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STATE OF NEW YORK  
STATE EMERGENCY MEDICAL SERVICES  
FOR CHILDREN  
Advisory Committee Meeting

DATE: December 8, 2009

TIME: 11:36 a.m. to 4:02 p.m.

LOCATION: Crowne Plaza  
State & Lodge Streets  
Albany, New York 12207

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2 APPEARANCES:

3 Arthur Cooper, M.D., M.S., Cochair

Kathleen Lillis, M.D., Cochair

4 Sharon Chiumento, B.S.N., E.M.T.-P

Ann Fitton, E.M.T.-P.

5 Jonathan S. Halpert, M.D., FACEP, R.E.M.T.-P.

Robert Kanter, M.D.

6 Rita Molloy, RN

Janice Rogers, M.S., RN, C.S., C.P.N.P.

7 Elise van der Jagt, M.D., M.P.H.

Ruth Walden

8 Lee Burns

Martha Gohlke

9 Lisa McMurdo

Jennifer Treacy, R.Ph.

10 Mike Tayler

11 GUESTS:

12 Sarah Macinski Sperry

Christopher Kus, M.D.

13 Wendy Weller, Ph.D.

Tim Czapranski, E.M.T.-P.

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2 (The meeting commenced at 11:36

3 a.m.)

4 DR. COOPER: Okay. I'd like to  
5 call the meeting of the State Emergency Medical  
6 Services for Children Advisory Committee to order.  
7 It's December 8, 2009, and we're delighted to have  
8 with us today some very special guests.

9 We have, of course, Lisa McMurdo  
10 and Jennifer Treacy, director and associate  
11 director of the Division of Quality Assurance and  
12 Patient Safety with the Department. They are the  
13 folks who are in charge of the division in which  
14 the Bureau of E.M.S. currently resides. And, of  
15 course, that is where we reside.

16 And in addition to that, we have  
17 Dr. Chris Kus, who is associate medical director  
18 for the Division of Family Health. Chris has about  
19 an hour with us, I believe, today to share with us  
20 quite a bit of information, which he will be doing  
21 momentarily.

22 One final note, of course, is  
23 that Dr. Wendy Weller and Sarah Sperry, who  
24 normally join us from the School of Public Health

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2 and the Bureau of Injury Prevention, are with us  
3 today as they have been in the recent past. And we  
4 continue to welcome your participation. Thank you  
5 so much for being here.

6 And last, but not least, it's my  
7 distinct honor to reintroduce to the group, Ms. Lee  
8 Burns, who has taken on the leadership of the  
9 Bureau.

10 As you can see, Lee has very  
11 broad shoulders, which is important because she is  
12 now doing three jobs. She's director of operations  
13 for the Bureau. She's assistant director for the  
14 Bureau, and now she's acting director for the  
15 Bureau. So, fortunately, there are three  
16 eight-hour shifts in a twenty-four-hour day, so you  
17 know, we will Lee will be able -- Lee will be  
18 able -- Lee will be able to handle it as she has  
19 always handled everything else. But she has taken  
20 over the leadership of the Bureau from Mr. Wronski,  
21 who has stepped off into retirement.

22 Lee, as you know, is -- is an  
23 active paramedic, has been for many years, and  
24 brings with her not only a -- a wealth, in terms of

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2 both depth and breadth of administrative experience  
3 within the Bureau, but also is one of us. She  
4 is -- she is a healthcare provider. And so, she  
5 understands the issues in a way that -- that not  
6 everyone else can, because they're not out in the  
7 street actually delivering the care, as Lee does.

8 Now, I -- it is true that she  
9 sometimes does that on a motorcycle, and we have  
10 been trying to convince her that that's not a wise  
11 thing to do, but -- but -- but she hasn't listened  
12 yet. Fortunately, she listens about most other  
13 things.

14 But -- so, Lee, so thank you, and  
15 God speed in your new assignment, and we will be  
16 here to support you in any way we can.

17 I'd like just very briefly to  
18 call for a review and approval of the minutes. All  
19 of you, I believe, received a copy of the minutes  
20 by e-mail. Are there any additions, deletions or  
21 corrections to those minutes?

22 In hearing none, I'll entertain a  
23 motion for approval.

24 DR. VAN DER JAGT: So moved.

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2 DR. COOPER: Thank you.

3 Ruth Walden, and Elise Van Der  
4 Jagt.

5 Discussion?

6 All in favor?

7 MS. WALDEN: Aye.

8 DR. VAN DER JAGT: Aye.

9 DR. COOPER: Opposed?

10 (The motion carried.)

11 DR. COOPER: Carries without  
12 dissent.

13 Thank you. I'd like to move  
14 right into our -- our agenda. In the interest of  
15 time, I will ask you simply to read the agenda that  
16 is before you because I know Dr. Kus has very  
17 limited time. Dr. Kus is going to be pinch hitting  
18 in addition for, you know -- for himself, for Ms.  
19 Winooski of the Bureau of Community Chronic Disease  
20 Prevention. He will lead off talking about the  
21 Department's asthma initiative, and -- and then  
22 will speak with us about the issue of which all of  
23 us are most concerned, namely the H1N1 pandemic and  
24 its affects on the children of New York State.

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2 Chris?

3 DR. KUS: Sure. Glad to be here  
4 and -- actually just to give you some update why  
5 it's -- it's great, Pat Winooski is the project  
6 director for our asthma grant from C.D.C. and has  
7 recently taken a position within the Bureau of  
8 Chronic Disease. So, this asthma grant was  
9 previously in the Division of Family Health. So,  
10 she moves over to the other division, and she says,  
11 "oh, I can't make it, so you better do it." So,  
12 just so you know that.

13 But what -- what I want to do is  
14 make it as useful as possible for you. So, as we  
15 go through this, if there are specific questions  
16 that you have, stop me, and -- and go from there.  
17 I have a pretty tight presentation for asthma.  
18 H1N1, there's lots of stuff, so we'll go through  
19 that, and see which things are most interesting to  
20 you or -- or would be helpful.

21 So, to start out with the New  
22 York State asthma program, this is really talking  
23 about asthma from a public health perspective,  
24 because we've had a grant from the Center for

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2 Disease Control and Prevention for almost ten years  
3 and state funding committed to asthma care,  
4 particularly looking at what can the public health  
5 agency do to improve outcomes relative to asthma  
6 care. And this comes from the New York State  
7 Asthma Plan 2006-2011, where we had quite a few  
8 stakeholders participate, but we also have now a  
9 partnership which involves different agencies,  
10 Academy of Pediatrics, respiratory therapists,  
11 different organizations because what we've realized  
12 is the -- the work of asthma is done out in the  
13 field, and is there a way that we can coordinate  
14 that activity with our partners to take advantage  
15 of -- of -- of the resources that they have.

16 So, we're kind -- we've kind of  
17 moved from an advisory group to a partnership group  
18 so that people, as opposed to reviewing a plan once  
19 every year or so, we have quarterly meetings, and  
20 we really try to move agendas that way so that  
21 people are really taking ownership of this. And so  
22 this is where the asthma plan came from. And the  
23 big line is despite improvements in awareness, care  
24 and management, asthma still remains an epidemic in

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2 New York State with significant public health and  
3 financial consequences.

4 Disparities are a big issue here,  
5 which when we talk about this, the disparities that  
6 we see in asthma are similar to the disparities we  
7 see with lead poisoning in children and have --  
8 have socioeconomic parts to it, but -- but in -- in  
9 a way, we've been talking about how to deal with  
10 that issue not just from one condition. And the  
11 idea is we're -- we're talking about what do we  
12 need to do to accelerate and spread improvements.  
13 It's -- it's really thinking about not doing more  
14 of what we're doing, but is there different thing  
15 that we need to do.

16 Next one.

17 So, give you a little information  
18 about the burden of asthma, the -- New York's  
19 action to control asthma, and the progress and next  
20 steps, and then hopefully, we'll highlight the  
21 emergency care system and how we -- we -- we'll --  
22 we can work across that system to improve care.

23 Next one.

24 So, this just gives you some

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2 sense of the prevalence of asthma in adults using  
3 the behavioral risk factors survey, which different  
4 states us and what you'll see is that our  
5 prevalence rate pretty much goes along with the  
6 U.S., although we're -- we tend to be the higher  
7 bar.

8 And then, if I -- if I took this  
9 information and tried to give you information with  
10 regard to children, what you see is, depending on  
11 the area that we're talking about, we can see  
12 prevalence rates up to fifteen percent in some of  
13 the New York City population, particularly east  
14 Harlem and -- and those areas. So, there's a  
15 range.

16 Next one.

17 How about hospital discharge  
18 rates?

19 What you're seeing is New York  
20 City above, and then you're seeing rest of the  
21 state, and -- and then New York State in the  
22 middle. So, high asthma hospitalization rates in  
23 the city, and one of the things we -- you know,  
24 we're talking about is: Is that a reflection of

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2 the -- the way care is delivered; is it a  
3 reflection of the way people use the healthcare  
4 delivery system?

5 These kind of global figures what  
6 we've -- we've got. If you go to our Web site, we  
7 have maps of different parts of the state. So,  
8 it's really useful to look at those hospitalization  
9 rates on counties and lower areas.

10 Total cost. This gives you  
11 the -- if you -- if you look at the top one, that's  
12 really the adjusted cost, and so that's gone up  
13 slightly, when we look -- adjusting the cost back  
14 in 1998, and it's kind of flattened right now, but  
15 still a -- a big cost in terms of healthcare  
16 delivery dollars, and Medicaid dollars for the  
17 state.

18 Next one.

19 Okay. How are we doing?

20 If we -- we talk about healthy  
21 people 2010 goals, and here you're -- we're looking  
22 at the emergency department rate per ten thousand,  
23 which is one of the things that's actually new data  
24 items that we have in -- in the idea of emergency

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2 room visits relative to asthma that we're starting  
3 to analyze, and -- and look at the quality of that  
4 data. But if you look here, all our numbers are  
5 above the Healthy People 2010, and they're also  
6 above what the United States in general has from  
7 2004 to 2006.

8 Next one.

9 How about discharge rates?

10 Similar profile here where we're  
11 not close to the Healthy People 2010, and we're  
12 higher than the -- the average U.S.

13 Next one.

14 Mortality rates. We, again, are  
15 generally higher -- well, we are on all except for  
16 over sixty-five in -- in terms of mortality rate  
17 for asthma.

18 Next one.

19 So, what are the challenges that  
20 we have in -- in terms of our system?

21 Well, one of them and -- and I  
22 guess this is the one where we talk a lot about  
23 giving the issue of healthcare reform, if you look  
24 at our healthcare delivery system, it's really

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2 focused on acute care versus chronic care  
3 management. So, is there a promise that we will  
4 look at chronic care a little bit differently? The  
5 concept of medical home being used as a way of  
6 enhancing rates for doctors and trying to over --  
7 trying to emphasize the -- the issue of  
8 coordination of care, you know, may -- may offer  
9 some possibilities. But if you -- if you look at  
10 the -- the amendments that have been proposed to  
11 health care reform, you look at the discussion,  
12 it's not too -- it doesn't look too promising to me  
13 in terms of chronic care.

14 And I think that's a huge issue  
15 here, because the incentive, particularly for  
16 pediatricians or family practitioners to take care  
17 of kids with chronic disease, financially, there's  
18 isn't an -- an incentive. There is no incentive to  
19 do that. So, I think that's a huge thing that  
20 we're talking about.

21 One of the things we're talking  
22 about is trying to get some -- since we have most  
23 of our kids in a managed care system, we're looking  
24 at performance measurements that reflect care of

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2 chronic disease. But that's -- those are hard to  
3 do, and they're just being developed.

4 When we look at it, the gap  
5 between what is recommended as good asthma care and  
6 actual practice persists, I'll get into it, but  
7 what -- what you got was the continuing effort to  
8 get consistent guidelines about what's expected of  
9 care.

10 The positive thing about it is if  
11 you look at the back of this document, it shows all  
12 the healthcare plans that were involved and agreed  
13 to this; which is huge -- a huge thing to do to get  
14 them all to agree to the same thing. So, we're  
15 clear about what should be done, one of the things  
16 we look at when we do some of the work with  
17 practices, is that the systems aren't generally in  
18 place to allow you to -- to do some of this.

19 An issue specifically for this  
20 group is the -- is the idea of using the emergency  
21 room for primary care. So, your acute visits go to  
22 the emergency room, and then how do you get the  
23 ongoing chronic care management to be involved, or  
24 the primary care doc to be involved?

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2 Reimbursement models do not  
3 support good asthma care. Real time information,  
4 not often available. I guess the promise of health  
5 information technology is -- particularly when --  
6 when we're talking about kids, the -- the  
7 penetrance of medical -- of electronic medical  
8 records is -- is not very high right now, and I  
9 think there's some promise to that. But one of the  
10 things that I'm concerned about in kids is that the  
11 general products of medical records aren't very  
12 well tailored to pediatrics. They're generally  
13 adult specific.

14 A defined set of valid measures  
15 for asthma care is limited. We've done a lot in  
16 terms of working on that, and we've put out a  
17 surveillance document, and there are some  
18 measurements in the core measures, which is the  
19 measures that the state looks at for managed care.

20 Efforts to spread and bring  
21 effective evidence-based interventions to scale are  
22 limited. And this is probably the biggest one.  
23 Despite evidence self-management support is not  
24 well incorporated into the mainstream health

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2 culture. Again, the idea that we're acute care as  
3 opposed to chronic care.

4 Next one.

5 This is the Health Department  
6 organization of how we are dealing with asthma.  
7 And we put it up here because it -- it -- it is --  
8 it could be an ongoing model for care of chronic  
9 disease in general, because what you see is that  
10 good asthma care goes across many of the different  
11 parts -- the centers of the Health Department.

12 And so our structure was set up  
13 with having a leadership team. You see Pat's name  
14 as the coordinator, and Dale Morris is the P.I. on  
15 the grant that we have from the Center for Disease  
16 Control, and we've divided it up into four groups.  
17 The surveillance group, the healthcare delivery  
18 group, the community group, which -- which I'm the  
19 team leader on, and the environmental and  
20 occupational health group. And within those  
21 groups, we have people from different bureaus,  
22 different divisions, that have some contact with  
23 regard to asthma meeting, and the plus of that is  
24 that as you do this, you find that there's a lot

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2 of -- a lot of things that you could work together  
3 on besides asthma, or you could combine some  
4 things. So, I think the model of trying to work  
5 across the --the Department -- people always talk  
6 about stovepipes and all that kind of thing, this  
7 is the idea of trying -- trying to work across the  
8 Department.

9 Next slide.

10 If people are interested, on our  
11 Web site there is asthma plan, and I think we  
12 still -- we have hard copies that -- that we can  
13 give to folks. With it, you'll -- you see the --  
14 the goals that are listed.

15 The first one really talks about  
16 that -- put all those words together about  
17 coordinated care. The second one is about the  
18 disparities issue. Third one is asthma-friendly  
19 communities, taking into consideration the  
20 environmental situations that kids are in. One of  
21 the activities that the -- the New York City  
22 program deals with, is standing buses in -- in --  
23 in front of schools and -- and those all play a  
24 role with this. And -- and then, the fifth one is

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2 saying that you can't do this within the Health  
3 Department. We really are trying to have a  
4 public/private collaboration to improve asthma  
5 outcomes.

6 Next one.

7 This tells you where our support  
8 comes from. The -- we've been very consistent. I  
9 think this is -- and people have -- have liked  
10 the -- the structure of -- of the program, so that  
11 we've had consistent funding from the Center for  
12 Disease Control and Prevention, and that's not  
13 all -- for all states. It's for a really small  
14 subset of states, probably -- I think it's less  
15 than ten right now. And we also have state funding  
16 that's been fairly consistent, probably for the --  
17 we've had it for the last, I think, about eight  
18 years, and our current funding for the state is two  
19 million dollars.

20 And -- and that funding goes to  
21 the main vehicle that we're trying to use to -- to  
22 get people to collaborate, which are regional  
23 asthma coalitions. And I would be interested to  
24 see if any folks on here are on those regional

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2 asthma coalitions, because they're supposed to  
3 take -- involve people from the different provider  
4 networks in terms of emergency room primary care  
5 doc.

6 I see one shaking head, so that's  
7 good.

8 And -- and the idea is that  
9 those -- those coalitions really try to bring  
10 people together and get them online in terms of  
11 what's the best way to help after they've assessed  
12 what's happening in their region. And -- and one  
13 of the tools that we've put into those coalitions  
14 in the last three years is an outcome learning  
15 network with the idea that it -- it's using the --  
16 how many people are familiar with learning  
17 collaboratives?

18 Oh, we got one, two.

19 Okay. The -- the idea of looking  
20 at the coalitions as a learning network, and that  
21 they will come up with projects that seem to fit --  
22 that should fit with what the goals are, that are  
23 in the grant, and then one of the key things about  
24 it is measuring outcomes about that, and to -- to

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2 see you're progressing because we can't say this is  
3 good, because of everybody getting together at a  
4 meeting; what -- what actually are they -- the  
5 outcomes that they're doing, if they put that  
6 together? And it's a way of people also getting  
7 information from all the other coalitions about  
8 things they might use. So, we've now gone into a  
9 WebEx series where people are sharing some other  
10 outcomes.

11 Next one.

12 This shows you the asthma  
13 coalitions, and this grant is going to be up for  
14 rebidding fairly soon, so one of the discussions  
15 that comes up is we -- we haven't had increased  
16 funding for the time that we've had the grant, so  
17 how do you effectively use it? So, the question  
18 will be are we -- we spreading it too thin? How  
19 should we be involved? And I think that's one of  
20 the discussions that'll come up with -- with our  
21 partnership.

22 Right now, there -- the -- the  
23 goals of the -- through our program is to say using  
24 the regional coalitions as a way to get best

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2 practices out there, that one of the things is to  
3 say we want to get out to people what's the state  
4 of the art in terms of clinical care. So, that's  
5 the -- the guidelines here, saying that we -- this  
6 is the way you should provide asthma care, and this  
7 is the second edition of -- of the guidelines.  
8 The -- and it came with the -- the updated  
9 guidelines from the -- the national program.

10 If you look at the guideline,  
11 the -- the -- the -- I think the biggest difference  
12 is there's a strong emphasis on control in this  
13 guideline. In the previous one, it was -- it was  
14 talking about classifying the asthma, but this one  
15 says you need to have some measure of control, and  
16 then -- and then when you use that measure of  
17 control, then it keys you into what treatments you  
18 should -- you should provide.

19 And I think I went through the  
20 rest.

21 Okay. So, that's what you got.

22 Okay. So, have -- have we made a  
23 difference?

24 This -- the first part is kind of

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2 what outcomes can we look at, and you can say --  
3 well, we may have contributed to a twenty-percent  
4 reduction in asthma hospital discharge rate among  
5 children zero to seventeen; a thirteen-percent  
6 reduction for the total population; and a  
7 thirty-percent reduction over all asthma death  
8 rate. And that, you know, that's -- that's  
9 targeting those -- those big outcome measures.

10 Next one.

11 What have we done to relate to  
12 that?

13 This is kind of more the process  
14 measure things. We had been really active in  
15 publishing and presenting at statewide and national  
16 meetings. We've been involved pretty actively  
17 with -- with federal -- with national groups,  
18 particularly the C.D.C. in terms of the direction.  
19 We provided technical assistance to fifteen other  
20 states involved in legislation, and we've had lots  
21 of graduate, doctoral and preventive medicine  
22 resident students that have rotated through.

23 So -- next one.

24 So, what do we do in 2009 to

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2 2010?

3 We continue with the idea of  
4 having this asthma partnership group. We're  
5 continuing with -- with the regional asthma  
6 coalition, and we're looking at our current agency  
7 infrastructure to see if that makes a difference.

8 We do regularly put out asthma  
9 surveillance systems and program evaluation, and --  
10 and hopefully have people use that information as  
11 they plan programs. And in terms of the actual  
12 healthcare delivery and quality, the consensus  
13 guidelines self-management toolkit that we put out,  
14 we have worked relative to benefits for asthma, and  
15 one of the biggest ones is there wasn't a  
16 certification for asthma educators, which there now  
17 is, and allows people to get that funded for. So,  
18 that's a little bit moving on in terms of chronic  
19 disease.

20 Next one.

21 We have a pretty big  
22 environmental part in terms of combining it with --  
23 with some of the healthy home environments that we  
24 do. We look at the school air quality and outdoor

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2 triggers, and -- and then we -- we've done a  
3 specific learning collaborative with school-based  
4 health centers where we worked with, I think it was  
5 about six to seven school-based health centers that  
6 were in the highest asthma hospitalization areas,  
7 and said this is a vehicle to see -- to see if we  
8 could improve care.

9 And what we found was like what  
10 happens in -- in a lot of practices, if you ask  
11 somebody "how many kids with asthma do you have?"  
12 They -- they can't really tell you. They can say  
13 we have a, lot or we have -- think we -- think we  
14 have this much. So, we worked with them to develop  
15 a -- a registry with regard to asthma. We --  
16 they -- they embedded the guidelines within their  
17 visit form, which helped them to continue it, and  
18 then we followed -- we tracked outcomes with that.  
19 And at -- at least during the time they  
20 participated with us, they continually improved the  
21 outcome of -- of good practice in that. And it was  
22 also used for -- the registry was used for a -- an  
23 immunization project, too. And actually, it's  
24 something you can use for H1N1, if you've got a

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2 listing of that, that's a higher risk group.

3 And I've already talked about the  
4 Asthma Outcomes Learning Network.

5 That's it.

6 DR. COOPER: Thank you, Chris, so  
7 much for that really very comprehensive  
8 presentation. I think all of us are really very  
9 pleased to know the -- the breadth of activities  
10 that the Department of Health has undertaken to try  
11 to get its arms wrapped around this -- this huge  
12 problem, which, you know, as we know affects our  
13 Downstate and lower socioeconomic groups really  
14 with a ferocity that's almost unimaginable.

15 Are there any questions for Dr.  
16 Kus?

17 Elise, and then Rita.

18 DR. VAN DER JAGT: Just -- just  
19 two questions. One is how are the E.M.S.  
20 providers, prehospital care, incorporated into the  
21 coalitions in the various areas? That's not clear  
22 to me. Sometimes we skip over that. We looked at  
23 emergency medicine, we looked at primary care  
24 physicians, we look at inpatient, but we don't

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2 necessarily use the providers, and what triggers me  
3 thinking about that is actually when Sharon passed  
4 around the A.L.S. protocols, you know, looking at,  
5 you know, the asthma protocol, managed that's acute  
6 care. But that brings to mind, you've got a whole  
7 lot of providers out there who deal with asthma on  
8 a daily basis. So, I was wondering what you would  
9 do with that.

10 And then, the second question I  
11 have, just very quickly, is did you -- have you --  
12 if you look at the -- these various parameters,  
13 obviously, you can see that New York City sticks  
14 out as being extremely high-risk area. If you  
15 compared New York City with the Upstate area,  
16 without including New York City in the Upstate  
17 area, is there -- is there a difference between  
18 those two and how great is it?

19 DR. KUS: Well, it's -- I mean  
20 it's -- it's big. I mean the difference between  
21 that -- although you can find in the Upstate area,  
22 particularly in some of the rural areas, you can  
23 find hospitalization rates that are higher, and --  
24 and when you look at it, it may be the access to

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2 care thing.

3 But I think one of the things  
4 we -- we see is in terms of the actual looking at  
5 rates, that global New York City and the global New  
6 York State, doesn't tell you the -- the -- the  
7 story. That's why looking at the -- the  
8 county-specific ones, and looking at the population  
9 is really the way to do it.

10 But still the load of -- is -- is  
11 actually concentrated in several -- in several  
12 parts of -- of New York City. The -- the -- the  
13 highest level.

14 Your E.M.T. question is a good  
15 one. I know that some's include it, but I -- what  
16 I can do is I will go back and I will see what our  
17 current list is, and what we've done to do it,  
18 because we -- when we enlisted people to -- to be  
19 involved, people were given the directions to  
20 really look at the -- the continuum of the  
21 healthcare delivery system. So, I -- I -- I know  
22 that there's a couple coalitions that involve  
23 people. But to give you a whole sense of that  
24 would be good. I'll -- I'll do that.

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2 DR. VAN DER JAGT: I just think  
3 that you have a whole lot of E.M.S. providers who  
4 are really good in education in that -- in that  
5 sphere of E.M.S. --

6 DR. KUS: Uh-huh.

7 DR. VAN DER JAGT: -- that might  
8 be really used as a -- as a tool to help some of  
9 the educational aspects of this.

10 I know you've got asthma  
11 educators, and things like that, but you know, I --  
12 at least in my area, E.M.S. providers are very  
13 interested in -- in whatever they can do to educate  
14 in the local communities. And if they can be part  
15 of this, I think you will have a whole lot more  
16 people to help out in this area.

17 DR. KUS: Yeah.

18 DR. COOPER: Chris, I was  
19 actually going to follow along with a similar  
20 comment, and -- because Elise has raised the issue,  
21 I'll follow along with it now. It really strikes  
22 me that we are missing a major opportunity in terms  
23 of community education, by not making greater use  
24 of our E.M.S. providers.

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2 The American Red Cross has  
3 created a whole slew of what it calls tear sheets.  
4 It's -- they're just -- they're just eight and a  
5 half by eleven sheets of paper that are bound  
6 together with, you know, a padding compound at the  
7 top just like a regular, you know, pad of paper  
8 that -- that -- that we use. And the tear sheet is  
9 a simple document, sort of explaining to the public  
10 simple measures that can be taken to, you know,  
11 reduce the impact of disease, you know, morbidity  
12 for themselves and their families. And I was  
13 wondering, you know, why not create a document like  
14 that, that -- that, if you will, takes, you know --  
15 or makes use of the teachable moment --

16 DR. KUS: Uh-huh.

17 DR. COOPER: -- that our -- our  
18 E.M.S. providers could actually, you know, tear one  
19 off, give it to the family, and say, "here you are,  
20 you know, think about primary care, think about --  
21 if you don't have primary care, we'll help you get  
22 it, et cetera, et cetera." All the things that we  
23 know that make a huge difference in terms of -- you  
24 know, in terms of getting control of this epidemic.

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2 And I think that -- I think that might be a nice  
3 project for us to work on together, you know,  
4 developing an instrument like that, that we could  
5 share with our E.M.S. providers.

6 Rita?

7 MS. MOLLOY: So, one of the  
8 things that I wanted to discuss with you to  
9 piggyback on what Elise said was, you know, I've  
10 been involved with the Asthma Coalition of Long  
11 Island for the last -- over a decade, and I'm on  
12 the school's environment committee, and I have been  
13 in an asthma-friendly schools initiative grant.  
14 This is year four --

15 DR. KUS: Uh-huh.

16 MS. MOLLOY: -- in my area. And  
17 one of the reasons why we were eligible for that  
18 grant was because our data for, you know, E.D. --

19 DR. KUS: Right.

20 MS. MOLLOY: -- discharge was way  
21 over the top for young children. So, we're looking  
22 to improve outcomes, but when you look at all these  
23 guidance documents, they really do recommend using  
24 an asthma action plan, which I see extraordinary

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2 resistance in the medical community to take the  
3 time to prepare.

4 And school nurses receive every  
5 one of these children into some setting, from very  
6 young ages, pre-K on. And to -- to miss an  
7 opportunity to have a document that would help it  
8 be more seamless for care, not just episodic  
9 treatment, but that emphasis now on controlling  
10 medication.

11 There is a tear-off sheet about  
12 the rules of two that exists that asthma coalitions  
13 have put together with the Lung Association that  
14 speak to that very issue, because people don't  
15 understand that just because they've surmounted the  
16 crisis by opening their airways, all of the other  
17 mechanisms that are involved in having, you know,  
18 these -- over time these chronic health conditions  
19 and the lung remodeling, and all of these things.

20 So, it's really a key that we're  
21 missing that we can't seem to get a buy-in from  
22 practitioners, or even discharging from an E.D., to  
23 have a long-term plan other than that episodic  
24 care.

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2 DR. KUS: Uh-huh.

3 MS. MOLLOY: And one of the  
4 things that I spend a lot of time -- myself  
5 personally doing with my clients is reeducating  
6 them and making them understand the difference  
7 between the mechanisms of action, why they need to  
8 feel comfortable using controller meds.

9 And you know, I'm going for my  
10 certification as an asthma educator. But part of  
11 the reason why I wanted to bring it to this table  
12 is I think we were missing the boat on the side,  
13 like Elise said, with the emergency providers, and  
14 then with the school nurses, because in New York  
15 State, even though we're not mandated as school  
16 nurses, we're very fortunate to have representation  
17 in just about every school in the state, where you  
18 do have a hands-on medical provider.

19 My frustration, though, is that  
20 the -- the medical information that comes to me  
21 after this treatment is very substandard. It may  
22 even say -- and I don't want to indict a hospital,  
23 so I won't even say where -- but it will say "was  
24 seen for illness/injury and can return to school."

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2 Well, it doesn't even tell me, so now I'm trying to  
3 get to the parent, trying to find out what, you  
4 know, transpired over the weekend, find out that  
5 this kid was bronchodialated back-to-back the night  
6 before, coming in, they haven't filled any  
7 prescriptions, there's nothing available for me to  
8 treat them in an emergency, and then, you know,  
9 we're off to the next episode.

10 So, I'm looking for a buy-in or a  
11 mechanism to make this more seamless, because we  
12 have some very good foundational people and -- and  
13 resources available, that we're underutilizing by  
14 not having a really good mechanism of getting the  
15 information from one party to the other.

16 A lot of people are afraid of the  
17 privacy issues. Well, if you have the parent there  
18 with the child anyhow, you can cross that bridge.  
19 The school needs to know. Where -- wherever the  
20 next person is that will be a provider of care or a  
21 caretaker of that person over a great deal of their  
22 waking hours, it's critically important, not just  
23 for the parent, to be told in the moment, who quite  
24 frankly they don't really get it in the moment

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2 because it's in the crisis.

3 DR. KUS: Right.

4 MS. MOLLOY: So, we need for  
5 that -- that ability to, you know, cross over time,  
6 and to get on board with the rest of the parties.

7 One of the things that the Asthma  
8 Coalition is trying really hard to do in my  
9 community is to reach pediatricians to get them,  
10 you know, a better comfort level of providing the  
11 controller medications, and to understand how they  
12 need to spend a little time educating the parents,  
13 because they don't really get it.

14 And -- and they don't. I can  
15 tell you. I've been doing this a long time. And  
16 I -- and I live with an asthmatic son, who I've,  
17 you know, had to reeducate school personnel over  
18 time. So, it's a really frustrating experience,  
19 especially when you do have a culture now of -- of  
20 realization that the emphasis needs to change, that  
21 what we're doing looks great at the top, but it's  
22 not working at the bottom, you know, so we need  
23 to -- we need to do something better. And I think  
24 by identifying the partners that we have that are

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2 there -- I mean we have a built-in structure to  
3 support the efforts at the top --

4 DR. KUS: Uh-huh.

5 MS. MOLLOY: -- but we need to  
6 find a better way of interfacing together.

7 DR. KUS: Uh-huh.

8 MS. MOLLOY: And I think the  
9 emergency room discharges could be a great place  
10 for that to start. You know how there's usually  
11 protocols for discharge where you -- certain amount  
12 of information has to be given, and a person has to  
13 leave armed with a certain amount of knowledge, so  
14 just to say that you need to go see your primary  
15 care physician in a day, you know, that's falling  
16 short because they're not going.

17 DR. KUS: Uh-huh.

18 MS. MOLLOY: They're not going  
19 for a myriad of reasons, either money, time, you  
20 know, many. And it might be -- it might be  
21 multifaceted, but you're really -- we're really --  
22 we're not doing as well as we could be doing it if  
23 we addressed that gap. So, that's really why I had  
24 asked for, you know, this to come to the table

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2 because you can say a hundred times over, asthma  
3 action plans are great, they're the standard of  
4 care. Let's do it. Let's do spirometry, you know,  
5 in the office, let's do peak flows here and there.  
6 Well, if nobody's -- if nobody's bought into it,  
7 and nobody is doing it, let's think why, and let's  
8 either change it or make it happen.

9 DR. KUS: Uh-huh. Uh-huh.

10 DR. COOPER: Bob Kanter.

11 DR. KANTER: Those are great  
12 comments about the acute aspects. I wonder if you  
13 could talk for a minute about the trade-offs  
14 between programs or initiatives dealing with  
15 dedicated to one chronic disease, the asthma,  
16 versus a broader perspective on just a chronic  
17 disease in general?

18 DR. KUS: Well, I think our  
19 feeling is people that worked in this is that the  
20 model this -- this kind of thinking fits to a great  
21 extent to -- to lots of chronic disease, and it --  
22 it really talks about the lack and -- of our  
23 health -- of our healthcare delivery system in  
24 terms of being able to provide that education. I

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2 mean chronic disease -- to be educated that you  
3 need to take the medicine when you're feeling good  
4 is a -- that's a -- that's a tough message to  
5 get -- for people to get across.

6 MS. MOLLOY: Uh-huh.

7 DR. KUS: So, I think there's a  
8 lot of commonalities, and we're actually looking at  
9 trying to, in fact, Pat going over to chronic  
10 disease may move us looking at it in a more similar  
11 fashion.

12 And most people would say -- who  
13 deal with chronic disease say about eighty percent  
14 that -- of things that you're doing are pretty  
15 similar: Coordination, parent education and family  
16 support are the -- the things that you -- you need  
17 to bring into it.

18 I guess the -- the issue I'm  
19 struggling with is -- is the -- what can we do?

20 I mean I -- because I think in --  
21 I -- I do have a note from -- because I knew  
22 this -- this question was coming up. But Pat sent  
23 me a note that specifically at -- in the Golisano  
24 Children's Hospital, Mark Lampil (phonetic

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2 spelling) is -- is trying to address asthma control  
3 in E.D.s by -- by actually doing something in terms  
4 of the area of -- of asthma action plans. I don't  
5 know specifically what it is, but I will follow up  
6 on -- on it, because I've always had a hard time  
7 understanding how you can do kind of that sit down  
8 asthma action plan kind of thing in an acute  
9 setting. But apparently they're trying to do it.  
10 And they're working to -- they're working  
11 specifically with their regional coalition, and --  
12 and -- and she also says that New York City wants  
13 to do a citywide policy on this. So -- and -- and  
14 apparently, it's working with the Association of  
15 Emergency Physicians to write a physician's  
16 statement. So, some of this then may be coming to  
17 the front. Now, I'll get further information on  
18 it.

19 I guess I -- I -- the part for  
20 me, is to try to figure out what -- what do you do  
21 because I think one of our messages up front is  
22 that you've got to get the family into a system of  
23 care to begin with. So, that -- that issue right  
24 up front; "do you have insurance? And I can get



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2 The other thing I want to just  
3 caution, you know, everybody about is that  
4 frequently legislators, you know, think they're  
5 doing a good thing and there's been bills that have  
6 been bandied around about stock albuterol for  
7 schools --

8 DR. KUS: Right.

9 MS. MOLLOY: -- so that we never  
10 get a person under good control --

11 DR. KUS: Right.

12 MS. MOLLOY: -- and we're  
13 treating crises all the time and bronchodilating  
14 people to death.

15 DR. KUS: Right.

16 MS. MOLLOY: So, honestly, I will  
17 tell you that the Asthma Coalition came to me, and  
18 asked me about this, because well-meaning, and you  
19 know, and well intentioned actions sometimes, you  
20 know, the road to hell is paved with good  
21 intentions, you can't always just, you know treat  
22 something in a vacuum. And I think that that's  
23 sometimes they way things are sponsored. So, for  
24 this, you know, group, I think it's really

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2 important for us to, you know, emphasize that  
3 that's not -- that's not the spirit of what --

4 DR. KUS: Right.

5 MS. MOLLOY: -- you know, the  
6 initiatives are.

7 And it's not helping someone over  
8 time, because you want to talk about chronic  
9 disease models and lung disease when you get older.  
10 Just undertreat them all these years, and who are  
11 they going to be when they're get old? Right. So,  
12 let's think about that.

13 DR. COOPER: I'd like to --  
14 before I recognize Tim Czapranski and Elise Van Der  
15 Jagt, our cochair, Kathy Lillis, has had a  
16 tremendous interest in this area over the years,  
17 and I just wanted to get her thoughts.

18 DR. LILLIS: So, I -- I put  
19 together an N.I.H. grant. Unfortunately, it wasn't  
20 funded, but what -- what the main initiative of the  
21 grant was to initiate chronic care in the emergency  
22 department for -- for asthma. So, the first part  
23 of the grant was doing a screening tool for anyone  
24 who came in with asthma to see if they met criteria

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2 for -- for persistent disease.

3 DR. KUS: Uh-huh.

4 DR. LILLIS: The second was a  
5 video that we were doing on an educational  
6 component, and it was based on one that was at  
7 Chindren's Hospital of Philadelphia, that it went  
8 through issues such as triggers, and -- and the  
9 difference between rescue meds versus chronic meds.

10 The third component was actually  
11 initiating the inhaled corticosteroids in the  
12 emergency department. And we were doing a  
13 randomized control trial, and we were either giving  
14 them the -- a one-month nonrefillable prescription  
15 for the inhalers, and actually in our pilot study,  
16 we actually gave them the sample drugs versus  
17 sending them back to the primary care providers.

18 All primary care providers were  
19 getting a letter saying that their patients met  
20 criteria for -- for chronic disease, and needed to  
21 be on this, and our primary hypothesis was that if  
22 we actually initiated in the department the primary  
23 care providers are going to be much more likely to  
24 continue the medications than to -- than to start

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2 them on somebody that -- that hasn't been started  
3 on it.

4 DR. COOPER: Uh-huh.

5 DR. LILLIS: And they were going  
6 to get -- the -- the list of guidelines of what --  
7 where they needed to go if they needed to have the  
8 step -- stepwise approach.

9 So, we -- we recognize that it's  
10 very episodic care, that -- that it -- that there's  
11 acute -- there is this perception that emergency  
12 physicians deal with -- with acute illness and  
13 primary care providers deal with the chronic  
14 illness.

15 DR. COOPER: Right.

16 DR. LILLIS: There was also some  
17 concerns when we rolled out our pilot to our  
18 community physicians, there was a little bit of  
19 pushback with the pediatrician "saying you can  
20 identify them, but we don't want to starting  
21 chronic meds on our patients." There was also the  
22 concern that if the emergency department provides  
23 the chronic meds, would the kids stop going to  
24 primary care providers and just use the emergency

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2 departments even more. So, we were actually going  
3 to survey the community pediatricians and find out  
4 if there had been any disruption in their -- their  
5 relationship with their patients, based on our  
6 study. And -- and that's again, why we only did a  
7 one -- one-month supply, and the families were  
8 told, "you need to follow up with your -- with your  
9 primary care provider within the month."

10 And we had gotten scored, and --  
11 and resubmitted. Unfortunately, with the funding,  
12 we -- we didn't get a high enough score to -- to be  
13 funded. But I mean I think it's -- it's  
14 initiative. I think emergency departments are  
15 going in this direction, when we were picking our  
16 PECARN sites, there were some studies -- some sites  
17 that couldn't participate in it, because of their  
18 existing physicians already prescribing inhaled  
19 corticosteroids, and their I.R.V.s would not allow  
20 them not to, or to randomize to --

21 DR. COOPER: Uh-huh.

22 DR. LILLIS: -- to not  
23 prescribing them. Children's Hospital in Milwaukee  
24 was -- was not allowed to participate, because

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2 their I.R.V. said, of course, every asthmatic  
3 should be on --- every child with persistent asthma  
4 should be on inhaled corticosteroids. So, they,  
5 again, would -- were not allowed to -- to  
6 randomize.

7 So, we are seeing this -- the  
8 shift in emergency department physicians becoming  
9 involved in identification of the -- of the  
10 particular patients, and then initiating it.

11 But it's not as simple as just  
12 saying, "why aren't these docs doing this," because  
13 there's -- there could be some detrimental effects  
14 from -- from doing this, in disruption of primary  
15 care providers and children --

16 DR. COOPER: Sure.

17 DR. LILLIS: -- using E.R.s  
18 instead of primary care providers. So, I think it  
19 has to be done in a -- in a systematic approach  
20 that -- that links them back to the primary care  
21 providers to -- to continue the care that's been  
22 initiated.

23 MR. CZAPRANSKI: Yeah. Both as a  
24 paramedic and as a father with a kid with asthma, I

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2 go into homes all the time, and -- and to the issue  
3 of using E.M.S., I mean we are really the only  
4 provider in that chain of care for that asthmatic  
5 that actually goes in the home and sees the  
6 circumstances by which the patient lives, and often  
7 identifies triggers.

8 Because, you know, we've gone  
9 through our home and done all the -- all the  
10 anti-asthma things you do, but when I go into  
11 homes, and I get a chance to talk to parents after  
12 we arrived at the hospital, because at the moment  
13 it's usually too acute to -- to talk to them, but  
14 we have time at the hospital, they're not aware of  
15 a lot of the things, or associations of the things,  
16 in their home or apartment as it relates to  
17 triggers.

18 I think the other thing is it's  
19 important as I sit on the Greater Rochester RHIO,  
20 which is looking into electronic medical records,  
21 when we pulled a group of physicians together and  
22 said, "if your patient goes to the hospital" - and  
23 these are primary care physicians - "are you aware?  
24 Do you get a copy of the prehospital care report?"

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2 Across the board, none of them did.

3 And so, again, by having an  
4 electronic P.C.R. rolled up into a regional  
5 electronic medical records that's available for  
6 that physician to review to say, "wow, you've been  
7 to the E.R. three times for asthma, I was not aware  
8 of this. We need to change your medications, or  
9 change your plan, or do something different."

10 It will also improve the  
11 continuity of care, because sometimes these  
12 patients go to different hospitals depending on  
13 who's code red. But there's a lot of things that  
14 will improve the quality of life and lower the cost  
15 by engaging E.M.S. to get out there and get in the  
16 homes and try to offer some additional information.

17 We bring them to the hospital,  
18 and you know, a lot of times you'll go in there,  
19 mom's smoking in the kitchen saying her kid's  
20 having trouble breathing, he's having an asthma  
21 attack.

22 But we get to the hospital.  
23 Nothing's ever done about that primary issue in the  
24 home, and so you're going to see the kid repeatedly

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2 throughout their lifetime. So, engaging E.M.S. I  
3 really want to push.

4 DR. COOPER: Elise?

5 DR. KUS: Can I just comment on  
6 that one? Across -- I mean across the state the --  
7 the service delivery system with regard to asthma,  
8 there are programs that include home visiting as --  
9 as part of it. So -- so, that -- so -- and -- and  
10 people are very clear with the idea that unless you  
11 see the home, you really aren't going to know  
12 what's -- what are some of the factors, but it --  
13 but it's not across the board for sure, and so  
14 anybody that -- that provides that info would be  
15 helpful.

16 DR. VAN DER JAGT: Rita, I  
17 appreciate very much what you have said about the  
18 schools, and it -- this made me think here a little  
19 bit, that maybe one of the things we should be  
20 looking at is the role of the school physician in  
21 the school system.

22 And -- and it -- what brings this  
23 to mind is, because of my connections with the  
24 American Heart Association Emergency Cardiovascular

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2 Care Committee, four -- I was looking at my C.V.  
3 actually, I think it's five years ago now, we -- we  
4 put together an emergency response plan for schools  
5 that was broadly disseminated, published in  
6 Pediatrics and in Circulation. It was an article  
7 that -- a guideline that was a joint venture  
8 between the American Academy of Pediatrics and the  
9 American Heart Association.

10 And although the -- the focus of  
11 that began to be the use of A.E.D.s in the schools,  
12 which was about the time that this was happening in  
13 New York State, it also discusses the management of  
14 asthma patients. And it actually suggests that  
15 school physicians are aware of the emergencies that  
16 might come up in their schools.

17 So, that makes me think that  
18 could we use that model of having the school  
19 physician who would -- initially what's going to be  
20 the A.E.D.s, and they have to endorse this as a  
21 reasonable thing to do, but that they also would be  
22 looking at identifying patients who have asthma,  
23 and then make sure that - just like we do with  
24 immunizations - that those patients have an asthma

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2 action plan in place in the nurse's office.

3 Because I'm thinking that, you know, that working  
4 together with school physicians -- I mean I have  
5 to -- I'm thinking of Sharon. Sharon's on the New  
6 York State E.C.C. at this point, the Heart  
7 Association. You might even want to bring that up  
8 there, because it really is part of what the Heart  
9 Association came up with as a preventive strategy,  
10 so there would not be an arrest in the schools.

11 So, there would not be these horribly sick kids  
12 that might occur there. But we all know that the  
13 real way to manage that is to prevent these from  
14 happening in the first place.

15 So, asthma action plans, school  
16 physicians, school nurses, it's a -- it becomes  
17 requirement, and then those patients if they -- you  
18 know, there's a question of, you know, what their  
19 peak flow might show, I mean you can -- there's a  
20 plan.

21 Anyway. Just some food for  
22 thought, that might be a coupling of some of these.  
23 And I don't know whether that would be part of the  
24 regional asthma network sort of discussions, how to

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2 solicit the use of the school system to -- in these  
3 preventive strategies. It clearly has to be  
4 coupled with their primary care physician.

5 But the school physician has  
6 responsibilities to a school, and it just seems  
7 logical to use that way of networking.

8 DR. KUS: One comment on that. I  
9 think -- I mean school districts are very  
10 different, and actually the -- the capacity of  
11 nursing within a school district can be almost  
12 nothing to a lot. So, I think you really have to  
13 have a -- a committed group to -- to do that. But  
14 part of what we had tried to do after we did with  
15 school-based health centers is to put together a  
16 plan, so that if a school saw that asthma was an  
17 issue they wanted to deal with, these are the --  
18 some of the things you could do. And I think one  
19 of the things we did, because the -- the idea was  
20 to put nebulizers in every school, which was the  
21 acute treatment, which we -- we wrote against,  
22 and -- and I will get to this group. Christian  
23 Gillibrand put a -- a proposal with regard to  
24 asthma, which we've commented on, and is going more

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2 toward a chronic disease management than it  
3 initially did, which was more get acute things to  
4 the -- okay for one day, and then the other one.

5 But I -- but I guess I'm  
6 concerned, because it's -- it -- the capacity of --  
7 of education -- I'm not as familiar with the city,  
8 because it's a different model, but here the --  
9 the -- the actual nursing connection, and actually  
10 the time that school docs spend, it would be  
11 interesting to know how much that is because I  
12 don't know that there's a -- they're a big player  
13 that -- I don't know that, but you might be -- know  
14 a bit more.

15 MS. MOLLOY: And --

16 DR. VAN DER JAGT: But the -- but  
17 the issue -- I'm sorry to interrupt, but the -- but  
18 the issue there is, is really we have the PAD  
19 program in the schools. Essentially, they have to  
20 register --

21 DR. KUS: Right.

22 DR. VAN DER JAGT: -- and that  
23 has to be under the -- under a physician. Why  
24 would you not take the same model for asthma,

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2 because if asthma --.

3 DR. COOPER: Because once you  
4 sign it up you don't use it.

5 DR. HALPERT: It's a different  
6 decision.

7 DR. VAN DER JAGT: Well, of  
8 course there's a different decision.

9 DR. HALPERT: The overseeing the  
10 physicians in the P.A.D. has absolutely zero  
11 contact unless there's a deployment of that device,  
12 which happens how often you use it.

13 DR. COOPER: Correct.

14 MS. MOLLOY: That's right. And  
15 you know how often they --

16 DR. COOPER: Right.

17 DR. HALPERT: Extensively --.

18 DR. VAN DER JAGT: But they have  
19 to set up -- the recommendation is that they set up  
20 that system, you know --.

21 MS. MOLLOY: Once. And then I  
22 never see them come back.

23 DR. HALPERT: Right. Well, see  
24 that's --.

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2 MS. MOLLOY: I've never seen them  
3 come back.

4 DR. HALPERT: Right.

5 DR. VAN DER JAGT: Right.

6 DR. HALPERT: Yeah. We signed  
7 off on it.

8 MS. MOLLOY: I don't even have an  
9 updated list of who's certified to use the  
10 defibrillator --

11 DR. VAN DER JAGT: Right.

12 MS. MOLLOY: -- other than  
13 myself.

14 DR. HALPERT: Right.

15 MS. MOLLOY: Because I'm not the  
16 overseer of the plan.

17 DR. HALPERT: You -- you have  
18 probably a hundred asthmatics you know about in  
19 your school.

20 MS. MOLLOY: My biggest crises in  
21 my office regularly that are, you know, not  
22 injury-related are asthma. All the time.

23 And the school doctor usually is  
24 on a contract with each district for, you know,

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2 services to a point. And it's usually more  
3 revolving around sports physicals and routine  
4 physicals, and it's scheduled in that measure.

5 DR. HALPERT: There's also the  
6 PAD doctors are not the school doctors.

7 MS. MOLLOY: And it isn't always.

8 DR. HALPERT: Right.

9 MS. MOLLOY: In ours it is not  
10 either.

11 And the other thing is when  
12 they're engaged by contract, yes, they could be  
13 called on in an emergency, because they are the  
14 overseer. Like, for instance, for my standing  
15 orders for epinephrine, the school doctor has to  
16 write that order. So, they do generate certain  
17 orders for us. And if there were a problem in my  
18 office, and I couldn't reach a primary physician on  
19 a student or a parent, I could try to field that  
20 call to that physician. It doesn't mean they would  
21 always be readily available to me.

22 But as a consultant basis,  
23 they're not normally there for that primary  
24 interaction, that's -- that's not encouraged. As a

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2 matter of fact, on my district Web site, it says we  
3 cannot give medical advice to the community, which  
4 I find interesting.

5 DR. HALPERT: Right.

6 DR. COOPER: Rita, I'm getting --

7 DR. HALPERT: I know you're  
8 getting --

9 DR. COOPER: -- I'm getting short  
10 of breath.

11 MS. MOLLOY: It's really an  
12 exciting topic though.

13 DR. COOPER: It is.

14 DR. HALPERT: But there's a lot  
15 more than I -- right.

16 DR. COOPER: But -- but if -- we  
17 have a lot more business to transact today. But it  
18 is very clear that this is a critical issue, and  
19 one that I'm not going to say we have neglected for  
20 far too long, but that we have neglected to utilize  
21 our opportunities for community education in the  
22 delivery of emergency care for children.

23 Now, we are the state's official  
24 advisory body on emergency medical services for

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2 children, and I think Dr. Kus has both shown us how  
3 much has been done, but in so doing shown us a  
4 glaring omission in our -- in our strategy, namely,  
5 utilization of emergency care providers to help get  
6 this epidemic under control.

7 So, here's what I'd like to do:

8 I'd like to ask Kathy Lillis to lead a working  
9 group, to come back at our next meeting, with a  
10 one-pager with half a dozen or so bullet points on  
11 it, as to what we can recommend explicitly that  
12 emergency providers do, both in the field and in  
13 the E.D., to help the statewide effort to bring  
14 this epidemic under control.

15 I'd like Dr. -- Dr. Van Der Jagt,  
16 Tim Czapranski and Rita Molloy to work with Kathy  
17 on that -- on that project.

18 And Chris, with your permission,  
19 we will ask you to serve with that group as well,  
20 so we can be sure that what we recommend is in sync  
21 with what the State Department of Health is doing.

22 And I think, based upon what  
23 comes back to our next meeting, if there is some --  
24 some simple instructional guide that we can

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2 create -- create in terms of a brochure, or a tear  
3 sheet, or something along those lines that will  
4 help with community outreach education efforts,  
5 something that could be delivered by our E.M.T.s  
6 and paramedics to families in the field, and  
7 something that perhaps could be utilized by  
8 emergency physicians and nurses in our hospitals,  
9 and by school nurses, for families maybe the same  
10 document, maybe three different versions of the  
11 same document, that to follow in the following  
12 three months, so we can come up with a real solid,  
13 not only action plan, but by March, but by June  
14 supporting documents to assist with that process.

15 Jan?

16 MS. ROGERS: I'd like to make one  
17 more comment, though, because first of all, the  
18 family has a responsibility for taking care of  
19 their child, and that's one piece that we -- we can  
20 educate them, but we can't make them do things and  
21 carry through. That's one point.

22 The second point is that when we  
23 get different players involved, we have the  
24 emergency room telling them things. We have the

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2 school nurse telling them things. We have, you  
3 know, E.M.S. telling them something. Parents are  
4 getting confusing messages from all of us, and I  
5 feel in a real dilemma in -- in my role, because I  
6 am telling parents things that the family doctor  
7 has not prescribed, and may not buy into. And so,  
8 where is the family in all of this? What do they  
9 make of all this conflicting information? The  
10 family doctor has not prescribed a long-term  
11 controller, but we are, you know.

12 So, I mean there's -- there's a  
13 lot of issues in my mind on who is responsible for  
14 giving that family a coordinated plan, like -- like  
15 you said?

16 And I don't -- I don't think it's  
17 the emergency room docs, because it has to be  
18 something that is followed up long-term, and I -- I  
19 have no problem with prescribing controller  
20 medications, especially on the basis of what Dr.  
21 Lillis said for a month, but then there has to be  
22 communication with the -- with the pediatrician to  
23 say that, "this is what we've done, and this is  
24 what we recommend." But then they have to follow

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2 through on that.

3 So, it -- there's -- there --  
4 it's all well and good to hit from all different  
5 angles, but someone has to be saying, "this is the  
6 coordinated issue," or "this is the coordinated  
7 plan for this family," or else they're getting all  
8 sorts of different view points.

9 And I think that's why families  
10 are so confused and don't know what to do, because  
11 they have too many -- too many fingers in the pot  
12 giving them little pieces. And I really believe it  
13 goes back to that primary care doctor to pull it  
14 all together, and I don't think that's always  
15 happening, but I think that's where it's got to  
16 come from, so the family has a consistent approach  
17 that they hear.

18 DR. COOPER: Jan, thank you for  
19 those comments. You are our voice of primary care  
20 at the -- at the table at the moment, and I would  
21 be delighted if you would work with the group,  
22 and -- and ensure that those thoughts are  
23 incorporated into the discussion.

24 DR. KUS: Can I just comment on

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2 that, because I mean I think that's a  
3 principle-based issue, and -- and -- and I would  
4 say from a pediatrician's point of view -- from the  
5 Academy of Pediatrics, that's the whole concept of  
6 medical home, which says the coordination is at the  
7 primary care level, and people should help  
8 facilitate it.

9 I think the issue we're dealing  
10 with it is if it does -- if it isn't realized or if  
11 it's not happening, what can other parts of the  
12 system do to help that. And I think that's -- but  
13 I -- I think the issue that you say -- that you  
14 mentioned is -- yeah, the answer should be they  
15 should be in a medical home that provides this  
16 coordination and coordinates with any care system  
17 that they've become involved in.

18 DR. HALPERT: Sometimes the  
19 medical home has an absentee parent problem.

20 MS. MOLLOY: Yes.

21 DR. HALPERT: And that's where we  
22 run into a real roadblock.

23 DR. COOPER: I --.

24 DR. HALPERT: What Rita says is

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2 correct, there's no orchestration, no coordination,  
3 and the reality of seeing this on a regular daily  
4 basis is, "hey, didn't someone ever tell you that  
5 if you have to use the rescue inhaler twice a day a  
6 day on a -- on a good day, you probably have wildly  
7 uncontrolled asthma? Didn't your primary care  
8 doctor? Do you have relationship with? Do you  
9 have insurance? You can -- you see them once or  
10 twice a year; didn't they tell you this?

11 Well, no. Well, why didn't -- I  
12 mean I know this, how come they don't know this.  
13 They're the ones who should know this more than I  
14 should know this.

15 I deal in acute episodic care.  
16 I'm the guy who stuffs the neb in your mouth, not  
17 the person to teach you how to avoid that.

18 DR. COOPER: Realized. John,  
19 thank you for reminding me that urgent care is part  
20 of the picture, so I'm going to ask you to join  
21 this group as well.

22 Tim?

23 MR. CZAPRANSKI: I'm not sure I  
24 dare.

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2 DR. COOPER: Tim? Tim, and  
3 that -- this will be the last comment because we've  
4 got to move on to other -- to other issues.

5 MR. CZAPRANSKI: When we talk  
6 about primary care, we envision primary care the  
7 way we receive primary care.

8 In the city of Rochester, primary  
9 care by pediatricians is supplied by the clinics  
10 who -- who shuffle residents through every year or  
11 two and it's a constantly changing environment for  
12 these parents and these families, and that's  
13 another issue that needs to be faced. It's not  
14 like they get their pediatrician when the kid's  
15 born and they go off when they're nineteen or  
16 twenty to college. That's not what's happening in  
17 the majority of these cases.

18 DR. COOPER: Lee, can we ask  
19 Commissioner Daines to join the work group?

20 DR. KUS: He can take my place.  
21 That's fine.

22 MS. MOLLOY: But I think --.

23 DR. COOPER: Okay. All right.  
24 Here's what we're going to do. Okay. So, again,

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2 we've got a working group. Kathy is going to lead  
3 it. Elise, John, Tim, Jan, Rita, are going to join  
4 it. You each -- Chris is going to help us staff  
5 it, and since there's about six of you each, each  
6 person gets a bullet point. Just kidding. Okay.  
7 But we want to come back -- we want to come back  
8 with -- with a working document that we can -- that  
9 we can forward to the commissioner and follow that  
10 up with whatever, you know, basic foundational  
11 templates for educational documents we think might  
12 be necessary in the next three-month period; okay?

13 And that'll be -- I think that'll  
14 be a really, really, really tremendously important  
15 contribution from this -- from this group to -- to  
16 the public health of New York State.

17 All right. Here's what we're  
18 going to do. Okay. We're going to take no more  
19 than ten minutes to get -- to get -- for everybody  
20 to get their lunch, and we're going to sit right  
21 back down, and hear Chris talk about H1N1. And in  
22 the -- in the thirty seconds he has left.

23 DR. KUS: With no questions;  
24 right?

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2 MS. MOLLOY: I wasn't going to  
3 take it anyway.

4 DR. VAN DER JAGT: Okay. Art,  
5 could I just make one -- one comment --

6 DR. COOPER: Sure.

7 DR. VAN DER JAGT: -- about  
8 this -- nothing to discuss, but just a comment. It  
9 just strikes me that maybe one of the reasons that  
10 asthma has sparked such discussion here, is that it  
11 really is a wonderful prototype, or model, for an  
12 E.M.S. disease, because it goes all the way from  
13 prevention, all the way through the entire system,  
14 and it goes full circle to rehab or does recovery.  
15 So, this might be a prototype that we could use  
16 even to look at how -- how do we manage with this  
17 Committee this kind of a situation, and with asthma  
18 it's really pretty, you know, it's -- it's so in  
19 the foreground here.

20 DR. COOPER: That was in the back  
21 of my mind in organizing this group. And let's all  
22 get our lunch, think about it, and for those of you  
23 that have additional thoughts about this problem,  
24 please be sure share them any member of the group,

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2 but especially with Kathy; okay?

3 (A recess was taken at 12:40  
4 p.m.)

5 (The meeting resumed at 12:52  
6 p.m.)

7 DR. COOPER: Everyone does have  
8 their lunch, I believe. We're missing only one or  
9 two folks. Chris Kus is on a very tight time  
10 scheduled as is Lisa McMurdo.

11 DR. KUS: Yeah. Let's move it  
12 back. Yeah.

13 DR. COOPER: So, we need to move  
14 along. So, Chris, if you would begin, I'd  
15 appreciate it.

16 DR. KUS: Sure. Asthma was  
17 supposed to be my short talk, but this -- so --  
18 okay. And -- and actually with this one, what I  
19 was going to do was really -- I -- there's --  
20 there's lots of slides, and things here, but I was  
21 going to go through some of it fairly quickly, but  
22 try to focus on things that would be most helpful  
23 to you.

24 To start out with, referring you

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2 to the -- the -- the New York State Web site and  
3 the New York City Web site, because they both put  
4 up ongoing information, and they -- there are  
5 documents that are created for various populations  
6 like child care and schools, and they coordinate  
7 well with the C.D.C. documents, so either it's a  
8 cover letter or it's there.

9 But they also give you a weekly  
10 activity report, which I think is helpful when we  
11 talk about care for kids within the context of  
12 what's going on in your community. And even going  
13 around the state realizing that the activity of  
14 H1N1 in the city is less than it had been in the  
15 spring, when you go to the western part of the  
16 state, it's going higher. So, you really need  
17 to -- to get an idea of -- of both of those places.

18 And when I looked at both of the  
19 sites today, they -- they do give you the  
20 information about activity within emergency rooms,  
21 so you have a sense of what's happening in -- in  
22 that area. The -- the most recent I have in terms  
23 of kids with regard to the rest of the state is  
24 that there have been, since March of -- of this

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2 year, there have been seven deaths in children zero  
3 to four, and fourteen deaths in children five to --  
4 to seventeen. The city has similar surveillance.  
5 I don't want to pull it out know, but -- but I  
6 think, again, that's a first place to go.

7 And one of the other things to  
8 realize is that this guidance changes frequently,  
9 so it's always good to check on what the guidance  
10 is from at -- at the Web site, and also going  
11 through the C.D.C. Web site. So -- so, this is  
12 really as of, I think, 11/25, or something like  
13 that, so -- next slide.

14 Stuff you already know, but  
15 prevention; we're talking about ACEP recommending  
16 H1N1 vaccinations to include all people six -- six  
17 months through twenty-four years of age, and  
18 household contacts and caregivers for children  
19 under six months of age. We've got both the live  
20 attenuated vaccine and the inactivated forms, and  
21 there are specific recommendations as who should  
22 not get the live attenuated -- some of the ones  
23 that you would realize -- would -- would be young  
24 children, also, somebody who has chronic disease,

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2 but we'll get more into that.

3 Next slide.

4 All medical facilities and  
5 offices should strictly adhere to infection control  
6 recommendations and the idea is that you want  
7 people who have existing indications for  
8 pneumococcal vaccinations should be vaccinated just  
9 as people should who should be getting the flu --  
10 the regular flu vaccine should be getting the  
11 regular flu vaccine.

12 DR. HALPERT: Can I stop you for  
13 a second --

14 DR. KUS: Yeah.

15 DR. HALPERT: -- and have you  
16 back up one slide?

17 DR. KUS: Sure.

18 DR. HALPERT: The question I saw  
19 flashing by the bottom, if you received the vaccine  
20 does not rule out any points of infection.

21 DR. KUS: Correct.

22 DR. HALPERT: Are you getting any  
23 sense yet about efficacy of the vaccination or is  
24 that --?

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2 DR. KUS: Yeah. I don't know of  
3 any sense that I can say.

4 DR. HALPERT: Okay.

5 DR. KUS: Yeah.

6 DR. HALPERT: Just curious.

7 DR. KUS: Uh-huh. The -- things  
8 to recommend for families is hand washing, the  
9 twenty-second use of hand washing, and the idea  
10 that alcohol-based hand sanitizers are -- if -- if  
11 no soap's available, is useful. People have  
12 already seen the idea of covering your mouth or  
13 nose with a tissue, and if you don't have a tissue,  
14 you've got all those ads about putting -- about  
15 coughing into your elbow, or into your shoulder, or  
16 anyplace except your hands.

17 Next one.

18 Right. Or your neighbor. No.  
19 Right. And these are, again -- we can go to the  
20 next one.

21 I'm going to highlight the  
22 bottom. When we -- for practical purposes, we're  
23 talking about an infection period of one day before  
24 to twenty-four hours after fever ends without the

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2 use of fever-reducing meds.

3 Next one.

4 Guidelines for daycares and  
5 schools. And the important things to recommend --  
6 to realize about this is that these are all going  
7 to be local decision making between the school  
8 system and the county health department. They're  
9 given guidance, but it really is going to be their  
10 local decision making with the idea that if you  
11 send kids home from school, or particularly from  
12 child care, you would -- you would want to make  
13 sure that they're not going to another place where  
14 there's a lot of kids, because what's the  
15 difference?

16 Not easily -- not always easy  
17 to -- to handle.

18 Next one.

19 FROM THE FLOOR: Next slide.

20 DR. KUS: Okay. Influenza  
21 symptoms in infants and young children. Usually  
22 the same symptoms between H1N1 and seasonal  
23 influenza. Also, if you're -- people talk about  
24 influenza-like illnesses having similar symptoms.

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2 One of the real things to talk about is that in --  
3 in young children, it's less likely to have typical  
4 influenza symptoms, so it's actually the child that  
5 could have H1N1 who doesn't have a fever and may  
6 not have a cough.

7 Next one.

8 How about older children?

9 The whole range of symptoms, and  
10 they're highlighting here that muscle pain,  
11 fatigue, diarrhea or vomiting seem to be something  
12 we're seeing more with H1N1. Again, this is  
13 general responses.

14 Next one.

15 This -- this to me is -- well --  
16 well, actually, this is the -- the idea is what --  
17 what are some of the symptoms and signs that you're  
18 going to see when children are progressing, and  
19 that there need to be -- you really need to take  
20 seriously, and -- and the -- indicating urgent  
21 medical attention, are fast breathing or troubled  
22 breathing, bluish or gray skin color, refusing to  
23 drink, severe vomiting, too irritable to -- to be  
24 held, and then the idea that you've had flu

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2 symptoms that improve, but then they're returning  
3 with fever and -- and worsening cough and rash on  
4 top of it.

5 And the -- the bottom part says  
6 the -- and this gets into the guidance -- parents,  
7 especially parents of infants and children known to  
8 be at higher risk for influenza complications,  
9 should be aware of this and vigilant watching for  
10 these warning symptoms -- signs. They're also the  
11 ones that, if you're considered high risk -- and  
12 we'll get into that -- that the -- the information  
13 given to the family is that you are the ones that  
14 should go talk to your doctor, go to the emergency  
15 room if things are more -- as opposed to the  
16 recommendation that if it's a mild disease you  
17 don't do that, because they're the ones that have  
18 more -- that have more risk for -- for the severe  
19 complications.

20 Next one.

21 This is the same kind of slides  
22 saying atypical presentations may occur such as  
23 just emphasizing that without fever.

24 This is the list here about



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2 this category to talk to their doctor ahead of time  
3 in terms of the treatment. And in fact, some  
4 primary care docs would give them some antiviral  
5 prescription ahead of time if they were really  
6 concerned. So, it's almost like coming up with  
7 a -- with a flu plan for kids who have a chronic  
8 disease.

9 DR. COOPER: Have we seen any  
10 Reye's syndrome?

11 DR. KUS: Not that I know of.

12 Otherwise healthy children.

13 Let's see, now, this is -- it's saying sixty-seven  
14 percent of children who died with 2001 H1N1 had at  
15 least one high-risk medical condition, and among  
16 these children, greater than ninety percent had  
17 neurodevelopmental conditions. I think it's less  
18 than this now. This really is -- is put out by  
19 the -- the study that C.D.C. did on a limited  
20 base -- basis of whatever -- I think it was  
21 forty-seven kids that they had. And so -- and I  
22 think when you -- when we look at our -- our  
23 information, that message that if you don't have a  
24 chronic disease you're -- you're home free is not

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2 the case. There are kids that have been -- that --  
3 that died of H1N1 who have -- who don't seem to  
4 have a specific chronic condition.

5 And -- and that's -- this -- this  
6 gets into the idea of don't delay antiviral  
7 treatment pending lab results, rapid tests and  
8 particular frequently provide false negatives.

9 Next one.

10 Diagnostic testing. Just quickly  
11 over that that. The -- the types of tests are  
12 the -- the rapid diagnostic test, the viral  
13 culture, the direct immunofluorescent assay, and --  
14 and the nucleic acid amplification tests.

15 Next one.

16 This kind of gives you a summary  
17 of what we're -- what -- what it is, is that it  
18 generally if -- if you get a positive it's  
19 probably -- it's -- it's highly specific, but the  
20 sensitivity is not there, and they're -- it's also  
21 important to realize which ones you can actually  
22 get a sense that it's H1N1 as opposed to not, which  
23 is viral culture with additional testing and the  
24 assay.

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2 Go to the next one.

3 Okay. Here's -- yeah, this is  
4 the one that gets into why test for influenza?  
5 Which is really testing if it will influence  
6 clinical management. So, if you've got an unusual  
7 clinical presentation, and you -- that may be one  
8 way to clarify it, if it impacts decisions about  
9 other diagnostic tests, it may guide the selection  
10 of an antiviral -- and -- and when we get into the  
11 medications, the difference about that. It  
12 reinforces antiviral prophylactic decisions,  
13 especially in sensitive situations. It could  
14 affect antibiotic treatment, and then depending on  
15 what is happening in terms of public health  
16 surveillance, again, the testing is really mostly  
17 being done in hospitalized patients, and our  
18 surveillance is really looking at what we're seeing  
19 in -- in terms of influenza-like illnesses.

20 Next one.

21 DR. VAN DER JAGT: We also test  
22 for cohorting reasons in hospitals.

23 DR. KUS: You do? Okay.

24 DR. VAN DER JAGT: And that's

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2 another reason for the influenza, they can cohort  
3 like with --.

4 DR. KUS: Got you. Okay.

5 Just -- there's a lot of slides on the medication,  
6 but I -- I think I'll just go through a few of  
7 them. The idea that we're talking about amantadine  
8 for influenza A, and the -- the neuraminidase  
9 inhibitors, important because the amantadine is not  
10 useful in terms of H1N1. That's why you would go  
11 into using Tamiflu and Relenza.

12 Next one.

13 As of October 2009, circulating  
14 H1N1 is resistant to the drugs. This gives you  
15 a -- the side effects.

16 Next one.

17 Next one.

18 Okay. Tamiflu. It goes into the  
19 idea of what dosages that you have, and the idea  
20 for kids is really putting it in terms of  
21 milligrams that your -- your prescription, because  
22 they will be using different suspensions at the  
23 pharmacy, and it talks about the emergency use  
24 authorization for children less than one -- one

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2 year, of Tamiflu.

3 Next one.

4 Just talks about common side  
5 effects.

6 Next one.

7 Relenza. Orally inhaled. So,  
8 we're talking about treatment of the influenza for  
9 greater than seven years of age, and prevention of  
10 influenza for ages greater than five.

11 Next one.

12 Talks about the dosage of it.

13 Next one.

14 The main thing I wanted to say on  
15 this -- I guess the -- the part that the powder is  
16 not recommended for use in any nebulizer or  
17 mechanical ventilator.

18 Next one.

19 This is the intravenous  
20 treatment, and the F.D.A. has issued an emergency  
21 use authorization to allow use of I.V. to treat  
22 certain hospitalized and critically ill patients.  
23 And then, it talks about which one is not  
24 responding to either the oral or inhaled antiviral,

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2 and that you need to request that from the C.D.C.

3 Next one.

4 DR. LILLIS: Just one comment  
5 about that. When you have a critically ill child  
6 it's very -- you have to request it specifically,  
7 and do you have any idea what the time delay is,  
8 and whether it --?

9 DR. KUS: I -- I don't, although  
10 I think the way C.D.C., the interactions I've had,  
11 it's I would think it's very quick because they've  
12 been very reachable, at least in -- in my part.  
13 But I don't know the answer.

14 DR. VAN DER JAGT: I think it's  
15 next day.

16 DR. KUS: Is it?

17 DR. VAN DER JAGT: In -- in terms  
18 of --.

19 DR. KUS: That was --

20 DR. LILLIS: We had a situation  
21 where we had a --

22 MS. MOLLOY: Talk to a  
23 microphone.

24 DR. LILLIS: -- critically ill

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2 child at a community hospital that we were trying  
3 to -- to transport to our facility, and the  
4 community hospital couldn't get it, and we -- we  
5 were trying to -- to figure out -- we called the  
6 C.D.C. and they basically referred us to their Web  
7 site and there wasn't anything.

8 DR. KUS: Oh.

9 DR. LILLIS: The child actually  
10 ended up dying at the community hospital before we  
11 could get it, and it probably has no point in an  
12 emergency resuscitation, but it was -- we were --  
13 it was the kind of thing where we were trying to do  
14 everything we could think of --

15 DR. KUS: Right. Right.

16 DR. LILLIS: -- and it was  
17 frustrating not to -- to have a form of a drug that  
18 you could give them when you were suspecting it was  
19 H1N1, and you couldn't give the -- the treatment --

20 DR. KUS: Right. Right.

21 DR. LILLIS: -- quickly.

22 DR. KUS: I'll take that back to  
23 our group, but I don't -- I don't have much --  
24 anything else.

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2 DR. COOPER: Elise and Bob, do  
3 you have any experience using it?

4 DR. VAN DER JAGT: Not really.  
5 We haven't given -- I felt for -- from flu, but we  
6 don't -- we never used that.

7 DR. COOPER: Bob?

8 DR. KANTER: We were about to,  
9 and then it became not necessary, but it should be  
10 rapidly available if you have the right contact at  
11 the C.D.C.

12 DR. COOPER: And who's the right  
13 contact?

14 DR. KUS: Yeah. That's right.

15 DR. KANTER: A variety of people.

16 DR. KUS: That's right.

17 DR. LILLIS: Bob, in -- in your  
18 experience were you using the oral -- were you  
19 using Tamiflu orally (off-mic) anything like  
20 that --.

21 DR. KANTER: Yes. Yeah. For all  
22 the patients. Yes. Yes.

23 DR. LILLIS: And you're intubated  
24 then later (off-mic).

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2 DR. KANTER: If we -- if we think  
3 their G.I. tract is working, the one kid where we  
4 considered it, that was an issue.

5 DR. HALPERT: I wonder if it's  
6 possible for this group to go track down that  
7 contact and disseminate that, because obviously  
8 other people are going to have the same questions  
9 you have.

10 DR. KUS: Okay. I can -- I can  
11 follow up with C.D.C. on that and see if I can  
12 get -- and our folks with -- with experiencing --  
13 yeah.

14 DR. COOPER: Thanks, Chris.  
15 That'll be great.

16 DR. KUS: Yeah. Yeah. But I  
17 know -- I mean the person who does the pediatric  
18 one I -- is -- I -- I know her well, and I'll  
19 contact see if she's got a -- what's been the  
20 experience.

21 These are specifically revised  
22 antiviral recommendations for children, basic  
23 support, the idea of -- of using antiviral  
24 authorized for children less than one through

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2 the -- the emergency usage one.

3 Next one.

4 So -- so, then you get into the  
5 idea of antiviral treatment really recommend --  
6 recommended for children who are -- fall within the  
7 high-risk category. So, children under two years  
8 of age, and that it -- children who have severe  
9 illness or evidence of clinical deterioration,  
10 symptoms of lower respiratory tract involvement, or  
11 illness requiring hospitalization.

12 Like always, use clinical  
13 judgment.

14 Next one.

15 And -- and this is the one in  
16 terms of primary care docs and also giving the  
17 advice to families about children with milder  
18 illness that it's not generally recommended to use  
19 antivirals with mild illness if they are not at  
20 high risk for the complications. You're really  
21 trying to give the message to the primary care docs  
22 to educate families that -- as to when to -- to go  
23 the emergency room, when to use the healthcare  
24 system, particularly in -- in -- in kids that

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2 aren't high -- I mean in kids that aren't at high  
3 risk. And that the idea that you are -- that there  
4 that you may consider prescribing antiviral  
5 medications if indicated for -- with -- with the  
6 office visit, giving them the idea that if things  
7 worsen contacting them and checking them in  
8 twenty-four hours.

9 And the -- the importance --  
10 the -- you know, the issue is that it's best -- the  
11 antiviral treatment at least it's been reported to  
12 be most effective within the first forty-eight  
13 hours of illness or onset. So, that kind of gets  
14 into the idea of a sick kid, and waiting some time  
15 for giving it.

16 Next one.

17 The idea of ensuring -- again,  
18 if -- if a child is at high risk, that they have --  
19 the -- the plan is to how they're going to get  
20 contact their doc, and how they're going to get  
21 medication or clinical evaluation if you need to.

22 Next one.

23 This talks about the dosage of  
24 it. And these are specific dosages for kids under

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2 one year of age, again saying that you're really  
3 prescribing it via milligrams for -- for children.

4 Next one.

5 This talks about actually  
6 specific -- the idea that since you're -- you're  
7 doing that by milligram it may be in a suspension  
8 that you want to take out the oral dosages  
9 dispenser there, and -- and give them an oral  
10 syringe, because you want that measured in a  
11 smaller dose.

12 Okay. Next one.

13 Alternatives to Tamiflu. We're  
14 talking about the compounded suspension, and they  
15 give you a couple of alternatives here.

16 Next one.

17 And then, the -- again, the big  
18 emphasis is to ensure proper dosing prescribed  
19 using product name and concentration. If  
20 prescribing in milliliters or teaspoons, or  
21 prescribed dose in milligrams. This gives you the  
22 Tamiflu dosage that's recommended.

23 Next one.

24 The Relenza. Not approved for

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2 kids greater than -- let's see -- no approved  
3 indication. Okay. So, it's really talking about  
4 over seven years of age.

5 Next one.

6 And I guess this is that staying  
7 in contact with the information you have in your  
8 community that you're using the date --  
9 surveillance data that's provided, so you can  
10 decide what you think you'll be treating, so you  
11 can provide the best medication related to that.

12 And next one.

13 This talks -- if you -- if you do  
14 get the R.E.D.T. result, what you can do in terms  
15 of how it can affect making your decision in terms  
16 of treating.

17 Next one.

18 And this again gets into the idea  
19 is if it's positive then you're sure you're dealing  
20 with -- with a -- a flu virus, but if it's negative  
21 you can't -- you can't really rule out that it's --  
22 that it's not influenza.

23 Next one.

24 What about prophylaxis?

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2 And it -- it -- it says can be  
3 considered for high-risk persons who had close  
4 contact with a person with influenza. Contact  
5 during their -- a person's infectious period. So,  
6 again, if -- if kids fall in that high-risk  
7 category and there's evidence that they've come in  
8 contact, you would -- you could consider  
9 prophylaxis. If you're going to do that, you want  
10 to do it early, and its duration is ten days  
11 following last exposure.

12 Next one.

13 In terms of the choice of the  
14 antiviral medication, you know, you want a  
15 medication that you think is most effective of what  
16 you think the influenza strain is going to be, and  
17 then this also talks about what -- what your --  
18 what you know about your area.

19 Next.

20 This gets back to the idea that a  
21 history of a recent 2009 H1N1 or seasonal influenza  
22 vaccine does not rule out an influenza infection.  
23 So, just because they had it, if you got the -- the  
24 symptoms, you really, really want to treat it the

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2 way you would otherwise.

3 Next.

4 What happens in terms of schools,  
5 camps, daycare, it's not really recommended to  
6 offer the prophylaxis to all persons potentially  
7 exposed. You would consider it if one of the -- if  
8 the people fall in the high-risk categories.

9 Next one.

10 Just to give you the idea about  
11 what recommendations are given for breastfeeding,  
12 the idea is that you want -- if somebody is sick  
13 with H1N1, you want them to consider -- continue  
14 breastfeeding, but it would be the -- the --  
15 express the breast milk, and it would be given by a  
16 healthy caregiver, and then the mom can resume  
17 contact with the baby and direct feeding after  
18 afebrile for twenty-four hours or antiviral for  
19 forty-eight hours.

20 This gets into some special  
21 considerations.

22 The bacterial community-acquired  
23 pneumonia, realizing that H1N1 and other flu  
24 predisposes you to that. So, you want to consider

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2 that this could be a -- on -- on top of the flu,  
3 you've got a bacterial infection. The idea that in  
4 treating fever, any products that could contain  
5 aspirin or -- or -- should not be used, and the --  
6 to recommend, since again we're talking about  
7 fever, the idea of using over-the-counter cold  
8 medications under four. There's already been the  
9 recommendation not to use that, but this enhances  
10 that.

11 Next one.

12 Well, if you get the live  
13 vaccine, let's see -- and the -- it's -- it's --  
14 it's really saying if you -- if you get that and  
15 then if you take antiviral medication, within two  
16 weeks of receiving that, it could affect the uptake  
17 of that vaccine, the response to it.

18 Okay. Let me just look which  
19 ones these are. This is just general.

20 Next one.

21 What about egg allergy?

22 And it really -- the -- the  
23 message is that you should be getting the history  
24 about the egg allergy. If it's a local allergy,

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2 then you really want -- you -- you -- you can  
3 administer the vaccine, and then -- and if you're  
4 really talking to -- in a circumstance that it --  
5 the child's doing worse, that you want to -- you --  
6 you can also do it as -- in a controlled situation.

7 Next one.

8 The Australia experience. It's  
9 not much different. Again, highlighting that  
10 you've got to consider it -- the diagnosis in any  
11 child with fever as well as any unwell child  
12 without fever.

13 Next one.

14 Hospitalizations. Well, we'll  
15 tie it into asthma. Asthma is a significant risk  
16 factor for severe disease unrelated to -- unrelated  
17 to the severity of asthma.

18 Next one.

19 One of the complications can be  
20 benign acute childhood myocitis. It's transient  
21 condition, recovery within one week. It occurs at  
22 the convalescent phase, and it's got that -- it --  
23 the difficulty in walking, severe bilateral calf  
24 pain, elevated enzymes, but the idea is that

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2 this -- you recover from this, so at least if you  
3 know about that diagnosis you can -- if -- if  
4 you're considering it, then you can prevent other  
5 investigations or interventions, and give in -- you  
6 know, it's helpful to say to the parent this --  
7 they're going to get over this part.

8 Next one.

9 This is just referring to a trial  
10 using a macrolide antibiotic where the combination  
11 with one of the other antivirals seem to do a  
12 little bit better. It boosted production of the  
13 mucosal I.G.A. against influenza virus.

14 Next one.

15 Summary.

16 Okay. So, factors affecting  
17 decisions. The severity of influenza illness.  
18 Most children don't need antiviral medications.  
19 The child's or adolescent's clinical presentation,  
20 underlying risk factors for influenza-related  
21 complications and -- and death and clinical  
22 judgment. So, if you're in a risk -- if you're  
23 clear it's in a risk category, they're treated  
24 differently, and the advice to parents is treated

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2 differently.

3 Next one.

4 Educate your patients and -- and  
5 their parents. This one is geared to pediatricians  
6 and family practitioners. How to reduce risk of --  
7 of influenza, how to care for someone who is ill at  
8 home, and the -- and one of the big things is  
9 really when you're sick in this situation, stay at  
10 home, and -- and when to call your healthcare  
11 provider.

12 Next one.

13 Key points. We've gone over most  
14 of this. The idea that the diagnostic testing has  
15 limitations; that healthy patients don't usually  
16 require treatment; and that -- if, again, if you're  
17 high risk you would want to consider prophylaxis.

18 Next one.

19 That's it?

20 DR. COOPER: Thank you, Dr. Kus.

21 Questions?

22 Dr. Lillis?

23 DR. LILLIS: Just a few comments.

24 In -- I think our area was particularly hard hit

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2 with some severe cases. We had at least five  
3 children who died at our hospital, and probably  
4 another --

5 DR. COOPER: Which -- which  
6 hospital is that?

7 DR. LILLIS: Women and Children's  
8 in Buffalo.

9 DR. COOPER: Okay.

10 DR. LILLIS: And I think probably  
11 another two in the community that didn't make it to  
12 our -- to our hospital, but my understanding is  
13 that none of those children had any underlying  
14 medical conditions, which is pretty scary when all  
15 the recommendations are really trying to identify  
16 the high-risk kids.

17 The other comment is, I know the  
18 five that were at our facility that passed away  
19 were MRSA positive, I didn't know if you have any  
20 comments about that. It was suspected that they  
21 were colonized with MRSA, and that when they came  
22 in, that perhaps the H1N1 affected their immune  
23 system, and then the combination of the H1N1 and  
24 MRSA were -- were too much. But we're -- and we're

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2 doing some studies on testing kids who -- who came  
3 in with suspected H1N1, and -- and whether or not  
4 they were colonized with -- with MRSA. But --

5 DR. KUS: So, that was how many  
6 kids you had; you had five you say?

7 DR. LILLIS: I -- we had two last  
8 season, and then at least three this season, and I  
9 believe two more that didn't -- that didn't get to  
10 make it to -- to Women and Children's.

11 DR. KUS: Okay.

12 DR. LILLIS: But all previously  
13 healthy with no underlying medical conditions.

14 DR. KUS: I don't know anything  
15 about that part of it, so I'll go back to our epi  
16 folks to see if there's anything that they might  
17 respond. But -- so they -- they had H1N1 and were  
18 colonized with MRSA?

19 DR. LILLIS: Well, you know,  
20 you -- you never know what they --

21 DR. KUS: Yeah.

22 DR. LILLIS: were when they came  
23 in --

24 DR. KUS: Yes.

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2 DR. LILLIS: -- but most -- most  
3 of them succumbed pretty quickly, and it was clear  
4 with -- within the first six hours that they  
5 weren't going to make it. They came in very sick.

6 And that was my other comment is  
7 we were surprised at how well they managed at home,  
8 and then there was suddenly an acute deterioration,  
9 and I did not know if other people across the  
10 state, but we had one -- one girl who walked in,  
11 and then was intubated within an hour, and then she  
12 just had total pus coming out of the E.T. tube as  
13 soon as she was intubated --

14 DR. KUS: Wow.

15 DR. LILLIS: -- and -- and pretty  
16 much within a few hours had succumbed to the -- the  
17 disease. And I was just impressed with how they --  
18 they managed at home, until they got to the point  
19 where they were so -- so ill that there -- that  
20 there wasn't much you -- you could do, and -- and  
21 that is also kind of scary from a public health  
22 standpoint.

23 It wasn't a gradual  
24 deterioration. And seeing such large numbers of

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2 patients, if you had seen those particular patients  
3 earlier in the course, you wouldn't have been able  
4 to identify that they were any -- that they were  
5 going to be the ones that developed the severe  
6 disease.

7 DR. KUS: Right.

8 DR. COOPER: Dr. Van Der Jagt?

9 DR. VAN DER JAGT: Very  
10 similarly, Kathy, was the -- we had one patient  
11 that presented exactly like that, who's currently  
12 still on ECMO. That patient was also MRSA  
13 positive. That's very interesting.

14 DR. LILLIS: It is interesting.

15 DR. VAN DER JAGT: And  
16 presented -- it was a transport patient, outlying  
17 hospital, very rapid over about six hours. In  
18 fact, between the two-hour transport that the kid  
19 was there on basically fifty percent O2 came to us,  
20 walked into the unit -- well, didn't walk in the  
21 unit -- came into the unit, and within five minutes  
22 was intubated, and within four hours after that was  
23 on ECMO. That's how rapid it is was. So, very  
24 similar to your experience in Buffalo. MRSA

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2 positive, too.

3 DR. KUS: Uh-huh.

4 DR. COOPER: Other comments?

5 MS. ROGERS: I have a question.

6 What is the expectation? H1N1 seems to be  
7 decreasing in our area, and what is the expectation  
8 for the future? Are we expecting another wave, or  
9 do you know?

10 FROM THE FLOOR: Seasonal flu is  
11 upcoming.

12 MS. ROGERS: I know seasonal flu  
13 is coming.

14 DR. KUS: Yeah. Yeah. I mean I  
15 guess the -- good parts, although I -- I -- I first  
16 wanted to responded to that one where healthy kids  
17 are dying from this, and I'm real interested to see  
18 what happens in terms of -- of the immunization  
19 rates of kids, because even with that kind of  
20 thing, the thing that's out there, people are  
21 not -- kids aren't getting as immunized as you  
22 would hope that they would -- would be, and you  
23 know, that -- that idea that you -- you can't use  
24 the -- the message has got to be if you're under

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2 twenty-four you get immunized. I mean that's --  
3 and -- and then I hear the responses about why you  
4 won't want to immunize, and I can't understand it.  
5 It's very hard to understand what the reasoning  
6 behind it is.

7 But the other part -- I guess  
8 the -- the -- the good part, it looks like the  
9 virulence is -- may be less than we expected, and  
10 looking good. And I think the question is whether  
11 this will mutate? And I don't know the answer  
12 to -- to those things. And I don't know what  
13 happens after that.

14 The other part is that they --  
15 they've just approved the -- the -- I think it's  
16 the fourteen valents vaccine for -- for kids for --  
17 for flu. So, that will be -- whether that makes  
18 any difference, I don't know. So, I don't -- I --  
19 I can't tell you that part.

20 DR. LILLIS: I -- I had read one  
21 report on two -- two girls who had attended a  
22 summer camp where one person came down with it, and  
23 they prophylaxed the whole camp, and then these two  
24 girls who had been prophylaxed, developed the

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2 disease, and both of them passed away and they  
3 were -- they were anticipating that it had been  
4 that they had actually -- there was a development  
5 in the resistance in there, and I would -- and it's  
6 the only case report that I had seen, but I didn't  
7 know if you could comment on resistance to -- to  
8 the antivirals or if you're aware of anything else.

9 DR. KUS: I -- I haven't seen it.  
10 I mean I -- I went to the C.D.C. site yesterday too  
11 to look for some of the stuff, but I haven't seen  
12 it, and I haven't seen it in our regular reports.  
13 We get a weekly report about the different  
14 conditions in there, and that's not been there,  
15 so --.

16 MS. MOLLOY: One question that I  
17 have, and I know that Dr. Halpert alluded to that  
18 when the slide was there, but I -- I've been  
19 reading a lot of reports about how fragile the  
20 vaccine is, and the handling of it, how imperative  
21 it is for the cold chain to be, you know,  
22 maintained, and I, particularly in order to find a  
23 dose for myself, because my primary care provider  
24 doesn't have confidence in the vaccine, so she's

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2 not ordering it, in order to go, I had to go to an  
3 unmasked clinic.

4 And the way in which they were  
5 distributing the vaccine was, you know, a little  
6 alarming, because they did have a lot of  
7 predrawn-up medication that's just sitting there on  
8 a table. They did not have gloves on when they  
9 gave the vaccinations. They're giving you cards,  
10 barcoded, telling you to maintain them for a year,  
11 which, you know, I've never had given to me when I  
12 received any other vaccine.

13 So, a couple of curiosities would  
14 be, you know, why are they doing that? Number one.

15 Number two, who's doing a study  
16 to see the efficacy of, you know, the vaccination  
17 over time? You know, we're going to, how are we  
18 going to monitor whether or not this is working,  
19 because how are we going to know if it's really  
20 preventing anything, and if it evolves, whether or  
21 not it's because we had failure already from the  
22 vaccine, or whether or not it's because, you know,  
23 the disease, itself, is evolving and changing to  
24 not be, you know, particular to the vaccination.

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2 DR. KUS: Uh-huh.

3 DR. LILLIS: And you know, I have  
4 concerns because, you know, there is an idea  
5 that -- when I read that other slide, it says just  
6 because you've had the vaccination doesn't mean to  
7 rule out that you've had --

8 DR. KUS: Right. Right.

9 DR. LILLIS: -- that you indeed  
10 have the flu.

11 Just like -- I saw that with  
12 chickenpox, you know -- you know, in my population.  
13 It was a fragile vaccine. A lot of children were  
14 vaccinated with one dose. Many of them had maybe  
15 a -- a smaller case of, you know, pox, but they  
16 definitely had chicken pox. And I -- I would see  
17 these outcroppings of them regularly. So, just --  
18 you know.

19 DR. KUS: So, those big  
20 questions, I -- I would suspect -- and I -- and  
21 I -- and I will have to go back and see, but if --  
22 I mean if we're doing any study like that, it would  
23 have to be C.D.C. doing it in several population  
24 areas. But then it's really going to depend on --

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2 I mean it sounds like the clinic that you're  
3 talking about wasn't -- wasn't using good practice.  
4 So, then that takes -- bets -- all bets are off  
5 when you start doing -- doing that.

6 So, I think in that sense you  
7 really have to be knowledgeable about that, and if  
8 somebody is not doing the -- I mean part of what  
9 our guidance out to local health departments, each  
10 of these, you know, the vaccines are really have  
11 been given to physicians and local health  
12 departments and other places, and they were  
13 registered here with the idea of giving them in --  
14 in good clinical -- using good clinical practice.

15 DR. LILLIS: But when you see  
16 people lining up at libraries and when you see it  
17 on the news these people, you know, they're wrapped  
18 around the block, in order to accommodate the large  
19 numbers of people that they're seeing, this is the,  
20 you know, practice that they've taken on. And I'm  
21 sure it's going on all over the place in that  
22 fashion, I would imagine --.

23 DR. KUS: Well, there -- I mean  
24 there are practices for doing mass immunizations,

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2 which we do -- we do here. And that's different.

3 I mean that's -- when I was a kid you took the  
4 little sugar pill and --

5 DR. LILLIS: Different than what  
6 I have.

7 DR. KUS: -- you went to school  
8 and all that kind of stuff. But -- and -- and  
9 that's appropriate in the sense that we were, you  
10 know, to try to get that many kids immunized.  
11 The -- I -- I -- I -- you know, they are -- there's  
12 guidance about how to do that, so I don't know what  
13 other recourse I can give you on that one.

14 But I will look -- I'll -- I'll  
15 talk with C.D.C. and ask them about that --  
16 those -- you know, the questions about how do you  
17 answer those -- the questions about the  
18 effectiveness and -- and so.

19 MR. CZAPRANSKI: The -- the  
20 question you had about the bar coding; public  
21 health clinics run by the county are required, by  
22 federal statute, to do that, so if you go to your  
23 physician and get your vaccine, it's not required,  
24 but if you go to a clinic that's got any

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2 association with a county health department,  
3 they're required to do those things. So, that's  
4 sort of the requirement in there.

5 MS. MOLLOY: Nobody knew the  
6 answer when I asked there, so --.

7 MR. CZAPRANSKI: Yeah. And the  
8 other thing is a lot of the shipments, they come  
9 already predrawn up in syringes. So, sometimes  
10 they're multidose vials, and sometimes they're  
11 already preloaded, depending on how they're shipped  
12 to you.

13 DR. COOPER: Ruth?

14 MS. WALDEN: He just answered  
15 what I was going to say. The -- the vials are  
16 shipped predrawn, and that's how the doctors or the  
17 clinics are ordering them.

18 DR. HALPERT: As a note of  
19 information, at my -- in my office itself, we  
20 ordered a thousand doses of ingestible and received  
21 twenty doses of nasal. I just want to put that out  
22 there. We were happy.

23 MS. WALDEN: Only in the Health  
24 Department.

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2 DR. HALPERT: We were happy.

3 DR. COOPER: Thank you, John.  
4 Elise?

5 DR. HALPERT: Good idea.

6 DR. VAN DER JAGT: I just have a  
7 question again relating to prevention and the  
8 E.M.S. provider. What are the recommendations for  
9 use of masks, and what is -- you know, what is the,  
10 you know, these E.M.S. providers are probably  
11 exposed a lot to this particular virus, or any flu  
12 virus, so are there recommendations that you have  
13 for them, and maybe Lee would like to talk about  
14 that a little bit, too. I don't know -- I just  
15 think it's something that needs to be addressed.

16 DR. KUS: I don't know the answer  
17 to -- to that one, but -- so, there we'll go.

18 DR. COOPER: Lee knows the  
19 answer.

20 DR. KUS: Oh, good.

21 MS. BURNS: Actually, the C.D.C.  
22 recommends N95s for patient care providers who are  
23 treating patients with flu-like symptoms. The  
24 Health Department has said that surgical masks are

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2 adequate. There's a -- there's a lot of -- of  
3 conversation at the local level. Some localities  
4 believe that they would just as soon err on the  
5 side of being conservative and use N95s. The N95s  
6 require fit testing.

7 One of the things that Jim Soto  
8 in -- in our office is -- is traveling around and  
9 is offering train-the-trainer fit testing programs,  
10 because prehospital care providers at the service  
11 level are not -- they don't have easy access to fit  
12 testing, or it's not available to them locally, so  
13 this, through a HRSA grant and our disaster  
14 preparedness folks, Jim is setting forth with fit  
15 testing kits and train-the-trainer programs in an  
16 effort to boost the ability for our prehospital  
17 care providers to be fit tested.

18 So, there is -- really the answer  
19 to your question is the C.D.C. guideline is N95s,  
20 state Health Department has said surgical masks.

21 DR. VAN DER JAGT: And how well  
22 are they following those regulations?

23 MS. BURNS: That's a very good  
24 question. I -- I think -- honestly, they don't

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2 want to be -- they don't want to be exposed, and  
3 they don't want to -- certainly don't want to take  
4 it home to their family.

5 DR. VAN DER JAGT: Right.

6 MS. BURNS: In -- in -- the -- in  
7 the Upstate environment particularly, if they're --  
8 if they are exposed and ill or their family is ill,  
9 they'll be out of work, and -- and in spite of the  
10 initial pushback to the mandatory flu injections  
11 that we had people driving around with cars, you  
12 know, complaining that their civil rights were  
13 being violated.

14 DR. VAN DER JAGT: Right.

15 MS. BURNS: But again, primarily,  
16 they -- they can't afford to be out of work, and  
17 they certainly don't want to expose their families.  
18 So, it -- it's -- anecdotally, I understand that  
19 it -- you know, it's fairly well adhered to, but I  
20 don't know.

21 DR. VAN DER JAGT: And most of  
22 them you think are -- are getting immunized? I  
23 mean --

24 MS. BURNS: That's a --

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2 DR. VAN DER JAGT: -- that's the  
3 preventive -- I mean --

4 MS. BURNS: Well, I can tell you  
5 I'm -- in Saratoga County they offered flu vaccines  
6 for emergency services, so police, fire and E.M.S.  
7 It was very well attended. Albany --.

8 DR. VAN DER JAGT: H1N1 though?  
9 I mean -- yeah.

10 MS. BURNS: Yes. Yeah. Both --  
11 both seasonal flu and H1N1.

12 DR. VAN DER JAGT: And H1N1.  
13 Yeah.

14 MS. BURNS: And Albany County  
15 just did one for, you know, E.M.S. and -- and  
16 emergency services.

17 Why are you looking like that?

18 DR. HALPERT: I didn't hear about  
19 it.

20 MS. BURNS: Oh, you're not on Tim  
21 Rabley's (phonetic spelling) list.

22 DR. HALPERT: I think I am.

23 MS. BURNS: Yes, you are. And --  
24 and they had -- it may have been seasonal, but I

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2 believe it also offered H1N1 at a separate time.

3 DR. HALPERT: Five weeks --?

4 MS. MOLLOY: Yeah, that's H1N1.

5 DR. HALPERT: That was not for  
6 emergency services. That was general.

7 MS. BURNS: They've --

8 MS. MOLLOY: That is the general.

9 MS. BURNS: -- they've been well  
10 attended.

11 MS. MOLLOY: That was the  
12 general.

13 DR. HALPERT: Now, in my -- in  
14 my -- I'm sorry to deduct on that, but we did put  
15 up, through my office, at cost, for uninsured  
16 emergency services workers who could provide any  
17 kind of valid I.D., you know, like a fifteen-dollar  
18 flu shot essentially. Now, we were going to throw  
19 into that the H1N1, but we couldn't get any, as I  
20 said. But we did put up -- we backed about a  
21 thousand doses, of which we administered at least a  
22 hundred coming in.

23 FROM THE FLOOR: Uh-huh.

24 DR. HALPERT: So, that was okay.

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2 FROM THE FLOOR: Uh-huh.

3 MS. MOLLOY: You know when we  
4 first talked about this, and Ed -- Ed Wronski was  
5 at the table, I did mention that, you know, since  
6 school nurses really will be seeing the sick  
7 children at school and identifying it, that  
8 somebody should think about having doses available  
9 for school nurses. And I've never seen any  
10 mechanism put into place to where anyone has  
11 secured doses, and you know, our school doctors are  
12 not doing that, because most of us are not PODs,  
13 most of us are not doing, you know, on-site, you  
14 know, inoculations of people, and I had to take a  
15 day off from work. I had to take a sick day, and  
16 go to like I said a mass clinic that I had to  
17 secure an appointment for, you know, a block  
18 appointment, which was basically all day. It was  
19 the middle of the afternoon, so I -- I -- there was  
20 no way that I could just, you know, slip out on a  
21 lunch break, which is never covered anyhow. So,  
22 okay, you know --.

23 DR. KUS: Let's -- I mean --  
24 because, I mean, on our Web site it talks about

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2 where you can immunizations, and -- and as a school  
3 nurse you would fit in the category who would be --  
4 should be able to get an immunization there. So, I  
5 don't think there was anything specific as you said  
6 for school nurses.

7 MS. MOLLOY: Right. But that  
8 means -- as I said, taking a day off from my --

9 DR. KUS: Right.

10 MS. MOLLOY: -- employment, which  
11 I had to do, because my appointment was oh, between  
12 eleven and twelve, and I was there from eleven to  
13 two.

14 DR. KUS: Right.

15 MS. MOLLOY: So, that's  
16 basically, you know, your day is shot. I had to  
17 drive three towns over from where I work in order  
18 to get it. So -- but I did that because I felt,  
19 you know, -- I felt compelled to do that, but --.

20 DR. KUS: The other -- the other  
21 thing that's important to know is actually the  
22 other immunization -- the immunization clinics and  
23 things like that are all county health department's  
24 decision about how they want to do that. They're

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2 given advice with that, but that's --.

3 MS. MOLLOY: I mean they took me  
4 once I told them what my category was --

5 DR. KUS: Yes.

6 MS. MOLLOY: -- they were, you  
7 know, willing to give me an appointment. The  
8 other --.

9 MR. CZAPRANSKI: I think, I mean  
10 like our county health department pushes out to the  
11 school-based clinics, and --

12 MS. MOLLOY: We don't have  
13 school-based clinics.

14 MR. CZAPRANSKI: -- and it's RNs  
15 and the physicians that -- in some of the schools,  
16 they're perfectly fine to go on and register and  
17 order their own vaccine for their population.

18 DR. KUS: Yeah.

19 MS. MOLLOY: If you have a  
20 school-based clinic, but we don't have one.

21 DR. KUS: Well, even physicians  
22 and RNs can go on, they don't need a school-based  
23 clinic to register and receive vaccine.

24 MS. MOLLOY: Right. But we --

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2 you need participation from your district.

3 My district, you know, this is --  
4 I know everything's on the record here, but -- I  
5 would prefer it wasn't because their -- their  
6 opinion is that we shouldn't even discuss flu  
7 vaccination with families, that we need to refer  
8 them to their primary physicians. And that's --  
9 you know, that's their comfort level. And it's  
10 what's stated on our Web site, you know, we're not  
11 to give medical advice. We were called into a  
12 meeting, and told, you know, to keep our opinions  
13 to ourselves, and you know, to refer people to  
14 their primary physicians.

15 So, it's very difficult because  
16 school districts have a culture of fear of, you  
17 know, lawsuits and reprisal for -- and they don't  
18 feel that they're medical homes or medical  
19 providers and --

20 DR. KUS: Right.

21 MS. MOLLOY: -- so that's a --  
22 that's a dilemma.

23 MS. BURNS: The other important  
24 thing to know is that the governor reupped the

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2 executive order allowing advanced E.M.T.s to  
3 inoculate in local health department-sponsored  
4 PODs.

5 DR. COOPER: Thank you, Lee.

6 Ann?

7 MS. FITTON: Yeah. I -- I just  
8 wanted to address one other thing. Outside of  
9 protecting ourselves with personal protective  
10 equipment, it certainly has been a thrust of -- of  
11 FDNY's for education for prehospital care  
12 providers, eleven thousand certified first  
13 responder/firefighters who are more reluctant than  
14 perhaps E.M.T.s and paramedics to don an N95 mask.  
15 Put a big push into that.

16 We did get six thousand doses of  
17 H1N1, and I believe they were -- and -- and we did  
18 a fourth day of POD, and I believe that all of  
19 those doses went to first responders.

20 A couple of other things we did  
21 do, is we bought a new kind of nebulizer with a  
22 one-way valve, so that -- excuse me, so that when  
23 we're treating people with respiratory or  
24 influenza-like illnesses on -- on the ambulances

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2 that they're -- are not get -- getting a steady  
3 stream of their, you know, respiratory droplets.

4 DR. COOPER: Uh-huh.

5 MS. FITTON: Which is, I think, a  
6 really important thing. They -- they are about six  
7 or seven dollars apiece. I did buy a supply of  
8 them, so that if we are at the clinic, and we need  
9 to go -- at the point that we rise above a certain  
10 level of influenza-like illnesses, they'll be put  
11 out into the street. So, it -- we're looking at  
12 other things besides just respiratory protection  
13 for the providers. Very important, hand washing  
14 can't be replaced; a good use of decontamination  
15 procedures, all very important. But there are  
16 other things out there that we can do to help make  
17 sure that we don't place patient care -- or  
18 compromise patient care.

19 DR. COOPER: Thank you, Ann.

20 Jan?

21 MS. ROGERS: I'd like to make a  
22 positive comment. As compared to June - and this  
23 is just anecdotal - as compared to June and the way  
24 that we've had through October, excuse me, it

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2 definitely seemed that there was a strong effect of  
3 whatever, whether it was media, education, whether  
4 it was the efforts of primary care doctors, but we  
5 seem to have a lot fewer primary care-type visits  
6 to the emergency room with flu-like symptoms.

7 I think we had much, much more in  
8 June that were people who didn't belong in the  
9 E.D.; they probably didn't belong at their doctor's  
10 offices for the level of illness that they had, and  
11 I've seen a marked difference in October. It seems  
12 we're getting more of the population that we should  
13 get and those are with the sicker children and also  
14 complications. So, whatever that effect is due to,  
15 I thank them.

16 MR. CZAPRANSKI: Just one  
17 comment. I want to thank the State and the Bureau  
18 of E.M.S. for keeping the updates on there. I mean  
19 in our area, we put out a weekly H1N1 update to all  
20 E.M.S., fire and police providers, and that's been  
21 very helpful, but I think the guidance that the  
22 State has given is good, because regionally you  
23 have to make a decision about -- based on what  
24 you're seeing in your community.

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2 DR. KUS: Right.

3 MR. CZAPRANSKI: Our call volume  
4 went up, we took back some of the fire/first  
5 response calls to influenza-like illness, because  
6 they didn't need the exposure, and we hadn't yet  
7 vaccinated that group. But we've held five clinics  
8 for E.M.S. providers already in our -- and we've  
9 pretty much hit everyone that -- that wanted an  
10 H1N1 vaccine, now, we're stepping it down, since  
11 the influenza-like illness is coming up. We're  
12 going from a level three to a level two, which now  
13 fire will do some more first responses, and so on  
14 and so forth.

15 But each community, I think, has  
16 to look at what's going on in their community, and  
17 then coupled with the guidance by the State it's  
18 been excellent for us.

19 DR. KUS: Good.

20 DR. COOPER: I'd like to conclude  
21 this part of the meeting by thanking Dr. Kus for  
22 sharing his expertise on two vitally important  
23 subjects.

24 I will ask Dr. Kus if he would be

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2 willing to provide a copy of the presentation to  
3 Ms. Gohlke for distribution to the Committee.

4 DR. KUS: Sure.

5 DR. COOPER: And once again, we  
6 really thank you for being with us, and extend, as  
7 always, our invitation to you and Dr. Kacica to  
8 join with us at -- at each one of our meetings,  
9 since so much of what we do overlaps with so much  
10 of what you do.

11 So, thank you very much.

12 Before we move off this subject,  
13 however, I would just like to ask Bob Kanter and  
14 Kathy Lillis if they would share their thoughts  
15 regarding a recent meeting held in New York City:  
16 The Task Force on Life and the Law, headed now by  
17 Beth Roxland, convened an expert panel to look at  
18 the issue of -- of ventilator allocation, and --  
19 and in H1N1, or other types of pandemic situations,  
20 where the need may outstrip the supply, you know.  
21 And I'll turn it over, at this point, to Bob and  
22 Kathy for preliminary observations, just to let the  
23 group know that this initiative is underway.

24 DR. KANTER: Well, this was a

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2 discussion about what would happen if the numbers  
3 of patients in a influenza pandemic, or any other  
4 kind of pandemic, greatly exceeded the capacity of  
5 intensive care, and particularly ventilator care,  
6 in our state.

7 And this, of course, is an  
8 unprecedented situation, and it's planning ahead  
9 for a sort of a worst-case situation. It's  
10 important to emphasize that even before you get to  
11 the question of rationing, which is the primary  
12 thrust of this meeting -- of that meeting, a  
13 bigger, more important way to prepare is the notion  
14 of mass critical care, where you're trying to  
15 extend your care to larger numbers of patients, and  
16 provide care to everyone who needs essential  
17 critical care by limiting your interventions to  
18 immediately lifesaving interventions, trying to  
19 increase the number of ventilators that are  
20 available, for example, by using transport  
21 ventilators, anesthesia ventilators and the like,  
22 in a hospital that may have run out of their  
23 conventional ventilators.

24 And that's a nationwide effort

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2 that is -- is going on in -- in other agencies  
3 and -- and work groups. But this particular task  
4 force of the New York State Department of Health  
5 considered an even worse circumstance, what if all  
6 those attempts to deliver mass critical care to  
7 much larger numbers than normal, still fell short,  
8 and you found yourself with three or four patients  
9 in the E.R. who need a ventilator, and you've got  
10 one ventilator. Who would get it?

11 And it won't surprise you to  
12 learn that the task force meeting did not come up  
13 with definitive answers, but the meeting that  
14 occurred a couple of weeks ago tried to apply some  
15 general work that's already been done for adults to  
16 the circumstance of children.

17 And I can just briefly summarize  
18 the rationing strategy:

19 You would, first of all, have  
20 fairly strict criteria for who needs a ventilator.

21 Then you would potentially  
22 exclude people who are too sick to benefit; and  
23 there's a lot of debate about what would be the  
24 criteria for that, and I'm not sure that we have

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2 good answers to that.

3 Then you would allocate the  
4 ventilators to those patients who need them and who  
5 don't have exclusion criteria. And then reevaluate  
6 them after a period of time, and if they are  
7 failing to improve and there's still a crisis  
8 shortage, you would withdraw patients who are  
9 failing to improve after a time trial of mechanical  
10 ventilation, and reallocate that ventilator to  
11 someone who is more likely to benefit from a short  
12 period of life support.

13 This is a work in progress. The  
14 intent is that we're laying the foundation for  
15 something that may come up a year or several years  
16 from now. This is, in no way, intended to be  
17 something that'll be -- that could be implemented  
18 this year. It would require a good deal of -- of  
19 public discussion, public consensus, a legal basis,  
20 operational plans, a great deal of professional and  
21 public education. But again, this task force is  
22 doing some very important work, laying the  
23 groundwork, and some very well thought out  
24 groundwork, for these very disturbing

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2 possibilities.

3 DR. COOPER: Thank you, Bob.

4 Kathy?

5 DR. LILLIS: I think the other  
6 thing that we addressed was when we're talking  
7 about the allocation of ventilators, well, what do  
8 you do with the patients who are on -- on home  
9 ventilators? And it was clear to the -- the  
10 committee that the -- we wouldn't be removing or  
11 taking those ventilators away from patients who --  
12 who were on home ventilators, but should those  
13 patients come into the hospital and need the  
14 resources, then that would be a time when they  
15 would be entered into the system and in -- into the  
16 guidelines.

17 I think that sitting on the  
18 committee and talking to other people on it, it  
19 was -- it was a very uncomfortable situation. It  
20 wasn't something that any of us in the room wanted  
21 to -- to do, or -- or to think about, and the  
22 committee frequently kept saying, "well, this is  
23 only after everything else has been done," and --  
24 and all of the -- you know, that we need to

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2 strongly say that the State needs to put resources  
3 in to make as many ventilators -- stockpile the  
4 ventilators, so that we're not in that situations,  
5 but should we be in that situation, we need to  
6 think ahead, and -- and come up with some  
7 guidelines.

8 DR. COOPER: Just one other small  
9 additional comment. The -- the patients that have  
10 home ventilators typically have a spare ventilator  
11 at -- at home with them, and that was mentioned as  
12 a potential source of additional equipment should  
13 the public, you know, require it at that particular  
14 point in time. Although I don't think anyone has  
15 any idea how many home ventilators are actually out  
16 there at this particular point in time.

17 A work in progress as Bob has  
18 said, much more to come on this, and we'll keep you  
19 updated as to where this work proceeds over the  
20 next several months.

21 Elise?

22 DR. VAN DER JAGT: Yeah. Just --  
23 obviously, you were dealing with a pretty difficult  
24 topic, and -- and -- because we're always thinking

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2 we can do everything for anyone. Did it -- it come  
3 up at all about hand bagging patients?

4 DR. LILLIS: Uh-huh.

5 DR. KANTER: Yes.

6 DR. VAN DER JAGT: Because we --  
7 we used to do that -- I mean not "we," I'm not that  
8 old. I'm old, but not that old, you know. But --  
9 but in the Third World, that gets done routinely,  
10 you know, for days on end, and there are just  
11 shifts of people who bag, to get kids through this.  
12 So, I'm just wondering if that came up in the  
13 discussions.

14 DR. COOPER: It did. Bob?

15 DR. KANTER: Well, it did.

16 It's -- it's a somewhat controversial area among  
17 the various national work groups that are  
18 considering this. The disadvantages are that it's  
19 very labor intensive and would take away from other  
20 aspects of intensive care; it exposes people more  
21 closely to transmittable infections. On the other  
22 hand, it may be lifesaving when you've got  
23 absolutely no other alternatives.

24 So, some of us think it's a good

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2 idea; however, it's not realistic to think that --  
3 to think that you could do this for large numbers  
4 of patients for many days at a time. Most of us  
5 think it would be a very important option for  
6 temporary life support, until you could get more  
7 definitive equipment.

8 DR. COOPER: Other comments?

9 Yes, sir?

10 MR. TAYLER: This was a  
11 discussion not just for pediatrics, it was -- it  
12 was the whole -- the whole lifespan? I'm assuming  
13 it wasn't just -- was it --?

14 DR. COOPER: No, this particular  
15 discussion was focused on children. The -- the --  
16 the task force had previously tackled the more  
17 general issue of how to deal with this problem in  
18 the general population, but the -- the initial  
19 draft report, which was issued in mid-2007, as I  
20 recall, did not explicitly address the special  
21 issues of children, and I -- and that was the  
22 reason that this particular subgroup was asked to  
23 come together to assist the Task Force on Life and  
24 the Law in fleshing out that -- the details of that

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2 particular component of the report, which, again,  
3 is still in draft form.

4 MR. TAYLER: Was there any  
5 consideration given to when the paramedics intubate  
6 the patient in the field, and then they come into  
7 your E.R. with this -- this -- with the patient  
8 intubated and you have no vents? I mean it's --  
9 it's another, you know, it -- it's similar to  
10 picking up a patient from home that -- that is on a  
11 home ventilator, but you know, you're still --  
12 you're back to a patient that now you're bagging  
13 them.

14 DR. COOPER: That specific issue  
15 I do not recall being discussed, but we could pass  
16 that point along to the powers that be.

17 DR. LILLIS: I think there was a  
18 very brief discussion that the guidelines that we  
19 were working on were really hospital-based, and  
20 that we would not change anything prehospital  
21 initially, but -- and that we couldn't really  
22 expect prehospital care providers to decide things  
23 like -- like that, who --

24 MR. TAYLER: Yeah.

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2 DR. LILLIS: -- and some of the  
3 things we were basing that was qualify of life,  
4 utilization of -- of resources and survivability --

5 MR. TAYLER: Uh-huh.

6 DR. LILLIS: -- in that we --  
7 that wasn't something that we could implement in a  
8 prehospital care setting.

9 MR. TAYLER: Yeah. And I can  
10 understand that.

11 I -- I just was wondering if it  
12 was a point considered, because it is -- is -- it  
13 is a distinct possibility, you know, that you --  
14 that you would run into this, and now it's -- it's  
15 your hospital patient. So, I -- I was just  
16 wondering if that -- if -- if in considering all of  
17 the possibilities that was -- that was also  
18 considered.

19 DR. COOPER: Okay. Thank you,  
20 Mike Tayler.

21 We're going to move on now to  
22 hear from Sarah Sperry, the research scientist of  
23 the Bureau of Injury Prevention for her report to  
24 the group.

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2 Ms. Sperry?

3 MS. MACINSKI SPERRY: Thank you.

4 DR. COOPER: And thank you again  
5 for being here.

6 MS. MACINSKI SPERRY: Just a bit  
7 of housekeeping, you know, it's the Health  
8 Department, I guess, that regulates how long food  
9 can stay out and the folks outside are very eager  
10 to snatch it away, so if you --

11 DR. HALPERT: Yeah. We noticed  
12 they are.

13 MS. MACINSKI SPERRY: -- if you  
14 haven't had your dessert, if you haven't had your  
15 seconds or whatever, now is the time, before he  
16 comes in and takes it away.

17 FROM THE FLOOR: Can somebody  
18 here suspend that rule?

19 MS. MACINSKI SPERRY: While  
20 Martha is bringing up the presentation, I'm going  
21 to start. I have got three separate handouts I'm  
22 passing out. I didn't make handouts of the  
23 presentation itself. I was trying to save some  
24 paper and make some happy trees. I'm more than

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2 happy to e-mail it to anyone who would like it.

3 DR. COOPER: Please. Please do  
4 that. Yeah. Thank you.

5 MS. MACINSKI SPERRY: Okay. But  
6 data I did as handouts, because it's easier to see,  
7 and -- all right.

8 So for this presentation, I just  
9 wanted to also share that I've defined childhood as  
10 those under nineteen. I know that there are -- are  
11 multiple definitions of what children are that  
12 float around. Our general cutoff in our bureau is  
13 nineteen, and so I -- I stuck with that, because it  
14 made cutting data easier.

15 So, who we are is we're part of  
16 the Division of Chronic Disease and Injury  
17 Prevention. We -- our bureau is kind of unique in  
18 our division in that we have both surveillance and  
19 program staff. Surveillance staff, we identify and  
20 monitor incidents of injury, whereas our program  
21 staff work to use evidence-based strategies to  
22 decrease the burden of injury.

23 Keep the slide up.

24 The -- if we were to have a

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2 Bureau of Injury Prevention mantra, it would be  
3 that injuries are not accidents. We do -- we call  
4 it the A word, and we don't use it when we speak of  
5 injuries or car crashes, because we believe that  
6 these are predictable and preventable events.

7 If they -- accident apparently  
8 implies some sort of uncontrollable act of fate,  
9 and if these things truly were uncontrollable acts  
10 of fate, we couldn't prevent them, and we know that  
11 we can.

12 This is just kind of a quick look  
13 at the various things that we do and work on.  
14 Injuries are a very broad topic area, and we work  
15 in a lot of places, and the main focus of my  
16 presentation is our surveillance and what we can do  
17 for you. I am, towards the end, going to touch on  
18 our childhood unintentional injury project, as that  
19 may also relate to your program.

20 So, our surveillance, we work to  
21 identify and monitor injury incidents. We do  
22 this -- we have the SPARCS data, we have the vital  
23 statistics death data, and we have our CODES  
24 project. CODES is a linked project, which I'll get

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2 into in a little bit, that looks at -- and I know  
3 that I've got the A word up there, that I just said  
4 we don't ever use it, but the accident information  
5 system comes from D.M.V., and that's what it's  
6 called. And this is our -- our crash reports.

7 So, the SPARCS, as you know, it's  
8 hospital discharge data, and E.D. data, vital  
9 statistics, death files come from death  
10 certificates for children.

11 Examples of the -- next slide,  
12 please.

13 I'm trying to go as -- as quick  
14 as I can to help you catch up on -- on time.

15 DR. COOPER: Thank you.

16 MS. MACINSKI SPERRY: The --  
17 there is -- this is -- by no means am I giving you  
18 an all inclusive list of variables for any of the  
19 things, various, or demographics, what happens to  
20 the patients.

21 Next slide, please.

22 And also we -- the data is coded  
23 with I.C.D.-nine and I.C.D.-ten coding. This gives  
24 us diagnosis codes and e-codes which are external

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2 cause of injury and place of injury. SPARCS uses  
3 I.C.D.-nine, whereas the death files use  
4 I.C.D.-ten.

5 And I'm -- now, I'm -- these  
6 are --.

7 MS. GOHLKE: Sorry.

8 MS. MACINSKI SPERRY: That's  
9 okay.

10 The handouts I gave you, so you  
11 can actually see things, because I know stuff is  
12 very small up there, this is an example of our --  
13 the standard data table we've produced. We  
14 generally do it for any sort of injury. We can do  
15 them by county, or you know, region, whatever, you  
16 have them. It's got age group, gender. We often  
17 look at traumatic brain injury. We can do spinal  
18 cord injury, what your hospitalization and E.D.  
19 charges are, and how long people are staying.

20 Leading causes tables. You have  
21 these. I just passed them out. Again, I did only  
22 zero through nineteen, because this is what we  
23 defined as children. So, if you want to just flip  
24 through quick. Then it goes to hospitalization,

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2 and then E.D. So, that's the leading causes for  
3 each.

4 Obviously, as the -- it goes from  
5 death to E.D. visits, your -- your mean annual  
6 frequencies are going up and up and up.

7 Next slide.

8 And this is your incidence of  
9 injury deaths. I didn't give you the graphs in the  
10 handouts, but on the back of the table, there is --  
11 can I just borrow this for a second? On the back  
12 of this - saving paper - is the -- the -- the data  
13 that goes into the chart. So, you can look at that  
14 if you want.

15 Oh, I thought I fixed that. It  
16 actually goes from 2000 to 2007, not from the year  
17 200. We don't have death data going back that far.

18 You want to -- go to the next  
19 one.

20 See it's -- while there is  
21 somewhat of a decline, it's still staying pretty  
22 consistent with our hospitalizations. And our E.D.  
23 visits, we only have data starting in 2005. So,  
24 that doesn't even go back as far as our 2000, let

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2 alone 200. So, anything that we do with E.D.  
3 visits and providing data, we can't give you  
4 anything before that. We can go back further for  
5 hospital and E.D. -- or hospital and death I mean.

6 So, then moving along as I said,  
7 we have another part of our program, which is our  
8 CODES project. And CODES is a linked database,  
9 which was actually what I was hired to work on.

10 It's -- was -- is sponsored by the National Highway  
11 Traffic Safety Administration. New York is one of  
12 nineteen states that receive funds to do CODES  
13 activity. Now, we are largely funded by the  
14 governor's highway traffic -- Governor's Traffic  
15 Safety Committee, and as I said, this is a linked  
16 database. We link in the data from SPARCS, and our  
17 National Resource Center for Codes, which is in  
18 Maryland, will take the -- the I.C.D.-nine codes,  
19 and perhaps some other information, and translate  
20 into the -- them into maximum abbreviate injury  
21 severity scores, and regular injury -- abbreviated  
22 injury severity scores. So, that give us another  
23 component of -- of data that we have to offer. We  
24 link to the prehospital care reports, which are

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2 graciously provided to us by our friends at E.M.S,  
3 and we very, very much appreciate them.

4 MS. BURNS: Yeah, yeah, yeah.

5 MS. MACINSKI SPERRY: I've got  
6 to, you know, throw it out there.

7 And as I said, also the accident  
8 information system from D.M.V.

9 Thanks.

10 This is just sort of a visual  
11 of -- of what CODES does. We have our accident  
12 information system data, which links to the P.C.R.  
13 data, E.M.S., and it links to the SPARCS data. So,  
14 through the crash data, we're able to have a  
15 complete picture of what happened before the crash;  
16 what happened after the crash; you know, all the  
17 way through, were they speeding; were they buckled;  
18 you know, how long were they on the ambulance; what  
19 happened in the hospital; what were they diagnosed  
20 with; where did they go -- were they discharged to?

21 Oh, there's my little guys.

22 The prehospital care report data,  
23 as our E.M.S. friends know very, very well, has  
24 three levels of data -- provider information, event

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2 information and patient information.

3 Next. Thanks.

4 Their provider information is  
5 information such as the agency, type of life  
6 support per certification, response time, and the  
7 P.C.R. data. The event information is like the  
8 location, the type of call, the date and the time,  
9 the patient information is, you know, a long list  
10 of more detailed information about the patients,  
11 some of which is used in linking, some of it's not.

12 The accident information system,  
13 which is our data source that you all may have the  
14 least exposure to, contains the police accident  
15 reports, ticketing -- which is ticketing  
16 information and motoring -- motorist reports. So,  
17 if you're in a -- involved in a crash, the police  
18 officer comes, theoretically writes up a crash  
19 report, you may or may not get a ticket, we get  
20 that information. Sometimes there is not a police  
21 crash report, but a motorist themselves will send in  
22 a report form to D.M.V. Those are the motorist  
23 reports. So, these are received by the D.M.V., by  
24 both police and individuals, and that data can be

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2 found at safeny.com.

3 Examples of data are -- include  
4 when, where, what they were doing, what was going  
5 on, how many vehicles were involved, vehicle  
6 information, contributing factors, number of  
7 occupants, where they're going, also individual  
8 level, role, age, gender.

9 The injury severity score in this  
10 dataset is referred to as KABCO. With this is  
11 assessed -- assessed by the police. It goes  
12 from -- it's a -- goes from K, which is killed, all  
13 the way down to O, which is noting, and/or no  
14 injury. There has been some work comparing -- done  
15 by NHTSA comparing the M.A.I.S. models with the  
16 KABCO model -- the KABCO scores and the M.A.I.S.  
17 is, they're finding a little bit better, in that  
18 KABCO being assessed by the police officer is --  
19 they see something that's very bloody, and they say  
20 it's a severe injury, when it may just be something  
21 that's very bloody, where someone may have a fairly  
22 severe internal injury that the police officer  
23 can't see, and therefore, is a lesser. So, with  
24 our CODES, we get to help kind of bridge this gap a

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2 little bit. So, this is -- all of these are -- are  
3 available sources for injury data, and whereas  
4 alone they're all beneficial, they can't produce  
5 the complete picture of crash and outcomes that  
6 CODES can. That's it.

7 We use common variables to link  
8 these, event variables, and individual variables,  
9 and this expands crash data, so that components of  
10 highway safety can be evaluated, creating a fuller  
11 picture of the crash.

12 Next, Martha.

13 As I said, we have -- we do our  
14 best to be resourceful and helpful at the Bureau of  
15 Injury Prevention. We will do customizable data  
16 requests for free. Our -- our Web site is getting  
17 updated with data, it's -- it's there and very  
18 small, and we're putting more and more data on it  
19 and that's exciting.

20 We produce fact sheets,  
21 brochures, obviously throw data out there, because  
22 that's what I do and I'm very partial to. We work  
23 on child injury, passenger safety, traumatic brain  
24 injury, poison prevention, choking, falls, et

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2 cetera.

3 We also have a childhood  
4 unintentional injury prevention project. This  
5 has -- is a two-part campaign to work with local  
6 partners in preventing childhood injuries. Phase  
7 one is -- is getting completed. They're up and not  
8 quite on Internet, but almost on Internet-land --  
9 a -- working on a user-friendly link on the D.O.H.  
10 Web site. And we have, I believe, forty-eight fact  
11 sheets that are -- are on their way through  
12 approvals in -- in D.O.H. for posting.

13 Phase two is developing a falls  
14 prevention -- childhood falls prevention toolkit to  
15 assist local partners, and to conduct a symposium  
16 to demonstrate this toolkit. This symposium is  
17 scheduled for March 31st, and if anyone is  
18 interested in this, let us know, we can send you an  
19 invite and -- oh, geez, where are my --.

20 DR. COOPER: Sarah, the falls  
21 that you're focusing on, all kinds of falls or  
22 specific types of high files, I would presume?

23 MS. MACINSKI SPERRY: All falls.

24 DR. COOPER: All falls.

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2 MS. MACINSKI SPERRY: So, if you  
3 go -- I didn't go through the -- the data I handed  
4 out, but falls are one of the leading causes of  
5 injury for actually all age groups, except for --

6 MS. MOLLOY: Right.

7 MS. MACINSKI SPERRY: -- like  
8 late teens. And it's pretty much they do a lot of  
9 falls from just like within the house, down the  
10 stairs, the falls that -- like my daughter falling  
11 off her chair in the kitchen the other day, I went  
12 (makes a noise), but there is -- you're doing a lot  
13 of work just to -- because there's -- it's -- it's  
14 such a simple little thing, but there's -- there's  
15 so much of it, and it -- it accounts for so much  
16 that -- money and morbidity and unfortunately,  
17 mortality as well, that that's what they're --  
18 it's -- it's really all falls, I guess.

19 MS. MOLLOY: Where is it going to  
20 be held?

21 MS. MACINSKI SPERRY: Glen  
22 Sanders in Scotia, New York.

23 MS. MOLLOY: Can you send that  
24 link to Martha, so she could send it to us?

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2 MS. MACINSKI SPERRY: Yeah. And  
3 then on the next page, I -- this is a list of  
4 everything that they're making fact sheets for.  
5 They're also -- these are -- are the topic areas.  
6 Well, most of them are broken out by age groups, so  
7 that parents, caregivers, medical professionals,  
8 can each, you know, get information for, you know,  
9 my zero to one year olds, and that they shouldn't  
10 be on a bicycle or what have you.

11 And lastly, this is our -- our  
12 general injury -- our -- well, Health Department  
13 Web site. You can link through it to the injury  
14 prevention. If you Google New York State injury  
15 prevention statistics, we come up first. I'm very  
16 excited. So -- but that's -- that's how to contact  
17 the bureau for anything that you need.

18 My e-mail's there at the bottom.  
19 If you would like to contact me for anything. I  
20 can always push you through to the -- the proper  
21 person that is in the area that you're interested  
22 in. And if any of you work with partners who you  
23 may -- think may be interested in what we're doing,  
24 being part of anything that we're working on, we're

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2 always happy to have new partners, and -- and have  
3 more people come to events and trainings and -- and  
4 share our information. So, anything that we can do  
5 to help out there in the community is what we're  
6 trying for.

7 DR. COOPER: Thank you so much.

8 Has either the Department, or the  
9 Department at the direction or request of NHTSA,  
10 thought about adding events to automated crash  
11 notification data to the CODES project?

12 MS. MACINSKI SPERRY: The crash  
13 notification data?

14 DR. COOPER: Well, there's a --  
15 right. There's a -- many, many vehicles,  
16 particularly General Motors vehicles, come equipped  
17 with something called OnStar, --

18 MS. MACINSKI SPERRY: Oh, like --  
19 like OnStar.

20 DR. COOPER: -- which is the  
21 generic name is advanced --

22 MS. MACINSKI SPERRY: Yeah.

23 DR. COOPER: -- automated crash  
24 notification.

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2 MS. MACINSKI SPERRY: Right. Not  
3 that I've heard of. And it's a -- a worthwhile  
4 thing to look into.

5 DR. COOPER: Perhaps. Yeah.  
6 Perhaps that's something that -- that, you know,  
7 you might want to begin to sort of ask NHTSA about.  
8 It's -- it's becoming a -- an increasingly  
9 important component of trauma triage in the field,  
10 among other things, and trying to link some of  
11 the -- you know, the -- the injury outcome data  
12 with delta V and so on. It's -- which, of course,  
13 the change in the velocity of the vehicle and so  
14 on, which is a, you know, an approximate indicator  
15 of the -- the speed of the vehicle at the time of  
16 the crash, and so on, can be very, very useful.

17 MS. MACINSKI SPERRY: I'm -- I'm  
18 sure that -- and just coming from a pure data  
19 standpoint, having that would be a lot more  
20 accurate than whatever is listed for -- because  
21 what we have is -- we don't have the speed that  
22 they were going. We have a -- a -- we actually  
23 have two variables; in contributing factors, they  
24 have unsafe speed listed, and then they also can

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2 have under ticketing information unsafe speed. But  
3 we're really only going to know how fast they were  
4 going if moments before the crash there was a  
5 police officer there with a radar gun. And that's  
6 not really going to happen. So, it's -- there --  
7 there are definite laws in -- in data collection,  
8 that we do the best that we can with. And things  
9 to make it more sensitive and specific would be  
10 great.

11 DR. COOPER: Other questions for  
12 Ms. Sperry?

13 Elise?

14 DR. VAN DER JAGT: I was just  
15 interested in your -- the county by county data you  
16 have here.

17 MS. MACINSKI SPERRY: Uh-huh.

18 DR. VAN DER JAGT: And the  
19 coupling it with your program of preventing  
20 falls --

21 MS. MACINSKI SPERRY: Yes.

22 DR. VAN DER JAGT: -- is just  
23 striking to me. Do you -- do you focus on specific  
24 counties.

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2 For example, there are two  
3 counties that are way, way above the rest of them.  
4 Steuben County in particular and St. Lawrence  
5 County. I'm interested in Steuben County, because  
6 it happens to be in our area and we found the same  
7 thing in the '80s and early '90s, that falls were a  
8 very high -- high rate of them. So, do you take  
9 that program that you're developing, and go to that  
10 county, and say, "how about using this, and see if  
11 you could do this?"

12 MS. MACINSKI SPERRY: I'm -- I'm  
13 not sure. I'm -- I'm surveillance.

14 DR. VAN DER JAGT: Uh-huh.

15 MS. MACINSKI SPERRY: But I'm not  
16 sure how the childhood one is working. We also --  
17 and I didn't talk about it here because you  
18 don't -- I mean I know that you care about older  
19 folks, but it's not your focus. We --.

20 DR. KANTER: Well, we are older  
21 folks --

22 FROM THE FLOOR: We don't care.

23 MS. KANTER: -- of course it's  
24 our focus.

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2 MS. MACINSKI SPERRY: We have  
3 another -- another falls program that's working on  
4 fall prevention in older adults, which is -- are  
5 those sixty-five plus, and that is working -- they  
6 have specific counties that they're working with,  
7 and -- and like test running. They're -- I -- I  
8 think they're doing Tai Chi. It's just all just  
9 starting. But that I know, I'm pretty sure they're  
10 working with Erie County -- one -- a county in Long  
11 Island, I think, and maybe Broome County. Don't --  
12 don't quote me on that one.

13 MS. MOLLOY: It's not he record.

14 MS. MACINSKI SPERRY: I know it's  
15 on the record, but I'm also on the record saying  
16 I'm not a hundred percent sure, so --.

17 MS. MOLLOY: Don't get nervous.

18 MS. MACINSKI SPERRY: So, yeah.

19 DR. KANTER: Yeah.

20 MS. MACINSKI SPERRY: I -- I  
21 would assume that -- that they're going to work on  
22 targeting specific counties, but I don't know the  
23 full breadth on that. The -- there's a position  
24 that is out for -- we're hiring a person to work on

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2 that, as we speak. Applications have been coming  
3 in. So, I don't know how far the -- the plans have  
4 progressed.

5 DR. COOPER: Dr. Kanter?

6 MR. KANTER: Just a note.

7 It's -- it's hard to interpret some of these rates  
8 on counties that have very small populations with  
9 low total occurrence rates.

10 MS. MACINSKI SPERRY: Yeah.

11 MR. VAN DER JAGT: Yeah. It is  
12 hard.

13 MS. MACINSKI SPERRY: Yeah.

14 We -- we try to star everything in our -- our data  
15 with -- that's based on a frequency of less than  
16 twenty as being unstable, and then we don't  
17 provide -- if you have five or fewer injuries or --  
18 of whatever nature, we don't report that data for  
19 confidentiality reasons, and --

20 DR. VAN DER JAGT: Sure.

21 MS. MACINSKI SPERRY: -- and I  
22 know when you -- you break it down to just by  
23 county, it -- it becomes a lot harder to interpret,  
24 and it's where -- where the E.D. data comes in a

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2 little more helpful than the -- the death data,  
3 because you've got a lot more of those.

4 DR. VAN DER JAGT: I -- I was as  
5 much interested in the process as anything else, as  
6 where the data gets used, you know. In other  
7 words, it's great to get data, and it's great, you  
8 know, if you're doing surveyance, and you're having  
9 all these exciting, drooling data points, but you  
10 know, I'm just wondering, one - and maybe this goes  
11 back to Dr. Cooper - is what do we as a committee  
12 do with this data? If we're going to present it  
13 here, are we supposed to take some action of some  
14 sort, or do we -- do we just say, "oh, well, that's  
15 nice," you know, or what do we do with it?

16 And then the second thing is --  
17 is what happens at the Bureau's level, you know,  
18 and how is this data used by county health  
19 departments, or regions of the state, or urban  
20 areas, or how is it used, so that we just don't  
21 continue to collect data without actually using it?

22 MS. MACINSKI SPERRY: On average,  
23 I think we're running six to seven data requests a  
24 month for individuals, be they like

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2 university-level researchers, private  
3 not-for-profits, we get a lot of work -- requests  
4 from traumatic brain injury programs that are --  
5 are looking for that stuff. We just did a couple  
6 of spinal cord injury data requests.

7 We -- we recently did a bunch of  
8 data to provide to Orange County, to their -- their  
9 police -- yeah, to their police departments,  
10 because they wanted -- the town of Goshen wanted to  
11 limit the -- the ability of the police officers --  
12 or stop them from doing the Stop D.W.I. programs,  
13 the Buckle-Up New York programs, and the -- the  
14 STEP program, which is inclusive of a lot of  
15 things. So, we're -- we did the data, you know,  
16 we -- and like as quickly as we could, got a bunch  
17 of tables out there to send out -- say, "look, no,  
18 these are our real problems. We've got people who  
19 are really getting injured, or really getting  
20 killed in your county from these -- these things.  
21 This is -- is important."

22 One of the -- the -- as I said,  
23 we have G.T.S.C. funding for the CODES project.  
24 We're using that right now. We're working -- we're

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2 developing county-level fact sheets, that w, ill  
3 hopefully -- we're going to -- we're developing  
4 them, we're going to be running them through focus  
5 groups of police officers and some various other  
6 stakeholders who have yet to be identified, and  
7 hopefully, that will help us really key on a -- a  
8 good helpful, useful, easy-to-read doc, because  
9 what -- coming from my epidemiology background,  
10 what is -- is good and easy data for me and for us,  
11 and you know, makes sense, "well, look at this,"  
12 doesn't make sense to the people that are actually  
13 on the ground running with it, trying to -- to do  
14 it and make changes and make things better. So,  
15 we're -- we're trying to make that -- make it --  
16 make it as user-friendly as possible, and then also  
17 do a more comprehensive listing of county tables  
18 and New York State data in general.

19 A couple -- a year or two ago,  
20 when Marjorie was still around, we did a very large  
21 data request for the State Trauma Advisory  
22 Committee, where the -- pretty much the tables that  
23 I gave you, I ran for hospital deaths -- well, we  
24 ran for hospitals deaths and E.D. visits for each

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2 of the trauma regions, so that then they could take  
3 their local data to their regional trauma advisory  
4 committees, and say, "look, this is what's going  
5 on" and -- and what they actually really did with  
6 it, I don't know.

7 We have started requesting that  
8 when people tell me that they're going to -- tell  
9 us, that they're going to make a brochure or give a  
10 presentation, or you know, do a press release, I've  
11 started following up with them, and -- and asking  
12 for copies of it, and keeping a -- a listing of the  
13 different things that our data has been done for,  
14 which is always fun, we're like, "look, it's really  
15 being used."

16 But we, you know, anywhere that  
17 we've got it for -- you know, it's -- and in terms  
18 of who uses it, part of it being such a long-winded  
19 answer, is that injury is such a broad topic. I --  
20 I came from an infectious disease background to  
21 injury, and it took me a really long time to -- to  
22 grasp this concept of it's -- it's burns, and it's  
23 poisoning, and it's assault, and it's a car crash,  
24 and this is all in one place, in -- in one topic

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2 area? And so, it -- our -- our data goes out all  
3 over the place. It's, you know, used in -- in teen  
4 driver work groups that the State puts on, and --.

5 MS. GOHLKE: Yeah. And it -- it  
6 just -- you know, the reason we asked Sarah to  
7 speak was because the last meeting we talked a lot  
8 about getting data for the regionalization meeting  
9 in May --

10 DR. COOPER: Right.

11 MS. GOHLKE: -- and there is some  
12 confusion amongst people at the table, and myself  
13 included, and I don't even know what all the Health  
14 Department collects. So, Sarah had offered, you  
15 know, to at least give us an overview of what her  
16 unit does, in case we wanted to hold something for  
17 our upcoming meeting.

18 DR. COOPER: Tim?

19 MR. CZAPRANSKI: The one slide  
20 you had with all the different tear-off sheets,  
21 which you had -- you had suffocation as a subject  
22 category --

23 MS. MACINSKI SPERRY: Yeah.

24 MR. CZAPRANSKI: -- does that

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2 include the same as sleeping? Because in -- in our  
3 county, what we've been calling an infant death  
4 is -- is a sleeping death. And that's where a  
5 child fatality occurs -- and I was just  
6 wondering -- I didn't see anything up there related  
7 to that fact sheet around say sleeping deaths.

8 MS. MACINSKI SPERRY: It -- it  
9 may be. I -- I know that that has been a -- an  
10 interesting discussion around the office, and --  
11 and with various conference calls with different  
12 people, and -- and what we have for coding versus  
13 what other people, you know, say exists and some  
14 discrepancies there, I -- that's not -- the -- the  
15 suffocation is not a fact sheet that I personally  
16 worked on, so I don't know what all is in it.  
17 It -- it may be in -- knock on wood, it'll be up  
18 there on the Internet to look at really soon.

19 DR. COOPER: I'd like to thank  
20 Sarah for her comprehensive presentation. I'm just  
21 going to note for posterity here on the record,  
22 that last year in New York State, according to the  
23 data that Sarah has presented, six hundred and  
24 thirty-three children died. We heard earlier today

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2 that seven children have died during the past year  
3 from H1N1. The magnitude of the epidemic of  
4 traumatic injuries so totally dwarfs the magnitude  
5 of the H1N1 epidemic as to be separated by two  
6 orders of magnitude. Yet, as we all know, as hard  
7 as Sarah and her colleagues are working, this data  
8 is languishing, and we're doing precious little to  
9 protect our precious little ones from traumatic  
10 injury, whereas we have Herculean efforts being  
11 undertaken to protect them from a disease of great  
12 pathogenicity, but very limited virulence.

13 Bob?

14 DR. KANTER: And that's scary. I  
15 think that there are a number of important  
16 questions, and the answers to which would allow us  
17 to do things that come from data that are available  
18 to you guys, and you -- you probably have access to  
19 the information in ways that's much harder for an  
20 individual researcher to obtain. So, linking  
21 across these databases is very powerful. Linking  
22 across multiple hospitalizations and the SPARCS  
23 database from a referring hospital to a -- a  
24 critical care or trauma center hospital is very

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2 powerful. And I think things like -- we talked  
3 about before, like using hospital discharge data to  
4 more objectively evaluate mortality risk in  
5 injuries, and to compare the performance of trauma  
6 hospitals to other hospitals is something that you  
7 may be able to do, and I know a number of us would  
8 be interested in helping if you would think that's  
9 worthwhile.

10 DR. COOPER: Thank you, Bob.

11 Okay. We are approaching a  
12 moment of perfect timing, because I know Lisa  
13 McMurdo had wanted to hear Bob Kanter's  
14 presentation on -- or preliminary presentation on  
15 regionalization, which, with input from this group,  
16 will be one of the keynote presentations at our  
17 regionalization stakeholder meeting in the spring.

18 So, Bob, if you would --

19 MS. GOHLKE: Can --

20 DR. COOPER: -- take it away.

21 MS. GOHLKE: -- can I just  
22 actually give an update where we are with this as  
23 background before you get started?

24 A smaller group of us are -- have

1                                   EMSC, 12-8-2009  
2       been working hard to plan this big important  
3       meeting on May 13th -- it should all be on your  
4       calendars -- down in New York City. And this is  
5       our -- our pediatric critical care regionalization  
6       meeting where we're going to bring stakeholders  
7       around the state to give us feedback on this  
8       concept of regionalizing critical care for children  
9       in the state and moving in that direction.

10                                This is kind of a next step to  
11       the white paper that was submitted to the  
12       commissioner with this concept and his permission  
13       for us to go forward with the stakeholder's meeting  
14       to get more broad feedback on this idea for New  
15       York. Many states have already done this, it is a  
16       performance measure of my grant, not to say that  
17       that's the reason that we're doing this, but it  
18       is -- the -- the feds do believe that this is  
19       the -- the right way to go for, you know, tertiary  
20       care for children and having an organized system to  
21       get them there when needed. So -- so, this  
22       regionalization meeting -- the stakeholder's  
23       meeting on May 13th, we've been planning it, and  
24       just to give you an outline of the agenda, so to

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2 speak, in the morning Dr. Kanter is going to give  
3 the 'regionalization one o one' talk, and the  
4 supporting information for why we have this  
5 meeting, why we're looking at this issue.

6 We're going to invite my E.M.S.C.  
7 counterparts from Illinois, and also the physician  
8 chair of their E.M.S.C. committee to come out and  
9 give us the testimonial of their system and the  
10 process that they went through, and to answer  
11 questions to stakeholders about what the process  
12 and what the issues were for their state. And then  
13 probably in the afternoon we're going to have a  
14 professional facilitator, you know, get feedback  
15 from folks have an organized process for receiving  
16 feedback from the stakeholders in the room about  
17 their feelings on this topic and issues that they  
18 have, to then present back to the commissioner with  
19 a recommendation of such.

20 So, that's just the lay of the  
21 land of where we're looking right now. We have  
22 planning conference calls, planning meetings set up  
23 on a monthly basis -- anybody is welcome to call  
24 in. The next one is next Monday, December 14th. I

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2 can e-mail a reminder with the call-in number. If  
3 you'd like to be a part of it, I think right now  
4 where we're at is we're getting the invitation list  
5 together. And this is probably the most crucial  
6 step to make sure that we get the right people  
7 attending this meeting, and we don't obviously want  
8 to just send a letter -- a generic letter to an  
9 organization that will get lost. We want to have  
10 people's names on the letter. So, if you know of  
11 somebody that you want to see invited and at the  
12 table, now is the time to let me know who you think  
13 should be at this meeting so we get them the  
14 letter. Okay?

15 So, no further ado, Dr. Kanter.

16 DR. KANTER: Thanks.

17 Well, this is meant to be a  
18 summary of the basic facts about regionalization of  
19 pediatric critical care. I think it's the  
20 information that every stakeholder would want to  
21 know about, whether the audience is providers in  
22 any part of the healthcare system: Representatives  
23 of hospitals; payers, the people who pay for the  
24 critical care; family members of very sick kids; or

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2 regulators who have to make this whole system work.  
3 The material here is a draft of what I think would  
4 be important to prevent -- to present at the  
5 stakeholder's meeting. So, if any of you have any  
6 comments as we go along, either interrupt or save  
7 them for the end. Either way, give me some  
8 perspective on how you think this information might  
9 be better presented.

10 It's an overview -- let's go to  
11 the next slide.

12 So, the first question is what is  
13 pediatric critical care? And here we're just  
14 emphasizing that critical care really implies a  
15 continuum, beginning in the prehospital setting,  
16 where E.M.S. providers respond rapidly to any kind  
17 of crisis in any location. The patient is then  
18 stabilized in an emergency department that must be  
19 relatively nearby the scene of the crisis. A very  
20 important element is that for common, low-risk  
21 conditions that require hospitalization, it's  
22 appropriate and desirable for the hospitalization  
23 to occur near home, but for those complex,  
24 high-risk conditions, pediatric intensive care is

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2 best provided in a critical care center, which may  
3 be located some distance away from home, and then  
4 it's essential that there be an orderly transition  
5 to rehabilitation care if -- if necessary, and then  
6 back to community-based care after the child  
7 recovers.

8 What is regionalization? Well,  
9 it's broadly a way of distributing services, so  
10 that the comprehensive services, which by the way  
11 are very expensive, are distributed in a way that  
12 balances a number of factors.

13 In trying to have high quality  
14 care, which for a -- a complex high-risk condition  
15 means that a critical care center needs to have a  
16 high enough volume that they can pay for those  
17 comprehensive resources, a high enough volume that  
18 they maintain proficiency by doing it often. You  
19 need to have the centers distributed, so that  
20 they're accessible. So, there needs to be a large  
21 enough number of them that they're a relatively  
22 short, or reasonable, travel distance from  
23 everywhere in the state. And you don't want to be  
24 distributing them redundantly because that's very

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2 expensive.

3 When we talk about high volume of  
4 activity, I'm considering high volume of activity  
5 as being somewhat synonymous with a regional  
6 center. A lot of the data, which we'll get to in a  
7 minute, talk about high-volume centers, some of the  
8 studies talk about regional centers, and for  
9 purposes of discussion, I think that high volume  
10 and regional is often synonymous.

11 And there is a great deal of  
12 information, which I won't review today talking  
13 about the fact that outcomes are better at  
14 high-volume regional centers across adult medical,  
15 surgical and traumatic conditions. We'll focus, in  
16 this talk, on pediatric data. There are a few  
17 specific differences of rural, suburban, urban and  
18 metro area needs and resources. We'll come back to  
19 that briefly at the end.

20 Now, New York State currently  
21 identifies these resources sort of by  
22 self-identification, and what we're arguing is that  
23 a more formal system of identification would be  
24 worthwhile, and the two components of that are

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2        accreditation; that is an impartial body verifies  
3        that a facility has specified services. And  
4        designation; which means that you have criteria for  
5        certain kinds of patients who have high-risk,  
6        complex conditions should receive care at specified  
7        centers, because those specified centers have the  
8        resources -- the appropriate resources to deal with  
9        them.

10                                So, let's just touch on some of  
11        the evidence. And we've talked, in this committee,  
12        about should we gather more evidence?

13                                Well, I think the evidence that  
14        we've summarized here, is pretty strong for  
15        pediatrics. And the evidence is as follows:

16                                A study from John Tilford, a  
17        multicenter study done in sixteen different  
18        pediatric intensive care units, asking how does  
19        volume in those different I.C.U.s relate to  
20        outcome? And the answer is that higher volume in  
21        an I.C.U. is associated with a better risk-adjusted  
22        mortality rate.

23                                Specifically, for every increase  
24        in a hundred admissions per year, you get about a

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2 five-percent reduction in relative risk. That's  
3 data from -- gathered prospectively from peds  
4 I.C.U. registries, contributed to by many I.C.U.s  
5 around the country.

6 Next study, Murray Pollack's very  
7 old study, gosh, it's almost twenty years old now  
8 but it's still one of the best. This was a study  
9 done retrospectively looking at hospital charts.  
10 They looked extensively at hospital charts in  
11 seventy-four some-odd hospitals in the state of  
12 Oregon and Washington, and to make a long story  
13 short, for those children with severe traumatic  
14 brain injuries, and severe respiratory failure -  
15 and it's -- it's combining a couple of -- of  
16 illnesses that were easy to identify, it's not  
17 specifically a trauma study -- it's combining  
18 severe trauma and severe respiratory failure two  
19 disorders, or two conditions that were relatively  
20 easy to identify - found that the severe ones'  
21 risk-adjusted mortality rate was much worse at the  
22 nonpediatric hospitals by a -- by a factor of seven  
23 or more.

24 Next study.

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2 For trauma specifically, one  
3 study looked at fifty-three hospitals,  
4 prospectively, using data collected prospectively  
5 in a trauma registry, comparing risk-adjusted  
6 mortality rates at American College of Surgeons  
7 verified trauma centers compared with other  
8 hospitals, significantly lower risk-adjusted  
9 mortality rate at the verified trauma centers than  
10 at other hospitals. They also compared pediatric  
11 trauma centers to verified adult trauma centers and  
12 did not find a significant difference in  
13 risk-adjusted outcome.

14 Art Cooper's older study shows  
15 similar findings.

16 Next study, another study on  
17 trauma for younger children, ten years and younger,  
18 this is a study using hospital discharge data from  
19 the A.H.R.Q. kid database, a huge study, so that  
20 the -- the information here is not quite as  
21 detailed as you can find in a trauma registry. On  
22 the other hand, the numbers of cases are much  
23 larger than you can do in a prospective detailed  
24 clinical study. And the finding here was that

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2 risk-adjusted mortality rates for severe trauma  
3 were lower at children's hospitals than adult  
4 hospitals.

5 Next.

6 A so-called ecological study in  
7 which they're not able to study a lot of detailed  
8 information about individual patients or individual  
9 hospitals, but rather they're studying conditions  
10 in counties looking at characteristics of the  
11 county that may be associated with risk. And in  
12 this study, they find that counties that lacked a  
13 pediatric I.C.U. had higher risk-adjusted mortality  
14 rates than counties that had an I.C.U. after  
15 controlling for a number of area characteristics  
16 like rural/urban characteristics, socioeconomic  
17 factors and whether or not an adult I.C.U. was  
18 available.

19 Next slide.

20 Moving on to other conditions:  
21 Cardiac surgery. In New York and Massachusetts,  
22 some old and still pretty good data showing an  
23 association between higher clinical volume of heart  
24 surgery, and a lower risk-adjusted mortality rate.

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2 There's a more recent study that  
3 some of you may have seen in circulation, I'm  
4 sorry, I forgot to put the full citation there. I  
5 can get that to you. Jim Marsims (phonetic  
6 spelling) study showed that the association  
7 between high volume and mortality was not quite as  
8 strong in this California study. Some low-volume  
9 pediatric centers still had pretty decent survival  
10 rates, but it's important to remember what a  
11 small-volume study is -- or a small-volume hospital  
12 is for cardiac surgery. It still means they're  
13 doing fifty to a hundred cases a year and taking  
14 care of the kids in the pediatric I.C.U. after the  
15 cardiac surgery. It's not just a small community  
16 hospital doing one or two kids a year.

17 Now, it's possible to have too  
18 much of a good thing, or you can have so many  
19 resources that you reach a point of diminishing  
20 return. This is Goodman's study of neonatology,  
21 and neonatal intensive care, looking at the work  
22 force of neonatologists. And if you go from  
23 relatively low to somewhat higher numbers of  
24 specialists per case, you get an improvement in the

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2 risk-adjusted outcome.

3 If you go further, increase the  
4 number of neonatologists way above that, there is a  
5 diminishing return. You don't see any further  
6 benefit on mortality and the conclusion from this  
7 national work force study was that there are many  
8 regions that had excessive numbers of  
9 neonatologists to no particular benefit.

10 All right. Are there gaps in New  
11 York State?

12 Well, there is some good news  
13 about this. If you do -- look at the national  
14 survey of I.C.U. -- pediatric I.C.U. beds per  
15 population, or -- yeah, per population - and this  
16 was Randolph's study that's published five years  
17 ago - New York State has slightly more PICU beds  
18 per population than the national average. We have  
19 relatively good geographical distribution of our  
20 trauma centers. Seventy-eight percent of kids in  
21 New York State live less than an hour drive from a  
22 verified trauma center. And in a study I did a few  
23 years ago, if you consider the state to be made up  
24 of eight hospital referral regions, we have a good

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2 comprehensive pediatric hospital with a peds I.C.U.  
3 in every one of the eight statewide regions.

4 The bad news is that although  
5 these resources are widely available, they're being  
6 used inconsistently. And one worry is that this  
7 regional variation may be a marker for some sort of  
8 regional barrier, preventing or limiting access to  
9 the existing resources.

10 Two studies -- this was my study  
11 published about seven or eight years ago, a  
12 retrospective study using hospital discharge data,  
13 and to make a long story short on this one, is if  
14 you looked at inpatient pediatric deaths in  
15 nonpediatric I.C.U. hospitals, looking at New York  
16 City, thirty-five percent of the inpatient deaths  
17 occurred in nonpediatric hospitals. In the rest of  
18 the state, only seventeen percent of inpatient  
19 deaths occurred in nonpediatric hospitals,  
20 suggesting that there was -- there's something  
21 different about referral practices in New York City  
22 and the rest of the state.

23 A more recent study in the next  
24 slide -- this is Hartman's study just published

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2 within the past year or so, a study of severe  
3 traumatic brain injury across six states from which  
4 they could get data. Just to point out, among  
5 those six studied states, New York had the highest  
6 per capita number of trauma centers. And these are  
7 either level-one trauma centers or pediatric trauma  
8 centers. So, we have the -- the highest per capita  
9 number of centers, and we have the best  
10 geographical access to those centers among the six  
11 study states. Nevertheless, our performance in  
12 getting the severe patients to one of those trauma  
13 centers was not so good. Fewer than eighty percent  
14 of the patients in New York received care in one of  
15 those high-level hospitals, and there was a great  
16 deal of regional variation with New York City, the  
17 Binghamton area and the Utica area being areas  
18 where even fewer patients were referred to the  
19 higher-level trauma hospitals.

20 What do national organizations  
21 say about regionalization of trauma -- of -- of  
22 critical care and trauma care?

23 And there's a long list of  
24 organizations there from A.A.P., S.E.C.M., American

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2 College of Surgeons, you can read the list -- also  
3 the E.M.S.C. federal level recommendations, which  
4 defines the performance measures that Martha was  
5 talking about that we are accountable for. All of  
6 them recommend various aspects of regionalized  
7 pediatric critical care and trauma care.

8 A little more evidence about what  
9 happens -- on the next slide, a little bit more  
10 evidence about what happens when states do formally  
11 designate pediatric hospitals for trauma and  
12 critical care. This was a retrospective study done  
13 in the state of Oregon. Oregon formally  
14 regionalized their pediatric trauma care in the  
15 late '80s, and found that after they had  
16 regionalized their risk-adjusted mortality rates  
17 for kids with trauma were lower than simultaneous  
18 observations in the state of Washington that had  
19 not yet regionalized care.

20 Next slide.

21 So, then Washington, a few years  
22 later, also regionalized. And this is a study not  
23 looking at outcomes, but simply looking at how the  
24 process of formally regionalizing affected

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2 admission patterns. And they were able to show a  
3 very successful shift in the admission patterns  
4 away from small community hospitals, increasingly  
5 toward adult trauma centers, and even more towards  
6 the designated pediatric trauma centers, a very  
7 objective effect, or a very objective change in  
8 referral patterns following that regionalization.

9 Next.

10 What's the experience in New York  
11 with the idea of regionalization? Well, we have  
12 very well-developed formal regionalization programs  
13 for burn care, for trauma care, including pediatric  
14 trauma care, for perinatal care, and more recently,  
15 for stroke care. And just to comment about trauma  
16 care, you might think that a well-regionalized  
17 trauma system would give us all the resources we  
18 need to regionalize the rest of pediatric critical  
19 care.

20 It's worth remembering that  
21 trauma accounts for probably less than ten percent  
22 of all the kids in a pediatric intensive care unit.  
23 So, I -- I guess the way I look at it is the trauma  
24 system provides us a good model for how to handle

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2 it, but there is no regulatory teeth to this.  
3 There's no direct and specific guidance for this,  
4 beyond the trauma patients extrapolating to the --  
5 the ninety percenters. So, of other peds critical  
6 care patients, we still lack guidance, and lack a  
7 well-developed process in New York.

8 Finally, what does  
9 regionalization mean for different groups like  
10 hospitals?

11 Well, I think most of it is good  
12 news. I think a well-regionalized system promotes  
13 the care of low-risk conditions, common conditions,  
14 near home. And so in a well-developed system, I  
15 think you're going to see clinical volume actually  
16 increase at some community hospitals.

17 I can tell you in my region, lots  
18 of kids are sent to the big pediatric hospital that  
19 could very nicely be cared for at the community  
20 hospital. And in fact, by doing that, by promoting  
21 the effective care of common low-risk conditions at  
22 community hospitals, you'll open up space at these  
23 very overcrowded children's hospitals, which right  
24 now sometimes prevents us from taking the next

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2 critically ill kid.

3 Next slide.

4 A community hospital that begins  
5 referring their very few critically ill kids to a  
6 pediatric hospital is going to have a negligible  
7 impact on that community hospital. And in fact,  
8 I'd argue it's going to be a benefit to the  
9 community hospital not to try, because taking care  
10 of a couple of severely ill, or severely injured  
11 kids a year in an adult I.C.U. is an overwhelming  
12 task. Even if they do it successfully, it's an  
13 overwhelming task of physicians and nurses who are  
14 not experienced in pediatric critical care.

15 Next slide.

16 Now, for hospitals that are  
17 already providing care for a modest number of  
18 critically sick children, they will have to decide  
19 do they want to strengthen their peds I.C.U.  
20 resources to meet standards for designation, or is  
21 it a better idea for them to shift their focus  
22 towards non-intensive care pediatrics?

23 And that's a decision that every  
24 community hospital that does a modest number of

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2 cases, that has a small peds I.C.U. program, is  
3 going to have to decide.

4 I can tell you that running a  
5 very small pediatric I.C.U. is an incredibly  
6 inefficient thing to try to do. If you have a  
7 four- or five-bed pediatric I.C.U., if you don't  
8 want to exhaust your staff, you need two or three  
9 physicians running it, ten nurses running it. It's  
10 impossible to pay for that on the caseload that  
11 you're going to see in a four-bed I.C.U., and if  
12 you have fewer staff than that, it usually is not a  
13 viable program.

14 And there's a nice report  
15 published in 2006, that describes case histories of  
16 I.C.U.s -- pediatric I.C.U.s that closed because --  
17 mostly because they were too small to survive.

18 Next slide.

19 There are differences, and I  
20 don't need to elaborate on this for this group.  
21 Some rural regions have really special important  
22 needs, distances between hospitals are long, so  
23 every hospital has to be capable of resuscitating  
24 and stabilizing a pediatric patient. Many small

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2 rural facilities do care for common low-risk  
3 conditions and appropriately transfer their sicker  
4 patients to a regional center. The circumstances  
5 are very different in a large urban area where a  
6 few hospitals will provide comprehensive care  
7 for -- for children, including critical care. Some  
8 hospitals will do emergency care and noncritical  
9 care, and some hospitals in a big city provide  
10 virtually no pediatric care. That's how it is, and  
11 that's how it should be.

12 Next slide.

13 Finally, when a system of  
14 regionalization is fully developed, regionalization  
15 is going to provide community hospitals with  
16 clearly identified resources at the peds critical  
17 care center, which right now is sometimes hard to  
18 find written down anywhere. It's all sort of  
19 informal. A well-developed regional system will  
20 give you rapid lines of communications with  
21 pediatric critical care centers for consultation or  
22 referral. It's going to provide a consistent  
23 interhospital transport services. And very  
24 importantly, should provide continuing professional

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2       education in pediatric resuscitation,  
3       stabilization, sometimes hospital care, all  
4       consistent with whatever that hospital's regional  
5       role is.

6                                   Moving on to families. What does  
7       it mean -- what does regionalization mean for  
8       families?

9                                   Well, it means that we're going  
10      to promote care for common low-risk conditions near  
11      home at an appropriate facility. And that's a -- a  
12      significant -- that's a significant benefit for  
13      families not to have to go to the pediatric  
14      hospital many miles away, if their child could  
15      receive good care close to home. But for complex  
16      high-risk conditions we really will have better  
17      outcomes if we transfer the child.

18                                  Next.

19                                  And although going far from home  
20      is hard for families, there's very good evidence in  
21      surveys -- and this was one study done in a  
22      cardiology context asking families about their  
23      preferences for where they'd like their child to  
24      have the high-risk cardiac surgery. But the same

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2 thing pertains to many other conditions. Parents  
3 tend to choose care, prefer care at a distant  
4 regional center if their child's condition is  
5 associated with a high mortality risk, and the  
6 resources are better equipped to deal with it at  
7 the regional center.

8 So, in conclusion, I think we do  
9 have very strong evidence that critically ill and  
10 injured kids should receive care at regional  
11 high-volume pediatric centers. We do have  
12 unfortunate evidence that there are barriers  
13 sometimes interfering with the use of existing  
14 resources in our state, and we have a good deal of  
15 experience with other states acting to improve  
16 their critical care system, and we have a fair  
17 amount of experience in New York State with  
18 regionalizing other types of services showing that  
19 regionalization helps.

20 DR. COOPER: Questions?

21 MS. CHIUMENTO: I just have one  
22 comment. I know that with neonates sometimes as  
23 they get a little bigger, they get transferred back  
24 to a home hospital.

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2 DR. KANTER: Yes.

3 MS. CHIUMENTO: Would it be worth  
4 mentioning something like that in your -- in  
5 your --?

6 DR. KANTER: You know, I think  
7 the volume of neonates that gets back-transported  
8 is large enough that that's a well-documented model  
9 for which there is good evidence. I'm not sure we  
10 have any such evidence as that for other kinds  
11 of -- of critical care.

12 MS. CHIUMENTO: Uh-huh. Just  
13 wondering.

14 DR. COOPER: Bob, I -- I think  
15 that following on the neonatal comment it might be  
16 worth including a slide or two on the success of  
17 regionalization of neonatal services indicating  
18 that for a, you know, a -- an arguably more complex  
19 population that -- that it -- that it has been done  
20 and it works very well.

21 DR. KANTER: You know what's -- I  
22 think you're probably right. I think there is  
23 enough evidence that we could do that. It was --  
24 it sort of implied by the Goodman study --

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2 DR. COOPER: Right.

3 DR. KANTER: -- that simply shows  
4 that up to a point it's helpful, beyond that point  
5 it's not.

6 The biggest problem with  
7 neonatology is, in this country right now, is that  
8 it reached its peak of benefit probably fifteen or  
9 twenty years ago, and the fragmentation of those  
10 regionalized services has really set us back a lot.  
11 It's not nearly as well-regionalized now as it was  
12 fifteen or twenty years ago.

13 DR. COOPER: Well, I -- and I  
14 think that that's a -- that that's a -- a good  
15 point, you know, and it -- it's -- in -- in many  
16 ways analogous to stopping immunization; you know,  
17 you immunize against an illness, in this case, you  
18 know, with regionalization, and meaning -- meaning  
19 the onus being critical pediatric illness, and then  
20 the system fragments and you lose benefits. So,  
21 it -- I think it's an argument, not only that it  
22 can be done and -- and should be done, but then  
23 when you think you're dealing with a previously  
24 solved problem, and you slack off in terms of the

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2 penetration of that -- of that exercise, that  
3 you're -- you know, your outcomes tend to show it.

4 DR. KANTER: Yeah. In fact,  
5 while we're on that subject, and we've talked about  
6 in this group before, some of the same problems are  
7 happening with trauma centers, is that -- is that  
8 many hospitals that have tried for years to provide  
9 trauma services are backing out, because the  
10 regional demands are too great.

11 MS. MCMURDO: Thank you.

12 This -- this has been very, very  
13 helpful for me especially.

14 In the other states that have  
15 done this, are there protocols and education; how  
16 do they actually do the system? And I assume at  
17 the meeting you're going to get into this on -- I  
18 know Illinois is going to come and talk, but I'm  
19 just trying to think logistically how you figure  
20 out which types of kids go where.

21 DR. KANTER: Yeah.

22 MS. MCMURDO: Secondly, I think  
23 it would be good in the slides if you could beef up  
24 the benefits at the community hospitals, because I

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2 am working with Martha and Lee to try to figure out  
3 how we best present this to the association -- the  
4 Hospital Associations; how we best get their  
5 buy-in. We're kind of carefully looking at how we  
6 proceed with this, so that we get -- get interest  
7 in buy-in and bring them in early enough --

8 DR. KANTER: Yeah.

9 MS. MCMURDO: -- before the May  
10 meeting, to kind of engage them, and I think having  
11 more info on what they might get out of it. I  
12 think you did a good job to summarize it, maybe  
13 some more specifics.

14 DR. KANTER: I wish there was  
15 more evidence about this.

16 MS. MCMURDO: Yeah.

17 DR. KANTER: There's just very  
18 little published information about how community  
19 hospitals have specifically benefited, or been  
20 harmed, by these sorts of things. There just is  
21 not much public information. But I'd love to have  
22 any other, you know, specific suggestions about how  
23 to beef up that -- that aspect of it.

24 Your first question about how it

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2 works, there's several answers to that. One is  
3 there's not a lot of published information about  
4 that either, but it does vary on a state-by-state  
5 basis.

6 It's the reason why -- why Martha  
7 had suggested asking the Illinois folks to come  
8 talk with us, because they have a -- a system they  
9 recently initiated, that by all accounts is working  
10 pretty well, and they'd be able to give us more  
11 particulars than you can extract from published  
12 information.

13 DR. COOPER: Lisa, I think there  
14 is a pretty good way that we could chase that  
15 information in time for the conference, and I -- I  
16 know you'll recall that a number of years ago -- I  
17 recall it, too.

18 MS. MCMURDO: How many years was  
19 that?

20 DR. COOPER: Well, I was just  
21 it's -- thinking it's more like seventeen years  
22 ago. When we were regionalizing the trauma system,  
23 the same issues arose with respect to community  
24 hospitals. Larry Motley (phonetic spelling) was

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2 the senior medical advisor for emergency medical  
3 services at that particular point in time, and he  
4 put together some data from SPARCS basically  
5 showing that with trauma, which has a much, much  
6 larger volume overall than critical pediatric  
7 illness that -- that most community hospitals lost  
8 maybe one or two patients a year, and -- and he had  
9 some cost data that, you know, showed that the  
10 impact of, you know, the -- the very, very small  
11 number of transfers on a hospital's bottom line was  
12 negligible, whereas the potential, you know,  
13 liability risk was huge. So, I think --.

14 MS. MCMURDO: Well, I also think  
15 they would gain patients, too. I think if you  
16 structured it right, they might get the proper  
17 patients directed to them that aren't being there  
18 anyway.

19 DR. COOPER: Right. And I was --  
20 I was just going to follow with that point. So, I  
21 think it's -- I think if we can -- if we can  
22 perhaps get some data, you know, to demonstrate how  
23 many patients are -- are being transferred, you  
24 know, and compare that with the potential number of

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2 patients that should not be transferred, I think it  
3 would show a -- a very, very interesting pattern,  
4 and as you say at least, I think would actually  
5 show, in many instances, a financial benefit to the  
6 hospital rather than a -- a detriment.

7 DR. KANTER: Now, something you  
8 can --

9 DR. COOPER: At least a wash.

10 DR. KANTER: One thing you --  
11 some of you may be able to help me with -- I  
12 certainly have information in my region about how  
13 many I.C.U. transports we get from each hospital.  
14 You're right, it comes to three to five kids from  
15 each hospital per year. You have similar  
16 information in your own centers and whether we can  
17 sort of pool that information.

18 DR. VAN DER JAGT: I -- I think  
19 that would be very interesting. We certainly have  
20 that information from our transport team, and  
21 from -- also from E.D. to outlying hospitals to our  
22 E.D. transfers.

23 DR. KANTER: I'd love to have  
24 that --.

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2 DR. VAN DER JAGT: That would be  
3 very -- I could very easily share that with you,  
4 the transport especially, that's -- that's  
5 nothing --

6 DR. KANTER: Yeah.

7 DR. VAN DER JAGT: -- we can do  
8 that in five minutes, you know, I think, to do  
9 that.

10 MS. GOHLKE: One of --.

11 DR. VAN DER JAGT: I have --

12 DR. COOPER: And think that  
13 would -- by the way, I think if we were able to  
14 pool the data from -- you know, from several peds  
15 I.C.U.s in New York State, that would make an  
16 eminently publishable study as well, and that would  
17 be, I think --

18 MR. VAN DER JAGT: Very.

19 DR. COOPER: -- a huge, huge  
20 contribution to the national debate on  
21 regionalization that actually saves the system  
22 money.

23 MS. GOHLKE: Well, yeah, and I  
24 was just going to add that, you know, if we go

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2 through -- all the way through with this process,  
3 we do need to collect some baseline data.

4 Other states who have done this,  
5 have not really done a good job with doing the  
6 before and after, so this is our chance to do it  
7 right, and to show outcome -- changes and outcome.

8 So, we've been going around for  
9 months and months on what data to collect, and one  
10 of the reasons why I had Dr. Kanter do this now was  
11 that data may or may not come to fruition before  
12 the meeting. It's -- like I said, it's been going  
13 in circles for months and nothing's come forward at  
14 this point. I asked Dr. Kanter to do this to -- if  
15 we don't have any data, you know, how does this  
16 presentation look? What are the gaps? And we've  
17 already mentioned a couple that maybe we should  
18 add.

19 MS. MCMURDO: But you know, Dr.  
20 Cooper had a good point. Maybe if --

21 MS. GOHLKE: Yeah.

22 MS. MCMURDO: -- maybe you and I  
23 can meet with Matt Leary and some of the folks in  
24 our -- the Health Department more familiar with the

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2 SPARCS stuff, and what the SPARCS has, that you may  
3 even know and we -- maybe we can try to see what we  
4 can pull together. I don't know. I don't know if  
5 it's doable by that date, but have you looked at  
6 that at all? Or -- because we -- I'd be willing  
7 to --.

8 MS. GOHLKE: Not with Matt Leary.  
9 We haven't, you know, gone down that road.

10 MS. MCMURDO: They know the  
11 SPARCS, what's in there, what's --.

12 DR. COOPER: Well, I can tell you  
13 that when -- that when this issue arose, because  
14 there was some push from the commissioner at that  
15 time, because there was a huge statewide trauma  
16 conference coming up, not unlike, you know, what  
17 we're doing here for peds, you know, the SPARCS  
18 folks moved pretty fast and got this data collected  
19 and together, you know, in record time.

20 And I suspect that given the fact  
21 that the commissioner has given this -- the current  
22 commissioner has given this high enough priority  
23 that he, himself, is attending the meeting, it --  
24 it -- it -- that may help our friends at SPARCS

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2 move this project along. It's not a huge project.

3 MS. MCMURDO: Right. Well, I  
4 think we just have to frame it. I mean there are  
5 staffing concerns though, I will admit right now,  
6 but --

7 DR. COOPER: Of course, we  
8 understand that.

9 MS. MCMURDO: -- we can try to  
10 work, and see if we can figure it out. But we may  
11 need one or two of you on a call to help guide us a  
12 little bit.

13 DR. COOPER: Sure. Uh-huh.

14 DR. KANTER: And then, Lisa, I  
15 think your suggestion about getting -- having some  
16 interaction with possible groups prior to a large  
17 meeting is a great idea. And you know, it -- you  
18 know who to contact better than I, but if you get  
19 questions or a -- a line of discussion that seems  
20 to represent a broad concern, you could let us know  
21 what the developing issues are, I think we could  
22 try to address those before the May meeting.

23 MS. MCMURDO: Yeah. I -- I had a  
24 meeting with HANYS in Greater New York last week

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2 not about this, but I brought this up, and just  
3 wanted to test the waters to see who -- who are the  
4 players there that they think we should be having  
5 at the meeting. And I -- I think if you have this  
6 in e-mail format, I think maybe sharing this with  
7 the top leadership there, maybe doing a call,  
8 because I think we have to approach it carefully  
9 with them.

10 FROM THE FLOOR: Uh-huh.

11 DR. COOPER: Right. My sense of  
12 it is --.

13 DR. KANTER: Martha has the  
14 PowerPoint, and if -- you know, you think that the  
15 PowerPoint in its present form is appropriate, use  
16 it.

17 MS. MCMURDO: How about smaller,  
18 I think for the leaders, you know, I'm talking like  
19 a Lorraine Ryan and Fred Heigle at Great -- at the  
20 two associations just to get things moving.

21 DR. COOPER: Yeah. My sense is  
22 that -- that at least from conversations with Ray  
23 Sweeney over the last three to five years --.

24 MS. MCMURDO: And he was at the

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2 meeting, too.

3 DR. COOPER: Yeah. The hospital  
4 association recognizes that -- that most of its  
5 members, and then of course most of its members are  
6 smaller institutions from across the state in terms  
7 of numbers, most of its members have long since  
8 been transporting out their -- their critically ill  
9 and injured kids. It's not a -- it's not a new  
10 thing for them, and I -- and I -- I -- I don't  
11 think that there will be a tremendous amount of  
12 pushback from -- from HANYS.

13 I'm a little less sure about  
14 Greater New York, but -- but -- but at the same  
15 time Greater New York has tended not to take  
16 explicit positions on issues like this when some of  
17 their members are, you know, are -- are -- you  
18 know, are clearly for it and some of their members  
19 less so.

20 DR. VAN DER JAGT: First of all,  
21 Bob, great presentation. This is very, very, very  
22 helpful. And I think it'll go a long way in  
23 helping with that stakeholder's meeting as  
24 background.

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2 Just a couple of questions I  
3 have. And one is a suggestion on one of your  
4 sides, the slide that talks about your study gaps  
5 in New York, it's, you know, in New York City  
6 thirty-five percent, and then it says of patient  
7 deaths occurring in non-PICU hospitals, in the  
8 remainder of New York City, only seventeen percent,  
9 you might want to just leave out that "only"  
10 because -- so, that we don't juxtapose, "well, the  
11 Upstate is doing much better than Downstate."

12 I know the intent is to show the  
13 variation, but I'm just wondering, just because of  
14 the sensitivities that might be there, whether it  
15 wouldn't be helpful just to state that even  
16 seventeen percent may be too high, you know, and --  
17 and so, I think rather than saying seventeen  
18 percent is great, you know, thirty-five percent is  
19 bad, just to be kind of sensitive to that, and just  
20 they're both may be -- may not be very acceptable.  
21 But they're -- they're two different numbers.

22 DR. KANTER: Well --.

23 DR. VAN DER JAGT: You don't have  
24 to respond to it. I'm just -- that's just an

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2 observation that -- it's just -- this is the way it  
3 hit me as -- as being, you know, I want to make  
4 sure --

5 DR. KANTER: Let -- let me ask --

6 DR. VAN DER JAGT: -- that it --  
7 it's -- comes across that way. Yeah. Yeah.

8 DR. KANTER: -- rather than  
9 respond, let me ask you should we be too sensitive,  
10 or should we try to provoke?

11 DR. VAN DER JAGT: Well, I --  
12 I -- I guess I -- I guess the question is -- can be  
13 looked at different ways. You know, I -- I'm not  
14 sure what the right percent is, you know, because  
15 there's going to be some percent -- there's no  
16 answer -- there's no answer to it, so --

17 DR. KANTER: Simply regional  
18 variations --

19 DR. VAN DER JAGT: Correct --  
20 correct.

21 DR. KANTER: -- may have been a  
22 prior problem.

23 DR. VAN DER JAGT: Correct.  
24 Exactly. And so, I think that one of the points of

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2 its variation is there are two different  
3 percentages.

4 The second thing is that maybe  
5 you can work that in elsewhere; nobody really knows  
6 the -- what exactly the right percent is because we  
7 know that there are children who, no matter what  
8 you do, are going to die in a small hospital. I  
9 mean we heard this morning from Kathy Lillis, you  
10 know, I mean kids that die there, within twelve  
11 hours they could die. So -- so, we do know that  
12 that occurs.

13 And then, that's also consistent  
14 with some of the -- the -- the work that's been  
15 done with identifying sick patients in the hospital  
16 with rapid response teams, which deaths are truly  
17 preventable, and which are really not preventable,  
18 or which events are preventable with the team  
19 versus not. I mean sort of the same kind of thing.  
20 So, that's number one.

21 The second question I had was  
22 whether something should be said in here about  
23 interfacility transfer. I'm not sure how to put it  
24 in exactly, but regionalization is more than just

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2     identifying places -- different places for  
3     different kinds of patients. This whole idea of  
4     interfacility transfer, which is part of the  
5     regionalization process, and in many parts actually  
6     already exists. I'm just wondering whether that --  
7     there's a way to put that in here as well as  
8     process, maybe under the next steps, or -- I'm not  
9     quite sure, but it needs to be addressed as an  
10    entity, because I think -- I -- I think it's easy  
11    enough to do the -- well, yes and no, but then  
12    the -- it -- the whole process of who transports,  
13    how do these transfers work is a big deal, I think.

14                                DR. KANTER: So, that part, I --  
15    I -- I see that as easier, because I --

16                                DR. VAN DER JAGT: Yeah.

17                                DR. KANTER: -- think there's a  
18    great deal -- first of all, the system already  
19    exists in most regions of our state.

20                                DR. VAN DER JAGT: Right.

21                                DR. KANTER: The E.M.S.C. federal  
22    level --

23                                DR. VAN DER JAGT: Right.

24                                DR. KANTER: -- has made some

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2 very explicit recommendations about it --

3 DR. VAN DER JAGT: Right.

4 Correct.

5 DR. KANTER: -- which we've  
6 already circulated a draft on for ourselves,  
7 hopefully for future distribution in our state. I  
8 think the real -- I think once hospitals agree that  
9 we should regionalize --

10 DR. VAN DER JAGT: Right.

11 DR. KANTER: -- the transport  
12 aspect is -- follows logically.

13 DR. VAN DER JAGT: Yeah.

14 DR. KANTER: The real question is  
15 should we have a more formal system of designation.

16 DR. VAN DER JAGT: Sure. Sure.

17 I think certainly one, step one and one step two,  
18 obviously, or the cart before the horse.

19 However --.

20 DR. COOPER: Well, I -- I --  
21 however, I'm not sure that Elise isn't right here,  
22 Bob. I -- I think that the -- I think that -- that  
23 it's -- it's well -- all well and good to say that  
24 regionalization is great, which we all support and

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2 the data supports and so on.

3 DR. VAN DER JAGT: Right.

4 DR. COOPER: But if it were the  
5 case --

6 DR. VAN DER JAGT: Right.

7 DR. COOPER: -- that if  
8 regionalization were great, but transport was  
9 terrible, that -- that -- that kids died during  
10 transport, you know, then you would have a  
11 compelling case against it.

12 DR. VAN DER JAGT: Right.

13 DR. COOPER: I think the point to  
14 be made here is -- is as -- just as you said a  
15 moment ago, the transport system exists, and in  
16 fact, it is incredibly safe provided that it's  
17 appropriately staffed. And you've done all the  
18 work in that area, so it should be a little -- it  
19 should be fairly easy to pop up a few more Kanter  
20 papers on that.

21 DR. KANTER: It is mentioned in  
22 the white paper, but --.

23 DR. COOPER: Yeah. But I think  
24 it's worth mentioning here.

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2 DR. VAN DER JAGT: I just think  
3 it needs to be addressed in the -- in this area.  
4 And I -- I do agree that we have made a lot of very  
5 good steps in the transfer process. We -- I think  
6 we are, I mean in various parts of New York State.

7 I also, however, am aware of the  
8 survey that Martha did, you know, that we do -- we  
9 also don't satisfy all the steps of the recommended  
10 transfer process. So, there is certainly work to  
11 be done in that area.

12 And then, the third thing, I just  
13 want to go back to that what your statement was,  
14 Art, about having some of the transport data. You  
15 know ever one of the areas, you know, PICUs in  
16 certainly Upstate New York, but also probably in --  
17 in -- in New York City, we have data on what kind  
18 of patients gets transferred to the hospital via  
19 the transport systems. And they are -- and this  
20 is, again, a little bit of a nuance, talking here  
21 about PICU patients and mortalities, but a lot of  
22 the transfers are not PICU, they're floor patients.  
23 But they're floor patients that cannot be taken  
24 care of in a smaller hospital, but they need a

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2 larger hospital, because the subspecialists are  
3 there.

4 And so, you know, that is an  
5 aspect of this that undoubtedly will be raised.  
6 You know, and here's an example: You know, a small  
7 community hospital, you know, because of insurance  
8 issues, says, well, you know, keep the diabetic  
9 with D.K.A. there, you know, sort of mild D.K.A.,  
10 just keep them there versus transfer. Our hospital  
11 will be on the floor, you know, with subspecialists  
12 there's a higher acuity in general there. It might  
13 be in the I.C.U. where it might be on the floor,  
14 not taking -- being taken care of very well.

15 Well, those things are going to  
16 come up. So, I think this not just -- just about  
17 PICU mortality. There's that other group of kids  
18 that may, just as well, need an interfacility  
19 transfer, and it may not be at the community  
20 hospital, although it could be depending on the --  
21 on the local expertise. So, just -- just another  
22 aspect of this.

23 DR. COOPER: Mr. Czapranski?

24 MR. CZAPRANSKI: Yeah. The --

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2 didn't we just discuss, at the State Counsel, that  
3 hospitals that cannot provide a service have to  
4 have an agreement with a transport facility or  
5 transport agency?

6 DR. VAN DER JAGT: And that's  
7 part of the -- you know --.

8 MR. CZAPRANSKI: Can we extend  
9 that -- look at extending that, I think, to  
10 pediatrics because I think that would force the  
11 discussion at the local hospital about how will we  
12 safely transport these patients we can't care for.

13 DR. COOPER: Well, this  
14 actually --

15 DR. VAN DER JAGT: This -- we  
16 have --

17 DR. COOPER: -- this -- this  
18 actually goes back to, you know --

19 DR. VAN DER JAGT: The survey  
20 done -- yeah.

21 DR. COOPER: -- hospital code  
22 from the -- from the 1980s. This goes back to the  
23 405.19 code. Hospitals that do not provide  
24 specialty services are required to have transfer

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2 agreements --

3 DR. VAN DER JAGT: Transfer  
4 agreements.

5 DR. COOPER: -- with hospitals  
6 that do. That's not something that's, you know,  
7 uniformly enforced, but it -- it has been on the  
8 books for over twenty years.

9 DR. VAN DER JAGT: And these were  
10 surveyed, and then --.

11 DR. COOPER: And what -- what the  
12 valued added here will be, through a formal process  
13 of regionalization, is in effect if you want to  
14 think of it this way, creating a giant statewide  
15 single, you know, transfer agreement, if you will,  
16 that, you know, while hospitals would still have to  
17 have individual agreements, it'll really spell out  
18 the -- you know, the what should be in -- in the  
19 agreement to a much greater level of detail, and  
20 that would really facilitate, you know, the  
21 Department's ability to ensure that -- that  
22 transfers are made appropriately, and in a timely  
23 manner, and that when transfers are not indicated,  
24 they don't need to be made.

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2 DR. KANTER: And you know, I --  
3 just for those who haven't seen the -- the  
4 paperwork that we have already been developing and  
5 circulating, we have a draft of interfacility  
6 transfer --

7 DR. COOPER: Yes, we do.

8 DR. KANTER: -- agreements.

9 DR. COOPER: Right.

10 DR. KANTER: And it spells out in  
11 some detail what kinds of patients would warrant a  
12 consultation for transfer, and talks in some detail  
13 about what the transporting equipment and personnel  
14 ought to be like. The big gap in our draft  
15 guidelines, are where should we send them? Because  
16 we haven't really identified the hospitals.

17 DR. VAN DER JAGT: Sure. Of  
18 course.

19 DR. COOPER: Bob, I have -- I  
20 have a couple of minor suggestions I'll share with  
21 you about the slides offline, but there is one  
22 comment I will make on the record that I haven't  
23 already made, and that is that it may be worth  
24 citing our own research here in New York State,

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2       regarding the contribution of the PICU to trauma  
3       care. We did publish that paper in Pediatric  
4       Critical Care Medicine six, seven years ago,  
5       showing that -- that it appeared anyway -- in  
6       effect that it appeared that the presence of a PICU  
7       was -- was perhaps the most significant factor --  
8       or at least among the most significant factors in  
9       terms of the improved outcome for trauma patients.

10                                And I think that will help drive  
11       the point home that, you know, well, we've  
12       regionalized, you know, critical care services for  
13       kids that the value there -- the primary value, may  
14       rest -- rest in -- in the pediatric critical care  
15       capability, rather than the trauma system itself.

16                                MR. TAYLER: Dr. Cooper?

17                                DR. COOPER: Yes?

18                                MR. TAYLER: Dr. Kanter, is -- is  
19       it my understanding that -- that, in building this  
20       system, you're looking to get the kids that need  
21       the higher level of care to the higher facility,  
22       but is it the intent that the kid would then stay  
23       there throughout the course, or for example, a sick  
24       kid from Ogdensburg gets transferred to you at

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2 Upstate in Syracuse, you take care of the -- the  
3 critical part of the needs, are you expected to  
4 keep the kid there throughout the entire recovery  
5 or ship them back to Ogdensburg, where they're  
6 home?

7 DR. KANTER: Well, again --.

8 MR. TAYLER: Because that -- that  
9 may be a piece that -- that you could --

10 MS. GOHLKE: I can answer that.

11 MR. TAYLER: -- buy into the  
12 what's in it for the community hospitals?

13 DR. KANTER: Yeah. I -- I think  
14 we -- we sort of touched on that earlier.

15 DR. COOPER: Yeah.

16 DR. KANTER: For neonatology, I  
17 think there's a very large volume of kids who need  
18 to stay in the hospital for some time after their  
19 critical care phase is done, and there's a fair  
20 amount of evidence that reverse transport is  
21 reasonable, safe, effective. There's much less  
22 information about that for other pediatric critical  
23 care, and in fact, the vast majority of pediatric  
24 critical care patients, when they get better, go

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2 home, not to another hospital. There are smaller  
3 numbers required for long hospital care, and that's  
4 usually just as labor intensive a  
5 subspecialty-oriented thing.

6 MR. TAYLER: I was just looking  
7 for another -- another way to -- to buy in the  
8 community hospitals into this. You know, what --  
9 what -- what would -- what would be in it for them,  
10 but just -- just a thought is all.

11 DR. COOPER: I think Mike -- Mike  
12 does raise a good point, you know, there's --  
13 there's no reason that a -- that a child who is  
14 transported for an injury, you know, can't be back  
15 transported when the -- when the capability exists  
16 in the -- in the community to do the follow-up  
17 care.

18 The problem, as you pointed out,  
19 Bob, is that for traumatic brain injury, and  
20 complex orthopedic injuries, that's -- that -- that  
21 is not normally the case, although in some  
22 instances it is. I mean there are -- there are  
23 areas in your own region, you know, where there are  
24 really outstanding pediatric orthopedists in the

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2 community, but no robust pediatric I.C.U.  
3 capability in that community; that's a perfect  
4 circumstance. But those -- those instances are  
5 uncommon.

6 MS. GOHLKE: Can I just add that  
7 my grant -- it was one part of the performance  
8 measure for, up until this year, that the kid had  
9 to go back to their original home and get any  
10 follow-up remaining care in the hospital there.  
11 But they since took it off, because I guess there's  
12 reimbursement issues, and you -- and you can't --.

13 DR. VAN DER JAGT: There are --  
14 cannot pay for it.

15 DR. KANTER: As a performance  
16 measure, your --

17 MS. GOHLKE: Right.

18 DR. KANTER: -- rate has been --.

19 MS. GOHLKE: So, they dropped  
20 that --

21 DR. VAN DER JAGT: Right.

22 MS. GOHLKE: -- because it causes  
23 too many problems. So, that -- would that be the  
24 case --

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2 DR. VAN DER JAGT: Right.

3 MS. GOHLKE: -- at least as far  
4 as the feds would want.

5 DR. COOPER: It always goes back  
6 to money, doesn't it.

7 DR. VAN DER JAGT: Yeah. I would  
8 have to echo what Bob says though, as I think that  
9 the populations are extremely different. The  
10 N.I.C.U. kinds of kids, they may be, you know, in  
11 another hospital for six weeks or more after the  
12 N.I.C.U. course. Most patients who come out of the  
13 PICU, you know, then they go home within a week. I  
14 mean, they're -- they're not really in the -- and  
15 most parents actually, at least in our experience,  
16 most parents do not want to be back transferred.

17 DR. KANTER: That is also  
18 correct.

19 DR. VAN DER JAGT: They feel very  
20 comfortable, they have bonded with the people there  
21 at that medical center, even though it may be a  
22 very short time, they don't trust going back. And  
23 so, I think it would be, again, very different than  
24 the neonatal, you know, but it will come up as a

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2 question I'm sure, and it's good to have some  
3 answers.

4 DR. HALPERT: Because the whole  
5 climate of this trust issue is real, too,  
6 because --

7 DR. VAN DER JAGT: Right.

8 DR. HALPERT: -- their -- their  
9 thought is that you sent my kid away in the first  
10 place, because you couldn't handle him --

11 DR. VAN DER JAGT: Right.

12 DR. HALPERT: -- what makes me  
13 want to give you my kid back now?

14 DR. VAN DER JAGT: Yeah. Yeah.  
15 There is -- there is --.

16 DR. HALPERT: You didn't fix him.  
17 You can't --.

18 DR. VAN DER JAGT: Exactly.  
19 Yeah.

20 DR. HALPERT: It may not be --.

21 DR. VAN DER JAGT: And you have  
22 to remember that the person who has to take care of  
23 those children are the -- is a pediatrician who,  
24 more and more, would prefer not to be in the

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2 hospital, would prefer to be seeing outpatients.

3 DR. COOPER: That's correct.

4 DR. VAN DER JAGT: So, there's  
5 another part of it.

6 DR. COOPER: All right. Unless  
7 (sic) there are no more burning questions for Bob,  
8 we're going to move on. I have been asked to take  
9 a very, very short break, which we will do right  
10 now, and we'll come back and attempt to complete  
11 the remainder of the agenda in very, very short  
12 order. It's three twenty-five, so no more than  
13 five minutes, please.

14 (A recess was taken at 3:25 p.m.)

15 (The meeting resumed at 3:30  
16 p.m.)

17 DR. COOPER: We will now proceed  
18 with the E.M.S. and -- E.M.S. report and E.M.S.C.  
19 grant report.

20 In the interest of time, of which  
21 we have precious little left, I will ask that Lee  
22 Burns and Martha Gohlke touch upon the -- the key  
23 highlights, so we will have time for the committee  
24 reports.

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2 MS. BURNS: Okay. In my new  
3 role, I have to tell you that the state is in a  
4 fiscal crisis.

5 FROM THE FLOOR: Wow.

6 FROM THE FLOOR: Really?

7 MS. BURNS: Yeah. And I knew  
8 that would come as a surprise to you.

9 With all -- all seriousness,  
10 the -- the budget situation is -- is bad, and  
11 continues to be bad. We have been, on a daily  
12 basis, fighting for our contractors and our program  
13 agencies. To date, twelve of them have been  
14 approved, there are nineteen total. We thought  
15 that, frankly, that once the -- the -- they started  
16 to get approved, and money got freed up, that all  
17 of them would be approved, but since the SEMAC  
18 meeting, there's been no -- there's been nothing  
19 new moving forward. So, we recommenced our battle  
20 with the division of budget. And I -- as I told  
21 the SEMAC and the SEMSCO, we have excellent  
22 partnership with -- with the -- our bureau of  
23 budget management, and to the point where they have  
24 been hand-delivering contracts, and you know, they

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2 have been doing all that they can do.

3 So, there is no good way to put  
4 this, but it is the Department's intention to make  
5 these sorts of meetings minimalist. They're  
6 expensive, and they're looking at other options, so  
7 keep your ears open. I -- you know, towards  
8 conference calls, WebExs, those sorts of things.

9 In that same vein, we  
10 experienced, much to our surprise, a sudden lack of  
11 prehospital care paper reports. We supply them to  
12 ambulance services. The warehouse -- we sent an  
13 order to the warehouse, and they called us and  
14 said, "oh, yeah, we don't have any of those."

15 So, what had happened was our  
16 print order had been approved in June, and because  
17 of all of the budget issues, O.G.S.'s contract with  
18 the new printer had never been approved. So,  
19 we're -- we've been told that the order's been put  
20 forth. P.C.R.s will be a little bit different.  
21 They'll be in shades of gray as opposed to red and  
22 black. But we're hoping to begin to receive  
23 P.C.R.s in the not-too-distant future.

24 Ryan White. The Ryan White Act,

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2 as you know, was reapproved by the feds. In an  
3 effort to get a good handle on it, the SEMAC and  
4 SEMSCO has -- has convened a technical advisory  
5 group, which includes staff from our AIDS institute  
6 who are experts in bloodborne diseases and the  
7 regulations, so that there's more to follow with  
8 that.

9 We discussed with our -- with the  
10 SEMSCO particularly something called project  
11 management. I think your group not necessarily so  
12 important, because you're -- you have very focused  
13 tasks for the next couple months, that is your  
14 stakeholders meeting. But I would be remiss if I  
15 didn't tell you that as you convene your meetings,  
16 you need to stay focused, you need to stay on-task,  
17 and you need to complete doable projects.

18 Our partners in the SEMSCO tend  
19 to come up - I -- I victimize my friends in the  
20 systems committee - we're going to change Part 800  
21 and update that. Well, we need to do that, there's  
22 no disputing that, but the reality is that you  
23 can't update Part 800 in one year, or decade, and  
24 so what we have -- what we're going to be doing

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2 with the -- with our councils is just trying to  
3 keep them focused and on-task and doing workable  
4 and attainable projects.

5 You -- you may also have been  
6 following the use of blood and blood products by  
7 prehospital care providers. That continues. Ed,  
8 just before he retired, went before the blood and  
9 tissue council, they are very positive about the  
10 regulatory change, which would include advanced  
11 life support providers monitoring and  
12 administering -- well, monitoring blood during  
13 critical care transfers. So, that sort of  
14 dovetails into your last discussion.

15 The next -- the regulations  
16 are -- are in the hands of our lawyers. The next  
17 step is that they go to the Governor's Office on  
18 Regulatory Reform. If there are no changes, they  
19 get -- they get published for sixty-day comment  
20 period, then they come back for final approval to  
21 the blood council.

22 I'm hoping that this occurs  
23 sometime before summer of 2010. So, just to keep  
24 you updated though, that does progress.

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2 I mentioned the respiratory  
3 training program. Jim is out there doing -- it's  
4 respiratory training and etiquette and fit testing  
5 train-the-trainers. He did his first program in  
6 Watertown at the end of -- well, I -- I think  
7 Friday night. He was a little disappointed that  
8 only eleven people showed up. I think -- and this  
9 caught my attention as Tim was speaking earlier,  
10 one of the issues from a prehospital care  
11 perspective is that there's so much information,  
12 all the time, that E.M.S. tends to focus on what is  
13 interesting to them, and they lose interest in  
14 things very quickly.

15 So, they're at a point where we  
16 have spent about a year now -- well, actually, more  
17 than that starting with SARS and seasonal flu, you  
18 know, barraging them with as much information as we  
19 can, under the logic that more is better, and  
20 they'll be better prepared, and now we're  
21 concerned, as we usually are, when we get to this  
22 point that all they're hearing is "blah, blah,  
23 blah, blah, blah." You don't have to commit that  
24 to minutes.

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2 So, that's a concern in this  
3 training program. So, with the help of our county  
4 coordinators and anybody who stands still long  
5 enough, we're beating the bushes to get people to  
6 these training classes.

7 Does that -- did you raise your  
8 hand?

9 MR. CZAPRANSKI: No.

10 MS. BURNS: Oh.

11 MR. CZAPRANSKI: But all the  
12 information the bureau puts down when we do all our  
13 weekly updates, we par it down.

14 MS. BURNS: Thank you.

15 And we par it down, too.

16 MR. CZAPRANSKI: Okay.

17 MS. BURNS: We, with the help of  
18 the SEMAC, are about to update our medical  
19 direction policy statement, which you may or may  
20 not be familiar with. It was put out a couple  
21 years ago -- a while ago actually. This actually  
22 Jeanne Alicandro from Suffolk County helped me put  
23 it together. It's essentially a policy statement  
24 to assist E.M.S. service medical directors in

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2 understanding really what the job is, what their  
3 responsibility is.

4 Yeah. The one you're thinking of  
5 is decades. A decade and a half.

6 What we did, we updated the  
7 medical director policy statement specifically to  
8 address -- it -- it -- it did not exclude pediatric  
9 patients, but it didn't encourage pediatric  
10 patients. So, we've updated it with some minor  
11 changes to include patients of all ages. That also  
12 comports with the E.M.S. for children grant  
13 process.

14 Also of interest to you, is that  
15 the SEMAC brought forward a proposal that was  
16 approved by the council to -- to amend Part 824,  
17 that's the equipment on ambulance -- ambulances  
18 regulations, to include -- and two -- these are two  
19 separate regulatory changes, one is to require an  
20 A.E.D. capable of defibrillating patients of all  
21 ages, or a defibrillator capable of defibrillating  
22 patients of all ages, and the second was to require  
23 that all ambulances carry EpiPen or epinephrine for  
24 patients of all ages.

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2 There is some wording to that.

3 We are working with them to do that. And as a part  
4 of that, we may bring forward to the SEMSCO --  
5 an -- an -- we're planning on bringing forward to  
6 the SEMSCO an updated equipment list, which will  
7 clearly visit the federal suggested guidelines for  
8 pediatric equipment, specifically at the B.L.S.  
9 level, because the regulations are basic life  
10 support. So, it won't -- it won't address A.L.S.,  
11 but we'll do what we can to address the -- the  
12 B.L.S. needs.

13 And we'll -- we'll -- there'll be  
14 more on that. And just so you know, New York's --  
15 the SEMAC approved New York City protocols - jump  
16 in here - that allow B.L.S. ambulances who -- who  
17 are already equipped with EpiPens to utilize them  
18 in -- in a severe asthmatic attack after they've  
19 done the Albuterol nebulizer. So, that protocol  
20 updates the New York City B.L.S. protocols.

21 And the last thing I have is  
22 we're very excited -- as I was sitting here, our  
23 G.T.S.C. grant, which has to do with electronic  
24 data collection and the NEMSIS dataset, we have --

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2 we're about this close to an executed contract with  
3 a company who will assist New York State in  
4 developing a state bridge, which will allow us to  
5 take data from all different types of vendors, put  
6 it into a NEMESIS-compliant dataset, push it to  
7 NEMESIS, and improve our prehospital data collection  
8 abilities and the data that we're collecting, and  
9 that's also covers your agenda item on NEMESIS

10 DR. COOPER: Thank you.

11 So, I presume that that is a  
12 bridge to somewhere as opposed to a bridge to  
13 nowhere?

14 MS. BURNS: Hopefully it's lot  
15 cheaper than the bridge to nowhere.

16 DR. COOPER: Martha?

17 Oh, any questions for -- for Lee?

18 DR. HALPERT: Yeah.

19 DR. COOPER: John.

20 DR. HALPERT: Yeah. A question  
21 on the New York City epi auto-injector program you  
22 mentioned. Would that be specific to pediatrics,  
23 or that's all players, or --?

24 MS. BURNS: I think what they --

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2 it's -- it is not age -- it is to all patients, but  
3 the age -- thirty-three jumps into my mind, and I  
4 can't remember why.

5 MS. CHIUMENTO: Yeah.

6 Thirty-three, I think, was the maximum -- that they  
7 can give them without medical control. Over  
8 thirty-three they added medical control.

9 DR. HALPERT: So, it's a standing  
10 order for E.M.T.s to utilize Epi auto-injector up  
11 to age thirty-three in the setting of respiratory  
12 stress questionable, or is probable, in asthmatics  
13 as your -- something like that.

14 MS. GOHLKE: I think they're --  
15 like that.

16 MS. CHIUMENTO: You know, Ann's  
17 shaking her head over here, so she may be more  
18 specific than -- but that was my recollection of  
19 the discussion, so --

20 DR. HALPERT: Okay.

21 MS. CHIUMENTO: -- go ahead.

22 MS. FITTON: I'd be happy to look  
23 at the protocol for you, but I believe the issue  
24 was that, first of all, the downside --

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2 MS. GHOLKE: Ann, could you just  
3 grab a mic?

4 MS. FITTON: -- is that with  
5 EpiPens for asthma patients is that we need to put  
6 the education piece in there as well as making sure  
7 that we're only doing this in the event that we  
8 cannot get an A.L.S. resource there.

9 DR. HALPERT: Uh-huh.

10 MS. FITTON: So, the -- you know,  
11 it's not -- it's -- it's -- the discussion here is  
12 almost as though E.M.T.s would be just  
13 administering epi on the basis of their assumptions  
14 that this is an asthma call.

15 DR. HALPERT: Right.

16 MS. FITTON: There are specific  
17 criteria for them to be able to do this. It has to  
18 be, first of all, a demonstrated inability of the  
19 system to deliver an A.L.S. resource to their  
20 location in a reasonable time. And I believe that  
21 time -- and, again, I'm speaking for E.M.S.  
22 operations here, I might be a little bit off of for  
23 this, but within a ten-minute upper -- upper limit.

24 So, if you have a child, or an

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2 adult, particularly an adult less than  
3 thirty-three, thirty-three was based on the  
4 American Heart age for patients who should be  
5 getting aspirin, et cetera, for chest pain, where  
6 we think that chest pain at thirty-three and above  
7 has a higher significance of having a -- a cardiac  
8 implication, therefore, thirty-three became the  
9 cutoff for this, based on A.H.A. criteria. So --  
10 so, it's -- it's -- it's just not that simple --  
11 that -- that -- that simplistic, that E.M.T.s will  
12 be delivering epinephrine. It is that the system  
13 is so overworked that we're unable to deliver that  
14 A.L.S. care.

15 DR. COOPER: Was -- was there's a  
16 low-end age on that?

17 MS. FITTON: That -- that -- that  
18 has yet to happen. I'd just like to tell you that  
19 that is yet to happen.

20 DR. COOPER: Okay. But there's  
21 no low-end age on that? That's age zero that  
22 they're --?

23 MS. BURNS: I think there is a  
24 low end age.

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2 MS. FITTON: Yes, that's also  
3 based on criteria that there has to be history of  
4 asthma --

5 MS. BURNS: I think there is a  
6 low end.

7 DR. COOPER: Yeah.

8 MS. FITTON: -- there has to be a  
9 diagnosed history of asthma, et cetera. So --

10 MS. BURNS: It think there was a  
11 low end.

12 MS. FITTON: -- it -- it would  
13 be --

14 MS. BURNS: I don't remember what  
15 it was but there was --.

16 MS. FITTON: I believe the lowest  
17 age is -- is age one.

18 DR. COOPER: Okay. All right.  
19 Martha?

20 MS. GOHLKE: Just want to draw  
21 your attention to the dates for next year that --  
22 it's an all inclusive list, that includes our other  
23 council meetings, so you just scan through, you'll  
24 see E.M.S.C. in there. The May 4th date is going

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2 to be by Webinar, which Mr. Tayler is going to  
3 help -- help me learn how to do with you all folks  
4 as guinea pigs from the E.M.S.C. committee. So,  
5 you can plan accordingly. You -- you won't need to  
6 travel on that day. You just need to --.

7 DR. VAN DER JAGT: I'm sorry.

8 Which date was that?

9 MS. GOHLKE: May 4th.

10 MR. VAN DER JAGT: May 4th.

11 DR. COOPER: Martha, may I just  
12 suggest that we might want to consider, since it's  
13 going to be by Webinar rather than in person, and  
14 the hotel dates don't matter, that maybe we move it  
15 after the stakeholder meeting.

16 MS. GOHLKE: No, I don't think  
17 it's a good idea. I strategically put it there in  
18 case there was last minute details that we need to  
19 take care of or talk about, and being that it's by  
20 Webinar, it's a good way.

21 DR. COOPER: Okay.

22 MS. GOHLKE: It won't cost  
23 anybody to touch base.

24 And if the feds don't look upon

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2 my stakeholders meeting as one of the four  
3 quarterly meetings of this committee, you can fall  
4 back on the Webinar as being the fourth meeting and  
5 we meet the grant requirement.

6 DR. COOPER: Okay.

7 MS. GOHLKE: So, there's --  
8 there's many reasons why to keep it on the  
9 calendar. So -- and then -- what else did I want  
10 to say?

11 Oh, the -- the -- the  
12 stakeholders meeting -- we'd love to have everybody  
13 there. We have limited funding, okay, to -- to get  
14 everybody there, but if you -- if you really want  
15 to be at the table, just let me know now, so I can  
16 start planning and figure out how we're going to  
17 pay for travel for you to be there. We -- we may  
18 possibly be able to get everybody there, but it  
19 depends on a lot of other factors. The money is  
20 coming directly from the grant, which your travel  
21 now doesn't come from the grant for these meetings,  
22 so there's a little balancing act we have to do.  
23 So, I just wanted to mention that.

24 I just wanted to let you know

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2 that the -- the Caris Foundation, and their --  
3 their steroid for the adrenal insufficiency went  
4 through the SEMAC and SEMSCO last week with Dr.  
5 Cooper's revisions that he made to our document  
6 that -- the document that got approved is in your  
7 folders there, if you're curious. It just puts  
8 Solu-Cortef on the state formulary for A.L.S.  
9 providers, and it opens the door for them to put it  
10 on their regional protocols, if they so choose.

11 So, it's still a regional  
12 decision whether or not it's going to be, you know,  
13 in the standing orders or not, but at least it  
14 opens the door, and it lets them know that we think  
15 it's a good idea. Okay.

16 So, the NEMSIS data, the only  
17 thing I want to add to what Lee talked about is  
18 Sharon has been helping out with this a lot, and  
19 you know, we've put it to your -- in front of your  
20 noses for your input. Now, is the time -- if -- if  
21 E.M.S.C. folks want input to what data --  
22 prehospital data we're collecting in the state  
23 because we're -- we're revising what we're doing,  
24 now is the time; okay? Because shortly you're not

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2 going to have a chance to give any input on it.  
3 So, if you want to -- if you want to give input,  
4 please e-mail Sharon as soon as possible, so you  
5 can -- so you can be heard.

6 I just wanted to mention, because  
7 this -- many of the nurses in the room may find  
8 this interesting. You can get your mandated  
9 reporter training online for free as your  
10 recertification or C.M.E. requirements through  
11 State Ed. The Office of Children and Family  
12 Services has a two-hour C.M.E. program for mandated  
13 reporters.

14 A link, if it's not on our Web  
15 site now, it will be shortly to the online  
16 training. It's free. It's twenty-four/seven. You  
17 can take it at your own pace. It goes directly to  
18 State Ed letting them know that you've taken it --  
19 taken it, and they can track it if you need to with  
20 them, and you can also print out a certificate, and  
21 it's available for E.M.S. providers, too. It's  
22 like nysmandatedreporter.org, I believe. But you  
23 can find it on our Web site.

24 Let's see. We did add -- we did

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2 add -- we talked about this a meeting or two ago,  
3 one of the grant requirements was that transporting  
4 vehicles have -- for children have to have their  
5 protocols accessible to them on the scene and  
6 during transport, so we've added that to the  
7 medical direction policy of the bureau, that it has  
8 to be either on the person or on the rigs, you  
9 know, for the sake of children. And adults, we  
10 have them for both, but it came from this grant for  
11 children. So, we did get that -- we did get that  
12 on board, literally.

13 We talked a lot about extra  
14 money, and the fact that the federal E.M.S.C.  
15 program believes that they're going to be funded  
16 better than ever in the coming year. We're still  
17 on, I guess, what's it's, continuation funding -- I  
18 can't remember what the proper terminology is, so  
19 2010 funding hasn't gone through yet. I e-mailed  
20 the project officer, and let her know that we had a  
21 bunch of ideas that we've been tossing around that  
22 we would like to know how we could get access to  
23 any extra funding, and she said she'll let us know  
24 as soon as possible. So, at least we got a seed

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2 planted, and she knows that we're eager to hear  
3 more about it.

4 I talked about the stakeholders  
5 meeting. So -- and one other comment is just that  
6 the subcommittee meetings in the morning, you know,  
7 we're restructuring this meeting that we start the  
8 general meeting at eleven, and we do subcommittees  
9 early. There were several people here that were on  
10 time that are part of subcommittees that the rest  
11 of the subcommittee wasn't here. So, either  
12 they -- they didn't get the communication on what  
13 time people were collecting -- I just don't think  
14 it's fair that some people are, you know, showing  
15 up on time and not getting the communication  
16 whether or not their subcommittee's meeting, or if  
17 it's meeting at nine-thirty or ten, or you know,  
18 it's just -- so keep that in mind, especially the  
19 chairs, that you've got to communicate better with  
20 your committee, and let them know what time you're  
21 meeting, because it's -- it's not fair, for  
22 travel -- people have to get up at an insane hour  
23 to get here. So, just out of respect for them.

24 Okay. That's it.

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2 DR. COOPER: Thank you, Martha.

3 Subcommittee reports, I think  
4 we've covered in interfacility. I'll just say for  
5 Nominations, that the Nomination Committee meeting  
6 did meet this morning, and came up with several  
7 potential names.

8 Sharon and Ann, Education?

9 MS. CHIUMENTO: Yes. I had sent  
10 out a patient transfer decision table. This is a  
11 first -- a first go at trying to take some of the  
12 different categories of patients that are out there  
13 in the literature already, and trying to see what  
14 would be the needs so we can start to develop  
15 educational documents for hospitals, you know,  
16 prehospital environments, ambulatory care centers,  
17 all that type of thing.

18 The first go-around is primarily  
19 for the hospitals, so interfacility transfer either  
20 from E.D. to E.D., or interfacility from a -- from  
21 a floor. Originally, I was going to try to do one  
22 be all end all. In our discussions, we kind of  
23 decide that maybe it would be better to look at the  
24 acute care settings first, and then look at the

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2 more chronic care needs later on. So, if somebody  
3 need to be going over because of rehab, that might  
4 be, you know, a different set of needs then for  
5 somebody who's going because of acute care -- of --  
6 of fractures, or whatever it might happen to be.  
7 So -- so, we're going to look at more the acute  
8 setting.

9 I -- I have some copies of the  
10 document. I would really like everybody's input  
11 because, you know, obviously, we're all coming from  
12 different backgrounds. Those of you who are  
13 in-hospital folks are going to have a much better  
14 idea of what you want to see in patients who are  
15 coming to you. What kind of needs you, you know,  
16 what kinds of -- of transport will they need -- all  
17 that type of thing.

18 So, the -- I'll -- I'll pass  
19 around -- I think I have eight copies here, so  
20 anybody who's interested in having a copy, based on  
21 some of the changes we made today, I will do an  
22 updated document, and we'll send that one out by  
23 e-mail. But if you want this, so that you just  
24 have something on -- on hand to start looking at,

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2 please -- please -- please take it. And then, once  
3 we finish that, then we'll move on to the other --  
4 the other populations that would be transferring  
5 patients, such as -- such as ambulatory care  
6 centers. So that's where we are at the moment.

7 And please, any input you can  
8 give us, that would be really useful. Okay.

9 DR. COOPER: Thanks.

10 Okay. Under old business, the  
11 E.M.S.C. dialogues, we were able to get the -- the  
12 approval of the Division of Legal Affairs to allow  
13 us to maintain the behavioral health specialist as  
14 one of our members in a voting capacity. The  
15 language seems a little bit awkward, so we have  
16 made a suggestion to some alternative language, and  
17 we'll see how that flies. But in concept it seems  
18 as though it has been approved, so we will put that  
19 on hold until the next meeting.

20 The NEMESIS data -- data elements  
21 have already been covered.

22 Before we go to new business,  
23 we'll briefly touch upon SEMSCO, SEMAC and STAC, I  
24 think most of the key issues from -- from SEMAC

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2 have been covered. Our major issue was the -- was  
3 the Caris protocol, which as you heard, was  
4 approved. And I think other issues have been  
5 made --.

6 MS. CHIUMENTO: I had just a  
7 couple --

8 MR. COOPER: Sharon, go ahead,  
9 please.

10 MS. CHIUMENTO: -- things.

11 The E.M.C. guideline on education  
12 on new drugs -- so, a new drug is added into a  
13 particular regions protocols, there -- there is now  
14 a standardized format for how they're going to  
15 educate their -- their providers on the use of that  
16 drug; indications, counterindications, side  
17 effects, all the kinds of things that we would  
18 normally see when a new drug comes on the market,  
19 is now a standardized format for E.M.S. as well.

20 In the past, it's been whatever  
21 they felt like educating, or however they wanted to  
22 train, and there was no formalized mechanism. Now,  
23 there will be a formalized template that they can  
24 use.

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2 There was a naloxone demo project  
3 that was intranasal naloxone by B.L.S. providers in  
4 the Albany region. So, that's something that will  
5 be looked at. It's not going to affect most of our  
6 patients, but it could affect some of our  
7 adolescent population.

8 And then, there was a discussion  
9 on Tamiflu distribution by E.M.S. in epidemic  
10 situations. And again, right now, it's just the  
11 preliminaries to getting the information together.  
12 It would be information that would be provided to  
13 regions, and then the regions would have to then  
14 make the decisions as to whether or not to utilize  
15 that -- that mechanism if there was an epidemic.

16 So, those are just couple of  
17 other little things we touched on.

18 Oh, one other thing and that's  
19 protocols. Please, the pediatric protocols that I  
20 sent out, did not get discussed at this last SEMAC  
21 meeting. The next SEMAC meeting is before our next  
22 E.M.S.C. Committee, and I know Dr. van der Jagt was  
23 looking at some of them last night, did find a  
24 couple of issue that he (sic) was -- some concerns

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2 he (sic) had. Please get those back to me, so that  
3 when we get to discussing that at the -- at the  
4 SEMAC and at the Medical Standards, I will be able  
5 to back -- bring back the input of this group as to  
6 whether or not something that's in the protocol is  
7 either not safe, or not recommended, or whether we  
8 want to make a recommendation that's not currently  
9 in the protocols.

10 DR. VAN DER JAGT: Uh-huh.  
11 Sharon, could I just comment on that?

12 Sharon's, as usual with his  
13 excellent work on all these prehospital care  
14 protocols is just outstanding. I would really  
15 endorse what Sharon says, because as you go through  
16 these prehospital care protocols, which is  
17 basically a -- a compilation of everything that is  
18 out there, it is quite amazing what people are  
19 allowed to do in their various areas. I was pretty  
20 floored actually last night.

21 All the way from, you know,  
22 R.S.I., which is, of course, understandable for  
23 paramedics particularly, but then there's, you  
24 know, procedural sedation, there's antibiotics

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2 being given, there's -- I mean there's all kinds of  
3 things in these protocols, and I -- there are  
4 dosing issues. There are a lot of dosing problems.  
5 So, I would -- again, I think one of the reasons we  
6 have this Committee is to make sure that we have  
7 input into these prehospital care protocols,  
8 because if mistakes get made, or if there is a  
9 problem out there prehospital care, you may not  
10 have a good outcome, and that makes me very  
11 worried, so --.

12 DR. HALPERT: I would just add as  
13 a continuance to that, having attended a few of  
14 those meetings as an observer, I think they are  
15 fairly comprehensive in their review of these  
16 protocols. It would surprise me if there are  
17 tremendous discrepancies, or concerns or mistakes  
18 out there. It's taken me a while to get my arms  
19 around the fact that a state body is really  
20 actively reviewing and trying to standardize all  
21 these protocols. I'm kind of a -- a local medical  
22 control guy historically, but be it as it may, I --  
23 I -- I think it's -- it would be great for us to  
24 sit down and review these ourselves, so that we are

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2 confident at our level that things are -- are  
3 squared up and by the book. But so far, it seems  
4 like at least there's been a fair amount of vetting  
5 of these protocols through the state mechanism.

6 DR. VAN DER JAGT: All I can say  
7 is read what Sharon has put together.

8 DR. COOPER: Point well -- points  
9 well noted by both. Thank you.

10 With respect to STAC, the work in  
11 the STAC is focused, I think, on three major things  
12 at the present time: First, the ongoing rewriting  
13 of the regulations. Second, formation of joint  
14 group with the SEMAC to look at prehospital  
15 tourniquet use. And third, the development and the  
16 review of the -- of a potential paper survey that's  
17 going to go out to all trauma centers to provide an  
18 interim look at trauma center operations in between  
19 formal on-site visits.

20 The Education Committee continues  
21 to do its good work in terms of arranging for  
22 prehospital trauma care programs for the Vital  
23 Signs Conference, and the Registry Committee  
24 continues to do its excellent work in terms of

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2 updating the registry to keep it, you know,  
3 consistent, timely and consonant with the national  
4 trauma dataset.

5 Mike, are there any other key  
6 issues that you feel --

7 MR. TAYLER: No, that was it.

8 DR. COOPER: -- you --?

9 MR. TAYLER: I mentioned it.

10 MS. GOHLKE: Okay.

11 DR. COOPER: Thank you. So --

12 MR. TAYLER: That's complete.

13 DR. COOPER: -- so, I believe we  
14 have covered everything on the formal agenda.

15 I will now combine the new  
16 business and round robin sections of our meeting.  
17 We are two minutes over time, I apologize for that.  
18 But I do think we've got the rest of the agenda  
19 done in pretty record time. Thank you all for  
20 cooperating in that endeavor.

21 Is there any new business?

22 Does anybody have anything that  
23 they want to add to our deliberations today?

24 Well, hearing none, we will stand

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2 adjourned until our next meeting, which is, Martha,

3 on --?

4 MS. GOHLKE: March 2nd.

5 DR. COOPER: March 2nd, here at

6 the Crowne Plaza.

7 Okay. Thank you very much. And  
8 we will see you all then. In the meantime, have a  
9 healthy and happy holiday season. And if you are  
10 driving home this evening, please be careful, it's  
11 my understanding that a storm is anticipated.

12 (The meeting concluded at 4:02  
13 p.m.)

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I, Howard P. Hubbard, do hereby certify that the foregoing was taken by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 238, inclusive, is a true record prepared by me and completed by Associated Reporters Int'l., Inc. from materials provided by me.

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Howard P. Hubbard, Reporter

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