5/27/2026 - STAC - Saratoga Springs, New York

NEW YORK STATE
DEPARTMENT OF HEALTH

STATE TRAUMA ADVISORY COMMITTEE

DATE: My 27, 2026
TIME: 1:03 p.m. to 2:19 p.m.

CHAIR: MATTHEW BANK

LOCATION: Holiday Inn Saratoga

232 Broadway

Saratoga Springs, New York

Reported by Monique Hines

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APPEARANCES:

Daniel Clayton
Tom Bonfiglio
Srinivas Reddy
Barbara Lee Steigerwald
Christy Meyer
Arthur Cooper
Steven Dziura
Douglas Fish
Amy Eisenhauer
Kurt Edwards
Kerrie Snyder
Derek Wakeman
James Vosswinkel
Abenamar Arrillaga
William Flynn, Jr.
Meghan Mullen
Mary Ives
Kartik Prabhakaran
Beth McGown
Michael Dailey
Donald Doynow
Jerry Rubano
Ariel Goldman
Wendy Patterson
Tafford Oltz
Melaina King
George Agriantonis
Frank Manzo
Roseanna Guzman-Curtis
Francesca Sullivan
George Stathidis
Michael Vella
Sarah Gorman
Peter Brodie
Chris Fisher

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(The meeting commenced at 01:03 p.m.)

CHAIR BANK: Okay. Thank you very much. So we're going to do our call to order. So first, we're going to do our attendance roll call. Dan, you want to do --

MR. CLAYTON: Yeah.

CHAIR BANK: -- the attendance?

MR. CLAYTON: Dr. Bank?

CHAIR BANK: Here.

MR. CLAYTON: Dr. Gesturing (phonetic spelling) is excused. Dr. Doynow?

MR. DOYNOW: Here.

MR. CLAYTON: Dr. Winchell? Absent. Dr. Goldman?

MR. GOLDMAN: Here.

MR. CLAYTON: Dr. Cooper?

MR. COOPER: Here.

MR. CLAYTON: Dr. Dailey?

MR. DAILEY: Here.

MR. CLAYTON: Dr. Roseanna Guzman-Curtis? Dr. Guzman-Curtis, she was here this morning.

CHAIR BANK: She was.

MR. CLAYTON: Melaina King. They're

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both from Central New York ARTAC (phonetic spelling). I'm wondering if they're meeting somewhere. Meghan Mullen?

MS. MULLEN: Here.

MR. CLAYTON: Dr. Flynn?

MR. FLYNN: I'm here.

MR. CLAYTON: Francis Manzo?

MR. MANZO: Here.

MR. CLAYTON: Kerrie Snyder?

MS. SNYDER: Here.

MR. CLAYTON: Dr. Edwards?

MR. EDWARDS: Here.

MR. CLAYTON: Dr. Prabhakaran?

MR. PRABHAKARAN: Here.

MR. CLAYTON: Kate McGuire is excused. Dr. Angus? Sorry, Dr. Angus retired. Congratulations to him. Dr. Klein is excused. Dr. Arrillaga?

MR. ARRILLAGA: Present.

MR. CLAYTON: Dr. Vosswinkel?

MR. VOSSWINKEL: Here.

MR. CLAYTON: Francesca Sullivan?

MS. SULLIVAN: Here.

MR. CLAYTON: Dr. Agriantonis?

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MR. AGRIANTONIS: Present.

MR. CLAYTON: Dr. Reddy?

MR. REDDY: Present.

MR. CLAYTON: And Dr. Tepperman is excused. We just have quorum.

CHAIR BANK: Yeah, I'm going to ask Dan to lead us through the Pledge of Allegiance.

ALL: I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one Nation under God, indivisible, with liberty and justice for all.

CHAIR BANK: So a couple of housekeeping items. First of all, Matthew Bank, Chair of STAC. If you need to speak, please, we have a stenographer taking minutes on this meeting. So please just step up to microphone, activate the microphone, and just tell us your name and where you're from.

This way we could attribute all your comments to you. So if you see something not smart, we track it back to you and kill you. We are going to do some introductions of some guests that we have. I'm not going to butcher their names, so we're going have Dan introduce them.

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MR. CLAYTON: So I'd like to welcome, first of all, from the department, the Deputy Director, Division of State E.M.S., that's Steven Dziura. He reports to Ryan Greenberg. Ryan is unfortunately not able to be here today but has sent Steven. And we also have from Office of Healthcare Delivery, Deputy Commissioner Dr. Douglas Fish. We also have from State E.M.S. Council over here in the orange, Beth McGown. She is from State E.M.S. Council. She's the Chair of SEMSCO. And we have also Barbara Lee Steigerwald, who is my direct supervisor over here, Esquire. She's the new Bureau Chief for Standards and Licensure in the -- in the Division of State E.M.S.

So welcome to Barbara Lee. She started back in December. And of course, you would have met her in January had we not had a snowstorm. So welcome to all.

CHAIR BANK: And Dan, I just want to note that we have Ms. King and Dr. Guzman-Curtis here. So we are going to mark you guys present.

MS. KING: Thank you.

CHAIR BANK: You're welcome. So the previous meeting minutes from October 2025 are on the

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website. Can I -- can I have a motion to approve the previous minutes of STAC?

MR. AGRIANTONIS: Move.

CHAIR BANK: Dr. Agriantonis and who seconded?

MR. REDDY: Second.

CHAIR BANK: And -- Dr. Reddy. Okay. So we are going to -- any other discussion? No, we will approve those minutes. A couple of just housekeeping items. I just want to announce the next STAC will be October 7th in Albany. So next STAC will be October 7th in Albany. I don't think we have a hotel yet.

MR. CLAYTON: Yes, but I -- I -- I know we have a -- we have a contract with the hotel, but after this STAC meeting, I'll have to email out to the listserv some information as to which one it is and give them further directions.

CHAIR BANK: Okay. Just another thing I want to announce. We are having an unprecedented number of hospitals applying to STAC Q.B.A. Trauma Center.

So it's -- it's pretty surprising. I think we have five hospitals now somewhere in the

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process of asking to either be a trauma center or to upgrade their trauma status. So it's interesting that there's a huge interest in trauma throughout the -- throughout the state. We're going to move to Division of State E.M.S. report. Dr. Dziura?

MR. DZIURA: I think I'm on. There we go. Thank you, good afternoon. Ryan didn't leave me his usual lengthy report, but there's a few things I'd like to touch on.

In the division, we continue to build out our staff under our new division realignment. Interesting to this group is -- is likely the data analyst positions that we're bringing on to help us be able to really organize and -- and understand what all the data we're collecting is actually telling us and support you folks as well on -- on all the councils.

In addition to that, I want to talk a little bit about the summer. So in a very short time, the 250 celebrations across the country will start kicking off. And right here in New York State, we're expecting a big influx of people for multiple events, beginning in really in June with the start of the FIFA games, and running through and -- and

probably hitting its crescendo in July, around July 2nd through the 9th, where we're seeing the -- the 4th of July events, including massive fireworks displays by Macy's, the Sail 250 event that's bring in hundreds of ships into the city. There's millions of extra people expected in the city. And of course, we always remain on - on aware and alert to any potential harm that could come of those events.

And as the trauma and the STAC, you know, I'm sure you're all preparing back at home for those types of incidents. At the department, we're doing a lot of planning for surge, burn plans, surge plans, as well as mobilizing additional E.M.S. assets to different parts of the state in anticipation of all these events.

Couple that with, over the past few weeks, if you've turned on the news, you've seen that we're also fighting some new epidemics in a few areas, Ebola and Hantavirus. We, you know, it's important that all hospitals start preparing for the potential to see one of those, although very low.

You know, everybody needs to be ready on the event that -- that they are presented with somebody either with recent travel to an area that's

-- that's experiencing this outbreak or symptoms of the outbreak.

We, at the department, are dusting off all the plans. There's new policies, you know, updated policies that'll come out, things you've seen before, but just with a new date on them and -- and the most up-to-date guidance. But we just want to remind folks, you know, be prepared for those types of things and ready to go. It's going to be a - a busy summer this year. Probably go by quick. Thank you.

CHAIR BANK: Any questions? Okay. We'll move on to the Trauma Program update, both Dan and Tom.

MR. CLAYTON: I have nothing, but if Tom has anything, I defer to him.

MR. BONFIGLIO: I don't have any report at this time.

CHAIR BANK: Okay. Very good. We'll move to the executive report. That's me. Really the only thing we talked about in the executive committee that will not be talked about by the various chairs of the subcommittees is the October 7th date for the next STAC, which is at the bottom of your agenda if

you guys haven't seen it.

And also, the amount of hospitals that are interested in either becoming a trauma center or moving up to a level of trauma centers. So after that, we have Christy talking about the very engaged registry committee.

MS. MEYER: All right. Good afternoon. Christy Meyer (phonetic spelling), Subcommittee Chair for Registry. We had a very robust discussion this afternoon or this morning, rather, to really highlight the data validation and data quality journey for the state.

We've had a good deal of change in registries throughout the state. More than fifty percent of registries have changed vendor. And we do have somewhat of a submission update, that 2025 records were due by April 1st, and quarter one records will be due July 1st. This does give us a narrow window to make some adjustments to some of the submission processes. And also, you know, kind of get those records going.

In addition to that, we did identify, thanks to Good Samaritan Hospital, who made an early submission for their first quarter, 2026 and found a

validation issue, that the TQIP fields were not included in the X.S.D. file.

That's that technical file that helps us transmit data from our registry to the state. Those edits have been corrected by ImageTrend. They have been sent out to the vendors, and some vendors will have test update uploads next week. So hopefully, we'll be able to update all end users in the state, and that will work.

In addition, we did have a technical advisory group that met very aggressively at the end of last year to look at the data dictionary fields for 2027. We will have two motions in just a moment, for this body to approve some of the changes that are recommended for 2027.

But I wanted to address the data validation and quality discussion that we had this morning. We are going to recommend that some kind of data validation process, and end user report, be available to trauma centers across the state so we can evaluate data quality.

There is a data validation process that you do receive its submission from ImageTrend, but it's very focused on technical data failures and

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not data quality, meaning that what is received is what's sent.

So hopefully, we will be creating a technical advisory group for that, with support from our Department of Health partners, and hopefully ImageTrend to make that a new process and a really strong resource for end users. So more to come on that, I don't know if anyone from the Department of Health team wanted to address that.

MR. STATHIDIS: Sure. George Stathidis. It's okay. George Stathidis, New York State Department of Health. The little light is not very bright, sorry.

So yes, just to echo what Christy said, you know, we do support the effort to have a data quality report. I feel strongly that here at the Department of Health, we -- we should help drive that effort. And it's important that trauma centers around the state have visibility, not only into the quality of their data, but into, you know, any other quarterly or other information that we can provide about their performance, which is indicated by their data. So again, fully support the effort there, happy to join any tag that's created and to help

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drive and lead that effort with you.

MS. MEYER: Thank you. And hopefully we'll get that moving in -- in the weeks to come to try to really have some quick solutions in that area. One additional interim follow-up will be a frequently asked question draft. The tag was working on creating a resource for end users to be able to apply data dictionary definitions and kind of those more difficult scenarios and do so consistently.

So similar to what the National Trauma Data Bank provides. They have a frequently asked question document that's readily available. We have a draft and we'll send that out to users across the state and hope to have an interim meeting to kind of finalize and discuss that shortly.

So a lot of activity, as always, from the registry committee. And we do have two motions to act upon to make dictionary edits for the 2027 data collection year. One with bullets in my -- yeah, this is actually the first motion. That's fixed wing. Okay.

So motion number one is approval to update the New York State trauma data dictionary transport mode pick list to include the following

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pick list items. It should read fixed wing medical transport followed by ground transport; or helicopter transport followed by ground transport. So those would be two new pick list items.

In addition, an update to include clarification that end users could collect G.C.S. using narrative patient assessment description, as long as there is not conflicting information in the medical record.

CHAIR BANK: Any discussion on this motion? Can I have a motion to send this to a vote?

MR. AGRIANTONIS: Motion.

CHAIR BANK: Can I have that second? Very good. Okay. So everybody on the STAC who's in favor of this motion, please raise your hand. Okay. Anybody who's non-favor, please raise your hand. So this will pass unanimously. So Christy, your second motion.

MS. MEYER: Okay.

MR. VELLA: This is a matter of staff motion?

MS. MEYER: Yeah, yeah. We can fix that. Thank you.

CHAIR BANK: We will fix the spelling.

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Thank you for pointing out, Dr. Vella.

MS. MEYER: Yes, I think they got that. Okay. So motion number two, again, another approval to update the New York state trauma data dictionary field for pre-hospital E.M.S. vital signs, to include that it should be the first E.M.S. assessed vital sign assessment. Additionally, add a clarification to collect all pre-hospital procedures performed in a transport to your facility by all transport agencies using the existing pick list. So in the event that there is a multiple agencies transporting to a single site, you would collect any of the pre-hospital procedures performed in that transport of care.

CHAIR BANK: Any discussion? Can I have a motion for approval? Dr. Agriantonis? Can I have a second? Dr. Cooper seconds. Can I have a vote? Everyone in favor of this motion, please raise your hand. Okay. Thank you. Anybody opposed? So the motion carries unanimously. Christy, any other motions from the registry committee?

MS. MEYER: This concludes today's discussion. Thank you.

CHAIR BANK: Thank you very much,

Christy. Okay. And now we're going to have the trauma center needs assessment. Dr. Winschel was not here, so Dr. Vella very generously agreed to be the fill-in Chair.

MR. VELLA: Hi, Mike Vella filling in for the Trauma Needs Assessment Committee. So as Dr. Bank already mentioned, there's a lot of movement from the trauma center designation standpoint. A couple of updates. Huntington Hospital is in the process of transitioning from a level three to a level two.

They have a port from the regional E.M.S. Council as well as a Regional Trauma Advisory Committee, and we will look at that motion after we report the rest of the centers. Plainview Hospital is in the process of obtaining level three designation with plans to meet with their Regional Trauma Advisory Committee in the near future.

Kings County Hospital has started the process of becoming a PEDS level two trauma center and again was recommended by the STAC to proceed with discussions with the Regional Trauma Advisory Committee. And Northern Westchester Hospital similarly has started the process of acquiring Level

Three Trauma Center designation. The other thing we discussed as a group was pediatric readiness and encourage all centers to go to pediatricready.gov and ensure that your center has the most up to date pediatric readiness verification process. So with that, we do have a motion to review.

So the State Trauma Advisory Committee Trauma Needs Assessment Subcommittee supports Huntington Hospital's suggestion from a Level Three to a Level Two Trauma Center based on geographic -- geographical and logistical constraints in their area. This is supported by the Regional Emergency Medical Services Council and Regional Trauma Advisory Committee and geographical logistical constraints in their coverage area.

CHAIR BANK: Any discussion on the motion?

MS. SNYDER: I have a -- I have a question. When you do these, these -- are these downstate hospitals? Is it possible to put in, like, the location of these hospitals, just so we have a reference point when you say, like, geographic --

MR. VELLA: Yes --

MS. SNYDER: -- constraint or --

MR. VELLA: We can add that, Suffolk County.

COURT REPORTER: Just the name of the person that spoke previously.

CHAIR BANK: So Huntington Hospital is in Huntington, which is in Suffolk County, which is the northwest corner of Suffolk County on Long Island.

MS. SNYDER: Okay.

CHAIR BANK: The question was asked by Kerrie Snyder from Albany.

COURT REPORTER: Sorry. Just for the record.

CHAIR BANK: Any other discussion on the motion? I think we could go directly to a vote. So everyone who agrees yes for the motion, please raise your right hand? Anyone voting no? So the motion will carry unanimously. Dr. Vella, anything else in your report?

MR. VELLA: No, that ends the discussion for the Trauma Needs Assessment. Thank you.

CHAIR BANK: Thank you very much. Do we have anyone from Injury Prevention?

MS. GORMAN: Hi, I m Sarah Gorman, University of Rochester. I just wanted to share that we had a presentation from Anthony Scalise from SUNY Upstate in the Syracuse area.

They presented his five-year, five-county study of geospatial mapping of Emergency Medical Services, dispatched falls among older adults. It was a very profound study of the forty-four thousand patient calls that were reviewed. Of -- - sixty-eight percent of them were actually transported, and the study identified the high-risk communities that can assist with targeted fall prevention and education.

This study was also prevented at TraumaCon this year, and it is actually going to be published in the Journal for Trauma Nursing in the next couple of weeks. Thank you.

CHAIR BANK: Any questions or discussion for the Injury Prevention Subcommittee? No. Okay. So we'll go to P.I. and again back to Dr. Vella.

MR. VELLA: Thank you. Mike Vella, Chair of the P.I. Subcommittee. So we had a very, very nice presentations. The first from Kerrie

Snyder and the group from Albany Medical Center Hospital that spoke about their, what I think is a pretty novel telehealth follow-up, following positive screens for -- for mental health in their trauma patients.

And then we also had a presentation from the N.Y.U. group, looking at screening for mental health, particularly in the outpatient setting, which I think, you know, is -- is less common.

So I think that was really what came out of the discussion was, screening in the outpatient setting, both at initial follow-up and then five weeks, and trying to hone in on that sweet spot in terms of how, you know, how and when we should be screening patients following injury, and then looking at novel ways to make sure that patients have access to care, because I know we all struggle with the inpatient and outpatient psych resources.

We briefly discussed two research projects as part of the New York State Trauma Research Collaborative, one related to ground level falls and triage and one related to interventional

radiology response times. Again, if you're interested in participating on this monthly meeting, or you're interested in any of those projects, please reach out to me.

And then finally, we discussed some topics for next time. Two of the topics that came to mind. There was a significant interest in looking at ways to improve the robustness of our trauma survivors network programs. And so one of the ideas that came up, we have some -- have somebody from the T.S.N. come and speak to us, whether that's in the P.I. Subcommittee, or I was going to reach out to the Injury Prevention Outreach Committee to see if that's something that they would -- would be willing to host.

And then I know we're all struggling with delirium screening; a number of our centers are in the red on the most recent TQIP report. So I will be sending an email out in the next couple of weeks for people to respond back if they're interested in presenting their center s delirium screening, and maybe even delirium prevention practices, whether you're doing well and want to present that, which would be ideal, because I think many of us are

struggling, or if you think maybe you're not doing so well and want to sort of talk about your processes and ways to improve. So more to come on that. I think that's what we're going to discuss next time. I don't have any additional discussion.

CHAIR BANK: Any questions for Dr. Vella? Okay. Thank you very much. Moving to the -- moving to systems, Dr. Rubano.

MR. RUBANO: Thanks, Dr. Bank. Systems did have a robust conversation, but nothing terribly exciting. We discussed the replant issue that remains in New York and the replant survey, which will be sent out, you know, one more time for any Center who hasn't had a chance to respond to -- to respond to it.

The Department of Health gave us an update on the trauma center designation change policy which is, at this point, in legal hands, and so we'll likely have an update in October.

And then we had really kind of a long chat about spinal motion restriction and an advisory group presentation that was led by Dr. Dailey, but that'll be discussed in more detail during new business. There were no motions from our

subcommittee.

CHAIR BANK: And that was Jerry Rubano from the Suffolk ARTAC. Any questions for Dr. Rubano? No. We ll move to pediatric, Dr. Wakeman.

MR. WAKEMAN: Derek Wakeman, STAC sub -- Subcommittee Co-Chair of Pediatrics. We have no motions. We talked about mainly two things today. We talked about pediatric readiness, and I'll build on what Dr. Vella said.

Just for clarification, the website is pedsready.org. If you're interested. So there's two main things. One is in New York State. Amy Eisenhower's office trying to enroll in emergency departments statewide into their database, called Always Ready for Children. We're up to fifty-four centers. There's two more that have recently applied. And then there is the National Pediatric Readiness Survey that is ongoing.

New York state is currently up to -- as of this morning, it was forty-seven percent compliance or completion. Now it's fifty. There's one added to the numerator, and two reduced from the denominator interestingly enough.

But anyway, we're up to fifty percent

now. The survey closes on May 31st, so please nudge and assist your referring E.D.s to complete. And then, we also talked a bit -- little bit about readiness for E.M.S. We typically talk a lot about readiness in the E.D., but I think E.M.S. is another area where we can be helpful.

There was a relatively recent survey about E.M.S. readiness and it suggested an overall relatively low readiness score, although there may have been -- it was probably underestimated the way the survey was done.

Regardless, we talked about ways to improve E.M.S. readiness, and Tom Moran shared with us, he's in the Albany area, that they offer free readiness trading to any E.M.S. agency. So that's an excellent resource.

And then finally, we talked again about teaching bleeding control to children. And I think this is a real opportunity for our subcommittee Dr. Green -- Director Greenberg had suggested this in the past, and I think we're going to start actually doing this. So we're going to build a working group.

There are -- there are centers within New York state who are doing lots of great work, and

so we're going to take their successes and try to build a toolkit, if you will, resources for those of us who aren't maybe doing this as well, who -- those of us who are interested.

So we've already put together some names of a working group and hopefully they're going to start to work on this and then report back to us next time. And that's all.

CHAIR BANK: Any questions for Dr. Wakeman? Okay. Thank you very much. Do we have Kate McGuire here or anyone from the A.T.S.? Oh. Okay. Thank you.

MR. CLAYTON: Mr. Tafford Oltz for New York State Division of A.T.S.

MR. OLTZ: Hi, Tafford Oltz, President-Elect, New York State Division of the A.T.S. We held our dinner meeting last night. We had a very nice report from Christy Meyer on legislative and injury prevention.

We also -- I presented -- was a 20 -- 2025 recipient of a grant -- I built a distracted -- portable distracted driving module that I take out to the schools. So I presented that to the group. And I -- last year we saw sixty-five hundred parents and

teens that we use this distracted driving grant that I used.

And then, we had our 2025 distinction awards. And also, a nice presentation from Josephine Peterson on safe state presentation of tools to help trauma centers through the A.T.S. And that's all I have for the report.

CHAIR BANK: Any A.T.S. questions? No? Okay. We'll move to SEMCO.

MR. CLAYTON: Actually, SEMAC.

CHAIR BANK: Yeah, I see.

MR. DOYNOW: So Don Doynow from SEMAC. We met two weeks ago. What's interest to this committee, Dr. Rubano sitting to my left here, is now the STAC representative to SEMAC.

The state has finally created a physician E.M.S. medical advisor position through Department of Health. This only took close to thirty years and I know that because I applied back in the 90s. And the position never went anywhere.

About eight years ago, SEMAC again, approached Ryan Greenberg, and finally, the position was posted. My understanding is there are a number of people who have applied, we don't know who they

are, that's a civil service position.

I don't know, Steve, if you have anything to -- to say about that, probably not at this point. But no one has been picked yet, but hopefully, we will have a position that will be advising D.O.H. on E.M.S. in the near future. And the last part, I'm going to turn over to my colleague, Dr. Dailey. It's basically a protocol for suspected spinal injuries and C-collar usage.

MR. DAILEY: Actually, I think that's actually planned for new business at that point.

MR. DOYNOW: Then, we will put that to new business. That's the end of my report.

CHAIR BANK: Any questions for Dr. Doynow? Okay. E.M.S.C., Dr. Cooper.

MR. COOPER: Thank you, Dr. Bank. E.M.S.C. met about two weeks ago or so, I think.

CHAIR BANK: Okay.

MR. COOPER: And we had a very, very good meeting, very busy. The highlight of our meeting was learning about the Oliver kits. The -- the Professor Dziura has a lovely, lovely young poo -- young -- young beast named Oliver. And Oliver kits have been created for every region, that include

mini-Oliver stuffies, to go out to various schools and other types of organizations, to teach kids about emergency medical services primarily in children, but E.M.S., in general.

Kudos to Ryan Greenberg, who arranged for Governor Hochul to sign a proclamation in honor of E.M.S.C. Day, which occurred on -- on May 20th, last week. There was extensive discussion about the Pediatric Read -- Readiness Project. You've already heard an update on that from -- from previous speakers. We spoke a fair amount about our current procedural sedation program, which has morphed into a procedural comfort program.

We are seeking to find ways that we can make in -- minimally invasive procedures somewhat more comfortable for children. A lot of work has been done on this. We've re -- we recently learned that the red cap platform that we were planning on using, is sort of based out of University of Rochester, will not allow the State to collect the data, so the platform has been trans -- transferred to the State's Drupal platform. More to come on that at our next meeting.

The Pediatric Assessment Triangle,

ambulance card that we update every few years after the -- the American Heart Association and the ILCOR come out with their new recommendations. Several changes were made primarily with respect to the neonatal resuscitation protocol. I won't go into further detail on that, because the neonatal resuscitation is primarily a delivery room issue.

We also spoke at some length, not about Part 800 regulations, but prior to that, just a brief mention to let you all know that the Pediatric Ag -- Agitation Project that we've been working on for quite some time. The videos are now posted on the Vital Signs Academy website.

They are really terrific, actually. Really focusing on how to, you know, make sure that kids that are transported for -- for trauma or to your trauma center can be, you know, can be successfully handled in terms of dealing with, you know, their -- their level of agitation. The Part 800 issues that -- that arose had to do with some technical issues regarding the chest, the -- the need -- the needle size for chest decompression, the -- which fuse -- infusion pumps were acceptable, and which ambulances need -- need to carry length-based

resuscitation tapes for, within their, you know, within their armamentarium.

Finally, a brief discussion on a child abuse screening tool on pediatric non-transports, it turns out that as many as twenty percent of -- of pediatric transports in New York State result in non-transport. And we need to look into that further.

Finally, it's time for us to look at the -- at the re -- revision to the -- the pediatric intensive care document that was created about fifteen years ago. That will be done over the summer and will be ready for you in the -- in the fall with an update on all of these -- all of these issues. Busy time for us. We'll be happy to answer any questions you might have at this point, but that concludes my report. I hope that was brief enough for you, Professor Bank.

CHAIR BANK: Dr. Cooper said he had a lot of stuff to say, and of course, the -- I said, oh, he's -- any -- anything Dr. Cooper wants to say is well-appreciated at STAC, but I did remind him of the time that everybody has -- spends here. Any questions for Dr. Cooper? Thank you very much.

Anyone -- any questions for any old

business? I -- I personally don't have anything. Anyone want to bring anything up that we have previously talked about and want to re-visit? If that's a no, then we're going to move to new business. Dr. Dailey, we really had a very interesting discussion about the need for spinal motion restrictions in the systems committee that Dr. Dailey wants to bring to this tax attention.

MR. DAILEY: There we go. Now, it's on.

Okay. As I had mentioned this morning, the order that we had hoped to bring this forward was STAC and then SEMAC. However, because of Snowmageddon, we shifted and ended up bringing it here first -- or sorry, bringing it to the SEMAC first. The SEMAC approved this -- this protocol and it comes here that way.

This morning we reviewed some slides and spent some time talking about the background behind a change in our spinal motion restriction protocol. Currently, any patient who has Level One blunt trauma criteria is required to be placed in a cervical collar.

We talked a lot about some articles

that have been written, reviewing the literature that's out there, and the fact that there is nothing to support the use of a rigid extrication collar. We talked a lot about the potential for harm, but not that harm actually is done when these patients do not get these collars. And we talked about some specific patient interactions where actually the placement of the collar caused discrete and clearly identifiable harm.

So what I bring to you now -- Tom, can we put up the protocol, it would be slide seven? So rather than going through all of the background again, which is the PECARN (phonetic spelling) criteria, Nexus, the Canadian C-spine rules and some literature.

What I thought we would do is let's just look specifically at the -- at the protocols, recognizing that from your seats right now, there's no way in heck you're going to be able to read these. The one to the left is our current protocol. And if you look, Box A, that is where it says that for blunt trauma patients meeting leveled criteria, these patients require cervical collar.

You'll notice in the proposed protocol

draft to the right, that no longer exists because what we want to do is establish the opportunity for our clinicians to act in the best interest of their patient.

I'll read the specifics to the right in Box B, which you'll notice is a lot less busy in the proposed protocol draft, rather than the current protocol, which is quite challenging to -- to follow. So the first is, does the patient have a significant blunt trauma -- does the patient with significant blunt trauma have the following?

Altered mental status or intoxication. Those are criteria from NEXUS. Cervical spine pain or tenderness, again, from NEXUS. Abnormal neurologic exam, this is from NEXUS, the Canadian C-spine and PECARN. Oh, actually, the altered mental status is also from PECARN. And distracting injury producing an unreliable exam. That unreliable exam sort of crosses into PECARN, as well as coming directly from NEXUS.

And then, the last thing is, is there a clinician concern for significant C-spine injury? If those are yes, we say spinal motion should be minimized. Consider the use of an appropriately

applied cervical collar.

There's two things that are important there. The first is that E.M.S. clinicians are not being required to place cervical collars on patients, right? The second is, that if it's going to be put on, it needs to be put on correctly. We all know some come in here, some come in here, and as a result of that, more often than not, they are incorrectly placed. The extrication collars are -- are particularly problematic.

If the answer to all of the things in the box to the left is no, then the patients without any of the above findings may be transported without the use of a cervical collar or any other means to restrict spinal motion. So that would be using towel rolls, which is one of my favorites, or any other mechanism to keep this person from -- from moving around.

Our concerns, obviously, is there are and there's an increased incidence of spinal -- cervical spine trauma in patients over the age of sixty-five. We know that that's a -- that that's a potential problem. But we also know that cervical collars are not the answer, because many of these

patients have got other concomitant situations that make it more challenging to be in these devices in the first place.

The goal here is that what we are doing is giving our E.M.S. clinicians enough opportunity to do the spinal motion restriction they wish to do, give them the latitude to slowly adjust their practice rather than changing their practice tomorrow. And ultimately, for us to improve care across the continuum from the hosp -- from the pre-hospital environment into the hospitals.

The last bullet under D, down at the bottom, you see it in red there, is lack of a cervical collar does not equal cervical spine clearance. That means these patients may very well still need imaging in the hospital. They need people to take care as they move them. Taking care of our patients and moving them carefully and judiciously, that's just good medicine. Doing imaging on patients who we believe need imaging, that's good medicine. Putting patients into positions that cause discomfort, cause anxiety, and cause long-term skin breakdown, not good medicine. So I think this is taking us very rapidly in a -- in a good direction.

The goal would be for this protocol to be updated for implementation in September. Leading up to that, Dr. Rubano and I will be getting together to do education that will be pushed out to the Emergency Nurses Association through ASAP and through our E.M.S. clinicians through the Vital Signs Academy, so that we can make sure that we have the same message going out to everybody. This doesn't mean you don't worry about cervical spine injuries. Cervical spine injuries happen. They're horrific. Just means this is a tool that we are not going to use haphazardly all over the place and potentially continue to injure our patients.

CHAIR BANK: Dr. Rubano, anything to add?

MR. RUBANO: No. Again, I think it was, you hit everything. It's not saying don't use collars, it's just saying use them when they're appropriate. And I don't want to put Dr. Goldman on the spot, but I think he made some very good points this morning about some of the detrimental effects that the collars can have in certain patient populations. So for those who weren't at the subcommittee meeting this morning, that may help them

with this.

MR. GOLDMAN: Thank you. Ari Goldman, Orthopedic Member of the STAC. There -- there are multiple recent studies that -- that investigate this. The -- the issue is -- is -- is not do we need the rigid collars or not, but are we doing harm to our patients by putting rigid collars on? Cadaveric studies have shown that you have to extend the neck almost twenty-five degrees to get a cervical collar on. And additionally, putting the collar on has narrowed the amount of cerebrospinal fluid, and can cause additional injury to an already traumatized cord.

Studies in systems where they've eliminated the use of rigid collars, all over this country and also throughout the entire country of Austria -- Australia, shows no increase in secondary neurologic injury without the use of C-collars.

The Wilderness Society of for -- the Society for Wilderness Medicine, sorry, has told their members not to use rigid C-collars anymore. There are multiple other studies, but this is not a -- this is a very conservative protocol. A lot of E.M.S. organizations have completely outrule --

outlawed the use of rigid collars. And I think this is not outlawing it. I think it's giving the provider in the field, their judgment to use whatever the best way is to immobilize the patient and get them to a hospital safely.

CHAIR BANK: So -- so just to be clear, this is a draft protocol, so we expect this to be probably in place in September officially? Or -- or is that -- is that where we're going? What -- what -- what else has to happen before this becomes official in New York State?

MR. DAILEY: This is -- this is actually past the SEMAC. Well sorry, med standards and SEMAC and the State E.M.S. Council. So the -- the motion that I made there that we've -- that was passed and approved, was that this would go into place with the protocol changes that are coming, if it was approved by this body, because I wanted to make sure this body was involved even though it occurred in an order that we didn't expect.

CHAIR BANK: Okay. So any questions for Dr. Dailey about the new draft cervical spine protocol? Dr. Reddy?

MR. REDDY: Dr. Reddy, Jacobi Medical

Center in New York City ARTAC. My only question is, if someone follows yes in that B in the proposed draft, I think we all would feel that they should be immobilized. I think we agree that the collar is not necessarily the answer, but they should be immobilized. And -- but we just left it as a should and not a must. Should that not be a must and not a should in the red box on -- on -- on the proposed draft?

MR. DAILEY: Maybe it's on. So I never want to write must in a protocol. Should and a strong should, right, is -- is as much as I -- as I would want to do. Because the problem is, if we've got somebody who is intoxicated, has a pretty good bump on their head, you can say that they have the potential for a spinal injury. Okay? But they're intoxicated. I have two choices. I can let them continue to move on their own, or I can fight them, sedate them, potentially paralyze and intubate them, in order to make sure that they don't move.

Should, leaves it much more safe for the people that are actually doing the practicing, both in the field and in the emergency department, because we all face that every day. This person's

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got a pretty good mechanism. They're altered. It seems like it's because of alcohol, substance, whatever. How far am I going to go? Where -- what is that point? So should, I would much prefer.

MR. FISHER: Chris Fisher, again, I can see it better from here. Sorry hear me? Oh ah, there we go. Hi, Chris Fisher from Stony Brook. Just reading that, I noticed you took out or is it removed the -- the part where it says any deformity of the spine. Is there a logic behind that?

MR. DAILEY: That's never been shown. That's not something that's been shown in anything else.

MR. FISHER: Okay.

MR. DAILEY: To - to -- to matter, if you will. So leaving it the way it was.

MR. FISHER: That's a good reason.

MR. DAILEY: Yeah.

MR. FISHER: Thank you.

MR. DAILEY: No, I thought you were going to comment on the fact that it still says down below in the key points and considerations that a long spine board is one of multiple -- modalities. And I was just talking to -- to folks over here, that

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that actually was supposed to come out of there too, because we've already theoretically moved past long backboards and we shouldn't be transporting people on long backboards anymore. But I've got a stack of them outside of my emergency department to say that we're not being particularly effective about that.

How -- however, one of the backboards I did find is from New York City E.M.S., yeah, that one's in my office now.

CHAIR BANK: But we could ask New York City to come up to Albany and get their backboard. Kerrie?

MS. SNYDER: Kerrie -- Kerrie Snyder from Albany Med. We could -- we could make fences. We could do the -- something with all the backboards downstairs or think of pallets. We could do things.

I just -- I just want to reiterate in our discussion this morning, we talked about the need to try and help match up E.M.S. documentation as part of this. Just, I think that's important to have on the record. This is going to need to be a collaborative approach amongst emergency medicine, nurses, E.D. providers, right? We don't want E.M.S. coming in, getting yelled at, because patients aren't

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in collars.

Also, for our P.I. teams who are responsible for the reviews, we need to be able to see the documentation, you know, the decision-making, what have you, you know, for following the -- the new guidelines. So I think that if we're going to do this, they need to both be done in conjunction.

CHAIR BANK: Yeah. So Dr. Dailey, I'm guessing that this would have to become official first, and then the education will be rolled out. Is that -- is that true?

MR. DAILEY: Plan would be to work on the education as soon as it's approved, so that the education is ready for E.M.S. agencies through the summer. And so it can be pushed out to ASAP and the E.N.A. in particular through the summer.

CHAIR BANK: This -- this is going to be a huge educational jump for E.M.S., E.M., nursing, trauma. So I would just ask, maybe you could come back in October, and just make sure that this is -- at that point, I would guess that this is going to be an official protocol. Maybe, if there's any changes, bring them back to us. And then, I would be very interested, at that point, of what educational

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efforts have been rolled out. And I can bring them to my own healthcare system and we should really just talk about it at STAC so everybody's aware of all the educational efforts.

MR. DAILEY: Agreed. And I think something that -- that everybody can do through this pro -- through this time would be to bring those comments back here, push those through Steve and folks at the -- at the division of E.M.S., so that we can get that information and continue to improve the education we're pushing out.

CHAIR BANK: And --

MR. DAILEY: We need -- we need to know when it's -- when it's failing. Because I don't think the fail is going to be for the patient care. The patient care will be okay. It's going to be the human-human interaction in the trauma bay and in the --

CHAIR BANK: Uh-huh.

MR. DAILEY: -- in the E.D. receiving patients from E.M.S. That's where a significant amount of the discomfort is going to -- going to land.

CHAIR BANK: And then we're going to

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send out these slides on the listserv.

MR. VELLA: Can I make one quick comment?

CHAIR BANK: Yes.

MR. VELLA: I don't -- I don't know if it's too late. So I -- I, you know, I appreciate the efforts here. I -- I've sort of been -- been a vocal, you know, proponent of, you know, aggressive imaging in elderly patients, even with minor mechanisms, because these patients hide perks, facets, and other things that, you know, we see from time to time.

So recognizing that the red appropriately so does not mandate a cervical collar, which I think is a good idea for the -- for the reasons discussed. It's still a little vague to me, you know, while I appreciate the guidelines should be used with caution in those over age of sixty-five. Has there been consideration to just moving age above sixty-five into the gray box as a yes?

So not necessarily mandating a collar, but should we in that patient population be more aggressive about maintaining some sort of a restriction? My only suggestion, it makes it a

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little less vague in -- in patients who oftentimes hide or can hide more significant spine injuries.

MR. DAILEY: That certainly sounds reasonable. And that is Dr. Vella down there, right?

MR. VELLA: Oh, sorry.

MR. DAILEY: Yeah.

MR. VELLA: Mike -- Mike Vella. Yup.

MR. DAILEY: No, I think that sounds very reasonable to put that into the gray box up into the left, because the idea that we shouldn't be moving people's heads around makes a -- makes a ton of sense when there is increased potential. That certainly is one of the things that the Canadian C-spine rules tells us. I don't think that requires this to go back anywhere for that change, since the -- since that advisory information's already included within the -- within the document. Moving it so it gets more attention I think is very reasonable.

CHAIR BANK: Any other questions for Dr. Dailey? And so Doctor, we want to put this in a motion for the STAC to approve this draft of the protocol. Is -- is that true? Is that what we want to do?

MR. DAILEY: No.

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CHAIR BANK: No. Okay.

MR. DAILEY: No, I think you're just voting to approve it.

CHAIR BANK: But voting to approve --

MR. DAILEY: With -- with the change if -- if the -- I would say first, let's have the body, a show of hands from the body, if they would, and I'll make the motion that we alter the bullet in the gray box to the left for Dr. Vella. And then, after that, then we vote to approve this as the -- as a change to the suspected spinal injuries protocol.

CHAIR BANK: So any other discussions before we vote with the changes that Dr. Dailey --

MR. REDDY: Dr. --

CHAIR BANK: -- oh, one more?

MR. REDDY: It was Dr. Reddy from New York City ARTAC. There was one other change you said the -- the SEMAC made on -- on the protocol that one last change.

MR. DAILEY: Removal of the long spine board is one of the multiple modalities line was supposed to come out.

MR. REDDY: I don't know if that something was moving up into the box. Also, a

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different thing was moving into the box, you said at the subcommittee that the --

MR. DAILEY: That was the A-sixty-five --

MR. REDDY: -- clinical judgment -- the clinical judgment or something?

CHAIR BANK: Okay. Any other questions? So the motion is to approve this with those changes, correct? You're going to come back in October for the final version and any educational efforts. These slides will be available, sent out on the listserv for education at all of our various institutions and SEMACs and ARTACs and everything. So can I have a motion for approval? Ms. King motions, do I have a second? Dr. Agriantonis seconds. Can I have a vote for approval with the changes that Dr. Dailey mentioned? Okay. And any nos? One no from Dr. Flynn. Any abstentions? One abstention. Dr. Flynn, any comments that you want to give?

MR. FLYNN: No.

CHAIR BANK: Okay. So the motion passed with one no and one abstention. Any other discussion, Dr. Agriantonis?

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MR. AGRIANTONIS: Still on new business.

CHAIR BANK: Oh, I'm sorry. Any other new business?

MR. AGRIANTONIS: Dr. Bank --

CHAIR BANK: Dr. Agriantonis?

MR. AGRIANTONIS: Yeah, I have a - a new business I want to bring to the STAC for consideration. The New York City ARTAC has recently revised and locally adopted or approved our -- their bylaws, the New York City bylaws. And they have been presented, distributed to the STAC members last week. So I want to bring forward for consideration with approval for the New York City ARTAC bylaws. I understand they have to age out another meeting, but this is the meeting we want to present them. And they've already been distributed.

CHAIR BANK: So the New York City ARTAC bylaws have been sent out to the STAC members. We will give the STAC members a little more time to read it. So we will be presenting this at the October STAC meeting and it has the age one STAC. But any questions for Dr. Agriantonis right now for any of the New York City ARTAC bylaws?

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MR. CLAYTON: So I don't believe -- correct me if I'm wrong on that and staff that this proposed bylaws have been forwarded, correct?

MR. BONFIGLIO: I -- I don't believe they have; they were forwarded by -- by the ARTAC.

MR. CLAYTON: Okay. I had something that we need to put that through the Division of Legal Affairs in connection with the approved bylaws.

CHAIR BANK: Okay. So we were planning on bringing this back in October anyway. But again, any questions right now from this point? We're not going to approve it right now because it's going to come back in October. We'll put it through the Division of Legal Affairs. But any questions just from the STAC about anything in the bylaws right now? No?

So we will approve -- I'll send it through the approval process and we'll bring this back in October. Okay. Any other new business?

MR. VELLA: Dr. Bank, just real quick, I know people want to get out of here. I -- I don't really have anything formal prepared. Maybe, we can address this in the October meeting. But on behalf of some of the helicopter E.M.S. agencies in our

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region as well as Dr. Guzman can't be in here, I know there's been some resistance in some elements across the state to allow helicopter services to perform finger thoracostomy. And that was requested that we bring that up to the STAC as part of protocols for appropriately trained and resourced helicopter E.M.S. agencies, to discuss at the STAC level. So what -- what is the best forum to bring that up for discussion next time?

CHAIR BANK: I -- I guess, you would bring that through either the P.I. committee or the systems committee. I would have people who are familiar with the topic present it. It can be discussed at the committee -- subcommittee and then, brought to the -- to STAC. I think we would probably discuss this in October -- October's meeting. I know Dr. Gesturing is very involved in this, so --

MR. VELLA: Yeah.

CHAIR BANK: -- his -- his input would be great, but I will bring people to the -- to the table who know about this. And -- and maybe even the SEMAC, is something the SEMAC would be interested in -- in -- in hearing about.

MR. VELLA: There we go. It was

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already approved by SEMAC in the past.

CHAIR BANK: Oh, it's already been approved through SEMAC? So I -- I think either the P.I. --

MR. VELLA: So maybe it's a new point.

CHAIR BANK: But it would be nice for -- for STAC to know about it also. But either through the P.I. committee, which would probably be very easy, Dr. Vella, for you to arrange and then bring it back to STAC in October.

MR. VELLA: Thank you.

CHAIR BANK: But it was already approved by SEMAC. Okay. So it is an approved New York State protocol at this point.

MR. DAILEY: Approval -- approved is an interesting term and sometimes challenging. The -- the challenge with this one is, where are the lines of the scope of practice? The thing I think that particularly with finger thoracostomy that we have to think about, and in -- in particular with the flight crews that we were talking about doing this is, this very clearly is the national standard.

Jamming fourteen gauges randomly into the chest and probably not actually into the intra-

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thoracic space, which we all know is what the literature shows is not optimal patient care. So the question will be on how we advance the scope on this, as it has met some roadblocks along the way. But certainly, this committee will be very helpful with that.

CHAIR BANK: Okay. So Dr. Vella, maybe we can bring this to the P.I. committee in our next STAC and then --

MR. VELLA: Yeah, I think Dr. Rubano and I were talking either to P.I. or systems. We can make sure it gets addressed.

CHAIR BANK: Any other new business? Dr. Dailey and then Kerrie or Kerrie and then Dr. Dailey?

MS. SNYDER: So Kerrie Snyder, Albany Med. This is not new business. It's going back to the old business. Can we get an update on where we stand with pre-hospital ground blood administration? The last -- my understanding is that it was supposed to be open for pub -- public comments last January.

MR. STATHIDIS: This is George Stathidis --

CHAIR BANK: George?

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MR. STATHIDIS: Yeah, from the Division of State E.M.S. So I can give a brief update. We are expecting the inter-facility blood and pre-hospital blood regulations to be coming out for public comment imminently. I don't have an exact date. That's something that will be informed of by our legal division.

But they are circulating for approvals and they should be coming out for public comment soon. When they are released for public comment, we'll be sure to share a link for where those comments can be made and a link for the draft regulations. Again, we're hoping that it's -- it's very soon.

MS. SNYDER: Thank you.

CHAIR BANK: Can we -- can we share that link just on the trauma listserv when -- when you get it? Dr. Dailey?

MR. DAILEY: Okay. Two things and I'll start with this one. First, to piggyback on what Kerrie just said, we have been quite dismayed at the length of time that it has taken for these regulations to -- to be issued and are concerned about the health and welfare of our hemorrhagic shock

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patients locally.

Locally here, we have already acquired some grant funding to support the implementation of E.M.S. blood programs, and we are using some of that money currently for blood refrigerators, which are now in our E.M.S. physicians' vehicles supported by the blood bank of the Albany Medical Center.

And we have six units of packed red cells in three different vehicles available for response to E.M.S. in the field. My great hope is that these regulations get finalized soon, make it through the rest of the regulatory process, and I no longer have to worry about answering the phone at three o'clock in the morning and going out to take care of a hemorrhagic shock patient that E.M.S. is perfectly capable of taking care of. So hopefully that will -- will move forward.

CHAIR BANK: Any other old business or new business? Sorry. Yes?

MR. DAILEY: Yes.

CHAIR BANK: Dr. Dailey?

MR. DAILEY: So I apologize for making new business, the -- the Mike Dailey show. But the last thing I wanted to talk about is a paper that was

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written by folks from Rochester, Albany, George Washington, and Innova (phonetic spelling) looking at tourniquet use.

We have changed the policy in the region to allow E.M.S. providers who reevaluate patients to do a tourniquet conversion to less and painful, less aggressive care of hemorrhage control. This thus far has proven quite successful. How it really is important for this group is that many centers have level criteria if there is a tourniquet that's placed. And as many as eighty percent of tourniquets are put on when they are not necessary.

By converting those tourniquets, once the patient can be evaluated in a calm environment in the back of an ambulance, we convert them to a different method of hemorrhage control. It, quite frankly, will reduce the additional pressures on the trauma service, who are already among the busiest physicians in our hospitals.

So I think this is something that's going really well right now. It actually follows work that was done in West Virginia quite successfully. And this started as a result of a project of looking at tourniquet use between law

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enforcement and E.M.S. And thus far, this has been quite successful. But I will keep this body informed as it continues to progress.

MR. VOSSWINKEL: Okay. Can I add a comment? I don't know if you guys can hear me. So Dr. Dailey knows this. We had a case in the University of Rochester where a ten-year-old boy had a tourniquet placed for a non-life-threatening gunshot wound, and because of a delayed transport actually suffered pretty significant harm from the tourniquet.

Like had he not had a tourniquet, he would have potentially gone home from the emergency department. Instead, he got compartment syndrome, needed fast shot, you know. You can just imagine, right? So these things can cause harm. It's sort of very similar to the cervical collar argument. So I do think we need to be responsible for advocating when they can be safely removed to remove them, particularly if transport s going to be longer than one to two hours, depending on what you read.

MR. VELLA: Yeah, I think that's -- Mike -- Mike Vella from Rochester. So very important topic, very lively discussion on one of the spotlight

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sessions at the C.O.T. in March that actually was led by the group from West Virginia who has publicly available protocols. If you Google West Virginia tourniquet conversion, you can find their protocols.

So you know, it's really two parts. It's -- its tourniquet conversion for the inappropriately placed tourniquets, meaning they're just like wrong. They're below the level of the injury, they're on the wrong extremity, which we see from time to time, because blood get, you know, blood smears over to the wrong side, that kind of stuff.

So that's like the obvious, you're going to take those down. But then the question we have to answer is, you know, what's the time on that? Do we take down all tourniquets? Do we do it at thirty minutes, one hour, two hours? There was a -- a lively debate about the timing of that, and I'm not sure we have an answer, but it's definitely -- I'm -- I'm glad you're thinking about it. And, you know, it's worth coming up with some protocols around that.

MR. DAILEY: I think one of the things important to recognize is that if a tourniquet was on and it worked, and you try to convert it to something else and it doesn't work, you turn -- put the

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tourniquet back on. Significant proportion of these cases, particularly the ones where tourniquets were placed by law enforcement, are very non-life threatening. Very few of them need to go to the operating room. One of the things that the original people that did some of this work were interested in doing was spending a lot more time training law enforcement in terms of when to put on tourniquets. And I was opposed to that and working with the state police pretty aggressively, I think that's not where we want to go.

When law enforcement arrives at the scene of somebody who is bleeding, law enforcement's first priority has to be, why are they bleeding? How is that a threat to me or the rest of the community around me? If we can get law enforcement to participate in hemorrhage control, that's a win for us. What we need is for E.M.S., after that scene is stable, after that scene is safe, reevaluate that -- reevaluate that patient, evaluate them appropriately, and then make decisions as to what the least traumatic method of hemorrhage control can be, and do that conversion appropriately.

CHAIR BANK: So just from personal

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experience, a lot of the posters and literature that originally came out of the Stop the Bleed campaign, actually, if you look at the algorithm, they say extremity bleeding please tourniquet, right. Which -- which is not medically correct, right? I had spoken to some of the people at the A.C.S. C.O.T. about this. If it really is extremity bleeding, place pressure, and if pressure stops the bleeding, you don't place a tourniquet, right? I mean, you just keep pressure, packing pressure, stuff like that. The videos that came out after that at STAC that we do have packing and pressure and that's how we teach it in A.T.L.S. That's how I teach at Stop the Bleed.

But interestingly enough, I think that definitely law enforcement, I see some E.M.S. people when I asked them why the tourniquet was placed, he said that there was bleeding from the extremity and now it's not bleeding anymore.

But then I asked him, did we pack, did we put pressure? And they said, no, it was just a tourniquet. And -- and I would agree with that number. I don't know where it came from, but ballpark about eighty percent of the tourniquets

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personally I take down, either are not bleeding or can be controlled really just by -- by pressure. And -- and so you know if -- if you don't -- if there's a prolonged transport, it is worrisome about that tourniquet. But it is interesting that -- that I saw a lot of literature come out from the Stop the Bleed campaign that just said bleeding from extremity, place tourniquet.

MR. VELLA: Well, we've taught, you know, five million people how to put tourniquets on whatever it is and said this is an -- should be anticipated. I mean, this is what we're dealing with, right? We're teaching this, so we're going to see inappropriately placed tourniquets and now we have to deal with it. But --

MR. DAILEY: I think the other thing, too, is remember that if all of you -- all you have is a hammer, everything is a nail. And police officers wear a significant amount of equipment on their belt. There is space for a tourniquet. There isn't space for a tourniquet, and an Israeli bandage, and some quick clot and all of these other things. We would have very large police officers in order for those belts to actually work that way. We don't want

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that. They don't want to be there either. So at the end of the day, it's that E.M.S. re-evaluation, appropriate care of that patient at that point, thumbs up to the police officer for getting involved with hemorrhage control, take it down, convert it over to something less traumatic.

CHAIR BANK: Okay. Any other new business or old business?

MR. EDWARDS: Old.

CHAIR BANK: Kurt? Kurt Edwards.

MR. EDWARDS: Kurt -- Kurt Edwards from Albany Medical Center. There it is. Dr. Banks, thank you for bringing up personal on the tourniquets. I do have a personal interest in tourniquets, in that as a young officer in the army, I went for my expert field medical badge and was taught how to apply a tourniquet and was taught by an instructor. These kills people. Don't ever put them on the field. This was after Vietnam. And then, of course, global war on terror changed that whole situation. I was President of the military during that time where we had to relearn the application of tourniquets.

And I always wondered why they went

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away because the Spanish wind-lit glass has been around since the 15th Century. And why did we ever go away? They were pervasively placed in Vietnam. It's because we caused compartment syndrome and hurt people. So I think that the judicious use when you become ubiquitous in the use of tourniquets, you will hurt people, and then people will say tourniquets are bad. They are lifesaving if applied appropriately. When we talk about applying appropriate, if you do not cut off the inflow or arterial flow, you have a venous tourniquet, and then it very quickly becomes a compartment syndrome.

So I do believe that the current use, I would hate for it to go away and have somebody say, let's don't put tourniquets on, and go back to what we learned, you know, go back to what it was after the Vietnam War. So I do have an interest in making sure they're applied appropriately and released.

CHAIR BANK: Dr. Cooper?

MR. COOPER: Yeah. Dr. Cooper. I -- I want to support Dr. Dailey's recommendation that we look toward developing, you know, a -- an approach whereby E.M.S. reevaluates the tourniquet placement in the field. Clearly, educational material is

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required and -- and that should be the -- the main focus.

But I would just ask, you know, the SEMAC to consider the idea of add -- adding a line to the protocol, just saying reevaluation may be indicated so that it's not something that gets lost in the weeds. This is an important point, and I -- I think Dr. Edwards experience in this area is very germane and added to the experience that we've heard -- heard from Dr. Vella and yourself, I think really should move us in this direct -- direction fairly promptly. Thank you.

CHAIR BANK: Dr. Goldman?

MR. GOLDMAN: Ari Goldman, Orthopedic Member of STAC. There -- there are studies out there looking at different types of tourniquets and their application amongst lay people, and the percentage that those tourniquets are placed incorrectly. So I think that, not only saying yay or nay to tourniquet, but maybe we have to specify what type of tourniquet our -- our E.M.S. colleagues are using in the field, may also help poor tourniquet placement.

MR. VELLA: Can we just -- we just wrote -- our group was involved in the National

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Consensus Paper through the American College of Surgeons. This was published in Journal of Trauma recently. Looking at improvised tourniquets, as you're sort of alluding to. And actually, the recommendation nationally from the A.C.S. is -- is in uncontrolled bleeding, which may not be the patients you're talking about.

In uncontrolled bleeding, that's not -- that's refractory to pressure and no commercial tourniquets available, the conditional recommendation is to place an improvised tourniquet, if there's no other option. So I just throw that out there that, that is sort of a guideline, but you know, we can't assume that people are going to have commercial tourniquets readily available if packing and pressure doesn't work.

CHAIR BANK: Any other comments for new business or old business? No? Can I have a motion to adjourn? Ms. King, motions. Can I have a second? Roseanna Guzman seconds. Thank you very much. We are adjourned.

(The meeting concluded at 02:19 p.m.)

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