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2	NEW YORK STATE DEPARTMENT OF HEATH	
3	EMERGENCY MEDICAL SERVICES FOR CHILDREN	
4	ADVISORY COMMITTEE MEETING	
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7		
8	DATE:	June 21, 2011
9	LOCATION:	Hilton Garden Inn Troy 235 Hoosick Street
10		Troy, New York 12180
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EMS For Children - 6-21-2011
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     APPEARANCES:
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     Arthur Cooper, M.D., MS, Chairman
     Sharon Chiumento, BSN, EMT-P
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     Jonathan S. Halpert, M.D., FACEP
 5
     Robert Kanter, M.D.
     Rita Molloy, R.N.
     Janice Rogers, MS, RN, CS, CPNP
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     Elise van der Jagt, M.D., MPH
 7
     Martha Gohlke, BA, EMT-B
     Lee Burns, BS, EMT-P
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- 1 EMS For Children 6-21-2011
- 2 (The hearing commenced at 1:00 p.m.)
- 3 DR. COOPER: Good afternoon, everyone.
- 4 It's really a pleasure to see everyone again after our long
- 5 absence from one another, except via teleconference, of
- 6 course. We have a -- a full, compact agenda today, so
- 7 we're going to try to move through it pretty quickly
- 8 because I know everyone is busy and has other
- 9 responsibilities.
- 10 Before beginning, however, I want to
- 11 acknowledge the -- the presence of some of our special
- 12 friends. Mary Ellen Hennessy is, I think -- are you head
- 13 of O.H.S.M. now or --?
- 14 MS. HENNESSY: No. God, no.
- DR. COOPER: No? Okay.
- MS. HENNESSY: Director of Certification
- 17 and Surveillance.
- 18 DR. COOPER: Okay. She is -- she is --
- 19 she is almost --
- MS. HENNESSY: That's for the record.
- 21 DR. COOPER: She's over almost everyone,
- 22 but the Commissioner. There's a few other there that she's
- 23 not over. And -- and, of course, Deb Sottolano is here
- 24 from the -- from the disaster program. And Sandra Haff is
- 25 here from Public Health Planning. So thank you so much for

- 1 EMS For Children 6-21-2011
- 2 being here. And thanks to all of our regular members for
- 3 taking time out of their busy schedules to be here. I
- 4 think most everyone knows everyone, but not necessarily, so
- 5 in case there's some folks who don't know everyone I'm just
- 6 going to take a moment and ask that we go around the room.
- 7 And we'll start with Janet -- Janice --
- 8 sorry. Excuse me.
- 9 MS. ROGERS: You can just cut it off at
- 10 Jan.
- DR. COOPER: Yeah.
- MS. ROGERS: It makes it easier. I'm Jan
- 13 Rogers. I'm a nurse practitioner at Strong E.D.
- 14 MS. CHIUMENTO: I'm Sharon Chiumento.
- 15 I'm a paramedic and a nurse, retired from that, but I'm
- 16 a -- also a member of -- or a SEMAC representative member
- 17 of SEMAC.
- 18 MS. HAFF: I'm Sandy Haff for
- 19 Certification and Surveillance.
- DR. SOTTOLANO: I'm Deb Sottolano,
- 21 Certification and Surveillance.
- 22 MS. MOLLOY: I'm Rita Molloy and I am a
- 23 school nurse and on the board of directors of the New York
- 24 State Association of School Nurses.
- 25 DR. COOPER: I'm Mark Cooper. I'm the

- 1 EMS For Children 6-21-2011
- 2 chair. I'm a pediatric trauma surgeon from Columbia and
- 3 Harlem in New York City.
- 4 MS. BURNS: I'm Lee Burns; I'm with the
- 5 E.M.S. program with the Health Department.
- 6 MS. GOHLKE: I'm Martha Gohlke, E.M.S.C.
- 7 Coordinator with the Department. And I've got to remind
- 8 people to use the microphones because we're on the record
- 9 and it helps the stenographer catch every word that you
- 10 say. Thanks.
- MS. HENNESSY: Mary Ellen Hennessy,
- 12 Division of Certification and Surveillance for O.H.S.M and
- 13 happy to be here. Thank you.
- 14 MR. CZAPRANSKI: Tim Czapranski,
- 15 paramedic, Monroe County E.M.S. Administrator and Chair of
- 16 State E.M.S. Council.
- 17 DR. KANTER: Bob Kanter, Pediatric
- 18 Critical Care, Syracuse.
- DR. VAN DER JAGT: Elise van der Jagt,
- 20 Pediatric Critical Care of Rochester.
- DR. HALPERT: Jonathan Halpert, Emergency
- 22 Medicine Physician, Albany.
- DR. COOPER: Thanks everyone. Just a
- 24 couple of regrets. First, from Cathy Willis, who could not
- 25 find anyone to relieve her of her growing responsibilities

- 1 EMS For Children 6-21-2011
- 2 today, and also from Susan Brillhart who is up to her -- up
- 3 to her head in -- in final examinations and things like
- 4 that for the Borough of Manhattan Community College School
- 5 of Nursing.
- And someone else has joined us. Yes?
- 7 DR. KACICA: Hi. Marilyn Kacica.
- 8 DR. COOPER: Marilyn. Great. Marilyn
- 9 Kacica is with us as well. Marilyn is Medical Director
- 10 from the Division of Family Health. And we're really,
- 11 really delighted to have so many folks from State Health
- 12 with us today. That's a rare pleasure and treat and we
- 13 thank all of you for taking time out from your busy day to
- 14 be with us.
- So the first item on the agenda is a
- 16 welcome. I think we've done that. And in terms of the
- 17 review of the agenda, Lee will be giving a report on the
- 18 activities of the -- the bureau. Martha will be giving a
- 19 report on the activities of the -- the E.M.S.C. grant and
- 20 the program, of course. And Mary Ellen will be helping us
- 21 with update on -- on the 405 Hospital Code project, the
- 22 regionalization project. I'll -- I'll ask Bob to give a
- 23 report as to where we are in terms of regionalization,
- 24 although that will probably depend in great measure upon
- 25 what we hear from Mary Ellen. We'll then hear about

- 1 EMS For Children 6-21-2011
- 2 education committee from Sharon and E.M.S. for Children
- 3 Committee membership update from Martha. We have a vote
- 4 for chair and vice chair today, regional emergency
- 5 preparedness activities update. I will be speaking
- 6 briefly, as will some others, I believe, and Sharon has the
- 7 A.L.S. protocol template for us as well.
- 8 And then as is our custom, we'll be
- 9 providing updates from our sister advisory committees to
- 10 the Health Department.
- 11 And here are our sodas and cookies.
- 12 Outstanding. Okay. So, Lee, take it away.
- MS. BURNS: While you are having soda and
- 14 cookies -- turn this on -- just a couple of quick things.
- 15 Nothing is quick. We have been working with our -- with
- 16 the Health Department's blood and tissue program in order
- 17 to have the regs changed to allow E.M.S. providers to
- 18 transport patients with blood or blood products running and
- 19 that has been a lengthy and ongoing process. So the -- the
- 20 reg changes was pretty simple and we've put together with
- 21 the help of -- of Dr. Linden and her staff an educational
- 22 program and got everything all set and we're now waiting
- 23 for the regs to be finalized. We're not really, really
- 24 sure where they are. We think they're in what is now --
- 25 what used to be the Governor's Office on Regulatory Reform

- 1 EMS For Children 6-21-2011
- 2 is now in the Division of Budgets somewhere. The blood and
- 3 tissue folks have -- have been up on that and say that the
- 4 regs are actually there, so -- interestingly. The State
- 5 E.M.S. Council, the SEMAC implored me to exercise my
- 6 influence -- I say that with some degree of sarcasm since I
- 7 have none -- to reach out, you know, to get the
- 8 commissioner to free up the regs. So I said that I would
- 9 certainly let the people above me know that the SEMAC and
- 10 SEMSCO and probably you, too, are very interested in this
- 11 and I did.
- We are -- we're reviewing State E.M.S.
- 13 Council E.M.S. awards. There's been some interesting
- 14 nominations. That is a good thing. It is disappointing to
- 15 me, though, that there are not nominations from every
- 16 corner of the state or nominations of people, you know,
- 17 that they're -- we're buried in nominations. That's very
- 18 frustrating.
- 19 Of significance, the State E.M.S. Council
- 20 at -- at our urging decided to -- well, they approved
- 21 the -- what's called the National E.M.S. Education
- 22 Standard -- and Sharon jump -- jump in when I screw this up
- 23 in some way. I -- I -- it -- as is our custom here in New
- 24 York State, in 1992, the feds came out with this great
- 25 E.M.T. curriculum. Well, in 1998, the cutting edge New

- 1 EMS For Children 6-21-2011
- 2 York State issued the new curriculum. In an effort to try
- 3 and avoid another four -- eight -- ten-year lapse, we
- 4 pushed the state council to allow us to adopt the National
- 5 E.M.S. Education Standards. So we're okay -- from an
- 6 A.L.S. perspective, our paramedics are really using
- 7 national standard curriculum currently. So it's really not
- 8 an issue at -- at the paramedic level. It'll be a lot of
- 9 work at the basic E.M.T. level. We're still cogitating
- 10 over the -- what we in New York State call certified first
- 11 responders. The feds call them emergency medical
- 12 responders. We probably ultimately will head towards a
- 13 national standard for E.M.R. The problem right now -- why
- 14 are you making faces, Jon?
- The problem we face in New York is that
- 16 the -- our public health law limits the amount of time
- 17 an -- a certified first responder can be trained to
- 18 fifty-one hours. The E.M.R. program is longer than that.
- 19 So statutorily it may require a change. We're still
- 20 arguing about that.
- Budget issues, there's no good news on
- 22 the budget horizon. I can't even sugarcoat it. We -- at
- 23 this point, we were told that there's another eleven point
- 24 two percent reduction in contract expenses. We're looking
- 25 at how that is going to affect our contractors. We have

- 1 EMS For Children 6-21-2011
- 2 many contractors. We have many contracts. We have a
- 3 contract with this hotel for -- as an example. So if --
- 4 you might not have the opportunity to enjoy their cookies
- 5 come the fall if we don't get a grip on all of this.
- 6 Actually, I think you have one more series of meetings.
- 7 We're very concerned about the SEMAC and SEMSCO meetings,
- 8 honestly. I am routinely asked by E.M.S. providers across
- 9 the state, you know, to -- you know, what's my priority?
- 10 My personal priority -- if I have to
- 11 cut -- if I -- if I have to choose what I do not want to
- 12 cut, it is -- it is training money. We pay for training.
- 13 And in explaining to the Health Department administration,
- 14 we pay for training in -- in New York State. If you want
- 15 to be an E.M.S. provider and you are involved in an E.M.S.
- 16 agency, the Department reimburses for training in its
- 17 entirety up to the paramedic level. We pay a good portion
- 18 of paramedic training. The law says that we will reimburse
- 19 E.M.T. training. I think that if you are -- if -- if you
- 20 are an E.M.S. person you -- you really understand this, but
- 21 E.M.S. providers make so little money that if we stopped
- 22 paying for training at the paramedic level or offsetting
- 23 the costs of this training, there will be no paramedics
- 24 very quickly because for the amount of money and the amount
- 25 of time, with all due respect, I would rather go to nursing

- 1 EMS For Children 6-21-2011
- 2 school and make a decent living. You know, the work is
- 3 hard and the -- the training long and the pay is almost
- 4 non-existent. And so that is -- that is a real concern for
- 5 me.
- And -- and, you know, I don't know what
- 7 the long-term financial outlook of this is. It's bad as --
- 8 as my colleagues in the Department will -- will
- 9 certainly -- they're victim, too. I mean we're -- we're
- 10 calling each other asking for toner cartridges. So I can
- 11 tell you that effective July 1st, we will no longer be
- 12 funding E.M.S. programs and Article 6 money to localities.
- 13 That's the county public health money. So it -- it --
- DR. COOPER: Wow.
- MS. BURNS: -- it greatly affects about
- 16 twenty counties. It has a huge negative impact on some
- 17 very large counties, Suffolk, West Chester and Erie most
- 18 notably. We were talking about -- Tim and I were talking
- 19 and you planned ahead. So this represents the bureau's
- 20 first bloodletting actually. So that's kind of it in a
- 21 nutshell. We lost our trauma coordinator. He left us for
- 22 State Emergency Management. I'm still mad at him.
- MS. GOHLKE: Mike Taylor?
- MS. BURNS: Yeah, Mike Taylor. He's
- 25 studying -- he's -- he's working in the radiological

- 1 EMS For Children 6-21-2011
- 2 program. So currently he's watching Fitzpatrick meltdown
- 3 virtually. Vital Signs is in October. We hope you will
- 4 all come. It is in Syracuse. It's in Syracuse; remember
- 5 that.
- 6 DR. COOPER: I'll remember that.
- 7 MS. BURNS: Because I'm afraid he'll show
- 8 up in Rochester.
- 9 DR. COOPER: Yeah. I had almost gone to
- 10 the wrong place on more than one occasion.
- DR. KANTER: That's bad.
- MS. BURNS: So October 13 through 16.
- 13 Martha will keep in touch. And, again, we'll -- I -- my
- 14 calendar says your meeting is September 21st -- 20th. I'm
- 15 close. If anything changes, we'll let you know. Right
- 16 now --
- MS. CHIUMENTO: 20th.
- 18 MS. BURNS: -- it's on the calendar. And
- 19 the last thing actually is should -- is not all that
- 20 negative unless you're one of these hospitals. The New
- 21 York City RTAC -- are you an RTAC member?
- DR. COOPER: I am.
- MS. BURNS: They -- they have been very
- 24 concerned about pediatric trauma in -- in the five
- 25 boroughs. And so with -- with -- the RTAC facilitated

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- 2 sending out a paper survey to all the trauma centers. The
- 3 Health Department, Ed had written a letter that went out as
- 4 a cover to it and the response was that the RTACs -- or
- 5 excuse me -- the trauma centers either responded that they
- 6 were capable of handling -- managing pediatric trauma or
- 7 they were not. And those that stated to the Department
- 8 that they weren't capable were sent out a paper survey and
- 9 they responded based on the paper surveys. Some of it was
- 10 a little surprising actually because I would think a paper
- 11 survey sort of -- it's a gift. So we are in the process of
- 12 working with Dr. Marks and the STAC and Dr. Simon who
- 13 chairs the RTAC and the committee to send letters out to
- 14 the hospitals that are deficient based on the paper
- 15 surveys. So it's a little intimidating for me personally
- 16 to be sending a C.E.O. of a major health network a you're
- 17 deficient in your surgery, but that -- we're hoping that
- 18 will go out this week. So they're about, oh, I think
- 19 eleven letters go out in the New York City Metropolitan
- 20 area.
- 21 We did -- subsequently, we did a similar
- 22 thing to the trauma centers in the rest of the state,
- 23 hoping against hope that we wouldn't get letters from, you
- 24 know, like Strong or Upstate saying we don't want to handle
- 25 pediatric trauma because then we're sort of out of luck.

- 1 EMS For Children 6-21-2011
- 2 But we're going to -- ultimately, we're going to send
- 3 follow ups to make sure that they, you know, they can
- 4 respond to the surveys and we'll send him deficiencies,
- 5 too, I guess. We'll keep you posted as to the results.
- 6 Some of them are significant. A lot -- you know, a lot of
- 7 them are education issues. PALS, as an example, is
- 8 requirement and there are huge numbers of them that do
- 9 not -- their staff don't have PALS certification. So we're
- 10 a little concerned. That's about it.
- DR. COOPER: Thank you so much, Lee. Any
- 12 questions for -- for Lee in terms of the staff report?
- 13 Hearing none, Martha, I see you have a comment to make or
- 14 are you ready for your report?
- MS. GOHLKE: I'm ready.
- DR. COOPER: Okay. Go for it.
- 17 MS. GOHLKE: Before I forget, I just want
- 18 to introduce my colleague, Dan Clayton, who's sitting
- 19 behind us here. He has the pleasure of sitting next to me
- 20 every day and overhearing everything I'm talking about, but
- 21 it's been a while since he's been to this meeting and he
- 22 kind of want to get reacquainted. He does a lot of things
- 23 in education and -- and administration and procurement and
- 24 contracts and he's kind of the jack-of-all-trades. When
- 25 Lee needs something done, she calls Dan into her office.

- 1 EMS For Children 6-21-2011
- 2 So thanks, Dan, for coming.
- 3 MR. CLAYTON: Good to be here.
- 4 MS. BURNS: Luckily he knows how to use a
- 5 calculator.
- 6 MS. GOHLKE: Yeah. And he's also a
- 7 paramedic. Not that that takes priority or --.
- 8 MR. CLAYTON: I didn't hear what you
- 9 said, so.
- 10 MS. GOHLKE: Not priority. As for the
- 11 grants, there's not really much going on other than normal
- 12 business. As usual, it's a year-to-year thing. It's been
- 13 reauthorized, but not reappropriated yet. But that's
- 14 normal for this time, so that's nothing. I'm not worried
- 15 yet.
- MS. BURNS: I got it today. It was --
- 17 the -- H.R. had sent me a note saying success. I don't
- 18 know what that means, though.
- MS. GOHLKE: That's just in our little
- 20 world, though.
- MS. BURNS: Oh.
- MS. GOHLKE: But in the bigger picture in
- 23 the federal world, hopefully, we'll -- you know, we'll have
- 24 funding for future. But, again, like I said this is normal
- 25 for this time of year, so I'm not looking for another job

- 1 EMS For Children 6-21-2011
- 2 yet. So that's a good thing. And so there's really not
- 3 much to report as far as E.M.S. for Children. I did go out
- 4 to Utah recently. I was asked to be on the board of
- 5 directors for the data contractor, the E.M.S. for Children
- 6 data contract. NEDARC is their acronym. And it was me and
- 7 one other state from the E.M.S. children's level and
- 8 physicians from around the nation giving them advice on
- 9 pediatric data and where they're -- they're headed. So
- 10 that was -- that was nice and very -- yeah, interesting.
- 11 So New York was represented out in Utah. So --
- DR. COOPER: Excellent.
- MS. GOHLKE: -- I had a loud voice as
- 14 usual, Dr. Cooper; you'd be happy. But it's -- the other
- 15 project that I work on is the electronic P.C.R. data
- 16 repository. Many of you are probably tired of me talking
- 17 about it, but that's probably moving along a little bit
- 18 quicker as far as projects that I work on. We're finally
- 19 joining twenty-first century and actually having an online
- 20 data repository for our patient care reporting. We had
- 21 more of an archaic system in the past, but now the beauty
- 22 of this new system is that the patient care data that we
- 23 collect at the state level will go to an online repository
- 24 and our contractors can -- who are responsible for doing
- 25 quality improvement in the E.M.S. regions that they're

- 1 EMS For Children 6-21-2011
- 2 responsible for, can actually access the data on a real
- 3 live online basis and do some real-time Q.I. projects
- 4 rather than late a few years down the line with the
- 5 Department getting the data out several years behind the
- 6 time. So that's really exciting as far as us catching up
- 7 to the twenty-first century. And we're actually going to
- 8 start taking real live data as of July 1 from around the
- 9 state from two of our vendors that are out there, emsCharts
- 10 and Sansio. So we're rolling out to the rest of the
- 11 vendors in the rest of the state throughout the year. So,
- 12 hopefully, by January of next year everybody who's doing
- 13 electronic P.C.R.s will be submitting their data to the
- 14 state directly monthly online to our repository.
- DR. KANTER: Is there any more paper
- 16 product to that?
- MS. GOHLKE: Yes. We will continue the
- 18 paper for those services that do not go electronic. Yes.
- 19 DR. VAN DER JAGT: What percent is
- 20 electronic?
- MS. GOHLKE: Forty?
- 22 MS. BURNS: Yeah. About forty percent of
- 23 the services are -- are using an electronic product, but
- 24 about two-thirds to three-quarters of the call volume is
- 25 coming to us electronically because the bigger services,

- 1 EMS For Children 6-21-2011
- 2 notably FDNY in New York City, is totally electronic. So
- 3 of the almost three million E.M.S. calls, a little over two
- 4 million of them are coming to us electronically.
- 5 MS. GOHLKE: And the -- the other benefit
- 6 to us doing -- collecting the data this way is we're going
- 7 to start transmitting it nationally. NEMSIS has been
- 8 waiting for New York State data for many years and so
- 9 hopefully by the end of the year we're going to blow the
- 10 roof of NEMSIS when they start submitting two million call
- 11 volume from New York City. So that's very exciting. I
- 12 can't wait to see their system crash, but they claim they
- 13 want our data, so we'll give it to them. So and then
- 14 hopefully, also we'll be able to use that data here
- 15 ourselves. We can look at some pediatric elements and,
- 16 again, we won't have to wait a couple years down the line
- 17 to get that data. So hopefully, it'll be a nice quick
- 18 turnaround system for us to utilize. So that's as far as
- 19 the E.M.S. for Children and the E.P.C.R. report that I
- 20 have, Dr. Cooper.
- 21 DR. COOPER: Martha, do you have any
- 22 great information to share with us from the E.M.S.C.
- 23 grantee meeting?
- 24 MS. GOHLKE: It was -- it was just that
- 25 it was done in a different format this year. Generally,

- 1 EMS For Children 6-21-2011
- 2 they bring the PCARN and the targeted issues grantees and
- 3 the E.M.S. for Children grantees together every year, but
- 4 because of funding they just brought the E.M.S. for
- 5 Children grantees together this year. So it was a very
- 6 short, abbreviated meeting, again, for -- for budget and
- funding issues, so I don't really have anything new from
- 8 that.
- 9 MS. COOPER: Okay.
- MS. GOHLKE: Yeah.
- DR. COOPER: I do have just a little bit
- of information from the federal level. Simply based on
- 13 conversations with the -- the medical director for the
- 14 E.M.S.C. National Resource Center in Washington, Dr. Joseph
- 15 Wright, as -- as all of you know, is the Senior Vice
- 16 President for Medical Affairs at the Children's National
- 17 Medical Center in Washington. Part of the reason that --
- 18 that things have been a little bit slow even at the federal
- 19 level at this time of year two-fold. First there's a new
- 20 director for the Federal E.M.S.C. program. Dan Kavanaugh,
- 21 who led that program on a staff level so successfully for
- 22 so many years, stepped down to pursue some other activities
- 23 within HRSA, which he had really put off for a very, very
- 24 long time and really wanted to get to before he lost that
- 25 opportunity.

- 1 EMS For Children 6-21-2011
- 2 It took them a while to find a worthy
- 3 successor, but a worthy successor indeed, they have found.
- 4 Beth Edgerton has assumed that role. Beth is an
- 5 emergency -- pediatric emergency physician, very, very
- 6 lovely person, knowledgeable, capable. She'll be a -- a
- 7 great addition to that program and incredibly worthy
- 8 successor to -- to Dan. But she was just getting up to
- 9 speed really in March. And, of course, it's a big program.
- 10 It's over twenty million -- twenty -- over twenty million
- 11 dollars and the director, of course, needs to have his or
- 12 her pulse on the finger of everything that's going on in
- 13 that program.
- 14 With respect to the PCARN activities,
- 15 PCARN was up for competitive renewal this year, and so many
- 16 of the current work is winding down pending notification of
- 17 new grantees as to who is going to be leading the charge in
- 18 the future. And because the -- the E.M.S.C. National
- 19 Resource Center and PCARN happen to be on, more or less,
- 20 the same grant cycle, the E.M.S.C. National Resource Center
- 21 itself was up for competitive renewal, and at least as of a
- 22 month ago in a -- in conversations with Joe Wright, he had
- 23 not yet heard. I don't believe any of the grantees have
- 24 yet heard about any of their awards. At least I haven't
- 25 heard from anyone yet about their PCARN awards. So I'm

- 1 EMS For Children 6-21-2011
- 2 guessing that -- that they have not heard. But Martha, it
- 3 looks like, may have some additional information.
- 4 MS. GOHLKE: All I know is that the
- 5 National Resource Center and NEDARC were both re-funded.
- DR. COOPER: Excellent. Okay.
- 7 MS. GOHLKE: I don't know at the same
- 8 level, though. But --
- 9 DR. COOPER: Yeah. Okay.
- 10 MS. GOHLKE: -- and -- and I don't know
- 11 about PCARN, but just N.R.C. and NEDARC.
- DR. COOPER: Right. Yeah. I'm sure
- 13 PCARN was as well, but whether again it was at the same
- 14 level. Certainly Joe had indicated that he had not been
- 15 able to find a successor -- had chosen not to find a
- 16 successor for Jasmine Week (phonetic spelling), who was the
- 17 Director of the E.M.S.C. National Resource Center, until
- 18 they knew that they were, of course, going to be funded.
- 19 Everything is, you know, of course, depending upon funding
- 20 now as always. So it's been -- a bit of an iffy year and I
- 21 think all of those details are still at this point shaking
- 22 out. So that's what we know as of this moment, and,
- 23 hopefully, we'll learn more as the -- as the future
- 24 unfolds.
- 25 Martha, while you have the microphone,

- 1 EMS For Children 6-21-2011
- 2 perhaps it makes sense just to go right into the issue of
- 3 the vetting since that's more or less staff --
- 4 MS. GOHLKE: Uh-huh.
- DR. COOPER: -- report issue anyway.
- 6 MS. GOHLKE: Okay. I do -- I -- I've
- 7 handed out this list before, but I just thought as a
- 8 reminder, somewhere in your packet you'll see the vetting
- 9 list that I've but up the line to executive. All our seats
- 10 turned over basically in June and July of this year, and as
- 11 you remember you all had to send me your C.V.s and letters
- 12 of recommendations if you wanted to serve again and they --
- 13 it has had some movement. That's the good -- that's the
- 14 good news. I'm -- you know, I'm the squeaky wheel that
- 15 keeps reminding him that we're waiting and we're waiting
- 16 and it -- so it has moved along and it has gotten some --
- 17 some executive approval. I do have to do some additional
- 18 paperwork I was just informed. And -- but that's a good
- 19 sign. That means that they're looking at things and things
- 20 are moving along.
- I had mentioned this before and I -- and
- 22 I still think it's a concern. We have a couple people's
- 23 names for one or two seats. You know, there's more than
- 24 one person, for example, for the critical care physician's
- 25 seat, for example. The good news is -- is our statute

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- 2 doesn't limit the number of members on our committee, nor
- 3 does it, you know, limit, you know, one person per seat.
- 4 So that's why we have proposal for additional people.
- 5 And -- but in the times of budgetary cuts, you know, I'm
- 6 afraid that executive is, you know, because we have to pay
- 7 transportation and reimburse people, I don't know if
- 8 everybody is going to get vetted. And, again, this is just
- 9 coming from my own head. I -- I have not been told this.
- 10 So I don't know yet. I don't know how it's all going to
- 11 shake out. But I -- I'd be surprised personally if -- if
- 12 all the names we put forward get approved, just because of
- 13 budgetary issues. So -- our seats don't expire. I mean,
- 14 you know, our statue says that people can serve as long as
- 15 they want to. So my argument to executive will be, you
- 16 know, in order to bring new people in, this is the way we
- 17 have to do it. I mean we can't, you know, kick people out.
- 18 Our statute doesn't allow that even if we wanted to, which
- 19 we don't. But we can't kick people out to get new people
- 20 in. So in order to get new blood in, get new -- new people
- 21 in, this is kind of how we have to, you know, strategize.
- 22 So that's my argument to bring other people in and
- 23 hopefully it'll fly.
- 24 But we'll -- you know, I started this
- 25 process almost a year ago trying to get the paperwork

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- 2 together and -- with the hope that by our September meeting
- 3 we'll actually hear and have the -- the people vetted for
- 4 the committee. And that's still my hope. And I did ask
- 5 the other day if for some reason we don't get word of the
- 6 results of the vetting by September's meeting what happens.
- 7 And I was told that you folks will continue to serve in the
- 8 seats until -- until told otherwise, unless you resign of
- 9 course. Not that -- again, I'm not suggesting anything.
- 10 But you are here as long as you want to be until you tell
- 11 me otherwise. So I hope to see you in September even if we
- don't hear about what's going on with the vetting. And if
- 13 for some reason you -- you don't want to be here in
- 14 September, you've got to write me a formal letter that
- 15 you're done. But everybody re-upped, so I don't expect
- 16 that to happen. So -- so you're here forever unless you
- 17 tell me otherwise.
- DR. COOPER: Wow.
- 19 MS. GOHLKE: So that's -- that's --
- 20 that's the update I have for the vetting.
- DR. COOPER: You can check out any time
- 22 you want.
- MS. GOHLKE: Yeah. Great. Right. Just
- 24 kind of like you and I.
- DR. COOPER: Well, that's very

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- 2 fascinating news. We're all delighted to be here, of
- 3 course, and to continue helping the Department plan for the
- 4 emergency health needs of children and I have no doubt that
- 5 even if some of us do not continue formally that we will
- 6 have a deep binding involvement with this committee for a
- 7 long time to come.
- 8 Okay. So let's move on to our old
- 9 business. And many of you, of course, will remember, in
- 10 fact, I hope all of you will remember that a year ago --
- 11 more than a year ago, about thirteen months ago, we were
- 12 very, very fortunate to have Commissioner Daines with us to
- 13 lead off our E.M.S.C. stakeholder meeting, which Martha did
- 14 a terrific job in organizing. And Commissioner Daines was
- 15 very, very receptive to the idea that we should be
- 16 considering regionalization of pediatric services in New
- 17 York State and authorized staff and O.H.S.M. to -- to --
- 18 continue along that path, look at ways that -- that that
- 19 could be accomplished. That led to a lengthy discussion
- 20 last fall in which we all felt that the best way to
- 21 accomplish that was through a regulatory process and that
- 22 that regulatory process probably should initiate rather
- 23 than with appropriateness review standards in Section 708
- 24 with minimum standards in Section 405 of the Public Health
- 25 Code.

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- Bob Kanter, with our help and input,
- 3 drafted an initial set of potential regulatory changes and
- 4 we all felt that the best thing to do, together with our
- 5 staff, was to run these up the flag pole to see how the
- 6 Department felt about what we were thinking. And I think
- 7 the Department was very, very receptive, but I think there
- 8 were also some questions. And -- and I believe that's, at
- 9 least in part, the reason Mary Ellen is with us today so
- 10 she can share some of those questions, perhaps concerns,
- 11 but I prefer to focus on the questions at this time.
- 12 So, Mary Ellen, if you will say what you
- 13 think.
- 14 MS. HENNESSY: Sure. Thank you. Again,
- 15 I -- I have to say thank you for inviting me here today. I
- 16 am on the regulatory side of the Department and so quite
- 17 often I have bad news to bear. And it's nice to work in a
- 18 collaborative relationship with you all and I have to tell
- 19 you I respect what you all do on a day-to-day basis
- 20 immensely.
- 21 I'll first kind of set a setting for how
- 22 we're going forward with certain types of regulatory reform
- 23 at this point. You all may know that HANYS has really
- 24 taken real flack for doing some healthcare reform via
- 25 regulations. A lot of it has to do with vary specific

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- 2 regulations that just don't seem to make sense anymore or
- 3 encumber providers from being able to move forward with
- 4 certain types of staffing, et cetera. To that end, they
- 5 produced a document, it's actually a booklet called Tied Up
- 6 in Knots, kind of getting through the regulatory system.
- 7 And we at the Department and O.H.S.M. have been meeting
- 8 with them over time to discuss all of these issues and
- 9 have, indeed, crafted new language in the regulations or
- 10 considered eliminating certain regulations that seem to be
- 11 troublesome.
- What we found over this time, though, is
- 13 that we have a new administration and our new
- 14 administration is really moving forward quite rapidly with
- 15 the governor's intentions of redefining government, and
- 16 looking at how all the agencies run, what our priorities
- 17 are, how we operate on a day-to-day basis. And, of course,
- 18 we're all feeling the effects of reducing state government
- 19 by a certain percentage, which was one of the governor's
- 20 intentions as well. What I will say is that those of us
- 21 who are working in government are a very cohesive team. We
- 22 really support each other, I believe, very well especially
- 23 in our divisions. Lisa McMurdo, who just walked in, and --
- 24 and Lee and all of the -- the people that are here, our
- 25 goal is to really provide the best oversight and care of

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- 2 patients receiving treatment in New York State facilities.
- 3 That being said, when we looked at your
- 4 regulations, your proposed regulations, I have to say that
- 5 it was a great alignment in anticipating where it would fit
- 6 in the code and all of the things that you wanted in here
- 7 so specific to pediatrics. A couple of comments I have,
- 8 though, are these. One is that we think this number might
- 9 already be taken by other regulations, so that's kind of a
- 10 non-issue. It's just 405.30 may be taken by something
- 11 else.
- 12 A lot of our leadership has looked at the
- degree of should we have very specific regs for pediatrics
- 14 as opposed to adding language to existing regs to make sure
- 15 that the pediatrics -- pediatric issues are counted. That
- seems to be where we'd like to go, as opposed to sectioning
- 17 out all new regulations in its own course because we -- I
- 18 feel that it may fly better that way if we add some
- 19 language.
- I also noticed that a lot of this could
- 21 be facilitated in moving forward through standards of care
- 22 or guidance documents that we, as surveyors, would hold the
- 23 facilities to. We can't say it's specifically in
- 24 regulation. We could, for instance, hold true to this is
- 25 how we're going to measure protocols, criteria, and

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- 2 resources for infants and children at our hospitals
- 3 treating pediatrics and, in essence, achieve the same goal.
- 4 This is how we're going to hold you accountable with this
- 5 level of care. It's tough under the 405 anyway because
- 6 these are minimum standards, and although we would like to
- 7 see things in an ideal setting we have to remember minimum
- 8 means minimum. So we want to make sure we have at least
- 9 the right things at the -- at the base and then hold them
- 10 to a higher accountability through our interpretive
- 11 quidance and so on.
- The other thing I'll say is because of
- 13 this regulatory reform, there were lots of comments by
- 14 facilities to our healthcare associations regarding
- 15 duplication of survey services. One of those duplications
- 16 was doing state surveys and federal surveys at the same
- 17 time. And those of you who work in a facility and received
- 18 any of our deficiencies and pulled your hair out or stabbed
- 19 yourself in the eye know how difficult that was to
- 20 interpret. What am I responding to? Is it state? Is it
- 21 federal? And you got two different sets of documents. We
- 22 decided, in response to what the healthcare facilities were
- 23 telling us, that it really was cumbersome. If we're out
- 24 there doing a federal survey, then that's what we should be
- 25 focusing on. If, however, we saw something egregious that

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- 2 really related to a state citation, we would still address
- 3 that. But for the most part, we're focusing on what the
- 4 federal government asks us to do as their agents when we go
- 5 in for a federal purpose survey. So, some of these
- 6 specifics about the pediatrics may not be able to get
- 7 drilled down to anyway because we would be looking at the
- 8 general headings under the federal conditions of
- 9 participation.
- 10 It is my impression, as certification and
- 11 surveillance director, that we expect all hospitals who
- 12 have these services to provide the right size equipment,
- 13 the right standards of protocols, but in order to beef that
- 14 up to meet your satisfaction we are very willing to add
- 15 language to some existing regs which I think will go
- 16 through faster and better and to incorporate tools that we
- 17 think will enable our providers to know this is how we're
- 18 going to measure you against these standards. And then
- 19 they will have all the information they need in order to
- 20 bring themselves up to that level.
- 21 So I'll stop here and I'll be asking for
- 22 any questions or interpretation.
- 23 DR. COOPER: I'll -- I'll ask a
- 24 question to start things off, Mary Ellen. I think we hear
- 25 you and understand, you know, where you're coming from. We

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- 2 all understand that -- that in the current environment with
- 3 healthcare reform or healthcare finance reform, it's not
- 4 really healthcare reform as we all know, kind of staring us
- 5 all in the face that hospitals are, you know, appropriately
- 6 concerned about the regulatory burden that they believe,
- 7 you know, cost them time and -- and money. So I -- I think
- 8 that, you know, anything that can be done to smooth that --
- 9 that road I think makes good sense. And -- and -- some of
- 10 the more specific issues I think you're suggesting could be
- 11 handled in policy and interpretation rather than regulation
- 12 per se. I think the regulations could be a little bit more
- 13 general, perhaps, you know, include reference to, you know,
- 14 a policy document. I don't know if that's doable in reg or
- 15 not. Certainly in statute there are references to
- 16 regulations the commissioner will develop. I'm -- I'm
- 17 guessing that there's probably a comparable wording for
- 18 regulation, you know, that goes along with the -- according
- 19 to the policies the commissioner will approve or something
- 20 along those lines. And I think that's something we can
- 21 all -- we all understand and something we can all work
- 22 with.
- I think for me -- and I don't know if
- 24 this is doable either, but I think what would be most
- 25 helpful, I think, for us in serving as your official

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- 2 advisors on -- on these matters is if there could be some
- 3 kind of meeting where we could actually go through this
- 4 document sort of line by line and say we think this could
- 5 go better here, we think this could go better there, that
- 6 sort of thing, so we can, you know, assist you better in
- 7 this -- in this process and, you know, in effect, sort of
- 8 say well, this is something that we feel is so important
- 9 that -- that it really does have to be addressed in
- 10 regulation, whereas this is something which, you know, more
- 11 appropriate to address by policy.
- 12 Part of the reason, I'm sure you know,
- 13 that the document was drafted in the way that it was is
- 14 that this is the advice that we had gotten from previous
- 15 administration in terms of the -- the way to go. And, of
- 16 course, we have a new governor, we have a new health
- 17 commissioner, and we have a new healthcare reform act, you
- 18 know, on the table. And all of these things are, you know,
- 19 making a, you know, rather large difference in how we all
- 20 do business. And so it's understandable that -- that, you
- 21 know, the view of things would -- you know, would change
- from, you know, May 2010 to June 2011. But I would ask on
- 23 behalf of our committee if setting up such a meeting would
- 24 be possible so we can get a better sense of what it is, you
- 25 know, you feel you -- you -- would help you best in -- in

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- 2 moving forward because what I'm hearing between the lines
- 3 is that there's a very strong commitment on the part of the
- 4 Department to doing this. It's really a matter of form
- 5 rather than function.
- 6 MS. HENNESSY: Right. I would agree. I
- 7 mean it would be worthwhile. What I would like to propose
- 8 is that we work internally, Sandra Haff and myself and some
- 9 people in my unit --
- DR. COOPER: Sure, yeah.
- MS. HENNESSY: -- with Martha and Lee and
- 12 anyone that they recommend, to slide this into the areas
- 13 that we think will work and then present that to you and
- 14 then we'll go through that line by line. Referring back to
- 15 what Bob has put here under each title. So you'll --
- 16 you'll see what the original proposal was and then where we
- 17 think it may fly and what would be regulatory type language
- 18 versus what is really guidance language.
- 19 DR. COOPER: Uh-huh. Uh-huh. Bob?
- DR. KANTER: Well, just to review a
- 21 couple of things. The -- the way the proposal was written
- 22 was wherever possible it was based on existing 405
- 23 regulation. So we really tried to resist the temptation to
- 24 extend into more than minimal standards based on the
- 25 precedent of other sections in existing 405 regs. We also

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- 2 tried very hard to write all the suggested items as things
- 3 that were definable and evaluatable based on existing
- 4 information. That is we intended that it would be
- 5 interpretable without doing any new surveys. Most of the
- 6 information refers to high volume hospitals should do this
- 7 or that. Volumes are already reported to the state and are
- 8 fairly self-defined on the basis of existing information.
- 9 So we were trying very hard to avoid a whole new regulatory
- 10 surveillance process.
- 11 When you get right down to it, I think
- 12 our interest is not exactly what format it's in. Our
- 13 interest is getting it implemented. I have two thoughts
- 14 about that. One is that it's better if it's in writing and
- 15 it's enforceable in some aspect. And information is really
- only useful if it's accessible. And having read through
- 17 the entire 405 regs in the process of writing these
- 18 proposals, I can tell you that it's not accessible if we
- 19 distribute the items in each of many other sections. It's
- 20 impossible to get to it quickly, systematically, reliably.
- 21 You've always missed something unless you spend hours on
- 22 it. And if someone is just trying to figure out, you know,
- 23 in their periodic review in each institution are we meeting
- 24 minimal standards, it would be an awful lot easier to go to
- 25 the pediatric section -- a lot more -- not only easier, but

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- 2 a lot more likely to work. If you go to the pediatric
- 3 section just as you go to the cardiac section, the
- 4 emergency section, the anesthesia section, the -- the
- 5 surgical section, each one of those is important --
- 6 self-evidently important. I don't think pediatrics is any
- 7 less important than those others.
- 8 MS. HENNESSY: A point well taken. I
- 9 understand your point about that, but my feeling is at this
- 10 point that there are other provider types or groups that
- 11 would also say ours needs to be ratcheted out. And so what
- 12 we would, in essence, be doing is for every type of
- 13 patient, perhaps group, we would be saying it deserves its
- 14 own set of regulations. And maybe that's not a bad idea
- 15 overall, just so it's in a compact way, but we would be
- 16 rewriting and rewriting and rewriting the basic regulations
- 17 that every hospital is required to have and then putting in
- 18 this individual group. It's not that I'm not sympathetic;
- 19 it's that I'm trying to, in a world of less regulation,
- 20 pushing forward an idea that may have better results in
- 21 total.
- 22 Now, that's not to say some of these
- 23 things couldn't get mentioned like a volume type of thing
- 24 in a very specific count, but I would have to discuss that
- 25 with this group and Lisa McMurdo's group, our O.H.S.M.

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- 2 directors, and so on. What didn't seem to go well was the
- 3 concept of having a whole entire new area of the reg. As
- 4 much as that makes sense to you and I, in the whole scheme
- 5 of things pushing that through I think that's going to be
- 6 a -- a heavier lift.
- 7 DR. COOPER: Mary Ellen, let me just --
- 8 let me just ask. Was -- was the push-back internal or was
- 9 it from hospitals?
- 10 MS. HENNESSY: No. We -- we have not
- 11 vetted these three through hospitals.
- DR. COOPER: Okay.
- MS. HENNESSY: We've discussed it
- 14 internally. However, what I would suggest to you --
- DR. COOPER: Yeah.
- 16 MS. HENNESSY: -- is that you may reach
- 17 out to HANYS who was looking at this whole reg reform type
- 18 of thing and making suggestions, if you will, to the
- 19 governor's office and to the Department to see how they
- 20 might support these efforts, our efforts together, is maybe
- 21 adding a person on the council or -- or at least it's a
- 22 quess.
- DR. COOPER: We do have, of course, you
- 24 know, a slot for hospital administration rep which is, you
- 25 know, been slow to be filled, as you know, but we do have a

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- 2 candidate who will be vetted, I -- I'm hoping. That having
- 3 been said, I do want to follow on Bob's comments for two
- 4 reasons. First of all, you know, many of us, perhaps most
- 5 of us, either work in facilities or have worked in
- 6 facilities and the facilities, at least in I think our
- 7 collective experience, and for those of you who disagree
- 8 please correct me if I'm wrong, tend to think of children a
- 9 little bit differently than they tend to think about, you
- 10 know, others. You know, it's -- and it's kind of a irony
- 11 because children are kind of, you know, always thought of
- 12 almost as another organ system. You know, there's hearts,
- 13 there's brains, there's bones, and then there's kids, you
- 14 know.
- DR. KANTER: Right.
- DR. COOPER: When, in fact, they're
- 17 people. You know? And, you know, one, you know, there --
- 18 there -- maybe there should be pediatric cardiac regs,
- 19 pediatric, you know, neurosurgical regs, et cetera, et
- 20 cetera, et cetera. And I'm, you know, I -- I think we all
- 21 recognize that that would be, you know -- you know,
- 22 something that probably would be a little bit -- going a
- 23 little bit too far, but -- but having said that, you know,
- 24 I -- I think the -- the hospital community might be a
- 25 little bit more receptive than you think to having all the

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- 2 pediatric regs, or not you personally of course, than --
- 3 than some have thought that, you know, that it might be
- 4 more -- a little bit more receptive having all the
- 5 pediatric regs in one place so they can -- you know, for
- 6 precisely the reason Bob has mentioned, you know, so -- to
- 7 find them.
- 8 MS. HENNESSY: Uh-huh.
- 9 DR. COOPER: You know, and say this is
- 10 what we need to be doing for kids and -- and, you know, to
- 11 me anyway, that makes sense. I mean reading through the --
- 12 you know, the -- you know, the 405s, you know, makes great
- 13 bedtime reading for the insomniac as you know. You know,
- 14 and trying to find -- trying to find all the -- all the
- 15 fine points can be -- can be daunting let alone, you know,
- 16 challenging. But I think there -- there may be some -- you
- 17 know, some value in -- in posing that question, and
- 18 certainly we could -- we could do that through our
- 19 professional associations.
- Obviously, we cannot do it as individuals
- 21 or as individual members of this committee since we
- 22 directly advise the commissioner and that would be -- you
- 23 know, that would be a violation of the -- of the way of the
- 24 law, you know, expects us to act as public officers or
- 25 quasi-public officers. But I -- I think that it's a

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- 2 question that probably does deserve to be asked before we,
- 3 you know, do a whole lot of work in trying to -- trying to
- 4 slim things down in the -- in the ways that you suggest,
- 5 which I think are perfectly fine. There's always, of
- 6 course, you know, the -- the option of creating, if you
- 7 will a, you know, sort of a road map saying that oh, by the
- 8 way here's a list of all the places in the code you have
- 9 to --
- MS. HENNESSY: That pertain to you.
- DR. COOPER: -- look for all the
- 12 pediatric stuff. But -- but it's often -- you know, it
- often makes a little bit more sense to kind of see the --
- 14 you know, the whole for you, as -- as opposed to, you know,
- in individual little parts, you know, that somewhere the
- 16 whole is always greater than some of its parts as we know.
- 17 And so I think it's -- I think it's worth at least posing
- 18 that question to the hospital community and seeing how they
- 19 feel about it. I -- I -- I'm willing to bet that they
- 20 would be okay with it.
- 21 Elise?
- 22 DR. VAN DER JAGT: I just want to -- just
- 23 to affirm what both Art and Bob have said. I -- I think
- 24 visibility is really important. I think one of the things
- 25 that is lacking in the current regs is that pediatrics is a

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- 2 special population. It's twenty percent of our population
- 3 and it has always been seen differently than, let's say,
- 4 the stroke patient or the cardiac surgery patient,
- 5 whatever. It is a much larger part of the population, and,
- 6 in fact, it's evolved into disciplines with sub-disciplines
- 7 and sub-disciplines. And so I think when Bob mentioned
- 8 about accessibility, I don't think the way it's currently
- 9 written that it truly is accessible and identifiable as a
- 10 separate population that is -- needs separate or special
- 11 care at least. It's almost to me it's going to be related
- 12 to, you know, what we do a lot with is kids with special,
- 13 you know, needs. Well, in some ways the entire pediatric
- 14 population is a population with needs that are different,
- 15 at least, if not special, compared to the adult population.
- 16 So -- so I think accessibility -- I think identity, if you
- 17 wish, is an important thing. And also our hospitals are
- 18 structured not in a pediatric person here, a pediatric
- 19 person here, a pediatric person here, and it's okay to have
- 20 three pediatric patients, one bed in each of three wards as
- 21 long as you -- that room looks okay. Even hospitals
- themselves recognize that it is a separate population
- 23 because they put them together separately. I mean they're
- 24 in a separate area.
- 25 MS. HENNESSY: It's because we require

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- 2 it.
- 3 DR. VAN DER JAGT: So -- well, no, but
- 4 I'm saying not even -- it's -- New York State had nothing
- 5 to do with it. It's just universal in -- across the world,
- 6 okay, that pediatrics is a separate population and they're
- 7 put together. So why would our regs not reflect the same
- 8 way what actually happens in hospitals, which means it's a
- 9 separate -- separate area. You know, it seems also to me
- 10 that in -- if -- if there was a concern about, you know,
- 11 particularly having it so separated out that it's --
- 12 there's a lot of duplication, it seems to me that within
- our world of electronic abilities of hyper-texting and
- 14 linking, that that at least might be helpful in terms of
- 15 pulling it together because I do understand that if the
- 16 hospital is looking at the, you know, let's say hand
- 17 hygiene, you know, or whatever the -- you know, it's going
- 18 to be somewhat similar, obviously, and you don't want to
- 19 duplicate and duplicate and duplicate. That, I do
- 20 understand. But I think it's a lot of it has to do with --
- 21 with identity and accessibility as a group and I think
- 22 having the hospital's input on that, that have to work with
- 23 this day by day, I think it would indeed be very helpful.
- 24 I think that from a grassroots this makes sense to do it
- 25 this way or it makes no sense.

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- MS. HENNESSY: Uh-huh.
- 3 DR. COOPER: Others? Jon?
- DR. HALPERT: I think you guys are right
- 5 on the nose. I think it's perfectly well, but the one spot
- 6 that you're perhaps overlooking is actually the emergency
- 7 part of the operation, the one area of the hospital where
- 8 kids typically are not segregated out. Now, in some
- 9 facilities they are. But those are typically tertiary care
- 10 centers that have the resources to do that. In most
- 11 emergency department operations kids, are roomed, bed --
- DR. COOPER: Uh-huh.
- DR. HALPERT: -- alongside adults with a
- 14 whole variety of problems, sometimes to their great
- 15 detriment, in my humble opinion. Well, I'm not sure how to
- 16 look at the average community hospital and get by and try
- 17 to segregate those folks off if there's even the ability
- 18 and the resource to do that with, but it's -- it's
- 19 certainly a consideration I think has to -- has to be
- 20 looked at.
- 21 DR. COOPER: Good point. Thanks, Jon.
- 22 Jan? Sharon? Rita?
- MS. MOLLOY: I agree with everything
- 24 that -- I agree with everything that you said. I've worked
- 25 in pediatrics in the hospital in, you know, a separate

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- 2 facility and I do think that having an accessible and
- 3 succinct area for hospitals to look, I participated with
- 4 hospitals have been, you know, certified and, you know,
- 5 the -- looking at the standards and, you know, meeting
- 6 them. And I think it is sometimes hard to -- if you didn't
- 7 have everything in one place, to do that as successfully as
- 8 you could. So I -- I would encourage that there is a -- a
- 9 section. I understand what you're saying. It would more
- 10 easily go through if it was, you know, language added to
- 11 something that exists. However, I support what everybody's
- 12 saying about making it separated.
- DR. COOPER: Elise?
- 14 DR. VAN DER JAGT: Maybe another question
- or another thought about this is, you know, currently, as I
- 16 remember in the regs, the neonatal section is a separate
- 17 section. Given the discussion about not separating
- 18 anything out, why would that even be separate then?
- 19 Pediatrics, I would say, is just as separate from adults as
- 20 neonates are from pediatric. I mean -- I mean that they're
- 21 a really separate population with very separate needs. And
- 22 I would say even in the E.D. here, Jonathan, is that in the
- 23 E.D. maybe we've fallen into the idea that well, everything
- 24 is fine, but maybe in some of the smaller hospitals there
- 25 should be a separate area even for pediatrics. I mean I'm

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- 2 not -- I'm not an E.D. doc, you know, I'm sort of --
- 3 DR. HALPERT: Right. I don't disagree
- 4 with you.
- 5 DR. VAN DER JAGT: And it certainly has
- 6 its own --
- 7 DR. HALPERT: The practicality.
- DR. VAN DER JAGT: -- the practicality --
- 9 the practicality is there, but we have sort of gone with
- 10 oh, I'll just throw them in with the adults, you know, but
- 11 that was also the way pediatric initially was back in the
- 12 '30s and '40s and '50s. It was in with the adults.
- MS. HENNESSY: Yes.
- 14 DR. VAN DER JAGT: And yet we've changed
- 15 it all because we recognized this was a very distinct
- 16 population, very distinct needs including environmental
- 17 needs. So I think that is a -- that -- that neonatal and,
- 18 you know, it's just like that. And I think that maybe that
- 19 would be helpful in terms of discussion, you know,
- 20 regarding that.
- 21 MS. HENNESSY: Thank you. I don't have
- 22 the history on that. I know it was in the past and I know
- 23 that we have entire resources and units actually dedicated
- 24 to neonatal care and -- and oversight and so on, a little
- 25 bit different than where we are with pediatrics right now.

- 1 EMS For Children 6-21-2011
- 2 You know, it comes under -- the surveillance comes under
- 3 us. I know that there is children wellness programs and
- 4 things like that. But we -- we will certainly bring your
- 5 comments back and -- and -- and talk about what the next
- 6 steps are.
- 7 DR. COOPER: In part -- in part, just on
- 8 a historical basis, in small part, the Comprehensive E.M.S.
- 9 Act -- E.M.S. Systems Act, I should say, of 1972 at the
- 10 federal level, that -- under the old 1200 series of Health,
- 11 Education and Welfare grants in the -- in the '70s, one --
- 12 a neonatal care was singled out as -- as something
- 13 requiring special attention; pediatrics was not.
- MS. HENNESSY: Uh-huh.
- DR. COOPER: Which is ironic, but that --
- 16 that, I think, at least in part, may be responsible and it
- 17 was clearly recognized and by -- by the late '70s and early
- 18 '80s that that was a terrible oversight and that's what led
- 19 to the, in fact, of the creation of the Federal E.M.S.C.
- 20 program. It was work out of the Los Angeles Pediatric
- 21 Society and the Los Angeles Department of Health and, you
- 22 know, work directly with the leaders in the American
- 23 Academy of Pediatrics and Cal Scia (phonetic spelling), a
- 24 pediatrician in Hawaii, working with Senator Inouye of
- 25 Hawaii to make sure that this all came to pass. So, I

- 1 EMS For Children 6-21-2011
- 2 think that -- that at the federal level where at least some
- 3 of these, you know, mistakes occurred, they recognized that
- 4 they were mistakes and have acted to, you know, correct the
- 5 wrong since and, so I think it's worthwhile for us to, you
- 6 know, consider doing the same here.
- 7 Someone had a hand up over here?
- 8 MS. CHIUMENTO: Just one brief comment
- 9 and that's from hospitals who do not have pediatrics, I
- 10 would think it would be easier for them to say this section
- 11 does not apply to us, rather than they having to go through
- 12 each part and say this one line doesn't apply to us or this
- 13 one little --
- 14 DR. COOPER: That's a good point.
- 15 MS. CHIUMENTO: -- subsection have to --
- 16 doesn't apply to us. And it seems to me that from their
- 17 standpoint it also would make -- be a little bit easier for
- 18 them to have it separated out.
- 19 DR. COOPER: Did -- Deb Sottolano, did
- 20 you have a comment? I thought you were --?
- 21 DR. SOTTOLANO: No, I -- I thought that
- 22 Dr. Kanter did.
- DR. COOPER: Oh, okay.
- 24 DR. KANTER: Just a point of
- 25 clarification. I'm not sure if I understood, Jonathan,

- 1 EMS For Children 6-21-2011
- 2 your comments about a separate area in the E.D. None of
- 3 the suggestions in the draft talk about a physical area in
- 4 emergency departments. Even for high volume E.D.s we
- 5 talked about training and services that should be provided.
- 6 We don't talk about a separate area at all. Whether it's a
- 7 good idea is another matter. We don't address it here.
- B DR. HALPERT: Right. Conceptually is I
- 9 was referring to. I think -- I think that it's an idea
- 10 whose time is worth at least evaluating seriously to some
- 11 degree because of the complications I think that are
- 12 routinely encountered trying to -- to manage the vast
- 13 differences in patient population, where in the regular
- 14 hospital setting it's typically segregated with -- with
- 15 good result, I would think.
- DR. COOPER: Any other comments at all
- 17 for Mary Ellen? Okay. Hearing none, I really, really
- 18 appreciate the work that you and Lisa and Martha and others
- 19 have done within the Department to run this up the
- 20 flagpole. And I'm hoping that what we can do from -- from
- 21 this point forward is work with our professional
- 22 associations to get this message across to HANYS I'll
- 23 actually be seeing the executive director of the A.A.P.
- 24 tonight at another meeting. And -- and hopefully, this can
- 25 be discussed in turn within the Department and -- and see

- 1 EMS For Children 6-21-2011
- 2 if it makes sense.
- I think that -- I think a lot of the
- 4 comments that have been made are right -- right on the mark
- 5 in terms of -- in particular Sharon's. You know, it's --
- 6 if -- as a -- as a person who, you know, has had some
- 7 responsibility at the hospital level of trying to deal
- 8 with, you know, regulatory compliance, it's -- you can
- 9 always end up missing that one line, you know, if it's not
- 10 kind of separated out into a -- into a easily digestible,
- 11 you know, form. And so it may -- I think it may well be
- 12 that not only are hospitals, you know, not resistant to
- 13 this type of approach, they may actually favor it. Which
- 14 is not to say, by the way that -- that so many of -- of --
- of the concepts couldn't be handled through reference to
- 16 policy. I -- I think many of them could. And I think, you
- 17 know, but -- but I think we need as -- as we suggested, I
- 18 think we need -- we need some guidance on that.
- So we'll look forward to work through the
- 20 professionals associations, with the hospital association,
- 21 and we'll look forward to -- to the Department sitting down
- 22 and figuring out which way it wants to go. Hopefully then
- 23 we can kind of get that information in one place and then
- 24 we can create the -- you know, a new version of the
- 25 document that, you know, as you had suggested internally

- 1 EMS For Children 6-21-2011
- 2 that you can then share with us and we can set up a meeting
- 3 to go through it line by line. Does that make sense?
- 4 MS. CHIUMENTO: Yes.
- DR. COOPER: Okay. Great. Great.
- 6 Thanks.
- 7 Bob?
- 8 DR. KANTER: I always find that things
- 9 like this go better if you sort of have an action plan and
- 10 a schedule. So in addition to the discussion with the
- 11 professional organizations and just so that we can sort of
- 12 plan our own personal work plans. Any thought about when
- 13 we might be really to get together with the Department to
- 14 talk about this just timing-wise more extensively?
- DR. COOPER: I mean I don't -- obviously,
- 16 I think it's up to Mary Ellen --
- DR. KANTER: Right.
- DR. COOPER: -- and her folks to decide
- 19 what the Department's timeline is going to be. They have
- 20 much on their plates at this particular point in time,
- 21 but -- but I think in terms of going through the A.A.P.
- 22 to -- to reach out to the hospital association, summer
- 23 would be the perfect time.
- 24 DR. KANTER: You know, I mean the context
- 25 is we've been talking about this for about seven or eight

- 1 EMS For Children 6-21-2011
- 2 years.
- 3 DR. COOPER: We all understand, yeah.
- 4 MS. GOHLKE: Yeah.
- 5 DR. COOPER: Mary Ellen?
- 6 MS. HENNESSY: I -- I think a couple of
- 7 things have to be done. We're certainly willing to -- to
- 8 meet with you at -- at any point in time. What it sounded
- 9 like to me is that you would like to talk to maybe the
- 10 healthcare association and some of your partners and when
- 11 you get a -- a feel for when the time is right to come back
- 12 to the table, we can certainly meet with you. And then we
- 13 can talk about possibilities. I can bring your comments
- 14 back to my administration and say, you know, they're --
- 15 they're still really wanting to have this focused area and
- 16 here are the people that they're going to reach out to, to
- 17 see what the reaction is, the hospitals themselves and the
- 18 associations, and -- and I think we should all get together
- 19 and talk about the results of both.
- DR. COOPER: Yeah. I -- I -- I'm
- 21 thinking that -- that -- honestly, I'm thinking that both
- 22 things could happen this summer, those internal
- 23 discussions -- internal to the -- to the profession and
- 24 internal to the Department, and that certainly by late
- 25 summer we should have a sense of where everybody stands so

- 1 EMS For Children 6-21-2011
- 2 that perhaps we could even, you know, begin to get
- 3 something together that we could perhaps look at on a
- 4 preliminary basis. Not -- not a final document
- 5 necessarily, but something we could look at on a
- 6 preliminary basis, you know, in September so we could
- 7 potentially, anyway, try to set up a meeting -- a formal
- 8 meeting. I know how hard -- difficult, you know, setting
- 9 up formal meetings in the summer could be for the
- 10 Department, so it's -- if we can set up a formal meeting
- 11 some time during the fall where we could begin to look --
- 12 look this over.
- MS. GOHLKE: One suggestion that comes to
- 14 mind, you know, we have our meeting confirmed for September
- 15 20th and we have the whole morning -- we have this room for
- 16 the whole day.
- DR. COOPER: That's great.
- 18 MS. GOHLKE: And if it works, you know,
- 19 we can always use the morning time to meet here earlier in
- 20 a smaller group or whomever decides they want to be a part
- 21 of the discussion and -- and do some preliminary work to
- 22 that meeting September 20th in the morning. Just a
- 23 thought.
- 24 DR. COOPER: That sounds like a great
- 25 idea. So let's -- let's point toward that.

- 1 EMS For Children 6-21-2011
- 2 Elise?
- 3 DR. VAN DER JAGT: Just a question about,
- 4 again, the process. So two things. One is are there any
- 5 other parties that need to be part of this discussion? You
- 6 know, you've got with HANYS, obviously, you know, and --.
- 7 DR. COOPER: Well, Greater New York --
- 8 Greater New York, of course.
- 9 DR. VAN DER JAGT: Okay.
- 10 DR. COOPER: Greater New York Hospital
- 11 Association.
- DR. VAN DER JAGT: Yes. Okay.
- DR. COOPER: Yes.
- DR. VAN DER JAGT: Are there any other --
- 15 you know, other groups that need to be brought into this
- 16 because you don't want to leave out anybody?
- DR. COOPER: No.
- 18 DR. VAN DER JAGT: And --.
- MS. MCMURDO: Iroquois? You don't want
- 20 to -- Iroquois as well? Not just -- is that under the
- 21 HANYS umbrella?
- 22 DR. COOPER: I'll -- well, my -- you
- 23 know, to be very honest with you I think some of my Upstate
- 24 colleagues would have a better sense of that than I do.
- 25 You know, if -- I think the issue is if we invite one of

- 1 EMS For Children 6-21-2011
- 2 the regional associations we're going to have to invite
- 3 them all, you know, and -- you know, whereas Iroquois is,
- 4 in many ways, you know, the largest and most and most
- 5 outspoken, you know, it's -- at times it's, you know -- you
- 6 know, but we can certainly ask. I mean it may well be
- 7 that, you know, that -- that, you know, in conversations
- 8 with HANYS and Greater New York that, you know, Greater New
- 9 York may feel that certain groups have -- you know, have a
- 10 particular, you know, contribution to make and HANYS may
- 11 feel the same way.
- I -- I -- I will say that my own
- 13 preliminary conversations, you know, with -- with HANYS
- 14 over the years, you know, through the academy or through
- 15 the College of Surgeons or what have you on a variety of
- 16 subjects, you know, have -- you know, it's always been --
- 17 you know, they've always been very receptive with special
- 18 needs of children and -- and wanting to do the right thing
- 19 by the children and -- and so on. So I -- you know, I --
- 20 you know, when you tread on regulatory grounds, of course,
- 21 you know, things do change, but -- but my sense has been
- 22 that, you know, that they are -- you know, that -- that
- 23 they will, again, as I said earlier, probably be far more
- 24 receptive than -- than we -- we might believe.
- 25 And, you know, I think honestly in the Upstate regions,

- 1 EMS For Children 6-21-2011
- 2 you know, in many ways de facto regionalization has already
- 3 occurred, whatever regionalization means. You know, that's
- 4 a little bit less to do with the downstate areas, but as
- 5 we'll see a little bit later on in -- in today's program
- 6 and which -- and I hope everyone can stay for this, the
- 7 work we've been doing in terms of pediatric disaster
- 8 preparedness in New York City has really -- has really been
- 9 terribly important in terms of getting the region itself to
- 10 think more about regionalization on a larger scale. And so
- 11 I think that even at the Greater New York level, you know,
- 12 we may -- we may find that -- you know, that -- that --
- 13 that -- that the road is quite a bit easier than we might
- 14 have expected.
- DR. VAN DER JAGT: All right. The second
- 16 part of my -- my question was what exactly is the process
- 17 because it's great to get opinions and thoughts about the
- 18 HANYS or other organizations, but then what exactly are the
- 19 steps that get taken before this is changed? For example,
- 20 who actually writes the -- any changes in 405.30 or
- 21 different number if it's a different number. Who actually
- 22 writes it? Who actually, you know, that's who actually
- 23 approves it? You know, I mean and what's the process?
- 24 I'm -- I'm not sure about what it is because we have so
- 25 often said I'll be able to talk with this group and this

- 1 EMS For Children 6-21-2011
- 2 group and then informally you get, well there's sort of
- 3 agreement with it or not in agreement with it, but I'm not
- 4 quite clear what the action is.
- 5 DR. COOPER: Well, let me just -- I'll
- 6 start that conversation -
- 7 -
- DR. VAN DER JAGT: Okay.
- 9 DR. COOPER: -- with a couple of brief
- 10 comments then turn it over to Mary Ellen because it's
- 11 really more in her bailiwick than ours. In terms of the --
- 12 in terms of what the -- the initial steps in the process,
- 13 we as a committee cannot -- cannot formally reach out to
- 14 professional associations. This has to be done informally
- 15 through our professional associations. And I -- I think,
- 16 you know, we can discuss that informally offline under the
- 17 auspices of the academy as to how we might -- how we might
- 18 address that particular piece of it. I think Mary Ellen
- 19 has already indicated that she's going to bring our
- 20 messages back to the -- to the -- you know, the hierarchy
- 21 in the Health Department for their -- for their discussion.
- 22 And at -- at -- at that point I -- if I heard Mary Ellen
- 23 correctly, once we get that information together toward the
- 24 end of the summer, Mary Ellen wants to work internally with
- 25 a -- with a small working group in the Department to help

- 1 EMS For Children 6-21-2011
- 2 put together some kind of, you know, outline or draft or
- 3 document as to how we might take what we have today and
- 4 turn it into something that the Department felt was -- was,
- 5 A, doable and, B, in comport with the information that they
- 6 got from the internal folks and that we brought them, you
- 7 know, through our professional associations, you know, as
- 8 something that -- that could fly. And at that point, I
- 9 think, you know, I'm a little confused because we used to
- 10 have the state hospital review and planning council and we
- 11 now have a combined public health council and -- and the
- 12 state hospital review and planning council.
- So take it from here and tell us what
- 14 happens then.
- MS. HENNESSY: We have a process and what
- 16 Art said is exactly right. I think once we get input from
- 17 you, we would craft the regs, either through the
- 18 recommendations that you're getting or that internally
- 19 we're getting or both. Sandra Haff, who has joined us here
- 20 today, happens to be the support to the chair of the codes
- 21 committee for the new public health and hospital --
- 22 MS. HAFF: Health planning council.
- MS. HENNESSY: Health Planning Council or
- 24 PHHPC.
- DR. COOPER: Say that again? PHHPC?

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- MS. HAFF: PHHPC, Public Health and
- 3 Health Planning Council. PHHPC.
- 4 DR. COOPER: PHHPC.
- 5 MS. HAFF: Like Philadelphia.
- 6 MS. HENNESSY: It's P -- right --
- 7 DR. COOPER: PHHPC. Okay. Good.
- MS. HENNESSY: -- PHHPC.
- 9 DR. COOPER: Public Health and Health
- 10 Planning Council. Okay. Good.
- MS. HENNESSY: Sandra is the person to
- 12 whom we all go when we have new regulations that need to be
- 13 moved forward. There is an internal process for how they
- 14 need to be vetted and to whom and a process for approving
- 15 them.
- 16 Sandra, I don't know if you want to go
- 17 into any details?
- 18 MS. HAFF: Well, we -- we have an
- 19 internal -- we have an internal reg advisory unit that we
- 20 present a concept to and then we work with our legal
- 21 department and we develop the reg. And then once it is
- 22 final it has to go out to -- it used to be the Governor's
- 23 Office of Regulatory Reform, now it's a unit within the
- 24 D.O.B., the Division of Budget. Then it goes to the
- 25 government, excuse me -- it goes to the governor's office

- 1 EMS For Children 6-21-2011
- 2 for review. And when it -- when it gets out of there, it
- 3 has a forty-five-day comment period. Once that is done, it
- 4 goes to PHHPC. And right now we have regs on at least once
- 5 before it's on for adoption. So it gets two hearing as
- 6 PHHPC codes committee meetings. So it's a long process,
- 7 nonetheless.
- 8 DR. VAN DER JAGT: Thank you.
- 9 DR. COOPER: It doesn't sound terribly,
- 10 terribly different from the --
- MS. HAFF: No.
- DR. COOPER: -- previous process. It
- 13 sounds like there are many, many --
- MS. HAFF: Layers.
- DR. COOPER: -- many layers -- many, many
- 16 heads to convince, you know, that something needs to be
- 17 changed which is, you know, we are after all a democracy
- 18 and that's probably not a bad thing. It's something we can
- 19 all get behind once it gets through a process like that.
- 20 So that's good. There's an old rule in -- at least that
- 21 it's old to me, you know, I've learned very early on in
- 22 my -- you know, in my experience with you all, but
- 23 generally speaking if eighty to eight-five percent of the
- 24 folks out there think something is a good idea, it's got a
- 25 pretty good chance of going forward. And I'm willing to

- 1 EMS For Children 6-21-2011
- 2 bet that that we probably have that eighty to eighty-five
- 3 percent out there right now. And we'll just work hard to
- 4 make sure that -- to make sure it happens. And, of course,
- 5 I -- I know that everyone here, meaning, you know, our
- 6 friends -- our -our partners in government as well as -- as
- 7 well as ourselves, you know, are all on the same page with
- 8 us. We all have the right for kids and it's a matter of
- 9 figuring out how to do it. I think that -- that everyone
- 10 was thrilled, in fact, when Commissioner Daines said do
- 11 this. And -- and I haven't heard Commissioner Shaw say
- 12 don't do this. So we -- I think we're going to continue to
- 13 move forward and, you know, do our best to get this done
- 14 with your support and your help, of course. So thank you
- 15 so much.
- I -- again, I hope you all can stick
- 17 around to hear this New York City Disaster presentation. I
- 18 know others may have some disaster presentations they may
- 19 make as well. I don't know. We've talked about that. I
- 20 don't know if others have anything to bring to the table on
- 21 that, but at this point I think we can close that issue
- 22 out.
- Bob, did you have anything further on the
- 24 regionalization report other than what we already
- 25 discussed?

- 1 EMS For Children 6-21-2011
- DR. KANTER: Just a tiny thing that
- 3 follows from it in the shorter term. So putting aside
- 4 revisions and regulations, what are we doing and what could
- 5 we do right now based on the existing regulations? For
- 6 quite some time, the National E.M.S.C. organizations have
- 7 been promoting guidelines for inter-facility pediatric
- 8 transfers of patients or consultations. And so in 2009,
- 9 this committee wrote a draft of guidelines based on
- 10 national recommendations and national performance goals as
- 11 well as based on precedence from other states guiding their
- 12 hospital system criteria and processes for inter-hospital
- 13 inter-facility transfers of pediatric patients. So there
- 14 is -- as I understand it, the next step in this since our
- 15 draft in 2009 is there is a working group in New York
- 16 State. Deb Funk is heading that group up, who will be
- 17 looking into this.
- 18 That said, I first heard about this in
- 19 early May and I haven't heard a word since, so I can't give
- 20 you any update on that. But in the meantime, I think
- 21 there -- I -- I have a suggestion and you all can tell me
- 22 what the best form for trying to work on this is.
- 23 Without --.
- 24 DR. COOPER: Bob, before you get into
- 25 that --

- 1 EMS For Children 6-21-2011
- 2 DR. KANTER: Yeah.
- 3 DR. COOPER: -- I -- I just -- I did do a
- 4 little tiny bit of homework on this issue since -- since
- 5 you brought it up. And correct me if I'm wrong, Martha and
- 6 Lee, especially Lee, but I -- I -- my understanding is that
- 7 Deb's group is really focusing more on inter-facility
- 8 protocols for E.M.S. folks, not so much on --
- 9 DR. KANTER: Uh-huh.
- DR. COOPER: -- indications for transfer,
- 11 which was the -- which was the gist of what we had -- had
- 12 focused upon.
- DR. KANTER: That wasn't so clear to me.
- 14 Yeah.
- DR. COOPER: And -- but I -- I do think
- 16 that -- that to the extent that it -- that it -- that it
- 17 can be accomplished, it would be useful if there could be
- 18 some discussion about that. I -- I had actually hoped we
- 19 might be able to invite Deb to come to the meeting today,
- 20 but, you know --
- 21 MS. BURNS: The committee hasn't
- 22 reconvened yet. There's --.
- DR. COOPER: Okay.
- MS. BURNS: I mean it's been seated. It
- 25 just hasn't --.

- 1 EMS For Children 6-21-2011
- DR. COOPER: Yeah. Sure.
- 3 MS. BURNS: What -- what we did, just to
- 4 digress ever so slightly -- and it's been a long time now.
- 5 The committee looked at -- initially with Dr. Funk heading
- 6 it, looked at really a scope of practice of E.M.S.
- 7 providers and possibly an expanded certification for, you
- 8 know, high tech inter-facility transfer. My brain is dead.
- 9 Critical care inter-facility transfer is what -- the word.
- 10 And Dr. Funk and her group put together training curricula,
- 11 basically, for lack of a better term, a scope of practice
- 12 and then had sort of moved towards educating sending and
- 13 receiving facilities. And it sort of -- it died with --
- 14 not died, but it -- it languishes well before your -- your
- 15 reign of terror with -- and so --.
- 16 DR. COOPER: You're going to regret that.
- MS. BURNS: I will. She -- she will get
- 18 even. I know that.
- MS. MCCURDO: It's a good thing Lee works
- 20 for me.
- MS. BURNS: Mary Ellen is quick, though.
- MS. HENNESSY: Well, you know what they
- 23 say about me.
- 24 MS. BURNS: But -- so the -- what the
- 25 committee has done so far is with -- both the Department

- 1 EMS For Children 6-21-2011
- 2 and the committee have pull all of the stuff that they did
- 3 years ago back together, redistribute it for consideration,
- 4 and -- and essentially modernization and updating so that
- 5 we could, again, you know, get -- the real issue is
- 6 actually a REMAC and E.M.S. community, one for the critical
- 7 care inter-facility transport piece, but also the component
- 8 of working with the hospitals. So that may dovetail into
- 9 what you're looking at, Dr. Kanter. And once we get all
- 10 that together, we'll sneak up on Mary Ellen with it also.
- 11 But it's -- the committee has not physically sat yet.
- 12 They're in the review stages.
- DR. COOPER: I think it would help --
- 14 pardon me, but I do think it would help if, you know,
- 15 copies of these documents could be made available to -- to
- 16 our group as well and I think that will help clarify. You
- 17 know, I have the -- you know, the privilege of
- 18 participating in some of those discussions a number of
- 19 years ago though the -- the SEMAC itself and there -- I
- 20 don't believe there's a whole a lot of overlap between what
- 21 they're -- what they did and what we're doing. The --
- 22 the -- you know, the -- the issue that Lee was speaking
- 23 about in terms of reaching out to the hospitals was sort of
- 24 as much educating the hospitals on what the
- 25 responsibilities of the sending and receiving physicians

- 1 EMS For Children 6-21-2011
- 2 are as to, you know, which particular kinds of patients
- 3 should be transferred, which is really not only our issue,
- 4 but it's also, you know, the federal issue in terms of the
- 5 performance measure that -- that they -- that they hold us
- 6 to in terms of the grants. But if -- if we could see those
- 7 documents and, you know -- I don't think we -- we will
- 8 probably have a whole lot to say except to say that --
- 9 that, you know, pediatric education needs to be included as
- 10 part of the -- as part of the program and that there has to
- 11 be some element for pediatric medical control, which is
- 12 also part of, you know, the -- the federal performance
- 13 measure issue.
- 14 But I -- I believe that those issues
- 15 are -- are already pretty well covered, if I'm not
- 16 mistaken. I haven't seen the documents in a while, but I
- 17 believe they're pretty well covered in those documents and
- 18 certainly if they aren't we can point that out. And I have
- 19 no doubt that Deb will -- you know, Deb will endeavor to,
- 20 you know, do what needs to be done in that regard.
- I'm sorry, Bob. I didn't mean to cut you
- 22 off.
- DR. KANTER: That's fine. The issue that
- 24 I would love to make some progress on now -- let's -- let's
- 25 say plainly what the national guidelines are really about.

- 1 EMS For Children 6-21-2011
- 2 Inter-facility transfer and consultation guidelines try to
- 3 identify patient criteria that warrant at least a
- 4 consultation, if not a transfer. National guidelines
- 5 suggest or -- or require a process for identifying
- 6 hospitals that are able to provide pediatric care. And the
- 7 national guidelines define a process which includes many
- 8 things, communications and, you know, the information that
- 9 ought to be exchanged, what sort of staff, what sort of
- 10 equipment, what sort of patient care should be deliverable
- 11 during the inter-facility transfer? And without
- 12 necessarily trying to implement all of that at once, it
- occurs to me that in New York State we could immediately do
- 14 a much better job on this using existing information and
- 15 that has to do with hospital identification.
- 16 Without going into revised regs or
- 17 revising our credentials for hospitals, we already at the
- 18 state level clearly identify NICUs at various levels. We
- 19 already clearly identify pediatric I.C.U. beds. We clearly
- 20 identify trauma centers. The only one that you can find
- 21 online, publicly, easily accessible is the trauma centers.
- 22 That is easy to find. It is not so easy to find who is
- 23 your nearest pediatric I.C.U. Now, if you know which
- 24 hospital they're at and you go to the hospital profile
- 25 website, you can find how many beds they have. But you

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- 2 have to know which hospital has them to find that.
- I would suggest without any new
- 4 categories or surveys or procedures, if you simply have a
- 5 source of information, which even better would include
- 6 contact information that's already publicly available, just
- 7 not organized in an accessible place, you could immediately
- 8 have a huge impact on one of the big performance areas in
- 9 national guidelines. It would require no new regulatory
- 10 process, just accessible, clear information about where the
- 11 pediatric I.C.U. is and how to get a hold of them.
- DR. COOPER: Mary Ellen, what do you
- 13 think about that? Is that something that we could do?
- 14 Certainly there is precedent in -- you know, in the
- 15 departmental structure for, you know, if you will, listing
- 16 in various places, you know, capabilities that various
- 17 hospitals have. Is that something that you could do, do
- 18 you think?
- MS. HENNESSY: My -- my mind is racing as
- 20 you say this because, you know, we do have the data. We do
- 21 know where these beds are. Right now the profile is kind
- 22 of set in a -- in a format that does not allow you to do
- 23 that search of all pediatric I.C.U. beds, et cetera. So
- 24 I'm thinking that we might have to publish something like
- 25 that on the main website of the Department. And the

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- 2 problem with publishing information is it always needs
- 3 updating as far as the contact information. You know, if
- 4 you put a person instead of a title or a number, it -- it
- 5 generally needs updating. But we could certainly put the
- 6 information -- I don't think that would be controversial at
- 7 all to regionally put the information where the -- where
- 8 the pediatric beds are. It's -- you know, I don't think
- 9 it's good.
- 10 MS. GOHLKE: I -- I would be willing to
- 11 make sure the contact information is updated. I mean
- 12 that's --.
- MS. HENNESSY: Uh-huh.
- 14 MS. GOHLKE: The feds would love to see
- 15 me do something like that anyway.
- MS. HENNESSY: Yeah.
- MS. GOHLKE: So --.
- 18 DR. KANTER: As hospitals get more savvy
- 19 about this, if they know that their single phone number for
- 20 all contacts is now being publicized in a very visible way,
- 21 the individual hospitals have some stake and interest in
- 22 ensuring that it stays accurate.
- DR. KACICA: You know, one of -- one of
- 24 the things that -- that we did last year was we reorganized
- 25 the website for pediatric and emergencies so then we have

- 1 EMS For Children 6-21-2011
- 2 information for providers, information for parents and
- 3 for -- and so it's easily found. So if we put it in the
- 4 information for providers, it would be a perfect place and
- 5 that would be very easy to do. So if someone has that list
- 6 right within the next month, you know, we can work on
- 7 getting that up there.
- 8 MS. CHIUMENTO: And that's on the public
- 9 website?
- DR. KACICA: It's on the public website.
- MS. COOPER: That's great. Thank you,
- 12 Marilyn. That's terrific. That's great.
- DR. VAN DER JAGT: Bob, I have a question
- 14 about that, though. I mean I think it's great to do that
- 15 and that's -- I don't mean to deny that. What exactly is
- 16 the objective because the people -- it's not the people who
- 17 are referring patients. They already know where they're
- 18 going to refer, I think.
- DR. KANTER: They don't. What happen
- 20 from, you know, at least once every week or two we get a
- 21 call from a E.R. doc who's moonlighting, doesn't usually
- 22 work there, he's been trying for forty-five minutes to
- 23 figure out where to send the patient and -- oh, thank God I
- 24 finally got through to you.
- 25 DR. VAN DER JAGT: I'm just wondering how

- 1 EMS For Children 6-21-2011
- 2 universal that is.
- 3 DR. HALPERT: Yeah.
- DR. VAN DER JAGT: That's certainly not
- 5 our experience.
- DR. HALPERT: That's -- that's really
- 7 kind of highlights a unique -- a different situation, you
- 8 know, the epidemic of low income staffing and E.D.s across
- 9 the country --
- DR. COOPER: Exactly.
- 11 DR. HALPERT: -- and in New York
- 12 specifically is a whole different aspect of what you're
- 13 talking about. You're right; that happens. It shouldn't
- 14 happen, but it happens right now quite a bit.
- 15 DR. VAN DER JAGT: But if I could --
- DR. HALPERT: It changes the whole
- 17 dynamic.
- 18 DR. VAN DER JAGT: -- if I could -- it's
- 19 a just a little push-back on that --
- DR. COOPER: Yeah.
- 21 DR. VAN DER JAGT: -- because I'm
- 22 thinking so there really is no nurse there. There is no
- one in that entire hospital who has ever --?
- DR. COOPER: Elise, press your button if
- 25 you're going to --.

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- DR. VAN DER JAGT: Oh, I'm sorry.
- 3 DR. COOPER: Okay.
- 4 DR. VAN DER JAGT: It is on.
- 5 MS. GOHLKE: There's too many mics on.
- 6 You can only have a couple on.
- 7 DR. COOPER: Okay.
- DR. VAN DER JAGT: Oh.
- 9 MS. GOHLKE: You can only have a
- 10 couple --
- 11 DR. VAN DER JAGT: That's because I have
- 12 a hard time I guess maybe imagining --.
- DR. HALPERT: It's just -- it's an
- 14 organizational issue. It's an internal organizational
- 15 issue --
- DR. VAN DER JAGT: It's hard to imagine
- 17 that a hospital actually --.
- DR. HALPERT: -- you know, that -- that
- 19 doc is not thinking outside the box to say who has the
- 20 information to help me. They're just saying I need to get
- 21 this information now. I'll make the phone call because in
- theory that's the best way to solve the problem.
- DR. COOPER: Are you suggesting that doc
- in the box isn't thinking outside the box?
- 25 MS. HENNESSY: It's because they're in

- 1 EMS For Children 6-21-2011
- 2 the box.
- 3 DR. HALPERT: That could be a new buzz
- 4 word --
- 5 MS. BURNS: Who do we have in a box?
- 6 DR. HALPERT: -- for an ad campaign.
- 7 DR. KANTER: You know, it's a function of
- 8 the doc who just doesn't work there all the time but the
- 9 other fact is for the last fifteen years we send out our
- 10 content information to our twenty-five hospitals and, you
- 11 know, for the next three months we -- everybody knows
- 12 what's going on. And then about four months later the
- 13 memory fades. It's marketing. You just got to keep
- 14 plugging away at the basic information.
- DR. COOPER: Yeah. I mean I -- I -- to
- 16 me, I see no downside in doing this. I -- I -- I, you
- 17 know, I think, yes, everyone's right here. I think that
- 18 there are certain regions, you know, in which, you know,
- 19 the referral lines are perhaps a little tighter than they
- 20 are in other areas, but they're -- but as Bob and John are
- 21 pointing out, there is no question that there's -- you
- 22 know, that there's, you know, folks out there who just
- 23 don't know where to send the patients. And so I -- I see
- 24 no downside in doing this. And -- and I think it would be
- 25 easy to do and I -- you know, and I -- I think it would be

- 1 EMS For Children 6-21-2011
- 2 really a great first step toward at least, you know, saying
- 3 these are the places that have these resources, you know,
- 4 for -- you know, for the -- for the public if not, you
- 5 know, only for providers.
- 6 Elise?
- 7 DR. VAN DER JAGT: Yeah. Again, I don't
- 8 mean to say that this shouldn't be done.
- DR. COOPER: Oh, no, of course.
- DR. VAN DER JAGT: I do agree with that.
- 11 I think that simply more in terms of how it will be used
- 12 and I think at least for the providers it is -- again, I
- don't know about New York City, but I think it would be
- 14 less --
- DR. COOPER: It's a mess.
- DR. VAN DER JAGT: -- likely that they
- don't know where to send it, but it may be more likely that
- 18 they don't know the number to contact. So I think with the
- 19 contact numbers that is probably very helpful because that
- 20 sometimes is not available. And I think about this Upstate
- 21 New York as well, Bob, --
- DR. COOPER: That's very true, yeah.
- DR. VAN DER JAGT: -- is that, you know,
- 24 if we cannot accept a patient, we do everything we can to
- 25 try to conference it in with, let's say, Syracuse and say

- 1 EMS For Children 6-21-2011
- 2 do you have a bed. If that doesn't happen or we lose
- 3 connection, they may not know the number to Syracuse or
- 4 to --
- DR. KANTER: Oh, dear.
- 6 DR. VAN DER JAGT: -- Buffalo or -- or
- 7 wherever. Or actually, there was -- I remember one year we
- 8 were sending patients to Ottawa, Canada because there
- 9 was -- there were literally no beds in Upstate New York for
- 10 critically ill patients. Well, you know, trying to find
- 11 the number is not so easy. So the number and the contacts
- 12 would be important to put on there and then make sure that
- 13 they're correct and continuously updated.
- DR. COOPER: Deb?
- DR. SOTTOLANO: Yeah, I just wanted to
- 16 mention because this conversation is kind of floating
- 17 around a couple of deliverables and things that we're
- 18 planning for the hospital preparedness program grant this
- 19 year. And one of the things is -- is that -- well, a few
- 20 things. One of the things is this survey at the hospital
- 21 now and I know, Dr. Kanter, you were saying about, you
- 22 know, major recourses being known. But I think we wanted
- 23 to elaborate a little bit more on the survey that Dr.
- 24 Kacica did relating to the pediatric tool kit and some of
- 25 the recourses there and get more in depth on that.

25

EMS For Children - 6-21-2011 1 2 And with so many changes, hospitals 3 closing, I mean I just saw a hospital that decertified twenty-five, you know, pediatric beds and so forth and so 4 5 many changes we really wanted to try to get more up-to-date 6 data. So one of our deliverables at the hospital level is 7 going to be a much more in-depth, you know, assessment and 8 make that available to the regional resource centers across the state and have them work on their deliverable which 9 would be kind of an outlining of regional resources and a 10 11 plan for dealing with surge and pediatric patients during 12 disaster. 13 One of the things that we can and we're 14 planning on doing is in our -- our commerce system, our 15 health commerce system, we have a communications directory in which we maintain roles and contact information is role 16 based. And our facilities are -- part of their 17 18 requirements are really to maintain that contact 19 information. We use it all the time for alerting and we 20 can alert twenty-four-seven. And one of the other things 21 we were looking at is also enabling hospitals to utilize that same alerting system. But beyond the alerting system, 22 they actually have access to look up based on roles in the 23 directory and get contact information. And so if there are 24

specific roles that you wanted to outline at each hospital,

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- 2 we can enable that and ask the hospitals to complete that
- 3 data. Their coordinators are asked to maintain that
- 4 quarterly and, you know, some are better than others, but
- 5 for the most part we've been extremely successful usually
- 6 with drills or exercises or real life events like H1N1. We
- 7 have the high nineties to a hundred percent response rates
- 8 from the hospitals getting a message. So --
- 9 DR. COOPER: Wow.
- 10 DR. SOTTOLANO: -- it's really been a
- 11 very well used system, well drilled, and so it's definitely
- 12 something we can help with keeping and maintaining updated
- 13 contact information. And I think some of those hospital
- 14 deliverables that we're working on for the grant this year
- 15 will also, you know, enable some of this information you're
- 16 looking for. So --.
- 17 DR. COOPER: Thank you so much, Deb.
- 18 That's really great information.
- 19 Jon?
- DR. HALPERT: One additional item this
- 21 brings to mind was a conversation we had here perhaps a
- 22 year ago, which was concerning the validity of some of this
- 23 information relative to centers promoting themselves as
- 24 tertiary care -- care receiving centers who really weren't
- 25 the best facility requirements or personnel requirements.

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- 2 And I don't know whatever the -- the outcome of that was,
- 3 but obviously to be taking list of names of places and
- 4 putting them on the website or whatever it was, if they
- 5 weren't actually able to hold up their end of the bargain,
- 6 would that be problematic in any way?
- 7 DR. COOPER: Well, it might be
- 8 problematic but -- for them, but at the same time if
- 9 they're holding themselves out to the public to be able to
- 10 provide a service and -- you know, and the available data
- is suggesting that it's not a service they're capable of
- 12 providing it that would certainly be something I think the
- 13 Department would be interested in knowing, I'm presuming.
- 14 DR. KANTER: But -- but the information
- is already on the hospital profile --
- DR. COOPER: Understood. Yeah.
- 17 DR. KANTER: -- website. So it's just a
- 18 matter of making it more accessible. It's already there.
- 19 DR. COOPER: Exactly. Exactly. Okay.
- 20 Just a time check. We have an hour and a quarter left. We
- 21 were not -- I didn't think we would be where we are right
- 22 now, but there we are. Sharon, do you have anything for
- 23 education other than the standards?
- 24 MS. CHIUMENTO: Not really because we had
- 25 been working on that facility transfer matrix which kind of

- 1 EMS For Children 6-21-2011
- 2 is tied into the previous conversation here. And I kind of
- 3 put it on hold for a little while until we figured out some
- 4 of these other pieces, so there really is nothing new to
- 5 report on that.
- DR. COOPER: Okay. Very good. All
- 7 right. Then the next item on the agenda is new business.
- 8 So we have -- the next item is a vote for chair and vice
- 9 chair. There is, I believe, one nomination for chair, and
- 10 at this point one nomination for vice chair. There had
- 11 originally been two nominations for vice chair, Dr. Kanter
- 12 and Dr. Van Der Jagt, but Dr. Van Der Jagt sent an e-mail
- 13 around to us all yesterday, I think we all saw it,
- 14 indicating that he felt that he would be overwhelmed with
- 15 responsibilities. Maybe whelmed is a better term with
- 16 responsibilities at -- at -- at Strong this coming year.
- 17 So only one of the two Golisano brothers will be -- will
- 18 be --.
- 19 DR. VAN DER JAGT: And that I had a lot
- 20 of confidence in this guy to your right, I have to tell
- 21 you.
- 22 DR. COOPER: Yes. Exactly. So we
- 23 have -- we have one nomination for chair and one nomination
- 24 for vice chair. Now, Robert's Rules do call for us giving
- 25 an opportunity to accept additional nominations from the

- 1 EMS For Children 6-21-2011
- 2 floor. So what I'll do is I will first call for
- 3 nominations for -- for chair. I was nominated for that
- 4 position and, with gratitude to my colleagues, accept that
- 5 nomination. Are there any other nominations from the
- 6 floor? And once again, I ask are there any other
- 7 nominations from the floor? And for a third time, I ask
- 8 are there any other nominations from the floor? Hearing
- 9 none, I will take it as the sense of the group that
- 10 nominations may be closed at this point.
- Okay. And for the office of vice chair
- 12 we have one nominee, and that, of course, is Dr. Kanter,
- 13 A.K.A. Robert Golisano. Are here any other nominations for
- 14 the office of vice chair? And, again I ask any other
- 15 nominations for the office of vice chair?
- DR. VAN DER JAGT: I move that we close.
- 17 DR. COOPER: There's a motion the
- 18 nominations be closed.
- DR. HALPERT: Do you have to ask that
- 20 three times?
- DR. COOPER: Multiple second.
- DR. VAN DER JAGT: Before you he added
- 23 the third time.
- 24 DR. HALPERT: Three times, it wasn't
- 25 worth it.

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- DR. COOPER: Unfortunately not, I have to
- 3 take the motion. Yeah.
- 4 DR. VAN DER JAGT: It's the Robert's
- 5 Rules of Order, yeah.
- 6 DR. COOPER: Yes. And hearing no -- no
- 7 other nominations being proposed even a third time;
- 8 correct? Yes. We will accept Dr. Kanter -- or Dr. Van Der
- 9 Jagt's motion the nominations be closed. I heard numerous
- 10 seconds. All in favor?
- 11 ALL: Aye.
- DR. COOPER: Okay. That's unanimous.
- 13 Okay. So we have only one nomination for chair and one
- 14 nomination for vice chair. And so I will ask that the
- 15 executive secretary cast a vote on behalf of the committee
- 16 for the slated officers as proposed. Okay.
- MS. GOHLKE: One vote casted for chair
- 18 and vice chair. Chair, Dr. Cooper and vice chair, Dr.
- 19 Kanter.
- DR. COOPER: Thank you. Okay. So that
- 21 was easy and quick. Thank you. And I want to personally
- 22 thank all of you for your incredible support, you know, and
- 23 collegiality over the past few years. And -- and I'm sure
- 24 you all know that nothing can be done without Martha and
- 25 we -- and, you know, Lisa and Mary Ellen and all the others

- 1 EMS For Children 6-21-2011
- 2 who work with us. You know, Deb and Marilyn, that's -- you
- 3 guys are great. And we really -- we really -- it's an
- 4 honor to work with such dedicated folks. New York is very
- 5 lucky. Okay. So --.
- 6 MS. GOHLKE: Before you move on, just one
- 7 caveat.
- 8 DR. COOPER: Yes?
- 9 MS. GOHLKE: I was asked to remind you
- 10 all that we have to re-vet the membership first before the
- 11 official naming of the chair and vice chair and that our
- 12 statute says that the commissioner has the final say in who
- 13 will be --
- DR. COOPER: Right.
- 15 MS. GOHLKE: -- chair and vice chair. So
- 16 we will put forth our recommendations as voted today and he
- 17 will do the final decision on that and those folks will get
- 18 a letter officiating the start. Until that happens, the
- 19 current chair and vice chair serve in their spots until the
- 20 new -- new members take over officers. Thanks.
- 21 DR. COOPER: Yes. Thank you.
- Okay. Regional emergency preparedness
- 23 activities update. That would be me and others. So I have
- 24 a brief presentation, which I will run though rather
- 25 quickly. It's nearly identical, except for the title

- 1 EMS For Children 6-21-2011
- 2 slide, to a presentation that we gave at the National
- 3 Association of E.M.S. Physicians in January.
- Jon, I don't know if you were -- if you
- 5 were there down at Bonita Springs.
- DR. HALPERT: This year, I didn't go.
- 7 DR. COOPER: Didn't go. Didn't get
- 8 there. So -- so it would be not old news to you. Let see
- 9 if the report's in here. Okay. I e-mailed this to Martha
- 10 last night and the file was corrupt, so we're praying --
- 11 we're praying it isn't corrupted on the disc. I rechecked
- 12 it this morning before -- before I came. It has found
- 13 the -- the hardware here.
- 14 (Off-the-record discussion)
- DR. COOPER: Okay. Okay. First of all,
- 16 I -- I just want to say that it's my honor and privilege to
- 17 be involved with a terrific group of collaborators in New
- 18 York City who applied for and received funding from the
- 19 City Department of Health which, of course, is based upon
- 20 their own grant funding, chiefly from the Federal Hospital
- 21 Emergency Preparedness Program. There may be some C.D.C.
- 22 funding sort of in there somewhere, but this is chiefly
- 23 through the help of the Hospital Emergency Preparedness
- 24 Program. And our grant has been running for three years.
- 25 Mike Frogel, who is director of general pediatrics at -- at

- 1 EMS For Children 6-21-2011
- 2 Cohen Children's and interim chair of pediatrics at Nassau
- 3 University Medical Center, which is being folded into the
- 4 ever-expanding North Shore L.A.J. system is the P.I. on the
- 5 grant. Mike is -- Mike is a general pediatrician but
- 6 with -- but with a huge experience in pediatric disaster
- 7 preparedness primarily through contacts in Israel. He's
- 8 been working with the Israeli Disaster Group for quite some
- 9 time.
- 10 Many of you know George Fulton who is
- 11 director of pediatric emergency services at Bellevue.
- 12 George is actually a nominee to the committee at the
- 13 present time. Mayer Sagy is the immediate past director of
- 14 pediatric critical care at Cohen Children's. It's the old
- 15 Schneider Children's for those of you who didn't know the
- 16 name had changed. And actually recently relocated to
- 17 N.Y.U. where he will be the director of pediatric critical
- 18 care services for New York University School of Medicine.
- 19 You know me. Kate Uraneck, who is an emergency medicine
- 20 physician with the health department, has been our project
- 21 officer. She's most deeply involved in radiation issues in
- 22 addition to the pediatric issues. I know that Deb -- and
- 23 Deb knows her very, very well as -- as do others. And Lou
- 24 Soloff, who is also an emergency medicine physician, has
- 25 been working primarily with the burn group in the city, has

- 1 EMS For Children 6-21-2011
- 2 served as our project consultants since many of the
- 3 mechanisms that we have used to set up our pediatric
- 4 response are based on some of the preliminary work done by
- 5 the burn group.
- 6 Now, who are the stakeholders?
- 7 Obviously, everyone interested in kids. Children's
- 8 hospitals and transport services, including hospitals that
- 9 are not specifically children's hospitals, but have a large
- 10 pediatric inpatient services, obviously, the pediatric
- 11 healthcare providers themselves, emergency healthcare
- 12 providers, city health, the fire department which runs the
- 13 municipal ambulance service, the office of emergency
- 14 management and, of course, the Greater New York Hospital
- 15 Association. There we go.
- 16 And the primary goal of the coalition
- 17 is -- is to, in fact, create a coalition of hospitals,
- 18 public health, and municipal services to ensure effective
- 19 use of critical care assets during and after a large scale
- 20 disaster affecting children through establishment of an
- 21 ongoing planning and advisory coalition. As Dwight
- 22 Eisenhower said, "Plans are nothing. Planning is
- 23 everything." It's got to be ongoing and continuous. And
- 24 as we all know primarily from the Israeli experience, but
- 25 other experiences as well, that the children who are

- 1 EMS For Children 6-21-2011
- 2 victims of disasters require critical care services in far,
- 3 far, far higher percentage than -- than -- than
- 4 other type of patients. In fact, at least in terms of
- 5 trauma, three times greater use of intensive care resources
- 6 in -- in -- in children who are victims of blast and -- and
- 7 penetrating trauma than -- than -- than those who are
- 8 victims of accidental or unintentional trauma.
- 9 In the first year of the grant we
- 10 developed recommendations for increasing pediatric critical
- 11 care surge capacity in our hospitals. Understanding that
- 12 the -- the need for critical care would be greatly
- 13 broadened and would require intensive care resources beyond
- 14 those that we had immediately available to us, we realized
- 15 that there would be a huge need to train pediatric
- 16 hospitalists and pediatric generalists in the critical care
- of pediatric patients. So we held a P.F.C.C.S. train --
- 18 the trainer course for the New York City hospitals. For
- 19 those of you who don't know about the P.F.C.C.S. course,
- 20 it's Pediatric Fundamental Critical Care Support Course of
- 21 the Society of Critical Care Medicine. And it really
- 22 focuses on, again, teaching hospitalists and generalists
- 23 about the care of critically ill children. And,
- 24 additionally, we wanted to develop recommendations for
- 25 pediatric -- pediatric elements of the triage component of

- 1 EMS For Children 6-21-2011
- 2 the city disaster plan and develop recommendations for
- 3 levels of care in the various New York City hospitals.
- In the second year, we developed formal
- 5 pediatric critical care surge capacity plans from five
- 6 participating hospitals which were revised based on -- on
- 7 experience. Additional intensivist instructors and
- 8 non-intensivist providers were trained in P.F.C.C.S. We
- 9 conducted a formal tiering process of pediatric hospitals
- 10 in accordance with the recommendations for levels of
- 11 pediatric care. And we developed a regionalized plan for
- 12 management of secondary transport of pediatric patients in
- 13 a disaster, understanding that in the -- the heat of all
- 14 the activities in and around a disaster there would be a --
- 15 a certain number of kids who would end up in places that
- 16 couldn't care for them adequately. Whether that was
- 17 because of the logistic needs of the -- of the municipal
- 18 and other ambulance services or simply because, you know, a
- 19 triage decision was made -- was made and something changed
- 20 between the time the primary triage decision was made and
- 21 the child arrived at the first receiving facility.
- 22 We kind of got side tracked a little bit
- 23 in the first year of the grant. The H1N1 issue came upon
- 24 us and -- and in the second year of the grant -- and
- 25 continued into the second year. And, of course, in the --

- 1 EMS For Children 6-21-2011
- 2 in the middle of the second year, the Haiti issue came upon
- 3 us. And both of these required our focusing on some other
- 4 issues for a little bit of time. But in effect, we -- we
- 5 look upon the -- the -- the process, if you will, as a --
- 6 as a -- a chain of survival not dissimilar to that which we
- 7 see in -- in the -- the adult and pediatric cardiac arrest
- 8 worlds. This chain of survival focuses on triage, tiering,
- 9 transport, and surge capacity.
- To focus first on triage, the -- the
- 11 P.D.C. recommends that pediatric specific field triage
- 12 criteria be applied in M.C.E.s when possible and
- 13 appropriate. Why when possible and appropriate? Once
- 14 again, you know the logistic needs of the -- of the city
- 15 and the service may be such that, you know, they are so
- 16 pressed for ambulances that they can only afford to take
- 17 the child to the closest facility, you know, not
- 18 necessarily the closest appropriate pediatric facility.
- 19 But they have committed to doing everything within their
- 20 power to get -- get the kids to the appropriate facilities
- 21 when possible and appropriate. Now, here's the -- here's
- 22 the modified triage grid. For those of you who are
- 23 familiar with START triage, that's an acronym for Simple
- 24 Triage and Rapid Treatment.
- 25 And this -- this does not seem to have

- 1 EMS For Children 6-21-2011
- 2 a -- a laser pointer.
- MS. GOHLKE: Yeah, the center yellow
- 4 button.
- 5 DR. COOPER: Yeah. That's what I
- 6 pressed. Oh, there it is. I pressed too hard.
- 7 Okay. This -- the -- the modified
- 8 triage grid was developed primarily by a subcommittee which
- 9 I had the honor to chair and in which Mario Gonzalez,
- 10 Associate Medical Director for the fire department and the
- 11 past chair of our State E.M.S. Council had a -- had a very,
- 12 very strong role. Whether you are an adult or a child, if
- 13 you're decapitated or dismembered, obviously, you're not
- 14 going to do well. Adults who -- whose airways cannot be
- 15 maintained in a -- in a resource-poor disaster environment
- 16 are -- are labeled as expectant. For kids, however,
- 17 because of the much higher proportion of respiratory rather
- 18 than cardiac arrest per se, kids with no signs of life are
- 19 getting five rescue breaths by a bag and mask as soon as
- 20 they get to a bag and mask. Clearly, folks in a -- in a
- 21 hot zone, if the zone is contaminated, are not going to be
- 22 attempting to bag these kids, nor are they explicitly
- 23 trained to do so. But once they get them outside the --
- 24 the hot zone an attempt will be made to give them those
- 25 five rescue breaths if possible. The remainder of the --

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- 2 of the algorithm is very much the same except to note that
- 3 because of the very limited experience with -- with an
- 4 assessment of kids, all children who look like infants,
- 5 that is to say they look like they're not old enough to
- 6 walk, are going to be labeled red and -- and be so treated.
- 7 In other words, as if they have critical illness.
- Now, there's a -- there's a unique area
- 9 in the New York City START algorithm that was added over
- 10 the last couple of years, chiefly at the insistence, wise
- 11 insistence I might add, of Dr. David Prezant, who was then
- 12 medical director of the -- of the Office of Medical
- 13 Affairs. Dr. Prezant is a pulmonologist and was deeply
- 14 concerned that there would be many individuals -- adults
- 15 with medical illnesses, you know, congestive heart failure,
- 16 chronic obstructive pulmonary disease, asthma, what have
- 17 you, who -- who, in the event of a disaster, for a variety
- 18 of reasons, would develop an exacerbation of their existing
- 19 medical conditions.
- 20 And, of course -- of course given the
- 21 high prevalence of respiratory illnesses in children, we
- 22 face a very similar issue. What do we do about the kids
- 23 who don't meet red criteria but are breathing fast? These
- 24 are kids who need a -- who need a, you know, an evaluation
- 25 by someone, you know, with skill. And so a new orange

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- 2 category was created involving respiratory distress,
- 3 increased work of breathing, labored respirations, changing
- 4 mental status, history of head trauma or cardiopulmonary or
- 5 chest trauma, and in effect these patients are placed at
- 6 the head of the yellow line. They're technically yellow,
- 7 but they get placed at the head of the yellow line, hence
- 8 they become the new urgent category or orange category.
- 9 This was brought forward to the SEMAC for
- 10 its approval. The SEMAC did approve it for use in New York
- 11 City. And it's my understanding that the discussions are
- 12 under way that might be applied in areas at least adjoining
- 13 New York City in the relatively near future, although I
- 14 think that's going to be for SEMAC and SEMSCO to determine
- 15 at some point in the near future.
- We all think that this is a category that
- 17 makes eminent sense because it'll get -- as all of you
- 18 know, the studies that have been done with respect to START
- 19 recognize that people are okay with the red and okay with
- 20 the green, but it's very hard to figure out where the
- 21 yellows go and there's a lot of missed triage in that
- 22 yellow category. This goes a long way toward fixing it in
- 23 our view. It's now been taught to about three thousand
- 24 E.M.S. providers in the city. We have about twenty-five
- 25 hundred E.M.T.s and another seven hundred paramedics and

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- 2 they're -- in table top drills, they're able to accurately
- 3 triage them at an accuracy rate of eighty to ninety
- 4 percent. So we think this -- this is helping.
- 5 MS. BURNS: A big part of this, just to
- 6 put it into perspective, is that in -- in a trauma triage
- 7 situation, pre-hospital, you're looking at trauma and you
- 8 may have somebody who outwardly is not traumatized, but
- 9 they're having an inferior wall M.I. and when you say to
- 10 them can you walk, they can walk and then they walk out to
- 11 the green. And the -- the problem has been -- and the city
- 12 found that they had a fair number of patients who were
- 13 not -- who had not sustained trauma, but had serious
- 14 medical conditions that needed to be up-triage. So the
- orange was a way to up-triage the patient so that they
- 16 would be recognized -- they're not red because they don't
- 17 fall into the criteria of red, but they're definitely
- 18 medically necessary patients. So it was -- it was also a
- 19 plan to up triage, which is very difficult to explain to
- 20 pre-hospital care providers because we triage now, that's
- 21 it.
- 22 DR. COOPER: Yes. Well, this has
- 23 required a bit of teaching, but -- but they seem to be
- 24 getting it at least down our way.
- MS. BURNS: Uh-huh.

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- DR. COOPER: Elise and Bob?
- 3 DR. VAN DER JAGT: Yeah. Was there any
- 4 thought given to mental health crises in that green group
- 5 sort of a similar thing that you know, you've got the
- 6 subgroups and then because it was that -- I know this all,
- 7 obviously, life versus death, but I'm wondering if the
- 8 mental health issue is -- how does that --?
- 9 DR. COOPER: The mental health issue
- 10 is -- mental health issues are something we're beginning to
- 11 focus on in year three of the grant.
- DR. VAN DER JAGT: Okay.
- DR. COOPER: It's -- this is -- this is
- 14 a -- this is a grid for pre-hospital providers to identify
- 15 patients with physiologic and anatomic abnormalities.
- DR. VAN DER JAGT: Yes. What I was
- 17 thinking here was more in terms of -- in the field still,
- 18 but then the -- the kids -- well, kids who are mass
- 19 hysteria, but they're not really injured, you know, but
- 20 they're -- but you can't always tell.
- MS. BURNS: At -- at the national level,
- 22 they're looking at that.
- DR. KANTER: Yeah, but you're not going
- 24 to know.
- DR. VAN DER JAGT: You're not going to

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- 2 know. How is that --?
- 3 DR. KANTER: I mean they'll be -- they'll
- 4 be perceived as mental status changes but you can't -- you
- 5 know, or something like that.
- DR. COOPER: Correct, I was just going to
- 7 say that. Right.
- 8 DR. VAN DER JAGT: No -- no. I'm not
- 9 saying that, but I --.
- 10 MS. BURNS: Or -- or they became a danger
- 11 in the scene --
- DR. VAN DER JAGT: Correct.
- MS. BURNS: -- and they get triaged so
- 14 that they can be transported away early because they're
- 15 a --
- DR. VAN DER JAGT: That's what I was
- 17 thinking along those lines.
- 18 MS. BURNS: -- they're -- it's a
- 19 behavioral problem.
- DR. VAN DER JAGT: Right. So where would
- 21 that fall in this --?
- 22 DR. COOPER: Yeah. This -- this is just
- 23 specifically the triage, you know, the physiologic triage
- 24 grid -- grid per se.
- Bob, did you have a --?

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- DR. KANTER: When I first saw the orange
- 3 category, I worried about the potential for over triaging
- 4 and I'm still kind of worried about that.
- DR. HALPERT: It's at the disaster level.
- DR. COOPER: Well, --
- 7 DR. KANTER: Well, but the point is you
- 8 have limited capacity.
- 9 DR. HALPERT: I know, but it's going
- 10 to --.
- DR. COOPER: Well, again, this is -- this
- is -- this -- this is not -- the oranges don't get moved
- 13 ahead of the reds. Okay. They get moved ahead of
- 14 yellows --
- DR. HALPERT: Yellow.
- DR. COOPER: -- without any of these
- 17 other findings. I didn't mention that green also leads you
- 18 to orange if -- you know, if -- if -- if a situation
- 19 such as the one that Lee describes attains. We think that
- 20 this is a -- this is a bigger mass and we're bringing this
- 21 to the world community and there's a -- there's a lot of
- 22 interest in it. You know, initially there was a tremendous
- 23 amount of push-back, but as people have a chance to think
- 24 about it they're -- they're understanding that -- that
- 25 these kinds of decisions are going to be made anyway.

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- 2 Which yellow patient do you transport first? It's best to
- 3 have at least some guidance as to which ones ought to go
- 4 first.
- 5 Okay. Just -- to move on. And, Elise,
- 6 this gets to your -- this gets to your point. Okay?
- 7 In addition to the triage grid, per se,
- 8 the fire department has agreed to implement expedited
- 9 procedures for rapid evacuation of pediatric patients in --
- 10 in the event of mass casualties. And this includes the --
- 11 the group of patients who may have, if you will, to use
- 12 your words, you know, a mass hysteria type of response in
- 13 the event of such a disaster. But, again, one of the
- 14 points that has been made to us as we have moved through
- 15 this planning process is precisely the one that you, you
- 16 know, wisely recognized immediately, which is that it
- doesn't take into account the extraordinary mental health
- 18 needs of children, particularly those who are unaccompanied
- 19 by -- you know, by -- by parents or caregivers. So this is
- 20 something we're going to be focusing on in the next year of
- 21 our grant. Now --.
- 22 MS. ROGERS: Can I ask a question?
- DR. COOPER: Of course.
- 24 MS. ROGERS: I wondered if any discussion
- 25 took place of parents with children and different

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- 2 categorizations of parent versus child and do parents
- 3 always get sent with their child? Was there discussion
- 4 about that?
- DR. COOPER: Yes. And -- and, again,
- 6 thank you for -- for bringing that point up. Every effort
- 7 will be made to keep families together in this process to
- 8 the -- again, when possible and when appropriate. That's
- 9 included in this. I should probably should have included a
- 10 little bit more information on this slide than -- you know,
- 11 than -- than I did. So thank you for that -- that -- that
- 12 important suggestion.
- So when does this whole plan get
- 14 triggered? Basically, if there are five or more patients
- 15 and the event is an expanding event, we will invoke the
- 16 plan. And, again, pediatric patients are defined in
- 17 disasters not by their age, but by their visual appearance.
- 18 Pediatric patient is an non-adolescent child who appears to
- 19 be of primary -- of primary school age or younger for
- 20 purposes of -- of our discussion here. And, of course, why
- 21 five or more? I mean it's an arbitrary number. Most plans
- 22 pick five or more expanding event as a definition of a --
- 23 you know, of something more than a -- something more than
- 24 a -- than a -- you know, than -- than a -- a regular event.
- 25 Some would say five or more is an M.C.I. Some would say

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- 2 twenty or more is an M.C.E., but those are very, very, you
- 3 know, loose numbers. It's really depending upon, as you
- 4 all know the mix of resources and needs. But what this
- 5 does is it triggers E.M.S. to ask a question and to say
- 6 should we be invoking our disaster response or our disaster
- 7 plan now or not? So if there's five or more pediatric
- 8 patients and it's an expanding incident, the FDNYC command
- 9 folks and under our -- under our coordination of
- 10 pre-hospital resources protocol in New York City, which
- 11 was, you know, put into place with -- with the support of
- 12 the commissioner of health back in 1994 FDNY has -- has
- 13 responsibility of coordinating all of those incidents at
- 14 the scene, so it's up to them to make the call as to
- 15 whether it exists or not.
- 16 Now, where do we take patients now that
- 17 we get into the tiering? We -- we attempt to facilitate
- 18 primary transport of kids to what we call pediatric
- 19 disaster receiving hospitals and we've divided them into
- 20 two tiers. In effect, those with a P.I.C.U. and those
- 21 without a P.I.C.U. The -- the tier-one hospitals are those
- 22 that have the P.I.C.U. They are intended to receive the
- 23 red, orange, and yellow patients. As you would guess,
- 24 they're committed to pediatric subspecialty care. They've
- 25 got pediatric surgical services, pediatric intensive care

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- 2 unit, pediatric emergency services all on site, as well as
- 3 comprehensive pediatric subspecialty support and -- and
- 4 anesthesia neurosurgery, and orthopedic surgery experienced
- 5 in the management of children.
- And for other kids, the two -- two
- 7 facilities, these are pediatric inpatient or hospitals that
- 8 are pediatric inpatient services, but don't have a P.I.C.U.
- 9 They might have -- they might have sort of a -- a step-down
- 10 or special care or expanded care kind of unit, but they
- 11 don't really have a full pediatric intensive care unit.
- 12 These are hospitals that are -- that are committed to
- 13 general pediatric care, they've got pediatric surgical
- 14 consultants, they're capable of resuscitation, and they've
- 15 got pediatric transfer agreement in place with a level one
- 16 in case they do have to transport that child in a -- in an
- 17 emergency situation.
- 18 And now, in terms of the transport
- 19 issues, we also recommended that we establish a system for
- 20 pediatric consultation and secondary transport of pediatric
- 21 patients to pediatric disaster receiving hospitals when
- 22 possible and appropriate. And for this, we have
- 23 established what's called a virtual pediatric consultation
- 24 center. Now, this builds off the work done by Lou Soloff
- 25 in the Burn Group. We have doctors on call or docs if you

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- 2 will and V.P.C.C., a virtual pediatric consultation center.
- 3 These are board certified pedia-intensivists who are
- 4 credentialed and indemnified by FDNY O.M.A. And the good
- 5 news that we just recently learned is that, unlike the burn
- 6 plan where it's sort of -- Rochester is going to provide
- 7 V.P.C.C. for the city and vice versa in the event of a --
- 8 of a major disaster, because we have many more pediatric
- 9 resources than burn resources, although still not enough,
- 10 we believe we can handle it in the city. So we're probably
- 11 going to be credentialing these by FDNY by under the
- 12 auspices of the Medical Reserve Corp and City Health. Sc
- 13 we don't necessarily have to go through ServNY, but that's
- 14 an issue that we still have to discuss with you all and
- 15 will be discussed at some point in the near future.
- It's -- the V.P.C.C. in the event that
- 17 the disaster plan was -- was activated, would be contacted
- 18 by a single dedicated telephone line and the -- the
- 19 responsibility of the V.P.C.C. is to create a continually
- 20 updated real time list of which patients have the highest
- 21 priority. So you can say, well, patient number one has
- 22 thirty percent burns, this patient has to go here. Patient
- 23 number two has, you know -- you know, a lacerated spleen.
- 24 This patient has to go here, et cetera, et cetera, et
- 25 cetera. And create a priority list as to which patient

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- 2 goes first depending upon, you know, which -- or when
- 3 ambulances become -- become available. Now, FDNY, the fire
- 4 department will be serving as the pediatric logistics
- 5 coordination center, which means they get real time
- 6 information on where the pediatric I.C.U. beds are, they
- 7 get the -- they get the priority list from the V.P.C.C.,
- 8 and they match, you know, the -- the highest level
- 9 patient need with the highest level resource need and
- 10 dispatch the -- the -- the specialty care transport teams
- 11 as needed. Until such time as the system is stood up, we
- 12 recognize that, as Elise was pointing out in an earlier
- discussion, most hospitals already have pre-established
- 14 relationships with P.I.C.U.s. Those will not be disrupted,
- 15 okay, unless there is a compelling need to do so. And so
- 16 there will be business as usual until the -- the V.P.C.C.
- 17 is activated. So everybody is free to send out their
- 18 ambulances and pick up their kids from their usual suspect
- 19 hospitals, so to speak, you know, until such time as the
- 20 V.P.C. has actually stood up.
- Now, kudos to Bob Kanter for leading an
- 22 effort that helped us develop this list here. Bob convened
- 23 a group some years ago of experts in pediatric intensive
- 24 care from across the state and looking at a number of
- 25 potential pediatric critical care treatments that might be

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- 2 offered in -- you know, in various places and in effect,
- 3 this -- this list is based upon that study. It was felt by
- 4 the group that Bob put together that the highest level of
- 5 pediatric critical care would be reserved for those
- 6 requiring the -- the treatments listed on the left and --
- 7 and a less robust, you know, group of treatments listed on
- 8 the right would be the -- the responsibility of --
- 9 of the second-tier hospitals which did not have the full
- 10 P.I.C.U. capabilities.
- Now, that takes us, of course, to the
- 12 surge. We did a back-of-the-envelope study or calculation
- 13 I should say, it wasn't really a study per se, although it
- 14 probably could have been if I ever gotten around to
- 15 publishing it, looking at the number of critical care beds
- in New York City and how they might actually be expanded.
- 17 And to make a long story short, the general sense is that
- 18 we -- that we need probably about -- in the range -- we've
- 19 got to find somewhere in the range between two hundred and
- 20 four hundred critical care beds in New York City in the
- 21 event of a major -- in the event of a major disaster. On
- 22 any given day -- on any given day, we have about fifty
- 23 available and through rapid discharge planning and so on
- 24 and so forth and -- and expanding, you know, critical care
- 25 capabilities and existing P.I.C.U.s, we can get up to

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- 2 probably, you know, in the range of -- of a hundred, but we
- 3 have to really double that for true -- true critical care,
- 4 and -- and maybe even triple it if we take into account
- 5 the -- the second-tier facilities as well. So, you know,
- 6 the premise is that -- that we really have to get everybody
- 7 involved.
- 8 What's going on here? This is -- okay.
- 9 And -- but -- but getting everybody
- 10 involved means getting everybody involved. It's -- we --
- 11 you can't just develop a plan for the city. Each
- 12 individual hospital has to have a plan that's in -- that
- 13 it -- that is in congruence with that that the city has
- 14 done. And, again, it has to be tiered so that we can make
- 15 sure that the patients get to the right resources that they
- 16 require. So to the conclusion here of this thought process
- 17 is that that a disaster coalition comprised of
- 18 representatives of everybody will be able to facilitate the
- 19 establishment of a comprehensive plan. We've done so with
- 20 respect to the pediatric component, okay, although we're
- 21 not totally done yet, but our colleagues in the adult world
- 22 have not yet really pulled it off. Our concept is really
- 23 to develop a situation for full -- for full-time -- or I
- 24 shouldn't say full-time -- real-time situation and
- 25 awareness based upon on-scene information indicating that

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- 2 an event has occurred, hospitals indicating that they have
- 3 the surge capability to deal with the issue, you know, and
- 4 sharing of information between those two loci that allow
- 5 the -- you know, the -- the various preparations that need
- 6 to be made to actually occur. And, of course, with a -- a
- 7 real-time system, we -- we then can engage ourselves in --
- 8 in triage activities that rank patients according to
- 9 diagnosis and severity or perhaps we should say acuity and
- 10 severity would probably be a better way to put it and then
- 11 transfer to hospitals based upon both proximity and their
- 12 relative capabilities in terms of hospital tiers.
- We'll skip all the little fancy arrows.
- So here's the operational concept. You
- 15 get E.D. notification. The first thing that happens is
- 16 that intensivists head down to the E.D. and begin to help
- 17 the E.D. staff figure out what's going on with the -- with
- 18 the most critically ill patients. In other words, you
- 19 know, in contrast to the usual boarding critical patients
- 20 in the E.D. that we see in the winter months, we actually
- 21 get the -- you know, the critical care docs down to the
- 22 E.D. to help with the process of beginning that critical
- 23 care and decompressing the E.D. to make room for more
- 24 patients. The beds -- during that -- during that interval
- 25 while patients are being evaluated and critical care begun

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- 2 with the assistance of pediatric intensivists in the E.D.,
- 3 beds are made available in the P.I.C.U. through rapid
- 4 discharge and expansion of the number of beds per cubicle
- 5 or expansion into available adjacent spaces or even into
- 6 more distant spaces such as endoscopy units and PACUs and
- 7 so on and ultimately even to floors that may be specially
- 8 equipped in the event of, you know, a major -- a major
- 9 event. So you can see it sort of follows a -- a step-wise
- 10 process here based first upon predictions and planning,
- 11 preparation, implementation, and, of course, ultimately
- 12 management. In other words, you know, preparation and
- 13 mitigation response, as -- as we have come to think of it.
- Now, at the present time we've figured
- 15 out we can add -- and this is based upon the eleven largest
- 16 available P.I.C.U.s that we can -- we can take in the
- 17 eleven largest P.I.C.U.s about a hundred and fifty beds,
- 18 almost double, okay, the capacity giving us, as I say, an
- 19 almost double capacity. This is again for true pediatric
- 20 I.C.U. beds. But, again, we need to triple it, okay, based
- 21 upon, you know, the fact that -- that in a -- in a major
- 22 disaster, you know, we're going to have more patients
- 23 than -- than we can handle even by doubling that number.
- 24 This, of course, based upon the recommendations of the
- 25 C.D.C. sponsored Pediatric Mass Casualty Critical Care Task

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- 2 Force upon which Bob Kanter served, among many others.
- 3 And, Bob, I think the special edition of
- 4 the journal is finally coming out in the next couple of
- 5 months. I haven't heard. You probably have.
- DR. KANTER: I don't have a date yet.
- 7 DR. COOPER: Don't have at date yet.
- 8 Okay. There will be a supplement in the Journal of
- 9 Pediatric Critical Care Medicine addressing many of these
- 10 issues. Bob is a co-author on a couple of those -- those
- 11 chapters or a couple of those papers.
- So we've gotten quite a bit of the way,
- 13 but we're looking actually to try to -- to triple the
- 14 number of -- of mass critical care beds, but double the
- 15 number of actual pediatric I.C.U. beds available to us.
- Now, you know, conceptually the sum of
- 17 many hospitals triage and surge plans may be equal to one
- 18 regional plan. Okay. But truly, you know, operationally
- 19 the sum of the individual plans may not be equal to one
- 20 effective regional plan. So we really, really need to have
- 21 real-time situational awareness. And this is the big --
- 22 this is the really troublesome piece at the present time.
- 23 And everyone is grappling with this. You know, how do we
- 24 use in effect the HERD system to make this happen or some
- 25 other system. And that conversation is still ongoing and I

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- 2 see Deb and Mary Ellen nodding their knowing heads as to
- 3 what a -- what a tough nut this has been to crack in terms
- 4 of -- in terms of where we need to go. But -- but this is
- 5 what we really have to have, you know. We all know that
- 6 the HERD system is sort of an internet-based computer
- 7 system, but what if that goes down. Where are our
- 8 back-ups, you know, all the other issues that we would
- 9 guess. So this is the -- the concept all put together. We
- 10 need an -- an on-scene activities dashboard, preparedness
- 11 information dashboard all coordinated through, you know,
- 12 real-time, you know, situation awareness capability.
- We need to train more people, you know,
- 14 particularly at our tier-two facilities in -- in F.C.C.S.
- or P.F.C.C.S. And in our third year, we have accomplished
- 16 much of this. We've done additional training of P.F.C.C.S.
- 17 We've surveyed all our instructors, our participants,
- 18 analyzing this data right now to see how they feel about
- 19 this training a couple of years out. We've got additional
- 20 surge plans at another group of hospitals. We conducted a
- 21 surge census -- census project or planning project this --
- 22 this past February. Preliminary results were presented at
- 23 the -- the city disaster -- pediatric disaster conference
- 24 one week ago today. And the -- the short of it is we're in
- 25 good but not great shape. We have more work to do. We're

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- 2 submitting the final draft this year and, of course, as I
- 3 mentioned we held the citywide pediatric disaster --
- 4 disaster symposium a week ago. Bob and Deb were able to
- 5 come and we're very grateful for both of your
- 6 participation.
- We have learned that we will be receiving
- 8 additional funding for a fourth year. We're not sure yet
- 9 how much funding that will be, but we're looking to conduct
- 10 a table -- a tabletop exercise hopefully followed by a
- 11 field exercise involving all pediatric hospitals. We want
- 12 to get ourselves from the two hundred beds to four hundred
- 13 total. We need to work more on the -- on the -- the
- 14 situational awareness piece and we need to make sure that
- 15 all the regional surge plans kind of get together or all
- 16 the individual hospital surge plans get together into a
- 17 single regional surge plan. It's a tall order, you know,
- 18 but -- but I wanted to give you a flavor of what's been --
- 19 what's been ongoing in the city so perhaps we can begin to
- 20 think about how as a state we might want to think about,
- 21 you know, regionalizing pediatric care in the event of a
- 22 disaster.
- 23 Marilyn Kacica and her group have been
- 24 really instrumental in -- in making sure that the pediatric
- 25 disaster resource, which the state expanded into a

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- 2 pediatric and obstetric disaster resource, which is really
- 3 cool, you know, is out there and available for all the
- 4 hospitals. But, you know, certainly our worry in the city
- 5 has been since we created a -- a document that was similar
- 6 to that, you know, and actually served as a platform upon
- 7 which the state built, you know, we're, of course, worried,
- 8 or we're worried that that -- that that little document
- 9 would be sitting on a shelf somewhere and, you know, no one
- 10 will remember where it is or what it said in the event of a
- 11 real disaster, which is part of the reason we got involved
- 12 in this coalition disaster planning process. And so part
- of bringing the issue here, you know, is how can we as, you
- 14 know -- you know, the -- you know, the -- the state
- 15 advisory group that's probably most familiar with these
- 16 issues, you know, and -- you know, perhaps -- perhaps in
- 17 some ways most expert in the issues, at least from the
- 18 medical care standpoint, how can we assist the state in
- 19 facilitating, you know, getting together a statewide
- 20 coalition, you know, that -- that works perhaps at least in
- 21 somewhat the same way that the city coalition does
- 22 recognizing, of course, that the resources are much more,
- 23 you know, spread out.
- 24 So I'll stop there. I hope that wasn't
- 25 too much and, you know, entertain any questions you might

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- 2 have briefly because we're kind of short on time at this
- 3 point, but -- but also begin to see if there are any
- 4 thoughts about how we might begin to initiate a
- 5 conversation at the state level.
- 6 MS. ROGERS: I take it your focus was
- 7 critical care only. Is that fair to say from the gist of
- 8 this?
- 9 DR. COOPER: Not entirely. You know,
- 10 we -- we recognize that it's the critically ill patients
- 11 who will be ending up in the E.D., you know, and will
- 12 require specialized resources and --.
- MS. ROGERS: Because I see total lack of
- 14 focus on the emergency departments and their role and also
- 15 the role of non-critical patients that would need to be
- 16 admitted. And maybe that is information that is
- 17 forthcoming from your group or a future goal, but when you
- 18 talk about surge capacity taking over hospital beds, we're
- 19 also going to be needing hospital beds for the non-critical
- 20 care children as well. So I mean it's -- it's good to look
- 21 at critical care because I think they need the largest
- 22 resources, you know, people, equipment, O.R. time, but I
- 23 think you have to consider, too, what the orange population
- 24 is going to need and what recourses are available, what
- 25 role the emergency department is going to play in -- in

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- 2 that as well as critically care -- critical care patients
- 3 and also, you know, what -- what resources we have for bed
- 4 space for orange patients as well. Maybe they need to be,
- 5 you know, transported to a different hospital because
- 6 our -- the tertiary care hospital has taken up beds for
- 7 critical care. So I think their needs to be a little bit
- 8 attention to balance and maybe that's something you're
- 9 going to get to in the future.
- DR. COOPER: I'll only respond that --
- 11 that the -- the types of conditions that the tier-two
- 12 hospitals would be receiving, you know, are meant to
- include patients who don't require necessarily, you know,
- 14 mass PICU care, but may require mass critical care in a
- 15 sense. Second, we gained guite a bit of experience with
- 16 emergency department surge during -- during the H1N1
- 17 epidemic. And third, I will take this message from this
- 18 committee back to the New York City group because this has
- 19 been one of the things that I've been harping on, actually,
- 20 for the last two or three years that we should -- we need
- 21 to focus more on explicit plans for the emergency
- 22 departments.
- I think that -- but I think in part the
- 24 City Health Department, which is funding this, of course,
- 25 felt that in large measure the -- the plans that were put

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- 2 in place during the H1N1 epidemic, you know, have helped
- 3 the emergency departments focus a lot on their surge
- 4 issues. And they, I think, also feel that the additional
- 5 resources that would be brought to bear by having the
- 6 intensive care folks, you know, help out with the surgical
- 7 emergency department, you know, as part of the pre-critical
- 8 care component of it is -- is addressing that issue. But I
- 9 think your point is very well taken. I have made this
- 10 point myself very loudly, that it needs to be much more
- 11 organized than it is. And with the support of this
- 12 committee I can take it back and say that the state
- 13 committee feels that this is something we should be
- 14 focusing on a little bit more -- more shall we say, you
- 15 know, evidently. All right. I think it's in there, but
- 16 it's -- it's kind of, as you suggested, hidden between
- 17 lines.
- 18 DR. KANTER: You know, I think Jan is
- 19 right that no community has a perfect plan yet or a perfect
- 20 capability, but on the other hand, if you look at the last
- 21 ten years worth of hospital preparedness and improvements,
- 22 much more has been done in the pre-hospital and E.D.
- 23 setting than critical care. And once your E.R. gets filled
- 24 up with critically ill and injured kids, the E.R. is
- 25 paralyzed for the next patient until you have a good

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- 2 critical care surge capability. And very little has been
- 3 done until now in that regard. There are a number of task
- 4 forces have looked this -- at this for adults and for
- 5 children, but I think the remarkable achievement here --
- 6 and I -- I think this is just incredible, terrific work, is
- 7 that -- this is not just a state model, I believe this is a
- 8 national and international model for how to do this. If
- 9 you look at all the abstract recommendations for I.C.U.
- 10 surge capacity, there's a lot of good generalizations.
- 11 This is my -- this is the first instance that I've read
- 12 about anywhere where an entire region has said on the basis
- of a hospital-by-hospital basis we intend to increase our
- 14 pediatric I.C.U. beds at this hospital by twenty-five
- 15 percent or a hundred percent. And even if they're not
- 16 making the -- the arbitrary target of tripling their
- 17 capacity, no one has done that --
- DR. COOPER: Right.
- DR. KANTER: -- whether that's the ideal
- 20 target or not, I don't know, but you have individual
- 21 hospitals stepping up and saying publicly we intend to
- 22 increase our beds by this much and here's how we're going
- 23 to do it. It's an incredible step and it serves as a
- 24 terrific model for how everyone else ought to be thinking
- 25 about that.

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 2
                       DR. COOPER: Thanks, Bob.
 3
                       MS. ROGERS: Yeah.
                       DR. COOPER:
 4
                                    Jan?
 5
                       MS. ROGERS: I -- I think that's true.
 6
     It -- it's that, but I also think that they need to be
 7
     incorporated, not just critical care, but the intermediate
 8
     care patients and I think it's -- it's excellent. Any work
 9
     that's done in this area is excellent, but I think you
     can't look at critical care in a vacuum. I think it has to
10
    be looked at in view of -- of the other surge of patients
11
12
     that we're going to have and what we do with them, not just
13
     on the E.D. level, but on the hospital level as well.
14
                       DR. COOPER: Thank you, Jan.
15
                       Elise?
16
                       DR. VAN DER JAGT: Just to talk a little
    bit what Jan was saying as well as I think that if you
17
18
     include the -- that interim period when you -- because
19
     right now the way looking at the -- at the way it's set up
20
     is it's field triage and then it's the definitive care, but
21
     that intermediate area is -- has not been addressed perhaps
22
     as well because E.D.s get congested and what do you do if
23
     they're over congested and they're -- they can't get to the
     PICU or wherever those critical care beds are because
24
25
     they're -- it's like you said, Bob, if the E.D. is
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- 2 paralyzed. So I think that that would be an added thing to
- 3 figure out what happens in that -- in that kind of
- 4 situation, rather than assuming that it'll just flow easily
- 5 through the E.D. and up.
- 6 MS. ROGERS: I know, there with assume.
- 7 DR. VAN DER JAGT: It doesn't happen that
- 8 way. So perhaps some thought could be given to that. The
- 9 other -- the other part, and, again, we've been talking a
- 10 little bit in our own area also about how do we do this
- 11 because we also do not have a pediatric disaster plan
- 12 that's worth anything and this is a wonderful model, I
- 13 think, that we can -- can use. Was there any
- 14 thought given to downloading hospitals, the general floor
- 15 beds to hospitals that are tier-two, say, from a tier-one
- 16 to a tier-two in order to make bed capacity because that's
- 17 what we were looking at currently? You know, we're saying,
- 18 okay, well, we have X number of beds. We can make some of
- 19 these beds I.C.U. beds, but in order to do that we would
- 20 have to transport these other people to a hospital that's
- 21 close by, in our case it would be Rochester General, you
- 22 know, to say so we can make room. But that would involve
- 23 obviously transport triage, you know, which kids, you know,
- 24 and how that would work. And that --.
- 25 DR. KANTER: What's to say Rochester

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- 2 General's not holding a bunch of critical care individuals
- 3 for the same reasons as that.
- DR. VAN DER JAGT: Precisely. Yeah. But
- 5 we have Highland Hospital which is right next to them.
- DR. KANTER: I'm just saying --.
- 7 DR. VAN DER JAGT: But we have a couple
- 8 of options.
- 9 DR. KANTER: And spillovers.
- DR. VAN DER JAGT: But it was more of the
- 11 idea that --
- DR. KANTER: Regionally.
- DR. VAN DER JAGT: -- to vacate, you
- 14 know, and then but that brings up the whole issue of --
- 15 of -- of triage at the -- inside the hospital as well as
- 16 from the scene because you're going to have to make beds.
- 17 And I just don't know whether that was discussed at your
- 18 meetings and how did you handle that.
- DR. COOPER: We actually did discuss it
- 20 to some extent and the general feeling was that the
- 21 limitations of the -- of the ambulance resources available
- 22 to us would be such that trying to, you know, think about
- 23 moving hospitals from, you know, I mean less than
- 24 critically ill patients from one hospital to another to
- 25 make room for critically ill patients, you know, seemed to

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- 2 be something that was probably beyond the logistic
- 3 resources that we had available to us in the event of a
- 4 major disaster. But I think it's a good thought and -- and
- 5 we actually, honestly, Elise, had not really thought about
- 6 that in a couple years because it evolved toward the -- you
- 7 know, the -- the -- the more pure expansion of the critical
- 8 care resources that we had. The rapid discharge plan of
- 9 patients from the I.C.U. and from the floors to make -- to
- 10 make -- make those beds available, certainly that is part
- 11 of the plan.
- 12 MS. ROGERS: And from the E.D.
- DR. KANTER: Yeah.
- 14 DR. COOPER: But actual transferring --
- 15 but transferring -- creating -- or having to actual --
- 16 moving those patients to a different facility as part of
- 17 the rapid discharge plan is not an issue we spent a lot of
- 18 time discussing for the reason I mentioned.
- Jan, I'm sorry; you -- you had --?
- MS. ROGERS: No, I said and from the E.D.
- 21 because --
- DR. COOPER: Yeah. Sure.
- MS. ROGERS: -- that's part of our
- 24 current disaster --
- DR. VAN DER JAGT: Uh-huh. Same thing.

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- 2 Right.
- 3 DR. COOPER: Yeah -- yeah.
- DR. VAN DER JAGT: Yeah.
- 5 MS. ROGERS: -- is to get whoever can
- 6 leave the E.D. who is not critical to leave if a disaster
- 7 is impending.
- BR. COOPER: Yeah, absolutely. Sure --
- 9 sure -- sure.
- DR. VAN DER JAGT: So -- so --.
- DR. COOPER: Mary Ellen, I'm sorry.
- MS. HENNESSY: I think there's a couple
- 13 of things to remember. One is that this was kind of
- 14 modeled after the B.B.C.C. which is the burn model.
- 15 Correct?
- DR. COOPER: To some extent -- to some
- 17 extent.
- 18 MS. HENNESSY: As far as reaching out to
- 19 the expert consultants. But one of the things that the --
- 20 the burn consultant issue has is that everybody goes to a
- 21 place for stabilization and then definitive care follows so
- 22 that the consultants in the burn model would actually be
- 23 working more towards the after effect of the initial
- 24 triage, rather than the initial triage itself.
- DR. COOPER: That -- yeah.

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- MS. HENNESSY: That was one
- 3 consideration.
- DR. COOPER: Absolutely. Yeah. And,
- 5 again, you know, the situations are not entirely
- 6 comparable. You know, we have many, many more pediatric
- 7 resources -- although not enough, we have many more
- 8 pediatric resources available to us than we have burn
- 9 resources available to us. You know, and so -- and -- and
- 10 the physiology, you know, and the treatment approach is
- 11 different. You know, the burn patients can be
- 12 stabilized --
- DR. KANTER: Right.
- 14 DR. COOPER: -- for twenty-four --
- 15 forty-eight -- seventy-two hours before they get -- before
- 16 they need the services of the burn unit whereas for
- 17 pediatric patients they really need, you know, the
- 18 expertise right up front.
- 19 MS. HENNESSY: Yeah. I think we're
- 20 talking probably mixed trauma burn, that type of things
- 21 where they're --
- DR. KANTER: Right.
- MS. HENNESSY: -- just a mess when they
- 24 come in. The -- the other thing I just wanted to mention
- 25 is that when you're talking about facilities ramping up to

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- 2 add a hundred beds -- fifty beds -- whatever, there -- in
- 3 order to -- to do that and kind of get that ultimate
- 4 reimbursement and things like that afterwards, there has to
- 5 be a declaration. You -- you need to do the right thing at
- 6 the right time, and you don't wait for any of this to
- 7 happen. That's an absolute.
- 8 We recently were on a call with C.M.S.,
- 9 David Wright, who works as the emergency preparedness
- 10 coordinator for C.M.S. now, and he was really talking to us
- 11 about the fact that you need to do what you need to do. At
- 12 Joplin, Missouri, people had to do what they needed to do.
- 13 But when you want to expand your beds to an X number amount
- 14 and, you know, you need to go through your state and
- 15 your -- and the feds, you just want to write that into your
- 16 plans just to make sure that that kind of piece sums up
- 17 the -- the -- the other end of it. And I know that in the
- 18 Upstate areas, the regional models have been in place with
- 19 the regional resource centers which is a little bit
- 20 different than what you're dealing with in the city. And I
- 21 don't know that specific pediatric critical care surge has
- 22 been addressed, but adult and pediatric in a general sense
- 23 has been ask for, so --.
- 24 DR. VAN DER JAGT: And -- and that is
- 25 precisely where we're sort of looking at that whole area as

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- 2 well is how do we triage. We have potentially -- we -- we
- 3 have to deal with hospitals that are in rural areas which
- 4 can be a resource --
- 5 MS. HENNESSY: Right.
- 6 DR. VAN DER JAGT: -- for us. So that --
- 7 the -- the whole issue of triage, making room and then
- 8 using those facilities as well, but that brings into a
- 9 whole dimension of geography and -- and how do you do this
- 10 as well as local expertise.
- MS. HENNESSY: And that brings in Lee and
- 12 her authorities over --
- DR. COOPER: Absolutely.
- MS. HENNESSY: -- you know, the secondary
- 15 transport.
- DR. COOPER: Absolutely. Bob?
- DR. VAN DER JAGT: Right.
- 18 DR. KANTER: So Art asked what is the
- 19 next step and what's the role of the state. And I can tell
- 20 you in my region what's happened for surge capacity is one
- 21 hospital, it happens to be the one I'm at, has made some
- 22 commitments for total increased surge beds of all hospital
- 23 types, not specifically critical care. I don't believe
- 24 that most regions around the state are going to take the
- 25 initiative on this until there is some kind of incentive

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- 2 and guidance at the state level about what the next step
- 3 is. I think the fact that New York City has done this, at
- 4 least on the pediatric side, is an incredible achievement.
- 5 I'm not sure you can expect that's going to happen in and
- 6 of itself at a statewide systematic level until there are
- 7 incentives or, more than incentives, some requirements at
- 8 the state level for surge capacity.
- 9 DR. COOPER: Deb?
- DR. SOTTOLANO: Yeah. And that goes back
- 11 to what I was mentioning before earlier with the H.P.P.
- 12 funding and the grant and that's the two pieces. And what
- 13 we were trying to envision was like a -- what would be a
- 14 multi-year process to creating regional plans of -- of a
- 15 similar nature. And that's why the early deliverables this
- 16 year -- one is the hospital assessment -- get -- one thing
- is to let hospitals know that they may all have a role in
- 18 pedes whether or not they normally --
- DR. VAN DER JAGT: Right.
- DR. SOTTOLANO: -- handle pedes
- 21 patients --
- DR. COOPER: Absolutely.
- DR. VAN DER JAGT: Exactly. Right.
- 24 DR. SOTTOLANO: -- is a huge issue.
- DR. COOPER: Huge.

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2	DR. SOTTOLANO: And so that's why we
3	wanted to do this survey at the hospital level, going back
4	to the tool kit, really not only getting like the very
5	discreet things like how many, you know, of this item do
6	you have, how many of that, but also presenting them in
7	that survey like scenarios and and trying to stretch
8	their thinking to how they might play a role in that type
9	of scenario. But at the same time, we're our and a
LO	separate deliverable is to ask the regional resource
11	centers to convene work groups within the region and to
12	discuss the same concept of how are we going to create a
13	regional plan. And the data from the hospital survey will
L 4	help to provide them with some of the information and
15	talking points.
16	And what we kind of envision of the
L 7	three-year plan is, you know, getting that work group
18	started, getting the survey results, subsequent years table
L 9	tops to kind of test out some of the, you know, concepts
20	that are coming out of the the groups and the
21	discussions and then starting to really hammer through and
22	putting together a piece of of the roles of different
23	hospitals and the resources, you know, in this type of a
24	disaster. One of the other things we're writing in and
25	it's kind it's one of the early points Lee made is about

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- 2 the training and within the grant there's also some monies
- 3 set aside for training. And a lot of the hospitals have
- 4 fulfilled their main trainings like B.D.L.S., A.D.L.S. and
- 5 things like that. And so they're looking to expand some of
- 6 the things we've mentioned as potential training and I
- 7 would really welcome other suggestions is PALS and some of
- 8 the -- the pediatric, you know, course work for nurses and
- 9 stuff like that. So -- yeah, so we wanted to, you know,
- 10 have that be kind of put into the grant language as well so
- 11 that hospitals know they can take advantage of that.
- DR. COOPER: Bob?
- DR. KANTER: There's nothing like a
- 14 simple target to sort of gain attention and crystallize
- 15 thinking. I can tell you that in my hospital right now the
- 16 simple target is is it possible to use all our critical
- 17 care beds for critically sick ventilated patients on short
- 18 notice? And the answer is that would be a stretch.
- MS. HENNESSY: Because?
- DR. KANTER: Because we don't have enough
- 21 ventilators, --
- MS. HENNESSY: Okay.
- DR. KANTER: -- staff --
- MS. HENNESSY: Okay.
- 25 DR. KANTER: -- et cetera. And we are

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- 2 beginning to try to deal with that notion. We actually --
- 3 if you -- if you go down to the basement and get all the
- 4 standby ventilators, we could make it.
- 5 MS. HENNESSY: Or you ask the state for
- 6 the -- yeah.
- 7 DR. KANTER: But there is nothing like
- 8 some guidance from the state level to say you all should be
- 9 increasing your critical care capacity by whatever
- 10 percent -- twenty-five percent or a hundred percent, as
- 11 some of the hospitals in New York City have done, to
- 12 crystallize people's thinking. Once you have a target,
- 13 then the hospital knows what they have to do to make this
- 14 happen. They know about the cross training, the stock
- 15 piles, you know, on and on. Until they're encouraged to
- 16 come up with a simple target, it's not going to happen.
- 17 DR. VAN DER JAGT: How would you propose
- 18 to do that, Bob?
- 19 DR. KANTER: I -- I -- the state needs
- 20 to --
- DR. COOPER: Well --.
- DR. KANTER: -- say New York City has a
- 23 good idea here; let's extend it.
- DR. COOPER: Marilyn?
- DR. KACICA: You know, I think, you know,

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- 2 the purpose of that tool kit was to have hospitals look
- 3 through it and assess themselves as to how they fit, what
- 4 are they capable of. In that very, you know, preliminary
- 5 survey that we did, we found out they weren't getting it
- 6 because they were still saying to us we don't take those
- 7 kind of patients. So there's -- so I think until you
- 8 require the hospitals, themselves, to write their own
- 9 addendum, to actually sit with the planning group that was
- 10 recommended, prior to even coming together regionally to --
- 11 to flesh out the holes, they're not going to think about
- 12 it. So I think that's the first requirement that you have
- 13 to have. Think about it in your institution and then move
- 14 outward.
- 15 DR. COOPER: What -- what I'd like to do
- 16 is I -- I -- I think this is -- this is a terrific
- 17 conversation which must be continued. But it seems to me
- 18 that in many ways we have strengths here at a state level
- 19 that we did not have at a city level at the time, you know,
- 20 we began building in our -- our program. Specifically, as
- 21 I indicated in part of the presentation, there is active
- 22 planning going on for burn, for radiation, you know, for
- 23 specific types of -- of -- of injuries in the city, but not
- 24 specifically looking at -- you know, at hospital
- 25 preparedness overall. You know? That's lacking. And at

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- 2 the state level, you followed a slightly different path and
- 3 you've looked at, you know, how individual hospital
- 4 readiness on an all hazards level as opposed to -- as
- 5 opposed to parsing it out into different types of --
- 6 different types of contingencies. And the fact that you're
- 7 building on -- you've got a three-year program slotted,
- 8 that you're building upon an initial assessment, you know,
- 9 and then, you know, and then based upon that assessment,
- 10 hospitals in the region get together and say as a region
- 11 how can we cool our assets so that, you know, we can
- 12 provide the greatest good for the greatest number, et
- 13 cetera, et cetera, et cetera.
- 14 It strikes me that -- that a role that we
- 15 could play in assistant that process is if we could develop
- 16 by our September meeting a one-pager, you know, that said
- 17 here are the key bullet points that we really need to have
- 18 or that hospitals really need to -- to be thinking through
- 19 explicitly in terms of targets for pediatrics along the
- 20 lines that -- that Bob had mentioned, that might help, you
- 21 know, Deb and -- and -- and her program, you know, say,
- 22 okay, as you're thinking through this process, okay, here
- 23 are the explicit issues we want you to focus on in terms
- 24 of -- in terms of pediatrics. And -- and that would
- 25 entail, you know, bringing in the resource that Marilyn's

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- 2 office developed where people have to look at the resource
- 3 and say, based upon this resource, which you're now going
- 4 to have to, you know, shake the dust off and get down of
- 5 the shelf -- based upon this resource, okay, you know, what
- 6 are you actually prepared to do at this particular moment?
- 7 And, oh, by the way here's what you really need to be
- 8 prepared to do, you know.
- 9 So does it make sense to sort of put
- 10 together a one-pager like that that could help, Deb?
- 11 And -- and I -- I think it could incorporate I think, Jan
- 12 and Elise, many of the points that you've made in terms of
- 13 bringing in the -- you know, the -- the emergency
- 14 resources. And I'm sorry, John has stepped out of the room
- 15 for the moment, but, you know, I -- I -- I'd like to see --
- 16 you know, John, you know, sort of participated in that
- 17 process as well from the standpoint of, you know, urgent
- 18 care centers, you know, and non-traditional resources that
- 19 can be -- you know, that can be brought -- you know,
- 20 brought to bear in terms of caring for, you know, some of
- 21 those decompression issues that Jan has been talking about
- 22 with respect to the E.D.
- 23 Mary Ellen?
- 24 MS. HENNESSY: Art, I just wanted to say
- 25 that the focus on the public health C.D.C. cooperative

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- 2 agreement this year --
- 3 DR. COOPER: Uh-huh.
- 4 MS. HENNESSY: -- is really on the -- the
- 5 first year of a five-year grant.
- 6 MS. COOPER: Okay.
- 7 MS. HENNESSY: Now, that is really going
- 8 to start focusing on different things. One of the biggest
- 9 words that we're hearing now are coalitions.
- DR. COOPER: Uh-huh.
- MS. HENNESSY: Coalitions are regional so
- 12 that people can rely and count on one another. A hospital
- doesn't have too much to say over an urgent care center
- 14 unless they have the cooperation of -- of the county and
- 15 the business ease and things like that within the region.
- 16 So we're -- we're happy about that. We're still in year
- 17 three of the hospital grant, however. So we're finishing
- 18 up on some of those things that they wanted as far as
- 19 deliverables for the states and the receivers of the money.
- Next year, in year one of the hospital
- 21 that we will start to see combined efforts with what the
- 22 C.D.C. public health agreements look like. So there's
- 23 coalition building and expectations. In pediatrics, I
- 24 think, that could be one of the subjects that leads the way
- 25 on what the coalitions can kind of address.

18

19

- EMS For Children 6-21-2011 1 DR. COOPER: Well, that's been our hope 2 3 in New York City that if we put together a robust pediatric plan that some of our adult colleagues will, you know, 4 5 begin to -- to follow along. And, you know, to its credit 6 Greater New York Hospital Association has been working on 7 these initiatives as well, you know, not -- not focused explicitly on disaster, but focused on critical care in a 8 broader -- in a broader sense as you -- as you're provably 9 10 familiar with their, you know, Critical Care Leadership 11 Network Program that they set up over the last few years. 12 And we recently were able this year to convince them that 13 they needed a Pediatric Critical Care Leadership Network 14 and we got that. You know, that was kicked off in March. You know, and that's focusing on, you know, on day-to-day 15 stuff as well as disaster stuff. You know, and the first 16 meeting was on medication errors, you know, and so on with 17
- But all these -- all these efforts and
 initiatives are related and -- and, you know -- you know, I
 think that we do have an opportunity here, you know, to
 sort of help, as you suggested, Mary Ellen, sort of use
 pediatrics as, you know, what -- if I could borrow a phrase
 from P.K. Carlton, who is one of the -- you know, was the

a, you know, clear focus on patient safety which is front

and center in everyone's mind.

- 1 EMS For Children 6-21-2011
- 2 former surgeon general of the -- of the Air Force and --
- 3 and, you know -- you know, got himself retired in a prompt
- 4 manner for doing the right thing on 9/11 in terms of
- 5 assigning a bunch of burn nurses to go some place he didn't
- 6 have some sergeant's authorization to transfer. You know?
- 7 P.K. is down at Texas A and M right now as probably you
- 8 well know. But P.K. used to speak of the red wedge, okay,
- 9 which is the, you know, the gearing up of the, you know,
- 10 the first twenty-four -- forty-eight -- seventy-two hours
- 11 and how do you prepare for that particular moment. And
- 12 it's a different red wedge, but maybe it's a, you know,
- 13 maybe it's a pink and blue wedge, you know, for using the
- 14 kids. You know, the issue how do you plan for kids as sort
- of like a model, as Bob was suggesting, you know, for how
- 16 we might do, you know, planning overall. And I think it --
- 17 it's got some cache because, you know, obviously families
- 18 care tremendously about what happens to their children.
- 19 And -- and I think if -- if the -- if the planning effort
- 20 could be initiated in and around children -- and we've got
- 21 the tools. I mean Marilyn did a phenomenal job putting
- 22 that resource together. Deb, you've got -- you've got
- 23 the -- you know, the -- the -- both the current program and
- 24 the future plan all lined up. And if we could provide, I
- 25 think, the specific pediatric input or -- or suggestions or

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- 2 bullet points or what have you that say here are the
- 3 components that we think, you know, not only hospitals, but
- 4 also using that sort of sum slide that I showed, you know,
- 5 that it's not just the hospital's plan, but as you said,
- 6 Mary Ellen, it's -- it's the regional plan that
- 7 incorporates all the hospital plans. If we focused on --
- 8 on a -- on a one-pager that said here are the --
- 9 you know, the half dozen or -- or dozen things you have to
- 10 have -- I'm thinking of a page, how many bullet points can
- 11 you fit on a page -- but, you know, here are the half dozen
- 12 things that -- that you have to have, you know, as a
- 13 region, and, oh, by the way you can't have those things
- 14 unless -- unless it -- it -- unless your hospitals, you
- 15 know, collectively -- individually and collectively have
- 16 these other things in -- in place. I mean not every
- 17 hospital has to have a PICU, but every hospital has to, you
- 18 know, has to have the ability to resuscitate and stabilize,
- 19 you know, and -- you know. You -- you all know the drill
- 20 as well as I do. But I think it -- I think -- would that
- 21 help? Would a document like that help in -- in your
- 22 planning at all, Deb, do you think?
- 23 DR. SOTTOLANO: I think it would be
- 24 helpful. And -- and actually, we are -- one of the things
- 25 we're talking about was to, perhaps, because the regional

- 1 EMS For Children 6-21-2011
- 2 resource centers are having a meeting in the end of July
- 3 and I had seen the presentations last week as well, and we
- 4 had thought that it would be helpful if -- if either
- 5 yourself or Kate or somebody could come and --
- DR. COOPER: Sure.
- 7 DR. SOTTOLANO: -- present the model
- 8 that, you know, had been developed in the city as well
- 9 knowing that we're putting out these deliverables and
- 10 trying to generate, you know, similar processes.
- DR. COOPER: I'd be happy to do that,
- 12 but, you know, I would defer to Kate and Mike and George if
- 13 they felt that they would prefer to do that. But -- but --
- 14 but, you know, which -- whatever works for you all.
- 15 Okay. Bob?
- DR. KANTER: At the risk of repeating
- 17 myself, but I will because I feel impatient, I think the
- 18 more the state can do to highlight what the New York City
- 19 Disaster Coalition has already done, it will serve as a
- 20 terrific example for others. Coalitions are really
- 21 important when they're based on real action. I think this
- 22 pediatric coalition in New York City is real action.
- 23 Sometimes coalitions are just a euphemism for sitting
- 24 around and talking and not doing too much. I think that
- 25 this coalition in New York City has done something.

- 1 EMS For Children 6-21-2011
- 2 They've sort of stepped up and taken a real concrete
- 3 position, saying that we as individual hospitals are going
- 4 to commit to doing what needs to be done to meet this
- 5 target and then they're talking to each other in a very
- 6 tangible and concrete way. It's an example, and I think
- 7 hospitals around the state should rapidly be falling in
- 8 line towards those kinds of targets.
- 9 MS. ROGERS: You know, Doctor, and you're
- 10 referring to, Dr. Cooper, is a kind of a set of targets for
- 11 a regional idea and then we can --.
- DR. COOPER: Thank you. I was just going
- 13 to make that comment. But, yes, I am -- so what I'll do
- 14 since I'll try to -- as just a first step since we have
- 15 something in New York City, I'll put something down on
- 16 paper and circulate it and some people can begin to think
- 17 about it and maybe make suggestions as to how we might use
- 18 that.
- Now, the good news is we've done a lot in
- 20 the last three hours. The bad news is we're already five
- 21 minutes over the end of our meeting time, and I had no idea
- 22 time would go so fast, and we still have Sharon's A.L.S.
- 23 protocol template to discuss.
- Sharon, do you think we have time to do
- 25 that?

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- MS. CHIUMENTO: We don't, Art,
- 3 unfortunately because this is going to take a whole -- a
- 4 very long discussion. What I'm going to ask, though, is
- 5 that all of physicians especially in this room take a look
- 6 at this document because the conversations are going to be
- 7 going on within the next couple of weeks and I want to
- 8 bring back E.M.S.C.'s viewpoints. And, so please, if you
- 9 can look at the document?
- 10 What this is, just as a quick overview,
- 11 is for many years we have been -- I've been setting up
- 12 medical standards and we have been reviewing the protocols
- 13 from all the different regions and regions come through and
- 14 they add different things to both the adult and the
- 15 pediatric protocol in their regions, which in New York
- 16 State, Article 30 says they may do. And what happens is
- 17 that sometimes it kind of gets away from us and nobody
- 18 realizes what exactly is going on across the state and just
- 19 how much variation there is. So within the last year --
- 20 year or two, I have actually compiled all of the protocols
- 21 from all of the regions in two grids and then start -- put
- 22 it into this document.
- What we've now decided to do is to take a
- 24 look at this document. There will be a working group from
- 25 the medical standards. It will be making some discussions

- 1 EMS For Children 6-21-2011
- 2 with this between now and the September meetings. We will
- 3 be saying are there things on here that we should be taking
- 4 away? Are there things here that are outdated? Are there
- 5 things that are not safe? Are there things that just, you
- 6 know, shouldn't be there? Are there things that should be
- 7 there that are not? Are there things that we can
- 8 consolidate? So if there's multiple drugs that can be used
- 9 for a particular purpose, do we need to have twelve
- 10 different medications for pain management in the
- 11 pre-hospital setting or can we do it with four?
- 12 So if you can just get back to me? This
- 13 grid is meant to be just a working document because I can't
- 14 be reviewing all of this that you -- be writing comments
- 15 all over everything. So if you can just -- they -- each
- one of the little items on here coincides with a bullet
- 17 point on the particular -- whatever it is. So P.D.R.
- 18 way -- if you look at the P.D.R. way management, the -- the
- 19 bullet points will coordinate with the treatments. Just
- 20 let me know. I don't need to know from you which -- which
- 21 level of care you think you should do it. What I do need
- 22 to know is if you think it should be removed and if you
- 23 think it should be a medical control only. Those are the
- 24 two most important things I need from you. Is it something
- 25 that you really think is a serious enough treatment that

- 1 EMS For Children 6-21-2011
- 2 should only be done with a physician's advice, whether it
- 3 be done by paramedics or critical cares. We'll leave that
- 4 for the CMAC to -- to decide. But if -- if we could at
- 5 least get your information back as to what you think should
- 6 be removed and what you think should be medical control
- 7 only. And then any other comments if you'd like to add
- 8 them to the end of the document I can then incorporate
- 9 those as well. Yes?
- DR. HALPERT: Could I make a comment?
- DR. COOPER: Go ahead.
- DR. HALPERT: First of all, Art, you
- 13 know, Sharon's put a ton of work into this already. It's
- 14 really a -- a great piece of work so far, and I don't
- 15 relish you having to try to tackle this one; this is not --
- 16 not fun, I suspect. From a medical control perspective,
- 17 this is a real tough document to -- to manage or really a
- 18 tough task to manage. Different hats. This committee
- 19 versus the -- the REMSCO I belong to or the REMAC I belong
- 20 to and then the concept of what you're trying to achieve
- 21 statewide. You know, when I was filling this -- out this
- 22 grid, I kept getting wrapped up because I could not keep my
- 23 mind on the fact that these modalities were all pointed
- 24 toward the pediatric patient population. Different animal
- 25 from the adult population --

- 1 EMS For Children 6-21-2011
- 2 MS. ROGERS: Right.
- 3 DR. HALPERT: -- of course in the E.M.S.
- 4 world. E.M.S. providers become very facile working on
- 5 adults with congestive heart failures, et cetera. But
- 6 looking at this specific to pediatric protocols, saying, of
- 7 course, I'd allow my paramedics to do this. Would I do
- 8 that with a potentially unstable two-year old? I don't
- 9 know. As -- as -- as a physician who writes
- 10 medical oversight, not just online, for whoever paramedics,
- 11 but for agency specific situation, it's different because
- 12 if you know your providers you can say oh, yeah, well, I
- 13 know. Elise is a great guy. He's a terrific paramedic,
- 14 really sharp. I'd let them take care of my family with my
- 15 eyes shut. You know? But if I don't know who that person
- 16 is and I'm sending in a -- a form like this to say will
- 17 this be applicable statewide, that's a real big
- 18 conversation.
- MS. ROGERS: Well, wait a minute. Before
- 20 we -- you -- you go there, maybe I should clarify one
- 21 point. This is not going to be a statewide protocol.
- DR. HALPERT: I understand that.
- MS. ROGERS: Yeah.
- 24 DR. HALPERT: But I know that
- 25 conceptually --

- 1 EMS For Children 6-21-2011
- MS. ROGERS: This is just --
- 3 DR. HALPERT: -- we're moving in
- 4 that direction.
- 5 MS. CHIUMENTO: And we may very well get
- 6 there eventually because there is some discussion.
- 7 DR. HALPERT: And I -- and I think that
- 8 when you look at this it's hard to look at through -- with
- 9 a set of glasses on and say can I comfortably say that sure
- 10 providers should be utilizing X, Y, Z, modality on standing
- 11 orders versus consultation or not at all depending on if
- 12 they are a critical care or primary care unit or whatever
- 13 it is. It's -- it's a really tough task to wrap your arms
- 14 around.
- MS. ROGERS: It is. And it is not going
- 16 to be -- and, you know, but that's why I wanted your input
- 17 at least on the pediatric version because I have the adult
- 18 and the pediatrics.
- DR. HALPERT: Okay. Yeah. Yeah.
- MS. ROGERS: And so I just want at least
- 21 your input here as to -- is there anything particularly
- 22 unsafe. You know?
- DR. VAN DER JAGT: Yeah. I think
- 24 that's --.
- DR. COOPER: It --.

- 1 EMS For Children 6-21-2011
- 2 MS. ROGERS: I know Elise already
- 3 commented on a couple things on our drive down that he felt
- 4 were -- were perfectly -- were just unsafe, and just, you
- 5 know, should not be in there at all. And so, you know,
- 6 those are the kinds of things that we need to bring our
- 7 feedback is to say okay, this is what -- and my goal was to
- 8 say E.M.S.C. really is uncomfortable with this particular
- 9 treatment and, you know --.
- 10 DR. HALPERT: Right. But there are
- 11 modalities that -- that I was unfamiliar with that
- 12 obviously came from different regions and I would like to
- 13 know what the rationale of the different regions were --
- MS. ROGERS: Sure.
- DR. COOPER: Yeah.
- DR. HALPERT: -- including their own
- 17 protocols.
- 18 MS. ROGERS: Right.
- DR. COOPER: In fairness to Sharon,
- 20 first, I -- I -- Sharon, I need to apologize to you. I --
- 21 I -- I completely lost track of the time.
- MS. ROGERS: Easy.
- DR. COOPER: I thought it was still about
- 24 three thirty. Honestly, and I looked at my -- and --
- 25 DR. KANTER: This would have taken two

- 1 EMS For Children 6-21-2011
- 2 hours.
- 3 MS. ROGERS: Yeah. It would take --.
- 4 DR. COOPER: And Lee -- and Lee --
- DR. VAN DER JAGT: This is the
- 6 biggest --.
- 7 DR. HALPERT: A day.
- DR. COOPER: And Lee -- and -- and
- 9 Lee tapped me or tapped her watch and said it's five after
- 10 four and I said oh, my god. Okay. So I'm so sorry. Okay.
- 11 I owe you a huge apology. However, I also just asked Lee
- 12 if it would be possible for us in very short order sometime
- in the next couple of weeks before you leave to -- to
- 14 respond, can we set up a conference call where we can
- 15 discuss this issue --
- MS. CHIUMENTO: That'd be great.
- DR. COOPER: -- you know, and solely --
- 18 nothing else, just discuss this one issue that Sharon has
- 19 put so much work into so we can get the input that -- to
- 20 her that she needs on the pediatric --?
- 21 DR. KANTER: Can it be a webinar?
- DR. VAN DER JAGT: Yeah, could that be a
- 23 webinar so that we can see the documents at the same time?
- 24 DR. KANTER: Yeah. See the protocols
- 25 involved.

- 1 EMS For Children 6-21-2011
- DR. COOPER: What I was going to -- yeah.
- 3 What I was going to suggest is even a -- even a poor
- 4 person's webinar where we just send out the PowerPoint
- 5 presentation ahead of time and then, you know, and
- 6 everybody has it on their computer screen and we do it, you
- 7 know, and we do it with, you know -- you know, as just a
- 8 routine conference call where people have the slides in
- 9 front of them so we know what we're discussing and --.
- MS. CHIUMENTO: Oh, you -- you actually
- 11 already do because this is what -- this is what we're
- 12 discussing is this document.
- DR. KANTER: Sure. Okay.
- 14 MS. CHIUMENTO: So all you need -- all we
- 15 would do is we would say, okay, look at this page one, is
- 16 there anything on this page one that you think should be
- 17 moved, is there anything you think should be district
- 18 medical control? And I think that's the only -- you know,
- 19 that's as much as input as I need from this group. I don't
- 20 think this group needs to say it should be critical care.
- 21 You would have to know the curriculum. You would have to
- 22 know, you know, all the pieces.
- DR. KANTER: The training. Right. So
- 24 practice.
- 25 MS. CHIUMENTO: And you don't -- you

- 1 EMS For Children 6-21-2011
- 2 don't have that piece of information.
- 3 DR. COOPER: All right.
- 4 MS. CHIUMENTO: So -- so if you can at
- 5 least just -- you can just get those two points taken care
- of, that would be great.
- 7 DR. COOPER: Okay. So I will work with
- 8 Martha in getting -- how soon do you need this information,
- 9 by the way?
- 10 MS. CHIUMENTO: Well, I was planning on
- 11 doing the -- the -- start doing conference calls with the
- 12 working group from med standards sometime towards the
- 13 middle of July. So if we can do this by the first or
- 14 second week in July --
- DR. COOPER: Okay. Great.
- MS. CHIUMENTO: -- that would give me
- 17 enough time.
- 18 DR. COOPER: That gives us a little bit
- 19 of time. Terrific. Okay. So I'll work with Martha in
- 20 getting a -- getting a time set up for a conference call,
- 21 where, again, it's going to be only this issue.
- MS. CHIUMENTO: Right.
- DR. COOPER: Okay. So we can get the
- 24 input to Sharon that she needs. And, you know, with deep
- 25 gratitude to Sharon for making sure that the pediatric

- 1 EMS For Children 6-21-2011
- 2 component and input is included, you know, as robustly as
- 3 it will be. That's -- we -- we're really grateful to you.
- 4 So, and, again, my apologies for losing track of the time.
- 5 So -- and, again, in the interest of
- 6 time, unless there are extraordinarily pressing issues on
- 7 the SEMAC SEMSCO reports or the STAC report, what I will
- 8 ask is that Jan and Sharon and Elise and I just put
- 9 together a very short summary of what took place at those
- 10 meetings so we can get that information out to the group
- and we'll just e-mail that or post that on the listserv or
- 12 send it out in whatever other way Martha feels is
- 13 appropriate. Okay?
- 14 Any other issues that we need to discuss
- 15 at this particular time?
- 16 Lee? Martha? Anything that you have for
- 17 us?
- 18 MS. BURNS: Drive carefully.
- DR. COOPER: Drive carefully. Good
- 20 advice from our director. Okay. And I'd like -- I'd like
- 21 to, again, thank you all for coming, thank Martha for doing
- 22 a great job getting everything together as she always does,
- 23 and thank Deb and -- and Marilyn for making time in their
- 24 busy schedules to be with us, and in absentia, Lisa and
- 25 Mary Ellen as well. Okay. And, of course, Sandra Haff,

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EMS For Children - 6-21-2011
 1
 2
     who's probably heard more about children today than she,
 3
     you know, usually does and probably got an earful from us.
     But we look forward to working with you as we get this --
 4
     get -- get the regionalization issues solved. Thank you.
 5
                       Thank you so much for coming. And
 6
 7
     everyone, we will see you in September. September 20th;
 8
     right, Martha?
 9
                       MS. GOHLKE: Right.
10
                       DR. COOPER: Right? And the conference
11
     call will be scheduled very shortly. So please -- please
12
     respond to Martha immediately when she suggests some dates
13
     as to which will work for you. Okay? Thanks so much for
14
     coming everybody.
15
                       (The meeting adjourned at 4:15 p.m.)
16
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25

1	EMS For Children - 6-21-2011
2	I, G. Michael France, do hereby certify that
3	the foregoing was taken by me, in the cause, at
4	the time and place, and in the presence of
5	counsel, as stated in the caption hereto, at
6	Page 1 hereof; that before giving testimony
7	said witness(es) was (were) duly sworn to
8	testify the truth, the whole truth and nothing
9	but the truth; that the foregoing typewritten
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19	July 6, 2011
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23	
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