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

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December 4, 2008  
9:05 A.M.  
Clarion Century House  
Latham, New York

APPEARANCES:

Susan Brillhart  
Sharon Chiumento  
Arthur Cooper, M.D.  
Ann Fitton  
Brian Gallagher  
Marjorie Geiger  
Martha Gohlke  
Jonathan Halpert, M.D.  
Robert Kanter, M.D.  
Kathleen Lillis, M.D.  
Sarah Macinski Sperry  
Tim Czapranski  
Diana Fendya  
Michael Tayler  
Lorie Liptak  
Wendy Stoddart  
Marilyn Kacica, M.D.

1 DR. LILLIS: I wanted to  
2 welcome everyone to the meeting this  
3 morning, and I'm Kathy Lillis. I'm the  
4 vice chair, or maybe the vice chair --

5 MS. GOHLKE: Elect.

6 DR. LILLIS: -- of the  
7 committee, and maybe we could just go  
8 around the room and introduce  
9 ourselves. Do you want to start?

10 MS. SPERRY: Sure. Sarah  
11 Sperry. I'm with the Bureau of Injury  
12 Prevention.

13 MR. CZAPRANSKI: Tim  
14 Czapranski. I'm with the New York --  
15 liaison for the New York State EMS  
16 Council.

17 MS. GALLAGHER: Brian  
18 Gallagher with the School of Public  
19 Health at SUNY Albany.

20 MS. CHIUMENTO: Sharon  
21 Chiumento, EMS provider, and also  
22 SEMAC/SEMSCO alternate liaison.

23 MS. GEIGER: Oh, I'm sorry,  
24 Marjorie Geiger, the Bureau of EMS.

1 MS. GOHLKE: Martha Gohlke,  
2 Bureau of EMS.

3 MS. FENDYA: Diane Fendya,  
4 I'm with the Emergency Medical Service  
5 for Children's Program, the National  
6 Resource Center that is part of the  
7 Children's National Medical Center in  
8 Washington, D.C.

9 DR. KANTER: Bob Kanter,  
10 pediatric critical care physician in  
11 Syracuse.

12 MS. BRILLHART: Susan  
13 Brillhart, pediatric critical care  
14 nurse in Manhattan.

15 MR. TAYLER: Michael Tayler  
16 from the Bureau of EMS.

17 DR. LILLIS: Okay, great.  
18 Can we get the minutes approved?

19 MS. GOHLKE: Well, you know,  
20 we don't have a quorum, I don't think,  
21 yet, so I think that's an issue. We  
22 can wait, maybe, on that.

23 DR. LILLIS: Okay. Good  
24 morning, Ann.

1 MS. FITTON: Good morning.

2 DR. LILLIS: We're just  
3 doing intros. Do you want to introduce  
4 yourself?

5 MS. GOHLKE: Since you're on  
6 stage.

7 DR. LILLIS: Well, that's  
8 Ann Fitton from the New York City Fire  
9 Department.

10 Okay, I guess we'll start with  
11 updates. Marjorie.

12 MS. GEIGER: Good morning  
13 everybody and welcome to a chilly  
14 morning but a warm morning in here.

15 I would like to just give you a  
16 few updates, one on a personal note.  
17 I'm moving on to a new position in the  
18 Department of Health. Some of you know  
19 this, some of you don't. I don't have  
20 a start date yet, but I am to assume  
21 the directorship of the Office of the  
22 Patient Safety Center. For those of  
23 you who are not familiar with this  
24 center, it is established in Public

1 Health Law. It's a relatively new  
2 center a few years ago. The current  
3 director has retired. And the good  
4 news is it's located on the same floor  
5 where I'm located now, so all my  
6 colleagues will continue to see me in  
7 partner with our office. And we have  
8 responsibility for preparing data  
9 analyses to assist the Commissioner and  
10 his stakeholders with improved --  
11 assessing patient care in New York  
12 State and ultimately improving patient  
13 safety issues. So it's somewhat of  
14 a -- new office-based surgery  
15 requirements are contained in this  
16 center. Some of you whose commissions  
17 are on the table are very familiar with  
18 that. So it's a wide open possibility.  
19 So welcome the partnership with the  
20 children's programs here because Martha  
21 has already come to me and so has  
22 Dr. Cooper on ideas.

23 And I just want to say it has  
24 been a real pleasure to work with the

1 EMSC program for 10 years. I've seen  
2 it evolve from, you know, a relatively  
3 new program in New York State to one  
4 that's rich. You folks are now vetted  
5 in Public Health Law. That's a real  
6 landmark achievement. You should be  
7 very proud of yourselves. You've  
8 produced many, many products that have  
9 aided the pre-hospital care providers,  
10 their system, and their patients and  
11 their families. We've had a voice at  
12 the national meetings where our former  
13 coordinator, Gloria, has presented, as  
14 well as Martha, and I know that each of  
15 you will continue to have a voice there  
16 at the national level in the future,  
17 and so I look forward to working with  
18 you on this.

19 Moving along, I want to let you  
20 know that Dr. Daines, our Commissioner  
21 of Health, and Dr. Morley, who is the  
22 medical director for our umbrella home  
23 in the Health Department, have reviewed  
24 your white paper, and there is

1 conceptual agreement to move ahead with  
2 the main recommendation, which is to  
3 hold the stakeholder's meeting.

4 So here comes Dr. C.

5 So at some point today we'll talk  
6 about how to process that, and move  
7 that ahead and plan for our  
8 stakeholder's meeting in 2009.

9 I just want everybody who's a  
10 long-time member -- like Sharon and  
11 Dr. Lillis and a few people around the  
12 table. Over our tenure of 10 years in  
13 New York State, we have had two  
14 stakeholder's meetings with the EMSC  
15 program, so we can look at that, those  
16 attendees that came in the past and  
17 include those, and I know Dr. Daines  
18 and Dr. Morley both have some additions  
19 that they would like to add to that,  
20 and, of course, we have some newcomers.  
21 So that's -- good morning, Dr. Cooper.

22 DR. COOPER: Hi.

23 MS. GEIGER: So that will be  
24 an initiative for 2009.

1                   Some of you have asked me to  
2                   report on the state of the affairs of  
3                   the New York State budget. I don't  
4                   need to tell you in less than -- any  
5                   more than one word. It's dismal.  
6                   Those of you who read the financial  
7                   pages of either your local paper or  
8                   national paper, you know that New York  
9                   State is struggling along with its  
10                  counterparts across the country. What  
11                  we don't know is what the impact will  
12                  hold for us in the new state fiscal  
13                  year, which starts April 1. So far the  
14                  EMS dedicated account has remained  
15                  whole. What its future will be in the  
16                  new calendar period, we don't know. So  
17                  we, along with all other programs  
18                  across the State, have to curtail our  
19                  staff hiring so there are no backfills,  
20                  essentially, in New York State, and we  
21                  are on a severe travel restriction. So  
22                  if you need us to come visit you across  
23                  the State, please give us as much  
24                  advance notice as possible because even

1 for a day trip we need to get prior  
2 approval to make that journey, and we  
3 want to continue to work with you in  
4 your communities, but we just need to  
5 add some factors along our review  
6 process.

7 I wanted to let you know that one  
8 of our area trauma centers has  
9 voluntarily de-designated itself,  
10 Arnott Ogden. We are mirroring,  
11 unfortunately, a trend that is seen  
12 across the country. Our area, or at  
13 the national level, they are known as  
14 level 2 centers, are struggling daily  
15 to maintain their subspecialty  
16 coverage. In Arnott Ogden's case, it  
17 was coverage for trauma surgery;  
18 whereas, other specialties that are  
19 facing similar issues are orthopedic  
20 surgeons and anesthesiologists. So  
21 Arnott Ogden took a year's reprieve on  
22 its trauma status, and they are  
23 partnering with some of the -- the  
24 regional trauma center to see if they

1 can have a feeder system for trauma  
2 surgery coverage. We don't know yet  
3 whether that will occur or not. So  
4 we'll keep this body apprised of that.

5 Secondly, there are a few  
6 legislative initiatives that the  
7 Governor has said. I don't know which  
8 ones focus on the Department of Health,  
9 but legislative initiatives that went  
10 into effect this past legislative  
11 session have had their budgetary  
12 amounts curtailed. So if any of them  
13 impact you, I suggest that you talk to  
14 your chief financial officer at your  
15 institutions.

16 And I don't really have any more  
17 to say unless you do. We have a guest  
18 here today, and I know Martha will be  
19 introducing Diana and why she's here.  
20 We're very pleased to have a federal  
21 liaison. On a personal note, Diana has  
22 been a real advocate for the New York  
23 State EMSC for Children's program.  
24 She's worked with us over the last

1 several years to make sure that we have  
2 that voice at the national level, that  
3 we continue to provide quality  
4 products, and she gives us advice on a  
5 daily basis. So I want to thank you  
6 for that.

7 MS. FENDYA: Thank you. It  
8 has been my pleasure.

9 MS. GOHLKE: I just thought  
10 I'd talk about the day's plan and the  
11 agenda and a little bit of additional  
12 information as far as travel and things  
13 like that you folks need to know. But  
14 if you look at your agenda in your  
15 packet, other than some updates from  
16 the different areas, Diana is going to  
17 talk a little bit, and Dr. Lillis is  
18 going to give us a PCARN update with  
19 her project. I wanted to spend a short  
20 time maybe developing the subcommittees  
21 and the by-laws. We have a nomination  
22 committee an education committee and an  
23 interfacility transfer committee  
24 outlined. I'd like to start

1           formulating some of that, so that way  
2           we can get to work on some of those  
3           areas. We can talk more about that in  
4           a bit, and then we'll also talk about  
5           dates for next year.

6                         In the past, you all have asked  
7           me to have an update with what the  
8           Health Department is doing with  
9           disaster or emergency preparedness. So  
10          after twisting some people's arms,  
11          Lorie Liptak, the associate director,  
12          as you can see in your agenda, of  
13          Health Systems, Emergency Preparedness,  
14          is going to come and give an overview  
15          of what the Department has been doing  
16          as of late. And Dr. Marilyn Kacica and  
17          Wendy Stoddart will be coming from the  
18          Division of Family Health to talk about  
19          the recent obstetrical, pediatric  
20          disaster preparedness tool kit that  
21          they recently released and rolled out.  
22          So they're going to do a walk-through  
23          of that tool kit for you folks, and  
24          they should be arriving about 11:00 to

1 join us.

2 SPEAKER: Well, you said --

3 MS. GOHLKE: Well, no,  
4 because it was on HPN, but supposedly  
5 now it's on the Health Department  
6 website, and we can do that, because it  
7 wasn't open to the public until they  
8 did their formal roll out. But we can  
9 ask Dr. Kacica today, but I think it  
10 has been put on the Health Department  
11 website. And they are going to bring  
12 some hard copies, some hard copies. I  
13 don't think they were going to promise  
14 20 for the whole group, but at least  
15 for the folks that work in the  
16 hospitals, I think they were going to  
17 provide a hard copy of that tool kit.

18 So, also Marjorie just talked  
19 about Diana Fendya. I also want to  
20 thank her for making the long trek.  
21 Diana co-presented with me yesterday at  
22 the SEMSCO meeting on the interfacility  
23 transfer agreements data that I  
24 presented to you folks -- that we've

1 presented to you folks at the last  
2 meeting. Diana was the person on the  
3 phone. And so our plan was to roll it  
4 out to them to let them know what --  
5 obviously, what the data showed, but  
6 also to talk about the plans that this  
7 committee has decided to work on the  
8 guidance document for hospitals to use  
9 to develop their transfer agreements  
10 and guidelines. It went very well. I  
11 didn't hear anything negative, I should  
12 say. So she came out for that, and  
13 that's why we prepared this meeting  
14 today so that she could meet you all  
15 face to face and realize that we all  
16 really do exist.

17 MS. FENDYA: Oh, I know you  
18 exist. You're doing lots of hard work,  
19 so --

20 MS. GOHLKE: So thank you  
21 again for coming out. And that's -- as  
22 Marjorie said, she has been a wonderful  
23 help to me. Especially, it's -- it  
24 will be a year in two weeks that I've

1           been here, and she's really been  
2           mentoring me along the way, and she's  
3           the clinical expert for the NRC, so  
4           it's helpful to me since I don't have  
5           that clinical expertise that I've  
6           actually been paired up with Diana. So  
7           I feel really fortunate that I've  
8           received Diana as my liaison. So I  
9           want to thank you for all the help  
10          you've provided me in the last year.

11                       MS. FENDYA: You haven't  
12           needed much mentoring, but have done  
13           quite well.

14                       MS. GOHLKE: Okay, so I  
15           think that was it as far as the agenda.

16                       Just a little bit more on the  
17           budget and the mileage. Some of you  
18           have already, you know, been  
19           familiarized with our new process for  
20           getting approval to travel. As of  
21           late -- it changes every few days, but  
22           as of late the policy is if travel is  
23           going to exceed \$500, we have to go  
24           through a very multi-layered process

1           for approval.  So I've been in contact  
2           with several of you folks trying to get  
3           your travel approved for this period.  
4           And it will be an ongoing basis.  So I,  
5           actually, think I forgot one person,  
6           but it will be okay.  But so help me --  
7           my point is, is help me to remember for  
8           future meetings, especially with  
9           mileage costs, if they don't go down,  
10          if they stay high as they are, many  
11          folks will exceed the \$500, and we just  
12          need -- you just need to help me flag,  
13          you know, your need to get approval.  
14          So, you know, obviously, I will do all  
15          the leg work, but we have to do it  
16          ahead of time, and then that gets  
17          involved with, if you end up taking  
18          special transportation and then those  
19          type of costs, we have to work well  
20          ahead of time.  So just to keep that in  
21          mind.

22                        The other thing is that they're  
23                        now requiring, as part of  
24                        documentation, that if you're putting

1 in for mileage reimbursement, you have  
2 to use the Map Quest website to show  
3 your mileage, which if you don't do it,  
4 that's fine. I will print it out, but  
5 if the mileage you write down on your  
6 reimbursement voucher differs from what  
7 Map Quest says that I print out, you'll  
8 get the one that Map Quest says. So,  
9 just so you know, that documentation  
10 has to go along with your paperwork  
11 that you submit for reimbursement.

12 MS. FENDYA: And, if it  
13 helps any, the feds make you do that,  
14 too.

15 MS. GEIGER: It's always  
16 been a requirement, but now under the  
17 tightened scrutiny of our finances it  
18 has become a requirement added to one's  
19 travel.

20 MS. GOHLKE: I'll be the  
21 bearer of bad news. I was hoping maybe  
22 Ed would do it. But as far as the food  
23 and the services that we're providing,  
24 along with the meetings for the future,

1           you know, we've had to cut back in all  
2           areas, and one of the ways that they're  
3           going to cut back slightly is with some  
4           of the food that is provided at the  
5           meetings. And so the food, not for  
6           today but for future meetings, is only  
7           going to be for voting members. Okay?  
8           Vetted voting members. So staff,  
9           stenographer, Tim is a non-voting  
10          member --

11                         MS. GEIGER: Can I just say  
12           something? We're still working on  
13           that, so we'll keep you posted. We'll  
14           let you know. We're still working on  
15           that.

16                         SPEAKER: Tell them we're  
17           hearty eaters that don't share.

18                         SPEAKER: Put a donation  
19           basket up there.

20                         MS. GOHLKE: And then I  
21           guess it's also an issue with travel as  
22           far as the liaisons go, so -- but I  
23           have put in for my grant to, hopefully,  
24           if it's approved, to have the liaisons

1           that attend the different meetings  
2           travel covered through my grant. So my  
3           grant actually just went in this week,  
4           and, you know, it starts March 1, so if  
5           everything goes through smoothly we  
6           should hear in the next few months, so  
7           hopefully that will all be covered,  
8           okay. So that's the good news.

9                         Anyways, so moving on, I was  
10           asked to talk at one of the national  
11           resource centers activities for  
12           grantees. They have what they call  
13           "town hall conference calls" for  
14           grantees to phone in and receive  
15           technical assistance or advice from  
16           other states regarding the different  
17           performance measures on the grants to  
18           help them see what other states are  
19           doing and hopefully move their  
20           processes along as well -- their,  
21           meaning the other states. And so this  
22           past Monday I presented on our white  
23           paper and how the State was attempting  
24           to move forward with the designation

1 system for pediatric medical  
2 emergencies. And I was kind of put  
3 into the early process. What does the  
4 State start to do in order to move this  
5 processing along? And there were two  
6 other states that presented that have  
7 already achieved that designation  
8 system. So we have been featured  
9 nationally for our work on the white  
10 paper, so that's -- I wanted to let you  
11 know.

12 MS. FENDYA: And I think  
13 it's important for the group to  
14 understand that facility recognition is  
15 not nationwide by a long shot. The  
16 reality of it is there are about four  
17 states in the entire country that have  
18 it well put together far, both  
19 pediatric medical emergencies. Trauma,  
20 obviously, is a little bit further  
21 along because of the trauma system  
22 development in most of the states. So  
23 most of the states have one or maybe a  
24 couple of pediatric trauma centers that

1       they can say, yes, we have facility  
2       recognition for traumatic injuries for  
3       kids. But as far as pediatric medical  
4       emergencies, most of the states are way  
5       far behind. So you guys have a jump  
6       start with the white paper. And many  
7       of the states have begun to ask, you  
8       know, what is the first step in that?  
9       Because most of EMSC is really focused  
10      in on the emergency care providers in  
11      the field, and there has been little  
12      done with hospitals at this stage of  
13      the game. So this is a huge step for  
14      the program, to be quite honest. Many  
15      of the managers are totally  
16      uncomfortable with hospital  
17      associations, totally uncomfortable --  
18      they wouldn't dare sit next to you  
19      because you've got critical care, but  
20      the reality of it is the program is  
21      forcing them to do this and it's going  
22      to be an interesting but difficult  
23      step, I think, for many of them. So I  
24      was glad Martha was in the beginning

1 stages and you guys had done something  
2 that she could say, okay, this is the  
3 first step of what New York, because a  
4 lot of people look to see what the  
5 bigger states, and the states that have  
6 been around for a while, have  
7 accomplished. So it was good to see  
8 that New York's -- just where they are,  
9 but they're a step ahead as well. We  
10 were glad she was there.

11 MR. TAYLER: Martha?

12 MS. GOHLKE: Yes.

13 MR. TAYLER: You said there  
14 were four states?

15 MS. FENDYA: Approximately,  
16 there's four states, yes.

17 MR. TAYLER: Can you name  
18 them?

19 MS. FENDYA: California has  
20 parts of it in place. Illinois has a  
21 very well put together program.  
22 Oklahoma has it in statute, and  
23 Tennessee has it in statute.  
24 Tennessee's program has been around for

1 a, while and Oklahoma's has been around  
2 for a while. Illinois is, probably,  
3 the one that most of us look at closely  
4 because theirs was totally based on  
5 volunteer processes. And those  
6 volunteer processes, they started out  
7 regionally. They were very strategic.  
8 Their team was very strategic. They  
9 said, okay, we're going to choose one  
10 region to go in, and hospital A is  
11 going to be the first one we're going  
12 to approach about applying. Hospital A  
13 applies. Then, obviously, Hospital B  
14 that's in the same community isn't  
15 going to let them have anything, so you  
16 get two hospitals for the price of one.  
17 Their state advisory team, actually,  
18 functioned as the first set of  
19 reviewers. They had a lot of bordering  
20 states. With me being in Missouri at  
21 the time, I actually went through their  
22 reviewer training process and reviewed  
23 some of their early hospitals that were  
24 recognized for pediatric facility

1 recognition. And I believe just a year  
2 and a half ago, they implemented their  
3 final step, which was recognizing  
4 hospitals that had pediatric critical  
5 care capabilities. They've collected  
6 data on mortality and morbidity,  
7 pre-initiation, and now they've got  
8 enough data available that they're in  
9 the process -- they've just had a paper  
10 accepted for publication. And, I'm  
11 sorry, I can't tell you which the  
12 journal is. It's not -- they had to  
13 make their revisions, so it should be  
14 coming out within the next year would  
15 be my guess. So we're very excited  
16 about that because the program actually  
17 needs proof. One of the problems that  
18 they, obviously, have is they can't say  
19 definitively that facility recognition  
20 was the true reason why mortality  
21 dropped because it could be the disease  
22 entities. There's just too many other  
23 --

24 MR. TAYLER: These are

1 states that we could look to for best  
2 practice or for models --

3 MS. FENDYA: Absolutely,  
4 absolutely. Rhonda Filippi from  
5 Tennessee spoke. Rhonda, I think, has  
6 a great program from Vanderbilt. But I  
7 would definitely -- I mean Rhonda, I'm  
8 sure, would be willing to come out to  
9 visit you all. She could probably do  
10 it over the phone, as well. Evelyn has  
11 gone so far as Virginia, actually, and  
12 is going to be going out to Illinois  
13 and going on site surveys, because they  
14 are in the process of trying to build  
15 upon their trauma system to do that.  
16 Oklahoma, theirs is just a little bit  
17 different. I don't -- I'm not totally  
18 as comfortable with theirs, but they  
19 went after it with their trauma  
20 designation process, and they put it  
21 into statute without any thought of it.  
22 If you're going after trauma  
23 recognition facilities, recognized for  
24 trauma, you're going to do it for

1 medical -- be after medical as well, so  
2 they just built it on the front end.

3 DR. KANTER: California's  
4 peds critical care designation is very  
5 strong because the state reimburses  
6 care at the designated hospitals at a  
7 higher level than at other hospitals.

8 MS. FENDYA: Interesting.

9 MS. GEIGER: I just want to  
10 introduce -- some of you may know, some  
11 of you may not know -- this is Ed  
12 Wronski, our director of EMS.

13 MR. WRONSKI: Good morning.

14 MS. GEIGER: He graces us  
15 with his presence on a periodic basis,  
16 but, more importantly, as part of the  
17 transition that I talked about earlier  
18 with my departure. Welcome, Ed.

19 MR. WRONSKI: Thank you.  
20 It's good to be here.

21 MS. GOHLKE: So I thought we  
22 would just take a look at the grant, at  
23 least the requirements for 2009 to  
24 2011, let you know when I told them we

1           were all going -- given, which is in  
2           yellow in your folder. I tried to make  
3           it as -- I tried make the 55 page grant  
4           as succinct as possible for you so you  
5           wouldn't have to read all of the 55  
6           pages. So I boiled it down to three  
7           which, obviously, are revolved around  
8           the performance measures, which  
9           hopefully you're getting up to speed,  
10          if not more than I am, at this point.

11                         Some measures, 66A and 66B, have  
12          to do with medical direction, online  
13          and offline pediatric medical  
14          direction, for EMS folks, you know, in  
15          the field, and then also the pediatric  
16          equipment that they're carrying on  
17          their vehicles. You know, this was a  
18          survey that I did earlier this year,  
19          and I actually just received my data  
20          back from the NDARK contractor from the  
21          EMSC folks, and I'll be looking through  
22          those in the next month or two, and my  
23          hope is to actually present the data at  
24          the next SEMSCO meeting because they're

1       also looking at defibrillators and, you  
2       know, the access to defibrillators on  
3       the transport vehicles, so it might  
4       play well with that discussion. So,  
5       hopefully, I'll have that for you folks  
6       to look at at our next meeting.

7                It was a little difficult to have  
8       a goal for the grant since I didn't  
9       know what our base line was. But just  
10      looking at the reports that were coming  
11      in, because I did a lot of the manual  
12      data entry myself, I think we're doing  
13      pretty good as far as access to online  
14      and offline medical direction and also  
15      pediatric equipment. Now the 2011 goal  
16      for the federal EMSC program is that at  
17      least 90 percent of the agencies have  
18      this, have all of this. And my  
19      guestimate, just by looking at some of  
20      the hard copies, is that we're probably  
21      close to 80, 90 percent, if not more.  
22      So without knowing the exact baseline I  
23      just, in my grant, wrote that we were  
24      going to improve by at least five

1           percent.  And I think we're going to be  
2           within reach of that 90 percent.  I  
3           just couldn't prove it because I didn't  
4           have the baseline.  And I thought five  
5           percent was a good achievable number,  
6           at least at this point, without  
7           actually knowing what the data shows  
8           yet.  So but I do think we'll -- I  
9           think the 90 percent is not out of  
10          reach for us by 2011.  We can talk more  
11          about that.

12                         MR. CZAPRANSKI:  I have a  
13          quick question.  There are a couple of  
14          ways to look at this.  The total number  
15          of services that have access may not  
16          represent 90 percent of the calls.  So  
17          you can get 90 percent of services that  
18          represent 60 percent of the pediatric  
19          calls, because some of the services may  
20          be large, or it may be just the  
21          opposite.  You may get 90 percent of  
22          the services that are 98 percent of the  
23          calls.  Have you called that out at  
24          all?

1 MS. GOHLKE: No. The feds  
2 allowed me to do a sample size, so I  
3 only had to survey, instead of the  
4 1,800 agencies plus New York State,  
5 467. So, yeah, I can look at that and  
6 see, see if those folks that are doing  
7 more of the calls, you know --

8 MR. CZAPRANSKI: Because you  
9 may already be past 90 percent of your  
10 call volume.

11 MS. GOHLKE: Yeah. I don't  
12 think that on a federal level they're  
13 going to care about the volume, you  
14 know, who is doing what the most. But,  
15 you're right. I mean as far as looking  
16 at statewide what we're doing, that  
17 could be something that I could tease  
18 out, just out of curiosity.

19 MS. FENDYA: Ed, I've got a  
20 question in reference to online,  
21 offline medical direction that came up  
22 at your meeting yesterday. And maybe I  
23 didn't hear the conversation totally  
24 correct, but I thought I understood

1 that they were going to be looking at  
2 what were the qualifications of the  
3 individuals who were providing online.  
4 Are they actually going to be doing a  
5 survey? Would it be conceivable -- how  
6 are they going to gather that  
7 information? Is that something that  
8 Martha could have a couple of  
9 questions? Our advisory committee here  
10 could offer some questions related to  
11 pediatric knowledge?

12 MR. WRONSKI: Sure. The  
13 whole issue of the online medical  
14 control was brought out because of a  
15 couple of regions who, in their  
16 systems, allow PAs and, in some cases,  
17 nurse practitioners to work online with  
18 the ALS providers. And there's --  
19 apparently, there may be one that uses  
20 paramedics to talk to paramedics.  
21 These are limited and scattered groups.  
22 The law says that a physician must  
23 provide online medical control or  
24 direct online medical control. So what

1           they want to do is meet and discuss  
2           what are the criteria for direction of  
3           online medical control if the paramedic  
4           or the critical care tech is going to  
5           talk to someone who is not the actual  
6           M.D?  What is the criteria?  What kind  
7           of training should that person have?  I  
8           think, certainly, we can introduce, you  
9           know, issues that you would like to  
10          have on the table for pediatrics when  
11          they're going through this process.  It  
12          is a very defined look at, when it's  
13          not an M.D., what are the rules.

14                         DR. COOPER:  If I might,  
15          Martha, I just want to amplify some of  
16          the remarks that Mr. Wronski just made.  
17          Even before Mr. Wronski was with the  
18          Bureau back in the late '80s and early  
19          '90s --

20                         MR. WRONSKI:  There was EMS  
21          before me?

22                         DR. COOPER:  There was, yes.  
23          We called it Eons Ago Medical Services  
24          -- the issue of who was providing

1 medical control online was extremely  
2 contentious. And at one point the  
3 statement that every contact, either by  
4 telephone or any electronic means, had  
5 to be a physician or paramedic came  
6 very close to being included in  
7 regulation which, of course, would have  
8 provided a great deal of less  
9 flexibility than perhaps the system  
10 warranted. That issue has not been one  
11 that has arisen with such force,  
12 really, for quite some time. The  
13 assumption has been that medical  
14 control is -- direct medical control is  
15 being provided either by a physician or  
16 by someone really sitting very, very  
17 close to a physician, but as  
18 Mr. Wronski indicated of late,  
19 information has surfaced indicating  
20 that that's not the case. Fortunately,  
21 the level of discomfort with that is  
22 nowhere near what it was 15 years ago,  
23 or more. And I think at this point the  
24 question is really to get a group to

1 sit down and think through how medical  
2 control should be provided, can be  
3 provided and in a modern era. I don't  
4 think the discussion has gotten quite  
5 so far as coming up with a notion  
6 necessarily of a detailed survey. A  
7 survey has already actually been  
8 conducted, but my guess is that  
9 probably more questions will need to be  
10 asked because the survey that was done  
11 was kind of informal, and -- but at  
12 such time as a survey might be created,  
13 I think, you know, your suggestion that  
14 we include some very, very specific  
15 questions regarding pediatrics would be  
16 appropriate; otherwise, we are going to  
17 be in a position where we're going to  
18 have to do that survey ourselves which  
19 will be a little bit more difficult,  
20 but --

21 MS. FENDYA: Well, Martha,  
22 actually, has done some stuff on it.

23 DR. COOPER: She has done  
24 some preliminary stuff, I know that.

1 MS. FENDYA: It may be  
2 helpful, I don't know.

3 MS. GOHLKE: I mean what I  
4 took away yesterday was that -- from  
5 the SEMSCO, when Dr. Marshall was  
6 talking at Med Standards, we could  
7 start looking at this, is that I'll  
8 start a little note and let him know  
9 what the grant's looking at and make  
10 sure that I'm in the loop on that when  
11 they discuss that.

12 So what I've -- what I've  
13 promised is with the data on the  
14 equipment and also the medical control  
15 is that, obviously, I'm going to  
16 present to the stakeholders, which  
17 include meetings such as this, and  
18 SEMSCO, and CME, also our 18 regional  
19 program agencies, and then help you all  
20 help me develop a plan on how we're  
21 going to improve our numbers. So we'll  
22 get to that down the road once we see  
23 what we have, and over the next couple  
24 of years develop and implement that

1 plan. And I have to do data collection  
2 again in two years on it, and then  
3 we'll see where we're at and see what  
4 we need to do. So that's the plan for  
5 those two sub-measures.

6 The sub-measure, 66-C, still on  
7 page 1 there at the bottom, that's the  
8 white paper and the categorization, and  
9 we're working towards that. So I said  
10 that we were going to -- upon approval  
11 from the Commissioner, of course --  
12 move ahead with reviewing, meeting with  
13 stakeholders, which Marjorie talked  
14 about. That will be our first step.  
15 And eventually reviewing other states'  
16 models and making a recommendation,  
17 hopefully, down the line on what we  
18 would see New York -- how we would like  
19 to see this roll out. So we'll review  
20 other states' models, make  
21 recommendations, and then, again, with  
22 approval and the go-ahead to move  
23 forward, we'll hopefully go down the  
24 line, and formulate it, and formalize

1           it, and hopefully have some regs.  
2           Wishful thinking in three years but,  
3           you know, you have to -- you have to  
4           speak positively in your grant, so --  
5           yes.

6                         DR. COOPER:   Martha, before  
7           we leave the first page, I just had  
8           a -- if you could -- I know that the  
9           statement was made that a stakeholder  
10          meeting has been approved, but I did  
11          note that you have meetings with  
12          stakeholders in boxes for several, not  
13          just one, but several times throughout  
14          the entire time cycle. Do we have the  
15          approval to do all of those or just for  
16          the first one at this point?

17                        MS. GOHLKE:   Just for the  
18          first one.

19                        DR. COOPER:   Just for the  
20          first one, okay.

21                        MS. GOHLKE:   Again, I'm  
22          positive. I'm a half-full-glass  
23          thinker, positive.

24                        DR. COOPER:   Okay, okay.

1 MR. TAYLER: Martha?

2 MS. GOHLKE: Yes.

3 MS. GEIGER: But that's a  
4 significant one.

5 DR. COOPER: Oh, absolutely.  
6 Oh, I'm not minimizing that one bit.

7 MR. TAYLER: Just a  
8 clarification on 66-C. The trauma and  
9 medical, are they exclusive? I mean  
10 there could be places that are  
11 designated as pediatric trauma centers  
12 but they're not children's hospitals  
13 for -- or there are children's  
14 hospitals who are not pediatric trauma  
15 centers, or is the expectation that if  
16 you deal with children, you deal with  
17 trauma and medical together? If you're  
18 going to be designated a pediatric  
19 hospital, you deal with both? What is  
20 the --

21 MS. GOHLKE: I don't think  
22 -- we haven't gone down that road yet,  
23 so we still have to decide how we are  
24 going to have it look, but I can't

1           imagine we're going to expect everybody  
2           to be the whole ball of wax.

3                       MR. TAYLER:   Well, I guess I  
4           was, maybe, asking what are the feds  
5           looking at.

6                       MS. FENDYA:   No, they can be  
7           exclusive, and they actually are in  
8           some the states already.   States that  
9           are saying that, yes, we have pediatric  
10          trauma centers identified -- my home  
11          state, we have three pediatric trauma  
12          centers without any problem, but we've  
13          never gone so far as doing a facility  
14          recognition program for medical  
15          facilities.   So, yeah, they could very  
16          much be exclusive.   There are going to  
17          be some hospitals that aren't going to  
18          have the trauma resources but could in  
19          fact be a -- and, actually, Illinois  
20          has got a level -- what do they call  
21          it? -- standby pediatric facility.  
22          They've got folks who are trained in  
23          pediatric resuscitation, but they have  
24          transfer agreements in place to move

1           them on.

2                           DR. COOPER:   The traditional  
3 model, if there is a traditional model  
4 in EMSC, dates back to the work of Jim  
5 Sidel in Southern California in the  
6 late 1970s, and they built a  
7 three-tiered system, which at the, you  
8 know, basic rung was something called  
9 an EDAP, an EDAP, an Emergency  
10 Department Approved for Pediatrics.  
11 The second rung was a PCCC, which is a  
12 Pediatric Critical Care Center.  
13 Obviously, to be a PCCC you had to have  
14 an EDAP. And then the third level was  
15 pediatric trauma center, and to be a  
16 pediatric trauma center you had to have  
17 both, an EDAP and a PCCC. So that has  
18 been the traditional model that has  
19 been advocated nationwide. But there,  
20 as Diana points out, are numerous  
21 variations that have been adopted  
22 nationwide.

23                           DR. HALPERT:   I think also  
24 that the language in 66-C is very

1       vague, and Art's reference is excellent  
2       because, probably, if you queried most  
3       hospitals in New York State right now  
4       they'd say they'd fit at least the  
5       profile of the EDAP. Their staff would  
6       qualify as emergency physician and a 24  
7       hour a day emergency department. And,  
8       certainly, the language in 66-C says  
9       stabilize and or manage. Well, that  
10      doesn't mean definitively, necessarily,  
11      but it means certainly to be able to  
12      initiate the process of care, and, if  
13      that requires transfer, obviously,  
14      transfer as well.

15                   DR. KANTER: I think this  
16      system, as it develops, is going to  
17      depend on the services that are needed  
18      and that already exist in each area,  
19      but they're also going to have to take  
20      into account some of the work force  
21      problems that have already been alluded  
22      to. Getting coverage is not only a  
23      problem in some of the level 2  
24      facilities, sometimes getting coverage

1 is a difficulty in the highest level  
2 centers.

3 DR. COOPER: I think there  
4 is another -- there is another issue  
5 too that is more common in the  
6 pediatric world than not, and that is  
7 that in most places the concentrations  
8 of resources are organized in such a  
9 way that you'll find most everything in  
10 one place, as opposed to part A here,  
11 part B over there and so on. It's just  
12 the nature of tertiary care pediatric  
13 practice, that they tend to exist in  
14 the same place. Of course, the bigger  
15 the Metropolitan area, the less that's  
16 true. New York City, for example,  
17 that's less true than it is in some of  
18 the upstate cities where, in effect,  
19 even if they are not free-standing  
20 children's hospitals, they are, in  
21 effect, de facto children's hospital,  
22 you know, in the sense of full-service  
23 children's facilities, inpatient  
24 facilities, within a university

1 hospital environment.

2 MS. GOHLKE: I think also  
3 one of the nuances with this  
4 performance measure -- and correct me  
5 if I'm wrong, Diana. I mean one of  
6 things that has changed with this new  
7 three-year cycle, I should say, is  
8 before 66-C you had the -- in order to  
9 meet it, you had to have the  
10 designation system for trauma and  
11 medical emergencies, and now it's split  
12 out. So now -- so we meet the measure  
13 as far as the trauma system for peds,  
14 and what they're having states do is  
15 focus on the trauma system first for  
16 peds, and if they've accomplished that  
17 then move towards medical emergencies.  
18 So because of that, the way it has been  
19 split up now, actually, New York State,  
20 as far as the pediatric rung goes,  
21 looks a little bit better because we  
22 meet it as far as the trauma. Now  
23 we're just working towards the medical  
24 emergencies. So that's one of the

1 pluses in the changes that they've done  
2 with the grant and as far as our  
3 accomplishments in the state. And one  
4 of the subcommittees, I put on here,  
5 that we would like to develop is,  
6 obviously, to work on this project, the  
7 interfacility -- well, that's the  
8 interfacility transfer, so we'll hold  
9 up on that.

10 So moving on to page 2 -- this is  
11 the interfacility transfer, 66-D and  
12 E -- this is the data that I showed you  
13 at the last meeting and that we  
14 presented yesterday at the SEMSCO  
15 meeting. And we did have our baseline  
16 data, so I basically said we would  
17 achieve the 90 percent, that all  
18 hospitals will have protocols and  
19 transfer agreements in place by 2011  
20 because we have decided to work on a  
21 guidance document to help hospitals do  
22 that. We talked about that at the last  
23 meeting, and that's the subcommittee I  
24 was referring to that I would like to

1 have formulated after today to start  
2 working on this process, on the  
3 guidance document. I think it's very  
4 doable, actually, in three years that  
5 we could develop this guidance document  
6 and roll it out to hospitals, and which  
7 is some of the activities I've outlined  
8 here. And then again have to resurvey  
9 in two years to see how they're doing,  
10 so actually we really only have two  
11 years to get the guidance document out  
12 before I resurvey, and then we'll see  
13 how we're doing after that survey,  
14 whether or not the hospitals have  
15 developed the protocols and agreements.  
16 Does that make sense?

17 MS. FENDYA: And a couple of  
18 things you may want to think about.  
19 Washington State jumped on this as soon  
20 as these measures came out this last  
21 time, and they actually developed a  
22 very beautiful document that looks at  
23 -- helps hospitals identify which  
24 patients need to be transferred out.

1 That was their first step. They came  
2 to some agreement on that, and then  
3 they worked on what the transfer  
4 agreement should actually look like,  
5 and then they worked on a template for  
6 guidelines. And the reality of it is,  
7 if you look at the guideline components  
8 that you surveyed on, those are  
9 components that are not specific to  
10 kids. Those are components that should  
11 be thought of for every patient that  
12 needs to be transferred, so it's sort  
13 of an easy sell, if you can work with  
14 and nourish that relationship with your  
15 hospital association. And I've already  
16 heard that there have been some  
17 difficulties there, but perhaps  
18 incorporating them at the beginning,  
19 they may be of some benefit to working  
20 with that component. The other thing  
21 that some of the states have found is  
22 that for those facilities that take  
23 care of the largest percentage of your  
24 pediatric patients, if you go to Art's

1 hospital and you go to Dr. Kanter's  
2 hospital and you say this is the  
3 template and the model we'd like you to  
4 work with, as you work with your  
5 transferring facilities, my guess is --  
6 because many of the states have done  
7 what I call a backwards survey.  
8 They've gone to the places that have  
9 received the pediatric patients, and  
10 then they've gone down and they've  
11 said, okay -- well, Ohio's a perfect  
12 example. They have seven kids'  
13 hospitals. They go to those seven  
14 kids' hospitals. They surveyed them to  
15 see who they have agreements with, and  
16 if they've got all of their other  
17 hospitals identified, it's very easy to  
18 say we have 100 percent of our  
19 hospitals have agreements with the  
20 kids' hospitals. Then those seven  
21 hospitals can roll out the template for  
22 the transfer guidelines because they've  
23 already got the agreements in place.  
24 So I think you should be able to

1           achieve 100 percent of that because  
2           you've got a large number of facilities  
3           in the State to take care of kids and  
4           do a good job with and, probably,  
5           already have agreements in place, would  
6           be my guess.

7                       MS. GOHLKE:   Seventy-eight  
8           percent, according to the survey.

9                       MS. FENDYA:   Well, that's  
10          because the hospital -- I'm sorry, some  
11          of those people who respond probably  
12          don't know they have those agreements  
13          in place.  I'm not sure who answered  
14          your surveys, but that's my bet.

15                      MS. GOHLKE:   Okay, questions  
16          on that one at all?  Okay, the next --

17                      DR. COOPER:   Yeah, I do.  I  
18          do think, as we move forward, we need  
19          to give some, you know, consideration  
20          to not so much the paper trail, but the  
21          actuality, and I think that follows on  
22          Diana's point.  The whole system is  
23          designed to get the right patient to  
24          the right place at the right time, and

1       both circumstances can exist.  You can  
2       have a good system for doing that  
3       without the paper.  You can also have a  
4       really nice looking paper but no system  
5       for doing that.  And I think that's  
6       where the latter is, is probably the  
7       greater problem at this particular  
8       point in time for us, in that you might  
9       have a very nice piece of paper, but if  
10      people don't have a very clear sense of  
11      which types of patients really need  
12      transfer and how fast, you know, really  
13      before they get into trouble, that's --  
14      you know, that, I think, needs to be a  
15      major focus of the direction that we  
16      take here.

17                   MR. WRONSKI:  Yeah, if I  
18      could comment?  In the trauma system,  
19      you know, we see problems with transfer  
20      issues, you know, over the history of  
21      trauma, and it has ebbs and flows.  You  
22      know, and some transfers are also  
23      driven by network systems.  So if  
24      you're in an area that has a network

1 system, the possibility of a child  
2 leaving that network are slim to none,  
3 but in some case it would be good if  
4 they did. Probably, in the future, if  
5 we haven't done it already -- Martha  
6 may know this, or Marjorie -- is  
7 working with our trauma registry data,  
8 at least for the trauma patients, and  
9 look at transfers and look at how major  
10 trauma for children are being  
11 transferred between facilities and --

12 MS. GEIGER: It's difficult  
13 to do since we're no longer  
14 community-based.

15 MR. WRONSKI: Yeah, I know,  
16 and it becomes difficult. What we  
17 could do, though, is we could talk to  
18 Dr. Hannan about what are the  
19 possibilities. I forgot Brian is here.  
20 We could talk to Brian right now. We  
21 have a meeting tomorrow morning. We'll  
22 bring this up, how we might manipulate  
23 the SPARCS data, which is every  
24 hospital, and, you know, in combination

1 with the trauma registry, you know, try  
2 to identify some of this. I don't know  
3 when we will be able to, but I think  
4 it's something to do in the future,  
5 anyway, the actual practice.

6 MS. GEIGER: I just want to  
7 remind everyone, we have a place holder  
8 on your agenda today, and we have a  
9 working lunch to start the conversation  
10 and identification of committee members  
11 who will be working on the  
12 interfacility transfer guidance  
13 document, because, as Martha indicates  
14 here in her to do list, next year,  
15 should we be so -- we'll be positive --  
16 when we get our new grant, that's one  
17 of our primary focal points. So later  
18 this morning we can discuss more in  
19 detail how to do this. And, secondly,  
20 I just want to remind the group that  
21 there will be a partnership with the  
22 State Trauma Advisory Committee on the  
23 next phase of their regulatory  
24 development. They have already

1 reviewed, to some degree, the proposed  
2 rule changes for regional and area  
3 trauma centers, and the next phase is  
4 to look at pediatric center designation  
5 requirements. So this will be another  
6 opportunity for the small group from  
7 here that will be partnering with  
8 Dr. Marx in the executive committee of  
9 the STAC. There are two ways to  
10 address this issue.

11 DR. LILLIS: I just had a  
12 question. Will the trauma registry  
13 differentiate from the time of the  
14 injury to the time of the transfer  
15 versus the time of the presentation at  
16 the facilities? Sometimes they end up  
17 at the pediatric trauma center but it  
18 will be a significant delay, and will  
19 that -- will we be able to capture --

20 MS. GEIGER: I don't mean to  
21 put you on the spot.

22 MS. GALLAGHER: Yeah, I  
23 think there is some information  
24 regarding the temporal sequence, but I

1 don't know how well defined it is, so  
2 we can --

3 DR. COOPER: That has always  
4 been a very difficult piece to tease  
5 out in the trauma registry.

6 DR. LILLIS: Sometimes there  
7 is a delay in the initial presentation,  
8 so we would definitely want to know if  
9 it's a delay in the presentation,  
10 basically how long were they in the  
11 community hospital before. We may get  
12 them three days later, and they'll end  
13 up there for a train wreck --

14 MS. GEIGER: But, Dr. Lillis  
15 -- but, Dr. Lillis, because we no  
16 longer are inclusive of community  
17 hospital data in the registry, it's  
18 even more challenging to identify very  
19 specific information.

20 MS. FENDYA: Is it  
21 conceivable? Can you pull out where  
22 children are dying from facilities? Is  
23 that possible? Because if you can pull  
24 out where kids are dying and you can

1 look at some ICD-9 codes as to what  
2 their diagnoses was, it might give you  
3 preliminary information as to who  
4 should have been transferred and  
5 wasn't, and sometimes that provides the  
6 evidence to --

7 MS. GEIGER: That would be  
8 SPARCS.

9 DR. KANTER: Yeah, that's a  
10 study that I actually did several years  
11 ago.

12 MS. FENDYA: Oh, well, then  
13 it's done.

14 DR. KANTER: Well, not  
15 specifically for trauma. Actually, it  
16 was for all causes, but the answer was  
17 the practices appeared to be quite  
18 different in New York City compared  
19 with the rest of the State. More -- I  
20 think in New York City there was a  
21 fairly substantial excess of pediatric  
22 deaths in non-pediatric hospitals. In  
23 the rest of the State, there was a much  
24 lower proportion of children dying in

1 non-pediatric hospitals.

2 MS. FENDYA: So you've got  
3 some evidence that would push the  
4 envelope to indicate that children need  
5 to be transferred, and then you could  
6 go back and look at why weren't they  
7 transferred.

8 DR. KANTER: Yes.

9 MS. FENDYA: Dr. Henry's got  
10 what he wanted.

11 MS. GOHLKE: And then the  
12 other caveat is the disaster  
13 preparedness folks will be here. And  
14 one of the items in the disaster tool  
15 kit that they're going to roll out to  
16 show you is reference to the  
17 interfacility transfer and how  
18 important that is, you know, in  
19 emergency preparedness. And I was  
20 hoping that they may stick around for  
21 our discussion about the interfacility  
22 transfer subcommittee and our next  
23 steps, because they may want to be  
24 involved in some way, especially as it

1 relates to disaster preparedness. So I  
2 kind of thought we could talk more  
3 about that after they get here and they  
4 do their presentation and maybe do  
5 something collaborative.

6 Okay, the next performance  
7 measure should be an easy one for us.  
8 One of it is to make -- the idea behind  
9 this performance measure is to make  
10 sure that the recertification of EMTs,  
11 ALS and BLS have pediatric refresher  
12 information in their course, and I  
13 think it was -- as I peruse through our  
14 training documents, it appears that  
15 there is one level of certification,  
16 recertification that's missing some  
17 pediatric retraining, and that was the  
18 EMT-Is. So it was inadvertently  
19 dropped when they revised it, I don't  
20 know how many years ago. It's quite a  
21 while ago. And it became apparent when  
22 I was going through them that this is  
23 the one refresher training that is  
24 missing a pediatric element to it. So

1 the education and training subcommittee  
2 of SEMSCO, in partnership with you all,  
3 will present it to them, and they can  
4 make a recommendation, and probably  
5 just to put back in what they had  
6 before, and somehow it just got  
7 dropped, and I'll bring it to you folks  
8 as well to see if you have any input on  
9 what's going to be put back into the  
10 curriculum, and that should be very  
11 doable within three years, to get that  
12 back within the refresher training, and  
13 then we'll be up to speed with this  
14 performance measure that all  
15 recertification levels of training have  
16 a pediatric component in it.

17 DR. COOPER: I think in some  
18 ways the more important issue, although  
19 it's not explicitly addressed in the  
20 grant application, is the issue of  
21 pediatric CME. New York State, as well  
22 as most other states, have, you know,  
23 generally resisted the idea of  
24 mandating a certain number of hours of

1 CME in peds. It's very thorny  
2 politically and so on, but I think that  
3 it's worth our thinking about some way  
4 to encourage as much, you know,  
5 exposure to pediatric subjects in CME  
6 as we possibly can.

7 MS. GOHLKE: There is a  
8 minimum number of hours -- there is a  
9 minimum number of hours to the CME. I  
10 don't have them off the top of my head  
11 for each level. And it wasn't the CME  
12 that we weren't needing the standard  
13 for; it was the actual refresher  
14 training, somebody who is to sit  
15 through the classroom training again  
16 that that curriculum is missing the  
17 peds component. I want to say it's  
18 three hours. Generally, it's three  
19 hours or more. Paramedic, I can't  
20 remember, I think it was more like nine  
21 hours, had to be for -- around  
22 pediatrics. So the CME group, the  
23 pilot CME program that we have, we were  
24 okay with as far as meeting the federal

1 requirements. It was just the  
2 classroom training that it was missing.

3 DR. COOPER: Right. I'm not  
4 speaking so much of the pilot program  
5 as the, you know, general CMEs that  
6 people are getting, you know, as a team  
7 throughout the year, which is, you  
8 know, honestly where much real  
9 education actually takes place, sort  
10 of, you know, more informal ongoing  
11 rather than the traditional, sort of,  
12 get your three hours in, you know, just  
13 before recertification time, which is,  
14 you know, never the best way to do  
15 things. No, obviously, I'm aware of  
16 the, you know, requirements that are  
17 there, but, you know, some way to  
18 increase the CME offerings that are  
19 generally available, I think, is  
20 something that we need to -- we need to  
21 wrestle with because that's really  
22 where the rubber ends up meeting the  
23 road in terms of actual practice.

24 MS. GOHLKE: Is there

1 anything you want to add to it?

2 MS. CHIUMENTO: No.

3 MR. TAYLER: Martha?

4 MS. GOHLKE: Yes.

5 MR. TAYLER: Are there

6 specifics on what the pediatric

7 training has to include or just --

8 MS. GOHLKE: No, no. You

9 mean as far as federal requirements?

10 MR. TAYLER: Yeah.

11 MS. GOHLKE: No.

12 MR. TAYLER: So it's

13 anything --

14 MS. GOHLKE: Or number of

15 hours.

16 MS. FENDYA: The only thing

17 I will say is that the federal program

18 -- the government has put making mega

19 dollars into the National Association

20 of EMS educators for their revision of

21 educational standards and curriculum

22 guidelines, so they have incorporated,

23 or integrated, pediatrics into that

24 because EMS-C put money into that and

1           said you will do this.

2                       MR. TAYLER:   The changes to  
3           the national standard curriculum that's  
4           coming out?

5                       MS. FENDYA:   Yes.  It's all  
6           posted, yeah.

7                       MR. TAYLER:   Okay.

8                       MS. FENDYA:   So you may want  
9           to look at that.

10                      MR. TAYLER:   Because New  
11           York State's EMS education has been  
12           holding back a little bit to see where  
13           those final documents and guidelines  
14           are on that, but if they -- my  
15           understanding is that they are coming  
16           out very quickly.

17                      MS. FENDYA:   The standards  
18           are out.  The standards have been  
19           finalized.  They're out.  The  
20           guidelines were the last piece of that  
21           project, and those were posted for  
22           comment, I want to say this past fall.  
23           And I think the comments were supposed  
24           to -- I'm under the impression that

1           they're going to be ready to go early.

2                       MR. WRONSKI:  Yeah, we've  
3           done that and looked at the media.  A  
4           lot of what the unknown is and the real  
5           problem with the education piece -- of  
6           course, everything is different, so  
7           it's scaring everybody -- is the  
8           educational materials that the  
9           publisher is going to provide.  And  
10          I've spoken to a few publishers, and  
11          they, themselves, are worried because  
12          it's new.  So that's really what our  
13          educators are looking at.  You know,  
14          what are these tool kits that are going  
15          to come out?  What are the publishers  
16          going to be able to provide?  And so,  
17          you know, when that happens, we should  
18          take a look at what they're providing  
19          for pediatrics.

20                      MR. TAYLER:  What prompted  
21          my question was, being the one that  
22          reviewed the continuing education  
23          applications into the state EMS office  
24          here, many of them had the PALS course,

1 Pediatric Advanced Life Support course,  
2 or the PPCC course or any of those. So  
3 I was wondering what the minimum  
4 requirement was if those courses, in  
5 fact, meet what is being asked for or  
6 if there were any standards, but it  
7 sounds like they would since you're  
8 telling me that there isn't really a  
9 guidance as to what the pediatric  
10 education needs to include at this  
11 point.

12 MS. GOHLKE: It was more  
13 that our requirements, our written  
14 requirements for recertification just  
15 inadvertently left out the pediatric  
16 one for the EMT-Is. Hopefully, they  
17 were still doing it, but we just didn't  
18 have it on paper.

19 MS. FITTON: I'd just like  
20 to weigh in on this, also. I mean  
21 Brian did this wonderful review of even  
22 PCR data looking for -- this is a while  
23 ago that you presented this --  
24 pediatric mortality, morbidity. And

1 most of the time we're having people  
2 document on a PCR that the kind of call  
3 that they did that involved a child was  
4 something other, or not selected, or --  
5 so if we're looking seriously at doing  
6 some sort of positive training, don't  
7 we really need to know what the  
8 providers need to have, what they lack?  
9 Is, really, PALS the answer? If you  
10 want to get CME, Art, then where the  
11 rubber meets road, what are those  
12 issues? We can't really, truly  
13 identify those issues.

14 MR. WRONSKI: Well, yeah,  
15 you can. You can't on a statewide  
16 basis right now. I'm hoping someday  
17 we'll get there. I happen to agree  
18 with you. What I've always wanted to  
19 have happen -- and it's not until the  
20 State has a robust quality improvement  
21 system, all right. And we've been  
22 rolling out. We've rolled out our  
23 second model of the quality improvement  
24 program to agencies, and we were doing

1 a little review of that the other day  
2 and how much improvement we still need.  
3 We still need to get the word out on  
4 it. If we have our 18 regions, each  
5 with a good regional QI process, what I  
6 would expect from that QI process, they  
7 also look at the types of patient  
8 they're treating and how they're doing  
9 that, and then tie that, you know, to  
10 the data, to the actual PCRs and the  
11 treatments, and each region would  
12 identify, you know, where is our  
13 problem. You know, they take out  
14 pediatrics, okay. Are we having  
15 problems with kids in EMS, and try to  
16 identify that in the QI process, and  
17 then drop in a CME program that would  
18 address that if there's a -- you know,  
19 if it's not isolated but it's across  
20 the board, and potentially we'll  
21 identify statewide issues as well, but  
22 I think that's the way to do it, is the  
23 marriage of the two.

24 MS. FITTON: Yeah,

1 absolutely, because CME that has  
2 nothing more than merit badge medicine  
3 behind it is really not meaningful.  
4 You know, some of the basic assessments  
5 of children can be so flawed as to make  
6 the treatment be harmful or not  
7 beneficial, let's say. I won't say  
8 harmful, but at least not beneficial,  
9 and I think -- I think we have a lot of  
10 really specific -- you know, I totally  
11 agree with you, we need CME, but it  
12 needs to be something based on some  
13 real recognition and assessment of the  
14 needs of our providers.

15 MR. WRONSKI: I agree.

16 DR. HALPERT: Frankly,  
17 that's probably going to take place  
18 with this particular revision, because  
19 really what occurs at the higher levels  
20 with the CCs and MTPs pediatric CON-ed  
21 programs is really the PALS, the merit  
22 badge programs, but the intermediate  
23 curriculum doesn't really make  
24 allowances for that particular level of

1 teaching so that when you reinstitute  
2 the CON-ed requirement for pediatrics  
3 at the EMT-I level it will probably be  
4 more of a focused kind of a vectored  
5 thing of informalized teaching in terms  
6 of what they, specifically, require and  
7 need as opposed to just having a  
8 classroom that is going to take six  
9 hours.

10 MS. FITTON: But I think  
11 we're talking about in the refresher  
12 part that Martha was talking about,  
13 absolutely, review of the essentials,  
14 review of the core competencies of  
15 EMT-Is should be done. Rob is talking  
16 about, if I hear him correctly, is the  
17 day-to-day; we don't have enough  
18 recognition of what providers in the  
19 field really need in order to provide  
20 appropriate patient care.

21 DR. HALPERT: It's more  
22 likely --

23 MS. FITTON: Yes,  
24 absolutely. The MTIs ought to have

1           their --

2                           DR. HALPERT:   It's more  
3           likely to occur with this particular  
4           mechanism.

5                           MS. FITTON:   I'm sorry, I  
6           couldn't hear him speak.

7                           DR. HALPERT:   It's more  
8           likely to occur with this particular  
9           mechanism.  What you're saying is  
10          correct, but just at that level.

11                          MS. FITTON:   I think there  
12          are two different things, the refresher  
13          which is held once every three years  
14          and really taps into my short term  
15          memory so that I pass my certifying  
16          exam and my skill exam is one thing,  
17          and I need to know this.  I think the  
18          other thing is what do I really need to  
19          do when the old crapola hits the fan  
20          and it's just me and my partner out  
21          here in the dark at the road side with  
22          the parents?  What do I really need to  
23          do?  How do we make that kind of  
24          training realistic, focused and

1           beneficial to the outcome for the  
2           patient? I think they're different  
3           things.

4                       MR. CZAPRANSKI: I think,  
5           going to Ed's point, about looking at  
6           the QI data is very important. When we  
7           did a study in Rochester on pediatric  
8           patients, we did two pieces, less than  
9           12 years and less than 18 years. And  
10          we found out that the number three  
11          response in the City of Rochester for  
12          pediatric calls was pedestrian struck  
13          which surprised us, but it led to a sit  
14          down with the police department,  
15          geographic location, trying to figure  
16          out safety control points, so it really  
17          got into the prevention side of things  
18          which effectively worked. And so I  
19          think when you look at QI data, not  
20          only will you identify regional trends  
21          that you could focus training on, but  
22          you will recognize other opportunities  
23          that may fall right into the prevention  
24          mode, and that's the value of looking

1 at that data, from your perspective.

2 MS. GOHLKE: Thank you. So,  
3 Ann, we'll have you chairing the  
4 subcommittee on --

5 (Discussion was held off the  
6 record.)

7 MS. GOHLKE: Okay, so just  
8 being conscious of time, the last  
9 performance measure of the grant is,  
10 you know, establishing permanence or  
11 statute a lot of these performance  
12 measures, basically making sure it's in  
13 statute so that way it stays there and  
14 becomes part of the system.

15 So, well, a couple of things. I  
16 mean these are very easy, no-brainers  
17 as far as -- obviously, our EMSC  
18 advisory committee isn't in statute --  
19 is in statute, and we just have to  
20 assure that we meet quarterly in order  
21 for that to be recognized at the  
22 federal level. The quarterly meetings  
23 are real important to meet that  
24 sub-measure and make sure that we have

1        pediatric representation on the state  
2        EMS board, which we do.  It's not in  
3        statute as far as the SEMSCO by-laws,  
4        but it is in as far as the SEMAC, so  
5        we're going to use that as an argument  
6        to say that we do have it in statute as  
7        far as this goes.  Unless, of course,  
8        we revise the by-laws in the future, we  
9        could always think to add something in  
10       the SEMSCO ones.

11                    MR. WRONSKI:  Yeah, what I  
12        talked to Martha about, so everybody  
13        understands it, is that SEMAC is a  
14        subcommittee of the state EMS Council;  
15        and, although it has separate statutory  
16        powers, it cannot act independently  
17        without the state EMS council, and the  
18        -- when this whole process started in  
19        '94, I think it was, we had a legal  
20        review which discussed the  
21        relationships between -- at the state  
22        level between the SEMAC and the state  
23        EMS council, the relationship between  
24        the REMACs and the regional council,

1 and it was highlighted very clearly for  
2 everyone that the SEMAC is a committee  
3 of the state EMS council and that they  
4 work together as a partnership. So,  
5 you know, I see them as, really, the  
6 same group. One drives the medicine  
7 and brings the final medical decisions  
8 to the state EMS council for the  
9 decision like the old Medical Standards  
10 committee did. And so there really is  
11 a valid argument, a legal argument to  
12 make, that as long as we have the  
13 pediatric representation on the SEMAC,  
14 we really do have it on the council  
15 because they're essentially the same  
16 body.

17 MS. GOHLKE: The third one  
18 is having the EMSC coordinator, so  
19 we're good on that one, so hopefully it  
20 will stay that way. And the last one,  
21 which is kind of the biggy part of this  
22 last sub-measure, is putting into  
23 statute all of the regulations for the  
24 online offline medical direction,

1       pediatric medical direction, the  
2       pediatric equipment, the  
3       categorization, the interfacility  
4       transfer. So I wasn't as optimistic  
5       that we would have everything in  
6       statute within three years, but I did  
7       say that we would meet -- we would have  
8       the statute, the pediatric element of  
9       the EMT-I curriculum, which we'll need  
10      that sub-measure. So we'll get a piece  
11      of it done within three years, and  
12      that's basically it as far as what I  
13      promised that we would do in the next  
14      three years. Okay?

15                 Dr. van der Jagt is not here, and  
16      he was the one that really was pushing  
17      to get an update on the transfer in New  
18      York City, and do you want to just talk  
19      about that a little bit?

20                 MR. WRONSKI: Sure, sure.  
21      The issue out of New York City -- I'll  
22      let a representative from New York City  
23      Fire jump in any time. But there was a  
24      concern raised by one of the trauma

1 surgeons in New York City that we might  
2 not be seeing children transported to  
3 the right facilities, at least in  
4 trauma, and there was a  
5 misunderstanding of where you can bring  
6 kids. The way it works is that a  
7 regional trauma center in New York  
8 State, when you're designated as a  
9 regional trauma center, or even as an  
10 area trauma center, but certainly a  
11 regional, is there's an expectation  
12 that you can treat the range of any age  
13 patient, child or not, so you should be  
14 able to treat pediatrics. But when the  
15 systems were created there were clearly  
16 some facilities, even the larger  
17 regional centers, in New York City who  
18 said, you know, we're not really that  
19 robust with kids. We can see them in  
20 the emergency room if they need to stop  
21 here and move them on, but we're not  
22 necessarily capable of providing the  
23 full spectrum of what a child might  
24 need. And the Department said at that

1 time, fine, we'll give you a waiver for  
2 that, and if you have a child show up  
3 at your door, you need to have a  
4 transfer agreement in place to move  
5 that child to the appropriate place for  
6 care. So that's the origination. So  
7 there were some regional centers who  
8 handled both adults and pediatrics and  
9 said we can do so, and then there were  
10 some others who did not. The confusion  
11 over time was, you know, who are they?  
12 And so back when Gloria Hale was here  
13 we did a little review of our in-house  
14 materials on the trauma centers and  
15 identified who of the city trauma  
16 centers were, in fact, pediatric  
17 capable, at least documentary, okay,  
18 who were not. And we also looked at  
19 that when we did the New York City  
20 review, where we did actual on-site  
21 reviews of every single trauma center  
22 in the City of New York and what their  
23 capabilities were. And so we had a  
24 letter that we shared with the fire

1 department a few years ago, actually,  
2 saying here's what we understand to be  
3 with the trauma centers in the city,  
4 who were also pediatric capable. And I  
5 think -- and I don't have it with me,  
6 but I think it had a good eight or nine  
7 of them, you know, half of them, who  
8 were capable of receiving pediatrics.

9 MS. GEIGER: It was more  
10 than that, actually, yeah. And I just  
11 want to add, Dr. Cooper, secondly, when  
12 we did our New York City full review of  
13 every 20 trauma centers, we found two  
14 in particular that were really  
15 confused. They thought they were --  
16 they thought they had designated back  
17 in the early '90s as both the full  
18 continuum, adult and children, and our  
19 clinical team concurred with that. So  
20 they wrote a letter to the Commissioner  
21 at the time and said please make us,  
22 you know, fully competent to handle  
23 both child and adult and we did. So  
24 that occurred as well. It was

1 reflected in the letter to the fire  
2 department of New York City. So it's  
3 actually more than half of the trauma  
4 centers.

5 MR. WRONSKI: There's quite  
6 a few. Dr. Cooper.

7 MS. GEIGER: There's way,  
8 way more than that.

9 DR. COOPER: The issue is,  
10 actually, a little more complicated  
11 than that even, because all of this is  
12 a moving target, and it depends upon,  
13 as, you know, Dr. Kanter was pointing  
14 out earlier, the actual concentrations  
15 of resources that exist at given points  
16 time which can change. And, you know,  
17 the New York City surveys were -- it's  
18 hard to -- it's hard to remember this  
19 now, but it's really almost five years  
20 ago --

21 MR. WRONSKI: Oh,  
22 absolutely.

23 DR. COOPER: -- that those  
24 surveys were actually conducted, and

1 the report was, you know -- took some  
2 time to write and be approved by  
3 executive staff, and so on, before it  
4 was, actually, provided to the  
5 Appropriateness Review Subcommittee of  
6 the State Hospital Review and Planning  
7 Council. And subsequent to the time  
8 the surveys were done, the report was  
9 written, and then the final  
10 determination was made, and then the  
11 letters went back and forth that  
12 Ms. Geiger's described, at least three  
13 of the centers basically changed their  
14 minds about whether they wanted to be  
15 caring for pediatric patients or not,  
16 and, you know, explicitly forwarded  
17 that information to, you know, the fire  
18 department and to the Regional Trauma  
19 Advisory Committee in New York City.  
20 But the fact of the matter is that, as  
21 time has gone by, you know, the  
22 confusion still exists, not perhaps so  
23 much because it wasn't clarified at one  
24 point, but because the confusion has

1 changed based on differing  
2 circumstances. And I think all of us  
3 accept the notion that, to the extent  
4 that it's possible, any patient ought  
5 to be taken to the facility that is  
6 best able to care for that patient.  
7 And if that means -- you know, I mean I  
8 looked at today's New York Times and  
9 the reports on WNYC as we were driving  
10 up here this morning, talking about the  
11 hypothermia project, and of course the  
12 radio reports about the STEMI centers  
13 and everything that is going on in the  
14 city in terms of redirecting patients  
15 and so on. This is all very much a  
16 moving target, and so the same thing is  
17 really true of the pediatric trauma  
18 patients. What I, personally, hope is  
19 one of the issues that will come out of  
20 the meeting that's taking place in late  
21 January, looking at the pediatric  
22 trauma regs, is that we'll make some  
23 kind of clarification about how this  
24 whole process is going to work because

1 we want patients to get to the right  
2 place in the first place, if possible,  
3 but that is not to say that every  
4 place, as Mr. Wronski's pointed out,  
5 has to be capable of resuscitating, you  
6 know, a critically ill or injured  
7 child.

8 DR. KANTER: And, of course,  
9 those needs are quite different in a  
10 metropolitan area versus the rural.

11 DR. COOPER: Absolutely.

12 MR. WRONSKI: I don't want  
13 to leave this sitting here, because  
14 what I'm hearing is that there may be  
15 regional centers in New York City who  
16 advised us that, yup, we're going to  
17 take care of kids and now we're not.  
18 I'll put it on the record, and I'll  
19 figure out how to handle this. That's  
20 unacceptable. Once you make a  
21 commitment that I'm a pediatric center,  
22 you make that commitment. If you're  
23 going to back away, they have to  
24 formally contact my office, and that

1 has not happened, that has not  
2 happened, and say we have a problem.  
3 Arnott Ogden in the southern tier  
4 contacted me six months prior to having  
5 to close their facility as an area  
6 trauma center, and they kept in regular  
7 touch with me, and Rochester General  
8 did the same. Shame on other  
9 facilities who don't do that with kids.  
10 That's not appropriate. So what I'll  
11 do is think about how to deal with  
12 this, but I believe what I'm going to  
13 do is send letters to all of the  
14 facilities in the city to reconfirm  
15 with them what their commitment is and  
16 get that in writing. So it is a  
17 concern to the Department any time this  
18 occurs, and we'll try to straighten  
19 this out and bring the information back  
20 to the committee.

21 MS. FITTON: To that end, if  
22 I could suggest in that letter, one of  
23 the things that happens is, as we all  
24 know hospital diversions are -- are

1 region in New York City, and I'm sure  
2 every place else. And so sometimes  
3 what's happening is those hospitals  
4 that are not affected by the New York  
5 City redirection policy where they're  
6 essentially precluded from receiving  
7 patients until they get the turnaround  
8 time in the hospitals under control,  
9 the facility under control, if, in  
10 fact, you're sending two kids to a  
11 pediatric trauma center because they're  
12 the most severely hurt out of seven or  
13 eight or ten kids, you have to send  
14 these kids to another place. I can't  
15 send eight kids to one hospital and  
16 then take that out of the loop. And  
17 some of these really busy trauma  
18 centers that do, in fact, deal with  
19 pediatric trauma are in some of the  
20 densest call volume areas that we have.  
21 And so if in fact I make the decision  
22 to overwhelm their facility, what in  
23 fact have I done to some child who is  
24 really going to be in need of their

1 care a half hour from now? One of the  
2 problems that comes out of that is when  
3 I make that decision, or when someone  
4 makes a decision, to spread these  
5 patients around, a hospital  
6 administrator may determine that, in  
7 fact, we are not sending them a fairly  
8 lucrative patient, a patient who is  
9 going to produce some income for them.  
10 That's not my concern. So sometimes  
11 the concerns of the hospitals, which  
12 are important -- they need to  
13 financially survive, I understand  
14 that -- are not the same as in the  
15 dynamics of the situation unfolding,  
16 and afterwards there's a criticism, or  
17 the after-action of a hot wash, or  
18 whatever we're doing. And they say,  
19 well, we didn't send these children to  
20 this pediatric trauma center, but I  
21 sent some. I'm not going to send them  
22 all. And even operationally for us in  
23 managing a large scale -- and when we  
24 say a large scale, anything more than

1       six patients becomes an MCI for us --  
2       it overwhelms the resources of more  
3       than three ambulances.  And when we  
4       look at these things we're not always,  
5       as far as the letter of the law,  
6       following the letter of the law in  
7       sending all of these kids to the  
8       pediatric trauma center because it  
9       doesn't make sense.  It doesn't always  
10      make sense, but people get up -- we get  
11      complaints that we have sidestepped our  
12      own protocols.  There are times that  
13      those protocols need to be interpreted  
14      for everybody's best benefit.

15                   MR. WRONSKI:  See, I  
16      wouldn't see it as sidestepping the  
17      protocol.  The way I see it is you've  
18      actually followed what is common  
19      ambulance protocol, but the key would  
20      be the understanding of the capability  
21      of the hospitals in your area at any  
22      given moment.  That's hard to do  
23      sometimes.  So the only thing I would  
24      ask is that, if you see this happening,

1       you know, if your system has to do this  
2       on some regular basis, that  
3       conversations be held -- you know, in  
4       New York City it would be with the New  
5       York City R-TAC -- and say, listen,  
6       here is an issue on pediatrics that you  
7       need to know on why we do certain  
8       things, and get some feedback. They  
9       may have some answers or they might not  
10      understand this, now they would, but I  
11      wouldn't see what you just described as  
12      anything but standard protocol. You  
13      know, it happens across the State. I  
14      just think it happens in New York City  
15      a lot more often because you have so  
16      many people.

17                   DR. LILLIS: Just a couple  
18      comments and questions. Ed, there is a  
19      very specific criteria for a pediatric  
20      trauma center, what sub-specialists  
21      need to be available. When you're  
22      looking at the trauma centers that can  
23      deal with adults and pediatrics, is  
24      there any qualifications that say that

1           they need pediatric sub-specialists to  
2           be available for those children?

3                       MR. WRONSKI:   In the  
4           hospitals that can take pediatrics?

5                       DR. LILLIS:   Correct.  The  
6           trauma centers that are doing both.

7                       MR. WRONSKI:   The  
8           expectations would be -- the current  
9           reg in 708 is not very specific.  I  
10          think Art can speak to that.  It  
11          doesn't -- one of the reasons we're  
12          meeting --

13                      DR. COOPER:   It's not  
14          specific at all.  You have to have  
15          pediatric surgery.

16                      MR. WRONSKI:   Right.

17                      DR. COOPER:   You have to  
18          have a pediatric intensive care area,  
19          quote, unquote, staffed by specialists  
20          credentialed by the hospital to provide  
21          that type of care, and you have to have  
22          a pediatric emergency area and  
23          specialists credentialed by the  
24          hospital to provide that type of care.

1           It's up to the hospital to make a  
2           determination. The only explicit  
3           specialty that is mentioned in terms of  
4           board certification is pediatric  
5           surgery. But remember that the  
6           pediatric surgery standards are built  
7           on top of the existing regional  
8           standards so all the requirements that  
9           have to be in place for a regional  
10          center for adults also have to be in  
11          place for regional center for children,  
12          but the degree of crosswalk has never  
13          actually been explicitly spelled out.

14                       MR. WRONSKI: Right, and  
15          there are reasons for that, and I mean  
16          a number of them; one of them is the  
17          availability of service specialists in  
18          pediatrics across, you know, the State.  
19          It just doesn't exist in some areas.  
20          And so what's an acceptable level of,  
21          you know, clinical expertise for  
22          children? So you leave it a little bit  
23          open. You know, when they say an area  
24          in the emergency department for

1 children, does that mean a separate,  
2 you know, standing pediatric emergency  
3 department? Nope, but it might mean,  
4 you know, these two beds or these two  
5 bays have, you know, pediatric  
6 equipment for kids. I think when we  
7 have this meeting in January, and a  
8 number of you have been invited to that  
9 to discuss the pediatric 708, I think  
10 that's the time to have a more detailed  
11 discussion on that. All I would  
12 suggest, though, is that when that  
13 happens is that you keep in mind the  
14 realities of the system. We're having  
15 trouble -- you know, Arnott Ogden  
16 closed because they didn't have a  
17 surgeon, a trauma surgeon, to cover.  
18 So when we build new regs we have to  
19 build them recognizing there are  
20 certain limitations. But that doesn't  
21 mean, you know, you shouldn't speak up  
22 at this meeting, you should.

23 DR. COOPER: Since we are on  
24 the record and since Mr. Wronski spoke

1 eloquently a moment ago about trauma  
2 centers accepting their  
3 responsibilities that they've agreed to  
4 accept to the public, I think it's  
5 important to note that there is no  
6 trauma center, which I'm aware of, in  
7 New York City at the present time that  
8 is not accepting its responsibilities.  
9 There are trauma centers whose  
10 concentrations of resources have been  
11 undergoing the same kinds of constant  
12 changes that many of our institutions  
13 experience and have expressed, you  
14 know, a desire to, you know, perhaps  
15 allow other facilities that may have  
16 better concentrations of resources to  
17 assume responsibilities in the future.  
18 I don't think anybody anywhere has  
19 shirked any responsibility. And I just  
20 wanted to make that very clear for the  
21 record. But there certainly are --  
22 there certainly have been changes in  
23 the resource matrix in New York City  
24 that occurred in the five years since

1 the surveys were conducted. And,  
2 unfortunately, the nature of, you know,  
3 the bureaucratic process in terms of  
4 designations, categorizations, and  
5 verifications and so on, is such that  
6 they occur at particular points in  
7 time, you know, on a relatively long  
8 time scale; whereas, the changes in  
9 actual resource availability can occur  
10 on a much different time scale. So I  
11 think it's a question of just making  
12 sure that those are properly matched,  
13 and I think it's much more of a  
14 discussion that, you know, as Ed has  
15 indicated, should take place at the  
16 regulatory meeting as well as sort of  
17 informally between the institutions  
18 involved and Ed's office.

19 DR. KANTER: It's also, just  
20 reflecting on the fact that it's very  
21 -- that if you look at the published  
22 evidence, there is no evidence that  
23 performance -- that quality of care is  
24 worse at a trauma center generally

1 defined than at a pediatric trauma  
2 center.

3 MS. GEIGER: Okay, we have  
4 our next steps on this issue lined up,  
5 and we appreciate the input from  
6 everybody.

7 At this point our next guest  
8 speakers are here, and they need a few  
9 minutes to set up, so if I have the  
10 liberty of the agenda to say that we'll  
11 take a five-minute break, and then  
12 we'll come back. And I know that, Dr.  
13 Lillis, you need to leave early today.  
14 So what Martha and I had a brief  
15 consultation on is, in our working  
16 lunch we'll become very consolidated,  
17 and we'll have you do your presentation  
18 first in recognition of your  
19 contribution to the agenda. And we'll  
20 have a five-minute break, and we'll  
21 introduce our next speakers, if we may.  
22 Thank you.

23 (A brief recess was taken.)

24 MS. GEIGER: Good morning,

1           again.  Other commitments -- can we  
2           start?  I know networking is a very  
3           critical piece of our work here, but  
4           can we hold it a few more minutes?

5                        Okay, everybody, I'd like to  
6           start again.  We're very honored and  
7           pleased to have three guests from the  
8           Department of Health who've agreed to  
9           come and speak with us today, and this  
10          is in response to a request that this  
11          body has made of the Department staff  
12          to learn a little more about our  
13          disaster preparedness programs.  Our  
14          first speaker is Laurie Liptak.  She is  
15          the associate director of emergency  
16          preparedness, and she's going to  
17          provide an update on her program's  
18          initiatives, followed by Dr. Marilyn  
19          Kacica and her colleague, Wendy  
20          Stoddart, from the Division of Family  
21          Health, and they're going to speak  
22          specifically about the pediatric and  
23          obstetrical emergency preparedness tool  
24          kit which Martha referenced earlier in

1 her bureau report. So I'll turn it  
2 over to Lorie. And, again, thank you  
3 for being here, Dr. Kacica, and Wendy  
4 as well. Thank you very much.

5 MS. LIPTAK: Thank you for  
6 having me. In interest of this shining  
7 product that they've done, because I  
8 think it's a phenomenal piece of work  
9 that they've done, I'm going to tailor  
10 my presentation a little bit. For  
11 those of you who are not familiar, the  
12 Health Emergency Preparedness Program  
13 is funded through an HHS federal grant.  
14 And the sole purpose of the grant --  
15 and I say sole, but it's a massive  
16 undertaking -- is to increase medical  
17 surg capacity and capability in  
18 hospitals. We do take some liberty.  
19 We push a lot of that planning out to  
20 the long term care centers. Both New  
21 York State and New York State City  
22 receive grant funding to undertake the  
23 same projects. Unfortunately, we don't  
24 have as much funding, time, staff and

1 mandates coming down from our federal  
2 partners that allows us to focus as  
3 much on pediatrics and newborn care as  
4 we would like to, so anytime we can get  
5 a product that comes through a  
6 partnership, it's wonderful.

7 Our program has predominantly  
8 been focusing on helping the hospitals  
9 get continuous emergency planning  
10 programs that are consistent and  
11 contain all the right elements across  
12 the board, and they focus predominantly  
13 on the type of injury, not necessarily  
14 the population that they're treating,  
15 and we have to get our biggest bang for  
16 the buck with the funding. However, in  
17 the past year we have had opportunities  
18 to make some changes to some of our  
19 preparedness efforts to support  
20 pediatric care. One of them is the  
21 ongoing stockpiling of certain  
22 antibiotics in the medical emergency  
23 response cash that can treat children.  
24 Marilyn has been part of that project

1 to make sure we have the right  
2 medications, and the right dosing  
3 capabilities, and the right formularies  
4 there. And the second piece we have  
5 been able to do is we purchased 850  
6 ventilators. The majority of them are  
7 in stockpile. The rest were deployed  
8 to hospitals. Approximately, 200 were  
9 deployed to hospitals. And one of the  
10 key elements when we made our decision  
11 to purchase was that they could be used  
12 on a pediatric patients, and they can  
13 go down to, I think it's five kilos, on  
14 little babies on those and with the  
15 supporting equipment to fund those. So  
16 we have had some sensitivity to make  
17 sure that we can take care of our --  
18 take care of our kids as well.

19 I wanted to diverge a little bit  
20 more about what the program do and  
21 share with you -- I wanted to share  
22 with you some results of exercise data  
23 that I handed out, and some of you may  
24 have heard of the Empire Express

1 Exercise that was done in June of 2008.  
2 Predominantly, the play activity  
3 occurred around lower New York State  
4 and Long Island and New York City, all  
5 around the slosh and evacuation zones  
6 so that would be associated with a  
7 category-three hurricane. Right now  
8 many of those planning initiatives are  
9 in infancy to mid state and we needed  
10 to test and understand where we were in  
11 those evacuation plans. And everyone,  
12 every jurisdiction has a plan in the  
13 event of a catastrophic hurricane to  
14 evacuate and not shelter a place. I'm  
15 not going to get into the merits of  
16 which one works better or not.  
17 However, in the case of this exercise  
18 we took liberty to actually collect  
19 data at a snapshot in time to  
20 understand, of the 13 identified health  
21 care facilities that would require  
22 evacuation, how many patients were  
23 there. And we broke it down to -- and  
24 you can see it on the second page.

1           What we did is we broke down  
2           pediatrics. Now I will tell you one of  
3           the issues we had is defining pediatric  
4           patients because the different  
5           professional associations, different  
6           hospitals and different physicians  
7           tweaked it at the beginning, at the  
8           end, each way. So what we did is we  
9           took the far ends of both spectrums and  
10          said this is our definition for this  
11          exercise. Then we asked them to  
12          report, after early discharge, how many  
13          patients would need to be evacuated,  
14          and then we split them out by  
15          transportation assistance level  
16          categories that were created for the  
17          purposes of this exercise -- and that's  
18          in front of you -- as well as  
19          understanding if there were any that  
20          were at harm of risk to themselves or  
21          others in risk of -- and then we did  
22          the same with newborn patients. And I  
23          have that in front of you. And then we  
24          asked the remaining hospitals how many

1        pediatric med surg and ICU beds do you  
2        have left in your facility. The great  
3        thing was is we had far more beds than  
4        we needed to evacuate the patients.

5                Now, I thought it was important  
6        to bring you this data today because  
7        you are working on the interfacility  
8        transfer guidelines. We did that too  
9        for evacuations and helped hospitals  
10       planning, but I want you to benefit  
11       from our mistake. Our mistake was we  
12       asked each individual facility if you  
13       had to evacuate, what are your plans?  
14       We failed to ask them if the entire  
15       region is evacuating what are your  
16       plans? And that was a huge planning  
17       gap. Okay? A big planning gap. So as  
18       we moved forward and looked at this and  
19       we started talking to our planning  
20       partners, EMS in particular, and asked,  
21       all right, you have this number of  
22       isolettes. What are you doing? And  
23       they had -- they didn't know what the  
24       resources were out there. They didn't

1 know if they had -- what type of  
2 transport ventilators were there. They  
3 didn't know if the floor mount brackets  
4 in their ambulances could secure those  
5 transport ventilators. They didn't  
6 know if they had the staff or the  
7 facilities would have the staff to send  
8 the transport ventilators. And that's  
9 why I share this data. And one other  
10 planning gap is every child has two  
11 parents, and both of those parents want  
12 to go with every child. They don't  
13 want to be separated, and that was a  
14 planning element that we did ask that  
15 question on our babies but failed to  
16 ask the question on our pediatric  
17 patients. And if there would ever be  
18 an age subpopulation where maybe the  
19 parents weren't as critical to go, say  
20 the 16 and 17 year olds, maybe it  
21 wasn't as sensitive for mom or dad to  
22 travel, versus a two- or three-year-old  
23 child.

24 So based on some of the elements

1 that we learned, we did come up with  
2 some opportunities for improvement, and  
3 some of them I mentioned. One is, in  
4 the event of an emergency in a large  
5 scale evacuation, the transport of  
6 these patients, what is the right  
7 definition for a pediatric patient that  
8 we could ask that everyone on those  
9 floors, and we take kids, could live  
10 with? I mean did we come up with a  
11 definition that everyone could live  
12 with or not? Again, how do we count  
13 the parents that would travel with  
14 these kids, and what guidance would we  
15 say on a regional evacuation? Do we  
16 say no parents? Do we say one parent?  
17 Do we say only a certain age group?  
18 How do we do that so that we're not  
19 overwhelming agencies such as FDNY in  
20 New York City who has agreed to take  
21 over coordination of EMS transfers? I  
22 didn't think -- I kind of lost my EMS  
23 hat when I asked a question about  
24 isolettes when we were doing that.

1           What does it mean to require an  
2           isolette versus a car seat?  There are  
3           some folks who think isolette is safer,  
4           but could they have gone on a car seat,  
5           and how do we different that when we  
6           are asking for that information?  And  
7           we talked about the resources, and,  
8           quite frankly, we did not get into the  
9           definitions of what is NICU services  
10          and what do they carry and what are the  
11          degrees and ranges of care.  We did not  
12          ask for our children -- it was our  
13          fault -- is what is too fragile a  
14          transfer?  As we're planning regional  
15          evacuations for a hurricane down there,  
16          maybe a subpopulation of NICU patients  
17          could be cohorted in a smaller area,  
18          and they're the right ones to shelter a  
19          place versus our adult patients.  
20          Where's the level of fragility for this  
21          population?  And then -- oh, one thing.  
22          The other piece that we failed to ask,  
23          and mainly because we're not regulated  
24          by the Department of Health, is what

1 about our pediatric patients that are  
2 in facility treatment patients, such as  
3 some of the mental health and drug  
4 addiction inpatient areas? How would  
5 they factor into any type of transfer  
6 in a large scale evacuation?

7 So I justed want to have an  
8 opportunity to share some of the data;  
9 although, it's not large, but some of  
10 our opportunities were missing and  
11 telling. And as we all move forward,  
12 just occur to you to think not only of  
13 day-to-day transfers but, God forbid,  
14 if we had to evacuate a region, what  
15 would those transfer protocols then  
16 look like, too?

17 DR. KANTER: So what age  
18 cut-off did you use?

19 MS. LIPTAK: We went three  
20 days to age 17 years, and we did  
21 research. We looked at what, you know,  
22 the American Pediatric Academy says,  
23 and we looked at what different  
24 hospitals say, and what are the EMS

1 protocols and where do they cut off?  
2 And that's a huge range, but that's the  
3 best we could come up with. Yes,  
4 ma'am.

5 DR. LILLIS: Did you look at  
6 timing? I mean in some of the  
7 disasters there is going to be limited  
8 time, and other types of evacuations  
9 there will be more notice and how to  
10 take care of, step one, you know,  
11 priority and things like that?

12 MS. LIPTAK: That was  
13 largely looked at in the context of a  
14 hurricane because the State Emergency  
15 Management organization actually has  
16 mapping softwares, and they used a  
17 model of another hurricane to  
18 understand and predict where and when  
19 in the path of a hurricane we would  
20 have those decision trees. If you're  
21 in the Gulf Coast, you're lucky. As a  
22 hurricane comes up the tip of Florida  
23 or Cuba, you probably have a good idea.  
24 We don't know what a hurricane is going

1 to do until it bounces off the coast of  
2 North Carolina, and we don't have three  
3 days. We're going to have hours. So  
4 that was a continuous theme and element  
5 throughout that, was to learn what we  
6 could actually do in that timeframe.  
7 But I know EMS does have some  
8 timeframes where they will or will not  
9 go in based on the wind and the  
10 weather, and the same thing with  
11 volunteers. As far as more detail,  
12 each hospital has a priority list how  
13 they would get out. And I have to tell  
14 you, quite frankly, the priority comes  
15 down to is when are the resources ready  
16 for them? When are they at the door,  
17 and when are the EMS resources ready to  
18 move them? To date, that's where it  
19 stands.

20 DR. COOPER: When the, you  
21 know, hurricane comes and we have hours  
22 to prepare, you know, I think that  
23 we're going to have to understand that  
24 there are going to be more than a few

1 altered standards of care, not merely  
2 with respect to the content of patient  
3 care but to the mechanisms and systems  
4 for patient transport. And those of us  
5 who work in New York City and have the  
6 opportunity from time to time to  
7 transport newborn infants requiring,  
8 you know, transport isolettes  
9 understand that the availability, the  
10 simple availability of transport  
11 isolettes themselves is an  
12 extraordinarily rate-limiting step.

13 MS. LIPTAK: Absolutely.

14 DR. COOPER: There are only  
15 two or three ambulance services in the  
16 entire city of New York that have a  
17 transport isolette, let alone two or  
18 three. Most academic medical centers  
19 perhaps have two transport isolettes,  
20 tops. Now, I recently had the  
21 opportunity to look into this issue in  
22 some depth for reasons I won't get  
23 into, but the transport isolettes,  
24 depending upon when company you choose

1 to go with, cost either \$40,000 or  
2 \$100,000. That's a whole lot different  
3 than, you know, purchasing a bunch of  
4 disaster vents, you know, with -- you  
5 know, that are similar to some of the,  
6 you know, compact version of the old  
7 Emerson's that some of us in this room  
8 grew up with. You know, we're taking  
9 about a major expenditure of resources,  
10 and I do think that the fortunate piece  
11 is that one of the companies is very  
12 shortly going to be manufacturing and  
13 making available on the market a pole  
14 mountable transport ventilator that can  
15 be used, you know, much more simply  
16 than the actual transport isolette --  
17 the self-contained transport isolette  
18 models that are currently in existence  
19 which will really facilitate things,  
20 but I think that we have to give a  
21 whole lot more thought to alternate  
22 standards of care in transport than we  
23 have to date. I don't know if others  
24 have experience with this. Bob, you

1 transport an awful lot of sick infants,  
2 you know, in adverse weather  
3 conditions. I did have a conversation  
4 just yesterday with one of your  
5 colleagues at one of the other state  
6 meetings talking about what happened in  
7 terms of the delays, you know, when the  
8 transport team was out for infant A and  
9 infant B required immediate transport.  
10 Maybe you have some additional thoughts  
11 on this.

12 DR. KANTER: Well, I think  
13 the resources can very quickly get  
14 exhausted, exactly as you say. And  
15 what we do in normal circumstances is a  
16 very high standard of care, but when  
17 you have multiple patients, never mind  
18 a disaster, to get the work done,  
19 things have to be modified in ways that  
20 we don't have many precedents for and  
21 we don't have much guidelines or  
22 experience with.

23 DR. LILLIS: We're going  
24 through a very real exercise right now

1 with -- we have a potential nurses and  
2 health care worker's strike lingering.  
3 And our facility involves -- it's with  
4 the SCIU. It involves more than 90  
5 percent of our hospital employees, and  
6 so the hospital has made a decision  
7 that it would be irresponsible and  
8 unsafe to try to continue to run the  
9 facility. So we're going through the  
10 planning stages right now, should we be  
11 given a 10 day strike notice, that the  
12 plan would be to basically shut down  
13 the children's hospital and evacuate 60  
14 to 80 NICU beds and 20 pediatric  
15 critical care beds, and that the  
16 emergency department would be shut down  
17 at the end of the 10 days as the  
18 pediatric trauma center and the only  
19 tertiary care hospital. So we're  
20 actually kind of working through some  
21 of the state steps at this point. And  
22 the physician leadership group  
23 yesterday actually met with the union  
24 to kind of hear both sides and see if

1 the physicians can help to facilitate,  
2 but we were told yesterday that it's  
3 only one meeting away, that there is  
4 one meeting left, and if things don't  
5 go well that they've already been given  
6 the authorization to strike. So we may  
7 be calling to see if there's any  
8 helpful -- but we would have to  
9 evacuate a large number of critically  
10 ill patients.

11 MS. LIPTAK: Well, we would  
12 love to find out how that works for  
13 you.

14 MS. FENDYA: -- you're going  
15 to work with them.

16 MS. LIPTAK: I'll do  
17 anything you need to. And I think one  
18 of the key things to say about the data  
19 that we collected is there were a lot  
20 of assumptions made going into this  
21 exercise for hospital evacuations in  
22 entirety. And those of us who have  
23 ever worked in the street, we shook our  
24 head -- or the floor, and we shook our

1 head saying it's not going to work.  
2 We're not -- and it won't work. There  
3 are no resources. And we finally had  
4 to get the numbers to prove it to  
5 everybody, to open up their eyes and  
6 say do you know what? It's not going  
7 to work. What's plan B? And that's, I  
8 think, where we are right now, in  
9 fairness. There are projects between  
10 the State and the City right now to  
11 bring in some structural engineers to  
12 actually look at the facilities and  
13 understand what has to be there in the  
14 physical building in the event of a  
15 hurricane to be able to shelter a place  
16 so we don't move these patients. And,  
17 again, the isolettes are key. They  
18 take forever to load, and there are  
19 always sensitivities with the babies  
20 and no resources. And so that's why I  
21 showed it to you, is that we did  
22 collect the data to inform, down in  
23 those regions, some of the decisions  
24 they were going to be making in the

1 future.

2 DR. KACICA: And wasn't the  
3 issue like in New Orleans with the NICU  
4 that they lost all power and couldn't  
5 keep going even if you could stay in  
6 the building?

7 MS. LIPTAK: And that's why  
8 they're looking at the generators and  
9 the locations of the generators, and  
10 where the switch is, the transfer  
11 switch is, and a lot of that detail --

12 MS. GEIGER: Plus, a lot of  
13 the floors were flooded. Even if they  
14 had -- you know, they just didn't have  
15 the space for them, whether they were  
16 adults or pediatric patients. And they  
17 couldn't -- because of the severe  
18 flooding, they literally couldn't, even  
19 if they had optimal resources, transfer  
20 the patients to another institution  
21 which also had lost power.

22 MS. LIPTAK: And one of the  
23 key things -- they did a pilot shelter  
24 in place study on our four facilities

1 down in the Long Island area. One of  
2 the key things they found already is  
3 there are no records on the windows, so  
4 they can't -- because the facilities  
5 are so old, there are no existing  
6 records on what the impact, the tensile  
7 strength, of the last of the windows  
8 is. And so until they can figure that  
9 out you can't shelter anybody in place.  
10 You would have to go -- you would have  
11 to find an interior secure, but I don't  
12 want to digress. This is off Martha's  
13 topic.

14 MS. GEIGER: And,  
15 Dr. Lillis, I'm sure your CEO knows  
16 this. He also needs to work with the  
17 Department's hospital services program  
18 senior managers if they really feel  
19 they're going to be curtailing services  
20 at your institution.

21 DR. LILLIS: There have been  
22 ongoing meetings, and I'm told that the  
23 Department of Health has been involved  
24 and is aware.

1 MS. GEIGER: Good, good,  
2 yeah, because they'll work with you in  
3 terms of a diversion plan as well.

4 Thank you very much. And Lorie  
5 has graciously agreed to stay for the  
6 whole conversation in case there are  
7 crossover questions.

8 It's our privilege to welcome  
9 Dr. Kacica and Ms. Stoddart here, and  
10 they'll tell you a little bit about  
11 their phenomenal work product. And the  
12 EMS for Children's program was involved  
13 with some predecessors to your joining  
14 this, and you were on it several years  
15 ago, and I know Dr. Cooper from New  
16 York City also worked on the New York  
17 City plan.

18 DR. KACICA: Right, exactly.  
19 I want to point out that we began this  
20 work probably about two years ago,  
21 after reviewing the New York City  
22 pediatric disaster management hospital  
23 guideline for this. And we were very  
24 impressed with the work that was done

1       there, but then wanted to go, maybe, a  
2       step further in that Upstate New York  
3       is very diverse and perhaps needed more  
4       basic guidance on different areas than  
5       the city hospitals, which are very  
6       close and have maybe more intensive  
7       services and that sort of -- more  
8       specialists, for sure. So that's how  
9       we began this, to just review the  
10      guideline, see how we could adapt it  
11      and make it useful for Upstate.

12                The other thing that we wanted to  
13      add to it was some basic information  
14      about obstetrics, so that if you don't  
15      normally deliver babies what do you do  
16      as an institution? So kind of a guide.  
17      So basically this presentation is just  
18      to walk you through the guide and make  
19      you familiar with it. We've rolled it  
20      out to local health departments and  
21      also to hospitals across the State,  
22      just to show them what is in each  
23      chapter and what they can use. We  
24      wanted to make sure that hospitals,

1 when they're planning for their  
2 disasters, also consider children and  
3 women because often they're the last  
4 ones on the list. And it's such a big  
5 endeavor. A lot of places haven't  
6 gotten there quite yet. So basically  
7 the guideline is supposed to be useful.  
8 It's certainly expert reviewed  
9 guidance, because, what we did, we took  
10 each chapter and, throughout the Health  
11 Department, got the expertise of the  
12 different programs and bureaus that  
13 dealt with the topic to look at it and  
14 to make it as current as possible. And  
15 we hope it assists hospitals who do not  
16 normally serve children or pregnant  
17 laboring women, but they may need to  
18 accept these patients in an emergency  
19 because that's where they're going to  
20 show up.

21 It's in multiple sections, and  
22 it's to guide discussion of planning  
23 for the institution, and it contains  
24 tools that may save time in these

1 discussions. So you should have a  
2 guideline in front of you, and  
3 basically it is in sections. And we  
4 had planning guidelines, staffing,  
5 training, what kind of security to  
6 anticipate, infection control, triage.  
7 There is a section on decontamination  
8 along with a CD or DVD. It talks about  
9 transportation, surg considerations,  
10 what kind of equipment you might need  
11 to have. There is an extensive section  
12 on dietary, if you don't normally work  
13 with children, a child birth section,  
14 psychosocial and family information and  
15 support. This is not a tool kit that  
16 you can just pick up and say here's my  
17 plan. It is not comprehensive with  
18 regard to that. It's really to take  
19 into a facility and then adapt to that  
20 unique environment.

21 In bringing all of this  
22 information together, we're hoping that  
23 hospitals will be proactive in their  
24 planning and respond to the special

1 needs of children and laboring women.  
2 And we've seen in the past that when  
3 we've had ice storms or so floods --  
4 and Lorie can talk to this -- how  
5 hospitals need a plan because if women  
6 can't go to where they normally go  
7 because it's flooded then somebody else  
8 needs to receive them. And this is  
9 just basically that.

10 So basically the goal was to  
11 provide hospitals, especially those who  
12 don't care for children and women, with  
13 proactive planning strategies. So I'm  
14 just going to take you through the  
15 different chapters, so if you have that  
16 in front of you.

17 Section 2 just deals with  
18 recommendations for planning. So we  
19 advise that you develop the committee  
20 or work group within each hospital, and  
21 then you might want to develop an annex  
22 to the comprehensive emergency  
23 management plan that relates to  
24 pediatric and obstetrical patients

1 specifically. We want relationships to  
2 be built so that facilities will be  
3 talking to each other before an event  
4 happens and that to us -- and to do  
5 this, specifically, planning for peds  
6 and women. We think it makes sense to  
7 appoint coordinators, or appoint people  
8 for these things, so to have a  
9 pediatric and obstetric physician  
10 coordinator and also a pediatric and  
11 obstetric nursing coordinator. Every  
12 facility has to look at the training  
13 needs of its staff, so to look at the  
14 clinical areas in pediatrics,  
15 obstetrical care and emergency care  
16 that might need to be addressed. And  
17 we really recommend throughout this  
18 that you really have to do disaster  
19 drills to find out what your gaps are  
20 or what you haven't thought of.

21 In section 3, you know, we talk  
22 about staffing considerations, so talk  
23 with your staff and see who's had  
24 previous pediatric or obstetric

1 experience and then create incident  
2 command positions associated with these  
3 groups. Train staff who are willing to  
4 serve pediatric, obstetrical patients  
5 in disasters because they might not  
6 being serving them now, but they feel  
7 that they can accommodate this. Within  
8 it we have a sample HICs job action  
9 sheet so that very concretely we give  
10 tasks that need to be addressed, having  
11 a pediatric service unit leader,  
12 medical technical specialist, pediatric  
13 logistics unit leader to deal with all  
14 of the different issues that might come  
15 up in the event of an emergency.

16 Section 4 talks about training  
17 considerations, so to educate staff  
18 around disaster management in the  
19 emergency treatment of adult, pediatric  
20 and obstetrical patients. And when  
21 you're doing your planning for training  
22 for the year, to consider this as one  
23 of the core issues that you should  
24 train around and also to consider surge

1 capacity, whether or not the hospital  
2 offers these services currently.

3 We think that the pediatric  
4 training should be provided for all  
5 direct care providers. And in this  
6 section it really talks about the  
7 different courses that are available,  
8 where you can get training, a lot of  
9 online resources so that it's all in  
10 one place and can serve as a reference.  
11 And these are just throughout the  
12 document, what we thought might be the  
13 training that would make a facility  
14 competent in serving these children.

15 As I said, there are multiple  
16 resources in the back of this section  
17 and also includes sources for birthing  
18 simulators so that if they wanted to  
19 drill on that, that would be provided.

20 We also talked a lot about  
21 security as far as pediatric tracking  
22 options. How would you identify and  
23 protect displaced children? And how  
24 would you identify them? And there is

1 a survey form in there which uses a  
2 picture for identification. This  
3 survey is in the book, and it can  
4 easily -- we tried to make these pages  
5 so you can lift them and copy them if  
6 you wanted to use them. So in this  
7 section the survey has the child  
8 demographics, what the child looks  
9 like, if the child is accompanied or  
10 unaccompanied, what the history or the  
11 treatment experience was in the  
12 facility, and then what's the case  
13 disposition and discharge? You know,  
14 what happened to the child? Where did  
15 they go? And this is just -- it's the  
16 slide of the form itself.

17 We also talked about setting up a  
18 pediatric safe area, and we have  
19 checklists in there for what you should  
20 have and you should run it. I was very  
21 interested, when you were talking about  
22 parents accompanying children, you  
23 know, where are they going? And even,  
24 you know, the youngest one certainly,

1 but you worry about the safety of  
2 adolescent girls alone. So I think  
3 there are a lot of considerations when  
4 dealing with these issues.

5 The infection control section has  
6 guidance documents. It talks about  
7 cohorting, what kind of environmental  
8 measures, care of newborns especially  
9 in the different times when there might  
10 be an outbreak, and what kind of staff  
11 to child ratios to consider. And these  
12 just outline the different guidelines,  
13 national guidelines that are available  
14 for hospitals.

15 Section 7 talks about pediatric  
16 hospital-based triage, so it talks  
17 about mass casualties involving  
18 children, triage recommendations, the  
19 visual assessment of children and  
20 triage area management. This is an  
21 algorithm that basically walks a  
22 facility through when a victim presents  
23 to the facility, so it talks about  
24 decontamination, what the patient looks

1       like and then where the patient needs  
2       to go. Is the patient critical? Is  
3       the patient potentially unstable, or is  
4       it minor and the patient can be fast  
5       tracked? So it gives sort of a  
6       step-through as to how to approach a  
7       patient.

8               The triage recommendations talk  
9       about communication, documentation,  
10      personnel. There's a job action sheet  
11      that says, What does a visual  
12      inspection officer do? What is a model  
13      for pediatric triage? And it color  
14      codes for acuity and patient sorting.  
15      The model that we found had red for  
16      critical unstable, yellow for  
17      potentially unstable and green for  
18      stable and fast track.

19              There's also pediatric assessment  
20      tools developed by our own department  
21      to help, those who don't normally see  
22      children, walk them through the  
23      different parameters of a child. So  
24      you talk about airway and appearance.

1           What's the normal pulse rate?  What's  
2           the normal respiratory rate?

3                   MS. GEIGER:  That looks  
4           familiar.

5                   DR. KACICA:  But it's a very  
6           helpful tool to those physicians who  
7           are basically afraid of children.  And  
8           I think having that piece of paper in  
9           front of them is very comforting.

10                   DR. COOPER:  Martha?

11                   MS. GOHLKE:  Yeah.

12                   DR. COOPER:  The reason --  
13           oh, this, Martha.  The reason you ever  
14           hear the chuckling is because this  
15           committee actually developed that.

16                   MS. STODDART:  And you  
17           probably did the next one, too.

18                   DR. KACICA:  Right.  And,  
19           you know, certainly, as Martha and Ed  
20           described earlier, they were our  
21           experts in this area, so we relied  
22           heavily on them.

23                   MS. STODDART:  Thank you,  
24           Marilyn.  Also, your next tool in the

1 document, too, we really liked. And  
2 some of the issues, as Marilyn  
3 identified, was the fact that these  
4 tools could be lifted from the  
5 document, laminated and utilized in the  
6 emergency room or wherever. It would  
7 be a source document related to  
8 children with special health care  
9 needs, was a big issue, because many of  
10 those children may not have been seen  
11 at these hospitals that they're  
12 appearing at, and this was a nice  
13 two-page source document we thought was  
14 an excellent one. Really liked the  
15 pictures, too.

16 Section 8 relates to  
17 decontamination, and it's in two  
18 sections. In the front you'll see the  
19 decontamination DVD which was put out  
20 by the AHRQ. And in reviewing this,  
21 this related specifically to setting up  
22 a portable decontamination unit. It  
23 refers to decontamination from children  
24 that are very young up to 16 years old.

1 And it could be something that is set  
2 up outside the hospital before the  
3 child is admitted. It's an excellent  
4 DVD, and 2005 is the year it was  
5 developed.

6 In the next section, this unit  
7 here -- this section here was given to  
8 us permission of, let's see, the  
9 Oklahoma University College of Pharmacy  
10 and Oklahoma City County Health  
11 Department. And basically what this  
12 section here did for us was again give  
13 us documents that could be used as  
14 handouts for the parents for  
15 administering the medications that the  
16 children may be taking. And the front  
17 page says how to prepare the  
18 medication, and then the flip side of  
19 the page is the actual dosage. So this  
20 is, again there's 10 different  
21 medications in here that we felt, at  
22 the time we created this, would be in  
23 that stockpile even though, as Lorie  
24 said, they are looking at pediatric

1 doses. At the time we started  
2 preparing this document, there was  
3 nothing related to that. So this may  
4 be a moot point but at least, let's  
5 say -- depending on the dosage, at  
6 least if they end up with adult doses,  
7 parents would know how to prepare it.  
8 And again, it could be laminated and  
9 handed to the parent or taken out sheet  
10 by sheet and provided to the parent.

11 The next one, as you were  
12 discussing, is about transportation.  
13 And we were considering transportation  
14 in the guidelines within the hospital  
15 to other facilities. And then this is  
16 the little graph from the age  
17 appropriate and weight and car seat  
18 usage, and so this is in the document  
19 also to be utilized.

20 Surg consideration in section 10  
21 related to the actual movement of  
22 children and adults within or without  
23 the facility depending on who could be  
24 stabilized, who needed to go if you had

1 transportation available depending on  
2 what kind of emergency you had. There  
3 are websites related to trauma scoring,  
4 injury severity scoring so that  
5 hospitals could utilize this to  
6 identify which child needed to be  
7 transported or could be transported.  
8 There is also a website from California  
9 which has an interfacility transfer  
10 agreement, which you can go on that  
11 website and copy it. And this document  
12 here related to the fact of creating  
13 those interfacility transfer  
14 agreements, especially, I think -- I  
15 come from -- my background is being in  
16 public health in St. Lawrence County,  
17 and being in a very rural county during  
18 the ice storm, it was difficult with  
19 transportation if we had to, and so  
20 this is something that really came to  
21 the forefront as we went through 19  
22 days without electricity up there.

23 MR. WRONSKI: If I could  
24 comment on that. That was a horrible

1 learning experience.

2 MS. STODDART: It was for  
3 all of us.

4 MR. WRONSKI: I had staff  
5 who were actually assigned to the  
6 different counties mainly because the  
7 EMS system -- many people don't know.  
8 There are today's services in that area  
9 of the State who, on an annual basis,  
10 all year might have 50 to 75 EMS calls.

11 MS. STODDART: Exactly.

12 MR. WRONSKI: And some of  
13 them were getting 50 calls a day all of  
14 a sudden and crushed.

15 MS. STODDART: And we had no  
16 count of people who were at home on  
17 ventilators. We had no idea who were  
18 there, and all we got -- because I was  
19 at the incident command center. All we  
20 got were calls for oxygen and  
21 generators. And it was like they just  
22 came out of the woodwork. We just had  
23 no idea who was there. I mean it was a  
24 great learning situation in the sense

1           that we didn't have a lot of medical  
2           emergencies. It was just those  
3           outlying emergencies with the  
4           electricity and the heat and all that  
5           which is a little bit more manageable  
6           than if you had some kind of real  
7           medical emergency where you have people  
8           just lined up outside the emergency  
9           room, because it at least allowed us to  
10          see all the infrastructure that did  
11          work or didn't work and, you know,  
12          shutting down roads because people were  
13          out there "bahaing" in their four-wheel  
14          drives, you know, just to see what it  
15          looked like with all of those  
16          electricity towers down and things like  
17          that. But it was very interesting and  
18          a good learning experience. But I  
19          think with the one thing, as Marilyn  
20          mentioned, it is -- and with having no  
21          pediatric facilities up there, no  
22          specialty OB facilities, if we ended up  
23          with a big crisis related to the seaway  
24          or something like that up there, you're

1 going to get, you know, DECON needs.  
2 You're going to get all of those things  
3 that we would envision. And then  
4 there's no child care especially for  
5 pediatric population.

6 Section 11 relates -- it's just a  
7 two-page thing related to  
8 recommendation for minimum pediatric  
9 equipment for these facilities who may  
10 not have any pediatric beds, or they  
11 have one or two, but it allows for at  
12 least talking about where could we  
13 store it if we needed to have some  
14 equipment.

15 Section 12 relates -- is in,  
16 again, three sections. It relates to  
17 sample menus for children, age 0 to 2,  
18 and these would be foods that need a  
19 little preparation. So we went through  
20 that section, and also the next section  
21 relates to the nutritional guidelines  
22 by age. And the nutritional guidelines  
23 by age is a fairly new document that  
24 came out of Ontario, Canada. And this

1 group there is their nutrition review  
2 committee, and what they did is  
3 reviewed this guideline and afforded us  
4 the opportunity to utilize it as a  
5 document, and it's brand new. It just  
6 came out in June of 2008, so we were  
7 very thankful to be able to have this  
8 as a guide to put in our document, too.

9 And these are just the samples  
10 that are in your binder. The emergency  
11 child birth section is -- we're  
12 thanking the OB, the American College  
13 of Nurse Midwives. They allowed us to  
14 utilize some of their documents, so  
15 that this is the how-to piece, if you  
16 had to do child birth in a place or in  
17 an area where you weren't familiar with  
18 child birth. Some of the areas we  
19 thought of were shelters. This could  
20 be a document that could be lifted, and  
21 you were connected with our special  
22 needs sheltering unit, this could be a  
23 document that, if you had to, you know,  
24 you would hope it wouldn't happen, but

1       you could use this document as a  
2       reference. It also lists supplies that  
3       would be needed. Possibly, this could  
4       be something that could be lifted and  
5       added to a supply list for the  
6       shelters. It focuses in on what you  
7       would need to do to get a maternal  
8       health history, a quick one, and  
9       guidelines. Also, there's care of the  
10      mother and the baby, and there are some  
11      pictures related to that as you go  
12      through this section.

13                And section 14, again any time  
14      during a disaster with children you  
15      want to address their psycho social  
16      needs. And the documents here reflect  
17      the characteristics of children: What  
18      is age specific at age specific time,  
19      and then their developmental adjustment  
20      during a crisis or a critical  
21      situation. What are their coping  
22      mechanisms? What's normal for them?  
23      And what might be abnormal that you  
24      want to address further with a mental

1 health professional. And then there  
2 are some fact sheets and resources in  
3 the back of this section.

4 We, also, wanted to -- during any  
5 emergency, if you have a large number  
6 of casualties coming in, you want  
7 develop in a facility a family  
8 information center, a support center.  
9 I think this is where you're seeing,  
10 you know, pictures being taken, posted,  
11 but you want to have that support in  
12 this center for parents or people that  
13 are looking for missing children,  
14 whatever, and you want to be sure that  
15 this is established in your facility  
16 and it has a resource for referral and  
17 support.

18 DR. KACICA: So, basically,  
19 we just want to emphasize it's not a  
20 ready-made plan and that, depending on  
21 the emergency, these materials may need  
22 to be updated. You know, it depends  
23 on, you know, the availability of  
24 pharmaceuticals or if you have to

1        modify adult pharmaceuticals for  
2        children.  There are multiple websites  
3        listed in here that are useful, and  
4        hopefully people will look at it before  
5        they need it because it's always hard  
6        to do it on the fly.  We want to make  
7        sure that they know about the other  
8        facilities in the area, and then also,  
9        you know, looking outside the region,  
10       what they might to do before it  
11       happens.  And we just want to  
12       acknowledge the number of individuals  
13       and entities that worked on this  
14       document.  Wendy named, you know,  
15       several during the time that were very  
16       gracious in letting us use their  
17       guidelines which made it very -- a lot  
18       easier for us, and then also within the  
19       Department and within the State the  
20       number of individuals who really  
21       contributed to this just by being  
22       asked, because, I think, people realize  
23       it is a very big issue near and dear to  
24       many people's hearts.  If there are

1 questions, there is a BML set up to  
2 receive questions, and then also if  
3 there is anything related to  
4 preparedness, Gene Bauer is the point  
5 person.

6 MS. GEIGER: I have a  
7 question. Is this available on the  
8 Department's web page?

9 DR. KACICA: Yes, it is. Do  
10 we have that slide?

11 MS. STODDART: I gave -- the  
12 slide, but Marilyn's got it on the  
13 sheet.

14 DR. KACICA: Yes. And,  
15 actually, that just happened within the  
16 last couple of weeks. It is at  
17 [www.newyorkhealth.gov](http://www.newyorkhealth.gov). And if you look  
18 on the left side there's a, I guess, a  
19 little section for emergency  
20 preparedness and response. Click on  
21 that and then it's listed there.

22 MS. GEIGER: Thank you.

23 MS. STODDART: And some of  
24 the websites that are in here when this

1 got published are incorrect now, but  
2 all the ones that are on the website,  
3 the public website, have been corrected  
4 as of two weeks ago. But if you ever  
5 deal with websites, you just go in and  
6 it's a moving target, because when I  
7 said print it now before they change  
8 the website, it was like it's done.  
9 But the one there, as of two weeks ago,  
10 because there are quite a few, like the  
11 births simulator changed, but you could  
12 find them, but they're just all over.

13 MS. CHIUMENTO: I just want  
14 to comment on what a wonderful resource  
15 this is. I remember when we looked at  
16 the New York City plans a couple years  
17 ago we thought it was a wonderful first  
18 document, but we were concerned that it  
19 might not be applicable to other parts  
20 of the State, like the rural areas, and  
21 this just really is presenting so many  
22 resources. I congratulate you on the  
23 wonderful job.

24 MS. STODDART: Thank you. I

1 think the appendix, too, and we forgot  
2 to mention in the back -- Marilyn, do  
3 you want to --

4 DR. KACICA: Yeah. In the  
5 back there's the critical -- survey  
6 that is done by emergency preparedness  
7 that basically lists all the different  
8 facilities and then what kind of  
9 services they deliver, so whether they  
10 have an ED, whether they don't, if they  
11 can take burn patients, trauma. And  
12 this is updated regularly, I think, by  
13 emergency preparedness.

14 MS. LIPTAK: Every quarter.  
15 Once a quarter they're required to  
16 update it.

17 DR. KACICA: And is that  
18 posted anywhere that people can get it?

19 MS. LIPTAK: Not right now.  
20 You have to have HERDS access to get  
21 it.

22 DR. KACICA: But that's  
23 facilities, but facilities could,  
24 right?

1 MS. LIPTAK: Regional  
2 resource centers and regional staff  
3 health departments can access it,  
4 things like that.

5 DR. KACICA: Because I think  
6 this is very helpful, too, a facility  
7 looking in their area when they're  
8 planning.

9 MS. LIPTAK: It's a frequent  
10 comment we hear. We're not surprised.

11 MS. CHIUMENTO: They have a  
12 link to their site.

13 DR. KACICA: Especially,  
14 keep it current, right?

15 MS. FENDYA: Lorie, do you  
16 know, are other states embarking on a  
17 similar type tool kit or --

18 MS. LIPTAK: That, I don't  
19 know.

20 DR. KACICA: You know, I can  
21 tell you because I -- from the  
22 Division, we belong to the Association  
23 of Maternal Child Health Programs, and  
24 I was co-chair of their emergency

1 preparedness committee for maternal and  
2 children. And, really, we are very  
3 much in advance of other states, and  
4 they were waiting for us to post our  
5 tool kit, so I think we are way out  
6 ahead.

7 MS. FENDYA: I've not heard  
8 of it in any other state, and I know,  
9 working with the EMSC program, many of  
10 the states have embarked on trying to  
11 do something related to disaster  
12 preparedness, and this is just a really  
13 great jumping off point.

14 MS. STODDART: I know when I  
15 was dealing with the Ottawa Nutrition  
16 Group, they wanted a -- you know, they  
17 wanted a link, too, because again I  
18 think -- I think we're pulling it  
19 together and pulling it for a rural  
20 area, which a lot of people will get  
21 sometimes if there aren't all those  
22 specialty services, that you really  
23 need to look at is how are they going  
24 to do this?

1 DR. COOPER: Just a few  
2 comments. First of all,  
3 congratulations on great work. This is  
4 really -- pulling this together is  
5 really tremendous.

6 Second, I would personally ask  
7 you to think about how we, as an EMS  
8 community, this committee taking the  
9 lead, can help you get the message out  
10 there that this resource is available,  
11 that hospitals across the state, to  
12 which children might be transported by  
13 the EMS system, are prepared to handle  
14 them? How can we help you get this out  
15 there? Understanding that, you know,  
16 you've kind of done the top down thing.  
17 We have access to helping you with the  
18 bottom up thing, and it might help some  
19 of the penetration in terms of getting  
20 the resource out there.

21 Third, I hope to have these for  
22 everyone today. Unfortunately, there  
23 are simply not enough copies available  
24 as of this date, but the New York City

1 group has produced now its third  
2 edition of the resource for city-based  
3 hospitals. It was published in August.  
4 It's spring bound now. They did a  
5 short print run, unfortunately, and  
6 most of the copies are already  
7 distributed. In addition, there is a  
8 pediatric disaster drill tool kit which  
9 has been developed, which is basically  
10 one-stop shopping. It contains all the  
11 resources you need to conduct your own  
12 pediatric disaster drill. And, last,  
13 but not least, under the subcontract  
14 from Diana Fendya's group, the EMSC  
15 National Resource Center, the Center  
16 for Pediatric Emergency Medicine in New  
17 York City, developed a prehospital  
18 pediatric disaster resource as well.  
19 And the discs have not been burned at  
20 this particular point. We did have a  
21 few discs that were hand burned, if you  
22 will, for another meeting, but there  
23 were not enough of them to go around,  
24 but I'm told that within a couple of

1 weeks I can have copies of all that  
2 information for everyone on this  
3 committee, and, of course, I'll make  
4 sure that Lorie and, you know, Wendy  
5 and Marilyn get copies as well of  
6 those. But all that stuff is  
7 downloadable now from the CPEM website,  
8 and I'll give that to you right now if  
9 you want to take out your pens. It's  
10 [www.cpem.org](http://www.cpem.org). It's very simple;  
11 [www.cpem.org](http://www.cpem.org). That's Center for  
12 Pediatric Emergency Medicine. So  
13 there.

14 MS. GEIGER: Dr. Kacica, and  
15 Ms. Stoddart, and Lorie, I just want to  
16 thank you. Some of us heard about your  
17 baby, so to speak, and to see it come  
18 to fruition like this, it's with much  
19 gratitude and appreciation from other  
20 colleagues here in the Department. And  
21 I echo Dr. Cooper's sentiment. If  
22 there is any way that the EMSC  
23 committee can help facilitate this to  
24 stakeholders, you know, please let us

1 know, as well our other three medical  
2 advisory committees. We'll definitely  
3 post the link on each of our respective  
4 list serves, if that's all right with  
5 you.

6 And then, just briefly, because I  
7 know you're on a tight time schedule,  
8 what were the comments from the county  
9 health departments? I'm just  
10 professionally curious. Were they  
11 positive, I hope?

12 DR. KACICA: Yeah, they were  
13 very positive, and also from the  
14 hospitals that we presented it to, we  
15 had a like a call, and I think there  
16 were over like 200 facilities.

17 MS. GEIGER: That's great.  
18 That's a good turn-out.  
19 Congratulations.

20 MS. FENDYA: Have you  
21 happened to think about putting  
22 together a poster presentation? The  
23 reason I ask, the EMSC grantee meeting  
24 is coming up in June, and I could see

1 56 states and territories being very  
2 interested in looking at this, and  
3 perhaps you submitting a post -- I can  
4 get the poster in, if you've got the  
5 poster. I just think there's lots of  
6 people, and all of the targeted issues  
7 people. The PCARN folks, they'll all  
8 be at that meeting, the EMS directors  
9 from around the country.

10 DR. KACICA: We were asked  
11 that question before, too. What was  
12 that meeting that she was talking  
13 about?

14 MS. STODDART: There's a  
15 perinatal one.

16 MS. FENDYA: Oh, yeah, that  
17 would be a new one.

18 DR. KACICA: Do you know  
19 what the problem is? We can't travel.

20 MS. FENDYA: Well, you don't  
21 need to travel for our meeting. I  
22 think all you would need to do is have  
23 your poster there, and I can assume  
24 responsibility for it being put up and

1 a copy of your little book because I'm  
2 not taking that back.

3 MS. GEIGER: Just as a way  
4 of introduction, the person speaking is  
5 our technical advisor from the National  
6 EMS for Children's Programs, so she  
7 works with -- she's a liaison to  
8 several states including New York, so  
9 she has a very large part. So she'll  
10 bring home the benefits of your pack --  
11 you know, your product and let her  
12 colleagues know, and so when she says  
13 she'll take responsibility, she's a  
14 woman of her word.

15 MS. FENDYA: I would love to  
16 be able to showcase it there. I think  
17 folks would really be enthralled with  
18 it, so I would -- I'd encourage you to  
19 do that.

20 MS. GEIGER: If there are no  
21 further questions for our guest  
22 presenters, we want to wrap up by  
23 saying thank you again, and there is  
24 time -- we do have lunch behind us.

1 Our agenda does say it's a working  
2 lunch, and, our guests, you're more  
3 than welcome to stay and join us and  
4 continue networking with our  
5 colleagues. And then when we resume,  
6 coming back to the table, our first  
7 presenter will be Dr. Lillis. She,  
8 also, has some travel plans. So we'll  
9 take a break.

10 (A brief recess was taken.)

11 DR. LILLIS: Thank you. The  
12 last time I gave a little update about  
13 the current projects that are occurring  
14 in PCARN, and this time I thought I  
15 would just give a little bit of a  
16 snapshot of some of the recent grant  
17 submissions so you can get an idea of  
18 what some of the possible future  
19 projects might be.

20 Last spring, there was an RO-1  
21 put in for procedural conscious  
22 sedation and procedural sedation  
23 project looking at mostly the  
24 complications associated with children

1 who have received procedural sedation  
2 in the emergency departments. We have  
3 not heard -- we have our next quarterly  
4 meeting in Washington next week, but I  
5 have not heard an update of whether or  
6 not this was funded. We should be  
7 hearing shortly.

8 I put in a multi-center asthma  
9 trial grant in November that was an  
10 RO-1 with the NHOBI looking for three  
11 and a half million dollars to involve  
12 five PCARN sites at initiating inhaled  
13 cortico-steroids in the emergency  
14 department, and I expect to hear in  
15 April about that grant.

16 The therapeutic hypothermia  
17 grant, which is a very large grant -- I  
18 want to say something in the order of  
19 30 million -- involving, I believe it's  
20 17 PCARN sites and 18 pediatric  
21 critical care sites in the country  
22 are -- correct me, what was the  
23 network, the critical care network? Do  
24 you know that?

1 DR. KANTER: I don't  
2 remember the exact name of it.

3 DR. LILLIS: In addition to  
4 the 17 PCARN sites, it will involve  
5 centers that aren't part of PCARN but  
6 are part of this critical care network.  
7 It was very, very favorably reviewed,  
8 and there were only a few very minor  
9 changes, and that was just recently  
10 resubmitted. One was the reviewers did  
11 not like the short form informed  
12 consent. They needed to go back and  
13 resubmit, but it's almost certain that  
14 that will be funded.

15 The two grants that are going in  
16 in January as RO-1s are going to be a  
17 diabetic acidosis grant, looking at  
18 different fluids, different types of  
19 fluid, and rehydration strategies in  
20 children who present in DKA. And  
21 another one that is being submitted is  
22 a pediatric patient safety grant, also  
23 going in as an RO-1 in January.  
24 Currently, we're looking at -- as part

1 of the pilot for the safety grant,  
2 we're looking at all the incident  
3 reports that are occurring in the  
4 pediatric hospitals within PCARN and  
5 developing some commonalities and then  
6 -- for the grant that will be an  
7 intervention targeting the particular  
8 areas where the incident reports -- the  
9 unsafe events are taking place and then  
10 studying that.

11 So that's just a quick update of  
12 what are some of the new proposals and  
13 new grants that are going in as well.  
14 We just have a number of things that  
15 are ongoing. Any questions?

16 DR. COOPER: I don't have a  
17 question, but I personally feel I would  
18 be remiss if I didn't congratulate  
19 Kathy on getting that grant.

20 DR. LILLIS: We didn't get  
21 the grant yet.

22 DR. COOPER: Well, there is  
23 more to this. Free advice is often  
24 worth what you pay for it, and Kathy

1 got more free advice from more people  
2 about that grant for far longer than  
3 anybody has ever had to accept free  
4 advice from anyone, and I think two  
5 years worth of vetting by her peers,  
6 and at every single meeting everybody  
7 wanted something different. And I  
8 think Kathy rewrote the grant to come  
9 back to, more or less, where it was  
10 right at the beginning about five  
11 times, you know, but through it all she  
12 persevered. Never, never did you hear  
13 even anything approaching, you know, a  
14 hint of, you know, disappointment. She  
15 just bore up under it and just did it.  
16 So if she doesn't get it, I think we're  
17 all going to be extremely disappointed  
18 because she put so, so much work into  
19 it.

20 DR. LILLIS: Thank you. The  
21 concept of the proposal was approved  
22 while I was on maternity leave with my  
23 last child, and I submitted this. This  
24 is actually my second resubmission, so

1 the third time I'm submitting the  
2 grant, but she turned four in  
3 September, so we've got to get this  
4 done.

5 MS. GOHLKE: Okay, thank  
6 you. Go ahead, Dr. Cooper.

7 DR. COOPER: Thank you,  
8 Martha. Well, Martha asked me to pick  
9 up the next component, which is to  
10 speak about the interfacility project,  
11 and what I thought I'd do in this  
12 regard, with all of your permission, is  
13 to sort of consider the interfacility  
14 transport committee and its next steps  
15 in the context of the broader work  
16 strategy for the committee for the  
17 coming year. And if you look up under  
18 the MAC's subcommittee development  
19 section on the agenda from 10:45 to  
20 11:00, you'll remember that we agreed  
21 that we would have a nominating  
22 committee, an education committee and  
23 an interfacility transfer committee.  
24 We may need to have a nominating

1 committee in the near future if Kathy  
2 and I aren't approved by the  
3 Commissioner, but for the moment we  
4 don't, and so -- but we do have the  
5 responsibility under our by-laws to  
6 look at both education and  
7 interfacility for the moment. And I  
8 spoke briefly with a couple of folks  
9 during the break and asked if they  
10 might be willing to consider  
11 facilitating the work of these two  
12 committees, and both of them graciously  
13 said yes. I wondered if Ann Fitton  
14 would take on the responsibility of  
15 coordinating the educational working  
16 group and Sharon the responsibility of  
17 coordinating the interfacility working  
18 group. And the reason that I asked  
19 these two folks to do this is because  
20 Ann has had an incredibly long and  
21 broad experience in working with  
22 pediatric curriculum development  
23 starting way, way back about 10, 15, 20  
24 years. In fact, Ann is one of the

1 people that developed the EC clamp  
2 that's used for pediatric ventilation  
3 around the world and is cited by the  
4 Heart Association in all of its  
5 teaching materials. Ann told me  
6 that -- actually developed that at the  
7 academy together back when we were all,  
8 you know, still in diapers. And she  
9 had the uncanny ability to pull  
10 together all the docs and all the  
11 nurses and everybody else that needed  
12 to, you know, be involved in that  
13 project to make it happen, so I thought  
14 she'd be a great person to sort of help  
15 think through some of our educational  
16 issues, and, you know, not to mention  
17 that she likes to stay out of the way  
18 of that stuff that hits the fan, which  
19 I won't mention further. Sharon, as  
20 many of you know, is a person who  
21 never, ever, ever, ever fails to  
22 deliver a project on time in color and  
23 under budget. And the interfacility  
24 group has two major tasks before it.

1 The first is to develop a set of  
2 interfacility guidelines to which  
3 patients need to be transferred and,  
4 second, to focus on, once those  
5 guidelines are sort of in place, how  
6 they might form the core of a document  
7 that could be used as a template for  
8 interfacility transport, an  
9 interfacility transport system for  
10 children. Sharon also serves on the  
11 SEMAC and SEMSCO and so on, and  
12 obviously an interfacility transport  
13 system for children has to be  
14 integrated with, and fully part of, an  
15 interfacility transport system for  
16 everybody. And so I thought her  
17 experience, both as a nurse and a  
18 paramedic, will actually be conducting  
19 the transports, both at the receiving  
20 end, you know, in the hospitals as a  
21 nurse and on the transporting end in  
22 the ambulance, that that kind of  
23 experience would really be invaluable  
24 in terms of helping, you know, bring

1 together all the elements here. Now,  
2 while it's my guess that people will  
3 want to be free to, you know, sort of  
4 work with as many of these efforts as  
5 they wanted to and, thinking it  
6 through, I thought that Susan, John and  
7 Tim might be more interested in the  
8 educational part of it -- Susan,  
9 because she's a professor of nursing;  
10 Tim, because he's so deeply involved in  
11 education in Rochester; and, John,  
12 because he's our emergency doc and more  
13 directly involved probably in many ways  
14 with prehospital education than many of  
15 us. And I thought Jan Rogers would be  
16 a good person to work on that group as  
17 well, because she reaches out to the,  
18 you know, nurse practitioner community,  
19 the family docs, really the primary  
20 care end of things. And I thought that  
21 Bob Kanter, Elise van der Jagt and  
22 Kathy Lillis would be able to work with  
23 Sharon in terms of helping to devise  
24 the interfacility protocols. I also

1 thought Ruth Walden would be an  
2 outstanding person to work with that  
3 group as well, because of her interest  
4 and focus on children with special  
5 health care needs. But, you know, I'm  
6 just your facilitator, so if those, you  
7 know, thoughts don't make sense to  
8 anybody and you kind of want to switch  
9 around a little bit, that's fine with  
10 me. But I think that those groupings  
11 of expertise, I think, would really --  
12 would really serve us really well.

13 In terms of moving towards  
14 specifically on the education component  
15 of it, I think that Martha has laid out  
16 nicely that, you know, the grant  
17 application is going to call for us to  
18 focus first and foremost on the EMT-I,  
19 so I think that would have to be the  
20 first component of work there.

21 And with respect to  
22 interfacility, I think that the first  
23 thing we really need to do is probably  
24 try to look at the literature and see

1        what the literature tells us about what  
2        kinds of patients belong in, you know,  
3        in what kinds of centers. And then  
4        that would sort of be the first step in  
5        sort of helping us to identify a group  
6        of patients, you know, that would  
7        benefit from transfer to secondary or  
8        tertiary care centers.

9                So those were my thoughts about  
10       those two areas that we all agreed upon  
11       at the last meeting should be a major  
12       focus for the coming year in which the  
13       grant obviously reflects.

14                The third major area that many  
15       people around this table have privately  
16       expressed to me for actually many  
17       months as a critical area for us to  
18       focus upon is disaster care. While we  
19       haven't focused on that explicitly, I  
20       would like to spend a bit of time at  
21       our next meeting just thinking about  
22       that, and I will bring the -- or make  
23       sure everybody has a copy of the  
24       prehospital resource before that so we

1 all can review it in some depth. And,  
2 personally, I think that our  
3 resuscitation card and children with  
4 special health care need card for  
5 ambulances were so well received, not  
6 only by the ambulance community but  
7 obviously by Martha and her staff --  
8 I'm sorry, Marilyn. I'm getting my M's  
9 mixed up here -- that trying to produce  
10 some kind of pediatric disaster card  
11 that could be useful in both  
12 environments might be very helpful.  
13 The Department has published a whole  
14 series of little pocket sized cards on  
15 radiation and biohazards and so on, and  
16 I was envisioning -- I was envisioning  
17 something like that for hospital-based  
18 providers to go in the pocket of the  
19 old lab coat, but, yet, again a version  
20 of our big plastic laminated card that  
21 goes into, you know, each ambulance in  
22 New York State to help with disaster  
23 care there, but that they'd basically  
24 be the same product with a slightly

1 different spin. Those are just very  
2 preliminary thoughts on that. I had  
3 the opportunity, obviously, of your  
4 input last time, in terms of education  
5 and or facility, to think a little bit  
6 more about that during the intervening  
7 period and, you know, but I do want to  
8 spend just a bit of time talking some  
9 about disasters next time.

10 I, also, just want to say that I  
11 think it has been incredibly valuable  
12 that we've been able to have with us  
13 our colleagues from the Division of  
14 Family Health, as well as the -- I'm  
15 not sure what your official bureau  
16 function is.

17 MS. LIPTAK: Health  
18 Emergency Preparedness Program.

19 DR. COOPER: The program.  
20 It's a program, okay, regularly. But  
21 it's my personal hope that both of your  
22 staffs will continue to, you know, come  
23 and be part of our deliberations as we  
24 move forward because it's all

1 integrated, as we know.

2 So those were my thoughts at the  
3 moment, and I just I open it up to --  
4 you know, turn it back to Martha and  
5 just open it up to general discussion.

6 MS. GOHLKE: Well, part of  
7 my idea behind this was to iron out a  
8 little bit of the logistics. I guess  
9 the first thing is the committee  
10 assignments. Does anybody have any  
11 ideas, or thoughts, or want to come  
12 forward with what Dr. Cooper is  
13 suggesting? I don't know if he talked  
14 to you all on the side previously and  
15 you're all in agreement or you're just  
16 being volunteered right now. Yeah.

17 DR. KANTER: I'm happy to be  
18 volunteered.

19 MS. GOHLKE: Now's the time  
20 to bow out, you know, or if you  
21 can't -- I'm going to close the doors  
22 and lock them shortly.

23 MS. BRILLHART: We will hunt  
24 you down.

1 DR. HALPERT: Our mission is  
2 to serve.

3 MS. GOHLKE: Okay, so --

4 MS. FENDYA: Can I move some  
5 of you to other states, please?

6 MS. GOHLKE: Okay, so it  
7 sounds like we're going to go forward  
8 then, Dr. Cooper, with your committee  
9 suggestions for the membership for each  
10 of those subcommittees. The only thing  
11 I guess I'd like to suggest is maybe  
12 just give a couple minutes thought to  
13 how and when you're going to meet and  
14 get your work started.

15 MS. GEIGER: Can I just say  
16 --

17 MS. GOHLKE: Yes,  
18 absolutely.

19 MS. GEIGER: -- in terms of  
20 logistics I think we initiated our  
21 meeting today with a note on the  
22 budgetary constraints. And the past I  
23 know that all of you are very  
24 receptive, and I hope you still are, to

1 the 21st century version of a meeting,  
2 which is known as teleconferencing, and  
3 that is -- remind me, Sharon and Dr.  
4 Cooper, that's how, really, the two  
5 laminated reference cards were  
6 developed, was a lot of time was spent  
7 in telemeetings and that met your busy  
8 schedules well. I seem to recall that  
9 worked. Similar, Dr. Kanter, the work  
10 that was completed on the white paper  
11 that we just submitted to Dr. Daines  
12 was also done through teleconferencing.  
13 And was that a good tool to use?

14 DR. KANTER: Oh, yes.

15 MS. GEIGER: Okay. And that  
16 way you don't have to travel, and you  
17 can still do your clinical and faculty  
18 work. So, in any event, I offer that  
19 as an option, and, you know, the  
20 Department will always facilitate that  
21 and arrange for that. So if the groups  
22 want to divide themselves up that way,  
23 Dr. Cooper, and we could get on your  
24 respective calendars -- Arthur, I'll

1 volunteer you. I hope you don't  
2 mind -- to work with your calendars and  
3 set up a series of telemeetings,  
4 teleconference meetings, I think that  
5 would be helpful. And I would ask,  
6 since we have Diana here, you had  
7 mentioned some other states that are in  
8 various stages of their, perhaps,  
9 interfacility transfer. And I know  
10 Martha has been really good at  
11 gathering those resources. I thought  
12 you could work with us a little bit,  
13 and maybe we could put together a  
14 compendium of what other states have  
15 done as our first step to review as  
16 this committee moves forward.

17 MS. FENDYA: The other place  
18 you may want to go to for interfacility  
19 transfer agreements and information,  
20 there is a tool kit on the EMS-C  
21 National Resource website, and that  
22 tool kit, fortunately, for you and for  
23 me, has been updated withing the last  
24 two months. And if you go to

1           www.childrens -- I don't have my  
2           glasses on -- childrensnational --

3                       MS. GOHLKE:   Childrens, with  
4           an s, childrensnational.org.

5                       MS. FENDYA:   And then when  
6           you look on the left-hand side it will  
7           say performance measures and resources  
8           for grantees.  When you go there, you  
9           click on tool kit.  There is a tool kit  
10          for performance measure 66-D and E.  
11          Right.  And I think that will provide  
12          -- I mean if everybody that works on  
13          that committee starts off just by  
14          reviewing that, it will give you some  
15          really nice information, and the Pub  
16          Med search, like I said, has just been  
17          updated within the last two months.

18                      MS. GOHLKE:   And I can help  
19          you pull together those resources, too.  
20          The other -- I mean just food for  
21          thought, and, again, this is, you know,  
22          your committee.  One of the other  
23          options is that we could structure this  
24          meeting similar to the other ones where

1 we have a general meeting in the  
2 afternoon and then the morning time for  
3 the subcommittees to meet. It's just a  
4 thought. We don't have to do it that  
5 way.

6 MS. CHIUMENTO: I was going  
7 to suggest that, actually.

8 MS. GOHLKE: It seems to  
9 work well with the other committees,  
10 but that's the other idea, option, I  
11 wanted to put on the table.

12 DR. COOPER: I think that is  
13 a great idea. I was actually going to  
14 suggest that, for some of the  
15 unscripted time this afternoon, some of  
16 the committees might want to break and  
17 spend just a little bit of time  
18 thinking about, first steps, who's  
19 going to assume responsibility for this  
20 and that. Diana, of course, is an  
21 ex-officio member of both  
22 subcommittees, so she probably knows.

23 MS. FENDYA: That's fine.  
24 If I can be of help, feel free to call.

1 DR. COOPER: No, seriously,  
2 as many of the calls as you can  
3 participate in would be a tremendous  
4 help to us and keep us abreast of what  
5 others are doing in the area and so on.  
6 But I think that's a great idea. Next  
7 time, Martha, you know, again,  
8 presuming that the appointments are  
9 appropriately, you know, approved and  
10 all the rest of that, you know, you  
11 know, we can work together and set an  
12 agenda that builds in, you know, some  
13 subcommittee time in the morning.

14 MS. GOHLKE: Can I just get  
15 a show of hands or something around the  
16 room if you agree that we should,  
17 maybe, structure subcommittees in the  
18 morning and meetings in the afternoon?  
19 If you think that's a good idea, we'll  
20 make sure to -- okay, all right, it  
21 looks like most people are in  
22 agreement.

23 MR. TAYLER: Just a --

24 MS. GOHLKE: Yeah.

1 MR. TAYLER: The  
2 subcommittee meetings for SEMSCO/SEMAC  
3 and also for STAC start far before 9:30  
4 in the morning, so just keep that in  
5 mind, that you'll probably find that  
6 you'll have to start your subcommittee  
7 meetings by 8:30 in order to get them  
8 overlapped and such, just --

9 MS. GOHLKE: Well, we don't  
10 have that many. At this point I think  
11 we'll be okay. Don't panic too much  
12 yet. If we get as many subcommittees  
13 as these other meetings have, then  
14 we'll have you stay five days. No,  
15 just kidding. But, okay, so we'll work  
16 in that general direction.

17 DR. COOPER: Maybe the  
18 Family Health Committee could meet at  
19 8:30. What do you think?

20 MS. GOHLKE: Yeah, right,  
21 right. They're local, yeah. And what  
22 I'll do is I'll keep you folks in the  
23 loop with how this plays out and the  
24 structure of it. And, you know, like

1 Dr. Cooper said, we'd love to have your  
2 involvement at any level even if  
3 it's -- I'll just keep you in the loop  
4 of what is being developed, and when  
5 you can make a meeting that would be  
6 great.

7 DR. COOPER: And, obviously,  
8 if there are any of these projects that  
9 particularly interest you and you want  
10 to participate directly, you know,  
11 please feel free to jump in. And  
12 because, I think, you know, as we've  
13 learned, that the work product that is  
14 developed is useful in more than one  
15 venue, and, you know, we could do so  
16 much more together, you know, by  
17 combining our resources than working in  
18 little silos.

19 MS. GOHLKE: Absolutely.  
20 Yeah, I was going to handcuff them  
21 later after the meeting, but I was  
22 trying to be nice.

23 (Discussion was held off the  
24 record.

1 MS. GOHLKE: Now I know,  
2 Dr. Cooper, that you didn't feel the  
3 need, necessarily, at this point to do  
4 the Nomination Committee, but I would  
5 kind of like to steer the group in that  
6 direction because we do have some seats  
7 to fill.

8 DR. COOPER: Okay.

9 MS. GOHLKE: And so it's not  
10 just the chair and a vice chair,  
11 because we know you both will be vetted  
12 soon, but we do have a few seats.

13 DR. HALPERT: If they don't  
14 get vetted today, do they still get to  
15 eat?

16 MS. GOHLKE: Yes. We do  
17 have a few seats that we still need  
18 fill, and even though the by-laws  
19 haven't gone through the executive  
20 office at this point and haven't been  
21 officially adopted, I mean they have,  
22 at least as far as we've agreed with  
23 what we'd like to put forward. There  
24 are some inactive members that we need

1 to decide what we're going to do and --

2 DR. COOPER: Why don't Kathy  
3 and I sort of, you know, since we have  
4 actually been nominated, that sort of  
5 makes us kind of eligible to sort of  
6 serve on the Nomination Committee. So  
7 why don't Kathy and I sort of work on  
8 that, and that will be our immediate  
9 additional task.

10 MS. GOHLKE: Okay, it sounds  
11 good. Okay, let's see what we got  
12 going. All right, at this point I'd  
13 like to, maybe, offer some time to  
14 Diana here to talk about the targeted  
15 issue grants and the status of those.

16 MS. FENDYA: You can hand  
17 that out. Actually, I'd like to begin  
18 with saying thank you to Martha and  
19 everybody here in New York who invited  
20 me. I just have had a wonderful time.  
21 I've learned so much from you all that  
22 I take back to our other grantees, and  
23 it's nice to be able to showcase  
24 friends and people that you know have

1       been working very hard for quite some  
2       time.  So I thank them very much for  
3       allowing me to come and join in your  
4       meeting yesterday and today, and I  
5       think you guys will certainly  
6       accomplish what you have set out.

7               And what Martha is passing out,  
8       the Emergency Medical Service for  
9       Children's Program -- I don't know how  
10      many of you are aware -- provides  
11      funding for both state partnership  
12      grants and targeted issue grants right  
13      now, plus PCARN.  The pediatric  
14      research group, that works together.  
15      And I know Kathy has kept you abreast  
16      of that.  This past year, 2008, we were  
17      able to award four targeted issue  
18      grants, and there is a summary on  
19      there, and I would think that our folks  
20      from Health Systems Emergency  
21      Preparedness would be interested in  
22      that one from Massachusetts, the  
23      reunite -- that particular one, I would  
24      think, would be of interest.  But I

1 think for all of us who work in peds  
2 trauma centers and have been involved  
3 with pediatric injury, obviously,  
4 Connecticut's study on driving  
5 simulation training and whether or not  
6 it really does pay off in number of  
7 violations and types of trauma that  
8 kids may be facing is probably going to  
9 be of some interest. Michigan's study,  
10 looking at some pediatric clinical  
11 simulation and the incidence and  
12 occurrences of pediatric errors, I  
13 would think Marjorie might be  
14 interested in that when that finally  
15 comes out to be. And then D.C.  
16 National, that's a study that I think  
17 for the first time we're going to have  
18 multi-site information on the  
19 involvement of families in pediatric  
20 trauma resuscitation. Is it good for  
21 child? Is it good for family? And how  
22 is it for the clinician? I think we  
23 all have our own biases one way or the  
24 another. True peds people feel like

1       that's not any big deal.  You ask a  
2       resident, they're really, really  
3       apprehensive about those kinds of  
4       things.  So it will be interesting to  
5       see, when we finally have the data, can  
6       we change?  Is the data going to show  
7       what most of us believe that it's good  
8       for everybody?  Or in most cases is it  
9       going to be good for the patient and  
10      for the family, and is that something  
11      we should be advocating?  The sad news  
12      is that, for those of us who have been  
13      around in the EMSC world for quite some  
14      time, we used to be able to award nine  
15      targeted issue grants at a time, but  
16      state governments are having lots of  
17      problems with funding these positions  
18      for EMSC and funding the activities of  
19      EMSC.  And as a result Dan Cavanaugh,  
20      our project officer, felt very, very  
21      compelled to go up -- to go up from  
22      \$115,000 per state in the territories  
23      per year to 130 is nothing.  We know  
24      that.  We know that this is, probably,

1       one program most of us believe they  
2       truly get their money's worth for. And  
3       people like Martha are hard to find.  
4       You guys are lucky to have her. You're  
5       lucky that the state supports and that  
6       Marjorie went after the grant a couple  
7       of years ago on her own because you  
8       just don't see that everywhere. I have  
9       states that are not kicking in any  
10      money for their EMSC manager, and if  
11      the grant is not sufficient the program  
12      goes away, so it's going to be  
13      interesting to see. We have great  
14      hopes with the new federal leadership  
15      that's coming that perhaps the program  
16      can go up some. The program will never  
17      be funded with goo gobs of dollars, and  
18      the reason it won't be is because then  
19      it becomes very vulnerable for cutting  
20      by Congress, but we're very, very  
21      hopeful they will be going after  
22      program reauthorization again. We've  
23      been trying that for how many years  
24      now, Art? About six years or

1 something? Ever since I joined the  
2 NRC, it seems like we're still fighting  
3 for the program to be reauthorized.  
4 And if it weren't for good people from  
5 ACEP and people from AAP and our family  
6 reps going to bat for us with Congress,  
7 I'm sure that the program would not --

8 MS. GEIGER: I'm glad you  
9 brought that up. At our last meeting,  
10 we did mention that the President had  
11 zeroed out this program entirely and  
12 Congress -- he has done that every  
13 year. And Congress, in their good  
14 wishes, has overridden that veto. This  
15 year Diana informed me that they're  
16 waiting for the new leadership to come  
17 in, both in Congress and in the  
18 President's office.

19 MS. FENDYA: And they're  
20 sitting tight with things. These whole  
21 performance measures, when the states  
22 -- the states don't like doing those,  
23 none of them do, and they all say, you  
24 know, we don't get enough money to

1 collect all of this data, blah, blah,  
2 blah. And our comeback is either you  
3 collect the data so we can definitively  
4 prove to Congress that this program is  
5 making a difference and that the  
6 emergency care of kids is beginning to  
7 improve, or the program goes away. So  
8 this set of state partnership grants  
9 that have gone in, I firmly believe are  
10 going to be judged much more critically  
11 than they've ever been. And Dan has  
12 said these are competitive. So Martha  
13 tried her hardest. She did a great job  
14 putting it together. She's very  
15 detailed oriented, and I am sure that  
16 the reviewers will be very pleased, but  
17 I'm not a reviewer, so I don't know.  
18 So they are going to be competitive. I  
19 wouldn't be surprised if some states --  
20 in the past, we've prided ourselves  
21 that every state got funding, and I'm  
22 not sure that that is going to happen  
23 this time because it's depending on how  
24 strict the reviewers are with the

1 criteria, so -- and you guys have got a  
2 good program. The targeted issue  
3 grants that are out there are  
4 interesting. It will be good to see  
5 how they go, but it will be more  
6 interesting to see what happens with  
7 the new leadership, whether or not we  
8 get more money for the states and more  
9 money for targeted issue grants. I'm  
10 not real hopeful initially, because I  
11 think we're too far in the whole right  
12 now, so I think we'll have to just sit  
13 tight and --

14 MS. GEIGER: We also just  
15 want to make note. We're really  
16 appreciative in New York State that one  
17 of the regional nodes for the PCARN  
18 research project is housed at Columbia  
19 Presbyterian. They are the PI. And  
20 Dr. Cooper and Dr. Lillis are key  
21 innovators in that project and Co-PIs;  
22 is that correct?

23 DR. COOPER: I'm Co-PI and  
24 she's site PI.

1 MS. GEIGER: Okay. So we're  
2 very pleased, and that has been a  
3 selling point in New York State when we  
4 make notice to the federal government  
5 of how critical EMS for Children's  
6 Program is in New York.

7 I would be amiss if I didn't let  
8 you know, Diana, some people around the  
9 table here were strong advocates  
10 working with Martha to ensure that we  
11 got data in. Tim, across the way, and  
12 Sharon, are both members of our other  
13 medical advisory committees. So when  
14 we made note on the record at those  
15 meetings they went back to their  
16 constituents and said please work with  
17 the EMS Children's Programs at the  
18 State to get their data in. And our  
19 partners around here that represent  
20 hospitals also brought the message  
21 back.

22 And, Lorie, we want you to know  
23 that HERDS was a wonderful tool for us  
24 to collect this, so that if you need to

1 -- so if you need to let your federal  
2 funding partner know that it had a very  
3 useful life in helping another federal  
4 grantee, we would be glad to sign a  
5 letter.

6 MS. LIPTAK: Well, what we  
7 really want is a data sharing -- what  
8 you were talking about the data. Open  
9 them up for data sharing. It's very --

10 MS. GEIGER: So you did. So  
11 your staff worked with us, so we want  
12 to go on the record and say thank you.

13 MS. FENDYA: That's great.

14 MS. GOHLKE: Thank you,  
15 Diana.

16 MS. FENDYA: You're welcome.

17 MS. GOHLKE: Okay, so we're  
18 moving right along now. I think next  
19 is any old business. Go ahead,  
20 Marjorie.

21 MS. GEIGER: Since  
22 Dr. Daines has indicated we could move  
23 ahead with our stakeholder meeting, did  
24 we talk about it when I was out of the

1 room? Did we talk about, Dr. Cooper or  
2 Martha, which committee, maybe the  
3 executive committee could be the first  
4 that we have a telemeeting with? I  
5 don't know how you feel about this,  
6 because I let Dr. Morley know when he  
7 was -- I helped him prep for this  
8 meeting with Dr. Daines, and I  
9 indicated that this group had done two  
10 prior stakeholder meetings under the  
11 terms of its earlier contracts with the  
12 federal government. It had a different  
13 focus, of course, at that time, but we  
14 certainly had a list of the attendees  
15 from that. Dr. Morley did share with  
16 me, most likely he and Dr. Daines would  
17 probably have some additions. And I  
18 said we would welcome any  
19 recommendations. So I don't know how  
20 this group feels about maybe just  
21 putting together the executive  
22 committee initially to help Martha  
23 scope out a time and an agenda,  
24 etcetera. So I just put that on

1 everybody's plate to think about. And  
2 the focus would be within the context  
3 of what you asked for in the white  
4 paper, a regional approach to pediatric  
5 services on the inpatient level. So  
6 what we could do, in the interim, is go  
7 back to our files, look at our  
8 invitation list that we had the last  
9 time, and I believe some of this issue  
10 was brought up at one of those  
11 stakeholder meetings. So, perhaps, we  
12 could find the testimony or remarks  
13 from the people who attended in the  
14 past as a primer, and then we could get  
15 some potential meeting dates or  
16 telephone times on respective  
17 calendars. Does that work for this  
18 group? I just don't want that to be  
19 one of your hanging participles since  
20 you've worked so hard over the last two  
21 years to get this to the Commissioner's  
22 attention and he agreed to that point.

23 DR. COOPER: Okay, all  
24 right, good, great. So I think there

1 are two other items that I know of that  
2 are unfinished business, one of which  
3 we have referred to, and that's the  
4 trauma regulation meeting which is  
5 going to take place on January 23 in  
6 New York City. Mike Tayler, you all  
7 know as our State Trauma Program  
8 Manager, is facilitating that meeting.  
9 And I think that what we, probably, do  
10 need to do, Martha, is to make sure  
11 that everybody has a copy of the regs  
12 that we have worked on to date so that  
13 people have -- you know, people have a,  
14 you know, structure in which to think  
15 and then a copy of the current  
16 pediatric regs. And I will -- Mike,  
17 just if you'll remind me, I'll send you  
18 a copy of the initial proposal that I  
19 circulated among the trauma reg group  
20 two or three meetings ago, but that,  
21 you know, we've put off because of  
22 unfinished business from the adult side  
23 and because we wanted to be sure that  
24 we had full involvement from this

1 committee.

2 And, you know, the process of  
3 writing regulations, as many of you may  
4 know, is long and difficult. It's  
5 easier to get laws passed through the  
6 legislature in this state than it is to  
7 get regulations, you know, through the  
8 various agencies in the Governor's  
9 office. But, you know, so the point  
10 I'm trying to raise is simply that  
11 there is ample time for comment. The  
12 group will bring forward a package, or  
13 will discuss a package of regulations  
14 at this next meeting, but it has to go  
15 back to the State Trauma Advisory  
16 Committee for its thought process.  
17 Under the statute, the STAC has the  
18 authority to develop appropriateness  
19 review standards for trauma centers and  
20 propose them for the State Hospital  
21 Review and Planning Council which has  
22 to adopt them, unlike the state EMS  
23 Council which itself can propose, you  
24 know, and adopt regulations subject to

1 the approval of the Commissioner. But  
2 there's an additional step with respect  
3 to the trauma piece so there will be  
4 ample time, for whatever package is  
5 developed, to come back to the  
6 committee at its next meeting for any  
7 additional input that might be desired,  
8 okay, so that, you know, everything is  
9 done with your input and approval as  
10 well.

11 And then the other piece, of  
12 course -- and it's fortunate that we  
13 have Brian with us today -- we have  
14 been working to look at developing a  
15 pediatric trauma report as a follow-up  
16 to the report that Lorie had  
17 spearheaded a number of years ago. And  
18 I just wondered, Brian, if you had  
19 any -- we're setting up a conference  
20 call to flush that out a little bit  
21 more, but I wonder, Brian, if you have  
22 any additional comments at this  
23 particular point in time?

24 MR. GALLAGHER: No. The

1 tables that were distributed to Martha,  
2 I think she has distributed them to  
3 some folks. Those are based on 2005  
4 and 2006 trauma registry data. That  
5 data should be considered preliminary  
6 at this point. It's not complete, but  
7 when we do decide which tables you want  
8 to have included, or if there should be  
9 additions to what I've set out already,  
10 then I would use the most up-to-date  
11 data when we finally do, you know, go  
12 ahead and produce some report. There  
13 also could be additional data sets  
14 which are brought to bear to look at  
15 what is happening in the pediatric  
16 population, and that's something that  
17 we can definitely discuss at that  
18 conference call, also.

19 MS. GEIGER: And just to  
20 remind everyone, Brian and his  
21 colleagues at the School of Public  
22 Health are also calling the trauma  
23 registry data for a 2002 to 2006  
24 statewide trauma report, so that's

1 going on simultaneously. And what  
2 Brian's alluding to, he's also managing  
3 our 2006 prehospital report database as  
4 well, which we're very pleased to  
5 announce is inclusive of New York City  
6 data for the first time.

7 DR. COOPER: So far as I  
8 know -- does anybody have any questions  
9 for Brian about that? So far as I  
10 know, those are the only, you know,  
11 truly outstanding pieces of unfinished  
12 business that we have before us. Is  
13 there anything else that you can think  
14 of?

15 MS. GEIGER: Well, just to  
16 summarize so we are clear, we have the  
17 pediatric trauma report, planning for  
18 the stakeholder's meeting in 2009 and  
19 preparation for meeting on the 23rd  
20 with your colleagues from STAC.

21 DR. COOPER: Right.

22 MS. GEIGER: Finalizing,  
23 which I know you've done, Dr. Cooper,  
24 the infrastructure of this committee.

1 DR. COOPER: Right.

2 MS. GEIGER: Yeah, and the  
3 primary one really I see is working on  
4 developing, starting for '09, the  
5 interfacility guidance --

6 DR. COOPER: Oh, absolutely.  
7 Those are the work issues. I just was  
8 speaking of the unfinished business.

9 MS. GEIGER: Yeah. Well,  
10 that's all moving forward.

11 DR. COOPER: Yeah, okay.  
12 Does anybody else have any other  
13 unfinished business, stuff that we had  
14 brought up at previous meetings that we  
15 didn't actually --

16 MS. GOHLKE: The only thing  
17 I see, Dr. Cooper, is there was some  
18 mention about ED overcrowding and --

19 DR. COOPER: Thank you.  
20 Thank you very much. Thank you very  
21 much. Yeah, I actually have had a  
22 couple of conversations with folks  
23 about this. And Dr. Morley,  
24 especially, who's our State Health

1 Department medical director, heads the  
2 Office of Medical Affairs for the State  
3 Health Department, I guess is the  
4 official title. But he has been, at  
5 the request of primarily ACEP but also  
6 SEMAC and numerous hospitals, deeply  
7 concerned about the ED overcrowding  
8 issue. It turns out that there is  
9 virtually no data with respect to ED  
10 overcrowding for kids, and I think it  
11 would be very worthwhile if we thought  
12 about a way perhaps to get some  
13 additional information about that. And  
14 what I'd like to do is, Martha, if we  
15 could, maybe convene a conference call  
16 of the ED director and pediatric ICU  
17 director group among us who actually  
18 would be responsible for administering  
19 pediatric ICUs in emergency  
20 departments, and, John, of course, as  
21 our emergency physician rep. You know,  
22 just to begin to think if we were to do  
23 a survey, or if the Department were to  
24 consider doing a survey, or if we,

1           ourselves, informally were going to do  
2           a survey, perhaps in conjunction with  
3           SEMAC, on the ED overcrowding issue,  
4           what specific additional questions  
5           might we want to ask with respect to  
6           pediatrics. Get some real data for  
7           Dr. Morley which is data he, actually,  
8           requested.

9                       MS. GEIGER: The Department  
10           has been surveying hospitals through  
11           the HERD system for the last year, two  
12           years, right?

13                      MS. LIPTAK: Only about a  
14           year.

15                      MS. GEIGER: A year.  
16           They've asked --

17                      MS. LIPTAK: They've been  
18           doing a routine bed count survey, but  
19           they've just redone a survey within the  
20           last year which is very specific to the  
21           ED overcrowding issue.

22                      MS. GEIGER: And that's real  
23           time data that you see from the  
24           hospitals at certain key points during

1 the week. Based on those findings, so  
2 it is being used, and consultation with  
3 a small group that Dr. Morley chairs  
4 with physician ED directors from across  
5 the State, the Commissioner is ready to  
6 release some guidance documents to all  
7 the hospitals in New York State. I  
8 can't say when that letter will go out  
9 because another program is managing  
10 that with Dr. Morley and Dr. Daines'  
11 office, but the Department has been  
12 working very diligently on this issue,  
13 and not seeing it as strictly an ED  
14 issue but rather a hospital  
15 organizational focal point, and so  
16 taking that in context is how  
17 Dr. Daines will frame his letter to the  
18 hospital community.

19 DR. COOPER: I think that  
20 asking, you know, Lorie to participate  
21 in that conference call and, perhaps,  
22 bringing forward any data she wants to  
23 share with us.

24 MS. GEIGER: Well, actually,

1           it wouldn't be -- I don't mean to  
2           dissuade Lorie.  It's not her staff.  
3           We've used that platform as a way to  
4           collect our data, so it's our partners  
5           in the hospital program.

6                         DR. COOPER:  Okay, whoever  
7           is the appropriate person in the  
8           Department to assist us.

9                         MS. GEIGER:  Yeah.  What we  
10          can do, Dr. Cooper, we can go back and  
11          see how timely a release the  
12          Commissioner's office is planning on  
13          this, and we'll let you know.

14                        DR. COOPER:  There is a tiny  
15          bit more to the story here.  I,  
16          actually, did have an opportunity to  
17          speak with Dr. Morley about this  
18          personally really within the last two  
19          or three weeks, because ACEP had asked  
20          me to provide a surgical perspective on  
21          the ED overcrowding issue at a national  
22          meeting that they held in conjunction  
23          with the AMA.  And Dr. Morley, at least  
24          in our online conversations, was, you

1 know, a little less secure about the  
2 quality of the data that is -- at the  
3 present time than he would have liked.  
4 At least that's what he indicated to  
5 me. That's no reflection on the  
6 Department. That's the reflection on  
7 the fact that the data is not always  
8 submitted in a timely, and full, and  
9 accurate, and appropriate manner. So I  
10 do think that, you know, it would be a  
11 good thing, given that Dr. Morley has  
12 asked in the past, I believe, at this  
13 meeting -- although, I may get my  
14 meetings confused at this point -- for  
15 a specific input on this issue that, in  
16 response to whatever information you  
17 can obtain from the Commissioner's  
18 office, Marjorie, that we, you know, go  
19 ahead and convene that conference call  
20 among ourselves and see if an  
21 opportunity does arise to do a survey  
22 in some way that we can make sure there  
23 is appropriate pediatric content in it.  
24 That's all. It's simple. Yeah. Okay,

1 so that was -- are there any other  
2 items of unfinished business?

3 Okay, new business that -- I had  
4 a couple of ideas that I wanted to just  
5 run by people. We have an immediate  
6 agenda before us, you know, in terms of  
7 the education and the interfacility  
8 stuff that we've already agreed upon.  
9 But I think that, particularly in and  
10 around the stakeholder meeting, it  
11 would be an outstanding time for us to  
12 consider putting together a white paper  
13 on the state-of-the-art EMSC in New  
14 York State. There hasn't really been a  
15 systematic review of the  
16 state-of-the-art of EMSC, you know, in  
17 New York State really since the very,  
18 very beginning, and that was just a  
19 very sort of preliminary snapshot. And  
20 one of the things that has been  
21 incredibly effective at a national  
22 level in terms of driving the national  
23 agenda, as all of you know, is the  
24 series that the National Highway

1 Traffic Safety Administration put out  
2 called the "EMS Agenda for the Future."  
3 And in and around the issue of our  
4 stakeholder meeting it made sense to me  
5 that we consider developing a white  
6 paper on the current state of EMSC in  
7 New York State, where we are now, and  
8 where we want to be, and how do we get  
9 there, and sort of lay out, you know,  
10 if you will, in general terms a work  
11 plan for the next five to ten years in  
12 terms of, you know, ensuring that, you  
13 know, when our kids are assuming our  
14 positions in medicine, nursing and  
15 public health and prehospital care that  
16 they're working with a much better  
17 system than the one that we inherited.  
18 So that was one thought that I had in  
19 terms of the meeting, the stakeholder  
20 meeting. I think that part and parcel  
21 of that would be at some point -- and I  
22 don't think that's now. I don't think  
23 we're anywhere near ready to do this  
24 yet, but I think at some point a

1 meeting with the Commissioner about  
2 where EMSC is and where it needs to go  
3 would be appropriate. Perhaps after  
4 that stakeholder meeting would be a  
5 better time and after we have, you  
6 know, a preliminary draft of the EMSC  
7 agenda for the future laid out for New  
8 York State. That might be the  
9 appropriate time. But I think we  
10 should keep the opportunity to, you  
11 know, keep EMSC on the agenda at that  
12 high a level at the Department would be  
13 useful and appropriate.

14 A little bit closer to the  
15 ground, both of the -- I shouldn't say  
16 both. All three -- the STAC, the SEMAC  
17 and the SEMSCO -- have agreed to  
18 jointly sign a letter to the  
19 Commissioner indicating that trauma is  
20 perhaps a specialty that represents,  
21 you know, a specialty that is not as  
22 available in New York State as it might  
23 be. We know that there are trauma  
24 centers closing for lack of trauma

1 professionals, and they have agreed to  
2 jointly write to the Commissioner to  
3 ask that the Doctors Across New York  
4 fund, that the legislature established  
5 last year, consider adding trauma  
6 surgeons to the list -- other trauma  
7 professionals to the list of endangered  
8 specialties, so to speak. And I would,  
9 you know, serve -- in addition to the  
10 comments that Bob Kanter made earlier,  
11 you know, just put the P word,  
12 "pediatric," again in there somewhere,  
13 again that the pediatric subspecialists  
14 are often among the most endangered of  
15 all, and apropos of earlier discussion  
16 about trauma centers in New York City,  
17 not only having as much pediatric  
18 expertise as some of them might like, I  
19 think that's, even in urban  
20 environments, that can be an issue. So  
21 I think if we signed and joined with  
22 our partners and our sister committees  
23 and jointly signed that letter. A  
24 letter to the Commission signed by all

1 the chairs by all the committees, I  
2 think, would be a very powerful  
3 document that would get some attention.  
4 I would like the committee to consider  
5 that briefly.

6 And last but not least in terms  
7 of new business, it's just sort of a  
8 very simple action item. Martha, I'm  
9 not sure that everybody on the EMSC  
10 subcommittee perhaps has necessarily  
11 all the famous EMS documents that all  
12 the other sister committees that have  
13 access to and sort of, if you will,  
14 manual sorts -- meaning Article 30,  
15 Part 800, a copy of the by-laws,  
16 perhaps, a copy of the performance  
17 measures. And maybe, in lieu of a  
18 formal manual or something like that,  
19 maybe sort of as a grouping, PDFs of  
20 those documents could be sent to  
21 everybody so everybody understands the  
22 statutory, regulatory basis for the  
23 work that we're doing here and  
24 understands their relationship with the

1 performance measures. But that's just  
2 sort of more of a housekeeping item  
3 than anything else. So those are the  
4 four issues that I thought of as  
5 potential new business items, and, you  
6 know, and all of them relate to  
7 projects that we're considering doing  
8 at the present time. And of those four  
9 new business items, the only actual  
10 action item that the committee would  
11 have to actually think about voting on  
12 today would be that letter. The rest  
13 is sort of administrative. So I'll  
14 just open it up for discussion at this  
15 point.

16 (Discussion was held off the  
17 record.)

18 MS. STODDART: So I think  
19 that we're now at a point where we're  
20 ready to discuss those four items and  
21 the potential white paper following the  
22 stakeholder meeting, the potential  
23 meeting with the Commissioner and then,  
24 of course, the issue of the letter

1 about joining with our sister  
2 committees in supporting of the  
3 expansion of the Doctors Across New  
4 York Program to include endangered  
5 trauma and pediatric specialties, and  
6 then last, of course, the administrator  
7 request for the documents for the  
8 members of the committee, so anybody,  
9 please?

10 MS. CHIUMENTO: Just one  
11 suggestion, and I suspect that you've  
12 already got in your head, but I would  
13 hope that you invite Dr. Daines to the  
14 stakeholder's meeting, as well. Even  
15 though we would have another meeting,  
16 perhaps, with him afterwards, I think  
17 he should be at least invited to  
18 attend.

19 MS. GEIGER: Absolutely.

20 DR. COOPER: Absolutely,  
21 yeah.

22 MS. CHIUMENTO: Okay, I hope  
23 so.

24 MS. GEIGER: And Dr. Morley.

1 DR. COOPER: Of course,  
2 yeah.

3 MS. GEIGER: And a few  
4 others.

5 DR. COOPER: Absolutely.

6 MS. CHIUMENTO: Maybe  
7 Marjorie can come, too.

8 DR. COOPER: That's right.  
9 It's, certainly.

10 MS. GEIGER: I'll have to be  
11 the historian.

12 DR. COOPER: That's right.  
13 Any other -- any thoughts about any of  
14 that -- any of those ideas?

15 DR. KANTER: Well, regarding  
16 the signing, cosigning the letter --

17 DR. COOPER: Yeah.

18 DR. KANTER: -- about  
19 vulnerable services, trauma and  
20 pediatric services, of course this is a  
21 national issue not just a New York  
22 State issue, and it's easy to say that  
23 we should express our concern about it.  
24 Do you have thoughts, or does the draft

1 of the letter suggest possible  
2 solutions?

3 DR. COOPER: Well, there is  
4 no draft at this particular point.  
5 There's a specific issue, though, and  
6 that's the fact that the legislature  
7 did appropriate money under a program  
8 called Doctors Across New York, which  
9 makes start-up funds available for  
10 various practices to bring on young  
11 associates or for new practices to sort  
12 of started in underserved areas. And  
13 so the thought would be that, while  
14 this year's funding has been extended,  
15 or the application period for this  
16 year's funding has been extended to  
17 December 15, obviously, you know,  
18 anything we do now, even with our  
19 sister committees, really will have  
20 very little bearing on this year's  
21 activities. But presuming that the  
22 doctor shortage in Upstate New York is  
23 going to get nothing, if not worse, as  
24 we go forward in the future, I think

1 most people anticipate that the  
2 legislature will continue this program,  
3 even though it was funded only  
4 initially for one year. Now with the  
5 budget situation being what it is right  
6 now, I don't think anybody really  
7 knows, you know, how it's going to play  
8 out. But I think the thought of the  
9 other three committees was that --

10 MS. GEIGER: The immediacy  
11 of the issue.

12 DR. COOPER: The immediacy  
13 of the issue.

14 MS. GEIGER: Just a quickie  
15 get it out.

16 DR. COOPER: Yes, exactly.  
17 Yeah.

18 DR. KANTER: The New York  
19 State -- the already funded New York  
20 State program, if I remember, it was  
21 primarily primary care?

22 MS. GEIGER: Well, actually,  
23 it was primarily a loan forgiveness or  
24 a loan support program. This is unique

1 in that funds were made available  
2 through a competitive process to  
3 support practices as start-up to  
4 recruit physicians new to an area, and  
5 it also provides funds to hospitals to  
6 put them into practices within the  
7 hospitals. The focus of the clinicians  
8 was to be primary care, obstetrics, and  
9 there was some room for emergency  
10 medicine, and the other piece I forgot,  
11 I am amiss, is community placement.  
12 And so that would make it unique. It  
13 was beyond the loan forgiveness idea.  
14 So it really gave monies to physicians  
15 to help them start up their practices  
16 in our medically underserved  
17 communities. And the sentiments of  
18 your colleagues in the other three  
19 advisory committees is, yes, that is  
20 very important, but we would just like  
21 to remind the Department that there is  
22 a need in the trauma community, as  
23 well. And I think that's the focus of  
24 the letter. It was meant to be short,

1 a snap shot. And if I can just say,  
2 Dr. Cooper, paraphrasing your  
3 counterparts, that a co-signed letter  
4 would add weight to the support for  
5 this idea. So, yes, there are a range  
6 of other issues, but they really wanted  
7 this to be succinct and current.

8 DR. KANTER: I would be in  
9 favor of it, and just -- you've already  
10 said it. Things are likely to get  
11 worse before they get better. Medicaid  
12 funding is going to be problematic and  
13 that predicts bad things for  
14 pediatrics.

15 DR. COOPER: You bet. Is  
16 everyone in agreement with sending that  
17 letter? I take Bob's comment as a  
18 motion. Is there a second?

19 MS. CHIUMENTO: Second.

20 DR. COOPER: Sharon.  
21 Discussion? All in favor? Okay, so  
22 we're unanimously in approval. Okay,  
23 good.

24 So any thoughts about the other

1 ideas?

2 MS. GEIGER: I'd just like  
3 to say, from a resource management  
4 perspective, we're certainly welcome to  
5 explore the issues that a secondary  
6 white paper would lend itself to, but  
7 we haven't implemented white paper  
8 number 1 yet. And you're looking at  
9 the staff of the EMSC program, and so  
10 if this committee would avow to  
11 resource allocation issues, we would  
12 like to, at least, get some planning  
13 underway for some of the initiatives  
14 contained in that first white paper  
15 before we even entertain an idea of  
16 white paper number 2, and, you know,  
17 that could be, perhaps, a focal point  
18 of the stakeholder's meeting.

19 DR. COOPER: That's exactly  
20 what I suggested, yeah, uh-hum, yeah.

21 MS. GEIGER: And not  
22 necessarily a workload for the EMS for  
23 Children's coordinator at this point in  
24 time.

1 DR. COOPER: Absolutely,  
2 absolutely, yup, no, and most of the  
3 work product --

4 MS. GEIGER: Because she  
5 also -- I mean I can speak in her  
6 defense. She worked extremely hard to  
7 meet the grant deliverables. As you  
8 can see, the federal government is very  
9 pleased with the workload that she's  
10 produced, and we want to continue those  
11 good graces. And once the -- if --  
12 when we get our award -- I'm just being  
13 very positive -- there are some things  
14 that we'll need to do to satisfy  
15 immediately. So that's all I have --

16 DR. COOPER: Understood,  
17 understood, yup, yup, and I support  
18 everything you say, yeah. The white  
19 paper concept was never meant to be  
20 anything other than sort of an  
21 outgrowth of the stakeholder meeting.

22 DR. HALPERT: Which,  
23 conceptually, is a very good idea, you  
24 know, in terms of the content of that.

1           Certainly --

2                       MS. GEIGER:   Actually, if  
3           memory serves me well, the white paper  
4           that you folks submitted to the  
5           Department on regional inpatient  
6           pediatric services did come up at our  
7           last stakeholder's meeting, and then I  
8           know Dr. Kanter and his colleagues on  
9           this committee did a follow-up  
10          research, and that was, as I recall,  
11          some of the genesis for this idea.

12                      DR. KANTER:   Art, the idea  
13          that you're outlining here, though, it  
14          is really to, if I understand it, is to  
15          start thinking about future agendas for  
16          EMSC work.  Is that --

17                      DR. COOPER:   Right, exactly,  
18          exactly, but it's more -- it's a little  
19          more global than that.  It's about  
20          where do we want to see the emergency  
21          health care system for kids 10 years  
22          from now, if you will.  Where is it  
23          now?  What do we think it ought look  
24          like 10, 15 years from now, and what

1 steps might need to be taken? And it's  
2 very futuristic, and it's not -- and  
3 that's why, you know, it's not  
4 something we could even -- we could  
5 possibly undertake this year and could  
6 possibly undertake without, you know,  
7 the input of a very, very broad, you  
8 know, stakeholder -- the stakeholder  
9 process. So that's really, you know,  
10 the thought process at this point.

11 MS. GEIGER: I'd just like  
12 to also say that, you know, you're  
13 having two initiatives scheduled for  
14 '09 that will lend itself to looking at  
15 a broader brush, a long term one is  
16 your stakeholder meeting, but,  
17 secondly, also combined with that, is  
18 the work that we're going to do with  
19 the School of Public Health with the  
20 pediatric trauma report, so that might  
21 provide some data.

22 DR. COOPER: Absolutely.

23 MS. GEIGER: Or at least  
24 snap shots of our health care delivery

1 system to say in 10 or 11, whenever we  
2 get around to white paper number 2, of  
3 what our vision for pediatric services  
4 in New York State should be.

5 MS. FENDYA: The other thing  
6 I might share too, the EMSC performance  
7 measures from the federal level are  
8 also going to be updated. I mean right  
9 now everybody is focusing in on this  
10 nine measures right now trying to  
11 achieve, so there has already been talk  
12 that the next set of measures have to  
13 be defined for the State so that --  
14 because some of the states are moving  
15 right ahead, such as yourself, so that  
16 would be something else that may help.

17 MS. GEIGER: That's true.  
18 We'll have -- excuse me, sorry, Kyle.  
19 Thank you, Diana. Thank you, Diana,  
20 for reminding me of that, so that then  
21 there are three ways to look at our  
22 vision for New York State over the next  
23 two years.

24 DR. COOPER: Indeed, if not

1 infinite.

2 MS. GEIGER: Always  
3 evolving.

4 DR. COOPER: Exactly. Any  
5 other thoughts? Does anybody have any  
6 other new business?

7 MS. GOHLKE: I just want to  
8 talk about dates for next year before  
9 we --

10 DR. COOPER: -- wrap up.

11 MS. GOHLKE: Yes, well, it  
12 looks like the Crown Plaza was the  
13 winner. We're going to be joining our  
14 colleagues, the SEMSCO/SEMAC colleagues  
15 and STAC and moving our meetings, along  
16 with them, down to the Crown Plaza in  
17 downtown Albany. They were the -- they  
18 were the lowest bidder, so -- and the  
19 winner. So dates, let's just talk  
20 about dates. We have gotten clearance  
21 from the hotel on some dates, and I've  
22 gone back and forth with Dr. Cooper and  
23 Dr. Lillis and have cleared it with  
24 their schedules too, so I worked with

1 the Tuesdays. At the last meeting, we  
2 discussed that Tuesdays were the  
3 preferable day of the week, so they all  
4 fall on a Tuesday. And I'd just like  
5 to through them. If there are any  
6 obvious objections, now is the time so  
7 you can start moving things around if  
8 you need to. March 17 will be the  
9 first meeting in '09. I know, St.  
10 Patrick's day, I know. I know.  
11 Obviously, he's not Irish, that's all I  
12 have to say.

13 DR. COOPER: Well, wait a  
14 minute. You suggested that day.

15 MS. GOHLKE: Oh, no, I did  
16 not. I did not. We'll have to do  
17 something festive. So, yes, March 17,  
18 June 2, September 29 and December 8.

19 MS. BRILLHART: September  
20 29?

21 MS. GOHLKE: September 29  
22 and December 8. My colleague, Mike  
23 Tayler here, down the line, is working  
24 hard at looking for a secure online

1 platform for us to, possibly, have the  
2 option of meeting through the internet  
3 as well, so whether that replaces an  
4 in-person meeting or not, I can't say  
5 yet, but that is a possibility, at  
6 least, also for people to attend  
7 remotely, if need be. So, hopefully,  
8 we'll get something in place at some  
9 point in '09 for that option as well.

10 DR. HALPERT: But we're  
11 still looking at four in-person  
12 meetings for next year.

13 MS. GOHLKE: We'll still  
14 looking at four meetings, and, right  
15 now they are in-person meetings.

16 DR. HALPERT: Okay.

17 MS. GEIGER: Okay. At the  
18 Crown Plaza in downtown Albany, which  
19 we're happy about, at least this far.  
20 This hotel can't handle the  
21 infrastructure. We can't get a  
22 hardline internet connection here, so  
23 --

24 DR. COOPER: I didn't know

1           that.

2                       MS. GOHLKE:   Yeah.  Unless  
3           they update soon.  So we can't do that  
4           platform here, and if we go down the  
5           road and need webcasting and things  
6           like that, then this hotel's really not  
7           an option for us anymore.  They can't  
8           do that here.  So they've been great to  
9           us, but unfortunately they can't meet  
10          our needs.  So that's why we're moving  
11          along to the Crown Plaza.  Okay?

12                     MS. FENDYA:   You do know  
13          that this June date is the same week as  
14          the EMSC grantee meeting.

15                     MS. GOHLKE:   Not, it's this  
16          week.  It's the week after.

17                     MS. FENDYA:   You're sure?

18                     MS. GOHLKE:   Yup, I'm sure,  
19          it's the week after, so we're okay.

20                     MS. FENDYA:   -- my calendar  
21          from me, but I noticed it.

22                     MS. GOHLKE:   Yes, this took  
23          a lot of planning.

24                     DR. COOPER:   I didn't know

1 about the EMSC grantee meeting dates.

2 MS. GOHLKE: The EMSC  
3 grantee meeting is the week of June 8.

4 DR. COOPER: Oh, we have  
5 SEMAC and SEMSCO that week, also.

6 MS. GOHLKE: Yes.

7 DR. COOPER: So we'll have  
8 to do some tap dancing that week.  
9 Okay.

10 MS. GOHLKE: Not our  
11 meeting, but the annual -- the national  
12 meeting.

13 DR. COOPER: I understand.  
14 I understand.

15 MS. GEIGER: Okay, okay.  
16 Yes.

17 MS. BRILLHART: The old  
18 business, did we ever go back and do  
19 the minutes?

20 MS. GOHLKE: Why don't we do  
21 that.

22 DR. COOPER: Thank you.

23 MS. GOHLKE: We just need to  
24 approve the minutes.

1 MS. BRILLHART: We didn't  
2 have a quorum then.

3 MS. GOHLKE: Oh, that's  
4 right. That's why they got held up.

5 SPEAKER: We need Dr.  
6 Cooper.

7 DR. COOPER: We may have to  
8 wait until next time to approve those  
9 minutes. And is there any -- just  
10 because we don't have a quorum. Is  
11 there any -- I mean most of the people,  
12 other than Kathy, the only -- everybody  
13 is still here, even our guests, so  
14 maybe we do have a quorum.

15 MS. GEIGER: The absentee  
16 member is Dr. --

17 DR. COOPER: Oh, well, then  
18 we do, okay. So we probably do, okay.  
19 All right, well, then we do have a  
20 quorum. Is there a motion to approve  
21 the minutes? Thank you, John. And  
22 Sue, thank you. Okay, all in favor?

23 SPEAKER: Aye.

24 DR. COOPER: Opposed? It

1 carries unanimously. Cool, all right.  
2 Okay, would folks like to break into  
3 subcommittees and meet briefly or --

4 MS. CHIUMENTO: Do you want  
5 a report SEMAC/SEMSCO?

6 DR. COOPER: Oh, gosh, yes,  
7 thank you. I'm sorry.

8 MS. CHIUMENTO: Just a very  
9 interesting meeting. Some very  
10 interesting things got passed and other  
11 things are being looked at, but are  
12 somewhat in parallel to some of the  
13 things we're doing. The Medical  
14 Standards Committee passed a  
15 post-arrest hypothermia protocol for  
16 the western region, which was later on  
17 passed by both SEMAC and SEMSCO. And  
18 it's very interesting -- as far as  
19 spontaneous circulation patients, they  
20 would actually start doing hypothermia  
21 in the field. They have a grant for 15  
22 units to actually provide cold saline  
23 in order to get the body temperatures  
24 down. They'll be using ice packs,

1 things like that, in order to get the  
2 temperature down. This kind of  
3 piggybacks sort of what New York City's  
4 doing. You've got kind of like  
5 preliminary stages where you're  
6 bypassing hospitals to go to hospitals  
7 that have capability for hypothermia,  
8 and they've gone the next step where  
9 they're actually implementing it in the  
10 field. So that was very interesting  
11 that that -- it will be interesting to  
12 see what their results are of that.

13 DR. HALPERT: But they're  
14 bringing those patients to unspecified  
15 hospitals, correct?

16 MS. CHIUMENTO: Yes, and  
17 that's part of the problem, is that the  
18 hospitals they go to may not  
19 necessarily have the capability,  
20 though. Right now they have four  
21 hospitals that have the capability.  
22 They said most of those patients would  
23 end up at those four hospitals, but the  
24 more rural areas would not,

1 necessarily, have the capability. They  
2 talk about the New York City burn  
3 transport plan.

4 MR. TAYLER: Sharon, just a  
5 question. What region was it approved  
6 with --

7 MS. CHIUMENTO: It was the  
8 western region.

9 MR. TAYLER: Which is what  
10 counties?

11 MS. CHIUMENTO: That would  
12 be --

13 MR. TAYLER: Erie.

14 MS. CHIUMENTO: Erie.

15 MR. TAYLER: Erie, Wyoming  
16 and --

17 MS. GEIGER: It's like  
18 nine --

19 MR. TAYLER: So it's more  
20 than just one REMSCO? One --

21 MS. GEIGER: Yes. There's  
22 one REMAC for three REMSCOs and three  
23 program agencies.

24 MR. TAYLER: Okay. And that

1 was adult only, right? It wasn't --

2 MS. CHIUMENTO: They did not  
3 have a specification of age in there,  
4 so I believe it would be all age  
5 groups. There was no -- I looked at  
6 the protocols. It didn't have any  
7 specification for age.

8 MR. TAYLER: Okay.

9 MS. CHIUMENTO: New York  
10 City's burn transport plan was also  
11 approved. They have a protocol that  
12 would help them to triage burn patients  
13 with three tiers of burn centers,  
14 trauma centers and then other  
15 hospitals. They have burn carts that  
16 would be available for each of the  
17 hospitals. It would be part of plan,  
18 that would have three days' worth of  
19 supplies, and they also -- allows New  
20 York City to change the protocols to  
21 allow transport outside of New York  
22 City if there is a major --

23 MS. GEIGER: Yeah, this  
24 protocol, we should clarify, is only in

1 a mass casualty event.

2 MS. CHIUMENTO: Right. So  
3 it will -- but it would allow them to  
4 go to non-New York City hospitals. It  
5 also sets up two virtual triage  
6 hospitals -- one in New York City and  
7 one in Rochester -- that would help to  
8 triage patients in a large scale  
9 disaster plan.

10 There was an ongoing discussion.  
11 Periodically, over the course of the  
12 last couple of years, got into  
13 discussions of whether medical control  
14 can be done by non-physicians,  
15 primarily mid-level physician  
16 assistants and nurse practitioners;  
17 although, there is, at least, one  
18 region that actually has paramedics  
19 giving control, medical control to  
20 other paramedics with physician  
21 oversight. And so there has been  
22 discussion as to what does this entail.  
23 The physician oversight of the law  
24 actually states that there needs to be

1 physician oversight, or direct  
2 physician contact, or physician  
3 oversight, and it doesn't specify  
4 exactly what that means. So there will  
5 be a committee that will be discussing  
6 just exactly defining who can give  
7 medical control under what  
8 circumstances, so that will be a very  
9 interesting thing. That will probably  
10 also affect us in pediatrics because,  
11 obviously, folks will giving medical  
12 control for pediatric patients, as  
13 well.

14           The Evaluation Committee came  
15 back with some very interesting studies  
16 that they've completed. There was one  
17 that -- it was a helicopter data that  
18 was analyzed for appropriate use doing  
19 -- based on a survey that went out  
20 looking at whether or not patients were  
21 being appropriately taken by helicopter  
22 to various centers. They felt that,  
23 based on their overall quick first  
24 view, it looked like that was quite

1 appropriate for the most part. They  
2 hope to tie to patient outcome data in  
3 the future. It has not been available  
4 up until now, but they're hoping with  
5 some of the tieing of the SPARCS data  
6 to the PCR data, and that type of  
7 thing, that in the future they will be  
8 able to look at some patient outcome  
9 data to see -- this was just basically  
10 based on the diagnosis that the patient  
11 ended up with in the ED and whether or  
12 not that was appropriate for -- and  
13 whether or not the patient was  
14 immediately discharged or kept.

15 They also did some farm-related  
16 injury data that they reviewed, and  
17 that was also collaborated with New  
18 York State PCR data and looked at some  
19 information related to that, and they  
20 hope to do a little bit more of that in  
21 the future, so that will be kind of  
22 interesting to see where that goes.

23 There was a QA survey that was  
24 done at the vital signs conference this

1 year that looked at the QA document  
2 that was produced by the Evaluation  
3 Committee, as well as whether or not QA  
4 was being done on an ongoing basis  
5 within agencies, and so we had some  
6 very good results with that; however,  
7 it's a very limited study because it  
8 was based on people who actually  
9 attended the vital signs, and so, you  
10 know, they really only represented a  
11 very small sample of New York  
12 population. But it did show us that,  
13 although QA is being done to some  
14 extent, there's still areas to improve  
15 upon and that we still need to work to  
16 get the PCR data that is in the manual  
17 out to a wider variety of people and  
18 across the State.

19           There was a regional survey that  
20 was done on pain management and medical  
21 control options related to that as  
22 well, and, again, they looked at how  
23 many of the regions had -- what  
24 percentage of their agencies carried

1 the capability to do pain control for  
2 each of the different drugs and what  
3 their medical control system was set up  
4 for that. So, again, that's just come  
5 back, and so I'm sure there will be  
6 more, looking at that in a little more  
7 detail. I'm trying to remember whether  
8 or not that actually had pediatric data  
9 in it. I think there was just one  
10 question related to pediatrics, whether  
11 or not there was a burn -- a pain  
12 management protocol for pediatrics,  
13 and, as I remember, the percentage was  
14 pretty high in the areas that did have  
15 that.

16 They also reported -- the last  
17 time I reported to you that there was  
18 an issue with AEDs and the fact that  
19 there was no state mandate for AEDs to  
20 be on ambulances, and so the Department  
21 of Health went back and was able to do  
22 a little bit of information gathering  
23 about how many areas that would affect,  
24 how many agencies that would affect.

1           What they found was that there was a 98  
2           percent "defib" coverage in the  
3           non-commercial ambulances. So in the  
4           volunteer setting the AEDs were pretty  
5           much out there. It was a little bit  
6           less than the commercial, 77 percent in  
7           the commercial; however, there was just  
8           really one outlier, one agency that was  
9           having a little bit more difficulty;  
10          although, they were covering most of  
11          their 911 calls with AED or  
12          defibrillator ambulances that have that  
13          capability. So if you took out the one  
14          outlier then that also brought the  
15          commercial ambulances up to the high  
16          90s, as well. There is a proposal that  
17          at the next meeting in February we will  
18          look to including writing some language  
19          to help, perhaps, get this put into  
20          state regulation in the future, so  
21          that's something for the future. And I  
22          suspect that we would probably want to  
23          make sure that there is something in  
24          that language about pediatric capable,

1 so if they do not already have the  
2 defibrillators that, you know, that  
3 they purchase them. I know that that  
4 was something that was mentioned at  
5 SEMAC and SEMSCO.

6 MS. GEIGER: I believe what  
7 SEMAC and SEMSCO put out about AED  
8 capacity, as ambulance services upgrade  
9 or replace their existing equipment, it  
10 needed to be reflective of both adult  
11 and pediatric needs, and that was also  
12 advised to our community PAD providers.

13 MS. CHIUMENTO: Right, but I  
14 think we need to make sure that  
15 language doesn't get left out of  
16 anything.

17 Let's see. Dates were set for  
18 vital signs. Vital signs is going to  
19 be October 15 through 18th of next  
20 year, so hopefully -- I know this year  
21 there was quite a large pediatric  
22 component to that, and so hopefully we  
23 can have a little influence on making  
24 sure there are some pediatric

1 components next year as well. I think  
2 -- do you want to mention anything  
3 about the Governor Safety Grant and the  
4 NEMSIS compliance?

5 MS. GEIGER: Yes, thank you  
6 very much, Sharon. I appreciate that.  
7 The Bureau of EMS is the recipient of a  
8 grant from the Governor's Traffic  
9 Safety Committee, and we're going to be  
10 using those funds to explore migration  
11 to the NEMSIS system, which is the  
12 National EMS Information System, and,  
13 secondly, to develop the infrastructure  
14 platform to receive data electronically  
15 from our EMS providers. So it's a  
16 three year grant. The first year is  
17 benchmarking and issuing an RFP for a  
18 technical consultant.

19 MS. CHIUMENTO: Is there  
20 anything that anybody wants to add that  
21 was at the meetings?

22 DR. COOPER: I would like to  
23 add that Sharon, in her usual modesty,  
24 failed to mention that she actually

1 personally, you know, did that entire  
2 QA study and --

3 MS. GEIGER: And she also  
4 religiously reviews every regional  
5 protocol. She sits on the Medical  
6 Standards Committee, and Dr. Marshall,  
7 who is the chairman, relies on her  
8 heavily to give a synopsis for her  
9 physician and nurse colleagues at that  
10 meeting.

11 MS. CHIUMENTO:  
12 Particularly, the pediatric components.  
13 That seems to be the one area where I  
14 really hone in and find the things that  
15 are not compliant --

16 DR. COOPER: Yes, she does.

17 MS. CHIUMENTO: -- with HA  
18 standards.

19 MS. GEIGER: They can just  
20 spend their time fruitfully on those  
21 major issues rather than -- for those  
22 of you who haven't seen a regional  
23 protocol, it can be the equivalent to a  
24 Manhattan white page.

1 DR. COOPER: Yes, exactly.

2 MS. CHIUMENTO: When you're  
3 reviewing it online, it's really  
4 difficult.

5 DR. COOPER: Any other  
6 questions regarding the SEMAC report?

7 Okay, regarding the STAC report,  
8 my report will be extremely brief.  
9 We've already covered the issues  
10 regarding trauma regulations, and the  
11 pediatric trauma report which,  
12 actually, did not come up at the STAC,  
13 but except by way of mention, a brief  
14 mention. It wasn't discussed in any  
15 depth.

16 The issue of trauma center  
17 closings that I believe was mentioned  
18 earlier in this meeting was discussed,  
19 and that's where the issue of the  
20 letter originated.

21 The other two major issues that  
22 were addressed were from the education  
23 committee and the data committee. The  
24 education committee put on, really, an

1 outstanding program on pediatric trauma  
2 for prehospital providers at Vital  
3 Signs this past October. And Grey  
4 Kelleher from Buffalo really  
5 spearheaded that program and really did  
6 a beautiful job. It's in collaboration  
7 with the New York Division of the  
8 American Trauma Society and works very  
9 closely with the trauma nurse program  
10 manager group from the STAC. And, once  
11 again, it was a great program and  
12 extremely well received by the  
13 providers.

14 And last, but not least, there  
15 was lengthy discussion about inclusion  
16 of potential additional data points in  
17 the trauma registry. And the short of  
18 it is this. The data committee, at  
19 some point in the relatively near  
20 future, will be undertaking a  
21 comprehensive review of the data set to  
22 see if there are data elements that we  
23 are collecting that we are not using,  
24 but the consensus was that a few new

1 data points would be added to allow  
2 base excess to be incorporated, or some  
3 measure of -- some biochemical measure  
4 of perfusion, electrolytes base excess,  
5 lactic acid levels and so on, so we can  
6 begin to get some sense about  
7 perfusion. What has driven this,  
8 actually, in large measure is the young  
9 people, particularly young males who  
10 come into the emergency department  
11 because of penetrating trauma, you  
12 know, who are walking and talking and  
13 really look pretty good, but they have  
14 that heart rate up around 120, 130, but  
15 good solid blood pressures until they  
16 don't have good solid blood pressures,  
17 of course. It also happens in little  
18 ones. And the decision was made to  
19 include enough data in the registry to  
20 allow us to look at that, because there  
21 is some sense that victims of  
22 penetrating trauma are not well  
23 recognized prognostically by the  
24 indicators that we already have, you

1 know, clinically such as respiratory  
2 rate, systolic blood pressure and  
3 Glasgow Coma Scale score. And as most  
4 of you know, base excess has also  
5 proven to be a very reliable indicator  
6 in the pediatric population of  
7 perfusion status, so it may turn out to  
8 be a blessing for the pediatric  
9 enrollees in the registry.

10 There was a lot of other routine  
11 business conducted, but I think those  
12 are the key points for you to mention  
13 here today, so --

14 MS. GEIGER: I just want to  
15 add, if I may?

16 DR. COOPER: Please, please,  
17 please.

18 MS. GEIGER: As you know,  
19 the Department of Health collaborates  
20 with the State Trauma Advisory  
21 Committee on conducting site surveys of  
22 trauma centers on a -- and I emphasize  
23 the word -- "periodic basis." Due to  
24 some budget and staffing constraints,

1 we're not going to be doing any site  
2 surveys in 2009, but, rather, the  
3 Survey Committee, under Dr. Shapiro's  
4 leadership, will be working with bureau  
5 staff to develop a self-reported survey  
6 tool, if you will, that the hospitals  
7 would report back to the Department of  
8 Health, and then, based on those  
9 findings, we would hopefully be able to  
10 identify hospitals that might need a  
11 site survey so we can target our very  
12 limited resources most appropriately.  
13 So they'll be undertaking that process  
14 in '09.

15 DR. COOPER: A focused  
16 review, when needed.

17 MS. GEIGER: Correct. Very  
18 much like the stroke program does now.

19 DR. COOPER: Okay, any  
20 other -- we've covered all the old  
21 business, all the new business and all  
22 our updates.

23 MS. GOHLKE: Any other  
24 announcements anybody else has?

1 MS. GEIGER: Just one other  
2 thing that might be of interest to this  
3 group that occurred at STAC, Brian, and  
4 Louise, and Dr. Hannan have been  
5 calling the trauma registry data to  
6 look at the incidents and prevalence of  
7 violent-related injuries and fatalities  
8 in New York State. And one thing that  
9 the School of Public Health noted in  
10 their epidemiological review was that  
11 right now it appears New York State  
12 residents have a different reasons for  
13 violent-related admissions in the  
14 trauma registry; whereas, the national  
15 trend tends to be more suicides, we  
16 have less suicides and more of some  
17 other categories. So I know that  
18 Louise Farrell was going to be reaching  
19 out to your bureau, Bureau of Injury  
20 Prevention, to see if you concur with  
21 our findings or, you know, what you  
22 might add to that. So just as an FYI.

23 MS. SPERRY: I know that she  
24 sent us the code, but I don't know that

1           it's gone -- that we've gotten beyond  
2           that yet.

3                       MS. GEIGER:  Yeah, no, we  
4           recognize that you have your to do list  
5           as well, but we just wanted to reach  
6           out to you folks because we know that  
7           you do a lot of work in that area.  So  
8           thank you for your time on that.

9                       MS. SPERRY:  Sure.

10                      DR. COOPER:  Okay, is there  
11           anything else anybody wants to bring up  
12           at this point?  Well, I think we've had  
13           a very, very full meeting, and thank  
14           you.  And we, of course, you know, have  
15           to say goodbye not only to Marjorie but  
16           also to the Century house, and  
17           temporarily, anyway, to Diana.

18                      MS. FENDYA:  Temporarily.  
19           Yes, very temporarily.

20                      DR. COOPER:  We do hope that  
21           she'll join us as often as life and  
22           times permit.

23                      MS. GEIGER:  She's now got a  
24           hairdresser in Albany, so she's got --

1                   (Discussion was held off the  
2                   record.)

3                   DR. COOPER: We'll count  
4                   your motion to adjourn. All right, so  
5                   Happy Holidays, and we will see you all  
6                   on March 17.

7                   (The meeting, concluded at 2:25  
8                   p.m.)

C E R T I F I C A T E

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I, Kyle Alexy, a Shorthand Reporter and  
Notary Public in and for the State of New  
York, do hereby certify that the foregoing  
record taken by me is a true and accurate  
transcript of the same, to the best of my  
ability and belief.

\_\_\_\_\_

Kyle Alexy

DATE: December 30, 2008