NEW YORK STATE
DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES FOR CHILDREN

Advisory Committee Meeting

DATE: November 30, 2010

TIME: 1:20 p.m. to 3:58 p.m.

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

MEMBERS:

Arthur Cooper, M.D., M.S. - Chair
Sharon Chiumento, B.S.N., E.M.T.-P.
Ann Fitton, E.M.T.-P.
Jonathan S. Halpert, M.D., FACEP, R.E.M.T.-P.
Robert Kanter, M.D.
Janice Rogers, M.S., R.N., C.S., C.P.N.P.
Elise van der Jagt, M.D.

GUESTS:

Lee Burns
Martha Gohlke
Sandra Haff
Sarah Macinski Sperry
Lisa McMurdo, R.N., M.P.H.
Debra L. Sottolano
Michael Tayler, R.N.
Jennifer Treacy, R.Ph.

GUEST SPEAKER:

Stephanie Willing

(The meeting commenced at 1:20 p.m.)

DR. COOPER: Welcome everyone to the November 30th, 2010, meeting of the New York State Emergency Medical Services for Children Advisory Committee. I -- I know that all of you have been preparing for this meeting and have a great deal of input to make today. We have several key items on the agenda that -- that need to be discussed.

I think first I need to acknowledge the presence of a couple of special guests. Of course, Lisa McMurdo, who is no stranger to our Committee, director of the division of healthcare quality and patient safety at the Department. We were graced with the presence of Sandra Haff during the previous Subcommittee meeting. And of course Deb Sottolano is with us, as she has been in the past, as well as Sarah Sperry and Jennifer Treacy. And we really appreciate all of you being here for the meeting today.

I -- another note, our vice-chair, Kathryn Willis is unable to be with us today due to a prior commitment, and Susan Brillhart had notified me this morning that she was very ill and would be unable to make the trip to be with us today, so we wish -- we wish her -- her a very, very speedy recovery.

MS. GOHLKE: Dr. Cooper?

DR. COOPER: Yes.

MS. GOHLKE: Rita Molloy and also Tim Czapranski had

last-minute family emergencies yesterday, which is why they're not here today, as well.

DR. COOPER: Thank you so much. I -- I was unaware of that. I really appreciate your bringing that to our attention.

I guess the first order of business is approval of minutes. Everyone received them via e-mail. Are there any additions, corrections or deletions?

Hearing none, can I have a motion for approval?

DR. VAN DER JAGT: I move.

DR. HALPERT: I move.

DR. COOPER: Dr. Van Der Jagt and Dr. Halpert, thank you very much, mover and seconder.

Discussion?

All in favor?

Opposed?

(The motion carried.)

DR. COOPER: Carries without dissent. Thank you.

Martha, would you review the agenda, please?

MS. GOHLKE: Normal business items including the Bureau report. I have a short update on the grant. We'll have progress reports from the Subcommittees, at least Education and Nomination.

With us today we have Stephanie Willing from the Bureau of Injury Prevention. She is going to talk to us about the

childhood unintentional injury project she's been diligently working on, and have been on a -- in our queue for a while to talk to us, but we haven't been able to -- to work her in until today. Dr. Cooper wants to talk about an E.M.S. disaster card concept that he has. Dr. Van Der Jagt and Sharon Chiumento are going to talk about the American Heart Association update, changes.

And then some old business: We were hoping that Pam Lawrence, who was here with us last time, who was collecting some baseline childhood data -- hospital data -- data for us. She was going to be here, but she was unable to make the meeting. We did send out, a couple of weeks ago, her changes to the baseline data that she's been collecting, via PowerPoint presentation.

As far as I know she hasn't received any feedback from the Committee on this, and -- which was one of the reasons why we put her on the agenda for today. But since she couldn't make it, I'm still going to ask that you review that data that she sent out via PowerPoint, and she's asking for your feedback on -- if -- if it works or -- she -- there was a bunch of suggestions from the last meeting, and she's made the changes and she needs you folks to look at it again.

And again, I just want to remind you folks that that data, if we ever do go down the road and make some changes to

our hospital systems, we need -- it would be great to show the baseline before and after changes. So, we need you to look at that baseline data that she's collecting now, so that, you know, we could possibly have some outcome data looking at the changes that we're making the New York State system, which we'd be one of the only states to do that as of this point, and that has good data, other than some basic mortality data on pediatrics which, as we know, is not reliable. So, we really do need you to look at that presentation that we sent out, and I'll resend it out again after the meeting.

DR. COOPER: Thank you.

MS. GOHLKE: And then we will give Sharon some time to work with the whole Committee on her interfacility matrix document. She's been working very hard with that and has had minimal feedback. So, we're going to force the whole Committee today to sit down and -- and go through the document with her so that we can give her some feedback and move that forward.

And if we have time, we'll have the updates from our sister Committees, SEMSCO, SEMAC and STAC.

DR. COOPER: Thank you very much.

Now, I'd like to ask Lee Burns, the acting director of the Bureau, to give us her customary report.

Lee.

MS. BURNS: I don't have too much to provide you, other

than it has been a year that I have been acting, so I'm getting pretty good at it, I think. I look to my bosses.

The -- the state budget - which is no secret to you - concerns are ongoing. We have participated in a number of -- of exercises and -- you know, work every day to try and figure out how not to spend money. So, a lot of our business is now being done electronically, and it, so far, we've gotten very good feedback from the providers across the state when they've gotten the information electronically.

I would turn to either Lisa or Jen if you have anything you want to add to all of this. I -- I think, you know, in light of the transition, everything's up in the air.

MS. MCMURDO: Yes, and I just -- just to comment on what Lee said about her acting position, and that it is -- she's acting only because we're unable to move forward because of the change in administration. It's not because of any lack of confidence in Lee's ability or how she's running the Bureau. We, you know, are very supportive of her and I'm sorry for the prolonged "acting" status for Lee.

On the budget, currently I believe they're projecting a nine- to ten-billion-dollar deficit for the next fiscal year, which is a little terrifying, frankly, considering what we've gone through with the last two, three budget cycles. So, we -- we, you know, are continuing to have further challenges and

changes ahead. But it's -- it's -- it's a bit daunting and nerve wracking and I'm not quite sure how priorities are going to fall out. There will have to be cuts, obviously, in the next year. Where they're going to be, I don't know. I would doubt E.M.S. is going to be immune, and these issues, but we will have to see as we go forward how it goes. But you know, I can't -- can't sit here and tell you we're not nervous about how things are going to shake out in the future.

So, sorry I don't have more positive things to say, but that is the reality that we're dealing with.

But as you know, our boss, Rick Cook, is always very optimistic, and he says this is the -- this is an opportunity for us to try and see how we can do things differently, and we are really making a concerted effort to do that, as Lee mentioned, in many other ways, to try to see if there's ways that we can do better, and ways that we continue to move forward the patient safety quality agenda that Jennifer and I have been trying to work with Dr. Morley on. And it's -- it's been difficult, frankly, in this climate, to carve out a separate piece from the surveillance and the regulatory piece. It's been difficult to move forward with that, but with the -- but the three of us in particular, are really committed with our leadership in the Department to try to continue to move forward.

Which is why we are supportive of what you're trying to

do here. And you know, where we might go with that, I can't tell you, but we are committed to trying to move ahead in those areas, even with the fiscal challenges.

So, that's all I would add to Lee's comments.

MS. BURNS: Internally in the Bureau what we have been working on - and I -- it's my mission to -- to work with staff and remind them all the time: That a lot of the things that we have done historically tend to be process oriented. We have a process for everything, we can, we're government, and when, you know, when questioned, you know, what is our product? And how can we deliver our product in a more efficient, faster way so that, you know, we're serving a provider base? And if we're not -- if we're so mired in our process that we're not delivering our product, we're -- we're really not effective.

So, that's one of our ongoing projects. Meetings for the future, as -- as Jonathan alluded, this is your last meal so eat -- you know, eat for next meeting.

We have secured a location which we're pretty pleased about, actually. Your next meeting will be at the Hilton Garden Hotel in Troy. It's easy to get to; parking on the surface. It's -- you know, it's a very nice facility. It's new. If any of you were at Ed Wronski's retirement party, we held it at the Hilton Garden, and they -- they are pleased to have us. So, new facility that -- which is kind of nice. With that said though,

you know, bring a bag lunch.

Part of -- part of all of this, and I know I -- I -- I have made Mike do this, but our incoming governor has very, very set thoughts on advisory councils, and he has identified in his writings the -- the Health Department as advisory council heavy. And so, our -- we've -- we're making efforts to again make more efficient our advisory councils, look at how we do business, and comply with the very restricted meeting schedule. So, I know Martha shared the meeting schedule with you. We will -- we're kind of playing it day-by-day, so your next meeting we're pretty good with.

On a -- on a brighter note, we're moving forward with our electronic P.C.R. process. We're just about to enter, at the end of January, year number three for our grant project. It is moving along. Martha facilitated four very exciting trainings across the state, which were very well attended and answered a lot of questions that we had in the Bureau, that our program agency partners had, and we're working with the Department's security people and -- and our data folks in our division to get everything ready to go live with this, we're hoping, in the early part of 2011. We're about to do some -- some data testing. I -- I -- we're looking for fictitious patients, though.

So, as we move forward, we're working with our regional

programs -- excuse me, our ambulance services across the state to move towards an electronic format.

We just completed, in November, one of the largest E.M.T. exam dates we've ever had, only to be bested by our December coming up E.M.T. exam date. So, in light of all that's going on, we're still -- we're still testing a tremendous number of E.M.S. certification candidates or recerts.

One of the things that faces us with regard to testing and E.M.T. certification programs at all levels is that the State is very slow to pay reimbursement vouchers, and so everyone from our core sponsors all the way down to -- to our exam proctors are -- are getting paid very slowly. So, that's a concern to us, so you may hear about that if you're in the E.M.S. community.

We -- the Department and the Bureau has done absolutely everything it can to process the vouchers. We're just waiting on payment, as is everybody else.

Our Disaster Preparedness Team, which is Jim Soto and Shawn Burtok (phonetic spellings), are about to go forth with a basic life support first response program for START triage. You may know, or not, several years ago -- it's probably been as much as five, actually -- we had a grant to provide something called a Smart Triage Kit, Smart being the dude who invented it, based on the START Triage principle.

I see you're glaring at me. I'll get to you.

FROM THE FLOOR: Not at all.

MS. BURNS: Anyway, we provided for all of our ambulance services these kits for all their vehicles, except for New York City because they're not part of our grant, A, and B they didn't want them.

And so, the -- the ambulance services -- the START training program and the triage kit were very well received. And -- and what it did, really, is it made uniform the emergency triage process statewide. And it's had some very successful results. So, we're about to embark on doing START Triage training and delivering Smart triage kits to our B.L.S. first-responding partners.

With that said, I -- I look at -- at Chief Fitton because the New York City docs had -- had put together and presented to the SEMAC and SEMSCO another color for triaging patients. And when the doctors presented it, all of the E.M.S. people in the room -- primarily myself -- sort of look at it, and there were too many squiggly lines and too many dots, and we were really -- I -- I was quite baffled and very concerned that it was -- it was very confusing.

Then I went to a training program sponsored by FDNY, and -- and the E.M.S. folks and they had much -- they explained it much better with a lot fewer lines and arrows and dots, and

so Jim is working with your folks to move forward with this orange category which, once explained by somebody similar to myself, is simple.

It is a form of up-triaging patients who, if they -- if they're having chest pain, the -- the START Triage model is for trauma. And so, it does not triage somebody who does not fit into a trauma -- into the trauma model. So, this -- this intermediary orange color allows you to up-triage a medical emergency. Somebody's having a cardiac event at the scene of an explosion, where there's mostly trauma.

It's really brilliant, actually. And once explained, it makes a ton of sense. So, I walked away from my -- my preconference with -- at Randall's Island going "wow".

So, that brings my report to a close, Mr. -- Dr. Chairman.

DR. COOPER: Any questions for Lee?

Hearing none, Martha, would you review the meeting dates, please?

MS. GOHLKE: The most exciting thing, for me, is that I don't have to renew my grant every year anymore. I just have to write an annual progress report, and I only have to renew it every three years. So, being that that's usually how I spend my Christmas holiday, I'm very excited.

I've also been asked to sit on the advisory board for

the -- for NEDARC, which is the National E.M.S. for Children for Data Analysis Resource Center. I'm one of two E.M.S.C. people like myself that have a seat on the Advisory Committee for three years. So, I can't tell if that's a compliment or if they just said, "you know, that pain in the you know what; guess what? We're going to put her on our advisory committee and make her work." So -- so, I guess that's exciting.

DR. COOPER: We're proud of you.

MS. GOHLKE: Thank you.

FROM THE FLOOR: Yeah.

DR. COOPER: Okay. We're proud of you.

FROM THE FLOOR: If they felt that way they wouldn't stay up there.

DR. COOPER: Yeah. That's absolutely right. We're very proud of you.

(Off-the-record discussion)

MS. GOHLKE: So, anyways, let's see, what else?

Money for next year. I -- last year I brought it up around this time. There's usually about twenty thousand dollars change in the grant to spend at will. The last couple of years we've offered it to E.M.S. agencies to do trainings for the providers in their regions, which they've wholeheartedly gobbled up.

But each year I also bring it to the Committee for your

ideas for 2011. If there's something else that we'd like to do with that amount of money, now's the time to start thinking about it. Because of as -- as of March 1 we'll have that money and I'll need to plan out how I'm going to spend it, and I don't want to offer it to the E.M.S. folks if you guys have a different idea on how you'd like to utilize that money. Or we could possibly do a little bit of both, depending on what we conceptualize. So, just food for thought.

Meeting dates in your folder. I sent out an e-mail a few weeks ago with proposed dates, and I just need to get back to the Hilton Garden Inn whether or not these dates are viable.

I know Dr. Cooper just mentioned that June 14th doesn't work for him next year, he'll speaking at a conference. So, I know that date that we need to relook at.

And then March 8th, the first meeting of next year, we're probably going to do by Webinar, so you don't have to plan traveling for that March date. But I'd like you to look at those dates and tell me as soon as possible, like within the next week, if there's something that's not doable on one of those days. I can try and work around it with the hotel and get a new date for the next year.

I did ask the hotel for June next year. Whether or not the week previous to the 14th, which is June 7th, was available, and they said it was not. If we -- would you prefer -- I guess

I'll ask the Committee that we look at either May 31st or June 21st, keeping it on a Tuesday, of course. Would either of those dates be preferable? Either the end of May or the -- towards the end of June?

FROM THE FLOOR: When's Memorial Day?

(Off-the-record discussion)

DR. COOPER: May -- May 31st is the world disaster meeting, so I -- I would ask that we avoid that.

MS. GOHLKE: Okay. Okay. So, May 31st doesn't work for Dr. Cooper, as well.

So, then we're really looking for June 21st, which is getting towards the end of the school year, but --.

FROM THE FLOOR: Summer begins that day.

MS. GOHLKE: Summer -- first day of summer.

(Off-the-record discussion)

MS. GOHLKE: Okay. We're going to put tentatively down June 21st unless people let me know otherwise.

So, just take a peek at your calendars, if you haven't so far, with those dates in the next week and let me know if those are a problem for next year.

And again, March 8th will be a Webinar unless otherwise told, but that's the plan right now. We tried to do that this past March -- or May, I think actually -- I can't remember. It fell through because I think people just weren't available, but

I don't know, we're going to try that medium at least once a year, if not twice a year, possibly, to reduce costs and -- and make it easier so people don't have to travel, obviously.

And the only other thing I wanted to talk a little bit about, we can either do it now or when we get to the Subcommittee progress reports, is the committee for next year, nominations.

Dr. Cooper, would you be okay if we discuss that now?

DR. COOPER: Go right ahead.

MS. GOHLKE: In your packet behind meeting dates is a yellow and green sheet. It has some names on it for the committee status. The folks that are highlighted in yellow -- although it has changed in the last few days, I haven't gotten your paperwork. I have gotten Dr. Halpert's and -- and Dr. Cooper's, and now I've gotten Ann Fitton's paperwork, but I -- if you want to -- if you want to sit next year on the Committee, I've got to get your C.V. and your letter of recommendation in. It was supposed to be in by today. So, you've got to get it in soon because the vetting process takes a while, and I'd like to get the whole package in and moving as soon as possible, because with the administration change it could take quite a while. So, I want to make sure we're at the start of the queue when things start rolling.

There are some folks who have expressed interest in

sitting on the Committee that are highlighted in green:

Ronnie was here last meeting, and I actually thought she was coming today, but she's not here yet.

And Kevin O'Toole is a parent -- would be a parent rep; he's actually state police and works -- he's also an E.M.T., so -- and he has a couple children with special needs. So, he would, I think, bring a nice aspect to the -- to the Committee that we don't have, especially with the police/first responder look at situations.

Kathryn Bass is from Buffalo. She's expressed an interest. And Wendy Woolley from Albany Med has expressed an interest.

We're probably going to move a couple people around, just because one of the requirements is that you're actively working in the setting for the seat that you're in. It's not necessarily a requirement for the statute for the Committee, but for the grant, you have to be working in the clinical setting that you're sitting in -- the seat that you're in. We can have -- our statute says we're not limited to the number of seats we have, we can have more than, which is why you can see we have a couple of people more than the seats that we have there, which is allowable with our statute.

But Rita Molloy will probably move to a parent-rep seat, and - which she's agreed to do - and Dr. Halpert's going

to move to the E.M.S.-physician seat, based on what -- where they're working.

And those are the only changes that I anticipate. We still have, obviously, some seats open that haven't been filled as of yet on the Committee. So, we still have some work to do to get some names identified and -- and the paperwork to go along with it, obviously, for those seats, so --.

DR. HALPERT: Can -- can we throw out just some brainstorming real quickly about --

MS. GOHLKE: Yes.

DR. HALPERT: -- about how to fill the position for a pediatrician?

I mean, it seems rather absurd that this organization can't get a general pediatrician to sit on it. I'm sorry, but there's -- just that to me, is -- is our -- what have we got to do? Who do you know? I mean, you know, get pediatrician?

DR. VAN DER JAGT: We don't think -- that should be fairly easy. I mean --

DR. HALPERT: You can --.

DR. VAN DER JAGT: -- I -- I have lots of contacts with pediatricians, in the Rochester at least. I could certainly -- I mean there are a number of people I could try.

DR. HALPERT: Regionally, I could care less. But I'm just saying we've got -- how can we not have a pediatrician

sitting on this Committee?

MS. GOHLKE: Dr. Cooper just reminded me of something, too. Also along with the seats, when you're -- when you're revetted your term, if you hold a -- a chair or vice-chair seat, that also turns over at the time. So, we also need to nominate and elect a chair and vice-chair. Dr. Lillis has decided not to serve on this Committee after her term, which ends either in June or July of next year, I think it's on here -- well, maybe not yet, but -- so, we definitely have a vice-chair seat that is vacant, which according to our statute, has to be filled -- not our statute, but the by-laws and D.L.A., says it has to be filled with a physician.

So, in addition to filling the easy pediatrician seat, we also need to fill the easy vice-chair seat, as well. And -- and chair, if -- if our -- if our illustrious chairman decides not to -- to serve again. So -- so, that's some food for thought for next year.

I know I have approached my children's pediatrician here locally, several times, and she appreciates the offer but at this time she's not interested. So, I have been working on my end to fill that seat in particular.

But yeah, if you have ideas, I mean, Dr. Lillis, Dr. Cooper and Rita Molloy are on the Membership Committee, so you should shoot ideas to them. Approach your colleagues if you

think they might be interested in serving on the Committee. It is a four-year commitment. Obviously, you'd have to go through the vetting process, which I like to make people aware that it may involve an in-person visit from the state police, and so that they're not taken off guard when they -- when they come knocking on your door to check their references and make sure that they're an appropriate person for the Committee.

And it is, of course, up to the final decision of the Commissioner whether or not somebody serves on the Committee. So, I just -- when you approach your colleagues, just let them know it's, you know, there's a process for it, and -- and it's not just up to, you know, us here who gets on the Committee, I guess. It's really important to let them know.

DR. KANTER: So, if there's no color that means you have all the necessary paperwork in?

MS. GOHLKE: Right. You're set, Dr. Kanter.

MS. BURNS: You're stuck, Dr. Kanter.

MS. GOHLKE: You're not allowed to go anywhere.

MS. BURNS: Not until you finish those regs.

(Off-the-record discussion)

DR. COOPER: Anything else?

Okay. I think Martha has basically given the Nomination/Membership report.

I don't believe the Education Committee met; correct?

FROM THE FLOOR: No, we did not. So, we can discuss the next item.

DR. COOPER: Okay. So, what I -- what we did do as all of you know, is have a lengthy meeting of the Regionalization Subcommittee --

MS. GOHLKE: Use the microphone.

DR. COOPER: -- as a Committee of the whole. And I'll just ask Bob Kanter if he would just briefly summarize what took place at that meeting.

DR. KANTER: We discussed a first draft of some proposed regulations for pediatric hospital care, including emergency care, inpatient care, and critical care that are based on existing 405 Regulations, which currently cover many aspects of hospital care, but which currently have a minimum amount of material regarding pediatrics. So, our first draft was to propose some minimum standards for pediatric hospital care, and we're working on a number of suggestions and revisions to submit for the process of exploring these through the Department.

DR. COOPER: Thank you very much.

Any questions for Dr. Kanter?

Hearing none, I just comment that I think we owe Bob a tremendous amount of gratitude for doing a tremendous amount of work to get a first draft together, and that we look forward to input from all the members of the committee in terms of

furthering the -- the work of our Regionalization group, and please get your comments to Bob about the draft that you have seen today.

I'd like now to move to new business, and we have a special guest with us today, Stephanie Willing, from the Bureau of Injury Prevention. She's the Child Injury Program Manager, and she's going to tell us a little bit about the childhood unintentional injury project.

Stephanie.

MS. WILLING: Hi. Thank you very much for inviting me to speak today. I know that we don't have that much time, so if you could save your questions until the end, I'd really appreciate it.

So, as I was introduced, my name is Stephanie Willing, and I work in the Bureau of Injury Prevention with Sarah Sperry. And I'll just briefly be talking about our child --

FROM THE FLOOR: Microphone.

MS. WILLING: -- child injury prevention campaign.

So, just to give you some brief background about our campaign -- in 2008 the W.H.O. released a report about childhood unintentional injuries. And then in 2008 later on, the C.D.C. released their own report about child injuries in the U.S. And so we wanted to take a look and see what the problem is -- the extent, the etiology, in New York State specifically.

And so, that's when we determined that we need to do something significant about these injuries. So, we came up with this idea for the injury-free kids campaign, and this is a two-phase project that we implemented in 2009 and currently are. So, in phase one we developed a series of health promotion materials. We first created fact sheets with prevention tips for parents and caregivers. And I'll go through these more in detail throughout the presentation. We also created a series of child injury prevention toolkits. And then we put all of those materials on our Web site, the D.O.H. Web site.

And in phase two we conducted two events, statewide events, and the first was to -- it's called the injury-free kids campaign event, and we invited practitioners from across the state to learn about the burden of childhood injuries. And then the second event we hosted was called partnering for policy, and that was specifically about how to advocate for policy change in New York State.

So, as I mentioned, the first part of the campaign was to create a series of fact sheets. We developed over thirty fact sheets on both unintentional and intentional injuries. Each fact sheet is laid out in the exact same manner. The beginning we talk about the problem, and we include the New York State data, and these are broken down by age group.

Then we have a section with injury tips for prevention,

and these are written in a question and answer format from a parent's perspective.

And then at the end we have a list of Web resources where parents can go for more information.

And there's just a list of topics. It's all-encompassing. We wanted to put as much information as we could on the Web site. I apologize, I was hope -- hoping we could have Internet access, but I have a screenshot of the Web site here for you, so you can see we have the fact sheets right here. And the parents could just click on their child's age group, and then a whole list of fact sheets would come up with each of the topics.

So, just to show you briefly, here's one example with A.T.V. safety, all-terrain vehicle. We have the problem, tips, and then at the end there would be links to additional Web sites.

So, then we developed additional toolkits. And our major audience are local health departments, but these could be also used in say, a hospital or a childcare facility. They're based upon specific injuries. So, bicycle safety -- and all these will be on the Web site shortly, right now we just have child passenger safety. That's on the Governor Traffic Safety Committee Web site. The fall prevention toolkit, which I actually brought today, if anyone would like to look at it, and

our shaken baby syndrome prevention toolkit.

They contain -- as you can see here -- this is the fall prevention toolkit; there are a bunch of different resources, brochures, different press releases that can be given out to the media, a sample letter to the editor that would describe the problem of falls and prevention tips. There's other resources like talking points about falls, and there's similar resources in each of the toolkits.

So, as I mentioned, we held the injury-free kids campaign symposium on March 31st to raise awareness of the burden of childhood injuries, and we invited people across the state, local health departments, state health departments, and nonprofits.

We had different presentations by our staff about the burden, tips, and we also had an excellent presentation from Mr. Darryl Gibbs from the Cynthia Gibbs Foundation to Prevent Shaken Baby Syndrome about his experiences educating decision-makers.

And then in the afternoon we showed each of the toolkits and we had breakout sessions describing each of the toolkits, and we got feedback about how they could be used at the local level.

So, on June 30th we held a policy training to help educate practitioners about strategies and tools they can use to promote policy change in their communities, and such things as

how to frame messages, the distinction between education and lobbying, because sometimes that can be confused. It's a fine line.

Oops, oops, sorry.

(Off-the-record discussion)

MS. WILLING: Thank you. Sorry.

So, then the best practices for how to work with the media to advocate for policy change.

So, this coming spring or summer we're going to be conducting regional policy trainings. A lot of people have been having, you know, budget issues, I'm sure everyone's familiar with, and can't travel. So, we have additional funding to conduct regional trainings, and we'll be doing that.

The fire prevention toolkit - there are five toolkits - it will be posted online in, hopefully, soon. It's going through a review process internally.

And we also worked with our art unit to create a couple posters to help market the Web site, which I brought in case anyone would like to look at them. And they can be posted, we're going to send them out electronically to health providers in case they would like to post them in their offices. Or they can be posted anywhere, libraries, schools.

Sarah might have mentioned this beforehand, but we have a Bureau electronic newsletter that goes out on a monthly basis,

and if anyone would like to sign up for that, you can just send me an e-mail. We have our newest upcoming events, injury prevention news across the state.

And if you have questions, here's my contact information and our Web site.

Thank you. Does anyone have questions?

DR. COOPER: Yeah. I was just going to thank Ms. Willing for a very, very comprehensive presentation. Great job. And congratulations on -- on getting an extraordinary amount of work done in a very short period of time, to hold a major statewide conference and a series of roll-outs regionally and develop all the hundred thousand fact sheets that you have developed, I'm sure it has taken quite a bit of your time and --.

MS. WILLING: Yes, thank you. This was originally a one-year grant, and it was extended for a second year. So, it -- it was a lot of work in a short amount of time.

DR. COOPER: That's right, no good deed goes unpunished. No, this is really -- this really does rank -- I mean, this is really incredible work, and -- and for those of us --

MS. WILLING: Thank you.

DR. COOPER: -- who have been deeply involved in injury prevention over the years, you know, it really -- it's really

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terrific. So --.

MS. WILLING: Thank you.

DR. COOPER: Any questions for Stephanie?

Lisa?

MS. MCMURDO: Do you have a linkages you need with the hospital community? Do you need us in O.H.S.M. to help you with that?

MS. WILLING: That would be great. We haven't -- I don't know how much participation we've had in the past, say that this -- our events and things from the hospital community. We only have certain distribution, like e-mail lists, and that's how we sort of advertise our events. But I don't know if you have access to those different --.

MS. MCMURDO: You can actually use the state alerting system and send out --.

MS. WILLING: Oh, that would be wonderful. Thank you.

DR. COOPER: I -- I -- I don't know if you have made any contacts with the State Chapter of the American Academy of Pediatrics, and also maybe of NAPNAP. I don't know if there's a State chapter for NAPNAP.

MS. MCMURDO: There's not a state chapter. There's local chapters, though.

MS. WILLING: Okay.

DR. COOPER: But certainly the -- and certainly the --

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the American Trauma Society here in New York State as well. Martha can give you my contact information and can get you in touch with all those folks.

I think there probably are a large number of pediatricians who'd be very interested in working with you on injury prevention. Certainly the trauma -- the trauma coordinators would. This is in -- in -- in all our various trauma centers. I think that would be -- you know, developing more partnerships --

MS. WILLING: Definitely.

DR. COOPER: -- you know, between those organizations would be very helpful.

And this is something, as Sarah knows, that we have tried to sort of get going in the past, and you know, now that you're here and able to spend really full-time on this project, it's -- it's -- it's really terrific. And I think we really need to build up on this base, and -- and you know, institutionalize it while we still have the opportunity to have you focusing your full attention on this -- on this issue.

MS. WILLING: Definitely. Thank you. That's --.

DR. COOPER: Good.

Other comments, questions?

Okay. Well, once again, congratulations on your presentation.

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MS. WILLING: Thank you.

DR. COOPER: The next item has to do with an E.M.S. disaster card. We really have a very full plate right now between the regionalization issues and some of these other things, but -- but some of us have been concerned for some time that in the event of a major disaster many of our colleagues in -- in emergency services, whether in hospital or prehospital, may not have a full and complete grasp of some of the special pediatric issues that -- that need to be addressed.

Many years ago in the aftermath of -- of September 11th, as you all recall, the Department created a small series of pocket cards, one for biological agents, one for chemical agents, one for radiological agents. Excuse me. We -- there was never a card created for blast injuries, nor was a card created for pediatric components of all those -- of all of those different types of injuries.

It was a little tiny pocket that, you know, literally would fit into your -- your shirt pocket or your jacket pocket that you could use in the E.D. or the I.C.U., what have you.

We all thought that that -- you know, when those little cards came out we all thought that they were really very good and very helpful, very useful. I still have mine sitting on my shelf, God forbid I ever need them. But I always hoped that we could get something together in the pediatric world.

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At the same time, two of the most successful projects that this Committee has undertaken over the years was a pediatric ambulance card that covers the basics of assessment and resuscitation for our prehospital colleagues, as well as a children with special healthcare needs advisory card for our prehospital providers. And I thought it would be appropriate if we began to push forward in terms of developing, you know, these aids that could be used by our colleagues statewide, both on -- on the in-hospital level and the prehospital level. It's something that I've wanted to do personally for a long time.

Certainly we have, as you know, reached out to our colleagues in the Department's emergency preparedness programs, and we're very lucky that Deb -- Deb Sottolano was able to be with us here again today. And given her interest and Mr. White's interest in this area, I was wondering if perhaps the Committee felt it would be appropriate for us to try to develop these cards at this point and maybe work with the Department in somehow getting them distributed.

We -- we do understand, of course, that funds are not even limited, they're nonexistent, you know, for printing and things like that. But they could be made available electronically, and that sort of thing, so people could download them and print them on their own. And -- and then if it at some lucky point in time, you know, some change floated down like

manna from the skies, we might be able to get them printed and distributed again.

But I just wanted to ask the group if they felt this was something that we should undertake at this time. And if so, I'd like to ask for some volunteers to -- to help work on it.

Bob Kanter's nodding yes. Sharon? Is nodding yes. John? Yes.

You all agree that -- does anybody disagree that this is a worthwhile project? That this is -- is something we should -- we should move toward developing?

I see Lee Burns is chomping at the bit here probably telling us not to take on too much, but -- but here she is.

MS. BURNS: I -- I actually -- I read lips badly, but I read his.

Here, again, just -- just to put this into perspective for you, not to minimize the importance of this, because one of the most sought-after items -- or two of the most sought-after items were the pediatric laminated cards and the special needs card, and we still get requests for them.

But with that said, I -- I have to tell you that we don't have the resources to commit staff, and -- on -- on the Bureau's part as well as our production control people who are the artists -- and I -- they're called something new now -- to get their attention to a new project. So, while I, you know --.

MS. CHIUMENTO: I was the one that designed the other two cards.

MS. BURNS: But they do all the artwork. It all has to go through the approval process and the laminate -- the printing them and laminating them was expensive.

In order for them to get up on the Web, the Department has to approve them. So, again, you know, depending on what you provide us as an end product, I can only say to you, quite frankly, that we have a very -- a very narrow focus right now, and this may not be included in it in any priority.

So, Deb, feel free to jump in.

MS. TREACY: No, I -- I -- I understand what you're saying now. I don't have any other comment.

DR. COOPER: This is, unfortunately, something that could become a priority tomorrow. And you know, that's, of course, the urgency in getting something like this done. I mean, we've talked about it for a long time. I think, you know, we all understand the constraints under which the Department is functioning, you know, and we understand that it will be difficult for the Department to provide any degree of any support for this project at this particular time, but -- you know, but at the same time, you know, we all also understand that if tomorrow the veritable mud hits the veritable fan, there'll be an awful lot of people turning -- turning to us, and

saying why don't we have something like this available.

So, I -- I think we owe it to the public, to whom we're ultimately responsible, to develop this -- this set of tools. And then, of course, all we can do is present it to the Department, and say, "we think this is worthwhile" and -- and then, of course, the Department is whom we advise, is obviously free to accept our advice or not.

Bob Kanter?

DR. KANTER: Well, if -- if we're successful in developing something as good as the last two information cards, it's going to take on a life of its own, because it's so useful.

There are a variety of ways you can get something like this distributed. The -- the -- the hardest part of it, and the most expensive part of it which, actually, is going to be free to the Department, is the expertise of the people who will be writing it free to the Department.

Beyond that, the distribution -- you know, if it's a standalone laminated card, that's great, but there are a lot of other publications that go out both electronically and by paper. And the one thing that comes to mind is the toolkit for emergency preparedness that, I believe, is being revised now. And something like this may be included in that, if -- if not as a -- or in addition to a standalone version. So, there's a lot of ways distributing it that wouldn't add a lot of costs.

MS. GOHLKE: Our -- our assessment card is included in that toolkit as well.

MS. HAFF: The toolkit has been revised, and it's published -- published on the Commerce Web site -- well, it's actually published on the public Web site that is linked to through the secure internal health commerce system, and we, you know, and Lee alluded to the approval process. And I don't know, you know, I mean, to publish on commerce, you don't have to go through the public, you know, the P.A.G. restrictions, but I'm certain that there would be still some internal review process. And so, that might be --.

MS. BURNS: Right now, for a variety of reasons, we -- most of our providers access our information through the public Web site, and though we're working with them to get them health commerce access for other reasons, it's a slow uphill battle.

DR. COOPER: Okay. Well, we will proceed, and -- and I'll take the responsibility of organizing this. And what I'll do is I will scan copies of the little paper pocket cards that were distributed a few years ago, so that you all can get a sense of what they look like. And then we can begin to think about how we might arrange the content and go forward from there; okay?

Elise?

DR. VAN DER JAGT: I'm wondering if that twenty

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2 thousand dollars in the grant could pay for some of this?
3 MS. GOHLKE: It could.
4 DR. VAN DER JAGT: I'm just thinking if everybody
5 thinks it's really important, then --
6 MS. GOHLKE: It could.
7 DR. VAN DER JAGT: -- this -- this is how to handle it.
8 MS. GOHLKE: Yeah, we really wouldn't be restricted
9 from it. Emergency Preparedness, I just want to add, gets a lot
10 more money than the hundred thirty thousand dollars E.M.S. for
11 Children does. So, if there's some way we can get the bigger
12 grant --
13 DR. VAN DER JAGT: To pay for it.
14 MS. GOHLKE: -- I would -- I -- that's what I would
15 like to do. But we can -- we can work that out.
16 MS. HAFF: That could be -- yeah, that -- and that
17 could be a deliverable, if we're talking about deliverables for
18 next year's grant.
19 DR. COOPER: Okay. All right. So, let's plan on, you
20 know, going forward with this, and you know, if we've got
21 something good, maybe we can find some funding to support it.
22 Yes, Ann?
23 MS. FITTON: I just say that I -- I already note that
24 there are such -- there are cards out there about blast
25 injuries, not necessarily pediatric ones, distributed by

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2 C.D.C. --
3 DR. COOPER: Right.
4 MS. FITTON: -- from Fitz-Johnson (phonetic spelling).
5 There are other groups that have done disaster preparedness
6 cards. I think the -- the fundamental issues you're going to
7 have are, we should have this card, if people don't have the
8 supplies, for instance, if they don't have the new antidote kits
9 for chemicals, then what is -- what is -- what -- what is their
10 alternative, I'm talking about prehospitally.
11 You know, I -- I think that, you know, it just needs to
12 be sure of what it is we're trying to ask people to do. In any
13 disaster, prehospitally, I'm going to tell you something, with
14 all due respect, we're not ventilating any kids six times in
15 thirty seconds and leaving them on the ground and black-tagging
16 them. That's not happening.
17 I know that's supposed to be what we're trained to do.
18 I understand the principle. But picking that kid up, as long as
19 all his parts are attached, he's going to the hospital.
20 I -- I think you have to really be specific and --
21 and -- and very focused in what you a ask prehospital care
22 provider to do in the face of all hell breaking loose -- if I
23 can say "hell" on the record --.
24 FROM THE FLOOR: Nope.
25 MS. FITTON: No? If all -- if all H-E double hockey

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2 sticks, is definitely breaking loose, what is it that you think
3 a card is going to do for that E.M.T. or paramedic under the
4 stress of -- of -- of that situation?
5 I -- I -- I just don't -- I just don't know what to
6 expect it to -- to benefit.
7 DR. KANTER: We haven't really even begun to designing
8 the card yet. But I think the information in it pertains not
9 only to the prehospital setting, but also to the hospital
10 setting, and I think of this potentially being somewhat akin to
11 the job action sheets that every hospital has in their disaster
12 plan.
13 That is, things that you may practice once or twice a
14 year, but you're not thinking about every day, but when you get
15 notified that there's an impending problem, that you review some
16 simple references that are readily at hand that remind you about
17 principles and basic operating procedures.
18 So, you're right, in the prehospital setting the -- the
19 E.M.S. providers are faced with split-second situations, and
20 even a card in their pocket may not be so helpful. But down the
21 line, there are lots of people whose work may be made more
22 orderly or organized by having something like that.
23 MS. FITTON: And I think that as long as that's the
24 focus, and we're not trying to kid ourselves that the E.M.T. or
25 paramedic making that decision whether to step over that kid or

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2 to pick that kid up and move him, is going to be helped by a
3 card. I don't think that's going to help, because quite
4 frankly, it's different than having an assessment reference,
5 it's different than having a special needs reference.
6 It's -- it's -- it's -- and -- and you know, it's a --
7 it's a shame that you haven't been able to participate in any of
8 the drills that we've done, real-life drills, I know that one
9 was part of the preconference. We've actually had people --
10 these little beat-up mannequins dressed in -- dressed in women's
11 clothing -- and -- and they're mannequins, okay? Everybody
12 there knows that they're mannequins, because we're drilling on
13 this stuff, and there are people that are actually angry and
14 upset, because there are children who -- who are -- are clearly
15 dead, and they're being picked up and moved.
16 Every single one of those children, eventually -- even
17 if the right reasoned occurs, the child is black tagged and we
18 step over him. There's another provider that comes behind him,
19 and even with the -- it's even with a black tag attached to that
20 kid, they pick that kid up and they bring it into triage.
21 I'm telling you it -- it's -- and then there's a lot of
22 hot wash, it becomes an extremely hot wash, and the bottom line
23 comes down to this, is -- is -- is that every kid deserves the
24 opportunity to be taken to the hospital. That's the bottom
25 line.

And I'm not saying that it's right, Art, but I just want you to be prepared, and to understand that -- that -- that a card is not going to help prehospital.

DR. HALPERT: I guess I fail to understand the reticence to still design a resource that's available, whether it's utilized or not. I certainly appreciate the situations that can occur that could preclude adhering to a prescribed plan. And certainly, I think a card of this nature would not be -- I would hope would not be intended to be used as a prescribed plan, because that's not how disasters work.

MS. FITTON: Again, I --.

DR. HALPERT: But having -- but -- but having resources and references available are typically not a bad thing.

MS. FITTON: And I don't say that it is a bad thing. What I've said several times, and let me -- let me just be sure that I -- I'm being clear, because perhaps I'm not, is the focus cannot be on what the prehospital care provider is going to be doing. If it's --

FROM THE FLOOR: Right.

MS. FITTON: -- if the focus is not on prehospital care, then I agree. It's a wonderful tool to have. The more tools you have, the better. But under -- I mean, under pressure, under the stress of the situation, with all kinds of -- of mayhem occurring, you cannot expect that a prehospital

provider's going to reach into their pocket for a card, read the card, and then do -- and then do what the card is telling --

DR. HALPERT: No, I --

MS. FITTON: -- them to do.

DR. HALPERT: -- wouldn't expect --

MS. FITTON: It's not --

DR. HALPERT: -- that.

MS. FITTON: -- going to --

DR. HALPERT: I would just --

MS. FITTON: -- happen.

DR. HALPERT: -- make that --

MS. FITTON: I'm sorry.

DR. HALPERT: -- available to them --

MS. FITTON: It's not --

DR. HALPERT: -- should they --

MS. FITTON: -- just --

DR. HALPERT: -- wish to have it.

MS. FITTON: -- my own -- I'm sorry. Let me just finish.

My only point is I don't think that it really has a genuine focus prehospitally. That's really my point.

DR. HALPERT: What's your thought on this, Art? You brought the whole thing up?

DR. COOPER: I think all of these cards are -- you

know, are intended as references --

DR. HALPERT: Right.

DR. COOPER: -- for -- for people to -- you know, to have available to them to utilize. I don't think anybody expects that -- that when faced with a child who's down, that somebody's going to pull -- you know, pull the card out of the ambulance and say I should do this, this, and the other thing. It's really more of a reference kind of -- kind of thing, at least that's how I see it.

Maybe I'm wrong. May -- maybe -- maybe that's -- maybe that's not the way people are using it.

DR. HALPERT: Mainly your intent is --

DR. COOPER: Maybe people are using it as a --

DR. HALPERT: -- pull them out as a last thing.

DR. COOPER: -- maybe people are using it as a laminated protocol. That's what the -- none of these cards were ever intended to be laminated protocols. They're -- they were simply intended to be reference documents for -- you know, for people to -- you know, to -- you know, to -- to have available to them. As -- as Bob says, kind of like a job action sheet that we would use in the hospital.

That's -- that -- you know, I -- maybe I'm wrong.

Bob.

DR. KANTER: Again, we haven't even talked, even in a

preliminary way, about the content, but the other analogy that comes to mind is the resuscitation algorithms in the A.L.S. guidelines, is they're meant to be a reference during a resuscitation and we -- I -- I imagine most hospitals, we certainly have them attached to the emergency cart, and when you've gotten partway through your resuscitation and you get confused or start running out of ideas, you glance at it. Since you're already familiar with it, you can sort of recognize the pathway and where you are on the pathway, and it sort of sets you back on track.

You know, airline pilots use checklists all the time, in fairly time-sensitive situations, to make their work more systematic too. So I can imagine some circumstances where you don't have time or capability of referring to something like that, but having it sometimes would be helpful.

MS. FITTON: The only thing is and -- and the difference, I think, is prehospitally and in-hospitally is that prehospitally we're talking in a disaster, one-to-a-hundred or one-to-a-thousand medicine; okay? So there isn't that same depth of resources, even -- even when the hospital gets inundated with lots of patients. We're talking about one provider caring for hundreds of people, and I don't truly believe, from my experience, that -- that a -- that a reference meant for them to use in a disaster is -- is helpful.

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2 I'm not saying it shouldn't be developed. I'm just
3 saying let's not kid ourselves, in a disaster, that people are
4 going to be guided by this card.
5 MS. GOHLKE: Could I -- one suggestion is that, you
6 know, not to spend a whole amount -- huge amount of time
7 developing a draft, but maybe sketching something quick
8 together, and we could always bring it to one of our other
9 SEMSCO, and hand it out and ask a quick, you know, question, do
10 you think this would be utilized; is it worth, you know,
11 development? And we can at least get a snapshot from those
12 providers which are how many on the SEMSCO? Sixty or so?
13 DR. COOPER: Sure.
14 MS. CHIUMENTO: Ann --.
15 DR. COOPER: Obvious -- obviously we --.
16 MS. GOHLKE: Plus -- plus the -- the peanut gallery.
17 So, the -- we could get just the -- a quick snapshot feel from
18 them whether or not they would think it would be utilized and
19 useful, and I don't know, if -- if that would -- you think that
20 it would be useful, we could then decide if we want to go
21 further with it or not.
22 DR. HALPERT: I just don't -- you know, I -- more
23 resources, to me, is better than less. I don't -- you know,
24 whether you choose to utilize resources, that's your business
25 entirely, but you know --

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2 MS. GOHLKE: Well --.
3 DR. COOPER: Well, once again --
4 DR. HALPERT: -- resources to --
5 DR. COOPER: -- you know --
6 DR. HALPERT: -- not having resources out there --.
7 DR. COOPER: -- I -- I, you know, the -- the - the
8 tools that we've developed in the past, the tools the Department
9 has developed in the past, you know, with -- which this
10 Committee had obviously no -- you know, no stake and input, you
11 know, toward, et cetera, et cetera, were only ever meant as --
12 as resources. They were not meant, as -- as I said, they're not
13 meant to be used -- never were meant to be used as laminated
14 protocols.
15 FROM THE FLOOR: Right.
16 DR. COOPER: They never were. They don't include
17 protocol content on them. They just include background
18 information, you know. You know, and others may have other
19 ideas, but -- but -- but you know, the idea that I personally
20 had was we would develop tools that were like the cards the
21 Department developed many years ago, and like the -- like the --
22 the laminated cards that we developed for use merely as
23 references, for the -- for our colleagues. Nobody -- and if
24 anybody -- you know, if anybody thinks that -- you know, that --
25 that -- that it's -- that it's, you know, my intent that people

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2 are going to sit there with a laminated card next to them during
3 a resuscitation, no, I -- I -- I do not think that.
4 MS. CHIUMENTO: Just a couple points.
5 Number one: Those cards that we developed, although
6 they were meant originally for E.M.S., have been used in the
7 hospital settings as well.
8 DR. COOPER: Yeah.
9 MS. CHIUMENTO: I know of several hospitals that have
10 taken them and put them up in their emergency departments. So
11 they do have multi-purposes, so we're -- we're not focusing on
12 one group.
13 The other thing is -- is I think, Ann, you're focusing
14 on a lot of the -- of the black -- the black tag patients, the
15 patients, the major disasters. But this card could also be used
16 for smaller disasters. For -- for instance, a farming incident
17 where you've got some organophosphate poisonings or something
18 like that going on. And maybe we don't go know so much with the
19 treatments, per se, but maybe some of the assessment. How we
20 decide what's going on and what -- what direction we should take
21 in the first place? Maybe it's something we might want to
22 include on the card.
23 So, I don't see it as just the -- the major START kind
24 of an incident. I see this as something that could -- can have
25 many more levels to it. Something that can, for instance,

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2 the -- the children with special healthcare needs. We're not
3 talking about the child in special -- in cardiac arrest. We're
4 talking about a child who's got a need, and so we're going to
5 try and just assess what's going on, and how we can best meet
6 that need currently.
7 So -- you know, so I can kind of see it both ends in
8 this. I think that there is some use for the E.M. -- E.M.S.,
9 but not -- I agree with Ann, not for the -- the treatment
10 directly, and in very large-scale disasters. I think it -- it
11 probably is not going to be used that way. It will be used in
12 smaller-scale incidents, and it will be used in -- more in the
13 assessment venue, I -- I think, if -- if we can include --
14 MS. FITTON: If -- if -- in this --
15 MS. CHIUMENTO: -- that kind of information.
16 MS. FITTON: -- in that framework, yes, but I -- I
17 mean, in -- in the, you know -- basically, I have been working,
18 from my -- the view of training the fire department, fire side
19 and E.M.S. side for the last year and a half, improvised
20 explosive device incidents. And I can tell you that you -- you
21 know what I mean?
22 Maybe, Jonathan, I am too focused on those specific
23 metropolitan-type incidents, that I don't think about farm
24 incidents, because I don't -- I don't deal with them, so -- and
25 so I just want to be sure that we recognize that when we have

one-to-a-hundred, or one-to-a-thousand medicine, that the ability of a reference card to assist the prehospital care provider is minimal. That's all I'm talking about, because we're talking about disaster preparation.

DR. HALPERT: Yeah, but I --

MS. FITTON: And this would -- that was --

DR. HALPERT: -- I understand that.

MS. FITTON: -- that was the -- that was the premise here.

DR. HALPERT: Yeah.

DR. COOPER: Yeah.

MS. FITTON: And the first thing we talked about was blast-wave injuries. I don't know that that's helpful. So all I'm saying. I'm not saying we shouldn't do it, I'm just saying that in the prehospital setting, like we already know, there's a -- if there is anybody within the blast wave, you're a patient. You're all patients, because we know that all of these injuries are not immediately identifiable. Some of them take time to present, they take time to develop, et cetera. So -- so there are already thing -- and -- and there are already things out there that could probably give you a jump start on this, Sharon, if you wanted to do this.

DR. HALPERT: But Sharon's point is excellent. It does -- definitely squares with what you're saying. I mean,

That's the extreme scenario. The reality is what we're dealing with is an ambulance with four volunteer E.M.T.s or two E.M.T.s and two attendants and a driver --

FROM THE FLOOR: I'd say you're optimistic.

DR. HALPERT: -- that rolls up on a school bus crash of thirty patients. That -- that is a disaster.

MS. FITTON: No, it's -- it's the --.

DR. HALPERT: That -- that's a five-to-one scenario.

MS. FITTON: So, that's what I'm saying.

DR. HALPERT: And that happens on a much more countable, predictable basis. And we have to -- it's reasonable to have resources available to those folks. And the resource card may just be the -- the crap's hitting the fan, what's the telephone number to call to ask for that pediatric specialist, or that triage or emergency specialist, to help me better direct these people to get resources better. It maybe something as -- there -- there's a blank filled in on the card specific to their local operating area, to -- to give them access.

FROM THE FLOOR: Uh-huh.

DR. HALPERT: You know, it's not necessarily --

MS. FITTON: Well --

DR. HALPERT: -- the sky's the limit. You're right. It's really -- you know, you -- to --

MS. FITTON: -- I -- I --

DR. HALPERT: -- to comprehend --

MS. FITTON: -- we deal with --

DR. HALPERT: -- dealing with --

MS. FITTON: -- thirty- or --

DR. HALPERT: -- scenarios like you --

MS. FITTON: -- forty- or --

DR. HALPERT: -- described --

MS. FITTON: -- fifty- and sixty-patient --

DR. HALPERT: -- you know --

MS. FITTON: -- scenarios every day.

DR. HALPERT: Right.

MS. FITTON: So you're right.

DR. HALPERT: Right. And that would --

MS. FITTON: It would --.

DR. HALPERT: -- be phenomenal to have access to that kind of management expertise as a resource to say, you know what? There's someone who does it all the time. But the -- but the -- but the -- the -- the squad up in Saranac Lake does not. But it can happen.

MS. GOHLKE: The -- the E.M.S. for Children survey shows that people don't know how to contact medical control or what it's about or -- I mean --

DR. HALPERT: And every -- every little --

MS. GOHLKE: -- I would like to see your efforts go

towards that.

DR. HALPERT: -- every little thing you can do to try to emphasize that --

MS. GOHLKE: Right.

DR. HALPERT: -- or reinforce that --

MS. GOHLKE: Right.

DR. HALPERT: -- through a reference card, for example, only helps.

MS. GOHLKE: And then, even, you know, in my own area in Albany County, we don't even know what the resources are, or who would we call if we need resources, and who has that information for a situation where it's a school bus accident and we need more --

FROM THE FLOOR: Eight five two --

MS. GOHLKE: -- extrication --

FROM THE FLOOR: -- six three three nine.

MS. GOHLKE: -- believe it or not, in Albany County I do not know who has the list of resources to dispatch. Who -- who -- who knows what's out there to dispatch for what needs? So, to me, I see that as the more -- the primary issue before you get to, you know, some sort of chemical, but that's just my opinion.

DR. COOPER: Okay. Appreciate all the comments. I still have a general sense we should proceed. Yes?

FROM THE FLOOR: Yes.

DR. COOPER: Okay. Okay. And we'll be sure that, you know, Ann's, you know, wise comments are -- are taken into consideration, and the -- the focus, again, was never intended to be on a guide to what to do, you know, at the side of the patient, but -- you know, but as a general background resource document, and we'll proceed in that -- in that direction.

Okay. Elise and Sharon, American Heart Association update.

DR. VAN DER JAGT: Yes. Could I plug the -- the projector into my computer?

MS. GOHLKE: Yeah.

DR. VAN DER JAGT: Is there a way to do that? I'm hoping it will work.

(Off-the-record discussion)

MS. ROGERS: While we're waiting for that to happen I would just like to make one comment in -- in that any -- any response to disaster, no matter where you are, you're not -- everything's different and you're not necessarily going to be following exact protocols, because you fly by the seat of your pants, and you do what you need to do in relation to the type of disaster you have.

However, I strongly believe that education -- preeducation, before the disaster happens, is where it's at.

So, hopefully, you can fall back on what your education is. So, I think I have the question of what is available for pediatric disaster education, which is a more global concept. And then if -- if that -- if in review of that it evolved that there are certain items that you could quickly review -- like when we know there's a disaster coming into the hospital, or a code coming in, you can look at our -- our heart association reference cards to refresh your memory on, okay, I know I need this, this, and this, and it -- it just -- it jogs your mind before you get on -- before the child arrives.

But I think a more global thought is what is there available in pediatric disaster education, so that you're forearmed and have at least some education backing up what your response in an emergent situation would be.

DR. VAN DER JAGT: Shall I go ahead?

DR. COOPER: Please.

DR. VAN DER JAGT: Well, thanks for asking me to present the -- the newest guidelines from the American Heart Association. The disclaimer is a bit that I was involved in the process. This is the second time around. One was in 2005 and this is 2010. And this whole development of these guidelines, I have to say, is one of the most intense, but also the most exciting kind of processes that we've been involved in.

As you can see here, A.H.A. guidelines for

cardiopulmonary resuscitation and emergency cardiac -- cardiovascular care is what we're talking about here. And the Web site is on there. And by the way, I can leave all these slides here, I can even send them to you as -- as a file, so I'd be happy to do that if you want to, but it is certainly available online.

What -- what I thought I'd do is explain just a little bit about the process first, and then go into a little bit about the adult guidelines, because they really are really very relevant for the pediatric ones as well, particularly since basic life support is one of the main issues that has been changed.

This slide comes from -- directly from circulation. This was a scientific evidence document that was presented -- was published, actually, in circulation in October of this year, so very recently. And the first part of that, which is the -- sort of the international consensus on cardiopulmonary resuscitation, just so that you know, it's just like we have the American Heart Association, who deals with all the resuscitation science, and it's a very large organization, obviously dealing with cardiovascular disease, there are many other resuscitation councils similar to that around the world. So that there's one in South Africa; there's one in Europe; there's one in Australia; there's one in Japan. There's a whole lot of

different analogous kind of organizations.

And the -- these -- this international consensus, and this committee that -- which has members from each of these councils, they come together and make the final decisions about it, based on a very broad consensus on the literature. And that broad consensus is -- is about four or five hundred people coming together, analyzing all the scientific evidence of -- on resuscitation, and then the final decisions do get made by this ILCOR committee.

The -- in November, I believe it was -- or the second -- next issue after -- in circulation, actually published not the science, which undergirds all these guidelines, but the actual guidelines. So, there's a -- there's a difference between those two. All the science, again, can be found online, it can be found in circulation, all the worksheets, every -- all the questions that were answered can be found easily available to the public.

But I just want to talk to you a little bit about the actual guidelines based on the science. And I'm not going to tell -- talk to you a lot about the science, because that would be -- fill hours and hours and hours. So, here are some of the things that I just -- are in this executive summary that you should be aware of. This is very general. But we all recognize that the outcome of cardiopulmonary arrest, particularly in

adult patients, but also in pediatric patients, is abysmal. The survival rates in adults, you know, are -- are -- are certainly less than ten percent. That's similarly true in pediatric patients, particularly if they're out-of-hospital arrests, which is where E.M.S. especially is involved. But even an in-hospital arrest, the outcome of this, to the -- to discharge is not very -- very good, maybe up to forty or fifty percent in pediatric inpatient arrests.

So the challenges were to really improve the C.P.R. quality for adults, children, and infants, because we do know from the evidence that bystander C.P.R., especially C.P.R. in the field, as soon as you can get it, done does increase the survival rate -- probably double- or triple-fold. So there is benefit to that. But there are lots of barriers, and you can see them here. I don't think we have to go through all of them, but there's all the thing, like failure to recognize that gasping, for example, which figures largely in one of the recommendations here, that gasping is not a normal form of breathing and should not prevent somebody giving cardiac compressions, because it could still be present during the time of a cardiac arrest.

We know there are low bystander C.P.R. response rates because nobody wants to do mouth-to-mouth anymore, and there's a real lot of concern about that, and that also again, plays into

the recommendations.

Problems with compressions and how they're executed, ineffective ventilations, if they are tried, and the then whole issue of electrical discharge and the delays, which can be either vertical -- based on vertical challenges, or you know, horizontal challenges to get them there. This is true no differently for adults than it is for -- for pediatric patients. It's the same thing. It's the same problem, and it's been noted that that's the -- that's the fact.

So the -- this is the -- some of the basic underlying sort of -- sort of foundational building blocks of C.P.R. It's been recognized that chest compressions really, in cardiac arrest, is the critical action. And as many of you know, several years ago, I think like, two years ago maybe, hands-only C.P.R. came out for adults, for -- for a witnessed arrest, not for pediatric patients. But that to really get the public, especially, to get involved in doing cardiac compressions, and not just standing there being afraid to do anything for fear that they would do something wrong, and to -- to do this. And this has been -- and it's caught on, I think, in a large way. And then, as there is more proficiency, particularly in healthcare providers, to add rescue breaths, and obviously, ultimately, a multi-team coordinated -- multi-rescuer team coordinated kind of C.P.R. But that hands-only, or the chest

compressions, is really basic.

So, what the -- you'll see in the new guidelines is they have fabricated a new chain of survival. And as you can see here, this is kind of brand new. And the adult chain of survival - and there is a different pediatric one and I'll show you that in a second - begins with calling. So this sort of -- of immediate recognition of cardiac arrest and activation of the emergency response system is -- is fundamental to adult cardiac arrest treatment. Early C.P.R., rapid defibrillation, which it means, of course, that's why you have to call early, and then it effects an life support, which puts -- pulls into -- into prehospital care E.M.S. providers.

And then now also, substantially more information on what do you do after the kid gets -- person gets resuscitated, and the whole issue of post-cardiac resuscitation care.

So, let me give you just a couple of the things on the adult side that are -- are really, really relevant, and actually spin over into pedes as well.

So, probably the -- the first two of these are most critical. This idea that bystanders should provide hands-only C.P.R. for the adult victim who suddenly collapses, with an emphasis to push hard and fast on the center of the chest, or follow the directions of the E.M.S. dispatcher. And maybe what I should say is I'm going to go through this whole presentation,

and then maybe we can talk about what -- how do we now -- what do we do? Do we change anything? How does this really work, and how do we educate? So, that's number one. So, clearly the emphasis on compression only.

The new thing: Initiate chest compressions before ventilation. So basically ventilations is not entirely out the door, but basically chest compressions is what it -- is what it is all about.

Here's another thing that we've had for probably thirty years, forty years, you know, the -- the -- the scenario of somebody, you know, putting their ear next to the -- next to the patient's mouth, and then looking at the chest and sort of look, listen, and feel, to see whether they were breathing or not. That was totally removed from the C.P.R. sequence because it was clear that it was confusing; people didn't know how to interpret any of this; and there was a delay in doing cardiac compressions, which was really the issue. So, now it's after delivery of thirty compressions, they can open the victim's airway. But it is not prior to the beginning of chest compressions.

The rate is at least a hundred. It used to be a hundred. It's a least a hundred, so it can be more than that. That's a difference.

The adult sternum should be depressed at least two

inches, about five centimeters, and you'll see how that relates to pediatrics in a second.

And then the whole issue about -- here, to help bystanders recognize cardiac arrest, dispatchers should ask about an adult victim's responsiveness. The lay rescuer should be taught to begin C.P.R. if the victim is not breathing - a note here - or only gasping. So, that was not in the previous rendition of this. The healthcare provider should be taught to begin C.P.R. if the victim has no breathing or no normal breathing, that is, only gasping. So it's really pretty much identical.

And by the way, this is all lifted directly -- these are the quotes from the guidelines; okay? This is not my verbiage.

The routine use of cricoid pressure in cardiac arrest is not recommended.

FROM THE FLOOR: Why?

DR. VAN DER JAGT: There is no evidence, and there is a real concern. There is some evidence that it actually interferes by compressing the trachea, and interferes ultimately with ventilation. So, that is -- that's something that was quite surprising to me, but it -- that is -- actually been studied, and there is a worksheet on that, actually. So it's not recommended.

MS. HAFF: Now, was it used to pinch off -- the logic be that it would close the esophagus off and --?

DR. VAN DER JAGT: That was the logic. There's also been no evidence that it actually prevents aspiration of stomach contents. So that trying to weigh those two, you know, if there's no evidence that it prevents aspiration of stomach contents, even during intubation attempt, you know, or -- or even when you're sedating somebody with R.S.I., apparently there's no evidence for that, and there is concerning evidence that it might actually depress the -- compress the trachea sufficiently to cause problems with ventilation.

This is the new B.L.S. algorithm. This will probably be put lots of different places, I suspect. Idea here is unresponsive, no breathing, or again, no normal breathing, only gasping. It's actually in there. Activate emergency response, get the -- get the defibrillator, start C.P.R., and then check rhythm and shock if indicated, and repeat every two minutes. So, it's kind of a simplification of what this is, rather than that sort of vertical kind of way of doing it.

Well, what else? There is -- there is some stuff on -- for the adults here, on monophasic versus biphasic wave form, with cardioversion, and that is just about energy. I don't want to spend a lot of time on this.

The precordial thump, surprisingly enough, is actually

back. I'm so surprised. I was trained on that in the '70s and we were thumping everybody, and it went away for a long time, and now it seems that it does -- it is allowed, it may be considered for patients with witnessed, note that, monitored, unstable V.T., including pulseless V.T., if a defibrillator is not immediately ready for use. But it should not delay C.P.R. So, I don't think it takes too long for people to give a thump, but then maybe it does. I think the decision to do it is probably what's delaying things.

FROM THE FLOOR: It was in our paramedic training though, on this.

DR. VAN DER JAGT: Was it?

FROM THE FLOOR: Yeah.

DR. VAN DER JAGT: Here is a big one. This is a big change, and this is also, as you'll see, in pediatric. Continuous waveform capnography is recommended for intubated patients throughout the period -- arrest period, and it is particularly true for two reasons: One is to confirm tracheal tube placement, but also to monitor C.P.R. quality and the detection of return of spontaneous circulations based on this, which precedes the ability to feel a pulse. And I'll show you the graph on that. And that is also true for pediatric patients. So that may have some implications for prehospital-care intubated patients who are undergoing

compressions, and I think that's something we may need to talk about.

This is a little bit about pacemakers. I don't think that there's a lot of -- of difference here. And then a little bit about the biphasic versus monophasic dose for atrial fibrillation. I'm not going to spend a lot of time on this, and I'm going to skip over this to get to the pediatric part of it, because it's hard to read these other graphs.

So, there's a whole section on pedes advanced life support and -- and again, I will do sort of the same thing, give you some update on what is different. So there's a new pediatric chain of survival, but you'll notice that it is different from the adult chain. So, the first one is - hopefully you know what this is.

FROM THE FLOOR: Is there a seat belt?

DR. VAN DER JAGT: It's a seat belt, thank you very much. Not everybody knew that. They thought maybe it was decapitating somebody or whatever, you know, but --

(Off-the-record discussion)

DR. VAN DER JAGT: -- but that was the -- what is it, the -- the -- the people who do the schematics and all that -- the graphic design, I think it's called. It is the seat belt. It is emphasis on prevention, which fits very well with E.M.S.C., obviously, anyway. Then it's compressions. And there

is one exception to that, and you'll note on the -- on the algorithm, which I will show you shortly, that the compression, if it is not a sort of witness-immediate arrest, like it would be for an adult where you had to run and the A.E.D. first, you actually do two minutes of compressions, rather than our more classically taught, I think, on minute. Then there's the call. Then there's the ambulance, obviously E.M.S., and then there is the post-resuscitative care.

So -- so, the question is what do we do with this A-B-C? I cannot begin to tell you how many discussions there were about this in the pediatric subcommittee that I'm on. The science is fairly clear. The question was more our intrinsic worry, because most pediatric arrests are from respiratory disease. Is this going to affect our ability to successfully resuscitate? And there's actually animal data, but there's not much in the way of actual pediatric data on this. Certainly adult data on this.

But the consensus was, after looking at all the evidence, that everyone should be treated exactly the same way. All the day from -- all the way from a patient who is one, two days old and is outside of the hospital and has an arrest, to the, you know, nine-hundred-year-old person; okay? So, initiate C.P.R. for infants and children with chest compressions rather than rescue breathings. And it's now C-A-B, not A-B-C. C.P.R.

should begin with thirty compressions for any lone rescuer or fifteen compressions if there are two healthcare providers, followed by two ventilations.

And if you think that this is like, well, this is such a weird thing, and we should really fight about this, I can tell you that if you look at the -- do the math, it's like an eighteen-second delay between giving the first ventilation and starting the compressions. I mean, it's only that short a time period. So, in the -- in the interest of not having the -- particularly the lay provider be confused about what they should do with pedes versus what they should do with adults, it was felt that this was the most reasonable way to go.

DR. HALPERT: Elise, the --

DR. VAN DER JAGT: Yeah.

DR. HALPERT: -- the science supposedly showed that that eighteen seconds different made a significant change in outcome?

DR. VAN DER JAGT: The -- there is no --

DR. HALPERT: I'm not challenging it, but --.

DR. VAN DER JAGT: -- there is -- there is no data on that.

DR. HALPERT: Okay.

DR. VAN DER JAGT: And it was done on a practical basis. And if you think about it, eighteen seconds, I mean,

you're never going to get data on that.

DR. HALPERT: Right.

DR. VAN DER JAGT: You'll never get data.

So the -- the issue was how do we make this as consistent as possible, particularly so that bystanders don't get confused, and in the process of -- of confusion, delay C.P.R., including C.P.R. on kids.

DR. HALPERT: Uh-huh.

DR. VAN DER JAGT: That was the issue. So, the thought was in the committee that eighteen seconds, we could live with that --

DR. HALPERT: Yeah.

DR. VAN DER JAGT: -- because that's what it ends up being.

DR. HALPERT: Okay. So, relative to adult standards, which you're trying to reperfuse a depleted --

DR. VAN DER JAGT: Correct.

DR. HALPERT: -- monocardium, not so much the --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- same thing here.

DR. VAN DER JAGT: That -- that's right. And the thing is, these are kids in cardiac arrest. That means they're already arrested, so that the -- the thought was, based on all the science that's available at least, and the practical idea

that, you know, people should do compressions and not be paralyzed and in fear that they would do the wrong thing, that, therefore, compressions one out over -- over ventilations.

Now, if the -- however, the child is in the NICU, and this should also probably apply to deliveries out in the field, I would think, it is still A-B-C for neonates in the hospital, in the NICU, okay, or the perinatal, peridelivery area, and the compression rate, as you know, is like -- is a three to one, which it has been for years. So -- so, there is that difference, and again, that's something that -- to -- to make that clear to the -- particularly the E.M.S. community, perhaps, at the time of delivery, you know, that if the baby is asphyxiated and needs compressions, it's not the C-A-B, it's A-B-C.

Secondly here, to achieve effective chest compressions, and there is data on this, actually, what is effective, there was a lot of discussion about this, the idea about how much compression, and it's at least one-third of the A.P. diameter, and it actually had measurements. And we actually had huge discussions about well, is it four centimeters, three and a half centimeters, four and a half centimeters.

And I think Ann would saying it's irrelevant. People are going to do what they're going to do. You know, they're going to do the best they can, and they're not going to measure

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half a centimeter, you know, so anyway, it is what it is. Four centimeters in infants, and five centimeters, which is the adult actual measurement as well.

The look, listen, and feel, as I said was also removed from the pediatric algorithm, because we're not --

MS. ROGERS: How are they --

DR. VAN DER JAGT: -- checking airways.

MS. ROGERS: -- assessing whether the patient is not -- is -- is in cardiac arrest?

DR. VAN DER JAGT: I'll show you that in a second.

MS. ROGERS: Okay.

DR. VAN DER JAGT: I'll come to that. Yeah. That's a good -- really good point. Really good point; okay? We're getting to -- in fact, right here.

MS. ROGERS: Oh, okay.

DR. VAN DER JAGT: So, if the infant or child is unresponsive, which means that they're not moving, they're just totally unresponsive, and not breathing, or only gasping, healthcare providers may take up to ten seconds of time to feel for a pulse. If within ten seconds you don't feel a pulse or are not sure, you begin chest compressions.

MS. ROGERS: But if they're -- they have to decide whether they're not breathing or not. They -- but they aren't doing look, listen, and feel to see if they're --

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DR. VAN DER JAGT: Nope.

MS. ROGERS: -- breathing or not?

DR. VAN DER JAGT: And that's --

MS. ROGERS: What are they --

DR. VAN DER JAGT: -- exactly right.

MS. ROGERS: -- just looking?

DR. VAN DER JAGT: They're just looking.

MS. ROGERS: Okay.

DR. VAN DER JAGT: Correct. Correct.

And I think again, it's -- it's the -- that there is no evidence that giving compressions to someone has some cardiac effect, that that is detrimental. So, the -- again, the feeling was, because of this, is that unresponsiveness, not visibly moving, obviously moving, obviously breathing, and only gasping, that those patients should still get compressions first; okay?

And then the pulse check is no more than ten seconds, and that's sort of the way it was the last time. Because healthcare providers, as well as bystanders or lay providers, are no better in feeling pulses in an acute crisis like this. And that's been tested, actually.

So, here it is, and I'm sorry for that. This isn't all that clear, but this is the pediatric B.L.S. for healthcare providers -- for healthcare providers. Note that. This is not for bystanders now. So, you've got an unresponsive, not

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breathing or only gasping, send someone to activate the emergency response system, to get the A.E.D., if there is someone else there. If there is no one else there, and it is not a sudden collapse, which would put you over here to get the A.E.D. first, before you start compressions, okay, you actually check for the pulse and you immediately go to compressions. And then, if you're still the lone provider, you've done thirty to two for two minutes, then you go and get the A.E.D., okay, so the only difference is that now is from one to two minutes. And then you move into the -- the rest of the dysrhythmia, which is no -- which is no different than the previous algorithm.

Let me think. I think that the rest is pretty much we discussed here.

Questions?

Yeah, Bob.

DR. KANTER: So, I obviously don't know these new guidelines as well --

DR. VAN DER JAGT: Right.

DR. KANTER: -- as you do --

DR. VAN DER JAGT: Sure.

DR. KANTER: -- but my quick reading through it, and it's not clear from what you said, is that for a pediatric patient --

DR. VAN DER JAGT: Yes.

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DR. KANTER: -- you give them chest compressions --

DR. VAN DER JAGT: Yes.

DR. KANTER: -- in general. But if you have a disorder or a situation where it's that a respiratory disorder was the primary problem --

DR. VAN DER JAGT: It doesn't --.

DR. KANTER: -- my understanding was that it's reasonable to begin with ventilation.

DR. VAN DER JAGT: It is not, actually. That's one, the -- the -- if the child is -- is in arrest based on these findings up here, unresponsive, not breathing, or only gasping, it is still compressions first.

DR. KANTER: Compressions first?

DR. VAN DER JAGT: Correct. And then ventilations. In other words, you do not open the airway, you do not give mouth -- give -- give two ventilations. And that's what's been very hard for people to understand. But that is exactly what is asking of us to do.

DR. KANTER: Well, there -- there's certainly some stipulation in the article, the pediatric A.L.S. article, that makes that --.

DR. VAN DER JAGT: Well, it -- it -- I think where the confusion is -- is that let's say it's up here and you feel a pulse, then the kid's technically not in cardiac arrest. Then

open the airway. Then use your A-B-Cs. And that is -- actually we've discussed that, because in -- I'm putting together the PALS manual and instructional materials, and done the algorithms. I mean, that's been discussed, that this could be where there's confusion, you know, if the child who has a respiratory arrest, basically, and then is not -- is -- is -- is not breathing and not gasping, then how do you then determine what it is; and that's where the pulse check comes in.

DR. KANTER: Well, we could probably recapitulate hours of your arguments --

FROM THE FLOOR: Yes.

DR. VAN DER JAGT: All I'm telling you -- all I'm telling you is what the consensus was, and that was an international consensus. So, I can refer you to the -- the -- you know, the science as best as I can, but -- but that is the -- the current understanding --

DR. HALPERT: And -- and that was --

DR. VAN DER JAGT: -- that is --.

DR. HALPERT: -- again, based on a scientific judgment, or a judgment of what --

DR. VAN DER JAGT: A combination.

DR. HALPERT: -- which --?

DR. VAN DER JAGT: Always a combination, and that's why these are guidelines --

DR. HALPERT: Right.

DR. VAN DER JAGT: -- you know. So there's the science. And remember that science is always less than you think. It's less than you think. I mean, than -- than you want to have.

DR. HALPERT: Well, that --

DR. VAN DER JAGT: You want to have more.

DR. HALPERT: -- that -- that goes back to our discussion this morning, which concerns me about utilizing things such as this as standard of care, and the law, and O.P.M.C. can find you --

DR. VAN DER JAGT: Correct.

DR. HALPERT: -- you know, liable for deviating or something --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- like that.

DR. VAN DER JAGT: And -- and that argument -- I mean, we've always --

DR. HALPERT: You know --

DR. VAN DER JAGT: -- struggled with that, right.

DR. HALPERT: -- and that -- that drives you up a wall.

DR. VAN DER JAGT: Yeah. Right. But I'm saying is what I was saying this morning however, was what we are doing here, in a group of ten people, we're setting up similar kinds

of standards, what we think should be in E.D.s and whatever. So here is a huge group, you know, who have looked at this --

DR. HALPERT: Sure.

DR. VAN DER JAGT: -- internationally, so that would probably carry a bit more weight. But they are still guidelines.

DR. HALPERT: Right.

DR. VAN DER JAGT: Because every individual patient is a little different.

DR. HALPERT: Right. The consensus is we'll do it this way because --

DR. VAN DER JAGT: But the consensus --

DR. HALPERT: -- due to the variety --

DR. VAN DER JAGT: -- is what you have.

DR. HALPERT: -- of responders, we'll have --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- an easier time --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- compressing versus opening an airway.

DR. VAN DER JAGT: That's right. That's right.

MS. CHIUMENTO: You know --

DR. VAN DER JAGT: But -- I'm sorry, go ahead, Sharon.

MS. CHIUMENTO: -- in the circulation here, and one of the things it also mentions is that it takes a few seconds to

put together a bag-valve mask or to get -- get -- get your -- get your oxygen --

DR. VAN DER JAGT: Absolutely.

MS. CHIUMENTO: -- you can do it right on the chest.

DR. VAN DER JAGT: Right.

MS. CHIUMENTO: So that's another reason for you to get --.

DR. VAN DER JAGT: And -- and the other thing is what has come up here. Remember, Bob, this is for -- particularly for you, this is for healthcare providers. So it's unusual to have only one healthcare provider, and that was another part of it, I know. Whether you're in a hospital or if you -- if you're E.M.S., you're going to have two people there by the time you get there; okay? So what happens, typically, is this is almost going to be simultaneous. You know, somebody's going to be on the chest, somebody's going to give breaths, and so it -- it may be just a bit of a moot point, rather than a significant change.

DR. KANTER: The -- the important thing is that there is very good objective evidence for the adult, that compression-only C.P.R. is slightly more effective than conventional old --

DR. VAN DER JAGT: Uh-huh.

DR. KANTER: -- C.P.R. with ventilation.

DR. VAN DER JAGT: Right.

DR. KANTER: And that the sooner you begin, and the less you interrupt, the chest compressions, the better the outcomes. That's --

DR. VAN DER JAGT: Uh-huh.

DR. KANTER: -- that's --

DR. VAN DER JAGT: Uh-huh.

DR. KANTER: -- clear from the scientific, objective evidence. The difficulty for -- for -- our job, our difficult job --

DR. VAN DER JAGT: Right.

DR. KANTER: -- is trying to train pediatric people --

DR. VAN DER JAGT: Right.

DR. KANTER: -- about this change --

DR. VAN DER JAGT: Right.

DR. KANTER: -- where there is not good evidence --

DR. VAN DER JAGT: Correct.

DR. KANTER: -- for the pediatric patient.

DR. VAN DER JAGT: Right. No, and -- and -- and that is absolutely correct. There is no denying that. I think what -- what -- the way I would sell it, or not sell it. It -- I mean, I think it's -- is the time frame, and with healthcare providers especially, you're essentially doing it at the same time. I mean, you're not spending a lot of time in nonventilation. You know, that's what you are doing. So, I

think that's what the part I think that is -- is an important part of having -- at least improving the understanding of it.

And we will probably never get information on, you know, the hands-only C.P.R. with children. I -- I just don't think it's going to happen. I just don't think -- I think that's a very difficult study to do.

FROM THE FLOOR: Not a big enough sample size either, so --.

DR. VAN DER JAGT: Correct. It would be very hard to do.

So then this is the cardiac arrest algorithm, which is -- and many of you recognize it. It is a -- it looks different than probably the one you've learned in PALS, or if you've seen from PALS. A couple of things, and again, you can't read this and I'm sorry, it's just -- it's very small print, and I -- you'd have to look at the manual. There is an E.C.C. handbook, by the way, which is already available for purchase, which you can obtain.

But here are a few things that you probably do need to know here, okay?

So, the C.P.R. for two minutes. C.P.R. for two minutes, and the -- the -- in this area through here, you will note, if you could read this, but you will not be able to, okay, that in terms of shock energy is where the next big change is.

So, the energy change has been, and I think I actually have it on the next slide, perhaps. Hang on a second here. Here we go.

Initial dose of two to four per kilo, which is really what's been -- currently been done. An initial dose of two per kilo may be used because it's easier to remember, that's the only things that -- to take away the range, but there is no data on this.

FROM THE FLOOR: Sorry, could you give me that in pounds, please?

DR. VAN DER JAGT: In pounds, right. There you go.

For refactory D.F. it is reasonable to increase the dose. Now, here is a difference; here's a new part: Subsequent energy levels should be at least four per kilo, but higher energy levels may be used, up to ten per kilo, or up to the adult maximum.

And there is data on this, actually. There's data, there's -- there's fairly good animal data on this especially, where the -- the young animals myocardium is certainly very more resistant to these high -- the injury from -- from this high amount of electricity. And there's also child data on patients who have -- have actually been defibrillated with very high doses, up to ten per kilo, where there was not, on autopsy, been shown to be significant myocardial damage. So, the thought is that probably in pediatrics we are underdoing this, rather than

overdoing this. So, that was a -- quite new actually, and it was very, very interesting. We've -- there --

DR. HALPERT: Improved --

DR. VAN DER JAGT: -- there are a number of -- I'm sorry.

DR. HALPERT: -- higher rates of cardio -- of conversion utilizing higher energy levels?

DR. VAN DER JAGT: Of defibrillation.

DR. HALPERT: Yes.

DR. VAN DER JAGT: Yes, that is correct, and that is correct. So, it -- and that they -- they were sure they didn't want to go right to four or six or eight per kilo, but in these escalating doses, because clearly in two per kilo, two to four per kilo, you're going to get a percentage of kids who are going to --

DR. HALPERT: Uh-huh.

DR. VAN DER JAGT: -- turn around from that. But this was the -- was the -- the consensus at this point.

The other major change was -- was that although a manual defibrillator was preferred for infants for defibrillation, now an A.E.D. equipped with a pediatric dose attenuator is also okay to use in that first year of life for infants. And if neither is available, an A.E.D. without a pediatric dose attenuator may be used, as well.

So, as you may remember, the heart -- the old A.H.A. guidelines for 2005, it was below one year of age you didn't use an A.E.D., including the pediatric-capable A.E.D., and now that's gone away. So, that can be done, and that's -- particularly would be relevant, again to E.M.S. providers on the outside, I think, especially basic E.M.T.s, that this can be done. Preferably a pediatric one, but if necessary a nonpediatric one could also be used.

A couple other things here. The issue about calcium administration, and for -- for A.L.S. that would be, and also for, obviously E.D. and in-hospital. Again, a -- even a stronger statement that it is not recommended except in these situations. So it is not a routine med. It should not be given. And it may be harmful. There is some data on there, apparently, that it could be harmful.

Here is another one that it would be relevant to many areas. And I -- there was actually -- there were worksheets on this. There was science presented on this about what was appropriate size for endotracheal tubes. First, to confirm again, that cuffed endotracheal tubes can be used in all ages, including pediatric patients and infants and neonates. The sizes that came up with -- out of these worksheets, which were well examined, were a little surprising to me actually, to be honest. Because that means a four millimeter tube up to two

years of age, for an uncuffed tube; and a three and half with the cuff up to two years of age. And if you may remember, most of the time it was up to one year of age, and then you sort of -- you know, you -- you start getting a little bit bigger tube size. But this is actually in the guidelines, and should be used. It is qualified in the guidelines also, by saying clearly you need to a tube that's smaller and a tube that's larger, you know, to -- easily available to you.

Here is a little bit about the end-tidals that can effect capnography. And this is a big deal, I think. The -- this is basically a capnography waveform. It's basically measuring the end-tidal C-O-twos continuously before intubation. If the person's intubated, you get this sort of, you know, waveform, obviously, and you can see the level here. So, this is zero to twelve point five, so maybe five or six. They do C.P.R. It maybe the end-tidal C-O-two is now sort of in the twelvish range. What you want to do is to get it above -- at least above ten, and probably above fifteen, to get the best possible evidence that you are to doing good cardiac compressions.

And then once there is return to spontaneous circulation, obviously pulmonary blood flow increases, and you get an -- immediately -- almost immediately -- within a few breaths, you will get evidence of a higher concentration of

end-tidal C-O-two. So this is something that is recommended for all patients who are intubated, who are --

Doctor --

DR. VAN DER JAGT: -- undergoing cardiac arrest.

MS. GOHLKE: -- Dr. Van der Jagt?

DR. VAN DER JAGT: Yes.

MS. GOHLKE: Do you know if the E.T. tube size coincide with the national equipment guidelines that were put out --

DR. VAN DER JAGT: You know, I --

MS. GOHLKE: -- last year?

DR. VAN DER JAGT: -- don't know that. We should --.

MS. CHIUMENTO: It should, because it doesn't -- the guidelines did not recommend for a particular age group. They just recommended a range, and I believe that -- that all those sizes would be in there --

DR. VAN DER JAGT: So they're all -- okay.

MS. CHIUMENTO: -- if I'm not mistaken. It seems like --.

MS. GOHLKE: You mean the number that you should have on -- on hand, I wonder also?

MS. CHIUMENTO: We always -- always had between an infant and a premie.

DR. VAN DER JAGT: Yeah. I mean, the -- the sizes are all going to be there.

(Off-the-record discussion)

MS. GOHLKE: No, they're not -- I mean, they just say, you know, you only need one E.T. tube between this size. So if you have two recommended sizes for --.

DR. VAN DER JAGT: Oh, one for cuffed and one for uncuffed, is what you're saying.

MS. GOHLKE: No, no. They -- the guidelines say, you know, you only need, you know, one tube between the size of two millimeters and four millimeters. I mean, I'm just throwing out an example. I'm not sure if it says this exactly, but they -- they say you only need one tube between those sizes. I'm just wondering if --.

DR. VAN DER JAGT: You know, I think -- I think the one thing about those tube sizes is that, remember, they are guidelines. It's a starting point. And it's very clear, even in the guidelines, to have one smaller and one larger, so there was some flexibility, clearly.

MS. GOHLKE: Yeah, but I think the guidelines -- the national guidelines that were put out last year say you only need one tube between a range of four millimeters. So, if that's saying you need two tube sizes within four millimeters, it wouldn't coincide. I was just wondering if there was any comparison to the national guidelines list.

DR. VAN DER JAGT: I -- I don't know. I don't know.

1 EMSC, 11-30-2010
2 MS. GOHLKE: Probably not.
3 DR. VAN DER JAGT: I'd have to look at it. I mean, I
4 just don't know.
5 DR. HALPERT: A small point to put towards Bob and
6 Elise also, just in terms of this whole cuffed tube --
7 DR. VAN DER JAGT: Uh-huh.
8 DR. HALPERT: -- situation, probably for many providers
9 in New York State, cuffed pediatric tubes are a relatively new
10 concept.
11 DR. VAN DER JAGT: That is correct.
12 DR. HALPERT: Any guidance regarding cuff inflation
13 pressures for those very small tubes, as --?
14 DR. VAN DER JAGT: Well, there typically should be no
15 more than about twenty --
16 MS. CHIUMENTO: There's no real --
17 DR. VAN DER JAGT: -- millimeters of mercury.
18 MS. CHIUMENTO: -- of the cuff though; right?
19 DR. VAN DER JAGT: No. There is no evidence also that
20 cuffed tubes are better than uncuffed tubes.
21 DR. HALPERT: Okay.
22 DR. VAN DER JAGT: So, you could use either.
23 DR. HALPERT: Okay.
24 MS. ROGERS: These are really a lot smaller than we
25 usual put in.

1 EMSC, 11-30-2010
2 DR. VAN DER JAGT: They are. The -- I think, not for
3 the first year of life, but that one-to-two year of age, that
4 they're small tubes, you know, and -- and I -- but the -- the --
5 the data's what it is. I mean, that's all I can say, you know,
6 and I did not do the worksheets on this one, but there is that
7 data on that, and what constitutes a reasonable size, but -- I
8 don't know. My -- only my own experience is -- is that if I
9 have a two-year-old, I don't start with a three and half or four
10 tube, you know, I'll usually start with a four five tube or
11 something, or even five, you know, so --.
12 FROM THE FLOOR: You're going to get air leak, you'd
13 think.
14 DR. VAN DER JAGT: Well, again, the -- I'm just
15 presenting the data, okay. What I'm telling you -- I -- I was
16 only asked to -- to present the guidelines.
17 (Off-the-record discussion)
18 DR. VAN DER JAGT: I wasn't asked to defend everything
19 that was said.
20 (Off-the-record discussion)
21 DR. VAN DER JAGT: What's that?
22 FROM THE FLOOR: Only in front of O.P.M.C., my friend.
23 FROM THE FLOOR: Exactly.
24 FROM THE FLOOR: I said it out loud. I'm not --.
25 DR. VAN DER JAGT: But I -- but I will say that there

1 EMSC, 11-30-2010
2 was a lot of discussion on this, and there is actually a fair
3 amount of evidence on this. So if you look at, actually, these
4 things, but most of those evidence is not an acutely ill
5 patients. It's in anesthesia patients, and I think it's a
6 different kind of patient, you know?
7 FROM THE FLOOR: Uh-huh.
8 DR. VAN DER JAGT: So, I'm not sure where it totally
9 crosses over into --
10 FROM THE FLOOR: You mean those unprepped airways
11 versus those prepped airways.
12 DR. VAN DER JAGT: -- you know, the stable kid who has
13 no lung disease, that kind of thing, so --
14 FROM THE FLOOR: Even twelve hours.
15 DR. VAN DER JAGT: Yeah. And -- and -- and issues like
16 that. So --
17 FROM THE FLOOR: Big difference.
18 DR. VAN DER JAGT: -- all right. Let's keep going
19 here. Okay.
20 Here's the bradycardia algorithm. I really think it --
21 they're -- it is essentially the same. The only difference is
22 that the considered transthoracic pacing is now formally really
23 in the -- in the algorithm, for patients who are intractable
24 with respect to epinephrine and atropine administration.
25 This cricoid pressure is also in the PALS guidelines.

1 EMSC, 11-30-2010
2 There's insufficient evidence to recommend routine cricoid
3 pressure application to prevent aspiration during endotracheal
4 intubation in children, so that has an effect on R.S.I. And do
5 not continue cricoid pressure if it interferes with ventilation
6 or the speed or ease of intubation, okay.
7 So remember this as there is insufficient evidence. It
8 does not mean you should never do this, but there's not enough
9 evidence to say that this should be routine.
10 There was a lot of discussion about etomidate.
11 Etomidate has been around the literature. I'm quite sure those
12 of you who deal with this like I do have read a fair amount of
13 that, actually probably. It clearly is done -- etomidate is
14 like, almost our standard drug for intubating in I.C.U. But
15 just to remember that there is data that if it's -- a child had
16 sepsis, that it has been associated with adrenal insufficiency,
17 and so in that situation, looking at the science on that, and
18 the series on that, it was not recommended for routine --
19 routine -- again, routine use in patients with evidence of
20 septic shock. So, that was on etomidate, and I believe that's
21 also true in adults. I think it's -- I can't remember now, but
22 in pedes for sure.
23 Then in the -- also pulses -- V-TAC with poor profusion
24 but with a pulse. Note the only difference I would say here, to
25 point out here, is that lidocaine is not formally in this

algorithm or in the algorithm for V-FIB. However, if you look at the actual guidelines, lidocaine is mentioned as an alternative, but it is not preferred to amiodarone for these indications. So, there -- that's a much stronger statement than amiodarone. And there is some adult data on amiodarone versus lidocaine, but again it's been interpolated for pediatric patients.

Another very interesting part here, oxygenation. There is increasing literature that's coming out here on the toxicity of oxygen, both in the perinatal sort of period, as well as in adults. There's -- actually I'm aware of one study at least where that was mentioned, and it was fairly recent, of adults who had P.O-twos of over three hundred, that the mortality of those patients was greater -- I.C.U. patients, was greater than if they were in a more normal range, so the -- the idea here is that this is postarrest. Once the circulation is restored, obviously do oximetry, titrate O-two administration to maintain the O-two sats greater or equal to ninety-four percent. And because a hundred percent, it could be who knows where that P.A.-O-two is. The recommendation is that it should be, you know, weaning oxygen to one hundred -- down, so that the saturation actually gets to be ninety-nine percent. So, it's great -- so it's going to be between ninety-four and ninety-nine percent, because once you get to a hundred, you -- you don't

know where you are. So, and that was because of oxygen toxicity.

And remember that correlates a little bit, or is analogous in the deliver room. And I think this was already in 2005, that bagging in an asphyxiated patient begins with room air, and then moves up if the patient does not improve their oxygenation. So, it's -- it's an interesting concept. You know, hyperoxia is potentially detrimental.

Hypothermia. There have been no published results, of course, of prospective randomized pedes trials of therapeutic hypothermia. There is currently a large trial underway. But based on adult evidence, therapeutic hypothermia may be beneficial for adolescents who remain comatose after resuscitation from a sudden, witnessed, out-of-hospital V.F. Therapeutic hypothermia may also be considered for infants and children who remain comatose after resuscitation from cardiac arrest not due to V-FIB.

So you can use it. There is no data, however, in pediatric patients, and so it was not strong enough to say you must use this. It was clearly in the middle. There -- I mean, there is no data on -- in pediatric patients. But if you use it, it is certainly within the realm of reason to use it.

MS. FITTON: Is there any --

DR. VAN DER JAGT: Yeah.

MS. FITTON: -- discussion about using hypothermia during cardiac --?

DR. VAN DER JAGT: There -- there is no data. There is no data in pediatric patients. There was discussions, I -- I suspect, on the adult side especially. I was on the pedes side. But because there's no data, it's hard to discuss it.

So the -- this is interpolated data from evidence from the adults. And some evidence from hypothermia used in asphyxiated newborns, and those were the two -- and animal data. And those were the three reasons why this came up as it is reasonable to do it, but there is no data. And actually, there have been some -- some other studies that have come out that suggested that there is no difference when you use it, and it may all be from the avoidance of fever, rather than inducing people to be, you know, at a low -- at a low temperature. Kind of interesting.

DR. HALPERT: Are any centers that you're aware of doing T.H. on kids, or no?

DR. VAN DER JAGT: Yeah. Well yes, there are. There is actually -- there's a large trial underway of now, I think, thirty-four hospitals, children's hospitals, who are doing a randomized --

FROM THE FLOOR: Nationally.

DR. VAN DER JAGT: -- control -- control trial over a

six-year period, of children who come in post-arrest -- post -- yeah, post-arrest, and who require mechanical ventilation or are comatose.

DR. HALPERT: You guys are not?

DR. VAN DER JAGT: Actually, we are. Are you guys on it?

DR. KANTER: Given the fact that --

DR. VAN DER JAGT: I don't know.

DR. KANTER: -- hypothermia is beneficial in the --

FROM THE FLOOR: Yeah. I am.

DR. KANTER: -- adult and the newborn --

FROM THE FLOOR: Yeah. Absolutely.

DR. KANTER: -- I'm surprised that anybody can get that study past an I.R.B.

DR. VAN DER JAGT: I -- I'm sorry. What's that again?

DR. KANTER: Given that there's proven benefit for the adult and for the newborn, I'm surprised anyone can get that randomized trial past --

DR. VAN DER JAGT: Right.

DR. KANTER: -- an I -- I.R.B.

DR. VAN DER JAGT: Well, there's also -- there is data on the pediatric side that suggests that it is not helpful. Actually there is -- there is retrospective studies in Pittsburgh; there is one from Canada, which is a multi-center

trial that -- retrospective. There's no prospective. Retrospective that there is no difference in outcomes if the therapeutic hypothermia is used. So, there is that data. There is some concern, obviously, about the adverse effects of therapeutic hypothermia. There's always that -- that part of it. But all the I.R.B.s have to sign off, including our own. I mean, they all have. So -- because there is no data, and it seems like you can test it.

Now, just -- while you're at that, there was an interesting trial in Australia, by the way, that just came out, where they actually did a double-blind placebo-control trial of epinephrine in cardiac arrest. And they --

FROM THE FLOOR: Don't go there.

DR. VAN DER JAGT: -- I was -- that was -- I was surprised --

FROM THE FLOOR: Don't go there.

DR. VAN DER JAGT: -- they got by the I.R.B. and they aborted it halfway through because they found out that epinephrine patients did better. So --

FROM THE FLOOR: Good.

DR. VAN DER JAGT: -- how they got that passed, I am not -- it was adults. Okay.

Anyway, here we go. Sudden, unexplained death -- there's a guideline about -- to make sure that as much

investigation is done, including autopsy, tissue pathology.

Single ventricle, there's a large section -- a fairly large section now on single-ventricle cardiac sort of physiology, and that, in this case, standard arrest resuscitation procedures should be done. There are a lot more kids presented to emergency departments now who have had surgery, for cardiac surgery. End-tidal C-O-two is not a reliable indicator in many of these patients, because their blood flow is not consistently going through the lungs, there's a lot of shunting.

And then for patients who have had single-ventricle repair, or a Fontan, cardiac arrest, moving right into ECMO -- ECMO arrest/cardiac arrest -- is -- should also be considered.

The neonatal -- I -- I told you about this already. Continue with the A-B-C and the three-to-one compression ratio. Pulse oxymetry is a very similar idea as oxygenation issues, as we -- I just mentioned to you in pediatrics.

And that's it. I'm sorry, Art. That's -- that was the last slide.

But are there any questions about that? That's sort of, in a nutshell, some of the changes that are there.

DR. COOPER: I'd like to ask -- or thank Elise for his usual incredibly thorough detailed presentation, with the appropriate color commentary about what took place on the

committee, always very, very interesting.

Any questions for Elise?

(No audible response)

DR. COOPER: Well, Thank you very much.

I think this does bring one issue to the -- to the fore, namely that we now have an outdated reference card out there with respect to pediatric resuscitation, and I have no doubt that our master of the -- of the -- of the cards will -- will be on it.

MS. CHIUMENTO: I think there's not that much. There's --

DR. COOPER: Yeah.

DR. VAN DER JAGT: A few things, but --.

DR. COOPER: There's just a few things that need to changed, yeah.

DR. VAN DER JAGT: And the -- and the other thing that I do think -- oops -- the other thing is that the -- the question of that capnography, I know that quite a few E.M.S. providers carry capnographs now, or capnometry at least. Am I -- am I right about that, or am I --

FROM THE FLOOR: Yes.

DR. VAN DER JAGT: -- wrong about that?

FROM THE FLOOR: If they're --

MS. CHIUMENTO: Any A.L. -- any service that can

intubate has to have it.

DR. VAN DER JAGT: Right. So -- so, my -- my question is only -- and it -- maybe it's not for this meeting, Art, because it -- I know we're running out of time, but some question about whether something about that should be put into guidelines. And maybe the adults are already considering that, you know, using capnometry as a way of assessing the adequacy of C.P.R.

DR. COOPER: Yeah, it's my understanding that these guidelines actually don't go into effect until March, at least that's what we're being -- that's what we're being advised, from the Heart Association, actually.

DR. VAN DER JAGT: They're -- I'm sorry?

DR. COOPER: That the guidelines -- the new -- the new guidelines and the new teaching is not supposed to go into effect until March. That that's -- that's what I've --

DR. VAN DER JAGT: Okay. So, let me explain to you what that means, for the people who may not know that.

The B.L.S. guidelines, the teaching materials for B.L.S. courses appear in the first part of 2011. The A.C.L.S. materials for courses, formal teaching, is available in the spring of 2011. And the PALS course materials are to be available in the June-July sort of period of next year. So, it's not that the guidelines are not --

DR. COOPER: Right.

DR. VAN DER JAGT: -- in effect, it's just that the courses teaching the guidelines will not be fully available until next year.

DR. COOPER: Okay.

DR. VAN DER JAGT: Okay?

DR. COOPER: Good.

DR. VAN DER JAGT: But the guidelines are out there; they are to be --.

DR. COOPER: Of course they are. Sure. Sure. Sure. Of course.

Okay. We have just a few items left on the agenda.

The STAC has not met since we met, so there won't be any report from the STAC.

I'll ask Jan and Sharon to give an update on SEMAC, if there is an update to give. And then I will ask Sharon to go through her interfacility matrix document from the Education Subcommittee.

I -- I must apologize to you all. I -- I have to catch a plane out of LaGuardia at seven-thirty to go to a meeting down in Tampa, Florida. It's the absolute latest plane I could get, and I -- I tried to get a flight out of here, out of Albany, but I couldn't. One flight a day, and it left at eleven or one o'clock this morning, something along those lines. So -- so,

I'm going to ask Bob Kanter if he would just chair the remainder of the meeting.

Is that all right, Bob, or the --?

DR. KANTER: Sure.

DR. COOPER: Okay. All right. Well, thanks so much, and I -- I apologize for missing the last few minutes, and I'll get an update from Martha in the next day or two.

So thank you all so much. It's -- you know, hope you all had a great Thanksgiving, and wish you all a very, very happy holiday season. Okay. Take care. Thank you.

DR. VAN DER JAGT: Our Thanksgiving's over; is yours coming?

DR. COOPER: Huh? I think I missed that.

DR. VAN DER JAGT: I think you meant Christmas.

DR. COOPER: Yeah, I think I did.

DR. VAN DER JAGT: Have a safe trip.

MS. CHIUMENTO: All right. Why don't I go ahead and do the SEMAC update?

The -- primarily -- a couple of things we worked on at the last meeting that relate somewhat back to here, this Committee: I had presented a comparison, by request of Dr. Henry, comparing the old New York State A.L.S. protocols that were developed in 1993, and -- with the current practice. I actually did a grid across all of New York State's protocols,

went online, looked at everybody's protocols, developed a grid to see what drugs were out there, what procedures were being done, everything, and what levels were doing those particular procedures.

Based on that, we -- I will be now working on updating the old standards for the next meeting. They decided they really didn't want to go with the -- with the protocol that we had developed before, feeling that there was just too many variations. So, I'm going to actually just kind of update the old standards with a kind of a bullet-point kind of a thing. And so hopefully we'll have that ready for the next meeting.

Paul Bishop from the Rochester area did a wonderful presentation on safety in the ambulances. There's been a lot of discussion about that recently, about, you know, what -- should we be seat-belted all the time; what procedures are acceptable to being doing -- done in a moving ambulance versus pulling over to the side of the road, or doing it before you get started, for the safety of the E.M.S. personnel, as well as the patient, so you don't go throwing -- getting thrown through the air if there's a sudden stopping of the vehicle. So -- so they now made some additional recommendations in the future.

There's been a lot of issues with drugs. Some of the drugs not being available, not only in E.M.S., but also in the hospitals, so there was a lot of -- of discussion back and forth

about alternatives, and how we -- how you handle a particular drug shortage in a region, and what you could use as an alternative in your protocols, and whether or not you then have to have those protocols vetted, since they were only a temporary measure. And so, basically, we kind of said, you know, you do what you have to do.

There was also -- there's been a continue -- continuing discussion on whether or not nonphysicians can do medical control, so in those mountain regions, rural regions, where there's a P.A., there's an N.P., somebody else on duty, there is no medical-control physician, what do you do? And so, that -- that's a continuing discussion. There has been no final decision's made on that.

And then -- and then also they will be also looking at the A.H.A. standards for -- across the board, so I'm sure that they will be glad that we have -- are looking at the pediatric ones as well.

That's it.

MS. BURNS: You forgot one.

MS. CHIUMENTO: I forgot one? Oh, what did I forget?

MS. BURNS: There -- there was lengthy discussions about the new changes to the Vehicle and Traffic Law regarding the drawing of blood alcohol levels by prehospital care providers.

MS. CHIUMENTO: Oh, yeah.

MS. BURNS: That, after speaking with the Department's attorneys at great length, the bottom line, though unpopular, is that the -- the way that the law is written, that the E.M.S. provider, the advanced E.M.T., actually falls outside of medical control, and a police officer may request an advanced E.M.T. to draw blood. What they say is that an advanced E.M.T. may choose not to draw blood, but to be honest with you, I don't see that happening.

So, we're working with our -- with the state police and -- and Mike Daly here in the Capital District, and -- and the police department -- the Nassau County police on a training program. Because a real big -- my big -- there were -- the physicians had a lot of liability concerns, because it-- although the lawyers disagreed, you know, is prehospital provider a delegated practice, and technically it isn't, but they operate under medical control, and any A.L.S. credentialing would be provided by the physician medical direction, so -- but my real concern is more practical.

And that is, and I think I may have said that to -- to you at the last meeting, if I am not appropriately trained to draw blood and a police officer requests and I do it, I taint his arrest, and therefore, his conviction. I am concerned about that. So we're working with Gary Faruchi (phonetic spelling)

from Nassau Police Department on a training program we can post and be used at the local level. So that will be kind of an ongoing.

I know the -- the SEMAC was very worked up about it, appropriately, and then SEMSCO, also. And the SEMAC put together a small group of physicians to look at some of the issues. And I've been in touch with a couple of them so far.

DR. HALPERT: The -- the last state E.M.S. -- or state ACEP/E.M.S. Committee meeting, that topic was very contentious as well. The consensus was, you know, the law's the law kind of a thing, so we've got to figure out a way to -- to do it, but there was no consensus beyond that --

FROM THE FLOOR: Right.

DR. HALPERT: -- in terms of what people believed or supported or thought was right.

MS. BURNS: I mean, at -- across the state, actually in central New York, Dr. Kanter, but there has been some instances where the REMAC has said we do not -- the drawing of -- the prehospital drawing of a blood alcohol is not in the protocols, and therefore you can't do it.

And we have had a provider do it at the request of -- of a police agency, and now the -- there's kind of a Q.A. head -- butting of heads at the local level, which the SEMAC will be presented with at their next meeting.

DR. VAN DER JAGT: I -- I have to say that I -- this just -- just really disturbs me, because it also deals, of course, with pediatric patients. I mean, we have pedes patients in this -- in this cadre of -- of issues, but it's really -- if it's not medically indicated, it is purely for, you know, legal issues --

MS. BURNS: Absolutely.

DR. VAN DER JAGT: -- then we're basically doing something that is not medically indicated for that care of that patient, and that falls outside of the purview, I think --

MS. BURNS: It's bigger --

DR. VAN DER JAGT: -- of what we are --

MS. BURNS: -- than that.

DR. VAN DER JAGT: -- to do.

MS. BURNS: -- actually. You may be requested to go to a local lockup, or a police officer may show up on your station doorstep and ask you to draw blood. Not only is it not medically indicated, there's no patient relationship.

FROM THE FLOOR: Exactly.

MS. BURNS: There's no patient.

DR. VAN DER JAGT: I mean, I call it a prostitution of the medical profession, and I -- and I think that that's really wrong. I mean, I -- I don't think it's right. They should have -- they should have their own technical people then, to do

what they need to do, but it should not fall under the medical licensure of the physician who's in charge of that, or the certification of the E.M.S. provider. That's just -- just I don't --.

MS. BURNS: The lawyers in the Department now believe that it affects the physician licensure. The -- my big concern, on -- on the broader picture, as a prehospital care provider, is that -- and I -- I was promptly put in my place, really, because I'm -- I'm, you know, ignorant about this stuff, but I think -- as I -- as I looked at it in the biggest picture, we -- we, the prehospital care provider, practice under medical control, and our protocols are developed by a -- based on a standard of care by physicians. When -- the way that this law is articulated, it now takes me, as a prehospital care provider, who operates under medical control under Public Health Law, and it removes me from Public Health -- from the -- the constraints or boundaries of my -- my section of Public Health Law, Article 30, and tells me that I can draw blood.

So my next -- because I'm a visual person, my next leap of concern was what's to suggest that a legislature wouldn't think that a paramedic could do open cardiac massage? And so now, that's not part of my practice, and -- but if you legislate it, and you train them --.

DR. HALPERT: Well, if you license them and then

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2 legislate what that all --.
3 MS. BURNS: Oh, you used the L word.
4 DR. HALPERT: I know. Well, that -- that -- that's
5 really what addresses --
6 MS. BURNS: I'm not --
7 DR. HALPERT: -- this kind of problem.
8 MS. BURNS: -- above smacking you.
9 DR. KANTER: Well, can -- can --?
10 DR. HALPERT: You know, that's what -- that's what the
11 issue comes down to, if you license them, and then delegate
12 through that licensure process, or delineate through that
13 licensure process, all that they can and cannot do, that is the
14 other -- that -- that's the other side of that coin. But the
15 way it's currently couched, it's very difficult to do that,
16 although I, personally, I will come out on the opposite side of
17 that coin. I will do anything that it takes to keep drunk
18 drivers off the road --
19 DR. KANTER: Can -- can --
20 DR. HALPERT: -- and locked away.
21 DR. KANTER: -- can I suggest this?
22 DR. HALPERT: I'm very much in favor of that aspect
23 of -- of what we do as --
24 FROM THE FLOOR: No.
25 DR. HALPERT: -- public safety and public service, and

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2 public health, and that we --.
3 DR. KANTER: Can I suggest that some of the legal
4 discussion may be beyond the scope of --
5 DR. HALPERT: Sure.
6 DR. KANTER: -- this group. It is worth pointing out
7 that some of our obligations with regard to public health are a
8 little different than our obligations as healthcare providers to
9 individual patients, but since the law is what it is, you know,
10 the question is how do you implement it, and --.
11 MS. BURNS: And we'll -- we'll --.
12 DR. VAN DER JAGT: But it affects not only E.M.S.
13 providers, because the next step is the policeman comes to the
14 E.D. and says, "I want you to draw blood on this patient."
15 MS. BURNS: They do that now.
16 FROM THE FLOOR: But that's the law. That's --.
17 DR. VAN DER JAGT: They do it now?
18 MS. BURNS: Yes.
19 FROM THE FLOOR: But typically --
20 DR. VAN DER JAGT: I didn't know that. I'm glad I'm
21 not down there.
22 DR. HALPERT: -- the physicians don't involve
23 themselves in that -- in that practice. The nurse draws the
24 blood with a kit. There's no chart generated, there's no
25 assessment performed. It's just a physical -- it's a -- it's a

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2 task.
3 MS. BURNS: And that's not an EMTALA violation?
4 DR. HALPERT: EMTALA means patient.
5 MS. BURNS: But COBRA, sorry.
6 DR. HALPERT: COBRA? I don't know. That's a good
7 question.
8 MS. CHIUMENTO: And one of the fundamental things we
9 teach people -- one of the fundamental things we teach people is
10 that they need to have consent. Where's the consent?
11 DR. HALPERT: You sign your license.
12 MS. FITTON: Where is the consent? There is no
13 consent, and -- and -- and the --.
14 MS. BURNS: But there may not be a patient.
15 MS. FITTON: I -- I -- but we're not really allowed to
16 touch anybody without their consent. And -- and hold on one --
17 one -- let me -- in the oath of Geneva, don't we say that we
18 will not use -- we will not make use of our medical knowledge
19 for -- for any purpose other than the patient's well-being? I
20 mean, I think that there is really an ethical issue that's --
21 that -- that we're getting sucked into, that -- that we don't
22 really don't need to. I mean, there's enough problems when we
23 deal with people who are emotionally disturbed, who present a
24 danger to themselves or to others. Are we saying then that
25 someone who is suspected of being intoxicated falls under that

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2 same umbrella --
3 MS. BURNS: I -- I don't know.
4 MS. FITTON: -- so we need to intervene?
5 MS. BURNS: I -- it is ongoing. The SEMAC has -- you
6 know, it has a group of physicians who are going to prepare some
7 questions and positions for the Department to review.
8 I will tell you that -- that the Department's house
9 counsel has reviewed this, and while the Department is certainly
10 interested in hearing what the physicians have to say, and if
11 given the -- you know, the opportunity -- an appropriate
12 opportunity, they will share it with the legislature. But as it
13 stands now, it is in effect.
14 DR. KANTER: You know, we -- we have about thirty
15 minutes left. I really think it would be important to get on to
16 Sharon's summary of the transfer guidelines, unless there's a
17 strong feeling that we want to continue this discussion.
18 (No audible response)
19 MS. CHIUMENTO: All right. You all have a copy of the
20 transfer matrix in your folders there. And I also sent it out a
21 couple of times in the last couple of weeks, so I'm hoping that
22 some of you at least did have a chance to look at it.
23 Just to kind of give you a little bit of background on
24 this -- basically, oh, back when we were first talking about
25 interfacility information, and Dr. Kanter presented his

wonderful white paper there, we -- we decided that we needed to move forward to develop some educational tools for hospitals and others -- clinics, other people who might be sending a patient into the hospital.

And so, based on that, I and the rest of the Education Committee, Jan and Ann being prominent members there, kind of looked at some material, trying to decide what kinds of things we would want to include in an information packet. And so you'll see on the very first page all the bullet points at the top. Those were the things that we thought should be included within the document.

And so for each of those bullet points there is at least a paragraph in this document, describing or discussing of that particular need, and -- and how somebody who is -- has a pediatric patient that they're not quite sure what to do with, might make some decisions as to whether or not the patient needs to be transported, if so, how do they need to go to the hospital? Which hospital should they go to? And you know, what -- and what stabilization -- what steps need to be taken before they go? So all those pieces of information -- and so what -- that was basically what this document was to be.

And in some ways I think we're kind of putting the cart before -- before the horse in talking, you know, about these different levels and things like that. What I did with this was

I based it on the information that is currently on the New York State Department of Health Web site. So I used who they decided were pediatric hospitals, who they decided were PICUs, who they decided were NICUs.

But in -- but having had a discussion with Dr. Kanter at the last meeting, you know, recognizing in some cases people may have beds -- certified beds, but that doesn't mean, necessarily, that those beds are staffed or are running full time. And so what I did was -- and when -- whenever there's an indication of a PICU or a -- of a pediatric unit, I put a little asterisk indicating if they had less than five beds, figuring that -- kind of -- kind of you had six, then I had five, so it was just -- and I was -- almost went with six, so we were on the same wavelength.

So, basically saying yeah, if they've got less than five or six beds, they probably don't have a full service PICU, and so you should at least be aware of that.

And then, also Mike also had sent me a little note as well, and -- and so what I did was I did a little bolded, and unfortunately I don't have page numbers, and I apologize for that. At the beginning of the pediatric, and at the beginning of the medical, it's -- I did put a note, bolded, "It is important to note that although the following hospitals were listed on the New York State Department of Health Web site," and

I gave the Web site, "there is no verification of whether the units are specifically dedicated to pediatrics, or if are adult units with pediatric beds or capabilities." So hopefully that will, again, alert the people to -- no?

MS. GOHLKE: Well, you're assuming people read --

MS. CHIUMENTO: Well, I know.

MS. GOHLKE: -- and then my other concern is that you're assuming that the Web sites are kept up regularly and up to date, which is not the case.

MS. CHIUMENTO: Right. No, but on --

MS. GOHLKE: And so --.

MS. CHIUMENTO: -- the other hand, that is the only information I have, so --.

MS. GOHLKE: Well, I mean, we -- we -- we need to, you know, get this to the right people in the Department --

MS. CHIUMENTO: Uh-huh. Uh-huh. I agree.

MS. GOHLKE: -- rather than go by the Web site and -- because they're not updated regularly.

MS. CHIUMENTO: Okay. Well, you know, whatever you want to do with it --

MS. GOHLKE: Yeah.

MS. CHIUMENTO: -- from here, this -- because this is draft, and --

FROM THE FLOOR: Yeah.

MS. CHIUMENTO: -- you can modify it in any way you want.

And so, basically I'm -- I broke it into trauma and -- and medical separately, however, I -- you know, I -- one of the things that I wanted to ask this group is whether we should combine it all in one, and just put, if it's a trauma center, put it in the column of the capabilities and just put it all in -- in one group, instead of having it all separated out like this?

Do we want to do it in a different way? I mean, I'm open to suggestions. This was just a first attempt to try to put something together to address some needs and -- but you know, if we want to go in a different direction, I'm fine with that. I just need to know, you know, what people's recommendations are. I was not getting much back on -- on -- on the e-mails, so I really would like the -- the opportunity to kind of talk about that a little bit here, and see what you're thoughts are.

DR. KANTER: Suggestions?

(No audible response)

DR. KANTER: I had a couple, Sharon.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: If you go to the first page --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- the paragraph on what patients need to be transported or transferred, you -- you might -- in -- in the language here, you might add -- the language in most states' documentation, and in the federal E.M.S.C. recommendations, they talk about criteria for consultation or transfer, and it may be --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- overstating it to say they all need to be transferred.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: But they certainly need a consultation.

FROM THE FLOOR: Right.

MS. CHIUMENTO: All right. That's an easy fix.

DR. KANTER: And then -- I don't know which page it is, but where you talk about what resources are necessary for a transport, and I may not have read it carefully enough, but something ought to be emphasized fairly strongly there is the need for medical direction, especially --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- for an unstable patient, online medical direction, and most people say -- most agencies and organizations say online direction by a emergency or critical care physician is warranted for an unstable patient.

MS. CHIUMENTO: Uh-huh. Okay. That's -- that's great.

I think that's a wonderful addition. And that's towards the back. It's -- it's one of the --

FROM THE FLOOR: It's on -- yeah, it's on the --

MS. CHIUMENTO: -- okay. So --

DR. KANTER: It's -- it's where you have the list of --.

MS. CHIUMENTO: Now in that case I did put trauma and medical together, so, again --

DR. KANTER: Yeah. Yeah.

MS. CHIUMENTO: -- we need to figure out whether we need -- want to do that in both places. So yeah, we want to add access to -- to pediatric medical control.

DR. KANTER: Yeah. Then you have a good long list here, and I -- I -- I don't know, it's -- it's -- there's no single right answer to whether you combine or separate trauma and medical.

The other way that some states express this is even more consolidated, is by broader categories of stability or instability. The -- the large category, regardless of what their disorder is --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- stable, low risk of deterioration; stable, medium risk of deterioration; stable, high risk of deterioration --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- and unstable. It makes for a simpler document.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: It always comes down to expert judgment anyway.

MS. CHIUMENTO: Yeah, and that's the -- but I -- my -- my recollection of the very beginning conversations was that we wanted to give that information -- we wanted to give them more expansive information, because we -- we might be dealing with people who had very little background in pediatrics. And so, you know, if -- if they -- it's an -- in the E.D. -- the medical E.D., if they get a patient in, they -- an adult -- primarily adult E.D., they need to transfer the patient out, they have very little pediatric background, so how do they make a decision as to whether or not the patient has --.

DR. KANTER: By -- by communication with the receiving hospital --

MS. CHIUMENTO: Okay.

DR. KANTER: -- who has an -- who has an expert.

And -- and I think that each one of these transfers --

MS. CHIUMENTO: Uh-huh.

DR. KANTER: -- I -- I -- I assume you say it somewhere in here, every one of them should involve a

physician-to-physician communication --

MS. CHIUMENTO: Right.

DR. KANTER: -- where the receiving hospital is presumed, is -- is chosen because they have expertise.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: So that the -- the -- the capabilities of the transporting staff should be decided by those -- by the referring and accepting physician. And I think that virtually always can and should happen.

MS. CHIUMENTO: Okay. I don't know.

MS. ROGERS: I think that's -- that's a mandate; isn't that? That they have to --

MS. CHIUMENTO: Right.

MS. ROGERS: -- they have to be attending to attending, an attending has to receive and accept?

DR. VAN DER JAGT: And I think you have it, actually.

MS. CHIUMENTO: Yes, I'm sure I do --

DR. KANTER: Residents can do it, but the point is you need a physician.

MS. CHIUMENTO: Right.

DR. VAN DER JAGT: Yeah, I think you actually have it in here.

MS. ROGERS: Oh, and -- and our residents can't accept a patient.

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DR. VAN DER JAGT: No, no, no.

DR. KANTER: Ours can.

DR. VAN DER JAGT: Oh, they can.

MS. ROGERS: Really?

DR. KANTER: Routinely. Not -- not for the I.C.U., but for the floor.

MS. ROGERS: Oh, they can. Ours can't

FROM THE FLOOR: Yeah, ours can't.

MS. CHIUMENTO: Yeah. It's under --

FROM THE FLOOR: They accept that --

MS. CHIUMENTO: -- it's under the -- it's under the -- on the back page --

FROM THE FLOOR: -- without first talking to a --

MS. CHIUMENTO: -- one of the steps.

FROM THE FLOOR: -- supervising physician.

DR. KANTER: Yes.

(Off-the-record discussion)

DR. KANTER: There -- there's -- there's no regulations about that.

DR. HALPERT: Just thinking that some residents aren't licensed.

DR. VAN DER JAGT: It probably doesn't matter a whole lot, as long as there's an agreement within the hospital medical staff --

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FROM THE FLOOR: Yeah.

DR. VAN DER JAGT: -- that that's an acceptable --

FROM THE FLOOR: Yeah. You need a hospital policy --

DR. VAN DER JAGT: -- that they will accept any patient that's accepted by a resident. I mean, that's what -- so I think you can do it a variety of different ways.

DR. KANTER: Yeah.

MS. CHIUMENTO: Yeah. Basically, it's -- I -- I have it under what other steps need to be completed before transfer. I think it's also someplace else in the document, receiving facility contacted, and patient accepted by appropriate service attending physician.

FROM THE FLOOR: Right. Yeah.

MS. CHIUMENTO: Yeah.

DR. KANTER: And then --.

MS. ROGERS: I like the idea of having some -- some qualification of how sick or how badly injured the child is. Because you look at some of these things, and they would not need to be transferred, necessarily. Surface burns may be insignificant enough that they could be handled by --.

FROM THE FLOOR: Right. If it's a less than ten percent burn, they might --.

MS. ROGERS: Yeah. I mean, so having some comment on the severity of the injury or illness would be appropriate.

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MS. GOHLKE: Did the -- the transport needs portion of this -- does that -- was that gleaned from somewhere else first, initially, or where -- how did this all -- where did this come from?

MS. CHIUMENTO: Most of the diagnose -- diagnostic categories came either from the Washington paper, or from the -- one that you referred me to, Elise, I brought it up here. Hang on one second, I'll tell you.

So, there were other documents --

FROM THE FLOOR: Oh, where they put --

MS. CHIUMENTO: -- for prime -- where primary goes -- yeah.

FROM THE FLOOR: -- just the criteria would be --

MS. CHIUMENTO: The admission criteria. Right.

MS. GOHLKE: Okay. Okay.

MS. CHIUMENTO: So -- so that -- that's where I got the categories from.

MS. GOHLKE: Right. And the -- the transport resource needs section?

MS. CHIUMENTO: The transport resource section --.

DR. VAN DER JAGT: Is that the various, like B.L.S., I.L.S., A.L.S. --

MS. GOHLKE: No, the last -- the right column, furthest right.

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MS. CHIUMENTO: That one really was more of a combination of experience --

MS. GOHLKE: Okay.

MS. CHIUMENTO: -- of people on the panel, and what -- in -- in the group.

Again, there's really -- I didn't have anything specific to go back to, because there's -- there was a lot of vague references in various places --

MS. GOHLKE: Right.

MS. CHIUMENTO: -- but my -- what I thought was being asked of me was to have something more specific rather than less specific.

MS. GOHLKE: Right.

MS. CHIUMENTO: You know, because there's a lot of papers already out there --

MS. GOHLKE: Right.

MS. CHIUMENTO: -- that have the less specific.

MS. GOHLKE: Right.

MS. CHIUMENTO: And we wanted something that was more -- you know, more -- like, find a document for people to help make them -- their decisions, so --

DR. VAN DER JAGT: I had -- I had actually --.

MS. CHIUMENTO: -- I'm not sure which way to go here, so it's just -- yeah.

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DR. VAN DER JAGT: No, it's -- it's a tremendous job.

MS. CHIUMENTO: Yeah, no, but -- but I just need to know whether we want, you know, how -- if I'm moving towards what Dr. Kanter was -- was suggesting, which I think is a great idea, how do I go about -- I -- I mean, I -- I guess I have a little bit harder time trying to just have it down in such a -- such a brief -- I'm not sure that that is as much -- I -- or that is -- the guidance is as much as I thought was what Art was asking in the beginning. So I just -- you know, I'm not just quite sure.

And if you have any ideas of how we can move from one to the other, I'd be -- you know, I don't mind doing the work, that's not the problem. I just need to know how to get from one to the other, and what we want and what we don't want.

DR. KANTER: I'm not sure I have a simple answer right now.

MS. CHIUMENTO: Yeah.

DR. KANTER: But I -- in general, I think that the -- the operational guidance that the decision makers need has to do with the stability or instability of the patient, more than the nature of his diagnosis.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: It's going to be a judgment call --

MS. CHIUMENTO: Sure.

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DR. KANTER: -- anyway.

DR. VAN DER JAGT: And I think you almost have to make these kind of general starting points, and then having some statement in there that just takes your -- I -- you know, the idea of talking with somebody about the area, so that the decision relates to the disability of that patient.

MS. CHIUMENTO: Uh-huh.

DR. VAN DER JAGT: So, again, I think --

MS. CHIUMENTO: Oh, I know.

DR. VAN DER JAGT: -- the one that -- that Janice, that -- the burn issue, well, you couldn't -- you can't say well, every burn has to go to a -- you know, a whatever, high-volume facility, but if the burn is three percent, And it's on a flat surface, not -- you know, not like a --

FROM THE FLOOR: Right.

DR. VAN DER JAGT: -- neck or a -- or a hand or something, then it doesn't need to be, but maybe they need to talk about it with somebody.

MS. CHIUMENTO: Uh-huh.

DR. VAN DER JAGT: Is there a way to do that?

MS. ROGERS: You know, there's -- there's a B.L.S. guidelines --

DR. VAN DER JAGT: Yes.

MS. ROGERS: -- for transfer --

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DR. VAN DER JAGT: Correct.

MS. ROGERS: -- for burns, for example.

DR. VAN DER JAGT: There -- there are actually guidelines - and I have to remember where these are now, because we just look -- we're looking at these, trying to define a triage thing for our transport system, which ones could truly be A.L.S., which ones needed a special team, and -- and I'm wondering if that would be helpful --

MS. CHIUMENTO: Oh, definitely.

DR. VAN DER JAGT: -- to look into -- because that was, again, based on I think stability, acuity, you know, which ones were okay with a B.L.S. team, which ones were okay with an A.L.S. team, and maybe that we could -- I -- I'll send that to you.

MS. CHIUMENTO:

DR. VAN DER JAGT: I'll find it for you.

MS. CHIUMENTO: Okay. That would be --

DR. VAN DER JAGT: I'll have that.

MS. CHIUMENTO: -- very --

DR. VAN DER JAGT: I don't have it --

MS. CHIUMENTO: -- very helpful

DR. VAN DER JAGT: -- here, but I can do that.

MS. CHIUMENTO: Yes, well, I did -- within that -- at the very beginning of each of these tables, say choice of unit

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will be determined by the severity of the patient's condition.

DR. VAN DER JAGT: Correct.

MS. CHIUMENTO: But --

FROM THE FLOOR: You know, some --.

MS. CHIUMENTO: -- but maybe what we do -- can do -- is -- and I -- and just thinking off the top of my head, is use your categories, and then put these things underneath categories -- I don't know, I'm just trying to -- you know, without all the extra materials and --.

MR. TAYLER: Sharon?

MS. CHIUMENTO: Uh-huh.

MR. TAYLER: I would -- I would leave it formatted as it is, but at the very beginning of it put it -- it -- I mean, transport decision is going to -- going to be based on what one physician says to the other.

MS. CHIUMENTO: Uh-huh.

MR. TAYLER: What the sending physician says to the receiving physician, and they're the ones that are going to decide, no, can't come here; yes, has to come here; you better send with a paramedic; you better send with a -- with a P.A.

MS. CHIUMENTO: Uh-huh.

MR. TAYLER: It -- it's going to be up to the physicians that are talking on the phone. So, why don't you just put at the very beginning of this, that these are

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guidelines and recommendations, that the ultimate decision is the -- is a decision made jointly between the -- between the sending and the receiving physician, and make a -- make a bold statement up front that says, you know, these -- these are what the guidelines are, but it's up to those two doc -- docs to decide how they're sent, what equipment they're sent with, if it -- and what facility they go to and such. And that may -- that may help address the severity issue, and the medical control issue, and -- and how you -- how you would format this differently, issue.

DR. VAN DER JAGT: The --

MR. TAYLER: Just -- just a suggestion to you folks, but --

FROM THE FLOOR: That's a good idea, actually.

MR. TAYLER: -- you know.

DR. VAN DER JAGT: I think the other thing is, in terms of the table, I'm wondering if it should be presenting problem, hospital resources necessary to treat that problem, and then the appropriate hospital, or the generally appropriate hospital.

MS. CHIUMENTO: Sure.

DR. VAN DER JAGT: Because that way you'd look at these are -- this is what's necessary to apply to that particular diagnosis, typically. And then you end up with a hospital. I mean, that just --.

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MS. CHIUMENTO: I just was -- was seeing it as these are the -- this is the -- the level of care that's needed, and then these are the -- the ancillary services that are needed. So, that's why -- why I put it that way, but I'm -- it's easy for me to --

DR. VAN DER JAGT: It's hardly --

MS. CHIUMENTO: -- switch the two.

DR. VAN DER JAGT: -- yeah. It's --.

FROM THE FLOOR: Uh-huh.

MS. ROGERS: Are --

MS. GOHLKE: I don't --.

MS. ROGERS: -- are these all supposedly referring to patients that are transferred for purposes of admission?

FROM THE FLOOR: I think so.

MS. ROGERS: Because -- okay. Because we get a lot of transfers --

FROM THE FLOOR: Or a diagnostic concern.

MS. ROGERS: -- from other hospitals that end up being --

FROM THE FLOOR: Discharged.

MS. ROGERS: -- dispo'd by us.

FROM THE FLOOR: Yeah.

DR. KANTER: You know, I -- I think that --

FROM THE FLOOR: Yeah, it's never a combination.

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MS. CHIUMENTO: Well, it could be --

DR. KANTER: -- well --.

MS. CHIUMENTO: -- either one. It can be used for --

DR. KANTER: No, I think it should --

MS. CHIUMENTO: -- either one here.

DR. KANTER: -- I -- I think this implies that you're talking about E.R. to E.R. transfers, as well as --

MS. CHIUMENTO: Right.

DR. KANTER: -- hospital to --

MS. CHIUMENTO: I think this is for everybody.

DR. KANTER: -- admit patients --.

FROM THE FLOOR: So that -- so that they --.

MS. CHIUMENTO: But not only E.R. to E.R.s, but it's like, you know, a standing clinic --

DR. KANTER: Yeah.

MS. CHIUMENTO: -- where they have a patient come in who's, you know, having a major problem.

DR. KANTER: Yes.

MS. CHIUMENTO: And what --

DR. KANTER: Yes.

MS. CHIUMENTO: -- what do they do with them? Do they send them to the local hospital, do they send them to -- a little further away, to a pediatric center, but with a pediatric transport team, or with somebody else who can do stabilization,

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so --

FROM THE FLOOR: Yeah, because --.

MS. CHIUMENTO: -- it was kind of, to me, all needs.

DR. KANTER: Yes.

MS. CHIUMENTO: And that was, and I think, that's what made it a little bit more difficult, because it -- because it's all -- you know, a --

DR. VAN DER JAGT: But it doesn't --

MS. CHIUMENTO: -- broad spectrum.

DR. VAN DER JAGT: -- make the role -- I mean, I -- for example, there's nowhere in here, under hospital resources, about pedes emergency physician, because that's really a specialty, you know, I mean, they're -- they know the triage, they know that, so that's a resource that hospitals frequently use, to say, would you -- I don't know about this kid, but could you guys take a look at the kid?

FROM THE FLOOR: Right.

DR. VAN DER JAGT: It goes on, you know, and it's -- but it's the expertise of the -- the pediatric emergency medicine healthcare provider --

MS. CHIUMENTO: That's very true.

DR. VAN DER JAGT: -- whether it's an N.P. or whether it's a, you know, whatever, but it's a -- it's a -- and that should be in there somehow, I think.

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MS. ROGERS: Even if it was in the text --

DR. VAN DER JAGT: Or it could be testing.

MS. ROGERS: You know, instead of -- because any and all of these patients could be -- arrive in our E.R., but somewhere in here, some statement that -- about the -- the pediatric emergency department --

MS. CHIUMENTO: Uh-huh.

FROM THE FLOOR: Right.

MS. ROGERS: -- as receiving, and as well --

FROM THE FLOOR: True.

MS. ROGERS: -- for evaluation purposes, I don't know. Have to read it more to figure out where it would fit.

DR. KANTER: Sharon, two other very simple suggestions.

MS. CHIUMENTO: Uh-huh.

DR. KANTER: On the page that talks about next steps before transfer --

MS. CHIUMENTO: Yeah.

DR. KANTER: -- one of the information items that the -- that needs to be worked out before the transfer is whether the -- there are any infection-control issues. It's one that's always inconvenient if you figure it out afterwards.

FROM THE FLOOR: That's a really --.

MS. CHIUMENTO: Okay.

DR. KANTER: And -- and then the other one that may

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need just a clarification, you talk about financial reimbursement for care during transport and at receiving facility in place. It needs to be clear that that's not meant to be a criterion or an obstacle to transfer. And I wonder if that's something that has to be worked out before the transfer, or something that can be worked out later.

MS. CHIUMENTO: Yeah, I'm -- I -- and I can't remember why -- how that got in there. I -- I don't remember what --.

DR. KANTER: The -- the -- the temptation is always going --

MS. CHIUMENTO: I mean, I can --

DR. KANTER: -- to be --

MS. CHIUMENTO: -- remove that very easily, so --.

DR. KANTER: -- yeah. I -- I don't have insurance.

MS. CHIUMENTO: I -- I can --

DR. KANTER: Oh, sorry.

MS. CHIUMENTO: -- I'd just remove it.

DR. KANTER: We don't have a bed.

MR. TAYLER: Yeah, you might want to --

(Off-the-record discussion)

MR. TAYLER: -- you might want to strike that.

DR. VAN DER JAGT: Well --.

MR. TAYLER: Seeing this is going to be a D.O.H. document --

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(Off-the-record discussion)

MR. TAYLER: -- you might want to strike that.

DR. VAN DER JAGT: Yeah, I think it's also that it's -- we're really talking about emergency transfers mostly; right? I mean, so it's really --rather than all transferred patients --

MS. CHIUMENTO: Yeah.

DR. VAN DER JAGT: -- I know on the adult side --

MS. CHIUMENTO: Yeah, I think that's --

DR. VAN DER JAGT: -- they always deal with --

MS. CHIUMENTO: -- what it was, but --

DR. VAN DER JAGT: -- you know, the person is in an adult --

MS. CHIUMENTO: -- some secondary --.

DR. VAN DER JAGT: -- facility, they're going to be there for five days and they can wait for a bed, but they're trying to figure out the financial end of it. In pedes it's virtually always an emergency transfer. And that's why -- I know in our institution, early on, you know, they -- it makes sense that these are always emergency transfers; financial is not an issue.

DR. KANTER: Yeah.

MS. CHIUMENTO: Right.

DR. VAN DER JAGT: We'll always accept them.

FROM THE FLOOR: Absolutely.

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MS. CHIUMENTO: And that can be --

DR. VAN DER JAGT: And be the --.

MS. CHIUMENTO: -- that bold --

DR. KANTER: Yeah.

MS. CHIUMENTO: -- and altogether.

DR. VAN DER JAGT: And that -- and that went --

MS. CHIUMENTO: That's easy to do.

DR. VAN DER JAGT: -- fine. And so maybe that should be --

FROM THE FLOOR: Yeah.

DR. VAN DER JAGT: -- so maybe either it's -- you know, policies regarding interfacility agreements about financial, you know, is -- is -- should be set up ahead of time.

MS. CHIUMENTO: Uh-huh.

DR. VAN DER JAGT: I mean, that should be the way it is, already there, you know, they know how it's going to work, because it should not hold up a transfer.

FROM THE FLOOR: Oh, you're --

FROM THE FLOOR: However --

DR. KANTER: All right. We are --

FROM THE FLOOR: -- isn't that an EMTALA issue anyway?

FROM THE FLOOR: I think so.

MS. CHIUMENTO: Yeah.

FROM THE FLOOR: I think that would be --

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DR. VAN DER JAGT: And it's an -- yeah.

FROM THE FLOOR: -- so --

DR. VAN DER JAGT: Yes, you're absolutely right.

MS. CHIUMENTO: Yeah. I can't remember what we -- why we put it in there, whether it was something I saw someplace else and just -- I don't know. I don't remember how it got there but we will remove it.

DR. KANTER: All right. We are getting up close to --

MR. TAYLER: On --

DR. KANTER: -- four o'clock --

MR. TAYLER: -- one more --

DR. KANTER: Right.

MR. TAYLER: -- one more thing, Sharon. The -- the phone numbers that are in here --

MS. CHIUMENTO: Uh-huh.

MR. TAYLER: -- and that plays into the second part of keeping this updated.

MS. CHIUMENTO: Uh-huh.

MR. TAYLER: The -- what are the phone numbers? Like, the switchboard, the main number, the number that's off our Web site --

MS. CHIUMENTO: The one --

MR. TAYLER: -- the D.O.H. Web site?

MS. CHIUMENTO: -- on the -- on your Web site.

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MR. TAYLER: Okay.

MS. CHIUMENTO: Yeah.

MR. TAYLER: There -- that -- that may require some thought, because there's -- you know, we don't want people calling the operator and then they like, "I don't know. Let me send you to the E.R." and then, you know --

FROM THE FLOOR: Right.

MR. TAYLER: -- like -- like Upstate Medical in Syracuse has a complete transfer center that all calls go to, and you know, you want to -- you want to make sure that -- that you put the right phone number --

MS. CHIUMENTO: Oh.

MR. TAYLER: -- in the document.

MS. CHIUMENTO: And if I have availability --

MR. TAYLER: So, it's just --

MS. CHIUMENTO: -- of those numbers --

MR. TAYLER: -- something --

MS. CHIUMENTO: -- I will get -- I'd be glad to --.

MR. TAYLER: -- yeah, it's some -- it's something we'll have to -- have to think about as we go along here --

MS. CHIUMENTO: I mean, just -- is there any --

MR. TAYLER: -- is all.

MS. CHIUMENTO: -- place in the Department of Health where they have that information?

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FROM THE FLOOR: No.

MR. TAYLER: We don't transfer patients, so --.

MS. CHIUMENTO: Yeah. Well, that's true.

MR. TAYLER: It's -- so we don't.

MS. HAFF: We do maintain facility contact information.We do maintain facility contact information by different roles of contact and so forth, so, and a role could be created that facilities would, you know, identify what the right information is. That -- it's --

DR. KANTER: Uh-huh.

MS. HAFF: -- regularly asked to be updated, so -- that might be something you can consider.

I'm sorry. I'm not a very loud speaker, I'm sorry.

I'm just saying we do maintain, you know, an active directory with -- with roles and -- and contact points that is updated by the facility, so we could create the --

MR. TAYLER: Yeah.

MS. HAFF: -- you know, that role and add it to the directory, and that could provide --

MR. TAYLER: Yeah.

MS. HAFF: -- this data.

MR. TAYLER: That's the -- that's the HERDS data; isn't it? The -- the --

MS. HAFF: The -- that's the communications directory

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and there --

MR. TAYLER: Okay.

MS. HAFF: -- the facilities are required, and -- and do -- we have to --.

MR. TAYLER: Yeah.

(Off-the-record discussion)

MS. HAFF: It's just another thought --

FROM THE FLOOR: Yeah.

MS. HAFF: -- another option.

FROM THE FLOOR: It's really good.

FROM THE FLOOR: Yeah.

FROM THE FLOOR: Yeah.

MR. TAYLER: Don't --.

MS. CHIUMENTO: Because I could put more than one phone number in. I mean, I could have a phone number for the E.D., I could have a phone number for, you know, the -- the transport team, you know -- or you know, whatever numbers -- it -- that's easy to add those things in. Again, keeping them current might be a problem, but --

FROM THE FLOOR: Right.

MS. CHIUMENTO: -- you know, but at least we could get --

MS. HAFF: Whenever you --

MS. CHIUMENTO: -- them a starting point.

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MS. HAFF: -- put something in a paper document, it's out of date in about a minute.

MS. CHIUMENTO: I know. We're working on a -- on a document that I happen to be the administrator for, that's a -- it's a Web -- it's a Web site. And then -- that can be printed -- can be downloaded and printed.

MS. HAFF: Yes.

MS. CHIUMENTO: But the -- the -- and what we -- we will be doing this every six months. We will be asking each contact person to update, so hopefully, we'll actually -- may have more current information than -- than you do, in some ways, but --

MS. HAFF: I hope so.

MS. CHIUMENTO: -- but unfortunately it's not -- it's not transfer centers; it's it would be E.D.s and the general number, I think is what they -- they have.

DR. KANTER: You know, once -- once you have a well-organized process of higher-level hospitals, you can work out some mandated process for updating the information, and in fact, the higher-level hospitals will have an incentive or an -- an interest to keep their own information updated.

MS. CHIUMENTO: Uh-huh. I agree.

DR. KANTER: All right. Any other discussion on this subject?

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MS. CHIUMENTO: And please feel free to e-mail me if you all start to get an idea.

DR. KANTER: Okay. Is there any other discussion about anything?

MS. GOHLKE: Just -- just a reminder that if you want to continue on the Committee and you haven't gotten your paperwork to me, I'd like to have the bundle put together by the end of the year to send up the line, and if you have any ideas for the vacant seats, as well, start talking to me and your colleagues, and we've got to try and fill those seats.

And think about, you know, chair and vice chair for next year, too. We would probably vote them in at the June meeting, and we can probably take nominations at the March meeting, which will be by Webinar.

And also let me know if those dates don't work for you, in the next week. Okay.

And have a nice holiday.

DR. HALPERT: Thank you very much.

DR. KANTER: Okay. What -- what's the proper way to end the meeting?

FROM THE FLOOR: All right.

MS. GOHLKE: We need a motion to --.

DR. KANTER: Motion to end the meeting?

FROM THE FLOOR: So moved.

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DR. VAN DER JAGT: Second.

DR. KANTER: Second. All in --

MS. GOHLKE: Second by -- okay.

DR. KANTER: -- all in favor?

MS. GOHLKE: Aye.

DR. VAN DER JAGT: Aye.

FROM THE FLOOR: Aye.

(The motion carried.)

DR. KANTER: Good.

MS. GOHLKE: Thank you

DR. KANTER: Thank you all.

DR. VAN DER JAGT: Thank you.

(The meeting concluded at 3:58 p.m.)

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I, Howard P. Hubbard, do hereby certify that the foregoing was taken by me, in the cause, at the time and place as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 139, inclusive, is a true record prepared by me and completed by Associated Reporters Int'l., Inc. from materials provided by me.

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Howard P. Hubbard, Reporter

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