

NEW YORK STATE  
DEPARTMENT OF HEALTH  
EMERGENCY MEDICAL SERVICES FOR CHILDREN

DATE: September 21, 2010  
TIME: 11:12 a.m. to 4:08 p.m.  
LOCATION: Crowne Plaza  
40 Lodge Street  
Albany, New York

1 (The meeting commenced at 11:12 a.m.)  
2 DR. COOPER: All right. Can we get everyone to take  
3 their seats please?  
4 (Off-the-record discussion)  
5 DR. COOPER: I'd like to take the opportunity to  
6 welcome everyone to the first meeting of the Emergency Medical  
7 Services for Children Advisory Committee for the academic year.  
8 We're all very glad to see that you --that you all arrived  
9 safely, and hope everyone had a pleasant and productive summer.  
10 We have a few special guests with us today, and I will  
11 take the opportunity to introduce them all, and ask that each  
12 say a word himself or herself.  
13 I'll start with Roni Cummings, who's a pediatric  
14 emergency nurse from the Albany area. Roni.  
15 MS. CUMMINGS: Hi. I'm Roni Cummings, and as Dr.  
16 Cooper said, that I am a pediatric --  
17 MS. GOHLKE: Roni, you've --  
18 MS. CUMMINGS: -- nurse.  
19 MS. GOHLKE: -- got to speak into the microphone. I'm  
20 sorry.  
21 MS. CUMMINGS: Oh, I see.  
22 MS. GOHLKE: Just pull it close to you.  
23 MS. CUMMINGS: Okay.  
24 MS. GOHLKE: We have got a stenographer who's taking  
25 down every word.

1 COMMITTEE MEMBERS:  
2 Arthur Cooper, M.D., Chair  
3 Dr. Susan Brillhart  
4 Lee Burns  
5 Sharon Chiumento  
6 Ann Fitton  
7 Martha Gohlke  
8 Jonathan S. Halpert, M.D.  
9 Robert Kanter, M.D.  
10 Kathleen Lillis, M.D.  
11 Rita Molloy  
12 Mike Tayler  
13 Elise van der Jagt, M.D.  
14 Speakers:  
15 Shawn Bertok  
16 Roni Cummings  
17 Pamela M. Lawrence  
18 Matthew Leary  
19 Debra L. Sottolano, Ph.D.  
20 Sarah Macinski Sperry  
21 Dr. Dennis White  
22  
23  
24  
25

1 MS. CUMMINGS: Okay. Got it.  
2 I am a pediatric nurse. I've been a pediatric nurse  
3 for years. I came from the Phoenix area, where I was also a  
4 flight nurse, worked in the emergency -- pediatric emergency  
5 room at that place. I am now here in New York, and a consultant  
6 with the New York State Nurses' Association. And my hope is to  
7 bring information back so that I can spread the word, get  
8 information, education, to the nurses of the state of New York.  
9 DR. COOPER: Great. Thank you so much, Roni, for --  
10 for being with us. You join some nursing colleagues here who  
11 have really made tremendous contributions to E.M.S.C. in -- in  
12 New York State, so really, welcome.  
13 And we have three folks from the Department with us.  
14 We have Deb Sottolano, Dr. Debra Sottolano, who is liaison  
15 to the Public Health Emergency Preparedness Program.  
16 And we have Dennis White who's associate director of  
17 that program. And I'll ask each to say a word about themselves.  
18 And again, welcome.  
19 DR. SOTTOLANO: Thank you. Yeah, I was very excited.  
20 Martha and Lee actually came over and spoke to me. I work in  
21 O.H.S.M. with them, and I'm the liaison between O.H. -- O.H.S.M.  
22 and the Public Health Preparedness Program, so we wanted to try  
23 to get some joint efforts together in -- in creating plans  
24 and -- and working on the pediatric end of emergencies. And  
25 we've been working on a burn plan that Dennis will speak about.

1 He's the director, but we had been talking with New York City,  
 2 and they are anxious to work together with us on -- on creating  
 3 a joint response plan, so that's why I got involved.  
 4 DR. COOPER: Thank you.  
 5 Dr. White.  
 6 DR. WHITE: Oh, good afternoon, or morning, I guess.  
 7 I'm probably a new kid on the block. After thirty-four  
 8 years working with Bureau of Communicable Disease Control in the  
 9 tower, on vector-borne diseases, I joined the Office of Health  
 10 Emergency Preparedness last November and was given two projects  
 11 to jump into, one being the burn plan that Deb mentioned. We're  
 12 trying to develop a state -- a New York State burn plan, working  
 13 very closely with New York City and the Cornell Weill folks down  
 14 in the -- in the city; and a development of an R.F.A., request  
 15 for applications, for a state medical emergency response team.  
 16 I'm also a colonel in the U.S. Army Reserves. I  
 17 command a combat support hospital. And given that history,  
 18 after twenty-two years in the Army, or during, still -- still  
 19 going strong, Bob Burhans thought that these types of projects  
 20 would be a perfect adjunct to that part of my life, that --  
 21 that -- that type of experience working for the Army Reserves.  
 22 And now, being blessed with the opportunity of looking at  
 23 pediatric surge, very similar to what the city and state are  
 24 looking with burn surge.  
 25 So I'm, again, very glad to be here, and thank you for

1 the invitation.  
 2 DR. COOPER: Thank you, Drs. Sottolano and White. Dr.  
 3 White, we will be spending a little bit of time, as you can  
 4 imagine, speaking specifically about pediatric issues. You may  
 5 be aware, I think most of the committee is aware, that New York  
 6 City has developed a pediatric program that is very similar to  
 7 the burn program, in terms of its -- in terms of its  
 8 organization and structure. And this is a perfect opportunity  
 9 today to discuss that, because there are some, as -- as you're  
 10 probably aware, institutional roadblocks to, you know, getting  
 11 it up and running, in terms of credentialing issues and -- and  
 12 so on and so forth. And -- and we need to make sure that those  
 13 are all worked out so that the program can get up and running in  
 14 a -- in a timely manner.  
 15 Pamela Lawrence is with us also today, from the Bureau  
 16 of Health Care Research and Information.  
 17 Pam, would you like to say a little bit about yourself?  
 18 You'll be speaking a little bit later.  
 19 MS. LAWRENCE: Sure. I don't know. I'm a little bit  
 20 intimidated, because almost all you folks know more about this  
 21 than I do.  
 22 What I've been doing for the past -- not almost all,  
 23 all of you.  
 24 What I've been doing for, like, the past six months,  
 25 off and on, is looking at the SPARCS data -- the SPARCS

1 pediatric data. I've looked at it for zero- to  
 2 eighteen-year-olds, and also -- I've got to use the mic?  
 3 MS. GOHLKE: You've got to use the mic.  
 4 MS. LAWRENCE: You guys could hear me; right? I --  
 5 FROM THE FLOOR: But it's getting taped.  
 6 MS. LAWRENCE: Oh, oh. Excuse me. I'm sorry.  
 7 I've been looking at the SPARCS data, the SPARC  
 8 pediatric data. Specifically I look -- was looking at outcomes  
 9 associated with transfers and different pediatric services  
 10 available.  
 11 Using administrative data is -- is somewhat limiting,  
 12 but I think that we have -- there are some ways around it and  
 13 the administrative data can be really useful in terms of what  
 14 we -- what we decide to implement in terms of transfers, and in  
 15 terms of regionalization. I think we can look at the pediatric  
 16 data and see what the effects of our efforts are.  
 17 DR. COOPER: Great. I'll look forward to your  
 18 presentation.  
 19 And of course, once again, we have with us Sarah Sperry  
 20 from the Bureau of Injury Prevention, who's a regular with us,  
 21 and thank -- thanks so much, Sarah.  
 22 And also today, Shaun Bertok, who's with us from Public  
 23 Health Emergency Preparedness and has been working very, very,  
 24 very closely with -- with the Bureau of Emergency Medical  
 25 Services.

1 So welcome, Shaun.  
 2 MR. BERTOK: Thank you.  
 3 DR. COOPER: Okay. What I will do at this point is ask  
 4 Martha to review the agenda for us very briefly; ask Lee to give  
 5 us a report from the Bureau; and -- and then Martha will go  
 6 ahead with a brief grant report, so we can get into the meat of  
 7 our meeting after that.  
 8 Martha.  
 9 MS. GOHLKE: Yeah, and we just followed regular format.  
 10 As Dr. Cooper said, we'll have a brief break for lunch, and --  
 11 and then we'll get to our subcommittee progress reports. And  
 12 some new business, we have Dr. Cooper and Dr. Kanter, and I  
 13 think Dr. Van der Jagt is also involved, in some state and  
 14 national emergency preparedness efforts. And they're going to  
 15 give us an update on what they've been involved with.  
 16 And as Dr. Sottolano said, I've been eagerly trying to  
 17 get some crossover -- crossover efforts between us and emergency  
 18 preparedness, because one of the efforts behind my grant is  
 19 making sure that surge/capacity issues and  
 20 emergency-preparedness, that children are being cared for  
 21 appropriately, with proper training and equipment, is what my  
 22 grant focuses on, not only in the ambulance environment, but the  
 23 emergency department environment. That's the purview of my  
 24 grant.  
 25 So, I know there's many ways that we can work together,

1 so I'm -- I'm ecstatic that Dr. Sottolano and Dr. White are here  
 2 today.  
 3 And then, as -- as Pam mentioned, she's been working  
 4 hard with some data -- to get us some baseline data on outcomes,  
 5 so to speak, for children who go through the system. So, if we  
 6 go down the road and change the system, hopefully we can do some  
 7 before and after comparison. And Pam will talk more about what  
 8 she's look -- been looking at for the last many months it seems,  
 9 for -- for feedback from us.  
 10 And we'll talk at length about our May stakeholders  
 11 meeting. Not everybody here is aware, but we had a big  
 12 statewide meeting in May, and we brought together stakeholders  
 13 to talk about pediatric care around the state, from basically  
 14 the nine-one-one system, through critical care, and about  
 15 whether or not we should make -- go down the road and make some  
 16 changes. So, we'll talk more about what happened at that  
 17 meeting a little later on.  
 18 And then I think you're going to talk a little bit  
 19 about -- you wanted Dr. Cooper -- the -- the Pedi-STAT for  
 20 iPhone on the agenda, so we'll talk about that.  
 21 And we have a quorum today, so if there's time, we --  
 22 we still need to vote and vet our bylaws. They've been on the  
 23 table for quite awhile, and last meeting we didn't have a  
 24 quorum. So, today we do, so we can vote on those, hopefully, if  
 25 there's time.

1 And Mike Tayler, who's sitting to my right, will give  
 2 us an update on the -- the pediatric trauma centers around the  
 3 state. I wrote New York City, but I think we're talking  
 4 statewide as -- as well. Okay.  
 5 DR. COOPER: Yeah.  
 6 MS. GOHLKE: And then again, if there's time, we have a  
 7 lot on the agenda today, so I'm doubtful we'll get done --  
 8 we'll -- or I should say I'm doubtful we'll get to everything by  
 9 four o'clock when we end, but if we have time, we'll talk about  
 10 the updates from the other committee meetings.  
 11 And that's what we've got going on today.  
 12 DR. COOPER: Great. Before we proceed, so we can be  
 13 sure that we get a few things taken care of, I -- I just want  
 14 everyone to take a quick look at the minutes, and make sure that  
 15 they meet with your approval, and if they do, I'll ask for a  
 16 motion to accept them as written.  
 17 MS. GOHLKE: We actually provide our minutes online  
 18 nowadays, to save, you know --  
 19 FROM THE FLOOR: Money.  
 20 MS. GOHLKE: -- postage and -- yeah.  
 21 DR. COOPER: Yes, those poor electrons.  
 22 MS. GOHLKE: Yeah.  
 23 DR. COOPER: We're not saving them anymore, though --  
 24 MS. GOHLKE: No.  
 25 DR. COOPER: -- I guess.

1 FROM THE FLOOR: "Save the electrons" is the --  
 2 DR. COOPER: That's right.  
 3 FROM THE FLOOR: -- new T-shirt.  
 4 DR. COOPER: That's right.  
 5 Any -- any issues with the minutes? Has everyone had  
 6 an opportunity to review them? They -- they were provided  
 7 online.  
 8 Yes, Roni?  
 9 MS. CUMMINGS: I have one question. The list of  
 10 attendees, is that considered part of the minutes?  
 11 DR. COOPER: Yes, it is.  
 12 MS. CUMMINGS: I have a misspelled name.  
 13 MS. GOHLKE: Okay.  
 14 DR. COOPER: We will take care of that.  
 15 MS. CUMMINGS: Thank you.  
 16 MS. GOHLKE: Thank you.  
 17 DR. COOPER: Thank you.  
 18 Any other issues?  
 19 (No audible response)  
 20 DR. COOPER: Hearing none, then may I have a motion for  
 21 approval?  
 22 Thank you, Kathy and Sharon, moved and second.  
 23 Discussion?  
 24 (No audible response)  
 25 DR. COOPER: Seeing none, all in favor?

1 Adopted without dissent. Thank you.  
 2 (The motion carried.)  
 3 DR. COOPER: Brief reports now from Education and  
 4 Nominating Committee.  
 5 For the Education Committee. Ann, are you giving the  
 6 report or --?  
 7 MS. FITTON: No.  
 8 DR. COOPER: Sharon. Okay.  
 9 MS. CHIUMENTO: In your packets you have the -- a copy  
 10 of the matrix that I've started to develop, the E.M.S.  
 11 interfacility transport matrix. This is supposed to be an  
 12 educational document that would go out to hospitals. And then  
 13 eventually, we'll probably do a version that can go to  
 14 ambulatory care centers and others.  
 15 It looks at --  
 16 FROM THE FLOOR: Thank you.  
 17 MS. CHIUMENTO: -- oh, thank you. Saw you coming.  
 18 It looks at what patients need to be transferred, what  
 19 kinds of considerations you need to have in -- in that process,  
 20 what hospitals might meet your needs, or the -- I should -- I  
 21 should say your patients' needs, and what things do you need to  
 22 get in -- in -- together before you transfer the patient.  
 23 A lot of the information, particularly the information  
 24 about the hospitals, was obtained off the Department of Health  
 25 Web site, so that's -- if that's current, then it's as current

1 as we're going to get, I think.  
 2 What we did this morning in the committee was kind of  
 3 looked at it. Dr. Van der Jagt in particular --  
 4 DR. VAN DER JAGT: Yeah.  
 5 MS. CHIUMENTO: -- put in several additions to it on  
 6 the couple places where we could expand some of the information.  
 7 So, we will go back and -- and do some further tweaking of the  
 8 document. But I ask that everybody on the committee, when  
 9 they -- when we send out the next document, please look at it  
 10 and see if there's other things that could be added,  
 11 particularly those who are physicians in hospitals, who, you  
 12 know, do these interfacility transfers. What kinds of pieces of  
 13 information would you want a transferring hospital to have?  
 14 What kinds of information do you -- you know, what do you need  
 15 to make this process go more smoothly? So -- so, please -- and  
 16 we -- hopefully we'll add some templates, so if you have any  
 17 templates that you use currently, maybe documents that you give  
 18 to the family as to how to get to the new hospital, or whatever  
 19 it happens to be, that we might be able to take and -- and adapt  
 20 for the statewide purpose, for hospitals, to be used in this  
 21 process.  
 22 DR. COOPER: Great. Thank you, Sharon.  
 23 Questions for Sharon?  
 24 (No audible response)  
 25 DR. COOPER: Hearing none, Kathy, can you give a brief

1 report from nominations?  
 2 DR. LILLIS: So, the Nominating Committee meet this  
 3 morning. We identified individuals to fill the seven positions  
 4 that are currently open. We also looked at the process for  
 5 reappointment. Most of us who were vetted in '07, the -- our  
 6 first four-year term is going to be expiring next spring. I  
 7 just ask individuals on the committee to make a determination if  
 8 they would like to continue through another four-year term. If  
 9 so, we're going to need things like updated C.V.s to move  
 10 forward, that needs to go to the -- the Commissioner.  
 11 The Nominating Committee had a discussion that it would  
 12 probably be best to proceed with sending forward three  
 13 appointments for the existing committee members, with the new  
 14 individuals that we would like to appoint to the Committee, as  
 15 one packet. So, we -- we were hoping that we'd have -- could  
 16 have all the paperwork available for the next meeting, so if  
 17 individuals could update their C.V.s, and evaluate if they're in  
 18 a situation to commit to the next four-year term and move  
 19 forward. There is a limit of two four-year terms. Some of us  
 20 have been on the committee longer, but we were currently vetted  
 21 in '07 if you look at the first appointment date. So moving  
 22 forward, this would be the end of the first four-year  
 23 appointment, and so everyone on the committee could move forward  
 24 with a second four-year term.  
 25 MS. CHIUMENTO: Do we send the C.V.s to Martha or to

1 you or --?  
 2 DR. LILLIS: To Martha.  
 3 DR. COOPER: Martha, yeah.  
 4 DR. LILLIS: Eventually they've got to make their way  
 5 to me, so you can e-mail them to me if you -- you have access to  
 6 do that, and you could cc one of the -- either Dr. Lewis or Dr.  
 7 Cooper, to let them know that it's on its way to me. That's  
 8 fine.  
 9 DR. COOPER: Just so everyone is clear about the reason  
 10 that some appointments have lasted for quite some time. This  
 11 Committee was not an official committee of the Department until  
 12 2007. It -- well, prior to that it was sort of an informal  
 13 advisory committee, funded through federal dollars, the federal  
 14 E.M.S.C. program. The Committee did not become, you know,  
 15 seated on a statutory basis until 2007. So, that's the reason  
 16 that there are -- the first set of four-year terms are expiring  
 17 in 2011.  
 18 Questions for Kathy?  
 19 (No audible response)  
 20 DR. COOPER: Seeing none, Lee, will you give us the --  
 21 the bureau report?  
 22 MS. BURNS: Certainly. Yesterday I met with my  
 23 supervisor and I asked her when there was going to be some good  
 24 news. And she looked at me and said, "Not any time soon." So I  
 25 will share that with you. We -- you can appreciate this, I'm

1 sure.  
 2 As you know, the state is in a severe fiscal crisis.  
 3 As a result of that, there are many, many, many lucky people in  
 4 the Health Department who are retiring, present company  
 5 excluded. And the -- the fallout from that, we'll -- we'll  
 6 probably get a real understanding of it at the end of next week  
 7 when those of us that are here come to work and it's very  
 8 lonely. There are so many people leaving the Health Department  
 9 that every time you log onto our news, it's awesome.  
 10 And with that, while I'm -- I'm thrilled for those  
 11 people, I hate them. But with that, the -- the real concern for  
 12 people like -- like me is that the institutional memory of the  
 13 Health Department has the opportunity to retire, and they are.  
 14 So, one of those people who we rely on a great deal, who --  
 15 she'll sound familiar to you, is our living and breathing  
 16 institutional memory, is Marjorie Geiger. And she leaves with  
 17 this. And -- and as I say to her, I'm thrilled for her, I'm  
 18 horribly jealous, and you know, I wish her the best, but -- but  
 19 she knows absolutely everything there is to know in the Health  
 20 Department, and there are hundreds of people like her that are  
 21 retiring.  
 22 And how is -- that effects you is that the mantra that  
 23 the state has used now for a very long time is do more with  
 24 less. It's sort of shifting to do less with even less, and so  
 25 our ability to -- to service our advisory councils is really a

1 question. So, if you don't hear from us, it's because everybody  
2 around us is doing double duty, or if Martha doesn't get back to  
3 you quite as quickly, it's because we've given her nine thousand  
4 other things to do. So, you know, and that will -- these --  
5 these -- these retirements greatly affect all of us.

6 Again, you know, I -- I -- I say that -- I sound like  
7 I -- I'm suffering from sour grapes. I am. And with that,  
8 E.M.S. is funded through something called a special revenue  
9 account. It's actually called an S.R.O. And historically the  
10 S.R.O.s have not really been negatively impacted in fiscal  
11 issues. They've asked them that they get cut back. A lot of  
12 the stuff that goes along with them gets hit hard. This year --  
13 this go-around, we were asked to do an exorcise, and -- so I'm  
14 still waiting to find out whether we're exorcised and they're  
15 actually going to do it. But the governor -- the word from the  
16 governor's office is that special revenue accounts are not  
17 exempt from the chopping block, and that a certain amount of  
18 money has to come out of the special revenue accounts, or they  
19 have to be cut by a certain amount of money.

20 So, we have done a ton of research. I get everybody in  
21 the E.M.S. Bureau into my office so that we can count on our  
22 hands and toes, because we're very simple folk. And we've --  
23 we've figured out where -- where we can cut. But what it has  
24 required us to do is prioritize the Bureau's - and -- and the  
25 Department's - mission, and the responsibility we have under

1 Public Health Law. And so, whether I -- I'm not going to really  
2 go into the ugly details, because we prioritized things that are  
3 our legislative responsibility. So the other stuff, as -- as a  
4 former employee of the state used to say, there's stuff you have  
5 to do or need to do, stuff that's kind of cool to do, and then  
6 there's the who-cares. And we've long since gotten rid of the  
7 who-cares. We're beginning to chip away at the niceties, and  
8 what will be left is the need-to-dos. So we'll see how that  
9 goes.

10 Vital Signs.

11 DR. COOPER: Lee, are you in a position to be more  
12 explicit at this point, about whether the programs that we're  
13 charged to support are in the -- in one of -- one of those lists  
14 that you described?

15 MS. BURNS: I'm not -- not really, because we're still  
16 in the exorcizing phase. I haven't -- I haven't included  
17 what -- a lot of what we do in the exorcizing phase, and you are  
18 actually pretty fortunate in that Martha -- Martha's grant picks  
19 up the predominance of your activities. So, it's a -- you're  
20 grant funded as opposed to coming out of a special revenue  
21 account. That's a plus. How it will affect you, I was going to  
22 get to this -- well, when you go to eat lunch, enjoy it. It is  
23 your last meal.

24 I -- you know, I can't speak for the rest of your day,  
25 but as with everything else, the Department is not approving

1 contracts that include food. And so, we are working with all of  
2 the -- the councils. We -- we work with four councils, and it's  
3 going to be quite a shock for them when they realize there's no  
4 food included. And we're trying to figure out a way to schedule  
5 them so that you're not -- you're not hypoglycemic by four  
6 o'clock, and you actually have some time to grab a bite to eat.  
7 So we'll -- more to follow.

8 Is that me?

9 DR. COOPER: I don't think so.

10 MS. GOHLKE: The two microphones are too close --

11 FROM THE FLOOR: Too close.

12 MS. GOHLKE: -- together.

13 MS. BURNS: All right. Thank you. Okay. Anyway, can  
14 you hear me?

15 FROM THE FLOOR: Get closer. That's better.

16 MS. BURNS: Okay. The -- the reason that we -- we  
17 really don't have a meeting schedule solidified for 2011 is that  
18 the process requires us to go out to bid for space. We have  
19 done that. We have done the paperwork for preapproval, which if  
20 you are a Health Department person, the 11 -- the dreaded 1184,  
21 so all of our ducks are in a row. Right now nothing is moving.  
22 And so rather than give you dates, we'll look at evenly  
23 spreading meetings through the year, and we'll keep you posted  
24 electronically.

25 But rest assured it will not include anything. So, the

1 next -- next meeting you might want to bring, you know, your own  
2 bread and water kind of thing, unfortunately.

3 So Vital Signs. On the brighter side. We held Vital  
4 Signs in New York City at the end of August. We had a terrific  
5 conference. While our numbers were a little bit lower, the  
6 conference itself was a great experience. The content was --  
7 was very rich. The people who participated, and there were  
8 about twelve hundred people, which is in and around five or six  
9 hundred less than we usually get, all the reviews have been  
10 really terrific. So, barring anything really ugly, we're --  
11 we're in the planning process for next year's event, which will  
12 be at Syracuse. Syracuse has historically drawn about two  
13 thousand persons, so we'll be significantly up, hopefully, next  
14 year.

15 The reason that our numbers were down, we -- we call it  
16 the Vital Signs perfect storm. We changed the time of year  
17 because New York City actually has a tourist season. You know,  
18 who knew? And it starts on September 1st. Again, who knew?  
19 And when you -- when you wandered around Times Square at night,  
20 you could not -- there wasn't a -- there wasn't a local person  
21 in the crowd. They're all foreigners. So, tourist season -- I  
22 only can imagine what Times Square looks like in tourist season.

23 So -- for the record, Susan is laughing at me.

24 Anyway, the -- the change of the venue, the change of  
25 the time of year, the change -- the fact that we put it in New

1 York City, and for those of us woodchuck types, getting into the  
 2 city is -- is -- there are some logistical issues involved with  
 3 that, because we go nowhere without our very large pickup  
 4 trucks. I say this, I have one. And so, getting the whole mind  
 5 set switched over to taking mass transportation or mortgaging  
 6 your home to park your pickup truck, because who knew they were  
 7 oversized vehicles when you put a light rack on the top of them?  
 8 And we had some issues with people who are just beginning to get  
 9 it.

10 But really, from a -- from a conference perspective, it  
 11 was a terrific event, and barring the parking, the only thing  
 12 is, you know, this acting-bureau-director thing has been very  
 13 interesting, and they said "You're going to drive the  
 14 twenty-eight-foot straight truck out of the city on Sunday  
 15 night." And so, they loaded it up and I got a teamster's card  
 16 and the keys from Tom Fortune, and bounced my way out of  
 17 midtown. And I -- my passenger said, you know, "What's your  
 18 plan?" So I said, "I don't know. I thought I'd hang a left on  
 19 like, Madison or Lexington, take it to the bridge at the end,  
 20 cross over, hang a left on the Major Deegan and go 'till I get  
 21 off at Exit 13, at the Northway." That wasn't satisfactory  
 22 enough. That however worked.

23 So please, please, please, keep Vital Signs on the top  
 24 of your thoughts, because again, with the budget the way it is,  
 25 there are questions about its future as well.

1 I talked about next year's meeting.  
 2 I -- I want to talk -- I'm not really sure how this  
 3 exactly affects E.M.S. for Children, other than it does. In --  
 4 in the summer, and I think either the end of July or early  
 5 August, the legislature passed an -- an amendment to the Vehicle  
 6 and Traffic Law, allowing allied healthcare providers to draw  
 7 B.A.C., blood alcohol content, samples, as a result of the death  
 8 of Jack Shea up in the north country. So it's called the Jack  
 9 Shea Law. And from an E.M.S. perspective, it doesn't really  
 10 alter the law. The wording is slightly different, but it  
 11 identifies E.M. -- advanced E.M.T.s as certified by the  
 12 Department. And our attorneys have interpreted that as --  
 13 actually as certified by Article 30, which means that advanced  
 14 E.M.T.s are still beholden to the "ugly medical control," which  
 15 is an outstanding thing. Article 30 requires that advanced  
 16 E.M.T.s practice under medical control both on and off line.

17 And so, in the previous law, it said specifically an  
 18 E -- advanced E.M.T. may draw blood alcohol level, under the  
 19 direct -- under medical control, the direction of -- of a  
 20 physician medical director. The big change in the law, though,  
 21 is that it allows just about everybody who can hold a sharp  
 22 implement in their hand to draw a blood alcohol level. And --  
 23 and that is sort of an aside -- that's a hospital issue, just  
 24 for -- for you who are practicing in facilities and E.R.s,  
 25 that's -- that's certainly an issue. A lab tech now can draw

1 blood alcohol level and -- whereas before they could not.

2 It's a -- the interesting thing is, and I've sent a  
 3 note to my boss and Dr. Morley yesterday, the REMACs across the  
 4 state have looked at this closely, and as a result of the  
 5 previous version of the law, which came out in about 2000, 2001,  
 6 the -- we have a policy statement, the Department, that really  
 7 empowers the REMACs to decide if they're going to grant medical  
 8 control to advanced providers to draw blood alcohol levels. And  
 9 many of them did, but --but it was specific that -- to avoid a  
 10 sheriff from calling an ambulance just to do a blood alcohol  
 11 level, because in order for us prehospital care providers to  
 12 practice, we have to have a patient relationship. In order for  
 13 you to grant medical control, we have to have a patient  
 14 relationship. And -- and somebody who may be under arrest but  
 15 is not a patient, we don't actually, by law, have the authority  
 16 to practice upon them. And so, this doesn't really change that,  
 17 and the REMACs, from west to east, have -- have got -- done a  
 18 little push-back. Which has -- I just -- much to my surprise,  
 19 got an e-mail note actually from the Commissioner, which to me  
 20 is surprising terrifying, really, that they are concerned  
 21 about -- about this, because, you know, is that going to rile up  
 22 the legislature. So, I'll keep you posted.

23 Again, the REMACs -- a lot of the physicians have  
 24 gotten very worried that this new law change negatively impacts  
 25 them and their prehospital care providers, but when in reality

1 it does not appear to change what the previous version said.

2 Do you know what I mean, John?

3 DR. HALPERT: You know, it's always confused me,  
 4 honestly --

5 FROM THE FLOOR: Can you use the microphone?

6 DR. HALPERT: Oh, I'm sorry.

7 MS. BURNS: He's a medical control physician.

8 DR. HALPERT: It's always confused me, because of the  
 9 point you made, which is if you happen -- one shouldn't respond  
 10 to a situation where there's no actual patient there to perform  
 11 or a medical procedure, yet when the police present that same  
 12 individual to the hospital for the blood draw, if they are not,  
 13 in fact, ill or injured, they're the same thing. They're not a  
 14 patient, and they're coming in for that -- for that forensic  
 15 procedure.

16 MS. BURNS: I --

17 DR. HALPERT: And I'm not sure why there's a  
 18 difference.

19 MS. BURNS: -- I -- I think simply because when they  
 20 get to the E.R. they are under arrest.

21 DR. HALPERT: No, I understand that --

22 MS. BURNS: Yeah.

23 DR. HALPERT: -- part of it. They're used to --  
 24 well --

25 MS. BURNS: That now they're the --

1 DR. HALPERT: -- we're back to -- we're still --.

2 MS. BURNS: -- now they're in police custody. I -- I

3 mean, I'm not an attorney. So, I don't really know.

4 DR. HALPERT: No, I -- I know. You're not the person

5 that's --.

6 MS. BURNS: I -- you know, I -- I think, again,

7 we'll -- this -- this -- nothing's simple, and everything's a

8 controversy, and this also is one. One of the -- the reason the

9 western New York folks became very concerned is that in a rural

10 county, the sheriff's department has begun calling the local

11 ambulance service to do blood draws. And the reason that the

12 sheriff told the ambulance folks was that he did not want to

13 have to send his sheriff's deputy two counties away to the

14 trauma center, to get a nurse to draw the blood, and so, it's

15 just easier to call the ambulance.

16 We -- honestly, we don't have the resources, I say --

17 FROM THE FLOOR: That's right.

18 MS. BURNS: -- we, the global E.M.S. community, to be

19 responding for that purpose. As much as it makes a ton of sense

20 when you have somebody who you really want -- you know -- you

21 know, it's a -- it's -- it's quite a dichotomy, because you

22 don't want these people out there. And yet we don't have the

23 resources to answer calls for -- nine-one-one calls for

24 ambulances, much less to go out and draw blood.

25 DR. HALPERT: Right. There's -- there's a lot of

1 argument both ways, and they all make sense. I mean, you want

2 to certainly assist with taking potential D.W.U.I. people off

3 the road. There's no argument about that. The district

4 attorneys have pushed back somewhat, saying we don't think you

5 guys would want us to be involved in the evidentiary collection

6 process.

7 MS. BURNS: Which is also --

8 DR. HALPERT: Which is true.

9 MS. BURNS: -- a great concern.

10 DR. HALPERT: What you're saying is completely true in

11 terms of resource utilization. And also just in terms of

12 metabolism and time, I mean, if you -- if I can draw at -- at

13 time zero, as opposed to maybe two or three hours from now,

14 perhaps the charge varies in terms of the -- the -- the B.A.C.

15 when it's drawn. I mean, there's a lot of --

16 MS. BURNS: Well, I --

17 DR. HALPERT: -- there's a lot of arguments about this,

18 and they all make sense.

19 MS. BURNS: -- again, I -- there's -- there -- no

20 question. And you know, the -- the issue of, you know, I -- I

21 am a volunteer, I draw the blood, I'm now subpoenaed in the

22 court.

23 DR. HALPERT: Sure.

24 MS. BURNS: I -- that's the --

25 DR. HALPERT: Police --.

1 MS. BURNS: -- you know. One of the -- my concerns is

2 that, you know, E.M.S. providers, now they can do this by law,

3 but they're not trained on the use of the kit. And if you use

4 the kit improperly, that throws everything away.

5 DR. HALPERT: Right.

6 MS. BURNS: And you don't want it -- that to happen.

7 DR. VAN DER JAGT: I -- I have several concerns about

8 this. One is that -- I'm sorry, is it not on? Thank you.

9 I have several concerns about this. From what I

10 understand that you're saying, Lee, is that there is,

11 fortunately, still a requirement for medical control; is that

12 correct? Because in the absence of that, you would have law

13 enforcement dictating medical procedures to a healthcare

14 provider. And maybe that sounds okay for alcohol levels, but

15 what if the officer says well, I want you to do an appendectomy

16 on this patient? I mean, under arrest, you know. So -- so, I

17 think there are some principles here that I have a great deal of

18 concern with -- with, if the medical control would not be there.

19 The second question I have relates to the parents' role

20 for children. Because if it is a sixteen-year-old, does this

21 mean that there is no parent role because the patient is under

22 arrest? Oh, they're not a patient I guess. Is under arrest?

23 What is the parent's role in allowing this to be done to their

24 child? And I may not -- I may not be familiar enough with the

25 scenario. But you know, I could see a kid coming -- the --

1 the -- the police officer calls the E.M.S. person. There is

2 no -- the medical control says, yes, you can go ahead and do

3 this, because I will take the responsibility or whatever, but

4 the parent says oh, but I don't want you to do this. This is an

5 invasive procedure, and I don't want you to do this on my child.

6 DR. HALPERT: I think that goes back to the D.M.V.

7 regulation, in terms of getting your license. If -- if you're a

8 licensed -- you know, junior license, learner's permit, whatever

9 it is, I think you're automatically subject to -- well, I'm not

10 sure. I don't -- in terms of having your blood drawn versus a

11 general drug test.

12 DR. VAN DER JAGT: Yeah, a Breathalyzer test is one

13 thing. I know there's controversy about that. But I mean, now

14 you're talking about invasive medical procedures.

15 MS. BURNS: And I don't know the answer to that

16 question. I -- I will find out, but I -- I don't know.

17 DR. COOPER: I -- I think that this is an issue that

18 obviously affects adult patients much more than it affects

19 pediatric patients. I think Dr. -- Dr. Van der Jagt, as always,

20 has raised some, you know, special concerns with respect to

21 pediatric issues that I think this Committee does need to be

22 concerned with.

23 Just for the information of the group, when this issue

24 was initially brought before the SEMAC in May, I -- I would have

25 to say - Lee, correct me if I'm wrong - but the major concern on

1 the part of the -- of the SEMAC, was that ambulances could be  
2 diverted long distances and essentially taking them out of  
3 service when they may be the -- you know, the sole unit  
4 available to respond to, you know, heart attacks, brain attacks,  
5 you know, motor-vehicle crashes, what-have-you.

6 All the other issues that you've heard mentioned today  
7 were also mentioned, but I think the main issue was, you know,  
8 the issue of, you know, which -- which competing public interest  
9 is greater: Saving the life of an innocent -- an -- an innocent  
10 victim or drawing a blood sample that -- you know, that -- that  
11 may or may not ultimately prove to be -- to be relevant?

12 From a scientific standpoint, all of this is a bit  
13 ironic, because the Breathalyzer tests these days have been  
14 really very, very well correlated with blood alcohol levels.  
15 And it's -- so, it's a little surprising to me that -- you know,  
16 that -- that this has become such a -- such a big issue.

17 I think the final point that needs to be made is that  
18 this is one of those bills that sort of gathers a great deal of  
19 steam very fast at the -- at the end of a legislative session,  
20 and everybody says oh, yeah, this is a great idea. Let's do it.  
21 And all the ramifications were not really well thought through.

22 So, I -- I think our best course here is to continue to  
23 advise the Department on -- on, you know, the -- the issues  
24 that -- that -- that may affect children, and let the Department  
25 do its -- its work through the other councils, with respect to

1 adults.

2 Is that acceptable to everybody?  
3 (No audible response)

4 DR. COOPER: Okay. Lee.

5 MS. BURNS: I think that brings my unbelievably good  
6 news to a close.

7 DR. COOPER: Okay. I -- I would like to ask if we  
8 would be willing to -- to send a very special letter of thanks  
9 to Marjorie Geiger for her years of support for this -- for this  
10 Committee and I'll -- I'll -- on behalf -- if I have your --  
11 your -- your assent, I will draft a letter and get it to her,  
12 with some appropriate, you know, measure of our thanks.

13 And I -- I see everyone nodding in assent, so we will  
14 go ahead and do that.

15 MS. GOHLKE: I know she holds this project near and  
16 dear to her heart, because she checks in with me all the time to  
17 find out what's going on, so I think she'd really appreciate  
18 that.

19 DR. COOPER: Okay. We will do that.  
20 Any questions for Lee?  
21 (No audible response)

22 DR. COOPER: Okay. Martha, do you want to tell us  
23 about the E.M.S.C. grant?

24 MS. GOHLKE: Yeah. Before I go through the  
25 nitty-gritty update on the grant, first of all I want to

1 announce that you've got a little flyer in front of your  
2 booklet, that Dr. Cooper was awarded the E.M.S. for Children  
3 Lifetime Achievement Award, which is a huge accomplishment. And  
4 he was -- back in May, I think, was the presentation of the  
5 award. It's stiff competition, and he -- he made the cut, so  
6 I'm very proud of the fact that he's from our state and the  
7 chair of our Committee, and he won this lifetime achievement  
8 award, which may times is awarded posthumously, so we're very  
9 glad he's alive, he's still with us here, and can -- can  
10 continue to do an excellent job.

11 DR. COOPER: There may be have been someone who wished  
12 it was posthumously.

13 Thank you very much, Martha.

14 MS. GOHLKE: It's very excited for -- for us in New  
15 York State.

16 And one other small announcement before I move on to  
17 the grant is, Sarah Sperry, who's -- is now an Albany All-Stars  
18 Roller Derby girl.

19 FROM THE FLOOR: Woohoo.

20 MS. GOHLKE: Her -- her name is Polly Morphic, so we'll  
21 be referring to her as Miss Polly from now on. You can see her  
22 in action this coming season. I'm looking forward to it. I'm  
23 her biggest fan.

24 FROM THE FLOOR: I'm afraid she's going to get hurt.

25 MS. GOHLKE: So, there's pictures of bruises -- massive

1 bruises on Facebook, so if you become friends with her you can  
2 see --.

3 MS. BURNS: She wanted to try injury -prevention  
4 firsthand.

5 MS. GOHLKE: Right. Yes. It's all fitting with injury  
6 prevention; isn't it?

7 Okay. In your -- in your packet, on the right-hand  
8 side, there's a double-sided E.M.S. Children performance  
9 measures. I'm just going to go through them as quickly as  
10 possible, so that I don't bore you. And we have a number of new  
11 people at the table, so I'd like to take a little bit of time,  
12 hopefully not too much.

13 But this is the nitty-gritty of the requirements for  
14 the grant. They keep tweaking these measurements, or these  
15 requirements, every year, which poses a challenge every time  
16 they tweak them. One of the major tweakings that they did for  
17 this grant year is they renumbered them, which is not a big  
18 deal. But the positive thing they did when they renumbered the  
19 performance measures is that they split them out to be their own  
20 performance measure. In the past they would lump them together,  
21 and even if you accomplished one of the measures, you didn't  
22 accomplish it, because you had to do the other four parts of it.  
23 So now they've split them out into each of their own, so as we  
24 make accomplishments and steps for improvement, we get  
25 acknowledged for it.

1 I just want to say a little bit about each one of them.  
 2 seventy-one is about online or medical-control direction. I  
 3 have to survey on this every few years, and this year is the  
 4 next time I have to survey the providers to get the reaction on  
 5 their experience with online medical control. The -- two years  
 6 ago we did the baseline survey, so now it's time to do the  
 7 follow-up survey. New York State has -- is leaps and bounds,  
 8 and we have medical control in place that meets the grant  
 9 requirements, but the survey results didn't show that the last  
 10 time around, and there's a bunch of reasons why that -- that may  
 11 have happened.

12 We're about to launch the survey again this fall. In  
 13 the next month I hope to launch it. We've been working on it  
 14 internally to make sure that the language of the survey works  
 15 for New York State providers, because everybody in their own  
 16 state calls things different things, to make sure that the  
 17 interpretation of the survey goes well. I didn't bring it with  
 18 me today, but if some folks would like to see it before it's  
 19 launched, I'll send it out to you and -- and any feedback you  
 20 can provide would be great.

21 What we have to have, ninety percent of the providers  
 22 have to say that they actually have access to pediatric-specific  
 23 online medical direction, at the scene of an emergency, in order  
 24 to meet the performance measure. So, there are some challenges  
 25 with that.

1 Seventy-two, this is the offline or the written  
 2 protocols. We meet that requirement, although we haven't gotten  
 3 acknowledged yet on a federal level, because we do have B.L.S.  
 4 offline protocols, so we meet that portion of it. We don't  
 5 necessarily dictate the A.L.S. written protocols, although we do  
 6 vet them at a state level. So, we will be working to get -- to  
 7 meet this performance measure by the feds, by sending all our  
 8 documentation, but we still have to survey on this. And again,  
 9 if the providers say that they don't have, or they don't know  
 10 about, the -- the written protocols, and we don't meet the  
 11 ninety percent threshold saying, yes, they have protocols  
 12 available to them when they need them, then we still don't meet  
 13 the performance measure. So, a lot of this is in the surveying  
 14 and making people also understand that they -- they do have  
 15 written protocols that they have to follow, and they have to  
 16 have access to them when they need them.

17 One of the things we did internally is we updated our  
 18 policy on this, and -- recently this past year, and it is now in  
 19 policy that the providers have to have the written protocols  
 20 either in their vehicle or on their person when they respond to  
 21 an emergency, so hopefully they do have access to those written  
 22 protocols at the scene of an emergency. So, we -- we've got to  
 23 get them to understand that, know that, and just sit and answer  
 24 the survey appropriately, which again, is another challenge. So  
 25 that's also going out with -- the same offline and online survey

1 is going out together this fall at some point. And like I said,  
 2 if you'd like to see the questionnaire, just let me know and  
 3 I'll e-mail it to you.

4 The next one, seventy-three, patient care units in the  
 5 state have to have pediatric equipment and supplies. You may  
 6 remember last year they updated the national recommendation on  
 7 what those supplies are for the pediatric patient. And we wrote  
 8 a policy again this past year for our providers, and we gave  
 9 them this list, and basically said we recommend highly that you  
 10 carry this equipment. And we are in the process of putting this  
 11 in regulation, which could take some time, but eventually this  
 12 will be in regs and you'll have to follow this policy, so we  
 13 suggest you do it now, basically is the short of the -- of the  
 14 policy. And that was -- is being rolled out as we speak.

15 And I have to survey on that too, so that is also going  
 16 out. So, they have to answer what equipment they're carrying on  
 17 their rigs with this fall survey. We probably, again, will not  
 18 meet the threshold to meet the performance measure, but we'll  
 19 get there the next time we survey around, probably in two years.

20 So we're on board with this, we're moving along, we're  
 21 showing progress, and I think that will be good for the feds to  
 22 see, that we've got in policy, basically.

23 Okay. Oh, and -- and I just want to put in here that  
 24 this is where I think some of the crossover could potentially  
 25 happen with disaster preparedness, in getting this equipment and

1 supplies. A lot of, you know, our fear about putting these  
 2 requirements on these voluntary agencies is the cost behind  
 3 purchasing a lot of this equipment, and the training to use the  
 4 equipment. So, I'm hoping that with our other funding efforts  
 5 in the Department of Emergency Preparedness, we may be able to  
 6 get together and talk about how we can do this, meet these  
 7 requirements together.

8 Okay. Seventy-four. Seventy-four and seventy-five  
 9 is -- or seventy-four in particular is what this Committee has  
 10 been working very hard on as of late. This is to be -- to  
 11 recognize that hospitals can stabilize and manage pediatric  
 12 medical emergencies, officially. You know, some sort of  
 13 official system within the state. I mean, unofficially we -- we  
 14 have that, but we don't have a more documented official system  
 15 that would meet the feds' requirements. And this is why our  
 16 stakeholders meeting -- part of the reason that we had the  
 17 stakeholders meeting back in May, which I'll talk more about in  
 18 a little bit. So, we don't meet this performance measure yet,  
 19 but as I've said many times before, the feds are looking at us  
 20 very closely for this, and every time I talk to either my  
 21 federal liaison or my project officer from HRSA, the first thing  
 22 they ask me about is this performance measure and where we are  
 23 with it, and they -- they're watching us very closely to see  
 24 what we do. And again I'll talk more about that stakeholders  
 25 meeting in a little bit.

1 Number seventy-five is the -- the trauma system for  
 2 pediatric patients. We do have a formalized system here in New  
 3 York State, and we have -- we have been acknowledged by HRSA to  
 4 have met this performance measure. However, they tweaked the  
 5 performance measure this past year. In the past it was that you  
 6 had a pediatric trauma system, you know, developed and  
 7 standardized, whatever you want to say, but now they say that at  
 8 least twenty-five percent of the hospitals have to be, you know,  
 9 a pediatric trauma center. We don't meet that twenty-five  
 10 percent, although as hospitals close, keep closing and closing,  
 11 who knows, maybe we will make that twenty-five percent  
 12 eventually. So, whether or not they take away that  
 13 acknowledgement that we meet that performance measure, or we're  
 14 grandfathered in, I'm not really sure yet. I kind of don't want  
 15 to ask that question, because I'm afraid of what the answer will  
 16 be.

17 MR. TAYLER: Are they saying that twenty-five percent  
 18 of all of our hospitals --

19 MS. GOHLKE: Yes.

20 MR. TAYLER: -- or twenty -- or twenty-five percent of  
 21 just the hospitals that are designated trauma centers?

22 MS. GOHLKE: No. Of all the hospitals.

23 MR. TAYLER: Of all the hospitals.

24 DR. COOPER: Twenty-five percent of all hospitals have  
 25 to be pediatric trauma centers?

1 MS. GOHLKE: Exactly.

2 DR. COOPER: We will get that fixed. That's -- that's  
 3 absurd. There's no one --

4 MS. GOHLKE: It's hard on a large state such as  
 5 ourselves to meet that performance measure.

6 DR. COOPER: No, no one -- no one in the nation can  
 7 meet that standard. I -- that -- that's a ridiculous --

8 FROM THE FLOOR: That's not even --

9 MS. GOHLKE: What I'm --

10 FROM THE FLOOR: -- true for adults.

11 MS. GOHLKE: -- what I'm getting --

12 FROM THE FLOOR: That's not true for adults.

13 FROM THE FLOOR: They only have one --

14 MS. GOHLKE: Exactly. So, you know, they may change  
 15 that performance measure again. You know, it keeps getting --  
 16 these numbers, these thresholds keep getting changed, so  
 17 we'll -- I'm sure we'll have more to say about that. Well, I'll  
 18 find out what they say about it, let's assume, when they -- they  
 19 check in with me, and -- and I'll find out, you know, what we've  
 20 met and what we haven't met.

21 FROM THE FLOOR: Do we --?

22 MR. TAYLER: To -- to put that into -- in perspective  
 23 for New York State, we have between -- depending on which list  
 24 you look at, we have between two hundred and two hundred and  
 25 fifty hospitals in the state. Because of the way our

1 hospitals -- because of the way our definition of hospital is in  
 2 the law, that's one thing, but -- so two hundred hospitals,  
 3 twenty-five percent of that is fifty hospitals who have to be  
 4 pediatric trauma centers. We only have forty hospitals in the  
 5 state that are trauma centers, period. So, we don't even meet  
 6 that for -- for total trauma centers.

7 MS. GOHLKE: Any other comments about -- from anybody?  
 8 (No audible response)

9 MS. GOHLKE: Let's see. So seventy-six -- seventy-six  
 10 and seventy-seven performance measures were made optional this  
 11 year, so states can choose to work on them or not. It's kind  
 12 of -- they refer to them as advanced performance measures, so if  
 13 the -- if a state has met all the other ones, they want you to  
 14 work on seventy-six and seventy-seven. This is the -- the  
 15 transfer agreements between hospitals. It's split into two  
 16 parts. One is guidelines, and the other is the actual transfer  
 17 agreement.

18 We -- we meet number seventy-seven performance measure  
 19 because we do have in the hospital code that they have to have  
 20 written transfer agreements. The policy and procedures behind  
 21 those are not well defined, and we don't dictate that at a state  
 22 level, so those bullet points that you see are the bullet points  
 23 that have to be included in their -- in their transfer policies.  
 24 And until the hospitals have that policy in writing, or we  
 25 dictate it at the state level, we won't met that performance

1 measure.

2 But we -- we were given the option to opt out this --  
 3 this grant year round, because they understand that we're  
 4 working on the, you know, standardizing our system, and that we  
 5 kind of want to work at that first, before we get to the level  
 6 of working with transfer agreements, because part of our -- we  
 7 need to categorize and figure out what is out there in the  
 8 state, and then go from there about transferring, when you know  
 9 what the resources are out there. So, they understand that we  
 10 are going to work on this measure, along with the standardized  
 11 pediatric hospital system that we're talking about. I don't  
 12 know if that makes sense. We'll get more -- back to it later.

13 That's pretty much the nitty-gritty. The other -- the  
 14 other remaining performance measures --

15 DR. COOPER: Martha --

16 MS. GOHLKE: -- have to with incorporating all these  
 17 other ones, and having somebody like myself there, and so  
 18 they're not to the detail of the other performance measures.

19 DR. COOPER: Martha, before you flip the page --

20 MS. GOHLKE: Yes.

21 DR. COOPER: -- what is the difference between  
 22 performance measure seventy-six and performance measure  
 23 seventy-seven?

24 MS. GOHLKE: Seventy-seven is the actual written  
 25 transfer agreement that hospitals have to have on paper, who

1 they're going to transfer to. They have to have a --  
 2 DR. COOPER: Yeah, so -- got you.  
 3 MS. GOHLKE: Okay.  
 4 DR. COOPER: So one -- so, seventy-seven is the piece  
 5 of paper --  
 6 MS. GOHLKE: Piece of paper, and the other one --  
 7 DR. COOPER: -- that documents seventy-six.  
 8 MS. GOHLKE: -- is the procedure and the policy behind  
 9 it.  
 10 DR. COOPER: Got you. Okay.  
 11 MS. GOHLKE: Okay.  
 12 DR. COOPER: Makes perfect sense.  
 13 MS. GOHLKE: We have drafted -- through the transfer  
 14 regionalization subcommittee, we drafted a best guidelines --  
 15 best practices guidelines about what should be included, and how  
 16 you should do transfers, and what should be, you know, included  
 17 in your policy behind your transfer agreements. And we're  
 18 waiting to release that best-practice document once we are able  
 19 to inventory our hospitals and be able to give some guidance on  
 20 where they should transfer, where the resources are in the  
 21 state. So, we're working on that. We have a good skeleton of a  
 22 best-practices document that we will put forward once we have a  
 23 little bit more movement on the pediatric hospital piece.  
 24 DR. COOPER: So to summarize, is it fair to say that we  
 25 are worried about seventy-one; seventy-two we're also worried

1 about but shouldn't be, because we do have the -- the pediatric  
 2 protocols in place. The hurdle is getting some of our E.M.T.s  
 3 to fill out a survey that says they know that there are  
 4 pediatric protocols, right, which seems a little over the top.  
 5 And that in seventy-five, twenty-five percent of all hospitals  
 6 are pediatric trauma centers. Those appear to be the ones that  
 7 are problematic for us, and -- you know, and again, as I say,  
 8 over the top --  
 9 MS. GOHLKE: Uh-huh.  
 10 DR. COOPER: -- in terms of -- in terms of what, as the  
 11 pediatric emergency, you know, medicine and nursing community,  
 12 we should expect or accept.  
 13 MS. GOHLKE: Yeah.  
 14 DR. COOPER: Is that right?  
 15 MS. GOHLKE: Uh-huh. Correct.  
 16 DR. COOPER: Does anybody disagree with that  
 17 assessment?  
 18 (No audible response)  
 19 DR. COOPER: Okay. So, I have the honor to sit on the  
 20 advisory committee for the -- the national E.M.S.C. program, and  
 21 I can assure you I will bring these issues up with them. This  
 22 is -- these points were not explicitly discussed in the recent  
 23 strategic planning process, which did include review of all the  
 24 performance measures. And I don't recall these issues being  
 25 discussed at any point during that process. I did have an

1 opportunity to participate in that process, you know, with the  
 2 exception of a follow-up conference call yesterday. So we'll  
 3 bring that forward.  
 4 Any other questions for Martha on performance measures?  
 5 Bob.  
 6 DR. KANTER: So, from the point of view of the federal  
 7 agency, E.M.S.C., within the H.R.S.A., there are various ways  
 8 that they can provide incentives for states to -- to comply with  
 9 these measures. One of them is reporting -- reporting the  
 10 performance, you know, a report card on all the states. Has  
 11 that been published, yet for the previous version of this  
 12 survey? I haven't seen it.  
 13 MS. GOHLKE: You mean the survey that we did that  
 14 they -- the national numbers that can from that?  
 15 DR. KANTER: Are -- are national numbers available?  
 16 MS. GOHLKE: They are available. I don't -- they're --  
 17 yes, they are.  
 18 DR. KANTER: All right.  
 19 MS. GOHLKE: Yeah. We have -- one of the contractors  
 20 that is contracted by HRSA to help us with our data collection  
 21 is NEDARC, N-E-D-A-R-C, and I'll check their Web site, but I  
 22 think they may have it posted on their Web site, when they  
 23 collect the national data.  
 24 DR. KANTER: I know you've shown us --  
 25 MS. GOHLKE: They --.

1 DR. KANTER: -- New York State data --  
 2 MS. GOHLKE: Yeah.  
 3 DR. KANTER: -- but I don't remember --  
 4 MS. GOHLKE: Yeah.  
 5 DR. KANTER: -- seeing the national --  
 6 MS. GOHLKE: Yeah, they did. Yeah. We -- so, it's  
 7 probably on their Web site and I can get that if you want, and  
 8 we can talk about it at a meeting.  
 9 The twenty-five percent threshold though, for the, you  
 10 know, the trauma centers wasn't there because this is a newer  
 11 edition. So -- but those of us from the larger states, they've  
 12 heard from us and they know that the -- that twenty-five percent  
 13 is unattainable. And -- but having Dr. Cooper's input from his  
 14 end, being on that Committee, would be helpful.  
 15 DR. COOPER: Okay. Other questions for Martha on  
 16 performance measures?  
 17 (No audible response)  
 18 DR. COOPER: Hearing none, Martha, is there anything  
 19 more that you have to report on the E.M.S.C. grant?  
 20 MS. GOHLKE: Nope, I think that's it.  
 21 DR. COOPER: Good. Okay. At this point, I'd like to  
 22 welcome Mr. Matt Leary from the Department, another special  
 23 guest today. Martha and -- or sorry. Matt and Pam, I believe,  
 24 work together.  
 25 Matt, perhaps you could just say a word about your

1 bureau and what you do, and -- and please accept of course our  
2 thanks for your support of our programs. Those of us around  
3 this table can't imagine a more pressing public health priority  
4 than the health and safety of our acutely ill and injured  
5 children. And so, for your support of our -- of our  
6 initiatives, we're deeply grateful.

7 MR. LEARY: Thank you very much. My name's Matthew  
8 Leary, and I'm the director of the Bureau of Health Care  
9 Research and Information Services, within the Division of  
10 Quality and patient Safety, and I am here today to support Pam's  
11 presentation, and find out how that we can help you to work with  
12 data, and crunch numbers, and possibly do some analysis to  
13 support your goals and needs. That's what I'm here for, thanks.

14 So my -- my bureau does I.T. services and number  
15 crunching basically.

16 DR. COOPER: Great. We -- we -- we like both. Thank  
17 you.

18 Okay. Well, there's one more issue that I -- I feel  
19 constrained to raise. It doesn't affect us very often, but as  
20 many of you may know, this past spring, in April, I believe, the  
21 legislature enacted, and the governor approved, the Family  
22 Health Care Decisions Act. The Family Health Care Decisions Act  
23 includes, as you know, provisions that are more explicit than  
24 they have been in the past, regarding the ability of surrogates  
25 to make decisions for patients who are incapacitated in one way

1 or another, and for families, in the absence of a -- of a duly  
2 appointed surrogate, meaning a health proxy, under -- under New  
3 York State Law, to make decisions in the best interest of the --  
4 of the -- the patient. That law was signed, I believe, toward  
5 the end of April.

6 We had a presentation about it at SEMAC in May.  
7 Thank you, Lee, for arranging that.

8 It was kind of last minute, that Lee was able to ask  
9 the division of legal affairs to do that for us, but it was, I  
10 think, very useful. And the law actually became effective June  
11 12 of 2010.

12 So -- so, for those of you who work with your hospital  
13 ethics committees, which now, by the way, are required to exist  
14 under the Family Health Care Decisions Act, and for those of you  
15 that have palliative care teams, this law is a very, very  
16 important law. It's particularly, of course, important for the  
17 parents of children with special healthcare needs, and those who  
18 may be victims of major trauma, or -- or who may have pediatric  
19 malignancies, and you know, have, in effect, terminal illnesses  
20 that require very, very intensive and heroic support at times.  
21 And you know, the issues, of course, regarding withdrawal and  
22 withholding of such care under appropriate circumstances, upon  
23 the advice of ethics committees, is a very important issue. So,  
24 I -- I wanted to make you aware that that law had been -- had  
25 been passed and signed. Of course, as with all new laws of this

1 magnitude - and it is a huge step forward for New York State.  
2 Prior to this time, the law required absolutely clear and  
3 convincing evidence that -- that -- that a patient wished not to  
4 have heroic support continued. And providing that clear  
5 compelling and clear and convincing evidence was often  
6 difficult, to say the least.

7 I'll just informally ask all of you, and you can sort  
8 of whisper in my ear during the lunch hour or something, as to  
9 whether you think it would be appropriate or useful to take the  
10 Committee's time to have a presentation regarding that new law,  
11 here at the next meeting, which may be an electronic meeting, as  
12 you all know. But if you feel it necessary, we can -- we can go  
13 ahead and arrange for that. I think that's the only -- the only  
14 issue that -- that I had arising from these report -- Martha's  
15 report that was not included in those reports.

16 Any further --?

17 MS. BURNS: Also --

18 DR. COOPER: Lee?

19 MS. BURNS: -- just for your own information, the  
20 Family Medical Decisions Act also puts into statute the MOLST  
21 process. In -- as -- prior to that, it was really a pilot  
22 project that had been approved by the Commissioner, and now it's  
23 in statute. So medical orders for life-sustaining treatment,  
24 MOLST, is now a Department -- it's another Department form, but  
25 it's --it's actually in statute.

1 DR. COOPER: Okay. Thank you. Any questions about  
2 that?

3 (No audible response)

4 DR. COOPER: Okay. Well, we're ahead of ourselves, I  
5 think, a little bit. That's wonderful news.

6 MS. GOHLKE: Let's go on to emergency preparedness now.  
7 Bob, will you come up, please?

8 DR. COOPER: Yes, that's what I was going to suggest  
9 that we do.

10 We are again, as I've indicated earlier today, honored  
11 to have with us Deb Sottolano and Dennis White -- Drs. Deb  
12 Sottolano and Dennis White from the Department. Deb, as you  
13 know, is the O.H.S.M. liaison to the -- to the Public Health  
14 Preparedness Program, and Dennis White is the associate director  
15 of that program. And I -- I don't need to indicate to anyone  
16 sitting around this table the intimate and intricate  
17 relationship that exists between disaster medicine and emergency  
18 preparedness on the one hand, and regionalization on the other,  
19 particularly with respect to children.

20 We know, of course, that -- that in the event of major  
21 disasters we can expect a surge in the need for critical-care  
22 capabilities that is three- to fourfold the normal level of --  
23 of activity, at least according to the -- the published data.  
24 There are several national efforts that are looking at this  
25 issue. Probably the most important one has been funded by the

1 Centers for Disease Control and Prevention. And Bob Kanter is  
2 one of the authors of the -- the special supplement to pediatric  
3 critical care medicine that will be published shortly, dealing  
4 with some of these issues.

5 In addition, of course, as you know the New York City  
6 group had an opportunity over the past few years to develop  
7 hospital resources for children in disasters, and off-the-shelf  
8 pediatric tabletop drills, to assist hospitals in preparing for  
9 pediatric disasters. The former has been, if you will, adopted  
10 by the State Health Department, and broadened to -- to focus on  
11 obstetric care as well as -- as well as pediatric care. And at  
12 the present time the New York City group has been focusing on,  
13 through its New York City Department-of-Health-funded pediatric  
14 disaster coalition, the development of a series of in-depth  
15 recommendations to be added to the -- to the citywide disaster  
16 plan, known as CIMS, the city emergency management system -- or  
17 city incident management system, excuse me.

18 The -- there -- there is as yet no explicit plan for  
19 regions outside of New York City to make sure that kids get to  
20 the appropriate places in the event of -- of major disasters,  
21 but again, to circle back to where I began these remarks, it is  
22 crystal clear that --that the need for pediatric critical care  
23 services, broadly defined to include sophisticated pediatric  
24 emergency and trauma care, is anywhere from three- to fourfold  
25 the normal magnitude. Whereas critical care beds statewide,

1 generally speaking are -- are at a minimum eighty percent full  
2 at all times.

3 That means that there is a very large gap between  
4 the -- the actual critical care beds that may be available at  
5 any moment in time, and the --and the pediatric patients that  
6 may need to be accommodated in -- in the event of a major  
7 disaster.

8 And this is what Bob, myself, and many other  
9 colleagues, nationwide, to focus on, you know, issues of mass  
10 critical care and pediatrics, with really a clear understanding  
11 that a statutory underpinning for such mass critical care  
12 decisions exists neither for adults nor -- nor for children, yet  
13 at the same time we will be called upon to manage these patients  
14 under less than optimal conditions.

15 Part of this discussion entails extensive discussions  
16 with the New York State Task Force on Life and the Law, headed  
17 by Beth Roxland, an attorney with a master's degree in  
18 bioethics, building upon the outstanding work done by Tia  
19 Powell, her predecessor in that role, who spearheaded the -- the  
20 development of a white paper on allocation of ventilators in the  
21 event of a pandemic influenza epidemic in the adult world.

22 A task force met last fall under the aegis of the Task  
23 Force on Life and the Law, focusing on pediatric issues, that --  
24 the intention is for the Task Force on Life and the Law to write  
25 a pediatric ventilator addendum to the -- to the original white

1 paper, and for all at some point in the relatively near future,  
2 God knows when, to be published.

3 But the bottom line is that there are a lot -- there's  
4 a lot of work going on with respect to emergency preparedness at  
5 a national, state, and regional level, and we, as pediatric  
6 providers, are in the thick of it. Over the summer, we've had  
7 quite a few discussions internally, and informally among members  
8 of the -- of the Committee and -- and Departmental leadership,  
9 about where we need to go. The -- I think the issues that were  
10 highlighted by --by -- by the earthquake in Haiti earlier this  
11 year, could not make it clearer that -- that the needs of  
12 children need to be front and center in the consideration of --  
13 of public health planning for major disasters, since, as you all  
14 are aware, depending upon the actual locale, as many of fifty  
15 percent of the patients encountered were children. And of  
16 course, the --the resources prepared for children are focused,  
17 geographically and economically, in most parts of the world, if  
18 they exist at all. And that is also true here in New York  
19 State.

20 So, to that end we felt that it was very important that  
21 this Committee begin to take as its next major project, and  
22 in -- and in conjunction with the regionalization project, you  
23 know, a very close look at the pediatric disaster needs in -- in  
24 New York State. Because again, you know, it's a system. It's  
25 not the I.C.U.s; it's not the trauma centers. It's -- it's the

1 entire system. And unlike many, many committees, our committee  
2 represents an entire system. We have parents, we have, you  
3 know, school nurses, we have hospital providers, we have urgent  
4 care providers, you know, and -- and of course, critical care  
5 and emergency nursing colleagues, as well as prehospital  
6 providers, all of whom are involved in the -- in the care of --  
7 of children, and will be deeply involved in it in the event of a  
8 disaster.

9 So, with that sort of introduction, all of you who are  
10 regular members of the Committee know this, you know, by heart,  
11 but for some of our guests today, I felt it was important to  
12 spell out why we are so interested in this, why it's such a  
13 critical issue for us, and you know, at this point I'm going to  
14 ask Bob Kanter if he would go ahead and speak about some of the  
15 work that he's been doing in this regard.

16 DR. KANTER: Great. Thanks, Art.

17 Well, you know that emergency preparedness involves an  
18 incredible spectrum of different issues, but the one project  
19 that I want to talk to you about involves critical care in very  
20 large public health emergencies. And you know, there are some  
21 patients in -- whether it's a sudden-impact event, a  
22 mass-casualty situation with traumatic injuries, or a much more  
23 sustained crisis, a pandemic or something like that, there are  
24 many patients whose survival depends on immediate access to  
25 resuscitation in the field, resuscitation continuing in the

1 emergency department setting, and then continuing on to either  
 2 surgical care and then intensive care. And if you look at  
 3 the -- our historical experience in the last ten years or so,  
 4 we've had some very terrible crises. The -- the 9/11 attacks,  
 5 Hurricane Katrina, the H1N1 and SARS outbreaks, but the fact is,  
 6 even with those very difficult events, there's really never been  
 7 an event in North America that completely overwhelmed  
 8 intensive-care services.

9 Now, Hurricane Katrina completely overwhelmed the  
 10 entire city of New Orleans, but that wasn't an intensive-care  
 11 problem, that was a mass-evacuation problem. And although  
 12 that's -- the -- the good news is that we have never faced an  
 13 overwhelming problem that completely exceeded our capacity to  
 14 provide intensive care. It's pretty easy to imagine scenarios  
 15 where events would exceed our capacity. And indeed, federal  
 16 planners, particularly the scenarios from the Department of  
 17 Homeland Security, have outlined plausible scenarios where  
 18 intensive-care resources would be exhausted. And in order to  
 19 deal with those kinds of concerns, there has been an effort by  
 20 critical-care professionals internationally, to begin thinking  
 21 about how to extend our existing resources to provide care to  
 22 much larger numbers of patients.

23 Many of you may be familiar with the symposium that was  
 24 published in the journal "Chest" in 2008, which outlines a  
 25 general approach to extending critical-care resources. And the

1 focus of that task force was on adults, and they acknowledged  
 2 that they didn't have much pediatric expertise, and recommended  
 3 that pediatric issues be taken up immediately. The approach,  
 4 the mass-critical-care approach attempts to organize existing  
 5 resources so that you could, on very short notice, triple the  
 6 capacity of every I.C.U. and provide essential life-saving  
 7 interventions for up to ten days in a very large public health  
 8 emergency.

9 And you would attempt to accomplish that by focusing  
 10 all your staff and resources specifically on immediately  
 11 life-saving interventions, and delaying or even foregoing other  
 12 aspects of care that we consider ordinary and routine on a daily  
 13 basis, but which would not be possible to provide in -- in this  
 14 sort of a mass-critical-care situation. And your standards of  
 15 care would shift from trying to maximize the survival of every  
 16 individual, and would shift to aim to optimize population  
 17 outcomes, so that you would try to allocate your resources to  
 18 those patients, and for those aspects of care, that are going to  
 19 maximize population outcomes.

20 And you would do this by substituting or adapting  
 21 whatever resources you have. Instead of nearly equivalent  
 22 resources that you don't have, you'd conserve resources, you'd  
 23 reuse things that are not ordinary reused, and -- and you would  
 24 do this with perhaps modest increases in stockpiles beyond what  
 25 we have now, particularly the -- the one item that needs to be

1 stockpiled above and beyond current resources is probably  
 2 mechanical ventilators. But you'd be using existing staff and  
 3 most of the other supplies in a hospital which can't be expanded  
 4 enormously, but you'd be extensively reorganizing how you do  
 5 this. And while all the authorities who have been thinking  
 6 about this acknowledge that there's absolutely no evidence and  
 7 no precedent for this, if we don't start thinking about it,  
 8 we're guaranteed to fail in a very large public health  
 9 emergency.

10 So, as public health emergency managers are starting to  
 11 think about this issue, it's crucial that we begin planning how  
 12 to include the pediatric implications in these developing plans.  
 13 So, this work is a -- has been carried out, over the past year  
 14 and a half or so, by a task force of pediatric experts advising  
 15 the Centers for Disease Control about how you would adapt these  
 16 general ideas for mass critical care to pediatrics.

17 And I can just give you a quick rundown of some of the  
 18 essential recommendations.

19 Number one: Every hospital that has a pediatric  
 20 I.C.U., or a neonatal I.C.U., should plan and prepare to provide  
 21 mass critical care in coordination with regional planning  
 22 efforts. And specially, we're going to aim to at least triple  
 23 our I.C.U. capacity temporarily, for at least ten days, and  
 24 provide essential life-saving interventions, which include  
 25 mechanical ventilation, I.V. fluid resuscitation, basal pressor

1 administration, antidotes and any microbial agents for specific  
 2 diseases, sedation and analgesia. And our plans to do this  
 3 should be graded in relation to varying size events, with clear  
 4 indications of triggers that would initiate different levels of  
 5 responses. And of course, all of this -- all of these ideas  
 6 about mass critical care would be only considered in --in very  
 7 large public health emergencies. These are not things you  
 8 consider doing when your hospital's a little short on staff for  
 9 the weekend. It's specifically for major public health  
 10 emergencies.

11 The pediatric committee completely endorses the idea  
 12 promoted by the adult general committee or task force, that you  
 13 need one ventilator for every patient, so you basically need to  
 14 have ventilators for triple your normal number of I.C.U.  
 15 patients. And that may involve adapting ventilators that  
 16 wouldn't ordinarily be used for patients in the I.C.U., whether  
 17 it's noninvasive ventilators, which you may only occasionally be  
 18 using in -- in -- in the I.C.U., BIPAP machines and such,  
 19 potentially anesthesia ventilators, whole -- transport  
 20 ventilators, a variety of alternatives.

21 The task force is promoting the idea that you would be  
 22 adapting alterations in how medications are used, what drugs  
 23 could be appropriately substituted for another, what would be  
 24 appropriate dose reductions to still get an adequate effect,  
 25 what rules would apply to restrict medications that were needed

1 for some patients, but optional for others, to conserve those  
2 drugs; shelf-life extension, things like that.

3 The other very important part of this is the  
4 preparation for pediatric care in nonpediatric hospitals. And  
5 there's quite a lot of information been reviewed by the task  
6 force about this. And I should mention at this point that New  
7 York State, I think, is way ahead of other states in having  
8 considered preparing for hospital care of children in  
9 emergencies, and this Committee has -- is well aware of the tool  
10 kit for hospital preparedness to help nonpediatric hospitals  
11 upgrade their ability to respond to emergency care of children.  
12 And I -- I think the intent of this national task force is that  
13 every state begin working along these lines, to improve the  
14 ability of all hospitals to take care of children in a crisis.

15 So, one of the things I'm hoping we might be able to  
16 accomplish today, very concretely, very short term, is start  
17 talking about how we on this Committee, and how we, in some of  
18 our own local efforts, can begin promoting the New York City and  
19 New York State toolkits that are already available, and maybe  
20 get some advice from some of the guests who are here today about  
21 how -- about what resources might be available. And I know  
22 resources are scare these days, but what resources -- what  
23 advice they have about trying to implement some of these  
24 preparations for pediatric preparedness in nonpediatric  
25 hospitals.

1 That's the quick overview of it.

2 DR. COOPER: Okay. Thank you, Bob. It will be my task  
3 for the next few minutes now to describe what we've been doing  
4 in New York City.

5 Now, as many of you know, New York City is often  
6 referred to as the country of New York, and is often treated by  
7 federal agencies, if you will, for programmatic purposes, as its  
8 own state or region. That does happen to be the case here for  
9 disaster preparedness activities. The New York City Department  
10 of Health, a couple of other major metropolitan areas, Los  
11 Angeles and Chicago, I think, certainly Los Angeles, perhaps not  
12 Chicago, have sort of been accorded that same status and given  
13 opportunities to apply independently of their states for federal  
14 funding to support disaster preparedness initiatives.

15 The New York City Department of Health and Mental  
16 Hygiene, first under Tom Frieden and Deb Berg, and more recently  
17 under Tom Farley and Isaac Weisfuse, Kate Uranek has done an  
18 outstanding job as the program officer, as has Lew Soloff on the  
19 burn side, with whom we've worked very, very closely, really as  
20 long ago as five years ago, recognized the need for regional  
21 planning for disasters.

22 As I indicated a moment or two ago, the -- the hospital  
23 disaster toolkit, and the off-the-shelf pediatric tabletop  
24 exercise were the grant products that were initially put  
25 together, based upon a pediatric work group for the Centers for

1 Bioterrorism Preparedness Planning. It was vetted through a  
2 larger pediatric disaster advisory group to the Health  
3 Department. The toolkit is now actually in its third edition  
4 and was published in hard copy this past year, in addition to  
5 being freely available via the Web, as you all know, and you  
6 have been provided with that Web address in the past. We can  
7 provide it again in the future if you need it.

8 Simultaneously, New York -- the New York City  
9 Department of Health and Mental Hygiene are working together  
10 with the group at New York Presbyterian Hospital, headed by  
11 Roger Yurt and Elliot Lazar, have put together a regional burn  
12 plan, recognizing of course that with respect to severe burns,  
13 which as you all know, accompany severe blast in the main, there  
14 are capacity to care for severely burned patients, including  
15 children, is extremely limited given that there are only  
16 eighteen hundred burn beds in the entire nation. And of course,  
17 New York's capacity is -- is in the range of about a hundred and  
18 fifty to two hundred beds overall, out of that -- out of that  
19 total, and that's stretching it a bit.

20 So, the burn plan got down to specific regional  
21 planning a little sooner than the pediatric group did, because  
22 the pediatric group was focusing chiefly on these resources  
23 first. But over the last two years, and now entering a third  
24 year, a formal pediatric disaster coalition, headed by Mike  
25 Frogle (phonetic spelling) who's director of general pedes at

1 the Schneider Children's Hospital, now known as the Cohen  
2 Children's Hospital of the North Shore L.I.J. system, and  
3 assisted by George Fulton of Bellevue as the co-P.I., have led  
4 a pediatric disaster coalition constituted broadly of a number  
5 of pediatric experts throughout New York City, to address  
6 systemwide planning that will accomplish the tasks of providing  
7 not only mass critical care, but also a system to identify  
8 children in need of mass critical care, and a system to get them  
9 there in a timely and efficient manner.

10 I'm pleased to say that we've made some enormous  
11 progress on all fronts. The Committee's work was divided into  
12 two primary thrusts, one focusing on triage. I had the  
13 opportunity to chair that group. And another focusing on surge,  
14 and Mayer Sagy, the former chair of pediatric critical care  
15 medicine at Cohen, has chaired that group. Mayer is now some  
16 sort of vice presidential capacity for that health system, in  
17 terms of planning and so on.

18 And the -- the short of it is -- is this. We've  
19 identified a -- and -- and together with our colleagues from the  
20 office of medical affairs at the Fire Department of the City of  
21 New York, who have really played an enormously productive role  
22 in terms of working through these issues, you know, a modified  
23 START triage system that -- that includes special provisions  
24 for -- for children in the following ways:

25 First: The provision of five rescue breaths rather

1 than simple airway opening prior to declaring pediatric patients  
2 unsalvageable, given, of course, as you all realize, the greater  
3 proclivity for respiratory failure and arrest in children.

4 And second: The recognition of infants under the age  
5 of twelve, due to the relative -- relative lack of experience of  
6 our prehospital providers in assessing them, you know, their  
7 identification in an -- in an immediate or red category, in the  
8 event of any kind of major disaster.

9 This program has been approved at the regional level,  
10 as well as by the State Emergency Medical Advisory Committee,  
11 and the SEMSCO and -- and you know, we -- is that true? The  
12 SEMAC voted on it for sure.

13 MS. BURNS: I -- I -- it -- they talked about it, but I  
14 don't think they did a final approval. I have to look.

15 DR. COOPER: That's not my recollection. My  
16 recollection is that they did, but -- but in any event, it  
17 has -- we'll have to check on that, but it certainly has been  
18 taught to New York City's E.M.S. providers.

19 Ann Fitton would know how many. I think we're just  
20 about all the way there at this point, Ann or not yet?

21 MS. FITTON: Well, the drills have been ongoing for  
22 about the last six months, and I believe that a good percentage  
23 of the thirty-two hundred prehospital care providers have  
24 received this, although I don't have any hard facts on that.

25 DR. COOPER: Okay. Yeah, according to Dario Gonzalez,

1 who has been the -- sort of the --the member of the O.M.A.  
2 staff, office of medical affairs staff, that has spearheaded  
3 disaster planning efforts, at least as of last spring, it was in  
4 the -- the several-hundred range of people who had been -- who  
5 had been trained, so beyond that I don't have any up-to-date  
6 information either. I -- surely everyone in the city believes  
7 that this has been approved at a state level, that -- that -- of  
8 there is no question.

9 But that system has been developed, has been taught.  
10 And so the -- the intention is for prehospital providers to  
11 either -- who are working for the fire department directly, or  
12 who are under contract to the fire department, to transport  
13 pediatric patients, when -- whenever possible, to appropriate  
14 pediatric facilities. And that constitutes a second ring or --  
15 or tier of activity, identification of the actual pediatric  
16 resources that hospitals in New York City can bring to bear with  
17 respect to pediatric issues. A spreadsheet exists that was  
18 prepared and finalized last spring. And our task this year is  
19 to contact each of the hospital C.E.O.s for their official  
20 confirmation that their hospital can provide these services in  
21 the event of a -- of a major disaster.

22 And of course, the third major component has to do with  
23 a system for secondary transport, so that kids who end up in the  
24 wrong place, either because they're brought there by a -- by  
25 well-meaning bystanders, parents, et cetera, or because they

1 deteriorate en route to a hospital that -- that was initially  
2 felt to be capable of caring for them, but their condition has  
3 now worsened, to have a system that allows these kids to be  
4 identified, prioritized, and transported to hospitals with  
5 P.I.C.U. capabilities on a secondary basis.

6 So, all these projects have been -- have been worked  
7 on, and plans have been developed on a pretty explicit basis in  
8 really a -- with the intention of following very explicitly the  
9 model that the burn system has already developed. For example,  
10 the -- the burn plan has what's called a virtual burn  
11 consultation center, whereby burn experts assist hospitals that  
12 receive burn patients, you know, in prioritizing which patients  
13 need to be transported to the burn centers first, if they end up  
14 not going to a burn center in the first place. Their -- the  
15 plan is to have an analogous virtual pediatric consultation  
16 center that makes the same kind of decisions.

17 Fortunately we're in -- we're in much better shape  
18 in -- in pediatrics, because -- you know, because of the fact  
19 that the pediatric resources are more available than are burn  
20 center resources. But once again, pediatric issues are very  
21 quirky. And to cite the example frequently -- frequently  
22 mentioned by my colleague George Fulton from Bellevue Hospital,  
23 we all remember that on -- or about a month after September  
24 11th, 2001, I believe it was on Veteran's Day as a matter of  
25 fact, a plane went down in the Rockaways, and it landed one

1 block from a public elementary school.

2 Now, what if it had been a Monday instead of the  
3 Tuesday that was Veteran's Day, and the plane had landed on the  
4 school instead of one block away? You know, in that  
5 circumstance, particularly in the Rockaways, which is a very  
6 remote part of New York City, not as the crow flies, but as the  
7 bus drives, you know, there's only one way to get out there from  
8 the city proper, and that's over a very narrow land bridge  
9 and -- an actual bridge. You know, what would have happened had  
10 we suddenly had the need to care for all these kids, you know,  
11 and provide critical care services to them? And that's not a  
12 far-fetched example, as you can see.

13 So -- so, even though our pediatric resources are more  
14 robust, okay, and in -- and -- and actually pretty well tend to  
15 be located reasonably close to where the kids are, okay, if you  
16 plot out population density versus pediatric resources, and  
17 public school density versus pediatric resources, there's not a  
18 bad match. Clearly there's more resources in Manhattan, but  
19 still, you know, overall there's not a bad match. You know,  
20 we're not in -- we're not in bad shape to be able to accomplish  
21 the -- the task of surging up. But -- but going from, you know,  
22 to three times your normal surge capability, anticipating, you  
23 know, that you'll be able to provide full critical care  
24 services, turns out to be, you know, a nearly impossible task  
25 to -- you know, to manage. You know fortunately, as Dr. Kanter

1 has pointed out, the intent is to triple mass critical care  
2 capability, rather than, you know, the -- the normal high-end  
3 optimal level of I.C.U. care that we normally provide. And  
4 this -- this has been taken into consideration.

5 Which leads me to segue into the work of Dr. Sagy and  
6 his subcommittee, which has really developed very, very  
7 extensive plans for individual hospitals to surge up to -- to  
8 levels that are two or three times the normal expected, you  
9 know, level of I.C.U. care that's provided in that facility.  
10 Five plans have been submitted and vetted to date. This year,  
11 during the third year of the grant, it's the expectation that  
12 ten to fifteen more of our hospitals will -- of our  
13 pediatric-capable hospitals will submit and have their -- have  
14 their surge plans vetted and developed.

15 But these are all very, very complicated issues, and  
16 they require, you know, a tremendous degree of advance planning.  
17 I think as Dr. Kanter has indicated, New York City is way ahead  
18 of many, many other areas in the nation, and certainly in the  
19 state in terms of this level of planning, but -- but you know,  
20 as we all know, there have been examples in New York State of  
21 this sort of thing happening. We all think of the -- of the --  
22 of the school back in the late '90s that was hit by the tornado.  
23 And the roof blew off and several kill -- children were killed.  
24 And you know, the resources to get them to Westchester Medical  
25 Center, which was the closest I.C.U. in the -- in those -- in

1 those days, they were -- they were pretty -- they were pretty  
2 complicated. And we need to have a much better plan state --  
3 statewide to accomplish that.

4 Now, so that will give you a flavor on what has been  
5 accomplished in New York City, and what -- what are the barriers  
6 to accomplishing that. We all know what the barriers are.

7 First of all, we don't have an official system for  
8 regionalization in New York State. It has not yet been  
9 formalized. The Commissioner, fortunately, and we are -- we are  
10 deeply thankful to Dr. Daines for his sponsorship of the  
11 stakeholder conference that took place last May. We need -- we  
12 need to formalize that system so that there is statutory and  
13 regulatory authority to get pediatric patients to the right  
14 places at the right time for the right care, in conformance with  
15 our national E.M.S.C. slogan, motto, and approach.

16 Second: We need to have that statewide plan. It's  
17 great that New York City has one, and we have the -- we have the  
18 most -- or the greatest concentration of children, of course, in  
19 the state, but --but the state needs a plan as well, as the  
20 Newburgh situation points out, as the -- some of the Buffalo  
21 anthrax situations point out, as some of the North Country ice  
22 storms point out. You know there's no question that --that New  
23 York City is not the only trouble spot, you know, with respect  
24 to children's disasters statewide.

25 Third: There still exists, Dennis and Deb, no

1 statutory authority for crisis standards of care. And this is a  
2 huge stumbling block. Even if people are credentialed, and --  
3 you know, and relieved of liability, you know, in the event  
4 of -- of disaster, you know, if the -- if -- if they are held to  
5 a standard that insists that the same level of care be provided,  
6 you know, in a disaster that's provided every day, you know,  
7 well, what do you think they're going to do, you know? And what  
8 choice will they have.

9 And what does that do to our triage systems? You know,  
10 where -- where -- you know, where we have the first-come,  
11 first-serve-ventilator, you know, allocation program at the  
12 present time. I.e., there is no -- there is no  
13 ventilator-allocation program. You know?

14 And last, but not least, okay, where are we in terms of  
15 the statutory relief from -- you know, from liability? We are  
16 just now getting to a point where, with the federal ESAR-VIP  
17 programs, and the Serve New York programs, we're just getting to  
18 a point where we can begin to get a reasonably robust list of --  
19 of providers statewide who can -- who can care for patients in  
20 disasters.

21 But you know, there are all kinds of obstacles that  
22 still need to be -- need to be jumped over. Most -- most  
23 important of which are standards-of-practice issues; you know?  
24 E.M.T.s and paramedics, particularly paramedics, being able to  
25 give, you know, immunizations in the event of a pandemic. You

1 fifty-eight, and that lunch is sitting across the way, so I'm  
2 going to -- I'm going to break the discussion at this point, ask  
3 everybody to get a plate, take about five or ten minutes to do  
4 that, and we'll continue with a working lunch, as is our custom.

5 And -- and I don't mean to put you on the spot, but I  
6 guess I do, Deb and Dennis, we'll ask you to respond to some of  
7 these issues, and -- and you know, not in any kind of way other  
8 than a collaborative way, and -- and get your advice as to how  
9 we all together can get some of these -- these problems bridged.  
10 And you know, what level of support, you know, your office is  
11 prepared to provide, particularly to be very brutally frank, at  
12 a time when the Department has been decimated by early  
13 retirements, and will be further decimated by a change of  
14 administrations.

15 How can we get the work done that we need to get done,  
16 and get it done timely? Because we just can't wait any longer.

17 Thanks. So we'll stand recessed for -- why don't we  
18 say one fifteen; okay?

19 (Off-the-record discussion)

20 DR. COOPER: Okay. We're five minutes over our  
21 anticipated start time, but that -- that -- hope that gave  
22 everybody a little more digestion time here. We still have  
23 quite a bit of work to get done today, so we're going to move  
24 right into it.

25 I do note that there's still plenty of -- of victuals

1 over there that -- that since this is our last meal, perhaps  
2 we -- we should, you know, eat a little more than usual, and  
3 make sure that -- make sure that we're well fortified for our  
4 next meeting.

5 FROM THE FLOOR: Can we save the leftovers for the next  
6 meeting?

7 DR. COOPER: Absolutely.

8 FROM THE FLOOR: You're going to need them. We really  
9 don't want you to starve to death.

10 DR. COOPER: So, we're now -- we'll go officially back  
11 on the record, and we'd like to, at this point, before we  
12 actually ask from -- for a response from our colleagues from  
13 Emergency Preparedness, I'd just like to ask if there are any  
14 questions either for me or for Dr. Kanter.

15 (No audible response)

16 DR. COOPER: Hearing none, I'd like to ask Dr. -- Drs.  
17 Sottolano and White if they have a word for us as to how we  
18 might proceed, recognizing, again, that time is of the essence.

19 DR. WHITE: I thank you for the fifteen minutes to get  
20 my thoughts together. And again, having -- having now been part  
21 of the Department for thirty-four years in a different area, and  
22 with this program only for ten months, I -- I would hate to be  
23 your -- your vision of the recalcitrant Department and the  
24 regulations and things that need to be done, that haven't been  
25 done yet. But having now joined the program and having the

1 experience of working with some other models that I think --  
2 are starting to work, I -- I'm encouraged with the questions,  
3 and certainly take to heart the issues that you brought up just  
4 prior to lunch.

5 In -- in the -- in the projects that I've been working  
6 on, again most of you probably have heard of ESAR-VIP, the Serve  
7 New York program is New York State's part of that program on a  
8 national basis, and has just this past week, I think, signed up  
9 our five thousandth volunteer. We have a tremendous database of  
10 individuals who now can contribute to this Serve New York  
11 process. Those who have indicated an interest on the Serve New  
12 York registration page, there's another part of that that takes  
13 it one step higher, as to those who have expressed an interest  
14 to be a state medical emergency response team member.

15 So, one of the processes that we've developed over the  
16 last four or five months is this formal request for  
17 applications. It will be announced imminently, to develop a  
18 state medical emergency response team by whoever is the lucky  
19 applicant that puts together the right package.

20 Both of those processes, and now the burn plan, have  
21 led to this hierarchical system in the health department, I  
22 suppose, where the State Office of Emergency -- Health Emergency  
23 Preparedness is developing a -- what they're referring to as a  
24 C.E.M.P., the comprehensive emergency management plan. That  
25 comprehensive emergency management plan will be something on the

1 shelf, and you know, probably the value of plans on the shelf.  
2 But it will be the foundation through which many of these  
3 activities will be based.

4 And let's take the burn plan in New York City, for  
5 example. New York City has done a tremendous amount of work  
6 over the last two to three years in developing a plan within New  
7 York City that allows for the production or creation of adequate  
8 numbers of burn beds in the event of a crisis. There are  
9 currently, as Dr. Cooper mentioned, roughly a hundred and -- a  
10 hundred and twenty, hundred and thirty, depending on who's  
11 counting, burn beds, that exist as burn beds, in the city.  
12 H.H.S. is looking at the -- the need for up to a thousand burn  
13 beds in the state. We need six hundred burn beds in Upstate New  
14 York; we need four hundred beds in New York City, to be  
15 compliant with the H.H.S. standards. And there is a process  
16 underway to identify those beds: Train the people in the  
17 facilities to handle the burn patients, and look at the triage  
18 transportation and training issues entirely.

19 When a disaster is declared, and that comprehensive  
20 emergency management plan has been vetted through the  
21 Department, signed, approved, and stamped, any of the plans that  
22 are part of that plan will, in fact, cover the individuals under  
23 the Public Officer's Law 17, P.O.L. 17, that provides the  
24 liability issues that you're looking for. We have a number of  
25 individuals in the Department that probably could speak to this

1 far better than I, especially from our legal affairs group, and  
2 that may be, in fact, someone you might want to invite next time  
3 around, to give you an update on how that is all taking place on  
4 the legal side.

5 But through the Serve New York volunteer process, the  
6 SMERT, S-M-E-R-T, state management -- state medical emergency  
7 management -- excuse me, state medical emergency response team  
8 process, and now most recently the burn plan, and what looks  
9 logically is the -- the pediatric plan, or whatever else may  
10 come down as far as emergency response, disaster preparedness,  
11 and planning to respond to those disasters. It should be part  
12 of -- formally part of the -- the state's comprehensive  
13 emergency management -- emergency management plan.

14 So, there has been decisions already that those  
15 plans -- the New York City plan, for example, will be an  
16 appendix to the state burn plan, which will be an annex to the  
17 comprehensive emergency management plan. So, it's -- there's a  
18 whole series of things that are taking place, but the bottom  
19 line is that when these -- when the state plan is finished, the  
20 liability and the protection and the so-called crisis standards  
21 of care will be, in fact, covered, and -- and under the  
22 declaration of an emergency, that disaster should be covered.

23 I would suggest that perhaps -- and I know you  
24 mentioned the next meeting may be a teleconference, either that  
25 meeting or the following meeting, I would -- I would -- I have

1 some names that I think you might want to consider, from our  
2 legal affairs office that would --

3 DR. COOPER: Great.

4 DR. WHITE: -- address that specifically.

5 But from the Office of Health Emergency Preparedness, I  
6 believe the process of the development of that comprehensive  
7 plan will fill every requirement that you're asking for. Time,  
8 I can't answer. How much time it will take to get there? I  
9 can't answer. But clearly, we have a model, through the burn  
10 plan, that will at least start that process, and through the  
11 Serve New York plan. By embodying the -- now the pediatric  
12 surge care plan in that process, and perhaps we need -- we need  
13 to formalize that -- that linkage, I think may in fact, answer  
14 your question.

15 I'm not answering from O.H.S.M. site, that may have, in  
16 fact, other responses, but I think we have at least a process of  
17 addressing it.

18 DR. COOPER: Well, that's great news. I will have one  
19 comment to make about your remarks, and then I would like to ask  
20 Deb if she would comment as well for the O.H.S.M. side,  
21 specifically, really with respect to how the Department can help  
22 us, if you will, marry the issues of regionalization and  
23 disaster preparedness, because they are completely intimately  
24 linked, to really move this forward as quickly as possible.

25 The question for -- for you, Dennis is this: All of

1 these systems are going to depend upon either gubernatorial or  
2 commission -- you know, commissioner-level, or county-level, you  
3 know, county-executive-level disaster declarations. The problem  
4 is that these declarations are -- often are not made until  
5 several hours, sometimes even a few days into a disaster event.  
6 And we all know that -- that the -- the tough decisions that  
7 have to be made, with respect to crisis standards of care, must  
8 be made, really, within the first six to twelve hours, typically  
9 long before a formal declaration is made. So theoretically,  
10 providers who are acting in good faith prior to the moment that  
11 disaster declaration is made, would not be fair game for -- you  
12 know, for those who, you know, were seeking to make hay while  
13 the sun was no longer shining, so to speak.

14 And how is the, you know, the -- the plan that, you  
15 know, your division is contemplating, going to address this  
16 extremely important, you know, time gap, and the activities that  
17 would constitute the major decisions that need to be made, with  
18 respect to triage, crisis standards, and so on, prior to the  
19 moment of the formal declaration?

20 DR. WHITE: That's all excellent points. I wish I had  
21 brought my other folder, but it's currently holding some of the  
22 current burn-plan issues.

23 Some of you may have seen this, but I believe there was  
24 a memorandum signed last July that addresses the fact that a  
25 provider acting upon good medical faith and care will, in fact,

1 be covered under those conditions and I need to find that. I --  
2 I -- I will allude to it now. I've seen it. I had it on my  
3 desk probably three days ago, but I didn't put it in this  
4 folder. So, I -- I will promise you to at least deliver a copy  
5 of that to you --

6 DR. COOPER: Thank you very much --

7 DR. WHITE: -- and we'll -- and we'll start from there.

8 DR. COOPER: -- for your help. Thank you.

9 DR. KANTER: You -- you know, the -- the problem is  
10 that in -- in -- in those general terms I think we can be  
11 somewhat reassured, but on the other hand, if your choices are  
12 to provide ordinary care to all the people that we can get to,  
13 and then there are some left over who we can't get to, that --  
14 that's -- that's not ordinary standards, by -- by any  
15 consideration.

16 DR. COOPER: Right.

17 DR. KANTER: Or we make the explicit choice to survey  
18 all the patients' needs, and decide that some of these patients  
19 aren't going to benefit from anything I do except pain medicine,  
20 and I'm going to try to optimize the population outcomes by  
21 allocating my resources in an unusual way. It's not clear that  
22 those very abstract liability protections really help the  
23 clinician.

24 DR. WHITE: Well, again, I don't know to the extent I  
25 can answer your questions as you wish, but I -- I did include

1 specific language in the burn plan that addresses that something  
 2 like the best available care for the greatest number of people.  
 3 So -- it's the -- the best care for the greatest good. You've  
 4 referred to it as the population care. I think it's the same  
 5 concept. It's just a matter of, again, getting it into a form  
 6 that's approved, and clearly, the role that SEMAC and STAC and  
 7 all the Commissioner's advisory committees, will play a  
 8 significant role in moving these things forward. So I think  
 9 it -- it -- it really will be a universal approach with a lot of  
 10 good smart people to make sure that the -- the Commissioner and  
 11 governor, at some point between now and the key time when this  
 12 is all approved, this moves forward and addresses those specific  
 13 needs.

14 DR. COOPER: Dennis, can -- can -- can you -- I realize  
 15 that you're not a legal scholar here, but can you say just a bit  
 16 more about Public Officer Law 17, and in terms of your  
 17 understanding of the liability protection that it currently  
 18 provides in the event of a declared disaster?

19 DR. WHITE: Yes, thank you. Again, I -- I'm not an  
 20 attorney, and I'm not a physician; I kind of just play one in  
 21 the army, but in -- in case of -- in -- in the -- a provider who  
 22 is acting in -- as an agent of the state, that's the importance  
 23 of having a state declaration of a disaster, and systems in  
 24 which the -- the providers are responding, that if -- if the  
 25 provider is, in fact, acting as an agent of the state as a

1 volunteer, and again, that -- that -- there's some significant  
 2 issues that I -- I really wish that it gets --

3 DR. COOPER: We will.

4 DR. WHITE: -- you get direct interpretation from an  
 5 attorney. But under those conditions the -- the issues of  
 6 liability, and trying to address what has been termed crisis  
 7 standards of care, are, in fact, protecting the individual  
 8 providing that care.

9 DR. COOPER: And there is a -- that is already on the  
 10 books; correct?

11 DR. WHITE: Yes.

12 DR. COOPER: So, it is not anticipated at this time  
 13 that the plan, the comprehensive emergency management plan that  
 14 you're developing, will need to go forward for some kind of  
 15 statutory approval?

16 DR. WHITE: Actually no, not statutory. It's just a  
 17 departmental approval of the plan. Once the plan is approved by  
 18 the Department, it's -- it's a fact.

19 DR. COOPER: Clearly an important piece.

20 DR. WHITE: Yes.

21 DR. COOPER: Deb?

22 DR. SOTTOLANO: Okay. I guess my -- I've kind of been  
 23 just a volunteer for a few weeks, so I'm just kind of getting  
 24 started in this process, but I do think that, as far as  
 25 regionalization, and even just the issues you raised that in the

1 public health preparedness grant, the hospital side of the  
 2 grant, I don't think there has been a lot of focus at all on  
 3 the -- on the special needs for pediatric disasters. I know  
 4 that many of our partners in the R.R.C.s have -- have been  
 5 asking and raising this as a need.

6 Just to give you a little information about the grant  
 7 itself, it -- we are in the third year now, approach -- going  
 8 into the third year of a three-year cycle on our grant  
 9 deliverables. And what we have are some basic standards that we  
 10 have to meet, deliverables that we have to meet as a state. And  
 11 then we implement those through the R.R.C.s, and the -- and the  
 12 grantee hospitals. So, we have got -- are working through those  
 13 deliverables.

14 Now, one of them is the burn, and as Dennis had said,  
 15 is a -- as a good kind of a model that we can use for -- under  
 16 that grant, all of the hospitals that are grantees are going to  
 17 be required to have certain burn training as, well as to be able  
 18 to stabilize a burn patient, should they have a burn issue come  
 19 in. So, I think under -- having the awareness of what the  
 20 issues are is the biggest thing for us to bring back to the  
 21 grant process, in terms of writing deliverables and trying to  
 22 bring -- enact these things through whatever activities we're  
 23 doing in the grant and incorporating them.

24 I'm personally involved in some other projects for  
 25 patient location and family reunification --

1 DR. COOPER: Great.

2 DR. SOTTOLANO: -- which is a huge pediatric issue --

3 DR. COOPER: Great.

4 DR. SOTTOLANO: -- as well. But you know, to hear your  
 5 feedback of the more -- some of the other specific things that  
 6 you are aware of, from your -- and bringing that into those  
 7 projects, I think is key. And now that we're just starting  
 8 these projects, we have other activities also under the grant.  
 9 For example, electronic information sharing that we're working  
 10 with the city on as well, and -- and -- and being able to have a  
 11 more immediate real-time awareness of that availability, to be  
 12 able to assist triage in the field. And you know, that type of  
 13 a project, again, can benefit by having the specific concerns of  
 14 pediatric -- the transport that we're talking about here in come  
 15 of these documents, and so forth.

16 With -- with respect to data sharing across the  
 17 different regions, and you talked about regionalization,  
 18 regionalization is a formal thing I'm not very familiar with,  
 19 but I do know that, in an informal way, I think that that's how  
 20 all of our projects are really coming to bear fruit, because  
 21 with the patient-locator process, we -- we've been starting to  
 22 work with the western region, and we're going to spread that out  
 23 to the different R.R.C.s and regions in the state.

24 And recently with New York City, we have been working,  
 25 of course, closely on the burn plan, but Kate Uranneck shared

1 with us your -- the pediatric disaster plan, and is asking us  
2 to -- to work -- look at that and comment and work and review  
3 with you on that.

4 And Dennis' director, Gene Roca, who is in charge of  
5 the health care preparedness program, has asked me to bring  
6 together -- convene a pediatric work group as well, to start  
7 looking at these plans, and to look at the other things and  
8 issues that we can start to incorporate into the grant  
9 activities. So, while it may not be the formal regionalization  
10 process, I think that regionalization is going to happen as a  
11 grassroots effort of experts sharing and recognizing the  
12 problems, and then just determining to -- to work together on  
13 some of the resolutions. So, I -- I -- I've seen a huge  
14 increase in activity between us and the city health department  
15 in just the last few months, so I take -- I think that's really  
16 important.

17 With respect to the standards of care, and that, I  
18 think, is -- and O.H.S.M. has a big part in that. Now, I'm only  
19 in O.H.S.M. seven months, so I can't really give you a huge  
20 at -- anyway, a description of what's been considered. I know  
21 Dr. Morley is on this work group, and I -- those are things that  
22 I can certainly, again, bring back and try. And Dr. -- Dr.  
23 Morley is one of the people I plan on including in this  
24 pediatric work group that we're going to try to form.

25 So, again, just bringing those questions back and --

1 and really pounding those out as experts, and coming up -- not  
2 waiting necessarily for the moment in the emergency, where our  
3 local jurisdiction is trying to face the question of how can --  
4 what standards of care am I going to use and what -- you know,  
5 what is my overarching, you know, directive in that. Let's try  
6 to think about them prior to these events and see what we can  
7 get, you know, in place, or you know, adopted through a regional  
8 effort, or -- or you know, work with the state on that.

9 So, I'm kind of new to that part of the process, so I  
10 can't speak directly on how that will happen. And I -- I think  
11 that's pretty much what I wanted to cover.

12 DR. COOPER: Would the working group that you're  
13 anticipating form -- forming be an internal group or external  
14 group or both?

15 DR. SOTTOLANO: It would be both.

16 DR. COOPER: Both.

17 DR. SOTTOLANO: It would be both. Gene Roca just  
18 really approached me on it. And because we -- we're so locked  
19 in, in terms of the grant activities right now, because we have  
20 this three-year cycle, we really want to try to define what the  
21 scope can be this grant -- this last grant year that we're tied  
22 to these other deliverables. But I think it's good timing for  
23 us to start planning of where we want to go. And as I said,  
24 even incorporating at least the -- the -- the concerns of the  
25 pediatric issues into what we're -- we're working on now, you

1 know, as in like, patient locator, things like that.

2 DR. COOPER: I -- I -- I think there's -- it's kind of,  
3 you know, in some ways, you know, whatever the opposite of a  
4 perfect storm is -- is -- is now, you know, because several, you  
5 know, strands are sort of all moving in the same direction, and  
6 lucky for us all they tend to involve mostly the same people.  
7 So, you know, it's a -- you know, we don't want to -- you know,  
8 I -- I think that whatever our group here, you know,  
9 particularly those of us who have spend a particularly, you  
10 know, great amount of time on disaster preparedness in the  
11 last -- in the last years, whatever we can do to help you, you  
12 know, in this regard is -- is really important.

13 And again, in no way, shape, or form do I mean to  
14 suggest that anyone here, you know, because we -- we -- we've  
15 talked about how disaster preparedness is really about the  
16 entire spectrum of -- of care. It's not just I.C.U.s. It's not  
17 just -- you know, it's -- it's everything from, you know, from  
18 the office to the school, to -- you know, to all the way  
19 through, you know, that really -- really are -- are important in  
20 terms of, you know, a planning component.

21 But you know, I -- I think in terms of the  
22 regionalization piece, you know, we are not, you know, the --  
23 the kind of people who are Draconian regulators, you know, we  
24 just want to be sure that the kids get to places that can take  
25 care of them. And many of the truly successful models that have

1 a -- that have, you know, been shown to -- to work, you know,  
2 throughout the nation, are really based upon voluntary  
3 participation. But the key -- the key piece there is that it  
4 may be a voluntary system, but it's also -- it's also  
5 state-recognized, so that -- you know, so that -- so that --  
6 in -- in other words, you know, E.M.S. providers can be  
7 directed, if you will, to take patients to, you know, these  
8 recognized, designated, whatever word you wish to use, pediatric  
9 centers. But without some kind of formal recognition process,  
10 you know, they're obligated to take, you know, patients to the  
11 closest, you know, appropriate hospital, which means a hospital  
12 with an E.D., which may or may not be prepared, you know, or  
13 optimally prepared. Everybody's prepared to stabilize and  
14 transport, or so we are told, and think, and so 405 says, but --  
15 you know, but we all know that there are different levels of --  
16 of that -- that kind of capability.

17 So, you know, I think a voluntary system is something  
18 that we are very comfortable working in, but there does have to  
19 be some kind of governmental recognition and sanction of such a  
20 voluntary system.

21 Lee had a comment. I'm sorry.

22 MS. BURNS: You mentioned the -- am I allowed to speak?

23 DR. COOPER: Yeah, you are.

24 MS. BURNS: Okay. You mentioned the -- the work group,  
25 and I -- I'm kind of hoping you would consider including the

1 bureau, Martha mostly, to participate in the work group.  
 2 DR. SOTTOLANO: Oh, yeah. I've already -- I've already  
 3 mentioned that to Martha, so absolutely.  
 4 DR. WHITE: Art.  
 5 DR. COOPER: Lee, you mean you're not going to  
 6 volunteer?  
 7 MS. BURNS: I did. I volunteered Martha.  
 8 DR. COOPER: Oh, so easy.  
 9 MS. BURNS: As good leader always does, don't you  
 10 think?  
 11 DR. VAN DER JAGT: Again, I'm responding to the work  
 12 group. I'm from Rochester, and I would just hope that part of  
 13 the work group would be of the Upstate New York area as well,  
 14 because the -- in -- in fact, in some ways for this disaster  
 15 planning, although it's certainly very different than New York,  
 16 there are also some perhaps easier ways for collaboration to  
 17 occur in the upstate regional areas than there might be in New  
 18 York.  
 19 And so, I -- I -- I just talking with Bob here. Bob's  
 20 in Syracuse, I'm in Rochester, Kathy's in -- in Buffalo. We all  
 21 work well together as regional pediatric centers, but yet we  
 22 have to serve a fairly, you know, extensive rural area, with  
 23 multiple hospitals. But the relationships are -- are quite  
 24 robust there, I think. So, it may be a great opportunity to  
 25 trial even, you know, if it's a plan that's developed as a

1 deliverable on your grant for pediatrics, as you think, it might  
 2 be an optimum place to do, that with your help. With -- so,  
 3 again, it's a way -- a short way of saying it is that we need to  
 4 be involved, I think, in that.  
 5 DR. SOTTOLANO: Yeah. And -- and I've been starting to  
 6 gather names from all the different regions, and in fact, the  
 7 Finger Lakes and Rochester are instrumental in our work with the  
 8 patient locating and family reunification -- reunification  
 9 piece, so you know, and that's what I -- what I meant when I --  
 10 I really think the important ideas are coming grassroots up.  
 11 And as you were saying, that I lead it for -- for the  
 12 recognition, and I think that's exactly how burn is going. Burn  
 13 really, you know, it started through this collaboration, and now  
 14 it's going to be an adopted part of our emergency response plan.  
 15 So, you know, I -- I agree completely with what you're saying,  
 16 and I think that, you know, that's where we'll try to go with  
 17 this process as well.  
 18 DR. COOPER: Great.  
 19 Bob.  
 20 DR. KANTER: Let me ask the same think in a slightly  
 21 more pragmatic or applied way in the short term. Suppose you  
 22 have a hospital, whether it's University Hospital in Syracuse or  
 23 Strong in Rochester, that serves as a regional resource for all  
 24 the nonpediatric hospitals, whether it's for emergency  
 25 preparedness or for any other continuing professional education

1 purpose that you can think of, and this regional resource  
 2 hospital wanted to start working with the couple of dozen  
 3 hospitals in our region, to help them organize -- these are  
 4 nonpediatric hospitals -- help them organize their pediatric  
 5 emergency preparedness, both organizationally, you know, in  
 6 terms of do they have enough equipment, supplies, have they  
 7 identified the right staff that are available to them? Have  
 8 they thought about child safety in a hospital that's not usually  
 9 taking care of many kids? How are they going to identify the  
 10 children? All those kinds of things, as well as an update on  
 11 their clinical skills and how they're going to do, you know, the  
 12 simple aspects of advanced life support, their decontamination  
 13 procedures, simple hospital care for those kids who may not be  
 14 sick enough to need transfer to a pediatric hospital, and the  
 15 pediatric hospital doesn't have room to accommodate the kids  
 16 anyway.  
 17 So, if you have a regional hospital that wants to help  
 18 the nonpediatric hospital think about these things in  
 19 preparation, do you have any guidance for how -- for -- for any  
 20 tangible help that the Department or the state can give us to  
 21 begin doing this soon, given that the existing grants, which we  
 22 do have, don't cover this?  
 23 DR. SOTTOLANO: So --  
 24 DR. COOPER: Great question.  
 25 DR. SOTTOLANO: -- I can -- I can only speak to the

1 R.R.C. process that I know, through the grant, and within that  
 2 process, you know, the regional resource centers do have the  
 3 ability to define different, you know, programs that they feel  
 4 were -- are regionally relevant to them, and they do work on  
 5 those deliverables. They define them. They -- we define what  
 6 their, you know, their measurement points are and so forth.  
 7 Other than that grant, I really cannot speak to what  
 8 available resources, financial or otherwise, might be available.  
 9 I know through the public health preparedness program, you were  
 10 talking earlier about different types of caches of things.  
 11 During H1N1 we had a cache of the right respirators, that most  
 12 hospitals fortunately did use, that were not the ones that  
 13 C.D.C. sent us. And so, you know, in that way we were able to  
 14 assist the hospitals, even though, you know, it was from a  
 15 different kind of a -- of a planning effort.  
 16 But I -- I can say that right now the grant is  
 17 literally, you know, strapped, and we have lost money  
 18 continuously on that, so other than working through the -- the  
 19 R.R.C. deliverables, that -- you know, I would not be aware of  
 20 any additional funding or resources that could be applied. So  
 21 I -- I think an opportunity, maybe to bring this forward as a  
 22 project, maybe in the next round of the R.R.C. deliverables,  
 23 especially, if we do lay some -- identify some of the critical  
 24 issues that we want to address would be -- oh, the -- the way we  
 25 could go for maybe next year, but still taking advantage of this

1 year to -- to, you know, develop some of that planning.  
 2 DR. KANTER: I -- I'm not directly involved in my  
 3 hospital's handling of this grant money, but do you have any  
 4 insight about the deliverables as they're currently stated to  
 5 apply it to this sort of thing?  
 6 DR. SOTTOLANO: Well, a lot of the deliverables are  
 7 regarding surge capacity and planning, and I certainly think  
 8 that surge -- and -- and some of the plans that we're looking at  
 9 like the New York City plan, should, in fact -- and I don't  
 10 think that they go to this depth in -- in terms of the pediatric  
 11 issues. So, that might be a way in which that can be  
 12 incorporated and kind of bump into, you know, getting at some of  
 13 the pediatric issues, even within this grant process. And I --  
 14 we are doing -- we have exercises that we'll be doing as well,  
 15 which are partnership exercises. And that's, you know, the  
 16 big -- in fact, a statewide full-scale exercise coming up with  
 17 relationship to that. And so, I think that some of the issues  
 18 about, you know, transport and some of that, can be addressed  
 19 or -- or you know, maybe we can notionalize that, or -- or try  
 20 to bring in those issues into the -- and I'm speaking --  
 21 FROM THE FLOOR: Uh-huh.  
 22 DR. SOTTOLANO: -- for myself, without even discussing  
 23 it with the -- with the person who plans our exercises, but I --  
 24 I think that that's a possibility that I would be willing to  
 25 bring back and mention that, you know, can we notionalize or

1 bring in some of these issues. It may be that only one or two  
 2 of the R.R.C.s will approach that question, because we sometimes  
 3 do do that. We'll -- we'll address a certain -- you know, we'll  
 4 take a little side group with one of the -- the groups, to  
 5 see -- have them work through an issue in -- as part of the  
 6 grant -- as part of the exercise. And then that will bring up a  
 7 whole 'nother set of the things we can go from. So that -- that  
 8 is another possibility that we might be able to do, that can  
 9 answer that question.  
 10 DR. COOPER: Great. I know that Dr. Sottolano's time  
 11 especially is short.  
 12 DR. SOTTOLANO: Right.  
 13 DR. COOPER: She indicated she had to leave by two, and  
 14 I hope she'll stick around for another five minutes. What I'd  
 15 like to do, given that her time is so short, I'd like to just  
 16 ask Jonathan, Rita, Sharon, and Ann if they would each comment,  
 17 in about one minute, how you think that particularly the role of  
 18 urgent centers might be able to participate in terms of  
 19 supporting pediatric disaster preparedness.  
 20 Rita, from a school standpoint; Sharon from a volunteer  
 21 E.M.S. standpoint; and Ann from a municipal E.M.S. standpoint.  
 22 Jon?  
 23 DR. HALPERT: I'll rearrange.  
 24 DR. COOPER: Because all -- because all resources  
 25 are -- we're going to need all hands on deck in the --

1 DR. HALPERT: Yeah, no doubt.  
 2 DR. COOPER: -- event of a major disaster.  
 3 DR. HALPERT: And -- and I think that, you know,  
 4 realistically you're kind of reading the tea leaves of New York  
 5 State, you know, nontraditional access to -- to a more  
 6 sophisticated means of healthcare is going to become the way of  
 7 the -- of the world over the next decade or two. You know, I  
 8 think that the conventional hospital-based orientation is just  
 9 not going to really be able to handle the capacity if things  
 10 were to occur.  
 11 So I think places like free-standing emergency centers  
 12 or urgent care centers that have, perhaps, something of a -- of  
 13 a larger vision from what the current version of it is, you  
 14 know, we certainly can -- can get part of this program,  
 15 certainly not to a large, large extent, because the -- the --  
 16 the means to carry stockpiles of resources is limited. What --  
 17 these organizations operate in an environment that's more  
 18 dictated by cost, profitability, that kind of a thing, as  
 19 opposed to having -- being subsidized and whatnot, it makes it  
 20 more difficult to -- to dedicate space to just holding onto  
 21 items that may or may not be used, and will time out and have to  
 22 be replaced, and you know, when that kind of thing occurs it's  
 23 difficult.  
 24 But it doesn't mean it's impossible. There are  
 25 certainly resource available to some extent, and if that means

1 having to really change things around and suddenly try and get  
 2 your hands on ten thousand doses of vaccine, or last year we got  
 3 our hands on a thousand doses of vaccine in fairly short order,  
 4 at least as far as the rest of the state was concerned, for  
 5 dissemination of that, and getting a plan in place to get that  
 6 vaccine distributed.  
 7 In our case, we did it specifically targeted to E.M.S.  
 8 workers in the region, and -- and -- and got that booted out  
 9 pretty quickly and -- and quite successfully, I -- I thought. I  
 10 think that that kind of possibility very much exists, and I  
 11 think that it's utilizing some of the resources that are now  
 12 being organized within the state, meaning within the industry  
 13 within the state, having people who work more cooperatively to  
 14 kind of devise preplanning, if you will, from an industry kind  
 15 of standpoint, but really turning that attention towards a  
 16 public safety or a public health standpoint.  
 17 Everyone seems to have those goals in mind. A lot of  
 18 people that I network with now, on a somewhat regular basis, in  
 19 eastern and northeastern New York, in the -- the acute-care  
 20 setting and the urgent-care setting, understand -- come from the  
 21 hospital or E.D. background, and understand what this is all  
 22 about. So, I think that being able to utilize these resources,  
 23 using some nontraditional resources in a -- as part of the  
 24 backstop, is certainly very tenable and doable.  
 25 DR. COOPER: Thank you. Rita?

1 MS. MOLLOY: I think especially with the H1N1 pandemic  
 2 concerns that we had, school nurses really were looked at and  
 3 factored into plans when they were looking at, you know,  
 4 community pods, and being able to disseminate vaccinations to  
 5 the vectors, which are the young children, to protect the  
 6 community at large. I think the dynamics of it, though, because  
 7 it would be a volunteer effort, per se, you know, has some  
 8 logistical work to be done, because I certainly -- I work  
 9 personally as a leader in my field with certain, you know,  
 10 parties from Red Cross and different other, you know, entities,  
 11 but you know, talking about, you know, statutory regulations and  
 12 what you can do in the scope of your practice, and also being,  
 13 you know, held harmless for outcomes, being financially  
 14 compensated, because if you're working for, you know, a local  
 15 school district, versus that who has then become your employer,  
 16 who re you, what master are you serving, you know, we have these  
 17 professional licenses that kind of, you know, make people  
 18 hesitant to -- to operate without a framework. And without  
 19 those, you know, things stated in place, a lot of people have  
 20 more question marks than answers.

21 So, I think you have a very willing community of, you  
 22 know, very well educated, very well prepared registered  
 23 professional nurses out there in schools who would be great  
 24 partners in a true disaster. Even they've talked about making  
 25 school communities into, you know, quasi-ambulatory centers, if

1 need be, if we had those types of, you know, scenarios occur.  
 2 And because of the types of buildings they are, perhaps in some  
 3 small fashion, if you had equipment in pods that was, you know,  
 4 taken to a site, you might be able to jury rig something, if --  
 5 if need be.

6 But I do think that that kind of framework needs to be  
 7 created a little more formally, and you know, it's a loose  
 8 concept that has potential. And I do think that when we plan,  
 9 especially with emergency situations, it's -- it's important to  
 10 look at those community partnerships, because the likelihood  
 11 is -- is that we're going to have to draw them in, in real time,  
 12 and -- and how do we get them. So, when we were talking earlier  
 13 about like, about the H.P.N. network, and ways of, you know,  
 14 blasting people with information, and drawing them in and see --  
 15 you know, like, you know, cast the line and see what fish you  
 16 could reel in. It depends on who's available at the time when  
 17 it happens, you know, when the need arises.

18 So, we could -- you know, we could certainly -- and I  
 19 think we should be looked at, as part of the larger planning,  
 20 but I think that dialogue needs to be had with -- with that  
 21 community at large, and not -- not directed top down. I think  
 22 that, you know, as partners, we need to be engaged in these kind  
 23 of exercises, or in these kinds of discussions, you know, from  
 24 the grassroots level, because it may be a volunteer effort at --  
 25 at that point.

1 DR. COOPER: Sharon.

2 MS. CHIUMENTO: Well, E.M.S., of course, just by the  
 3 nature of what we do, are already intricately involved in -- in  
 4 any kind of a disaster setting. We're going to be the primary  
 5 triage. We're going to be the people out in the field. We're  
 6 going to be deciding, we've got all these patients, who are the  
 7 sickest, who needs to be transported first, how are they going  
 8 to be transported, where are they going to be transported. So  
 9 there's a lot of components at that level.

10 In addition to that, we're also the people who are  
 11 going to be transporting between hospitals, so doing the  
 12 secondary transports. So, you're not going to be able to spare  
 13 hospital staffs or pediatric transport units or that type of  
 14 thing, and you're going to be needing E.M.S. to play a bigger  
 15 role in that -- in that level, in transporting patients, because  
 16 everybody's going to be needed in -- in their -- their -- their  
 17 facilities.

18 The other thing is -- is that E.M.S., at times, has, in  
 19 the past, had to learn how to use their resources to the  
 20 maximum. So, you may need to transport multiple patients on one  
 21 ambulance. Normally it's one patient, one -- one ambulance.  
 22 Now, E.M.S., for instance, back when we had the ice storm in  
 23 Rochester, back what, ten years ago, we -- I remember  
 24 transporting five patients from one family that was carbon  
 25 monoxide poisoning, you know, that type of thing. So, we

1 need -- we need to learn, and -- and -- and do more education of  
 2 E.M.S. providers as to how they expand what resources they have.  
 3 I mean, they're pretty good at it. They do some pretty good  
 4 jury rigging, but you know, it's -- it's just a matter of maybe  
 5 doing a little more education for those people who have not been  
 6 involved in a situation like that, so that they will be able to  
 7 say, all right. Wait a minute. I know, this is what I can do.  
 8 This is how I can transport my patients. I can put people on --  
 9 on a portable oxygen, and I can use all the things, and you  
 10 know, there's different ways of expanding the resources you have  
 11 on the ambulance and getting them to a hospital.

12 And then I think the fourth component is when you have  
 13 multiple patients ascending (sic) on a hospital, E.M.S. is going  
 14 to end up not getting back into service very quickly. And in  
 15 many ways, it's going to end up helping in the -- in the -- we  
 16 may be doing some treatment in the emergency setting. Normally,  
 17 once you bring them to the hospital, you're not supposed to be  
 18 doing additional treatment. But if you're strapped and they  
 19 need an additional pair of hands to put a tube down or -- or to  
 20 give a draw or start an I.V., you know, we're there anyways with  
 21 our patients waiting in line. We may be able to do some of  
 22 this, to help expand the emergency department's abilities in --  
 23 in a crisis situation.

24 DR. COOPER: Ann.

25 MS. FITTON: I -- I have prepared two different kinds

1 of things. I have pandemic preparation, and I have an acute  
 2 contained incident. So, let me talk about what I see that  
 3 impacts the prehospital care providers.  
 4 Let's say H1N1, which was somewhat of a real issue  
 5 for -- for the E.M.S. in May of last year and how do we prepare  
 6 for that? Part of that requires us to two real foci. One focus  
 7 is obviously what is the best for all of the patients, but  
 8 really what's also equally important is how do I protect the  
 9 provider? So, it requires us to do a couple of things. The  
 10 pandemic, or you know, a mini epidemic, or a large saturation of  
 11 resources for a particular type of medical disease, requires us  
 12 to do -- be able to quickly educate our providers, quickly  
 13 ensure that we have them educated on how they should protect  
 14 themselves and protect their patients, in terms of personal  
 15 protective equipment, biosubstance isolation, that sort of  
 16 thing.  
 17 But even before the ambulance is rolling to a patient,  
 18 really what happens in the emergency medical dispatch center is  
 19 critically important. One of the things that happens when you  
 20 have a large public awareness of some acute illness is that you  
 21 have this huge number of the Ws, the "worried wells." The  
 22 worried wells start to call nine one one and tie up resources  
 23 unnecessarily. So, some of the things may be to have on hand at  
 24 call centers, or nine-one-one receiving centers, providers,  
 25 nurses, physicians, I'm not really sure, who can answer

1 questions. Because people are calling because they don't want  
 2 to take a chance if it's their kid who's sick, or their mom or  
 3 dad or whoever might be sick. So, there are other ways to  
 4 handle the calls other than directly dispatching an ambulance to  
 5 every single one of those. When you have a huge bump in your  
 6 numbers of calls that you receive every day, remember people  
 7 having M.I.s are not -- that -- that's still going on. People  
 8 are still having M.V.A.s. There are all kinds of things still  
 9 happening. This is an additional burden.  
 10 So the question for E.M.S., when you have that sort of  
 11 mini epidemic, whatever you would like to call it, is how do you  
 12 handle the -- that surge? Because before you get the surge in  
 13 the hospital, it -- a lot of it comes through us. Not all of  
 14 it, but a lot of it comes through us. And I think there's  
 15 really a good opportunity here to have a partnership.  
 16 How do we keep the public aware? How do we not end up  
 17 with people panicking, wanting all of the elementary schools  
 18 closed up, as was called for, in part, by some folks during  
 19 the -- the -- the -- during that.  
 20 And the other -- another aspect, I think, that would  
 21 have -- would have been very -- would have been very  
 22 informative, had we been able to really follow up and track with  
 23 every one of the calls that we typed as fever and cough, how did  
 24 that actually -- what was the patient's actual disposition out  
 25 of a hospital? Were they admitted, were they sent out of the

1 E.R.? That would have been appropriate.  
 2 So -- so, those are just my thoughts about -- I mean,  
 3 in -- in terms of -- in terms of the large-scale, isolated  
 4 incidents, so you've had a major accident. You have thirty kids  
 5 on a school bus who are all -- have a huge mechanism of injury,  
 6 how do you deal with that? I -- it -- I think we deal with that  
 7 pretty well, basically. That's a different stress on us, from  
 8 the prehospital perspective, because essentially all of these  
 9 people need fairly similar services, maybe not all the same  
 10 services, but fairly similar services, and it's matter of  
 11 ensuring that you don't overwhelm one particular hospital.  
 12 You talked about trauma centers. Well, you know,  
 13 trauma centers have -- you know, they have limits also. They  
 14 don't have fifty CAT scans.  
 15 DR. COOPER: That's right.  
 16 MS. FITTON: They don't have forty M.R.I.s. If you  
 17 have -- if you have fifty patients, and you're pretty sure all  
 18 of them need surgical intervention, you've got to send them to  
 19 different hospitals, and you do have to -- as Sharon pointed  
 20 out, you do have to start triaging them. Who are the most  
 21 critically injured? Who needs to get to the closest trauma  
 22 centers? And then -- and then move on beyond that. And that --  
 23 that -- that's certainly a part of it.  
 24 One of the things that we do routinely, that helps us  
 25 in these kinds of things, is when we know that we're going to

1 something that's bad, very, very bad, and you just know that  
 2 that's what it's going to be, was we start to canvas, out of our  
 3 dispatch center, the hospitals for their availability. And  
 4 then, once we make the assessment, we ask them what they can  
 5 handle, and we start moving the patients that way. Sometimes it  
 6 means -- and we're very luckily, I know, in New York City, to  
 7 have a lot of trauma centers. Sometimes it means rather than  
 8 taking a patient to the closest trauma center, we're going to  
 9 the third trauma center. And it may not be that -- and it may  
 10 be that -- that -- that we're still working on getting patients  
 11 out. We're not sure yet what we're going to get, but we know  
 12 that whoever's stuck still in this mangled mess is likely to be  
 13 a lot more critically injured and less able to withstand the  
 14 transport time. That's -- that would be the way I would  
 15 approach it.  
 16 And it could be that this person is dead before they  
 17 get out, before they could come to C.T. So, making those  
 18 decisions, and -- and supporting the officers who make those  
 19 decisions, are really a part of -- of what we -- what we do  
 20 well, and I -- I think, when you have these big-scale incidents  
 21 like this, and I know I'm going well over a minute, Art, but who  
 22 are you to tell me what a minute is?  
 23 But one of the really important things we do --  
 24 DR. COOPER: That was not me. That was not me.  
 25 MS. FINSTON: -- is we do something called a after

1 action. And it -- it -- it just means let's look at what  
2 happened here. Why did we do X instead of Y? If the system  
3 says that we should transport everybody to the closest trauma  
4 center, why, in fact, did we not do that? We -- and -- and can  
5 we learn something so that the next time we have a better  
6 flexibility sometimes in responding to that -- that -- that  
7 particular kind of -- but I think the two -- I think they're  
8 sort of apples and oranges.

9 DR. COOPER: All terrific points, and I -- I wish we  
10 had the rest of the day to continue to, you know, speak about  
11 this. I know Dr. Sottolano has to leave. Dr. White,  
12 fortunately will be able to stay with us for a little bit  
13 longer. I'm -- I'm just going to ask if there's any truly,  
14 truly burning issue that you want Dr. Sottolano to hear before  
15 she takes off, because if not we're going to segue right into  
16 the regionalization discussion, and -- because both Pam and Matt  
17 have been very patient here, waiting to -- to give their  
18 presentation.

19 (No audible response)

20 DR. COOPER: Hearing none, thank you so much.

21 DR. SOTTOLANO: Thank you.

22 DR. COOPER: And I hope we can continue this dialogue  
23 and -- and Deb and Dennis, please, I -- I know Martha will let  
24 you know in advance of when the future meetings of this  
25 Committee are going to be held, but -- but I -- I think I have

1 Lee's blessing in -- in extending to you a permanent invitation  
2 to join -- join with us. It's more than an invitation. That's  
3 almost a -- you know, a -- you know, a command. Yeah. We need  
4 you. We need you to be here with us as we plan; okay?

5 DR. SOTTOLANO: Thank you. I wish I could stay because  
6 each one of you has things that I'd like to ask you more and  
7 tell you more, but you know, we'll --

8 DR. COOPER: Well, so --

9 DR. SOTTOLANO: -- hopefully continue --.

10 DR. COOPER: -- make sure you get their cards before  
11 you run out the door; okay?

12 DR. SOTTOLANO: That's your job, but --.

13 DR. COOPER: All right.

14 FROM THE FLOOR: Thank you.

15 FROM THE FLOOR: Thank you.

16 DR. COOPER: Thank you, Deb.

17 Okay. In the interest of time --.

18 MS. GOHLKE: Actually, we're going to talk about the  
19 meeting first, before we go to the presentation.

20 DR. COOPER: Oh, okay. Fine. Okay. Go right ahead.

21 MS. GOHLKE: I want to give some background before Pam  
22 stands up.

23 I want you to turn your attention to the document that  
24 has a square at the top, and it's the title of our stakeholder's  
25 meeting, improving the care of critically ill and injured

1 children; we'll read from the back forward. That's how you read  
2 everything; right? Read in the back first, then you move your  
3 way left.

4 Most of you may remember we had a very important  
5 meeting on May 13th this year, and the folks that attended are  
6 listed in the back, starting on page six. We had more than  
7 fifty stakeholders statewide come to New York City to talk about  
8 pediatric care in the state, and whether or not we should make  
9 improvements and possibly regionalize the system, for lack of a  
10 better term.

11 Prior to this, the Committee worked very hard for many  
12 years in justifying the need for the Health Department and the  
13 Commissioner to look at pediatric care in the state, and they  
14 wrote a white paper justifying why this needs to be looked at.  
15 Although it focuses a little bit more on critical care, the  
16 Committee is interested in looking at the continuing care of  
17 children throughout -- throughout the continuum, and not just  
18 critical care. But -- so we had -- so the Commissioner, you  
19 know, read the white paper and said go forth, and let's see what  
20 the next steps are. And so we brought together these  
21 stakeholders from around the state.

22 And you can see the agenda on page five. We  
23 actually -- the Commissioner actually spoke -- spoke for a  
24 little while at the meeting, and gave his endorsement of looking  
25 at next steps, and we had a very structured process. Dr. Kanter

1 talked about, again, the rationalization or the need for  
2 improving the system in New York State. We had folks from  
3 Illinois present on their regionalized system and how it's  
4 working, and gave -- gave kind of a testimonial of how it worked  
5 in their state. Dr. Marx, the chair of the State Trauma  
6 Advisory Committee, talked about the evolution of New York  
7 State's trauma system.

8 And then we had, like I said, a very structured  
9 discussion, with a professional facilitator, to get feedback  
10 from the stakeholders in the room on what their experience is,  
11 and where they think that the state should -- should head, so  
12 not only was the Health Department hearing from this Committee,  
13 but they were hearing, statewide, what should be done.

14 And if you keep going forward to the document on page  
15 one, there's basically a bulleted summary of the priorities that  
16 the folks in the room thought that the state should take a very  
17 close look at and work on. In between pages one and five is the  
18 structured process that we went through, and basically how  
19 people voted in the room on what the state should do to improve  
20 the system.

21 I'm just going to go through and read the bullets aloud  
22 on page one. You can follow along. But folks in the room felt  
23 that we had to get a good inventory or a handle on what the  
24 existing resources are for pediatric emergencies in the  
25 hospitals. We -- we don't have a good handle on what exists out

1 there. Operating certificate is not necessarily what's going on  
2 out in the real world, so we need to have a better inventory  
3 of -- of resources, beds and staffing and -- and resources to  
4 attend to children.

5 They -- the -- the group really felt that we do need to  
6 establish levels of, you know, care for children. That's what  
7 Illinois did. They have a four-tiered system. At some point,  
8 you know, someone held up a sign in the room that said adopt  
9 Illinois' process; adopt Illinois' system. The -- the  
10 stakeholders, they felt -- all of them felt that we really do  
11 need to do something like this in the state. I mean, we have a  
12 system for perinatal, burn, trauma, now cardiac and stroke.  
13 Where's children? I mean, you know, it's -- it's long behind  
14 the times kind of thing. We need a more structured system to  
15 meet the needs and the care of children in our state.

16 We need to have some data, oh, I'm sorry. Skipped one.  
17 Interfacility transfer plans and agreements. Again,  
18 get a more structured process, or a rote process maybe, that in  
19 an emergency there's no questions. You have it down on paper.  
20 Where are you going to transport and how you're going to do  
21 that. So, this group, like I said, has already started working  
22 on a best-practice guidance document that is ready to be rolled  
23 out when we're ready to get to that point, on help -- on helping  
24 hospitals get to -- getting their transport plans and  
25 agreements.

1 And just a little caveat here. A couple years ago when  
2 I did my survey of the hospitals, and whether or not they had  
3 these interfacility transport agreements in place, and any  
4 policies and procedures, there were several hospitals that said  
5 no, we don't, but we'd love your help, and can you give us some  
6 guidance on how -- what you'd like to see in our -- you know,  
7 our -- our operating plans and our procedures. So, they want --  
8 they want the help. They would love to have some guidance from  
9 us on how to do that.

10 We need some data, and we need to analyze the data and  
11 so we can see whether or not the system is not working or  
12 working. And that's where Pam's going to talk a little bit  
13 about what she's been working on and I'll get back to that in a  
14 second.

15 So another thought from the group was that we need a  
16 repository for all the -- the -- the best-practice guidance  
17 documents that are already out there. There is a lot already  
18 developed, and rather than recreate the wheel, we need to have a  
19 central repository to collect those. It -- it's -- it may -- it  
20 may seem somewhat obvious that the E.M.S. for Children does have  
21 a Web page.

22 FROM THE FLOOR: Yeah.

23 MS. GOHLKE: And I'm constantly having it updated, but  
24 the National Resource Center, I'll just add here for a moment,  
25 is the contractor for HRSA through this grant. That really is

1 the repository for any best-practice documents that relate to  
2 children. So, my thought process is to really make a good link  
3 to their Web page, because they're much more thorough than I  
4 could be, and much more up to date, and it makes sense to,  
5 not -- again, not recreate the wheel.

6 The fifth bullet there, you know, this is -- this is  
7 for the public good. We need to do this. I mean, whether or  
8 not the resources are there, for the good of the healthcare of  
9 the -- of New York State and our children, this has -- this has  
10 got to be done. And if the public gets behind it and tells the  
11 Health Department you've got to do it, then hopefully it will  
12 happen. So, we need to sell it to the public that this is the  
13 right thing to do, so they can also help advocate for it.

14 They -- they think a task force, whether or not it's  
15 this Committee or another one, is a good idea, to help continue  
16 to work forward on this.

17 And of course, the incentives behind these goals would  
18 be nice. Having a little monetary reimbursement to go along  
19 with any type of change or improvements that we make is  
20 obviously a good thing.

21 And -- so, those are the -- those were the priorities  
22 that this stakeholder's meeting came up with, to charge the  
23 Health Department to work on.

24 So -- so, the next steps. So, you know, I took this  
25 back. We had folks at the Health Department, in different areas

1 of the Health Department, attend the meeting. They heard this  
2 for themselves. And we spoke -- you had a couple meetings  
3 afterwards, and as you've heard, resources is a huge issue right  
4 now with the state. And you know, having some sort of a  
5 designation, or a surveillance type system to look at pediatric  
6 hospitals, at this point in time in the Health Department is  
7 just -- you know, with lack of resources, is an insurmountable  
8 task. And they -- and the executive folks at the Health  
9 Department feel that, you know, they can't -- they can't  
10 dedicate resources to something that formalized and that large  
11 of a process.

12 However, they do think that there is a lot that can be  
13 done with regulation to improve minimum standards at least, for  
14 hospitals with the care of children. Specifically the 405  
15 hospital codes. It's been decades since those have been looked  
16 at from a pediatric focus. So, they -- they wholeheartedly  
17 suggested that this Committee look at the code -- codes --  
18 sections of the codes, and you know, make suggestions for  
19 improvement.

20 Again, just to reinforce, the 405 codes are a minimum  
21 standard for hospitals, they're not -- it's not a best-practice  
22 guidance document. So, I mean, we could do both in conjunction.  
23 We can work on regulatory code, and then an also roll out  
24 best-practice guidance documents through this Committee,  
25 through, you know, posting it on a Web page and offering it to

1 hospitals when they -- when they seek out help. But to put real  
2 fine standards in the hospital code is not going to fly because,  
3 again, it's -- it's minimum standards. It's not best-practice,  
4 necessarily.

5 So, I just say that with a word of caution, that in  
6 order to get anything changed in code, you know, it may, again,  
7 it has to be minimum-standards thought behind it, not  
8 necessarily all-encompassing, what we'd like to see,  
9 necessarily, every single hospital have.

10 Lee, do you want to add to that at all?

11 MS. BURNS: Actually, not really.

12 MS. GOHLKE: Okay. That means I did okay. I guess  
13 I --.

14 DR. COOPER: Martha, let me -- I'd like an answer to  
15 that --.

16 DR. KANTER: When you -- when you talk about minimum  
17 standards, does that mean that anything in the 405 regulations  
18 has to apply to all hospitals? Or is there a way to write it so  
19 that it tailors minimum standards for different kinds of  
20 hospitals that are already identifiable somehow?

21 MS. BURNS: The 405s identify different types of  
22 hospitals.

23 MS. GHOLKE: Acute care.

24 MS. BURNS: Yeah. They're acute care facilities, but  
25 the -- the -- in our conversations, were specifically to -- to

1 identify what we thought we could do on a short-term basis, a  
2 mid-term basis, and a -- and a long-term basis. And initially,  
3 the meetings included looking at specifics of 405, such as  
4 there's a huge -- there's a -- there's some -- 405 talks about  
5 quality assurance. Well, there's no mention of pediatric  
6 patients in any of the quality-assurance requirements of 405.  
7 And so, just simply changing the wording in that section of 405  
8 to include pediatric patients would be huge, and would have very  
9 big ramifications for the rest of the code.

10 Another thing is that 405 does not include the  
11 requirement for emergency departments to have pediatric  
12 equipment and supplies. Who knew? And -- and looking at the  
13 405s for equipment and supplies, and adding just the, you know,  
14 stuff you -- you would not even think about, because it's  
15 intuitive, into the 405s, would be part of a short -- our  
16 short-range plan, so that immediately you would be improving the  
17 care of pediatric patients in all acute care facilities.

18 I mean, again, I know you're tired of hearing this,  
19 however, the Department, for every reason, is not willing at  
20 this point to commit to moving forward with regionalization, not  
21 only because of the internal issues with surveillance, and  
22 changing the -- you know, the whole prospect right now, but also  
23 because it -- they hear from the hospital associations, the  
24 hospitals are in dire straits as well. And so, what we -- we  
25 are thinking is, at least for now, we could make the best

1 changes, without major financial impact on those facilities.  
2 And we -- we need your expertise in looking at the regulations.

3 As -- and as Martha said eloquently, regulations are a  
4 minimum standard, but I say that our ambulance providers are --  
5 to make them understand, regulations are the worst you can be  
6 and still be, you know, legal and within regulation. So,  
7 that -- that doesn't place a really glowing picture on it, but  
8 if we can raise the minimum standard ever so slightly, I think  
9 it will make a huge impact on pediatric care, at the risk of  
10 having Dr. Cooper elbow me.

11 MR. TAYLER: If -- if I could just liken this to the --  
12 to the -- the trauma system in the state, the -- the way the  
13 Department established those regulations decades ago was that  
14 405 was the bare-bones minimum -- as Lee said, the bare-bones  
15 minimum for every hospital in the state. If you -- if your  
16 hospital wanted to do any kind of specialty service, then it  
17 became what's known as the appropriateness review standards, and  
18 that's Section 708. 405 is the bare-bones minimum, 708 is -- is  
19 the specialty services.

20 In 4 -- in 708, you find -- you find all the trauma  
21 stuff, you find the emergency department, the emergency care  
22 stuff, you find the burn stuff. You -- if you recall, when CAT  
23 scans -- CAT scanners first came out, that was a huge deal. So,  
24 there's stuff in 708 regarding appropriateness review for having  
25 a CAT scanner and such, but when so -- and the STAC has also

1 identified this, that although all the trauma stuff is written  
2 in 708, there -- there are some things that could be changed in  
3 405 that -- to beef up trauma care in the state, that every  
4 hospital should be doing.

5 So, bring that back to -- to your pediatric efforts,  
6 there are things in 405 that should be beefed up for every  
7 hospital, but when you get into the -- into the regionalization,  
8 and if you get to the point of designating specialized pediatric  
9 hospitals, that whole section's going to be either -- either 708  
10 or a completely other section of -- of regulation specific to  
11 those -- to those facilities.

12 But 4 -- 405 -- there's a lot in 405 that -- that, you  
13 know, specialty services across the board look to beef up.  
14 Cardiac services is the one that they just really recently  
15 established, and when they looked to see what cardiac services  
16 was throughout regulation, they decided that it was -- that it  
17 was too scattered a section, they -- and they consolidated it  
18 into one or two specific sections for cardiac services.  
19 That's -- that's where that all came about recently. That  
20 came -- part of that came out of 708, part of it came out of  
21 405, out of some other section, but -- and so, that's the road  
22 you're looking at going down.

23 DR. COOPER: I -- I think that as we have, you know,  
24 discussed earlier in this meeting, you know, when Deb was still  
25 here, you know, the approach that has sort of grown out of our

1 collective national experience, and you know, that was  
 2 highlighted at the stakeholder meeting as a -- you know, as a  
 3 system that's, you know, largely voluntary, but has some degree  
 4 of, you know, state recognition or support or sanction. And how  
 5 we -- how we achieve that is the -- you know, is the -- is the  
 6 tougher nut to crack. And -- and a lot of it will have to do  
 7 with, I think, specific advice we may get from the division of  
 8 legal affairs as to what's actually doable in regulation, what  
 9 isn't doable in regulation, from this particular standpoint.  
 10 But the one thing that I think is critical for all of  
 11 us, we -- we really pushed that boulder, you know, way, way up  
 12 the hill. And we don't want to be like Sisyphus and find  
 13 ourselves pushing it up there again. During the interregnum  
 14 here between administrations and -- and between Wall Street  
 15 largesse, with respect to the budget, we're going to have  
 16 everything we can do just to hold that boulder halfway up the  
 17 hill just to keep it from rolling back down and crushing us.  
 18 But we -- that we have to do.  
 19 And you know, I -- I think that we need to focus a  
 20 little bit on how we actually get that -- get that task  
 21 accomplished.  
 22 MS. GHOLKE: And -- and I just want to add that also in  
 23 your packet, there's little sheet called suggested 405 codes.  
 24 Folks from the hospital services actually put together a couple  
 25 sections that they thought would be a good starting point for

1 the Committee to look at, to address pediatric care in those  
 2 areas of code. And here's the code, so we have the code for  
 3 reference here. I think it's important as we move forward,  
 4 whether the -- you know, this is done in a subcommittee or the  
 5 larger committee, that we, you know, have a time line, and --  
 6 and try to stick to it. Also justify the need for this  
 7 Committee to continue to exist and meet on a regular basis, and  
 8 to have a actual work product come out of it that's going to  
 9 benefit the Department, I think, is really important.  
 10 And we got -- it is definitely -- we got the boulder up  
 11 there, and we need to keep the momentum, and we've gotten the  
 12 green light from the Department to start working on some  
 13 regulations, so we really need to keep the momentum going  
 14 forward.  
 15 DR. COOPER: This is a -- this is an opportunity that  
 16 your advisory committee will not -- will -- will not to pass up,  
 17 I can assure you.  
 18 MS. GOHLKE: Right.  
 19 DR. COOPER: Elise?  
 20 DR. VAN DER JAGT: So -- so, my understanding that is,  
 21 because of the current financial budget, all those things, that  
 22 we will be going the pathway of regionalization by regulation.  
 23 And -- and I mean, I'm trying to be very --  
 24 MS. GOHLKE: Yeah. Yeah.  
 25 DR. VAN DER JAGT: -- blunt and basic about it. I

1 mean, it was just something we had shied away from --  
 2 MS. GHOLKE: Yeah.  
 3 DR. VAN DER JAGT: -- previously, I think to some  
 4 degree, but is this because -- is that the way --  
 5 MS. GOHLKE: But --  
 6 DR. VAN DER JAGT: -- we then do it, and then what  
 7 exactly is the process? Because I could see us looking at  
 8 regulations, like we sometimes do, for the next ten years.  
 9 MS. GOHLKE: Right.  
 10 DR. VAN DER JAGT: You know, before it actually gets  
 11 past.  
 12 MS. GOHLKE: Well, I -- I know --  
 13 DR. VAN DER JAGT: So, how -- what's the mechanism?  
 14 MS. GOHLKE: -- Lee and I have great concern about this  
 15 taking ten years; okay?  
 16 DR. VAN DER JAGT: Have a what?  
 17 MS. GOHLKE: We have -- we have great concern about  
 18 something taking ten years, and we don't want that to happen --  
 19 DR. VAN DER JAGT: Or even five.  
 20 MS. GOHLKE: -- or even five, for various reasons.  
 21 MS. BURNS: I'm looking for retirement soon.  
 22 MS. GOHLKE: As far as the federal grant goes, and  
 23 their perspective on this, they -- they think regionalization  
 24 through regulation would -- would be fine on their end; okay?  
 25 They're -- they're okay with that process. I mean --

1 DR. VAN DER JAGT: It would certainly be not any  
 2 foreign nature to New York State.  
 3 DR. COOPER: Well, please -- please do remember that --  
 4 that we took great --  
 5 FROM THE FLOOR: It's definitely a part --  
 6 DR. COOPER: -- and I -- I believe that this -- that  
 7 this did have a significant impact upon the thinking of the  
 8 people in the high levels of the Department.  
 9 One of the things that we used the conference to do was  
 10 remind them that the Department already has a statutory  
 11 requirement to develop a system for regionalization. That --  
 12 that pave -- that, in and of itself, paves the way for us to  
 13 develop a regulatory structure to support that, you know,  
 14 provided that it's a doable one and doesn't cost anybody a whole  
 15 lot of money at this particular point in time.  
 16 That -- that having been said, the Department is also  
 17 very sensitive to the -- to the fact that this grant is -- or  
 18 that this program is largely supported by a federal grant, and  
 19 the federal grant has certain expectations in terms of our  
 20 making progress. So, the fact that -- that the E.M.S.C. Law,  
 21 Article 30-C of the Public Health Law, does mandate the -- one  
 22 of the powers and duties of the Department -- and underscore,  
 23 one of the powers and duties of the Department is to develop a  
 24 statewide system for regionalization. The tools that the  
 25 Department has to do that, in a way that makes it real, is the

1 regulatory process.  
 2 And you know, and -- and if -- in order to keep the  
 3 money flowing from the fed, they have to make those regulations,  
 4 seems to me that we're in a much stronger -- a much stronger  
 5 place than many of our sister advisory bodies, you know, who  
 6 don't have that -- that -- that level of explicit authority and  
 7 support.  
 8 MS. BURNS: I -- I would further add, though, that I  
 9 think making some changes to the regulation as a first step  
 10 improves the care provided to all pediatric patients, not just  
 11 the critically ill or injured ones.  
 12 DR. COOPER: Absolutely.  
 13 MS. BURNS: And -- and while -- you know, as the -- the  
 14 unbelievably long bureaucrat that I am, I mean, I would like to  
 15 think that even if we chip away this process, we're improving  
 16 patient care. So, if it's by regulation, it's a good start.  
 17 And the end result may be that we regionalize in better times,  
 18 when it -- it's -- you know, when it's not tied so -- to tightly  
 19 to reimbursements, where the facilities are looking at, to quote  
 20 Dr. Cooper actually, you know, they -- they're going to get the  
 21 patients anyway. They don't care whether they're a pediatric  
 22 center or a trauma center. They're coming there. So, I think  
 23 this is a good start for -- for us.  
 24 And as I said in the last couple meetings, and -- and  
 25 Martha articulated also, the Department is looking to its

1 advisory committees to -- to present a product, to be able to  
 2 finish a project and complete something that results in positive  
 3 change. And -- and they are -- they're mercenaries about making  
 4 that happen. And I think you have that capacity. You should --  
 5 you should seize the day.  
 6 DR. VAN DER JAGT: I -- I think -- I just pulled up the  
 7 minimum standards, Part 405, the whole -- the whole part.  
 8 MS. BURNS: Yeah, it's short -- short reading.  
 9 DR. VAN DER JAGT: What's that?  
 10 MS. BURNS: Short reading.  
 11 DR. VAN DER JAGT: It's very likely, but I can't help  
 12 but be struck by there are many, many sections in here --  
 13 MS. BURNS: Yeah, here it is.  
 14 DR. VAN DER JAGT: -- that -- yeah, exactly. But there  
 15 are many sections in here, in addition to -- to these here, that  
 16 do not talk anything about pediatrics, but they do talk about  
 17 burn patient, they talk about AIDS patient, they talk about all  
 18 kinds of patients. They talk about N.G. tube placement.  
 19 Look -- I'll pulled up nursing.  
 20 MS. BURNS: And the Department --.  
 21 DR. VAN DER JAGT: Well, you know, you could have  
 22 various -- no, so are we free to look at each one of these?  
 23 MS. BURNS: I would say yes.  
 24 DR. VAN DER JAGT: And then --  
 25 MS. BURNS: I mean, I think we --

1 DR. VAN DER JAGT: -- should we --  
 2 MS. BURNS: -- should --  
 3 DR. VAN DER JAGT: -- prioritize --  
 4 MS. BURNS: Yeah.  
 5 DR. VAN DER JAGT: -- perhaps, where we need to put --  
 6 MS. BURNS: Yes.  
 7 DR. VAN DER JAGT: -- the most bang for our buck?  
 8 MS. BURNS: Yes.  
 9 DR. VAN DER JAGT: Because it's getting to -- it -- I  
 10 can see it going almost every single section you could add some  
 11 pediatrics, but we -- that's obviously not feasible --  
 12 MS. BURNS: Right.  
 13 DR. VAN DER JAGT: -- I don't think.  
 14 DR. COOPER: I -- I think -- I think that understanding  
 15 the -- you know, the -- the -- the process of regulatory  
 16 adoption, I have had some experience with this, as you know,  
 17 that going before the State Hospital Review -- Review and  
 18 Planning Council with a set of proposed regulations, you know,  
 19 is a daunting task, and -- and it -- it's -- A, it's easier said  
 20 than done, but having -- having said that -- okay, the simpler,  
 21 the cleaner --  
 22 MS. BURNS: Yeah.  
 23 DR. COOPER: -- the more straightforward it is --  
 24 MS. BURNS: Absolutely.  
 25 DR. COOPER: -- you know, the -- the -- the more

1 understandable it is to, you know, to individuals, remember, who  
 2 are gubernatorial, not commissioner-level appointees, and  
 3 they're there, you know, on some level because they are  
 4 political appointees. Okay. Being very clear and  
 5 straightforward about why this is, you know, in the best  
 6 interest of the -- of the entire public, you know, I think that  
 7 will suit us, I think, in a -- in a much better way than -- than  
 8 trying to micromanage the whole document.  
 9 MS. GOHLKE: Yes, Dr. Kanter.  
 10 DR. KANTER: Before we get into the nuts and bolts of  
 11 where we take this, I just -- I -- I wonder if you got any other  
 12 feedback that you're prepared to share with us in this meeting,  
 13 either from individual hospitals or from hospital associations,  
 14 about the stakeholder discussion? I mean, was there any --  
 15 MS. GHOLKE: Well --.  
 16 DR. KANTER: -- obviously, everyone's constrained by  
 17 money right now. Were there any other constraints or objections  
 18 or problems?  
 19 MS. GOHLKE: No, I -- I mean, they were there, present  
 20 at the meeting. They've heard the people in the room, and I've  
 21 gotten a few e-mails asking hey, what's going on, from HANYS,  
 22 and you know, like, keep us in the loop, and you know, if we  
 23 could be part of anything. So, nothing negative.  
 24 DR. KANTER: Good.  
 25 MS. GOHLKE: Just -- actually they're trying to hold us

1 accountable, and making sure that we're not forgetting about  
2 them and they're -- and they're willing to help out, and -- so,  
3 I think it's been all positive. I'm trying to think of one  
4 physician has e-mailed me several times from the city, to --  
5 just blanking. But anyway, so there is people that want this to  
6 keep moving forward, and will give their help if we want them to  
7 be included.

8 DR. COOPER: I think the bottom line is the ball is in  
9 our court.

10 Elise.

11 DR. VAN DER JAGT: Just to follow up on what Bob says  
12 is -- so there were a number of hospital administrators there at  
13 that stakeholders' meeting?

14 MS. GHOLKE: Yeah.

15 DR. VAN DER JAGT: Would they be -- would they be  
16 supportive of -- of us going through the regulations and begin  
17 to change them, and eventually proposing it, because that's the  
18 kind of people you need to be on the same page as we are. If  
19 they say this is great --

20 MS. GHOLKE: Well, I think that --

21 DR. VAN DER JAGT: Love this.

22 MS. GOHLKE: -- yeah --.

23 DR. VAN DER JAGT: Love this, but you know, oh, by the  
24 way, don't touch the regulations because we're overregulated as  
25 it is, then there's a disconnect.

1 MS. GHOLKE: Well --

2 DR. VAN DER JAGT: So, I'm having a little bit of  
3 concern before we put all --

4 MS. GHOLKE: Again --

5 DR. VAN DER JAGT: -- a lot of it on here, that we at  
6 least have some folks who --

7 MS. GHOLKE: Right.

8 DR. VAN DER JAGT: -- we see that this is a reasonable  
9 way to look at this, in this situation where we have no money.

10 MS. GHOLKE: Right.

11 DR. VAN DER JAGT: It's very difficult to get this  
12 implemented in other ways.

13 MS. GHOLKE: Well, the -- the hospital administrators  
14 were the ones with the very strong, you know, you need a  
15 financial incentive behind what you do. And so, that's what  
16 they would like to see happen.

17 I think the -- that the balance of the struggle for me  
18 and this Committee to work on the 405 codes is, again, that it's  
19 minimum standards. And we're going to want a lot more than --  
20 than can be put in minimum standards. And we're just going to  
21 have to figure out another way, either through best-practice  
22 documents and guidance documents that -- that isn't regulation,  
23 to put forth the other -- what we'd like to see the system look  
24 like, or what we'd like to see the hospitals do, that can't be  
25 done in 405 because they are minimum standards. And I think

1 that's just going to be the struggle that we're going to have.

2 DR. COOPER: Well, Martha's raised a very, very  
3 important point. And we -- we need to remember that the  
4 regulatory process in New York State, at least with respect to  
5 hospitals, is multi-tiered. And of those multiple tiers in  
6 which regulations exist, there are two main tiers. And Mike  
7 commented on those a moment ago. There are the minimum  
8 standards, the 405, through which you receive a statement of  
9 deficiency if you're inspected and you don't meet them.

10 There's also the 708s, the appropriateness-review  
11 standards.

12 MR. TAYLER: The -- the what?

13 DR. COOPER: Pardon me?

14 MR. TAYLER: Say it again.

15 DR. COOPER: The 700 series. It's the 405s with  
16 respect to -- to minimum emergency department standards.  
17 There's also the 708s, which we refer to typically as the trauma  
18 standards, but there's an -- there's another section of 708  
19 which deals with emergency department standards.

20 MR. TAYLER: Okay.

21 DR. COOPER: Which are appropriateness-review  
22 standards; okay? These -- the 7 -- the 708 level of -- of  
23 standards deal what some in the past referred to as the planning  
24 standard. In effect, it refers to the optimal standard that we  
25 would like everyone to aspire to in New York State, whereas the

1 405 is the minimum standard. And -- you know, and there's no  
2 reason that we can't work on both.

3 Now, the irony is historically it's pretty easy  
4 actually. The irony is -- the irony is that -- that -- that the  
5 708 standards were originally developed for emergency  
6 departments. They were on the way to being adopted as  
7 emergency-department standards when the -- when the Libby Zion  
8 scandal broke at -- at -- down in the city in the mid-80s. And  
9 it was the Libby Zion issue that led to the creation of the Bell  
10 Commission that short-circuited the 708 process.

11 The original -- the original intent was to create an  
12 optimal standard for emergency departments, okay, but then the  
13 Libby Zion thing came along, and what ended up happening was  
14 that it created a minimum standard for emergency departments.  
15 And the optimal standards, in effect, have lain fallow for a  
16 number of years. SEMAC was explicitly given the authority to  
17 rewrite those standards back in 2005, when Article 30-B of the  
18 Public Health Law was passed, and it made some preliminary steps  
19 to do that, but it hasn't -- it hasn't followed through with  
20 that.

21 But the point is -- the point is that -- that -- that  
22 we have both routes to -- to pursue. And you know, the minimum  
23 standards are -- you know, are -- are the absolute minimum  
24 standards. And just to cite an -- to cite a very brief example  
25 of the way something could work out, and I'm not way shape or

1 form wedded to this, you might say that the minimum standard is  
 2 that if you're not an emergency medicine or board-certified  
 3 emergency medicine physician working in an emergency department  
 4 that accepts children, at the very least you have to have PALS  
 5 training; okay? You might say something along those lines.  
 6 Okay. I'm not suggesting that that's right.

7 At an optimal level, you might say that it would be --  
 8 we would like people to have some equivalent of APLS or  
 9 something along those lines. That -- just as a -- just as a,  
 10 you know, as the kind of thing that you -- that you can do, you  
 11 know, at those different levels, it's a little different.

12 Martha, and then Elise.

13 MS. GHOLKE: If I could make a suggestion. I've been  
 14 here almost three years, and -- and now I've gone through this  
 15 little process here with the Health Department, in talking about  
 16 this regionalization process. And my experience in sitting  
 17 through the -- the 708 regs at the trauma meeting for three  
 18 years now, and it's actually -- they've been working on them for  
 19 five years and still aren't done making revisions.

20 What I would suggest is that you -- that we do this in  
 21 baby steps, and we do the 405 codes first, because that's what  
 22 we've been given the green light with, and that's what  
 23 Department feels they're okay with. I don't -- honestly don't  
 24 feel that they'll be okay with 708 regs at this point. I think  
 25 we need to start here, give them it -- this as a work product,

1 complete it, hand it over, and if we're given the green light to  
 2 go with 708 codes from that -- the regulations, then I think we  
 3 should tackle that process.

4 I don't want the ball of wax to get so big that it  
 5 takes us five years to do both at the same time. And I actually  
 6 think the Department, based on the feeling I've gotten in these  
 7 last few meetings, they don't want to see 708 regs just yet with  
 8 pediatric care. I think they want to see this as a starting  
 9 point, and they're okay with this. And then, let's see how that  
 10 goes and then maybe we can increase it to 708 regs after we do  
 11 the -- the 405. I think bite-sized chunks is a better way to  
 12 go.

13 DR. KANTER: Certainly anything that we learn in  
 14 writing 405 draft regulations, we can then apply --

15 DR. COOPER: Absolutely.

16 DR. KANTER: -- to the next.

17 MS. GHOLKE: And we -- and we could have a, you know,  
 18 interfacility best-practice guidance document that we post and  
 19 distribute, but it's just -- it's just not 708 regs right away.  
 20 You know, we can still have that guidance for hospitals to  
 21 follow if they want it, and what we'd like to see, but I don't  
 22 want to tackle 708 regs until we get the green light, until we  
 23 finish 405 codes, if that makes any sense.

24 DR. VAN DER JAGT: So obviously, again, looking at  
 25 this, there's a whole section in Part 405, and I do agree that

1 Part 405 should be where we should go, if that's the green light  
 2 we're getting.

3 MS. GHOLKE: Yeah.

4 DR. VAN DER JAGT: But there's a whole section, for  
 5 example, on perinatal services, which basically outlines  
 6 regionalization of perinatal care. So, why do we not put a -- I  
 7 mean, there is -- you put another article in there on  
 8 pediatrics --

9 DR. COOPER: That's --

10 DR. VAN DER JAGT: -- or -- and/or --

11 DR. COOPER: -- that's what was --

12 DR. VAN DER JAGT: -- I mean, is that what we're  
 13 looking --

14 DR. COOPER: -- just suggested.

15 DR. VAN DER JAGT: -- is that what we're looking at?

16 DR. COOPER: Yeah.

17 DR. VAN DER JAGT: Because it talks about their -- you  
 18 know, about what neonatal --

19 MS. GOHLKE: Well --

20 DR. VAN DER JAGT: -- one, two and --

21 MS. GOHLKE: -- I -- you know --

22 DR. VAN DER JAGT: -- three is and -- and I was --

23 MS. GOHLKE: -- what I think --

24 DR. VAN DER JAGT: -- wondering why we --

25 MS. GOHLKE: -- would be a good --

1 DR. VAN DER JAGT: -- would not approach it that way.

2 MS. GHOLKE: -- starting point is for the subcommittee  
 3 to meet and to talk about --

4 DR. VAN DER JAGT: Right.

5 MS. GHOLKE: -- what they'd like to prioritize, and --  
 6 and a time line for that.

7 DR. VAN DER JAGT: Okay.

8 MS. GHOLKE: And then we'll convey that to the  
 9 executive folks and make sure that they're on -- I want to make  
 10 sure that they're on board with this process --

11 DR. VAN DER JAGT: Right.

12 MS. GOHLKE: -- throughout the whole thing, so that way  
 13 we don't get to the end and they say no. That's not --

14 DR. VAN DER JAGT: That's what I'm --

15 MS. GOHLKE: -- what we want.

16 DR. VAN DER JAGT: -- concerned about is that --

17 MS. GOHLKE: So --

18 DR. VAN DER JAGT: -- big deal.

19 DR. COOPER: Sure.

20 MS. GHOLKE: -- if we get can together and develop  
 21 priorities and a process and a time line, present it, make sure  
 22 that they're still okay with everything, and then we'll move  
 23 forward --

24 DR. COOPER: Yeah.

25 MS. GOHLKE: -- from there.

1 DR. COOPER: I'm not suggesting that the two proceed  
 2 in --  
 3 MS. GOHLKE: Right.  
 4 DR. COOPER: -- parallel, you know -- you know, and I  
 5 personally happen to believe that the 405 code is more  
 6 important, because it's not so much at the high-end places we're  
 7 concerned, it's the -- you know, it's the places that lack  
 8 pediatric resources that we're -- that we're really concerned;  
 9 right?  
 10 MS. GHOLKE: The last thing Lee and I want is for you  
 11 guys to be spin your wheels for five years and then nothing  
 12 happens.  
 13 FROM THE FLOOR: Right.  
 14 FROM THE FLOOR: Right.  
 15 DR. COOPER: Yeah. I -- I -- I have to -- I just have  
 16 to say, as an editorial comment, that -- that the pediatric  
 17 community is a whole more together than the trauma community, as  
 18 in terms of where it wants to go, because I -- I don't see that  
 19 being a huge problem.  
 20 Be that as it may -- be that as it may, one thing I do  
 21 think that's important is that we -- we keep not only the  
 22 Department involved in the loop, that -- but that we keep our  
 23 hospital association partners involved, and -- and in the loop.  
 24 You know, with their -- you know, the -- if the history of the  
 25 Department over the last twenty or thirty years has taught us

1 anything, it's that getting a special way to reimbursement is  
 2 going to be, you know, extremely difficult. You know, that  
 3 we're -- we're -- we're -- we're going to be much more  
 4 successful in proposing a minimum standard for all hospitals  
 5 that -- that -- that a good eighty-five percent of the hospitals  
 6 meet now; okay? And that's -- that's the general rule in the --  
 7 in the -- I mean, in -- in the -- in the regulatory world.  
 8 If -- if eighty-five percent of your -- of your -- of your  
 9 constituency is in support of it, as long as it is relatively  
 10 noncontroversial, you've got a pretty good shot at getting it --  
 11 getting it to happen.  
 12 And -- and there's -- and I don't see that there's  
 13 anything terribly controversial that we're -- that we're going  
 14 to -- we're going to propose, you know, and I -- I think we  
 15 should just go forward and get this, you know, work product  
 16 done. I -- I -- I'm actually, you know, in -- in -- in a way  
 17 surprised, but also incredibly pleased, that -- that the  
 18 Department, you know, particularly at the present time, has said  
 19 hey, look, you know, we can't really think of a better way to do  
 20 this, so let's -- let's go ahead and -- let's go ahead and do  
 21 it.  
 22 So, let's be mindful of the opportunity that we've been  
 23 given and just charge ahead and -- you know, and get it done.  
 24 I'd like to see a draft of something for the next meeting. And  
 25 Bob, I know that you will want to be intimately involved with

1 that --  
 2 DR. KANTER: Sure.  
 3 DR. COOPER: -- so, since you've led our  
 4 regionalization charge, I'll ask if you would continue our  
 5 regionalization charge in -- in this particular way.  
 6 And anybody that wants to work with -- work with Bob on  
 7 that, please let me know, with a copy to Martha, and we'll be  
 8 sure that that -- you know, that that -- that that happens.  
 9 Pam Lawrence has been waiting forever, and she's been  
 10 so kind and so patient.  
 11 MS. LAWRENCE: I wouldn't go that far.  
 12 DR. COOPER: Okay.  
 13 MS. GHOLKE: Let me just --  
 14 DR. COOPER: Oh, well, you've -- we've made you be  
 15 patient. How's that?  
 16 MS. GHOLKE: Let me -- let me just explain how Pam came  
 17 to our table. Thank you.  
 18 MS. LAWRENCE: Picked me.  
 19 MS. GHOLKE: Lucky her.  
 20 FROM THE FLOOR: She was assigned.  
 21 MS. GHOLKE: So, when the white paper came out and we  
 22 talked about having the stakeholder's meeting, and Dr. Morley  
 23 was intimately involved with us planning the stakeholder's  
 24 meeting, and has become more involved with this Committee, which  
 25 he was going to be here today, but other priorities, along with

1 the recent agenda for Tracy, he -- he wanted to know, you know,  
 2 outcome, what's the situation of children and the care of  
 3 children, with trauma centers, nontrauma centers, and hospitals  
 4 in New York, and that's a -- you think it would be a simple  
 5 question to ask and answer, and it's not, because you can't just  
 6 look at mortality with children because children don't generally  
 7 die, and the ones -- it's only, you know, a handful when you  
 8 look at the population, that die, and so you can't draw any good  
 9 conclusions from mortality rates with children. So you've got  
 10 to be, you know, much more adept in looking at the data and  
 11 the -- the severity of the injury and illness, and decide was  
 12 it, you know, a hospital problem, or was it, you know, just the  
 13 course of the illness type of thing.  
 14 So, Dr. Morley somehow made his way to Pam Lawrence,  
 15 and said, "Can you -- can you look at this, and see what you can  
 16 get for information on outcomes of children in New York State?"  
 17 So, she's been working to pull together some information and  
 18 needs our feedback at this point, because she's got a lot going  
 19 on and she needs some help and direction in where you'd like her  
 20 to focus her efforts. And my thought is, obviously, you know,  
 21 I've talked to Matt, her boss, and would like her continuing  
 22 efforts, because as we go down this road, we've got to have --  
 23 DR. COOPER: Please.  
 24 MS. GOHLKE: -- baseline data. And that's basically  
 25 what she's working on is the situation now, as it works in New

1 York State. And then if we change the system, obviously, we'd  
 2 love to see if there is a change with the care of children.  
 3 So, this could be a very long project for Pam.  
 4 DR. COOPER: But an exciting one.  
 5 MS. GHOLKE: Yes. And we welcome her --  
 6 DR. COOPER: Because -- because if --  
 7 MS. ROSS: -- her help, and so I turn it over to you.  
 8 DR. COOPER: -- right. Because if we can show with  
 9 outcome data that the changes we made have made a difference --  
 10 MS. GHOLKE: Absolutely.  
 11 DR. COOPER: -- that would be huge.  
 12 MS. GHOLKE: And you know, a lot of -- a lot of other  
 13 states have gone down this road -- have not got the before and  
 14 after data to show whether or not --  
 15 DR. COOPER: Huge.  
 16 MS. GOHLKE: -- changing the system actually works, so  
 17 this is a great opportunity for us to --  
 18 DR. COOPER: It could really --  
 19 MS. GOHLKE: -- do it right --  
 20 DR. COOPER: -- make a difference for kids everywhere.  
 21 MS. GOHLKE: -- and publish and show whether or not our  
 22 efforts are making a difference.  
 23 MS. LAWRENCE: Okay. Actually, what I was going to say  
 24 a little while ago is that I -- just sitting here in the past  
 25 couple of -- just sitting here in the past couple hours, trying

1 to ignore this microphone, I learned enough that I could already  
 2 improve on what I did. So -- and -- and what I did, when I show  
 3 it to you, I'm sure in some cases you'll find it quite naive,  
 4 and -- and some of it you already know empirically, because this  
 5 is what you folks do for a living. So -- but -- and that's why  
 6 I need your help, because this is what you folks do for a  
 7 living, and I can do a better job if I know what's of interest  
 8 to you; when I get certain results, if I know -- if you can  
 9 typically tell me -- or you might be able to tell me why the  
 10 results may have come out like this.  
 11 At any rate, what I'm handing out right now is -- is a  
 12 one-page -- a one-page list, it's denominator data is what it  
 13 is. And the reason I'm handing it out is because as I go  
 14 through -- as I go through the presentation, I'm going to drill  
 15 down into the data. The denominators change and it's easy to  
 16 get confused. But if you have like, a sheet, you can refer  
 17 to -- you can refer to what I used to come up with this data,  
 18 and it will -- it will just -- it will be better.  
 19 But if I go too fast, if you want me to slow down, ask  
 20 me to slow down. If you're getting bored, let me know that too.  
 21 And I don't -- just push the yellow button? Is that  
 22 the way it works?  
 23 MS. GHOLKE: The arrow -- the right arrow button.  
 24 MS. LAWRENCE: The right arrow button.  
 25 MS. GHOLKE: Yeah. There you go.

1 MS. LAWRENCE: That one.  
 2 MS. GHOLKE: There you go.  
 3 MS. LAWRENCE: Okay.  
 4 MS. GHOLKE: The yellow -- the yellow button is a laser  
 5 pointer if you wanted to use it.  
 6 MS. LAWRENCE: Cool. Okay. I started with -- took  
 7 four years of -- originally, I started with three, but I put the  
 8 2008 data, so eventually, I ended up with four years of SPARCS  
 9 data. I had to remove the -- the hospitalizations of children  
 10 with an H.I.V.-associated diagnosis, and the reason for that is  
 11 I couldn't match up their records to get a history for a  
 12 particular child. I could see their individual  
 13 hospitalizations, but because of the data that was missing to  
 14 keep those records anonymous, I couldn't follow one kid through  
 15 several hospitalizations. And I took out the healthy newborns,  
 16 and then I removed the kids fifteen and over. I've also done  
 17 this for children zero to eighteen, and in that case, we left  
 18 the fifteen and ups in.  
 19 Now, for four years of data, we have six hundred  
 20 thousand-odd hospitalizations of children age fourteen or less.  
 21 These are excluding newborns and children with a -- with a  
 22 diagnosis associated with H.I.V. Whoopsy daisy. Oh. I'll get  
 23 it. Okay.  
 24 This is just a tabular form of the -- of what I just  
 25 showed you, so you can see what the process was to get down to

1 those six hundred-odd (sic) kids.  
 2 I then wanted to look at hospitalizations due to  
 3 injury. And from the -- the -- from all the hospitalizations,  
 4 six hundred (sic) kids, I took those with an admitting diagnosis  
 5 or principal diagnosis that indicated injury. And the way I did  
 6 that is I looked at the I.C.D.-Nine codes for injury and  
 7 poisoning and took out the poisoning. I ended up with about  
 8 thirty-five hundred hospitalizations due to injury.  
 9 DR. COOPER: Pam?  
 10 MS. LAWRENCE: Yeah?  
 11 DR. COOPER: Sorry. I'm hoping that's a typo, because  
 12 nine sixty through nine eighty is injury.  
 13 MS. LAWRENCE: Nine sixty through --  
 14 FROM THE FLOOR: What is a typo?  
 15 DR. COOPER: The nine sixty and nine seventy codes are  
 16 all --  
 17 FROM THE FLOOR: All right.  
 18 DR. COOPER: -- injury codes. I think it's just the  
 19 nine eighties that are poisoning.  
 20 MS. LAWRENCE: Well, that may -- that may, in fact, be  
 21 a typo. And I can -- I can check --  
 22 DR. COOPER: If you'd just double-check that, because  
 23 it --  
 24 MS. LAWRENCE: I will. I will --  
 25 DR. COOPER: -- obviously if it's wrong it will affect

1 your numbers --  
 2 MS. LAWRENCE: Okay. Yeah.  
 3 DR. COOPER: -- big time.  
 4 MS. LAWRENCE: And actually we -- we can just --  
 5 DR. COOPER: And all the -- yeah.  
 6 MS. LAWRENCE: And you're going to find --  
 7 DR. COOPER: All the serious bodily injuries are in the  
 8 nine sixty --  
 9 MS. LAWRENCE: Then I suspect that's a typo.  
 10 DR. COOPER: Yeah. Okay.  
 11 MS. LAWRENCE: Yeah. Yeah. Because we have -- so it's  
 12 nine eighty; right?  
 13 DR. COOPER: I think. I just --  
 14 MS. LAWRENCE: Okay.  
 15 DR. COOPER: You should just double check that.  
 16 MS. LAWRENCE: And I can -- and actually I can check  
 17 that fairly easy. I can probably check it before we leave here  
 18 today.  
 19 DR. COOPER: Sure.  
 20 MS. LAWRENCE: And then I wanted to look -- well, and  
 21 then I wanted to look at hospitalizations due to critical  
 22 illness. And originally when I started this, when I was first  
 23 asked to do this, I thought well, the way you find critical --  
 24 children who are critically ill is you look for the kids that  
 25 cost the most, that are in the hospital for the longest, that

1 have the most hospitalizations.  
 2 Well, that will find you some critically ill children,  
 3 but also find you some children that are not critically ill,  
 4 that are just in the hospital for other reasons. And -- but Dr.  
 5 Kanter sent me an article by Odetola. Is that how you say his  
 6 name?  
 7 DR. KANTER: Uh-huh.  
 8 MS. LAWRENCE: Okay. And that was very helpful,  
 9 because what that enabled me to do is look at the -- look at the  
 10 procedure codes for mechanical ventilation, and the diagnostic  
 11 codes that indicated some sort of respiratory failure --  
 12 respiratory arrest, apnea, and I came up with about twenty-seven  
 13 hundred kids -- twenty-seven thousand, excuse me, kids, who met  
 14 the criteria for critical illness. And this is in a four-year  
 15 period. This is 2005 to 2008.  
 16 Okay. Then I went -- to look at the kids who are  
 17 specifically trauma kids. One would expect that they would have  
 18 an injury, and that they would be critically ill. Now, the --  
 19 this probably doesn't get all the trauma kids, but it probably  
 20 gets a significant subset of them. So, what I did is I looked  
 21 for the intersection of injured kids and critically ill kids,  
 22 and I found, in the four-year period, there's not that many of  
 23 them. There's one thousand one hundred and ninety-one.  
 24 DR. COOPER: That's right.  
 25 MS. LAWRENCE: And this is just a Venn diagram that

1 shows the -- the relationship of the datasets to each other.  
 2 The universe was six hundred and forty-four thousand kids that  
 3 had been hospitalized in the four years; the hospitalizations  
 4 due to the injury, about thirty-five hundred; hospitalizations  
 5 due to critical illness, which were twenty-seven hundred, and  
 6 the intersection, which is a little over a thousand. Okay.  
 7 And here I prepared some -- some of the parameters that  
 8 those kids -- some of the characteristics of those kids. number  
 9 of hospitalizations is not equal to the number of children. You  
 10 know, some of these children are hospitalized for their -- for  
 11 all hospitalized children and critically-ill children, I think  
 12 the maximum number of hospitalizations in the four-year period  
 13 was fifty-five. For injured children it was less, but I don't  
 14 remember exactly what it was.  
 15 You'll notice that -- that for injury, greater number  
 16 of males -- there's greater number of males than females.  
 17 Actually, pretty much all categories there's a greater number of  
 18 males than females.  
 19 The mean length of stay is for critically ill -- is the  
 20 longest for critically ill children. Critically ill, injured  
 21 children it's shorter. For -- for all hospitalized children,  
 22 that's just your, you know, the kid who goes in for a  
 23 tonsillectomy is included in that group. The kid who goes in,  
 24 maybe has pneumonia, stays a couple days, goes home, is in that  
 25 group. And their lengths of stay are a lot shorter.

1 MR. LEARY: Excuse me, Pam?  
 2 MS. LAWRENCE: Yeah.  
 3 MR. LEARY: Why don't you move a little closer to keep  
 4 the noise down?  
 5 MS. LAWRENCE: Okay, I'm -- I'm sorry.  
 6 MR. LEARY: It's the air conditioning.  
 7 MS. LAWRENCE: Can you hear me now?  
 8 DR. COOPER: Even a little closer, if you would.  
 9 MS. LAWRENCE: Okay.  
 10 MS. GOHLKE: You can move it towards -- closer so  
 11 you're comfortable.  
 12 MS. GOHLKE: Okay. We're going to -- we're going to  
 13 make a mess here, yet.  
 14 FROM THE FLOOR: There you go.  
 15 MS. LAWRENCE: Okay. Okay. Also you'll notice --  
 16 DR. COOPER: Thank you.  
 17 MS. LAWRENCE: -- the kids -- that the injured children  
 18 are -- tend to be older than the hospitalized (sic) children.  
 19 Critically ill children seem to be the youngest of the group.  
 20 And the costs are -- these costs are unadjusted. We  
 21 have -- we've -- I've put in for a -- I've requested the data  
 22 that is going to allow me to adjust the charges between  
 23 facilities and between years. I haven't got that data yet, but  
 24 as soon as I get that I will adjust those charges. But you can  
 25 see that critically ill children are the most expensive.

1 Critically ill -- critically ill, injured children somewhat  
 2 less. The -- with all hospitalized children, and injured  
 3 children being cheaper.  
 4 None of this is surprising. None of this is rocket  
 5 science here. And even -- and -- you probably know a lot of  
 6 this, but actually we -- it's concrete. One of the things I was  
 7 interested in is -- is does pediatric service availability  
 8 affect outcomes? Do those facilities that offer comprehensive  
 9 pediatric services, do they do better in terms of outcomes  
 10 than -- than facilities with no -- either with no pediatric  
 11 services, or with a pediatrics department only.  
 12 I used HCFA's data to do this, and I'm aware, now, that  
 13 there may be a better data source, and we may be able to be more  
 14 specific in terms of pediatric services by looking at pediatric  
 15 trauma centers and looking -- looking -- drilling down a little  
 16 bit more into the data.  
 17 I'm also aware that facility X's PICU is not  
 18 equivalent -- may not be equivalent to facility Y's, depending  
 19 on -- depending on what resources they have. And that might be  
 20 something we want to look at, at some point, as well. But --  
 21 but -- but for this much -- for this -- for this study, we  
 22 grouped the hospitalizations by the pediatric services offered.  
 23 And this is -- your first set of denominator data is -- is this  
 24 data right here. Children -- children -- children, regardless  
 25 of hospitalizations, most of them go to a facility with

1 pediatrics and a PICU. The reason for this is these tend to be  
 2 larger facilities. Just because they're in the facilities that  
 3 has a PICU doesn't mean they're in the PICU. That means they're  
 4 just in the facility. And -- and fewest children go to the  
 5 facilities with no pediatric services. So, kids are going where  
 6 it's appropriate for them to go.  
 7 You'll notice that when -- with all hospitalized  
 8 children, as you get -- as you go further down, you'll notice  
 9 that the numbers for the critically ill injured children are  
 10 starting to get kind of scarce, because there aren't that many  
 11 of them. Most of those do go to a facility with -- with  
 12 pediatrics and a PICU. This is -- that's awful.  
 13 DR. COOPER: Think you skipped one.  
 14 MS. LAWRENCE: Oh, okay. Oh, yes I did. And actually  
 15 that's not much better, and I apologize for this. But what this  
 16 is, it shows the percentages of children and the various  
 17 outcomes associated with -- for the children. Most kids,  
 18 regardless of the category they're in, whether they're --  
 19 whether we're talking about all hospitalized injured children,  
 20 critically ill children, or critically ill, injured children,  
 21 most kids go home. This is especially true for the -- all  
 22 hospitalized children and injured children. Most -- all of  
 23 those -- you can't see that from this slide, but all of those  
 24 are in the ninety percent -- ninety percent category.  
 25 Critically ill children, it drops down to the fifty and

1 sixty percent range, and for critically ill, injured children  
 2 it's, once again, fifty to sixty percent for -- I apologize for  
 3 this slide being so bad. It hard, I mean --  
 4 FROM THE FLOOR: It's got to be the projector's  
 5 problem.  
 6 MS. GOHLKE: Yeah, I was going to say the image is  
 7 fine --  
 8 MS. CHIUMENTO: If we turn out the lights --  
 9 MS. GOHLKE: -- on the screen.  
 10 MS. CHIUMENTO: -- in the front there, it might help.  
 11 MS. GOHLKE: Huh?  
 12 MS. CHIUMENTO: Turn off the light. It might help.  
 13 That's better.  
 14 MS. LAWRENCE: It -- that's better. It's not -- it's  
 15 not -- it's far from perfect, but it's better.  
 16 Children who transfer to another facility -- hospitals  
 17 with -- with no pediatric services and pediatrics only are much  
 18 more apt to transfer -- transfer than are hospitals with  
 19 pediatrics and PICU. And I believe -- believe that's just a  
 20 function of where -- children who are in a facility with  
 21 comprehensive pediatric services are apt to stay there. There's  
 22 not very many other places to send them to.  
 23 In terms of -- in terms of outcome, those kids that are  
 24 ultimately transferred to an alternate level of care, most of  
 25 those -- most of those are actually -- most of those are kids

1 from pediatric and PICU who are critically ill, injured and  
 2 they -- a lot of them go to rehab. That's where they go to.  
 3 And the -- and -- and here's where the issue of  
 4 pediatric mortality comes in. Most kids don't die, although for  
 5 critically ill and critically ill, injured children, we have in  
 6 the range of ten percent group, and then you'll notice that  
 7 that's regardless of pediatric services offered.  
 8 Oops, what happened there? What happened -- can you --  
 9 can you fix it?  
 10 Now, this is -- this is the same data -- what I'm going  
 11 to do is show this data in terms of -- this is the same data you  
 12 just saw, but it's -- but it's -- but I graphed it. The dark  
 13 purple is all hospitalized children. The light purple is  
 14 injured children. The teal colored is critically ill children.  
 15 And the dark blue is critically ill, injured children. And  
 16 you -- what you're seeing there is, regardless -- on the -- on  
 17 the left is no pediatric services, in the middle is pediatrics  
 18 only, on the end is pediatrics and PICU. And what you're seeing  
 19 there is these look remarkably similar, and most kids -- most  
 20 kids who are injured are -- or all hospitalized children or  
 21 injured children, most kids -- ninety percent of them go home.  
 22 And for critically ill and critically ill, injured, that drops  
 23 down a little. These are kids who go to another facility. Most  
 24 of the kids that are transferred to another facility come from a  
 25 facility with pediatrics only, which is the group in the middle.

1 And I apologize that you can't see the numbers. This is -- this  
2 is -- this is awful. Excuse me. Okay. So, what I wanted to  
3 do, when after -- these are the kids that go -- that were  
4 transferred to another facility. I just wanted to look at those  
5 kids who were transferred.

6 So from the next slide, I will -- I -- oops --.

7 MS. GOHLKE: Pam, we're thinking it might be the cord  
8 issue. You want to see if -- see if we can just swap it out  
9 real quick, see if that helps?

10 MS. LAWRENCE: Okay.

11 (Off-the-record discussion)

12 MS. SPERRY: While they're swapping things, can I ask a  
13 question?

14 MS. LAWRENCE: Yeah.

15 MS. SPERRY: Why did you remove poisoning from injury?

16 MS. LAWRENCE: Because --.

17 DR. KANTER: What was the question?

18 MS. SPERRY: Why poisoning was removed from injury?

19 MS. LAWRENCE: Mostly -- mostly because I didn't think  
20 poisoning was part of injury, and because -- and because I've  
21 had no clinical guidance with this. This is some -- this is one  
22 of the things that you can help me with. If it's -- if it's  
23 good to leave poisoning in, I'd be happy to do that. If it -- I  
24 think there are probably better ways to divide the pediatric  
25 services available at hospitals than to use the HCFA's data, but

1 I also -- I need your help to do that, too.

2 MS. SPERRY: We -- the bureau of injury prevention, we  
3 have - actually just finished them this morning - tables of how  
4 we divide e-codes per causes of injury. And injury is this -- I  
5 came from a communicable background, and going to injury was  
6 just shocking, because it's just such an inclusive thing.

7 MS. LAWRENCE: Uh-huh.

8 MS. SPERRY: So, it -- I -- I totally understand the  
9 not -- but does this include all intensive injury, like --  
10 poisoning. Intentional injury like assault, as well as  
11 unintentional injury?

12 MS. LAWRENCE: I believe it does, but I would have to  
13 check. I'm going to check -- based on Dr. Cooper's concern  
14 about the I.C.D.-9 books, I'm going to check that just to make  
15 sure.

16 MS. SPERRY: Yeah, because the numbers seem --.

17 MS. LAWRENCE: Oh, look at that, a thing of beauty.

18 DR. KANTER: What happened?

19 MS. GOHLKE: It's a cord issue.

20 DR. KANTER: A cord issue?

21 MS. GOHLKE: Yeah.

22 MS. LAWRENCE: What a thing of beauty. Thank you.

23 MR. TAYLER: Which one you on?

24 MS. LAWRENCE: I don't really --.

25 MS. GOHLKE: She -- she has it there.

1 MS. LAWRENCE: Okay. Let's go back to -- yeah. Okay.  
2 These are kids that were discharged to another  
3 facility. And you'll notice the -- the scale is changed. In  
4 the -- in the slide -- in the slide before kids were discharged  
5 to home. It was a hundred percent. This one is only the  
6 maximum -- the max -- the maximum actually was for critically  
7 ill children and that's thirty percent.

8 But you'll notice that transfer to another facility  
9 seems to happen with critically ill children and critically ill,  
10 injured children, have -- it seems to happen mostly at -- at  
11 facilities with no pediatric services or facilities with  
12 pediatrics only. And I -- but I just wanted to look at these  
13 kids for a minute. And so, the next few slides deal with only  
14 children who were discharged to another facility, and where they  
15 actually went, what type of facility they actually went.

16 This is people who were discharged from a facility with  
17 no pediatric services -- services, who were transferred to  
18 another facility by facility type. And they were transferred to  
19 another hospital, to a cancer -- a cancer center or a children's  
20 hospital -- hospital got bitten off there, sorry about that --  
21 to a psychiatric facility, to a facility not elsewhere  
22 described. That's -- that's a category in SPARCS data, to a  
23 federal facility, and critical-access facility. Children are  
24 almost never discharged to a federal facility or a critical  
25 access hospital. There were just minor numbers in -- in all

1 children, and that's why they were -- that's why those two  
2 categories were included.

3 For -- for children discharged from a facility with no  
4 pediatric -- with no pediatric services, they were typically  
5 transferred to another hospital, or they were transferred to a  
6 cancer -- to a -- probably, in this case, to a cancer center or  
7 children's hospital. For the critically -- for the injured  
8 children, the critically ill children, that probably was to a  
9 children's hospital.

10 I'm not sure why -- and this is another area where I am  
11 in need of clinical guidance, why some kids were transferred to  
12 a psychiatric facility. Could be that they -- these were  
13 children that -- that were already in a psychiatric facility, or  
14 that maybe -- especially like for the -- for the injured  
15 children, it could be that children with psychiatric  
16 disabilities are more apt to become injured, for whatever  
17 reason, or --.

18 DR. BRILLHART: But if they tried to commit suicide --

19 MS. LAWRENCE: Oh, yeah, that -- that's --

20 DR. BRILLHART: -- then they go to psych.

21 MS. LAWRENCE: -- suicides --.

22 DR. VAN DER JAGT: Yeah, they took an overdose, or --

23 MS. LAWRENCE: You're right.

24 DR. VAN DER JAGT: -- they -- they did something, and  
25 they were medically then stable --

1 DR. BRILLHART: Yeah.  
 2 DR. VAN DER JAGT: -- they went to the --  
 3 DR. BRILLHART: They were medically cleared, but they  
 4 need to go to psych.  
 5 MS. LAWRENCE: Right. Or the other -- the other case I  
 6 thought of is somebody who is so traumatized by their -- by  
 7 their injury that they ended up there. But that's something  
 8 that I was unsure.  
 9 DR. KANTER: I -- I just might mention in that -- in  
 10 this context, that psychiatric illnesses are one of the fastest  
 11 growing causes of child hospitalization in the U.S. right now --  
 12 the fastest growing cause of hospitalization.  
 13 DR. VAN DER JAGT: Could I ask also, are these mutually  
 14 exclusive categories?  
 15 MS. LAWRENCE: They're subsets.  
 16 DR. VAN DER JAGT: I have a hard time understanding the  
 17 first category and the second category.  
 18 MS. LAWRENCE: Okay. The first category -- now,  
 19 what -- what are you talking about?  
 20 DR. VAN DER JAGT: Hospital to another hospital, and  
 21 the second category is -- I can't -- it's hard to see sitting  
 22 back here, but then it says to a cancer center for children?  
 23 MS. LAWRENCE: Yes, they are --  
 24 DR. VAN DER JAGT: It's a hospital.  
 25 MS. LAWRENCE: Right. These --.

1 DR. VAN DER JAGT: So -- so is that hospital included  
 2 in the other --?  
 3 MS. LAWRENCE: No, it's not included in the other  
 4 hospital. To another hospital -- these are categorizations in  
 5 HCFA's -- not HCFA's -- in -- in the SPARCS database. Another  
 6 hospital would be -- just a transfer to another hospital. So a  
 7 cancer center or children's hospital, would be a hospital  
 8 specific -- specifically to meet the needs of the children.  
 9 DR. COOPER: Pam?  
 10 MS. LAWRENCE: Yeah.  
 11 DR. COOPER: But how -- A, How did you define  
 12 children's hospital?  
 13 DR. VAN DER JAGT: Right. What is --?  
 14 DR. COOPER: And B, are trauma centers included in the  
 15 all-other-hospital category?  
 16 MS. LAWRENCE: Yes, the trauma centers are included,  
 17 but I did not define children's center -- cancer center and  
 18 children's hospital. That -- that was defined in SPARCS,  
 19 and --.  
 20 DR. COOPER: Do we know how SPARCS defines it?  
 21 MS. LAWRENCE: No, but I can find out.  
 22 FROM THE FLOOR: To bring it to you -- the level you  
 23 might be interested, you might want to know what actual hospital  
 24 they went to.  
 25 FROM THE FLOOR: Right.

1 DR. COOPER: Right.  
 2 MS. LAWRENCE: And I did not do any facility-specific  
 3 work, but that's something we can do as --.  
 4 FROM THE FLOOR: This definition might be out of sync.  
 5 DR. COOPER: We can work -- we can -- we can work with  
 6 you on that.  
 7 MS. LAWRENCE: Yeah.  
 8 DR. VAN DER JAGT: Yeah. Right. I think one of the --  
 9 one -- one of the reasons is -- is that, at least in a study we  
 10 did back in the early '80s, there was a lot of local transfer  
 11 from a small community's hospital to a larger community hospital  
 12 with pediatric services. And that -- and then the other  
 13 possibility would be that a smaller hospital with no pediatric  
 14 services would transfer to a tertiary care center, which, at  
 15 least in upstate New York, is -- they're all children's  
 16 hospitals. Whether they're designated as such or -- or not,  
 17 they are full-service hospitals.  
 18 MS. LAWRENCE: Right.  
 19 DR. VAN DER JAGT: So, maybe that's the distinction  
 20 here. One is sort of the smaller community hospital with  
 21 pediatric service, which is the first column, and then --  
 22 because they're coming from a hospital with no pede services.  
 23 And then in the second column is all the tertiary, ordinary,  
 24 full comprehensive children's center in the state. That may be  
 25 a way to do it. Which would fall together with cancer centers.

1 MS. LAWRENCE: And -- and I'm not sure, but I can -- I  
 2 can verify that.  
 3 But anyway, these are the -- this is -- this is for  
 4 just facilities with no pediatric services. What would be  
 5 interesting to know, and we'll -- and we'll -- and we'll look  
 6 at -- we'll look at some of this later on, but it would be  
 7 interesting to know is are they being -- being transferred from  
 8 a facility with no pediatric services to a facility with more  
 9 comprehensive pediatric services?  
 10 DR. VAN DER JAGT: Correct. And I think that I would  
 11 suggest that we really focus -- maybe do later on in the show is  
 12 that, to focus on that first column --  
 13 MS. LAWRENCE: Uh-huh.  
 14 DR. VAN DER JAGT: -- the last two categories of  
 15 patients. Because a question would be -- is if a patient get  
 16 transferred from a pediatric facility -- a facility with no  
 17 pedes patients --  
 18 MS. LAWRENCE: Uh-huh.  
 19 DR. VAN DER JAGT: -- to one -- well, if it's -- if  
 20 it's a critically ill patient, and it goes to one with some just  
 21 general pediatric services --  
 22 MS. LAWRENCE: Uh-huh.  
 23 DR. VAN DER JAGT: -- that's the hospital where I would  
 24 be concerned also, might -- the kid might die, actually --  
 25 MS. LAWRENCE: Right.

1 DR. VAN DER JAGT: -- because they don't have that  
 2 comprehensive facility and no I.C.U.  
 3 DR. COOPER: We can -- we can work with you for any of  
 4 those definitions.  
 5 DR. VAN DER JAGT: That would be --.  
 6 MS. LAWRENCE: Yeah, and -- and my purpose --  
 7 DR. VAN DER JAGT: It's twenty-five percent.  
 8 MS. LAWRENCE: -- my purpose is -- in coming here is  
 9 because I know I need your help, so just bear with me.  
 10 DR. COOPER: Yeah. Absolutely.  
 11 DR. VAN DER JAGT: No, you're doing fine. It's just  
 12 I'm just -- we're just raising questions as it --.  
 13 MS. LAWRENCE: Yeah, and -- and -- and that's --  
 14 that's -- that's wonderful. This -- this is actually what I  
 15 need.  
 16 This is a facility with pediatrics only, and I'm  
 17 noticing that they transfer most of their kids to another  
 18 hospital. I'm wondering if most of those kids are being  
 19 transferred to -- the kids who get transferred are being  
 20 transferred mostly to another hospital, not to a cancer center  
 21 or a children's hospital, not to a psychiatric hospital. But  
 22 I'm wondering if these kids aren't the kids that are in need of  
 23 services greater than the pediatrics -- the facility with  
 24 pediatrics only can offer? I -- and I don't know.  
 25 DR. COOPER: No, no, again, I -- again, it looks as

1 though we have a definition problem. I'm willing to bet that --  
 2 that the vast majority of those "another hospitals" are  
 3 hospitals that provide, you know, children's-hospital-equivalent  
 4 level care.  
 5 DR. VAN DER JAGT: Right.  
 6 MS. LAWRENCE: Okay.  
 7 DR. BRILLHART: But they're not --  
 8 DR. COOPER: But they're not freestanding --  
 9 DR. BRILLHART: -- But they're not --  
 10 DR. COOPER: -- children's hospitals.  
 11 DR. BRILLHART: -- pediatric care. They're going to  
 12 a --  
 13 DR. COOPER: Not Schneider, not --  
 14 DR. BRILLHART: -- children's hospital.  
 15 DR. COOPER: -- not -- not --  
 16 MS. LAWRENCE: Okay.  
 17 DR. COOPER: -- not Buffalo.  
 18 MS. LAWRENCE: Oh, I got it. Okay. I got you.  
 19 DR. BRILLHART: But it's not labeled. It doesn't --.  
 20 MS. LAWRENCE: And because the -- because the -- okay.  
 21 And I -- I -- and I'm not even sure, though I know there are a  
 22 few places around the state that have hospitals within hospitals  
 23 that are children's hospitals, and --.  
 24 DR. COOPER: That's exactly what we're talking about,  
 25 yeah.

1 MS. LAWRENCE: These are discharges from facilities  
 2 with a pediatric and a PICU. Some of them are going to another  
 3 hospital. Some of them are going to cancer -- to cancer  
 4 center/children's hospital. You'll notice that the critically  
 5 ill, injured children are pretty much evenly distributed between  
 6 these two. And I -- I guess those are the -- those are the  
 7 kids, I guess, that we're primarily concerned about. You'll  
 8 notice, too, that the numbers are getting -- the numbers are  
 9 kind of small. The critically ill, injured children who were  
 10 transferred -- there were only ninety-eight.  
 11 These are children who are discharged to an alternate  
 12 level of care. Now, these kids are probably -- this is skilled  
 13 nursing, Medicare, certified long-term care, and rehab is  
 14 included in here. And I -- you'll notice that -- note that the  
 15 people with no pediatric services -- pediatric only, they look  
 16 kind of similar. Pediatrics and PICU, a lot more -- especially  
 17 for the critically ill, injured children, a lot more of them are  
 18 being -- are going to this -- and I think that's just a function  
 19 of the fact that -- and we have -- and I have -- I've made no  
 20 correction for this at this point, sicker kids tend to go to the  
 21 hospitals with more services. So, in -- in the -- the final  
 22 outcome, these kids are more apt to need rehab/long-term care  
 23 than are kids that go to other hospitals.  
 24 And I did drill down into these kids, and you'll notice  
 25 that a hundred percent of the critically ill, injured children

1 went to -- went to --  
 2 DR. BRILLHART: Inpatient rehab.  
 3 MS. LAWRENCE: -- inpatient rehab, yes.  
 4 And critical -- and -- and also for those that went to  
 5 a skilled nursing facility -- and I guess that a lot of them  
 6 went to a skilled nursing facility, and I guess what that is an  
 7 indicator of is what the child's needs were at the point of  
 8 discharge, and whether they -- there was a chance for  
 9 rehabilitation to get the kid back out, or if the kid was going  
 10 to need long-term skilled nursing care.  
 11 DR. BRILLHART: Well, and within -- within psychs, like  
 12 St. Mary's Bayside, has some skilled nursing facility beds --  
 13 MS. LAWRENCE: Yeah.  
 14 DR. BRILLHART: -- and some inpatient rehab beds.  
 15 MS. LAWRENCE: And to be honest --  
 16 DR. BRILLHART: So, it could be the same facility but  
 17 with different bed assignments.  
 18 MS. LAWRENCE: And then once again, I'm -- I -- this --  
 19 this is the SPARCS discharge codes and I'm not really familiar  
 20 with how they determined which they went. I'm sure there's a  
 21 person putting in the codes and I'm sure they -- they coded it  
 22 by the type of bed the person -- the person was getting. But --  
 23 and -- and these are things I -- I -- these are all things I  
 24 need to know.  
 25 Okay. Okay. These are the pede -- these, the no --

1 these are children with no -- transfer with no pediatric  
 2 services. These are children transferred from facilities with  
 3 pediatrics only. You'll notice, once again, all the kids -- the  
 4 critically ill, injured kids went to rehab. There were only  
 5 four of them. And these are the kids that were transferred --  
 6 and there's a lot more of these. There's a lot of kids that  
 7 were in -- no, no -- ah, I labeled it wrong, and I apologize --  
 8 yes, I labeled it wrong.

9 This is not pediatrics only. These are the pediatrics  
 10 and PICU kids. And I -- I apologize for that. I just noticed  
 11 that. They're kind of -- and once again, evenly distributed  
 12 between skilled nursing and inpatient rehab.

13 These are the kids who died which, once again, shows  
 14 mortality data is not much good, because essentially, no one  
 15 dies, because it's got less than -- we've got less than fifteen  
 16 percent, and it's mostly the critically ill, and critically ill,  
 17 injured kids who are -- are -- who aren't making it. Most of  
 18 the -- most of -- most hospitalized children, most injured  
 19 children are discharged, either -- either to another facility,  
 20 to home. They have an outcome other than death.

21 This is just a review. I wanted to show you how much  
 22 the profiles, based on services, how similar they are between  
 23 types of services. On the left, no pediatrics services. On the  
 24 right are places with both a pediatric and a PICU. They still  
 25 look extremely similar. The orange color is kids that went

1 home, and happily, most kids go home. The kids -- the green --  
 2 the green are -- are the kids that were transferred to another  
 3 facility. The teal, which there aren't very many of them -- the  
 4 teal looks black here, they went to an alternate level of care.  
 5 And the blue are kids who died or went to palliative care.

6 Length of stay by illness and injury category. You'll  
 7 notice that most kids -- most kids in the -- in the -- all --  
 8 all hospitalized children and injured children stay ten days or  
 9 less. That's not true -- that -- that's not necessarily --  
 10 well, actually, most kids -- most critically ill, injured and --  
 11 and -- and critically ill children are also in that category.  
 12 but if you look at the next line, these are kids that stayed  
 13 eleven days or longer. And you'll notice that all children and  
 14 injured children have dropped way down, and the -- the  
 15 critically ill, and critically ill, injured children are staying  
 16 for a longer length of time.

17 Okay. One of the -- you know, the point of doing this  
 18 was to see how -- how hospital services affected outcomes. And  
 19 so I wanted to look at the simplest case. We have kids  
 20 hospitalized up to fifty times in this database, and so, to look  
 21 at the -- the simplest case, I looked at children hospitalized  
 22 once in a facility with -- with no -- with -- no or limited  
 23 pediatric service -- services, that's a facility without a PICU,  
 24 and -- or ones in a facility with a PICU. And then I looked at  
 25 children who were hospitalized twice, once in a facility with no

1 PICU, and with an immediate transfer to a facility with a PICU.  
 2 So, what I mean by an immediate transfer, is they stayed in the  
 3 facility with no PICU for a while, and then without being  
 4 discharged home they went right from the facility with no  
 5 pediatric -- no or limited pediatric services facility with a  
 6 PICU.

7 And what I was thinking is that children hospitalized  
 8 in a facility with PICU show more favorable outcomes than those  
 9 hospitalized in a facility with no PICU. I was kind of naive  
 10 because the sicker kids go to the facility with the PICU, and  
 11 you would expect the kids who have are hospitalized in a  
 12 facility -- that -- that the sicker kids would have poorer  
 13 outcomes, and you'll -- you'll see what I found based on this.

14 But I'm wondering -- I -- I'm thinking that this should  
 15 be true for those kids who are critically ill and injured.  
 16 And -- and children transferred -- especially the critically  
 17 ill, injured and -- and critically ill children, those kids  
 18 transferred should do better once they're transferred; should do  
 19 as -- as well as the -- if not as well as the children who are  
 20 initially in the PICU, at least better than the children who are  
 21 hospitalized in a facility with no PICU.

22 And what I found is that's not the case. I think the  
 23 phenomenon of sicker kids going to hospitals with more  
 24 comprehensive services is far more robust than -- than the  
 25 phenomenon that kids who have appropriate services do better.

1 For all -- regardless of category, the transfers did worse, and  
 2 the kids in the PICU, not -- did not significantly so, but did  
 3 no better than the children with no PICU. Oops.

4 Transfers to alternate level -- level of care for these  
 5 kids. The transfers were far more likely to go to an alternate  
 6 level of care. Once again, no PICU and PICU outcomes look  
 7 remarkably similar. PICU does a little bit worse and -- and for  
 8 critically ill, injured children. Oops.

9 Oh, yeah. Last one is the mortality. None of our  
 10 transferred injured children, critically ill children died. But  
 11 no PICU and PICU kids are significantly different than  
 12 transferred kids. No PICU and PICU look alike. Transferred  
 13 kids don't look so similar, and they don't seem to do as well.  
 14 I don't know if it's that we don't notice that they need a  
 15 transfer, or by the time we do realize they need a transfer  
 16 they're so sick that they don't do as well.

17 And this is just -- these four outcomes -- these four  
 18 graphs are for hospitalized children, injured children,  
 19 critically ill children, and injured, critically ill children.  
 20 And regardless of the illness/injury category, the kids who were  
 21 transferred seemed to do less well than the kids who were not --  
 22 were -- who stayed in the facility that they were -- that they  
 23 were in.

24 One thing I did notice, which I thought was kind of  
 25 interesting, is that for all hospitalized children, if you

1 delayed the transfer, the outcome was worse. Okay. The --  
 2 the -- for all hospitalized children, those that died or had  
 3 palliative care chosen for them, were hospitalized for five plus  
 4 days before they were transferred. Those that went to an  
 5 alternate level of care, it was about three and a half days.  
 6 Those who eventually went home it was about three days. You'll  
 7 notice, along the bottom, the number of observations, especially  
 8 for the alternate level of care. I'm very suspicious of only  
 9 ten observations. I'm not much happier about the ninety-two  
 10 observations. I'd like to have more. And possibly, when we get  
 11 the 2009 data and put it in with this, we'll get something that  
 12 we can rely on more heavily.

13 I did do this for -- for injured children. Did not  
 14 find this phenomenon. Both -- no one died, and both those  
 15 discharged from and those transferred to an alternate level of  
 16 care, it's just a coincidence that it turned out to be exactly  
 17 the same amount of time. We've got, once again, we've got  
 18 seventy-three observations for -- for injured children who  
 19 transferred, and seven -- and only seven, for the alternate  
 20 level of care. So, once again, I'm a little suspicious of these  
 21 low numbers. Hopefully we'll get some more data that we can  
 22 rely on a bit more heavily.

23 Same thing for critically ill children transferred. An  
 24 outcome of home -- this is not significant at -- at any -- at --  
 25 at, you know, we'd want a probability of at least point o --

1 point o five or less. This is not significant, but it seemed  
 2 that the critically ill children that delay before transfer  
 3 seemed to help them out. Most of the -- the longest length of  
 4 time, but once again, don't read too much into this. These --  
 5 these -- you know, these are very low numbers. And there's only  
 6 nine observations in the critically ill, injured children.  
 7 These are also not significant numbers.

8 Okay. One thing I wanted to do is we have some  
 9 concerns about the limitations of administrative data. And I  
 10 wanted to make sure that the SPARCS data could -- could do --  
 11 could provide data that -- that we could use. So, what I --  
 12 what I did is I just repeated -- and you have a copy of this  
 13 study -- it's by Odetola in your -- in your -- in your packet.  
 14 I essentially just went through and used the SPARCS data to do  
 15 what he did. And this is just -- I used children aged zero to  
 16 eighteen. I used -- to determine critical illness, I used the  
 17 same criteria of mechanical ventilation, apnea, or respiratory  
 18 arrest or respiratory failure.

19 What -- what Odetola did is he further identified  
 20 comorbid chronic conditions in critically ill children, and  
 21 looked at the differences between critically ill children with  
 22 comorbid chronic conditions -- conditions, and children who are  
 23 critically ill with no comorbid chronic conditions. I used  
 24 the -- I -- just as Odetola did, I -- I -- I essentially did  
 25 what he did. And I used -- and I used the method of Futener

1 (phonetic spelling) to identify the comorbid conditions and  
 2 essentially, what that is to identify by I.C.D.-9 codes the --  
 3 the comorbid conditions. He categorized these as neuromuscular,  
 4 cardiovascular, respiratory, renal, gastrointestinal,  
 5 hematologic, immunologic, metabolic, other genetic or  
 6 congenital, or malignancies. And essentially, the differences  
 7 between -- between what the Odetola study and what we -- what we  
 8 did is his study was based on nationwide data. He used the  
 9 A.H.R.Q. kids data. His data spanned ten years in four-year  
 10 intervals. I used SPARCS data from New York State only, and I  
 11 used the same data -- essentially the same data, except that I  
 12 included the fifteen- to eighteen-year-olds in this group that I  
 13 used for the -- the study we just -- we just looked at.

14 Odetola, on page -- on page two, table one, is --  
 15 proportion of critically ill children with comorbid illness.  
 16 You'll see I have a slightly higher percentage of children with  
 17 comorbid illness than he did. We both had 200 -- 2006 data.  
 18 For his two year -- for his 2006 he had a little over forty  
 19 percent. I have fifty-two point three percent. This is a  
 20 repeat of his table on page three. He -- our results are  
 21 remarkably similar. I -- and for our 2000 -- we both did 2006.  
 22 For 2006 his children with comorbid illness, he had sixty-eight  
 23 point nine percent. I had seventy-six point six percent for --  
 24 excuse me -- for children age one and less. And for children  
 25 one to four he had nine point five one. I had thirteen point

1 nine.

2 And basically, what I'm doing here is I'm just looking  
 3 to see if we can use SPARCS to recreate something that was done  
 4 with the A.H.R.Q. And we did get -- you know, it's not exactly  
 5 the same, but it is similar, and we were able to -- we were  
 6 able -- it -- it does look remarkably similar.

7 One thing I noticed, and he doesn't really talk about  
 8 this, or actually -- he does in the text, but it's not in the  
 9 table, that a total for -- with the SPARCS data, at least for  
 10 fifty-one point three percent hospitalizations involved children  
 11 with one or more comorbid chronic conditions, and thirty percent  
 12 of children with comorbidity. And that's fifteen percent of all  
 13 children. These are critically ill children we're talking about  
 14 at this point. This is not -- so that should say all critically  
 15 ill children had more than one comorbid chronic -- chronic  
 16 condition.

17 The table -- this table is roughly equivalent to his  
 18 table on -- once again on page two. And our results are  
 19 similar. I'm a little bit concerned because my neuromuscular  
 20 results -- he had much higher rates in older children than I  
 21 did. And I honestly don't know why I didn't get those higher  
 22 rates. I want to go back and look at those again. His  
 23 neuromuscular, you can see, they're -- they're much higher than  
 24 mine. And I'm thinking that that's -- I'm thinking that that's  
 25 because some of the neuromuscular disorders are not noticed till

1 the kids are older. And I'm not sure why that didn't come  
2 through on this.

3 Treatment characteristics, which is the last -- the  
4 last one. It's roughly equivalent to his table three on page  
5 four of his article. And once again, we both have 2006 data.  
6 And they are -- the data is similar; not exactly, but -- but  
7 similar. So I think we get the -- the -- the upshot from this,  
8 and the reason I did it, is I think we can, with enough  
9 expertise, and enough surgical inclusion-exclusion of cases, to  
10 make sure that we get a lot of signal, very little noise, we can  
11 use the SPARCS data to help us -- to help us guide us through  
12 this -- this process.

13 Okay. What I want from you -- what I need from you is  
14 if -- if I'm going to keep on doing this, I -- you know, I need  
15 some guidance about who these kids are, what kind of diagnoses  
16 we want to include, what's in -- what's a good -- one of the  
17 problems that I had when I was doing this is I had a real hard  
18 time deciding what a good outcome is, because for -- for some --  
19 for some -- for a critically ill child with a certain condition,  
20 maybe the best you can hope is that they don't die. For another  
21 kid, that might not be such a good outcome. And -- but anyway,  
22 one -- one of the things I need is -- is a sophisticated eye to  
23 look at this stuff.

24 And also, I would like some help generating hypotheses,  
25 because I think my hypothesis with -- with the PICU and no PICU

1 and the transfer, I don't think it was specific enough. I don't  
2 think it was specific enough. I don't think I divided the  
3 hospitals correctly. And I -- when -- and after -- after all is  
4 said and done, after we do this stuff, when I find stuff and  
5 it's like the psychiatric -- like the -- the kids that end up  
6 being discharged to psychiatric facility, I need some assistance  
7 to help interpret and explain the -- the findings.

8 Some things we can do, and I'm sure you can think of  
9 other things we can do, is maybe geocoding of facilities, to  
10 determine access; look at where the critically ill children,  
11 critically ill, injured children are, where the PICUs are. Do  
12 children with identified comorbid conditions live closer to a  
13 PICU? That might be true. That might be true for -- for two  
14 reasons. They're more apt to be diagnosed, because they've been  
15 at facilities where they were able to diagnose them. And it  
16 might be true because the parents might move closer to the  
17 facilities with the -- that meet the kids' needs. And are there  
18 disparities in available services between urban and rural areas?  
19 Are you more apt to get to a facility with a PICU if you live in  
20 New York City than if you live in West Chazy, New York?

21 And that's it.

22 DR. COOPER: Well, Pam -- Pamela, we're -- we are all  
23 deeply grateful to you for this extraordinary amount of work  
24 that you put into this project. And you can be assured that we  
25 will be following up with you very soon. We are perilously

1 close to the end of the meeting and we still have a bit of work  
2 that we have to do. What I'd like to do is -- is ask Pam if she  
3 would make the corrections in the presentation that she  
4 identified needed to be made, share a copy of the presentation  
5 with Martha. Martha will get it out to us electronically, and  
6 we'll set up a time in between now and our next meeting to do a  
7 conference call of interested parties, sooner rather than later,  
8 to give Pam enough time to do the appropriate analyses that we  
9 think are the next things to do, you know, so we can help you  
10 with that.

11 The -- I think, of all the things we have to do here  
12 other than the corrections, perhaps the most pressing is  
13 figuring out which hospitals are quote unquote "pediatric" and  
14 which ones are not, you know, in terms the -- the level of  
15 comprehensive services that are provided, which, you know,  
16 probably, you identified yourself. You know, and that's going  
17 to be very, very helpful in terms of our -- of our -- you know,  
18 of our analyses.

19 The -- I think you -- you know, you were -- Bob -- Bob  
20 Kanter and I were sharing a smile with each other as you were  
21 talking about appropriate outcomes because, of course, this is  
22 the issue that we all wrestle with all the time. And you know,  
23 our -- our hope is, I -- I mean, it would be amazing if we  
24 could -- if we could ultimately use data like this in some way  
25 to figure out a risk adjustment strategy that could be used with

1 respect to administrative data, that would hold some water,  
2 because that would really allow us to, you know, to -- to make a  
3 huge difference in terms of, you know, the -- the standards and  
4 so on. And very briefly, if you could -- if you could link the  
5 levels of care that are being provided to the risk-adjusted  
6 outcomes achieved in those -- in those areas, that's -- that's  
7 really -- that's really critical.

8 SPARCS has as a limitation that it doesn't include, you  
9 know, necessarily explicit statements about disabilities that  
10 people may have at discharge. It focuses primarily on an  
11 outcome with -- you know, and you know, diagnoses and diagnoses  
12 codes -- diagnosis codes and procedure codes. So, in a -- in a  
13 population where -- where mortality is low, morbidity becomes,  
14 obviously, much more important. Not that that is not true in  
15 other populations as well. But for -- for us, even trying to  
16 figure out differences of care, looking at complications is --  
17 you know, is in some ways even more important than looking at,  
18 you know, at deaths because, you know, the deaths are so  
19 infrequent events. And with the small cell numbers, as you  
20 pointed out in several instances here, it's sometimes a little  
21 hard to know if the data is -- you know, is either from -- I  
22 mean, it's all, from a descriptive statistical standpoint, since  
23 this is the population, these -- by definition, you know, these  
24 differences are significant, but the question is are they  
25 clinically significant? They may -- you know, they may from

1 a -- be, just from a descriptive statistical standpoint, you  
 2 know, significant, because in fact, this is the population.  
 3 It's the whole population. But whether it mean -- whether, I  
 4 mean, as they say, the importance of the difference is that it  
 5 makes a difference, and -- you know -- and you know, where are  
 6 the -- where are these differences that are -- that are  
 7 meaningful in terms of, you know, how we provide care?  
 8 But I don't mean to, you know, in any way cut off  
 9 discussion, but we've got a couple of things we've got to get  
 10 through yet.  
 11 Are there specific questions for Pam that we can --  
 12 that we can -- that we have right now, or can we save them for  
 13 the conference call?  
 14 MR. LEARY: I just have one suggestion.  
 15 DR. COOPER: Sure, please.  
 16 MR. LEARY: Is that, in addition to the presentation,  
 17 that we give you the information about which -- which hospitals  
 18 were which, according to --  
 19 DR. COOPER: Absolutely, please.  
 20 MR. LEARY: -- the way this --  
 21 FROM THE FLOOR: Yeah, that would be very helpful.  
 22 MS. GOHLKE: -- was done this time. Okay.  
 23 DR. COOPER: Very helpful. Okay. Great. Thank you so  
 24 much.  
 25 DR. BRILLHART: I just wanted to comment that, for a

1 nonclinical person, I thought she did a good job of drilling  
 2 down through that data.  
 3 DR. COOPER: Absolutely. Hear, hear. That's a  
 4 great -- thank you, Susan for -- you know, it was -- it was  
 5 marvelous, actually. We were -- we were -- we were thrilled.  
 6 Really, because we were not expecting, you know -- because, to  
 7 be very honest with you, for -- for several months the  
 8 information we had was that this information would not be  
 9 helpful, and we all suspected it might be, and you have shown us  
 10 that it's -- and we have some more work to do, but this will be  
 11 very, very helpful to us in -- in working toward our ultimate  
 12 goal, making sure the right kid gets to the right place with the  
 13 right care at the right time.  
 14 Okay. I'm going to comment briefly on the Pedi-STAT  
 15 for iPhone issue. We clearly do not have time to get into that  
 16 today. At the -- at the -- so we'll put it on the agenda for  
 17 the Webinar, but there's not much really to say at this  
 18 particular moment, but a lot to think about. The issue arose in  
 19 terms of how we provide our E.M.S. providers in this current  
 20 electronic world with real-time, you know, data about -- about  
 21 equipment and drug dosing. In other words, you know, a Broslow  
 22 (phonetic spelling) tape on your P.D.A., if you want to think of  
 23 it that way. How can, you know, how do we -- how do we utilize  
 24 the current electronic gadgetry available to us, whatever you --  
 25 whatever you want to call it, apps on your cell phone, whatever,

1 how do we figure -- how do we figure out a way that we can use  
 2 current electronics to get equipment and -- and drug dosing  
 3 information to our prehospital providers in -- in a reliable  
 4 and -- and valid way?  
 5 And so, that's really -- that's really the question  
 6 that arose at the SEMAC. It arose in the context of, you know,  
 7 is this the right drug dose, how do we make sure that our  
 8 providers are getting the -- getting the right drug doses, et  
 9 cetera, et cetera.  
 10 So I'd just invite you all to think about that and  
 11 we'll address that issue on the -- on the next -- in our next --  
 12 at our next meeting, which will be -- which will be electronic.  
 13 DR. HALPERT: Art, was that -- was that a question that  
 14 SEMAC posed, or had an answer to that question?  
 15 DR. COOPER: It was -- it was -- it was a point of  
 16 discussion that was -- that was raised, and I -- I indicated  
 17 that I would bring it back to the E.M.S.C. Committee for further  
 18 discussion.  
 19 Lee, is that your recollection?  
 20 DR. HALPERT: That was specific to pediatric concerns,  
 21 not overall protocol concerns?  
 22 DR. COOPER: It was specific to pediatric concerns, but  
 23 there's no reason it couldn't be a -- you know, an overall  
 24 protocol issue.  
 25 DR. HALPERT: Yeah, I was just curious --

1 DR. COOPER: Yeah.  
 2 DR. HALPERT: -- if that was the discussion that they  
 3 had.  
 4 DR. COOPER: Yeah.  
 5 MS. BURNS: Only because this was for -- this -- this  
 6 app was for pediatric E.M.S.; yes?  
 7 DR. COOPER: So, yeah, so that's what this is -- this  
 8 specific issue. Thank you for reminding me. There's the  
 9 specific issue, this one, and the more global issue of how we  
 10 get accurate information to our prehospital providers  
 11 electronically. You know, and that could even go, you know,  
 12 further. It could go as broadly as, you know -- you know, a  
 13 slimmed down version of, you know, the -- pediatric protocols  
 14 that fits on one screen, or something like that, so that people  
 15 can see it easily, now that everybody's got an iPad, or a --  
 16 DR. HALPERT: Right.  
 17 DR. COOPER: -- cell phone or whatever, you know --.  
 18 DR. HALPERT: Just because it's electronic doesn't mean  
 19 it's necessarily better either, in my experience.  
 20 DR. COOPER: Understood.  
 21 DR. HALPERT: But that's a whole other --.  
 22 DR. COOPER: Understood. And that's -- and that's  
 23 really the question.  
 24 DR. HALPERT: Right.  
 25 DR. COOPER: You know, there -- it's -- there's a

1 narrow question, but the narrow question really has to be  
 2 answered within the context of the broader one.  
 3 So I'm going to invite you all to think about that.  
 4 Mike, can you comment briefly on the pede -- the New  
 5 York City slash New York State pediatric trauma center issue?  
 6 MS. GOHLKE: It's bylaws first --.  
 7 DR. COOPER: I wanted to get to Mike --  
 8 MS. GOHLKE: All right.  
 9 DR. COOPER: -- because I think that's more important.  
 10 MS. GOHLKE: Okay.  
 11 MR. TAYLER: The -- so we got, over the last, probably  
 12 year now, the -- the list from the chief executive officers of  
 13 the trauma centers in New York City. In the five boroughs there  
 14 are eighteen trauma centers. We sent a letter to all the  
 15 C.E.O.s saying do you meet the pediatric requirements, i.e., do  
 16 you also consider yourself -- do you also considered yourself  
 17 both an adult and pediatric trauma center?  
 18 So we got the letters back from them. That narrowed  
 19 the field down now to the -- I think there are eleven. I think  
 20 there's eleven of those that the C.E.O.s said yes we are a  
 21 pediatric trauma center. From there, the STAC said okay. Let's  
 22 ask them to prove it. So, in conjunction with the New York City  
 23 R-TAC, we put together a paper survey about fifteen pages long,  
 24 sent it to those eleven hospitals, and said please fill out this  
 25 survey and return it to the New York City R-TAC, so they can see

1 how you are a pediatric trauma center.  
 2 That's in progress right now. We just got all the --  
 3 all the surveys back. We had -- we had one hospital that, I  
 4 believe, they are going to -- once they took a look at the  
 5 survey, they decided that they really could not meet the  
 6 standards, so I think they are about to send us a letter saying  
 7 that they are bowing out of the pediatric business -- pediatric  
 8 trauma business. More to come on that. I've not seen any  
 9 letters, so more to come on that.  
 10 But -- so, the -- the New York City R-TAC, under the  
 11 guidance of Dr. Ron Simons from Belleview, who chairs the R-TAC,  
 12 is -- is looking over those surveys now, hopefully to report on  
 13 a little bit at the STAC next week, and -- and -- and to come.  
 14 In addition to that, that whole progest was -- project  
 15 was started under the -- the prior bureau director, Ed Wronski.  
 16 The current acting director said well, since we did it for New  
 17 York City, it probably would be a good idea to do it for the  
 18 rest of the state. So, she directed me, in her own way, to do  
 19 the same thing for the rest of the state. And I'm just  
 20 completing now getting the letters from the C.E.O.s -- the -- as  
 21 to who is and who isn't pediatric. No real surprises there, I  
 22 have to tell you. Although it -- the -- the -- the question of  
 23 simply getting a letter from the -- from Department of Health  
 24 asking are you or are you not a pediatric trauma center, it  
 25 really has made the C.E.O.s sit up and take notice that, well,

1 are we or are we not? Do we meet the regulations or don't we?  
 2 A lot of the delay in getting the letters back from the C.E.O.s  
 3 has been, once they get the letter from me saying -- asking the  
 4 question, they run to their -- their trauma medical director,  
 5 the trauma program managers, and say we need to review this  
 6 entire thing to make sure that we are up to date, because I'm  
 7 not going to sign a letter attesting that we are when, in fact,  
 8 we don't meet the standards.  
 9 So that's -- that's a lot of the delay right there  
 10 from -- in getting the C.E.O. letters, because they're making  
 11 sure that they are before -- before actually telling the  
 12 Department that they are or are not. So, so -- the project  
 13 continues and -- and more to come on that. Your next meeting is  
 14 when, November?  
 15 MS. GOHLKE: November 30th.  
 16 MR. TAYLER: Is it? I'm -- I'm hoping to have more  
 17 from -- from them, particularly a report out from the New York  
 18 City R-TAC as to -- as to what they thought about the surveys  
 19 from New York City folks, so more to come.  
 20 DR. COOPER: And that's the Webinar, correct --  
 21 MS. GOHLKE: No.  
 22 DR. COOPER: -- Martha?  
 23 MS. GOHLKE: It's an in-person meeting.  
 24 DR. COOPER: Oh, it is?  
 25 MS. GOHLKE: There's no Webinar scheduled.

1 DR. COOPER: Oh, I thought there was.  
 2 MS. GOHLKE: No.  
 3 DR. COOPER: No?  
 4 MS. GOHLKE: We -- we had one scheduled for last --  
 5 DR. COOPER: For June, I know.  
 6 MS. GOHLKE: -- June, and that was cancelled.  
 7 DR. COOPER: I know, but I thought we were doing  
 8 another Webinar this year.  
 9 MS. GOHLKE: No.  
 10 DR. COOPER: No. Oh, okay.  
 11 MS. GOHLKE: So, November 30th.  
 12 DR. COOPER: Even better. It's always better  
 13 face-to-face.  
 14 MS. GOHLKE: And we're here.  
 15 DR. COOPER: Okay. All right. I'm going to save the  
 16 updates from the sister advisory committees, because they have  
 17 not met very recently, and most of the issues have been covered,  
 18 so we will now take a quick look at the bylaws.  
 19 Martha, remind me where we are in this process. Are we  
 20 ready to approve?  
 21 MS. GOHLKE: Well, there -- this has gone through many  
 22 changes. The -- the last set of changes are -- are noted in  
 23 your copy from D.L.A., the Department of Legal Affairs. We had  
 24 some back and forth discussion about the pediatric behavioral  
 25 expert that was omitted by D.L.A. because it was not in our

1 statute. That seat was not in our statute so therefore, D.L.A.  
 2 said it needs to be pulled from our bylaws. But we did add the  
 3 little caveat there that's underlined, "in addition to the  
 4 aforementioned seats, the E.M.S. M-SCAT recommends a seat for a  
 5 pediatric behavioral specialist be included as a full voting  
 6 member." So, we hope that the Commissioner will vet somebody if  
 7 we propose a candidate for that seat. But it is up to his or  
 8 her discretion, really, whether or not they get vetted, but --  
 9 we went back and forth on this, but I think what we decided the  
 10 last time was that we need to vote on these and move them  
 11 forward. If we want to revise them again, you know, that's  
 12 fine. But we need -- we -- we need to vote on them and get them  
 13 passed because now, actually, our whole membership is due to be  
 14 revetted, and if we don't have bylaws in place, that could hold  
 15 everything up, so and the last meeting we didn't have a quorum.

16 We have a quorum today, so I think we need to take a  
 17 vote.

18 DR. COOPER: All right.

19 DR. VAN DER JAGT: I move that we accept these bylaws  
 20 as amended, and ask them to send them to us.

21 DR. BRILLHART: Second.

22 DR. COOPER: Discussion.

23 Bob.

24 DR. KANTER: Can we -- I -- I just haven't have a  
 25 chance to read this carefully. Is there anything else we should

1 be thinking about before we approve them?

2 MS. GOHLKE: Well, I think the couple of things -- you  
 3 you've got to -- you can serve two consecutive four-year terms,  
 4 and then you have to take a year break before you can be back on  
 5 the Committee again. I think that --.

6 DR. VAN DER JAGT: Is that something that's required by  
 7 State --

8 MS. GOHLKE: No, it's written in the statute that way.

9 DR. VAN DER JAGT: The statute?

10 MS. GOHLKE: Yeah.

11 DR. VAN DER JAGT: Oh, it is?

12 MS. GOHLKE: Yeah. So, this -- D.L.A. basically --  
 13 what the D.L.A. did was they took our bylaws and they took the  
 14 statute and put them side by side, and they wanted to make sure  
 15 they were consistent, and this is the way our statute's written.  
 16 So -- so, that's why we need to follow in suit with that.

17 The other thing is -- the other thing that the  
 18 executive department felt very strongly about is that the chair  
 19 and vice chair need to be physicians, because we are giving  
 20 medical advice for the pediatric community. And if the chair  
 21 was absent for whatever health-related reasons for an extended  
 22 period of time, then the vice chair must also be a physician.  
 23 So that is one of the changes.

24 The other thing that I just realized when I was  
 25 glancing at these is that the chair and vice chair turns over

1 with the membership. So, pretty much everybody is up in either  
 2 June or July 2011, and that's when the chair and vice chair  
 3 would turn over, too. So, in addition to vetting -- either  
 4 revetting current members or bringing in new folks, we also need  
 5 to think about who we're going to recommend for chair and vice  
 6 chair to the Commissioner, who has ultimate say in all these  
 7 seats, just as a reminder. We can make our recommendations, but  
 8 the Commissioner has the final say, yay or nay, for all of these  
 9 seats.

10 So, that's pretty much, I think, the major changes that  
 11 were made by D.L.A.

12 DR. COOPER: Martha, the one question that I had was  
 13 regarding on page one this -- this --- we had -- we had, I  
 14 think, not disagreed with D.L.A., but you know, in the end that  
 15 it was clearly their, you know, say-so as to whether the -- you  
 16 know, the behavioral health person was included in the list.  
 17 But we thought this construction here was a little funny, you  
 18 know. Is that what they -- did you take that back to them and  
 19 they --

20 MS. GOHLKE: Yes. I mean, I --.

21 DR. COOPER: -- and they just said leave it this way?

22 MS. GOHLKE: I mean, we can -- I say -- I still think  
 23 we need to vote on this, if you want to change the language --

24 DR. COOPER: All right, fine.

25 MS. GOHLKE: -- you know, we -- we can do that.

1 DR. COOPER: But I -- but you took this -- but you  
 2 took -- you took our comment that we thought this construction  
 3 was a little funny back and they said too bad, leave it this  
 4 way?

5 MS. GOHLKE: In those -- those exact terms, no, but  
 6 you've got to understand how hard it is to get the attention of  
 7 D.L.A. --

8 DR. COOPER: All right. Okay.

9 MS. GOHLKE: -- when it comes to these bylaws.

10 DR. COOPER: All right, okay. Okay. Okay.

11 All -- discussion? Further discussion?

12 (No audible response)

13 DR. COOPER: Then, in that case, all in favor of  
 14 approving the bylaws as written, with the understanding we can  
 15 amend them, according to process, at any time.

16 Please raise your hands high. One, two, three, four,  
 17 five, six, seven. Okay. Seven.

18 Opposed?

19 Abstentions?

20 (The motion carried.)

21 DR. COOPER: Okay. It carries without dissent, so  
 22 there we are. We're done with the bylaws for now.

23 MR. TAYLER: Dr. Cooper?

24 DR. COOPER: Yes, sir.

25 MR. TAYLER: If I could just make a quick comment so

1 that everybody realizes, this is not -- don't be disheartened if  
2 you think that this is a -- that -- that this is being slammed  
3 through and this is a rush, rush thing and we ought to have it  
4 completed. Please don't feel discouraged or slighted by that.  
5 It -- it's -- it really is the process, at which I found out  
6 when I took over the STAC a couple of years ago. It's -- I -- I  
7 went through the same thing with the STAC and getting their  
8 bylaws and their vetting settled. You -- you're going through  
9 the same process as STAC did. So -- so, don't -- don't feel  
10 slighted in any way as to -- as to, you know, these aren't  
11 complete -- really complete or anything like that. It -- it's  
12 simply a process. Just bear with them.

13 DR. BRILLHART: Mike, we've been working on them for  
14 three years.

15 MS. GOHLKE: Yeah, exactly. This hasn't been a rush  
16 process --.

17 DR. BRILLHART: At some point you got to vote and then  
18 make changes.

19 MS. GOHLKE: Yeah, yeah.

20 DR. COOPER: Okay. We still have like thirty seconds,  
21 I think.

22 So, Sharon, is there anything from SEMAC or SEMSCO  
23 that --

24 MS. CHIUMENTO: There is --

25 DR. COOPER: -- is pressing, that needs to be

1 mentioned?

2 MS. CHIUMENTO: -- just -- well, not pressing, but just  
3 two quite quick comments. You may see in some regions propofol  
4 being added to protocols for patients who are trapped -- for  
5 long entrapments. You may also see --

6 DR. COOPER: Entrapments? You mean in cars --

7 MS. CHIUMENTO: Entrapments.

8 DR. COOPER: -- or do you mean disasters?

9 MS. CHIUMENTO: No.

10 DR. COOPER: You mean extrications?

11 MS. CHIUMENTO: Extrications.

12 DR. COOPER: Extrications.

13 MS. CHIUMENTO: Long -- long extrications. Just --  
14 wait, my paper -- oh, here we go. And also ketamine. Oh,  
15 ketamine is for prolonged extrications; propofol is for  
16 interfacility transports.

17 DR. COOPER: Okay. That sounds a little better.

18 MS. CHIUMENTO: Okay. So those both, and then the  
19 other thing was Tim Czapranski, whom you have all seen at this  
20 meeting, will be -- is proposed for next year's chair, so we may  
21 actually see him in a different role.

22 And the last thing, I think, and Ann may want to  
23 comment on this is FDNY's data on the use of the ResQPOD, and  
24 the fact that they actually had decreased survival when -- when  
25 the ResQPOD was used, and they've now removed it from -- from

1 their vehicles. So, I don't know if you want to comment that --  
2 on that.

3 MS. FITTON: I think you said it very nicely, Sharon.  
4 We thought the ResQPOD would be a tremendous tool to help us  
5 have sustained ROSC. We worked very hard to educate all of our  
6 providers. We did video drills, in-person drills. We trained  
7 the officers first. We provided training in a period of about  
8 forty-five days prior to the deployment of the ResQPOD. Then  
9 when we reached out, and we got our C.F.R. component on board,  
10 also, with this. After ninety days looking at the data, we had  
11 a significant --

12 MS. CHIUMENTO: Six point six.

13 MS. FITTON: -- decrease -- about eight percent  
14 decrease in prehospital ROSC and a -- an even higher -- and I  
15 wish I had known you were going to blindside me this -- with  
16 this, Sharon, because I would have brought the data with me, so  
17 I would not seem to be struggling for these numbers, but I --.

18 MS. CHIUMENTO: The numbers that I've got here are a  
19 six point six drop of -- with pod use versus non-pod use and  
20 then, after you stopped it -- you had a one point nine eight  
21 percent decrease from one year to the next.

22 MS. FITTON: Well, I -- I think that -- I -- I -- with  
23 all -- with all due respect, Sharon, I believe that you have  
24 some of the information but not all of it --

25 MS. CHIUMENTO: Well, that's all that was in the notes.

1 MS. FITTON: -- and -- and therefore, I'm going to  
2 decline to confirm your numbers. But definitely, I -- our  
3 thought was that it would be better off to remove it, and they  
4 did. And since that time -- we have just passed the next ninety  
5 days, and I'm told that we're -- we're in the process of looking  
6 at our data. What we don't do is we don't continually look at  
7 the data, because the more you look at the data, the more  
8 certain you are of the data, believe it or not. So, what we  
9 decided to do was to leave it at the same exact amount of time,  
10 ninety-day period, and to reevaluate. We should have those  
11 numbers shortly.

12 DR. COOPER: All right. Thank you, Ann.

13 Anything else, Sharon?

14 MS. CHIUMENTO: Nothing.

15 DR. COOPER: I don't believe that there's anything from  
16 the STAC meeting that we haven't carried -- covered in the  
17 course of other discussion. I think the main issue before the  
18 STAC has to do with, you know, the issue of the regs and the  
19 pediatric trauma issue we've already heard about. I will say  
20 that, because of the -- the difficulty with getting the regs  
21 through for a variety of reasons, STAC will be considering, next  
22 week at a fairly lengthy discussion in the morning, the  
23 possibility that we should adopt American College of Surgeons'  
24 criteria and ask -- ask trauma centers to seek verification  
25 through the American College of Surgeons. The standards for the

1 American College of Surgeons are somewhat more rigorous than  
 2 they are at the state level, and certainly, the process of  
 3 seeking verification through the college is much more  
 4 labor-intensive and far more costly. So, it remains to be seen  
 5 how the STAC will fall out on that.  
 6 And there has been some consideration to looking at the  
 7 idea that, perhaps, we need, in 2010 and following years, to  
 8 look at a different method of accreditation entirely. You know,  
 9 perhaps looking at process measures, which is what the  
 10 regulations largely do, you know, is an antiquated approach, and  
 11 perhaps we should be looking at outcome measures and saving, you  
 12 know, the process measures for centers that either do really  
 13 well so we can figure out what we're doing -- what they're doing  
 14 better, so it can be exported to other centers. And to look at  
 15 the ones who are doing worse than the -- than the -- than the  
 16 average, and figure out why they're not doing so well, and offer  
 17 suggestions for improvement.  
 18 So, this is all a big subject for discussion at the  
 19 STAC meeting next Wednesday, and I suspect it will be a very  
 20 interesting meeting.  
 21 That concludes the -- the agenda. We got everything  
 22 done, pretty much. We're only five minutes over time.  
 23 Is there any new business that needs to be covered?  
 24 MS. GOHLKE: I do have a correction to something I said  
 25 earlier.

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1 DR. COOPER: Please.  
 2 MS. GOHLKE: Regards to the bylaw -- bylaws now that  
 3 they're voted in. Lee -- Lee, of course, was looking at the  
 4 statute when we were talking about the bylaws. One of the --  
 5 one of the things that was taken out by D.L.A., that I had  
 6 misspoke on, was the fact that you -- basically, the members can  
 7 serve consecutive terms, regardless of how long. And we had it  
 8 in here in the bylaws originally that you can only do two terms  
 9 and then you had to take a year off before you could come back.  
 10 But D.L.A. pulled the statute and said your statute doesn't say  
 11 that. It says basically, somebody can continue to serve for as  
 12 long as they want, and as long as they're vetted by the  
 13 Commissioner.  
 14 So, I just wanted to make that correction on the  
 15 record.  
 16 DR. COOPER: So, we do not have to be off for a year?  
 17 MS. GOHLKE: You have to be revetted. You have to go  
 18 through the revetting --  
 19 DR. COOPER: Understood.  
 20 MS. GOHLKE: -- process, but yeah, you can stay on as  
 21 long as your heart desires.  
 22 DR. BRILLHART: But -- but do we --  
 23 DR. COOPER: As long as you're --  
 24 DR. BRILLHART: -- do we need to revote --  
 25 DR. COOPER: -- the nominating --

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1 DR. BRILLHART: -- with that correction?  
 2 DR. COOPER: -- bodies --.  
 3 MS. GOHLKE: Right. And that, too, yeah. I'm sorry.  
 4 DR. BRILLHART: Do we need to revote with that  
 5 correction?  
 6 MS. BURNS: No, it's in it -- that's how it's written  
 7 in the bylaws.  
 8 MS. GOHLKE: Well, we could. We could do a -- we could  
 9 make it official and do a revote.  
 10 DR. COOPER: At Martha's request, I'll ask for a motion  
 11 to reconsider. That requires two-thirds of a vote.  
 12 Jonathan, thank you.  
 13 From -- is there a second to that motion? Susan, thank  
 14 you.  
 15 Discussion?  
 16 (No audible response)  
 17 DR. COOPER: All those in favor, please raise your  
 18 hands.  
 19 Opposed?  
 20 (The motion carries.)  
 21 DR. COOPER: Carries without dissent.  
 22 Okay. Is the -- is there a motion to approve the  
 23 bylaws as written with our new understanding?  
 24 MS. CHIUMENTO: So motion.  
 25 DR. COOPER: Yes, Sharon primary; John secondary.

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1 Discussion?  
 2 (No audible response)  
 3 DR. COOPER: All in favor?  
 4 (The motion carried.)  
 5 DR. COOPER: Motion carries unanimously without  
 6 dissent.  
 7 Thank you. Okay. So there you go.  
 8 MS. GOHLKE: Excellent. Thank you.  
 9 DR. COOPER: All right. Our next meeting, as we have  
 10 heard, is Tuesday; right, November 30th --  
 11 MS. GOHLKE: Yeah. Yes.  
 12 DR. COOPER: -- in this very room?  
 13 MS. GOHLKE: Yeah. And actually, I have one more  
 14 comment.  
 15 DR. KANTER: With no lunch.  
 16 MS. GOHLKE: Actually, we do have lunch for one more  
 17 meeting for this calendar year. I think Lee was hoping this was  
 18 the last one of the year, but it's not.  
 19 MS. BURNS: Holiday season, council season, I get  
 20 abuse.  
 21 MS. GOHLKE: Right. 2000 -- starting 2011 we are  
 22 without food. But -- so yeah, you don't have to bring lunch for  
 23 the next meeting, as far as I know.  
 24 DR. COOPER: Nothing like a little --.  
 25 MS. GOHLKE: And for next year we've to start thinking

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1 of dates for next year. And ultimately, it's up to whatever  
 2 vendor hotel we go with what dates they have available.  
 3 But I'm -- my question to you is Tuesdays -- does this  
 4 time slot on Tuesdays generally work for people?  
 5 DR. COOPER: Yeah.  
 6 MS. GOHLKE: Should we stay with this eleven to four on  
 7 Tuesdays?  
 8 DR. COOPER: Yeah, it's good.  
 9 MS. GOHLKE: And -- and if there's --  
 10 DR. HALPERT: I move.  
 11 MS. GOHLKE: -- if there's a big meeting -- trauma  
 12 meeting or something that you need to be to, or several folks  
 13 might be to, just let me know and I'll try to avoid that date,  
 14 although I'll probably hear from Mike. But if there's  
 15 something, you know, one Tuesday you absolutely can't make, just  
 16 let me know and I'll try to work around it.  
 17 DR. COOPER: Yes, and all -- we have to avoid all  
 18 children's birthdays.  
 19 MS. GOHLKE: Yes.  
 20 MS. CHIUMENTO: We have to what?  
 21 DR. COOPER: Avoid all children's birthdays.  
 22 MS. GOHLKE: Okay. So, you can let me know by e-mail  
 23 if, you know, a date doesn't work for you. But otherwise, we'll  
 24 keep the Tuesday, eleven-to-four time slot. Thanks.  
 25 DR. COOPER: Good. Anything else to come before us?

1 (No audible response)  
 2 DR. COOPER: And seeing no objection, we will stand  
 3 adjourned until November 30th.  
 4 Thank you all for your attention  
 5 (The meeting concluded at 4:08 p.m.)  
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1 I, Peter DeLorenzo, do hereby certify that the  
 2 foregoing was taken by me, in the cause, at the time  
 3 and place, and in the presence of council, as stated  
 4 in the caption hereto, at Page 1 hereof; that the  
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 6 pages number 1 to 190 inclusive, is a true record  
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