
17 actually first got really recognized, the
18 Department's web page, there was what the
19 Department calls a BML, a bureau mail
20 log. And we -- it was EMS.state.ny.us.
21 And we were deluged in e-mail from spam
22 to the most unbelievable stuff.

23 And several of us, my colleague in
24 education and I, went whining to Ed and

1 begged him for permission to take that
2 down. And we purposely did that because
3 it ranged from graduate students wanting
4 us to do their research, which is a
5 full-time job based on just the number of
6 requests that we get, to racy stuff I
7 wouldn't even want to talk to you about.

8 And so the Department took it
9 down. And there is a main mail log that
10 the department uses. I think it's
11 DOH.health.state. It is available and it
12 goes through our public affairs group.
13 And a lot of it, I have implored them to
14 screen. And the coordinator that we deal
15 with directly is quite good at that.

16 And we get a lot of -- a lot of
17 stuff that -- people have gotten very
18 lazy about doing their own research, and
19 so it's just easy to send a note to this
20 mail log and someone from the Health
21 Department will tell them how to do it.
22 We don't have the time or inclination to
23 do that. So we have quite purposely not
24 provided individual e-mail addresses.

1 MS. CHIUMENTO: The one specific
2 one was related to the EMSC group and
3 people had some questions about that.

4 MS. GOHLKE: Then we put you
5 through the exercise of the phone and if
6 you're really doing this and have lots of
7 endurance, you'll get through to someone.

8 MS. BURNS: We're really good
9 about that.

10 DR. COOPER: The reason that Kathy
11 and I felt that we should spend a little
12 bit of time showing the web site is so
13 you not only had a sense about what was
14 up there but what was up there about us
15 and the kinds of information that we as a
16 committee could put out there, you know,
17 to the public and to our providers if we
18 felt that it was important to do so.

19 So I think we would both ask you
20 all to think about stuff that you think
21 might be there that isn't there.

22 There are two things that I can
23 think of off the top of my head that we
24 might want to put up there and those are

1 the ambulance reference cards that we --

2 MS. GOHLKE: They're on there,
3 under products.

4 DR. COOPER: Oh, it's under
5 products. Okay. They're there.
6 Excellent.

7 MS. BURNS: We got you covered.

8 MS. GOHLKE: Come on, throw us
9 another one.

10 DR. COOPER: So as you can see, I
11 don't visit this web site very often in
12 my travels. But if there are other
13 things that you think should be there,
14 please let Martha know. And please, to
15 the extent that you have the ability,
16 please share with all of our colleagues
17 that we are well represented on the
18 website. There are nice work products up
19 there and that the site is there for, you
20 know, our colleagues and public's use.

21 MS. BURNS: Very quickly. You
22 might have noticed we just updated our
23 public access defibrillation policy. One
24 of the things -- I drive Gary nearly

1 insane. He's a very good natured person.

2 The Department has a very tight
3 forms approval process. It is
4 bureaucracy versus bureaucracy. So he
5 keeps me out of their hair. But the new
6 policy which really does affect you as
7 pediatric experts is we moved -- the
8 SEMAC and State Council approved several
9 new training curriculum for public access
10 defibrillation. And in the effort to be
11 more flexible and get them more quickly
12 up and available to PAD sites, we moved
13 them from the notification form to the
14 actual policy. So if you are dealing
15 with schools who should not necessarily
16 be defibrillating children but you have
17 issues with this stuff, this is all
18 available.

19 With regard to that, and we're
20 going to work with the state EMS council
21 and SEMAC as well, and the result of this
22 circumstance on Long Island a couple week
23 ago, we're looking at working with the
24 Department and all of you as experts now

1 that essentially ten years has passed
2 since the public access enabling
3 legislation was enacted -- we're kind of
4 shooting for EMS week -- but to send out
5 some sort of public relations type
6 information that will essentially remind
7 these public access defibrillation sites
8 a couple of things, which we take for
9 granted. One is how are your batteries?
10 Have you had your machine program
11 updated? Are your pads in current date?
12 Do you have pediatric pads? Do you have
13 pediatric interface? Have you had your
14 training updated? Because we discovered
15 as a result of this -- we knew this, but
16 it had never been tested. We don't have
17 enforcement authority under article 30
18 when an event occurs, which actually is
19 frankly good.

20 But I think the Department feels
21 in talking with Dr. Morley and Ed that a
22 public education type awareness, even if
23 we sent out pamphlets to all of our PAD
24 sites and our EMS community -- hey, you

1 remember these machines you plunked on
2 the wall? Ten years has passed. Are
3 they up-to-date with programming?
4 Because at issue with that -- this
5 situation occurred because the machine
6 was not programmed in accordance with the
7 SEMAC guidelines at the time and current
8 defibrillation protocols.

9 So that's sort of what we're going
10 to do. So we'll reach out to your group
11 and share what we come up with for you to
12 take a look at.

13 DR. COOPER: Okay. Outstanding.
14 Any questions or comments for Gary?

15 MR. TUTHILL: Thank you for having
16 me.

17 (Discussion off the record.)

18 DR. COOPER: Thank you. Okay.
19 Let's now move on to old business. I
20 think we've pretty well covered the
21 regionalization white paper update. Ed,
22 thank you very much for going over that
23 with us a little bit earlier.

24 Ed or Martha, can you give us an

1 update on the status of the EMSC bylaws?

2 MS. GOHLKE: Just briefly, just to
3 let you know where they're at. We had a
4 couple meetings with Department counsel
5 folk and DLA.

6 DLA is finally, like two days ago
7 maybe, sent back their comments on the
8 bylaws. And we didn't have time to send
9 that out and have you look at them; we'll
10 do that for the next meeting.

11 There wasn't a huge amount of
12 changes. The biggest change was -- I
13 don't know if you remember, but we were
14 following the STAC bylaws and their
15 guidance that they had gotten back from
16 DLA a year or two ago on reducing the
17 terms from four years to three years.
18 And we just changed ours in accordance
19 because we thought that's what DLA
20 wanted. But come to find out, our
21 statute -- because our statute said four
22 year terms, we're going to follow the
23 statute. We have to follow the statute.
24 So we're going to go back to the four

1 year term for membership for the
2 committee. That's probably the biggest
3 change in there and maybe also staggering
4 the terms was the other one, so we don't
5 have a turnover of the whole membership,
6 you know, all at once in four years. We
7 can do it every two years with half the
8 membership.

9 Other than that, just some quick
10 reminder things. I'll get them ready for
11 you and send them out before the next
12 meeting. At the next meeting, we'll have
13 you review them and then hopefully maybe
14 we can vote on them at the next meeting.

15 DR. COOPER: Very good. Thank you
16 so much.

17 On the pediatric disaster card, I
18 don't think there is a lot to report
19 here. We've been, I think, focusing on
20 education and interfacility transport for
21 the last few months, but I would like to
22 get a jump start on that for the next
23 meeting.

24 Now a word to the wise, which

1 includes everyone in the room, of course.
2 Unfortunately on May 20, and I say
3 unfortunately because it conflicts with
4 the EMS memorial ceremony in Albany, the
5 New York City Department of Health has
6 organized an immovable conference on
7 pediatric disaster care.

8 The pediatric disaster coalition
9 of New York City is holding a one-day
10 conference on all the pediatric surge
11 planning that's been going on in New York
12 City both in respect to mass casualty
13 triage and expanding the pediatric ICU
14 bed capacity within New York City. So
15 there may be some new information
16 available in terms of disaster triage or
17 mass casualty disaster triage and certain
18 issues that come out of that meeting.

19 And, of course, I think while I
20 have not been told explicitly that the
21 meeting is open to the public, I'm sure
22 any member of the state EMSC advisory
23 committee that wish to attend may do so.
24 It is going to be held on May 20th at

1 Baruch College in Manhattan.

2 So once again, if you're
3 interested in working on the disaster
4 card, please contact Sharon -- I'm
5 looking at Sharon -- Martha, but I'm
6 hoping Sharon will want to participate.

7 MS. CHIUMENTO: I'm on a fixed
8 income now.

9 DR. COOPER: I know. As we all
10 are in this current economic climate,
11 right? Okay.

12 I now want to turn to new business
13 and I want to spend just a few moments
14 going over the proposed pediatric trauma
15 regulations. Clearly --

16 MS. GOHLKE: Right-hand side.

17 DR. COOPER: Right-hand side.
18 Thank you. On the right-hand side of
19 your packets, third from last. Okay.

20 We had some fairly specific
21 instruction from the group that was
22 charged to go over the regulations and
23 make pediatric recommendations, and I'll
24 just cover some of the highlights with

1 you before we go through this in a little
2 bit greater detail.

3 The group felt that we should make
4 a stab at coming up with, at the least, a
5 bottom line definition of what
6 constituted a pediatric trauma patient,
7 not that there couldn't be regional or
8 local variations, but it made sense that
9 there be some kind of statewide standard.

10 The group felt that there should
11 be emphasis on the multiple disciplinary
12 management of pediatric trauma. The
13 group did not want to follow the American
14 College of Surgeons model which
15 designates level one and two pediatric
16 trauma centers.

17 And right behind the state draft
18 is the current chapter in the green book
19 from the American College of Surgeons
20 that -- that describes what the American
21 College of Surgeons has put into place
22 for you to read, digest and compare with
23 what's on the printed page here.

24 And, in fact, the group felt

1 pretty much as though it wanted the
2 pediatric trauma centers to be, whenever
3 possible, linked with the level one
4 centers. They wanted a statement that
5 everybody should be capable of
6 resuscitating a pediatric patient, no
7 matter what facility, that there should
8 be written transfer agreements between
9 facilities not designated as
10 pediatric-capable and those that were and
11 that there ought to be some way to direct
12 pediatric patients to the appropriate
13 facilities with appropriate consultation
14 and also to review the transfers at a
15 later date. Those were the -- those were
16 the main themes that emerged from the
17 meeting.

18 So going through the document
19 section by section, and again, hitting on
20 the high points. On the first page,
21 section five, change the wording from
22 "services" to "centers" because that's
23 what the group felt it wanted.

24 Section one describes what

1 constitutes a pediatric patient. I think
2 we thought in the past that using a
3 fifteen/fourteen split, since that's
4 consistent with pre-puberty, post-puberty
5 as well as the CDC definitions that it
6 uses for epidemiologic research. That
7 seems to make the most sense. But that
8 locally the definition could be changed
9 if there was reason to do so.

10 The next section talks about who
11 can be a pediatric trauma center and
12 basically you can be a pediatric trauma
13 center if you're a general or specialty
14 hospital, being a pediatric specialty
15 hospital, but you've got to meet the
16 standards for regional trauma centers or
17 level one trauma centers and meet all the
18 standards that are applicable for
19 children as well as the additional
20 standards listed below.

21 The next section referred to
22 pediatric trauma in area trauma centers,
23 because the group only wanted one level
24 center. The comment about all trauma

1 centers and stations being capable of
2 resuscitation is next. The statement
3 about written transfer agreements is
4 next. The next longest paragraph adapts
5 language from the systems section of the
6 current code that specifies a process for
7 getting the patient to the right place if
8 he or she meets major trauma criteria and
9 -- but does provide an opportunity for a
10 patient who would ordinarily meet major
11 trauma criteria not to go to the center
12 if a consultation with a trauma
13 specialist at the center suggested for
14 some reason it's not a wise idea.

15 The next three sections all
16 focused on, again, language adapted from
17 the systems section of the current
18 document that expands on these
19 principles, talking about decisions to
20 transfer being the responsibility of the
21 physician in the initial receiving
22 hospital but is expected to occur in a
23 timely manner, that the transfer should
24 be made as soon as possible and that the

1 mode of transportation should involve
2 pediatric critical care transport teams
3 whenever possible.

4 It defines the minimum components
5 of the pediatric trauma team, an
6 emergency physician, emergency nurse and
7 pediatric surgeon. It talks about the
8 requirements of -- to be the pediatric
9 surgeon on duty in the hospital, again
10 mirroring language that is currently in
11 the code as adapted for the proposed
12 revisions.

13 Moving on. Most of the rest of
14 the document involves some technical
15 matters, the addition of the word "care"
16 to mirror language elsewhere in section
17 eleven.

18 Reference to successful course
19 completion in section twelve, together
20 with a switch from the fifth to the
21 fourth year, consistent with the
22 revisions that are suggested for the main
23 document.

24 And then moving on. The next two

1 sections are minor technical corrections.
2 Section fifteen refers to the pediatric
3 ICU. It was the feeling, as you recall,
4 that it should be a pediatric intensive
5 care unit rather than a pediatric
6 intensive care area and that the people
7 directing the care should be
8 appropriately trained and certified. The
9 same with the emergency department.

10 And then the last four sections
11 focused on a pediatric PI program. That
12 PI program has to include review of all
13 transfers and that findings have to be
14 shared with the regional PI process, that
15 there be support for pediatric social
16 services and child life programs and that
17 there be affiliation with a child
18 advocacy center or equivalent for
19 potentially abused children.

20 So I think this covers most of the
21 issues that came up in the January
22 meeting as that had not already been
23 addressed in the first draft of this
24 document, mainly the social services and

1 child life issues.

2 And I've done the best I could to
3 try to cover the flavor of those
4 discussions. Bob, I think you and Ed and
5 Martha -- I think you were all there for
6 those discussions and you can tell me if
7 I've missed the boat on any of this or if
8 I exceeded what was asked.

9 MR. WRONSKI: Well, I did leave at
10 one point and so I missed part of the
11 discussions, but in general it looks like
12 you covered what the committee wanted.
13 Again, that's going to take another
14 couple of read-throughs, just like you're
15 reading through it to determine if we
16 missed something.

17 DR. COOPER: Absolutely.

18 MR. WRONSKI: Martha had a couple
19 of comments from a federal reviewer who
20 brought up that you might want to build
21 something in on pediatric rehab and how
22 that would be available, on injury
23 prevention capabilities in the hospital,
24 do they have any.

1 I guess the question will be as we
2 look at this, because regional centers
3 and area centers in the trauma regs have
4 that in it, how does that apply to
5 pediatric sections or do we need to build
6 it in separately. I think we need to
7 look at questions like this.

8 So what I'll ask Martha to do,
9 too, is to share the comments from the
10 federal officer just for consideration,
11 not that we're saying they should go in
12 there, but these were thoughts that they
13 came up with, so we should look at it,
14 think about it.

15 From my perspective, the simpler
16 and smoother and less complex the reg is,
17 the easier it is to explain and get
18 through the process.

19 But if you look at the original
20 pediatric section of the trauma regs,
21 they were simple to the point of not
22 being able to accomplish what we should
23 be able to accomplish now, which is to
24 build a more robust pediatric service or

1 center.

2 So there is a different purpose to
3 the current rewrite. And so look at
4 these from the perspective of if a trauma
5 center is going to accept a major trauma
6 child, this really addressed what needs
7 to be in place and comment in that
8 fashion.

9 DR. COOPER: One other comment
10 that I neglected to mention in the
11 beginning of my remarks was there was a
12 pretty clear sense that the overriding
13 principle should be to get a major
14 pediatric connotation to a pediatric
15 trauma center via primary transport
16 whenever possible without having to rely
17 on secondary transport interfacility, if
18 the time and circumstances permit.

19 We have for a very long time had
20 circumstances in many parts of the state
21 where kids are transported to a nearby
22 facility and then essentially
23 automatically transported on to a larger
24 center when they were close enough to a

1 larger center to get there safely. And I
2 think all thought that was probably not
3 the way we wanted to go in the future.

4 DR. KANTER: I think you've done a
5 great job and I think item five deals
6 nicely with the contingencies about
7 primary versus secondary transport. I
8 wonder -- I can't remember the discussion
9 and I wonder if you could just make a
10 comment on number eight, the
11 interhospital transport when that is
12 necessary. Many centers deal with this
13 by using a local non-pediatric
14 specialized transport service that is
15 readily available from a referring
16 hospital, because to wait for the
17 specialized pediatric service would add a
18 good deal of delay time. You cover that
19 by saying it depends on the individual
20 circumstances, but I wonder if you could
21 add any stronger emphasis on that?

22 DR. COOPER: Sure. Good point.
23 Good suggestion.

24 DR. LILLIS: I had the same

1 concern, particularly --

2 COURT REPORTER: Could you speak
3 into the microphone, please?

4 DR. LILLIS: I had the same
5 concern, particularly the way it's worded
6 that they should use specialized
7 pediatric transport wherever and whenever
8 available. The things before that take
9 into account --

10 COURT REPORTER: I'm sorry. I
11 can't hear you.

12 DR. LILLIS: It should be cleaned
13 up a little -- lightened up a little bit.

14 DR. KANTER: This is one of the
15 things where the more explicit you are in
16 your guidelines, sometimes you tie
17 people's hands. And to emphasize, a lot
18 of these decisions are made on an
19 individual case basis.

20 DR. COOPER: Absolutely.
21 Obviously you're all seeing these for the
22 first time today and there is, you know,
23 no intent, obviously, to do anything
24 other than to look at them today for your

1 thought and review and comments over the
2 next few months. I don't suspect that we
3 will be wrapping this up even with the
4 STAC before we meet again, so I think
5 we'll have an opportunity to -- to look
6 at these in more detail next time and
7 make the --

8 I will -- I will take it as the
9 sense of the committee that the change
10 that you and Kathy have recommended is
11 the one that should be made and I'm
12 seeing everyone nod "yes" so we'll make
13 that change and that will become draft
14 2.1.

15 And with your permission, I'll
16 also follow the advice relayed from
17 Martha that we might want to include
18 something about burns, rehab, injury
19 prevention and possibly disaster
20 management, as well, but in a very
21 general way so as to follow the advice of
22 the federal context, but at the same
23 time, not make these regs too burdensome.

24 DR. LILLIS: I've just got a

1 question about pediatric sub-specialties
2 -- was there any discussion about that?

3 DR. COOPER: There really wasn't
4 extensive discussion about pediatric
5 sub-specialists except to note that there
6 are no more in the traditional sense for
7 pediatric neurosurgery or pediatric
8 orthopedic -- orthopedic surgery.

9 While the truth of the matter is
10 that most pediatric neurosurgeons are far
11 more interested in tumors and shunts and
12 most pediatric orthopedists are far more
13 interested in complex congenital
14 reconstructive work than they are in
15 taking care of trauma patients. And a
16 neurosurgeon who cares for a fair amount
17 of trauma and an orthopedist who cares
18 for a fair amount of musculoskeletal
19 injury in adults as well as children
20 probably can do as good as and perhaps a
21 better job than a pediatric specialist
22 who's really focused on congenital
23 issues.

24 But other than -- other than that,

1 there wasn't really extensive discussion
2 and that's why I just suggested leaving
3 the language more or less the way it was
4 at the top of page three.

5 Although I think, Kathy, your
6 point that this particular wording refers
7 only to the anesthesiologist who probably
8 should refer to the neurosurgeon or the
9 orthopedist and other specialists and you
10 know -- and just say they should be
11 experienced and really kind of
12 highlight -- not that it really changes
13 the meaning. It's an inclusive phrase,
14 but by highlighting neurosurgery,
15 orthopedics and anesthesia is the focus
16 that we really need it to be. A good
17 suggestion.

18 MR. WRONSKI: If I could just
19 comment. In a separate discussion that
20 occurred with our neurosurgical board
21 member in trauma, the issue came up as a
22 sideline about pediatric neurosurgery.
23 The big issue was availability. There is
24 simply not many and then there is simply

1 not many who have enough children to
2 concentrate in that area.

3 And so the general thinking of the
4 state trauma committee was we don't want
5 to put something in that's so restrictive
6 because it doesn't exist. You wouldn't
7 find it in most regions. And so they
8 were more comfortable with the idea that
9 the neurosurgeon or whatever specialty it
10 was had some experience with children and
11 could show that and could treat children
12 but they didn't want to necessarily
13 mandate some things.

14 They're having a hard enough time
15 getting neurosurgeons to be available for
16 trauma without having -- putting in the
17 pediatric neurosurgery. It just may not
18 be there.

19 DR. COOPER: Thanks Ed for
20 bringing that point up. That was another
21 critical issue that was discussed, yes.
22 Okay.

23 Obviously, this process will
24 remain open until the regs are published

1 in the state register. There is not only
2 our internal comment period among
3 ourselves before we refer this to STAC,
4 but there is also their internal comments
5 process as well as when it finally goes
6 to the State Hospital Review and Planning
7 Council, their process followed by a
8 public comment period. So this is hardly
9 the last time you will have an
10 opportunity to look at this and comment
11 on it. But obviously the sooner the
12 comments come forward, the sooner we get
13 them incorporated and the sooner we can
14 move on to other issues that are equally
15 if not of more importance.

16 MS. GOHLKE: If you think this
17 warrants a conference call, if you'd like
18 to sit down one more time as a group and
19 talk about it, we can do that too.

20 DR. COOPER: Sure. Why don't you
21 do that. I will ask that if you have
22 comments about the regs other than the
23 ones we've already mentioned, that you
24 e-mail them to me, obviously with a copy

1 to Martha, and if you feel that there are
2 -- there are -- there is a need for us to
3 communicate via conference call, let us
4 know and we'll be happy to --

5 MS. GOHLKE: I know a couple of
6 people wanted to be at the January
7 meeting but couldn't make it. So those
8 folks that wanted to be a part of this,
9 as well.

10 DR. COOPER: All right. Before we
11 move to the updates from our sister
12 committees, I'd like now to return to the
13 one item of new business that we deferred
14 from earlier in the meeting and then ask
15 Brian if he would just briefly comment on
16 the status of the trauma report. In
17 fact, why don't we ask him to do that
18 first. Brian, if you could comment on
19 that briefly, where we are with that.

20 MR. GALLAGHER: Sure. The
21 committee -- sort of a sub-committee,
22 which was formed to look at the question
23 of updating what is now a little bit out
24 of date stuff, pediatric trauma reports,

1 which was produced a number of years ago.
2 The committee met and discussed a
3 couple of different approaches to putting
4 together a pediatric trauma report.
5 Originally, the thought was we might
6 follow the same format as the previous
7 report, but after some consideration by
8 the sub-committee, it was decided that
9 trying to use the format which is in
10 place by the national trauma data bank
11 would probably be the best approach, so
12 that data which is available from New
13 York State will be readily comparable to
14 the national data.

15 So the NTBD data, which is not
16 comprehensive -- not that every trauma
17 case in the country is contained in that
18 data set, but it is a representative
19 sample of national data and that's the
20 format that was used.

21 And based on the availability of
22 New York State's trauma data, it was
23 decided that the 2002 to 2006 period
24 would be appropriate for a report. So

1 what I did, with conjunction with Martha,
2 was basically take the NTBDs 2006
3 pediatric trauma report, which contains
4 '02 to '06 national data, reproduced that
5 and put New York State 2002 to 2006 data
6 side by side with the national data so
7 that we could see what type of
8 differences there were between New York
9 State and the nation.

10 And there is a variety of tables,
11 distribution of cases, morality --
12 mortality, method of injury, different
13 organ systems. And these were all broken
14 up into two age categories, zero to
15 fourteen and fifteen to nineteen.

16 So I think the product is a good
17 starting point for a discussion of how
18 New York State pediatric trauma data,
19 relatively contemporary data, compares to
20 the nation. And hopefully it will be
21 helpful for this body and others who are
22 interested in the outcome.

23 DR. COOPER: Thank you, Brian.
24 Any questions for Brian? Brian, do you

1 have any kind of rough timetable for us?

2 MR. GALLAGHER: Yes. Martha has
3 the products now.

4 DR. COOPER: Great.

5 MS. GOHLKE: I'm sorry. I missed
6 the question.

7 DR. COOPER: A rough timetable on
8 getting the reports.

9 MS. GOHLKE: Ed?

10 MR. WRONSKI: I got to see the
11 report during the week and it is very
12 interesting. It does show some
13 differences with the national data, but
14 whether it does or not, some of the
15 tables are interesting to look at for
16 what we're seeing for children.

17 So we can share the draft -- that
18 particular draft with you. We will send
19 it out by e-mail. We'll send it out for
20 the members to take a peek at it, give us
21 some comments.

22 What we're going to be doing is
23 coming up with some narrative to kind of
24 surround it, say a couple things about

1 the kids. There may be some things that
2 we want to point out in the data set.
3 There may be some things there that we
4 really think you should take a look at.

5 But what I'd ask -- what we're
6 looking to do is try to get this out as
7 soon as possible. It doesn't mean we
8 can't still work with data, but what I'd
9 like to do is have a report in a somewhat
10 finalized form so that it's out and
11 released sometime this summer, if
12 possible. That's optimistic, but if we
13 can get your comments, write our
14 narrative, send it up the chain and get a
15 letter from the Commissioner to support
16 it, we can have this out as a report that
17 would be a partnership -- and make it a
18 very clear partnership between us, the
19 Department, the School of Public Health
20 and the EMSC committee and obviously the
21 State Trauma Advisory Committee and the
22 trauma centers, where much of this data
23 can come from. And I think that would
24 be useful to just promote, you know,

1 pediatric issues and kids issues in the
2 state.

3 DR. COOPER: Terrific. So we'll
4 look for that in the e-mail. And we'll
5 ask that any comments that are
6 forthcoming be circulated back to Martha
7 so she can collate that and then the
8 group that got together to look at the
9 report or the basic structure of the
10 report will review that and consider what
11 changes, if any, need to be made. Okay.
12 Does that make sense? Good. Okay.
13 Moving right along.

14 The last issue under new business
15 that I have is to revisit the issue that
16 we led the meeting off with earlier this
17 morning and that is the issue of the
18 addition of glucocorticoids in
19 prehospital protocols.

20 I will just invite you, if you
21 would, to look behind the agenda in your
22 packet and you'll see an e-mail from Rita
23 Molloy, who couldn't be with us today,
24 but has concerns about -- about the issue

1 and wanted to bring this to our
2 attention. I think you all have that.
3 Yes.

4 So I'll just give you a moment to
5 read it, but in short she is arguing that
6 we need a systematic approach that
7 involves those responsible in the schools
8 as well as others.

9 MS. BRILLHART: When I read this,
10 what I see is having been involved in
11 developing some school plans, section
12 504(b) plans -- when I read the e-mail, I
13 see you're saying that school nurses
14 aren't actually mandated in New York
15 State. So the only way to make sure that
16 you can legally carry through the section
17 504 plan would be to make sure that if
18 EMS is involved they could carry though
19 that plan. Because school nurses aren't
20 mandated, then how can you make sure that
21 can actually be administered if it's not
22 in place in EMS?

23 I think she's saying, Hey, yeah --
24 you know, for this legally-mandated

1 school plan that we have in place. For
2 the kids who are very allergic, we have
3 epi-pens on the ambulances now. We have
4 never carried through on a 504 plan for a
5 kid with adrenal insufficiency unless
6 it's put in place with EMS.

7 DR. COOPER: That's what I meant
8 by having a -- you know, a system
9 approach, but you said it much better
10 than I did, so thank you.

11 DR. KANTER: Well, when you think
12 about emergency plans and emergency
13 medical services, it's a continuum which
14 begins in the community, at home, in the
15 school, wherever and includes responders
16 at the scene at various levels. And then
17 a very short time later involves a
18 hospital.

19 The question is what needs to be
20 done immediately at the scene and what
21 needs to be done in the steps after that.
22 And among countless needs, how do we
23 realistically apply -- I don't want to
24 restate too many things that we all said

1 this morning, but I really believe that
2 this particular one from all the
3 scientific evidence I know, the real
4 issues are what's the shock algorithm
5 that takes care of it at the scene in the
6 first minutes. And if you know, that
7 part of the origin of the shock is
8 hypobulemia, hypoglycemia, and adrenal
9 insufficiency, it seems to me that it's
10 perfectly reasonable for the provider at
11 the scene to give hydrocortisone or
12 Solu-Medrol or whatever they've got. But
13 it doesn't change the fact that the
14 immediately life-threatening issue is
15 hypobulemia hypoglycemia.

16 And with respect to some of the
17 things we heard this morning, I'm not
18 sure about the scientific evidence of
19 myocardial function. I think hypobulemia
20 affects myocardial function and turning
21 somebody around with a dose of steroids
22 alone, I don't think there's a lot of
23 evidence to support that.

24 DR. HALPERT: I would chime in on

1 your heels, too, in terms of more of a
2 reality check. You know, it's not a
3 known person with adrenal insufficiency
4 walking around who suddenly is flat out
5 on the ground near death. It's a kid
6 that's been sick with a significant
7 stressor that's been imminent, dwindling,
8 lingering, involved and haven't been
9 properly cared for for whatever reason.

10 Typically, if they're known to
11 have adrenal insufficiency and they're on
12 medication for that based on their known
13 -- they are told if you get sick, you
14 develop a respiratory infection, you
15 double your dose and you call us kind of
16 a thing.

17 People with this kind of a problem
18 really -- they're from out of area,
19 they've lost access to medication, they
20 don't speak the language, things like
21 that where they have not been able to get
22 access to the proper care for a fairly
23 protracted period. Maybe not weeks.
24 Maybe -- it could be hours, it could be

1 twelve hours, twenty-four hours, but it's
2 not two minutes.

3 And that's why it's kind of like
4 my point of -- Sharon brought up the
5 point of shock protocol. You know. You
6 give that medication as part of your
7 evolutionary workup and treatment of the
8 presenting problem, but it's probably not
9 the first thing you're going to give.

10 It's going to be saying, well,
11 this person's not getting better at the
12 scene. Let's give them a course of
13 glucocorticoids --

14 COURT REPORTER: Could you use the
15 microphone? I'm having a hard time
16 hearing you.

17 DR. KANTER: I worry that if you
18 have a standalone protocol for adrenal
19 insufficiency, the implication is he's
20 sick, we give him the hydrocortisone,
21 he's all better now. When in effect,
22 what he really has is a ruptured spleen
23 or septic shock or, you know, anything
24 else in the textbooks.

1 DR. COOPER: I haven't reviewed
2 today's blue packet in detail. The same
3 presentation, if not identical but close
4 to the same presentation was given at
5 SEMAC a couple weeks ago. And as I
6 understand the Rhode Island protocol -- I
7 read it at that time; I haven't read this
8 one today -- if memory serves me
9 correctly, the Rhode Island protocol is
10 basically to give glucocorticoid to
11 people wearing a bracelet. It's not give
12 it to anybody that presents in shock.

13 So my own personal view on that is
14 that this could be handled by some kind
15 of note or footnote or caution box -- we
16 do like those caution boxes in protocols.
17 You know, that said, Hey, if you've done
18 everything else in terms of shock
19 management and the person's wearing a
20 bracelet that says they're adrenally
21 insufficient, give glucose and
22 glucocorticoids or considering giving
23 glucose and glucocorticoids. The
24 question, I think, is whether -- whether

1 that would require medical control or
2 not, and my thought would be yes,
3 primarily because you have the extra time
4 to -- the extra time in the sense that it
5 takes a while for you to get, you know,
6 the fluids started and so on, which is
7 far more important.

8 People don't normally think about
9 giving glucose in a shock protocol, and
10 in fact, you know, sugars are high enough
11 in many trauma patients already. And as
12 we all know, sugar would ordinarily not
13 be given in shock protocol in part for
14 that reason.

15 So I think that perhaps our best
16 advice might be to add some kind of
17 caution -- as I said, some kind of
18 caution or note or something in that
19 protocol that says if you got the silver
20 bracelet give -- give resuscitation dose
21 of glucose and resuscitation dose of
22 glucocorticoid. And it doesn't matter to
23 me which one it is. Most services are
24 carrying Solu-Medrol for asthma patients

1 and in some cases COPD patients. But I
2 don't think we should get into
3 Solu-Medrol for shock -- septic shock in
4 the field. That comes much, much later.
5 This is really the only time that you
6 really can give it and I happen to share
7 your concerns about that -- your
8 statement that the evidence about the
9 overwhelming improvement in myocardial
10 contractility perhaps is not quite as
11 great as was stated this morning and does
12 appear to be more volume related, or --
13 so those are my views. Kathy?

14 DR. LILLIS: I guess I'm -- I
15 would disagree a little bit with Jon. In
16 fact, I have seen patients who have
17 quickly deteriorated, for example,
18 patients with vomiting where they can't
19 get their oral doses at home.

20 DR. HALPERT: Yeah, but they're
21 sick with vomiting.

22 DR. LILLIS: But I have seen some
23 -- and who come in blue and in shock and
24 have very quickly deteriorated before my

1 eyes.

2 I think that there's a couple --
3 lots of different steps from having all
4 paramedics carrying it. And I
5 particularly don't think that we're
6 there, but I think there are things that
7 need to be put in place, particularly
8 with the patients who are known -- who
9 have, whether it's the ID bracelet or
10 some kind of identifying protocol at home
11 where the paramedic facility can assist
12 with the distribution of their own
13 medication, because I think most of these
14 kids carry their kits -- and right now --
15 or at least in a school setting or on a
16 field trip or wherever where it's not
17 easily administered and people who are
18 trained well to administer.

19 I guess I would advocate that we
20 do work with the EMS system to help these
21 families that may be in situations,
22 because I think it can be
23 life-threatening. I think it can make a
24 difference by administering this early

1 and I would advocate trying to have the
2 EMS system help deliver the patient's own
3 meds.

4 DR. COOPER: You think it should
5 be the patient's own meds?

6 DR. LILLIS: I think as a first
7 step. I understand the ramifications of
8 trying to implicate this statewide and
9 having all agencies carry this. An easy
10 solution would be -- at least step-wise
11 and we'll see how that goes, but
12 training, educational programs.

13 But I think -- at least when I
14 investigated it at my hospital with my
15 pediatric endocrinology department, they
16 felt that all patients that are followed
17 by their division all have medication at
18 home readily available. And I think EMS
19 can be helpful in helping us --

20 DR. KANTER: Well, as an
21 educational initiative or a statewide
22 improvement initiative, there is no
23 question that you want to treat adrenal
24 insufficiency in an effective way. And I

1 don't know what the rules are about using
2 a family's own medications, if that is an
3 authorized thing to do. Maybe it would
4 be a good idea to work on that. But as
5 you said the responders do have some kind
6 of glucocorticoid with them, typically,
7 most especially for asthma and we ought
8 to use that if it appears to be
9 indicated. I think it's more
10 important -- far more important for
11 asthma than it is for --

12 DR. COOPER: Absolutely.

13 DR. KANTER: And by the way,
14 adrenal insufficiency should be suspected
15 in a whole lot of other patients that
16 just --

17 DR. COOPER: Sure.

18 DR. KANTER: So it is important
19 and an educational initiative probably
20 could be beneficial.

21 But I just want to say, again, if
22 you look at the presentation, you get the
23 idea that the doses of hydrocortisone is
24 the only step in intervention and I don't

1 believe that's true. I think the whole
2 advanced life support algorithm pertains
3 here.

4 MS. BURNS: Speaking as just a
5 representative of the statewide system, I
6 just -- there are about 1,200 EMS --
7 certified EMS services in the state.
8 Just about -- just under 700 of them are
9 advanced life support. There are 6,000
10 plus or minus a few paramedic level
11 providers.

12 At the risk of sounding callous,
13 or as one of my colleagues say, have hair
14 on my heart, one of the things that I do
15 in our office and with the state council
16 is just to remind you that in our last
17 data year there were 2.7 million EMS
18 calls. While I appreciate intensely this
19 situation, we are routinely faced with
20 these kinds of things.

21 We should be carrying factor five
22 on our rural ambulances because we had an
23 incident up in the Adirondack's where a
24 patient didn't have time before he went

1 on vacation to get his factor five and he
2 was in a small watercraft crash.

3 We've had the Marfan's who contact
4 us and demand that we do training on
5 Marfan's and triple A situations.

6 So, you know, I think we have to
7 appreciate the fact that -- and be
8 sensitive to the needs of these people,
9 but remember that the volume of EMS
10 responses are such that I'm afraid we're
11 not going to capture the imagination or
12 interest of our EMS providers.

13 And I think starting with your
14 group, not to mislead you in any way, you
15 direct us and we will do it, but you need
16 to understand the likelihood that we send
17 out stuff from the hemophilia group --
18 they had a group at our conference and
19 we've done a lot of this.

20 But when an ambulance service
21 looks at their call volume, they're
22 treating chest pain, chest pain, chest
23 pain, chest pain. They're unfortunately
24 -- much to their horror, they're not

1 treating trauma, trauma, trauma, trauma
2 and pediatric victims of adrenal
3 insufficiency. So I think that you have
4 to put it into perspective.

5 MR. CZAPRANSKI: Can I comment?
6 It would be nice to have an AED on every
7 ambulance first.

8 DR. HALPERT: It would be nice to
9 have an EMT on every ambulance first.

10 MR. CZAPRANSKI: This is an ALS
11 protocol. Would it make sense to turf
12 this to the SEMAC to say, Give this to
13 the regional council's as a review and
14 consideration for their regions, because
15 I think those regional councils and those
16 REMACs were made of physicians and EDs in
17 various hospitals that can look at the
18 frequency and utilization and then
19 determine if this consideration is
20 correct.

21 I like the way that Sharon
22 mentioned it, it ought to be under the
23 shock protocol, which it is in the State
24 of Ohio, in their shock protocol,

1 pediatric. One thing about the Rhode
2 Island thing, Providence plantations.

3 DR. HALPERT: It goes way back.

4 MS. CHIUMENTO: Interestingly
5 enough, one of the things that the
6 Medical Standards committee is looking at
7 is having regional options. And I think
8 this would fit perfectly into that
9 segment. So at the bottom of the
10 protocol, have things everybody does for
11 shock. And down at the bottom, regional
12 options might include this and it would
13 give the regions the options.

14 DR. HALPERT: I don't want to
15 over-simplify this, but, you know,
16 paramedics are equipped to manage
17 patients in shock. Paramedics are
18 equipped to utilize injectable
19 glucocorticoids. It's real simple.

20 MS. BRILLHART: Can I ask a
21 completely naive question? If they
22 respond and one of the kids has CAH and
23 he's got a medical protocol there and
24 he's got his meds, but the school nurse

1 isn't on the premises so there's
2 technically nobody else that can do that,
3 what's the current standard? The
4 paramedics just have to say no, we can't
5 and scoop and go?

6 DR. HALPERT: Call medical
7 control.

8 DR. COOPER: They could get a
9 discretionary decision.

10 DR. HALPERT: Right.

11 MS. BRILLHART: Okay. Because I
12 guess the feeling -- the first thing that
13 Rita's talking about is there is a
14 medical plan in place. It's signed off
15 by the doc. It's signed off by the
16 parents. It's signed off by the school.
17 The kid has their own meds. But the
18 person that can do it isn't in today and
19 they're calling for help.

20 MR. WRONSKI: There is always --
21 particularly an advanced life support
22 provider can always call medical control
23 and get authority to use these meds. In
24 those areas where sometimes medical

1 control isn't available, sometimes a
2 provider -- an advanced life support
3 provider will punt and decide to do that.
4 But rather than have them punt, I think
5 that what can happen here -- and what I'm
6 hearing is that there's a consensus,
7 including from my own staff, that there
8 are things in place to deal with the
9 broader spectrum of what's happening to
10 these patients and they're included
11 within that broader spectrum.

12 But I don't think there's an
13 argument that if you knew this patient,
14 for instance, had a bracelet or you knew
15 they were suffering from this, then that
16 would be part of your decision scheme as
17 to how to treat them. So if you knew
18 they had adrenal insufficiency, you could
19 build that into your thinking process.

20 And what I would ask is that we do
21 develop some education that we can share
22 with our REMACs, we develop local ALS
23 protocols and provide them with that
24 information.

1 I was just -- I was given a note,
2 and I don't know how we got this so
3 quick. I'm always impressed. The only
4 four regions -- four regional REMACs, and
5 there are sixteen REMACs medical groups,
6 have Solu-Medrol in their ALS protocols
7 out of the sixteen. So it may be
8 something to bring this up as -- should
9 all the sixteen regions consider having
10 that within their protocols, not simply
11 for this but for other reasons and have a
12 discussion with the SEMAC on that and
13 give advice in that regard. I would also
14 certainly include it in the education and
15 outreach.

16 What we've done before, EMS should
17 be in touch with both families and
18 schools in their area for any specialty
19 issues regarding children. Are there
20 people in your community or even adults
21 who have certain types of diseases or
22 maladies that you should know about? So
23 if you're going to a certain street and a
24 certain house, you know what you're

1 walking into. So they should know the
2 plans if possible.

3 MS. BRILLHART: I was just kind of
4 leaning towards or thinking about if we
5 have the section 504 plan and we can't
6 back it up with EMS then who are the
7 parents going to sue? The school? EMS?
8 The pediatrician who signed off on that
9 but it's not carry-outable (sic)?

10 I was thinking if the stuff falls
11 through the cracks, who's in trouble?
12 You know what I mean? Having been
13 somebody who has been part of setting up
14 a training process for a 504 plan.
15 That's all. I was just thinking of
16 keeping people out of trouble.

17 DR. COOPER: I guess my general
18 sense is that -- I guess my general sense
19 is that we can finesse this. You know.
20 This is one of those -- let me give an
21 example from New York City.

22 There is some data from the fire
23 department that suggests that if a case
24 occurs frequently enough, that there are

1 some folks in the office of medical
2 affairs who are hellbent on having a
3 protocol specifically for those kids as
4 separate from pediatric shock protocol.
5 This, to me, is sort of like that issue.
6 You know. It's something that occurs
7 with enough regularity in enough places
8 and the treatment for it is standardized
9 enough that the system ought to be able
10 in some way if not to prescribe the
11 treatment at least not obstruct it. And
12 on some level perhaps facilitate it under
13 the appropriate circumstances.

14 And that it's not clear to me that
15 that means that we want to make every
16 single region have to come to the SEMAC
17 asking for a special exemption to be able
18 to do this if they were to choose to do
19 it.

20 To me, I think we can -- I think
21 we can do this in a way through some kind
22 of note or something along the lines as a
23 medical control thing if you got the
24 silver bracelet on and you're treated for

1 shock, give glucose and consider
2 glucocorticoids under medical control.
3 Something along those lines that would,
4 you know, not be encouraging people to
5 rely on that as a primary treatment but
6 it wouldn't really obstruct anybody from
7 doing it if there was a legitimate need
8 to do so.

9 So I think that's kind of the
10 approach we should take. We have a
11 saying down in New York City about our
12 pediatric protocols. Refer to them as
13 conservative yet permissive. They're
14 very conservative in terms of stressing
15 BLS, but we don't block appropriate ALS
16 treatments when the situation calls for
17 them.

18 So to me this falls into that
19 category very nicely. We want to be
20 conservative but we do want to be
21 permissive here and not obstructive.

22 So I'd like to suggest that we
23 craft a letter to the SEMAC which I will
24 circulate to everybody and see if we can

1 capture that flavor. Sharon.

2 MS. CHIUMENTO: In some ways, it's
3 very similar to what we did with
4 epi-pens. Originally, when the epi-pens
5 became available, it was for BLS and then
6 for ALS, but it is the same kind of
7 things. First we said, well, if patients
8 had their own epi-pen, we could
9 administer. And then we said agencies or
10 regions could then allow agencies within
11 their region to carry epi-pens. So this
12 is a very similar type of thing. It's
13 step-wise. You're not forcing everyone
14 to carry the epi-pens, but you're
15 allowing them to use what's there in a
16 patient's own possession and/or to carry
17 it if their own region approve it. It's
18 a very similar process.

19 DR. COOPER: It's permissive
20 rather than --

21 MS. WALDEN: I'd just like to add
22 one thing and that is that parents have
23 a certain responsibility in this as well
24 as all patients do, also, and that is to

1 wear a medic-alert bracelet or to notify
2 their squad that they have this
3 condition. And in that instance, they
4 can sign a paper authorizing the squad to
5 give the medication if the squad carries
6 it or provide a sample or a vial that can
7 be stored for that child.

8 They tell you this is the most
9 important thing is communication,
10 communication, communication, but I still
11 think we have to put some responsibility
12 back to the parents.

13 DR. COOPER: I do think that
14 limiting this to patients that have a
15 silver bracelet on their arms is -- I
16 think in a way is the enforcer of gradual
17 responsibility. I mean, you're
18 absolutely right. It isn't just the
19 bracelet relying on the world to take
20 care of the child. There is a whole lot
21 more than that. In the very least, if
22 there's a bracelet on -- I'm sure that in
23 your experience, as in mine, if parents
24 go to that length to protect their child,

1 they usually go to other lengths, as
2 well.

3 MS. BRILLHART: Dr. Cooper, if I
4 can make a friendly amendment?

5 DR. COOPER: Sure.

6 MS. BRILLHART: Knowing children
7 as we do, they leave the house in their
8 nice conservative tops and get to school
9 with something completely different on
10 because they stored it at their friend's
11 house.

12 I'd like to add a friendly
13 amendment that they have a silver
14 bracelet or a signed section 504 plan in
15 place.

16 DR. HALPERT: Or a tattoo on their
17 body.

18 MS. BRILLHART: Yes.

19 MR. CZAPRANSKI: I think add, or
20 other appropriate identification of their
21 medical condition.

22 MS. CHIUMENTO: I'm thinking also
23 of the forms that Ruth showed us -- the
24 pocket fold-up forms -- any of those

1 forms that would identify the patient has
2 a problem.

3 MS. WALDEN: Those forms are now
4 on our website, as well.

5 MR. WRONSKI: I congratulate the
6 committee for figuring out a way to
7 support President Obama's parental
8 responsibility initiative.

9 DR. COOPER: Okay. Very good. So
10 I take it then that I will craft a letter
11 that reflects the sense of the committee
12 in this regard, which I will circulate to
13 everyone before it goes out so that
14 people can, you know, make comments,
15 agree or disagree, what have you. And if
16 there is not substantial agreement, we
17 will bring it back next time. Is that
18 fair? Okay. Good.

19 MS. GOHLKE: I just want to
20 mention -- speaking from somebody who's
21 having an allergy attack and I have to
22 get to my next prednisone application
23 here soon, it is four o'clock. But
24 anyway --

1 MS. ROGERS: Sorry. We're not
2 authorized to do that.

3 MS. GOHLKE: I want to make a
4 suggestion. I know people benefit from
5 the updates, but maybe we can provide it
6 by e-mail after the meeting.

7 MS. CHIUMENTO: All the things
8 that I had to bring to the committee have
9 been spoke about already.

10 MS. GOHLKE: Okay.

11 DR. COOPER: And likewise for
12 STAC. The key issues were the regulatory
13 issues.

14 MS. GOHLKE: I just want to draw
15 your attention to -- the committee dates
16 are in your folder. Hopefully you
17 already have them and you already have
18 them on your calendar, but the EMSC
19 committee dates are on along with all our
20 other committees for those of you who are
21 on several.

22 And I just wanted to also point
23 out, I sent this around by e-mail, but
24 Dr. Kanter and Dr. Cooper's latest

1 publication is also in hard copy and in
2 your folders, as well.

3 DR. COOPER: I need to publicly
4 disclaim major responsibility for this.
5 Dr. Kanter was clearly the leader on this
6 project.

7 DR. KANTER: Team effort.

8 DR. COOPER: And I was proud to be
9 a member of the team, but he really -- he
10 really did the work on that.

11 MR. WRONSKI: I did a quick read
12 and I'll read it more carefully, but it
13 looks very good. Very nice.

14 MS. GOHLKE: Our next meeting is
15 June 2.

16 MS. BRILLHART: I was just going
17 to make a motion to adjourn so she can
18 stop typing while we do our nice social
19 stuff.

20 DR. COOPER: Okay. So the next
21 meeting then is June 2nd, right here at
22 the Crowne Plaza Hotel. And hearing no
23 other calls for new business, I'll ask
24 for a motion to adjourn.

1 DR. HALPERT: Yes.

2 DR. COOPER: Thank you all and we
3 will see you on June 2.

4 (Whereupon, the meeting adjourned
5 at 4:06 p.m.)

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C E R T I F I C A T E

I, Nora B. Lamica, a Shorthand Reporter and
Notary Public in and for the State of New York, do
hereby certify that the foregoing record taken by
me is a true and accurate transcript of the same,
to the best of my ability and belief.

Nora B. Lamica

DATE: March 24, 2009