

NEW YORK STATE DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES FOR CHILDREN
ADVISORY COMMITTEE MEETING

DATE: June 21, 2011

LOCATION: Hilton Garden Inn Troy
235 Hoosick Street
Troy, New York 12180

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

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 2 (The hearing commenced at 1:00 p.m.)
 3 **DR. COOPER:** Good afternoon, everyone.
 4 It's really a pleasure to see everyone again after our long
 5 absence from one another, except via teleconference, of
 6 course. We have a -- a full, compact agenda today, so
 7 we're going to try to move through it pretty quickly
 8 because I know everyone is busy and has other
 9 responsibilities.
 10 Before beginning, however, I want to
 11 acknowledge the -- the presence of some of our special
 12 friends. Mary Ellen Hennessy is, I think -- are you head
 13 of O.H.S.M. now or --?
 14 **MS. HENNESSY:** No. God, no.
 15 **DR. COOPER:** No? Okay.
 16 **MS. HENNESSY:** Director of Certification
 17 and Surveillance.
 18 **DR. COOPER:** Okay. She is -- she is --
 19 she is almost --
 20 **MS. HENNESSY:** That's for the record.
 21 **DR. COOPER:** She's over almost everyone,
 22 but the Commissioner. There's a few other there that she's
 23 not over. And -- and, of course, Deb Sottolano is here
 24 from the -- from the disaster program. And Sandra Haff is
 25 here from Public Health Planning. So thank you so much for

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

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2 today, and also from Susan Brillhart who is up to her -- up
3 to her head in -- in final examinations and things like
4 that for the Borough of Manhattan Community College School
5 of Nursing.

6 And someone else has joined us. Yes?
7 **DR. KACICA:** Hi. Marilyn Kacica.
8 **DR. COOPER:** Marilyn. Great. Marilyn
9 Kacica is with us as well. Marilyn is Medical Director
10 from the Division of Family Health. And we're really,
11 really delighted to have so many folks from State Health
12 with us today. That's a rare pleasure and treat and we
13 thank all of you for taking time out from your busy day to
14 be with us.

15 So the first item on the agenda is a
16 welcome. I think we've done that. And in terms of the
17 review of the agenda, Lee will be giving a report on the
18 activities of the -- the bureau. Martha will be giving a
19 report on the activities of the -- the E.M.S.C. grant and
20 the program, of course. And Mary Ellen will be helping us
21 with update on -- on the 405 Hospital Code project, the
22 regionalization project. I'll -- I'll ask Bob to give a
23 report as to where we are in terms of regionalization,
24 although that will probably depend in great measure upon
25 what we hear from Mary Ellen. We'll then hear about

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2 is now in the Division of Budgets somewhere. The blood and
3 tissue folks have -- have been up on that and say that the
4 regs are actually there, so -- interestingly. The State
5 E.M.S. Council, the SEMAC implored me to exercise my
6 influence -- I say that with some degree of sarcasm since I
7 have none -- to reach out, you know, to get the
8 commissioner to free up the regs. So I said that I would
9 certainly let the people above me know that the SEMAC and
10 SEMSCO and probably you, too, are very interested in this
11 and I did.

12 We are -- we're reviewing State E.M.S.
13 Council E.M.S. awards. There's been some interesting
14 nominations. That is a good thing. It is disappointing to
15 me, though, that there are not nominations from every
16 corner of the state or nominations of people, you know,
17 that they're -- we're buried in nominations. That's very
18 frustrating.

19 Of significance, the State E.M.S. Council
20 at -- at our urging decided to -- well, they approved
21 the -- what's called the National E.M.S. Education
22 Standard -- and Sharon jump -- jump in when I screw this up
23 in some way. I -- I -- it -- as is our custom here in New
24 York State, in 1992, the feds came out with this great
25 E.M.T. curriculum. Well, in 1998, the cutting edge New

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2 education committee from Sharon and E.M.S. for Children
3 Committee membership update from Martha. We have a vote
4 for chair and vice chair today, regional emergency
5 preparedness activities update. I will be speaking
6 briefly, as will some others, I believe, and Sharon has the
7 A.L.S. protocol template for us as well.

8 And then as is our custom, we'll be
9 providing updates from our sister advisory committees to
10 the Health Department.

11 And here are our sodas and cookies.
12 Outstanding. Okay. So, Lee, take it away.

13 **MS. BURNS:** While you are having soda and
14 cookies -- turn this on -- just a couple of quick things.
15 Nothing is quick. We have been working with our -- with
16 the Health Department's blood and tissue program in order
17 to have the regs changed to allow E.M.S. providers to
18 transport patients with blood or blood products running and
19 that has been a lengthy and ongoing process. So the -- the
20 reg changes was pretty simple and we've put together with
21 the help of -- of Dr. Linden and her staff an educational
22 program and got everything all set and we're now waiting
23 for the regs to be finalized. We're not really, really
24 sure where they are. We think they're in what is now --
25 what used to be the Governor's Office on Regulatory Reform

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2 York State issued the new curriculum. In an effort to try
3 and avoid another four -- eight -- ten-year lapse, we
4 pushed the state council to allow us to adopt the National
5 E.M.S. Education Standards. So we're okay -- from an
6 A.L.S. perspective, our paramedics are really using
7 national standard curriculum currently. So it's really not
8 an issue at -- at the paramedic level. It'll be a lot of
9 work at the basic E.M.T. level. We're still cogitating
10 over the -- what we in New York State call certified first
11 responders. The feds call them emergency medical
12 responders. We probably ultimately will head towards a
13 national standard for E.M.R. The problem right now -- why
14 are you making faces, Jon?

15 The problem we face in New York is that
16 the -- our public health law limits the amount of time
17 an -- a certified first responder can be trained to
18 fifty-one hours. The E.M.R. program is longer than that.
19 So statutorily it may require a change. We're still
20 arguing about that.

21 Budget issues, there's no good news on
22 the budget horizon. I can't even sugarcoat it. We -- at
23 this point, we were told that there's another eleven point
24 two percent reduction in contract expenses. We're looking
25 at how that is going to affect our contractors. We have

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

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

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

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

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

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

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

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

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

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

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

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

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

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 2 doesn't limit the number of members on our committee, our
 3 does it, you know, limit, you know, one person per seat.
 4 So that's why we have proposal for additional people.
 5 And -- but in the times of budgetary cuts, you know, I'm
 6 afraid that executive is, you know, because we have to pay
 7 transportation and reimburse people, I don't know if
 8 everybody is going to get vetted. And, again, this is just
 9 coming from my own head. I -- I have not been told this.
 10 So I don't know yet. I don't know how it's all going to
 11 shake out. But I -- I'd be surprised personally if -- if
 12 all the names we put forward get approved, just because of
 13 budgetary issues. So -- our seats don't expire. I mean,
 14 you know, our statute says that people can serve as long as
 15 they want to. So my argument to executive will be, you
 16 know, in order to bring new people in, this is the way we
 17 have to do it. I mean we can't, you know, kick people out.
 18 Our statute doesn't allow that even if we wanted to, which
 19 we don't. But we can't kick people out to get new people
 20 in. So in order to get new blood in, get new -- new people
 21 in, this is kind of how we have to, you know, strategize.
 22 So that's my argument to bring other people in and
 23 hopefully it'll fly.
 24 But we'll -- you know, I started this
 25 process almost a year ago trying to get the paperwork

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

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

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 2 Bob Kanter, with our help and input,
 3 drafted an initial set of potential regulatory changes and
 4 we all felt that the best thing to do, together with our
 5 staff, was to run these up the flag pole to see how the
 6 Department felt about what we were thinking. And I think
 7 the Department was very, very receptive, but I think there
 8 were also some questions. And -- and I believe that's, at
 9 least in part, the reason Mary Ellen is with us today so
 10 she can share some of those questions, perhaps concerns,
 11 but I prefer to focus on the questions at this time.

12 So, Mary Ellen, if you will say what you
 13 think.

14 **MS. HENNESSY:** Sure. Thank you. Again,
 15 I -- I have to say thank you for inviting me here today. I
 16 am on the regulatory side of the Department and so quite
 17 often I have bad news to bear. And it's nice to work in a
 18 collaborative relationship with you all and I have to tell
 19 you I respect what you all do on a day-to-day basis
 20 immensely.

21 I'll first kind of set a setting for how
 22 we're going forward with certain types of regulatory reform
 23 at this point. You all may know that HANYS has really
 24 taken real flack for doing some healthcare reform via
 25 regulations. A lot of it has to do with vary specific

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 2 regulations that just don't seem to make sense anymore or
 3 encumber providers from being able to move forward with
 4 certain types of staffing, et cetera. To that end, they
 5 produced a document, it's actually a booklet called Tied Up
 6 in Knots, kind of getting through the regulatory system.
 7 And we at the Department and O.H.S.M. have been meeting
 8 with them over time to discuss all of these issues and
 9 have, indeed, crafted new language in the regulations or
 10 considered eliminating certain regulations that seem to be
 11 troublesome.

12 What we found over this time, though, is
 13 that we have a new administration and our new
 14 administration is really moving forward quite rapidly with
 15 the governor's intentions of redefining government, and
 16 looking at how all the agencies run, what our priorities
 17 are, how we operate on a day-to-day basis. And, of course,
 18 we're all feeling the effects of reducing state government
 19 by a certain percentage, which was one of the governor's
 20 intentions as well. What I will say is that those of us
 21 who are working in government are a very cohesive team. We
 22 really support each other, I believe, very well especially
 23 in our divisions. Lisa McMurdo, who just walked in, and --
 24 and Lee and all of the -- the people that are here, our
 25 goal is to really provide the best oversight and care of

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 2 patients receiving treatment in New York State facilities.
 3 That being said, when we looked at your
 4 regulations, your proposed regulations, I have to say that
 5 it was a great alignment in anticipating where it would fit
 6 in the code and all of the things that you wanted in here
 7 so specific to pediatrics. A couple of comments I have,
 8 though, are these. One is that we think this number might
 9 already be taken by other regulations, so that's kind of a
 10 non-issue. It's just 405.30 may be taken by something
 11 else.

12 A lot of our leadership has looked at the
 13 degree of should we have very specific regs for pediatrics
 14 as opposed to adding language to existing regs to make sure
 15 that the pediatrics -- pediatric issues are counted. That
 16 seems to be where we'd like to go, as opposed to sectioning
 17 out all new regulations in its own course because we -- I
 18 feel that it may fly better that way if we add some
 19 language.

20 I also noticed that a lot of this could
 21 be facilitated in moving forward through standards of care
 22 or guidance documents that we, as surveyors, would hold the
 23 facilities to. We can't say it's specifically in
 24 regulation. We could, for instance, hold true to this is
 25 how we're going to measure protocols, criteria, and

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 2 resources for infants and children at our hospitals
 3 treating pediatrics and, in essence, achieve the same goal.
 4 This is how we're going to hold you accountable with this
 5 level of care. It's tough under the 405 anyway because
 6 these are minimum standards, and although we would like to
 7 see things in an ideal setting we have to remember minimum
 8 means minimum. So we want to make sure we have at least
 9 the right things at the -- at the base and then hold them
 10 to a higher accountability through our interpretive
 11 guidance and so on.

12 The other thing I'll say is because of
 13 this regulatory reform, there were lots of comments by
 14 facilities to our healthcare associations regarding
 15 duplication of survey services. One of those duplications
 16 was doing state surveys and federal surveys at the same
 17 time. And those of you who work in a facility and received
 18 any of our deficiencies and pulled your hair out or stabbed
 19 yourself in the eye know how difficult that was to
 20 interpret. What am I responding to? Is it state? Is it
 21 federal? And you got two different sets of documents. We
 22 decided, in response to what the healthcare facilities were
 23 telling us, that it really was cumbersome. If we're out
 24 there doing a federal survey, then that's what we should be
 25 focusing on. If, however, we saw something egregious that

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 2 really related to a state citation, we would still address
 3 that. But for the most part, we're focusing on what the
 4 federal government asks us to do as their agents when we go
 5 in for a federal purpose survey. So, some of these
 6 specifics about the pediatrics may not be able to get
 7 drilled down to anyway because we would be looking at the
 8 general headings under the federal conditions of
 9 participation.

10 It is my impression, as certification and
 11 surveillance director, that we expect all hospitals who
 12 have these services to provide the right size equipment,
 13 the right standards of protocols, but in order to beef that
 14 up to meet your satisfaction we are very willing to add
 15 language to some existing regs which I think will go
 16 through faster and better and to incorporate tools that we
 17 think will enable our providers to know this is how we're
 18 going to measure you against these standards. And then
 19 they will have all the information they need in order to
 20 bring themselves up to that level.

21 So I'll stop here and I'll be asking for
 22 any questions or interpretation.

23 **DR. COOPER:** I'll -- I'll -- I'll ask a
 24 question to start things off, Mary Ellen. I think we hear
 25 you and understand, you know, where you're coming from. We

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

23 I think for me -- and I don't know if
 24 this is doable either, but I think what would be most
 25 helpful, I think, for us in serving as your official

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 2 advisors on -- on these matters is if there could be some
 3 kind of meeting where we could actually go through this
 4 document sort of line by line and say we think this could
 5 go better here, we think this could go better there, that
 6 sort of thing, so we can, you know, assist you better in
 7 this -- in this process and, you know, in effect, sort of
 8 say well, this is something that we feel is so important
 9 that -- that it really does have to be addressed in
 10 regulation, whereas this is something which, you know, more
 11 appropriate to address by policy.

12 Part of the reason, I'm sure you know,
 13 that the document was drafted in the way that it was is
 14 that this is the advice that we had gotten from previous
 15 administration in terms of the -- the way to go. And, of
 16 course, we have a new governor, we have a new health
 17 commissioner, and we have a new healthcare reform act, you
 18 know, on the table. And all of these things are, you know,
 19 making a, you know, rather large difference in how we all
 20 do business. And so it's understandable that -- that, you
 21 know, the view of things would -- you know, would change
 22 from, you know, May 2010 to June 2011. But I would ask on
 23 behalf of our committee if setting up such a meeting would
 24 be possible so we can get a better sense of what it is, you
 25 know, you feel you -- you -- would help you best in -- in

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 2 moving forward because what I'm hearing between the lines
 3 is that there's a very strong commitment on the part of the
 4 Department to doing this. It's really a matter of form
 5 rather than function.

6 **MS. HENNESSY:** Right. I would agree. I
 7 mean it would be worthwhile. What I would like to propose
 8 is that we work internally, Sandra Haff and myself and some
 9 people in my unit --

10 **DR. COOPER:** Sure, yeah.

11 **MS. HENNESSY:** -- with Martha and Lee and
 12 anyone that they recommend, to slide this into the areas
 13 that we think will work and then present that to you and
 14 then we'll go through that line by line. Referring back to
 15 what Bob has put here under each title. So you'll --
 16 you'll see what the original proposal was and then where we
 17 think it may fly and what would be regulatory type language
 18 versus what is really guidance language.

19 **DR. COOPER:** Uh-huh. Uh-huh. Bob?

20 **DR. KANTER:** Well, just to review a
 21 couple of things. The -- the way the proposal was written
 22 was wherever possible it was based on existing 405
 23 regulation. So we really tried to resist the temptation to
 24 extend into more than minimal standards based on the
 25 precedent of other sections in existing 405 regs. We also

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 2 tried very hard to write all the suggested items as things
 3 that were definable and evaluatable based on existing
 4 information. That is we intended that it would be
 5 interpretable without doing any new surveys. Most of the
 6 information refers to high volume hospitals should do this
 7 or that. Volumes are already reported to the state and are
 8 fairly self-defined on the basis of existing information.
 9 So we were trying very hard to avoid a whole new regulatory
 10 surveillance process.

11 When you get right down to it, I think
 12 our interest is not exactly what format it's in. Our
 13 interest is getting it implemented. I have two thoughts
 14 about that. One is that it's better if it's in writing and
 15 it's enforceable in some aspect. And information is really
 16 only useful if it's accessible. And having read through
 17 the entire 405 regs in the process of writing these
 18 proposals, I can tell you that it's not accessible if we
 19 distribute the items in each of many other sections. It's
 20 impossible to get to it quickly, systematically, reliably.
 21 You've always missed something unless you spend hours on
 22 it. And if someone is just trying to figure out, you know,
 23 in their periodic review in each institution are we meeting
 24 minimal standards, it would be an awful lot easier to go to
 25 the pediatric section -- a lot more -- not only easier, but

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 2 a lot more likely to work. If you go to the pediatric
 3 section just as you go to the cardiac section, the
 4 emergency section, the anesthesia section, the -- the
 5 surgical section, each one of those is important --
 6 self-evidently important. I don't think pediatrics is any
 7 less important than those others.

8 **MS. HENNESSY:** A point well taken. I
 9 understand your point about that, but my feeling is at this
 10 point that there are other provider types or groups that
 11 would also say ours needs to be ratcheted out. And so what
 12 we would, in essence, be doing is for every type of
 13 patient, perhaps group, we would be saying it deserves its
 14 own set of regulations. And maybe that's not a bad idea
 15 overall, just so it's in a compact way, but we would be
 16 rewriting and rewriting and rewriting the basic regulations
 17 that every hospital is required to have and then putting in
 18 this individual group. It's not that I'm not sympathetic;
 19 it's that I'm trying to, in a world of less regulation,
 20 pushing forward an idea that may have better results in
 21 total.

22 Now, that's not to say some of these
 23 things couldn't get mentioned like a volume type of thing
 24 in a very specific count, but I would have to discuss that
 25 with this group and Lisa McMurdo's group, our O.H.S.M.

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 2 directors, and so on. What didn't seem to go well was the
 3 concept of having a whole entire new area of the reg. As
 4 much as that makes sense to you and I, in the whole scheme
 5 of things pushing that through I think that's going to be
 6 a -- a heavier lift.

7 **DR. COOPER:** Mary Ellen, let me just --
 8 let me just ask. Was -- was the push-back internal or was
 9 it from hospitals?

10 **MS. HENNESSY:** No. We -- we have not
 11 vetted these three through hospitals.

12 **DR. COOPER:** Okay.

13 **MS. HENNESSY:** We've discussed it
 14 internally. However, what I would suggest to you --

15 **DR. COOPER:** Yeah.

16 **MS. HENNESSY:** -- is that you may reach
 17 out to HANYS who was looking at this whole reg reform type
 18 of thing and making suggestions, if you will, to the
 19 governor's office and to the Department to see how they
 20 might support these efforts, our efforts together, is maybe
 21 adding a person on the council or -- or at least it's a
 22 guess.

23 **DR. COOPER:** We do have, of course, you
 24 know, a slot for hospital administration rep which is, you
 25 know, been slow to be filled, as you know, but we do have a

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 2 candidate who will be vetted, I -- I'm hoping. That having
 3 been said, I do want to follow on Bob's comments for two
 4 reasons. First of all, you know, many of us, perhaps most
 5 of us, either work in facilities or have worked in
 6 facilities and the facilities, at least in I think our
 7 collective experience, and for those of you who disagree
 8 please correct me if I'm wrong, tend to think of children a
 9 little bit differently than they tend to think about, you
 10 know, others. You know, it's -- and it's kind of a irony
 11 because children are kind of, you know, always thought of
 12 almost as another organ system. You know, there's hearts,
 13 there's brains, there's bones, and then there's kids, you
 14 know.

15 **DR. KANTER:** Right.

16 **DR. COOPER:** When, in fact, they're
 17 people. You know? And, you know, one, you know, there --
 18 there -- maybe there should be pediatric cardiac regs,
 19 pediatric, you know, neurosurgical regs, et cetera, et
 20 cetera, et cetera. And I'm, you know, I -- I think we all
 21 recognize that that would be, you know -- you know,
 22 something that probably would be a little bit -- going a
 23 little bit too far, but -- but having said that, you know,
 24 I -- I think the -- the hospital community might be a
 25 little bit more receptive than you think to having all the

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2 pediatric regs, or not you personally of course, than --
3 than some have thought that, you know, that it might be
4 more -- a little bit more receptive having all the
5 pediatric regs in one place so they can -- you know, for
6 precisely the reason Bob has mentioned, you know, so -- to
7 find them.

8 **MS. HENNESSY:** Uh-huh.

9 **DR. COOPER:** You know, and say this is
10 what we need to be doing for kids and -- and, you know, to
11 me anyway, that makes sense. I mean reading through the --
12 you know, the -- you know, the 405s, you know, makes great
13 bedtime reading for the insomniac as you know. You know,
14 and trying to find -- trying to find all the -- all the
15 fine points can be -- can be daunting let alone, you know,
16 challenging. But I think there -- there may be some -- you
17 know, some value in -- in posing that question, and
18 certainly we could -- we could do that through our
19 professional associations.

20 Obviously, we cannot do it as individuals
21 or as individual members of this committee since we
22 directly advise the commissioner and that would be -- you
23 know, that would be a violation of the -- of the way of the
24 law, you know, expects us to act as public officers or
25 quasi-public officers. But I -- I think that it's a

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2 question that probably does deserve to be asked before we,
3 you know, do a whole lot of work in trying to -- trying to
4 slim things down in the -- in the ways that you suggest,
5 which I think are perfectly fine. There's always, of
6 course, you know, the -- the option of creating, if you
7 will a, you know, sort of a road map saying that oh, by the
8 way here's a list of all the places in the code you have
9 to --

10 **MS. HENNESSY:** That pertain to you.

11 **DR. COOPER:** -- look for all the
12 pediatric stuff. But -- but it's often -- you know, it
13 often makes a little bit more sense to kind of see the --
14 you know, the whole for you, as -- as opposed to, you know,
15 in individual little parts, you know, that somewhere the
16 whole is always greater than some of its parts as we know.
17 And so I think it's -- I think it's worth at least posing
18 that question to the hospital community and seeing how they
19 feel about it. I -- I -- I'm willing to bet that they
20 would be okay with it.

21 Elise?

22 **DR. VAN DER JAGT:** I just want to -- just
23 to affirm what both Art and Bob have said. I -- I think
24 visibility is really important. I think one of the things
25 that is lacking in the current regs is that pediatrics is a

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

25 **MS. HENNESSY:** It's because we require

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

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

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

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

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

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2 think that -- that at the federal level where at least some
3 of these, you know, mistakes occurred, they recognized that
4 they were mistakes and have acted to, you know, correct the
5 wrong since and, so I think it's worthwhile for us to, you
6 know, consider doing the same here.

7 Someone had a hand up over here?

8 **MS. CHIUMENTO:** Just one brief comment
9 and that's from hospitals who do not have pediatrics, I
10 would think it would be easier for them to say this section
11 does not apply to us, rather than they having to go through
12 each part and say this one line doesn't apply to us or this
13 one little --

14 **DR. COOPER:** That's a good point.

15 **MS. CHIUMENTO:** -- subsection have to --
16 doesn't apply to us. And it seems to me that from their
17 standpoint it also would make -- be a little bit easier for
18 them to have it separated out.

19 **DR. COOPER:** Did -- Deb Sottolano, did
20 you have a comment? I thought you were --?

21 **DR. SOTTOLANO:** No, I -- I thought that
22 Dr. Kanter did.

23 **DR. COOPER:** Oh, okay.

24 **DR. KANTER:** Just a point of
25 clarification. I'm not sure if I understood, Jonathan,

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2 your comments about a separate area in the E.D. None of
3 the suggestions in the draft talk about a physical area in
4 emergency departments. Even for high volume E.D.s we
5 talked about training and services that should be provided.
6 We don't talk about a separate area at all. Whether it's a
7 good idea is another matter. We don't address it here.

8 **DR. HALPERT:** Right. Conceptually is I
9 was referring to. I think -- I think that it's an idea
10 whose time is worth at least evaluating seriously to some
11 degree because of the complications I think that are
12 routinely encountered trying to -- to manage the vast
13 differences in patient population, where in the regular
14 hospital setting it's typically segregated with -- with
15 good result, I would think.

16 **DR. COOPER:** Any other comments at all
17 for Mary Ellen? Okay. Hearing none, I really, really
18 appreciate the work that you and Lisa and Martha and others
19 have done within the Department to run this up the
20 flagpole. And I'm hoping that what we can do from -- from
21 this point forward is work with our professional
22 associations to get this message across to HANYS I'll
23 actually be seeing the executive director of the A.A.P.
24 tonight at another meeting. And -- and hopefully, this can
25 be discussed in turn within the Department and -- and see

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2 if it makes sense.

3 I think that -- I think a lot of the
4 comments that have been made are right -- right on the mark
5 in terms of -- in particular Sharon's. You know, it's --
6 if -- as a -- as a person who, you know, has had some
7 responsibility at the hospital level of trying to deal
8 with, you know, regulatory compliance, it's -- you can
9 always end up missing that one line, you know, if it's not
10 kind of separated out into a -- into a easily digestible,
11 you know, form. And so it may -- I think it may well be
12 that not only are hospitals, you know, not resistant to
13 this type of approach, they may actually favor it. Which
14 is not to say, by the way that -- that so many of -- of --
15 of the concepts couldn't be handled through reference to
16 policy. I -- I think many of them could. And I think, you
17 know, but -- but I think we need as -- as we suggested, I
18 think we need -- we need some guidance on that.

19 So we'll look forward to work through the
20 professionals associations, with the hospital association,
21 and we'll look forward to -- to the Department sitting down
22 and figuring out which way it wants to go. Hopefully then
23 we can kind of get that information in one place and then
24 we can create the -- you know, a new version of the
25 document that, you know, as you had suggested internally

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2 that you can then share with us and we can set up a meeting
3 to go through it line by line. Does that make sense?

4 **MS. CHIUMENTO:** Yes.

5 **DR. COOPER:** Okay. Great. Great.

6 Thanks.

7 Bob?

8 **DR. KANTER:** I always find that things
9 like this go better if you sort of have an action plan and
10 a schedule. So in addition to the discussion with the
11 professional organizations and just so that we can sort of
12 plan our own personal work plans. Any thought about when
13 we might be really to get together with the Department to
14 talk about this just timing-wise more extensively?

15 **DR. COOPER:** I mean I don't -- obviously,
16 I think it's up to Mary Ellen --

17 **DR. KANTER:** Right.

18 **DR. COOPER:** -- and her folks to decide
19 what the Department's timeline is going to be. They have
20 much on their plates at this particular point in time,
21 but -- but I think in terms of going through the A.A.P.
22 to -- to reach out to the hospital association, summer
23 would be the perfect time.

24 **DR. KANTER:** You know, I mean the context
25 is we've been talking about this for about seven or eight

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

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

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

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

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 2 you know, in many ways de facto regionalization has already
 3 occurred, whatever regionalization means. You know, that's
 4 a little bit less to do with the downstate areas, but as
 5 we'll see a little bit later on in -- in today's program
 6 and which -- and I hope everyone can stay for this, the
 7 work we've been doing in terms of pediatric disaster
 8 preparedness in New York City has really -- has really been
 9 terribly important in terms of getting the region itself to
 10 think more about regionalization on a larger scale. And so
 11 I think that even at the Greater New York level, you know,
 12 we may -- we may find that -- you know, that -- that --
 13 that -- that the road is quite a bit easier than we might
 14 have expected.

15 **DR. VAN DER JAGT:** All right. The second
 16 part of my -- my question was what exactly is the process
 17 because it's great to get opinions and thoughts about the
 18 HANYS or other organizations, but then what exactly are the
 19 steps that get taken before this is changed? For example,
 20 who actually writes the -- any changes in 405.30 or
 21 different number if it's a different number. Who actually
 22 writes it? Who actually, you know, that's who actually
 23 approves it? You know, I mean and what's the process?
 24 I'm -- I'm not sure about what it is because we have so
 25 often said I'll be able to talk with this group and this

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

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 2 put together some kind of, you know, outline or draft or
 3 document as to how we might take what we have today and
 4 turn it into something that the Department felt was -- was,
 5 A, doable and, B, in comport with the information that they
 6 got from the internal folks and that we brought them, you
 7 know, through our professional associations, you know, as
 8 something that -- that could fly. And at that point, I
 9 think, you know, I'm a little confused because we used to
 10 have the state hospital review and planning council and we
 11 now have a combined public health council and -- and the
 12 state hospital review and planning council.

13 So take it from here and tell us what
 14 happens then.

15 **MS. HENNESSY:** We have a process and what
 16 Art said is exactly right. I think once we get input from
 17 you, we would craft the regs, either through the
 18 recommendations that you're getting or that internally
 19 we're getting or both. Sandra Haff, who has joined us here
 20 today, happens to be the support to the chair of the codes
 21 committee for the new public health and hospital --

22 **MS. HAFF:** Health planning council.
 23 **MS. HENNESSY:** Health Planning Council or
 24 PHHPC.

25 **DR. COOPER:** Say that again? PHHPC?

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 2 **MS. HAFF:** PHHPC, Public Health and
 3 Health Planning Council. PHHPC.
 4 **DR. COOPER:** PHHPC.
 5 **MS. HAFF:** Like Philadelphia.
 6 **MS. HENNESSY:** It's P -- right --
 7 **DR. COOPER:** PHHPC. Okay. Good.
 8 **MS. HENNESSY:** -- PHHPC.
 9 **DR. COOPER:** Public Health and Health
 10 Planning Council. Okay. Good.
 11 **MS. HENNESSY:** Sandra is the person to
 12 whom we all go when we have new regulations that need to be
 13 moved forward. There is an internal process for how they
 14 need to be vetted and to whom and a process for approving
 15 them.

16 Sandra, I don't know if you want to go
 17 into any details?

18 **MS. HAFF:** Well, we -- we have an
 19 internal -- we have an internal reg advisory unit that we
 20 present a concept to and then we work with our legal
 21 department and we develop the reg. And then once it is
 22 final it has to go out to -- it used to be the Governor's
 23 Office of Regulatory Reform, now it's a unit within the
 24 D.O.B., the Division of Budget. Then it goes to the
 25 government, excuse me -- it goes to the governor's office

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2 for review. And when it -- when it gets out of there, it
3 has a forty-five-day comment period. Once that is done, it
4 goes to PHHPC. And right now we have regs on at least once
5 before it's on for adoption. So it gets two hearing as
6 PHHPC codes committee meetings. So it's a long process,
7 nonetheless.

8 **DR. VAN DER JAGT:** Thank you.

9 **DR. COOPER:** It doesn't sound terribly,
10 terribly different from the --

11 **MS. HAFF:** No.

12 **DR. COOPER:** -- previous process. It
13 sounds like there are many, many --

14 **MS. HAFF:** Layers.

15 **DR. COOPER:** -- many layers -- many, many
16 heads to convince, you know, that something needs to be
17 changed which is, you know, we are after all a democracy
18 and that's probably not a bad thing. It's something we can
19 all get behind once it gets through a process like that.
20 So that's good. There's an old rule in -- at least that
21 it's old to me, you know, I've learned very early on in
22 my -- you know, in my experience with you all, but
23 generally speaking if eighty to eight-five percent of the
24 folks out there think something is a good idea, it's got a
25 pretty good chance of going forward. And I'm willing to

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2 bet that that we probably have that eighty to eighty-five
3 percent out there right now. And we'll just work hard to
4 make sure that -- to make sure it happens. And, of course,
5 I -- I know that everyone here, meaning, you know, our
6 friends -- our -our partners in government as well as -- as
7 well as ourselves, you know, are all on the same page with
8 us. We all have the right for kids and it's a matter of
9 figuring out how to do it. I think that -- that everyone
10 was thrilled, in fact, when Commissioner Daines said do
11 this. And -- and I haven't heard Commissioner Shaw say
12 don't do this. So we -- I think we're going to continue to
13 move forward and, you know, do our best to get this done
14 with your support and your help, of course. So thank you
15 so much.

16 I -- again, I hope you all can stick
17 around to hear this New York City Disaster presentation. I
18 know others may have some disaster presentations they may
19 make as well. I don't know. We've talked about that. I
20 don't know if others have anything to bring to the table on
21 that, but at this point I think we can close that issue
22 out.

23 Bob, did you have anything further on the
24 regionalization report other than what we already
25 discussed?

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2 **DR. KANTER:** Just a tiny thing that
3 follows from it in the shorter term. So putting aside
4 revisions and regulations, what are we doing and what could
5 we do right now based on the existing regulations? For
6 quite some time, the National E.M.S.C. organizations have
7 been promoting guidelines for inter-facility pediatric
8 transfers of patients or consultations. And so in 2009,
9 this committee wrote a draft of guidelines based on
10 national recommendations and national performance goals as
11 well as based on precedence from other states guiding their
12 hospital system criteria and processes for inter-hospital
13 inter-facility transfers of pediatric patients. So there
14 is -- as I understand it, the next step in this since our
15 draft in 2009 is there is a working group in New York
16 State. Deb Funk is heading that group up, who will be
17 looking into this.

18 That said, I first heard about this in
19 early May and I haven't heard a word since, so I can't give
20 you any update on that. But in the meantime, I think
21 there -- I -- I have a suggestion and you all can tell me
22 what the best form for trying to work on this is.
23 Without --

24 **DR. COOPER:** Bob, before you get into
25 that --

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2 **DR. KANTER:** Yeah.

3 **DR. COOPER:** -- I -- I just -- I did do a
4 little tiny bit of homework on this issue since -- since
5 you brought it up. And correct me if I'm wrong, Martha and
6 Lee, especially Lee, but I -- I -- my understanding is that
7 Deb's group is really focusing more on inter-facility
8 protocols for E.M.S. folks, not so much on --

9 **DR. KANTER:** Uh-huh.

10 **DR. COOPER:** -- indications for transfer,
11 which was the -- which was the gist of what we had -- had
12 focused upon.

13 **DR. KANTER:** That wasn't so clear to me.
14 Yeah.

15 **DR. COOPER:** And -- but I -- I do think
16 that -- that to the extent that it -- that it -- that it
17 can be accomplished, it would be useful if there could be
18 some discussion about that. I -- I had actually hoped we
19 might be able to invite Deb to come to the meeting today,
20 but, you know --

21 **MS. BURNS:** The committee hasn't
22 reconvened yet. There's --.

23 **DR. COOPER:** Okay.

24 **MS. BURNS:** I mean it's been seated. It
25 just hasn't --.

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

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

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

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

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

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

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

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

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

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

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

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

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 2 And with so many changes, hospitals
 3 closing, I mean I just saw a hospital that decertified
 4 twenty-five, you know, pediatric beds and so forth and so
 5 many changes we really wanted to try to get more up-to-date
 6 data. So one of our deliverables at the hospital level is
 7 going to be a much more in-depth, you know, assessment and
 8 make that available to the regional resource centers across
 9 the state and have them work on their deliverable which
 10 would be kind of an outlining of regional resources and a
 11 plan for dealing with surge and pediatric patients during
 12 disaster.

13 One of the things that we can and we're
 14 planning on doing is in our -- our commerce system, our
 15 health commerce system, we have a communications directory
 16 in which we maintain roles and contact information is role
 17 based. And our facilities are -- part of their
 18 requirements are really to maintain that contact
 19 information. We use it all the time for alerting and we
 20 can alert twenty-four-seven. And one of the other things
 21 we were looking at is also enabling hospitals to utilize
 22 that same alerting system. But beyond the alerting system,
 23 they actually have access to look up based on roles in the
 24 directory and get contact information. And so if there are
 25 specific roles that you wanted to outline at each hospital,

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 2 we can enable that and ask the hospitals to complete that
 3 data. Their coordinators are asked to maintain that
 4 quarterly and, you know, some are better than others, but
 5 for the most part we've been extremely successful usually
 6 with drills or exercises or real life events like H1N1. We
 7 have the high nineties to a hundred percent response rates
 8 from the hospitals getting a message. So --

9 **DR. COOPER:** Wow.

10 **DR. SOTTOLANO:** -- it's really been a
 11 very well used system, well drilled, and so it's definitely
 12 something we can help with keeping and maintaining updated
 13 contact information. And I think some of those hospital
 14 deliverables that we're working on for the grant this year
 15 will also, you know, enable some of this information you're
 16 looking for. So --

17 **DR. COOPER:** Thank you so much, Deb.
 18 That's really great information.

19 Jon?

20 **DR. HALPERT:** One additional item this
 21 brings to mind was a conversation we had here perhaps a
 22 year ago, which was concerning the validity of some of this
 23 information relative to centers promoting themselves as
 24 tertiary care -- care receiving centers who really weren't
 25 the best facility requirements or personnel requirements.

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 2 And I don't know whatever the -- the outcome of that was,
 3 but obviously to be taking list of names of places and
 4 putting them on the website or whatever it was, if they
 5 weren't actually able to hold up their end of the bargain,
 6 would that be problematic in any way?

7 **DR. COOPER:** Well, it might be
 8 problematic but -- for them, but at the same time if
 9 they're holding themselves out to the public to be able to
 10 provide a service and -- you know, and the available data
 11 is suggesting that it's not a service they're capable of
 12 providing it that would certainly be something I think the
 13 Department would be interested in knowing, I'm presuming.

14 **DR. KANTER:** But -- but the information
 15 is already on the hospital profile --

16 **DR. COOPER:** Understood. Yeah.

17 **DR. KANTER:** -- website. So it's just a
 18 matter of making it more accessible. It's already there.

19 **DR. COOPER:** Exactly. Exactly. Okay.
 20 Just a time check. We have an hour and a quarter left. We
 21 were not -- I didn't think we would be where we are right
 22 now, but there we are. Sharon, do you have anything for
 23 education other than the standards?

24 **MS. CHIUMENTO:** Not really because we had
 25 been working on that facility transfer matrix which kind of

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 2 is tied into the previous conversation here. And I kind of
 3 put it on hold for a little while until we figured out some
 4 of these other pieces, so there really is nothing new to
 5 report on that.

6 **DR. COOPER:** Okay. Very good. All
 7 right. Then the next item on the agenda is new business.
 8 So we have -- the next item is a vote for chair and vice
 9 chair. There is, I believe, one nomination for chair, and
 10 at this point one nomination for vice chair. There had
 11 originally been two nominations for vice chair, Dr. Kanter
 12 and Dr. Van Der Jagt, but Dr. Van Der Jagt sent an e-mail
 13 around to us all yesterday, I think we all saw it,
 14 indicating that he felt that he would be overwhelmed with
 15 responsibilities. Maybe whelmed is a better term with
 16 responsibilities at -- at -- at Strong this coming year.
 17 So only one of the two Golisano brothers will be -- will
 18 be --.

19 **DR. VAN DER JAGT:** And that I had a lot
 20 of confidence in this guy to your right, I have to tell
 21 you.

22 **DR. COOPER:** Yes. Exactly. So we
 23 have -- we have one nomination for chair and one nomination
 24 for vice chair. Now, Robert's Rules do call for us giving
 25 an opportunity to accept additional nominations from the

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

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

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

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

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 2 Cohen Children's and interim chair of pediatrics at Nassau
 3 University Medical Center, which is being folded into the
 4 ever-expanding North Shore L.A.J. system is the P.I. on the
 5 grant. Mike is -- Mike is a general pediatrician but
 6 with -- but with a huge experience in pediatric disaster
 7 preparedness primarily through contacts in Israel. He's
 8 been working with the Israeli Disaster Group for quite some
 9 time.

10 Many of you know George Fulton who is
 11 director of pediatric emergency services at Bellevue.
 12 George is actually a nominee to the committee at the
 13 present time. Mayer Sagy is the immediate past director of
 14 pediatric critical care at Cohen Children's. It's the old
 15 Schneider Children's for those of you who didn't know the
 16 name had changed. And actually recently relocated to
 17 N.Y.U. where he will be the director of pediatric critical
 18 care services for New York University School of Medicine.
 19 You know me. Kate Uranek, who is an emergency medicine
 20 physician with the health department, has been our project
 21 officer. She's most deeply involved in radiation issues in
 22 addition to the pediatric issues. I know that Deb -- and
 23 Deb knows her very, very well as -- as do others. And Lou
 24 Soloff, who is also an emergency medicine physician, has
 25 been working primarily with the burn group in the city, has

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 2 served as our project consultants since many of the
 3 mechanisms that we have used to set up our pediatric
 4 response are based on some of the preliminary work done by
 5 the burn group.

6 Now, who are the stakeholders?
 7 Obviously, everyone interested in kids. Children's
 8 hospitals and transport services, including hospitals that
 9 are not specifically children's hospitals, but have a large
 10 pediatric inpatient services, obviously, the pediatric
 11 healthcare providers themselves, emergency healthcare
 12 providers, city health, the fire department which runs the
 13 municipal ambulance service, the office of emergency
 14 management and, of course, the Greater New York Hospital
 15 Association. There we go.

16 And the primary goal of the coalition
 17 is -- is to, in fact, create a coalition of hospitals,
 18 public health, and municipal services to ensure effective
 19 use of critical care assets during and after a large scale
 20 disaster affecting children through establishment of an
 21 ongoing planning and advisory coalition. As Dwight
 22 Eisenhower said, "Plans are nothing. Planning is
 23 everything." It's got to be ongoing and continuous. And
 24 as we all know primarily from the Israeli experience, but
 25 other experiences as well, that the children who are

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 2 victims of disasters require critical care services in far,
 3 far, far higher percentage than -- than -- than -- than
 4 other type of patients. In fact, at least in terms of
 5 trauma, three times greater use of intensive care resources
 6 in -- in -- in children who are victims of blast and -- and
 7 penetrating trauma than -- than -- than those who are
 8 victims of accidental or unintentional trauma.

9 In the first year of the grant we
 10 developed recommendations for increasing pediatric critical
 11 care surge capacity in our hospitals. Understanding that
 12 the -- the need for critical care would be greatly
 13 broadened and would require intensive care resources beyond
 14 those that we had immediately available to us, we realized
 15 that there would be a huge need to train pediatric
 16 hospitalists and pediatric generalists in the critical care
 17 of pediatric patients. So we held a P.F.C.C.S. train --
 18 the trainer course for the New York City hospitals. For
 19 those of you who don't know about the P.F.C.C.S. course,
 20 it's Pediatric Fundamental Critical Care Support Course of
 21 the Society of Critical Care Medicine. And it really
 22 focuses on, again, teaching hospitalists and generalists
 23 about the care of critically ill children. And,
 24 additionally, we wanted to develop recommendations for
 25 pediatric -- pediatric elements of the triage component of

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

22 We kind of got side tracked a little bit
 23 in the first year of the grant. The H1N1 issue came upon
 24 us and -- and in the second year of the grant -- and
 25 continued into the second year. And, of course, in the --

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2 in the middle of the second year, the Haiti issue came upon
3 us. And both of these required our focusing on some other
4 issues for a little bit of time. But in effect, we -- we
5 look upon the -- the -- the process, if you will, as a --
6 as a -- a chain of survival not dissimilar to that which we
7 see in -- in the -- the adult and pediatric cardiac arrest
8 worlds. This chain of survival focuses on triage, tiering,
9 transport, and surge capacity.

10 To focus first on triage, the -- the
11 P.D.C. recommends that pediatric specific field triage
12 criteria be applied in M.C.E.s when possible and
13 appropriate. Why when possible and appropriate? Once
14 again, you know the logistic needs of the -- of the city
15 and the service may be such that, you know, they are so
16 pressed for ambulances that they can only afford to take
17 the child to the closest facility, you know, not
18 necessarily the closest appropriate pediatric facility.
19 But they have committed to doing everything within their
20 power to get -- get the kids to the appropriate facilities
21 when possible and appropriate. Now, here's the -- here's
22 the modified triage grid. For those of you who are
23 familiar with START triage, that's an acronym for Simple
24 Triage and Rapid Treatment.

25 And this -- this does not seem to have

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

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2 of the algorithm is very much the same except to note that
3 because of the very limited experience with -- with an
4 assessment of kids, all children who look like infants,
5 that is to say they look like they're not old enough to
6 walk, are going to be labeled red and -- and be so treated.
7 In other words, as if they have critical illness.

8 Now, there's a -- there's a unique area
9 in the New York City START algorithm that was added over
10 the last couple of years, chiefly at the insistence, wise
11 insistence I might add, of Dr. David Prezant, who was then
12 medical director of the -- of the Office of Medical
13 Affairs. Dr. Prezant is a pulmonologist and was deeply
14 concerned that there would be many individuals -- adults
15 with medical illnesses, you know, congestive heart failure,
16 chronic obstructive pulmonary disease, asthma, what have
17 you, who -- who, in the event of a disaster, for a variety
18 of reasons, would develop an exacerbation of their existing
19 medical conditions.

20 And, of course -- of course given the
21 high prevalence of respiratory illnesses in children, we
22 face a very similar issue. What do we do about the kids
23 who don't meet red criteria but are breathing fast? These
24 are kids who need a -- who need a, you know, an evaluation
25 by someone, you know, with skill. And so a new orange

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2 category was created involving respiratory distress,
3 increased work of breathing, labored respirations, changing
4 mental status, history of head trauma or cardiopulmonary or
5 chest trauma, and in effect these patients are placed at
6 the head of the yellow line. They're technically yellow,
7 but they get placed at the head of the yellow line, hence
8 they become the new urgent category or orange category.

9 This was brought forward to the SEMAC for
10 its approval. The SEMAC did approve it for use in New York
11 City. And it's my understanding that the discussions are
12 under way that might be applied in areas at least adjoining
13 New York City in the relatively near future, although I
14 think that's going to be for SEMAC and SEMSCO to determine
15 at some point in the near future.

16 We all think that this is a category that
17 makes eminent sense because it'll get -- as all of you
18 know, the studies that have been done with respect to START
19 recognize that people are okay with the red and okay with
20 the green, but it's very hard to figure out where the
21 yellows go and there's a lot of missed triage in that
22 yellow category. This goes a long way toward fixing it in
23 our view. It's now been taught to about three thousand
24 E.M.S. providers in the city. We have about twenty-five
25 hundred E.M.T.s and another seven hundred paramedics and

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

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

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

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

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

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

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

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

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 2 will and V.P.C.C., a virtual pediatric consultation center.
 3 These are board certified pedia-intensivists who are
 4 credentialed and indemnified by FDNY O.M.A. And the good
 5 news that we just recently learned is that, unlike the burn
 6 plan where it's sort of -- Rochester is going to provide
 7 V.P.C.C. for the city and vice versa in the event of a --
 8 of a major disaster, because we have many more pediatric
 9 resources than burn resources, although still not enough,
 10 we believe we can handle it in the city. So we're probably
 11 going to be credentialing these by FDNY by under the
 12 auspices of the Medical Reserve Corp and City Health. So
 13 we don't necessarily have to go through ServNY, but that's
 14 an issue that we still have to discuss with you all and
 15 will be discussed at some point in the near future.

16 It's -- the V.P.C.C. in the event that
 17 the disaster plan was -- was activated, would be contacted
 18 by a single dedicated telephone line and the -- the
 19 responsibility of the V.P.C.C. is to create a continually
 20 updated real time list of which patients have the highest
 21 priority. So you can say, well, patient number one has
 22 thirty percent burns, this patient has to go here. Patient
 23 number two has, you know -- you know, a lacerated spleen.
 24 This patient has to go here, et cetera, et cetera, et
 25 cetera. And create a priority list as to which patient

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 2 offered in -- you know, in various places and in effect,
 3 this -- this list is based upon that study. It was felt by
 4 the group that Bob put together that the highest level of
 5 pediatric critical care would be reserved for those
 6 requiring the -- the treatments listed on the left and --
 7 and a less robust, you know, group of treatments listed on
 8 the right would be the -- the -- the responsibility of --
 9 of the second-tier hospitals which did not have the full
 10 P.I.C.U. capabilities.

11 Now, that takes us, of course, to the
 12 surge. We did a back-of-the-envelope study or calculation
 13 I should say, it wasn't really a study per se, although it
 14 probably could have been if I ever gotten around to
 15 publishing it, looking at the number of critical care beds
 16 in New York City and how they might actually be expanded.
 17 And to make a long story short, the general sense is that
 18 we -- that we need probably about -- in the range -- we've
 19 got to find somewhere in the range between two hundred and
 20 four hundred critical care beds in New York City in the
 21 event of a major -- in the event of a major disaster. On
 22 any given day -- on any given day, we have about fifty
 23 available and through rapid discharge planning and so on
 24 and so forth and -- and expanding, you know, critical care
 25 capabilities and existing P.I.C.U.s, we can get up to

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 2 goes first depending upon, you know, which -- or when
 3 ambulances become -- become available. Now, FDNY, the fire
 4 department will be serving as the pediatric logistics
 5 coordination center, which means they get real time
 6 information on where the pediatric I.C.U. beds are, they
 7 get the -- they get the priority list from the V.P.C.C.,
 8 and they match, you know, the -- the -- the highest level
 9 patient need with the highest level resource need and
 10 dispatch the -- the -- the specialty care transport teams
 11 as needed. Until such time as the system is stood up, we
 12 recognize that, as Elise was pointing out in an earlier
 13 discussion, most hospitals already have pre-established
 14 relationships with P.I.C.U.s. Those will not be disrupted,
 15 okay, unless there is a compelling need to do so. And so
 16 there will be business as usual until the -- the V.P.C.C.
 17 is activated. So everybody is free to send out their
 18 ambulances and pick up their kids from their usual suspect
 19 hospitals, so to speak, you know, until such time as the
 20 V.P.C. has actually stood up.

21 Now, kudos to Bob Kanter for leading an
 22 effort that helped us develop this list here. Bob convened
 23 a group some years ago of experts in pediatric intensive
 24 care from across the state and looking at a number of
 25 potential pediatric critical care treatments that might be

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 2 probably, you know, in the range of -- of a hundred, but we
 3 have to really double that for true -- true critical care,
 4 and -- and maybe even triple it if we take into account
 5 the -- the second-tier facilities as well. So, you know,
 6 the premise is that -- that we really have to get everybody
 7 involved.

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

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 2 an event has occurred, hospitals indicating that they have
 3 the surge capability to deal with the issue, you know, and
 4 sharing of information between those two loci that allow
 5 the -- you know, the -- the various preparations that need
 6 to be made to actually occur. And, of course, with a -- a
 7 real-time system, we -- we then can engage ourselves in --
 8 in triage activities that rank patients according to
 9 diagnosis and severity or perhaps we should say acuity and
 10 severity would probably be a better way to put it and then
 11 transfer to hospitals based upon both proximity and their
 12 relative capabilities in terms of hospital tiers.

13 We'll skip all the little fancy arrows.

14 So here's the operational concept. You
 15 get E.D. notification. The first thing that happens is
 16 that intensivists head down to the E.D. and begin to help
 17 the E.D. staff figure out what's going on with the -- with
 18 the most critically ill patients. In other words, you
 19 know, in contrast to the usual boarding critical patients
 20 in the E.D. that we see in the winter months, we actually
 21 get the -- you know, the critical care docs down to the
 22 E.D. to help with the process of beginning that critical
 23 care and decompressing the E.D. to make room for more
 24 patients. The beds -- during that -- during that interval
 25 while patients are being evaluated and critical care begun

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 2 with the assistance of pediatric intensivists in the E.D.,
 3 beds are made available in the P.I.C.U. through rapid
 4 discharge and expansion of the number of beds per cubicle
 5 or expansion into available adjacent spaces or even into
 6 more distant spaces such as endoscopy units and PACUs and
 7 so on and ultimately even to floors that may be specially
 8 equipped in the event of, you know, a major -- a major
 9 event. So you can see it sort of follows a -- a step-wise
 10 process here based first upon predictions and planning,
 11 preparation, implementation, and, of course, ultimately
 12 management. In other words, you know, preparation and
 13 mitigation response, as -- as we have come to think of it.

14 Now, at the present time we've figured
 15 out we can add -- and this is based upon the eleven largest
 16 available P.I.C.U.s that we can -- we can take in the
 17 eleven largest P.I.C.U.s about a hundred and fifty beds,
 18 almost double, okay, the capacity giving us, as I say, an
 19 almost double capacity. This is again for true pediatric
 20 I.C.U. beds. But, again, we need to triple it, okay, based
 21 upon, you know, the fact that -- that in a -- in a major
 22 disaster, you know, we're going to have more patients
 23 than -- than we can handle even by doubling that number.

24 This, of course, based upon the recommendations of the
 25 C.D.C. sponsored Pediatric Mass Casualty Critical Care Task

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 2 Force upon which Bob Kanter served, among many others.
 3 And, Bob, I think the special edition of
 4 the journal is finally coming out in the next couple of
 5 months. I haven't heard. You probably have.

6 **DR. KANTER:** I don't have a date yet.

7 **DR. COOPER:** Don't have at date yet.

8 Okay. There will be a supplement in the Journal of
 9 Pediatric Critical Care Medicine addressing many of these
 10 issues. Bob is a co-author on a couple of those -- those
 11 chapters or a couple of those papers.

12 So we've gotten quite a bit of the way,
 13 but we're looking actually to try to -- to triple the
 14 number of -- of mass critical care beds, but double the
 15 number of actual pediatric I.C.U. beds available to us.

16 Now, you know, conceptually the sum of
 17 many hospitals triage and surge plans may be equal to one
 18 regional plan. Okay. But truly, you know, operationally
 19 the sum of the individual plans may not be equal to one
 20 effective regional plan. So we really, really need to have
 21 real-time situational awareness. And this is the big --
 22 this is the really troublesome piece at the present time.

23 And everyone is grappling with this. You know, how do we
 24 use in effect the HERD system to make this happen or some
 25 other system. And that conversation is still ongoing and I

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 2 see Deb and Mary Ellen nodding their knowing heads as to
 3 what a -- what a tough nut this has been to crack in terms
 4 of -- in terms of where we need to go. But -- but this is
 5 what we really have to have, you know. We all know that
 6 the HERD system is sort of an internet-based computer
 7 system, but what if that goes down. Where are our
 8 back-ups, you know, all the other issues that we would
 9 guess. So this is the -- the concept all put together. We
 10 need an -- an on-scene activities dashboard, preparedness
 11 information dashboard all coordinated through, you know,
 12 real-time, you know, situation awareness capability.

13 We need to train more people, you know,
 14 particularly at our tier-two facilities in -- in F.C.C.S.
 15 or P.F.C.C.S. And in our third year, we have accomplished
 16 much of this. We've done additional training of P.F.C.C.S.
 17 We've surveyed all our instructors, our participants,
 18 analyzing this data right now to see how they feel about
 19 this training a couple of years out. We've got additional
 20 surge plans at another group of hospitals. We conducted a
 21 surge census -- census project or planning project this --
 22 this past February. Preliminary results were presented at
 23 the -- the city disaster -- pediatric disaster conference
 24 one week ago today. And the -- the short of it is we're in
 25 good but not great shape. We have more work to do. We're

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 2 submitting the final draft this year and, of course, as I
 3 mentioned we held the citywide pediatric disaster --
 4 disaster symposium a week ago. Bob and Deb were able to
 5 come and we're very grateful for both of your
 6 participation.

7 We have learned that we will be receiving
 8 additional funding for a fourth year. We're not sure yet
 9 how much funding that will be, but we're looking to conduct
 10 a table -- a tabletop exercise hopefully followed by a
 11 field exercise involving all pediatric hospitals. We want
 12 to get ourselves from the two hundred beds to four hundred
 13 total. We need to work more on the -- on the -- the
 14 situational awareness piece and we need to make sure that
 15 all the regional surge plans kind of get together or all
 16 the individual hospital surge plans get together into a
 17 single regional surge plan. It's a tall order, you know,
 18 but -- but I wanted to give you a flavor of what's been --
 19 what's been ongoing in the city so perhaps we can begin to
 20 think about how as a state we might want to think about,
 21 you know, regionalizing pediatric care in the event of a
 22 disaster.

23 Marilyn Kacica and her group have been
 24 really instrumental in -- in making sure that the pediatric
 25 disaster resource, which the state expanded into a

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 2 pediatric and obstetric disaster resource, which is really
 3 cool, you know, is out there and available for all the
 4 hospitals. But, you know, certainly our worry in the city
 5 has been since we created a -- a document that was similar
 6 to that, you know, and actually served as a platform upon
 7 which the state built, you know, we're, of course, worried,
 8 or we're worried that that -- that that little document
 9 would be sitting on a shelf somewhere and, you know, no one
 10 will remember where it is or what it said in the event of a
 11 real disaster, which is part of the reason we got involved
 12 in this coalition disaster planning process. And so part
 13 of bringing the issue here, you know, is how can we as, you
 14 know -- you know, the -- you know, the -- the state
 15 advisory group that's probably most familiar with these
 16 issues, you know, and -- you know, perhaps -- perhaps in
 17 some ways most expert in the issues, at least from the
 18 medical care standpoint, how can we assist the state in
 19 facilitating, you know, getting together a statewide
 20 coalition, you know, that -- that works perhaps at least in
 21 somewhat the same way that the city coalition does
 22 recognizing, of course, that the resources are much more,
 23 you know, spread out.

24 So I'll stop there. I hope that wasn't
 25 too much and, you know, entertain any questions you might

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 2 have briefly because we're kind of short on time at this
 3 point, but -- but also begin to see if there are any
 4 thoughts about how we might begin to initiate a
 5 conversation at the state level.

6 **MS. ROGERS:** I take it your focus was
 7 critical care only. Is that fair to say from the gist of
 8 this?

9 **DR. COOPER:** Not entirely. You know,
 10 we -- we recognize that it's the critically ill patients
 11 who will be ending up in the E.D., you know, and will
 12 require specialized resources and --

13 **MS. ROGERS:** Because I see total lack of
 14 focus on the emergency departments and their role and also
 15 the role of non-critical patients that would need to be
 16 admitted. And maybe that is information that is
 17 forthcoming from your group or a future goal, but when you
 18 talk about surge capacity taking over hospital beds, we're
 19 also going to be needing hospital beds for the non-critical
 20 care children as well. So I mean it's -- it's good to look
 21 at critical care because I think they need the largest
 22 resources, you know, people, equipment, O.R. time, but I
 23 think you have to consider, too, what the orange population
 24 is going to need and what recourses are available, what
 25 role the emergency department is going to play in -- in

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 2 that as well as critically care -- critical care patients
 3 and also, you know, what -- what resources we have for bed
 4 space for orange patients as well. Maybe they need to be,
 5 you know, transported to a different hospital because
 6 our -- the tertiary care hospital has taken up beds for
 7 critical care. So I think their needs to be a little bit
 8 attention to balance and maybe that's something you're
 9 going to get to in the future.

10 **DR. COOPER:** I'll only respond that --
 11 that the -- the types of conditions that the tier-two
 12 hospitals would be receiving, you know, are meant to
 13 include patients who don't require necessarily, you know,
 14 mass PICU care, but may require mass critical care in a
 15 sense. Second, we gained quite a bit of experience with
 16 emergency department surge during -- during the H1N1
 17 epidemic. And third, I will take this message from this
 18 committee back to the New York City group because this has
 19 been one of the things that I've been harping on, actually,
 20 for the last two or three years that we should -- we need
 21 to focus more on explicit plans for the emergency
 22 departments.

23 I think that -- but I think in part the
 24 City Health Department, which is funding this, of course,
 25 felt that in large measure the -- the plans that were put

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 2 in place during the H1N1 epidemic, you know, have helped
 3 the emergency departments focus a lot on their surge
 4 issues. And they, I think, also feel that the additional
 5 resources that would be brought to bear by having the
 6 intensive care folks, you know, help out with the surgical
 7 emergency department, you know, as part of the pre-critical
 8 care component of it is -- is addressing that issue. But I
 9 think your point is very well taken. I have made this
 10 point myself very loudly, that it needs to be much more
 11 organized than it is. And with the support of this
 12 committee I can take it back and say that the state
 13 committee feels that this is something we should be
 14 focusing on a little bit more -- more shall we say, you
 15 know, evidently. All right. I think it's in there, but
 16 it's -- it's kind of, as you suggested, hidden between
 17 lines.

18 **DR. KANTER:** You know, I think Jan is
 19 right that no community has a perfect plan yet or a perfect
 20 capability, but on the other hand, if you look at the last
 21 ten years worth of hospital preparedness and improvements,
 22 much more has been done in the pre-hospital and E.D.
 23 setting than critical care. And once your E.R. gets filled
 24 up with critically ill and injured kids, the E.R. is
 25 paralyzed for the next patient until you have a good

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 2 critical care surge capability. And very little has been
 3 done until now in that regard. There are a number of task
 4 forces have looked this -- at this for adults and for
 5 children, but I think the remarkable achievement here --
 6 and I -- I think this is just incredible, terrific work, is
 7 that -- this is not just a state model, I believe this is a
 8 national and international model for how to do this. If
 9 you look at all the abstract recommendations for I.C.U.
 10 surge capacity, there's a lot of good generalizations.
 11 This is my -- this is the first instance that I've read
 12 about anywhere where an entire region has said on the basis
 13 of a hospital-by-hospital basis we intend to increase our
 14 pediatric I.C.U. beds at this hospital by twenty-five
 15 percent or a hundred percent. And even if they're not
 16 making the -- the arbitrary target of tripling their
 17 capacity, no one has done that --

18 **DR. COOPER:** Right.

19 **DR. KANTER:** -- whether that's the ideal
 20 target or not, I don't know, but you have individual
 21 hospitals stepping up and saying publicly we intend to
 22 increase our beds by this much and here's how we're going
 23 to do it. It's an incredible step and it serves as a
 24 terrific model for how everyone else ought to be thinking
 25 about that.

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2 **DR. COOPER:** Thanks, Bob.

3 **MS. ROGERS:** Yeah.

4 **DR. COOPER:** Jan?

5 **MS. ROGERS:** I -- I think that's true.

6 It -- it's that, but I also think that they need to be
 7 incorporated, not just critical care, but the intermediate
 8 care patients and I think it's -- it's excellent. Any work
 9 that's done in this area is excellent, but I think you
 10 can't look at critical care in a vacuum. I think it has to
 11 be looked at in view of -- of the other surge of patients
 12 that we're going to have and what we do with them, not just
 13 on the E.D. level, but on the hospital level as well.

14 **DR. COOPER:** Thank you, Jan.

15 Elise?

16 **DR. VAN DER JAGT:** Just to talk a little
 17 bit what Jan was saying as well as I think that if you
 18 include the -- that interim period when you -- because
 19 right now the way looking at the -- at the way it's set up
 20 is it's field triage and then it's the definitive care, but
 21 that intermediate area is -- has not been addressed perhaps
 22 as well because E.D.s get congested and what do you do if
 23 they're over congested and they're -- they can't get to the
 24 PICU or wherever those critical care beds are because
 25 they're -- it's like you said, Bob, if the E.D. is

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 2 paralyzed. So I think that that would be an added thing to
 3 figure out what happens in that -- in that kind of
 4 situation, rather than assuming that it'll just flow easily
 5 through the E.D. and up.

6 **MS. ROGERS:** I know, there with assume.

7 **DR. VAN DER JAGT:** It doesn't happen that
 8 way. So perhaps some thought could be given to that. The
 9 other -- the other part, and, again, we've been talking a
 10 little bit in our own area also about how do we do this
 11 because we also do not have a pediatric disaster plan
 12 that's worth anything and this is a wonderful model, I
 13 think, that we can -- can -- can use. Was there any
 14 thought given to downloading hospitals, the general floor
 15 beds to hospitals that are tier-two, say, from a tier-one
 16 to a tier-two in order to make bed capacity because that's
 17 what we were looking at currently? You know, we're saying,
 18 okay, well, we have X number of beds. We can make some of
 19 these beds I.C.U. beds, but in order to do that we would
 20 have to transport these other people to a hospital that's
 21 close by, in our case it would be Rochester General, you
 22 know, to say so we can make room. But that would involve
 23 obviously transport triage, you know, which kids, you know,
 24 and how that would work. And that --.

25 **DR. KANTER:** What's to say Rochester

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

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

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

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

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

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

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

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

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 2 the training and within the grant there's also some monies
 3 set aside for training. And a lot of the hospitals have
 4 fulfilled their main trainings like B.D.L.S., A.D.L.S. and
 5 things like that. And so they're looking to expand some of
 6 the things we've mentioned as potential training and I
 7 would really welcome other suggestions is PALS and some of
 8 the -- the pediatric, you know, course work for nurses and
 9 stuff like that. So -- yeah, so we wanted to, you know,
 10 have that be kind of put into the grant language as well so
 11 that hospitals know they can take advantage of that.

12 **DR. COOPER:** Bob?

13 **DR. KANTER:** There's nothing like a
 14 simple target to sort of gain attention and crystallize
 15 thinking. I can tell you that in my hospital right now the
 16 simple target is is it possible to use all our critical
 17 care beds for critically sick ventilated patients on short
 18 notice? And the answer is that would be a stretch.

19 **MS. HENNESSY:** Because?

20 **DR. KANTER:** Because we don't have enough
21 ventilators, --

22 **MS. HENNESSY:** Okay.

23 **DR. KANTER:** -- staff --

24 **MS. HENNESSY:** Okay.

25 **DR. KANTER:** -- et cetera. And we are

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 2 beginning to try to deal with that notion. We actually --
 3 if you -- if you go down to the basement and get all the
 4 standby ventilators, we could make it.

5 **MS. HENNESSY:** Or you ask the state for
6 the -- yeah.

7 **DR. KANTER:** But there is nothing like
 8 some guidance from the state level to say you all should be
 9 increasing your critical care capacity by whatever
 10 percent -- twenty-five percent or a hundred percent, as
 11 some of the hospitals in New York City have done, to
 12 crystallize people's thinking. Once you have a target,
 13 then the hospital knows what they have to do to make this
 14 happen. They know about the cross training, the stock
 15 piles, you know, on and on. Until they're encouraged to
 16 come up with a simple target, it's not going to happen.

17 **DR. VAN DER JAGT:** How would you propose
18 to do that, Bob?

19 **DR. KANTER:** I -- I -- the state needs
20 to --

21 **DR. COOPER:** Well --.

22 **DR. KANTER:** -- say New York City has a
23 good idea here; let's extend it.

24 **DR. COOPER:** Marilyn?

25 **DR. KACICA:** You know, I think, you know,

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 2 the purpose of that tool kit was to have hospitals look
 3 through it and assess themselves as to how they fit, what
 4 are they capable of. In that very, you know, preliminary
 5 survey that we did, we found out they weren't getting it
 6 because they were still saying to us we don't take those
 7 kind of patients. So there's -- so I think until you
 8 require the hospitals, themselves, to write their own
 9 addendum, to actually sit with the planning group that was
 10 recommended, prior to even coming together regionally to --
 11 to flesh out the holes, they're not going to think about
 12 it. So I think that's the first requirement that you have
 13 to have. Think about it in your institution and then move
 14 outward.

15 **DR. COOPER:** What -- what I'd like to do
 16 is I -- I -- I think this is -- this is a terrific
 17 conversation which must be continued. But it seems to me
 18 that in many ways we have strengths here at a state level
 19 that we did not have at a city level at the time, you know,
 20 we began building in our -- our program. Specifically, as
 21 I indicated in part of the presentation, there is active
 22 planning going on for burn, for radiation, you know, for
 23 specific types of -- of -- of injuries in the city, but not
 24 specifically looking at -- you know, at hospital
 25 preparedness overall. You know? That's lacking. And at

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 2 the state level, you followed a slightly different path and
 3 you've looked at, you know, how individual hospital
 4 readiness on an all hazards level as opposed to -- as
 5 opposed to parsing it out into different types of --
 6 different types of contingencies. And the fact that you're
 7 building on -- you've got a three-year program slotted,
 8 that you're building upon an initial assessment, you know,
 9 and then, you know, and then based upon that assessment,
 10 hospitals in the region get together and say as a region
 11 how can we cool our assets so that, you know, we can
 12 provide the greatest good for the greatest number, et
 13 cetera, et cetera, et cetera.

14 It strikes me that -- that a role that we
 15 could play in assistant that process is if we could develop
 16 by our September meeting a one-pager, you know, that said
 17 here are the key bullet points that we really need to have
 18 or that hospitals really need to -- to be thinking through
 19 explicitly in terms of targets for pediatrics along the
 20 lines that -- that Bob had mentioned, that might help, you
 21 know, Deb and -- and -- and her program, you know, say,
 22 okay, as you're thinking through this process, okay, here
 23 are the explicit issues we want you to focus on in terms
 24 of -- in terms of pediatrics. And -- and that would
 25 entail, you know, bringing in the resource that Marilyn's

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 2 office developed where people have to look at the resource
 3 and say, based upon this resource, which you're now going
 4 to have to, you know, shake the dust off and get down of
 5 the shelf -- based upon this resource, okay, you know, what
 6 are you actually prepared to do at this particular moment?
 7 And, oh, by the way here's what you really need to be
 8 prepared to do, you know.

9 So does it make sense to sort of put
 10 together a one-pager like that that could help, Deb?
 11 And -- and I -- I think it could incorporate I think, Jan
 12 and Elise, many of the points that you've made in terms of
 13 bringing in the -- you know, the -- the emergency
 14 resources. And I'm sorry, John has stepped out of the room
 15 for the moment, but, you know, I -- I -- I'd like to see --
 16 you know, John, you know, sort of participated in that
 17 process as well from the standpoint of, you know, urgent
 18 care centers, you know, and non-traditional resources that
 19 can be -- you know, that can be brought -- you know,
 20 brought to bear in terms of caring for, you know, some of
 21 those decompression issues that Jan has been talking about
 22 with respect to the E.D.

23 Mary Ellen?

24 **MS. HENNESSY:** Art, I just wanted to say
 25 that the focus on the public health C.D.C. cooperative

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 2 **DR. COOPER:** Well, that's been our hope
 3 in New York City that if we put together a robust pediatric
 4 plan that some of our adult colleagues will, you know,
 5 begin to -- to follow along. And, you know, to its credit
 6 Greater New York Hospital Association has been working on
 7 these initiatives as well, you know, not -- not focused
 8 explicitly on disaster, but focused on critical care in a
 9 broader -- in a broader sense as you -- as you're provably
 10 familiar with their, you know, Critical Care Leadership
 11 Network Program that they set up over the last few years.
 12 And we recently were able this year to convince them that
 13 they needed a Pediatric Critical Care Leadership Network
 14 and we got that. You know, that was kicked off in March.
 15 You know, and that's focusing on, you know, on day-to-day
 16 stuff as well as disaster stuff. You know, and the first
 17 meeting was on medication errors, you know, and so on with
 18 a, you know, clear focus on patient safety which is front
 19 and center in everyone's mind.

20 But all these -- all these efforts and
 21 initiatives are related and -- and, you know -- you know, I
 22 think that we do have an opportunity here, you know, to
 23 sort of help, as you suggested, Mary Ellen, sort of use
 24 pediatrics as, you know, what -- if I could borrow a phrase
 25 from P.K. Carlton, who is one of the -- you know, was the

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 2 agreement this year --
 3 **DR. COOPER:** Uh-huh.
 4 **MS. HENNESSY:** -- is really on the -- the
 5 first year of a five-year grant.
 6 **MS. COOPER:** Okay.
 7 **MS. HENNESSY:** Now, that is really going
 8 to start focusing on different things. One of the biggest
 9 words that we're hearing now are coalitions.

10 **DR. COOPER:** Uh-huh.

11 **MS. HENNESSY:** Coalitions are regional so
 12 that people can rely and count on one another. A hospital
 13 doesn't have too much to say over an urgent care center
 14 unless they have the cooperation of -- of the county and
 15 the business ease and things like that within the region.
 16 So we're -- we're happy about that. We're still in year
 17 three of the hospital grant, however. So we're finishing
 18 up on some of those things that they wanted as far as
 19 deliverables for the states and the receivers of the money.

20 Next year, in year one of the hospital
 21 that we will start to see combined efforts with what the
 22 C.D.C. public health agreements look like. So there's
 23 coalition building and expectations. In pediatrics, I
 24 think, that could be one of the subjects that leads the way
 25 on what the coalitions can kind of address.

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

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

23 **DR. SOTTOLANO:** I think it would be
 24 helpful. And -- and actually, we are -- one of the things
 25 we're talking about was to, perhaps, because the regional

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

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

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

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 2 with this between now and the September meetings. We will
 3 be saying are there things on here that we should be taking
 4 away? Are there things here that are outdated? Are there
 5 things that are not safe? Are there things that just, you
 6 know, shouldn't be there? Are there things that should be
 7 there that are not? Are there things that we can
 8 consolidate? So if there's multiple drugs that can be used
 9 for a particular purpose, do we need to have twelve
 10 different medications for pain management in the
 11 pre-hospital setting or can we do it with four?

12 So if you can just get back to me? This
 13 grid is meant to be just a working document because I can't
 14 be reviewing all of this that you -- be writing comments
 15 all over everything. So if you can just -- they -- each
 16 one of the little items on here coincides with a bullet
 17 point on the particular -- whatever it is. So P.D.R.
 18 way -- if you look at the P.D.R. way management, the -- the
 19 bullet points will coordinate with the treatments. Just
 20 let me know. I don't need to know from you which -- which
 21 level of care you think you should do it. What I do need
 22 to know is if you think it should be removed and if you
 23 think it should be a medical control only. Those are the
 24 two most important things I need from you. Is it something
 25 that you really think is a serious enough treatment that

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 2 should only be done with a physician's advice, whether it
 3 be done by paramedics or critical cares. We'll leave that
 4 for the CMAC to -- to decide. But if -- if we could at
 5 least get your information back as to what you think should
 6 be removed and what you think should be medical control
 7 only. And then any other comments if you'd like to add
 8 them to the end of the document I can then incorporate
 9 those as well. Yes?

10 **DR. HALPERT:** Could I make a comment?

11 **DR. COOPER:** Go ahead.

12 **DR. HALPERT:** First of all, Art, you
 13 know, Sharon's put a ton of work into this already. It's
 14 really a -- a great piece of work so far, and I don't
 15 relish you having to try to tackle this one; this is not --
 16 not fun, I suspect. From a medical control perspective,
 17 this is a real tough document to -- to manage or really a
 18 tough task to manage. Different hats. This committee
 19 versus the -- the REMSCO I belong to or the REMAC I belong
 20 to and then the concept of what you're trying to achieve
 21 statewide. You know, when I was filling this -- out this
 22 grid, I kept getting wrapped up because I could not keep my
 23 mind on the fact that these modalities were all pointed
 24 toward the pediatric patient population. Different animal
 25 from the adult population --

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2 **MS. ROGERS:** Right.

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

19 **MS. ROGERS:** Well, wait a minute. Before
 20 we -- you -- you go there, maybe I should clarify one
 21 point. This is not going to be a statewide protocol.

22 **DR. HALPERT:** I understand that.

23 **MS. ROGERS:** Yeah.

24 **DR. HALPERT:** But I know that
 25 conceptually --

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2 **MS. ROGERS:** This is just --

3 **DR. HALPERT:** -- we're -- we're moving in
 4 that direction.

5 **MS. CHIUMENTO:** And we may very well get
 6 there eventually because there is some discussion.

7 **DR. HALPERT:** And I -- and I think that
 8 when you look at this it's hard to look at through -- with
 9 a set of glasses on and say can I comfortably say that sure
 10 providers should be utilizing X, Y, Z, modality on standing
 11 orders versus consultation or not at all depending on if
 12 they are a critical care or primary care unit or whatever
 13 it is. It's -- it's a really tough task to wrap your arms
 14 around.

15 **MS. ROGERS:** It is. And it is not going
 16 to be -- and, you know, but that's why I wanted your input
 17 at least on the pediatric version because I have the adult
 18 and the peditrics.

19 **DR. HALPERT:** Okay. Yeah. Yeah.

20 **MS. ROGERS:** And so I just want at least
 21 your input here as to -- is there anything particularly
 22 unsafe. You know?

23 **DR. VAN DER JAGT:** Yeah. I think
 24 that's --

25 **DR. COOPER:** It --

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 2 **MS. ROGERS:** I know Elise already
 3 commented on a couple things on our drive down that he felt
 4 were -- were perfectly -- were just unsafe, and just, you
 5 know, should not be in there at all. And so, you know,
 6 those are the kinds of things that we need to bring our
 7 feedback is to say okay, this is what -- and my goal was to
 8 say E.M.S.C. really is uncomfortable with this particular
 9 treatment and, you know --.

10 **DR. HALPERT:** Right. But there are
 11 modalities that -- that I was unfamiliar with that
 12 obviously came from different regions and I would like to
 13 know what the rationale of the different regions were --

14 **MS. ROGERS:** Sure.
 15 **DR. COOPER:** Yeah.
 16 **DR. HALPERT:** -- including their own
 17 protocols.
 18 **MS. ROGERS:** Right.
 19 **DR. COOPER:** In fairness to Sharon,
 20 first, I -- I -- Sharon, I need to apologize to you. I --
 21 I -- I completely lost track of the time.
 22 **MS. ROGERS:** Easy.
 23 **DR. COOPER:** I thought it was still about
 24 three thirty. Honestly, and I looked at my -- and --
 25 **DR. KANTER:** This would have taken two

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 2 hours.
 3 **MS. ROGERS:** Yeah. It would take --.
 4 **DR. COOPER:** And Lee -- and Lee --
 5 **DR. VAN DER JAGT:** This is the
 6 biggest --.
 7 **DR. HALPERT:** A day.
 8 **DR. COOPER:** And Lee -- and -- and -- and
 9 Lee tapped me or tapped her watch and said it's five after
 10 four and I said oh, my god. Okay. So I'm so sorry. Okay.
 11 I owe you a huge apology. However, I also just asked Lee
 12 if it would be possible for us in very short order sometime
 13 in the next couple of weeks before you leave to -- to
 14 respond, can we set up a conference call where we can
 15 discuss this issue --

16 **MS. CHIUMENTO:** That'd be great.
 17 **DR. COOPER:** -- you know, and solely --
 18 nothing else, just discuss this one issue that Sharon has
 19 put so much work into so we can get the input that -- to
 20 her that she needs on the pediatric --?
 21 **DR. KANTER:** Can it be a webinar?
 22 **DR. VAN DER JAGT:** Yeah, could that be a
 23 webinar so that we can see the documents at the same time?
 24 **DR. KANTER:** Yeah. See the protocols
 25 involved.

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 2 **DR. COOPER:** What I was going to -- yeah.
 3 What I was going to suggest is even a -- even a poor
 4 person's webinar where we just send out the PowerPoint
 5 presentation ahead of time and then, you know, and
 6 everybody has it on their computer screen and we do it, you
 7 know, and we do it with, you know -- you know, as just a
 8 routine conference call where people have the slides in
 9 front of them so we know what we're discussing and --.

10 **MS. CHIUMENTO:** Oh, you -- you actually
 11 already do because this is what -- this is what we're
 12 discussing is this document.
 13 **DR. KANTER:** Sure. Okay.
 14 **MS. CHIUMENTO:** So all you need -- all we
 15 would do is we would say, okay, look at this page one, is
 16 there anything on this page one that you think should be
 17 moved, is there anything you think should be district
 18 medical control? And I think that's the only -- you know,
 19 that's as much as input as I need from this group. I don't
 20 think this group needs to say it should be critical care.
 21 You would have to know the curriculum. You would have to
 22 know, you know, all the pieces.
 23 **DR. KANTER:** The training. Right. So
 24 practice.
 25 **MS. CHIUMENTO:** And you don't -- you

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 2 don't have that piece of information.
 3 **DR. COOPER:** All right.
 4 **MS. CHIUMENTO:** So -- so if you can at
 5 least just -- you can just get those two points taken care
 6 of, that would be great.
 7 **DR. COOPER:** Okay. So I will work with
 8 Martha in getting -- how soon do you need this information,
 9 by the way?
 10 **MS. CHIUMENTO:** Well, I was planning on
 11 doing the -- the -- start doing conference calls with the
 12 working group from med standards sometime towards the
 13 middle of July. So if we can do this by the first or
 14 second week in July --

15 **DR. COOPER:** Okay. Great.
 16 **MS. CHIUMENTO:** -- that would give me
 17 enough time.
 18 **DR. COOPER:** That gives us a little bit
 19 of time. Terrific. Okay. So I'll work with Martha in
 20 getting a -- getting a time set up for a conference call,
 21 where, again, it's going to be only this issue.
 22 **MS. CHIUMENTO:** Right.
 23 **DR. COOPER:** Okay. So we can get the
 24 input to Sharon that she needs. And, you know, with deep
 25 gratitude to Sharon for making sure that the pediatric

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2 component and input is included, you know, as robustly as

3 it will be. That's -- we -- we're really grateful to you.

4 So, and, again, my apologies for losing track of the time.

5 So -- and, again, in the interest of

6 time, unless there are extraordinarily pressing issues on

7 the SEMAC SEMSCO reports or the STAC report, what I will

8 ask is that Jan and Sharon and Elise and I just put

9 together a very short summary of what took place at those

10 meetings so we can get that information out to the group

11 and we'll just e-mail that or post that on the listserv or

12 send it out in whatever other way Martha feels is

13 appropriate. Okay?

14 Any other issues that we need to discuss

15 at this particular time?

16 Lee? Martha? Anything that you have for

17 us?

18 **MS. BURNS:** Drive carefully.

19 **DR. COOPER:** Drive carefully. Good

20 advice from our director. Okay. And I'd like -- I'd like

21 to, again, thank you all for coming, thank Martha for doing

22 a great job getting everything together as she always does,

23 and thank Deb and -- and Marilyn for making time in their

24 busy schedules to be with us, and in absentia, Lisa and

25 Mary Ellen as well. Okay. And, of course, Sandra Haff,

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2 who's probably heard more about children today than she,

3 you know, usually does and probably got an earful from us.

4 But we look forward to working with you as we get this --

5 get -- get the regionalization issues solved. Thank you.

6 Thank you so much for coming. And

7 everyone, we will see you in September. September 20th;

8 right, Martha?

9 **MS. GOHLKE:** Right.

10 **DR. COOPER:** Right? And the conference

11 call will be scheduled very shortly. So please -- please

12 respond to Martha immediately when she suggests some dates

13 as to which will work for you. Okay? Thanks so much for

14 coming everybody.

15 (The meeting adjourned at 4:15 p.m.)

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2 I, G. Michael France, do hereby certify that

3 the foregoing was taken by me, in the cause, at

4 the time and place, and in the presence of

5 counsel, as stated in the caption hereto, at

6 Page 1 hereof; that before giving testimony

7 said witness(es) was (were) duly sworn to

8 testify the truth, the whole truth and nothing

9 but the truth; that the foregoing typewritten

10 transcription, consisting of pages number 1 to

11 143, inclusive, is a true record prepared by me

12 and completed by Associated Reporters Int'l.,

13 Inc. from materials provided by me.

G. Michael France, Reporter

July 6, 2011

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