10-13-2021 - STAC Meeting

NEW YORK STATE
DEPARTMENT OF HEALTH

STAC - Track 2
Meeting

DATE: October 13, 2021 at 8:03 a.m.

CHAIR: Matthew Bank

VENUE: WebEx

Reported by Janet Wallravin

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APPEARANCES:

Matthew Bank
Lambros Angus
Peter Brodie
Maggie Ewen
Glorial Husilli
Daniel Clayton
Cristy Meyer
Jolene Kittle
Marc Musicus
Matthew Conn
Ronald Simon
William Hallinan
Patricia O'Neill
Cherisse Berry
William Marx
Mark Gestring
Robert Winchell
Ryan Greenberg
Mary Ives
William Flynn
Jasmin Adderley
Peter Brady

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(The meeting commenced at 08:04 a.m.)

MR. BANK: Okay Daniel, it's eight o two. We have thirty almost forty people on the call and it looks like people are joining very quickly. Do you want to just start?

MR. CLAYTON: Sure, we can do that, Dr. Bank. Just so you know we're having a little technical issue with registration for some individuals for some reason are having trouble getting registered for Track One and/or Track Two. So we're trying to troubleshoot that right now. So thank you for your patience.

Couple things I want to point out is that the meeting is being recorded for archival purposes. And also, as a backup for the stenographer and speaking of the stenographer, Janet Wallravin, who you'll see as a panelist is on as stenographer this morning. Thank you, Janet, for being with us.

I'd also like to make sure that with regard to the stenographer that you please a) had your camera on when you're speaking and b) that you announced your name so that the stenographer has that for the -- for the minutes. Other than that -- oh, one other thing. Dr. Bank is the presenter for this.

We are going to have a couple of other presenters then I'm going to have Peter move them up as panelists from the attendee list.

So if you're a presenter this morning, for PI, please be aware I will have Peter move you up to panelist so that you can present. Other than that, Dr. Bank, I think you're set to go. Thank you. Dr. Bank, you're on mute.

MR. BANK: Thanks, Dan. No matter how many meetings I do, I still do that. So thank you everybody for coming to the PI workgroup. We have a few things that we want to do today. We have three people who graciously volunteered to present.

So we have Maggie, Maggie Ewen from Bellevue Hospital. She's going to talk about improving the timeliness of trauma surgeon arrival and Marc Musicus from Westchester Medical Centers and talk about geriatric falls and injury prevention. And Gloria Musilli from North Shore University Hospital. She's going to talk about Incidental Findings on Imaging in Trauma Patients.

So everybody, I -- I just want to point out and I've seen this made some really beautiful presentations and spent some time on it.

Unfortunately, we have to get approval from the D.O.H. before we can present the slides. And that approval process is just taking a long time.

So although everybody who signed up to present did make some slides, did submit them. Unfortunately, we're not going to be able to see them right now because they were not approved by the D.O.H. So I just want to apologize to -- to those presenters because I know they did spend some time on it. When it eventually gets approved, I'll ask Dan, maybe we can send it out on the listserv.

MR. CLAYTON: Right. Yeah.

MR. BANK: So Maggie, are you on the call currently?

MR. CLAYTON: Yes, Maggie is on. Marc is still having some trouble getting on. So if Gloria and Maggie could go first, Doctor, that would probably be beneficial.

MR. BANK: Gloria, are you on the call.

MS. MUSILLI: I am. Hi, Dr. Bank.

MR. BANK: Hey, I think you could just turn your camera on and then just start your presentation.

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MS. MUSILLI: Okay. I have -- the camera says it's not allowed.

MR. CLAYTON: Okay, Gloria, that -- this is Dan Clayton. That, that's fine. Just go ahead with your presentation --

MS. MUSILLI: Okay.

MR. CLAYTON: -- we just had technological issues. Thank you.

MS. MUSILLI: Okay, sorry about that. Okay, I wasn't expecting to be first but --.

MR. BANK: Technical difficulty.

MS. MUSILLI: No worries. So good morning, everyone. My name is Gloria Musilli. I'm the Nurse Registrar at North Shore University Hospital. I'm happy to present a performance improvement project we've been working on for the past two years. And it's entitled, "Improving Communication of Significant Unexpected Findings in Trauma Patients."

So I have nothing to disclose. I'll start with a brief introduction on why we implemented this project. So everybody on the call today probably knows first-hand that trauma patients undergo a lot of testing. And advanced cross-

sectional imaging is an essential tool when it comes to identifying injury.

And it's this sophisticated imaging that often yields the discovery of incidental findings. So in other words, unexpected or unrelated to the trauma. And during our review of literature, we found so many great studies on the prevalence of incidental findings. And most of these studies pointed out how incidentals actually increase as the population ages. And our average age at North Shore is seventy-two years old.

So I don't think anyone would be shocked to learn that a seventy-two-year-old thyroid is a lot more apt to grow nodule than that of a twenty-five-year-old. We also know that early identification and treatment of more significant findings helps decrease morbidity and increase survival.

So for us, it wasn't enough to just identify these findings, we actually wanted to do something about them. So moving on to our objectives, they were pretty simple and straightforward. First, we needed to elicit collaboration from both the administrative and

clinical sides. We also needed buy-in from everyone involved.

We needed to create a process for identifying these findings. And we sought to develop a clinical management guideline. But our overall goal was to improve communication of findings between our clinical staff and our patients. So when it comes to methods, as I just mentioned, developing a clinical management guideline was crucial.

All involved parties were educated on the steps required for compliance, including number one, identifying the finding, number two, documenting it in the H&P. Three, informing the patient, not only informing them, but providing a paper copy and then establishing follow-up instructions for them.

Even at the patient's request, we would reach out to their P.C.P. and notify them and then if they wanted us to schedule a follow-up appointment, we would do that as well. And then the final step is documenting everything that was done. And we would typically do that in the discharge document so that it could be printed and given to the patient on discharge.

So that seems like a lot, right. But

our process so seamlessly streamlined everything that it was truly a can't miss project. And compliance was monitored by the Nurse Registrar, which is me. And the doctors were reminded on daily rounds of any patients that required follow-up. So any sort of missing link in the chain was made aware right away.

So let me walk you through the process. A patient gets admitted to our service. So to trauma, we review their scans and discover a nine-millimeter pulmonary nodule. The clinical staff is either already aware of this or they're made aware of it on rounds. The finding is then documented in the H&P. We then physically speak to the patient and provide them with a copy of the results.

We also, at that time, ask the patient if they'd like us to call their P.C.P. If so, we call and even possibly set up that follow-up appointment for them. And then we document all of this in the patient's discharge instructions. And then we even document another note that indicates all steps of the incidental findings project were taken and completed.

We also set up a chalkboard in trauma one in our registry to monitor these patients. So

for any patient in which compliance had yet to be achieved, I let the team know on morning rounds. And if any step in that chain is omitted, we consider the whole process to be noncompliant, so we're really strict with compliance.

Okay, so let's talk about results. If you could see the PowerPoint right now, you'd be looking at our charts and graphs. But from October 2019 to May 2021, a total of about a thousand patients were admitted to our trauma service. And of those, two hundred and thirty patients were found to have a significant unexpected finding.

So that yielded an incidental finding rate of twenty-three percent. And most of these incidentals were found in the thyroid, lungs and kidneys and then other areas included the pelvis, pancreas, and some vasculature as well. And when we look at our compliance graphs, we started with eighty-one percent compliance. And we quickly climbed to a hundred percent for nine consecutive months, and that was during the height of the pandemic.

So one could argue that that success was secondary to us having less volume or just having

the luxury of being able to focus more attention on the project. So although we still do achieve many months with a hundred percent compliance, our average is ninety-six percent. So the success of our project has been multifaceted.

Of course, our residents, PAs, trauma attendings all played a huge role, but one crucial component has been our trauma registry. Without it, we wouldn't have been able to sufficiently track all incidental findings and monitor compliance. A performance improvement audit is created in trauma one, on every single patient that has an incidental finding, and then I track the compliance using that chalkboard.

So although this project may seem daunting, it was actually pretty easy for us as we tapped into our own resources by utilizing the role of the Trauma Nurse Registrar. So I was already starting about ninety-eight percent of trauma service charts in the registry. And that included me reviewing their scans.

So adding that extra step of screening for incidental findings was pretty much a piece of cake, like it was just one extra step I had to take,

which really doesn't impact my workflow that much. So if you guys already have a concurrent registry process, and a strong lead or nurse registrar, there's really no reason not to implement such an easy yet rewarding process into your program.

So in conclusion, the use of our process can help trauma centers improve communication of incidental findings among the team and patients. And by utilizing the role of your nurse registrar, you can successfully implement the process to fit into an existing concurrent workflow. And this undertaking is simple for any trauma center to execute, as it focuses on basic pillars of quality care, including issue identification, communication, and follow-up.

MR. BANK: That -- that was great Gloria. If anybody has any questions, just put them in the chat. I can always just read them out to the group. One -- one thing that I put in the chat is that it seems like a lot of work. I mean, you talked about reviewing, they have to review all the images, identify any incidental findings, go to the patient, talk to them about it.

You mentioned possibly helping them

make appointments for follow up, getting other doctors involved. And then documentation requirements are -- are pretty large. So did you get any pushback from the clinical team because I could see saying to do this, and then who's ever on your trauma server stuff physicians, advanced practice providers, just saying that, you know, that they do our work already, this is probably, you know, can easily be, you know, half an hour, forty-five minutes for just one patient one incidental findings. So, did you get a pushback from them? Did you -- what was your feeling?

MS. MUSILLI: Yeah, I remember in the beginning of the project, when we first started telling the other trauma attendings about, you know, their patient that has a six-millimeter pulmonary nodule. Some of them would just be like this patient's ninety-five years old, what are we going to do about it, you know, what could possibly be done?

But I think as the culture change, and especially having Dr. Bank be so prominent and really pushing for this project, it really set off a culture that everyone became so, you know, almost blinded by these incidental findings that like if we had one, we

knew right away, you have to start the process.

And so not only did our team really take on the challenge, we've inspired other services to, medicine does this now, ortho does it. The project even went up to the C-Suite level. It was presented to our upper leadership. And it's really been such an inspirational project because when you take a step back, you can almost see yourself saving these patients from, you know, months from now, the nodule turning into something worse or, you know, we found masses a couple times too, lesions, different things that were actually metastatic.

And so yeah, when you put it in perspective of you could be saving a life, I think that really changed our culture. And I haven't received pushback for months now.

MR. BANK: So for full disclosure, I was -- I was part of this project. And when we originally were thinking about it, we did do a little bit of a retrospective analysis looking over the last six months at ... incidental findings and it was very concerning. I don't think that the trauma servers had a real feeling for this.

It's not something that we tracked but

when you really sat down and looked at it, there were some really concerning findings that we could not find, that were non-traumatic, mostly in the older population, but we cannot find documentation that the patients were ever made aware of these findings. And it was -- it was concerning, because these are findings that definitely need to be followed up even in -- in the radiology meeting.

They said, you know, suggest MRI, suggest six months follow-up, and -- and different things. So you know it definitely -- the older population you get the more of these findings come out but it can be very, very concerning. And I'm very happy that we ended up getting back to most of these people and came back to our P.M.D.s to follow-up these findings.

Any questions for Gloria? Okay, thank you. We have a presentation, so I know that they're still working on some IT issues with Marc. So I know Maggie, are you on the line?

MS. EWEN: Yup, I'm here.

MR. BANK: Thanks. If you do have the ability to turn your camera on. Yeah, there you go.

MS. EWEN: Yup.

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MR. BANK: Excellent. So Maggie is from Bellevue Hospital, correct?

MS. EWEN: Yes.

MR. BANK: And she's going to be talking about improving timeliness of trauma surgeon arrival to level one trauma activations.

MS. EWEN: Thanks, Dr. Bank. Good morning, everyone. Thank you for allowing me to share this recent PI Project that we did at Bellevue, in which we sought to improve the timeliness of trauma surgeon arrival to our highest tier trauma team activations, which we hear all our level one activations.

My name is Maggie Ewen. I'm the adult TPM of Bellevue. I'd like to thank my collaborators on this project. Dr. Shrewsbury, our associate TMD, Dr. Michael Klein, one of our trauma surgeons, and also our in-house IT and Programming Wizard, Dr. Marc ... our adult TMD and Dekeya Slaughter, our Injury Prevention and Trauma Outreach Coordinator.

Just to give you some background on the very beginnings of this project. Back in 2018, Dr. Shrewsbury came to us from Shock Trauma in Maryland. And she was surprised to find that here at

Bellevue, it wasn't really the standard nor was it the norm for the trauma surgeon to be present in the trauma bay prior to patient arrival.

In fact, we looked into it, we did a little bit of spot checking and we found that the trauma team was present in the ED prior to patient arrival only about twenty-eight percent of the time. About sixteen percent of the time, it was the same time as the patient. And the vast majority of the time it was after patient arrival sixty-five percent of the time.

So Bellevue is an Urban Adult Level One and Pediatric Level Two Trauma Center. We're located on the east side of Lower Manhattan. And as many of you know, we have very short patient transit times in the city and there's no system in place for direct field notification of incoming trauma patients.

And of course, short transit times are a good thing. We didn't want to change that. However, we did want to figure out a way that we can make the most of that short interval -- interval of time between the scene of injury and hospital arrival. So prior to the initiation of this PI

Project, notification of our trauma team, in-house of incoming critically injured patients was done using a traditional page operator system.

So from the scene of injury, the field E.M.T. would notify E.M.S. Central Dispatch, who would then notify our triage nurse via a landline telephone. Triage nurse would then jot that information down. Pick up the phone again, relay that information to the hospital page operator, which was then transcribed by the operator into a text page and disseminated to the trauma team.

Not only was this a time-consuming process but it also left a lot of room for a transcription error. So in June of 2018, one of our trauma surgeons, Dr. Michael Klein, created a web-based Trauma Activation System. This allowed the triage nurse to bypass the hospital page operator and directly alert the trauma team via text page.

So the nurse would receive the information. She could enter basic patient demographics, age -- age and gender, vital signs and they could just check off a checkbox with the mechanism of injury and the corresponding activation criteria. And of note this system incorporated logic

with which further sought to decrease human error by automatically upgrading patients from level two to level one when certain items were entered.

For example, if the patient was unresponsive, intubated, or a heart rate of greater than one-twenty was entered into the system. We found that this significantly improved the quality of information that was transmitted to the trauma team by minimizing what we called the broken telephone effect of passing information through multiple channels.

And we measured this change in accuracy by comparing six data points of interest. We looked at patient age, gender, mechanism of injury, vital signs, mental status, and ETA. And we found that the web-based system delivered on average four point six pieces of information compared to the page operator system, which delivered two point nine.

So despite improvements in the quality of trauma team activations, there still remained a wide lag in the time from E.M.S. notification to trauma team activation via the pager system, resulting in the trauma surgeons still rarely being present in the emergency department prior to patient

arrival.

This contributed, of course, to a severe limitation in terms of prepping for the patient arrival by debriefing, clarifying role assignments with our emergency medicine, nursing, and operating room colleagues. And in addition, the resuscitation will often be interrupted upon trauma team arrival in order for our E.M. colleagues to provide handoff and summarize what had already been done for the patient.

So then in 2019, we took this a step further trauma program, initiated collaboration with our hospitals telecommunications department to explore options for expedited trauma attending notification of incoming patients who met level one criteria. So in October of 2019, we created and implemented a trauma internal communication policy.

And it mandated the use of push to talk phones for initial notification of full trauma team activations. So under this policy, direct communication was initiated by the triage -- triage nurse immediately after receiving prehospital notification from E.M.S. dispatch.

Using a push-to-talk smartphone app,

triage nurses can communicate vital information about the incoming patients to the In-House Trauma Attending, Adult E.D Attending, Pediatric E.D. Attending, E.D. Charge Nurse On-Call Anesthesiologists, and the O.R. Charge Nurse. This app also allowed for immediate two-way communication among all involved parties.

Also, under this policy each -- each department was responsible for ensuring that its phone was always charged and that it was functioning. We also mandated testing to occur once per shift that was initiated by the trauma attending and each member of the group would respond in a roll call fashion and we monitor compliance with this daily testing and roll call participation until routine compliance was achieved.

So next, we measure the effects of this change by tracking the time from the E.M.S. call to Trauma Team notification via the push-to-talk phone and we saw a marked decrease in time to activation from a mean of four minutes and seventeen seconds in October of 2019 to a mean of one minute and forty-two seconds in December of 2020.

Furthermore, we tracked -- we used our

Trauma Registry to track trauma surgeon arrival to determine if this earlier notification did in fact result in the trauma surgeon arriving to the patient bedside before the patient. We measure the percentage of the times that the surgeon was there prior to patient for all level ones. And we did see a drastic improvement from twenty-five percent of the time in October of 2019 to seventy-one percent of the time in December of 2020.

Of note, we did suspend data collection from March to July of 2020 due to the COVID crisis. We found the use of the push-to-talk phones to be beneficial to all involved parties. It decreased redundancy for the triage nurses by allowing them to notify all vital parties with a single push of a button.

Also, having the trauma team present in the emergency department prior to patient arrival, were often allowed the trauma and emergency medicine -- medicine teams to sufficiently prepare for the patient arrival, clarify and assign roles outside of the chaos of an active resuscitation.

In fact, our emergency medicine colleagues have recently expanded the use of the

push-to-talk phones within their department and they now use them for semi alerts, stroke alerts and partial trauma team activations as well. Thank you and I'm happy to take any questions.

MR. BANK: Thank you very much, Maggie. That -- that's really interesting. I like to point out that the H&H System I think has the best fleeces so we're going to, I'm going to have to pursue Northwell to get something as nice as -- I see Bellevue, I see Jacoby has some beautiful stuff. I don't know if every county in Lincoln and everybody has the same fleeces but they -- they're very nice, nicer than the one I get ... some questions.

I know my own institution we have the same system that -- that E.M.S. calls medical control and then medical control will call the chargers and the chargers will call the page operator and then the page will go out which does take, you know, probably four- or five-minutes total.

We did try to get the E.D. charge nurses to use a different application in Microsoft Teams to -- to -- to really blast the message out but it was difficult to -- to train everybody to get the application on their computer to make sure everybody

was using it correctly. So it was that difficult because it sounds like there's a lot of training you guys had to do with multiple different E.D. charge nurses to use this.

MS. EWEN: Yeah, I would say that was certainly the biggest challenge. We had a couple of things that worked in our favor in regards to that. First of all, this, the implementation of the -- the alerting application corresponded with when our hospital was transitioning to a new electronic medical records system.

So we actually had the link built into the triage nurses' screen. So she can just click -- she could just sort of click a link and enter all the information there. So that was helpful. Because it took away that installing, you know, the software on their computers and whatnot, it was all just there.

And same with the push-to-talk phone. It's one phone, and we just have it Velcro to the wall behind the -- behind the nurse and plugged in as well. So it's not like there's a handoff of the phone in between -- in between shifts. Getting the message out and training people was absolutely a challenge.

However, you know, we just got on the ground. And we -- we did what we could. We offered to do in services, myself, our PI Coordinator. Also we had very engaged trauma surgeons, Dr. Klein and Dr. Berry especially were really, really good about giving immediate feedback when they would not receive push-to-talk notification or if they noticed the page did not come through the system.

We really depended on our trauma surgeons and our PA's as well to give that feedback in real time. It really took a while to get off the ground, as you see, you know, we started in October 2019 -- or rather in 2018, when we first noticed the issue. And we're just, you know, we just finally saw the results that we've been hoping for.

MR. BANK: So a question from Ron Simon. What type of push-to-talk system did you use? Did it require significant costs and allowed that training to get started?

MS. EWEN: So it's just a smartphone app on an Android phone. Our Telecommunications department had the phones already. So it was just the terms of getting them approved for the different people that we wanted to have them. Of course, in a

perfect world, we would want all of our residents, all of our A.P.P.s to carry a phone, that was a limiting factor for us.

Although we do hope to make that argument once we saw the success of this project. I'm not sure what -- you know what the exact cost was. However, I would say that Dr. Berry was an incredible advocate for really pushing to the highest levels of hospital administration. We showed a lot of data from other trauma centers and we were able to make that argument. Again, it took time and it took a lot of persistence.

MR. BANK: And then, this was just a one-time thing. So -- so the -- the charge nurse will get the information, hit the push-to-talk, talk on it. And then it's just a one-time thing. So for instance, I get a page, sometimes I'm with a patient. I'll silence my pager, I'll finish the conversation and then I'll step out and look at my page, which is just nice to do.

But they don't have that ability, right. So if it's a push-to-talk, they have to listen to the first time it goes to -- because they won't be able to see it and then -- then hear it in a

couple of minutes?

MS. EWEN: That's true. However, we still do use the alerting application after the push-to-talk is done. So they'll hear. They'll get the notification. Okay, there's a level one, get moving. And then usually a minute or two later the pager will go off and all that information will be there.

MR. BANK: And then lastly, you said that you had about, I think you said seventy percent now of the other trauma ... or in the trauma bay before the patient arrives. And what -- what do you have any idea? And that seems pretty, pretty good. But I would guess at a certain percentage where patients that you don't get free hospital notification from that just kind of roll in.

So is -- is it that that thirty percent you still have to get better or that thirty percent will never get better because those patients are being activated when the patient actually arrives.

MS. EWEN: So this -- for this data we utilize only, we only looked at patients that we were receiving pre-notification on. The nurses are encouraged of course, if we don't get pre-

notification and someone rolls in and they meet criteria, they then go through the activation, but we excluded that from this data.

So there are def -- there definitely are still opportunities. We have really slow elevators here at Bellevue, seems strange but that is something that we kind of can't get around. So we're kind of trying to figure out things like that. But yeah, there are -- aren't always -- we're never going to reach a hundred percent. But we think we could probably do a little bit better than we have. We think, you know, our goal initially was eighty percent and I think that we can eventually get to that point.

MR. CLAYTON: Dr. Bank --.

MR. BANK: Sorry, go ahead.

MR. CLAYTON: I -- I apologize for the interruption. Dr. Bank, I just want to make sure you saw Cristy Meyer's question in the chat.

MR. BANK: Right. From Cristy Meyer, is the triage nursing notification part of the medical record. So the process that you're doing to the document then in -- in the triage nursing note?

MS. EWEN: So not that there's no way

for the push-to-talk system. It's -- it's not part of the policy. So occasionally, the nurse will write in their triage note that they use the push-to-talk phone. However, since the -- the web-based system is embedded into our electronic medical record, that we do have a record of.

MR. BANK: So -- so that's how you captured for your registry.

MS. EWEN: Exactly.

MR. BANK: Great project. Thank you very much, Maggie for -- for presenting.

MS. EWEN: Thank you.

MR. BANK: Can I ask you one question just you mentioned the elevators. And I'm just looking out your window. You seem kind of high. I'm guessing you're in the Department of Surgery, Division of Trauma wherever you sit. What floor are your offices on?

MS. EWEN: We're on the 12th floor and our Emergency Department is on the ground floor. Of course.

MR. BANK: And -- and you sit in the same floor as the Trauma Surgeons?

MS. EWEN: Yeah.

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MR. BANK: So -- so when they get this notification they're on the -- then they may be in their office on the 12th floor.

MS. EWEN: Yeah, exactly.

MR. BANK: Wow. That's an obstacle.

MS. EWEN: Yeah, yeah, for sure. And, of course, you know, if -- if the trauma attending is in the operating room, they'll hand off the phone to the backup attending as well. So that's another part of the system.

MR. BANK: ... the stairs I would think. Hopefully, you have some young trauma attendings. Okay, thank you very much, Maggie. So Marc from Westchester, are you -- are you on the call?

MR. MUSICUS: I'm here. Thanks, Dr. Bank.

MR. BANK: Great, thank you. So Marc is from Westchester Medical Center, as we talked about Geriatric Falls and Secondary Injury Prevention and Awareness.

MR. MUSICUS: Thanks, Dr. Bank. Good morning, everybody. So you know, this -- this topic is sort of an interesting one because I feel like it

affects each and every one of us, if not every day, certainly every week in our level one and level two trauma centers across the state and also across the nation.

And the lead author on this study, which was an I.R.B. approved study, is our chief trauma medical director Kartik Prabhakaran. And you know, the goal of this study, I -- I wanted to share some slides but I'm going to try to talk through some of the -- the prettier slides so that we can sort of get the gravity of this situation.

But you know, the goal of the study was really to study the geriatric patients that were admitted to our medical center sixty-five years older, status folk post fall with these related injuries in order to address this growing and problematic trend. Just -- just to give you an example. Here, in -- in Westchester Medical Center in 2020, about twenty-seven percent of our trauma admissions were geriatric trauma patients that were admitted status post fall. That's just about five hundred sixty geriatric patients.

And -- and I know, we all see this trend of older people falling and for the purpose of

this study we targeted geriatric, sixty-five years old or older and that were admitted to the hospital. Obviously, we know that, you know, these fall related injuries represent not only a significant source of morbidity, but they're also a huge drain on -- a huge drain on resources both in hospitals, as well as social services.

And sadly, we also know anecdotally and historically, when -- when an elderly person falls, there's a significant loss of quality of life and of course, potential death. So the -- the idea and goal behind this study was to take a look at both proactively and prospectively, all the patients who were admitted to the trauma center that fell within our specific category and then study them upon discharge.

And there's a couple of different factors that went into bringing this study about and -- and really, a lot of it is in hospital. And what we did was target through our senior trauma registrar, the patients that were admitted, he actually provides and filters data of all of these target patients admitted to W -- W.M.C. post fall.

They're then put into a database by

myself and our -- our trauma Program Manager, Kate McGuire. And we then have this database basically every week that we go into and identify patients on the floors that fall into the category of geri falls. We go upstairs, we gain consent from each patient.

A lot of times, there -- there's certain issues that would prevent us from doing that. If they're in the SICU, the NICU, the TICU and we have to wait. But for the most part, we are able to gain consent. And this has been ongoing by the way since July and then enroll them into the study prior to discharge.

Typically, consent is either from the patient or surrogate and then enrollment begins. We then go back to them and provide a state independent questionnaire. The questionnaire is a ten-question questionnaire that -- that basically asks specific questions like, have you fallen in the past year? Have you been advised to use a cane? Do you feel unsteady?

And there's a bunch of different questions, roughly ten questions, that are then scored and then put into our database. The other part of the in-hospital approach is a timed up and go

assessment which is done through our physical therapy, physical therapy department. And it really provides sort of this multidisciplinary approach to looking at how and why they fell.

The time ... for those of you that don't know is scored twelve and higher or twelve and lower. And based on that score, we get a risk assessment. The patients are also given a mind mobility plan, and an awareness home safety checklist. At -- at that point, typically the patient will be here anywhere from a week to a month and they'll receive whatever treatment is required.

And then there is a four, eight and twelve-week retrospective that we do with follow-ups. And -- and basically, these questions are done by our research team where they call the patient either at home or at their nursing facility or really wherever they are. And a bunch of different questions are asked of the patient.

Such as, have you reviewed your medication list? Have you completed the home safety checklist? Have you had a follow-up appointment with your primary care provider? And this happens four, eight and twelve weeks, retrospectively.

And so what we're really able to do then is to take all of this data and see which factors are most significant or most relevant and seeing if bringing in awareness and also the ability to discuss the issues of falls and see if recidivism is the same, worse, or better within this target group.

Ideally, once all of the data is submitted. We will compare those that implement the interventions to those that don't. Subjects that don't implement the interventions will be the control group and univariates are going to be performed for continuous variables. And after one year, the experimental and the control group will be evaluated and analyzed and a retrospective on fall recidivism will be discovered.

So it's really, as you can see, it's a very large, multidisciplinary multifactorial approach in addressing falls within the sixty-five and older geriatric population. A lot of moving pieces to it. But obviously, the goal is to prevent falls in the elderly population.

MR. BANK: Great presentation. Thank you very much, Marc. You know, as you were talking

about all this follow up. I guess, these follow-ups are done by phone, correct?

MR. MUSICUS: They are.

MR. BANK: It -- it just seems like an enormous amount of work. I -- I would love my trauma program to be able to do this but we almost need a whole another F.T.E. because these are hundreds of hundreds of patients.

MR. MUSICUS: So it's a great -- that's a great point, Dr. Bank. I think what, you know, what we've done is we've enlisted the help of our trauma fellows, our trauma residents. There's also certain trauma nursing staff that has been involved. But you're right, it is a real big undertaking. It would take at least eight to ten people minimum to keep this project going and to keep the study going.

We -- and we do have fortunately we do have those resources here at Westchester Medical Center. But again, I think from Dr. Prabhakaran's standpoint, you know, it is becoming such an epidemic within the geriatric population of falls that looking at this proactively and retrospectively and trying to create awareness, hopefully will present -- prevent

recidivism.

The one thing I also want to mention, we -- we also produced a five-minute geriatric falls prevention and awareness video based on the C.D.C.'s Ten Step Guidelines. We're using that in, we really wanted to do in person presentations at nursing facilities and geriatric centers, as well as the O.F.A.'s ...

But because of the COVID situation, we're only able to send it out. But that's also another component of this where we are able to present sort of the best practices of falls awareness. And that will hopefully be a little bit more significant as the COVID situation decreases.

But we think it's really all about bringing awareness and education to this population to hopefully prevent and -- the recidivism rate of falls.

MR. BANK: Were you able to get funding for this? Does -- does W.M.C. fund this --?

MR. MUSICUS: So -- good question. So right now, W.M.C. is funding it. However, we are looking for grants and funding sources along the way. This obviously is not a study that's going to end in

the next three or four months.

So yeah, we are -- we're hoping to get some grants and some funding working with our internal department to do that.

MR. BANK: And then once the study finishes if -- if you do show that you can make a difference, I -- I would guess you would want to continue forever going forward.

MR. MUSICUS: Yeah, I think in a modified format, a modified approach we will. There -- there probably will be a concerted effort. Right now we're just trying to get this study off the ground, and we did so as of July. So I'm sure by next July we will have, there -- there is a lot of parts of it that have evolved.

And so I think, you know, by next July we probably will have some other add-ons that will be part of it.

MR. BANK: Any questions for Marc from the audience?

MR. CLAYTON: Dr. Bank, Dr. Angus has the question for Marc. Do you have a geriatrician at Westchester?

MR. MUSICUS: Yeah, that's an

outstanding question. We knew going in that we did not -- we did have a nurse practitioner who had a specialty in geriatrics and then was moved off of the study. I know, internally, W.M.C. is looking to embark on a geriatric program. However, as of today, we don't, but we're hoping to.

MR. BANK: Great. Any other questions from the audience? And Marc, you said, you twenty -- I think you mentioned at the beginning, did I hear that right twenty-seven percent of your patients were falls?

MR. MUSICUS: Yeah. So in 2020, roughly twenty-seven percent of the trauma admissions were status post fall, that's about five hundred and sixty-four geriatric trauma patients. This year, I think -- yeah, this year, I think we're going to do closer to six hundred.

MR. BANK: I think it's low, I think N.T.D.B. falls are the most common mechanism of injury reported. So most trauma centers during a forty, fifty percent range.

MR. MUSICUS: Yeah.

MR. BANK: So wow.

MR. MUSICUS: I think the only

difference is that number that I gave you was the admissions -- the patients that were admitted.

MR. BANK: And admitted to anybody, submitted to orthopedics, neurosurgery or just ... trauma admissions?

MR. MUSICUS: Correct. It's sixty-five and older that were admitted to the hospital. Dependent, right, depending upon the fall, yeah, neuro, ortho, yeah.

MR. BANK: I see. Okay. Thank you. Any other questions for Marc? Thank you very much. So real quick, I have a presentation. I have some slides, but I'm just going to briefly go over it. So thank you to everybody. Thank you to all the presenters. Just some updates about the collaborative and some statistics, our last collaborative reports.

We have about seventy-five to eighty percent of all eligible trauma centers in New York state are part of the collaborative. So our data is pretty -- is pretty robust, compared to the rest of the state. Our last report, which was a 2021 spring report, was a first report that really the data encompasses -- encompass all the first leave of COVID

in New York in March, April, and May of 2020.

And then, at least a few months after that, you know, that summer, where we saw some changes in our trauma demographic. So if you look at that and you have to go backwards in the collaborative. Typically, for the collaborative, we have about fourteen hundred admissions per month, among all the twenty-six different hospitals.

So about twenty-six hundred admissions a month, it’s pretty steady -- sorry, fourteen hundred admissions a month. It's pretty steady, fourteen hundred admissions a month that meet TQIP criteria, I should say. And it's pretty steady going backwards there. And I have a graph on this, but there's a dramatic decrease in March of 2020, April of 2020, and May of 2020.

So we went from fourteen -- thirteen to fourteen hundred TQIP accepted admissions a month in the collaborative to in April of 2020 we had eight hundred and seventy-four. So again, about fourteen hundred to about eight hundred and seventy-four. So we lost about forty, almost fifty percent of our volume dramatically within the COVID crisis.

June and July, we saw an immediate

bounce back to get in thirteen hundred and fourteen hundred admissions. And then in the summer, for July and August, we actually overshot. So we had about sixteen hundred, almost seventeen hundred admissions per month in the collaborative.

So we did see a dramatic -- a dramatic decrease in the -- in the COVID, I'm sorry, in the trauma numbers during COVID. And then dramatic bounce back immediately upon, I guess, reopening of the state in July and August of 2020, which was very interesting. When you kind of looked at the breakdown, interesting enough, penetrating trauma has gone up to the collaborative members typically we are below the national average, sometimes about forty to fifty percent the national average.

In the spring of 2021, the national average for penetrating trauma for TQIP centers was four-point six percent and in New York centers was four-point two percent. So we are getting much closer to being very close to the national average for all TQIP centers for penetrating trauma.

We typically are much higher than the average for isolated hip fractures and we continue that trend for TQIP centers for admissions for

isolated hip fractures in the United States is eleven point nine. And for New York centers, it's seventeen-point seven percent. So we're about fifteen percent higher than the rest of the country for isolated hip fractures.

The reason why I particularly point that out is because those two mechanisms -- mechanisms of injury are the only two mechanisms of injury that we have some statistical significance versus the rest of the country. So for risk adjusted mortality, New York centers do significantly worse. Our relative risk is one point five seven. So -- and that is statistically significantly worse than the -- than the rest of the country.

And for isolated hip fractures our mortality is significantly better. Our relative risk is zero point seven three. So it is interesting that we do hip fractures very well. And penetrating trauma, which is becoming more common in the -- in New York State, we release for the TQIP analysis. We don't do as well as the rest of the country.

If you then just look at individual hospitals, because it may be that there are just a few hospitals that are kind of, you know, doing

incredibly well, incredibly poorly and pulling the mean of the rest of the group. That is not true. So if you -- if you look at all of the hospitals and where their spread is, both -- for both penetrating trauma and isolated hip fractures.

We don't have any hospital in the New York City collaborative that is doing statistically better than average in penetrating trauma, in penetrating trauma. So zero, zero percent of our trauma centers are doing better than average in penetrating trauma. And it's the same of isolated hip factors.

We have zero centers who are doing worse than average in isolated hip fractures. So interestingly enough, it's pretty tight grouping and both isolate hip fractures and -- and penetrating trauma, which I find interesting because there's a really a huge difference between our trauma centers from extremely urban trauma centers to suburban trauma centers to very rural trauma centers and, you know, dramatically different parts of the state.

So it is interesting that the trauma centers all are pretty tight and close to each other in the statistical analysis. Just to -- I'll give a

little review of our previous GI projects, acute kidney injury, we're continuing to show that our data entry and acute kidney injury is reasonable because we're ballpark pretty close to the rest of the country on our level of acute kidney injuries.

And previously, for both surgical site infection and catheter-associated U.T.I.s, we had three consecutive reports showing that New York State ... worse than average for those two indicators. We did a project for both surgical site infection and catheter-associated U.T.I.

We reloaded the data to TQIP and both of those are now in the gray. ... green band and gray, so they are not statistically significant. So for example, surgical site infection, which in the fall of 2019, our relative risk was two point zero five. So twice, twice as common in a New York State center trauma surgical site infection than the rest of the country and in the spring of 2021, is one point two three.

And similarly, for counties in the fall of 2019, were one point seven four. So significantly above the average and in the spring of 2021, we are at zero point eight four. So we're

actually below average, not statistically significant, but in general it is the trend towards below average over a catheter-associated U.T.I.

So at the collaborative meeting, we had discussed all of this -- all of this data and just to give you a feeling of the numbers that we're talking about, is in our spring 2021 report for the collaborative we had six hundred and eighty-eight penetrating traumas and seventy-nine mortalities for an observed eleven point five percent mortality for the state for penetrating trauma.

Conversely, for isolated hip fractures, we had almost twenty-nine hundred two thousand eight hundred and eighty-four isolated hip fractures and eighty-three mortalities for an observed rate of two point nine percent mortality for isolated hip fractures. And just to give you some situational awareness, the rest of the country has three point five percent mortality for isolated hips.

So we're at two point nine versus three point five. And then the rest of the country is at ten-point nine percent mortality for penetrating trauma. And we are eleven point five. So ballpark almost a point -- percentage point

difference for both penetrating and isolated hip factors. So it was discussed at a bunch of meanings of -- of what to do in terms of doing a P.I. project and some research projects on these numbers.

And we did decide to go with isolated hip factors. So one other statistic that we found very interesting was that there is wide, I think, spread agreement in the literature that delaying the opera fixation of hip fractures in geriatric patients will increase mortality. And the typical deadline that people talk about is forty-eight hours.

So in New York State, interestingly enough, fourteen percent of our hip fractures are fixated more than forty-eight hours and then the rest of country, it's seven point two. So despite us having a doubling of the number of patients with isolated hip fractures and doubling of when they go after forty-eight hours, we actually are doing better than average.

So it was very interesting that this indicator that most people consider an indicator of -- - of quality for isolated hip fractures and if your hospital is to double the average, compared to other TQIP centers, I'm betting that the ... reviewers are

going to ask you why that is when you get your review.

But despite that, the hospitals for outcomes are really very good. So we did decide to do a quality project on this. There was a data form sent out to all of the collaborative hospitals asking for a lot of their outcome data, their demographic data, some process measures of when patients went to the O.R. or some demographic data about their hospital.

We've got a bunch of data back, but -- but not everybody yet. So by the TQIP conference in November, I hope to present some of this. We also have prior ... approval on this. So if we do find anything that is publishable, we will hopefully be running this up.

Any questions about that? And from -- from Ron, it says, not only is reduced mortality impressive by itself, we also have an older population than average in TQIP. Absolutely, so, you know, this is very interesting to me, because if you look at our demographics and our process measures, they would point strongly to our absolute mortality being worse than average, to say nothing about risk

adjusted mortality, but our absolute mortality as well as our risk adjusted mortality is better than the rest of the country.

So it is interesting that this really flies in the face of all the literature saying older people die more and people that are delayed to the O.R. die faster or more commonly. So to gather the data and to really look at the data of why maybe we are doing so well, when it kind of flies in the face of common sense, I think this can be very interesting.

I can give you a few things from the few centers that have sent data insofar, that I personally found it very surprising and I don't know if anybody on the call, but the amount of isolated hip factors to actually admitted to the trauma surface. So there are multiple centers that over fifty percent of the isolated hip fractures are admitted to the trauma service.

And the questions are trauma service, orthopedic service or anything else. In my personal institution, the vast majority of hip fractures are admitted to orthopedic service. So it is interesting that maybe admission to the trauma service can be

correlated with mortality. But so far, it is interesting. There's a bunch of centers that are admitting sixty, seventy percent of the isolated hip factors to the trauma surgeons.

Any questions about that or any questions about for any of our presentations -- presenters?

MR. CLAYTON: Dr. Bank, it's Dan Clayton. Dr. Simon had a comment in the chat for you.

MR. BANK: Did -- we said not only see reduce mortality and impressing itself, we can also -- we also have an older presentation, right? That's fine. Yeah. So yeah, I read that. And I agree with Ron, it's -- it's very interesting. I'm not sure how that works. But hopefully by breaking it down and really seeing what the data is, we're going to delve into that.

To anybody who has not sent me their results, was confused at all by the form. There were some emails going back and forth, please just email me. If I didn't get back to you, it's not that I'm ignoring you. It's just that your email may have gotten lost in the hundred emails that we all get

every day.

So just please send me a reminder email and I will get back to you. And I'm hoping that we have everybody's form back by the November TQIP conference. So we can at least present some of the raw data.

MR. CLAYTON: Dr. Bank, Dan Clayton again, for the steographer. Just to reiterate, for those of you who were not on at the beginning of the subcommittee meeting, the PowerPoints for today's presentations were not approved in enough time by the department to actually be show -- be showing them today.

However, I do want to make sure that people understand that I'm going to send them out on the trauma listserv tomorrow. So Mark, Gloria's and Maggie's presentations as well as Dr. Bank -- Banks from the last ten or fifteen minutes will be included in an email to the trauma listserv tomorrow, so everyone should receive it.

MR. BANK: Thank you very much. Thank you to all the presenters. It is eight fifty-eight. So I think we have to give way to the next -- the next committee, which is going to be on this track,

is it transit systems ...

MR. CLAYTON: It's trauma needs assessment, doctor, and that's going to be at nine fifteen. And that's on track two, trauma needs assessment at nine fifteen. So there's actually a fifteen-minute break. And then on track one for those of you who are interested at nine fifteen will be systems with Dr. Simon.

And that's track one, but we're currently on track two, any questions? Thank you, everybody.

MR. BANK: Thank you, everybody.

THE REPORTER: Off the record.

(Off the record, 8:59 a.m.)

(On the record, 1:58 p.m.)

MR. CLAYTON: Just a couple of housekeeping items before we get started. Number one is that web -- this is being recorded. Our technical expert today is Peter Brodie, from the Bureau. Thanks to Mr. Brodie for being here to help out technologically.

A couple of other things. Janet Wallravin is our court stenographer today. She's a panelist. Please, when you're speaking, make sure

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that your camera's on and that you're unmuted and that you also announce your name so the stenographer can make appropriate notes to that effect.

I think that's all. So with that in mind, I think Dr. Winchell is going to be a few minutes late. So I give Dr. Berry the floor. Thank you.

MR. : Dan, before -- just -- can I ask a quick question before that starts.

MR. CLAYTON: Sure, doctor.

MR. : Is transcribing subcommittees new? I mean, in the past these used to be more kind of free open discussions.

MR. CLAYTON: That might have been part of the legislative piece about these meetings. I think there was a piece of the legislation that was put through up until January 15th that requires subcommittees to be recorded and -- but they're not being webcast. This is not being webcast, whereas the STAC meeting this afternoon will be publicly available beyond just, you know, the -- the trauma community.

MR. : Okay.

MR. CLAYTON: So that would be

webcast. But the subcommittee meetings are not being webcast. They're just being recorded.

MR. : Start interrupt --.

MR. CLAYTON: And transcribed, I'm sorry and transcribed, just like the inner meetings where that happened between May and October, when we did the interim meetings, I think that is your question, doctor?

MR. : Yes, I'm sorry, Cherisse.

MS. BERRY: No problem.

MR. CLAYTON: Thank you.

MS. BERRY: All right. So we'll get -- we'll get started. Dr. Winchell will be joining soon, he just had a patient-related issue that he's dealing with. So we had our interim meeting, June 22nd, and we had discussed that we had submitted the common needs assessment survey formal report to the STAC.

We then went into this new initiative that we had brought forth between SEMSCO, SEMAC, E.M.S.C. and STAC looking at, you know, leadership and how we can come together to sort of break down barriers to communication. Some of the issues that came out of the report, we thought we could -- we

would be able to address this at the leadership level, between all organizations between pre-hospital and hospital, trauma system leadership, now one mission, one voice, one team.

And really having a fundamental understanding of what our system should be versus what our current trauma system is. It's really vital. We have a lot of trauma centers in New York that we lack integration. And so we really do need an integrated plan. And having gone through the COVID experience, we recognize the need to have that plan.

And so how do we go about developing that, you know, we talked about, you know, the need for, you know, obtaining -- potentially obtaining ... and consultation from -- from the American College of Surgeons. That's something that we're going to have to further discuss at our next meeting.

What we wanted to spend the majority of the time during this meeting is to sort of go over the provisional trauma center designation proposal. So we had a really lengthy discussion during that interim meeting about the criteria needed for designating trauma centers in New York.

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And so at the end, are you able to show that draft so that we can go through it one by one? If not, I can pull it up, if you can allow me to share.

MR. CLAYTON: Dr. Berry, we don't have any approved audio or visuals for the meeting today.

MS. BERRY: Okay. I can -- I can just go through it then. We submitted this back in July. And so we're just waiting for it to, you know, be reviewed. And we'll go over it today. This again came out of not just our meeting in June, but a collection of suggestions from prior meetings over the years.

And so, you know, here we start by saying the facilities interested in pursuing trauma center designations shall submit a letter of intent and supporting materials to the D.O.H. requesting provisional designation. Requests for new provisional trauma center designation will be reviewed by the STAC, using the following guidelines, and will make recommendations to the D.O.H., regarding the need for the proposed new center.

So in general, proposed center will be determined to be beneficial if number one, we'll go

through this and then we'll open it up. So population coverage, so the estimated catchment area, defined as an area with a sixty-minute access by ground, calculated using a standard geographic information system or G.I.S. system-based approach of the proposed center does not overlap, the estimated catchment area of existing centers or if the overlap is less than ten percent of the population coverage of an existing center.

And number two, additional capacity is needed. So if the existing trauma center with which the proposed centers coverage area overlaps is on diversion for trauma patients more than five percent of the time or if more than twenty percent of patients meeting New York State criteria for transport to a trauma center are taken to non-designated facilities within the catchment area of the existing center with which the proposed centers coverage area overlaps.

So if these -- these are, you know, initial screening criteria, so if these initial -- if these screening criteria are not met, the STAC will then request additional information from the proposed trauma center that would document how the new center

will be a benefit to the population served either in terms of improved access, improved baseline capacity or improved system resilience.

Further, these criteria must be met without compromising the quality of care at the existing center. The ability of the existing center to maintain adequate patient volume to meet verification standards or adversely affecting cost effectiveness at a system level.

Information that might be important to this evaluation could include, number one, demonstration of the proposed trauma center would improve access for subpopulation of injured patients. And finally, demonstration that there is sufficient volume such that the existing center would not be adversely affected.

So I just want to open up the floor for thoughts on -- on this criteria, essentially allowing the STAC to review the applications before centers become designated.

MR. GESTRING: Cherisse, can I ask you. So this is, you say STAC is going to decide or the Department of Health is going to decide?

MS. BERRY: We would review -- we

would review any request for designation and then make recommendations.

MR. WINCHELL: You know, we're -- we're only an advisory committee, right, so we don't really have standing to say yes or no, you know what --.

MR. GESTRING: That's kind of where -- that's kind of where I was going Rob, I just --

MR. WINCHELL: You know, all we have is --

MR. GESTRING: -- ... anywhere else.

MR. WINCHELL: -- the ability to make a recommendation to the Department of Health. And that's where we started this.

MR. GESTRING: And then the thought would be the Department of Health bureau, B.M.S., would then go on considering the recommendation of STAC and go along with the process?

MR. WINCHELL: So yeah, obviously, it would be our hope that the department would value our opinion, unless there's other data or other things that we're not seeing, you know, but that -- you know. And then if the STAC didn't think the trauma center belonged there, it would be my hope, we would,

as a state, conclude it didn't belong there, either. But at least that would -- but this would be the initial process.

Right now -- right now, if I wanted to become a provisional trauma center, there is no process in place as to how, what, or where I do. And if I then get enough data to be a verified trauma center, there's equally nothing as to whether I need to be there. And so this at least puts a, hey, let's take a look at this from the should, rather than could aspect and, you know, hopefully fairly generic, we can put some process in place that's transparent, you know. And at least start the dialogue around it, even if we don't have something actionable.

MR. GESTRING: And so that's exactly right. Let me just ask one more question and I'll shut up. So the other question was related, so talking about places that want to be provisional trauma centers and Cherisse gave a good breakdown of -- of what the criteria would be for that.

What about the ability to approach places that are currently not but that are really in the rural areas and, you know, kind of encouraging them to become provisional level twos, and I guess we

don't really have threes yet but something to help, you know, kind of populate some trauma center care in those -- in those rural areas that currently don't have that?

MR. WINCHELL: Yeah. So I think that's a great initiative. I think it's slightly different than this one, in that a place like that is a slam dunk on this, because they will almost undoubtedly fit within that no coverage within sixty minutes, which is for sure you should be there, right.

No one's going to argue. You know, and then that becomes more of us from the advocacy position from STAC or from the department of how we would approach those people and actually try and encourage them to sign up.

MR. MARX: Can I -- can I say something real quick?

MR. WINCHELL: Yeah.

MR. MARX: If a center wants to become a trauma center -- if a hospital wants to become a trauma center, they send in a letter to Dan and Dan takes a look at that. They look at the hospital to see whether or not they have the appropriate

infrastructure to, you know, support being a trauma center and then it would go to the department and they would give approval for them being a provisional trauma center after -- after Dan and Ryan take a look at the hospital, I think, in person.

And so probably, we don't have anything written down, and we really should. And the second thing is that we have tried to encourage some hospitals to become trauma centers. And we haven't done it formally, but we have done it. And, you know, it's a matter of convincing their medical staff that gets in appropriate for them to do and get their buy in.

Because if the medical staff isn't going to do it, there, you know, it's not going to be successful.

MR. GREENBERG: Hi, everyone, it's Ryan. Sorry, I'm having some computer problems here. So you can't see me at the moment. But hopefully, I'll have that resolved shortly. So just two things on it. One, there is a process and it's policy 1804. I think Dan is in the process of putting it up.

So that is the process that an institution has to follow, there is -- so they have

to meet certain criteria, they have to submit certain criteria. We do go on site. We do a site visit. Matter of fact, I was just on another site visit recently because the initial site visits we went to go see, one of the hospitals was missing a number of items and said they needed to correct.

So before we would consider them for provisional that had just occurred. And because of the time period that also passed between the first visit and -- and now when we went to go see the other items we did -- they resubmitted their initial documents, make sure that they are all up to date.

And, you know, the one thing that we don't look at right now, in part, there's just not a, you know, a specific standard. And I think that's part of what this is, you know, exciting to move forward with. And this is something that, you know, we are as a department, you know, think, you know, can be a positive thing is to have some of those other variables looked at, you know. How does it affect the system, what's around it, so on and so forth.

Like, and I -- forgive me, I'm not sure who it was who had said it. But you are

correct, it is an advisory committee and as such, it would be an advisory to the department on -- on recommendations on what should happen related to new -- Dan's moving cameras now. So you know, it is an advisory situation, but we believe in many senses is a very collaborative approach in how we approach things and where things are.

And, you know, could be a very good collaborative approach in this regard as well. So we will, you know, continue to look forward on that front, to have this committee looking at it actually. One of the things that that we need to check with legal on is, you know, does the committee have the ability to look at some of the documents that are submitted as well, and not just some of the things that we outlined so far.

But if we look at policy 1804 in the documents that provisional hospitals have to submit in order to meet compliance in order to obtain provisional status, you know, can those documents be included in -- in what this committee looks at to make a decision.

And then yes, it is, you know, it is a recommendation, recommendation would be, you know,

heavily considered and kind of move forward from there, but obviously, it is ultimately up to the department and the commissioner of health on determination on, you know, who would become a trauma center or not.

That is one thing that I would say, you know in some of the wording and some of the things that there is, you know -- we, you know, with some of the wording from -- from, you know, kind of where things are might need to be tweaked or worked with a little bit just to, you know, kind of align with those beliefs and where we are. But happy to answer any questions on that.

MR. WINCHELL: So have we had -- have we had anybody apply recently is there -- is there current interest in a new trauma center anywhere?

MR. GREENBERG: We do. We have three applications -- at least two, there are two, there are two, but there's one that just messaged me the other day to express interest. So I have a follow-up phone call with them.

WINCHELL: Okay. So there are three, one -- one which will be granted provisional status probably in the very near future and then the two

others that are fairly early on in the process.

MR. GREENBERG: But so it might be interesting to see how they stack up against our criteria. Just as, you know, again, we're an advisory committee, it doesn't -- it's nothing but advice to know where we're headed with that, if it's not confidential information. It would give us a chance to kind of test around the process, maybe.

MR. WINCHELL: Yeah. So I mean, like I said, one's pretty much complete. So I don't know if that would be the right one. But we can always do, you know, an after analysis, just to see where it would line up. We also can do a retro analysis to see where things lined up comparative in the last, you know, three years since I've been here.

MR. GREENBERG: Yeah.

MR. WINCHELL: And, you know, relate to these standards. I don't think there's a negative in that point and matter of fact, if we do a retro look at it, we might be able to look at what those impacts were so, you know.

MR. GREENBERG: Yeah.

MR. WINCHELL: We need a criteria -- yeah, and how does that affect -- think that would be

great. Yeah, if we could, if we could get the -- which hospitals those are, we could kind of see how they stack up just as an internal check. And to kind of get an -- get an idea of how things work ... be perfect.

MR. GREENBERG: Yeah, no, I think that's a great idea. Are there questions, comments, concerns? Okay.

MS. BERRY: Okay. So it seems like the action items on this proposal would be submission to legal and doing that analysis that we were just talking about? Everyone agree?

MR. WINCHELL: Sounds good.

MS. BERRY: Great.

MR. GESTRING: Maybe I'll -- maybe I'll ask again another question, I'm sorry. So Ryan kind of alluded to a little bit and Rob touched on it. But, you know, the confidentiality side of this, how -- you know, how much information will be available for STAC to discuss and recommend on?

MR. WINCHELL: Well, as long as it's not confidential, that I, as hospital X have applied, then, you know, the most of what's in our -- the -- what's in our initial proposal to look at is all

public domain stuff, right, where you are, how you sit compared to the other trauma centers.

And so, again, my only question would be if there's some thing that it's confidential, that I even applied, that we weren't supposed to know who they are, none of what we're really looking at, have any other thing we have to ask from the hospital. You know, Dan's analysis clearly does, but -- but the one that we looked at really doesn't.

MR. GESTRING: Thank you.

MR. GREENBERG: So the part that I was referring to on the confidential side I think who applied is really not on the confidential side. And matter of fact, I would go one step further and say, often and who applied, they know, you know, they're -- they're advertising it within their community. They're saying that they're working towards it.

I mean, I haven't really seen promise vendors who haven't been very boisterous about going for whatever that is.

MR. WINCHELL: Sure.

MR. GREENBERG: I don't think that part's of the problem, you know, but we do ask for, you know, some very specific information. And, you

know, in that capacity, you know, you know, cases and performs improvements and, you know, different things that kind of move forward to get to that provision ... That's the part that I'm just not sure, you know, where and there, what can or what can't be shared.

And also, obviously, what the effect of, you know, this is, is -- as a state council meeting and review things, we obviously have, you know, C.O.N. processes and things and other councils and stuff like that and I think we just would have to look at that. And it could be something as much as, you know, if we start to look deeper into things that, you know, different things or prophecies would have to change slightly in order to accommodate that and, you know, make it something that can be streamlined and work with it.

MR. CLAYTON: Doctor --.

MR. GREENBERG: Yeah.

MR. CLAYTON: Sorry, this is Dan Clayton. Just wanted to make sure that Dr. Joseph's question gets posed. Dr. Joseph is asking in the Q&A -- I think this is a great approach, will recommendations be made to the college as well?

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MR. WINCHELL: So you know, I can comment to that one, going back a few years, the -- the college is utterly agnostic as to whether a hospital should be a trauma system with -- trauma center within a given system. And that's by deliberate choice. When I was still chair of the systems committee, we went out in the ... and said, hey, wouldn't it be helpful to you if we asked you as the lead agency, whether you wanted this hospital to be a -- to be a trauma center and would you like this to be a question on the V.R.C. application.

And they vehemently opposed the concept. So, you know, they -- they didn't even want us to ask. So we would have no input to the college process. And I would argue that we don't really -- I'm not sure that we really even need to be involved in the existing state process of making sure the infrastructure is adequate for them to be a provisional trauma center. I think that the D.O.H. requirements, they're fine.

You know, our potential point of inflection here is before the application even goes in would be regardless of how well you're prepared, is this something that that looks like we need it in

the state system. You know, again, I think that can be determined largely on publicly and I think can be completely on publicly available data.

MR. GREENBERG: You know, and the other side is, there's nothing that says that we can't do two sets of data, you know, to where this committee is looking at the items that you're talking about, which are clearly very public. And the department is looking at the other items that are outlined in policy 1804. So you know, there's nothing that says they have to be combined.

MR. WINCHELL: But again, our, you know, our name is needs assessment committee, I don't think, you know, again, between the state and the V.R.C., I don't think we need to get into the weeds of the -- are they meeting the standards and are they going to get past the verification visit?

MR. GREENBERG: The one thing I would, you know, that we would have to look at is obviously, you know, you spoke about the need portion and let's say that the committee determined there wasn't a need for another hospital. You know, part of the state process would have to have a mean -- a reason for not approving someone who meets all the other criteria.

And you know, backed by a statute or reg that says, you know, based on the -- and things like that. So we would just, obviously, also have to look at that component as well.

MR. WINCHELL: Right. You know, that that's one of the questions we need to pose to our friends in the legal department, you know, as to whether our current broad based statute about maintaining the building, maintaining a, you know, a trauma system, whether that trying to optimize it from a patient care standpoint and a financial standpoint, is within our existing purview or whether we'd have to ask for additional -- additional statutory support to do that.

MR. GREENBERG: And that is the point, you know, and I think that's the part that this committee again, you know, when you talk about the advisement in that -- in that front, you know, the regs and the statute are what they are today, obviously, regs is much easier to change than the statute.

But if there are things there that, you know, makes the system better in the future, that pathway of starting and what that would look like in

the future are things that, you know, we can always discuss and move towards.

MS. BERRY: And with -- with -- with that, Ryan, does the D.O.H. take into consideration one of the last things we put in our proposal, which -- which was, you know, what if -- if a center is applying for designation and it would adversely affect the volume of another existing center, does the D.O.H. take that into consideration currently, before allowing for that approval go through?

MR. GREENBERG: I don't know that we have a specific thing that's come up with that one currently, right now. We do look at, you know, the demands in the system, but the volume itself and, you know, the specific effects say on every institution or everything around, I don't know that come up in that specific provisional status. If you're talking, you're on mute or you might not be talking to us.

MS. O'NEILL: I was talking to you. Thank you, I thought ...

MR. GREENBERG: I see lips moving and I'm like, well, maybe she's talking to someone who walked in her office. Dr. O'Neill.

MS. O'NEILL: I was saying that this

did come up about, I don't even remember how many years ago, it's probably more than ten, Bill will remember, when -- just one second. Now, that I'm unmuting. ... I'll call you back in two minutes.

This came up when Barnabas in the Bronx, St. Barnabas in the Bronx applied for a trauma center designation. And they were in very close proximity to Jacobi and Lincoln. And there was an effort, in fact, we did an internal review at the new -- at the New York, greater New York artech, trying to establish a needs assessment.

And it was determined by the artech group, that there really was no need for a trauma center back then. But there was nothing within statute or regulation that gave the department or the STAC -- other than recommend that it wasn't required, there was nothing that was in place to enforce it.

And -- and the general sense politically was that they couldn't prevent it from becoming a trauma center. So that is something that still has to be addressed, if that's the direction we want to go to. And that's been the limiting factor that we've had within the trauma program is in -- as many other states have had.

But that's the one hurdle that we still would have to address.

MR. MARX: Yeah, the original legislation allowed any hospital to apply to be a trauma center. And until we had the new statute, a new regulation is put into place, anybody could be a trauma center, if they wanted to be a trauma center. All you had to do is apply and then demonstrate to the department that you had the necessary infrastructure to support a trauma program.

And then you went off on -- on your way. The new process with the -- using the college for verification, really improved on the process, because if a hospital can't get verified, then the state won't designate them.

MR. GESTRING: Ryan, can I ask, where are we with non-trauma centers reporting trauma center patient management?

MR. GREENBERG: In the middle of a pandemic.

MR. GESTRING: Okay.

MR. GREENBERG: We, you know, the process is started, but I have not checked on the compliance of it, you know, some more recent days,

they are supposed to -- non-trauma centers are supposed to be reporting. But I -- in all honesty have not checked the compliance of it, we've -- you know, with the amount of stuff that's going on, within, you know, the pandemic, those functions, it's been a, you know, it's something that I'm happy to go take a look and take a look back at.

But that started or was supposed to go in effect during it.

MR. GESTRING: It's -- the only reason I bring it up is it might help inform what we're talking about right now. Because --

MR. GREENBERG: Hundred percent.

MR. GESTRING: -- trauma centers, trauma registry, record what they take care of, but it doesn't record everything that's out there. And, you know, we've had that conversation in a lot of different ways over the years. But that would help you when you look at facilities and how many trauma patients are actually taken care of already.

MR. GREENBERG: Well, I mean, even without looking at that, I think the other thing that you're really looking at is how many transfers were there and how many transfers from non-trauma centers.

And I understand that we're looking at the others, you know, to see what trauma patients ended up potentially not getting transferred, in order to see what that volume is too that maybe should have been.

But we also, I think, still need to be looking at the number of patients that were transferred. And, you know, that will show, you know, within a given region, within a given area, you know, how much trauma is happening there. And is that the right choice to keep the trauma center in the region or to put a trauma center in that region because of it. You know, and that might fall into I think, you know, when Dr. Berry's kind of final points there, were there other outlining reasons or other things that can be justified and why a given area may need a trauma center.

MR. MARX: When -- when we originally started, we had a HRSA Grant for trauma center development and the state paid for your trauma program manager and the registrar. And part of their job was to go to the community hospitals in their region to collect the data.

And it was difficult at the time because there was a lot of concern about HIPAA

violations. But once the money went away from the -- from the support for the registrars the whole thing just kind of fell apart.

MR. GREENBERG: How long ago was that?

MR. MARX: Oh my God, 1999.

MR. GREENBERG: Something --.

MR. MARX: Something like that. I know it was -- I -- I know I started around, in New York around 1992. And we had the HRSA Grant for two years. And then actually the department was taking money out of the dormitory authority banking account to support it. And when Antonia Novello became the Commissioner of Health, she changed priorities and there was a new auditing system implemented.

And we were told that we could not use that money either for STAC meetings anymore or for support for the registrars. So that went away whenever Dr. Novello was -- was -- was the commissioner.

MR. GREENBERG: Interesting. Yeah, so I think, you know, I think it's two-fold. I think and I don't know, Dr. Berry, you know, how you accounted that one into your equation two, you know, if it's something that maybe we need to think about

this also just number of transfers coming from the hospital that maybe applied.

And you know, what were they currently receiving and now they're going for trauma status and, you know, does that play a factor into it, I probably think it should. The other thing that I -- I didn't -- I don't remember seeing here is how do we evaluate or what does this committee, you know, how do you feel we can evaluate the value of a center becoming a level three, versus a level one or level two.

And I do think that there is value in that both, I think, it will add to some better reporting, too. But, you know, having a level three trauma center in -- in certain areas, that then is required to, you know, both treat, stabilize, and at the appropriate time transfer, when, depending on severity and complexity of the case, those that help us in better understanding what's going on within our trauma community.

And you know, possibly other cases that that would have been otherwise treated locally, possibly not as a trauma patient. But, you know, really kind of taking that level three to, you know,

to a positive component for the system and how that would play out. You know, has the committee or Dr. Berry, have you considered that one from that point of view of how that would be factored in?

MR. BERRY: No, definitely, I think that's something that has come up a few different times in the meeting, as far as, designation criteria for level three centers. And I think it comes up to -- it falls under the purview of the criteria that we were -- that we listed in our proposal, with population coverage and additional need -- needs capacity. And I think that would be, the proposal isn't all inclusive for both level threes, twos and ones.

MR. WINCHELL: So you know, because I think we -- where we originally started with the level three idea because it was felt that would be the only one that was palatable at the time that this subcommittee was formed. The idea of looking holistically, I think, makes a ton more sense. You know, you could argue that, you know, whether we need another position statement or something, you know, level three trauma centers really come in two very distinct species, right?

There is the level three trauma center out in the middle of nowhere, where there -- where the patients are going either way. And I would argue that it's not us coming in and making sure they meet the standards. It's us actually going out there and trying to help them build capacity to take care of the patients that they're going to see no matter what, because they're the closest facility.

And that's completely different from the level three center that wants to open up within the catchment area of an existing one or two, where the value added is a much more, I think -- I think it's a more nebulous concept as to whether they're really needed to offload capacity from the level one or level two center, whether they really feel an access need or whether they're sort of, you know, because it’s just --.

I think when the college conceived of level three concept, that's not what they perceive the level three center would be. And so I think that that's where a lot of the -- the issues come up, right. And certainly, that's where the issues come up almost always about Level threes that might not need to be in the system.

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MS. BERRY: I think --.

MR. GREENBERG: Sorry, hold on.

MS. BERRY: I was just going to say, I think that if we read -- if we ever reach a point where we can have an overall assessment of the state needs, so that we can then identify, you know, areas that we really need trauma centers and sort of be proactive, as opposed to waiting for centers to apply, that would be one of the more beneficial things for our system, sort of a true assessment of the state need for trauma centers.

I think, you know, having an external evaluation of that would be helpful.

MR. GREENBERG: I definitely agree. And sorry, that was mute there for a second. We completely agree and we've spoken about it, you know, before with the A.C.S. coming in and we've also spoken about, you know, the internal side first and then, you know, progressing to the external and so that we can solve some of the low-hanging fruit first, I guess we would say.

Dr. Winchell, you mentioned about the level threes. So from your point of view, what do you think the -- what do you think the intention was

in the creation of the level three, from the college?

MR. WINCHELL: Very much think that the intention was to try and add a -- add some -- some system that -- you know, some system access point, in areas of the country where the resources to have a level one or level two were not really ever going to exist. You know, and so if you go out in the middle of, you know, rural Upstate New York, no one's ever going to put a level two trauma center there, because there is not the structural basis to support it.

And the idea that engaging the hospital that is there, to try and have them be a level two or level -- have a level -- have them be a level three center can improve the care at that hospital, improve their ability to interact with the system, improve our ability to see the data about the patients they're taking care of, even if it doesn't actually change what their capacity is or bring a neurosurgeon on call at a place where there won't be any neurosurgeons.

And that's why again, I think our verification view of them is very different. In the -- you know, if you're a referral center as a one or

two, then you need to be meticulous that the standards are maintained, because we're going to bypass other centers to get there. If you're a level three, it doesn't help me to flunk you as a level three, because the patients are still coming anyway.

And the focus should really, I think, for us be much more on helping to build capacity and get better in doing the things they do, you know, along the lines of, you know, R.T.D.D.C. kind of visit rather than a white gloves, dust on the mantle verification visit. And on that ... the approach we've pushed from the systems committee over the past ten or a dozen years.

MR. GREENBERG: So it's -- I mean, I know you're kind of far away, I feel like a high school teacher at the moment, but we know and to this map, which, I apologize, if you can't see it. This is our hanging in my office. The red dots are trauma centers around the state, which many of you already know.

And so, you know, as we start looking at this and your needs assessment and kind of the bullet points that you point out, there's most of the hospitals in the state would not fall into -- if we

leave, you know, kind of, above our Downstate area, most of the hospitals around the state, if you leave that area there, they don't have that six mile radius. I mean, there's nowhere we can really see the pockets of where we don't see our trauma center, you know.

And then we get to like, Long Island or New York City where it pops out in the -- in the other side, you know, where they're very, very close. And, you know, it would come more into that, you know, driving by ground situation. And the question that would also come is, you know, is the sixty-minute driving by grounds the right number and it was combination with other things, you know, is that the right thing?

I'm not saying it is or it isn't, but it's definitely something that I think we need to is, you know, on the clinical side to determine, well, that patient by ground on the ambulance took forty-five minutes to get somewhere versus something else, you know, versus ... or possibly stabilize it what could be a level three, is that beneficial. That's the stuff that this committee will get to determine.

But the only reason why I brought this

out is, I think, and when you talk about that outreach to other hospitals, there's a ton of opportunity in what I'll call most of the state from a land point of view, to hopefully influence other hospitals that might be on the fence that are concerned that too much work, you know, don't know which direction to go.

And to, you know, try and get more level threes out there, that there is an access point that the patient can get stabilized and then hopefully get transferred, in whatever means, whether that be by ground or air. So I'm applying to a level two or level one.

MR. WINCHELL: Okay.

MS. BERRY: Do we have access to the data of looking at secondary transfers to sort of begin that process now and identifying potential levels threes. I'm looking, sort of -- looking at that over time like a trend analysis of certain hospitals that are not designated but have a high percentage of trauma patients that didn't result in secondary transfers.

Could we potential do that analysis to -- to be able to identify those hospitals?

MR. GREENBERG: Yeah. But, you know, what we can do is we can try and go back to our data team and estimate they can put that information. I mean, I guess the question is when do we want to pull that information from.

It just was a gap in when we have it but there's also the question of, you know, what happened in the past two years and is that number still the same. Or, you know, do we look at in this particular case data from 2018-2019 because there wasn't, you know, the middle of the pandemic and not as much going on and things like that.

And you know, I think that's one thing that you just want to give us some guidance on and what you'd want to look at and probably take a look at from there.

MR. WINCHELL: Well so, you know, in an ideal world, we would look at in real time, right? If we could -- if we could design the system, you know, I would like to know this month how many -- how many transfers, yes, part of our systems Q.I., because that's part of the pulse right of how things are going both where geographically the hospitals sit and second, you know, how we're directing E.M.S.

traffic and whether we're doing the right thing, you know.

So you talk, you know, from an aspirational standpoint, the sooner we have the data, the better we can work with it. And to me it's just goes off after that, right. The most recent data will invariably be the best data. It's just going to be whatever our technical limitations are on -- on getting stuff we can work with.

MR. GESTRING: That is actually the one that I was going to ask also. So what -- when you talk about the New York state trauma system, are you including Northern Pennsylvania and Vermont, because in those areas like, when you draw your New York state map, there -- there's a void in, you know, the Southern tier, which is filled right now by something in Northern Pennsylvania.

And same thing in the upper, north country there where patients go across to Vermont. So is that part of the calculation or how -- how are you looking at that?

MR. GREENBERG: So if you ... but -- but on our map, at least, when we look at it from the state point of view, we do include the -- the border

line ones. Now, there are some that are a little bit deeper that we know our E.M.S. system are going to, based on knowing their area, but the true border line ones we do, we also list on our maps, and that --.

MR. WINCHELL: And I think it's ... we include those in the analysis as well. You know, it becomes a more of a strategic question of whether we, you know, have an interest in keeping New York patients in New York vis-à-vis sending them to Vermont. And equally, I have no control over what trauma centers in Vermont, what their standards are.

MR. MARX: So you know, along those lines, University of Vermont is a verified level one trauma center. And they have tried to become part of the New York state trauma system. They have a -- they have affiliated with the Massena Memorial Hospital up there. It's now part of the University of Vermont system. They sent people over to Vermont on a regular basis. They have to even use a ferry in the winter when the bridge closes.

We've got hospitals along the Southern tier that will send patients to Guthrie. But even on the far western edge of New York state, some of those patients may go to Pittsburgh because they can't fly

or fly from the southern part of the state to Buffalo, which is sort of the Buffalo's catchment area because of the -- because of the geography and the wind shears up there.

Some of those patients also go to Erie, Pennsylvania. So we know -- we can have an idea of where people are going and what we need in different areas. We know along the Southern tier, we need people. We know that we need people from along eighty-seven in the Catskills down to about Newburgh.

We know that a lot of places above Albany come all over the place. We just got a transfer a couple weeks ago from Glens Falls, because Albany was overwhelmed with COVID. But you know, there's -- patients are going all around the state and they're going all around outside the state.

And I don't know. I think some of the things that would help us would be to have some these outside trauma centers, like one of the New York trauma centers become part of our system. We would at least get the data and know what the -- the magnitude of the issue is with -- with some of these volume problems in the remote areas.

You know, so we have to get the data

and I don't know how we can get it other than trying to bring some of these facilities into our system. The problem -- the one problem with Pennsylvania is they don't use the college for verification. They use the Pennsylvania trauma system foundation. And while their verification requirements are similar, they're not exactly the same as the college's.

MS. O'NEILL: I think I have a question and a -- and a comment. In terms of data, we can actually get data out of the trauma registry. The registry does document secondary transfers as part of the registry. So we could ideally pick traumatic injury, say, head it close, head injuries, head injuries, or pelvic fractures, some of the more obvious traumas.

And then query our most recent year or two in the registry. I don't know that COVID would matter if you're looking at -- if we choose to look at certain traumatic diagnoses, because it wouldn't affect -- the COVID numbers won't affect the trauma transfers, at least not in terms of at least telling us where they're coming from, where they're going, and how long it took from their primary transfer to their secondary transfer and their final arrival at

their final destination.

So we could have data from there. And the question I had was to you, Ryan, in terms of the E.M.S. system, wouldn't some of the helicopter and this, some of the E.M.S. systems have some records that we could query for -- for the secondary transfers or prolonged primary transfers?

MR. GREENBERG: So two-fold. So -- so one, and just to go back to whoever adapted before in relation to the timeliness of it, you know, think about how long it takes for your registry to submit that data and submit it to the state. I will also tell you that we also do a fair amount of teaching in some cases. Some, for some of our trauma centers to be compliant and timely in their submission.

So you know, there's -- there's not a real time data from our side because of the submissions coming from the trauma centers. So we would have to significantly change that if we're really trying to look at it real time.

MS. O'NEILL: Well, I -- I agree, but I know that this problem isn't new. The problem's been going on for years and I think the -- the locations where there's a deficit is probably the

same geographic locations. So although you're correct, we would want the more timely month current data, but I'm not sure that we can't still get reasonable information just to document and have some proof of where the problem areas are.

MR. GREENBERG: Absolutely, and -- and I don't think it's changing that much. So --.

MS. O'NEILL: Correct.

MR. GREENBERG: But I -- I just want to answer the part of, you know, being as realistic and timely as the -- timely ... The secondary component of your question related to the E.M.S. transfers, we can look at things. It's a little bit harder for us to look at the E.M.S. data, just not knowing why they did a transfer.

So there's nothing in that transfer or from a data and informatics point of view, sort of it was a transfer, that would say, this was the transfer of a trauma patient that, you know, needs to go for higher level of care. That would get down to, you know, that small amount that really is what we're looking, kind of, achieve in -- in the questions being asked right now.

So you know, that would be the

challenging part of that, but, yes, could we look at, you know, prolonged transfers or, you know, how often an ambulance point from one hospital to another, but it -- it can be for everything, I mean, you it could be for ... if that's needed, you know, something else ...

So you know, or you even just load balancing which really, to be honest, would throw off a number of our transfers right now because working system load balance every day. And so all of a sudden you start seeing movement of patients possibly even, you know, trauma patients, if the health system that maybe has more than one trauma center in it, appropriately load balancing and transferring those patients from that point of view.

So that would make it a little bit more challenging being able to identify what you're looking for on that part. Now, on the flipside, what we probably would be able to -- to look at a little bit better with our scene response to a trauma center were certain, you know, types of injury going to non-trauma centers.

And you know, trying to determine from there. Now again, that's only good as the -- the

chart being written and -- and how they document it. And so, if that E.M.T. or paramedic feels that, you know, this was not a trauma patient, but we would ... saying, hey, we want to see every potential hip injury. You know, and did they go to community hospital or trauma center, you know, that, you know, can deviate now in that component.

So the transfer is a lot harder, the -- the scene by nature of what the injury is, nature of injury would probably be more realistic.

MS. O'NEILL: So just a really quickly, Ryan, I don't know if there is a filter like there is NEMSIS data set on secondary transfers. But in the NEMSIS data set, there is a filter for CDC field triage criteria and it's broken down in both physiologic and mechanistic.

So if the -- if -- if E.M.S. is filling that out even on secondary transfers, we may be able to capture it in that way.

MR. GREENBERG: So that field is there and we capture it. The question is, you know, how reliable of a source is it. And you know, the accuracy of it, and the -- the crew that's filling it out. And -- and are they charting on paper or

electronic, still have to remember that we have a portion of our state that still charts on paper, you know ...

And when we start to look at a lot our rural areas, that's the significant portion of where we see that paper charting exist.

MR. CLAYTON: Dr. Winchell, it's Dan Clayton. I just wanted to bring to your attention that we're about to finish out from the close of the meeting and I wanted to, maybe you wanted to summarize or go over the meeting points, the next action steps.

MR. WINCHELL: Sure, and I think we kind of summarized -- I think, Cherisse already sort of summarized the action points with respect to the -- yeah, the needs-based assessment, right, of ... down the legal piece and then trying to run the analysis on the current, and maybe the most recent applicants that we've had.

Yeah, I think the other one was, they're on trying to explore our access to the data. Yeah, it's -- yeah, and looking into what -- what the best metrics may be to try and look at, you know, what data we have to, also assess need and how well

the system is functioning. Anybody else want to help with the summary?

MS. BERRY: I think moving forward with the proposal to legal for evaluation, so that we can hopefully progress and be able to, you know, be advised on ... the next set -- set of applicants.

MR. WINCHELL: Anybody else on the committee, something else whom we should have on the action item list for next time?

MR. CLAYTON: Dr. Winchell, I also wanted to make a point as I did during the prior sub-committee meeting that took place from eight to nine this morning that we are permitted between this meeting and the meeting in January to do interim sub-committee meetings, virtually.

MR. WICHELL: Yeah.

MR. CLAYTON: So we -- we should definitely plan on, and maybe we want to do that now. I don't know if you want to plan on the next sub-committee meeting that we can do virtually. That's up to you and Dr. Berry, but I did want to bring that up generally, so that everyone knows we'll -- we'll schedule those.

MR. WINCHELL: Yeah. No, thanks, Dan.

I think -- like Dan said, I think we definitely should try and meet once or perhaps twice, virtually between now and the next stack to try and keep the ball rolling. I don't know that we can pull together a date right this minute unless -- unless somebody has one in mind. But I think we can certainly start working on that in the, you know, in the -- in the immediate aftermath.

MR. CLAYTON: Is there anything else from any of the sub-committee members or attendees, any questions in the chat that haven't been addressed or the Q&A?

MR. GESTRING: Just take a minute to commend Dr. Berry and Dr. Winchell for tackling something that is a difficult job and we -- we've been trying to do this for a long time so finally it’s getting some clarity. So thank you guys for doing that.

MR. MARX: Appreciate it.

MR. WINCHELL: Again, I -- I, again would like to thank both, you know, Dan and Ryan. I think we made some real progress here and I think, I'm very hopeful we'll make some real progress in getting some data that we can use to -- to move these

things forward. And again, I think those -- those are both, again, really big steps.

MR. CLAYTON: Well, if, I guess, Dr. Winchell, do you want to entertain a motion for adjournment?

MR. WINCHELL: Yeah. And I also forgot, Peter, I didn't see on the call, who's also been helping us along the data side. Yeah, I think if there is nothing else we can entertain, we can probably call it a day for today and have a couple of minutes for the next go round. Any -- any other last-minute comments from anywhere else?

Okay, then thanks very much for your ongoing energy and -- and work with us in moving this forward and we'll adjourn the meeting and we'll see you all a little bit later.

MS. BERRY: Thanks ...

MR. WINCHELL: Thanks.

THE REPORTER: Off the record.

(Off the record, 10:12 a.m.)

(On the record, 10:30 a.m.)

MR. CLAYTON: Go on the record?

MS. MEYER: Yes. Thank you. So Cristy Meyer. I'm the co-chair of the Registry

Subcommittee here at STAC and my colleague, Mary Ives.

MS. IVES: Helps if I take it off mute.

MS. MEYER: All right. So we'll be working together to work through the agenda. Hopefully, everyone had a chance to kind of review it. I -- I will kind of open up the session with the much-awaited discussion of the 2021 data dictionary.

I just want to bring us back to 2019. Hopefully, you can see and hear me. I have a little bit of a WebEx notice about bandwidth. But back in 2019, the subcommittee had convened a workgroup to work through revising and reviewing the data dictionary that had not been reviewed since 2016.

There was lots of work to be done in a short period of time. We made those recommendations to the STAC and to the Department of Health. And throughout the last, I guess, year-and-a-half, there's been a lot of work to finalize the change log and the actual data dictionary document, which from STAC goes to the Department of Health for final approval.

I -- I would just want to turn it over

for a moment to either Peter Brodie or Dan Clayton to kind of pick up where it goes from there. And then how it's coming back to us today, so we can kind of talk about what the next steps are to make sure that we have data submission here in New York State.

MR. CLAYTON: Okay. Sure, Cristy. Peter had to step out of the room momentarily, but I will try to address that from a program level. So when the data dictionary was finalized by STAC and specifically the registry subcommittee and are -- and approved by STAC, it came to the department. That was while Kathy was still here, Kathy Burns, my predecessor. Of course, you all remember her. She retired in February and is enjoying retirement, I'm sure.

So what happens after that is, it has to go through an Executive Deputy Commissioner clearance procedure which is multiple layers of the health department. Obviously, we all know the health department is gigantic. It has multiple layers.

So the Bureau of E.M.S. and trauma systems is only one small, tiny portion of the center for health care providers services and oversight of the Office of Primary Care and Health Systems

Management of the New York State Health Department.

And of course, we have key partners in the health department like Legal and Public Affairs that have to review these documents during what we call the E.D.C.C. process, Executive Deputy Clearance Commissioner -- Executive Deputy Commissioner Clearance procedure.

So that was all happening probably, I would say, from February to -- to May. We got an initial approval in May, but then it was discovered that there were issues with -- with the data dictionary with some of -- some of the elements of it. So we had to fix those things.

Actually, it was our various stoop partners of Public Affairs Group within the health department that noticed that. So Cristy and I went back to work on trying to fix those issues with the data dictionary. And then Public Affairs Group, when those changes were all made and Ryan approved it again, because that's what they required.

Public Affairs group requires a director to once again say, okay, yes, the Bureau has made these changes at the recommendation of PAG, Public Affairs Group, and now it goes back to Ryan

for his approval. And so there's a lot of bouncing back and forth as you can see.

And then Public Affairs Group actually has to do all the cleanup of it. They made it publishable. They are the ones that did all of the creative marketing, publishing work on it. So that's where it sat and of course, during all of this as we all know, the pandemic was happening, and we had variants and waves of the -- of the COVID-19 virus.

So I -- as I brought up yesterday during the New York State A.T.F. chapter meeting, and I'll say it again now, the primary mission of the department or priority of the department has been COVID-19 response ever since February of 2020 or even a little bit before that. And that continues to this day.

So there's obviously been a lot of delays in this process. We would have liked to have had it out sooner, but it is our anticipation that Cristy and I had this conversation yesterday and Dr. Greenberg is looped in that that data dictionary will be released within the ensuing two to three business days.

So with that in mind, Cristy, did I

address everything that you wanted me to address at least at this point?

MS. MEYER: Yes, I -- again, I want to make the timeline clear that the goal certainly was to collect data this year for 2021 using those new data fields.

MR. CLAYTON: Correct.

MS. MEYER: With a plan to really try to ramp up and review this on a routine basis, so that we don't get five or six years behind. Obviously, we did get very behind on releasing this. So we did meet under Dan's leadership, really pulling the vendors together and deciding how we were going to roll this out and move forward.

Obviously, we are all under all kinds of different constraints with -- whether it would be staffing changes, whether it be staffing in general. Some of us were redeployed and helping with COVID response and maybe still are.

So in recognition of that challenge, the recommendation was made to Dan and the team at the Department of Health to and many STAC members who were actually -- and trauma community members wanted to put off the data dictionary launch, the official

data collection launch to 2022.

That being said, we want to make sure that we're continuing to collect data here in New York State. I think we've come up with a plan for whatever data in alignment with the prior dictionary has been collected will be submitted and accepted to the Department of Health Data Registry for the 2021 cycle.

I hope I got that right, Dan. There will be some mismatch. There were some changes. So I don't know if you want to go over some of that and -- and that way we can help people understand how -- how this will work.

MR. CLAYTON: I think it's good if we keep it at a -- at a high level, Cristy. And I can always do something as a follow-up in an email to the trauma listserv or to the registrars, so they are -- they're more aware at a granular level.

But I think, correct me if I'm wrong, Cristy that and remember I, you know, I was not involved in any of this until February when -- when Kathy retired. So I'm -- I'm kind of coming in on the late end of it. But my understanding is that some of the data points that we're going to be

missing -- remember that you're going to still be submitting 2021 patient, all right.

But some of the data points that we're going to be missing, because of the new data dictionary, is mostly E.M.S.-related patient care context data points. Is that correct, Cristy? It's the N.T.D.S.? Is it E.M.S. data points we're going to be missing pre-hospital?

MS. MEYER: Yes. So as projected right now, as we ran some testing with the vendors, it looks like the E.M.S. fields, the procedure location fields. So if the E.D. procedure section where we were collecting procedures moving forward with a location, I know some people had not updated that in their vendor.

And then in addition, pre-hospital blood. Those seem to be the fields that we probably will not be able to collect in the New York State Trauma Registry from every center. It may vary center by center. So again, as Dan said, there'll be some follow-up to some of the centers to troubleshoot this as we go along.

And then the N.T.D.S. fields again, should all be included except highest level of

activation and for Ryder arrival date and time. What's interesting about that field is that New York State continues to collect that in the way that they had before. So that's the only N.T.D.S. field that should be affected.

So again, this -- we'll -- we'll send out more guidance from the vendors and, you know, try to troubleshoot this for different groups of non-image trend users and different various users across this, you know, across the state. That way people can submit.

But the biggest question was, do we have to go back and then correct all the data to the new data dictionary, and the answer to that is, no. So hopefully, we will catch everybody up on some data submissions soon.

I know that 2020 submissions have been completed it looks like across the state. There may be some -- some -- a quarter that might be missing or something from some centers. And then some centers have already began submitting 2021.

So hopefully that -- that dictionary will be out in the next few days. We can troubleshoot with centers as we move forward and some

plan for education and helping everybody get up to speed for a 2022 admission, January admission, data collection change.

MR. CLAYTON: I would also ask Cristy that if any trauma centers are having any issues, that in addition to sending a ticket to your vendor to please keep me in the loop as to any issues you're having, so that I can keep Cristy and Peter in the loop.

We've been very, as Cristy pointed out, we've been in contact. We've collaborated very well with the -- with the vendors including but not limited to image trend and E.S.O. and Landsat, and D.I. And we've all had -- we had a -- a couple of meetings prior to today recently to make sure that things were going to work and we were going to be able to set this in motion the best way possible without -- with as few hiccups as possible.

So again, if you have issues in submitting, please make sure that Peter and I are looped in. I'll -- I'll make sure that Peter puts his email address in the -- or the generic -- shared mailbox address for data informatics in the chat session.

Just keep us in the loop if you're having issues, so that we can kind of monitor what's going on and assist along the way as well. Are there questions on what Cristy or I covered? Peter is back in the room.

MS. MEYER: So just one thing to clean up. You will have logic errors and schema errors with some of the submissions this year, okay? There are some expected, it may be different for some centers versus other centers. So we will speed through those.

We will accept the data as submitted and work with any -- any different center that's having exquisite problems where it's really affecting large volumes of data. But through some testing. It looks like we're going to get the bulk of data and be able to move forward.

And certainly, this supports some of the discussion that we've had about what the New York State Extension future looks like, but we'll get to that in a few minutes.

Hopefully, that puts some anxiety across the state a little bit at -- at ease. I know there were some questions of whether we were going to

have to go back and correct all this stuff to be able to submit, and we're hoping to be able to kind of move -- move forward from here.

Before we go on to the next question, if anyone has any questions, please put it in the chat now. And then, of course, please keep Dan in the loop. I'm -- Mary and I are happy to help also as we move forward now that we have kind of a real -- real launch here.

MR. CLAYTON: Cristy, Matt Conn has inserted a question in the chat. He's asking if the programmer should bypass any field procedure locations from N.T.D.B. TQIP commission.

MS. MEYER: So wait for some more guidance from our vendors, but I believe that's the plan at this point that if there are schema errors about the procedural location, we're -- we're going to actually disregard those and continue to submit their own.

MR. CLAYTON: Are there other questions relative to what Cristy and I have covered in the last ten minutes or so? Comments, concerns? Madam Chair?

MS. MEYER: All right. I'm going to

tag off to Mary. She has some things to cover about the New York State Data submission process. We wanted to review something for the upcoming submissions and -- and maybe the future.

MS. IVES: Yeah, it kind of comes off what you were saying about the submission process. We got -- Dan has been very great at sending out the audit reviews. So everybody is very well and up to date on -- on where their current status is with submission. We do have one recommendation that we wanted to bring forward and get some information about from the group.

Our current submission process is done by discharge date. And this creates a little bit of a mismatch in the schema because the data is collected by admission date for N.T.D.S. fields, are -- are collected by the admission year.

So this creates a little bit of a mismatch with discharge date and admission date. So what we were thinking about is getting your guys' input on changing it to being collected for the admission date, instead of the discharge date on that. This will keep a little bit of alignment between the N.T.D.S. and QIP -- TQIP submission

process.

Does anybody have any feedback on that little suggestion that we have?

MS. MEYER: I know from our center's perspective, the schema sometimes is a mismatch because you're collecting in an admission year, but you're submitting to a discharge date which is just a different data set from the next year. So --

MS. IVES: Yeah.

MS. MEYER: -- it basically sparks lists to reconcile longer and sometimes those -- the records actually just kind of go out. I don't know if other people experienced that, but in alignment with our data dictionary, it probably is easier to submit by admission date just as we do to N.T.D.S.

MS. IVES: I know from -- from our center here, there are usually some exclusions -- or I mean, sparks ... There will be some data that is in there and it -- it just was missed because of the date. So it's something that we have to -- you know go back and redo. So does anybody else have those kinds of issues?

All right. Well, it kind of brings us back to the -- the whole reconciliation process for

sparks and how that process goes down.

MR. CLAYTON: Mary?

MS. IVES: I know he -- yeah?

MR. CLAYTON: Sorry, it's Dan Clayton. Thanks, but sorry for the interruption.

MS. IVES: That's okay.

MR. CLAYTON: There was a comment from somebody in the question, Jasmin Adderley said that -- she had asked that about using the arrival admission date previously and my predecessor, Ms. Burns, that is Kathy Burns, not Lee Burns, said that was unable to be changed.

I -- I -- I don't know anything about that. But if that's what she said and that's what everyone else remembers, I guess, it would be worth looking into again. But, you know, we can certainly talk about.

MR. CONN: Hi, Dan, it's Matt Conn. So I was very vocal about aligning with the National Trauma Data Standard and TQIP and doing it by admission date. We've been told by the data professionals and New York State Department of Health that because of the way the state collects the data, they do it by discharge date. That's how they align

the sparks list.

I would be interested in having a conversation with the data professionals at the New York State level to realign that because they -- to Cristy Meyer's point, it is creating data mismatches. It is creating misalignments and schema errors because we're doing N.T.D.B. and TQIP by admission year, and we're doing New York State by discharge year.

Does that affect a tremendous amount of patients depending on how large your center is? It could affect a couple of hundred patients, I think, with my center affected less than ten or twenty. But it is creating data mismatches.

In addition to, you know, New York State not collecting all of the patients because if the patient gets sent from one New York State trauma center to another New York State trauma center, the trauma center that actually discharges the patient to their post-acute care is the one that gets to take credit for it according to New York State rules.

I'm interested in -- in visiting a realignment because it -- it is creating some angst, some anxiety and some confusion with all of these

centers including mine.

MS. MEYER: Matt, to your point, I'd like to make that recommendation if everybody's in agreement that we push this to the demo team, I think, Dan, because they run these reconciliations. And in addition, kind of, pass it through the vendors to understand if this would create any kind of issue.

I know that we do submit national data by admission date. I think there'll be more of a lag potentially if you have some patients who are, you know, admitted longer. But again, this would be in alignment with the way we're collecting data.

So I think it makes a whole lot of sense. I just need to understand from the state process and the -- the state registry process if it would create a problem. But to be honest, after some discussion, I'm not sure that it would.

So I think it's worth pushing that forward if this group would -- would want to investigate this. And then we can get back to you guys at the next meeting.

MS. IVES: I definitely think it's something that we should look into as much as we can just to solve some of that issues that people are

having about.

MS. MEYER: I don't know if there's any other comments just about the submission process. And if everybody's in agreement, we can move this forward to evaluate it.

MR. CONN: Does anybody disagree with moving this forward to realign the states that it matches up with how N.T.D.B. collects that. I think that's the -- in my experience, Cristy with -- with running these virtual meetings is that's the better way to ask it. Instead of saying does everybody agree and waiting for the hands to go up and a thousand voices? Does anybody disagree? Seems like no.

MS. MEYER: Okay. So we will take that forward and Mary and I can meet with Dan and -- and see what the plan will be afterwards. Right. I guess, that dovetails right into sparks reconciliation and -- and kind of a good discussion on what that process is. And, you know, certainly making sure that we're all doing these submissions.

MS. IVES: Yeah, just -- just a little. We want to go over the process a little bit just as a reminder. We, the sparks list comes from

the hospital discharge ICD-10 diagnosis lists that are submitted by usually medical records, Health Information Management from every facility.

The facility's ICD-10 discharge lists are then compared to the submitted exclusion lists that come out of our registry. So when we submit our data, they take our data and they compare it with the -- the list -- list compiled from the ICD-10 discharges from the hospital.

They look for any kind of exclusions on that list that comes out. Any records that are not found on the sparks list, and that come from our hospital, we get -- we get that list and that's it, an audit we get from Dan.

That kind of shows us what we're missing for our records that should be submitted into the sparks. So what we would do, we would -- we reconcile that list, compare them, and input any records that are missed. And then, also at that time, it's good to do the exclusions too, because you'll have them pretty much right in front of you.

They submit them, if you go through and you notice that that patient doesn't have an ICD-10 code that is related to something we need to

submit, then you will exclude that patient. It's the -- I like to submit exclusions as often as I can remember to. I try to do it quarterly with my submission to the state.

That way, I'm kind of doing both at the same time. I don't know if anybody else has a process that they would like to talk about? Maybe to kind of streamline it for all the people that are new during this process.

MS. O'NEILL: I have a question. Cristy, it was my impression that the intent of the exclusion list was to do a quarterly and not to wait until the sparks list is -- is out. So can -- is that true? I mean, what is the ideal process that everyone should be following?

MR. CLAYTON: So --.

MS. IVES: I believe -- go ahead.

MR. CLAYTON: It's Dan Clayton. So the answer that question Dr. O'Neill is, that the Department is willing to allow either one. So you either do it on a quarterly basis, or you wait for the sparks exclusion list to come out and then reconcile. So that, to my knowledge in the eight months I've been in the position, that's always been

the answer from DMAR.

MS. O'NEILL: I just want to -- I brought it up because in our, you know, our call with DMAR about two months ago, when we discussed the sparks exclusion list and the sparks and the reconciliation that some centers aren't even sending in. I thought the impression I got, and that's why he asked the question, that their expectation was that we were doing it quarterly because several centers including my own were -- were doing it when the sparks data came back primarily. So moving forward either way is acceptable?

MR. CLAYTON: Yeah, it's actually -- it has been acceptable.

MS. MEYER: So I just want to say in a timeline fashion, the 2020 submissions, I believe the plan from the DMAR team was to run that sparks analysis in October of 2021, which is now. I don't know the exact date. I know that Dan had been sending out the ... calls for data and calls for things with some due dates.

But my understanding from that call that Dr. O'Neill and I had had with the DMAR team, they were planning on doing that big reconciliation

for 2020 in this fourth quarter and then anticipating to get that back to everybody.

So hopefully everybody understands the exclusion list submission process. There's that special mailbox and that trauma group that you should be sending that document to. And that will help that sparks list that comes back to your site to be very small, rather than doing it kind of at the end. So that's my own best practice recommendation.

In addition, keeping the exclusion list as you go along. If you're concurrent about the industry, you have a nurse or a registrar that's concurrently putting patients in your registry, have them put it on your exclusion list if they can, or reconcile at the end of the month.

At our site, we created an ICD-10 list that we look at. Actually, I believe we do it twice a month. And you -- you know, a lot of cases on there are not acute traumas. There are chronic ICD-10 trauma codes. And it helps us keep up with that, so that when it's time for that quarter to be submitted, it's kind of done.

So those are just kind of my insight tips. I know Mary might have some too.

MS. IVES: Yeah, I pretty much follow the -- the exact same thing that you did. I have my exclusion list on my desktop every day and once in a while I come across a patient that I know is going to be excluded just because it's a chronic, or it's an over thirty day or over two-week injury. So I just exclude them.

And then the big thing is trying to remember to send that exclusion in and it's -- it's a nice process to do it when you do your submission quarterly because it's just two boxes checked at the same time.

MS. O'NEILL: So just for me as the surgeon. What you do is, you'll have a daily list of the admissions in the ICD-10 diagnosis codes that the hospital is recording which will eventually be in the sparks data. And as you review those, if it's not an acute trauma and looks like either -- or it's a non-trauma at all, because you investigate and realize it's spontaneous, hypertensive bleed and not a traumatic subdural or subarachnoid, you immediately write it onto your exclusion list.

And then Cristy, my understanding is, if you're -- if you do submit your list quarterly,

then they -- the DMAR takes them off your sparks list before they send you your sparks.

MS. MEYER: Yes. So they'll use that exclusion list to reconcile your facility spark list before it comes back to you. So certainly, if you're doing this concurrently, you're coming across these patients, it's going to save you time.

I remember a very long list coming back to me when ... about seven years ago doing this. So it has shortened, I'm happy to say. And most of my mismatches are truly because of this admit date, discharge date mapping thing where I actually have them in there, but they didn't get uploaded for some kind of reason.

So it does lighten your load and you're kind of spreading the work out all along, you know, the time period. You know, the patient's fresh where you can really clarify these things with your surgeons or your neurosurgeons and understand the injury as they're coming in.

You know, we often see things like hybrid spinal cord injuries that are chronic that somehow end up on that list. Because remember, billing rules are so different than, you know, trauma

injury coding rules.

So we do end up. It's an imperfect list because we do end up in a lot of things on there that are just noise. But I think it's good to remember this is a process that you should be doing. It saves the work for everyone and it really kind of levels sets the data.

Does anyone have any other comments or questions about the spark's reconciliation process and, again, please reach out, phone a friend. There are many experts on this call today that would share their process or -- or be able to help you. I know, Mary and I are always interested to help people too, so.

MS. IVES: Absolutely.

MS. MEYER: I do see a question in the chat. Jasmin Adderley has a question. I have a question regarding internal validation and image trend. Is this a good time to ask? I'm not sure if I can help the question, but certainly, this is a forum designed to understand how we're submitting and -- and processing data.

So if you have a more specific question, maybe we could answer it. If not,

certainly offline after this session. I'm happy to -- to connect you. I don't know if you want to type -- type more in the chat. Go ahead, Dan.

MR. CLAYTON: Peter said that he can unmute Jasmin if you want to address her question or have us address the question.

MS. MEYER: Sure. If Jasmin wants to ask, I think -- sometimes these things are helpful for everyone to discuss.

MR. CLAYTON: Ms. Adderley? Jasmin, you may have to unmute yourself, but we've given you the --.

MS. ADDERLEY: Hello?

MR. CLAYTON: Yes, hi, Jasmin.

MS. ADDERLEY: Hi, hi, this is Jasmin Adderley. My only question was, were there any rules added to image trend for internal validation? I remember sometime in 2020, we had submitted a lot of data. And then it came back to us a couple months later that a lot of the fields were missing. And that we found out through that that there weren't any internal validation rules assigned to image trend.

So I know that you guys are going to be working on that and I was just trying to see if

there's been any update regarding that.

MS. MEYER: So my knowledge, Jasmin, I don't think anything has changed. Although I do think it's something we should talk about with the vendor and understand, you know, certainly once we get data submission flowing the way that we like. We talked a lot in this group about having validation processes that really help make sure the state data is valid.

So maybe -- maybe that's offline. We'll follow-up on that. And see if you can give some exact -- if you email me the exact examples you're talking about. Maybe we can try and ... with you.

MS. ADDERLEY: Okay. Thank you.

MS. MEYER: But in future state, I agree. It would be so nice to have some -- I know N.T.D.S. just finally started sending us back some kind of quarterly, kind of data validation card, which is nice with some set parameters, so that -- that should help.

All right. So now that we finally have a plan for this 2021, I know that in the spring, we had a meeting, and it seems so long ago. But we

did have a discussion about what the future of our data dictionaries and state looks like, how we align it closer to the N.T.D.S. to do less work, but still support some of the initiatives that the Department of Health which we have to meet, and our trauma system assessment here in New York State.

So how do we do that, the recommendation from -- comes from this group. But my recommendation as a co-chair has been to have a workgroup work on this, so that there are representatives from different areas.

So I would like to recommend that we convene a workgroup. The work group would need to get together and work on a couple meetings before April of 2021. Final recommendations, and -- and Dan can keep me honest on this. These vendor changes need to be to the vendors by April.

So it really gives a very short window of work, a little different than what N.T.D.S. changes do. Just to remind everyone, the N.T.D.S. fields are automatically included in the New York State submissions and the image trend application that is part of their -- the registry function in New York State.

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Be it that over the last few years, we had to make a lot of edits with this dictionary to fix some of the -- the way that that was being uploaded. But what are the recommendations that we need to make as -- as a subcommittee to make it more efficient, to make sure that vendor and schema matching is done in a timely way, so that if we do make changes to the dictionary and certainly, we're -- we're not looking to make subsequent, you know, changes every -- every year.

But how do we get a small group together to get some recommendations for our January meeting? So it's a short order. If people are interested, I'm hoping that we don't have to make quite as many recommendations, but I do -- I do think that we should continue this work because we'll get behind again, and then, you know, not -- not find a way to keep up on it.

I don't know if anyone has any comments on that or any questions? Should we do this? And then how do we do it, I'm -- I'm happy to leave that. So I'll leave it this way. If you are interested, please contact either Dan Clayton, Mary Ives or myself. It will be a short order for people

to volunteer and have -- have some discussion to try to come in alignment and make our work a little more efficient here in New York.

One other thing just to give a little future of what the N.T.D.S. is looking at. As everybody knows, the E.M.S. field values were removed from the dictionary with anticipation that a P.U.U.I. number would be submitted from E.M.S. agencies, so that they -- we would then submit the P.U.U.I. number and they would match those E.M.S. data points.

It doesn't seem that New York State is the only state having trouble doing that. And I think if Peter or Dan can keep me honest, that project in New York State for the NEMSIS level P.C.R. would not be completed till 2023 at the earliest.

So that leaves a gap in E.M.S. data collection to match the N.T.D.S. directly. So I'm hoping that everybody will understand that the next version of dictionary from N.T.D.S. is going to make those fields optional to submit in lieu of this P.U.U.I. process.

So hopefully that makes sense to people. If anyone has any questions, these are the types of things that I think the workgroups should

kind of parse through and understand and -- and make some recommendations on how we continue to collect and match E.M.S. data with trauma process.

MS. O'NEILL: I have a question, Cristy. Oh, I'm sorry.

MS. MEYER: Sure.

MS. O'NEILL: So what you're saying is that they're proposing that rather than our trauma registrars submitting the times of the E.M.S. times, right, all of those. That we would instead be given a P.U. -- P.U.I. number that will link eventually electronically for the purpose of TQIP and N.T.D.B.

But the question I have is, if that means that our group were going to then stop submitting, reporting that data within our registry, the timing of some of the E.M.S. arrival times, times on scene, et cetera play a very important role often in P.I. processes.

So the thought I would have is that should be -- I don't know if I'm making myself clear. But if we were, as a group, to decide that we no longer have to put those into our -- our registry for the trauma program in New York and also for our individual programs, we have to think of whether that

might be an issue for us in terms of P.I. reviews in future cases.

MS. MEYER: So that is the discussion that we had in that workgroup in 2019. You know, we do collect a lot of information even above what the national data standard used to be. And missing that data definitely eliminates some of the P.I. processes for pre-hospital care.

So our intent, at least at my center, was to continue collecting that locally, so that we could make changes and make plans. As we all know, changes are made sometimes. I -- I've -- we saw this with GCS-40, you know, they've rolled out this big initiative to do GCS-40 and like no one's submitted it and they kind of rolled back on it.

This seems bigger than that to me, just to be honest. I think that understanding the pre-hospital system part of trauma care is really important whether local or state wise. And matching that data is awfully hard with the current P.C.R. status we have.

The P.U.U.I. would match it more directly. So we would just have to record that one number. But, you know, we're not there yet. And I -

- I think those are the type of things that the workgroup should tackle and really understand and make those recommendations. But yes, that is something that N.T.D.S. is probably going to add back in, because this year they're going to lose that year of collection because many parts of the country are not submitting data that way.

So I hope that's clear to everybody. But that's kind of the projected future. And I don't know if there's any comment from Dan or Peter about what that state of -- of P.C.R. is going to look like in the next few years.

MR. BRADY: Hey Christy, it’s Peter Brady here. I actually moved from -- hiding behind my screen, come over here to see you. The -- the -- the requirement for the P.U.U.I. that you're discussing is a component of NEMSIS three point five. The transition by both software vendors and state to three five has been significantly delayed. Obviously, they're blaming everything on COVID. So you know, that just continues being the blame.

But even image trend, as our E.P.C.R. repository has not completed the testing required to be able to offer that service, you know, for NEMSIS

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three five, so that will not be changing. We can't even begin to look at that until image trend knows the full scope of what they're doing related to that.

So you know, as I mentioned before on a call that Matt Conn was leading, that change won't happen until 2023 at the earliest. We have twenty-one E.P.C.R. software programs and -- I'm sorry, twenty-two E.P.C.R. software programs in New York State and we have to make sure that all twenty-two of them are going to function on following the same pathway before we can even consider the move.

MR. CONN: Hi, Peter and Dan, and everybody else, it's Matt Conn. So now I just have some questions. And maybe some of this is just my frustration coming -- might be my frustration coming through. Other states, and I know that New York is like this, but I'm wondering if we can't become like this.

Other states, other regions, other areas as the state or local government authorities tell their areas this is what you're going to do, this is what you're going to use, and this is how we're going to do it. It creates a lot more consistency across services, interoperability and

platforms.

And is that something that New York State would be interested in because I think in the long run, go -- moving toward that model would probably eliminate a lot of these issues.

MR. BRADY: New York State Public Health Law Article 30 requires New York State E.M.S. agencies to submit data to the state in a format directed and approved by the state by the Department of Health. They currently do that with NEMSIS three four. Transitioning to three five is not on the option list.

But when we start telling software vendors and E.M.S. agencies they have to prepare for the move is when we are ready to start telling them that. We don't have all the details for everything that we need. This is just one small component of what's coming. We already do that now, Matt. It says we're waiting for the process to roll out.

MR. CONN: Let me be clear. Los Angeles County, when they decide which trauma registry vendor, all of their facilities in the county, whether they are public or private, Los Angeles County tells them this is the trauma registry

vendor you're going to use.

MR. BRADY: And we're in New York State. New York State allows E.M.S. agencies to select the software vendor that works for them. New York State also provides a platform if an E.M.S. agency is not in a position to be able to afford or is not in a position to be able to deploy a software vendor.

New York State provides him with a complementary software program. However, to tell the Fire Department of New York who does eight hundred and seventy-five thousand E.M.S. calls per year or to tell the two hundred and eighty E.M.S. agencies currently using E.M.S. charts across the state. That's a ... change will cause quite the uproar in New York.

New York State is a free economy state. And the agencies are allowed to pick the software vendor that they would like. We direct the standard. They select the path -- the platforms.

MS. MEYER: Just -- just --.

MR. CONN: So -- so what -- what I'm hearing is the answer for New York State to have the -- appetite to standardize which vendors and

streamline which vendors are used does not exist.

MR. BRADY: New York state sets requirements that software vendors have to meet in order to participate in providing an E.P.C.R. service in New York State. All twenty-two software vendors currently providing that service in New York State has met the standards and has tested with New York State.

Right now, New York State does not have NEMSIS three five because it's not finished being developed and tested at the national level. When that is done, all twenty-two will have to test. If they don't successfully test, they're not even able to make the transition, then we'll have a conversation with E.M.S. agencies and the software vendors that currently use that program.

MS. MEYER: So in -- in the interest of understanding this process and in -- certainly in time, and -- and I hear you, Matt, I do. We do have to recognize the limitations of vendor, you know, training and the resources that we have here in the state.

So part of what we do in the workgroup is analyze what the trends are, what's available and

what's not. And then hopefully make decisions to collect data that's as complete as we can, so we can move forward in analyzing outcomes for our patients.

So while some states do have different requirements and regulations, this is the current status here in New York. So I think it's a great discussion. I think it's really important to keep this in mind when we do recommend changes. Does it make end users do some more work? Potentially.

And those are things that we, as a group, could try to streamline and make recommendations. So I'm happy to add that to the discussion. I think this is an ongoing discussion and very valuable for everybody to understand.

Any other comments or please, again, enter into the chat if you'd like to join the workgroup. I'm happy to answer you here in the chat or email Mary, Dan, or myself, and we'll add you to the workgroup. It will require some meetings in the next few months just to do some additional analysis of the data dictionary once that's released to everyone.

But lots of work to be done and I -- I always thank the volunteers who are -- are willing to

put the time in. So thank you to everybody. That -- we wanted to round out today's discussion about best practice and education. I think validation goes very much hand in hand with this.

If Mary just wants to comment on some of the things, you know, just to poll the group on what we need to move forward.

MS. IVES: Sure, absolutely. Well, Cristy and I were talking earlier about, you know, best -- best practices and education. And I know that we -- we must have a lot of new registrars joining. I know I keep seeing the listserv saying, please add, so and so is a -- is a new -- new member.

So we need to be able to reach out and make sure that we all have the support and education that we need. Does -- does anybody have any ideas on any type of educational things that we could do to help the new registrars that are out there or are there any, you know, pertinent questions that someone may have that, you know, we can use --.

MR. CLAYTON: Well, Mary, it's Dan Clayton. I'd like to interject.

MS. IVES: Sure, Dan.

MR. CLAYTON: I don't think that you

and I brought this up during the first part of the subcommittee meeting. But it's our intention to put together an educational program for the registrars on the 2021 data dictionary and, you know, submitting et cetera. We're hoping to do an interim subcommittee meeting between this meeting and the January meeting in which -- at which time we will do that.

So that's our -- that's our plan right now. So that's one educational thing that we can provide to all the new registrars as well as the existing ones that have been on for quite a while. Cristy, do you have anything to add to that?

MS. MEYER: So what I'm hoping with Dan's help is that we can record the next subcommittee meeting as a webinar to provide education on the new data dictionary, and the submission exclusion processes we talked about today.

There does seem to be new registrar staff. I'd love to be able to do this more than just once a year, but it will be a test run in December with Dan and hopefully Peter Brodie's help.

We'd like to record this and put this on the web, so that new registrars can review it, and everybody will have a resource if they want to go

back to review some of the content that we hoped to provide. So hopefully, I'm thinking, probably the second week in December, we'll, you know, kind of nail down a date for everyone. And hopefully that will be posted shortly.

And again, if this is education something that resonates with you, we always would like to have volunteers to help. So if this is something you'd like to participate in for presenting or preparing, please let me know.

But looks like December. That will be our interim meeting. Thanks for your support on that, Dan. I appreciate it.

MS. IVES: Yes, thank you. That sounds wonderful. I mean, it's also with the new -- we are anticipating the new A.C.F. standards to increase the registry also. We're going to need more staffing. So that's something that will be available for anybody new coming on board which I think is going to be great.

ICD-10 trauma coding courses are also going to be part of the new standards that are going to be required. So any type of education that anybody comes across that's interested are the ones

to, you know, inform the group. We will make sure that it gets put out, so everybody knows what type of education is out there.

I know there's a bunch of wonderful classes that are available online to take. So we can start putting together a list, if need be, and just putting it out there, so everybody's aware of all the education that's coming up for the new registrars and the old ones for that matter. We all -- we all need a little bit of re-education sometimes.

MS. MEYER: And again, participation in this meeting, the more experts that we have participating and sharing best practice, we'd like to highlight your projects or your registry education a short presentation for January would be welcome.

So if you want to volunteer to present a validation project, or any registry education topic, please contact Mary, myself, or Dan. We'll put you on the agenda for next time. And you know, just a slide or two on a project that you're working on and how you've been able to improve your data would be really, really great.

MR. CLAYTON: Actually, Cristy, I've mentioned this during other subcommittee meetings,

but maybe not everybody that's on this -- on this WebEx was on those calls. It's my intent to hold interim subcommittee meetings between today and the January meetings. I don't anticipate that there are going to be subcommittee meetings at -- on the next STAC day in January because we will have held one, two, perhaps even three. Usually two in -- in between especially because the holidays are coming up. And we've only got three months until the next meeting or thereabouts.

So I'm open to that idea. I just -- I would shift it and say that it would probably be more during an interim virtual subcommittee meeting between now and mid-January that that -- those presentations takes place.

MS. MEYER: We definitely should touch base and work out scheduling soon, so we can get those dates out to people. I guess I'll leave a moment or two here. If anyone has any additional questions, please again, put in the chat. If you want to volunteer for any of these opportunities to -- to be involved, I think there's a lot of experts here.

We'd love to share some of the best

practice and some of your expertise as we look to continue to grow and revise the data collection process here in New York State.

MS. IVES: And Cristy, it's Mary. I just wanted to make sure that we're going to discuss the December webinar to review the da -- data dictionary in depth. We'll send out a notification on when we plan to have that webinar. Is that -- is that correct?

MS. MEYER: Yup. So we will try to get a date set for that in the next couple days. Even if we send it out with the data dictionary, that might be helpful for everyone to kind of plan ahead. The intent is to tape that session and make it available.

So I'm not sure who the I.T. expert is for that. I know Peter Brodie is really helpful, but hopefully somebody can -- can assist and -- and we can make that link available to people in the future.

MR. CLAYTON: So it's Dan Clayton. We're looking at some time after Hanukkah, which I think ends around the sixth at sundown, and maybe up until and including the 20th or 21st. We don't want to get too close to the Chris -- the Christmas

holiday. But that's kind of the span of time we're looking at doing the -- the educational session on an interim subcommittee meeting virtually.

MS. IVES: Sounds great. Thank you, Dan.

MS. MEYER: Thanks so much. All right. So that's the content we had today. Again, barring any additional comments, I -- I recommend that we adjourn the meeting. But I just wanted to give people extra -- a few extra minutes here if there's something additional you want to share. Our emails are in the chat. So take a look.

And you know, certainly if -- if you want to volunteer for any of these things or want to even just learn more about it, I'm happy to -- to speak to anybody about it.

MR. CLAYTON: Madam Chair, I'm just wondering if somebody wants to make that motion for adjournment?

MR. CONN: Motion to adjourn.

MS. MEYER: Matt Conn makes a motion to adjourn. Do we have a second?

MS. IVES: Mary Ives, I'll second.

MS. MEYER: Can I say all opposed?

MS. IVES: I second.

MS. MEYER: So we have a motion to adjourn? Hearing no opposition, meeting adjourned.

MR. CLAYTON: Thank you. We can go off the record, Janet.

THE REPORTER: We are off the record.

MS. MEYER: Thank you, everyone.

Meeting adjourned.

(Off the record, 11:22 a.m.)

(The proceeding concluded.)

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STATE OF NEW YORK

I, JANET WALLRAVIN, 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 1 hereof; that the foregoing typewritten transcription consisting of pages 1 through 144, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 2nd day of November, 2021.

JANET WALLRAVIN

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