STATE OF NEW YORK
STATE EMERGENCY MEDICAL SERVICES
FOR CHILDREN
Advisory Committee Meeting

DATE: December 8, 2009

TIME: 11:36 a.m. to 4:02 p.m.

LOCATION: Crowne Plaza
State & Lodge Streets
Albany, New York 12207

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APPEARANCES:
Arthur Cooper, M.D., M.S., Cochair
Kathleen Lillis, M.D., Cochair
Sharon Chiumento, B.S.N., E.M.T.-P
Ann Fitton, E.M.T.-P.
Jonathan S. Halpert, M.D., FACEP, R.E.M.T.-P.
Robert Kanter, M.D.
Rita Molloy, RN
Janice Rogers, M.S., RN, C.S., C.P.N.P.
Elise van der Jagt, M.D., M.P.H.
Ruth Walden
Lee Burns
Martha Gohlke
Lisa McMurdo
Jennifer Treacy, R.Ph.
Mike Tayler
GUESTS:
Sarah Macinski Sperry
Christopher Kus, M.D.
Wendy Weller, Ph.D.
Tim Czapranski, E.M.T.-P.

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(The meeting commenced at 11:36 a.m.)

DR. COOPER: Okay. I'd like to call the meeting of the State Emergency Medical Services for Children Advisory Committee to order. It's December 8, 2009, and we're delighted to have with us today some very special guests.

We have, of course, Lisa McMurdo and Jennifer Treacy, director and associate director of the Division of Quality Assurance and Patient Safety with the Department. They are the folks who are in charge of the division in which the Bureau of E.M.S. currently resides. And, of course, that is where we reside.

And in addition to that, we have Dr. Chris Kus, who is associate medical director for the Division of Family Health. Chris has about an hour with us, I believe, today to share with us quite a bit of information, which he will be doing momentarily.

One final note, of course, is that Dr. Wendy Weller and Sarah Sperry, who normally join us from the School of Public Health

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and the Bureau of Injury Prevention, are with us today as they have been in the recent past. And we continue to welcome your participation. Thank you so much for being here.

And last, but not least, it's my distinct honor to reintroduce to the group, Ms. Lee Burns, who has taken on the leadership of the Bureau.

As you can see, Lee has very broad shoulders, which is important because she is now doing three jobs. She's director of operations for the Bureau. She's assistant director for the Bureau, and now she's acting director for the Bureau. So, fortunately, there are three eight-hour shifts in a twenty-four-hour day, so you know, we will Lee will be able -- Lee will be able -- Lee will be able to handle it as she has always handled everything else. But she has taken over the leadership of the Bureau from Mr. Wronski, who has stepped off into retirement.

Lee, as you know, is -- is an active paramedic, has been for many years, and brings with her not only a -- a wealth, in terms of

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both depth and breadth of administrative experience within the Bureau, but also is one of us. She is -- she is a healthcare provider. And so, she understands the issues in a way that -- that not everyone else can, because they're not out in the street actually delivering the care, as Lee does.

Now, I -- it is true that she sometimes does that on a motorcycle, and we have been trying to convince her that that's not a wise thing to do, but -- but -- but she hasn't listened yet. Fortunately, she listens about most other things.

But -- so, Lee, so thank you, and God speed in your new assignment, and we will be here to support you in any way we can.

I'd like just very briefly to call for a review and approval of the minutes. All of you, I believe, received a copy of the minutes by e-mail. Are there any additions, deletions or corrections to those minutes?

In hearing none, I'll entertain a motion for approval.

DR. VAN DER JAGT: So moved.

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DR. COOPER: Thank you.

Ruth Walden, and Elise Van Der Jagt.

Discussion?

All in favor?

MS. WALDEN: Aye.

DR. VAN DER JAGT: Aye.

DR. COOPER: Opposed?

(The motion carried.)

DR. COOPER: Carries without dissent.

Thank you. I'd like to move right into our -- our agenda. In the interest of time, I will ask you simply to read the agenda that is before you because I know Dr. Kus has very limited time. Dr. Kus is going to be pinch hitting in addition for, you know -- for himself, for Ms. Winooski of the Bureau of Community Chronic Disease Prevention. He will lead off talking about the Department's asthma initiative, and -- and then will speak with us about the issue of which all of us are most concerned, namely the H1N1 pandemic and its affects on the children of New York State.

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Chris?

DR. KUS: Sure. Glad to be here and -- actually just to give you some update why it's -- it's great, Pat Winooski is the project director for our asthma grant from C.D.C. and has recently taken a position within the Bureau of Chronic Disease. So, this asthma grant was previously in the Division of Family Health. So, she moves over to the other division, and she says, "oh, I can't make it, so you better do it." So, just so you know that.

But what -- what I want to do is make it as useful as possible for you. So, as we go through this, if there are specific questions that you have, stop me, and -- and go from there. I have a pretty tight presentation for asthma. H1N1, there's lots of stuff, so we'll go through that, and see which things are most interesting to you or -- or would be helpful.

So, to start out with the New York State asthma program, this is really talking about asthma from a public health perspective, because we've had a grant from the Center for

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Disease Control and Prevention for almost ten years and state funding committed to asthma care, particularly looking at what can the public health agency do to improve outcomes relative to asthma care. And this comes from the New York State Asthma Plan 2006-2011, where we had quite a few stakeholders participate, but we also have now a partnership which involves different agencies, Academy of Pediatrics, respiratory therapists, different organizations because what we've realized is the -- the work of asthma is done out in the field, and is there a way that we can coordinate that activity with our partners to take advantage of -- of -- of the resources that they have.

So, we're kind -- we've kind of moved from an advisory group to a partnership group so that people, as opposed to reviewing a plan once every year or so, we have quarterly meetings, and we really try to move agendas that way so that people are really taking ownership of this. And so this is where the asthma plan came from. And the big line is despite improvements in awareness, care and management, asthma still remains an epidemic in

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New York State with significant public health and financial consequences.

Disparities are a big issue here, which when we talk about this, the disparities that we see in asthma are similar to the disparities we see with lead poisoning in children and have -- have socioeconomic parts to it, but -- but in -- in a way, we've been talking about how to deal with that issue not just from one condition. And the idea is we're -- we're talking about what do we need to do to accelerate and spread improvements. It's -- it's really thinking about not doing more of what we're doing, but is there different thing that we need to do.

Next one.

So, give you a little information about the burden of asthma, the -- New York's action to control asthma, and the progress and next steps, and then hopefully, we'll highlight the emergency care system and how we -- we -- we'll -- we can work across that system to improve care.

Next one.

So, this just gives you some

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sense of the prevalence of asthma in adults using the behavioral risk factors survey, which different states us and what you'll see is that our prevalence rate pretty much goes along with the U.S., although we're -- we tend to be the higher bar.

And then, if I -- if I took this information and tried to give you information with regard to children, what you see is, depending on the area that we're talking about, we can see prevalence rates up to fifteen percent in some of the New York City population, particularly east Harlem and -- and those areas. So, there's a range.

Next one.

How about hospital discharge rates?

What you're seeing is New York City above, and then you're seeing rest of the state, and -- and then New York State in the middle. So, high asthma hospitalization rates in the city, and one of the things we -- you know, we're talking about is: Is that a reflection of

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the -- the way care is delivered; is it a reflection of the way people use the healthcare delivery system?

These kind of global figures what we've -- we've got. If you go to our Web site, we have maps of different parts of the state. So, it's really useful to look at those hospitalization rates on counties and lower areas.

Total cost. This gives you the -- if you -- if you look at the top one, that's really the adjusted cost, and so that's gone up slightly, when we look -- adjusting the cost back in 1998, and it's kind of flattened right now, but still a -- a big cost in terms of healthcare delivery dollars, and Medicaid dollars for the state.

Next one.

Okay. How are we doing?

If we -- we talk about healthy people 2010 goals, and here you're -- we're looking at the emergency department rate per ten thousand, which is one of the things that's actually new data items that we have in -- in the idea of emergency

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room visits relative to asthma that we're starting to analyze, and -- and look at the quality of that data. But if you look here, all our numbers are above the Healthy People 2010, and they're also above what the United States in general has from 2004 to 2006.

Next one.

How about discharge rates?

Similar profile here where we're not close to the Healthy People 2010, and we're higher than the -- the average U.S.

Next one.

Mortality rates. We, again, are generally higher -- well, we are on all except for over sixty-five in -- in terms of mortality rate for asthma.

Next one.

So, what are the challenges that we have in -- in terms of our system?

Well, one of them and -- and I guess this is the one where we talk a lot about giving the issue of healthcare reform, if you look at our healthcare delivery system, it's really

focused on acute care versus chronic care management. So, is there a promise that we will look at chronic care a little bit differently? The concept of medical home being used as a way of enhancing rates for doctors and trying to over -- trying to emphasize the -- the issue of coordination of care, you know, may -- may offer some possibilities. But if you -- if you look at the -- the amendments that have been proposed to health care reform, you look at the discussion, it's not too -- it doesn't look too promising to me in terms of chronic care.

And I think that's a huge issue here, because the incentive, particularly for pediatricians or family practitioners to take care of kids with chronic disease, financially, there's isn't an -- an incentive. There is no incentive to do that. So, I think that's a huge thing that we're talking about.

One of the things we're talking about is trying to get some -- since we have most of our kids in a managed care system, we're looking at performance measurements that reflect care of

chronic disease. But that's -- those are hard to do, and they're just being developed.

When we look at it, the gap between what is recommended as good asthma care and actual practice persists, I'll get into it, but what -- what you got was the continuing effort to get consistent guidelines about what's expected of care.

The positive thing about it is if you look at the back of this document, it shows all the healthcare plans that were involved and agreed to this; which is huge -- a huge thing to do to get them all to agree to the same thing. So, we're clear about what should be done, one of the things we look at when we do some of the work with practices, is that the systems aren't generally in place to allow you to -- to do some of this.

An issue specifically for this group is the -- is the idea of using the emergency room for primary care. So, your acute visits go to the emergency room, and then how do you get the ongoing chronic care management to be involved, or the primary care doc to be involved?

Reimbursement models do not support good asthma care. Real time information, not often available. I guess the promise of health information technology is -- particularly when -- when we're talking about kids, the -- the penetrance of medical -- of electronic medical records is -- is not very high right now, and I think there's some promise to that. But one of the things that I'm concerned about in kids is that the general products of medical records aren't very well tailored to pediatrics. They're generally adult specific.

A defined set of valid measures for asthma care is limited. We've done a lot in terms of working on that, and we've put out a surveillance document, and there are some measurements in the core measures, which is the measures that the state looks at for managed care.

Efforts to spread and bring effective evidence-based interventions to scale are limited. And this is probably the biggest one. Despite evidence self-management support is not well incorporated into the mainstream health

culture. Again, the idea that we're acute care as opposed to chronic care.

Next one.

This is the Health Department organization of how we are dealing with asthma. And we put it up here because it -- it -- it is -- it could be an ongoing model for care of chronic disease in general, because what you see is that good asthma care goes across many of the different parts -- the centers of the Health Department.

And so our structure was set up with having a leadership team. You see Pat's name as the coordinator, and Dale Morris is the P.I. on the grant that we have from the Center for Disease Control, and we've divided it up into four groups. The surveillance group, the healthcare delivery group, the community group, which -- which I'm the team leader on, and the environmental and occupational health group. And within those groups, we have people from different bureaus, different divisions, that have some contact with regard to asthma meeting, and the plus of that is that as you do this, you find that there's a lot

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of -- a lot of things that you could work together on besides asthma, or you could combine some things. So, I think the model of trying to work across the --the Department -- people always talk about stovepipes and all that kind of thing, this is the idea of trying -- trying to work across the Department.

Next slide.

If people are interested, on our Web site there is asthma plan, and I think we still -- we have hard copies that -- that we can give to folks. With it, you'll -- you see the -- the goals that are listed.

The first one really talks about that -- put all those words together about coordinated care. The second one is about the disparities issue. Third one is asthma-friendly communities, taking into consideration the environmental situations that kids are in. One of the activities that the -- the New York City program deals with, is standing buses in -- in -- in front of schools and -- and those all play a role with this. And -- and then, the fifth one is

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saying that you can't do this within the Health Department. We really are trying to have a public/private collaboration to improve asthma outcomes.

Next one.

This tells you where our support comes from. The -- we've been very consistent. I think this is -- and people have -- have liked the -- the structure of -- of the program, so that we've had consistent funding from the Center for Disease Control and Prevention, and that's not all -- for all states. It's for a really small subset of states, probably -- I think it's less than ten right now. And we also have state funding that's been fairly consistent, probably for the -- we've had it for the last, I think, about eight years, and our current funding for the state is two million dollars.

And -- and that funding goes to the main vehicle that we're trying to use to -- to get people to collaborate, which are regional asthma coalitions. And I would be interested to see if any folks on here are on those regional

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asthma coalitions, because they're supposed to take -- involve people from the different provider networks in terms of emergency room primary care doc.

I see one shaking head, so that's good.

And -- and the idea is that those -- those coalitions really try to bring people together and get them online in terms of what's the best way to help after they've assessed what's happening in their region. And -- and one of the tools that we've put into those coalitions in the last three years is an outcome learning network with the idea that it -- it's using the -- how many people are familiar with learning collaboratives?

Oh, we got one, two.

Okay. The -- the idea of looking at the coalitions as a learning network, and that they will come up with projects that seem to fit -- that should fit with what the goals are, that are in the grant, and then one of the key things about it is measuring outcomes about that, and to -- to

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see you're progressing because we can't say this is good, because of everybody getting together at a meeting; what -- what actually are they -- the outcomes that they're doing, if they put that together? And it's a way of people also getting information from all the other coalitions about things they might use. So, we've now gone into a WebEx series where people are sharing some other outcomes.

Next one.

This shows you the asthma coalitions, and this grant is going to be up for rebidding fairly soon, so one of the discussions that comes up is we -- we haven't had increased funding for the time that we've had the grant, so how do you effectively use it? So, the question will be are we -- we spreading it too thin? How should we be involved? And I think that's one of the discussions that'll come up with -- with our partnership.

Right now, there -- the -- the goals of the -- through our program is to say using the regional coalitions as a way to get best

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practices out there, that one of the things is to say we want to get out to people what's the state of the art in terms of clinical care. So, that's the -- the guidelines here, saying that we -- this is the way you should provide asthma care, and this is the second edition of -- of the guidelines. The -- and it came with the -- the updated guidelines from the -- the national program.

If you look at the guideline, the -- the -- the -- I think the biggest difference is there's a strong emphasis on control in this guideline. In the previous one, it was -- it was talking about classifying the asthma, but this one says you need to have some measure of control, and then -- and then when you use that measure of control, then it keys you into what treatments you should -- you should provide.

And I think I went through the rest.

Okay. So, that's what you got.

Okay. So, have -- have we made a difference?

This -- the first part is kind of

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what outcomes can we look at, and you can say -- well, we may have contributed to a twenty-percent reduction in asthma hospital discharge rate among children zero to seventeen; a thirteen-percent reduction for the total population; and a thirty-percent reduction over all asthma death rate. And that, you know, that's -- that's targeting those -- those big outcome measures.

Next one.

What have we done to relate to that?

This is kind of more the process measure things. We had been really active in publishing and presenting at statewide and national meetings. We've been involved pretty actively with -- with federal -- with national groups, particularly the C.D.C. in terms of the direction. We provided technical assistance to fifteen other states involved in legislation, and we've had lots of graduate, doctoral and preventive medicine resident students that have rotated through.

So -- next one.

So, what do we do in 2009 to

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2010?

We continue with the idea of having this asthma partnership group. We're continuing with -- with the regional asthma coalition, and we're looking at our current agency infrastructure to see if that makes a difference.

We do regularly put out asthma surveillance systems and program evaluation, and -- and hopefully have people use that information as they plan programs. And in terms of the actual healthcare delivery and quality, the consensus guidelines self-management toolkit that we put out, we have worked relative to benefits for asthma, and one of the biggest ones is there wasn't a certification for asthma educators, which there now is, and allows people to get that funded for. So, that's a little bit moving on in terms of chronic disease.

Next one.

We have a pretty big environmental part in terms of combining it with -- with some of the healthy home environments that we do. We look at the school air quality and outdoor

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triggers, and -- and then we -- we've done a specific learning collaborative with school-based health centers where we worked with, I think it was about six to seven school-based health centers that were in the highest asthma hospitalization areas, and said this is a vehicle to see -- to see if we could improve care.

And what we found was like what happens in -- in a lot of practices, if you ask somebody "how many kids with asthma do you have?" They -- they can't really tell you. They can say we have a, lot or we have -- think we -- think we have this much. So, we worked with them to develop a -- a registry with regard to asthma. We -- they -- they embedded the guidelines within their visit form, which helped them to continue it, and then we followed -- we tracked outcomes with that. And at -- at least during the time they participated with us, they continually improved the outcome of -- of good practice in that. And it was also used for -- the registry was used for a -- an immunization project, too. And actually, it's something you can use for H1N1, if you've got a

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listing of that, that's a higher risk group.

And I've already talked about the Asthma Outcomes Learning Network.

That's it.

DR. COOPER: Thank you, Chris, so much for that really very comprehensive presentation. I think all of us are really very pleased to know the -- the breadth of activities that the Department of Health has undertaken to try to get its arms wrapped around this -- this huge problem, which, you know, as we know affects our Downstate and lower socioeconomic groups really with a ferocity that's almost unimaginable.

Are there any questions for Dr. Kus?

Elise, and then Rita.

DR. VAN DER JAGT: Just -- just two questions. One is how are the E.M.S. providers, prehospital care, incorporated into the coalitions in the various areas? That's not clear to me. Sometimes we skip over that. We looked at emergency medicine, we looked at primary care physicians, we look at inpatient, but we don't

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necessarily use the providers, and what triggers me thinking about that is actually when Sharon passed around the A.L.S. protocols, you know, looking at, you know, the asthma protocol, managed that's acute care. But that brings to mind, you've got a whole lot of providers out there who deal with asthma on a daily basis. So, I was wondering what you would do with that.

And then, the second question I have, just very quickly, is did you -- have you -- if you look at the -- these various parameters, obviously, you can see that New York City sticks out as being extremely high-risk area. If you compared New York City with the Upstate area, without including New York City in the Upstate area, is there -- is there a difference between those two and how great is it?

DR. KUS: Well, it's -- I mean it's -- it's big. I mean the difference between that -- although you can find in the Upstate area, particularly in some of the rural areas, you can find hospitalization rates that are higher, and -- and when you look at it, it may be the access to

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care thing.

But I think one of the things we -- we see is in terms of the actual looking at rates, that global New York City and the global New York State, doesn't tell you the -- the -- the story. That's why looking at the -- the county-specific ones, and looking at the population is really the way to do it.

But still the load of -- is -- is actually concentrated in several -- in several parts of -- of New York City. The -- the -- the highest level.

Your E.M.T. question is a good one. I know that some's include it, but I -- what I can do is I will go back and I will see what our current list is, and what we've done to do it, because we -- when we enlisted people to -- to be involved, people were given the directions to really look at the -- the continuum of the healthcare delivery system. So, I -- I -- I know that there's a couple coalitions that involve people. But to give you a whole sense of that would be good. I'll -- I'll do that.

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DR. VAN DER JAGT: I just think that you have a whole lot of E.M.S. providers who are really good in education in that -- in that sphere of E.M.S. --

DR. KUS: Uh-huh.

DR. VAN DER JAGT: -- that might be really used as a -- as a tool to help some of the educational aspects of this.

I know you've got asthma educators, and things like that, but you know, I -- at least in my area, E.M.S. providers are very interested in -- in whatever they can do to educate in the local communities. And if they can be part of this, I think you will have a whole lot more people to help out in this area.

DR. KUS: Yeah.

DR. COOPER: Chris, I was actually going to follow along with a similar comment, and -- because Elise has raised the issue, I'll follow along with it now. It really strikes me that we are missing a major opportunity in terms of community education, by not making greater use of our E.M.S. providers.

The American Red Cross has created a whole slew of what it calls tear sheets. It's -- they're just -- they're just eight and a half by eleven sheets of paper that are bound together with, you know, a padding compound at the top just like a regular, you know, pad of paper that -- that -- that we use. And the tear sheet is a simple document, sort of explaining to the public simple measures that can be taken to, you know, reduce the impact of disease, you know, morbidity for themselves and their families. And I was wondering, you know, why not create a document like that, that -- that, if you will, takes, you know -- or makes use of the teachable moment --

DR. KUS: Uh-huh.

DR. COOPER: -- that our -- our E.M.S. providers could actually, you know, tear one off, give it to the family, and say, "here you are, you know, think about primary care, think about -- if you don't have primary care, we'll help you get it, et cetera, et cetera." All the things that we know that make a huge difference in terms of -- you know, in terms of getting control of this epidemic.

And I think that -- I think that might be a nice project for us to work on together, you know, developing an instrument like that, that we could share with our E.M.S. providers.

Rita?

MS. MOLLOY: So, one of the things that I wanted to discuss with you to piggyback on what Elise said was, you know, I've been involved with the Asthma Coalition of Long Island for the last -- over a decade, and I'm on the school's environment committee, and I have been in an asthma-friendly schools initiative grant. This is year four --

DR. KUS: Uh-huh.

MS. MOLLOY: -- in my area. And one of the reasons why we were eligible for that grant was because our data for, you know, E.D. --

DR. KUS: Right.

MS. MOLLOY: -- discharge was way over the top for young children. So, we're looking to improve outcomes, but when you look at all these guidance documents, they really do recommend using an asthma action plan, which I see extraordinary

resistance in the medical community to take the time to prepare.

And school nurses receive every one of these children into some setting, from very young ages, pre-K on. And to -- to miss an opportunity to have a document that would help it be more seamless for care, not just episodic treatment, but that emphasis now on controlling medication.

There is a tear-off sheet about the rules of two that exists that asthma coalitions have put together with the Lung Association that speak to that very issue, because people don't understand that just because they've surmounted the crisis by opening their airways, all of the other mechanisms that are involved in having, you know, these -- over time these chronic health conditions and the lung remodeling, and all of these things.

So, it's really a key that we're missing that we can't seem to get a buy-in from practitioners, or even discharging from an E.D., to have a long-term plan other than that episodic care.

DR. KUS: Uh-huh.

MS. MOLLOY: And one of the things that I spend a lot of time -- myself personally doing with my clients is reeducating them and making them understand the difference between the mechanisms of action, why they need to feel comfortable using controller meds.

And you know, I'm going for my certification as an asthma educator. But part of the reason why I wanted to bring it to this table is I think we were missing the boat on the side, like Elise said, with the emergency providers, and then with the school nurses, because in New York State, even though we're not mandated as school nurses, we're very fortunate to have representation in just about every school in the state, where you do have a hands-on medical provider.

My frustration, though, is that the -- the medical information that comes to me after this treatment is very substandard. It may even say -- and I don't want to indict a hospital, so I won't even say where -- but it will say "was seen for illness/injury and can return to school."

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Well, it doesn't even tell me, so now I'm trying to get to the parent, trying to find out what, you know, transpired over the weekend, find out that this kid was bronchodialated back-to-back the night before, coming in, they haven't filled any prescriptions, there's nothing available for me to treat them in an emergency, and then, you know, we're off to the next episode.

So, I'm looking for a buy-in or a mechanism to make this more seamless, because we have some very good foundational people and -- and resources available, that we're underutilizing by not having a really good mechanism of getting the information from one party to the other.

A lot of people are afraid of the privacy issues. Well, if you have the parent there with the child anyhow, you can cross that bridge. The school needs to know. Where -- wherever the next person is that will be a provider of care or a caretaker of that person over a great deal of their waking hours, it's critically important, not just for the parent, to be told in the moment, who quite frankly they don't really get it in the moment

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because it's in the crisis.

DR. KUS: Right.

MS. MOLLOY: So, we need for that -- that ability to, you know, cross over time, and to get on board with the rest of the parties.

One of the things that the Asthma Coalition is trying really hard to do in my community is to reach pediatricians to get them, you know, a better comfort level of providing the controller medications, and to understand how they need to spend a little time educating the parents, because they don't really get it.

And -- and they don't. I can tell you. I've been doing this a long time. And I -- and I live with an asthmatic son, who I've, you know, had to reeducate school personnel over time. So, it's a really frustrating experience, especially when you do have a culture now of -- of realization that the emphasis needs to change, that what we're doing looks great at the top, but it's not working at the bottom, you know, so we need to -- we need to do something better. And I think by identifying the partners that we have that are

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there -- I mean we have a built-in structure to support the efforts at the top --

DR. KUS: Uh-huh.

MS. MOLLOY: -- but we need to find a better way of interfacing together.

DR. KUS: Uh-huh.

MS. MOLLOY: And I think the emergency room discharges could be a great place for that to start. You know how there's usually protocols for discharge where you -- certain amount of information has to be given, and a person has to leave armed with a certain amount of knowledge, so just to say that you need to go see your primary care physician in a day, you know, that's falling short because they're not going.

DR. KUS: Uh-huh.

MS. MOLLOY: They're not going for a myriad of reasons, either money, time, you know, many. And it might be -- it might be multifaceted, but you're really -- we're really -- we're not doing as well as we could be doing it if we addressed that gap. So, that's really why I had asked for, you know, this to come to the table

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because you can say a hundred times over, asthma action plans are great, they're the standard of care. Let's do it. Let's do spirometry, you know, in the office, let's do peak flows here and there. Well, if nobody's -- if nobody's bought into it, and nobody is doing it, let's think why, and let's either change it or make it happen.

DR. KUS: Uh-huh. Uh-huh.

DR. COOPER: Bob Kanter.

DR. KANTER: Those are great comments about the acute aspects. I wonder if you could talk for a minute about the trade-offs between programs or initiatives dealing with dedicated to one chronic disease, the asthma, versus a broader perspective on just a chronic disease in general?

DR. KUS: Well, I think our feeling is people that worked in this is that the model this -- this kind of thinking fits to a great extent to -- to lots of chronic disease, and it -- it really talks about the lack and -- of our health -- of our healthcare delivery system in terms of being able to provide that education. I

mean chronic disease -- to be educated that you need to take the medicine when you're feeling good is a -- that's a -- that's a tough message to get -- for people to get across.

MS. MOLLOY: Uh-huh.

DR. KUS: So, I think there's a lot of commonalities, and we're actually looking at trying to, in fact, Pat going over to chronic disease may move us looking at it in a more similar fashion.

And most people would say -- who deal with chronic disease say about eighty percent that -- of things that you're doing are pretty similar: Coordination, parent education and family support are the -- the things that you -- you need to bring into it.

I guess the -- the issue I'm struggling with is -- is the -- what can we do?

I mean I -- because I think in -- I -- I do have a note from -- because I knew this -- this question was coming up. But Pat sent me a note that specifically at -- in the Golisano Children's Hospital, Mark Lampil (phonetic

spelling) is -- is trying to address asthma control in E.D.s by -- by actually doing something in terms of the area of -- of asthma action plans. I don't know specifically what it is, but I will follow up on -- on it, because I've always had a hard time understanding how you can do kind of that sit down asthma action plan kind of thing in an acute setting. But apparently they're trying to do it. And they're working to -- they're working specifically with their regional coalition, and -- and -- and she also says that New York City wants to do a citywide policy on this. So -- and -- and apparently, it's working with the Association of Emergency Physicians to write a physician's statement. So, some of this then may be coming to the front. Now, I'll get further information on it.

I guess I -- I -- the part for me, is to try to figure out what -- what do you do because I think one of our messages up front is that you've got to get the family into a system of care to begin with. So, that -- that issue right up front; "do you have insurance? And I can get

you insurance is critical," and then we have to then have ways of making sure that the quality of care that's provided is good. But it does, to me, fit with the idea of, if I'm a primary care doc, and I'm not apologizing for them. If I'm a primary care doc given today's current system, it -- it -- it -- the incentive for you to -- to spend that time is really not a luxury that lots of them have. So, I -- I think there are people that do it because they think that that's an important thing. But if you become good taking care of chronic disease -- children with chronic disease, then you get more of them, and -- and it doesn't fit in terms of a reimbursement system.

MS. MOLLOY: I agree, but we could use some of the people who we have who are capable of being educators as -- as a way of offsetting that time spent --

DR. KUS: Uh-huh.

MS. MOLLOY: -- that they need to spend. I mean they just need to write the orders, particularly to get the people to have the availability of those medications.

The other thing I want to just caution, you know, everybody about is that frequently legislators, you know, think they're doing a good thing and there's been bills that have been bandied around about stock albuterol for schools --

DR. KUS: Right.

MS. MOLLOY: -- so that we never get a person under good control --

DR. KUS: Right.

MS. MOLLOY: -- and we're treating crises all the time and bronchodilating people to death.

DR. KUS: Right.

MS. MOLLOY: So, honestly, I will tell you that the Asthma Coalition came to me, and asked me about this, because well-meaning, and you know, and well intentioned actions sometimes, you know, the road to hell is paved with good intentions, you can't always just, you know treat something in a vacuum. And I think that that's sometimes they way things are sponsored. So, for this, you know, group, I think it's really

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important for us to, you know, emphasize that that's not -- that's not the spirit of what --

DR. KUS: Right.

MS. MOLLOY: -- you know, the initiatives are.

And it's not helping someone over time, because you want to talk about chronic disease models and lung disease when you get older. Just undertreat them all these years, and who are they going to be when they're get old? Right. So, let's think about that.

DR. COOPER: I'd like to -- before I recognize Tim Czapranski and Elise Van Der Jagt, our cochair, Kathy Lillis, has had a tremendous interest in this area over the years, and I just wanted to get her thoughts.

DR. LILLIS: So, I -- I put together an N.I.H. grant. Unfortunately, it wasn't funded, but what -- what the main initiative of the grant was to initiate chronic care in the emergency department for -- for asthma. So, the first part of the grant was doing a screening tool for anyone who came in with asthma to see if they met criteria

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for -- for persistent disease.

DR. KUS: Uh-huh.

DR. LILLIS: The second was a video that we were doing on an educational component, and it was based on one that was at Chindren's Hospital of Philadelphia, that it went through issues such as triggers, and -- and the difference between rescue meds versus chronic meds.

The third component was actually initiating the inhaled corticosteroids in the emergency department. And we were doing a randomized control trial, and we were either giving them the -- a one-month nonrefillable prescription for the inhalers, and actually in our pilot study, we actually gave them the sample drugs versus sending them back to the primary care providers.

All primary care providers were getting a letter saying that their patients met criteria for -- for chronic disease, and needed to be on this, and our primary hypothesis was that if we actually initiated in the department the primary care providers are going to be much more likely to continue the medications than to -- than to start

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them on somebody that -- that hasn't been started on it.

DR. COOPER: Uh-huh.

DR. LILLIS: And they were going to get -- the -- the list of guidelines of what -- where they needed to go if they needed to have the step -- stepwise approach.

So, we -- we recognize that it's very episodic care, that -- that it -- that there's acute -- there is this perception that emergency physicians deal with -- with acute illness and primary care providers deal with the chronic illness.

DR. COOPER: Right.

DR. LILLIS: There was also some concerns when we rolled out our pilot to our community physicians, there was a little bit of pushback with the pediatrician "saying you can identify them, but we don't want to starting chronic meds on our patients." There was also the concern that if the emergency department provides the chronic meds, would the kids stop going to primary care providers and just use the emergency

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departments even more. So, we were actually going to survey the community pediatricians and find out if there had been any disruption in their -- their relationship with their patients, based on our study. And -- and that's again, why we only did a one -- one-month supply, and the families were told, "you need to follow up with your -- with your primary care provider within the month."

And we had gotten scored, and -- and resubmitted. Unfortunately, with the funding, we -- we didn't get a high enough score to -- to be funded. But I mean I think it's -- it's initiative. I think emergency departments are going in this direction, when we were picking our PECARN sites, there were some studies -- some sites that couldn't participate in it, because of their existing physicians already prescribing inhaled corticosteroids, and their I.R.V.s would not allow them not to, or to randomize to --

DR. COOPER: Uh-huh.

DR. LILLIS: -- to not prescribing them. Children's Hospital in Milwaukee was -- was not allowed to participate, because

their I.R.V. said, of course, every asthmatic should be on --- every child with persistent asthma should be on inhaled corticosteroids. So, they, again, would -- were not allowed to -- to randomize.

So, we are seeing this -- the shift in emergency department physicians becoming involved in identification of the -- of the particular patients, and then initiating it.

But it's not as simple as just saying, "why aren't these docs doing this," because there's -- there could be some detrimental effects from -- from doing this, in disruption of primary care providers and children --

DR. COOPER: Sure.

DR. LILLIS: -- using E.R.s instead of primary care providers. So, I think it has to be done in a -- in a systematic approach that -- that links them back to the primary care providers to -- to continue the care that's been initiated.

MR. CZAPRANSKI: Yeah. Both as a paramedic and as a father with a kid with asthma, I

go into homes all the time, and -- and to the issue of using E.M.S., I mean we are really the only provider in that chain of care for that asthmatic that actually goes in the home and sees the circumstances by which the patient lives, and often identifies triggers.

Because, you know, we've gone through our home and done all the -- all the anti-asthma things you do, but when I go into homes, and I get a chance to talk to parents after we arrived at the hospital, because at the moment it's usually too acute to -- to talk to them, but we have time at the hospital, they're not aware of a lot of the things, or associations of the things, in their home or apartment as it relates to triggers.

I think the other thing is it's important as I sit on the Greater Rochester RHIO, which is looking into electronic medical records, when we pulled a group of physicians together and said, "if your patient goes to the hospital" - and these are primary care physicians - "are you aware? Do you get a copy of the prehospital care report?"

Across the board, none of them did.

And so, again, by having an electronic P.C.R. rolled up into a regional electronic medical records that's available for that physician to review to say, "wow, you've been to the E.R. three times for asthma, I was not aware of this. We need to change your medications, or change your plan, or do something different."

It will also improve the continuity of care, because sometimes these patients go to different hospitals depending on who's code red. But there's a lot of things that will improve the qualify of life and lower the cost by engaging E.M.S. to get out there and get in the homes and try to offer some additional information.

We bring them to the hospital, and you know, a lot of times you'll go in there, mom's smoking in the kitchen saying her kid's having trouble breathing, he's having an asthma attack.

But we get to the hospital. Nothing's ever done about that primary issue in the home, and so you're going to see the kid repeatedly

throughout their lifetime. So, engaging E.M.S. I really want to push.

DR. COOPER: Elise?

DR. KUS: Can I just comment on that one? Across -- I mean across the state the -- the service delivery system with regard to asthma, there are programs that include home visiting as -- as part of it. So -- so, that -- so -- and -- and people are very clear with the idea that unless you see the home, you really aren't going to know what's -- what are some of the factors, but it -- but it's not across the board for sure, and so anybody that -- that provides that info would be helpful.

DR. VAN DER JAGT: Rita, I appreciate very much what you have said about the schools, and it -- this made me think here a little bit, that maybe one of the things we should be looking at is the role of the school physician in the school system.

And -- and it -- what brings this to mind is, because of my connections with the American Heart Association Emergency Cardiovascular

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Care Committee, four -- I was looking at my C.V. actually, I think it's five years ago now, we -- we put together an emergency response plan for schools that was broadly disseminated, published in Pediatrics and in Circulation. It was an article that -- a guideline that was a joint venture between the American Academy of Pediatrics and the American Heart Association.

And although the -- the focus of that began to be the use of A.E.D.s in the schools, which was about the time that this was happening in New York State, it also discusses the management of asthma patients. And it actually suggests that school physicians are aware of the emergencies that might come up in their schools.

So, that makes me think that could we use that model of having the school physician who would -- initially what's going to be the A.E.D.s, and they have to endorse this as a reasonable thing to do, but that they also would be looking at identifying patients who have asthma, and then make sure that - just like we do with immunizations - that those patients have an asthma

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action plan in place in the nurse's office. Because I'm thinking that, you know, that working together with school physicians -- I mean I have to -- I'm thinking of Sharon. Sharon's on the New York State E.C.C. at this point, the Heart Association. You might even want to bring that up there, because it really is part of what the Heart Association came up with as a preventive strategy, so there would not be an arrest in the schools. So, there would not be these horribly sick kids that might occur there. But we all know that the real way to manage that is to prevent these from happening in the first place.

So, asthma action plans, school physicians, school nurses, it's a -- it becomes requirement, and then those patients if they -- you know, there's a question of, you know, what their peak flow might show, I mean you can -- there's a plan.

Anyway. Just some food for thought, that might be a coupling of some of these. And I don't know whether that would be part of the regional asthma network sort of discussions, how to

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solicit the use of the school system to -- in these preventive strategies. It clearly has to be coupled with their primary care physician.

But the school physician has responsibilities to a school, and it just seems logical to use that way of networking.

DR. KUS: One comment on that. I think -- I mean school districts are very different, and actually the -- the capacity of nursing within a school district can be almost nothing to a lot. So, I think you really have to have a -- a committed group to -- to do that. But part of what we had tried to do after we did with school-based health centers is to put together a plan, so that if a school saw that asthma was an issue they wanted to deal with, these are the -- some of the things you could do. And I think one of the things we did, because the -- the idea was to put nebulizers in every school, which was the acute treatment, which we -- we wrote against, and -- and I will get to this group. Christian Gillibrand put a -- a proposal with regard to asthma, which we've commented on, and is going more

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toward a chronic disease management than it initially did, which was more get acute things to the -- okay for one day, and then the other one.

But I -- but I guess I'm concerned, because it's -- it -- the capacity of -- of education -- I'm not as familiar with the city, because it's a different model, but here the -- the -- the actual nursing connection, and actually the time that school docs spend, it would be interesting to know how much that is because I don't know that there's a -- they're a big player that -- I don't know that, but you might be -- know a bit more.

MS. MOLLOY: And --

DR. VAN DER JAGT: But the -- but the issue -- I'm sorry to interrupt, but the -- but the issue there is, is really we have the PAD program in the schools. Essentially, they have to register --

DR. KUS: Right.

DR. VAN DER JAGT: -- and that has to be under the -- under a physician. Why would you not take the same model for asthma,

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because if asthma --.

DR. COOPER: Because once you sign it up you don't use it.

DR. HALPERT: It's a different decision.

DR. VAN DER JAGT: Well, of course there's a different decision.

DR. HALPERT: The overseeing the physicians in the P.A.D. has absolutely zero contact unless there's a deployment of that device, which happens how often you use it.

DR. COOPER: Correct.

MS. MOLLOY: That's right. And you know how often they --

DR. COOPER: Right.

DR. HALPERT: Extensively --.

DR. VAN DER JAGT: But they have to set up -- the recommendation is that they set up that system, you know --.

MS. MOLLOY: Once. And then I never see them come back.

DR. HALPERT: Right. Well, see that's --.

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MS. MOLLOY: I've never seen them come back.

DR. HALPERT: Right.

DR. VAN DER JAGT: Right.

DR. HALPERT: Yeah. We signed off on it.

MS. MOLLOY: I don't even have an updated list of who's certified to use the defibrillator --

DR. VAN DER JAGT: Right.

MS. MOLLOY: -- other than myself.

DR. HALPERT: Right.

MS. MOLLOY: Because I'm not the overseer of the plan.

DR. HALPERT: You -- you have probably a hundred asthmatics you know about in your school.

MS. MOLLOY: My biggest crises in my office regularly that are, you know, not injury-related are asthma. All the time.

And the school doctor usually is on a contract with each district for, you know,

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services to a point. And it's usually more revolving around sports physicals and routine physicals, and it's scheduled in that measure.

DR. HALPERT: There's also the PAD doctors are not the school doctors.

MS. MOLLOY: And it isn't always.

DR. HALPERT: Right.

MS. MOLLOY: In ours it is not either.

And the other thing is when they're engaged by contract, yes, they could be called on in an emergency, because they are the overseer. Like, for instance, for my standing orders for epinephrine, the school doctor has to write that order. So, they do generate certain orders for us. And if there were a problem in my office, and I couldn't reach a primary physician on a student or a parent, I could try to field that call to that physician. It doesn't mean they would always be readily available to me.

But as a consultant basis, they're not normally there for that primary interaction, that's -- that's not encouraged. As a

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matter of fact, on my district Web site, it says we cannot give medical advice to the community, which I find interesting.

DR. HALPERT: Right.

DR. COOPER: Rita, I'm getting --

DR. HALPERT: I know you're getting --

DR. COOPER: -- I'm getting short of breath.

MS. MOLLOY: It's really an exciting topic though.

DR. COOPER: It is.

DR. HALPERT: But there's a lot more than I -- right.

DR. COOPER: But -- but if -- we have a lot more business to transact today. But it is very clear that this is a critical issue, and one that I'm not going to say we have neglected for far too long, but that we have neglected to utilize our opportunities for community education in the delivery of emergency care for children.

Now, we are the state's official advisory body on emergency medical services for

children, and I think Dr. Kus has both shown us how much has been done, but in so doing shown us a glaring omission in our -- in our strategy, namely, utilization of emergency care providers to help get this epidemic under control.

So, here's what I'd like to do: I'd like to ask Kathy Lillis to lead a working group, to come back at our next meeting, with a one-pager with half a dozen or so bullet points on it, as to what we can recommend explicitly that emergency providers do, both in the field and in the E.D., to help the statewide effort to bring this epidemic under control.

I'd like Dr. -- Dr. Van Der Jagt, Tim Czapranski and Rita Molloy to work with Kathy on that -- on that project.

And Chris, with your permission, we will ask you to serve with that group as well, so we can be sure that what we recommend is in sync with what the State Department of Health is doing.

And I think, based upon what comes back to our next meeting, if there is some -- some simple instructional guide that we can

create -- create in terms of a brochure, or a tear sheet, or something along those lines that will help with community outreach education efforts, something that could be delivered by our E.M.T.s and paramedics to families in the field, and something that perhaps could be utilized by emergency physicians and nurses in our hospitals, and by school nurses, for families maybe the same document, maybe three different versions of the same document, that to follow in the following three months, so we can come up with a real solid, not only action plan, but by March, but by June supporting documents to assist with that process.

Jan?

MS. ROGERS: I'd like to make one more comment, though, because first of all, the family has a responsibility for taking care of their child, and that's one piece that we -- we can educate them, but we can't make them do things and carry through. That's one point.

The second point is that when we get different players involved, we have the emergency room telling them things. We have the

school nurse telling them things. We have, you know, E.M.S. telling them something. Parents are getting confusing messages from all of us, and I feel in a real dilemma in -- in my role, because I am telling parents things that the family doctor has not prescribed, and may not buy into. And so, where is the family in all of this? What do they make of all this conflicting information? The family doctor has not prescribed a long-term controller, but we are, you know.

So, I mean there's -- there's a lot of issues in my mind on who is responsible for giving that family a coordinated plan, like -- like you said?

And I don't -- I don't think it's the emergency room docs, because it has to be something that is followed up long-term, and I -- I have no problem with prescribing controller medications, especially on the basis of what Dr. Lillis said for a month, but then there has to be communication with the -- with the pediatrician to say that, "this is what we've done, and this is what we recommend." But then they have to follow

through on that.

So, it -- there's -- there -- it's all well and good to hit from all different angles, but someone has to be saying, "this is the coordinated issue," or "this is the coordinated plan for this family," or else they're getting all sorts of different view points.

And I think that's why families are so confused and don't know what to do, because they have too many -- too many fingers in the pot giving them little pieces. And I really believe it goes back to that primary care doctor to pull it all together, and I don't think that's always happening, but I think that's where it's got to come from, so the family has a consistent approach that they hear.

DR. COOPER: Jan, thank you for those comments. You are our voice of primary care at the -- at the table at the moment, and I would be delighted if you would work with the group, and -- and ensure that those thoughts are incorporated into the discussion.

DR. KUS: Can I just comment on

that, because I mean I think that's a principle-based issue, and -- and -- and I would say from a pediatrician's point of view -- from the Academy of Pediatrics, that's the whole concept of medical home, which says the coordination is at the primary care level, and people should help facilitate it.

I think the issue we're dealing with it is if it does -- if it isn't realized or if it's not happening, what can other parts of the system do to help that. And I think that's -- but I -- I think the issue that you say -- that you mentioned is -- yeah, the answer should be they should be in a medical home that provides this coordination and coordinates with any care system that they've become involved in.

DR. HALPERT: Sometimes the medical home has an absentee parent problem.

MS. MOLLOY: Yes.

DR. HALPERT: And that's where we run into a real roadblock.

DR. COOPER: I --.

DR. HALPERT: What Rita says is

correct, there's no orchestration, no coordination, and the reality of seeing this on a regular daily basis is, "hey, didn't someone ever tell you that if you have to use the rescue inhaler twice a day a day on a -- on a good day, you probably have wildly uncontrolled asthma? Didn't your primary care doctor? Do you have relationship with? Do you have insurance? You can -- you see them once or twice a year; didn't they tell you this?

Well, no. Well, why didn't -- I mean I know this, how come they don't know this. They're the ones who should know this more than I should know this.

I deal in acute episodic care. I'm the guy who stuffs the neb in your mouth, not the person to teach you how to avoid that.

DR. COOPER: Realized. John, thank you for reminding me that urgent care is part of the picture, so I'm going to ask you to join this group as well.

Tim?

MR. CZAPRANSKI: I'm not sure I dare.

DR. COOPER: Tim? Tim, and that -- this will be the last comment because we've got to move on to other -- to other issues.

MR. CZAPRANSKI: When we talk about primary care, we envision primary care the way we receive primary care.

In the city of Rochester, primary care by pediatricians is supplied by the clinics who -- who shuffle residents through every year or two and it's a constantly changing environment for these parents and these families, and that's another issue that needs to be faced. It's not like they get their pediatrician when the kid's born and they go off when they're nineteen or twenty to college. That's not what's happening in the majority of these cases.

DR. COOPER: Lee, can we ask Commissioner Daines to join the work group?

DR. KUS: He can take my place. That's fine.

MS. MOLLOY: But I think --.

DR. COOPER: Okay. All right. Here's what we're going to do. Okay. So, again,

we've got a working group. Kathy is going to lead it. Elise, John, Tim, Jan, Rita, are going to join it. You each -- Chris is going to help us staff it, and since there's about six of you each, each person gets a bullet point. Just kidding. Okay. But we want to come back -- we want to come back with -- with a working document that we can -- that we can forward to the commissioner and follow that up with whatever, you know, basic foundational templates for educational documents we think might be necessary in the next three-month period; okay?

And that'll be -- I think that'll be a really, really, really tremendously important contribution from this -- from this group to -- to the public health of New York State.

All right. Here's what we're going to do. Okay. We're going to take no more than ten minutes to get -- to get -- for everybody to get their lunch, and we're going to sit right back down, and hear Chris talk about H1N1. And in the -- in the thirty seconds he has left.

DR. KUS: With no questions; right?

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MS. MOLLOY: I wasn't going to take it anyway.

DR. VAN DER JAGT: Okay. Art, could I just make one -- one comment --

DR. COOPER: Sure.

DR. VAN DER JAGT: -- about this -- nothing to discuss, but just a comment. It just strikes me that maybe one of the reasons that asthma has sparked such discussion here, is that it really is a wonderful prototype, or model, for an E.M.S. disease, because it goes all the way from prevention, all the way through the entire system, and it goes full circle to rehab or does recovery. So, this might be a prototype that we could use even to look at how -- how do we manage with this Committee this kind of a situation, and with asthma it's really pretty, you know, it's -- it's so in the foreground here.

DR. COOPER: That was in the back of my mind in organizing this group. And let's all get our lunch, think about it, and for those of you that have additional thoughts about this problem, please be sure share them any member of the group,

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but especially with Kathy; okay?

(A recess was taken at 12:40 p.m.)

(The meeting resumed at 12:52 p.m.)

DR. COOPER: Everyone does have their lunch, I believe. We're missing only one or two folks. Chris Kus is on a very tight time scheduled as is Lisa McMurdo.

DR. KUS: Yeah. Let's move it back. Yeah.

DR. COOPER: So, we need to move along. So, Chris, if you would begin, I'd appreciate it.

DR. KUS: Sure. Asthma was supposed to be my short talk, but this -- so -- okay. And -- and actually with this one, what I was going to do was really -- I -- there's -- there's lots of slides, and things here, but I was going to go through some of it fairly quickly, but try to focus on things that would be most helpful to you.

To start out with, referring you

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to the -- the -- the New York State Web site and the New York City Web site, because they both put up ongoing information, and they -- there are documents that are created for various populations like child care and schools, and they coordinate well with the C.D.C. documents, so either it's a cover letter or it's there.

But they also give you a weekly activity report, which I think is helpful when we talk about care for kids within the context of what's going on in your community. And even going around the state realizing that the activity of H1N1 in the city is less than it had been in the spring, when you go to the western part of the state, it's going higher. So, you really need to -- to get an idea of -- of both of those places.

And when I looked at both of the sites today, they -- they do give you the information about activity within emergency rooms, so you have a sense of what's happening in -- in that area. The -- the most recent I have in terms of kids with regard to the rest of the state is that there have been, since March of -- of this

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year, there have been seven deaths in children zero to four, and fourteen deaths in children five to -- to seventeen. The city has similar surveillance. I don't want to pull it out know, but -- but I think, again, that's a first place to go.

And one of the other things to realize is that this guidance changes frequently, so it's always good to check on what the guidance is from at -- at the Web site, and also going through the C.D.C. Web site. So -- so, this is really as of, I think, 11/25, or something like that, so -- next slide.

Stuff you already know, but prevention; we're talking about ACEP recommending H1N1 vaccinations to include all people six -- six months through twenty-four years of age, and household contacts and caregivers for children under six months of age. We've got both the live attenuated vaccine and the inactivated forms, and there are specific recommendations as who should not get the live attenuated -- some of the ones that you would realize -- would -- would be young children, also, somebody who has chronic disease,

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but we'll get more into that.

Next slide.

All medical facilities and offices should strictly adhere to infection control recommendations and the idea is that you want people who have existing indications for pneumococcal vaccinations should be vaccinated just as people should who should be getting the flu -- the regular flu vaccine should be getting the regular flu vaccine.

DR. HALPERT: Can I stop you for a second --

DR. KUS: Yeah.

DR. HALPERT: -- and have you back up one slide?

DR. KUS: Sure.

DR. HALPERT: The question I saw flashing by the bottom, if you received the vaccine does not rule out any points of infection.

DR. KUS: Correct.

DR. HALPERT: Are you getting any sense yet about efficacy of the vaccination or is that --?

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DR. KUS: Yeah. I don't know of any sense that I can say.

DR. HALPERT: Okay.

DR. KUS: Yeah.

DR. HALPERT: Just curious.

DR. KUS: Uh-huh. The -- things to recommend for families is hand washing, the twenty-second use of hand washing, and the idea that alcohol-based hand sanitizers are -- if -- if no soap's available, is useful. People have already seen the idea of covering your mouth or nose with a tissue, and if you don't have a tissue, you've got all those ads about putting -- about coughing into your elbow, or into your shoulder, or anyplace except your hands.

Next one.

Right. Or your neighbor. No. Right. And these are, again -- we can go to the next one.

I'm going to highlight the bottom. When we -- for practical purposes, we're talking about an infection period of one day before to twenty-four hours after fever ends without the

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use of fever-reducing meds.

Next one.

Guidelines for daycares and schools. And the important things to recommend -- to realize about this is that these are all going to be local decision making between the school system and the county health department. They're given guidance, but it really is going to be their local decision making with the idea that if you send kids home from school, or particularly from child care, you would -- you would want to make sure that they're not going to another place where there's a lot of kids, because what's the difference?

Not easily -- not always easy to -- to handle.

Next one.

FROM THE FLOOR: Next slide.

DR. KUS: Okay. Influenza symptoms in infants and young children. Usually the same symptoms between H1N1 and seasonal influenza. Also, if you're -- people talk about influenza-like illnesses having similar symptoms.

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One of the real things to talk about is that in -- in young children, it's less likely to have typical influenza symptoms, so it's actually the child that could have H1N1 who doesn't have a fever and may not have a cough.

Next one.

How about older children?

The whole range of symptoms, and they're highlighting here that muscle pain, fatigue, diarrhea or vomiting seem to be something we're seeing more with H1N1. Again, this is general responses.

Next one.

This -- this to me is -- well -- well, actually, this is the -- the idea is what -- what are some of the symptoms and signs that you're going to see when children are progressing, and that there need to be -- you really need to take seriously, and -- and the -- indicating urgent medical attention, are fast breathing or troubled breathing, bluish or gray skin color, refusing to drink, severe vomiting, too irritable to -- to be held, and then the idea that you've had flu

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symptoms that improve, but then they're returning with fever and -- and worsening cough and rash on top of it.

And the -- the bottom part says the -- and this gets into the guidance -- parents, especially parents of infants and children known to be at higher risk for influenza complications, should be aware of this and vigilant watching for these warning symptoms -- signs. They're also the ones that, if you're considered high risk -- and we'll get into that -- that the -- the information given to the family is that you are the ones that should go talk to your doctor, go to the emergency room if things are more -- as opposed to the recommendation that if it's a mild disease you don't do that, because they're the ones that have more -- that have more risk for -- for the severe complications.

Next one.

This is the same kind of slides saying atypical presentations may occur such as just emphasizing that without fever.

This is the list here about

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children and youth at highest risk for influenza complications. And we'll have something on our Web site. And I think C.D.C. has a brochure on their Web site geared towards families to give them advice about what to do. But children under two years, and even five years -- less than two years is a little bit slightly higher at risk. And then children who have chronic conditions, and there's a whole list here, but the message is really it turns out to be a particular group is children who have neurological problems and respiratory difficulty, that's a big one. But besides that, you've got other ones listed here as -- as -- as far as chronic kidney, liver disease and metabolic disorders, and of course, immunosuppression.

Next one.

And that's the -- what I was talking about before, advise parents that children who are considered high risk to seek the advice of healthcare provider if the child has signs or symptoms of influenza.

We've been recommending that to families who have chronic disease that puts them in

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this category to talk to their doctor ahead of time in terms of the treatment. And in fact, some primary care docs would give them some antiviral prescription ahead of time if they were really concerned. So, it's almost like coming up with a -- with a flu plan for kids who have a chronic disease.

DR. COOPER: Have we seen any Reye's syndrome?

DR. KUS: Not that I know of.

Otherwise healthy children. Let's see, now, this is -- it's saying sixty-seven percent of children who died with 2001 H1N1 had at least one high-risk medical condition, and among these children, greater than ninety percent had neurodevelopmental conditions. I think it's less than this now. This really is -- is put out by the -- the study that C.D.C. did on a limited base -- basis of whatever -- I think it was forty-seven kids that they had. And so -- and I think when you -- when we look at our -- our information, that message that if you don't have a chronic disease you're -- you're home free is not

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the case. There are kids that have been -- that -- that died of H1N1 who have -- who don't seem to have a specific chronic condition.

And -- and that's -- this -- this gets into the idea of don't delay antiviral treatment pending lab results, rapid tests and particular frequently provide false negatives.

Next one.

Diagnostic testing. Just quickly over that that. The -- the types of tests are the -- the rapid diagnostic test, the viral culture, the direct immunofluorescent assay, and -- and the nucleic acid amplification tests.

Next one.

This kind of gives you a summary of what we're -- what -- what it is, is that it generally if -- if you get a positive it's probably -- it's -- it's highly specific, but the sensitivity is not there, and they're -- it's also important to realize which ones you can actually get a sense that it's H1N1 as opposed to not, which is viral culture with additional testing and the assay.

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Go to the next one.

Okay. Here's -- yeah, this is the one that gets into why test for influenza? Which is really testing if it will influence clinical management. So, if you've got an unusual clinical presentation, and you -- that may be one way to clarify it, if it impacts decisions about other diagnostic tests, it may guide the selection of an antiviral -- and -- and when we get into the medications, the difference about that. It reinforces antiviral prophylaxic decisions, especially in sensitive situations. It could affect antibiotic treatment, and then depending on what is happening in terms of public health surveillance, again, the testing is really mostly being done in hospitalized patients, and our surveillance is really looking at what we're seeing in -- in terms of influenza-like illnesses.

Next one.

DR. VAN DER JAGT: We also test for cohorting reasons in hospitals.

DR. KUS: You do? Okay.

DR. VAN DER JAGT: And that's

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another reason for the influenza, they can cohort like with --.

DR. KUS: Got you. Okay. Just -- there's a lot of slides on the medication, but I -- I think I'll just go through a few of them. The idea that we're talking about amantadine for influenza A, and the -- the neuraminidase inhibitors, important because the amantadine is not useful in terms of H1N1. That's why you would go into using Tamiflu and Relenza.

Next one.

As of October 2009, circulating H1N1 is resistant to the drugs. This gives you a -- the side effects.

Next one.

Next one.

Okay. Tamiflu. It goes into the idea of what dosages that you have, and the idea for kids is really putting it in terms of milligrams that your -- your prescription, because they will be using different suspensions at the pharmacy, and it talks about the emergency use authorization for children less than one -- one

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year, of Tamiflu.

Next one.

Just talks about common side effects.

Next one.

Relenza. Orally inhaled. So, we're talking about treatment of the influenza for greater than seven years of age, and prevention of influenza for ages greater than five.

Next one.

Talks about the dosage of it.

Next one.

The main thing I wanted to say on this -- I guess the -- the part that the powder is not recommended for use in any nebulizer or mechanical ventilator.

Next one.

This is the intravenous treatment, and the F.D.A. has issued an emergency use authorization to allow use of I.V. to treat certain hospitalized and critically ill patients. And then, it talks about which one is not responding to either the oral or inhaled antiviral,

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and that you need to request that from the C.D.C.

Next one.

DR. LILLIS: Just one comment about that. When you have a critically ill child it's very -- you have to request it specifically, and do you have any idea what the time delay is, and whether it --?

DR. KUS: I -- I don't, although I think the way C.D.C., the interactions I've had, it's I would think it's very quick because they've been very reachable, at least in -- in my part. But I don't know the answer.

DR. VAN DER JAGT: I think it's next day.

DR. KUS: Is it?

DR. VAN DER JAGT: In -- in terms of --.

DR. KUS: That was --

DR. LILLIS: We had a situation where we had a --

MS. MOLLOY: Talk to a microphone.

DR. LILLIS: -- critically ill

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child at a community hospital that we were trying to -- to transport to our facility, and the community hospital couldn't get it, and we -- we were trying to -- to figure out -- we called the C.D.C. and they basically referred us to their Web site and there wasn't anything.

DR. KUS: Oh.

DR. LILLIS: The child actually ended up dying at the community hospital before we could get it, and it probably has no point in an emergency resuscitation, but it was -- we were -- it was the kind of thing where we were trying to do everything we could think of --

DR. KUS: Right. Right.

DR. LILLIS: -- and it was frustrating not to -- to have a form of a drug that you could give them when you were suspecting it was H1N1, and you couldn't give the -- the treatment --

DR. KUS: Right. Right.

DR. LILLIS: -- quickly.

DR. KUS: I'll take that back to our group, but I don't -- I don't have much -- anything else.

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DR. COOPER: Elise and Bob, do you have any experience using it?

DR. VAN DER JAGT: Not really. We haven't given -- I felt for -- from flu, but we don't -- we never used that.

DR. COOPER: Bob?

DR. KANTER: We were about to, and then it became not necessary, but it should be rapidly available if you have the right contact at the C.D.C.

DR. COOPER: And who's the right contact?

DR. KUS: Yeah. That's right.

DR. KANTER: A variety of people.

DR. KUS: That's right.

DR. LILLIS: Bob, in -- in your experience were you using the oral -- were you using Tamiflu orally (off-mic) anything like that --.

DR. KANTER: Yes. Yeah. For all the patients. Yes. Yes.

DR. LILLIS: And you're intubated then later (off-mic).

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DR. KANTER: If we -- if we think their G.I. tract is working, the one kid where we considered it, that was an issue.

DR. HALPERT: I wonder if it's possible for this group to go track down that contact and disseminate that, because obviously other people are going to have the same questions you have.

DR. KUS: Okay. I can -- I can follow up with C.D.C. on that and see if I can get -- and our folks with -- with experiencing -- yeah.

DR. COOPER: Thanks, Chris. That'll be great.

DR. KUS: Yeah. Yeah. But I know -- I mean the person who does the pediatric one I -- is -- I -- I know her well, and I'll contact see if she's got a -- what's been the experience.

These are specifically revised antiviral recommendations for children, basic support, the idea of -- of using antiviral authorized for children less than one through

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the -- the emergency usage one.

Next one.

So -- so, then you get into the idea of antiviral treatment really recommend -- recommended for children who are -- fall within the high-risk category. So, children under two years of age, and that it -- children who have severe illness or evidence of clinical deterioration, symptoms of lower respiratory tract involvement, or illness requiring hospitalization.

Like always, use clinical judgment.

Next one.

And -- and this is the one in terms of primary care docs and also giving the advice to families about children with milder illness that it's not generally recommended to use antivirals with mild illness if they are not at high risk for the complications. You're really trying to give the message to the primary care docs to educate families that -- as to when to -- to go the emergency room, when to use the healthcare system, particularly in -- in -- in kids that

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aren't high -- I mean in kids that aren't at high risk. And that the idea that you are -- that there that you may consider prescribing antiviral medications if indicated for -- with -- with the office visit, giving them the idea that if things worsen contacting them and checking them in twenty-four hours.

And the -- the importance -- the -- you know, the issue is that it's best -- the antiviral treatment at least it's been reported to be most effective within the first forty-eight hours of illness or onset. So, that kind of gets into the idea of a sick kid, and waiting some time for giving it.

Next one.

The idea of ensuring -- again, if -- if a child is at high risk, that they have -- the -- the plan is to how they're going to get contact their doc, and how they're going to get medication or clinical evaluation if you need to.

Next one.

This talks about the dosage of it. And these are specific dosages for kids under

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one year of age, again saying that you're really prescribing it via milligrams for -- for children.

Next one.

This talks about actually specific -- the idea that since you're -- you're doing that by milligram it may be in a suspension that you want to take out the oral dosages dispenser there, and -- and give them an oral syringe, because you want that measured in a smaller dose.

Okay. Next one.

Alternatives to Tamiflu. We're talking about the compounded suspension, and they give you a couple of alternatives here.

Next one.

And then, the -- again, the big emphasis is to ensure proper dosing prescribed using product name and concentration. If prescribing in milliliters or teaspoons, or prescribed dose in milligrams. This gives you the Tamiflu dosage that's recommended.

Next one.

The Relenza. Not approved for

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kids greater than -- let's see -- no approved indication. Okay. So, it's really talking about over seven years of age.

Next one.

And I guess this is that staying in contact with the information you have in your community that you're using the date -- surveillance data that's provided, so you can decide what you think you'll be treating, so you can provide the best medication related to that.

And next one.

This talks -- if you -- if you do get the R.E.D.T. result, what you can do in terms of how it can affect making your decision in terms of treating.

Next one.

And this again gets into the idea is if it's positive then you're sure you're dealing with -- with a -- a flu virus, but if it's negative you can't -- you can't really rule out that it's -- that it's not influenza.

Next one.

What about prophylaxis?

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And it -- it -- it says can be considered for high-risk persons who had close contact with a person with influenza. Contact during their -- a person's infectious period. So, again, if -- if kids fall in that high-risk category and there's evidence that they've come in contact, you would -- you could consider prophylaxis. If you're going to do that, you want to do it early, and its duration is ten days following last exposure.

Next one.

In terms of the choice of the antiviral medication, you know, you want a medication that you think is most effective of what you think the influenza strain is going to be, and then this also talks about what -- what your -- what you know about your area.

Next.

This gets back to the idea that a history of a recent 2009 H1N1 or seasonal influenza vaccine does not rule out an influenza infection. So, just because they had it, if you got the -- the symptoms, you really, really want to treat it the

way you would otherwise.

Next.

What happens in terms of schools, camps, daycare, it's not really recommended to offer the prophylaxis to all persons potentially exposed. You would consider it if one of the -- if the people fall in the high-risk categories.

Next one.

Just to give you the idea about what recommendations are given for breastfeeding, the idea is that you want -- if somebody is sick with H1N1, you want them to consider -- continue breastfeeding, but it would be the -- the -- express the breast milk, and it would be given by a healthy caregiver, and then the mom can resume contact with the baby and direct feeding after afebrile for twenty-four hours or antivirus for forty-eight hours.

This gets into some special considerations.

The bacterial community-acquired pneumonia, realizing that H1N1 and other flu predisposes you to that. So, you want to consider

that this could be a -- on -- on top of the flu, you've got a bacterial infection. The idea that in treating fever, any products that could contain aspirin or -- or -- should not be used, and the -- to recommend, since again we're talking about fever, the idea of using over-the-counter cold medications under four. There's already been the recommendation not to use that, but this enhances that.

Next one.

Well, if you get the live vaccine, let's see -- and the -- it's -- it's -- it's really saying if you -- if you get that and then if you take antiviral medication, within two weeks of receiving that, it could affect the uptake of that vaccine, the response to it.

Okay. Let me just look which ones these are. This is just general.

Next one.

What about egg allergy?

And it really -- the -- the message is that you should be getting the history about the egg allergy. If it's a local allergy,

then you really want -- you -- you -- you can administer the vaccine, and then -- and if you're really talking to -- in a circumstance that it -- the child's doing worse, that you want to -- you -- you can also do it as -- in a controlled situation.

Next one.

The Australia experience. It's not much different. Again, highlighting that you've got to consider it -- the diagnosis in any child with fever as well as any unwell child without fever.

Next one.

Hospitalizations. Well, we'll tie it into asthma. Asthma is a significant risk factor for severe disease unrelated to -- unrelated to the severity of asthma.

Next one.

One of the complications can be benign acute childhood myocitis. It's transient condition, recovery within one week. It occurs at the convalescent phase, and it's got that -- it -- the difficulty in walking, severe bilateral calf pain, elevated enzymes, but the idea is that

this -- you recover from this, so at least if you know about that diagnosis you can -- if -- if you're considering it, then you can prevent other investigations or interventions, and give in -- you know, it's helpful to say to the parent this -- they're going to get over this part.

Next one.

This is just referring to a trial using a macrolide antibiotic where the combination with one of the other antivirals seem to do a little bit better. It boosted production of the mucosal I.G.A. against influenza virus.

Next one.

Summary.

Okay. So, factors affecting decisions. The severity of influenza illness. Most children don't need antiviral medications. The child's or adolescent' clinical presentation, underlying risk factors for influenza-related complications and -- and death and clinical judgment. So, if you're in a risk -- if you're clear it's in a risk category, they're treated differently, and the advice to parents is treated

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differently.

Next one.

Educate your patients and -- and their parents. This one is geared to pediatricians and family practitioners. How to reduce risk of -- of influenza, how to care for someone who is ill at home, and the -- and one of the big things is really when you're sick in this situation, stay at home, and -- and when to call your healthcare provider.

Next one.

Key points. We've gone over most of this. The idea that the diagnostic testing has limitations; that healthy patients don't usually require treatment; and that -- if, again, if you're high risk you would want to consider prophylaxis.

Next one.

That's it?

DR. COOPER: Thank you, Dr. Kus.

Questions?

Dr. Lillis?

DR. LILLIS: Just a few comments. In -- I think our area was particularly hard hit

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with some severe cases. We had at least five children who died at our hospital, and probably another --

DR. COOPER: Which -- which hospital is that?

DR. LILLIS: Women and Children's in Buffalo.

DR. COOPER: Okay.

DR. LILLIS: And I think probably another two in the community that didn't make it to our -- to our hospital, but my understanding is that none of those children had any underlying medical conditions, which is pretty scary when all the recommendations are really trying to identify the high-risk kids.

The other comment is, I know the five that were at our facility that passed away were MRSA positive, I didn't know if you have any comments about that. It was suspected that they were colonized with MRSA, and that when they came in, that perhaps the H1N1 affected their immune system, and then the combination of the H1N1 and MRSA were -- were too much. But we're -- and we're

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doing some studies on testing kids who -- who came in with suspected H1N1, and -- and whether or not they were colonized with -- with MRSA. But --

DR. KUS: So, that was how many kids you had; you had five you say?

DR. LILLIS: I -- we had two last season, and then at least three this season, and I believe two more that didn't -- that didn't get to make it to -- to Women and Children's.

DR. KUS: Okay.

DR. LILLIS: But all previously healthy with no underlying medical conditions.

DR. KUS: I don't know anything about that part of it, so I'll go back to our epi folks to see if there's anything that they might respond. But -- so they -- they had H1N1 and were colonized with MRSA?

DR. LILLIS: Well, you know, you -- you never know what they --

DR. KUS: Yeah.

DR. LILLIS: were when they came in --

DR. KUS: Yes.

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DR. LILLIS: -- but most -- most of them succumbed pretty quickly, and it was clear with -- within the first six hours that they weren't going to make it. They came in very sick.

And that was my other comment is we were surprised at how well they managed at home, and then there was suddenly an acute deterioration, and I did not know if other people across the state, but we had one -- one girl who walked in, and then was intubated within an hour, and then she just had total pus coming out of the E.T. tube as soon as she was intubated --

DR. KUS: Wow.

DR. LILLIS: -- and -- and pretty much within a few hours had succumbed to the -- the disease. And I was just impressed with how they -- they managed at home, until they got to the point where they were so -- so ill that there -- that there wasn't much you -- you could do, and -- and that is also kind of scary from a public health standpoint.

It wasn't a gradual deterioration. And seeing such large numbers of

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patients, if you had seen those particular patients earlier in the course, you wouldn't have been able to identify that they were any -- that they were going to be the ones that developed the severe disease.

DR. KUS: Right.

DR. COOPER: Dr. Van Der Jagt?

DR. VAN DER JAGT: Very similarly, Kathy, was the -- we had one patient that presented exactly like that, who's currently still on ECMO. That patient was also MRSA positive. That's very interesting.

DR. LILLIS: It is interesting.

DR. VAN DER JAGT: And presented -- it was a transport patient, outlying hospital, very rapid over about six hours. In fact, between the two-hour transport that the kid was there on basically fifty percent O2 came to us, walked into the unit -- well, didn't walk in the unit -- came into the unit, and within five minutes was intubated, and within four hours after that was on ECMO. That's how rapid it is was. So, very similar to your experience in Buffalo. MRSA

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positive, too.

DR. KUS: Uh-huh.

DR. COOPER: Other comments?

MS. ROGERS: I have a question. What is the expectation? H1N1 seems to be decreasing in our area, and what is the expectation for the future? Are we expecting another wave, or do you know?

FROM THE FLOOR: Seasonal flu is upcoming.

MS. ROGERS: I know seasonal flu is coming.

DR. KUS: Yeah. Yeah. I mean I guess the -- good parts, although I -- I -- I first wanted to responded to that one where healthy kids are dying from this, and I'm real interested to see what happens in terms of -- of the immunization rates of kids, because even with that kind of thing, the thing that's out there, people are not -- kids aren't getting as immunized as you would hope that they would -- would be, and you know, that -- that idea that you -- you can't use the -- the message has got to be if you're under

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twenty-four you get immunized. I mean that's -- and -- and then I hear the responses about why you won't want to immunize, and I can't understand it. It's very hard to understand what the reasoning behind it is.

But the other part -- I guess the -- the -- the good part, it looks like the virulence is -- may be less than we expected, and looking good. And I think the question is whether this will mutate? And I don't know the answer to -- to those things. And I don't know what happens after that.

The other part is that they -- they've just approved the -- the -- I think it's the fourteen valents vaccine for -- for kids for -- for flu. So, that will be -- whether that makes any difference, I don't know. So, I don't -- I -- I can't tell you that part.

DR. LILLIS: I -- I had read one report on two -- two girls who had attended a summer camp where one person came down with it, and they prophylaxed the whole camp, and then these two girls who had been prophylaxed, developed the

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disease, and both of them passed away and they were -- they were anticipating that it had been that they had actually -- there was a development in the resistance in there, and I would -- and it's the only case report that I had seen, but I didn't know if you could comment on resistance to -- to the antivirals or if you're aware of anything else.

DR. KUS: I -- I haven't seen it. I mean I -- I went to the C.D.C. site yesterday too to look for some of the stuff, but I haven't seen it, and I haven't seen it in our regular reports. We get a weekly report about the different conditions in there, and that's not been there, so --.

MS. MOLLOY: One question that I have, and I know that Dr. Halpert alluded to that when the slide was there, but I -- I've been reading a lot of reports about how fragile the vaccine is, and the handling of it, how imperative it is for the cold chain to be, you know, maintained, and I, particularly in order to find a dose for myself, because my primary care provider doesn't have confidence in the vaccine, so she's

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not ordering it, in order to go, I had to go to an unmasked clinic.

And the way in which they were distributing the vaccine was, you know, a little alarming, because they did have a lot of predrawn-up medication that's just sitting there on a table. They did not have gloves on when they gave the vaccinations. They're giving you cards, barcoded, telling you to maintain them for a year, which, you know, I've never had given to me when I received any other vaccine.

So, a couple of curiosities would be, you know, why are they doing that? Number one.

Number two, who's doing a study to see the efficacy of, you know, the vaccination over time? You know, we're going to, how are we going to monitor whether or not this is working, because how are we going to know if it's really preventing anything, and if it evolves, whether or not it's because we had failure already from the vaccine, or whether or not it's because, you know, the disease, itself, is evolving and changing to not be, you know, particular to the vaccination.

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DR. KUS: Uh-huh.

DR. LILLIS: And you know, I have concerns because, you know, there is an idea that -- when I read that other slide, it says just because you've had the vaccination doesn't mean to rule out that you've had --

DR. KUS: Right. Right.

DR. LILLIS: -- that you indeed have the flu.

Just like -- I saw that with chickenpox, you know -- you know, in my population. It was a fragile vaccine. A lot of children were vaccinated with one dose. Many of them had maybe a -- a smaller case of, you know, pox, but they definitely had chicken pox. And I -- I would see these outcroppings of them regularly. So, just -- you know.

DR. KUS: So, those big questions, I -- I would suspect -- and I -- and I -- and I will have to go back and see, but if -- I mean if we're doing any study like that, it would have to be C.D.C. doing it in several population areas. But then it's really going to depend on --

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I mean it sounds like the clinic that you're talking about wasn't -- wasn't using good practice. So, then that takes -- bets -- all bets are off when you start doing -- doing that.

So, I think in that sense you really have to be knowledgeable about that, and if somebody is not doing the -- I mean part of what our guidance out to local health departments, each of these, you know, the vaccines are really have been given to physicians and local health departments and other places, and they were registered here with the idea of giving them in -- in good clinical -- using good clinical practice.

DR. LILLIS: But when you see people lining up at libraries and when you see it on the news these people, you know, they're wrapped around the block, in order to accommodate the large numbers of people that they're seeing, this is the, you know, practice that they've taken on. And I'm sure it's going on all over the place in that fashion, I would imagine --.

DR. KUS: Well, there -- I mean there are practices for doing mass immunizations,

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which we do -- we do here. And that's different. I mean that's -- when I was a kid you took the little sugar pill and --

DR. LILLIS: Different than what I have.

DR. KUS: -- you went to school and all that kind of stuff. But -- and -- and that's appropriate in the sense that we were, you know, to try to get that many kids immunized. The -- I -- I -- I -- you know, they are -- there's guidance about how to do that, so I don't know what other recourse I can give you on that one.

But I will look -- I'll -- I'll talk with C.D.C. and ask them about that -- those -- you know, the questions about how do you answer those -- the questions about the effectiveness and -- and so.

MR. CZAPRANSKI: The -- the question you had about the bar coding; public health clinics run by the county are required, by federal statue, to do that, so if you go to your physician and get your vaccine, it's not required, but if you go to a clinic that's got any

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association with a county health department, they're required to do those things. So, that's sort of the requirement in there.

MS. MOLLOY: Nobody knew the answer when I asked there, so --.

MR. CZAPRANSKI: Yeah. And the other thing is a lot of the shipments, they come already predrawn up in syringes. So, sometimes they're multidose vials, and sometimes they're already preloaded, depending on how they're shipped to you.

DR. COOPER: Ruth?

MS. WALDEN: He just answered what I was going to say. The -- the vials are shipped predrawn, and that's how the doctors or the clinics are ordering them.

DR. HALPERT: As a note of information, at my -- in my office itself, we ordered a thousand doses of ingestible and received twenty doses of nasal. I just want to put that out there. We were happy.

MS. WALDEN: Only in the Health Department.

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DR. HALPERT: We were happy.

DR. COOPER: Thank you, John.

Elise?

DR. HALPERT: Good idea.

DR. VAN DER JAGT: I just have a question again relating to prevention and the E.M.S. provider. What are the recommendations for use of masks, and what is -- you know, what is the, you know, these E.M.S. providers are probably exposed a lot to this particular virus, or any flu virus, so are there recommendations that you have for them, and maybe Lee would like to talk about that a little bit, too. I don't know -- I just think it's something that needs to be addressed.

DR. KUS: I don't know the answer to -- to that one, but -- so, there we'll go.

DR. COOPER: Lee knows the answer.

DR. KUS: Oh, good.

MS. BURNS: Actually, the C.D.C. recommends N95s for patient care providers who are treating patients with flu-like symptoms. The Health Department has said that surgical masks are

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adequate. There's a -- there's a lot of -- of conversation at the local level. Some localities believe that they would just as soon err on the side of being conservative and use N95s. The N95s require fit testing.

One of the things that Jim Soto in -- in our office is -- is traveling around and is offering train-the-trainer fit testing programs, because prehospital care providers at the service level are not -- they don't have easy access to fit testing, or it's not available to them locally, so this, through a HRSA grant and our disaster preparedness folks, Jim is setting forth with fit testing kits and train-the-trainer programs in an effort to boost the ability for our prehospital care providers to be fit tested.

So, there is -- really the answer to your question is the C.D.C. guideline is N95s, state Health Department has said surgical masks.

DR. VAN DER JAGT: And how well are they following those regulations?

MS. BURNS: That's a very good question. I -- I think -- honestly, they don't

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want to be -- they don't want to be exposed, and they don't want to -- certainly don't want to take it home to their family.

DR. VAN DER JAGT: Right.

MS. BURNS: In -- in -- the -- in the Upstate environment particularly, if they're -- if they are exposed and ill or their family is ill, they'll be out of work, and -- and in spite of the initial pushback to the mandatory flu injections that we had people driving around with cars, you know, complaining that their civil rights were being violated.

DR. VAN DER JAGT: Right.

MS. BURNS: But again, primarily, they -- they can't afford to be out of work, and they certainly don't want to expose their families. So, it -- it's -- anecdotally, I understand that it -- you know, it's fairly well adhered to, but I don't know.

DR. VAN DER JAGT: And most of them you think are -- are getting immunized? I mean --

MS. BURNS: That's a --

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DR. VAN DER JAGT: -- that's the preventive -- I mean --

MS. BURNS: Well, I can tell you I'm -- in Saratoga County they offered flu vaccines for emergency services, so police, fire and E.M.S. It was very well attended. Albany --.

DR. VAN DER JAGT: H1N1 though? I mean -- yeah.

MS. BURNS: Yes. Yeah. Both -- both seasonal flu and H1N1.

DR. VAN DER JAGT: And H1N1. Yeah.

MS. BURNS: And Albany County just did one for, you know, E.M.S. and -- and emergency services.

Why are you looking like that?

DR. HALPERT: I didn't hear about it.

MS. BURNS: Oh, you're not on Tim Rabley's (phonetic spelling) list.

DR. HALPERT: I think I am.

MS. BURNS: Yes, you are. And -- and they had -- it may have been seasonal, but I

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believe it also offered H1N1 at a separate time.

DR. HALPERT: Five weeks --?

MS. MOLLOY: Yeah, that's H1N1.

DR. HALPERT: That was not for emergency services. That was general.

MS. BURNS: They've --

MS. MOLLOY: That is the general.

MS. BURNS: -- they've been well attended.

MS. MOLLOY: That was the general.

DR. HALPERT: Now, in my -- in my -- I'm sorry to deduct on that, but we did put up, through my office, at cost, for uninsured emergency services workers who could provide any kind of valid I.D., you know, like a fifteen-dollar flu shot essentially. Now, we were going to throw into that the H1N1, but we couldn't get any, as I said. But we did put up -- we backed about a thousand doses, of which we administered at least a hundred coming in.

FROM THE FLOOR: Uh-huh.

DR. HALPERT: So, that was okay.

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FROM THE FLOOR: Uh-huh.

MS. MOLLOY: You know when we first talked about this, and Ed -- Ed Wronski was at the table, I did mention that, you know, since school nurses really will be seeing the sick children at school and identifying it, that somebody should think about having doses available for school nurses. And I've never seen any mechanism put into place to where anyone has secured doses, and you know, our school doctors are not doing that, because most of us are not PODs, most of us are not doing, you know, on-site, you know, inoculations of people, and I had to take a day off from work. I had to take a sick day, and go to like I said a mass clinic that I had to secure an appointment for, you know, a block appointment, which was basically all day. It was the middle of the afternoon, so I -- I -- there was no way that I could just, you know, slip out on a lunch break, which is never covered anyhow. So, okay, you know --.

DR. KUS: Let's -- I mean -- because, I mean, on our Web site it talks about

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where you can immunizations, and -- and as a school nurse you would fit in the category who would be -- should be able to get an immunization there. So, I don't think there was anything specific as you said for school nurses.

MS. MOLLOY: Right. But that means -- as I said, taking a day off from my --

DR. KUS: Right.

MS. MOLLOY: -- employment, which I had to do, because my appointment was oh, between eleven and twelve, and I was there from eleven to two.

DR. KUS: Right.

MS. MOLLOY: So, that's basically, you know, your day is shot. I had to drive three towns over from where I work in order to get it. So -- but I did that because I felt, you know, -- I felt compelled to do that, but --.

DR. KUS: The other -- the other thing that's important to know is actually the other immunization -- the immunization clinics and things like that are all county health department's decision about how they want to do that. They're

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given advice with that, but that's --.

MS. MOLLOY: I mean they took me once I told them what my category was --

DR. KUS: Yes.

MS. MOLLOY: -- they were, you know, willing to give me an appointment. The other --.

MR. CZAPRANSKI: I think, I mean like our county health department pushes out to the school-based clinics, and --

MS. MOLLOY: We don't have school-based clinics.

MR. CZAPRANSKI: -- and it's RNs and the physicians that -- in some of the schools, they're perfectly fine to go on and register and order their own vaccine for their population.

DR. KUS: Yeah.

MS. MOLLOY: If you have a school-based clinic, but we don't have one.

DR. KUS: Well, even physicians and RNs can go on, they don't need a school-based clinic to register and receive vaccine.

MS. MOLLOY: Right. But we --

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you need participation from your district.

My district, you know, this is -- I know everything's on the record here, but -- I would prefer it wasn't because their -- their opinion is that we shouldn't even discuss flu vaccination with families, that we need to refer them to their primary physicians. And that's -- you know, that's their comfort level. And it's what's stated on our Web site, you know, we're not to give medical advice. We were called into a meeting, and told, you know, to keep our opinions to ourselves, and you know, to refer people to their primary physicians.

So, it's very difficult because school districts have a culture of fear of, you know, lawsuits and reprisal for -- and they don't feel that they're medical homes or medical providers and --

DR. KUS: Right.

MS. MOLLOY: -- so that's a -- that's a dilemma.

MS. BURNS: The other important thing to know is that the governor reupped the

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executive order allowing advanced E.M.T.s to inoculate in local health department-sponsored PODs.

DR. COOPER: Thank you, Lee.

Ann?

MS. FITTON: Yeah. I -- I just wanted to address one other thing. Outside of protecting ourselves with personal protective equipment, it certainly has been a thrust of -- of FDNY's for education for prehospital care providers, eleven thousand certified first responder/firefighters who are more reluctant than perhaps E.M.T.s and paramedics to don an N95 mask. Put a big push into that.

We did get six thousand doses of H1N1, and I believe they were -- and -- and we did a fourth day of POD, and I believe that all of those doses went to first responders.

A couple of other things we did do, is we bought a new kind of nebulizer with a one-way valve, so that -- excuse me, so that when we're treating people with respiratory or influenza-like illnesses on -- on the ambulances

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that they're -- are not get -- getting a steady stream of their, you know, respiratory droplets.

DR. COOPER: Uh-huh.

MS. FITTON: Which is, I think, a really important thing. They -- they are about six or seven dollars apiece. I did buy a supply of them, so that if we are at the clinic, and we need to go -- at the point that we rise above a certain level of influenza-like illnesses, they'll be put out into the street. So, it -- we're looking at other things besides just respiratory protection for the providers. Very important, hand washing can't be replaced; a good use of decontamination procedures, all very important. But there are other things out there that we can do to help make sure that we don't place patient care -- or compromise patient care.

DR. COOPER: Thank you, Ann.

Jan?

MS. ROGERS: I'd like to make a positive comment. As compared to June - and this is just anecdotal - as compared to June and the way that we've had through October, excuse me, it

definitely seemed that there was a strong effect of whatever, whether it was media, education, whether it was the efforts of primary care doctors, but we seem to have a lot fewer primary care-type visits to the emergency room with flu-like symptoms.

I think we had much, much more in June that were people who didn't belong in the E.D.; they probably didn't belong at their doctor's offices for the level of illness that they had, and I've seen a marked difference in October. It seems we're getting more of the population that we should get and those are with the sicker children and also complications. So, whatever that effect is due to, I thank them.

MR. CZAPRANSKI: Just one comment. I want to thank the State and the Bureau of E.M.S. for keeping the updates on there. I mean in our area, we put out a weekly H1N1 update to all E.M.S., fire and police providers, and that's been very helpful, but I think the guidance that the State has given is good, because regionally you have to make a decision about -- based on what you're seeing in your community.

DR. KUS: Right.

MR. CZAPRANSKI: Our call volume went up, we took back some of the fire/first response calls to influenza-like illness, because they didn't need the exposure, and we hadn't yet vaccinated that group. But we've held five clinics for E.M.S. providers already in our -- and we've pretty much hit everyone that -- that wanted an H1N1 vaccine, now, we're stepping it down, since the influenza-like illness is coming up. We're going from a level three to a level two, which now fire will do some more first responses, and so on and so forth.

But each community, I think, has to look at what's going on in their community, and then coupled with the guidance by the State it's been excellent for us.

DR. KUS: Good.

DR. COOPER: I'd like to conclude this part of the meeting by thanking Dr. Kus for sharing his expertise on two vitally important subjects.

I will ask Dr. Kus if he would be

willing to provide a copy of the presentation to Ms. Gohlke for distribution to the Committee.

DR. KUS: Sure.

DR. COOPER: And once again, we really thank you for being with us, and extend, as always, our invitation to you and Dr. Kacica to join with us at -- at each one of our meetings, since so much of what we do overlaps with so much of what you do.

So, thank you very much.

Before we move off this subject, however, I would just like to ask Bob Kanter and Kathy Lillis if they would share their thoughts regarding a recent meeting held in New York City: The Task Force on Life and the Law, headed now by Beth Roxland, convened an expert panel to look at the issue of -- of ventilator allocation, and -- and in H1N1, or other types of pandemic situations, where the need may outstrip the supply, you know. And I'll turn it over, at this point, to Bob and Kathy for preliminary observations, just to let the group know that this initiative is underway.

DR. KANTER: Well, this was a

discussion about what would happen if the numbers of patients in a influenza pandemic, or any other kind of pandemic, greatly exceeded the capacity of intensive care, and particularly ventilator care, in our state.

And this, of course, is an unprecedented situation, and it's planning ahead for a sort of a worst-case situation. It's important to emphasize that even before you get to the question of rationing, which is the primary thrust of this meeting -- of that meeting, a bigger, more important way to prepare is the notion of mass critical care, where you're trying to extend your care to larger numbers of patients, and provide care to everyone who needs essential critical care by limiting your interventions to immediately lifesaving interventions, trying to increase the number of ventilators that are available, for example, by using transport ventilators, anesthesia ventilators and the like, in a hospital that may have run out of their conventional ventilators.

And that's a nationwide effort

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that is -- is going on in -- in other agencies and -- and work groups. But this particular task force of the New York State Department of Heath considered an even worse circumstance, what if all those attempts to deliver mass critical care to much larger numbers than normal, still fell short, and you found yourself with three or four patients in the E.R. who need a ventilator, and you've got one ventilator. Who would get it?

And it won't surprise you to learn that the task force meeting did not come up with definitive answers, but the meeting that occurred a couple of weeks ago tried to apply some general work that's already been done for adults to the circumstance of children.

And I can just briefly summarize the rationing strategy:

You would, first of all, have fairly strict criteria for who needs a ventilator.

Then you would potentially exclude people who are too sick to benefit; and there's a lot of debate about what would be the criteria for that, and I'm not sure that we have

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good answers to that.

Then you would allocate the ventilators to those patients who need them and who don't have exclusion criteria. And then reevaluate them after a period of time, and if they are failing to improve and there's still a crisis shortage, you would withdraw patients who are failing to improve after a time trial of mechanical ventilation, and reallocate that ventilator to someone who is more likely to benefit from a short period of life support.

This is a work in progress. The intent is that we're laying the foundation for something that may come up a year or several years from now. This is, in no way, intended to be something that'll be -- that could be implemented this year. It would require a good deal of -- of public discussion, public consensus, a legal basis, operational plans, a great deal of professional and public education. But again, this task force is doing some very important work, laying the groundwork, and some very well thought out groundwork, for these very disturbing

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possibilities.

DR. COOPER: Thank you, Bob.

Kathy?

DR. LILLIS: I think the other thing that we addressed was when we're talking about the allocation of ventilators, well, what do you do with the patients who are on -- on home ventilators? And it was clear to the -- the committee that the -- we wouldn't be removing or taking those ventilators away from patients who -- who were on home ventilators, but should those patients come into the hospital and need the resources, then that would be a time when they would be entered into the system and in -- into the guidelines.

I think that sitting on the committee and talking to other people on it, it was -- it was a very uncomfortable situation. It wasn't something that any of us in the room wanted to -- to do, or -- or to think about, and the committee frequently kept saying, "well, this is only after everything else has been done," and -- and all of the -- you know, that we need to

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strongly say that the State needs to put resources in to make as many ventilators -- stockpile the ventilators, so that we're not in that situations, but should we be in that situation, we need to think ahead, and -- and come up with some guidelines.

DR. COOPER: Just one other small additional comment. The -- the patients that have home ventilators typically have a spare ventilator at -- at home with them, and that was mentioned as a potential source of additional equipment should the public, you know, require it at that particular point in time. Although I don't think anyone has any idea how many home ventilators are actually out there at this particular point in time.

A work in progress as Bob has said, much more to come on this, and we'll keep you updated as to where this work proceeds over the next several months.

Elise?

DR. VAN DER JAGT: Yeah. Just -- obviously, you were dealing with a pretty difficult topic, and -- and -- because we're always thinking

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we can do everything for anyone. Did it -- it come up at all about hand bagging patients?

DR. LILLIS: Uh-huh.

DR. KANTER: Yes.

DR. VAN DER JAGT: Because we -- we used to do that -- I mean not "we," I'm not that old. I'm old, but not that old, you know. But -- but in the Third World, that gets done routinely, you know, for days on end, and there are just shifts of people who bag, to get kids through this. So, I'm just wondering if that came up in the discussions.

DR. COOPER: It did. Bob?

DR. KANTER: Well, it did. It's -- it's a somewhat controversial area among the various national work groups that are considering this. The disadvantages are that it's very labor intensive and would take away from other aspects of intensive care; it exposes people more closely to transmittable infections. On the other hand, it may be lifesaving when you've got absolutely no other alternatives.

So, some of us think it's a good

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idea; however, it's not realistic to think that -- to think that you could do this for large numbers of patients for many days at a time. Most of us think it would be a very important option for temporary life support, until you could get more definitive equipment.

DR. COOPER: Other comments?

Yes, sir?

MR. TAYLER: This was a discussion not just for pediatrics, it was -- it was the whole -- the whole lifespan? I'm assuming it wasn't just -- was it --?

DR. COOPER: No, this particular discussion was focused on children. The -- the -- the task force had previously tackled the more general issue of how to deal with this problem in the general population, but the -- the initial draft report, which was issued in mid-2007, as I recall, did not explicitly address the special issues of children, and I -- and that was the reason that this particular subgroup was asked to come together to assist the Task Force on Life and the Law in fleshing out that -- the details of that

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particular component of the report, which, again, is still in draft form.

MR. TAYLER: Was there any consideration given to when the paramedics intubate the patient in the field, and then they come into your E.R. with this -- this -- with the patient intubated and you have no vents? I mean it's -- it's another, you know, it -- it's similar to picking up a patient from home that -- that is on a home ventilator, but you know, you're still -- you're back to a patient that now you're bagging them.

DR. COOPER: That specific issue I do not recall being discussed, but we could pass that point along to the powers that be.

DR. LILLIS: I think there was a very brief discussion that the guidelines that we were working on were really hospital-based, and that we would not change anything prehospital initially, but -- and that we couldn't really expect prehospital care providers to decide things like -- like that, who --

MR. TAYLER: Yeah.

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DR. LILLIS: -- and some of the things we were basing that was qualify of life, utilization of -- of resources and survivability --

MR. TAYLER: Uh-huh.

DR. LILLIS: -- in that we -- that wasn't something that we could implement in a prehospital care setting.

MR. TAYLER: Yeah. And I can understand that.

I -- I just was wondering if it was a point considered, because it is -- is -- it is a distinct possibility, you know, that you -- that you would run into this, and now it's -- it's your hospital patient. So, I -- I was just wondering if that -- if -- if in considering all of the possibilities that was -- that was also considered.

DR. COOPER: Okay. Thank you, Mike Tayler.

We're going to move on now to hear from Sarah Sperry, the research scientist of the Bureau of Injury Prevention for her report to the group.

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Ms. Sperry?

MS. MACINSKI SPERRY: Thank you.

DR. COOPER: And thank you again for being here.

MS. MACINSKI SPERRY: Just a bit of housekeeping, you know, it's the Health Department, I guess, that regulates how long food can stay out and the folks outside are very eager to snatch it away, so if you --

DR. HALPERT: Yeah. We noticed they are.

MS. MACINSKI SPERRY: -- if you haven't had your dessert, if you haven't had your seconds or whatever, now is the time, before he comes in and takes it away.

FROM THE FLOOR: Can somebody here suspend that rule?

MS. MACINSKI SPERRY: While Martha is bringing up the presentation, I'm going to start. I have got three separate handouts I'm passing out. I didn't make handouts of the presentation itself. I was trying to save some paper and make some happy trees. I'm more than

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happy to e-mail it to anyone who would like it.

DR. COOPER: Please. Please do that. Yeah. Thank you.

MS. MACINSKI SPERRY: Okay. But data I did as handouts, because it's easier to see, and -- all right.

So for this presentation, I just wanted to also share that I've defined childhood as those under nineteen. I know that there are -- are multiple definitions of what children are that float around. Our general cutoff in our bureau is nineteen, and so I -- I stuck with that, because it made cutting data easier.

So, who we are is we're part of the Division of Chronic Disease and Injury Prevention. We -- our bureau is kind of unique in our division in that we have both surveillance and program staff. Surveillance staff, we identify and monitor incidents of injury, whereas our program staff work to use evidence-based strategies to decrease the burden of injury.

Keep the slide up.

The -- if we were to have a

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Bureau of Injury Prevention mantra, it would be that injuries are not accidents. We do -- we call it the A word, and we don't use it when we speak of injuries or car crashes, because we believe that these are predictable and preventable events.

If they -- accident apparently implies some sort of uncontrollable act of fate, and if these things truly were uncontrollable acts of fate, we couldn't prevent them, and we know that we can.

This is just kind of a quick look at the various things that we do and work on. Injuries are a very broad topic area, and we work in a lot of places, and the main focus of my presentation is our surveillance and what we can do for you. I am, towards the end, going to touch on our childhood unintentional injury project, as that may also relate to your program.

So, our surveillance, we work to identify and monitor injury incidents. We do this -- we have the SPARCS data, we have the vital statistics death data, and we have our CODES project. CODES is a linked project, which I'll get

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into in a little bit, that looks at -- and I know that I've got the A word up there, that I just said we don't ever use it, but the accident information system comes from D.M.V., and that's what it's called. And this is our -- our crash reports.

So, the SPARCS, as you know, it's hospital discharge data, and E.D. data, vital statistics, death files come from death certificates for children.

Examples of the -- next slide, please.

I'm trying to go as -- as quick as I can to help you catch up on -- on time.

DR. COOPER: Thank you.

MS. MACINSKI SPERRY: The -- there is -- this is -- by no means am I giving you an all inclusive list of variables for any of the things, various, or demographics, what happens to the patients.

Next slide, please.

And also we -- the data is coded with I.C.D.-nine and I.C.D.-ten coding. This gives us diagnosis codes and e-codes which are external

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cause of injury and place of injury. SPARCS uses I.C.D.-nine, whereas the death files use I.C.D.-ten.

And I'm -- now, I'm -- these are --.

MS. GOHLKE: Sorry.

MS. MACINSKI SPERRY: That's okay.

The handouts I gave you, so you can actually see things, because I know stuff is very small up there, this is an example of our -- the standard data table we've produced. We generally do it for any sort of injury. We can do them by county, or you know, region, whatever, you have them. It's got age group, gender. We often look at traumatic brain injury. We can do spinal cord injury, what your hospitalization and E.D. charges are, and how long people are staying.

Leading causes tables. You have these. I just passed them out. Again, I did only zero through nineteen, because this is what we defined as children. So, if you want to just flip through quick. Then it goes to hospitalization,

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and then E.D. So, that's the leading causes for each.

Obviously, as the -- it goes from death to E.D. visits, your -- your mean annual frequencies are going up and up and up.

Next slide.

And this is your incidence of injury deaths. I didn't give you the graphs in the handouts, but on the back of the table, there is -- can I just borrow this for a second? On the back of this - saving paper - is the -- the -- the data that goes into the chart. So, you can look at that if you want.

Oh, I thought I fixed that. It actually goes from 2000 to 2007, not from the year 200. We don't have death data going back that far.

You want to -- go to the next one.

See it's -- while there is somewhat of a decline, it's still staying pretty consistent with our hospitalizations. And our E.D. visits, we only have data starting in 2005. So, that doesn't even go back as far as our 2000, let

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alone 200. So, anything that we do with E.D. visits and providing data, we can't give you anything before that. We can go back further for hospital and E.D. -- or hospital and death I mean.

So, then moving along as I said, we have another part of our program, which is our CODES project. And CODES is a linked database, which was actually what I was hired to work on. It's -- was -- is sponsored by the National Highway Traffic Safety Administration. New York is one of nineteen states that receive funds to do CODES activity. Now, we are largely funded by the governor's highway traffic -- Governor's Traffic Safety Committee, and as I said, this is a linked database. We link in the data from SPARCS, and our National Resource Center for Codes, which is in Maryland, will take the -- the I.C.D.-nine codes, and perhaps some other information, and translate into the -- them into maximum abbreviate injury severity scores, and regular injury -- abbreviated injury severity scores. So, that give us another component of -- of data that we have to offer. We link to the prehospital care reports, which are

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graciously provided to us by our friends at E.M.S, and we very, very much appreciate them.

MS. BURNS: Yeah, yeah, yeah.

MS. MACINSKI SPERRY: I've got to, you know, throw it out there.

And as I said, also the accident information system from D.M.V.

Thanks.

This is just sort of a visual of -- of what CODES does. We have our accident information system data, which links to the P.C.R. data, E.M.S., and it links to the SPARCS data. So, through the crash data, we're able to have a complete picture of what happened before the crash; what happened after the crash; you know, all the way through, were they speeding; were they buckled; you know, how long were they on the ambulance; what happened in the hospital; what were they diagnosed with; where did they go -- were they discharged to?

Oh, there's my little guys.

The prehospital care report data, as our E.M.S. friends know very, very well, has three levels of data -- provider information, event

information and patient information.

Next. Thanks.

Their provider information is information such as the agency, type of life support per certification, response time, and the P.C.R. data. The event information is like the location, the type of call, the date and the time, the patient information is, you know, a long list of more detailed information about the patients, some of which is used in linking, some of it's not.

The accident information system, which is our data source that you all may have the least exposure to, contains the police accident reports, ticketing -- which is ticketing information and motoring -- motorist reports. So, if you're in a -- involved in a crash, the police officer comes, theoretically writes up a crash report, you may or may not get a ticket, we get that information. Sometimes there is not a police crash report, but a motorist themself will send in a report form to D.M.V. Those are the motorist reports. So, these are received by the D.M.V., by both police and individuals, and that data can be

found at safeny.com.

Examples of data are -- include when, where, what they were doing, what was going on, how many vehicles were involved, vehicle information, contributing factors, number of occupants, where they're going, also individual level, role, age, gender.

The injury severity score in this dataset is referred to as KABCO. With this is assessed -- assessed by the police. It goes from -- it's a -- goes from K, which is killed, all the way down to O, which is noting, and/or no injury. There has been some work comparing -- done by NHTSA comparing the M.A.I.S. models with the KABCO model -- the KABCO scores and the M.A.I.S. is, they're finding a little bit better, in that KABCO being assessed by the police officer is -- they see something that's very bloody, and they say it's a severe injury, when it may just be something that's very bloody, where someone may have a fairly severe internal injury that the police officer can't see, and therefore, is a lesser. So, with our CODES, we get to help kind of bridge this gap a

little bit. So, this is -- all of these are -- are available sources for injury data, and whereas alone they're all beneficial, they can't produce the complete picture of crash and outcomes that CODES can. That's it.

We use common variables to link these, event variables, and individual variables, and this expands crash data, so that components of highway safety can be evaluated, creating a fuller picture of the crash.

Next, Martha.

As I said, we have -- we do our best to be resourceful and helpful at the Bureau of Injury Prevention. We will do customizable data requests for free. Our -- our Web site is getting updated with data, it's -- it's there and very small, and we're putting more and more data on it and that's exciting.

We produce fact sheets, brochures, obviously throw data out there, because that's what I do and I'm very partial to. We work on child injury, passenger safety, traumatic brain injury, poison prevention, choking, falls, et

cetera.

We also have a childhood unintentional injury prevention project. This has -- is a two-part campaign to work with local partners in preventing childhood injuries. Phase one is -- is getting completed. They're up and not quite on Internet, but almost on Internet-land -- a -- working on a user-friendly link on the D.O.H. Web site. And we have, I believe, forty-eight fact sheets that are -- are on their way through approvals in -- in D.O.H. for posting.

Phase two is developing a falls prevention -- childhood falls prevention toolkit to assist local partners, and to conduct a symposium to demonstrate this toolkit. This symposium is scheduled for March 31st, and if anyone is interested in this, let us know, we can send you an invite and -- oh, geez, where are my --.

DR. COOPER: Sarah, the falls that you're focusing on, all kinds of falls or specific types of high files, I would presume?

MS. MACINSKI SPERRY: All falls.

DR. COOPER: All falls.

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MS. MACINSKI SPERRY: So, if you go -- I didn't go through the -- the data I handed out, but falls are one of the leading causes of injury for actually all age groups, except for --

MS. MOLLOY: Right.

MS. MACINSKI SPERRY: -- like late teens. And it's pretty much they do a lot of falls from just like within the house, down the stairs, the falls that -- like my daughter falling off her chair in the kitchen the other day, I went (makes a noise), but there is -- you're doing a lot of work just to -- because there's -- it's -- it's such a simple little thing, but there's -- there's so much of it, and it -- it accounts for so much that -- money and morbidity and unfortunately, mortality as well, that that's what they're -- it's -- it's really all falls, I guess.

MS. MOLLOY: Where is it going to be held?

MS. MACINSKI SPERRY: Glen Sanders in Scotia, New York.

MS. MOLLOY: Can you send that link to Martha, so she could send it to us?

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MS. MACINSKI SPERRY: Yeah. And then on the next page, I -- this is a list of everything that they're making fact sheets for. They're also -- these are -- are the topic areas. Well, most of them are broken out by age groups, so that parents, caregivers, medical professionals, can each, you know, get information for, you know, my zero to one year olds, and that they shouldn't be on a bicycle or what have you.

And lastly, this is our -- our general injury -- our -- well, Health Department Web site. You can link through it to the injury prevention. If you Google New York State injury prevention statistics, we come up first. I'm very excited. So -- but that's -- that's how to contact the bureau for anything that you need.

My e-mail's there at the bottom. If you would like to contact me for anything. I can always push you through to the -- the proper person that is in the area that you're interested in. And if any of you work with partners who you may -- think may be interested in what we're doing, being part of anything that we're working on, we're

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always happy to have new partners, and -- and have more people come to events and trainings and -- and share our information. So, anything that we can do to help out there in the community is what we're trying for.

DR. COOPER: Thank you so much.

Has either the Department, or the Department at the direction or request of NHTSA, thought about adding events to automated crash notification data to the CODES project?

MS. MACINSKI SPERRY: The crash notification data?

DR. COOPER: Well, there's a -- right. There's a -- many, many vehicles, particularly General Motors vehicles, come equipped with something called OnStar, --

MS. MACINSKI SPERRY: Oh, like -- like OnStar.

DR. COOPER: -- which is the generic name is advanced --

MS. MACINSKI SPERRY: Yeah.

DR. COOPER: -- automated crash notification.

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MS. MACINSKI SPERRY: Right. Not that I've heard of. And it's a -- a worthwhile thing to look into.

DR. COOPER: Perhaps. Yeah. Perhaps that's something that -- that, you know, you might want to begin to sort of ask NHTSA about. It's -- it's becoming a -- an increasingly important component of trauma triage in the field, among other things, and trying to link some of the -- you know, the -- the injury outcome data with delta V and so on. It's -- which, of course, the change in the velocity of the vehicle and so on, which is a, you know, an approximate indicator of the -- the speed of the vehicle at the time of the crash, and so on, can be very, very useful.

MS. MACINSKI SPERRY: I'm -- I'm sure that -- and just coming from a pure data standpoint, having that would be a lot more accurate than whatever is listed for -- because what we have is -- we don't have the speed that they were going. We have a -- a -- we actually have two variables; in contributing factors, they have unsafe speed listed, and then they also can

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have under ticketing information unsafe speed. But we're really only going to know how fast they were going if moments before the crash there was a police officer there with a radar gun. And that's not really going to happen. So, it's -- there -- there are definite laws in -- in data collection, that we do the best that we can with. And things to make it more sensitive and specific would be great.

DR. COOPER: Other questions for Ms. Sperry?

Elise?

DR. VAN DER JAGT: I was just interested in your -- the county by county data you have here.

MS. MACINSKI SPERRY: Uh-huh.

DR. VAN DER JAGT: And the coupling it with your program of preventing falls --

MS. MACINSKI SPERRY: Yes.

DR. VAN DER JAGT: -- is just striking to me. Do you -- do you focus on specific counties.

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For example, there are two counties that are way, way above the rest of them. Steuben County in particular and St. Lawrence County. I'm interested in Steuben County, because it happens to be in our area and we found the same thing in the '80s and early '90s, that falls were a very high -- high rate of them. So, do you take that program that you're developing, and go to that county, and say, "how about using this, and see if you could do this?"

MS. MACINSKI SPERRY: I'm -- I'm not sure. I'm -- I'm surveillance.

DR. VAN DER JAGT: Uh-huh.

MS. MACINSKI SPERRY: But I'm not sure how the childhood one is working. We also -- and I didn't talk about it here because you don't -- I mean I know that you care about older folks, but it's not your focus. We --.

DR. KANTER: Well, we are older folks --

FROM THE FLOOR: We don't care.

MS. KANTER: -- of course it's our focus.

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MS. MACINSKI SPERRY: We have another -- another falls program that's working on fall prevention in older adults, which is -- are those sixty-five plus, and that is working -- they have specific counties that they're working with, and -- and like test running. They're -- I -- I think they're doing Tai Chi. It's just all just starting. But that I know, I'm pretty sure they're working with Erie County -- one -- a county in Long Island, I think, and maybe Broome County. Don't -- don't quote me on that one.

MS. MOLLOY: It's not he record.

MS. MACINSKI SPERRY: I know it's on the record, but I'm also on the record saying I'm not a hundred percent sure, so --.

MS. MOLLOY: Don't get nervous.

MS. MACINSKI SPERRY: So, yeah.

DR. KANTER: Yeah.

MS. MACINSKI SPERRY: I -- I would assume that -- that they're going to work on targeting specific counties, but I don't know the full breadth on that. The -- there's a position that is out for -- we're hiring a person to work on

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that, as we speak. Applications have been coming in. So, I don't know how far the -- the plans have progressed.

DR. COOPER: Dr. Kanter?

MR. KANTER: Just a note. It's -- it's hard to interpret some of these rates on counties that have very small populations with low total occurrence rates.

MS. MACINSKI SPERRY: Yeah.

MR. VAN DER JAGT: Yeah. It is hard.

MS. MACINSKI SPERRY: Yeah. We -- we try to star everything in our -- our data with -- that's based on a frequency of less than twenty as being unstable, and then we don't provide -- if you have five or fewer injuries or -- of whatever nature, we don't report that data for confidentiality reasons, and --

DR. VAN DER JAGT: Sure.

MS. MACINSKI SPERRY: -- and I know when you -- you break it down to just by county, it -- it becomes a lot harder to interpret, and it's where -- where the E.D. data comes in a

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little more helpful than the -- the death data, because you've got a lot more of those.

DR. VAN DER JAGT: I -- I was as much interested in the process as anything else, as where the data gets used, you know. In other words, it's great to get data, and it's great, you know, if you're doing surveyance, and you're having all these exciting, drooling data points, but you know, I'm just wondering, one - and maybe this goes back to Dr. Cooper - is what do we as a committee do with this data? If we're going to present it here, are we supposed to take some action of some sort, or do we -- do we just say, "oh, well, that's nice," you know, or what do we do with it?

And then the second thing is -- is what happens at the Bureau's level, you know, and how is this data used by county health departments, or regions of the state, or urban areas, or how is it used, so that we just don't continue to collect data without actually using it?

MS. MACINSKI SPERRY: On average, I think we're running six to seven data requests a month for individuals, be they like

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university-level researchers, private not-for-profits, we get a lot of work -- requests from traumatic brain injury programs that are -- are looking for that stuff. We just did a couple of spinal cord injury data requests.

We -- we recently did a bunch of data to provide to Orange County, to their -- their police -- yeah, to their police departments, because they wanted -- the town of Goshen wanted to limit the -- the ability of the police officers -- or stop them from doing the Stop D.W.I. programs, the Buckle-Up New York programs, and the -- the STEP program, which is inclusive of a lot of things. So, we're -- we did the data, you know, we -- and like as quickly as we could, got a bunch of tables out there to send out -- say, "look, no, these are our real problems. We've got people who are really getting injured, or really getting killed in your county from these -- these things. This is -- is important."

One of the -- the -- as I said, we have G.T.S.C. funding for the CODES project. We're using that right now. We're working -- we're

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developing county-level fact sheets, that w, ill hopefully -- we're going to -- we're developing them, we're going to be running them through focus groups of police officers and some various other stakeholders who have yet to be identified, and hopefully, that will help us really key on a -- a good helpful, useful, easy-to-read doc, because what -- coming from my epidemiology background, what is -- is good and easy data for me and for us, and you know, makes sense, "well, look at this," doesn't make sense to the people that are actually on the ground running with it, trying to -- to do it and make changes and make things better. So, we're -- we're trying to make that -- make it -- make it as user-friendly as possible, and then also do a more comprehensive listing of county tables and New York State data in general.

A couple -- a year or two ago, when Marjorie was still around, we did a very large data request for the State Trauma Advisory Committee, where the -- pretty much the tables that I gave you, I ran for hospital deaths -- well, we ran for hospitals deaths and E.D. visits for each

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of the trauma regions, so that then they could take their local data to their regional trauma advisory committees, and say, "look, this is what's going on" and -- and what they actually really did with it, I don't know.

We have started requesting that when people tell me that they're going to -- tell us, that they're going to make a brochure or give a presentation, or you know, do a press release, I've started following up with them, and -- and asking for copies of it, and keeping a -- a listing of the different things that our data has been done for, which is always fun, we're like, "look, it's really being used."

But we, you know, anywhere that we've got it for -- you know, it's -- and in terms of who uses it, part of it being such a long-winded answer, is that injury is such a broad topic. I -- I came from an infectious disease background to injury, and it took me a really long time to -- to grasp this concept of it's -- it's burns, and it's poisoning, and it's assault, and it's a car crash, and this is all in one place, in -- in one topic

area? And so, it -- our -- our data goes out all over the place. It's, you know, used in -- in teen driver work groups that the State puts on, and --.

MS. GOHLKE: Yeah. And it -- it just -- you know, the reason we asked Sarah to speak was because the last meeting we talked a lot about getting data for the regionalization meeting in May --

DR. COOPER: Right.

MS. GOHLKE: -- and there is some confusion amongst people at the table, and myself included, and I don't even know what all the Health Department collects. So, Sarah had offered, you know, to at least give us an overview of what her unit does, in case we wanted to hold something for our upcoming meeting.

DR. COOPER: Tim?

MR. CZAPRANSKI: The one slide you had with all the different tear-off sheets, which you had -- you had suffocation as a subject category --

MS. MACINSKI SPERRY: Yeah.

MR. CZAPRANSKI: -- does that

include the same as sleeping? Because in -- in our county, what we've been calling an infant death is -- is a sleeping death. And that's where a child fatality occurs -- and I was just wondering -- I didn't see anything up there related to that fact sheet around say sleeping deaths.

MS. MACINSKI SPERRY: It -- it may be. I -- I know that that has been a -- an interesting discussion around the office, and -- and with various conference calls with different people, and -- and what we have for coding versus what other people, you know, say exists and some discrepancies there, I -- that's not -- the -- the suffocation is not a fact sheet that I personally worked on, so I don't know what all is in it. It -- it may be in -- knock on wood, it'll be up there on the Internet to look at really soon.

DR. COOPER: I'd like to thank Sarah for her comprehensive presentation. I'm just going to note for posterity here on the record, that last year in New York State, according to the data that Sarah has presented, six hundred and thirty-three children died. We heard earlier today

that seven children have died during the past year from H1N1. The magnitude of the epidemic of traumatic injuries so totally dwarfs the magnitude of the H1N1 epidemic as to be separated by two orders of magnitude. Yet, as we all know, as hard as Sarah and her colleagues are working, this data is languishing, and we're doing precious little to protect our precious little ones from traumatic injury, whereas we have Herculean efforts being undertaken to protect them from a disease of great pathogenicity, but very limited virulence.

Bob?

DR. KANTER: And that's scary. I think that there are a number of important questions, and the answers to which would allow us to do things that come from data that are available to you guys, and you -- you probably have access to the information in ways that's much harder for an individual researcher to obtain. So, linking across these databases is very powerful. Linking across multiple hospitalizations and the SPARCS database from a referring hospital to a -- a critical care or trauma center hospital is very

powerful. And I think things like -- we talked about before, like using hospital discharge data to more objectively evaluate mortality risk in injuries, and to compare the performance of trauma hospitals to other hospitals is something that you may be able to do, and I know a number of us would be interested in helping if you would think that's worthwhile.

DR. COOPER: Thank you, Bob.

Okay. We are approaching a moment of perfect timing, because I know Lisa McMurdo had wanted to hear Bob Kanter's presentation on -- or preliminary presentation on regionalization, which, with input from this group, will be one of the keynote presentations at our regionalization stakeholder meeting in the spring.

So, Bob, if you would --

MS. GOHLKE: Can --

DR. COOPER: -- take it away.

MS. GOHLKE: -- can I just actually give an update where we are with this as background before you get started?

A smaller group of us are -- have

been working hard to plan this big important meeting on May 13th -- it should all be on your calendars -- down in New York City. And this is our -- our pediatric critical care regionalization meeting where we're going to bring stakeholders around the state to give us feedback on this concept of regionalizing critical care for children in the state and moving in that direction.

This is kind of a next step to the white paper that was submitted to the commissioner with this concept and his permission for us to go forward with the stakeholder's meeting to get more broad feedback on this idea for New York. Many states have already done this, it is a performance measure of my grant, not to say that that's the reason that we're doing this, but it is -- the -- the feds do believe that this is the -- the right way to go for, you know, tertiary care for children and having an organized system to get them there when needed. So -- so, this regionalization meeting -- the stakeholder's meeting on May 13th, we've been planning it, and just to give you an outline of the agenda, so to

speak, in the morning Dr. Kanter is going to give the 'regionalization one o one' talk, and the supporting information for why we have this meeting, why we're looking at this issue.

We're going to invite my E.M.S.C. counterparts from Illinois, and also the physician chair of their E.M.S.C. committee to come out and give us the testimonial of their system and the process that they went through, and to answer questions to stakeholders about what the process and what the issues were for their state. And then probably in the afternoon we're going to have a professional facilitator, you know, get feedback from folks have an organized process for receiving feedback from the stakeholders in the room about their feelings on this topic and issues that they have, to then present back to the commissioner with a recommendation of such.

So, that's just the lay of the land of where we're looking right now. We have planning conference calls, planning meetings set up on a monthly basis -- anybody is welcome to call in. The next one is next Monday, December 14th. I

can e-mail a reminder with the call-in number. If you'd like to be a part of it, I think right now where we're at is we're getting the invitation list together. And this is probably the most crucial step to make sure that we get the right people attending this meeting, and we don't obviously want to just send a letter -- a generic letter to an organization that will get lost. We want to have people's names on the letter. So, if you know of somebody that you want to see invited and at the table, now is the time to let me know who you think should be at this meeting so we get them the letter. Okay?

So, no further ado, Dr. Kanter.

DR. KANTER: Thanks.

Well, this is meant to be a summary of the basic facts about regionalization of pediatric critical care. I think it's the information that every stakeholder would want to know about, whether the audience is providers in any part of the healthcare system: Representatives of hospitals; payers, the people who pay for the critical care; family members of very sick kids; or

regulators who have to make this whole system work. The material here is a draft of what I think would be important to prevent -- to present at the stakeholder's meeting. So, if any of you have any comments as we go along, either interrupt or save them for the end. Either way, give me some perspective on how you think this information might be better presented.

It's an overview -- let's go to the next slide.

So, the first question is what is pediatric critical care? And here we're just emphasizing that critical care really implies a continuum, beginning in the prehospital setting, where E.M.S. providers respond rapidly to any kind of crisis in any location. The patient is then stabilized in an emergency department that must be relatively nearby the scene of the crisis. A very important element is that for common, low-risk conditions that require hospitalization, it's appropriate and desirable for the hospitalization to occur near home, but for those complex, high-risk conditions, pediatric intensive care is

best provided in a critical care center, which may be located some distance away from home, and then it's essential that there be an orderly transition to rehabilitation care if -- if necessary, and then back to community-based care after the child recovers.

What is regionalization? Well, it's broadly a way of distributing services, so that the comprehensive services, which by the way are very expensive, are distributed in a way that balances a number of factors.

In trying to have high quality care, which for a -- a complex high-risk condition means that a critical care center needs to have a high enough volume that they can pay for those comprehensive resources, a high enough volume that they maintain proficiency by doing it often. You need to have the centers distributed, so that they're accessible. So, there needs to be a large enough number of them that they're a relatively short, or reasonable, travel distance from everywhere in the state. And you don't want to be distributing them redundantly because that's very

expensive.

When we talk about high volume of activity, I'm considering high volume of activity as being somewhat synonymous with a regional center. A lot of the data, which we'll get to in a minute, talk about high-volume centers, some of the studies talk about regional centers, and for purposes of discussion, I think that high volume and regional is often synonymous.

And there is a great deal of information, which I won't review today talking about the fact that outcomes are better at high-volume regional centers across adult medical, surgical and traumatic conditions. We'll focus, in this talk, on pediatric data. There are a few specific differences of rural, suburban, urban and metro area needs and resources. We'll come back to that briefly at the end.

Now, New York State currently identifies these resources sort of by self-identification, and what we're arguing is that a more formal system of identification would be worthwhile, and the two components of that are

accreditation; that is an impartial body verifies that a facility has specified services. And designation; which means that you have criteria for certain kinds of patients who have high-risk, complex conditions should receive care at specified centers, because those specified centers have the resources -- the appropriate resources to deal with them.

So, let's just touch on some of the evidence. And we've talked, in this committee, about should we gather more evidence?

Well, I think the evidence that we've summarized here, is pretty strong for pediatrics. And the evidence is as follows:

A study from John Tilford, a multicenter study done in sixteen different pediatric intensive care units, asking how does volume in those different I.C.U.s relate to outcome? And the answer is that higher volume in an I.C.U. is associated with a better risk-adjusted mortality rate.

Specifically, for every increase in a hundred admissions per year, you get about a

five-percent reduction in relative risk. That's data from -- gathered prospectively from peds I.C.U. registries, contributed to by many I.C.U.s around the country.

Next study, Murray Pollack's very old study, gosh, it's almost twenty years old now but it's still one of the best. This was a study done retrospectively looking at hospital charts. They looked extensively at hospital charts in seventy-four some-odd hospitals in the state of Oregon and Washington, and to make a long story short, for those children with severe traumatic brain injuries, and severe respiratory failure - and it's -- it's combining a couple of -- of illnesses that were easy to identify, it's not specifically a trauma study -- it's combining severe trauma and severe respiratory failure two disorders, or two conditions that were relatively easy to identify - found that the severe ones' risk-adjusted mortality rate was much worse at the nonpediatric hospitals by a -- by a factor of seven or more.

Next study.

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For trauma specifically, one study looked at fifty-three hospitals, prospectively, using data collected prospectively in a trauma registry, comparing risk-adjusted mortality rates at American College of Surgeons verified trauma centers compared with other hospitals, significantly lower risk-adjusted mortality rate at the verified trauma centers than at other hospitals. They also compared pediatric trauma centers to verified adult trauma centers and did not find a significant difference in risk-adjusted outcome.

Art Cooper's older study shows similar findings.

Next study, another study on trauma for younger children, ten years and younger, this is a study using hospital discharge data from the A.H.R.Q. kid database, a huge study, so that the -- the information here is not quite as detailed as you can find in a trauma registry. On the other hand, the numbers of cases are much larger than you can do in a prospective detailed clinical study. And the finding here was that

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risk-adjusted mortality rates for severe trauma were lower at children's hospitals than adult hospitals.

Next.

A so-called ecological study in which they're not able to study a lot of detailed information about individual patients or individual hospitals, but rather they're studying conditions in counties looking at characteristics of the county that may be associated with risk. And in this study, they find that counties that lacked a pediatric I.C.U. had higher risk-adjusted mortality rates than counties that had an I.C.U. after controlling for a number of area characteristics like rural/urban characteristics, socioeconomic factors and whether or not an adult I.C.U. was available.

Next slide.

Moving on to other conditions: Cardiac surgery. In New York and Massachusetts, some old and still pretty good data showing an association between higher clinical volume of heart surgery, and a lower risk-adjusted mortality rate.

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There's a more recent study that some of you may have seen in circulation, I'm sorry, I forgot to put the full citation there. I can get that to you. Jim Marsims (phonetic spelling) study showed that the association between high volume and mortality was not quite as strong in this California study. Some low-volume pediatric centers still had pretty decent survival rates, but it's important to remember what a small-volume study is -- or a small-volume hospital is for cardiac surgery. It still means they're doing fifty to a hundred cases a year and taking care of the kids in the pediatric I.C.U. after the cardiac surgery. It's not just a small community hospital doing one or two kids a year.

Now, it's possible to have too much of a good thing, or you can have so many resources that you reach a point of diminishing return. This is Goodman's study of neonatology, and neonatal intensive care, looking at the work force of neonatologists. And if you go from relatively low to somewhat higher numbers of specialists per case, you get an improvement in the

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risk-adjusted outcome.

If you go further, increase the number of neonatologists way above that, there is a diminishing return. You don't see any further benefit on mortality and the conclusion from this national work force study was that there are many regions that had excessive numbers of neonatologists to no particular benefit.

All right. Are there gaps in New York State?

Well, there is some good news about this. If you do -- look at the national survey of I.C.U. -- pediatric I.C.U. beds per population, or -- yeah, per population - and this was Randolph's study that's published five years ago - New York State has slightly more PICU beds per population than the national average. We have relatively good geographical distribution of our trauma centers. Seventy-eight percent of kids in New York State live less than an hour drive from a verified trauma center. And in a study I did a few years ago, if you consider the state to be made up of eight hospital referral regions, we have a good

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comprehensive pediatric hospital with a peds I.C.U. in every one of the eight statewide regions.

The bad news is that although these resources are widely available, they're being used inconsistently. And one worry is that this regional variation may be a marker for some sort of regional barrier, preventing or limiting access to the existing resources.

Two studies -- this was my study published about seven or eight years ago, a retrospective study using hospital discharge data, and to make a long story short on this one, is if you looked at inpatient pediatric deaths in nonpediatric I.C.U. hospitals, looking at New York City, thirty-five percent of the inpatient deaths occurred in nonpediatric hospitals. In the rest of the state, only seventeen percent of inpatient deaths occurred in nonpediatric hospitals, suggesting that there was -- there's something different about referral practices in New York City and the rest of the state.

A more recent study in the next slide -- this is Hartman's study just published

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within the past year or so, a study of severe traumatic brain injury across six states from which they could get data. Just to point out, among those six studied states, New York had the highest per capita number of trauma centers. And these are either level-one trauma centers or pediatric trauma centers. So, we have the -- the highest per capita number of centers, and we have the best geographical access to those centers among the six study states. Nevertheless, our performance in getting the severe patients to one of those trauma centers was not so good. Fewer than eighty percent of the patients in New York received care in one of those high-level hospitals, and there was a great deal of regional variation with New York City, the Binghamton area and the Utica area being areas where even fewer patients were referred to the higher-level trauma hospitals.

What do national organizations say about regionalization of trauma -- of -- of critical care and trauma care?

And there's a long list of organizations there from A.A.P., S.E.C.M., American

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College of Surgeons, you can read the list -- also the E.M.S.C. federal level recommendations, which defines the performance measures that Martha was talking about that we are accountable for. All of them recommend various aspects of regionalized pediatric critical care and trauma care.

A little more evidence about what happens -- on the next slide, a little bit more evidence about what happens when states do formally designate pediatric hospitals for trauma and critical care. This was a retrospective study done in the state of Oregon. Oregon formally regionalized their pediatric trauma care in the late '80s, and found that after they had regionalized their risk-adjusted mortality rates for kids with trauma were lower than simultaneous observations in the state of Washington that had not yet regionalized care.

Next slide.

So, then Washington, a few years later, also regionalized. And this is a study not looking at outcomes, but simply looking at how the process of formally regionalizing affected

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admission patterns. And they were able to show a very successful shift in the admission patterns away from small community hospitals, increasingly toward adult trauma centers, and even more towards the designated pediatric trauma centers, a very objective effect, or a very objective change in referral patterns following that regionalization.

Next.

What's the experience in New York with the idea of regionalization? Well, we have very well-developed formal regionalization programs for burn care, for trauma care, including pediatric trauma care, for perinatal care, and more recently, for stroke care. And just to comment about trauma care, you might think that a well-regionalized trauma system would give us all the resources we need to regionalize the rest of pediatric critical care.

It's worth remembering that trauma accounts for probably less than ten percent of all the kids in a pediatric intensive care unit. So, I -- I guess the way I look at it is the trauma system provides us a good model for how to handle

it, but there is no regulatory teeth to this. There's no direct and specific guidance for this, beyond the trauma patients extrapolating to the -- the ninety percenters. So, of other peds critical care patients, we still lack guidance, and lack a well-developed process in New York.

Finally, what does regionalization mean for different groups like hospitals?

Well, I think most of it is good news. I think a well-regionalized system promotes the care of low-risk conditions, common conditions, near home. And so in a well-developed system, I think you're going to see clinical volume actually increase at some community hospitals.

I can tell you in my region, lots of kids are sent to the big pediatric hospital that could very nicely be cared for at the community hospital. And in fact, by doing that, by promoting the effective care of common low-risk conditions at community hospitals, you'll open up space at these very overcrowded children's hospitals, which right now sometimes prevents us from taking the next

critically ill kid.

Next slide.

A community hospital that begins referring their very few critically ill kids to a pediatric hospital is going to have a negligible impact on that community hospital. And in fact, I'd argue it's going to be a benefit to the community hospital not to try, because taking care of a couple of severely ill, or severely injured kids a year in an adult I.C.U. is an overwhelming task. Even if they do it successfully, it's an overwhelming task of physicians and nurses who are not experienced in pediatric critical care.

Next slide.

Now, for hospitals that are already providing care for a modest number of critically sick children, they will have to decide do they want to strengthen their peds I.C.U. resources to meet standards for designation, or is it a better idea for them to shift their focus towards non-intensive care pediatrics?

And that's a decision that every community hospital that does a modest number of

cases, that has a small peds I.C.U. program, is going to have to decide.

I can tell you that running a very small pediatric I.C.U. is an incredibly inefficient thing to try to do. If you have a four- or five-bed pediatric I.C.U., if you don't want to exhaust your staff, you need two or three physicians running it, ten nurses running it. It's impossible to pay for that on the caseload that you're going to see in a four-bed I.C.U., and if you have fewer staff than that, it usually is not a viable program.

And there's a nice report published in 2006, that describes case histories of I.C.U.s -- pediatric I.C.U.s that closed because -- mostly because they were too small to survive.

Next slide.

There are differences, and I don't need to elaborate on this for this group. Some rural regions have really special important needs, distances between hospitals are long, so every hospital has to be capable of resuscitating and stabilizing a pediatric patient. Many small

rural facilities do care for common low-risk conditions and appropriately transfer their sicker patients to a regional center. The circumstances are very different in a large urban area where a few hospitals will provide comprehensive care for -- for children, including critical care. Some hospitals will do emergency care and noncritical care, and some hospitals in a big city provide virtually no pediatric care. That's how it is, and that's how it should be.

Next slide.

Finally, when a system of regionalization is fully developed, regionalization is going to provide community hospitals with clearly identified resources at the peds critical care center, which right now is sometimes hard to find written down anywhere. It's all sort of informal. A well-developed regional system will give you rapid lines of communications with pediatric critical care centers for consultation or referral. It's going to provide a consistent interhospital transport services. And very importantly, should provide continuing professional

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education in pediatric resuscitation, stabilization, sometimes hospital care, all consistent with whatever that hospital's regional role is.

Moving on to families. What does it mean -- what does regionalization mean for families?

Well, it means that we're going to promote care for common low-risk conditions near home at an appropriate facility. And that's a -- a significant -- that's a significant benefit for families not to have to go to the pediatric hospital many miles away, if their child could receive good care close to home. But for complex high-risk conditions we really will have better outcomes if we transfer the child.

Next.

And although going far from home is hard for families, there's very good evidence in surveys -- and this was one study done in a cardiology context asking families about their preferences for where they'd like their child to have the high-risk cardiac surgery. But the same

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thing pertains to many other conditions. Parents tend to choose care, prefer care at a distant regional center if their child's condition is associated with a high mortality risk, and the resources are better equipped to deal with it at the regional center.

So, in conclusion, I think we do have very strong evidence that critically ill and injured kids should receive care at regional high-volume pediatric centers. We do have unfortunate evidence that there are barriers sometimes interfering with the use of existing resources in our state, and we have a good deal of experience with other states acting to improve their critical care system, and we have a fair amount of experience in New York State with regionalizing other types of services showing that regionalization helps.

DR. COOPER: Questions?

MS. CHIUMENTO: I just have one comment. I know that with neonates sometimes as they get a little bigger, they get transferred back to a home hospital.

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DR. KANTER: Yes.

MS. CHIUMENTO: Would it be worth mentioning something like that in your -- in your --?

DR. KANTER: You know, I think the volume of neonates that gets back-transported is large enough that that's a well-documented model for which there is good evidence. I'm not sure we have any such evidence as that for other kinds of -- of critical care.

MS. CHIUMENTO: Uh-huh. Just wondering.

DR. COOPER: Bob, I -- I think that following on the neonatal comment it might be worth including a slide or two on the success of regionalization of neonatal services indicating that for a, you know, a -- an arguably more complex population that -- that it -- that it has been done and it works very well.

DR. KANTER: You know what's -- I think you're probably right. I think there is enough evidence that we could do that. It was -- it sort of implied by the Goodman study --

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DR. COOPER: Right.

DR. KANTER: -- that simply shows that up to a point it's helpful, beyond that point it's not.

The biggest problem with neonatology is, in this country right now, is that it reached its peak of benefit probably fifteen or twenty years ago, and the fragmentation of those regionalized services has really set us back a lot. It's not nearly as well-regionalized now as it was fifteen or twenty years ago.

DR. COOPER: Well, I -- and I think that that's a -- that that's a -- a good point, you know, and it -- it's -- in -- in many ways analogous to stopping immunization; you know, you immunize against an illness, in this case, you know, with regionalization, and meaning -- meaning the onus being critical pediatric illness, and then the system fragments and you lose benefits. So, it -- I think it's an argument, not only that it can be done and -- and should be done, but then when you think you're dealing with a previously solved problem, and you slack off in terms of the

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penetration of that -- of that exercise, that you're -- you know, your outcomes tend to show it.

DR. KANTER: Yeah. In fact, while we're on that subject, and we've talked about in this group before, some of the same problems are happening with trauma centers, is that -- is that many hospitals that have tried for years to provide trauma services are backing out, because the regional demands are too great.

MS. MCMURDO: Thank you.

This -- this has been very, very helpful for me especially.

In the other states that have done this, are there protocols and education; how do they actually do the system? And I assume at the meeting you're going to get into this on -- I know Illinois is going to come and talk, but I'm just trying to think logistically how you figure out which types of kids go where.

DR. KANTER: Yeah.

MS. MCMURDO: Secondly, I think it would be good in the slides if you could beef up the benefits at the community hospitals, because I

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am working with Martha and Lee to try to figure out how we best present this to the association -- the Hospital Associations; how we best get their buy-in. We're kind of carefully looking at how we proceed with this, so that we get -- get interest in buy-in and bring them in early enough --

DR. KANTER: Yeah.

MS. MCMURDO: -- before the May meeting, to kind of engage them, and I think having more info on what they might get out of it. I think you did a good job to summarize it, maybe some more specifics.

DR. KANTER: I wish there was more evidence about this.

MS. MCMURDO: Yeah.

DR. KANTER: There's just very little published information about how community hospitals have specifically benefited, or been harmed, by these sorts of things. There just is not much public information. But I'd love to have any other, you know, specific suggestions about how to beef up that -- that aspect of it.

Your first question about how it

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works, there's several answers to that. One is there's not a lot of published information about that either, but it does vary on a state-by-state basis.

It's the reason why -- why Martha had suggested asking the Illinois folks to come talk with us, because they have a -- a system they recently initiated, that by all accounts is working pretty well, and they'd be able to give us more particulars than you can extract from published information.

DR. COOPER: Lisa, I think there is a pretty good way that we could chase that information in time for the conference, and I -- I know you'll recall that a number of years ago -- I recall it, too.

MS. MCMURDO: How many years was that?

DR. COOPER: Well, I was just it's -- thinking it's more like seventeen years ago. When we were regionalizing the trauma system, the same issues arose with respect to community hospitals. Larry Motley (phonetic spelling) was

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the senior medical advisor for emergency medical services at that particular point in time, and he put together some data from SPARCS basically showing that with trauma, which has a much, much larger volume overall than critical pediatric illness that -- that most community hospitals lost maybe one or two patients a year, and -- and he had some cost data that, you know, showed that the impact of, you know, the -- the very, very small number of transfers on a hospital's bottom line was negligible, whereas the potential, you know, liability risk was huge. So, I think --.

MS. MCMURDO: Well, I also think they would gain patients, too. I think if you structured it right, they might get the proper patients directed to them that aren't being there anyway.

DR. COOPER: Right. And I was -- I was just going to follow with that point. So, I think it's -- I think if we can -- if we can perhaps get some data, you know, to demonstrate how many patients are -- are being transferred, you know, and compare that with the potential number of

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patients that should not be transferred, I think it would show a -- a very, very interesting pattern, and as you say at least, I think would actually show, in many instances, a financial benefit to the hospital rather than a -- a detriment.

DR. KANTER: Now, something you can --

DR. COOPER: At least a wash.

DR. KANTER: One thing you -- some of you may be able to help me with -- I certainly have information in my region about how many I.C.U. transports we get from each hospital. You're right, it comes to three to five kids from each hospital per year. You have similar information in your own centers and whether we can sort of pool that information.

DR. VAN DER JAGT: I -- I think that would be very interesting. We certainly have that information from our transport team, and from -- also from E.D. to outlying hospitals to our E.D. transfers.

DR. KANTER: I'd love to have that --.

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DR. VAN DER JAGT: That would be very -- I could very easily share that with you, the transport especially, that's -- that's nothing --

DR. KANTER: Yeah.

DR. VAN DER JAGT: -- we can do that in five minutes, you know, I think, to do that.

MS. GOHLKE: One of --.

DR. VAN DER JAGT: I have --

DR. COOPER: And think that would -- by the way, I think if we were able to pool the data from -- you know, from several peds I.C.U.s in New York State, that would make an eminently publishable study as well, and that would be, I think --

MR. VAN DER JAGT: Very.

DR. COOPER: -- a huge, huge contribution to the national debate on regionalization that actually saves the system money.

MS. GOHLKE: Well, yeah, and I was just going to add that, you know, if we go

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through -- all the way through with this process, we do need to collect some baseline data.

Other states who have done this, have not really done a good job with doing the before and after, so this is our chance to do it right, and to show outcome -- changes and outcome.

So, we've been going around for months and months on what data to collect, and one of the reasons why I had Dr. Kanter do this now was that data may or may not come to fruition before the meeting. It's -- like I said, it's been going in circles for months and nothing's come forward at this point. I asked Dr. Kanter to do this to -- if we don't have any data, you know, how does this presentation look? What are the gaps? And we've already mentioned a couple that maybe we should add.

MS. MCMURDO: But you know, Dr. Cooper had a good point. Maybe if --

MS. GOHLKE: Yeah.

MS. MCMURDO: -- maybe you and I can meet with Matt Leary and some of the folks in our -- the Health Department more familiar with the

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SPARCS stuff, and what the SPARCS has, that you may even know and we -- maybe we can try to see what we can pull together. I don't know. I don't know if it's doable by that date, but have you looked at that at all? Or -- because we -- I'd be willing to --.

MS. GOHLKE: Not with Matt Leary. We haven't, you know, gone down that road.

MS. MCMURDO: They know the SPARCS, what's in there, what's --.

DR. COOPER: Well, I can tell you that when -- that when this issue arose, because there was some push from the commissioner at that time, because there was a huge statewide trauma conference coming up, not unlike, you know, what we're doing here for peds, you know, the SPARCS folks moved pretty fast and got this data collected and together, you know, in record time.

And I suspect that given the fact that the commissioner has given this -- the current commissioner has given this high enough priority that he, himself, is attending the meeting, it -- it -- it -- that may help our friends at SPARCS

move this project along. It's not a huge project.

MS. MCMURDO: Right. Well, I think we just have to frame it. I mean there are staffing concerns though, I will admit right now, but --

DR. COOPER: Of course, we understand that.

MS. MCMURDO: -- we can try to work, and see if we can figure it out. But we may need one or two of you on a call to help guide us a little bit.

DR. COOPER: Sure. Uh-huh.

DR. KANTER: And then, Lisa, I think your suggestion about getting -- having some interaction with possible groups prior to a large meeting is a great idea. And you know, it -- you know who to contact better than I, but if you get questions or a -- a line of discussion that seems to represent a broad concern, you could let us know what the developing issues are, I think we could try to address those before the May meeting.

MS. MCMURDO: Yeah. I -- I had a meeting with HANYS in Greater New York last week

not about this, but I brought this up, and just wanted to test the waters to see who -- who are the players there that they think we should be having at the meeting. And I -- I think if you have this in e-mail format, I think maybe sharing this with the top leadership there, maybe doing a call, because I think we have to approach it carefully with them.

FROM THE FLOOR: Uh-huh.

DR. COOPER: Right. My sense of it is --.

DR. KANTER: Martha has the PowerPoint, and if -- you know, you think that the PowerPoint in its present form is appropriate, use it.

MS. MCMURDO: How about smaller, I think for the leaders, you know, I'm talking like a Lorraine Ryan and Fred Heigle at Great -- at the two associations just to get things moving.

DR. COOPER: Yeah. My sense is that -- that at least from conversations with Ray Sweeney over the last three to five years --.

MS. MCMURDO: And he was at the

meeting, too.

DR. COOPER: Yeah. The hospital association recognizes that -- that most of its members, and then of course most of its members are smaller institutions from across the state in terms of numbers, most of its members have long since been transporting out their -- their critically ill and injured kids. It's not a -- it's not a new thing for them, and I -- and I -- I -- I don't think that there will be a tremendous amount of pushback from -- from HANYS.

I'm a little less sure about Greater New York, but -- but -- but at the same time Greater New York has tended not to take explicit positions on issues like this when some of their members are, you know, are -- are -- you know, are clearly for it and some of their members less so.

DR. VAN DER JAGT: First of all, Bob, great presentation. This is very, very, very helpful. And I think it'll go a long way in helping with that stakeholder's meeting as background.

Just a couple of questions I have. And one is a suggestion on one of your sides, the slide that talks about your study gaps in New York, it's, you know, in New York City thirty-five percent, and then it says of patient deaths occurring in non-PICU hospitals, in the remainder of New York City, only seventeen percent, you might want to just leave out that "only" because -- so, that we don't juxtapose, "well, the Upstate is doing much better than Downstate."

I know the intent is to show the variation, but I'm just wondering, just because of the sensitivities that might be there, whether it wouldn't be helpful just to state that even seventeen percent may be too high, you know, and -- and so, I think rather than saying seventeen percent is great, you know, thirty-five percent is bad, just to be kind of sensitive to that, and just they're both may be -- may not be very acceptable. But they're -- they're two different numbers.

DR. KANTER: Well --.

DR. VAN DER JAGT: You don't have to respond to it. I'm just -- that's just an

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observation that -- it's just -- this is the way it hit me as -- as being, you know, I want to make sure --

DR. KANTER: Let -- let me ask --

DR. VAN DER JAGT: -- that it -- it's -- comes across that way. Yeah. Yeah.

DR. KANTER: -- rather than respond, let me ask you should we be too sensitive, or should we try to provoke?

DR. VAN DER JAGT: Well, I -- I -- I guess I -- I guess the question is -- can be looked at different ways. You know, I -- I'm not sure what the right percent is, you know, because there's going to be some percent -- there's no answer -- there's no answer to it, so --

DR. KANTER: Simply regional variations --

DR. VAN DER JAGT: Correct -- correct.

DR. KANTER: -- may have been a prior problem.

DR. VAN DER JAGT: Correct. Exactly. And so, I think that one of the points of

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its variation is there are two different percentages.

The second thing is that maybe you can work that in elsewhere; nobody really knows the -- what exactly the right percent is because we know that there are children who, no matter what you do, are going to die in a small hospital. I mean we heard this morning from Kathy Lillis, you know, I mean kids that die there, within twelve hours they could die. So -- so, we do know that that occurs.

And then, that's also consistent with some of the -- the -- the work that's been done with identifying sick patients in the hospital with rapid response teams, which deaths are truly preventable, and which are really not preventable, or which events are preventable with the team versus not. I mean sort of the same kind of thing. So, that's number one.

The second question I had was whether something should be said in here about interfacility transfer. I'm not sure how to put it in exactly, but regionalization is more than just

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identifying places -- different places for different kinds of patients. This whole idea of interfacility transfer, which is part of the regionalization process, and in many parts actually already exists. I'm just wondering whether that -- there's a way to put that in here as well as process, maybe under the next steps, or -- I'm not quite sure, but it needs to be addressed as an entity, because I think -- I -- I think it's easy enough to do the -- well, yes and no, but then the -- it -- the whole process of who transports, how do these transfers work is a big deal, I think.

DR. KANTER: So, that part, I -- I -- I see that as easier, because I --

DR. VAN DER JAGT: Yeah.

DR. KANTER: -- think there's a great deal -- first of all, the system already exists in most regions of our state.

DR. VAN DER JAGT: Right.

DR. KANTER: The E.M.S.C. federal level --

DR. VAN DER JAGT: Right.

DR. KANTER: -- has made some

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very explicit recommendations about it --

DR. VAN DER JAGT: Right. Correct.

DR. KANTER: -- which we've already circulated a draft on for ourselves, hopefully for future distribution in our state. I think the real -- I think once hospitals agree that we should regionalize --

DR. VAN DER JAGT: Right.

DR. KANTER: -- the transport aspect is -- follows logically.

DR. VAN DER JAGT: Yeah.

DR. KANTER: The real question is should we have a more formal system of designation.

DR. VAN DER JAGT: Sure. Sure. I think certainly one, step one and one step two, obviously, or the cart before the horse. However --.

DR. COOPER: Well, I -- I -- however, I'm not sure that Elise isn't right here, Bob. I -- I think that the -- I think that -- that it's -- it's well -- all well and good to say that regionalization is great, which we all support and

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the data supports and so on.

DR. VAN DER JAGT: Right.

DR. COOPER: But if it were the case --

DR. VAN DER JAGT: Right.

DR. COOPER: -- that if regionalization were great, but transport was terrible, that -- that -- that kids died during transport, you know, then you would have a compelling case against it.

DR. VAN DER JAGT: Right.

DR. COOPER: I think the point to be made here is -- is as -- just as you said a moment ago, the transport system exists, and in fact, it is incredibly safe provided that it's appropriately staffed. And you've done all the work in that area, so it should be a little -- it should be fairly easy to pop up a few more Kanter papers on that.

DR. KANTER: It is mentioned in the white paper, but --.

DR. COOPER: Yeah. But I think it's worth mentioning here.

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DR. VAN DER JAGT: I just think it needs to be addressed in the -- in this area. And I -- I do agree that we have made a lot of very good steps in the transfer process. We -- I think we are, I mean in various parts of New York State.

I also, however, am aware of the survey that Martha did, you know, that we do -- we also don't satisfy all the steps of the recommended transfer process. So, there is certainly work to be done in that area.

And then, the third thing, I just want to go back to that what your statement was, Art, about having some of the transport data. You know ever one of the areas, you know, PICUs in certainly Upstate New York, but also probably in -- in -- in New York City, we have data on what kind of patients gets transferred to the hospital via the transport systems. And they are -- and this is, again, a little bit of a nuance, talking here about PICU patients and mortalities, but a lot of the transfers are not PICU, they're floor patients. But they're floor patients that cannot be taken care of in a smaller hospital, but they need a

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larger hospital, because the subspecialists are there.

And so, you know, that is an aspect of this that undoubtedly will be raised. You know, and here's an example: You know, a small community hospital, you know, because of insurance issues, says, well, you know, keep the diabetic with D.K.A. there, you know, sort of mild D.K.A., just keep them there versus transfer. Our hospital will be on the floor, you know, with subspecialists there's a higher acuity in general there. It might be in the I.C.U. where it might be on the floor, not taking -- being taken care of very well.

Well, those things are going to come up. So, I think this not just -- just about PICU mortality. There's that other group of kids that may, just as well, need an interfacility transfer, and it may not be at the community hospital, although it could be depending on the -- on the local expertise. So, just -- just another aspect of this.

DR. COOPER: Mr. Czapranski?

MR. CZAPRANSKI: Yeah. The --

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didn't we just discuss, at the State Counsel, that hospitals that cannot provide a service have to have an agreement with a transport facility or transport agency?

DR. VAN DER JAGT: And that's part of the -- you know --.

MR. CZAPRANSKI: Can we extend that -- look at extending that, I think, to pediatrics because I think that would force the discussion at the local hospital about how will we safely transport these patients we can't care for.

DR. COOPER: Well, this actually --

DR. VAN DER JAGT: This -- we have --

DR. COOPER: -- this -- this actually goes back to, you know --

DR. VAN DER JAGT: The survey done -- yeah.

DR. COOPER: -- hospital code from the -- from the 1980s. This goes back to the 405.19 code. Hospitals that do not provide specialty services are required to have transfer

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agreements --

DR. VAN DER JAGT: Transfer agreements.

DR. COOPER: -- with hospitals that do. That's not something that's, you know, uniformly enforced, but it -- it has been on the books for over twenty years.

DR. VAN DER JAGT: And these were surveyed, and then --.

DR. COOPER: And what -- what the valued added here will be, through a formal process of regionalization, is in effect if you want to think of it this way, creating a giant statewide single, you know, transfer agreement, if you will, that, you know, while hospitals would still have to have individual agreements, it'll really spell out the -- you know, the what should be in -- in the agreement to a much greater level of detail, and that would really facilitate, you know, the Department's ability to ensure that -- that transfers are made appropriately, and in a timely manner, and that when transfers are not indicated, they don't need to be made.

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DR. KANTER: And you know, I -- just for those who haven't seen the -- the paperwork that we have already been developing and circulating, we have a draft of interfacility transfer --

DR. COOPER: Yes, we do.

DR. KANTER: -- agreements.

DR. COOPER: Right.

DR. KANTER: And it spells out in some detail what kinds of patients would warrant a consultation for transfer, and talks in some detail about what the transporting equipment and personnel ought to be like. The big gap in our draft guidelines, are where should we send them? Because we haven't really identified the hospitals.

DR. VAN DER JAGT: Sure. Of course.

DR. COOPER: Bob, I have -- I have a couple of minor suggestions I'll share with you about the slides offline, but there is one comment I will make on the record that I haven't already made, and that is that it may be worth citing our own research here in New York State,

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regarding the contribution of the PICU to trauma care. We did publish that paper in Pediatric Critical Care Medicine six, seven years ago, showing that -- that it appeared anyway -- in effect that it appeared that the presence of a PICU was -- was perhaps the most significant factor -- or at least among the most significant factors in terms of the improved outcome for trauma patients.

And I think that will help drive the point home that, you know, well, we've regionalized, you know, critical care services for kids that the value there -- the primary value, may rest -- rest in -- in the pediatric critical care capability, rather than the trauma system itself.

MR. TAYLER: Dr. Cooper?

DR. COOPER: Yes?

MR. TAYLER: Dr. Kanter, is -- is it my understanding that -- that, in building this system, you're looking to get the kids that need the higher level of care to the higher facility, but is it the intent that the kid would then stay there throughout the course, or for example, a sick kid from Ogdensburg gets transferred to you at

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Upstate in Syracuse, you take care of the -- the critical part of the needs, are you expected to keep the kid there throughout the entire recovery or ship them back to Ogdensburg, where they're home?

DR. KANTER: Well, again --.

MR. TAYLER: Because that -- that may be a piece that -- that you could --

MS. GOHLKE: I can answer that.

MR. TAYLER: -- buy into the what's in it for the community hospitals?

DR. KANTER: Yeah. I -- I think we -- we sort of touched on that earlier.

DR. COOPER: Yeah.

DR. KANTER: For neonatology, I think there's a very large volume of kids who need to stay in the hospital for some time after their critical care phase is done, and there's a fair amount of evidence that reverse transport is reasonable, safe, effective. There's much less information about that for other pediatric critical care, and in fact, the vast majority of pediatric critical care patients, when they get better, go

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home, not to another hospital. There are smaller numbers required for long hospital care, and that's usually just as labor intensive a subspecialty-oriented thing.

MR. TAYLER: I was just looking for another -- another way to -- to buy in the community hospitals into this. You know, what -- what -- what would -- what would be in it for them, but just -- just a thought is all.

DR. COOPER: I think Mike -- Mike does raise a good point, you know, there's -- there's no reason that a -- that a child who is transported for an injury, you know, can't be back transported when the -- when the capability exists in the -- in the community to do the follow-up care.

The problem, as you pointed out, Bob, is that for traumatic brain injury, and complex orthopedic injuries, that's -- that -- that is not normally the case, although in some instances it is. I mean there are -- there are areas in your own region, you know, where there are really outstanding pediatric orthopedists in the

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community, but no robust pediatric I.C.U. capability in that community; that's a perfect circumstance. But those -- those instances are uncommon.

MS. GOHLKE: Can I just add that my grant -- it was one part of the performance measure for, up until this year, that the kid had to go back to their original home and get any follow-up remaining care in the hospital there. But they since took it off, because I guess there's reimbursement issues, and you -- and you can't --.

DR. VAN DER JAGT: There are -- cannot pay for it.

DR. KANTER: As a performance measure, your --

MS. GOHLKE: Right.

DR. KANTER: -- rate has been --.

MS. GOHLKE: So, they dropped that --

DR. VAN DER JAGT: Right.

MS. GOHLKE: -- because it causes too many problems. So, that -- would that be the case --

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DR. VAN DER JAGT: Right.

MS. GOHLKE: -- at least as far as the feds would want.

DR. COOPER: It always goes back to money, doesn't it.

DR. VAN DER JAGT: Yeah. I would have to echo what Bob says though, as I think that the populations are extremely different. The N.I.C.U. kinds of kids, they may be, you know, in another hospital for six weeks or more after the N.I.C.U. course. Most patients who come out of the PICU, you know, then they go home within a week. I mean, they're -- they're not really in the -- and most parents actually, at least in our experience, most parents do not want to be back transferred.

DR. KANTER: That is also correct.

DR. VAN DER JAGT: They feel very comfortable, they have bonded with the people there at that medical center, even though it may be a very short time, they don't trust going back. And so, I think it would be, again, very different than the neonatal, you know, but it will come up as a

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question I'm sure, and it's good to have some answers.

DR. HALPERT: Because the whole climate of this trust issue is real, too, because --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- their -- their thought is that you sent my kid away in the first place, because you couldn't handle him --

DR. VAN DER JAGT: Right.

DR. HALPERT: -- what makes me want to give you may kid back now?

DR. VAN DER JAGT: Yeah. Yeah. There is -- there is --.

DR. HALPERT: You didn't fix him. You can't --.

DR. VAN DER JAGT: Exactly. Yeah.

DR. HALPERT: It may not be --.

DR. VAN DER JAGT: And you have to remember that the person who has to take care of those children are the -- is a pediatrician who, more and more, would prefer not to be in the

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hospital, would prefer to be seeing outpatients.

DR. COOPER: That's correct.

DR. VAN DER JAGT: So, there's another part of it.

DR. COOPER: All right. Unless (sic) there are no more burning questions for Bob, we're going to move on. I have been asked to take a very, very short break, which we will do right now, and we'll come back and attempt to complete the remainder of the agenda in very, very short order. It's three twenty-five, so no more than five minutes, please.

(A recess was taken at 3:25 p.m.)

(The meeting resumed at 3:30 p.m.)

DR. COOPER: We will now proceed with the E.M.S. and -- E.M.S. report and E.M.S.C. grant report.

In the interest of time, of which we have precious little left, I will ask that Lee Burns and Martha Gohlke touch upon the -- the key highlights, so we will have time for the committee reports.

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MS. BURNS: Okay. In my new role, I have to tell you that the state is in a fiscal crisis.

FROM THE FLOOR: Wow.

FROM THE FLOOR: Really?

MS. BURNS: Yeah. And I knew that would come as a surprise to you.

With all -- all seriousness, the -- the budget situation is -- is bad, and continues to be bad. We have been, on a daily basis, fighting for our contractors and our program agencies. To date, twelve of them have been approved, there are nineteen total. We thought that, frankly, that once the -- the -- they started to get approved, and money got freed up, that all of them would be approved, but since the SEMAC meeting, there's been no -- there's been nothing new moving forward. So, we recommenced our battle with the division of budget. And I -- as I told the SEMAC and the SEMSCO, we have excellent partnership with -- with the -- our bureau of budget management, and to the point where they have been hand-delivering contracts, and you know, they

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have been doing all that they can do.

So, there is no good way to put this, but it is the Department's intention to make these sorts of meetings minimalist. They're expensive, and they're looking at other options, so keep your ears open. I -- you know, towards conference calls, WebExs, those sorts of things.

In that same vein, we experienced, much to our surprise, a sudden lack of prehospital care paper reports. We supply them to ambulance services. The warehouse -- we sent an order to the warehouse, and they called us and said, "oh, yeah, we don't have any of those."

So, what had happened was our print order had been approved in June, and because of all of the budget issues, O.G.S.'s contract with the new printer had never been approved. So, we're -- we've been told that the order's been put forth. P.C.R.s will be a little bit different. They'll be in shades of gray as opposed to red and black. But we're hoping to begin to receive P.C.R.s in the not-too-distant future.

Ryan White. The Ryan White Act,

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as you know, was reapproved by the feds. In an effort to get a good handle on it, the SEMAC and SEMSCO has -- has convened a technical advisory group, which includes staff from our AIDS institute who are experts in bloodborne diseases and the regulations, so that there's more to follow with that.

We discussed with our -- with the SEMSCO particularly something called project management. I think your group not necessarily so important, because you're -- you have very focused tasks for the next couple months, that is your stakeholders meeting. But I would be remiss if I didn't tell you that as you convene your meetings, you need to stay focused, you need to stay on-task, and you need to complete doable projects.

Our partners in the SEMSCO tend to come up - I -- I victimize my friends in the systems committee - we're going to change Part 800 and update that. Well, we need to do that, there's no disputing that, but the reality is that you can't update Part 800 in one year, or decade, and so what we have -- what we're going to be doing

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with the -- with our councils is just trying to keep them focused and on-task and doing workable and attainable projects.

You -- you may also have been following the use of blood and blood products by prehospital care providers. That continues. Ed, just before he retired, went before the blood and tissue council, they are very positive about the regulatory change, which would include advanced life support providers monitoring and administering -- well, monitoring blood during critical care transfers. So, that sort of dovetails into your last discussion.

The next -- the regulations are -- are in the hands of our lawyers. The next step is that they go to the Governor's Office on Regulatory Reform. If there are no changes, they get -- they get published for sixty-day comment period, then they come back for final approval to the blood council.

I'm hoping that this occurs sometime before summer of 2010. So, just to keep you updated though, that does progress.

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I mentioned the respiratory training program. Jim is out there doing -- it's respiratory training and etiquette and fit testing train-the-trainers. He did his first program in Watertown at the end of -- well, I -- I think Friday night. He was a little disappointed that only eleven people showed up. I think -- and this caught my attention as Tim was speaking earlier, one of the issues from a prehospital care perspective is that there's so much information, all the time, that E.M.S. tends to focus on what is interesting to them, and they lose interest in things very quickly.

So, they're at a point where we have spent about a year now -- well, actually, more than that starting with SARS and seasonal flu, you know, barraging them with as much information as we can, under the logic that more is better, and they'll be better prepared, and now we're concerned, as we usually are, when we get to this point that all they're hearing is "blah, blah, blah, blah, blah." You don't have to commit that to minutes.

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So, that's a concern in this training program. So, with the help of our county coordinators and anybody who stands still long enough, we're beating the bushes to get people to these training classes.

Does that -- did you raise your hand?

MR. CZAPRANSKI: No.

MS. BURNS: Oh.

MR. CZAPRANSKI: But all the information the bureau puts down when we do all our weekly updates, we par it down.

MS. BURNS: Thank you.

And we par it down, too.

MR. CZAPRANSKI: Okay.

MS. BURNS: We, with the help of the SEMAC, are about to update our medical direction policy statement, which you may or may not be familiar with. It was put out a couple years ago -- a while ago actually. This actually Jeanne Alicandro from Suffolk County helped me put it together. It's essentially a policy statement to assist E.M.S. service medical directors in

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understanding really what the job is, what their responsibility is.

Yeah. The one you're thinking of is decades. A decade and a half.

What we did, we updated the medical director policy statement specifically to address -- it -- it -- it did not exclude pediatric patients, but it didn't encourage pediatric patients. So, we've updated it with some minor changes to include patients of all ages. That also comports with the E.M.S. for children grant process.

Also of interest to you, is that the SEMAC brought forward a proposal that was approved by the council to -- to amend Part 824, that's the equipment on ambulance -- ambulances regulations, to include -- and two -- these are two separate regulatory changes, one is to require an A.E.D. capable of defibrillating patients of all ages, or a defibrillator capable of defibrillating patients of all ages, and the second was to require that all ambulances carry EpiPen or epinephrine for patients of all ages.

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There is some wording to that. We are working with them to do that. And as a part of that, we may bring forward to the SEMSCO -- an -- an -- we're planning on bringing forward to the SEMSCO an updated equipment list, which will clearly visit the federal suggested guidelines for pediatric equipment, specifically at the B.L.S. level, because the regulations are basic life support. So, it won't -- it won't address A.L.S., but we'll do what we can to address the -- the B.L.S. needs.

And we'll -- we'll -- there'll be more on that. And just so you know, New York's -- the SEMAC approved New York City protocols - jump in here - that allow B.L.S. ambulances who -- who are already equipped with EpiPens to utilize them in -- in a severe asthmatic attack after they've done the Albuterol nebulizer. So, that protocol updates the New York City B.L.S. protocols.

And the last thing I have is we're very excited -- as I was sitting here, our G.T.S.C. grant, which has to do with electronic data collection and the NEMSIS dataset, we have --

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we're about this close to an executed contract with a company who will assist New York State in developing a state bridge, which will allow us to take data from all different types of vendors, put it into a NEMSIS-compliant dataset, push it to NEMSIS, and improve our prehospital data collection abilities and the data that we're collecting, and that's also covers your agenda item on NEMSIS

DR. COOPER: Thank you.

So, I presume that that is a bridge to somewhere as opposed to a bridge to nowhere?

MS. BURNS: Hopefully it's lot cheaper than the bridge to nowhere.

DR. COOPER: Martha?

Oh, any questions for -- for Lee?

DR. HALPERT: Yeah.

DR. COOPER: John.

DR. HALPERT: Yeah. A question on the New York City epi auto-injector program you mentioned. Would that be specific to pediatrics, or that's all players, or --?

MS. BURNS: I think what they --

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it's -- it is not age -- it is to all patients, but the age -- thirty-three jumps into my mind, and I can't remember why.

MS. CHIUMENTO: Yeah. Thirty-three, I think, was the maximum -- that they can give them without medical control. Over thirty-three they added medical control.

DR. HALPERT: So, it's a standing order for E.M.T.s to utilize Epi auto-injector up to age thirty-three in the setting of respiratory stress questionable, or is probable, in asthmatics as your -- something like that.

MS. GOHLKE: I think they're -- like that.

MS. CHIUMENTO: You know, Ann's shaking her head over here, so she may be more specific than -- but that was my recollection of the discussion, so --

DR. HALPERT: Okay.

MS. CHIUMENTO: -- go ahead.

MS. FITTON: I'd be happy to look at the protocol for you, but I believe the issue was that, first of all, the downside --

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MS. GHOLKE: Ann, could you just grab a mic?

MS. FITTON: -- is that with EpiPens for asthma patients is that we need to put the education piece in there as well as making sure that we're only doing this in the event that we cannot get an A.L.S. resource there.

DR. HALPERT: Uh-huh.

MS. FITTON: So, the -- you know, it's not -- it's -- it's -- the discussion here is almost as though E.M.T.s would be just administering epi on the basis of their assumptions that this is an asthma call.

DR. HALPERT: Right.

MS. FITTON: There are specific criteria for them to be able to do this. It has to be, first of all, a demonstrated inability of the system to deliver an A.L.S. resource to their location in a reasonable time. And I believe that time -- and, again, I'm speaking for E.M.S. operations here, I might be a little bit off of for this, but within a ten-minute upper -- upper limit.

So, if you have a child, or an

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adult, particularly an adult less than thirty-three, thirty-three was based on the American Heart age for patients who should be getting aspirin, et cetera, for chest pain, where we think that chest pain at thirty-three and above has a higher significance of having a -- a cardiac implication, therefore, thirty-three became the cutoff for this, based on A.H.A. criteria. So -- so, it's -- it's -- it's just not that simple -- that -- that -- that simplistic, that E.M.T.s will be delivering epinephrine. It is that the system is so overworked that we're unable to deliver that A.L.S. care.

DR. COOPER: Was -- was there's a low-end age on that?

MS. FITTON: That -- that -- that has yet to happen. I'd just like to tell you that that is yet to happen.

DR. COOPER: Okay. But there's no low-end age on that? That's age zero that they're --?

MS. BURNS: I think there is a low end age.

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MS. FITTON: Yes, that's also based on criteria that there has to be history of asthma --

MS. BURNS: I think there is a low end.

DR. COOPER: Yeah.

MS. FITTON: -- there has to be a diagnosed history of asthma, et cetera. So --

MS. BURNS: It think there was a low end.

MS. FITTON: -- it -- it would be --

MS. BURNS: I don't remember what it was but there was --.

MS. FITTON: I believe the lowest age is -- is age one.

DR. COOPER: Okay. All right. Martha?

MS. GOHLKE: Just want to draw your attention to the dates for next year that -- it's an all inclusive list, that includes our other council meetings, so you just scan through, you'll see E.M.S.C. in there. The May 4th date is going

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to be by Webinar, which Mr. Tayler is going to help -- help me learn how to do with you all folks as guinea pigs from the E.M.S.C. committee. So, you can plan accordingly. You -- you won't need to travel on that day. You just need to --.

DR. VAN DER JAGT: I'm sorry. Which date was that?

MS. GOHLKE: May 4th.

MR. VAN DER JAGT: May 4th.

DR. COOPER: Martha, may I just suggest that we might want to consider, since it's going to be by Webinar rather than in person, and the hotel dates don't matter, that maybe we move it after the stakeholder meeting.

MS. GOHLKE: No, I don't think it's a good idea. I strategically put it there in case there was last minute details that we need to take care of or talk about, and being that it's by Webinar, it's a good way.

DR. COOPER: Okay.

MS. GOHLKE: It won't cost anybody to touch base.

And if the feds don't look upon

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my stakeholders meeting as one of the four quarterly meetings of this committee, you can fall back on the Webinar as being the fourth meeting and we meet the grant requirement.

DR. COOPER: Okay.

MS. GOHLKE: So, there's -- there's many reasons why to keep it on the calendar. So -- and then -- what else did I want to say?

Oh, the -- the -- the stakeholders meeting -- we'd love to have everybody there. We have limited funding, okay, to -- to get everybody there, but if you -- if you really want to be at the table, just let me know now, so I can start planning and figure out how we're going to pay for travel for you to be there. We -- we may possibly be able to get everybody there, but it depends on a lot of other factors. The money is coming directly from the grant, which your travel now doesn't come from the grant for these meetings, so there's a little balancing act we have to do. So, I just wanted to mention that.

I just wanted to let you know

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that the -- the Caris Foundation, and their -- their steroid for the adrenal insufficiency went through the SEMAC and SEMSCO last week with Dr. Cooper's revisions that he made to our document that -- the document that got approved is in your folders there, if you're curious. It just puts Solu-Cortef on the state formulary for A.L.S. providers, and it opens the door for them to put it on their regional protocols, if they so choose.

So, it's still a regional decision whether or not it's going to be, you know, in the standing orders or not, but at least it opens the door, and it lets them know that we think it's a good idea. Okay.

So, the NEMSIS data, the only thing I want to add to what Lee talked about is Sharon has been helping out with this a lot, and you know, we've put it to your -- in front of your noses for your input. Now, is the time -- if -- if E.M.S.C. folks want input to what data -- prehospital data we're collecting in the state because we're -- we're revising what we're doing, now is the time; okay? Because shortly you're not

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going to have a chance to give any input on it. So, if you want to -- if you want to give input, please e-mail Sharon as soon as possible, so you can -- so you can be heard.

I just wanted to mention, because this -- many of the nurses in the room may find this interesting. You can get your mandated reporter training online for free as your recertification or C.M.E. requirements through State Ed. The Office of Children and Family Services has a two-hour C.M.E. program for mandated reporters.

A link, if it's not on our Web site now, it will be shortly to the online training. It's free. It's twenty-four/seven. You can take it at your own pace. It goes directly to State Ed letting them know that you've taken it -- taken it, and they can track it if you need to with them, and you can also print out a certificate, and it's available for E.M.S. providers, too. It's like nysmandatedreporter.org, I believe. But you can find it on our Web site.

Let's see. We did add -- we did

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add -- we talked about this a meeting or two ago, one of the grant requirements was that transporting vehicles have -- for children have to have their protocols accessible to them on the scene and during transport, so we've added that to the medical direction policy of the bureau, that it has to be either on the person or on the rigs, you know, for the sake of children. And adults, we have them for both, but it came from this grant for children. So, we did get that -- we did get that on board, literally.

We talked a lot about extra money, and the fact that the federal E.M.S.C. program believes that they're going to be funded better than ever in the coming year. We're still on, I guess, what's it's, continuation funding -- I can't remember what the proper terminology is, so 2010 funding hasn't gone through yet. I e-mailed the project officer, and let her know that we had a bunch of ideas that we've been tossing around that we would like to know how we could get access to any extra funding, and she said she'll let us know as soon as possible. So, at least we got a seed

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planted, and she knows that we're eager to hear more about it.

I talked about the stakeholders meeting. So -- and one other comment is just that the subcommittee meetings in the morning, you know, we're restructuring this meeting that we start the general meeting at eleven, and we do subcommittees early. There were several people here that were on time that are part of subcommittees that the rest of the subcommittee wasn't here. So, either they -- they didn't get the communication on what time people were collecting -- I just don't think it's fair that some people are, you know, showing up on time and not getting the communication whether or not their subcommittee's meeting, or if it's meeting at nine-thirty or ten, or you know, it's just -- so keep that in mind, especially the chairs, that you've got to communicate better with your committee, and let them know what time you're meeting, because it's -- it's not fair, for travel -- people have to get up at an insane hour to get here. So, just out of respect for them.

Okay. That's it.

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DR. COOPER: Thank you, Martha.

Subcommittee reports, I think we've covered in interfacility. I'll just say for Nominations, that the Nomination Committee meeting did meet this morning, and came up with several potential names.

Sharon and Ann, Education?

MS. CHIUMENTO: Yes. I had sent out a patient transfer decision table. This is a first -- a first go at trying to take some of the different categories of patients that are out there in the literature already, and trying to see what would be the needs so we can start to develop educational documents for hospitals, you know, prehospital environments, ambulatory care centers, all that type of thing.

The first go-around is primarily for the hospitals, so interfacility transfer either from E.D. to E.D., or interfacility from a -- from a floor. Originally, I was going to try to do one be all end all. In our discussions, we kind of decide that maybe it would be better to look at the acute care settings first, and then look at the

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more chronic care needs later on. So, if somebody need to be going over because of rehab, that might be, you know, a different set of needs then for somebody who's going because of acute care -- of -- of fractures, or whatever it might happen to be. So -- so, we're going to look at more the acute setting.

I -- I have some copies of the document. I would really like everybody's input because, you know, obviously, we're all coming from different backgrounds. Those of you who are in-hospital folks are going to have a much better idea of what you want to see in patients who are coming to you. What kind of needs you, you know, what kinds of -- of transport will they need -- all that type of thing.

So, the -- I'll -- I'll pass around -- I think I have eight copies here, so anybody who's interested in having a copy, based on some of the changes we made today, I will do an updated document, and we'll send that one out by e-mail. But if you want this, so that you just have something on -- on hand to start looking at,

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please -- please -- please take it. And then, once we finish that, then we'll move on to the other -- the other populations that would be transferring patients, such as -- such as ambulatory care centers. So that's where we are at the moment.

And please, any input you can give us, that would be really useful. Okay.

DR. COOPER: Thanks.

Okay. Under old business, the E.M.S.C. dialogues, we were able to get the -- the approval of the Division of Legal Affairs to allow us to maintain the behavioral health specialist as one of our members in a voting capacity. The language seems a little bit awkward, so we have made a suggestion to some alternative language, and we'll see how that flies. But in concept it seems as though it has been approved, so we will put that on hold until the next meeting.

The NEMSIS data -- data elements have already been covered.

Before we go to new business, we'll briefly touch upon SEMSCO, SEMAC and STAC, I think most of the key issues from -- from SEMAC

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have been covered. Our major issue was the -- was the Caris protocol, which as you heard, was approved. And I think other issues have been made --.

MS. CHIUMENTO: I had just a couple --

MR. COOPER: Sharon, go ahead, please.

MS. CHIUMENTO: -- things.

The E.M.C. guideline on education on new drugs -- so, a new drug is added into a particular regions protocols, there -- there is now a standardized format for how they're going to educate their -- their providers on the use of that drug; indications, counterindications, side effects, all the kinds of things that we would normally see when a new drug comes on the market, is now a standardized format for E.M.S. as well.

In the past, it's been whatever they felt like educating, or however they wanted to train, and there was no formalized mechanism. Now, there will be a formalized template that they can use.

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There was a naloxone demo project that was internasal naloxone by B.L.S. providers in the Albany region. So, that's something that will be looked at. It's not going to affect most of our patients, but it could affect some of our adolescent population.

And then, there was a discussion on Tamiflu distribution by E.M.S. in epidemic situations. And again, right now, it's just the preliminaries to getting the information together. It would be information that would be provided to regions, and then the regions would have to then make the decisions as to whether or not to utilize that -- that mechanism if there was an epidemic.

So, those are just couple of other little things we touched on.

Oh, one other thing and that's protocols. Please, the pediatric protocols that I sent out, did not get discussed at this last SEMAC meeting. The next SEMAC meeting is before our next E.M.S.C. Committee, and I know Dr. van der Jagt was looking at some of them last night, did find a couple of issue that he (sic) was -- some concerns

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he (sic) had. Please get those back to me, so that when we get to discussing that at the -- at the SEMAC and at the Medical Standards, I will be able to back -- bring back the input of this group as to whether or not something that's in the protocol is either not safe, or not recommended, or whether we want to make a recommendation that's not currently in the protocols.

DR. VAN DER JAGT: Uh-huh. Sharon, could I just comment on that?

Sharon's, as usual with his excellent work on all these prehospital care protocols is just outstanding. I would really endorse what Sharon says, because as you go through these prehospital care protocols, which is basically a -- a compilation of everything that is out there, it is quite amazing what people are allowed to do in their various areas. I was pretty floored actually last night.

All the way from, you know, R.S.I., which is, of course, understandable for paramedics particularly, but then there's, you know, procedural sedation, there's antibiotics

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being given, there's -- I mean there's all kinds of things in these protocols, and I -- there are dosing issues. There are a lot of dosing problems. So, I would -- again, I think one of the reasons we have this Committee is to make sure that we have input into these prehospital care protocols, because if mistakes get made, or if there is a problem out there prehospital care, you may not have a good outcome, and that makes me very worried, so --.

DR. HALPERT: I would just add as a continuance to that, having attended a few of those meetings as an observer, I think they are fairly comprehensive in their review of these protocols. It would surprise me if there are tremendous discrepancies, or concerns or mistakes out there. It's taken me a while to get my arms around the fact that a state body is really actively reviewing and trying to standardize all these protocols. I'm kind of a -- a local medical control guy historically, but be it as it may, I -- I -- I think it's -- it would be great for us to sit down and review these ourselves, so that we are

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confident at our level that things are -- are squared up and by the book. But so far, it seems like at least there's been a fair amount of vetting of these protocols through the state mechanism.

DR. VAN DER JAGT: All I can say is read what Sharon has put together.

DR. COOPER: Point well -- points well noted by both. Thank you.

With respect to STAC, the work in the STAC is focused, I think, on three major things at the present time: First, the ongoing rewriting of the regulations. Second, formation of joint group with the SEMAC to look at prehospital tourniquet use. And third, the development and the review of the -- of a potential paper survey that's going to go out to all trauma centers to provide an interim look at trauma center operations in between formal on-site visits.

The Education Committee continues to do its good work in terms of arranging for prehospital trauma care programs for the Vital Signs Conference, and the Registry Committee continues to do its excellent work in terms of

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updating the registry to keep it, you know, consistent, timely and consonant with the national trauma dataset.

Mike, are there any other key issues that you feel --

MR. TAYLER: No, that was it.

DR. COOPER: -- you --?

MR. TAYLER: I mentioned it.

MS. GOHLKE: Okay.

DR. COOPER: Thank you. So --

MR. TAYLER: That's complete.

DR. COOPER: -- so, I believe we have covered everything on the formal agenda.

I will now combine the new business and round robin sections of our meeting. We are two minutes over time, I apologize for that. But I do think we've got the rest of the agenda done in pretty record time. Thank you all for cooperating in that endeavor.

Is there any new business?

Does anybody have anything that they want to add to our deliberations today?

Well, hearing none, we will stand

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adjourned until our next meeting, which is, Martha, on --?

MS. GOHLKE: March 2nd.

DR. COOPER: March 2nd, here at the Crowne Plaza.

Okay. Thank you very much. And we will see you all then. In the meantime, have a healthy and happy holiday season. And if you are driving home this evening, please be careful, it's my understanding that a storm is anticipated.

(The meeting concluded at 4:02 p.m.)

EMSC, 12-8-2009

I, Howard P. Hubbard, do hereby certify that the foregoing was taken by me, in the cause, at the time and place, as stated in the caption hereto, at Page 1 hereof; that the foregoing typewritten transcription, consisting of pages number 1 to 238, inclusive, is a true record prepared by me and completed by Associated Reporters Int'l., Inc. from materials provided by me.

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Howard P. Hubbard, Reporter

_____Date

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