

STATE OF NEW YORK
EMERGENCY MEDICAL SERVICES FOR CHILDREN

Advisory Committee Meeting

DATE: September 29, 2009
TIME: 11:12 a.m. to 4:05 p.m.
LOCATION: Crowne Plaza
State & Lodge Streets
Albany, New York 12207

EMSC, 9-29-2009
APPEARANCES:
Arthur Cooper, M.D., MS - Chair
Susan Brillhart, MS, RN, CPNP
Lee Burns
Sharon Chiumento, BSN, EMT-P
Martha Gohike
Jonathan S. Halpert, M.D., FACEP, REMT-P
Robert Kanter, M.D.
Rita Molloy, RN
Janice Rogers, MS, RN, CS, CPNP
Mike Taylor
Elise van der Jagt, M.D., MPH
Ruth Walden
Edward G. Wronski
GUESTS:
Tim Czapranski
Sarah Macinski Sperry
Wendy Weller, Ph.D.

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(The meeting commenced at 11:12 a.m.)
DR. COOPER: All right. Let's -- let's begin the meeting. We're on the record as of now.
Good morning everyone. I'd like to thank everyone for coming to the September meeting of the State Emergency Medical Services for Children Advisory Committee.
We've had, of course, a very busy summer thinking about preparing for the epidemic that may or may not come. And I think that has consumed quite a bit of the effort of the Department of Health at this particular point.
And Chris Kus from the Department of Health is actually on the agenda to join with us and update on what has transpired from the Department's point of view, but before he arrives, I think we have some business to transact, and -- and then, of course, quite a bit afterwards as well.
So, I -- I want to just begin the meeting before approving the minutes by extending

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Discussion?
All in favor, please signify by saying aye.
FROM THE FLOOR: Aye.
DR. COOPER: Opposed?
(The motion carried.)
DR. COOPER: It goes without dissent.
Martha, please tell us about today's agenda.
MS. GOHLKE: Okay. Dr. Cooper kind of ran through that we're going to have a H1N1 presentation.
It's pretty standard: We'll have the Bureau of E.M.S. report. We'll have the E.M.S. for Children grant report. Subcommittees will report out and we'll get to some old business, new business, and hopefully have time for updates from our other committees and anything going on in your 20 regions.
I just want to take a second, so look through your packet, just to point out since we won't touch upon everything necessarily today.

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Behind your agenda, which we will have lunch around twelve-thirty as usual, behind your agenda is a summary of the last meeting. My notes from the 5 last meeting. Behind that you'll see pediatric sponsor trainings, which I'll talk about in my 7 report.
Behind that you'll see the bylaws. They've actually gone through the department of legal affairs, and they're ready to be voted on, today if we have time.
And you'll see new travel forms behind that. Mike Taylor has helped out by highlighting the information that you need to complete. It hasn't really changed. It's just the forms are, you know, a little neater, and you can now fill them out electronically. So, if you prefer to type in your information, I did e-mail them out. If you didn't get them, let me know, and 20 I'll resend it to you.
Behind that is the symposium, I don't know what they're calling it. The one-day disaster management and emergency preparedness in 24 Westchester, that -- that Dr. Cooper's and Dr.

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anything that suggests otherwise, that it's changed into anything more dangerous, but the fear right now is really the numbers of people, and that it -- 5 also our flu season seems to have changed somewhat, with H1N1. And whether that is modeled again this year, and we have a longer flu season than we have had in the past, we'll just have to monitor what's happening and determine that.
From the Bureau perspective, we have issued recently -- and you can see this on our Web site, and I apologize, we did not bring a copy with us, but we did produce an updated memorandum and guidance document to E.M.S. on H1N1. It does not contain anything new. It is really just for our purposes saying, here's a reminder. This is like the seasonal flu. Use a surgical mask. And if you're using a -- if you're advanced life support, and you had a procedure which aerosolizes, 20 then you'd like -- you would need to use an N95.
I'll bring that up because there is some controversy about whether or not an N95 should be worn all the time. It's the Department of Health's position in that is no, you don't have

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And the recommendation from public health to us, is that the surgical mask --
THE REPORTER: I'm sorry.
(Off-the-record discussion)
MR. WRONSKI: One, two, three.
All right.
THE REPORTER: Okay.
MR. WRONSKI: Okay. So, the N95 is a contested point and still being discussed. But in the Department's position, it's not necessary for us to mandate the N95 for use all the time. So, you'll hear that, and again, it comes from our public health office, so it's been vetted, and that is the Department -- New York State Department of Health's position.
We are -- the other controversial issue, and you may individually have your own opinions on this, is the mandated vaccination. And E.M.S. is not mandated to be vaccinated.
However, however, an interpretation by -- let me back up.
Recent regulations that were passed and approved, which have been under

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2 long conversations on it, and nine one one is not
3 affected, except for the exceptions I gave you, and
4 that's the hospital-owned or -operated or
5 -contracted E.M.S. services.
6 Any - any questions on that?
7 Because I know you may gets asked when you get
8 back. Is that clear?
9 If it changes, we'll let you
10 know. But I -- I don't see it changing at this
11 time.
12 Other issues:
13 Vital Signs is being held in the
14 month of October, and it starts on the 15th and
15 runs through, I think, Sunday the 18th. It's
16 pre-conferences in the great City of Rochester.
17 Pre-conferences on the Thursday and Friday. I don't
18 recall if there's Wednesday pre-conferences.
19 MS. GOHLKE: No, there isn't.
20 DR. COOPER: No.
21 MR. WRONSKI: It's Thursday and
22 Friday. Saturday and Sunday are the main event, so
23 to speak.
24 At present we have good

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2 attendance. Our anticipation is that we should
3 peak out some where around eighteen hundred people,
4 which is a good size conferences, particularly in
5 economic times as they are. So, we're excited
6 about that.
7 And I have been told that if you
8 can, the commissioner is going to be in Rochester
9 on Thursday, and he hopes -- he's trying to put our
10 conference on his scheduled to make an appearance
11 there Thursday and stop in and -- and say hello at
12 the pre-conferences, take a look at what we do up
13 there. And that's great. We haven't had a
14 commissioner personally visit the conference in a
15 while, so that would be nice.
16 Some additional news, and I'm
17 going to ask for all of your support on this -- and
18 that means you needs to buy a ticket. Next year,
19 we're going to New York City. We'll be at the
20 Sheraton. We'll be there at the end of August.
21 All right. We have worked with the Sheraton before
22 and we've worked with them very strongly over the
23 last few months, as well as other bidders, but my
24 goal for years has been to try to move the move the

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2 point eight million dollars for E.M.S. Budget for
3 E.M.S.C., Martha may have some discussion of that
4 later, but I think there's good news on the horizon
5 there, you know, potentially more money down the
6 road and that would be good. But clearly, there's
7 support at the federal level for E.M.S.C., and
8 there's certainly support at the state level, you
9 know, for this program. It's proved very effective
10 over the years and we'd like to make sure we keep
11 it and make it a healthy program.
12 I think those are all the big
13 issues that I wanted to report on, unless there's
14 questions from anyone.
15 DR. COOPER: Ed, I think there's
16 one issue that is worth mentioning. The State
17 Trauma Advisory Committee, as you know, in
18 collaboration with the American Trauma Society,
19 annually organizes a -- a pre-conference workshop on
20 care of trauma patients. This year it's going to
21 be on traumatic brain injury, last year it was on
22 pediatric trauma.
23 I'm wondering if this committee
24 might want to consider working with the Department

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2 and -- and setting up an annual workshop on
3 pediatric issues of -- of relevance to the
4 prehospital community. I think that would be an
5 excellent project for the Education Committee to
6 take on.
7 And I can see Sharon's
8 volunteering to take that on.
9 MS. CHIUMENTO: (Off-mic).
10 DR. COOPER: But -- but -- but
11 this is something I think to think about, because
12 we have, obviously, a long time to think about
13 doing such a thing, and of course, we need to
14 discuss that with the Department and the planners
15 of the Vital Signs Conference Board for 2010. But
16 it might be a wonderful opportunity for this
17 committee and for the children of New York State to
18 sort of have that level of visibility on an annual
19 basis. So, I would ask the Committee to consider
20 that.
21 MR. WRONSKI: The -- well,
22 certainly, we support education on pediatrics. We
23 always try to have some programs like Vital Signs
24 that focus on children. So, we could certainly

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2 DR. VAN DER JAGT: Minor. He
3 smiles.
4 MR. WRONSKI: Like the --.
5 MR. WRONSKI: That's right.
6 That's correct.
7 DR. VAN DER JAGT: I told him he
8 has to stay for the day.
9 MR. WRONSKI: That's correct.
10 Yes, I have to stay for the day. The humorous
11 side. I -- I hope I've been of some worth to
12 E.M.S.C. and to the other committees over the
13 years, but I'm retiring from state service at the
14 end of the year. I'm going to continue work with
15 Martha to run the program for next year. The
16 Advocates Committee meeting.
17 And by the way, I don't know if
18 Martha's mentioned to you, we have sent dates to
19 the commissioner's office, and they are reviewing
20 those dates to -- to let us know when the
21 commissioner would be available, and he would
22 commit some time to come to that advocacy meeting
23 when it's held. That's the only thing he's holding
24 up the specific date right now. We're waiting for

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2 a commitment by his office.
3 DR. COOPER: You're speaking of
4 the stakeholders meeting, right?
5 MR. WRONSKI: The stakeholders
6 meeting.
7 DR. COOPER: Yes, okay.
8 MR. WRONSKI: Right. The --
9 yeah, I change titles all the time. Martha reminds
10 me of that. It's time to move on since I can't
11 remember the title of one thing or another.
12 But -- and that's good news. So,
13 I'll continue to work with Martha while I'm here.
14 But I -- it's been a pleasure. The E.M.S.C. has
15 been a -- a fun group. My former assistant
16 director, Marjorie, was the primary player for
17 E.M.S.C. But we always met and discussed your --
18 your role and how to improve that, and -- and make
19 sure we had commitment for it, and you know, it's
20 been a pleasure for me to come to the few meetings
21 I've been able to in the last year.
22 And I -- I think this Committee,
23 you know now that it's statutorily created, and
24 that was great, it's going to have a long life.

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2 MR. WRONSKI: So, that's great.
3 That's great. That's great.
4 DR. COOPER: That I haven't had
5 the opportunity, the microphone, to publicly thank
6 Ed for this incredible service.
7 Ed, sadly from the point of view
8 of many of us, because he's been such an
9 outstanding leader for the Bureau, and oh, by the
10 way, I think the only member of the Department of
11 Health staff ever to win the commissioner's award
12 for excellence in emergency medical services. I
13 have not had the opportunity really to publicly
14 thank him for all he has done. I think John has
15 summed it up really very, very well. If we think
16 back to 1992 when Ed joined the Bureau, the Article
17 30 revisions had just been passed.
18 Ed, I don't recall if you had a
19 hand in -- in that or not.
20 MR. WRONSKI: I was in one of the
21 last meetings.
22 DR. COOPER: But -- but that --
23 that process was seen through to completion, the
24 implementation of those -- of those changes took

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2 place throughout the '90, the seating of the SEMAC,
3 the seating of REMACS, really the development of
4 a -- of fully organized and inclusive system for
5 emergency medical service throughout New York State
6 really developed during that period of time.
7 And then, of course, no surprise
8 to anyone here, we had a number of other E.M.S.
9 milestones along the way:
10 We saw the public access
11 defibrillation legislation passed. We saw the
12 infrastructure for the trauma system enacted into
13 law. And we've seen the infrastructure for the --
14 for Emergency Medical Services for Children enacted
15 into law.
16 Those are really pretty
17 extraordinary milestones in terms of
18 accomplishments for an E.M.S. system really over
19 essentially a fifteen-year period. And Ed quietly,
20 behind the scenes, advocated, I am told quite
21 passionately for many of these initiatives at --
22 at -- at times when others in the Department were
23 not advocating quite so passionately. And it --
24 it's because of Ed's support that most of these

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2 pretty good it will, on an annual basis, and it's
3 going to be extended to an extra six million over
4 the next four years, so --
5 DR. COOPER: Just in New York
6 State or --
7 MS. GOHLKE: No, no, no.
8 DR. COOPER: -- the whole nation?
9 MS. GOHLKE: No. The whole
10 nation.
11 DR. COOPER: Okay.
12 MS. GOHLKE: So, from twenty --
13 some twenty -- twenty-six million to thirty-one
14 million over the next four years, something like
15 that. Don't quote me on it, but I think that's the
16 accurate.
17 And although I don't think the
18 E.M.S. for Children State Partnership grants may
19 get more money, what she inferred was that she's
20 going to entertain ideas for projects. So, I think
21 it would be great if we can, you know, put forward
22 a suggestion. I know at the last meeting we talked
23 extensively about training of emergency departments
24 and urgent care and school nurses in -- in --

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2 relative to pediatrics, and that there's a need
3 there.
4 You know, just kind of thinking
5 off the top of my head, you know, if we could do --
6 if we could put together a proposal to do some sort
7 of a statewide training, whether it's, you know,
8 all hospitals or community hospitals, or urgent
9 care centers, or -- or a mixture of all those, and
10 another idea is to obviously maybe do something
11 within the northeast and collaborate with other
12 states. You could have a training team going
13 around to the different states. That would be
14 much -- received much more favorably, obviously, if
15 we're partnering with other states and doing a
16 bigger training program, then it would be more
17 money.
18 And then, another idea is that I
19 was talking to my E.M.S. for Children counterparts
20 in New Jersey, and they have a whole simulation --
21 pediatric simulation program that they put into
22 emergency departments and they have all the
23 mannequins, and they - even before all this -
24 offered to come to New York State, and we could

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2 dollars and then some a little bit for next year
3 just on E.M.S. for Children grant. So, that's also
4 food for thought. I mean I -- I come from a -- a
5 trainer background, so I'm very oriented to
6 trainings, and you know, I think they're good, and
7 worthwhile, which is why we did this year.
8 But it is something we could look at for next year.
9 I am about ready to write the
10 grant, the continuation grant, for another year.
11 It's due in November for next year. Not that
12 things can't be revised along the way, but again,
13 if you have any ideas, now is the time to discuss
14 them and put them forth, and we can think about
15 them for next year. For the coming years. It
16 doesn't even have to be for next year. It can be
17 for future years.
18 And we're also going to do one
19 more training that's not listed on here. The --
20 the Buffalo folks want to offer a PEP course as
21 well, the beginning of next year, so they're going
22 to get the monies to offer that PEP course in their
23 region in probably January or February. So, your
24 federal tax dollars hard at work.

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2 Let me see what else I had. Oh,
3 meeting dates for next year. I don't know if you
4 brought your calendars, but we can talk -- we have
5 some dates in Pennsylvania and you can maybe
6 reflect upon them, and see if something is just
7 outright wrong and you can't do. Now, and these
8 are not etched in stone. So, I don't want you to
9 pen them in your calendars; okay? Because we still
10 have to work with the hotel and I have to work with
11 the other committees to try and organize things.
12 But we did do an initial look at the calendar. The
13 first meeting -- and I -- I looked to keep them on
14 Tuesdays, because I know last year that was
15 preferable for most people.
16 So, the first meeting we looked
17 at maybe possibly March 2nd; the second meeting of
18 2010, possibly May 4th; the third meeting would be
19 September 21st; and the fourth and last meeting of
20 2010 would be November 16th.
21 FROM THE FLOOR: Just repeat the
22 dates one more time --
23 MS. GOHLKE: Sure.
24 FROM THE FLOOR: -- I want to

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2 will last. I can tell you it's strictly budget,
3 and it doesn't have anything to do with the
4 E.M.S.C. It has to do with the whole picture of --
5 of the state. So, again, you know, we'll have
6 meetings, we'll continue this, but there may be
7 some changes next year.
8 DR. COOPER: Martha, I just --
9 MS. GOHLKE: Yes?
10 DR. COOPER: -- a -- a couple of
11 thoughts regarding your comments so far. I think
12 the -- the first thing is that with respect to
13 training, I don't know the extent to which we have
14 the capability, if you will, to conduct a needs
15 assessment to try to determine where the real gaps
16 in training really are. Now, I -- now, I don't
17 mean, by this, the normal kind of survey where we
18 ask people, you know, do you feel comfortable?
19 Have you been trained? Et cetera. But actually, a
20 hard look at the Department's databases to
21 determine where potential preventable morbidity and
22 mortality may actually lie.
23 And I -- I -- I am trying to, of
24 course, stimulate the wheels inside of Bob Kanter's

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2 brain on this one, because he knows the databases
3 probably as well as anyone.
4 And of course, we all recognize
5 that there are problems in terms of, you know,
6 robust measures or -- or benchmarks, if you will,
7 for pediatric morbidity and mortality, other than
8 in the trauma world, and to some extent, you know,
9 the asthma world and the critical care world. The
10 more general sort of range of illnesses to which
11 children are subject, perhaps don't have the same
12 level of intensity or in terms of availability of
13 scores to determine how sick they are and what the
14 expected outcomes might be.
15 But this might be a potential
16 project, Dr. Weller, that this committee could work
17 on in the future with the -- with the -- with the
18 School of Public Health. If there were some way
19 for us to identify where preventable morbidity and
20 mortality was, and it -- it -- it could even be
21 qualitative rather than quantitative research at
22 this particular point in time. And I know Susan
23 Brillhart has been focusing on -- on that in terms
24 of her doctoral work. There -- there may be

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2 in an urgent care center that, you know, are
3 really, really useful to people on the front lines.
4 And so, that might be one more
5 course that we consider in the armamentarium. And
6 then, of course, I would be remiss if I didn't
7 mention the Society of Critical Care Medicine's new
8 pediatric fundamentals of critical care support
9 course. The New York City Department of Health has
10 federal dollars that it has used to support a
11 pediatric disaster coalition in New York City.
12 One of the projects that the
13 pediatric disaster coalition has taken on is the
14 funding of -- of train the trainer programs for the
15 pediatric fundamentals of critical care support
16 course. The idea of being that a pediatric
17 hospitalist or -- or general hospitalists, who care
18 for children infrequently, may be needing of this
19 level of education, particularly if we are hit with
20 something like a massive pandemic flu outbreak.
21 So, these are other trainings,
22 Martha, that could be added to the -- to the list.
23 Since our focus is on emergencies rather than on
24 critical care, I think that APLS is probably a -- a

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2 good place to start, at least at the higher ends,
3 in terms of physicians and -- and in -- in offices
4 and urgent -- urgent care centers, and Susan and
5 Jan, for, you know, pediatric nurse practitioners
6 as well, because it's ideally suited to them as
7 well. But I think these are courses that we should
8 also be considering.
9 But once again, to the extent
10 that we can utilize the data within the Health
11 Department and find out where the real gaps are in
12 terms of knowledge, at least in terms of the
13 outcomes that we're seeing, as the result of lack
14 of knowledge, that could help us really target the
15 kinds of educational offerings that we really need
16 to be providing for the public.
17 Sarah, and then Jan.
18 MS. SPERRY: Hi. I just wanted
19 to let you know that with the Bureau of Injury
20 Prevention, we have -- have a lot of injury
21 prevention data that we actually have a
22 presentation of all of our different data sets and
23 what we've done that we've done for some things. I
24 would be happy to forward that along to the

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2 able to sponsor it. We tried sponsoring from
3 Strong and financially we couldn't. We had some
4 faltering, and were not able to, you know, continue
5 with the course, but that was an excellent course
6 for school nurses.
7 We're trying to bring back a
8 one-day course right now, that Rita and I have been
9 working on. And this will focus just on trauma
10 because, you know, you cannot do it all in one day.
11 But we thought at least if we broke it up, we would
12 be able to make a presentation in that respect.
13 DR. COOPER: Thank you.
14 MS. MOLLOY: Yes. I actually
15 took that course when it was offered. It was very,
16 very comprehensive. And we're hoping that we'll at
17 least revisit the model to take across the state
18 regionally every spring. So, that's the goal.
19 DR. COOPER: Okay. Well, a lot
20 of opportunities to -- to think about in terms of
21 programs for education for our peers, but once
22 again, to the extent that we can -- we can target
23 them at -- at providers that we know most need them
24 in terms of preventable morbidity, mortality, the

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2 if it's something that we can do separate next
3 year.
4 DR. HALPERT: Just my -- my only
5 concern would be --
6 MS. GOHLKE: So --
7 DR. HALPERT: -- if there is any
8 immediacy here where we need dot have something so
9 we've got the funding, and then kind of tailor it
10 after the fact to a more data driven kind of a
11 program. That's my only question.
12 MS. GOHLKE: Yeah. I'll -- I'll
13 find out. It -- I'll find out. I don't know how
14 urgent it is to get it in.
15 DR. HALPERT: Oh.
16 MS. GOHLKE: Yeah.
17 DR. COOPER: Thank you. Martha
18 and the -- more on the grant updates?
19 MS. GOHLKE: Nope.
20 DR. COOPER: That's it?
21 MS. GOHLKE: Yeah.
22 DR. COOPER: Okay. Cool. All
23 right. Well, I think we've identified, you know, a
24 potential rich area for future work. Bob Kanter

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2 better we're going to be, I think. John?
3 DR. HALPERT: Question for
4 Martha. Given what's been talked about, which is
5 all really good information, and is going to turn
6 into some very useful and reasonable product, is
7 there any kind of a time table at this point in
8 your mind that would be where we have to be
9 concerned about having something ready to go to
10 utilize funds available or no?
11 MS. GOHLKE: Well, I can put a
12 feeler out to our project officer, and see if they
13 would entertain something for early -- as early as
14 2010, which would be March 1.
15 DR. HALPERT: Okay.
16 MS. GOHLKE: That's when the
17 funding is supposed to go into effect. So, for
18 2010. So, I would assume as early as 2010, but
19 it's sad to say that, you know, we -- we wouldn't
20 be considered later.
21 But I can -- I can talk to her,
22 and see how she wants to receive the information,
23 if she needs a formal -- if she wants me to include
24 it in my E.M.S. for Children renewal this fall, or

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2 and I were informally speaking about our next
3 global project before the meeting, and this might
4 fill the need, and of course, I know Elise is --
5 was long ago, it's really twenty years, was working
6 on the issue of some kind of sort of score to
7 identify sick kids as part of his original E.M.S.C.
8 grant in New York State. And Elise, I certainly
9 hope that this would be something that you'd be
10 willing to, you know, participate in as well. I
11 think this would be a real -- an incredible
12 culmination for your incredible career, you know,
13 in -- in E.M.S.C.
14 Okay. Chris is not here yet. We
15 have covered the Bureau of E.M.S. report, and the
16 E.M.S.C. grant report. So, what I'd like to do now
17 is move into the subcommittee progress reports, and
18 see where we -- where we go from there.
19 I -- I think that education met
20 briefly and informally, and I also believe that the
21 interfacility group sort of met briefly and
22 informally on a -- a related project, namely the
23 data point project and I know Wendy Weller -- Dr.
24 Wendy Weller from the School of Public Health was

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2 here especially to participate in that.
3 So, Sharon why don't we hear
4 first from Education, and then we'll hear from
5 whomever coordinated the discussion on the -- the
6 data points.
7 MS. CHIUMENTO: Okay. As you
8 said, we had a very brief conversation this morning
9 based on some logistics over the summer, we didn't
10 get things clarified till last week, but I kind of
11 brought to -- brought to the Committee some
12 preliminary resources, some preliminary templates
13 to start working with.
14 And one of the things that I had
15 done is gone on to -- and I only -- I apologize, I
16 only have about eight copies, because I thought it
17 was just going to go out to our -- to Committee
18 members, and so I didn't make enough for everybody,
19 but there should be enough to go almost all the way
20 around.
21 Basically, this is a list of
22 resources that I was able to find online. Some of
23 which were identified earlier by Bob Kanter with --
24 when they were making -- write -- writing the white

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2 some kind of a potential patient evaluation guide,
3 something that will help them make a decision as to
4 what patients should be transferred?
5 If -- once that decision was
6 made, what kind of a transport needs to be done?
7 Does it need to be an A.L.S., a B.L.S. ambulance,
8 an A.L.S. ambulance with a person from staff or the
9 pediatric transport team? So, that's what A, B, A
10 plus and P stand for if underneath that column.
11 Transportation equipment needs.
12 So, once you figure out what level of care, is
13 there specialized equipment that's going to be
14 needed to transport that type of patient?
15 Then, from there, you would need
16 to get information about the destination --
17 who's -- how do you contact? How do you arrange
18 for the transport? What treatments need to be done
19 to stabilize the patient prior to transport? What
20 kinds of paperwork needs to be gathered to go along
21 with the patient, and then anything else you might
22 think of.
23 So, please, if any of you come up
24 with anything else that you think we should be

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2 paper, and then other things where there are people
3 that have already developed some of the guidelines
4 and some of the -- the templates that we might want
5 to look at and see how -- if any of it's applicable
6 in New York State, which I suspect a lot of it is.
7 And -- and -- and how we can modify it for our
8 purposes. So, basically, I gave that to our
9 the -- the Committee members who were there and for
10 the other people who were on the Committee. If you
11 don't get a copy today, let me know, and I can -- I
12 can e-mail it to you.
13 The second thing that we did was
14 I developed a template -- and, again, I have a few
15 copies here of interfacility -- what were going to
16 be our training needs.
17 So, I took -- I identified three
18 primary areas, the M.D. offices/clinics/urgent
19 care, the non-pediatric or lower-level pediatric
20 hospitals, and E.M.S.
21 So, what kinds of -- of training
22 needs do -- related to interfacility transports do
23 I -- did -- would I -- could be identified for
24 those groups? So, you'll see that should there be

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2 including in our -- our work box, or you know,
3 basically is what we're calling it -- kind of a --
4 kind of a -- the kinds of materials that we would
5 like to develop for these different levels, related
6 to interfacility transport.
7 DR. VAN DER JAGT: One thing
8 is -- and I don't see it here -- is the timing
9 issue of how urgent --
10 MS. CHIUMENTO: Uh-huh. Okay.
11 DR. VAN DER JAGT: -- it is that
12 the patient reaches its destination.
13 MS. CHIUMENTO: So, we could -- I
14 would -- I would put the under the patient
15 evaluation guide, but, yeah, I would --
16 DR. VAN DER JAGT: Perhaps.
17 It's --
18 MS. CHIUMENTO: -- include that
19 as a --
20 DR. VAN DER JAGT: -- almost like
21 a --
22 MS. CHIUMENTO: -- subsection of
23 that, but thank you.
24 DR. VAN DER JAGT: -- a separate

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2 thing --
3 MS. CHIUMENTO: Yeah.
4 DR. VAN DER JAGT: -- because
5 this is constantly one of those areas that we look
6 at --
7 MS. CHIUMENTO: Beautiful.
8 DR. VAN DER JAGT: -- whether the
9 difference between ground transport or air
10 transport, and how -- how rapidly it has to happen.
11 DR. COOPER: Elise makes a very
12 good point. We often think only in terms of
13 severity, but acuity --
14 DR. VAN DER JAGT: Acuity is
15 the --.
16 DR. COOPER: -- is probably more
17 important from the standpoint of the E.M.S.
18 provider, and the interfacility transport provider.
19 DR. VAN DER JAGT: It -- it also
20 relates to the -- the current thinking, at least in
21 specialty teams of pediatric critical care, is can
22 we bring critical care to that patient --
23 MS. CHIUMENTO: Uh-huh.
24 DR. VAN DER JAGT: -- at the

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2 So, the diagnosis. So, I just
3 did a sample here. So, chest trauma. What kinds
4 of needs would that patient have? Well,
5 potentially, they would need a trauma surgeon.
6 They would probably need a PICU. They would
7 probably need possibly a ventilator. And then
8 somebody -- Susan mentioned possibly a pediatric
9 cardiac surgeon.
10 So, basically, we'll kind of say,
11 all right, now, that you've figured out what you
12 got wrong with your patient, what are you going to
13 need? What kind of hospital are you going to need?
14 You know, do -- do you -- do you have those
15 capabilities in your hospital, or do you need to
16 send the patient out?
17 If you send the patient out, then
18 hopefully, we could eventually develop for each
19 region a list of the hospitals that have those
20 capabilities for them, so that they can then say,
21 oh, okay. Strong Memorial has the capability that
22 Rochester General doesn't. Both of them have
23 pediatric, but one has this capability the other
24 doesn't, so I'm going to send them to that. So --

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2 point of care where he enters the E.M.S. system.
3 So, that timing issue to get it there, versus --
4 MS. CHIUMENTO: Uh-huh.
5 DR. VAN DER JAGT: -- having a
6 scoop and run code as a mode, where you -- the
7 definitive care is not until much later. So,
8 there's a timing issue of when the care reaches the
9 patient is probably the issue there.
10 MS. CHIUMENTO: Okay. That's a
11 great point. Thank you, Elise.
12 Anybody else have anything else
13 that they can think of that we haven't considered
14 here?
15 If you think of anything, again,
16 contact me and we'll add it on to our list
17 of things.
18 On the back of that sheet then is
19 an interfacility decision matrix. So, basically
20 once we hit -- decide what kinds of education we
21 need to do for each of those populations, then the
22 next point is what -- how can we look at -- for a
23 particular diagnosis. So, maybe this is what also
24 come in, Elise. We can add a column here.

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2 so, give them a little bit of information about
3 what hospitals have available to them.
4 Once they've figured out which
5 hospital to go to, then the next thing you're going
6 to need to decide it how -- how am I going to
7 transport? So, that's where that -- that -- in what
8 kinds of needs am I going to need? So, in this
9 case, we might want a pediatric transport team. We
10 might want to transport that. We might want chest
11 tube capability, and again, we can add to this
12 needs list as we go along. But this was just a
13 preliminary template to just get us started with
14 discussions.
15 So, you, for each particular
16 diagnosis, what would be the transport needs, and
17 then based on that, what type of transport? So,
18 should it be a pediatric team, or -- or can it be
19 an A.L.S. ambulance?
20 And then the last thing. What
21 steps do I need to put into place before I transfer
22 this patient?
23 So, a patient like this would
24 probably have to have a chest tube, probably may

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2 have to be intubated and be put on a ventilator.
3 May have -- you want to get them copies of the --
4 of radiology reports. Things like that.
5 So, what's going to need to go
6 with the patient once E.M.S. arrives. So, these
7 are the kinds of things we see in our toolbox as
8 our decision matrix.
9 Again, if you see additional
10 things, please let us know, and what we're going to
11 try to do is take some of the resources from this
12 list, look and see what's already out there, start
13 to develop our matrix based on that, and then from
14 that send it out for the rest of you to help us to
15 figure out what else we need to do in New York
16 State, or what else is left off the list.
17 So, that's basically what we
18 accomplished today. Okay.
19 DR. COOPER: Well, that's quite a
20 bit.
21 Two comments. The first, really
22 a question, the -- the interfacility decision
23 matrix that you have outlined in the reverse side,
24 I realize that you just set this up in terms of

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2 critical care units --
3 MS. ROGERS: There's --
4 DR. COOPER: -- and --.
5 MS. ROGERS: -- there's another
6 piece to -- to that, because, I think when
7 we -- we want to look at the critical care
8 transport, but there's a huge area of transport
9 from pediatric offices and urgent care centers that
10 I really feel there's a lack of education, a lack
11 of knowledge, about what E.M.S. types of transport
12 are available to them. We are frequently getting
13 children in cars that are sent with their -- their
14 parents that should have been sent -- should have
15 been sent by ambulance. And I find that a -- a larger
16 gap at this point in time, than I see the critical
17 care.
18 DR. COOPER: Jan's probably
19 right. That's the tip of the iceberg.
20 MS. CHIUMENTO: That's why we
21 identified all three groups, so it's not just for
22 interfacility transport.
23 MS. ROGERS: But it's urgent for
24 transport data.

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2 example -- of an example of how it might go, but is
3 your plan to sort of utilize the general categories
4 of types of patients that, you know, Bob Kanter --
5 MS. CHIUMENTO: Uh-huh.
6 DR. COOPER: -- has drafted paper
7 on interfacility transfers.
8 MS. CHIUMENTO: Oh, yes.
9 DR. COOPER: Okay.
10 MS. CHIUMENTO: We will be
11 definitely working with Dr. Kanter through to --
12 DR. COOPER: Okay. So, that
13 will -- so the left-hand column --
14 MS. CHIUMENTO: -- help us with
15 this. Yes.
16 DR. COOPER: -- so the left-hand
17 column --.
18 MS. CHIUMENTO: Yeah. And Dr.
19 van der Jagt as well.
20 DR. COOPER: Yeah. So, the
21 left-hand column will really focus on the kinds of
22 patients who require --
23 MS. CHIUMENTO: Uh-huh.
24 DR. COOPER: -- transfer to

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2 MR. WRONSKI: Yeah. I --
3 DR. COOPER: You're right on the
4 one thing.
5 MS. ROGERS: Yeah.
6 DR. COOPER: I -- I -- I think
7 when we're considering interfacility transport, we
8 don't mean only hospital to hospital transport. We
9 mean --
10 MS. ROGERS: Uh-huh. Yeah.
11 DR. COOPER: -- you know,
12 designated healthcare provider to designated
13 healthcare provider transport. So, I think
14 you're -- you're absolutely right, Jan. I think --
15 I -- I -- I think that it is probably our working
16 model.
17 And my comment is simply that I
18 didn't see a pediatric general surgeon on this
19 list, and for the most --.
20 MS. CHIUMENTO: Oh, we'll just
21 add that right on. Thank you.
22 DR. COOPER: For most -- for
23 conditions, a pediatric general surgeon will be the
24 person that will be providing the -- the surgical

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2 care.
3 So, I -- I -- I want to -- as we
4 work globally toward regionalization, which is, of
5 course, our ultimate goal, we all understand that a
6 robust critical care transport capability is the
7 glue that's going to be holding a system like that
8 together. And it's, I think, very nice to see our
9 educational activities, and our -- you know, our
10 sort of system building activities working together
11 toward the same general end.
12 And -- and Martha, another
13 potential note for our -- our December meeting,
14 The State E.M.S. Counsel has not focused, perhaps,
15 as -- as directly as it could on the development of
16 a specialty care transport course in -- in New York
17 State. It's been talked about, and Deb Funk's work
18 in terms of the -- the specialty care transport
19 report, as well as the administration of blood
20 products in ambulances, I think have been
21 extraordinarily important, necessary, you know,
22 foundation projects for a -- the development of a
23 critical care transport type of program.
24 But as we've discussed, and as

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2 your matrix is suggesting, you know, with --
3 without a critical care transport capability, and
4 educated critical care transport capability,
5 regionalization just won't work. Or at least it
6 won't work well.
7 And so, it seems to me that it
8 might be worthwhile to invite Deb Funk to our next
9 meeting, to sort of see where she thinks we might
10 be able to go in terms of development of a
11 specialty care transport, if not a curriculum, at
12 least a curriculum guideline that -- that various
13 programs throughout the state might -- you know,
14 might utilize. And you know, it would seem to me
15 that this committee would be ideal to sort of
16 suggest what the pediatric components for such a
17 program might be, and ultimately to assist in
18 developing them.
19 So, Elise?
20 DR. VAN DER JAGT: Well, there
21 are certainly, as far as peds transport are
22 concerned, there are courses actually that now have
23 been put out. The A.A.P. has done that, and it's
24 from their section on transport medicine.

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2 we -- as we move forward.
3 MR. WRONSKI: Can I ask a
4 question and I may have missed it -- in the
5 discussion, Sharon. You mentioned that there may
6 be a lack of information available to office --
7 physicians' offices about transfer capabilities
8 of -- of ambulances, and -- and that in some cases
9 they may be sending kids, you know, by vehicle when
10 they should call the ambulance; is -- is -- is that
11 something that, you know, all of you have
12 experienced or seen --
13 DR. VAN DER JAGT: Sure.
14 MR. WRONSKI: -- out there?
15 Yeah.
16 DR. VAN DER JAGT: Yeah.
17 MR. WRONSKI: And the -- because
18 those are issues. I mean as you know the -- the
19 Department has really been focusing on office-based
20 surgery, but really the scope that they're --
21 they're really are interested in is the kind of
22 care that goes on in offices; and is it
23 appropriate?
24 So, you know, I -- I think the

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2 Department would be interested in this kind of
3 information, and also promoting better education of
4 the physicians' offices to understand what --
5 what's available out there to them.
6 I -- I hadn't really heard this
7 before, so I -- I just wanted to probe that a
8 little bit.
9 Yes?
10 DR. KANTER: I think the simple
11 issue is in a physician's office should they send
12 the kid with the family automobile or should they
13 call nine one one.
14 MR. WRONSKI: Right. Right.
15 DR. KANTER: Once they get to
16 nine one one --
17 MR. WRONSKI: Right.
18 DR. KANTER: -- they get the
19 proper guidance.
20 MR. WRONSKI: Right.
21 DR. KANTER: It's that deciding
22 whether to make that call, that sometimes --
23 MR. WRONSKI: Uh-huh.
24 DR. KANTER: -- needs a little

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2 DR. VAN DER JAGT: Well, they
3 wouldn't go to the car.
4 MS. CHIUMENTO: Oh, no.
5 DR. VAN DER JAGT: No, no.
6 That's not the way it would work. They typically
7 do it right there, but the question is how does
8 that kid get transported? You know, what's the
9 best way? Is it an ambulance or just a -- you
10 know, an ambulance they call?
11 And many of those folks do not
12 understand the E.M.S. system and their
13 capabilities. You know, they're used to working in
14 a hospital, they're an anesthesiologist. You know
15 they had not really sure who to call.
16 DR. HALPERT: Sure. Sure.
17 DR. VAN DER JAGT: So, they -- I
18 mean -- in the best circumstances, at least in our
19 area, would be let's say if it's Lattimer Road,
20 they call, you know, our hotline, and our -- and
21 or -- and we have -- we send our critical care
22 transport team out there. But not everybody knows
23 that, because those are, you know, "call nine one
24 one." Well, and who do they call from nine one

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2 one?
3 DR. HALPERT: Right. Well, but
4 also statewide E.M.S. is so disparate --
5 DR. VAN DER JAGT: Right.
6 DR. HALPERT: -- in terms of
7 their practice --
8 DR. VAN DER JAGT: It's very
9 disparate.
10 DR. HALPERT: -- then you would
11 try --
12 DR. VAN DER JAGT: Right.
13 DR. HALPERT: -- you may be
14 comfortable in your setting in Rochester right now,
15 but you take a job next month --
16 DR. VAN DER JAGT: Precisely.
17 DR. HALPERT: -- at a
18 surgi-center in --
19 DR. VAN DER JAGT: Right.
20 DR. HALPERT: -- Tioga County, I
21 don't know --
22 DR. VAN DER JAGT: -- exactly.
23 DR. HALPERT: -- you know, and
24 you're thinking, "hey, if I call nine one one, I'm

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2 MR. CZAPRANSKI: My concern is
3 that -- that typically, I find prehospital care
4 provided in a pediatrician's office much superior
5 to the general care provided by general
6 practitioners or cardiologists that are seeing
7 adult patients. And I think --
8 DR. COOPER: Yeah.
9 MR. CZAPRANSKI: -- pediatrics
10 does a better job than the adult -- or the
11 physicians treating the adult population.
12 So, Ed, I think it's not just
13 pediatrics that doesn't use an ambulance when it's
14 appropriate. I think it's a lot of other physician
15 practice groups that also need to be addressed as
16 well.
17 DR. HALPERT: Well, you know, it
18 goes both ways, Tim, I got to tell you. We have a
19 tremendous amount of pushback from providers who
20 show up, and you called for -- I got a forty-five
21 year old man with active chest pain who looks okay
22 and has normal vital signs and E.K.G., but has a
23 story that needs to be brought in for a full
24 evaluation. And you know, what? Would I send that

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2 person to the -- to the telemetry floor without
3 being cared for properly from -- in the E.D.? No.
4 Would I send them to the hospital?
5 him driving himself and without proper
6 interfacility, if you will, evaluation? No.
7 But yet the provider sometimes
8 will show up and look at you six ways from Sunday,
9 and say, "hey'd you call an ambulance for this guy?"
10 He's fine."
11 The answer is he's really not
12 fine. We don't know how fine he is at this moment.
13 I would like him to have optimum care between here
14 and there.
15 MR. CZAPRANSKI: I agree.
16 DR. HALPERT: So, I think it goes
17 both ways in terms of that.
18 MR. WRONSKI: The -- well, one of
19 the things I'll -- I'll do, and -- and I'd suggest
20 to the Committee at some point next year you might
21 benefit from taking a look at some of the materials
22 that the office-based surgery group is looking at,
23 what the Department's doing as far as it's Q.I.
24 initiatives there. So, you understand what they're

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2 and more children inappropriately sent to the
3 emergency department during the daytime. I
4 understand after hours, but during the daytime when
5 they could have easily been evaluated at the
6 doctor's office and sent home.
7 And I suspect, it's -- it's
8 office nurses who may take calls in the office, or
9 telephone triage nurses, who are taking calls that
10 kind of -- for example, a child with a head injury
11 who vomited once. "Oh, go to the E.D. you may need
12 a CAT scan." I mean we hear types of -- of
13 comments like this all the time when they could
14 have much more easily gone to their doctors, they
15 could have examined the child and decided they
16 didn't need emergency-level care.
17 And I think that's another piece
18 of the prehospital community that needs education
19 on -- on the telephone triage aspect.
20 DR. COOPER: Bob?
21 DR. KANTER: Does the state have
22 any data on numbers of children having outpatient
23 surgery who get transferred to the hospital?
24 DR. COOPER: I -- I -- I was

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2 going to ask that question myself. But Martha, I
3 think that that's a question we need answered.
4 MS. GOHLKE: We -- we can
5 certainly check with SPARCS. I -- I'm guessing
6 it's going to be difficult to get. I think that's
7 a very difficult thing. Yeah, I don't know that --
8 that that SPARCS would -- or if it's coded very well. I
9 think it would be hard to get.
10 DR. COOPER: Okay. Because, once
11 again, Dr. Weller, can't be with us for a whole lot
12 longer. I'd like to segue -- this is, in fact, a
13 nice segue into a discussion of the data point
14 issue.
15 And Dr. Weller, well, do you have
16 any thoughts for us on -- on this issue?
17 DR. WELLER: Many thoughts.
18 Well, we talked a little bit this morning about
19 some of the things that we can and can't do. And
20 what would actually be useful in terms of your
21 needs in terms of, you know, potentially supporting
22 regionalization of pediatric trauma. So, we went
23 through a list of -- that was applied initially by,
24 I think, your federal contact --

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2 so, you know, we -- we may -- we already have that
3 information somewhere. And whether -- and I'm sure
4 that that's something that -- that we talk
5 about --
6 MR. WRONSKI: Is -- is there --?
7 DR. VAN DER JAGT: It sounds like
8 mortality is -- is a -- there is a field in the
9 SPARCS data set as to whether or not these patients
10 died in the hospital or not. So, the thought was
11 just to look at mortalities at all the hospitals,
12 and try to determine whether, you know, that's an
13 area that we should be focusing on. But that's
14 predicated on also whether if there are patients
15 identified who died in a hospital, is that hospital
16 a pediatric-capable hospital, in any way, or is it
17 just a general hospital with, say -- let's say,
18 peds I.C.U., where there's -- there's no even
19 pediatric-certified beds there, you know, why would
20 that patient stay there and then die? You know,
21 that's the kind of thing. We do have to
22 categorize, or at least explain, the hospital
23 designations -- or at least the certifications --
24 what they're certified to do --

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2 MS. WALDEN: Uh-huh.
3 DR. VAN DER JAGT: -- on their --
4 based on their operating certificate.
5 DR. COOPER: For those who
6 attended the meeting, I -- I guess the -- the
7 most fundamental question I would have at this
8 moment is, is there any low-hanging fruit that can
9 be pursued with some vigor in the near future that
10 could at least give us a good springboard to go
11 forward.
12 And secondarily, are there
13 potentially some very, very limited data points
14 that if we had -- that we do not have access to,
15 either through SPARCS or through the trauma
16 registry, that if we had access to them with
17 respect to kids, it would make a big difference for
18 us.
19 The -- the -- it's very difficult
20 to get changes to SPARCS, as you know, but --
21 but -- but it is not so difficult to get changes in
22 the registry. It's -- it's a matter of approaching
23 the Registry Subcommittee for the STAC, and saying
24 this is a -- this is a key issue for us. We need

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2 So if through discussion, and --
3 I -- it might be worthwhile to ask the -- the
4 Registry Committee to include a pediatric-specific
5 data point, at least insofar as the trauma patients
6 are concerned. It could be added and collected at
7 least on a pilot project basis.
8 Just a thought, you know,
9 something for us to -- you know, to look forward
10 to, but I think that is one avenue that we could
11 pursue.
12 DR. VAN DER JAGT: I think that
13 the -- the hard thing, I think, with the pediatric
14 patients is this question of severity. They have
15 the same label, but the label doesn't necessarily
16 mean the same severity, and I think that's the hard
17 thing, I think, with some of these diagnoses,
18 whether it's medical or even trauma.
19 I think Bob -- what Bob was
20 suggesting, there may be a trauma severity score
21 or some -- some way of assessing the severity and
22 translating it to the pediatric population. But
23 there in the medical patients, that it becomes even
24 more difficult for us. So, one of the -- again,

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2 the thought, I think, was really just to -- to
3 start, at least, toward the regionalization. You
4 certainly wouldn't want to have people dying in
5 facilities, which have less than the
6 pediatric-capable resources.
7 That would be one. I mean either
8 you're dead or you're not dead. So, it's a little
9 bit easier to --
10 MR. WRONSKI: Sure. Absolutely.
11 DR. KANTER: I'll just say again
12 what we discussed at the earlier meeting, although
13 additional analysis of recent information would be
14 useful if we can get it, I really do think there's
15 enough published information, much of it regarding
16 New York State, that supports regionalization.
17 And I don't -- I don't feel the
18 least bit uncomfortable about using existing
19 published information to make a strong case for it
20 at stakeholder's meetings. So, if we can get more,
21 it would be nice. But I really believe that the
22 easy studies regarding SPARCS have already been
23 done. There are number of interesting questions
24 and big projects that will take a long time.

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2 question is -- is selling formal regionalization,
3 versus what already takes place as informal
4 regionalization.
5 Because I -- I would say that in
6 Upstate New York, by and large, and actually the
7 study that we did back in the '80s showed that there
8 were very -- one or two patients who you would say,
9 we really should have been transferred, the
10 others were all appropriately transferred.
11 You know, so in Upstate -- that's
12 all I can speak to, that's all I know, is that by
13 and large, large, large, large, is that the really
14 sick kids get to the main medical centers, the peds
15 medical center. Now, maybe you could argue about
16 timing of some of that, but basically, they go
17 there, because nobody wants them. No -- none of
18 the smaller hospitals want these kids. I mean
19 they -- they don't want them to die in their
20 hospitals. And I think that that -- we've shown
21 that. So, although they're not formally
22 designated, the process of regionalization actually
23 occurs.
24 Now, I don't know what -- to what

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2 degree that happens in Downstate. I mean I'm not
3 as familiar with that. I mean certainly in Bob's
4 study it would suggest that maybe not. You know,
5 certainly in the area of trauma that's not the
6 case. So, that perhaps there a formal
7 regionalization might be a little bit more
8 necessary potentially.
9 But -- but it is really not the
10 concept, so much, I think, as it is do you
11 formalize it or informal -- or keep it with the
12 informal structure.
13 And that was way back when we --
14 that first grant in late '80s that was sort of the
15 same issue, as I -- as I remember.
16 MR. WRONSKI: Yeah.
17 DR. VAN DER JAGT: Do you make a
18 voluntary? Do you make this legislative? How do
19 you do this?
20 It was already ninety-nine
21 percent there in some areas.
22 Can you break it by making it,
23 you know, now you have to do it this way? And I --
24 and I think that's -- that's the question.

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2 regionalization of many if not all of its high-end
3 services, including pediatric secondary and
4 tertiary care. The -- I think Health and Hospitals
5 in the past -- and I don't think I'm saying it to
6 anything out of school -- has been committed to the
7 notion that each of its facilities in effect should
8 be not only the family doctor, but the -- but the
9 entire medical home for all of its patients, within
10 reason.
11 And to that end, all of the
12 hospitals have tried to maintain pretty high-end
13 pediatric capabilities. Not -- some have been more
14 successful at it than others. But I think that at
15 least within the municipal hospital system, which
16 is about twenty percent of the -- of the -- of the
17 hospital -- hospital number, and probably slightly
18 more of the hospital population in New York City, I
19 think we will see some -- some -- some
20 regionalization. And it's -- of course, it's the
21 communities that the public hospitals service where
22 historically the highest rates of pediatric
23 morbidity and mortality, as well as adult morbidity
24 and mortality, have been located.

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2 Health until the end of the year. Whether or not
3 her stay on the contract extends beyond that is yet
4 to be determined. So, she's primarily working on
5 the pediatric trauma report that Brian had started
6 for us, and that was her primary mission to
7 hopefully complete it before she's done. And she's
8 working very hard on it and gave me an update
9 today.
10 So -- anyway. So -- and then, we
11 have this other side project, so to speak, sort of,
12 with the stakeholders meeting. And the -- at -- at
13 our last meeting, where we left off was that we
14 were going to meet with Dr. Morley, who's the
15 medical director of health systems management for
16 the Department and talk to him about the
17 stakeholder, who is our direct line to the
18 commissioner. And we met with him on June 23rd.
19 And I say "we" meaning Dr. Kanter came in, in
20 person and -- and Dr. Cooper was on the phone,
21 myself and Ed, and we talked about the stakeholders
22 meeting, and we did a -- a quick draft of the
23 agenda, what we would like to cover, which is we
24 wanted to have some data, obviously, to either

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2 So, we may stand to see -- or --
3 or we may -- we may -- not stand to see, but we may
4 actually live to see some -- some changes, in --
5 in -- in -- in where pediatric patients are cared
6 for over the next few years in the city.
7 And that, Bob, may impact upon,
8 you know, the results, and maybe you'll have to
9 repeat your study in a few years. And we'll see
10 where -- see where we've gone.
11 Any other comments about the
12 data?
13 MS. GOHLKE: Yeah. I have.
14 MR. WRONSKI: Martha?
15 MS. GOHLKE: Yeah. Okay. So, I
16 need to summarize and recap here for myself. For
17 my own sanity.
18 Just for those of you that
19 haven't been involved in these discussions since
20 the last meeting, let me just update you. First of
21 all, Dr. Wendy Weller, welcome. She's the new
22 Brian Gallagher from the School of Public Health.
23 She's actually taken his spot on the trauma
24 contract that we have with the School of Public

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2 support or answer questions about the care of
3 children in the states. So, this is where the
4 whole data question started coming from.
5 And we also were talking about
6 maybe having a testimonial from another state come
7 in and talk about their regionalization process and
8 how they work it, and -- and have them come in, in
9 the morning. So, the morning would kind of focus
10 on, you know, hopefully the commissioner is going
11 to be there to talk, some New York State data, a
12 testimonial from another state. And then the
13 afternoon we were going to have hopefully a
14 professional facilitator, and the afternoon would
15 consist of either small groups, or some way for
16 people to provide feedback of the people, the
17 participants, that are there. And so, that was --
18 that's kind of a draft agenda where we got so far.
19 As I mentioned previously, we
20 are -- we have some dates identified, and they're
21 up at the commissioner level right now, because
22 they're trying to get it on his calendar. And as
23 soon as we have that, which hopefully, will be
24 momentarily, you know, we will start finishing the

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2 agenda, and trying to get the people there, because
3 we can't do it until we have the dates. So, I'll
4 keep you all apprised as soon as we have a
5 potential date of -- obviously, the whole committee
6 is going to be invited to the meeting. Whether or
7 not you want to come is up to you. But obviously,
8 we're going to have the -- you know, the chair and
9 the vice chair and Dr. Kanter will be there, and --
10 and anybody else that's interested. They'll be the
11 key players and presenters for the meeting.
12 As for the data, you know, I
13 don't want to waste the School of Public Health's
14 time if we feel like we have the existing
15 information and ready for presentation. I guess
16 the question that I have is do we want Dr. Weller
17 to look at some of the data points that we -- that
18 my federal partner provided for us as suggestions.
19 Like I said, potentially, she's
20 only here till the end of the year, and if we
21 feel -- really feel like the existing data is good
22 enough, and that's what we want to go with, you
23 know -- you know, I don't want to put her down this
24 road if we don't need to.

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2 be there, and I -- I -- I know that everyone
3 will -- will take that seriously.
4 With respect to the data points,
5 Bob, I -- I happen to share your view that we have
6 plenty of data to support regionalization. But
7 I -- but I also agree with Martha that the --
8 and -- and Elise to a certain extent that the issue
9 is, is there something else that we could ask that
10 would -- you know, that would, you know, that we
11 have not asked to date, that our data -- a question
12 that our data can answer that Dr. Weller could --
13 could assist us with. And I, personally, do think
14 that that's worth at least a call, at least some
15 further exploration. And you know, if the answer
16 is no, then the answer is no.
17 But I mean -- and I'm comfortable
18 proceeding with what we have. There's no question
19 that the -- that the body of data that we have is
20 as good as any. I can tell you that the data in
21 support of trauma regionalization based on the big
22 schemania (phonetic spelling) conference that was
23 held in 1998, was no more robust at that time than
24 the -- than the data that, you know, exists for

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2 So, that's one question for the
3 Committee, is do we -- and if so, if we do want to
4 have her look at some additional data, we may need
5 to have a call in the very near future to narrow
6 down where we didn't get to today on some
7 I.C.D.-nine codes that she needs to look at. And
8 we need to do it soon, obviously, because not only
9 is she potentially not here after the end of the
10 year, but the meeting, in my mind, is right around
11 the corner. And I -- I don't like to wait till the
12 last minute for anything.
13 So -- so, I -- I put that
14 question out to the Committee, if we -- if we want
15 to meet again, on a small conference, call, other
16 people are welcome to join in if this interests
17 you. I don't mean to exclude anybody. It's just a
18 matter of trying to get the work done when we can't
19 do it all here today.
20 DR. COOPER: A couple of
21 comments. First of all, I would hope that everyone
22 would come to the stakeholder meeting. I think
23 that that's critical. I -- I think all of us, as
24 members of this committee, have a responsibility to

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2 pediatric patients.
3 But I'm comfortable we can make a
4 strong case at the stakeholder meeting, and you
5 know, I -- I -- the choir will be there, and I
6 think they will get it. I think we have to reach
7 beyond the choir at this time, to some of our
8 decision makers, both in the hospital world and the
9 corporate world, and -- and in the political world,
10 to you know, make some of these things happen.
11 And that's really the group we --
12 we need to be speaking with. But at the same time,
13 if there is data that -- additional data that we
14 can get that would strengthen the case both
15 locally, regionally and nationally, we should do
16 it.
17 So, I -- I would personally like
18 to see us, you know, do a call. I don't think it
19 has to be a long one, but what I would ask is that
20 perhaps as a result of this morning's discussion
21 and Diana's comments, you know, and the additional
22 comments that have been made on the record here
23 this morning that Martha work with Dr. Weller and
24 come up with a -- you know, a list of potential

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2 data points that -- additional data points that
3 have been, at least, brought forward and really say
4 a yes or no as to whether it's something that
5 either, A, is possible; and if possible, B, would
6 it -- would it add any significant value to what we
7 already have?
8 Bob?
9 MR. KANTER: Something that we
10 did not talk about this morning, and I don't know
11 anything about it, but New York State has several
12 types of subspecialty care that already are
13 regionalized; trauma, perinatal, stroke, and there
14 are couple of others. Are there good data from
15 some of those other areas that we haven't really
16 talked about --
17 DR. COOPER: That's a great
18 question.
19 MR. KANTER: -- that might be
20 useful in this discussion?
21 DR. COOPER: I -- I -- I -- the
22 answer is I don't know.
23 But I think Martha and Wendy, I
24 think, we should probably explore that within the

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2 address a note to the whole Committee, and if
3 you're interested in -- in participating in the
4 call, just let me know, and -- and we'll go forward
5 from there. And we can -- we can be a Data
6 Committee at least temporarily.
7 DR. VAN DER JAGT: The other
8 thought I just had is, you know, this -- this
9 Illinois model that --
10 MS. GOHLKE: Uh-huh.
11 DR. VAN DER JAGT: -- that just
12 recently came out.
13 MS. GOHLKE: Yeah.
14 DR. VAN DER JAGT: Whether there
15 couldn't be some useful information gained from
16 talking with them --
17 MS. GOHLKE: Uh-huh.
18 DR. VAN DER JAGT: -- and any
19 data that they may have used to help sell their
20 points --
21 MS. GOHLKE: Yeah.
22 DR. VAN DER JAGT: -- in making
23 this. So, that -- they've already said, okay,
24 well, we looked at X number of I.C.D.-nine codes,

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2 MS. GOHLKE: Right.
3 DR. VAN DER JAGT: -- this is how
4 we went about doing this --
5 MS. GOHLKE: Uh-huh.
6 DR. VAN DER JAGT: -- these are
7 our results. And what I liked about the way they
8 presented this was that --
9 MS. GOHLKE: Okay.
10 DR. VAN DER JAGT: -- they had
11 sort of a three-level process of what it was
12 like --
13 MS. GOHLKE: Uh-huh.
14 DR. VAN DER JAGT: -- you know, a
15 sort of an emergency department that were sort of
16 capable for peds, and then there was the ones that
17 were a little more capable --
18 MS. GOHLKE: Right.
19 DR. VAN DER JAGT: -- for
20 pediatrics. And now they are working on
21 implementing the pediatric critical care --
22 MS. GOHLKE: Uh-huh.
23 DR. VAN DER JAGT: -- component
24 of it. If you look at the last part of this,

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2 MS. GOHLKE: Right.
3 DR. VAN DER JAGT: -- of -- of
4 skill to be able to do that site recognition.
5 MS. GOHLKE: Yeah. Well, last
6 week at the federal meeting, Illinois, Tennessee
7 and Oklahoma, were the three that presented,
8 because they have gone through this regionalization
9 process.
10 DR. VAN DER JAGT: Sure. Sure.
11 MS. GOHLKE: They just gave a
12 very broad stroke, they didn't get to your
13 questions. But two of them -- I talked to them
14 would be very willing to -- Illinois and Tennessee
15 would be very willing to come to our --
16 DR. VAN DER JAGT: They would be
17 willing?
18 MS. GOHLKE: -- to our meeting.
19 DR. VAN DER JAGT: Great.
20 MS. GOHLKE: My understanding
21 with California is that it's a -- it's a county
22 regional, not a statewide regionalization process.
23 So, that would be a little --
24 DR. VAN DER JAGT: Harder. Yeah.

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2 next week or so, before we get the call together to
3 see if there's anything that we can glean from
4 those databases that might help us answer questions
5 beyond what we're already capable of answering.
6 Great point.
7 Any other thoughts about data?
8 MR. KANTER: Well, we did come up
9 with a -- a few questions that none of us think we
10 can complete by the meeting, but there are some
11 interesting things that could be exploited in the
12 SPARCS database. And I -- I just would love to see
13 this Committee drive some of those ongoing
14 discussions.
15 DR. COOPER: I -- I -- I agree.
16 And so, why don't we split the call into two parts?
17 Why don't we do -- you know, look at it first, is
18 there anything reasonable, practical, you know, any
19 ultra-low-hanging fruit, so to speak, that we can
20 get together for the spring meeting, and you know,
21 if -- if so, great, if not let's look at -- at more
22 of a medium-range plan on what we can -- what we
23 can pull out of the data that exists.
24 MS. GOHLKE: So, I'll -- I'll

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2 or we did look at mortalities --
3 MS. GOHLKE: Right.
4 DR. VAN DER JAGT: -- and
5 that's -- this is very helpful, this was not very
6 helpful to look at, to look at preparation for
7 their rollout --
8 MS. GOHLKE: Uh-huh.
9 DR. VAN DER JAGT: -- of their
10 process.
11 MS. GOHLKE: Right.
12 DR. VAN DER JAGT: That would be
13 one -- one thing to ask them and -- and that, you
14 know, when they sound like they were doing a fairly
15 good job at doing this. And they basically
16 adopted, of course, a California model of the
17 E.M.S.C.
18 MS. GOHLKE: Uh-huh.
19 DR. VAN DER JAGT: The second
20 thing is -- is the -- to -- if we would want them
21 to discuss at the stakeholders meeting --
22 MS. GOHLKE: Uh-huh.
23 DR. VAN DER JAGT: -- as a
24 testimonial sort of part of this --

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2 that's what they are currently working on.
3 MS. GOHLKE: Uh-huh.
4 DR. VAN DER JAGT: So, I would be
5 very interested in, one, again, asking them, maybe
6 they're -- they're the ones that would be giving --
7 able to give a testimonial --
8 MS. GOHLKE: Right.
9 DR. VAN DER JAGT: -- in the
10 spring.
11 Secondly, where are they in this
12 process?
13 MS. GOHLKE: Uh-huh.
14 DR. VAN DER JAGT: Because E.D.s
15 is one thing --
16 MS. GOHLKE: Uh-huh.
17 DR. VAN DER JAGT: -- but where
18 it really gets kind of sticky, and the whole
19 hospital needs to be involved, is when it gets
20 started dealing with critical care kind of
21 capabilities.
22 MS. GOHLKE: Uh-huh.
23 DR. VAN DER JAGT: That's a
24 whole -- almost like a different level --

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2 MS. GOHLKE: -- different than
3 what we're proposing here.
4 But Illinois, Tennessee and
5 Oklahoma was a statewide regionalization.
6 DR. VAN DER JAGT: Right. Right.
7 MS. GOHLKE: So, there is
8 potential that they could come to our meeting. We
9 can even set aside funds to make sure that their --
10 their travel is covered.
11 DR. VAN DER JAGT: And what
12 seems -- I mean they took an approach that actually
13 was the original approach here in New York State,
14 which was a voluntary application --
15 MS. GOHLKE: Yeah.
16 DR. VAN DER JAGT: -- four levels
17 of designations.
18 MS. GOHLKE: They started
19 voluntary, then they went to mandatory.
20 DR. VAN DER JAGT: Oh, they did?
21 Okay.
22 MS. GOHLKE: They did. Yeah.
23 because --
24 DR. VAN DER JAGT: All right.

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2 I --
3 MS. GOHLKE: -- voluntary --
4 well, they -- and they said there was no
5 resistance.
6 DR. VAN DER JAGT: No, Yeah,
7 they were sort of doing it already.
8 MS. GOHLKE: It was interesting
9 that -- they tried -- yeah, they tried it out
10 and -- and they were, you know, the hospitals, once
11 they saw that it was working and it was okay, then
12 they were fine with it.
13 DR. VAN DER JAGT: Right.
14 MS. GOHLKE: So, it was a -- a
15 process they say. So -- but -- so, yeah, food for
16 thought. And I -- I don't know about their data.
17 They didn't present any data at the meeting, so
18 I'll ask them. I'll give him a call and see if
19 they -- they have any data to show.
20 MS. CHIUMENTO: Yes.
21 DR. COOPER: Speaking -- oh, go
22 ahead. I'm sorry, you wanted to --.
23 MS. CHIUMENTO: I'm just curious
24 if other states have done this?

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2 o'clock. So, why don't we plan on picking up our
3 lunches and starting up again no later than
4 one-thirty? Okay.
5 (A recess was taken at 1:00 p.m.)
6 (The meeting resumed at 1:40
7 p.m.)
8 DR. COOPER: Okay. We are
9 officially back on the record at this point. And
10 it's -- I would like, sadly, to announce that Dr.
11 Kus is actually unable to be with us. There -- he
12 is going to make available to us some information,
13 via e-mail, regarding the Department's views of --
14 of H1N1 at this -- at the present time.
15 And -- and Marjorie, what I will
16 also ask is that the updated presentation that Bob
17 Burhans gave for the -- the State E.M.S. Council be
18 made available, since that's a little bit easier to
19 follow in terms of where the Department stands.
20 And I'm sure that there will be some information
21 included in what Dr. Kus distributes that, you
22 know, will address some of the E.M.S. issues, and
23 perhaps Ed and Martha, we might reach out to
24 Marilyn Kacica to see if she has anything from her

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2 DR. VAN DER JAGT: Right. That
3 might be helpful for you to determine --.
4 MS. CHIUMENTO: What data --
5 MS. GOHLKE: Yeah. Right.
6 MS. CHIUMENTO: -- they used for
7 that.
8 MS. GOHLKE: I'll -- I'll call my
9 counterparts in the other --
10 MS. CHIUMENTO: Yeah.
11 MS. GOHLKE: -- states and see
12 what they --.
13 DR. COOPER: Yeah.
14 MS. GOHLKE: -- see if they have
15 any -- what they used.
16 DR. COOPER: Okay. Well,
17 speaking of food for thought, I think it's time for
18 food for body. And the -- the lunch is here, and
19 before the hotel staff come in and --
20 MS. GOHLKE: Take it away before
21 we can eat it.
22 DR. COOPER: -- take it away
23 before we get a chance to devour it, I think we'd
24 better take a lunch. So, it is presently one

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2 end that we should be aware of in terms of H1N1.
3 I had anticipated that the H1N1
4 update would probably take forty-five minutes to an
5 hour of our time, and we have been able to go
6 through much of the afternoon agenda in
7 anticipation of that. So, I think we do have a
8 little bit of time that we thought we might not
9 have. So, I might want to just take -- spend a
10 moment, and -- and ask any of the Committee members
11 if they have had any special insights with respect
12 to how H1N1 is affecting pediatric care within
13 their regions, that we might be able to share. A,
14 with each other, and B, with the Department so we
15 can help the Department -- or provide some
16 information that it might not already have had from
17 the trenches, so to speak.
18 So, I'll just open it up to
19 anyone who might have some thoughts about it.
20 MR. WRONSKI: Yeah. I -- some of
21 the things that would be interesting here are
22 pediatricians in your region open to giving the
23 vaccine themselves, and how are children going to
24 avail themselves to the vaccine in, you know,

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2 you -- your area; would -- do you have any sense
3 of that -- how that's going to work?
4 MS. BRILLHART: I think that
5 the --.
6 MR. WRONSKI: Yes, I know.
7 MS. BRILLHART: I think that
8 they -- I think they might -- I can't answer that
9 question for sure, but I can say that Elmhurst
10 Hospital already has in the PICU R.S.V. and
11 pertussis. So, that whole stuff that usually
12 starts later, is early this year. And I think
13 people are looking at that and saying, oh, my gosh,
14 okay, what do we need to start trying to do to
15 prevent this?
16 MS. MOLLOY: (Off-mic).
17 MR. WRONSKI: Did you have a
18 comment, Rita?
19 MS. MOLLOY: No, there's just
20 some consternation among health providers about,
21 you know, the mandatory nature of the emergency
22 legislation for the vaccine. So, I was wondering
23 if -- if the other parties at the meeting are
24 hearing buzz about that.

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2 And to my knowledge, there has
3 not been a single case of Guillian-Barre, which is
4 what everyone's worried about in the last thirty
5 years from any of these vaccines. And so -- so, I
6 think that -- that we need to do all we can to help
7 any of our less up-to-date colleagues understand
8 that -- you know, that the vaccine is safe, and --
9 and that, if anything, people are taking extra
10 precautions to ensure that it's extra safe at this
11 particular point in time.
12 MS. MOLLOY: Thank you.
13 DR. COOPER: Sue, then Tim.
14 MS. BRILLHART: Well, and if I
15 could comment, I think that from my perspective,
16 the students have all been mandated. So, they're a
17 little freaked. And what I've noticed is there's
18 been no education that I have come across, that
19 this is the same companies, the same process, the
20 same everything. So, most of the public --
21 including some healthcare providers, because we
22 didn't know -- are looking at it like they're --
23 they've rushed through a brand new vaccine thinking
24 it's like the H.V.P. vaccine, it's like the

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2 MS. GOHLKE: About what?
3 DR. COOPER: About the mandatory
4 immunization requirements.
5 MS. GOHLKE: Oh.
6 MS. MOLLOY: Yes.
7 DR. COOPER: Is that an issue in
8 other parts of the state, has it been on a table?
9 It's always asked.
10 MS. MOLLOY: No, in this state.
11 DR. COOPER: It sure has been an
12 issue in -- in New York City. Many people are very
13 upset. Many people look upon the H1N1 vaccine, if
14 you will, as an experimental vaccine, which, of
15 course, as we all know is, you know, a -- a gross
16 distortion of reality, since it's -- it's
17 manufactured, and -- and you know, and has been
18 prepared and vetted and -- and -- and manufactured
19 in precisely the same way that every other seasonal
20 vaccine is manufactured, using the same
21 manufacturers, the same factories, and so on and so
22 on. So, we could, you know, it -- it is unlikely
23 that we would expect -- you know, that there would
24 be significant issues arising from this vaccine.

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2 meningococcal meningitis vaccine. It's a whole
3 brand new process as opposed to, we've just taken a
4 different strain and dropped it in an already
5 perfected process.
6 So, an education P.S.A. would be
7 wonderful to have people understand that it's a
8 process that we use every single year and it's
9 perfectly safe.
10 DR. COOPER: The commissioner
11 just did send out a letter to the entire healthcare
12 provider community. And I believe that every
13 licensed and certified professional was targeted to
14 receive this -- this mailing.
15 MS. BRILLHART: No, I didn't get
16 it.
17 DR. COOPER: Did others receive
18 that -- that mailing as well?
19 Bob, I see you nodding yes.
20 Elise, did you get it?
21 DR. VAN DER JAGT: When was this?
22 DR. COOPER: The last couple of
23 days. Maybe Monday.
24 Bob?

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2 MR. KANTER: You know,
3 realistically, I think the more important public
4 reaction that you're going to see shortly, is
5 people clamoring to get the vaccine.
6 DR. COOPER: Right.
7 MR. KANTER: And I think that's
8 going to way outweigh personal reservations about a
9 mandatory vaccine.
10 MS. CHIUMENTO: Tim?
11 MR. CZAPRANSKI: That's -- you
12 know in our county, we have two ambulance services
13 that are contracted with University Hospital, so
14 they have to have the vaccine, the ambulance
15 agencies, and their stance is just the opposite of
16 this: "So, we take priority, like we get it
17 first?" And it was sort of excited about getting
18 it and getting early. What we're seeing in our
19 county is a shortage of pediatric Tamiflu. And --
20 DR. COOPER: Yes.
21 MR. CZAPRANSKI: -- we also won't
22 see who in our community has registered at the
23 department of health until October 2nd when the
24 State makes that registry available, so we can see

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2 understanding, too, is that it was put into the
3 normal process. It was just given priority --
4 MR. CZAPRANSKI: That's right.
5 MR. WRONSKI: -- over everything.
6 MR. CZAPRANSKI: That's right.
7 MR. WRONSKI: And -- and so,
8 that's why you saw it come out. And as -- as a
9 matter of fact, I -- one public health physician I
10 spoke to said that, you know, had the H1N1 last
11 year come out at a different time frame. It really
12 would have been the seasonal flu, okay, this year,
13 just that it came out differently.
14 So, I'll let them know that
15 public education would be very useful, and maybe
16 that'll give, you know, calming effect to some
17 healthcare providers who are worried about the
18 vaccine.
19 DR. COOPER: Jan?
20 MS. ROGERS: Last spring when --
21 when the H flu hit and -- I couldn't understand, at
22 first, why the press was so quiet in our community.
23 DR. COOPER: Right.
24 MS. ROGERS: It was all the

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2 all the different groups that signed up in our
3 county to receive and give the vaccine. So, we --
4 we still don't know that yet.
5 MR. WRONSKI: So, maybe the
6 Department went the wrong way, and they should have
7 said, "we're going to withhold it from the
8 healthcare providers, until" --.
9 MR. CZAPRANSKI: Yeah.
10 MR. WRONSKI: Maybe that would
11 have been the way to go. But yeah, there is --
12 there is some misinformation.
13 I'll pass on to Bob Burhans and
14 others. And there's this -- there's a series of
15 subcommittees that was set up by the Department. I
16 think there's nine of them, that look at clinical
17 care facilities, vaccination, there's a -- a public
18 education committee. I'll make sure that they have
19 heard what you've suggested, that it would be good
20 to do a P.S.A. on this, and get -- make sure
21 information's out there that this process of
22 developing the vaccine, you know, what was the
23 regular process. You know, I won't say it wasn't
24 pushed, I think it was pushed hard. But my

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2 hysteria from Texas and people dying here and dying
3 there and a lot of hysteria, and then when it
4 actually hit our region, we didn't hear anything
5 from the press. And we were absolutely dying for
6 them to come out and say something to educate
7 people.
8 DR. COOPER: Yeah.
9 MS. ROGERS: And I think it was
10 because it was hitting children only, and it wasn't
11 hitting the adult community is part of my surmise
12 that that happened.
13 But if they -- if the Health
14 Department is talking about P.S.A.s, people really
15 need to be strongly encouraged to stay home and
16 rest, and to educate them about what signs and
17 symptoms would be important to go to your doctor or
18 to go to the emergency department.
19 I'm not sure -- education is not
20 always the be all and end all in these situations,
21 but I think it would be helpful to have that part
22 of the announcement, because we got -- I mean we've
23 already had people come in with -- I was telling
24 one story where the kid was totally well, had had a

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2 headache and vomited once, and he came in, by that
3 time he was totally well, but people were afraid he
4 had the swine flu.
5 DR. COOPER: Yeah.
6 MS. ROGERS: So, I mean there's
7 so much fear of -- of this illness, that it -- any
8 public education that we can do to try to help
9 people understand when it's appropriate, and -- and
10 what -- that their doctor's not going to be able to
11 do anything for you unless you have certain
12 complications.
13 DR. COOPER: I think there are
14 three issues that I would like to mention that
15 grew, in part, out of personal experience, but in
16 part out of discussions that took place at that --
17 at our city department of health disaster
18 conference on September 15th, where among other
19 things, our city disaster plans were that if --
20 because of the nature of the H1N1 threat, a
21 substantial amount of time during the conference
22 was devoted to H1N1.
23 Point number one is that
24 facilities really need to have specific plans for

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2 recognized the critical need to have a public
3 health answering point, similar to the public
4 safety answering point, where public health
5 questions can be -- can -- can be answered.
6 And so, they're working with
7 three one one and nine one one to develop a
8 specific questionnaire, you know, or a set of
9 questions, much like the emergency medical dispatch
10 priority system, and that Clausen has developed
11 and -- and others, you know, have developed as
12 well, utilizing their own programs, you know, to
13 ensure that patients get the appropriate advice as
14 to where to go.
15 This is -- is based upon some of
16 the work done by Skip Burkle, a -- an international
17 disaster expert, together with some of our
18 colleagues, in the aftermath of the Toronto SARS
19 epidemic several years ago. And -- and it develops
20 a -- a specific triage methodology known as SEIRRV.
21 That's stands for surveillance, expose, infected,
22 removed or recovered and vaccinated. And the
23 SEIRRV triage system can be very useful in terms of
24 helping the public health answering point sort out

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2 kids to ramp up their -- their emergency department
3 capabilities. In -- in Queens, the -- the St.
4 Francis Prep epicenter of the epidemic, resulted in
5 specific local facilities namely -- namely
6 Schneider Children's and Queens General having
7 about a three hundred percent increase in the
8 number of emergency department visits. There
9 literally was not enough space and not enough
10 staff. And hospitals need to explicitly consider
11 what spaces they're going to use, make sure that --
12 that there are plans in place to, you know, staff
13 and equip those spaces in a way that -- that --
14 that will work for children and families that
15 separates those that are in the E.D. for who
16 quote/unquote normal things, from those who are,
17 you know, coughing all over everybody, making sure
18 that those who are in the special I.L.A. waiting --
19 waiting area have surgical masks to wear, et
20 cetera, things like that. That's point one.
21 And point two is that the city
22 has recognized, and -- and actually this has been
23 mentioned in several forums to the State Health
24 Department, the city health department has finally

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2 who needs to go where. And I think Jan's point
3 that people need to stay home if they're sick is --
4 is vital.
5 The third issue I think that was
6 of some particular note, aside, of course, from the
7 normal issues in the city, namely cultural
8 competency issues with some of our, you know,
9 non-English speaking populations and so on, is the
10 point that Sue was -- was alluding to a little bit
11 earlier, that when -- when a very young child
12 initially come in with a fever and the sniffles,
13 you know, does that child have R.S.V.? Does that
14 child have H1N1? And of course, you know, the
15 answer is who knows initially?
16 And a lot -- you know, there's a
17 tremendous rush to give a lot of those kids
18 Tamiflu, you know, in the -- without necessarily
19 really knowing that -- that they need it, and
20 which -- which, A, depletes the supplies, but B, if
21 you went the other route and tested everybody, you
22 know, you wouldn't be able to test them quickly
23 enough, you know, and we don't have -- we don't
24 have the capability to do the testing anyway.

Page 126 1 EMSC, 9-29-2009 2 I mean there are -- as you all 3 know, there's some point of care testing 4 capabilities that are, you know, that exist, but 5 they're not specific for H1N1. 6 But I think we have a tremendous 7 amount of education that's -- that's yet to be 8 done. 9 The last point that I want to 10 mention with respect to children, is that I 11 personally believe that we have not reached out 12 enough to the office-based pediatricians at all. 13 MDNY (phonetic spelling) has been 14 doing a great job of reaching out to the -- you 15 know, to the office-based general practitioners 16 that make up the majority of their membership, but 17 reaching out specifically to the pediatricians, 18 that's something that's being done -- has been done 19 very poorly across the state, and I've reached out 20 to the leadership of the academy about this, and I 21 think they're beginning to -- to -- to get the 22 message. But it's too late, I hope not too 23 little. 24 I'm sorry, John.

Page 127 1 EMSC, 9-29-2009 2 DR. HALPERT: No, thank you. 3 Excellent points. Excellent points you make, 4 especially in regard to the very young child 5 presenting with nonspecific symptoms, and really 6 reframing this in terms of what Ed mentioned right 7 off the get-go this morning. If this was a year 8 ago, it would be a kid with sniffles and runny nose 9 who we'll observe and say, "well, you know, suction 10 the nose, hydrate the kid, watch for fever," that 11 kind of thing. Not to discredit the -- the nature 12 of influenza at all. It's a very serious illness. 13 It doesn't matter if it's H1N1 or any number of 14 seasonal stains, significant yearly morbidity and 15 mortality associated with it. 16 But it doesn't change our ability 17 at this point in time to accurately assess for it. 18 What we have to assess for is the severity of -- of 19 the patient in front of us, no matter what the 20 ideology. 21 Okay. So, I mean, you know, 22 saying, "the kid's got a runny nose, take Tamiflu," 23 is obviously not what we want to be promoting. 24 Getting some better information

Page 130 1 EMSC, 9-29-2009 2 DR. COOPER: Yeah. 3 DR. VAN DER JAGT: -- or you 4 know, after your symptoms are gone, whichever is 5 longer, you know, that you need to stay out of 6 work. 7 Well, if the staff is supposed to 8 take care of patients, then that poses a bit of 9 dilemma, because -- all right. In fact, I had one 10 of my hospitalists, this morning, saying, "what do 11 I do? I -- I had a fever and sore throat last 12 night. Do I follow the C.D.C. guidelines or the 13 New York State Department of Health guidelines, 14 which guidelines are our hospital doing?" 15 "Because one would say that I got 16 to be out for at least a week," and she happens to 17 be on call this weekend, of course. You know the 18 other one says, you know, oh, I'm feeling a little 19 bit better, you know, so they -- they can come back 20 to work. Right? 21 So, there is a bit of -- I 22 believe that where education, you know, that 23 might be helpful is, that there's some consistency 24 in what's out there. So, we happen to follow the

Page 131 1 EMSC, 9-29-2009 2 New York State Department of Health wherever 3 possible. So -- 4 DR. COOPER: Yeah. The -- 5 the -- 6 DR. VAN DER JAGT: I'm not on 7 call the weekend. She's on call. Thank you very 8 much. 9 But anyway, that's one thing. 10 The second question that -- that 11 I had about what people were doing is one of the 12 thoughts that we had is whether we should be giving 13 the vaccine to kids on -- who are inpatients who 14 are out -- on the way out, just like we do with 15 other immunizations that they have not had. Should 16 we be giving the H1N1 vaccine to those patients -- 17 the patient comes in for, let's say, an 18 appendicitis, we have to take care of that for a 19 few days, you know, and then, you know, on the way 20 out okay, "well, you're, you know, you're in the 21 age group where you really need to have this." 22 High priority with some of these children. 23 DR. COOPER: That's a great 24 thought. That -- that -- that's a -- that's an

Page 134 1 EMSC, 9-29-2009 2 sure they know that, and there is a little bit of 3 confusion by some as to when to return to work. 4 DR. VAN DER JAGT: I -- I have 5 just one more thing, it's a question I think that's 6 sort of related to those two items. One is we've 7 heard that there's a shortage of masks. 8 DR. COOPER: Huh. 9 DR. VAN DER JAGT: And then 10 that's a concern. 11 DR. COOPER: Masks. 12 DR. VAN DER JAGT: So, because 13 there's a lot of masks used. 14 But the other thing that -- 15 that -- 16 MS. GOHLKE: Elise. 17 DR. VAN DER JAGT: Oh, I'm sorry. 18 I beg your pardon. My voice is usually louder. 19 I'm sorry. 20 I said there is a concern about 21 there being a shortage of masks, you know, not the 22 N-95 masks, but the standard masks. But that also 23 brings up the issue about how effectively we are 24 protecting people around kids who might be infected

Page 135 1 EMSC, 9-29-2009 2 with H1N1. For example, in hospital, that is the 3 kid who comes up from the E.D., possible H1N1, but 4 there's no mask on the patient, goes up through all 5 over the kind -- everywhere, what about that? 6 They get to the floor, and now 7 all of a sudden you put the -- you know, 8 everybody's on precautions. 9 Well, you translate that also 10 ambulances. I mean what do you do in ambulances? 11 Do they all wear masks? Does the kid wear masks? 12 Does -- I mean if they come in? I mean how is that 13 being looked at? Because that's a -- a public 14 health sort of spread of disease, and -- and how 15 are you doing that? And also in E.D.s, it's the 16 same way. 17 DR. HALPERT: Another great point 18 though because we're -- we're seeing so many people 19 who are kind of getting -- they're really enjoying, 20 I think, almost the idea of sitting in a waiting 21 room with a mask on. It's kind of the southeast 22 Asia earthquake effect -- 23 DR. VAN DER JAGT: Uh-huh. 24 DR. HALPERT: -- you know?

Page 138 1 EMSC, 9-29-2009 2 disease, they should be wearing a surgical mask. 3 And that -- that's standard practice in E.M.S. 4 Whether or not they do it varies 5 with the provider. And on region. On how, you 6 know, your squad or your region pushes the point. 7 Our latest guidance suggests wear it. You know, if 8 you have this type of patient, wear it, and offer 9 your patient the mask if they can tolerate it. 10 But again, it's -- it's going to 11 vary, a lot. 12 MS. MOLLOY: May I just say 13 something? 14 MR. WRONSKI: Please. 15 MS. MOLLOY: You know, this is 16 Rita Molloy. 17 A lot of school nurses are 18 telling me that their district superintendent has 19 told them not to mask children, and they feel that 20 that's going to be something that upsets parents, 21 upsets children, and so even though I understand 22 their guidelines, sometimes it isn't always 23 possible for us to follow them, because of internal 24 protocols. I don't think that they're opposing us

Page 139 1 EMSC, 9-29-2009 2 masking ourselves, but they have -- many of the 3 district coordinators have told me that they've 4 been instructed not to mask students. 5 MR. WRONSKI: Yeah. You know, 6 again, I -- I guess -- and maybe I shouldn't say 7 this, but let's go back to what we first said about 8 this particular flu. 9 It's a flu. And when we had 10 seasonal flu, and it wasn't SARS and it wasn't H1N1 11 and it didn't have a piggy name around it, we 12 didn't say, you know, to everybody, put a mask on, 13 don't mask all the kids in the school. But we did 14 say, you know, if you have a child with the flu, 15 it's a good thing to isolate them, and tell them to 16 stay home till they're better and come back to 17 school. 18 So, I understand what you're 19 principal is saying, and you know, he may not be 20 wrong. At the same time, you know, good pure 21 medicine says offer the mask. But you're in a 22 school, not in a hospital and not in a healthcare 23 setting. And -- and -- and sometimes we forget 24 that. And there are some limitations of what you

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2 MR. WRONSKI: Yeah.
3 MS. MOLLOY: So, I'm just putting
4 it out there that, you know, you can make all the
5 recommendations you want as a guideline, but --
6 MR. WRONSKI: Yeah.
7 MS. MOLLOY: -- you know, push
8 comes to shove it's -- it's still going to be a --
9 a difficult situation to control, because the --
10 the people who are carrying around the illness are
11 largely school-age children, and --
12 MR. WRONSKI: Right.
13 MS. MOLLOY: -- you know, we are
14 working against a different system than that --
15 than the traditional healthcare system.
16 MR. WRONSKI: Yeah. It's
17 understood.
18 MS. ROGERS: There's a couple
19 points that I'd like to make. The first thing is
20 that people are -- are infectious before they
21 develop symptoms.
22 MS. MOLLOY: Right.
23 MS. ROGERS: So from that aspect,
24 it's very difficult to -- to protect people.

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2 home. And they said, well, we -- we go to the
3 hospital, because she teaches foreign students who
4 generally don't have, you know, connections to
5 practitioners on a personal basis, so they go to a
6 clinic or they go to the hospital.
7 And I said no, don't go there.
8 They said why that's where the
9 doctors are.
10 I said yes, it's where the sick
11 people are, look.
12 So, then they all shook their
13 head. And I said you know that make sense. We
14 hadn't thought about that.
15 So what you're saying is -- is
16 actually true, unless you really need to go to a
17 hospital, you don't need to go there.
18 DR. COOPER: Any other thoughts
19 about H1N1?
20 Elise?
21 DR. VAN DER JAGT: Just a comment
22 on -- Martha, you sent around a memo or something
23 about these ventilators on a Web site?
24 MS. GOHLKE: Yes.

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2 For a second, I don't -- point,
3 I'm not sure how other people's are -- emergency
4 rooms are, but ours there is no infection control.
5 It's -- by the design of the Department and the
6 numbers of patients, the size of our waiting room,
7 infection control is extremely difficult in our
8 department.
9 FROM THE FLOOR: That's true
10 everywhere.
11 MS. ROGERS: And third, kind of
12 tongue in cheek, maybe we should put in the P.S.A.s
13 don't go to your doctor's office or the emergency
14 room because you will be exposed to swine flu.
15 MR. WRONSKI: Well, I -- I
16 will -- I will tell you my wife teaches and about a
17 month ago or so, I visited her in one of her
18 classes, and this -- this is adults, and they
19 started to question me about H1N1. And that this
20 group generally thought if they got it, they were
21 going to die, you know, so I told them no.
22 MS. ROGERS: Yes.
23 MR. WRONSKI: And -- but I told
24 them, you know, go -- if -- if you're ill, stay

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2 DR. VAN DER JAGT: Wasn't that
3 you that sent that around?
4 You go to a Web site, and it was
5 an instruction booklet on how to use -- was it
6 National Clearing or National some -- someplace
7 where they kept older ventilators -- LP10s,
8 Univents, and another one that I wasn't familiar
9 with.
10 MS. GOHLKE: Uh-huh.
11 DR. VAN DER JAGT: I'm sorry?
12 MS. GOHLKE: Byrd.
13 DR. VAN DER JAGT: No, it wasn't
14 a Byrd. No, that is really old or the Emerson.
15 No, it's not that.
16 But -- but what was very helpful
17 about that was that one is to know that there would
18 be a ventilators for kids that were really sick. I
19 mean who needed that kind of care. But secondly,
20 the instruction booklet, I went to the -- to the
21 Web site, is extremely helpful. It's a very good
22 instruction booklet on how these ventilators
23 work --
24 DR. COOPER: Yeah.

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2 DR. VAN DER JAGT: -- for those
3 who might not use them regularly.
4 MS. GOHLKE: Huh.
5 DR. VAN DER JAGT: And so, I -- I
6 would just first of all thank you for sending that
7 memo around. I was not familiar with it. I sent
8 it to all of our critical care folks, our E.D.,
9 folks, because my concern is that if we do end up
10 with kids that are quite ill -- not the ones that
11 are not ill, but -- you where they're going to end
12 up? They're going to end up in the emergency
13 department, and they're going to end up in the
14 I.C.U., and perhaps the general floors, on these
15 vents, if they would need that. And then there's
16 going to be an inadequate number of people who can
17 really work them.
18 DR. COOPER: Right.
19 DR. VAN DER JAGT: So, they need
20 to have some information on it.
21 DR. COOPER: Elise --
22 DR. VAN DER JAGT: So, that was
23 really good. We were very grateful.
24 DR. COOPER: That reminds me

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2 MR. CZAPRANSKI: Yeah. I just --
3 you know, I think the local county health
4 departments, and I can only speak for Monroe
5 County, are doing a lot. We've been in the I.C.S.
6 command structure for three weeks now. Our
7 operational periods are seven days, so we meet
8 every Monday evening because there's not a lot
9 going on, not a lot of information known.
10 And then, every Tuesday morning
11 for fire, police and E.M.S., there's a single
12 bulletin that comes out that's posted for everyone
13 to look at with all the updates. We try to keep it
14 to one page. And all the providers are going
15 there, so they can look at one source for the
16 updates to that.
17 And on the nine one one center,
18 we're looking at the Claussen thirty-six card,
19 which is the pandemic flu card. So, we -- this --
20 the end of this week, we'll have all our
21 dispatchers trained on the new thirty-six card.
22 And then we'll tie it into the two one one system,
23 where if a caller comes through and -- and goes
24 through that triage process, and it's not a

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2 of -- of one of the meetings of the Critical Care
3 Society in New York. The -- one of the pediatric
4 critical care physicians reminded us all -- and of
5 course, I hadn't thought of this, I -- to be
6 honest -- that when kids are sent home on -- on
7 home vents they are virtually always sent home with
8 a spare -- with a spare home vent. And as a result
9 of that -- that that's an untapped source of surge
10 ventilatory capacity that we may not have thought
11 about --
12 MS. GOHLKE: And adults.
13 DR. COOPER: -- as part of the
14 surge.
15 Yes. So, yeah, and adults as
16 well. Yes. Exactly.
17 So, there aren't a lot of people
18 out there on home vents, but you know, it may be
19 that you just need one additional vent in your
20 I.C.U. that may be in place, that you -- you could
21 get it if necessary.
22 MR. CZAPRANSKI: Yeah.
23 DR. COOPER: Tim, you had a
24 point?

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2 critical patient, they'll get turned to an advisory
3 line, one for Spanish, two for English, press pound
4 4 go back to the nine one one dispatcher.
5 So, we're looking at all those
6 things and they've been in evolution for the last
7 three or four weeks.
8 But a lot of our P.S.A.s we
9 started last spring, knowing that this was going to
10 come back around again, just waiting for the time
11 to get those P.S.A.s out there, and have it
12 right -- right at the right time. But the
13 epidemiologists in that group, you know, the county
14 health department, and law department and everybody
15 else, and there's really a lot of -- a ton of work
16 being done behind the scenes that may not be
17 visible. And -- and that's out there.
18 And we have four stages in our --
19 from the -- in our nine one one center right now.
20 We're on stage one for fire and E.M.S. Stage two
21 will be sort of a restricted response by first
22 response fire or police that don't need to go on
23 these calls, if I.L.L. increases in the community.
24 And then stage three would include the activation

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2 of the thirty-six card, further restricting
3 response to first responders. And then four would
4 be matching the E.M.S. resources to the severity of
5 the calls when we run into E.M.S. shortages, as
6 well as increased call volume.
7 So, all those things are in play
8 now. It's -- it's a lot of work, but it's --
9 it's -- we can flip those switches any time.
10 DR. COOPER: Thank you. Great.
11 Any other comments on H1N1?
12 Okay. Then let's move on to our
13 old business. I -- I think we've more or less
14 covered the issues about hospitalization, and the
15 stakeholders meeting and the data discussion.
16 With respect to Pediatric Trauma
17 Regulations, the Pediatric Trauma Regs were a focus
18 of the meeting that was held, I believe at the end
19 of July, in the city prior to the September STAC
20 meeting. And the fact is that I believe most of
21 the recommendations that this committee had were --
22 were adopted. There was a sense that these regs
23 were going to be pushed along, I think, at a -- at
24 a fairly rapid clip, but I think it's clear now

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2 before I came on board and such. So, it is moving
3 along. But we are to a point where the -- it's
4 time for us to -- to step back, look to see what
5 we've talked about so far, and get the big picture
6 again of what it is we are proposing, because
7 So, all those things are in play and then
8 we present it to the community, the community will
9 show us the big picture. And maybe not in such a
10 kind way.
11 So, we want to make sure that we
12 are -- that we know what we're doing before we --
13 before we actually make the proposal for these
14 changes.
15 So, the -- the E.M.S.C. -- the --
16 the Pediatric Trauma Regulations, I think the only
17 issue we have was just some wording pieces on it
18 that -- that we need to work out, which is the same
19 that we have on the rest of the regulations, and so
20 then we pass them along to the attorney at the
21 division of legal affairs for our attorney's
22 comment on them. And Ed Wronski and I spent three
23 hours with the attorney and barely got to the
24 definition section. So, we have some work there to

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2 that's not going to happen.
3 The Executive Committee for the
4 State Trauma Advisory Committee is really now
5 considering a relook at what it's done so far.
6 It's made a commitment to consider adding
7 level-three trauma centers when previous only level
8 one and level two have been included. And so, I
9 think the process is going to be continuing on for
10 probably another several months, if not longer,
11 before a final resolution is made. So, we will
12 have an opportunity to look, once again, at the
13 Pediatric Trauma Regs as they're proposed.
14 I -- I don't believe that there's
15 anything terribly controversial in the -- in that
16 section of the regs that would necessarily need our
17 input at this particular time, but I'll invite Mike
18 Tayler to chime in if he has any additional
19 information he wants to -- to give us.
20 MR. TAYLER: The -- you're --
21 you're correct, Dr. Cooper. The -- the regs are
22 moving along fast and furious at this point
23 compared to what they have moved in the past. This
24 project has been going on for at least three years

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2 do with -- with our division of legal affairs to --
3 to get them on board with what the proper wording
4 should be and all that.
5 So, the -- initially, we had
6 hoped that the regulations were going to -- the --
7 the regulations are compiled, put together, by the
8 Bureau of E.M.S., the division of legal affairs,
9 the State Trauma Advisory Committee with input from
10 E.M.S.C. and SEMSCO/SEMAC, along the way and such.
11 But the -- the STAC then puts them forth -- or they
12 come out of STAC, and -- and we put them forth
13 through the Department, but they have to go to the
14 State Hospital Review and Planning Council. They
15 are the only ones who can approve these -- these
16 regulations, give the big blessing before the
17 commissioner signs off.
18 So, we had hoped to take these to
19 SHRPC the end of this year or first part of next
20 year. It's going to be a little longer than that.
21 because as I said, we have to -- we have to get the
22 big picture again, and get our attorney on board
23 with what the -- what the language actually says
24 and -- and such. So, they are moving along faster

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2 than what they -- than what they had been -- what
3 they have been in the past. The -- we -- we see
4 the light at the end of the tunnel, it's just
5 getting there.
6 MR. WRONSKI: If I could add just
7 one thing. The -- what -- what happens when you --
8 please, don't take offense, but when you put a lot
9 of passionate, well-trained medical professionals
10 in a room, and it's more than two, there's a lot of
11 opinions. And we had reached a certain stage in
12 the trauma development that -- last year where we
13 thought we were going to go to the SHRPC this year.
14 But there has been a more intense discussion over
15 some key issues.
16 And so, what I would encourage
17 you to do is not just -- as -- and this is as a
18 medical provider, when the regs are finally out in
19 their final draft form, take a look at those --
20 those key issues that -- you know, and some of the
21 key issues not to discuss them in detail today, but
22 they include things like what level of resident
23 coverage would you want for an in-house regional
24 trauma center versus an area trauma center? If you

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2 It's been a long process, but
3 even though it's been three years, do remember that
4 generally they meet on these regs about three times
5 a year. So, it's really three to four days a year.
6 Mike spends his entire career on this, but the
7 members spend about three days a year. So -- but
8 it's -- it's -- it's been a worthwhile process, and
9 the -- and the reg, and -- regs that are as old as
10 the Trauma Regs, you know, needed to be revisited
11 and looked at.
12 DR. COOPER: Any further comments
13 on that?
14 I can assure you that we will
15 update you as the need arises.
16 The next item on the agenda is
17 the status of the New York City pediatric trauma
18 centers, and I don't know if we have the plan or
19 final on that yet, Ed?
20 MR. WRONSKI: I do.
21 DR. COOPER: Outstanding.
22 MR. WRONSKI: As of this morning.
23 DR. COOPER: Okay. Let's hear
24 about it.

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2 have a level three, what is it you expect a level
3 three to be and do? And -- and that's gone back
4 and forth a little bit. So, some of those key
5 issues.
6 Neurosurgery. Is it okay to use
7 a neurosurgical P.A.? And when? And how often?
8 And -- and are you comfortable with that? In what
9 kind of setting?
10 So, these are issues that have
11 been on the table and off the table and back on the
12 table for quite a while, and it -- and it has
13 nothing to do with the -- the process of writing a
14 sentence. That's something that Mike and -- and --
15 and our attorneys will do fairly quickly when --
16 when this is done. Right now, it's the concept.
17 What, from a medical point of view, is the State
18 Trauma Advisory Committee comfortable with in -- in
19 the new trauma system that they're envisioning?
20 So, that's -- that's why it's
21 taking a little time. But I think we're actually
22 down to just a couple of key issues, and I -- I --
23 I think you'll see these regs go to SHRPC towards
24 the end of next year and get adopted.

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2 MR. WRONSKI: Okay. Mike.
3 MR. TAYLER: Yeah, stand by.
4 MR. WRONSKI: Yes, we received
5 the last two letters -- one yesterday and one in
6 this morning's mail before I -- and -- and just --
7 Mike will go through it, but just to let you know,
8 what we've done is we've sent the list to the New
9 York City Regional Trauma Advisory Committee and
10 asked them to take a look at this and give us any
11 comments. And it's a way of vetting the list, at
12 least from the Committee's point of view, and then
13 the Department itself will determine if it needs to
14 do anything further to vet the list. Because right
15 now, it's a -- it's a list that was created based
16 on what we already knew hospitals to be designated
17 as, and also a self-evaluation list of some
18 hospitals. Are they still meeting the standard?
19 And let us know.
20 Got that, Mike.
21 MR. TAYLER: Uh-huh.
22 (Off-the-record discussion)
23 DR. COOPER: For those on the
24 phone, Mike is just hooking up a projection.

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2 MS. MOLLOY: Okay.
3 DR. COOPER: It'll just take a
4 second.
5 Just before he gets up there, one
6 of the things that I -- I think this review will do
7 is kind of set a -- a model for us to take a look
8 at, not just from a New York City perspective, but
9 from all regions, how to periodically review
10 standing of trauma centers.
11 We are developing a -- a short
12 self-review form that'll go to trauma centers that
13 they'll need to fill out probably every two years,
14 just saying, yeah, we are meeting the standards,
15 here's some key changes in our facility, and notify
16 the Department, because we don't go out often
17 enough to do site reviews. This particular review
18 focuses on pediatrics and was a self-eval by those
19 facilities.
20 MR. TAYLER: Well, move on, if
21 you want, while I see if I can get this.
22 (Off-the-record discussion)
23 DR. COOPER: Okay. Well, while
24 we are waiting for the -- the list to come up on

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2 about earlier, deciding what kinds of data points
3 we want to look at. Concurrently, we're working
4 with the School of Public Health to execute a
5 contract, so that we could -- we could integrate data
6 from all different types of products that services
7 are using out there. We're chattering at the --.
8 DR. COOPER: Concern.
9 MS. BURNS: Yeah. We're
10 chattering with -- with Jane McCormick and her data
11 group in STAC to -- to see how we can best
12 integrate prehospital data with trauma registry
13 data, so the end result would be that we could
14 electronically transfer a patient -- a prehospital
15 patient into the hospital's trauma registry.
16 So, there's a lot on the horizon
17 with this. And -- and every time I -- I think
18 about it, I get the chills. But we're moving.
19 I had the opportunity, thanks to
20 Mr. Wronski, to attend the national director's
21 meeting last week, and to talk with a number of
22 other states who are -- in their mind, they're a
23 little bit ahead of us, but when they start
24 realizing that we have statewide data already,

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2 the screen, I'm going to just ask a little bit out
3 of order -- ask Lee Burns to update us on the
4 NEMESIS data elements.
5 Is that also required for you,
6 Lee or no?
7 MS. BURNS: No.
8 DR. COOPER: Okay.
9 (Off-the-record discussion)
10 MS. BURNS: Basically what we've
11 done with -- we're moving forward with the --
12 our -- our grant, and part of our grant is to
13 develop a NEMESIS-compliant state data set. And as
14 we had discussed at an earlier meeting, we're
15 looking for your feedback on the kinds of data
16 elements you would be interested in.
17 With that said, we -- we're doing
18 this also with our -- our colleagues at -- at
19 SEMSCO, SEMAC is going to have some say in it,
20 obviously, as is the STAC. So, what we're going to
21 wind up doing is essentially focusing on a
22 NEMESIS-compliant New York State data set.
23 So, a lot of things are going on
24 with that. One is, as Sharon chattered with you

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2 we're actually a lot ahead of them. So, it's sort
3 of a -- an interesting give and take. And as of
4 now, the NEMESIS technical group has about four
5 point one million records, and they receive data
6 from nine states. So, we're -- we're really quite
7 on track. I think we'll be -- for the last state
8 to sign on to NEMESIS we'll probably be within the
9 next probably six months submitting some data to
10 NEMESIS. So, it's not as grim as it sounds when I
11 say -- I ease them, you know, we're the cutting
12 edge, we're the last state to sign the M.O.U.
13 So, we'll keep you in the loop,
14 and -- did I miss anything?
15 MS. CHIUMENTO: No, I just --
16 I -- I actually made up just a quick grid if
17 anybody who's interested in that the data points
18 are that we're looking at.
19 MS. BURNS: Yeah. What -- what
20 I've --
21 DR. COOPER: Yeah. Please.
22 MS. BURNS: What I've focused
23 you --
24 MS. CHIUMENTO: -- done --.

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2 MS. BURNS: -- the advisory
3 counsels on are patient care-related data.
4 And quite specifically, because
5 we have the capacity to provide NEMESIS with the
6 demographic data, a fair portion of the demographic
7 data from our database, you know, the data -- the
8 NEMESIS data requires certain -- for each record, a
9 certain amount of baseline data. We're able to do
10 that. And then, the rest of -- you know, the
11 patient demographics stuff is -- is relatively --
12 I -- I hate to say it's a no-brainer. It's
13 certainly not, but it's relatively straightforward.
14 So, I didn't want to bog you down in that sort
15 of -- the -- the minutia with I could use your
16 expertise in the patient care stuff.
17 DR. COOPER: Thank you, Lee.
18 Any questions for Lee?
19 Mike, how are we doing?
20 MR. TAYLER: It's not -- it's not
21 going to work here, so I can display it, but --.
22 DR. COOPER: Would you please
23 just let's just go through it?
24 MR. TAYLER: The -- okay.

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2 actually is Nassau's ZIP Code, but --.
3 MR. TAYLER: Yeah.
4 MR. KANTER: Isn't Buffalo a peds
5 trauma center, too? Buffalo Children?
6 MR. TAYLER: Okay. These were
7 New York City only.
8 MR. KANTER: Oh, these are New
9 York City.
10 MR. TAYLER: Yeah.
11 MR. KANTER: Beg your pardon, my
12 mistake.
13 MR. TAYLER: Yeah. So, we have
14 those two and then the following are -- have said
15 that they are both adult and pediatric. Bellevue,
16 Elmhurst, Harlem, Jamaica, Lincoln, Jacobi, New
17 York Presby, Richmond University Medical Center on
18 Staten Island, Staten Island University North, and
19 Kings County Hospital. So, those have said that
20 they are both adult and pediatric, that they do
21 have a PICU, that they do receive pediatric trauma
22 patients to their -- through their E.R., and they
23 do keep them.
24 DR. KANTER: Can you read that

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2 DR. COOPER: So, Rita, you're not
3 missing anything here. We --
4 MS. MOLLOY: Okay. It's by
5 Braille.
6 MR. TAYLER: There are eighteen
7 trauma centers in New York -- in the five boroughs.
8 Of -- of those eighteen, we have two that are
9 pediatric-only centers. Children's Hospital of New
10 York, Presbyterian and Schneider's L.A.J., which
11 interestingly is, I guess, physically in Nassau
12 County not in the five boroughs of New York, but we
13 always consider it New York City.
14 DR. HALPERT: The site is
15 actually in the five boroughs, although it's not
16 in the --.
17 MR. TAYLER: It is?
18 DR. HALPERT: Yes, it's just on
19 the east side of the line.
20 MR. TAYLER: It maps funny when
21 you -- when you map something by ZIP Code, it
22 doesn't -- it maps very funny. Like -- like right
23 on the line.
24 DR. HALPERT: Yeah. The ZIP Code

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2 list more time?
3 MR. TAYLER: Sure. Bellevue,
4 Elmhurst, Harlem, Jamaica, Lincoln, Jacobi, New
5 York Presby, Richmond, Staten Island North, and
6 Kings County.
7 MR. WRONSKI: And what this means
8 is from my perspective is that a regional trauma center
9 specifically is considered well-capable of treating
10 major trauma for adults and pediatrics when they
11 were originally designated when the system started,
12 but they were given the option, if they did not
13 feel they had a robust enough pediatric capability,
14 they would advise the Department of such. And
15 there were a number of centers, you know, who did
16 that originally. And so, they were adult-only
17 regional centers.
18 And they were questions today
19 because New York City has so many centers, how many
20 of those regional centers, since they're all
21 regional centers, actually had fully functional
22 pediatric trauma departments. Different from a
23 children's hospital, you know, like Buffalo or
24 Schneider's, which has a whole array, you know,

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2 their focus is entirely on children. These
3 regional centers are saying we have enough
4 capability to treat major trauma for pediatrics.
5 And that's what this list was about, to get, today,
6 what the hospitals are confirming they're capable
7 of doing. And -- and we're sharing that with the
8 RTAC in New York City for comment. And then we'll
9 do a final vetting ourselves.
10 DR. HALPERT: And just to refocus
11 this. I believe this came from a question that
12 arose nine months ago or something --
13 MR. WRONSKI: Yes.
14 DR. HALPERT: -- where certain
15 places were billing themselves as capable, but in
16 fact, didn't have an intensivist or a surgeon or
17 I.C.U. to manage these kids.
18 MR. WRONSKI: Right. That was
19 the question.
20 DR. HALPERT: But in fact --
21 well, you're not sure where that's going to fall
22 out yet, but you're compiling the --
23 MR. WRONSKI: Right.
24 DR. HALPERT: -- the information

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2 is it still somewhat informal?
3 MR. WRONSKI: It -- no,
4 there's -- there's actual Pediatric Trauma Regs.
5 They are not as specific as the ones being written
6 now, but they are -- they -- they do have specific
7 criteria for pediatrics, and you don't need to be a
8 children's hospital to meet those, but you do have
9 to have pediatric capability and training for your
10 staff, you know, in your trauma center.
11 DR. COOPER: Okay. Well, I -- I
12 have no doubt that there will be more to come. It
13 sounds like Ed's outlined at least to chapter
14 three, which is getting input from the community
15 and then at chapter four, which is the Department
16 making decisions about how it wants to proceed in
17 terms of ultimately delineating the institutions on
18 that list.
19 Okay. We are now then going to
20 move on to discuss the bylaws. Now, the process of
21 dealing with these bylaws has been an interesting
22 one. The department of legal affairs -- or the
23 division of legal affairs, I should say, of the
24 Health Department has played a -- a more

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2 to track it.
3 MR. WRONSKI: Right. Yeah. I --
4 I think this is chapter two. The first chapter was
5 the -- we're not so sure we know who is or isn't,
6 let's do the study. Now, we did the initial study.
7 Part three is to vet it, and say yeah, this is --
8 we're comfortable with this list, but --.
9 DR. HALPERT: So, eighteen places
10 bill themselves as trauma centers. Ten of them say
11 they can handle the kids --
12 MR. WRONSKI: Right.
13 DR. HALPERT: -- as part of their
14 thing.
15 MR. WRONSKI: Right.
16 DR. HALPERT: Two of them do only
17 kids.
18 MR. WRONSKI: Right.
19 DR. HALPERT: So, six others just
20 do adults, in theory.
21 MR. WRONSKI: Right. Yes.
22 Correct.
23 DR. KANTER: So, do you have
24 criteria for the pediatric-capable centers here, or

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2 commentative role in the process of the new bylaws
3 than was the case many, many years ago, when many
4 of us first began to spend time working with the
5 Health Department here in Albany. But the document
6 that you have before you does represent the latest
7 iteration of -- of -- of the bylaws as we have seen
8 them, and as they have now been further revised by
9 the -- by the division of legal affairs.
10 I would make one comment. I note
11 that the division of legal affairs has recommended
12 deletion of the -- the pediatric behavioral health
13 expert. I'm not sure why this is the case, and to
14 me it's a fairly glaring omission.
15 MS. GOHLKE: Well, I can tell you
16 why.
17 I mean one of the things that the
18 D.L.A. does is they look at the statute and they
19 look at the bylaws and make sure it doesn't
20 contradict with -- with one another. The bylaws --
21 or the -- the statute was written specific to the
22 seats and the disciplines that fill the seats. Not
23 all statutes do, like Mike's for the trauma leaves
24 it wide open, but ours are specific, and they --

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2 this -- they came from our grant. You know, from
3 the feds' desire who they want to see sitting on
4 these committees. And the pediatric behavioral
5 health expert was not listed in the statute.
6 So, in fact, we were not limited
7 to these seats, so we can -- we can fill with more
8 people if we want. We can put some somebody on
9 there, but it's -- this is just being consistent
10 with the statute. And that's not in the statute,
11 so that's taken out.
12 And -- and then a lot -- and
13 that's what I did. When I went through -- I mean
14 there were other changes, too. Some of them were
15 very small, and you know, just grammar or whatever.
16 But I left in the -- the more significant ones,
17 obviously, that the D.L.A. changed. The -- one of
18 the items that was up for question of -- is when
19 does your appointment start and when does it end?
20 And what was decided was that it starts when you
21 get the dated commissioner's letters. So, as of
22 the date of your letter, and the statute says that
23 it's a four-year term. We had changed it from --
24 from a four to a three, this is going back now. It

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2 you could -- you can live your life with us.
3 The only thing that was changed
4 was that the vice chair could be anybody in the
5 Committee, the chair had to be a physician, and the
6 vice chair could be anybody. D.L.A. has said that
7 both have to be a physician. And the -- the
8 thought process behind that is because if the chair
9 was out for a significant period of time and
10 they're advising on medical matters, it needs to be
11 a physician. So -- so, both -- we weren't happy to
12 about that, but that's -- that's the ruling.
13 I think that was pretty much the
14 main changes. They just moved some stuff around,
15 order. And let me see if there's anything else.
16 DR. VAN DER JAGT: There was one
17 other thing, Martha.
18 MS. GOHLKE: Yes?
19 DR. VAN DER JAGT: Because I just
20 had a question about it --
21 MS. GOHLKE: Yes.
22 DR. VAN DER JAGT: -- this is
23 changed. The chairs' terms also can be in
24 perpetuity?

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2 has to stay at a four, because that's what the
3 statute says. So -- so, your term ends when four
4 years from the date of your letter.
5 And then, we have language in
6 here to help rather than all turnover in four
7 years, we'd like to rotate -- you know, do half,
8 you know, every two years, bring in the new
9 members, and -- and move the other ones out. Right
10 now we don't have all the seats filled.
11 So, most of you were vetted in
12 '97 (sic), so right now, we're at the two-year
13 mark. It would be good to fill the other seats,
14 and then your turns would come up in two years,
15 which would be -- you'd fill your four-year term.
16 The other things was that we had
17 language in there that you couldn't serve more than
18 two terms in a row. The statute says that they may
19 serve as -- as -- unlimited time. That's not the
20 wording, but basically we can't limit it to just
21 two terms. So, you can -- you can stay on forever.
22 Aren't you happy about that?
23 Yes. You have to be -- go
24 through the vetting process again, but you know,

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2 MS. GOHLKE: Yes.
3 DR. VAN DER JAGT: Because it
4 just says it's renewable. It's not --
5 MS. GOHLKE: Yeah.
6 DR. VAN DER JAGT: -- it's not
7 like it's --.
8 MS. GOHLKE: Yeah. Because
9 that's the way it's worded in the statute.
10 DR. VAN DER JAGT: Because we had
11 put in initially, I think, two consecutive terms,
12 and then it changes -- the chair changes.
13 MS. GOHLKE: In the --
14 DR. VAN DER JAGT: In this case,
15 the chair can go on --
16 MS. GOHLKE: Yeah.
17 DR. VAN DER JAGT: -- for
18 thirty-five years? I mean --.
19 MS. GOHLKE: That's the way it's
20 worded in the statute.
21 DR. VAN DER JAGT: Okay.
22 MS. GOHLKE: So, it had to be --.
23 MR. WRONSKI: And I think he
24 should too.

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2 DR. COOPER: Yes, this chair has
3 no interest in service --
4 MR. KANTER: Longer.
5 MR. TAYLER: Yeah. I -- I just
6 went though all this with -- with the --
7 MS. GOHLKE: Yeah.
8 FROM THE FLOOR: Trauma.
9 MR. TAYLER: -- State Trauma
10 Advisory Committee, with the STAC bylaws, and had
11 lengthy discussions with -- with the attorney
12 that's been working with this -- with us on these
13 bylaws, and -- and there was quite enlightening.
14 The truly -- the commissioner appoints you, and
15 unless the statute says differently, it -- it --
16 it -- the -- you can't, by your bylaws, restrict
17 the power of the commissioner.
18 MS. GOHLKE: Our status does it
19 differently though, Ed.
20 MR. TAYLER: So, the -- the
21 statute says that -- that terms of four years,
22 which may be renewed, so that means you can't have
23 anything in your bylaws --
24 MS. GOHLKE: Right.

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2 MR. TAYLER: -- saying
3 differently or telling the commissioner to do
4 something different.
5 MS. GOHLKE: Right.
6 MR. TAYLER: That was one of
7 the -- one of the things that -- that the
8 attorney brought out from the STAC bylaws, was that
9 we don't -- you don't have any authority to tell
10 the commissioner what to do. So, that -- that
11 was -- that was why the -- your question, Dr. van
12 der Jagt, why it had to be changed, because it was
13 limiting the authority of the commissioner, and --
14 and contrary with statute, so --
15 DR. COOPER: Thank you. And this
16 doesn't mean that we cannot, over some period of
17 time, you know, decide that, you know a four-year
18 term for chair, a two-year term -- a two-year term
19 repeated, however that is, would be useful, and
20 then ask the commissioner to consider, you know,
21 replacement of the chair, and the chair goes back
22 to his seat on the Committee.
23 MR. WRONSKI: Sure. Sure. Sure.
24 DR. COOPER: You -- you can do

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2 that they -- that they should be so recognized in
3 the bylaws.
4 DR. KANTER: Well, but the bylaws
5 say the same thing, to include but not limited to.
6 DR. COOPER: Right. But how --
7 but most bylaws specify what their membership is.
8 As -- as long as D.L.A. is okay with that. You
9 know as long as the understanding is that -- that
10 the Department can, you know, in effect, chose
11 additional advisors to be officially appointed
12 vetted members of the Committee, you know, that
13 have voting rights, that's not a problem. But
14 again, that's -- that's not usual. Most bylaws do
15 specify precisely who their members are, so that
16 they know, you know, what the quorum is, when the
17 majority is present, when it's not, and so on and
18 so on.
19 So, I think that may be, you
20 know, a -- a point that the D.L.A. possibly
21 overlooked, and perhaps we should, you know, ask
22 them about that.
23 DR. VAN DER JAGT: But look at
24 the process -- it looks like the process is still

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2 here. I mean, so that if we would want a pediatric
3 behavioral person on the Committee, we would -- for
4 this, it looks like, make a nomination of a person
5 for consideration for membership. And there would
6 be no question that would be a member. So, I'm not
7 sure that we've changed this. I think we have it.
8 This is the minimum.
9 And we, as a Committee, could
10 say, you know, after we've identified somebody or
11 we think, you know, this is a person who we think
12 be asked; right?
13 DR. COOPER: Yeah. All I'm
14 saying is that, that's not usually the way bylaws
15 are done. But if that's okay with the
16 Department --
17 MS. GOHLKE: I agree with what
18 you're saying, Dr. Cooper, for purposes of the
19 bylaws, but our discussion with D.L.A. was what
20 you're saying, is that we're not limited to this.
21 DR. COOPER: Right.
22 MS. GOHLKE: This is just what
23 the -- you know, being reflective of what the
24 statute, and we can add members, as we so desire.

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2 that, you know, ten years down the line there's
3 been a -- when there's nobody's been there, then
4 you have to rethink it all afresh, that maybe there
5 should be a pediatric behaviorist on this group.
6 MS. GOHLKE: Uh-huh.
7 DR. VAN DER JAGT: And that's a
8 little bit more cumbersome, than having put it into
9 the bylaws to begin with, you know.
10 MS. GOHLKE: Uh-huh.
11 DR. VAN DER JAGT: That's the --.
12 MS. BRILLHART: When I look at
13 that, my concern is how important do we think
14 pediatric behavioral health is, which in my mind
15 is -- is it's very important. The statutes set a
16 minimum, however, if we think that pediatric
17 behavioral health is important, shouldn't we leave
18 it in the bylaws?
19 We're saying, okay the statute's
20 a minimum, but we believe that this is important,
21 we'd like it in our bylaws, because the Committee,
22 at this point in time, believes that it's
23 imperative considering all the things that are
24 going on in our world right now.

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2 Because I could see where,
3 especially with the current budget issues, they
4 could say, "no, you can't add any more members than
5 the minimum right now, we cannot afford it."
6 MS. GOHLKE: Uh-huh.
7 MS. BRILLHART: So, if they're
8 not in the bylaws, they're not getting on.
9 MS. GOHLKE: Uh-huh.
10 DR. VAN DER JAGT: So -- so, if
11 we -- I mean we could -- we not do the following?
12 MS. BRILLHART: That's how I was
13 looking at it.
14 DR. VAN DER JAGT: Could we not
15 do the following? That this is -- membership is to
16 include but not limited, and you have all that
17 whole list of people --
18 MS. BRILLHART: Uh-huh.
19 DR. VAN DER JAGT: -- then you
20 also say in addition, you know, we will have this?
21 A pediatric behavioralist.
22 MS. GOHLKE: Yeah, we can go
23 back. We can go back.
24 DR. VAN DER JAGT: Because that

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2 MR. TAYLER: -- I think that
3 we --
4 DR. VAN DER JAGT: -- I would
5 think, I mean, we have to say that this --.
6 MR. TAYLER: -- I -- I think
7 the -- so, that's why I think it was why the
8 attorney said take it out, because of the way this
9 is worded.
10 This is -- the bylaws are -- are
11 worded right now to say the membership will
12 include, boom. And if you're going to word the
13 bylaws that way, then -- then you have to go by
14 what's in statute.
15 MS. GOHLKE: It may just be a
16 matter of putting it in, in a different sentence,
17 saying, in addition --
18 DR. VAN DER JAGT: I think that's
19 what I would suggest.
20 MS. GOHLKE: -- to this --
21 DR. COOPER: Yeah.
22 MS. GOHLKE: -- you know.
23 DR. VAN DER JAGT: I don't -- I
24 don't think that it would be --

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2 MS. GOHLKE: Okay.
3 DR. VAN DER JAGT: -- appropriate
4 for bylaws --
5 DR. COOPER: Yeah.
6 DR. VAN DER JAGT: -- to be
7 included in there "recommendations to." I think
8 you have to say this is what it is.
9 MS. GOHLKE: That's the
10 difference between his statute and our --
11 DR. VAN DER JAGT: So, that's
12 maybe the difference between --.
13 MS. GOHLKE: -- our statute is
14 that ours --
15 DR. VAN DER JAGT: Right.
16 MS. GOHLKE: -- are much more
17 specific than his.
18 DR. VAN DER JAGT: Right.
19 MS. GOHLKE: And -- and the
20 commissioner has less leeway with ours than he does
21 with Mike's the way it's worded.
22 DR. VAN DER JAGT: Uh-huh.
23 DR. KANTER: Well, if we really
24 think this is important, we should immediately

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2 unanimous sentiment of our Committee. That --
3 MS. BRILLHART: So, then, do we
4 pass them as they are, if we're going to do that?
5 DR. COOPER: Well, that -- I -- I
6 think the -- the process for amending the bylaws
7 requires that changes in bylaws age two meetings,
8 as I recall. So, if we were to do that, as a -- as
9 an amendment to the bylaws, we adopt today, we
10 wouldn't be able to, you know, get that solved
11 until sometime in the spring. And maybe even later
12 if the face-to-face meeting that we have, you know,
13 or the non-face-to-face meeting that we have,
14 excuse me, as in the winter months when travel is
15 difficult anyway.
16 So, theoretically we might not be
17 able to seat an individual until the summer. So,
18 I'm -- I'm thinking that it might make more sense
19 if we indicate to the Department that with that
20 exception, we think these bylaws are good to go,
21 and we -- we would like clarification on that piece
22 of it, and that we'll plan on a final vote at the
23 December meeting.
24 Is that acceptable to everybody?

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2 MS. CHIUMENTO: Yeah. She gave a
3 report and I passed out that. And if anybody has
4 any has any comments on them, they can just get
5 them to --
6 MS. GOHLKE: What about sending
7 your rating sheet, and letting people go
8 through --
9 MS. CHIUMENTO: I did that.
10 MS. GOHLKE: Okay. So, Sharon
11 has helped us out a lot, and she has an electronic
12 spreadsheet of this, and we'll send it out to all
13 you folks. So, what you can do is you can go
14 through, and if you think that the data element is
15 important to include, because we're not going to
16 include all four hundred and seventy-nine data
17 elements that NEMESIS wants. But the Department's
18 going to hone them down to the -- the nitty gritty;
19 okay?
20 So, for this Committee to
21 identify what pediatric data elements you want the
22 Health Department to track and collect, and then
23 there's a rating. You say yes or no. Yes, yes we
24 should include it. No, we should not include it.

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2 Ed?
3 Martha?
4 Is that okay with you?
5 MS. GOHLKE: Uh-huh.
6 DR. COOPER: Lee?
7 MR. WRONSKI: Yeah. If you have
8 a question we'll ask it.
9 DR. COOPER: Yeah. Okay. All
10 right. Good.
11 Okay. So, let's now move on to
12 new business.
13 MS. GOHLKE: Can we -- can we
14 just talk about the --
15 DR. COOPER: Of course.
16 MS. GOHLKE: -- the NEMESIS data
17 elements. I don't think we have next steps
18 identified yet.
19 DR. COOPER: Oh, I thought we
20 did. Okay. Go ahead.
21 MS. GOHLKE: Well, unless I
22 missed it. I -- I could have missed it.
23 DR. COOPER: No. Lee was -- Lee
24 was -- Lee was -- you know.

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2 And then, there is a -- a Likert -- Likert scale
3 that's one to five; how important do you think this
4 data element is? And rate it -- I can't remember
5 if five is high or one is high, but you'll see when
6 you get it.
7 MS. CHIUMENTO: Five is higher.
8 MS. GOHLKE: Rate the importance
9 of that data elements. So, if there's any
10 discrepancy across the group, obviously you're
11 going to go with one that's weighted --
12 DR. COOPER: Okay.
13 MS. GOHLKE: -- you know, more
14 heavily. Does that make sense?
15 And then last --
16 MS. CHIUMENTO: Near the bottom
17 there's -- a little range that explains also the
18 Likert scale. So --
19 MS. GOHLKE: Right.
20 MS. CHIUMENTO: -- like a five
21 would be essential, absolutely must collect data
22 data.
23 DR. COOPER: Sure. Sure.
24 MS. GOHLKE: Right.

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2 MS. CHIUMENTO: Where maybe a
3 three would be some it would be nice to have,
4 a might -- might be useful for some things, but
5 not -- not as much as in the day-to-day operations.
6 MS. GOHLKE: And we'll give you a
7 couple week turnaround time to do it, because what
8 we want to do is bring this to the -- you know, the
9 state council meeting before their next meeting, so
10 that you get -- they get your input on what the
11 pediatric data elements are that you guys think
12 should be there. And then -- so, your voice will
13 be heard at the next state council meeting, okay?
14 MR. WRONSKI: Yeah. If I -- if I
15 can mention -- you know, when this is all done, I
16 won't be here, but -- but I have a real interest in
17 the data, and I had hoped that before I left,
18 NEMESIS would be in place, we'd have a state report
19 on P.C.R.s, well, that hasn't happened, although a
20 lot of good things have happened. We have a
21 contract to move this along. We have actually
22 collected and -- and begun our own internal
23 analysis of a lot of the P.C.R. data. We've shared
24 it with bureau of injury prevention. We've shared

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2 care of their patients.
3 So, think of the core elements
4 that really make sense to you. And then think
5 about what you would do with that.
6 So, try to pose a question,
7 and -- and -- and as -- as scientist and -- and
8 physicians and nurses, I think you already do this,
9 but I -- I really ask you to do that. If you do,
10 decide that you would like number two sixty-two,
11 possible injury check, okay, well, why's that
12 important? All right. What's the details of that,
13 that makes it sense for you to do? I just grabbed
14 something there. It just was staring at me.
15 The -- give it some real thought.
16 And then -- and then, make the recommendation.
17 If -- in the future we will
18 modify this, particularly as New York State becomes
19 more of a true electronic data collection system,
20 and periodically we may add five elements or ten
21 elements for maybe that year, and just take a look
22 at it. That's all possible. But right now we'd
23 like to come up with a core, this is what we'll do.
24 But you've got to give it some careful thought.

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2 it with the trauma folks, and with other internal
3 Department offices for their use in actually
4 identifying issues.
5 So, if the data has been made
6 more useful in the last five years, than many, many
7 other times internally. But really to make it what
8 we want, we want it to be useful out there to the
9 provider. And certainly, we -- we want it more
10 contemporary. And we're close to that.
11 But -- what I ask though, is that
12 when you recommend something on this list, you do
13 two things: You remember that the people who are
14 filling it out, who they are, what their training
15 is, all right, what's their capability of giving
16 you a fairly reasonable, accurate, you know, data
17 check, you know, on what you're asking for; and
18 that it doesn't encumber them.
19 That you're not asking -- that's
20 why we're not going to do the four hundred data
21 points, it just won't happen. Even if all four
22 hundred are -- are arguably good to collect; it's
23 not going to happen. We're not going to ask
24 E.M.T.s to do that, we're going to ask them to take

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2 Thank you.
3 DR. COOPER: Thank you, Ed.
4 MS. CHIUMENTO: The database will
5 actually have an explanation on each of those
6 points, so if you're not quite clear what it is
7 the -- the data -- the -- the -- then it would have
8 an explanation of those points.
9 DR. VAN DER JAGT: Okay. Because
10 I was just going to say I went to www.nemesis --
11 MS. CHIUMENTO: Don't do that.
12 DR. VAN DER JAGT: -- which has
13 all --
14 MS. CHIUMENTO: That'll hurt you.
15 MR. KANTER: -- the data elements
16 in it.
17 MS. CHIUMENTO: Yeah. That has
18 everything, including --
19 DR. VAN DER JAGT: Well, it's
20 very interesting. It has lots of stuff on it.
21 MS. BURNS: The only thing is
22 what's up on NEMESIS, isn't current --
23 FROM THE FLOOR: Yeah. Including
24 your social security number and everything.

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2 DR. VAN DER JAGT: Yeah. I think
3 so.
4 MS. CHIUMENTO: And your -- and
5 your home address as a medical director.
6 FROM THE FLOOR: That's right.
7 MS. BURNS: Don't spend too much
8 time with NEMESIS currently, because that data set
9 up on their Web page is what they're currently
10 using. They're looking to switch over to a newer
11 version, NEMESIS 3.0, which is what -- which is
12 what --
13 MR. KANTER: Uh-huh.
14 MS. BURNS: -- the research
15 Sharon has done and what really by the -- by the
16 time we get to it where we need to be. It will --
17 it will be up and running.
18 I -- I mean I think once we
19 execute a contract through the School of Public
20 Health, in concept with a vendor, we could be
21 collecting NEMESIS data from huge portions of the
22 state in a -- in a template format, which will
23 give us -- get us started. So, you know, all is not
24 lost.

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2 DR. COOPER: No, no. I -- I
3 couldn't agree with you more actually. I -- I
4 personally believe we collect far too much data,
5 and you know, we don't -- I'd -- I'd rather have us
6 collect a whole lot less and analyze it a whole lot
7 more.
8 MR. WRONSKI: Right.
9 MS. BURNS: One of -- one of Dr.
10 Henry's concerns about -- about this, in a big
11 global way, is that the P.C.R., for all of its
12 weakness, over the years is essentially when you
13 look at it, it's an assessment format. It -- it
14 pushes the provider to do certain things at certain
15 points in the patient care encounter. And there --
16 he's very concerned, and -- and he's really on the
17 money, that the electronic systems out there,
18 they're very glitchy, but they don't do that. And
19 that the actual documentation happens after the
20 patient -- after the assessment, and after the
21 interaction with the patient care, and after the
22 treatment. And so, he has kind of been poking at
23 me to -- to keep a P.C.R. or -- or something that
24 could be modified as a worksheet, so that a -- a

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2 But just to underscore what Ed
3 says, one of the staff members in -- in the bureau
4 is -- is a paramedic in a service that is using an
5 election patient care record, a -- a
6 commercially-prepared product that's being used all
7 over the state. And he -- he's very concerned
8 about the way that it flows, and that having looked
9 at many a paper P.C.R. in my time, yesterday, I --
10 you know, I think that you have to remember that
11 this first and foremost is a patient record, a
12 contemporaneous patient record.
13 While it will be very useful for
14 us in a thousand different ways between injury
15 prevention, patient safety, protocol development,
16 quality assurance, and on and on and on, it is
17 first and foremost a patient care record. And I --
18 I don't want to, frankly, burden the prehospital
19 environment, because we're interested in -- in
20 something that may not necessarily comport with
21 their day to day practice. So, I think we need to
22 start from a very pragmatic platform. Even if it
23 hurts.
24 Dr. Cooper.

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2 weaker provider who has not, you know, tattooed
3 this on their psyche, can use this as a tool for
4 the whole encounter process.
5 DR. HALPERT: That's an excellent
6 point, Lee, I have to say. Because really it's --
7 it's not so much, you know, as much documentation
8 as communication, and it teaches providers to --
9 to communicate in a way that other healthcare
10 providers can understand. And if you get it
11 tattooed into your psyche long enough, maybe you'll
12 speak that language, which I think has always been
13 of the cruxes for why E.M.S. providers are
14 oftentimes kept in the periphery of the healthcare
15 establishment, they don't talk the same talk
16 necessarily. And -- and that's a -- and that's
17 a -- to their -- to their detriment, and the
18 patient's detriment at times as well.
19 So, I -- I don't disagree that
20 removing that element can have some significant
21 long-term negative implications, though I certainly
22 understand the need to have a more progressive
23 mechanism at -- at hand sometimes.
24 DR. COOPER: To that end, and

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2 while we are thinking about this, I'd like to place
3 that issue sort of in a mental parking lot for us
4 to consider at a future meeting, Martha.
5 The pediatric assessment skills
6 of our providers and, again we have to remember
7 that while most of the work is done by career
8 people, most of the people are volunteer. And it's
9 the volunteers with the least pediatric experience
10 who probably most need, you know, a -- a P.C.R. as
11 I -- that, in some way, guides the assessment and
12 leads to an appropriate disposition.
13 I think some of us that have at
14 least a little gray hair remember that there was a
15 famous professor of medicine by the name of
16 Lawrence Weed, who introduced the SOAP system,
17 which in the 1970s was -- was completely
18 revolutionary, and the -- he wrote a book called
19 Medical Records that Guide and Teach that really
20 changed the way we document everything in the
21 hospital medical record.
22 And I -- I -- I think that while
23 we take it for granted today, the subjective,
24 objective, assessment and plan approach has -- has

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2 perfectly happy with. What it chose to do at the
3 Medical Standards meeting was to allow
4 hydrocortisone to be placed upon the -- upon the
5 statewide formulary, which, of course, opens the
6 door for regions to be able to adopt the use of
7 hydrocortisone within their -- within their
8 regions. But it doesn't really provide tremendous
9 guidance as to how a regional protocol to deal with
10 adrenal insufficiency might be written.
11 And I -- I don't believe that the
12 Medical Standards Committee outright rejected the
13 notion that there should be a guideline, but it --
14 it didn't -- it didn't feel that the document that
15 was presented to it, necessarily was adequate to
16 the task. So, that is going to come up again at
17 the -- at the December meeting of -- of the SEMAC,
18 but think in principle, the concept that we
19 advocated, that hydrocortisone be available for
20 patients with acute adrenal insufficiency, by
21 regional option, that certainly was supported, in
22 that, hydrocortisone is now a recognized option
23 among the -- the state prehospital pharmacopeia.
24 MS. CHIUMENTO: Well, actually,

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2 made a huge difference in the way physicians and
3 nurses think about assessment of their patients.
4 So, I -- I think a -- a tool such
5 as a P.C.R. that -- that does drive a thought
6 process, I think is a very -- very useful tool, and
7 we should perhaps think about how, as future
8 editions of the P.C.R., particularly electronic
9 ones are rolled out, that we try to -- try to build
10 in that capability, especially for pediatric
11 patients.
12 Martha, does that take care of
13 the next steps component of the NEMESIS?
14 MS. GOHLKE: Yeah.
15 DR. COOPER: Okay. Good. So, I
16 think we have a plan on that.
17 So, now to move to old -- old --
18 sorry. Well, let's -- let's do the first part of
19 updates before we do other new business. I think
20 the key issue from SEMAC, insofar as I'm concerned,
21 was the discussion about the CARES issue. And
22 the -- the document that Andy Johnson had prepared,
23 which circulated among us, and I thought we all
24 thought was pretty good, the SEMAC was not

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2 it has to be voted on at in the December meeting,
3 because there was no quorum.
4 DR. COOPER: Oh, thank you for
5 reminding about that, Sharon. Okay.
6 So, there's clearly the intent to
7 do that, and we will be working with Andy Johnson
8 in the interim to come up with a little bit better
9 language. He was provided with some additional
10 draft language at the meeting, which hopefully will
11 be circulated in time before the -- before the
12 December meeting. We're hope that -- we're hoping
13 Ed Wronski will be there, just so he can see -- see
14 that -- that piece adopted. But we're not entirely
15 clear whether that's going to happen yet or not.
16 He may be clear, but --
17 MR. WRONSKI: No comment.
18 DR. KANTER: Do you want to say
19 another word about what the deficiencies is in the
20 letter were?
21 FROM THE FLOOR: Yeah. What's
22 the problem?
23 DR. COOPER: I'm being a little
24 vague because my -- my tired brain doesn't remember

Page 206 1 EMSC, 9-29-2009 2 the precise details, and -- and -- 3 MS. GOHLKE: I think -- I 4 think -- it was the -- I think -- 5 DR. COOPER: Yes? 6 MS. GOHLKE: -- I think -- 7 correct me if I'm wrong, but I believe it was 8 because the suggested protocol -- the suggested 9 document, or whatever, that we're calling it that's 10 going to be sent out to the regions, about the 11 Solu-Cortef was that it's cheaper and that it can 12 be used across the board for any conditions. I'm 13 paraphrasing. And the concern was that for 14 respiratory -- 15 DR. COOPER: That's right. 16 That -- yeah. Martha's right. That's right. 17 MS. GOHLKE: That you would -- 18 you would use Solu-Medrol more so that Solu-Cortef. 19 The way it was worded was that they didn't think 20 they agreed that Solu-Cortef should be used across 21 the board, so they wanted that distinguished in the 22 document. 23 DR. COOPER: And that was -- 24 yeah. Thank you, Martha.

Page 207 1 EMSC, 9-29-2009 2 MS. GOHLKE: Yeah. 3 DR. COOPER: And that was the 4 additional language that was provided, to indicate 5 that -- for respiratory conditions, you know, 6 that -- that methylprednisolone is the more 7 commonly advocated agent, and for adrenal crisis 8 that hydrocortisone is the more commonly advocated 9 agent, and more appropriate in both cases, so -- 10 DR. KANTER: Well, I think the 11 important thing about the letter that this 12 Committee felt strongly about, is that if there's 13 any language about the treatment of adrenal 14 insufficiency -- 15 MS. GOHLKE: Yeah. 16 DR. KANTER: -- is that a 17 glucocorticoid, by itself -- 18 MS. GOHLKE: Yes. 19 DR. KANTER: -- is not a 20 treatment. That it must be done -- 21 DR. COOPER: That -- that -- 22 DR. KANTER: -- and in the 23 context -- 24 DR. COOPER: Absolutely.

Page 210 1 EMSC, 9-29-2009 2 DR. COOPER: -- to include 3 hydrocortisone as a possibility for the -- the -- 4 the -- prehospital pharmacopeia. That -- that was 5 really the major pediatric issue of concern. 6 MS. CHIUMENTO: There was 7 actually a couple other little things in there. 8 DR. COOPER: Please. 9 MS. CHIUMENTO: Yes. 10 DR. COOPER: Please. 11 MS. CHIUMENTO: One of the things 12 was that a pilot was approved for the REMO region 13 on hypothermia. And after R.O.C. and -- but also 14 they're now including in -- within cardiac arrest. 15 So, this is something new. 16 There's one region of the state 17 that is in New York City where they're bypassing 18 hospitals that do not have hypothermia capacity, to 19 go to hospitals that do have hypothermia capacity 20 for patients with R.O.S.C. The Buffalo region 21 added R.O.S.C. in the prehospital setting by 22 certain ambulances that have the -- that -- that 23 have been designated within the city of Buffalo, 24 but that is just for R.O.C. patients. This

Page 211 1 EMSC, 9-29-2009 2 protocol goes one step further, and now is going 3 to -- would like to start doing our hypothermia, 4 basically cold I.V. fluids, during the cardiac 5 arrest treatment itself. So, going right -- right 6 all the way through. 7 Now, I don't know whether there 8 would be a difference in that for pediatrics or 9 not. 10 DR. COOPER: Well, -- 11 MS. CHIUMENTO: I think they're 12 starting off with adult patients, but it might be 13 something that we would like to comment one way or 14 the other on. 15 DR. COOPER: Yeah. 16 DR. VAN DER JAGT: They're were 17 actually looking at this at the international level 18 about protocols for a therapeutic hypothermia in 19 pediatric patients. And as you know that there's 20 no data on this. There's -- there's absolutely no 21 data on pediatric patients. So, I think it would 22 have to be, at least as a first go-around, would 23 probably not be relevant to peds. Even though 24 personally I think it works, but you know, but

Page 214 1 EMSC, 9-29-2009 2 just -- with -- in adult's I.V. fluids or cooling 3 apparatuses or whatever. 4 Then there's also the avoidance 5 of too high of a temperature. And I don't know how 6 well that's been promulgated in the protocols that 7 we have prehospital care. Because a kid who is in 8 arrest and who becomes febrile, or the ambulance is 9 heated up, you know, to try to keep the kid warm, 10 that may not be in the best interests of that child 11 and there is some data on that. 12 DR. COOPER: Uh-huh. 13 DR. VAN DER JAGT: So, I don't 14 know -- do you know --? 15 MS. CHIUMENTO: I don't think -- 16 there's -- there's nothing in the protocol -- 17 DR. HALPERT: That's only in 18 the -- 19 MS. CHIUMENTO: -- it's not 20 defined yet, but --. 21 DR. HALPERT: -- only in the -- 22 in the discussion phase, nothing specific. 23 DR. COOPER: Suffice it to say 24 that the discussions that I have participated in,

Page 215 1 EMSC, 9-29-2009 2 have not been directed toward anyone other than 3 adults, and we're quite some distance away from 4 including children in any -- in any hospital 5 studies involving arrests and hypothermia. 6 DR. VAN DER JAGT: It's coming. 7 It'll be coming. 8 MS. CHIUMENTO: Yes. 9 DR. VAN DER JAGT: We're not 10 there yet. 11 DR. COOPER: Yes. 12 MS. CHIUMENTO: Yes. That's why 13 I brought it to you, just so you're aware that --. 14 DR. VAN DER JAGT: I -- I know 15 our experience at Strong, we've had a number of 16 kids that we've done the hypothermia protocol on, 17 who were -- who arrested at home, immediate 18 bystander C.P.R., had the whole bit, and then we 19 put them in cold -- you know, made them cold too 20 for twenty-four hours. And they've all done well. 21 But whether that is truly -- 22 DR. KANTER: Well, it -- it goes 23 beyond this -- 24 DR. VAN DER JAGT: -- it's purely

Page 218 1 EMSC, 9-29-2009 2 are basically shock patients -- 3 DR. VAN DER JAGT: Correct. 4 MS. CHIUMENTO: -- you've got to 5 keep them warm. 6 DR. VAN DER JAGT: So, they keep 7 them warm. 8 MS. CHIUMENTO: And so, turn up 9 the ambulance -- 10 DR. VAN DER JAGT: Right. 11 MS. CHIUMENTO: -- heat as high 12 as you can. If you weren't sweating, it wasn't hot 13 enough. 14 DR. VAN DER JAGT: That is our -- 15 MS. CHIUMENTO: So -- so, a lot 16 of that has to be -- 17 DR. VAN DER JAGT: So, that's the 18 concern. 19 MS. CHIUMENTO: -- relearned, 20 and -- 21 DR. VAN DER JAGT: Right. 22 MS. CHIUMENTO: -- and retaught. 23 DR. VAN DER JAGT: Right. And 24 there are actually -- there -- there are the Heart

Page 219 1 EMSC, 9-29-2009 2 Association/ILCOR guidelines are very much specific 3 about the avoiding the hyperthermia part. They're 4 much less, you know, if -- if -- you could use 5 cold, but you just don't have the study that it's 6 been determined. 7 DR. KANTER: But of course, in 8 the -- in caring for a critically sick child or 9 infant, you're trying to avoid cold stress 10 unnecessarily as well as avoiding hyperthermia. 11 It's a little tough for the ambulance to get 12 everything perfect. 13 MR. WRONSKI: That's right. 14 DR. VAN DER JAGT: We're talking, 15 of course, mostly about the select group that is 16 arrested patients, not the other patients. 17 MS. CHIUMENTO: Right. Only 18 arrest patients. 19 DR. VAN DER JAGT: There will be 20 more data that comes out, of course, in the 21 January -- the 2010 American Heart 22 Association/ILCOR guidelines, resuscitation 23 guidelines that come out, the newest ones, January 24 2010. So, there'll be more data on that.

Page 222 1 EMSC, 9-29-2009 2 MR. WRONSKI: And -- and there's 3 an issue - and it will be an issue - of the 4 community hospitals who will protest vigorously if 5 we bypass their E.D.s and they are certified as a 6 outstanding E.D. You know, who -- who are we to 7 bypass them and say that they're not capable of 8 doing something? 9 So, it -- it may be a 10 recommendation, but yet it's signed off by the 11 commissioner, and there's going to have to be some 12 real information to say, okay, where is this, in 13 fact, true; where does this happen? 14 DR. VAN DER JAGT: Maybe I can -- 15 I -- I -- in Rochester --. 16 MR. WRONSKI: Well, you don't 17 have to name anybody. 18 DR. VAN DER JAGT: No, no, no, 19 no, no, no. I -- I mean in Rochester we have 20 struggled with this for about 30 years. 21 MR. WRONSKI: Yeah. 22 FROM THE FLOOR: Sure, only 23 thirty years. 24 DR. VAN DER JAGT: You know, and

Page 223 1 EMSC, 9-29-2009 2 we currently have a very good large community 3 hospital, excellent E.D., in fact, one of the 4 busiest in the state; however, they do not have a 5 pediatric trauma surgeon. They don't have the 6 resources necessary there. And -- and they are 7 literally within fifteen minutes of the main 8 medical center. So, that's where that's come up. 9 So, do you send the kid there versus going to the 10 medical center with all the delays that might occur 11 at that. So, I think it is a legitimate question 12 to ask. 13 MR. WRONSKI: Well, I'm -- I'm 14 not saying it's not legitimate question. 15 DR. VAN DER JAGT: And it's 16 something we probably just need to struggle with, 17 you know, how to do that. 18 MR. WRONSKI: Yeah. 19 MS. CHIUMENTO: And then there's 20 one last thing and that is the last state A.L.S. 21 standards were written in 1993. So, they are very 22 much outdated. Every time we've tried to do a new, 23 protocol, standard, whatever you want to call it, 24 we -- we get lots of -- it gets shot down by all

Page 226 1 EMSC, 9-29-2009 2 MS. CHIUMENTO: They -- we did 3 not vote on -- we didn't have a quorum, and so we 4 did not vote on the individual protocols. 5 This would not be something that 6 would go to -- to the each region, and that region 7 would have to live by that document. This would be 8 a -- basically a template of what is acceptable by 9 New York State --. 10 MS. BURNS: A baseline. 11 MS. CHIUMENTO: -- standards. 12 MS. BURNS: A baseline standard. 13 DR. HALPERT: Okay. 14 MS. CHIUMENTO: A baseline. So, 15 that if you wanted to something that wasn't on 16 there, you would bring that back to SEMAC to get it 17 added to the list. But I tried to make sure that 18 all -- 19 DR. HALPERT: Okay. 20 MS. CHIUMENTO: -- regional 21 protocols are covered in there, as -- as on -- on 22 their Web sites currently. 23 MS. BURNS: Another -- another 24 piece to this is that by developing this minimum

Page 227 1 EMSC, 9-29-2009 2 standard for A.L.S., the regions would then have 3 an -- you know, have -- it would be a lot -- a lot 4 less work making a change -- 5 MS. CHIUMENTO: Uh-huh. 6 MS. BURNS: -- you know, to some 7 of the stuff that everybody is doing statewide. 8 A.C.L.S. algorithms, for example. 9 MS. CHIUMENTO: Right. 10 MS. BURNS: So, it would be -- it 11 would, in -- in concept, make it easier for the 12 regions, while at the same time allowing them to 13 their -- their regional preferences. And as you 14 know there are many. 15 MS. CHIUMENTO: Uh-huh. 16 MS. BRILLHART: Sharon, that's an 17 amazing amount of work and an awesome project, but 18 what happened to being retired? 19 MS. BURNS: I ask her that every 20 time I see her. If you get an answer, give me a 21 call. 22 MS. CHIUMENTO: I -- as I said, 23 as I tell people, I retired from that one job, I 24 didn't retire from E.M.S. or life. So --.

Page 230 1 EMSC, 9-29-2009 2 respect to the STAC, I think the two major 3 pediatric issues were, in fact, the -- the 4 Pediatric Trauma Regs, which we've also discussed; 5 the pediatric center issue, which we've already 6 discussed; and the bypass issue, which Sharon just 7 reminded us all of. 8 And I don't -- and Mike, I don't 9 recall any other major pediatric issues that arose. 10 MR. TAYLER: No, that needs --. 11 DR. COOPER: And a long 12 discussion about the regs, and as I've already 13 indicated, you know, the key discussion point there 14 had to do with the resident coverage levels, the 15 neurological coverage, and whether there should be 16 level-three trauma centers or not. And I think 17 that it's fair to say that the group voted in favor 18 of common sense for the first two, and does agree 19 that having a level three at least makes conceptual 20 sense and gave the Executive Committee its 21 instructions to go back, and you know, come up with 22 something that we could think about. 23 Mike, anything more from the STAC 24 of any great note?

Page 231 1 EMSC, 9-29-2009 2 MR. TAYLER: Hold on. 3 Nope, that's it, Dr. Cooper. 4 that's all. 5 DR. COOPER: Okay. All right. 6 We now get to new business. I want once again to 7 call to your attention the document that you have 8 in your folder regarding the disaster conference 9 that's going to take place at Westchester Medical 10 Center Maria Frainie Children's Hospital on October 11 28th. 12 This is really, if you will, a 13 national, maybe even international, level 14 conference in terms of the -- in terms of the 15 quality and the breadth of the -- you know, of the 16 experience. It's probably the least expensive 17 C.M.E. one could possibly ever obtain, and I urge 18 as many as possible of you to try to come, and 19 publicize it as much as you can within your various 20 regions. It's going to be a terrific conference. 21 Two questions arose of which I am 22 aware that probably should at least be mentioned on 23 the record, although we may not have answers for 24 them. In the process of thinking through some of

Page 234 1 EMSC, 9-29-2009 2 difficulties with running a state-sponsored team. 3 Logistically assuring that you'll have access to 4 the manpower, and for instance, right now the state 5 team that we send across the country and within the 6 state to help manage disasters, is made up almost 7 solely, I believe solely, of state employees who 8 have specific experience and capabilities, and 9 they're cross-agency. We pull them from different 10 agencies. I have three people across the state who 11 are a member of the team, O.F.C. has members, SEMO 12 has members, D.O.T., et cetera, et cetera. 13 So, how the state might do a 14 pediatric team is a good question. I don't know 15 that it has had the capability and staffing to do 16 that itself. It might be a different hybrid model 17 to reach out to outside folks. But again, you 18 know, I don't know details right now, and we'll try 19 to find out. 20 DR. COOPER: Okay. Thank you. 21 Anybody else want to talk about 22 that or no? 23 MR. KANTER: Just a related 24 thing. This -- on Sunday, there was a front page

Page 235 1 EMSC, 9-29-2009 2 story in the Syracuse Newspaper. The title had 3 something to do with who will get the ventilators 4 in a pandemic, and addresses -- 5 MS. CHIUMENTO: First come, first 6 served. 7 DR. KANTER: Huh? 8 MS. CHIUMENTO: First come, first 9 served. 10 MR. KANTER: Well, it addresses 11 the discussion up to the point of the New York 12 State Task Force on Life and the Law publication. 13 I wonder is there any -- has there been any 14 discussion at the state level that's appropriate to 15 talk about yet, going beyond that statement of 16 principles? What are we really going to do this 17 winter, if we were faced with having to make those 18 kinds of decisions? 19 MR. WRONSKI: Good -- that's a 20 good question. It's probably going to be in-time 21 decisions, you know, as it's happening. 22 The Committee on Life and the Law 23 met and provided some guidance for what they 24 thought, you know, should be considered. But I

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2 there just is not any legal basis, administrative
3 process, and the other thing that we all should
4 read is a very good article in the New York Times
5 magazine a few weeks ago about the disaster in New
6 Orleans, about how badly things can go when there
7 hasn't really been good preparation of
8 physicians --
9 DR. COOPER: Right.
10 MR. KANTER: -- for triage
11 principals and decisions about how to handle a
12 crisis.
13 DR. COOPER: Right. Right.
14 MR. KANTER: Physicians with the
15 very best of intentions will, based on
16 misunderstanding and misinformation, will make bad
17 decisions at times.
18 DR. COOPER: Right.
19 MR. KANTER: I think we all have
20 a lot of work to do, and frankly, I think most of
21 these -- these -- the guidance for this isn't going
22 to come -- can't come from individual physicians.
23 It's got to come from higher-level policymakers.
24 DR. COOPER: Bob, I actually have

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2 and I'll forward -- I'll forward mine to you.
3 And Martha, why don't I forward
4 the e-mail just to you, so you have it and you can
5 get it to everybody.
6 MR. WRONSKI: That's good news.
7 DR. COOPER: Yeah.
8 MR. WRONSKI: Okay. Just -- just
9 to follow on that, the State Disaster Preparedness
10 Committee that's made up of SEMAC and the STAC, and
11 Dr. Coopers sits on that also, made recommendations
12 as long as two years ago, and one of their
13 recommendations was just what you said, they asked
14 for more definitive guidance on the area of triage,
15 and on changes of practice during a disaster. And
16 they wanted some real guidance from the Department
17 as to what's -- what should you do, and what's
18 allowable. And so, it's been heard. There's been
19 some guidance, but I agree with you, there's not
20 enough. And I -- and I think it's a tough issue,
21 to figure out exactly what to say in advance.
22 DR. COOPER: I might just say that
23 the issue specifically of triage, Ed, was discussed
24 at some length at the City Disaster Conference --

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2 some incredibly late-breaking news on this issue.
3 Late-breaking as early as checking my e-mail at the
4 lunch hour.
5 I -- you will probably find the
6 same announcement on your e-mail when you get home.
7 But the Task Force on Life and the Law is convening
8 a special high-level pediatric blue ribbon group
9 which is going to meet some time this fall, so they
10 say, to a one meeting thing with a lot of time for
11 commentary and so on, at least to begin to get
12 some, you know, some community wisdom behind
13 decisions that need to be made, and I think that
14 you, personally, can take a tremendous amount of
15 credit for, you know, leading that charge, and --
16 and getting that letter together from the pediatric
17 critical care community in New York State built
18 largely upon the article that, you know, you wrote
19 on rationing of care in pediatric disasters. So,
20 you know, I think you're pushing has made a
21 difference, and they've -- they have -- they have
22 heard you.
23 So, if you don't get that e-mail,
24 if it's not on your e-mail, please drop me a note

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2 City Disasters and Children -- Children and
3 Disaster Conference that was held on September
4 15th.
5 All the presentations from that
6 conference are posted on a Web site that all of you
7 can review and download. And I will also get that
8 link -- that link to Martha.
9 We did our -- our pediatric
10 disaster coalition in the city did propose a
11 modification of START. Not jumpSTART, but a
12 modification of START for -- for use in pediatric
13 patients.
14 Why not jumpSTART? Why not
15 something else? Honestly, the fire department felt
16 that it had a massive, massive, massive retraining
17 issue, if -- if we deviated a whole lot from START.
18 And absent any -- any clear and compelling
19 scientific evidence that another disaster system
20 was better than -- than START, that they did not
21 feel that they could make the investment in -- in
22 retraining.
23 They did feel that they could
24 make some -- some minor chances around edges of

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2 start with respect to kids, which basically include
3 ensuring that no child is black-tagged unless he or
4 she receives five rescue breaths somewhere along
5 the -- along the line, which is consistent with
6 jumpSTART. And also including in effect
7 up-triaging of all infants to a red category
8 because of the inability of, you know,
9 marginally-trained prehospital providers to
10 identify, you know, sick kids.
11 There's also going to be included
12 in the city disaster scheme, per the fire
13 department, an orange or urgent triage category,
14 which, in effect, identifies patients who are sort
15 of -- if you will, not as red as some other reds.
16 And you know, if you want to think of it this way,
17 patients with respiratory distress instead of
18 respiratory failure. That kind of -- that kind
19 of -- that kind of thing. But that these patients
20 will be identified primarily through a -- through
21 a -- through a secondary triage process. That the
22 reds will be culled out first from the yellows and
23 the greens, and then yellows and greens will be
24 looked at to see if anybody is really sicker, you

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2 DR. KANTER: The -- the other
3 message to the -- the State Department of Health is
4 thank goodness New York City is making all this
5 progress, but it -- it just raises the unfortunate
6 circumstance that New York City may have one color
7 coding system and Buffalo may have a different, and
8 until we have guidance from a more central level,
9 we're going to have fragments that are incompatible
10 with each other.
11 MR. WRONSKI: Well, one of the
12 problems -- and it's a historic one, but it's --
13 also underlined and supported, cemented by the feds
14 is that New York City is different, will be
15 different, it's paid differently, and functions
16 differently. And they do have their own set of
17 rules regarding disasters. It's supported by the
18 federal government, and all the money that turns to
19 the state is meant for everybody outside of New
20 York State (sic) and all the rules and the -- and
21 the guidance, all right, are -- are initially
22 were -- were two different camps. And slowly
23 they've learned to try to share that information.
24 I have been invited a number of

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2 know, that was initially thought. So, it's -- it's
3 still a bit of a work in progress, but that's the
4 direction that the city is taking.
5 DR. KANTER: The -- you know, for
6 a pandemic, most -- I believe most of triage
7 decisions will not be made in the prehospital
8 setting.
9 DR. COOPER: Absolutely correct.
10 DR. KANTER: They'll be made in
11 the E.R. or some other hospital area.
12 DR. COOPER: Absolutely correct.
13 And -- and that's -- that's why -- that's why loud
14 and -- loud and clear the Pediatric Disaster
15 Coalition in the City has really been focusing on
16 the public health answering point issue.
17 And we've gotten some traction on
18 that as I indicated and it's basically following
19 the SERV (phonetic spelling) methodology that Skip
20 Burke has advocated, and you know, and moving
21 precisely in the direction that you -- that you
22 recommend. Most triage will not be E.M.S. based
23 triage for -- for pan flu or other, you know, acute
24 febrile respiratory ailments.

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2 times to Downstate to sit in on New York City
3 meetings, although I get most of my inside
4 information, such as the triage, from a couple of
5 physicians I've known for seventeen years and
6 they'll talk to me privately. They'll say "here's
7 what's happening."
8 The -- but that doesn't
9 necessarily happen in a formal way between the City
10 and the State. It -- it -- it does happen, there
11 are bridges, but there are differences. And
12 sometimes the differences are related to the fact
13 that they're a very tight, geographically tight,
14 city with many millions of people sitting in it.
15 And so, some ways of functioning, at least with
16 large numbers of people, be driven by that
17 particular demographic, but most not.
18 And we -- we try to model each
19 other. The triage came out by the city. It's not
20 necessarily something that we're going to do in the
21 rest of the state, but there won't be a Buffalo
22 model. There won't be a Rochester. There won't be
23 a, you know, Upstate model, and there'll be a New
24 York City model.

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2 DR. KANTER: Ultimately, we all
3 have to answer the question when we're overwhelmed
4 in a protracted way, what should we try to
5 guarantee --
6 MR. WRONSKI: Right.
7 DR. KANTER: -- what ate we
8 permitted to forgo or delay, and I don't think we
9 have any guidance about that right now.
10 MR. WRONSKI: It's not enough.
11 DR. COOPER: We do not.
12 MR. WRONSKI: There is -- there
13 is -- there is some out there, but there is --
14 there clearly is not enough. I agree with you.
15 DR. VAN DER JAGT: And how to
16 approach families about that. Because that's going
17 to be a big issue for the -- the United States.
18 DR. HALPERT: The problem with
19 the two systems is it really isn't so much Buffalo
20 versus New York City, it's Yonkers versus New York
21 City. Because you're going to draw your resources
22 in that situation from those around you.
23 MR. WRONSKI: Right.
24 DR. HALPERT: And if they're not

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2 take the pulse and that sort of thing, which you
3 may not have time to do, you know, in a -- in a --
4 in a true crushing situation. So, that's -- that's
5 kind of the thought process that -- that went on.
6 Trying to keep it as simple as possible, and you
7 know, while retaining what all of us felt pretty
8 strongly were the absolute essentials in terms of,
9 you know, making sure that kids have, you know,
10 the -- the -- the kids who -- who were, you know,
11 apparently unresponsive did have at least one shot
12 at -- you know, at making it before they were
13 declared expectant.
14 So, anyway, more to come. It's a
15 work in progress. And I think everyone recognizes
16 and even at -- even at the New York City REMAC,
17 exactly these same discussions were held, there's a
18 lot of pushback even from folks in the city who are
19 not based within the -- you know, the city
20 government, about the inclusion of a -- of a -- of
21 an orange triage category that no one else in the
22 nation has.
23 But this has been championed
24 internally in the fire department, and you know, so

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2 talking the same language, then you have a problem
3 essentially.
4 MR. WRONSKI: Yeah.
5 DR. COOPER: Yeah. This, again,
6 I -- I do -- I do commend my colleagues I the fire
7 department for recognizing all the issues that
8 we've raised, and therefore, trying, as closely as
9 possible, to stick to the, you know, the START
10 model. At the same time, we all know that the
11 START model, you know, is not necessarily, you
12 know, ideal for children.
13 Of course, I set aside the issue
14 that there is data to suggest that, you know, it
15 just doesn't work, but that's another -- that's
16 another -- another matter entirely.
17 But they have tried, I think, to
18 stick as close as possible to the -- to the
19 national model, but recognizing that there are
20 special considerations with respect to children.
21 And the -- for many, many reasons, the -- the --
22 the jumpSTART model is perhaps a little bit more,
23 you know, applicable to smaller scale disasters
24 where you actually have time to sort of, you know,

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2 far the medical leadership in the fire department
3 has been able to convince their commissioner and --
4 and the mayor that this is -- that this is the
5 right way to go, and it's happening.
6 We'll see. Time will tell.
7 That's what's happening at the present time.
8 MS. MOLLOY: This is Rita. I'm
9 going to sign off now.
10 DR. COOPER: Okay, Rita. Thank
11 you for -- for being with us.
12 MS. MOLLOY: Thanks, and good
13 rest of the meeting.
14 DR. COOPER: Yeah, we're almost
15 done.
16 MS. MOLLOY: Okay. Bye-bye.
17 DR. COOPER: Thank you, take
18 care.
19 Elise, I know you had one issue
20 that you raised by e-mail in the --
21 DR. VAN DER JAGT: Yes.
22 DR. COOPER: -- in the -- in the
23 week or two prior to the meeting.
24 DR. VAN DER JAGT: Right. The --

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2 the -- we've had --
3 DR. COOPER: Uh-huh.
4 MS. GOHLKE: Hold on.
5 DR. COOPER: No? You got it?
6 DR. VAN DER JAGT: We've had
7 experiences in Rochester where kids are coming into
8 the emergency department with respiratory failure,
9 for one reason or another, and are intubated with
10 the sort of standard approach, of you know uncuffed
11 tubes, E.T. tubes under age eight or so. And then,
12 we find out when we get to the I.C.U. that the --
13 they really need a cuffed tube. Which means --
14 then necessitates a -- a reintubation.
15 So, that's been -- internally,
16 we're doing some dialoguing about that between the
17 E.D. and the PICU, but as I was thinking through
18 that, you know we have kids also that are intubated
19 in the field, and it becomes sort of the same
20 issue. And so, that made me think, well, gee,
21 knowing now that we are able certainly to use
22 uncuffed tubes in the younger-age population,
23 should we say something about this, these potential
24 kinds of issues, as an advisory about that, so that

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2 get a fair number of irreversible subglottic
3 injuries from excessively tight cuff inflation.
4 There's no question that can be used very
5 effectively in I.C.U.s and by good
6 anesthesiologists. We are using --
7 DR. VAN DER JAGT: No.
8 DR. COOPER: -- it routinely down
9 to the newborn in selective situations. But I --
10 people in the prehospital setting, and people in
11 E.R.s that are seldom doing it in children will
12 just have automatically inflate the cuff. We're
13 going to get a lot of subglottic injuries in that
14 environment.
15 DR. VAN DER JAGT: I -- I don't
16 know -- I don't know about the -- obviously the
17 experience in the E.M.S. world, because we haven't
18 been doing this. There's no data out there, I
19 think. Certainly, the data in hospital is there
20 are uncuffed versus cuffed tubes. You could use
21 both of those, even down to a very young age --
22 DR. COOPER: Yes.
23 DR. VAN DER JAGT: -- without
24 having to what used to be thought was the worry

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2 to avoid yet another intubation in a kid who might
3 be high risk.
4 DR. COOPER: What percent of your
5 patients that you admit need reintubation for
6 either a tighter or a cuffed tube?
7 DR. VAN DER JAGT: Well, it -- it
8 all comes in spurts, you know, to be honest. You
9 know, I think in the last month we've had three or
10 four.
11 DR. COOPER: Five percent? Ten
12 percent?
13 DR. VAN DER JAGT: Well --
14 DR. COOPER: Thirty percent?
15 DR. VAN DER JAGT: -- I --
16 it's -- I don't know. I can't answer that.
17 DR. COOPER: The problem -- I --
18 I, you know, obviously, we all face this. I think
19 it's about five percent. And the concern is if you
20 have inexperienced people -- people who have little
21 experience using cuffs in infants or young
22 children --
23 DR. VAN DER JAGT: Uh-huh.
24 DR. COOPER: -- you're going to

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2 about subglottic, you know, stenosis and all this
3 with cuffed tubes. That's not the case anymore.
4 DR. COOPER: Well, you -- you --
5 DR. VAN DER JAGT: And so I
6 think --
7 DR. COOPER: -- you avoid that
8 danger or you avoid those complications by
9 meticulous, compulsive, constant tension to the
10 inflation of the cuff.
11 DR. VAN DER JAGT: Correct. But
12 the -- I think that one of the issues here,
13 however, is even if the tube is put in place
14 without the cuff inflated, you know, then you've
15 got the tube there if you need it. If you've got
16 the cuff there, but if it's not inflated, and
17 there are certainly younger kids especially if you
18 make, you need, you know, if you put an uncuffed
19 tube in, it's a leaky tube. If you put a cuffed
20 tube in with the cuff deflated, there is still
21 enough resistance around it that you're not going
22 to get up having it. So, that was the question.
23 I mean -- so the issue of whether
24 you inflate a cuff on a cuff -- on a -- on a cuffed

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2 tube in the field, versus just putting one in so
3 that you -- so that -- to avoid yet another
4 intubation, which is a -- which is a -- which is
5 considered can be high risk for a kid. So --
6 DR. COOPER: My -- my concern is
7 about --
8 DR. VAN DER JAGT: So, I'm not --
9 I'm not asking to do this.
10 DR. COOPER: Yes.
11 DR. VAN DER JAGT: I'm just
12 asking it as a point of discussion. I'm not sure
13 which way to go on it. But there are those --
14 DR. HALPERT: I think it's a good
15 point --
16 DR. VAN DER JAGT: -- situations
17 that --
18 DR. HALPERT: -- but it's just
19 the sense that I get from the SEMAC over the past
20 three, four years. Their action has been to move
21 intubation away from the pediatric arena -- arena
22 in general, because of a variety of --
23 DR. VAN DER JAGT: Absolutely.
24 DR. HALPERT: -- complicating

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2 issues.
3 DR. VAN DER JAGT: Absolutely.
4 MS. CHIUMENTO: I thought we
5 weren't intubating --
6 DR. COOPER: Right. My -- my
7 own -- my own concerns --
8 FROM THE FLOOR: Adults too.
9 FROM THE FLOOR: Yeah. Well --
10 DR. COOPER: My own concerns are
11 that, you know, the data does not support, you
12 know, the use of -- of endotracheal tubes in the
13 prehospital environment at least in, you know,
14 places where most paramedics are, which is rapid
15 transport urban systems.
16 DR. VAN DER JAGT: In cities.
17 DR. COOPER: Right. Rapid
18 transport urban systems; right.
19 But at the other concern that I
20 have from the trauma perspective, you know, is
21 that, you know, the -- the kids often have a lot of
22 secretions. It's not that they don't in
23 nontraumatic issues as well, you know, they often
24 have a lot of stuff in their mouths. They often,

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2 because that's what has -- it -- precisely we have
3 expert people in the emergency department, and yet
4 you know, the kid comes up and we have to replace
5 the tube. And so, I'm not so sure --
6 MS. CHIUMENTO: Well, if they
7 can't make those decisions in the E.D. I don't
8 know who you're going to expect E.M.S. people to
9 make that kind of a decision.
10 DR. VAN DER JAGT: I'm not saying
11 they should make.
12 MS. CHIUMENTO: Yeah.
13 DR. VAN DER JAGT: I'm just
14 saying should they do so put a tube in that you can
15 inflate the cuff or not, you know, do you have it.
16 That's all. I'm just asking a question. I'm bring
17 it up only because we have seen it certainly in our
18 institution.
19 DR. COOPER: Well, it's certainly
20 a worthy discussion. I mean absolutely.
21 DR. VAN DER JAGT: And -- it's,
22 you know, it -- and people feel so strongly that
23 this is just not a discussable point, we should
24 move on, because I don't think it really is --

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2 DR. COOPER: Well, the -- no, no,
3 I --
4 DR. KANTER: You know, the -- the
5 American --
6 DR. VAN DER JAGT: -- is an
7 issue. But I -- I am concerned because a lot of
8 those kids are high risk, you know. And changing a
9 tube is not something you just, "oh, I'll just
10 change a tube."
11 DR. KANTER: The American Heart
12 Association has already taken a clear position that
13 a cuffed tube is an option down to the smallest --
14 DR. VAN DER JAGT: Precisely.
15 It's not better, but it's an option.
16 DR. KANTER: It's an option.
17 DR. VAN DER JAGT: Equal -- equal
18 to an option --
19 DR. KANTER: Well -- well, I
20 agree with that. And I don't think we have enough
21 data to go far beyond that.
22 DR. COOPER: It does, as I
23 recall -- I mean I could be wrong. But as I
24 recall, it does -- it does suggest that, you know,

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2 MS. CHIUMENTO: Right now.
3 DR. VAN DER JAGT: I will -- I
4 will bring it up as the --
5 MS. CHIUMENTO: Whether or not
6 the change is mentioned -- no, no. I think --
7 we -- I think you should bring it up at the
8 national level.
9 DR. VAN DER JAGT: Well, I'm
10 not --
11 DR. COOPER: Yeah. Yeah.
12 DR. VAN DER JAGT: That's what I
13 was going to say.
14 MS. CHIUMENTO: Right. I -- I
15 really think that --
16 DR. VAN DER JAGT: I will if I
17 have a -- we had a meeting coming up.
18 MS. CHIUMENTO: -- as of next
19 year we're going to have the rollouts. Because
20 next year we're going to have a big rollout. So,
21 if -- if that's the direction that they -- that
22 they decide to go --
23 DR. VAN DER JAGT: Exactly.
24 Exactly.

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2 MS. CHIUMENTO: -- I think that's
3 a wonderful opportunity.
4 DR. VAN DER JAGT: It may be too
5 late to do that already, but I don't know.
6 MS. CHIUMENTO: So right now I
7 wouldn't I -- I wouldn't do it right now.
8 DR. VAN DER JAGT: Well, you
9 know.
10 DR. KANTER: Having brought up
11 the issue though, I'd like to just relate it back
12 to the previous --
13 DR. VAN DER JAGT: Yeah.
14 DR. KANTER: -- discussion.
15 If your hospital is planning to
16 take care of much larger numbers of infants than
17 normal in a surge situation, I'd suggest the three
18 o cuffed tube could be used to handle almost any
19 size infant in a disaster situation.
20 DR. VAN DER JAGT: Yeah. That's
21 a --
22 DR. COOPER: That is true.
23 DR. VAN DER JAGT: That's a good
24 point actually.

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2 which have never been in the E.M.T. curriculum
3 before.
4 There's a whole big emphasis on
5 patients with special needs, which we have not had
6 before.
7 And some of the individual
8 modules, the airway module, much information on
9 treatment of airway obstructions and rescue
10 breathing in -- in the infant and child, and the
11 communications. There's a whole section on dealing
12 with special communications, including
13 communications medical control with each other,
14 with documentation, things like that, on pediatric
15 patients. And in the documentation, one of the
16 things that they also expanded is documentation of
17 youth situations.
18 In the respiratory emergencies,
19 they've added Pertussis the acute respiratory
20 diseases, they've increased the emphasis on asthma
21 and included cystic fibrosis now in the chronic
22 respiratory diseases, and they've also added
23 age-related differences in respiratory disease.
24 Cardiovascular, they've added

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2 age-related cardiovascular issues, including at the
3 upper levels, much more discussions of congenital
4 heart defects. Endocrine, age-related issues
5 related to diabetes. Neurology, they're including
6 a much expanded role of seizures, different types
7 of seizures, and how that affects patients, as well
8 as age-specific issues related to mental health
9 changes.
10 In toxicology, they've removed
11 Ipecac finally.
12 DR. VAN DER JAGT: Good.
13 MS. CHIUMENTO: And they've now
14 added a section on nerve agent poisoning. So --
15 particularly the Mark I kits and our use of
16 atropine, which has not been there before. This is
17 at the E.M.T. level. And it's been a -- been at
18 the paramedical level. But we've not seen it at
19 the E.M.T. level.
20 There's age-related differences
21 in G.I. illness. There is a hematology area now,
22 which includes sickle cell crises, sickle cell
23 disease and hemophilia.
24 In trauma, there's an increased

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2 moved in a great direction here, and --
3 MR. WRONSKI: Yeah. I --
4 there's so much that you went over --
5 MS. CHIUMENTO: Uh-huh.
6 MR. WRONSKI: -- it might be
7 useful at some point that the Committee actually --
8 you would share with the Committee, you know, a
9 list of these things, just so we understand it.
10 MS. CHIUMENTO: Oh, actually, I
11 have a whole PowerPoint and a whole thing. So, I
12 can bring that at another time. I just figured
13 because of the lateness --
14 MR. WRONSKI: Yeah.
15 MS. CHIUMENTO: -- and because
16 you were probably --
17 MR. WRONSKI: Yeah. It's late in
18 the day and -- and this is going to be hard to
19 assimilate this so much --
20 MS. CHIUMENTO: Uh-huh. Uh-huh.
21 MR. WRONSKI: -- so I think it
22 deserves another time when we concentrate a little
23 bit on it, and -- of course, although the
24 curriculum contains this, the reality is that the

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1 EMSC, 9-29-2009
2 early in the process, but as I did not participate
3 in the final versions, I -- I -- all I can say is,
4 gasp, I'm not -- I'm not sure that -- that precise
5 knowledge about somebody's conditions necessarily,
6 you know, assists an -- an E.M.T. in recognizing
7 the difference between respiratory distress and
8 failure. And you know, when to give supplemental
9 oxygen and when to bag a patient, you know, which,
10 you know, is probably the most crucial decision
11 that they -- they will be called upon to make,
12 but -- but you know, clearly the -- the fed has
13 gotten the message that children are not little
14 adults, which is a good thing.
15 MR. WRONSKI: Uh-huh.
16 MS. CHIUMENTO: And it does say
17 simple level knowledge. It's interesting because
18 each level -- one will be simple, one will be
19 complex, one will be expanded, you know, so they
20 just -- it increases at each level. But it's at
21 the -- at the E.M.T. levels.
22 DR. COOPER: I suppose that would
23 mean spelling it sort of correctly, right? I --
24 MS. CHIUMENTO: Oh, no.

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2 state curriculum has to be written to address it,
3 and the new thinking is that the publishers are
4 going to provide all the materials for this.
5 And -- and so, I think it's good
6 that we take a peak, and -- and be sure that while
7 they may mention this needs to be in the
8 curriculum, they're not actually giving all the
9 tools like they did in the old days on how to teach
10 it. So, it's going to be up to the state, and it's
11 going to be up to the publishers to do that. And
12 you know, we might want to peek at that now and
13 then.
14 DR. COOPER: Well, it's good to
15 see that our emergency medical technicians will now
16 be completing full pediatric residencies before --
17 MR. WRONSKI: Yeah.
18 DR. COOPER: -- before being
19 allowed into the back of an ambulance.
20 MS. CHIUMENTO: I think you've
21 got to realize all these things will be covered --
22 we'll allow it.
23 DR. COOPER: I -- I -- I did have
24 an opportunity to participate in this process,

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1 EMSC, 9-29-2009
2 Pertussis is simply a cough, the kids cough a lot.
3 DR. COOPER: I don't see what --
4 I haven't seen a case of pertussis in shall we say
5 my life.
6 MS. CHIUMENTO: You -- somebody
7 was saying -- didn't you say -- John, didn't you
8 say that you've experienced pertussis?
9 DR. COOPER: Personally, no. I
10 have not.
11 DR. VAN DER JAGT: Oh, that's --
12 that's awful.
13 MS. CHIUMENTO: Somebody --
14 somebody was just recently telling me --
15 DR. VAN DER JAGT: Susan.
16 MS. CHIUMENTO: -- that they --
17 DR. VAN DER JAGT: Susan.
18 MS. CHIUMENTO: Susan, was it
19 you?
20 MR. KANTER: To die.
21 MS. BRILLHART: Yeah. What?
22 MS. CHIUMENTO: That you've seen
23 pertussis?
24 MS. BRILLHART: Yeah. Well, I

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1 EMSC, 9-29-2009
2 said Elmhurst this past Saturday had a -- a
3 pertussis kid and an R.S.V. kid both turning blue
4 in the PICU and the pertussis kid had to be
5 reintubated. Babies.
6 DR. COOPER: Wow.
7 MS. BRILLHART: So, it's --
8 pertussis and R.S.V. is already out there, so the
9 flu is coming.
10 MR. WRONSKI: Pertussis has
11 always --
12 DR. COOPER: Okay. I have not
13 personally seen a case of pertussis.
14 MR. WRONSKI: -- here.
15 DR. COOPER: All right. Is there
16 another new business, guys and gals?
17 Okay. Well, Martha, insisted
18 that we stop by four o'clock, and we're right about
19 there.
20 MS. CHIUMENTO: We're right
21 there. We're right there.
22 DR. COOPER: We next meet on
23 December --
24 MS. GOHLKE: 9th, I believe, let

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1 EMSC, 9-29-2009
2 I, Howard P. Hubbard, do hereby certify that the
3 foregoing was taken by me, in the cause, at the time
4 and place, as stated in the caption hereto, at Page 1
5 hereof; that the foregoing typewritten transcription,
6 consisting of pages number 1 to 275, inclusive, is a
7 true record prepared by me and completed by
8 Associated Reporters Int'l., Inc. from materials
9 provided by me.
10
11
12 Howard P. Hubbard, Reporter
13 Date
14
15 rhp/h/jmg/plim

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1 EMSC, 9-29-2009
2 me double check.
3 DR. COOPER: -- 9th, we believe.
4 MS. GOHLKE: Still under the 9th?
5 FROM THE FLOOR: 8th. December
6 8th.
7 MS. GOHLKE: You're right it's
8 the 8th.
9 DR. COOPER: December 8th.
10 MS. GOHLKE: Tuesday the 8th.
11 DR. COOPER: Tuesday, December
12 8th, right here in this very room. And of course,
13 we're hoping Mr. Wronski to join us for one final
14 appearance, but you now, we're -- we won't hold our
15 breaths. But we might -- we might prod a little
16 bit, we'll see.
17 Thank you all for coming.
18 MR. WRONSKI: Thank you.
19 (The meeting adjourned at 4:05
20 p.m.)
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22
23
24

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