1/29/2025 - STAC - MS Teams

NEW YORK STATE

DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: January 29, 2025

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

CHAIR: MATTHEW BANK

VENUE: MS Teams

Reported by Annette Lainson

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APPEARANCES:

ABENAMAR ARRILLAYA
ARIEL GOLDMAN
ARTHUR COOPER
CRISTY MEYER
DANIEL CLAYTON
DONALD DOYNOW
FRANK MANZO
GINA WIERZBOWSKI
GEORGE ANGUS
KARTIK PRAHHAKARAN

KERRIE SNYDER
KIM WALLENSTEIN

KURT EDWARDS
MARK GESTRING
MATTHEW CONN
MEGHAN MULLEN
MICHAEL DAILEY
MICHAEL VELLA
ROBERT KERN
RONALD SIMON
ROSEANNA GUZMAN-CURTIS
RYAN GREENBERG
SHELDON TEPERMAN

THOMAS BONFIGLIO

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

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

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

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

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

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

MR. CLAYTON: Dr. Bank?

CHAIR BANK: Here.

MR. CLAYTON: Dr. Wallenstein.

MS. WALLENSTEIN: Here.

MR. CLAYTON: Dr. Guzman-Curtis?

MS. GUZMAN-CURTIS: Here.

MR. CLAYTON: Dr. Gestring? Mr.

Manzo?

MR. MANZO: Here.

MR. CLAYTON: Dr. Prabhakaran?

MR. PRABHAKARAN: Here.

MR. CLAYTON: Ms. Maguire?

MS. MAGUIRE: Here.

MR. CLAYTON: Dr. Angus?

MR. ANGUS: Present.

MR. CLAYTON: Dr. Reddy is excused. Dr. Agriantonis? I believe he's also excused. I think he has an A.C.S. visit. 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. Arillaya?

MR. ARILLAYA: Present.

MR. CLAYTON: Dr. Vosswinkel, I believe is excused. Dr. Flynn, same thing, excused. Ms. Mullen?

MS. MULLEN: Here.

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

MR. DAILEY: Here. Here.

MR. CLAYTON: Dr. Doynow?

MR. DOYNOW: Here.

MR. CLAYTON: Dr. Goldman?

MR. GOLDMAN: Here.

MR. CLAYTON: And Dr. Cooper?

MR. COOPER: Here.

MR. CLAYTON: We have just met quorum.

CHAIR BANK: Okay. Thank you very much, Dan. So the next order of business is, can I have a motion to approve the previous meeting -- meeting minutes? The transcript of the October 2024 STAC is on the website. I have read it. Do I have a motion to approve the transcript?

MR. CONN: Matthew Conn, New York City RTAC (phonetic spelling), motion to approve.

CHAIR BANK: Do I have a second?

MR. TEPERMAN: Second.

CHAIR BANK: Teperman, second. Can I have a vote of everybody agreeing to approval in the minutes? So we have nineteen in favor. Any against? Zero against. So, we will approve the minutes.

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

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

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

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

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

look forward to more coming on that.

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

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

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

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

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

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

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

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

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

mean?

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

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

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

CHAIR BANK: Director Ryan?

MR. GREENBERG: Yes?

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

I believe Dr. Dailey is -- is in

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

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

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

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

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

those are? This is related to the nurse reviewer.

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

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

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

After the package comes back from

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

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

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

MR. TEPERMAN: Question.

MS. WIERZBOWSKI: Yes.

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

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

MS. WIERZBOWSKI: So my --.

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

MS. WIERZBOWSKI: I think --

MR. GREENBERG: -- a period?

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

MR. GREENBERG: You say immediately?

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

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

The challenge will be -- and -- and

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

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

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

MR. GREENBERG: Sure.

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

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

that normally are predictable, but are not exact.

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

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

MR. GREENBERG: Review six months.

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

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

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

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

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

MR. CLAYTON: Yes. We --

MR. SIMON: So we can do --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: Director.

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

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

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

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

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

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

excellence that that is out there from around the state.

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

MR. CONN: Thank you. It does.

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

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

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

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

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

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

MR. TEPERMAN: Okay.

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

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

who the reviewers will be and so forth.

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

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

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

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

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

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

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

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

MR. TEPERMAN: Question.

MR. GREENBERG: Yeah.

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

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

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

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

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

don't handle things in between.

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

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

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

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

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

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

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

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

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

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

the STAC to the A.C.S.

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

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

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

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

subcommittee.

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

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

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

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

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

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

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

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

things or?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: So Cristy, just for this

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

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

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

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

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

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

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

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

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

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

So at that first hospital that they go

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

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

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

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

MS. SNYDER: Kerrie Snyder from

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. MEYER: Again, I know we have this

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: Cristy?

MR. CLAYTON: Whatever your wish.

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

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

process and to improve this across the state.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

so it was run by Dr. Gestring.

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

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

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

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

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

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

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

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

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

MR. GESTRING: Ten thousand-dollar cookies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GESTRING: Dr. Bank?

CHAIR BANK: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. VELLA: Yeah, of course.

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

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

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

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

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

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

the same product.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: Okay. And --.

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

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

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

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

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

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

MR. SIMON: Correct.

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

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

of approving R TAG bylaws.

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

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

MR. CLAYTON: Dr. Bank?

CHAIR BANK: Yes.

MR. CLAYTON: Dr. Wallenstein?

MS. WALLENSTEIN: Yes.

MR. CLAYTON: Dr. Guzman-Curtis?

MS. GUZMAN-CURTIS: Yes.

MR. CLAYTON: Dr. Gestring? Mr. Manzo?

MR. MANZO: Yes.

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

MS. MAGUIRE: Yes.

MR. CLAYTON: Dr. Angus?

MR. ANGUS: Yes.

MR. CLAYTON: Matt Conn?

MR. CONN: Yes.

MR. CLAYTON: Dr. Teperman?

MR. TEPERMAN: Yes.

MR. CLAYTON: Ms. Snyder?

MS. SNYDER: Yes.

MR. CLAYTON: Dr. Edwards?

MR. EDWARDS: Yes.

MR. CLAYTON: Dr. Arillaya?

MR. ARILLAYA: Aye.

MR. CLAYTON: Ms. Mullen?

MS. MULLEN: Yes.

MR. CLAYTON: Dr. Dailey?

MR. DAILEY: Yes.

MR. CLAYTON: Dr. Doynow?

MR. DOYNOW: Yes.

MR. CLAYTON: Dr. Cooper?

MR. COOPER: Yes.

MR. CLAYTON: Passes unanimously.

CHAIR BANK: Okay. Thank you. Ron, you want to go to your next motion?

MR. SIMON: Okay. So the -- okay, Ron Simon again. So the second motion was that we approved that there be a poll sent out to all trauma centers to evaluate the availability of replantation services throughout the state.

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

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

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

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

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

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

CHAIR BANK: Discussions. Dr. Goldman?

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

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

before we send it out.

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

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

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

MS. SNYDER: Second. Kerrie Snyder seconds.

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

MR. SIMON: Ron Simon again. I --

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

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

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

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

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

CHAIR BANK: So --

MR. GREENBERG: -- non-trauma centers?

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

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

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

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

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

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

MR. GREENBERG: No, I meant to.

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

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

MR. SIMON: Right.

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

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

without that one month pre-look?

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

MR. SIMON: Okay. Understood.

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

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

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

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

different questions.

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

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

CHAIR BANK: Right, absolutely.

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

CHAIR BANK: So any further discussion on this motion?

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

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

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

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

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

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

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

Guzman, Central R TAG.

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDMAN: Right.

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

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

MR. GOLDMAN: Yup.

MR. VELLA: For example, Albany calls

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

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

CHAIR BANK: So --

MS. SNYDER: Can --

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

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

MR. GOLDMAN: There you go.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. VELLA: Very well.

MR. SIMON: Thank you.

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

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

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

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

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

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

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

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

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

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

MS. WALLENSTEIN: One more.

CHAIR BANK: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

as any of these.

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Anyone want to bring any new business --

MR. TEPERMAN: Yes --

CHAIR BANK: -- on the STAC?

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

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

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

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

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

And it is probation, right?

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

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

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

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

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

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

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

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

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

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

CHAIR BANK: Any discussion? Dr. Cooper.

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

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

But I can also tell you that as Dr.

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

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

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

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

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

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

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

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

And I think, you know, he and his

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

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

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

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

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

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

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

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

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

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

MR. COOPER: That --.

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

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

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

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

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

the -- for the vote for V.A.

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

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

MR. CLAYTON: Yeah.

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

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

CHAIR BANK: Abstention.

MR. CLAYTON: -- if we have any.

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

people at the beginning.

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

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

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

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

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

MR. CLAYTON: 30th.

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

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

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

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

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

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

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

East dates.

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

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

Thank you very much.

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

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

1/29/2025 - STAC - MS Teams

STATE OF NEW YORK

I, ANNETTE LAINSON, 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 108, is a true record of all proceedings had at the hearing.

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

ANNETTE LAINSON, Reporter

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