

NEW YORK STATE DEPARTMENT OF HEALTH

EMSC MEETING

DATE: December 6, 2011

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 2 **PARTICIPANTS:**
 3 Committee Members
 4 Ann Fitton
 4 Janice Rogers
 5 Arthur Cooper, M.D.
 5 Elise van der Jagt, M.D.
 6 Robert Kanter, M.D.
 6 Sharon Chiumento
 7 Jonathan Halpert, M.D.
 7 Susan Brillhart
 8 DOH staff.
 9 Martha Gohlke
 9 Lee Burns
 10 Linda Tripoli
 10 Sandra Haff
 11 Kathy Ericson
 11 Debra Sottolano
 12 Christopher Kus, M.D.
 12 Sarah Sperry
 13 Invited guests:
 13 Tim Czypranski
 14 Kathryn Bass, M.D.
 14 Sergey Kunkov, M.D.
 15 George Foltin, M.D.
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 2 **MS. GOHLKE:** So I have Ann Fitton on the line,
 3 Jan Rogers, Dr. Bass, Dr. Cooper, Dr. van der Jagt, Dr.
 4 Kunkov, Dr. Kus, Sarah from Injury, otherwise known as
 5 polymorphic, and Dr. Kanter. And then here in the room,
 6 we have Deb Sottolano, Lee Burns, Sandy Haff, Kathy
 7 Ericson, Linda Tripoli, and myself, Martha Gohlke. And
 8 somebody else just signed on.
 9 **MS. CHIUMENTO:** Sharon Chiumento.
 10 **MS. GOHLKE:** Hi, Sharon.
 11 **DR. KANTER:** Hey, Sharon. How are you?
 12 **MS. CHIUMENTO:** Pretty good. Thanks. How
 13 about all of you?
 14 **MS. GOHLKE:** Is there -- is there anyone else I
 15 missed? Okay. Okay.
 16 Dr. Cooper, you said you have an agenda in
 17 front of you. Did you just want to run through it
 18 real --?
 19 **DR. COOPER:** I do.
 20 **MS. GOHLKE:** Okay.
 21 **DR. COOPER:** Sure. Well, for those of you who
 22 do not have agendas in front of you, first, welcome.
 23 And I will briefly review the agenda. Lee Burns is
 24 going to provide us with an E.M.S. report. Martha will
 25 then provide us with an E.M.S. for Children report.

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 2 We're then going to speak about where we stand with the
 3 405 Hospital Codes update, and Martha will handle that.
 4 And Elise van der Jagt is going to speak a little bit
 5 about the -- where we are with the new PALS materials.
 6 And then Bob is going to speak about where we are with
 7 respect to emergency preparedness stuff, particularly
 8 with respect to the Mass Critical Care supplement that
 9 was recently published in the Journal of Pediatric
 10 Critical Care Medicine. And then -- and finally, we'll
 11 be providing some updates from some of our sister
 12 advisory committees.

13 As all of you know from Martha's previous
 14 e-mails, we have no specific issues today requiring a
 15 debate or vote, so we elected to have this meeting via
 16 teleconference to save the wear and tear on ourselves
 17 and the state budget. And so, without further adieu,
 18 I'll ask first if there are any questions. And then
 19 hearing none, I will ask Lee if she would give the
 20 Bureau report.

21 **MS. BURNS:** For those of you who are STAC
 22 members, this is somewhat of a -- familiar. I don't
 23 know why this is so difficult, but it is. There --
 24 effective on January 21 of 2012, there is a change in
 25 the SEMAC law, the State Emergency Medical Advisory

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 2 Committee, which essentially adds two positions and a
 3 position for the chair. I -- I can provide you with the
 4 exec law if you're oddly interested. But the end result
 5 of it is that it requires the Commissioner to appoint a
 6 chair. And so the Commissioner has decided that -- and
 7 actually, I -- just to take a step back, the
 8 Commissioner and Dr. Henry have decided that they will
 9 appoint someone other than Dr. Henry as chair of the
 10 SEMAC. Dr. Henry felt that he's been doing it long
 11 enough, and Dr. Shah is all about change and moving
 12 forward and no new millennium and all that sort of
 13 thing. And so they -- they -- it -- it was done in
 14 concurrence with one another. Although having -- having
 15 been the person to have to talk with Dr. Henry about it,
 16 it was heart wrenching, more for me than him
 17 interestingly. He thought he'd Snoopy dance off into
 18 the sunset thinking that, you know, he has one less
 19 thing to do.

20 But he has -- for those of you who don't know
 21 Dr. Henry, he's been the chair of our SEMAC for
 22 seventeen years. He has probably been involved in
 23 E.M.S. at the state level for thirty years and then
 24 years before that at the local hospital service and
 25 regional levels, and he has dedicated a lifetime to

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 2 pre-hospital and emergency care. So mark your calendars
 3 should you be so inclined to come to beautiful downtown
 4 Troy. We are having a reception for him after the SEMAC
 5 meeting, which is January 31st. We're going to -- we're
 6 going to get everybody together in -- in a relatively
 7 informal environment and have, you know, and sendoff for
 8 Dr. Henry.
 9 In his -- with -- again, with -- with his
 10 concurrence -- with his concurrence, the -- the
 11 Commissioner has put forward for nomination Dr. Tim
 12 Haydock to be the next SEMAC chair. And Dr. Haydock
 13 actually has been with the SEMAC since its inception.
 14 Dr. -- Dr. Cooper, you know Tim. And he has been an
 15 advocate for E.M.S. and pre-hospital care forever. He
 16 has been the director of emergency departments in the
 17 Hudson Valley and New York City. He has been a
 18 really -- a formidable chair of SEMAC appeals committees
 19 over the years. And while he -- he -- the plus is he
 20 comes to us with extensive institutional memory, but
 21 he -- he -- as -- he doesn't have anything to prove, as
 22 it were. So he -- we -- we talked with him, and he
 23 is -- he is so honored. He was Dr. Henry's first choice
 24 for replacement, so that sort of soothes my ruffled
 25 feathers. So that is -- that is a good thing, and we're

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 2 very pleased for Dr. Haydock. And Dr. Henry will be,
 3 obviously at the SEMAC meeting in January.
 4 The budget continues to plague us, and -- and I can't
 5 imagine that any of you live under a rock, but we every
 6 day have to come with new and creative ways to fund and
 7 cut things. And just in case you have forgotten or
 8 didn't know, effective July 1st of this year, 2011, the
 9 E.M.S. no longer funds county E.M.S. programs through
 10 the Municipal Health Services Plan. The governor cut
 11 that out of his budget as -- as E.M.S. was considered an
 12 optional service. The end result is that there -- we're
 13 trying to figure out other ways to fund a number of
 14 these programs. But I -- I think we've seen -- we've
 15 seen counties sort of retract from some of the -- their
 16 E.M.S. activities.
 17 The only good side to that is that it was a
 18 reimbursement fee of funding and the county is really --
 19 you know, E.M.S. is not high on their public health
 20 radar scope as a general rule, unfortunately. The other
 21 is that our -- one of our fulltime jobs is to maintain
 22 E.M.S. education funding. If we sustain another
 23 significant budgetary cut, we're going to have to rework
 24 the way we fund E.M.S. training, and that will be a
 25 disaster of epic proportions. Let's see what else.

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 2 **DR. COOPER:** Lee, can you -- can you give us a
 3 hint as to where we stand in terms of the overall
 4 allocation of funds to the Bureau this year then?
 5 **MS. BURNS:** At the moment, I -- I don't know.
 6 The governor's budget should be released in the -- early
 7 2012. We've asked for the same amount of money,
 8 nineteen point seven million, that we requested last
 9 year. The state council approved their budget for
 10 twenty-three point five million dollars.
 11 **DR. COOPER:** Yeah.
 12 **MS. BURNS:** So we're -- actually, we're going
 13 to provide that to the Commissioner today. I --
 14 honestly, our -- I do not -- you know, when -- when the
 15 governor's budget came forward with nineteen point seven
 16 million in the -- in the '11-12 fiscal year -- when it
 17 got transferred over, the -- by law, they cut out about
 18 ten percent of it. So we ended up with just over
 19 eighteen million dollars for all of -- for everything.
 20 For those of you in the room even, that money not only
 21 pays for training, but the -- you know, the department
 22 operations as well as all of our contractors and
 23 counsel. So in the end, it's a very little bit of
 24 money. And the law says that half -- you know, the --
 25 the fund is cut in half, and half is dedicated to

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 2 training and the costs of training and certifying E.M.S.
 3 providers, and the other half for everything else. And
 4 that never works out well. Whoever thought of that,
 5 Art --.
 6 **DR. COOPER:** That was not me.
 7 **MS. BURNS:** I've -- I'm staring at the spider
 8 phone thing because I'm convinced, but anyway. So in
 9 answer -- the long answer to your quick question is I
 10 honestly don't know. I will be surprised if we are
 11 unhindered. Again, because even if they come across
 12 with a pretty decent budget, they'll require us to cut
 13 it by law again. I'm sure of it. So we're -- we're --
 14 we're very, very worried about that from a training
 15 perspective, and that doesn't even touch the issue of
 16 how to fund --
 17 **DR. COOPER:** Right.
 18 **MS. BURNS:** -- staff and counsel.
 19 Speaking of staff, I -- I don't know -- did -- you did
 20 meet Linda Tripoli at your last E.M.S. for Children face
 21 to face meeting. She's sitting here. She is a gift
 22 from God so much so that Dr. -- Dr. Simon offered to
 23 surgically cut her in half so she could do more. We may
 24 take him up on that. We believe he has the technology
 25 to do that.

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2 The other thing was we held Vital Signs in
3 October. We are very, very pleased with the way it
4 turned out. We had about fifteen hundred registrants.
5 The overall evaluations were very positive. The
6 participants had a lot of really constructive ideas and
7 input. And should you be so inclined -- and -- and Dr.
8 Kanter, I implore you to be inclined -- we are back in
9 Syracuse for next year's event.

10 **DR. KANTER:** Great.
11 **MS. BURNS:** We're just down the street from
12 you. I'll pick you up on my way by in the morning.

13 **DR. KANTER:** All right.
14 **MS. BURNS:** And from the Bureau specifically,
15 we lost two more E.M.S. folks to State Emergency
16 Management. That brings our total of three people who
17 have transferred over there. And so their absence is
18 felt every day, and the -- the amount of work that they
19 leave behind is staggering.

20 And the other thing to note is that Karen
21 Meganhoffen, who has been with the Department forever --
22 well, part of forever, is retiring at the end of
23 December. She is our E.M.S. education associate
24 director. So we have -- we have attacked Andy Johnson
25 to take it over upon her departure, but she -- she

1 leaves us with a huge workload. She's a good friend,
2 and she is -- has been an advocate for the E.M.S.
3 community for her twenty-five plus years here.
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5 And lastly, we have submitted a request to be
6 approved to hold the meetings for 2012. I think you
7 have a March meeting. Do they -- they have one more
8 meeting in the contract.

9 **MS. GOHLKE:** Yes, they have one more meeting.
10 Yeah.

11 **MS. BURNS:** So you all have one more face to
12 face meeting scheduled and contracted for at the Hilton
13 up the hill from us. And after that, we've been allowed
14 to possibly maybe go to contract. It's -- you know, if
15 you are with a state facility, you know what I'm talking
16 about. You have to ask permission to ask permission to
17 ask permission to go to a contract. And then you have
18 to ask permission to have the contract approved. So
19 we're in the process of taking bids for meeting space.
20 So no dates past your March meeting have been scheduled
21 till we know who is the lowest of low bidders. And you
22 never know, you could be having your meetings at the
23 toll plaza at Exit 23.

24 **MS. GOHLKE:** Or Lee's office.

25 **MS. BURNS:** Yeah. You could -- you could be

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2 stuffed in here with us, but we're -- we should know
3 more in the coming weeks as we get the bid -- the bid
4 responses back.

5 **DR. COOPER:** Well, Lee, the conference room
6 there is -- is a little tight, but it's not terrible.
7 So you know --

8 **MS. BURNS:** Well, your -- you know, for your
9 committee, the conference room here would actually --
10 either that or O.P.M.C. boardroom.

11 (Off-the-record discussion)

12 **DR. FULTON:** This is George Fulton on the line.

13 **UNIDENTIFIED MALE:** Hello.

14 **DR. COOPER:** Hey, George.

15 **MS. BURNS:** Hi, Dr. Fulton.

16 (Off-the-record discussion)

17 **MS. BURNS:** The other -- the other thing about
18 that is if you're local to us in Albany, the governor
19 has a plan, and it's just got a -- it's kind of a
20 frightening terminology he's using -- restacking state
21 workers. I'm a little worried about what that exactly
22 means. But for us, we're in Troy, which is nine miles
23 north and across the river from the Empire State Plaza.
24 And there's a lot -- due to retirements and scale backs
25 and all the other joyous things that happen in

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2 government, there's a lot of empty space in the Corning
3 Tower, which is really the central location for the
4 Health Department. So the news media and the
5 Department -- the Department reacted to a story that we
6 would -- you know, they're going to move all of the
7 peripheral Health Department offices back into Albany.
8 We believe we will -- our -- our lease in this office
9 space is over, and our days here are numbered, but we
10 don't know what that means. It could be five years from
11 now. But the -- what has to happen downtown -- and this
12 is the computer terminology I use. They have to defrag
13 the Tower because there's a lot of empty space, but it's
14 in little pockets everywhere. And they're talking about
15 moving four to six hundred people into the Tower. We
16 hope we are the last of those people. So we may have
17 more options open to us downtown in conference space in
18 the Tower building for the -- the E.M.S. for Children
19 Committee your size. But here in this building, our
20 sixth floor large conference room would comfortable hold
21 the E.M.S. for Children. It just wouldn't be easy for
22 the public to get into.

23 So we -- we have not -- oh, that's just between
24 us in this room and you people. We have not suggested
25 that to the Department. Otherwise, they'd put you in --

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 2 you know, in a supply closet. So I think that's about
 3 it.
 4 **DR. COOPER:** Just to summarize then, Lee, in
 5 terms of the -- the meetings, as I understand it, the --
 6 the -- the SEMAC and SEMSCO are meeting on January 31st
 7 and February 1st with a reception for Dr. Henry in the
 8 late afternoon/early evening of -- of January 31st. I
 9 believe STAC is meeting on the -- February 15th. And
 10 the day for our meeting, Martha, is?
 11 **MS. GOHLKE:** March 20th.
 12 **DR. COOPER:** March 20th?
 13 **MS. GOHLKE:** Correct.
 14 **DR. COOPER:** Okay. And all of those meetings
 15 at the present moment are at the Hilton Garden Inn in --
 16 in beautiful downtown Troy, correct?
 17 **MS. GOHLKE:** Right. And there -- we're
 18 contracted for that, so --
 19 **DR. COOPER:** Yes.
 20 **MS. GOHLKE:** -- it's -- it's cast in wet
 21 concrete.
 22 **DR. COOPER:** Excellent. Okay. Okay. Any --
 23 any other questions for Martha -- I'm sorry -- for Lee,
 24 anybody?
 25 **MS. GOHLKE:** I just --

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 2 **DR. COOPER:** Okay. Go ahead, Martha. I'm
 3 sorry.
 4 **MS. GOHLKE:** I just thought I heard four beeps.
 5 I heard Dr. Fulton came on the line, but who else came
 6 on since we started?
 7 **DR. HALPERT:** Dr. Halpert.
 8 **MS. GOHLKE:** Hi, Dr. Halpert.
 9 **DR. COOPER:** Hey, Jon.
 10 **DR. HALPERT:** Hey.
 11 **MR. CZAPRANSKI:** Tim Czapranski is also here.
 12 **DR. COOPER:** Hey, Tim.
 13 **MS. BRILLHART:** Yeah, Susan's here too.
 14 **DR. COOPER:** Hey, Susan. How are you doing?
 15 Martha, maybe -- maybe at some point during the call,
 16 you might want to just run down the list one more time
 17 just to make sure that we haven't missed anybody.
 18 **MS. GOHLKE:** Okay. I'll give my report, then
 19 I'll go through it again.
 20 **DR. COOPER:** Okay.
 21 **MS. GOHLKE:** I feel like we've just met, and I
 22 think I told you all that I have to go through the
 23 renewal process for the grant every year. So the grant
 24 is with H.R.I. right now being reviewed. And so
 25 hopefully it goes through by the end of the week when

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 2 it's due. No changes are perceived with that.
 3 Everything's status quo. So you know, keep -- keep our
 4 fingers crossed.
 5 I may have told you -- I can't remember the --
 6 there was an extra thirteen thousand dollar supplemental
 7 funding opportunity for us grantees through the same,
 8 you know, conduit of money through HRSA. And we applied
 9 for it here in New York State, and we decided to use it
 10 for an online continuing education program on the safe
 11 transport of children -- which really what that means is
 12 how the E.M.T. is to use a child safety seat and putting
 13 it in the ambulance. So there's really no training on
 14 how to restrain a child in the ambulance so we can get
 15 them the to the hospital safely depending on the
 16 condition of the child. Or if it's the parent that's
 17 hurt, where you put the child in the ambulance, that
 18 type of thing.
 19 There is no set policy nationally or at state,
 20 which is why this issue really hasn't been tackled until
 21 now. Well, it's not really even being tackled. It's
 22 just -- this online continuing education program will
 23 just give some guidance and some points for the E.M.T.
 24 to think about when they're -- when they put the child
 25 in the ambulance. It's going to be designed in a

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 2 generic way so that it's applicable to anybody in the
 3 nation. Since it is online, it's -- it's obviously
 4 accessible to everybody, so there won't be any New York
 5 State policy associated with it for that very reason so
 6 that everybody can take the information and run with it.
 7 And it has the backing from HRSA, so they're pretty
 8 excited about it because nothing's, you know, been
 9 developed to this point with the -- with that issue.
 10 So that's moving right along, and CentreLearn is the
 11 contractor -- they're out of Pennsylvania -- who is
 12 doing the online development. And that needs to be done
 13 in the next -- well, by the end of the grant year, which
 14 is the end of February, so maybe -- well, actually, I
 15 guess we won't be able to view it before. I may be able
 16 to send something out online to you for you just to get
 17 comments before then, but it'll be done by our next
 18 meeting hopefully.
 19 For the survey results, if you remember, I have
 20 to occasionally do surveys for the grants, and we did.
 21 The last round of surveys ended earlier this past year.
 22 The -- the feds have finally solidified the national
 23 results, and they've now permitted me to use them. So I
 24 will be developing a little presentation that'll combine
 25 the national results and comparing to New York State

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 2 results, and then I'll present them to you at our next
 3 meeting in March.
 4 They'll also get presented to the next
 5 SEMAC/SEMSCO meeting in January. And they're going to,
 6 just by timing, get to see it first. And we'll have a
 7 short discussion on recommendations on how to tackle
 8 some of the issues that came out of the survey results
 9 of New York State. You may remember it's about online
 10 and offline protocols for pediatric and also the
 11 pediatric equipment that is carried in the ambulances.
 12 That's what we surveyed this year on. So I'll have more
 13 for that at our next meeting.
 14 As for the vetting package that's been up at
 15 the Governor's office since June, my understanding is
 16 there's still no movement on it. So those folks that
 17 have applied to be on the committee, I hope you'll
 18 continue to attend. And we'll set aside grant funds to
 19 pay for your transportation in order to do that until
 20 hopefully the package goes through, which I've been
 21 given no indication if and when that'll happen. So
 22 that's the update with that.
 23 The other project, just as a FYI, that involves
 24 us is the electronic repository for our data. Our
 25 pre-hospital data, the patient care reports that the

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 2 E.M.T. fills out in the ambulance, we -- we have a new
 3 repository where we're putting the data. And I'm
 4 involved with that project, and we've now extended that
 5 repository to our hospital trauma patient registry data.
 6 So we've expanded that repository to now select that
 7 hospital data, which has proved to be quite the
 8 challenge and -- and very interesting as well. So --.
 9 **DR. COOPER:** Martha, would you mind saying just
 10 a little bit more between the lines on that?
 11 **MS. GOHLKE:** Well, it's -- it's a very
 12 complicated process, I guess.
 13 **DR. COOPER:** Yeah.
 14 **MS. GOHLKE:** You know, the School of Public
 15 Health, as far as the trauma side, was our data
 16 repository before. And so we're actually no longer
 17 using the School of Public Health, and we've contracted
 18 with a software company called ImageTrend for both the
 19 pre-hospital and the trauma data. So the -- there's
 20 many benefits to us switching up the way we've done
 21 things. One is with the ImageTrend system, the data
 22 will be available to hospitals and E.M.S. agencies.
 23 Technically online they could actually access their data
 24 and, you know, do some quality looks at the data
 25 themselves, whereas in the past, they had to wait every

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 2 four or five years for the Health Department to produce
 3 a report. So nobody could really see their data until
 4 that happened. And with this new online repository,
 5 they'll be able to access it whenever they want to.
 6 So that's one of the huge benefits to this -- this new
 7 system that we're using. It also has a huge cost
 8 savings benefit to the Department as well, which, as you
 9 know -- you know, we keep asking could we cut our costs.
 10 So those are the two huge benefits to the new system.
 11 But it's not as simple as just moving where the data is
 12 being collected. But the -- how I see it affecting this
 13 program is that we're going to have quicker access to
 14 some of the pediatric data that we might want to look at
 15 as we move down the line with our projects here. So I
 16 think that's going to have -- eventually, it's going to
 17 trickle down to -- to our needs in this -- in this
 18 committee.
 19 **DR. COOPER:** Do we have a sense, Martha, as to
 20 when the transition will be, you know, essentially
 21 complete, understanding that, of course, there are
 22 always bugs that have to be worked out?
 23 **MS. GOHLKE:** Yes. On the pre-hospital side,
 24 believe it or not, we have been in the process for this
 25 for a little over three years now, and we've gotten I

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 2 would say that majority of the call volume or the
 3 software vendors that deal with the majority of our call
 4 volume online. We're -- we're currently getting
 5 about -- I don't know -- fifteen to twenty thousand
 6 calls or -- or patients care reports in the repository
 7 monthly. So we're really moving along on the
 8 pre-hospital side. We have not started putting the data
 9 in on the hospital trauma side yet. We are still
 10 collecting the -- the data from hospitals, and we're
 11 working on the data dictionary for the trauma side in
 12 order to start collecting that into the repository. And
 13 that's probably going to be another few months.
 14 It's -- we -- we do think -- as always, it's never easy.
 15 This is one of my mantras here in New York State. It's
 16 never easy. We -- we do think very differently here in
 17 New York State than the rest of the nation when it comes
 18 to our trauma data patient collection information. So
 19 as a result, it's been a challenge to try and
 20 standardize with these software companies that are
 21 standardized more on a national level than on a state
 22 level. So we have to tailor the -- the software to our
 23 needs and the -- interesting, that's -- that's the best
 24 word I can use. And it -- and unfortunately, it's not
 25 as easy as it -- it -- it sounds, I guess.

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2 **UNIDENTIFIED FEMALE:** Are there differences in
3 the data?
4 **UNIDENTIFIED FEMALE:** And Dr. Cooper, just to
5 let you know, just before Thanksgiving, we did establish
6 a portal though the Health Commerce Network to begin to
7 receive data again. So that e-mail has gone out. And
8 we are receiving trauma data from our facilities.
9 **DR. COOPER:** Right. I was aware of that.
10 **MS. GOHLKE:** They're just holding it in reserve
11 until we can get the repository ready to accept it.
12 **DR. COOPER:** Right.
13 **MS. GOHLKE:** So -- so we're still taking it
14 from the hospitals. So anyway, that's -- that's the
15 only project that I've spent some time on as well. And
16 hopefully, they'll -- this committee will be able to
17 benefit from that data selection in the future.
18 **DR. COOPER:** Great.
19 **MS. GOHLKE:** And -- and so let me just run down
20 the -- the attendance again to make sure I have
21 everybody. You are being recorded, in case you weren't
22 aware, instead of -- we're not taking -- we don't have a
23 stenographer. Instead, we're recording the call. So we
24 are on the record.
25 So I have in attendance Ann Fitton, Jan Rogers,

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2 Dr. Bass, Deb Sottolano, Lee Burns, Sandy Haff, Kathy
3 Ericson, Linda Tripoli, Dr. Cooper, Dr. van der Jagt,
4 Dr. Kunkov, Dr. Kus, Sarah from Injury Prevention, Dr.
5 Kanter, Sharon Chiumento, Dr. Fulton, Dr. Halpert, Tim
6 Czapranski, Susan Brillhart, anyone else? Oh, and
7 myself, Martha Gohlke.
8 **DR. BASS:** Yeah. I'm going to have to leave in
9 a few minutes because I have a case that's coming up in
10 the O.R. This is Dr. Bass.
11 **MS. GOHLKE:** Okay. Thanks, Dr. Bass. Okay.
12 That's the end of my report, Dr. Cooper.
13 **DR. COOPER:** Okay. Well, thank you, Martha.
14 Any -- any questions for Martha? Hearing none, then
15 we'll move on to -- to old business. Martha, could you
16 give us an update as to where we stand with respect to
17 the 405 Hospital Codes?
18 **MS. GOHLKE:** Yes.
19 **DR. COOPER:** Which is to say, the
20 regionalization project.
21 **MS. GOHLKE:** Yes. Sandy Haff, Deb Sottolano,
22 and Kathy Ericson are here in the room with me. They've
23 been working right along and putting their nose to the
24 grindstone so they can please add to anything that I
25 miss, but just to give a brief summary, because there

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2 are some newer people on the phone. So we are trying to
3 improve the care for children that go to hospitals
4 for -- not trauma, but with medical reasons. We don't
5 have a regionalized -- a formal regionalized or
6 designation system in New York State. And it is one of
7 the grant deliverables under the E.M.S. for Children
8 grant that we -- that we do. So we have a trauma system
9 for peds, but not medical emergency system for peds as
10 required by the grant.

11 So many years ago, we -- we started down this
12 road in order to try and work in this direction. And to
13 make a long story very short, we decided to make some
14 improvements. And with concessions of the Health
15 Department and the Advisory Committee, the direction
16 we're headed at this point is we are looking at the 405
17 Hospital Codes, the minimum standards for hospitals to
18 open their doors and improving some of the language in
19 regards to pediatrics and those minimum standards. And
20 we've decided to do a parallel document -- a guidance
21 document alongside that that would have a higher
22 recommended level of care or requirements for hospitals
23 that choose to maybe go above and beyond the minimum
24 standards.

25 So the minimum standards, or the 405 Hospital

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2 Codes regulatory process, the guidance documents is not
3 a regulatory. It's a -- it's a guidance document, for
4 lack of a better term. We haven't -- they -- they
5 haven't really given it an official title yet. That's
6 just what we call it.

7 So about a year ago, your -- your fearless
8 leaders, Dr. Kanter and Dr. Cooper, had put together a
9 proposal to improve the minimum standards. And we've
10 gone back and forth -- the Health Department being we --
11 to draw some compromises. And right now, our mini
12 workgroup -- as I mentioned, Kathy Ericson, Deb
13 Sottolano, Sandy Haff, and myself -- have been working
14 to put that into regulatory language based on the
15 recommendations last fall. We're just about there with
16 most of the -- most of the recommendations as far as
17 putting them into the 405 Hospital Code. Hopefully
18 we'll have a document for you to look at shortly before
19 the next meeting hopefully.

20 And the next thing that we're going to tackle
21 is we've decided to do some PICU minimum standards in
22 the 405 Code as well as put PICU into the guidance
23 document, obviously. A note of interest is -- you know,
24 I keep saying that the feds are looking at New York
25 State closely because we're one of a few states that's

1
2 going through this process currently. And every state
3 kind of handles it differently, and we're the first to
4 tackle PICU. So they're very interested to see what we
5 write up as far as PICU standards in a -- at a state
6 level process. So they're watching that very closely.
7 They're interested to see what we develop.

8 So that's where we are with it. Does anyone
9 have any additions or questions?

10 **UNIDENTIFIED FEMALE:** No. Just that we're
11 going through each -- each section section-by-section,
12 and that's -- it's a tedious process, but we're, you
13 know, going through it thoroughly and hope we can have
14 something by the (unintelligible).

15 **DR. COOPER:** I'm wondering -- and Martha, I'll
16 leave this to you and Lee and Sandra and Deb and --
17 among others. You know, if it does come to pass that we
18 have a document to review prior to the next meeting,
19 which I'm hoping we will, and I -- you've indicated I
20 think that we -- we may well, does it make sense perhaps
21 to try to meet before the next committee meeting as we
22 did earlier this year?

23 **MS. GOHLKE:** Yes. I think that makes a lot of
24 sense.

25 **UNIDENTIFIED FEMALE:** You mean the same day?

1
2 **MS. GOHLKE:** Yes, the same day. We had a
3 morning prior to the meeting. So on March 20th, our
4 meeting would probably start at one o'clock as usual.
5 And then the morning of, we had a smaller group that met
6 with the Health Department to -- to review line-by-line
7 kind of thing. It's kind of a tedious review of the --
8 the -- the code changes. So yeah, I think that makes
9 sense. We can set that up. So if you want to block
10 your -- your whole day there, Dr. Cooper, on March 20th?

11 **DR. COOPER:** That's what I was kind of thinking
12 about, yeah.

13 **MS. GOHLKE:** And Dr. Kanter.

14 **DR. KANTER:** You know -- it's Bob. I think
15 that discussion will be most useful if we have a copy of
16 the draft actually before -- you know, somewhat before
17 that.

18 **MS. GOHLKE:** (unintelligible)

19 **DR. COOPER:** Of course. Of course. Yes, of
20 course.

21 **DR. KUNKOV:** I'm sorry. March 20th? This is
22 Sergey Kunkov. March 20th is our in-person meeting,
23 right?

24 **MS. GOHLKE:** Correct. Yes.

25 **DR. KUNKOV:** Okay. Over in Troy.

1
2 **MS. GOHLKE:** That'll be the meeting in Troy.
3 Correct.

4 **DR. KUNKOV:** Okay.

5 **MS. GOHLKE:** From one to four, unless
6 otherwise -- unless we change it. But that's normally
7 one to four o'clock on March 20th.

8 **DR. COOPER:** Right.

9 **DR. KANTER:** It's -- it's Bob. Just a couple
10 of things that I think are so important that they ought
11 to not wait till that more complete discussion is
12 complete. One issue that would be very easy and
13 inexpensive for the Department of Health to do -- and
14 we've talked about this before -- is more clearly
15 identifying pediatric I.C.U.'s on a publicly available
16 Department of Health website based on existing
17 information that's already available piecemeal in the
18 hospital profiles. It would require no new regulatory
19 process. It is -- it goes above and beyond anything
20 about regulating minimum standards and is simply a more
21 effective way to provide information about access to
22 existing resources that's already there on the website,
23 but not in a usable fashion. So I just want to say once
24 again that I -- I think that would be a very achievable,
25 important advance that would cost fairly little to do.

1
2 **MS. GOHLKE:** So noted. Thanks, Dr. Kanter.
3 **DR. KANTER:** The other item that I think is so
4 important that it must be mentioned again -- and this
5 probably goes in other regulatory frameworks beyond the
6 pediatric critical care. It's a -- it's an issue that's
7 important way beyond the specifics of critical care --
8 is the issue that pediatric x-ray, particularly C.T.
9 scans, x-ray dosage has been problematic nationally and
10 certainly in New York State and needs to be regulated
11 more specifically in the state.

12 **MS. GOHLKE:** Okay. Thanks. Also noted. Thank
13 you.

14 **DR. COOPER:** Anything more on the 405 Hospital
15 Codes update? So in summary then, we'll try to set
16 aside the morning of March 20th to review. We will
17 hopefully have a draft document a week or ten days prior
18 to that date. And Bob, I think you've also mentioned
19 the issue of the -- of -- of the safety stuff. And we
20 should make sure that that's on the agenda as well,
21 although that's not explicitly directly related to the
22 405, is that correct?

23 **DR. KANTER:** Right.

24 **DR. COOPER:** Okay. Good. All right. Any
25 other questions for Martha or Bob on the 405? Okay.

1
 2 Then I -- I think we just, of course, need to thank
 3 Sandra for her really excellent work in this area and
 4 we -- Sandra, we really appreciate all that you're doing
 5 to help us make this become a reality.
 6 **MS. HAFF:** You're welcome.
 7 **DR. COOPER:** Okay. Elise, do you have anything
 8 to -- to say about the new PALS materials? We -- we
 9 know that you're one of the stalwarts on the national
 10 committee, and the -- the new PALS course materials
 11 became available in early October after our last meeting
 12 and -- and wondered if you wanted to share any thoughts
 13 regarding these new materials. I personally have not
 14 seen them. I must say that we placed the order
 15 virtually the day they became available, and we haven't
 16 gotten them yet.
 17 **DR. VAN DER JAGT:** Sorry.
 18 **DR. COOPER:** No, no. It's not your fault,
 19 obviously. I just wondered if you had -- you obviously
 20 have seen them, and perhaps, you know, you have any
 21 thoughts to -- you know, to -- to -- to make about them
 22 or to share about them at this time?
 23 **DR. VAN DER JAGT:** Yes. Can you hear me? I
 24 don't know if I -- is everybody -- can everybody hear
 25 me?

1
 2 **DR. COOPER:** Yeah.
 3 **DR. VAN DER JAGT:** Okay. I just wanted to make
 4 sure that I can keep my mute on. There are a couple
 5 things actually here that I would like to bring before
 6 the committee. And as -- as Art eluded to, I'm at
 7 the -- on the pediatric subcommittee of the Emergency
 8 Cardiovascular Care Committee of the Heart Association.
 9 And we had a meeting in September, I believe, after the
 10 last E.M.S.C. meeting. And in that meeting -- the
 11 overall meeting as well -- is they went over the impact
 12 goals for 2020, and I -- I really think that these are
 13 relevant to what we do in New York State for children.
 14 Now granted, the American Heart Association has a focus
 15 on prevention of cardiac arrest in both adults and
 16 children. But let me share with you what their goal is
 17 to occur in the next ten years.
 18 That for all out-of-hospital arrests for
 19 children, that the survival would increase from seven
 20 point nine percent to fifteen point eight percent, which
 21 is basically doubling. And that the -- the goal is to
 22 improve the survival from cardiac arrest in-hospital
 23 from thirty-five percent, which is the high side, to
 24 fifty percent. Now that is an outcome variable relating
 25 to survival from cardiac arrest. The other goal is a

1
 2 process variable that the goal is a double out of
 3 hospital C.P.R. bystander response across the board,
 4 children as well as adults, from thirty-one percent to
 5 sixty-two percent, knowing that it currently is, in
 6 children, probably even less than thirty-one percent.
 7 So I -- I wanted to bring the -- before we go to the
 8 PALS materials, I wanted to bring that first before the
 9 Committee and put it in terms of a question, I guess.
 10 How can New York State's Emergency Medical Services for
 11 Children Advisory Committee help reduce childhood
 12 mortality from cardiac arrest, keeping in mind these two
 13 goals of the American Heart Association, and is there an
 14 opportunity to partner with the American Heart
 15 Association in some way?
 16 **DR. COOPER:** Any thoughts about that? Anybody?
 17 One thought I had, Elise, is -- is that I -- I think
 18 that to a certain extent, our group is not fully
 19 empowered, shall we say, to take on a challenge like
 20 that in the sense that, you know, we have a specific
 21 role to advise the Commissioner on -- on some of these
 22 issues. However, it does seem to me that if -- if we
 23 were to perhaps suggest that partnerships could be
 24 developed, you know, with, say the -- the A.A.P. to
 25 reach office space providers, and with the A.A.F.P., the

1
 2 family practitioners, to reach other office space
 3 providers, and perhaps through NAPNAP or some of our
 4 sister nursing organizations, and certainly ENA, that we
 5 might be able to perhaps get the message out there a
 6 little bit more about -- about some of the, you know,
 7 preventive activities that can take place in and around
 8 cardiac arrests in children. Meaning of course, as
 9 well, education as to how to, you know, nip cardiac
 10 arrest in the bud, should -- you know, should it --
 11 should it develop.
 12 And I'm wondering also, Martha, I know that,
 13 you know, in the past, we have been able to create
 14 partnerships with -- you know, with the schools through
 15 S.E.D. And I'm wondering if there might be some way
 16 that we could, you know, maybe bring together a meeting
 17 of all these folks, you know, kind of under our
 18 auspices, you know, or maybe as part of one of our
 19 meetings where we could begin to discuss some of these
 20 issues as to how we might, you know, help approach
 21 the -- the issue of reducing the burden of, you know,
 22 morbidity and mortality from pediatric -- pediatric
 23 cardiac arrest in childhood.
 24 Elise, does that -- is that -- does that kind
 25 of approach make sense to you or -- or --?

1
2 **DR. VAN DER JAGT:** Yeah, I think -- uh-huh.
3 I -- I think -- I think in large part it does for sure.
4 Now remember that the -- the -- this is the -- the goals
5 here. I guess I'm just asking, I think, and I'm sort of
6 brainstorming here with you, if you don't mind. You
7 know, I look at these goals, and I look at, for example,
8 the goal to increase survivals from cardiac arrest. In
9 other words, this is not a preventive mortality -- a
10 prevention of cardiac arrest. This is actually
11 improving survival when it happens.

12 **DR. COOPER:** Right. Well, I'm thinking of
13 prevention in the sense of broadly defined primary,
14 secondary, and tertiary prevention.

15 **DR. VAN DER JAGT:** Yeah. Yeah, I understand.
16 So -- so the -- the -- the question is -- for example,
17 immediately comes to -- for if it's out-of-hospital, the
18 E.M.S. community is immediately involved, you know?

19 **DR. COOPER:** Correct.

20 **DR. VAN DER JAGT:** As is bystander C.P.R. is
21 immediately involved. In fact, that it's also -- and
22 the goal is also for improving survival in-hospital,
23 immediately critical care and the emergency department
24 is involved and general floors are involved. So it
25 really is within the spectrum, the -- the breadth of

1
2 E.M.S.C. And so the question is that our -- one, do we
3 think this is an important goal within New York State to
4 look at this? And the second thing is -- is the -- the
5 process of how do we go about that. And even in the
6 absence of partnering with the A.H.A. because they're
7 certainly -- these are goals in general. Can we do
8 something to engender that? Should we be looking at
9 cardiac arrests? Should we look at the quality of how
10 it's done -- the C.P.R. is done so to be looking at
11 making sure that people are trained in C.P.R., whether
12 it's through the school system, which I know has been
13 tried, you know, a number of years now. And -- and
14 every time, it just barely doesn't pass.
15 You know, how do we -- how do we as an -- as a
16 committee -- as an advisory committee, you know, how do
17 we begin to -- to tackle this? Do we think that, for
18 example, these goals are sufficiently important that
19 it's worth it to push it up as a very important part of
20 our agenda, you know, for the next few years? That's --
21 those are the questions I'm asking -- probably more
22 questions than probably suggestions.

23 **DR. COOPER:** Other thoughts?

24 **DR. KUNKOV:** Sergey Kunkov, yeah. I was
25 thinking -- yeah, if we -- the -- the issue is the low

1
2 rate of C.P.R. provider by bystanders for these kids.
3 If the thing is truly below like -- like below
4 thirty-one percent, I was just wondering if, you know,
5 it's not a school-based intervention, but it definitely
6 can be something to do with the school partnership with
7 P.T.A., you know, committees, and, you know, trying to
8 get the parents because the parents are with kids all
9 the time. They are the ones especially with the young
10 kids there. They spend most of their -- their time with
11 them. So if, you know, P.T.A.'s can raise the awareness
12 and offer like -- I don't know -- like free or semi-free
13 C.P.R. classes. And at least that could raise the
14 awareness about the general direction where to go when
15 the kid collapses, you know? It can be their kid or it
16 could be their neighbor kid. That might actually --
17 because that's sort of bringing the -- the help to --
18 directly to the field because the parents are always
19 there. Some parent is always -- is always watching the
20 kids, you know?

21 **DR. VAN DER JAGT:** Right, right.

22 **DR. KUNKOV:** So I don't know if you -- you
23 know, like say school -- school-based, like it's either
24 a school nurse -- but no, not the school nurse, but
25 like, you know, the P.T.A. committee is always doing

1
2 things, you know? They -- they do all kinds of crazy
3 things, and these seem to be the worthwhile -- I don't
4 know -- at least exploring.

5 **DR. VAN DER JAGT:** On another -- and I mean,
6 noted. Do we have any data on this for New York State
7 about, for example, our own statistics for survival from
8 cardiac arrest in children, in-hospital or
9 out-of-hospital? Do we have that as a starting point
10 even? And again, it's all predicated on the fact of it
11 whether we as a committee believe it's important to
12 prevent kids from dying in this particular way.

13 **DR. KANTER:** Elise, it's Bob. You know,
14 regarding the in-hospital -- the inpatient cardiac
15 arrest, I think the two important interventions there
16 are not so much manual hands-on techniques. I think the
17 important interventions are early identification of high
18 risk patients and then proper clarification of
19 therapeutic goals so that I'm actually a little
20 surprised that the current estimate of in-hospital
21 survival is only thirty-five percent. I -- I think in
22 some hospitals it's considerably higher than that
23 already.

24 **DR. VAN DER JAGT:** This data, I believe, Bob,
25 is from the -- the -- what used to be called the

1
2 N.R.C.P.R. database that has looked at both in-patient
3 pediatric as well as adult cardiac arrests. And that is
4 a registry of now -- probably I think it's a couple
5 hundred hospitals. Well, I mean, we're part of it as
6 well, but there's a couple hundred now. It called now
7 Get With The Guidelines Resuscitation. And that's where
8 that data comes from.

9 **DR. KANTER:** It may be -- I -- I -- perhaps the
10 Heart Association is already doing this, but it seems to
11 me that reviewing the -- the existing data for best
12 practices may be an important way to go. Again, I think
13 early identification of high-risk patients and proper
14 clarification of therapeutic goals at the end of life
15 are the really high-yield approaches to improving
16 survival from C.P.R.

17 **DR. VAN DER JAGT:** I guess one of the questions
18 is really -- I mean, that's -- I -- I mean, I'm not
19 disagreeing with you. I totally agree, actually.
20 The -- the question is -- is really whether this
21 particular area should be high in the priority list of
22 E.M.S.C. advisory committee. That's what I guess what
23 I'm basically asking. You know, in -- should we be
24 looking at our cardiac arrest issues? Should we be
25 doing that and then use the Heart Association

1
2 potentially as a resource? And there is a New York
3 State E.C.C. committee that Sharon actually sits on. I
4 don't -- Sharon, do you have any thoughts about this
5 because you sit on that committee currently.

6 **MS. CHIUMENTO:** Not as far as E.C.C. Committee
7 goes. However, one of the thoughts that I was -- I had
8 was once we get this repository of data up and available
9 for E.M.S., we could at least look at some -- some
10 trending there. There are some data points that have
11 always been in the E.M.S. database, such as whether or
12 not C.P.R. was done prior by -- by a bystander prior to
13 arrival of E.M.S.

14 **DR. VAN DER JAGT:** Right.

15 **MS. CHIUMENTO:** And -- and we can look at that.
16 We can look at whether E.M.S. did various treatments. I
17 believe A.E.D. is one of the things that is -- is also a
18 current data point, as well as the -- the vital signs.
19 So you can look and see whether or not there was return
20 of spontaneous circulation in the field. So I think
21 we've got some data we can start looking at to see at
22 least in the E.M.S. setting. We won't know long term
23 outcome data except that I believe that we -- do we
24 still have SPARCS capability to look at E.D.
25 information?

1

2 **UNIDENTIFIED FEMALE:** Yes.

3 **DR. VAN DER JAGT:** Well, we probably have
4 SPARCS information for the in-hospital -- for the
5 in-house hospitalization, of course.

6 **MS. CHIUMENTO:** So we may be able to start to
7 tie this data together -- tie some of the E.M.S. data
8 together with the SPARCS outcome data and have an idea
9 now of, you know, where are we. You know, you asked
10 before what are our statistics like?

11 **DR. VAN DER JAGT:** Right.

12 **MS. CHIUMENTO:** At least these can get us a
13 little bit of an idea of what's going on in that
14 interchange. As far as E.C.C. Committee, I think that
15 all of these changes -- I believe we've -- we've only
16 had one meeting recently, and there's been very little
17 discussion of a lot of these things because of a lot of
18 things -- changeover in -- in -- in -- in the committee
19 membership as well as the fact that the -- the --
20 none -- none of the materials had come out. So we
21 really haven't really looked at a lot of issues beyond
22 just getting the PALS materials out. So you know, so --
23 so nothing specific as far as the goals go. No, that
24 has not been looked at at the E.C.C. committee at this
25 point.

1

2 **DR. COOPER:** Uh-huh. Well, you know, I'm
3 wondering if -- if this is the kind of thing that might
4 require a little bit, you know, longer discussion sort
5 of outside the -- you know, the main committee meeting.
6 You know, I -- I mean, I -- I -- I don't think there's
7 anybody who would disagree that, you know, trying to,
8 you know, improve C.P.R. survival or -- or not C.P.R.,
9 but cardiac arrest survival in children is a worthy
10 goal.

11 But it -- but as Elise points out, you know,
12 that means we're talking about improving the survival
13 once it's actually happened, which really means, as Bob
14 pointed out, early recognition, you know, and as others
15 have pointed out, better education, which was why I had
16 thought, you know, when Elise first presented this a few
17 minutes ago, that what we needed to do was perhaps
18 organize a meeting among some of our colleagues from the
19 A.A.P., the A.A.F.P., ENA, NAPNAP, you know, ourselves,
20 and of course, the schools, because we really need to
21 reach out to -- you know, to the -- the people that are
22 with kids when these sorts of things occur to make sure
23 that -- you know, that the appropriate education
24 regarding recognition and -- you know, and provision of
25 care are in place.

1
2 So I'm -- I'm kind of open to suggestions as to
3 how we might -- how we might do that. Certainly, as
4 others have pointed out, you know, creation of an
5 infrastructure, both in terms of, you know, having, you
6 know, a regionalization and, you know, critical care
7 services available as well as having a database to
8 really track how we're doing, all of these elements
9 are -- are really critical, but you know, the bottom
10 line is, you know, we have to have people who -- who can
11 recognize cardiac arrest, you know, as it's -- as it's
12 beginning to occur as opposed to after it's already
13 happened, and those folks have to be trained.
14 So does anybody have any thoughts other than getting a
15 meeting together?

16 **DR. VAN DER JAGT:** Yeah. So here -- here --.

17 **DR. COOPER:** Go ahead.

18 **DR. VAN DER JAGT:** Here is my thought. I
19 just -- I just think probably thinking not even about
20 the process so much, but first of all, I think -- is --
21 does the Committee feel this is a reasonable objective
22 for us to pursue? Because once we make that decision,
23 then we can develop a process for pursuing it. But is
24 it the situation that we think well, it's sort of
25 important, but it's not that important. There are

1 limited resources. You know, this is really, you know,
2 not worth something we can devote a lot of attention to.
3 That puts a whole different spin on it.
4 If we say that no, this is critically
5 important -- we're trying to prevent death from cardiac
6 arrest or at least sort out how we can do better, then
7 the -- the mechanism would be -- all right -- we've
8 decided that that's an objective of the EMSCAC. And
9 then secondarily then (unintelligible) get this going,
10 then you establish some liaisons with some of these
11 other groups, A.E.P., ASAP (phonetic spelling), you
12 know, a critical care group, whatever. Hospital --
13 hospitals group, whatever. There's -- E.M.S. -- so I
14 think that -- but to me, the most important thing is
15 does the Committee feel that there's something we should
16 pursue. And then -- or if we think we don't -- if we
17 think that we don't have enough information or we're not
18 sure or we don't want to go it alone until we have input
19 from others to whether this is a laudable effort to do
20 in New York State to focus on this area, that's fine,
21 too, you know? But -- but I think to see how important
22 this really is.

23 **UNIDENTIFIED MALE:** One thing I would throw
24 out -- and again, this doesn't get into the purview of
25

1
2 the Committee, but that there had been resources
3 committed for -- on a hospital care, specifically the
4 school A.E.D. program, and I haven't seen information
5 about the outcome of that program. And so that might be
6 something to -- to look at because at least there
7 were -- there are resources committed to -- to that
8 program to prevent deaths.

9 **DR. VAN DER JAGT:** Right. And we have been --
10 have been collecting data on that. I -- I -- I don't
11 know where we are with that right now, Martha, but I
12 know that we were collecting data because it was
13 required reporting if an A.E.D. had been used, as I
14 remember, for a -- to -- to resuscitate a child.

15 **DR. COOPER:** Well, I -- I -- you know, I'm -- I
16 don't know how -- but please, everyone else chime in,
17 but I -- I don't know how others feel about this, but
18 you know, I mean, we are a Committee whose primary focus
19 is on emergency medical services for children. It would
20 seem to me that -- you know, that rescue from -- you
21 know, from cardiac arrest, certainly from respiratory
22 arrest is -- is -- is the critical --.

23 **DR. HALPERT:** Elise is asking two questions.
24 Is this a laudable thing? Absolutely. Is it a
25 plausible thing? That's hard to answer given the

1 climate these days, right? But I mean, is it right in
2 the --

3 **DR. COOPER:** Well, that's --.

4 **DR. HALPERT:** -- wheelhouse of our -- of our
5 program? Of course it is. I mean, that's --.

6 **DR. COOPER:** That's kind of -- that's kind of
7 where I was going, Jon. I -- I mean, I -- it's hard
8 to -- it's hard to -- to -- to think that this isn't a
9 laudable call, given that -- you know, given our charge
10 but I don't -- I don't think -- I don't think we can --
11 I don't think we can figure out if it's plausible
12 without getting people together to brainstorm it.

13 **DR. KANTER:** It's Bob.

14 **DR. COOPER:** Yeah.

15 **DR. KANTER:** You know, I think goals like this
16 are always somewhat symbolic, but in this case, very
17 important. I -- I mean, I don't -- I -- I -- I guess I
18 differ a little bit. I think we can certainly endorse
19 those goals which are based on reasonable, scientific
20 expectations of the American Heart Association. A lot
21 of their thinking is evidence based, evidence driven.
22 I can't resist relating this back to the previous
23 discussion. In order to improve performance in any kind
24 of acute care, you have to use the best evidence-based
25

1 standards for that care. And that goes to the heart
2 of -- of many of the recommendations we've made for the
3 405 minimal standards. They are aimed at early
4 identification, and they're aimed at proper equipment
5 and procedures for doing acute care procedures and
6 basic. And advanced life support is at the heart of
7 those suggested improvements.

8 **DR. COOPER:** Well, where do people want to go?
9 I mean, I think we probably should not spend a whole lot
10 more time --

11 **DR. KANTER:** Right, right.

12 **DR. COOPER:** -- discussing this issue at the
13 present moment. Shall we defer further discussion until
14 the -- until our March agenda?

15 **DR. VAN DER JAGT:** Yes. Maybe I could propose
16 something, Art, is that why don't I try to put something
17 together before that meeting as some areas to look at --
18 some objectives potentially, data perhaps, and see if I
19 can put something together and then circulate it.

20 **DR. COOPER:** That's fine. I mean -- I mean,
21 I -- I mean, I'll be very honest with everyone. I
22 mean -- I mean, I think we all -- I think all of us
23 would agree that this is a laudable goal. I think all
24 of us understand, as Bob has said, that without an

1 infrastructure, you know, on the -- on the -- on the --
2 on the E.M.S. and hospital side to ensure that people
3 know how to resuscitate, you know, kids and are
4 prepared, in fact, to resuscitate kids from cardiac
5 arrests and deal with the sequelae, you know, we're not
6 going to be making a whole lot of progress.

7 But at the same time, you know, I -- I can't help but
8 feel that -- that, as Bob also said, that the
9 recognition part of it, which really takes place outside
10 the hospital environment, is really pretty critical.

11 And I'm not sure we can -- once again, I -- I do think
12 we probably have to bring in some of our partners to --
13 you know, to really -- to have an intelligent discussion
14 about this as to how we might be able to implement
15 any -- you know, any -- any strategies that we might --
16 that we might, you know, come up with.

17 So Elise, I guess I'd ask if you put this together that
18 you might give some thought as to -- as to how we could,
19 you know, bring in some of our partners for a
20 discussion, you know, as to -- and how we might, you
21 know, go forward in a way that -- that makes sense.

22 **DR. VAN DER JAGT:** I would be glad to do that,
23 Art. Okay.

24 **MS. FITTON:** I'd just like -- I'd just like to

1 chime in here because we are in -- in New York City, my
2 E.M.S. academy has a unit that goes out and teaches the
3 public bystander C.P.R. So I will bring with me in
4 March some of the materials and some of the -- some of
5 the challenges that we've found in the city in getting
6 cooperation. It may not be quite as -- as easy. Lots
7 of folks think it is laudable. It is not as easy
8 necessarily to get the kinds of cooperation that you
9 might in turn, you know, think would be there.

10 And the -- and the second part of that being, you know,
11 the American Heart Association, with all due respect,
12 also makes it more difficult in some ways to get the
13 word out of there because of their need to have you use
14 their materials and pay their fees. And it makes it --
15 they -- they put additional obstacles in the way.

16 Anyway, we've come -- we've -- we've come up with a
17 strategy to get around them, and we'll bring it with
18 you -- I'll bring it with me in March so you can get an
19 idea of what we're actually doing to put boots on the
20 ground about this.

21 **DR. COOPER:** Great. Great.

22 **DR. VAN DER JAGT:** Art, I -- could I just
23 finish this as well? And I Just Want to comment a
24 little bit on the Ann's --

1 **DR. COOPER:** Sure. But please bear in mind
2 that we have about twenty minutes left.

3 **DR. VAN DER JAGT:** The time is -- yeah, the
4 time is really short. I realize that. The -- I just
5 want to make it very clear I am not specifically saying
6 A.H.A. All I took was their goals, which is in the
7 abstract. And rather than anything to do with material,
8 courses, anything the Heart Association produces, even
9 thought I'm -- in one hand, I mean, I'm part of that
10 organization. This is not the intent here at all. The
11 intent is here purely to focus on the reality and the
12 evidence that's out there that we don't do very well
13 with cardiac arrest survival.

14 The -- the second part I want to talk about was
15 the PALS update, Art?

16 **DR. COOPER:** Go ahead.

17 **DR. VAN DER JAGT:** The -- the new Pediatric
18 Advanced Life Support materials that you said that are
19 based on the 2010 evidence-based international
20 guidelines on resuscitation were produced and sent out
21 October 2011. For those of you who don't use those
22 materials, it's basically a two day course that is based
23 on twelve simulations: four cardiac cases -- all
24 pediatrics -- four cardiac, four respiratory, and four

1
2 shock cases. That course is, I think, improved even
3 from the previous ones, and there's a great deal of
4 emphasis on the art of simulation and debriefing so that
5 actually some of the differences are that the
6 debriefing, which is basically the facilitation of
7 discussion after a simulation, has been doubled. The
8 time for that's been doubled. So that has been an
9 improvement.

10 The Heart Code PALS, which is an online ability
11 to take the Pediatric Advanced Life Support training is
12 supposed to come out somewhere in the middle or late
13 part of 2012. And then so that you are aware, also, the
14 other course which is the Pediatric Emergency Assessment
15 Resuscitation Stabilization course, PEARS Course, is
16 supposed to be coming out in the spring of 2012. And
17 right now, the various training centers around the New
18 York State, which -- of which there are quite a few
19 which are emergency cardiovascular care training
20 centers, Heart Association training centers, they are
21 supposed to be training their -- and updating their
22 instructors on these new courses, and I believe it's
23 April 1st they're supposed to all be teaching from these
24 materials.

25 **DR. COOPER:** Okay. So Elise, it -- it does

1
2 sound as though the -- the course is -- is somewhat
3 similar to the -- to the previous version except that
4 the time for the -- you know, the -- the discussion and
5 feedback on the -- on the twelve cases has been
6 increased. Is that -- is that a fair summary of what
7 you said?

8 **DR. VAN DER JAGT:** Yeah. And of course, the --
9 the course structure is -- is -- is similar except for
10 the debriefing part of it.

11 **DR. COOPER:** Yeah.

12 **DR. VAN DER JAGT:** The other thing is that for
13 those who want to renew their courses, they -- they did
14 make a change in policy that if you do not take a
15 renewal within that two year period, you have to take an
16 entire new course over again. I mean, all I can tell
17 you -- that's -- that's not me, okay? It just pushes
18 people to -- you know, as they get to the two year mark
19 for their course renewal to pay attention to that date.
20 Because we do know scientifically that there is a
21 tremendous erosion of skills.

22 **DR. COOPER:** Yeah. Okay. Any additional
23 questions for Elise or comments on the -- on the -- on
24 this issue? Okay. Well, hearing none, let's move on
25 now to the new business, which focuses at least to start

1
2 on emergency preparedness activities. As many of you
3 know, Bob Kanter was one of the principal movers in
4 terms of getting out the supplement on pediatric
5 emergency mass critical care that was published in
6 November in the Journal of Pediatric Critical Care
7 Medicine. And so I think we all felt that it would be a
8 good opportunity for Bob to speak a little bit about --
9 about that supplement and what it might mean for us in
10 New York State. Bob?

11 **DR. KANTER:** Good. Thank you. So the November
12 supplement in Pediatric Critical Care Medicine, which is
13 supposed to be available for free electronically
14 online -- I haven't verified that, but everyone should
15 check that out. It's --.

16 **DR. COOPER:** We -- we did send it out, Martha,
17 yes? Hello?

18 **MS. GOHLKE:** Sorry. No, I haven't sent it out.

19 **DR. COOPER:** Oh, okay. Because you -- I think
20 I did sent you all the -- I think I did send it to you,
21 yes? Or did I not?

22 **MS. GOHLKE:** All the attachments? Yes.

23 **DR. COOPER:** Yeah.

24 **MS. GOHLKE:** I didn't -- I didn't realize you
25 wanted me to forward that.

1
2 **DR. COOPER:** Oh, okay. That's -- my apologies
3 to -- to -- for -- for that. But can we get it out to
4 everybody?

5 **MS. GOHLKE:** Sure.

6 **DR. COOPER:** Okay. Thanks.

7 **DR. KANTER:** Good.

8 **DR. COOPER:** I'm sorry, Bob. Go ahead.

9 **DR. KANTER:** So this is a report from an
10 international task force of experts that included people
11 in peds critical care. It's trauma and surgery,
12 neonatology, general pediatrics, emergency medicine,
13 peds emergency medicine, disaster preparedness, E.M.S.,
14 as well as a variety of other subspecialties, infectious
15 disease, toxicology, and this is all from a physician as
16 well as nursing point of view, pharmacy implications,
17 and public health implications, and a variety of
18 representatives from various local state and federal
19 government agencies. And this task force met over a
20 couple of years to deal with the question what do we do
21 when a public health emergency surge threatens to
22 overwhelm intensive care resources?

23 The task force basically reviewed and endorsed
24 general ideas about how to handle this that had been
25 previously proposed by a general task force, mainly of

1
2 adult experts. That was previously published in the
3 magazine, CHEST, in 2008. The gist of it is that, up to
4 a point, I.C.U.'s can handle ordinary surges, and I'm
5 sure everybody's hospital, and any of you who work in
6 any capacity with a hospital, your hospital occasionally
7 takes care of critically ill or injured patients at a
8 slightly larger number than your supposed I.C.U.
9 capacity. Most hospitals can go up to something like a
10 hundred ten, hundred twenty percent of your normal
11 capacity by doing -- making a variety of
12 institution-specific adjustments that basically maintain
13 standards of care exactly where they always are.

14 However, above that level -- and going above
15 that level is just about unprecedented with a very few
16 exceptions of a few major emergencies like we've seen in
17 the past year, say in -- in Tuscaloosa with the tornado
18 or in Joplin with the tornado are two good examples
19 where, at least temporarily, hospitals have tried to and
20 succeeded in accommodating much larger numbers of
21 critically -- critically ill patients.

22 The report is in several parts. The first is a
23 summary of treatments and triage recommendation which
24 basically outlines the strategies that you would use.

25 And the strategy basically is when your surge threatens

1
2 to overwhelm your I.C.U. capacity to accommodate it, you
3 begin shifting. Instead of providing maximal
4 interventions to every individual patient to try to
5 maximize the individual's survival, you shift your
6 therapeutic goals and begin to try to optimize
7 population outcomes, which means that individuals will
8 each get less care, and you're trying to provide or
9 guarantee immediately life saving therapy to more
10 patients with the goal of maximizing the population
11 outcome. That -- that basically is a summary of the
12 strategy.

13 The tactics, the -- the specific approaches
14 you're going to use to achieve that include things like
15 substituting nearly equivalent therapies instead of
16 those you don't have for adapting not so equivalent
17 therapies because they're all you have, a variety of
18 strategies to conserve or reuse resources, some plans
19 about at least minimum stockpiles, and then some ideas
20 about triage allocation or rationing when, despite your
21 best efforts, you're still not able to provide life
22 saving interventions to all who need them.

23 The report includes a very detailed set of
24 suggestions for pediatric equipment and supplies for
25 hospitals based on how many intensive care beds you

1
2 intend to provide. I should say that the goal stated
3 throughout all these discussions is that hospitals
4 should begin thinking about how they would triple their
5 I.C.U. capacity above normal everyday circumstances.
6 That was the goal of the adult task force report three
7 years ago, and it's -- you know, and that's been
8 endorsed by the pediatric task force as well. It's a
9 number that's almost unimaginable if you haven't thought
10 about how you would do it.

11 The goal of stating an ambitious number like
12 that is to get hospitals to think way beyond normal
13 everyday operating procedures and think about how they
14 would really focus their resources on immediate life
15 saving interventions to much larger than normal numbers
16 of patients. Tripling your I.C.U. capacity -- think
17 about that. It's almost unimaginable until you do a lot
18 of work on stockpiles, procedures, practicing with your
19 colleagues on how that might be achieved.

20 I will tell you that this has been accomplished
21 in a few places. The Rhode Island nightclub fire,
22 the -- and the tornadoes in both Tuscaloosa and Joplin,
23 those communities have achieved this sort of --
24 accommodated those sorts of surges, but it's not
25 something that anybody would like to face. And it'll be

1
2 a lot easier to face it if you've thought about it ahead
3 of time.

4 The report includes a very good consideration
5 of integrating pediatric-specific services into regional
6 systems of care. No region, even a very well -- a well
7 prepared region can handle very large pediatric surges.
8 The number of pediatric facilities is just too limited
9 to -- to handle very large surges. We're going to be
10 sharing resources with -- across adult, pediatric, and
11 neonatal services depending on what the -- what the
12 nature of the event is.

13 The report outlines educational approaches, the
14 report outlines community operation, the report outlines
15 legal and ethical issues that are mostly common across
16 adult and pediatric fields, although the -- there is an
17 important question about public awareness. And
18 regardless of what the legal and ethical principals are,
19 what will public preferences be for treating children as
20 a priority group? I don't have an answer to that. The
21 committee -- the task force did not have an answer to
22 that, but it's an issue that warrants a lot more public
23 discussion.

24 And then, finally, there are some
25 considerations in the report for promoting

1
 2 family-centered care in the midst of an emergency, and
 3 some international considerations. So it's a long
 4 report. I urge everyone who has any interest or role in
 5 hospital and critical care to take a look at the report.
 6 I believe this ought to be a stimulus for a lot of
 7 thinking in every community with a pediatric I.C.U. And
 8 in those communities that don't have pediatric or
 9 critical care capabilities, it should be the stimulus
 10 for thinking about how the hospitals and the E.M.S.
 11 services will interface with the peds critical care
 12 services in their region, if not in their community.
 13 Specifically, I -- I -- I would hope that our group, our
 14 committee, after we've all had a chance to take a look
 15 at these -- this report, might find a way to endorse
 16 some or all of the ideas in the report, and I certainly
 17 think that the report emphasizes the importance of work
 18 that the Department of Health has already done, both at
 19 the state level and the New York City level, outlining
 20 strategies and tactics for non-pediatric hospitals to
 21 take in preparation for a public health emergency so
 22 that they can deal with whatever comes and then
 23 interface effectively with regional critical care
 24 services. That's just a quick overview.

25 **DR. COOPER:** Thanks, Bob. Any -- any -- it's
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1
 2 really a -- you know, a -- for those of you who've had
 3 an -- an opportunity to review this document, it's
 4 really a major tour de force about the current state of
 5 thinking among -- you know, particularly the nation's
 6 critical care professionals. But as Bob indicated,
 7 there are many from outside the United States who
 8 participated in this -- in this project.
 9 Are there any thoughts or comments about it that -- or
 10 as to how we might proceed specifically in New York
 11 State in helping some of our colleagues prepare
 12 themselves for an eventuality such as this? George,
 13 perhaps you might want to comment on -- on some of the
 14 surge work that's been done in New York City, you know,
 15 as you've been, you know, the co-P.I. on the New York
 16 City grant. Hello? George, are you still with us?
 17 Okay. Well, that being the case, I guess George is not
 18 still with us.

19 As many of you know, our New York City project,
 20 as we discussed I think a couple of meetings ago, has
 21 developed a system to -- you know, to expand surge
 22 capacity in the New York City's regional pediatric
 23 I.C.U.'s. And so far, we've been able to come up with
 24 perhaps -- or assist them to perhaps, you know, capture
 25 a doubling of -- of critical care beds. But so far we
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1
 2 have not quite been able to reach that tripling. And
 3 what is clear is that one does need to focus a great
 4 deal of activity on it at a regional level, and a lot of
 5 people have to be involved in -- in the plan.

6 **MS. SOTTOLANO:** Dr. Cooper?

7 **DR. COOPER:** Yes?

8 **MS. SOTTOLANO:** Hi. This is Deb Sottolano.

9 **DR. COOPER:** Hi, Deb.

10 **MS. SOTTOLANO:** Hi. I -- I -- I'm kind of
 11 really excited because this is a nice timing for this
 12 discussion because on Friday, we're having our regional
 13 resource center meeting here in Albany for the eight
 14 regional resource centers around the state. And I know
 15 I've -- I've -- I've chatted with both you and Dr.
 16 Kanter about the two hospital deliverables that I put in
 17 for this year that are very related to this. And the
 18 first deliverable, the deliverable for the hospitals on
 19 the ground is that I'm -- I'm doing a survey that -- of
 20 pediatric resources at each hospital, but I'm also
 21 putting in, at the end of the survey, a scenario that is
 22 kind of saying, you know, this is what you're facing.
 23 And it is kind of a pretty large surge of serious, you
 24 know, patients, and asking them, you know, how much --
 25 what they could do and how much they could do and where

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1
 2 they would not be able to, you know, meet the need,
 3 and -- and what they would need to be able to meet the
 4 need.

5 And the second part is the regional -- the
 6 regional resource centers actually working to create --
 7 based on this data, looking at what is available and
 8 what the capacities are locally, you know, to create
 9 kind of a regional approach to that. And I'm going to
 10 be working on the survey with B.R.R.C.'s on Friday, you
 11 know, going through the draft with them and getting
 12 their comments. And I had also always hoped that, you
 13 know, the -- I could get the feedback from the Committee
 14 on that survey, too. Please keep in mind I'm not a
 15 physician, but I -- I did research in looking for things
 16 and trying to add in the right things, and you know, I
 17 really would appreciate your input on that. The survey
 18 was supposed to go out earlier this year, but we all
 19 kind of got at least a month or more behind after the
 20 storms and all the emergency response that we were --

21 **DR. COOPER:** Sure.

22 **MS. SOTTOLANO:** So I -- if I could, you know,
 23 use the -- the mailing list, and if I could send it out
 24 to folks if they wouldn't mind taking a look at the
 25 survey and give me whatever your thoughts are to improve

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1
 2 it.
 3 **DR. COOPER:** Martha, is that okay with you and
 4 Lee?
 5 **MS. GOHLKE:** Oh, I think that's a great idea.
 6 **DR. COOPER:** Okay. Terrific. So yes, Deb,
 7 please get that out as soon as possible to the
 8 Committee, and we'll take a look at it and get feedback
 9 back to you. By the way, while we were -- while Bob was
 10 chatting about the -- the special supplement, I -- I --
 11 I just -- I -- I did e-mail it out to everybody at least
 12 through the -- the e-mail list that I had that Martha
 13 had sent out yesterday reminding us of all the meetings.
 14 So you should all have -- you should all have it in your
 15 inbox at this particular point.
 16 **MS. SOTTOLANO:** Great. Thank you.
 17 **DR. COOPER:** Are there any other -- any other
 18 thoughts for -- for Bob or questions for Bob?
 19 Hearing -- hearing none, I -- I might just say that --
 20 that, you know -- you know, this -- Deb, this -- the
 21 results of this survey might, you know, help provide us
 22 with an opportunity, you know, to see how the Committee
 23 could, you know, begin to support the regional resource
 24 centers in -- you know, in preparing for, you know,
 25 pediatric emergencies, and you know, so in addition to,

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 2 you know, helping -- helping, you, you know, design the
 3 questionnaire in a way that makes, you know, the best
 4 sense, perhaps, you know, when the results become
 5 available, you could give, you know, a little summary
 6 of -- of -- of your findings to the Committee at -- at a
 7 future meeting. I'm hoping that that might happen even
 8 as soon as March. And you know, and then -- and then we
 9 could, you know, begin to see how we could help -- help
 10 implement some of the -- some of the -- you know, the
 11 suggestions that are contained in -- in the -- in the --
 12 the critical care supplement. Does that make sense to
 13 everybody?
 14 **DR. KANTER:** Yeah. Art, it's Bob.
 15 **DR. COOPER:** Yeah.
 16 **DR. KANTER:** One last -- one last point. And I
 17 think we need to get very concrete about what our
 18 current limits are even before we get into the very
 19 complicated regional considerations about operational
 20 plans and practicing and -- and things like that. There
 21 are some limits that we certainly face. Without --
 22 and -- and without dealing with these, no operational
 23 plans are going to be meaningful. Hospitals do not have
 24 the ventilator stockpiles, and hospitals do not have the
 25 onsite stockpiles of supplies and equipment to do

1
 2 advanced life support -- immediately life saving
 3 interventions for many more than their normal number of
 4 I.C.U. patients.
 5 Those states that have successfully dealt with
 6 major events like this are states that tended to have
 7 large mobile stockpiles already distributed quite
 8 strategically around the state. And what comes to mind
 9 is Alabama, which was well prepared for weather
 10 emergencies, may be a national model for that kind of
 11 distribution. I think we have some work to do in New
 12 York State for thinking about basic core stockpiles that
 13 would include pediatric-appropriate supplies and
 14 equipment.
 15 **DR. COOPER:** Yeah. I -- I'm hoping that --
 16 that perhaps, you know, Deb's questionnaire could, you
 17 know, help -- help us, you know, get to some of the, you
 18 know, these limitations -- you know, structural
 19 limitations that you're -- that you're mentioning, Bob,
 20 because, you know, I -- I -- I'm not sure that the state
 21 necessarily knows for absolute certain who has
 22 ventilators, who doesn't, how many they have, and so on,
 23 and who's actually prepared to meet, you know, a surge
 24 in terms of some of the limitations that you mentioned.
 25 And Deb, I think if you're doing a questionnaire, this

1
 2 would be a perfect opportunity to try to gather some of
 3 that information. This -- I think, you know, I mean, if
 4 we're faced with a pandemic issue, we're going to --
 5 we're going to be -- we're going to be in the deep
 6 weeds, you know, if -- if -- if we haven't got the
 7 ventilators to support the -- you know, particularly
 8 the -- you know, the -- the -- the vulnerable pediatric
 9 population. And we're going to have, you know, as a --
 10 as a -- as a -- you know, as a group of professionals
 11 who are interested in this area, you know, a lot of
 12 questions to answer, you know, to our patients if and
 13 when, you know, a pandemic influenza situation should --
 14 should strike us.
 15 So you know, to the extent that the
 16 questionnaire that you're designing can actually collect
 17 some specific information on that, I think it would be
 18 very good.
 19 **MS. SOTTOLANO:** Yeah. Those are a lot of the
 20 types of questions that were in the pediatric toolkit
 21 and some of the other articles I found about what the,
 22 you know, recommended equipment, supplies, I -- you
 23 know, I put that in there. I did just -- I also want to
 24 mention, I know our -- you know, stockpile does have a
 25 large number of ventilators. I -- I don't know what

1
2 percent would be pediatric appropriate, but I -- I
3 think -- was thinking Dr. Kanter's idea was a good one
4 about, you know, we had a CHEMPACK which is deployed,
5 you know? We had like a hub and spoke model CHEMPACK
6 deployment around the state for both E.M.S. and
7 hospitals, so it might not be a bad idea to -- you know,
8 a similar approach we might be able to do eventually for
9 peds, you know?
10 **DR. COOPER:** Absolutely. And but I -- I think
11 before we do that, we're going to have to have the data
12 to -- to suggest why we -- why we have that need.
13 **MS. SOTTOLANO:** Right, definitely.
14 **DR. COOPER:** Any -- any other comments on this
15 very, very difficult issue? Well, hearing none, as you
16 can see, we're actually a couple of minutes over. But
17 Elise, I think you were able to attend a STAC meeting
18 last week, correct?
19 **DR. VAN DER JAGT:** I actually did not attend
20 it, but I did review the entire meeting today to see
21 what was discussed. I know that you were unable to do
22 it as well.
23 **DR. COOPER:** Yeah, yeah.
24 **DR. VAN DER JAGT:** If I could just bring up --
25 and we could probably save it for the next meeting as

1
2 well, but I just -- a couple things that I think are --
3 **DR. COOPER:** Sure.
4 **DR. VAN DER JAGT:** -- of note. One is they
5 passed an adult C-spine clearance guideline. They
6 actually have been working on this since, I think, at
7 least the summer, if not way before then. This would be
8 for patients who are over eighteen years of age. It
9 would be how to consider removing a cervical collar in
10 the case of a -- of a traumatized patient, and what are
11 some of the algorithms that would be followed through.
12 The algorithm, I believe, will be communicated and even
13 posted on the trauma web page because it actually was
14 passed by the committee.
15 So the question I have is whether there should
16 be something similar in the pediatric -- for the
17 pediatric patients and whether that could be an agenda
18 item perhaps in March, if that's when the next meeting
19 is. The -- I had brought this up actually at the
20 September meeting, and the feeling was to the get the
21 adult ones done first and then to see whether we could
22 adapt it to pediatrics in some way.
23 **DR. COOPER:** Yeah. Elise -- Elise, I know that
24 Jamie Ullman, who's the neurosurgical representative to
25 the STAC, chief of neurosurgery at Elmhurst in Queens,

1
2 is actively seeking to work on a -- on a pediatric
3 protocol to follow up on the one that was developed
4 for -- for the adults. And so I -- I -- I don't know
5 whether -- whether she's going to be ready by March.
6 But without a doubt, that -- that's -- that's on the --
7 on -- on the front burner, not the back burner.
8 **DR. VAN DER JAGT:** Right. And so my -- my
9 thought again was a little bit of a process issue -- is
10 it would be nice if the E.M.S. -- the E.M.S.C. committee
11 would be able to have some input into that, and I --
12 **DR. COOPER:** Well, I -- I think it will. I --
13 I don't think there's any question about that. I've
14 actually already spoken with Jamie about that.
15 **DR. VAN DER JAGT:** Okay. That's fantastic.
16 And but anyway, it was passed at this last meeting in
17 September.
18 Then the only other thing is there was a fair
19 amount of discussion about the peds trauma center survey
20 in -- for New York City which has been done. And Linda
21 Tripoli was the one who really did that. And Linda,
22 certainly feel free to comment on this. There were
23 apparently three centers that did not meet the criteria
24 for trauma center. Two of those apparently did correct
25 their deficits, which were basically appointing of a --

1
2 appointment of a peds trauma director. And they're
3 looking again to resurvey whether that really was
4 happening. And one center had decided that they would
5 no longer be a peds trauma center. That was in New York
6 City.
7 And it's my understanding, Linda, that there is
8 now also a survey that was sent to upstate centers for
9 those centers that were taking care of peds trauma
10 patients to see how they would satisfy the -- the survey
11 criteria. Am I correct about that?
12 **MS. TRIPOLI:** Yes. And their responses are due
13 to us by December 13th.
14 **DR. VAN DER JAGT:** Great. So -- so that's in
15 process. And then, finally, there was -- well, a
16 couple -- two more things, very quickly. The --
17 apparently, Bill Marx and Dr. O'Neill are going to be
18 meeting with the Commissioner to explain a little bit
19 about STAC and R-TAC and couple different things about
20 how STAC functions, and I was just -- was wondering if
21 whether there might not be a similar meeting arranged
22 with the -- the E.M.S.C. Advisory Committee so that he
23 would be -- the new commissioner would be informed about
24 what we do. And that was, again, just following a
25 little bit of a pattern of the -- the -- the STAC

1
2 committee.
3 **DR. COOPER:** Elise, that's a -- that's a --
4 that's a terrific idea. I had actually made a mental
5 note after Bill had told me he arranged that to -- to do
6 that, but I'm glad you're bringing it up on the agenda
7 because I think it -- it would be an important
8 opportunity for us. And -- and Lee, we haven't had a
9 chance to discuss this yet, but I -- I -- and I'm not
10 sure if you directly facilitated that meeting for Bill,
11 but I wondered if you could help us in that same way
12 to -- to get some of our issues moved forward.
13 **DR. VAN DER JAGT:** Great. That's -- that's --
14 that's great. So we're on the same page, obviously.
15 And that's --.
16 **DR. COOPER:** Lee -- Lee, can -- are you -- are
17 you able to help us with that?
18 **MS. BURNS:** I will -- I -- I -- I'll certainly
19 reach out to his office and let you know how best to
20 proceed. It -- it's sort of hit and miss --
21 **DR. COOPER:** Right.
22 **MS. BURNS:** -- and he's scheduled through
23 January now.
24 **DR. COOPER:** Sure. No, we're not talking
25 immediately, obviously. Is this -- did -- now, did Bill

1
2 initiate this on his own or did -- did you help him with
3 it?
4 **MS. BURNS:** Yes, and Yes.
5 **DR. COOPER:** Okay. Well, then perhaps --
6 perhaps what I should do then is -- particularly if --
7 if we have the support of the Committee that, you know,
8 perhaps Bob and I, you know, as co-chairs should, you
9 know, draft a letter to the Commissioner and request a
10 meeting. And Lee, obviously we'll, you know, share the
11 letter with you before it gets sent, and -- you know,
12 and we can make sure that, you know, you're okay with
13 what we're writing and so on so that we can, you know,
14 all be on the same page. Does that work?
15 **MS. BURNS:** Yeah. That's fine.
16 **DR. COOPER:** Bob, you okay with that?
17 **DR. KANTER:** Sure. Yeah.
18 **DR. COOPER:** Okay. Elise, anything else?
19 **DR. VAN DER JAGT:** There was -- I think
20 something's in the future -- there was a plea made that
21 the Regional Trauma Advisory Committees really looked --
22 would look at their data, the -- the quality for -- for
23 quality monitoring and performance improvement. And
24 that just made me think of well, what is the pediatric
25 data that should be looked at and should the EMSCAC have

1
2 some input into that?
3 **DR. COOPER:** I think that's a great question.
4 You know, to be very honest with you, Elise, at the
5 moment, I think we're -- we're in enough of a flux in
6 terms of, you know, the data itself, you know, and in
7 terms of access to it and getting the system up and
8 running that even if we focused a great deal of
9 attention on that issue right now, we probably wouldn't
10 be able to implement it for some months.
11 **DR. VAN DER JAGT:** Correct.
12 **DR. COOPER:** But -- but so -- you know, but
13 I -- I think what you're suggesting is really important,
14 and we should clearly play a role in -- in guiding
15 the -- you know, the -- both the STAC and the R-TACs
16 in -- in focusing on what key pediatric issues need to
17 be looked at.
18 **DR. VAN DER JAGT:** Right.
19 **MS. GOHLKE:** So with the whole regionalization
20 talk, we've mentioned before about the need to have a
21 pre-imposed changed, you know, data report, for lack of
22 a better term. And Pam Lawrence (phonetic spelling),
23 you know, if you remember back, it's been a year or so,
24 you know, tried to tease out some of the -- the care
25 issues and -- and produced a PowerPoint presentation on

1
2 where to actually start with documenting the care that
3 exists and the outcomes right now. And I -- I think she
4 kind of -- kind of got discouraged with the Committee
5 because they weren't really giving her really good
6 feedback, and that's why she doesn't attend these
7 meetings anymore because she doesn't really feel it's
8 worth her time.
9 So before we launch on another project with
10 data, because mind you -- data, you know, having the
11 researcher's resource behind to do all this -- I -- I
12 can't do that -- is another issue. And we have to get
13 Pam back involved if -- if this is going to be the case,
14 and I'm not sure that -- you know, she was looking at
15 SPARCS data. That's probably where -- we don't have to
16 wait for this new repository. This is -- that's a
17 add-on to what we currently have. We should be looking
18 at the SPARCS information now that we have and maybe get
19 Pam back involved. So --.
20 **DR. COOPER:** Well, yeah. Yes, Martha, I --
21 I -- I agree with you that -- that -- that things are
22 frustrating, but as you -- as you said a moment ago,
23 we're talking about at a -- at a pre and post --
24 **MS. GOHLKE:** Yeah.
25 **DR. COOPER:** -- kind of -- kind of snapshot.

1
 2 And you know, I think that the regionalization project
 3 is -- is the key interim step that, without which, we --
 4 there won't be a post, you know, so to speak. So you
 5 know, I -- I agree with you completely. We have to find
 6 a way to figure out how to get Pam back -- Pamela back
 7 involved.

8 But you know, at the same time, you know,
 9 making sure that we have the pieces in place so we can
 10 actually make the changes that we need to -- to make to
 11 look at the -- to look at -- at how the -- the system
 12 does, in fact, change. I think that's also critically
 13 important, and we can't lose sight of that.

14 **MS. GOHLKE:** Right.

15 **DR. VAN DER JAGT:** Uh-huh. Well, I think one
 16 of the things would be that should we identify for the
 17 STAC and then for the R-TAC some key points for
 18 pediatric trauma that could be routinely looked at
 19 across the state? You know, that -- and that's what I
 20 was thinking about.

21 **DR. COOPER:** Yeah, understood. Well, why don't
 22 we -- why don't we -- why don't we put this item on the
 23 agenda for the next meeting, Martha --

24 **MS. GOHLKE:** Okay.

25 **DR. COOPER:** -- so we can, you know, begin to

1
 2 rev that up again?
 3 **MS. GOHLKE:** Yeah.
 4 **DR. COOPER:** All right. Elise, anything else?
 5 **DR. VAN DER JAGT:** No, that was it. Thank you
 6 very much for the time. I appreciate it.

7 **DR. COOPER:** Thank you. Well, we are clearly a
 8 little bit over our time. Not unusual for us, but are
 9 there any pressing issues that we should cover before
 10 we -- before we sign off and wish everyone a happy
 11 holiday? Any -- any -- anyone? Please? Okay.

12 Well, hearing none, I'm just going to ask Lee and Martha
 13 to stay on phone for a minute after we -- after we drop
 14 off. And I -- I personally want to wish everyone a very
 15 happy and safe holiday season. And we'll look forward
 16 to seeing you in the New Year.

17 **MS. GOHLKE:** Thank you.

18 **MS. CHIUMENTO:** Art, there's just one comment
 19 I'd like to make in the --.

20 **DR. COOPER:** Please, Sharon. Go ahead. Go
 21 ahead.

22 **MS. CHIUMENTO:** The cards that we had done,
 23 it's the -- the revised.

24 **DR. COOPER:** Yes.

25 **MS. CHIUMENTO:** They were out of vital signs,

1
 2 they went out -- they went out like hotcakes. They seem
 3 like they went out pretty quickly.

4 **DR. COOPER:** Fabulous.

5 **MS. CHIUMENTO:** They're really liking having
 6 the updated cards.

7 **DR. COOPER:** Great. Great. Okay. Well,
 8 anything else? Then once again, hearing none, I'd like
 9 to wish everybody a happy healthy holiday season, and
 10 we'll see you all in the New Year.

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transcript from the electronic sound recording of the
proceedings in the above-entitled matter.

Phil Smith

January 12, 2012

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