

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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2 APPEARANCES:

3 ABENAMAR ARRILLAYA

AMY EISENHAUER

4 ARTHUR COOPER

CARRIE CARGIA

5 CHARLES FASANYA

CRISTY MEYER

6 DANIEL CLAYTON

DONALD DOYNOW

7 ERIC COHEN

FRANK MANZO

8

GEORGE AGRIANTONIS

GEORGE ANGUS

9

JAMES VOSSWINKEL

10 JEROME MORRISON

KARTIK PRAHHAKARAN

11 KATE MAGUIRE

KERRIE SNYDER

12 KIM WALLENSTEIN

KURT EDWARDS

13 MARK GESTRING

MATTHEW CONN

14 MEGHAN MULLEN

MICHAEL DAILEY

15

MICHAEL VELLA

ROBERT KERN

16

ROBERT WINCHELL

ROSEANNA GUZMAN-CURTIS

17

RYAN GREENBERG

18 SHELDON TEPERMAN

THOMAS BONFIGLIO

19 WILLIAM FLYNN, JR.

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2 (The meeting commenced at 1:33 p.m.)
3 MR. BANK: Okay. We're going to call
4 these meeting -- we're going to call this meeting to
5 order. And first we're going to do our attendance
6 roll call.
7 MR. CLAYTON: Thank you, Dr. Bank.
8 Dr. Bank?
9 MR. BANK: Here.
10 MR. CLAYTON: Dr. Wallenstein.
11 MS. WALLENSTEIN: Here.
12 MR. CLAYTON: Dr. Guzman-Curtis.
13 MS. CURTIS: Here.
14 MR. CLAYTON: Dr. Gestring.
15 MR. GESTRING: Here.
16 MR. CLAYTON: Frank Manzo.
17 MR. MANZO: Here.
18 MR. CLAYTON: Dr. Prabhakaran.
19 MR. PRABHAKARAN: Here.
20 MR. CLAYTON: Kate Maguire.
21 MS. MAGUIRE: Here.
22 MR. CLAYTON: Dr. Angus.
23 MR. BANK: I believe he was excused.
24 MR. CLAYTON: Dr. Reddy. Dr.
25 Agriantonis.

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2 MR. AGRIANTONIS: Present.
3 MR. CLAYTON: Mr. Conn.
4 MR. CONN: Present.
5 MR. CLAYTON: Dr. Teperman.
6 MR. TEPERMAN: Present.
7 MR. CLAYTON: Kerrie Snyder.
8 MS. SNYDER: Here.
9 MR. CLAYTON: Dr. Edwards.
10 MR. EDWARDS: Here.
11 MR. CLAYTON: Dr. Arrillaga.
12 MR. ARRILLAGA: Present.
13 MR. CLAYTON: Dr. Vosswinkel.
14 MR. VOSSWINKEL: Here.
15 MR. CLAYTON: Dr. Flynn.
16 MR. FLYNN: I'm here.
17 MR. CLAYTON: Megan Mullen.
18 MS. MULLEN: Here.
19 MR. CLAYTON: Dr. Oman is excused.
20 Dr. Winchell.
21 MR. WINCHELL: Here.
22 MR. CLAYTON: Dr. Dailey.
23 MR. DAILEY: Here.
24 MR. CLAYTON: Dr. Doynow?
25 MR. DOYNOW: Here.

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2 MR. CLAYTON: Dr. Goldman. And Dr.

3 Cooper.

4 MR. COOPER: Here.

5 MR. CLAYTON: We have more than what's

6 necessary for quorum.

7 MR. BANK: Okay. Next order of

8 business. The minutes from the previous STAC, which

9 was May 29th, 2024, are posted on the website for

10 anybody to review them, posted there for a number of

11 weeks. Can I have a motion for acceptance of our

12 previous minutes?

13 MR. AGRIANTONIS: Motion.

14 MR. BANK: Second?

15 MR. CONN: Second.

16 MR. BANK: Everybody in favor?

17 Nineteen in favor. Anybody opposed? No. So motion

18 will carry. Okay. So to go right into our reports.

19 Director Ryan, anything to report?

20 MR. CLAYTON: Do you want to start

21 with the election stuff first?

22 MR. BANK: Okay.

23 MR. CLAYTON: Before you can start --

24 MR. BANK: So we're going to go a

25 little bit out of order. One of the things that we

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

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

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

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

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

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

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

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

20 MR. AGRIANTONIS: Okay. Thank you.

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

25 MR. CLAYTON: Yes.

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2 MR. VOSSWINKEL: Okay.

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

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

7 MR. CLAYTON: Yes. Not a problem.

8 MR. VOSSWINKEL: Thank you.

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

21 MR. BANK: Okay. Any other questions?

22 MS. MAGUIRE: Tell us when you hit
23 send.

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

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

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

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

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

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

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

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

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

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

25 There's a new memorial that took about

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2 two and a half years to design, make, and come to
3 fruition. The new memorial can fit up to three-
4 hundred names on it. Hopefully we never fill that.
5 But it took us about twenty years. So the last
6 memorial was created in 2004 and ran out of space in
7 2023. And the new memorial arrived in 2024. From
8 our side in the -- the bureau and the regulatory
9 side, and this really has a lot to do on the trauma
10 side as well as we are starting to move a lot related
11 to regulatory updates.

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

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

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

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

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

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

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

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2 address issues as they arise. End of report.

3 MR. TEPERMAN: Question.

4 MR. GREENBERG: Yes, sir.

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

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

25 We have not been able to identify a

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2 pattern to date. So we are starting to look at that.
3 We're talking to some other people. We've been in
4 communications with the A.C.S. to -- from their side
5 to find out, you know, are you seeing this
6 nationally? Is this unique to New York? Or -- or
7 things of that things. And I think, you know, in the
8 next meeting or two at the next STAC, hopefully we'll
9 have some more information for you. And the
10 standards, you know, they really just recently
11 change, and we're starting to see this with the new
12 standards, more complexities and more deficiencies.
13 THE REPORTER: And I just need his
14 name.
15 MR. GREENBERG: Whose name?
16 THE REPORTER: Doctor.
17 MR. TEPERMAN: Oh, Dr. Teperman here.
18 Sorry.
19 THE REPORTER: Thank you.
20 MS. GUZMAN-CURTIS: I'm Roseanna
21 Guzman from Upstate. I was at the C.O.T. meeting
22 whenever that was last week. And I did jot down some
23 notes of the most frequently cited standards in the
24 visit. So I can list those off if that's of interest
25 to the group. So most frequently cited was seven

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2 point three, five point three one, seven point six,
3 four point three one, five point three zero, six
4 point two, four point three two, four point three
5 three, five point two one, five point one seven, and
6 five point two nine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 MR. BONFIGLIO: Thank you.

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

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

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

21 THE REPORTER: Yes. Move closer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 THE REPORTER: And your name is?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 THE REPORTER: And your name?

25 MR. BANK: And having -- having been

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

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

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

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

22 MR. BANK: Yeah.

23 MR. GREENBERG: Much appreciated.

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

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

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

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

21 MR. CLAYTON: Yes.

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

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

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

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

6 MR. CLAYTON: Okay.

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

9 MR. CLAYTON: I did see that.

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

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

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

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2 MR. CLAYTON: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

16 MR. BANK: Okay. Yeah.

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

19 MR. BANK: Yeah.

20 MR. GREENBERG: Oh.

21 MR. BANK: There you go.

22 MR. GREENBERG: Just got cold in here.

23 MR. BANK: Yeah.

24 MR. CLAYTON: Move to strike that
25 statement.

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2 MR. GREENBERG: Yeah. Eric, just --

3 MS. GUZMAN-CURTIS: Yes, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. TEPERMAN: Great.

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

25 MR. CLAYTON: Even if it wasn't?

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2 MR. BANK: If it wasn't he has left
3 the building, so he had to go on a train to see his
4 daughter compete somewhere. So next will be the --
5 we're go back in order the executive committee.
6 We've already discussed the increase in number of
7 failures and deficiencies, which we also discussed at
8 the executive committee. We discussed the voting for
9 vice chair. I want to point out that the January
10 meeting date is now out, it's going to be January
11 29th at the Troy Hilton Garden Inn. So we'll be back
12 in Troy on January 29th. The dates for all the 2025
13 meetings will be very quickly. The next week --
14 well, or right now are up on our website, but our
15 next date is going to be January 29th at the Troy
16 Hilton Garden Inn.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. BANK: Any questions for Dr.
7 Winchell?

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

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

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

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

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

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

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

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

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

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

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2 the report.

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

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

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

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

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

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

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

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

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2 on a red cap?

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

5 MR. CLAYTON: I think it's -- yes, you
6 can work with me, but Peter Brody from our data
7 informatics experience will also be critical to this
8 --

9 MR. BANK: Okay.

10 MR. CLAYTON: -- survey. Thank you.

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

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

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

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

25 MR. BANK: Any questions for Dr.

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2 Vella? Mark?

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

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

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2 the wheel and oversupplying this rare resource.

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

21 MR. DAILEY: I agree.

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

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

6 MR. BANK: Dr. Cooper.

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

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

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2 to store and administer blood as well.

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

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

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

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

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

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

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

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

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

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

14 MR. BANK: Any questions for Dr.
15 Wallenstein?

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

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

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

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

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

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

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

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

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

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

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

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

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

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2 be very useful resource for us at SEMAC.

3 MR. BANK: Have you gotten any names
4 yet?

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

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

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

25 The two major business items discussed

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

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

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2 MR. BANK: Any questions for Dr.

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

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

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

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

5 MR. ARRILLAGA: Just abstention.

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

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

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

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

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

9 MR. TEPERMAN: Okay. Good.

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

20 MR. CLAYTON: The commissioner.

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

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

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

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

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

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

5 MS. SNYDER: I put it away.

6 MR. BANK: Okay.

7 MS. SNYDER: But it is under
8 replantation.

9 MR. BANK: So the --

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

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

15 MS. SNYDER: I believe if --

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

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

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

24 MR. BANK: If you don't have a replant
25 --

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

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

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

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

22 MR. VOSSWINKEL: Correct.

23 MR. BANK: This is a regional
24 protocol.

25 MR. VOSSWINKEL: They -- they -- it

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2 says regional transfer agreement.

3 MS. SNYDER: No.

4 MR. BANK: No.

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

7 MR. BANK: Yeah.

8 MR. VOSSWINKEL: Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MR. TEPERMAN: Thank you.

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

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

4 MR. TEPERMAN: Motion.

5 MR. BANK: Second?

6 MR. VOSSWINKEL: Second.

7 MR. BANK: First and second. Okay.

8 We are done. Thank you very much.

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

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2 STATE OF NEW YORK

3 I, MONIQUE HINES, do hereby certify that the foregoing
4 was reported by me, in the cause, at the time and place,
5 as stated in the caption hereto, at Page hereof; that
6 the foregoing typewritten transcription consisting of
7 pages 1 through 78, is a true record of all proceedings
8 had at the hearing.

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

11
12 MONIQUE HINES, Reporter

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