10/30/2024 - STAC - Albany, New York

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: October 30, 2024

TIME: 1:33 p.m. to 3:01 p.m.

CHAIR: MATTHEW BANK

LOCATION: Marriott

189 Wolf Road

Albany, New York 12205

Reported by Monique Hines

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APPEARANCES:

ABENAMAR ARRILLAYA
AMY EISENHAUER
ARTHUR COOPER
CARRIE CARGIA
CHARLES FASANYA
CRISTY MEYER
DANIEL CLAYTON
DONALD DOYNOW
ERIC COHEN
FRANK MANZO

GEORGE AGRIANTONIS
GEORGE ANGUS

JAMES VOSSWINKEL
JEROME MORRISON
KARTIK PRAHHAKARAN
KATE MAGUIRE
KERRIE SNYDER
KIM WALLENSTEIN
KURT EDWARDS
MARK GESTRING
MATTHEW CONN
MEGHAN MULLEN
MICHAEL DAILEY

MICHAEL VELLA
ROBERT KERN

ROBERT WINCHELL
ROSEANNA GUZMAN-CURTIS

RYAN GREENBERG
SHELDON TEPERMAN
THOMAS BONFIGLIO
WILLIAM FLYNN, JR.

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(The meeting commenced at 1:33 p.m.)

MR. BANK: Okay. We're going to call these meeting -- we're going to call this meeting to order. And first we're going to do our attendance roll call.

MR. CLAYTON: Thank you, Dr. Bank. Dr. Bank?

MR. BANK: Here.

MR. CLAYTON: Dr. Wallenstein.

MS. WALLENSTEIN: Here.

MR. CLAYTON: Dr. Guzman-Curtis.

MS. CURTIS: Here.

MR. CLAYTON: Dr. Gestring.

MR. GESTRING: Here.

MR. CLAYTON: Frank Manzo.

MR. MANZO: Here.

MR. CLAYTON: Dr. Prabhakaran.

MR. PRABHAKARAN: Here.

MR. CLAYTON: Kate Maguire.

MS. MAGUIRE: Here.

MR. CLAYTON: Dr. Angus.

MR. BANK: I believe he was excused.

MR. CLAYTON: Dr. Reddy. Dr. Agriantonis.

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MR. AGRIANTONIS: Present.

MR. CLAYTON: Mr. Conn.

MR. CONN: Present.

MR. CLAYTON: Dr. Teperman.

MR. TEPERMAN: Present.

MR. CLAYTON: Kerrie Snyder.

MS. SNYDER: Here.

MR. CLAYTON: Dr. Edwards.

MR. EDWARDS: Here.

MR. CLAYTON: Dr. Arrillaga.

MR. ARRILLAGA: Present.

MR. CLAYTON: Dr. Vosswinkel.

MR. VOSSWINKEL: Here.

MR. CLAYTON: Dr. Flynn.

MR. FLYNN: I'm here.

MR. CLAYTON: Megan Mullen.

MS. MULLEN: Here.

MR. CLAYTON: Dr. Oman is excused.

Dr. Winchell.

MR. WINCHELL: Here.

MR. CLAYTON: Dr. Dailey.

MR. DAILEY: Here.

MR. CLAYTON: Dr. Doynow?

MR. DOYNOW: Here.

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MR. CLAYTON: Dr. Goldman. And Dr. Cooper.

MR. COOPER: Here.

MR. CLAYTON: We have more than what's necessary for quorum.

MR. BANK: Okay. Next order of business. The minutes from the previous STAC, which was May 29th, 2024, are posted on the website for anybody to review them, posted there for a number of weeks. Can I have a motion for acceptance of our previous minutes?

MR. AGRIANTONIS: Motion.

MR. BANK: Second?

MR. CONN: Second.

MR. BANK: Everybody in favor? Nineteen in favor. Anybody opposed? No. So motion will carry. Okay. So to go right into our reports. Director Ryan, anything to report?

MR. CLAYTON: Do you want to start with the election stuff first?

MR. BANK: Okay.

MR. CLAYTON: Before you can start --

MR. BANK: So we're going to go a little bit out of order. One of the things that we

want to just get done with quickly is that we have an opening for the Vice Chair of STAC. The voting members of STAC were e-mailed the three candidates names, and, you know, it was Dr. Gestring, Dr. Wallenstein, and Dr. Rubano. They were e-mailed --

MR. CLAYTON: E-mail is coming in now.

MR. BANK: They're -- they were e-mailed the names two days ago, and they were e-mailed also first of all, all three of these candidates are excellent. All three of them have very engaged in STAC. All three of them are very well known to the trauma community. There were -- everybody -- all the voting members were e-mailed two days ago. Just a brief paragraph, which was self-written by -- by all of them. So what we need to do, which is vote. The vote will be for our nomination for the vice chair of STAC that goes to the Healthcare Commissioner.

And the Health Care commissioner is the actual one who actually appoints the vice chair of STAC. So what this has to be is it only the voting members of STAC can vote, and only if you are physically present at this meeting. So what we are going to do is, Dan Clayton is going to send out an e-mail in the next few minutes to everybody saying,

what is your vote? And you can just reply to this vote. You could -- if you're one of those three doctors, please vote for the best candidate, vote for yourself.

If -- if you think you're the best candidate, then vote for yourself. If you don't, then don't vote for yourself. So you'll reply to that e-mail with -- with your vote. But again, because -- only the voting members of STAC, and only if you're physically present at this meeting, we just want to do that quickly so that by the end of this meeting, we'll have a tally of those votes and we can announce it.

MR. AGRIANTONIS: Just -- just want to -- do we have a Wi-Fi access for this room?

MR. CLAYTON: Yes. And the Wi-Fi password under Marriott Conference is Marriott with a capital M 2024.

MR. AGRIANTONIS: Okay. Thank you.

MR. VOSSWINKEL: If we don't have access to our e-mail, can we use another e-mail to e-mail you with? I -- I have a county e-mail on my phone. I don't have the state access.

MR. CLAYTON: Yes.

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MR. VOSSWINKEL: Okay.

MR. CLAYTON: Or if -- if there's -- yes, you can e-mail.

MR. VOSSWINKEL: So I will just e-mail you separately then.

MR. CLAYTON: Yes. Not a problem.

MR. VOSSWINKEL: Thank you.

MR. CLAYTON: So if somebody's going to be using an alternate e-mail address to send me, I'm going to provide my e-mail address right now, because obviously I don't have it if it's an alternate e-mail address. It's Daniel D-A-N-I-E-L, dot Clayton, C-L-A-Y-T-O-N @health.ny.gov. I'm going to be sending to all the vetted STAC members that are here present physically in the room today to the standard e-mail addresses that I normally send to. Please do not reply all. I'm putting that in big red letters. Do not reply all. Only reply to me. Thank you.

MR. BANK: Okay. Any other questions?

MS. MAGUIRE: Tell us when you hit send.

MR. BANK: It is coming. In the meantime --

MR. GREENBERG: Sorry. So for the Bureau report, I'm actually going to start -- Tom, do you want to start off on anything that you want to report out on? And then we'll go down the line. And then --

MR. BONFIGLIO: As everyone knows, we've got lots of surveys going on right now. We've had a lot of discussions this morning about the results of those surveys, and I would just encourage everyone to keep working hard as you are, obviously. And I look forward to being on all of your surveys. I'm learning a lot from every single hospital that I -- that I joined. So nothing -- no actual news on -- on that front.

MR. GREENBERG: All right. So just on Bureau Report, very high level, a lot going on at the Bureau, a lot of growth going on. You'll see a number of positions that were posted and some more that are coming down the pipe. So we're excited to -- to see the growth of that one. You'll see data and informatics just in collections of things, as well as with the STAC data, the trauma data from around the state. We're looking at reporting and our annual report and speeding up the process. So there's been

several meetings related to this with our data and informatics team, both internal to the Bureau as well as part of the Department of Health to figure out what we can do to speed up the process.

One of the biggest things that was voted on at the last meeting, we had meetings about, and I think registry's going to talk a little bit more about it, is the elimination of the SPARCS data related to our annual report. It will affect about probably two to four percent of our trauma data not being included in the report. However, it will speed up by hopefully many, many months, our ability to get the report out, the annual report out on a timely basis. And we felt like that should take priority over it. So we are going to move to that.

The SPARCS data will not be something that you'll be coming out to the trauma centers, as well as some other steps in the process. And again, we're going to put out some written communications on that as well coming up in the next couple of weeks, or probably by the end of the year, just that everybody's on the same page related to that.

For E.M.S. for children, I'm going to let them report out a little later. I want to thank

University of Rochester. We were out for vital signs at -- in -- just a couple weeks ago in Rochester, New York. It's the first time we've been there in seven years, and it -- we had an excellent opportunity there. We also had an excellent keynote on Sunday morning. So thank you Doc for being your keynote on Sunday morning. It was a really excellent opportunity to speak about trauma, but also to bring our upstate and downstate trauma community together in presentation of some case studies.

And then allowing E.M.S. providers to learn from those different case studies and experiences. So thank you to -- to both who participated or allowing that to -- to happen and come together. Our E.M.S. memorial was just in September. And then our next one will be in May. So we were a little bit off schedule because we have a new E.M.S. memorial. For those of you who haven't been to the Empire State Plaza this is -- we had our old memorial, which ran out of space on it, unfortunately. We had about a hundred and twenty-five names that were on it. We had no more space on it.

There's a new memorial that took about

two and a half years to design, make, and come to fruition. The new memorial can fit up to three-hundred names on it. Hopefully we never fill that. But it took us about twenty years. So the last memorial was created in 2004 and ran out of space in 2023. And the new memorial arrived in 2024. From our side in the -- the bureau and the regulatory side, and this really has a lot to do on the trauma side as well as we are starting to move a lot related to regulatory updates.

So, on the -- on the E.M.S. side, we had our first statutory update about three years ago now, or for the last three years, we had some statutory updates, which happened for the first time in twenty-five years. We had our first regulatory update for the first time in twenty years. The first regulatory update that went through was related to education, and it is the first of seven packets. Now you may turn and say, what does that have to do with us here in trauma? What it has to do is the understanding that, you know, regulations are designed, but they're not designed just to stay the way they are. And stagnant for a long period of time, that we need to be regularly looking at them in

order to keep them modern in order to, as a system improves and advances that sort of the regulations that apply to it.

So there were several committees today that we had meetings with that we spoke about different regulatory sets, better clarifications as some things. Regulations don't change overnight. They can take upwards of two to three years from the thought process of which ones need to be updated to actual implementation. And so I think we're going to start looking at that for a number of different items related to trauma now. And if anybody is interested in being a part of that, I think the chair is going to be talking a little bit about that later on and how you can participate in that.

Again, this is not something that's going to happen overnight. This is something that is two to three years down the road probably. But if we don't start talking about it now, two, three years from now, we're going to say, hey, this is even more outdated. And what do we need to do to -- to move forward?

Lastly, I'd like to talk just about what we're seeing in a number of the surveys coming

out. So as you know, the -- the standards have changed with the A.C.S. and that in New York State, the A.C.S. verifies trauma centers and then the Department of Health designates trauma centers. We are seeing across the board an increased number of deficiencies being identified in the verification visits. We're seeing an increased number of failures in different institutions across the state, not in one particular area. And so we just want to flag this for people. Again, the trauma community and each of you really do a phenomenal job of working to help one another.

We're seeing, obviously, more systems and systems are working together on things, but that you should be aware of, you know, what -- what's happening. If you know that your verification visits coming up, talk to some others who have gone through the process already, especially on the new standards and new about tools that are being evaluated with so that we're not seeing as many deficiencies as we are. So I think there's going to be more to come on that in the next, you know, six to twelve months from our side in the department. But just wanted to flag for everyone, and we are continuing to monitor it and

address issues as they arise. End of report.

MR. TEPERMAN: Question.

MR. GREENBERG: Yes, sir.

MR. TEPERMAN: Director, have you -- has the department formed a -- a gestalt as to why that may be? In other words, do you think it's a care issue? Is it the incredible complexity of the Gray book, which was supposed to be easier, which is not easier? So is it a paperwork thing or is it a care issue thing, do you think?

MR. GREENBERG: I think it's too early to tell at the moment. I think it's something that we're now starting to look at and -- and addressing internally to why this is happening. I think, I don't -- I don't want to say -- I guess I -- I -- the problem that's coming up is we're not seeing consistent patterns. We're not saying like, okay, everybody across the board is not doing well in this standard, or everybody across the board's here. So with it being as diverse in what people are getting sanctioned on, it's making it harder for us to identify is it a care issue? Is it the new standards issue? Is it something else?

We have not been able to identify a

pattern to date. So we are starting to look at that. We're talking to some other people. We've been in communications with the A.C.S. to -- from their side to find out, you know, are you seeing this nationally? Is this unique to New York? Or -- or things of that things. And I think, you know, in the next meeting or two at the next STAC, hopefully we'll have some more information for you. And the standards, you know, they really just recently change, and we're starting to see this with the new standards, more complexities and more deficiencies.

THE REPORTER: And I just need his name.

MR. GREENBERG: Whose name?

THE REPORTER: Doctor.

MR. TEPERMAN: Oh, Dr. Teperman here. Sorry.

THE REPORTER: Thank you.

MS. GUZMAN-CURTIS: I'm Roseanna Guzman from Upstate. I was at the C.O.T. meeting whenever that was last week. And I did jot down some notes of the most frequently cited standards in the visit. So I can list those off if that's of interest to the group. So most frequently cited was seven

point three, five point three one, seven point six, four point three one, five point three zero, six point two, four point three two, four point three three, five point two one, five point one seven, and five point two nine.

And I also thought that another thing that was of interest in the discussion was that they are looking at whether or not all type ones should be type ones and because of some of these patterns that they're seeing should be that -- should they be type twos and or what kind of combinations merit not verifying a trauma center. They didn't elaborate on it beyond that, but I did jot that down because they mentioned that they've done two hundred and thirty-five visits up to date under the new standards.

MS. TEPERMAN: It might be helpful, Dan, if we could take those numbers, translate them into what the actual C.D. is, and maybe put them out to all of us and we can look at them.

MR. PRABHAKARAN: I -- I agree. Kartik Prabhakaran and Hudson Valley RTAC. And I would actually suggest that just like the national C.O.T.V.R.C. put together that data, which they shared in San Francisco, it may be helpful for us to

put together our own data for the State of New York with respect to all of the visits. And frequently cited, doesn't have to be level one, any opportunities for improvement or deficiencies, because we probably could learn from each other.

MR. BANK: So -- Matt Bank. So what would the -- for the people in this room, would do you be open to that? I mean, that -- that requires a lot of trust, and this would be anonymous. But your centers would -- we -- we'd find somebody who would anonymize it and they would send out their deficiencies or their weaknesses, and then we could -- at this meeting, we could list it that in -- in the State of New York the most common weakness was X, Y, and Z. And the most common deficiency was X, Y, and Z. Do we feel that there'll be value in that?

MR. BONFIGLIO: Dr. Bank, I have all the information and would be -- if it's your pleasure, if it's the -- the committee's pleasure, I'm happy to compile all the areas of deficiency at over all of the centers that have been -- have had a visit in the past twenty-four months, or if you tell me what the -- what the timeframe was since the new standards were put into effect, I can -- I can

summarize what -- what standards have had challenges and -- and where other things have come up as well.

MR. BANK: I -- I think that if that would be helpful. Mark.

MR. GESTRING: I -- I would say deficiencies would be very helpful. Weakness is less helpful. Because weakness list is a wish list. And it could be very long, but deficiencies are absolute.

MR. BONFIGLIO: I'm -- I'm happy to compile that. I can keep a running tally of deficiencies and break it out by -- I -- I want to keep it anonymous, certainly, so that we maintain privacy between centers. But as things progress, we could start to break them out and say, well, this is most prevalent in a level three or a level one, or whatever. But for now, I can just put together the most common deficiencies or all the deficiencies detected in -- in all the -- the visits. And you can -- you can do with it what you see fit.

MR. TEPERMAN: Ryan, you know, there was one other thought. And you know, I -- I think I asked Dr. Winchell this once, I'm not sure if I did. When Mike Rotondo (phonetic) first came here in 2010 or '11, there was a wink and a nod that they were

going to sort of just put us into the shallow end of the pool and would take it easy on, you know, really coming down on trauma centers. And there was this notion that as our trauma centers became more mature, they would become more strict. I think Dr. Winchell might be the -- the most knowledgeable in the room about the -- about whether that's possible putting on the spot there.

MR. WINCHELL: Yeah, we got it. So I think that's a -- that paraphrases perhaps a different -- the V.R.C. process has changed substantially, both with the new standards, which are far more concrete and less subjective than they used to be. The advantage and the disadvantage of the old system was as the reviewer, it was kind of up to me to decide how this looked and if it looked okay. And there's no question that as we sequentially went to hospitals with maturity, we would expect to see a higher level of achievement in -- in that subjective realm. And -- and I think that probably paraphrasing what Dr. Rotondo was meaning.

It's harder to do that in the new world order, which is very black and white. Yes, no, on a bunch of much more granular things, which was

done with the specific intent of taking out the subjectivity. Unfortunately, it has taken out the subjectivity. And -- and I think that also -- that just, there's a slightly different approach in the way the current V.R.C. is operating, and there's a much larger group of people involved in the post review evaluations. It used to be one or two people signing off of them, and now it's a bigger group who I think have a more activist view. And I think those two things are probably at -- at the heart of it.

MR. BONFIGLIO: Thank you.

MR. BANK: Could you step up to the table please, sir? Use a microphone and introduce yourself.

MR. FASANYA: Yes. I'm Charles Fasanya. I'm the Trauma Medical Director at Good Sam University Hospital at Level one.

MR. BANK: You got to come into the microphone.

THE REPORTER: Yes. Move closer.

MR. BANK: Stand up, hold the microphone, move closer.

MR. FASANYA: My name is Charles Fasanya. I'm the trauma Medical Director at Good Sam

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University Hospital, a level one adult and PEDS level two on Suffolk County. I just wanted to mention that some of the changes in the Gray book, just as we're seeing it, are very resource dependent. For instance, just on PEDS, the child abuse physician specialist, if you look at mental health screening or geriatrics, the IR time, just some of these standards have changed from the Orange book where they're quite difficult to achieve and need a lot of resources. So I don't think it's just a matter of necessarily quality, how you define quality, but a matter of resource, it's all about resources and the academic tertiary centers generally have more resources than the community or hospitals. That's what we're seeing anyway.

MR. GREENBERG: Thank you. And I think it is -- you know, it's feedback and comments like that, that it's important to be sharing and identifying, and then also from an advisory group, you know, not only obviously advising, you know, our program within the department, but the commissioner health, and then, you know, making any recommendations or feedback to the American College of Surgeons. So --

MR. BANK: Yeah. Just to -- to dovetail on that, if you think about that list that our colleague from upstate, I'm sorry, I don't -- I don't remember your name, but if you think about that list, so what you described there was two hundred and twenty visits and you read off maybe fifty C.D.s. This may not be a New York centric problem. This may be a -- a Gray book, V.R.C. national problem.

MR. GREENBERG: From the discussions I've had, I don't think it is New York centric. And, and I will also say from the regulator, you know, side of things, we don't expect everything to be perfect every time. I don't think anybody in this room probably does. Medicine is not perfect. You know, things are not perfect every time. And having a verification process where everybody doesn't always pass everything is probably validation to a process as well. Because if everybody did, then there probably isn't a validation in a process, but it is just a notable difference of late than what it was before.

MR. VOSSWINKEL: Can I make a -- a request or a suggestion? If you look at the deficiencies, a -- a lot of them are resource, for

instance, attendance at multidisciplinary committee meetings, registry course completions, alcohol screening. These are the most common things. My concern is that institutes have not given enough resources to the trauma center, your trauma center, everything's functioning well. And then, oh my God, we have our verification. Would it be beneficial? And could we send a letter to all the trauma centers in the state? Just reminding them how important it's to maintain your verification and make sure resources go to the place.

You know, I'm also a reviewer and lots of times we see that the year pops up and they weren't given the resources. They didn't have the registry, they weren't doing the screening. So I don't know how much it's really on the people in this room who are working really hard. It's to make sure the institutes didn't stay engaged in the verification process.

MS. SNYDER: I -- I just want to make comment. So I looked up all these standards, and you're right, a lot of it is resources, but it's not just trauma, right? We have forty-five hundred patients in our registry trying to get every single

one of them. Audit C screening and intervention are here. So Audit C are nurses screen. So trying to get, all -- our nurses have a one two six ratio right now on the floors, right? And that's no call-ins and everything is on a good day. Obviously they're not screening in the I.C.U. nor should be. It's not the appropriate time to be screening.

And then you've got Audit C intervention. So who here does not have enough social workers or who is doing your interventions, right? There's a lot of things that are dedicated to that. The other one's registry, we go back to the certification. How many trauma programs here have a brand new registrar that is struggling to pass an exam that they have absolutely no business even taking in the first year or so that they're working there? That to me is an unrealistic expectation.

Response times for neurosurgery and orthopedic, thirty minute response times. Mental health screening. Again, it goes back to screening. Who is doing your screening? It's not necessarily trauma programs out there doing it, right? And depending on how many patients you are, maybe you -- maybe you do, but when you have big programs with a

lot of patients trying to screen, we exclude ground level falls for our mental health screening, it's still a lot of patients that need to be screened. And then again, you have to set them up for a referral. I think the peer review attendance was one.

I think one is seven point three, and Dr. Avery mentioned that last year at T-Quip, the effectiveness of your interventions, you can't just close a loop anymore saying that we provided education to so and so, doctor for under triage. Every single loop -- every single loop requires you to go back and make sure that that problem was fixed. And it doesn't say just the big issues, right? It is part of loop closure. So if you have little loops things that you think it's probably a one-off somebody under triage, somebody, those are -- they're all going to require somebody to circle back.

THE REPORTER: And your name is?

MS. SNYDER: And I think there's a lot of work. Sorry, Kerrie Snyder from Albany Med.

MR. TEPERMAN: All right. Teperman again. Director Greenberg, I -- just to follow on to what -- what Dr. Vosswinkel said. There's an element

of preaching to the choir in this room, right? We're all trauma professionals and as you have dedicated our life to this work, so if a letter like that goes out first it doesn't come to us. It comes to our bosses.

MR. VOSSWINKEL: Absolutely. And that would going to be my point. Just, you know, unfortunately, I think institutes realize a little bit too late and a nice reminder from the Department of Health, whatever this is, listen, your trauma center, we hope you stay current. We hope you put the resources and support your people. Any way to paraphrase that because it's really being prepared before you go into the year, then scrambling once the year falls on top of you.

MR. TEPERMAN: Yeah. And the department is concerned that things are slipping.

MR. GREENBERG: I definitely think there's an opportunity. And I also -- you know, this is the point of meetings like this is to discuss that, you know, so if it is six months before verification or a letter that's sent, you know, from myself or from the department that goes to your C.E.O.s, and we regularly communicate with the

C.E.O.s of institutions to say, your verification is up within the next -- you know, or should be scheduling within the next twelve months. There's an expectation that your program is, you know, meeting the -- you know, meeting the standards that are set, so on and so forth.

The -- the one thing I will say, and I think we can work on that one, it's a great idea. But Kerrie to -- you know, the point of the standards and things is that these are the standards that -- that everybody in this room agreed to say, yes, this is what we want to uphold. This is what we think we should go by. This is what the trauma community has set as standards. There's a reason that New York State doesn't have its own independent standards and something else. And so these didn't just come out of nowhere.

We know what they are, you know, they need -- some of them are challenging to meet and that's understand, you know, understandable and maybe even need modification. And that's a part of providing feedback to the bodies that set the standards that are there. But there's no real surprise in most of these standards when they go in,

there's no surprise of saying, I didn't know that standard seven point two point one point four, you know, was in there. And so this is what's there today and the importance of, of meeting those standards and able to respond to them.

MR. VOSSWINKEL: And one more comment and on a positive note you notice that the I.R. response for hemorrhage control isn't listed. So the college is looking at that to see if they can modify that from where it was. Can't say that officially. So all the other standards I fully agree with Mr. Greenberg, is that we should be doing it, but getting the hospital to maintain your resources, being a squeaky wheel always helps.

MR. GREENBERG: Maintain, and I would definitely also say replace when someone leaves for good reason or promotion or whatever else. That is one that we often see of -- takes more time than most would probably want to see. And often, you know, could lead to problems.

MR. TEPERMAN: Just -- just a little color on this. There -- there is an element, you know, so speaking -- speaking of as a systems person, there's -- there's a little element of C.D. fatigue

in the C-suite, which is to say that you know, our bosses have embraced this complex program of verification, but they have stroke and they have STEMI and they have -- they have a lot of mouths to feed, and the college is a little bit overdoing it perhaps. And they -- you know, so -- so many mouths to feed and only, you know, like my C.E.O. likes to say, you know, yes, we're the second largest city agency.

We have a big budget, but we have a lot of things to do. Everything is balanced. So I do think Voss's idea about saying to the C.E.O.s, look, we're seeing a pattern of -- of increased failures. You know, this -- this is partially a resource thing, we'd like you to help with this, but I see it from the C-suite point of view. I mean, every time I -- I go in there, they -- they like, oh my God, what's he going to ask for? Now, I don't go in so much anymore because I'm afraid.

MR. DAILEY: I think my -- my only comment here is that when we went from a New York state verification to the A.C.S., the goal was that we were adopting a national standard and it would be budget neutral, right? That -- that clearly has been

an epic fail and not true. When that budget -- when that budget concession to the C-suite is distinctly led -- led straight back to patient care and outcomes, it's easy, right? When on the other hand, it's, well, how did you close that loop with that one individual paramedic who made that one decision at one point? And how are you going to document that?

Which then takes the time of the registrar, the P.I. folks, the E.M.S. folks and the agency that transported the patient in. Then what it is, is pedantic nonsense. We have to be really careful to make sure that in our communication back to the A.C.S., we remind them New York had a robust system to make sure that our trauma system was working prior to engaging the A.C.S. We would prefer to maintain something that is purely patient focused and easy to identify where the investments are being made for our patients, not just to generate more paper, like making sure we've got the minutes of every meeting attended by any of the people who are involved in the -- the trauma program.

MR. BANK: Well said, sir. Well said.

THE REPORTER: And your name?

MR. BANK: And having -- having been

on stack when we adopted, I think that the budget neutral was aimed at the D.O.H., but it was never supposed to be budget neutral to the hospital. And I personally went into my C.E.O. when this happened, and I'm sure every trauma medical director here had the same conversation. But I personally went to my C.E.O. and we went over the millions of dollars that would take, and they -- they wanted to do this, but it was budget neutral to the D.O.H. That's true. But it was -- it was -- I don't think we ever real -- we never thought there was going to be budget neutral to the individual hospitals.

MR. CLAYTON: For this stenographer, the gentleman just speaking was Dr. Dailey, Dr. Michael Dailey.

MR. BANK: But this is a very robust discussion.

MR. GREENBERG: And to the chair, I just want to thank you for the budget neutral for the department.

MR. BANK: Yeah.

MR. GREENBERG: Much appreciated.

MR. BANK: And how's that working out directly? Very robust discussion, but -- but just to

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move to the subcommittee reports, want you go a little bit of orders Eric Cohen, if you're the systems report.

MR. CLAYTON: Can -- can we -- Dr. Chair, may -- may I suggest first of all, I -- I want to apologize to Dr. Jerry Rubano because I aired on the dominations. It's Dr. Jerry Rubano, Dr. Gestring, and Dr. Wallenstein that are candidates for the vice chair position. Kartik Prabhakaran is not supposed to be on there. I apologize. That's my error. I am nullifying hereby as of fourteen o seven hours. I'm nullifying the first vote. I'm going to send another e-mail. Please respond to it. Reply just to me with your vote. The three candidates, again, are for vice chair would be Dr. Gestring, Dr. Wallenstein, and Dr. Jerry Rubano. Apologies to Dr. Rubano.

MS. SNYDER: Dan, Kerrie Snyder from Albany Med. I did not get the first e-mail. So --

MR. CLAYTON: Yes.

MS. SNYDER: -- if you could just double check your -- your list that you're sending it to.

MR. CLAYTON: Yes. And I do -- I do

have you on the e-mail if you want to come over and take a look, Kerrie, so I would --

MS. SNYDER: No, wait and see if I get it on my phone.

MR. CLAYTON: Okay.

MS. SNYDER: I e-mailed you separately, but if this --

MR. CLAYTON: I did see that.

MS. SNYDER: -- is being nullified I'm going to -- okay.

MR. CLAYTON: Yes. Please, everyone that is here physically present, that is a STAC voting vetted number please reply to the e-mail that I'm going to send you right now with the correct nominees. Thank you. Eric.

MR. BANK: Richard, if you are -- if you do not get the e-mail and you are STAC voting member who's physically present right now, you don't get the e-mail, you can still e-mail Dan with one of the names, Dr. Wallenstein, Dr. Gestring, Dr. Rubano and -- for your vote. And Kartik is a great guy, but he's not running for the vice chair -- he's not running for vice chair position, so if you vote for him, we will not count it.

MR. CLAYTON: Okay.

MR. BANK: So now we are going to go to Eric Cohen for the systems subcommittee report.

MR. COHEN: Yes. Acting chair for Ron Simon, the chair of the committee. We met today, we had a couple of robust discussions. The first one revolved around the letter regarding the A.I.S. upgrade to the American College of Surgeons from the T-Quip Collaborative. That letter was sent on behalf of the T-Quip Collaborative, received a reply with the A.C.S. with no official response other than they've received our letter. Additionally, we had asked the -- if this letter could be sent on behalf of the STAC previously, but because of the logistics involved in getting it approved, it was actually just approved the other day and will be signed today and also be going out. Letter will be going out on behalf of the STAC to the same context regarding all the issues with the A.I.S. upgrade.

Ongoing discussions regarding the four o five regulations, which are still moving through the legislative process and is currently sitting in chambers for the next stage of approval, which will be followed by a period for public comment and then

further removal through the legislative process. As we discussed briefly before, and Cristy will probably also touch on in the registry committee, we discussed the impacts of the SPARCS data to the New York State Trauma Registry Report.

The SPARCS additions to New York State Trauma Registry Report hover around four percent after they're sent back and would not -- the decision was it would not drastically impact of the statistical significance. So it was moving forward, it was decided that the SPARCS data will not be used in the New York State Trauma Registry in an effort to decrease the turnaround times for that report. We discussed the process of -- of de designating trauma centers that failed the verification process and what that looks like and what's involved with a trauma center wishing to change their level of verification, be it a level two to a level one, or a level one to a level two.

And the state advised us that they're still working out on these processes some of which are connected to the four o five, some of them are not. And they have advised us that they'll provide an update on their work at the January meeting. Two

new business items brought before the committee. One consisted of the Central New York RTAC has revised their bylaws, which by legislative process has to be brought forth as a motion by the systems committee to the STAC for approval.

But the bylaws were not received by everybody on the subcommittee. So the decision was made to table that for right now. And we will work -- the systems subcommittee will work with Mr. Clayton and Director Greenberg and the state to have an Ad hoc virtual meeting of the systems committee in the near future to address any concerns prior to -- so that we can discuss the bylaws and address any concerns prior to the January meeting where hopefully we can finalize the motion to approve.

And then last but not least, we announced the upcoming retirement plans for Dr. Simon, who is the current chair of this committee. So this committee is now going to be recruiting a new chair. This does not have to be a vetted stack member or a physician. So anybody with interest in chairing the system subcommittee, please reach out to Dr. Bank. And that is all I have.

MR. BANK: So just a -- a real quick

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comment on -- on Eric's report. Number one, we will send out the -- the central RTAC bylaws to all the voting members of STAC in -- in addition to going to the assistance committee. Because we do -- the assistance committee needs to do their motion, but it will come to the STAC in January. We will vote on it, and we just want to make absolutely sure that there's no issue of anybody saying they didn't have the opportunity to review it. So we will send out the RTAC new bylaws to all the voting members in STAC, or Dr. Guzman who's sitting right to my left is going to shoot me. Hopefully not.

MR. GREENBERG: You're in good hands in this room, I think.

MR. BANK: Okay. Yeah.

MS. GUZMAN-CURTIS: Not after I get done with it.

MR. BANK: Yeah.

MR. GREENBERG: Oh.

MR. BANK: There you go.

MR. GREENBERG: Just got cold in here.

MR. BANK: Yeah.

MR. CLAYTON: Move to strike that statement.

MR. GREENBERG: Yeah. Eric, just --

MS. GUZMAN-CURTIS: Yes, please.

MR. GREENBERG: -- one question. You said, do you plan on having an interim meeting at all in between a Webex or anything that --

MR. COHEN: We're -- we're going to work with the state to organize an ad hoc meeting once the --

MR. GREENBERG: Microphone. Okay. Sorry about that. Thank you.

MR. BANK: And just to repeat what Eric said we are working for a new chair of the system subcommittee. You do not need to be a physician. You do not need to be a voting member of STAC. We would -- you do need to be heavily engaged in STAC, a history of engagement in STAC, and we would prefer somebody who has knowledge and experience in trauma systems. And if you are any interest, please e-mail me. You could e-mail Dan, you could send it to me. Anything you want.

MR. DAILEY: Dr. Bank, if I may. Eric, if -- if you would and just for the record, I am -- it's Michael Dailey again, sorry. And I am not speaking as a voluntary chair applicant for the

committee. But I am suggesting to that committee when they review those bylaws. And to be honest with you, I don't think I've ever seen a set of RTAC bylaws before. But the thing that was most notable looking at those was that this RTAC is responsible for eighteen counties across New York that's actually spawning, or that's crossing multiple E.M.S. regions.

And what I didn't see noted anywhere in there was that there was required involvement from either the REMAC chair or anybody else representing the rank and file E.M.S. systems that, that RTAC is responsible for. So the one thing that I would ask for systems to do would be to make sure that there is very clearly delineated E.M.S. engagement and E.M.S. medical direction engagement in that RTAC as we have I suspect in a non-regulatory way at our RTAC. So --

MS. SNYDER: We do have bylaws, Kartik and I were actually talking about this morning. We're going to dig them out because we have used them before. We will dig them out and review them again.

MR. TEPERMAN: Teperman. So I -- I just want to -- Mr. Cohen this morning made I think an excellent comment about why we were pausing this process, which was it's an opportunity now. And he

used the word Guinea pig, but it's an opportunity to use this as a template for all of us to learn about what RTAC bylaws should look at. And when it comes time for us to revise our bylaws, we will have had lessons learned. I think that was your point, Matt.

MR. MORRISON: Jerry Morrison. And I'm the bylaws committee chair for the Central New York REMAC. Dr. Dailey, we do have Garland E.M.S. or E.M.S. coverage in the form of each REMAC. We have four REMACs within our central New York trauma region. Each one is represented on the RTAC. And we also have two physician representatives from Air Medical Services.

MR. TEPERMAN: And are those -- are those sort of a voluntary representation, or are they delineated in the bylaws?

MR. MORRISON: They're specifically delineated that there is a representative from each group.

MR. TEPERMAN: Great.

MR. BANK: Okay. I think Eric has left the building, so I think that's the end of his report, therefore so --

MR. CLAYTON: Even if it wasn't?

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MR. BANK: If it wasn't he has left the building, so he had to go on a train to see his daughter compete somewhere. So next will be the -- we're go back in order the executive committee. We've already discussed the increase in number of failures and deficiencies, which we also discussed at the executive committee. We discussed the voting for vice chair. I want to point out that the January meeting date is now out, it's going to be January 29th at the Troy Hilton Garden Inn. So we'll be back in Troy on January 29th. The dates for all the 2025 meetings will be very quickly. The next week -- well, or right now are up on our website, but our next date is going to be January 29th at the Troy Hilton Garden Inn.

Also at the stack in May, we had discussed here of updating the letter to the M.E. about autopsy reports. Governor, at the time, Governor Cuomo had signed the legislation specifically stating at the trauma centers, or I -- I should say, at the Quality Assurance Committee of any hospital where a patient died has a right to see the M.E. reports. That was over ten years ago now, and we had a -- at the last STAC we'd asked for updating

this letter. So that letter has been updated. By the end of the day, I will sign it and it will be up. We'll send it out through the listserv and it'll be up on the D.O.H. trauma systems website.

So it -- it's again, just stating very clearly the legislation that has been signed more than ten years ago. So I advise you if you are having concerns or issues by your medical examiner of sending reports because of HIPAA or any other regulatory roadblock, please go to the website. Download the -- download the letter. It is an official letter from STAC and from the D.O.H., and you can send that to the medical -- your medical examiner. And that is the end of the executive committee report. Any questions? Okay. Next is going to be registry. Cristy.

MS. MEYER: Hi. Good afternoon. So, Cristy Meyer from the Registry Committee. So there's been a good deal of discussion about A.I.S. 2015. That is the coding language that develops the injury severity score for our patients. And many of the registry vendors had notified earlier this year, trauma programs throughout the state, that they would not upgrade their product to meet the new submission

standards that will be effective from the National Trauma Data Bank in January 2025. In lieu of this, many trauma centers have had to switch vendors or transition to new registry vendor software which resulted in an increased cost, a certain risk of non-compliance to meet those data collection and submission standards, and certainly the training associated with it.

As you heard earlier, a letter is being sent today as approved by STAC and the Department of Health Process, by end of business today to the American College of Surgeons to notify them of the significant hardship. In addition, we are joined by the New England Trauma Registry Collaborative, which is twenty-two hospitals across the New England region. Their registry team sent a similar letter in addition to the T-Quip letter. So we'll look forward to that, but certainly a pretty big lift for trauma centers and programs and the risk of data throughout the early part of 2025.

In addition, we had discussed the 2025 New York State Trauma Registry schema file which helps everyone make those submissions will be available in November of this year. That will

include the 2025 inclusion of the first pre-hospital care reports into the referring hospital centers here throughout New York. So to help centers that are receiving a lot of transfers get the P.C.R. from the first scene E.M.S. agency. So that hopefully will be moving forward for a January, 2025 launch.

In addition, you also heard the update from systems that the SPARC reconciliation and exclusion submission process will no longer be required. But individual centers are encouraged to reach out to the STAC Department of Health designees, either Dan Clayton or Tom Bonfiglio, or myself or Mary Ives, co-chair of the Registry Committee to discuss further data support needs for your center. In addition to that, we'll be creating a project to develop end user validation reports so that centers across the state when they submit data to the New York State, will get some kind of output to understand their data quality and the acceptance of records.

We did do a quite a little bit of a review of the 2025 national trauma data bank fields and validation processes that'll be changing as of January. And we had a brief discussion about

pediatric field any kind of data fields that might be required in the state, and we referred that back to the pediatric committee. And please accept this report is submitted. Any questions?

MR. BANK: Any questions for Cristy? Okay. Very well. We'll move to Trauma Center Needs Assessment, Dr. Winchell.

MR. WINCHELL: Right. Thanks very much. Robert Winchell. With respect to the primary function of the needs assessment subcommittee, we had over the series of the past few months reviewed an application by Long Island Community Hospital to increase their designation level from three to two. And going through the process that we had recently established, again, over the past eighteen months, had reached a conclusion that we think the STAC should recommend to the Department of Health that they support this.

Interestingly enough, the two processes are kind of going in parallel anyway, but the committee would request that we, we put forward a motion to recommend to the Department of Health that Long Island Community Hospital be approved as a provisional level two center.

MR. BANK: So we have a motion as stated by Dr. Winchell. Everybody who votes yes, please raise your hand. Okay. So we have eighteen yes. Any noes? We have no noes, no one abstaining. So the motion will carry.

MR. WINCHELL: And then as some feedback from the setter and from others involved in the process, we were apprised of the fact that the description of our needs assessment process on the website was perhaps not as clear as it should be, and we're working on making improvements so that the approach, which is any prospective center looking for a new designation or change upgrade in an existing designation would put out a letter of intent to the Department of Health, would then go through the needs assessment program, would then submit their application and all of the pieces that go into that.

And there was some concern the way the wording went, that people might be putting the cart before the horse. So that'll be showing up on the website soon, by way of clarification, not really a change in the process. And then we had some additional discussion on sort of the future directions of where we go with -- with new centers

with needs assessment. And I think that probably concludes the report for the moment.

MR. TEPERMAN: May I? Just a thought. Did you have something?

MR. BANK: Any questions for Dr. Winchell?

MR. TEPERMAN: More of a comment, Teperman. There -- there was a conversation this morning in systems and I'm just going to paraphrase a little bit that I think -- well, I think Director Greenberg was hoping that this body would -- would give the department some help in the crafting of new regulations, which would be -- I don't know, would give more authority or more direction to the Department of Health in -- in the needs assessment arena. And I -- Ryan, I don't -- I don't want to speak for you, but my sense was you -- a lot of this is, is coming from policy and it would be cleaner or better for this to be perhaps written into regulation. So what I'm suggesting here is you know, this is a pretty sophisticated system that Dr. Barry and Dr. Winchell have put together. And that perhaps in regulation that the idea that that STAC will make recommendations to the department, which of course

you can take or not take, but via the needs assessment, something like that. I don't know if that's what we're looking for in terms of regulatory help.

MR. GREENBERG: So I think it's just a -- from a regulatory point of view, it's the situation of sometimes the trauma needs assessment may come back with something that isn't favorable to do. And currently today, there's not a process to approve or not approve something based on something that may not be a need. So it's not necessarily that the department, you know, need to -- you know, specifically wants to have more regulations or things of that. But if there's an expectation from this body that there is times when we may not approve something, or we may approve them at a lower level, or we may do something else, that those should be codified in regulation so that it's fair and consistent across the board and has knowledge on what it is.

And there was some discussion within the committee about, well, you know, is there additional authority needed or things of that nature from -- from this group? And I don't believe there

is, I think this group would still work in the same format. They would make a recommendation, but the department would use some of the additional regulation to whatever that pathway is in that process to help kind of mold and guide the future of the trauma system based on what this council feels it should be.

MR. WINCHELL: And, yeah. Robert Winchell, again. If I could kind of expanding that a little bit, the -- in a broader scope, most systems, or may I could say maybe the best way to put it is the best practice for trauma system development would be a written trauma system plan that outlined our approach to regulatory support, to finances, to P.I., to the registry, to trauma center designation. And -- and that's a step that we never quite finished, it seems, as a state. And that perhaps, you know, the time may be appropriate for us to try and put together a global trauma system plan of which these individual components would be a sub-piece of how much regulatory or statutory support do we need for the Department of Health to be able to say no? What is the process for doing that? And all, you know, down the line to several things around, again, what

are the -- what's our direction and vision for the next five to ten years for the trauma system?

MR. BANK: Any other questions for Dr. Winchell? Okay. So we're going to move to injury prevention. Robert Kern.

MR. KERN: Rob Kern. Thanks. We have no motions for discussion. This afternoon -- this morning's presentation focused on a presentation from my co-chair Sloan about the Otago Exercise Program for potential integration and false prevention for programs throughout the state who wish to take that up. Discussion of National Injury Prevention Day, which is approaching on November 18th, 2024. And thanks to Safe Kids Worldwide and Mercedes-Benz, who donated and made up ten thousand new books along the Clifford, the Big Red Dog. Franchise about safety, and have donated several hundred books to us to distribute to libraries and -- and schools about taking walks and pedestrian safety and childcare seats, et cetera, et cetera. Thank you.

MR. BANK: Any questions for injury prevention? Okay. So we are going to move to performance improvement. I know my name is on the agenda, but my co-chair, Dr. Vella, is going to give

the report.

MR. VELLA: Hi. Thanks. Mike -- Michael Vella, University of Rochester. So we had a great lecture from Dr. Eric Sloan about massive transfusion, particularly whole blood which brought us to our -- our only motion. And are we going to pull this up, Mr. Clayton? Are we just going to --

MR. CLAYTON: Yeah. We -- we can put it up. Jeff, if we could put up the motion.

MR. VELLA: So the motion will be to allow us to send a survey out to all New York State designated trauma centers, assessing whole blood utilization, and we wanted to keep it somewhat simple, but collect some important data points. And so, as you can see, it would sort of ascertain what, what trauma level, if people would feel helpful -- if people would feel it would be helpful to separate -- combine adult and pediatric base on different levels. We could add an additional variable there.

And then the use of whole blood, which really gets at to, are you currently using, were you a past user, but want to start again, a past user, but not interested in starting again, a current -- not a current user, not interested in starting, not a

current user interested. And then three, four, and five would sort of get at the number of, if you are a user, the number of units that you're getting delivered each month, the number of units transfused, the number of units allowed to be transfused per patient per your protocol, and then the source of the whole blood.

And feel free to sort of edit that. I just sort of added some options there. So we felt like those were some interesting variables to start the conversation of what is the utilization of whole blood across the state.

MR. BANK: So any questions about this motion? It's basically a poll trying to assess the state of whole blood transfusion in New York. Okay. There's a motion. So I'm going to ask everybody who is voting yes just please raise your hand. So we have twenty yes. Any no? Any abstentions? So the motion carries, we will put this poll together and hopefully we'll be able to get some data back, maybe by the next STAC.

MR. VELLA: Yeah, the goal is what -- what -- in terms of putting this survey together how does that look? Is that something you want me to do

on a red cap?

MR. BANK: I think we -- I'll -- I'll work with Dan.

MR. CLAYTON: I think it's -- yes, you can work with me, but Peter Brody from our data informatics experience will also be critical to this --

MR. BANK: Okay.

MR. CLAYTON: -- survey. Thank you.

MR. VELLA: So then my hope would be to get this survey out. We need to try to figure out a way to make sure we only get one per center. We can sort of brainstorm that, and then it would be great to be able to have the data back and need to be able to put a couple of slides together, which will be due December 4th for the next meeting. So a little bit of a strict timeline, but if we could, shouldn't take too long, it would be great to be able to present this data.

And then the only thing we talked about, we presented some data from a couple of centers, from three centers looking at D.O.A. and looking at some potential opportunities for documentation as it relates to the previous T-Quip

report that showed a higher mortality for shock patients on the T-Quip collaborative. And one of the thoughts we had at the last STAC meeting was, could this be due to capturing of injury severity and documentation of patient vital signs which determine whether or not someone is truly a D.O.A. versus not? And so, at least two out of three centers, busy level one centers had anywhere between a twenty and forty percent per year since 2018.

Twenty to forty percent rate of needing to adjust patient charts for patients who should have been D.O.A. But were not documented that based on the vital signs. And so I think we're going to brainstorm some ways that we can create some strategies universally that can be used across the state to improve this. We have to do a little bit more behind the scenes there hopefully for the next meeting. And I think that's going to look like some sort of a flow diagram to help people understand the various definitions and maybe some pointers on how to ensure that patients are -- that -- that institutions are validating their data in these domains. That's all I have.

MR. BANK: Any questions for Dr.

Vella? Mark?

MR. GESTRING: It -- it is less of a question, maybe more of a question for -- for Dr. Dailey. So this morning we had a lecturer from Dr. Sam Aldi about blood and it -- the issue of pre-hospital blood came up and we were informed basically what he said was that the legislative part is done and now the E.M.S. portion's being done in terms of -- the E.M.S. legislative part in terms -- or regulatory part in -- in terms of getting blood on ambulance, on ground ambulances. And I was wondering if she could just update us on where that stands or unless you were planning to do that during your report later, I think it's super important for us to hear about that.

MR. DAILEY: No, thank you. And I'll defer to Dr. Doynow now as well here. But we've started a tag with Doug Isaacs from the Fire Department of New York serving as one of the lead folks on that to discuss how the current aired medical regs that have been worked on really collaboratively with the department will then apply to ground ambulances and how we can then from there develop some best practices so we're not reinventing

the wheel and oversupplying this rare resource.

MR. TEPERMAN: Just -- thank you for that Dr. Dailey. Just repeating some of my previous comments in -- in this body that we hope, or I hope that as you roll out those regulations in particular for the ground ambulance, you include the possibility of notifying the trauma center. Not asking -- not asking permission, not asking their opinion, but just notifying the -- the trauma center that that transfusion is in process. Because as you know Doug Isaac's his thinking is he's going to put it on the rescue rigs, which would mean a trap job, which mean -- which would mean that you'd know about it a long period of time, ahead of time. And those cases tend to be very resource intensive for the trauma center as you know, it's crush jobs or, you know, it's myoglobin, it's -- it's blood, it's the O.R. So it would be useful for the trauma center to know that such a patient an hour from now is coming.

MR. DAILEY: I agree.

MR. DOYNOW: Dr. Doynow. We don't expect there to be blood on every ground ambulance. And it's a limited resource. We're trying to look to see how we're going to distribute blood products to

appropriate ambulances. Makes no sense if you're ten minutes from a trauma center to be starting blood, it does make sense if you're an hour away. So start at that.

MR. BANK: Dr. Cooper.

MR. COOPER: I -- thank you Arthur Cooper, New York. I just wanted to point out, for those of you who don't know, is that Dr. Vella had a huge hand in getting this legislation passed. And we should all -- we owe him on all the partners who worked on this big gratitude. Thank you.

MR. GREENBERG: Just -- just also to understand too, so the blood regs or should I say the blood statute was passed for pre-hospital, I think two years ago now, just for Air Medical. Last year it was updated to take out the word air medical, and now it's just ambulance. Which our air medical programs are considered an ambulance as well. And the regulations that are going to align with the statute are forthcoming. And so they'll be coming up in the pipeline too. And so when you talk about number of agencies that would participate in this, it does start to limit down a bit when they will see the regulations and the work that is behind it to be able

to store and administer blood as well.

MR. TEPERMAN: Dr. Chair. Just moving backwards to -- to Dr. Vella's presentation on the survey. I'm just wondering if it -- if it can be done in such a fashion that it's available for -- for publication research down the road. I'm just thinking out loud, you know, with my center -- my system hat on, something like the green -- the Green Book open, right? It would be very interesting to hear from New York State about what the status is of our trauma centers in terms of whole blood. And I'm also asking you know, because it's a department function, is it possible to publish such a thing or is it against the rules?

MR. BANK: I don't think it's against the rules. I think that it would be excellent. I think that understanding where we are in New York State is the first step. The second step would be to understand if whole blood would be helpful to our -- our patients. That -- that would be our second step. And then the third step would be putting whatever best practice we decide. If we do decide that whole blood would be helpful to our patients, then I -- I think it would be great for us to write about and

probably have a poll while we're implementing it, and then after implementing it, of -- of showing that a -- a, A.P.I. project can actually happen at an entire state level.

There aren't many publications like that I, I don't think off the top of my head. But, but you know, we -- we would have to see. But I definitely think that the first step would get this poll done. And then -- and then another poll later on as we implement this. Any other questions for Dr. Vella? And I think we're at Dr. Wallenstein for Pediatric Trauma.

MS. WALLENSTEIN: Thank you. Kim Wallenstein with the pediatric subcommittee. So we had a pretty good, robust discussion this morning. We covered three main topics. We have no motions to present to STAC. Our first topic included our T-Quip Collaborative and our results that seemed to be improving over time with nothing that we really did, but that's good. We did talk about ways to leverage the data, though in the future to help centers that may be having issues with certain metrics.

We had heard from different places across the country that what they do is they bring in

centers that may be, say, high outlier -- outliers or low outliers to give talks about what they've done to either improve their system or to keep their system as a high achiever. We had one presentation that sort of modeled this, and we're going to see if we can make that a standing agenda to have centers come and sort of teach us how to improve our -- our metrics and our data and our processes.

The second topic we talked about was the always ready for children pediatric readiness program. Amy Eisenhower updated us on that, and we heard, to our delight, that there are seventeen applications currently in process to add to the thirteen that are already on the site. So that's more than doubling what I had seen on the website recently, which is great. In looking at that, it looks like it's mostly the higher level centers, but I was happy to see that there are some more rural centers that are becoming involved with this process, usually that are satellites of the larger centers, which indicates that at least some places are doing some robust outreach to those centers to get them involved with pediatric readiness. And we'll continue to work with E.M.S.C. to enhance that and to

keep that up into make sure that all of the rural centers come on board.

Our third area was talking about a potential New York State Pediatric Trauma imaging project to look at not so much developing a guideline that everybody has to follow, because I think everybody knows how difficult that would be, but more to model some guidelines and to see if people are following their own internal guidelines in a way that improves their processes and improves patient -- patient care. And we're going to be continuing that work as well. And that's about it.

MR. BANK: Any questions for Dr. Wallenstein?

MR. TEPERMAN: Just -- hi, Dr. Wallenstein. Teperman again. That -- that last project that would be with an eye towards limiting excess radiation for kids?

MS. WALLENSTEIN: That is correct. Yeah. That is sort of the main goal. We're looking mainly because of that at C.T. scans, not so much plain X-rays. But there's a -- a big -- there's always been a big push, especially in smaller kids, to limit the amount of radiation.

MR. BANK: Any other questions for Dr. Wallenstein? Okay. So we're going to move forward with Carrie Garcia from the New York chapter A.T.S.

MS. GARCIA: Just checking. This is Carrie Garcia. We had a well-attended dinner meeting in which we had about eighty members attend. Updates were shared from each of the committees, as well as upcoming conference dates, educational opportunities, and the division financial standing. There was a motion to increase grant funding which was approved. So as of November 1st, grant funding applications for 2025 will be available. And as well as distinction awards will be available. Deadline for both applications will be December 13th. All are available through Basecamp.

There was a very robust presentation from Rob Curran about a project that New York's Presbyterian. While Cornell did with their grant funding that they received through the A.T.S., which started three years ago, they have a program called stem. I have to check my notes. Give me just a moment. Surgery Trauma Emergency Medicine. It's an exposure type of program that takes about twenty students per year and exposes them not only to the

impact of the -- of an injury or an incident, but as well as takes them through how it affects the patients, the facility, the providers.

I think -- personally, I think that this is a very well thought out, a really good program. I think there is a lot of potential, which is why I'm sharing it here so far. With the three years that they have done this, they've, they've impacted sixty-five students. They've been able to assist assisting, getting college credits for these students all through this program. So that is all I have.

MR. BANK: Any questions for Carrie? So moving right along for SEMAC. Dr. -- Dr. Donald.

MR. DOYNOW: Don Doynow. So a few things at SEMAC, steer medical guidelines for New York State Forest Rangers were passed. I have a copy if anybody wants to see that. New York City EMS had some minor changes to their protocols. IGEL Pilot Project has gone well basically has shown that B.L.S. providers can place IGELS for airway management without difficulty. Eventually that project will sunset, but not as of yet. We've already discussed ground-based blood products, which was discussed at

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SEMAC. We've had a number of new physicians who are vetted to SEMAC. We're awaiting D.O.H. to vet one of our STAC members to SEMAC. So we'll leave that up to Ryan. But I do appreciate those who've stepped up. I realize it's adding an extra four meetings to your calendar every year of those people who -- who did step up. Next SEMAC meeting is December 4th. It should be in Troy. And that's the end of my report. Does anybody have any questions, or, Mike, do you have anything to add?

MR. CLAYTON: And December 4th, incidentally, happens to be the day that I need to have materials from -- from STAC subcommittee, chairs for PowerPoint and agendas for the next meeting in January. So maybe we'll have physicians doing typing up at -- at SEMAC but --

MR. BANK: So I -- I think we have a couple names already, but just to -- to echo Donald Doynow, anybody who's interested in becoming the trauma representative from STAC to SEMAC, please, you know, send one of us an e-mail or Dan an e-mail. It has to be a physician that is actively involved in the treatment of trauma patients, correct?

MR. DOYNOW: That's correct. And it'd

be very useful resource for us at SEMAC.

MR. BANK: Have you gotten any names yet?

MR. DOYNOW: We do. Ryan has the names.

MR. BANK: Okay. Good. But just -- just to make sure that everybody has equal opportunity, please, you know, send us any more names you have. Okay. Any questions for -- about SEMAC? Okay. Then to work -- to move to Dr. Cooper E.M.S.C.

MR. COOPER: Thank you, Mr. Chairman. Arthur Cooper, New York, on behalf of the state E.M.S.C. Advisory Committee. We met in late September. The three main items discussed were follows. First, I want to announce that Dr. Elise of Rochester Pediatric critical care and hospital physician was selected for the Robert K. Canter leadership award based on his many, many years of service, really lifetime career service to -- emergency medical services for children. He received that award at the Vital Science Conference in Rochester a couple of weeks ago. So congratulations to Elise.

The two major business items discussed

had to do with the development of the pediatric agitation teaching materials, New York City bureau of training at the fire department graciously offered to provide its video capabilities to film some of these scenarios. The first scenario has been -- has been videoed. It is currently undergoing editing, and we are hopeful that it will be ready for you know, presentation to the E.M.S.C. committee at its November 29th meeting upcoming in a month or so. And second major item of business has to do with the -- the guidelines document that was created in 2015, speaking about enhanced guidelines for emergency departments and critical care units that care for children.

That document is almost ten years old. And the committee felt that it was high time that it -- to receive a -- a review with an eye toward making potential additional recommendations should -- should it -- it seem as though such recommendations would be warranted. So again, we will be meeting the week before the -- the -- or so before the upcoming SEMAC meeting, and we hope to have more information for SEMAC at that time, as well as for the STAC at its January meeting. Thank you.

MR. BANK: Any questions for Dr. Cooper? Okay. I don't think we have any old business right now to move to new business. We were talking to the executive committee, the -- it -- it seems like there's a -- a little bit of time in between when the subcommittees finished their meetings. And when we start this -- this meeting at -- at STAC the STAC has traditionally met at one thirty. We've had a couple of times we've met at one. So we wanted to throw out as a -- let's say, as a motion to the STAC of trying to start the stack at one instead of one thirty going forward. We think, especially for people that are -- have to drive -- driving home to give them another thirty minutes of daylight of -- of driving home might probably be safer. So just any discussion about that?

MR. TEPERMAN: I think it's a good idea. Teperman, New York.

MR. BANK: I -- I checked of the audio visual crew. They feel they could turn over the room appropriately. So again, just any discussion about moving stack going forward from one thirty to one. Okay. So I'm going to throw that as a motion. So anybody who wants to vote yes, please raise their

hand. Okay. So we have nineteen. Any no? And any abstention? Dr. Arrillaga, was that a comment or was that a no?

MR. ARRILLAGA: Just abstention.

MR. BANK: Abstention. Okay. So we have -- we have we have nineteen yes. No nos. One -- and raise your hand if you are not here. Okay. No one is not here. Well, there are a few people not here, and they did not raise their hands. So one abstention, so the motion will carry. So we are going to look -- unless there's some logistical issue that I can't figure out off the top of my head, we're going to try to move the January STAC to start at one and give everybody just half an hour more to get out of here and drive -- drive home.

After that, just want to list. I know I -- I mentioned this before, but I got a couple of names for burn surgeons. I reached out to them. We have a -- a opening on the STAC for a burn surgeon. I did reach out to a couple people. They -- they didn't get back to me immediately. They got back to me just right before this STAC, so I couldn't put anything together. But just one more time, I want to just send out anybody who's interested in burn

position, please send me their -- their -- just an e-mail that they're interested and their C.V. And probably hopefully in January, we will send out to STAC members all the nominated burn surgeons.

MR. TEPERMAN: Well, Matt, you got -- you have some names, right?

MR. BANK: We -- we have two names.

MR. TEPERMAN: Okay. Good.

MR. BANK: But I -- I did reach out to them and they -- they had just come back to me, so I -- I just wanted to be fair. And announce this one more time. And also, just to be fair to get to STAC their names and their self-descriptions of themselves with enough time to read it. So hopefully, we'll -- we'll do that the next STAC in January. Lastly the vice chair position. So we completed the voting and the -- and the nomination for the STAC, nomination to -- to --

MR. CLAYTON: The commissioner.

MR. BANK: There you go. I'll let Dan handle this.

MR. CLAYTON: So there are twenty STAC members, voting members present here today. We have twenty votes, and the nominee that's being moved

forward to the commissioner for consideration is Dr. Mark Gestring.

MR. BANK: Okay. Under new business, in our agenda also, we talked about a technical advisory group and we -- we've discussed this at - at this meeting for the provisional designation trauma centers. We discussed this under Dr. Winchell's report for a while. So we -- we have more work to go, but I'm not going to recapitulate all of the previous discussions we've had on this. Any other -- anyone else want to make any other volunteering or new business for the STAC?

MS. SNYDER: I -- Kerrie Snyder from Northeast. The only thing that I want to -- I had e-mailed Matt Banks about it a few weeks ago. It didn't get onto any agenda, but I would like us to, at the next STAC start to think about looking at if we can have a state replantation protocol. Everybody's either supposed to have a regional and/or state protocol. I think replantation is an issue in a wide part of our state. So I'm a little bit concerned about where we're going. And I think it would be an important topic for us as a state to discuss.

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MR. BANK: So the -- the standard, which -- which standard is that? Kerrie, if, you know.

MS. SNYDER: I put it away.

MR. BANK: Okay.

MS. SNYDER: But it is under replantation.

MR. BANK: So the --

MS. SNYDER: Eighty-four point something, it's under the --

MR. BANK: The standard is that we either have a regional or state written protocol for re-implantation -- for replantation.

MS. SNYDER: I believe if --

MR. VOSSWINKEL: I -- I believe that's if you don't have a transfer. So it's not that you have to have a state or regional.

MS. SNYDER: If you don't have a transfer agreement.

MR. VOSSWINKEL: If you have a state or a regional, it will supplant if you don't have one.

MR. BANK: If you don't have a replant --

MR. VOSSWINKEL: You don't have an individual transfer agreement, a state or a regional is adequate, but it doesn't mean there has to be a state or a regional.

MR. BANK: So it -- it would be helpful. So if you have a random, you know, region and you have five trauma centers, and one of them does replant, I -- you know, I would think that that region would have a -- a protocol that says trauma center X, Y, and Z that has the replant capability. E.M.S. should go there.

MR. VOSSWINKEL: Correct. So pre-hospital, I think recommendations to bring to a center, which Suffolk does have, I think is -- is reasonable when I discuss this with my institute to have automatic transfer agreements between institutes, I think that's outside of the jurisdiction of us.

MR. BANK: So again, this is not transfer agreements.

MR. VOSSWINKEL: Correct.

MR. BANK: This is a regional protocol.

MR. VOSSWINKEL: They -- they -- it

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says regional transfer agreement.

MS. SNYDER: No.

MR. BANK: No.

MR. VOSSWINKEL: This is protocol. So if it's a protocol, we have one regional.

MR. BANK: Yeah.

MR. VOSSWINKEL: Correct.

MR. BANK: It's a regional transfer protocol. Oh, thank you. I'm going to read it directly. Measures of compliance, documentation of a regional and or state triage and transfer process for center's without capability or continuous coverage.

MR. VOSSWINKEL: So we -- define what process means.

MR. BANK: So process, but -- but I think it'll be -- I think this is mainly aimed at prehospital providers to make sure that the prehospital providers bring the patient to the proper center originally, and we don't need to transfer.

MR. VOSSWINKEL: Full -- full agreement with that process.

MR. DAILEY: Dr. Bank, I'd just like to point out this is actually a problem when it comes to the hospitals themselves. And it's not restricted

just to -- to our ambulance friends. You know, as an emergency physician at a level one center where we get people brought to us with the need for specialty care, that sometimes goes beyond our capabilities. I can tell you the challenges of finding a patient an appropriate destination for a replant that will make life changing -- a life changing situation for that patient is an amazing challenge for anybody in Northern New York.

So having gotten a lot of phone calls or been engaged with a lot of phone calls with a lot of potentially accepting surgeons at institutions that theoretically have the capability, I would say that this is definitely a project for this committee to work on rather than have this fall elsewhere within the Department of Health, that I think would be a mistake for all of our institutions.

MR. TEPERMAN: And where would you put it? Matt, would you put it with the systems committee? Start with a conversation?

MR. BANK: So we -- we could put the systems committee. Interestingly, like many things, this is a tale of two states. So in the downstate area I think it's incredibly useful. You could have

an E.M.S. agency bypass a level one trauma center and go to another level in transfer that has replant capability, and it's really only a twenty minute ride. But that was a huge in -- between that patient of not having to be transferred and everything. So it was really, really be huge in the New York City, and Westchester area, where we have definitely have replant capability, but it may not be the level one center that is closest to you.

Upstate is a much tougher egg to crack, right? Because you may have a hundred, a hundred and fifty miles, my understanding is in between a level one that does not have replant and a level one that does have replant. But I think that starting off with STAC, you discussed it at systems and at least figuring out the downstate one which maybe be an easier egg to crack. And then moving upstate and at least talking with the trauma centers, who has replant services available, and how could we incentivize the trauma centers to develop agreements?

And again, I -- I agree with, with Dr. Vosswinkel, that this is not saying that we're telling people that they need to -- to accept the transfer, but -- but I think that we could -- we

could help at least organize that at the STAC level. But again, at -- on the downstate level, this would be incredibly helpful that E.M.S. takes the patients to the right destination the first time.

MR. TEPERMAN: May I -- may I suggest also as we go through this, that it might be helpful to invite one of the replant experts who oversees one of these centers into these discussions to understand what -- what the -- the complexities that they deal with on the receiving end.

MR. BANK: And -- and just to amplify that, again, I -- I've been the trauma director of two different level ones. One of them has been a replant center, one of them has not been replant center. So I a hundred percent understand the issues of -- of replant. And it can be hard because it's a very time dependent thing. And it can be very life changing for -- for the patient. But it will start bringing this to the system committee in January and start the discussion.

MR. TEPERMAN: Thank you.

MR. BANK: Any other discussions of new business? Okay. Just one more time. Just next meeting will be January 29th at the Troy Hilton

Garden. Do I have a motion -- can I get a -- a motion to -- motion to adjourn?

MR. TEPERMAN: Motion.

MR. BANK: Second?

MR. VOSSWINKEL: Second.

MR. BANK: First and second. Okay. We are done. Thank you very much.

(The meeting concluded at 3:01 p.m.)

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STATE OF NEW YORK

I, MONIQUE HINES, 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 78, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 15th day of November, 2024.

MONIQUE HINES, Reporter

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