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

Tuesday, June 2, 2009
11:00 a.m.
The Crowne Plaza
30 Lodge Street
Albany, New York

APPEARANCES:

Robert Amler, M.D.
Susan Brillhart
Lee Burns
Sharon Chiumento
Arthur Cooper, M.D.
Tim Czapranski
Louise Farrell
Ann Fitton
Martha Gohlke
Robert Kanter, M.D. (telephonically)
Christopher Kus, M.D.
Kathleen Lillis, M.D.
Rita Molloy
John Morley, M.D.
Janice Rogers
Sarah Macinski Sperry
Elise van der Jagt, M.D.
Edward Wronski

1 DR. COOPER: I'd like to begin the
2 meeting and welcome everyone to the June 2, 2009
3 meeting of the Emergency Medical Services for
4 Children Advisory Committee. My name is Dr.
5 Arthur Cooper and I have the honor of chairing the
6 committee.

7 We have quite a bit of business to
8 transact today, but before we do that, I want to
9 do two things. First, of course, is to formally
10 introduce to the committee my friend and
11 colleague, Dr. Robert Amler, who is the dean of
12 the School of Public Health of New York Medical
13 College. We are so grateful and honored to have
14 someone of his stature joining our committee. Rob
15 is filling a pediatric toxicologist position on
16 the committee and we're really glad that you're
17 going to be with us from here on.

18 And, of course, our other dear
19 friend and colleague, Dr. John Morley, who is the
20 medical director for the Office of Health Systems
21 Management needs no introduction to anyone here.
22 John is, of course, all of you know, an
23 intensivist, medical intensivist by background and
24 has been really a tremendous asset to the
25 department in terms of moving forwards its medical
26 programs, particularly with OHSM. And I know that
27 John has had a particular interest in recent

1 months in issues surrounding pediatric
2 regionalization and so on and hopefully we'll hear
3 a little bit more about that this morning.

4 Now, unfortunately, John can only be
5 with us for about an hour and a half, so after we
6 open the meeting, taking a few moments to take
7 care of some housekeeping items, I will ask that
8 we move right into the subcommittee report from
9 the inter-facility group. And I know Bob Kanter
10 is with us on the telephone. Bob is the chair of
11 that group and I know that he and Elise van der
12 Jagt and Kathy Lillis will have a fair amount to
13 say about that this morning.

14 So the first thing that I would like
15 to do is just quickly approve the minutes. I know
16 everyone received them via e-mail. Are there any
17 additions, deletions or corrections to the
18 minutes? Hearing none, then I'd like to ask for a
19 motion for approval.

20 MS. BRILLHART: Motion.

21 MS. CHIUMENTO: Seconded.

22 DR. COOPER: Thank you, Susan
23 Brillhart and Sharon Chiumento. Discussion? All
24 in favor?

1 SPEAKERS: Aye.

2 DR. COOPER: Opposed? Carries
3 without dissent. Next we have review of the
4 agenda from Martha Gohlke. Martha, would you take
5 over please?

6 MS. GOHLKE: Yes. Dr. Cooper
7 mentioned we're going to rework a little bit the
8 agenda. We're going to talk about regionalization
9 of critical care hospitals and the also
10 stakeholders meeting that goes along with that,
11 and also the inter-facility transfer guidelines
12 document. We'll start off with that while we have
13 Dr. Morley here with us. Eventually, we're going
14 to get to the pediatric trauma center regulations.
15 They're nearing the end of their revision, so
16 we're going to take one last peek as the pediatric
17 group and make sure that the trauma center
18 regulations reflect what we'd like to see in the
19 pediatric portion of them. And we're going to
20 just take care of some old business - EMS-C
21 bylaws, the pediatric disaster card.

22 And the one thing that's not on the
23 agenda that we need to revisit is the adrenal
24 insufficiency decision that this group wants to

1 put forward to the SEMAC, and Dr. Cooper has
2 kindly drafted a letter for us to reflect on.
3 Then we'll eventually fit lunch in there, but then
4 we'll get to the Bureau of EMS Report, where Mr.
5 Ed Wronski will present that, and then I'll talk
6 about the EMS-C grant.

7 And we'll continue on at that point
8 with the sub-committee report-outs, what they did
9 this morning, and then our new business. We have
10 the national equipment list that we're going to
11 look at from the pediatric side and see what this
12 group recommends, if any changes, to our part 800
13 regs on what ambulances carry on them as far as
14 pediatric equipment.

15 And then Ms. Lee Burns, next to me
16 here, is going to talk about where the Department
17 is in moving toward NEMSIS compliance and our
18 grant that goes along with that. And then if we
19 have time today, we'll get to doing some updates
20 from our sister committees that met last quarter,
21 the SEMSCO, SEMAC and the STAC reports.

22 And if we have time, we'll be able
23 to do a round robin report-out from the members to
24 see what's going on in their regions. And

1 hopefully that will be it.

2 DR. COOPER: Okay. Thanks, Martha.
3 I'd like, now, to turn to Elise van der Jagt to --
4 and Kathy Lillis to share with us the discussions
5 that took place this morning, together with Dr.
6 Morley, with respect to the inter-facility
7 transfer issue. Dr. Kanter, I trust you will feel
8 more than free to chime in.

9 DR. KANTER: Sure.

10 DR. COOPER: And after we have an
11 initial discussion about what transpired this
12 morning, I'd like to move right into consideration
13 of the documents that Dr. Kanter prepared in his
14 usually elegant style. We received relatively few
15 comments on these documents, even though they were
16 circulated some time ago. I personally believe
17 that that's because they were so well prepared
18 that there was almost nothing to say. So, we will
19 have an opportunity, however, to review and
20 consider formally -- we may or may not wish to
21 adopt the document today. My guess is we probably
22 want to reflect on it a little bit longer before
23 we actually adopt it. But I think that, Bob, on
24 behalf of the committee, I know we all thank you

1 for a terrific start and I'm willing to bet very,
2 very near finish on that -- on that document.

3 DR. KANTER: Thanks Art. I might
4 just mention here, most of the material in there
5 has really been collected from other precedences
6 in other states. Only a couple of sections really
7 include new material that I wrote, but most of
8 it's really -- the credit goes to others over the
9 past few years.

10 MS. GOHLKE: And there is a current
11 draft on the left-hand side of your folder, one or
12 two pages back.

13 DR. COOPER: Okay. Elise and Kathy?

14 DR. VAN DER JAGT: Yes. Thank you
15 very much -- thank you very much, Dr. Cooper, for
16 your comments. I'm just reporting about the
17 sub-groups that we put together in the last few
18 times. Dr. Lillis and I --

19 COURT REPORTER: Can you please
20 speak into the microphone?

21 DR. VAN DER JAGT: Sure. Again, I'm
22 Elise van der Jagt. I'm one the pediatric
23 critical care physicians on this committee from
24 Rochester, New York. Dr. Lillis from Buffalo is

1 on this committee with me, and, of course, Dr.
2 Kanter on the phone is here, because he's actually
3 the lead for that committee.

4 We had a very focused discussion
5 with Dr. Morley this morning regarding how to move
6 forward with inter-facility transfer guidelines
7 and pediatric emergency care. It seems that maybe
8 the right thing to do as we discuss this is to
9 make sure that the Department of Health is very
10 actively involved in this process. I reflected
11 back to the committee that we had a similar
12 endeavor about two years ago -- and we made a lot
13 of progress during that time -- but it really did
14 not move in the direction that we wanted it to.
15 Perhaps it was, at the time, the way the climate
16 was, in general. We are in a much better position
17 to do so at this time with the background of
18 trauma systems that have been developed, with the
19 fact that there is a real need to tie together the
20 pediatric community regarding these very ill kids.
21 Also, the process of designation --

22 So as we have to do this, the
23 stakeholders for this kind of process -- for a
24 variety of -- a variety of --

1 COURT REPORTER: I don't know what
2 the problem is, but there's a lot of static. I'm
3 sorry.

4 MR. WRONSKI: Shut that one off.

5 DR. VAN DER JAGT: Let me try this.
6 Is that better?

7 COURT REPORTER: Yes.

8 DR. VAN DER JAGT: Great. Sorry for
9 the little burps here and there. It is not me, I
10 assure you.

11 Anyway, the process, we thought,
12 that would be important is that there is a
13 stakeholders meeting that we thought it would be
14 best to be involved. But prior to that, it would
15 be very productive for key members to meet with
16 Dr. Morley and others to do a pre-meeting on what
17 do we want to accomplish in the stakeholders
18 meeting that you would aim for probably around
19 September or early fall. So that was the
20 agreement. Dr. Morley agreed that that would be
21 helpful. Ed Wronski was also in on that meeting
22 and also agreed that that seemed very reasonable.

23 So the recommendation is that we
24 actually have a pre-meeting, probably in the next

1 month or so if we can figure that out. And that
2 could be by calling in, a few key people face to
3 face. There should be a discussion about what
4 should happen at the stakeholders meeting.

5 The second thing that we started
6 doing was to review the inter-facility guidelines
7 that you so wonderfully put together, Bob. It was
8 really very well done. But it does indeed
9 require, I think, a little more contemplation in
10 some areas. For example, the first part of this
11 is to make sure that we have very clear definition
12 of such things as pediatric hospitals. There's
13 also -- we might want to consider having a better
14 definition of pediatric as a help for the
15 hospitals involved in this process of transfer and
16 regionalization.

17 And like you said, Dr. Kanter, is
18 that much of this was taken from previous
19 experiences. I'm actually very excited about
20 that. One of the goals of EMS-C is that we borrow
21 from what others have done in the past rather than
22 re-invent the wheel. So having the guidelines
23 that have been promulgated by other states,
24 particularly other regions, having them referenced

1 so nicely is exactly as I understand EMS-C to be.

2 So, again, I compliment you for
3 getting the guidelines together. So anyway,
4 that's all I have to report. Dr. Lillis, do you
5 have any other comments?

6 DR. LILLIS: No. I think there is
7 just a few comments. Sharon has been collecting
8 them through the regions, as well. I think we
9 need to fine tune --

10 I just have a couple of very small
11 things. I think it's important to encourage both
12 transferring and receiving hospitals to have
13 either written or taped documentation of the
14 communication that occurs involving the transfer.
15 And so I think -- I think we need to flush out a
16 little bit. I don't think we're ready to vote on
17 it today, but I think we're close.

18 MS. CHIUMENTO: One other point is,
19 the rest of the group that was not on that
20 committee has not seen that document yet, either,
21 so I think it would probably be a wise idea --

22 DR. KANTER: I'm sorry. I can't
23 hear that last comment.

24 MS. CHIUMENTO: I'm sorry. Since

1 the rest of -- the other group, the training and
2 education committee, has not seen this document
3 until today, it probably would be a wise idea to
4 hold off until next time so they have an
5 opportunity to look through it and understand it
6 before they --

7 DR. KANTER: Good.

8 DR. COOPER: Bob, did you have
9 comments?

10 DR. KANTER: Well, let me just spend
11 a minute talking about what I was attempting to do
12 here. This draft of the consultation and transfer
13 guidelines is structured around the EMS-C national
14 resource center recommendations. And they really
15 have five areas described in their performance
16 measures, which has determined a lot of what our
17 advisory committee has been aiming for in every
18 area over the past couple of years. The five
19 areas are initiating the process of consultation
20 or transfer.

21 And I should emphasize that involves
22 -- consultation may be the appropriate action
23 rather than a transfer. Selecting the appropriate
24 facility, because it's hard to have transfer

1 guidelines if you don't have some guidance about
2 which centers are the appropriate one to receive
3 the patient. Selecting the appropriate transport
4 service. Some description in detail the process
5 for patient transfer and a list, probably in a
6 checklist form, of what information needs to be
7 transferred both between hospitals as well as to
8 the family.

9 The EMS national resource center
10 describes the need for a document that outlines
11 these guidelines. They also suggest or recommend
12 that formal agreements exist between hospitals and
13 they point out that the same document may be both
14 the contract or the agreement as well as spell out
15 the steps in the process.

16 For the first three items,
17 initiating the transfer consultation, selecting
18 the facility and selecting the appropriate
19 transport service, there is enough material
20 already published from a number of states cited in
21 the draft that I just selected the best stuff that
22 I could find from published sources.

23 Now, to adapt those for New York
24 State, particularly for selecting the appropriate

1 care facility, I mean, that gets to the heart of
2 all our discussion about regionalization, and I
3 have no illusion that we certainly can't implement
4 that right away. But I think -- I've tried to
5 give you a flavor of how other states have handled
6 it and how I believe that New York State could
7 handle it in much the same way that we've handled
8 trauma, perinatal and a number of other
9 sub-specialty services that warrant
10 regionalization.

11 For the process of transferring the
12 patient, I have added a number of items in the
13 draft that don't appear in other statements, but
14 they're perfectly straightforward things. Anybody
15 who has been directly involved in handling
16 inter-hospital consultations or transfers will
17 recognize them, particularly Elise who has been
18 directly involved in this may think of a few other
19 ways to add to that.

20 And then the transfer of patient
21 information. Likewise, a checklist that comes --
22 much if it comes from other published sources. So
23 it's -- my intent here was just to put something
24 down on paper that would be a starting point to

1 work from. It's very similar to the approaches
2 taken by other states. Some of it's redundant and
3 we may make it more concise. Most importantly, I
4 think we have a lot of groundwork to do on the
5 concept of the regionalizing and the concept of
6 designating hospitals. That's essential for any
7 of this to really be something we can implement.

8 DR. COOPER: I have a few comments
9 to make with respect to this -- this process. The
10 first is that Mr. Wronski took an important step
11 toward better defining our regionalization
12 planning a month or two ago in querying the
13 hospitals in New York City regarding their
14 capability to care for pediatric trauma patients.

15 I think many of you are familiar
16 with the process of trauma center designation in
17 New York State, but for those of you who are not,
18 a number of years ago in the early 1990s, in fact,
19 New York State made a decision to designate
20 regional and area trauma centers, and that process
21 has been revisited on a regional basis throughout
22 the years, particularly focusing in the early
23 2000s on New York City, which underwent a very,
24 very large system review at the request of the

1 state hospital review and planning council.
2 Because of the way the designation process
3 initially worked, that is to say the designation
4 was based on categorization rather than
5 verification when initially put forward, and
6 because of the numerous changes that have taken
7 place in the healthcare system since the centers
8 were initially designated, many of the hospitals
9 that once were capable of caring for pediatric
10 patients have either formally or informally, if
11 you will, stepped back from that role and
12 indicated that they would rather have others take
13 it on. And this has led to some confusion,
14 particularly in New York City.

15 Now, this is less of a problem in
16 the upstate regions because pediatric facilities
17 tend to be focused at our university medical
18 centers. But in the downstate region, not only
19 New York City, by the way, but also the
20 Westchester region in Nassau county, there --
21 there has, at times, existed some confusion as to
22 which hospitals were pediatric capable and which
23 are not. And so this led Mr. Wronski to query the
24 trauma centers in New York City within the last

1 two months regarding their decision to participate
2 in the trauma system. And at this particular
3 point, we have some preliminary data indicating
4 that there has been a response, but about half the
5 centers that have been queried have not yet
6 responded. In general, those institutions that
7 have historically indicated the desire to care for
8 children are still doing so.

9 So I don't think we anticipate any
10 large changes at this particular point, although I
11 do believe that some of the -- some of the
12 information may be subject to verification at a
13 later date.

14 I think that's a very, very
15 important first step and I invite Mr. Wronski to
16 make any additional comments about this he feels
17 are appropriate at this time.

18 MR. WRONSKI: The reason we did this
19 was there had been expressed, locally and in New
20 York City, some confusion as to which regional
21 trauma centers, in fact, were capable of accepting
22 and keeping major trauma. All of the regional
23 centers can certainly stabilize trauma coming in
24 the door, but not all had the capabilities of

1 keeping the child and providing the services that
2 the child may need. And so we -- while we have
3 files in the department which indicate who are the
4 hospitals who originally were designated and
5 confirmed as pediatrics as of the last review of
6 the city in 2000 -- in the year 2000 or 2001, we
7 did our last review of the city of New York and
8 visited all of the hospitals, but there were still
9 some years since that time and some facilities may
10 have changed.

11 So it was recommended we do this
12 survey, and we have, and we have seven facilities
13 right now who have not notified us what they are
14 capable of doing with pediatrics, and we're
15 reaching out to them by telephone to get their
16 responses to our letter.

17 In regard to verification, if there
18 is questions after we share this information,
19 particularly with the region, we may followup with
20 specific facilities just to confirm that they
21 understood the letter and they understood the regs
22 and what the requirements were to maintain a
23 pediatric capability for trauma. But it points
24 out that in any large system, whether that be the

1 New York City system or the upstate system, you
2 periodically need to self-evaluate yourself and
3 the state needs to evaluate how things changed and
4 we'll work with you on this so we know where the
5 children should go.

6 DR. COOPER: Thanks, Mr. Wronski.
7 Any other comments on that issue? Elise?

8 DR. VAN DER JAGT: Just a question,
9 Mr. Wronski, on this. It seems to me that
10 pediatric trauma, as it is taken care of, there's
11 a lot of overlap -- I'm not sure that there's
12 identical institutions, but I think many of the
13 same resources that would need to be there for
14 pediatric trauma patients would also need to be
15 there for pediatric medical patients. So I'm
16 wondering if there's a way to merge those two
17 concepts so that can help us in the
18 regionalization process issue.

19 MR. WRONSKI: Well, one of the
20 things I think that has to happen, as we further
21 look at regionalization, look at what
22 regionalization already exists and what kind of
23 pediatric categorizations exist out there. What
24 if hospitals have already committed to a certain

1 type of care in children and it's not just trauma?
2 We have certain other programs that are committed
3 to by hospitals that are pediatric specific, so
4 that when we get to a point, if we do develop a
5 regional system in pediatric care, I think you
6 have to weigh those things and put them on the
7 table for who -- what hospitals would, in fact, be
8 considered children's hospitals in a complete way
9 and not just trauma.

10 And I do agree with you that many of
11 the hospitals who are pediatric trauma centers or
12 have the capability of having both an adult and a
13 pediatric trauma capability, typically can bring
14 the medical care to their own children. Not in
15 all cases, but I think in many.

16 So I think you have to weigh it,
17 when we further discuss the regionalization, is
18 the hospital we're saying is a children's
19 hospital, are they also a trauma hospital and do
20 they have to be, and -- and look at what criteria
21 we weigh for trauma for pediatrics versus what
22 else you might need for medicine and put that all
23 in the equation that we'll eventually come out
24 with.

1 DR. COOPER: Thanks, Mr. Wronski.
2 Any other comments on this? Well, I think that
3 segways (sic) nicely into the second comment that
4 I had regarding the regionalization issue, and
5 that has to do with a project taking place in New
6 York City at the present time in and around the
7 activities of the so-called pediatric disaster
8 coalition.

9 The New York City Department of
10 Health and Mental Hygiene issued an RFP about a
11 year ago to look at issues in or around
12 regionalization of pediatric care during
13 disasters. And a coalition led by Mike Froegall
14 (phonetic), the director of the division of
15 general pediatrics at North Shore Allied
16 Healthcare Systems successfully competed for the
17 grant in collaboration with the Center for
18 Pediatric Emergency Medicine at New York
19 University Medical Center and Bellevue Hospital
20 Center and the New York Presbyterian Hospital,
21 both sites, the Weill Cornell Medical Center site
22 and the Columbia University Medical Center site.
23 And the concept that is emerging and will be
24 presented at the special conference to be held

1 next September is two-fold. First, tiering of
2 hospitals based upon global pediatric
3 capabilities, and second, a triage scheme --
4 simplified triage scheme that identifies patients
5 for rapid transport to pediatric-capable centers.
6 Simply stated, patients who have critical organ
7 failure or distress will be triaged preferentially
8 to tier one facilities. Patients who do not have
9 critical organ failure or distress, but
10 nevertheless have significant illness or injury,
11 would be transferred to tier two pediatric
12 facilities.

13 And the -- the thought process
14 behind this has to do as much with distribution of
15 pediatric resources as anything else. It turns
16 out that the pediatric resources are reasonably
17 well distributed throughout the city, at least
18 insofar as where the children are.

19 We have expert assistance -- Dan
20 Moranus from the New York City Department of
21 Health has been an outstanding mapmaker and has
22 been able to map both population in terms of zip
23 code of residence, and a primary school of where
24 the kids are, and comparing that to the location

1 of pediatric healthcare facilities. The match is
2 actually fairly good, far better than we actually
3 expected. The distribution of trauma centers,
4 however, is not quite so robust. So the thought
5 process has been that since every comprehensive
6 pediatric care facility does have access to a
7 pediatric surgeon, that in times of major
8 disaster, we would, in effect, treat comprehensive
9 pediatric facilities more or less the same with
10 the understanding that, whenever possible,
11 seriously injured kids would go to the trauma
12 centers.

13 But it's more important at the
14 particular moment in time to get them to hospitals
15 that knew how to care for kids. I think that it's
16 possible that we could plan a brief presentation
17 on how that system would be laid out at our next
18 meeting, but I think it's -- it's food for thought
19 on how we might want to proceed in terms of our
20 own regionalization scheme, particularly in light
21 of the comments that Dr. van der Jagt just made,
22 indicating that the same concentration of
23 resources that's necessary to care for seriously
24 injured children is also necessary to care for

1 seriously ill children. So those are the two
2 developments that I thought were relevant to this
3 discussion.

4 But now an observation. It is very
5 clear that regionalization and inter-facility
6 transfer of pediatric patients are inexplicitly
7 linked. There already exists, of course, an
8 informal system for regionalization within the
9 state. The issue is one of formalizing it, but
10 formalizing it is important, because in the
11 formalization process, we're able to give guidance
12 to the system as to which patient should be
13 transported under what circumstances and also to
14 identify the resources necessary to conduct those
15 transports. That is really the glue -- an
16 inter-facility transport system is really the glue
17 that holds together any system of regionalization.

18 And so the inter-facility transfer
19 guidelines that both the feds and this committee
20 have committed to developing really have to go
21 forward part and parcel, as Bob Kanter has said,
22 with a system for regionalization. So to that
23 end, I wanted to ask Dr. Morley, at this point,
24 since he was able to clear his calendar to be with

1 us, if he could give us his thoughts, recognizing
2 of course that these do not necessarily officially
3 represent the viewpoint of the department at this
4 moment.

5 DR. MORLEY: Thanks, Art. We're
6 early enough in the process that we're really
7 without significant opinion at this time whether
8 there is a significant interest in finding out
9 what the recommendations are, what it's based
10 upon. There's a real interest in quality
11 improvement and safety in the department. I think
12 that's some of the energy and some of the momentum
13 that's going to carry this forward.

14 This, very clearly, is an issue that
15 relates to improvement in quality and safety in
16 the healthcare system. So until we get further
17 recommendations, we're sort of open to just about
18 any thoughts.

19 DR. COOPER: Well, that's great
20 news. And I know of no other group that would be
21 more able or willing to provide those
22 recommendations than this one.

23 DR. MORLEY: Same here.

24 DR. COOPER: So I think at this

1 point, I'll leave it open to Elise and Kathy as to
2 how we proceed this morning in terms of further
3 discussion regarding either the documents or the
4 process. I know you did have an opportunity to
5 discuss this at the meeting before this one.

6 DR. VAN DER JAGT: If I could make a
7 comment about this. Given, I think, Sharon
8 Chiumento's very appropriate comments that no one
9 else has seen these transfer guidelines document
10 that Bob Kanter has developed, it seems to be one
11 of the things we should do, at least, is
12 distribute them to the committee for additional
13 comment.

14 I would also want to make sure that
15 I give Sharon Chiumento some credit here. She was
16 actually -- I was not here at the last meeting,
17 but she was actually able to be here and chair the
18 sub-committee and really got us on -- to look at
19 the documents and make sure we were where we were.
20 Am I right, Sharon? So I think I'd like to
21 correct myself previously and thank Sharon
22 Chiumento for being the interim at the last
23 meeting.

24 MS. CHIUMENTO: I was just the force

1 behind things. Bob did all the work.

2 DR. VAN DER JAGT: All right. But
3 you were the coordinator then. And the only
4 reason Sharon was not part of our committee
5 discussions this morning was she was pulled over
6 to the education committee.

7 But anyway, I think the
8 recommendation I would make is that we distribute
9 these guidelines or documents to the rest of the
10 members and that you comment on them and please
11 get comments back to Martha. Would it be best to
12 have it come back to you, the comments on this
13 document?

14 MS. GOHLKE: Sure.

15 DR. VAN DER JAGT: That might be the
16 easiest, to have one central person to collate
17 them. And if you could use a tracking instrument
18 to put the comments in, that would be, perhaps,
19 the best way to do it.

20 MS. GOHLKE: I can also send it out
21 electronically, and if you know how to use the
22 tracking function yourself, it will automatically
23 do that. But if you don't, just send your
24 comments to me and I can put them in.

1 DR. COOPER: Bob, does that work for
2 you?

3 DR. KANTER: Yes. That's great.

4 DR. COOPER: Okay. Great.

5 DR. VAN DER JAGT: I think, also
6 then, what would happen is that when we meet with
7 Dr. Morley, a number of us in this committee and
8 perhaps a few others, that we have a document to
9 read in front of us, a draft. It would not have
10 been voted on or anything, just a draft. And we
11 have people's input that we could bring to that
12 meeting.

13 DR. COOPER: Good.

14 DR. LILLIS: The only other comment
15 that I would add is I do think we need to move
16 forward. The fall will be here before you know
17 it. So I would get a push to try to get a
18 planning meeting on the calendar as soon as
19 possible.

20 DR. COOPER: Right. I was just
21 going to suggest that we do that. That will
22 necessitate our having, I think, a fairly complete
23 draft before that meeting. I would anticipate
24 that a planning meeting with Dr. Morley might

1 happen before the Labor Day weekend. That's going
2 to mean that folks are going to have to review the
3 document, get their comments back to Bob through
4 Martha, really by August 1st, so those comments
5 can be included.

6 And it might be possible - I don't
7 know, Mr. Wronski and associates - if this would
8 work, but I know we do have EMS meetings for the
9 week before Labor Day. It might be possible to
10 try to squeeze a meeting in at the same time so
11 that we most appropriately utilize everyone's
12 resources.

13 MR. WRONSKI: We could -- here is
14 one of the keys, and I do believe that the
15 committee as a whole all have to send comments to
16 Martha and the chair regarding suggestions for
17 planning the fall meeting, but the actual meeting
18 we'd like to limit to six, seven people at most so
19 that we can arrange it. The more you invite to a
20 meeting, the more difficult it is to set on a
21 date.

22 And what we're hoping to do is that
23 representatives from the EMS committee who
24 participate in this would have already had

1 feedback from the larger committee so that you can
2 come to the meeting with Dr. Morley and Lisa
3 McMurdo and work out some details and get the
4 department's perspective on what an agenda should
5 look like and then we'd move ahead.

6 But my recommendation to this
7 committee is that that particular group that would
8 meet with Dr. Morley and Lisa be a small group,
9 but that the committee feed its information to the
10 small group so that everyone's heard. And then
11 the larger meeting in the fall, of course, would
12 be more extensive.

13 But as I see it also, I don't think,
14 necessarily, every member of the EMS-C committee
15 should be at the fall meeting, but if that's your
16 wish, then we'll try to arrange that. What we do
17 want to do is invite as many stakeholders as we
18 can to broaden the meeting's power. And I've
19 already spoken to the hospital association and
20 they've agreed to attend the meeting and send a
21 representative. And, specifically, I spoke to
22 Fred Heigel, who's one of their vice presidents,
23 and he commented that they're certainly interested
24 in this. Obviously they are because we're talking

1 about hospitals, so they'd be interested. And
2 that doesn't mean they say they want
3 regionalization, but it does mean that they're
4 very interested in anything that's recommended
5 about their hospitals and they'd like to be at the
6 table. So that's good.

7 And -- but we haven't formally
8 reached out to other groups at this point,
9 although we have some suggestions for who those
10 people might be. But the planning meeting would
11 finalize those recommendations, and we'd like to
12 hear from you, too.

13 DR. COOPER: In terms of proceeding
14 on a procedural level, my personal sense would be
15 that we would shoot to have the planning meeting
16 in late August or the very first week in September
17 before the Labor Day holiday. EMS-C meets again
18 on September 29th, and my own thinking, and this
19 would be subject to further discussions with Ed
20 and Martha, of course, is that we should probably
21 shoot for a time a little bit later in the fall,
22 because people are going to have to have an
23 opportunity to review the document ahead of time,
24 to set their calendars and so on. And I think

1 that it would be important to have the whole EMS
2 committee on board with the final plans, the
3 stakeholder meeting and so on, bearing in mind
4 everything Mr. Wronski said about an invitation to
5 the stakeholder meeting. It may not be necessary
6 for everyone on the committee to be there, but
7 certainly everyone on the committee does need to
8 have an involvement in signing off on the
9 planning, since this is such an important issue
10 for this committee. So I personally would be
11 thinking somewhere along the lines of the first
12 week in November for the stakeholder meeting makes
13 the most sense, and that would give -- that would
14 give us an opportunity for the planning meeting,
15 for the EMS-C meeting and lead time for people to
16 set their calendars. As Kathy's pointed out, the
17 summer will be here -- will be over before we know
18 it, and I'm willing to bet that most people have
19 their September calendars, at least the first
20 couple of weeks in September, already pretty well
21 set at this point, at least in terms of major
22 commitments. So subject to further discussion, of
23 course, with Ed and Martha and John, we will
24 proceed in that -- along those lines.

1 DR. KANTER: If I could just mention
2 -- it's Bob Kanter. I think -- I agree with that
3 thought. I think that one of the important things
4 that will add to our working draft is really
5 getting some more detailed feedback from decision
6 makers at the Department of Health, and I think
7 the pre-meeting in late August or September will
8 be very helpful to us because we can bring
9 together work done by other states and other
10 professional organizations well enough and we can
11 write a draft that reflects our understanding of
12 medical issues. But really, those have to be
13 implemented in a way that makes sense for New York
14 State, and I'm looking forward to getting some
15 guidance from decision makers in the Department,
16 which will make this much more meaningful and
17 something that could be presented for discussion
18 to outside stakeholders. And having a little time
19 to digest those suggestions from the Department of
20 Health would be helpful before we actually meet
21 with the stakeholders.

22 DR. COOPER: Great. Elise?

23 DR. VAN DER JAGT: I just wonder
24 whether it would be useful to have some contact

1 with the organizations that we are involved with
2 before we have the stakeholders meeting. I'm
3 thinking that the hospital stakeholders,
4 particularly, are not going to be able to
5 determine content. They're going to be able to
6 determine implementation and help in that process
7 and things, but in terms of are these -- like, for
8 example, are these the kind of kids that typically
9 should be transferred from one facility to
10 another, that kind of input. It would be nice to
11 get the endorsement of the professionals who deal
12 with those. So you're talking here about -- ACEP,
13 AMA probably -- I mean, some of the folks --
14 they're stakeholders, but they also have a lot of
15 input -- and rather than worry about that, if we
16 go to a stakeholder's meeting and we're looking at
17 the possible implementation of categorization, if
18 we don't already have some buy-in from the various
19 groups -- maybe I should put it somewhat
20 differently. If we have buy-in from these various
21 groups, our case would be made much stronger --
22 I'll put it that way -- than if we say, well,
23 we're not quite sure yet. And there are
24 questions. Does this represent the whole entire

1 pediatric community? If not, we haven't done our
2 homework and it's going to slow the process down.
3 If we already made those steps, then we can say,
4 look, we've run it by these various people.
5 They're all in agreement. This is the way we
6 really should do this. Then I think it is going
7 to be a lot easier.

8 DR. KANTER: You know, I think it is
9 worth mentioning that the AAP, specifically, and
10 sometimes in collaboration with other groups,
11 Society for Critical Care Medicine, as well as
12 ACEP, have already published very extensive
13 documents that deal with definitions of pediatric
14 hospitals in the emergency care, critical care,
15 trauma care. So I think you'd be talking to the
16 converted when we ask for any specific support or
17 sponsorship.

18 DR. VAN DER JAGT: The only comment
19 I would add to that is it is one thing to have, in
20 general, the ACEP endorsement. It's another thing
21 to say AAP folks in New York State stand behind
22 this document based on these guidelines. I think
23 there is a difference in implementation. So the
24 endorsement of guidelines, I think, by those who

1 are actually in this state might be a benefit
2 rather than a demerit, and even though we agree
3 with them, having it on paper is, I think, an
4 added benefit.

5 MR. WRONSKI: This is Ed Wronski,
6 Dr. Kanter. One of the steps that I had planned,
7 and to get permission from the department, is
8 prior to us finalizing a date, we do know -- as I
9 mentioned, I've already spoken to HANYS. What I'd
10 like to do is reach out to other major
11 organizations, some that you mentioned, and let
12 them know we are planning a fall meeting. We
13 don't have a date yet, but that we're giving them
14 a heads up would they have an interest in
15 participating. And give them the basis of what
16 led to this fall meeting, which is EMS white paper
17 and share with them that white paper and we would
18 make it. And I need to let the EMS-C committee
19 know this, the department has not endorsed the
20 white paper; it's permitted its committee to
21 develop it as part of the response to the federal
22 request that we do so here in New York. And the
23 department has agreed to a stakeholders meeting to
24 discuss these concepts and potentially others at

1 the meeting, but that we would share with key
2 people who are identified early that this is the
3 document that has lead to the discussions. They
4 would have time to digest that, too, and make
5 comments, but we would try as early as we can to
6 get commitment from ENA, from the pediatric and
7 ACEP community, to attend the meeting, as well as
8 a few others. We would probably agree to and
9 identify other participants at the late August or
10 September meeting, but even prior to that, reach
11 out to some of the other major organizations and
12 get their buy-in to this. And I think that it
13 would help give power to an eventual meeting in
14 the fall.

15 DR. COOPER: As we think about
16 finalizing the plans for the meeting or even
17 initiating plans rather than finalizing, I think
18 it's going to be really important that we have
19 access to whatever data the department may have in
20 its possession as to the numbers and patterns of
21 pediatric transport. Certainly, we can do that
22 with respect to trauma. I'm a little less certain
23 we can do that with respect to critical care
24 technicians, and we might need to work, perhaps,

1 through some of the pediatric critical care
2 directors throughout the state to get some
3 preliminary information as to transfers and so on.

4 But I'm reminded in this regard that
5 when the trauma system was first being put into
6 place, there was -- I'm not going to say
7 resistance, but some acida on the part of hospital
8 CEOs, primarily from rural areas, that they might
9 be losing significant numbers of patients,
10 particularly revenue-generating patients -- and
11 this by the way is no slight on rural hospitals.
12 We all know that fifty to sixty percent of the
13 bottom line of all rural hospitals is made up on
14 the basis of their operative volume, and to lose
15 even a single large operative case - you know -
16 can really have pretty significant detrimental
17 effects on their ability even to stay open at
18 time. So that's a real issue for the CEOs. But
19 what happened at that particular point in time is
20 that Dr. Larry Motley, who was then senior medical
21 advisor for emergency medical services to the
22 department, was able to work with the statewide
23 planning and research cooperative system, or
24 SPARCS, and to demonstrate that even in the most -

1 you know - even in the busiest rural facilities,
2 it was rare to transfer more than one or two
3 patients during an entire year, such that the
4 impact on the financial bottom line was really
5 nowhere near so great as many of the rural
6 hospital CEOs perhaps had thought, and that was a
7 significant factor in convincing the hospital
8 associations to support rather than oppose the
9 development of the statewide trauma system.

10 So I really do believe that to
11 whatever extent we can develop data on the actual
12 numbers and patterns of pediatric transfers
13 involved, such data would be really invaluable in
14 helping us work toward a system of zero as opposed
15 to mere de facto regionalization as we have right
16 now.

17 So Bob, I'm going to sort of invite
18 you and the inter-facility transport group to sort
19 of think through what simple data might be
20 obtainable from the department. I think your
21 studies have demonstrated - you know - that such
22 data is attainable and you may have greater
23 expertise than almost anyone in the room or the
24 department in terms of running this data. But I

1 think it's going to be important for us to gather
2 it and present at the -- at the stakeholder
3 meeting.

4 DR. KANTER: I think that the work
5 that I've done mostly from the SPARCS database is
6 now several years old, but is probably the
7 compelling set of observations for New York State
8 that shows that there are some improvement
9 opportunities. It also shows that there may be
10 differences in how the system of transfers works
11 in New York City versus upstate. I think to go
12 beyond that would be difficult.

13 The SPARCS data are not available
14 until a couple of years after the data are
15 collected. I don't know of any other set of data
16 that's available that address these issues to
17 begin collecting new data in a new format would
18 really not give us information for a couple years.

19 So I would be certainly happy to
20 summarize in whatever form you want to the
21 existing observations, and in fact, they're
22 outlined in the white paper. And I take any
23 suggestions or guidance that anybody can give me,
24 but I don't know of any other sources of data that

1 are available.

2 DR. COOPER: Yeah. I wasn't
3 suggesting, Bob, that there were necessarily any
4 other sources of data, but as you pointed out, the
5 data that you collected is now at least a few
6 years old and if there were some way of looking at
7 that on a more contemporary basis - you know -
8 just in a snapshot sort of way, recognizing the
9 fact that staff time is extremely limited in this
10 day and age, that that might be useful. But I'll
11 leave that to you and your group.

12 DR. KANTER: Sure.

13 MR. WRONSKI: This is Ed Wronski.
14 I'll put Louise on the spot. When is the latest
15 SPARCS data expected to be available as a complete
16 set to SPARCS? Right now, it's --

17 MS. FARRELL: 2007 is available.

18 MR. WRONSKI: 2007 is currently
19 available?

20 MS. FARRELL: Yes.

21 MR. WRONSKI: All right. So I don't
22 know, Dr. Kanter, when the last run you did of
23 SPARCS was, but right now, 2007 is a complete data
24 set. So if that's not part of it, we might look

1 at that. I can tell you that in the Department --
2 in the Bureau of EMS, we just received a final
3 data set for EMS runs, which is 2007 also. And in
4 house, I have someone who can manipulate that
5 data. It has certain limitations, but it can
6 certainly say where are children going and we can
7 do some runs there.

8 Maybe in conjunction with looking at
9 SPARCS and then EMS-C data -- I mean, the bureau's
10 EMS data, and then also I can have a conversation
11 with FDNY EMS in the city and they have very
12 contemporary data. Literally, they can tell you
13 what happened yesterday in the system from an EMS
14 perspective. Although there are limitations, the
15 transfer cases would not be within their data.
16 They would only have the 9-1-1 data. But that has
17 a sort of usefulness, where are kids who are
18 experiencing emergencies going as a first hand?
19 They would not, in their database, be able to say
20 where they transferred to later or how many of
21 them needed to be transferred out. We'd have to
22 see if we could figure that out in another way.

23 But those are three things to look
24 at right off the top of my head and we can see if

1 there are other data sets out there within the
2 Department that are already in existence that
3 might tell us something.

4 DR. VAN DER JAGT: One other area of
5 data might be the mortality data, the death
6 certificate data. I don't know how that is
7 collated currently. When I was using it, it was
8 all manual; there were almost no computers. That
9 was a long time ago. But I would think that now
10 -- I think that -- I wonder whether now, at least,
11 if there is any better way that that data could be
12 collated. The reason I mention that is if we are
13 looking at, particularly, mortality in
14 non-pediatric facilities, then that might suggest
15 that there is a need to really refine this process
16 of transfers as a first cut. Again, I don't know
17 what's available, but that's another database.

18 The second potential database might
19 be -- part of what we're seeing is -- I believe
20 every pediatric transport team probably keeps a
21 database where they're transporting from, what
22 kinds of diagnoses they are. We certainly have
23 that here at Strong, Buffalo, Syracuse. Downstate
24 - I don't know what's down there. But that data,

1 although it is the top of the data, these are
2 patients who are actually transferring by a
3 pediatric specialty group and there are diagnoses
4 attached to them. And so that might be another
5 resource we might want to consider to use as a way
6 of saying, These are the kind of patients we're
7 talking about. Again, I'm just thinking off the
8 top of my head here and it's not well thought
9 through.

10 DR. COOPER: Great. I think we
11 certainly have developed, or shall we say, cooked
12 a lot of food for thought here for the planning
13 toward regionalization and inter-facility
14 transfer. I think we got a lot of really great
15 ideas as to how to proceed. It's shaping up, I
16 think, to perhaps be a busier summer than any of
17 us anticipated in terms of getting this off the
18 ground. But - you know - that's life in the fast
19 lane, so we'll move forward and we'll get that
20 done.

21 Unless there are any further
22 comments about this issue, I'd like to move the
23 agenda, because we still have a fair amount of
24 business to transact. Good. It is now 12:07. We

1 can expect lunch to be here in relatively short
2 order, so I don't really want to get involved in
3 another lengthy discussion at this point, but
4 rather I'd like to proceed and deal with some of
5 the housekeeping issues -- or, not housekeeping so
6 much, but some of the briefer agenda times that we
7 may -- we may not get to if we don't get to them
8 now.

9 I'll begin simply by noting that
10 Kathy Lillis and I have been working together over
11 the last couple weeks to begin to identify some
12 names of individuals who might fill the empty
13 chairs around this table, and we identified one
14 really solid candidate for two of the positions.
15 And these are candidates who, I think, the
16 Governor would be pleased to learn are of a
17 diverse background and will help us, not really in
18 terms of diversity, but really in terms of
19 extraordinary expertise these individuals have
20 brought to the state and could bring to this
21 committee. The trick will be getting them to say
22 yes, but I think in one case, perhaps two, we have
23 a tentative yes. The tough one is trying to
24 identify pediatric psychiatrists. We are working

1 on that one, but no solid leads as yet. So Kathy,
2 did you want to add anything to that?

3 DR. LILLIS: No.

4 DR. COOPER: Okay. Sharon, Are you
5 prepared to give a brief report on the education
6 committee or do you want to defer? Ann, do you
7 want to --

8 MS. CHIUMENTO: We kind of
9 co-chaired this morning.

10 DR. COOPER: Okay.

11 MS. CHIUMENTO: Since I was coming
12 in cold, I had Ann to stand in. But I can tell
13 you, the thing we were looking at was the EMT-I
14 refresher. There was some concerns that there
15 wasn't any in the very early versions of EMT-I
16 refresher and people were able to drop out. When
17 I went back and looked this morning, I actually
18 discovered there is still some EMT-Is. Almost all
19 of them are related to airway, airway management,
20 they're not separated out. They're kind of hard
21 to find. They are buried within all the other
22 skills, pediatric versus adult in airway types of
23 issue rather than being specifically a pediatric
24 component. So we talked about that. We don't

1 have a total conclusion yet. It looks like it's
2 not going to be as big an issue as we originally
3 thought. We do have a couple of ideas that we
4 would like to explore a little further.

5 DR. COOPER: Great. I think one of
6 the issues that, at least, I was hoping we would
7 focus on, in addition to the prehospital
8 component, is the readiness of the system, in
9 general, for pediatric care, pediatric emergency
10 care in particular. And this, I think, is going
11 to come to the fore, at least in part, during our
12 discussion about the pediatric trauma regs, but it
13 certainly has come to the fore in New York City
14 during our discussions about disaster
15 preparedness.

16 Two thoughts of note that have just
17 really emerged in the last few months -- last few
18 weeks, really, I should say, the planning in and
19 around the disaster capability in New York City
20 had primarily been focused on PICU beds and the
21 ability to surge those resources in time of need.
22 To that end, in addition to a regional triage
23 plan, a regional surge plan is being developed.
24 And the new society of critical care medicine,

1 pediatric fundamental critical care support
2 course, has been taught to a cadre of intensivist
3 instructors whose responsibility it will be to get
4 that out to the community at large in case
5 non-pediatric hospitals rush and say non-pediatric
6 intensive care unit hospitals are first in the
7 service to provide some interim intensive care
8 before kids can be transferred to larger hospitals
9 with more extensive PICU capability. But during
10 the last few weeks, what we have seen, of course,
11 with the H1N1 pandemic affecting our facilities is
12 that we have not really thought through the issue
13 of ED surge as well as perhaps we could have. And
14 that is something we're going to have to focus on
15 and what sort of training do individuals who are
16 working in non-pediatric facilities have in terms
17 of readiness of pediatric care.

18 We all know, of course, that our
19 emergency medicine colleagues do receive extensive
20 training in pediatrics during residency, but of
21 course if one takes a position in a hospital that
22 does not admit children, those skills can get a
23 little rusty. And at the same time, we have large
24 numbers of nursing colleagues and physician

1 extender colleagues who may never have had any
2 kind of in-depth training in the management of
3 pediatric emergencies. So is it possible that
4 something more extensive or more in depth,
5 something, for example, like the advanced
6 pediatric life support course which is put on by
7 the AAP and ACEP - you know - might be of use.

8 So I think as we think these issues
9 through, I think we want not simply to limit our
10 thought process to the pre-hospital environment,
11 but also focus on the in-hospital environment.
12 And, of course, to finish this line of thought,
13 we're all aware that our nursing colleagues have
14 developed an outstanding course for emergency
15 management of children known as NPC, which is
16 available through ENA, the emergency nurse's
17 association, which is largely a self-learning type
18 of program but an outstanding resource for
19 readiness for pediatric emergencies. Given the
20 fact that we're all preparing ourselves to respond
21 in case of a disaster is now potentially including
22 world-wide pandemics. Some of the issues, I
23 think, are becoming a little more current than
24 they might have been a few minutes ago, so I'm

1 hoping, Sharon, as your committee works through
2 the pre-hospital issues that some thought is given
3 to physician and nursing training, particularly
4 for non-pediatric facilities, as well. Elise?

5 DR. VAN DER JAGT: Yes. I totally
6 agree with that line of reasoning. I think that
7 we need to look at the entire system of care,
8 rather than just pre-hospital or emergency
9 medicine. I think one of the key issues for this
10 is that there is an excellent ability to accept
11 pediatric patients, whether -- and perhaps need to
12 go to another center. So the child who comes
13 into, whether it's the doctor's office or
14 emergency room or whether the child is
15 hospitalized in a rural hospital, like where I am,
16 rural hospitals where there is relatively limited
17 experience at the institution. The ability to
18 assess that patient and say this kid cannot be
19 here. This kid needs a higher level of care.
20 There are --

21 I would ask that the education
22 committee look at some of the venues that are out
23 there to educate physicians and nurses who are in
24 many of these places. You mentioned already, Art,

1 some of the courses. There's EMT courses.
2 Certainly there's a trauma equivalent to that for
3 nursing.

4 But also another thing -- one course
5 that's come out more recently is PEARS. And PEARS
6 is designed specifically for those who are not
7 experts in pediatric care, but who are in a
8 position where they are going to have to assess
9 whether or not that child needs more than they can
10 give by themselves or even in the rural hospital.
11 That course is put out by the American Academy of
12 Pediatric Physicians. PEARS stands for Pediatric
13 Emergency Assessment Resuscitation and
14 Stabilization. That means that sort of in the
15 first five minutes, look, this kid needs more
16 help. This kid needs oxygen. This kid is in
17 respiratory distress that we can't manage here.
18 Who do I call? How do I put a monitor on it? And
19 then, how do I make communication with the next
20 level of care? Courses like that might be
21 considered as being useful in upgrading the
22 educational ability or the ability of people who
23 are in non-pediatric facilities. And that's --
24 that particular course I am involved with. I'll

1 put my cards on the table. I am on the committee
2 that help put that course together, but it was
3 designed specifically for the non -- it was really
4 designed for those people.

5 DR. LILLIS: I'd just like to make a
6 comment. Some of the -- when we did some of the
7 work on the regionalization and looked at what
8 some of our colleagues around the country and some
9 of the different states have tied the education of
10 the providers to the regionalization level. So in
11 order to be at a certain level, the physician
12 working in that institution had to obtain
13 certification. So I think that's something to
14 keep in mind as we move forward, as well.

15 DR. COOPER: Great. All good
16 comments.

17 MS. GOHLKE: Dr. Cooper?

18 DR. COOPER: Yes. Please.

19 MS. GOHLKE: Going back to the EMT-I
20 curriculum. One of the things that I talked about
21 with the sub-committee from this point on is if we
22 do get to the point of revising what's there and
23 adding to it, one of the comments that was
24 suggested was -- is this is the refresher

1 curriculum that they do every three years? And
2 most of the pediatric instruction that they get
3 was in the basic course, so it makes sense, as we
4 talked about, to maybe do a refresher on what's
5 covered in the basic course in the refresher
6 EMT-Is. At least they're getting refreshed on
7 that basic level information, at least a portion
8 of it.

9 And the other point was the SEMSCO
10 education and training sub-committee is also
11 comparing, given the new national curriculum, to
12 make revisions, or recommendations for revisions,
13 for our curriculum. And if it's possible for
14 either Tim or Sharon, who usually comes to the
15 SEMSCO meeting, to at least stay in the loop of
16 what education and training committee's doing so
17 that we're not overlapping, and obviously, I'll be
18 a part of that, too. But if it's possible to jump
19 in on that committee, when possible.

20 DR. COOPER: Great. Thanks, Martha.

21 MS. CHIUMENTO: There is one other
22 point.

23 DR. COOPER: Please.

24 MS. CHIUMENTO: And it is something

1 that I thought of after -- and that is I went back
2 and looked at the CME content, and that required
3 two hours of pediatric, so I think that we
4 probably need at least a minimum of two hours in a
5 refresher course if it's required in the core
6 content classes.

7 DR. COOPER: Good.

8 MS. GOHLKE: And that's one of the
9 things -- actually, my grant wants us to qualify
10 the hours that is required. So keep that in mind
11 with the revisions. If we can quantify it, that's
12 great. Because it's hard when it's buried to
13 prove that it's covered and how much time is being
14 devoted to it.

15 DR. COOPER: Good. Elise?

16 DR. VAN DER JAGT: Could I make a
17 comment again around the physician nurse
18 education? I'd like to make a motion that the
19 education committee formally look at some of the
20 needs that the -- particularly the hospitals have
21 with regards to their education around pediatric
22 urgency problems. That they also assess what is
23 available that might be recommended to them for
24 improving their education quality, and thirdly,

1 that they would give some thought to the process
2 whereby something like that might be implemented.

3 And I think as we're having these
4 discussions about involvement of hospitals in
5 inter-facility transfer guidelines, is there a way
6 to bring the hospitals in the community into this
7 educational endeavor, because by and large, we are
8 talking about hospital employees who would need to
9 have education and experience. It is expensive to
10 have courses, it takes time, there needs to be
11 buy-in, and in some ways it's a lot easier to do
12 it in the EMS community, but we need to make sure
13 -- we have to have the hospitals on board if there
14 is going to be education at that level. There are
15 a lot of variables.

16 So the education committee should
17 give some thought to how that process -- or how to
18 start that process. So again, three points. One
19 is the need; two, what are the possibilities for
20 taking care of that need; and thirdly, what is the
21 process.

22 DR. COOPER: Is there a second on
23 that motion?

24 DR. LILLIS: Second.

1 DR. COOPER: Moved and seconded by
2 Doctors van der Jagt and Lillis.

3 MS. CHIUMENTO: One question before
4 we vote on it, and that is, do we have any ability
5 to then move our recommendations forward? In EMS,
6 we have a much more easier pathway and we have
7 some authority that we can look to. I'm not sure
8 whether that exists, and you'll have to tell me,
9 because I don't know.

10 DR. VAN DER JAGT: If I could
11 respond to that, Sharon. I think that that's
12 precisely where I want to go with this. The third
13 point is to get across that process. If we have
14 to talk about this process, then I think that,
15 again, it goes back to people like Dr. Morley to
16 try to figure out how do we do this. What's the
17 process for this? I think too long it has been
18 that all we are doing is EMS, EMS and ED. But it
19 is an entire system, and if we don't take this
20 opportunity to develop the system and bring in
21 those stakeholders, it will never work. You're
22 going to be left out with it.

23 So even though we may not have
24 authority over what the process is, I would like

1 very much to have the education committee begin to
2 work with that process, give it your best shot,
3 put in your ideas in, bring it back to this
4 committee. It will take time.

5 DR. COOPER: Again. It's been moved
6 and seconded by Doctors van der Jagt and Lillis.

7 DR. AMLER: Do we need a motion
8 before --

9 DR. COOPER: I was just going to
10 open it up for further discussion. I do have one
11 thought on this. Well, really, two.

12 The first is that any system of
13 regionalization, first, has to be recognition.
14 Without the education recognition, it may be
15 difficult. So education is really part of the
16 entire regionalization thought process. So I
17 think that it may be worthwhile -- Bob, you may
18 not want to hear this, but I think it may be very,
19 very useful if the inter-facility document be
20 complimented by an education document, nothing
21 extensive, but just a very brief review of what
22 courses are out there and which programs we think
23 might be appropriate at which level as a companion
24 to that because that's a key component to any

1 regionalization plan. And I think for us to fail
2 to take the opportunity to discuss this with our
3 stakeholders if we're having a statewide
4 stakeholder's meeting, I think would be, without
5 any doubt, a lost opportunity. So I'll ask you to
6 work with Bob in terms of figuring out how that
7 might be done.

8 I think in terms of the
9 inter-facility document per se, it may be nothing
10 more than referencing back and forth between the
11 documents. I think creation of a short piece on
12 how education might help to support this
13 regionalization might be very, very useful.

14 DR. KANTER: You know, educational
15 components in New York State have been an implicit
16 and very important part of regionalization
17 systems. The best is for perinatal
18 regionalization, but I think there is certainly
19 some of that for trauma and other of the
20 well-developed regional systems. So it fits very
21 well. I'm not sure it should go in the transfer
22 guidelines, but certainly in any kind of formal
23 regionalization.

24 DR. COOPER: One other comment in

1 this regard, and Mr. Wronski may or may not
2 remember this, but as long ago as about fifteen
3 years, we had a meeting together with Mr. Olsson
4 and Mr. Michelin, and later a followup meeting
5 with Mr. Olsson and Dr. Motley, regarding the
6 issue of PALS training, which are -- which is, of
7 course, included as a requirement for pediatric
8 trauma centers but not for general hospitals,
9 whereas if one is not trained in emergency
10 medicine, we require HLS and ACLS at least as a
11 minimum standard of physicians working in
12 emergency departments and emergency services. You
13 know. And the issue then was why are children
14 excluded from that mix, because children's issues,
15 of course, are not covered in any great extent at
16 all in HLS and they're not covered at all in ACLS.

17 So that's an issue that has been on
18 the table for at least that long, and I don't
19 think that it's tenable for us to move in the
20 future into this new millennium here without
21 making equal provisions for children in our law
22 with respect to resuscitation education. Any
23 further comments on this -- on this motion?

24 DR. KANTER: My only other thought

1 is that real capabilities in this area, I think,
2 depend on experience. And courses are good for
3 maintaining skills, but I think if you compare
4 what happens in New York State emergency
5 departments, for example, with what you hear from
6 colleagues around the country, given that there's
7 a much larger number of emergency medicine, even
8 if not pediatric emergency medicine certified
9 people staffing ERs in New York State compared
10 with other states, the level of care is really
11 dramatically better. And it's anecdotal, but it's
12 consistent. When you talk to people in some other
13 states referring to pediatric hospitals, the
14 stabilization in the community hospitals is quite
15 good in New York State ERs compared with other
16 states.

17 So I'm, of course, in favor of
18 adding to educational experience and practice
19 through drills and courses and whatnot, but I
20 think requirements for board certification in the
21 pertinent fields is a necessary part of really
22 good capabilities.

23 DR. COOPER: Bob, I don't think
24 anybody disagrees at all. I think it's an issue,

1 once again, of insuring that there's at least a
2 modicum of the ability to recognize that so that
3 children can be transferred to the very
4 individuals that you so accurately recognize are
5 the backbone of the pediatric care system.

6 Mr. Wronski had a comment and then I
7 think we need to close this out for the moment.

8 MR. WRONSKI: There was some
9 question as to what is the authority of the EMS-C
10 committee. Its main authority is that you are a
11 seated body of experts in pediatrics, and as a
12 group, at any time, you can make recommendations
13 to the Commissioner about a certain topic,
14 whatever that may be. And that's your authority
15 and power, because you send forward things as a
16 group. I.

17 T's also possible as part of that to
18 make a recommendation after you do some study.
19 You know, what kind of courses are out there?
20 That's been mentioned by a number of people at the
21 table. What kind of training is available? Who
22 should take that training? And those are things
23 you can put together as advice. It doesn't have
24 to be a mandate, but some of the smaller hospitals

1 may or may not know what the newest information is
2 out there, what the newest courses are, where they
3 would seek that information and we could certainly
4 provide them that in a document that says, As you
5 care for kids, these are programs that would be
6 available to your staff if you want to make it
7 available to your staff and here's how you do it
8 and here's what that course does. Yes?

9 MS. ROGERS: I think the
10 availability -- I know with nursing -- emergency
11 nursing and the availability of EMT-P, as you all
12 know, I think the crux of the matter is cost and
13 paying for these courses for nurses to take,
14 especially in the hospitals that have low
15 pediatric volume, because they don't see the value
16 of the dollar placed in education.

17 MR. WRONSKI: Right.

18 MS. ROGERS: And I think anything
19 that we propose should have some thought given to
20 how they would fund this and the value of
21 education for nurses.

22 MR. WRONSKI: I don't disagree. A
23 lot of the reasons that any given hospital may not
24 have nurses who are up-to-date in PALS, another

1 course, or EMT-P or PEARS would be in the cost to
2 the facility to fund that program and take the
3 nurse off the floor and put them in a room to take
4 that program. And so that varies. Susan?

5 MS. BRILLHART: One of the current
6 issues with all the budget cuts is that in many
7 places, the nursing education department has been
8 completely decimated. So the knowledge and the
9 experience that used to be there to put these
10 courses together isn't there, the bodies aren't
11 there, and I'm not sure how they're going to do it
12 right now. Hopefully, that will change again as
13 the funding gets better and they get budgets --
14 but right now, as I look around New York City,
15 what used to be a nursing education department of
16 fifteen is down to one or two.

17 MR. WRONSKI: Right. And that's --
18 that's actually something that, while I don't want
19 to hear it, I need to hear. And this committee is
20 a place to actually bring those things up that you
21 are visualizing and experiencing these issues in
22 your given regions, because things can change
23 dramatically.

24 Two years ago, anybody mentioning

1 that GM would be a bankrupt institution would be
2 scoffed at, and today that's a reality. So it's a
3 dramatic change, and this happens in medicine,
4 too. So although I agree with Dr. Kanter that --
5 and I've talked to my EMS colleagues at the
6 national meeting about their systems and what kind
7 of hospitals they have and training they have.
8 New York State does have, right down to the
9 community level, a better trained group of
10 professionals than many, many states. And that's
11 not - you know - saying that other states have
12 poor medical care. It's simply what they've
13 brought to bear over the years, and New York
14 State's brought a lot to bear and put in a lot of
15 requirements over the years. So we built a fairly
16 well structured system and a well trained system,
17 but it's going through changes right now that are
18 affecting that and we have to recognize that and
19 put something in place to make sure the training
20 continues. I -- in any event, I still think
21 there's a worth in putting documents together and
22 guidance and here's what you can do and maybe that
23 document can contain ways to do something in a
24 cost-effective manner, which would bring you to

1 regionalization. If you had regionalized systems
2 like you do in trauma, sometimes they can provide
3 a regional program run by, say, the trauma center,
4 which is offered to many of the community
5 hospitals. Rita?

6 MS. MOLLOY: I'd just like to say
7 that we, Jan, is working with the New York City
8 Association of School Nurses to bring a program
9 back to school nurses to train for pediatric
10 emergencies that she used to do as a three-day
11 course and she's going to skim it down to one day.
12 But we are finding more and more now with the
13 schools that we are giving very urgent and
14 emergent care for a steady period of time and kids
15 are coming in sicker and sicker and untreated.
16 You know. They're being allowed to use the school
17 nurse as if they were a free-standing health
18 clinic. And so to prepare the nurse to be better
19 able to deal with pediatric emergencies, I do
20 think it's an important piece in hospital care.
21 When you talk about communities, school nurses are
22 a key. When you look at who identified the H1N1
23 trend, it was the school nurse - you know - and it
24 was her heads-up identification of what's going on

1 that really led for people to look at that more
2 closely. So I think that when you look at
3 community resources and you look at education and
4 training, you have to remember that you have a key
5 resource in the school nurses that are out there
6 who see the kids first.

7 MR. WRONSKI: Thank you.

8 DR. VAN DER JAGT: I'd like to
9 comment on it. First off, the PEARS course
10 actually is also designed for school nurses.
11 That's just a side note.

12 The comment about -- from Susan is
13 very relevant, I think, and I think that now is
14 exactly the time that this group needs to bring
15 out a paper statement, whatever you want to call
16 it, about the really important need of education
17 being out there for nursing staff in situations
18 where kids can be recognized. And it's going to
19 cost some money, absolutely. But that's not our
20 purview. Our purview is this is necessary. And I
21 would venture to suggest that this really falls
22 under the broad rubric of quality and safety and
23 that's, I think, where it belongs. Education is
24 critical to that.

1 Nowadays, many places do simulations
2 in education, simulating difficult situations.
3 That is important for hospitals where they do not
4 routinely see patients everyday, and so pediatric
5 patients, the unusual event, the unusual situation
6 lends itself to the increase of education, so that
7 when it does come up, people respond
8 appropriately. That is something hospitals are
9 going to have to struggle with. They have to
10 figure out, how do you fund this? How do you work
11 with it?

12 And I do agree it needs to be rolled
13 into, in large part, to regionalization and
14 categorization. In the NICU, the neonatal model,
15 their regional centers, actually, are charged to
16 help with the educational efforts around
17 certification. That is rolled into the perinatal
18 network. Why can that not be also done for
19 pediatrics or seriously ill children? It is a
20 very peculiar situation.

21 But there are ways to do this, and I
22 would just ask, again, for a motion -- I would ask
23 that the education committee begins to look at
24 that third point, the process whereby that might

1 be implemented, and it might be in the form of
2 white paper or some point of recommendations. I
3 know we are just an advisory committee, but that
4 is where it has to start. Now I'll shut up.

5 DR. LILLIS: I just think that -- it
6 sounds like we have both committees now working on
7 it. I think the educational committee, as well as
8 the inter-facility, are working on it and I think
9 we both need to come together or on a conference
10 call, but I think we can both go back, do our
11 homework, and come together.

12 DR. COOPER: Okay. Lunch is ready.
13 There is a motion on the floor, which we have
14 discussed, I think, at great length. This might
15 actually be -- it's not the first motion, but
16 close. So I will ask Elise to very briefly
17 restate the motion for the record.

18 DR. VAN DER JAGT: The motion is
19 that --

20 COURT REPORTER: Please use the
21 microphone.

22 DR. VAN DER JAGT: I'm sorry. The
23 motion is that the education committee be charged
24 with, one, assessing the educational needs of

1 providers, other than EMS providers, regarding the
2 recognition and initial management of seriously
3 ill or injured pediatric patients. Two, that they
4 would develop a list of kinds of educational
5 resources that might be employed to improve the
6 knowledge and skills of providers. And three,
7 that they would develop an implementation process
8 whereby education can be brought to those
9 providers.

10 DR. COOPER: Is that motion clear to
11 everyone? Then I'd like to ask for a show of
12 hands. All in favor of the motion, please signify
13 by raising their hand. Nine in favor. All
14 opposed? One. Motion carries, nine to one.

15 Okay. Lunch is ready. Here's what
16 I would like to do. First, it is apparent from
17 the highly informed and timely comments from our
18 nursing colleagues that nursing, as an issue, is
19 something we have not paid nearly enough attention
20 to over the years. So I would like to ask our
21 nursing colleagues to caucus during the lunch
22 hour, or the lunch half hour, as the case may be,
23 as to how they think it might be best accomplished
24 to address the needs of nursing with respect to

1 pediatric emergency care in New York State. We
2 are all aware that, particularly in rural
3 environments, nurses are often the only pediatric
4 experts that are out there. And certainly that is
5 true in schools and certainly that's true in
6 foster care environments and many other venues, as
7 well. So I think some of our sister committees
8 within the bureau do have nursing councils or
9 nursing committees, and I think it would be
10 appropriate if we had one here, but I'd like you
11 all to figure out how that might best be
12 accomplished.

13 MS. ROGERS: Can I add one thing to
14 that?

15 DR. COOPER: Sure.

16 MS. ROGERS: There is another level
17 of care which is in great need of pediatric
18 education, and I think that's the urgent care
19 level, which is highly staffed by mid-level
20 providers, whether they be physicians assistants
21 or nurse practitioners. And with the growth of
22 the free-standing urgent care centers, I find
23 there is great need for pediatric education at
24 that level. And I don't know if anybody really

1 has thought of that or addressed it, but from the
2 kids that I see referred into the ED from some of
3 these areas, I think they warrant some thought as
4 far as their educational needs, as well.

5 DR. COOPER: Okay. Let's --

6 MS. ROGERS: I'll fix the world.

7 DR. COOPER: I think that's a great
8 suggestion, but I'd like to start with our nursing
9 colleagues for the moment and we can expand that
10 discussion into -- since you are all mid-levels, I
11 think we should expand that discussion through
12 your group. Okay.

13 What I'd like to do -- we covered,
14 actually, much of the detail on the agenda
15 already. What I'd like to do is have everybody
16 get lunch, take a few minutes to chat,
17 particularly our nursing colleagues, and when we
18 come back -- it is now, I believe -- oh my gosh,
19 12:45. Let's plan to be back -- is 1:15 too soon?
20 I think we are going to need the time. So let's
21 try to be back about 1:15.

22 I'll ask for Mr. Wronski and Martha
23 Gohlke to give their reports. I would then like
24 to consider the CARES letter, the letter regarding

1 the prehospital steroid use. Then I'd like to
2 move into the trauma regs, and last but not least,
3 consider the ambulance equipment list. That's a
4 lot of stuff to take care of before four o'clock,
5 but I think we can do it if we're efficient.

6 (Whereupon, a lunch recess was
7 taken.)

8 DR. COOPER: Okay. I'd like to
9 officially go back on the record now. And before
10 we actually get into discussing the letter from --
11 or the letter to the CARES foundation regarding
12 the glucocorticoid issue, I just wanted to comment
13 that at the last meeting of the State Trauma
14 Advisory Committee, we had a really outstanding
15 report from Ed Hannum - excuse me - regarding the
16 2003 to 2006 data set. And the report is quite
17 lengthy and so I won't ask Elise to recite it from
18 memory at this particular moment. But suffice it
19 to say that in comparison to national data, we
20 appear to be doing very well in New York State.
21 Our overall risk adjusted mortality rate in New
22 York State compares very, very favorably with
23 national data. We are somewhere around half to
24 two-thirds of the mortality in the rest of the

1 country, as I recall, and perhaps the best news is
2 that the risk adjusted mortality statistics shows
3 with a very, very few outliers throughout the
4 state, all of our trauma centers and non centers
5 that are included are performing very, very well
6 and achieving mortality rates based on the risk
7 adjusted mortality rates that one would expect to
8 receive based upon the risk adjusted mortality
9 rate. So, once again, it appears that the report
10 indicates the design of the system that -- that we
11 have adopted in New York State and I think that's
12 great news. Louise and Ed are finishing the
13 trauma report, the general trauma report, over the
14 next few weeks and then we'll be able to turn to
15 the pediatric trauma report and hopefully we'll
16 have a report on that at the next meeting.

17 Okay. I'd like now to turn to the
18 glucocorticoid issue. And as you remember at the
19 last meeting, I was charged with writing a letter
20 on behalf of the committee addressing the issue of
21 glucocorticoid administration. You'll remember
22 that representatives from the CARES foundation
23 were present with us last time and made a case for
24 inclusion of language in the protocols for

1 paramedics to be able to administer corticoid
2 steroids to patients in Addisonian crisis.

3 We held extensive discussions in and
4 around that issue, and the consensus of the
5 meeting, it seemed to me, was that we did
6 recommend the use of corticoid steroids, but under
7 fairly limited circumstances. I have gotten two
8 comments back from all of you, one from Tim
9 Czapranski and one from Bob Kanter suggesting some
10 slight modification of the language. Bob
11 suggested that the phrase "under the limited
12 circumstances described herein" be struck. He
13 felt that we made a strong enough case as to what
14 those limited circumstances were. And Tim
15 Czapranski suggested that we reword the phrase at
16 the end of the fourth long paragraph regarding
17 cost-effectiveness. And I, of course, will be
18 doing that -- will be doing both things.

19 And as you can see, we have before
20 us a letter from Richie Kanter, who's director of
21 pediatric emergency services at Upstate Medical
22 University supporting the use of this medication
23 in the pre-hospital environment. And I wanted to
24 really get your thoughts and hopefully your

1 approval to go ahead and send this letter to Mark
2 Henry, who's director of emergency medicine for
3 Stony Brook and also chairs the SEMAC.

4 MS. GOHLKE: Dr. Cooper?

5 DR. COOPER: Yes.

6 MS. GOHLKE: Not to reopen a can of
7 worms, but Debby Brown from the CARES foundation
8 has my direct line and calls me frequently on
9 this, and she knows that we're meeting today. And
10 one of the things that she wanted to emphasis, and
11 I told her I would relay, is that the patient
12 shouldn't necessarily be in decompensated shock,
13 and you said it in your letter here. What they
14 would like to see is that many times, the kids are
15 not at that point but they still need their
16 medication, and for whatever reason, the school
17 nurse or the lack of the school nurse or the
18 caregiver that's with the child at that time, for
19 whatever reason, doesn't feel comfortable
20 administering the medication and wants EMS to be
21 able to do that before they get to the point of
22 decompensated shock. So I'm just putting that out
23 there.

24 DR. COOPER: Thank you, Martha.

1 MS. CHIUMENTO: One thing that might
2 help with that is if we have a protocol for shock,
3 then it's perfectly fine for us to go call medical
4 control. Under the circumstances, it seems like
5 that would be the easiest way to address that
6 rather than saying all the different circumstances
7 that we might get. Just have it for the one thing
8 and then medical control could give us
9 authorization.

10 DR. COOPER: I think that the
11 discussion last time was really very, very much on
12 the mark of suggesting that all the other
13 treatments needed to be given first. Normally, we
14 teach that if the patient is not in decompensated
15 shock, that fluid administration is less of a
16 priority than support of airway and keeping the
17 child warm and stressing rapid transport and so
18 on. But if the committee wishes to so move in
19 that direction, that's fine. You will remember
20 that several committee members last time were
21 fairly clear that they felt that the corticoid
22 steroids should really be given only under the
23 circumstances of all other treatments being
24 administered first. But it's your call.

1 DR. LILLIS: I was extremely late
2 for the last meeting, so I wasn't really able to
3 participate. But I was hoping this would be a
4 little more liberal than what the committee has
5 decided. I think this is too rigid and too far
6 down. I think the goal should be to prevent them
7 from getting there, even compensated shock. If
8 they're in compensating shock, my recommendation
9 would be that they should be given glucocorticoids
10 if they are in compensated shock.

11 DR. VAN DER JAGT: Just a quick
12 question. I was not here at the last meeting. So
13 these are patients that have already been
14 identified as having risk for congenital adrenal
15 insufficiency?

16 DR. COOPER: Yes.

17 DR. VAN DER JAGT: It just seems to
18 me that if they've already been identified as
19 having that condition and knowing that it doesn't
20 take a whole lot to throw people into this
21 decompensated state, that we should be relatively
22 liberal about it. And I have to agree with Mark,
23 as well as Kathy. I think that decompensated
24 shock, that's next to cardiac arrest. You don't

1 want to get there. So at the minimum or maximum,
2 I guess, compensated shock or any shock state
3 would certainly be a criteria, but probably more
4 important is if there is any suggestion of any
5 instability in a child who has that diagnosis and
6 is on the steroids, that it should be able to be
7 given.

8 The other question, and I may not
9 have scanned this correctly, is this under -- is
10 it off-line or is it under direct medical control?

11 DR. COOPER: The way it is right
12 now, it's listed as a medical control option.

13 DR. VAN DER JAGT: Okay.

14 DR. COOPER: It could be made a
15 standing order, if you feel that that's important
16 enough.

17 DR. VAN DER JAGT: I would look to
18 the EMS providers to see what would be best.
19 Because if there is any problem with
20 communications by ALS with medical control
21 someplace where you can not communicate.

22 MR. CZAPRANSKI: I think that's
23 different, depending on what part of the state
24 you're in. In our area, it's not, but that's not

1 to say there aren't other areas that have that
2 prolem. As far as giving it, usually when someone
3 calls 9-1-1 for one of these patients, they're
4 already going to be in trouble --

5 MS. BURNS: One of the things to
6 note -- and I might have missed it in your letter,
7 but there are kind of two issues with regard to
8 this from last meeting. One was that the CARES
9 foundation wants all ALS ambulances across the
10 state to be carrying Solu-Cortef for this. We
11 know, having looked at it across the state, that
12 not all the regions are carrying a prednisone.
13 Most of it would be Solu-Medrol. It's not
14 universal across the state. Some regions have it,
15 some don't. So I kind of -- you talked about it
16 in your second to last paragraph about assisting
17 the patient or family in the provision of their
18 medication. What I'm unclear about is, is this
19 committee suggesting that Solu-Medrol and/or
20 Solu-Cortef be added to the ALS formularies across
21 the state? And the issue would be that it would
22 then end up having to be a regional conversation,
23 because the REMACs actually decide on what their
24 formularies are, and in fact, the REMAC in the

1 central New York area most recently removed
2 Solu-Medrol from their formulary because, in Dr.
3 Olsson's words, they just didn't use it enough and
4 it took so long to work. By the time the patient
5 got it, they were at the hospital, so they took it
6 out.

7 So it's two parts I'm not sure that
8 I'm clear on in terms of your letter. Is the
9 committee recommending the addition of these
10 medications to ALS formularies, and then B -- or
11 one and B, one and two -- two, are you suggesting
12 protocols to assist in the administration of the
13 medication?

14 MR. CZAPRANSKI: I read the letter
15 to suggest that, yes, it would be added in the
16 formulary, but it would be up to the individual
17 REMAC to approve regional protocols related to
18 their region. That's the way I read it, unless
19 I'm mistaken.

20 DR. COOPER: Again, this letter is
21 written based on the discussion points that I
22 heard at the last meeting. And if I
23 misinterpreted, please go back and correct me.
24 You all have copies of the minutes. But my

1 understanding, again, was that we all felt that
2 the primary treatments for shock were far more
3 compelling than the administration of corticoid
4 steroids and that we did not feel that
5 glucocorticoids or corticoid steroids should be
6 added to the formulary exclusively for this
7 purpose. If they were available within the region
8 for other purposes, they could be used for this
9 purpose. But that's what I heard from you all.
10 If you feel that that's not correct and if I
11 misread the sense of the group, please correct me.

12 MS. BRILLHART: I think that was the
13 sentiment expressed at the last meeting, but
14 actually seeing it on paper and reading it and
15 thinking about it -- we might have changed our
16 position a little bit and we'd be willing to
17 rethink it.

18 DR. COOPER: Well, SEMAC is meeting
19 next week. I would like to get this letter out to
20 them. Ann?

21 MS. FITTON: I think in most EMS
22 systems, if you cannot -- if you don't normally
23 carry a drug, there is not necessarily training to
24 support the use of another drug. What you say

1 here is there is no reason to prohibit ALS
2 professionals who are trained and authorized to
3 use certain equivalent drugs. I think that's the
4 problem right there --

5 DR. COOPER: And that particular
6 paragraph was meant to address primarily assisting
7 with hydrocortisone as opposed to
8 methylprednisolone and if they were presented with
9 that drug from the family. But I see your point.
10 I thought I had mentioned somewhere in the letter
11 that the training component needed to be
12 emphasized, but obviously it hasn't been
13 sufficiently emphasized.

14 MS. CHIUMENTO: And in another
15 circumstance, I had been looking at statewide
16 protocols. And in the protocols in particular,
17 there are about a quarter of the regions that do
18 not carry any steroid at all. The ones that do
19 almost always carry Solu-Medrol. I think there
20 were only two regions that carry Solu-Cortef.

21 The other thing is we really don't
22 have -- and correct me if I'm wrong on this, but
23 we really don't have mandated medications that we
24 have to carry at a BLS level. It's really up to

1 the regions. We have protocols that we follow
2 across the state, but there is not a specific
3 mandate that we have to carry a specific drug like
4 we do for equipment. So, you know, I don't know
5 we can go that direction. But I think we can
6 certainly make it an option for the regions to
7 utilize it.

8 And the other point about shock. I
9 think compensated shock would be fine. We talked
10 last time about shock, but I don't think we
11 specifically said compensated shock, at least that
12 was my recognition. So I can certainly see going
13 with at least early stages of compensated shock,
14 because I don't know that the education is out
15 there right now for them to recognize the rest.
16 They don't really know about the process that
17 well. They maybe learned about adrenal crisis in
18 their original paramedic training, and probably
19 have not repeated it since. To say you recognize
20 it and give it might be problematic. If they say
21 "I know how to treat shock" you're adding one more
22 possible option for this particular kind of shock.
23 Just a couple thoughts.

24 DR. LILLIS: That's the way I look

1 at it. This condition is a life threatening
2 condition, and if they don't get these
3 medications, they can die, very quickly. And that
4 time is up right now. For me, if a child is in
5 anaphylactic shock, you give him an epi. It's a
6 medication where the child's been diagnosed, the
7 child has the medication there. I think we need
8 to be stronger that we're going to be encouraging
9 all the regions to have some kind of corticoid
10 steroid. And I think it may be unreasonable at
11 this point to require them all to carry
12 Solu-Cortef. I think a recommendation to EMS
13 agencies that they carry some kind of
14 glucocorticoid for these situations, because I
15 think we have to keep in mind, this is life
16 threatening. These are not kids where there's a
17 question what the diagnosis is. There's a parent
18 there saying, My kid is adrenal insufficient.
19 This is a life-saving technique, and I think we,
20 as EMS providers, need to help facilitate that.

21 MS. ROGERS: I just have a question
22 about the availability of the drug. Kids who have
23 anaphylactic reactions carry epi pens themselves.
24 Is it available for patients with adrenal

1 insufficiency to carry their own?

2 SPEAKER: No.

3 MS. ROGERS: And why not?

4 DR. LILLIS: There is a kid -- and
5 when I talked to my endocrine department, they
6 said yes. They said all their families, over 200
7 families, they have meds at home and things like
8 that. The parents are instructed to give,
9 generally, three times the maintenance dose. The
10 problem is when they can't get -- when the patient
11 becomes to the point when they can't get their
12 oral steroids, they can't get an oral dose because
13 of issues with shock or something like that, then
14 they need an IV route.

15 MS. ROGERS: And it can't be IM.

16 DR. VAN DER JAGT: I agree that for
17 those patients, if they're in our endocrinology
18 department, they certainly do triple the dose, but
19 it's an oral dose. That's different than, I
20 thought, what we're talking about here, right?
21 We're talking here about control -- so the idea is
22 that the EMS provider is called and that
23 medication is critical to that child's wellbeing,
24 because without it, the kid may actually die.

1 MS. ROGERS: But that's why I'm
2 asking. Why is that medication not available to a
3 family to have to carry themselves for the child?
4 They carry epinephrine, and it's an injectable
5 medicine.

6 DR. VAN DER JAGT: I think it may
7 not be as relevant to this discussion, but if you
8 have adrenal insufficiency, do parents really need
9 to have an injectable form at home?

10 MS. ROGERS: That way it would
11 alleviate an entire system --

12 MS. GOHLKE: Our recollection -- Lee
13 and I were just chatting here, is that the
14 families do have the IM injection. If for some
15 reason either the caregiver panics or there's not
16 an RN in the school that can give it, there's
17 somebody backing up the school nurse who is not an
18 RN, so they can't give the IM injection. So they
19 want two things, basically. One is they want EMS
20 to be able to give the patients IM injections for
21 them in case the caregiver can't do it or their
22 backup. And, they would also like to see that
23 they carry it, as well, in cases where it's not
24 available on site. Our understanding is they do

1 have the IM injection in the home.

2 DR. VAN DER JAGT: So then my
3 question is that we should use the same criteria
4 that they recommend for injection of that drug.
5 Obviously, if they have it at home and the parent
6 can give it, there are certain criteria that they
7 tell parents. If you have this, this, this, this
8 this, then you really need to give this
9 medication. Why would ours be different? There's
10 might just be if the child is vomiting, is sort of
11 lethargic - you know - I'm not sure what's going
12 on. They have a fever. Just go ahead and give
13 them the IM injection. So now we're substituting
14 EMS for that for those providers or those parents
15 who feel uncomfortable giving it. But our
16 criteria, then, should be the same.

17 And I do think that these are a
18 little bit too strict. You know. Even shock --
19 these parents don't want their kids to be in shock
20 and they may feel they need to have that steroid
21 to prevent shock.

22 On the other hand, I'd also agree, I
23 think, that what you're getting at, Art, in the
24 letter -- by the way, thank you for doing that.

1 It's hard to sort these things out. But we also
2 don't want people to not pay attention to --
3 because in the absence of steroids for sure --
4 steroids also take some time to work. That needs
5 to be given. And so -- we want to make sure that
6 part is in there, as well.

7 DR. COOPER: I wish Bob Kanter were
8 here this time, because Bob was -- to say -- to
9 use the work strident, I think, would be to
10 understate the case. He was very, very strong
11 that this should really follow virtually
12 everything else.

13 I can see that - you know - that as
14 Susan pointed out a little while ago, we have a
15 slightly different group here this time who feels
16 differently.

17 DR. LILLIS: Could you explain to me
18 what his letter is saying today, because I'm not
19 --

20 DR. VAN DER JAGT: One thing -- I
21 forgot now.

22 DR. COOPER: Well, let me -- in
23 terms of practicality -- and this is why, by the
24 way, why I wanted it bring the letter back to you

1 all to review it before I sent it, because I had a
2 feeling it would be a little controversial, even
3 though I thought I had a pretty clear notion of
4 what the group felt last time.

5 What I'm hearing is that, as the
6 letter is written, it's too strict. I'm hearing
7 that we should not limit it solely to
8 decompensated shock, but should at the very least
9 allow administration in compensated shock. I'm
10 hearing that -- that the statement about
11 appropriate training for these medications in this
12 particular setting absolutely has to be included
13 as a first step before -- before it's
14 administered. Those are the two key changes that
15 I'm hearing, vis-a-vie what's on the printed page.
16 Are there other changes that need to be made?

17 MS. CHIUMENTO: Addressing Kathy's
18 point about these are kids with hypoglycemia and
19 nausea/vomiting, could we make that the
20 indication? If you have a patient who is
21 hypoglycemic, fits this problem and has altered
22 mental status, would that be sufficient to give
23 the drug? I don't know.

24 DR. COOPER: I'm open to your -- one

1 at a time, please.

2 DR. LILLIS: There is really limited
3 reason not to give this medication, and a patient
4 who is on these meds and they're having anything,
5 any kind of stressful thing where their adrenal
6 glands would normally be kicking in to deal with
7 it, whether it be fever or vomiting or even
8 sometimes extremely stressful situations, they
9 need this additional medication. It's not like
10 it's such -- it's a dangerous drug. It should be
11 really liberal use for it.

12 So I'm really -- when I first read
13 it, and I apologize. I wish I'd been there for
14 the discussion, because I came having -- I got
15 stuck in some other city last time and the
16 discussion was over by the time I got here. But I
17 talked to my pediatric endocrinologists and I
18 talked to different people in our community, and
19 we really felt, at least in Buffalo, there was
20 really no reason not to support the EMS community
21 in giving these kids this. And I understand from
22 the EMS community, there's a training issues,
23 there's a cost issue, and there's -- the kits that
24 the families have are very inexpensive. They're

1 like six dollars and they have a shelf life of
2 something like four or five years. It's not like
3 cost would be a huge thing.

4 I think education is going to be an
5 issue and actually getting these agencies to
6 provide it and actually carry it. I see very
7 little downside to supporting the use of this, and
8 I think it's lifesaving and I think there's a lot
9 of meds that we carry that have very limited use.

10 And how many patients do we really
11 see in anaphylactic, if you look at the whole
12 state? These are kids with a known disease, so I
13 would be in favor of really supporting it, and
14 with the limitation of not requiring it but do
15 everything we can to have the EMS community
16 support these kids getting the medication.

17 DR. COOPER: Elise? And again, I
18 can't stress enough how I need some specific
19 guidance into how this should be changed. I tried
20 to capture what I believed were the committee's
21 feelings, that we wanted to facilitate the
22 administration of this, but we wanted not to
23 neglect other fundamental treatments, as well. If
24 you think that -- that even limiting it to

1 compensated shock is too strong, then please say
2 that.

3 DR. VAN DER JAGT: I would -- first
4 of all, I would endorse everything that Kathy
5 said. There is virtually no negative downside to
6 giving one single dose. There is no side effect,
7 either hypoglycemic or hyperglycemic. There
8 really is not any major side effect of this
9 medication, so we need to be, I think, very
10 liberal under these conditions.

11 Second thing is, I think that the
12 criteria for when to give this needs to be
13 consistent with the CARES network, if that's what
14 it is, but there needs to be the same criteria
15 that endocrinologists apply -- that they give to
16 the parents, because if it is different, then
17 there are two standards of care, two different
18 standards of care. One is the parent and one is
19 EMS, but it's actually the same conditions. And
20 that makes no sense to me. So I think it does
21 need to be consistent with that.

22 And then the third thing is -- four
23 things. The third thing is that going back to the
24 question about shock, I think it should be more

1 liberal, likely fitting those criteria.

2 But the last thing is that we should
3 give the option to either give Methylprednisolone
4 or hydrocortisone. It doesn't have to be one or
5 the other, as long as the doses are okay. It
6 could be either one. It depends on what the local
7 folks have.

8 DR. COOPER: So suggest criteria in
9 addition to compensated shock. That would --

10 DR. VAN DER JAGT: Symptoms of
11 adrenal insufficiency.

12 DR. COOPER: Which symptoms of
13 adrenal insufficiency do you want to list, because
14 this has to be protocolized (sic) and trends to
15 EMTs and paramedics. So how would you say this
16 for our pre-hospital colleagues?

17 MS. BURNS: With all due respect, at
18 this point, you're not writing a protocol. So
19 what I would say, in terms of your letter to the
20 SEMAC, and you'll be there and you can elaborate
21 on it in person as well as Sharon and Tim, maybe
22 to simplify your letter, make it bullet points
23 that address the specific issues that EMS for
24 Children council committee supports this. Here's

1 why. These are the circumstances. We support the
2 administration of a corticosteroid, and SEMAC,
3 please consider this. That leaves them open to
4 bring it forward to the regions without -- without
5 some of the system and political issues, and you
6 converse about it.

7 DR. COOPER: When I suggested that
8 -- that I want language that could be included in
9 a protocol, I'm not meaning to suggest we're
10 writing that protocol. I am meaning to suggest
11 that we have to provide guidance to the SEMAC in
12 terms of our own views with respect, particularly,
13 to the pediatric patients so we can say --
14 because, you know -- we can, I think, make the
15 effective argument in terms of the pediatric
16 patients. I have no doubt whatever that our adult
17 colleagues are going to have their own views with
18 respect to adult patients and the system at large.

19 And I can tell you that when this
20 issue was presented to the SEMAC at large, it did
21 not receive a warm reception, which is in part, to
22 be very frank, why I brought it here, because it
23 was brought to the SEMAC primarily as a pediatric
24 issue, yet that's where it played it out.

1 And I do not believe that the SEMAC,
2 even now, is going to receive the suggestion very
3 warmly. So that's why I think our strongest case
4 here in terms of advancing this is to paint this
5 as explicitly as we can, not to write a protocol
6 for them but to suggest the circumstances under
7 which we feel, based upon our expertise, this drug
8 should be administered to children.

9 MS. GOHLKE: Can I just add? They
10 keep sending us the state of Rhode Island
11 protocols. That's ideal -- I guess they like how
12 it's presented there. They have included it in
13 there shock section, but what it just says is if
14 you have a child who is symptomatic for shock,
15 going into shock, and they have a medic-alert
16 bracelet or some documentation, then give the
17 Solu-Cortef. So again --

18 MS. CHIUMENTO: Actually, that's why
19 we decided to go that direction, because I
20 remember the conversation with SEMAC. They were
21 very low to do protocol specific for this and we
22 had to fit it into another protocol, and shock
23 seemed to be the place to put it. They are very
24 hesitant to develop individual protocols --

1 DR. VAN DER JAGT: I think that it
2 might be helpful to start out that fourth
3 paragraph, actually, by -- in patients who have
4 been identified by a bracelet to have adrenal
5 insufficiency or other conditions. That is no
6 different than the bracelet that you have for the
7 person who is diabetic. It doesn't mean to say
8 that you don't do an evaluation, but if you
9 already have that kind of patient, you treat the
10 condition that they have.

11 MS. GOHLKE: And that's what the
12 CARES Foundation wants. They don't want a whole
13 diagnostic procedure done in the field. They're
14 just talking about those patients that are known
15 to be -- that are presented with the documentation
16 or bracelet.

17 DR. VAN DER JAGT: And in those
18 patients -- and the second definition would be,
19 who show symptoms and signs of adrenal
20 insufficiency, and we can define what those are.
21 It could be shock. It could be vomiting. And
22 whatever the criteria -- there are a number of
23 criteria.

24 DR. COOPER: Right. I understand.

1 What I'm asking for now, because time is --

2 DR. VAN DER JAGT: And thirdly --
3 I'm sorry, Art. But thirdly is the issue of --
4 and considering that there is no negative
5 consequence of giving the dose. I think that
6 third one is very important when you're weighing
7 benefits versus risks --

8 DR. COOPER: Sure.

9 DR. VAN DER JAGT: -- and given the
10 fact that delayed treatment of congenital adrenal
11 insufficiency results in significant morbidity and
12 mortality. That is -- those four points, I think,
13 probably should be included.

14 DR. COOPER: Okay. So do you want
15 to restate your four points?

16 DR. VAN DER JAGT: Maybe that would
17 be better, rather than waste time here. Would you
18 mind --

19 DR. LILLIS: Could you wait maybe
20 forty-eight hours and then --

21 DR. COOPER: It's up to the -- it's
22 up to the committee. I had hoped we could get the
23 committee to sign off on it today so I could get
24 the letter out. And if we do that, we won't have

1 the committee all together to be able to sign off
2 on it.

3 And under the new rules, in order to
4 make official policy recommendation, we have to be
5 here discussing it. The writing of the letter is
6 secondary -- but to the policy conclusions -- but
7 the policy conclusions have to be reached here
8 today. Am I correct, Mr. Wronski?

9 MR. WRONSKI: What you need to have
10 done today is the generalized policy statement.
11 The details about how the wording is and what you
12 might add to it and specifics can be done
13 elsewhere, but as long as it follow -- yes, we
14 support this. This is how we support it and we
15 want to send this letter to SEMAC to do that.
16 Those would be the policy types of statement you
17 make.

18 DR. VAN DER JAGT: I have my four
19 points.

20 DR. COOPER: Sure. Let's have them.

21 DR. VAN DER JAGT: Number one, in
22 patients who are clearly identified as having
23 congenital adrenal insufficiency or a similar --

24 DR. COOPER: Sure.

1 DR. VAN DER JAGT: And given the
2 high -- and given the high morbidity and mortality
3 of delays in treatment or untreated congenital
4 adrenal insufficiency, and given the low risk of a
5 single dose of Solu-Medrol, it is recommended --
6 and I'm sorry, the fourth one was patients showing
7 symptoms of adrenal insufficiency.

8 DR. COOPER: So number one is
9 identify, number two is given high morbidity
10 mortality, number three, no morbidity mortality
11 for the treatment itself, and number four with
12 these conditions. That's fine. What conditions?
13 We go right back to that question. Which
14 particular conditions, other than compensated
15 shock, do you wish to list?

16 DR. KUS: Chris Kus, I'm a
17 pediatrician with the state health department. I
18 think the message of whatever is given by
19 endocrinologists is the same. And one suggestion,
20 and I don't know if they have it, but for
21 conditions related to the newborn screening
22 program, they have developed national ACT sheets.
23 Now, I don't know if that ACT sheet for this one
24 may have this, but that may be one place to look

1 at.

2 DR. COOPER: Okay. All right. I
3 have -- let's do this. First of all, does
4 everybody agree with Elise's four bullet points?

5 SPEAKERS: Yes.

6 DR. COOPER: Okay. All right. So
7 in terms of the fourth bullet point, the actual
8 symptomology, other than compensated shock, what
9 other conditions do you want to list? Because
10 again, our pre-hospital providers are going to
11 need to be able to recognize adrenal -- we're
12 asking them, in effect, to recognize Addisonian
13 crisis in the field in a patient that's got --
14 that's wearing a bracelet.

15 DR. LILLIS: I disagree. I don't
16 think the fourth point should be patients with
17 symptoms of adrenal insufficiency. I think that
18 there is -- in a patient with this condition -- we
19 can give them some guidelines on what it's going
20 to be based on -- but from what I've been taught,
21 if they sneeze funny, they should get this
22 medicine. I mean, seriously. This -- if you
23 withhold it, this is a deadly type of thing. If
24 they develop a fever, they should get this. If

1 your child develops vomiting/diarrhea -- I mean,
2 there is a very liberal reason to give it, and
3 parents are doing this -- are giving this at home
4 orally all the time.

5 MS. ROGERS: Trauma would be another
6 one.

7 DR. LILLIS: Trauma. So there's a
8 very limited reason not to -- not to give it. So
9 I think we need to seek what their guidelines are.

10 MS. BRILLHART: Off the record. Can
11 we take a three-minute break and --

12 DR. COOPER: Okay. Let's go off the
13 record for just a minute.

14 MS. MOLLOY: Could I just say --

15 COURT REPORTER: Are we on or off
16 the record?

17 DR. COOPER: Go ahead. We can go
18 back on.

19 MS. MOLLOY: Only because I wasn't
20 here last time and I do think that the state plans
21 for -- really intervene early on, so the child
22 never gets in a crisis like that. So I do think
23 --

24 DR. COOPER: Off the record.

1 (Discussion off the record.)

2 DR. COOPER: Okay. We're back on
3 the record. And I want to just take a moment,
4 before we get back to this issue, of introducing
5 Dr. Chris Kus, who is with us from the Division of
6 Family and Health -- actually, he's director of
7 the Division of Family and Health and he is with
8 is today and I hope for many, many meeting in the
9 future. So thanks for --

10 DR. KUS: I'm actually associate
11 medical director.

12 DR. COOPER: Okay.

13 DR. AMLER: Well, still an important
14 job.

15 DR. COOPER: Yes. Okay. All right.
16 I think where we are at this point is that we have
17 four points that the letter should emphasize.
18 First, that the patient should be readily
19 identifiable. Second, that the condition
20 untreated has a high morbidity/mortality. Third,
21 that the treatment has an extremely low morbidity.
22 That is to say, really, no morbidity whatsoever.
23 And last, that it should therefore be given
24 whenever there are signs of potential adrenal

1 insufficiency.

2 And we've came up with a list from
3 the CARES website that includes fever, trauma,
4 shock, hypoglycemia, altered mental status -- so I
5 think that about covers it. So I think we can say
6 something along the lines of -- as I say, symptoms
7 of adrenal insufficiency, including the following.

8 One other issue has to do with the
9 self-administration component. And I'm glad Lee
10 is back in the room. Lee, have we historically
11 allowed self-administration to mean a parent can
12 say, Give this medication to my child.

13 MS. BURNS: Historically, not
14 really, no.

15 DR. COOPER: Do you think that as
16 director of operations that that would be a
17 reasonable recommendation to make to the SEMAC?

18 MS. BURNS: Yeah. I mean, I think
19 under the direction of a parent or guardian or
20 whatever the appropriate phrase that would cover
21 schools would probably be fine.

22 DR. COOPER: Okay. We will ask that
23 -- that --

24 SPEAKER: I would say with consent,

1 not under the direction of parent or guardian.

2 DR. COOPER: Right. Right.

3 Exactly.

4 DR. LILLIS: Is there a mechanism
5 where physicians that have been following patients
6 can have EMS providers follow their
7 recommendations in the life issues and DNRs and
8 things like that in the state DOH form? Do we
9 have anything where there's medication that they
10 can --

11 MR. WRONSKI: Not in EMS. What we
12 have done in the past is sent guidance out to
13 services to try to identify within their
14 communities patients with special healthcare needs
15 and what their meds might be, etcetera. They
16 might even, in some cases, talk to families about
17 what kind of emergencies might occur. I'm sorry.
18 In EMS, there's no state form -- that's what
19 you're asking, right -- which would be readily
20 accepted by all EMTs as giving them permission to
21 do something. That doesn't mean that if there was
22 a letter or something in place or a bracelet that
23 said this person suffered from a particular
24 problem that that would alert the EMT that this

1 means I should look for the drug and maybe give
2 it. But there is no specific form or bracelet
3 specific to drugs that we have advised EMS they
4 can accept. But I think that's probably done in
5 some regions or areas where they've had some local
6 training in that regard.

7 MS. CHIUMENTO: I would like to
8 add-on to that. What happens a lot of times is --
9 not even just at the regional level but at the
10 local agency level, if they identify a patient
11 with a need, a letter would go to the ambulance
12 board. The medical director will then put out a
13 phone call specific to that patient.

14 So we do that quite frequently in
15 our county, several different things like that
16 where a specific protocol that they decided on by
17 the medical director based on conversations with
18 the family and physician. So we've done that.
19 But no, there is no general way of knowing that.

20 DR. AMLER: I'm sorry to be naive
21 here, but how does that work -- is that kept on
22 the --

23 MS. CHIUMENTO: In our agency, we
24 have it posted on the bulletin board in one

1 location where we can come in and we can see that.
2 They usually don't identify patients by name
3 because of HIPAA, so they identify an address. If
4 you the get a patient at this address with this
5 particular problem --

6 MR. WRONSKI: I don't actually know
7 --

8 MR. CZAPRANSKI: If a call comes in
9 from that address, it comes up on the 9-1-1 data
10 card -- a note comes up to tell mutual aid
11 agencies, if they're not aware of that patient,
12 that these are the criteria, this is what they're
13 going into. So we also, in addition to training
14 the primary agency responsible, but also the
15 mutual aid agencies that may be surrounding that
16 area that may go into there. If their primary
17 resources are gone, then there's backup on the
18 9-1-1 center that carries those caution notes with
19 it.

20 DR. AMLER: And how is that
21 operation utilized in a large community, like
22 Queens?

23 MR. CZAPRANSKI: I don't know.

24 MS. FITTON: I'm led to

1 understand -- potentially, what we have in our CAD
2 is something called a premises history, where in
3 times of a blackout -- if a blackout happens in
4 ten blocks, then there is a database indicating
5 apartments or homes where people may be on medical
6 support and requires us to go there and to make
7 sure they're okay. Premises history is person who
8 is repeatedly stricken with a particular medical
9 condition or for some other reason. People have
10 -- the mayor -- as a matter of fact, there is a
11 premise history on the mayor's home. Anything
12 that -- residences that we may not be particularly
13 aware of. Some of the diplomatic residences, as
14 well -- any number of premises, but it does pop up
15 in this system. It pops right up in the CAD, you
16 can see it on the computer screen on the way to
17 the call.

18 DR. AMLER: Thank you.

19 MR. WRONSKI: If I could comment.
20 It does vary dramatically. The reason the City
21 can now do things like this is because of the
22 advent of computers and being able to maintain
23 those kinds of files.

24 In my town, although it is now

1 somewhat computerized, when I rode with the squad,
2 we would know that if we got a call from this
3 address, it was almost certainly an asthma attack
4 of a certain person who lived there. And if we
5 had this other address, we knew that it was an
6 elderly woman who could not get to her wheelchair.
7 And that's really all she was calling about,
8 because we'd been there fifty times in the last
9 five years and that was always why she called.

10 Of course, that can be misleading.
11 There are issues. We may not realize what
12 happened, but it really depends on where the
13 system is. But I think right down to the rural
14 squads to the big city, there are systems in place
15 that attempt to identify these patients. How well
16 we do that varies.

17 DR. AMLER: I appreciate the
18 clarification. My personal volunteer ambulance
19 experience was decidedly pre-computer.

20 DR. COOPER: Okay. Is everyone
21 comfortable with Elise's four points? And we're
22 comfortable with the listing of adrenal
23 insufficiency? Is there any objection to
24 rewriting the letter in that way? Do you want to

1 see the letter before it goes to the SEMAC?

2 DR. AMLER: I would.

3 DR. COOPER: Yes. Okay. Fine. All
4 right. Here is what I will do. I'll get the
5 letter roughed up tonight, I'll get it to Martha,
6 she'll send it out and you'll all have until
7 Friday to get comments back to me. Okay. All
8 right. But all the comments have to be within the
9 context of the four things we just agreed to.
10 Otherwise, we're going to have to go back and
11 revisit according to the policy direction we have
12 from the -- whatever office it is that's telling
13 us we have to do things in a particular way.
14 Okay. Good. All right. Yes? Thank you.

15 All right. Ed and Martha, do you
16 have any key items to mention in terms of staff
17 reports and EMS-C updates?

18 MR. WRONSKI: Yeah. Just a couple
19 of things. I'd just like to thank those of you
20 who were able to attend the EMS memorial on May
21 21st at the Empire State Plaza, where we added two
22 fallen EMTs to the memorial, and particular thanks
23 to FDNY EMS for sending their pipe and drums band
24 up to assist again in that ceremony. It was well

1 appreciated by the family members and the
2 Commissioner did speak at that particular event.

3 I'd like to just mention swine flu.
4 We've all had our different experiences. The City
5 had a huge experience. It was not a huge event in
6 the sense that it was an epidemic of enormous
7 proportions to New York or anywhere in the
8 country, but it certainly was an epidemic event
9 and a learning event for our public health folks
10 and for our EMS folks and hospitals in New York
11 City, where those that weren't well continued to
12 go to the emergency department and where the
13 schools, until fairly recently, were closed. I
14 don't think they're closed currently, but I may be
15 wrong. I'd have to go back and check. And I
16 think it was up to as many as thirty or so schools
17 that were closed. And again, whether this was a
18 right or wrong decision, it was a decision made in
19 light of unknown factors and it certainly affects
20 children.

21 So EMS-C should think about these
22 events, study them as a group of professionals and
23 give any advice you think that you learned from
24 these events to the department to consider in

1 future events.

2 We are planning for the fall and the
3 flu season to come and whether or not there will
4 be another strain of this and some different event
5 and how better to respond given the learning
6 lessons of this last one. And despite all the
7 planning -- years of planning for pandemic flus
8 and other events, you always learn something when
9 it actually happens. And I'm always amazed how
10 the weren't well were a factor and how they can
11 overwhelm our hospitals. I don't know if all of
12 you know, but in New York City, at one point, in
13 the borough of Queens, they were actually setting
14 up tents outside of hospitals to screen patients
15 that were ambulatory. And if they were only there
16 for flu reasons, they were sent one way, and other
17 patients were sent the other way. And there was
18 even consideration of having ambulances go to
19 tents to be screened, although that didn't occur.
20 But it has a huge effect and I hope we don't have
21 a recurrence of an unknown flu, but it seems like
22 that's something that probably may happen in the
23 future and we have to learn from each event.

24 DR. AMLER: I actually worked on

1 swine flu since 1976 at the CDC. I think it would
2 be very, very fascinating to capture the
3 experiences of FDNY and New York City EMS over the
4 last eight to ten weeks since this thing started
5 and probably over the next twenty weeks or so as
6 this goes on. I know you keep very accurate
7 records of everything that goes on. I think it
8 would be really fascinating to describe that
9 experience and perhaps look at the use of personal
10 protective equipment and the degree to which
11 personnel appeared to be protected. You could
12 only know that statistically, but that would be
13 very useful information. I hope somebody is
14 thinking about putting that together.

15 MS. FITTON: Yes. I think that a
16 couple things. That's very important because the
17 preparation that was there. There was a lot of
18 immediate thought of safeguarding EMTs and
19 paramedics and our 10,864 certified first
20 responders -- I think it really turned out to be
21 pretty well, because we have had few, if any,
22 people diagnosed with H1N1 as a result of their
23 work. There may be a couple a firefighters and
24 perhaps an EMT who may or may not -- during their

1 travels, but really it's a very important thing
2 for the FDNY. We had people call in sick, but did
3 they really have H1N1.

4 MR. WRONSKI: Absolutely.

5 DR. AMLER: The reason to try to do
6 a systematic analysis is exactly that, because we
7 know that there are many, many unreported cases,
8 because even very convincing cases have not been
9 getting tested as a matter of policy and practice.
10 So simply to go with the confirmed or reported
11 cases would be certainly very useful, because this
12 is not the first or the last flu epidemic and
13 we're going to have these issues in the future.

14 MS. FITTON: All that we can see is
15 we added a fever and cough category to our CAD to
16 try to capture as many as possible. The call
17 volume had already increased, but we had an
18 increase of about 700 calls a day. About 300 were
19 identified as fever and cough. However, we don't
20 know really what happened with them. We also
21 can't really quite tell you, at this point, what
22 the other 400 calls per day were. We believe that
23 they had some root in the H1N1, but if there was
24 some other issue there, we don't know. We had

1 mutual aid -- which is something --

2 MR. WRONSKI: Last time there was
3 any type of real mutual aid was in the World Trade
4 Center disaster. Otherwise, FDNY has always been
5 able to handle its call volume along with its
6 ordinary partners. But they've actually, on at
7 least four occasions, maybe five now, called out
8 for mutual aid to ambulance services who were not
9 in the 9-1-1 system on a normal basis, aren't
10 dispatched by FDNY and they're doing so today, as
11 a matter of fact. The call volume -- just so you
12 understand what we're talking about, about ten
13 years, the normal call volume was somewhere around
14 3,000 a day or less. It's gone up to about 3,400,
15 but right now they're breaking 4,000 on a regular
16 basis. So 4,000 9-1-1 calls a day. My ambulance
17 squad in the town I live in, which serves
18 Crossgates Mall, does 3,000 calls annually and
19 they sometimes sweat making those calls. So when
20 you think about 4,000 a day, it's an incredible
21 system. But they are at the point -- they're not
22 breaking, but they are bulging and they are using
23 the other available resources -- there actually
24 are hundreds of other ambulance services that are

1 not in the 9-1-1 system that are in New York City,
2 so they have the ability to expand fairly quickly
3 to do this, and not all systems have that but New
4 York City does. So that's one lucky thing.

5 MS. FITTON: I know we want to get
6 off this topic, but the other thing about this
7 whole thing is that the call volume peaks about
8 noon time, one o'clock in the afternoon, two
9 o'clock. By three o'clock -- but by seven or
10 eight o'clock at night, we're back down to the
11 normal call volume --

12 DR. AMLER: You're saying you
13 actually had a shift in time --

14 MS. FITTON: Yes. Usually our peak
15 time was three to six in the day. Now it's
16 starting earlier and ending later, but there's
17 such a large spike in call volume that it requires
18 us to get mutual aid and it has been a challenge.

19 DR. AMLER: It's only by recording
20 these kinds of experiences that we insure -- we
21 always make mistakes in emergencies, but at least
22 we don't repeat the same ones. Not that you made
23 mistakes, but I'm saying that it's only by
24 learning those kinds of curves and trends that --

1 MS. FITTON: I think everybody is
2 looking at this very carefully, because we are all
3 concerned by what's happening -- not only for the
4 public, but also for our own providers.

5 DR. AMLER: Thank you.

6 MR. WRONSKI: The -- the other big
7 piece we learned during swine flue was many areas
8 -- areas -- let me put it this way. Many
9 ambulance services, not areas, did not have
10 adequate supplies of N-95s, which were the primary
11 recommended personal protective equipment. But
12 many small squads don't carry the N-95 in any kind
13 of numbers. Counties often have the supplies.
14 The state has a backlog of supplies, but we could
15 not distribute it until there was a true
16 overwhelming emergency that we needed to get them
17 out. We hope that ambulance services will have
18 these supplies, at least for a couple of days if
19 not a week, when something begins. But we found
20 out that, in many cases, that's not the case.

21 Okay. Quickly, the school of public
22 health analysis. It was mentioned already that
23 they are almost done with the state report. Once
24 that state report on trauma centers is done and

1 trauma systems, we will be spending time to
2 finalize the pediatric report and bring it here to
3 you. So that will be probably be done over the
4 summer months and completed. We also hope to have
5 an EMS report. We lost a school of public health
6 analyst who was specifically working with our EMS
7 data, because we were going to do a very specific
8 pre-hospital care report. And he had done a fair
9 amount of work on that already, but we're waiting
10 until the school of public health can hire someone
11 to concentrate on that and hopefully before the
12 year is out, you'll also see a pre-hospital care
13 report come out from our pre-hospital. So you
14 know what that means, it's about 2.8 million calls
15 in any given year. And our 2007 data is being
16 what we call cleaned at the moment, but it
17 contains roughly the same as the amount of data we
18 had in 2006, which again, when you add New York
19 City data that we've been receiving, it's a total
20 of about 2.8 million calls that we actually have.
21 We know we're missing 200 to 300,000 other calls
22 that we don't collect, so the system is actually a
23 three million a year system. And that's a fairly
24 conservative estimate.

1 Last thing I just wanted to mention
2 for all of you to keep in mind is the state
3 budget. And the state budget, despite the federal
4 dollars, stimulus dollars, despite the slow
5 turnaround of the economy, it's still in bad
6 shape. We're going to be in bad shape for a
7 little while. It's probably -- all estimates are
8 for the next two fiscal years, it's going to be a
9 long haul, but it is going in the right direction,
10 the economy, and the economy does drive the
11 government budgets, as well. So we're hoping for
12 better times in the future. But right now we are
13 being limited in what we can do as far as the
14 spending of money, so keep that in mind if you ask
15 if we can do any mandates or anything. If they
16 cost money, it probably will be a real pushback
17 from localities if they're expecting any
18 government money to pay for something. But that
19 doesn't mean you shouldn't make recommendations
20 for good medicine, but there may not be funding to
21 sit behind it for a while. That's all my report.

22 DR. COOPER: Good. Any questions
23 for Mr. Wronski? Martha?

24 MS. GOHLKE: From the EMS for

1 Children grant side, you may remember me
2 mentioning at the last meeting that New York was
3 being highlighted on one of the technical
4 assistance conference calls for the grantees
5 across the nation. New York is one of the top
6 leading states that has incorporated the majority
7 or a good portion of the priorities of the grant
8 into mandates or into policy. So we recently had
9 that call and Gloria Hale jumped in on it, so it
10 was a good combined effort and she got kudos for
11 all her work that she's done over the ten years
12 that she was here. And Dr. Cooper was very
13 helpful with preparing for that, because I wasn't
14 here during a lot of that. I had to get help from
15 my colleagues on what to talk about. But anyway,
16 so New York is being looked at very closely in a
17 favorable light, not only just because we've
18 gotten a lot of the priorities and mandates, but
19 the white paper and the move toward
20 regionalization of pediatric hospitals is being
21 highlighted as well for our movement and the white
22 paper. And if a state the size of New York can do
23 it, then the smaller states will hopefully be able
24 to do it, too. So they're looking at us very

1 closely for the work that we're doing on this
2 grant. So we keep going. And I think with the
3 effort on the education committee and the
4 inter-facility transfer community -- committee,
5 we're going to have a couple more mandates in
6 place within the next year. So we'll look great
7 again next year.

8 DR. AMLER: Which federal agency?

9 MS. GOHLKE: HRSA. So next week,
10 Lee and I have the pleasure of going to the annual
11 EMS for Children grantee meeting. It's every
12 June. Since Marjorie is no longer here, somebody
13 had to go, so I have to bring my boss. She got
14 volunteered to go. So we'll be reporting on that
15 at the next meeting. We look forward to that.

16 The only thing I want to mention is
17 that with the Governor's traffic safety grant we
18 have with the NEMSIS movement that Lee's going to
19 talk about in a second and we talked about
20 previously, some of my effort and my salary has
21 been moved on to that grant so it has brought up a
22 chunk of money on the EMS for Children grant that
23 we can now utilize for other purposes.

24 And what I'd love to do -- for this

1 grant year we're doing a another PET course at the
2 Vital Signs Conference this fall, which we did
3 last year and it was very highly received. And
4 you can only reach fifty EMS providers at a time
5 and there was a waiting list, so we decided to do
6 it again. And the only thing that we're going to
7 do and we're going to talk about this and present
8 it at the next State EMS Council meeting is we're
9 going to offer small chunks of money to the
10 regions of the state to do pediatric training for
11 EMS providers in the regions. And it's going to
12 be done through a very easy mechanism of purchase
13 orders. It's not contracts, so it's going to be
14 very easy for me to access some money to do either
15 pediatric training or offer honorariums to
16 speakers to come at the conferences they already
17 have setup. So that's how we're planning to
18 utilize the money, which since I've been here for
19 a year and a half, I think one of the most common
20 requests or things that I hear from providers in
21 the field is they don't have enough training on
22 pediatrics and they're terrified to go on a
23 pediatric call. So I'm pleased to be able to
24 offer some money so they can actually get some

1 more training. So I'm thrilled that we've been
2 able to do that with this additional grant.

3 Speaking of which -- so for next
4 year, next grant year, assuming we are continually
5 funded on this other grant and so is my salary,
6 we'll also have this little portion of money that
7 if we do identify some sort of a statewide
8 training need that we'd like to do, you know, we
9 can talk about using the EMS for Children funds
10 for other types of pediatric training. So just
11 food for thought. It's something that takes a
12 little time to plan, but we can start thinking now
13 for next year.

14 And the only thing I just wanted to
15 mention was the by-laws, just to get you
16 up-to-date. They're still with the department of
17 legal affairs. Basically, that's all I have to
18 say on them. So we're still waiting for their
19 final word. Maybe by next meeting, we'll have
20 them to vote on, but they're still stuck over
21 there for the time being. And that's it.

22 DR. COOPER: Thanks, Martha. Any
23 questions for Martha? Okay. Well, let's move to
24 ambulance equipment list. We have copies of the

1 list on the left side of your folder, and Martha
2 has done a line by line, which is on a yellow
3 sheet of paper comparing the --

4 MS. GOHLKE: Let me explain, if I
5 can, all the handouts. On the left side, starting
6 with equipment for ambulances, this is the
7 national ACEP/AP emergency physician list that was
8 recently released. It's adults and -- it's all
9 equipment. It is not just pediatric equipment.
10 It's all equipment that's recommended that we
11 carry. From that list, behind that, is the EMS
12 for Children. And what they did is they extracted
13 the pediatric equipment out of the national list
14 that they're going to focus on. So, you know,
15 that is -- if you remember, I had to survey on
16 this last year. I had to survey 467 providers on
17 the pediatric equipment that they were carrying on
18 their ambulances and they're not going to make me
19 survey on this whole national list. What they're
20 going to make me survey on is this smaller reduced
21 pediatric list. So from there, what I did is on
22 this yellow sheet, like Dr. Cooper said, I did a
23 line by line of the equipment that the EMS for
24 Children federal side is looking for. It may not

1 be all inclusive of pediatric equipment that's on
2 the national list, but it's what the feds are
3 looking for. It's a starting point, basically, is
4 what I'm trying to say. You also have of part 800
5 regs of what we currently ask ambulance services
6 to carry on their transport vehicles.

7 So on the left-hand side of the
8 yellow piece of paper, you see what is missing
9 that the feds are looking for, and on the right
10 hand side, you can see what it is we do have in
11 place for those equipment. And what we need to do
12 is decide if we're going to recommend that we at
13 least put into policy, if not into regulatory part
14 800, additional pieces of equipment. The feds
15 would obviously like us to mandate that all
16 ambulances carry this equipment, but it's -- it's
17 subject to interpretation on whether or not a lot
18 of people think that it's good to carry, not good
19 to carry, that type of thing. So we wanted to get
20 your opinion on what your thoughts on some of
21 these pieces of equipment.

22 DR. VAN DER JAGT: Martha?

23 MS. GOHLKE: Yes.

24 DR. COOPER: Before we go ahead on

1 this, I think it's worth mentioning one other
2 thing. There have been, over the years, a few
3 SEMAC mandates that have really become de facto
4 the standard of care in New York State. AEDs for
5 example, pulse oximetry, for example, but they're
6 not included in part 800. So the fact that you
7 don't see something listed on the right side of
8 the page don't necessarily mean that the bureau
9 doesn't expect it to be there. So in that sense,
10 it's a little misleading. But I think the
11 over-arching question is, really, the whole
12 question of the part 800s for both adults and
13 children and how should they be written in a way
14 that allows a bottom line requirement, yet at the
15 same time, flexibility for new equipment, deletion
16 of old equipment, so on, as medical science
17 indicates that could be done. Change in
18 regulation in New York State is an extremely,
19 extremely difficult process, so I think that part
20 of our charge here should be to address that
21 issue.

22 So I would suggest that we first
23 focus on the pieces of equipment on this list that
24 we think are appropriate, mandatory necessary,

1 what have you, and then focus on the larger issue
2 of how best to get that accomplished within the
3 framework of policy or regulation. Elise, you had
4 a comment?

5 DR. VAN DER JAGT: You helped me
6 clarify -- I was wondering about the difference
7 between what we do and what's in the code. But my
8 understanding is that our job is to figure out
9 what's written in the code and be very careful
10 about it.

11 DR. COOPER: No, not necessarily.
12 Our job is to say, in effect, whether we -- as I
13 see it -- it's up to you. As I see it, our job is
14 to say whether we agree with the list that the
15 EMS-C stakeholder folks came up with, because
16 that's really what we're going to be measured
17 against. And then make -- subsequently to make a
18 recommendation, if those items are not included in
19 some kind of formal listing, how should we insure
20 that that happens.

21 MR. CZAPRANSKI: I have a question.
22 If we look at the part 800s and see what we carry
23 on 800 that might no longer be useful. I know,
24 for instance, we have two or three suction -- we

1 have meconium aspirators. Perhaps we need to look
2 at what we can drop from part 800 that was useful
3 years ago but is no longer useful.

4 And second, on the yellow page under
5 ALS, it says IV catheters, four, sizes 24 through
6 14. Is that supposed to be four sizes or four
7 catheters?

8 MS. GOHLKE: Four of the different
9 sizes.

10 MR. CZAPRANSKI: You might want to
11 specify that.

12 MR. WRONSKI: In answer to a couple
13 questions here. I'll go first to the list. My
14 operations director, Lee Burns, has been tasked
15 with the rewriting of the regulations on
16 operations, and one of the specific ones is to
17 take a look at our equipment list over time and
18 determine what we should drop and what we should
19 add. And, in fact, there was a TAG at the State
20 EMS council that was doing some of that, although
21 I think it's kind of disappeared because it was a
22 daunting task.

23 But anyway, we're going to do it
24 inhouse over the next year, probably two years,

1 and play with it and try to make it more
2 up-to-date. We would certainly take
3 recommendations. The State EMS council, as you
4 know, is the statutory body that has to, along
5 with the department, agree to regulatory change.
6 But if there's something specific that pediatric
7 -- that EMS-C thinks it should comment on, it can
8 either go in or come out, you can certainly make
9 that recommendation.

10 In regard to how to get this done.
11 What I told Martha is that once we looked at this
12 and determined what we all agree makes sense to
13 have available, we can first do a policy. What
14 many of you may not know is that automatic
15 defibrillators are carried on ambulances because
16 we asked them to do that. We didn't regulate it.
17 In 1994 or 5 when we went from pilots with AEDs to
18 "this is the good thing to do and everybody should
19 do it," there was an argument about whether to go
20 with reg. We didn't go with the reg, because the
21 system was -- is -- was then very big. So 4,000
22 ambulances, not counting all the first-response
23 vehicles. So the system needed time to buy the
24 equipment and put it on board. Today, except for

1 one exception in an inter-facility venue, 99.9
2 percent of all 9-1-1 ambulances carry an automatic
3 defibrillator. It's very rare that that would not
4 occur. So -- but we still think it's time to do
5 it as a reg. So when we do our reg change, we are
6 going to add that there be a defibrillator
7 capability on all responding EMS vehicles --
8 certified vehicles. But we know policy works and
9 we can certainly begin it that way and that can go
10 out fairly quickly once we agree what should be in
11 it.

12 The other piece is that I have been
13 toying with language for regs and equipment down
14 the road that might -- besides having some
15 specific equipment, also say that any ambulance
16 which is required by either the state protocol or
17 a regional for advanced life support have certain
18 equipment in order to carry out that protocol,
19 needs to have that equipment on board. Otherwise,
20 why would we write the protocol, and protocols are
21 mandated. So we may play with some language which
22 would give Dr. Cooper that flexibility so that if
23 we wanted something, the only reason we want it is
24 because we're going to put it in the protocol. So

1 we'll toy with the language on that.

2 MS. CHIUMENTO: One question real
3 quick. The question is, did you have a chance to
4 read -- I'm guessing that most of the things were
5 on that survey, and my recollection is there was
6 only a few things that is not on that list that
7 were the problem areas -- which were the ones that
8 had the small percentage of carrying. So I'm
9 wondering if we may already be in compliance, so
10 that's the good thing. The one that I see that we
11 probably do not have in place is -- tape. The ALS
12 providers probably carry that, but I don't think
13 any of the BLS agencies do.

14 MS. GOHLKE: Looking at that, I
15 don't see anything that sticks out. But --

16 MR. WRONSKI: I think that tape is
17 on all ambulances now because we sent out the kit.
18 Didn't the kit contain it?

19 MS. BURNS: No.

20 MS. CHIUMENTO: That was a different
21 tape. That's the one for MCI.

22 MR. WRONSKI: It's not the same
23 tape?

24 MS. CHIUMENTO: It's not the same

1 tape.

2 MR. WRONSKI: Excuse me.

3 MS. BURNS: The problem is that they
4 are not that extensive, as you know, and we train
5 our EMTs to size those airway devices. For us to
6 say you need to have a length based tape because
7 it will tell you what size your airway is, is kind
8 of a waste.

9 MS. CHIUMENTO: That would be the
10 one I would differ on.

11 MS. BURNS: In looking at
12 performance measures for BLS services, we're not
13 in horrible shape, quite frankly. One of the
14 things that is an intricacy is that we don't
15 regulate advanced life support equipment and
16 supplies. That is done at the regional level. So
17 our ability to comply with the ALS list is going
18 to be problematic from a regulatory perspective.

19 MS. GOHLKE: The good thing is our
20 providers do look at the advisories and the
21 policies we have and they do follow them. So like
22 Ed would say, if at a minimum we put it in the
23 policy and then eventually, if we want to, to put
24 it into the regs.

1 But also I want to remind people
2 that one of the things that my survey did show was
3 the question on why don't you carry certain pieces
4 of equipment and the most common answer is because
5 it's not mandated. So it does have a lot of
6 weight, whether it's in policy or reg, either one.

7 DR. COOPER: I would like to, in the
8 interest of saving us a great deal of time and
9 also following the precedence that in the past
10 when a national standard such as American Heart
11 Association guidelines has been developed, that we
12 an EMS-C committee adopt as a general principal
13 the notion that we support the adoption of the
14 national equipment list in the same way we have in
15 SEMAC supported the adoption of the American Heart
16 Association guidelines into our protocols. As you
17 can see from the copy of the document that's
18 posted on the website, the current ambulance
19 equipment list is endorsed by the American College
20 of Surgeons for Trauma, the American College of
21 Emergency Physicians, the National Association of
22 EMS Physicians, the EMS-C stakeholder group and
23 the American Academy of Pediatrics. That's a
24 pretty reasonable list of folks who have gotten

1 behind this particular document. I did have an
2 opportunity to participate in this process, and I
3 can assure you, there was quite a bit of
4 discussion about the inclusion or non-inclusion of
5 items that would be difficult for volunteer
6 squads, particularly in rural areas, be able to
7 carry. People really did think that they wanted
8 to be cost-conscious as well as medically correct
9 in terms of insuring that equipment that is
10 absolutely known to increase morbidity and
11 mortality are included, while at the same time
12 insuring that other equipment that is not
13 necessarily so well supported in terms of the
14 science did not make it to a mandatory list. As
15 you know from reviewing the equipment list, there
16 are -- is a core group and there is an expanded
17 list of items that are recommend but not required
18 by this standard, not that this standard is
19 anything but a recommendation in and of itself,
20 but I think the simplest thing for us to do,
21 personally, is to recommend that the SEMAC support
22 -- that the SEMSCO support the inclusion of the
23 required items on the list, recommend that the
24 recommended items be carried, and that we work

1 with the department to seek the kind of
2 flexibility in the regulatory language that Ed
3 Wronski is suggesting. In other words, if there
4 is a protocol that supports the use of a
5 particular piece of equipment, it really needs to
6 be carried.

7 DR. AMLER: I think that's well
8 said. Let's face it. There are no two people
9 that will agree on the very same thing, because we
10 all have somewhat different views, but if this is
11 a consensus standard that's being promulgated
12 nationally, I think it is very important for our
13 state to be as close as we can to the standard,
14 given that there is special circumstance --

15 Let's face it. We have five
16 neighboring states and we want to have our
17 emergency operations as seamlessly as possible --

18 DR. COOPER: Other comments? Can I
19 ask if there might be a motion in regard to this
20 -- this issue?

21 DR. AMLER: So moved.

22 DR. VAN DER JAGT: Second.

23 DR. COOPER: We moved and seconded
24 that.

1 DR. AMLER: Whatever Art just said.

2 DR. COOPER: So what I had suggested
3 that the committee might do is that it support --
4 that it recommend to the state EMS council that
5 the consensus standards be adopted for use in New
6 York State, that the elements that the consensus
7 group considered necessary for pre-hospital care
8 be required and that those that are considered
9 optional be recommended. So that's the motion,
10 and again, is that what you understood?

11 DR. AMLER: That's exactly what I
12 was going to say.

13 DR. COOPER: Elise?

14 DR. VAN DER JAGT: I would say yes.

15 DR. COOPER: Discussion? All in
16 favor?

17 MS. CHIUMENTO: May I make one
18 comment?

19 DR. COOPER: Sure.

20 MS. CHIUMENTO: These are the
21 mandatory or these are the optional or these are
22 the --

23 MS. GOHLKE: These are not optional;
24 these are mandatory. I did not include the

1 optionals. These are the ones they're going to
2 ding states on if they don't have. That's what
3 they did. They narrowed down the list. And I
4 didn't go as far as the optional and neither did
5 they. So there may be other stuff you'll want to
6 recommend, but I don't know.

7 MR. WRONSKI: Let me explain, for
8 the record, what a federal "ding" for EMS means.
9 It means that Martha's salary might be lowered.
10 Since currently they're unable to pay Martha's
11 salary from what they give us, it's not much of a
12 ding. But if it is something you recommend, we
13 certainly will pursue that with the state council
14 and discuss how to do it. But the federal ding
15 isn't what should be driving this.

16 MS. BURNS: Can we, Dr. Cooper, the
17 bureau, prepare - like - a draft policy for your
18 consideration --

19 DR. COOPER: Sure.

20 MS. BURNS: -- in light of your
21 motion?

22 DR. COOPER: That's your call, not
23 mine. But I think we'd be happy -- on behalf of
24 the committee, I think we'd probably be very happy

1 if we did that.

2 MR. WRONSKI: Lee will do that, but
3 what I'd like, before we do that, is that Martha
4 and Lee will also discuss this with the state EMS
5 council and systems and SEMAC and get feedback
6 from them so we know we're at some sort of
7 consensus, because I don't issue policy, as Dr.
8 Cooper knows, on equipment, etcetera, unless I
9 know I have general support from that body, as
10 well.

11 MS. BRILLHART: Question. Looking
12 at this equipment for ambulances, it does have the
13 EMS-C partnership for children stapled on it. Is
14 it a correct assumption that everything that we
15 would get dinged on is that list?

16 MS. GOHLKE: Yes.

17 MS. BRILLHART: Okay.

18 DR. COOPER: Once again, I want to
19 support what Mr. Wronski said. The ding is not
20 the reduction in Martha's salary, unless Martha's
21 the person who's speaking.

22 MS. GOHLKE: Exactly.

23 DR. COOPER: The ding is, obviously,
24 if you don't have this equipment, we're doing a

1 less than perfect job for our children. And this,
2 as Mr. Wronski's indicated, needs to be the first.

3 MS. GOHLKE: Like Dr. Cooper said,
4 we don't necessarily have to belabor over this.
5 They spent years doing this.

6 MS. BRILLHART: I just wanted to
7 make sure that by saying "yes" to a document -- if
8 it's all-inclusive, that makes it very easy for
9 us.

10 MS. GOHLKE: Let me just clarify.
11 What do you mean by all-inclusive?

12 MS. BRILLHART: Of the mandatory
13 federal list for EMS-C.

14 MS. GOHLKE: Okay. So the national
15 list has all their pediatric items on it -- let me
16 just say this -- that aren't on the EMS for
17 Children list. EMS for Children federal list
18 didn't include all of it. Because they felt like
19 maybe some of it wasn't necessarily had to be
20 carried by every transfer EMS. So they extracted
21 from the national list.

22 DR. COOPER: Further discussion?
23 All in favor, please signify by raising your
24 hands. One - two - three - four - five - six -

1 seven - eight - nine - ten. Against? None.

2 Okay. Ten. Motion carries without dissent.

3 Thank you. Lee, can you tell us about NEMSIS?

4 MS. BURNS: It says it's a
5 ten-minute overview. I won't take ten minutes. A
6 couple things I want to give you, for those of you
7 who are EMS-C people specifically and not EMS
8 people specifically.

9 Just to give you a quick overview of
10 our current pre-hospital care report system, it
11 talked briefly about the GTSC that Martha eluded
12 to. The national EMS information system, which is
13 NEMSIS, you heard that thrown about, and the grant
14 process for integrating state and regional trauma
15 system grants or information. At present, as Ed
16 said, we have just under three million EMS
17 responses in our 2006 data year. For the first
18 time, that includes comprehensive New York City
19 information. Our PCR system, our pre-hospital
20 care report system, is a paper and electronic
21 information and they were about 1,200 that were
22 required to report under public health law. As of
23 last week, 140 of them are using an electronic
24 patient care record. We have a great deal of

1 success in regional systems. Tim and Sharon come
2 from Monroe-Livingston. They are one of our first
3 electronic-submitting regions. New York City is
4 probably ninety-eight percent electronic. FDNY is
5 certainly all electronic. The rest of them are
6 using a form that's provided to them by the
7 Department. We affectionately call it the PCR.
8 And the agencies complete the record, submit it to
9 their local program agency, the program agencies
10 do something called screening, which we're looking
11 to streamlining out, and then it's submitted to a
12 contractor of the department, who keypunches all
13 these records and give them to us in a monthly
14 data disk.

15 What we are hoping to be able to do
16 and what we've been doing with our data over the
17 years is compiling the electronic and the paper
18 data and compiling EMS education record registry.
19 2006 is the first year that includes a SPARCS
20 identifier, which if Louise were here, she'd look
21 pleased. We were elated. It has allowed our
22 school of public health partners to be able to
23 connect a sample of trauma data with pre-hospital
24 care data. So that is a huge step forward for us.

1 We believe that our data is used for
2 many different sorts of things. At the agency
3 level, we would like to think that it's used for
4 quality improvement and management issues. At the
5 regional level, the physician groups, REMACs, are
6 using it for protocol development, education and
7 system monitoring and at the SEMSCO meeting. And
8 again we are in the baby step stages of linking it
9 to trauma. We used it for some of the STEMI
10 discussions and program development, which has
11 enabled them to develop some statewide BLS
12 protocols.

13 So NEMSIS. NEMSIS basically is
14 somewhere, somebody, probably in the early 60s
15 decided we should have a national system. And in
16 the last five years through national highway
17 traffic safety, they established something called
18 national EMS information system project. I think
19 it was a Freudian slip, but they found it. One of
20 the things for -- New York City has had some issue
21 with the concept, but it was supported by the
22 national EMS directors in concept in an effort to
23 build EMS curriculum for education and look at
24 patient outcomes, system evaluation and quality

1 assurance at the national level. So, I mean, it's
2 huge. We had the opportunity to meet with the
3 NEMSIS national advisory folks a couple weeks ago,
4 and even the information that they've collected
5 from the few states that are submitting was very
6 interesting. Way over my head, personally, the
7 whole data process, but --

8 For our purposes, NEMSIS is composed
9 of two components. One is a demographic data set
10 and it's standardized. From a functional
11 perspective, we'll be able to manage that at a
12 department level, I think. And the other is the
13 EMS data set that we're calling the patient care
14 component. For the vendor type in you, there are
15 two levels of compliance, gold and silver. I
16 figured if you were gold compliant, you were
17 golden - duh - but what NEMSIS explained to us is
18 there were 479 data points and if the software
19 collects 479 data points, it's considered to be
20 gold compliant. They evaluate it. If it collects
21 478 or fewer, it is considered silver compliant.
22 At present, there are 39 gold compliant and 38
23 silver compliant. There is a question about
24 whether it's more of a selling point. This is

1 what the United States looks like by NEMSIS at
2 present. We actually are a blue state. We were
3 thrilled. So for us, NEMSIS is a reality. We're
4 in an incredibly good position. I never thought
5 I'd say that out loud.

6 MS. GOHLKE: We've come a long way.

7 MS. BURNS: When I get all excited
8 about a trauma report, Mike Taylor beats me into
9 submission. He's my resident kill-joy. We -- New
10 York State has been collecting statewide data
11 since the mid 80s really, and our public health
12 law requires that ambulances and advanced life
13 support services submit patient data to the
14 department. Why is that important? I never
15 really considered it to be all that important
16 until most recently as I've spoken with other
17 states. By law, our providers are required, but
18 also -- it's a matter of habit now. They don't
19 argue with us. They submit almost willingly. So
20 it gives us a huge leg-up in the overall data
21 collection process. And when the NEMSIS people
22 said, how much data do you think you could provide
23 us, my response was, Well, all of it. And our
24 data from New York State is over a third of what

1 their current data set is for the last five years.
2 So they did this goofy dance of joy. They were
3 very pleased with our cooperation or interest.
4 The reason that that is important to note is we
5 are proud to announce to you that New York State
6 was the last state to agree to participate in
7 NEMSIS, and I think they caught Ed in a moment of
8 weakness and they asked him, How's it going today,
9 and he said, Pretty good, and the next thing we
10 had agreed to an MOU. He was afraid to come home
11 from the national directors for fear Marjorie and
12 I would kill him. But -- so we're in very
13 surprisingly good shape. Our GTSC grant enables
14 us to explore this on a national level. I say
15 this was Marjorie's farewell gift to the EMS
16 bureau. The grant is a three year grant. I'm
17 killing the GTSC people single-handedly. Anyway,
18 the idea is to develop a statewide electronic PCR
19 platform at the department level. There's no way,
20 from the financial perspective, the state is
21 capable of putting an electronic PCR program in
22 every ambulance station across the state. It's
23 not financially feasible. It also, with the
24 complexities of our EMS systems, it doesn't meet

1 the needs. What is good in the metropolitan area
2 of New York City is not necessarily good in the
3 southern tier or north country. While I would
4 love to have a uniform program, I don't think it
5 would be particularly well received because I
6 think there are some local preferences. The
7 project also will help us encourage migration from
8 a paper-based system to an electronic-based
9 system. We're hoping to be able to start
10 submitting data to NEMSIS at the end of this year,
11 maybe early next, what we have.

12 The other joyous thing about New
13 York is that we have true electronic data
14 submitters, and part of the process was the
15 service agrees to use a NEMSIS compatible product.
16 And we tell them in the agreement that, at the
17 point that the department requests NEMSIS data,
18 they will submit it. And from a realistic
19 perspective, it's easier for them to provide us a
20 NEMSIS data set than it is the New York State data
21 set.

22 The grant also has a provision, a
23 pilot, regional pre-hospital data with the
24 regional trauma data. I spoke with the trauma

1 registrars at the STAC meeting and they sort of
2 look glazed and excited. The think what I said to
3 them was we're not going to require you to do more
4 work. We would like to be able to connect data so
5 that it would make your life a little bit easier.
6 So we're kind of hoping for that. And the big
7 picture, and I think this will help you as well as
8 the State EMS council and SEMAC, it will give you
9 a much richer patient data set to look at.

10 So what does this have to do with
11 you? I think I covered that. Our goal is --
12 Sharon nods her head, because she's been tortured
13 to death with it. We are in the process, and
14 Sharon gave us a huge leg up with work she had
15 done before. Currently, New York State collects
16 sixty-six data elements on the PCR. It is capable
17 of collecting almost ninety. A patient care data
18 set at NEMSIS is eighty-four required data points.
19 We're going to look to you to assist us in
20 additional data points that would be useful in
21 evaluating pre-hospital care in New York State.
22 We're going to be working with the state EMS
23 council on that, too, and the trauma folks. So
24 you can look forward to that fun in the coming

1 months once we are able to glean down what we want
2 to present to you. 479 data elements is not
3 workable. Most of them, according to NEMESIS, are
4 not actually patient-care related; they're
5 demographic related. We had a good laugh when
6 Sharon figured this out. Some of those data
7 points include medical directors, home address,
8 phone number, date of birth. That's not something
9 that New York State is going to participate in at
10 that level, but it's capable of it. Again, I hate
11 to get overly excited, but I think that the grant
12 has given us a push forward. It's a direction
13 that the State has to go in. It's a direction
14 that will assist you in what you want to do and I
15 think we have a combined interest in that. Did I
16 go over ten minutes?

17 DR. COOPER: I don't know, but you
18 covered the water. Are there any questions?

19 MS. MACINSKI SPERRY: What is the
20 first year --

21 MS. BURNS: 2006. You have that.

22 MS. MACINSKI SPERRY: That's
23 exciting.

24 MS. BURNS: We have 2007 in house,

1 so we are pretty encouraged. We hope to be able
2 to have a comprehensive 2007 data set by the end
3 of this month, early next, which really is huge
4 for us.

5 DR. VAN DER JAGT: Two questions One
6 is, do the local agencies have an opportunity to
7 get money from the grant to help them develop this
8 system?

9 MS. BURNS: No, not this grant.
10 Although there are a number of HRSA grants
11 available, it would require them to do some local
12 work. Something in the Rochester -- I want to say
13 --

14 MR. CZAPRANSKI: In the RHIOs
15 grants -- there is an opportunity for the RHIO
16 grants in electronic PCRs. So in our area, Monroe
17 County didn't need to because they're already
18 moving to improving PCR. However, some of the more
19 rural counties in the finger lake area, did use
20 RHIO grant funding to procure electronic PCR.

21 MS. BURNS: And they are. They are
22 almost eight percent implemented in that region
23 using EMS charts.

24 DR. VAN DER JAGT: Which leads to my

1 next question. If we wish to do a study on that
2 data, what is the mechanism of obtaining data from
3 that data bank? How does that work?

4 MS. BURNS: I don't think they are
5 there. I'm not sure. I don't know what it
6 requires.

7 DR. VAN DER JAGT: If it is
8 promulgated in your slides, what's the data flow
9 and how does that work?

10 MS. BURNS: At present, by public
11 health law, we are permitted or enabled to share
12 it with our advisory body. But if you want to do
13 a study on your own, I'm not sure what the process
14 is. I'd have to check.

15 MS. CHIUMENTO: One other point,
16 just talking about QA/QI. The individual agency,
17 when they collect the data, they can actually do
18 it within house and look at the performance. It
19 may not be at the state level yet, but it is being
20 used at the lower levels, too.

21 MS. BURNS: Also, the regions are
22 very interactive in using their own data,
23 particularly north and New York City have some
24 amazing information. Suffolk County is about to

1 go online using an electronic file form. The
2 southern tier Binghamton area is nine percent up.
3 Central New York, Syracuse area and its counties,
4 as well as the north country that's based out of
5 Watertown. You know those counties up there -- I
6 can name them for you, but they have a good porton
7 of participation. So it's growing by leaps and
8 bounds.

9 MR. WRONSKI: I'm sorry. I just
10 want to very quickly, and maybe you already
11 covered it, but one of the big things we'll ask
12 you to do is from a pediatric perspective, because
13 the state council is going to look at the whole
14 spectrum of what we're collecting, which would be
15 for all patients, but take a look at the NEMESIS
16 data set to see if they have things -- they may
17 not say they're pediatric specific, but maybe
18 they're very important for you from the
19 perspective of understanding care of kids in
20 pre-hospital. And so you might want to underline
21 that it's very important to make sure we include
22 that in the collection. But my goal is to create
23 a document -- a data set. The document is already
24 created, 479 data points. We can't do that to our

1 EMS providers. What will happen is you won't get
2 any data. So we need to keep it to a core,
3 usable, somewhat user-friendly process and that's
4 what we'd like to do. But we'd like your input
5 into kids, what you think is important.

6 DR. VAN DER JAGT: Could it be
7 possible to see what those data points are
8 currently?

9 MS. BRILLHART: They're online.

10 DR. VAN DER JAGT: Oh. They're
11 online?

12 MS. BURNS: NEMESIS.ORG.

13 DR. VAN DER JAGT: What I want to
14 have --

15 MS. BRILLHART: It goes state by
16 state and shows what states submit what data, so
17 you can see what New York submits and what other
18 states are submitting.

19 MS. BURNS: New York is not
20 submitting yet.

21 MS. BURNS: I can provide you with
22 the sixty-six. We can give you a data dictionary.

23 DR. VAN DER JAGT: The only reason
24 is if we are expected to provide input into the

1 additional twenty-four data points, it would be
2 helpful to know what's already there.

3 MR. WRONSKI: We've done a line by
4 line, and Lee can provide you with that. It shows
5 what -- Sharon has done it, too.

6 MS. BURNS: That's the one I wrote
7 NEMESIS on.

8 DR. VAN DER JAGT: Is that something
9 we should have on the agenda for another meeting?
10 If you're asking for input on what should be going
11 there --

12 MS. BURNS: What I would propose to
13 you is that when we -- we have a lot of work
14 before we actually get to that. What I would like
15 to do, with your permission, once we get to that
16 point, we'll provide it to you electronically so
17 we're not handing it out at a meeting and hoping
18 you can read it, but you would have the chance to
19 mull it over, and at the next meeting, decide if
20 you want it as an agenda item or you want to have
21 an offline non-policymaking electronic
22 conversation about it. This is an overview
23 because -- the -- between our reality of NEMESIS
24 compliance and our grant deliverables, for me it's

1 a little overload. So we have to get our ducks in
2 a row on many fronts. So I would gladly provide
3 you resource information before I would ask you to
4 talk about it.

5 MR. WRONSKI: One last thing. The
6 policy item that you can vote on whenever you
7 choose to, that you support New York State's
8 efforts in moving the state toward an electronic
9 data set. All of the picking of the data points
10 are not really policy, they are supporting the
11 policy, and we can do that online, offline, in
12 between. The policy would be that we move towards
13 electronic NEMESIS data compliance.

14 MS. CHIUMENTO: So moved.

15 DR. AMLER: Second.

16 MS. BRILLHART: Second.

17 MS. FITTON: We also had a report
18 from the school of public health. One of the
19 interesting issues there was -- checked off
20 "other" as diagnosis or "unknown.

21 MS. BURNS: Or pain.

22 MS. FITTON: So it is great to look
23 at data points, but when you keep checking
24 "unknown" or "other" the data isn't necessarily

1 going to reveal anything to us.

2 MR. WRONSKI: But we already have
3 that information available to us.

4 MS. FITTON: You clearly have
5 nothing else to do.

6 MS. BRILLHART: We have a report on
7 scene times. It says all emergency calls,
8 1,400,000 almost, under "other" is almost 500,000.

9 MS. CHIUMENTO: Part of that is
10 because the current New York State PCR, which is
11 where a lot of this data came, had a very limited
12 list of possible issues.

13 MS. BURNS: The "other" on the form
14 itself allows the provider to write something,
15 which is not captured on the data set. So that's
16 the other. The other "other" is pain, and pain
17 also allows the provider to document left knee
18 pain, which is not a keypunch item.

19 MR. WRONSKI: In looking at
20 statewide data over the past five years, and we
21 had some, even though it's paper, largely. Now,
22 luckily, we have New York City's electronic data.
23 It is interesting to watch what providers put
24 down. And we know a lot is driven by the

1 limitations of the form, the limitations of
2 keypunching, but some of it isn't. For instance,
3 a very simple one a couple years ago: Was a
4 patient male, female or other? And one year we
5 had seventeen percent other. But it suggested
6 they didn't know if the person was male or female.
7 It was a very high percentage. So why that given
8 year that occurred -- but what really needs to
9 happen with data is we create this but when we do
10 the data set, we're going to need you and
11 everybody else locally to train and educate, train
12 and educate. Because it's only as good as what
13 the human being writes on the form.

14 MS. BURNS: As an example of that,
15 one of our conversations recently, and this is a
16 huge issue. When a caller dialed 9-1-1 and they
17 interacted with an EMD point, the dispatcher --
18 that duration of time between the time that the
19 dispatcher gives -- or discusses with the caller
20 is not documented for us. We don't actually know
21 when the caller accessed the 9-1-1 system. But in
22 looking at the current ACR that you're using in
23 New York City, you will note that the top number,
24 the top time is accessed to 9-1-1 and the hour

1 actual review of documents, that is not completed
2 by the provider. So the question really is where
3 does the CAD system link to the pre-hospital care
4 report. And there's no doubt there.

5 MR. CZAPRANSKI: In Rochester what
6 we're doing is putting in a new CAD system, and
7 the electronic PCR, when it's closed by the
8 technician, goes to the RHIO, which then pulls the
9 data from the 9-1-1 CAD and populates those
10 automatically.

11 MS. BURNS: That would be an
12 interesting study, how long is the caller on the
13 phone with the dispatcher.

14 MR. CZAPRANSKI: And the physician
15 at the ED, when they pull up that medical record,
16 that PCR for the patient, there will be a direct
17 link where they can actually listen to the 9-1-1
18 call.

19 MS. FITTON: Of course, on scene
20 time does not exclude vertical response.

21 MS. BURNS: The NEMSIS data set
22 does. There's arrived on the scene and access to
23 the patient, which is something we have been
24 really mulling over at the State council because

1 that is a real issue, access point. You pull up
2 and you have a seven story walk up there. Those
3 of us who aren't getting any younger, it means
4 twenty minutes from the time you get out of the
5 ambulance and get to the patient. But that will
6 be addressed in the NEMESIS data set, actually.
7 And I think it is also addressed in your system
8 now, although I'm not sure it's populated.

9 MS. FITTON: There are certain
10 issues for us -- security measures -- delays --

11 MS. BURNS: Again, we talk about
12 data, but it is as good as the provider who
13 completes the form and has a clear understanding
14 of the form, not necessarily -- we had comments
15 earlier about doorknobs and those types of things.
16 It's not that. It's how much information that the
17 provider has on hand. Do they know what time it
18 is when they actually get to the patient, those
19 kinds of things, and that greatly affects the data
20 that we get.

21 MS. CHIUMENTO: The interpretation
22 is what does it mean to be on scene. Does that
23 mean you're down the street or you've stopped the
24 ambulance and getting out?

1 MS. BURNS: It is a local
2 interpretation.

3 MR. CZAPRANSKI: One of the things
4 is we have difficulty in verification. Was the
5 proper EMD code used? Was that consistent with
6 patient diagnosis? Being able to tie that data
7 together is going to help us a lot as we continue
8 to move forward in the process.

9 DR. KUS: Is there a method for the
10 providers to locally or regionally look at the
11 data? That's really a telling part --

12 MR. WRONSKI: Right now -- all of
13 the regions get our data. What you find is
14 sometimes there's a disconnect on what would the
15 usefulness of the statewide database years after
16 the fact. From a state perspective, it is very
17 useful, because I use the state system in a
18 picture, even though it's a gross picture, it has
19 certain basic things and it's very useful for me
20 to describe the system to the legislatures when
21 they ask. When you get down to a region, it
22 varies on its usefulness, and when you get down to
23 an agency, again, the most important data for the
24 agency data is they've got the PCR and if they

1 were to collect it locally, in their own little
2 software base, which they can purchase fairly
3 cheaply, in most cases, it would be more useful
4 than the state data set. But what we hope by
5 going electronic is that that will then drive a
6 much more useful and contemporary system.

7 DR. COOPER: Further discussion?
8 Hearing none, there is a motion on the floor to
9 recommend acceptance of the use of the NEMSIS data
10 set and facilitate and foster the reporting of the
11 data to the Department of Health in electronic
12 format. Further discussion? All in favor? One -
13 two - three - four - five - six - seven - eight -
14 nine. Against? Zero. Okay. Carries without
15 dissent.

16 Okay. The final item on the agenda
17 has to do with pediatric trauma regulations. Now,
18 all of you saw these in the preliminary form in
19 which they were delivered to the department. Mike
20 Tayler is the trauma program manager within the
21 bureau of EMS for the department and he was
22 charged by the department with taking the -- those
23 recommendations, which were written in the former
24 regulatory language style and converting them to

1 the language style that the department now prefers
2 to use.

3 MR. WRONSKI: Dr. Cooper is correct
4 in that ultimately that will happen. But,
5 actually, the language here still needs to be
6 modified by regulatory writers, professionals at
7 it, and Division of Legal Affairs. This is done
8 right now by Mike, who is new at this and it's his
9 first -- his attempt to get all the concepts down
10 in writing, but there will be some modification
11 here to do.

12 DR. COOPER: Thanks, Mr. Wronski,
13 for that clarification. The fact of the matter is
14 that this particular format is, as said, Mike's
15 best attempt to put it into the language the
16 department prefers. Obviously, until it is in
17 line with the language the department prefers, it
18 is not going to be sent anywhere or approved by
19 anybody. But it's quite a bit different from the
20 old style of regulatory language in which the
21 recommendations were written. I trust that many
22 of you have been through these regulations. I
23 myself have been through them with the a fairly
24 fine tooth comb. And I'm just going to point out

1 a few areas that, I believe, do not necessarily
2 represent the thought process that we had in mind.
3 Now, the pediatric section in the regs begins on
4 page sixty-eight, and the first significant
5 difference between what we had recommended and
6 what is on the printed page is on page
7 seventy-two, and it is in the top half of the page
8 where you will see under 3.A.2 (1) and (2). You
9 will notice that there is no flexibility for
10 members of a pediatric trauma team to perform more
11 than one function. That was not quite our intent.
12 Many times, pediatric emergency physicians will go
13 ahead and intubate without the assistance of an
14 anesthesiologist, and this more or less states
15 that the anesthesiologist has to be part of that
16 team. I don't think anyone would disagree that
17 the anesthesiologist has to be available to
18 assist, but in many circumstances, the pediatric
19 emergency medical physician will be doing the
20 intubation, which is the primary reason that the
21 anesthesiologist is called. Additionally, it says
22 that any practitioner assigned to cover
23 minimally-required special treatment shall not be
24 simultaneously assigned to cover neurosurgery.

1 The whole purpose or one of the whole purposes of
2 inhouse pediatric trauma resuscitation team is to
3 initiate the trauma resuscitation and to consult
4 the neurosurgeon who will be potentially
5 performing any neurosurgical procedure or advising
6 regarding the need for same or diagnostic workup,
7 you know, as appropriate. So there needs to be
8 some additional flexibility there. I believe
9 that's not quite what we had suggested. I believe
10 that at the top of page seventy-three, there needs
11 to be clarification regarding whether pediatric
12 emergency medicine physicians are exempted from
13 the requirement to take HLS and PALS on a regular
14 basis if they are a recent residency graduate.
15 The way it's written, it says only board-certified
16 emergency medicine physicians and there are two
17 ways to become a pediatric emergency physician.
18 One is through pediatric and one is through
19 emergency medicine. So theoretically, a pediatric
20 emergency medicine physician not trained in
21 emergency medicine would not meet this
22 requirement, so that needs to be clarified.

23 The section regarding the staffing
24 -- sorry the staffing of the facilities in

1 emergency departments on pages seventy-four and
2 seventy-five appear acceptable. The sections on
3 pages seventy-six and seventy-seven regarding the
4 surgical response seem appropriate. The section
5 on the pediatric intensive care unit may need --
6 which is on page seventy-eight -- may a little bit
7 of wordsmithing (sic). I'm sorry. That the PACU,
8 not the PICU. Excuse me. Moving on to page
9 eighty. The wording with respect to the PICU may
10 need a little wordsmithing (sic). Because the
11 language here says that the PICU has to be
12 directed or co-directed by a surgeon. This is
13 language from the adult -- don't gag, Dr. Van der
14 Jagt.

15 DR. VAN DER JAGT: I didn't gag. I
16 was clearing my throat.

17 DR. COOPER: The language we
18 submitted, if you're a pediatric intensivist or a
19 pediatric surgical intensivist and that needs to
20 be clarified. The subsections on neurosurgery and
21 orthopedics seem acceptable. On page eighty-five,
22 there is language indicating that all surgical and
23 medical specialists have to have advanced training
24 and experience in, quote, unquote, the management

1 of pediatric. What that means, I think, needs to
2 be clarified. What was included in the language
3 that we had submitted was experience in the
4 management of children as opposed to advanced
5 training and experience in pediatrics. It is very
6 difficult to find surgical sub-specialists who
7 staff trauma centers in most areas who actually
8 are card carrying specialists. And in fact in
9 neurosurgery and orthopedics and all pediatric
10 credentials in those specialties, there is board
11 certification in neither of them at the present
12 time, although there are certificates of
13 additional competency or what have you. That
14 having been said, the focus of pediatric
15 neurosurgeons and pediatric orthopedists is
16 congenital anomalies, not the management of
17 trauma. And, in general, the trauma orthopedists
18 and trauma neurosurgeons handle a number of kids
19 as opposed to the pediatric specialists, although
20 that's institution-dependent. But for the most
21 part, the trauma neurosurgeons handle it.
22 Obviously, if you're talking about a children's
23 hospital, it may be a different situation. Those
24 were the key issues that appeared to reflect a

1 slight, if you will, over-interpretation of what
2 we had submitted, at least what I had identified,
3 and those points explicitly will be commented on
4 by our process.

5 Now, what is that process? The
6 State Trauma Advisory Committee met last week --
7 which is a segway into the final section of the
8 agenda -- and recommended to the department that
9 there be a subsequent meeting of the regulatory
10 group and that the State Trauma Advisory Committee
11 have an opportunity to look at these one more time
12 before they submit it to the department for
13 additional consideration. Even that will be far
14 from the last time we receive the regulation,
15 because they have to go to the State Hospital
16 Review and Planning Council and they have to go
17 through public comment and all kinds of other
18 stuff before they're actually adopted. But we're
19 very close to having a draft that will be
20 submitted to the STAC for consideration. So I
21 don't believe Martha has received any specific
22 comments. Maybe you have.

23 MS. GOHLKE: From Diana, from my
24 federal liaison. One of her main comments on the

1 existing draft is in regard to pediatric training
2 at each level that providers are receiving, and
3 there is pretty much generic wording for each
4 level of provider, but they have recent training
5 in pediatric advanced life support and in advanced
6 trauma life support or equivalent training and
7 experience. Her concern is two-fold. Who is
8 credentialing this other training and experience.
9 Is it the State? Is it ACS? And I walk a fine
10 line of the federal requirements at the risk of
11 being hit by my state counterparts here on either
12 side. But she has some concerns about how that is
13 worded and how we're insuring that good pediatric
14 training is out there. So I just wanted to put
15 that forth.

16 DR. COOPER: Martha just pointed out
17 --

18 MS. GOHLKE: In most of the levels
19 of providers, it's worded that way. And then we
20 hear the concerns of our nurse counterparts that
21 many times, training within the hospitals is cut
22 back, then I get even more concerned about what
23 Diana is pointing out to us in these trauma regs.
24 And that's what our main focus is, to make sure

1 these people can take care of pediatrics.

2 DR. COOPER: Let me respond to that.
3 Although the wording is a tad different, just a
4 tad different than what existed in the current
5 code, the language and the thrust of this language
6 is really no different than what existed since
7 1989. The reason that one cannot use capital
8 letters for HALS or PALS is because those are
9 proprietary products and what is being referred to
10 here is, in effect, the content of those anagrams.
11 And what is typically done to -- to make an
12 appropriate comparison is to list the goals and
13 objectives of the educational program side by side
14 and see if those goals and objectives are similar
15 and if there appears to be a significant number of
16 clock hours in the training program.

17 MS. GOHLKE: She's understanding of
18 that, but her point is, is the State overseeing
19 that, is the State going to make sure that the
20 training that they're getting is - you know - the
21 objectives are met.

22 DR. COOPER: Perhaps Mr. Wronski is
23 better to answer this than I, but having
24 participated in numerous surveys over the years,

1 to be very frank, the time and effort required to
2 put together programs that are different from
3 advanced trauma life support, pediatric advanced
4 life support, are just not worth the effort and
5 virtually no one has done that. What has been
6 done in the past is that nursing training has been
7 intramural and has not been really prescribed in
8 terms of the level of depth. But that's in the
9 current code. The current code says intramural or
10 extramural training for nurses in pediatric
11 trauma, without further specification. So this
12 actually, in many ways, represents the tightening
13 of the current language rather than the loosening
14 of it. So I do think it is important for us to
15 recognize that in the end, it is the department
16 that wrote -- and while it will do so on the
17 advice of the -- generally speaking, the site
18 visitors that may visit a particular program have
19 found a preview by staff. In my personal
20 experience and to my personal knowledge, there has
21 not been an issue with that determination of
22 equivalency in the past. And as I say, it's
23 difficult to accomplish, so many people have used
24 PALS or ATLS as the golden standard.

1 MS. GOHLKE: And in line with the
2 comments, how recertification or retraining
3 happens. I mean, obviously from a quality
4 assurance perspective, if nobody is looking over
5 their shoulder, that's where the concern is. And
6 if we can't look over their shoulder as a state
7 for whatever the reasons are, budget, whatever,
8 staffing, then the regs, she would argue, would be
9 a little more descriptive in the type of training.

10 MR. WRONSKI: As you get further
11 from the street or the hospital, as a government
12 employee, you tend to be more prescriptive. And
13 the State, I'm told, always writes these
14 prescriptive regs. We're in Albany, we're not at
15 the hospital. And etcetera, etcetera. Anyway, my
16 belief is similar to Dr. Cooper's. The majority
17 of places don't bother writing their own, because
18 it takes a lot of time and you need the experts to
19 do it and take the time out to do it. Most of
20 them use a canned product, a nationally approved
21 product, but there are exceptions, but they have
22 usually been -- how the given medical director for
23 a trauma program will evaluate the background and
24 experience of an individual, not necessarily their

1 training but the sections of the trauma code that
2 talks about someone who -- a surgeon who has
3 experience in training, takes care of kids in
4 trauma, and therefore they can cover the trauma
5 program but they are not board certified in trauma
6 in some way and the director makes that call and
7 those are individually based. And I have run
8 across some programs where they have done a couple
9 of in-house training programs developed by a
10 specialist in that hospital, but they're rare.
11 Most -- again, ninety percent or more, are the
12 national programs. I understand the concern of
13 the feds on this. The State of New York doesn't
14 get out often to do the surveys and that's for a
15 variety of reasons, although we do plan to start
16 surveys again, hopefully later this year, but that
17 will be here nor there. The most we are going to
18 get to at any point is three or four surveys a
19 year and there's forty-two at present or
20 forty-three trauma centers. So it will take quite
21 a while before we get to see them. We are going
22 to institute a paper process where every two years
23 we are going to ask for information from every
24 trauma center to give us -- tell us if they're

1 up-to-date in their standards. We could consider
2 putting a line in there that talks about do you
3 use that national ATLS, ACLS products or do you
4 have your own? We could see about doing it that
5 way, self-eval, but the reality is we don't get
6 out to the trauma centers often enough. But
7 always remember, too, the 708 code is a planning
8 code. It's not a 405 code, which is a mandatory
9 code. The 708s are standards that apply to trauma
10 centers but not as rigorously as a 405. My option
11 with a trauma center, if it doesn't follow the 708
12 standard, is to remove their designation as a
13 trauma center. A hospital that doesn't follow 405
14 doesn't necessarily get de-designated as a
15 hospital. They get enforcement, fines, people can
16 get fired, etcetera, etcetera. That doesn't
17 happen in the 708s, because it is a different set
18 of standards. And so we need to be cautious about
19 how we write stuff and, in my view, we have to
20 have some wiggle room like this language and we'll
21 just have to convince the federal government that
22 what we're writing makes sense for this state and
23 that we'll watch it as closely as we can.

24 MS. GOHLKE: We can debate this more

1 back in the office, but my argument to that would
2 be this is a planning code and not a regulatory
3 code. Why can't we set a best practice standard
4 and then recommend these courses rather than --

5 MR. WRONSKI: We could. We could go
6 that way.

7 DR. VAN DER JAGT: Could I just
8 comment on that a little, Martha? As I understand
9 it, there should be something more specific in
10 this regarding the education or training.

11 MS. GOHLKE: If not more specific,
12 then we have to guarantee that we're -- if they're
13 going to do some other training program, some
14 outside entity should be looking at the goals and
15 objectives and making sure that they are not just
16 doing an hour of fluff, that type of thing, and
17 claiming they've done the training.

18 DR. VAN DER JAGT: I'm wondering. I
19 have to agree --

20 COURT REPORTER: I need you to speak
21 up a little. I can't hear you.

22 DR. VAN DER JAGT: You can not put
23 in here something that's proprietary -- or Apple
24 or TNCC or something that's a national course.

1 And here's another way of looking at that is --
2 there may very well be specific training that is
3 much better than what's currently offered, so then
4 you're actually not doing best practices. If you
5 look at the Pittsburgh simulation center, they
6 have a number of simulation courses that are not
7 nationally accredited, but they are extremely good
8 courses but probably much more real and much more
9 training that is probably better education.

10 MS. GOHLKE: And I don't think she's
11 --

12 DR. VAN DER JAGT: So another
13 question is, is there something that is more
14 specifically related to the curriculum or the
15 goals and objectives? That's what you're getting
16 at, right? It's not the products.

17 MS. GOHLKE: We're not looking for
18 the folks that are doing above and beyond. We are
19 looking for those folks that are doing less than.

20 DR. VAN DER JAGT: Right. Right. I
21 do understand that, but I think the question then
22 is how do you put in this, the goals and
23 objectives that you desire, and that is very
24 cumbersome and very complex and I'm a little bit

1 concerned if you put it in here, it would not be
2 the right place for it.

3 DR. COOPER: Well, what is clear is
4 that the Commissioner of Health has the ultimate
5 responsibility to insure that the Department is
6 enforcing its own regulations. It seems to me
7 that if something is in the reg and its talking
8 about equivalency and the Department would be
9 enforcing it on some level, that it's up to the
10 Department to determine that equivalency. And we
11 recognize, of course, that as Mr. Wronski has
12 said, the Department can visit trauma centers on
13 an infrequent basis, but that's true of every
14 system. There is no verification system of which
15 I'm aware of that a site visits trauma systems
16 more often than every three years. The Department
17 perhaps extends that to every four or five, but
18 there is still an awful lot of dead space, if you
19 want to think of it that way, in between site
20 visits, that hospitals could, if they were so
21 moved, try to skirt the intended reg and frankly,
22 probably could get away with it to some extent if
23 they so chose.

24 On the other hand, I think to a

1 certain extent, we have to rely on the fact that
2 people who work in trauma centers are doing their
3 best to live up to the letter and the spirit of
4 the law and that they're keeping accurate and
5 appropriate records of the training that takes
6 place and that at such time the Department comes
7 to call -- by the way, the Commissioner can visit
8 any healthcare facility at any time, any day of
9 the week or any hour of the day or night to
10 determine if requirements are being met. While
11 that doesn't happen often -- a hospital in which a
12 serious adverse event takes place, they're held to
13 a certain standard and frowned upon in
14 investigation for not having met that standard.
15 So I think that there are certainly sufficient
16 safeguards in place that would allow an
17 appropriate, if you will, review of what
18 equivalency means. That having been said, I don't
19 think this is an issue specific to the pediatric
20 trauma standards. It's specific To general trauma
21 standards, to the 405 code for emergency
22 departments, and to many, many other provisions of
23 the health code where specific training is being
24 called for and language regarding equivalency is

1 included. So if this issue were to be addressed
2 in terms of providing, if you will, in a succinct
3 phrase, something like in a form to be decided by
4 the Department or a manner to be decided by the
5 Department in terms of equivalency, it would have
6 to be included across the board in all the
7 sections of the code. But to me it's not
8 necessary because it's self-evident and
9 understood.

10 DR. KUS: I want to make a comment.
11 Be careful what you wish for. If you say you want
12 an equivalent training program, then you could
13 say, Submit it to us, and I don't know if you want
14 to do that. When you look at the regs, there's a
15 lot of places that talk about physicians who are
16 not board certified but are board eligible and
17 expert experienced. Are we saying by virtue of
18 the fact they are making the judgment on the
19 person they're employing. I think that's probably
20 where you're going. As you said, we argue about
21 this with all the regs, particularly how often you
22 see them. And are you --

23 DR. VAN DER JAGT: Could I ask a
24 question of Kathy? I'm sorry.

1 COURT REPORTER: I can't hear you.

2 DR. VAN DER JAGT: My voice must be
3 so soft. What I want to ask was -- isn't there a
4 requirement that the emergency medicine physician
5 have taken ACLS, is that person -- small ACLS or
6 is it the ACLS course? Because that relates to
7 this. That's the New York State requirement that
8 physicians have ACLS certification. How is that
9 accomplished -- maybe you know.

10 MR. WRONSKI: Yes. I drafted the
11 letter with the signature of my boss many years
12 ago. This particular one, I know I have intimate
13 knowledge of. The question was, in fact, the same
14 issue was equivalency, and equivalency was the
15 board certification of an emergency medicine
16 physician whose residency-trained and board
17 certified. That the nature of their training, in
18 fact, did not require you to take that program
19 independently. What the Department opined was
20 that if you were board certified in emergency
21 medicine, you didn't need to take this course as
22 well. But they fully expected that when the
23 standards changed, that you would update yourself
24 on the standards. So if we looked in the site

1 survey, we would look to see that the personnel
2 file of a particular emergency physician on duty
3 had either recertified in ACLS ATLS or had an
4 update so they have the updated information. But
5 they weren't required to have that training, as
6 long as they were board certified in emergency
7 medicine.

8 DR. VAN DER JAGT: Is it
9 specifically ATLS and ACLS?

10 MR. WRONSKI: Not in the regs. The
11 Department can't endorse a particular product.

12 DR. COOPER: Ladies and Gentlemen,
13 we have come to point in our meeting where we are
14 fifteen minutes over time and I know that our
15 stenographer may not be able to continue with us a
16 whole lot longer. So here is what I would like to
17 do. Do I have general consensus that the issues
18 that have been discussed in the latter part of the
19 meeting are issues we should comment upon? Yes?
20 Is there anybody who objects to that? Okay. That
21 will be done. And any other comments need to be
22 gotten to Martha so we can formally get those to
23 the group that's going to review the regulatory
24 requirements.

1 I think we have pretty much covered
2 the key points that were discussed at the STAC
3 meeting with the regs and trauma report, and SEMAC
4 has not met since we met so there is nothing new
5 to report from SEMAC since the March meeting.

6 So we've come to the end of the
7 formal agenda and deference to our stenographer,
8 who cannot stick with us too much longer, I would
9 like to ask the group if they would like to either
10 end of meeting at this point or take a very short
11 break and come back in five minutes?

12 SPEAKER: What's left?

13 DR. COOPER: Basically, old business
14 and new business. Let's take about a three minute
15 break. Okay.

16 (Whereupon, a brief recess was
17 taken.)

18 DR. COOPER: We have almost everyone
19 back, so we are on the record. We've come to the
20 end of the formal agenda, and I believe we have
21 covered all the issues on the formal agenda with
22 the exception of the pediatric disaster card, but
23 we will defer discussion on that until next time
24 because we are simply out of time.

1 So at this point, I'll ask if there
2 is any old or new business that people wish to
3 bring up, including any round robin comments that
4 people wish to make about emergency medical
5 services for children issues that are of import in
6 your region. Hearing none --

7 MR. WRONSKI: I have one comment,
8 and this will be very short. One comment. I have
9 been lucky enough to have a lot of good staff,
10 staff who want to run programs in a proper way,
11 and I always want to make comments when they've
12 gone out of their way to do something extra. And
13 even though Martha and I disagree on one aspect of
14 the language here on the reg, I want to put on the
15 record that I'm very pleased with her work with
16 the EMS-C committee and I'm particularly pleased.
17 She recently graduated from EMT school and she's
18 now an EMT. That's all.

19 DR. COOPER: Thank you. Did you
20 have an opportunity to personally deliver the
21 pediatric protocol --

22 MR. WRONSKI: No. We'll have to do
23 that at some point, maybe here.

24 DR. COOPER: All right. I have no

1 further information to bring to the committee
2 other than to remind us all that we are meeting
3 next on September 29th of this year, here in
4 Albany. That is a Tuesday.

5 MS. BRILLHART: It is also the
6 second day of Yom Kippur.

7 DR. COOPER: Oh, it is.

8 MS. BRILLHART: We knew it when we
9 set it up, because I brought it up then. It is
10 going to cause travel trouble for any --

11 DR. COOPER: As of this moment, the
12 meeting will be Tuesday, the 29th of September. I
13 will work with Ed and Martha to see if there's any
14 flexibility on that in lieu of the Jewish holidays
15 and the conflict. I doubt that there will be, but
16 we'll see what we can do about that. Any other
17 old or new business? I'll entertain a motion for
18 adjournment.

19 DR. LILLIS: So moved.

20 DR. COOPER: Thank you, Dr. Lillis.
21 We will see you in September.

22 (Whereupon, the meeting concluded at
23 4:24 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: June 22, 2009