1 5/4/2022 – STAC Meeting - WebEx
2 NEW YORK STATE
3 DEPARTMENT OF HEALTH
4 STATE TRAUMA ADVISORY COMMITTEE MEETING
5
6 DATE: May 4, 2022
7 TIME: 1:14 p.m.
8 CHAIR: Dr. Patricia O'Neil
9 VENUE: WebEx
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2 APPEARANCES:
3 Dr. Patricia O’Neil, CHAIR
Peter Brodie, Host
4 Jack DeMay, Co-host
Abby Rothwell
5 Abnamar Arrillaga
Adam Oplinger
6 Alexander Kaczor
Alexandra Kim
7 Alicia Broadbent
Altin Gonja
8
Amanda Brooks
Amanda Zilnicki-Ceckowski
9
Ambika M.
10 Amy Eisenhauer
Andrea Tobin
11 Anna Barker
Ariel Goldman
12 Arlene Brown
Arthur Cooper
13 Bashar Fahoum
Beth Moses
14 Bethlehem Emmons-Post
Blanca Agosto
15
Blanca Marichal
Brenda Vargas
16
Brooke Nelson
Carrie Castor
17
Carrie Garcia
18 Cherisse Berry
Christine Russo
19 Clarence Avendanio
Colleen Savage
20 Cristy Meyer
Dana Hrycko
21 Daniel Clayton
Daniel Genovese-Scullin
22 Dave Briscoe
Dawn Johnson
23
Debora Lori
Deborah Kufs
24
Dekeya Slaughter
25 Desiree Catalano

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2 Donald Doynow
Donna Kahm
3 Donna Porcelli
Eden Marden
4 Eileen Vetack
Eileen Van Auken
5 Elena Morris
Ellen Jordan
6 Emily Smith
Eric Cohen
7 Eric Klein
Frank Manzo
8
Frank Monaco
Gary Hecker
9
George Agriantonis
10 Glennys Espinal
Gloria Musilli
11 Irisa Berisha
James Baker
12 James Vosswinkel
Jamie Ullman
13 Jane Riole
Jared Hier
14 Jason Allen Winslow
Jennifer Feliciano
15
Jennifer McKillop
Jill Hayward
16
Jill Rivera
Jinky DeCastro-Singson
17
Joanne Scarpinato
18 John Fisher
Jose Prince
19 Joseph Bove
Josetta Dufus
20 Judy Lussier
Julia Solby
21 Julia Vincent
Kaitlyn Restaino
22 Kartik Prabhakaran
Kat Gonzalez
23
Kate Dellonte
Kate Maguire
24
Kerrie Snyder
25 Kim Wallenstein

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2 Kristi Ladowski
Kristin Farrugia
3 Kurt Edwards
Lamarcia Parkin
4 Lambros Angus
Lauren Wittman
5 Leon Bowman
Lindsay Quinnell
6 Lisa Cappolino
Lolita Gole
7 Lynn Model
Lutisia Croft
8
Lynn Pellicci
Mabelle Pizzutiello
9
Maggie Ewen
10 Manjola Laci
Marc Gestring
11 Marc Musicus
Marcia Lewis
12 Margaret Vercruysse
Maribel Contreras
13 Marisa Easop
Mary Yves
14 Matthew Bank
Matthew Conn
15
Meghan Mullen
Melaina King
16
Michael Daily
Michele Schombs
17
Michelle Capestany
18 Michelle Mann
Miranda Wasilenko
19 Mitchell Price
Neysha Fletcher
20 Paris Ayana-Dattilo
Patricia Riley
21 Patricia Salajka
Praise Nesaany
22 Rachael Podsiadlo
Raymond Smith
23
Rebecca Wager
Robert Davis
24
Robert Finkelstein
25 Robert Graham

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2 Robert Madlinger
Robert Winchell
3 Ronald Simon
Roseanna Guzman
4 Ryan Greenberg
Samantha Pulliam
5 Sandra Oranvil
Sarah Peterson
6 Sharon Valentine
Sheldon Teperman
7 Sonia Nash
Stacey Pinto
8
Stacie Gell
Stephen Brucato
9
Steven Monsam
10 Susan Henderson
Susan O'Connell
11 Susan Sesto
Susan Simmons
12 Tafford Oltz
Tamara Roberts
13 Tammy Trombley
Tania Dufour
14 Theresa Allen
Tiffany Fabiano
15
Tony Knight
Tracy Beier
16
Valerie Ozga
Vincent Ouimette
17
Vladimir Rubinshteyn
18 William Flynn
William Hallinan
19 Yashani Singh
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2 (The meeting commenced at 01:14 p.m.)
3 MR. GREENBERG: Morning, this is a
4 reminder to everybody at the very, very beginning,
5 please make sure, for back-end’s assistance, to say
6 your full name when you do speak. I know we are on
7 WebEx, and it does have the names underneath but it
8 does help her in that process.
9 So please make sure that -- that you
10 do. For those who are Bennett members, it is
11 strongly encouraged for you to be on camera while you
12 are -- while you're speaking or while you're
13 participating in the conversation.
14 And I will now pass it off to ...
15 anything else.
16 MR. CLAYTON: Thank you, Director
17 Greenberg. Dr. O'Neil as acting chair, would you
18 like to call the main ...?
19 MS. O'NEIL: Yes, I officially call
20 the staff meeting to order. Can we proceed with the
21 roll call attendance?
22 MR. CLAYTON: Dr. O'Neil?
23 MS. O'NEIL: O'Neil is here.
24 MR. CLAYTON: Dr. Doynow?
25 MR. DOYNOW: Here.

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2 MR. CLAYTON: Dr. Winchell?
3 MR. WINCHELL: Here.
4 MS. O'NEIL: For the stenographer, can
5 you put your name before you -- your response?
6 MR. CLAYTON: Dr. Ullman?
7 MS. ULLMAN: Ullman is here.
8 MR. CLAYTON: Dr. Goldman?
9 MR. GOLDMAN: Goldman is here.
10 MR. CLAYTON: Dr. Cooper?
11 MR. COOPER: Dr. Cooper is there.
12 MR. CLAYTON: Dr. Daily?
13 MR. DAILY: Dr. Daily is here.
14 MR. CLAYTON: I believe Jolene Kiddle
15 is absent, excused. Jolene, are you on by any
16 chance?
17 MS. O'NEIL: I believe she is attending
18 T.C.C.A.
19 MR. CLAYTON: That's correct. I just
20 wanted to check. Dr. Wallenstein?
21 MS. WALLENSTEIN: Dr. Wallenstein is
22 here.
23 MR. CLAYTON: Dr. Flynn?
24 MR. FLYNN: Here.
25 MR. CLAYTON: Dr. Gestring?

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2 MR. GESTRING: Gestring here.
3 MR. CLAYTON: William Hallinan?
4 MR. HALLINAN: Hallinan is here.
5 MR. CLAYTON: Kerrie Snyder?
6 MS. SNYDER: Kerrie Snyder is here.
7 MR. CLAYTON: Dr. Angus. Dr. Angus is
8 having technological issues getting in. We'll come
9 back to him. Dr. Bank?
10 MR. BANK: Dr. Bank is here.
11 MR. CLAYTON: Dr. Arrillaga?
12 MR. ARRILLAGA: Arrillaga is present.
13 MR. CLAYTON: Dr. Vosswinkel? We'll
14 come back to Dr. Vosswinkel. I think he is having
15 technological issues as well. Dr. Prince?
16 MR. PRINCE: Present.
17 MR. CLAYTON: Dr. Agriantonis?
18 MR. TONUS: Dr. Agriantonis is here.
19 MR. CLAYTON: Dr. Simon?
20 MR. SIMON: Simon is here.
21 MR. CLAYTON: Dr. Teperman?
22 MR. TEPERMAN: Teperman is here.
23 MR. CLAYTON: Tammy Sikes? Dr.
24 Vosswinkel? Dr. Vosswinkel, are you on? You might
25 be muted.

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2 MR. VOSSWINKEL: On. Yes, yes, I'm
3 on. Thank you. I was having technical difficulty.
4 MR. CLAYTON: Thank you, Dr.
5 Vosswinkel. So roll call complete. We have quorum.
6 MS. O'NEIL: Okay. So, you should all
7 have received a copy of the minutes from our prior
8 meeting, which -- it's hard to believe it was October
9 2021.
10 So does anyone have any corrections or
11 edits to the minutes that they want to bring to our
12 attention? Hearing no response, can I have a motion
13 to approve the minutes?
14 MR. BANK: Motion to move.
15 Ms. O'NEIL: A second?
16 MR. BANK: To approve the minutes,
17 sorry.
18 MR. TEPERMAN: Teperman seconds.
19 THE REPORTER: I'm sorry. Who -- who
20 made the motion.
21 MR. BANK: That was me. Matthew Bank.
22 THE REPORTER: Thank you.
23 MS. O'NEIL: And Teperman second.
24 MR. TEPERMAN: Teperman second. Dr.
25 Teperman.

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2 MS. O'NEIL: All in favor say aye?
3 (All in unison saying aye)
4 MS. O'NEIL: Okay. The minutes are
5 accepted. So we're going to go a little bit out of
6 order from the published agenda. What I'd like to do
7 now is spend a few moments to honor a great friend
8 and colleague of ours that, Bill Marks, that before
9 we proceed with the rest of the meeting, I just like
10 to dedicate a few moments to honor his memory.
11 As you know, Bill passed away
12 unexpectedly on February 9th, you know, it certainly
13 came as a shock to his family, to his trauma team and
14 to all of us. So let me share a few facts. Can we
15 put up his photo? Thank you.
16 So let me share a few facts about Bill
17 that some of you may or may not know already. So Dr.
18 Bill Marks was born on October 3rd, 1951, in St.
19 Louis, Missouri. He was actually raised by his
20 grandparents. His grandfather was a physician, which
21 is where he developed his passion for medicine.
22 And growing up, Bill, was a love of --
23 had a love of the outdoors. And it's not really
24 surprising that he was drawn to the Boy Scouts. It's
25 even not surprising that he rose to the rank of Eagle

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2 Scout.
3 And in fact, if you -- I think I can
4 just picture Bill in his Boy Scout uniform. He sort
5 of exemplifies our image of the American Boy Scout.
6 After high school, Bill completed his undergraduate
7 degree from the University of Missouri and his D.O.
8 from the University of Health Sciences at the College
9 of Osteopathic Medicine.
10 Bill then accepted an Army Medical
11 scholarship and completed his surgical training
12 including his critical care fellowship at the
13 Letterman Army Medical Center in San Francisco,
14 California.
15 After his training, he relocated
16 completely east, to the East Coast and in 1993, Bill
17 joined the faculty at SUNY Upstate Medical Center,
18 where he actually remained for the next thirty years,
19 working continuously between the Upstate and the
20 Syracuse, Syracuse V.A. campuses.
21 During these years, Bill's
22 accomplishments are actually too many for us to cite
23 here today. But I do want to highlight his
24 dedication and service to essentially three
25 organizations beyond his contributions to Syracuse

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2 team, and that really reflect him as a person and as
3 a surgeon.
4 First is his commitment and service to
5 the military. Bill had a twenty-two-year
6 distinguished career in the U.S. Army Medical Corps.
7 He served in Operation Desert Storm and rose to the
8 rank of Lieutenant Colonel before he retired in 2001.
9 The second is dedication to the
10 American College of Surgeons, where he served both on
11 the Board of Governors in addition to his
12 contributions to the committee on trauma. Bill first
13 served as the New York upstate Chair of the Committee
14 on Trauma Regional Committees, and then served a two-
15 year term as the Chief of Region II, which included
16 New York, New Jersey, and Puerto Rico.
17 He was subsequently served as -- as a
18 reviewer for the Verification Committee of the
19 C.O.T., and most recently served as the chair of the
20 V.R.C., during which time as you know, he played a
21 major role in the formation and the publication of
22 the new two hundred and twenty-two trauma center
23 verification standards.
24 And finally, and to us, probably the
25 most important is recognizing him for his long-

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2 standing commitment to shaping the New York State
3 trauma system and assuring equal access and quality
4 of care to all trauma victims within the -- within
5 the -- within the State.
6 I'm not sure exactly what year Bill
7 began his participation in -- in the STAC. I believe
8 it was around 1994-1995 but many of you who have been
9 on the committee as long as we have may remember that
10 in those early years, Bill actually volunteered and
11 did cite back at the time when the State did their
12 own verification visits.
13 Bill volunteered and along with Ed
14 Ronski went to every single downstate trauma center
15 to confirm that they met the State verification
16 standards. Subsequently in 2006, Bill was elected as
17 our state chair and he had served twelve years in the
18 role of our state chair.
19 Over that time, he served under three
20 different health commissioners, three bureau chiefs,
21 Ed Ronski, Lee Burns and now Ryan Greenberg. And I
22 think his biggest contribution and his legacy will be
23 his -- his accomplishments in leading the STAC and
24 the New York trauma system to the American Colleges
25 of Surgery, trauma verification standards.

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2 As many of you know, it was not always
3 a smooth process and there were many bumps along the
4 way, especially in those early years but Bill always
5 remain steadfast, calm, and with a voice of reason.
6 He was a wonderful liaison for all of us between the
7 college, the bureau, and the commissioner.
8 You know, I've been honored to serve
9 as his vice chair for the past twelve years. He made
10 it a real partnership for us. And I think we can all
11 say without any hesitation that the trauma care in
12 New York State is better because of Dr. Bill Marks.
13 And let me close with just a few words
14 that have been used to describe Bill of which there
15 are many more, but in going back over some of his
16 tributes, people have defined him as determined,
17 wonderful, calm, kind, and humble.
18 And so let me finish before my voice
19 breaks with just let's have just a brief moment of
20 silence to remember Bill as you knew him and reflect
21 over some of the great pictures that we have of him
22 before we move on.
23 So with that, we'll move on to our
24 agenda, which we will ask the -- going to take the
25 prerogative of the chair and we're going to go a

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2 little bit out of order today because we have one
3 piece of business that is really essential.
4 So before we move on to the Bureau's
5 report, we're going to move on to new business, which
6 is the nomination of the nomination process and the
7 election of our subsequent chair of STAC.
8 So let me just review a little bit of
9 the process. So several months ago, a nomination
10 group was put together, we sent out because a lot of
11 this had to be done electronically and virtually
12 because of COVID and because of our meetings are not
13 in person.
14 We sent out several electronic
15 requests for nominations. Those nominees were
16 vetted. So I have two nominees to present to the
17 STAC today, who for election to the as the state
18 chair. That is Dr. Matt Bank and Dr. Robert
19 Winchell, whom I think we all know fairly well
20 through their participation in STAC and both served
21 as subcommittee members.
22 We're going to allow a few minutes for
23 each of them to give a little bit of a statement
24 about their interest in serving as the chair but I
25 want to outline the following process and also state

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2 that before I go through the process, I'm going to
3 open up the floor for additional nominations in case
4 there are any nominations that anyone wants to
5 present from the floor.
6 So let me officially open up the floor
7 for any nominations that anyone else may want to add
8 to the slate. So again, our two nominees at present
9 the slate includes Dr. Matt Bank and Dr. Robert
10 Winchell.
11 Is there any nominations that anyone
12 wants to make from the floor? Hearing no response,
13 I'm going to assume that there are no further
14 nominations.
15 MR. CLAYTON: ...
16 MS. O'NEIL: Yes. Ryan?
17 MR. CLAYTON: I know it sounds crazy.
18 But part of the process, you just have to ask that
19 three times.
20 MS. O'NEIL: Announce it three times?
21 MR. CLAYTON: Yes.
22 MS. O'NEIL: Okay. So second attempt.
23 Is there -- are there any additional nominations for
24 the -- sorry, the chair of STAC position? Hearing no
25 response, I'm going to announce it a third time.

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2 I am asking the staff members. Are
3 there any nominations for the position of chair of
4 STAC that they want to present from the floor?
5 Hearing no response, I'm presenting to the STAC
6 voting members, two nominees to fill the position of
7 STAC, Dr. Matt Bank and Dr. Robert Winchell.
8 Now, the process, we had hoped that we
9 would be in person and so we will -- we're going to
10 proceed with an electronic vote. Now, I know many of
11 you, including myself, had wanted a completely
12 blinded vote.
13 So we are doing it as -- as blind as
14 we possibly can. And the reason we're doing this, at
15 the beginning of the meeting, is so that we will have
16 time to tap the votes so that we hope that we will
17 have a STAC chair to put forward at the end of the
18 meeting.
19 So we are asking those of you who are
20 voting members to email Dan, just Dan, directly with
21 your choice of the two candidates.
22 MR. CLAYTON: Doctor --
23 MS. O'NEIL: Yes?
24 MR. CLAYTON: So now, you just say,
25 everybody's --

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2 MS. O'NEIL: Sorry, I forgot. I
3 forgot a very important point.
4 MR. CLAYTON: Please, please, hold off
5 on voting for a minute if you --
6 MS. O'NEIL: Yes, yes.
7 MR. CLAYTON: Yes, put the email in
8 there but please do not send an email yet. There's
9 one more step.
10 MS. O'NEIL: Yes. Thank you, Ryan, I
11 -- I apologize to everybody, I got a little
12 distracted. There's a very important step that we
13 want to proceed with before you give your vote.
14 We want to give each of the candidates
15 an opportunity to -- to speak to you and for an
16 opportunity of the staff members to get to know our
17 candidates a little bit better and to have a sense of
18 their vision as a potential STAC chair.
19 So we will go in alphabetical order.
20 Dr. Bank, do you mind going first?
21 MR. BANK: Sure. Thank you.
22 MS. O'NEIL: Let me also just say to
23 the STAC members, to please put this into
24 perspective. They had -- they had sent us a written
25 description of their -- their -- their thoughts but

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2 it didn't get sent with the -- with the C.V.s, and so
3 some of this is a last-minute request for them.
4 So please put that into perspective.
5 This is not something that they had time to prepare.
6 Sorry, I just wanted to put that out there, Matt.
7 MR. BANK: Sure. So they -- they want
8 me to say a couple words about myself. A very simple
9 background. I was born in New York, went to
10 elementary school, junior high, high school, medical
11 school, general surgery training and I've lived since
12 then in New York.
13 I've been a trauma medical director at
14 New York Trauma Centers since '08. I've been part of
15 the STAC for the last twelve years. I've been the
16 chair of the P.I. subcommittee, which I founded in
17 2015.
18 Just from New York State's
19 perspective, one of the things I'm very proud of,
20 honestly, is being the founding chair of the New York
21 State trauma collaborative.
22 For many years, we didn't have really
23 timely risk adjusted data for New York State,
24 organizing the trauma collaborative we have now
25 thirty trauma centers. We're able to actually get

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2 data back to the State and review the State system,
3 using this data within multiple A.I. projects.
4 Now, ... starting a pediatric
5 collaborative using our model so now there's a
6 brother, sister organization of the pediatric neuro
7 trauma collaborative. And still to this day, it's
8 the only really timely risk adjusted data we have for
9 the New York State Trauma System.
10 My vision for STAC is just -- I think
11 there's a couple of things that can be improved. The
12 number one thing is communication. We have a lot of
13 very talented people who are just finding it hard to
14 -- to find time to sit in the same room.
15 Obviously, the vendors and the
16 registry committee, if we could get them just to stay
17 in the same room for once a month, I think we could
18 solve all the problems of the uploads to the trauma
19 registry.
20 I think that we could get assistance
21 committee and some of the D.O.H. analytics people to
22 sit in the same room maybe once a month going forward
23 and we can get a much better annual report out.
24 Some things I think it also might be
25 able to be improved is just the transparency, getting

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2 some relatively summary data back to the R.T.A.C. So
3 each R.T.A.C. could know it's not going to be
4 completely up to date. They can know what their
5 primary triage is, what their volume is, what their
6 mortality is in their area, not by center, but just
7 by summary.
8 I think that will be great because
9 right now the R.T.A.C.s don't have much data to go on
10 and just to add this meeting at the staff meeting, to
11 present data, every STAC of where we are in terms of
12 volume and what's happening around the State. That's
13 it.
14 MS. O'NEIL: Thank you, Matt. Does
15 anyone have any -- any comments or do they have any
16 specific questions they want to ask Matt at this
17 point? Right. So Rob, now, I'm going to hand ... to
18 Rob Winchell to you.
19 MR. WINCHELL: Sure. Thanks -- thanks
20 very much. So one, you know, it's absolutely an
21 honor to be nominated as a potential candidate for
22 the STAC chair. Following Matt's lead in going back
23 to the cradle, I was born and raised in a small town
24 in California and spent most of my first forty years
25 well west of the Mississippi.

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2 I have been a New Yorker since 2015
3 when I moved here to take the job of chief of trauma
4 and burn and surgical critical care at Weill Cornell,
5 and to bring us up to speed to be a level one trauma
6 center within the State of New York.
7 I've been involved with trauma systems
8 developments for my entire career. I trained and was
9 on the faculty at U.C. San Diego and was involved in
10 the development and implementation of the trauma
11 center in San Diego going back to the mid '80s.
12 I've subsequently served as chair of
13 the C.O.T.'s Trauma Systems Committee and lead the
14 trauma systems consultation program for nine years.
15 I've been a reviewer for more like twelve and
16 probably participated in twenty state and regional
17 trauma system consultations, done work
18 internationally as well in trauma systems.
19 Some folks might say I've spent more
20 time in this -- some might consider healthy doing
21 that work. I first became involved with the New York
22 system in 2012, when I actually came out here with
23 the American College of Surgeons Dog and Pony Show,
24 to a staff meeting, in which we work to convince the
25 Department of Health to take on the American College

2 of Surgeons verification program for trauma centers,
3 which we all subsequently did.
4 I then spent a couple of years doing a
5 lot of trauma center site visits in New York,
6 ultimately got tapped on the shoulder to come to New
7 York City and actually build one of the -- one of the
8 trauma centers that we have decided to set up under
9 the V.R.C.
10 And I have been involved in person
11 with the STAC since -- since I arrived in 2015. I've
12 chaired the subcommittee for needs assessment, which
13 was set up in 2017 or '18. I don't remember
14 precisely --precisely when.
15 Anyway, you know, I think that looking
16 back in this ten or so years that I've been involved
17 with the process here. I think we've made a lot of
18 progress as a system. It's hard to look at the
19 systems which brought a geologic timeframe, it seems
20 sometimes but we've made great progress I think in
21 the data availability in Matt's TEQIP subcommittee in
22 adopting the verification and the qualification
23 around trauma standards that we've all trauma center
24 standards we've done in terms of the codification of
25 many parts of the trauma system.

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2 I think we have a very good working
3 relationship with the Department of Health. And I
4 think we're very well-positioned to continue to grow
5 in all of those areas focusing, I think certainly my
6 area of interest in trauma -- needs based trauma
7 center designation and how we try and control where
8 new centers come up, how we get better access to data
9 for day-to-day trauma systems, operational Q.I., our
10 ongoing prevention efforts and registry efforts.
11 And again, I think we have tremendous
12 opportunities moving forward in the future. And I'll
13 stop there. And again, if anyone has any questions.
14 MS. O'NEIL: This is Dr. O'Neil.
15 Anyone --
16 MR. GESTRING: Can I ask?
17 MS. O'NEIL: Yes. I was going to ask
18 if anyone has any questions.
19 MR. GESTRING: I am sorry. This is
20 Marc G-string. I have a general question for I guess
21 for you. How is the vice chair selected? How does
22 that process work?
23 MS. O'NEIL: For me?
24 MR. GESTRING: Well, is your term
25 limited or, you know, is there going to be a new vice

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2 chair with a new chair. How -- how is that going to
3 work?
4 MS. O'NEIL: It's a good question. I
5 have agreed to stay on a little bit longer as the
6 vice chair to make more even transition period with
7 the new state chair at some point in the near future.
8 It's not determined exactly when I
9 will be replaced and there will be a new voting
10 process for the vice chair. So that we will in the
11 near future, it's not clear when, be voting for a
12 vice chair.
13 And I think what may come up later in
14 one of the subcommittee meetings, we are rebut, you
15 know, that the original intent, or at least the
16 future intent will be that the election of the chair
17 and the vice chair will be staggered, in order that,
18 you know, there are some even transition period so
19 that they would overlap.
20 MR. GESTRING: Thank you.
21 MS. O'NEIL: Any other questions for
22 either of our candidates? Okay. I would just like
23 to say as the current acting chair that, you know, I
24 believe that both candidates are excellent. They
25 both contributed significantly to the STAC and to the

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2 trauma system and also to direct trauma care at their
3 individual institutions.
4 And unfortunately, the problem with
5 voting is that we have one winner and one not, and so
6 I just want to say personally to both candidates that
7 and I'm sure the -- my fellow staff members feel the
8 same, that we are very pleased that you both agreed
9 to step up to the plate and that whatever the final
10 decision is, I think that it will be a win-win.
11 And that hopefully, one of -- whoever
12 does not will consider at least possibly running for
13 vice chair when the time comes. With that, I'm going
14 to -- I'm instructing each of the voting members, you
15 should know who you are, to email Dan directly with
16 your choice and then we will proceed with the agenda.
17 And then at the end of the -- as we
18 approach the end of the meeting, hopefully we will
19 have an answer and a tally of the election.
20 MR. CLAYTON: That's going to be all.
21 MS. O'NEIL: Does every -- Ryan?
22 MR. CLAYTON: Sorry. I -- I just want
23 to add one thing to that one. So everybody is due
24 emails, Dan Clayton at the end of the meeting, or --
25 or possibly at a pause in the middle, what we will do

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2 is announce those ballots that are received not who
3 they are voting for but just that they are received
4 in order to confirm that we've received everybody's
5 ballot who did vote.
6 So please just understand that, you
7 know, through this process, we will -- you're going
8 to email Dan, we will then read off whose emails we
9 have or whose ballots we have received and then we'll
10 need a little bit more time, possibly, and then,
11 we'll be able to get the results.
12 MS. O'NEIL: So if I hear you, Ryan,
13 you're suggesting that about midway through the
14 agenda, I'll give Dan the ability to cite who has so
15 far responded. And then in case we're missing any
16 votes.
17 MR. CLAYTON: That would be my
18 suggestion.
19 MS. O'NEIL: Okay. Just in case I get
20 distracted. Do what you always do, and just remind
21 me.
22 MR. CLAYTON: ...
23 MS. O'NEIL: Yes. We'll anticipate
24 maybe doing that roughly after the trauma needs
25 assessment report. So going back to the agenda, we

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2 will now hear from the Bureau. Ryan, do you want to
3 give your report?
4 MR. GREENBERG: Absolutely, just give
5 me a second to look at my agenda here. And they're
6 going to turn the cameras to actually see me this
7 time.
8 I'm really ... in stenographers. My
9 name is Ryan Greenberg. I'm the Director of Bureau
10 of E.M.S. and Trauma Systems for the State of New
11 York. Thanks everybody for taking the time today and
12 for participation in this morning's meeting. Also
13 thank you for the quick adjustments in travel changes
14 and meeting changes when this went from a hybrid
15 meeting to a virtual meeting.
16 I do want to point out -- before I
17 give my report, I've gotten a number of questions
18 related to what future meetings will look like. June
19 7th, is what looks like will be a pretty significant
20 game change for these meetings related to open
21 meeting law.
22 So most likely after June 7th, there
23 really and we're waiting on additional clarification
24 on it. The meetings will predominantly be back in
25 person, there might be some exceptions to it, there

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2 might be some things that would allow some people to
3 participate virtually. However, they've also stated,
4 and Dan, correct me if I'm wrong on this one, that
5 virtual participants in the future after June 7th
6 will not count towards a quorum.
7 MR. CLAYTON: That's my understanding.
8 MR. GREENBERG: So that's a -- that's
9 a big factor. If you're allowed to vote, they
10 wouldn't count towards a quorum on our ability to
11 have a meeting.
12 So again, that is a pretty big
13 significant change. We were, you know, kind of the
14 last two weeks have gotten some information on this,
15 Division of Legal Affairs is continuing to look into
16 that and provide some additional guidance and we will
17 be putting out additional information on that. I
18 just want everybody and all the members to understand
19 and know that.
20 MR. TEPERMAN: Ryan, it's Dr.
21 Teperman. I'll -- I'll let you get through your
22 report. But just a point of clarification --
23 MR. GREENBERG: Sure.
24 Mr. TEPERMAN: -- when the next
25 variant hits then the next huge surge hits and it's

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2 our September meeting, which I need to have and you
3 determine for health reasons that it does need to be
4 virtual, it seems to me, we're going to have to be
5 able to hold that meeting and vote virtually. I
6 assume that this is kind of like during peacetime,
7 you got to be there. Can you clarify?

8 MR. GREENBERG: Yes. So -- so the
9 wording in -- in the way that it was worded in some
10 of the language that came out is it does allow for
11 some things to, you know, for circumstances, for
12 people not to be in person.

13 And it does sound like it has and this
14 is a part that legal is really looking into it. It
15 does sound like it has some contingencies in it,
16 should we have a spike or wave? And should there be
17 other determinations related to public health
18 emergency and would allow these meetings to continue
19 in this manner.

20 However, it wouldn't be automatic,
21 meaning if there's not that wave, if there's not, you
22 know, some of those things that are, you know, it
23 won't be as flexible as it is today but there will
24 still be flexibility.

25 And the good news is that it's

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2 actually the extension is through 2024. So again,
3 don't look at it as, oh, we'll be able to do hybrid
4 between now and 2024 but, you know, when we have more
5 clarification from D.L.A., and like you said, you
6 know, if there's a wave, which I'm really hoping
7 there isn't, but if there is a wave, come September
8 and, you know, people going back to schools and
9 things of that nature, it does look like there will
10 be some options for the Department of Health and
11 everybody who has, you know, a state council to have
12 some flexibility, but it will be more rigid in what
13 that flexibility is.
14 MR. TEPERMAN: Thank you, sir.
15 MR. GESTRING: Can I -- can I just add
16 to that? It was -- ... hybrid meetings, right? I
17 mean, as soon as you make the option, hybrid, people
18 will stay home on their computers.
19 So we either come in there in person,
20 all of us, or we do it hybrid from home. And we saw
21 that just with the meeting you have organized now,
22 right?
23 I mean, very few people decided to
24 drive to Albany to be there in person when the hybrid
25 option was there. So -- so I just think, you call it

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2 what it is and just say we're either in person or
3 we're on Zoom, but not there's -- I don't see a way
4 that we're going to work hybrid across the whole
5 state personally and get actually people in the room.
6 MR. GREENBERG: And I think, you know,
7 some of the biggest feedback, and it was, I think,
8 hybrid, you know, it definitely has a time and a
9 place and especially through this pandemic, and we've
10 had some --some pretty successful hybrid meetings,
11 you know, just a couple of weeks ago, we had the
12 council meetings, which were hybrid, and it allowed
13 for some who weren't able to make it in.
14 But there's, you know, I think a lot
15 of people have also focused and said, you know,
16 within the council meeting, there's a tremendous
17 amount that's done at the council meeting and there's
18 a tremendous amount that's done outside of the
19 council meeting.
20 And part of that, in some cases, it's
21 just networking and knowing and meeting new people
22 and being able to share ideas and best practices that
23 aren't a topic of the State council meeting, but
24 happened in the hallway, it may happen at lunch, it
25 may happen, you know, with these other things.

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2 So as important as those meetings are,
3 you know, that there's that component, and I would
4 also say, you know -- you know, we hear about the
5 dinners that they do before and our registrar who
6 come together who, you know, both have a committee
7 but there's a lot of them who also again, have those
8 other discussions and things that are -- that have
9 equally as much value to the side.
10 So, you know, I think there's a lot of
11 really benefits to -- to being in person permitting,
12 obviously that, you know, a safe environment that we
13 are planning.
14 MR. GESTRING: Agree more. Thank you.
15 MR. GREENBERG: So I will try and go
16 quickly just based on that but I thought that was a
17 really important topic for us to discuss. One of the
18 things, you know, that a lot of people didn't realize
19 is we, you know, through Omicron within the Bureau of
20 E.M.S., we actually went back into a deployment mode.
21 We had both federal and state
22 resources deployed -- deployed around the State. We
23 brought in almost another hundred and thirty state
24 and federal assets to help in both 911 responses,
25 both load balancing of hospitals, there was actually

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2 a pretty significant amount of assistance that we
3 also provided with load balancing of our critical
4 care patients, our trauma patients or anything that
5 couldn't get access to a bed in certain locations.
6 And I really want to, you know, do a
7 shout out. And a thank you to -- to all the
8 hospitals who helped in load balancing, who, you
9 know, really worked to allow, you know, a bed
10 matching to occur and to find them home.
11 The reason why we brought in some of
12 our critical care assets was our transfers were north
13 of four and five hours, and we were able to find a
14 bed into bed matching, or I.C.U.s, and different
15 specialty cares.
16 So just a thank you to all those
17 hospitals that were able to help them in that front.
18 And, you know, on the operation side -- we're going
19 to look on the E.M.S. side.
20 On the operation side, we're starting
21 to get back to some of our routine stuff, both on the
22 trauma side as well as on the E.M.S. side, where
23 inspections are starting to go, we had ... that of
24 our A.C.S. inspections are starting to, you know,
25 maintain, and continue and still going on virtually

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2 but we're happy to see those continuing on.
3 We've had some staff changes and some
4 staff additions in the bureau, we welcome several new
5 staff members, including one that is not working
6 directly with this council, but is working with our
7 sister councils.
8 Teresa, who is sitting here with us
9 today, actually, we help them on our state councils
10 but I do believe you'll see a number of crossover as
11 well as by sitting here today.
12 So if you do start to see some new
13 names and communications, please understand. We are
14 happy to say that we have some new staff members that
15 are here.
16 On the education front, we continue on
17 the E.M.S. side to deal with number of different
18 education funds related to continuing education and
19 using our L.M.S. in our platform on the vital signs
20 Academy.
21 And one of the things as we see the
22 pandemic starting to, you know, be at a reasonable
23 pace. I can't say over but at a reasonable pace is
24 to start to look at our trauma community and
25 determine in our trauma community.

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2 Are there other opportunities that we
3 can put online? Are there things for our registrar
4 that we can put, you know, some standard training or
5 things like that are continuing in on the L.M.S.
6 system that we do have.
7 So we do have one for our state E.M.S.
8 system but that easily can be extended to our trauma
9 community as well. And so, you know, now that we're
10 getting to a point, we'd like to start looking at
11 that.
12 On the data side, we continue to grow
13 forward in data collection and Mr. Myers knows what
14 we're talking about that one on a report on that as
15 well as that report out there, one of the bigger
16 things towards the end of 2022, beginning of 2023.
17 We're going to start move -- we start
18 moving our trauma data into a platform called
19 Biospatial ... This is a platform that we're
20 currently putting our E.M.S. data in. It's an
21 analytical platform and the relationship that we set
22 up about two years ago, in order to help take the
23 large amount of data that we have and start to put it
24 in an analytical form that can be used on a smaller
25 scale.

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2 So we're excited to see it on the
3 E.M.S. side and once we roll out the E.M.S. and get
4 that moving, our next step will be the rollout to
5 trauma side.
6 I know many of you have spoken about
7 our trauma report and, unfortunately, the annual
8 report that hasn't come out in several years. The
9 goal is hopefully to get those reports back up,
10 operational with significant feedback from this group
11 on what they want to see.
12 But as well as to look at it with
13 Biospatial on an almost live basis and what can we
14 see in more real time. So that will be exciting and
15 something that we haven't seen on this front or on
16 the E.M.S. sides.
17 E.M.S. for children, I know Dr. Cooper
18 and ... later, so I'm going to pass on that one. For
19 those of you who do attend our E.M.S. memorial, it's
20 normally in May, so it would have been a few weeks
21 away.
22 This year, it's going to be in
23 September again, we did this in last year. The
24 memorial unfortunately has to be expanded and so that
25 expansion process is in the process right now and we

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2 do look forward to having that memorial in September.
3 It'll be September 20th. For those who can attend,
4 there are ten honorees who are going up on the
5 memorial this year.
6 From the director's office, E.M.S.'s
7 week is in May, just a couple of weeks away. And
8 actually just yesterday or Monday, we released an
9 opportunity for those E.M.S. agencies and E.M.S.
10 partners to submit for E.M.S. Directors Awards for
11 E.M.S. meet.
12 And so I don't think we sent it out to
13 the trauma listserv but we will take care of getting
14 that link out there for -- if there is a trauma
15 center who would like to recognize an E.M.S. agency
16 or an E.M.S. provider.
17 We absolutely would welcome it, an
18 opportunity again once a year. We review all the
19 submissions that are there and we issue out a certain
20 number of awards every year.
21 In the past few years, we do about a
22 hundred awards a year ... E.M.S. week, and we would
23 absolutely love to hear from some of our comments ...
24 related to the E.M.S. ...
25 And many of you might have interacted

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2 with both and load balancing and other -- other
3 reasons over the course of the past two years, or
4 surge operation center, which is a statewide
5 initiative that helps both hospitals, nursing homes,
6 and healthcare facilities has been in operation
7 primarily under the leadership of Deputy Director
8 Steve Dziura, and his team and Jenna and Mary, who
9 really done just an outstanding job.
10 For this group, I just want you to
11 understand a little bit about what the scourge
12 operations center does and it handles a lot but
13 particularly to Omicron, it really went into back ...
14 that surge operation center to date has handled just
15 under six thousand cases, it has handled just about
16 just under three hundred diversion notations on E.R.
17 is not on diversion.
18 It's handled just under four thousand
19 transport requests, this will be load balancing
20 requests or different requests related to trying to
21 get a patient move that otherwise the normal means
22 would not be able to be accomplished.
23 It has handled about three hundred
24 fifty bed matching cases. It has sent out sixty E.D.
25 strike teams, which were E.M.S. strike teams that

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2 were going to an E.D. and help during the surge.
3 It has handled just under four
4 thousand IoT in their facility to transports, and
5 just under ten thousand E.M.S. transports. So where
6 we've gone out into the community, and due to
7 Omicron, or COVID, or whatever, whatever the name
8 might be, have signed E.M.S. resources into an area.
9 So again, big thank you to District
10 Chief Marie Raymos, District Chief ... Deputy
11 Directors there on the work that they're doing there.
12 Thank you to all of you actually, in your hospitals,
13 in the partnership, because it really has been a
14 partnership, getting phone calls from us in the
15 middle of night trying to bed match and find a
16 patient, the appropriate care is critical and is
17 really -- would not be able to tell without the two
18 partnerships.
19 Regulation side, we're going to talk a
20 little bit more about you know, some changes going on
21 in trauma, or change in -- in the trauma ... trauma
22 books, and what that will mean to ... So we'll leave
23 that later in -- in the meeting. But we do recognize
24 that one.
25 So we will be working on the Bureau

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2 side to help update that. It is important for
3 everyone to know that the executive orders are still
4 in place, the ones that have been in place so far,
5 and the ones that are helping allow us to have
6 different scope of practice things and vaccines and
7 so on and so forth.
8 However, they are renewed every thirty
9 days and it is unknown at the point that that will be
10 ended for those hospitals say, using paramedics near
11 New York or assistant trauma care, whatever that
12 might be, just recognize that -- that it is still
13 only able to happen through the executive orders.
14 And the executive orders are renewed every thirty
15 days. We're not sure when they will expire.
16 Important one for this group that you
17 may not be aware of is that there is a rural health
18 taskforce council that's being set up to put together
19 a white paper for rural health E.M.S. And this is
20 important on the trauma side because I do believe a
21 portion of what they will look at will be access to
22 trauma care -- access to care, and period, but a
23 secondary is access to trauma care.
24 And so that council is being set up as
25 -- as we speak, made up of representatives that are

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2 nominated from the Senate, from the assembly, from
3 state fire, from different groups that the elected
4 when they put this through the ledge has determined
5 that we have seen on the council.
6 So that will be probably in the next
7 four to five months be set up and start working in
8 there to for you to have that project done just about
9 under a year after that the committee starts working.
10 And I think
11 MS. O'NEIL: Thank you, Ryan. So
12 pretty full report, I guess, since it's been so long
13 since we've actually had a formal meeting. So Dan,
14 are you available to give your report, your trauma
15 program update?
16 MR. CLAYTON: Yes, Dr. Chair, thank
17 you. So I'll be brief. Ryan has covered a lot of
18 material. I will tell you that since our last
19 meeting in October, Patty Riley has come on board as
20 a new employee with us in late October.
21 I think at our last STAC meeting she
22 was on the meeting but it was not public yet that she
23 was coming on board. So many of you've had a chance
24 to meet her on some of our virtual subcommittee
25 meetings and telephones conversations and emails but

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2 Patty Riley joined us on late October and she is an
3 R.N., which I am not.
4 So it is nice to have an Allied
5 Healthcare professional on board that will
6 eventually, you know, be able to go to the A.C.S.
7 C.O.T. verification review committee visits with me
8 and with Ryan, and -- and have her perspective. So
9 glad to have her on board.
10 Also, I wanted to tell you that since
11 early January, actually late December, up until last
12 week anyway for me, I've been working the Search
13 Operation Center as has Patty and she continues to
14 work the Search Operation Center as Ryan indicated
15 and explained just a few minutes ago.
16 So Patty has devoted pretty much a
17 hundred percent of her time to the Search Operation
18 Center since late December. I've been doing a mix of
19 both trauma work and Search Operation Center since
20 then but as of last week, I believe I'm off Search
21 Operation Center, so I -- I'm going to be able to
22 devote more time and attention now to trauma, which
23 is what I want to do.
24 So we have had some virtual meetings
25 and sub-committee meetings. As you know, we had a

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2 registry recently. We -- I have participated in
3 several A.C.S. visits, reverification visits, which
4 have all gone very well.
5 And I think with that in mind, I have
6 nothing further for trauma at this point, just
7 hopefully, you know, from here forward the ability to
8 get back to my trauma work in -- in all from the
9 Search Operation Center focus.
10 So thank you. Are there questions on
11 the trauma section report? Hearing none. Go ahead,
12 Dr. Chair, thank you.
13 MS. O'NEIL: Well, let me just give
14 recognition to both Dan and Patty having had, you
15 know, some phone calls, emails, and meetings with
16 them over the course of the last several months.
17 They really have been overextended
18 with all their additional responsibilities during
19 COVID. So let me personally thank you Dan and Patty
20 for your extra effort and work that you've done to
21 help New York State.
22 So I will proceed with my report. I
23 have basically -- oh, before I go to the one item I
24 wanted to bring up, let me just -- I hate to go back
25 and circle back to the chair election.

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2 Something that Ryan and I plan to tell
3 you and remind you, I think you all know but just as
4 a matter of point, the -- today, we will elect our
5 preference for the STAC chair but we are simply
6 advising the commissioner.

7 So the ultimate decision and
8 appointment to the STAC chair position will be at the
9 discretion of the commissioner. So we just want to
10 remind you that the process will be that we will
11 refer our recommendation to the commissioner.

12 The commissioner and the whole -- the
13 individual will get vetted by the -- the department -
14 - by the commissioner's office and then the final
15 decision will be made by the -- by the commissioner.

16 The timeframe for that may take a few
17 months, it's unclear which to -- to go back to your
18 question mark, which is another reason why it's
19 important for my -- for the vice chair position to be
20 staggered right now, so that we have an acting chair
21 until the new chair is actually appointed.

22 So with that clarification, the one
23 item that I wanted to bring up which I think all of
24 you probably do know by now is that in March -- or
25 last month, it was actually into April where the new

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2 2022 American ... Standards Trauma -- Trauma Center
3 verification standards have been printed and
4 released.
5 If you haven't seen the grey book,
6 which it will now be referred to permanently as the
7 grey -- grey book. It is now available. The actual
8 verification standards will be going into effect for
9 trauma center compliance as of September 2023.
10 So if you are a New York City -- New
11 York State Center, who will be coming up for
12 verification site review, from September 2023 on, you
13 will be required to meet the -- the new standards of
14 2022.
15 If you didn't get a -- a copy yet, I
16 can just let you know if you go on to the facs.org
17 website under trauma systems, you can get a free PDF
18 version or you can ... or you can ask and pay to have
19 a printed copy forwarded to you.
20 There are some new requirements that
21 we are all sorting out. So I think from the various
22 sub-committees as we move forward and during the
23 process between now and 2023, I'm sure we will have
24 many conversations among ourselves within the STAC
25 and within our sub-committees, you know, clarifying

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2 those new standards and trying to evaluate how each
3 of us can best meet those new standards.
4 And so that brings up one important
5 point that Ryan referenced is that we will now have
6 to move forward and revise the 405 regulation -- 405
7 section, the trauma section of the 708 standards,
8 where the reference to the 2014 standards are.
9 If you remember, we had at the time
10 that the 708s were being revised, we try to make it
11 to a -- to a reference to the current standards but
12 the legal department said that was not possible, so
13 that anytime there's a new publication, we will have
14 to have a revision.
15 But it's a simple revision, it's cited
16 in six different places. I went through the 405
17 section but it's a straightforward simply
18 substitution. So the -- unlike the original 708
19 revisions, this should not take a long time and Ryan
20 and I have talked about it and we do anticipate that
21 the revised version should be easily accepted and --
22 and in place by September of 2023.
23 As he stated the more time consuming
24 part will be there and form filling out all the
25 documentation needed to make the change.

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2 MS. SNYDER: Dr. O'Neil.
3 MS. O'NEIL: Yes.
4 MS. SNYDER: Kerrie Snyder from the
5 Albany Med. Can I just ask a question? Is it -- it
6 is -- just to refresh my memories is it the 405 regs
7 that require us to have the nurse ... for
8 verification?
9 MS. O'NEIL: Yes, if you hold that
10 thought. I'm going to bring that up under O
11 business, okay?
12 MS. SNYDER: Okay. Yeah.
13 MS. O'NEIL: I think it's important
14 for us to move forward with the -- the meeting but,
15 yes, I'm going to come back to that for sure and I
16 anticipated that that was going to come up in today's
17 meeting, so we're prepared to address it, okay.
18 I just -- I just don’t want to get
19 into any potential discussions on it yet but we will
20 -- I will definitely be bringing it up.
21 MS. SNYDER: Thank you.
22 MS. O'NEIL: Okay. Does anyone have
23 any questions or comments about the 2022 verification
24 standards? I'm still going through all of them.
25 MR. GESTRING: Dr. O'Neil.

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2 MS. O'NEIL: Yes.
3 MR. GESTRING: Can we just point out
4 that the grey book is dedicated to Bill Marks?
5 MS. O'NEIL: Thank you. That's a very
6 good point.
7 MR. GESTRING: We should -- we should
8 make sure -- we should make sure that gets in the
9 record.
10 MS. O'NEIL: Yes. And when you -- if
11 you have not already reviewed your copy, if you look
12 at the very beginning, there's a formal dedication of
13 the -- of the publication to Bill along with a
14 picture of Bill on the -- on the -- within the
15 beginning of the publication.
16 Thank you for bringing that up, Dr.
17 Gestring. Okay. Does anyone have any comments or
18 questions about my report? Right. So we'll move on
19 then to registry, Christy Meyer.
20 MS. MEYER: Hi, thank you. So the
21 registry committee, this is Christy Meyer, Co-chair,
22 I work closely with Mary Ives. We convened a work
23 group once again to look at the date dictionary and
24 make some edits.
25 The committee met with the group of

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2 ten members from trauma center leadership from around
3 the State, so registrars and trauma program managers.
4 We met about ten times, probably every two weeks
5 throughout the later part of '21 and came up with
6 some field edits, a couple of laminations and the
7 sub-committee would like a motion to move our
8 recommended edits forward for approval for January
9 2023 admission. So that's the biggest order of
10 business for this committee.
11 MS. O'NEIL: Since this is a motion
12 coming from a sub-committee, it does not need a
13 second, so we can proceed with a vote. All in favor,
14 say aye.
15 MS. SNYDER: Aye.
16 MR. CLAYTON: Aye.
17 MS. MEYER: Aye.
18 MS. O'NEIL: ... this does not require
19 a rollcall vote, so. Any nays?
20 Before I accept the vote, I did omit
21 one thing. Was there anyone who had any questions or
22 had a -- or anything they wanted to discuss before we
23 finalize the vote? Hearing no questions and hearing
24 no nays, the motion carries.
25 MS. MEYER: Thank you. In addition,

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2 just to kind of bring everybody up to speed, we will
3 bring the change log recommendations through the
4 Department of Health approval process hoping to kind
5 of speed that up and get the vendor edits and vendor
6 updates ready by the end of the summer early fall, so
7 we'd be in advance of the January 2023 data
8 collection period.
9 So we hope to speed that up. In
10 addition, hope to have another registrar education
11 webinar, fourth quarter 2022 to support ... for the
12 2023 admissions.
13 One big order of business is, we have
14 seen a hundred percent data submission from trauma
15 centers for 2019 and -- and 2020. 2021 continues to
16 be a challenge, so we are looking into the situation
17 with our vendors and with trauma centers that
18 continue to have some submission issues, so eighty-
19 nine percent of centers have submitted data for 2021
20 with a forty-eight percent total completion of
21 submissions.
22 So we have to push that forward in the
23 coming months and then, certainly, there are some
24 changes in the grey book that we will try to support
25 as we all process the next step to come into

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2 compliance.
3 MS. O'NEIL: Christy, I have a quick
4 question. How much of the back log for the updated -
5 - the new data for the -- for 2021 is due to a vendor
6 issue and how much is a more of an institutional
7 issue because I do know there were vendor issues for
8 quite a while.
9 In corollary to that is do you think
10 it's feasible that we'll be able to get the vendors
11 to make the appropriate changes to your
12 recommendations by the end of the summer because, you
13 know, sometimes our -- our hopes with vendor to
14 accomplish those doesn't always go the way we hoped
15 it will.
16 MS. MEYER: So I think that's a more
17 complicated question. I don't have the submission
18 values for each center but I do know that we've had
19 some centers express difficulty with their vendor and
20 with -- ImageTrend uploading.
21 So we do recommend that centers that
22 are still having trouble, please reach out to, you
23 know, Dan and Patty, so we can make those connections
24 and we will be working with Peter Brody from the, you
25 know, Department of Health also to work through these

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2 challenges.
3 So hopefully, we'll have more
4 information. The next step really is to get the
5 changes through the Department of Health process, so
6 that we can get it to the vendors and then they can
7 make those changes.
8 So any delay on that of course will
9 delay the final product but we hope to be able to
10 align that with what N.T.D.S. does, which is usually
11 by August, we'll have the updated changes. So that's
12 kind of a target here.
13 MS. O'NEIL: Is my -- my understanding
14 is the changes then will be made within the
15 individual software of each vendors' registry program
16 but it also requires them to adjust the upload
17 program that will match for ImageTrend to receive it.
18 And that -- that has been a bit of a -- a gap at
19 different times along this process.
20 MS. MEYER: Yeah. So the changes last
21 year were really officiated in October of 20 -- you
22 know, 21, so the timeframe is really short. So we're
23 hoping to extend that out to meet what’s kind of
24 industry standard a little bit more with the N.T.D.S.
25 So I'm hopeful, we have approval so

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2 we'll move these changes forward and they're not as
3 expansive as what we did last time. So that's the
4 other side, there's some fields being eliminated,
5 there are some pic listings being updated, there are
6 really some dictionary changes that should support
7 standardization and abstraction.
8 So I -- I hope it's not as substantive
9 as what we did in the past. And the only other thing
10 on -- on the radar is to look at A.I.S. submission
11 burdens, so we currently submit in two zero five two
12 oh eight version. The 2015 version will be on the
13 radar report N.T.D.S. and probably something, as a
14 state, we'll have to consider but there's no clear
15 guidance from the national trauma data yet. So we
16 are monitoring that as well as the 2022 ranks so.
17 MS. O'NEIL: Now, you just jogged my
18 memory about something that came up and since we
19 haven't had an in person or a meeting since October,
20 this is actually for Ryan.
21 Ryan, I vaguely remember that the
22 contract for ImageTrend was coming to an end in prior
23 conversations and that would require the Department
24 to put out an R.F.P. and wouldn't guarantee that
25 ImageTrend, which continued to be our data

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2 repository.
3 Is that something we have to be aware
4 of or is that not an issue right now, or is it
5 something that might become an issue in the very near
6 future?
7 MR. GREENBERG: It's definitely
8 something that would become an issue in the future
9 and by the way, it would be an issue, you know,
10 forever because of just state proposing and -- and
11 ... But I do believe we're on a two-year extension,
12 I'm going to look over it, keep waiting for a second.
13 Yeah, we're on a two-year extension
14 right now. So it -- it won't be an immediate change
15 or something of that nature. There are few processes
16 we’ll properly start sometime in the next year and
17 ... process and then we’ll have a pretty -- you know,
18 probably in the nine to twelve months period of, you
19 know, forward -- whatever start.
20 And that thing, it changes, you know,
21 it was a, not -- there's not a, you know, an
22 abundance of people who or organizations who focus on
23 this type of collections, data collection, things
24 like that but they're definitely -- but there
25 definitely are a few.

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2 And, you know, they definitely are
3 competitive against each other and we've seen in
4 other states, you know, those changes happening, you
5 know, ... back and forth a little bit.
6 MR. CLAYTON: For the record, that was
7 Ryan Greenberg, Director of the Bureau of E.M.S. and
8 trauma systems for the stenographer.
9 MR. GREENBERG: Thank you.
10 MS. O'NEIL: Thank you, Dan. Yeah,
11 so, for the members of the committee who may not see
12 the full extent of that is once the R.F.P. goes out
13 and as Ryan knows better than me, sometimes the
14 decision to accept a certain vendor is based on
15 financial issues or whatever other issues that are
16 involved.
17 But if we were to change the vendor
18 for our -- our registry repository, that also means
19 that all the vendors may have to then change their
20 upload programs which could lead to more delays in
21 the upload of data to the registry, correct, Christy?
22 And that's why it's a little bit of a
23 hold your breath because at a time when the registry
24 sub-committee and our registrars and our trauma
25 program managers have done such a heroic effort to

2 finally get our data better organized and make so
3 many progresses.
4 It has the potential to really be a
5 big setback, potential, not necessarily but a
6 potential. So hopefully we can delay it as much as
7 possible. Anything else, Christy, that you want to
8 report?
9 MS. MEYER: No, that concludes the
10 report.
11 MR. GESTRING: Dr. O'Neil.
12 MS. MEYER: Yes.
13 MR. GESTRING: Gestring. I just want
14 to make note of the fact that today is trauma
15 registry professional day, I believe, if I'm not
16 mistaken, and I just wanted to recognize our
17 colleagues who do that work and for the ...
18 MS. O'NEIL: Thank you, Marc. I
19 completely forgot and they absolutely deserve public
20 recognition. With that, we'll move to Dr. Winchell
21 for trauma center needs assessments.
22 MR. WINCHELL: All right. Thank you
23 very much. We have two informational items kind of
24 progress related and -- and then one motion and a
25 request for a vote.

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2 And the first is -- many of you
3 probably remember from our last several meetings, we
4 had been working on a document and the process to
5 allow for the STAC to weigh in on an advisory basis
6 to assess the need for a potential new trauma center.
7 So in other words, for the STAC to be
8 able to look at new request for provisional trauma
9 center designation to set up a set of criteria and
10 evaluate whether they seem to meet our criteria for
11 need or not.
12 And then, which is based in part on
13 geography and population coverage and part on some
14 measures, pardon me, capacity and patient volume.
15 And so that's been through a couple of drafts, it has
16 now been approved by the legal department at the
17 Department of Health.
18 And so we're planning to put this
19 process in place. Again, it's an advisory vote only,
20 it gives us a chance to STAC to suggest to the
21 Department of Health what we think to be the right
22 course of action.
23 The final decision around trauma
24 center designation remains with -- with a state
25 agency. And so we're looking to hopefully get that

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2 into -- into position and -- and into play here in
3 the coming months. Are there any questions with
4 respect to that one?
5 MS. O'NEIL: No, I would just say that
6 thank you to your committee because that is something
7 that we have really been requesting for a period of
8 time and it's well needed.
9 MR. WINCHELL: The second information
10 to the progress report has to do with getting access
11 to prehospital data to help us both with needs
12 assessment by looking at patient flow, and
13 distribution of -- of calls and also to assist with
14 our operational trauma system, quality assurance and
15 performance improvement.
16 And -- and that project has been
17 largely spearheaded by my co-chair, Dr. Berry. And
18 Tracy, do you want to give us a quick run down of
19 where that project stands?
20 MS. BERRY: Sure, thank you, Dr.
21 Winchell. So in collaboration with Peter Brody and -
22 - and Ryan and the data informatics unit, we have
23 established a process for requesting this prehospital
24 data.
25 We are in the midst of doing the final

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2 edits of that process, but there is a process. And
3 so once we're able to finalize that, we can present
4 this at the next STAC. And begin obtaining this data
5 for -- for Q.I. purposes.
6 MR. WINCHELL: And thank you, Dr.
7 Berry. Any questions or thoughts with respect to
8 that item? And in finally, the action item we have
9 for the STAC at large.
10 Again, as most of you who've been in
11 this room over the past several years are aware we
12 have been working through a process to think about
13 having the trauma system's consultation program of
14 the American College of Surgeons Committee On Trauma
15 pay a visit to us here in New York State to help us
16 looking at our -- it provides an external eye on how
17 our system looks and what things we might prioritize
18 in terms of trying to make our system better.
19 And we've been working to lay the
20 groundwork. Many people have been working to lay the
21 groundwork for that process over the space of quite a
22 number of years.
23 And I think we have finally reached
24 the point of consensus in making an official
25 recommendation and so we're forwarding a seconded and

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2 unanimously approved motion from the system needs
3 sub-committee for vote at the STAC, included the text
4 in the chat box.
5 But to read it the STAC system sub-
6 committee recommends that the Department of Health
7 seek authorization and funding, approximately a
8 hundred thousand dollars, to request a consultative
9 visit from the trauma system consultation program of
10 the American Colleges Surgeons committee on trauma.
11 MS. O'NEIL: So since this is a motion
12 that has already been forwarded from a sub-committee,
13 it does not need a second. Now, let me just recheck,
14 I believe we had decided that this needs a roll call
15 vote given the substance of the motion and the
16 recommendation. Is that right, Ryan?
17 MR. CLAYTON: Correct, Dan Clayton
18 speaking, yes, that's correct.
19 MR. GREENBERG: And it -- it would be,
20 same thing I believe it'd be a motion, seconded
21 motion discussion, so.
22 MS. O'NEIL: So we don't need --
23 correct. Is there any -- thank you for reminding me.
24 Do we -- does anyone have any questions for Dr.
25 Winchell or any comments for discussion?

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2 MR. GREENBERG: And I -- I apologize

3 just to backup one. I want to make sure that it was

4 a motion that was seconded then the discussion, then

5 the vote.

6 MS. O'NEIL: Well, it was the motion

7 that came from a sub-committee. So we -- I was under

8 the impression, it didn't need a seconding because

9 it's coming directly from a sub-committee.

10 MR. WINCHELL: I'd be simple enough to

11 request a second from the current committee as well.

12 MS. O'NEIL: Agreed?

13 MR. WINCHELL: Yes, I would agree for

14 that --.

15 MS. O'NEIL: Yeah, so --.

16 MR. SIMON: Ronald Simon, I second it.

17 MS. O'NEIL: Okay. For discussion,

18 does anyone have any questions or points to bring up

19 regarding discussion of the motion on the table? So

20 just to repeat the motion, the STAC system sub-

21 committee recommends that the Department of Health

22 seeks authorization and funding approximately a value

23 of one hundred thousand dollars to request a

24 consultative visit from the trauma systems

25 consultation program of the American Colleges

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2 surgeons committee on trauma. Mr. Clayton, can we
3 have a roll call vote?
4 MR. CLAYTON: Yes, doctor. Dr.
5 O'Neil.
6 MS. O'NEIL: O'Neil says aye.
7 MR. CLAYTON: Dr. Doynow.
8 MR. DOYNOW: Doynow --.
9 MR. CLAYTON: I'm sorry. Dr. Doynow,
10 I didn't catch your response.
11 MR. DOYNOW: Doynow, yes.
12 MR. CLAYTON: Thank you. Dr.
13 Winchell.
14 MR. WINCHELL: Dr. Winchell is in
15 favor.
16 MR. CLAYTON: Dr. Ullman.
17 MR. ULLMAN: Dr. Ullman says yes.
18 MR. CLAYTON: Dr. Goldman. Dr.
19 Goldman. Dr. Cooper.
20 MR. COOPER: Cooper says yes.
21 MR. CLAYTON: Dr. Daily.
22 MR. DAILY: Daily says yes.
23 MR. CLAYTON: Dr. Wallenstein.
24 MS. WALLENSTEIN: Wallenstein says
25 yes.

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2 MR. CLAYTON: Dr. Flynn. Dr. Flynn,
3 you might be on mute. Dr. Gestring.
4 MR. GESTRING: Enthusiastic yes for
5 Dr. Gestring.
6 MR. CLAYTON: Willian Helenin.
7 MR. HELENIN: William Helenin,
8 enthusiastic yes.
9 MR. CLAYTON: Kerrie Snyder.
10 MS. SNYDER: Kerrie is a yes.
11 MR. CLAYTON: Dr. Angus. Dr. Angus?
12 Dr. Bank.
13 MR. BANK: Bank is a yes.
14 MR. CLAYTON: Dr. Arrillaga.
15 MR. ARRILLAGA: Arrillaga says aye.
16 MR. CLAYTON: Dr. Wasilenko.
17 MR. WASILENKO: Wasilenko says yes.
18 MR. CLAYTON: Dr. Prince.
19 MR. PRINCE: Dr. Prince says yes.
20 MR. CLAYTON: Dr. Agriantonis.
21 MR. AGRIANTONIS: Dr. Agriantonis says
22 aye.
23 MR. CLAYTON: Dr. Simon.
24 MR. SIMON: Simon says yes, please.
25 MR. CLAYTON: And Dr. Teperman.

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2 MR. TEPERMAN: Teperman says aye.
3 MR. CLAYTON: Roll call complete,
4 motion passes.
5 MS. O'NEIL: Right. So there were no
6 nays and no abs -- abstentions. So I'm happy to
7 announce that the motion carries, congratulations to
8 the sub-committee and I would say congratulations to
9 the Bureau and to the committee members as a whole
10 because this is something that, you know, we've
11 talked about for at least five years that I'm aware
12 of. And so I'm very excited that that we can
13 recommend this to the department and to the
14 commissioner. Anything else --.
15 MR. CLAYTON: I just have to say this
16 is something the committee has always wanted but
17 really who we owe thanks to is the executive staff
18 now of STAC, who now kind of agrees with us and is
19 allowing this to move forward.
20 So that -- that's a big piece of this
21 and it's really a credit to the STAC that we have
22 such a good executive team now working with us.
23 MS. O'NEIL: Meaning the Bureau.
24 MR. CLAYTON: Meaning the Bureau.
25 MS. O'NEIL: Right.

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2 MR. WINCHELL: And I would strongly
3 second Dr. Simon's position as well.
4 MR. CLAYTON: Dr. Winchell speaking.
5 MS. O'NEIL: Okay. So as we announced
6 earlier, we're at that point where Dr. -- Mr. Clayton
7 Dan, do you think you could give us a summary of the,
8 how many voting members have responded to the vote
9 for the state chair?
10 MR. CLAYTON: Okay. So what I've been
11 instructed to do by Director Greenberg is read the
12 names of the STAC voting vetted members who have
13 responded to me one way or the other, okay?
14 So I am about to read the names of the
15 individual STAC members who have voted one way or the
16 other. Dr. Doynow, Dr. Ullman, Dr. Goldman, Dr.
17 Cooper, Dr. Daily, Dr. Wallenstein, Dr. Flynn, Dr.
18 Gestring, Willian Helenin, Kerrie Snyder, Dr. Angus,
19 Dr. Bank, Dr. Arrillaga, Dr. Vosswenkel, Dr. Prince,
20 Dr. Agriantonis, Dr. Simon and Dr. Teperman. Those
21 are the individuals who have sent me an email vote.
22 MS. O'NEIL: So if there are any
23 voting members whose names are not on that list, we
24 encourage you to forward your vote and let Dan know
25 or you can even let the group know if you're having

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2 trouble accessing his email in any way.

3 Any -- any issues about the voting

4 that anyone needs to bring up about reaching out to

5 Dan? Okay. So we'll proceed with our agenda while

6 Dan is working on that. So we now will have the

7 report from Kristi Ladawski for injury prevention and

8 education.

9 MS. LADAWSKI: Dr. O'Neil, so this is

10 Kristi Ladawski with the injury prevention and

11 education subcommittee. I'll be brief, just some

12 updates to share.

13 So May is trauma awareness month.

14 Topic is Safe Surroundings, there's some webinars

15 from E.T.S. that our professionals can attend if

16 interested. And of course, it's also Stop the Bleed

17 month. And there is Stop the Bleed day and they're

18 really making a push for everyone to participate in

19 that and have programs offered in a wide scale,

20 really getting back out there into the community.

21 A few New York conferences coming up.

22 We have the Columbia Injury Prevention Conference,

23 which is virtual, that is on May 24th. That -- and

24 then we also have West Chester's roadside to bedside

25 conference that is going back to in person. And that

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2 is just a save the date at the moment. The
3 announcement hasn't gone out, but it'll be July 15th,
4 from twelve to five p.m.
5 For the New York State falls
6 prevention grant funding that comes to an end June
7 30th. There is one more Tai Chi for arthritis
8 instructor certification that may have a few spots
9 available but it is quite an intensive training
10 because it is virtual.
11 So if any of our members are
12 interested in becoming a certified Tai Chi instructor
13 or have community partners with someone who is
14 interested, you definitely need to reach out as soon
15 as possible, just to make sure that they have the
16 time, first, the availability to attend and the time
17 needed to properly prepare for those certifications.
18 There is no more a matter of balance Master Trainer
19 sessions. That concluded.
20 So if anyone is not already involved
21 with the matter of balance and looking to become
22 involved, just reach out to us and we will get you
23 connected with a Master Trainer who will, you know,
24 will get you into coach trainings but no more Master
25 Trainings are being funded.

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2 We do not have -- we have not received
3 information if the new cycle -- if Stony Brook
4 applied for the new grant cycle for that three years
5 with a subcontract in place to continue the New York
6 State Department of -- of Health's current work.
7 So that would continue to support
8 those Tai Chi for Arthritis certifications and the
9 matter of balance trainings. And then, I don't --
10 and at the state level, and at a local Long Island's
11 level, it would also support stepping on and the
12 Otago Exercise Program, so.
13 We are eagerly awaiting that
14 notification but we do not have anything to report
15 unfortunately at this time. So we just remind
16 everyone, you know, to be prepared that after June
17 30th, there may be no additional state funding for
18 these evidence-based older adult falls prevention
19 programs.
20 And your trauma centers will either
21 have to find other funding options or again, just
22 fund in house if you continue those programs or
23 decide to implement them.
24 MS. O'NEIL: Kristi, in the matter of
25 --

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2 MS. LADAWSKI: Yes.
3 MS. O'NEIL: Now if I remember, and
4 I'm not up on top of this as much as I should be, a
5 lot of that monies in those trainings are for train
6 the trainer. Right? So do we have a list of those
7 that were trained? And would the subcommittee have a
8 list so that if centers wanted to have a session,
9 that those trainees that are now the trainers. Would
10 they be able to work something out?
11 MS. LADAWSKI: Yes, for a matter of
12 balance, no for Tai Chi, because that is very strict
13 with the Master Trainer requirements. And there's
14 only one Master Trainer in New York State. She's not
15 a trauma professional. She's a true Tai Chi
16 practitioner and Master Trainer. So, yes, for a
17 matter of balance, we do have a list of all of the
18 individuals who were certified as Master Trainers.
19 For a matter of balance, you do have
20 to be first trained as a coach by a Master Trainer.
21 And you have to have an M.O.U. in place to work under
22 that Master Trainer. You can't go off and just do
23 your own programs. You have to continue to work
24 alongside that Master Trainer under their guidance
25 and under that M.O.U. So, yes, absolutely.

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2 If anyone is not already a Master
3 Trainer for a matter of balance at your site, or
4 knows who your Master Trainer is locally, then reach
5 out to us and we have a full list. And we'll let you
6 know a few options in your area.
7 MS. O'NEIL: So is it site specific or
8 the trainer can still work under that M.O.U. but
9 could run a session at another institution. Say in
10 their region.
11 MS. LADAWSKI: So the Master Trainer
12 themselves are connected under an organization. And
13 that organization has an M.O.U. with main health who
14 is the national license holder. But -- so for
15 example myself I'm a Master Trainer, Stony Brook
16 holds an M.O.U. with Main Health but as a Master
17 Trainer, I can train coaches from other
18 organizations, and they can work under me as their
19 Master Trainer as long as they have that M.O.U. with
20 us at Stony Brook in place.
21 MS. O'NEIL: All right.
22 MS. LADAWSKI: Does that help clarify?
23 MS. O'NEIL: Yeah. I think so.
24 MS. LADAWSKI: Okay. And for example,
25 Rob, who I'm not sure if he's on here. He's in New

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2 York City. He just held a virtual coach training,
3 where anybody from the State could attend that coach
4 training but now has to put an M.O.U. in place with
5 their local Master Trainer who's willing to have them
6 work.
7 So a few of my Long Island folks
8 attended. So they'll be working under me, even
9 though Rob trains them. And I will be taking them
10 under our license agreement to work under me as a
11 Master Trainer. So lots of options in place or a
12 matter of balance at least.
13 And Tai Chi instructors need to be
14 recertified every two years. So do know that there's
15 that financial commitment as well that you'll have to
16 recertify every two years once becoming certified.
17 And then, just one final update to
18 share with the group. As many of you may know,
19 injury prevention is a very broad discipline. And we
20 do a lot of different types of activities to prevent
21 the types of injuries that we are focused on.
22 So that creates a lot of challenges in
23 our tracking and reporting, which is a requirement
24 for the grey book and all previous books. So while
25 we have been bringing this up on a national scale,

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2 that we would like to see a little bit more
3 clarification for our injury prevention professionals
4 in trauma centers to have some more of a standardized
5 approach to that tracking and reporting.
6 It's not being done at a national
7 level. They said go ahead New York. If you can
8 figure it out, we'd love to hear it, especially since
9 we're such a diverse state. That is quite the big
10 undertaking.
11 So with the new standards in place
12 with the grey book, we figured let's take a small
13 portion of that, which would be the logic model that
14 is being mentioned. That would be -- that'll kind of
15 help us see, okay, where do we want to be long term.
16 So let's make sure that we've drawn
17 all of the connections on our roadmap and the
18 resources needed, the activities that we are doing,
19 the outcomes and outputs that we are tracking and
20 reporting since we do have a lot of similarities in
21 the mechanisms that we are addressing, and at least
22 do that together at a statewide level and then you
23 can personalize it for your trauma center.
24 So we will be working on logic models
25 in the near future. So that is all for our

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2 subcommittee. Thank you.
3 MS. O'NEIL: Any questions or comments
4 for Kristi? All right. Thank you, Kristi. And so
5 then we'll move on to regional P.I. with Dr. Bank.
6 MR. BANK: Okay. Can you give me the
7 ability to share the screen just to bring up a couple
8 of slides?
9 MR. CLAYTON: Yes, we're working on
10 it, Doctor.
11 MR. BANK: Thank you. Got it. Thank
12 you. Let's see. Okay. Hopefully everybody's seeing
13 the slides now.
14 MS. O'NEIL: Yes.
15 MR. BANK: Great, thank you. So just
16 in the interest of time, we're going to go through
17 this pretty quick. This was the agenda for our
18 meeting, we had a really robust discussion. I'm
19 going to go through this much faster, though.
20 We're not going to go over the
21 collaborative data, we had a very robust discussion
22 about that. I'm not going to show that right now.
23 So we -- we did have some discussion on the effect of
24 COVID on the New York State trauma system.
25 This is the first time that we've

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2 really been able to get some data out of the New York
3 State Trauma Registry, because 2020 is about ninety-
4 eight percent done right now.
5 2021, it's only about fifty percent
6 done. We only have about fifty percent of the data.
7 So we can't really take this graph out much more to
8 the right.
9 We did include all of 2019 which we
10 have some pretty good data on. So COVID and the
11 COVID crisis -- we’re not really post COVID yet.
12 It's kind of terminology by me. But the COVID crisis
13 really hit New York, which was pretty much ground
14 zero for COVID in the spring of 2020 was late March
15 of 2020 into the end of May 2020 and this was the
16 COVID crisis here.
17 So pre COVID, New York State. So
18 these numbers are all -- all New York State and all
19 trauma centers pediatric adult numbers one, two,
20 three. So everything that's reported to the New York
21 State registry is here.
22 We typically are somewhere between
23 mid-four thousands and mid-five thousands on a
24 monthly admissions basis -- basis to all trauma
25 admissions in New York State. And you can see just

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2 how sharp we created in April of 2020, with the COVID
3 crisis.
4 So we're about twenty-seven hundred
5 patients in the worst of it. So pre COVID crisis, we
6 had almost five thousands patients on average a
7 month.
8 During the COVID crisis, we -- that
9 dropped down more than thousands patients. And then
10 post COVID crisis, we have a pretty robust rebound in
11 the summer of 2020. Back up to high five thousands.
12 If you take this, you just divide it up a little bit.
13 So these are the first four -- four
14 different areas. So this is Upstate. Upstate is
15 defined as any center that's above the Westchester
16 line. And then this is New York City, which is the
17 five boroughs. Then we have Suffolk County, Nassau
18 County and Westchester County.
19 So interestingly enough, and this,
20 just trust me, if you go back into 2018 and 2017, the
21 New York and Upstate curves pretty much mirror each
22 other. And there are some they go up in the summer,
23 they come down in the winter, but pretty much they're
24 always, you know, pretty much in sync, pretty
25 parallel lines, during COVID, which was again this

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2 March, April, May 2020.
3 Everybody takes Westchester, Suffolk
4 Nassau, and the City and Upstate. But interesting
5 enough, the -- the area that lost the most line by
6 far was New York City.
7 So New York City dropped below their
8 volume in April of 2020. Dropped below Upstate New
9 York, which rarely happens. And then, when they have
10 the recovery in the summer of 2020, New York City
11 seems to recover almost in parallel -- parallel with
12 Upstate.
13 Upstate actually jumps up to -- to
14 some pretty high numbers here. It's interesting to
15 see as we kind of get towards 2021 here. The -- the
16 lines are parallel to each other. So once we get
17 some 2021 data, we'll be able to look at this and
18 we'll be able to see the next few waves of COVID and
19 what the -- what the effect was on the New York State
20 Trauma System.
21 There's a pretty robust discussion
22 about really drilling down on these numbers and
23 really taking a look at it. Was it interpersonal
24 violence that decreased and then again, increased in
25 2020. The summer 2020, was it car accidents, was it

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2 elderly people falling and breaking their hips, we
3 really don't know.
4 We are going to drill down on that
5 hopefully this summer, and -- and the next STAC --
6 STAC have a much more detailed analysis of this. But
7 just taking looking -- looking at the mechanisms of
8 injury and also probably looking at mortality,
9 because during that real COVID crisis there was a
10 real effect on the trauma system in terms of beds and
11 emergency room beds and I.C.U. all sorts of resources
12 that were probably being pulled away from the trauma
13 patient at that time.
14 So we will work the registry committee
15 to really get a more robust look at this. And
16 hopefully, by the fall maybe you can have the ability
17 to look at 2020 numbers.
18 The other thing that we looked at was
19 a hip fracture project. And this is eighteen
20 different trauma centers that gave us their -- their
21 data. And these are mortality and hospital event
22 risk ratios.
23 So the blue is the TQIP relative risk
24 that you get in your TQIP report. And the orange is
25 the hospital, that's your hospital complications.

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2 These are eighteen different trauma centers in New
3 York. So interesting enough, we do pretty well
4 because if -- if you ... here in your relative risk
5 then you're doing very well. You're doing better
6 than average.
7 So we can see four ice skate hip
8 fractures, our mortality, which is the blue lines is
9 -- is pretty good. Six -- number six trauma center
10 didn't have enough data to -- for them to analyze it
11 in their TQIP report.
12 So hospital events if you move to
13 hospital events. It -- it vary dramatically varies
14 more than ... We have a couple of centers. Centers
15 two, centers thirteen, and centers eight that are,
16 you know, significantly above the line turn to
17 hospital events for ice skate hip fractures. And
18 then we have a bunch of places that, like,
19 institutions ten, eleven, twelve, they're really have
20 both mortality ...
21 So this, you know, has some -- some
22 thought provokes, you know, provokes a lot of
23 thought. And about what is it about certain centers
24 that are doing very well, and certain centers that
25 are not.

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2 One of the things that we looked at
3 was admitting service where these traumas, these
4 isolated hips are going to. There's -- there's
5 definitely some stuff published on performance
6 improvement projects, admitting ice skate hip
7 fractures, different services can improve looser time
8 to the O.R.
9 And what we found was from these
10 eighteen different trauma centers that there is
11 really no culture in New York and no real system in
12 New York to ...
13 So we have some pretty large centers.
14 So and center four, here's center number six, has
15 over two hundred isolated hips a year. And almost
16 ninety percent of their hips are admitted directly to
17 the trauma service.
18 So the trauma services is handling
19 these two or three hips a year. And then the busiest
20 center in all of New York is this 305 here. The
21 center eleven and -- and they're admitting almost
22 ninety percent of their patients directly to
23 orthopedic -- to orthopedic service.
24 We have other places that are
25 relatively busy, here's -- here's institution fifteen

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2 and they're admitting the past and dragging their
3 patients to other, which is by far is usually the
4 medical service.
5 So, very a few ... hips getting to
6 ortho. Probably about twenty five percent get
7 admitted to trauma. And the large amount getting
8 admitted to another place. These -- these asterisks
9 are just the places that do not have an orthopedic
10 residency and everyone in these other places has an
11 orthopedic residency.
12 So we're trying to see if maybe having
13 orthopedic residency means you're more likely to be
14 admitted to orthopedics, or maybe less likely to be
15 admitted to orthopedics. But you can kind of see,
16 you know, institution four, institution eight, both
17 are relatively busy, both don't have orthopedic
18 residencies and four, admits almost all of their
19 patients to the trauma service, and eight admits
20 almost all the patients to orthopedic service.
21 So from a meeting service, it's kind
22 of difficult to figure out. This is another graph of
23 our time to ... fixation. So you can see that there
24 is a pretty frank culture among the New York trauma
25 centers that most places are gaining their hips to

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2 the O.R. in the mid twenty hours.
3 So somewhere between twenty-five,
4 twenty-six, twenty-seven hours. Now, then an
5 exception of -- of a few. So there's a few that are
6 into the past thirty-eight hours really to the high
7 30s and low 40s.
8 So really the academy centers of how
9 fast they're able to get their hips to the operating
10 room. It appears just us in the mean way, compared
11 to the rest of the country twenty-four hours as a
12 mean instead of twenty-one hours was the mean. Well,
13 we're doing pretty well. We do have a bunch of
14 hours.
15 If you then take those outliers and
16 put them on a scatter gram. So this is operative
17 time to fixation versus mortality ratio. So here's
18 the mortality ratio on the X axis and the times to
19 the O.R. in hours on the Y axis and there is -- what
20 she -- which has been published in the literature
21 multiple times.
22 But there is a slope here, right. So
23 places that get their patients to the O.R. pretty
24 quick within -- all by twenty-four hours, the
25 mortality ratios are all pretty low. Once you start

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2 climbing in terms of times to the O.R. you're getting
3 up here and the mortality rate ratios are definitely
4 getting higher.
5 Interesting enough the one center that
6 does have over forty-five hours averaged to get to
7 their patients, the O.R. still has a mortality ratio
8 of less than one. And, yeah, that is it. I was
9 trying to be very efficient.
10 MS. O'NEIL: Anyone have any questions
11 for Dr. Bank? Or want any clarification of the data?
12 MR. GOLDMAN: Hi, it's Ariel -- it's
13 Ariel Goldman. Good afternoon everybody.
14 MS. O'NEIL: Go ahead, Ariel. Ariel
15 is our orthopedic liaison.
16 MR. GOLDMAN: I want to -- I want to -
17 - can you hear me?
18 MR. BANK: Yeah --
19 MS. O'NEIL: Yes.
20 MR. BANK: -- we can hear you.
21 MR. GOLDMAN: Okay. Sorry. The
22 orthopedist on the panel. I just want to thank Matt
23 and his leadership with the P.I. committee for -- for
24 bringing geriatric hip fractures to -- to light here.
25 It's a, you know, huge part of -- of

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2 trauma care, our -- our ground level -- ground level
3 falls, and our older patients. I can't stress enough
4 how important it is to get the patients to the O.R.
5 early. The scatterplot that was just shared with us
6 really speaks volumes as to the necessity for -- for
7 urgency.
8 There's -- there's multiple articles
9 in the -- in the orthopedic literature in the past
10 six months that say that maybe we should be even
11 getting them even sooner. So patients are calling it
12 a hip attack, where patients and -- and we've all
13 seen these sorts of patients that come in with the
14 ground level fall isolated hip fracture, multiple
15 medical problems, and they're spilling some troponin
16 and those proponents are -- are -- are from cardiac
17 stress, not from an M.I.
18 And those -- those patients they bring
19 to the O.R. within six to eight hours and they're --
20 they're getting them fixed. And they're -- they're
21 saving I.C.U. time and multiple days in the I.C.U. as
22 opposed to cohorts that they're waiting for
23 optimization and clearance on, even though they were
24 spilling troponin.
25 And so this is obviously -- I'm just

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2 posing that as -- as an example. I'm not saying we

3 should be doing that. But, you know, this -- this

4 field is -- is evolving and the cost of care across

5 our -- our country, and particularly in our state,

6 you know, is -- is -- is -- is increasing when it

7 comes to hip fractures and ways to control those

8 costs and improve patient outcomes for our most, you

9 know, our -- our -- our -- our most fragile

10 population in trauma is -- is essential.

11 MR. BANK: Thank you.

12 MS. ULLMAN: Hi, it's Jamie Ullman.

13 I'm sorry, Matt, if I missed it, but is it -- is it

14 safe to say that the admitting service of these

15 patients is not a correlate to outcome?

16 MR. BANK: Correct. For the eighteen

17 places that we looked at, the admitting service was

18 not a correlate to outcome. I can't say from reading

19 some papers from multiple institutions that when you

20 do have a problem, one of the problems you can look

21 at is your minimum service.

22 As I've seen other institution switch

23 the main service and -- and improve their efficiency

24 for means but as far as a culture to pay upon their

25 institution, I -- I think we can safely say that you

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2 could do whatever works for you.
3 You committed to orthopedics medicine
4 or trauma, and whatever works at your institution,
5 you know, there's -- there's -- there it -- it can
6 work.
7 MS. O'NEIL: Yeah. I -- I -- there's
8 no clear publications on this but I think in general,
9 what he is saying is that it's really about your
10 institutional processes and algorithm for getting the
11 patients through your system and that even among
12 different centers, the involvement of medicine in the
13 pre op clearance, etcetera.
14 And the perioperative management may
15 vary but it's really about the level of attention
16 that those individual services paid to that service.
17 You know, I -- I know from different institutions
18 I've been at that medicine services pay very
19 different levels of attention to these different
20 perioperative patients.
21 So it's probably not necessarily the -
22 - what service they're on but the quality of care
23 that they get while on that service.
24 MR. WINCHELL: I -- I am --
25 MS. O'NEIL: And the time --.

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2 MR. WINCHELL: -- it's Dr. Winchell.
3 I might spin that slightly different. It's not
4 really what name you attach to the service. It's the
5 fact that you dedicated processes and dedicated
6 people looking at this group.
7 And that's been shown to improve both
8 process and outcome measures in several arrangements.
9 I think that there are many different ways to skin
10 that cat.
11 MS. O'NEIL: Better said than what I
12 said. Thank you, Rob.
13 MS. ULLMAN: So it's essentially
14 expedience.
15 MS. O'NEIL: It's not just time to the
16 hour, though, because I will tell you that some of
17 our patients are intentionally delayed like patients
18 with uncontrolled comorbidities and pulmonary
19 hypertension, that they, for medical purposes,
20 they're actually better to be delayed slightly.
21 But -- but there's no doubt that you
22 want those -- all those patients that go in as fast
23 as possible.
24 MR. WINCHELL: So yeah, and Dr.
25 Winchell again. I think one of the -- one of the

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2 metrics that people have started looking at in trying
3 to look at this is failure to rescue, again, not
4 whether your patients do or don't get into trouble,
5 but how good your institution is at getting them out
6 of trouble.
7 And that's one of the big things
8 that's often been attributed to the halo effect of
9 being a trauma center or being an emergency or a
10 higher volume center is that those centers tend to do
11 better at fishing their patients out of trouble if
12 they happen to get there. You know, the patients who
13 are going to sail are going to sail either way
14 probably.
15 MS. O'NEIL: Anyone have any other
16 comments or questions for Dr. Banks? Matt, do you
17 have anything else you want to add?
18 MR. BANK: Nope. Thank you very much.
19 MS. O'NEIL: Okay. And then we
20 proceed to systems with Dr. Simon.
21 MR. SIMON: Good afternoon, everybody.
22 So we spent the majority of the Systems committee
23 talking about final revisions to the -- to the New
24 York State file stack bylaws. And I'm going to
25 review what we talked about in two groups.

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2 The first group are kind of the
3 changes that we're going to lump together and read
4 them off because I don't think there'll be really
5 much controversy about them.
6 So I'll just go through them very
7 quickly and then we'll go on to the more complicated
8 ones. So we moved the term trauma stations from the
9 bylaws because there are no more trauma stations than
10 our level three and level four trauma centers.
11 We removed the evaluation and survey
12 subcommittees because they don't exist anymore. We
13 added the trauma and data center needs assessment
14 subcommittee of the systems committee. And a
15 description of that is below. And so that was added.
16 We added a nomination committee and a
17 description. We added the performance improvement
18 committee and a description. And we added the
19 pediatric subcommittee and description for that.
20 And I think these are -- these are
21 just changes that -- that are already occurring in
22 STAC and we just needed to update the bylaws to -- to
23 reflect those changes in STAC. So are there any
24 questions about those changes in the bylaws?
25 MS. O'NEIL: So Ron, are you making an

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2 emo -- a motion to approve those changes
3 collectively?
4 MR. SIMON: Well, I guess, I have to
5 make the motion and then we can, okay. So -- so I
6 move that we make the ... the -- the changes that I
7 just mentioned in the -- the upcoming updated bylaws.
8 MR. TEPERMAN: Dr. Teperman seconds.
9 MS. O'NEIL: Anyone have any need for
10 clarification of the motion or anything for
11 discussion?
12 MS. ULLMAN: It's Jamie Ullman. For
13 the -- not meeting less than three meetings per year.
14 Is that --?
15 MR. SIMON: We're not -- we're not
16 there yet.
17 MS. ULLMAN: What?
18 MR. SIMON: We're not there yet.
19 MS. O'NEIL: He's going to present the
20 other items individually that might require some
21 discussion. So in order to -- his motion currently
22 is to address the removal of the trauma stations, the
23 removal of evaluation surge -- survey committees, the
24 addition of the trauma center needs assessment. The
25 addition of wording for nomination committee's

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2 description and the addition of performance
3 improvement committee, and the addition of the
4 pediatric subcommittee to the current vice -- bylaws.
5 And we're going to separate the motion.
6 So the motion that's on the table is
7 to accept those points collectively. Any additional
8 questions or clarification? So the motion has been
9 seconded. So we will proceed to a vote. I believe.
10 Go ahead, Jamie, do you have a question?
11 MS. ULLMAN: No, no, at that I -- I
12 went ahead of us, so.
13 MS. O'NEIL: Let we get there. No
14 problem. All right. It's a little confusing. We're
15 trying to make it as simple as possible because -- so
16 we understand. So moving forward, we proceed to a
17 vote. I have --.
18 MR. COOPER: ...
19 THE REPORTER: I'm sorry. I can't
20 catch that.
21 MR. COOPER: ...
22 MS. O'NEIL: I think someone is
23 unmuted. Can -- is someone trying to say something?
24 They need to identify themselves and we're having
25 trouble hearing you. Yeah, I think that was --.

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2 MR. GREENBERG: Dr. O'Neil, I believe
3 that was Dr. Cooper. I'm not sure if Dr. Cooper was
4 trying to talk to someone in the background. Dr.
5 Cooper, can you confirm if you're trying to talk to
6 the counsellor or if you have any --?

7 MR. COOPER: I was simply unmuted. So
8 I could -- I was simply unmuted so I could vote.
9 Yes, that's all. I'm sorry.

10 MS. O'NEIL: Okay. So we'll proceed
11 with the vote for those -- for the motion that's on
12 the table. Do we need a roll call vote? Or can we
13 proceed with this general vote?

14 MR. CLAYTON: I believe it's a roll
15 call vote, director. Correct.

16 MS. O'NEIL: Okay.

17 MR. CLAYTON: Roll call vote. Dr.
18 O'Neil?

19 MS. O'NEIL: Aye.

20 MR. CLAYTON: Dr. Doynow?

21 MR. DOYNOW: Doynow, yes.

22 MR. CLAYTON: Dr. Winchell?

23 MR. WINCHELL: Winchell in favor.

24 MR. CLAYTON: Dr. Ullman?

25 MS. ULLMAN: Ullman, yes.

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2 MR. CLAYTON: Dr. Goldman?
3 MR. GOLDMAN: Goldman, yes.
4 MR. CLAYTON: Dr. Cooper?
5 MR. COOPER: Yes. Cooper votes yes.
6 MR. CLAYTON: Dr. Daily?
7 MR. DAILY: Daily, yes.
8 MR. CLAYTON: Dr. Wallenstein?
9 MS. WALLENSTEIN: Wallenstein, yes.
10 MR. CLAYTON: Dr. Flynn? Calling
11 again for Dr. Flynn? Dr. Gestring?
12 MR. GESTRING: Gestring, yes. Thank
13 you.
14 MR. CLAYTON: William Hallinan?
15 MR. HALLINAN: Hallinan is a yes.
16 MR. CLAYTON: Kerrie Snyder?
17 MR. SNYDER: Kerrie Snyder is yes.
18 MR. CLAYTON: Dr. Angus? Dr. Bank?
19 MR. BANK: Dr. Bank is yes.
20 MR. CLAYTON: Dr. Arrillaga?
21 MR. ARRILLAGA: Arrillaga, aye.
22 MR. CLAYTON: Dr. Wasilenko?
23 MR. WASILENKO: Wasilenko votes yes.
24 MR. CLAYTON: Dr. Prince?
25 MR. PRINCE: Yes.

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2 MR. CLAYTON: Dr. Agriantonis? Dr.
3 Agriantonis? Dr. Simon?
4 MR. SIMON: Simon, yes.
5 MR. CLAYTON: Dr. Teperman?
6 MR. TEPERMAN: Teperman, Aye.
7 MR. CLAYTON: Roll call complete.
8 Motion passes.
9 MS. O'NEIL: Okay. Ron, you want to
10 move to your next motion?
11 Dr. Simon, do you want to move to your
12 next motion?
13 MR. SIMON: You know it’s that mute
14 button really keeps throwing me off. Okay. So I'm
15 going to go for the easy one first, especially since
16 Jamie had an interest in it, so I thought I would
17 bring that up. So number eight and then we'll get
18 back to number two, which will take the majority of
19 the discussion.
20 But we added that the State Trauma
21 Advisory Committee shall be scheduled for four
22 meetings per year. The STAC shall meet for no less
23 than three meetings per year. So we -- we really
24 thought and -- and when we wrote this that four
25 meetings is really optimal. But there are times when

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2 things happen and we can't do four meetings and we
3 can only get three meetings done.
4 So we thought that we phrased it in a
5 way that pushes us to have four meetings, but also
6 allows us to have three meetings if there's a problem
7 and one of the meetings needs to be cancelled.
8 MS. SNYDER: Dr. Simon, this is Kerrie
9 Snyder from Albany Med. I'm no lawyer, but isn't it
10 a problem having the word shall, for both shall have
11 four meetings and shall meet for no less than three.
12 Shouldn’t the first sentence be the State Trauma
13 Advisory Committee should be scheduled for four
14 meetings per year?
15 MR. SIMON: Well, my -- my issue with
16 should means it's not mandatory. And what we really
17 want the State to do and the State is supportive on
18 this, is we want the State to plan on having four
19 meetings a year. So we shall, meaning it's stronger
20 than we should. We shall have four meetings
21 scheduled.
22 But we didn't want to be so rigorous
23 that if there was a problem, that we couldn't cancel
24 one.
25 MS. SNYDER: I just think there -- I

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2 think it -- I don't think legally that makes any
3 sense.
4 MS. O'NEIL : I think --.
5 MR. TEPERMAN: I think it's fine.
6 It's me -- it's Teperman. I think it's fine and --
7 and we debated this for quite a while, I think it's
8 fine.
9 MS. ULLMAN: May I ask a question
10 about that? It's Jamie Ullman. So there have been
11 times where certain budgetary constraints for the
12 state government had said that we couldn't meet so
13 many times, and -- and then so that's sort of gone a
14 little bit back and forth over the years.
15 So would anyone anticipate a time
16 where they say, well, we don't have the budget to do
17 more than two meetings. That's just one point. And
18 then the other point is, I think it should just say
19 that the State Trauma Advisory Committee as a whole
20 shall be scheduled. Because then you're doing a
21 whole lot of other interim subcommittee meetings.
22 So I just -- that would be just a
23 point of clarification for the document.
24 MR. SIMON: I'm sorry, I -- I missed
25 the clarification. I didn't follow it.

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2 MS. ULLMAN: State Trauma Advisory ...
3 whole I'm guessing that this is the -- the in person
4 or the meeting of the entire committee as a whole in
5 the formal committee meeting that will occur x number
6 of times a year because there are interim virtual
7 meetings of various subcommittees.
8 So I just thought for clarification
9 that it just says the State Trauma Advisory Committee
10 as a whole whatever shall, would, could, be scheduled
11 for four meetings per year or whatever meetings per
12 year. And now I'm just questioning that does this
13 account for any contingencies that were also
14 mentioned about whether or not there may be
15 constraints to number of meetings, such as budgetary
16 constraints and -- and other factors, even pandemic
17 or whatever.
18 So I mean, one can consider language,
19 just to clarify that as well or too because I know
20 you're trying to be a little bit -- give some leeway
21 in this document so that we don't, you know, that
22 you're not subscribing to one -- one particular
23 number, but -- but there are other circumstances that
24 might change the situation.
25 MS. O'NEIL: Well, actually, Jamie,

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2 the committee members actually wanted to stress that
3 we thought to be successful that we really needed to
4 have a minimum of three meetings a year and try to
5 avoid the -- the scenario where we might go down to
6 two meetings a year.
7 So I think that was the intent of
8 putting in that language. I would tend to agree with
9 Kerrie, though, that I would -- I think the -- the
10 language of the State Trauma Advisory Committee
11 should meet -- should be scheduled for four times a
12 year, but shall meet for no less than three meetings
13 a year is a better way to phrase it.
14 Although I don't feel that strongly
15 about it because it does -- it is actually a little
16 bit contradictory using shall twice. And to answer
17 your question, I may be wrong but we're referring to
18 the meeting as a whole in general, when you talk
19 about the State Trauma Advisory Committee, you're
20 talking about the formal committee and the
21 subcommittees, my understanding is, maybe Dan or Ryan
22 can weigh in.
23 We can have as many subcommittee
24 meetings in between the formal STAC meeting as much
25 as we want. We're not limited by these bylaws or by

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2 convention.
3 MS. ULLMAN: That's correct. But I
4 think sometimes and I've done numerous bylaws and
5 then you look back on it and there was one word in
6 there that was very nebulous and you can just
7 interpret it as you will, I've just had a situation
8 with -- you know, on elections of a committee of one
9 of our national organizations.
10 So I'm just saying that you might just
11 want to make that really clear that it will be the
12 State Trauma Advisory Committee, the full or formal
13 committee, whatever, however, you want to turn that
14 be scheduled for x number of meetings per year.
15 MR. TEPERMAN: I would just say
16 though, if you look in the bylaws, when it says STAC,
17 it's implicit in there and -- and also it's Teperman
18 speaking. The -- just in terms of the shall clause.
19 So there is two different things that are happening
20 in this state. The first shall refers to the
21 scheduling, and the second shall refers to the actual
22 having of a meeting.
23 So with my -- you know, non-lawyer but
24 having grown up in a household of lawyers, I think
25 it's fine. And also, we spent a fair amount of time

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2 in the committee of moving this back and forth and I
3 think we landed on perfect language.
4 MS. ULLMAN: Well, that's why you're
5 having a discussion here Dr. Teperman is for anyone
6 else to suggest potential, you know, changes to the
7 language. I wasn't at the committee meeting, I
8 apologize. But I just think that -- that if you want
9 to write a definition in the bylaws that STAC will
10 refer to the committee as a whole at the beginning of
11 the document then you don't need to repeat it here.
12 I know, this sounds -- it may sound
13 trite or trivial. But I think that -- believe me,
14 when somebody is looking back at bylaws and if
15 something wasn't followed, then -- then at least you
16 have some clear definition of what we're talking
17 about.
18 MR. SIMON: So is it possible to if --
19 can this be run by legal quickly in a curbside
20 consult and see what they think without forcing this
21 to be delayed for another two years.
22 MS. O'NEIL: Well, Ron, if you were to
23 add though -- I'm just giving a little bit of a
24 comment. If you were to add the word whole, the
25 State Trauma Advisory Committee as a whole shall be

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2 scheduled for four meetings per year, et cetera, et
3 cetera. It -- I don't think it changes the content
4 or the implication of the statement.
5 So it would be an easy compromise to
6 make. Because it -- I mean, I -- I would agree with
7 Dr. Teperman that when we talk about the STAC, it's
8 implicit that we're talking about the whole
9 committee. But if you were to add a simple word as
10 whole, I don't think it changes the intent of the
11 statement. So I could go either way.
12 MR. SIMON: How about if we said
13 formally, the State Trauma Advisory Committee shall -
14 -.
15 MS. O'NEIL: Formally is vague, I
16 don't know, then someone might interpret that as in
17 person versus virtual versus so --.
18 MR. SIMON: All right. I -- you know,
19 I could it's -- we could put the whole and we could
20 say the whole State Trauma Advisory Committee, but
21 that to me suggests that there's a half and I don't -
22 - there is no half. So you know, I kind of -- I kind
23 of go -- I kind of agree with Sheldon.
24 I -- I think everyone -- no matter
25 what you do, if you write a sentence, there's going

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2 to be somebody in the room that will have some
3 legitimate problem with it. And no matter how you
4 change it, you're going to still have a problem.
5 Somebody's going to have a problem. I -- I think if
6 somebody mentions the State Trauma Advisory Committee
7 it's very, very clear to -- to me, at least, what
8 we're talking about.
9 We're not talking about a sub-
10 committee. We're talking about the State Trauma
11 Advisory Committee, which is one big committee.
12 MS. O'NEIL: Okay. So we have the
13 motion is a put forward. Does anyone have any other
14 comments related to any other aspect of that -- that
15 motion? Then I suggest we move forward with the vote
16 for the motion that's on the table, which will be
17 accepting the added statement that the State Trauma
18 Advisory committee shall be scheduled for four
19 meetings per year.
20 The STAC shall meet for no less than
21 three meetings per year. That's the motion that's on
22 the table. Can we move forward with the vote, having
23 no further comments or discussion? Dan, do we need a
24 roll call vote?
25 MR. CLAYTON: Yes, we do. I was just

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2 waiting to see if there was anybody else that had any

3 comments. I'm sorry.

4 MS. O'NEIL: No problem.

5 MR. CLAYTON: So we could do roll call

6 if you're ready, Doctor.

7 MS. O'NEIL: I'm ready.

8 MR. CLAYTON: Dr. O'Neil?

9 MS. O'NEIL: Yes, I accept.

10 MR. CLAYTON: Dr. Doynow?

11 MR. DOYNOW: Doynow, yes.

12 MR. CLAYTON: Dr. Winchell?

13 MR. WINCHELL: Winchell in favor.

14 MR. CLAYTON: Dr. Ullman?

15 MR. : Ullman says I guess, yes.

16 MR. CLAYTON: Dr. Goldman? Dr.

17 Goldman? Dr. Cooper?

18 MR. COOPER: Yes.

19 MR. GOLDMAN: Goldman, yes.

20 MR. CLAYTON: Dr. Daily?

21 MR. DAILY: Daily is I guess, no.

22 MR. CLAYTON: I’ll take that as a no.

23 MR. DAILY: Thank you.

24 MR. CLAYTON: Dr. Wallenstein?

25 MS. WALLENSTEIN: Wallenstein, yes.

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2 MR. CLAYTON: Dr. Flynn? Dr. Flynn?
3 Dr. Gestring?
4 MR. GESTRING: Dr. Gestring, yes.
5 MR. CLAYTON: Dr. Gestring, I believe
6 I heard you but could you repeat your vote please?
7 MR. GESTRING: I said, yes.
8 MR. CLAYTON: Thank you. William
9 Hallinan?
10 MR. HALLINAN: I shall vote yes.
11 MR. CLAYTON: Kerrie Snyder?
12 MS. SNYDER: Kerrie Snyder is a no.
13 MR. CLAYTON: Dr. Angus?
14 MR. ANGUS: ...
15 MR. CLAYTON: Dr. Bank?
16 MR. BANK: Dr. Bank is a yes.
17 MR. CLAYTON: Dr. Arrillaga?
18 MR. ARRILLAGA: Arrillaga vote aye.
19 MR. CLAYTON: Dr. Vosswinkel?
20 MR. VOSSWINKEL: Vosswinkel vote yes.
21 MR. CLAYTON: Dr. Prince.
22 MR. PRINCE: Yes.
23 MR. CLAYTON: Dr. Agriantonis? Dr.
24 Agriantonis, you might be on mute.
25 MR. DEMAY : I muted him. I just

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2 unmuted.

3 MR. CLAYTON: Might have your phone

4 muted. Dr. Simon?

5 MR. SIMON: Simon says yes.

6 MR. CLAYTON: Dr. Teperman?

7 MR. TEPERMAN: Teperman, aye.

8 MR. CLAYTON: Roll call complete,

9 motion passes.

10 MS. O'NEIL: Thank you, Dan. And Ron,

11 another motion to put forward?

12 MR. SIMON: That was the easy one.

13 Are we going to get through this one? Okay. All

14 right. So the final -- the final changes involve

15 term limits for the chair and vice chair. And the --

16 what was agreed upon, I want to read all four -- I'm

17 going to read all four of them. And -- sorry, all

18 five of them.

19 And I'll read -- I'll read all five

20 then we can discuss them one by one. I guess that

21 makes the most sense. So the first is act -- as far

22 as qualifications for chair and vice chair of the

23 STAC. Active membership in New York State STAC for a

24 minimum of two years with active membership as

25 described as missing no more than one unexcused

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2 meeting per year with all excuses being evaluated by
3 the executive committee. That's one.
4 Two, a term has been defined as three
5 years, three. A member may be reappointed to the
6 same position for a maximum of two consecutive times.
7 MS. O'NEIL: Terms.
8 MR. SIMON: Terms, okay.
9 Approximately twelve months prior to the expiration
10 of a member's term, the executive secretary shall
11 ascertain if the member is interested in
12 reappointment. And this just allows us a heads-up.
13 It used to be six months. But with the way meetings
14 have been, it's just kind of felt that six months is
15 not enough time, if somebody doesn't want to run, to
16 find replacements for them and have them vetted and
17 whatnot.
18 So the -- the change there is from six
19 to twelve months. And then the last point is, after
20 a period of one term out of a previous held position,
21 a member can become eligible for reappointment. So
22 what that means, just to be clear, is if you are a
23 chair or two terms, then you have to sit out one term
24 before you can run again to be chair.
25 That does not mean that if you were

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2 chair for two terms that you couldn't then go and run
3 to be vice chair. It's just that you need -- you
4 need to take one term out between holding the same
5 post after two consecutive sessions. So with that
6 said, I think it's just easier to start with A, and
7 then run through them if anybody has any comments.
8 So the first one for comments are
9 active membership in STAC is required for a minimum
10 of two years with active membership described as
11 missing no more than one unexcused meeting per year,
12 with all excuses being evaluated by the executive
13 committee. And we did this because we didn't want to
14 start saying that -- and it's okay, excuses
15 maternity, paternity leave, medical leave, military
16 leave.
17 We didn't want to get into all of the
18 different possibilities because we knew we would
19 leave one out. And so we said we would just empower
20 the executive committee to come up with a reasonable
21 decision on whether or not an absence is excusable or
22 not. Comments?
23 MR. DAILY: Dr. Daily. So Dr. Simon,
24 I'm just a little bit confused because at the end of
25 the day, we can make any of -- any of our

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2 requirements that we want, but the commissioner makes
3 the decision on who the chair is.
4 So would it make not more sense for us
5 just to say that we` recommend this be a two-year
6 membership on the STAC and then allow the
7 commissioner the grounds to make their own decision?
8 MR. SIMON: Well, I'm not the oldest
9 person, although I'm a little concerned that I might
10 be the oldest person here. I do not -- I do not
11 remember though, I will ask Art because Art is our
12 historian per excellence. Art, do you ever remember
13 that a time when a recommendation by the STAC hasn't
14 been approved by the commissioner?
15 MR. COOPER: I do not recall such a
16 thing. Prior to the early 2000s, however,
17 commissioner made the ...
18 THE REPORTER: I'm sorry, I'm having
19 trouble hearing Mr. Cooper.
20 MR. COOPER: ... and then that
21 recommendations for especially to my knowledge there
22 is ... circumstance in which a commissioner has --
23 MR. SIMON: Dr. Cooper.
24 MR. COOPER: ... accept a
25 recommendation.

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2 MR. CLAYTON: Dr. Cooper, this is Dan
3 Clayton, we're catching about twenty percent maybe of
4 what you're saying which isn't enough contextually.
5 MR. GOLDMAN: Well, I think -- I think
6 Art said that --.
7 MR. COOPER: How is that? Is it
8 better?
9 MS. ULLMAN: Yes. That's better.
10 MR. COOPER: I'm sorry, ... what I
11 said was the ... early 2000s, commissioner made his
12 recommendation depending ... after about early 2000s
13 STAC ... action but no, there's never been a time to
14 my knowledge that commissioner has turned down a
15 recommendation ...
16 MR. SIMON: So again, you cut in and
17 out a little bit, but I heard most of it. And
18 basically, the commissioner has never denied STAC's
19 recommendation since the early 2000s.
20 MR. COOPER: That's right.
21 MR. SIMON: When -- when we -- when we
22 began the process of making a referral. And I think,
23 as far as the comment about a two-year term versus a
24 three year term, there -- there is just a feeling
25 that it takes -- it takes a bunch of months to figure

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2 out the job and to start meeting the people and to
3 start defining who you are.
4 So we thought two years was a little
5 bit too short. And we thought three years was kind
6 of the right length of time, not too long, not too
7 short.
8 MS. O'NEIL: Particularly since we
9 generally meet only three to four times a year,
10 right. So two years would mean you'd at most be
11 chairing for four meeting -- eight meetings at best.
12 And it may be a little bit hard to move things
13 forward with that. Of course, you do have the
14 ability to be reinstated for a second term.
15 But should you not, we thought that
16 three years was better and more effective than two.
17 Any comments on -- well, let's -- let's just clarify
18 where -- I didn't hear any discussion or comments or
19 negative comments related to the unexcused meetings
20 or the active membership requirement for a minimum of
21 two years.
22 Is there any further comment -- is
23 there any comments related to that or questions
24 related to A -- to A? Any further comments then
25 related to a term being defined as two versus three

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2 years?

3 MS. ULLMAN: It's Jamie Ullman, I

4 support three years. One year is definitely not

5 enough. Two, it may just at the end of that two say

6 too, you know, there's a lot I still want to do. And

7 three years I think is great.

8 MS. O'NEIL: Okay. Maybe you want to

9 move forward to item C then, Ron?

10 MR. SIMON: Okay. So reappointments,

11 the reappointment to the same position for a maximum

12 of two consecutive terms.

13 MS. WALLENSTEIN: It's Kim

14 Wallenstein. I think that's a -- that just seems a -

15 - that's a little bit unclear because reappointed to

16 terms sort of suggests that the person is there three

17 times. So maybe it should just be a member maybe

18 appointed to the same position for two times -- two

19 terms.

20 MR. SIMON: Well, but if they do a

21 crappy job, then they may not be reappointed. It's

22 not a six year -- it's not a six-year position. It's

23 a three-year position and then after three years, you

24 can run again for the same job.

25 MS. WALLENSTEIN: Right. But the way

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2 -- I mean, maybe nobody else sees this the way that I
3 do. But the way I'm seeing it when you say the
4 member may be reappointed to the same position, I
5 guess if you say a maximum of two consecutive terms,
6 but still it seems like they're reappointed for two
7 terms and they've been there the initial term.
8 So that makes it three total when I
9 think you mean two total.
10 MR. SIMON: I hear you. So if I took
11 out reappointed and I just made it a member may be
12 appointed to the same position a maximum of two
13 consecutive times.
14 MS. WALLENSTEIN: Right.
15 MR. SIMON: That would fix that.
16 MS. O'NEIL: Terms, terms.
17 MR. SIMON: Yeah, two terms. So it's
18 just taking out the "re" from appointed.
19 MR. TEPERMAN: I think that's good.
20 We have a point there.
21 MR. SIMON: It -- it just goes to show
22 that then I'm not absolutely unmovable on anything in
23 these things. But that's -- I have no problem with
24 that. Anybody else want to make a comment on the two
25 reappointments because --.

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2 MR. TEPERMAN: That was -- that was --
3 it was Teperman. I agree with what both of you were
4 saying.
5 MR. SIMON: Okay. So I'm adjusting
6 reappointment to just appointed -- appointed. A
7 member may be appointed to the same position a
8 maximum of two consecutive terms. And I -- I kind of
9 agree that that does seem to flow better. Okay.
10 Next. So the next one is basically after two terms,
11 you have to wait.
12 I'm sorry, the next one is twelve
13 months prior to the expiration that the person in
14 that seat should let the executive secretary know
15 whether or not they're interested in reappointment.
16 And again, that's just to help move the process
17 along.
18 MS. ULLMAN: So -- it's Jamie Ullman
19 again. Just to comport with C, it's probably after
20 twelve months prior to the expiration of a member’s
21 first term. The executive secretary shall ascertain
22 if a member is interested in reappointment.
23 MR. SIMON: Okay. I just put that in.
24 MR. TEPERMAN: Teperman agrees.
25 MR. SIMON: No further discussion.

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2 And then the last one is after a period of one term
3 out of a previously held position, a member can
4 become eligible for reappointment. Now, there I
5 think reappointment is okay.
6 MS. ULLMAN: Well, why don't you say
7 just a new appointment. They're not -- they're --
8 they're -- you know, running a new after this --
9 they've had a chance to do it and they've done it
10 before, but then they can't do it anymore. But
11 that's only a three-year statute of limitations or
12 whatever you want to say.
13 And then -- then now they're able to
14 run again and become again a new chair.
15 MR. TEPERMAN: This one -- it's
16 Teperman. This one, Ron, I think you are okay here.
17 I would respectfully disagree. I think this one is
18 okay.
19 MR. SIMON: I think the reappointment
20 here is actually the right word because they're being
21 reappointed to the same position.
22 MS. ULLMAN: Okay. I concede.
23 MR. SIMON: Okay. Boy, we are good.
24 All right. Has -- so is there any other discussion
25 and Trish, you want to take it from here?

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2 MS. O'NEIL: Yeah. So just one last -

3 - is there any further discussion of any of the four

4 points, one, two, three, five points that are on the

5 table? And -- and Ron, you've already made changes

6 to the language that was proposed, correct?

7 MS. SIMON: Yes, I've made all of the

8 changes and I will -- I will send it to Dan.

9 MS. O'NEIL: And we've all -- and

10 we've all seen those changes in language that were

11 proposed and accepted that are before us. So one

12 last time. Does everyone agree with the -- the

13 motion will be to move forward with these two except

14 one A, B, C, D and E as they are written on the

15 screen?

16 MR. SIMON: No, no. It's not --.

17 MS. O'NEIL: Which one is missing?

18 MR. SIMON: Actually, I don't know. I

19 wasn't watching the screen. Did someone update the

20 screen as we were discussing things?

21 MS. O'NEIL: I thought you were, but

22 you were -- okay.

23 MR. CLAYTON: Yes.

24 MR. SIMON : I don’t know ...

25 MR. CLAYTON: Dan Clayton says yes to

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2 Dr. Simon's question.
3 MS. ULLMAN: So ... has not been
4 updated to terms, just F.Y.I. and number C.
5 MS. O'NEIL: Number C. Yeah, I'm just
6 trying to make the ability to vote for these
7 collectively a little easier since there were some
8 discussions with recommended changes, so we don't
9 have to repeat the motion to include the language
10 changes on every item or every line because that
11 would be pretty tedious.
12 MR. SIMON: Right. Teperman says I
13 think we have it now. I think that they change
14 terms. I think we have it now.
15 MS. O'NEIL: Okay. So to the
16 committee members, are you satisfied with the
17 language that is listed there in front of us that we
18 can move on now to a vote to accept the
19 qualifications for chair and vice chair that include
20 items -- sub-items, A, B, C, D, E, as written?
21 Hearing no negatives, I think we can proceed then
22 with the roll call vote.
23 MR. CLAYTON: Roll call vote. Dr.
24 O'Neil?
25 MS. O'NEIL: Yes.

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2 MR. CLAYTON: Dr. Doynow?
3 MR. DOYNOW: Doynow, yes.
4 MR. CLAYTON: Dr. Winchell.
5 MR. WINCHELL: Winchell, yes.
6 MR. CLAYTON: Dr. Ullman?
7 MS. ULLMAN: Yeah, Dr. Ullman, yes.
8 MR. CLAYTON: Dr. Goldman? Dr.
9 Cooper?
10 MR. COOPER: Cooper, yes.
11 MR. CLAYTON: Dr. Daily? Dr. Daily?
12 MR. DAILY: Not currently on.
13 MR. CLAYTON: Not currently on. Thank
14 you. Dr. Wallenstein?
15 MS. WALLENSTEIN: Wallenstein, yes.
16 MR. CLAYTON: Dr. Flynn?
17 MR. FLYNN: Yes.
18 MR. CLAYTON: Dr. Gestring?
19 MR. GESTRING: Gestring, yes.
20 MR. CLAYTON: William Hallinan?
21 MR. HALLINAN: Hallinan, yes.
22 MR. CLAYTON: Kerrie Snyder?
23 MS. SNYDER: Kerrie Snyder, yes.
24 MR. CLAYTON: Dr. Angus? Dr. Bank?
25 MR. BANK: Dr. Bank is yes.

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2 MR. CLAYTON: Dr. Arrillaga?
3 MR. ARRILLAGA: Arrillaga votes aye.
4 MR. CLAYTON: Dr. Vosswinkel?
5 MR. VOSSWINKEL: Vosswinkel votes yes.
6 MR. CLAYTON: Dr. Prince?
7 MR. PRINCE: Yes.
8 MR. CLAYTON: Dr. Agriantonis?
9 MR. AGRIANTONIS: Dr. Agriantonis,
10 aye.
11 MR. CLAYTON: Dr. Simon?
12 MR. SIMON: Dr. Simon, aye.
13 MR. CLAYTON: Dr. Teperman?
14 MR. TEPERMAN: Teperman, aye.
15 MR. CLAYTON: Roll call complete,
16 motion passes.
17 Excuse me, I'm sorry, Dr. Daily, is
18 apparently back on. Dr. Daily, do you have a vote on
19 this, the term limit vote?
20 MR. DAILY: Yes. Dr. Daily, yes
21 MR. CLAYTON: Thank you. Roll call
22 complete, motion passes.
23 MS. O'NEIL: Thank you, Dan. Just one
24 more item for clarification on this. So we now have
25 accepted the bylaws as they are written and presented

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2 today, but there is two additional steps. Dan and
3 the Bureau will need to present this to legal counsel
4 to accept any wording.
5 And at which time then it needs to
6 move up to the commissioner's -- to the
7 commissioner's office for their approval as well
8 before it becomes final.
9 MR. SIMON: I just wanted to say we
10 got this done in fourteen months.
11 MS. O'NEIL: Better than the seven
12 zero eight regs.
13 MR. SIMON: Right -- right, that --
14 that's ...
15 MS. O'NEIL: Well, I will say it did
16 seem to be a little tedious at times. I -- I think
17 trying to work virtually and with all the disruption
18 that we had over the last few years, it -- it did
19 seem to be quiet a lengthy process. But at least I
20 think we've accomplished a lot today.
21 And it's amazing that we finally make
22 some progress on several items. So we have one more
23 sub-committee report before we move on to our liaison
24 reports. And Dr. Wallenstein, can you give us the
25 pediatric trauma report?

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2 MS. WALLENSTEIN: All right. Thank
3 you. Kim Wallenstein, I'm the co-chair of the
4 pediatric sub-committee. I will make this brief. We
5 have no motions that need to be voted on. We talked
6 about several initiatives in pediatrics.
7 Dr. Wakeman from Rochester, New York,
8 which has just been accredited as a level one
9 pediatric trauma center presented some research that
10 they have done there in quality initiatives about
11 reducing radiation in children which was very
12 interesting and how their algorithms helped them
13 reduced the radiation exposure in their trauma
14 population.
15 He also discussed our New York State
16 collaborative research consortium that has been
17 successful in having one publication accepted this
18 year and also an abstract that was presented at
19 pediatric trauma society. So that was our research
20 component.
21 We had a discussion of some injury
22 prevention and how that has changed during the era of
23 COVID in terms of the lack of in person ability to do
24 a lot of the classes that have moved online and with
25 different sort of Q.R. codes to get things across to

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2 families. And so a lot of the technology has been
3 used for that.
4 The Safe Sitter program has sort of
5 been transitioned to a safe at home program for
6 younger children who are in the house more in this
7 era. We've been -- Dr. Cooper some -- some issue
8 from E.M.S.C. which I'm sure he will also -- I don't
9 know if he's going to give his report during this,
10 but he discussed two protocols from E.M.S.C. that
11 they've been looking at with agitated patients and
12 also pandemic issues.
13 The two initiatives that we talked
14 about briefly that we're going to have to explore in
15 the future and potentially bring back to either STAC
16 or STAC sub-committees are -- number one, would be
17 the new field triage guidelines which just came out
18 and we still need to review those in detail to see
19 what the latest iteration is going to do for the
20 triage of pediatric patients.
21 And then also as everybody knows and
22 we've talked about the new grey book has been
23 published and there is a lot of components to do with
24 pediatrics that even the adult centers who care for
25 pediatric patients are going to have to follow. And

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2 so we will look over those to see how we can help our
3 adult colleagues deal with those situations within
4 their population. So that was my report.
5 MS. O'NEIL: Thank you, Kim. I -- I
6 had specifically reached out to Kim and Jose Dr.
7 Prince that asking that their sub-committee help
8 moving forward in the subsequent months in subsequent
9 meetings maybe help provide us with some guidance
10 with the new PECC requirements the P.E.C.C., the
11 pediatric emergency department coordinator, I can't
12 remember what the second C stand for.
13 Many of us have heard and been
14 introduce to it briefly through TQIP but it's
15 actually pretty extensive and it's actually more of
16 an emergency department thing than it is specific
17 trauma service issue. And so I thought that we could
18 really -- and may have experience and knowledge of
19 how it came through from the E.M., emergency --
20 sorry, I think it primarily came out of the emergency
21 medical services for children guidelines.
22 And so I am hoping that they can help
23 us, adults, trauma surgeons, and programs get some
24 assistance from them in helping us move forward with
25 that because that's a pretty big new requirement.

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2 MS. WALLENSTEIN: And Kim Wallenstein
3 again. That -- it's a -- I had to write it down too
4 because I always forget what I see, it's a pediatric
5 emergency care coordinator?
6 MS. O'NEIL: Right.
7 MR. CLAYTON: Dr. Wallenstein -- Dr.
8 Wallenstein, it's Daniel Clayton from the Bureau.
9 Amy Eisenhauer from E.M.S.C. would like to comment.
10 MS. EISENHAUER: So just to clarify
11 some -- some questions that Dr. O'Neil might have had
12 or any of the group might have had, so E.M.S. for
13 children ... state and the several territories that
14 E.M.S.C. ... one of their ... is to have pediatric
15 emergency care coordinator ... arriving here at the
16 bureau and becoming the program manager ... and
17 Central Health Care Services assisted her and helping
18 in pre-hospital pediatric emergency care coordinator
19 program that is currently active in our state.
20 There has -- there -- there is an
21 emergency department version of the program and
22 essentially the person is championed in that
23 emergency department to promote pediatric specific
24 education ... appropriate their level of care,
25 appropriate for their facility champion appropriate

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2 child, specific size equipment, right.
3 So obviously different equipment is
4 different sizes, children need different things. And
5 then interact with, you know, not only the pre-
6 hospital tech, but the E.M.S. provider as well to
7 make that ... So if you give me a moment, I can pull
8 up that information from the E.I.I.C. site.
9 We currently don't have one for E.D.
10 and some of that was COVID and everybody was busy and
11 there wasn't really an opportunity to insert such a
12 program into the emergency department while everybody
13 was ... However, there is a ... consortium of
14 E.M.S.C. program manager and there is already a
15 program that has been developed and is upgrading
16 within several of our neighboring state.
17 And I mentioned this ... injury
18 prevention or the pediatric sub-committee, but I will
19 be happy to organize the workgroup with our trauma
20 colleagues and some E.M.S.C. colleagues and those who
21 have interest to review this program to attest it
22 however New York State need. I understand that in
23 motion now that this is the criteria, a new criteria.
24 And now there is an opportunity to get
25 it underway because it definitely would be beneficial

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2 and a lot of research around how having a ...
3 coordinator and specific education in the E.R.
4 improve outcome for patients, for pediatric patients
5 specifically.
6 MS. O'NEIL: Thank you for that
7 clarification. Does anyone have any further
8 questions for Amy or for Dr. Wallenstein? Okay. So
9 we'll move forward then with the report from the New
10 York State Chapter of the A.T.S. As I mentioned
11 earlier Gerry Morrison is attending the T.C.C.A.
12 meeting and so Carrie Garcia has agreed to give the
13 report on his behalf.
14 MS. GARCIA: Yes. Can you hear me?
15 MS. O'NEIL: Yes, we can.
16 MS. GARCIA: Okay. Great. For those
17 who do not know me. Hello, my name is Carrie Garcia.
18 I'm the current president elect for the New York
19 State A.T.S. chapter. I'll be reporting out our most
20 recent meeting for the current president Jerome
21 Morrison as he is attending T.C.A.A. which has an
22 agenda. Okay.
23 So we met virtually on April 19th and
24 the meeting was well attended. We began the meeting
25 with a moment of silence to Honor Dr. Bill Marks

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2 before beginning each committee's report out. From
3 the education committee, it was reported that in
4 response to the new requirements outlined in the new
5 standards book, a survey to evaluate educational
6 needs will be distributed prior to the next meeting.
7 The injury prevention and outreach
8 committee reported on the -- on the currently
9 scheduled and planned events for the month of May, as
10 May is the designated trauma awareness month and Stop
11 the Bleed month. The latest A.T.S.I.P. newsletter
12 was also presented with a call for submissions for
13 the upcoming June issue.
14 The legislative committee reported
15 that a call for members has gone out as there is much
16 legislation surrounding trauma care. Current work on
17 Stop the Bleed legislation, and updates to national
18 funding for mission zero allocations were shared.
19 Also noted is there is an upcoming legislative
20 meeting which will be held on June 8 for anyone who
21 would like to attend.
22 Eric Cohen reported that E.N.A. is
23 currently looking for case scenarios to be added to
24 the nurse residency program that E.N.A. has
25 developed. He also shared that there is a new

2 version of T.N.C.C. which is expected to be rolled
3 out next year. Ann Glazer reported that S.T.N. is
4 looking for committee participants and if there is a
5 new initiative for recruitment which would focus on
6 cultivating a more diverse group of participants.
7 Finally, Gerry asks that I thank Dan
8 and Patty for graciously allowing us to use the New
9 York State Department of Health Trauma ListServ for
10 distribution of information from the A.T.S.
11 committee. However, Gerry is working with A.T.S. on
12 the development of a separate A.T.S. ListServ to be
13 able to provide the most up-to-date educational
14 offerings, grants, awards, et cetera.
15 That's all I have, thank you for your
16 time.
17 MS. O'NEIL: Thank you, Carrie.
18 Anyone have any questions or comments for Carrie?
19 MR. TEPERMAN: Yeah, hey, it's Sheldon
20 Teperman. Hey, Carrie.
21 MS. GARCIA: Hi, Sheldon Teperman.
22 MR. TEPERMAN: Long time no see. So
23 just clarification about the ListServ. So the only
24 way that A.T.S. members had been sort of been able to
25 communicate globally with education in the past had

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2 been to jump on the -- the STAC ListServ, there

3 hadn't been, you know --

4 MS. GARCIA: A separate ListServ?

5 MR. TEPERMAN: -- there had not been?

6 MS. GARCIA: Uh-huh.

7 MR. TEPERMAN: Okay.

8 MS. GARCIA: We were definitely

9 submitting everything through the trauma ListServ

10 through Dan.

11 MR. TEPERMAN: Okay. Until -- until

12 Dan and Dan's people get this figured out, like,

13 you're going to continue to do it this way?

14 MS. GARCIA: Yes, yeah.

15 MR. TEPERMAN: Okay. Thanks, Carrie,

16 very well done.

17 MS. GARCIA: Thank you.

18 MS. O'NEIL: And I should say I should

19 apologize on behalf of the bureau and the executive

20 committee. We do apologize that today's meeting was

21 set for now. We did not realize that the T.C.C.A.

22 meeting was scheduled. Moving forward, you know, we

23 do attempt to try to organize the meeting dates

24 around to avoid other non-meetings.

25 And unfortunately, we sometimes forget

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2 some of the meetings that -- that our nursing
3 colleagues attend and our other trauma colleagues
4 attend. So for the next academic year or the year
5 moving forward, we are making a much greater effort
6 to get a list of all meetings that our membership are
7 likely to attend and try to avoid a conflict as much
8 as possible.
9 So our apologies do go out to our
10 colleagues who are unable to attend today because of
11 that. And so can we move forward to the SEMAC
12 report? Dr. Doynow, are you here?
13 MR. DOYNOW: All right. Dr. Doynow.
14 I will try to be brief. So we met in April. There
15 were three actions that were voted on and approved by
16 SEMAC and SEMSCO. Pediatric Pandemic Protocol was
17 accepted, the adult pandemic protocol which was
18 modified previously and we discussed the COVID
19 hotline which has been changed to pandemic hotline
20 for unfortunately the next pandemic that may occur.
21 The O.P.A. for the opioid pilot
22 project, Suboxone was added to the medication list.
23 For information, the collaborative protocol changes
24 that were previously voted and accepted have been
25 released, they should be out there. The outline for

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2 collaborative protocol changes in the future which
3 basically outlines a timeframe for the process was
4 discussed.
5 And we voted on it at the next
6 meeting. I.G.L. pilot study was approved for --
7 statewide with an educational program that was being
8 developed. I believe Dr. Cooper is going to talk
9 about the pediatric agitation protocol. Dr. Young
10 who retired from the health department after many
11 years received a New York State Lifetime Achievement
12 Award.
13 Anything else to report Mark Phelps
14 from SEMSCO and myself had a virtual meeting with
15 Commissioner Bassett. We proposed that the D.O.H.
16 create a position there would be a statewide E.M.S.
17 medical director. She requested that we present to
18 her a job description. My committee was formed to do
19 that and that job description will be reviewed at the
20 next meeting.
21 Which at this point would be either
22 June or July and then will be sent on to the
23 department for their approval and hopefully they will
24 move on that position. That's it from SEMAC.
25 MS. O'NEIL: Dr. Doynow, are you able

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2 to give us sort of a brief overview of what your
3 committee anticipates the role of that new position
4 would be? I mean, I know we are not asking you for a
5 little -- a literal description right now, since you
6 still have to write up the description. But what was
7 the general intent for creating that -- that
8 position?
9 MR. DOYNOW: Intent would be that
10 there would be a physician that the department would
11 be able to use for advice in regards to E.M.S. in the
12 state. Previously, Dr. Young was a physician who the
13 Department would go to. Many states actually have a
14 statewide E.M.S. medical director. Unfortunately,
15 New York is not one of them.
16 So basically that position -- that
17 person would oversee E.M.S. throughout the state, and
18 --.
19 MS. O'NEIL: And with -- and they
20 would have a separate rule completely from SEMAC and
21 SEMSCO, but have a close liaison, a relationship with
22 you?
23 MR. DOYNOW: That is correct. And it
24 would be a D.O.H. position. Ryan may want to comment
25 on the -- the meeting with the Commissioner the

2 thought was that it would be a part-time position,
3 will not be a full-time position.
4 MS. O'NEIL: Ryan, do you have any
5 ...?
6 MR. GREENBERG: That -- that's
7 correct. And I think we are just -- you know,
8 working on next steps and what that would look like.
9 MS. O'NEIL: Okay. Well, I know we'd
10 be very interested in our next meeting to get more
11 information about the job description and -- and how
12 that will play into all about our relationships.
13 MR. GREENBERG: Absolutely, once we
14 have that, I certainly will bring it forward to you.
15 MS. O'NEIL: Thank you.
16 MR. GREENBERG: Welcome.
17 MS. O'NEIL: And then last. Art, can
18 you give us your report from the E.M.S.C.?
19 MR. COOPER: I sure can. Can you hear
20 me all right?
21 MS. O'NEIL: Much better this time.
22 MR. COOPER: Okay. Fine, thank you. I
23 think Amy Eisenhauer has already indicated much of
24 what I had planned to say. She reported first our
25 meeting on the pediatric ... project at the agency,

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2 in this agency-level. The ... E.M.S. agencies are
3 basically well prepared, but not ideally prepared for
4 pediatrics unfortunately only twenty percent of -- of
5 thereabouts of the agencies actually responded to the
6 survey not surprising given the COVID epidemic,
7 similar issues obtained nationally.
8 She also reported on the pediatric ...
9 care coordinate position at the E.M.S. agency level.
10 The southwestern group that handled that program
11 under sub-contract until recently that Amy has -- has
12 -- had taken it over. I'm sure she may have recently
13 ... at some point.
14 Don has already commented on the fact
15 that the pediatric pandemic protocol was adopted by -
16 - by SEMAC similar to the adult protocol, of course,
17 although pediatric illnesses, pediatric vital signs
18 were included with the exception of blood pressure
19 which is difficult to obtain in children and SEMAC
20 had decided to omit from the -- the final version of
21 the protocol.
22 And finally, we spend a good deal of
23 time in our most recent meeting dealing with the
24 pediatric pandemic protocol and there is a group
25 consisting of colleagues from the child and

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2 adolescent psychiatry group who had put together
3 national standards just a few years ago on this issue
4 focusing much more on de-escalation and on drug
5 therapy.
6 Although it is recognized that
7 ketamine is not an ideal drug for kids and so out
8 there and all diphenhydramine and benzydamines are -
9 were in the protocol that E.M.S.C. submitted to SEMAC
10 for consideration. We were informed that to -- that
11 the protocol should first have gone to the
12 collaborative group for its review. Although Dr.
13 Daily was kind enough to indicate that the medicine
14 being proposed was -- appeared to him at first ...
15 It's my understanding that the
16 collaborative protocol group will be reviewing that
17 prior to the next SEMAC meeting with protocol ...
18 SEMAC. Both of this protocol ... by the
19 commissioner. We have --
20 MR. TEPERMAN: Hey, Art.
21 MR. COOPER: -- ... And I think that
22 wraps up the report. Thank you.
23 MR. TEPERMAN: Hey, Art it's Shel
24 Teperman.
25 MR. COOPER: Yes. Hi, Shel how are

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2 you.
3 MR. TEPERMAN: Just to comment, you
4 know, this -- this relates to something that's been
5 woven in to the rest of the day which is about the
6 violent surge that we are having and one of the
7 things that you may know H&H has been doing is we
8 brought on these behavioral health associates, theses
9 B.H.A.s.
10 And I've watched them work with the
11 kids in terms of de-escalation. These are folks that
12 have, you know, they usually have B.A.s or Bachelor
13 of Science they -- they have education that allows
14 them to -- to do this kind of work. And I've seen
15 them be able to work with the children, so they
16 didn't have to use mediations.
17 So just putting it out there to STAC
18 that there is this -- those folks usually work in --
19 in CPIP in -- in, you know, psychiatry emergency
20 rooms. But now we're having them in our adult
21 emergency room and our peds emergency room and
22 they're really going great de-escalation work
23 MR. COOPER: Shel, thank you. The
24 entire thrust of the proposed protocol focuses on de-
25 escalation. There's a fair bit of education more

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2 than some other protocols because of the -- of the
3 need for additional education, de-escalation,
4 additional educational modules are anticipated. Your
5 -- your suggestion is a good one. The protocol is
6 for E.M.S. rather than hospital emergency department.
7 So I think it's unlikely we would be
8 able to get specific de-escalators involved and the
9 C.O., but SEMAC can wrestle with that in our next
10 meeting. Dr. Daily, would you wish to comment on,
11 you know, where this is with respect to the
12 collaborative group.
13 MR. DAILY: No, I think Dr. Cooper you
14 highlighted that really well for -- for the ...
15 period, thank you.
16 MR. COOPER: Thank you, Dr. Daily.
17 Any questions?
18 MR. CLAYTON: Yeah. There is a
19 comment by Amy Eisenhauer. Amy Eisenhauer will be
20 next to speak, Amy.
21 MS. EISENHAUER: Thank you. So my
22 comment was related to add on to the conversation
23 about education. So two of the pediatric
24 psychiatrics that had joined us. One of the women --
25 Dr. Jennifer Havens, she had worked with ... and

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2 their ... program and training them and all the team
3 of responders on de-escalation of adult and pediatric
4 patient and she is part of our E.M.S.C. committee and
5 was an integral part of some of these ... in the de-
6 escalation and training.
7 She also did a class for -- as a
8 pediatric ... at Vital Sign last year which was well
9 received with ... training and programs for ... And
10 then the other pediatric psychiatric Dr. ... is
11 working with the E.M.S.C., E.R.M.C. for the
12 improvement research center on the national level
13 E.M.S.C. initiative for pediatric education.
14 So we -- we did consider education on
15 de-escalation for E.M.S. provider that a large part
16 of is an issue.
17 MR. COOPER: Thank you, Amy, very
18 much. And any questions for either myself or for
19 Amy? All right. Well, that concludes my report,
20 thank you very much.
21 MS. O'NEIL: Thank you, Art. So that
22 brings us to old business. I'm going to bring up
23 something that we have discussed previously and bring
24 it forward to the group for a motion. And ...
25 actually coming back to what Carrie at the very

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2 beginning of the meeting.
3 As many of you remember we have had
4 some conversations, some quite heated at times
5 regarding the nurse reviewer requirement that are
6 currently in the 708 standards. And so given that
7 we'll be making revisions to 708 to address the new
8 2022 standards, I would like to make a motion that we
9 move forward with the revision to that section that
10 refers to the nurse reviewer.
11 And having gone back over the previous
12 conversation in reviewing it with -- with Ryan, I
13 would like to make a motion that we change the
14 current requirement from a nurse -- nurse reviewer
15 will be required for all verification site visits for
16 New York State designation or verification I should
17 say.
18 And it will change to -- the nurse
19 reviewer will be required for the first verification
20 visit which means that it will no longer be required
21 for all verification visits. It's a simple language
22 change, but basically what it will do is, it will
23 require the nurse reviewer for all future new sites
24 being verified since the current trauma system -- all
25 of our trauma centers are currently verified and

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2 coming up for only re-verification.
3 And of course it's already a
4 requirement if you're doing a consultation visit as
5 part of the A.C.S. requirements. So I'd like to put
6 forward a motion. Is there any -- well, we should --
7 can it be seconded, do I have a second?
8 MR. GESTRING: I'll second, Gestring.
9 MS. O'NEIL: And any discussion or
10 clarification? Does everyone understand what we're
11 proposing?
12 MR. COOPER: Dr. O'Neil -- yeah,
13 chair, the chair normally cannot make a motion, but -
14 -
15 MS. O'NEIL: Thank you.
16 MR. COOPER: -- I think Dr. Gestring
17 can make the motion if he wishes and I will second.
18 MS. O'NEIL: Thank you for that
19 clarification.
20 MR. GESTRING: Gestring will be more
21 than happy to make that motion. It's the way Dr.
22 O'Neil stated it.
23 MR. FLYNN: This is Bill Flynn, with a
24 question. The value of having the nurse at the
25 initial verification and not at the subsequence is --

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2 is what?
3 MS. O'NEIL: It was -- this -- and
4 this has been discussed back and forth at multiple
5 points. The bureau feels that for a new site coming
6 on for new -- newly review for designation, a trauma
7 center that has not been previously designated that -
8 - well, two-points really.
9 Number one, that it keeps a process
10 fair since all previous trauma centers had to have
11 the nurse reviewer so that's one point. But the real
12 and more important point is that the bureau feels
13 that the nurse reviewer adds to the review process
14 enough that the bureau feels that for a new center
15 coming up for review that they want to continue to
16 keep that reviewer in.
17 And, you know, we've had many
18 discussions in the pass between different points of
19 view whether the nurse reviewer does or doesn't add
20 anything to the review. We've had people who felt
21 that it just added more -- it was more cumbersome
22 without adding value and others that had felt that it
23 did add values.
24 So we think that this is a very fair
25 compromise. It maintains a fairness. And it also

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2 maintain a slightly more -- I don't want to say
3 stricter, but a little bit tighter process for any
4 new trauma center coming up for review.
5 MS. O'NEIL: Can he ...
6 MR. GREENBERG: Not for review but for
7 verification. I think ...
8 MS. O'NEIL: Well -- yes. We do for
9 verification.
10 MR. GREENBERG: Thank you. You know,
11 it's also on our side and the bureau side, it also is
12 a consistency thing. We know that all of the trauma
13 centers to date were at least verified at first by
14 the same makeup of a team including the nurse both on
15 a consultative on -- and on their initial.
16 And so any -- any facility going
17 forward would be evaluated by that same standard in
18 the process of becoming a trauma center.
19 MR. CLAYTON: And for the record, that
20 was Ryan Greenberg, Director of the Bureau.
21 MR. TEPERMAN: Dr. Teperman here.
22 Make this -- makes sense to me -- the consistency
23 makes sense to me. I -- I think the bureau is
24 signaling the higher standard that Trish talked about
25 and this is a good compromise.

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2 MS. O'NEIL: Any further -- any
3 further comments, questions, need for clarification?
4 Do we need to restate the motion? Okay. So I don't
5 hear any -- any comments or further comments so I
6 think we can proceed with the vote. And I think this
7 definitely calls for a roll call vote.
8 MR. CLAYTON: Okay. Dr. O'Neil?
9 MS. O'NEIL: Yes.
10 MR. CLAYTON: Dr. Doynow?
11 MR. DOYNOW: Doynow, yes.
12 MR. CLAYTON: Dr. Winchell?
13 MR. WINCHELL: Winchell in favor.
14 MR. CLAYTON: Dr. Ullman?
15 MS. ULLMAN: Ullman, yes.
16 MR. CLAYTON: Dr. Cooper?
17 MR. COOPER: Cooper, yes.
18 MR. CLAYTON: Dr. Daily?
19 MR. DAILY: Daily, yes.
20 MR. CLAYTON: Dr. Wallenstein?
21 MS. WALLENSTEIN: Wallenstein, yes.
22 MR. CLAYTON: Dr. Flynn?
23 MR. FLYNN: Flynn, no.
24 MR. CLAYTON: Dr. Gestring?
25 MR. GESTRING: Yes.

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2 MR. CLAYTON: Dr. Gestring, can you
3 just repeat that please?
4 MR. GESTRING: Gestring yes, I'm
5 sorry.
6 MR. CLAYTON: Thank you. William
7 Hallinan?
8 MR. HALLINAN: William Hallinan is a
9 yes.
10 MR. CLAYTON: Kerrie Snyder?
11 MS. SYNDER: Kerrie Snyder is a yes.
12 MR. CLAYTON: Dr. Angus? Dr. Bank?
13 MR. BANK: Dr. Bank is a yes.
14 MR. CLAYTON: Dr. Arrillaga?
15 MR. ARRILLAGA: Arrillaga votes aye.
16 MR. CLAYTON: Dr. Vosswinkel?
17 MR. VOSSWINKEL: Vosswinkel votes yes.
18 MR. CLAYTON: Dr. Prince?
19 MR. PRINCE: Yes.
20 MR. CLAYTON: Dr. Agriantonis?
21 MR. AGRIANTONIS: Agriantonis, aye.
22 MR. CLAYTON: Dr. Simon?
23 MR. SIMON: Simon says hell yeah.
24 MR. CLAYTON: Dr. Teperman?
25 MR. TEPERMAN: Teperman, aye.

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2 MR. CLAYTON: Roll call complete
3 motion passes.
4 MS. O'NEIL: Thank you, Dan. And so
5 we move now to new business as we are winding down.
6 Well, actually, I should go back -- I'm sorry. Under
7 old business, we had Dr. Winchell and Dr. Berry
8 giving an update for the -- the trauma systems
9 improvement. And I believe Dr. Winchell and Dr.
10 Berry you can confirm that you feel that you've
11 addressed it in your report.
12 MR. WINCHELL: Yes, I don't think we
13 have anything else to add.
14 MS. O'NEIL: Okay. Thank you. So, is
15 there any new business someone wants to bring up from
16 the floor?
17 MR. GESTRING: O'Neil, I have new
18 business, Dr. Gestring.
19 MS. O'NEIL: Yes. Go ahead.
20 MR. GESTRING: And so I realize it's
21 getting late, but there are two items I wanted to
22 bring to the floor. First, I would ask the State
23 Trauma Advisory Committee to formally acknowledge and
24 honor the two pilots that were lost last week in the
25 crash of an air medical helicopter in Western New

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2 York.
3 With E.M.S. week just around the
4 corner events such as this remind us of the difficult
5 work done by our E.M.S. colleagues across the state
6 each and every day. We are a big team, but such
7 losses are felt deeply in -- in our close knit
8 community. And I felt it was necessary to bring this
9 to the attention of the State Trauma Advisory
10 Committee.
11 MS. O'NEIL: Thank you.
12 MR. GESTRING: Second item I wanted to
13 bring up, I would like to make the members of the
14 STAC aware of that the revised national field triage
15 guideline for E.M.S. were released officially early
16 this week. They are posted and can be reviewed by
17 anybody ... fieldtriageguidelines all one word.
18 The process business is summarized in
19 a manuscript that is now published online ahead of
20 print in the journal of trauma. This is an open
21 access manuscript that is available to anyone
22 interested in reviewing it. It can be accessed on
23 that website as well. But further I'd like to remind
24 the STAC that national field triage guidelines were
25 accepted some years ago by this group to serve as the

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2 New York State Field Triage Guidelines.
3 At that time, a provision was included
4 that would update New York State to in parallel with
5 the national guidelines. I -- I assume it's safe to
6 -- to assume -- I assume it's safe to think that this
7 process will -- will happen whatever the STAC can do
8 to help with the implementation and timelines such
9 that the New York State can mirror what the national
10 guidelines would be. I think, important to talk
11 about. Thank you.
12 MS. O'NEIL: Thank you, Dr. Gestring
13 for bringing that to our attention. We have
14 discussed at the executive committee that because the
15 guidelines just came out so recently that we haven't
16 had time to look at them that we do plan to put it on
17 the agenda for next -- the next meeting.
18 And Dr. Daily and Dr. Doynow, I'm
19 assuming that your committees will also be looking at
20 that and maybe can give us any follow up or report
21 from your committee on our next meeting.
22 MR. DOYNOW: Doynow, absolutely.
23 MS. O'NEIL: And I know it came up in
24 -- in the sub-committee for pediatrics that they were
25 going to look at it also at the next meeting to see

2 how it may affect the pediatric trauma. So I think
3 that's a great suggestion. And we will add it to old
4 business at the next meeting.
5 And it will be brought up at the
6 different sub-committees for discussion. Okay.
7 Anyone else have any new business they want to bring
8 up? Okay. Well, then I guess we need to finish our
9 original new business. Dan, are you able to give us
10 an update on the election process?
11 MR. CLAYTON: Ryan, did you want to
12 say anything before -- I see your finger on the mute
13 button, that's why I'm asking you.
14 MR. GREENBERG: No, I was just going
15 to ... number of votes that were received. And then
16 the final.
17 MR. CLAYTON: Okay.
18 MR. GREENBERG: No.
19 MR. CLAYTON: Do you want to break
20 down or not?
21 MS. O'NEIL: No, I think we should
22 just go with -- I mean, it's my opinion where we can
23 -- we can pull the rest of the committee members.
24 But I think it's fine to just move forward with the
25 results.

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2 MR. CLAYTON: Okay. So eighteen
3 people voted and the answer is Dr. Bank.
4 MS. O'NEIL: Congratulations, Dr.
5 Bank. So as we stated earlier, that will be our
6 recommendation to the commissioner. The commissioner
7 -- will be taken and brought up to the commissioner
8 and as our recommendation and then we will hear back.
9 Do you think we will have an answer -- I mean, if
10 they still have to go through the vetting process.
11 So Ryan, it's been so long since we've
12 chosen a new chair. Do you anticipate any timely
13 delays or any delays?
14 MR. GREENBERG: I don't anticipate any
15 delays. But like you said, it's been so long in this
16 particular case. You mentioned the vetting process.
17 I don't know that this would go through an additional
18 vetting process. It will go through a verification
19 process, but not the vetting process that we think of
20 when we think of coming on to the STAC.
21 So that is a good thing. But we will
22 end -- you know, we'll put this to ... process. And,
23 you know, present to the commissioner's office for
24 recommendation as a nomination for the chair.
25 MS. O'NEIL: Okay. Announcements, any

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2 announcements before we go through the -- to the
3 tentative date for the next meeting? So the only
4 announcement that we have is that we have a tentative
5 date. It hasn't been confirmed as yet for October
6 12th. September has a lot of conflicting meetings
7 and holidays.
8 October also has a few conflicts
9 including the clinical congress. A few Jewish -- I
10 think of one of the Jewish holidays and -- and E.M.S.
11 But I can't remember -- and vital signs, I think. So
12 we have a tentative date for October 5th -- 12,
13 October 12th, Wednesday. We are still looking for
14 venues and we will send out a confirmation.
15 And the plan is for an entire all in-
16 person meeting unless otherwise contra-indicated.
17 MR. TEPERMAN: I heard the venue was
18 going to be in Hawaii, Teperman.
19 MS. O'NEIL: I wish. Don’t we all
20 wish. Maybe you can fly us to Bora Bora.
21 MR. TEPERMAN: ... can only get you
22 about two hundred miles.
23 MS. O'NEIL: So any -- any last
24 announcements anyone wants to make? Okay. So the
25 meeting is adjourned.

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2 MR. TEPERMAN: Guys, thank you for
3 taking us through all that.
4 MS. O'NEIL: Yeah, it did feel like a
5 bit of a marathon today.
6 MR. TEPERMAN: We can go off the
7 record.
8 (The meeting concluded at 4:13 p.m.)
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2 STATE OF NEW YORK
3 I, BECKY FOSTER, do hereby certify that the foregoing was
4 reported by me, in the cause, at the time and place, as
5 stated in the caption hereto, at Page 1 hereof; that the
6 foregoing typewritten transcription consisting of pages 1
7 through 149, is a true record of all proceedings had at
8 the hearing.
9 IN WITNESS WHEREOF, I have hereunto
10 subscribed my name, this the 19th day of May, 2022.
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12
13 BECKY FOSTER, Reporter
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A

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