

1 1/29/2025 - STAC - MS Teams

2 NEW YORK STATE

3 DEPARTMENT OF HEALTH

4 STATE TRAUMA ADVISORY COMMITTEE

5
6 DATE: January 29, 2025

7 TIME: 1:09 p.m. to 3:12 p.m.

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9 CHAIR: MATTHEW BANK

10 VENUE: MS Teams

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19 Reported by Annette Lainson

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2 APPEARANCES:

3 ABENAMAR ARRILLAYA

ARIEL GOLDMAN

4 ARTHUR COOPER

CRISTY MEYER

5 DANIEL CLAYTON

DONALD DOYNOW

6 FRANK MANZO

GINA WIERZBOWSKI

7 GEORGE ANGUS

KARTIK PRAHHAKARAN

8

KERRIE SNYDER

KIM WALLENSTEIN

9

KURT EDWARDS

10 MARK GESTRING

MATTHEW CONN

11 MEGHAN MULLEN

MICHAEL DAILEY

12 MICHAEL VELLA

ROBERT KERN

13 RONALD SIMON

ROSEANNA GUZMAN-CURTIS

14 RYAN GREENBERG

SHELDON TEPERMAN

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THOMAS BONFIGLIO

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2 (The meeting commenced at 1:09 p.m.)

3 CHAIR BANK: Call this meeting of the
4 New York State Trauma Advisory Group to order, and
5 our first order of business -- this is Dr. Bank, by
6 the way. Our transcription service is virtual. So,
7 if you want to speak, please, you need to speak into
8 a microphone.

9 And please just state your name at the
10 beginning of your comments. Thank you very much.
11 And Dan, are you going to lead us through these
12 Pledge of Allegiance?

13 MR. CLAYTON: Sure. I'll do the
14 Pledge of Allegiance.

15 ALL: I pledge allegiance to the flag
16 of the United States of America.

17 CHAIR BANK: So I think we're going to
18 -- to do an attendance roll call.

19 MR. CLAYTON: Dr. Bank?

20 CHAIR BANK: Here.

21 MR. CLAYTON: Dr. Wallenstein.

22 MS. WALLENSTEIN: Here.

23 MR. CLAYTON: Dr. Guzman-Curtis?

24 MS. GUZMAN-CURTIS: Here.

25 MR. CLAYTON: Dr. Gestring? Mr.

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2 Manzo?

3 MR. MANZO: Here.

4 MR. CLAYTON: Dr. Prabhakaran?

5 MR. PRABHAKARAN: Here.

6 MR. CLAYTON: Ms. Maguire?

7 MS. MAGUIRE: Here.

8 MR. CLAYTON: Dr. Angus?

9 MR. ANGUS: Present.

10 MR. CLAYTON: Dr. Reddy is excused.

11 Dr. Agriantonis? I believe he's also excused. I

12 think he has an A.C.S. visit. Mr. Conn?

13 MR. CONN: Present.

14 MR. CLAYTON: Dr. Teperman?

15 MR. TEPERMAN: Present.

16 MR. CLAYTON: Kerrie Snyder?

17 MS. SNYDER: Here.

18 MR. CLAYTON: Dr. Edwards?

19 MR. EDWARDS: Here.

20 MR. CLAYTON: Dr. Arillaya?

21 MR. ARILLAYA: Present.

22 MR. CLAYTON: Dr. Vosswinkel, I

23 believe is excused. Dr. Flynn, same thing, excused.

24 Ms. Mullen?

25 MS. MULLEN: Here.

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2 MR. CLAYTON: Dr. Winchell? Not here.

3 Dr. Dailey?

4 MR. DAILEY: Here. Here.

5 MR. CLAYTON: Dr. Doynow?

6 MR. DOYNOW: Here.

7 MR. CLAYTON: Dr. Goldman?

8 MR. GOLDMAN: Here.

9 MR. CLAYTON: And Dr. Cooper?

10 MR. COOPER: Here.

11 MR. CLAYTON: We have just met quorum.

12 CHAIR BANK: Okay. Thank you very

13 much, Dan. So the next order of business is, can I

14 have a motion to approve the previous meeting --

15 meeting minutes? The transcript of the October 2024

16 STAC is on the website. I have read it. Do I have a

17 motion to approve the transcript?

18 MR. CONN: Matthew Conn, New York City

19 RTAC (phonetic spelling), motion to approve.

20 CHAIR BANK: Do I have a second?

21 MR. TEPERMAN: Second.

22 CHAIR BANK: Teperman, second. Can I

23 have a vote of everybody agreeing to approval in the

24 minutes? So we have nineteen in favor. Any against?

25 Zero against. So, we will approve the minutes.

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2 We're going to move to the Bureau of E.M.S. and
3 Trauma Systems Report. Director Ryan?

4 MR. GREENBERG: Good afternoon,
5 everyone. I'm going to try and keep it brief.
6 Actually, I think we'll be able to on this one. So,
7 a lot of really good things going on within the
8 bureau. We're excited about where things are going.

9 Many of you might have been seen,
10 we've been able to hire several new people. You'll
11 start to see some new faces, some additional support.
12 One of the things that we're actually working on
13 expanding in 2025 is our council support team.

14 So hopefully there'll be more support
15 for council operations of all four of our councils.
16 And that's important for us to be able to support
17 some of the research that's being done, some of the
18 initiatives, some of the things that need to happen
19 behind the scenes so that each of you are able to,
20 you know, do what you do on your day to day, which is
21 critical.

22 But also be able to take your subject
23 matter expertise and take on different projects and
24 things that we can support you behind the scenes on
25 that one. So, want to thank you for that one and

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2 look forward to more coming on that.

3 We continue to get more applications
4 for provisional designations. And you know,
5 predominantly, obviously in our level three area, we
6 have also in this past year, in 2024, started to see
7 movement of different institutions moving from level
8 three to level two, and some from level two to level
9 one.

10 That has identified for us some
11 opportunities to be able to further structure what
12 those processes look like. And you know, we're
13 excited, and I think we'll be reported later on, that
14 we'll be working with a team from one of your
15 committees to further kind of put that in place.

16 We have a very specific structure for
17 a level three -- to become a level three provisional
18 trauma center. We don't as much for the others. And
19 so, we're going to work on streamlining that and
20 making it in a similar policy format to everybody who
21 knows, who wants to either become a different level
22 or move or -- or even to go down a level for whatever
23 reason will have a structure to that.

24 And so, thank you to the chair for
25 supporting that one and having a working group that's

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2 going to work with us on that. There are a number of
3 new E.M.S. regs that are going to come out in 2025.

4 We had educational regs that changed
5 in June, we have another educational reg packet that
6 will probably come through as well as equipment regs
7 and some other things that are going. But though
8 there is one reg packet that I think will be
9 important.

10 Just want to know we've had some
11 conversations about it before, which is the blood
12 regulation. So last year there was a statutory
13 change that moved E.M.S. from where it used to be
14 only Air Medical was able to carry blood. Now,
15 ground or air can carry blood.

16 And there is a regulatory set that we
17 are working on right now on the backend of what a
18 ground agency would need to have in place. And to be
19 able to do that, there are protocols that will come
20 with it as well.

21 I bring that up in this meeting,
22 obviously, because, you know, to start carrying blood
23 in the field that's, you know, could change the
24 dynamic of the patient that you're seeing. I know
25 there's been some discussions about what does that

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2 mean?

3 You know, pre-hospitality, when we
4 look nationally, we've seen, you know, a -- a pretty
5 large spike in the number of pre-hospital cases that
6 are receiving blood. And I'm sure Dr. Dailey
7 probably can talk more about it.

8 So I think that's something that's on,
9 you know, on the horizon for that one. We know the -
10 - obviously the regs are. And the regs do go out for
11 public comment. When they go out for public comment,
12 they're not out for public comment just for E.M.S.

13 They're out there for, you know,
14 anybody in New York state, including trauma,
15 community -- community. So if you do feel passionate
16 about, you know, those reg sets or things that might
17 be in it, by all means, feel free to comment during
18 that.

19 CHAIR BANK: Director Ryan?

20 MR. GREENBERG: Yes?

21 CHAIR BANK: I'm sorry to interrupt.
22 Just at this -- at -- in this venue we have, and I --
23 I -- I've been suggesting that the department include
24 in the regulations as suggestion or requirement.

25 I believe Dr. Dailey is -- is in

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2 agreement with this, that if a patient is headed to a
3 trauma center and is being transfused, that the
4 E.M.S. unit simply tell the trauma center that
5 there's a transfusion happening.

6 I think -- Dr. Dailey -- I don't want
7 to speak for you. Can we think about including that
8 in the regulations?

9 MR. GREENBERG: So, we absolutely can
10 look at the regs and actually Gina's here who's going
11 to talk about the four or five nurse review
12 regulations, but we can make a note to look at that.
13 I most likely -- it sounds like that recommendation
14 would actually best be fit in protocol rather than
15 regulation.

16 But I think that's absolutely
17 something that we can and being that we update the
18 protocols once a year might be something that we want
19 to start to look at sooner than later. And I would
20 say that that's not only a ground thing, that would
21 be an air thing too, that if, you know, they are
22 there and -- and putting that out there, that they
23 should make notification. Absolutely.

24 CHAIR BANK: Gina, would you like to
25 talk about the four or five regulations and where

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2 those are? This is related to the nurse reviewer.

3 MS. WIERZBOWSKI: Yes, happy to. Good
4 afternoon. My name is Gina, G-I-N-A. Last name is
5 Wierzbowski, W-I-E-R-Z-B-O-W-S-K-I. So the update to
6 the 405.45 trauma center nurse reviewer regulations,
7 to refresh the group's memory, the only change that
8 was made was to take a requirement for our nurse
9 reviewer for -- from every trauma verification and
10 reverification to only the initial verification
11 visit.

12 That was the minor change that was
13 made to the regulatory package. The regulatory
14 package has made its way through the process, and I
15 know it's been a long process, and we thank you for
16 your patience. It actually was published in the
17 state register today for public comment.

18 It will be open for public comment of
19 any and all kind up until March 31st of this year.
20 We will be sending out an email to the trauma
21 LISTSERV and to other groups that we interact with to
22 direct you to those links so that you may see it and
23 read it. And if you feel inclined to comment, we
24 encourage you to do so.

25 After the package comes back from

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2 public comment, the department will then assess the
3 comments we receive and decide if we need to make any
4 further regulatory changes or not, based upon those
5 comments. Hopefully there won't be substantial
6 comments that cause us to change the regulation.

7 If -- if the comments come back and
8 everything looks good, then the package would then
9 have to go to PHHBIC (unintelligible) for a vote and
10 approval. and then after that, it probably would be
11 -- well, I won't say probably, I will say hopefully
12 all of this would play out into line up with PHHBIC's
13 June meeting in New York City.

14 That would be ideal. That would mean
15 it would go quite quickly but it can be hopeful.
16 And then once it comes back from a vote from PHHBIC,
17 then it would continue through its last few stages of
18 approvals internally and then would be published and
19 enacted permanently.

20 MR. TEPERMAN: Question.

21 MS. WIERZBOWSKI: Yes.

22 MR. TEPERMAN: So with all of that and
23 understanding the point you made about the comments
24 and potential changes, assuming that doesn't happen,
25 what would potentially be the first visits, and --

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2 and maybe Director Ryan can help with this, that
3 would no longer be subjected to the nurse reviewer
4 requirement?

5 MS. WIERZBOWSKI: So my --.

6 MR. GREENBERG: Was there an
7 implementation date on it --

8 MS. WIERZBOWSKI: I think --

9 MR. GREENBERG: -- a period?

10 MS. WIERZBOWSKI: -- oh gosh, now
11 you're testing my memory. I don't think there was an
12 implementation date. I think they are effective once
13 they take a -- immediately.

14 MR. GREENBERG: You say immediately?

15 MS. WIERZBOWSKI: But I would press --
16 you know, I -- I mean, director, I would defer to you
17 to -- to give that opinion.

18 MR. GREENBERG: So I -- I do believe
19 they're effective immediately, which means, in
20 theory, the day after they get approved, then that
21 person is no longer required to have a nurse
22 reviewer. They still could. They're -- there's
23 nothing in the regulations that say you can't have
24 more. You just can't have less.

25 The challenge will be -- and -- and

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2 again, we don't think there will be, you know,
3 resistance or things of that nature that come back to
4 it. But if there is, and if there's substantial
5 change that needs to occur, then we'd have to go back
6 out for comment.

7 So, you know, reality is you're
8 removing a nurse reviewer. Well, if the non-trauma -
9 - nurse community comes back in force and says, well,
10 we think it shouldn't happen, that could drive
11 different things along.

12 MR. TEPERMAN: Understood. So just
13 continuing with the thought experiment. So assume
14 that implementation is July 1st.

15 MR. GREENBERG: Sure.

16 MR. TEPERMAN: So, and just with the
17 thought experiment, let's say a center is -- is to
18 have a visit at July or August, the nurse has already
19 been assigned. Would that center ask for that nurse
20 to be unassigned?

21 MR. GREENBERG: My recommendation
22 would probably be not to change it at that point, if
23 it's already been set in place and it's there because
24 the other thing is -- is that if they approve in
25 June, it still has a couple more steps on our side

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2 that normally are predictable, but are not exact.

3 And so until we physically see it in
4 print out there and done, I would not make that
5 change.

6 MR. TEPERMAN: Okay. And with the
7 thought experiment, and people could -- folks can
8 correct me, right? The -- the reviewers get assigned
9 six months ahead of time, eight months, a year?

10 MR. GREENBERG: Review six months.

11 MR. TEPERMAN: Six months, three
12 months. All right. So in theory so this reg -- the
13 soonest that centers could delete the nurse reviewer
14 would be fall of this coming year, if I'm
15 understanding that?

16 MR. GREENBERG: I don't know if I'd
17 use the word delete, but I think as soon as that -- a
18 nurse reviewer would no longer be required on a site
19 visit, I would say safely would be the fall. Always
20 more eloquent than not.

21 MR. SIMON: Just -- just for all of
22 the people in this room that really don't want the
23 nurse reviewers anymore, then the onus is on you to
24 respond when the state sends out the link for the
25 comments that everybody who has any interest in this

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2 should write and say, we think this is a really good
3 regulation, and it should pass.

4 Because it -- if there's no one that
5 says yay, and there are one or two people that say
6 nay, that could swing the vote in a way that we don't
7 want them to be. So, however, you -- you're going to
8 send out -- the link is going to be sent out?

9 MR. CLAYTON: Yes. We --

10 MR. SIMON: So we can do --

11 MR. CLAYTON: -- Dan Clayton from the
12 Bureau, a link will be sent out, the emails already
13 prepared, and I will send it out for informational
14 purposes on how you can make -- how you or your
15 facility, or your R TAG or any entity can make
16 comments publicly about the regulation change.

17 I'd also like to remind people -- for
18 the record, by the way, that was Dr. Ronald Simon,
19 he's our systems subcommittee chair for the steno.
20 And just please, folks, especially because we have a
21 remote stenographer today, please make sure you
22 announce your name before you speak. Thank you.

23 MR. GREENBERG: This is Ryan
24 Greenberg. Any other additional questions about the
25 four of us? Great questions though. And -- and I

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2 appreciate it. And like I said, we can give an
3 estimate on timelines, but there's a lot of variables
4 in play.

5 I would also say, you know, just to
6 echo the public comment period, which is, you know,
7 when it's out. It doesn't have to be a long letter.
8 It doesn't have to be a lot. It could be a simple
9 sentence of this is really good or not, if you
10 believe in that.

11 Or if you have opposition, why that
12 opposition would be there and why you think that
13 shouldn't pass or if there's obviously any changes
14 that you think should go to it as well. Okay. I do
15 have one other item, but is there any other questions
16 or things before I get to the last item on my list?

17 CHAIR BANK: So, as many of you may
18 know there is an individual who is quasi retiring. I
19 thought he was retiring, but now I'm only finding out
20 that he's partially retiring, which is good for us,
21 who, when we had heard about it we started to do some
22 research on how long Dr. Simon has been with the STAC
23 and has been both a member and a leader of this
24 advisory council.

25 And I, you know, I've -- I've been

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2 here for seven years, and I can tell you he's been
3 here for many, many more than that. But he has, you
4 know, been both a mentor and a guide for me in
5 learning about the trauma system.

6 I know and hear on a regular basis on
7 how much he has helped many of you as well as he has
8 helped shaped this STAC and the committees that he's
9 worked on, as well as the state trauma system. And
10 so, on behalf of myself and the Bureau of E.M.S. and
11 Trauma Systems, if you can step up for a second?

12 Okay. We would like to present with
13 you -- this is a state E.M.S. director citation
14 presented to Dr. Ron Simon for recognition of his
15 over eighteen years of State Trauma Advisory Council
16 membership and leadership. Thank you for your
17 dedication to trauma care and the advancement of the
18 New York State Trauma System.

19 MR. SIMON: Thank you very much.
20 Thank you.

21 CHAIR BANK: Is that -- Director Ryan,
22 is that the end of your report?

23 MR. GREENBERG: That's the end of my
24 report, but I really -- Dr. Simon, I just want to say
25 when we looked back, we had to keep going back

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2 because we -- we thought we had all the files and
3 then we had to keep looking to -- to where it was
4 back into the early 2000s to find your first vetting
5 application packet which is not digitized, just in
6 case you're wondering.

7 So break out the paper files to -- to
8 see how far it went back. But in -- in truly
9 sincerely, on behalf of the department, the
10 commissioner, myself, and the entire trauma team,
11 thank you again for everything that you did. And I
12 hope you enjoy the partial retirement and the well-
13 deserved time.

14 CHAIR BANK: Dan and Tom, any trauma
15 program updates?

16 MR. CLAYTON: Other than the fact
17 that, you know, we continue, Tom specifically -- Dan
18 Clayton, by the way, from the Bureau. Tom is
19 participating in A.C.S. visits routinely. So please
20 make sure that you include him on invites for your
21 visits, surveys, sessions.

22 And if you have any questions about
23 LISTSERV issues, you know, you can certainly email me
24 but include Mr. Bonfiglio as well because he's taking
25 an active role in making sure that LISTSERVs are

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2 update -- for updated for TQIP and the trauma
3 LISTSERV, which has -- as you probably all know,
4 hundreds of people on it, upwards of five hundred on
5 the trauma LISTSERV.

6 I think fewer on the TQIP, but still a
7 -- a massive amount of people. So please continue to
8 keep Tom and me updated on what you have for
9 LISTSERVs. Mr. Conn, do you have a question or
10 concern?

11 MR. CONN: I -- I do have a question.
12 Matthew Conn, New York City R TAG. I just -- I'm in
13 my lead. I'm in my reporting year right now. My
14 visit is scheduled for March of 2026.

15 And since the -- the bureau has
16 expanded and we've gotten more roles approved and --
17 and hired into in the Bureau of E.M.S. and Trauma
18 Systems, I just want to have a -- a better
19 understanding, a shared understanding of what that
20 participation in the site surveys is going to look
21 like, if possible.

22 CHAIR BANK: Director.

23 MR. GREENBERG: Absolutely. So I'd
24 love to say the trauma systems portion of our bureau
25 has grown tremendously. Unfortunately, it hasn't.

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2 We've been able to backfill some positions that were
3 there.

4 I think the expectation of what you
5 can expect in the future, particularly as we start to
6 move back towards the in-person visits, site visits,
7 is similar to what you saw before, which is, you
8 know, myself Dan, Tom, you know.

9 In many of the cases we'll try and be
10 on site, if not for the full thing at least for part
11 of it, or partial ones. And you know, that active
12 role will be, you know, similar to what you saw
13 before. So, an active participation in it, but a lot
14 of it really is steered by the American College of
15 Surgeons.

16 The other component that you're going
17 to see that we are happy to be finally, you know, for
18 the most part out of COVID and able to travel again,
19 is prior to COVID, we really had the opportunity to
20 come see a number of trauma centers not during a site
21 visit to where we actually got to spend some time.

22 You know, not during inspection, not
23 during anything else, nothing from a, you know,
24 formal point of view, but more from a learning about,
25 you know, the programs, the individual programs, the

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2 excellence that that is out there from around the
3 state.

4 And so, I would expect that you, in
5 the more near future, would see us on more of those
6 types of interactions. And then with the A.C.F. as -
7 - is that coming up. Does that answer your question?

8 MR. CONN: Thank you. It does.

9 MR. GREENBERG: Absolutely. And if we
10 will be on site, you'll know ahead of time. So that
11 -- that -- that is the other thing too. So I -- I
12 will tell you, we will make it a committed point to
13 let you know ahead of time if we're going to be on
14 site for the A.C.S. or if we're going to be virtual
15 for that matter.

16 In addition to that, you know, for
17 visits that we're just coming, because we're in the
18 geographic area and want to get to see some of
19 different trauma centers and the work that you're
20 doing then, you know, obviously, we'll -- we'll
21 schedule those ahead of time too.

22 And then last, but not least, if there
23 is anything that's going on in your communities, if
24 there's a, you know, a larger than normal community
25 outreach event or injury prevention event, or

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2 something that you think would be beneficial for us
3 to see in person, we would love to come out and see
4 those and be a part of those as well.

5 MR. TEPERMAN: Who's best to -- best
6 to send that kind of email to Dan, to both of you to
7 -- to you, Dan and Tom. What -- how best to notify?

8 MR. GREENBERG: I think the -- the
9 best -- if you were to send it to all three of us,
10 and then most likely it would be Tom who will
11 navigate, you know, who'd be showing up or you know,
12 what we have the availability to be able to do.

13 MR. TEPERMAN: Okay.

14 MR. BONFIGLIO: Director Dan, thank
15 you. Tom Bonfiglio with the Department. Just to
16 your question, Matt. For those that have had me on
17 the surveys that -- in the past year or so,
18 typically, I -- I shadow the lead reviewer, but I --
19 I just asked for access to all three meeting rooms,
20 typically, which is the nurse and -- and the other
21 two reviewers.

22 And I ask for the charts ahead of
23 time. So, whenever you're sending your P.R.Q. and
24 you have your charts I get the notification along
25 with you, you know, when -- with the notification of

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2 who the reviewers will be and so forth.

3 I generally introduce myself to the
4 reviewers ahead of time. I let them know that I'll
5 be there. And then I typically participate in
6 generally the lead reviewers' room, but not
7 necessarily. So, I -- I don't ask a lot of
8 questions.

9 Once in a while, I -- I'll -- I'll ask
10 a question or two, but I've always read all the
11 charts and I'm familiar with everything that -- that
12 you're going to be going through. So, my goal is to
13 be helpful. So, I'm not looking to ask questions
14 that are going to trip you up with -- with the A.C.S.
15 or anything like that. Just to support the process.

16 And then if background is needed on
17 the E.M.S. system or on the trauma system or state
18 regulation, I -- I can be a resource during the
19 review. I'm also happy to come out ahead of time,
20 and I've made the offer to a few centers, and I'm
21 happy to come out prior to your review, and we can
22 run through things together in a dry run sort of
23 situation.

24 If it's something that a center hasn't
25 had a lot of reviews and you'd like to go through one

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2 with me, that's fine. And so those are, you know,
3 sort of a -- a painless and harmless way to go
4 through it sometimes.

5 MR. GREENBERG: So, one other point I
6 will bring up, which I think is important too, is,
7 you know, one of the things that is not handled
8 between surveys is complaints. So the A.C.S. between
9 verification visits essentially is, this isn't our
10 role, our role is to verify, and we don't handle in
11 between.

12 So, there is another dynamic that
13 thankfully doesn't come up too often but does come up
14 where if we do receive complaints or there's
15 expressed concerns that have been expressed from a
16 variety of different ways that could yield an onsite,
17 you know, site visit, then that would be the other
18 challenge that we'd be there for.

19 You most likely would know ahead of
20 time in many of the cases that were coming on site
21 and what the reason is for.

22 MR. TEPERMAN: Question.

23 MR. GREENBERG: Yeah.

24 MR. TEPERMAN: Teperman. In an
25 anonymous way, without giving away what the

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2 particular instance is what -- what kind of thing
3 would the department bureau of E.M.S. and trauma show
4 up for? What kind of complaint? Without --
5 obviously without giving, you know, anything away.

6 MR. GREENBERG: I mean, it can be a
7 variety of things, but you know, if -- if you think
8 of the gray book and the standards that are in it,
9 and if someone was to file a complaint saying, hey,
10 this is not being followed, or you know, we think
11 there's patient harm or patient safety issues related
12 to a process that are not following internally may be
13 reported by a patient family, maybe reported by a
14 patient, maybe reported by a staff member.

15 Those are any of the things that --
16 that we would come on site for related to it.
17 Because -- and in some cases, even from complaints
18 that might be made to the American College of
19 Surgeons, they will tell us that, hey, we don't
20 handle this. This might have channeled through them.
21 They would pass that to us.

22 In most cases, we would know about
23 that ahead of time. But if it does happen to happen
24 that way, that's another pathway to it. It's
25 actually one of the ways that we found out that they

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2 don't handle things in between.

3 CHAIR BANK: Dan and Tom, anything
4 else in the trauma program update?

5 MR. CLAYTON: No, Dr. Chair, thank
6 you.

7 CHAIR BANK: Okay, thank you. Going
8 to the executive subcommittee. So, one of the
9 progress of the chair is I get to make a small
10 speech. So a small speech would be when I first came
11 to STAC, there were three people that really took me
12 aside and showed me where the bathroom was, and asked
13 me if I wanted to have a couple drinks at some trauma
14 meetings.

15 And it was Bill Marks and Trish O'Neal
16 and Ron Simon. I was really never able to tell Bill
17 or Trish how much I appreciated that until they
18 passed away. So, I just wanted to be able to look
19 over at Ron and the one person I -- I get, and to say
20 thank you very much for all your mentorship over the
21 years.

22 Moving on from that, if you go through
23 the minutes of the -- and the transcript of the
24 October 2024 STAC meeting, there were a few loose
25 threads that we just wanted to clean up. At the

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2 meeting, there was a lot of discussion about the most
3 common deficiencies for New York State for the V.R.C.
4 reviews in 2024.

5 So since then, I just want to -- this
6 has been sent out on the LISTSERV, but I just want to
7 read it out. The -- our four -- the four
8 deficiencies that were given out to trauma centers by
9 the V.R.C. in 2024, these all the gray book.

10 The Standard 7.3, which is documented
11 effectiveness of the Pitts program. Standard 5.31,
12 which is the alcohol misuse intervention. Standard
13 6.2, which is trauma registry, patient completion.
14 And standard 9.1, which is research and scholarly
15 activities.

16 These are the four deficiencies that
17 were given out to New York State Trauma Centers in
18 2024. They're all off the gray book. I think that
19 Tom put this out in the LISTSERV, but I also wanted
20 to just read it out here.

21 The other thing that had been
22 discussed at STAC in October was STAC sending a
23 letter to the A.C.S. talking about the timeframe for
24 registries to be compliant, the A.I.S. 2015 coding.
25 I want everybody to know that that letter was sent by

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2 the STAC to the A.C.S.

3 We did get a reply. The reply said,
4 and I'm going to paraphrase here, they used very
5 politically correct language, but the paraphrase was,
6 no.

7 They did say that they looked at it
8 again, and they respected our views and that they --
9 are reviewed all stakeholders and the registry
10 software again. However, they're going to stick to
11 the current timeframe for software to be compliant
12 for A.I.S. 2020 -- 2020 to 2015.

13 I think Cristy may have more to say
14 about that in her registry report. But that letter
15 was sent and we did get a reapply. Also, previously
16 we -- the bylaws of STAC state that the chair has to
17 appoint the -- the chairs of the subcommittees, so
18 it's me.

19 Previously, we announced the chairs of
20 subcommittee at this meeting. There's a little
21 change in process. I wanted to make sure that we
22 announced that there was a need for a subcommittee
23 chair. So at the last STAC in October 2024, we did
24 mention that Dr. Simon was retiring. He would no
25 longer, in his retirement, be the chair of the system

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2 subcommittee.

3 We did mention that we did get some
4 people showed interest. So at this STAC, we're just
5 going to announce that Dr. Robano and Dr. Teperman
6 will be co-chairs of the system subcommittee moving
7 forward.

8 In that same vein, Cherise Berry, who
9 is previously the co-chair of the Trauma and Needs
10 Assessment Committee, has now started practice in New
11 Jersey. So she'll no longer be a part of the trauma
12 -- New York State Trauma Community, which we will
13 miss her.

14 But there will be an opportunity for
15 the co-chair of the Trauma Needs Assessment
16 Committee, so if anybody is interested in that,
17 please just send me an email and hopefully we'll be
18 able to announce the co-chair of the Trauma Needs
19 Assessment Committee in May. The current -- the
20 other co-chair is Dr. Winchell.

21 Lastly, there was a lot of discussion
22 at the P.I. committee, and then also at this
23 committee about updated medical examiner letter. So
24 there was a letter in 2023 or 2024, I don't remember,
25 from the Healthcare Commissioner to Medical Examiners

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2 just reviewing the -- at that time, new legislation,
3 which had been just signed by Governor Cuomo at the
4 time about the giving access to the Medical Examiner
5 reports for trauma centers.

6 There's a lot of discussion at STAC
7 about updating the letter. So that letter has been
8 updated. It is on the -- the New York State D.O.H.
9 trauma website. So please, if you're interested,
10 there's any issues with your M.E. not understanding
11 that we do have regulatory access to M.E. reports,
12 you can go on to the website.

13 And that letter, which is now dated of
14 twenty -- I think it's a November 2024 date. You can
15 download that and you can use that to help educate
16 your M.E.s as to the regulations surrounding M.E. and
17 autopsy reports for trauma patients in New York
18 State. I think that is it for the executive report.

19 MR. GREENBERG: Just a point of
20 clarification. So, for the -- well, for starters,
21 let me say congratulations and thank you to the two
22 new chairs for system, so much appreciated. Second,
23 for the Trauma needs assessment, vice-chair position,
24 is it -- sorry, co-chair, is it sending you, how
25 would you like that process? Are they sending you

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2 things or?

3 CHAIR BANK: So -- yeah, so please
4 just email me. It's -- you can email Dan and he
5 always knows where to catch me. Trust me, I speak to
6 him every day and every other day. But you can also
7 please read the email at me. It's M Bank, M-B-A-N-
8 K@northwell.edu.

9 And yeah, I think everything else is
10 going to be covered in the subcommittee reports. So,
11 unless there's any -- any questions about my report.
12 Okay, so we'll move to registry with Cristy.

13 MS. MEYER: Good afternoon, everyone.
14 Cristy Meyers subcommittee chair for the Registry
15 Committee. Great engagement in the meeting this
16 morning. We had a lot of discussion about the New
17 York State Trauma Registry upload process.

18 Certainly, encouraging members across
19 the state if they're having some difficulty, they can
20 certainly reach out to Peter Brody at the E.M.S. data
21 email to get them up to speed on the submission
22 process.

23 As Dr. Bank alluded to, we have made
24 that transition to the 2015 A.I.S. coding in the
25 dictionary for this year, all admissions as of

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2 January 2025 will need that coding standard in the
3 data submission to TQIP and New York State.

4 We do hear that there's a lot of
5 transition to new vendors and new vendor software
6 across the state, which will be ongoing throughout
7 the first half of this year. That will challenge
8 some of the timeliness of -- of data upload to New
9 York State, and also potentially some members meeting
10 the June 1st deadline for the TQIP submission for
11 quarter one of 2025.

12 There was good discussion around
13 certainly contacting the A.C.S., if that affects you.
14 And certainly, we're going to have some follow-up
15 interim subcommittee meeting between now and May to
16 provide some vendor support through one of the
17 largest vendors here in New York State.

18 There'll be a little bit of a work
19 group spearheaded by Maggie Ewen with E.S.O., one of
20 the vendors. There are a lot of challenges as you
21 onboard something new. So, we'll be helping to
22 support registry teams across the state with that.

23 And also, just for clarification for
24 everyone, there are four vendors in state, Image
25 Trend, E.S.O., N.Q.S. and Juniper. We did have two

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2 representatives at the registry committee meeting
3 this morning to give their insights and their contact
4 information.

5 And we'll be looking forward to the
6 X.S.D. submission file and the New York State Trauma
7 Registry Dictionary upload onto the website shortly
8 that has been approved.

9 In terms of changes to the New York
10 State data dictionary and submission this year, we
11 will be collecting not only the P.C.R., prehospital
12 care report, into your center but if you have
13 received a patient as a transfer, we will be
14 collecting that first E.M.S. contact into the
15 referring center this year.

16 There's a little bit of challenge
17 getting that documentation, and there was quite a
18 robust discussion about the challenges. We also
19 heard through some recent A.C.S. visits that the
20 A.C.S. reviewers did look for that documentation.

21 So it's certainly very important to
22 understand the processes of care and the systems of
23 care for our patients. With that, we did receive a
24 motion to put forward for discussion and
25 consideration at this committee, really that the

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2 initial field P.C.R.s are very difficult for trauma
3 centers to obtain.

4 There are HIPAA and all kinds of
5 access challenges. So as a receiving center, you
6 can't just go onto a website and retrieve that. It's
7 something that has to be sent to you from the
8 referring center.

9 So the motion reads out that we are
10 looking for support from the Department of Health to
11 create a submission. And we'll bring it up here on -
12 - on here, that we're requesting the STAC to submit a
13 proposal to create a process to request the initial
14 scene P.C.R. from the New York State P.C.R.
15 repository for inter-facility trauma patients.

16 So the pre-hospital care report from
17 E.M.S. is sent to a repository that's at the state
18 level. And the request is to create some kind of
19 process to get the P.C.R. from there. I'll leave it
20 there for some discussion at this point and any
21 clarification needed.

22 MR. CONN: Step one friendly amendment
23 to that, and that's if the process could not be
24 specific to trauma patients because this impacts
25 receiving centers for stroke, STEMI, vascular cases

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2 but any of those cases where we have patients that
3 are transferred from one facility to another where
4 there potentially is an E.M.S. P.I. component that we
5 should be investigating at Ultimate Receiving Center.

6 CHAIR BANK: Also, a friendly grammar
7 suggestion, inter-facility transfer patients, is it
8 inter-facility transfer trauma patients or patients
9 in general? I think the word transfer has to be in
10 there.

11 MS. SNYDER: I think the reason the
12 focus is on the inter-facility transfer is those same
13 P.C.R.s the designation that E.M.S. providers put on
14 those P.C.R.s is the outside hospital, which then
15 prevents the when -- then when they're transferred
16 into a trauma center, we cannot go into Elite View or
17 any of these online options to see that P -- P.C.R.
18 because the designation is not for us Albany Med.

19 And I think -- to Dr. Dailey's point,
20 I think this is an excellent suggestion to use it.
21 You know, it really isn't just trauma that this
22 affects the inability to have the entire patient care
23 record.

24 MR. CONN: So, Matthew Conn, New York
25 City R TAG. I do not disagree with Dr. Dailey at

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2 all. I think that creating a mechanism to get any
3 P.C.R. for any inter-facility transfer patient coming
4 to your facility is a good thing.

5 That -- my thought out loud might be
6 that that request might come from the SEMAC as the
7 emergency medicine folks. Unfortunately, for
8 everybody else, as -- as the trauma group, we may not
9 be able to step outside that purview. But I'll leave
10 that up to Chair Bank and Director Greenberg.

11 MR. GREENBERG: A request or an
12 opportunity to express a desire is always one of this
13 council. The direction in which it should go,
14 whether it be to me, to me and the person to the
15 right of you to -- would be the way of channeling it
16 and kind of looking at it from that point of view.
17 So definitely understand the -- the way you express
18 it.

19 And yes, definitely would fall into
20 partially on the domain of the SEMAC, but I think you
21 both have things that you're looking for and trying
22 to achieve with it, so.

23 MR. CONN: I want to make sure that we
24 are not overstepping any -- any boundaries unduly.

25 CHAIR BANK: So Cristy, just for this

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2 -- Matt Bank, just -- I'm just reading your thing.
3 So if we pass this motion the next step would be STAC
4 would then work within the STAC to create a process
5 to get the P.C.R. from the New York State P.C.R.
6 repository.

7 So you're asking us to then go back
8 and create a process among the STAC. That request to
9 STAC to submit a proposal to create a process to
10 submit a proposal at the Department of Health,
11 creates a process to request the initial scene. Is
12 that -- is that what you mean?

13 MS. SNYDER: Kerrie Snyder from
14 Northeast R TAG. I'm going to answer that. So this
15 was my request at the registry committee, and I was
16 advised that I should send a proposal to New York
17 State Department of Health for this to have some kind
18 of system set up to allow us to get seeing P.C.R.s.

19 And my response to that is, this is
20 not a response from Kerrie Snyder. This is a
21 response from the trauma community. So it should not
22 come from me, it should come from the registry --
23 either the registry committee or the STAC at large.

24 MR. CONN: So just -- right. So you
25 would request a STAC to submit a proposal to the

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2 Department of Health to create a process to request
3 the initial scene P.C.R. from New York State P.C.R.
4 repository. Is that -- that true? Because I just
5 want to trade because we have to submit a proposal to
6 somebody, either it's a STAC or it's a D.O.H.

7 And Ryan, is this true? I'm just
8 trying to -- we -- we can't submit a proposal to the
9 D.O.H. that they do something.

10 MR. GREENBERG: You can make a request
11 or a recommendation. It really, you know, wouldn't
12 be a proposal, but it -- that -- that's the extent of
13 what it would.

14 MR. CONN: So we -- is -- which would
15 be a request that the STAC submit a proposal to a New
16 York State D.O.H. to create a process to request the
17 initial scene P.C.R. from the P.C.R. repository for
18 transfer patients.

19 MR. GREENBERG: And -- and I will tell
20 you, this isn't something that we haven't looked at
21 before, so I think it's important to understand we
22 have. The automated process of this is challenging
23 because nowhere on their patient care report, how
24 would they, right?

25 So at that first hospital that they go

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2 to, doesn't know where they're going to end up next,
3 right? So, if they go to community Hospital A, but
4 now they're going to end up at trauma center B,
5 there's nothing that's necessarily linking that.

6 I do question, you know, is the right
7 thing to try and put a process in place with us,
8 which we have, you know, kind of looked into and
9 identified, would be very challenging for us to be
10 able to facilitate or work through versus is the
11 right pathway for charts and you know, these things
12 to make it to the RIHs and you know, our Regional
13 Information Hubs that then link it together as just a
14 patient and those centers can grab from the patient
15 within it.

16 But I think the letter is all us, you
17 know, that absolutely welcoming and to have those
18 further discussions of what that would look like.
19 But I also want to be realistic to -- to what our pro
20 -- what our capabilities might be.

21 MR. CONN: So the -- this would be a
22 request to D.O.H. and the D.O.H. can say no. But --
23 but the -- there just should be a request to create
24 this process from the STAC. Any other discussion?

25 MS. SNYDER: Kerrie Snyder from

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2 Northeast R TAG, again. So, I would defer to you the
3 best method to allow trauma centers to gain access to
4 the P.C.R.s. It is incredibly, incredibly time-
5 consuming, people trying to track these down when we
6 know they live in a state repository.

7 So, whether that -- whether it comes
8 out of the state repository or there's an
9 intermediate hub where they reside, we are asked to -
10 - we have to be A.C.S. compliant. The A.C.S. one of
11 the standards is that we audit each patient that is
12 to ensure that E.M.S. followed the appropriate trauma
13 triage criteria.

14 It's impossible to do that without
15 seeing P.C.R.s. We've had people talk today that
16 their reviewers wanted the initial scene P.C.R.s for
17 all of their charts that they reviewed. You know,
18 Albany gets -- about 40 percent of our patients are
19 transferred in, so that's somewhere around eighteen
20 or nineteen hundred a year that we are to imagine the
21 process of trying to track down that many transfers
22 in.

23 It is an impossible task. It is a
24 full-time job for somebody. And we know they live
25 within a system that New York State controls. So

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2 we're asking for some kind of support to gain access
3 to these P.C.R.s so that we can do the job that we
4 are required to do.

5 MR. GREENBERG: And -- and like I
6 said, we are happy to continue to look into it. It's
7 not something that we haven't looked into before.
8 Obviously, the sending facility should also be
9 sending the patient medical record and the associated
10 documents, including the patient care report that
11 should be at that facility.

12 We also know in some trauma patients
13 that happened so quick the patient care report isn't
14 even done at that point. One of the things that we
15 might be able to look at and have a discussion, I
16 know I saw E.S.O. here before. He might've left.
17 Did he leave Peter? Yeah. Okay.

18 Is to have a conversation with some of
19 the vendors to find out how have they handled this in
20 other places. Reality is, I would say about 80
21 percent of our patient care reports are handled
22 through three major E.P.C.R. vendors.

23 And so, you know, is there a way that
24 if a patient leaves a facility that that P.C.R. can
25 be tagged to forward onto yours so it's in your

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2 bucket as well as theirs. You know, I just -- the
3 answer of it just coming to us is not always, you
4 know, the best answer or the most efficient or even
5 possible, right?

6 So as you -- as you sit there and say,
7 well, you know, it takes us so much time to figure
8 this out, and where are they, everything else, that
9 time might not change on our front either, right?
10 Like not getting us anywhere better. This might be a
11 much kind of bigger solution.

12 Anyone here from New York City R TAG,
13 they were working. Thank you, Matt. Sorry. But I -
14 - was it Mount Sinai who was working on a solution
15 that's -- that's for P.C.R.s.

16 MR. CLAYTON: Use your mic, please. I
17 did see some representation from Mount Sinai
18 Morningside here. Are you still -- hi, you guys
19 working on something? Okay.

20 MR. GREENBERG: So -- so it might not
21 be in the trauma community, that's why it's --
22 forgive me, it's all blurred. But that they were
23 working on something that was, you know, not only
24 getting the P.C.R. directly to the institution, but
25 getting it directly into the E.P. -- into the E.M.R.

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2 CHAIR BANK: Well, if you find out who
3 that organization is and which -- which bucket they
4 live in, we'll be more than happy to -- to get
5 connected and see what they figured out as a
6 solution.

7 MR. GREENBERG: Right. So let --
8 let's take a look at that one as well. Again, it
9 might be the other hat that I wear. Let's bring that
10 one. But happy to look at it, happy to have
11 discussions about it. I understand the frustration.
12 And we do want you to get the patient care report,
13 it's just figuring out what that pathway is.

14 MR. MANZO: Hey, Ryan, Frank Manzo
15 from Finger Lakes R TAG. I agree. This is very
16 complex because -- but to me, one of the solutions
17 may be, like you said, the sending facility because
18 they're the only one who has that P.C.R. of the
19 initial transporting agency attached to the
20 encounter, right?

21 Because you could look in the -- the
22 state system and see that patient was transported
23 three times to that other facility in the same day,
24 and the third time they got transferred to a trauma
25 center. So you won't even know based on name and

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2 date that you have the right P.C.R.

3 So the sending facility would know
4 that it's attached to the appropriate counter, so
5 just a thought.

6 MS. MEYER: I -- I would just like --
7 Cristy Meyer. I would like to suggest that we should
8 really be forming a -- a tactical advisory group.
9 This is a shared vision. I think you need to
10 understand from emergency or wherever else these
11 patients are coming from, that there's an onus on
12 them.

13 And from a system perspective, I think
14 that there's data opportunity here. And finding a
15 way to manage that in a system where you're -- you're
16 talking about maybe four to three different -- you
17 know, three to four different platforms, it may look
18 different and -- and it's not a one size fits all per
19 se.

20 So that's what I would kind of
21 recommend, I think, is a tactical advisory group that
22 really would push this forward because I don't think
23 it's -- it's -- it's a moving target as well. As
24 technology changes, we're going to have to change
25 things.

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2 So people going to Epic. There's an
3 epic shared vision where you can get access to things
4 from people who are on Epic statewide. So, there's a
5 lot of other pathways, and I think it -- it is a
6 little bit regional. So I would suggest that that
7 should be taken into account.

8 MR. CONN: If I can jump on from that.
9 I'd just like to remind everybody there is already a
10 group that is designated through the SEMAC with
11 encouragement from the STAC to look at how this I.T.
12 infrastructure can ultimately integrate.

13 The other thing is, I'm sure at some
14 point our bridge technology will be coming up for
15 R.F.P. again. My suggestion would be to have
16 representation from that TAG work with the department
17 on -- on the development of that next bridge, R.F.P.,
18 to make sure that we really are going in as many
19 different directions as we need to with our I.T.
20 infrastructure.

21 CHAIR BANK: Okay, so we have this
22 motion. First of all, any other discussion? So, we
23 have this motion that Cristy's put on the floor.
24 Jane, do you want to? Okay. So we had --.

25 MS. MEYER: Again, I know we have this

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2 motion, but I wanted to put it out there that maybe
3 the request is for the STAC to create a TAG. A TAG
4 that will work on this proposal and solution. That's
5 -- that's what I would suggest, but I don't know if
6 anyone else has more comments on that.

7 CHAIR BANK: So we're going to change
8 the motion to request that the STAC create a TAG.
9 Dan, what does TAG stand for again? Technical
10 Advisor Group. I know it wasn't tactical. Okay.
11 Technical Advisor Group to create a process to
12 request the initial scene P.C.R. from the New York
13 State P.C.R. repository for interfacility transfer
14 patients.

15 Just a question there, Mr. Director.
16 I'm just waiting for him. Mr. Director, because the
17 Department's looking at this, would the TAG be
18 helpful?

19 MR. GREENBERG: Absolutely.
20 Particularly if they want to do some research into
21 how other states are doing it and make ideas or
22 suggestions. And the other thing is, is that
23 reality, you know, the Department is looking at it,
24 but when the Department looks at things, we sometimes
25 see -- see things in a different light.

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2 And so having a TAG or something like
3 this, you know, even -- even from Cristy to -- to Dr.
4 Dailey, you know, the view of what Dr. Dailey may
5 need versus the view of what Cristy may need or time
6 periods or things like that could be different.

7 And so having that feedback and
8 recommendations is extremely helpful. But thank you
9 for asking us that as well.

10 CHAIR BANK: So just to clean up the
11 motion a bit, it's request to STAC -- the STAC,
12 create a TAG to create a process. So, submit a
13 proposal to D.O.H. We're going to take out. Thank
14 you. So, request the STAC to create a TAG to create
15 a process to request the initial scene PCR from the
16 New York State P.C.R. repository for inter-facility
17 transfer patients.

18 MR. DOYNOW: Yeah. It's Don Doynow
19 from SEMAC. May I make a suggestion that the TAG
20 works with the SEMAC TAG so we don't have duplication
21 of efforts here?

22 CHAIR BANK: So another way to do this
23 for right now, is to ask Cristy to withdraw her
24 motion because we're trying to -- the -- because we
25 can actually have this TAG group who would then

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2 report back to the registry about a much more focused
3 motion as to taking in the comments from all the
4 stakeholders.

5 MR. CLAYTON: Understand, understand.
6 I don't understand.

7 CHAIR BANK: So we have a motion here.
8 And -- but the motion, I -- I guess the motion is
9 just to create a TAG group. And do you want -- Dan,
10 do we need this? Would -- would then be made a
11 proposal to the D.O.H.?

12 MR. CLAYTON: Yeah. Dan Clayton from
13 the bureau. We can strike that if you wish, doctor.

14 CHAIR BANK: Cristy?

15 MR. CLAYTON: Whatever your wish.

16 CHAIR BANK: Cristy, your motion. So,
17 we can either just create the TAG group first. I
18 don't think we need a motion to create the TAG group,
19 but we -- we can -- we can have a motion to create
20 it. We -- we create TAG groups all the time without
21 a motion, but -- but we can have a motion to create
22 it.

23 MS. MEYER: So, I would suggest that
24 we create the TAG and that we, out of that TAG will
25 come hopefully a motion to -- to make a formal

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2 process and to improve this across the state.

3 CHAIR BANK: So we -- we don't need a
4 motion to create a TAG, but you -- you can still have
5 this if you want, but we can go forward with creating
6 TAG without a motion.

7 MS. MEYER: So I will withdraw the
8 motion and we will move forward with the TAG as
9 suggested by the registry committee.

10 CHAIR BANK: All right. And -- and
11 then just a show of hands, how many people would be
12 in favor of creating a Tactical Advisory Group to --
13 to report back to the STAC to help Cristy pull the --
14 and Kerrie and everybody else in the state report --
15 get the first P.C.R. for interfacility transfer
16 patients.

17 Everybody, yes? It doesn't have to be
18 a natural vote, but. No's? So there's no no's. So
19 -- we'll -- we'll go forward. Cristy, if you want to
20 retract your motion and then we can go forward with
21 creating a TAG group. And hopefully in May we'll
22 have results, the report of this TAG group.

23 MR. CLAYTON: I'm not going to --.

24 MS. MEYER: I so move to withdraw the
25 motion and we'll move forward with the TAG group.

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2 And I will work with members from the subcommittee to
3 form that group.

4 CHAIR BANK: Any other questions? Any
5 more of your report, Cristy?

6 MS. MEYER: Just look for a
7 subcommittee meeting scheduled in probably March to
8 follow up on some of these issues. And one last
9 thing that we've been waiting for, for many years is
10 mining some non-trauma center data in the state.

11 So there's been considerable progress
12 from Wendy Patterson and the DMAR team. And some --
13 another TAG to look at non-trauma centered data using
14 the Sparks data that's collected statewide. There
15 was a small report given on that, and there'll be
16 more information to come in May. So we can make some
17 progress on collecting that data. And that is the
18 conclusion of my report.

19 MR. BONFIGLIO: Yeah, I just want to
20 make a suggestion. I think there's another group
21 that faces this same challenge of getting scene
22 P.C.R.s and original P.C.R.s. and that's the stroke
23 and STEMI community. I was previously a stroke
24 coordinator and get what the guidelines absolutely
25 requires all of the pre-hospital information.

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2 It might be -- and I -- you may have
3 already done this, but trauma program managers get
4 with your stroke and STEMI coordinators, you all
5 likely have one if you're a trauma center to see how
6 they're getting that stuff from E.M.S. because that -
7 - that's all reported on a monthly or quarterly basis
8 back to E.M.S. on how they're doing, because the P.I.
9 process is really robust when it comes to first
10 medical contact, E.K.G., and -- and things of that
11 sort.

12 And it's not dissimilar to trauma. So
13 your hospital may already have an established
14 mechanism to get those scene P.C.R.s from E.M.S.

15 It's just a matter of -- of
16 replicating the model because I know that the stroke
17 and STEMI -- STEMI community is --is doing that in
18 your hospitals now.

19 CHAIR BANK: Tom, is there somebody
20 that you could use -- we could use as a -- a
21 communication point that we quickly could talk to?

22 MR. BONFIGLIO: I would -- sure. I
23 mean, I'd be happy to try and help. I mean -- and my
24 own personal experience that -- previously with the
25 University of Rochester, they've got a great system

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2 going and they report out to every single E.M.S.
3 agency on a quarterly basis their stroke and STEMI
4 numbers.

5 And so they're -- they're getting
6 looks at all of those E.M.S. P.C.R.s. So the -- I --
7 I don't know if Dr. Gestring would be able to, I -- I
8 don't know who the -- the team is currently for
9 stroke and STEMI at the -- I -- I know a few. But --
10 .

11 MR. GREENBERG: I think the other
12 thing is internal to the department. We have some --
13 opportunities as well as some staff members who might
14 have worked on stroke programs directly before coming
15 to our bureau who might have some knowledge space.

16 Thank you, George. You just got
17 voluntold to be part of this active TAG and advisory
18 group. So, we'll -- we'll work on our sources and
19 help you as well.

20 CHAIR BANK: Any other questions for
21 Cristy? And can I ask Dr. Vella if he can call
22 Cristy and tell us what great system University of
23 Rochester has for getting the P.C.R.s? Okay. So
24 we'll move to the next reports, the Trauma Center
25 Needs Assessment. Dr. Winchell was not here today,

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2 so it was run by Dr. Gestring.

3 MR. GESTRING: Hi, I am Mark Gestring
4 from Finger Lakes Trauma R TAG. I had the privilege
5 of running this committee meeting today, and we have
6 just a few things to report.

7 First, Long Island Community Hospital
8 transitioned from a level three trauma center to a
9 level two trauma center. Next, South Shore Hospital,
10 also on Long Island, transition from a level two
11 trauma center to a level one trauma center.

12 This prompted conversation, which then
13 led to the creation of a technical advisory group to
14 look at the process or how trauma centers can change
15 level. So I think a small group from -- from the
16 Needs Assessment Committee will work with systems
17 committee to try and see exactly what their process
18 should look like.

19 But both of those centers successfully
20 changed their designation, but I think this, the STAC
21 probably needs a better understanding of the process
22 for how that would work. So that -- that took up the
23 majority of the conversation.

24 The other thing that was discussed
25 during the needs assessment meeting was the status of

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2 the A.C.S. trauma system evaluation. Many of you'll
3 remember that that evaluation was approved by the
4 STAC, and there was interest in moving forward with
5 that process.

6 And at the same time that the STAC
7 approved it, the college changed the price and it
8 changed -- it changed significantly the financial
9 commitment to that process. So I think the question
10 coming back to the group was exactly how we're going
11 to meet what's going to happen in the future.

12 And I think Director Greenberg maybe
13 has some comments about that. But for the most part,
14 the meeting was well-attended, was productive, and we
15 have no action items from the meeting other than the
16 ones I just reported.

17 CHAIR BANK: Dr. Gestring, I heard
18 you're going to -- you're going to hold a bake sale
19 for that?

20 MR. GESTRING: Ten thousand-dollar
21 cookies.

22 CHAIR BANK: So -- so part of the
23 discussion subcommittee and at the executive
24 committee was just to kind of repo the STAC in a --
25 in a somewhat unofficial way of -- and -- and just to

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2 open the, the discussion of do we feel that a systems
3 consultation from the American College of Surgeons is
4 -- is -- is worth it?

5 I mean, we -- we previously had talked
6 about this, the answer is yes. Then the price
7 doubled. We are going to open some conversations
8 with the C.O.T. just to see why the price doubled.
9 Maybe use a fire sale for all I know. How we can get
10 this for cheaper.

11 But any discussion that people feel
12 that this would not be beneficial for the New York
13 State Trauma System?

14 MR. GESTRING: But just a question, so
15 the goal -- the stated goal of -- of that assessment
16 would be what?

17 CHAIR BANK: So the -- the A.C.S. has
18 a system that they come in and they do look at
19 states. They have, I'm being told, some people who
20 are very experienced in this. One of the things that
21 could be helpful with is to push the D.O.H. to give
22 us more resources in areas that the A.C.S. agreed
23 that we need more resources in this particular area.

24 And in fair analogous, I feel, to my
25 own verification visits. So before the A.C.S. came

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2 in, it was always a struggle to get some resources
3 from my hospital leadership. And then once the --
4 once the A.C.S. came in, they say, okay, you know,
5 you need this, you need that.

6 The records have to be completed in so
7 much time, and each registrar can only have so many
8 records. It really gave us a lot of leverage to get
9 some more resources from our administration. Any
10 other comments?

11 So this is just an unofficial poll.
12 There's no motion on the floor, but for everybody
13 just in the room who feels that a systems
14 consultation would still be desirable, if we could
15 get it done, just please raise your hand.

16 MR. EDWARDS: I have a -- Dr. Edwards
17 Northeast region. I have a -- your poll is asking at
18 the hundred and fifty thousand-dollar A.C.S. price.
19 Is that what we want to support for? Or just do we
20 want to have the state system looked at it?

21 CHAIR BANK: Right. It's not that
22 we're going to pay hundred and fifty thousand
23 dollars, it's just that we are searching for ways to
24 get this done. It may not be hundred and fifty
25 thousand dollars. We could ask the C.O.T., hey, why

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2 is it hundred and fifty thousand dollars? If they
3 came back to us and said it's ten thousand dollars,
4 would we then say, you know, that -- that -- that's
5 worth it?

6 But before we even went to them, we
7 wouldn't say, hey, is this -- is this worth it at
8 all? Or -- or if they give it to us for free, we
9 wouldn't even want it. So -- so it seems like we got
10 about half the room raised their hand.

11 So anybody who does not feel that --
12 irregardless of their price, if they give it to us
13 for free, do not think that it would be helpful,
14 please raise your hand. Irregardless is a new word.
15 But for you guys who don't know that, I'll use
16 regardless of the price, would it be helpful?

17 Okay. So I think that we still feel
18 that although the price is -- is as Dr. Edwards
19 pointed out, is a obstacle but if we could overcome
20 that obstacle, you know, it would -- it might be
21 helpful to the system. Okay. One other thing, I
22 apologize, I -- I missed from the executive report.

23 Just want to reminder break from STAC
24 that probably the -- one of the most important things
25 of -- of -- of being on STAC is just coming. So

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2 please, especially if you're a voting member on STAC
3 that you really need to -- to come every time we here
4 -- every time we're here we need to have a quorum.

5 If we don't have a quorum, we have to
6 cancel the meeting. And, you know, I personally put
7 this on my calendar and make sure that I'm not in
8 surgery or anything. And there's a bunch of surgeons
9 on this committee, a bunch of people who are very
10 busy, who create a lot of time to come here.

11 So please, everybody who's a voting
12 member of the STAC, who counts as a quorum, please,
13 I'm begging your attendance is -- is very, very
14 important. Any other questions for Dr. Gestring?
15 Okay.

16 MR. GESTRING: Dr. Bank?

17 CHAIR BANK: Sure.

18 MR. GESTRING: Just one additional
19 comment on just to dovetail off what Dr. Bank was
20 just mentioning. We just signed a contract for the
21 October meeting, and it's going to be October 30th,
22 which is a Thursday, and will be at the Saratoga
23 Holiday Inn.

24 Saratoga Holiday Inn on October 30th.
25 So that would mean that the A.T.S. -- I -- I don't

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2 want to speak for the A.T.S., but it would seem that
3 that would lead me to believe that the A.T.S. dinner
4 meeting would be the night prior. Saratoga Holiday
5 Inn. Thank you.

6 CHAIR BANK: Okay. Dr. Teperman just
7 showed me his iPhone that says that irregardless is a
8 word and it is used by people with very high
9 intelligence. So the next subcommittee will be
10 Injury Prevention Education, Mr. Kern.

11 MR. KERN: Good afternoon, Rob Kern,
12 Injury Prevention. Our committee has no action
13 items, proposal, suggestions, motions. We did
14 discuss various different items today, including
15 performance of National Injury Prevention Day, which
16 involved all every trauma center, Upstate, Downstate,
17 Long Island, every area performing various different
18 functions throughout.

19 We wanted to go over A.T.S. has
20 awarded several initiatives, grants for further
21 advancement injury prevention. Six were fully
22 funded, and four were partially funded. So we
23 discussed that a little bit further.

24 And on one note my co-chair, Salonia
25 Salowitz (phonetic spelling) has been granted a big

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2 promotion at Nassau University Medical Center. And I
3 want to thank him for his dedication, enthusiasm, and
4 time. He'll no longer be able to serve as a co-
5 chair.

6 I do wish him well and want to open up
7 that process for people who are interested in either
8 coming on as co-chair, et cetera, of this committee.
9 Thank you.

10 CHAIR BANK: Any questions for the
11 Injury Prevention Education subcommittee? One -- so
12 we're just going to go to the regional P.I.
13 committee. It actually has my name, but it is
14 actually chaired by Dr. Vella.

15 MR. VELLA: Thanks. Michael Vella, V-
16 E-L-L-A, chair of the P.I. subcommittee. We don't
17 have any motions to approve. We did have a good
18 discussion on a couple of topics. The first one was
19 Whole blood.

20 I want to thank the department as well
21 as the participants in the whole blood survey. We
22 got forty-four responses regarding the use of whole
23 blood across the state of those forty-four centers,
24 six, so what is that? Fourteen percent of centers
25 are using Whole blood.

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2 The -- of the remaining thirty-eight
3 centers not currently using Whole blood, thirty-five
4 or ninety-two percent of those centers expressed an
5 interest in the future of -- of using Whole blood.
6 And so, the action item from that is to put together
7 a sort of a working group among the six centers,
8 using Whole blood to create a repository of protocols
9 and to assist centers who are interested in starting
10 whole blood programs. We then reviewed the most
11 recent fall 2024 TQIP report that --

12 MR. TEPERMAN: Dr. Villa, apologies
13 for interrupting, but just some -- something on the
14 whole blood. Is that all right?

15 MR. VELLA: Yeah, of course.

16 MR. TEPERMAN: I -- I think there was
17 a -- a good conversation that I'd like to have
18 entered into the record a back and forth about the
19 importance of whole blood because I -- I am concerned
20 that it's a fad. And I shared with you and I think,
21 you know, you have a -- a -- a robust understanding
22 of the -- better understanding even than I of the
23 literature.

24 But if I can actually accurately frame
25 the conversation, I have this concern that the

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2 largest series of whole blood M.T.P.s are two and
3 four units of blood. And I have difficulty
4 understanding why the outcomes are better in those
5 patients if you have a thirty-unit M.T.P. and you
6 just use four units of blood.

7 So my -- and -- and you --
8 appropriately, you didn't counter, but you, you said,
9 I think that's a true statement of the literature,
10 but it -- there is this odd benefit to using those
11 small number of units. So I -- I'm just cautioning,
12 and I wanted this in the record, that I think whole
13 blood is a -- is a fad.

14 It is not the same as the walking
15 blood banks that our military uses. I -- I work with
16 the Seals. They do something called Solo, which is
17 Seals old low-titer blood, a -- a war fighter drops
18 and needs a transfusion and they -- they -- they grab
19 the war fighter next to him that's been identified
20 ahead of time, that has been tested for retrovirus
21 and has low-titers and gets a -- a warm transfusion.

22 This is -- the civilian practice is a
23 different form of blood. And some of the original
24 folks that were pushing whole blood forward are not
25 as enthusiastic as they once were because it's not

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2 the same product.

3 So I -- I'm just putting into the
4 record a caution that I believe it's a fad. It's
5 appropriate, I think, and we talked this morning with
6 Dr. Dailey, it's very appropriate on -- in -- in the
7 E.M.S. front, because they don't -- they don't have
8 large capacity.

9 They don't -- they can't carry
10 platelets in F.F.P. and all that. it makes a lot of
11 sense to me in whole blood. But in a trauma center,
12 especially in M.T.P. circumstance I caution folks
13 that I think it's a fad.

14 MR. VELLA: All right, thank you for
15 those comments. I think it -- Dr. Edwards?

16 MR. EDWARDS: Yeah, I -- I was just
17 going to comment on the -- I think that there is a
18 problem in discernment in talking about the
19 literature. Whole blood, as an entity for the first
20 unit versus whole blood and a massive transfusion
21 program.

22 I think that Dr. Holcomb's done some
23 fine work on trying to say, what is the first product
24 that should go in in a trauma bay? And I know that
25 you've supported saying E.M.S. because of the ease,

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2 but I -- I think you're going to cloud the issue by
3 talking about an M.T.P. and using whole blood as the
4 sole source as opposed to walking blood bank, which
5 I'm very familiar with.

6 So I do caution, I am a huge advocate
7 for whole blood because it eliminates the requirement
8 it -- should platelets go in first or F.F.P. go in
9 first, or how much should I do? I think that whole
10 blood is something that the literature has to be
11 separated between whole blood M.T.P.

12 And Whole blood is the first unit
13 because such a small percentage of our trauma
14 patients get M.T.P.s, but a significant amount of
15 patients get that first blood with brain bleeds and
16 it provides all the coagulation factors.

17 I think there's a definite benefit to
18 whole blood. So don't -- I -- I would caution
19 discernment to say, are we talking about whole blood
20 as an M.T.P. doing 2015 units? We're talking about M
21 -- talking about whole blood as benefit for the first
22 unit going in. Thank you. This is Dr. Edwards
23 Northeast TAG.

24 MR. VELLA: Great. Thank you for
25 those comments. I -- and I think it's also important

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2 to understand that we're certainly not advocating
3 mandating the use of whole blood. And again, this
4 would just be for centers that have done their own
5 analyses, determine that it's appropriate, you know,
6 we would provide that support.

7 We then reviewed the TQIP data from
8 the fall 2024 TQIP report. I don't have anything
9 unremarkable to report from that. Overall, so it was
10 a good report. We weren't sort of outliers in a
11 negative way for anything in the most recent report.
12 There's some nuances that we -- we sort of discussed.

13 And then we did review -- I think it
14 was Director Greenberg or Dr. Bank who brought up the
15 deficiency criteria. At the beginning we did briefly
16 review those.

17 And then I put out a call for
18 individuals for the next STAC meeting centers that
19 have done well in those four domains, if they'll be
20 willing to reach out to me and put together a
21 presentation that they could present at the next STAC
22 meeting about how they're dealing with those issues
23 if they've done well.

24 And then the idea was brought up, and
25 I think it's a great one, and this is something we

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2 can look at later on down the line in sort of a
3 coaching format, that if there are centers that are
4 struggling with a particular domain, they could pair
5 up buddy up with sort of a coach or another center
6 that has done well in that domain to help them and --
7 and partner with them. That's all I have.

8 CHAIR BANK: Any questions for Dr.
9 Villa? Okay. And then in one of his last reports to
10 us, Dr. Simon from Assistance Committee.

11 MR. SIMON: All right. Dan, can you
12 put up the -- yes. Can we have the screen put up,
13 please?

14 CHAIR BANK: Okay. And --.

15 MR. SIMON: Thank you. Okay. While
16 that's coming up, we talked about the four zero five
17 regs, but that's already been discussed, so I'm not
18 going to waste time. We talked about Sparks data and
19 that was also brought up. So I'm going to leave that
20 alone.

21 The de-designation process, I think
22 we've also mentioned, and that's also still in
23 process. So the issues that we discussed that were
24 brought up for motions are one that the STACs -- the
25 STACs Systems Committee moves to accept the revised

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2 bylaws from the Central New York R TAG, which were
3 presented in October and were sent to everybody for
4 comment.

5 CHAIR BANK: So Ron, you want to do
6 this one at a time?

7 MR. SIMON: I think you going to -- we
8 have to vote on them, right? So -- yeah, they're two
9 separate motions though. Yeah. Okay.

10 CHAIR BANK: So the first motion is
11 from the system subcommittee. The STAC system
12 subcommittee moves to accept to revise bylaws from
13 the central. So I guess our motion would be the STAC
14 accepts the revised bylaws from the Central New York
15 R TAG. That would be the motion.

16 MR. SIMON: Correct.

17 CHAIR BANK: So I -- I'm going to
18 second that motion. any discussion for the motion?
19 Okay. So everybody on the voting member STAC,
20 everybody who agrees for the STAC to accept the
21 revised bylaws for the central committee.

22 MR. CLAYTON: There we go. Dan
23 Clayton from the Bureau. This is a statutory vote.
24 It is actually in Article 30 of Public Health Law
25 that the STAC does have the statutory responsibility

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2 of approving R TAG bylaws.

3 So given that -- that it's a statutory
4 vote, it needs to be by roll call. Thank you, Dr.
5 Chair.

6 CHAIR BANK: Okay. Any other
7 questions? So Dan, you want to do the roll call
8 vote?

9 MR. CLAYTON: Dr. Bank?

10 CHAIR BANK: Yes.

11 MR. CLAYTON: Dr. Wallenstein?

12 MS. WALLENSTEIN: Yes.

13 MR. CLAYTON: Dr. Guzman-Curtis?

14 MS. GUZMAN-CURTIS: Yes.

15 MR. CLAYTON: Dr. Gestring? Mr.

16 Manzo?

17 MR. MANZO: Yes.

18 MR. CLAYTON: Dr. Prabhakaran? For
19 the record, that was a yes from Dr. Prabhakaran. Ms.
20 Maguire?

21 MS. MAGUIRE: Yes.

22 MR. CLAYTON: Dr. Angus?

23 MR. ANGUS: Yes.

24 MR. CLAYTON: Matt Conn?

25 MR. CONN: Yes.

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2 MR. CLAYTON: Dr. Teperman?

3 MR. TEPERMAN: Yes.

4 MR. CLAYTON: Ms. Snyder?

5 MS. SNYDER: Yes.

6 MR. CLAYTON: Dr. Edwards?

7 MR. EDWARDS: Yes.

8 MR. CLAYTON: Dr. Arillaya?

9 MR. ARILLAYA: Aye.

10 MR. CLAYTON: Ms. Mullen?

11 MS. MULLEN: Yes.

12 MR. CLAYTON: Dr. Dailey?

13 MR. DAILEY: Yes.

14 MR. CLAYTON: Dr. Doynow?

15 MR. DOYNOW: Yes.

16 MR. CLAYTON: Dr. Cooper?

17 MR. COOPER: Yes.

18 MR. CLAYTON: Passes unanimously.

19 CHAIR BANK: Okay. Thank you. Ron,

20 you want to go to your next motion?

21 MR. SIMON: Okay. So the -- okay, Ron

22 Simon again. So the second motion was that we

23 approved that there be a poll sent out to all trauma

24 centers to evaluate the availability of replantation

25 services throughout the state.

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2 And this was an issue that was brought
3 up by one of the centers who said that they -- in
4 their region, that they were having problems with re-
5 plantation and the state of re-plantation services in
6 -- in the state of New York is not really understood
7 or known.

8 And we thought before we really get
9 into a discussion about it, that we should do a poll
10 to see if and where it's a problem within the state.
11 And the poll the -- what we agreed to at least
12 initially are -- the answers are is get -- the
13 questions are, is getting replant services a problem
14 in your institution?

15 What level trauma center are you? Are
16 you a pediatric trauma center? And if yes, do you do
17 replants? Are you a replant center? Are you a
18 certified replant center? Because as many of us
19 learned today, there are replant -- people who do
20 replants and there are centers that are certified to
21 do them.

22 Are -- are replant services available
23 twenty-four hours a day, seven days a week at your
24 service, at your institution? And do you accept air
25 transportation? And we would just -- leaving that

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2 open in case, our thoughts were that we would put
3 this together in a -- a paper when this is all said
4 and done about the state of replantation care in New
5 York state or state of trauma care.

6 And so we want to make sure that we
7 get all of the questions that we might need for our
8 research publication in on first pass.

9 CHAIR BANK: Discussions. Dr.
10 Goldman?

11 MR. GOLDMAN: Hi, Dr. Ari Goldman,
12 orthopedic member. I -- I agree with those
13 questions. I think that we should also add how many
14 hand surgeons do you have on your call panel taking
15 replant call, and also are they willing to accept
16 out-of-region transfers? I think those are important
17 questions that we need to know the answers to as
18 well.

19 CHAIR BANK: So -- so to Dr. Goldman's
20 point, after -- Ron, after this assistance meeting
21 Jordan Kersch and Rachel Kaifa had approached me
22 saying they were very interested in working on this,
23 and they had asked for just a little time to review
24 the literature and maybe really come up with a set of
25 -- of questions to make sure that we cover everything

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2 before we send it out.

3 So -- so maybe I'm just asking is it
4 possible to just work with them and I don't think we
5 need to, and Dan, correct me if I'm wrong, do we need
6 to actually approve this motion to send out this poll
7 if later on we came up with some more questions?

8 MR. CLAYTON: Well, I would suggest,
9 since it's already in the form of a motion, that we
10 move forward with it, but it is not a statutory vote,
11 so we don't have to do a roll call, just be a raise
12 of hands.

13 CHAIR BANK: Yeah. So if we -- yeah,
14 so if so with the provision that we could still edit
15 this afterwards and add some more -- more questions
16 if Rachel Jordan come up with some interesting stuff.
17 With that provision we can -- so motion has been made
18 on the floor. It's -- it's on the screen. Do we
19 have anyone to second it?

20 MS. SNYDER: Second. Kerrie Snyder
21 seconds.

22 CHAIR BANK: Kerrie Snyder seconds.
23 So can we just have a show of hands of everybody
24 who's in favor of the motion with -- sorry, Ron?

25 MR. SIMON: Ron Simon again. I --

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2 would it be fair to say we'll give them thirty days
3 to put -- put together any additional questions, and
4 that will give us an additional sixty days to get it
5 ready for the next meeting so that this can be
6 presented to the next STAC?

7 CHAIR BANK: Okay. So the motion is
8 on the screen. Any other questions, discussions
9 about the thirty days?

10 MR. TEPERMAN: Agree with the thirty
11 days, Teperman.

12 CHAIR BANK: Huh-uh? We're just
13 having some internal discussions about whether this
14 is enough time to get on the May STAC agenda.

15 MR. GREENBERG: Just out of curiosity,
16 and I know it came up in conversation before that
17 there are some non-trauma centers that might provide
18 some of these services. I -- I don't know for that
19 to be a fact or not, but it's -- is this intended
20 just to go to trauma centers or is this intended for
21 --

22 CHAIR BANK: So --

23 MR. GREENBERG: -- non-trauma centers?

24 CHAIR BANK: -- so you -- thank you
25 for reminding me. It would be to all trauma centers

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2 and regional R TAGs. The reason why it sent to the R
3 TAGs, the R -- R TAGs, I'm hoping have regional
4 knowledge of where the replant centers are, and they
5 could clue us in on replant centers that are not
6 necessarily trauma centers.

7 So it would go to all trauma centers
8 and the R TAG. The R TAG questions would be a little
9 different. The R TAG questions would be, can you
10 tell us what the replant centers are in your area?

11 MR. SIMON: Just adding, I -- I, you
12 know, second Dr. Simon's idea that we should get this
13 ready for the May meeting. And the centers --
14 apparently the centers that are not trauma centers
15 are in my R TAG. And I will see to it that we get
16 responses from them.

17 MR. GREENBERG: So the only other
18 thing I would keep in mind on this one is if you are
19 looking to get in for the next meeting, which would
20 be the May meeting. The May meeting is the last week
21 in May, which means by the last week in April, is
22 when we would need this material for, in order to get
23 through, you know, kind of our processes and putting
24 it into the formats that need to happen. So just in
25 -- in backing up into that --.

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2 MR. SIMON: Just to understand, and
3 I'm sorry, I didn't mean to interrupt.

4 MR. GREENBERG: No, I meant to.

5 MR. SIMON: Just to understand, as I'm
6 assuming the -- the role, you -- the rules are
7 slides. Any slides that are presented, you need the
8 month, right? If we're just presenting the results
9 of a survey without slides, do you still, that can be
10 done, right?

11 MR. GREENBERG: If you're just
12 reporting on numbers, then yeah, it's a different
13 situation. But I think also, even if we were to come
14 up with something that was a one pager, you know,
15 that was very simple, but people can have and take
16 with them and not just be a discussion point?

17 MR. SIMON: Right.

18 MR. GREENBERG: Then that could be
19 helpful. And so again, I think if -- if the goal is,
20 if we can try and have it done by the last week in
21 April, I think that would help in giving you that
22 option of whether or not to present something, even
23 if it's a single flyer or something else.

24 MR. SIMON: Yeah. So follow-up
25 question would be, can you hand out pieces of paper

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2 without that one month pre-look?

3 MR. GREENBERG: I think everything is
4 preferred to go through the appropriate processes.

5 MR. SIMON: Okay. Understood.

6 CHAIR BANK: Okay. So, we have the
7 motion that the system subcommittee that the STAC
8 approves the poll to be sent out to all trauma
9 centers and R TAGs to evaluate the availability of
10 replantation services throughout the state.

11 Questions include, we could all read
12 this, but is getting replant services a problem in
13 your institution? What level of trauma center are
14 you? Are you a pediatric trauma center? If yes, do
15 you do replantation? Are you a replant center?

16 Are you a certified replant center?
17 Are replant services available at your institution
18 twenty-four seven? Do you accept air transport? Are
19 you willing to accept out-of-region transfers? How
20 many hand surgeons do you have?

21 And any -- so we are going to just
22 prove this motion with the caveat that we may just
23 alter these questions after thirty days of looking at
24 the literature and make sure that all the questions
25 we have, we want answered. And there'll be slightly

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2 different questions.

3 The R TAGs, the R TAGs will just be
4 asked what are the replant services available in your
5 region?

6 MR. SIMON: And Matt, I believe Dan
7 offered the services of -- of the Bureau to help put
8 this together and --.

9 CHAIR BANK: Right, absolutely.

10 MR. CLAYTON: If you come up with the
11 questions, we will put together a Drupal survey for
12 you, collect the information and then provide you
13 that summary of the information that was collected.

14 CHAIR BANK: So any further discussion
15 on this motion?

16 MR. WAKEMAN: Derek Wakeman,
17 Rochester, are you limiting replant to like digits?
18 There are other things that are replanted.

19 CHAIR BANK: I -- I would go with the
20 broad definition of just are you a replant center? I
21 don't know if you -- if you know, Ari or anybody
22 wants to comment on -- on the different types of
23 replant centers.

24 MR. GREENBERG: So I -- I'll comment
25 on this one and say in this particular case, I think

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2 it might be better to stay broad. Particularly from
3 some of the conversations that we had earlier today
4 and some of the resources including the surge
5 operation center out of -- which operates as, you
6 know, being able to help connect people.

7 The more information we have, the more
8 information we can help in connecting different
9 institutions when they're looking to try and place a
10 particular patient or get them to the correct place.
11 So I -- I would go broad and see how it turns out.
12 And Jacob has already signaled to me that he's
13 excited to create the survey for you in whatever way
14 you want.

15 MR. GOLDMAN: My comment is really
16 just in -- it's in regards to the question about hand
17 surgeons that really -- that's in -- that's specific
18 to a digit. You know, along that same line, you may
19 ask about urologists or plastic surgeons, you know,
20 people's lips get bitten off and they are -- are
21 replanted. Anyway, just -- just general question.

22 MS. GUZMAN-CURTIS: Yeah, I think
23 that's a great point. The standard mentions,
24 examples being ears, scalp, penis. So, I think we
25 should be broader. I agree. Oh, sorry. Rosanna

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2 Guzman, Central R TAG.

3 MR. TEPERMAN: Teperman. The --
4 generally speaking, and Doctor, I think it's Dr.
5 Goldman over there, can correct, has a lot knowledge
6 on that. Generally speaking, these are microvascular
7 surgeons which fall -- who fall in the domain of
8 plastics often and occasionally orthopedics, but
9 often plastic surgeons.

10 And it's those people that put the --
11 pretty much everything back. So, I -- I do think
12 it's microvascular surgeons, right? So how many
13 microvascular certified surgeons do you want to have
14 on staff that participate in your replant center
15 would be the way to ask the question, I think.
16 Right? Does that -- does that help or hurt Dr.
17 Goldman?

18 MR. GOLDMAN: Ari Goldman. I agree
19 with that statement.

20 MS. GUZMAN-CURTIS: In our center,
21 E.N.T. does a lot of the facial stuff. I'm not sure
22 if they're truly certified as microvascular surgeons
23 though. So I -- I wonder if we should just ask it in
24 a way that we are commenting on any surgeons that
25 participate in replantation services.

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2 MR. DAILEY: I would respectfully --
3 sorry, Mike Dailey. I would respectfully ask if we
4 would not ask question H, as that demonstrates
5 volitional violation of MTAL.

6 MR. GOLDMAN: I -- respectfully, I
7 know Doctor Bank added that -- no. Doctor Bank
8 didn't add that. He raised -- he raised the
9 question, you know. I -- I think it's important
10 information and I think it's an interpretation of
11 EMTALA and I -- I think we need to know the answer to
12 that, right?

13 So I'm just thinking about my system
14 and trying to help, all right, because we're trying
15 to help here. So I'm thinking about volunteering
16 Bellevue. Of course, I got to ask my C.E.O.,
17 Bellevue C.E.O. and the -- and the replant surgeons
18 there.

19 And I think it just will be helpful to
20 understand -- if we're going to try to help each
21 other, if the centers will -- will agree for it.
22 There -- there's just no requirement. There's just
23 no -- no EMTALA requirement.

24 The doc -- it says, I have to take a
25 patient from California. It's an over reading, I

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2 think, respectfully, of EMTALA and I think we need to
3 know the answer here. I could be wrong. I just
4 think it's an over reading of it.

5 MR. VELLA: Is -- is a better way to
6 ask this -- Mike -- Mike Vella. Is it better way to
7 ask that, are they willing to go into the transfer
8 agreement? That was the issue that we had at our
9 center is we -- is we, you know, we're as robust as
10 they come and meet -- meaning, like, we do like two
11 of these years.

12 So, meaning, like, we have a replant
13 center, but it's not very active because we just
14 don't see these a ton.

15 MR. GOLDMAN: Right.

16 MR. VELLA: So I think the heavy part
17 to sell, but, you know, so I'm thinking about the new
18 leadership at Bellevue. And that puts them in a --
19 creating a transfer agreement specifically puts them
20 in a very difficult position.

21 So -- I would advise them not to
22 create a, you know, I -- I would advise them to do
23 this on a case-by-case basis.

24 MR. GOLDMAN: Yup.

25 MR. VELLA: For example, Albany calls

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2 us up and there's no one between Albany and Bellevue
3 that's willing to do this and there's no one Upstate.
4 And we're trying to help and we're trying to lean
5 into it. And we're going to look at it on a -- on a
6 case-by-case basis based upon whatever parameters it
7 is that allows us to accept the patient. I would
8 give us leeway to do that.

9 MR. GOLDMAN: I mean, I definitely
10 agree with that in theory, but don't you need a
11 transfer agreement for the purposes of the site visit
12 to say that this is where we send this pay? I may be
13 misinterpreting that but.

14 CHAIR BANK: So --

15 MS. SNYDER: Can --

16 CHAIR BANK: -- so, for right now, you
17 know --.

18 MS. SNYDER: -- can I just make one
19 comment to that? We don't need this for the purpose
20 of A.C.S. verification. Sorry, Kerrie Snyder,
21 Northeast. We need this to care for our patients --

22 MR. GOLDMAN: There you go.

23 MS. SNYDER: -- first. Because our
24 logistics spender -- center can spend hours and hours
25 trying to track down a center that is willing to take

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2 care of a patient in need, right? Doctor Edwards
3 said it this morning, we are leaving these fingers on
4 the table because we run out of time because we can't
5 get anybody to accept our patients.

6 Do we need it for A.C.S. verification?
7 Yes. That's secondary. Our primary goal is to have
8 a process where we can pick up a phone and say hey,
9 we have, you know, a -- we have a forty-year-old, you
10 know, construction worker who supports a family of
11 five, who just cut off three fingers with a saw and
12 needs a -- needs to have these fingers replanted.
13 Can some -- can you help us?

14 We need somebody to be able to say yes
15 to without spending four hours making phone calls.

16 MR. GOLDMAN: Yeah, I think having the
17 transfer agreements facilitates that. I mean, you
18 can't -- I don't know if you can do it on a case-by-
19 case basis. I think there needs to be a system in
20 place to allow it to happen smoothly, because if you
21 talk to our surgeons about it, the main factor is
22 time, right, as you alluded to me. By the time they
23 get here, in some cases, it's too late.

24 CHAIR GREENBERG: I -- I just -- so I
25 think in -- excuse -- just for the one question. I

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2 think related to this question, I think there's an
3 opportunity here for a thirty-day period where we can
4 work with you on some of the questions and I think if
5 there's a question about the best wording on that
6 particular one.

7 I understands the need to know what
8 the answer is and I also understand the sensitivity
9 of the way that it may be currently phrased. And we
10 would be happy to work with D.L.A., our legal team,
11 to phrase it in such a manner that gets the answer
12 while at the same time meets compliance and
13 regulation.

14 CHAIR BANK: That's perfect. Thank
15 you to Mr. Director. So we've read out the motion
16 and as a corollary to the motions that we are going
17 to work on this. Again, we have two STAC members
18 that have agreed to -- to work this and work with the
19 D.O.H.

20 So, all in favor of sending out this
21 poll once we wordsmith the questions a little bit
22 more, please raise your hand. Okay. So seventeen,
23 four. Anyone against? No -- no one against, so the
24 motion passes.

25 MR. VELLA: Question. Mr. -- Dr.

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2 Chair. This process is going to happen under the
3 auspices of the system subcommittee with help from
4 you and the D.O.H. Is that my understanding?

5 CHAIR BANK: So I'm hoping that this
6 data will flow back to the system subcommittee and
7 then be reported at the main STAC in May.

8 MR. VELLA: Right. So -- okay.
9 Great. Thank you.

10 CHAIR BANK: Dr. Simon, any other
11 report from your committee?

12 MR. SIMON: No, I -- I complete the
13 systems committee report and my stint on the systems
14 committee.

15 MR. VELLA: Very well.

16 MR. SIMON: Thank you.

17 CHAIR BANK: Okay. So we'll move to
18 Dr. Wallenstein about the pediatric calling
19 committee.

20 MS. WALLENSTEIN: Thank you. Kim
21 Wallenstein from the pediatrics subcommittee. So we
22 talked about a few things from old business. We
23 talked about our ideas for statewide imaging
24 projects. A poll was sent out about whether or not
25 people had imaging guidelines in place and there is a

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2 wide variety of -- of that currently in place with
3 ours -- with our trauma programs.

4 We are moving forward to make this
5 into, sort of, a project and the first step will be
6 to identify the existing guidelines, create
7 guidelines, if necessary, and then track compliance.
8 And we talked about the steps of our -- our project
9 being to, sort of, review what we have and provide
10 education and then incorporate it in the P.I.
11 process.

12 And our goal for the next meeting will
13 be to start assessing our own guidelines and discuss
14 our challenges. We talked about two main things for
15 new business, one of which will become a motion
16 probably for the next STAC meeting.

17 And that was brought forward as a
18 proposal to require stop the bleed kits and teaching
19 in our schools, in the state. And we had talked
20 about, sort of, asking for staff support, for
21 legislative support to include these kids and also
22 education.

23 We talked a little bit about who's
24 going to be educated. I think we sort of settled, at
25 least, at first on teachers as teaching the children

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2 or nurses might be a little bit more challenging. We
3 talked about the fact that several states do also
4 have this legislation in place and have had good
5 compliance with that.

6 So we are working on getting a motion
7 together for that and we'll hopefully have that for
8 the next meeting. Any comments or issues on that?

9 CHAIR BANK: Any questions for Dr.
10 Wallenstein? Is that the end of your report?

11 MS. WALLENSTEIN: One more.

12 CHAIR BANK: Okay.

13 MS. WALLENSTEIN: So, the -- the only
14 other thing we talked about was another issue that
15 was brought forth about tourniquets. I don't know
16 about all of your centers, but I'm pretty sure that
17 everybody has had experiences that are not stellar
18 with tourniquets being applied and then left in place
19 for a prolonged period of time causing potentially
20 harm to patients.

21 And so, there was the discussion about
22 having need for E.M.S. guidance for tourniquets and
23 tourniquet conversion. We're going to be working on
24 that potentially involving SEMAC in that discussion.
25 And that is the end.

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2 CHAIR BANK: Any question for Dr.
3 Wallenstein? Okay. Thank you. We're going to go to
4 the New York Chapter A.T.S. I think Kerrie is not
5 here, so it's going to be Kate McGuire, who's going
6 to give the report?

7 MS. MAGUIRE: Yes. Thank you. Just
8 quick updates for the A.T.S. for our dinner last
9 night, some robust attendance and really wonderful
10 discussions regarding new legislation for organ
11 donation and an increase in donors in New York State.
12 So really great to hear that.

13 The eleventh edition of A.T.L.S. will
14 be coming out in the next couple of months. So look
15 out for that as well as some rural trauma across the
16 New York State and Tri State region. So more
17 education regarding rural trauma and access to care.

18 We also had our distinction awards,
19 where we were able to really look at seven key
20 individuals in New York State and really highlight
21 their work in 2024. We were able to provide about
22 twenty thousand dollars in grants for many injury
23 prevention efforts across New York State.

24 Mostly, we looked at injury
25 prevention, but there were some education initiatives

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2 that we were able to also support. At the end, we
3 were able to really honor Dr. Simon and his legacy of
4 excellence. So really a -- a great legacy that he
5 served for us.

6 And then the only thing that we did
7 also vote on towards the end was a poll that had went
8 out the last A.T.S. regarding salaries for different
9 levels of trauma professionals. And we have decided
10 to continue that poll. So, we only had sixty-eight
11 responses.

12 So, we just really encourage those to
13 really respond so that we can have a more robust
14 response and understanding of salary needs across
15 trauma professionals. So, thank you.

16 CHAIR BANK: Any questions for Ms.
17 McGuire? Okay. And moving right along SEMAC, Dr.
18 Doynow.

19 MR. DOYNOW: Our report will be quick
20 as it's getting late in the afternoon. We are
21 working on ground-based blood transfusion protocol.
22 Let Dr. Dailey talk more about that. We've had a
23 number of new members join SEMAC, including a
24 psychiatrist. We're still waiting for D.O.H. to vet
25 a surgeon to us.

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2 Next SEMAC meeting is February 27th
3 and just mentioned this on a Thursday, not on a
4 Wednesday, if everybody would like to join. And Dr.
5 Dailey, would you like to comment on the ground-based
6 blood transfusion protocols?

7 MR. DAILEY: I think the most
8 important thing we have right now happening for
9 ground-based transfusions, quite frankly, is the
10 development of regulations. There have been a group
11 of stakeholders who've been working extremely
12 successfully with the department at developing those
13 regulations.

14 We look forward to those ultimately
15 being promulgated and them being extremely helpful.
16 The one thing we discussed here this morning was the
17 idea that regional input is going to be important as
18 we make sure that we are appropriately using this
19 precious resource, and that we have good oversight
20 over the process.

21 And the other thing that Dr. Teperman
22 had asked was to make sure that indeed as part of the
23 trauma process, the trauma centers were getting early
24 notification on any patient that was receiving blood.
25 That certainly is something we will make sure as --

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2 as any of these.

3 The other thing that I would note is
4 that the protocol to actually administer blood for
5 patients that are in hemorrhagic shock from trauma is
6 already in place and has already been approved by the
7 commissioner. That's been in place for two years.

8 We're just in the process of now
9 waiting for the regulation and then the -- the
10 systems themselves to develop beyond that. So, thank
11 you.

12 CHAIR BANK: Dr. Doynow, can I just
13 ask you maybe just two or three sentences for the
14 surgeon who'll be the liaison to SEMAC? What would
15 be the responsibilities? How often do you meet?
16 What would you expect from them?

17 MR. DOYNOW: Well, it would be four
18 times a year rather than three times a year that --
19 that we folks meet. Essentially, it would be part of
20 the -- the quorum for SEMAC to give SEMAC advice from
21 a surgical standpoint. That would be basically it.

22 CHAIR BANK: It's just four times a
23 year in the Albany area in person?

24 MR. DOYNOW: Yes, it's in the Albany
25 area. The venue has changed from time to time, it's

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2 usually here. Ryan may want to comment on where the
3 next few are going to be.

4 CHAIR GREENBERG: Albany region. So
5 Saratoga or Albany. It tends to move just based on
6 availability.

7 CHAIR BANK: So if any surgeons wanted
8 to volunteer, they would speak with you?

9 MR. DOYNOW: They can speak with me or
10 actually with Ryan.

11 CHAIR BANK: Okay.

12 MR. DOYNOW: I think Ryan has a list
13 of some folks who are interested.

14 CHAIR BANK: Okay. Thank you.
15 Lastly, Dr. Cooper, E.M.S.C.

16 MR. COOPER: Dr. Cooper. Thank you,
17 Mr. Chair. E.M.S.C. has four things to report today.
18 First, briefly, since the STAC last met, Dr. Elise
19 Vanderjagt, our vice chair, was selected to receive
20 the Robert K. Kantor award for incredible service to
21 the children of New York State.

22 And that -- that award was made at the
23 Vital Signs Conference in Rochester, where he hails
24 from. So, that all those here who know Dr.
25 Vanderjagt understand the depth and breadth of his

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2 contributions to E.M.S.C. over the years and will
3 currently support that -- that award.

4 Second, the -- the pediatric agitation
5 work group continues to develop educational products
6 for pre-hospital providers. And anybody else who's
7 interested, you know, videos have already been
8 produced and we hope to see this project finishing up
9 sometime by the middle of this year.

10 Third, there's a procedural sedation
11 work group which has been focusing on procedural
12 sedation and making sure that there's appropriate
13 guidance out there for folks who rarely, if ever,
14 sedate children so that, you know, it can be done
15 safely.

16 You know, there -- the focus so far
17 has been mostly on procedures that commonly require
18 sedation, even as simple as I.V. insertion and of
19 course, you know, splinting of fractures and so on.
20 But that's a work group in progress.

21 And then finally, there is another
22 work group who's focusing on review of the pediatric
23 emergency and critical care guidance that was
24 published more than ten years ago now and needs an
25 update based upon the latest and greatest

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2 information. And that's -- those are the major
3 points about -- about E.M.S.C.

4 Amy Eisenhower, our program manager,
5 does regularly let -- let us all know how we're doing
6 with Always Ready for Children. Progress continues
7 in that front or almost on a weekly basis by -- by
8 getting more and more sites vetted and -- and up and
9 running in the Always Read -- Ready for Children
10 program, for which we're all extremely grateful.

11 And that concludes my brief report and
12 I'll be happy to answer any questions that any of you
13 might have.

14 CHAIR BANK: Any questions for
15 E.M.S.C. for Dr. Cooper? Okay. So move along old
16 business. I think I discussed most of the follow-up
17 from the last STAC at the beginning of the executive
18 committee report. Any other comments for old
19 business?

20 Okay. Anyone want to bring any new
21 business --

22 MR. TEPERMAN: Yes --

23 CHAIR BANK: -- on the STAC?

24 MR. TEPERMAN: -- Dr. Chair. So, I'm
25 -- I'm going to bring a motion and I'll -- I'll read

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2 the motion and then frame it. The motion will be
3 that the STAC suggest to the department that Director
4 Ryan call the Chair of the V.R.C.C.O.T. and discuss
5 with them the concerning fifty-six percent non-
6 success rate of gray book reviews.

7 So, to frame it, we started the
8 conversations about this and as of the TQIP
9 announcement of these pretty alarming statistics. So
10 at eight percent failure to verify and then the rest,
11 a focused review. So a lot of the -- the back and
12 forth, there has been with both leadership here and
13 elsewhere, has been, you know, just to paraphrase,
14 what -- what is the big deal about a focused review?

15 And if you are a program manager or a
16 trauma medical director who -- who is concerned about
17 the well-being of the trauma center, the focus of the
18 program office and their morale and mental health, a
19 focused review is not just a big deal. It's a huge
20 deal.

21 And yes, a complete failure of a
22 review is a slightly bigger deal. But nobody wants
23 to go in front of their C.E.O. or in front of the
24 community or the community of doctors at the hospital
25 and say they're -- they've been placed on probation.

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2 And it is probation, right?

3 The standard verification review is
4 three years. Anything less than that is a non-
5 success. I've been speaking to the creators of the
6 orange book and in no way when they wrote the orange
7 book, did they contemplate a fifty-six percent non-
8 success rate with the C.D.s in their book. Something
9 like ten or fifteen percent, perhaps.

10 The college is getting this wrong.
11 They're making a mistake. They never got up in the
12 morning, wrote the grade book and thought fifty-six
13 percent of their centers would not be successful.
14 Others have said to me, well, what's the point? And
15 of course, this is just a request.

16 Mr. Greenberg and the department will
17 do as they see fit. But you know, having just gotten
18 to know Ryan over the last three years, we are very
19 privileged here to have Ryan as the director of
20 Bureau of E.M.S. He will get this right.

21 If he -- if we pass this amendment, if
22 he so chooses to do this, and he calls up the V.R.C.,
23 number one, his language and his framing of it will
24 be very respectful, but they will understand that a
25 very erudite and knowledgeable lead agency director

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2 is concerned about what's happening here and they
3 will, I guess, change practice.

4 So, I can read the -- the -- the
5 suggested motion again. But the idea is to start
6 letting the V.R.C. know that what they're doing is
7 not good. And others have said to me, other leaders
8 have said to me, well, there's a V.R.C. or C.O.T.
9 meeting in March, right.

10 And another way of framing this is, so
11 they're telling us our P.I. is no good, right. It
12 was -- one of the things we're failing on, right?
13 And they're taking trauma centers out. I want to
14 turn that question around to them.

15 Look at you, look at the V.R.C., look
16 at your Q.A., right. This thing got away from you.
17 You obviously have a quality assurance problem that
18 is gigantic and it is a runaway train that you never
19 meant to fail fifty-six percent of your trauma
20 centers.

21 And so far as I can tell, there is no
22 corrective action and no one is doing anything about
23 it. So, to re -- and I know there'll be discussion,
24 rephrase my motion, motion would be that the STAC
25 suggest to the department, the Department of Health,

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2 that director Ryan call the Chair of the V.R.C.C.O.
3 to -- C.O.T. and discuss with them the concerning
4 fifty-six percent non-success rate of gray book
5 reviews. Those are my comments and those are my
6 request -- that's my request.

7 CHAIR BANK: Any discussion? Dr.
8 Cooper.

9 MR. COOPER: First, I'll second the
10 motion, so we can have the discussion. This is Dr.
11 Cooper for the stenographer. First of all, many of
12 you were in the room this morning when I made my
13 remarks about, you know, the focus of our system
14 really needs to be on performance improvement rather
15 than, you know, the old-fashioned quality assurance
16 where we were looking for the bad guys and, you know,
17 and -- and chucking them out.

18 We -- we -- we need to be a system
19 that identifies not necessarily weaknesses, even in
20 regular performance improvement at our own hospitals.
21 We -- we don't even use the term weakness anymore.
22 We speak about opportunities for improvement, right?
23 And that's really what the system really ought to be
24 focused on, you know.

25 But I can also tell you that as Dr.

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2 Teperman has suggested, you know, the -- there are
3 real world consequences to facilities that -- that --
4 that are not necessarily passed for a full three-year
5 verification at -- at their -- at their site visit
6 and by the V.R.C. subsequently.

7 I'm aware of -- of one center where
8 the trauma program manager was fired, you know, after
9 the hospital received, you know, a -- a request for a
10 focus visit in one year, which it passed with flying
11 colors. And the trauma center director was demoted.

12 You know, it caused pretty, you know,
13 significant disruption within that -- within that
14 hospital. And, you know, it wasn't pretty. You
15 know, there are -- and -- and I can also tell you
16 that when this information was brought to the C.E.O.
17 of my own institution, the immediate response was a
18 chuckle and a laugh to say, well, you know, anybody
19 that is going to fail, fifty -- fifty-six percent of
20 the people who, you know, who replied, that's an
21 unsustainable system.

22 And, you know, the impli -- the clear
23 implication was that my C.E.O. would go to the, and I
24 don't mean to put words in his mouth, but the clear -
25 - the clear implication was that he would be arguing,

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2 you know, with the corporate leadership that if this
3 is the way, you know, that business good -- is going
4 to be conducted, that we should not really be
5 participating in that system.

6 So, you know, as -- as we all agreed
7 this morning, okay, and as I agreed with Dr. Bank and
8 others, we absolutely have to have standards, okay.
9 There's no question about that, you know. Nobody's
10 arguing with that, you know.

11 And -- and as Director Ryan has
12 pointed out that there are rare circumstances, very
13 rare circumstances where -- where -- where failure to
14 meet standards are so egregious that, you know, that
15 no amount of, you know, of, you know, soft and cuddly
16 performance impure -- improvement measures are going
17 to -- are going to fix the problem.

18 But those -- those circumstances are
19 extremely rare, you know -- you know. And of course,
20 I personally deeply appreciated Director Ryan's
21 remarks and indicating how the department does work
22 extremely hard to work through the performance
23 improvement, you know, window rather than the quality
24 assurance window.

25 And I think, you know, he and his

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2 colleagues in the -- in the division of -- within the
3 bureau have, you know, really demonstrated that. But
4 this is -- this is not an -- this is not an unserious
5 problem.

6 And I -- I do think that -- that it
7 would not hurt if -- if a phone call were made, you
8 know, by Director Ryan to the -- to the head of the
9 V.R.C. as -- as Dr. Teperman has suggested, you know,
10 and said, hey, look, you know, we're concerned about
11 this. We've got a big system here, you know.

12 We've got a lot of people we're
13 responsible for, you know. And -- and if we start
14 failing, you know, fifty-six percent of the -- of the
15 trauma centers in New York State, we're going to be
16 in trouble and our -- and our people are going to --
17 are going to be up in arms.

18 So, I -- I would just simply ask that
19 -- that we all give this motion very serious
20 consideration. I will be voting in favor of it
21 because I see no harm in making that telephone call
22 at all, you know -- you know. And -- but again, I
23 want to reiterate the fact that I -- that I strongly
24 support the direction that Director Ryan has taken
25 with -- taken with this.

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2 And that, you know, we all -- I know
3 that we all support, you know -- you know, an
4 opportunity if whatever we -- we might want to call
5 it. We're now calling it provisional designation if
6 someone doesn't, you know, doesn't perform as well as
7 might be expected, you know.

8 But looking for all possible ways, you
9 know, to ensure that our patients continue to get the
10 best care because let's face it, ladies and
11 gentlemen, we all know this, okay, to take a trauma
12 center offline does seriously disrupt, you know, the
13 -- you know, the flow of patient care in a -- in --
14 in a particular -- in whatever region that may happen
15 to be.

16 It will likely increase transport
17 times and we all know that time is tissue, whether
18 you're talking about the heart, the brain or the
19 body. And you know, so again, I would simply ask
20 that all of us here give this -- give this motion by
21 Dr. Teperman very serious consideration. Thank you.

22 I -- I appreciate the opportunity to
23 speak on this -- this subject.

24 CHAIR BANK: And just a -- you've gone
25 through -- I just want to correct on the language

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2 here. Just, if you have a focus review, just so
3 everybody knows, you are still a verified trauma
4 center. There's no --

5 MR. COOPER: That --.

6 CHAIR BANK: -- there's no provisional
7 -- there's no probational. That's number one.
8 Number two, the A.C.S. does not take the trauma
9 centers offline, right? That's a New York State
10 D.O.H. decision. So, I just want to be correct on
11 the -- the terminology.

12 And Ryan, you're the ultimate one
13 that's going to have to weigh in on this.

14 CHAIR GREENBERG: Anybody is welcome
15 to make a recommendation at any time. We are happy
16 to take that, absorb it and handle it appropriately.

17 CHAIR BANK: Okay. Anybody -- any
18 other comments that may want to vote, to ask Ryan to
19 make a phone call, yes or raise your hand. So, it's
20 eight, nine. Any no votes? Two. So how many people
21 today on the STAC?

22 MR. CLAYTON: Well, we initially had
23 seventeen for quorum here and now we're down to
24 sixteen. So, because we had one member leave and I
25 guess we have to have fifty-one percent, right, for

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2 the -- for the vote for V.A.

3 CHAIR BANK: So, fifty-one percent,
4 the motion carries. Okay. Thank you. And -- oh, we
5 have eight? I'm sorry. I apologize. Let's do it
6 one more time. I apologize. I thought I screwed up.
7 Just raise -- raise your hand if you want to vote
8 yes.

9 So, I'm sure I count ten. If anybody
10 else wants to count again, for my inability to count
11 to ten, please -- please feel free. Anybody opposed?
12 Four?

13 MR. CLAYTON: Yeah.

14 CHAIR BANK: Five? Five. So, we have
15 ten plus five. Again, my math skills are fifteen.
16 We had seventeen people when we started, but -- but
17 they either abstained or left. So, Dan, is this okay
18 that we -- the motion carries then?

19 MR. CLAYTON: You have not asked the
20 extension - abstention --

21 CHAIR BANK: Abstention.

22 MR. CLAYTON: -- if we have any.

23 CHAIR BANK: You're the only one to
24 abstain -- three people abstain. So, my math skills
25 are eighteen people in the room, but we had seventeen

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2 people at the beginning.

3 MR. CLAYTON: Very skilled. The yays
4 still win despite the nays and the abstentions.

5 CHAIR BANK: Okay. Therefore, Dan's
6 right as always. And we'll ask doctor -- Director
7 Ryan to make a phone call. Any other new business?
8 Any announcements that anyone wants to make?

9 MR. CLAYTON: I would just repeat that
10 the, obviously, the May meeting is on the agenda, but
11 the one for October is October 30th at Saratoga
12 Holiday Inn, which is right on Broadway in Saratoga.
13 Nice time of year to visit in the fall.

14 STAC is, to my knowledge, has not been
15 there now since I've been doing trauma.

16 CHAIR BANK: So -- so the May 28th
17 meeting is here at the Troy Houghton Garden Inn. And
18 the October, what's the date?

19 MR. CLAYTON: 30th.

20 CHAIR BANK: October 30th is not going
21 to be here. This means Saratoga. And we are
22 currently looking at the January 2026 dates. If
23 anybody, by the way, just to throw this out there as
24 announcement, if anybody knows of any large conflicts
25 within January, I know the East conference, which a

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2 lot of us to go to -- I don't know the dates for
3 that.

4 But if anybody knows of any dates of
5 things that for whatever reason, we should not be
6 meeting in that particular day in January of 2026.
7 You could look at --.

8 CHAIR GREENBERG: So I -- I would go
9 even one step further. If anybody knows of any major
10 trauma conferences, events, anything for 2026, if
11 they can send those to Dan and Tom, now would be the
12 time because we are working on the 2026 schedule now.

13 So if you do know of any of your
14 associations or things of that nature, please go
15 ahead and let us know about that. And yes, Peter
16 Book.

17 MR. COOPER: And Dr. Cooper, the only
18 meetings of any size of which I'm aware in January
19 are the NAFSP (phonetic spelling) meeting earlier in
20 the -- earlier in the year. It's usually around the
21 first weekend or so and -- and East. I'm not a
22 member of East, but that's the other one. It's
23 usually around mid January. So those are the only
24 ones that I'm personally aware of.

25 CHAIR BANK: We -- we -- we have the

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2 East dates.

3 MR. CLAYTON: Dan Clayton from the
4 Bureau. We have asked all of our executive
5 subcommittee from across the fields, I.P.E., E.M.S.,
6 you know, pediatrics, registry to make sure that
7 we're trying to stay away from conflicting dates.
8 We're doing our best on that.

9 CHAIR BANK: Any other comments,
10 questions, new businesses, random thoughts? Okay.
11 Go to a motion to adjourn, anybody second?

12 Thank you very much.

13 CHAIR GREENBERG: That was Mr. Conn
14 who did -- just in case you didn't. Have a good day
15 everyone, travel safe. And we can go off the record.

16 (The meeting concluded at 3:12 p.m.)

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2 STATE OF NEW YORK

3 I, ANNETTE LAINSON, do hereby certify that the foregoing
4 was reported by me, in the cause, at the time and place,
5 as stated in the caption hereto, at Page hereof; that
6 the foregoing typewritten transcription consisting of
7 pages 1 through 108, is a true record of all proceedings
8 had at the hearing.

9 IN WITNESS WHEREOF, I have hereunto subscribed
10 my name, this the 11th day of February, 2025.

11 ANNETTE LAINSON, Reporter
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