STATE OF FLORIDA DEPARTMENT OF HEALTH

RULE DEVELOPMENT WORKSHOP

RE: RULES 64J-2.006, .010, .012, .013, and .016

Taken on: June 28th, 2016 at 9:00 a.m.

Location: Palm Beach County Health Department
800 Clematis Street
West Palm Beach, Florida 33401

Taken before JESICA MARIA GARCIA GUTIERREZ, Court Reporter and Notary Public in and for West Palm Beach County, State of Florida at Large.

APPEARANCES:

LEAH COLSTON - MODERATOR
(FDOH Bureau Chief of Emergency Medical Oversight)
STEVE MCCOY - PANEL
(FDOH EMS Administrator)
JOSHUA STURMS - PANEL
(FDOH Data Administrator)
KAREN CARD - PANEL

I N D E X

MS. COLSTON: All right. Good morning. I think we'll go ahead and get started. It's 9:05. For the record, we are at the Florida Department of Health. The location is 800 -- forgive me if I say this wrong -- Clematis --

AUDIENCE: Clematis.

MS. COLSTON: -- Clematis Street in West Palm Beach, Florida. Today is June 28th, 2016 and we are gathered here for the purpose of conducting a rule workshop for 64J-2.006, .010, .012, .013, .016. For those of you who are joining us on the conference call line, the phone lines have been muted on your end to minimize the background noise that we might encounter. We will take comments. Please send -- we'll take comments via email. I apologize. Please send your requests to speak if you are on the phone to: joshua,J-O-S-H-U-A,.sturms,S-T-U-R-M-S,@flhealth.gov. and we are monitoring that email real time, so please submit your request to speak if you are on the conference call line at any time. We will hear speakers in the room first and then we will go to the conference call participants and hear speakers on the phone.

Just some housekeeping, please make sure that your phones are on mute. Also, if you need to use the restrooms, they are out these doors to your left and then another left down the hall there there's the men's and the lady's. There are also vending machines there in case you need water or refreshments.

I would like to express a special thank you to the West Palm Beach County Health Department for allowing us to conduct our little workshop here today. They did so on relatively short notice and so we definitely appreciate that. I know that the director, Dr. Alonso was going to try to be here, but we also have the governor here as well on some Zika related issues and they are upstairs. So we understand if she's not able to make it down here to say hello, but I know that she is very interested in what's happening with the trauma community so I'm sure she would be here if she could.

My name is Leah Colston, for the record, that's L-E-A-H, C-O-L-S-T-O-N. I'm the bureau chief for emergency medical oversight at the Florida Department of Health in Tallahassee and

I'll be serving as your moderator today. This is the second in a series of three rule workshops for these rules. The last one was held on June 21st in Tallahassee. If you were able to attend that rule workshop, you will recall that we had indicated we would have transcripts ready as soon as possible. The transcripts unfortunately weren't ready in time, but they will be ready on July 1st and so just, you know, as a note for everybody who is here and listening, we'll post those to our trauma website. We will also send out to our DL on both the EMS and the trauma side notification with the link to the transcripts. Of course, they may be in draft because we're asking for a quick turnaround time, but the reason I'm saying this is because we would like for the trauma community and the EMS community to make sure that they have time to review the transcripts and the discussions that we are having regarding these rules. These are -- we are working on trying to develop an approach. We've had a lot of issues with the trauma rule -- trauma rules and so we'd like to kind of move forward from that and get as much

feedback as possible.

DR. ALONSO: Good morning.

MS. COLSTON: Oh, good morning. So she made it. Would you like to -- I just said thank you and I said all kinds of nice things, so I'm sorry you missed it.

DR. ALONSO: Well, I'm going to say a few nice things and then I've got to get out of here. It's going to be a crazy day, folks. I'm Dr. Alonso. I'm the director here at the Department of Health. I know many of you. How are you all doing this morning? I was planning to spend the day with you until noon, but unfortunately I've got the governor coming here today. We're going to be talking about Zika and funding and there's a few items that have hit the news this morning, so it's going to be a little bit crazy so I have to leave and go take care of him. But at least I let you guys keep this room.

MS. COLSTON: Yes, she was very kind.

DR. ALONSO: So I'm really looking forward to what you're going to do. I have Chris. Where's Chris? There's Chris. She'll be my representative here today and she's been very

in tune with what we're doing in terms of trauma, and the birth reviews, and falls especially for our seniors, and a lot of other things. I know you're going to be talking the rules and -- but it all ties in together. And this is a great group. They're very involved and lots of good folks here.

MS. COLSTON: Yes. Thank you very much. We appreciate it.

DR. ALONSO: Thank you.

MS. COLSTON: So she made it after all. Have fun today. Okay.

So, as I kind of mentioned, we're -- you know, this is the second in a series of three. We've had quite a bit of activity going on. We're trying to improve some relationships that, you know, quite frankly are not conducive to us being able to move forward in a way that will help us evolve our trauma system. We acknowledge a lot of things. Our trauma statutes and the system itself has not been really evolved since, you know, 20 plus years, maybe even 30, I don't know, it's going on that I guess, so we'd like to kind of work on getting together with the community in a

collaborative effort to try to make sure that what we build is something that the community, number one, consensus on because you guys are the boots on the ground. But then in addition to that, we'd also like to make sure that whatever we develop is something that we've developed in conjunction with the stakeholders so that it's useful to you guys, it helps inform the State of Florida for things that we need as far as data and all that sort of stuff. I mean, you know, to be honest with you, all of this stuff I think we're -- we're in a really good place right now. The environment is so ripe for some good change to happen. I think there's a lot of things that we can do. Unfortunately we're trying to gather comments in a rule promulgation environment, so that's kind of restrictive, but what I would encourage you to do is to submit your comments. This is why we're doing this. We're trying to get as much feedback. We have no rule language and that's kind of interesting. You know, I'm sure everybody was kind of thinking: Huh, what's going on here, you know, they're going to try to pull a fast one again. There are no

predispositions. There are no -- there's no rule language. There's nothing that we have because why should we develop rule language in the absence of input from the stakeholders. So that's part of the reason that we're here is to try to get some feedback on what our idea is and how we would like to look at approaching this because we have an idea. Everybody always has ideas and so of course we have an idea and we want to communicate that idea to you and tell you what we're thinking. Now, from there it's open season. You guys can say, hey, we think that's a good idea with these caveats or we think that idea sucks. What I would also encourage you to do is if you like the idea, you think it's great, say so. If there is somewhere that we need to look or improve, let us know that. If you think it's a completely terrible idea, tell us why you think it's terrible. Don't just tell us it's terrible because we get that. If you think it's terrible, we completely understand that. What we want to understand is how to fix what's terrible about it. We won't know how to go in and correct what you think is wrong with it.

I'm not saying that everybody's recommendations, and everybody's proposals, and everybody's thoughts are going to, you know, all -- everybody's going to be happy and once this process is over, we're all going to walk away and be extremely happy. But the idea is is that if you have the opportunity to present it and discuss it amongst yourselves, then you understand if your idea isn't adopted for whatever reason why because the community has said: Well, you know, yeah, we get that; but your peers are saying: This is why it won't work. And there's a number of folks that are discussing it. It's not just the state saying: We think this is good and this is what should happen, and saying: Okay, guys, you know, go forth and do whatever we tell you to do. So I would encourage that. Be sure that you let us know, you know, okay, you have these thoughts. And the thought may be so vague that it's not bad or good, but, I mean, either way, I'd love to hear it. That we've messed up in the past and we know that. We want to fix that, but we also want to move forward. And we also want to figure out how to best implement rules that

will allow us to grow the trauma system the way it needs to be grown.

So, let's see. I just want to make sure I've covered everything. Hopefully you all have signed in. There was a sign-in sheet right outside the door here. If you're on the phone, I would encourage you to email joshua.sturms@flhealth.gov to let him know or let us know that you are in attendance today. We would like to be able to document the attendance for the rule workshops and so please make sure you email. There were sign-in sheets outside the door also. So this is of course a rule workshop, if you would like to provide comment today, you will fill out that speaker form and submit that so we can call on you to speak. I think that's it.

So what I'd like to do is just kind of talk to you about what the department's position is. This is nothing new. The environment today for trauma is very different than what it was sometime ago back in the 90s. We didn't have a lot of trauma centers and we were just trying to get folks to be trauma centers, come be a trauma center. Through the

years, you know, folks have worked on different things. We worked on an allocation methodology. We had the ACS tell us that was a great thing and, you know -- because a lot of states don't necessarily have that and sometimes it's a free market system, they allow folks to do whatever they want in another. There's other different models out there and it varies from state to state. Because of the allocation methodology and all of the locality involved, we've been in litigation for a long time. It's not been so bad lately. We are in litigation, but I think the litigation in previous years kind of stymied our ability to talk to our trauma community and get their input. And, you know, I mean, I get it. You know, we're all in a position where whatever we say, we're legally bound and we may be grilled for it. I've been there and I've done that, you know. And so when we say things, even if we have the best intentions, we can be sued over it and that's just the nature of the business. But I think moving forward, you know, what we're doing this under rule promulgation now so we're limited to how we do

things. Until we can get past the litigation, it's going to make it very difficult for us to do other things. And I'm not saying that that'll ever happen, but I think right now even though we're in litigation, I will still pick up the phone and call a trauma program manager or a trauma program manager can call me and say: Hey, I need to know this. Am I afraid of being sued and possibly getting fired? Yes, of course. But I just feel like I don't want to shut the doors to what we're trying to do. You know, I know that I'm not a clinician and I'm not that person that you can call for that expertise, but certainly we can get that for you and try to be responsive to that. So, you know, again, even with everything that's going on, I want to make sure that we're still able to talk to our trauma community and I would like for it not to be in this arena only. You know, we're working on a couple of things where we're actually trying to pull together an advisory council. We've heard, you know, over, and over, and over again with the last few rule workshops we need an advisory council. I agree wholeheartedly and I'm working on it. You know

that with the state sometimes things happen a little bit slow, so just know that we're working on that because that is a critical piece to the evolution of trauma and to bringing it to the state that we'd like it be at. By statute there's a limit to the number of trauma centers in the state and that number is 44 and that was developed some time ago by the legislature during a time when population was a little different, you know, situation was a little different, demographics and all that, and we know that there's wide variability between the panhandle and Pensacola and the Keys. So a lot of things have changed and we haven't necessarily grown our trauma system to change with the way the State of Florida ha changed. We're burgeoning at 20 million plus in population now, so it 44 the right number? We don't know. What we would like to convey is that any legislative changes are going to be -- we need to be in it for the marathon and not for the sprint because that's a long process, but we're willing to do that.

The other part of that is we need to look at our rules. Our rules currently kind of

outline an allocation methodology where we actually limit the number of trauma centers per TSA. And so we have this statutory cap for the state and then we've got an additional cap for the rule. And our legal office is kind of really starting to look at things and questioning, okay, so are interpreting this right; is this the right way to do this; if it is right, you know, how do we look at the allocation methodology; and how are we defining need, you know, what is need defined by; and is our allocation methodology something that we actually need to review and look at.

We've gotten some guidance from the ACS and what the ACS has outlined that we should do and things that we should have. The ACS produces guidelines. Most of you that are from the trauma area and even outside of that know the Orange Book and their guidelines for patient triage and things that you should have in your trauma system and that will most likely change. As healthcare does, it changes rather quickly and so we need to look at we proposed in the past adopting the ACS Orange Book as our trauma standards and we've heard kind of input

from both sides. You know, the ACS standards or guidelines are not necessarily as good as Florida standards. And, you know, there are some things that if we allowed the Orange Book to be adopted, you know, it might weaken our trauma system because the educational for nurses are a little different, you know, or whatever the case might be, and then there's the financial burden that's implied within some of those Orange Book standards as well. So there are a lot of things I think we can consider.

You know, we've got this long history, this long background. We have an opportunity now to look at some rules. Certainly this isn't going to be the last set of rules that we look at because when and if we can get to a point where we can change these rules, and there are other rules that we'll need to look at and change as well. And then hopefully based on what we receive as feedback from you guys, when we look at these changes to the rules, and we've done this already at the state level, we realized that there are changes in statute that will have to be made and so we

would look closely at what that looks like as well. You know, and we've kind of gotten feedback from both ends, you know, change the statute first and then change your rules and different things and, you know, I wonder if it's the chicken or the egg that comes first. I think either way all of this discussion that we're going to have is going to be beneficial to us being able to make changes moving forward whether it's rule statute or otherwise. So again, I would just encourage you to come forth, speak, be heard, have some solutions, have some recommendations. We are certainly collecting all of these. We have a court reporter here today, so when you come up to the microphone to speak, please state your name, the organization that your with, and also spell your name for the record so that we can get this. And again, once these transcripts are ready, we will post these as well to the trauma website and we'll send out notification.

I'd like to welcome my panel here today, Steve McCoy who is the EMS section administrator, Joshua Sturms who is the data section administrator, and then Karen Card who

has been very intimately involved with allocation methodology and trauma registry and things of that nature. So this workshop is intended to gain feedback from you. You know, I know that you may have some questions and we'll do our best to answer whatever questions you may have if we can. But, you know, from my perspective, we're kind of walking into this with an open mind and not trying to have any predispositions so that we can just hear what folks have to say or hear your recommendations. So any questions? Great. All right. Well, we will go ahead and move forward then.

I've got three requests to speak. Any online? Oh, one more. Okay. Thomas Dibernardo.

MR. DIBERNARDO: Good morning. Thomas Dibernardo, D-I-B-E-R-N-A-R-D-O, Sunrise Fire Rescue and The Broward Fire Chiefs Association I just have a few comments for consideration.

First, I applaud difficult meetings because that's what makes Florida the best and I appreciate that. Sometimes it's through these tough times that we still rise above the others. I also will concentrate on the trauma

assessment, so I'm using this rule because it refers to the trauma assessment as the main topic of my comments here.

First, I applaud having some kind of assessment. I think that was challenging in itself to create an assessment so there's some methodology that folks could use. From an EMS perspective, I in my area am the deployment specialist. I model all vehicles where they go and how they go in the past and in predictive modeling, so my concerns centers around a couple of issues and that is the predictive model. I don't want to catch the trauma assessment report here or the formula catch you in a circle. If you were to change your allocation up or down, then I would say you would have to redeploy your model on the effects of that. So if you have, for example, a reduction of trauma centers, I would take all those EMS calls and redeploy them under the same formula. You would create a circle. So, for example, in Broward County and I could submit this, but it's -- I don't want to go into numbers here. For example, the effects of the Coral Springs zip code would increase by 18

minutes now making it 39 minutes. For the Miramar zip code, it would add 15 minutes, thus making it 36 minutes. By the time you change an allocation or reduction in Broward County and then redeploy your formula, you would then increase the allocation back to Broward County. So I would like for you to take that in consideration in your formulas. If you're going to have a reduction or an addition, redeploy the formula to see the effects.

Also another area that needed to be considered during your formula and I'll submit this also as long as Cheryl Harasi (phonetic) gives me a replacements and that is the locations. So, for example, in Broward County our three trauma centers happen to be in the zip code of the highest number of traumas, trauma alerts. So therefore when you're doing means and averages, that would be very difficult because the response times for the bulk of the call are going to be within a few minutes, thus the outlying communities would suffer an intermediate average. So, for example, in the Pompano area for the North Broward Hospital district there's 225 EMS

trauma alerts just in that zip code. That would have an untoward effect to the Coral Springs 20 miles out that has 200 also. So as you go further west in the area of Broward County, the means and averages would have an untoward effect on your formula. So I just ask that when we make these formulas that we also do some kind of predictive modeling because the last thing we need you to do is come up with an allocation of up or down, redeploy your formula and have to change it again. So that is all I have. Thank you.

MS. COLSTON: Thank you.

MR. DIBERNARDO: And I can submit these too.

MS. COLSTON: Thank you. Next speaker is Chief Donatto.

MR. DONATTO: Good morning. Thank you guys very much for coming down here to South Florida for these meetings. We appreciate it. It's an awful long way for us to go to Tallahassee, but so Darryl Donatto, D-O-N-A-T-T-O, the Town of Palm Beach Fire Rescue, also the Florida Fire Chiefs Association.

You mentioned something earlier about the EMS system or the system and what I really want to make sure that we convey on behalf of the Florida Fire Chiefs is that every decision that you guys make at the state in Tallahassee with all the wisdom of government you have an impact on a system, you have an impact on my parents who live in a little small community called Palm Beach Gardens, you have an impact on somebody's children. It impacts the entire system. The pre-hospital component is a critical part of the system. So as you consider your things about lawsuits, and legislation, and rules, all those things will impact the system. They impact the operations of every fire rescue agency in the southeast, every fire rescue agency in the state and ultimately that impacts lives. I know we've entered into a new time. It's very unfortunate. We have these mass attacks out there, but they do surface some things. They surfaced the need for us to be prepared and for us to have adequate capacity and build that capacity in. Most of what I see in these reports is fighting over who gets to have a

trauma center in what area and how many you want and we want you to be cognoscente of the impact of those decisions as you consider them. In your prior recommendations, in your recommendation for a single trauma center within Palm Beach County where we currently have two and, you know, those two systems provide us with capacity to do whatever goes on. Those two centers, they provide us with the capacity for whatever goes on and I just I fear that, you know, some decision making that takes place in Tallahassee far removed from the people down in Palm Beach County is going to have a negative impact on my parents, my children, my friends, and the other people in this area. You know, in my mind we have an area like Palm Beach County and I can't speak for the entire state, but an area like Palm Beach County where we have what I would consider one of the best trauma systems available, it's funded locally, it has decision makers that live in this community, it's evaluated continuously by very bright minds who care about people, but who also live in this community, they're invested, they have family

that lives in this community, and they care about these outcomes because ultimately they care about the impact those things have on their family, down to that level, and what I don't want to see is the state dictating the level of expectation we should be able to have within Palm Beach County. And I'm sure that that's the same for Broward and Dade and other counties. So I'd urge you to consider allowing local areas to establish their own levels of expectation, especially where they're willing to fund and to kindest words possible, stay out of it down here. The state has great intentions, but they don't always come out so well for the folks that live in a particular area. You can't dictate the same thing for the panhandle as you can for a dense area like the southeast.

I appreciate you listening to what I've got to say. And when you get some more concrete plans, get something in writing. I'm sure we'll be back to talk more about that. Thank you.

MS. COLSTON: Great. Thank you. Kathy Holzer.

MS. HOLZER: Katherine Holzer. Holzer is H-O-L-Z-E-R. Safety Net Hospital Alliance of Florida. The Safety Net Hospital Alliance is composed of membership includes seven level one trauma centers, six level two, and the two free standing pediatric trauma centers. First, we'd like to thank the department for taking a more collaborative approach. We look forward to a day where we have an advisory council and we look forward to continuing to work on these rules. We're particularly appreciative that you chose to do regional meetings. It is not always possible for our trauma centers or the EMS folks to make it to Tallahassee and this is most appreciated. I will not repeat my comments from the prior meeting, but really as we begun to work on preparing written recommendations, I have a series of questions which you may or may not be able to answer today.

You've sort of outlined some of your reasoning around the revisions to or thought process of looking at revising 64J-2.010, the allocation rule. As it relates to trauma registry rule, the application, the extension,

and the site -- are there similar drivers for the department around what revisions they believe should be made or is this just part of a process of annually reviewing these rules and looking at updates?

MS. COLSTON: From my perspective, I don't think this has anything to do with our annual review. I think this is something that based on a lot of things that have happened even in the last six months have just kind of caused our executive leadership to kind of sit back and say: Hey, program, we need to kind of look at this and look at how we can fix things. I think one of the biggest drivers for the Department of Health in some changes is the desire of our state's general to really try to fix some of our relationship issues that we've had in the past. That sounds bad. I sound like I'm on Oprah, but we -- you know, it kind of goes back to what I said before and even to what Chief Donatto kind of mentioned, you know, the state has done some things and we've kind of pushed some things down with the best of intentions I'm pretty sure, but, you know, now it's kind of time to sit back and we're looking

at the community feedback perspective, you know. And not to say that anything was done without community feedback in the past. I know that there were a lot of workshops and a lot of activities that went into building some of the existing rules, but I think for a couple of years we've kind of gotten away from that, so. And I think that things have changed. So to me it's more than one thing. It's kind of a complex situation where we're just here now. It's time for us to start looking outside the box and thinking outside the box as to what we need to do and how we need to proceed, you know, because sometimes you get so stuck on this is the way, and we've got these rules, and, you know, this is -- it's been -- we've got all this stuff that exists, but change is hard, you know, and we already know. I mean, from a state perspective, you know, we go left and, you know, litigation, right, litigation, you know, so there's -- it's one of those things where you want to try to work with the community and you want to think about the best way to do that and so I think there are number of things that have gotten us to where we are

now.

MS. HOLZER: And then just a general comment. Well, we have certainly repetitively talked about the need for transparency and inclusioness [SIC] around the allocation rule. We believe that is equally true as it relates to all the other rules. You know, we would like to see a more transparent process, a clearer approach to how you evaluate trauma applications, you know, what role the trauma agencies might play in that process, transparency with posting that scoring on your website as it relates to site visits. Again, the more transparency you can put around the process, I think the closer we get to returning to the day when we all worked collaboratively and get beyond some of the issues.

And again, just to echo what the first speaker said, the assessment really does need to be an assessment of the trauma system and of the trauma system within a TSA because every TSA is vastly different. You know, what we can do in TSA-1 does not mirror what we can do in to say TSA-19. EMS, fire rescue have to be our partners in that process and so we look forward

to providing the department with comments and we appreciate your taking the time to come to South Florida.

MS. COLSTON: Thank you. Final speaker request, Cheryl Rashkin.

MS. RASHKIN: Good morning, all. My name is Cheryl, C-H-E-R-Y-L, Rashkin, R-A-S-H-K-I-N. I am the manager of the Broward County Trauma Agency which is a part of the office of medical examiner and trauma services in Broward County. I've been down there since the agency was established working in other arenas and working very closely with all hospitals through emergency management courses in the affiliations and also with the EMS providers. They sort of trained me down in Broward County because they do things a little bit differently from when I came from Palm Beach County. But I have roots in both and one of those major roots is the way trauma centers are allocated in a certain area. The formula, yes, is outdated. It needs to be addressed and revised. And to follow-up to Kathy's comments, we have to look at it independently for each one of the region because we are so different. What's good here

in Palm Beach County with 2 trauma centers that has worked for over 20 years -- I'm sorry -- almost 30 years is a little bit different than it is in Broward County because we have three. I could not imagine either one of those communities with less than what they have now. And I know as time goes on and the population increases within those given areas, both of those counties are very lucky because they do have a trauma agency in place and they both work strongly with not only the trauma centers and the EMS providers, but all acute care facilities and that's the key component. They all work as a team. This coming week our county is in the process of reviewing it's trauma transport protocols. Every emergency medical director for every acute care facility, plus the nursing managers for those same emergency departments, along with all EMS providers in the community, any other interested party in the community, along with the trauma centers are invited to a workshop to look at the current TTPs and see if they need to be updated, strengthened, and what can we do to facilitate the needs of our residents and

visitors in Broward County to get them to a faster approach into a trauma center. That doesn't mean our acute care facilities can't handle the job because we rely on them also. Without those acute care facilities in the outlying areas, say here in Palm Beach County, is way out in Canal Point or Pahokee, in Broward it's way out on Alligator Alley. We also help service the Seminole Tribe who are great working partners with our community. So they facilitate the needs of the EMS crews and save the lives of a patient and airlifting to the closes facility if air can't come all the way west. So those are components that we rely on, we look at.

Chief Dibernardo brought up various statistics based on our county and our county's needs and they're true to force. I rely on the Fire Chiefs Association and a program they garnered through an EMS grant many years ago -- deployment status of all of their units, so that helps facilitate the needs in our community to know if we have the right units in the right location and the right facilities in the right location because not only is it used

for their trauma side of the house, it's also used for the stroke, and the cardiac, and pediatric, and I can go down the list based on what the capabilities of our acute care facilities are which are extensive. So when you look at our system of trauma, you have to look at all the components that comprise trauma. It's not just that initial injury and an initial golden hour. That is critical, but you have to look at all the other components that go into place such as the families. What are you going to be doing with families of these trauma patients because it continues once they leave the facility into the rehab. So you have to look at this as a system wide component and not just what is good for the state overall. Check your systems. The idea of going to regionalized trauma agencies, it's a nice thought. I don't think it'll work too well down here in the south area because we are such an urban community. You have three large communities that have 7, 9 -- 9 trauma centers between all of us? Yes. So we have quite a few. So are you going to make one entity in charge of all of those? Oh, my gracious. I

only have three to work with plus 16 acute care facilities. I don't see that group being able to really function well. They might be able to give some minor insight and guidance, but when it comes to the hospital community, they're a family and they stay within their own families and that means the community in which they are based. So we all work as a team. When you're going through and you're looking at your approval process for trauma centers, those of us that are lucky enough to have trauma agencies, I'm sorry, less than a month to review a hospital's application and getting my trauma advisory committee together in less than a month's time to look at that, review all the qualifications, it's a bit tight, so you may want to include that in the thoughts also and giving that process a little bit more time. The facilities have a little bit of time in garnering the information and gathering the information that they need to make the application. I might ask that in that process they involve the community, they talk to their community partners in putting together the data. The hospitals already do a great job.

There's no doubt about it. And they all know hot to write an application form. But they need to make sure they've got the community buy-in as they're going forward. As several did just in the Miami-Dade area just recently. So that's what you need to do is you need to get that buy-in so it's all community, it's all a system and you have to work together. So that's the component. If you take a look at 012, give the trauma agencies in the community a little bit more time to review the application process. On 2010, I'll back up Chief Dibernardo and Donatto, you have to go on what's good for that community. Population is wonderful, but EMS and their response times and the needs of community outweigh those components. Thank you.

MS. COLSTON: Thank you. So we have not received any requests to speak via the telephone. Are there any other requests to speak?

DR. BORREGO: Good morning.

MS. COLSTON: Good morning.

DR. BORREGO: Robert Borrego. I'm the trauma medical director at West Palm Hospital.

THE COURT REPORTER: Doctor, can you spell your name for me? I'm sorry.

DR. BORREGO: Robert Borrego, B-O-R-R-E-G-O. I've been the medical director, to correct the record, for 25 years and that has been the length that we've had a trauma system in Palm Beach County. I've been fortunate, in fact, you will see that I'm one of the very few handful of trauma medical director that has been in 1 center for 25 years. The reason for that is, number 1, that I started and I have seen a program grow from the beginning in 1991 with 2 level 2 trauma centers, but we have both outgrown to being 2 level 1 trauma centers. We have been able to do that because we have a strong working relationship between the two centers, the EMS system, and the trauma agency. And I could vouch for you right now that without that in place, there is no way that I would be in one center for 25 years. It takes a long time for a trauma center to mature and become a level 1 trauma center -- to have the experience, the capabilities, and the finesse to be able to work with a community, the EMS system takes

twenty years at least.

To reference something that Chief Donatto said and to echo him and to reflect back on what happened recently in Orlando, the only way that a place like Palm Beach County, our set up, our structure, our infrastructure to be able to handle something like that will be only through the collaborative work between the two trauma centers, St. Mary's and Delray Medical Centers. Without these -- without all our collaboration and our work, we would never be able to handle something like that because we are not an institution where there is a large medical center, a university, or a large stationary center. We do see 3,000 -- between the two trauma centers. We have a very high ISS score. And we have in the past handled mass casualties. And it is -- what I would propose is to have further collaboration between EMS and the agency, the trauma centers, to be able to set up a system where we will be able to handle a catastrophe such as the one in Orlando by the appropriate triage to the 2 centers that would be able to handle that, being said from the experience, the

capabilities, and the growth that has taken over 25 years to become 2 level 1 trauma centers for Palm Beach County.

And I just like to make these statements and I hope that it's -- this is taken into consideration with any changes made in how Palm Beach County handles its trauma patients, and their families, and all those that are concerned. Thank you.

MS. COLSTON: Thank you. Next speaker, Chief Dyal.

MR. DYAL: Good morning. David Dyal, D-Y-A-L. Welcome to sunny South Florida. Nice and warm. I've got a couple of comments to make and primarily it's on the TTPs, the trauma transport protocols.

We have EMS medical directors who establish our protocols throughout our industry and that's by law they ware the ones who develop the TTPs as well as our treatment protocols. And I know that the rule requires us to send our TTPs up to Tallahassee for approval and I really don't think that that's appropriate. Whatever our medical directors in cooperation with our local hospitals and trauma

centers, whatever they decide to do should be -- I don't mind putting, you know, file with the state if that's what you want, but as far as having an approval process, I think that's invalid.

The second part of that is, and I'll air some dirty laundry here, we had a case in Martin County that the providers were sued because we took a patient who met all the trauma transport protocol protocol scores to take him to a trauma center. We were sued and the plaintiff won the suit because we didn't take him to the closest hospital. So if we're going to have TTPs that the state approves, or puts them on file, or whatever, what's the point if I don't have some kind of protection from lawsuit because we followed our TTPs and did not go to the local non-trauma center and there's no direction to the legal system in which to tell them that we are obligated to do so? So if you're going to go back and revisit all this, something has to be done to direct the legal system to give us some type of immunity if we're following protocol. That's the primary thing that I wanted to talk about

was the trauma transport protocols.

And just in general. I don't have a dog in the hunt on trauma centers. We are blessed to be able to be between a couple very good ones, so we fly north and south and anywhere they want -- they need to go. In fact, we even -- we fly directly to burn centers and bypass our local trauma centers if the patient is significantly burnt. But it seems to me that the state ought to be in the business of establishing standards. And then if a hospital meets those standards and the market will drive it, then so be it. Let the hospitals work their markets and sink or swim, but they need to meet your standards. So set some standards, set standards for EMS, set standards for the hospital, whoever, and then let the market drive it.

That's the end of my comments. Thank you.

MS. COLSTON: Thank you. Are there any other comments or requests to speak that we have not gotten from the audience?

MR. STURMS: I got an email to ask to spell my name again. If they're getting rejected, maybe it's for having the wrong

email.

MS. COLSTON: Okay. On the phone, if you want to submit a request to speak, the email address is: joshua,J-O-S-H-U-A,.sturms,S-T-U-R-M-S,@flhealth.gov.

So perhaps we can take a break for about 7 minutes until 10:00 o'clock to give some folks that are one the phone time to submit their requests if they'd like to speak.

(Thereupon there was a brief recess and the proceedings continued as follows:)

MS. COLSTON: Okay. Thank you. So we are doing one last final check of the email to see if we've gotten any written comments and so I'm going to give Josh just a second. But while he keeps checking on that, I just wanted to make sure we didn't have any from attendees here? Okay.

So one of the things, you know, as we let Josh kind of look for what he's looking for, one of the things that I just wanted to say is we've gotten some interesting recommendations today. You know, a lot of folks have some

different ideas. You know, and I'm not the expert on this stuff, you guys are, so I'm glad we're getting these recommendations. I would just encourage you, I know that some folks may not want to kind of go into a lot of detail about what they think. You know, we all hope that this is a safe environment where we can talk about things that we want to talk about and get our ideas out there, at least that's what I'd like to be able to do. I don't think that I can do that on my own. I think you guys are the ones with the ideas. But when I talk about all the great recommendations that we've gotten today, sometimes it is a recommendation. We think that you should kind of look at variability and standards or, you know, have a minimum standard; I'll just use this one as an example: Have a minimum standard and use it as a guideline. Everybody meets, you know, A, B, and C and then if you want to be a little better and add in D, E, and F, all the way down to Z, then you need to have the latitude to be able to do that. You know, and I think that's an interesting concept. I think that's something that's good to consider. You know,

all things considered with making sure that we're still meeting any statutes or regulatory requirements or anything like that. So to that end, we will be accepting written comments for these workshops, even the one that we held on the 11th -- 21st. I'm sorry. I'm thinking about the one in the future. We'll be accepting written comments all the way through July 21st, so that's about two weeks after the very last workshop. So as you submit your comments, especially for those folks who have made recommendations and, you know, quite frankly very interesting recommendations. You know, I don't want to call anybody out in this arena or do anything to make you give more than what you're willing to, but your written comments, I would encourage you to comment, expand on what those recommendations are a little bit so that we can understand. Because for me a recommendation is very valuable as long as I understand the mechanics behind it, you know, then we can actually develop something moving forward and champion those things that we're looking for, communicate it better in a venue like this where there's, you

know, something we're going to give to an advisory council for consideration, or something that we discuss and use as the justification for why we're going to propose a rule that we're going to propose. So I would encourage anybody who is, you know, listening, or making recommendations, or anything of that nature, if you have comments about it, it's what I said before, but expand on what you're recommending. Tell us how you would do that. If it were a perfect world and this were your pie in the sky with the unicorns and balloons floating around, tell us how you would do what you're proposing to do. How would you do what you're recommending because that is going to be where we can find the most value in what we're getting here today is to see what you -- what the actual thought processes are behind the recommendations.

So, Josh, did I fill up enough, blow enough hot air to see if we can get these things printed out? It wasn't really hot air. That's a true statement. I really do want that though. I mean, so hopefully you guys will think about it. I don't care if you submit a

book. Just zip it, PDF it, zip it and send it on and we will look at that because I think that's going to be really valuable stuff.

MR. STURMS: We're going to try an alternative method to get my email up.

MS. COLSTON: So we're having a little bit of technical difficulties. If we un-mute, can we just kind of --

MR. STURMS: They can un-mute themself -- get on presentation.

MS. COLSTON: Okay. So on the phone, we're having some technical difficulties which always seems to plague us during trauma rule stuff. I don't know why. So if there were any requests to speak that you submitted, we're having some trouble pulling that off the email, but if you'd like to star six to un-mute right now and we'll just try to take your comments in order. Star six to un-mute your line if you're a participant on the conference call. Okay. Hearing no takers. I'm sorry to make you guys wait. I just don't want to miss out if somebody's actually submitted something. Star six to un-mute on the line.

So July 21st is the deadline to submit

written comments. July 1st which is Friday we will have the transcript from the June 21st -- my dates are just gone -- June 21st workshop that was held in Tallahassee. July 11th we are having the third workshop. It will be held in Orlando the day before the EMS Advisory Council meeting, so hope to see everybody there.

MS. RASHKIN: Can you change the time to that meeting to 9:30 because traveling to that location in Orlando is a little difficult during rush hour?

MS. COLSTON: 9:30?

MS. RASHKIN: Yes.

MS. COLSTON: It's already been noticed --

MS. RASHKIN: -- noticed it, but.

MS. COLSTON: Yeah, it's already been noticed so --

MS. RASHKIN: Just to let you know that that area is really bad.

MS. COLSTON: Okay. We'll delay as long as possible, but, yeah.

MR. STURMS: There was one comment that was sent in.

MS. COLSTON: Was it a request to speak or just a comment?

MR. STURMS: It was just a comment.

MS. COLSTON: Okay. Do you want to read it?

MR. STURMS: Sure. The comment is from Dr. Malvezzi from the Nicklaus Children's Trauma Hospital. His comment is: In the current apportionment of trauma centers from Miami-Dade, only the adult trauma centers are counted. Is the pediatric trauma center to be evaluated aside from the adult centers? There's an additional question that says: If the number of trauma centers is reduced, is Nicklaus Children's, previously Miami Children's Center, going to be sacrificed despite the known advantage to children of being taken care of in a dedicated stand alone pediatric hospital?

MR. MCCOY: And basically it's a question from Nicklaus Children's Hospital related to pediatric centers and how they're going to be apportioned in allocation. I think going back to what Leah said earlier is is there's no predisposed verbiage here. I don't imagine us just in a final rule forgetting about trauma centers. I think that's absurd myself. But

there is no predisposed language to do that. There is no formula change or anything that represents that at this time and that's what we're trying to get feedback. And obviously from comments submitted like this, it's evident that we need do a better job of pediatric hospitals, especially those two stand alones. That's noted and we thank you for your comments, doc.

MS. COLSTON: Okay. So if there are no other comments either by phone or in the room, we will conclude this workshop. Again, written comments please, especially expanding on those recommendations that we brought forward today, that'd be great. I'm always available by telephone, so if you shoot me an email, I will be happy to return your call if you have any questions or I can help in any way. Thank you for your attendance and maybe we'll see you on July 11th.

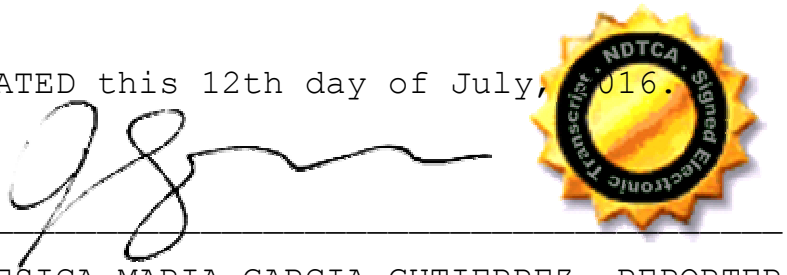
(This concludes the Department of Health's Rule Development Workshop)

TRANSCRIPT CERTIFICATE

STATE OF FLORIDA)
COUNTY OF WEST PALM BEACH)

I, JESICA GUTIERREZ, Reporter, certify that I was authorized to and did digitally report the foregoing proceedings and that the transcript is a true and complete record of my digital notes.

DATED this 12th day of July, 2016.



JESICA MARIA GARCIA GUTIERREZ, REPORTER

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