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

DATE: March 2, 2010
TIME: 11:13 a.m. to 12:37 p.m. and
1:00 p.m. to 3:37 p.m.
LOCATION: Crown Plaza, Capital Room
Albany, New York

1 E.M.S.C.A.C. - 3-2-2010

2 PRESENT:

3 Arthur Cooper, M.D., MS, Chair

4 Susan Brillhart, MS, RN, CPNP (Telephonically)

Lee Burns

5 Sharon Chiumento, BSN, EMT-P

Tim Czapranski, EMT-P

6 Ann Fitton, EMT-P

Marjorie Geiger, RN

7 Martha Gohlke

Ed Hannon, M.D.

8 Robert Kanter, M.D. (Telephonically)

Christopher Kus, M.D.

9 Kathleen Lillis, M.D.

Sarah Macinski Sperry

10 Mike Tayler

Jennifer Treacy

11 Wendy Weller, Ph.D.

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2 (The meeting commenced at 11:13
3 a.m.)

4 DR. COOPER: All right. Welcome
5 everyone. This is the March 2, 2010 meeting of the
6 State Emergency Medical Services for Children
7 Advisory Committee. My name is Dr. Arthur Cooper,
8 and as you know, I have the honor of serving as
9 your chair.

10 And we have a rather full agenda
11 today. And so, we well plan on proceeding with the
12 agenda. I'll note that Dr. Robert Kanter of
13 Upstate Medical University in Syracuse is joining
14 us via conference call, so I'll ask the
15 stenographer to make note of that. And we have,
16 fortunately, our guests from the School of Public
17 Health, Dr. Wendy Weller, and from the Bureau of
18 Injury Prevention in the Department, Sarah Sperry.

19 Welcome and thank you for joining
20 us as always.

21 And we do anticipate that a very
22 dear old friend of ours, Marjorie Geiger, former
23 Assistant Director for the Bureau of Emergency
24 Medical Services, who now heads the Safety Center

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2 within the Department of Health, will be here this
3 afternoon to give us a briefing on the very
4 important activities of -- of that center.

5 So, we do have a full agenda, and let's not tarry
6 and let's move on and get through it.

7 I'd like first to call for
8 approval of the -- of the minutes.

9 DR. LILLIS: So moved.

10 MS. CHIUMENTO: Second.

11 DR. COOPER: It's moved and
12 seconded by Dr. Lillis and Ms. Chiumento. Any
13 additions, deletions, or corrections to the
14 minutes?

15 (No audible response)

16 DR. COOPER: Hearing none, all in
17 favor, please signify by saying aye.

18 FROM THE FLOOR: Aye.

19 DR. COOPER: Opposed?

20 (No audible response)

21 (The motion carried.)

22 DR. COOPER: Carries unanimously.

23 Thank you so much.

24 Martha, would you be kind enough

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2 to review the agenda for us, as per the agenda?

3 MS. GOHLKE: Yes. Thank you, Dr.
4 Cooper. So, it follows pretty much normal format.
5 Lee Burns, when she arrives will give her Bureau of
6 E.M.S. report. I'll talk -- I have a brief report
7 about the grant -- the status of the E.M.S. for
8 Children grant. We'll have the subcommittee
9 progress report -- report out, and then we'll get
10 to old business.

11 One of the agenda items today was
12 the bylaws, but we don't have a quorum today, so
13 we'll have to put off voting on the bylaws for a
14 time when we meet in person and we have a quorum.

15 As Dr. Cooper mentioned, Mike
16 will give us an update on the pediatric trauma
17 centers in New York City and what's been going on
18 with them. The -- we had a brief subcommittee --
19 asthma subcommittee meeting on -- via phone that
20 Dr. Lillis will update us on. And the School of
21 Public Health, Dr. Wendy Weller, will talk about a
22 summary of the pediatric report, which they're just
23 about getting finished to publish or produce for
24 us.

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2 We have -- for new business, we
3 have protocol that the Health Department is
4 looking -- is developing, and we -- they asked us
5 to bring it to this committee for your feedback, as
6 a type of focus-group feedback. So we'll get to
7 that. And Dr. Cooper is going to talk about the
8 American Heart meeting that he went to earlier
9 this -- or last month. Marjorie Geiger will be
10 coming to talk about the Patient Safety Center, and
11 Dr. Lillis will be talking about her project that's
12 funded under the Patient Safety Center as well.

13 And Marjorie Geiger also asked
14 for feedback from this committee on the pharyngitis
15 article that you were sent ahead of time. So,
16 she'll be here at that point to actually hear your
17 feedback on that article. And then if we have
18 time -- which it looks like we will today, we'll
19 have the updates from the other committee meetings.

20 And that's our full agenda.

21 DR. COOPER: Thank you, Martha.
22 Since Lee has been unavoidably detained, perhaps
23 you could proceed and give us the E.M.S.C. grant
24 report.

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2 MS. GOHLKE: Sure. Well, as
3 usual, the grant year ends February 28th, and it's
4 March 2nd today, and I have not heard if we've been
5 re-funded. But this is normal. They always are
6 kind of late with these announcements. I -- I have
7 no indication that we will not be funded.
8 Everything looks very good. We just haven't gotten
9 the official word. And I'm still here and nobody
10 told me not to show up this morning for work, so --
11 but so, the other thing I just want to mention, and
12 I don't have much to talk about the grant, is the
13 only thing different -- and you have a sheet in
14 your folder -- it has -- it says E.M.S.C. State
15 Partnership performance measures, and I've
16 highlighted in yellow a couple lines.

17 The only thing they've really
18 changed around with this grant in the past year is
19 they renumbered the grant performance measures.
20 They used to be in the sixties, now they're in the
21 seventies. And the reason they did this was
22 because a lot of them were rolled in together.
23 So -- so, like they used to be sixty-eight-A, -B,
24 -C, and -D, and if you didn't accomplish -A, -B,

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2 -C, and -D, then you didn't accomplish performance
3 measure sixty-eight. So they changed the
4 numbering, and they basically separated out all the
5 performance measures, so that if you meet one of
6 them we can show growth with the program, and that
7 we've done some, you know, measures of
8 accomplishment on the grant. So it was really to
9 our benefit that they renumbered the performance
10 measures, so we can make baby steps to
11 accomplishing the entire grant performance
12 measures.

13 And then one of the things I just
14 decided to highlight for you was performance
15 measures seventy-four and seventy-five. This is
16 kind of what we've been focusing more so lately on
17 with these meetings, and this grant is trying to
18 meet these performance measures. We actually --
19 performance measure seventy-five is recognizing
20 pediatric trauma centers or a standardized system
21 for traumatic injuries for children. We actually
22 already, in the eyes of the federal government,
23 meet that performance measure, because we do have a
24 pediatric trauma system set up in New York State.

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2 What we don't meet is the system to manage
3 pediatric medical emergencies, which is what the
4 subcommittee, the interfacility and -- what else do
5 we call them -- regionalization subcommittee has
6 been working diligently on, in order to try and
7 move us forward to meet this performance measure.
8 And this is where our stakeholder's meeting on May
9 13th comes into play, to bring people around the
10 state to talk about standardizing or developing a
11 system in New York State to address medical
12 emergencies in a more coordinated standardized way
13 in New York State.

14 So, I just -- you know, we don't
15 really talk about the performance measures of this
16 grant, but I just wanted to reiterate, this is why
17 we're doing the stakeholder's meeting in May. One
18 of the impetuses is that this is what the federal
19 government, with this grant, is saying that each
20 state should move towards doing.

21 Are there any questions about the
22 grant or performance measures that I can answer for
23 anybody?

24 (No audible response)

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2 MS. GOHLKE: That's about it. I
3 mean those are the major changes as far as the
4 grant's concerned and hopefully we'll get our award
5 for next year, and we'll be moving forward.

6 DR. COOPER: Martha, just one
7 question. Where do we stand as far as the fed is
8 concerned, with respect to the other performance
9 measures, understanding that seventy-four we do not
10 yet meet.

11 MS. GOHLKE: Okay. See if I can
12 remember off the top of my head. Let's see. The
13 first one, seventy-one, percent of prehospital
14 providers in the state have online pediatric
15 medical direction. You have to have -- you have to
16 have at least ninety percent of the providers
17 reporting that they have access to online pediatric
18 medical direction and the survey that we did a few
19 years ago did not show that we had ninety percent
20 access to this, so we don't meet that performance
21 measure.

22 Offline you also need ninety
23 percent. When we did our survey we did not meet
24 that. The providers did not say that -- over

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2 ninety percent of providers did not say that they
3 had access to offline medical direction. So
4 according to the survey, and the data from that
5 survey, we do not meet that performance measure,
6 according to the feds.

7 DR. COOPER: I'd like to just
8 stop briefly --

9 MS. GOHLKE: Yes.

10 DR. COOPER: -- and comment on
11 that.

12 MS. GOHLKE: Yes.

13 DR. COOPER: Dr. Henry, who as
14 you know is chair of the SSEMAC --

15 MS. GOHLKE: Yes.

16 DR. COOPER: -- is quite
17 convinced that we do meet that --

18 MS. GOHLKE: Right.

19 DR. COOPER: -- because, of
20 course, emergency medicine physicians who provide
21 medical control both online and offline for
22 prehospital providers do spend a significant amount
23 of time during their residencies caring for
24 children, and it's his view that if -- if there's a

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2 board-certified emergency-medicine physician who is
3 providing the online or -- or -- and/or offline
4 medical control, that that performance measure has
5 been met.

6 MS. GOHLKE: Yes.

7 DR. COOPER: Now, certainly, the
8 intent of the federal government here is to make
9 sure that there is access to explicit pediatric
10 expertise --

11 MS. GOHLKE: Right.

12 DR. COOPER: -- but I do think
13 there may be some wiggle room here --

14 MS. GOHLKE: Well --.

15 DR. COOPER: -- and perhaps we
16 could get some assistance from the federal
17 government in helping to sort out exactly what --
18 what this means.

19 MS. GOHLKE: Yeah, I -- I mean, I
20 can -- I can get into that. I mean -- at a policy
21 level one of the things that we did for offline
22 medical direction is we didn't have a policy
23 stipulating that offline protocols be on the
24 ambulance or on the provider at the -- at the

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2 scene, which is what's required is that they have
3 to have the offline and online medical control at
4 the scene. So, we did write a policy statement
5 that now all rigs have to carry the -- the written
6 protocols either on the person or on the rig. So
7 policy-wise, you know, we've set that up so that it
8 should be there.

9 But the issue that the feds have
10 is that if the provider doesn't know about it or
11 doesn't have access to it, for whatever the reason
12 is, and they're reporting that they don't have
13 access to the pediatric-specific protocols, that's
14 the problem. And if they're in an area where there
15 isn't cell coverage, and they don't have access to
16 online medical control, that's a problem, the feds
17 feel, even though we may have a policy statement or
18 we may have the physical set up as such that they
19 should have it. So there's the policy side of it
20 and then there's the practical, whether or not they
21 really do have it at the scene. So they're trying
22 to --

23 MR. KANTER: All right. It's
24 fine, but you know, I -- I agree with Art, I -- I

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2 think it -- the -- the questions -- it's hard to
3 know what the responders to the survey really mean
4 when they say this --

5 MS. GOHLKE: Exactly.

6 MR. KANTER: -- but Art is
7 correct --

8 MS. GOHLKE: Yes.

9 MR. KANTER: -- that a board
10 certified emergency physician certainly is adequate
11 online medical control. And furthermore, except in
12 the biggest cities, it's unlikely you're ever going
13 to get any better than that.

14 MS. GOHLKE: The --.

15 MR. KANTER: So if you can get
16 that, that's a success.

17 MS. GOHLKE: Yeah. And -- but,
18 you know, we do know that it's -- it's not always
19 necessarily the medical controls being with an
20 emergency-medicine physician. So -- so there is --
21 and we do know that that is the case in some areas.
22 So we can't actually go to the feds and say we know
23 for sure that it's a M.D. that's answering the
24 phone, giving online medical control.

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2 You know, part of it is the
3 survey, obviously, and part of it is how --
4 people's perception when they're answering the
5 survey. I honestly think that a lot of providers
6 don't know that the pediatric protocols are in the
7 adult -- with -- combined with the adult protocols,
8 and they're thinking is there a separate document,
9 and no there isn't. So maybe they answered no.

10 I mean, there's obviously
11 problems with the survey, but we were way off in
12 our numbers. I mean, if we were off five percent,
13 that would be one thing, but when we're off forty
14 percent, the providers are off by forty percent,
15 it's kind of hard to argue to the feds that they do
16 actually have this in the field. So we -- we have
17 to resurvey. That was just a baseline survey that
18 we did a couple years ago. We have to resurvey
19 this year, which I'm dreading. And we will do our
20 best to make sure that the survey language is very
21 clear, and it -- the -- the -- I haven't seen it
22 yet, but the survey, I've been told, is much better
23 this year. So, hopefully our results will be much
24 better as a result.

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2 But the data is part of the
3 supporting information that the feds need, to see
4 whether or not we've accomplished the performance
5 measures.

6 Tim?

7 MR. CZAPRANSKI: Just one comment
8 on the cellular coverage piece. That doesn't mean
9 they can't get medical control. There's been a lot
10 of times when I've used a patients home landline to
11 get medical control, where there is no cellular
12 coverage. So some time during the call, I had the
13 opportunity to do that from a landline, as opposed
14 to --

15 MS. GOHLKE: But whether the
16 provider --

17 MR. CZAPRANSKI: -- a cell tower.

18 MS. GOHLKE: -- does that and
19 knows that, I mean, I know in my agency that we
20 have A.L.S. respond to all our calls, and I've
21 actually heard my B.L.S. counterparts say "I would
22 never call medical control. I would never do
23 that." I mean, it's like -- they have the
24 perception that they -- they are not the ones to

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2 call, that it's always the A.L.S. provider, and
3 that the B.L.S. provider doesn't call. So we know
4 that as a group. We know how the system's set up,
5 but the provider, who is the one that needs to
6 access pediatric medical control, for whatever
7 reason feels that it's either not available, or
8 they can't do it. And that's the problem is that
9 they don't have it at the scene, and that's what
10 the feds see.

11 We can set up all the policies we
12 want, you know, it makes -- try and get that
13 information out there, and maybe that's part of the
14 problem is we haven't disseminated how they need to
15 get medical control information at the scene, which
16 this committee could work on. But the -- you know,
17 if they -- if they don't feel they have access to
18 it in the field, that's -- that's where the problem
19 lies.

20 DR. COOPER: You know, I've
21 always felt that this particular measure would be
22 the one that would trip us up, if any -- if any one
23 did, for precisely the reasons that both you and
24 Mr. Czapranski mentioned, Martha. The -- the --

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2 the -- more the custom than the reality, that basic
3 life support providers don't feel that they should
4 be calling medical control.

5 I'm wondering, as we think about
6 this, if there might not be some way that we could
7 begin to educate our basic life support colleagues,
8 you know, in this -- in this area. And I think
9 that what might help is a conversation with SEMAC
10 as to how to begin this discussion, followed -- not
11 this year, of course, because the program's already
12 set -- but the following year, by -- by perhaps a
13 special session at Vital Signs. What does
14 pediatric -- what is pediatric medical control?
15 What does it mean? How do you get it?

16 MS. GOHLKE: Right.

17 DR. COOPER: You know,
18 particularly if you're a basic life support
19 provider, you know, especially in a rural area.
20 You know, in the -- in the city, of course, with a
21 centralized nine-one-one response and -- and
22 dispatch center, you know, we -- we can clearly
23 provide that at a basic life support level, as well
24 as an advanced life support level, and that's well

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2 understood. And I -- I think that the same is
3 probably true for most of the upstate cities. But
4 I think we have a huge problem in -- in the less
5 urban areas of the city, in terms of people knowing
6 where they can access medical control, or even if
7 they can. I mean, there are -- we may believe that
8 they can, but maybe they can't. So, I think this
9 is something we should -- we should look at.

10 So, Martha, I'm going to ask that
11 you organize a conference call with a few members
12 of -- of SEMAC, to be selected by Dr. Henry, as to
13 how we might begin to, you know, focus a little bit
14 more on this particular performance measure, and
15 how we might meet it. And of course, since we have
16 to do the survey this year, it would be very nice
17 if we could, you know, make some progress on that
18 before we actually do the survey, and maybe even
19 develop some guidance for people that could be
20 written up in the form of a policy or something
21 along those lines, that would at least keep the --
22 you know, the issue front and center, would provide
23 us with some, you know, support at a federal level,
24 to indicate that this is a problem we're actively

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2 engaged in -- in correcting, so that the next time
3 we get around to doing this survey, which I presume
4 will be two years after this, you know, we'll be in
5 much, much better shape. And I think the
6 combination of having some kind of written policy
7 that can be distributed to all the regions, every
8 single ambulance service, so on, coupled with an
9 educational session at Vital Signs, not this year,
10 but next, I think might be very, very useful in --
11 in helping us meet that -- meet that target.

12 MS. GOHLKE: And -- and just to
13 reassure everybody, believe me, they hear from New
14 York, and they know that we are working diligently
15 and -- and that we're not just okay with the -- the
16 data numbers, that there was a problem with the
17 survey, and that means -- I've gone back and forth
18 with them on this, and they're aware that we are
19 doing better than we show on paper. That's
20 just --.

21 DR. COOPER: I -- I -- I have no
22 doubt that -- that we are letting them know that on
23 a regular basis, but I am concerned that there are
24 providers out there that believe they may not have

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2 access, and that is a problem. Because those are
3 the people who obviously need it the most.

4 Sharon?

5 MS. CHIUMENTO: Martha, I was
6 going to say one of the things is do you have
7 access -- do you have the ability to change your
8 question? You may want to ask them how they get
9 control -- medical control, if they have -- if they
10 have to -- if they have patient refusal, or if they
11 can --

12 MS. GOHLKE: I can't --

13 MS. CHIUMENTO: -- give an
14 example.

15 MS. GOHLKE: -- I can't get to
16 that depth of -- of tweaking questions.

17 MS. CHIUMENTO: Okay.

18 MS. GOHLKE: I can use, you know,
19 language that we use in New York State, but the
20 question's got to stay standardized for every
21 state.

22 MS. CHIUMENTO: Okay.

23 MS. GOHLKE: So, I -- I can't ask
24 subsequent questions like that. I think they have

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2 a lot of open-ended areas for people to comment on,
3 but I can only tweak so much, and the let us do
4 that, and we will do that, but I can't go to the
5 depths that you're --.

6 MS. CHIUMENTO: Right. Because I
7 think people do use medical control, they just
8 don't realize that that's what they're doing.

9 MS. GOHLKE: Right.

10 MS. CHIUMENTO: They -- they
11 think medical control is for getting orders.

12 MS. GOHLKE: Yeah.

13 MS. CHIUMENTO: In some cases
14 charcoal would be an -- be a basic order that they
15 might get.

16 MS. GOHLKE: Yeah.

17 MS. CHIUMENTO: But many regions,
18 if they're going to do a refusal, the patient is
19 doing -- doing a refusal, they also have to contact
20 medical control. They just may not recognize that
21 as medical control.

22 MS. GOHLKE: Yeah.

23 MS. CHIUMENTO: So, it might be,
24 if there's some way to give them that information

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2 or --

3 MS. GOHLKE: Yeah.

4 MS. CHIUMENTO: -- you know,
5 that -- that explanation --

6 MS. GOHLKE: Yeah.

7 MS. CHIUMENTO: -- when you send
8 out the survey you may actually get a better
9 response.

10 MS. GOHLKE: Yeah. I can't tweak
11 it to that point, but I mean, if we were only five
12 percent off, you know?

13 MS. CHIUMENTO: Yes.

14 MS. GOHLKE: We're not. We're
15 way off, especially on the B.L.S. offline
16 protocols. So -- but I hear what you're saying.

17 MS. CHIUMENTO: Yeah.

18 MS. GOHLKE: And we do -- we are
19 able to tailor somewhat some of the -- some of the
20 semantics.

21 DR. COOPER: Thank you, Martha.

22 Now, so I think that we have
23 spent quite a bit of time during the last year
24 addressing performance measure seventy-three. You

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2 gave us an update on seventy-four and seventy-five.
3 Seventy-six, I believe, is related to seventy-four
4 and that's -- and that's part of what Dr. Kanter's
5 subcommittee is working on. For those who are on
6 the telephone, that is the percentage of hospitals
7 in the state that have written interfacility
8 transfer guidelines. That will be part and parcel,
9 of course, of our regionalization project.

10 And performance measure
11 seventy-seven, same, because that covers
12 interfacility guidelines for pediatric patients.

13 Now, seventy-eight we do have
14 some work to do, and I think that will come up
15 under the Education Committee report. That has to
16 do with adoption of requirements by the state for
17 pediatric emergency education, for license renewal
18 for B.L.S. and A.L.S. providers.

19 Seventy-nine we meet because
20 we're in law. That's whether we have an E.M.S.C.
21 subcommittee established in -- in law.

22 MS. GOHLKE: We don't actually
23 meet seventy-nine.

24 DR. COOPER: We do not?

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2 MS. GOHLKE: No. I'm -- I'm not
3 full-time off the grant, so unfortunately we don't
4 meet it. So --.

5 MS. BURNS: Neither do most
6 states, because most of their (off-mic) full-time
7 positions.

8 DR. COOPER: Well, you sure seem
9 full time to me, Martha.

10 MS. GOHLKE: That -- yeah. I --
11 I actually split my time over this and our other
12 Governor's Traffic Safety grant. So in the eyes of
13 the feds, I'm not working a hundred percent of my
14 time on this grant. So, for that reason we don't
15 meet that -- that performance measure.

16 DR. COOPER: Oh.

17 MS. GOHLKE: Yeah.

18 DR. COOPER: Well, I -- I -- I
19 know Lee Burns will come up with a creative way to
20 solve that problem.

21 MS. BURNS: Yes. We're going to
22 lay her off part time.

23 MS. GOHLKE: That's the only
24 option, Dr. Cooper.

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2 DR. COOPER: Yeah.

3 MS. GOHLKE: Thank you for your
4 advice.

5 DR. COOPER: That wasn't
6 exactly -- it wasn't exactly what I had in mind.

7 FROM THE FLOOR: Well, since Lee
8 can do three jobs, is there a reason Martha can't?

9 MS. BURNS: I --.

10 MS. GOHLKE: That's what I'm
11 telling the feds. I said I can do more than this
12 one grant, you know, you should be happy that I,
13 you know, can multi-task.

14 DR. COOPER: And performance
15 measure eighty, again, more of the same. It's more
16 about permanent.

17 MS. GOHLKE: Yeah.

18 DR. COOPER: So -- so with the
19 exception of that one little glitch in our
20 permanence issues, I think Marsha -- or Martha
21 meets them, or we meet them. So the real issues we
22 have to focus on are the -- are the med control
23 piece, and the -- the specific pediatric
24 educational requirement piece.

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2 MS. GOHLKE: Well, the -- and
3 the -- and -- and the pediatric equipment we still
4 have a ways to go on too.

5 DR. COOPER: Well, what --.

6 MS. GOHLKE: We don't have it in
7 regs, all the list of the pediatric equipment.

8 DR. COOPER: Yeah. I -- I'm
9 aware of that, but I mean --

10 MS. GOHLKE: Yeah.

11 DR. COOPER: -- I'm talking about
12 areas where we -- where we don't have a plan in
13 place.

14 MS. GOHLKE: Right.

15 DR. COOPER: You know, for
16 example, we -- we -- we -- we've made significant
17 progress on the ambulance equipment guidelines.
18 We've made significant progress on regionalization.
19 We haven't made quite so much headway with respect
20 to medical control and explicit iteration in regard
21 in -- in our -- in our policies and procedures,
22 regarding meeting the educational requirements.

23 MS. GOHLKE: I actually have
24 more -- the least amount of confidence in

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2 seventy-three with the equipment, than I do with
3 seventy-one and seventy-two.

4 DR. COOPER: Really?

5 MS. GOHLKE: I think we've made
6 more headway. I mean, there's issues about putting
7 all the equipment in regs and then making sure that
8 they're on the ambulances, but -- that are probably
9 more difficult to overcome than what we've done on
10 the -- on the medical-control side.

11 DR. COOPER: Well, you -- you
12 know, correct me if I'm wrong, with respect to the
13 regulatory piece, but my understanding, Lee, was
14 that we had moved away from being quite so explicit
15 in regulation per se, and that the regulations are
16 meant to specify general categories of equipment
17 that we need to have, and -- and the rest can be
18 referred to in terms of policy.

19 MS. BURNS: We -- actually, we
20 have looked at that as an overreaching philosophy,
21 but in terms of actually enacting that, and working
22 with our partners on the systems committee at the
23 state council, it's been a -- it's been a slow
24 process. Most recently, we did -- we put together

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2 some policies in order to address some requests for
3 regulatory change, but -- but because of the whole
4 regulatory approval process is so complicated and
5 slow, we -- we sort of dealt with it by policy not
6 so much by actual regulation change.

7 Though in -- in response to your
8 comment, what we've been working with, both in --
9 in the bureau, as well as with the state council,
10 is to modernize the equipment list, and make it so
11 that it does -- it's not -- the -- it's not as
12 prescriptive as it is -- because, frankly, stuff
13 changes, and the regulations, by their nature are
14 outdated almost as soon as you enact them. So,
15 we're exploring the possibility of wording it in
16 such a way that the regulations address, for
17 example, the need for -- for communications. But
18 our regulations specifically talk about radio
19 communication -- duplex radio communications. And
20 that -- that's really quite outdated. I mean, with
21 cellular telephone, we're, obviously, you know,
22 we're well in advance of duplex radio
23 communications, or you know, radio telemetry. So,
24 we're looking at -- at putting it together so that

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2 it's -- it's more rational, and it's -- and it's
3 more malleable as technology improves.

4 DR. COOPER: I'm sure I speak for
5 the entire committee in -- in supporting the
6 Department in moving toward a much more
7 streamlined, flexible approach to the regulatory
8 process, insofar as equipment is concerned. I
9 don't -- given the fact that these equipment
10 guidelines are updated, usually about every three
11 to five years, by -- by the -- by the fed, through
12 either a contract or -- or a grant to some
13 professional organization, if not the E.M.S.C.
14 program itself, and given the fact that our
15 regulations change far less often than that, I
16 think that this is something that we could do now
17 to help ease regulatory burden, and of course,
18 easing regulatory burden is always easier than
19 stiffening regulatory burden. And maybe the --
20 maybe this is something that could go through with
21 a little bit more ease than some of the other
22 regulations that are proposed.

23 So I -- unless I hear an
24 objection, I -- I -- I think I do speak for the

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2 committee in saying that we would urge the
3 Department to move forward along that line, and --
4 and setting general categories of equipment that
5 must be present on ambulances within the regs, and
6 handling the remainder by reference, in terms of --
7 in terms of policy.

8 So noted. Thank you, Lee.

9 I'd like to just acknowledge that
10 Ms. Jennifer Treacy from the Health Department has
11 joined us. She is the official within the Health
12 Department who is responsible in part for oversight
13 of the E.M.S. programs. She works -- she works
14 very closely with Lee, and -- and with Lisa
15 McMurdo. And we're delighted that she's been able
16 to join us today.

17 Thank you, Jennifer for being
18 here.

19 MS. TREACY: My pleasure.

20 DR. COOPER: Yeah. Yeah. Thank
21 you.

22 Okay. Well, this is actually a
23 perfect time for us to move into the -- the E.M.S.
24 Bureau report, and since Ms. Treacy has just

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2 arrived, it will save -- it will save you and Lee
3 the -- the -- the need to get together for a formal
4 briefing at some point in the near future, and I'm
5 sure both of you have many, many things to do on
6 your calendars, and so we can do this publicly
7 and -- and save you both a little bit of time.

8 Lee?

9 MS. BURNS: This should sound
10 strangely familiar to those of you who attended the
11 SEMSCO meeting, or watched the Webcast, because I
12 know everybody tuned in. The report is -- is very
13 similar.

14 In terms of budget issues, one of
15 the things that we have been plagued with is a lack
16 of prehospital patient care report forms. I'm
17 pleased to tell you - though it doesn't affect most
18 of you - we have them now. There was a lot of --
19 we got a lot of mail at every level in the
20 Department, from legislators to fire chiefs, saying
21 that they were horrified that the Department was no
22 longer going to be printing these forms. And when
23 I saw the first one, I was horrified that the
24 Department was no longer going to be printing these

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2 forms, but we never were not going to print them.
3 We have printed them and we have been approved.
4 We're in the -- we have gone through the approval
5 process for a follow-up order. So, we -- we -- we
6 have forms. So, that is important to most of the
7 E.M.S. community.

8 Interestingly, and -- and of
9 import is that the governor's budget includes two
10 things that are of concern, or at least should be
11 brought to the attention of the E.M.S. community
12 and -- and E.M.S. for Children. One -- and they're
13 in there because the governor's budget is
14 specifically intended to reduce the effect of
15 the -- of the financial situation on local
16 government. So, one of -- the governor's budget
17 includes an item that would change General
18 Municipal Law 209(b) and allow fire departments or
19 districts to bill for ambulance service. At this
20 point, 209(b) prohibits fire departments and fire
21 districts from billing for ambulance service. It
22 exempts you guys. Actually it exempts
23 municipalities. A municipality may bill for
24 ambulance service. There are many, many

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2 municipalities whose -- whose ambulance service is
3 operated by its fire department, who are permitted
4 under law to bill.

5 Dr. Kanter, I'm just looking at
6 Ann Fitton, since you -- you miss the joy of the
7 visual.

8 (Off-the-record discussion)

9 MS. BURNS: The other -- I -- I'd
10 lie down on railroad tracks for Ann Fitton, I've
11 got to tell you.

12 So, the other thing that does
13 concern us is there is an indication, though it's
14 not in the governor's budget, that there -- the
15 governor's budget includes a portion of
16 consolidation. And what it does is it creates
17 something that is loosely called the Division of
18 Homeland Security and Emergency Management, and
19 there may be something else in there, I -- I'd have
20 to look. But currently, the budget includes the
21 consolidation of the Office of Fire Prevention and
22 Control, State Emergency Management, and several
23 other emergency-management type branches in state
24 government, into this division. And just so you

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2 know, the state police are called The Division of
3 State Police. So this would be another division
4 under the Executive Branch.

5 E.M.S. had originally, in the
6 first version that I saw, had not been included.
7 Most recently, there is an indication or a concern
8 that E.M.S. would be included should this be
9 approved. And speaking for myself selfishly, I
10 kind of like working for the Health Department. So
11 there is a real concern about that.

12 The other -- with regard to the budget issue, it is
13 important that you know that with the approval and
14 consultation of the governor's office, the State
15 Health Department is combining the State Hospital
16 Review and Planning Committee, SHRPC, and the
17 Public Health Council. These -- these are two huge
18 advisory councils to the Commissioner and the
19 governor.

20 And the reason that that is going
21 on, and the reason that I tell you this, is that
22 the budget situation is so severe that, in an
23 effort to make government more efficient, make the
24 advisory councils more efficient, and

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2 project-oriented as well as save money, they are
3 consolidating these -- these very large boards.
4 Both of them have -- have very big responsibilities
5 in statute.

6 So with that said, keep your ears
7 open, because it is not -- it is not beyond the
8 Department's, you know, horizon, that we in the
9 Bureau of E.M.S. staff four advisory councils. And
10 the question really is the efficiencies of how --
11 you know, how best to manage the groups, and
12 whether it would make sense to consolidate them as
13 well. So, for your information.

14 Dr. Kanter, did you have a
15 question?

16 MR. KANTER: No.

17 MS. BURNS: Okay. With that
18 said, this is my -- my -- I -- I did this with
19 the -- the SEMSCO committees, as well as the SEMAC
20 and the SEMSCO Council. One of the things -- it's
21 kind of my -- my routine nagging, if you will.
22 Because the councils, by their nature, are being
23 examined very closely, I think that it is hugely
24 important that our councils really, really look at

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2 work plans, attainable projects, tracking for the
3 completion of them, bringing them to a close, and
4 essentially producing a -- an item at the end of
5 whatever the project may be.

6 We've also kind of stepped
7 forward into looking at long-range planning
8 possibilities, so that, using the SEMSCO as an
9 example, the chair is elected for a one-year term
10 and by the time he hit -- you know, he has to hit
11 the ground running and by the time anything is able
12 to even come close to looking like it could be
13 considered to be done, it's time for the next
14 chair. So one of the things that this year's chair
15 and his -- his vice chairs -- who -- Tim Czapranski
16 who's here is one of them, is really looking at
17 attainable projects that will have a consistency
18 and carryover so that -- and that they are brought
19 to closure, so that the councils are -- they are
20 productive, but there is evidence that they are
21 productive. So nagging session complete.

22 St. Vincent's Medical Center is a
23 continuing issue. It -- it is looking at -- at --
24 it's work -- has been working with lenders and the

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2 state for ongoing funding. It is in a financial
3 crisis, and it doesn't look good, according to Ann.
4 She shakes her head. We're -- we're actually -- we
5 know. They essentially will run out of money --
6 they've run out of money. They -- the -- the
7 question really is what the next steps are, and the
8 Department continues to work with them on next
9 steps, particularly considering their outreach
10 clinics, their community-based health
11 organizations. Much to our -- we're very
12 encouraged. The Department is extremely concerned
13 about emergency department and trauma care issues,
14 as well as the nine-one-one system impact, and the
15 impact of the loss of their ambulances in the
16 nine-one-one system. So, we've -- we -- we're on
17 the radar scope with that, which is actually very
18 encouraging. Not so much for St. Vincent's but
19 that it's at least -- you know, it -- it's at least
20 under consideration. FDNY has been gracious with a
21 lot of local data, so we're -- we're working with
22 that as well.

23 The Ryan White project to bring
24 New York State regs and Ryan White -- the current

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2 Federal Ryan White Act to consistent --

3 consistency, continues. Our partners in the AIDS

4 Institute issued an advisory, just to -- to provide

5 resources as the work continues. Tangential to

6 that, one of the fire groups has been working with

7 the legislature on a bill that would allow for

8 source patient testing, I think with -- with Mr.

9 Godfrey (phonetic spelling). We have -- had

10 conversations with them and we have a meeting

11 with -- with them again -- I want to say this week,

12 but I think tomorrow or Thursday -- not to discuss

13 the merits specifically of the bill, but the

14 concerns that the Department has are that the

15 current -- the way the current bill is written and

16 it's been around a while also, is that it is

17 specific to H.I.V./AIDS, and one of the -- what the

18 feds are looking at is a way to include the ability

19 to utilize the Ryan White Act, and source patient

20 testing, for other blood-borne infectious diseases,

21 as well as new and emerging diseases, so that it --

22 it doesn't -- because the reality is that exposure

23 to H.I.V./AIDS is not as big a concern as it was

24 ten or fifteen years ago, though it's a concern.

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2 However, the likelihood of being exposed to one of
3 the hepatitises is greater. So that -- that is
4 ongoing.

5 The E.M.S. Memorial is May 19th.
6 I would -- I would implore you all to come. We are
7 inducting three line-of-duty-death E.M.S. providers
8 this year, one of -- one of whom was the -- was
9 outside of -- of September 11th, murdered on -- on
10 the -- while treating a patient. So, this -- we
11 believe this year's service is going to actually be
12 a big one. Most of St. Lawrence and Jefferson
13 County will be here, but -- but it's -- it's a
14 very -- it's a very nice event. And I think --
15 you've come.

16 DR. COOPER: Oh, yeah.

17 MS. BURNS: So dust off your
18 black suits and please feel -- please come.

19 On -- on a less morose note,
20 Vital Signs, again, is in New York City this year.
21 The plans are continuing. Our staff there has made
22 cite visits and they're very -- they're --they're
23 very excited. The cite visit went really well.
24 They have a very good working relationship with

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2 the -- the hotel and the contractors. The speaker
3 schedule is complete and has been sent to print,
4 and I -- I -- I'm doing the quotes in the air thing
5 because we're not actually going to print the big
6 brochure. We're going to print a small number of
7 the big brochure we've always printed, but we're
8 printing small cards to mail out, and put the whole
9 brochure on the Web site, and people can actually
10 register online. So that's going on.

11 And then the other thing is that
12 there are a whole host of -- of this is -- I'm
13 saying this. I wrote it down. But we have very
14 cool preconferences. I'm -- I'm going to follow
15 Ann Fitton. That's my job for the whole weekend.
16 Ann facilitated a preconference with the FDNY Fire
17 Training Academy, where -- where they're going to
18 do a bus explosion scenario, and a tour of the
19 academy. And we went and it was raining sideways.
20 It was -- the weather was so bad. But -- oh, my
21 God, it's going to be great. It's going to be way
22 cool. So mark your calendars for the end of
23 August.

24 H1N1. Interestingly, the --

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2 things have stabilized to the point really where
3 the Department has -- has reduced their H1N1
4 calls -- conference calls, which I think is good,
5 personally.

6 DR. COOPER: Which is good.

7 MS. BURNS: The -- the folks
8 that -- they continue to do surveillance on
9 patients and facilities for H1N1. The numbers
10 appear to be stabilizing or lowering. Their --
11 their -- their -- they believe that the vaccine is
12 effective. The distribution continues to be
13 ongoing.

14 The -- with regard to the
15 executive order allowing advanced E.M.T.s to
16 participate in PODs, give vaccinations during PODs
17 actually expired at -- is -- expires at the end of
18 March. However, the Commissioner is working on
19 regulations to allow -- give him the power to
20 approve prehospital-care providers to participate
21 as the need may be necessary.

22 We're doing a respiratory
23 train-the-trainer program, which is ongoing. So
24 far, we've completed training in nineteen counties.

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2 There are another ten or so counties on the queue
3 to -- to participate in the training. What it is
4 is basically respiratory disease protection, C.M.E.
5 and fit-testing training, so that people can go
6 back to their services and fit-test their
7 providers, and train other providers to do
8 fit-testing.

9 So, I think -- the last thing
10 that is actually quite huge for us, is we were
11 approved for year number two of our G.T.S.C.
12 Electronic P.C.R. grant. We have entered into a
13 contract with Image Trend, to be what they call the
14 state bridge, to accept data from all the regions
15 in the state. It's a huge project. And so, while
16 Martha is working on E.M.S. for Children a hundred
17 percent of her time, she is also working
18 ninety-nine percent of her time on the G.T.S.C.
19 grant, which is why she looks like she's going to
20 kill me. So, stay tuned for that. Year number two
21 started on the 1st of February, and we're preparing
22 to do our application for year number three. But
23 the results of it will be really huge.

24 And that, Doctor, is my report.

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2 DR. COOPER: Lee, I do think
3 there was one other issue of great impact that did
4 transpire at the most recent meeting of the --
5 of -- of the council, that related explicitly to
6 your report.

7 MS. BURNS: Okay.

8 DR. COOPER: And that has to do
9 with the -- the NEMSIS data elements and so on.
10 And I -- I wanted to give you an opportunity to
11 comment on that, because it does directly impact
12 upon our work here as well.

13 MS. BURNS: Actually, thank you,
14 because that's true. With -- in -- with work from
15 the bureau staff under -- really under the
16 leadership of Mike and -- and Martha, as well as
17 the evaluation committee of the state council, they
18 have settled on the data elements that will bring
19 us into compliance with the NEMSIS dataset, as well
20 as build a New York State prehospital patient
21 registry.

22 You should look way happier.

23 So, this actually -- the work --
24 I -- I -- I missed you, Sharon, because -- Sharon

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2 was also instrumental in this and dogmatic, might I
3 add, as she is with many of her projects. But --
4 but the -- this is -- this is absolutely a
5 show-stopper. This is huge.

6 DR. COOPER: It is huge.

7 MS. BURNS: So it allows us to
8 move forward. The -- on the -- you know, the --
9 it's -- it's so mind-bogglingly complicated, but
10 simplistically, it will allow us to collect
11 prehospital care data that we have really -- I say
12 we, the Department, and our physician community,
13 including Dr. Cooper, for years have -- have really
14 sought after. So, this is -- this is a
15 breathtaking step forward.

16 DR. COOPER: Thank you, Lee.

17 I -- I can honestly say that, other than being a
18 cheerleader, I had nothing to with making sure that
19 this happened. But Sharon, as usual did a yeoman's
20 job, as did Mike and Martha in bringing this to
21 fruition. This is probably the most important
22 thing we can do from a quality-improvement
23 standpoint, because finding common ground with our
24 sister E.M.S. services throughout the nation allows

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2 us to benchmark our own data and our own results,
3 versus -- versus outcomes elsewhere. We have never
4 had the opportunity to do that before.

5 Jennifer, I'm going to just take
6 a moment and editorialize one little bit. We have
7 had, in E.M.S. over the years, a very, very
8 difficult problem with timeliness of data, that is
9 to say, an insoluble problem to this date. The --
10 the data when it becomes available, is generally
11 three to four years old, has major holes in it, and
12 has really made it impossible for us to conduct
13 meaningful quality improvement, which is our charge
14 under, you know, under the -- the statute.
15 Anything the Department can do to facilitate the --
16 the -- the adoption of -- of these data elements,
17 creation of electronic means of reporting, i.e.,
18 the registry that -- that Lee was speaking about,
19 would be deeply appreciated, and of course, with
20 respect to the Department's appropriate focus on
21 patient safety, there's nothing that -- nothing
22 that we can do in E.M.S. that would be more
23 important than making sure we have timely, accurate
24 data, submitted electronically, that could be

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2 analyzed, you know, appropriately, to give feedback
3 to our E.M.S. services. There's really, of course,
4 no more important focus for the Health Department
5 than patient safety and quality improvement, and --
6 and that's the tool that will allow it to happen.
7 And we've been years and years and years without
8 it. And we finally, finally, finally, due to the
9 work of Sharon and -- and Mike and Martha and the
10 evaluation committee, supported by Lee, of course,
11 have -- have the -- have -- have some light at the
12 end of the tunnel. So, please, anything you can do
13 from your end would be deeply appreciated by the
14 entire E.M.S. system, I can assure you. Not to
15 mention, of course, the citizens of New York State.

16 Okay. Any questions for Lee
17 Burns?

18 (No audible response)

19 DR. COOPER: Jennifer, on behalf
20 of the leadership group in the Health Department,
21 do you have anything you'd like to report on this
22 morning?

23 MS. TREACY: Well, not really. I
24 think Lee covered it all. Maybe if the budget

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2 is -- trying to think of how to -- you know, I
3 think we kind of hit on all the high points when we
4 were being asked to, you know project costs, ways
5 to save money (off-mic) I don't think -- I don't
6 really have any good news, I'm sorry.

7 DR. COOPER: That's okay. That's
8 okay. I just think that, you know, on behalf of
9 everyone here, we need to put in our plea to the
10 sister three councils, that to the extent that
11 E.M.S. can be held harmless in the budget
12 situation, that it is. We learned the hard way on
13 September 11th, and have learned the hard way on
14 subsequent -- during subsequent disaster events, be
15 they biological disasters, SARS, Pan-Flu, and so
16 on, that without a vigorous and robust E.M.S.
17 service to deal with the public health emergencies
18 when they arise - and of course we never know when
19 they're going to arise. It could happen -- it
20 could be happening right now as we speak, and
21 without our -- without our knowledge - without
22 emergency medical services there to -- you know, to
23 begin sorting us out of the mess, we will be
24 nowhere. And the amount of money that we spend on

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2 E.M.S. in New York State is -- is laughably small.
3 In -- in the parlance of the federal government,
4 it's decimal dust in terms of the -- the dollars
5 that -- that are -- that are used to support the
6 activities here. Yet it's the one thing that
7 everyone relies upon, you know, when the mud hits
8 the fan. And -- and -- and if we don't have that
9 robust E.M.S. service, the Commissioner is going to
10 be red-faced in front of the -- you know, in front
11 of the cameras explaining why -- why that was not
12 the case.

13 So I'm happy to say that on the
14 public record, and ask that you share that
15 observation, and I'm sure I speak for the entire
16 committee in -- in bringing that to you. We're not
17 asking for any increases, you know, with --
18 although we all know we're terribly, terribly
19 underfunded to do the work that we -- that we need
20 to do. What we are asking is that what little we
21 have, on behalf of the public that we serve, not be
22 cut.

23 Okay. Any other questions or
24 comments for either Lee or Jennifer?

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2 (No audible response)

3 DR. COOPER: Okay. Hearing none,
4 let's move into subcommittee progress reports. And
5 I -- I will give a report on behalf of Dr. Kanter,
6 who I believe is -- has taken a break from the
7 call.

8 Bob, are you there?

9 DR. KANTER: Sorry, I'm now back
10 on.

11 DR. COOPER: Oh, you are.
12 Excellent. Okay. Well -- well, hang on, Bob, then
13 let me -- let me get the volume back up here a
14 little bit.

15 MS. BRILLHART: Mike?

16 DR. COOPER: Yeah. Oh, Susan.
17 Hi.

18 MS. BRILLHART: Hi.

19 DR. COOPER: Hang on. Am I going
20 the wrong way? This one?

21 DR. LILLIS: Yeah.

22 DR. COOPER: Oh. Okay. Oh,
23 there we go. Okay. Thank you. Kathy had to help
24 me. I'm electronically challenged.

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2 Bob and Sue, are you there now?

3 MS. BRILLHART: Hi. I am. And I
4 also wanted to interject when you were doing the
5 St. Vincent's report, I don't know if people know,
6 but St. Vincent's is closed to all pediatrics.
7 There is no pediatric inpatient under age of
8 thirteen at St. Vincent's anymore.

9 DR. COOPER: That is true. Do
10 you know the -- the effective date of that, Susan?

11 MS. BRILLHART: Yes, that was the
12 first Monday in February --

13 DR. COOPER: Okay.

14 MS. BRILLHART: -- if anybody has
15 a calendar. Because we could --

16 DR. COOPER: February 1st.

17 MS. BRILLHART: -- the last
18 Saturday in January and they closed on Monday.

19 DR. COOPER: February 1st.

20 MS. BRILLHART: Okay.

21 DR. COOPER: Ann Fitton has
22 indicated that the emergency department, however,
23 is still accepting pediatric patients as of this
24 moment.

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2 MS. BRILLHART: Yes, it is, but
3 just understand that they -- then they'll need to
4 be transferred, because they don't -- they have
5 literally closed their unit. So, just an F.Y.I.

6 DR. COOPER: Okay. Thank you.
7 Just for the record, joining us by conference call
8 is -- is Susan Brillhart, professor of nursing
9 at -- at CUNY B.M.C.C.

10 Okay. Bob, are -- are you ready
11 to give the interfacility report?

12 DR. KANTER: Sure. I think --
13 now, Martha, please step in if you have any more
14 recent information than I do, but in a general way,
15 the Department is planning, in a number of
16 respects, to organize and maximize a fruitful
17 discussion among stakeholders at the May 13th
18 meeting, regarding improving statewide pediatric
19 emergency and critical care, and aspects of
20 regionalizing pediatric emergency and critical
21 care. The guest list is in preparation, and the
22 Department is giving some consideration to how much
23 the Department wants to define some objectives
24 ahead of time, as opposed to just leaving an

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2 open-ended discussion for the stakeholders. And --
3 and -- and along all those lines, the agenda is
4 being finalized.

5 But, Martha, you may have some
6 more recent information than I do.

7 MS. GOHLKE: No, that's -- that's
8 the most recent. We -- we have ongoing monthly
9 conference calls that you're welcome to call into
10 if you want to participate. We're -- we are kind
11 of moving right along with this. And if you want
12 to come to the May 13th meeting down in New York
13 City, you're welcome as part of this committee.
14 You just need to let me know sooner rather than
15 later, because I have to do a bunch of travel
16 paperwork that you'd be traveling off the E.M.S.
17 for Children grant. So, I guess that was the only
18 thing I wanted to add.

19 DR. COOPER: Thank you, Martha.

20 Bob --

21 MR. KANTER: Yeah.

22 DR. COOPER: -- do you have
23 any -- any specific personal thoughts about --
24 about where we're heading on this, in terms of the

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2 agenda? Are there issues that you believe perhaps,
3 given that Jennifer Treacy is with us, that we need
4 to call to the attention of John Morley or the
5 Commissioner, here on the public record?

6 DR. KANTER: Yes. Well, I -- I
7 think first of all, I did have the opportunity to
8 speak with Dr. Morley a couple of weeks ago about
9 some of these things, and in a general way, think,
10 my own recommendation is that, to whatever extent
11 the Department can explore ahead of time the
12 various methods that the Department could use to
13 promote improvements, I think if the Department
14 considers these things ahead of time, and at least
15 sort of takes tentative positions on what
16 regulatory objectives in the long run would be
17 useful, before the stakeholder meeting, I believe
18 the stakeholder discretion might be somewhat
19 clearer and more fruitful. Certainly, we want
20 good, open input from all the stakeholders, but I
21 think if the State Department of Health begins
22 thinking about objectives that are desirable and
23 feasible from the Department's point of view, I
24 think the discussion might be structured in a more

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2 effective and fruitful way. And I -- and I talked
3 to Dr. Morley about that. And we'll -- I'm sure
4 we'll hear more about it.

5 DR. COOPER: Thanks, Bob. I -- I
6 could not agree with your sentiments more. This
7 will now be the third stakeholders meeting that we
8 have held on the issue of regionalization over the
9 years, and you know, every time we hold the meeting
10 on regionalization, the literature has grown and
11 supports regionalization even more than it did the
12 last time, and at this -- yet there has been no
13 progress except with respect to pediatric trauma
14 regionalization, which was accomplished really in
15 the late '80s. And so, I -- I think that the
16 Department, as you suggest, will have -- or -- or
17 be receiving a much greater value for the -- you
18 know, the investment in the stakeholder meeting, if
19 there is a -- if you will, if not an actual
20 on-paper strawman, at least a -- at least an -- an
21 in-our-head strawman, as to how far the Department
22 is willing to go. And that will allow the people
23 who are attending the stakeholder meeting to
24 actually give the Department, really, some pretty

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2 explicit advice as to how -- how the task can best
3 be accomplished.

4 You know, we -- we -- we're in an
5 era where we all know that -- that we can no longer
6 afford to have every -- every hospital capable of
7 doing everything, if that was ever the case.
8 That's certainly true with respect to critical care
9 pediatrics. And this is really, in many ways, the
10 one unsolved piece of our -- of our
11 pediatric-emergency-care puzzle. Neonatal
12 regionalization occurred in the early '70s,
13 pediatric trauma regionalization occurred in the
14 last '80s and early '90s. Yet here we are, some
15 twenty years later, and you know, while there is de
16 facto regionalization in most areas of the state,
17 in that the large -- the largest geographic areas
18 of the state, simply outside the major cities,
19 don't have the pediatric resources, and
20 automatically send the patients into the big
21 children's centers. In the downstate areas, that's
22 not the case.

23 And as you know, Bob, and as
24 you'll be covering at the stakeholder meeting,

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2 there is some data to suggest that outcomes could
3 be improved, patient safety could be improved, if
4 regionalization did occur for medical patients, as
5 well as trauma patients and neonatal patients. So,
6 once again, I think, Bob, if I hear you correct,
7 the -- hear you correctly, the message that we hope
8 Lee and Jennifer can take the Department is that we
9 really feel that it's really incumbent upon the
10 Department to give us some guidance as to how far
11 it's willing and able to go in terms of
12 regionalization, so we can give them the best
13 advice possible at the upcoming meeting.

14 MR. BURNS: And Dr. Cooper --.

15 DR. KANTER: Yes. And it -- you
16 know, it may be worth just spending a moment on
17 defining my terms more explicitly.

18 MS. BURNS: Yeah.

19 DR. KANTER: Regionalization
20 means different things to different people. You
21 know, I think at the simplest level, we would be --
22 we -- there might be some advances if pediatric
23 facilities even identified themselves more clearly.
24 But regionalization also means some statement from

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2 the Department about what capabilities should be
3 available at each level of pediatric hospital, for
4 emergency and critical care services. And then
5 after you've defined what should be available,
6 accreditation would imply that you've independently
7 verified that indeed a facility has those services.
8 Then the state could also participate in publicly
9 identifying those that are accredited, an even
10 stronger mechanism of promoting the use of these
11 hospital would be to designate them, not only say
12 here they are, but certain hospitals should be used
13 for services of certain kinds of patients, with a
14 list of criteria. And then, an even stronger
15 Department action might involve some incentives or
16 requirements that would enforce the use of
17 designated facilities.

18 And then, finally, it -- it's, I
19 think, implied by everyone who's thought about
20 regionalization, is pediatric centers have certain
21 responsibilities to assist other services and other
22 agencies in the region for preparation,
23 coordination, education and such, as well as data
24 collection and -- and -- and guiding quality

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2 improvement.

3 So I think all of these things
4 are elements of what could happen in a
5 well-regionalized system. Again, these -- the full
6 spectrum of these activities could be quite
7 expensive. I'm not sure that anyone dreams that
8 this could happen immediately, but I think the more
9 the state sort of identifies some of these
10 elements, and tries to decide what's feasible and
11 desirable right away, and what would be on longer
12 time line to achieve them, might help structure a
13 more -- a better conversation at the stakeholder's
14 meeting.

15 DR. COOPER: Martha Gohlke has --
16 has something to add to the conversation.

17 MS. GOHLKE: I just wanted to add
18 that New York is being looked at very closely as we
19 go through this process, because we're one of the
20 few states that are going through the process. I
21 mean, there's a bunch of states that have already
22 gone through it and have already had their
23 designation system set up, for lack of a more
24 agreeable term. But -- but then there's a bunch of

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2 states that haven't gone down this road.

3 Our white paper that the -- this
4 committee wrote is now being highlighted by the
5 Federal E.M.S.C. program as one of the recommended
6 steps that -- that states take to go down this
7 road. HRSA had designated two people to come to
8 our meeting in May because they're watching our
9 process very closely, and we're being held up as
10 the Federal E.M.S.C. example at this point, to
11 other states on how do you go through this process,
12 what do you need to do, what's recommended. You
13 know, what happened when New York went through it?
14 So not only is it, you know, vitally important for
15 the care of children in our state, but right now we
16 are setting an example for the Federal E.M.S.C.
17 program to shine on other states. So this is --
18 this is a big meeting not only for our state, but
19 as far as the Federal E.M.S.C. program goes and --
20 and their recommendation to other states, so I just
21 wanted to add that.

22 DR. COOPER: Thanks, Martha.

23 You know, Jennifer, as -- as
24 everyone around this table knows, and you know, and

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2 the Department knows, you know, the process of
3 accreditation of specialized centers really
4 involves a three-step process, the first being
5 categorization, where the facility reviews its --
6 its -- its own compliance with -- with standards
7 that have been set by an appropriate body, in this
8 case the Department, through regulation or
9 what-have-you. The second step being an onsite
10 verification, and the third being some type of
11 designation based upon, you know, the findings of
12 the verifying body, versus the, you know, the --
13 the standards that have been set. So
14 categorization, verification, and designation are
15 key elements of the process.

16 Article 30 of the Public Health
17 Law does include -- excuse me -- Article 30B of the
18 Public Health Law does includes an explicit
19 obligation on the part of the SEMAC to develop
20 appropriateness-review standards for emergency
21 departments, and -- as well as trauma centers,
22 which would include both adult and pediatric
23 components.

24 What we don't have is -- is -- is

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2 a -- is statutory language explicitly doing the
3 same thing for pediatric critical care areas. Now,
4 there is the general language in Article 30(c) that
5 indicates that the -- the Department of Health does
6 have the obligation to regionalize pediatric care.
7 That was part and parcel of the -- of the federal
8 grant requirements, and -- and the -- and the
9 E.M.S.C. legislature was built around the federal
10 grant requirements. And the -- the legislature, in
11 its infinite wisdom, determined that in order to
12 continue to receive the federal support for
13 emergency medical services for children, that it
14 would enact the -- you know, the general categories
15 of performance measures into law.

16 So, we -- there is an obligation
17 under Public Health Law for the Department to
18 establish a system of regionalization. And since,
19 by precedent, we do that for adult and pediatric
20 trauma, and adult and pediatric emergency services,
21 through a process of categorization, verification,
22 and designation, via appropriateness-review
23 standards, it -- it makes sense that we follow the
24 same process, you know, with respect to pediatric

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2 critical care on the medical side.

3 But I think there's one piece
4 that -- that we often neglect, and that is the
5 entry point into the system. And by that I do not
6 mean, in this particular case, E.M.S., although
7 E.M.S. is the access point for everyone. By this I
8 mean actual standards for the -- the most basic
9 level of emergency department that will receive,
10 you know, sick patients, you know, adult/pediatric,
11 across the board. And too often when we think
12 about designation and regionalization of -- of
13 critical care services, we think at the highest end
14 and we forget the lowest end. There are specific
15 obligations at the -- at the -- at the intake
16 point, to be able to, you know, resuscitate,
17 stabilize and transfer. And I know that Bob has
18 not neglected this in the white paper, and this
19 will be an important subject for discussion at the
20 stakeholder meeting.

21 But -- but regionalization is
22 about getting the right patient to the right place
23 at the right time. It's not about getting the
24 critical patient to the critical service at the

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2 right time. That's part of it. But it's also
3 about making sure that at the -- at the intake
4 points we've provided - excuse me - for the special
5 needs of children as well.

6 Are there other -- any other
7 comments on the interfacility report?

8 (No audible response)

9 DR. COOPER: Okay. Sharon, do
10 you want to give the education report, together
11 with Ann?

12 MS. CHIUMENTO: Actually, on the
13 education components, today we finished working on
14 the RIS (phonetic spelling), still open for anybody
15 else who may want to comment on it. I sent it out
16 in the -- in an e-mail, so if anybody else has any
17 additional comments. We added a few things. We
18 added technametry (phonetic spelling) and oxymetry
19 to the -- to the list of procedures that may be
20 required on an ambulance for different types of
21 transport. And so, hopefully that will -- that
22 will -- the next step now will be to try to put
23 this into some kind of a narrative format. Right
24 now it's a very, very, very (off-mic) and so

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2 hopefully, the next step will be put it into some
3 type of a narrative - ooh, there we go - some type
4 of narrative format that can then be put into a
5 manual for the hospitals -- the outlying
6 hospitals -- the hospitals that are going to be
7 doing the transferring, so that they have some
8 things to help them with their decision-making
9 process, as well as the components that they're
10 going to need before transport. So what kinds
11 of -- what kind of -- of a vehicle are they going
12 to need; what kind of crew are they going to need?
13 Is it going to be A.L.S., B.L.S.? Is there going
14 to need to be an interfacility transport team?
15 That type of thing. What types of hospital should
16 it be? Lots of different kinds of information that
17 we will be putting together in a manual.

18 So this is kind of our first
19 step. We're ready to now start putting into a
20 narrative format, so that's where we are.

21 DR. COOPER: Ann, do you have any
22 to add?

23 MS. FITTON: I'd just like to
24 tell you what a pleasure it is to work with Sharon.

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2 She thinks of things that I -- I -- I don't know
3 how she does it. She has such a mind for detail.
4 It's a very detailed report, and her thoroughness
5 is a credit to all of us.

6 MS. CHIUMENTO: I have to tell
7 you though, Ann came up with several things today
8 that I had not thought of, so I was very pleased --

9 DR. COOPER: She always does.

10 MS. CHIUMENTO: -- to have her
11 input.

12 DR. COOPER: Okay. I think that
13 we all heard from Lee Burns a little bit earlier,
14 that finding work to do and getting it done, and
15 showing the Department and the public that we are,
16 in fact, completing tasks that we assign ourselves,
17 you know, in order to improve the public's health,
18 you know, is -- is of the utmost import, you know,
19 to us as a committee. So to that end, I -- I need
20 to ask every single member of the committee to
21 review the work that Ann and Sharon have done
22 together with their colleagues on the Education
23 Committee and get any comments to them, really
24 rather promptly.

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2 I'd like to ask if Sharon and Ann
3 could plan toward having something ready for
4 official adoption by the committee by the end of
5 the year, so that we can -- we can provide that
6 particular component of it, or get that particular
7 task done, and -- and then perhaps, although we
8 need to discuss this a little bit more, consider
9 moving on toward how we educate our colleagues
10 in -- in the E.M.S. world about where and how they
11 can obtain medical control in an appropriate manner
12 in the -- in the -- in the future, and that can be
13 a major focus for the next year.

14 Speaking of getting work done, I
15 have no doubt that once we have the stakeholder
16 conference that Bob's group will be active in terms
17 of producing perhaps some draft regulatory language
18 that the Department might consider, adopting or at
19 least a process, if not, a regulatory model at this
20 particular point, in terms of moving toward a --
21 you know, a three-pronged categorization,
22 verification, designation model for accreditation
23 of pediatric critical care services, together with
24 the appropriate interfacility transfer guidance

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2 documents that would be needed to support that
3 effort, and that we can have that done by the end
4 of year.

5 And then, of course, it will be
6 up to the Department, although we imagine we will
7 continue to keep -- keep the pressure on to do
8 something about it, to the extent that we have the
9 ability to do that.

10 And now, of course, I want to
11 recognize Kathy Lillis, who has been doing a great
12 job and heading up the nominations group, to give
13 us some indication of progress there, which I
14 believe since the last meeting has been quite
15 substantial.

16 Kathy.

17 DR. LILLIS: Thanks, Art. The
18 nominating committee has identified individuals for
19 all but -- I believe all but one of the open
20 positions and have gotten individuals who have
21 expressed an interest in being on the committee.
22 So we're in the process of collecting their C.V.s,
23 writing letters of support, and then they will be
24 forwarded up to -- up to the Commissioner.

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2 Art, are we going to bring the
3 nomination to here for input or --?

4 DR. COOPER: That's a good
5 question.

6 Martha and Lee, is it -- is it
7 your advice, on behalf of the Department, that the
8 nominations should come to -- before the committee
9 for formal approval, or -- I believe these are
10 direct commissioner appointments, so they don't
11 explicitly need to come to the committee, but you
12 know, they -- they could. It's really up to you as
13 to what you think is the appropriate thing to do.

14 MS. BURNS: I -- I mean, I think
15 if -- discussing them here would be appropriate,
16 but the -- the vetting process is the Department's.

17 DR. LILLIS: Maybe I -- I have a
18 suggestion or recommendation that the subcommittee
19 gather them all together and then send out a copy
20 of their -- their C.V.s as in one e-mail and ask
21 the members of the committee to review their C.V.s
22 and gather any additional input, if there's anyone
23 has concerns or -- or any other items for
24 recommendation that we can include in the letter

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2 that would go up to the Commissioner, that would be
3 helpful as well.

4 MR. TAYLER: Dr. Cooper?

5 DR. COOPER: Yes, sir.

6 MR. TAYLER: From the -- from the
7 Trauma Advisory Committee's side, it -- the
8 Commissioner's appointing-office people like to see
9 endorsements along with the -- along with the
10 nominees, they like to see endorsements. So on the
11 trauma side, if it's from like, the Regional Trauma
12 Advisory Committee representative, then it's the --
13 it's the RTAC that sends me the endorsement letter.
14 If it's an outside entity like -- well, like
15 yourself, it -- you will -- you are being vetted to
16 the State Trauma Advisory Committee as the
17 pediatric trauma surgeon, so your endorsement is
18 looking to come from a pediatric surgical or trauma
19 surgical group of some sort.

20 But there -- there are those on
21 the STAC that technically, it -- it's an
22 endorsement from the STAC it -- itself. So, it --
23 it -- it kind of goes back to what statute says,
24 what bylaw says. It has been my experienced with

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2 the State Trauma Advisory Committee as to where the
3 endorsements comes from -- whether they come from
4 an outside group or from a region, or from this
5 state-level committee itself. But they -- again,
6 they do like to see the endorsement letters, as
7 well as the C.V.s and such.

8 And just to -- to Dr. Lillis'
9 comment, keep in mind confidentiality issues with
10 the -- with the C.V.s. Don't -- I -- I wouldn't
11 send around C.V.s even to -- to the group here,
12 that -- that has information that might be
13 confidential on it and such. It just -- it --
14 someone might take that as -- as feeling intrusive,
15 you know, so just -- just a -- just a thought is
16 all.

17 DR. COOPER: Thank you, Mike.
18 Good advice from someone who has obviously recently
19 suffered through the process.

20 To that end, I -- I might just
21 share with the group just a tiny bit of information
22 on some of the individuals that have been
23 identified. There's a -- to fill the -- the seat
24 of the pediatric toxicologist, being vacated by Dr.

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2 Amler, dean of -- of the School of Public Health at
3 New York Medical College, but recently promoted to
4 vice president for intergovernmental affairs, he no
5 longer has time to be with us for that reason, an
6 individual has been identified who is -- heads a
7 large regional poison center in upstate New York.

8 For the pediatric E.M.S.
9 physician we've identified an individual who has
10 an -- a very, very extensive background in
11 pediatric prehospital care, has been previously
12 identified as one of the National E.M.S.C. Heroes,
13 Lifetime Achievement Award. We have an individual
14 who is a participant at a national level in the
15 American Academy -- American Academy of Pediatrics,
16 dealing with specialty-care issues, who actually
17 functions at the present time in a rural
18 environment, with -- with close ties with the
19 military, which have special needs for their
20 population. We've identified an individual who is
21 also deeply involved with the National American
22 Academy of Pediatrics, who has very, very special
23 interests in pediatric behavioral health and their
24 interface with primary care.

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2 And there's one other, Kathy.

3 (Off-the-record discussion)

4 DR. COOPER: Oh, yes. Yes, yes,
5 yes. And we've identified an emergency medicine
6 physician who serves as medical director to a
7 municipal hospital in New York City, that has a
8 very, very large pediatric medical and surgical
9 services affiliated with it.

10 And I'm happy to report that --
11 that we have been able to reach out to these
12 candidates, and all of them have indicated that
13 they might be willing to serve, depending, of
14 course, upon the -- you know, the vetting process
15 that takes place.

16 DR. LILLIS: Pediatric
17 physiatrist --?

18 DR. COOPER: Oh, yes. And there
19 is a pediatric physiatrist as well, a pediatric
20 rehabilitation specialist, who had been previously
21 identified, who heads a large pediatric
22 rehabilitation group in one of our major children's
23 hospitals.

24 So, I think we've got an

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2 outstanding group of candidates that really
3 represent geographically, gender-wise, and
4 culturally a very, very diverse cross segment of --
5 or cross section of New York State's population.
6 So, I think that that's all to the good.

7 MS. GOHLKE: Just one thing.

8 DR. COOPER: Martha.

9 MS. GOHLKE: I think the only
10 seat that hasn't been identified yet is the -- we
11 have one seat for another parent representative.
12 There's two seats on the committee, one of which
13 Ruth Walden, who's ill today, couldn't be here, she
14 has the parent representative for children with
15 special healthcare needs. The other seat that's
16 still open is the parent of a ill or injured child
17 that basically has gone through the nine-one-one
18 system. And that's the other seat that we need to
19 fill, and I don't think they've identified -- the
20 committee has identified anyone yet. So we could,
21 obviously utilize suggestions from the group as for
22 a parent representative. It's not that they have
23 to come from this area, but it's something to
24 consider. When you're asking about a parent

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2 representative to travel across the state, it might
3 be wiser if we want somebody to actually be sitting
4 in the seat, to think of somebody local here to
5 these meetings, but obviously, it doesn't have to
6 be, but that is one other seat that we need to
7 fill.

8 DR. COOPER: Thank you, Martha.

9 As always, the nominations
10 process is wide open, so if other folks have
11 candidates that they have identified that -- or
12 that they -- that they know of, that they want to
13 bring to the committee's attention, please get in
14 touch with either Kathy or -- or myself, and -- and
15 we'll -- we'll review the -- the recommendation and
16 make a suggestion to the committee when we bring it
17 back in June. Okay?

18 Yeah, Chris.

19 MR. KUS: The Health Department.

20 DR. COOPER: Oh, yes. Yes.

21 Thank you, Chris, for joining us -- Dr. Christopher
22 Kus from the Health Department Division of Family
23 Health.

24 DR. KUS: Just one suggestion

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2 with the parent one is to maybe check with Ruth --
3 we actually have groups of parents that go through
4 parents training, to -- to -- to sit on policy
5 groups, and I'm not sure that one would fit that,
6 but it's always helpful to have somebody who's gone
7 through policy making, and gotten some -- some
8 experience about what it takes to sit on an
9 advisory group.

10 MS. GOHLKE: Absolutely.

11 DR. COOPER: Chris, that's great
12 advice. Thank you.

13 And Martha, perhaps we could
14 reach out to Chris and ask him about several of
15 these advisory groups that -- or parents groups
16 that he knows of.

17 DR. KUS: Yeah. I -- yeah.
18 Definitely. I'll actually -- I'll -- I'll talk
19 with Ruth. She works with us and we have parent
20 champions and parents in the regents that might
21 know, so that -- that might be a way to recruit
22 somebody.

23 DR. COOPER: That would be great.

24 And we -- we have -- we have stumbled in the dark

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2 with respect to finding a way to identify a parent
3 of an ill or injured child, and I -- I think you've
4 just opened a major door for us here.

5 Okay. Well, it is now twelve
6 thirty-seven. We are only a couple of minutes
7 behind on our agenda, but at the same time we've
8 also covered quite a bit of the subcommittee
9 progress report issues, so we might actually even
10 be ahead. So lunch is here. It is behind you. So
11 why don't we take a few minutes for lunch, and plan
12 on reconvening at one o'clock. That will give
13 everyone a chance to do what they have to do and --
14 and we'll see you back at that time. Thank you.

15 DR. KANTER: Art?

16 DR. COOPER: Yes, Bob?

17 DR. KANTER: I have a couple
18 things I need to take care of. Would it be all
19 right if I checked back in with you at two-thirty?

20 DR. COOPER: Sure. That would be
21 fine.

22 DR. KANTER: Okay.

23 DR. COOPER: Thanks, Bob.

24 DR. KANTER: Good.

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2 MS. GOHLKE: Good. Okay.

3 (A luncheon recess was taken at
4 12:37 p.m.)

5 (The meeting resumed at 1:00
6 p.m.)

7 DR. COOPER: I'd like to welcome
8 everybody back from that excellent lunch, and we'll
9 proceed with old -- old business, according to the
10 agenda.

11 As Martha has shared with you,
12 even though we do have enough members to make a
13 quorum, attending the meeting electronically and in
14 person, apparently electronically doesn't count, so
15 we can't officially have a quorum today. So
16 we're -- as Martha announced earlier, we're not in
17 a position to finalize the E.M.S.C. bylaws, so
18 we'll have to defer that until next time.

19 So at this point, I'd like to ask
20 Mike Tayler if he'd give us the update on the New
21 York City Pediatric Trauma Center situation.

22 Mike.

23 (Off-the-record discussion)

24 DR. COOPER: No. Okay. No

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2 problem. What I'll do then is I'll skip down to
3 the -- the American Heart Association meeting
4 update.

5 As all of you know, the American
6 Heart Association holds a meeting to revise the --
7 its resuscitation guidelines every five years or
8 so. And that meeting was held the first week in
9 February in Dallas. I had the opportunity to
10 attend, as did Elise van der Jagt. Elise is the
11 official representative from this area to the Heart
12 Association, and I had asked that he give us a
13 short report. He's unable to be with us today, so
14 he said, "Would you do it?" And I said, "Of course
15 I will."

16 I -- I need to begin my remarks
17 by saying that the Heart Association has a very,
18 very strict conflict-of-interest and -- what's the
19 word -- nondisclosure policies, and -- and the
20 guidelines are officially embargoed until they're
21 published in circulation, which will happen later
22 this fall. But I certainly can share with you, you
23 know, some of the major themes that were discussed,
24 as opposed to the actual outcomes of those

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2 discussions, and offer a personal opinion that it
3 does not seem that there will be huge changes in --
4 in the pediatric resuscitation guidelines this time
5 around.

6 Those of you who follow the
7 literature on this could have guessed that, because
8 there has not been a lot of new science that has
9 emerged over the last few years, but I would -- I
10 would have to say that probably the biggest
11 controversy regarding the 2010 guidelines to be,
12 you know, published in the fall, had to do with
13 compression-only C.P.R. There's a fair amount of
14 information on that, and it is possible that we
15 will see -- it is possible. I -- I -- I do not
16 know that the final outcome will be. I'm not on
17 the committee that will make that decision. But it
18 is possible that we will see a much more prominent
19 role for compression-only C.P.R. among the lay
20 community, not among professional rescuers. So at
21 least that's what it seems at this particular
22 point. I don't think I'm talking out of school
23 sharing that global insight. Not because of
24 anything the Heart Association has said or not

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2 said, but because once again, the science that has
3 emerged points us in -- in that general direction.
4 What -- explicitly what the guidelines will say,
5 I -- I can't tell you. But again, I can tell you
6 that the committee has met, that the documents, the
7 worksheets will all be submitted and published a
8 little bit later this spring.

9 Actually -- excuse me, they will
10 be published as part of the -- the -- the -- the
11 guidelines process in the -- in the fall. They
12 will probably be posted to a Web site some time
13 this spring for everyone to comment upon. But
14 that's where things -- we -- but again, we can
15 expect new guidelines to be available in October.

16 And Martha, I -- I think we can
17 plan that at the December meeting we might want to
18 spend a fair amount of time looking at the new
19 guidelines and how they might impact upon pediatric
20 protocols, so we can make appropriate
21 recommendations to the SEMAC, and so they can vote
22 on them, potentially, as soon as their first
23 meeting in 2011.

24 The -- I look to my left because

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2 the mistress of protocols is sitting two seats to
3 the left of me, and you know, I -- I know she will
4 be --

5 MS. BURNS: That's why I'm
6 waiting to find out what the changes are going to
7 be.

8 DR. COOPER: -- I know she will
9 be on top of it, and -- and advise us all and come
10 up with her usual detailed presentation iterating
11 all the changes, so that we'll -- we'll be the
12 first to know. So --

13 MS. FITTON: Excuse me, Art.

14 DR. COOPER: Yeah, sure.

15 MS. FITTON: Is there any -- is
16 there any discussion about the role of hyperthermia
17 for children? I mean, I know there's no science
18 out there, however, is there any discussion?

19 DR. COOPER: There was
20 discussion, but as you say there is no science on
21 it. So, there is one multi-center study that is --
22 that is -- has not yet been published. It's being
23 conducted under the auspices of the PECARN Research
24 Network, and until that study is published, I don't

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2 think we're going to have any -- any guidance.

3 MS. FITTON: Several --?

4 DR. COOPER: Yeah. Yeah. There
5 was -- that was --

6 MS. BURNS: Several.

7 DR. COOPER: -- several. There
8 was an -- there was an extensive discussion about
9 hypothermia at the conference, but it's not clear
10 what -- again, what the recommendation is going to
11 be. I think the Heart Association clearly
12 recognizes that while it's a relatively simple
13 straightforward treatment for patients in cardiac
14 arrest, it's very, very difficult to establish
15 hypothermia as a standard of care in the United
16 States, because the -- the greatest majority of the
17 land mass is, you know, covered by basic life
18 support, you know, personnel, who will not have the
19 ability to administer, you know, ice cold saline
20 in -- in the field to their patients, and where
21 there -- there may be relatively long distances,
22 you know, to the closest E.D., and where most E.D.s
23 in, you know, the more rural parts of the nation
24 don't have I.C.U.s where therapeutic hypothermia

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2 could be continued.

3 So I think while all recognize
4 that there is science that is emerging that
5 supports, you know, hypothermia as a -- you know,
6 as a therapy for follow up -- excuse me, not follow
7 up -- for follow on therapy of patients in cardiac
8 arrest in adults, it's not clear where the Heart --
9 Heart -- Heart Association is going to be able to
10 go with that. And it -- it probably will not be
11 able to make it, you know, if you will, "the
12 standard of care," quote, unquote, because simply
13 nowhere near everyone in the country can meet that
14 standard.

15 Any other questions?

16 (No audible response)

17 DR. COOPER: Okay. So, again,
18 everything is, you know, embargoed in terms of the
19 final discussions, until October. Elise will be
20 participating in them. I will not. But Elise is
21 not able to speak about any specifics either. So,
22 those are the -- I think the -- the -- the general
23 themes that emerged, and we'll all anxiously await
24 what the Heart Association has to say.

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2 Okay. Mike, are you ready?

3 (Off-the-record discussion)

4 MR. TAYLER: Two seconds.

5 (Off-the-record discussion)

6 MS. GOHLKE: The system's slow.

7 MR. TAYLER: If you recall, when
8 Ed Wronsky was still here, there came the question
9 of -- the last time we surveyed the trauma centers
10 throughout the five boroughs of New York City was
11 in 2002-2003. The -- and at that time, we knew who
12 was -- who was an adult-only trauma center, who was
13 a pediatric-only trauma center, and who was both.

14 Now, the difference -- the
15 difference is this: Every trauma center,
16 regardless, has to be able to receive any patient,
17 of any age, with any condition, into their
18 emergency department. From there, they have to
19 stabilize them and then decide whether they're
20 going to ship them to an appropriate facility for
21 I.C.U., further surgery, whatever, if they are
22 going to ship them to another facility, or if they
23 are going to admit them to that facility. So, keep
24 in mind that when you talk pediatric trauma

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2 centers, we have three trauma centers in New York
3 State that are pediatric-only, because they don't
4 generally accept adult patients in their E.R. That
5 would be Schneider's L.I.J., Women's and Children's
6 in Buffalo, and -- what's the other one in New York
7 City?

8 DR. COOPER: Morgan Stanley.
9 Morgan Stanley Children's Hospital/New York
10 Presbyterian.

11 MR. TAYLER: New York --
12 Children's Hospital/New York Presbyterian, yeah,
13 are the three.

14 But just because they say that
15 those are pediatric trauma centers does not mean
16 that -- that they are the only pediatric trauma
17 centers in the state. We have forty -- I think we
18 have forty-one trauma centers now. All forty-one
19 of them can accept pediatric trauma patients. They
20 have to stabilize them and then decide whether they
21 go -- whether they are going to admit them to that
22 facility or ship them. So under that, we -- we did
23 the surveys of New York City back in 2002-2003.
24 From those surveys, we knew who was admitting, who

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2 was stabilizing and shipping, who was
3 pediatric-only, who was adults-only, who was doing
4 both.

5 Then -- let me see, this is 2010.
6 Along about 2007, we started hearing thoughts that
7 maybe some of the trauma centers who said that they
8 were pediatric weren't quite capable anymore of
9 doing pediatric. And sure enough we discovered
10 that there was. So, under Mr. Wronsky, what we did
11 was send a letter to all the trauma centers in the
12 five boroughs. The -- well, there was nineteen at
13 the time, Mary Immaculate Hospital has since
14 closed. The -- we sent a letter to all the -- all
15 nineteen trauma centers and asked them: Do you do
16 pediatrics? Do you meet the 708 -- the -- the Part
17 708 regulations to be a pediatric trauma center?
18 And they eventually all -- it was thought-invoking.
19 I got a lot of phone calls from -- from hospital
20 administrators saying, "We thought we were, but
21 maybe we're not quite, so we'll get back to you."
22 It wasn't so clear cut, and it took well over a
23 year to get all those responses back from -- from
24 just nineteen hospitals. So, it was

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2 thought-invoking on the part of the administration
3 of these hospitals, whether they actually were
4 pediatric trauma centers, wanted to be pediatric
5 trauma centers, or not. The letters came back to
6 Ed Wronsky from the chief administrative officer,
7 chief executive officer, from the higher-ups in the
8 hospital, so that -- that -- that this is a
9 definitive word from the hospital administration of
10 what they want to be.

11 In that, we then took that list
12 and gave it to the New York City Regional Trauma
13 Advisory Committee, and said give us your take on
14 this. There were some surprises at the hospitals
15 that said they were, and some surprises at the
16 hospitals that said they weren't. The -- so the
17 New York City RTAC looked at this, to see is this
18 going to impact pediatric trauma care in the five
19 boroughs? So from there, they went borough by
20 borough, and they said "Okay. So -- so up on my
21 map here, this is Staten Island. So, we have
22 Staten Island University North and Richmond
23 University Medical Center. Is there -- are either
24 of those going to do pediatrics on Staten Island?

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2 And sure enough, both of them came back and said
3 yes, they -- they admit both adult and pediatric
4 trauma. So, from the New York City RTAC
5 perspective, the borough of Staten Island is okay.
6 They cover both adult and pediatric.

7 The -- okay. Help me here, Dr.
8 Cooper. I know this is Manhattan. What's this?

9 DR. COOPER: Brooklyn.

10 MR. TAYLER: I'm not a New York
11 City boy. Help me out here.

12 DR. COOPER: Brooklyn.

13 MR. TAYLER: In Brooklyn --

14 MS. BURNS: Art, you're
15 horrified; aren't you?

16 MR. TAYLER: Well, I'm not a New
17 York City boy. I'm a country boy, way up north by
18 Canada.

19 DR. COOPER: No, not horrified.

20 MR. TAYLER: I can tell you more
21 about Canada --

22 DR. COOPER: Just frightened.

23 MR. TAYLER: -- than New York
24 City.

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2 DR. COOPER: Right.

3 MR. TAYLER: Thirteen o four

4 is --

5 DR. COOPER: Lutheran.

6 MR. TAYLER: Lutheran. King's

7 County.

8 DR. COOPER: Thirteen o one, and

9 twelve eighty-five is Brookdale.

10 MR. TAYLER: Twelve eight-six

11 is --.

12 DR. COOPER: Brookdale.

13 MR. TAYLER: Brookdale? How do

14 you know this, Dr. Cooper?

15 Brookdale said they are adult

16 only. Kings County said that they are adult and

17 pede, and Lutheran said that they are adult only.

18 So, again, New York City RTAC felt there's at least

19 one pediatric center in Brooklyn, so Brooklyn's

20 okay.

21 Even with the recent in

22 Manhattan, all this, fourteen fifty-eight is --

23 DR. COOPER: The one on the left

24 Vinny's, the one on your right is Bellevue.

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2 MR. TAYLER: -- fourteen

3 fifty-eight?

4 MS. BURNS: He doesn't even have
5 to book to tell you where these are.

6 MR. TAYLER: Yeah. Yeah. Yeah.

7 It's the Harvard grad in him. He just knows.

8 DR. COOPER: It's the --.

9 MR. TAYLER: St. Vincent's --

10 DR. COOPER: Right.

11 MR. TAYLER: -- is here?

12 DR. COOPER: That's Vincent's.

13 Bellevue is on the other -- right. That's --.

14 MR. TAYLER: Okay. St. Vincent's
15 is the one that is closing -- maybe closing,
16 they're in trouble. They -- even with the loss of
17 them, the --

18 MS. BURNS: She just learned
19 that.

20 MR. TAYLER: -- there are still
21 pediatric trauma centers in the five -- in the --
22 in the borough of Manhattan. So, that's the
23 perspective that the New York City RTAC took on it,
24 that -- how they looked at it. And they -- their

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2 recommendation back to the State Trauma Advisory
3 Committee was that, although some of the responses
4 back from these hospitals, from these C.E.O.s were
5 surprising, they do not feel that it will impact
6 either adult or pediatric trauma care in the -- in
7 the five boroughs of New York.

8 So at this point, where we go
9 with it, we are -- that report was given by Dr. Ron
10 Simon out of Bellevue, who chairs the New York City
11 RTAC. He gave that report to the State Trauma
12 Advisory Committee. We are waiting for him to put
13 that in writing for us, the bureau, and then we can
14 act upon that as far as contacting the New York
15 City REMAC and REMSCO, to talk about where
16 ambulances should be directed for what kind of
17 patients in the -- in the city.

18 So -- so, Ann, if you could
19 relate that back to -- back to your folks, because
20 the -- the first time we put this out I did like,
21 the next day, get a phone call from Chief McFarland
22 saying --.

23 MS. FITTON: You got that
24 what --?

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2 MR. TAYLER: What's that?

3 MS. FITTON: I'm just saying --

4 MR. TAYLER: And that's okay.

5 MS. FITTON: -- what its

6 frequency was --.

7 MR. TAYLER: And that's okay. He
8 was -- but he was -- he was concerned that -- that
9 F.D.N.Y. needed to do something right now. The --
10 the standstill is that FDNY shouldn't change
11 anything until we, the bureau, talk to New York
12 City REMSCO and REMAC medical directors, and -- and
13 go from there. So, he was rightfully concerned.
14 But -- and he called me right away, and -- but --
15 and that's okay. But just a piece -- a piece to
16 FDNY leadership if you would, that we're -- they'll
17 be hearing more on this. Don't take --

18 MS. FITTON: Sure.

19 MR. TAYLER: -- don't take any
20 immediate action right now to -- to rock the boat.

21 Okay. Questions?

22 (No audible response)

23 DR. COOPER: Martha, did you have
24 anything?

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2 MS. GOHLKE: I just want to add
3 so, we -- we started this because we had heard
4 rumblings of goings-on in New York City. So we
5 completed, so to speak, as Mike says, we -- we did
6 our investigations, and -- and -- and it -- it
7 occurred to us that, you know, this may not just be
8 a New York City phenomenon, even though that's
9 where we heard the rumors. And so, we're going to
10 do similar with the upstate trauma centers, and
11 send them the letter and verify whether or not
12 they're doing pediatric -- they're admitting
13 pediatric trauma or not. Especially since we're
14 going down the road of the stakeholder's meeting of
15 looking at care of children across the continuum,
16 it would be good, obviously, to make sure that what
17 we think is going on upstate really is, and maybe,
18 in fact, it isn't -- and have it on paper. So
19 that's our next step is to send out the same
20 letter, asking hospitals to verify if they're --
21 they're admitting pediatric trauma.

22 DR. COOPER: Thank you, Martha.
23 Always an interesting subject,
24 particularly as healthcare systems mature,

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2 downsize, right-size - whatever the word is -
3 consolidate, which leads me to a new bit of
4 information for the group.

5 There -- as many of you are
6 aware, the governor's budget calls for an
7 additional three-hundred-and-seventy-million-dollar
8 cut from the reimbursements through the Health and
9 Hospitals Corporation, which has already sustained
10 close to a billion dollars worth of cuts over the
11 last couple of years. The Health and Hospitals
12 Corporation is very, very actively considering
13 getting as many as half of -- well, I shouldn't say
14 half, a good number of its facilities out of the
15 trauma business. There is a sense on the part of
16 the H.H.C. leadership, and the executive vice
17 president of Health and Hospitals Corporation is,
18 in fact, a trauma surgeon, that there may be too
19 many trauma centers within the Health and Hospitals
20 system. Well, let me rephrase that. Not that
21 there are too many trauma centers, but that -- but
22 that the system can no longer afford to sustain
23 that many trauma centers. And so, it is certainly
24 possible that at least one, and as many as two of

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2 the six trauma centers in New York City that are
3 operated by Health and Hospitals may -- may
4 disappear.

5 They're really looking at having
6 no more than one per borough at this point, and --
7 as we know, they do not have any acute-care
8 facilities in Staten Island, so they would be
9 looking at cutting back one trauma center in
10 Manhattan possibly, cutting back one in the Bronx
11 possibly. They only have one each in -- in -- in
12 Queens and in -- in Brooklyn. So, we'll be
13 following that -- that story very closely.
14 H.H.C. has retained -- this is not, of course,
15 anything private, they have sustained -- they
16 have -- they have retained Deloitte and Touche, a
17 major national healthcare consulting firm, to help
18 them plan for the future. They're anticipating as
19 much as a one-point-five-billion - that's with a
20 B - -dollar budget shortfall, out of a total budget
21 of about six billion dollars. That's a twenty-five
22 percent cut in their overall operating expenses,
23 which for hospitals that run on -- in New York
24 State, that run on a margin of about a half to one

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2 percent, and -- and H.H.C. is not one of those
3 fortunate hospitals -- hospital systems, you know,
4 that kind of hole in the budget is devastating. So
5 that's where it is.

6 They have apparently made a
7 decision not to close any facilities, because
8 they've determined that closing facilities will
9 lose patients, and will end up in a revenue-neutral
10 situation, and the job loss in the primarily poor
11 communities that those hospitals serve would --
12 would so undercut the tax base that it would not be
13 worth, you know, the hit to the system to close the
14 facility. So, what they're looking to doing
15 instead is dramatically cutting back on -- on high
16 -end services, and consolidating wherever they can.
17 And very clearly, trauma services is one of the
18 services that's on the chopping block.

19 So we may be revisiting this,
20 Mike, in a very short period of time.

21 Chris.

22 DR. KUS: Martha and -- and --
23 and Mike, so -- so you asked the hospitals about
24 are they doing this. Is there a procedure that

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2 say, they change their status that they're supposed
3 to inform somebody? So, the idea is to -- I mean,
4 can you have a real-time view of what it is? Is
5 there -- how does that work?

6 MR. TAYLER: No --

7 DR. KUS: Okay.

8 MR. TAYLER: -- is the long and
9 short of it. The -- the trauma regulations are the
10 original regulations from 1990. They are in the
11 process of being reviewed and -- and updated, but
12 that is a long and arduous process that is taking
13 us several years, and we still are a ways away from
14 getting that done. The -- so, we're still on the
15 1990 regulations.

16 The -- the gentleman's agreement
17 is that if you are going to change your status or
18 stop providing a service, that -- that you, you
19 know, let the Department of Health know, but truly
20 there -- there isn't much of a regulatory statute
21 to -- to -- to go on, that they have to notify us.
22 For example, Arnot Ogden was a trauma center in
23 Elmira. They -- they notified everyone that they
24 were no longer going to be a trauma center by

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2 sending a letter to all of the affected
3 stakeholders, E.M.S. agencies, and such in the
4 surrounding area. That same letter was cc'd to Ed
5 Wronsky in my office, as a, you know, F.Y.I.
6 we're -- we're -- we're closing our doors. There
7 was no prenotification to the Department of it.
8 We, in fact, kind of heard through the grapevine
9 that they were closing, and -- and we made a phone
10 call to Arnot and they said yeah, the letter's
11 coming.

12 So, really, there -- there is no
13 requirement for them to notify us. There will be
14 in the new regulations, once they come out, because
15 this is one of the problems that we've identified.
16 But it -- it -- it -- unfortunately, it's -- for
17 example, if a trauma center has a robust pediatric
18 trauma service run by a group of -- of renowned
19 pediatric surgeons, and the group decides to
20 pullout of the hospital for whatever reason, the
21 hospital could just stop admitting pediatric
22 trauma, and -- and start shipping pediatric trauma,
23 and that's -- that's what the fallback would be.
24 But there -- there would be no notification to us

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2 that that occurred.

3 DR. KUS: See, that's kind of --
4 I mean, in the area -- in the era of preparedness
5 and knowing capacity, that's -- that's amazing to
6 me.

7 MR. TAYLER: Uh-huh.

8 DR. KUS: I mean, because talk
9 about preparedness capacity --.

10 MR. TAYLER: It's something that
11 was not -- that was not thought of in 1990. You
12 know, preparedness was just not --.

13 DR. KUS: But it's here now. I
14 mean, I guess it's -- the -- the question is: Is
15 there a way to do it -- do something in this -- in
16 this area with regard --

17 MR. TAYLER: That's --

18 DR. KUS: -- to not going through
19 regs and all that kind of -- I mean, it just seems
20 like it's -- but anyways --

21 MR. TAYLER: Uh-huh.

22 DR. KUS: -- I -- I hear what
23 you're saying.

24 MR. TAYLER: Yeah.

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2 DR. COOPER: Okay. Any other
3 questions for Mike?

4 (No audible response)

5 DR. COOPER: I do think that
6 it -- it may be worth, Mike, as we move forward on
7 this, again, as we discussed earlier, for pediatric
8 services or pediatric critical care services, the
9 process of -- of, you know, a special franchise to
10 receive a certain kind of patient, you know, should
11 be following general accreditation guidelines, you
12 know, in that there ought to be a categorization,
13 verification, and designation process in place.

14 You know, it strikes me that
15 asking the C.E.O.s of the hospitals, you know, what
16 capabilities they have is the categorization
17 component, but before decisions are made
18 consideration should be given to an onsite
19 verification of that. It's not always been the
20 case that what you're told you're going to get is,
21 in fact, what you get. And you know, for that
22 reason - hang on - for that reason, it may be worth
23 considering a verification step in that process,
24 prior to making any decisions. But that's

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2 obviously something that the Department will have
3 to take under advisement.

4 Okay. I'd like to move on to the
5 pediatric trauma report.

6 Wendy, are you given that, or is
7 Ed Hannan giving that?

8 DR. WELLER: I'm giving it, but
9 probably --

10 DR. COOPER: Oh, I'm sorry. I'm
11 sorry. I skipped over Kathy. I'm so sorry.
12 The -- the ad hoc asthma subcommittee.

13 Kathy.

14 DR. LILLIS: Okay. Just very
15 briefly, we -- we had a conference call a week or
16 so ago, and discussed a little bit of where we were
17 with things. The recommendation from that meeting
18 was that we would have a conference call with the
19 bureau's asthma subcommittee. I don't know -
20 Martha, do you know the exact title of what it
21 is -- what it was, but Marilyn Canseca (phonetic
22 spelling) said that there's a very active asthma
23 subcommittee within the Department of Health, and
24 suggested that the asthma subcommittee from this

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2 group have a conference call with -- with that
3 group, so we're in the process of trying to
4 coordinate that at -- at this point.

5 DR. COOPER: Okay.

6 DR. LILLIS: I think we can move
7 on to the trauma report now.

8 DR. WELLER: Yeah.

9 (Off-the-record discussion)

10 DR. COOPER: All right. I'd like
11 to thank Kathy for that report.

12 This is -- once again, I mean, as
13 we discussed last time, this is a really important
14 issue for us as, a -- as a Department, you know,
15 advisory body, and of course, for the Department.
16 The number of kids with asthma is phenomenal, and
17 we need to pull all our resources together. But it
18 starts in the -- in the field and in the emergency
19 department, and you know, so Chris, any help, and
20 Jennifer, any help you can give us in getting this
21 conference call together, and getting the resources
22 of the Department, you know, all together in one
23 place, to -- to deal with the front-end issue here,
24 that we -- that we face, would be greatly

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2 appreciated.

3 DR. KUS: I -- I wasn't on the
4 call, but Marilyn was on the call, who works in
5 my -- we -- we both work together, and -- and I
6 think the idea is that -- that the asthma program
7 itself, which is -- actually has an advisory group,
8 that we have a whole way of dealing with it, is to
9 try to link this issue within the -- that
10 structure, which think would be the -- the way to
11 do it, because then it becomes part of the -- you
12 know, whether there's amendments to state plans
13 or -- or activities, that would be the way to go.
14 So, yes, we'll get that call set up.

15 DR. COOPER: Thank you, Chris.

16 Wendy, are you ready?

17 DR. WELLER: Yes.

18 DR. COOPER: Thank you.

19 DR. WELLER: If I can remember
20 how to work this.

21 I've been asked to give an update
22 or an overview of the -- the second pediatric
23 trauma report that we're currently finishing up
24 right now. So, I'm just going to give a little bit

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2 of an overview of that. If -- I'm going to start
3 out just with very brief background that most of
4 you are probably familiar with. We're going to
5 talk a little bit about the data sources, because
6 we use New York State Trauma Registry data, but
7 also some data from other sources. And then I'll
8 give you some of the select findings. You have to
9 keep in mind that the report is about two hundred
10 pages, so you don't want to be here all day, you
11 know, looking at slides, so I just picked out a few
12 kind of key findings to -- to show you. And then
13 I'll just back up with some conclusions.

14 Just a little bit of background,
15 as you -- most of you know, that the initial
16 pediatric trauma report was -- in New York was
17 released in 2002, and that was based on 1994 to
18 1998 New York State Trauma Registry data. And it
19 basically provided a descriptive overview of
20 pediatric trauma in New York.

21 Like I said, the second report
22 is -- is currently being finalized. And the second
23 report addresses a few things. It first compares
24 more recent New York City Trauma Registry data,

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2 from 2002-2006, to that first report -- findings
3 from the --the first report. But it also compares
4 pediatric trauma in New York State to national
5 data, using data from the National Trauma Data
6 Bank. And they actually produced a pediatric
7 report that was released in -- in 2007. And so
8 basically we've kind of reproduced that national
9 report, using -- using New York data, and kind of
10 compared the findings.

11 I just want to spend a few
12 minutes talking about the data sources, and some of
13 the caveats associated with the data sources,
14 because it's important to keep in mind when
15 you're -- you're looking at the -- the findings.
16 In terms of the New York State Trauma Registry, it
17 does include data from all area and regional trauma
18 centers in New York State. In '94 to '98, there
19 were forty-eight trauma centers. In 2002 to 2006
20 there were forty-four trauma centers.

21 When the report was first done,
22 and when -- and when the trauma registry was first
23 implemented, information from nontrauma centers was
24 collected. It's no longer collected, so it was in

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2 the first report. It's not in the second report.
3 So, you know, we had to -- we are -- we're in the
4 process actually of doing, you know -- looking at
5 noncenter -- you know, excluding noncenter data,
6 and what it looks like with and without.

7 It also includes all deaths in
8 the emergency department, admissions with injuries
9 that are considered, you know, severe, as defined
10 by I.C.D.-9 diagnosis codes that were identified by
11 the -- the -- the State Trauma Advisory Committee.
12 And data are collected from the prehospital care
13 report, the emergency department record, and the
14 face sheet from SPARCS. And pediatric patients are
15 defined as those nineteen years of age and under.

16 And you just have to keep in
17 mind, there are some differences between the '94
18 and '98 data, and the 2002 and 2006 data. And some
19 of the -- the most important one probably is the
20 inclusion of, or exclusion of, nontrauma centers.
21 So, nontrauma centers were included in the original
22 report, but we don't really collect that
23 information anymore, so we examined the data with
24 and without noncenters in there.

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2 Also, previously, patients who
3 were dead on arrival were included in the registry,
4 but they stopped collecting data when they -- they
5 stopped including them in the registry as of 2006.
6 So, the D.O.A. information for 2002 to 2006 is
7 really incomplete. So, again, we've done some,
8 kind of, looking at the data with and without the
9 D.O.A.s, and -- and I've actually excluded some of
10 those from -- from this presentation.

11 The National Trauma Data Bank is
12 another data source that we use. It's -- it's
13 national dataset, but it's a little bit different
14 than New York. It's maintained by the American
15 College of Surgeons, and data is voluntarily
16 submitted to this -- to this databank from
17 hospitals and trauma centers across the -- the
18 United States. So, unlike New York that requires
19 trauma centers to submit data, you know, hospitals
20 can decide whether or not they want to submit data
21 to the National Trauma Data Bank. And the
22 inclusion criteria for the National Trauma Data
23 Bank are a little bit different than New York's.
24 So, again, you have to keep that in mind when

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2 you're -- you're making comparisons between New
3 York and the nation.

4 DR. COOPER: Just one caveat,
5 Wendy. There -- there -- it is mandatory for
6 level-one and level-two
7 American-College-of-Surgeons-verified trauma
8 centers to submit data to the -- to the National
9 Trauma Data Bank.

10 DR. WELLER: Uh-huh.

11 DR. COOPER: It's voluntary for
12 everyone else, but it is mandatory for them.
13 There's also some crossover between trauma centers
14 in New York State and the N.T.D.B. --

15 DR. WELLER: Uh-huh.

16 DR. COOPER: -- because there
17 are -- there are many centers that submit data to
18 the N.T.D.B. from New York State, although not all.

19 Ed.

20 DR. HANNAN: There's also no
21 means of actually verifying the cases --.

22 DR. COOPER: That's correct.

23 Correct.

24 DR. WELLER: Right. So they can

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2 sense that it's not all, you know -- so it's --
3 it's a little bit different than -- than New York.

4 Also, the -- the inclusion
5 criteria for defining a trauma case is a little bit
6 different for the National Trauma Data Bank than
7 New York. They have a little bit broader
8 definition than New York State. And they do
9 include deaths on arrival. They also include
10 deaths in the emergency rooms. And they also use
11 I.C.D.-9 Codes, the diagnosis codes to, you know,
12 identify trauma patients, but the codes that they
13 use are much broader than New York's. Those are
14 the codes there, excluding a few that are minor
15 things like bug bites and things like that. But
16 generally, it -- it's broader, and includes more
17 things, and maybe sometimes, you know, things of
18 lesser severity than -- than New York does.

19 And like I said, basically we're
20 using 2002 to 2006 National Trauma Data Bank data
21 to actually, you know, reproduce that report and
22 compare it to New York. And again, they do define,
23 in terms of age, pediatric patients, again,
24 under -- nineteen and under. So, again, there are

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2 some differences, you know, and again, if we look
3 at the issues of doing these comparisons, again,
4 the most -- probably the most important line that
5 we're talking about of the national data is that
6 the New York State Trauma Registry probably, and it
7 does, include trauma patients that are more
8 severely injured than the National Trauma Data
9 Bank, because New York tends to limit it to
10 I.C.D.-9 Codes that are expected to result in
11 higher severity scores. And that's not the case
12 for the National Trauma Data Bank. So, you have to
13 be very careful when you're looking at things like
14 mortality rates, because it -- and if they're not
15 adjusted for severity, because they can, you know,
16 it can be a little bit misleading.

17 Also, again, we talked about, you
18 know, whether or not they have to submit to it,
19 whether that's mandatory. It may result in some
20 biases, you know, if certain trauma centers don't
21 submit, you know, all their data, or just, you
22 know, partial -- part of their data. Also the
23 national data set includes D.O.A. versus, you know,
24 New York, which stopped requiring those to be

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2 included in the registry.

3 Also, the National Trauma Data
4 Bank kind of breaks things into more refined
5 categories. It includes some of the mechanisms of
6 injuries that aren't included in the New York
7 dataset -- data registry, including things like
8 burns, suffocations, and -- and poisoning, so you
9 can't really make comparisons across the two and --
10 for those things.

11 So let me just report a few --
12 again, these are just a few key findings from the
13 report that's being finalized. I'll start out with
14 New York State data comparing the two time periods
15 in New York State, because those are a little more
16 straightforward than the national comparison. And
17 here on this table - these slides are kind of hard
18 to see; PowerPoint was giving me a very difficult
19 time when I put this together.

20 But you see that most general
21 characteristics of pediatric trauma patients in New
22 York were similar between the two time periods.
23 About one in five trauma patients were children in
24 both time periods. The vast majority of pediatric

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2 patients, trauma patients, were male almost, you
3 know, three in four. The largest age group in both
4 time periods was children between the ages of
5 fifteen and nineteen. And of course, New York City
6 accounted for the largest share of -- of trauma --
7 pediatric trauma patients, and it was -- it was --
8 it was similar in both periods.

9 There were some regional
10 differences when you looked at the regions with the
11 highest percentage of pediatric trauma patients
12 outside of New York, between the two time periods.
13 In -- in -- the earlier time period in Central New
14 York, they kind -- were kind of the second largest
15 percentage. In the more recent period, the Finger
16 Lakes Region accounted for the most. And the
17 regions with the lowest percentage of pediatric
18 trauma patients were a little bit different in --
19 in both years. Nassau in the earlier time period,
20 and northeastern New York in the -- in the second.

21 When you look at where these
22 children are being treated, the vast majority of
23 pediatric trauma patients are being seen at
24 regional trauma centers. And these figures

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2 exclude -- again these exclude noncenters, you
3 know, so it's just looking at regional versus area
4 centers. And you can see, you know, eighty percent
5 in -- almost ninety percent in the most recent
6 years, but the vast majority is children seen at
7 regional trauma centers.

8 And in both years, both time
9 periods, falls and motor-vehicle crashes were the
10 leading mechanism of injury. Falls accounted for
11 about twenty-two percent of pediatric trauma
12 injuries in both time periods, motor-vehicle
13 crashes, almost the same, you know, percentage,
14 about twenty-one percent in -- in both time
15 periods.

16 And if you look at children who
17 died in the emergency room, first of all, there
18 were a very small percentage of pediatric trauma
19 patients who actually died in the emergency room,
20 less than one percent in either, you know, the
21 earlier time period or the later time period. But
22 if you look at that small population, you see that
23 the mechanism of injury, you know, was similar
24 between the two time periods, in terms of

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2 motor-vehicle crashes accounted for twenty-seven
3 percent in the earlier time period, a little bit
4 more in the most recent time period, at about
5 thirty-three percent. And assaults accounted for,
6 again, about twenty percent in the earlier time
7 period, almost -- what is it? I can't see.
8 Twenty-six percent more recently. So, of little
9 bit higher percentage in -- in more recent years,
10 but they were both the same, you know, leading
11 causes of death during the times.

12 And probably not surprisingly,
13 most pediatric trauma patients were transported to
14 the hospital by ambulance. Again, it's a little
15 bit smaller -- the percentage is a little bit
16 smaller in the more recent time period. But again,
17 you know, they both were -- in both time periods,
18 the -- you know, the majority of children were
19 transported this way.

20 So, those are just kind of very
21 brief, you know, very few select findings from just
22 the first chapter of the report, which compares,
23 you know, New York data in the two time periods.
24 I'm going to talk a little bit now about New York

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2 State compared to the National Trauma Data Bank.

3 These are a little more difficult, and the slides
4 aren't particularly pretty, they're kind of hard to
5 read.

6 But this first graph shows the
7 number of pediatric trauma injuries by age and
8 gender, and - I'm going to see if I can work the
9 pointer and then get the slides to work again.

10 This first graph on the left shows the -- it shows
11 New York State basically. And the second graph
12 over here on the right shows national data. And
13 the X axis is age and the Y axis is the number of
14 incidents. And of course, you can't compare New
15 York directly to the nation in terms of number,
16 just because of the sample sizes. It's so
17 different. But this bottom line on each of the --
18 the bottom lines on each of these -- this dotted
19 line -- it -- it's -- it represents females, and
20 the solid line represents males. And -- although
21 you can't compare the exact, you know, numbers, you
22 can see that the patterns are similar for both New
23 York and the nation, in terms of numbers at each
24 age with, you know, a trauma, you know, incident.

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2 In both cases, boys -- they're --
3 at each age, you know, boys have more trauma
4 than -- represent more trauma cases than -- than
5 girls. Also, you can kind of see that, you know,
6 there's kind of this peak at the lower ages, and
7 then it's relatively stable for a while, and then
8 it increases again. And you -- it increases kind
9 of a bit later for girls than -- than boys, and
10 this is kind of getting into the teenage years
11 here. And you see that the difference between
12 girls and boys kind of -- it -- it gets larger, you
13 know, as -- as children get older.

14 Oh, that wasn't supposed to do
15 that. All of a sudden it changed the -- which goes
16 which way. Oh, I know why. See. I knew I
17 shouldn't have turned on the pointer.

18 Okay. This is showing -- it's
19 similar to the first slide in that it's broken out
20 by age and gender, and it's -- it's showing
21 mortality rates, and each age for girls and boys,
22 although the slides are set up a little bit
23 different in terms of the left is females and the
24 right are males. And again, fairly similar

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2 patterns, you know, the national are -- again,
3 there are these dotted lines. There's sort of like
4 more variation in New York, and it's somewhat due
5 to sample sizes; the sample sizes are much lower,
6 you know. These curves are smoother for the -- the
7 nation. But again, you see that, you know, New
8 York tends to be higher at each age than the
9 national data. Again, you know, these aren't
10 adjusted for anything, and -- but you see that in
11 both cases, kind of younger children, the mortality
12 rates -- and mortality here is just defined as the
13 number of children at a given age who die divided
14 by the total number of children in that age group.

15 DR. COOPER: Now, Wendy, these
16 are -- you're comparing a straight comparison
17 between our dataset and the N.T.D.B.; correct?

18 DR. WELLER: Uh-huh.

19 DR. COOPER: It -- it is
20 possible, I believe, to -- to subselect N.T.D.B.
21 with only, you know, I.S.S.-8 or -9 and above.

22 DR. WELLER: Right. And I'll
23 show some of those --

24 DR. COOPER: Little bit later?

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2 DR. WELLER: -- a little bit
3 later.

4 DR. COOPER: Okay.

5 DR. WELLER: And we're actually,
6 you know -- I'm -- I'm breaking it out a little bit
7 finer, in finer categories, but --

8 DR. COOPER: Thank you.

9 DR. WELLER: -- so you can see
10 that -- you can see that, again, at kind of the
11 lower ages, there's kind of a peak in terms of
12 mortality. It kind of remains somewhat constant,
13 and then there's a big peak again as -- as children
14 get older.

15 The most common type of injury by
16 far in, you know, both the nation and in New York
17 was blunt trauma. And this is true for -- most of
18 these slides break out children who are, again, you
19 know, fourteen and younger, and fifteen and older,
20 so that's what's on the left and the right. And
21 you see that, you know, for both New York and --
22 and in the nation, you know, blunt trauma is by far
23 the most common type of injury. And again, you
24 know, it kind of ignore the burn bars, because New

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2 York doesn't collect data on burns, but I couldn't
3 get it off of here, because it's a -- an object --
4 embedded as an object.

5 This graph is just children
6 between the ages of zero and fourteen, and it shows
7 trauma cases by the most commonly involved organ
8 systems, I -- is it organ systems? Yeah. And you
9 can see, again, for -- for children who are zero to
10 fourteen, the most commonly involved organ system
11 was the brain and -- and/or skull. And you can see
12 that, you know, for New York, the percentages are
13 much larger. They're the first bars in each
14 category, you know. But again, remember that
15 inclusion criteria is a little bit different for
16 New York trauma patients versus the nation. And
17 also you see that in the nationwide data, there's a
18 huge percentage that's kind of classified as other
19 and unknown, so that doesn't particularly help
20 things either.

21 For older children -- this is the
22 same chart, but for older children. And you can
23 see, again, you know, brain and/or skull injuries
24 were pretty much the most common type of injuries

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2 in terms of organ systems. But for older children,
3 you know, it wasn't uncommon for other types of
4 organ systems to -- to be involved.

5 And this -- this -- the rest of
6 the slides actually get into looking at trauma by
7 very -- you know, by injury severity score,
8 which -- injury severity scale score, which is one
9 way of measuring severity. And again, you have to
10 be a little bit careful comparing these, because
11 the categories of severity scores are -- are
12 relatively crudely defined, you know, from one to
13 eight, to nine to fifteen, fifteen to twenty-four,
14 and greater than twenty-four. And remember that
15 New York tries to get patients included in the
16 trauma registry that have severity scores of at
17 least eight or nine.

18 So, you can see that the majority
19 of children in both New York and nationwide have
20 severity scores less than or equal to -- less than
21 fifteen, but again, you know, you see that -- that
22 New York has a slightly -- has a larger percentage
23 of children in the -- that nine-to-fifteen range
24 compared to the nation. But again, you know, if

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2 you work it out even finer, that one to eight
3 category, you would probably see, you know,
4 differences as well.

5 And this shows mortality rates by
6 I.S.S. scores. And you can see that by far, you
7 know, mortality rates were highest among children
8 with the highest severity scores. So, it was with
9 severity scores greater than twenty-four, both
10 nationally and in New York.

11 And there are only two slides
12 left, but both of them discuss length of stay.
13 This is showing mean hospital length of stay.
14 And -- and it shows that length of stay increased
15 as severity scores increased. And this is, again,
16 was true both in New York and nationally. We see
17 that there are -- the length of stay is greater in
18 New York than nationally, but again, these are only
19 kind of crudely adjusted for severity. You know,
20 if you looked at severity as either a kind of
21 continuously or in more refined categories, that
22 might change things a little bit, but you know, in
23 the -- the greatest severity score, you know,
24 category, those greater than twenty-four, the

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2 length of stay are fairly similar between New York
3 and the nation.

4 And this is a very similar slide
5 except this is getting at intensive-care-unit
6 lengths of stay rather than just hospital stays.

7 And again, you know, a similar finding in that
8 length of stay increases with severity score. And
9 again, you know, this -- the similar caveats hold.

10 So, again, this is a very brief
11 overview of what's in the report. The report is --
12 is long. But some of the things that we can
13 conclude based on what we found is that the common
14 measures of pediatric trauma in New York between
15 that '94-98 time period and the 2002-2006 time
16 period, were relatively similar. Things, you know,
17 look about the same in both time periods. There
18 were several similarities in pediatric trauma
19 between New York and the nation, especially when
20 you look at patterns, not so much if you look at
21 actual rates, but again, it's a little bit of a
22 challenge, because it's hard to make direct
23 comparisons for -- for some of those things,
24 especially when they were looking at things like

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2 number of -- of cases and so forth.

3 And also the actual case fatality
4 rates or mortality rates and lengths of stay tended
5 to be longer in New York than across the nation,
6 but again, you know, if you -- if we do more
7 adjustments for severity, this may kind of even out
8 a little bit, you know, so the take-home message
9 is -- is there are a lot of similarities, but you
10 do need to be a little bit cautious when you're
11 interpreting differences between New York and --
12 and the nation in general.

13 Oh, one last thing.

14 Acknowledgments. I just, you know, want to
15 acknowledge the people who are on this slide, you
16 know, including those from the Department of Health
17 and the Bureau of Emergency Medical Services, the
18 committee, and those at the -- the School of Public
19 Health, especially Ian Kramer (phonetic spelling)
20 was a student who worked with me on this, and he
21 did an incredible amount of, you know, data
22 analysis, of -- it was a lot of things.

23 That's it.

24 MS. MACINSKI SPERRY: When the

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2 report is finished, will it be available online or
3 will you send out copies and --?

4 DR. WELLER: I -- I --

5 MS. GOHLKE: It will be available
6 online.

7 DR. WELLER: -- it's going to be
8 available online.

9 MS. SPERRY: Awesome. If -- got
10 to be available online.

11 DR. WELLER: Right. You can see
12 the last one is online as well.

13 DR. COOPER: Thank you, Wendy.

14 The -- this is really very, very
15 interesting, and from my standpoint, very important
16 and powerful data. We all recognize that, you
17 know, that the law of large numbers, which is not
18 really a law, doesn't necessarily really apply
19 when, you know -- even though we have such a large
20 dataset in the National Trauma Data Bank, it
21 doesn't necessarily mean, you know, because it is
22 voluntary, it is a contribution-based registry, it
23 doesn't -- it is not necessarily truly reflective
24 of the population of seriously injured children

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2 across the nation.

3 But it is reassuring to see
4 that -- that the patterns and the case mortality
5 rates at least appear to be in the same ballpark,
6 if not exactly identical. And once again,
7 recognizing that direct comparisons are -- are
8 fraught with -- you know, with difficulty. We do
9 have a population-based registry, at least insofar
10 as the trauma centers are concerned. We don't have
11 noncenters in the data anymore. But -- but it is a
12 population-based, so long as -- or insofar as
13 trauma centers are concerned.

14 Still and all, you know -- you
15 know, comparison with the N.T.D.B. is the best
16 we've got, in terms of national benchmarking at
17 this particular point. We could compare ourselves
18 with -- you know, directly with other states, such
19 as Pennsylvania, which, you know, is -- is
20 demographically and geographically not dissimilar
21 from our own, and they --they also have a
22 population-based registry insofar as trauma centers
23 are concerned. But that would not give us anywhere
24 near the numbers that the N.T.D.B. does.

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2 But with all the -- you know,
3 the -- the -- you know, the -- the whereases and so
4 on involved, it does make sense to me that -- that
5 at least for a few defined categories of patients,
6 it might make sense to run some comparisons between
7 our dataset and the N. -- and the component of the
8 N.T.B. that is eight or -- eight -- eight and above
9 or nine and above, whichever we choose, so that we
10 can at least run a more direct comparison in terms
11 of, you know, similar severity of cases. And I --
12 I think that would be very helpful.

13 And I -- I think at least to the
14 policymakers in New York State, to realize that
15 trauma care here -- pediatric trauma care here in
16 New York State is as good as, or hopefully perhaps
17 even a little better than, elsewhere, I think would
18 be, you know, tremendously important. So to the
19 extent that that can be done, given the resources
20 that you have available to you, recognizing of
21 course, that they're slim, you know, I think that
22 would be all to the good.

23 Ed, do you have any comments --
24 additional comments that you might want to make

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2 about this report?

3 DR. HANNAN: Pretty much what you
4 said. I mean, I believe -- I've worked with the
5 National Trauma Data Bank and polled the data
6 before, and -- and let me just comment on that. I
7 mean because there are many hospitals in the
8 database with a considerable number of patients who
9 have recorded zero percent mortality rate in the
10 database, so -- there are two problems. It can be
11 that the deaths are not reported among the
12 patients who are reported, but I think another
13 potential problem is -- is that, you know, there
14 could be patients who died who were not reported at
15 all, the case was not reported. So I suspect that
16 the overall mortality rate, if it was truly
17 representative of all the hospitals in the
18 database, would be higher than it is.

19 I do agree that the best way of
20 compare it -- comparing it to New York would be to
21 look at the -- the set of N.T.D.B. patients who
22 are -- as -- as equivalent as possible to the ones
23 that are in the New York database, in terms of
24 getting a true view of how they compare.

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2 But I -- I think the -- the
3 normal expectation would be that mortality rate
4 would be higher in New York than in the N.T.D.B.,
5 because there is this verification using SPARCS in
6 New York State, which is not done nationally, both
7 with respect to completeness of data, but also with
8 respect to whether or not the patient actually
9 died.

10 DR. COOPER: A very good point,
11 and I might also add that, as much as we gnash our
12 teeth and tear our hair out at the problems with
13 data collection in our own system, you know, we
14 look like, you know, Mount Olympus compared with
15 the National Trauma Data Bank. There are huge
16 fields of data that are missing entirely, some very
17 critical ones, as you indicate, such as mortality
18 data.

19 DR. HANNAN: Yeah. Yeah, just
20 one other thing I forgot to mention is that, you
21 know, you can see from what Wendy presented is that
22 there's a very large number of cases for which the
23 mechanism of injury are still unknown.

24 DR. COOPER: Absolutely.

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2 DR. HANNAN: And so for those
3 cases, you know, who knows what mechanisms they
4 were in, and then if you were trying to compare
5 them -- you know, so I mean there's clearly a --
6 in -- in addition to miscommunications, and
7 probably inaccurate reporting on death, there's
8 also data in, you know -- with regard to things
9 like mechanism of injury, that are not reported
10 properly.

11 DR. COOPER: Absolutely. And --
12 and -- you know, as you know, Ed, because you were
13 an invited guest of the committee on trauma last
14 March, I believe, if not -- or maybe it was
15 October, I don't remember -- the N.T.B. -- N.T.D.B.
16 is spending far, far, far more time than -- than --
17 than makes me comfortable, as a member of the
18 N.T.D.B. committee, discussing data imputation,
19 whereas we spend our time, you know, corralling the
20 people to actually submit the real data points,
21 rather than trying to impute, you know, values into
22 a -- into a -- you know, a system that looks like
23 Swiss cheese at times, in terms of the -- you know,
24 the -- the number of missing data elements.

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2 And the missing data elements are
3 far from random. It's not as thought it's, you
4 know -- you know, something that imputation, as
5 good as the techniques are becoming, could -- could
6 ever easily fix. So that, you know, I think
7 everyone recognizes the -- the problems with the --
8 with the voluntary contribution-based registry.
9 We're not there yet nationally as -- you know, as
10 far as we are in New York, and as we all know, even
11 here in New York we took a major, and in my view,
12 pardon me, tragic step back, you know, almost ten
13 years ago, when we stopped collecting data from
14 noncenters. And I do pray that by the time I'm
15 done, you know, with this phase of my life's work,
16 we will see, you know, the opportunity to get -- to
17 get that rectified, either through inclusion of
18 admitting vital signs in SPARCS, which would be a
19 best first approximation, or the actual data itself
20 from the noncenters, which would be ideal.

21 But you know, for those of you
22 who don't know - I don't know that there is anybody
23 in this room who doesn't know, but it should be
24 said in the public record - that the work that Ed

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2 Hannan and Louise Farrell and Wendy Weller and
3 others in Ed's department have been doing over the
4 years, has really set a national standard in terms
5 of quality reporting. And we are so privileged and
6 honored to have Ed and his -- his -- his unit
7 working with us. It's -- it's -- it's really a
8 Godsend in terms of, you know, the ability to
9 analyze data.

10 So, Ed, as always, and Wendy,
11 thank you so much for -- for all you do for us and
12 the people of New York State. It's great.

13 Any other questions for Ed,
14 Wendy.

15 Martha.

16 MS. GOHLKE: I just want to echo
17 your -- your thanks to the School of Public Health
18 for all this work, because it is a huge document
19 and it's been a long process meeting our needs.
20 Just so you know, at this point, you know, the --
21 the publication has to go all the way up the line
22 through the Health Department for approval before
23 it can be published. We just went through it with
24 the trauma report. We'll try to speed the process

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2 as much as we can, but it's going to take some time
3 before it's actually available to the public.

4 DR. COOPER: Is the trauma report
5 actually approved at this point?

6 MS. GOHLKE: Mike?

7 DR. HANNAN: No.

8 DR. WELLER: Actually though,
9 it's --.

10 DR. HANNAN: My -- my
11 understanding is that it -- it -- D.O.H. executive
12 has cleared it. It is now with the governor's
13 office, which is a step that we hadn't expected,
14 but --.

15 DR. WELLER: They did.

16 DR. HANNAN: They did. It's now
17 with the governor's office, and my understanding is
18 that once the governor's office releases it, then
19 it's off to Commissioner Daines.

20 DR. COOPER: Oh, it goes to the
21 governor's office before it goes to Commissioner
22 Daines?

23 DR. HANNAN: Yes.

24 DR. COOPER: Wow. Now, that's

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2 interesting.

3 DR. HANNAN: That's --.

4 MS. GOHLKE: It's good to know
5 that your work is not going unread.

6 DR. COOPER: That's -- that's a
7 new twist.

8 DR. HANNAN: That's right. New
9 twist.

10 DR. COOPER: Well, we'll be
11 looking at the -- at the New York Post and the New
12 York Daily News to see, you know, the latest
13 revelation from the -- you know, from the
14 governor's office regarding pediatric trauma.

15 So in any event, that's great.
16 So, Ed and -- and Wendy, I hope that, you know, we
17 can collaborate in terms of turning this
18 potentially -- at least a subset of this into a --
19 in to a publication that will, you know, serve to
20 educate the national trauma community as we, you
21 know, have always educated our own here in New York
22 State. It's -- it's -- it's important data, and
23 nobody does the job that I know that we do with
24 pediatric trauma, in terms of, you know, collecting

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2 and analyzing the data, and that's something that I
3 personally hope we can continue as we move forward.
4 Okay.

5 Well, we are expecting Marjorie
6 in the not too distant future, but in the meantime
7 we have finished, I believe, the old business on
8 the agenda. So we now are going to move into new
9 business, and Martha is going to share with us some
10 information about the unexplained child death
11 protocol. And then --

12 MS. GOHLKE: I'm not going to
13 share so much information as I'm going --

14 DR. COOPER: -- and --

15 MS. GOHLKE: -- to ask for
16 feedback.

17 DR. COOPER: -- and then I will
18 ask Sarah Sperry if she would give her report about
19 the -- about the upcoming conference. So Martha
20 and then Sarah.

21 Martha, go ahead.

22 MS. GOHLKE: You -- we want you
23 guys to be a focus group so to speak on this
24 document that is getting close to completion. It's

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2 been a work in progress for a while. I don't want
3 to give you too much background at this point,
4 because we want your honest feedback from a
5 provider who is going to be receiving this in the
6 emergency department. This is a document that will
7 be sent to the emergency departments of hospitals
8 on how to handle hospital pediatric fatality
9 protocol.

10 So, I'm hoping that you looked at
11 this, this was sent out before the meeting, and I
12 told my colleague who is in this group developing
13 this, that I would get your feedback and thoughts
14 on -- on this document. And I -- and I'll fill you
15 in a little bit as I get your feedback, but I don't
16 want to do that -- I don't want to slant your
17 feedback right away. And if we haven't had a
18 chance to look at this, we can always put it to a
19 another meeting, if we need to.

20 DR. COOPER: Well, Martha,
21 were -- were there specific points on which you
22 wanted feedback?

23 MS. GOHLKE: No.

24 DR. COOPER: Just the whole

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2 document?

3 MS. GOHLKE: Yeah. It's only --

4 DR. COOPER: Okay.

5 MS. GOHLKE: -- it's only -- it's

6 not very long. It's only about four pages --

7 DR. COOPER: Okay.

8 MS. GOHLKE: -- plus an

9 algorithm.

10 DR. COOPER: Well --

11 MS. FITTON: Martha, I had a

12 suggestion --

13 DR. COOPER: Oh.

14 MS. FITTON: -- for you.

15 MS. GOHLKE: Yeah.

16 MS. FITTON: They talk about, you

17 know, the protocol guidelines.

18 MS. GOHLKE: Uh-huh.

19 MS. FITTON: And you talk about

20 complete a full assessment --

21 MS. GOHLKE: UH-huh.

22 MS. FITTON: -- include a history

23 and a physical of the patient, document the

24 findings. I think they should specifically include

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2 any prehospital care records.

3 MS. GOHLKE: Okay.

4 MS. FITTON: And -- and I -- you
5 know, again, just being a prehospital care
6 provider, there is a wealth of information that may
7 be really pertinent to a later investigation of
8 what exactly happened that no one could know except
9 for those people who were objectively involved at
10 the scene. That's my only suggestion for you.

11 DR. COOPER: And it's actually an
12 incredibly important suggestion, you know, that
13 once the child reaches the hospital, you know,
14 it -- it obviously focuses on treatment, and the --
15 the focus of child fatality review is on etiology
16 rather than treatment, so that preventive
17 strategies can be put into place that will, you
18 know, reduce that burden to us -- to us all.

19 DR. KUS: How available is that
20 information to hospital personnel?

21 MS. FITTON: What happens is the
22 patient isn't actually signed over to the hospital
23 until the receiving nurse, or occasionally the
24 receiving physician -- always, really a nurse,

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2 signs for the patient. So it should become -- a
3 copy goes to that --

4 DR. KUS: So they should get that
5 when they --.

6 MS. FITTON: -- they get a copy
7 of that. You know, sometimes it is discarded, and
8 sometimes it's a valuable piece of information.
9 But I think -- and -- and part of that, really, the
10 value depends on -- the value really depends on how
11 the prehospital-care folks have -- have made their
12 documentation. But it's a link. It's the only
13 link from the hospital back to scene of wherever
14 this -- the call for nine-one-one occurred.

15 DR. KUS: I -- I -- I mean, I
16 totally agree in -- in -- in the context we're
17 doing, trying to develop a better child death
18 review process across the state, that would -- it's
19 a -- it's a retrospective review with team members,
20 but in looking at deaths, the issue of death-scene
21 investigation is critical, and so one of the
22 questions is how much death-scene investigation is
23 included in that report?

24 FROM THE FLOOR: Probably not

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2 very much.

3 MS. FITTON: Actually there
4 should be no investigation included in that report,
5 but there should be an observation of the
6 findings -- or the -- excuse me. There should be
7 observation of how the child presented, of where
8 that child presented.

9 DR. KUS: It -- it could be the
10 terms that we're using, because I --

11 MS. FITTON: Okay.

12 DR. KUS: -- what I -- what I'm
13 saying is that --

14 MS. GOHLKE: Assessment.

15 DR. KUS: -- the assessment of
16 what -- what you found --

17 MS. GOHLKE: Conditions.

18 DR. KUS: -- there.

19 MS. FITTON: Right. And just
20 take the -- just take, for instance, one of -- one
21 of the -- the sore topics in -- in my personal
22 repertoire, co-sleeping.

23 DR. KUS: Yeah, oh, I'm -- keep
24 going. Yes.

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2 FROM THE FLOOR: What was that?

3 MS. FITTON: I -- you know,
4 co-sleeping when --

5 DR. KUS: We'll -- we'll get
6 into --.

7 MS. FITTON: -- when a big old
8 adult --

9 FROM THE FLOOR: Oh, yeah.

10 MS. FITTON: -- is sleeping in
11 the same bed with some little tiny baby, and
12 surprise, surprise the baby ends up dead. Things
13 of that nature are -- are certainly there. So
14 there -- there can be some -- you know, some
15 linkage. And -- and -- and so like, Dr. Cooper and
16 I both -- both have served on a committee in New
17 York City which explores some of these, you know --
18 some of these factors. Now, it may be that when
19 the people come to the emergency room, the parents,
20 they may have one story --

21 DR. KUS: Right.

22 MS. FITTON: -- yet in the
23 excited moments when they first called
24 nine-one-one --

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2 DR. KUS: Right.

3 MS. FITTON: -- there's a story
4 that's available also, looking at the nine-one-one
5 tapes.

6 DR. KUS: Right.

7 MS. FITTON: The second story is
8 what they told the E.M.T.s and the paramedics at
9 the scene. The third story is really going to be
10 what, when they're separated perhaps, the parents.

11 DR. KUS: Right.

12 MS. FITTON: What one of them may
13 have told them in the back of the bus -- back of
14 the ambulance, excuse me, on the way to the
15 hospital. So -- so, it -- that's -- that's --
16 that's my point.

17 The -- the other thing is I
18 think -- I think Tim wanted to talk about this too,
19 I think he had a point to make.

20 MR. CZAPRANSKI: Yeah, just the
21 inclusion of the -- all prehospital care documents,
22 which to me includes the nine-one-one piece. I sit
23 on the child fatality review team, and we do the
24 retrospective studies, and sometimes the cops

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2 automatically go to, "Well, the kid wasn't even in
3 bed; it was found on the floor." And I have to
4 tell them, "Well, when they called nine-one-one,
5 the telecommunicator instructed them, 'Is the child
6 breathing?' 'No.' 'Well, let's get it on the
7 floor and start doing these things.'" But they
8 were not realizing that those things happened.

9 So the location of the child as
10 documented by even E.M.S. may be triggered by
11 nine-one-one telecommunicators doing over-the-phone
12 instructions. So, I think the review of all those
13 documentation proceedings is important to come up
14 with the right summary.

15 MS. GOHLKE: The other thing --

16 DR. COOPER: Yeah.

17 MS. GOHLKE: -- that this process
18 outlined, Dr. Kus, is on the E.M.S. and the
19 prehospital level, once we get down the road of
20 actually implementing this, is on a policy level,
21 that if there is a child that died, who's under the
22 age of eighteen, that the law enforcement has to be
23 called just for that reason, because E.M.S. is not
24 doing that. It's the law enforcement. So, that's

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2 something that we'll have to do policy-wise, to
3 have the law enforcement called for -- for children
4 that die under the age of eighteen.

5 DR. KUS: So -- so, I -- I -- and
6 again, this doesn't completely, but -- but this is
7 a big interest, because of what you mentioned in
8 terms of co-sleeping, and -- and -- and there's a
9 whole story on that, and even the language I tend
10 to rather call it bed-sharing; some people think
11 co-sleeping is the kid sleeps in the same room with
12 the person, so there's a whole issue with that,
13 and -- and one of the things that happens is -- is
14 you intimate by what's -- by somebody sleeping
15 together, that they may have rolled over. Well, if
16 you don't have a lot of information to say that
17 that's what happened, that the kid was suffocated,
18 it's hard to make that kind of judgment. But
19 that's the point.

20 So -- so, you're saying the --
21 the actual description of how the kid was found, it
22 sounds like you -- your folks are getting some of
23 that too; right?

24 MS. GOHLKE: Well, like

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2 preservation of evidence, and interviewing the
3 family, and all that --

4 DR. KUS: Right.

5 MS. GOHLKE: -- investigative,
6 law enforcement needs to be --

7 DR. KUS: Right.

8 MS. GOHLKE: -- brought in for
9 that information.

10 DR. KUS: Right.

11 MS. GOHLKE: And that needs to be
12 their focus and not prehospital's, so the gap that
13 we identified through doing this, was that law
14 enforcement's not always there --

15 DR. KUS: Right.

16 MS. GOHLKE: -- for whatever
17 reason --

18 DR. KUS: Right.

19 MS. GOHLKE: -- in each county.

20 DR. KUS: Right.

21 MS. GOHLKE: So, we just need to
22 make sure the prehospital provider gets law
23 enforcement there, if they've come upon a scene
24 like that.

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2 DR. KUS: Right. But I think the
3 point of -- of making sure that whoever is doing
4 this at the hospital has the information that's in
5 the -- from the transport part, is critical. And
6 your point about how -- did the child die in bed,
7 did the child -- not having that information is --
8 if you don't have it, you're -- you're making a
9 wrong judgment. Yeah. Thank you.

10 MS. FITTON: And -- and Dr. Kus,
11 just another thing, not all of these deaths are
12 going to happen from the home. You know, another
13 thing which is right up there with co-sleeping is
14 kids not belted into a safety seat --

15 DR. KUS: Right.

16 MS. FITTON: -- in the car.

17 DR. KUS: Right.

18 MS. FITTON: Unfortunately, you
19 know, at the -- at the scene, it's pretty apparent
20 when a -- when a child is ejected from a car that
21 they were not --

22 DR. KUS: Right.

23 MS. FITTON: -- strapped into the
24 car, so those -- those sorts of things may also

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2 become -- but the -- the difference is here that as
3 a -- as a prehospital care provider, we may -- we
4 are supposed to be mandated reporters of child
5 abuse.

6 DR. KUS: Right. Right.

7 MS. FITTON: I don't know that
8 universally the first thing anyone would be
9 thinking of, after -- after caring for this child
10 with this extensive trauma, would be doing that
11 suspected child abuse report. Although, again,
12 that -- that may be something that we need to be
13 more aggressive about in our policies.

14 DR. COOPER: You know, the -- the
15 issue of child fatality review panels is -- is a
16 huge one in the child-abuse world, as all of you
17 know, you know, the -- for obvious reasons. There
18 are many, many, many children who die, and whom
19 the -- the information that is gleaned from the
20 various health professionals that have cared for
21 that child, up to and including the medical
22 examiner, is never collated in one place, and never
23 reviewed by a policy-making body that is in a
24 position to say hey, we're seeing these particular

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2 trends; we need to make these public health
3 interventions to decrease this -- you know, the
4 burden of -- of unnecessary child death.

5 But I -- I think, Chris, you
6 heard a couple of really important points here
7 today. I mean, the hospital-fatality protocol is
8 wonderful, you know, as far as it goes. But the
9 problem is that, as you heard from both Ann and
10 Tim, you know, the dispatch tapes are not part of
11 the E.M.S. record. And that's going to be the
12 first glimpse, you know, at what's -- what's going
13 on. And as Tim pointed out, things may have
14 changed drastically by the time the E.M.S. crew
15 gets there, and it may have changed, you know,
16 epically by the time the child reaches the
17 hospital.

18 So if, you know, in its
19 discussions with the -- sorry -- in the
20 Department's discussions with the legislature,
21 honestly, this law really needs to be amended and
22 expanded, to ensure that the child fatality review
23 panels have access to the nine-one-one tapes to the
24 extent that they can, and the other piece that's

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2 vitally important is -- is the inclusion of the
3 prehospital care report in the patient -- in -- in
4 the patient record.

5 Now, we were doing better and
6 better and better, not great. You know, when --
7 when I started in the system, lo these many moons
8 ago, you know, we were lucky to get, you know,
9 thirty to forty percent of the -- of the P.C.R.s
10 included in the hospital record.

11 FROM THE FLOOR: Uh-huh.

12 DR. COOPER: We were up around
13 sixty to seventy percent across the board, which
14 still isn't great, but a -- but a vast improvement,
15 you know, when we started making the shift over to
16 electronic medical records. And now it has -- it
17 has slid back considerably, because, you know,
18 people don't know how -- don't know how to get the
19 electronic medical record -- you -- you know, get
20 that information included in the E.M.R.

21 FROM THE FLOOR: Uh-huh.

22 DR. COOPER: So, two stipulations
23 that would be vitally important would be getting
24 access to the nine-one-one tapes, and getting

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2 included in this policy, you know, a mandate that
3 the hospital scan the P.C.R. and include it as part
4 of the hospital record. You know?

5 MS. GOHLKE: I just want to
6 clarify what Dr. Kus is asking is different than
7 what we have in front of us.

8 DR. KUS: Right.

9 MS. GOHLKE: Okay. They're
10 not -- they're two separate issues, so --

11 DR. KUS: Well -- well, they're
12 somewhat related.

13 MS. GOHLKE: Oh, I mean -- yeah.

14 DR. COOPER: Well, but -- but
15 they are --

16 MS. GOHLKE: I mean, I --

17 DR. COOPER: -- they are --

18 DR. KUS: They're somewhat
19 related.

20 DR. COOPER: -- they're --.

21 MS. GOHLKE: -- I got the
22 feedback --

23 DR. KUS: Yeah.

24 DR. COOPER: Yeah.

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2 MS. GOHLKE: -- that

3 nine-one-one, you know, transcript --

4 DR. KUS: Right. Right.

5 MS. GOHLKE: -- and what goes on

6 the P.C.R needs to be --

7 DR. KUS: Yes.

8 MS. GOHLKE: -- included.

9 DR. KUS: Yeah.

10 DR. COOPER: Right. But I -- I

11 understand that, but Dr. Kus also does have some

12 influence over the process, which is, obviously --

13 DR. KUS: Right.

14 DR. COOPER: -- why he's bringing

15 it to us for our discussion --

16 DR. KUS: Right.

17 DR. COOPER: -- you know, and

18 those two pieces of -- of information, I think,

19 would be very useful.

20 The last piece that I want to

21 mention is that child fatality review, even though

22 it's mandated, okay, now in New York State, is not

23 universally done the way it should be done. You

24 know. It's done well -- very well in Rochester,

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2 for example. It's done very well in Syracuse,
3 because of the nature of those particular
4 communities.

5 But in New York -- in New York
6 City, for example, the child fatality review panel
7 is -- is solely a public-health panel that exists
8 under the New York City Department of Health. The
9 medical examiner of New York City has steadfastly
10 refused to participate, you know, in any and all
11 such efforts. And the accountability review panel
12 for the Administration for Children Services, you
13 know, sees only the -- the -- the -- about half the
14 cases, because only about half the cases are known
15 to A.C.S., you know, prior to the child's death.

16 And somehow -- somehow in our
17 collective lifetimes, we need to solve that
18 problem, because without getting an opportunity to
19 look at all the child deaths, you know, in one
20 place at one time, we're in real trouble. All
21 right.

22 DR. KUS: Martha, I'm going to
23 say one more thing on this part --

24 MS. GOHLKE: Sure.

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2 DR. KUS: -- because it
3 specifically speaks to that. The -- the good news,
4 and I'm hoping it will happen in our lifetime is,
5 we've been, at the State Department -- I'm real
6 interested in child death review, and part of it is
7 because you -- when you review it, you realize what
8 little information we have about how kids die.
9 There is a -- now a national dataset to -- that you
10 can report to, so that it's a form that the review
11 panel should fill out, then it would be uploaded to
12 the state, and it's uploaded to national, which
13 includes a lot of these reviews. That's the first
14 time I've seen standardized data. So we've wanted
15 to do that.

16 The -- you mentioned about the
17 idea about child fatality review, the way we --
18 we've been partnering with the Office of Children
19 and Family Services, because they have been
20 reviewing deaths that are submitted to their
21 hotline, or are in their facilities. And the
22 public health message is unless you're reviewing
23 all of the deaths, you're missing some.

24 So, we've now got the agreement

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2 to work together, and we actually have a grant to
3 try to do this, to try to improve the amount of
4 deaths that have a child death review, which is,
5 again, it's a retrospective review involving all of
6 the players that should be involved, so you look at
7 systems. It's then going to be -- we -- we
8 actually got -- and this is a plus, we got the
9 Office of Children and Family Services, because
10 they've got the money. We don't have the money to
11 do some of these reviews, but they have the money
12 to -- to do these teams, to adopt this national
13 data form for their teams to follow up, so we will
14 have -- maybe in my lifetime, the first time we
15 actually get more data on this. So -- and --
16 and -- and we have a group working together to say
17 that our -- that our goal is to review all
18 children's deaths, and do it in this fashion, so
19 that we're able to collect the data, and not -- and
20 not miss something. And then hopefully, gradually
21 regularly improve it by improving -- because --
22 because I think the message is that a child's death
23 is really a local community response. And you've
24 got to get that community to look at that death,

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2 and then we need to aggregate those into the state
3 level, then aggregate to the federal level, so that
4 you can actually find some of those trends.

5 So we have a program working
6 pretty well with the Office of Children and Family
7 Services, which is amazing, in terms of
8 cross-agency because their line is child abuse and
9 neglect --

10 MS. GOHLKE: Right.

11 DR. KUS: -- and our line is
12 saying you've got to review all deaths, otherwise
13 you're going to miss some. So, that's --
14 that's --.

15 MS. GOHLKE: I -- and I just want
16 to -- I need a clarification as well, that the
17 child death review teams, and correct me if I'm
18 wrong, are triggered by a report to the -- the
19 S.C.R.; correct?

20 DR. KUS: The -- the --

21 DR. COOPER: Not always.

22 DR. KUS: -- there's two
23 different -- it's a -- it's complicated, and that's
24 why we're trying to simplify it. But they're --

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2 they talk about two different types of reviews
3 that -- there's the multi-disciplinary team --

4 DR. COOPER: Right.

5 DR. KUS: -- ones, which is where
6 they're reviewed real-time, hopefully.

7 MS. GOHLKE: Right.

8 DR. KUS: Then there's the
9 retrospective review.

10 MS. GOHLKE: Right.

11 DR. KUS: And the way the law is
12 written now, is the teams that can do the
13 retrospective review can review all deaths.

14 MS. GOHLKE: Okay. But normally
15 speaking, one of the triggers to the system is
16 child abuse, neglect report to the -- the report
17 registry; correct? I mean, I know you say that
18 they could broaden if they wanted to --.

19 DR. KUS: Well, it -- it depends
20 on the -- and -- and as I think, Dr. Cooper --
21 Cooper mentioned, it depends on the child fatality
22 team, what the --

23 MS. GOHLKE: Okay.

24 DR. KUS: -- goal is actually for

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2 that team to be knowledgeable about any deaths --

3 MS. GOHLKE: Right.

4 DR. KUS: -- and start the review
5 process that way.

6 MS. GOHLKE: Okay.

7 DR. KUS: But you're right in
8 the --

9 MS. GOHLKE: Okay.

10 DR. KUS: -- sense the way the
11 system had been working is --

12 MS. GOHLKE: Okay.

13 DR. KUS: -- on the -- on the
14 silo that it relates specifically to child abuse
15 and neglect.

16 MS. GOHLKE: And I -- I didn't
17 want to go talk about this until I got more of your
18 feedback, but I think we need to go here, is the
19 focus of this is for children that died that don't
20 get called in, they aren't -- that aren't --

21 DR. KUS: Right.

22 MS. GOHLKE: -- looked at as a
23 child abuse or neglect case, and that so to speak,
24 slipped through the cracks.

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2 DR. KUS: Right.

3 DR. COOPER: That's right.

4 MS. GOHLKE: So --

5 DR. KUS: That's exactly right.

6 Yeah.

7 MS. GOHLKE: -- that's -- that's
8 the perspective of -- of this document -- one of
9 the perspectives of this document, is the child
10 that dies for no apparent reason, or so the
11 provider thinks.

12 DR. KUS: Yeah.

13 DR. COOPER: Yeah.

14 DR. KUS: The unexpected, you
15 know --

16 MS. GOHLKE: Right.

17 DR. KUS: -- unexpected death,
18 yeah.

19 DR. COOPER: The only problem is
20 that this only fills one of the cracks.

21 DR. KUS: Right.

22 DR. COOPER: And we're -- and
23 what we've been speaking about, of course, is
24 trying to fill a few more of them, and to make sure

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2 that the information, once it's all collected, all
3 gets to one central place where we can review it
4 and think about it.

5 DR. KUS: And -- and the group
6 that's doing this is working with the Office of
7 Children and Family Services, and we've been
8 involved in it, so we're trying to make sure that
9 this is integrated in a whole child-death-review
10 system for the state.

11 MS. GOHLKE: Right.

12 DR. KUS: So we've got to put
13 that together.

14 MS. GOHLKE: And -- and the other
15 thing is that you the providers in the hospital,
16 you've got policymakers about ready to send out
17 this document to the hospital. We want to make
18 sure that it's functional --

19 DR. KUS: Sure.

20 MS. GOHLKE: -- for use when it
21 gets to the hospital --

22 DR. KUS: Right. Right.

23 MS. GOHLKE: -- and that's the
24 purpose of having this committee --

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2 DR. KUS: Right.

3 MS. GOHLKE: -- look at it at
4 this point.

5 DR. COOPER: Right. And when --
6 again, so I think that's why my personal specific
7 suggestion is to make sure that some direction is
8 included in the document to scan the P.C.R. into
9 the hospital record, so that -- you know, so that
10 it actually makes it there.

11 DR. HANNAN: Art?

12 DR. COOPER: Yes, Ed?

13 DR. HANNAN: When I first read
14 this, I -- I was -- being more familiar with --
15 with adult trauma and adult hospitalizations, I was
16 more expecting to see something along the lines
17 of -- so when unexpected deaths are explored in the
18 adult setting, what is being looked at is whether
19 or not there was a problem that occurred in the
20 hospital, that was the fault of the hospital. And
21 so, I guess the question here is does that
22 situation fall under this also --

23 DR. COOPER: Yes.

24 DR. HANNAN: -- or is this

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2 limited to child abuse, to that part -- so, okay.
3 Because when you read this -- in the beginning,
4 when I was reading this I was thinking that --
5 that's all I'm going to see, and then all it did
6 see, seemingly, was looking at situations of -- of
7 child abuse and -- and --

8 MS. GOHLKE: You're saying --

9 DR. HANNAN: -- neglect or
10 whatever.

11 MS. GOHLKE: -- you saw child
12 abuse when you looked at this, or you didn't see
13 it?

14 DR. HANNAN: I'm saying I was not
15 expecting to see that, because I was naively
16 looking at it from the standpoint --

17 MS. GOHLKE: Right.

18 DR. HANNAN: -- of adult -- adult
19 explorations of unexpected deaths. But then when I
20 started reading it --

21 MS. GOHLKE: Yeah.

22 DR. HANNAN: -- all I saw was
23 child abuse. I didn't see anything about whether
24 there should be an exploration of whether or not

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2 there was a -- there was a problem, you know, of
3 treatment in the hospital setting. And I'm just
4 questioning whether it --

5 DR. COOPER: Yeah.

6 DR. HANNAN: -- that was meant to
7 be in here or not. Because typically in the adult
8 setting, that's what it would all be about.

9 DR. COOPER: Right.

10 DR. HANNAN: It would be oh,
11 somebody died, it was an unexpected death. The
12 person came in with a D.R.G. or a condition that --
13 that has a point one percent mortality, and they
14 died. What happened --

15 MS. GOHLKE: Oh, you mean --

16 DR. HANNAN: -- during the time
17 that -- that --

18 MS. GOHLKE: -- so you -- you see
19 it from the perspective of the possible neglect of
20 the hospital and treatment --.

21 DR. HANNAN: Well, I'm wondering
22 if that -- if that is -- if --

23 MS. GOHLKE: Okay. That's --

24 DR. HANNAN: -- the intent is

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2 to --

3 MS. GOHLKE: -- that's good
4 feedback.

5 DR. HANNAN: -- add that as well
6 or not.

7 MS. GOHLKE: That's good
8 feedback.

9 DR. HANNAN: And -- and -- and
10 maybe the answer is no, that's not what we're
11 looking for.

12 DR. COOPER: No, the answer is --

13 DR. HANNAN: But --.

14 DR. COOPER: -- very clearly yes.
15 I -- I -- I actually read it both ways.

16 DR. HANNAN: But I don't see --
17 when I started reading it --

18 DR. KUS: Correct. You're right.

19 DR. HANNAN: -- I see it all
20 tilting toward the --

21 DR. KUS: Correct.

22 DR. HANNAN: -- the -- the -- the
23 patient -- or child abuse, you know, that kind of
24 thing. I don't see anything about what were --

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2 what were the -- what was the nature of the
3 treatment --

4 DR. KUS: You're right.

5 DR. HANNAN: -- was there
6 anything that went wrong during the treatment
7 process, that kind of thing.

8 DR. COOPER: You're absolutely
9 right. And -- you know, and from my standpoint,
10 reading the purpose, you know, it was all
11 inclusive. My own thinking along the lines is
12 that -- is that most of that stuff would be -- most
13 of the in-hospital stuff would be picked up, you
14 know, through NYPORTS, and so you'd have access to
15 that database as well.

16 But your point, Ed, as always, is
17 very well taken. The -- the -- this document
18 should reflect, you know, also that any -- any
19 appropriate, you know, documentation regarding
20 NYPORTS type events that occur, you know, in the
21 hospital, or potentially even in -- in E.M.S.,
22 ought to be, you know, included, you know, in -- in
23 the -- in the overall look-see.

24 DR. KUS: This is a -- I mean,

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2 Martha, note this one, because this is an important
3 point to clarify, because as I understood, the
4 intent was more the issue of transport and
5 emergency room death, and -- and not in the
6 hospital, and that's why it's written this way, but
7 we need to clarify --

8 MS. GOHLKE: I have it so noted.
9 I have it so noted.

10 DR. HANNAN: It says here up in
11 the top in the --.

12 DR. COOPER: Yeah.

13 DR. KUS: I -- I -- I know that.
14 I know that. But I'm -- I'm saying from -- had
15 the -- the intent people had put for it.

16 MS. GOHLKE: Uh-huh. Uh-huh.

17 DR. KUS: So this is a critical
18 point --

19 MS. GOHLKE: Yeah.

20 DR. KUS: -- to clarify.

21 MS. GOHLKE: Yeah.

22 DR. KUS: Absolutely.

23 MS. GOHLKE: Absolutely.

24 DR. COOPER: But it's also --

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2 from the standpoint of the public-health-policy
3 question, which is how are children dying, where,
4 why, under what circumstances --

5 DR. KUS: Right.

6 DR. COOPER: -- you know, and
7 what can we do to stop it, it's all important.
8 Child abuse component is important; the E.M.S. part
9 is important; the in-hospital part is important.
10 You know, it's all important, and -- and it's
11 important that they all be looked at, you know,
12 by -- through the --

13 FROM THE FLOOR: Uh-huh.

14 DR. COOPER: -- same child
15 fatality review process.

16 DR. KUS: Right. Correct.
17 Correct. Absolutely.

18 MR. CZAPRANSKI: It's funny, the
19 way --

20 DR. KUS: Absolutely.

21 MR. CZAPRANSKI: -- I looked at
22 it was this fills a gap, because we're good at
23 catching when they call nine-one-one and there's a
24 child fatality. We're not good at catching when

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2 the patients go to the hospital by their parents
3 directly, and overt (sic) the nine-one-one system.

4 MS. GOHLKE: Uh-huh.

5 MR. CZAPRANSKI: And this sort of
6 brings that piece back, because only sixty-eight
7 percent of the patients that get to --

8 DR. COOPER: Correct.

9 MR. CZAPRANSKI: -- the hospitals
10 come via E.M.S.

11 DR. COOPER: That's right.

12 MR. CZAPRANSKI: So --.

13 MS. FITTON: It also brings to
14 mind the fact that the -- you know, just look at
15 what happened with H1N1, where suddenly a large
16 number of our children, who should not die from
17 flu-like illnesses, were dying. So, it might
18 actually have a -- the ability to see what our
19 preventive measures are, you know -- you know, what
20 additional --

21 DR. COOPER: Absolutely. Sure.

22 MS. FITTON: -- are there any
23 early signs and symptoms that the parents or -- or
24 whoever simply treated with Tylenol or Advil or

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2 whatever, thinking that that was the right thing to
3 do, only to have a disaster on their hands. Those
4 sorts of things that -- that -- that actually --

5 DR. COOPER: That's the whole
6 point. Absolutely.

7 MS. FITTON: -- if somebody
8 looked a little --.

9 DR. KUS: See -- see, that's -- I
10 mean, it -- it's an interesting thing, because, you
11 know, the -- how does this -- and I think we have
12 to clarify. I mean, way back when, when I -- when
13 we trained, you go to morbidity/mortality
14 conferences in the -- in the hospital where people
15 look at that.

16 DR. COOPER: Uh-huh.

17 DR. KUS: This -- as I had seen
18 it had not been that kind of intent, but we've got
19 to clarify that, absolutely.

20 MS. GOHLKE: Sure.

21 DR. COOPER: Well, you know --

22 DR. HANNAN: You know, and -- and
23 just as another example, I mean, so for instance
24 with the -- you know, the problem in NYPORTS, the

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2 problem in trying to find this in the adult
3 setting, is -- you know, what it says is: Is this
4 an unexpected or unexplained death? Well, you
5 know, here I am, and I'm supposed to report, you
6 know, an unexpected or an unexplained death on my
7 watch, and unexpected and unexplained is very hard
8 to define.

9 DR. COOPER: Yeah.

10 DR. HANNAN: And -- and so, you
11 know, the temptation for us is that, you know,
12 well, it -- it's probably not going to be -- it --
13 it's much more often not going to be reported
14 than -- when it -- when it did occur, than reported
15 when it did not occur. And so --

16 DR. COOPER: Right. Right.

17 DR. HANNAN: -- and so, I mean --
18 so, then the question is what is unexpected or
19 unexplained? Can you give somebody any guidance as
20 to what that means?

21 DR. COOPER: Another great point.

22 DR. HANNAN: And -- and people
23 need more guidance when suddenly they're not
24 talking about something that happened to the

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2 patient in the home setting, but something that
3 happened in the hospital setting, and the person
4 who's reporting it is in the hospital setting.
5 That's much more challenging, and much more a
6 potential conflict of interest.

7 So, I mean, one of the ways that
8 it would be done in -- in the adult setting, for --
9 to -- to make things less arbitrary, would be to --
10 to take a look at the -- at the D.R.G., the patient
11 diagnosis, I.C.D.-9 Code, whatever, and define an
12 unexpected or unexplained death as a set of
13 patients with diagnosis codes that has -- has an
14 extremely low mortality. And so, it's -- it's
15 unexpected, if the patient dies and the mortality
16 rate for patients who are supposedly look like that
17 is less than whatever -- point one percent, point o
18 five percent or something like that, and those
19 cases are immediately -- are automatically
20 reviewed, because, you know, there just was not the
21 expectation.

22 DR. COOPER: Ed, another --
23 another very insightful comment. And this just
24 points out why we have to have you at these

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2 meetings every time.

3 DR. KUS: See -- see, this is
4 a -- I mean, it really is very interesting, because
5 I think, again, in -- in -- in a child death review
6 situation, a lot of times when you get the death to
7 review, people will look at it and say "It's a kid
8 with leukemia who died from leukemia, so that's one
9 where we've got a cause here, and it's -- and it's
10 a death that seems to be explained." So on --
11 on -- at the outside point of view, the unexpected
12 is, you know, somebody, you know, is with -- we --
13 we talked about kids -- specifically relates to
14 kids under one. There's a lot of kids under one
15 that die and we don't know exactly why -- that's
16 where SIDS and -- and that part of it is.

17 But if you're talking in the
18 hospital, you know, you can do via codes there,
19 does -- or it could be a judgment to say jeez, this
20 kid should -- shouldn't have died. And so, that --
21 and then it gets -- it's -- it's complicated.

22 DR. HANNAN: Yeah. I mean, I
23 guess on the other side of the coin, and if
24 you'd -- if -- again, if you're talking about an

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2 unexpected or an unexplained death, I mean,
3 typically it would be -- you know, given what I
4 saw --

5 DR. COOPER: Right.

6 DR. HANNAN: -- when I looked at
7 this patient, I didn't think that this patient
8 should have died. But suppose the patient comes in
9 with -- with a severe head injury, and so the death
10 is expected, but the circumstances that caused it
11 in the home --

12 DR. COOPER: Right.

13 DR. HANNAN: -- may have been
14 an --

15 MS. GOHLKE: Right.

16 DR. HANNAN: -- abuse case. So,
17 it's not flagged --

18 MS. GOHLKE: Yeah.

19 DR. HANNAN: -- you know, by
20 those standards. It's not flagged as an unexpected
21 death --

22 MS. GOHLKE: Right.

23 DR. HANNAN: -- but it is -- it
24 is a child-abuse case --

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2 MS. GOHLKE: Uh-huh.

3 DR. HANNAN: -- that's fallen
4 through the cracks, if that's --

5 MS. GOHLKE: Right.

6 DR. HANNAN: -- how you're --.

7 MR. GOHLKE: Well, let me just
8 also talk about the -- the how we got to this point
9 and maybe just -- it may bring some more questions
10 to the table. So, a child died in New York State,
11 and it was unexplained, unexpected and -- but there
12 was no evidence of neglect or abuse, so it didn't
13 go through the child, you know, hotline reporting
14 because of that.

15 And then afterwards, the sibling
16 ended up dying, and then they realized that there
17 was abuse and neglect in the home, which probably
18 should have been picked up with the first child
19 dying, but wasn't, and therefore, you get the right
20 lawmakers involved, a law came about to New York
21 States saying now you've got to develop a policy to
22 deal with how you -- you know, picking up cases of
23 neglect and child abuse in cases that you wouldn't
24 think necessarily is there, for the prevention and

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2 death of other children. So, that was the -- that
3 was the narrow focus kind of what we were given
4 with.

5 And you know, hospitals already
6 have a policy in place for infant mortality and
7 for, you know, suspected child abuse. But we
8 didn't have something in place for the unexplained,
9 unexpected, and the challenge I think with this
10 document was not to have people see this and say,
11 oh, this is a -- this is a child-abuse thing. We
12 already know what we're doing on this. Why are we
13 getting this document? We've -- we've already got
14 these policies in place, because we have to draw it
15 that this is something new that they don't have,
16 and what they need to do. Basically, any -- any
17 child that dies under -- under the age of eighteen,
18 has to undergo an autopsy, is -- is basically what
19 this says. And then you've got to rule out child
20 abuse, basically for a situation that wasn't
21 naturally triggered.

22 DR. KUS: Well, I -- well, I
23 think, again, the idea that there's a well-defined
24 group of about child -- about child death review

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2 process, and the whole idea is to look at all the
3 systems and realize that a kid that came into a
4 hospital with head trauma, the hospital could have
5 done their job and the kid died, but this kid
6 shouldn't -- shouldn't -- why did this kid have
7 head trauma, and that's where the other systems
8 need to be involved.

9 DR. COOPER: Right.

10 DR. KUS: So I think that's --
11 that is -- that is the -- a critical part. But all
12 this kind of discussion brings us back to try to
13 make clear about how we're -- how we're going to
14 use this -- how it integrates into the -- into the
15 whole system.

16 DR. COOPER: So, to summarize --.

17 DR. KUS: And -- and -- and just
18 to make a point, it might be useful -- there is a
19 specific defined sudden unexpected infant death for
20 kids under -- SUID for kids under one year of age.
21 There is a definition of which kids those are;
22 there's a criteria; there's a whole protocol about
23 reviewing those things. And what we're trying to
24 do is start using that in New York State in those

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2 investigations. And it gets into the issue of did
3 they die because there was overlaying and
4 suffocation, or was it SIDS? I mean, there's --
5 that's the big -- one of the biggest ones.

6 DR. COOPER: So, to summarize,
7 our task was to really focus on this document,
8 which is an attempt on the part of the legislature
9 and the executive, in follow up to the
10 legislature's directive, to fill a crack in the
11 reporting system, specifically with respect to
12 hospitals.

13 I think we've reached consensus
14 that we need to scan the P.C.R. into the hospital
15 documents, that we need to define what we mean by
16 unexpected, and some quantitative measurement of
17 that, with respect to what Dr. Hannan had
18 suggested, specific diagnostic codes, specific, you
19 know, case-fatality rates associated therewith, and
20 inclusion of appropriate, you know, NYPORTS data,
21 you know, or -- or NYPORTS type reports into
22 this -- into this database or into this report
23 needs to be -- be -- needs to be made.

24 I think the goal here, as we've

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2 all come to -- to think of it, to analogize to the
3 trauma system, is that we're really looking at
4 population-based child-fatality review. We're not
5 really looking at hospital-specific child-fatality
6 review, you know,
7 child-protective-services-specific fatality review,
8 we're looking at all childhood deaths. And they
9 all have to come to the same place so that the --
10 so that all the outliers can be identified, and all
11 the problems can be picked up at the get-go.

12 And then separately from that we
13 need to ask the powers that be to be certain that
14 they have access in the cases, were E.M.S. is
15 involved, to the dispatch tapes so that they can,
16 you know, get as much as possible about the
17 circumstance at home as -- as -- as they can.

18 Does -- does that summarize
19 pretty much where we came to in our discussion, as
20 far as everyone's concerned?

21 (No audible response)

22 DR. COOPER: Great. Okay. Bob
23 has rejoined us.

24 Welcome, Bob.

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2 DR. KANTER: Thanks.

3 DR. COOPER: And I know Susan has
4 been on the whole time. Thank you, Susan.

5 MR. BRILLHART: Yeah, thanks.

6 DR. COOPER: And Sarah, I know
7 you wanted a word, and then we're going to ask an
8 old friend of ours to give us a little presentation
9 on what she's doing now.

10 MS. GEIGER: Since when do you
11 call me old?

12 MS. MACINSKI SPERRY: Okay.
13 Thanks.

14 DR. COOPER: Well, old friend.
15 Not a friend who is old.

16 MS. MACINSKI SPERRY: I just
17 wanted to throw out a quick reminder promotion.
18 When I was at the last meeting, I presented our --
19 some of our injury data, and I had talked about how
20 we were -- had a childhood unintentional-injury
21 project, and part of that was an upcoming symposium
22 on childhood -- unintentional childhood injuries.

23 I did give everyone's contact
24 information to Stephanie, who's running the --

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2 basically she's running our unintentional childhood
3 injury program, and everyone should have received
4 an invitation via e-mail. The -- there will -- it
5 just is a quick -- whatever. It's going to be
6 Injury -- it's called Injury-free Kids. It's a
7 one-day symposium. It will be on March 31st at
8 Glen Sanders, which is in Scotia, outside of
9 Schenectady, and it's free. We don't -- we can't
10 pay for your travel, but it is free. You are --
11 you're all welcome to come. I have -- I brought
12 some information on it. If there's anybody who
13 didn't get it, has misplaced it, is interested, I
14 can share that.

15 And also, if you'd like to mark
16 on calendars, on June 30th, there's going to be
17 another symposium, which will be on childhood
18 injury policy. So that's June 30th. And March
19 31st, is this one coming up.

20 If you are interested but can't
21 make it to the March 31st symposium, I can give you
22 Stephanie's e-mail address and she would be happy
23 to e-mail you materials from the symposium. They
24 will be handing out fancy toolkits for starting

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2 injury-prevention programs in your community. She
3 won't -- there may be some paper copies, but you
4 won't get the fancy toolkit that apparently is
5 amazing, but I haven't seen it yet. So, you may be
6 able to get paper copies. Definitely you can get
7 materials e-mailed to you if you're interested.

8 MS. BURNS: Who's the target
9 audience?

10 MS. MACINSKI SPERRY: Target
11 audience. That's local public health partners.

12 MS. GOHLKE: Okay.

13 MS. MACINSKI SPERRY: It's --
14 it's really, I think, reaching out as -- as broadly
15 as possible, because it's -- it's such a broad
16 topic and has so many different players.

17 MS. GOHLKE: Got you.

18 MS. MACINSKI SPERRY: But --
19 yeah. I'm -- again, not my baby, so I'm not
20 totally full of details, but it -- it should be
21 good, and we're very excited about it. There's a
22 whole lot of fact sheets and materials and
23 information that are -- are involved, and I -- I
24 talked to Martha at lunchtime about having --

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2 during the next E.M.S.C. meeting, the Webinar,
3 having Stephanie come on and talk about the
4 project. And hopefully by then our new Web site
5 will be up and running with all of this material,
6 and we're hoping to have -- and this is probably a
7 better answer to your question.

8 We've been in this very long
9 process working on what we want in our Web site
10 and -- and on this project. And we're looking at
11 having it really a very broad topic, given that it
12 will have information for parents and for --
13 parents and caregivers, so not just like, parents,
14 but you know, grandparents and daycares and
15 what-have-you. And for professionals and -- oh,
16 and there was a third one. But there -- there
17 were -- I think -- I think they were working on --
18 at least at one point in the idea phase we wanted
19 to have some information targeted straight to kids.
20 I don't know if we'll be able to do that with
21 D.O.H. Web site limitations, but it's -- there's --
22 well, it -- there will be information on -- on
23 everything like, the developmental stages of
24 children, and how that relates to the injuries that

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2 are pertinent to them, what parents can do, and
3 data that backs it up, and a much evidence-based
4 practices as possible for prevention.

5 DR. COOPER: Thank you, Sarah, so
6 much. It sounds like a really exciting conference,
7 and as soon as you get the information about that
8 childhood injury policy conference, that would be
9 very, very useful for us as well. I --

10 MS. MACINSKI SPERRY:

11 DR. COOPER: -- I will mark on my
12 calendar to try to make both conferences on behalf
13 of the committee, but I think everybody, you know,
14 who can come from the committee, you know,
15 should -- should try -- should try to come. I know
16 my injury prevention coordinator at my place will
17 be coming to the -- to the March 31st conference,
18 but this is --

19 MS. MACINSKI SPERRY: Wonderful.

20 DR. COOPER: -- the first I've
21 heard about the -- the June 30th conference, so
22 that's great.

23 MS. MACINSKI SPERRY: Yeah.

24 It's -- it's still in the works. I had asked

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2 before I left. I was like, "Well, what do I tell
3 them it's called." And Stephanie is like, "We're
4 having a meeting this afternoon to talk about
5 names."

6 DR. COOPER: Okay.

7 MS. MACINSKI SPERRY: So, it --
8 it doesn't -- doesn't even have a name yet, but
9 it's -- it's hopefully going to be at the same
10 place, and --.

11 DR. COOPER: Okay. Great. All
12 right. Thank you so much.

13 MS. MACINSKI SPERRY: Thank you.

14 DR. COOPER: Okay. Well, it's my
15 distinct pleasure and honor to welcome back a dear
16 friend. As all of you know, Marjorie Geiger was
17 assistant director of the Bureau of E.M.S. for
18 many, many years, did an outstanding job in that
19 capacity, and was stolen away from us by the
20 Department for other purposes -- I'm not going to
21 say grander, but certainly more overarching
22 purposes, namely creation of a patient safety
23 center for the Department and the -- the citizens
24 that we serve.

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2 And I asked Marjorie if she might
3 not come today to tell us a little bit about the
4 work that the patient safety center is doing, to
5 see if there might not be, you know -- first to
6 educate us, and second to see if there might not be
7 areas in which, you know, the work of her center
8 and our committee might overlap, and to see how we
9 could support the patient safety efforts of the
10 Department. And so, without further adieu, we want
11 to welcome Marjorie back among us, and really
12 looking forward to your presentation.

13 MS. GEIGER: Thank you, Dr.
14 Cooper. The patient safety center wants to thank
15 Dr. Cooper and Martha for extending this
16 opportunity to come and have conversation.

17 Forward. Oh, Michael taught me,
18 but -- there we go.

19 We are governed by the Health
20 Information and Quality Improvement Act of 2000,
21 which is contained in the New York State Public
22 Health Law. It gives us an ambitious charge.
23 First of all, it established the patient safety
24 center, reporting right now through, as Jennifer

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2 would tell you, the Division of Healthcare, Quality
3 and Patient Safety. We also serve at the pleasure
4 of Dr. Morley, who's the medical director of the
5 Office of Health Systems Management. So he
6 partners with us quite a bit, helps us with our
7 case reviews that I'll go into in a little while.

8 We have a very ambitious charge
9 which is to maximize patient safety, reduce medical
10 errors, and improve the quality of healthcare by
11 improving the systems of data-collection, analysis,
12 and dissemination to providers and the public. And
13 I'll talk a little bit about the information
14 systems that we currently have in place. One of
15 the oldest is the physician profile, and that
16 actually is a mandate in our governing statute.
17 And I'll -- I'll go into a little more in depth on
18 that. We also manage the hospital and other
19 provider profiles. Consumers may go to the
20 Department of Health Web site and look up extensive
21 information on quality indicators, but as well as
22 demographic information on all hospitals in New
23 York State. So a simple click on the Department of
24 Health's Web page hospital profile will get you

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2 there, as well as nursing home, home healthcare
3 agencies, and other long-term-care providers.
4 Hospitals have access through the Health Provider
5 Network to their own quality measures and
6 benchmarking systems on potentially preventable
7 complications, known fondly in the business as
8 P.P.C.s, and I'll talk about that in a little
9 while. And we are also charged specifically in
10 Public Health Law for overseeing the
11 office-based-surgery program.

12 Physician profile provides
13 information to consumers, providers, and other
14 interested parties on approximately eighty-two
15 thousand licensed physicians. As I mentioned, it's
16 accessible by the public on the Department of
17 Health's Web page, provides extensive mandatory
18 information on clinical training, expertise,
19 hospital privileges, any actions taken by the
20 Department of Health or the State Education
21 Department against that licensee's medical record,
22 and whether a hospital has eliminated or sanctioned
23 privileges. We are also required to display for
24 the public certain medical malpractice information

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2 for as long as ten years.

3 Now, for you physicians in the
4 room, Drs. Cooper and Kus, you may not know this,
5 but every time you reregister with the State
6 Education Department on your license, you are
7 required to update your profile. So, Dr. Daines,
8 Dr. Kus, has a list of those Department of Health
9 physicians who have not done that yet, so --

10 DR. KUS: Just -- just as you
11 know, we -- we have a regular meeting, and it came
12 up at one of our --

13 MS. GEIGER: Right.

14 DR. KUS: -- full meetings.

15 MS. GEIGER: So --

16 DR. KUS: I didn't know about it
17 before.

18 DR. COOPER: I -- I can tell you,
19 having recently gone through the relicensure
20 process, that -- that there is no mention of doing
21 so in the S.E.D. --

22 DR. KUS: No.

23 DR. COOPER: -- materials.

24 MS. GEIGER: Yes, there is, Dr.

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2 Cooper.

3 DR. COOPER: There is?

4 MS. GEIGER: It's not in large
5 font, but certainly it's for the new physicians --.

6 MS. BURNS: You stabbed him in
7 the aorta.

8 DR. KUS: I -- I agree that it --
9 it is not --.

10 MS. GEIGER: It -- that is an
11 S.E.D. form. We are partnering with them to
12 resolve that, but it is there.

13 DR. COOPER: I will go back -- I
14 will go back -- I will go back and look. I --.

15 MS. GEIGER: And I'll show it to
16 you.

17 DR. COOPER: That would be good.
18 That would be good.

19 MS. GEIGER: Okay. But it is on
20 the Department of Health's Web page. Ding, ding,
21 ding. But any event, I just point it out, that --
22 that it's there.

23 DR. COOPER: Thank you for
24 coming.

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2 MS. GEIGER: Sorry, Dr. Cooper.

3 I couldn't even find it, I have to admit, until I
4 scrolled down and saw, in the world's smallest
5 font, that it's -- that it is indeed there.

6 DR. COOPER: I will go back and
7 look.

8 MS. GEIGER: It's at the bottom
9 of a page, and literally -- you are correct, it is
10 not the most critical piece of information.

11 DR. COOPER: I'll see if I can
12 get my bifocals updated as well.

13 MS. GEIGER: Oh, likewise for me.
14 You should have seen us in the room trying to find
15 it. So, it is a little confusing to the community.

16 As I mentioned, we profile two
17 hundred and -- approximately two hundred and
18 thirty-five hospitals, six hundred and fifty
19 nursing homes, a long -- many, many other long-term
20 care providers. And again, this is accessible to
21 the community on the Department of Health's Web
22 page.

23 We partner with a lot of folks
24 inside the Department of Health. Our good friends

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2 at the School of Public Health, the SPARCS Program,
3 to provide, from administrative data, information
4 to hospitals on their Health Provider Network
5 account for quality improvement. And we are in the
6 process of working with 3M, which is a research
7 firm, and our SPARCS counterparts, as well as the
8 Medicaid program, to use and provide the
9 potentially-preventable-readmissions benchmarking
10 data.

11 You should know that the federal
12 government has the -- what's known as P.P.R.s, or
13 potentially preventable readmissions, as an
14 indicator under healthcare reform, both versions,
15 in the House and on the Senate. What ultimately
16 will come out of that federal legislation remains
17 to be seen. But it will have the potential to
18 alter reimbursement at both the federal level and
19 at the state level, for readmissions that were
20 found to be totally preventable, so it's something
21 to watch for all of us.

22 As I mentioned, a new program
23 under our purview is the office-based surgery
24 program. This is a interesting way, for the first

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2 time ever, to control and manage office-based
3 medical practices, something that in New York State
4 had been uncharted territory up until this point.
5 So, those practices performing what's known as
6 office-based surgery, have to do two things: One
7 they have to be accredited by one of our three
8 designated accrediting bodies, and I'll show you
9 who they are in a future slide, and the physician
10 or physicians, in that practice must report to the
11 Department, in one business day, an adverse event
12 directly related to the performance of that
13 office-based surgery.

14 So in Public Health Law, this is
15 the definition of office-based surgery: It's a
16 "procedure that requires general anesthesia,
17 moderate sedation, or deep sedation, and any
18 liposuction procedure, where that procedure is
19 performed by a licensee in a location other than a
20 hospital. It excludes minor procedures and
21 procedures requiring minimal sedation."

22 And these are the adverse events
23 defined in Public Health Law: A patient death
24 within thirty days of the procedure, an unplanned

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2 transfer from that office to a hospital, an
3 unscheduled admission to a hospital within
4 seventy-two hours of the procedure. So a patient
5 may be discharged from that practice and be --
6 self-report to a hospital later.

7 Yes?

8 MR. TAYLER: Just out of
9 curiosity, does -- does this also include dental
10 procedures?

11 MS. GEIGER: Dentists are
12 excluded unless they're duly licensed and using
13 their medical license for an office-based-surgery
14 practice.

15 MR. TAYLER: For those crazy
16 dental procedures where they have to knock you out?

17 MS. GEIGER: Right.

18 MR. TAYLER: Okay.

19 MS. GEIGER: But then -- and then
20 any other serious or life-threatening event. What
21 was newly added is compliance with the hospital
22 infection acquired program. So that's a reportable
23 event as well.

24 There are protections of

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2 confidentiality. This program came about in part
3 because the law guarantees no disclosure, other
4 than within use by the Department, and so that the
5 physician reporting does have some levels of
6 confidentiality.

7 Accredited O.B.S. practices are
8 displayed on the Web site as another profile. So
9 families and patients who want to know if their
10 surgeon-to-be is accredited, they can go to that
11 Web site, and listed there, I'm sorry that it -- it
12 comes out poorly, are the three designated
13 accrediting bodies by the Department.

14 To date, we have approximately
15 nine hundred accredited practices in New York
16 State, and since the law went into effect requiring
17 the reporting of adverse events, the Department of
18 Health has received approximately eleven hundred
19 such reports. The top three reports relate to
20 colonoscopy, access vascular issues, and upper
21 endoscopy. And that should be no -- no surprise,
22 because most of those are the outpatient
23 procedures.

24 We've received other reports

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2 related to the issues -- T.O.P. stands for
3 termination of pregnancy. Also other GYN and
4 dermatology issues. Very few --

5 DR. COOPER: Marjorie?

6 MS. GEIGER: Yes?

7 DR. COOPER: Marjorie, what --
8 what -- I mean, across the board, what -- these
9 would be the categories in which the events
10 occurred, but what are the general types of
11 adverse --

12 MS. GEIGER: Bleeding.

13 DR. COOPER: Bleeding.

14 MS. GEIGER: Bleeding.

15 DR. COOPER: Just bleeding.

16 MS. GEIGER: Or a reaction to the
17 sedation or anesthesia.

18 DR. COOPER: Uh-huh.

19 MS. GEIGER: Or in the access
20 vascular, issues relating to the comorbidity of the
21 patient, the complexity. These --

22 DR. COOPER: Okay.

23 MS. GEIGER: -- access and
24 vascular patients are very sick patients.

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2 DR. COOPER: Yeah. Yeah. Of
3 course. Yeah.

4 MS. GEIGER: And so, they may
5 have other underlying conditions related to the
6 reason that they need that, and that would prompt
7 an unexplained transfer or admission later.

8 DR. COOPER: Thank you.

9 MS. GEIGER: We also have a
10 partnership with a contract with the New York State
11 Chapter of the American College of Physicians.
12 We're one of the few states participating in a
13 voluntary near-miss reporting system. Near misses
14 are those of patient events that fortunately are
15 caught or identified prior to causing serious harm
16 or impact to the patient. But there's many lessons
17 to be learned from these near-miss events. So the
18 College of Physicians in New York State has created
19 a very innovative collection tool, where
20 internal-medicine residents may report these near
21 misses in total confidentiality. And the goal of
22 this three-year project is to drill down that data,
23 and learn those lessons, and help identify for the
24 State of New York, best practices.

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2 Once we have their new contract
3 approved, we will be expanding the scope of project
4 to other primary-care residents, including those
5 that are pediatric residents.

6 So, Dr. Cooper, we hope to work
7 with your hospital in that endeavor.

8 DR. COOPER: Great. That would
9 be terrific.

10 MS. GEIGER: Okay. We're pretty
11 excited about that. And you know, I feel very much
12 at home. We have two medical advisory committees
13 that we're staff to. One is the patient safety
14 enhancement project, and the other one deals --
15 initially started focusing primarily on antibiotic
16 use in New York State, but has certainly expanded
17 its scopes to reduce infections and identify
18 infections that are resistant to antibiotics.

19 And before you go, I have some
20 material for you on what these committees have
21 produced on behalf of the Department.

22 DR. COOPER: Great. Thank you.

23 MS. GEIGER: The attorney general
24 had an out-of-court settlement with an unnamed

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2 pharmaceutical company, and that out-of-court
3 settlement resulted in a several-million-dollar
4 fine, if you will. The attorney general made that
5 available to the Commissioner of Health, who
6 accepted it, and Office of Health Systems
7 Management was the recipient of some of the funds,
8 to support medication-safety initiatives. Dr.
9 Sturman (phonetic spelling) of the Wadsworths Labs
10 in the Department, also received a share to improve
11 pharmaceutical research that will ultimately lead
12 to improved patient outcomes in New York State.

13 So the Office of Health Systems
14 Management used these funds for a three-phase
15 project. The first one we made an award to a
16 company to analyze our NYPORTS medication errors,
17 as mandatory reporting in this system. Our second
18 contractor has surveyed all New York State
19 hospitals, to obtain state-of-the-art information
20 on their pharmaceutical-safety systems. And then
21 they drilled down that data to go onsite visits of
22 approximately fifty select hospitals. The end goal
23 is to provide Dr. Daines with two to three case
24 studies of what would constitute best practices in

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2 hospital-based pharmaceutical-safety systems.

3 And then last but not least, we
4 used the bulk of the funds to support nineteen
5 hospitals, to study and implement small
6 pharmaceutical-safety projects. And these range
7 from the use of health-information technology,
8 provider education, patient education, or a
9 combination of all of those. And some of the
10 physicians on this esteemed group actually are
11 recipients of these small grants.

12 And then, it is our goal to have
13 a public dissemination of the study findings in
14 Albany on June 9th of this year, and we'll keep
15 Martha apprised of that, and send an invitation to
16 the members of this committee. And as I mentioned,
17 other funds were used by the Department of Health's
18 Wadsworth Laboratory, and they will also be sharing
19 their findings at this June 9th meeting.

20 And last but not least, we have a
21 part time Ph.D. epidemiologist in the patient
22 safety center, who has done remarkable research.
23 And I have for you reactivation of the quality
24 newsletter that was last produced by the Department

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2 about three years ago. It draws specifically on
3 SPARCS and our NYPORTS data system. And our goal
4 here, each issue - and we call it the Periodic
5 Quality Newsletter, so we don't hem ourselves in on
6 a date, but our goal is to get it out
7 semi-quarterly - is to have one particular issue
8 that we drill down from the NYPORTS data system.
9 And we looked for hospitals, so those of you who
10 are affiliated with hospitals, I -- I extend an
11 invitation to you. If you think that you have a
12 lesson learned from a NYPORTS issue, please contact
13 us, and we would love to learn what your root-cause
14 analysis showed you, how you used those findings
15 and that root-cause analysis to improve your
16 systems, your processes, et cetera. These are
17 things that we can't drill down from a
18 root-cause-analysis evaluation, but certainly our
19 hospital partners can help us do that. So, I want
20 to provide that to you.

21 We also take under special
22 research initiatives and collaboration with other
23 units in the Department of Health, and at the
24 request, of course, of Dr. Morley, our medical

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2 director.

3 There's our phone number. You
4 can reach us, we have a special e-mail for the
5 office-based surgery program that continues to
6 generate a lot of questions, particularly when we
7 migrated to the mandatory accreditation process.
8 But a simple little e-mail to the Department of
9 Health's Web page will find us as well. And my
10 e-mail has not changed when I migrated over to the
11 patient safety center, so everybody here in this
12 room can still find me at that same e-mail. In
13 fact, some of you have.

14 So, does that answer your
15 questions, Dr. Cooper?

16 DR. COOPER: That is great.
17 That's really great.

18 MS. GEIGER: And you know,
19 there's more to come. The patient safety center
20 came a long way under its previous director who
21 took it from, really, the law until what it's
22 evolved today. Our goal is to continue to build on
23 the success of its previous director.

24 I didn't make a slide, but some

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2 of our next steps are we did submit with our
3 epidemiologist, and she received approval, to have
4 access to very deep layers of the Department's
5 administrative database known as SPARCS, so it's
6 our goal to marry and integrate the various data
7 systems that we have access to. Our office-based
8 surgery, which is very case-specific on patients,
9 SPARCS, the vital records, both at New York City
10 and the rest of the state, and we also included
11 E.M.S. in there too, because we want to follow our
12 patients from prehospital care to, you know,
13 unfortunately when they die.

14 And then to use those analyses
15 over time to help generate, perhaps, patient
16 guidelines for our office-based-surgery program,
17 and certainly in partnership with our hospital
18 program colleagues. So, that's a long-term goal.

19 And we're in the process of
20 drafting a report, the first ever, on the
21 office-based-surgery program, which will be more a
22 demographic release of information, not the whys
23 and the hows right now. But we hope that that
24 release will generate some interest among the

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2 practice community.

3 And as I mentioned, in June, we
4 have a public dissemination of our pharmaceutical
5 safety grant, which we certainly hope will generate
6 interest and ideas on how to move those findings
7 further.

8 And ultimately, we'll be working
9 with our colleagues in the office of Medicaid on
10 the use of the potentially preventable
11 readmissions. Where that will go, we're not quite
12 sure yet, but that's certainly under development.

13 And more newsletters, of course.
14 These are available on the Web if people don't want
15 to print, but I do have a few hard copies that our
16 friends in public affairs made available to us.

17 Does anybody have any questions
18 or comments?

19 DR. COOPER: Just -- Marjorie,
20 how -- how do you perceive that -- you know, that
21 the activities here might interface with yours?

22 MS. GEIGER: Well, it --

23 DR. COOPER: It sounds as though
24 you've kind of evolved into some fairly specific

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2 niches, of which this, at this point, is not
3 necessary one.

4 MS. GEIGER: Pediatrics are
5 reportable events in NYPORTS, including the one
6 that you just mentioned in your previous
7 conversation. It's not that we see a lot of those,
8 but again, if you have an idea for the quality and
9 safety newsletter, and certainly some partnerships
10 with our two medical advisory bodies, if you -- if
11 you want to -- I -- you know, we can certainly put
12 you on future agendas. We don't meet as a body
13 like these folks do. We have been -- historically,
14 we've -- we do monthly telephone meetings, because
15 we don't have the funds to support face to face.
16 But we certainly could do that. There's not a lot
17 of volume in the office-based-surgery world, of
18 pediatric patients --

19 DR. COOPER: Right.

20 MS. GEIGER: -- simply because
21 the procedures that are done are more targeted to
22 the adult community. But you know, Dr. Morley did
23 reach out to you, Dr. Cooper, and Dr. Kanter, when
24 he wanted to ask a specific question about some

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2 rare occurrences among the -- so I see, Dr. Morley
3 doing that, you know, if those events occur in our
4 office-based-surgery environment. And as the --
5 the reportable events increase, and it's not
6 because there's poor care out there, it's just the
7 community knows -- learns that it is a mandatory
8 reporting system, so you just expect the volume to
9 grow --

10 DR. COOPER: Uh-huh. Uh-huh.

11 MS. GEIGER: -- as that knowledge
12 becomes more --

13 DR. COOPER: Sure.

14 MS. GEIGER: -- persuasive among
15 the community, we may reach out to this committee
16 again.

17 DR. COOPER: Okay.

18 MS. GEIGER: So, definitely a
19 role. And if -- once we get our data analysis
20 underway, and I don't see that happening quite yet
21 this year, because we only have one part-time
22 epidemiologist --

23 DR. COOPER: Uh-huh. Uh-huh.

24 MS. GEIGER: -- assigned to us.

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2 But should we get more resources of that nature,
3 and we start to do the linkages, I see us
4 partnering with the Bureau of E.M.S. and our
5 hospital colleagues, and maybe coming back to this
6 community, even though the volume is small, it
7 may --

8 DR. COOPER: Right.

9 MS. GEIGER: -- be of enough
10 interest to engage this committee.

11 DR. COOPER: Well, we'd love to
12 continue to support the activities of your -- of
13 your center.

14 The -- the reaching out that Ms.
15 Geiger is referring to is an issue related to
16 sedation of children in nonhospital-affiliated
17 imaging centers, and you know, the potential
18 untoward effects of -- of sedation.

19 I have -- just for the record --
20 I have identified a couple of national standard
21 policies on sedation --

22 MS. GEIGER: Oh, good.

23 DR. COOPER: -- in such centers,
24 and I'm going to -- I just --

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2 MS. GEIGER: Well --.

3 DR. COOPER: -- yes. I just -- I
4 just got ahold of those the other day, and haven't
5 been back in the office since I got them. And I'm
6 going -- I'll be forwarding them to you and to
7 John.

8 MS. GEIGER: Good.

9 DR. COOPER: You know --

10 MS. GEIGER: He'll appreciate
11 that.

12 DR. COOPER: -- yeah. Yeah, as
13 soon as I get back tonight, actually.

14 MS. GEIGER: Good.

15 DR. COOPER: So, that's -- so
16 that's -- that's great news. If the -- Bob and
17 Sue, you're still there, I hope?

18 DR. KANTER: Yeah.

19 MS. GEIGER: Oh, hi, Dr. Kanter.
20 Hi --

21 DR. KANTER: Hi, Marjorie.

22 MS. GEIGER: -- hi, Susan, how
23 are you?

24 DR. KANTER: Question, if I may?

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2 MS. GEIGER: Sure.

3 DR. KANTER: On slide nine of
4 your presentation, regarding potentially
5 preventable medical complications --

6 MS. GEIGER: Yes?

7 DR. KANTER: -- it's -- you don't
8 have the space to go into detail there, but I'm
9 wondering if you could say a word more about the
10 methodology of that surveillance from
11 administrative data, because if it's the tool that
12 I think it is, I have -- I do have some concerns
13 about it.

14 MS. GEIGER: Can I get back to
15 you on that? I'm little fuzzy on that one.

16 DR. KANTER: Yes.

17 MS. GEIGER: But I'll -- I'll --
18 I'll -- oops, I don't know what I just did. Sorry.
19 My slides went a little haywire.

20 DR. COOPER: There's slide nine
21 for you.

22 MS. GEIGER: Yeah. Can I get
23 back to you on that, because -- because --

24 DR. KANTER: Certainly.

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2 MS. GEIGER: -- yeah.

3 DR. KANTER: But just for --
4 for -- for your information, I forwarded an article
5 to Martha and Art that talks about a sort of an
6 evaluation and critique of the one tool that I'm
7 familiar with. And although it's a tool -- it's
8 from the A.H.R.Q. --

9 MS. GEIGER: Uh-huh.

10 DR. KANTER: -- and has a good
11 deal of merit as a screening tool. But one group
12 of investigators who wrote this paper really
13 strongly suggest it's not ready for use in public
14 comparisons of hospitals.

15 MS. GEIGER: Okay.

16 DR. KANTER: So, if it happens to
17 be the same tool, you might just take that into
18 consideration.

19 MS. GEIGER: Okay. I'll -- I'll
20 look at that and we'll get back to you.

21 DR. COOPER: Bob, as you recall,
22 Marjorie's e-mail address is mag05.

23 DR. KANTER: Yeah.

24 DR. COOPER: And so, perhaps you

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2 could forward that to her as well?

3 DR. KANTER: Sure.

4 DR. COOPER: Thank you so much.

5 MS. GEIGER: Thanks, Dr. Kanter.

6 DR. KANTER: I'm going to have to
7 sign off now. Thank you all very much.

8 DR. COOPER: Bob, can you stick
9 with us for just one more minute?

10 DR. KANTER: Oh, sure.

11 DR. COOPER: Thank you. Because
12 the next item on the agenda is the issue that
13 Marjorie specifically asked us to comment on, which
14 is the Centor paper on expanding the pharyngitis
15 paradigm for adolescents and young adults. This is
16 the issue of the *Fusobacterium necrophorum*
17 screening in the E.D. And I was hoping that Kathy
18 and -- might be able to be with us for this.
19 Informally, I have -- as I had e-mailed to
20 Marjorie, discussed this issue with numerous
21 colleagues in New York City. No one in pediatric
22 emergency departments in New York City is regularly
23 screening for this organism.

24 And Bob, I wanted to ask you your

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2 thoughts about it.

3 DR. KANTER: Well, I think -- I
4 think it's a very important clinical disorder, but
5 I also think that the full-blown illness, with
6 Lemierre's Syndrome is quite rare. I don't have
7 any idea whether bacteriological screening is going
8 to substantially address the rare severe illnesses.
9 I view this as a professional-education issue about
10 a rare complication of pharyngitis. And I think
11 the -- the clinical recognition of the kid who's
12 not responding to standard management, develops a
13 neck swelling, especially unilateral neck swelling,
14 with pain and trismus and such. I think that is --
15 is -- should be urgently recognized as a
16 life-threatening situation. I'm not aware of any
17 evidence that screening for the organisms is -- is
18 going to really address a rare, serious
19 complication.

20 MS. GEIGER: Thank you, Dr.
21 Kanter. I can bring that back to our medical
22 advisory group.

23 DR. COOPER: Did you hear that,
24 Bob?

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2 DR. KANTER: Yeah.

3 DR. COOPER: Okay.

4 DR. KANTER: That's great.

5 DR. COOPER: Yeah.

6 MS. GEIGER: Thank you very much.

7 They'll appreciate that.

8 DR. KANTER: Thanks. And see you

9 all later. Thank you very much.

10 DR. COOPER: Okay, Bob. Thank

11 you.

12 MR. AKNTER: Bye-bye.

13 MS. BRILLHART: Bye, Bob.

14 DR. COOPER: Marjorie, I would --

15 I would, you know, have very little to add to what

16 Bob said. It's -- you know, although pediatric

17 surgery does not normally deal with Lemierre's,

18 it's usually handled by E.N.T.

19 MS. GEIGER: Uh-huh.

20 DR. COOPER: In my place, I

21 usually end up getting called, because our E.N.T.

22 coverage is -- is not as deep and broad as I would

23 like. And it -- it's -- I can't remember the last

24 time I saw a case of the full-blown syndrome

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2 either, if ever. And so, this is, I think, an
3 important issue, as Bob says, but it's primarily
4 one of education.

5 MS. GEIGER: Okay.

6 DR. COOPER: And as I -- as I
7 indicated, the -- none of my emergency-medicine
8 colleagues felt that this was something that they
9 would -- you know, or that they were currently
10 screening for on a regular basis, or that the
11 current epidemiology, at least to their knowledge,
12 suggest it should be routinely screened for.

13 MS. GEIGER: All right. I really
14 appreciate that.

15 DR. COOPER: Okay.

16 MS. GEIGER: Thank you.

17 DR. COOPER: You're welcome.

18 Okay. I think at this point we
19 have completed the -- the -- the full agenda,
20 except for the -- the updates, I see a lot of
21 people jumping up at this point. And I think
22 that -- that with respect to SEMSCO and SEMAC, Tim,
23 I'll ask you to comment on -- on SEMSCO, but I
24 think, with respect to SEMAC, really the big issues

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2 had to do with approval of the New York City
3 hypothermia protocol, and the modified
4 disaster-triage algorithm, that included an urgent
5 category for patients with medical illnesses
6 that -- that did not -- did not, according to
7 START, reach the red category, but were clearly far
8 sicker than the normal yellow, which is more of an
9 orthopedic category. I think that really those
10 were the really the two major issues that were --
11 that came out of SEMAC last time. The others we've
12 already commented on.

13 How about SEMSCO? Anything from
14 SEMSCO --

15 MR. CZAPRANSKI: The only
16 thing --

17 DR. COOPER: -- that's worth
18 commenting on?

19 MR. CZAPRANSKI: -- the only
20 thing is SEMSCO really dealt with a lot of C.O.N.
21 appeals. The only other thing was you're familiar
22 with, Dr. Cooper, was the five breaths for -- for
23 pediatric patients.

24 DR. COOPER: I'm sorry?

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2 MR. CZAPRANSKI: We dealt mostly
3 with appeals, but the only thing really important,
4 which you're aware of, was the five breaths for
5 pediatric patients.

6 DR. COOPER: Right. Right.
7 Exactly.

8 And Martha, we will -- I think it
9 will be worthwhile if we share with the -- the --
10 the E.M.S.C. Committee, the approved, you know,
11 triage algorithm from New York City, so that they
12 have a -- they have an idea what -- that, I can
13 actually forward that too you, if you don't have an
14 electronic copy.

15 MS. GOHLKE: Could you? Because
16 what they've provided us is very complicated,
17 and -- and Brad Kaufman said that he had a simpler
18 algorithm than Dr. Freese's slide.

19 DR. COOPER: You mean for the
20 hypothermia or for the -- the triage algorithm?

21 MS. GOHLKE: Triage algorithm.

22 DR. COOPER: I have the one that
23 Dr. Gonzalez presented.

24 MS. GOHLKE: Okay.

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2 DR. COOPER: The -- the one --
3 the one main slide that he presented.

4 MS. GOHLKE: Is there a -- Ann,
5 is there a simpler algorithm than -- than the
6 slides the doctors are using for orange?

7 MS. FITTON: Yeah, actually, I
8 will e-mail you the --

9 MS. GOHLKE: Yeah.

10 MS. FITTON: -- the drill that we
11 did on this, or the journal article on it, that --
12 that really just fully explains. It's probably the
13 easiest way to do it.

14 MS. GOHLKE: Yeah.

15 MS. FITTON: The algorithm simply
16 is that somebody who has a complaint, or reason to
17 believe that they're exposed to, but it's probably
18 among people who are walking, identifies himself
19 with a complaint and is assessed. Now, if you look
20 at START criteria, they may not be breathing more
21 than thirty times a minute.

22 MS. GOHLKE: Right.

23 MS. FITTON: They're walking, so
24 they're essentially a green tag, yet they've got --

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2 they -- they've got, you know, chest pain,
3 difficulty breathing. They still don't meet the
4 criteria for the yellow-tag patients, so this
5 orange category is a little nebulous. What the
6 design of it is, is to catch those patients that
7 have the complaint of, particularly, illness
8 following a -- during the midst of a -- an M.C.I.
9 Consider the patient who may have asthma, who is
10 standing outside their home watching it burn to the
11 ground. Potentially, they don't have -- they may
12 not even have been in the fire, but they may now
13 simply have an asthma attack, exacerbated by the
14 stress. Similar things with chest pain. We see, a
15 lot of times, when we have major motor-vehicle
16 accidents, say with a bus that's -- has elderly
17 citizens going to Atlantic City.

18 MS. GOHLKE: Who would have
19 thought?

20 MS. FITTON: And -- and actually
21 patients are not complaining about any specific
22 injury, but commonly their complaints are of chest
23 pain, difficulty breathing, and when they get
24 assessed we just have a reason to think that -- so

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2 they're not red tag. They're not yellow tag. We
3 don't want them to be a green-tag patient. We're
4 treating them for medical -- medical conditions.
5 And that's -- that's -- that's essentially how
6 it -- how it evolves. Initially, they're probably
7 green tag.

8 MS. GOHLKE: The --

9 MS. FITTON: But they get an
10 assessment.

11 MS. GOHLKE: -- the algorithm
12 that Dario Gonzales shared, though, is very --
13 it -- it's very complicated. I was just thinking
14 there should be something simpler.

15 MS. FITTON: Actually, what we
16 tried to do was to convince Dr. Gonzales that we
17 need to separate out this -- this chart that they
18 had, and we have something a little more simple for
19 training purposes. I'd be more than happy to share
20 that with you.

21 DR. COOPER: Okay. Is there any
22 other -- oh, yes -- sorry. With respect to SEMSCO
23 and SEMAC, one other issue that was discussed, that
24 I think was of some interest and import, had to do

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2 with the safety group that works with the State

3 E.M.S. Council and SEMAC. Given the -- the fact

4 that we know that the -- the design of most

5 ambulances is inherently unsafe, particularly when

6 a provider must free himself or herself up from

7 seat-belt restraint in order to perform patient

8 care tasks, you know, the safety group had been

9 working to develop a listing of procedures that

10 they felt it was, you know, permissible to release

11 one's self from restraints in order to perform the

12 patient-care activities, and those in which it was

13 less permissible. This was intended not as a hard

14 and fast, you know, ruling, but as a guideline to

15 sort of give folks riding in the back of ambulances

16 a sense of, you know, what -- what they ought to

17 be, you know, doing while the ambulance is moving,

18 what they ought to be doing -- or what -- or what

19 they ought not to be doing while the ambulance is

20 moving, and what they ought to ask the driver to

21 pull over, you know. And you know, who presumably

22 is a fellow E.M.T., you know, to say hey, I've got

23 to -- I've got to, you know, do something here,

24 would you please pull over and let me -- let me do

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2 it, so it can be done safely in a -- in a nonmoving
3 vehicle. You know, that -- that list was presented
4 to the SEMAC, I believe also to the safety
5 committee of SEMSCO, and that is, you know, an
6 ongoing discussion point among the two groups and
7 will be, I think, not finalized, but brought up as
8 a -- as a prefinal draft at the -- at the next
9 meeting of the council, if I'm not mistaken.

10 In terms of the State Trauma
11 Advisory Committee, there's relatively little to
12 report on that front. STAC did meet earlier this
13 year. The -- the -- the regulations are still kind
14 of in limbo. You already heard from Mike about
15 the -- the pediatric trauma situation --
16 designation situation in New York City, and you
17 heard from Wendy and Ed about the School of Public
18 Health pediatric trauma report.

19 A lot of the meeting was taken up
20 with discussion of a system that's being developed
21 for review of trauma centers, you know, in between
22 the formal onsite visits, sort of a paper survey
23 tool that's -- that's being developed. And I
24 believe that -- that those were the really critical

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2 issues from the STAC

3 Mike, were -- was there anything
4 else that needs to really be brought up, so far as
5 you're concerned?

6 MR. TAYLER: No, that's it.

7 DR. COOPER: Okay. So that
8 completes the reports from our sister committees.

9 Now, it is now almost
10 three-thirty. I have one issue that I wanted to
11 bring up to the group, and I -- and there are
12 clearly we will have to put this off until another
13 meeting. But since we last met, there have been
14 two major events in this hemisphere, one in Haiti
15 and one in Chile, that have, you know, caused us
16 all a great deal of, you know, concern for our
17 fellow human beings, and have reminded us that
18 tragedy can strike anywhere at any time.

19 In the aftermath of the Haiti
20 event, the National Disaster Life Support
21 Foundation developed a PowerPoint, Just-In-Time
22 training, for hurricane victim -- or for medical
23 professionals who were -- who were entering the
24 earthquake zone, and -- and what to expect, what

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2 to -- what sorts of issues might be encountered and
3 so on. And it struck me that -- that it might be
4 worthwhile our considering developing a series of
5 Just-In-Time trainings, you know, a few, for common
6 types of issues that -- disaster issues we might
7 face here in New York State, that might involve
8 children.

9 You know, and I think of, you
10 know, ice storms that occur pretty regularly. We
11 do have floods from time to time, you know. It
12 might be worth our considering developing
13 something, so that, you know, if -- if anything
14 were to happen, that we could get some information
15 out there to our -- our peers very, very quickly,
16 that would, you know, facilitate their being able
17 to, you know, deal with children's issues. So I
18 just put that on the table as a project that we
19 might want to -- we might want to -- to consider in
20 the, you know, over the next several months.
21 It's -- it's a time-limited, doable project,
22 keeping in mind that, you know, Lee has exhorted us
23 to look for work projects that can be completed
24 within a short period of time and finalized. And

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2 so I was thinking that we might want to consider
3 doing something like that, you know, for, you know,
4 over the next several months. We have two more
5 meetings this year. It's not out of the -- out of
6 the range of possibility that we could at least get
7 one done.

8 MS. GOHLKE: Three.

9 DR. COOPER: Three?

10 MS. GOHLKE: Yeah.

11 DR. COOPER: Oh, you're right.

12 Of course. Yes. June, September, December. Yeah,
13 so we definitely have been getting one done.

14 MS. GOHLKE: May, September, and
15 December.

16 DR. COOPER: Sorry. I got the
17 months wrong.

18 MR. GOHLKE: Yeah.

19 DR. COOPER: Listen to Martha
20 about the months. I -- I -- I have trouble
21 remembering my calendar for tomorrow. I have to
22 look at it tonight.

23 MS. GOHLKE: Yeah.

24 MS. BURNS: Just with -- with

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2 regard to that, perhaps when you -- you know, you
3 flesh out your thoughts even more, we can involve
4 the Department's disaster preparedness planning, I
5 don't know what their unit is called, but they --
6 they have been building a -- what is being called a
7 volunteer database for response to disasters and
8 events. We've been working with them specifically,
9 frankly, to exclude E.M.S. providers, not because
10 we don't love them, but because E.M.S. -- the
11 E.M.S. providers --

12 DR. COOPER: Absolutely.

13 MS. BURNS: -- are already
14 encumbered. And they would volunteer, and --
15 and -- it's very difficult to track them, so what
16 we've asked is that we not advertise the volunteer
17 database to the E.M.S. community, mainly because
18 they're going to be going anyway. And we need them
19 to be responding as part of the statewide
20 mobilization plan and all those things.

21 But I'll speak with Laurie Liptac
22 (phonetic spelling), who is one of the associate
23 directors, and she's in charge of it, and she could
24 probably explain to you whether there is any

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2 Just-In-Time training for health professionals, or
3 you know, she may be -- they may be the venue to
4 point, other than prehospital-care-provider
5 training, but Just-In-Time training to nursing,
6 physicians, mental-health professionals, and those
7 kind of things, so it certainly would dovetail well
8 into your thought, I think; wouldn't it?

9 DR. COOPER: Okay. Yeah.

10 Absolutely. Sure.

11 MR. CZAPRANSKI: I -- I'll just
12 add that I think the Department of Health has a
13 great process already in place, or a platform in
14 place to put that on. When in Monroe County we
15 wanted paramedics to do vaccinations for H1N1, we
16 worked with the State Department of Health's
17 system, and within twenty-four hours we had it up
18 and running, where someone would go on, register,
19 take the course, it would spit out reports, a
20 successful completion of the reports by their, you
21 know, level of training, et cetera. It was a very
22 robust, but simply and quickly put together, on the
23 spot, to get it done. So it was -- it was a lot of
24 work on their part, but it was very, very well

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2 received.

3 DR. COOPER: Okay. Well, I think
4 this is something that will occupy at least some of
5 our attention over the next several months, and
6 I'll -- I'll reach out -- I'll be reaching out to a
7 few of you to begin to, you know, begin the process
8 of putting this together. Ice storms came to my
9 mind immediately, you know, because that's
10 something we have almost every year somewhere.
11 Floods, because that's something we have almost
12 every year somewhere. You know, we could probably
13 do something on, you know, a school bus, you know,
14 that happens at least once a year somewhere. But
15 if there are other ideas about -- about, you know,
16 disasters involving children, that occur here
17 within New York State with -- with -- with some
18 regularity, you know, that would be --.

19 MS. GOHLKE: I'm horrified to
20 tell you that school shootings occur with some
21 degree of regularity.

22 DR. COOPER: Yeah, I know. They
23 haven't in New York State, yet have -- have we?

24 MS. GOHLKE: We've had a couple.

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2 DR. COOPER: Have they -- have
3 we?

4 MS. FITTON: There was one in
5 Columbia County.

6 MS. GOHLKE: Yeah. Luckily no
7 kids were shot.

8 DR. COOPER: That's -- yeah.
9 Yeah. Yeah.

10 MS. GOHLKE: But they're -- it's
11 a -- it's unfortunately -- it's frighteningly
12 commonplace in -- across the country, and we've had
13 a couple of incidents in New York.

14 DR. COOPER: Well, yeah, this --
15 this idea comes from the mad scramble that took
16 place after -- after --

17 FROM THE FLOOR: Haiti.

18 DR. COOPER: -- the Haiti
19 earthquake, to put together a training program. A
20 lot of us spent about forty-eight hours going
21 through multiple drafts, you know, at all hours of
22 the day and night, to put this -- this thing
23 together, and hold a Webinar about two days after
24 the, you know, after the event occurred, you know.

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2 And it wasn't, you know, pretty, you know, the --
3 the final product was okay. But you know, it
4 wasn't as -- as perfect as it could or should have
5 been. And for events that occur here in New York
6 State with some regularity, it would be nice for us
7 to have a -- you know, a databank of -- of
8 Just-In-Time trainings available, that we could,
9 you know, get out to our providers in a -- in a
10 hurry, to remind them of, you know, the issues that
11 they might be facing.

12 You know, we all -- although
13 we -- we do have floods from time to time in the
14 upstate area, I think downstate we're obviously --
15 as Ann well knows, deeply worried about the
16 category three hurricane that inevitably will --
17 you know, will befall the New York City area.

18 MS. FITTON: Plus all the
19 potential manmade disasters.

20 DR. COOPER: Absolutely. Sure.
21 Yeah.

22 So okay. Is there any other new
23 business to come before the committee?

24 MR. BURNS: You're like -- you

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2 are it of the committee. Oh.

3 DR. COOPER: Okay. Then our next
4 meeting, Martha, is June --

5 MS. GOHLKE: May.

6 DR. COOPER: Sorry. May -- May
7 what?

8 MS. GOHLKE: Our -- our next
9 meeting is a Webinar, so we will not be meeting in
10 person.

11 DR. COOPER: Oh, okay.

12 MS. GOHLKE: Is May 4th. My
13 assistant here -- not really -- he's -- he's going
14 to actually teach me how to use the -- the forum,
15 the Webinar forum, WebEx. He'll be helping me
16 getting notices out, and you will have to register
17 in order to attend the Webinar, but -- so, that
18 will be coming via e-mail eventually, when we get
19 closer to that point.

20 And then the stakeholder's
21 meeting in New York City, just as a reminder, is
22 May 13th. Folks that want to be there, need to
23 talk to me, so I can make sure you get reimbursed
24 for your travel, sooner rather than later, because

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2 this process is long and arduous. So, those are
3 the next two meetings in May.

4 DR. COOPER: Great. Okay. So
5 May 4th and May 13th. Wonderful.

6 Well, that's -- we have, as
7 always, a full agenda of tasks to accomplish, and I
8 deeply appreciate everyone making the trip to
9 Albany. And for those of you who could not attend
10 today, but were able to attend by phone, thank you.

11 And last but not least, Marjorie,
12 thank you so much for taking time to be with us
13 here today.

14 MS. GEIGER: And likewise the
15 patient safety center appreciates being here. We
16 look forward to working together.

17 DR. COOPER: Thank you.

18 Okay. We stand adjourned.

19 (The meeting concluded at 3:37
20 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, and in the presence of council, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 229, inclusive, is a true record prepared by me and completed by Associated Reporters Int'l., Inc. from materials provided by me.

Howard P. Hubbard, Reporter

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