5/11/2023 - STAC - Albany, New York

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: May 11, 2023

TIME: 1:37 p.m. to 3:23 p.m.

CHAIR: MATTHEW BANK

LOCATION: Marriott Hotel
189 Wolf Road
Albany, New York

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APPEARANCES:

RYAN GREENBERG
ABENAMAR ARRILLAGA
L.D. GEORGE ANGUS
GEORGE AGRIANTONIS
ARTHUR COOPER
ERIC COHEN
DANIEL CLAYTON
STEVE DZIURA
DONALD DOYNOW
MICHAEL DAILEY

ROBERT CURRAN
ARIEL GOLDMAN

MARK GESTRING
WILLIAM FLYNN
CRISTY MEYER
KATE MAGUIRE
WILLIAM HALLINAN
ROSEANNA GUZMAN-CURTIS
SRINIVAS REDDY
KARTIK PRABHAKARAN
JOHN MORLEY
SHELDON TEPERMAN
TAMMY SYKES

KERRIE SNYDER
RONALD SIMON

ROBERT WINCHELL
KIM WALLENSTEIN

JAMES VOSSWINKELL
JAMIE ULLMAN
AMY EISENHOWER
JEROME MORRISON
KRISTY LYN LADOWSKI
PATRICIA RILEY
CHERISSE BERRY

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(The meeting commenced at 1:37 p.m.)

MR. CLAYTON: Good morning, everyone. We'll be starting in just about two minutes, just getting some final things put together. Thanks so much.

MR. BANK: Okay. We're going to call the meeting to order. And our first order of business is the attendance roll call.

MS. SYKES: I'm sorry. Can you put your microphone on so we can hear?

MR. CLAYTON: Thank you. Sorry about that. Thank you. Dr. Bank?

MR. BANK: Here.

MR. CLAYTON: Dr. Wallenstein is excused. Dr. Roseanna Guzman Curtis?

MS. GUZMAN: Here.

MR. CLAYTON: Dr. Gestring is excused. William Hallinan? Dr. Prabhakaran?

MR. PRABHAKARAN: Here.

MR. CLAYTON: Kate Maguire?

MS. MAGUIRE: Here.

MR. CLAYTON: Dr. Angus?

MR. ANGUS: Here.

MR. CLAYTON: Dr. Reddy?

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MR. REDDY: Here.

MR. CLAYTON: Dr. Agriantonis?

MR. AGRIANTONIS: Here.

MR. CLAYTON: Dr. Prince is excused. Dr. Teperman?

DR. TEPERMAN: Here.

MR. CLAYTON: Kerrie Snyder?

MS. SNYDER: Here.

MR. CLAYTON: Dr. Arrillaga?

MR. ARRILLAGA: Present.

MR. CLAYTON: Dr. Voswinkell is excused. Dr. Flynn?

MR. FLYNN: I'm here.

MR. CLAYTON: Megan Mullen?

MS. MULLEN: Here.

MR. CLAYTON: Dr. Ullman? Dr. Winchell is excused. Tammy Sykes?

MS. SYKES: Here.

MR. CLAYTON: Dr. Dailey?

MR. DAILEY: Here.

MR. CLAYTON: Dr. Dailey is present for the record. Dr. Doynow is excused. Dr. Goldman? And Dr. Cooper is excused. And we have quorum. I'd like to also, at the chair's request, recognize our

new members, which are Dr. Reddy. Welcome.

MR. REDDY: Thank you. Thank you.

MR. CLAYTON: Also like to welcome Megan Mullen.

MS. MULLEN: Thank you.

MR. CLAYTON: From Western New York RTAC. We have Dr. Guzman Curtis down at the other end of the table over here.

MS. CURTIS: Thank you.

MR. CLAYTON: She's from Central New York RTAC. We have Dr. Prabhakaran next to her from Hudson Valley RTAC, and also from Hudson Valley RTAC is Kate Maguire next to him. So welcome to our new vetted voting members.

MR. BANK: Okay. So just a couple of housekeeping things. We've asked -- everybody, please if you have any comments, because this is all for the minutes, please speak into the mic. Turn your mic on. It's the little face with the voice coming out of it in front of you. And please identify yourself, which I just forgot to do. So this is Dr. Bank. She's laughing at me. There you go. So, this is Dr. Bank. So please just speak into your mic and identify yourself for the minutes. We

are going to start off with -- from my first STAC, something that's a little unusual. I'm going to ask the families of Dr. Marks and Dr. O'Neill to come up to the front so that we can give them a proclamation from the STAC for all of the work that Dr. O'Neill and Dr. Marks have done with the STAC over the last twenty years.

MR. GREENBERG: Come on out this way. Got to make it onto camera. Good afternoon, everyone. My name's Ryan Greenberg. I'm the Director of the Bureau of EMS and Trauma Systems and want to thank everybody for being here today, but in particular for what I would say are our true honored guests for being here. The past year has been, ironically, a little bit traumatic for our trauma committee as we lost two of our leaders in a very short period of time and quite unexpectedly in some cases. So in the past year, we've been speaking a lot about this, and we really want to make sure to recognize each of them and to make sure their families know how much they meant to us within the trauma community, the STAC and the Department of Health. And so, Dr. Guzman, I think, is going to step up and say a few words first, and then we have a

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resolution of recognition for each of our Former Chair and Vice Chair.

MS. GUZMAN: I'm just going to go off of my written words. I don't want to fumble this. So, Dr. Marks served as our Trauma Medical Director and Division Chief of Trauma and Acute Care Surgery at SUNY Upstate from 2014 until his untimely death. During his tenure, he oversaw the development of multiple guidelines and protocols for trauma patients and critically ill surgical patients. He recruited multiple surgeons, a large portion of whom were women. He led our trauma program through two verifications. He was a strong supporter of ATLS and trauma education, making our center one of the busiest in New York State for ATLS courses. At the state level, Dr. Marks served as a chair of the STAC, playing a key role in the State's decision to adopt the ACS standards for trauma center verification. Additionally, he served as New York State Chair and Region Two Chief for the COT for two terms prior to starting his service on the Central COT committee in 2014.

On occasion, a few of us would be having a raucous conversation down the hall,

discussing cases and reviewing films together. He let us be young surgeons growing and finding our way, but never more than a few doors away ready to share advice, guidance, and experience. He offered the encouragement and grace that allowed us to forgive ourselves and learn from our mistakes. You cut, you cry, he once told me, after a heartbreaking case that left me replaying every decision I had made in the care of that patient. His pep talks were not peppered with enthusiasm by any means. Just quiet, steady determination that made us strong and rebuilt our confidence when challenging cases brought it down. These very qualities made Dr. Marks such a great leader. He garnered support from other specialties, nursing and administration. He was well-respected within our institution but also regionally and nationally.

One of our emergency colleagues said it best. Dr. Marks is the best person to have a disagreement with. What powerful words and what an idea for all of us to reflect on. Those words describe a leader with true convictions who is able to state and defend his position while remaining level-headed and humble enough to consider another's

point of view. Undoubtedly, this allowed for further growth and development of our trauma program while establishing and maintaining good rapport across the institution and beyond.

He was a talented surgeon and administrator and a dedicated family man. I think his wife Shar said it best. You guys and trauma were the love of his brain, while the kids and I were the love of his heart. It is my most sincere hope that we all continue his legacy, honoring him by holding our trauma centers to the highest standards, using his work, along with the work of many of you here to guide us. Thank you for the privilege and honor to speak about a wonderful mentor, friend, surgeon and leader.

MR. BANK: I just want to say a few words about Trish. People may not realize, but Trish was everything at Kings County Medical Center. And when I mean everything, she was a nursing student, nurse, medical student, surgical resident, chief surgical resident, surgical attending, and the Director of Trauma at Kings County Medical Center. So pretty much every position I could possibly think of, Trish had in Brooklyn. Most recently, she was

the Vice Chair of Surgery and the Trauma Medical Director of Brookdale Hospital. On a national level, she was the Vice Chair, then Chair of the Greater New York COT, and most recently she was on the Central COT. More important than any of that is that she was a friend and mentor to an entire generation of trauma surgeons in the Greater New York area. And I just would very proud to give this award to her twin sister Anne.

MR. GREENBERG: There's an entire resolution that goes with this and we debated on whether or not reading it, and we really felt, in this particular case, the words, from each of their dear friends and colleagues, says a lot of what is also on here. But we just wanted to come to the final part. Sorry. This is -- when we look back, this is actually one of the only resolutions, or two resolutions, that the STAC has actually given out. And that's the influence of -- the impact that they've made on to STAC. The teamwork that they had together, and I know when we got to eat dinner last night, we got to sit and talk about. But I've only been here about five years and getting to work with both of them, particularly sitting across the table

and to watch your dynamic, to watch almost in some cases, there was a lack of words. It was just a look and they were -- each knew what the other one was thinking. And I had to be like, what just happened? It was just truly amazing.

And then to, you know, to go on site and get to see them in their hospitals and during site visits and stuff like that, and to see them not only at the state level, but at their local level and every role that they filled, you know, in some hospitals. So, at the bottom of this one -- so, to Dr. Marks, this is a resolution of recognition and appreciation honoring Dr. William Marks. Now, therefore, in this resolution, that the New York State Department of Health Bureau of EMS and Trauma Centers recognizes and expresses their appreciation and gratitude for the significant contributions of William Marks to the State Trauma System over the course of this distinguished career and whose work will continue to improve the quality of patient care and trauma systems throughout New York State for many years to come. And I truly mean that.

MR. BANK: Okay. For Trish.

Similarly, this is an incredibly long proclamation.

I'm just going to read the bottom paragraph. The New York State Department of Health, Bureau of Emergency Services and Trauma Systems issues this resolution to recognize and express their appreciation and gratitude for the significant contributions of Patricia O'Neill to the State Trauma System over the course of her distinguished career, and whose work will continue to improve the quality of trauma care and trauma systems throughout New York for many years to come.

DR. TEPERMAN: He's a professional.

MR. GREENBERG: So I really just want to -- and they weren't around the corner. I want to thank the families both for coming from near and far to be here to accept this and recognize that you're always a part of our trauma community. And truly the work that they did will live on for many, many years to come. So thank you.

MR. BANK: So just to continue the meeting, the minutes of the last STAC were sent out a few months ago. Do I have anybody, motion to approve the minutes? George --

MR. AGRIANTONIS: I move --

MR. BANK: -- do you have a motion to

approve the minutes?

MR. AGRIANTONIS: -- I move to approve.

MR. BANK: Very good. Dr. Doynow, any second to approve the minutes? Dr. Flynn.

MR. FLYNN: Second that motion.

MR. BANK: Thank you very much. So we will approve the minutes. Next is the Bureau of EMS report from the Director Ryan.

MR. GREENBERG: Thank you very much. Sorry, I'm just trying to get my computer going on. So a lot going on in the Bureau, both on the EMS side and the trauma side. We're excited to now have a policy fellow with us, Gina sitting on the side. We have Gina over here, who has been helping us tremendously with the 405 regulations and all the paperwork that needs to -- that had to be completed on it in order for it to be submitted. We are working on that pipeline and moving things through. One of the things that I just want to express to this entire council is related to, you know, regulatory updates. So it's been a little bit since we've done regulatory updates for the 405s related to trauma. And I think even in the spirit of some of the

committee meetings that I had today, that it would appear that the future will have more regulatory updates in a positive way, in ways that the -- based on the guidance of the members of this council.

We are working on establishing what that process will be in a more streamlined process. What we would need from the beginning as well as all the way through. As those 405s do go up, we'll make sure to notify all the council members once they are up and open for public comment. My guess is that will probably be in the fall. Hopefully the early fall, but it does have to align with FIPIC and some of the other meetings. So those are moving through those 405 changes. I know some people have asked related to the 405 changes. What if I have an upcoming site visit or something else? Those would all have to be based on the regs that are currently in place. Just to give you a little bit of a timeline, again, we have to align with the FIPIC process, FIPIC meetings. It has to be out for public comment for a set number of days, I believe it is sixty, then it comes back. When they come back, if there is significant changes or comments that have to be addressed, it would then have to be revised, go

back out for public comment a second time, and then come back.

So the process doesn't happen quickly. The ultimate goal too is as we move forward, that we get better at -- or say, the process becomes smoother because we do it on a more regular basis. So we look forward in the future to -- even if it's small updates or things or -- we recognize, you know, different standards that want to be set specifically in the regulations, that it would speed up that process. We have a number of applications that are coming in and we have some updates that have happened or about to get published related to policy statements on provisional appointment. Provisional appointment is for those hospitals that are looking -- most of them, what we're getting are level threes that are looking to become a level three institution or recognized.

They have to become provisional first with us. We had a policy out there, we've done some modifications to that. In the near future you'll see that published up again. There are some new things that will be out there for institutions going forward for applications related to getting some feedback

from trauma needs assessment as well. So those are some of the major things going on, on the trauma side. On the EMS side, good situational awareness for everybody here as well. We were part of the budget this year, and two of the major things that were part of the budget that also will affect the trauma community is within Part S, which was the part of the budget related to EMS. It spoke about system and agency performance standards as well as an EMS task force. Those are two of the things that came in.

And the way that a system in the -- system and agency performance standard may come circling around to affect the trauma community is, it will allow our State EMS council to add some performance measures and expectations into an EMS system or an agency that will help with sustainability to the system, but hopefully also patient care delivery models and being able to get care to them in a certain amount of time, or knowing what is -- who's going to respond, how often they're going to respond. And so this will hopefully help in being able to get them the care they need into the hospital and designated facility. So we'll have more

information on that in the next meeting or two for STAC, but we think that can be an exciting one for you as well. The second one is the EMS task force. And so what we learned through the pandemic is that responding to a disaster is not something that really can be done on the fly really easily.

And so, like many of our larger states that we look around the country, we, it was approved and put into legislation to create an EMS task force. The CMS task force is being designed to help in response to disasters and community needs when a significant event occurs. We think back to Covid or we think back to the Buffalo snowstorm. You know, in order for us to mobilize can take days at times in order to get contracts in place and things like that. This state EMS task force would allow us to have those resources, contracts already in place, and then be able to, at the need of something, immediately respond. When we look just to our neighboring state, when we look to Massachusetts, who recently had a pretty significant fire in a hospital and they had to evacuate, I believe, a hundred and sixty patients in a very short period of time, this is another example of something that might need activation of a task

force in order to be able to handle such a large response that can't wait days, but rather needs hours. So we're very excited about that one as well.

We continue to move forward on a number of educational things. There's also a number of educational pilot programs that are going to happen on the EMS side. I bring this up for the trauma community, because again, it can open up more opportunities for the trauma community to be involved in different community events. We have a -- an EMS agency internship program that'll be starting, where they'll do eight to twelve hours. But again, recognition, maybe it's at, you know, an outreach from a trauma center to give more education to an EMS agency or for people who are thinking about coming into the field. Our next meeting for SEMSCO will be in September. EMS for children, I think is going to report later, so I'm not going to report on those. Our Vital Signs Conference is October 17th to the 22nd.

Next week for anybody who is -- sorry, two weeks from now, anybody who's around on May 23rd, we have our EMS Memorial at the EMS, at the State Plaza. We'd love to see some of you here. There are

eight honorees who will be going up onto the Memorial this year. Important for all of us to recognize, Executive Order 4 may expire in May, so just keep that one in mind. Executive Order 4, that is the one related to a staffing crisis. There are a number of things related to EMS that will affect certification in some of the processing that happens with that, but we also bring that up as situational awareness for here. If you do have something that is operating under Executive Order 4, they're thirty-day renewals. So either May 20th or May 22nd is set to expire. I do not know if it'll be renewed another thirty days. If you do have something within your institution that would affect or your operations, please keep that one in mind. One of the big questions that I got is, well, what about providers working in alternative work sites?

So EMS providers working in non-traditional environments, such as an ER or maybe a clinic or things like that, that is currently allowed under that executive order, that would come to an end. So if they are a part of your program under that executive order, please keep that one in mind. We have the Rural Health Task Force, which met two

weeks ago -- or sorry, last week, and had a very successful meeting. This is a -- it's a great group. We're really looking at, you know, what are some of the solutions to help in rural health and delivery of EMS services out there and a regular occurrence comes up in the conversation about trauma centers. So it's not just about EMS but it's about accessing hospitals and getting the patient to the right care at the right time, and how often when we're in some of our truly rural parts of the state. How difficult it is to get a patient to definitive care particularly in the winter months where during the summer months we have access to air medical services and things of that nature that helps us, you know, really relieve some of those stressors. But in the wintertime becomes a lot more stress. And then last, but far from least, I just want to thank all of the BEMS team members who are here with us today. We had two days of council meetings for the past two days. A lot of our district chiefs are here today and our -- some of our unit chiefs. And this is all about -- we're truly one system. We're one ecosystem. And so we're working to make sure that we all know different roles and responsibilities and how different councils and

things work. So just want to thank you all for being here today and spending time with STAC. And that's it. I'm happy to take any comments, questions, or concerns. Back to you.

MR. BANK: Okay. Dr. Bank again. Trauma program update, Dan and Patty.

MR. GREENBERG: Share a mic with Patty.

UNKNOWN MALE: Hi.

MR. CLAYTON: Tech support to aisle four.

UNKNOWN MALE: There you go.

MR. CLAYTON: Thank you. I'm hitting the wrong button. Dr. Chair, I have nothing further from trauma program update. Director Greenberg covered it and there will be some other items that are going to be brought up later on in the meeting. But nothing else further now. Thank you very much.

MR. BANK: So we're going to go into our subsistent -- subcommittee reports. We're going to go a little out of order because there's a couple of reports that -- for people who just have to leave a little early. So we're going to take systems first by Eric Cohen, and then trauma needs assessment is

going to be done by Dr. Berry instead of Dr. Winchell. Eric?

MR. COHEN: Thank you. Representing Ron Simon from the systems committee. We looked at the New York State Trauma Registry Report and tried to see what information we would like to see coming out of the trauma registry report. And that sort of took a turn into the trauma registry report itself and how it's operationalized and how are we getting the data in and out of the trauma registry report. And two motions were brought forward from the committee. The first motion was to evaluate the impact of the SPARCS validation process on the state trauma data report and is it necessary. And then the second motion that was brought forward was to ask New York State to switch from a three-year cycle to an annual report for the registry -- New York State Trauma Registry Report. Those are the two motions brought forward by the systems committee.

MR. TEPERMAN: Just a -- it's Teperman. Just to add some color to that. So the group expressed concern as we all have expressed concern about the fact that the report that the state produces, although we are grateful for the amount of

work that goes in, is produced very late. We're looking at the 2015 report. Now, the idea behind the STAC -- the SPARCS resolution, Director Greenberg demonstrated for us that if we were to remove that part of the process, if it could be done legally and elegantly, we would save x number of months or maybe even a year and the reports could be generated sooner. So this resolution asks the state to see what the effect of -- what's the statistical effect of removing the SPARCS data validation process from the entire cycle. And we shall see.

MR. GREENBERG: And I think it's just important too. For those who are not familiar with what the SPARCS data is, essentially, what happens in that process is we take the trauma registry data, we look at the SPARCS data, which comes in from the hospital side for all patients. We compare the two. If there's any outliers or if there's a number of cases that aren't there, we then notify those hospitals. They then tell us this didn't meet their criteria, or oh, yep, we missed that one, let's put it in. And so part of that conversation was trying to determine the statistical significance of some of that. And I think there -- you know, this is

something we're going to go look at. This is not a definitive, but I think Cristy and I are going to take a look at, you know, what that is, what the impact would be, how to look at it, and maybe bring some solutions in the September meeting based on what we find, stuff like that. Is there anything else you want to add to that?

MS. MEYER: I think we'll be able to get some really great data out to the team to understand the impact of this and it will potentially shave off a lot of workload for registry teams across the state. So if there's no value in that exercise, we probably shouldn't do it. So thank you.

MR. BANK: Okay. Any more discussion? So the first motion is to evaluate the impact of the SPARCS validation process on the state trauma data report and is it necessary. Do we have --?

MR. TEPERMAN: Second.

MR. BANK: Teperman.

MR. BANK: So --.

MR. CLAYTON: So Director Greenberg and Dr. Bank, correct me if I'm

wrong, but because this is not a statutory matter, we don't have to do a roll call

vote on this. It's just a, you know, raise of hands, correct?

MR. GREENBERG: Yep.

MR. CLAYTON: Thank you.

MR. BANK: Okay. So everybody in favor of the motion, please raise your hand. Any opposed? Motion carries. Any abstentions? If you're abstaining, don't raise your hand. That's everybody. Okay. And then the second motion is to ask New York State to switch from a three-year cycle to an annual report -- an annual registry report. Everybody who wants the motion to pass --

MR. TEPERMAN: Sir, I think --.

MR. BANK: -- raise your hand?

MR. TEPERMAN: But Eric, I think could bring a little color to it, just an explanation.

MR. COHEN: So, yeah, again, historically, the turnaround time for these reports is long. So the report that's coming out now is going to cover from 2015 to 2020, I believe, a five-year period. And the thought process behind this was if it takes so long to get this data in and validated, if we do this on a yearly cycle, it would at least give us a look back period to -- on some

data that's -- we can do something with. Looking at five, six-year-old data at this point is kind of not necessarily the most helpful way of looking at things. So by turning this into a one year report, an annual registry report, as opposed to a three-year report, at least we're getting some data that we can act upon in real time. That's the thought process of why we would like to switch to an annual report as opposed to the traditional three-year report that the NYSTR normally covers.

MR. BANK: Okay. So just to restate the motion, to ask New York State to switch from a three-year cycle to an annual registry -- an annual report -- registry report, I should say. So everybody in favor, raise your hand?

MR. CLAYTON: Dr. Bank, I'm not sure if we had a second on that.

MR. BANK: Anyone want to second it?

MR. FLYNN: Second.

MR. BANK: Dr. Flynn seconds it. So everybody in favor, please raise your hand. Anyone opposed, please raise your hand. And any abstentions? So the motion will carry. Okay. Thank you very -- Eric, is that it?

MR. COHEN: That concludes the report. Thank you.

MR. BANK: Okay. So now Dr. Berry from the trauma needs assessment subcommittee.

MS. BERRY: Thank you, Dr. Bank. I am Dr. Cherisse Berry representing the trauma needs assessment committee, along with the chair who's Dr. Robert Winchell. We had a robust conversation during our committee meeting. Proposed an amendment to the approved process for trauma center needs assessment. This amendment is as follows. The New York State Department of Health shares any new trauma center applications to our committee for review for all new designation requests and any requests for a change in level. The trauma needs committee reviews. The new application or requests for change in trauma center level, applies the screening criteria, takes into consideration our tech recommendations, particularly for level 3 and level 4 trauma centers, and makes recommendations to the STAC. The STAC then reviews the trauma needs assessment committee recommendations based on those criteria and approves those recommendations. The STAC will then make approved recommendations to the state. The state takes the

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recommendations of the committee under advisement prior to deciding to designate a new trauma center or change the level of an existing trauma center. There was a motion that was carried in committee. And so I put the motion on the floor for the members of the STAC for approval.

MR. TEPERMAN: Teperman, second.

MR. BANK: Any discussion?

MR. ARRILLAGA: I have some discussion. I'd like to repeat what I said in the subcommittee that to remind this body that the ACS verification, which the state does, and is not some -- many other states in the -- in this union do not do that. That the ACS -- and this is with respect to the request for level up, that the ACS verification process already does a lot of what is intended with this motion. And I think it -- in some way, it should be included in the language that, for example, to making a commitment to go from level 2 to level 1 requires its significant commitment. This is not something that's done on a whim. Not only financially with monies that have to be paid to the ACS for the consultation visit and the verification visit, but the commitment to train -- to have PGY-4s

and PGY-5s in your trauma center, and therefore commitment to train the surgeons of the future. Plus, the commitment to contribute to the scientific literature, which is basically the difference between a level 1 and level 2. In addition to being able to have the adequate numbers, whether that be the total numbers or the numbers of patients with ISS greater than 15, it's a significant commitment that is not done on a whim. And that at least from the examples in my neck of the woods, where a hospital down the street requested a change of level 2 to level 1, and they did not meet the requirements so the ACS didn't verify them. And in our case, in Good Sam at West Islip, where we just recently requested a upgrade from level 2 to level 1, and the ACS gave us a provisional verification because we did not meet the research requirements. So I just wanted to make those comments to this body.

MR. BANK: Any additional discussion? So for the motion that is being displayed right now, all in favor, please raise your hand? Any opposed? And any abstentions? So the motion will pass. Thank you very much. And I think we can -- want to go back -- put the agenda back up. So we're going to go back

up to the top of the agenda. Oh, I'm -- I apologize. Dr. Berry, was it?

MS. BERRY: I have a couple more things for the --.

MR. BANK: Yeah, I apologize.

MS. BERRY: No worries.

MR. BANK: Dr. Berry, please continue to report.

MS. BERRY: No problem. Two other points. We are working with the state on a data usage agreement to link EMS and hospital data for the STAC for internal needs to set up metrics for needs assessment and system operational metrics, really focused on ambulance runs, destination, hospital access times, ideally connecting to hospital volume and outcome measures. And finally, in our last STAC, we had discussed and approved ACS COT system consultation program for funding for that. However, since that time that -- that was approved, the cost of the systems' consultation has doubled from sixty five thousand to a hundred and fifty thousand dollars. So that is not within the budget. So we discuss the need for additional funding, applying for grants. So until we can afford the increase in cost,

we are going to put a hold right now on the systems consultation. And that concludes my report. Thank you.

MR. BANK: Thank you very much. So we are just going to go back up to the top of our agenda. The executive report from me, the executive committee met. We discussed a few things. One of the things that we want to try to move towards over the next year or so is just to assign vetted members of STAC to the different subcommittees. Right now we don't really have a clear list of what vetted members of STAC sit on each subcommittee, but we want to make sure that there's a good representation on each subcommittee of vetted STAC members, and also hopefully, and those vetted STAC members will come from a wide geographic representation of the state. So probably the next year, we're going to be developing a process for this, and we'll be asking the vetted STAC members to choose some subcommittees that they want to serve on. In addition to that, in the next few months, we're going to be developing a process to choose a new vice chair of STAC. Also keeping in mind to try to have the greatest geographic representation on the STAC. I think that

is it for my executive report. And now we can go to registry by Cristy.

MS. MEYER: Good afternoon, everyone. So the registry committee was able to meet today and overview some of the registry work groups work over the last six to eight months. So a very large group of individuals from across trauma center levels and across the state met every other week to come up with the 2024 data dictionary changes for New York State. We hope to make those recommendations to this group today for approval so we can move through that whole vendor process to make some changes. Certainly, not as substantive as prior years, but we were able to recommend a few eliminations. So the PCR status, so there's a specific field for whether the PCR collected is incomplete or missing. That actually can be derived from the data already collected and submitted. So it's somewhat redundant, so we recommend removing that individual field. In addition, there's a lot of discussion and certainly a lot of requirement to look in the new gray book at EMS field triage and EMS practice of field triage. So we recommended to add not just the PCR into the receiving hospital from referring transfer centers,

but the initial field scene PCR into the submission process for New York State so we can do that scene evaluation.

There are some limitations to this data collection. By collecting the scene PCR, we will be able to determine some of those limitations for the receiving trauma centers to do that good work of PI and EMS follow back. In addition, we just want to change the language of the level of activation to meet the standardized field definitions for higher -- highest activation and intermediate activation. There's a whole lot of different language that centers use, but this is standardized language and one last change to add a height of fall table, so when a provider does not document the height of the person's fall. We have standardized estimates for us to use for things like a bed, a bunk bed, subway platforms and things like that. And that concludes the submission for this year's data dictionary changes. They would be effective January 1st, 2024, if this so -- this body so moves.

MR. BANK: So you want to read the motion? So the motion is to move forward with trauma registry subcommittee, trauma registry admission

changes, beginning with emissions on January 1st, 2024. Anyone to second that motion?

MS. SNYDER: I'll second. Kerrie Snyder.

MR. BANK: All in favor? Any opposed? Any abstentions? Okay. So the motion's carried. Is that the end of your report?

MS. MEYER: Just a couple things. So now that we are going to move those changes forward, I will work with our Department of Health leadership to meet with vendors and start working on those changes. We know that takes a substantive amount of time. So we'll work on that. One of the other things that the work group that will convene this year to do work for that following year will be focused on, is the definition of dead on arrival or DOA and dead in the ER or DIE. Those -- there's a lot of variation in registry practice, trauma center practice. I see some nods in the crowd. So we hope to advise this group and that data collection point in collaboration with our department health agencies, our EMS agencies, and some national standards, and our TQIP collaborative. So it'll be a little bit of work over the next few months. But we do want to

standardize that definition. We will be convening the work group. It has been a very robust group. We had a lot of new representatives and very seasoned members, so if that's something you want to bring home to your center. And we had a wonderful presentation for the micro mobility abstraction tool. So e-codes collecting the micro mobility devices that are leading to many injuries across our state and nation.

Actually, there's a resource tool that'll be on the registry page as well as a training tool and we'll hope to work with the Bureau of Injury Prevention to actually make more recommendations in the future, on how to understand that. And we have two volunteer trauma centers to give some presentations in the fall at STAC in October. So, looking forward to a great year and thank you to everyone for your help. This concludes my report.

MR. BANK: Thank you very much, Cristy. So the trauma needs assessment we already did. And injury prevention, I think Cristy is not here, but Dan, you are going to fill in.

MR. CLAYTON: Yes, I do, Doctor. I have a report that was provided by The Injury

Prevention Education Subcommittee, and I'm just in the process of bringing that up right now to provide both the chair and the vice chair of the IPE subcommittee had to leave for other reasons for this afternoon. So I'm going to read what was provided to me by Sloan pretty much verbatim. "The Injury Prevention Education Subcommittee of STAC would like to thank Kristy Ladowski for her service and contribution to STAC over the years. She will be leading the ACL Falls grant and will be tracking data of various fall programs for Tai Chi for Arthritis, stepping on in a matter of balance in New York State."

Updates from the Bureau of -- Bureau of Occupational Health and Injury Prevention, which is a Bureau of the State Health Department, Christina Akey, was fall coordinator and there was discussion about implementing traffic safety and public health initiatives with New York State Health Department for pedestrians and distracted drivers. A campaign with NHTSA making coloring books on safety initiatives to hand out in schools and by DSS. The CPS symposium in Lake Placid last week was well received. Performing outreach was also discussed to inform communities

where car seat checks will be offered to caregivers and parents. There's a press release that was sent out on drowsy driving and the Stay Awake, Stay Alive campaign.

They're working on offering trainings for coaches and injury professionals, injury prevention professionals to be certified in evidence-based fall prevention. Also, Tai Chi for arthritis and fall prevention, and a matter of balance. Under fall prevention, Mark Musicus from Westchester Medical Center presented a PowerPoint presentation on fall recurrence in geriatric trauma patients. They track patients 65 and older admitted to trauma for falls and provide outreach and awareness to help prevent repeat falls. They've been using the study tool for objective data and surveys to determine overall outcomes. They have a five-minute fall prevention video featured in the Office of Aging by the hospital in catchment area. Feel free to reach out to Mark Musicus for the presentation and video. I can get -- and by the way, for that particular PowerPoint presentation that he did this morning as part of IPE, we'll make sure that that's available on the State Health Department website. So when I

follow up early next week with things related to this meeting, I'll make sure that PowerPoint, or the link to it on our website is included.

So under injury prevention needs and opportunities, the ATS Prevention Council had a symposium last week. They're looking for experienced IP professionals to become mentors for new IPEs. FYI, May is Stop the Bleed month, offered STB program at legislative office on the 10th of May. So that was just yesterday. Many STB programs has stopped the bleed, of course, for those -- for the record, offered throughout the state and schools and community. There's another session on gun safety on June 2nd, wear orange, have gun lock boxes, offer blood drives and Stop the Bleed programs. And ATS will offer four webinars next week for National Trauma Awareness Month. There were no seconded motions that were brought forward for the full committee this afternoon from IPE and unless there are questions, that concludes my report, Doctor.

MR. BANK: Thank you very much. So the next subcommittee is the Regional PI, which will be my report. We had three really robust discussions. One of them was after a presentation by

Peter Brody, the DOH about a bios, spatial EMS database that enables you to pull up very accurate data of trauma cases throughout New York State. It was very impressive. It's most recently led to a publication from NASA University Medical Center in the Journal of Trauma Nursing. And Peter demonstrated that from the entire committee and demonstrated a way forward if any hospital wants to access to that database. Secondly, from Mr. Teperman --.

MR. TEPERMAN: Hey, Matt. Just on that, sorry. It's Teperman. I think Peter indicated that he might via the Listserv or via Dan, be able to send out to us what that the process of going through the legal requirements that DUA is, so that we can understand it.

MR. BANK: I'll follow up with Peter, and on the Listserv we'll get out the contact information of how you start the paperwork to get in -- to get access to that data.

MR. GREENBERG: I just want to stress there -- there's a difference in bios spatial being used from a regional point of view for quality assurance, which we're working on that, to a then an

institution wanting to look at essentially their own data that they would've had anyway. So it's just two different documents, one happens slightly faster than the other.

MR. TEPERMAN: So in other words, if an RTAC wanted it, then that process -- the RAC chair would request it?

MR. GREENBERG: Correct. And I think we're already working on that for some of RTACs.

MR. TEPERMAN: Yeah, generally speaking, the RTACs don't have lawyers to help them out with it. So it would need to be fairly simple.

MR. GREENBERG: Noted.

MR. TEPERMAN: Noted

MR. BANK: So our second presentation at the PI committee was from Staten Island University Hospital, where they had a very interesting presentation of improving their care of hip fracture patients and patients with femoral shaft fractures by decreasing their time to the OR. Lastly, we talked about the new AST, COT, Trauma Field Triage Guidelines. How they're -- we are trying to operationalize them and the role of the RTACs. Also the fact that the new guidelines have now been

officially adopted by New York State. It is on the New York State DOH website. You can -- anybody who wants can download the protocols. And when you go out to introduce this to EMS, you can say that this is the official New York State DOH protocol for field triage.

MR. TEPERMAN: And we had a question. It's Teperman again. We had a question for Ryan, is the -- does the state have a process for helping to educate EMS systems and EMS providers about something like the new trauma triage guidelines? Do you guys do that? Or because there was conversation about how maybe that would have to fall to the RTACs?

MR. GREENBERG: We have a form for that?

MR. TEPERMAN: No.

MR. GREENBERG: So, yeah. So, I think that's a -- it's a mixture of things that would come with that. And so there are pathways to do that. I think probably one of the best pathways, you know, in a partnership model would be to work with the STAC and work with Vital Signs Academy, which is an online learning platform available to every state EMS provider to maybe do a, you know, a one hour CME that

they would get credit for as well under the trauma category, which is a requirement for them if they're using the CME program. You know, beyond that, there are obviously regional councils that do different education. But each regional council is a little bit different in how they deliver their care. And then obviously the agencies that are responsible for, you know, their providers, making sure that they're well informed. So I think there's a number of different outlets in looking at it. If anything, I think that would be a great partnership of two different councils. So training in ed from the SEMSCO and, you know, education or someone representative from the STAC or a physician who might sit on both and can help facilitate that. I think would, you know, help bridge that. But I would say, I think some of the -- probably the fastest and first step might be something on Vital Signs Academy, and I think Amy wants to comment on that one.

MS. EISENHOWER: So, as I mentioned in the subcommittee, there has been some education on this from one of the regions, Gary Hecker from Jacobi had presented last month. And I contacted our folks that do the editing for the library on Vital Signs

Academy. So we're going to work out speeding up that editing. But also Doug Sandbrook from Upstate will be on the Vital Signs Academy, for the EMSC evening, because we sponsor two nights a month. So that will be Tuesday the sixth at six p.m. and you can register for that on the Vital Signs Academy website.

MR. CLAYTON: And for the record, this is Dan Clayton, but that was Amy Eisenhower. I know she doesn't have a sign up. So that was Amy Eisenhower speaking. And I was just going to also note that Doug Sandbrook did a presentation today through SUNY Upstate Medical University on this same subject. So it is being done out there. Doug Sandbrook is the paramedic Program Director at SUNY Upstate and he's also very involved with SEMSCO, SEMAC as well. Thank you.

MS. EISENHOWER: Amy Eisenhower again. Also, Dr. Jeremy Cushman and Vincent ... from the Monroe Livingston region. They also have an educational repository, so if you're in that region, you can go on their website. They have some education on there already and they have offered to share it with other regions and make it available.

MR. DAILEY: And this is Dr. Dailey.

I'm just going to add to that. Let's not forget that one of the authors of all of these documents and some of the educational materials from the ACS was Mark Gestring, who's not joining us today, therefore gets volunteered for things. And I have already gotten fantastic reports about his education around this material. So I think we'll have to make sure that we make contact with him as well.

MS. SNYDER: Kerrie Snyder from Albany Med. I just will make one comment just for the people who are not familiar with the Gray Book yet, the new ACS standards. It is specific to an audit filter in the Gray book that trauma setters are evaluation -- evaluating that these patients were triaged according to the current guidelines for where you are to the appropriate designated trauma center. So I think that's important for the EMS community to know that these standards are out there. And trauma centers in the next year are going to be starting to give feedback to EMS if field criteria are not met.

MR. BANK: Okay. Thank you. The last report is that we have a new co-chair, Dr. Vella, who is the Trauma Medical Director of University of Rochester, will now be the co-chair of the regional

PI committee. And Amy, anything on pediatric trauma?

MS. EISENHOWER: Yes. So many of the pediatric trauma surgeons are at a conference this week. So Dr. Kim Wallenstein gave me a brief report to share. There was no subcommittee meeting today, this morning, as all the pediatric trauma surgeons are away. However, she did want me to share that -- let's see.

MS. EISENHOWER: On the TQIP data and the new ACS standards, for example, mental health in patients that are received at trauma centers. Also EMS for Children Advisory Committee and the pediatric trauma subcommittee have been working together on the emergency department, pediatric emergency care coordinator program. That was the bulk of our last meeting and pediatric recognition program that is also part of the new gray book standards on having pediatric representation to be reverified or verified as a trauma center. And I will have a presentation on that under old business. Any questions?

MR. BANK: Okay. Thank you. Is that the end of your report?

MS. EISENHOWER: That is the end of my report.

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MR. BANK: So Jerry, any information about the New York State chapter of the ATS meeting?

MR. MORRISON: Good afternoon. We had the honor of hosting a tribute to Dr. Marks and Dr. O'Neill last night. We had heard from our committees of two success stories, so one of which was a collaborative effort through this body and other entities in the state, which helped bring a DMAP, a Disaster Management Emergency Preparedness, course here yesterday, in conjunction with our meetings. Is also -- as already previously mentioned in the Injury Prevention report, there was a Stop The Bleed program conducted for legislators yesterday as fruit has been born from that already. So Kristy has gotten requests for Stop The Bleed courses already. And also, one of our important goals with that is to increase the awareness of the legislature of Stop The Bleed and its importance. We shared the grant awards for this year, and we were able to fund grants in a total of $15,000. We also had our Distinction Awards. Our trauma medical director of the year was Dr. Robano. Our trauma program manager was Skyler Trujillo, Registrar of Distinction Jillian Kobal(phonetic spelling). PI coordinator, Kate

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Delant(phonetic spelling), Injury Prevention Coordinator, Adam Aplinger(phonetic spelling) and the educator of the year was Eric Cohen. And that concludes my report.

MR. BANK: Jerry, would you mind if any of the people who got those awards would just stand up so we can recognize them if they're in this room, just --.

MR. MORRISON: Please.

MR. BANK: Thank you very much. And Dr. Dailey from SEMAC just walked out. He's coming back?

MR. DAILEY: Sorry, Dr. Chair. If you could give me a minute.

MR. BANK: Sure. Okay, we will continue. Amy, back to you.

MS. AMY: Hello again. Also Dr. Cooper is out of the country presenting a paper in Ireland. So I'm also Dr. Cooper today. So we had our most recent EMS for Children Advisory Committee meeting last week via WebEx. So this will be a brief summary of that. So the EMS for Children Grant was awarded for the next four years. So we're very excited about that. That started April 1st. Many of

the performance measures are similar to the last grant cycle and they conclude pediatric recognition programs for both emergency departments and EMS agencies. Pediatric emergency care coordinators for both emergency departments and EMS agencies and then preparation for disasters, whether that be patients with special needs, whether that's medical needs or otherwise, general preparation for pediatrics in disasters and then also things like reunification with, unfortunately, many of the -- many of the things that have been unfolding around the country.

So reunifying children with their families, whether that be in the field or at the hospital later. Also there is a pediatric readiness quality collaborative through the EMS for children EIIC. And that is enrolling through June 23rd. Primarily they do focus on hospitals, but EMS is welcome also. And they really make it easy. They do a lot of education around quality improvement and the process and they really make it easy if you haven't done any quality improvement before, and then they also have everybody work together. So if you're very familiar with quality improvement, you want to participate. Everybody works together and kind of

grows together, which is very lovely.

Our next EMS for Children Advisory Committee meeting will be here in the Capital Region at the Hilton Garden in Troy and the next one will be September 5th from one p.m. to four p.m., and then the one after that will be December 5th kind of tagging onto -- I'm sorry, December 4th. And that will be tagging onto SEMAC and SEMSCO on the front end of those meetings. We also discussed safe transport of pediatric patients and the work that has gone on with that. Much thanks to my predecessor Martha GoldKey for kind of beginning that process and giving us a good foundation to build on. We've now included safe transport of newly born patients. So how do you appropriately transport mom or caregiver and newly born baby depending on the scenario that has occurred in the field?

We had presentations at the Governor's Traffic Safety Council Conference, the Child Passenger Safety Technician Conference last week in Lake Placid. Both were very full rooms. Lots of interest, lots of questions. So two of our EMS pediatric emergency care coordinators, Tom Orpakowski (phonetic spelling) and Anthony Singh presented with

Peter Diandrio on all the devices for pediatric transport and ambulances. So if there is no car seat, what do you use? And there are many devices on the market now to safely get kids from where they are to the hospital. Also in the afternoon, I presented on how to transport newly born patients. And much thanks to Dr. Dailey for making this on the radar for many EMS agencies across the state. I'm very excited to say that many have reached out to me to add these new devices to their equipment on their ambulances. Many of these devices for newly born patients only came out in the last two or three years. So this is really kind of a new initiative and endeavor. We also discussed pediatric agitation and mental health. We do have an education work group and that continues.

As I mentioned, the Vital Signs Academy has two EMS for children education days a month. And Sarah Grover, one of our Family Action Network members and also a practicing paramedic here in New York State, will be presenting on Vital Signs Academy and also at our Vital Signs Conference in the fall on therapeutic communication and de-escalation for all patients. But with a special section on

pediatrics. We also have been discussing pediatric triage as many of you have been. So we do have a work group. And thank you, Dr. Dailey, for volunteering. Dr. Gestring, who's not here, I will be reaching out to him to include him in our meetings. We also have been reviewing length based measuring tapes and medication doses and how those match or don't match in our collaborative protocols. So that is ongoing. And then also we discussed and the EMS for Children Advisory Committee supported the Always Ready for Children pediatric recognition program and emergency department PAC program that we will talk about shortly. All right. And I think that is the bulk of our meeting. Does anybody have any questions about any of those things? And that is the end of my report.

MR. BANK: Okay. Very good. Thank you very much. And now back to Dr. Dailey from the State EMS Council.

MR. DAILEY: Thank you very much. I'd like to point out that most of the reports from the members of the bureau that have reported out today was part of the business there yesterday was met very well. We did have an additional guest yesterday at

the med standards which was fantastic. Dr. Morley, Deputy commissioner, came in, spent some time talking with us about some mental health concerns. In particular some work that was done by Dr. Sullivan from the Office of Mental Health. I probably don't have to tell anybody in this room, but we have a bit of a mental health crisis right now in New York. The governor is going to contribute a significant amount of money towards moving mental health agenda forward, which is very exciting. This is going to impact EMS and it will continue to be a strain on trauma centers, obviously. But that's something that gets significant amount of attention, which is huge. The majority of the work that went in proceeds through med standards and then into the SEMAC. Among the things that we did was discuss some updates to protocols that will be implemented over the course of the next nine months. One of which is an update to the MOLST protocol, the medical orders for life sustaining treatment.

Another was an update to the seizure protocol. And the third that is pertinent to patients suffering trauma in particular is pain management with some updates to pain management,

including doses of ketamine at appropriate low doses for pain. Spent some time talking about blood product regulation development. And some of the members of the Bureau have been doing a significant amount of work with stakeholders in terms of creating regulations around the recent legislation that allows air ambulances to transport blood products and then to administer blood products primarily in the field. And then we discussed that there is currently legislation pending at both the Assembly and the Senate that would allow ground ambulances to also store and then initiate blood transfusion. On that legislation we need to give a close look to, to make sure indeed, that it's going to allow EMS providers to initiate those transfusions. But it's exciting to see some expansion there particularly given the work that's being done and a number of other communities across the country. One that I know Dr. Edwards here is well aware of is San Antonio where they have been doing significant amount of blood transfusions in the field over the course of the last five years and have had fantastic results for their patients.

MR. TEPERMAN: Dr. Dailey just --

MR. DAILEY: Yes, sir.

MR. TEPERMAN: -- just a comment. If I may, Mr. Chair, is it okay if I ask a question at this point? Of course, Mr. Chair. We've had -- it's Teperman. We've had conversations about EMS, in this case ground transfusions. And what I've said at previous meetings is I think that it's very important to have medical control over that decision. I don't think it should be necessarily left to the medic on the ground. So my feeling was that the STAC should have a conversation where we had a conversation about making a recommendation. Obviously, we don't have agency per se to tell folks what to do, but to make a recommendation that there be formal medical control when in a unit of blood or plasma is being contemplated for transfusion. Maybe there can be discussion. I think the -- I think that's extremely reasonable. I think that's part of the protocol development process. I think at this point, since we have a significant amount of legislative hurdles to get through prior to that occurring, that I'm not sure that's something we should do anything more than considering it now at this point.

MR. BANK: Did anybody else have a thought, any of the STAC members have a thought on

that? Trauma surgeons and all? So Dr. Dailey, where in the process do you think we should insert that opinion?

MR. DAILEY: I think as we have done before Dr. Bank, that the right thing for us to do would be as we look into treatment of hemorrhagic shock, that those protocols come here for discussion and input on as this is the body that would be most appropriate to add to that.

MR. BANK: So, Dr. Teperman -- and Dr. Dailey, will, as these things become more mature, bring it back in to the STAC and we can make our recommendations at that point.

MR. TEPERMAN: I think we welcome that. And just to touch on that one, currently right now it's blood products is only available by air medical programs. It's not by ground ambulances. Ground ambulances can do inner facility if they're an ambulance transfusion service. But then it's, again, continuation, not a starting blood situation. There is legislation that's out there right now in this session proposing to include ground ambulances in that same framework, in the same legislation that's out there for air ambulance. But it's, you know, it

-- I don't know what will happen, you know, in this session on that one. The other thing to keep in mind, and I think this is part where Dr. Dailey is going to on this one, is in order for us to work on those regulations and then put them out, you're probably looking at, you know, twelve to eighteen months before you'll see those regulations get implemented. And so that timeline would give the point of where maybe a protocol or something would relate to that as well.

MR. DAILEY: I think the director's timeline is optimistic.

MR. GREENBERG: I am a glass is half full person.

MR. DAILEY: As opposed to the people around this table who are the glass is about to break people.

MR. GREENBERG: It's bleeding and they're trying to control it.

MR. DAILEY: Exactly. We'll get there in a minute. So, along with that, and I'd like to point out the director opened this, I did not. One thing that remains is a problem that we have is the ambulance transfusion service process where the

regulations and the advisement that's come from both Wadsworth and the department has unfortunately gone awry. So there is no way -- and this impacts rural hospitals in particular, there's no way for emergent transfusions to be carried by ambulances that have not previously been vetted as transfusion services, even if the paramedics on board that ambulance are trained in the management of transfusions. And that is particularly a problem that impacts rural areas. It impacts areas where there are ambulance shortages. This is something that the rural ambulance task force needs to take on and something we need to continue to work on. I realize that this body has discussed that before but it remains an issue. So, from that, the other thing that I wanted to take some time to talk about is actually something that I did with -- with Dr. Gestring a number of years ago. And Dr. Bank and I have been talking about this over the last few weeks as well.

And historically, just so you know, there is a state ed guideline that goes out to our school nurses, which advises the school nurses and school medical directors as to how they should provide care in schools. And I scribbled some ideas

here and I thought I would -- thought I would read them to make it a little bit easier. So in 2018, this body became aware of some interpretations in stated guidelines that hemostatic dressings for emergent hemorrhage control were considered an over-the-counter medication and would need a patient-specific order for use and could not be used by school nurses without jeopardizing their license. Dr. Gestring and I worked with Linda Kalel, who was the executive director from the Center for School Health at the time and issued some updated advisories that seemed to reconsider this directive while at the same time reminding people of that concern.

And once again, this document has been reissued with some language that I think will cause many nurses to pause because there's a footnote that says hemostatic gauze is considered an over-the-counter medication and therefore needs a patient-specific order by a physician for nurses to administer. They do not fall under those medications that may be ordered, dispensed, or administered under a non-patient specific order in New York State. Basically what this does is it eliminates the use of hemostatic dressings in school Stop The Bleed kits.

So what our real goal here is to assure that our school nurses really feel professionally assured and safe in their role. We need to assure that our schools are as safe as possible in the face of potential tragedy. And we've certainly seen potential tragedy and tragedy. We recognize these dressings are carried by our police officers, EMS providers. They're carried by the military. These are promulgated to the public through the American Colleges of Surgeons through the Stop the Bleed program and these kits are available nationwide.

And what we really need to do is clarify this interpretation in order to assure the school nurses feel comfortable with it. There's no doubt, and I'm sure around this table that hemostatic dressings may be lifesaving. So having regulations interpreted a little bit less conservatively would be extremely key to us. Notably, these -- these hemostatic dressings are not over-the-counter medications according to the FDA. These are actually class two medical devices, notable medical devices that are probably handed out on a relatively regular basis by school nurses. Other class two devices include tampons. All right. So the requirement for

a nurse to have a patient specific order may actually have some limitations in state law, but probably is not hindered in this case by a class two medical device.

Notably, education law 6909 says that it in our end may execute a non-patient specific regimen prescribed or ordered by a licensed physician or certified nurse practitioner person pursuant to regulations promulgated by the commissioner. We had a little bit of a misunderstanding earlier as someone was saying STB and people thought they were actually saying STD. So, I'd just like to point out that patient speci -- non-patient specific orders that RNs may follow include administering immunizations, emergency treatment of anaphylaxis and testing for syphilis, gonorrhea and chlamydia, but not using hemostatic dressings. So the bottom line is that these dressings may already be available in schools, should be able to be used by school nurses.

I can't imagine anybody at this table that thinks that's a bad idea. And what we need to do is ultimately change the interpretation of the existing regulations and how this legislation is being reviewed or just have a legislative solution.

We had a legislative solution to naloxone when approximately eight years ago, we realized that we could train everybody in a school to use naloxone for an opioid overdose except the school nurse who was not allowed to use it. And we implemented a legislative solution through some of our partners in the legislature. If necessary, that's how we could go, because this is a type two medical device and not a over-the-counter medication. I think the easier way to do it would be for the Commissioner of Health to have a conversation with the commissioner of education and issue guidance to school nurses that say that these are appropriate for use.

MR. TEPERMAN: Dr. Dailey, would it help if this body made that recommendation formally?

MR. DAILEY: That is exactly what I was about to request, Dr. Teperman.

MR. TEPERMAN: Okay.

MR. DAILEY: So I now have my second for my motion that this body request the commissioner of health, work with the commissioner of education to resolve this issue so our schools are safer places.

MR. BANK: So, I just want to clearly state your motion.

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MS. AMY: Hang on a second.

MR. BANK: Here we go. We're going to bring it up. The motion would be that the New York State Commissioner of Health works with the Department of Education to enable registered nurses in New York State to use hemostatic gauze in a non-patient specific order. Hemostatic gauze -- I should say with, not in --.

MR. DAILEY: With --.

MR. BANK: With a non-patient specific order. And just for everybody, because this terminology is a little strange. I understand. The terminology that we're using happens to be the terminology in the regulations. And what this allows nurses to do is not have an order for a specific patient, but to use their own judgment in applying hemostatic gauze to a bleeding patient.

MR. GREENBERG: Dr. Dailey, wasn't there something yesterday that was brought up related to this might be able to occur today because under -- I forget the terminology they used, but under an emergency action, that nurse would be able to use the device even in a non-specific patient order?

MR. DAILEY: That actually is reading

through some of the opinion that came through from the State Board of nursing. The answer is no. Thank you.

MS. MEYER: Could I ask for clarification that this would not just apply to schools, but any nurse in the course of their duty of work would be prohibited from using hemostatic laws without a patient specific order?

MR. BANK: I think that if we just keep it registered nurses in New York State, they would apply to all RNs in New York State no matter where they are.

MR. TEPERMAN: But we're specifically going after the Department of Education. That's what the ask is here.

MR. DAILEY: I would suggest we not use the term going after.

MR. TEPERMAN: So, Dr. Dailey, you always speak more elegantly than I.

MR. BANK: So -- yeah. Just to clarify, although it is school nurses that we are talking about, I think that the regulations that we're talking about that limit the scope of practice in this particular case come from the Department of

Education.

MR. DAILEY: Yes.

MR. BANK: So it would really be the Department of Education that would need to change this, and that would apply to all New York State RNs and not just the RNs in schools.

MR. DAILEY: Yes. The important thing is that the Nurse Practice Act, which is an extremely beautiful piece of legislation, already allows a nurse in the course of their non-employment duty to use something like that. This is absolutely fine because they're able to act in emergencies with indemnification. So that situation is fine. If there were additional things available for them at a scene in a hospital, for example, the question would be how the Hospital Pharmacy and Therapeutics Committee were to address that product. But putting it in this letter and then ultimately changing the regulation would apply to all nurses.

MR. BANK: Kerrie?

MS. SNYDER: One of our TPMs pointed out that all nurses and schools are not just registered nurses but also licensed practical nurses.

So, I don't know if you want to limit your language here.

MR. BANK: Okay. So we would change it to the New York State Commissioner of Health works with the Department of Education to enable registered and or should we say, licensed nurses? Would that cover everything?

MS. SNYDER: Registered or --.

MR. BANK: Licensed -- registered or licensed practical nurses to use hemostatic gauze with a non-patient specific order. And then I know that there are about twenty, maybe less, nurses in this room right now. So just of all the RNs that are in this room, does anybody feel that this is a bad idea? I'm getting resounding silence, and then a bunch of nurses shaking their heads, which I think means no, they don't think it's a bad idea. Okay.

MS. SNYDER: The students themselves could use the things ... the nurse cannot. You teach a child ...

MS. EISENHOWER: I'm sorry. Can you use your mic?

MS. SNYDER: You want ...

MR. BANK: If you're going to be

sarcastic, you need to put it on the microphone.

MS. SNYDER: Okay. The students, when you go in and you teach Stop The Bleed in school and they buy a kit, the students themselves can bandage up their best friend who got shot, but the nurse responding cannot. I don't think we have to say anything else on the subject.

MR. BANK: Okay. So, I'm going to read this one more time, then we'll see if we get it seconded. The New York State Commissioner of Health, the -- our motion is that the New York State Commission of Health works with the Department of Education to enable registered or licensed practical nurses in New York State to use hemostatic gauze with a non-patient specific order. Can I have somebody second that?

MR. TEPERMAN: Teperman, second.

MR. BANK: All in favor? Any opposed? Any abstention? So the motion will carry. We're going to go back to agenda so old business. Anybody with any old business? Amy has some old business.

MS. EISENHOWER: So, several months ago, Peter Birdie was kind enough to give a short presentation on the pediatric recognition programs as

suggested by Emergency Medical Services for Children Federal. And I had anticipated to be here. However, I had a sore throat and it was COVID time. And so I was told stay home, and I furiously texted him from my phone. So, I did not get to see all of you then. However, this is the follow-up program. So, there's a pediatric recognition program component to this which is always ready for children. And the people to implement the pediatric recognition program in hospitals and in emergency departments will be the emergency department pediatric care coordinators.

So why have any of this? So there has been multiple research papers and studies in conjunction with EMS for children hospital surveys, over the last about ten years. And Dr. Gosh Hill and Dr. Kate Remick have really kind of been at the helm for that. And it's been increasingly demonstrated that having a PAC within an EMS agency, an emergency department or hospital, is one of the strongest drivers of improved quality of emergency care for children. And we'll talk more about what the PACs do to achieve that in a few moments. So having a higher level of pediatric readiness in emergency departments has also been shown to be associated with decreased

morbidity and mortality in critically ill and injured children regardless of trauma designation. So, I realize that probably I'm speaking to the choir here today because you guys are already doing this work, and probably this is just putting a title on things you already do. And so the purpose of having a PAC is to ensure that children receive the same quality of emergency care as their adult counterparts, which is really why EMS for children was founded in the '80s.

So having an improved pediatric readiness score means that your pediatric readiness is improving or is already really great. And increased staff awareness and competencies in pediatric best practices. So, this would be obviously understanding your standard operating procedures or any policies you might have for pediatric patients. Also having competencies related to pediatric patients, specifically, not just having competencies and training for adult patients. Also having the appropriately sized equipment, right? Children -- one of the most difficult things about treating children is they have a variety of sizes. Very tiny to very large, some of them larger than

myself. So, right -- having the right-sized equipment whatever that might be, and having that at the ready, so when they come into your emergency department that you would be able to grab that equipment quickly and treat them quickly.

And then also sustainable pediatric education and improvement programs to ensure that children who present to the ER -- who present to a safe ER receiving the best care we can possibly provide. And I don't think that anybody would argue that. So this person or people, because it can be a team of people. I do recognize, and much of EMSC recognizes, that we all already have overflowing plates. And so when we work in a team, sometimes the work is easier. It's an easier lift. And so working in a team environment might be beneficial at your hospital. So a pediatric champion or champions for pediatric care. And so they suggest both a physician PAC, and a registered nurse as a PAC. So having two PACs. I also recognize that you may not have those roles at your hospital especially if it's a smaller hospital. So specializing in emergency medicine or pediatric emergency medicine. And then the registered nurse should have an interest or training

in emergency care of children. And this could be full time or part time.

So, promoting and verifying adequate skill and knowledge of ED physicians, ED healthcare providers, and other staff. And obviously that would be, you know, via appropriate training. So nurses would train nurses and other caretakers in the ER and then the physicians would also focus on physician training, participate in emergency department, pediatric quality improvement, patient safety, injury and illness prevention, and clinical care activities, which many of your trauma centers are already required to have. And as I mentioned earlier in the EMSC report, EMS for children at the Federal level puts out several QI projects where they really already have a lot of things developed and assist with completing that project. Currently there's a Stop Suicide project for pediatric patients which has been ongoing the last six months. We have one hospital in New York State that's part of it. So I'm looking forward to seeing their results.

And then of course we have the Pediatric Readiness Project, which is enrolling till June. So if you enroll in that, and then you enroll

in this, you'll be ahead of the game. So assist with development and periodic review of emergency department policies, procedures, and standards for medications, equipment and supplies to ensure accessibilities for pediatric patients. And then also ensure pediatric needs are addressed in hospital disaster emergency preparedness plans. So we have been working with OHEP to include some work on that, on their HERDS work. And I know that they were able to commit some grant funding in that program. So if your -- if your hospital has already been working with OHEP on disaster management, there is a deliverable in there. I think it's deliverable number five for pediatric disaster preparedness and the survey which I will discuss in a moment.

So there are three levels of the recognition program. So there's Pediatric Engaged. So just for some reference, the National Pediatric Readiness Assessment or Pediatric Readiness Project. So the assessment is the survey. It comes out every five years. I want to say the last one we did, of course, was during Omicron. So many people were not able to complete it because everybody was underwater. And that was generally across the country. It wasn't

just New York State. So what they did was they developed a tool, which is the survey, but you can complete that survey yourself, and that's available at pedsready.org.

And so you can take that survey, as many times as you like. If you want to do it quarterly, every six months, every year, you don't want to do it at all. You can't unfortunately join us then. But you don't have to do it. It's not a requirement but it's there for your use to review your pediatric readiness level. And they issue you a gap report. So you can kind of understand where you're at, and that mirrors the assessment. And I believe the next assessment is 2024. So it's coming up. So you would complete that, get your gap reports. You would have a score, and that's any score for Pediatric Engaged. And then identify an emergency department pediatric emergency care coordinator. So that's Pediatric Engaged. So maybe your hospital is a smaller facility just starting out. Wants to do more but doesn't know where to start. This would be a great place.

So then Pediatric Ready, again you're going to do the NPRA or the NPRP. Your readiness

score would be seventy or above. And then you're going to have the pediatric emergency care coordinator. So this is maybe, you know, hospitals that started this work already but want to increase their engagement. And then there's Pediatric Innovator, and I would say for the folks from trauma hospitals, whether they're pediatric or adult, probably are already doing a lot of these things. So you would do the NPRA or NPRP have an eighty or above on the readiness assessment. You would identify a PAC or PACs.

And then, what we would ask is sharing your best practice and resources. What makes you an innovator? What things are you doing? Have you done any quality improvement projects? You know, do you have -- where did you find the inspiration to build your policies? What research have you done? So any of those things. Being willing to share that with the other PACs to say, we've been doing this, it worked really great or probably most importantly in anybody that's embarked on any kind of quality improvement, what really didn't work. We did this. It was awful. Probably you shouldn't. So willing to share those best practices and resources. And my

hope is after this gets off the ground, maybe in a few years, have professional development days, have symposia, you know, as we move forward.

So, how do you participate? So, I have a pediatric data specialist who is not here today but Jacob DeMay (phonetic spelling) is wonderful. And we are in the process of updating the website to include this information. So I have an EMSC website on the bureau site. So we're going to update this to have the Always Ready for Children program information, the emergency department information and then Jacob will develop a form for you to enroll. Complete that NPRA or NPRP at pedsready.org. And then submit that application with commitment letter to us via that portal, and then start advancing your patient care. And my other hope is to come out to many of your RTAC meetings. I have some of them so if you have some coming up, I have all summer to come out and visit and say hi and answer any questions you might have or present this to your RTAC, and your other hospitals in the area.

So again, like many things with EMSC, you're not having to do all of this alone. EMS for children has several arms. So we have a research arm

called PECARN, and there's some of their work going on in New York State as well as across the country. We also have a EMSC data center, and they administer our surveys and then crunch that data, clean it up, send it back to us for us to share with all of you. We have an education development research site. So if you google EMSC EIIC, there are lots of toolkits and there's education for anywhere from pre-hospital providers, special needs families, hospitals. They build infographics, they build videos, all sorts of information on there, on a variety of topics. And then of course, there's the assessments. And then many of these initiatives from EMSC are supported by places like American Academy of Pediatrics, Emergency Nurses' Association, ASEP, and many others, NASEMSO is a part of that. So National Association of State EMS officials. So they really do span the board of emergency care stakeholders.

So our next steps is any other review and approval working with our public affairs group on the webpage and resources. My hope is that we roll this out this summer so that you all are ready for any verification or re-verification you might need to do with ACS, starting in the fall. Does anybody have

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any questions? Well, if you think of some, you can reach me here. And I'm happy again to come out to your RTAC meetings to talk with folks, whether those are virtual or in person, just let me know a little bit ahead of time so that I can make plans to get out to your area. Thank you.

MR. BANK: Thank you very much for bringing up the agenda again. Okay. We are almost done. Anyone with any new business? One just comment from me is that yesterday we had a DMAP course, which was extremely well attended. We had twenty-five seats, so we had twenty-four people come. I just wanted to get from -- any ideas from the STAC of whether people think that this was helpful. It did take a lot of effort to arrange of having these types of courses the day before STAC from the New York State Trauma Community. Some things that were suggested to me would be to have another DMAP course, to have a TNCC instructor course, to have an ATLS instructor course. There are other things that would be interesting to their trauma community, but it does take a lot of effort. It's not from the STAC, I'll be honest, but the STAC can liaison with different organizations including the COT, the ATS, CNA, those

types of things to give these courses. So would there be interest in coming up a day early, do you think, from the New York State Trauma community to take some of these things? And if so, what courses would you suggest?

MS. SNYDER: I think definitely we need to hold another DMAP course that's required. It's going to be required for all trauma centers for the gray book. I don't remember if TNCC is as rigorous as an ATL instructor course. ATLS, I don't think either of them are like as specific as things that can't be offered, but I definitely think DMAP. I don't think it's bad to do ATLS instructor. Also ATLS director courses are very hard to come by.

MR. BANK: So the instructor course typically has, yeah the ATL instructor course, typically has somewhere, I think, between about six to ten people. That's ballpark where it typically is. ATL course directors there's not an actual course you have to take. You have to find a State Faculty and train with them. I am a State Faculty, so I would be happy to either help someone train or find someone to train them for a course director. So the ATL instructor courses are a little bit smaller.

DMAP is typically about 20 to 25 people. There are about forty-five, forty-six trauma centers. So we had, probably about, we had some DOH people, some -- a couple of trauma centers and two people. So we probably had about fifteen to sixteen trauma centers represented at the DMAP course yesterday. So there's probably another twenty-five, thirty trauma centers that needs somebody. So we can look into maybe doing another DMAP course the day before STAC in October also. If there are any other courses that people, you know, think would be helpful, I can't even imagine which ones please.

MR. ARRILLAGA: Hello, Arrillaga, Suffolk RTAC. I participated in yesterday's course. It was very good. And I certainly agree with the three courses that you suggested. We were also told yesterday -- those of us who took the course yesterday that we were all DMAP instructor potential. So, I'll presume there is an instructor course for the DMAP and perhaps we should have that here as well.

MR. BANK: Sure. That's a great -- I'm going to speak to Mike Vela, who is the course director from yesterday, and we'll see. I'm not sure

what the requirements are for that, but I'm sure he would know. So we could put that out. Okay. So we could look at – I'll ask Mike and the DMAP course was put on by the University of Rochester staff, with Eric Cohen. So we'll ask them if they are -- if we could impress them to do another one. So any announcements?

MR. CLAYTON: Doctor, the only announcement is up there on the screen that our next meeting is scheduled for Wednesday, October 11th, and it will be up here in the Capital District area. We don't have a hotel secured yet, but I'm working on quotes to -- for proper procurement. So hopefully we'll have something solidified in the next few weeks that I can share with you. But October 11th, here in the Albany area.

MR. GREENBERG: Just a reminder, if you're a vetted member, it's important to attend because we need quorum in order to meet. And we were, I think, just over quorum for this meeting to be able to occur.

MR. BANK: Dr. Dailey, any comments?

MR. DAILEY: Yeah, the only item of new business that I have, and this is just my

apologies. The only item of new business that I have is -- it's just I suspect something that needs to go to systems, is the ability of the image trend bridge to be accessed by the level one and level two trauma centers that take incoming transfers so that they can then attempt to access the initial EMSPCR in particular for PI projects. And completion of an understanding of what actually occurred in chapter one of that patient encounter. Currently, I know at least our center, we can't do that. It creates a significant amount of additional work for us. And if we had open access into that image trend bridge and could find that initial PCR, it would be extremely helpful.

MR. BANK: I'm not, yeah, I'm not sure where that would go with systems. Probably, I could bring it up to Ron Simon, who's the chair of systems. He couldn't be here, but I could bring it up to him in between the STAC and we could see if we could at least bring somebody to the systems committee that would at least be able to speak to that.

MR. GREENBERG: Just for clarification, are you looking for immediate or are you looking for -- because you mentioned it related

to PI or so at that time.

MS. DAILEY: The sooner the better, but obviously not, you know, fifteen minutes after the severe crash. My expectation is that the bad crash on 85 right now won't have a PCR. It's completed for a couple of hours. And that's -- I'm okay with that timeline.

MR. GREENBERG: Okay.

MR. BANK: And as our resident expert in registry, I'll call in our registry chair, who's completely not prepared, but Christie, any comments of -- from your standpoint of the registry being able to pull in the first PCR on transport patients?

MS. MEYER: So Cristy Meyer from registry. I, you know, I really believe that we're missing a whole segment of the patient's care routinely here in New York State. This has gone on for some time and that's why we wanted to collect the first PCR in this next year of data. I think it will really be eye-opening. And I think at the current state, the registrars across the state are doing a considerable amount of work to get what little bit we probably are getting of the story as a center that receives over seven hundred transfers a year. It's a

very small number of patients that we really get that first piece of the story. If we truly want to improve EMS process and primary triage, we really need this information. I do think that we are professionals that work under HIPAA guidelines to access information properly.

MS. SNYDER: We have access to repositories with every patient encounter that comes into our facility. And, obviously, I need to look at trauma patients. So I query that for trauma patients. So I don't think it's under that different guise other than I guess we could consider looking at data use agreements with our regional transfer agreements and kind of expand that. Maybe that's the avenue to go in. But I do think we need support to access that first part of the story because that's where change is really going to happen. It's very hard to get it late in the game once we've already gotten the patient from the referring center to piece together what happened initially. You know, is this something that was obvious at the scene and maybe a different turn could have had a different outcome. But certainly part of the story that we're missing pretty considerably now.

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MR. BANK: Any other new business? The only announcement was that our next STAC will be in October 11th. Any motions for adjournment? Okay. So we are adjourned. Thank you very much.

(The meeting concluded at 3:23 p.m.)

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STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 83, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 31st day of May, 2023.

DANIELLE CHRISTIAN, Reporter

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