5/29/2024 - STAC - Troy, New York

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: May 29, 2024

TIME: 1:10 p.m. to 2:25 p.m.

CHAIR: MATTHEW BANK

LOCATION: Hilton Garden Inn

235 Hoosick Street

Troy, New York

Reported by Danielle Christian

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APPEARANCES:

ABENAMAR ARRILLAYA
AMY EISENHAUER
ARIEL GOLDMAN
ARTHUR COOPER
CARNI GARCIA
CRISTY MEYER
DANIEL CLAYTON
DEREK WAKEMA
DONALD DOYNOW
FRANK MANZO

GEORGE AGRIANTONIS
GEORGE ANGUS

JAMES MCDONALD
JAMES VASSWINKEL
JAMIE ULLMAN
JOHN MORLEY
KARTIK PRAHHAKARAN
KATE MAGUIRE
KERRIE SNYDER
KIM WALLENSTEIN
KURT EDWARDS
L.D. GEORGE ANGUS
MARK GESTRING

MARY IVES
MATTHEW CONN

MEGHAN MULLEN
MICHAEL DAILEY

MICHAEL VELLA
ROBERT CURRAN
RONALD SIMON
ROSEANNA GUZMAN-CURTIS
RYAN GREENBERG
SHELDON TEPERMAN
SRINIVAS REDDY
WILLIAM FLYNN, JR.

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(The meeting commenced at 1:10 p.m.)

SECRETARY CLAYTON: We are calling to order and the first thing on the agenda is to do the attendance roll call. Dr. Bank?

CHAIRMAN BANK: Here.

SECRETARY CLAYTON: Dr. Wallenstein?

DR. WALLENSTEIN: Here.

SECRETARY CLAYTON: Dr. Guzman-Curtis?

DR. GUZMAN-Curtis: Here.

SECRETARY CLAYTON: Dr. Gestring?

DR. GESTRING: Here.

SECRETARY CLAYTON: Frank Manzo?

MR. MANZO: Here.

SECRETARY CLAYTON: Dr. Prabakaran?

DR. PRABAKARAN: Here.

SECRETARY CLAYTON: Kate Maguire?

MS. MCGUIRE: Here.

SECRETARY CLAYTON: Dr. Angus?

CHAIRMAN BANK: Dr. Angus has been excused.

SECRETARY CLAYTON: Thank you. Dr. Reddy?

DR. REDDY: Here.

SECRETARY CLAYTON: Dr. Agriantonis?

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DR. AGRIANTONIS: Here.

SECRETARY CLAYTON: Matt Cann?

MR. CANN: Here.

SECRETARY CLAYTON: Dr. Taperman?

DR. TAPERMAN: Here.

SECRETARY CLAYTON: Kerrie Snyder?

MS. SNYDER: Here.

SECRETARY CLAYTON: Dr. Edwards?

DR. EDWARDS: Here.

SECRETARY CLAYTON: Dr. Arrillaga?

DR. ARRILLAGA: Present.

SECRETARY CLAYTON: Dr. Vosswinkel?

DR. VOSSWINKEL: Here.

SECRETARY CLAYTON: Dr. Flynn?

DR. FLYNN: I'm here.

SECRETARY CLAYTON: Meghan Mullen?

MS. MULLEN: Here.

SECRETARY CLAYTON: Dr. Dailey?

DR. DAILEY: Here.

SECRETARY CLAYTON: Dr. Winchell is excused. Dr. Ullman is excused. Dr. Doynow?

DR. DOYNOW: Here.

SECRETARY CLAYTON: Dr. Goldman?

DR. GOLDMAN: Here.

SECRETARY CLAYTON: And Dr. Cooper?

DR. COOPER: Here.

SECRETARY CLAYTON: We have quorum.

DR. SIMON: We missed Dr. Simon.

SECRETARY CLAYTON: My apologies, Dr. Simon.

DR. SIMON: Right here.

SECRETARY CLAYTON: Dr. Simon is also noted as present.

DR. SIMON: I was just going to leave.

SECRETARY CLAYTON: No, please don't.

CHAIRMAN BANK: So Dan Clayton's going to lead us in the Pledge of Allegiance and we could all stand.

SECRETARY CLAYTON: I pledge allegiance to the flag of the United States of America and to the republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

DR. COOPER: Mr. Chairman?

CHAIRMAN BANK: Dr. Cooper?

DR. COOPER: I raise my voice at this -- at this time to announce to the group the passing of Dr. Palmer Bessey, Joe Bessey, a dear friend of

ours for many, many years. Joe died within the last -- the last month or so peacefully at home surrounded by his family. But as we all know, he made enormous contributions to our trauma system here in New York State. And I just would ask for a moment of silence at his path.

CHAIRMAN BANK: Okay. Thank you very much. And -- and just on a personal level with Dr. Bessey I -- I was on STAC with him for many, many, many years and he had a -- a lot of -- a lot of wisdom.

Okay. We are now on the record. So I'm going to make a motion for approval of the previous minutes. They are on the D.O.H. website. Can I have a second of the motion?

MR. CURRAN: I second.

CHAIRMAN BANK: Can I have just a roll call everybody who approves the -- for the -- the approval of the previous minutes please just raise your hand. Think we're good there. Okay. So the Bureau of E.M.S. and trauma systems report, Director Greenberg.

DIRECTOR GREENBERG: Good afternoon, everyone. I'm going to keep it a little bit on the

brief side today. So just to report out on -- on bureau activities, we've been quite active in the bureau. Happy to say that we've been onboarding several new STAC members as well posting the number of STAC members. Many of you might have seen that we had three different nursing positions posted that are in the recruitment process for -- just for the -- the trauma program. So we're excited to -- to see this growth within the trauma program within the bureau.

And so as we move through that I think you'll start to see some different transitions moving along with it. Some different transitions on processes as well as some additional abilities to pick up the different projects and things that the STAC would like to take initiatives on that, you know, prior to now we might have had some limited bandwidth in our capabilities to do some of those things. And so hopefully we'll be able to support that more as well.

We are also going through a little bit of some reorganization within the bureau, and you'll hear more about that I think at our -- our next STAC meeting. But part of that reorganization is also to work with supporting more of our councils in

different ways including, you know, the vetting process, paperwork and -- and different projects that some of our committees pick up on as well as some data analysis and different things that come along on that side.

So we're excited to see kind of what the future yields as well as, you know, our new trauma nurses coming on into the program. And I think we're going to talk a little bit more about, a little bit later on during the systems report, about some of our involvement related to A.C.S. visits and that interaction. Starting to return a little bit more to where we were before COVID, when we were in person, but what that looks like now post COVID with being virtual visits and how those interactions happen as well as the department coming out with some additional communications on what that will look like.

So everybody has an understanding of what that transition looks like and what the, you know, kind of a -- the new way in the future looks like with virtual visits still being on the reverification side. And I think we'll remain virtual for the most part for reverification, and

you'll continue to see us for provisional visits in person as well as for those initial consultation and the initial verification visits.

The one thing I did want to touch on is the -- the nursing regs. So the Four o fives, as we know, had some regulatory changes has happened. We've moved from the orange book to the Grey Book. For those of you who were paying attention during the process, that actually happened during emergency reg change process so it allowed us to move that portion much faster than the nurse component which was the other half of those regulatory changes.

The emergency regs have now been adopted as full regs. They went out for public comment period. Came back. Went in front of FIPIC and were adopted so those are now completed. The nurse regulation packet is still going through that process. It has not gone out for public comment yet so we'll be waiting for that period of time to happen. Once it goes out for public comment it goes out for a sixty day period. It comes back. If there's any particular comments to it that need significant changes it will go back out for public comment period again. And then come back. If it

doesn't then it will go in front of FIPIC and for the final vote and then to go into regulation.

So for those who do have trauma inspections or verification visits coming up, the nurse evaluator is still in there and you do need to prepare for your visit with that nurse evaluator as it is regulation. And then you'll know that we're getting closer to possibly that change happening when you start to see that public comment period back out there. So it's one of the changes that are happening with it.

Just some other informational stuff. You know, particularly in your -- in the -- the world of trauma we know you're doing a lot of really great things in innovation and some of the, you know, things that are happening. And we try and recognize on the E.M.S. side, and we have some new E.M.S. innovation awards that are happening this past couple years, but they will -- they're open for new innovation awards for E.M.S. agencies.

And so if, within your trauma world, you're seeing some really great things happening in the world of E.M.S. that you think should be recognized for some innovative ideas, there's a

number of different categories, you can find the portal to submit or nominate, self-nominate or nominate an E.M.S. agency for some innovation that's happening on our website. So please consider doing that when those nominations for this year's awards are due by July 1st.

Our vital signs conference will be in Rochester this year and we're really excited to see the University of Rochester as well as the trauma program really, you know, kind of being a spotlight of our conference being there. We haven't been to Rochester in a number of years, and so we're really excited about coming back there in October. That will be October 16th to the 18th. There is a flyer in the hallway.

For those of you who come to our E.M.S. memorial you know that it normally is during E.M.S. week. It did not happen during E.M.S. week this year because we have a new memorial that's coming in. It was supposed to be delivered in time for this year but unfortunately just in production it was more important for us to get the new memorial correct and right than it was to rush through it. So that memorial was moved from May to September. It

will happen on Thursday, September 19th for anybody who would like to join us. It's open to our entire E.M.S. and trauma community to join us.

And then last I wanted to talk about the Safe Streets for All grant. This is a federal government grant that is giving away hundreds of millions of dollars a year in order to make our streets safer. This is a big push also from our federal partners at NTSA (phonetic spelling) as well as NASEMSO which is Nassau Association of State E.M.S. Offices to get states involved in receiving some of this funding. We have a local agency or a local town, the Town of Colonie, who's received several million dollars towards safer streets which they are putting towards some innovation both in E.M.S. as well as even simple things in putting safer ways to cross the streets.

So improving their crosswalks, different lighting for things in order to reduce the number of trauma patients. And so really exciting opportunity. There is a lot of money there. If anybody would like some more information feel free to -- to speak to me after and we can share that, but I think there's some great opportunities that are out

there.

As the Town of Colonie moves forward on that one, we'll also be hopefully providing this group an update because I think it's really informational and really important to look at that, you know, essentially injury prevention through safer streets. And so that is a big one going on in that side. I think at this point that is where I'll end our report for today.

CHAIRMAN BANK: Okay. Thank you very much. Trauma program update, Dan?

SECRETARY CLAYTON: I have nothing to report. Thank you.

CHAIRMAN BANK: Okay. I always start off as subcommittee from the executive subcommittee. So, Dr. Simon has put in multiple hours of writing the bylaws which came out of the systems committee. We have gone over them at this meeting many, many, many times. There is one hang-up from the bylaws which we need to bring for a vote from the STAC. Currently we meet three times a year. Typically it's January and May and October. The new bylaws have us meeting quarterly, so four times a year.

We're not going to do that unless

everybody in the STAC is willing to come here for four times a year. We need to have a quorum which is over sixteen by the way. So we want to put that to a vote. More actually, I'm sorry, we should have a discussion first and then we could put it for a vote. Okay. So we're going to make a motion to accept the bylaws as they are which would mean quarterly meetings of STAC. And then we can have a discussion on that motion. Anyone want to second that motion?

UNIDENTIFIED SPEAKER: I'll second it.

CHAIRMAN BANK: We have a second. So any discussion on the motion? Yeah.

DR. SIMON: I think that -- and we've already established that state laws prevent us from doing anything remotely. So just, you know, I'm looking at some of my colleagues that are describing the fact that it -- we're five and a half hours to Buffalo, four and a half hours Rochester. It's only two and a half hours for us but still it's a lot to be away from our families and to be away from the trauma centers. I think three times a year is working well.

I think four times a year is, speaking for myself and also for my system, New York City

Health and Hospitals, it's difficult for us to free up -- that's a lot of trauma surgeons leaving the city. So I think three is -- we're doing a good job. That's what I think.

CHAIRMAN BANK: Dr. Gestring?

DR. GESTRING: Can't we be vague and say two to five or something like that and leave it to the -- the -- you know, the events of the whatever is going on at the time? Most -- I mean, most years three times is fine but some years maybe we need to do more.

CHAIRMAN BANK: So as Ryan just reminded me, we can put in the bylaws a minimum of three.

DR. GESTRING: That would be fine.

DR. DAILEY: Why do we have to have a number in at all?

DIRECTOR GREENBERG: I think most bylaws have a minimum in it in order to ensure that you do meet on a regular basis and to a certain (unintelligible). You can make that minimum one time or two times, but I think that's normally why that's there. There is also some guidance to a minimum of three allows the department to help in budgeting as

well so that we can kind of know where we are.

CHAIRMAN BANK: I just want to say that this room and everything you see here is financially supported by the Department of Health and although, you know, Department of Health has the best people in the history of the world working for them, obviously, to my right, it -- putting it in our bylaws just assure that financial support for at least that number of meetings.

SECRETARY CLAYTON: Dr. Chair, Matt Cann has a comment or question.

MR. CANN: Thank you. Do the bylaw changes need to be circulated for any period of time before they get voted on by the committee?

CHAIRMAN BANK: They -- they've been circulated multiple times by Dr. Simon and --.

DR. SIMON: Oh, my God, yes. Many times.

CHAIRMAN BANK: So they -- they have been circulated and we are just talking about this one time.

DR. SIMON: The -- the bylaws were approved by this committee probably two years ago, and -- and they've been kind of floating around

through legal. And -- and this wordsmithing I think has kind of come out of that process.

MR. CANN: Okay. So this is just a -- a tag on to something that's already been in process for a while?

DR. SIMON: Yes.

MR. CANN: Okay.

DR. SIMON: It's -- it's a very specific motion on one line in the bylaws. And -- and I'll just say and duck, I -- I was one of the four -- the -- the few people who -- who thought that we should have four meetings a year just because I -- I very much value the -- the -- the ability of all of the trauma people around the -- the state to get together. And I -- and I think that brings real value.

But I -- I understand all of the problems with the -- the four times a year. So -- but I did think that there was a value to at least having the option for a fourth so I -- I would really support the idea of saying a minimum of three and giving us a little bit of -- of wiggle room if we need an extra meeting.

DIRECTOR GREENBERG: So just to -- to

clarify one thing too. So these -- these bylaws that -- that essentially your -- you would move forward would from here go to legal to make sure that they're, you know, kind of all compliant and everything else on that side. And then from legal would move to be read here and, forgive me, I can't remember if it's in at least two meetings or three meetings before it officially becomes the final.

CHAIRMAN BANK: So I'm going to change the motion a little bit so I apologize. But just to make it a little bit more clear, I think we could word it as the motion is to change the sentence in the bylaws to the STAC must meet at least three times a year. If this motion passes we will change the bylaws. If this motion fails then the -- then the previous bylaws, the -- the sentence would stay the STAC must meet at least quarterly. So the motion would be to change the sentence from the STAC must meet at least quarterly to the STAC must meet at least three times a year.

DR. GESTRING: I would second that.

CHAIRMAN BANK: So any further discussion? So we're going to have a vote. So everybody, again, if you vote yes the sentence will

be changed to the STAC must meet at least three times a year. So everybody -- all the voting members of STAC who vote yes please raise their hand. So we have one, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty. So we have twenty so the motion will pass. So the STAC bylaws will be changed that single sentence to the STAC must meet at least three times a year.

So this will be -- the motion passes and we will come back and read it again at the next STAC. Secondly, just from the executive committee, we want to talk a little bit about the vice chair and burn positions. I apologize this is taking a long time. There were some issues with the old bylaws and new bylaws and the voting that we had to -- to work through. For the vice chair positions, I -- everybody who had self-nominated I sent out an e-mail a little earlier apologizing for how long this is taking. If you did not get an email then I do not have your name.

If anybody else wants to self-nominate or nominate anybody else for the vice chair position

there's still time. What is going to happen is that we will ask all the people who are -- have been nominated to write a quick little paragraph about why they want to be a vice chair. We will send it out to the voting members of STAC over the summer. And then at this meeting in October, we will vote for the vice chair. And the same thing of the burn surgeon.

We have two positions, actually three positions that are both in the old bylaws and new bylaws who have made it pretty easy. One is in Nassau County RTAC representation which the Nassau County RTAC is -- has given us a name. And the other is the burn surgeon and the vice chair. Any questions about that? Matt?

MR. CANN: Yeah. So if somebody's interested in the vice chair position, do they send you an e-mail and say I'm interested, I'd like to be considered or what -- what is the process by which these people are going to be selected?

CHAIRMAN BANK: That's exactly right. You'd send me an e-mail. It's M as in Matthew Bank B-A-N-K at Northwell.edu. We will then send your names to the nomination committee -- their nomination committee just to make sure they read their bylaws to

make sure that as per the bylaws you are -- you are cleared, I don't know what the word. You're clear -- you meet the criteria to be a vice chair. So, for example, you need to be a physician, and once you get through the nomination committee that compares you to bylaws then we will ask you to write a little paragraph about yourself.

The -- your paragraph and, you know, I think your C.V. will be shared with the voting members of STAC over the summer. And then at this meeting in October we will have a voting mechanism.

DR. PRAHAKARAN: Matt, if there are multiple nominations for the burn surgeon or for any other position, how are those positions selected?

CHAIRMAN BANK: I think it's going to be the same mechanism. So we will send out -- we'll ask the burn physicians to write a little paragraph about yourself, why they feel that they would be a good candidate for the burn position. We'll probably have them submit their C.V.s, we'll have them go through the nomination committee. Nomination committee will make sure that they meet the qualifications for a burn surgeon on STAC. And then once they do we'll send out their paragraph about

themselves to the rest of the STAC members. And then at this meeting in October we will vote for that.

That name, just so everybody knows, they are not then appointed as the burn surgeon, for example. That name goes to the commissioner for vetting. And then once that person is vet the commissioner is the person who will appoint to the STAC. So the STAC is responsible for sending that name to the commissioner and then they're responsible for the vetting and the appointment. Any other questions? Okay. Cristy, the Registry Committee.

MS. MEYER: Good afternoon everyone. Cristy Meyer from the registry subcommittee. We have a few action items for everyone today, but just to give everybody an update, the subcommittee met and we discussed the 2024 data dictionary and change log which are officially approved through the Department of Health process. So those will be uploaded on the website. Just notably there are some definition updates including Dead on Arrival and Died in the E.D. so please take note of those.

We will also pull those definitions out in like maybe a one pager to make it a little easier for people to see. We also eliminated the

field for P.C.R. Status and updated the level of activation field to reflect full or partial activation just because centers have different language of how they active their highest level and partial activations.

We did have in between a meeting to talk about vender transitions and education and also a vendor showcase for people throughout the state to attend. A couple vendors gave presentations. We had a great presentation from the data management at Analysis and Research Group. Wendy Patterson gave us SPARCS reconciliation analysis to really showcase all the findings of SPARCS reconciliation. Finding that in a given year there might be four point five percent of records that were submitted that may have been recovered in that process.

So we do have a few motions in regards to the SPARCS reconciliation. There's a motion. I'll read it for the group. So the registry subcommittee puts forth a motion that the New York State SPARCS reconciliation process will no longer be included in the data validation process for the New York State trauma report.

CHAIRMAN BANK: Okay. So there's a

motion on the floor. Can I have a second?

DR. GESTRING: I'll second it.

CHAIRMAN BANK: Anyone want to discuss this motion? Okay. No further discussion. Can we have a vote? Everybody who's in favor of this motion please just raise your hand. So we have twenty-one members for so the motion will pass.

MS. MEYER: Okay. So in follow up from January --.

CHAIRMAN BANK: Cristy, any opposed?

MS. MEYER: Oh, I'm sorry, I'm sorry.

CHAIRMAN BANK: Any abstained? Okay.

DIRECTOR GREENBERG: Just one thing on that. So related to the SPARCS data in that regard, so this will go as a recommendation up to the commissioner's office about what the future would look like. Again, thank you to Wendy and her team from DMAR for participating this morning. I think this is a really exciting opportunity for the department and for the STAC to be able to create a more timely report, and that we've looked at it historically to see that, you know, kind of the amount of effort and time that we put in towards the comparison with that SPARCS data. SPARCS data is,

you know, kind of what's the value of that versus the time that we end up waiting for it so thank you everyone on that.

Another conversation I think is important for everyone to know about that is related to our non-trauma center institutions and how many trauma patients are coming there. And so what we think we're going to look at and hopefully we'll have more information by the next meeting is looking at our, you know, on a very small scale, our non-trauma centers looking at the SPARCS data from the year prior, seeing how many patients would have met that criteria. And then reporting out on that as well as we think we'll be able to identify if they were transferred to a trauma center.

Now that won't have as much information on it. It won't have, you know, the extensive details and things of that component that obviously the registry brings in, but we think as a -- as a first step to starting to look at this and thank you, Doc, for, you know, bringing that up. But I think that's another one that's important for everybody who maybe wasn't at the morning meetings and is watching now to know next steps on those as

well. So thank you.

MS. MEYER: And I just want to add that another finding from the start -- SPARCS analysis is that there's no validation process during submission in the image trend platform. So when end users across the state submit there will be some follow up to try to create a validation process so that we're not missing submissions which I think will help kind of further support elimination of this process. So more to come on that.

In another follow up from January there was a lot of discussion about the abbreviated injury scale 2015 version becoming the requirement for submission and data collection as of January 1st, 2025. We were notified in January that a very large number of trauma centers would be impacted by the change because the vendors were not going to meet that requirement or there would be substantial cost. So in follow up from the motion from January's meeting, we have drafted a letter, which I'll read to you now. Motion two and three are related to that letter. This letter is intended to go to the American College of Surgeons Verification Review Committee in relation to the A.I.S. 2015 transition.

So this is a letter intended to come from the subcommittee of the registry and from the State Trauma Advisory Committee to the American College of Surgeons on Trauma Verification Review Committee. A.C.S. verified trauma centers are anticipating the required transition to A.I.S. 2015 as of January 1st, 2025. In New York State more than fifty percent of end users have received a vendor announcement that their current registry product will not be updated to meet this standard. Other centers have received recent notification from their registry vendors that in order to meet the new A.I.S. 2015 requirements, there will be a ten thousand dollar yearly upgrade fee.

The impact of this sudden announcement received in late January 2024 will require registry software transitions for almost fifty percent of end users in less than twelve months just in New York State alone. These A.I.S. 15 compliant registries are also more than twice the cost of many current -- centers current product. The timeline for uplighting -- updating vendor software and in many cases exceeding the afforded time period may make compliance with data collection and submission using

the required A.I.S. 2015 scale difficult if not impossible to meet.

In addition, trauma centers did not have advance knowledge of the decision from the registry vendors which did not allow the cost of the new registry to be added to the 2024 budget cycle. This time frame may impact the ability of trauma centers in New York State to meet data collection and reporting standards needed to prepare for their upcoming visits and the required TQIP submission compliance. Given the three year reverification cycle and this extremely short notice of vendor noncompliance with the A.I.S. 2015 updates, New York State trauma centers are anticipating a considerable gap in the ability to remain compliant with data submission standards.

Our leadership team has initiated conversations with vendors as well as provided statewide registry team education on vendor transitions, but it appears more support is needed to meet the guideline for the transition to A.I.S. 2015 submission by January 1st, 2025. We will continue to work with the vendors and trauma centers in New York State to support the registry requirements for

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transition to A.I.S. 2015.

Meeting the standard by January 1st, 2025 appears to be a considerable challenge. We respectfully request that the deadline for the mandatory transition to A.I.S. 2015 be extended by a minimum of one calendar year.

CHAIRMAN BANK: Okay. So the motion has been read to approve that letter as read. Do I have a second for the motion?

DR. GESTRING: I'll second.

CHAIRMAN BANK: Do we have discussion from the floor?

DR. GESTRING: I have a question. So the letter is fine. My questions is who is the letter from? And you had mentioned it's from the subcommittee and I would say that it should be from the State Trauma Advisory Committee so not the subcommittee. I think the subcommittee submits it to STAC and then the letter is sent under STAC letterhead because I think it has more weight that way. And I think most organizations work that way. It's more of a bureaucratic question, but I think you guys composed the letter and then it's sent under, you know, with Dr. Banks' signature on the STAC

letterhead I think is how it works. You guys can correct me on that but I think it needs to come from the state -- I'm sorry from the state trauma advisory committee not from the committee -- not from the individual committee.

CHAIRMAN BANK: Any further discussion? Art?

DR. COOPER: Thank you, Mr. Chairman. I just wonder if there would be a formal departmental endorsement of this -- of this letter. I think if it came from the Department of Health as opposed to the STAC alone it would also carry a good deal more weight. Thank you.

DIRECTOR GREENBERG: Sure. So, you know, following this motion we would take that letter, move it up the chain and then have that come out from you as well as, you know, with the commissioner's approval supported by that.

DR. COOPER: Thank you.

MS. SNYDER: Can I just ask about how long that chain takes just not offense but I'm trying to ask before?

DIRECTOR GREENBERG: I understand.

MS. SNYDER: Yeah.

DIRECTOR GREENBERG: We will try and expedite that one based on the time sensitivity of the letter and the nature and what it's expressed to.

MS. SNYDER: Okay.

CHAIRMAN BANK: So could we send this letter from the STAC and then later on after it has moved through D.O.H. bureaucracy send another letter from the D.O.H.?

DIRECTOR GREENBERG: I'd be happy to get back to you on that answer.

CHAIRMAN BANK: So we do have a motion on the floor and it's been seconded. Any further discussion? Okay. So everybody who -- who's for the motion please raise your hand. So twenty-one for. Any against? Any abstain? So the motion passes. Is that the end of your report from registry, Cristy?

MS. MEYER: I just have one additional project that is being convened by Jane McCormick (phonetic spelling) and her team looking at statewide registry inclusion data of patients with minor injuries. We used to in New York State and certainly nationally be able to exclude patients from our hospital registry protocol. And that actually changed in 2019 and certainly we've been following

suit here in New York State. So we don't make medical related admission exclusions and we're accepting patients with as little as a laceration. So there's a project that Jane McCormick and her team will be convening so please see her for additional information and this concludes my report.

CHAIRMAN BANK: Okay. Thank you very much, Cristy. So we're going to move to Trauma Center Needs Assessment that did not meet today. So we're going to move past that. And Injury Prevention Education. Anyone from injury prevention? Oh, there you go. Look at that. How we doing?

MR. CURRAN: Thank you. So we met this morning. We were -- received updates from around the state based especially on Stop the Bleed activities throughout the month of May. A newsletter has been distributed throughout membership for A.T.S. as well as STAC. For everyone's activities for the last couple of months. As we tune up for the summer we'll be focusing on September which is usually fall's prevention activities as well as reminding everybody about November 18th which is National Injury Prevention Day and trying to get things on everybody else's calendar who else they work with and

partnerships. The sheriffs, libraries, schools, colleges, et cetera for various activities throughout. Thank you.

CHAIRMAN BANK: Thank you very much. Any questions for Injury Prevention Subcommittee? Okay. We'll move along to the Performance Improvement. My co-chair, Dr. Vella is going to talk a little bit about what we discussed in the meeting.

DR. VELLA: Thank you. So we spent the meeting talking the spring 2024 collaborative TQIP report in terms of comparing the outcomes of the New York State collaborative relative to the other TQIP centers across country, spending the majority of time focusing on the shock subgroup of patients to find is those who arrive with a blood pressure less than ninety from various causes where we were noted to have an increased mortality and morbidity relative to centers across the country.

We identified a couple potential issues related that -- that may be the cause of that especially as they relate to capture of comorbid conditions and injuries. And as it relates to that we don't have any formal motions but we do have sort of three action items moving forward. Number one,

there was a letter sent out I think in 2011 or 2012 to -- from the D.O.H. to medical examiners across the state highlighting the importance of sending autopsy reports to the trauma centers so that they can use that in terms of injuries identified which will increase the severity of injury for many patients.

And so the plan is to share that letter from 2011 and then also have the Department of Health work on a new updated letter to send out to medical examiners across the state. Number two, as Cristy already mentioned, the data dictionary for criteria pertaining to dead on arrival, we've adjusted those slightly which we think changing those criteria may have an impact on the outcomes especially for penetrating trauma patients and those who are in shock as it relates to defining what actually constitute -- constitutes a sign of life on arrival.

And related to that the third thing is that we as a group are going to look at with the changes in the data dictionary definitions related to D.O.A. look -- looking at if -- if incorporating those changes will impact the morbidity mortality of the shock patients in the TQIP report. So our group

will look at that moving forward as a project. And that's all I have.

CHAIRMAN BANK: I would just like to add if anybody wants to volunteer for any of the future presentations, we've had some really impressive innovative P.I. projects. You know, please e-mail me or Dr. Vella. I would be happy to give you some time to present in the future STACs of any of your P.I. projects. Any questions for Dr. Vella? Great. So we can move on to the Systems Committee. Dr. Simons.

DR. SIMON: Most of the -- the work of the systems committee has been already reviewed either by the state or by the registry subcommittee. The only thing that I wanted to add was that the systems committee along with the executive committee is going to be working on revising and updating a trauma center D designation process that Dr. Banks and I started several years ago actually. Right when we started a verification process we started a D designation process. So that's something else that the -- the systems committee will be looking at. But that's all I have to report.

DR. TAPERMAN: Just -- just -- it's

Taperman from New York. Just to -- to add on to that. There was a -- a discussion at the systems committee and Director Greenberg was very helpful in elucidating not so much a change in practice but a continuation of a former practice which was to have more involvement of the state Department of Health representatives doing the verification visits.

You know, I would just say in general, if -- if you look at the long history of -- of what the state and the STAC have accomplished for the New York State trauma system, it's nothing less than miraculous in terms of the improvement of care and the -- the systems overall. So that's the background of this. So the -- the -- the change or the evolution is that each of the state representatives is going to be more engaged, more involved in the actual visits. Or there would be an apparent more involvement in the actual visits.

So one of the discussions, and I don't think Director Greenberg disagreed, was a suggestion that in order for those representatives to participate in the most meaningful way that they should receive the same kinds of training that we all go to which would be the -- the topic course and the

optimal course, right. So an understanding of how to run the trauma center, an understanding of how to do the P.I. work because the P.I. work is kind of complicated.

And the Grey Book itself is complicated. And I think that that if the -- if the goal is to optimize trauma care and to identify issues and problems that the reviewers may not have identified. I think the state's representatives stand the best chance of being effective if they had that level of training. And the second part that was emphasized is the level of stress that occurs for the program manager, in particular, program director and also for the trauma medical director during those verifications.

It is, you know, the buck stops with the T.M.D. and a T.P.M. and the program directors, absolutely, right. So everybody else gets to sidestep it but if there is a C.D. that comes right down on the -- on those folks head. And I would also -- it's not so much a caution but just, you know, I'm going to use a metaphor here. What's the name of that game where you have, you know, you have the stick and you have to go underneath it and if you hit

it --.

UNIDENTIFIED SPEAKER: Limbo.

MR TAPERMAN: Limbo, right. Limbo, thanks for that. So in my mind a little bit this is much more the college than it is -- much more the college than it is the state. The college keeps taking that stick and making it lower and lower and lower. And at some point none of us are going to be able to thin ourselves out, especially me, to get underneath that stick.

And it is a caution, right, so we have five failures, right. And I wonder one thing we haven't talked about, Ryan, is -- is that happening all over the country? I mean, there -- that may be happening all over the country. And maybe they put that stick too low. So long story short, adding stress that might be unnecessary to the environment of that verification is something that I would caution us about.

Certainly if it's an important question, hasn't been asked, and it's a burning question for the D.O.H. you should ask the question. But if it could be asked in a gentler tone or another circumstance without adding stress to that already

crazy visit and pushing the stick off the -- off of the STAC, as it were, maybe not. So two things. The training and the limbo.

DIRECTOR GREENBERG: Anyone else picturing Dr. Taperman now doing the limbo? So thank you for bringing it up. So, you know, I think there's been some discussion and -- and I would like to express my gratitude and my team's gratitude on -- on people bringing forth, you know, when they have concerns or when things change, you know, kind of where those concerns are and -- and why they've happened. And do you know there's always, and I think as we look at it in any quality improvement, there's always opportunity for advancement or to do things better or differently or things that move forward.

Prior to COVID, myself and Kathy used to show up at many of these visits. And when you show up in person there's a little bit of a different environment, there's a different tone. I think there's even a different level of discussion that goes back and forth not only with myself and with Kathy or any of the trauma team but also with the reviewers who were there. And who can have that

conversation and talk through things.

When you move online I think even though we do a really good job of that in some cases, we also lose some of that and things change when they're, you know, are -- are things that happen online. When we were there before, we were part of that visit. And maybe, you know, maybe you heard us in some questions, maybe you didn't, maybe it was, you know, walking down the hallway or the different things that happened that our questioned were answered in those manners.

And now all of a sudden when we ask a question it's in front of an entire group because there's only an entire group when you're on camera. And so we have absolutely started to transition back to being more of these visits. We were never at a hundred percent of them before and I will say we probably won't be at a hundred percent of them in the future. But we absolutely are starting to attend and be at more of these visits.

And as we are there and -- and things have changed, you know, one of the big things that was, you know, came before us if we wanted to look at a chart there was a, you know, series of charts

there. We'd pull a chart and we have a look at it or look at an injury prevention program and there would be a book and everything else. Where now we need to request that ahead of time and that's very different. There's a different feeling, it's a different tone.

And so I think there's been some great feedback today and in the past couple of days related to that. I think even in the executive committee we spoke. And so the department's going to put out some additional communication about what that will look like in the future. We are looking to be that, you know -- you know, part of that process and to be in that collaborative approach. Obviously, we are regulators. We have a job to do from that side as well.

But to -- to put that understanding there so that there's not, you know, kind of like oh my God I was just asked for these documents or I just did this, and it's a change for someone or a concern to someone as if did something go wrong and they've asked this question ahead of time. That's not the goal of -- of any of this. I don't think that's a goal of a verification visit, a consultation visit or anything. But rather, you know, kind of what does

that process look like in the future.

So you -- you will see more of us. Like I said, we're excited to be able to grow staff. We will be putting out some additional communication so that everybody has an understanding of that and they can share it with their hospital when we do ask for something. And I think, you know, kind of get feedback on some of the additional training particularly as we're bringing on some new nurses. Some with, you know, very extensive trauma background. Some with some lesser trauma background that, you know, those courses will absolutely add a lot of benefit and be able to, you know, kind of, again, you know, look at things and add additional value to them, so thank you for that and look forward to providing you guys more.

CHAIRMAN BANK: Kartik.

DR. PRAHAKARAN: I want to echo Dr. Taperman's statement and the rationale behind it, but also to add a brief comment. Personally, I welcome anybody who can raise the bar of our trauma programs or any trauma program and that includes the Department of Health. And I can assure this committee that I firsthand, over the last few years,

have been witness to how the D.O.H. does raise the bar for individual trauma programs. And I remain very appreciative of the support and guidance that I personally and we in our health system has received from the D.O.H. So thank you again.

But to that extent I think when it comes to the participation in the verification or reverification process, I think this has to do with process. And Dr. Taperman spoke about training of people that are part of the process. But I would bring it back to how the process, you know, is designed and potentially conducted. Now, what I mean by that, is that the D.O.H. is always invited to be part of the reverification process or verification process, whether that's virtual or in person.

But the question is what is that participation meant to be. Is it meant to be as an observer, a supporter of the trauma center, an extra set of eyes, another reviewer because I think that, you know, when Dr. Taperman talks about stress level I would say that if we're trying to raise the bar of how a trauma program performs, the verification two day visit or reverification visit is too late. It should be before that.

So can there be D.O.H. support for preparation for a verification visit? I think many trauma centers potentially would welcome that if it doesn't create too much additional work in what already is a stressful process. But my worry is that if a trauma center staff is asked additional questions during a review process that the reviewers themselves and the American College of Surgeons didn't potentially think to ask, could it make that trauma center look inferior or flawed in the eyes of the V.R.C. And I think that's where we have to be really careful in what is said during those visits.

DIRECTOR GREENBERG: So I understand and appreciate where you're coming from. And -- and, like I said, you know, when it comes to that collaboration and I think, you know, one of your hospitals is, you know, we've been a part of that in the recent future in -- in sorry, the recent past. When it comes down to, you know, some of those questions and the verification visit and the American College of Surgeons and, you know, their, you know, kind of feedback on some of those things of -- of us being in the past I just want to echo this really isn't much of a change for us from where we were

prior to COVID.

I think there's a difference now post COVID and -- and being on screen and seeing that difference. But we were very much an active part of that verification visit, questions that were asked, different things along, you know, visits in the hallway. Like I said, you know, walking place to place. And I -- I don't see that being much different now. I think the feel of it is a little bit different because it's virtual and so there's a different kind of aspect to that.

And I think that's an adjustment and -- and I will tell you, you know, myself. And we will go back and we'll take a look at that because the -- the goal is not to add more stress. The goal is to, you know, strengthen the trauma system as a whole. The goal is to work collaboratively including, you know, what the recommendations of the STAC and, you know, good data coming back and forth like from DMAR and adding value to these that, you know, can show kind of why in some cases it's so critical to add a trauma center to a particular area. And the value that that brings.

And so, you know, those are some of

the goals that are there. But I think you bring up some excellent points and some of those that should -- should also be looked at with us so that everybody, you know, is -- is assessed and treated in a -- in a fair way based on the standards that are out there. And based on a process that's been used for now for many, many years. Little bit of a gap or a little bit of a difference maybe during COVID but, you know, prior to COVID and now being post COVID. Oh, that's exciting to say. Primarily post COVID.

CHAIRMAN BANK: Any further discussions for systems committee? Okay. Thank you, Dr. Simon. Pediatric Trauma, Dr. Wallenstein.

DR. WALLENSTEIN: Hi, good afternoon. Kim Wallenstein with the -- the pediatric subcommittee. So we have no motions for the committee but we did talk about several different topics. One of the keys ones was pediatric readiness. We all know that there is the Always Ready for Children Program which is being pushed out to the states. There is a working group that I'm a part of that is trying to roll that out so that more centers are -- are part of it.

Right now there are nine centers in

the entire state that are signed up. It's up to date on their website but certainly there are more out there that would benefit from being part of that program. So we discussed a little bit about regional ways to approach that. We also mentioned the not necessity but it would be nice if we had a way to know who the PECs were, the -- the emergency care coordinators for the different hospitals in the state.

And there really is no requirement that anybody or any hospital lets the department know that. And that would require a lot of regulation and oversight and that just doesn't exist right now. But that may be an ask in the future. Highlighting the importance of pediatric readiness, we looked at the data on regional transfers to our hospitals for patients that are activated traumas that come in to our hospitals from outside.

And as we thought, most of those are from non-verified trauma centers or non-verified hospitals which means that they're not being captured by the A.C.S. verification process which requires you to have a pediatric coordinator to go through all of the pediatric readiness information. So obviously

those hospitals don't have to do that and therefore they are not required to be pediatric ready.

We also talked about our TQIP data. We had noticed that on our one previous -- previous to this current one that came out we were high outliers in mortality -- T.B.I. mortality for the fifteen to eighteen year olds. We looked first at the data of who takes care of that population amongst our trauma centers and it really does vary because of the age group of fifteen to eighteen is higher than the A.C.S. definition of pediatric which is fourteen and under.

However, we looked at these data because we were such high outliers. It didn't make a lot of sense because our individual centers we seemed fine. We're about the ratio of one. But when you put all the centers together we were very high outliers, around two point three. And we queried TQIP and they told us that it did make statistical sense because when you group people together it's different than if people are separate because of the numbers being very low.

In any case, those numbers have improved so we're just going to keep an eye on that.

And we are going to look into our hospital events for the E.R. children age zero to fourteen. We did a bit of TQIP data. The only other thing is Dr. Wakeman presented a new potential Q.I. project for the state looking at our radiology imaging guidelines and trying to reduce radiation for children, and looking at our adherence to our individual imaging guidelines which is a great new project that we're just going to be starting if anybody is interested in helping us out with that. You can e-mail either me or Dr. Wakeman. And that's all.

DR. TAPERMAN: Just -- it's Taperman, New York. I -- I'm trying to remember, you know, COVID gets in the way. So the pediatric readiness program, is it for non-pediatric trauma centers? I'm -- I'm googling it but I'm confused.

DR. WALLENSTEIN: It is for everybody.

DR. TAPERMAN: It's for everybody because I'm noticing that the pediatric ready -- on the website they're mostly pediatric -- mostly pediatric trauma centers.

DR. WALLENSTEIN: And -- and that's, yes, and that is a problem --

DR. TAPERMAN: Yeah.

DR. WALLENSTEIN: -- because I think that every center needs to be on that site because there's all different levels and Amy Eisenhauer, can -- it's her baby. She can speak to it a lot better than I can. But it's from just people who are interested in learning what it is, and you can sign up as a -- as a program that -- because you've looked at that questionnaire to fill out and you're interested in being pediatric ready all the way up to pediatric innovators who are more (unintelligible) with it like the pediatric trauma centers. It's not really meant to just be pediatric trauma centers because those are captured by the A.C.S.

MS. EISENHAUER: Amy Eisenhauer. So, yeah, to speak to that the northeast region of E.M.S. for children program manager's work together on this and that was one of the key things of deciding to have three different levels so -- so that everybody could be involved. So there is kind of an entry level where no matter your assessment score or where you're at currently with your pediatric readiness, you can still be a part of it. Then there's kind of pediatric ready which is the median which is a score of seventy or above on the survey and then the

innovator is eighty or above.

And we were talking in the meeting and, right, more centers have to join so that we could see further evidence. But happily a lot of the local hospitals are already eighty or above. Now is that that they joined and they're already doing those things and they said hey we're already doing this, we should be recognized? Or is it like a happy surprise?

CHAIRMAN BANK: Okay. Any other questions about pediatric readiness or Dr. Wallenstein? Okay. Thank you. Moving right along, Carrie Garcia for the New York State Chapter of the A.T.S. Is Carrie on there?

MS. GARCIA: Right here, yes. Hi, Carrie Garcia. We had a well-attended dinner meeting last night. There were no major updates from any of the committees other than I would say education. The New York State Division of A.T.S. along with the New York State C.O.T. will be hosting a virtual A.I.S. 15 course June 17th and 18th at a discounted rate to the members. The -- what we're looking for are members, A.T.S. members. It will be open to two participants for -- per facility as well as preference given to

the registrars.

There will also be an October class that was announced. We also had presentations by New York Presbyterian Queens who has been a previous recipient of grant funding from the A.T.S. and they share their (unintelligible) initiatives that they used the previous grant award money from.

The other thing that we did was a Getting to Know You as there are many new members of not only A.T.S. but also members that are within the facilities of New York. So we did Getting to Know You event with Sheldon Taperman leading everyone to getting to know you. That is all I have to report.

DR. TAPERMAN: Just -- just adding, I -- I think Carrie did a -- a wonderful job facilitating that getting to know you. And I -- I -- it was really one of the most enjoyable parts of STAC, no -- no offense Ryan and -- and Matt. But there's so many new faces. I mean, I -- I led the T.M.D. group and we just had some fun going around talking trauma trivia. And I think it was the same for the program managers and the registry folks and other folks. And I would encourage the A.T.S. to -- to do that at every STAC. I thought it was

wonderful, Carrie.

CHAIRMAN BANK: Any further questions for Carrie? Okay. Great. Moving right along, Dr. Doynow, the SEMSCO.

DR. DOYNOW: Okay. Yeah, SEMAC and SEMSCO met on 5/8. I'll be brief. We approved the New York City Rescue Task Force protocols. There was discussion and support for ground ambulances being able to give blood products. Hopefully that will move along similar to what currently air transport is able to do. Critical care technicians, which is an older provider certification is going to sunset within a couple of years.

There was a bridge program that those technicians can upgrade to paramedicine. So that's been going on for a number of years. And sixty-three critical care techs enrolled this year to upgrade to paramedicine. There was a discussion of first responders, mental health and what initiatives were out there. And we're currently awaiting state D.O.H. to let a STAC member to be a member of SEMAC. Dr. Dailey, you have anything to add to?

DR. DAILEY: I think the only thing I would add would be on that Senator Hinchey from

Hudson Valley as well as Assemblywoman Warner from the Saratoga area have been very, very key at helping us move the ground ambulance blood program forward. They were the key elements of the air blood program as well. So we've been finding some allies across public safety for that. And went and presented to the Emergency Nurses Association and they were enthusiastic supporters as well. So we're certainly hopeful that this continues to move forward for our patients. Thanks.

DR. DOYNOW: And that's the end of the report.

DR. TAPERMAN: Matt, if I may add. So I remember some spirited discussions in previous STACs about the -- the ground ambulances transfusing blood, you know, which we supported. And at that time I made a comment. I'm just going to repeat the comment that I think it would be favorable if at the time the blood transfusion was begun that the trauma center to which the patient is going is alerted to the fact that the blood is being transfused so that they can prepare their blood bank, prepare the operating room. Just a -- a heads up on it. It should be a relatively unusual event and I think it

would be helpful for the trauma center to know that ahead of time.

DR. DAILEY: I think, Dr. Taperman, that's a very reasonable thing to -- to talk about. And I think early notification within the trauma systems themselves is something that's been important. One thing that we've had extensive discussions about so far, and these will continue, is these are going to have to be regionalized programs.

They're not going to be every agency with an ambulance is going to suddenly start carrying blood when this does happen. This is going to be a very strictly regulated program with a significant amount of oversight. In order to achieve the success we've already seen in other parts of the country, we're going to have to make sure that -- that there's very tight, tight oversight on this. So absolutely.

DR. TAPERMAN: And we appreciate that. And I know my friend Doug Isaacs at F.D.N.Y. is very, very much looking forward to getting blood on his rigs, probably the rescue rigs I would guess. And he -- he knows my mind on this so I'm just repeating it out loud.

DIRECTOR GREENBERG: I think, you

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know, obviously ground is a little bit forthcoming. We're trying to get there and -- and definitely been dealing with some obstacles in getting there recently with Dr. Isaacs in trying to overcome some of them. Dr. Dailey, from an air medical point of view who is now fully engaged in carrying blood and administering blood, are you seeing that they're providing that pre-notification to your facility whether it be via Pulsara or (unintelligible), you know, a voice communication? Or is that something that you feel needs to be updated next year in the protocols to put a recommendation on those protocols to have that formally out there?

DR. DAILEY: No, from -- so, Ryan, I'll -- I'll turn it over to Kerrie Snyder as well for commentary from the Albany Med trauma program. But from my perspective our air partners are extremely good at pre-notification. Quite frankly, so are our ground providers. So I have very few concerns about making sure that that occurs.

MS. SNYDER: Yeah, so Kerrie Snyder, Dr. Edwards from Albany Med. We have not seen any issues with identification, early notification of that. Checked with our P.I. coordinators as well.

They're all looked at so, yeah, it's been good.

DIRECTOR GREENBERG: Terrific.

CHAIRMAN BANK: Okay. That's great. Any other questions about SEMSCO or SEMAC? Okay. Moving to Dr. Cooper for E.M.S. for Children.

DR. COOPER: Thank you, Mr. Chairman. The -- the E.M.S.C. Advisory Committee met earlier this month. And one of the first orders of business was to learn that our dear friend and partner, Amy Eisenhauer had received a very well deserved promotion. And she would not be continuing with the committee in a full time role but would continue to be involved sort of kind of overseeing the -- many of the aspects of the committee's work. But a search for a successor will begin as soon as the appropriate time, you know, occurs. And while we will miss Amy's incredible support, we'll also be happy for her support in a new -- in a new role.

The meeting itself focused on a few things about which you've already heard, particularly, always -- the Always Ready for Children Program. I will not repeat what's -- what's already been said by Kim Wallenstein that consumed a fair amount of time at our -- at our meeting. But there

were three other issues that I think are worth noting for this group.

The first is that the -- the Pediatric Agitation Group continues -- continues its good work. This was, as many of you are -- will recall, spread by the fact that -- that SEMAC put in place a new protocol change that, you know, focused on management of agitation in -- in all patients. But the -- in the pediatric world the -- the focus is really on, in a major way, on de-escalation rather than -- rather than on medication.

And so a work group was formed to make some recommendations to SEMAC which resulted in the formation of an -- of an educational work group to put together a special program, special education program on pediatric agitation with the assistance of individuals from the child psychiatry world who have been instrumental in helping us with that -- with that work.

Sharon Chimento (phonetic spelling) has been leading that -- that work group to put together scripts and so on for, you know, for three separate scenarios involving agitated children. It's -- it's worth noting for this group that, you know,

because many of our pediatric trauma patients, okay, either come to the hospital as a result of agitation or become agitated as a result of their injuries or what have you. And so the plan is to make this -- this training available as broadly as possible throughout the state once -- once it's ready. And our thanks to our colleagues at the fire department of the City of New York who are helping us with the video production and -- and so on.

Secondly, we were honored to have with us again Jennifer Goldman of the Department of Health, a child psychiatrist who is leading up the -- the program in terms of the crisis stabilization centers that are being stood up throughout New York State. Prior to her meeting with our group, there had not been, you know, a significant effort to -- to focus on the -- the behavioral health needs of children.

But with her involvement in our group she's now fully on board with that and pediatric agitation training is going to be included in all the training for the -- the crisis stabilization center staff. More to come on that as to the extent to which behaviorally, you know, challenged individuals

will be taken to crisis stabilization centers versus emergency departments. But, you know, that's -- that's, I think, a call that is going to be made a little bit further down the road.

And finally I just want to mention that Meghan Williams of LaGuardia -- formerly LaGuardia now Borough of Manhattan Community College together with her students in the paramedic program there have been leading an effort to try to, if you will, rectify the -- the differences between the length based resuscitation tapes that are in current use for determining weighted and drug and equipment -- drug doses and equipment sizes in children with other methods such as the hand heavy method that's out there and, you know, what's written in our protocols in terms of the, you know, the -- the weight based guidance that may -- that is already in place.

Suffice it to say that this is a very complicated issue because the -- although the differences are very minor between the -- all the various methods of calculating a weight and drug doses, you know, they are real and confusing. And at this point we're still in the process of trying to

determine, you know, how that will all play out. But kudos to Meghan and her students who've done such a great job in terms of helping us sort that out. That really touches on the key issues that were discussed at our recent meeting. I'll be happy to answer any questions that may arise at this point. Thank you, Mr. Chairman.

CHAIRMAN BANK: Any questions for Dr. Cooper? Okay. We'll move along. Any old business? So any new business?

DR. GESTRING: Dr. Bank?

CHAIRMAN BANK: Sorry, Mark.

DR. GESTRING: So just under new business. I -- I wanted to propose that the committee entertain the idea of adding a committee on trauma update to the standing agenda for this meeting. Committee on trauma is very active in the State of New York but it runs parallel almost to what STAC does. Less involved with regulatory stuff but more involved with education and can feed back TQIP information and verification information.

The C.O.T. is well represented in this room, and I think, you know -- you know, two, three, four minute update at each meeting regarding C.O.T.

activities in upstate and greater New York wouldn't be a bad idea. So I'd like the group to consider that.

CHAIRMAN BANK: So I think with the two chairs in the room like Kartik and Mike, any -- any comments from you guys of just giving a -- a update?

DR. PRAHAKARAN: I'd welcome it. I -- I think it's a great idea. I think that the mission on purpose of the C.O.T. runs in parallel to STAC with a lot of crossover in terms of activities and purpose. And there's probably a lot of room not only for updates but also for collaboration between the two entities given that everyone in this room is -- is really a member of both. But happy to -- to follow Dr. Gestring's suggestion. Dr. Vella?

DR. VELLA: No, I agree. I think that's a great suggestion.

CHAIRMAN BANK: Okay. So we'll work with C.O.T. leadership on seeing how we can get that on the agenda. Sort of new business. One new business from me. We have moved this meeting obviously from one thirty to one. I just ask everybody for any positive, negative comments about

maybe doing this in the future. Any comments. Was it a good idea, a bad idea? It kind of happened by accident.

DR. GESTRING: We should start it at twelve. That's a great idea.

CHAIRMAN BANK: And -- and it can be difficult like if some people are driving today in the morning here and from around the state it can be four or five hours to get here from Buffalo or something like that. So any other comments?

MS. SNYDER: Albany appreciates getting out early.

CHAIRMAN BANK: (unintelligible) if you're coming from the furthest away, correct? Is Buffalo the further part of the state?

UNIDENTIFIED SPEAKER: I believe it is, yes.

DIRECTOR GREENBERG: Do -- do we factor in Long Island traffic time?

CHAIRMAN BANK: Yeah, so -- so geographically I think it's about four hours. From a time wise it's probably my house definitely to get here. But any -- any comments because you're -- you're probably driving here in the morning

sometimes. Any comments of making it a little earlier?

UNIDENTIFIED SPEAKER: Travel the day before.

CHAIRMAN BANK: Okay. Oh, Kerrie did you --?

MS. SNYDER: No, I said Albany appreciates getting out early, so.

CHAIRMAN BANK: Okay. So you're all talking fine and dandy about maybe seeing on the agenda if we can start at one rather than one thirty. It's easy. I know the trains for people who come -- who take the train, the Amtrak it is easier getting out a little earlier and making the train. So announcements? Dan, the -- the announcement, the next STAC?

SECRETARY CLAYTON: So the next STAC meeting is tentatively scheduled for October 9th. That's a Wednesday, and we are currently looking at a hotel in Schenectady. So that will be new. One of the problems we've encountered just briefly is that the -- the fall tends to be a very busy time for conferences. And trying to find a facility that can host us in the -- the normal areas of the capital

district that we typically go to has been challenging.

And in you got to remember that we have a hundred and fifty plus people that we have to accommodate. And, you know, we also try to work with our A.T.S. partners for the dinner the night before too. So it's a -- that's -- that's what that's about.

DIRECTOR GREENBERG: And part of Schenectady, although we've never been there before, is to make Albany Med travel a little bit further and Buffalo travel a little bit less. Sorry, Long Island.

CHAIRMAN BANK: Any other new business? Okay. Any other comments about anything? Okay. So I make a motion for adjournment.

DR. GESTRING: Second.

CHAIRMAN BANK: Thank you very much.

(The meeting concluded at 2:25 p.m.)

5/29/2024 - STAC - Troy, New York

STATE OF NEW YORK

I, DANIELLE CHRISTIAN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 66, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 5th day of June, 2024.

DANIELLE CHRISTIAN, Reporter

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