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1
2 STATE OF NEW YORK
3 STATE EMERGENCY MEDICAL SERVICES
4 FOR CHILDREN
5 Advisory Committee Meeting
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10 DATE: December 8, 2009
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12 TIME: 11:36 a.m. to 4:02 p.m.
13
14 LOCATION: Crowne plaza
15 State Lodge Streets
16 Albany, New York 12207
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1 EMSC, 12-8-2009
2 APPEARANCES:
3 Arthur Cooper, M.D., M.S., Cochair
4 Kathleen Lillis, M.D., Cochair
5 Sharon Chiumento, B.S.N., E.M.T.-P
6 Ann Fitton, E.M.T.-P.
7 Jonathan S. Halpert, M.D., FACEP, R.E.M.T.-P.
8 Robert Kanter, MD
9 Rita Molloy, RN
10 Janice Rogers, M.S., RN, C.S., C.P.N.P.
11 Elise van der Jagt, MD, MPH
12 Ruth Walden
13 Lee Burns
14 Martha Gohlke
15 Lisa McMurdo
16 Jennifer Treacy, R.Ph.
17 Mike Tayler
18 GUESTS:
19 Sarah Macinski Sperry
20 Christopher Kus, M.D.
21 Wendy Weller, Ph.D.
22 Tim Czapranski, E.M.T.-P.
23
24

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1 EMSC, 12-8-2009
2 (The meeting commenced at 11:36
3 a.m.)
4 DR. COOPER: Okay. I d like to
5 call the meeting of the State Emergency Medical
6 Services for Children Advisory Committee to order.
7 It s December 8, 2009, and we re delighted to have
8 with us today some very special guests.
9 We have, of course, Lisa McMurdo
10 and Jennifer Treacy, director and associate
11 director of the Division of Quality Assurance and
12 Patient Safety with the Department. They are the
13 folks who are in charge of the division in which
14 the Bureau of E.M.S. currently resides. And, of
15 course, that is where we reside.

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2 and the Bureau of Injury Prevention, are with us
3 today as they have been in the recent past. And we
4 continue to welcome your participation. Thank you
5 so much for being here.
6 And last, but not least, it s my
7 distinct honor to reintroduce to the group, Ms. Lee
8 Burns, who has taken on the leadership of the
9 Bureau.
10 As you can see, Lee has very
11 broad shoulders, which is important because she is
12 now doing three jobs. She s director of operations
13 for the Bureau. She s assistant director for the
14 Bureau, and now she s acting director for the
15 Bureau. So, fortunately, there are three

16 And in addition to that, we have

17 Dr. Chris Kus, who is associate medical director

18 for the Division of Family Health. Chris has about

19 an hour with us, I believe, today to share with us

20 quite a bit of information, which he will be doing

21 momentarily.

22 One final note, of course, is

23 that Dr. Wendy Weller and Sarah Sperry, who

24 normally join us from the School of Public Health

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16 eight-hour shifts in a twenty-four-hour day, so you

17 know, we will Lee will be able -- Lee will be

18 able -- Lee will be able to handle it as she has

19 always handled everything else. But she has taken

20 over the leadership of the Bureau from Mr. Wronski,

21 who has stepped off into retirement.

22 Lee, as you know, is -- is an

23 active paramedic, has been for many years, and

24 brings with her not only a -- a wealth, in terms of

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2 both depth and breadth of administrative experience

3 within the Bureau, but also is one of us. She

4 is -- she is a healthcare provider. And so, she

5 understands the issues in a way that -- that not

6 everyone else can, because they re not out in the

7 street actually delivering the care, as Lee does.

8 Now, I -- it is true that she

9 sometimes does that on a motorcycle, and we have

10 been trying to convince her that that s not a wise

11 thing to do, but -- but -- but she hasn t listened

12 yet. Fortunately, she listens about most other

13 things.

14 But -- so, Lee, so thank you, and

15 God speed in your new assignment, and we will be

16 here to support you in any way we can.

17 I d like just very briefly to

18 call for a review and approval of the minutes. All

19 of you, I believe, received a copy of the minutes

20 by e-mail. Are there any additions, deletions or

21 corrections to those minutes?

22 In hearing none, I ll entertain a

23 motion for approval.

24 DR. VAN DER JAGT: So moved.

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2 DR. COOPER: Thank you.

3 Ruth Walden, and Elise Van Der

4 Hunting.

5 Discussion?

6 All in favor?

7 MS. WALDEN: Aye.

8 DR. VAN DER JAGT: Aye.

9 DR. COOPER: Opposed?

10 (The motion carried.)

11 DR. COOPER: Carries without

12 dissent.

13 Thank you. I d like to move

14 right into our -- our agenda. In the interest of

15 time, I will ask you simply to read the agenda that

16 is before you because I know Dr. Kus has very

17 limited time. Dr. Kus is going to be pinch hitting

18 in addition for, you know -- for himself, for Ms.

19 Winooski of the Bureau of Community Chronic Disease

20 Prevention. He will lead off talking about the

21 Department s asthma initiative, and -- and then

22 will speak with us about the issue of which all of

23 us are most concerned, namely the H1N1 pandemic and

24 its affects on the children of New York State.

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2 Chris?

3 DR. KUS: Sure. Glad to be here

4 and -- actually just to give you some update why

5 it s -- it s great, Pat Winooski is the project

6 director for our asthma grant from C.D.C. and has

7 recently taken a position within the Bureau of

8 Chronic Disease. So, this asthma grant was

9 previously in the Division of Family Health. So,

10 she moves over to the other division, and she says,

11 oh, I can t make it, so you better do it. So,

12 just so you know that.

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2 Disease Control and Prevention for almost ten years

3 and state funding committed to asthma care,

4 particularly looking at what can the public health

5 agency do to improve outcomes relative to asthma

6 care. And this comes from the New York State

7 Asthma Plan 2006-2011, where we had quite a few

8 stakeholders participate, but we also have now a

9 partnership which involves different agencies,

10 Academy of Pediatrics, respiratory therapists,

11 different organizations because what we ve realized

12 is the -- the work of asthma is done out in the

13 But what -- what I want to do is

14 make it as useful as possible for you. So, as we

15 go through this, if there are specific questions

16 that you have, stop me, and -- and go from there.

17 I have a pretty tight presentation for asthma.

18 H1N1, there s lots of stuff, so we ll go through

19 that, and see which things are most interesting to

20 you or -- or would be helpful.

21 So, to start out with the New

22 York State asthma program, this is really talking

23 about asthma from a public health perspective,

24 because we ve had a grant from the Center for

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13 field, and is there a way that we can coordinate

14 that activity with our partners to take advantage

15 of -- of -- of the resources that they have.

16 So, we re kind -- we ve kind of

17 moved from an advisory group to a partnership group

18 so that people, as opposed to reviewing a plan once

19 every year or so, we have quarterly meetings, and

20 we really try to move agendas that way so that

21 people are really taking ownership of this. And so

22 this is where the asthma plan came from. And the

23 big line is despite improvements in awareness, care

24 and management, asthma still remains an epidemic in

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2 New York State with significant public health and

3 financial consequences.

4 Disparities are a big issue here,

5 which when we talk about this, the disparities that

6 we see in asthma are similar to the disparities we

7 see with lead poisoning in children and have --

8 have socioeconomic parts to it, but -- but in -- in

9 a way, we ve been talking about how to deal with

10 that issue not just from one condition. And the

11 idea is we re -- we re talking about what do we

12 need to do to accelerate and spread improvements.

13 It s -- it s really thinking about not doing more

14 of what we re doing, but is there different thing

15 that we need to do.

16 Next one.

17 So, give you a little information

18 about the burden of asthma, the -- New York s

19 action to control asthma, and the progress and next

20 steps, and then hopefully, we ll highlight the

21 emergency care system and how we -- we -- we ll --

22 we can work across that system to improve care.

23 Next one.

24 So, this just gives you some

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2 the -- the way care is delivered; is it a

3 reflection of the way people use the healthcare

4 delivery system?

5 These kind of global figures what

6 we ve -- we ve got. If you go to our Web site, we

7 have maps of different parts of the state. So,

8 it s really useful to look at those hospitalization

9 rates on counties and lower areas.

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2 sense of the prevalence of asthma in adults using

3 the behavioral risk factors survey, which different

4 states us and what you ll see is that our

5 prevalence rate pretty much goes along with the

6 U.S., although we re -- we tend to be the higher

7 bar.

8 And then, if I -- if I took this

9 information and tried to give you information with

10 regard to children, what you see is, depending on

11 the area that we re talking about, we can see

12 prevalence rates up to fifteen percent in some of

13 the New York City population, particularly east

14 Harlem and -- and those areas. So, there s a

15 range.

16 Next one.

17 How about hospital discharge

18 rates?

19 What you re seeing is New York

20 City above, and then you re seeing rest of the

21 state, and -- and then New York State in the

22 middle. So, high asthma hospitalization rates in

23 the city, and one of the things we -- you know,

24 we re talking about is: Is that a reflection of

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2 room visits relative to asthma that we re starting

3 to analyze, and -- and look at the quality of that

4 data. But if you look here, all our numbers are

5 above the Healthy People 2010, and they re also

6 above what the United States in general has from

7 2004 to 2006.

8 Next one.

9 How about discharge rates?

10 Total cost. This gives you
11 the -- if you -- if you look at the top one, that s
12 really the adjusted cost, and so that s gone up
13 slightly, when we look -- adjusting the cost back
14 in 1998, and it s kind of flattened right now, but
15 still a -- a big cost in terms of healthcare
16 delivery dollars, and Medicaid dollars for the
17 state.
18 Next one.
19 Okay. How are we doing?
20 If we -- we talk about healthy
21 people 2010 goals, and here you re -- we re looking
22 at the emergency department rate per ten thousand,
23 which is one of the things that s actually new data
24 items that we have in -- in the idea of emergency

10 Similar profile here where we re
11 not close to the Healthy People 2010, and we re
12 higher than the -- the average U.S.
13 Next one.
14 Mortality rates. We, again, are
15 generally higher -- well, we are on all except for
16 over sixty-five in -- in terms of mortality rate
17 for asthma.
18 Next one.
19 So, what are the challenges that
20 we have in -- in terms of our system?
21 Well, one of them and -- and I
22 guess this is the one where we talk a lot about
23 giving the issue of healthcare reform, if you look
24 at our healthcare delivery system, it s really

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2 focused on acute care versus chronic care
3 management. So, is there a promise that we will
4 look at chronic care a little bit differently? The
5 concept of medical home being used as a way of
6 enhancing rates for doctors and trying to over --
7 trying to emphasize the -- the issue of
8 coordination of care, you know, may -- may offer
9 some possibilities. But if you -- if you look at
10 the -- the amendments that have been proposed to
11 health care reform, you look at the discussion,
12 it s not too -- it doesn t look too promising to me
13 in terms of chronic care.
14 And I think that s a huge issue
15 here, because the incentive, particularly for
16 pediatricians or family practitioners to take care
17 of kids with chronic disease, financially, there s
18 isn t an -- an incentive. There is no incentive to
19 do that. So, I think that s a huge thing that
20 we re talking about.
21 One of the things we re talking
22 about is trying to get some -- since we have most
23 of our kids in a managed care system, we re looking
24 at performance measurements that reflect care of

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2 chronic disease. But that s -- those are hard to
3 do, and they re just being developed.
4 When we look at it, the gap
5 between what is recommended as good asthma care and
6 actual practice persists, I ll get into it, but
7 what -- what you got was the continuing effort to
8 get consistent guidelines about what s expected of
9 care.
10 The positive thing about it is if
11 you look at the back of this document, it shows all
12 the healthcare plans that were involved and agreed
13 to this; which is huge -- a huge thing to do to get
14 them all to agree to the same thing. So, we re
15 clear about what should be done, one of the things
16 we look at when we do some of the work with
17 practices, is that the systems aren t generally in
18 place to allow you to -- to do some of this.
19 An issue specifically for this
20 group is the -- is the idea of using the emergency
21 room for primary care. So, your acute visits go to
22 the emergency room, and then how do you get the
23 ongoing chronic care management to be involved, or
24 the primary care doc to be involved?

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2 Reimbursement models do not
3 support good asthma care. Real time information,
4 not often available. I guess the promise of health
5 information technology is -- particularly when --
6 when we re talking about kids, the -- the
7 penetrance of medical -- of electronic medical

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2 culture. Again, the idea that we re acute care as
3 opposed to chronic care.
4 Next one.
5 This is the Health Department
6 organization of how we are dealing with asthma.
7 And we put it up here because it -- it -- it is --

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8 records is -- is not very high right now, and I

9 think there s some promise to that. But one of the

10 things that I m concerned about in kids is that the

11 general products of medical records aren t very

12 well tailored to pediatrics. They re generally

13 adult specific.

14 A defined set of valid measures

15 for asthma care is limited. We ve done a lot in

16 terms of working on that, and we ve put out a

17 surveillance document, and there are some

18 measurements in the core measures, which is the

19 measures that the state looks at for managed care.

20 Efforts to spread and bring

21 effective evidence-based interventions to scale are

22 limited. And this is probably the biggest one.

23 Despite evidence self-management support is not

24 well incorporated into the mainstream health

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2 of -- a lot of things that you could work together

3 on besides asthma, or you could combine some

4 things. So, I think the model of trying to work

5 across the --the Department -- people always talk

6 about stovepipes and all that kind of thing, this

7 is the idea of trying -- trying to work across the

8 Department.

9 Next slide.

10 If people are interested, on our

11 Web site there is asthma plan, and I think we

12 still -- we have hard copies that -- that we can

13 give to folks. With it, you ll -- you see the --

14 the goals that are listed.

15 The first one really talks about

16 that -- put all those words together about

17 coordinated care. The second one is about the

18 disparities issue. Third one is asthma-friendly

19 communities, taking into consideration the

20 environmental situations that kids are in. One of

21 the activities that the -- the New York City

22 program deals with, is standing buses in -- in --

23 in front of schools and -- and those all play a

24 role with this. And -- and then, the fifth one is

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2 asthma coalitions, because they re supposed to

3 take -- involve people from the different provider

4 networks in terms of emergency room primary care

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8 it could be an ongoing model for care of chronic

9 disease in general, because what you see is that

10 good asthma care goes across many of the different

11 parts -- the centers of the Health Department.

12 And so our structure was set up

13 with having a leadership team. You see Pat s name

14 as the coordinator, and Dale Morris is the P.I. on

15 the grant that we have from the Center for Disease

16 Control, and we ve divided it up into four groups.

17 The surveillance group, the healthcare delivery

18 group, the community group, which -- which I m the

19 team leader on, and the environmental and

20 occupational health group. And within those

21 groups, we have people from different bureaus,

22 different divisions, that have some contact with

23 regard to asthma meeting, and the plus of that is

24 that as you do this, you find that there s a lot

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2 saying that you can t do this within the Health

3 Department. We really are trying to have a

4 public/private collaboration to improve asthma

5 outcomes.

6 Next one.

7 This tells you where our support

8 comes from. The -- we ve been very consistent. I

9 think this is -- and people have -- have liked

10 the -- the structure of -- of the program, so that

11 we ve had consistent funding from the Center for

12 Disease Control and Prevention, and that s not

13 all -- for all states. It s for a really small

14 subset of states, probably -- I think it s less

15 than ten right now. And we also have state funding

16 that s been fairly consistent, probably for the --

17 we ve had it for the last, I think, about eight

18 years, and our current funding for the state is two

19 million dollars.

20 And -- and that funding goes to

21 the main vehicle that we re trying to use to -- to

22 get people to collaborate, which are regional

23 asthma coalitions. And I would be interested to

24 see if any folks on here are on those regional

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5 doc.

6 I see one shaking head, so that s

7 good.

8 And -- and the idea is that

9 those -- those coalitions really try to bring

10 people together and get them online in terms of

11 what s the best way to help after they ve assessed

12 what s happening in their region. And -- and one

13 of the tools that we ve put into those coalitions

14 in the last three years is an outcome learning

15 network with the idea that it -- it s using the --

16 how many people are familiar with learning

17 collaborative?

18 Oh, we got one, two.

19 Okay. The -- the idea of looking

20 at the coalitions as a learning network, and that

21 they will come up with projects that seem to fit --

22 that should fit with what the goals are, that are

23 in the grant, and then one of the key things about

24 it is measuring outcomes about that, and to -- to

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5 outcomes that they re doing, if they put that

6 together? And it s a way of people also getting

7 information from all the other coalitions about

8 things they might use. So, we ve now gone into a

9 WebEx series where people are sharing some other

10 outcomes.

11 Next one.

12 This shows you the asthma

13 coalitions, and this grant is going to be up for

14 rebidding fairly soon, so one of the discussions

15 that comes up is we -- we haven t had increased

16 funding for the time that we ve had the grant, so

17 how do you effectively use it? So, the question

18 will be are we -- we spreading it too thin? How

19 should we be involved? And I think that s one of

20 the discussions that ll come up with -- with our

21 partnership.

22 Right now, there -- the -- the

23 goals of the -- through our program is to say using

24 the regional coalitions as a way to get best

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2 practices out there, that one of the things is to

3 say we want to get out to people what s the state

4 of the art in terms of clinical care. So, that s

5 the -- the guidelines here, saying that we -- this

6 is the way you should provide asthma care, and this

7 is the second edition of -- of the guidelines.

8 The -- and it came with the -- the updated

9 guidelines from the -- the national program.

10 If you look at the guideline,

11 the -- the -- the -- I think the biggest difference

12 is there s a strong emphasis on control in this

13 guideline. In the previous one, it was -- it was

14 talking about classifying the asthma, but this one

15 says you need to have some measure of control, and

16 then -- and then when you use that measure of

17 control, then it keys you into what treatments you

18 should -- you should provide.

19 And I think I went through the

20 rest.

21 Okay. So, that s what you got.

22 Okay. So, have -- have we made a

23 difference?

24 This -- the first part is kind of

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2 what outcomes can we look at, and you can say --

3 well, we may have contributed to a twenty-percent

4 reduction in asthma hospital discharge rate among

5 children zero to seventeen; a thirteen-percent

6 reduction for the total population; and a

7 thirty-percent reduction over all asthma death

8 rate. And that, you know, that s -- that s

9 targeting those -- those big outcome measures.

10 Next one.

11 What have we done to relate to

12 that?

13 This is kind of more the process

14 measure things. We had been really active in

15 publishing and presenting at statewide and national

16 meetings. We ve been involved pretty actively

17 with -- with federal -- with national groups,

18 particularly the C.D.C. in terms of the direction.

19 We provided technical assistance to fifteen other

20 states involved in legislation, and we ve had lots

21 of graduate, doctoral and preventive medicine

22 resident students that have rotated through.

23 So -- next one.

24 So, what do we do in 2009 to

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2 2010?

3 We continue with the idea of

4 having this asthma partnership group. We re

5 continuing with -- with the regional asthma

6 coalition, and we re looking at our current agency

7 infrastructure to see if that makes a difference.

8 We do regularly put out asthma

9 surveillance systems and program evaluation, and --

10 and hopefully have people use that information as

11 they plan programs. And in terms of the actual

12 healthcare delivery and quality, the consensus

13 guidelines self-management toolkit that we put out,

14 we have worked relative to benefits for asthma, and

15 one of the biggest ones is there wasn't a

16 certification for asthma educators, which there now

17 is, and allows people to get that funded for. So,

18 that's a little bit moving on in terms of chronic

19 disease.

20 Next one.

21 We have a pretty big

22 environmental part in terms of combining it with --

23 with some of the healthy home environments that we

24 do. We look at the school air quality and outdoor

2 triggers, and -- and then we -- we've done a

3 specific learning collaborative with school-based

4 health centers where we worked with, I think it was

5 about six to seven school-based health centers that

6 were in the highest asthma hospitalization areas,

7 and said this is a vehicle to see -- to see if we

8 could improve care.

9 And what we found was like what

10 happens in -- in a lot of practices, if you ask

11 somebody how many kids with asthma do you have?

12 They -- they can't really tell you. They can say

13 we have a, lot or we have -- think we -- think we

14 have this much. So, we worked with them to develop

15 a -- a registry with regard to asthma. We --

16 they -- they embedded the guidelines within their

17 visit form, which helped them to continue it, and

18 then we followed -- we tracked outcomes with that.

19 And at -- at least during the time they

20 participated with us, they continually improved the

21 outcome of -- of good practice in that. And it was

22 also used for -- the registry was used for a -- an

23 immunization project, too. And actually, it's

24 something you can use for H1N1, if you've got a

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

3 And I've already talked about the

4 Asthma Outcomes Learning Network.

5 That's it.

6 DR. COOPER: Thank you, Chris, so

7 much for that really very comprehensive

8 presentation. I think all of us are really very

9 pleased to know the -- the breadth of activities

10 that the Department of Health has undertaken to try

11 to get its arms wrapped around this -- this huge

12 problem, which, you know, as we know affects our

13 Downstate and lower socioeconomic groups really

14 with a ferocity that's almost unimaginable.

15 Are there any questions for Dr.

16 Where?

17 Elise, and then Rita.

18 DR. VAN DER JAGT: Just -- just

19 two questions. One is how are the E.M.S.

20 providers, prehospital care, incorporated into the

21 coalitions in the various areas? That's not clear

22 to me. Sometimes we skip over that. We looked at

23 emergency medicine, we looked at primary care

24 physicians, we look at inpatient, but we don't

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2 necessarily use the providers, and what triggers me

3 thinking about that is actually when Sharon passed

4 around the A.L.S. protocols, you know, looking at,

5 you know, the asthma protocol, managed that's acute

6 care. But that brings to mind, you've got a whole

7 lot of providers out there who deal with asthma on

8 a daily basis. So, I was wondering what you would

9 do with that.

10 And then, the second question I

11 have, just very quickly, is did you -- have you --

12 if you look at the -- these various parameters,

13 obviously, you can see that New York City sticks

14 out as being extremely high-risk area. If you

15 compared New York City with the Upstate area,

16 without including New York City in the Upstate

17 area, is there -- is there a difference between

18 those two and how great is it?

19 DR. KUS: Well, it's -- I mean

20 it's -- it's big. I mean the difference between

21 that -- although you can find in the Upstate area,

22 particularly in some of the rural areas, you can

23 find hospitalization rates that are higher, and --

24 and when you look at it, it may be the access to

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2	care thing.		2	DR. VAN DER JAGT: I just think	
3	But I think one of the things		3	that you have a whole lot of E.M.S. providers who	
4	we -- we see is in terms of the actual looking at		4	are really good in education in that -- in that	
5	rates, that global New York City and the global New		5	sphere of E.M.S. --	
6	York State, doesn't tell you the -- the -- the		6	DR. KUS: Uh-huh.	
7	story. That's why looking at the -- the		7	DR. VAN DER JAGT: - that might	
8	county-specific ones, and looking at the population		8	be really used as a -- as a tool to help some of	
9	is really the way to do it.		9	the educational aspects of this.	
10	But still the load of -- is -- is		10	I know you've got asthma	
11	actually concentrated in several -- in several		11	educators, and things like that, but you know, I --	
12	parts of -- of New York City. The -- the -- the		12	at least in my area, E.M.S. providers are very	
13	highest level.		13	interested in -- in whatever they can do to educate	
14	Your E.M.T. question is a good		14	in the local communities. And if they can be part	
15	one. I know that some's include it, but I -- what		15	of this, I think you will have a whole lot more	
16	I can do is I will go back and I will see what our		16	people to help out in this area.	
17	current list is, and what we've done to do it,		17	DR. KUS: Yeah.	
18	because we -- when we enlisted people to -- to be		18	DR. COOPER: Chris, I was	
19	involved, people were given the directions to		19	actually going to follow along with a similar	
20	really look at the -- the continuum of the		20	comment, and -- because Elise has raised the issue,	
21	healthcare delivery system. So, I -- I -- I know		21	I'll follow along with it now. It really strikes	
22	that there's a couple coalitions that involve		22	me that we are missing a major opportunity in terms	
23	people. But to give you a whole sense of that		23	of community education, by not making greater use	
24	would be good. I'll -- I'll do that.		24	of our E.M.S. providers.	
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2	The American Red Cross has		2	And I think that -- I think that might be a nice	
3	created a whole slew of what it calls tear sheets.		3	project for us to work on together, you know,	
4	It's -- they're just -- they're just eight and a		4	developing an instrument like that, that we could	
5	half by eleven sheets of paper that are bound		5	share with our E.M.S. providers.	
6	together with, you know, a padding compound at the		6	Rita?	
7	top just like a regular, you know, pad of paper		7	MS. MOLLOY: So, one of the	
8	that -- that -- that we use. And the tear sheet is		8	things that I wanted to discuss with you to	
9	a simple document, sort of explaining to the public		9	piggyback on what Elise said was, you know, I've	
10	simple measures that can be taken to, you know,		10	been involved with the Asthma Coalition of Long	
11	reduce the impact of disease, you know, morbidity		11	Island for the last -- over a decade, and I'm on	
12	for themselves and their families. And I was		12	the school's environment committee, and I have been	
13	wondering, you know, why not create a document like		13	in an asthma-friendly schools initiative grant.	
14	that, that -- that, if you will, takes, you know --		14	This is year four --	
15	or makes use of the teachable moment --		15	DR. KUS: Uh-huh.	
16	DR. KUS: Uh-huh.		16	MS. MOLLOY: -- in my area. And	
17	DR. COOPER: -- that our -- our		17	one of the reasons why we were eligible for that	
18	E.M.S. providers could actually, you know, tear one		18	grant was because our data for, you know, E.D. --	
19	off, give it to the family, and say, here you are,		19	DR. KUS: Right.	
20	you know, think about primary care, think about --		20	MS. MOLLOY: -- discharge was way	
21	if you don't have primary care, we'll help you get		21	over the top for young children. So, we're looking	
22	it, et cetera, et cetera. All the things that we		22	to improve outcomes, but when you look at all these	
23	know that make a huge difference in terms of -- you		23	guidance documents, they really do recommend using	
24	know, in terms of getting control of this epidemic.		24	an asthma action plan, which I see extraordinary	
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2	resistance in the medical community to take the		2	DR. KUS: Uh-huh.	
3	time to prepare.		3	MS. MOLLOY: And one of the	
4	And school nurses receive every		4	things that I spend a lot of time -- myself	
5	one of these children into some setting, from very		5	personally doing with my clients is reeducating	
6	young ages, pre-K on. And to -- to miss an		6	them and making them understand the difference	
7	opportunity to have a document that would help it		7	between the mechanisms of action, why they need to	
8	be more seamless for care, not just episodic		8	feel comfortable using controller meds.	
9	treatment, but that emphasis now on controlling		9	And you know, I m going for my	
10	medication.		10	certification as an asthma educator. But part of	
11	There is a tear-off sheet about		11	the reason why I wanted to bring it to this table	
12	the rules of two that exists that asthma coalitions		12	is I think we were missing the boat on the side,	
13	have put together with the Lung Association that		13	like Elise said, with the emergency providers, and	
14	speak to that very issue, because people don t		14	then with the school nurses, because in New York	
15	understand that just because they ve surmounted the		15	State, even though we re not mandated as school	
16	crisis by opening their airways, all of the other		16	nurses, we re very fortunate to have representation	
17	mechanisms that are involved in having, you know,		17	in just about every school in the state, where you	
18	these -- over time these chronic health conditions		18	do have a hands-on medical provider.	
19	and the lung remodeling, and all of these things.		19	My frustration, though, is that	
20	So, it s really a key that we re		20	the -- the medical information that comes to me	
21	missing that we can t seem to get a buy-in from		21	after this treatment is very substandard. It may	
22	practitioners, or even discharging from an E.D., to		22	even say -- and I don t want to indict a hospital,	
23	have a long-term plan other than that episodic		23	so I won t even say where -- but it will say was	
24	care.		24	seen for illness/injury and can return to school.	
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2	Well, it doesn t even tell me, so now I m trying to		2	because it s in the crisis.	
3	get to the parent, trying to find out what, you		3	DR. KUS: Right.	
4	know, transpired over the weekend, find out that		4	MS. MOLLOY: So, we need for	
5	this kid was bronchodialated back-to-back the night		5	that -- that ability to, you know, cross over time,	
6	before, coming in, they haven t filled any		6	and to get on board with the rest of the parties.	
7	prescriptions, there s nothing available for me to		7	One of the things that the Asthma	
8	treat them in an emergency, and then, you know,		8	Coalition is trying really hard to do in my	
9	we re off to the next episode.		9	community is to reach pediatricians to get them,	
10	So, I m looking for a buy-in or a		10	you know, a better comfort level of providing the	
11	mechanism to make this more seamless, because we		11	controller medications, and to understand how they	
12	have some very good foundational people and -- and		12	need to spend a little time educating the parents,	
13	resources available, that we re underutilizing by		13	because they don t really get it.	
14	not having a really good mechanism of getting the		14	And -- and they don t. I can	
15	information from one party to the other.		15	tell you. I ve been doing this a long time. And	
16	A lot of people are afraid of the		16	I -- and I live with an asthmatic son, who I ve,	
17	privacy issues. Well, if you have the parent there		17	you know, had to reeducate school personnel over	
18	with the child anyhow, you can cross that bridge.		18	time. So, it s a really frustrating experience,	
19	The school needs to know. Where -- wherever the		19	especially when you do have a culture now of -- of	
20	next person is that will be a provider of care or a		20	realization that the emphasis needs to change, that	
21	caretaker of that person over a great deal of their		21	what we re doing looks great at the top, but it s	
22	waking hours, it s critically important, not just		22	not working at the bottom, you know, so we need	
23	for the parent, to be told in the moment, who quote		23	to -- we need to do something better. And I think	

24	frankly they don t really get it in the moment	24	by identifying the partners that we have that are
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2	there -- I mean we have a built-in structure to	2	because you can say a hundred times over, asthma
3	support the efforts at the top --	3	action plans are great, they re the standard of
4	DR. KUS: Uh-huh.	4	care. Let s do it. Let s do spirometry, you know,
5	MS. MOLLOY: -- but we need to	5	in the office, let s do peak flows here and there.
6	find a better way of interfacing together.	6	Well, if nobody s -- if nobody s bought into it,
7	DR. KUS: Uh-huh.	7	and nobody is doing it, let s think why, and let s
8	MS. MOLLOY: And I think the	8	either change it or make it happen.
9	emergency room discharges could be a great place	9	DR. KUS: Uh-huh. Uh-huh.
10	for that to start. You know how there s usually	10	DR. COOPER: Bob Kanter.
11	protocols for discharge where you -- certain amount	11	DR. KANTER: Those are great
12	of information has to be given, and a person has to	12	comments about the acute aspects. I wonder if you
13	leave armed with a certain amount of knowledge, so	13	could talk for a minute about the trade-offs
14	just to say that you need to go see your primary	14	between programs or initiatives dealing with
15	care physician in a day, you know, that s falling	15	dedicated to one chronic disease, the asthma,
16	short because they re not going.	16	versus a broader perspective on just a chronic
17	DR. KUS: Uh-huh.	17	disease in general?
18	MS. MOLLOY: They re not going	18	DR. KUS: Well, I think our
19	for a myriad of reasons, either money, time, you	19	feeling is people that worked in this is that the
20	know, many. And it might be -- it might be	20	model this -- this kind of thinking fits to a great
21	multifaceted, but you re really -- we re really --	21	extent to -- to lots of chronic disease, and it --
22	we re not doing as well as we could be doing it if	22	it really talks about the lack and -- of our
23	we addressed that gap. So, that s really why I had	23	health -- of our healthcare delivery system in
24	asked for, you know, this to come to the table	24	terms of being able to provide that education. I
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2	mean chronic disease -- to be educated that you	2	spelling) is -- is trying to address asthma control
3	need to take the medicine when you re feeling good	3	in E.D.s by -- by actually doing something in terms
4	is a -- that s a -- that s a tough message to	4	of the area of -- of asthma action plans. I don t
5	get -- for people to get across.	5	know specifically what it is, but I will follow up
6	MS. MOLLOY: Uh-huh.	6	on -- on it, because I ve always had a hard time
7	DR. KUS: So, I think there s a	7	understanding how you can do kind of that sit down
8	lot of commonalities, and we re actually looking at	8	asthma action plan kind of thing in an acute
9	trying to, in fact, Pat going over to chronic	9	setting. But apparently they re trying to do it.
10	disease may move us looking at it in a more similar	10	And they re working to -- they re working
11	fashion.	11	specifically with their regional coalition, and --
12	And most people would say -- who	12	and -- and she also says that New York City wants
13	deal with chronic disease say about eighty percent	13	to do a citywide policy on this. So -- and -- and
14	that -- of things that you re doing are pretty	14	apparently, it s working with the Association of
15	similar: Coordination, parent education and family	15	Emergency Physicians to write a physician s
16	support are the -- the things that you -- you need	16	statement. So, some of this then may be coming to
17	to bring into it.	17	the front. Now, I ll get further information on
18	I guess the -- the issue I m	18	it.
19	struggling with is -- is the -- what can we do?	19	I guess I -- I -- the part for
20	I mean I -- because I think in --	20	me, is to try to figure out what -- what do you do

21 I -- I do have a note from -- because I knew

22 this -- this question was coming up. But Pat sent

23 me a note that specifically at -- in the Golisano

24 Children s Hospital, Mark Lampil (phonetic)

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21 because I think one of our messages up front is

22 that you ve got to get the family into a system of

23 care to begin with. So, that -- that issue right

24 up front; do you have insurance? And I can get

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2 you insurance is critical, and then we have to

3 then have ways of making sure that the quality of

4 care that s provided is good. But it does, to me,

5 fit with the idea of, if I m a primary care doc,

6 and I m not apologizing for them. If I m a primary

7 care doc given today s current system, it -- it --

8 it -- the incentive for you to -- to spend that

9 time is really not a luxury that lots of them have.

10 So, I -- I think there are people that do it

11 because they think that that s an important thing.

12 But if you become good taking care of chronic

13 disease -- children with chronic disease, then you

14 get more of them, and -- and it doesn t fit in

15 terms of a reimbursement system.

16 MS. MOLLOY: I agree, but we

17 could use some of the people who we have who are

18 capable of being educators as -- as a way of

19 offsetting that time spent --

20 DR. KUS: Uh-huh.

21 MS. MOLLOY: -- that they need to

22 spend. I mean they just need to write the orders,

23 particularly to get the people to have the

24 availability of those medications.

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2 The other thing I want to just

3 caution, you know, everybody about is that

4 frequently legislators, you know, think they re

5 doing a good thing and there s been bills that have

6 been bandied around about stock albuterol for

7 schools --

8 DR. KUS: Right.

9 MS. MOLLOY: -- so that we never

10 get a person under good control --

11 DR. KUS: Right.

12 MS. MOLLOY: -- and we re

13 treating crises all the time and bronchodilating

14 people to death.

15 DR. KUS: Right.

16 MS. MOLLOY: So, honestly, I will

17 tell you that the Asthma Coalition came to me, and

18 asked me about this, because well-meaning, and you

19 know, and well intentioned actions sometimes, you

20 know, the road to hell is paved with good

21 intentions, you can t always just, you know treat

22 something in a vacuum. And I think that that s

23 sometimes they way things are sponsored. So, for

24 this, you know, group, I think it s really

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2 important for us to, you know, emphasize that

3 that s not -- that s not the spirit of what --

4 DR. KUS: Right.

5 MS. MOLLOY: -- you know, the

6 initiatives are.

7 And it s not helping someone over

8 time, because you want to talk about chronic

9 disease models and lung disease when you get older.

10 Just undertreat them all these years, and who are

11 they going to be when they re get old? Right. So,

12 let s think about that.

13 DR. COOPER: I d like to --

14 before I recognize Tim Czapranski and Elise Van Der

15 Jagt, our cochair, Kathy Lillis, has had a

16 tremendous interest in this area over the years,

17 and I just wanted to get her thoughts.

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2 for -- for persistent disease.

3 DR. KUS: Uh-huh.

4 DR. LILLIS: The second was a

5 video that we were doing on an educational

6 component, and it was based on one that was at

7 Chindren s Hospital of Philadelphia, that it went

8 through issues such as triggers, and -- and the

9 difference between rescue meds versus chronic meds.

10 The third component was actually

11 initiating the inhaled corticosteroids in the

12 emergency department. And we were doing a

13 randomized control trial, and we were either giving

14 them the -- a one-month nonrefillable prescription

15 for the inhalers, and actually in our pilot study,

16 we actually gave them the sample drugs versus

17 sending them back to the primary care providers.

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

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

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2 them on somebody that -- that hasn't been started
3 on it.
4 DR. COOPER: Uh-huh.
5 DR. LILLIS: And they were going
6 to get -- the -- the list of guidelines of what --
7 where they needed to go if they needed to have the
8 step -- stepwise approach.
9 So, we -- we recognize that it's
10 very episodic care, that -- that it -- that there's
11 acute -- there is this perception that emergency
12 physicians deal with -- with acute illness and
13 primary care providers deal with the chronic
14 illness.
15 DR. COOPER: Right.
16 DR. LILLIS: There was also some
17 concerns when we rolled out our pilot to our
18 community physicians, there was a little bit of
19 pushback with the pediatrician saying you can
20 identify them, but we don't want to start
21 chronic meds on our patients. There was also the
22 concern that if the emergency department provides
23 the chronic meds, would the kids stop going to
24 primary care providers and just use the emergency

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2 departments even more. So, we were actually going
3 to survey the community pediatricians and find out
4 if there had been any disruption in their -- their
5 relationship with their patients, based on our
6 study. And -- and that's again, why we only did a
7 one -- one-month supply, and the families were
8 told, you need to follow up with your -- with your
9 primary care provider within the month.
10 And we had gotten scored, and --
11 and resubmitted. Unfortunately, with the funding,
12 we -- we didn't get a high enough score to -- to be
13 funded. But I mean I think it's -- it's
14 initiative. I think emergency departments are
15 going in this direction, when we were picking our
16 PECARN sites, there were some studies -- some sites
17 that couldn't participate in it, because of their
18 existing physicians already prescribing inhaled
19 corticosteroids, and their I.R.V.s would not allow
20 them not to, or to randomize to --
21 DR. COOPER: Uh-huh.
22 DR. LILLIS: -- to not
23 prescribing them. Children's Hospital in Milwaukee
24 was -- was not allowed to participate, because

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2 their I.R.V. said, of course, every asthmatic
3 should be on -- every child with persistent asthma
4 should be on inhaled corticosteroids. So, they,
5 again, would -- were not allowed to -- to
6 randomize.
7 So, we are seeing this -- the
8 shift in emergency department physicians becoming
9 involved in identification of the -- of the
10 particular patients, and then initiating it.
11 But it's not as simple as just
12 saying, why aren't these docs doing this, because
13 there's -- there could be some detrimental effects
14 from -- from doing this, in disruption of primary
15 care providers and children --

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2 go into homes all the time, and -- and to the issue
3 of using E.M.S., I mean we are really the only
4 provider in that chain of care for that asthmatic
5 that actually goes in the home and sees the
6 circumstances by which the patient lives, and often
7 identifies triggers.
8 Because, you know, we've gone
9 through our home and done all the -- all the
10 anti-asthma things you do, but when I go into
11 homes, and I get a chance to talk to parents after
12 we arrived at the hospital, because at the moment
13 it's usually too acute to -- to talk to them, but
14 we have time at the hospital, they're not aware of
15 a lot of the things, or associations of the things,

16 DR. COOPER: Sure.

17 DR. LILLIS: -- using E.R.s

18 instead of primary care providers. So, I think it

19 has to be done in a -- in a systematic approach

20 that -- that links them back to the primary care

21 providers to -- to continue the care that s been

22 initiated.

23 MR. CZAPRANSKI: Yeah. Both as a

24 paramedic and as a father with a kid with asthma, I

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16 in their home or apartment as it relates to

17 triggers.

18 I think the other thing is it s

19 important as I sit on the Greater Rochester RHIO,

20 which is looking into electronic medical records,

21 when we pulled a group of physicians together and

22 said, if your patient goes to the hospital - and

23 these are primary care physicians - are you aware?

24 Do you get a copy of the prehospital care report?

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2 Across the board, none of them did.

3 And so, again, by having an

4 electronic P.C.R. rolled up into a regional

5 electronic medical records that s available for

6 that physician to review to say, wow, you ve been

7 to the E.R. three times for asthma, I was not aware

8 of this. We need to change your medications, or

9 change your plan, or do something different.

10 It will also improve the

11 continuity of care, because sometimes these

12 patients go to different hospitals depending on

13 who s code red. But there s a lot of things that

14 will improve the qualify of life and lower the cost

15 by engaging E.M.S. to get out there and get in the

16 homes and try to offer some additional information.

17 We bring them to the hospital,

18 and you know, a lot of times you ll go in there,

19 mom s smoking in the kitchen saying her kid s

20 having trouble breathing, he s having an asthma

21 attack.

22 But we get to the hospital.

23 Nothing s ever done about that primary issue in the

24 home, and so you re going to see the kid repeatedly

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2 throughout their lifetime. So, engaging E.M.S. I

3 really want to push.

4 DR. COOPER: Elise?

5 DR. KUS: Can I just comment on

6 that one? Across -- I mean across the state --

7 the service delivery system with regard to asthma,

8 there are programs that include home visiting as --

9 as part of it. So -- so, that -- so -- and -- and

10 people are very clear with the idea that unless you

11 see the home, you really aren t going to know

12 what s -- what are some of the factors, but it --

13 but it s not across the board for sure, and so

14 anybody that -- that provides that info would be

15 helpful.

16 DR. VAN DER JAGT: Rita, I

17 appreciate very much what you have said about the

18 schools, and it -- this made me think here a little

19 bit, that maybe one of the things we should be

20 looking at is the role of the school physician in

21 the school system.

22 And -- and it -- what brings this

23 to mind is, because of my connections with the

24 American Heart Association Emergency Cardiovascular

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2 Care Committee, four -- I was looking at my C.V.

3 actually, I think it s five years ago now, we -- we

4 put together an emergency response plan for schools

5 that was broadly disseminated, published in

6 Pediatrics and in Circulation. It was an article

7 that -- a guideline that was a joint venture

8 between the American Academy of Pediatrics and the

9 American Heart Association.

10 And although the -- the focus of

11 that began to be the use of A.E.D.s in the schools,

12 which was about the time that this was happening in

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2 action plan in place in the nurse s office.

3 Because I m thinking that, you know, that working

4 together with school physicians -- I mean I have

5 to -- I m thinking of Sharon. Sharon s on the New

6 York State E.C.C. at this point, the Heart

7 Association. You might even want to bring that up

8 there, because it really is part of what the Heart

9 Association came up with as a preventive strategy,

10 so there would not be an arrest in the schools.

11 So, there would not be these horribly sick kids

12 that might occur there. But we all know that the

13 New York State, it also discusses the management of
14 asthma patients. And it actually suggests that
15 school physicians are aware of the emergencies that
16 might come up in their schools.
17
18 So, that makes me think that
19 could we use that model of having the school
20 physician who would -- initially what s going to be
21 the A.E.D.s, and they have to endorse this as a
22 reasonable thing to do, but that they also would be
23 looking at identifying patients who have asthma,
24 and then make sure that - just like we do with
immunizations - that those patients have an asthma

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13 real way to manage that is to prevent these from
14 happening in the first place.
15
16 So, asthma action plans, school
17 physicians, school nurses, it s a -- it becomes
18 requirement, and then those patients if they -- you
19 know, there s a question of, you know, what their
20 peak flow might show, I mean you can -- there s a
21 plan.
22
23 Anyway. Just some food for
24 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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2 solicit the use of the school system to -- in these
3 preventive strategies. It clearly has to be
4 coupled with their primary care physician.
5
6 But the school physician has
7 responsibilities to a school, and it just seems
8 logical to use that way of networking.
9
10 DR. KUS: One comment on that. I
11 think -- I mean school districts are very
12 different, and actually the -- the capacity of
13 nursing within a school district can be almost
14 nothing to a lot. So, I think you really have to
15 have a -- a committed group to -- to do that. But
16 part of what we had tried to do after we did with
17 school-based health centers is to put together a
18 plan, so that if a school saw that asthma was an
19 issue they wanted to deal with, these are the --
20 some of the things you could do. And I think one
21 of the things we did, because the -- the idea was
22 to put nebulizers in every school, which was the
23 acute treatment, which we -- we wrote against,
24 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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2 toward a chronic disease management than it
3 initially did, which was more get acute things to
4 the -- okay for one day, and then the other one.
5
6 But I -- but I guess I m
7 concerned, because it s -- it -- the capacity of --
8 of education -- I m not as familiar with the city,
9 because it s a different model, but here the --
10 the -- the actual nursing connection, and actually
11 the time that school docs spend, it would be
12 interesting to know how much that is because I
13 don t know that there s a -- they re a big player
14 that -- I don t know that, but you might be -- know
15 a bit more.
16
17 MS. MOLLOY: And --
18 DR. VAN DER JAGT: But the -- but
19 the issue -- I m sorry to interrupt, but the -- but
20 the issue there is, is really we have the PAD
21 program in the schools. Essentially, they have to
22 register --
23
24 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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2 because if asthma --.
3
4 DR. COOPER: Because once you
5 sign it up you don t use it.
6
7 DR. HALPERT: It s a different
8 decision.
9
10 DR. VAN DER JAGT: Well, or
11 course there s a different decision.
12
13 DR. HALPERT: The overseeing the

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2 MS. MOLLOY: I ve never seen them
3 come back.
4
5 DR. HALPERT: Right.
6 DR. VAN DER JAGT: Right.
7 DR. HALPERT: Yeah. We signed
8 off on it.
9
10 MS. MOLLOY: I don t even have an
11 updated list of who s certified to use the

10

physicians in the P.A.D. has absolutely zero

10

defibrillator --

11

contact unless there s a deployment of that device,

11

DR. VAN DER JAGT: Right.

12

which happens how often you use it.

12

MS. MOLLOY: -- other than

13

DR. COOPER: Correct.

13

myself.

14

MS. MOLLOY: That s right. And

14

DR. HALPERT: Right.

15

you know how often they --

15

MS. MOLLOY: Because I m not the

16

DR. COOPER: Right.

16

overseer of the plan.

17

DR. HALPERT: Extensively --.

17

DR. HALPERT: You -- you have

18

DR. VAN DER JAGT: But they have

18

probably a hundred asthmatics you know about in

19

to set up -- the recommendation is that they set up

19

your school.

20

that system, you know --.

20

MS. MOLLOY: My biggest crises in

21

MS. MOLLOY: Once. And then I

21

my office regularly that are, you know, not

22

never see them come back.

22

injury-related are asthma. All the time.

23

DR. HALPERT: Right. Well, see

23

And the school doctor usually is

24

that s --.

24

on a contract with each district for, you know,

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2

services to a point. And it s usually more

2

matter of fact, on my district Web site, it says we

3

revolving around sports physicals and routine

3

cannot give medical advice to the community, which

4

physicals, and it s scheduled in that measure.

4

I find interesting.

5

DR. HALPERT: There s also the

5

DR. HALPERT: Right.

6

PAD doctors are not the school doctors.

6

DR. COOPER: Rita, I m getting --

7

MS. MOLLOY: And it isn t always.

7

DR. HALPERT: I know you re

8

DR. HALPERT: Right.

8

getting --

9

MS. MOLLOY: In ours it is not

9

DR. COOPER: -- I m getting short

10

either.

10

of breath.

11

And the other thing is when

11

MS. MOLLOY: It s really an

12

they re engaged by contract, yes, they could be

12

exciting topic though.

13

called on in an emergency, because they are the

13

DR. COOPER: It is.

14

overseer. Like, for instance, for my standing

14

DR. HALPERT: But there s a lot

15

orders for epinephrine, the school doctor has to

15

more than I -- right.

16

write that order. So, they do generate certain

16

DR. COOPER: But -- but if -- we

17

orders for us. And if there were a problem in my

17

have a lot more business to transact today. But it

18

office, and I couldn t reach a primary physician on

18

is very clear that this is a critical issue, and

19

a student or a parent, I could try to field that

19

one that I m not going to say we have neglected for

20

call to that physician. It doesn t mean they would

20

far too long, but that we have neglected to utilize

21

always be readily available to me.

21

our opportunities for community education in the

22

But as a consultant basis,

22

delivery of emergency care for children.

23

they re not normally there for that primary

23

Now, we are the state s official

24

interaction, that s -- that s not encouraged. As a

24

advisory body on emergency medical services for

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2

children, and I think Dr. Kus has both shown us how

2

create -- create in terms of a brochure, or a tear

3

much has been done, but in so doing shown us a

3

sheet, or something along those lines that will

4

glaring omission in our -- in our strategy, namely,

4

help with community outreach education efforts,

5

utilization of emergency care providers to help get

5

something that could be delivered by our E.M.T.s

6

this epidemic under control.

6

and paramedics to families in the field, and

7 So, here's what I'd like to do:

8 I'd like to ask Kathy Lillis to lead a working

9 group, to come back at our next meeting, with a

10 one-pager with half a dozen or so bullet points on

11 it, as to what we can recommend explicitly that

12 emergency providers do, both in the field and in

13 the E.D., to help the statewide effort to bring

14 this epidemic under control.

15 I'd like Dr. - Dr. Van Der Jagt,

16 Tim Czapranski and Rita Molloy to work with Kathy

17 on that -- on that project.

18 And Chris, with your permission,

19 we will ask you to serve with that group as well,

20 so we can be sure that what we recommend is in sync

21 with what the State Department of Health is doing.

22 And I think, based upon what

23 comes back to our next meeting, if there is some --

24 some simple instructional guide that we can

7 something that perhaps could be utilized by

8 emergency physicians and nurses in our hospitals,

9 and by school nurses, for families maybe the same

10 document, maybe three different versions of the

11 same document, that to follow in the following

12 three months, so we can come up with a real solid,

13 not only action plan, but by March, but by June

14 supporting documents to assist with that process.

15 Jan?

16 MS. ROGERS: I'd like to make one

17 more comment, though, because first of all, the

18 family has a responsibility for taking care of

19 their child, and that's one piece that we -- we can

20 educate them, but we can't make them do things and

21 carry through. That's one point.

22 The second point is that when we

23 get different players involved, we have the

24 emergency room telling them things. We have the

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2 school nurse telling them things. We have, you

3 know, E.M.S. telling them something. Parents are

4 getting confusing messages from all of us, and I

5 feel in a real dilemma in -- in my role, because I

6 am telling parents things that the family doctor

7 has not prescribed, and may not buy into. And so,

8 where is the family in all of this? What do they

9 make of all this conflicting information? The

10 family doctor has not prescribed a long-term

11 controller, but we are, you know.

12 So, I mean there's -- there's a

13 lot of issues in my mind on who is responsible for

14 giving that family a coordinated plan, like -- like

15 you said?

16 And I don't -- I don't think it's

17 the emergency room docs, because it has to be

18 something that is followed up long-term, and I -- I

19 have no problem with prescribing controller

20 medications, especially on the basis of what Dr.

21 Lillis said for a month, but then there has to be

22 communication with the -- with the pediatrician to

23 say that, this is what we've done, and this is

24 what we recommend. But then they have to follow

1 EMSC, 12-8-2009

2 through on that.

3 So, it -- there's -- there --

4 it's all well and good to hit from all different

5 angles, but someone has to be saying, this is the

6 coordinated issue, or this is the coordinated

7 plan for this family, or else they're getting all

8 sorts of different viewpoints.

9 And I think that's why families

10 are so confused and don't know what to do, because

11 they have too many -- too many fingers in the pot

12 giving them little pieces. And I really believe it

13 goes back to that primary care doctor to pull it

14 all together, and I don't think that's always

15 happening, but I think that's where it's got to

16 come from, so the family has a consistent approach

17 that they hear.

18 DR. COOPER: Jan, thank you for

19 those comments. You are our voice of primary care

20 at the -- at the table at the moment, and I would

21 be delighted if you would work with the group,

22 and -- and ensure that those thoughts are

23 incorporated into the discussion.

24 DR. KUS: Can I just comment on

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2 that, because I mean I think that's a

3 principle-based issue, and -- and -- and I would

4 say from a pediatrician's point of view -- from the

1 EMSC, 12-8-2009

2 correct, there's no orchestration, no coordination,

3 and the reality of seeing this on a regular daily

4 basis is, hey, didn't someone ever tell you that

5 Academy of Pediatrics, that s the whole concept of
6 medical home, which says the coordination is at the
7 primary care level, and people should help
8 facilitate it.
9 I think the issue we re dealing
10 with it is if it does -- if it isn t realized or if
11 it s not happening, what can other parts of the
12 system do to help that. And I think that s -- but
13 I -- I think the issue that you say -- that you
14 mentioned is -- yeah, the answer should be they
15 should be in a medical home that provides this
16 coordination and coordinates with any care system
17 that they ve become involved in.
18 DR. HALPERT: Sometimes the
19 medical home has an absentee parent problem.
20 MS. MOLLOY: Yes.
21 DR. HALPERT: And that s where we
22 run into a real roadblock.
23 DR. COOPER: I --.
24 DR. HALPERT: What Rita says is

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2 DR. COOPER: Tim? Tim, and
3 that -- this will be the last comment because we ve
4 got to move on to other -- to other issues.
5 MR. CZAPRANSKI: When we talk
6 about primary care, we envision primary care the
7 way we receive primary care.
8 In the city of Rochester, primary
9 care by pediatricians is supplied by the clinics
10 who -- who shuffle residents through every year or
11 two and it s a constantly changing environment for
12 these parents and these families, and that s
13 another issue that needs to be faced. It s not
14 like they get their pediatrician when the kid s
15 born and they go off when they re nineteen or
16 twenty to college. That s not what s happening in
17 the majority of these cases.
18 DR. COOPER: Lee, can we ask
19 Commissioner Daines to join the work group?
20 DR. KUS: He can take my place.
21 That s fine.
22 MS. MOLLOY: But I think --.
23 DR. COOPER: Okay. All right.
24 Here s what we re going to do. Okay. So, again,

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5 if you have to use the rescue inhaler twice a day a
6 day on a -- on a good day, you probably have wildly
7 uncontrolled asthma? Didn t your primary care
8 doctor? Do you have relationship with? Do you
9 have insurance? You can -- you see them once or
10 twice a year; didn t they tell you this?
11 Well, no. Well, why didn t -- I
12 mean I know this, how come they don t know this.
13 They re the ones who should know this more than I
14 should know this.
15 I deal in acute episodic care.
16 I m the guy who stuffs the neb in your mouth, not
17 the person to teach you how to avoid that.
18 DR. COOPER: Realized. John,
19 thank you for reminding me that urgent care is part
20 of the picture, so I m going to ask you to join
21 this group as well.
22 Tim?
23 MR. CZAPRANSKI: I m not sure I
24 dare.

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2 we ve got a working group. Kathy is going to lead
3 it. Elise, John, Tim, Jan, Rita, are going to join
4 it. You each -- Chris is going to help us staff
5 it, and since there s about six of you each, each
6 person gets a bullet point. Just kidding. Okay.
7 But we want to come back -- we want to come back
8 with -- with a working document that we can -- that
9 we can forward to the commissioner and follow that
10 up with whatever, you know, basic foundational
11 templates for educational documents we think might
12 be necessary in the next three-month period; okay?
13 And that ll be -- I think that ll
14 be a really, really, really tremendously important
15 contribution from this -- from this group to -- to
16 the public health of New York State.
17 All right. Here s what we re
18 going to do. Okay. We re going to take no more
19 than ten minutes to get -- to get -- for everybody
20 to get their lunch, and we re going to sit right
21 back down, and hear Chris talk about H1N1. And in
22 the -- in the thirty seconds he has left.
23 DR. KUS: With no questions;
24 right?

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2MS. MOLLOY: I wasn't going to

3take it anyway.

4DR. VAN DER JAGT: Okay. Nature,

5could I just make one -- one comment --

6DR. COOPER: Sure.

7DR. VAN DER JAGT: - about

8this -- nothing to discuss, but just a comment. It

9just strikes me that maybe one of the reasons that

10asthma has sparked such discussion here, is that it

11really is a wonderful prototype, or model, for an

12E.M.S. disease, because it goes all the way from

13prevention, all the way through the entire system,

14and it goes full circle to rehab or does recovery.

15So, this might be a prototype that we could use

16even to look at how -- how do we manage with this

17Committee this kind of a situation, and with asthma

18it's really pretty, you know, it's -- it's so in

19the foreground here.

20DR. COOPER: That was in the back

21of my mind in organizing this group. And let's all

22get our lunch, think about it, and for those of you

23that have additional thoughts about this problem,

24please be sure share them any member of the group,

25but especially with Kathy; okay?

26(A recess was taken at 12:40

27p.m.)

28(The meeting resumed at 12:52

29p.m.)

30DR. COOPER: Everyone does have

31their lunch, I believe. We're missing only one or

32two folks. Chris Kus is on a very tight time

33scheduled as is Lisa McMurdo.

34DR. KUS: Yeah. Let's move it

35back. Yeah.

36DR. COOPER: So, we need to move

37along. So, Chris, if you would begin, I'd

38appreciate it.

39DR. KUS: Sure. Asthma was

40supposed to be my short talk, but this -- so --

41okay. And -- and actually with this one, what I

42was going to do was really -- I -- there's --

43there's lots of slides, and things here, but I was

44going to go through some of it fairly quickly, but

45try to focus on things that would be most helpful

46to you.

47To start out with, referring you

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2to the -- the -- the New York State Web site and

3the New York City Web site, because they both put

4up ongoing information, and they -- there are

5documents that are created for various populations

6like child care and schools, and they coordinate

7well with the C.D.C. documents, so either it's a

8cover letter or it's there.

9But they also give you a weekly

10activity report, which I think is helpful when we

11talk about care for kids within the context of

12what's going on in your community. And even going

13around the state realizing that the activity of

14H1N1 in the city is less than it had been in the

15spring, when you go to the western part of the

16state, it's going higher. So, you really need

17to -- to get an idea of -- of both of those places.

18And when I looked at both of the

19sites today, they -- they do give you the

20information about activity within emergency rooms,

21so you have a sense of what's happening in -- in

22that area. The -- the most recent I have in terms

23of kids with regard to the rest of the state is

24that there have been, since March of -- of this

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26year, there have been seven deaths in children zero

27to four, and fourteen deaths in children five to --

28to seventeen. The city has similar surveillance.

29I don't want to pull it out now, but -- but I

30think, again, that's a first place to go.

31And one of the other things to

32realize is that this guidance changes frequently,

33so it's always good to check on what the guidance

34is from at -- at the Web site, and also going

35through the C.D.C. Web site. So -- so, this is

36really as of, I think, 11/25, or something like

37that, so -- next slide.

38Stuff you already know, but

39prevention; we're talking about ACEP recommending

40H1N1 vaccinations to include all people six -- six

41months through twenty-four years of age, and

42household contacts and caregivers for children

43under six months of age. We've got both the live

44attenuated vaccine and the inactivated forms, and

45there are specific recommendations as to who should

46not get the live attenuated -- some of the ones

47that you would realize -- would -- would be young

48children, also, somebody who has chronic disease,

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1	EMSC, 12-8-2009	
2	but we ll get more into that.	
3	Next slide.	
4	All medical facilities and	
5	offices should strictly adhere to infection control	
6	recommendations and the idea is that you want	
7	people who have existing indications for	
8	pneumococcal vaccinations should be vaccinated just	
9	as people should who should be getting the flu --	
10	the regular flu vaccine should be getting the	
11	regular flu vaccine.	
12	DR. HALPERT: Can I stop you for	
13	a second --	
14	DR. KUS: Yeah.	
15	DR. HALPERT: -- and have you	
16	back up one slide?	
17	DR. KUS: Sure.	
18	DR. HALPERT: The question I saw	
19	flashing by the bottom, if you received the vaccine	
20	does not rule out any points of infection.	
21	DR. KUS: Correct.	
22	DR. HALPERT: Are you getting any	
23	sense yet about efficacy of the vaccination or is	
24	that --?	
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1	EMSC, 12-8-2009	
2	use of fever-reducing meds.	
3	Next one.	
4	Guidelines for daycares and	
5	schools. And the important things to recommend --	
6	to realize about this is that these are all going	
7	to be local decision making between the school	
8	system and the county health department. They re	
9	given guidance, but it really is going to be their	
10	local decision making with the idea that if you	
11	send kids home from school, or particularly from	
12	child care, you would -- you would want to make	
13	sure that they re not going to another place where	
14	there s a lot of kids, because what s the	
15	difference?	
16	Not easily -- not always easy	
17	to -- to handle.	
18	Next one.	
19	FROM THE FLOOR: Next slide.	
20	DR. KUS: Okay. Flu	
21	symptoms in infants and young children. Usually	
22	the same symptoms between H1N1 and seasonal	
23	influenza. Also, if you re -- people talk about	
24	influenza-like illnesses having similar symptoms.	
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2	DR. KUS: Yeah. I don t know of	
3	any sense that I can say.	
4	DR. HALPERT: Okay.	
5	DR. KUS: Yeah.	
6	DR. HALPERT: Just curious.	
7	DR. KUS: Uh-huh. The -- things	
8	to recommend for families is hand washing, the	
9	twenty-second use of hand washing, and the idea	
10	that alcohol-based hand sanitizers are -- if -- if	
11	no soap s available, is useful. People have	
12	already seen the idea of covering your mouth or	
13	nose with a tissue, and if you don t have a tissue,	
14	you ve got all those ads about putting -- about	
15	coughing into your elbow, or into your shoulder, or	
16	anyplace except your hands.	
17	Next one.	
18	Right. Or your neighbor. No.	
19	Right. And these are, again -- we can go to the	
20	next one.	
21	I m going to highlight the	
22	bottom. When we -- for practical purposes, we re	
23	talking about an infection period of one day before	
24	to twenty-four hours after fever ends without the	
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2	One of the real things to talk about is that in --	
3	in young children, it s less likely to have typical	
4	influenza symptoms, so it s actually the child that	
5	could have H1N1 who doesn t have a fever and may	
6	not have a cough.	
7	Next one.	
8	How about older children?	
9	The whole range of symptoms, and	
10	they re highlighting here that muscle pain,	
11	fatigue, diarrhea or vomiting seem to be something	
12	we re seeing more with H1N1. Again, this is	
13	general responses.	
14	Next one.	
15	This -- this to me is -- well --	
16	well, actually, this is the -- the idea is what --	
17	what are some of the symptoms and signs that you re	
18	going to see when children are progressing, and	
19	that there need to be -- you really need to take	
20	seriously, and -- and the -- indicating urgent	
21	medical attention, are fast breathing or troubled	
22	breathing, bluish or gray skin color, refusing to	
23	drink, severe vomiting, too irritable to -- to be	
24	held, and then the idea that you ve had flu	
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2 symptoms that improve, but then they're returning

3 with fever and -- and worsening cough and rash on

4 top of it.

5 And the -- the bottom part says

6 the -- and this gets into the guidance -- parents,

7 especially parents of infants and children known to

8 be at higher risk for influenza complications,

9 should be aware of this and vigilant watching for

10 these warning symptoms -- signs. They're also the

11 ones that, if you're considered high risk -- and

12 we'll get into that -- that the -- the information

13 given to the family is that you are the ones that

14 should go talk to your doctor, go to the emergency

15 room if things are more -- as opposed to the

16 recommendation that if it's a mild disease you

17 don't do that, because they're the ones that have

18 more -- that have more risk for -- for the severe

19 complications.

20 Next one.

21 This is the same kind of slides

22 saying atypical presentations may occur such as

23 just emphasizing that without fever.

24 This is the list here about

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2 children and youth at highest risk for influenza

3 complications. And we'll have something on our Web

4 site. And I think C.D.C. has a brochure on their

5 Web site geared towards families to give them

6 advice about what to do. But children under two

7 years, and even five years -- less than two years

8 is a little bit slightly higher at risk. And then

9 children who have chronic conditions, and there's a

10 whole list here, but the message is really it turns

11 out to be a particular group is children who have

12 neurological problems and respiratory difficulty,

13 that's a big one. But besides that, you've got

14 other ones listed here as -- as -- as far as

15 chronic kidney, liver disease and metabolic

16 disorders, and of course, immunosuppression.

17 Next one.

18 And that's the -- what I was

19 talking about before, advise parents that children

20 who are considered high risk to seek the advice of

21 healthcare provider if the child has signs or

22 symptoms of influenza.

23 We've been recommending that to

24 families who have chronic disease that puts them in

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2 this category to talk to their doctor ahead of time

3 in terms of the treatment. And in fact, some

4 primary care docs would give them some antiviral

5 prescription ahead of time if they were really

6 concerned. So, it's almost like coming up with

7 a -- with a flu plan for kids who have a chronic

8 disease.

9 DR. COOPER: Have we seen any

10 Reye's syndrome?

11 DR. KUS: Not that I know of.

12 Otherwise healthy children.

13 Let's see, now, this is -- it's saying sixty-seven

14 percent of children who died with 2001 H1N1 had at

15 least one high-risk medical condition, and among

16 these children, greater than ninety percent had

17 neurodevelopmental conditions. I think it's less

18 than this now. This really is -- is put out by

19 the -- the study that C.D.C. did on a limited

20 base -- basis of whatever -- I think it was

21 forty-seven kids that they had. And so -- and I

22 think when you -- when we look at our -- our

23 information, that message that if you don't have a

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2 the case. There are kids that have been -- that --

3 that died of H1N1 who have -- who don't seem to

4 have a specific chronic condition.

5 And -- and that's -- this -- this

6 gets into the idea of don't delay antiviral

7 treatment pending lab results, rapid tests and

8 particular frequently provide false negatives.

9 Next one.

10 Diagnostic testing. Just quickly

11 over that that. The -- the types of tests are

12 the -- the rapid diagnostic test, the viral

13 culture, the direct immunofluorescent assay, and --

14 and the nucleic acid amplification tests.

15 Next one.

16 This kind of gives you a summary

17 of what we're -- what -- what it is, is that it

18 generally if -- if you get a positive it's

19 probably -- it's -- it's highly specific, but the

20 sensitivity is not there, and they're -- it's also

21 important to realize which ones you can actually

22 get a sense that it's H1N1 as opposed to not, which

23 is viral culture with additional testing and the

24 chronic disease you're -- you're home free is not

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24 assay.

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2 Go to the next one.

3 Okay. Here's -- yeah, this is

4 the one that gets into why test for influenza?

5 Which is really testing if it will influence

6 clinical management. So, if you've got an unusual

7 clinical presentation, and you -- that may be one

8 way to clarify it, if it impacts decisions about

9 other diagnostic tests, it may guide the selection

10 of an antiviral -- and -- and when we get into the

11 medications, the difference about that. It

12 reinforces antiviral prophylactic decisions,

13 especially in sensitive situations. It could

14 affect antibiotic treatment, and then depending on

15 what is happening in terms of public health

16 surveillance, again, the testing is really mostly

17 being done in hospitalized patients, and our

18 surveillance is really looking at what we're seeing

19 in -- in terms of influenza-like illnesses.

20 Next one.

21 DR. VAN DER JAGT: We also test

22 for cohorting reasons in hospitals.

23 DR. KUS: You do? Okay.

24 DR. VAN DER JAGT: And that's

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2 year, of Tamiflu.

3 Next one.

4 Just talks about common side

5 effects.

6 Next one.

7 Relenza. Orally inhaled. So,

8 we're talking about treatment of the influenza for

9 greater than seven years of age, and prevention of

10 influenza for ages greater than five.

11 Next one.

12 Talks about the dosage of it.

13 Next one.

14 The main thing I wanted to say on

15 this -- I guess the -- the part that the powder is

16 not recommended for use in any nebulizer or

17 mechanical ventilator.

18 Next one.

19 This is the intravenous

20 treatment, and the F.D.A. has issued an emergency

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2 another reason for the influenza, they can cohort

3 like with --.

4 DR. KUS: Got you. Okay.

5 Just -- there's a lot of slides on the medication,

6 but I -- I think I'll just go through a few of

7 them. The idea that we're talking about amantadine

8 for influenza A, and the -- the neuraminidase

9 inhibitors, important because the amantadine is not

10 useful in terms of H1N1. That's why you would go

11 into using Tamiflu and Relenza.

12 Next one.

13 As of October 2009, circulating

14 H1N1 is resistant to the drugs. This gives you

15 a -- the side effects.

16 Next one.

17 Next one.

18 Okay. Tamiflu. It goes into the

19 idea of what dosages that you have, and the idea

20 for kids is really putting it in terms of

21 milligrams that you -- your prescription, because

22 they will be using different suspensions at the

23 pharmacy, and it talks about the emergency use

24 authorization for children less than one -- one

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

3 Next one.

4 DR. LILLIS: Just one comment

5 about that. When you have a critically ill child

6 it's very -- you have to request it specifically,

7 and do you have any idea what the time delay is,

8 and whether it --?

9 DR. KUS: I -- I don't, although

10 I think the way C.D.C., the interactions I've had,

11 it's I would think it's very quick because they've

12 been very reachable, at least in -- in my part.

13 But I don't know the answer.

14 DR. VAN DER JAGT: I think it's

15 next day.

16 DR. KUS: Is it?

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

18 of --.

19 DR. KUS: That was --

20 DR. LILLIS: We had a situation

21 use authorization to allow use of I.V. to treat
22 certain hospitalized and critically ill patients.
23 And then, it talks about which one is not
24 responding to either the oral or inhaled antiviral,

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21 where we had a --
22 MS. MOLLOY: Talk to a
23 microphone.
24 DR. LILLIS: -- critically ill

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2 child at a community hospital that we were trying
3 to -- to transport to our facility, and the
4 community hospital couldn't get it, and we -- we
5 were trying to -- to figure out -- we called the
6 C.D.C. and they basically referred us to their Web
7 site and there wasn't anything.
8 DR. KUS: Oh.
9 DR. LILLIS: The child actually
10 ended up dying at the community hospital before we
11 could get it, and it probably has no point in an
12 emergency resuscitation, but it was -- we were --
13 it was the kind of thing where we were trying to do
14 everything we could think of --
15 DR. KUS: Right. Right.
16 DR. LILLIS: -- and it was
17 frustrating not to -- to have a form of a drug that
18 you could give them when you were suspecting it was
19 H1N1, and you couldn't give the -- the treatment --
20 DR. KUS: Right. Right.
21 DR. LILLIS: -- quickly.
22 DR. KUS: I'll take that back to
23 our group, but I don't -- I don't have much --
24 anything else.

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2 DR. COOPER: Elise and Bob, do
3 you have any experience using it?
4 DR. VAN DER JAGT: Not really.
5 We haven't given -- I felt for -- from flu, but we
6 don't -- we never used that.
7 DR. COOPER: Bob?
8 DR. KANTER: We were about to,
9 and then it became not necessary, but it should be
10 rapidly available if you have the right contact at
11 the C.D.C.
12 DR. COOPER: And who's the right
13 contact?
14 DR. KUS: Yeah. That's right.
15 DR. KANTER: A variety of people.
16 DR. KUS: That's right.
17 DR. LILLIS: Bob, in -- in your
18 experience were you using the oral -- were you
19 using Tamiflu orally (off-mic) anything like
20 that --.
21 DR. KANTER: Yes. Yeah. For all
22 the patients. Yes. Yes.
23 DR. LILLIS: And you're intubated
24 then later (off-mic).

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2 DR. KANTER: If we -- if we think
3 their G.I. tract is working, the one kid where we
4 considered it, that was an issue.
5 DR. HALPERT: I wonder if it's
6 possible for this group to go track down that
7 contact and disseminate that, because obviously
8 other people are going to have the same questions
9 you have.
10 DR. KUS: Okay. I can -- I can
11 follow up with C.D.C. on that and see if I can
12 get -- and our folks with -- with experiencing --
13 yeah.
14 DR. COOPER: Thanks, Chris.
15 That'll be great.
16 DR. KUS: Yeah. Yeah. But I
17 know -- I mean the person who does the pediatric
18 one I -- is -- I -- I know her well, and I'll

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2 the -- the emergency usage one.
3 Next one.
4 So -- so, then you get into the
5 idea of antiviral treatment really recommend --
6 recommended for children who are -- fall within the
7 high-risk category. So, children under two years
8 of age, and that it -- children who have severe
9 illness or evidence of clinical deterioration,
10 symptoms of lower respiratory tract involvement, or
11 illness requiring hospitalization.
12 Like always, use clinical
13 judgment.
14 Next one.
15 And -- and this is the one in
16 terms of primary care docs and also giving the
17 advice to families about children with milder
18 illness that it's not generally recommended to use

19 contact see if she s got a -- what s been the
20 experience.
21
22 These are specifically revised
23 antiviral recommendations for children, basic
24 support, the idea of -- of using antiviral
25 authorized for children less than one through

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19 antivirals with mild illness if they are not at
20 high risk for the complications. You re really
21 trying to give the message to the primary care docs
22 to educate families that -- as to when to -- to go
23 the emergency room, when to use the healthcare
24 system, particularly in -- in -- in kids that

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2 aren t high -- I mean in kids that aren t at high
3 risk. And that the idea that you are -- that there
4 that you may consider prescribing antiviral
5 medications if indicated for -- with -- with the
6 office visit, giving them the idea that if things
7 worsen contacting them and checking them in
8 twenty-four hours.
9 And the -- the importance --
10 the -- you know, the issue is that it s best -- the
11 antiviral treatment at least it s been reported to
12 be most effective within the first forty-eight
13 hours of illness or onset. So, that kind of gets
14 into the idea of a sick kid, and waiting some time
15 for giving it.
16 Next one.
17 The idea of ensuring -- again,
18 if -- if a child is at high risk, that they have --
19 the -- the plan is to how they re going to get
20 contact their doc, and how they re going to get
21 medication or clinical evaluation if you need to.
22 Next one.
23 This talks about the dosage of
24 it. And these are specific dosages for kids under

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2 one year of age, again saying that you re really
3 prescribing it via milligrams for -- for children.
4 Next one.
5 This talks about actually
6 specific -- the idea that since you re -- you re
7 doing that by milligram it may be in a suspension
8 that you want to take out the oral dosages
9 dispenser there, and -- and give them an oral
10 syringe, because you want that measured in a
11 smaller dose.
12 Okay. Next one.
13 Alternatives to Tamiflu. We re
14 talking about the compounded suspension, and they
15 give you a couple of alternatives here.
16 Next one.
17 And then, the -- again, the big
18 emphasis is to ensure proper dosing prescribed
19 using product name and concentration. If
20 prescribing in milliliters or teaspoons, or
21 prescribed dose in milligrams. This gives you the
22 Tamiflu dosage that s recommended.
23 Next one.
24 The Relenza. Not approved for

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2 kids greater than -- let s see -- no approved
3 indication. Okay. So, it s really talking about
4 over seven years of age.
5 Next one.
6 And I guess this is that staying
7 in contact with the information you have in your
8 community that you re using the date --
9 surveillance data that s provided, so you can
10 decide what you think you ll be treating, so you
11 can provide the best medication related to that.
12 And next one.
13 This talks -- if you -- if you do
14 get the R.E.D.T. result, what you can do in terms
15 of how it can affect making your decision in terms

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2 And it -- it -- it says can be
3 considered for high-risk persons who had close
4 contact with a person with influenza. Contact
5 during their -- a person s infectious period. So,
6 again, if -- if kids fall in that high-risk
7 category and there s evidence that they ve come in
8 contact, you would -- you could consider
9 prophylaxis. If you re going to do that, you want
10 to do it early, and its duration is ten days
11 following last exposure.
12 Next one.
13 In terms of the choice of the
14 antiviral medication, you know, you want a
15 medication that you think is most effective of what

16	of treating.	16	you think the influenza strain is going to be, and
17	Next one.	17	then this also talks about what -- what your --
18	And this again gets into the idea	18	what you know about your area.
19	is if it s positive then you re sure you re dealing	19	Next.
20	with -- with a -- a flu virus, but if it s negative	20	This gets back to the idea that a
21	you can t -- you can t really rule out that it s --	21	history of a recent 2009 H1N1 or seasonal influenza
22	that it s not influenza.	22	vaccine does not rule out an influenza infection.
23	Next one.	23	So, just because they had it, if you got the -- the
24	What about prophylaxis?	24	symptoms, you really, really want to treat it the
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2	way you would otherwise.		2	that this could be a -- on -- on top of the flu,	
3	Next.		3	you ve got a bacterial infection. The idea that in	
4	What happens in terms of schools,		4	treating fever, any products that could contain	
5	camp, daycare, it s not really recommended to		5	aspirin or -- or -- should not be used, and the --	
6	offer the prophylaxis to all persons potentially		6	to recommend, since again we re talking about	
7	exposed. You would consider it if one of the -- if		7	fever, the idea of using over-the-counter cold	
8	the people fall in the high-risk categories.		8	medications under four. There s already been the	
9	Next one.		9	recommendation not to use that, but this enhances	
10	Just to give you the idea about		10	that.	
11	what recommendations are given for breastfeeding,		11	Next one.	
12	the idea is that you want -- if somebody is sick		12	Well, if you get the live	
13	with H1N1, you want them to consider -- continue		13	vaccine, let s see -- and the -- it s -- it s --	
14	breastfeeding, but it would be the -- the --		14	it s really saying if you -- if you get that and	
15	express the breast milk, and it would be given by a		15	then if you take antiviral medication, within two	
16	healthy caregiver, and then the mom can resume		16	weeks of receiving that, it could affect the uptake	
17	contact with the baby and direct feeding after		17	of that vaccine, the response to it.	
18	afebrile for twenty-four hours or antiviral for		18	Okay. Let me just look which	
19	forty-eight hours.		19	ones these are. This is just general.	
20	This gets into some special		20	Next one.	
21	considerations.		21	What about egg allergy?	
22	The bacterial community-acquired		22	And it really -- the -- the	
23	pneumonia, realizing that H1N1 and other flu		23	message is that you should be getting the history	
24	predisposes you to that. So, you want to consider		24	about the egg allergy. If it s a local allergy,	
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2	then you really want -- you -- you -- you can		2	this -- you recover from this, so at least if you	
3	administer the vaccine, and then -- and if you re		3	know about that diagnosis you can -- if -- if	
4	really talking to -- in a circumstance that it --		4	you re considering it, then you can prevent other	
5	the child s doing worse, that you want to -- you --		5	investigations or interventions, and give in -- you	
6	you can also do it as -- in a controlled situation.		6	know, it s helpful to say to the parent this --	
7	Next one.		7	they re going to get over this part.	
8	The Australia experience. It s		8	Next one.	
9	not much different. Again, highlighting that		9	This is just referring to a trial	
10	you ve got to consider it -- the diagnosis in any		10	using a macrolide antibiotic where the combination	
11	child with fever as well as any unwell child		11	with one of the other antivirals seem to do a	
12	without fever.		12	little bit better. It boosted production of the	

13 Next one.

14 Hospitalizations. Well, we ll

15 tie it into asthma. Asthma is a significant risk

16 factor for severe disease unrelated to -- unrelated

17 to the severity of asthma.

18 Next one.

19 One of the complications can be

20 benign acute childhood myocitis. It s transient

21 condition, recovery within one week. It occurs at

22 the convalescent phase, and it s got that -- it --

23 the difficulty in walking, severe bilateral calf

24 pain, elevated enzymes, but the idea is that

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13 mucosal I.G.A. against influenza virus.

14 Next one.

15 Summary.

16 Okay. So, factors affecting

17 decisions. The severity of influenza illness.

18 Most children don t need antiviral medications.

19 The child s or adolescent clinical presentation,

20 underlying risk factors for influenza-related

21 complications and -- and death and clinical

22 judgment. So, if you re in a risk -- if you re

23 clear it s in a risk category, they re treated

24 differently, and the advice to parents is treated

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2 differently.

3 Next one.

4 Educate your patients and -- and

5 their parents. This one is geared to pediatricians

6 and family practitioners. How to reduce risk of --

7 of influenza, how to care for someone who is ill at

8 home, and the -- and one of the big things is

9 really when you re sick in this situation, stay at

10 home, and -- and when to call your healthcare

11 provider.

12 Next one.

13 Key points. We ve gone over most

14 of this. The idea that the diagnostic testing has

15 limitations; that healthy patients don t usually

16 require treatment; and that -- if, again, if you re

17 high risk you would want to consider prophylaxis.

18 Next one.

19 That s it?

20 DR. COOPER: Thank you, Dr. Kus.

21 Questions?

22 Dr. Lillis?

23 DR. LILLIS: Just a few comments.

24 In -- I think our area was particularly hard hit

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2 with some severe cases. We had at least five

3 children who died at our hospital, and probably

4 another --

5 DR. COOPER: Which -- which

6 hospital is that?

7 DR. LILLIS: Women and Children s

8 in Buffalo.

9 DR. COOPER: Okay.

10 DR. LILLIS: And I think probably

11 another two in the community that didn t make it to

12 our -- to our hospital, but my understanding is

13 that none of those children had any underlying

14 medical conditions, which is pretty scary when all

15 the recommendations are really trying to identify

16 the high-risk kids.

17 The other comment is, I know the

18 five that were at our facility that passed away

19 were MRSA positive, I didn t know if you have any

20 comments about that. It was suspected that they

21 were colonized with MRSA, and that when they came

22 in, that perhaps the H1N1 affected their immune

23 system, and then the combination of the H1N1 and

24 MRSA were -- were too much. But we re -- and we re

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2 doing some studies on testing kids who -- who came

3 in with suspected H1N1, and -- and whether or not

4 they were colonized with -- with MRSA. But --

5 DR. KUS: So, that was how many

6 kids you had; you had five you say?

7 DR. LILLIS: I -- we had two last

8 season, and then at least three this season, and I

9 believe two more that didn t -- that didn t get to

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2 DR. LILLIS: -- but most -- most

3 of them succumbed pretty quickly, and it was clear

4 with -- within the first six hours that they

5 weren t going to make it. They came in very sick.

6 And that was my other comment is

7 we were surprised at how well they managed at home,

8 and then there was suddenly an acute deterioration,

9 and I did not know if other people across the

10 make it to -- to Women and Children s.

11 DR. KUS: Okay.

12 DR. LILLIS: But all previously

13 healthy with no underlying medical conditions.

14 DR. KUS: I don t know anything

15 about that part of it, so I ll go back to our epi

16 folks to see if there s anything that they might

17 respond. But -- so they -- they had H1N1 and were

18 colonized with MRSA?

19 DR. LILLIS: Well, you know,

20 you -- you never know what they --

21 DR. KUS: Yeah.

22 DR. LILLIS: were when they came

23 in --

24 DR. KUS: Yes.

10 state, but we had one -- one girl who walked in,

11 and then was intubated within an hour, and then she

12 just had total pus coming out of the E.T. tube as

13 soon as she was intubated --

14 DR. KUS: Wow.

15 DR. LILLIS: -- and -- and pretty

16 much within a few hours had succumbed to the -- the

17 disease. And I was just impressed with how they --

18 they managed at home, until they got to the point

19 where they were so -- so ill that there -- that

20 there wasn t much you -- you could do, and -- and

21 that is also kind of scary from a public health

22 standpoint.

23 It wasn t a gradual

24 deterioration. And seeing such large numbers of

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1 EMSC, 12-8-2009

2 patients, if you had seen those particular patients

3 earlier in the course, you wouldn t have been able

4 to identify that they were any -- that they were

5 going to be the ones that developed the severe

6 disease.

7 DR. KUS: Right.

8 DR. COOPER: Dr. Van Der Jagt?

9 DR. VAN DER JAGT: Very

10 similarly, Kathy, was the -- we had one patient

11 that presented exactly like that, who s currently

12 still on ECMO. That patient was also MRSA

13 positive. That s very interesting.

14 DR. LILLIS: It is interesting.

15 DR. VAN DER JAGT: And

16 presented -- it was a transport patient, outlying

17 hospital, very rapid over about six hours. In

18 fact, between the two-hour transport that the kid

19 was there on basically fifty percent O2 came to us,

20 walked into the unit -- well, didn t walk in the

21 unit -- came into the unit, and within five minutes

22 was intubated, and within four hours after that was

23 on ECMO. That s how rapid it is was. So, very

24 similar to your experience in Buffalo. MRSA

1 EMSC, 12-8-2009

2 positive, too.

3 DR. KUS: Uh-huh.

4 DR. COOPER: Other comments?

5 MS. ROGERS: I have a question.

6 What is the expectation? H1N1 seems to be

7 decreasing in our area, and what is the expectation

8 for the future? Are we expecting another wave, or

9 do you know?

10 FROM THE FLOOR: Seasonal flu is

11 upcoming.

12 MS. ROGERS: I know seasonal flu

13 is coming.

14 DR. KUS: Yeah. Yeah. I mean I

15 guess the -- good parts, although I -- I -- I first

16 wanted to responded to that one where healthy kids

17 are dying from this, and I m real interested to see

18 what happens in terms of -- of the immunization

19 rates of kids, because even with that kind of

20 thing, the thing that s out there, people are

21 not -- kids aren t getting as immunized as you

22 would hope that they would -- would be, and you

23 know, that -- that idea that you -- you can t use

24 the -- the message has got to be if you re under

1 EMSC, 12-8-2009

2 twenty-four you get immunized. I mean that s --

3 and -- and then I hear the responses about why you

4 won t want to immunize, and I can t understand it.

5 It s very hard to understand what the reasoning

6 behind it is.

7 But the other part -- I guess

1 EMSC, 12-8-2009

2 disease, and both of them passed away and they

3 were -- they were anticipating that it had been

4 that they had actually -- there was a development

5 in the resistance in there, and I would -- and it s

6 the only case report that I had seen, but I didn t

7 know if you could comment on resistance to -- to

8 the -- the -- the good part, it looks like the

9 virulence is -- may be less than we expected, and

10 looking good. And I think the question is whether

11 this will mutate? And I don't know the answer

12 to -- to those things. And I don't know what

13 happens after that.

14 The other part is that they --

15 they've just approved the -- the -- I think it's

16 the fourteen valents vaccine for -- for kids for --

17 for flu. So, that will be -- whether that makes

18 any difference, I don't know. So, I don't -- I --

19 I can tell you that part.

20 DR. LILLIS: I -- I had read one

21 report on two -- two girls who had attended a

22 summer camp where one person came down with it, and

23 they prophylaxed the whole camp, and then these two

24 girls who had been prophylaxed, developed the

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2 not ordering it, in order to go, I had to go to an

3 unmasked clinic.

4 And the way in which they were

5 distributing the vaccine was, you know, a little

6 alarming, because they did have a lot of

7 predrawn-up medication that's just sitting there on

8 a table. They did not have gloves on when they

9 gave the vaccinations. They're giving you cards,

10 barcoded, telling you to maintain them for a year,

11 which, you know, I've never had given to me when I

12 received any other vaccine.

13 So, a couple of curiosities would

14 be, you know, why are they doing that? Number one.

15 Number two, who's doing a study

16 to see the efficacy of, you know, the vaccination

17 over time? You know, we're going to, how are we

18 going to monitor whether or not this is working,

19 because how are we going to know if it's really

20 preventing anything, and if it evolves, whether or

21 not it's because we had failure already from the

22 vaccine, or whether or not it's because, you know,

23 the disease, itself, is evolving and changing to

24 not be, you know, particular to the vaccination.

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2 I mean it sounds like the clinic that you're

3 talking about wasn't -- wasn't using good practice.

4 So, then that takes -- bets -- all bets are off

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4 So, then that takes -- bets -- all bets are off

8 the antivirals or if you're aware of anything else.

9 DR. KUS: I -- I haven't seen it.

10 I mean I -- I went to the C.D.C. site yesterday too

11 to look for some of the stuff, but I haven't seen

12 it, and I haven't seen it in our regular reports.

13 We get a weekly report about the different

14 conditions in there, and that's not been there,

15 so --.

16 MS. MOLLOY: One question that I

17 have, and I know that Dr. Halpert alluded to that

18 when the slide was there, but I -- I've been

19 reading a lot of reports about how fragile the

20 vaccine is, and the handling of it, how imperative

21 it is for the cold chain to be, you know,

22 maintained, and I, particularly in order to find a

23 dose for myself, because my primary care provider

24 doesn't have confidence in the vaccine, so she's

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2 DR. KUS: Uh-huh.

3 DR. LILLIS: And you know, I have

4 concerns because, you know, there is an idea

5 that -- when I read that other slide, it says just

6 because you've had the vaccination doesn't mean to

7 rule out that you've had --

8 DR. KUS: Right. Right.

9 DR. LILLIS: -- that you indeed

10 have the flu.

11 Just like -- I saw that with

12 chickenpox, you know -- you know, in my population.

13 It was a fragile vaccine. A lot of children were

14 vaccinated with one dose. Many of them had maybe

15 a -- a smaller case of, you know, pox, but they

16 definitely had chicken pox. And I -- I would see

17 these outcroppings of them regularly. So, just --

18 you know.

19 DR. KUS: So, those big

20 questions, I -- I would suspect -- and I -- and

21 I -- and I will have to go back and see, but if --

22 I mean if we're doing any study like that, it would

23 have to be C.D.C. doing it in several population

24 areas. But then it's really going to depend on --

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1 EMSC, 12-8-2009

2 which we do -- we do here. And that's different.

3 I mean that's -- when I was a kid you took the

4 little sugar pill and --

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5

when you start doing -- doing that.

6

So, I think in that sense you

7

really have to be knowledgeable about that, and if

8

somebody is not doing the -- I mean part of what

9

our guidance out to local health departments, each

10

of these, you know, the vaccines are really have

11

been given to physicians and local health

12

departments and other places, and they were

13

registered here with the idea of giving them in --

14

in good clinical -- using good clinical practice.

15

DR. LILLIS: But when you see

16

people lining up at libraries and when you see it

17

on the news these people, you know, they re wrapped

18

around the block, in order to accommodate the large

19

numbers of people that they re seeing, this is the,

20

you know, practice that they ve taken on. And I m

21

sure it s going on all over the place in that

22

fashion, I would imagine --.

23

DR. KUS: Well, there -- I mean

24

there are practices for doing mass immunizations,

5

DR. LILLIS: Different than what

6

I have.

7

DR. KUS: -- you went to school

8

and all that kind of stuff. But -- and -- and

9

that s appropriate in the sense that we were, you

10

know, to try to get that many kids immunized.

11

The -- I -- I -- I -- you know, they are -- there s

12

guidance about how to do that, so I don t know what

13

other recourse I can give you on that one.

14

But I will look -- I ll -- I ll

15

talk with C.D.C. and ask them about that --

16

those -- you know, the questions about how do you

17

answer those -- the questions about the

18

effectiveness and -- and so.

19

MR. CZAPRANSKI: The -- the

20

question you had about the bar coding: public

21

health clinics run by the county are required, by

22

federal statute, to do that, so if you go to your

23

physician and get your vaccine, it s not required,

24

but if you go to a clinic that s got any

1

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2

association with a county health department,

3

they re required to do those things. So, that s

4

sort of the requirement in there.

5

MS. MOLLOY: Nobody knew the

6

answer when I asked there, so --.

7

MR. CZAPRANSKI: Yeah. And the

8

other thing is a lot of the shipments, they come

9

already predrawn up in syringes. So, sometimes

10

they re multidose vials, and sometimes they re

11

already preloaded, depending on how they re shipped

12

to you.

13

DR. COOPER: Ruth?

14

MS. WALDEN: He just answered

15

what I was going to say. The -- the vials are

16

shipped predrawn, and that s how the doctors or the

17

clinics are ordering them.

18

DR. HALPERT: As a note of

19

information, at my -- in my office itself, we

20

ordered a thousand doses of ingestible and received

21

twenty doses of nasal. I just want to put that out

22

there. We were happy.

23

MS. WALDEN: Only in the Health

24

Department.

1

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2

DR. HALPERT: We were happy.

3

DR. COOPER: Thank you, John.

4

Elise?

5

DR. HALPERT: Good idea.

6

DR. VAN DER JAGT: I just have a

7

question again relating to prevention and the

8

E.M.S. provider. What are the recommendations for

9

use of masks, and what is -- you know, what is the,

10

you know, these E.M.S. providers are probably

11

exposed a lot to this particular virus, or any flu

12

virus, so are there recommendations that you have

13

for them, and maybe Lee would like to talk about

14

that a little bit, too. I don t know -- I just

15

think it s something that needs to be addressed.

16

DR. KUS: I don t know the answer

17

to -- to that one, but -- so, there we ll go.

18

DR. COOPER: Lee knows the

19

answer.

20

DR. KUS: Oh, good.

21

MS. BURNS: Actually, the C.D.C.

22

recommends N95s for patient care providers who are

23

treating patients with flu-like symptoms. The

24

Health Department has said that surgical masks are

2 adequate. There s a -- there s a lot of -- of
3 conversation at the local level. Some localities
4 believe that they would just as soon err on the
5 side of being conservative and use N95s. The N95s
6 require fit testing.
7 One of the things that Jim Soto
8 in -- in our office is -- is traveling around and
9 is offering train-the-trainer fit testing programs,
10 because prehospital care providers at the service
11 level are not -- they don t have easy access to fit
12 testing, or it s not available to them locally, so
13 this, through a HRSA grant and our disaster
14 preparedness folks, Jim is setting forth with fit
15 testing kits and train-the-trainer programs in an
16 effort to boost the ability for our prehospital
17 care providers to be fit tested.
18 So, there is -- really the answer
19 to your question is the C.D.C. guideline is N95s,
20 state Health Department has said surgical masks.
21 DR. VAN DER JAGT: And how well
22 are they following those regulations?
23 MS. BURNS: That s a very good
24 question. I -- I think -- honestly, they don t

2 want to be -- they don t want to be exposed, and
3 they don t want to -- certainly don t want to take
4 it home to their family.
5 DR. VAN DER JAGT: Right.
6 MS. BURNS: In -- in -- the -- in
7 the Upstate environment particularly, if they re --
8 if they are exposed and ill or their family is ill,
9 they ll be out of work, and -- and in spite of the
10 initial pushback to the mandatory flu injections
11 that we had people driving around with cars, you
12 know, complaining that their civil rights were
13 being violated.
14 DR. VAN DER JAGT: Right.
15 MS. BURNS: But again, primarily,
16 they -- they can t afford to be out of work, and
17 they certainly don t want to expose their families.
18 So, it -- it s -- anecdotally, I understand that
19 it -- you know, it s fairly well adhered to, but I
20 don t know.
21 DR. VAN DER JAGT: And most of
22 them you think are -- are getting immunized? I
23 mean --
24 MS. BURNS: That s a --

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1 EMSC, 12-8-2009
2 DR. VAN DER JAGT: -- that s the
3 preventive -- I mean --
4 MS. BURNS: Well, I can tell you
5 I m -- in Saratoga County they offered flu vaccines
6 for emergency services, so police, fire and E.M.S.
7 It was very well attended. Albany --.
8 DR. VAN DER JAGT: H1N1 though?
9 I mean -- yeah.
10 MS. BURNS: Yes. Yeah. Both --
11 both seasonal flu and H1N1.
12 DR. VAN DER JAGT: And H1N1.
13 Yeah.
14 MS. BURNS: And Albany County
15 just did one for, you know, E.M.S. and -- and
16 emergency services.
17 Why are you looking like that?
18 DR. HALPERT: I didn t hear about
19 it.
20 MS. BURNS: Oh, you re not on Tim
21 Rabley s (phonetic spelling) list.
22 DR. HALPERT: I think I am.
23 MS. BURNS: Yes, you are. And --
24 and they had -- it may have been seasonal, but I

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1 EMSC, 12-8-2009
2 believe it also offered H1N1 at a separate time.
3 DR. HALPERT: Five weeks --?
4 MS. MOLLOY: Yeah, that s H1N1.
5 DR. HALPERT: That was not for
6 emergency services. That was general.
7 MS. BURNS: They ve --
8 MS. MOLLOY: That is the general.
9 MS. BURNS: -- they ve been well
10 attended.
11 MS. MOLLOY: That was the
12 general.
13 DR. HALPERT: Now, in my -- in
14 my -- I m sorry to deduct on that, but we did put
15 up, through my office, at cost, for uninsured
16 emergency services workers who could provide any
17 kind of valid I.D., you know, like a fifteen-dollar
18 flu shot essentially. Now, we were going to throw
19 into that the H1N1, but we couldn t get any, as I
20 said. But we did put up -- we backed about a
21 thousand doses, of which we administered at least a
22 hundred coming in.
23 FROM THE FLOOR: Uh-huh.
24 DR. HALPERT: So, that was okay.

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2	FROM THE FLOOR: Uh-huh.	2	where you can immunizations, and -- and as a school				
3	MS. MOLLOY: You know when we	3	nurse you would fit in the category who would be --				
4	first talked about this, and Ed -- Ed Wronski was	4	should be able to get an immunization there. So, I				
5	at the table, I did mention that, you know, since	5	don't think there was anything specific as you said				
6	school nurses really will be seeing the sick	6	for school nurses.				
7	children at school and identifying it, that	7	MS. MOLLOY: Right. But that				
8	somebody should think about having doses available	8	means -- as I said, taking a day off from my --				
9	for school nurses. And I've never seen any	9	DR. KUS: Right.				
10	mechanism put into place to where anyone has	10	MS. MOLLOY: -- employment, which				
11	secured doses, and you know, our school doctors are	11	I had to do, because my appointment was oh, between				
12	not doing that, because most of us are not PODs,	12	eleven and twelve, and I was there from eleven to				
13	most of us are not doing, you know, on-site, you	13	two.				
14	know, inoculations of people, and I had to take a	14	DR. KUS: Right.				
15	day off from work. I had to take a sick day, and	15	MS. MOLLOY: So, that's				
16	go to like I said a mass clinic that I had to	16	basically, you know, your day is shot. I had to				
17	secure an appointment for, you know, a block	17	drive three towns over from where I work in order				
18	appointment, which was basically all day. It was	18	to get it. So -- but I did that because I felt,				
19	the middle of the afternoon, so I -- I -- there was	19	you know, -- I felt compelled to do that, but --.				
20	no way that I could just, you know, slip out on a	20	DR. KUS: The other -- the other				
21	lunch break, which is never covered anyhow. So,	21	thing that's important to know is actually the				
22	okay, you know --.	22	other immunization -- the immunization clinics and				
23	DR. KUS: Let's -- I mean --	23	things like that are all county health department's				
24	because, I mean, on our Web site it talks about	24	decision about how they want to do that. They're				
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1	EMSC, 12-8-2009	1	EMSC, 12-8-2009				
2	given advice with that, but that s --.	2	you need participation from your district.				
3	MS. MOLLOY: I mean they took me	3	My district, you know, this is --				
4	once I told them what my category was --	4	I know everything s on the record here, but -- I				
5	DR. KUS: Yes.	5	would prefer it wasn t because their -- their				
6	MS. MOLLOY: -- they were, you	6	opinion is that we shouldn t even discuss flu				
7	know, willing to give me an appointment. The	7	vaccination with families, that we need to refer				
8	other --.	8	them to their primary physicians. And that s --				
9	MR. CZAPRANSKI: I think, I mean	9	you know, that s their comfort level. And it s				
10	like our county health department pushes out to the	10	what s stated on our Web site, you know, we re not				
11	school-based clinics, and --	11	to give medical advice. We were called into a				
12	MS. MOLLOY: We don t have	12	meeting, and told, you know, to keep our opinions				
13	school-based clinics.	13	to ourselves, and you know, to refer people to				
14	MR. CZAPRANSKI: -- and it s RNs	14	their primary physicians.				
15	and the physicians that -- in some of the schools,	15	So, it s very difficult because				
16	they re perfectly fine to go on and register and	16	school districts have a culture of fear of, you				
17	order their own vaccine for their population.	17	know, lawsuits and reprisal for -- and they don t				
18	DR. KUS: Yeah.	18	feel that they re medical homes or medical				
19	MS. MOLLOY: If you have a	19	providers and --				
20	school-based clinic, but we don t have one.	20	DR. KUS: Right.				
21	DR. KUS: Well, even physicians	21	MS. MOLLOY: -- so that s a --				
22	and RNs can go on, they don t need a school-based	22	that s a dilemma.				
23	clinic to register and receive vaccine.	23	MS. BURNS: The other important				
24	MS. MOLLOY: Right. But we --	24	thing to know is that the governor reupped the				
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2 executive order allowing advanced E.M.T.s to
3 inoculate in local health department-sponsored
4 PODs.
5 DR. COOPER: Thank you, Lee.
6 Ann?
7 MS. FITTON: Yeah. I -- I just
8 wanted to address one other thing. Outside of
9 protecting ourselves with personal protective
10 equipment, it certainly has been a thrust of -- of
11 FDNY s for education for prehospital care
12 providers, eleven thousand certified first
13 responder/firefighters who are more reluctant than
14 perhaps E.M.T.s and paramedics to don an N95 mask.
15 Put a big push into that.
16 We did get six thousand doses of
17 H1N1, and I believe they were -- and -- and we did
18 a fourth day of POD, and I believe that all of
19 those doses went to first responders.
20 A couple of other things we did
21 do, is we bought a new kind of nebulizer with a
22 one-way valve, so that -- excuse me, so that when
23 we re treating people with respiratory or
24 influenza-like illnesses on -- on the ambulances

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2 that they re -- are not get -- getting a steady
3 stream of their, you know, respiratory droplets.
4 DR. COOPER: Uh-huh.
5 MS. FITTON: Which is, I think, a
6 really important thing. They -- they are about six
7 or seven dollars apiece. I did buy a supply of
8 them, so that if we are at the clinic, and we need
9 to go -- at the point that we rise above a certain
10 level of influenza-like illnesses, they ll be put
11 out into the street. So, it -- we re looking at
12 other things besides just respiratory protection
13 for the providers. Very important, hand washing
14 can t be replaced; a good use of decontamination
15 procedures, all very important. But there are
16 other things out there that we can do to help make
17 sure that we don t place patient care -- or
18 compromise patient care.
19 DR. COOPER: Thank you, Ann.
20 Jan?
21 MS. ROGERS: I d like to make a
22 positive comment. As compared to June - and this
23 is just anecdotal - as compared to June and the way
24 that we ve had through October, excuse me, it

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2 definitely seemed that there was a strong effect of
3 whatever, whether it was media, education, whether
4 it was the efforts of primary care doctors, but we
5 seem to have a lot fewer primary care-type visits
6 to the emergency room with flu-like symptoms.
7 I think we had much, much more in
8 June that were people who didn t belong in the
9 E.D.; they probably didn t belong at their doctor s
10 offices for the level of illness that they had, and
11 I ve seen a marked difference in October. It seems
12 we re getting more of the population that we should
13 get and those are with the sicker children and also
14 complications. So, whatever that effect is due to,
15 I thank them.
16 MR. CZAPRANSKI: Just one
17 comment. I want to thank the State and the Bureau
18 of E.M.S. for keeping the updates on there. I mean
19 in our area, we put out a weekly H1N1 update to all
20 E.M.S., fire and police providers, and that s been
21 very helpful, but I think the guidance that the
22 State has given is good, because regionally you
23 have to make a decision about -- based on what

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2 DR. KUS: Right.
3 MR. CZAPRANSKI: Our call volume
4 went up, we took back some of the fire/first
5 response calls to influenza-like illness, because
6 they didn t need the exposure, and we hadn t yet
7 vaccinated that group. But we ve held five clinics
8 for E.M.S. providers already in our -- and we ve
9 pretty much hit everyone that -- that wanted an
10 H1N1 vaccine, now, we re stepping it down, since
11 the influenza-like illness is coming up. We re
12 going from a level three to a level two, which now
13 fire will do some more first responses, and so on
14 and so forth.
15 But each community, I think, has
16 to look at what s going on in their community, and
17 then coupled with the guidance by the State it s
18 been excellent for us.
19 DR. KUS: Good.
20 DR. COOPER: I d like to conclude
21 this part of the meeting by thanking Dr. Kus for
22 sharing his expertise on two vitally important
23 subjects.

24 you re seeing in your community.

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2 willing to provide a copy of the presentation to

3 Ms. Gohlke for distribution to the Committee.

4 DR. KUS: Sure.

5 DR. COOPER: And once again, we

6 really thank you for being with us, and extend, as

7 always, our invitation to you and Dr. Kacica to

8 join with us at -- at each one of our meetings,

9 since so much of what we do overlaps with so much

10 of what you do.

11 So, thank you very much.

12 Before we move off this subject,

13 however, I would just like to ask Bob Kanter and

14 Kathy Lillis if they would share their thoughts

15 regarding a recent meeting held in New York City:

16 The Task Force on Life and the Law, headed now by

17 Beth Roxland, convened an expert panel to look at

18 the issue of -- of ventilator allocation, and --

19 and in H1N1, or other types of pandemic situations,

20 where the need may outstrip the supply, you know.

21 And I ll turn it over, at this point, to Bob and

22 Kathy for preliminary observations, just to let the

23 group know that this initiative is underway.

24 DR. KANTER: Well, this was a

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2 that is -- is going on in -- in other agencies

3 and -- and work groups. But this particular task

4 force of the New York State Department of Heath

5 considered an even worse circumstance, what if all

6 those attempts to deliver mass critical care to

7 much larger numbers than normal, still fell short,

8 and you found yourself with three or four patients

9 in the E.R. who need a ventilator, and you ve got

10 one ventilator. Who would get it?

11 And it won t surprise you to

12 learn that the task force meeting did not come up

13 with definitive answers, but the meeting that

14 occurred a couple of weeks ago tried to apply some

15 general work that s already been done for adults to

16 the circumstance of children.

17 And I can just briefly summarize

18 the rationing strategy:

19 You would, first of all, have

20 fairly strict criteria for who needs a ventilator.

24 I will ask Dr. Kus if he would be

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2 discussion about what would happen if the numbers

3 of patients in a influenza pandemic, or any other

4 kind of pandemic, greatly exceeded the capacity of

5 intensive care, and particularly ventilator care,

6 in our state.

7 And this, of course, is an

8 unprecedented situation, and it s planning ahead

9 for a sort of a worst-case situation. It s

10 important to emphasize that even before you get to

11 the question of rationing, which is the primary

12 thrust of this meeting -- of that meeting, a

13 bigger, more important way to prepare is the notion

14 of mass critical care, where you re trying to

15 extend your care to larger numbers of patients, and

16 provide care to everyone who needs essential

17 critical care by limiting your interventions to

18 immediately lifesaving interventions, trying to

19 increase the number of ventilators that are

20 available, for example, by using transport

21 ventilators, anesthesia ventilators and the like,

22 in a hospital that may have run out of their

23 conventional ventilators.

24 And that s a nationwide effort

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2 good answers to that.

3 Then you would allocate the

4 ventilators to those patients who need them and who

5 don t have exclusion criteria. And then reevaluate

6 them after a period of time, and if they are

7 failing to improve and there s still a crisis

8 shortage, you would withdraw patients who are

9 failing to improve after a time trial of mechanical

10 ventilation, and reallocate that ventilator to

11 someone who is more likely to benefit from a short

12 period of life support.

13 This is a work in progress. The

14 intent is that we re laying the foundation for

15 something that may come up a year or several years

16 from now. This is, in no way, intended to be

17 something that ll be -- that could be implemented

18 this year. It would require a good deal of -- of

19 public discussion, public consensus, a legal basis,

20 operational plans, a great deal of professional and

21	Then you would potentially	21	public education. But again, this task force is
22	exclude people who are too sick to benefit; and	22	doing some very important work, laying the
23	there s a lot of debate about what would be the	23	groundwork, and some very well thought out
24	criteria for that, and I m not sure that we have	24	groundwork, for these very disturbing
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2	possibilities.	2	strongly say that the State needs to put resources
3	DR. COOPER: Thank you, Bob.	3	in to make as many ventilators -- stockpile the
4	Kathy?	4	ventilators, so that we re not in that situations,
5	DR. LILLIS: I think the other	5	but should we be in that situation, we need to
6	thing that we addressed was when we re talking	6	think ahead, and -- and come up with some
7	about the allocation of ventilators, well, what do	7	guidelines.
8	you do with the patients who are on -- on home	8	DR. COOPER: Just one other small
9	ventilators? And it was clear to the -- the	9	additional comment. The -- the patients that have
10	committee that the -- we wouldn t be removing or	10	home ventilators typically have a spare ventilator
11	taking those ventilators away from patients who --	11	at -- at home with them, and that was mentioned as
12	who were on home ventilators, but should those	12	a potential source of additional equipment should
13	patients come into the hospital and need the	13	the public, you know, require it at that particular
14	resources, then that would be a time when they	14	point in time. Although I don t think anyone has
15	would be entered into the system and in -- into the	15	any idea how many home ventilators are actually out
16	guidelines.	16	there at this particular point in time.
17	I think that sitting on the	17	A work in progress as Bob has
18	committee and talking to other people on it, it	18	said, much more to come on this, and we ll keep you
19	was -- it was a very uncomfortable situation. It	19	updated as to where this work proceeds over the
20	wasn t something that any of us in the room wanted	20	next several months.
21	to -- to do, or -- or to think about, and the	21	Elise?
22	committee frequently kept saying, well, this is	22	DR. VAN DER JAGT: Yeah. Just -
23	only after everything else has been done, and --	23	obviously, you were dealing with a pretty difficult
24	and all of the -- you know, that we need to	24	topic, and -- and -- because we re always thinking
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2	we can do everything for anyone. Did it -- it come	2	idea; however, it s not realistic to think that --
3	up at all about hand bagging patients?	3	to think that you could do this for large numbers
4	DR. LILLIS: Uh-huh.	4	of patients for many days at a time. Most of us
5	DR. EDGE: Yes.	5	think it would be a very important option for
6	DR. VAN DER JAGT: Because we --	6	temporary life support, until you could get more
7	we used to do that -- I mean not we, I m not that	7	definitive equipment.
8	old. I m old, but not that old, you know. But --	8	DR. COOPER: Other comments?
9	but in the Third World, that gets done routinely,	9	Yes, sir?
10	you know, for days on end, and there are just	10	MR. TAYLER: This was a
11	shifts of people who bag, to get kids through this.	11	discussion not just for pediatrics, it was -- it
12	So, I m just wondering if that came up in the	12	was the whole -- the whole lifespan? I m assuming
13	discussions.	13	it wasn t just -- was it --?
14	DR. COOPER: It did. Bob?	14	DR. COOPER: No, this particular
15	DR. KANTER: Well, it did.	15	discussion was focused on children. The -- the --
16	It s -- it s a somewhat controversial area among	16	the task force had previously tackled the more
17	the various national work groups that are	17	general issue of how to deal with this problem in

18 considering this. The disadvantages are that it s
19 very labor intensive and would take away from other
20 aspects of intensive care; it exposes people more
21 closely to transmittable infections. On the other
22 hand, it may be lifesaving when you ve got
23 absolutely no other alternatives.
24 So, some of us think it s a good

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18 the general population, but the -- the initial
19 draft report, which was issued in mid-2007, as I
20 recall, did not explicitly address the special
21 issues of children, and I -- and that was the
22 reason that this particular subgroup was asked to
23 come together to assist the Task Force on Life and
24 the Law in fleshing out that -- the details of that

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2 particular component of the report, which, again,
3 is still in draft form.
4 MR. TAYLER: Was there any
5 consideration given to when the paramedics intubate
6 the patient in the field, and then they come into
7 your E.R. with this -- this -- with the patient
8 intubated and you have no vents? I mean it s --
9 it s another, you know, it -- it s similar to
10 picking up a patient from home that -- that is on a
11 home ventilator, but you know, you re still --
12 you re back to a patient that now you re bagging
13 them.
14 DR. COOPER: That specific issue
15 I do not recall being discussed, but we could pass
16 that point along to the powers that be.
17 DR. LILLIS: I think there was a
18 very brief discussion that the guidelines that we
19 were working on were really hospital-based, and
20 that we would not change anything prehospital
21 initially, but -- and that we couldn t really
22 expect prehospital care providers to decide things
23 like -- like that, who --
24 MR. TAYLER: Yeah.

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2 DR. LILLIS: -- and some of the
3 things we were basing that was qualify of life,
4 utilization of -- of resources and survivability --
5 MR. TAYLER: Uh-huh.
6 DR. LILLIS: -- in that we --
7 that wasn t something that we could implement in a
8 prehospital care setting.
9 MR. TAYLER: Yeah. And I can
10 understand that.
11 I -- I just was wondering if it
12 was a point considered, because it is -- is -- it
13 is a distinct possibility, you know, that you --
14 that you would run into this, and now it s -- it s
15 your hospital patient. So, I -- I was just
16 wondering if that -- if -- if in considering all of
17 the possibilities that was -- that was also
18 considered.
19 DR. COOPER: Okay. Thank you,
20 Mike Tayler.
21 We re going to move on now to
22 hear from Sarah Sperry, the research scientist of
23 the Bureau of Injury Prevention for her report to
24 the group.

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2 Ms. Sperry?
3 MS. MACINSKI SPERRY: Thank you.
4 DR. COOPER: And thank you again
5 for being here.
6 MS. MACINSKI SPERRY: Just a bit
7 of housekeeping, you know, it s the Health
8 Department, I guess, that regulates how long food
9 can stay out and the folks outside are very eager
10 to snatch it away, so if you --
11 DR. HALPERT: Yeah. We noticed
12 they are.
13 MS. MACINSKI SPERRY: -- if you
14 haven t had your dessert, if you haven t had your
15 seconds or whatever, now is the time, before he

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2 happy to e-mail it to anyone who would like it.
3 DR. COOPER: Please. Please do
4 that. Yeah. Thank you.
5 MS. MACINSKI SPERRY: Okay. But
6 data I did as handouts, because it s easier to see,
7 and -- all right.
8 So for this presentation, I just
9 wanted to also share that I ve defined childhood as
10 those under nineteen. I know that there are -- are
11 multiple definitions of what children are that
12 float around. Our general cutoff in our bureau is
13 nineteen, and so I -- I stuck with that, because it
14 made cutting data easier.
15 So, who we are is we re part of

16 comes in and takes it away.

17 FROM THE FLOOR: Can somebody

18 here suspend that rule?

19 MS. MACINSKI SPERRY: While

20 Martha is bringing up the presentation, I m going

21 to start. I have got three separate handouts I m

22 passing out. I didn t make handouts of the

23 presentation itself. I was trying to save some

24 paper and make some happy trees. I m more than

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16 the Division of Chronic Disease and Injury

17 Prevention. We -- our bureau is kind of unique in

18 our division in that we have both surveillance and

19 program staff. Surveillance staff, we identify and

20 monitor incidents of injury, whereas our program

21 staff work to use evidence-based strategies to

22 decrease the burden of injury.

23 Keep the slide up.

24 The -- if we were to have a

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2 Bureau of Injury Prevention mantra, it would be

3 that injuries are not accidents. We do -- we call

4 it the A word, and we don t use it when we speak of

5 injuries or car crashes, because we believe that

6 these are predictable and preventable events.

7 If they -- accident apparently

8 implies some sort of uncontrollable act of fate,

9 and if these things truly were uncontrollable acts

10 of fate, we couldn t prevent them, and we know that

11 we can.

12 This is just kind of a quick look

13 at the various things that we do and work on.

14 Injuries are a very broad topic area, and we work

15 in a lot of places, and the main focus of my

16 presentation is our surveillance and what we can do

17 for you. I am, towards the end, going to touch on

18 our childhood unintentional injury project, as that

19 may also relate to your program.

20 So, our surveillance, we work to

21 identify and monitor injury incidents. We do

22 this -- we have the SPARCS data, we have the vital

23 statistics death data, and we have our CODES

24 project. CODES is a linked project, which I ll get

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2 into in a little bit, that looks at -- and I know

3 that I ve got the A word up there, that I just said

4 we don t ever use it, but the accident information

5 system comes from D.M.V., and that s what it s

6 called. And this is our -- our crash reports.

7 So, the SPARCS, as you know, it s

8 hospital discharge data, and E.D. data, vital

9 statistics, death files come from death

10 certificates for children.

11 Examples of the -- next slide,

12 please.

13 I m trying to go as -- as quick

14 as I can to help you catch up on -- on time.

15 DR. COOPER: Thank you.

16 MS. MACINSKI SPERRY: The --

17 there is -- this is -- by no means am I giving you

18 an all inclusive list of variables for any of the

19 things, various, or demographics, what happens to

20 the patients.

21 Next slide, please.

22 And also we -- the data is coded

23 with I.C.D.-nine and I.C.D.-ten coding. This gives

24 us diagnosis codes and e-codes which are external

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2 cause of injury and place of injury. SPARCS uses

3 I.C.D.-nine, whereas the death files use

4 I.C.D.-ten.

5 And I m -- now, I m -- these

6 are --.

7 MS. GOHLKE: Sorry.

8 MS. MACINSKI SPERRY: That s

9 okay.

10 The handouts I gave you, so you

11 can actually see things, because I know stuff is

12 very small up there, this is an example of our --

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

3 each.

4 Obviously, as the -- it goes from

5 death to E.D. visits, your -- your mean annual

6 frequencies are going up and up and up.

7 Next slide.

8 And this is your incidence of

9 injury deaths. I didn t give you the graphs in the

10 handouts, but on the back of the table, there is --

11 can I just borrow this for a second? On the back

12 of this - saving paper - is the -- the -- the data

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10 of more detailed information about the patients,
11 some of which is used in linking, some of it s not.
12
13 The accident information system,
14 which is our data source that you all may have the
15 least exposure to, contains the police accident
16 reports, ticketing -- which is ticketing
17 information and motoring -- motorist reports. So,
18 if you re in a -- involved in a crash, the police
19 officer comes, theoretically writes up a crash
20 report, you may or may not get a ticket, we get
21 that information. Sometimes there is not a police
22 crash report, but a motorist themselves will send in
23 a report form to D.M.V. Those are the motorist
24 reports. So, these are received by the D.M.V., by
both police and individuals, and that data can be

10 dataset is referred to as KABCO. With this is
11 assessed -- assessed by the police. It goes
12 from -- it s a -- goes from K, which is killed, all
13 the way down to O, which is noting, and/or no
14 injury. There has been some work comparing -- done
15 by NHTSA comparing the M.A.I.S. models with the
16 KABCO model -- the KABCO scores and the M.A.I.S.
17 is, they re finding a little bit better, in that
18 KABCO being assessed by the police officer is --
19 they see something that s very bloody, and they say
20 it s a severe injury, when it may just be something
21 that s very bloody, where someone may have a fairly
22 severe internal injury that the police officer
23 can t see, and therefore, is a lesser. So, with
24 our CODES, we get to help kind of bridge this gap a

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2 little bit. So, this is -- all of these are -- are
3 available sources for injury data, and whereas
4 alone they re all beneficial, they can t produce
5 the complete picture of crash and outcomes that
6 CODES can. That s it.
7
8 We use common variables to link
9 these, event variables, and individual variables,
10 and this expands crash data, so that components of
11 highway safety can be evaluated, creating a fuller
12 picture of the crash.
13
14 Next, Martha.
15
16 As I said, we have -- we do our
17 best to be resourceful and helpful at the Bureau of
18 Injury Prevention. We will do customizable data
19 requests for free. Our -- our Web site is getting
20 updated with data, it s -- it s there and very
21 small, and we re putting more and more data on it
22 and that s exciting.
23
24 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

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2 cetera.
3
4 We also have a childhood
5 unintentional injury prevention project. This
6 has -- is a two-part campaign to work with local
7 partners in preventing childhood injuries. Phase
8 one is -- is getting completed. They re up and not
9 quite on Internet, but almost on Internet-land --
10 a -- working on a user-friendly link on the D.O.H.
11 Web site. And we have, I believe, forty-eight fact
12 sheets that are -- are on their way through
13 approvals in -- in D.O.H. for posting.
14
15 Phase two is developing a falls
16 prevention -- childhood falls prevention toolkit to
17 assist local partners, and to conduct a symposium
18 to demonstrate this toolkit. This symposium is
19 scheduled for March 31st, and if anyone is
20 interested in this, let us know, we can send you an
21 invite and -- oh, geez, where are my --.
22
23 DR. COOPER: Sarah, the falls
24 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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2 MS. MACINSKI SPERRY: So, if you
3 go -- I didn t go through the -- the data I handed
4 out, but falls are one of the leading causes of
5 injury for actually all age groups, except for --
6
7 MS. MOLLOY: Right.

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2 MS. MACINSKI SPERRY: Yeah. And
3 then on the next page, I -- this is a list of
4 everything that they re making fact sheets for.
5 They re also -- these are -- are the topic areas.
6 Well, most of them are broken out by age groups, so

7 MS. MACINSKI SPERRY: -- like
8 late teens. And it s pretty much they do a lot of
9 falls from just like within the house, down the
10 stairs, the falls that -- like my daughter falling
11 off her chair in the kitchen the other day, I went
12 (makes a noise), but there is -- you re doing a lot
13 of work just to -- because there s -- it s -- it s
14 such a simple little thing, but there s -- there s
15 so much of it, and it -- it accounts for so much
16 that -- money and morbidity and unfortunately,
17 mortality as well, that that s what they re --
18 it s -- it s really all falls, I guess.
19 MS. MOLLOY: Where is it going to
20 be held?
21 MS. MACINSKI SPERRY: Glen
22 Sanders in Scotia, New York.
23 MS. MOLLOY: Can you send that
24 link to Martha, so she could send it to us?

7 that parents, caregivers, medical professionals,
8 can each, you know, get information for, you know,
9 my zero to one year olds, and that they should n
10 be on a bicycle or what have you.
11 And lastly, this is our -- our
12 general injury -- our -- well, Health Department
13 Web site. You can link through it to the injury
14 prevention. If you Google New York State injury
15 prevention statistics, we come up first. I m very
16 excited. So -- but that s -- that s how to contact
17 the bureau for anything that you need.
18 My e-mail s there at the bottom.
19 If you would like to contact me for anything. I
20 can always push you through to the -- the proper
21 person that is in the area that you re interested
22 in. And if any of you work with partners who you
23 may -- think may be interested in what we re doing,
24 being part of anything that we re working on, we re

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2 always happy to have new partners, and -- and have
3 more people come to events and trainings and -- and
4 share our information. So, anything that we can do
5 to help out there in the community is what we re
6 trying for.
7 DR. COOPER: Thank you so much.
8 Has either the Department, or the
9 Department at the direction or request of NHTSA,
10 thought about adding events to automated crash
11 notification data to the CODES project?
12 MS. MACINSKI SPERRY: The crash
13 notification data?
14 DR. COOPER: Well, there s a --
15 right. There s a -- many, many vehicles,
16 particularly General Motors vehicles, come equipped
17 with something called OnStar, --
18 MS. MACINSKI SPERRY: Oh, like --
19 like OnStar.
20 DR. COOPER: -- which is the
21 generic name is advanced --
22 MS. MACINSKI SPERRY: Yeah.
23 DR. COOPER: -- automated crash
24 notification.

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2 MS. MACINSKI SPERRY: Right. Not
3 that I ve heard of. And it s a -- a worthwhile
4 thing to look into.
5 DR. COOPER: Perhaps. Yeah.
6 Perhaps that s something that -- that, you know,
7 you might want to begin to sort of ask NHTSA about.
8 It s -- it s becoming a -- an increasingly
9 important component of trauma triage in the field,
10 among other things, and trying to link some of
11 the -- you know, the -- the injury outcome data
12 with delta V and so on. It s -- which, of course,
13 the change in the velocity of the vehicle and so
14 on, which is a, you know, an approximate indicator
15 of the -- the speed of the vehicle at the time of
16 the crash, and so on, can be very, very useful.
17 MS. MACINSKI SPERRY: I m -- I m
18 sure that -- and just coming from a pure data
19 standpoint, having that would be a lot more
20 accurate than whatever is listed for -- because
21 what we have is -- we don t have the speed that
22 they were going. We have a -- a -- we actually
23 have two variables; in contributing factors, they
24 have unsafe speed listed, and then they also can

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2 have under ticketing information unsafe speed. But
3 we re really only going to know how fast they were
4 going if moments before the crash there was a

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2 For example, there are two
3 counties that are way, way above the rest of them.
4 Steuben County in particular and St. Lawrence

5 police officer there with a radar gun. And that s

6 not really going to happen. So, it s -- there --

7 there are definite laws in -- in data collection,

8 that we do the best that we can with. And things

9 to make it more sensitive and specific would be

10 great.

11 DR. COOPER: Other questions for

12 Ms. Sperry?

13 Elise?

14 DR. VAN DER JAGT: I was just

15 interested in your -- the county by county data you

16 have here.

17 MS. MACINSKI SPERRY: Uh-huh.

18 DR. VAN DER JAGT: And the

19 coupling it with your program of preventing

20 falls --

21 MS. MACINSKI SPERRY: Yes.

22 DR. VAN DER JAGT: - is just

23 striking to me. Do you -- do you focus on specific

24 counties.

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2 MS. MACINSKI SPERRY: We have

3 another -- another falls program that s working on

4 fall prevention in older adults, which is -- are

5 those sixty-five plus, and that is working -- they

6 have specific counties that they re working with,

7 and -- and like test running. They re -- I -- I

8 think they re doing Tai Chi. It s just all just

9 starting. But that I know, I m pretty sure they re

10 working with Erie County -- one -- a county in Long

11 Island, I think, and maybe Broome County. Don t --

12 don t quote me on that one.

13 MS. MOLLOY: It s not he record.

14 MS. MACINSKI SPERRY: I know it s

15 on the record, but I m also on the record saying

16 I m not a hundred percent sure, so --.

17 MS. MOLLOY: Don t get nervous.

18 MS. MACINSKI SPERRY: So, yeah.

19 DR. KANTER: Yeah.

20 MS. MACINSKI SPERRY: I -- I

21 would assume that -- that they re going to work on

22 targeting specific counties, but I don t know the

23 full breadth on that. The -- there s a position

24 that is out for -- we re hiring a person to work on

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5 County. I m interested in Steuben County, because

6 it happens to be in our area and we found the same

7 thing in the 80s and early 90s, that falls were a

8 very high -- high rate of them. So, do you take

9 that program that you re developing, and go to that

10 county, and say, how about using this, and see if

11 you could do this?

12 MS. MACINSKI SPERRY: I m -- I m

13 not sure. I m -- I m surveillance.

14 DR. VAN DER JAGT: Uh-huh.

15 MS. MACINSKI SPERRY: But I m not

16 sure how the childhood one is working. We also --

17 and I didn t talk about it here because you

18 don t -- I mean I know that you care about older

19 folks, but it s not your focus. We --.

20 DR. KANTER: Well, we are older

21 folks --

22 FROM THE FLOOR: We don t care.

23 MS. KANTER: -- of course it s

24 our focus.

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2 that, as we speak. Applications have been coming

3 in. So, I don t know how far the -- the plans have

4 progressed.

5 DR. COOPER: Dr. Edges?

6 MR. KANTER: Just a note.

7 It s -- it s hard to interpret some of these rates

8 on counties that have very small populations with

9 low total occurrence rates.

10 MS. MACINSKI SPERRY: Yeah.

11 MR. VAN DER JAGT: Yeah. It is

12 hard.

13 MS. MACINSKI SPERRY: Yeah.

14 We -- we try to star everything in our -- our data

15 with -- that s based on a frequency of less than

16 twenty as being unstable, and then we don t

17 provide -- if you have five or fewer injuries or --

18 of whatever nature, we don t report that data for

19 confidentiality reasons, and --

20 DR. VAN DER JAGT: Sure.

21 MS. MACINSKI SPERRY: -- and I

22 know when you -- you break it down to just by

23 county, it -- it becomes a lot harder to interpret,

24 and it s where -- where the E.D. data comes in a

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2 little more helpful than the -- the death data,

3 because you ve got a lot more of those.

4 DR. VAN DER JAGT: I - I was as

5 much interested in the process as anything else, as

6 where the data gets used, you know. In other

7 words, it s great to get data, and it s great, you

8 know, if you re doing surveyance, and you re having

9 all these exciting, drooling data points, but you

10 know, I m just wondering, one - and maybe this goes

11 back to Dr. Cooper - is what do we as a committee

12 do with this data? If we re going to present it

13 here, are we supposed to take some action of some

14 sort, or do we -- do we just say, oh, well, that s

15 nice, you know, or what do we do with it?

16 And then the second thing is --

17 is what happens at the Bureau s level, you know,

18 and how is this data used by county health

19 departments, or regions of the state, or urban

20 areas, or how is it used, so that we just don t

21 continue to collect data without actually using it?

22 MS. MACINSKI SPERRY: On average,

23 I think we re running six to seven data requests a

24 month for individuals, be they like

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2 developing county-level fact sheets, that w, ill

3 hopefully -- we re going to -- we re developing

4 them, we re going to be running them through focus

5 groups of police officers and some various other

6 stakeholders who have yet to be identified, and

7 hopefully, that will help us really key on a -- a

8 good helpful, useful, easy-to-read doc, because

9 what -- coming from my epidemiology background,

10 what is -- is good and easy data for me and for us,

11 and you know, makes sense, well, look at this,

12 doesn t make sense to the people that are actually

13 on the ground running with it, trying to -- to do

14 it and make changes and make things better. So,

15 we re -- we re trying to make that -- make it --

16 make it as user-friendly as possible, and then also

17 do a more comprehensive listing of county tables

18 and New York State data in general.

19 A couple -- a year or two ago,

20 when Marjorie was still around, we did a very large

21 data request for the State Trauma Advisory

22 Committee, where the -- pretty much the tables that

23 I gave you, I ran for hospital deaths -- well, we

24 ran for hospitals deaths and E.D. visits for each

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2 university-level researchers, private

3 not-for-profits, we get a lot of work -- requests

4 from traumatic brain injury programs that are --

5 are looking for that stuff. We just did a couple

6 of spinal cord injury data requests.

7 We -- we recently did a bunch of

8 data to provide to Orange County, to their -- their

9 police -- yeah, to their police departments,

10 because they wanted -- the town of Goshen wanted to

11 limit the -- the ability of the police officers --

12 or stop them from doing the Stop D.W.I. programs,

13 the Buckle-Up New York programs, and the -- the

14 STEP program, which is inclusive of a lot of

15 things. So, we re -- we did the data, you know,

16 we -- and like as quickly as we could, got a bunch

17 of tables out there to send out -- say, look, no,

18 these are our real problems. We ve got people who

19 are really getting injured, or really getting

20 killed in your county from these -- these things.

21 This is -- is important.

22 One of the -- the -- as I said,

23 we have G.T.S.C. funding for the CODES project.

24 We re using that right now. We re working -- we re

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2 of the trauma regions, so that then they could take

3 their local data to their regional trauma advisory

4 committees, and say, look, this is what s going

5 on and -- and what they actually really did with

6 it, I don t know.

7 We have started requesting that

8 when people tell me that they re going to -- tell

9 us, that they re going to make a brochure or give a

10 presentation, or you know, do a press release, I ve

11 started following up with them, and -- and asking

12 for copies of it, and keeping a -- a listing of the

13 different things that our data has been done for,

14 which is always fun, we re like, look, it s really

15 being used.

16 But we, you know, anywhere that

17 we ve got it for -- you know, it s -- and in terms

18 of who uses it, part of it being such a long-winded

19 answer, is that injury is such a broad topic. I --

20 I came from an infectious disease background to

21 injury, and it took me a really long time to -- to

22 grasp this concept of it s -- it s burns, and it s

23 poisoning, and it s assault, and it s a car crash,

24 and this is all in one place, in -- in one topic

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2 area? And so, it -- our -- our data goes out all

3 over the place. It s, you know, used in -- in teen

4 driver work groups that the State puts on, and --.

5 MS. GOHLKE: Yeah. And it -- it

6 just -- you know, the reason we asked Sarah to

7 speak was because the last meeting we talked a lot

8 about getting data for the regionalization meeting

9 in May --

10 DR. COOPER: Right.

11 MS. GOHLKE: -- and there is some

12 confusion amongst people at the table, and myself

13 included, and I don't even know what all the Health

14 Department collects. So, Sarah had offered, you

15 know, to at least give us an overview of what her

16 unit does, in case we wanted to hold something for

17 our upcoming meeting.

18 DR. COOPER: Tim?

19 MR. CZAPRANSKI: The one slide

20 you had with all the different tear-off sheets,

21 which you had -- you had suffocation as a subject

22 category --

23 MS. MACINSKI SPERRY: Yeah.

24 MR. CZAPRANSKI: -- does that

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2 that seven children have died during the past year

3 from H1N1. The magnitude of the epidemic of

4 traumatic injuries so totally dwarfs the magnitude

5 of the H1N1 epidemic as to be separated by two

6 orders of magnitude. Yet, as we all know, as hard

7 as Sarah and her colleagues are working, this data

8 is languishing, and we're doing precious little to

9 protect our precious little ones from traumatic

10 injury, whereas we have Herculean efforts being

11 undertaken to protect them from a disease of great

12 pathogenicity, but very limited virulence.

13 Bob?

14 DR. KANTER: And that's scary. I

15 think that there are a number of important

16 questions, and the answers to which would allow us

17 to do things that come from data that are available

18 to you guys, and you -- you probably have access to

19 the information in ways that's much harder for an

20 individual researcher to obtain. So, linking

21 across these databases is very powerful. Linking

22 across multiple hospitalizations and the SPARCS

23 database from a referring hospital to a -- a

24 critical care or trauma center hospital is very

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2 include the same as sleeping? Because in -- in our

3 county, what we've been calling an infant death

4 is -- is a sleeping death. And that's where a

5 child fatality occurs -- and I was just

6 wondering -- I didn't see anything up there related

7 to that fact sheet around say sleeping deaths.

8 MS. MACINSKI SPERRY: It -- it

9 may be. I -- I know that that has been a -- an

10 interesting discussion around the office, and --

11 and with various conference calls with different

12 people, and -- and what we have for coding versus

13 what other people, you know, say exists and some

14 discrepancies there, I -- that's not -- the -- the

15 suffocation is not a fact sheet that I personally

16 worked on, so I don't know what all is in it.

17 It -- it may be in -- knock on wood, it'll be up

18 there on the Internet to look at really soon.

19 DR. COOPER: I'd like to thank

20 Sarah for her comprehensive presentation. I'm just

21 going to note for posterity here on the record,

22 that last year in New York State, according to the

23 data that Sarah has presented, six hundred and

24 thirty-three children died. We heard earlier today

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2 powerful. And I think things like -- we talked

3 about before, like using hospital discharge data to

4 more objectively evaluate mortality risk in

5 injuries, and to compare the performance of trauma

6 hospitals to other hospitals is something that you

7 may be able to do, and I know a number of us would

8 be interested in helping if you would think that's

9 worthwhile.

10 DR. COOPER: Thank you, Bob.

11 Okay. We are approaching a

12 moment of perfect timing, because I know Lisa

13 McMurdo had wanted to hear Bob Kanter's

14 presentation on -- or preliminary presentation on

15 regionalization, which, with input from this group,

16 will be one of the keynote presentations at our

17 regionalization stakeholder meeting in the spring.

18 So, Bob, if you would --

19 MS. GOHLKE: Can --

20 DR. COOPER: -- take it away.

21 MS. GOHLKE: -- can I just

22 actually give an update where we are with this as

23 background before you get started?

24 A smaller group of us are -- have

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2 been working hard to plan this big important

3 meeting on May 13th -- it should all be on your

4 calendars -- down in New York City. And this is

5 our -- our pediatric critical care regionalization

6 meeting where we re going to bring stakeholders

7 around the state to give us feedback on this

8 concept of regionalizing critical care for children

9 in the state and moving in that direction.

10 This is kind of a next step to

11 the white paper that was submitted to the

12 commissioner with this concept and his permission

13 for us to go forward with the stakeholder s meeting

14 to get more broad feedback on this idea for New

15 York. Many states have already done this, it is a

16 performance measure of my grant, not to say that

17 that s the reason that we re doing this, but it

18 is -- the -- the feds do believe that this is

19 the -- the right way to go for, you know, tertiary

20 care for children and having an organized system to

21 get them there when needed. So -- so, this

22 regionalization meeting -- the stakeholder s

23 meeting on May 13th, we ve been planning it, and

24 just to give you an outline of the agenda, so to

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2 can e-mail a reminder with the call-in number. If

3 you d like to be a part of it, I think right now

4 where we re at is we re getting the invitation list

5 together. And this is probably the most crucial

6 step to make sure that we get the right people

7 attending this meeting, and we don t obviously want

8 to just send a letter -- a generic letter to an

9 organization that will get lost. We want to have

10 people s names on the letter. So, if you know of

11 somebody that you want to see invited and at the

12 table, now is the time to let me know who you think

13 should be at this meeting so we get them the

14 letter. Okay?

15 So, no further ado, Dr. Kanter.

16 DR. EDGE: Thanks.

17 Well, this is meant to be a

18 summary of the basic facts about regionalization of

19 pediatric critical care. I think it s the

20 information that every stakeholder would want to

21 know about, whether the audience is providers in

22 any part of the healthcare system: Representatives

23 of hospitals; payers, the people who pay for the

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2 speak, in the morning Dr. Kanter is going to give

3 the regionalization one o one talk, and the

4 supporting information for why we have this

5 meeting, why we re looking at this issue.

6 We re going to invite my E.M.S.C.

7 counterparts from Illinois, and also the physician

8 chair of their E.M.S.C. committee to come out and

9 give us the testimonial of their system and the

10 process that they went through, and to answer

11 questions to stakeholders about what the process

12 and what the issues were for their state. And then

13 probably in the afternoon we re going to have a

14 professional facilitator, you know, get feedback

15 from folks have an organized process for receiving

16 feedback from the stakeholders in the room about

17 their feelings on this topic and issues that they

18 have, to then present back to the commissioner with

19 a recommendation of such.

20 So, that s just the lay of the

21 land of where we re looking right now. We have

22 planning conference calls, planning meetings set up

23 on a monthly basis -- anybody is welcome to call

24 in. The next one is next Monday, December 14th. I

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2 regulators who have to make this whole system work.

3 The material here is a draft of what I think would

4 be important to prevent -- to present at the

5 stakeholder s meeting. So, if any of you have any

6 comments as we go along, either interrupt or save

7 them for the end. Either way, give me some

8 perspective on how you think this information might

9 be better presented.

10 It s an overview -- let s go to

11 the next slide.

12 So, the first question is what is

13 pediatric critical care? And here we re just

14 emphasizing that critical care really implies a

15 continuum, beginning in the prehospital setting,

16 where E.M.S. providers respond rapidly to any kind

17 of crisis in any location. The patient is then

18 stabilized in an emergency department that must be

19 relatively nearby the scene of the crisis. A very

20 important element is that for common, low-risk

21 conditions that require hospitalization, it s

22 appropriate and desirable for the hospitalization

23 to occur near home, but for those complex,

24 critical care; family members of very sick kids; or

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24 high-risk conditions, pediatric intensive care is

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2 best provided in a critical care center, which may

3 be located some distance away from home, and then

4 it's essential that there be an orderly transition

5 to rehabilitation care if -- if necessary, and then

6 back to community-based care after the child

7 recovers.

8 What is regionalization? Well,

9 it's broadly a way of distributing services, so

10 that the comprehensive services, which by the way

11 are very expensive, are distributed in a way that

12 balances a number of factors.

13 In trying to have high quality

14 care, which for a -- a complex high-risk condition

15 means that a critical care center needs to have a

16 high enough volume that they can pay for those

17 comprehensive resources, a high enough volume that

18 they maintain proficiency by doing it often. You

19 need to have the centers distributed, so that

20 they're accessible. So, there needs to be a large

21 enough number of them that they're a relatively

22 short, or reasonable, travel distance from

23 everywhere in the state. And you don't want to be

24 distributing them redundantly because that's very

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2 accreditation; that is an impartial body verifies

3 that a facility has specified services. And

4 designation; which means that you have criteria for

5 certain kinds of patients who have high-risk,

6 complex conditions should receive care at specified

7 centers, because those specified centers have the

8 resources -- the appropriate resources to deal with

9 them.

10 So, let's just touch on some of

11 the evidence. And we've talked, in this committee,

12 about should we gather more evidence?

13 Well, I think the evidence that

14 we've summarized here, is pretty strong for

15 pediatrics. And the evidence is as follows:

16 A study from John Tilford, a

17 multicenter study done in sixteen different

18 pediatric intensive care units, asking how does

19 volume in those different I.C.U.s relate to

20 outcome? And the answer is that higher volume in

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2 expensive.

3 When we talk about high volume of

4 activity, I'm considering high volume of activity

5 as being somewhat synonymous with a regional

6 center. A lot of the data, which we'll get to in a

7 minute, talk about high-volume centers, some of the

8 studies talk about regional centers, and for

9 purposes of discussion, I think that high volume

10 and regional is often synonymous.

11 And there is a great deal of

12 information, which I won't review today talking

13 about the fact that outcomes are better at

14 high-volume regional centers across adult medical,

15 surgical and traumatic conditions. We'll focus, in

16 this talk, on pediatric data. There are a few

17 specific differences of rural, suburban, urban and

18 metro area needs and resources. We'll come back to

19 that briefly at the end.

20 Now, New York State currently

21 identifies these resources sort of by

22 self-identification, and what we're arguing is that

23 a more formal system of identification would be

24 worthwhile, and the two components of that are

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2 five-percent reduction in relative risk. That's

3 data from -- gathered prospectively from peds

4 I.C.U. registries, contributed to by many I.C.U.s

5 around the country.

6 Next study, Murray Pollack's very

7 old study, gosh, it's almost twenty years old now

8 but it's still one of the best. This was a study

9 done retrospectively looking at hospital charts.

10 They looked extensively at hospital charts in

11 seventy-four some-odd hospitals in the state of

12 Oregon and Washington, and to make a long story

13 short, for those children with severe traumatic

14 brain injuries, and severe respiratory failure -

15 and it's -- it's combining a couple of -- of

16 illnesses that were easy to identify, it's not

17 specifically a trauma study -- it's combining

18 severe trauma and severe respiratory failure two

19 disorders, or two conditions that were relatively

20 easy to identify - found that the severe ones

21 an I.C.U. is associated with a better risk-adjusted
22 mortality rate.
23 Specifically, for every increase
24 in a hundred admissions per year, you get about a

21 risk-adjusted mortality rate was much worse at the
22 nonpediatric hospitals by a -- by a factor of seven
23 or more.
24 Next study.

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1 EMSC, 12-8-2009
2 For trauma specifically, one
3 study looked at fifty-three hospitals,
4 prospectively, using data collected prospectively
5 in a trauma registry, comparing risk-adjusted
6 mortality rates at American College of Surgeons
7 verified trauma centers compared with other
8 hospitals, significantly lower risk-adjusted
9 mortality rate at the verified trauma centers than
10 at other hospitals. They also compared pediatric
11 trauma centers to verified adult trauma centers and
12 did not find a significant difference in
13 risk-adjusted outcome.
14 Art Cooper's older study shows
15 similar findings.
16 Next study, another study on
17 trauma for younger children, ten years and younger,
18 this is a study using hospital discharge data from
19 the A.H.R.Q. kid database, a huge study, so that
20 the -- the information here is not quite as
21 detailed as you can find in a trauma registry. On
22 the other hand, the numbers of cases are much
23 larger than you can do in a prospective detailed
24 clinical study. And the finding here was that

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1 EMSC, 12-8-2009
2 risk-adjusted mortality rates for severe trauma
3 were lower at children's hospitals than adult
4 hospitals.
5 Next.
6 A so-called ecological study in
7 which they're not able to study a lot of detailed
8 information about individual patients or individual
9 hospitals, but rather they're studying conditions
10 in counties looking at characteristics of the
11 county that may be associated with risk. And in
12 this study, they find that counties that lacked a
13 pediatric I.C.U. had higher risk-adjusted mortality
14 rates than counties that had an I.C.U. after
15 controlling for a number of area characteristics
16 like rural/urban characteristics, socioeconomic
17 factors and whether or not an adult I.C.U. was
18 available.
19 Next slide.
20 Moving on to other conditions:
21 Cardiac surgery. In New York and Massachusetts,
22 some old and still pretty good data showing an
23 association between higher clinical volume of heart
24 surgery, and a lower risk-adjusted mortality rate.

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2 There's a more recent study that
3 some of you may have seen in circulation, I mean
4 sorry, I forgot to put the full citation there. I
5 can get that to you. Jim Marsims (phonetic
6 spelling) study showed that the association
7 between high volume and mortality was not quite as
8 strong in this California study. Some low-volume
9 pediatric centers still had pretty decent survival
10 rates, but it's important to remember what a
11 small-volume study is -- or a small-volume hospital
12 is for cardiac surgery. It still means they're
13 doing fifty to a hundred cases a year and taking
14 care of the kids in the pediatric I.C.U. after the
15 cardiac surgery. It's not just a small community
16 hospital doing one or two kids a year.
17 Now, it's possible to have too
18 much of a good thing, or you can have so many

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2 risk-adjusted outcome.
3 If you go further, increase the
4 number of neonatologists way above that, there is a
5 diminishing return. You don't see any further
6 benefit on mortality and the conclusion from this
7 national work force study was that there are many
8 regions that had excessive numbers of
9 neonatologists to no particular benefit.
10 All right. Are there gaps in New
11 York State?
12 Well, there is some good news
13 about this. If you do -- look at the national
14 survey of I.C.U. -- pediatric I.C.U. beds per
15 population, or -- yeah, per population -- and this
16 was Randolph's study that's published five years
17 ago -- New York State has slightly more PICU beds
18 per population than the national average. We have

19 resources that you reach a point of diminishing
20 return. This is Goodman s study of neonatology,
21 and neonatal intensive care, looking at the work
22 force of neonatologists. And if you go from
23 relatively low to somewhat higher numbers of
24 specialists per case, you get an improvement in the

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19 relatively good geographical distribution of our
20 trauma centers. Seventy-eight percent of kids in
21 New York State live less than an hour drive from a
22 verified trauma center. And in a study I did a few
23 years ago, if you consider the state to be made up
24 of eight hospital referral regions, we have a good

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2 comprehensive pediatric hospital with a peds I.C.U.
3 in every one of the eight statewide regions.
4 The bad news is that although
5 these resources are widely available, they re being
6 used inconsistently. And one worry is that this
7 regional variation may be a marker for some sort of
8 regional barrier, preventing or limiting access to
9 the existing resources.
10 Two studies -- this was my study
11 published about seven or eight years ago, a
12 retrospective study using hospital discharge data,
13 and to make a long story short on this one, is if
14 you looked at inpatient pediatric deaths in
15 nonpediatric I.C.U. hospitals, looking at New York
16 City, thirty-five percent of the inpatient deaths
17 occurred in nonpediatric hospitals. In the rest of
18 the state, only seventeen percent of inpatient
19 deaths occurred in nonpediatric hospitals,
20 suggesting that there was -- there s something
21 different about referral practices in New York City
22 and the rest of the state.
23 A more recent study in the next
24 slide -- this is Hartman s study just published

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2 within the past year or so, a study of severe
3 traumatic brain injury across six states from which
4 they could get data. Just to point out, among
5 those six studied states, New York had the highest
6 per capita number of trauma centers. And these are
7 either level-one trauma centers or pediatric trauma
8 centers. So, we have the -- the highest per capita
9 number of centers, and we have the best
10 geographical access to those centers among the six
11 study states. Nevertheless, our performance in
12 getting the severe patients to one of those trauma
13 centers was not so good. Fewer than eighty percent
14 of the patients in New York received care in one of
15 those high-level hospitals, and there was a great
16 deal of regional variation with New York City, the
17 Binghamton area and the Utica area being areas
18 where even fewer patients were referred to the
19 higher-level trauma hospitals.
20 What do national organizations
21 say about regionalization of trauma -- of -- of
22 critical care and trauma care?
23 And there s a long list of
24 organizations there from A.A.P., S.E.C.M., American

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2 College of Surgeons, you can read the list -- also
3 the E.M.S.C. federal level recommendations, which
4 defines the performance measures that Martha was
5 talking about that we are accountable for. All of
6 them recommend various aspects of regionalized
7 pediatric critical care and trauma care.
8 A little more evidence about what
9 happens -- on the next slide, a little bit more
10 evidence about what happens when states do formally
11 designate pediatric hospitals for trauma and
12 critical care. This was a retrospective study done
13 in the state of Oregon. Oregon formally
14 regionalized their pediatric trauma care in the
15 late 80s, and found that after they had

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2 admission patterns. And they were able to show a
3 very successful shift in the admission patterns
4 away from small community hospitals, increasingly
5 toward adult trauma centers, and even more towards
6 the designated pediatric trauma centers, a very
7 objective effect, or a very objective change in
8 referral patterns following that regionalization.
9 Next.
10 What s the experience in New York
11 with the idea of regionalization? Well, we have
12 very well-developed formal regionalization programs
13 for burn care, for trauma care, including pediatric
14 trauma care, for perinatal care, and more recently,
15 for stroke care. And just to comment about trauma

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16 regionalized their risk-adjusted mortality rates

17 for kids with trauma were lower than simultaneous

18 observations in the state of Washington that had

19 not yet regionalized care.

20

21 Next slide.

22

23 So, then Washington, a few years

24 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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16 care, you might think that a well-regionalized

17 trauma system would give us all the resources we

18 need to regionalize the rest of pediatric critical

19 care.

20

21 It s worth remembering that

22 trauma accounts for probably less than ten percent

23 of all the kids in a pediatric intensive care unit.

24 So, I -- I guess the way I look at it is the trauma

system provides us a good model for how to handle

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2 it, but there is no regulatory teeth to this.

3 There s no direct and specific guidance for this,

4 beyond the trauma patients extrapolating to the --

5 the ninety percenters. So, of other peds critical

6 care patients, we still lack guidance, and lack a

7 well-developed process in New York.

8 Finally, what does

9 regionalization mean for different groups like

10 hospitals?

11 Well, I think most of it is good

12 news. I think a well-regionalized system promotes

13 the care of low-risk conditions, common conditions,

14 near home. And so in a well-developed system, I

15 think you re going to see clinical volume actually

16 increase at some community hospitals.

17 I can tell you in my region, lots

18 of kids are sent to the big pediatric hospital that

19 could very nicely be cared for at the community

20 hospital. And in fact, by doing that, by promoting

21 the effective care of common low-risk conditions at

22 community hospitals, you ll open up space at these

23 very overcrowded children s hospitals, which right

24 now sometimes prevents us from taking the next

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2 critically ill kid.

3

4 Next slide.

5 A community hospital that begins

6 referring their very few critically ill kids to a

7 pediatric hospital is going to have a negligible

8 impact on that community hospital. And in fact,

9 I d argue it s going to be a benefit to the

10 community hospital not to try, because taking care

11 of a couple of severely ill, or severely injured

12 kids a year in an adult I.C.U. is an overwhelming

13 task. Even if they do it successfully, it s an

14 overwhelming task of physicians and nurses who are

15 not experienced in pediatric critical care.

16

17 Next slide.

18 Now, for hospitals that are

19 already providing care for a modest number of

20 critically sick children, they will have to decide

21 do they want to strengthen their peds I.C.U.

22 resources to meet standards for designation, or is

23 it a better idea for them to shift their focus

24 towards non-intensive care pediatrics?

And that s a decision that every

community hospital that does a modest number of

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2 cases, that has a small peds I.C.U. program, is

3 going to have to decide.

4 I can tell you that running a

5 very small pediatric I.C.U. is an incredibly

6 inefficient thing to try to do. If you have a

7 four- or five-bed pediatric I.C.U., if you don t

8 want to exhaust your staff, you need two or three

9 physicians running it, ten nurses running it. It s

10 impossible to pay for that on the caseload that

11 you re going to see in a four-bed I.C.U., and if

12 you have fewer staff than that, it usually is not a

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2 rural facilities do care for common low-risk

3 conditions and appropriately transfer their sicker

4 patients to a regional center. The circumstances

5 are very different in a large urban area where a

6 few hospitals will provide comprehensive care

7 for -- for children, including critical care. Some

8 hospitals will do emergency care and noncritical

9 care, and some hospitals in a big city provide

10 virtually no pediatric care. That s how it is, and

11 that s how it should be.

12

Next slide.

13 viable program.
14 And there s a nice report
15 published in 2006, that describes case histories of
16 I.C.U.s -- pediatric I.C.U.s that closed because --
17 mostly because they were too small to survive.
18 Next slide.
19 There are differences, and I
20 don t need to elaborate on this for this group.
21 Some rural regions have really special important
22 needs, distances between hospitals are long, so
23 every hospital has to be capable of resuscitating
24 and stabilizing a pediatric patient. Many small

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

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2 education in pediatric resuscitation,
3 stabilization, sometimes hospital care, all
4 consistent with whatever that hospital s regional
5 role is.
6 Moving on to families. What does
7 it mean -- what does regionalization mean for
8 families?
9 Well, it means that we re going
10 to promote care for common low-risk conditions near
11 home at an appropriate facility. And that s a -- a
12 significant -- that s a significant benefit for
13 families not to have to go to the pediatric
14 hospital many miles away, if their child could
15 receive good care close to home. But for complex
16 high-risk conditions we really will have better
17 outcomes if we transfer the child.
18 Next.
19 And although going far from home
20 is hard for families, there s very good evidence in
21 surveys -- and this was one study done in a
22 cardiology context asking families about their
23 preferences for where they d like their child to
24 have the high-risk cardiac surgery. But the same

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2 DR. EDGE: Yes.
3 MS. CHIUMENTO: Would it be worth
4 mentioning something like that in your -- in
5 your --?
6 DR. KANTER: You know, I think
7 the volume of neonates that gets back-transported
8 is large enough that that s a well-documented model
9 for which there is good evidence. I m not sure we

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2 thing pertains to many other conditions. Parents
3 tend to choose care, prefer care at a distant
4 regional center if their child s condition is
5 associated with a high mortality risk, and the
6 resources are better equipped to deal with it at
7 the regional center.
8 So, in conclusion, I think we do
9 have very strong evidence that critically ill and
10 injured kids should receive care at regional
11 high-volume pediatric centers. We do have
12 unfortunate evidence that there are barriers
13 sometimes interfering with the use of existing
14 resources in our state, and we have a good deal of
15 experience with other states acting to improve
16 their critical care system, and we have a fair
17 amount of experience in New York State with
18 regionalizing other types of services showing that
19 regionalization helps.
20 DR. COOPER: Questions?
21 MS. CHIUMENTO: I just have one
22 comment. I know that with neonates sometimes as
23 they get a little bigger, they get transferred back
24 to a home hospital.

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2 DR. COOPER: Right.
3 DR. KANTER: -- that simply shows
4 that up to a point it s helpful, beyond that point
5 it s not.
6 The biggest problem with
7 neonatology is, in this country right now, is that
8 it reached its peak of benefit probably fifteen or
9 twenty years ago, and the fragmentation of those

10 have any such evidence as that for other kinds
11 of -- of critical care.

12 MS. CHIUMENTO: Uh-huh. Just

13 wondering.

14 DR. COOPER: Bob, I -- I think

15 that following on the neonatal comment it might be

16 worth including a slide or two on the success of

17 regionalization of neonatal services indicating

18 that for a, you know, a -- an arguably more complex

19 population that -- that it -- that it has been done

20 and it works very well.

21 DR. KANTER: You know what s -- I

22 think you re probably right. I think there is

23 enough evidence that we could do that. It was --

24 it sort of implied by the Goodman study --

10 regionalized services has really set us back a lot.

11 It s not nearly as well-regionalized now as it was

12 fifteen or twenty years ago.

13 DR. COOPER: Well, I -- and I

14 think that that s a -- that that s a -- a good

15 point, you know, and it -- it s -- in -- in many

16 ways analogous to stopping immunization; you know,

17 you immunize against an illness, in this case, you

18 know, with regionalization, and meaning -- meaning

19 the onus being critical pediatric illness, and then

20 the system fragments and you lose benefits. So,

21 it -- I think it s an argument, not only that it

22 can be done and -- and should be done, but then

23 when you think you re dealing with a previously

24 solved problem, and you slack off in terms of the

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2 penetration of that -- of that exercise, that

3 you re -- you know, your outcomes tend to show it.

4 DR. KANTER: Yeah. In fact,

5 while we re on that subject, and we ve talked about

6 in this group before, some of the same problems are

7 happening with trauma centers, is that -- is that

8 many hospitals that have tried for years to provide

9 trauma services are backing out, because the

10 regional demands are too great.

11 MS. MCMURDO: Thank you.

12 This -- this has been very, very

13 helpful for me especially.

14 In the other states that have

15 done this, are there protocols and education; how

16 do they actually do the system? And I assume at

17 the meeting you re going to get into this on -- I

18 know Illinois is going to come and talk, but I m

19 just trying to think logistically how you figure

20 out which types of kids go where.

21 DR. KANTER: Yeah.

22 MS. MCMURDO: Secondly, I think

23 it would be good in the slides if you could beef up

24 the benefits at the community hospitals, because I

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2 am working with Martha and Lee to try to figure out

3 how we best present this to the association -- the

4 Hospital Associations; how we best get their

5 buy-in. We re kind of carefully looking at how we

6 proceed with this, so that we get -- get interest

7 in buy-in and bring them in early enough --

8 DR. KANTER: Yeah.

9 MS. MCMURDO: -- before the May

10 meeting, to kind of engage them, and I think having

11 more info on what they might get out of it. I

12 think you did a good job to summarize it, maybe

13 some more specifics.

14 DR. KANTER: I wish there was

15 more evidence about this.

16 MS. MCMURDO: Yeah.

17 DR. KANTER: There s just very

18 little published information about how community

19 hospitals have specifically benefited, or been

20 harmed, by these sorts of things. There just is

21 not much public information. But I d love to have

22 any other, you know, specific suggestions about how

23 to beef up that -- that aspect of it.

24 Your first question about how it

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2 works, there s several answers to that. One is

3 there s not a lot of published information about

4 that either, but it does vary on a state-by-state

5 basis.

6 It s the reason why -- why Martha

7 had suggested asking the Illinois folks to come

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2 the senior medical advisor for emergency medical

3 services at that particular point in time, and he

4 put together some data from SPARCS basically

5 showing that with trauma, which has a much, much

6 larger volume overall than critical pediatric

7 illness that -- that most community hospitals lost

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8 talk with us, because they have a -- a system they

9 recently initiated, that by all accounts is working

10 pretty well, and they d be able to give us more

11 particulars than you can extract from published

12 information.

13 DR. COOPER: Lisa, I think there

14 is a pretty good way that we could chase that

15 information in time for the conference, and I -- I

16 know you ll recall that a number of years ago -- I

17 recall it, too.

18 MS. MCMURDO: How many years was

19 that?

20 DR. COOPER: Well, I was just

21 it s -- thinking it s more like seventeen years

22 ago. When we were regionalizing the trauma system,

23 the same issues arose with respect to community

24 hospitals. Larry Motley (phonetic spelling) was

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2 patients that should not be transferred, I think it

3 would show a -- a very, very interesting pattern,

4 and as you say at least, I think would actually

5 show, in many instances, a financial benefit to the

6 hospital rather than a -- a detriment.

7 DR. KANTER: Now, something you

8 can --

9 DR. COOPER: At least a wash.

10 DR. KANTER: One thing you --

11 some of you may be able to help me with -- I

12 certainly have information in my region about how

13 many I.C.U. transports we get from each hospital.

14 You re right, it comes to three to five kids from

15 each hospital per year. You have similar

16 information in your own centers and whether we can

17 sort of pool that information.

18 DR. VAN DER JAGT: I - I think

19 that would be very interesting. We certainly have

20 that information from our transport team, and

21 from -- also from E.D. to outlying hospitals to our

22 E.D. transfers.

23 DR. KANTER: I d love to have

24 that --.

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2 through -- all the way through with this process,

3 we do need to collect some baseline data.

4 Other states who have done this,

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Other states who have done this,

8 maybe one or two patients a year, and -- and he had

9 some cost data that, you know, showed that the

10 impact of, you know, the -- the very, very small

11 number of transfers on a hospital s bottom line was

12 negligible, whereas the potential, you know,

13 liability risk was huge. So, I think --.

14 MS. MCMURDO: Well, I also think

15 they would gain patients, too. I think if you

16 structured it right, they might get the proper

17 patients directed to them that aren t being there

18 anyway.

19 DR. COOPER: Right. And I was --

20 I was just going to follow with that point. So, I

21 think it s -- I think if we can -- if we can

22 perhaps get some data, you know, to demonstrate how

23 many patients are -- are being transferred, you

24 know, and compare that with the potential number of

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2 DR. VAN DER JAGT: That would be

3 very -- I could very easily share that with you,

4 the transport especially, that s -- that s

5 nothing --

6 DR. KANTER: Yeah.

7 DR. VAN DER JAGT: -- we can do

8 that in five minutes, you know, I think, to do

9 that.

10 MS. GOHLKE: One of --.

11 DR. VAN DER JAGT: I have -

12 DR. COOPER: And think that

13 would -- by the way, I think if we were able to

14 pool the data from -- you know, from several peds

15 I.C.U.s in New York State, that would make an

16 eminently publishable study as well, and that would

17 be, I think --

18 MR. VAN DER JAGT: Very.

19 DR. COOPER: -- a huge, huge

20 contribution to the national debate on

21 regionalization that actually saves the system

22 money.

23 MS. GOHLKE: Well, yeah, and I

24 was just going to add that, you know, if we go

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2 SPARCS stuff, and what the SPARCS has, that you may

3 even know and we -- maybe we can try to see what we

4 can pull together. I don t know. I don t know if

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5 have not really done a good job with doing the

6 before and after, so this is our chance to do it

7 right, and to show outcome -- changes and outcome.

8 So, we've been going around for

9 months and months on what data to collect, and one

10 of the reasons why I had Dr. Kanter do this now was

11 that data may or may not come to fruition before

12 the meeting. It's -- like I said, it's been going

13 in circles for months and nothing's come forward at

14 this point. I asked Dr. Kanter to do this to -- if

15 we don't have any data, you know, how does this

16 presentation look? What are the gaps? And we've

17 already mentioned a couple that maybe we should

18 add.

19 MS. MCMURDO: But you know, Dr.

20 Cooper had a good point. Maybe if --

21 MS. GOHLKE: Yeah.

22 MS. MCMURDO: -- maybe you and I

23 can meet with Matt Leary and some of the folks in

24 our -- the Health Department more familiar with the

5 it's doable by that date, but have you looked at

6 that at all? Or -- because we -- I'd be willing

7 to --.

8 MS. GOHLKE: Not with Matt Leary.

9 We haven't, you know, gone down that road.

10 MS. MCMURDO: They know the

11 SPARCS, what's in there, what's --.

12 DR. COOPER: Well, I can tell you

13 that when -- that when this issue arose, because

14 there was some push from the commissioner at that

15 time, because there was a huge statewide trauma

16 conference coming up, not unlike, you know, what

17 we're doing here for peds, you know, the SPARCS

18 folks moved pretty fast and got this data collected

19 and together, you know, in record time.

20 And I suspect that given the fact

21 that the commissioner has given this -- the current

22 commissioner has given this high enough priority

23 that he, himself, is attending the meeting, it --

24 it -- it -- that may help our friends at SPARCS

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

3 MS. MCMURDO: Right. Well, I

4 think we just have to frame it. I mean there are

5 staffing concerns though, I will admit right now,

6 but --

7 DR. COOPER: Of course, we

8 understand that.

9 MS. MCMURDO: -- we can try to

10 work, and see if we can figure it out. But we may

11 need one or two of you on a call to help guide us a

12 little bit.

13 DR. COOPER: Sure. Uh-huh.

14 DR. KANTER: And then, Lisa, I

15 think your suggestion about getting -- having some

16 interaction with possible groups prior to a large

17 meeting is a great idea. And you know, it -- you

18 know who to contact better than I, but if you get

19 questions or a -- a line of discussion that seems

20 to represent a broad concern, you could let us know

21 what the developing issues are, I think we could

22 try to address those before the May meeting.

23 MS. MCMURDO: Yeah. I -- I had a

24 meeting with HANYS in Greater New York last week

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2 not about this, but I brought this up, and just

3 wanted to test the waters to see who -- who are the

4 players there that they think we should be having

5 at the meeting. And I -- I think if you have this

6 in e-mail format, I think maybe sharing this with

7 the top leadership there, maybe doing a call,

8 because I think we have to approach it carefully

9 with them.

10 FROM THE FLOOR: Uh-huh.

11 DR. COOPER: Right. My sense of

12 it is --.

13 DR. KANTER: Martha has the

14 PowerPoint, and if -- you know, you think that the

15 PowerPoint in its present form is appropriate, use

16 it.

17 MS. MCMURDO: How about smaller,

18 I think for the leaders, you know, I'm talking like

19 a Lorraine Ryan and Fred Heigle at Great -- at the

20 two associations just to get things moving.

21 DR. COOPER: Yeah. My sense is

22 that -- that at least from conversations with Ray

23 Sweeney over the last three to five years --.

24 MS. MCMURDO: And he was at the

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2 meeting, too.

3 DR. COOPER: Yeah. The hospital

4 association recognizes that -- that most of its

5 members, and then of course most of its members are

6 smaller institutions from across the state in terms

7 of numbers, most of its members have long since

8 been transporting out their -- their critically ill

9 and injured kids. It s not a -- it s not a new

10 thing for them, and I -- and I -- I don t

11 think that there will be a tremendous amount of

12 pushback from -- from HANYS.

13 I m a little less sure about

14 Greater New York, but -- but -- but at the same

15 time Greater New York has tended not to take

16 explicit positions on issues like this when some of

17 their members are, you know, are -- are -- you

18 know, are clearly for it and some of their members

19 less so.

20 DR. VAN DER JAGT: First of all,

21 Bob, great presentation. This is very, very, very

22 helpful. And I think it ll go a long way in

23 helping with that stakeholder s meeting as

24 background.

2 Just a couple of questions I

3 have. And one is a suggestion on one of your

4 sides, the slide that talks about your study gaps

5 in New York, it s, you know, in New York City

6 thirty-five percent, and then it says of patient

7 deaths occurring in non-PICU hospitals, in the

8 remainder of New York City, only seventeen percent,

9 you might want to just leave out that only

10 because -- so, that we don t juxtapose, well, the

11 Upstate is doing much better than Downstate.

12 I know the intent is to show the

13 variation, but I m just wondering, just because of

14 the sensitivities that might be there, whether it

15 wouldn t be helpful just to state that even

16 seventeen percent may be too high, you know, and --

17 and so, I think rather than saying seventeen

18 percent is great, you know, thirty-five percent is

19 bad, just to be kind of sensitive to that, and just

20 they re both may be -- may not be very acceptable.

21 But they re -- they re two different numbers.

22 DR. EDGE: Well -.

23 DR. VAN DER JAGT: You don t have

24 to respond to it. I m just -- that s just an

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2 observation that -- it s just -- this is the way it

3 hit me as -- as being, you know, I want to make

4 sure --

5 DR. EDGE: Let - let me ask -

6 DR. VAN DER JAGT: - that it -

7 it s -- comes across that way. Yeah. Yeah.

8 DR. KANTER: -- rather than

9 respond, let me ask you should we be too sensitive,

10 or should we try to provoke?

11 DR. VAN DER JAGT: Well, I -

12 I -- I guess I -- I guess the question is -- can be

13 looked at different ways. You know, I -- I m not

14 sure what the right percent is, you know, because

15 there s going to be some percent -- there s no

16 answer -- there s no answer to it, so --

17 DR. KANTER: Simply regional

18 variations --

19 DR. VAN DER JAGT: Correct --

20 correct.

21 DR. KANTER: -- may have been a

22 prior problem.

23 DR. VAN DER JAGT: Correct.

24 Exactly. And so, I think that one of the points of

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2 its variation is there are two different

3 percentages.

4 The second thing is that maybe

5 you can work that in elsewhere; nobody really knows

6 the -- what exactly the right percent is because we

7 know that there are children who, no matter what

8 you do, are going to die in a small hospital. I

9 mean we heard this morning from Kathy Lillis, you

10 know, I mean kids that die there, within twelve

11 hours they could die. So -- so, we do know that

12 that occurs.

13 And then, that s also consistent

14 with some of the -- the -- the work that s been

15 done with identifying sick patients in the hospital

16 with rapid response teams, which deaths are truly

17 preventable, and which are really not preventable,

18 or which events are preventable with the team

19 versus not. I mean sort of the same kind of thing.

20 So, that s number one.

21 The second question I had was

22 whether something should be said in here about

23 interfacility transfer. I m not sure how to put it

24 in exactly, but regionalization is more than just

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2	identifying places -- different places for	
3	different kinds of patients. This whole idea of	
4	interfacility transfer, which is part of the	
5	regionalization process, and in many parts actually	
6	already exists. I m just wondering whether that --	
7	there s a way to put that in here as well as	
8	process, maybe under the next steps, or -- I m not	
9	quite sure, but it needs to be addressed as an	
10	entity, because I think -- I -- I think it s easy	
11	enough to do the -- well, yes and no, but then	
12	the -- it -- the whole process of who transports,	
13	how do these transfers work is a big deal, I think.	
14	DR. KANTER: So, that part, I --	
15	I -- I see that as easier, because I --	
16	DR. VAN DER JAGT: Yeah.	
17	DR. KANTER: -- think there s a	
18	great deal -- first of all, the system already	
19	exists in most regions of our state.	
20	DR. VAN DER JAGT: Right.	
21	DR. KANTER: The E.M.S.C. federal	
22	level --	
23	DR. VAN DER JAGT: Right.	
24	DR. KANTER: -- has made some	
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2	very explicit recommendations about it --	
3	DR. VAN DER JAGT: Right.	
4	Correct.	
5	DR. KANTER: -- which we ve	
6	already circulated a draft on for ourselves,	
7	hopefully for future distribution in our state. I	
8	think the real -- I think once hospitals agree that	
9	we should regionalize --	
10	DR. VAN DER JAGT: Right.	
11	DR. EDGES: - the transport	
12	aspect is -- follows logically.	
13	DR. VAN DER JAGT: Yeah.	
14	DR. KANTER: The real question is	
15	should we have a more formal system of designation.	
16	DR. VAN DER JAGT: Sure. Sure.	
17	I think certainly one, step one and one step two,	
18	obviously, or the cart before the horse.	
19	However --,	
20	DR. COOPER: Well, I -- I --	
21	however, I m not sure that Elise isn t right here,	
22	Bob. I -- I think that the -- I think that -- that	
23	it s -- it s well -- all well and good to say that	
24	regionalization is great, which we all support and	
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2	the data supports and so on.	
3	DR. VAN DER JAGT: Right.	
4	DR. COOPER: But if it were the	
5	case --	
6	DR. VAN DER JAGT: Right.	
7	DR. COOPER: -- that if	
8	regionalization were great, but transport was	
9	terrible, that -- that -- that kids died during	
10	transport, you know, then you would have a	
11	compelling case against it.	
12	DR. VAN DER JAGT: Right.	
13	DR. COOPER: I think the point to	
14	be made here is -- is as -- just as you said a	
15	moment ago, the transport system exists, and in	
16	fact, it is incredibly safe provided that it s	
17	appropriately staffed. And you ve done all the	
18	work in that area, so it should be a little -- it	
19	should be fairly easy to pop up a few more Kanter	
20	papers on that.	
21	DR. KANTER: It is mentioned in	
22	the white paper, but --.	
23	DR. COOPER: Yeah. But I think	
24	it s worth mentioning here.	
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2	DR. VAN DER JAGT: I just think	
3	it needs to be addressed in the -- in this area.	
4	And I -- I do agree that we have made a lot of very	
5	good steps in the transfer process. We -- I think	
6	we are, I mean in various parts of New York State.	
7	I also, however, am aware of the	
8	survey that Martha did, you know, that we do -- we	
9	also don t satisfy all the steps of the recommended	
10	transfer process. So, there is certainly work to	
11	be done in that area.	
12	And then, the third thing. I just	
13	want to go back to that what your statement was,	
14	Art, about having some of the transport data. You	
15	know ever one of the areas, you know, PICUs in	
16	certainly Upstate New York, but also probably in --	
17	in -- in New York City, we have data on what kind	
18	of patients gets transferred to the hospital via	
19	the transport systems. And they are -- and this	
20	is, again, a little bit of a nuance, talking here	
21	about PICU patients and mortalities, but a lot of	
22	the transfers are not PICU, they re floor patients.	
23	But they re floor patients that cannot be taken	
24	care of in a smaller hospital, but they need a	
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1	EMSC, 12-8-2009		1	EMSC, 12-8-2009	
2	larger hospital, because the subspecialists are		2	didn't we just discuss, at the State Counsel, that	
3	there.		3	hospitals that cannot provide a service have to	
4	And so, you know, that is an		4	have an agreement with a transport facility or	
5	aspect of this that undoubtedly will be raised.		5	transport agency?	
6	You know, and here's an example: You know, a small		6	DR. VAN DER JAGT: And that's	
7	community hospital, you know, because of insurance		7	part of the -- you know --,	
8	issues, says, well, you know, keep the diabetic		8	MR. CZAPRANSKI: Can we extend	
9	with D.K.A. there, you know, sort of mild D.K.A.,		9	that -- look at extending that, I think, to	
10	just keep them there versus transfer. Our hospital		10	pediatrics because I think that would force the	
11	will be on the floor, you know, with subspecialists		11	discussion at the local hospital about how will we	
12	there's a higher acuity in general there. It might		12	safely transport these patients we can't care for.	
13	be in the I.C.U. where it might be on the floor,		13	DR. COOPER: Well, this	
14	not taking -- being taken care of very well.		14	actually --	
15	Well, those things are going to		15	DR. VAN DER JAGT: This -- we	
16	come up. So, I think this not just -- just about		16	have --	
17	PICU mortality. There's that other group of kids		17	DR. COOPER: -- this -- this	
18	that may, just as well, need an interfacility		18	actually goes back to, you know --	
19	transfer, and it may not be at the community		19	DR. VAN DER JAGT: The survey	
20	hospital, although it could be depending on the --		20	done -- yeah.	
21	on the local expertise. So, just -- just another		21	DR. COOPER: -- hospital code	
22	aspect of this.		22	from the -- from the 1980s. This goes back to the	
23	DR. COOPER: Mr. Czapranski?		23	405.19 code. Hospitals that do not provide	
24	MR. CZAPRANSKI: Yeah. The --		24	specialty services are required to have transfer	
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1	EMSC, 12-8-2009		1	EMSC, 12-8-2009	
2	agreements --		2	DR. KANTER: And you know, I --	
3	DR. VAN DER JAGT: Transfer		3	just for those who haven't seen the -- the	
4	agreements.		4	paperwork that we have already been developing and	
5	DR. COOPER: -- with hospitals		5	circulating, we have a draft of interfacility	
6	that do. That's not something that's, you know,		6	transfer --	
7	uniformly enforced, but it -- it has been on the		7	DR. COOPER: Yes, we do.	
8	books for over twenty years.		8	DR. KANTER: -- agreements.	
9	DR. VAN DER JAGT: And these were		9	DR. COOPER: Right.	
10	surveyed, and then --		10	DR. KANTER: And it spells out in	
11	DR. COOPER: And what -- what the		11	some detail what kinds of patients would warrant a	
12	valued added here will be, through a formal process		12	consultation for transfer, and talks in some detail	
13	of regionalization, is in effect if you want to		13	about what the transporting equipment and personnel	
14	think of it this way, creating a giant statewide		14	ought to be like. The big gap in our draft	
15	single, you know, transfer agreement, if you will,		15	guidelines, are where should we send them? Because	
16	that, you know, while hospitals would still have to		16	we haven't really identified the hospitals.	
17	have individual agreements, it'll really spell out		17	DR. VAN DER JAGT: Sure. Of	
18	the -- you know, the what should be in -- in the		18	course.	
19	agreement to a much greater level of detail, and		19	DR. COOPER: Bob, I have -- I	
20	that would really facilitate, you know, the		20	have a couple of minor suggestions I'll share with	
21	Department's ability to ensure that -- that		21	you about the slides offline, but there is one	
22	transfers are made appropriately, and in a timely		22	comment I will make on the record that I haven't	
23	manner, and that when transfers are not indicated,		23	already made, and that is that it may be worth	

24	they don t need to be made.	24	citing our own research here in New York State,
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2	regarding the contribution of the PICU to trauma	2	Upstate in Syracuse, you take care of the -- the
3	care. We did publish that paper in Pediatric	3	critical part of the needs, are you expected to
4	Critical Care Medicine six, seven years ago,	4	keep the kid there throughout the entire recovery
5	showing that -- that it appeared anyway -- in	5	or ship them back to Ogdensburg, where they re
6	effect that it appeared that the presence of a PICU	6	home?
7	was -- was perhaps the most significant factor --	7	DR. KANTER: Well, again --.
8	or at least among the most significant factors in	8	MR. TAYLER: Because that -- that
9	terms of the improved outcome for trauma patients.	9	may be a piece that -- that you could --
10	And I think that will help drive	10	MS. GOHLKE: I can answer that.
11	the point home that, you know, well, we ve	11	MR. TAYLER: -- buy into the
12	regionalized, you know, critical care services for	12	what s in it for the community hospitals?
13	kids that the value there -- the primary value, may	13	DR. KANTER: Yeah. I -- I think
14	rest -- rest in -- in the pediatric critical care	14	we -- we sort of touched on that earlier.
15	capability, rather than the trauma system itself.	15	DR. COOPER: Yeah.
16	MR. TAYLER: Dr. Cooper?	16	DR. KANTER: For neonatology, I
17	DR. COOPER: Yes?	17	think there s a very large volume of kids who need
18	MR. TAYLER: Dr. Kanter, is -- is	18	to stay in the hospital for some time after their
19	it my understanding that -- that, in building this	19	critical care phase is done, and there s a fair
20	system, you re looking to get the kids that need	20	amount of evidence that reverse transport is
21	the higher level of care to the higher facility,	21	reasonable, safe, effective. There s much less
22	but is it the intent that the kid would then stay	22	information about that for other pediatric critical
23	there throughout the course, or for example, a sick	23	care, and in fact, the vast majority of pediatric
24	kid from Ogdensburg gets transferred to you at	24	critical care patients, when they get better, go
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2	home, not to another hospital. There are smaller	2	community, but no robust pediatric I.C.U.
3	numbers required for long hospital care, and that s	3	capability in that community; that s a perfect
4	usually just as labor intensive a	4	circumstance. But those -- those instances are
5	subspecialty-oriented thing.	5	uncommon.
6	MR. TAYLER: I was just looking	6	MS. GOHLKE: Can I just add that
7	for another -- another way to -- to buy in the	7	my grant -- it was one part of the performance
8	community hospitals into this. You know, what --	8	measure for, up until this year, that the kid had
9	what -- what would -- what would be in it for them,	9	to go back to their original home and get any
10	but just -- just a thought is all.	10	follow-up remaining care in the hospital there.
11	DR. COOPER: I think Mike -- Mike	11	But they since took it off, because I guess there s
12	does raise a good point, you know, there s --	12	reimbursement issues, and you -- and you can t --.
13	there s no reason that a -- that a child who is	13	DR. VAN DER JAGT: There are -
14	transported for an injury, you know, can t be back	14	cannot pay for it.
15	transported when the -- when the capability exists	15	DR. KANTER: As a performance
16	in the -- in the community to do the follow-up	16	measure, your --
17	care.	17	MS. GOHLKE: Right.
18	The problem, as you pointed out,	18	DR. KANTER: -- rate has been --.
19	Bob, is that for traumatic brain injury, and	19	MS. GOHLKE: So, they dropped
20	complex orthopedic injuries, that s -- that -- that	20	that --

21 is not normally the case, although in some

22 instances it is. I mean there are -- there are

23 areas in your own region, you know, where there are

24 really outstanding pediatric orthopedists in the

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21 DR. VAN DER JAGT: Right.

22 MS. GOHLKE: -- because it causes

23 too many problems. So, that -- would that be the

24 case --

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2 DR. VAN DER JAGT: Right.

3 MS. GOHLKE: -- at least as far

4 as the feds would want.

5 DR. COOPER: It always goes back

6 to money, doesn't it.

7 DR. VAN DER JAGT: Yeah. I would

8 have to echo what Bob says though, as I think that

9 the populations are extremely different. The

10 N.I.C.U. kinds of kids, they may be, you know, in

11 another hospital for six weeks or more after the

12 N.I.C.U. course. Most patients who come out of the

13 PICU, you know, then they go home within a week. I

14 mean, they're -- they're not really in the -- and

15 most parents actually, at least in our experience,

16 most parents do not want to be back transferred.

17 DR. KANTER: That is also

18 correct.

19 DR. VAN DER JAGT: They feel very

20 comfortable, they have bonded with the people there

21 at that medical center, even though it may be a

22 very short time, they don't trust going back. And

23 so, I think it would be, again, very different than

24 the neonatal, you know, but it will come up as a

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

3 answers.

4 DR. HALPERT: Because the whole

5 climate of this trust issue is real, too,

6 because --

7 DR. VAN DER JAGT: Right.

8 DR. HALPERT: -- their -- their

9 thought is that you sent my kid away in the first

10 place, because you couldn't handle him --

11 DR. VAN DER JAGT: Right.

12 DR. HALPERT: -- what makes me

13 want to give you my kid back now?

14 DR. VAN DER JAGT: Yeah. Yeah.

15 There is -- there is --.

16 DR. HALPERT: You didn't fix him.

17 You can't --.

18 DR. VAN DER JAGT: Exactly.

19 Yeah.

20 DR. HALPERT: It may not be --.

21 DR. VAN DER JAGT: And you have

22 to remember that the person who has to take care of

23 those children are the -- is a pediatrician who,

24 more and more, would prefer not to be in the

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1 EMSC, 12-8-2009

2 hospital, would prefer to be seeing outpatients.

3 DR. COOPER: That's correct.

4 DR. VAN DER JAGT: So, there's

5 another part of it.

6 DR. COOPER: All right. Unless

7 (sic) there are no more burning questions for Bob,

8 we're going to move on. I have been asked to take

9 a very, very short break, which we will do right

10 now, and we'll come back and attempt to complete

11 the remainder of the agenda in very, very short

12 order. It's three twenty-five, so no more than

13 five minutes, please.

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

15 (The meeting resumed at 3:30

16 p.m.)

17 DR. COOPER: We will now proceed

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1 EMSC, 12-8-2009

2 MS. BURNS: Okay. In my new

3 role, I have to tell you that the state is in a

4 fiscal crisis.

5 FROM THE FLOOR: Wow.

6 FROM THE FLOOR: Really?

7 MS. BURNS: Yeah. And I knew

8 that would come as a surprise to you.

9 With all -- all seriousness,

10 the -- the budget situation is -- is bad, and

11 continues to be bad. We have been, on a daily

12 basis, fighting for our contractors and our program

13 agencies. To date, twelve of them have been

14 approved, there are nineteen total. We thought

15 that, frankly, that once the -- the -- they started

16 to get approved, and money got freed up, that all

17 of them would be approved, but since the SEMAC

18 with the E.M.S. and -- E.M.S. report and E.M.S.C.
19 grant report.
20 In the interest of time, of which
21 we have precious little left, I will ask that Lee
22 Burns and Martha Gohlke touch upon the -- the key
23 highlights, so we will have time for the committee
24 reports.

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18 meeting, there's been no -- there's been nothing
19 new moving forward. So, we recommenced our battle
20 with the division of budget. And I -- as I told
21 the SEMAC and the SEMSCO, we have excellent
22 partnership with -- with the -- our bureau of
23 budget management, and to the point where they have
24 been hand-delivering contracts, and you know, they

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1 EMSC, 12-8-2009
2 have been doing all that they can do.
3 So, there is no good way to put
4 this, but it is the Department's intention to make
5 these sorts of meetings minimalist. They're
6 expensive, and they're looking at other options, so
7 keep your ears open. I -- you know, towards
8 conference calls, WebExs, those sorts of things.
9 In that same vein, we
10 experienced, much to our surprise, a sudden lack of
11 prehospital care paper reports. We supply them to
12 ambulance services. The warehouse -- we sent an
13 order to the warehouse, and they called us and
14 said, oh, yeah, we don't have any of those.
15 So, what had happened was our
16 print order had been approved in June, and because
17 of all of the budget issues, O.G.S.'s contract with
18 the new printer had never been approved. So,
19 we're -- we've been told that the order's been put
20 forth. P.C.R.s will be a little bit different.
21 They'll be in shades of gray as opposed to red and
22 black. But we're hoping to begin to receive
23 P.C.R.s in the not-too-distant future.
24 Ryan White. The Ryan White Act,

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1 EMSC, 12-8-2009
2 as you know, was reapproved by the feds. In an
3 effort to get a good handle on it, the SEMAC and
4 SEMSCO has -- has convened a technical advisory
5 group, which includes staff from our AIDS institute
6 who are experts in bloodborne diseases and the
7 regulations, so that there's more to follow with
8 that.
9 We discussed with our -- with the
10 SEMSCO particularly something called project
11 management. I think your group not necessarily so
12 important, because you're -- you have very focused
13 tasks for the next couple months, that is your
14 stakeholders meeting. But I would be remiss if I
15 didn't tell you that as you convene your meetings,
16 you need to stay focused, you need to stay on-task,
17 and you need to complete doable projects.
18 Our partners in the SEMSCO tend
19 to come up - I -- I victimize my friends in the
20 systems committee - we're going to change Part 800
21 and update that. Well, we need to do that, there's
22 no disputing that, but the reality is that you
23 can't update Part 800 in one year, or decade, and
24 so what we have -- what we're going to be doing

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1 EMSC, 12-8-2009
2 with the -- with our councils is just trying to
3 keep them focused and on-task and doing workable
4 and attainable projects.
5 You -- you may also have been
6 following the use of blood and blood products by
7 prehospital care providers. That continues. Ed,
8 just before he retired, went before the blood and
9 tissue council, they are very positive about the
10 regulatory change, which would include advanced
11 life support providers monitoring and
12 administering -- well, monitoring blood during
13 critical care transfers. So, that sort of
14 dovetails into your last discussion.
15 The next -- the regulations

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1 EMSC, 12-8-2009
2 I mentioned the respiratory
3 training program. Jim is out there doing -- it's
4 respiratory training and etiquette and fit testing
5 train-the-trainers. He did his first program in
6 Watertown at the end of -- well, I -- I think
7 Friday night. He was a little disappointed that
8 only eleven people showed up. I think -- and this
9 caught my attention as Tim was speaking earlier,
10 one of the issues from a prehospital care
11 perspective is that there's so much information,
12 all the time, that E.M.S. tends to focus on what is
13 interesting to them, and they lose interest in
14 things very quickly.
15 So, they're at a point where we

16 are -- are in the hands of our lawyers. The next
17 step is that they go to the Governor s Office on
18 Regulatory Reform. If there are no changes, they
19 get -- they get published for sixty-day comment
20 period, then they come back for final approval to
21 the blood council.
22 I m hoping that this occurs
23 sometime before summer of 2010. So, just to keep
24 you updated though, that does progress.

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16 have spent about a year now -- well, actually, more
17 than that starting with SARS and seasonal flu, you
18 know, barraging them with as much information as we
19 can, under the logic that more is better, and
20 they ll be better prepared, and now we re
21 concerned, as we usually are, when we get to this
22 point that all they re hearing is blah, blah,
23 blah, blah, blah. You don t have to commit that
24 to minutes.

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1 EMSC, 12-8-2009
2 So, that s a concern in this
3 training program. So, with the help of our county
4 coordinators and anybody who stands still long
5 enough, we re beating the bushes to get people to
6 these training classes.
7 Does that -- did you raise your
8 hand?
9 MR. CZAPRANSKI: No.
10 MS. BURNS: Oh.
11 MR. CZAPRANSKI: But all the
12 information the bureau puts down when we do all our
13 weekly updates, we par it down.
14 MS. BURNS: Thank you.
15 And we par it down, too.
16 MR. CZAPRANSKI: Okay.
17 MS. BURNS: We, with the help of
18 the SEMAC, are about to update our medical
19 direction policy statement, which you may or may
20 not be familiar with. It was put out a couple
21 years ago -- a while ago actually. This actually
22 Jeanne Alicandro from Suffolk County helped me put
23 it together. It s essentially a policy statement
24 to assist E.M.S. service medical directors in

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1 EMSC, 12-8-2009
2 understanding really what the job is, what their
3 responsibility is.
4 Yeah. The one you re thinking of
5 is decades. A decade and a half.
6 What we did, we updated the
7 medical director policy statement specifically to
8 address -- it -- it -- it did not exclude pediatric
9 patients, but it didn t encourage pediatric
10 patients. So, we ve updated it with some minor
11 changes to include patients of all ages. That also
12 comports with the E.M.S. for children grant
13 process.
14 Also of interest to you, is that
15 the SEMAC brought forward a proposal that was
16 approved by the council to -- to amend Part 824,
17 that s the equipment on ambulance -- ambulances
18 regulations, to include -- and two -- these are two
19 separate regulatory changes, one is to require an
20 A.E.D. capable of defibrillating patients of all
21 ages, or a defibrillator capable of defibrillating
22 patients of all ages, and the second was to require
23 that all ambulances carry EpiPen or epinephrine for
24 patients of all ages.

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1 EMSC, 12-8-2009
2 There is some wording to that.
3 We are working with them to do that. And as a part
4 of that, we may bring forward to the SEMSCO --
5 an -- an -- we re planning on bringing forward to
6 the SEMSCO an updated equipment list, which will
7 clearly visit the federal suggested guidelines for
8 pediatric equipment, specifically at the B.L.S.
9 level, because the regulations are basic life
10 support. So, it won t -- it won t address A.L.S.,
11 but we ll do what we can to address the -- the
12 B.L.S. needs.

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1 EMSC, 12-8-2009
2 we re about this close to an executed contract with
3 a company who will assist New York State in
4 developing a state bridge, which will allow us to
5 take data from all different types of vendors, put
6 it into a NEMSIS-compliant dataset, push it to
7 NEMSIS, and improve our prehospital data collection
8 abilities and the data that we re collecting, and
9 that s also covers your agenda item on NEMSIS
10 DR. COOPER: Thank you.
11 So, I presume that that is a
12 bridge to somewhere as opposed to a bridge to

13 And we ll -- we ll -- there ll be
14 more on that. And just so you know, New York s --
15 the SEMAC approved New York City protocols - jump
16 in here - that allow B.L.S. ambulances who -- who
17 are already equipped with EpiPens to utilize them
18 in -- in a severe asthmatic attack after they ve
19 done the Albuterol nebulizer. So, that protocol
20 updates the New York City B.L.S. protocols.
21 And the last thing I have is
22 we re very excited -- as I was sitting here, our
23 G.T.S.C. grant, which has to do with electronic
24 data collection and the NEMSIS dataset, we have --

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1 EMSC, 12-8-2009
2 it s -- it is not age -- it is to all patients, but
3 the age -- thirty-three jumps into my mind, and I
4 can t remember why.
5 MS. CHIUMENTO: Yeah.
6 Thirty-three, I think, was the maximum -- that they
7 can give them without medical control. Over
8 thirty-three they added medical control.
9 DR. HALPERT: So, it s a standing
10 order for E.M.T.s to utilize Epi auto-injector up
11 to age thirty-three in the setting of respiratory
12 stress questionable, or is probable, in asthmatics
13 as your -- something like that.
14 MS. GOHLKE: I think they re --
15 like that.
16 MS. CHIUMENTO: You know, Ann s
17 shaking her head over here, so she may be more
18 specific than -- but that was my recollection of
19 the discussion, so --
20 DR. HALPERT: Okay.
21 MS. CHIUMENTO: -- go ahead.
22 MS. FITTON: I d be happy to look
23 at the protocol for you, but I believe the issue
24 was that, first of all, the downside --

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1 EMSC, 12-8-2009
2 adult, particularly an adult less than
3 thirty-three, thirty-three was based on the
4 American Heart age for patients who should be
5 getting aspirin, et cetera, for chest pain, where
6 we think that chest pain at thirty-three and above
7 has a higher significance of having a -- a cardiac
8 implication, therefore, thirty-three became the
9 cutoff for this, based on A.H.A. criteria. So --

13 nowhere?
14 MS. BURNS: Hopefully it s lot
15 cheaper than the bridge to nowhere.
16 DR. COOPER: Martha?
17 Oh, any questions for -- for Lee?
18 DR. HALPERT: Yeah.
19 DR. COOPER: John.
20 DR. HALPERT: Yeah. A question
21 on the New York City epi auto-injector program you
22 mentioned. Would that be specific to pediatrics,
23 or that s all players, or --?
24 MS. BURNS: I think what they --

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1 EMSC, 12-8-2009
2 MS. GHOLKE: Ann, could you just
3 grab a mic?
4 MS. FITTON: -- is that with
5 EpiPens for asthma patients is that we need to put
6 the education piece in there as well as making sure
7 that we re only doing this in the event that we
8 cannot get an A.L.S. resource there.
9 DR. HALPERT: Uh-huh.
10 MS. FITTON: So, the -- you know,
11 it s not -- it s -- it s -- the discussion here is
12 almost as though E.M.T.s would be just
13 administering epi on the basis of their assumptions
14 that this is an asthma call.
15 DR. HALPERT: Right.
16 MS. FITTON: There are specific
17 criteria for them to be able to do this. It has to
18 be, first of all, a demonstrated inability of the
19 system to deliver an A.L.S. resource to their
20 location in a reasonable time. And I believe that
21 time -- and, again, I m speaking for E.M.S.
22 operations here, I might be a little bit off of for
23 this, but within a ten-minute upper -- upper limit.
24 So, if you have a child, or an

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1 EMSC, 12-8-2009
2 MS. FITTON: Yes, that s also
3 based on criteria that there has to be history of
4 asthma --
5 MS. BURNS: I think there is a
6 low end.
7 DR. COOPER: Yeah.
8 MS. FITTON: -- there has to be a
9 diagnosed history of asthma, et cetera. So --

10 so, it s -- it s -- it s just not that simple --

11 that -- that -- that simplistic, that E.M.T.s will

12 be delivering epinephrine. It is that the system

13 is so overworked that we re unable to deliver that

14 A.L.S. care.

15 DR. COOPER: Was -- was there s a

16 low-end age on that?

17 MS. FITTON: That -- that -- that

18 has yet to happen. I d just like to tell you that

19 that is yet to happen.

20 DR. COOPER: Okay. But there s

21 no low-end age on that? That s age zero that

22 they re --?

23 MS. BURNS: I think there is a

24 low end age.

10 MS. BURNS: It think there was a

11 low end.

12 MS. FITTON: -- it -- it would

13 be --

14 MS. BURNS: I don t remember what

15 it was but there was --,

16 MS. FITTON: I believe the lowest

17 age is -- is age one.

18 DR. COOPER: Okay. All right.

19 Martha?

20 MS. GOHLKE: Just want to draw

21 your attention to the dates for next year that --

22 it s an all inclusive list, that includes our other

23 council meetings, so you just scan through, you ll

24 see E.M.S.C. in there. The May 4th date is going

1 EMSC, 12-8-2009

2 to be by Webinar, which Mr. Tayler is going to

3 help -- help me learn how to do with you all folks

4 as guinea pigs from the E.M.S.C. committee. So,

5 you can plan accordingly. You -- you won t need to

6 travel on that day. You just need to --,

7 DR. VAN DER JAGT: I'm sorry.

8 Which date was that?

9 MS. GOHLKE: May 4th.

10 MR. VAN DER JAGT: May 4th.

11 DR. COOPER: Martha, may I just

12 suggest that we might want to consider, since it s

13 going to be by Webinar rather than in person, and

14 the hotel dates don t matter, that maybe we move it

15 after the stakeholder meeting.

16 MS. GOHLKE: No, I don t think

17 it s a good idea. I strategically put it there in

18 case there was last minute details that we need to

19 take care of or talk about, and being that it s by

20 Webinar, it s a good way.

21 DR. COOPER: Okay.

22 MS. GOHLKE: It won t cost

23 anybody to touch base.

24 And if the feds don t look upon

1 EMSC, 12-8-2009

2 my stakeholders meeting as one of the four

3 quarterly meetings of this committee, you can fall

4 back on the Webinar as being the fourth meeting and

5 we meet the grant requirement.

6 DR. COOPER: Okay.

7 MS. GOHLKE: So, there s --

8 there s many reasons why to keep it on the

9 calendar. So -- and then -- what else did I want

10 to say?

11 Oh, the -- the -- the

12 stakeholders meeting -- we d love to have everybody

13 there. We have limited funding, okay, to -- to get

14 everybody there, but if you -- if you really want

15 to be at the table, just let me know now, so I can

16 start planning and figure out how we re going to

17 pay for travel for you to be there. We -- we may

18 possibly be able to get everybody there, but it

19 depends on a lot of other factors. The money is

20 coming directly from the grant, which your travel

21 now doesn t come from the grant for these meetings,

22 so there s a little balancing act we have to do.

23 So, I just wanted to mention that.

24 I just wanted to let you know

1 EMSC, 12-8-2009

2 that the -- the Caris Foundation, and their --

3 their steroid for the adrenal insufficiency went

4 through the SEMAC and SEMSCO last week with Dr.

5 Cooper s revisions that he made to our document

6 that -- the document that got approved is in your

1 EMSC, 12-8-2009

2 going to have a chance to give any input on it.

3 So, if you want to -- if you want to give input,

4 please e-mail Sharon as soon as possible, so you

5 can -- so you can be heard.

6 I just wanted to mention, because

7 folders there, if you re curious. It just puts
8 Solu-Cortef on the state formulary for A.L.S.
9 providers, and it opens the door for them to put it
10 on their regional protocols, if they so choose.
11 So, it s still a regional
12 decision whether or not it s going to be, you know,
13 in the standing orders or not, but at least it
14 opens the door, and it lets them know that we think
15 it s a good idea. Okay.
16 So, the NEMSIS data, the only
17 thing I want to add to what Lee talked about is
18 Sharon has been helping out with this a lot, and
19 you know, we ve put it to your -- in front of your
20 noses for your input. Now, is the time -- if -- if
21 E.M.S.C. folks want input to what data --
22 prehospital data we re collecting in the state
23 because we re -- we re revising what we re doing,
24 now is the time; okay? Because shortly you re not

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1 EMSC, 12-8-2009
2 add -- we talked about this a meeting or two ago,
3 one of the grant requirements was that transporting
4 vehicles have -- for children have to have their
5 protocols accessible to them on the scene and
6 during transport, so we ve added that to the
7 medical direction policy of the bureau, that it has
8 to be either on the person or on the rigs, you
9 know, for the sake of children. And adults, we
10 have them for both, but it came from this grant for
11 children. So, we did get that -- we did get that
12 on board, literally.
13 We talked a lot about extra
14 money, and the fact that the federal E.M.S.C.
15 program believes that they re going to be funded
16 better than ever in the coming year. We re still
17 on, I guess, what s it s, continuation funding -- I
18 can t remember what the proper terminology is, so
19 2010 funding hasn t gone through yet. I e-mailed
20 the project officer, and let her know that we had a
21 bunch of ideas that we ve been tossing around that
22 we would like to know how we could get access to
23 any extra funding, and she said she ll let us know
24 as soon as possible. So, at least we got a seed

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1 EMSC, 12-8-2009
2 DR. COOPER: Thank you, Martha.
3 Subcommittee reports, I think
4 we ve covered in interfacility. I ll just say for

7 this -- many of the nurses in the room may find
8 this interesting. You can get your mandated
9 reporter training online for free as your
10 recertification or C.M.E. requirements through
11 State Ed. The Office of Children and Family
12 Services has a two-hour C.M.E. program for mandated
13 reporters.
14 A link, if it s not on our Web
15 site now, it will be shortly to the online
16 training. It s free. It s twenty-four/seven. You
17 can take it at your own pace. It goes directly to
18 State Ed letting them know that you ve taken it --
19 taken it, and they can track it if you need to with
20 them, and you can also print out a certificate, and
21 it s available for E.M.S. providers, too. It s
22 like nysmandatedreporter.org, I believe. But you
23 can find it on our Web site.
24 Let s see. We did add -- we did

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1 EMSC, 12-8-2009
2 planted, and she knows that we re eager to hear
3 more about it.
4 I talked about the stakeholders
5 meeting. So -- and one other comment is just that
6 the subcommittee meetings in the morning, you know,
7 we re restructuring this meeting that we start the
8 general meeting at eleven, and we do subcommittees
9 early. There were several people here that were on
10 time that are part of subcommittees that the rest
11 of the subcommittee wasn t here. So, either
12 they -- they didn t get the communication on what
13 time people were collecting -- I just don t think
14 it s fair that some people are, you know, showing
15 up on time and not getting the communication
16 whether or not their subcommittee s meeting, or if
17 it s meeting at nine-thirty or ten, or you know,
18 it s just -- so keep that in mind, especially the
19 chairs, that you ve got to communicate better with
20 your committee, and let them know what time you re
21 meeting, because it s -- it s not fair, for
22 travel -- people have to get up at an insane hour
23 to get here. So, just out of respect for them.
24 Okay. That s it.

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1 EMSC, 12-8-2009
2 more chronic care needs later on. So, if somebody
3 need to be going over because of rehab, that might
4 be, you know, a different set of needs then for

5

Nominations, that the Nomination Committee meeting

6

did meet this morning, and came up with several

7

potential names.

8

Sharon and Ann, Education?

9

MS. CHIUMENTO: Yes. I had sent

10

out a patient transfer decision table. This is a

11

first -- a first go at trying to take some of the

12

different categories of patients that are out there

13

in the literature already, and trying to see what

14

would be the needs so we can start to develop

15

educational documents for hospitals, you know,

16

prehospital environments, ambulatory care centers,

17

all that type of thing.

18

The first go-around is primarily

19

for the hospitals, so interfacility transfer either

20

from E.D. to E.D., or interfacility from a -- from

21

a floor. Originally, I was going to try to do one

22

be all end all. In our discussions, we kind of

23

decide that maybe it would be better to look at the

24

acute care settings first, and then look at the

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5

somebody who's going because of acute care -- of --

6

of fractures, or whatever it might happen to be.

7

So -- so, we're going to look at more the acute

8

setting.

9

I -- I have some copies of the

10

document. I would really like everybody's input

11

because, you know, obviously, we're all coming from

12

different backgrounds. Those of you who are

13

in-hospital folks are going to have a much better

14

idea of what you want to see in patients who are

15

coming to you. What kind of needs you, you know,

16

what kinds of -- of transport will they need -- all

17

that type of thing.

18

So, the -- I'll -- I'll pass

19

around -- I think I have eight copies here, so

20

anybody who's interested in having a copy, based on

21

some of the changes we made today, I will do an

22

updated document, and we'll send that one out by

23

e-mail. But if you want this, so that you just

24

have something on -- on hand to start looking at,

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1

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2

please -- please -- please take it. And then, once

3

we finish that, then we'll move on to the other --

4

the other populations that would be transferring

5

patients, such as -- such as ambulatory care

6

centers. So that's where we are at the moment.

7

And please, any input you can

8

give us, that would be really useful. Okay.

9

DR. COOPER: Thanks.

10

Okay. Under old business, the

11

E.M.S.C. dialogues, we were able to get the -- the

12

approval of the Division of Legal Affairs to allow

13

us to maintain the behavioral health specialist as

14

one of our members in a voting capacity. The

15

language seems a little bit awkward, so we have

16

made a suggestion to some alternative language, and

17

we'll see how that flies. But in concept it seems

18

as though it has been approved, so we will put that

19

on hold until the next meeting.

20

The NEMSIS data -- data elements

21

have already been covered.

22

Before we go to new business,

23

we'll briefly touch upon SEMSCO, SEMAC and STAC, I

24

think most of the key issues from -- from SEMAC

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1

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2

have been covered. Our major issue was the -- was

3

the Caris protocol, which as you heard, was

4

approved. And I think other issues have been

5

made --.

6

MS. CHIUMENTO: I had just a

7

couple --

8

MR. COOPER: Sharon, go ahead,

9

please.

10

MS. CHIUMENTO: -- things.

11

The E.M.C. guideline on education

12

on new drugs -- so, a new drug is added into a

13

particular regions protocols, there -- there is now

14

a standardized format for how they're going to

15

educate their -- their providers on the use of that

16

drug; indications, counterindications, side

17

effects, all the kinds of things that we would

18

normally see when a new drug comes on the market,

19

is now a standardized format for E.M.S. as well.

20

In the past, it's been whatever

21

they felt like educating, or however they wanted to

22

train, and there was no formalized mechanism. Now,

23

there will be a formalized template that they can

24

use.

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2

There was a naloxone demo project

3

that was intranasal naloxone by B.L.S. providers in

4

the Albany region. So, that s something that will

5

be looked at. It s not going to affect most of our

6

patients, but it could affect some of our

7

adolescent population.

8

And then, there was a discussion

9

on Tamiflu distribution by E.M.S. in epidemic

10

situations. And again, right now, it s just the

11

preliminaries to getting the information together.

12

It would be information that would be provided to

13

regions, and then the regions would have to then

14

make the decisions as to whether or not to utilize

15

that -- that mechanism if there was an epidemic.

16

So, those are just couple of

17

other little things we touched on.

18

Oh, one other thing and that s

19

protocols. Please, the pediatric protocols that I

20

sent out, did not get discussed at this last SEMAC

21

meeting. The next SEMAC meeting is before our next

22

E.M.S.C. Committee, and I know Dr. van der Jagt was

23

looking at some of them last night, did find a

24

couple of issue that he (sic) was -- some concerns

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2

he (sic) had. Please get those back to me, so that

3

when we get to discussing that at the -- at the

4

SEMAC and at the Medical Standards, I will be able

5

to back -- bring back the input of this group as to

6

whether or not something that s in the protocol is

7

either not safe, or not recommended, or whether we

8

want to make a recommendation that s not currently

9

in the protocols.

10

DR. VAN DER JAGT: Uh-huh.

11

Sharon, could I just comment on that?

12

Sharon s, as usual with his

13

excellent work on all these prehospital care

14

protocols is just outstanding. I would really

15

endorse what Sharon says, because as you go through

16

these prehospital care protocols, which is

17

basically a -- a compilation of everything that is

18

out there, it is quite amazing what people are

19

allowed to do in their various areas. I was pretty

20

floored actually last night.

21

All the way from, you know,

22

R.S.I., which is, of course, understandable for

23

paramedics particularly, but then there s, you

24

know, procedural sedation, there s antibiotics

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1

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2

being given, there s -- I mean there s all kinds of

3

things in these protocols, and I -- there are

4

dosing issues. There are a lot of dosing problems.

5

So, I would -- again, I think one of the reasons we

6

have this Committee is to make sure that we have

7

input into these prehospital care protocols,

8

because if mistakes get made, or if there is a

9

problem out there prehospital care, you may not

10

have a good outcome, and that makes me very

11

worried, so --.

12

DR. HALPERT: I would just add as

13

a continuance to that, having attended a few of

14

those meetings as an observer, I think they are

15

fairly comprehensive in their review of these

16

protocols. It would surprise me if there are

17

tremendous discrepancies, or concerns or mistakes

18

out there. It s taken me a while to get my arms

19

around the fact that a state body is really

20

actively reviewing and trying to standardize all

21

these protocols. I m kind of a -- a local medical

22

control guy historically, but be it as it may, I --

23

I -- I think it s -- it would be great for us to

24

sit down and review these ourselves, so that we are

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1

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2

confident at our level that things are -- are

3

squared up and by the book. But so far, it seems

4

like at least there s been a fair amount of vetting

5

of these protocols through the state mechanism.

6

DR. VAN DER JAGT: All I can say

7

is read what Sharon has put together.

8

DR. COOPER: Point well -- points

9

well noted by both. Thank you.

10

With respect to STAC, the work in

11

the STAC is focused, I think, on three major things

12

at the present time: First, the ongoing rewriting

13

of the regulations. Second, formation of joint

14

group with the SEMAC to look at prehospital

15

tourniquet use. And third, the development and the

16

review of the -- of a potential paper survey that s

17

going to go out to all trauma centers to provide an

18

interim look at trauma center operations in between

19

formal on-site visits.

20

The Education Committee continues

21

to do its good work in terms of arranging for

22

prehospital trauma care programs for the Vital

23

Signs Conference, and the Registry Committee

24

continues to do its excellent work in terms of

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2	updating the registry to keep it, you know,			2	adjourned until our next meeting, which is, Martha,		
3	consistent, timely and consonant with the national			3	on --?		
4	trauma dataset.			4	MS. GOHLKE: March 2nd.		
5	Mike, are there any other key			5	DR. COOPER: March 2nd, here at		
6	issues that you feel --			6	the Crowne Plaza.		
7	MR. TAYLER: No, that was it.			7	Okay. Thank you very much. And		
8	DR. COOPER: -- you --?			8	we will see you all then. In the meantime, have a		
9	MR. TAYLER: I mentioned it.			9	healthy and happy holiday season. And if you are		
10	MS. GOHLKE: Okay.			10	driving home this evening, please be careful, it s		
11	DR. COOPER: Thank you. So --			11	my understanding that a storm is anticipated.		
12	MR. TAYLER: That s complete.			12	(The meeting concluded at 4:02		
13	DR. COOPER: -- so, I believe we			13	p.m.)		
14	have covered everything on the formal agenda.			14			
15	I will now combine the new			15			
16	business and round robin sections of our meeting.			16			
17	We are two minutes over time, I apologize for that.			17			
18	But I do think we ve got the rest of the agenda			18			
19	done in pretty record time. Thank you all for			19			
20	cooperating in that endeavor.			20			
21	Is there any new business?			21			
22	Does anybody have anything that			22			
23	they want to add to our deliberations today?			23			
24	Well, hearing none, we will stand			24			
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2	I, Howard P. Hubbard, do hereby certify that the			abbreviate 135:20	135:13 162:4,4	adolescent 92:19 233:7		
3	foregoing was taken by me, in the cause, at the time			abbreviated 135:21	acts131:9	adrenal 225:3		
4	and place, as stated in the caption hereto, at Page 1			abilities218:8	actual 14:6 23:11 27:4	ads 70:14		
5	hereof; that the foregoing typewritten transcription,			ability 34:5 107:16	52:9	adult 15:13 162:14		
6	consisting of pages number 1 to 238, inclusive, is a			150:11 201:21	acuity 199:12	165:11 166:3,17 172:5		
7	true record prepared by me and completed by			able4:17,18,18 36:24	acute13:2 14:21 16:2	174:11 221:2,2		
8	Associated Reporters Int'l, Inc. from materials			97:3 112:4 136:14	26:5 36:12 38:8 43:11	adults 10:2 121:15 147:4		
9	provided by me.			156:7 166:7 172:2	43:12 46:13 51:21 52:3	227:9		
10	BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB			183:10 185:11 186:13	62:15 91:20 96:8	advanced 115:2 143:21		
11	Howard P. Hubbard, Reporter			220:17 224:18 231:11	229:24 230:5,7	213:10		
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