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1		FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL
2		FLORIDA DEPARTMENT OF HEALTH
3		2555 Judge Fran Jamieson Way Viera, Florida 32940
4		May 24, 2018
5		Commencing at 9:00 a.m.
6	Present:	David Summers, R.N.
7		Mark McKenney, M.D.
8		Zeff Ross
9		Malcolm Kemp
10		Joseph Ibrahim, M.D.
11		Robert "Larry" Reed, M.D.
12		Donna York, R.N.
13		Darwin Ang, M.D.
14		Nicholas Namias, M.D.
15		Lisa DiNova, R.N.
16		Glenn Summers, M.D.
17	- 7	Brad Elias, M.D.
18	Also Present:	Leah Colston, Bureau Chief, Em. Med. Oversight
19		Cindy Dick, Assistant Deputy Secretary
20		Amanda Bush, Esq., Office of General Counsel
21		Kate Kocevar, Trauma System Administrator
22		Michael Leffler, OMC Manager
23	Court Rep	orter: Elizabeth J. Beyer, FPR
24		Angell Reporting Service 8195 N. Wickham Road, Suite 200
25		Melbourne, FL 32940 (321) 259-8500

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MS. COLSTON: We do have a few folks here, it looks 1 2 like, attending from the public, so we are very excited. This is our first Florida Trauma System Advisory Council 3 meeting. We're very excited about this. 4 5 We do have a court reporter here today, which is 6 standard with all of our advisory council meetings, so we 7 would ask, for the purposes of our court reporter and for people attending on the phone, that you please use the 8 microphones that are available. If we have to pass them, 9 10 we'll try to be proactive and get the microphones where they're needed. 11 12 We are definitely looking forward to setting up the 13 council today. It will be a primarily administrative 14 meeting for us today as we look to solidify our bylaws and 15 work through our plan of action at least for the next year. 16 We have some activities by statute that we're going 17 to be required to do by December 31st, so we have some 18 priorities that are already set. 19 We are going to be looking forward to receiving 20 recommendations from you about what our other priorities will be, as far as addressing some things in the trauma 21 22 system and looking at areas that we can work on. I know 23 there are a lot of good ideas that are ready to be floated. 24 We want to get those documents as well, and start thinking 25 about how we can begin to address those things.

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1	I'd like to introduce Dr. Maria Stahl. She's a
2	county health officer here. Her team and herself has been
3	gracious enough to allow us to use this facility for our
4	first meeting. So, Dr. Stahl?
5	MS. STAHL: Thank you, Leah. I know there's many
6	physicians here, but I'm not a physician. I'm a nurse NP
7	doctor, just to clarify.
8	Welcome to Brevard County. I'm glad that we were
9	able to host you all here. I don't know if any of you have
10	been to Brevard County before, but it's nice and sunny
11	yesterday and today. It's going to probably be rainy after
12	today. We have had ten days of clouds and yuck, but it
13	really is a beautiful county with 72 miles of coastline.
14	I hope you found us okay. I know there are some
15	here that drove this morning from Tallahassee. Oh, my
16	goodness, I don't think I could do that.
17	Welcome. It's wonderful that you're all
18	volunteering and are willing to get together and look at the
19	trauma system here in the state of Florida. It's just
20	wonderful. If there's anything we can do, if there is
21	anything you ever want to use this building for, it's open
22	anytime you guys want it. We host a lot of state meetings,
23	a lot of local meetings.
24	For anyone that needs the restroom if you
25	haven't found them already it's out in the lobby. Men's

is to the left; women's to the right, just before you go 1 2 through the front door. You're welcome if you ever want to come and see the 3 rockets, enjoy the space center, go to Port Canaveral and 4 take a cruise. We're here for you. I was just telling Leah 5 6 that I'm going on a cruise tomorrow, a three-day cruise. 7 It's going to be nice and rainy, so I don't know if I'm going to enjoy it. 8 9 But welcome to Brevard County. I'm going to hand 10 it back over to Leah. MS. COLSTON: For the court reporter's benefit, my 11 name is Leah Colston. I am the bureau chief for emergency 12 13 medical oversight. I know most everybody here, but just for 14 the record. We'll also introduce Kate Kocevar in the back, 15 the trauma system administrator. Amanda Bush, who is with our general counsel's office. Our interim division 16 director, Doug Woodlief. Raise your hand, Doug. Our 17 18 assistant deputy secretary, Cindy Dick, is here as well. 19 Special recognition, Michael Leffler, who is also 20 with the trauma program at the state. He's been very active 21 in coordinating all of this. 22 So I guess we'll go ahead and get started. Would 23 you please rise for the Pledge of Allegiance? 24 (Pledge of Allegiance.) 25 MS. COLSTON: Thank you.

1	MR. LEFFLER: Are we going to do some council
2	introductions?
3	MS. COLSTON: If we could, since this is our first
4	official council meeting, I want to kind of just go around
5	the table. I have already introduced our staff. If you
6	could each give an introduction and what your representation
7	is, and then we'll also acknowledge our members, other
8	members that are here as well. Starting here with
9	Dr. Elias.
10	DR. ELIAS: I'm Brad Elias. I'm an emergency
11	physician in Jacksonville. I guess I represent the
12	nontrauma hospitals. Baptist Medical Center is a large
13	community medical center in downtown Jacksonville, primarily
14	stroke and cardiovascular hospital, but we get our share of
15	traumas, and transfer out.
16	I also served as a medical director for
17	Jacksonville Fire Rescue, one of the largest fire rescue
18	departments in the state.
19	DR. SUMMERS: Glenn Summers, from Sacred Heart
20	Pensacola. We are a pediatric and Level II trauma center.
21	I also teach residents. I'm representing the Panhandle, and
22	happy to be here.
23	MS. DiNOVA: Hi. I'm Lisa DiNova. I am the
24	Florida Hospital Association representative on this council.
25	I am from St. Joseph's Hospital in Tampa. We're an adult

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1	Level II and pediatric trauma center. I'm excited that we
2	get to have this council reinstated.
3	DR. NAMIAS: I'm Nick Namias. I'm from Jackson
4	Memorial Hospital. I was appointed as the member of the
5	community on trauma with pediatric surgical experience, but
6	my main role is I'm a medical director of a not-for-profit
7	Level I trauma center.
8	DR. ANG: My name is Darwin Ang. I'm the trauma
9	director of Ocala Regional. It's a Level II trauma center,
10	both state- and national-verified. I represent
11	investor-owned trauma centers in the state of Florida.
12	MS. YORK: I am Donna York. I'm from UF Health
13	Shands Hospital in Gainesville, and I'm representing the
14	nonprofit trauma program managers.
15	DR. REED: Larry Reed. I'm from IU Health
16	Methodist Hospital in Indianapolis. I'm an acute care
17	surgeon there. I am the state trauma medical director. By
18	virtue of my position, I cannot live in the state of
19	Florida.
20	DR. IBRAHIM: Joe Ibrahim. I work at Orlando
21	Health as trauma medical director. I'm here in the role of
22	trauma surgeon working at a Level I center.
23	MR. KEMP: Mac Kemp. I'm deputy chief of Leon
24	County EMS. I'm here to represent Florida EMS Advisory
25	Council.

1	MR. ROSS: Good morning. I'm Zeff Ross. I'm the
2	executive vice president with Memorial Healthcare System and
3	the CEO of Memorial Regional Hospital. I represent the
4	Safety Net Alliance. Thank you.
5	MR. SUMMERS: I'm David Summers. I'm the trauma
6	nurse outreach coordinator for the Trauma Agency for the
7	Health Care District of Palm Beach County. I represent the
8	trauma agencies.
9	MS. COLSTON: We have a couple of attendees in the
10	room. We'll go ahead and introduce them.
11	MS. HOLZER: Kathy Holzer, Safety Net Hospital
12	Alliance of Florida.
13	MS. STRENTH: Michelle Strenth, Orlando Health.
14	MR. SPIVEY: Rob Spivey, Holmes Regional Medical
15	Center.
16	MS. COLSTON: Thank you. I know we have several
17	attendees on the phone. In the interest of time, we will
18	not open the phone line at this time. This is a publicly
19	noticed and, of course, documented meeting, so there will be
20	an opportunity, based on what we have on the agenda, for
21	public comment. We do have speaker cards in the back for
22	the attendees that are in the room. Those attending by
23	phone, if you wish to make a public comment please send an
24	e-mail to Kate.Kocevar, K-o-c-e-v-a-r, @FLhealth.gov, for
25	the attendees on the phone.

We're going to go ahead and move forward. Just to 1 2 kind of give you guys an overview -- you have the agenda in front of you. This is our first meeting, and our goals 3 today will be to go ahead and set the foundation for the 4 function of the advisory council as well as to get some 5 6 draft bylaws or some good draft bylaws that we can submit to 7 our legal folks so we can get those approved and done. Those will be the bylaws that you all operate as a council 8 9 by, so you want to have some good documents. 10 We have developed a draft based on other advisory councils that we currently have, I think the EMS Advisory 11 Council. But we'll take a look at those, we'll go through 12 13 those. We will make sure that operationally those work for 14 this council. Then we're going to go ahead and try to get those finalized once we leave here. 15 16 We also want to work through a charter, which is actually documenting what this council is developed to do. 17 18 It's also going to, more importantly, lay out our tasks for 19 the next year. Typically a work plan or charter is good for 20 We can extend it, we can amend it however you all a year.

21 want to, but for this first year we know that we have some 22 work that we need to do.

23 So we want to go ahead and look at the other things 24 that we might be able to complete in this year. We'll have 25 the draft developed, hopefully the final draft. We do have

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a finite amount of time to do that in. No rush, because we 1 2 can develop a draft. We can all go and digest it, and in another week we'll collect comments, and then we'll finalize 3 something that we can move forward to. 4 5 Primarily those are the things that I really want 6 to try to get through, so we can all have a good path moving forward on what the council intends to complete over the 7 next year. Some things we already know are in the statute. 8 9 There are other priorities that we may want to outline as 10 well, so let's think about that. 11 As part of our orienting you to your duties on this 12 council, we're going to have a presentation from our general 13 counsel's office, by Amanda Bush. There are very specific 14 laws that govern the activities of this council, including 15 communication between members. Some of you are already 16 familiar with these rules and responsibilities, but we want 17 to make sure that we're giving everybody the same 18 information right offhand so we can move forward. 19 At this particular point in time, Amanda is going 20 to talk to us about our sunshine laws. MS. BUSH: It's a thrilling, thrilling topic. 21 22 Hopefully I won't make all you guys fall asleep this 23 morning. 24 So government in the sunshine of course is a very 25 important part of your responsibilities on this council.

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Florida's Government in the Sunshine Law is found in
 Chapter 286 Florida Statutes, and Article 1, Section 24, of
 the Florida constitution. Both provide a right of access to
 governmental proceedings of public boards.

5 The sunshine law applies to any board or commission 6 of any state agency. It includes elected and appointed boards and commissions, advisory boards and committees. 7 Private organizations that have been delegated authority to 8 9 perform a government function or that play an integral role 10 in the decision-making process of an agency have also been found to be part of the -- required to comply with the 11 12 sunshine law.

I'm sorry. I have some notes here which unfortunately don't show up. So there are some limited exceptions. If the board or committee is only for the purpose of fact-finding, not making any recommendations or decisions to the agency, those are not -- those do not follow the sunshine law.

All right. So requirements under the sunshine law. This is found in Section 286 of the Florida Statutes. All meetings of public boards and commissions must be open to the public at all times. Reasonable notice of such meetings must be given, and minutes of the meetings must be taken and open for public inspection. That's part of the public records law, which we'll touch on at the end of this

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1 presentation.

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So what triggers the sunshine law? When two or more members of a board or commission -- or council, in your situation -- are gathered together to discuss issues on which foreseeable action or recommendations may be taken by the council. Telephone calls between members are included. This applies to all functions of the board and commission, including formal and informal functions.

9 So not only official votes and recommendations, 10 which of course would be the formal actions, but also any 11 sort of deliberations or discussions which lead up to those 12 formal actions are also included.

13 You cannot use nonmembers to act as liaisons to get 14 around the sunshine law. You may not engage in written 15 correspondence, including e-mails, regarding council 16 matters. Of course there is an exception to that. Reports can be circulated, again, with the understanding that any 17 18 sort of discussion or comments must be had at a publicly-held meeting. Of course that written report is 19 20 subject to public disclosure under public records law.

21 Council meetings may be conducted by telephone 22 conference, as long as the procedural requirements are 23 adhered to; and, of course, a quorum of the members must be 24 present on the call.

Council members can attend social events where

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there may be more than one council member. Of course, the important thing there is that you don't discuss any matters that may come before the board or are presently before the board for consideration.

One of the procedural technical requirements: 5 6 reasonable notice, including time; place; agenda, if 7 available, or a statement of the general subject matter to be considered. Those notices must be published seven days 8 9 in advance of the meeting, unless there's an emergency 10 session. Notice should generally be published in the Florida Administrative Register, and also needs to be 11 12 physically posted in a location where the public may have 13 access to it, or placed on the agency's website.

Meeting minutes should be kept; can be a brief summary or memorandum reflecting the events of the meeting. Verbatim transcripts are not required, although sometimes we may elect to have that. Minutes should capture all members in attendance and their votes and/or recommendations.

19 If the meeting is being held by conference call or 20 conference call participation is allowed, then the notice 21 should include any conference call number and any required 22 passcodes.

As far as the publication of the notification, department staff takes care of that and assists with that function.

1	We must allow the public a reasonable opportunity
2	to be heard on board actions before any sort of official
3	action, such as a vote, is made. You may set reasonable
4	rules and policies for conduct at a public meeting, to
5	ensure orderly conduct. You can limit comments to items on
6	the agenda. You can allow for reasonable time for the
7	length of comments. And you should, of course, have a large
8	enough space to accommodate attendees.
9	Avoid again, these are just kind of some general
10	things. Avoid inaudible discussions. Open to the public
11	means everyone: staff, media, public, everyone. You cannot
12	prohibit the use of nondisruptive recordings.
13	If a council meeting is adjourned and will
14	reconvene at a later date, you have to notice that second
15	meeting.
16	Penalties. Courts interpret sunshine laws
17	liberally, and exceptions very strictly. Actions taken at
18	meetings held in violation of the sunshine law are void.
19	There are ways to correct that, but generally the
20	recommendation, of course, is don't do it.
21	Public officers who violate can be found guilty of
22	a noncriminal infraction, and fined up to \$500. Members who
23	knowingly violate can be found guilty of a second-degree
24	misdemeanor. That would include violations that occur
25	outside of the state. And that second-degree misdemeanor

1 may be sentenced to prison, not to exceed 60 days, and/or a
2 fine up to \$500.

Let's talk a little bit about, what is a public 3 So you see here a laundry list. This includes 4 record. 5 documents, letters, maps, et cetera, regardless of the 6 physical form in which they exist; electronic records, 7 e-mails, text messages, handwritten comments, regardless of their location, whether it's on e-mail, it's in a file 8 9 somewhere; those are public records if they're made or 10 received pursuant to law or ordinance in connection with a transaction of official business. 11

12 So generally the courts have found that any 13 material used to perpetuate, communicate, or formalize 14 knowledge is a public record. Agendas, meetings, materials 15 associated with this council are public record. The record 16 does not need to be in the final form; it may be a draft. 17 If that draft has been circulated for review or comment, 18 that is considered a public record.

19 Situations where you may have a private entity that 20 is subject to the sunshine law, those records in possession 21 of that private entity will also fall under the requirements 22 of sunshine.

E-mail and text messages in connection with council business, regardless of what phone or computer you're using, are considered to be public records.

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So what is not? As I hinted at before, personal 1 2 drafts or notes that you may take for your sole use are not a public record. As I mentioned, if those drafts or notes 3 are communicated to one another or used in any way to 4 perpetuate, communicate, or formalize that knowledge, it is 5 6 a public record. Personal e-mails and records that are not related 7 to official council business are not public record. 8 But, 9 again, be careful with that, because your personal e-mails, 10 especially if you have it on your business system, your work system, could still be subject to review under public 11 12 records, to make sure that all of the public records have 13 been disclosed. Again, because public records are 14 interpreted broadly, the possibility exists that e-mail you 15 believe is private could be determined to be a public 16 record. 17 Also, a record not in existence. So do not create 18 a record to summarize or explain other records in response 19 to a public records request. If you do create that record 20 in response, that becomes a public record. 21 So just in general, tips. Consider each 22 council-related e-mail to be a public record. Don't mix 23 your personal and council records or your personal and 24 council e-mails and texts. Again, text messages are public 25 records. I suggest avoiding using text messages for that

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1 purpose.

2 Do not destroy public records. Of course, as you may be familiar, we have the public records law under 3 4 Section 119.07. Every person who has custody of a public record shall permit that record to be inspected and copied. 5 6 So no purpose or reason is to be given by the requestor for 7 asking for those records. If they ask for it, we don't get to ask them why they want it. They are not required to be 8 in writing. 9

10 Then we'll touch on what happens if you violate the public records law. They allow for an immediate hearing 11 upon filing of court matters. If the court finds that the 12 13 agency has withheld, you have to comply with that court 14 order within 48 hours. Reasonable costs and attorney's fees will be assessed if the public record was unlawfully 15 16 withheld. Violations (sic) are guilty of a noncriminal infraction and a fine up to \$500. Again, a knowingly 17 18 violated public records law is subject to suspension and 19 removal. A person who commits does commit a first-degree 20 misdemeanor, which will subject you to a year prison, a fine of \$1,000, or both. 21

22 So that is a very brief kind of overview. The 23 First Amendment Foundation publishes a Government in the 24 Sunshine manual, which is a very helpful resource. You can 25 find it here at their website. They also have it online as

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1	well as in the printed version.
2	Any questions?
3	DR. IBRAHIM: So if we have a Florida Committee on
4	Trauma Meeting because there are several of us here that
5	attend those meetings as well and some of the same issues
6	come up, how does that apply? Is that considered a public
7	meeting?
8	DR. NAMIAS: The Florida Committee on Trauma is not
9	a public government meeting, but I suppose now if you and I
10	are there we can't discuss the business of this council, but
11	as the chair of the committee I could probably stand at the
12	podium and present what happened at this meeting, right,
13	without public notice?
14	MS. BUSH: Correct.
15	DR. NAMIAS: But you and I, and anyone else that
16	participates in this committee, can't Darwin also
17	DR. IBRAHIM: We couldn't even openly discuss
18	like if you were saying something and I had a question on
19	that? That's kind of my concern.
20	DR. NAMIAS: I would interpret that, for fear of
21	prison, as no, because I present it informationally. I
22	suppose I don't think it would be a proxy if others who
23	are not on this council discussed it at COT, but the three
24	of us and anyone else who comes to COT couldn't participate
25	in that discussion; is that fair?

1	MS. BUSH: That would be the recommendation, always
2	proceed with caution, you know, err on the side of caution
3	perhaps. Again, nobody wants to go to jail.
4	Any other questions?
5	MS. COLSTON: Dr. Ibrahim, we will, as part of
6	council activities, set up commons hours. We're going to
7	set those up regularly, especially in the interest of
8	fostering an environment where you guys can do the work that
9	you need to do, where these discussions and formal
10	discussions can be held. We will still notice them
11	publicly, but it will be an opportunity for you guys to get
12	on this call and able to have discussions that you need to.
13	Yes, ma'am?
14	MS. DICK: I have a question in general. I know
15	some of our council sometimes our councils e-mail each
16	other. They will e-mail the whole group, thinking they're
17	not having individual sidebar meetings. None of that
18	information is public notice. Is that permissible activity?
19	Can they discuss, as a group, outside of publicly noticed
20	meetings
21	MS. BUSH: No.
22	MS. DICK: That includes e-mail, phone calls,
23	anything like that?
24	MS. BUSH: Right. Exactly.
25	MS. COLSTON: Typically what we've done is, if

there's a message that needs to go out to the group, we, as administrators of the group, send it out to the broad group. We set up a time where we can talk about whatever was sent out.

So there's a lot of formalities. We're pretty used 5 6 to negotiating and navigating all these different things. 7 We're going to facilitate that, make sure you guys have the opportunities that you need to talk. At any point in time 8 9 you can call us and say, hey, we think we need to have a 10 call or a commons hour. We can set something up. We're happy to facilitate that, as well. Just keep in mind that 11 12 we do have to notice these things at least seven days in 13 advance, you know, unless it's an emergency. I don't know 14 what would constitute an emergency.

MS. BUSH: Well, that's a whole other discussion.

16 MS. COLSTON: We will always set something up, and 17 we can do it as regular as weekly right now if you guys want 18 to, in the interest of getting this set up. It's not going 19 to be mandatory attendance, but it will give you an 20 opportunity, if you guys do want to talk about business, you can call into that number, and we'll leave the line open for 21 22 however long and have someone on there to facilitate 23 whatever it is that y'all need to get this thing going. 24 I see Dr. McKenney just came in. We had 25 introductions, so I'll give you the opportunity to be

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introduced. 1 2 DR. MCKENNEY: Mark McKenney. I'm the medical director at Kendall SM. 3 MS. COLSTON: Thank you so much. 4 5 So next we're going to talk about what brought us 6 here to this state. You guys know that we had House Bill 65 7 that was successfully passed, giving us the ability to have a trauma system advisory council with some defined roles. 8 We're very excited about that. It does more than just that, 9 10 but that is one of the key things that it does do. We want to talk about -- a little bit about the 11 statutes, not necessarily so much the rules. There are 12 13 rules that govern us. I'm sure many of you are aware of 14 those rules. We do want to talk about the statutes as they 15 relate to the rules and responsibilities of this council. 16 I keep talking about an assignment that is due at 17 the end of the year. That is one thing that's outlined in 18 the statute, that we do have to do. We will facilitate the 19 completion of that study with you. You guys can estimate --20 we'll make sure we create some dates and deadlines, so that 21 we can successfully get that submitted. 22 Kate Kocevar, our trauma system administrator, is 23 going to come up and talk to you about the rules and 24 statutes that kind of govern our council and all the 25 activities that relate to trauma.

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1	MS. KOCEVAR: Good morning, everyone. My name is
2	Kate Kocevar. I am a trauma system administrator. I get
3	the pleasure of discussing the wonderful things in the
4	Florida Statutes, rules, and standards.
5	As indicated, House Bill 65 gave us this advisory
6	council that we sit here today with. Part of that is to
7	really go through and find out what exactly the statute
8	empowers this council to do. As indicated, we talked about
9	homework assignments, and we do have one. This one is due
10	by January of 2019. That is for us to take a look at a
11	pediatric study. So that, unfortunately, is our first
12	homework assignment as this council.
13	That said, let us kind of take a look at our slides
14	here and go through things. All right. So this is going to
15	be Florida constitutional statutes. You can probably see
16	that. Okay. So the role of the Department of Health.
17	People wonder who we are sometimes, so this is who we are.
18	Chapter 395, Part 2 of Florida Statutes: to plan,
19	establish, and maintain an inclusive trauma system. In
20	that, what we look at is defined roles for trauma centers
21	and acute care hospitals. Part of that, as we talked about
22	with the standards and rules that we have, we have these
23	things that allow us to go in and look at facilities, make
24	sure everything is flowing properly. So you wonder why we
25	do come in, this is part of why we do.

1 We establish local and regional trauma systems 2 designed to meet the specific needs of the population, actively foster the provision of trauma care, and serve as a 3 catalyst for improvements. I think everybody wants to 4 5 continue to make our trauma centers the best here in this 6 state. 7 A statute means a codified law that's enacted by the Florida legislature and approved by the governor. 8 9 Chapter 395, as I talked about, are the Florida Statutes 10 that govern the Florida trauma system. Rule means each agency's statement of general 11 applicability that implements, interprets, or prescribes law 12 13 or policy. So a lot of times we talk about the rules. We 14 have to say, look, we have these statutes. Does the statute 15 give us the authority to make the rules? Those are one of 16 the things we have to look at, do the standards fully connect with one another. A lot of times when we've found 17 18 ourselves saying, well, we'd like to do something different; 19 here's the standard conversation that would come back, that 20 would say, well, do we have statutory authority to make a new rule? Do we have statutory authority to essentially 21 22 change a rule? Those are things that we have to kind of 23 work on with this council, and just advise them when they 24 come up on issues of whether it's provided in the statute or 25 whether they have rule authority to do such a thing.

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1	The statute must grant the department authority to
2	make a rule, as I said. Rules must be adopted using the
3	statutorily prescribed process. So there is a process. We
4	don't just sit down and make a rule, and say, that's what we
5	want to do. There's an entire process. There's a hearing,
6	public notice, this type of thing before really a rule can
7	be fully developed. Then, as you can imagine, it goes
8	through general counsel to ensure that we have that
9	statutory authority to be able to implement that rule.
10	Rules may not enlarge, modify, or contravene
11	specific provisions of the law implemented. Rules must be
12	supported by logic or facts. Rules may impose requirements
13	or solicit information not specifically required by the
14	state.
15	Chapter 395, this is the statute that we were
16	referring to. First and foremost we're just going to do the
17	brief topics of the statutes; we're not going to go into
18	extreme detail into all the statutes. The first one is
19	395.40. It says: legislative findings of intent. That is
20	actually the title of that particular section. It requires
21	the establishment of an inclusive trauma system designed to
22	meet the needs of all injured trauma victims who require
23	your care; encourages the Department of Health to actively
24	foster the provision of trauma care, and serve as a catalyst

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for improvement. As you can see, there are some words that

1 keep coming back each time we look at these things, and 2 "improvement" is one of them.

The next section, 395.401, trauma system service plans; approval of trauma centers and pediatric trauma centers; procedures; renewal. A long topic title, but it allows the department to adopt standards for verification of trauma centers, based on national guidelines, including those established by the American College of Surgeons.

9 So in the book that you have here today, you'll see 10 that the standards are in the back, 1150-9, which are the 11 standards that we use when we come into a trauma center. 12 Those are the standards that you will use when you set your 13 trauma centers up, and follow what's in there.

We also have an outline that requires for the establishment of local and regional trauma agencies. As you know, we have some in our -- there are some agencies here in the state of Florida, and others that are in the process of developing one. So those rules also kind of are an area to quide them.

20 395.4015 is state and regional trauma planning and 21 trauma regions. This requires the department to create a 22 state trauma system, plan and use the state trauma system 23 plans as a basis for establishing a statewide inclusive 24 trauma system. It directs the department to use the 25 Regional Domestic Security Task Forces, also known as RDSTF,

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use them to develop regional trauma agencies. 1 2 Now, 395.402, legislative findings and intent. This assigns counties. As you're aware with Bill 1165 we 3 went from 19 counties to 18 counties, combined one. 4 So we are down to 18 now. It allocates the number of trauma 5 6 systems to each TSA, and establishes the Florida Trauma 7 System Advisory Council. This is where we come in. So that was the rule that kind of came through here. 8 One of the things that I want to kind of 9 10 specifically read from the actual statute that was written indicates that when the decision to apply to create the 11 12 Florida Trauma System Advisory Council -- it specifically 13 noted, "to promote an inclusive trauma system and enhance 14 cooperation among trauma system stakeholders. The advisory 15 council may submit recommendations to the department on how 16 to maximize existing trauma center, emergency department, and emergency medical services infrastructure and personnel 17 18 to achieve the statutory goal of developing an inclusive 19 trauma system." 20 That is what the advisory council's basis is. That 21 is kind of like your motto. This is what you're going to be 22 handling. It's important to realize as an advisory council 23 group you can certainly provide a lot of leadership, but we must ensure to include all stakeholders when these ideas 24

come through the council, and make sure we address everyone

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1	equally in that way.
2	All right. 395.4025, trauma centers; selection;
3	quality assurance; records. It delineates the trauma center
4	selection and designation process. It requires the
5	department to conduct an analysis of the Florida trauma
б	system by August 2020, and every three years after that. It
7	grants authority to the department to collect trauma
8	registry data, so that's still part of the statute, the
9	registry is still part of that.
10	Trauma payments, which is Section 395.4036, directs
11	the distribution of red light camera and other traffic fine
12	revenues to state-verified trauma centers. Funds are to
13	ensure the availability and accessibility of trauma services
14	throughout the state. The statutory reference now requires
15	the department to use the Agency for Health Care
16	Administration also known as AHCA data to evaluate
17	trauma patient volumes.
18	Reviewing trauma registry data this is
19	Section 395.404 requires that all trauma centers
20	participate in the National Trauma Data Bank. The use of
21	what we call the NTDB data is limited to quality improvement
22	and trauma system assessment purposes. It directs all
23	trauma centers and acute care hospitals to report all
24	transfers of trauma patients and the outcomes. Just
25	remember when you're filing this NTDB, that's what you'll be

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filing through the state trauma registry.

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2	395.4045, emergency medical service providers;
3	trauma transport protocols; transport of trauma alert
4	victims to trauma centers; interfacility transfer also
5	known as TTP, so you know that language. That establishes
6	the requirements for EMS providers and trauma agencies for
7	the development of trauma transport protocols. It directs
8	the department to develop trauma triage scoring for adults
9	and pediatrics. In this section you'll be able to see that
10	it's outlined very clearly about what measures those adult
11	scorecards and pediatric scorecards.
12	So that is a little bit about what we have to work
13	with in our division. We want to make sure that we stay
14	within all the statutes, rules, and standards. As the
15	council gets underway to the business at hand, we are here
16	to guide you through that. We just have to make sure that
17	we continue to use these boundaries that we have, and we
18	work within them in order to establish council activity or
19	recommendations that you want to provide to the department,
20	so that we know that meets all the standards that we have
21	here.
22	Does anybody have any questions?
23	DR. NAMIAS: Will these slides be posted on the DOH
24	website?
25	MS. KOCEVAR: They're already on there. All right.

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1 Thank you very much. I appreciate it.

2 MS. COLSTON: Thanks for that question, Dr. Namias. We did post on the trauma website all of the documents we 3 are handing out today. For those who are accessing those 4 5 documents, please remember these are all drafts, but in the 6 interest of putting out public documentation we will always 7 post our documents on the website. Those things are subject to change. Once we revise those, we'll walk away today with 8 9 some new draft language and we will relay those documents 10 with the new updated drafts, so everyone should always have access to those. 11

12 Typically no more than a 24-hour delay, but 13 sometimes we have issues, so we will try to stay on top of 14 that as best as we can, and also send things out by e-mail. That makes it easier for everybody. Just in the interest of 15 16 ensuring that gets out, we will send everything to council 17 members. Again, these are public records so you may forward 18 them as you see fit. We're probably going to go ahead and 19 do that as well.

So, no other questions about statutes and rules? Great. So I'm going to change the order of the agenda a little bit. Sorry, Amanda. We will still cover the same content -- I'll just put that as a qualifier. We're going to talk about bylaws next. We are getting ready to move to the section of this council meeting where we're going to

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ORIGINAL

look at our bylaws. Understand that the bylaws that you 1 2 have in front of you are simply a draft, so your input is appreciated and desired. If you see something in here that 3 you're uncomfortable with, this is the forum and we will 4 5 change things as we need to. But these are drafts. We 6 currently use a very similar model for our EMS Advisory 7 Council. This is a template that has been vetted thoroughly by our legal office, so it contains a lot of the required 8 elements in there. 9

Michael Leffler is going to talk to you about that a little bit. There are some differences between the EMS Advisory Council structure and this particular advisory council structure. But, again, any input that you may have or ideas that you may have to make these bylaws a good operational document for you, we'll welcome those comments. Mike?

MR. LEFFLER: Good morning. There should be a handout for each of you there, that has a copy of draft bylaws. I'm going to walk through it a little bit, and just let you know where we came from and where we're going with some of this stuff in each article.

The difference between EMS bylaws -- we looked at several different councils and commissions that the department does. We incorporated ideas that we thought would best work for this council. Ultimately, the bylaws

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ORIGINAL

are by and for this council, so this is a draft. We are looking for input and change. Our hope is to give you a little bit of a chance to look over these as we go through them; and when we meet again in July we hope to take that up as the first order of business of the council, would be to vote in approved bylaws.

Article 1 talks about naming the council. In
statute this is the Florida Trauma System Advisory Council.
We came up with the shortened name of FTSAC or just Council
as a short name. FTSAC is not the most audibly pleasing
name, so there may be some opportunity for improvement
there.

13 Council composition and membership. Council 14 membership is outlined in statute. Council members are 15 appointed by the governor, and, you know, we've aligned with 16 that. Council membership is voluntary. The statute also says that we cannot reimburse you for travel and per diems 17 18 to participate in council activities; however, if you're a 19 Department of Health employee and would otherwise receive 20 compensation outside of council, certainly there's nothing 21 to prohibit you from getting reimbursement for activities 22 that you otherwise would have gotten reimbursed for; but you 23 cannot be reimbursed for travel or per diem for council 24 activities.

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Attendance requirements: Council members who fail

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to be physically present for two consecutive or three total regular meetings within their term shall essentially be considered to have abandoned their position, and it may be reappointed. I know that you guys are all very busy. There's lots of scheduling conflicts. The department will work with you all to find meeting times that work for all of us.

8 Article 3 is the council's purpose. We've outlined 9 six items that we have felt, you know, truly embody the idea 10 of what the department and the division of the council is 11 doing. I will let you guys do that. That's another 12 opportunity where we can possibly enhance the division of 13 the council.

14 Article 4 is officers. This is probably an area 15 where we change the greatest from EMS and some of the other 16 councils that you may be familiar with. We're appointing a 17 moderator and a secretary, two officers. The moderator will 18 essentially chair the meetings, will be responsible for 19 facilitating the meetings, working with the department on 20 agenda setting, but doesn't have the normal powers we have given to chairmen of other advisory councils. 21

The secretary, the role of secretary is going to determine the presence of a quorum. Will be in line with the normal duties of a secretary under Robert's Rules of Order. The council can adopt additional officers. Looking

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at this, we didn't see a need to do that at this time. 1 Τf 2 you guys have visions for additional officers, we would certainly like feedback in terms of that. 3 All members of the council are eligible to serve as 4 officers of the council, so whether -- whatever your 5 6 affiliation, it does not prevent you from being an officer 7 on the council. Role of the Department of Health. The Department 8 of Health is directed under Florida statute to administer 9 10 the council. So we will work to provide meeting space; do the scheduling; public notices; agenda setting. 11 We will facilitate the activities of this council. 12 That is our 13 role. Ultimately council business that we come together and 14 put in our charter is the responsibility of the council, but 15 we will help you put the meetings together, and we'll help 16 make the council activities happen. 17 There are a couple of different kinds of meetings. 18 I just want to kind of run through them. Regular meetings, 19 the statute requires us to meet at least quarterly, so those 20 will be our regular meetings. If there's need to have a 21 formal meeting outside of the quarterly meeting, we'll call 22 those special meetings. They're required to be noticed 23 seven days in advance. We are going to try to provide as 24 much advance notice as possible for those meetings, to 25 ensure that everybody has the opportunity to facilitate.

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ORIGINAL

There are more people, obviously, that need to facilitate 1 2 than just the council members. We hope to get everybody in the trauma community to be engaged in council activities, 3 so, you know, we will put that notice out as soon as 4 5 possible for regular and special meetings. 6 Emergency meetings are very complicated, but there 7 is a procedure in Statute 120 that allows us to schedule emergency meetings. This is determined if there is a public 8 9 health emergency or something that affects the safety and 10 welfare in the state of Florida, there is a procedure for us to schedule emergency meetings. 11 12 I want to talk about the commons hour concept.

13 What this is, is an idea where we provide a telephone line, 14 or a meeting space, or both. The council doesn't take any 15 official action. It's an informal opportunity for council 16 members to dialogue and take up council business informally. Anybody can listen in. Anybody can participate, but it 17 18 allows -- I think it will facilitate some of the work of the 19 council inside of the sunshine, and be as least disruptive 20 to everybody as possible.

What we would require is that you guys come to us and say, we'd like to have a meeting to discuss trauma transport protocols, or whatever the issue is. We can go ahead and notice those meetings with an agenda. The agenda will simply say "informal discussion," so there's an

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1	opportunity to deviate from there. But I think it provides
2	us an opportunity to have constant dialogue in the sunshine.
3	MR. ROSS: Excuse me. A question: If indeed
4	public attends that meeting, since it's publicly noticed,
5	are they permitted to be part of that discussion as well?
6	MR. LEFFLER: The question is, is public
7	participation allowed during those meetings? Yes. This is
8	an informal opportunity. The stakeholders obviously have
9	business that's affected by whether it's council
10	subcommittees or other things that are going on, so we
11	encourage everyone to participate.
12	MS. COLSTON: However, the same rules apply. They
13	will complete a speaker card and be able to provide public
14	comment at the end.
15	MR. LEFFLER: Correct.
16	The next article is Article 6. It relates to
17	committees, subcommittees, and ad-hoc workgroups. Council
18	can create its own committees and subcommittees as they
19	need. We would like to work together to keep council
20	subcommittees anchored on the charter of the missions of
21	council, so we want to kind of have some oversight and
22	thought when we create these subcommittees. But the council
23	has the opportunity to create those committees. It should
24	be headed by a member of council, and are generally made up
25	of three to ten persons. Subcommittees are two to five

1	persons. It just needs to be a member of the committee, so
2	if you have someone who is not a council member, they can
3	head up a subcommittee. Ad-hoc workgroups are designed for
4	special assignments.
5	Annually, council will create a charter. We'll
6	work with the department to create a charter. This will
7	guide the activities of those committees, subcommittees, and
8	workgroups.
9	Article 7 just says that the council will approve
10	bylaws by a two-thirds vote.
11	Anyway, we'd like you guys to look over this in the
12	next couple of weeks, and provide input. My hope is that
13	when we come back together in July, this can be the first
14	order of business of the council so that we can set up and
15	institute rules that we need to function.
16	Are there any questions?
17	DR. ELIAS: I just have a question regarding
18	subcommittees. So if two and three committees are doing
19	work, how does that affect sunshine?
20	MR. LEFFLER: If there's a subcommittee and there
21	are two people who are not appointed to the council doing
22	work for the council, is that considered sunshine activity?
23	DR. ELIAS: Or even if they are council members.
24	MR. LEFFLER: If they are council members, it would
25	certainly need to be public notice.

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1	MS. BUSH: Certainly. Absolutely. So we're
2	talking about a subcommittee. If they're talking about
3	issues that are going to foreseeably come before this
4	council or are before this council, then it either needs to
5	be publicly noticed, or you need not to discuss it.
б	Again, if it's a subcommittee, there certainly
7	could be nuances if there's a subcommittee that comes out of
8	this group.
9	MR. LEFFLER: The department is going to notice,
10	err on the side of caution, all meetings that are related to
11	council business.
12	DR. NAMIAS: So I sit on the Florida EMS Advisory
13	Council, which Mr. Kemp chairs. As an outsider to
14	government coming in, this thing is serious. Basically, if
15	you're going to talk to somebody else about anything to do
16	with this committee, it's got to be in the sunshine. It
17	seems onerous, but if you think about it, it's probably a
18	good thing; it's just a little difficult.
19	MS. COLSTON: Again, we will pretty much facilitate
20	as we need to, as we need meeting time. We're going to
21	establish a schedule of meetings today, so those will be
22	opportunities, especially with the commons meetings, that we
23	can set up where you don't have to be there, but if you want
24	to talk about stuff you can.
25	MR. LEFFLER: And a copy of these bylaws is

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available on the Florida Trauma System Advisory site. 1 I have a bunch of -- first I want to 2 DR. NAMIAS: thank you for -- although these were provided sort of 3 last-minute, thank you for providing a few weeks now to go 4 over these, so that we're not just pushing these things 5 6 through today. 7 But this is the only chance to talk about it with council, so I'd like to make a few comments that people 8 might want to think about. I guess we'll need to know and 9 10 have as part of this what will constitute a quorum when we get together. If three members show up and two vote, does 11 12 that count? I don't know if that's a state law, or rule, or 13 whatever, but --14 MR. LEFFLER: I believe the quorum question is addressed in there. I believe it's 50 percent plus one. 15 Ιf 16 not, we certainly can add that. 17 DR. NAMIAS: It did say that some things would be 18 voted on by 50 percent plus one. The reason we got to this 19 place where we are now is because of the contentiousness 20 there's been in the state for the last almost ten years now. 21 So 50 percent plus one would allow there really to be voting 22 blocs without consensus. 23 I think we should adopt something like two-thirds 24 or 75 percent, so that way even if there is a bloc it would 25 require, reasonably, people from the other bloc, so

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1	hopefully what we're serving is the people and not our
2	MR. LEFFLER: I agree. If that's something you
3	suggest, that you guys feel is necessary, we certainly would
4	be open to that. I will say that this council (sic) will
5	listen to all points of view of the council. If the council
6	passes a resolution, it doesn't mean that the other side of
7	the issue is not heard, and the department hasn't gleaned
8	concepts from that. But we would certainly be open to
9	75 percent, or whatever you guys feel is necessary.
10	MS. COLSTON: What I'm hearing is that one of the
11	recommendations, just so that we're clear because I'm
12	taking notes is that we want to make it a 75 percent
13	majority with the vote. So we will insert that in. Does
14	everybody understand what that recommendation is, what we're
15	asking?
16	DR. REED: I heard suggested two-thirds.
17	DR. NAMIAS: I don't know, but not 50 percent plus
18	one. If there's some other set of rules of procedure that
19	has a standard set for this, then we should do that, but I
20	think 50 percent plus one really puts a risk that we get a
21	bloc.
22	MS. COLSTON: I definitely understand.
23	DR. NAMIAS: Our goal is to serve the people.
24	MS. COLSTON: We're going to go ahead and here's
25	what I recommend that we do. This is a little bit out of

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1	the Robert's Rules of Order type of meeting, because it's a
2	workgroup session.
3	Can we entertain a motion to change the bylaws
4	to
5	DR. NAMIAS: Can we do that?
6	MR. LEFFLER: Just before we take that up, I just
7	want to be clear. These bylaws belong to the council.
8	These are your bylaws, so it's up to you guys to decide what
9	is the way you want to do business. This was just
10	recommendations from the department, from looking at
11	different councils and other workgroups within the
12	department.
13	DR. REED: It says draft all over it.
14	MS. COLSTON: Correct, sir. I'll entertain a
15	motion and a second. I need to note we have a court
16	reporter, but Kate if you could also be documenting our
17	action items from here, and I am as well.
18	DR. NAMIAS: We make a motion to change a draft; is
19	that what we're doing?
20	MS. COLSTON: We're making a motion to change
21	something very specific. It's kind of outside what the
22	standard is.
23	DR. NAMIAS: I make the motion that all of our
24	business, in order to pass, has to pass by a two-thirds
25	majority of those present.

1	MS. COLSTON: Of the membership. Our quorum would
2	be two-thirds. We're kind of redefining our quorum at this
3	particular point. There's a motion on the floor to amend.
4	Is there a discussion? Questions?
5	DR. McKENNEY: Sometimes the meetings will be
6	inconvenient with the call schedule. Is there a way to
7	phone in so you have all 12 members? You start getting down
8	to small numbers and
9	MS. COLSTON: Absolutely. Yes, absolutely. We did
10	have a phone line for today and we will
11	DR. McKENNEY: Going forward, we'll have a phone
12	line, and you can vote on that phone line if you're present
13	on the phone?
14	MS. COLSTON: Absolutely, as long as it's you and
15	not your clone or anything like that. We want a real member
16	of council.
17	DR. NAMIAS: What if it is your clone? Let's say
18	Dr. McKenney happens to be called into a mass casualty and
19	he has to go operate. Can his trauma program manager sit
20	in? Can he have a clone, subject to the rules of
21	attendance? I would say this says that if you miss two
22	consecutive meetings, you're out. If he sends his proxy to
23	two consecutive meetings, he's still out or me, or
24	whoever.
25	MS. COLSTON: I will defer to our general counsel

1 on that. 2 MS. BUSH: The question is whether or not their 3 proxy can vote? Yeah. Like you said, there's a lot of 4 DR. NAMIAS: trauma surgeons here, busy people, not really very well 5 So, for instance, if I can't make it because I'm 6 scheduled. 7 called away to an emergency, or I have a planned something that I have to go do; instead of losing the voice of my 8 9 position, can a proxy take my position for that vote or the 10 next one, still subject to -- you can't be appointed and then delegate to somebody. If you do it twice in a row, it 11 12 counts for two absences, and you're fired. 13 MS. BUSH: The question for me is, are you allowing 14 for proxies within your bylaws? DR. NAMIAS: Can we do that? 15 16 (All talking at once.) MS. BUSH: -- appointed by the governor's office --17 18 MS. COLSTON: Yes, and that's where I hesitate. Ι 19 would assume if we can document proxy votes --20 MS. BUSH: We have to confer with the governor's 21 office on that. We have to get back to the group. 22 MS. DICK: I think the issue that's a little gray 23 for me is that these are appointments by name. Some are 24 done by agency only. So I'm drawing an analogy to the Domestic Security Oversight Council, which Dr. Philip is 25

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actually the appointed member, but I serve at every meeting and vote. But I don't know. We'll have to work with the governor's office to determine if it's -- since these were appointments that were applied for and selected by name, if it's different in this case. We'll certainly get back to council.

7 DR. NAMIAS: My only point is -- as you bring this 8 to the governor's office -- we are not trying to lighten the 9 responsibilities of the member. The member needs to find 10 the proxy. The proxy has to be there. If you send a proxy 11 twice in a row, you're absent twice in a row.

MS. DICK: Understood. It may be a case where -- I don't know, we have to find out the legal answer to this -but it may be a case where you designate a specific proxy, if it's allowed, and that specific person is the only person that can come. That's a great question. We'll get that information and bring it back to you.

18 MR. LEFFLER: I will take that up next time, as19 soon as we get back.

20 DR. NAMIAS: One more question. We made a motion 21 and a second. Do we vote?

MS. COLSTON: Do we have any other discussion about changing it to a two-thirds vote of the quorum, so the actual membership of the council, 12 members, two-thirds of that, we are going to change that --

1	DR. SUMMERS: I think there's confusion.
2	Two-thirds of the members represent a quorum? That's
3	totally different than a vote of two-thirds.
4	MS. COLSTON: I'm sorry. So it's two-thirds of the
5	membership would equal a quorum? Thank you.
6	DR. NAMIAS: No, that just means that we can vote
7	with two-thirds of the people there. What I'm saying is
8	whatever we define a quorum as, if we make quorum, of those
9	who are voting you need a two-thirds majority to pass any
10	MR. LEFFLER: I'm not trying to confuse the
11	question on the floor, but you're saying that a quorum is
12	50 percent, but two-thirds to pass a resolution?
13	DR. NAMIAS: I haven't said what the quorum should
14	be. I don't know what the quorum should be. Whatever the
15	rules for a quorum are, I'm good with it, whether it's two
16	people, or five people, or ten people, or all the people,
17	whatever that is.
18	Of those if we have established quorum so that
19	we can have a meeting and business, of those members that
20	vote there should be a two-thirds majority to make anything
21	happen, so that we avoid the risk of a bloc vote.
22	MR. ROSS: As an example, if I understand correctly
23	there are 12 members on the council. If we do a quorum
24	at three-quarters, that would be nine people. Then
25	two-thirds of the quorum, you would need six to pass the

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1	vote
2	MR. SUMMERS: Eight.
3	MR. ROSS: No, of those present would be six, of
4	those present to have a quorum. I'll repeat it. Maybe I
5	said it incorrectly.
6	If we have 12 people on the council, and a quorum
7	is three-quarters, it's nine people. To pass something is
8	two-thirds. You would need six people.
9	DR. NAMIAS: Exactly right. Yes.
10	MS. COLSTON: Okay. Any comments or questions
11	about that?
12	MS. YORK: I think it goes back to if you can't be
13	here, how can you vote?
14	DR. MCKENNEY: Well, you could be on the phone;
15	right? You don't have to physically be here. You can be on
16	your phone, but if you're not at your phone then you get the
17	quandary if you can have a representative or not.
18	DR. NAMIAS: And that's a separate question.
19	We've already said and I didn't know that if Dr. Ang
20	can't make it, he can call in on the phone and be present,
21	and he can vote; right?
22	MS. COLSTON: That's correct.
23	MS. DICK: Hang on, Leah, for just one second.
24	Just for clarity's sake, there's really two issues on the
25	table here, and I think we should separate them. One is

	F F F F F F F F F F F F F F F F F F F
1	what a quorum is.
2	DR. NAMIAS: And I didn't ask that. Whatever a
3	quorum is.
4	MS. DICK: So that's either part of this motion or
5	not. Do you want quorum to not be part of what you're
б	discussing right now?
7	DR. NAMIAS: No. I don't want it to be part of
8	this.
9	MS. DICK: Your motion is that two-thirds of the
10	members present
11	DR. NAMIAS: Of the members voting.
12	MS. DICK: Takes two-thirds to pass, of the members
13	voting. I'm assuming you wouldn't have a vote if there
14	wasn't a quorum.
15	DR. NAMIAS: Correct.
16	MS. DICK: So that's two different issues there.
17	We heard I heard discussion initially, two-thirds of the
18	whole council.
19	DR. NAMIAS: No. No.
20	MS. DICK: So the motion is, two-thirds of the
21	members voting to pass, period?
22	DR. NAMIAS: Correct. Yes.
23	MS. DICK: More discussion on that issue?
24	MS. COLSTON: So what are we defining quorum as?
25	MS. DICK: Don't do that yet.

1	MS. COLSTON: Okay.
2	MS. YORK: I thought I got it, but now I'm
3	confused. I thought your initial concern was having a bloc
4	of people. So if you have a vote in an official quorum, and
5	you only need two-thirds of that, you could in fact then
б	have a bloc.
7	So that's different than saying two-thirds of the
8	council have to approve it. So that's where I got confused.
9	MS. DICK: That's what I was trying to clarify.
10	DR. NAMIAS: I think if you accepted this
11	appointment, you need to make it a point to be here. If you
12	choose to abdicate your responsibility to be here, then
13	you've given up your position to whatever bloc might form.
14	You need to be here.
15	It needs to be noticed well in advance, so we can
16	confirm our schedules. You need to have the opportunity to
17	do it by phone if we can't do the travel. That's a good
18	thing. I didn't know we had that. We're going to ask if we
19	can get a proxy
20	MS. DICK: We're going to find out.
21	DR. NAMIAS: We're going to find out. That would
22	also make it easier to vote. But, yes, it does mean that if
23	the members who chose to come were all on one side or the
24	other of an issue, yes, they could be a bloc that's how
25	politics and government work so be here, I guess.

1	MS. DICK: I'm just trying to clarify what the
2	discussion is.
3	DR. NAMIAS: So you're saying if, for instance
4	what is typically a quorum in these councils?
5	MS. DICK: Fifty percent, plus one.
6	DR. NAMIAS: So 50 plus one, so we need six?
7	MR. LEFFLER: Plus one, so seven.
8	DR. NAMIAS: So if we have seven, two-thirds of
9	that seven, what does that work out to?
10	MS. DICK: Two and a third.
11	DR. REED: Say a couple of members are carpooling,
12	and crash, and are hospitalized. Okay.
13	MS. DICK: The other members are operating on them,
14	and the meeting is canceled.
15	DR. REED: My question relates to unavoidable
16	nonattendance, meaning you can't even get on the phone. Do
17	we have an option to later cast our vote on an issue?
18	MS. DICK: I want to be really clear this is
19	what I whispered in Michael's ear before, that he tried to
20	iterate on my behalf this is all up to you, these entire
21	bylaws. If you want to say you can be absent all the time;
22	if you want to say people can never be absent; if you want
23	to say they're absent but they have a justifiable reason, so
24	it shouldn't count against them; these are your bylaws.
25	DR. REED: I think on the issue of voting on

ORIGINAL

1	things, it is separate from the quorum for an actual
2	meeting, a public publicly noticed meeting. For the
3	actual vote we would like the input of all members, whether
4	they attend or not. I don't see why we can't get votes from
5	the people who are there, but then follow up with e-mail or
6	whatever to those members who are not.
7	MS. DICK: You can't follow up. You can't follow
8	up, because voting has to be in the sunshine. You can't
9	follow up. It has to be in the sunshine.
10	DR. REED: What I'm saying is, the members who were
11	unable to attend for unavoidable
12	DR. NAMIAS: That's the problem. That vote is out
13	of the sunshine. Their vote would have to be publicly
14	noticed.
15	MS. DICK: What I would suggest in that
16	circumstance is that you defer that vote until everybody is
17	ready. You can hold these commons hours, you can do a
18	week's notice, and we can convene for that specific issue
19	and revote.
20	DR. NAMIAS: Can we vote at commons hours?
21	MS. DICK: You can. We publicly notice it and
22	DR. REED: I think that would be preferable, so we
23	get input from all the members on any votes, any issues, you
24	know. So we have to have a full vote cast.
25	MS. DICK: That's up to you guys. There's a motion

1	on the floor I'm trying to we're getting into multiple
2	things.
3	DR. NAMIAS: Two-thirds of the vote
4	MS. DICK: The motion on the floor is two-thirds of
5	the people present, which is very different than two-thirds
6	of the council. The motion on the floor is two-thirds of
7	the people voting
8	DR. NAMIAS: Let's say people voting. It sounds
9	like we're also about to change who might vote and when.
10	MS. DICK: Two-thirds of the people voting on an
11	issue; that's your motion?
12	DR. NAMIAS: Yes, that's the motion.
13	MS. DICK: Even if I'm not going to confuse
14	anybody.
15	DR. NAMIAS: rabbit-hole scenarios.
16	DR. REED: That carries the vote.
17	MS. DICK: Two-thirds of the people vote, is the
18	motion?
19	DR. NAMIAS: Yes.
20	MS. DICK: Are we good? Any more discussion on
21	that? Do you guys want to officially vote on it? Do you
22	want to just nod if that's something you want us to we're
23	going to continue these bylaws at another meeting. We can
24	agree that we're going to edit the bylaws to incorporate
25	that change.

1	DR. NAMIAS: This is a discussion. So if anyone
2	wants to discuss it but it seems like no one is really
3	objecting to that idea.
4	DR. REED: Here's the rabbit hole. Do we need
5	two-thirds to pass this vote?
6	MS. DICK: No, because we're not voting. You will
7	when you get to adopting bylaws, but we're not I want to
8	make sure that we're
9	DR. NAMIAS: These bylaws are ours, you know.
10	Larry, you know, you're sort of the moderator by default
11	today because you're sort of from outside. We'll just look
12	to you, since you're holding the microphone.
13	MS. DICK: What might be easier is so we've got
14	this issue to incorporate into our edits. I understand
15	you've not made a final decision on anything. What might be
16	beneficial is to just take these bylaws out and just go
17	through them one by one. I heard you discuss quorum, how
18	many. I heard you discuss voting. I heard you discuss
19	attendance.
20	Why don't you just go through them, and whatever
21	collective suggestions you want to make for edits, you want
22	us to bring back to the group when next you meet, then you
23	guys can discuss and vote on them.
24	DR. REED: Did we ever second the two-thirds?
25	MS. COLSTON: No.

ORIGINAL

1	MS. DICK: I think we had a nod, a bunch of nods.
2	MS. COLSTON: Do we have a second?
3	DR. IBRAHIM: Second.
4	MS. COLSTON: Dr. Ibrahim seconds. Okay. So we're
5	going to insert that.
6	We're going to go ahead and walk back, start on the
7	first page and discuss what the bylaws are. So the name,
8	Article 1, the name of the council. The short title; do you
9	guys want to revisit the short title, either Council or
10	FTSAC? Any changes?
11	DR. NAMIAS: It's fine. We need not worry about
12	the name.
13	MS. COLSTON: Excellent. So we're good with
14	Article 1.
15	Article 2 is composition and membership. So it
16	kind of just lays out what Statute 395.402(2)(b) outlines
17	DR. NAMIAS: That's in statute; right? So there's
18	nothing to discuss.
19	MS. COLSTON: Absolutely.
20	DR. NAMIAS: Is the part about attendance in the
21	statute?
22	MS. COLSTON: No. That would be our next point of
23	discussion. So this is you have a question?
24	MR. KEMP: I would say for the members failing to
25	be physically present or if they can't make a phone call, I

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1	think we should allow the moderator, if there is a good
2	excuse, if someone gets in a car wreck and can't get here,
3	that the moderator has the ability to give excuse that
4	absence, so that people are not thrown off council.
5	DR. NAMIAS: I suppose that, since this is a trauma
б	council, that we wouldn't schedule these meetings during the
7	meetings of the Eastern Association, the Western Trauma
8	Association, The American Association for the Surgery of
9	Trauma, the American College of Surgeons, the American
10	Surgical Association, the Southern Surgical Association, all
11	of the things that many of us are likely to be at.
12	MS. COLSTON: Absolutely.
13	DR. McKENNEY: You could call in if they were at
14	the same time. There's six or eight meetings
15	DR. NAMIAS: It will be tight.
16	MR. LEFFLER: We're taking this up as a different
17	agenda item later on, but at least for this first year our
18	vision is that this council meets in conjunction with the
19	EMS Advisory Council. I know you have lots of other things
20	that you attend, but we felt that was the most natural link
21	as far as facilitating an inclusive trauma system, was to
22	have all the components at the table if possible.
23	So at least for the next year we're looking at
24	meeting in conjunction with the EMS Advisory Council, but
25	that's up to you guys.

1	MS. COLSTON: Today if we can get kind of those
2	dates, so we can look at trying to schedule walk out of
3	here with at least a meeting schedule for the next
4	DR. NAMIAS: EMSAC is probably scheduled; isn't it?
5	MS. COLSTON: EMSAC is scheduled for July 9th
6	through the 12th right now. That is our next anticipated
7	meeting for the EMS Advisory Council.
8	We're doing that because we have got a task in
9	front of us and we want to give you guys the opportunity to
10	start working on that. But we do want to get these other
11	dates that we're talking about, so when we discuss the
12	meeting schedule development after this, we'll kind of start
13	looking at dates.
14	DR. NAMIAS: So, Mac, you're proposing that the
15	moderator get to decide if someone's excuse is reasonable?
16	MR. KEMP: Yes.
17	DR. NAMIAS: I like that.
18	MS. COLSTON: Is there a motion to make that change
19	in the bylaws, the draft bylaws?
20	MR. KEMP: I make that motion.
21	MS. COLSTON: So we're going to leave the council
22	members failing to be physically present for two consecutive
23	or three total regular meetings, we're going to leave that
24	language in there. We're just going to add, moderator may
25	excuse the absence for good cause. Is that language okay

1	with everybody?
2	DR. NAMIAS: Yes.
3	MS. YORK: Is this going to be defined? Do you
4	have to be physically present, or does physically present
5	include phone?
6	MS. COLSTON: We can just remove the word
7	"physically," and just leave "must be present." That would
8	cover us for telephonic
9	MS. YORK: Okay. Because being physically present
10	and being on the phone is not the same thing.
11	MS. COLSTON: So the ask is to remove "physically."
12	Motion?
13	MR. KEMP: So moved.
14	MS. COLSTON: Second?
15	DR. McKENNEY: Second.
16	MS. COLSTON: Okay. So that is our edits that
17	we're going to incorporate for Article 2, composition and
18	membership.
19	Moving forward to Article 3, purpose. So the
20	purpose of the council is kind of just very generic. I
21	think we pulled this language out of statute and some other
22	areas.
23	Do we have any recommendations for edits to this
24	particular section?
25	DR. NAMIAS: Would the council participate in rule

1	development?
2	MS. COLSTON: Yes.
3	DR. NAMIAS: Is that in this somewhere?
4	MS. COLSTON: Number 3, "Provide recommendations to
5	the department on state statutes, administrative rules,
6	planning documents, and policies related to the care of
7	severely injured persons."
8	MR. ROSS: Something that I would suggest we
9	recognize that every topic is going to have pros and cons.
10	We are going to make reports and/or recommendations. I
11	think it would behoove us and be of benefit if at the end of
12	the report we put in the minority opinion, so that advice is
13	heard.
14	MS. COLSTON: Your recommendation is to include
15	some statement in here about providing recommendations,
16	maybe in Number 3
17	MR. ROSS: That's where I put it.
18	MS. COLSTON: Okay. So give me the language again.
19	Minority opinion
20	MR. ROSS: Minority opinion be expressed.
21	DR. NAMIAS: Like the supreme court.
22	MR. LEFFLER: That's what I was saying earlier.
23	The department is going to hear feedback from all points of
24	view, regardless of what the council's recommendation
25	MR. ROSS: It's good to have a council the

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1 recognition by others that the council discussed this. 2 MS. COLSTON: Okay. So I'm going to draw up some draft language. You guys can shoot it up as you want to. 3 Minority opinions shall be represented in all 4 5 recommendations provided by this council. 6 DR. McKENNEY: It's probably a dumb question, but 7 where does the majority opinion go? MR. KEMP: It's in the main recommendations. 8 9 DR. McKENNEY: But who does it go to? Literally, 10 where does it go? Where do we send it? MS. COLSTON: So that would depend. We're your 11 12 administrators. We're going to take that, whatever it is --13 it depends on what it is. We would then put that through 14 our chains as far as -- let's say, for example, it's a rule 15 change. So the recommendation comes from this council, then 16 of course it would come to us as the trauma section folks. 17 We would then push it to our general counsel, our executive 18 leadership team, so that we can manage it appropriately and 19 make sure that whatever the recommendations are, our legal 20 has had -- then we would conduct the rule workshops and all 21 of the rule promulgation activities associated with that. 22 MS. DICK: There also is, I think, an expectation 23 that this council creates and submits to the legislature a 24 report at the end. There's a specific statutory requirement 25 for that.

1	MS. COLSTON: Yes.
2	MS. DICK: That report would then go to the
3	legislature. Other kind of more routine business would
4	funnel up from the surgeon general.
5	
	MR. LEFFLER: Like I said, part of the advantage of
6	this council is the ability to talk about some of these
7	administrative rule changes before we have formal workshops
8	and formal hearings where our communication is somewhat
9	limited. It allows us to have collegial discussion outside
10	of the rule promulgation process.
11	DR. NAMIAS: What this is doing is basically what
12	the Florida COT used to do, which is good, except now you
13	have it legislatively mandated, balanced membership, you
14	know, so that it's, theoretically, if it works the way it's
15	supposed to, truly representative.
16	MR. LEFFLER: Correct.
17	MS. COLSTON: Okay. Any other discussion?
18	MR. ROSS: I had one other thought. That is on
19	page 2, last sentence: "The council shall have a defined
20	charter or work plan approved by the department and the
21	council." I think it should state with priorities, you
22	know, listing the priorities as such, in order, so that
23	we'll know what we're working on first and what's going to
24	come up at the end.
25	MS. COLSTON: Okay. Once we discuss that, I'm

1	happy is that a recommendation through a motion?
2	MR. ROSS: Motion.
3	MS. COLSTON: Second?
4	DR. McKENNEY: Give me the motion one more time.
5	MS. COLSTON: So the motion for Article 3 I'll
6	list both of them is to add to Number 3, "Minority
7	opinions shall be represented in all recommendations
8	provided by the council."
9	And at the very end where it talks about, "The
10	council shall have a defined charter or work plan approved
11	by the department," we are going to add, "with defined
12	priorities."
13	DR. REED: With prioritization of issues.
14	MS. COLSTON: Excellent.
15	DR. McKENNEY: Second.
16	MS. COLSTON: So we have a motion and a second.
17	Moving on to article did that answer your question,
18	Dr. McKenney?
19	DR. McKENNEY: Yes.
20	MS. COLSTON: Article 4, officers. As Michael
21	mentioned, we said we have a moderator and secretary. If
22	you decide otherwise, we can change that. As it stands now,
23	the recommendation is to have a moderator and a secretary.
24	These officers are going to be selected by majority vote of
25	the council, and approved by the state surgeon general.

These officers will serve a one-year term, much like the EMS
Advisory Council chair does, and may be reappointed for
consecutive terms, not to exceed two.

Are we good with this first statement, thedefinition of officers? Mac?

6 MR. KEMP: Being the chair of a council, this may 7 sound silly. But a parliamentarian has been of great assistance to me, because you're so intent on running the 8 9 meeting and doing whatever, that when something comes up on 10 how to proceed through the Robert's Rules of Order, all that sort of thing -- it's not what I'm thinking about. 11 So just 12 having someone that I can turn to and say, what's the proper 13 process to go forward. Just having someone in that role that understands. 14

15 MR. LEFFLER: We considered a parliamentarian. We 16 certainly can add that to this as a recommendation. We 17 could also provide department staff that can serve as 18 parliamentarian. Obviously, we're not a member of council.

MR. KEMP: It's just helpful to know how to proceedwhen you get stuck.

MS. COLSTON: All right. We can do a combo, add a parliamentarian to be filled by department staff, if that's okay. Is that a motion, Mac?

24 MR. KEMP: Yes.

25

MS. COLSTON: Second?

1	MR. SUMMERS: Second.
2	MR. ROSS: One other thought that I had with regard
3	to secretary. Rather than having anyone on the council
4	doing this with any slant possible, DOH may be the one,
5	rather than us designating somebody here. DOH has the
б	transcripts, DOH has the administrative issues dealing with
7	the meetings. I would suggest that the secretary be the
8	DOH.
9	MS. COLSTON: Okay. Any questions or discussion?
10	DR. REED: Do we even need that position, then?
11	Can we just have the DOH staff support that role?
12	MR. LEFFLER: The motion would be that DOH would
13	serve as secretary and parliamentarian?
14	DR. REED: Second.
15	MS. COLSTON: We have a second. So when we define
16	the secretary we are going to just change some language.
17	Secretary will be staffed by department program staff to
18	ensure accurate minutes, et cetera.
19	DR. NAMIAS: Not being a parliamentarian myself,
20	does anything in Robert's Rules of Order contradict what we
21	said about what we're going to require for a majority? Does
22	Robert's Rules just say who gets to speak when, or does it
23	define what is a majority, and a quorum, and all that?
24	MR. LEFFLER: My understanding with Robert's Rules
25	of Order is that it allows the institution to set up those

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1	rules. We can certainly provide the background on that
2	issue. We'll clarify that. My understanding is that it
3	allows the institution to decide.
4	MS. COLSTON: Mr. Ross?
5	MR. ROSS: If indeed Robert's Rules may not permit
6	such, I would suggest I know that a number of legislative
7	bodies, of which I guess this is one, distant cousin, call
8	it what you want use Mason's Manual. That may be more in
9	concert with what we've already stated. So you may want to
10	use that.
11	MR. LEFFLER: We'll look at that, too. We could
12	even add a statement in there that says the council shall
13	use modified Robert's Rules of Order, as approved by the
14	council. We'll find a way to incorporate that.
15	MS. COLSTON: So I'm going to go back. I'm not
16	sure, did we second changing parliamentarian being a DOH
17	position and also
18	DR. NAMIAS: I second.
19	MS. COLSTON: Okay. Great. Do we want to add any
20	other officers, other than parliamentarian?
21	MS. DICK: Just a suggestion for the group. If
22	you're only having a moderator as the only council officer,
23	maybe you want a comoderator or a second
24	MR. LEFFLER: The bylaws do allow the moderator to
25	appoint a moderator pro tem.

ORIGINAL

1	MS. COLSTON: That's temporary.
2	MR. LEFFLER: But they could serve
3	MS. COLSTON: Do you want to have a comoderator, or
4	something along those lines?
5	MS. DICK: The person then automatically takes that
6	role if the moderator is, you know, called away to surgery
7	or
8	MS. COLSTON: I'm sorry. That's not an official
9	recommendation, just the council
10	DR. REED: I think it would be at the time of a
11	meeting. If the moderator is on the phone and goes away, he
12	could say, Nick, would you continue moderating until I get
13	back.
14	MS. DICK: What if you're the one in the car? If
15	you're the moderator and you're the one
16	DR. REED: Well, you could still do that by
17	designating that person or your surviving spouse.
18	(Laughter.)
19	MS. DICK: I guess that's my question. Do you want
20	to designate in advance somebody who would serve in that
21	capacity in the moderator's absence, or do you just want the
22	group to point at somebody and say, it's you today?
23	MR. ROSS: It makes sense to have another
24	moderator.
25	MS. COLSTON: Is there a motion to add a

1	comoderator position?
2	MR. ROSS: Yes.
3	MS. COLSTON: So pretty much the same language, it
4	will just say the comoderator will preside in the absence of
5	the moderator, or as otherwise designated.
6	MS. YORK: That gets rid of that pro tem?
7	MS. COLSTON: Yes, that's correct.
8	DR. NAMIAS: So we have to make sure they don't
9	travel to the meeting in the same mode of conveyance,
10	separate flights, or buses, or vehicles.
11	MS. COLSTON: Is there a motion to add a
12	comoderator, Mr. Ross?
13	MR. ROSS: Yes.
14	MS. COLSTON: Second?
15	MS. DiNOVA: Second.
16	MS. COLSTON: And a second. Any other additions?
17	Any other comments regarding Article 4, officers?
18	Moving forward, Department of Health's role. This
19	is just kind of basic generic language of what the
20	department is responsible for doing, as outlined in statute.
21	Do we need to look at that?
22	MR. ROSS: No. I would just reflect now the
23	secretarial and parliamentarian.
24	MR. LEFFLER: Ex officio?
25	MR. ROSS: Right.

1	MS. COLSTON: Moving to Article 6, meetings.
2	Michael talked to you a little bit about regular meetings,
3	special meetings, emergency meetings, and commons hours
4	meetings. Do we have any additions? Do we need to add
5	anything or edit any language?
6	DR. NAMIAS: The third line says physical
7	attendance. We talked about phone.
8	MS. COLSTON: Excellent. We'll say, "Attendance of
9	a majority of appointed council members." Where is that?
10	DR. NAMIAS: Article 6, fourth line.
11	MS. COLSTON: Okay. We'll change it. We'll make
12	sure that that lines up.
13	MR. SUMMERS: You just drop the word "physical";
14	right?
15	MS. COLSTON: Yeah. That's okay. I just changed
16	it. I took off the word "physical."
17	Any other comments?
18	DR. NAMIAS: Now we talk about the quorum.
19	MS. COLSTON: Okay. Let's talk about the quorum.
20	MR. ROSS: Exactly. My opinion, you were appointed
21	by the governor. You really have a responsibility to be
22	here. So I think two-thirds is even light, but two-thirds
23	would constitute a quorum.
24	DR. NAMIAS: I'm okay.
25	MR. ROSS: Three-quarters is better, to be honest.

1	DR. MCKENNEY: You can call in.
2	MR. KEMP: If that works, that's fine. Just be
3	aware being in another environment if you can't, for
4	some reason, have a quorum storm's coming is most common
5	it's embarrassing to have a publicly noticed meeting and
6	all that stuff, and no quorum. All you can do is sit and
7	talk and take no votes, do nothing. You're just kind of
8	just there.
9	So I understand. The higher you set the bar,
10	though, the more chance of likelihood there is that you're
11	going to have a meeting with nothing getting done of value
12	whatsoever.
13	DR. McKENNEY: A hurricane is really the one thing
14	that could bugger up a big chunk of the state. Maybe it's
15	best not to have a meeting where votes are taking place if
16	you're struggling to help get people or get yourself through
17	a hurricane. We can reschedule; right?
18	MR. LEFFLER: I can tell you from a department
19	point of view, if there's a hurricane we would cancel the
20	meeting.
21	MS. COLSTON: We'll do that with sufficient notice.
22	Hopefully by setting up a meeting schedule well in advance
23	we'll have some options. I know things change, but
24	hopefully having a meeting schedule well in advance we
25	want to try to get at least six months to a year, as far as

ORIGINAL

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1	knowing when our meetings are, so that y'all can plan
2	accordingly. We're going to try not to schedule on top of
3	other things. It's going to be an intricate dance that
4	we'll have to do, but we'll do our best.
5	But it's up to you guys if you want to set the bar
6	high. I think everybody here sometimes we go in with
7	good intentions. If this doesn't work for us our first
8	year, we're going to look at these again next year and we
9	can change it that particular point.
10	DR. McKENNEY: I like three-quarters. You can call
11	in. It seems like there should be very little to get in
12	your way.
13	DR. REED: And we may be able to submit proxies.
14	MR. LEFFLER: So we have a motion on the floor for
15	three-quarters?
16	DR. ANG: Second.
17	MS. COLSTON: So three-quarters of the council
18	constitutes a quorum. I'll put that language in.
19	Any other discussion about any of these meeting
20	types, committee, subcommittee, workgroup meetings?
21	MR. ROSS: Yes. One suggestion. With regard to
22	the regular meetings properly noticed to the public. At the
23	same time can the materials be sent to us, so that we have
24	at least seven days, which I think is even minimal?
25	MR. LEFFLER: I can tell you, we'll try and get

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1	stuff out as quickly as possible. We're looking at 30 days
2	at a minimum.
3	MR. ROSS: That would be perfect, because all of us
4	have lives and schedules.
5	MS. COLSTON: Absolutely. This time we were under
6	the gun to get the meeting scheduled. We'll have time for
7	you all to take a look at what's out here and what you have
8	in front of you, so we can vote on it, which is why we're
9	not looking at taking any action. We want to have something
10	good that we can walk away with, that we'll be voting on at
11	the next council meeting.
12	Any other discussion regarding Article 6?
13	DR. REED: Under special meeting, are we going to
14	change the physical attendance on special meetings, as well?
15	MS. COLSTON: We will change the word "physical" in
16	areas with reference.
17	DR. REED: Then the quorum for the special meeting,
18	as well?
19	MS. COLSTON: Yes.
20	DR. McKENNEY: Three-quarters.
21	MS. COLSTON: Okay. The last article is just a
22	statement that the bylaws may be established until otherwise
23	amended by two-thirds majority vote of council. Okay.
24	There are no other changes or edits
25	DR. NAMIAS: I'm sorry. Where?

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1	MS. COLSTON: Article 7, last page.
2	DR. NAMIAS: A two-thirds majority. Is that where
3	we voted a two-thirds majority of the entire council, or of
4	those present when voting? What is that; same as everything
5	else?
6	MR. LEFFLER: I would say my recommendation
7	would be for the adoption of bylaws to be two-thirds of the
8	council, the entire council.
9	MS. COLSTON: If we're going with three-fourths, I
10	would say three-fourths.
11	MR. LEFFLER: Excuse me.
12	DR. NAMIAS: Whatever it is, make it consistent.
13	MS. COLSTON: Absolutely. Got it.
14	DR. REED: Again, there is the issue of quorum
15	versus vote. We said three-quarters of the appointed
16	membership.
17	MS. COLSTON: Two-thirds of the members voting.
18	DR. REED: Two-thirds of the quorum?
19	MS. COLSTON: Okay. So maybe we need to change
20	wording here.
21	DR. NAMIAS: We said three-quarters is a quorum.
22	Then separately, whatever we vote on, it takes two-thirds to
23	pass a vote.
24	MS. COLSTON: Two-thirds of the voting members?
25	DR. ANG: Specific to the bylaws. It's not like

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1	other recommendations. The bylaws should have a more
2	stringent
3	DR. NAMIAS: A higher bar if you're going to change
4	the bylaws.
5	DR. ANG: Yes.
6	MS. COLSTON: So Dr. Ang made a comment so
7	everybody can hear that the two-third majority vote is
8	specific to the bylaws. He's stated that should probably be
9	more stringent criteria.
10	DR. NAMIAS: Two-thirds of what?
11	DR. ANG: Of everybody on the council as it is
12	right now.
13	MS. COLSTON: So just leave it as is?
14	DR. ANG: Correct, I'm saying as is. We made
15	changes to recommendations and voting by the council for
16	representation of those that are voting and present, but
17	this is for the bylaws, which I think should be more
18	stringent. Leave it as is.
19	MS. COLSTON: Okay. So a motion to leave it as is,
20	Article 7, bylaws?
21	DR. NAMIAS: Yeah.
22	MS. COLSTON: Second?
23	DR. NAMIAS: That's fine.
24	MS. COLSTON: Okay. All right.
25	MS. YORK: So once I get home this evening when

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1	it's raining, and I go through these again, how do I provide
2	any comments that I may or may not have?
3	MR. LEFFLER: I think the best thing to do is you
4	can send them to me. I could provide a document to the
5	entire council once I get everybody's comments. We can put
6	them at the top of the items motions to hear before we
7	vote on the bylaws. We can do live edits when we before
8	we vote on them, to make sure they're in line with what
9	council has.
10	So we can perform this exercise briefly once again
11	before we actually take up a vote on the bylaws.
12	DR. NAMIAS: I just feel compelled to make it
13	clear to people that might not have been involved in
14	sunshine before. The point is, you can send it to him
15	because he's not a member of the council.
16	MR. LEFFLER: I can communicate with all of you.
17	DR. NAMIAS: We can't send it to each other.
18	MR. LEFFLER: Right.
19	MS. COLSTON: We can disseminate them, because it
20	is a public document. We will disseminate everyone's
21	comments out prior to the meeting well in advance. But we
22	will take a discussion of the concerns at the next council
23	meeting. But you will send everything to the Department of
24	Health.
25	MS. YORK: Is there a deadline time?

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1	MS. COLSTON: Not yet. We'll set that up and
2	contact you. We are going to pull all this stuff together.
3	We're going to have a draft, a new draft of the bylaws.
4	We'll go ahead and get that out, get that up on the web so
5	everybody will have access to it, so you can digest what was
6	discussed here, and then we'll have a call for comments.
7	Okay. So at this point, unless there's further
8	discussion, we're going to conclude the discussion of the
9	bylaws. We'll make the appropriate edits, and we'll move
10	forward. Okay.
11	MS. COLSTON: Do you want to take a break?
12	MR. LEFFLER: For the record, we'll take ten
13	minutes.
14	MS. COLSTON: We'll reconvene at 10:45.
15	(A break was taken.)
16	MS. COLSTON: We'll reconvene right now. Before we
17	move to our next order of business we're going into
18	discussion of the charter Donna, you have a question?
19	MS. YORK: I have a question. Under the bylaws on
20	Article 2 because it says council membership shall be on
21	a voluntary basis, and members receive no compensation. Is
22	this expected to come out of my pocket, versus my work
23	people? That is my question.
24	MS. COLSTON: Well, you're asking if your job can
25	pay for your travel?

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1	MS. YORK: Exactly.
2	MS. COLSTON: Yes.
3	DR. REED: It should be, there's no compensation
4	from the state.
5	MS. COLSTON: We can make that change. No
6	compensation from the state. That is correct. That is in
7	the statute. It was surprising to us, because there is no
8	we will not pay for travel.
9	MS. YORK: I just wanted to make sure I was legal.
10	MS. COLSTON: It's not specific to who can pay for
11	it, but we can't pay for it.
12	MS. YORK: Okay. That's fine.
13	MS. COLSTON: Any other questions? Okay.
14	In your packets that you received you should have a
15	draft charter, kind of like this. Does everybody have one?
16	So this is what is referenced in your bylaws document. This
17	is going to be your charter work plan. We will work through
18	this with you. This will become the public record for the
19	priorities, so we can amend the bylaws to discuss
20	priorities. We'll get to where those priorities are going
21	to be listed.
22	Then once we complete this document and adopt it,
23	we will post this on the website as well. But this will
24	become our work plan for the year. We are going to define
25	what we want to do. One of the things is already
prepopulated in there, because the statute says so. We'll add additional things as necessary, based on council recommendations.

I just want to walk through this. It's kind of 4 simple. There's little qualifying statements in gray, just 5 6 to kind of help you guys understand what this is. We give a 7 background on the charter that defines why this team is in existence. It's not just because of HB 1165, although 8 9 that's what gives us the authority, but also because this is 10 a group to kind of give us recommendations on our trauma You can amend that statement, add to it, as you 11 system. 12 please. If you want to add more, try to keep it very simple 13 for purposes of discussion.

Council mission is the next area. It outlines what's important to this particular council, what is our mission, what do we want to do. I didn't feel like the Department of Health should even try to prepopulate that. This mission is going to be something that's defined by members of council, so you guys can think about that, what you want the mission to be.

Again, this is going to become something that is our guiding document for when you're talking about business, if you're giving updates, you can disseminate this as you want: here's what the Trauma System Advisory Council is currently doing. So think about what you want your mission

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1	to be, so that way we can accurately provide details on what
2	that is.
3	Dr. Reed?
4	DR. REED: Shouldn't the mission be the same as the
5	purpose?
6	MS. COLSTON: It should be, if that is the
7	recommendation. Okay.
8	DR. NAMIAS: You mean in the bylaws?
9	DR. REED: No, purpose meaning what's in this
10	background here: "The purpose of the council is to promote
11	an inclusive trauma system and enhance cooperation among
12	trauma system stakeholders by providing recommendations to
13	the Department of Health on how to maximize existing trauma
14	center, emergency department, and emergency medical services
15	infrastructure (including personnel)."
16	DR. NAMIAS: I second that. We could spend the
17	next three days wordsmithing a mission.
18	MS. COLSTON: All right. So motion and second for
19	moving the mission or defining the mission as "promoting an
20	inclusive trauma system," all that language all the way down
21	to the end of what is currently listed in that line.
22	DR. NAMIAS: Although I seconded it, it only
23	maximizes existing trauma centers, emergency department, and
24	EMS infrastructures. There's nothing about growth or
25	change.

1	MS. YORK: Right.
2	DR. REED: Okay.
3	MS. COLSTON: So let's add to that, then.
4	DR. REED: Existing and future. Existing and
5	future trauma centers.
6	MS. COLSTON: Any discussion or any other
7	recommendations on that? So if I might make a suggestion
8	for background, since we are going to move a majority of
9	this I'll leave the definition of the statute as our
10	background as to how it was created. If you guys have any
11	other background information that you want you know,
12	really we try to cite the authority, so that way our
13	authority is found in the statute, so we can leave it as
14	generic as the statutory language. Is that amenable? Yes?
15	Okay.
16	Any other changes, then, to our mission? Okay. So
17	the next section on the left, then, is council members
18	appointed by the governor. Of course, that is in need of no
19	edits. It's just simply an outline of who you are and what
20	your statutory representation is.
21	Lisa?
22	MS. DiNOVA: Under mine they have it as FHS. It's
23	FHA. It's a typo.
24	MS. COLSTON: Thank you. And we're going to place
25	some M.D.s on here. We do realize that I think we

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1	populated this based on something, so we're going to edit
2	that as well to add the M.D.s.
3	DR. NAMIAS: The time frame. So my understanding
4	I don't remember if it was in the law or where else I
5	might have read it my understanding is that this is a
6	three-year council. I understand that some people were to
7	have been appointed for one, some for two, and some for
8	three, so there's staggered turnover. This just says one
9	year, it doesn't say
10	MS. YORK: Under the charter.
11	DR. NAMIAS: The charter is one year?
12	MS. COLSTON: Yes. Because the time frame this
13	is really defining our time frame for completing things. If
14	we talk about so I have the initial meeting being 5/24,
15	but we can say one year effective whenever this is approved
16	to the next year. It depends on how you want to qualify the
17	time frame. It's really just saying a definitive date to
18	accomplish whatever our priorities are going to be that are
19	outlined in this particular document.
20	MS. DiNOVA: Should we then, under council members
21	where our names are, should we put what our appointment date
22	time frames are?
23	MS. COLSTON: No. You don't have to worry about
24	that. We'll manage that and update it as needed.
25	But the time frame, this is a time frame relative

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to what we identify as priorities and what we're going to complete. We're going to talk about, at the bottom of the page where it says assignments, action steps, and deliverable -- it's anticipated that those are the things that we want to complete in the next year.

6 We can change this time frame and make it two or 7 three years, whatever the case may be, but typically you're going to want to update this. So once that pediatric study 8 is completed, that's going to fall off. It's easy sometimes 9 10 when you're going in to update your bylaws, that you update your work plan as well. You can carry things over, add new 11 12 things, you can do whatever you want to, but this document 13 is really intended to kind of make sure we don't work on 14 things that we haven't identified as priorities. It kind of 15 helps us not do the scope creep thing, and keeps us lined up 16 and focusing in on the priorities at hand.

Any other questions? Okay. So we've got some 17 18 corrections to do with council members. We'll take care of 19 that. Moving over to stakeholders. This really kind of 20 just helps us keep in mind who our stakeholders are 21 internally, external to the council. I tried to put down 22 the ones that just immediately popped into my mind. Ιf there are others that are not included -- I know that there 23 24 are -- we want to kind of think about those as well.

If there are things that need to be communicated

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out -- this is going to help us in a number of different ways. For us, as administrators of the group, if we need to be communicating, messaging, doing anything of that nature, we want to be able to identify if we have addressed that stakeholder group and we haven't left that stakeholder group out.

7 If we're thinking along the lines of data collection or any information that we might need from 8 interested stakeholders, we need to identify who those folks 9 10 might be, and if there is a mechanism to obtain that data so 11 that we can make informed decisions as a council -- so that 12 you can, not me -- that we have reached out appropriately to 13 that particular group. It just kind of helps us understand 14 who might be impacted by the activities that are being 15 undertaken by this council.

Dr. Reed?

16

17 DR. REED: In Indiana when we set up our trauma 18 system -- which was really recent, just within the past 19 decade -- we also looked at rehabilitation, long-term acute 20 care facilities, those kinds of end-of-the-road care facilities for trauma, because it does hit the continuum. 21 22 In fact, we have all of those facilities even submitting 23 data to the trauma registry, so we can get a complete 24 continuum of care story about how trauma patients are 25 managed.

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1	I think this council would be very interested in
2	making sure that those aspects of the trauma patient's
3	journey are also reviewed, or changed, or fixed, whatever
4	needs to be done. That could be a part of this continuum.
5	MS. COLSTON: Absolutely. We actually do have a
6	registry, RMIS, Rehabilitation Management Information
7	System, with our Brain and Spinal Cord Injury Program, that
8	collects a lot of that data. We're going to try to tie
9	those two sets of data together.
10	That's a good call. Any other recommendations?
11	Donna, and then Dr. Ibrahim.
12	MS. YORK: I'd sort of like to see these realigned,
13	put the citizens and visitors at the top, because that's
14	really who we serve, then put everything else beneath it.
15	Should we have something in there, like the doctor
16	was talking about, with trauma and what you're going to do
17	with that? That's not listed.
18	MS. COLSTON: Absolutely.
19	DR. NAMIAS: Since the American College of Surgeons
20	verified this, and it's part of our part of this charter
21	later on is to study the use of the ACS versus the Florida
22	system for verification, is the college or college's this
23	is for discussion, I really don't know the answer do you
24	think the college's committee on trauma is a stakeholder?
25	MS. DiNOVA: I actually thought the same thing for

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1	FCOT or for AFTC also, the trauma coordinators, because
2	they'll be wanting reports back.
3	DR. NAMIAS: I think they probably are, at least
4	the Florida COT, and maybe the national COT or the American
5	College of Surgeons, but I guess then you get into whatever
6	college of neurosurgeons, orthopedists, all of them. Maybe
7	just COT, because that invites participation by all members.
8	MS. COLSTON: Any recommendation?
9	DR. ANG: What about health care providers that
10	provide trauma services, like physicians and nursing, as
11	opposed to one organization?
12	MS. DiNOVA: Where it says "trauma centers" "and
13	providers"; does that cover it?
14	DR. ANG: Yes, I think so.
15	MS. COLSTON: Trauma care providers, something
16	along those lines maybe.
17	DR. SUMMERS: Maybe that's a separate entity,
18	because that then becomes exclusive when you put trauma
19	centers there. Trauma health care providers is a lot of
20	folks at hospitals that are not trauma centers, that provide
21	a lot of initial care.
22	MS. COLSTON: So I'm going to remove trauma centers
23	and acute care hospitals, and put trauma care providers?
24	DR. SUMMERS: I think they certainly can be there.
25	MS. COLSTON: So leave them, but we'll add in

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1	trauma care providers. Let me recap to make sure. We've
2	gone over a lot.
3	We're going to move Florida citizens and visitors
4	to the top; add rehabilitation and long-time care. Disaster
5	management partners I'll come up with some folks. If you
6	have any specific ideas on who that might be, let me know.
7	We do work with disaster preparedness at the Department of
8	Health, so we can come up with some things.
9	I have American College of Surgeons or the National
10	Committee on Trauma, FCOT, trauma program managers, trauma
11	care providers. That's where we are right now.
12	Let me get Dr. Ibrahim now.
13	DR. IBRAHIM: They may be included in this, but you
14	said disaster management, so we're kind of on the same page.
15	What about law enforcement? Do they fall under any of
16	these, or should we include them separately? They are
17	involved in a lot of it as well.
18	MS. COLSTON: I think that would be separate.
19	MR. ROSS: Any local trauma agency, if there are
20	any out there, I think that's important.
21	MS. COLSTON: Adding in local/regional trauma
22	agencies.
23	Dr. Elias?
24	DR. ELIAS: Health care coalitions.
25	MS. COLSTON: Is everyone here familiar with what a

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1 health care coalition is from the Department of Health 2 standpoint? Do you mind talking about that a little bit? 3 DR. ELIAS: So across the state there are health 4 5 care coalitions, which are basically a collaboration of a 6 full spectrum of providers: EMS, hospitals, nursing homes, 7 dialysis care centers, things like that. Basically it's a gathering of medical providers. 8 There are 16 of these health care coalitions 9 10 scattered throughout the state, and we are kind of combining them also to correlate with the RDSTF, the Regional Domestic 11 12 Security Task Force regions. We're trying to consolidate 13 them in some form or fashion. 14 It is a way to reach a wide variety of medical 15 providers, from EMS through hospital systems. That's how 16 some of the federal funding passing through the state is 17 being distributed amongst the locals. 18 So I think that's a good gathering point to reach a 19 wide variety of health care providers. 20 MS. COLSTON: Thank you. Any questions for Dr. Elias on that? 21 22 Any other partners, stakeholders? Okay. 23 MR. KEMP: Yes. Rural health care providers. Ι 24 know they're included in some of this, but I think we need 25 to be very specific to include them because they're

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1	underserved and forgotten.
2	MS. COLSTON: Excellent recommendation. Any
3	others?
4	So if you guys think about other stakeholders later
5	on, that's great, just make sure you include that when we
6	send out the drafts, so that we can edit accordingly. I
7	think we have a really good beginning list. So there is no
8	further recommendations on this?
9	We'll look at the time frame really quick, then
10	we'll have some discussion about the time frame. Is a year
11	sufficient? Do you want to reevaluate in another year, have
12	some defined things that we're going to get done this year,
13	and keep it at a year? It's not locked into this, so if we
14	adopt it for a year this time, and then we revisit next
15	year, we can make a two-year plan. This is just a work
16	plan. It outlines what we're doing over the next year
17	pretty solidly. Any comments, recommendations, changes?
18	MR. SUMMERS: The last one to add to stakeholders
19	would be injury prevention expertise.
20	MS. COLSTON: Thank you. Under stakeholders we're
21	going to add injury prevention partners, or something along
22	those lines.
23	The time frame? Is council good with the time
24	frame?
25	MR. ROSS: One year from adoption?

1	MS. COLSTON: One year from adoption, yes, sir.
2	The date will be updated once these are adopted. Okay.
3	Sorry this got cut off a little bit, but the next
4	section is where we're going to outline what it is that this
5	council is working on. It's going to outline your
6	priorities, but in addition to outlining priorities
7	because it's great if we identify a priority for the
8	council, but we also want to identify what we're doing to
9	address that priority.
10	So it's very important that be identified as
11	something that we want to get done. We identify the work
12	that's associated with that, the steps that we need to take,
13	major steps. Then, you know, what the deliverable is going
14	to be. You know, we want some tangible things that tell us,
15	here's where we are, here's what we're going to do to
16	address that: recommendations to the department,
17	recommendations to the governor's office or whomever.
18	Then we want to go ahead and document what that is,
19	because also our checklist says, hey, we've got a great
20	council. We finally got what we wanted. Here are the
21	things we said we were going to do in the first year.
22	Here's what that stuff is, and here's what the data is
23	associated with whatever it is that we're doing.
24	Ideally, let's think through all those things
25	logically. I filled in what we have to start with, because

1	that's the one thing I know we've got to do. We will
2	definitely be the ones to facilitate that. We're going to
3	talk about what our ideas are for when we should have kind
4	of a finished product, because, working in state government,
5	when they get ready to turn things in to the governor's
6	office there's a whole approval process that adds probably
7	two to four weeks to that. So in order to make sure that we
8	have it in by December 31st, which is also prime time
9	holiday time, everybody's doing Christmas and Thanksgiving,
10	that sort of thing, we want to make sure we can get the
11	group where we need to be so we can have that done.
12	DR. NAMIAS: Question about that item. As I'm
13	reading it I know it's in statute. Why is this in
14	statute? Why is you know, this can be blah, blah, blah,
15	and the process for standalone pediatric trauma; but why not
16	for combined adult/pediatric? Why not for adult only? Why
17	this? What was what is the point of contention that led
18	to this being in the statute? We can't discuss this in the
19	hallway, so we have to do it here.
20	MS. COLSTON: I agree. I wish I had an answer for
21	you. That was another Department of Health item that was
22	introduced as part of the language. It was initiated
23	between the folks that developed the language.
24	DR. REED: I mean, on a study there's usually a
25	hypothesis. Was any hypothesis given? What data are we

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1 going to be analyzing and measuring? 2 MS. DICK: Really, honestly, DOH was not privy to the conversation that led to the language of the statute. 3 We were asked to do legislative bill analysis on the impact 4 of the statute. Chair Young, Senator Young was the primary 5 6 driving force. 7 You know, we tried last year. I mean, you guys all know the history of trauma shenanigans over the last 8 9 20 years in this state. This particular bill language was 10 brought forth by Senator Young. We understand that she brought various stakeholders together to craft the language. 11 12 DOH was not privy to those conversations. 13 The one thing I can suggest, if you want some 14 insight into that, go back and get on the house or senate 15 websites and find the hearings that this bill was discussed. 16 Just watch it, watch the presentations that were given by 17 different people, watch the language. 18 The honest answer -- not trying to be -- the honest answer is we don't know. 19 20 DR. NAMIAS: I understand that. So my question, I 21 guess, is partly rhetorical. There's no medical mystery 22 here; right? This was baked into the legislation. There's 23 some stakeholder that needed this, and this was part of a 24 horse-trade to get this in here. 25 So what I would say our Numbers 2, 3, 4, 5, 6,

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1	and 7 should be: ACS verification process versus Florida
2	verification process for all trauma centers for not
3	standalone for every variation on this should be included
4	in this study, and would satisfy the statute mandate to
5	study this, but we shouldn't limit it to this.
6	MS. DICK: Again, that's entirely up to you.
7	DR. NAMIAS: That would be my motion for the group,
8	that we expand this. And, Larry, as far as the word
9	"study," I don't think they mean a scientific study with a
10	hypothesis. They're looking for guidance, it appears, from
11	hopefully a supermajority
12	DR. REED: So all we need is pros and cons?
13	DR. NAMIAS: Yeah, from a supermajority. It's
14	funny that this one thing of all the things in the world
15	would be the thing in the statute.
16	My motion is to if we're taking motions yet
17	my suggestion is that we should expand it to not just
18	standalone pediatric trauma centers, but to all varieties of
19	trauma centers, every permutation we can come up with.
20	DR. ANG: (Raises hand.)
21	DR. NAMIAS: Is that a second?
22	DR. ANG: (Nods head.)
23	DR. NAMIAS: We have a second to my right.
24	MS. COLSTON: Motion to expand this to a study of
25	all trauma centers.

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1	DR. NAMIAS: All types.
2	MS. COLSTON: Motion on the floor has been
3	seconded?
4	DR. ANG: I second.
5	DR. REED: The types are actually variable.
6	Florida has Level I, Level II, pediatric. A college can do
7	Level III. Florida doesn't.
8	DR. NAMIAS: That would be part of this study.
9	MS. COLSTON: So we're going to change that to
10	cover all types. I don't know what that entails, so I'll
11	need your help. Is that going to be feasible to be
12	completed by the deadline of December 31st?
13	DR. REED: Oh, yeah, if all we need is pros and
14	cons.
15	DR. NAMIAS: A study of this, volumes, utilization
16	once you're getting those numbers for any one kind of
17	trauma center, I don't think it's any harder to get it for
18	all the trauma centers.
19	DR. ANG: There's going to be different opinions on
20	all those different levels of trauma centers and stakeholder
21	interest. I think if we're to prioritize, we should
22	prioritize I'm not saying don't study all the different
23	permutations, but prioritize the one thing that's in the
24	statute as number one, then kind of go through the rest of
25	them, so at least we get that done by December 31st.

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1	DR. NAMIAS: How many standalone pediatric trauma
2	centers are there in Florida?
3	MR. LEFFLER: Nicklaus and All Children's, and
4	Wolfson is a provisional. So Wolfson is a provisional
5	pediatric in Jacksonville. All Children's is in St. Pete,
6	and Nicklaus Children's Hospital in Miami.
7	DR. NAMIAS: You've already got one lawsuit, I
8	heard the other day. Are you guys going to be able to talk
9	about that? Are any of us going to be able to talk about
10	that, because of this lawsuit?
11	MS. DICK: You guys can talk about pediatric care
12	and trauma transport protocols, anything you want to talk
13	about on this council. We obviously can't talk about the
14	specific details of ongoing litigation.
15	DR. NAMIAS: We can, but you guys won't be able to.
16	All right.
17	MS. DICK: You're not a party to the lawsuit. You
18	can discuss it all you want.
19	DR. MCKENNEY: Who are the parties to the lawsuit;
20	Nicklaus and the Department of Health?
21	MR. SUMMERS: And Kendall, I believe.
22	DR. NAMIAS: Is Kendall a party to the lawsuit? I
23	knew it was Nicklaus and the Department of Health. I didn't
24	know about Kendall.
25	MS. DICK: Listen. Listen. That's okay. I don't

1 expect the council to take up -- I don't expect the council 2 to take up the issues related to whether pediatric trauma 3 patients go to Nicklaus or Kendall.

The council is going to take up the issue of, what 4 5 is the best system that we can create for the transport of 6 pediatric patients or whomever else. If you discuss 7 conceptually things that may or may not end up being a part of a specific discussion in court, that's okay. You're not 8 trying to mediate this particular issue; you're talking 9 10 about a statewide system. That's fine. They're looking for that. 11

DR. NAMIAS: We have -- by statute we have to address this. This is not an option. Whether it's prioritized or not, this is the one thing we have to do.

I'm just saying, for the sake of -- the legislators, obviously they weren't sitting there between, you know, parks and environment, and came up with standalone pediatric trauma centers. There's a reason it's there.

As a council we have to do that, but we can expand it to the logical thing, which is all kind of trauma centers.

22 DR. ANG: I agree. I just want to make sure that 23 we're prioritizing.

24 MS. COLSTON: So is the recommendation to separate 25 it out? Still address it as a priority, but to ensure that

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1 we meet the deadline, we separate it? 2 DR. NAMIAS: Maybe we should, so there's no question that we didn't fulfill our responsibilities. 3 Pediatric should be the first one. DR. REED: 4 That will be the model for how we do the other ones. 5 6 MS. COLSTON: We're going to talk about what it's 7 going to take to do this study. Again, I'll want some kind of key milestone steps for what it would take for y'all to 8 9 complete that study, so we can kind of keep the progress 10 moving forward on that, ensure we are going to be able to get our purpose of, number one, doing the pediatric study. 11 12 What are some key things we are going to need to do; 13 identify the data set we are going to need to use? 14 DR. ANG: We need to define the context of the 15 study. Dr. Reed mentioned you need a hypothesis for the 16 study, and Dr. Namias says this is not the type of study that needs a hypothesis. Who's going to define the study? 17 18 That will determine everything else. 19 DR. REED: We're looking at the verification 20 process by the two types, then we have a listing of what the 21 verification process is for the state of Florida. The 22 college has their PRQ, or whatever it is, that you've got to 23 complete. That process is available on the websites. We 24 can certainly have access to COT personnel. 25 Now here's the question I have, though. Does

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working on the study have to live under the sunshine stuff? 1 2 We can't do any work on the study unless we're all together in a publicly noticed forum? 3 MS. COLSTON: You can do your work on it, you just 4 can't work together. You can do your work. You can get 5 6 together --7 DR. NAMIAS: You can't discuss it. DR. REED: So if we need to discuss it, we need to 8 9 pull up one of the commons things: we've got some data, is 10 this where we want to go with it? 11 MS. COLSTON: That's correct. 12 DR. NAMIAS: Which is why I keep -- it seems like 13 we keep coming to a closure, but I keep saying that once we 14 leave here we can't talk about it. MR. LEFFLER: We can facilitate that discussion as 15 16 you guys need it or request. I don't know how to itemize the items we 17 MR. KEMP: 18 need for data for this kind of study. 19 DR. SUMMERS: We kind of just did this in our 20 institution. We looked at going with ACS certification, and 21 we looked at the differences. They're pretty easy to 22 quantitate. You can just put them side by side, in terms of 23 the things that the ACS asks for that are different and 24 unique from what Florida does. A lot of them are 25 overlapping, with minor differences. That's pretty easy,

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1 just to quantify that. 2 DR. REED: Do you have that, that that could be a starting point for us? 3 I mean, that could be something that 4 DR. SUMMERS: 5 I could provide through Michael. б MS. COLSTON: So let me just read the language out 7 of the statute, because there are certain things we really do have to address, and also requirements associated with 8 9 obtaining and maintaining verification; which pediatric 10 trauma centers in the state have obtained, are in the process of obtaining, or are capable of obtaining such 11 verification; the barriers to obtain verification -- this is 12 13 related to the American College of Surgeons verification --14 barriers to obtain; then policy proposals that address the need and value of such verification. Those are the things 15 that --16 17 DR. McKENNEY: Can you read that list again? 18 MR. LEFFLER: It should be the last page in your 19 book. 20 MS. COLSTON: We did include statutes in there. Ιt 21 looks like this. It looks just like this. 22 DR. McKENNEY: So this is the primary issue that we 23 have to address, by statute. 24 MS. COLSTON: That's correct. 25 DR. McKENNEY: We can go above and beyond, but we

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1	can't go below addressing this issue?
1 2	MS. COLSTON: That's correct.
2	DR. REED: So Glenn's got sort of a comparison list
4	that could give us aid, I think.
5	DR. SUMMERS: At least a framework that we could
6	put the different centers in. The centers we need to look
7	at for our charter are going to be different than my place,
8	but the framework is going to be same; just put their
9	numbers in.
10	MS. COLSTON: Can you share that with us, so that
11	we can kind of share you know, I don't know how you guys
12	want to do this. This is something that the council is
13	charged with doing.
14	Do you want to identify specific folks who are
15	going to work on this? Certainly you can have your own
16	little workgroup that's going to develop this. Already
17	there's a few major folks that are
18	DR. REED: I think we can communicate through
19	messaging, having stuff on the website, maybe.
20	DR. NAMIAS: Commons meetings.
21	DR. SUMMERS: Tell me if this is allowable. I can
22	send obviously, my folks will want to redact some of the
23	things in terms of specific costs.
24	MS. COLSTON: Absolutely.
25	DR. SUMMERS: But I can send the framework to

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1	Michael, and Michael can then disseminate it to the group.
2	We can decide whether that's something we can use going
3	forward or not.
4	DR. REED: Don't redact the dollar sign, but redact
5	the number.
6	DR. SUMMERS: My considerable fee will be redacted.
7	(Laughter.)
8	DR. REED: Redact the numbers, but we want to know
9	that that's where to put the money in.
10	DR. SUMMERS: It actually worked well for us. We
11	kind of exhaustively looked at this as our institution was
12	trying to make this decision. We've done a comparison. We
13	can do a better comparison, probably, with this group of
14	people. It's a place to start.
15	MS. COLSTON: So we'll look for you to send that to
16	Michael, once you've done the redactions, and we'll get that
17	out to the group as well.
18	DR. REED: Great. Then the state should have at
19	least some information on which pediatric trauma centers
20	have obtained or are in the process of obtaining
21	MR. LEFFLER: We can provide that. Molly Lorenzo
22	has been very helpful with us in providing information on
23	which trauma centers are pursuing various ACS
24	DR. REED: You have them for the state, too; right?
25	MR. LEFFLER: Yes.

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1	DR. NAMIAS: Our charter says standalone. If I'm
2	looking at the right thing in the statute, it doesn't say
3	standalone. Is it Section 13? I'm looking at 2018-66, Law
4	of Florida, Section 13. It doesn't say standalone.
5	MS. COLSTON: Is that in the statute?
6	DR. REED: No. It says pediatric.
7	DR. NAMIAS: Study the national certification of
8	pediatric trauma services.
9	MS. KOCEVAR: That was directly out of the statute.
10	That was copied there. That was just physically copied.
11	MS. COLSTON: Which one?
12	MS. KOCEVAR: What you see right there.
13	MS. COLSTON: Okay. So it's not "standalone," so
14	where did that come from?
15	DR. NAMIAS: Maybe the horse-traders forgot to get
16	their word in the statute.
17	MR. KEMP: I've got the statute here. It doesn't
18	say standalone.
19	MS. COLSTON: Okay. So we'll strike that. That's
20	a typo on our part. So it's all; it's not just standalone.
21	DR. REED: It varies, obviously, based upon the
22	data we get.
23	MS. COLSTON: What other data do you think we're
24	looking at, as far as verified centers?
25	DR. REED: Well, there's going to be issues related

1	to cost. There's issues that are going to be related to
2	personnel requirements for facilities.
3	DR. SUMMERS: Some of it will be difficult to
4	quantify as well, because they charge an institution fees
5	for getting it done, but then there's costs that would be
6	associated with the state for having a different set of
7	reviewers, those types of things. That's going to be a lot
8	more difficult to pull.
9	DR. REED: But the state knows what it charges per
10	survey.
11	DR. NAMIAS: But the statute says that the product
12	we have to provide is a study evaluating the laws, rules,
13	regulations, standards, and guidelines for the designation
14	of pediatric trauma centers in this state in this state
15	as compared to national, so that's ACS.
16	So, I mean, that shouldn't be hard to get our hands
17	on at all; right? We know what a doctor costs, what a nurse
18	costs, what a TPM costs.
19	MS. YORK: I mean, you're going to have
20	assumptions, but you're going to have assumptions in any
21	kind of study like this. Cost is going to vary a little bit
22	from a more rural place to a more populated place, just
23	because of what you have to pay individuals. But you should
24	be able to make some assumptions.
25	DR. REED: There's going to be ranges, minimum of

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1 this, maximum of that. 2 MS. DiNOVA: We're not looking at how much it would cost to become a pediatric center. What we should be 3 looking at is, how much would it cost for a state-verified 4 5 or state-designated center to become an ACS-verified center. 6 That's what we're comparing; isn't it? 7 DR. SUMMERS: Initially. Then there's the continuum as well. 8 MS. DiNOVA: Right, the continuum. But we're not 9 10 talking about a facility that's not already a pediatric trauma center becoming a pediatric trauma center. 11 We're talking about what is the cost difference between what 12 13 Florida requires and what the ACS requires. 14 DR. REED: There could be some issues related to becoming a trauma center. If Florida requires all this 15 16 equipment, for example, in their statutes, and the college 17 doesn't specify as detailed equipment and resources. So 18 there could be some piece of equipment they have got to have 19 -- which they probably already have -- but it could be a 20 cost item if the facility doesn't, because it's different. 21 MR. LEFFLER: Let's try to use the microphone. 22 DR. REED: I think there could be differences in 23 the cost of becoming a trauma center, if the requirements 24 are different in some specific areas. I know, for example, 25 for Level I, Florida requires an operating microscope for

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1 neurosurgery. I'm not sure the college specifies that. 2 DR. NAMIAS: So Florida has always been a little more demanding than the college. A lot of us in Florida are 3 happy with that. So there's some requirements, I think, for 4 vascular capabilities in Florida that aren't requirements 5 6 for the college. 7 So, I mean, I guess that's what we're going to look at and study, is the value -- cost and value of maintaining 8 9 our higher standards that Florida has, versus going strictly 10 to the college. I don't really have a dog in that fight right now, I just want to figure out what's right. 11 12 MS. COLSTON: So it looks like there's some really 13 good discussion going on about defining the parameters of 14 this study. We can continue to do that here, but keep in 15 mind that we are going to set up a commons hour and we're 16 going to walk through really a lot of the details of what that should look like. 17 18 Once we define the parameters and determine the 19 content of the study, then we're going to hold several, I 20 quess, commons hour workgroup meetings so you quys can work 21 through this. Whatever way the Department of Health can 22 support that, beyond setting up the meeting space and those types of meetings for you, just let us know about that. 23 24 We want to kind of set a deadline for a final draft 25 for this of November 30th, because that will give us a full

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1	month kind of, sort of, not counting the holidays to
2	get this approved through the Department of Health
3	structure, for submission of the report.
4	Is that palatable? Do you think we can do that?
5	It sounds like it is feasible if we can set up workgroups
б	and get this thing moving forward. So will that work? Our
7	final draft deadline will then be November 30th, so I'll go
8	ahead and kind of just put those major steps in. I'm not
9	going to put in the things that we have talked about, as far
10	as what elements you guys are going to be looking at for the
11	study. I'm going to put those very broad defining
12	parameters.
13	DR. REED: I think you can put, from this
14	Section 13, 1(a) through (d) in there as the things to be
15	looked at in the statute.
16	MS. COLSTON: Okay. Yes. I'll add that in. Under
17	our deliverable on that is going to be to develop and submit
18	a report by December 31, 2018.
19	So the second thing that was discussed was
20	expanding this study to all types of trauma centers. I
21	would assume that it will have some of the similar things
22	that you'd wanted to look at. We can further define that
23	later. We can start with the very basic things. The
24	outcome, I would assume, would be a report of a similar
25	type.

1	DR. NAMIAS: Similar.
2	MS. COLSTON: Okay. So we have got two good
3	things, two solid items that we're going to work through,
4	you all will be working through.
5	What are some of the other priorities? I'm sorry,
6	Lisa, did you have a question?
7	MS. DiNOVA: I was just going to say, if we're
8	going to do those things do we need to set a separate
9	deadline, or do we want to look at all of them also by the
10	November 30th and December 31st dates?
11	DR. REED: No.
12	MS. COLSTON: Let's think about what we want our
13	deadline to be for that.
14	MS. DiNOVA: Separate items?
15	MS. COLSTON: It's going to be a separate item. So
16	when do we want to have that completed by? It's up to the
17	council.
18	DR. REED: Let's see how the peds one is. We could
19	finish that within a month or two, if the data comes easily,
20	and then just set these other. I mean, this is priority
21	two. I mean, I think prioritization of these items is all
22	we need to do, then say we'll go from one to the other. Set
23	the deadline when we start.
24	MR. SUMMERS: And then the purpose would be it
25	would go to the legislature; correct? Of the report.

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1	MR. LEFFLER: Yes. Yes. It goes to the speaker of
2	the house, the president of the senate, and the governor.
3	MS. COLSTON: We're on the pediatric, number one.
4	The second one doesn't have the same requirements.
5	MR. SUMMERS: Do you know the dates for the session
6	for next year?
7	MR. LEFFLER: It starts in March next year.
8	MR. SUMMERS: So we have a little cushion.
9	DR. NAMIAS: So we could potentially get the
10	November 30th deadline for this one; and, depending on
11	what we find, we might set ourselves a January 30th or
12	February 28th, so they can have it before session. We don't
13	even know if they're going to act on it or stick it on a
14	shelf.
15	MR. SUMMERS: But they'll have it.
16	MR. KEMP: If you want to effect legislation, even
17	with March they start committee hearings and everything
18	way into, I mean
19	MS. COLSTON: January.
20	MR. KEMP: December. So that's why they wanted
21	this report by December 31st, for the committees to start
22	looking at this, because you have to be way ahead of it in
23	order to get anything introduced for this coming session.
24	You may not got this session, but that's okay, maybe get the
25	next.

1	MS. COLSTON: It depends on if you're trying to
2	propose something. If it's simply something you want to
3	give to them to inform them on what is happening with the
4	trauma system, I think that's fine. When you're talking
5	about actually proposing some legislative action, a bill, or
6	something along those lines but if we're not doing that,
7	I think it's okay for us to
8	DR. NAMIAS: We're not doing that, but presumably
9	if legislators are getting this report, they're going to use
10	it to think about legislation.
11	MS. COLSTON: They could.
12	DR. NAMIAS: Maybe we should push ourselves up to
13	an earlier deadline than November 30th. Speaking for
14	myself, and probably most trauma surgeons, if you give me a
15	deadline of November 30th, it will be done on November 29th.
16	So if you give us October 30th, it will be done October
17	29th. Maybe we should push the deadline up to late
18	September, so we can get it in their hands before they go to
19	committee.
20	MS. COLSTON: It's completely at the will of the
21	council. You guys can decide.
22	DR. NAMIAS: I propose a September 30th deadline
23	for the pediatric study.
24	MR. SUMMERS: I second.
25	THE COURT: Any discussion? Any dissent? So we're

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1	adopting September 30th as the due date for the
2	DR. NAMIAS: Pediatric study.
3	DR. McKENNEY: After we finish it, what has to be
4	done? It has to go through the Department of Health?
5	MS. COLSTON: You submit it. It will come to us.
6	DR. McKENNEY: You have to review it?
7	MS. COLSTON: Not review for purposes of any more
8	than running it through our executive chain so that they
9	have visibility on what's happening. It has to go up
10	through us, to the EOG.
11	DR. McKENNEY: That maybe takes a few weeks?
12	MS. COLSTON: It's possible. We can make miracles
13	happen when we need to. I just didn't want us to back up
14	against a wall and be rushed to try to get that done.
15	DR. SUMMERS: Your submission would be the end of
16	October, if we give you this information the end of
17	September?
18	MS. COLSTON: Or as soon as we can get it approved.
19	We won't hold onto it any longer than we need to, to submit
20	it up the chain. If everybody's happy, and nobody has
21	questions for example, if Dr. Philip, the surgeon
22	general, has questions, of course she'll call and ask
23	questions as needed. We want to give her that opportunity.
24	But once we get it and it's approved, we'll send it to them.
25	It says on or before December 31st.

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1	DR. NAMIAS: Remind us of the organizational chart.
2	The council has to provide it the report to the the
3	council provides it to the legislature?
4	MS. COLSTON: Yes.
5	DR. NAMIAS: So where does the DOH and the surgeon
6	general fall into the org. chart, between the legislature
7	and this council, for this purpose?
8	MS. COLSTON: We're the administrative arm of
9	the
10	DR. NAMIAS: So you are the council, really. You
11	are the council?
12	MS. COLSTON: Well, no, we're not the council.
13	We're the ones that are administering the support. Anything
14	that's submitted, we, as the executive agency that supports
15	whatever it is, will submit it as your liaison.
16	MR. LEFFLER: We transmit it on your behalf.
17	DR. NAMIAS: Does the DOH or the surgeon general
18	have the authority to refuse it? Change it?
19	MS. COLSTON: I don't want to say that we do. This
20	is a report that's developed by you as a council. I mean,
21	the only thing that may happen is if Dr. Philip is reviewing
22	and she has questions, you know, maybe not even for the
23	intent of changing what your findings are, she just may have
24	questions.
25	I think it's important you know, she's our

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1	state's surgeon general, so she should know what is
2	happening with this particular component that falls within
3	the realm of regulatory responsibilities for the Department
4	of Health. But it's not the intent is not to change the
5	content of the report as the council has developed it.
6	DR. SUMMERS: Perhaps we can then use our December
7	31st deadline for our second phase of this study, for part
8	two.
9	MS. COLSTON: Recommendation for December 31st as
10	the second phase deadline.
11	DR. NAMIAS: Second.
12	MR. SUMMERS: Leah, your September 30th is a
13	Sunday, if that changes your thought process at all.
14	MS. COLSTON: Can we make that October 1st, then,
15	instead of September 30th? Thank you.
16	Any further discussion on this? Of course it's
17	hard to see now, but use your imagination. We're going to
18	have some nice little milestones there and some other
19	things. This will be very well organized.
20	We've got two taskings right now: conduct the
21	legislatively required pediatric study; and then conduct
22	the study incorporating all of the other types of trauma
23	centers. Due date is October 1st for the pediatric;
24	December 31st for all the others. You are going to send us
25	a template for review that's redacted.

1	So are there any other questions or discussion
2	about those two taskings that you've identified for this
3	council so far? Excellent.
4	Okay. So do we have any other priorities that we
5	want to look at this year?
6	MS. YORK: I was on some e-mails this week where
7	people were asking some questions about differences
8	because our Pamphlet 150 is dated. Is that in statute, or
9	is that rule?
10	MS. COLSTON: That's rule.
11	MR. LEFFLER: Administrative rule.
12	MS. YORK: So I know it's not an easy change to
13	make changes to, but there were some issues about what is
14	acceptable for CME, because the differences in line with
15	this, because of differences between ACS verification and
16	state verification, what will be accepted and what will not.
17	Maybe it's time to relook at the Pamphlet 150. I
18	would put that not at the top, because, you know, maybe we
19	do all this and we say, hey, maybe everybody needs to do ACS
20	or not, I don't know. But it's a document that's been there
21	since, I don't know
22	MR. LEFFLER: 2010 was the last revision. It's
23	certainly been in most of its substantial form for quite
24	some time.
25	MS. YORK: Right. I was thinking it's from the

1	'80s or '90s. There were some updates done, but not
2	substantive.
3	MS. COLSTON: Okay. Council, we have a
4	recommendation to look at Pamphlet 150-9. Michael, correct
5	me if I'm wrong, but it would be one thing for y'all to look
6	at Pamphlet 150-9 as a group. In order to incorporate
7	changes, then we'd need to look at rule promulgation. I
8	don't know
9	MR. LEFFLER: It really would be based on the
10	substance of the change. If the cost, regulatory cost is
11	going to exceed \$200,000 in the first year, or a million
12	dollars over the first five years, there is another
13	substantial regulatory burden on the department to look at
14	cost savings opportunities and estimate those.
15	MS. COLSTON: That goes to the rule promulgation.
16	MR. LEFFLER: That is part of the rule promulgation
17	part. But as far as looking at if you want to look at a
18	specific standard that wouldn't affect regulatory costs
19	per se, it might be much easier for the department to take
20	that up. It would depend on what the substance of the
21	recommendations were. They would have to go through the
22	rule promulgation process regardless.
23	MS. COLSTON: Right. But not to look at it,
24	though. This group, as subject matter expertise, could take
25	a look at Pamphlet 150-9, then we can do the rule

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1	promulgation accordingly.
2	So I just want to put that out there. What we'll
3	be working on is something that, in order to change it,
4	would then necessarily need to go into a rule. The reason I
5	caution that is because whenever we go into a rule, it turns
6	into this big hodgepodge of stuff. We need to kind of
7	really be cognizant about the communication, what we're
8	trying to do with that, all that stuff, incorporate that
9	kind of thing so that we're getting buy-in from our entire
10	stakeholder community as we can. Maybe that will make the
11	rule promulgation process a little smoother.
12	DR. NAMIAS: Optimistically, I would hope that rule
13	change would be easier if it comes through this council. So
14	we can go through all that stuff before then.
15	MS. COLSTON: I hope so, too. Yes.
16	DR. NAMIAS: Maybe to restate what Donna's
17	saying maybe you're looking at recommendations for
18	modernization, for making it more contemporary. Because
19	it's really studying something that's part of the study that
20	we're doing, but at the same time we can make
21	recommendations for modernizations, just in case nothing
22	comes out of our study.
23	MS. COLSTON: In order to do this, we're going to
24	add this in. We're going to add "modernization" on that
25	line. That's relatively nondangerous.

1	So let's think about how you guys want to attack
2	that, because that's a huge thing. Are we looking at all of
3	them? I would think so. Are we looking at all the
4	standards? Let's think about how we would want to do that.
5	We don't have to discuss it now, we'll just identify it as a
б	priority. But, you know, do you want to break it up into,
7	we'll do this by such-and-such a date? I know you've
8	already got things on your plates, so maybe we don't
9	identify any of that. Maybe we just identify it as a
10	priority for now, and we can go back and revisit that. What
11	say you?
12	DR. NAMIAS: Does the department have this thing in
13	a Word document, as opposed to .pdf?
14	MR. LEFFLER: Yes.
15	MS. COLSTON: Yes, we do.
16	MR. LEFFLER: We will make the Word document
17	available.
18	MS. COLSTON: We'll get that out to you guys, just
19	for purposes of follow-up from this meeting.
20	So we're going to add that. We're not really going
21	to add any other language as far as when we're looking at
22	action steps. We're not going to define action steps just
23	yet for any deliverables we're just going to identify it
24	as a priority then we can address that.
25	Now do we want to identify when we will start to

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1	look at that? To be determined on or in January 2019, or
2	something along those lines, just so that we can keep that
3	forward motion and it doesn't just sit there, nah, we'll get
4	to it later. Even if it's to say, we might not be able to
5	do that this year, or in January, let's do it in March, or
6	whatever the case may be. Do you want to identify the
7	next
8	DR. NAMIAS: I think we can subcommittee that out
9	at the same time. There's 12 of us here. Some can look at
10	that.
11	MS. COLSTON: Okay. We are now entertaining a
12	recommendation for a subcommittee to address the standards,
13	so a trauma standard subcommittee. Do we have any
14	volunteers?
15	(Several members raise their hands.)
16	MS. COLSTON: Okay. Trauma standards subcommittee,
17	I've got Dr. Reed, Dr. Namias, Dr. Ibrahim, Mr. Summers,
18	Lisa, and Dr. Summers. Anybody else that I missed?
19	DR. McKENNEY: What's the purpose of the
20	subcommittee, I guess?
21	MS. COLSTON: The subcommittee will begin to
22	review, for modernization purposes, Pamphlet 150-9.
23	So Dr. Reed, Dr. Namias, Dr. Ibrahim, Dr. Ang,
24	Mr. Summers, Dr. Summers, Lisa, and Donna; correct?
25	MR. ROSS: Okay. You need an administrator.

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1	MS. COLSTON: Mr. Ross. Excellent. That's a great
2	deal of the council, but that's excellent. So we will also
3	kind of work through I guess we'll have we can arrange
4	subcommittee meetings, since we're setting that up now, so
5	we can arrange that. Keep in mind that we are going to work
6	on dates here in just a moment, but we'll set up the same
7	kind of meeting concept for the subcommittee as well. So
8	you just tell us what your needs are, and we'll get that
9	done.
10	Okay. We've got three priorities now. Everybody
11	comfortable with that? Great. Okay.
12	DR. SUMMERS: If you don't mind, I really feel at
13	some point, maybe next year, the year after, somehow or
14	another this group ought to look at access, which so much of
15	what we are trying to do is improve access to trauma care
16	statewide.
17	Really I don't know of anybody that's looked at
18	that recently, in terms of how we are doing, what we're
19	doing, what we should do differently. We're going to
20	eventually need to look at allocation and all those types
21	of things. I think that's something that we ought to put on
22	our radar to look at in this body at some point or another,
23	looking at access to care, trauma care, in the state of
24	Florida in 2019, or 2020, or whatever we're going to do.
25	I think that's an important part of what we're
	I chilme char b an importante parte or what we re

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1	trying to set up here and what we should be looking at as
2	providers.
3	DR. NAMIAS: Aren't we going to be advisory for the
4	needs 2020 study?
5	MS. COLSTON: Absolutely. It's not in here. I
6	took it out because that's three years down the road type of
7	thing, so we'd start looking at it in at least two years or
8	so. So we can add it here if you want. I have no problem
9	with that, if you want to start looking at it now, but I
10	think, you know, it depends on what you want. It is on the
11	radar, though. It won't fall off, because we have to do
12	that.
13	DR. SUMMERS: I think it ought to be on there.
14	MS. COLSTON: Okay. Do we want to add that as a
15	priority?
16	DR. NAMIAS: I second that.
17	MS. COLSTON: Okay. I'm denoting "access to trauma
18	care"; is that okay? We'll put it to be determined. I'm
19	also going to put some language in the assessment that's
20	going to be 2020. So it will be on this charter. We can
21	carry things over from this charter over to next year's
22	charter, or whatever we decide to do whatever you all
23	decide to do. I say "we" because it's just we'll get you
24	there, but you guys are going to carry the torch.
25	Yes, Mac?

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1 MR. KEMP: I'm glad you brought that up. That was 2 on the top of my list, not being a trauma center. Trauma centers are very important, but this is much larger than 3 trauma centers. A patient has to get to the trauma center 4 5 alive, so we need to look at the entire trauma system, 6 including EMS, air, and ground. And, you know, whatever 7 training needs to occur, maybe even law enforcement with active shooters. 8 9 All of the things that are going on now, as far as 10 tourniquet use, different types of bandages, things like that, are things that we should weigh in on in the state of 11 12 Florida. How do we want to handle these larger types of 13 trauma incidents as they occur? And then distribution of 14 trauma patients when we have mass events, because one trauma 15 center -- doesn't matter which one -- cannot handle it. 16 So we've got to be able to look at these things on 17 a Las Vegas-type incident basis, things like that. 18 Geospatial analysis of what is the reach of the ground 19 ambulance, what is the reach of an air ambulance to the 20 trauma center, to a pediatric trauma center. 21 We have some tools now that Department of Health, 22 Biospatial And some of those other things, that we can pull 23 some of that data and get some good information about where 24 in Florida we should look at it, from a patient perspective 25 -- not from a trauma center or EMS, but from a patient

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1	perspective, how well are you going to be served, based on
2	where you are geographically.
3	MS. COLSTON: Excellent. Thank you.
4	Okay. So we've got now full priorities, one maybe
5	we'll look at that's on our radar. Do we have any other
6	comments or discussion about any other priorities? I know
7	we have a motion and second. If we're good, we can move
8	forward.
9	The rest of this really is just the council
10	procedures, council lead roles and responsibilities, which
11	we don't really need to talk about lead roles and
12	responsibilities because we just discussed it in bylaws,
13	except for, you know, you actively participate as council
14	members. It's just kind of some general rules and
15	procedures that we'll live by.
16	We kind of note that the meetings will be held at
17	least quarterly, so that means that, you know, there are
18	other things that may take place as well. Under procedures,
19	we note the sunshine laws. We state that we will always
20	publish agendas in advance of the meeting. We may need to
21	amend Number 5, where we talk about to be conducted in
22	accordance with Robert's Rules of Order, because we modified
23	that just a little bit, change that.
24	Then, you know, as an ask we always want you all as
25	active members of this council to make sure that any notes,

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or minutes, or anything that's produced by us is reviewed by you, to make sure that we've captured everything correctly. We will use our court reporter's notes to kind of develop things that we miss, but I pretty much take really good notes, make sure that they're as accurate as possible, but we want you guys to review them and be active participants in that process.

We've talked about constraints and assumptions. 8 9 That's, again, just something for purposes of understanding 10 what we can and can't do, as far as our resources. There are some things that we have to complete, so we've got these 11 12 deliverables. When we talk about priorities and development 13 of such, we need to understand what are the things that are 14 absolutely required of us, what things can we kind of push 15 back to the wayside, the kind of proposals that should be on the radar but we understand there's a workload earlier that 16 17 we've already identified, so that may not get addressed this 18 year.

These are things that typically, if we're using this document -- it is going to be a publicly available document -- we want folks to understand what this council is faced with, and it does have unique challenges and barriers. Please feel free to amend that section or the assumptions section as you see fit. If there's anything I've missed --I don't know everything, and certainly you guys have a

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1	better perspective than I do, so you can complete that as
2	necessary.
3	That is the end of our charter, so if there are no
4	other questions, I think we have a good draft. We will get
5	this disseminated out to you all as soon as we have the
6	edits that you've recommended here. Any questions or
7	concerns?
8	I just want to say that we're moving right along.
9	It's ten minutes to 12. We have some things left on the
10	agenda as far as developing a meeting schedule. Do you want
11	to go ahead and move into that?
12	MR. LEFFLER: Yes. We have looked at what meeting
13	schedule will work best from the department's perspective,
14	as far as facilitating meetings using available resources.
15	Ultimately, the meeting schedule is up to you guys and your
16	availability to do those meetings.
17	Our suggestion, at least for our next regular
18	council meeting, would be to hold it during the EMS Advisory
19	Council week, which is January 11th and excuse me
20	July 11th and 12th. What we had envisioned was the
21	Wednesday, July 11th, we would have a three-hour working
22	meeting in the afternoon. Then immediately after the EMS
23	Advisory Council we'd take a break for an hour or so, then
24	move into the Trauma Advisory Council on Thursday afternoon.
25	DR. MCKENNEY: That would be July 12th

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1	MR. LEFFLER: Yes, correct.
2	DR. McKENNEY: at around what time?
3	MR. LEFFLER: The working meeting would be the
4	afternoon of July 11th; then the council meeting would be
5	the afternoon of July 12th, around 1:00.
6	DR. NAMIAS: FCOT is also at the EMSAC, so it's all
7	there. Just have to make sure it's not at the same hour.
8	MR. LEFFLER: Yes. We've worked with our partners,
9	to try to ensure there's minimal interference. I know Mac,
10	for example, and Dr. Elias, you guys have activities that
11	you have to participate in. We've been working with EMS
12	staff, to make sure we can facilitate a schedule that's
13	conducive to everyone.
14	DR. MCKENNEY: When is FCOT? I don't have that in
15	front of me.
16	DR. NAMIAS: It's at EMSAC, July 10th and 11th.
17	DR. MCKENNEY: Where is this going to be?
18	MR. LEFFLER: It's going to be in Orlando at the
19	Caribe Royale Hotel.
20	MS. COLSTON: We will send that information.
21	MR. LEFFLER: We'll send that information out.
22	This is just, at this point, for discussion purposes. Is
23	there any objection to July 11th and 12th?
24	DR. REED: I've got a conflict, but I can move it.
25	MR. SUMMERS: I'll have EMS meeting obligations

1	also.
2	DR. NAMIAS: It's at the EMS meeting.
3	DR. McKENNEY: We're working around that.
4	MR. LEFFLER: We're working with EMS staff, to make
5	sure to defuse any conflicts for members of the council
6	MS. DiNOVA: Also FCOT organizers, so they can get
7	the timing of what those are?
8	MR. LEFFLER: I believe I spoke to FCOT's executive
9	director, Brian Hart. I think we asked them to reach out to
10	(inaudible) who actually provides us the space to hold that,
11	to coordinate that.
12	So with trauma coordinators, I think the same thing
13	is appropriate. Certainly we're working to provide a
14	schedule that's conducive to everybody.
15	As far as future meetings, at least that's July.
16	October, we're looking at meeting in St. Augustine. A date
17	hasn't been nailed down, but that's where the direction I
18	was looking at for October. We can certainly schedule any
19	special meetings or commons hours in between.
20	DR. REED: On the July 12th, we'll actually meet
21	all day or
22	MR. LEFFLER: We'll meet to conduct council
23	business. The idea would be that
24	MS. COLSTON: It's 1:00 to 5:00 in the afternoon.
25	MR. LEFFLER: it's an opportunity to be able to

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ORIGINAL

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1	make any amendments to the bylaws, to the charter, to do any
2	work relating to the pediatric survey, do any other work.
3	Then the next day during the council meeting would be
4	official adoption of all of those things.
5	DR. REED: The next day being the 12th or the 13th?
6	MR. LEFFLER: That's correct, the 12th.
7	MS. COLSTON: On the 11th, what time is that?
8	MR. LEFFLER: 1:00 to 5:00 in the afternoon.
9	MS. COLSTON: On both days?
10	MR. LEFFLER: Yes.
11	MS. COLSTON: We had to do the 12th because the EMS
12	Advisory Council meets in the morning from 9:00 to 12:00.
13	MS. YORK: So four hours.
14	MR. LEFFLER: Four hours.
15	DR. NAMIAS: So 1:00 to 5:00 the 11th and the 12th.
16	MR. LEFFLER: Correct.
17	MS. COLSTON: Ideally, we would want to give you
18	more than a month-and-a-half's notice or whatever, but we
19	figured that because FCOT was being held at the same time
20	that we would try to squeeze it in.
21	DR. NAMIAS: FCOT thanks you. You just improved
22	our attendance.
23	MR. LEFFLER: So are we set for July? Is that
24	agreeable to everybody?
25	MR. KEMP: Yes. Just to address EMS Advisory

ORIGINAL

1	Council Meetings in general, we meet January, April, July,
2	and October of each year. Generally speaking right now, the
3	January meeting has been held the last few years in Daytona.
4	I think the contract still extends for another year or so.
5	It's in conjunction with one of the large fire conferences
6	on the East Coast, Fire-Rescue East.
7	So the advantage of being with the EMS Advisory
8	Council is we always have different room space available.
9	We would make room for the trauma group here. The April
10	meeting moves all the time. It usually is in south Florida
11	somewhere. This past year and the year before was in West
12	Palm Beach Palm Beach Gardens, that's where it was.
13	MR. LEFFLER: We're looking at doing Palm Beach
14	County again in this upcoming October. It probably will not
15	be in the same location we held it previously.
16	MR. KEMP: You mean next April?
17	MR. LEFFLER: Yes. Sorry.
18	MR. KEMP: October is a little bit more north.
19	July is always in Orlando, because of a medical conference
20	there; we kind of associate with that. Then the October
21	meeting is sometimes north, sometimes south. I like it to
22	be more north personally myself.
23	So anyway, that's just generally how it is. We
24	will work with the department and EMS to make sure we
25	accommodate this meeting, if you choose to combine the

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1 meeting with what we are doing. 2 MR. LEFFLER: We can take an official vote on this at our first meeting, as far as adopting a future meeting 3 This is for planning purposes and kind of 4 schedule. 5 understanding -- the statute directed the department to put 6 this together with existing available resources. This is 7 the most judicious way for us to maximize our resources. DR. NAMIAS: The American College of Surgeons in 8 9 October is the 21st through 25th. You know, some senior 10 people might have responsibilities before or after, so I would just say like the 19th through the 27th could 11 12 potentially be conflicts with the surgeons' meeting. 13 MR. LEFFLER: We'll work on that. 14 MS. COLSTON: There are other options. We don't 15 necessarily have to hold all of the meetings in conjunction 16 with the EMS Advisory Council. We're not locked into that. We definitely appreciate -- because it's already a standing 17 18 meeting -- that we can just kind of build on that. But I 19 know that there are other meetings that we can -- like FCOT, 20 tag into one of their quarterly meetings, just try to figure 21 out how to do that. 22 I think as we kind of think about this, maybe we 23 can't select dates right now beyond giving you what we've 24 already given you. And that's good information, because we 25 already need to look at a different meeting space for

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ORIGINAL

October for this group. But if we can, what we'd like for 1 2 you all to do is submit to Mike Leffler a calendar of all the major meetings that are taking place, whether it's for 3 you personally or just in general. If it's duplicative and 4 being reported by a bunch of different folks, that doesn't 5 6 matter. We'll sort it out when we get it. I'd rather have 7 That way we can kind of look at it from our more than less. end, what dates we might be able to propose for meetings, 8 9 who we might be able to tag onto, you know. If we can call 10 the FCOT folks that we work with and say, hey, can we hold our meeting in conjunction with where you guys are, or 11 12 subsequent.

So if you can get all of that. When we send out the follow-up information from this meeting, that will be something that we include as one of your deliverables back to us, is kind of a calendar of what you all have going on over the next year, so that we can set that up.

18 This is also going to help us -- I think what we 19 probably want to do is go ahead and maybe set up some 20 commons hours meetings. Do we have a day of the week that 21 works best for everybody here? Probably not. I'm just 22 throwing it out there hypothetically. If we do it on a 23 Friday in the morning, or Friday in the afternoon, or 24 Monday, whatever. What would the group recommend? 25 What we can do is just go ahead and set one up

ORIGINAL

1	every week, so whether you guys are there or not we're going
2	to set up an hour. We'll be there, so if anybody jumps on
3	we can kind of help take minutes in general of what's going
4	on. If we don't need them that frequently after the next
5	couple of months, we can kind of decrease it. We'll let you
6	know what that is, but at least you guys will know that
7	there's a dedicated spot available for you to be able to
8	discuss whatever. Are you good with doing that? If so,
9	what day would be good? Once a week.
10	DR. NAMIAS: I don't know that any day is better
11	than any other, but times. I would say I know mornings are
12	tough for the surgeons. That's when everything happens. I
13	think 3:00 or 4:00 we could, you know, hopefully be done
14	with rounds or whatever. You might still miss, but
15	MR. LEFFLER: If you look at the bylaws suggestion,
16	participation in the commons hour meetings is not required.
17	MS. COLSTON: You won't be dinged for that.
18	DR. NAMIAS: But if it's in the mornings, the
19	surgeons will never be there.
20	MS. COLSTON: So general consensus then is 3:00 or
21	4:00 would be good?
22	DR. REED: Random days of the week. Everybody's
23	got a different schedule.
24	MS. COLSTON: So is one day a week good enough
25	right now, or do we want two days?

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1	DR. McKENNEY: Let's start with one, then if we get
2	bogged down
3	MS. COLSTON: We're just going to start with
4	Monday, and schedule every one after that: Tuesday,
5	Wednesday, all at 3:00 or 4:00? You guys pick.
6	MS. DiNOVA: 3:00 to 4:00.
7	MS. COLSTON: Okay. So we'll go ahead and get
8	those set up. We're going to send those out as calendar
9	invites, so they'll be on your calendar. They're going to
10	be weekly for right now until this group decides otherwise.
11	Okay.
12	MR. LEFFLER: That will help facilitate some of the
13	premeeting stuff, as far as the meeting in July.
14	So I guess the next step is, Dr. Namias, you're
15	going to send me a list of meetings that we could possibly
16	hold it in conjunction with. We'll plan on July for our
17	next meeting, then we'll look, in the July meeting, what our
18	future meeting schedule will be for the rest of the year.
19	MS. COLSTON: And everybody send in
20	MR. LEFFLER: Everybody can send me any conflicts.
21	MS. COLSTON: Whatever it is, even if it's
22	anticipated, can you just note it as anticipated, but just
23	let us know that that may be a barrier or a taken date. But
24	everybody can send what they have, whether you know it for
25	sure or whether it's anticipated, so that way we can at

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1	least try to come up with a good meeting schedule.
2	We would, if at all possible, like to kind of keep
3	the January and July, at least, to try to coincide with
4	EMSAC, because there's a lot of the trauma folks that meet
5	during that time. We try to get more bang for the buck, and
6	for you guys, too, since we don't pay for your travel.
7	MR. LEFFLER: And there are some exciting things
8	going on at EMSAC directly related to trauma, that certainly
9	this group, I think, would have an interest in.
10	MS. COLSTON: So any other questions or concerns
11	about the meeting schedule? We'll put a deadline on there,
12	maybe a couple of weeks. I don't know if that's too short
13	of a time, but if you could just respond back so we can kind
14	of collate all that information, and then we'll start
15	looking at proposed dates.
16	MS. YORK: So we set a meeting for July. We're
17	going to have these commons meetings.
18	We set a deadline for the pediatric stuff for
19	October 1st, before the October meeting I'm just saying.
20	MS. COLSTON: Yes. Do you have a recommendation as
21	to what we might want to do with that?
22	MS. YORK: No. I'm just throwing that out there.
23	MR. LEFFLER: We can schedule special meetings as
24	necessary, too, for purposes of if we want to schedule a
25	meeting specifically to discuss and adopt the study.

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1	MS. YORK: Okay. We have a little time. Okay.
2	MS. DiNOVA: Why don't we change the charter to say
3	instead of October 1st for the October meeting?
4	MS. YORK: Yeah. If we do it for the October
5	meeting, we could have it done and then vote on it at the
6	October meeting.
7	MS. COLSTON: Okay. Let's keep that in mind.
8	Leave it at October 1st now, with the thought that we can
9	change it to coincide with the meeting that's going to be
10	held in October, if we can do it in October.
11	Any other comments or questions? Thank you for
12	that. As always, none of this stuff is set in stone. This
13	is your council. We are here to support you. We appreciate
14	whatever you guys want to give us, opinions of, you need to
15	fix this, we need to do that. I think this is a great
16	thing.
17	I think we accomplished pretty much everything we
18	wanted to accomplish today.
19	MR. LEFFLER: We did. There is a public comments
20	section available.
21	MS. COLSTON: Okay. So almost done. Great work
22	today. We want to now open the phone lines you'll
23	probably need to do it for public comment, if any was
24	received. We did not receive any requests to speak via the
25	phone line. We don't have any from here in the room,

1	either. We appreciate those folks who were able to attend
2	today, both in person and on the phone.
3	At this particular point in time, then, I would
4	like to ask Cindy Dick, our assistant deputy secretary, to
5	come and provide some closing remarks for us.
6	MS. DICK: My closing remarks will be very brief.
7	I know it's between lunch and travel back home. It's
8	basically this: Everybody that's sitting at this table
9	right now on this council is well aware of the last six
10	for sure years of the Florida trauma system, and how, I
11	believe, our progress towards a real patient-centric,
12	quality-driven trauma system has been distracted by a lot of
13	other issues.
14	I am really, really excited that this council has
15	been created in the statute and brought together, because
16	you guys are the people that really are the minds that need
17	to create and craft the trauma system in Florida, a
18	patient-centric approach to the trauma system in Florida.
19	I think, as was mentioned earlier, that includes
20	from time of injury, you know, all the way through patient
21	rehabilitation and reintegration back into what is some sort
22	of their new normal.
23	My history, for those of you who don't know me, I
24	come from 27 years of fire service. I come from a
25	prehospital care perspective. I was mentioning to

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Dr. Reed, actually, last night, there's been a great deal of debate by a lot of really smart people about what's the most important thing for trauma patients. Is it time? Is it distance to the nearest stabilization facility? Getting them to a Level I trauma center? What is the most important thing?

7 The only thing I can come down with at the end is, ask any paramedic if they want to transport a trauma alert 8 9 patient for two hours, you know. So I'm thrilled that we 10 have people from the prehospital community here. We have people from trauma agencies. We have people from trauma 11 12 centers, for-profit, not-for-profit. None of that should 13 matter when it comes down to the work of this council, which 14 is, how do you design and create a sustainable trauma system that focuses on what's best for Floridians. 15

The registry, I think, is a good tool that is available. Everything that DOH has, the brain and spinal cord injury registry, the trauma registry, anything that we have is available to you, to help inform your decisions.

I think that you've got one specific mandate per statute for a report, but, to me, the sky is, you know, it's unlimited for you in the work that you do. I'm just really excited. I know that you are all giving up very, very valuable time to travel here, to be here, to focus on this, without personal gain to come from it. You know, the gain

here is going to be the legacy that you leave to people that 1 2 come to Florida and sustain a traumatic injury, and what the 3 outcome is of that. 4 So I just want to thank you so much for your time. 5 I'm going to attend as many of these as I can, just because 6 I love to hear the dialogue and the good conversation. I'm 7 going to ask that you do what I know that you will do, which is stay focused on the product, and take all the other 8 nonsense out of the way. I'm excited. Thank you for your 9 10 time. Go forth and do great things. 11 MS. COLSTON: Meeting adjourned. Thank you very There will be a follow-up e-mail out to you shortly 12 much. 13 -- well, maybe not today, it's a big drive back -- but 14 sometime soon. Thank you. 15 (This meeting adjourned at 12:08 p.m.) 16 17 18 19 20 21 22 23 24 25

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1	CERTIFICATE OF REPORTER
2 3 4	STATE OF FLORIDA))SS COUNTY OF BREVARD)
5	I, ELIZABETH J. BEYER, a Notary Public in and for
6	the State of Florida at Large, do hereby certify that I did
7	report the proceedings in the Meeting held on the
8	aforementioned cause before the Florida Trauma System
9	Advisory Council; and, that the foregoing pages 1
10	through 130 constitute a true and correct transcription, to
11	the best of my ability, of the proceedings in said Meeting.
12	
13	I FURTHER CERTIFY THAT I am not a relative,
14	employee, attorney, or counsel of any of the parties, nor am
15	I a relative or employee of parties' attorney or counsel
16	connected with the action, nor am I financially interested
17	in the event of this cause.
18	
19	WITNESS MY HAND in the City of Melbourne, County of
20	Brevard, State of Florida, this 6th day of June 2018.
21	
22	Elizalish J. Bayer
23	ELIZABETH J. BEYER
24	
25	

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\$200000 108:11	3954022b 51:16	accessing 28:4	30:18,21,24 32:12,16 33:3	adhoc 34:17 35:3
\$500 13:22 14:2	6th 131:20	accessing 20.4	35:7 56:21 78:14	adjourned 13:13
16:17		accommodate	118:10 (14)	130:11,15
	9th 53:5	13:8 121:25		,
'80s 108:1			activity 18:18	administer 32:9
100 100.1	@flhealthgov	accomplish 76:18	27:18 35:22	
'90s 108:1	7:24	127:18	actual 25:10	administering 105:13
10th 118:16	abandoned 31:3	accomplished	42:24 48:1,3 (4)	105.15
		127:17		administration
11th	abdicate 46:12		acute 6:16 21:21	26:16
117:19,20,21		accordance	26:23 78:19 80:23	
118:4,16,23	ability 20:7 52:3	115:22	(5)	administrative
120:7,15 (8)	57:6 131:11 (4)	accordingly 66:2	add 37:16 53:24	2:13 12:11 55:5 57:7 60:6 105:8
12th 53:6	able 3:9 8:24	83:6 109:1	58:6,11 59:16,21	107:11 (7)
117:20,25	18:12 23:9 27:9	05.0107.1	61:12,19 62:25	107.11 (7)
118:5,23 119:20	34:13 66:13 78:4	accurate 60:18	63:11 64:4	administrator
120:5,6,11,15 (10)	89:8,9,15 91:10	116:5	73:2,11,12 75:3	1:21 4:15 20:22
	97:24 111:4		76:2 77:11 80:25	21:2 111:25 (5)
13th 120:5	114:16 119:25	accurately 74:1	81:4 83:18,21	
19th 122:11	123:8,9 124:7 128:1 (20)	achieve 25:18	100:16 109:24,24 110:20,21	administrators 19:2 56:12 78:2
17th 122.11	120.1 (20)		113:8,14 (28)	17.2 30.12 70.2
1a 100:14	absence 52:4	acknowledge 5:7		adopt 24:6 31:25
	53:25 62:21 63:4		adding 81:21	37:23 72:22 83:14
1st 106:14,23		acs 79:21 87:1	adding 81:21	
	53:25 62:21 63:4 (4)	acs 79:21 87:1 92:20,23 95:23		37:23 72:22 83:14 126:25 (6)
1st 106:14,23 126:19 127:3,8 (5)	53:25 62:21 63:4	acs 79:21 87:1 92:20,23 95:23 97:15 98:13	adding 81:21 addition 84:6	37:23 72:22 83:14 126:25 (6) adopted 23:2
1st 106:14,23	53:25 62:21 63:4 (4)	acs 79:21 87:1 92:20,23 95:23	adding 81:21	37:23 72:22 83:14 126:25 (6)
1st 106:14,23 126:19 127:3,8 (5)	53:25 62:21 63:4 (4) absences 41:12	acs 79:21 87:1 92:20,23 95:23 97:15 98:13	adding 81:21 addition 84:6 additional 31:25	37:23 72:22 83:14 126:25 (6) adopted 23:2
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4)	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4)
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13)	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16
 1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 100:7 	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12)	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 100:7 101:10 102:10,11	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16
 1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 100:7 	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12)	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 100:7 101:10 102:10,11 103:13,15,16,22	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10 107:16 access 10:3 12:13	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12 13:2,17 (4)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15 78:4 116:17 addressing 2:21	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric 85:16 adults 27:8
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 100:7 101:10 102:10,11 103:13,15,16,22 104:1 106:12,15 (12)	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10 107:16 access 10:3 12:13 28:11 71:5 91:24	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12 13:2,17 (4) active 4:20 114:8 115:25 116:6 (4)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15 78:4 116:17	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric 85:16 adults 27:8 advance 12:9
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 101:10 102:10,11 103:13,15,16,22 104:1 104:1 106:12,15 (12) 31st	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10 107:16 access 10:3 12:13 28:11 71:5 91:24 112:14,15,23	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12 13:2,17 (4) active 4:20 114:8 115:25 116:6 (4) actively 22:3	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15 78:4 116:17 addressing 2:21 94:1	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric 85:16 adults 27:8 advance 12:9 19:13 32:23,24
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 101:10 102:10,11 103:13,15,16,22 104:1 104:1 106:12,15 (12) 31st 2:17 85:8 88:12,25 101:10	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10 107:16 access 10:3 12:13 28:11 71:5 91:24	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12 13:2,17 (4) active 4:20 114:8 115:25 116:6 (4)	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15 78:4 116:17 addressing 2:21	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric 85:16 adults 27:8 advance 12:9 19:13 32:23,24 46:15 62:20
1st 106:14,23 126:19 127:3,8 (5) 21st 122:9 24hour 28:12 25th 122:9 27th 122:11 28th 102:12 29th 103:15,17 30th 99:25 101:10 102:10,11 103:13,15,16,22 104:1 104:1 106:12,15 (12) 31st	53:25 62:21 63:4 (4) absences 41:12 absent 42:11 47:21,22,23 (4) absolutely 36:1 40:9,9,14 51:19 52:12 67:5 68:13 79:5,18 94:24 113:5 116:14 (13) acceptable 107:14 accepted 46:10 107:16 access 10:3 12:13 28:11 71:5 91:24 112:14,15,23	acs 79:21 87:1 92:20,23 95:23 97:15 98:13 107:15,19 (9) acsverified 98:5 act 11:13 102:13 action 2:15 11:5 13:3 33:15 39:17 67:9 77:3 103:5 110:22,22 131:16 (11) actions 11:10,12 13:2,17 (4) active 4:20 114:8 115:25 116:6 (4) actively 22:3	adding 81:21 addition 84:6 additional 31:25 32:2 73:2 additions 63:16 64:4 address 2:25 25:25 84:9,16 90:13,25 93:8,14,23 110:24 111:12 120:25 (12) addressed 37:15 78:4 116:17 addressing 2:21 94:1	37:23 72:22 83:14 126:25 (6) adopted 23:2 84:2 adopting 50:7 104:1 122:3 adoption 68:7 83:25 84:1 120:4 (4) adult 5:25 27:10 85:16 adultpediatric 85:16 adults 27:8 advance 12:9 19:13 32:23,24

115:20 (10)	agenda 7:20 8:2	33:7,18 57:9	annually 35:5	56:18 78:12
115.20 (10)	12:6 13:6 28:21	60:25 61:3 (6)	annuany 55.5	50.10 70.12
advantage 57:5	31:20 32:11	00.25 01.5 (0)	answer 42:13	approval 24:4
121:7	33:24,24 52:17	almost 37:20	58:17 79:23 85:20	85:6
121.7	117:10 (11)	127:21	86:18,19 (6)	05.0
advice 55:12		127.21	00.10,19 (0)	approve 35:9
	agendas 14:14	amanda 1:20	anticipated 53:6	46:8
advise 22:23	115:20	4:15 9:13,19	77:4 125:22,22,25	
		28:22 (5)	(5)	approved 8:7
advisory 1:1	agree 38:2 49:24			22:8 30:6 57:20
2:3,6 6:24	85:20 90:22 (4)	ambulance	anytime 3:22	58:10,25 61:13
8:5,10,11 10:7		114:19,19		76:15 100:2
20:8 21:5	agreeable 120:24		anyway 35:11	104:18,24 (11)
25:7,12,14,20,22		amenable 75:14	121:23	
29:6,12,12 30:8	ahca 26:16			april 121:1,9,16
31:21 36:12 37:1		amend 8:20 40:3	applicability	
52:19,24 53:7	ahead 4:22 7:10	72:19 73:11	22:12	area 24:18 31:14
59:273:24 113:3	8:1,4,14,23 28:18	115:21 116:23 (6)		73:14
117:18,23,24	33:24 38:24 51:6		applied 42:4	
120:12,25 121:7	71:4 84:18 100:8	amended 67:23	P 10 5 11 7	areas 2:22 54:22
122:16 131:9 (36)	102:22 117:11	amendment	applies 10:5 11:7	67:16 98:24 (4)
affect 35:19	123:19,25 125:7 (18)	16:23	apply 17:6 25:11	arm 105:8
108:18	(10)	10.23	34:12	arm 103.8
100.10	air 114:6,19	amendments	34.12	arrange 112:3,5
affected 34:9		120:1	appoint 61:25	
	alert 27:3 129:8	120.1	uppoint 01.25	article 10:2 29:21
affects 33:9		american 24:8	appointed 6:4	30:7 31:8,14
	aligned 30:15	52:8,9,9 79:19	10:6 30:15 35:21	34:16,16 35:9
affiliation 32:6		80:4 81:9 93:13	41:10,17 42:1	51:8,14,15
	alive 114:5	122:8 (9)	64:9,20 68:15	54:17,19
aforementioned			75:18 76:7 (12)	58:5,17,20 63:17
131:8	allegiance	amount 9:1		64:1,10 67:12,21
	4:23,24		appointing 31:16	68:1 69:20 71:20
aftc 80:1		analogy 41:24	• • •	(24)
	alliance 7:4,12		appointment	
afternoon	u (05.5	analysis 26:5	46:11 76:21	asleep 9:22
117:22,24 118:4,5 119:24 120:8	allocates 25:5	86:4 114:18	annaintmanta	acmosta 70:2
123:23 (7)	allocation 112:20	analyzing 86:1	appointments 41:23 42:4	aspects 79:2
125.25 (7)		analyzing 80.1	41.25 42.4	assessed 16:15
agencies 7:8	allow 3:3 13:1,6	anchored 34:20	appreciate 28:1	assesseu 10.15
24:15,16 25:1	16:11 21:23 37:21		122:17 127:13	assessment 26:22
27:6 81:22 129:11	52:1 61:24 (8)	andor 12:18 14:1	122:17 127:13	113:19
(7)		55:10		
	allowable 94:21		appreciated 29:3	assignment 20:16
agency 7:6		ang 1:13 6:8,8		21:12
10:6,10,17 16:13	allowed 12:20	44:19 66:16 68:25	approach 128:18	
26:15 41:24 81:19	34:7 42:15	69:5,6,11,14		assignments 21:9
105:14 (9)		80:9,14 87:20,22	appropriate 71:9	35:4 77:3
	allowing 41:13	88:4,19 90:22	119:13	
agency's 12:13		91:14 111:23 (19)		assigns 25:3
22:11	allows 24:6		appropriately	
1				

				TDI
assistance 59:8	audibly 30:10	barrier 125:23	70:3 90:5 117:13	bogged 125:2
			123:21 129:15	005500 12012
assistant 1:19	august 26:6	barriers 93:12,14	131:11 (11)	book 24:9 93:19
4:18 128:4	augustine 119:16	116:22	better 64:25	bottom 77:2
assists 12:24	augustille 119.10	based 7:20 8:10	95:13 117:1	
	authority 10:8	24:7 73:2 76:1	124:10 (4)	boundaries 27:17
associate 121:20	22:15,20,21,25	96:21 108:9 115:1		
	23:1,9 26:7 73:9	(8)	between 9:15	brad 1:17 5:10
associated 14:15 56:21 84:12,23	75:12,13 105:18 (12)	basic 63:19	11:6 29:11,22 85:23 90:16 98:12	brain 79:7
93:8 97:6 (6)	(12)	100:23	105:6 107:15	129:17
<i>y y y i i i i i i i i i i</i>	automatically	100.25	119:19 128:7 (11)	127.17
association 5:24	62:5	basis 24:23 25:20		break 71:11,15
52:7,8,8,10,10 (6)		71:21 114:17 (4)	beyer 1:23	110:6 117:23 (4)
	availability 26:13	haadh 7.7	131:5,23	b 1 2 1 0
assume 41:19 100:21,24	117:16	beach 7:7 121:12,12,13 (4)	beyond 93:25	brevard 3:8,10 4:9 131:3,20 (5)
100.21,27	available 2:9	121.12,12,13 (7)	99:22 122:23	r. 7 131.3,20 (3)
assuming 45:13	12:7 37:1 91:23	beautiful 3:13		brian 119:9
	110:17 116:20		big 65:14 109:6	
assumptions	117:14 121:8	become 72:18,24	130:13	brief 12:14 16:22
97:20,20,24 116:8,23 (5)	122:6 124:7 127:20 129:17,19	73:21 98:3,5 (5)	bill 20:6 21:5	23:17 128:6 (4)
110.0,23 (3)	(13)	becomes 15:20	25:3 86:4,9,15	briefly 70:10
assurance 26:3	()	80:18	103:5 (7)	~j · • • - •
	avoid 13:9,10			bring 42:7,17
attack 110:1	43:21	becoming	biospatial 114:22	50:22
attend 11:25 17:5	avoiding 15:25	98:11,15,23	bit 14:3 20:11	broad 19:2
48:4,11 52:20	avoluing 15.25	begin 2:25	27:12 28:22	100:11
128:1 130:5 (7)	aware 20:13 25:3	111:21	29:11,19 30:3	
	65:3 128:9 (4)		38:25 64:2 82:3	broadly 15:14
attendance 12:18	healtenand (1.1	beginning 83:7	84:3 97:21 115:23	hanabt 20.5
19:19 30:25 40:21 50:19 51:20	background 61:1 73:7 74:10	behalf 47:20	121:18 (14)	brought 20:5 86:10,11 114:1
64:7,8 67:14	75:8,10,11 (6)	105:16	blah 85:14,14,14	128:15 (5)
120:22 (10)				
	baked 86:22	behoove 55:11	bloc 37:24,25	buck 126:5
attendees 7:9,17,22,25 13:8	balanced 57:13	belong 39:7	38:21 43:21 46:3,6,13,24 (8)	huggon 65:14
(5)	Dalanceu 57.15	belong 59.7	40.5,0,15,24 (8)	bugger 65:14
	bandages 114:10	below 94:1	blocs 37:22	build 122:18
attending 2:2,8				
7:22	bang 126:5	beneath 79:14	board 10:5,15	building 3:21
attends 34:4	bank 26:20	beneficial 50:16	11:3,7 12:3,4 13:2	bunch 37:2 51:1
attenus 54.4	Jain 20.20		(7)	123:5
attorney	baptist 5:12	benefit 4:11	boards	
131:14,15		55:11	10:4,7,7,21 (4)	burden 108:13
attomaria 16.14	bar 65:9 66:5	hast 22.5 20.14	hadias 61.7	humor 1.10 4.10
attorney's 16:14	69:3	best 22:5 28:14 29:25 65:15 66:4	bodies 61:7	bureau 1:18 4:12
L	1	1	1	1

				±55
buses 63:10	capabilities 99:5	caution 18:2,2	chair 17:11 31:18	35:5,6 57:20
DUDUD 03.10		36:10 109:5 (4)	59:2,6 86:5 (5)	58:10 71:18
bush 1:20 4:15	capable 93:11	50.10 109.5 (4)	57.2,0 00.5 (5)	72:15,17 73:7
9:13,21 17:14		center 4:4	chairmen 31:21	76:10,11 79:20
18:1,21,24 19:15	capacity 62:21	5:12,13,20		94:7 96:1
36:1 41:2,13,17,20		6:1,7,9,22 7:15	chairs 36:13	113:20,21,22
(14)	capture 12:17	24:11 25:16 26:3	chang 50.15	117:3 120:1 127:2
		74:14 88:17 98:3,	challenges	(23)
business	captured 116:2	5,5,11,11,15,23 11	116:22	()
14:11,24 15:8,10	·····	4:2,4,15,20,20,25		checklist 84:19
17:10 19:20 27:15	car 52:2 62:14	129:5 (28)	chance 30:3 37:7	
30:5 32:13 33:16			65:10	chief 1:18 4:12
34:9 35:14 36:11	card 34:13	centers 6:11		6:23
39:9,24 43:19		21:20 22:5	change 22:22	
57:3 71:17 73:22	cardiovascular	24:4,5,7,13	28:8,21 29:5 30:2	children's
119:23 (20)	5:14	26:2,12,19,23 27:4	31:15 39:3,18,20	89:3,5,6
		74:23 75:5	42:25 49:9,25	
busy 31:4 41:5	cards 7:21	80:12,19,20,22	53:18 56:15 58:22	choose 46:12
		82:7 87:2,18,19,25	60:16 64:11 65:23	121:25
buyin 109:9	care 6:16 7:7	88:18,20 89:2	66:9 67:14,15	
	12:24 21:21 22:3	90:18,21 93:10	68:19 69:3 72:5	chose 46:23
bylaws 2:14	23:23,24 26:15,23	94:6,6 95:19,23	74:25 77:6 88:9	
8:6,6,8 28:24	55:677:18	96:24 97:14	105:18 106:4	christmas 85:9
29:1,1,14,19,22,25	78:20,20,24 80:9,1	100:20 106:23	107:12 108:10	
30:6 35:10 36:25	5,19,21,23,23	114:3,4 129:12	109:3,13 115:23	chunk 65:14
39:3,7,8 41:14	81:1,4,11,24	(40)	127:2,9 (36)	aindr. 1.10 4.19
47:21,24 49:23,24 50:7,9,16 51:7	82:1,5,7,9,19,23 89:11	ceo 7:3	changed 64:15	cindy 1:19 4:18 128:4
53:19,19 61:24	112:15,23,23		79:3	120.4
67:22 68:7,25	112:13:23:25	certain 93:7	17.5	circulated 11:17
69:1,4,8,17,20	(36)		changes 51:10	14:17
70:7,11 71:3,9,19	(50)	certainly 25:23	57:7 67:24 69:15	1111/
72:16,19 74:8	careful 15:9	30:20 32:3 35:25	75:16 83:17	circumstance
77:10 115:12		36:1,6 37:16	106:13 107:13	48:16
120:1 124:15 (49)	caribe 118:19	38:3,8 42:5 59:16	108:7 (9)	
		61:1 80:24 91:24		cite 75:12
calendar	carpooling 47:11	94:15 107:23	changing 42:23	
123:2,16 125:8,9		116:25 119:13,18	61:16 105:23	citizens 79:13
(4)	carries 49:16	126:8 (20)		81:3
			chapter 10:2	
camera 26:11	carry 77:11	certificate 131:1	21:18 22:9 23:15	city 131:19
	113:21,24		(4)	
canaveral 4:4		certification		clarify 3:7 46:9
	case 42:5,12,14	92:20 96:7	charge 97:4	47:1 61:2 (4)
cancel 65:19	77:7 109:21 111:6			
appealed 47.14	(6)	certify 131:6,13	charged 94:13	clarity's 44:24
canceled 47:14	cast 47:17 48:24	cetera 14:5 60:18	charges 97:9	clear 38:11 39:7
cannot 6:18	(asi +1.11 +0.24		charges 71.7	47:18 70:13 (4)
11:13 13:11	casualty 40:18	chain 104:8,20	chart 105:1,6	(+)
30:17,23 114:15		10110,20		clearly 27:10
(6)	catalyst 22:4	chains 56:14	charter 8:16,19	
	23:24		32:14 34:20	clone 40:15,17,20
			1	

				100
closing 128:5,6	34:12 36:19	126:10,20	common 65:4	completely
••••••	38:10,22,24	127:7,21 130:11		103:20
closure 92:13	39:14,20	(203)	commons 18:6	
	40:1,9,14,25 41:18	()	19:10 33:12 36:22	completing 76:13
clouds 3:12	42:22 43:4	combine 121:25	48:17,20 64:3	B
	44:10,22 45:24		92:9 94:20	completion 20:19
cme 107:14	46:1 50:25	combined 25:4	99:15,20 119:19	
	51:2,4,13,19,22	85:16	123:20 124:16	complicated 33:6
coalition 82:1	52:12 53:1,5,18,21		126:17 (15)	-
	54:6,11,14,16	combining 82:10		comply 10:11
coalitions 81:24	55:2,4,14,18		communicate	16:13
82:5,9	56:2,11 57:1,17,25	combo 59:21	14:13 15:5 70:16	
	58:3,5,14,16,20		94:18 (4)	component 106:2
coast 121:6	59:21,25 60:9,15	comfortable		
	61:4,15,19	112:11	communicated	components
coastline 3:13	62:1,3,8,25		15:4 77:25	52:22
	63:3,7,11,14,16	coming 24:1		
codified 22:7	64:1,8,11,15,19	36:14 65:4 92:13	communicating	composition
	65:21 66:17	102:23 (5)	78:3	30:13 51:15 54:17
cognizant 109:7	67:5,15,19,21			
	68:1,9,13,17,19,24	commencing 1:5	communication	computer 14:24
coincide 126:3	69:6,13,19,22,24		9:15 57:8 109:7	
127:9	70:19	comment 7:21,23		concept 33:12
	71:1,11,14,16,24	14:17 34:14 69:6	community 5:13	112:7
collaboration	72:2,5,10,13	127:23 (6)	6:5 33:3 109:10	4 20 0
82:5	74:6,18 75:3,6,24		129:10 (5)	concepts 38:8
collate 126:14	76:12,23 79:5,18 80:8,15,22,25	comments 9:3 11:18 13:5,7 14:7	comoderator	aanaantually
collate 120.14	81:18,21,25 82:20	29:15 37:8 44:10	61:23 62:3	conceptually 90:7
collect 9:3 26:7	83:2,20 84:1	63:17 64:17	63:1,4,12 (5)	90.7
concer 7.3 20.7	85:20 87:24	70:2,5,21 71:6	03.1,4,12 (3)	concern 17:19
collection 78:8	88:2,9 90:24 91:6	83:17 115:6	compared 97:15	46:3
	92:4,11 93:6,20,24	127:11,19 (18)	compared 97.15	10.5
collective 50:21	94:2,10,24 95:15		comparing 98:6	concerns 70:22
	96:5,11,13,19,23	commission 10:5	comparing 50.0	117:7 126:10
collects 79:8	99:12 100:16	11:3,7	comparison 94:3	11,1,1,1,20110
	101:2,12,15		95:12,13	concert 61:9
college 24:8 52:9	102:3,19	commissions	,	
79:19,22 80:5,6	103:1,11,20	10:7,21 29:23	compelled 70:12	conclude 71:8
81:9 88:6 91:22	104:5,7,12,18			
93:13 98:16	105:4,8,12,19	commit 16:19	compensation	conducive 118:13
99:1,3,6,10 122:8	106:9,14 107:10		30:20 71:21	119:14
(16)	108:3,15,23	commits 16:19	72:3,6 (4)	
	109:15,23			conduct 13:4,5
college's	110:15,18	committee 10:15	complete 8:24	26:5 56:20
79:22,24	111:11,16,21	17:3,8,11,16 35:1	9:7 34:13 72:22	106:20,21 119:22
collegial 57:0	112:1 113:5,14,17	36:16 66:20 79:24	77:2,5 78:23	(7)
collegial 57:9	115:3 118:20 119:24	81:10 102:17	91:9,23 116:11	conducted 11:21
colston 1:18 2:1	119:24 120:7,9,11,17	103:19 (12)	117:1 (11)	115:21
4:11,12,25 5:3	120.7,9,11,17 122:14	committees 10:7	completed 77:9	113.21
7:9,16 18:5,25	122.14 124:17,20,24	34:17,18,23	88:12 101:16	confer 41:20
19:16 20:4 28:2	124.17,20,24	35:7,18 102:21 (7)	00.12 101.10	
17.10 20.7 20.2	120.0,1,17,21			

		1	T	1
conference 11:22	14:18,25 17:6	convene 48:18	99:8 108:10,10,14	76:6,20 77:18,21
12:19,20,21	31:3 35:22 59:15		(11)	78:11,15 79:1
121:19 (5)	(7)	conversation		83:23 84:5,8,20
		22:19 86:3 130:6	costs 16:14 94:23	89:13 90:1,1,4,19
conferences	consistent 68:12		97:5,17,18,18	94:12 101:17
121:5		conversations	108:18 (7)	103:21 105:2,3,7,1
	consolidate 82:12	86:12		0,11,12,20 106:5
confirm 46:16			cot 17:23,24	107:3 108:3
	constant 34:2	conveyance 63:9	57:12 80:4,4,7	109:13 112:2
conflict 118:24			91:24 (7)	115:9,10,13,25
	constitute 19:14	cooperation		116:21
conflicts 31:5	37:10 64:23	25:14 74:11	council 1:1	117:18,19,23,24
119:5 122:12	131:10 (4)	23.14 /4.11	2:3,6,13 5:1,4,24	117:18,19,23,24
	151:10 (4)	1		· · ·
125:20 (4)		coordinate	6:2,25	120:3,12 121:1,8
	constitutes 66:18	119:11	8:5,8,12,14,17	122:16 127:13
confuse 43:10			9:7,12,14,25	128:9,14 129:13
49:13	constitution 10:3	coordinating	11:3,6,15,21,25	131:9 (220)
		4:21	12:1 13:13	
confused 46:3,8	constitutional		14:15,23	council's 25:20
	21:15	coordinator 7:6	15:8,23,24	31:8 55:24
confusion 43:1			17:10.23 18:6.15	
	constraints 116:8	coordinators	20:8,15,24	councilrelated
conjunction		80:1 119:12	21:6,8,12 22:23	15:22
52:18,24 121:5	contact 71:2		25:7,12,15,22,25	
122:15 123:11	contact / 112	copied 16:5	27:15,18 28:16,25	councils 8:11
125:16 (6)	contains 29:8	96:10,10	29:7,12,13,25 30:1	18:15 29:23
123.10(0)		50.10,10	,5,7,8,9,13,13,14,1	31:16,21 39:11
connect 22:17	contemporary	copy 29:18 36:25	6,18,20,23,25	47:4 (7)
	109:18	copy 29.18 30.23	31:10,13,25 32:4,5	47.4(7)
annacted 121.16	109.10	and 70.7 120.19		annal 1.20.22.9
connected 131:16		cord 79:7 129:18	,7,10,12,13,14,16	counsel 1:20 23:8
	content 28:23	. 12.10	33:2,3,14,15,16,19	40:25 56:17
connection	99:19 106:5	correct 13:19	34:9,17,19,21,22,2	131:14,15 (6)
14:10,23		17:14 34:15 39:14	4 35:2,5,9,14,21,2	
	contention 85:17	44:22 45:15,22	2,23,24	counsel's 4:16
cons 55:9 87:12		57:16 63:7 69:14	36:4,4,11,13 37:8	9:13
88:14	contentiousness	72:6 92:11 93:24	38:4,5,5 39:7	
	37:19	94:2 101:25 108:4	40:16 41:25	count 37:12
consecutive 31:1		111:24 118:1	42:6,24 43:23	47:24
40:22,23 53:22	context 91:14	120:6,16 131:10	44:6 45:18 46:8	
59:3 (5)		(21)	49:6 51:8,9	counties 25:3,4,4
. /	continue 22:5		52:4,6,18,19,24	
consensus 37:22	27:17 49:23 62:12	corrections 77:18	53:7,21 54:20,25	counting 100:1
124:20	99:14 (5)		55:25 56:1,5,15,23	
		correctly 43:22	57:6,19,21	counts 41:12
consider 15:21	continuum	116:2	58:8,10,25	
	78:21,24 79:4		59:2,6,18 60:3	county
considerable	98:8,9 (5)	correlate 82:11	61:12,14,22 62:9	3:2,8,10,13 4:9
95:6			64:9 66:17	6:24 7:7 121:14
20.0	contract 121:4	correspondence	67:11,23 68:3,8,8	131:3,19 (10)
consideration		11:15	69:11,15	131.3,17 (10)
12:4	contradict 60:20	11.13	70:5,9,15,22 71:20	couple 7:9 32:17
12.4		aast 07.1 21		35:12 47:11 124:5
considered 10.0	aantua 02:10	cost 97:1,21	73:2,14,15,19,24	
considered 12:8	contravene 23:10	98:3,4,12,20,23	74:10 75:17	126:12 (6)

course 7:19 9:24 11:10,16,19,23	data 26:8,16,18,20,21	102:20,21 104:25 106:6,9,24 (12)	delay 28:12	designate 42:14 62:20
		10000,2,2,1 (12)	delegate 11.11	
12:1 13:7,20 16:2	78:7,10,23 79:8,9		delegate 41:11	
56:16 75:18	84:22 85:25 91:13	decide 39:8 53:15		designated 63:5
104:22 106:16	92:9,18 96:22,23	58:22 61:3 95:2	delegated 10:8	
(14)	101:19 114:23	103:21 113:22,23		designating 60:5
			deliberations	62:17
	(19)	(8)		02:17
court 1:23 2:5,7			11:11	
4:11 16:12,12,13	date 13:14	decides 125:10		designation 26:4
39:15 55:21 90:8	76:17,21 84:2		delineates 26:3	97:13
	· · · · · · · · · · · · · · · · · · ·	de states 25.11	ucilitates 20.5	27.15
103:25 116:3 (12)	104:1 106:23	decision 25:11		
	110:7 119:16	50:15 95:12	deliverable 77:4	designed 22:2
courts 13:16	125:23 (9)		84:13 100:17	23:21 35:3
14:12		decisionmaking		
17.12				
	dated 107:8	10:10	deliverables	desired 29:3
cousin 61:7			110:23 116:12	
	dates 20:20	decisions 10:17	123:15	destroy 16:2
cover 28:22 54:8	53:2,11,13 101:10	78:11 129:19	120110	
		70.11 129.19		
80:13 88:10 (4)	102:5 112:6		demanding 99:3	detail 23:18
	122:23 123:8	decrease 124:5		
craft 86:11	126:15 (10)		denoting 113:17	detailed 98:17
128:17	120.15 (10)	dedicated 124:7		
120.17		ueuicateu 124.7		3 4 13 74 1
	david 1:6 7:5		department 1:2	details 74:1
crash 47:12		default 50:10	12:24 21:16	89:14 99:16
	days 3:12 12:8		23:1,23 24:6,21,24	
create 15:17,19	14:1 19:12 32:23	defer 40:25 48:16	25:15,16 26:5,7,15	determine 31:23
20:20 24:21 25:11				
	66:24 67:1 74:17		27:8,19 29:24	42:3 91:18 99:18
34:18,22,23 35:5,6	120:9 124:22,25	define 43:8	30:19 31:5,10,19	(4)
90:5 128:17	(11)	60:15,23 72:24	32:8,8 35:6 36:9	
129:14 (13)		91:14,17 99:18	38:7 39:10,12	determined
129.11 (13)	daytona 121:3	100:22 110:22 (9)	55:5,23 57:20	15:15 33:8 111:1
	uaytona 121:5	100:22 110:22 (9)	· · · · · · · · · · · · · · · · · · ·	
created 75:10			58:11 59:17,22	113:18 (4)
128:15	deadline 70:25	defined 20:8	60:17 63:18,20	
	88:12 91:1 99:24	21:20 54:3 57:19	65:18 70:23 73:17	develop 9:2 25:1
creates 56:23	100:7 101:9,13,23	58:10,11 73:18	74:13,14,23 81:7	27:8 94:16 100:17
creates 30.23	, , ,	· ·		
	102:10	83:12 (8)	82:1 84:16 85:21	116:3 (6)
creep 77:15	103:13,15,17,22		89:20,23 99:21	
-	106:7,10	defines 73:7	100:2 104:4 106:3	developed
criteria 69:9	126:11,18 (17)		108:13,19 110:12	8:10,17,25 23:7
	120.11,10 (17)	defining 15.24	114:21 121:24	
		defining 45:24		85:23 105:20
cruise 4:5,6,6	deadlines 20:20	74:19 76:13 99:13	122:5 (58)	106:5 (7)
		100:11 (5)		
cushion 102:8	deal 112:2 129:1		department's	developing 24:18
		definitely 2.12		1 0
		definitely 2:12	117:13	25:18 117:10
custody 16:4	dealing 60:6	38:22 85:2 122:17		
		(4)	departments	development
cut 84:3	debate 129:2		5:18	27:7 53:12 55:1
cut 04.5		J. C	5.10	
		definition 59:5		116:12 (4)
dance 66:3	decade 78:19	75:9	deputy 1:19 4:18	
			6:23 128:4 (4)	deviate 34:1
darwin 1:13 6:8	december 2:17	definitive 76:17		
17:16			design 120.14	dialogue 22.16
1/.10	85:8 88:12,25		design 129:14	dialogue 33:16
	100:18 101:10	defuse 119:5		34:2 130:6
1				

	1	1		1
dialysis 82:7	125:6 127:2 (15)	118:22 (34)	28:3,5,7,9 55:6 (8)	40:5,11,17,18
anij 515 02.7				41:4,15,25 42:7,20
dick 1:19 4:18	directed 32:9	discussions 11:11	dog 99:10	43:1,6,13
18:14,22 41:22	122:5	13:10 18:9,10,12	uog)).10	44:9,14,18,19
42:12 44:23 45:4,	122.3		doh 27:23	
,	P	(5)		45:2,7,11,15,19,22
9,12,16,20,23,25	direction 119:17	1	60:4,5,6,8,11,12	46:10,21
46:9,20		disruptive 33:19	61:16 86:2,12	47:3,6,8,11,15,25
47:1,5,10,13,18	directly 96:9		105:5,17 129:17	48:10,12,20,22
48:7,15,21,25	126:8	disseminate	(13)	49:3,8,12,15,16,19
49:4,10,13,17,20		70:19,20 73:23		50:1,4,9,24
50:6,13 51:1	director 4:17	95:1 (4)	dollar 95:4	51:3,4,11,17,20
56:22 57:2 61:21	5:16 6:6,9,17,21			52:5,13,15
62:5,14,19 86:2	20:3 119:9 (8)	disseminated	dollars 108:12	53:4,14,17
87:6 89:11,17,25		117:5		54:2,15,25 55:3,21
128:4,6 (46)	directs 24:24		domestic 24:25	56:6,9 57:11
	26:10,22 27:7 (4)	dissent 103:25	41:25 82:11	58:4,13,15,18,19
diem 30:23				60:10,14,19 61:18
	disaster	distance 129:4	done 8:7 18:25	62:10,16 63:8
diems 30:17	81:4,7,14		41:24 65:11 79:4	64:6,10,18,24
		distant 61:7	83:12 84:11 85:11	65:1,13
difference 29:22	disclosed 15:13		88:25 95:12,16	66:10,13,16
98:12		distracted 128:12	97:5 103:15,16	67:13,17,20,25 68:
	disclosure 11:20		104:4,14 108:1	2,12,14,18,21,25 6
differences 29:11		distributed 82:17	112:9 124:13	9:3,5,6,10,11,14,2
92:21,25 98:22	discuss 11:4 12:2		127:5,21 (21)	1,23 70:12,17 72:3
107:7,14,15 (7)	17:10,17 18:19	distribution		74:3,4,8,9,16,22
	33:22 36:5	26:11 114:13	donna 1:12 6:12	75:2,4 76:3,11
different 19:6	50:2,17,18,18,23		71:18 79:11	78:16,17 79:11,19
22:18 29:23 32:17	51:7,18 53:11	district 7:7	111:24 (5)	80:3,9,14,17,24
39:11 42:5 43:3	57:25 72:19 85:18			81:12,13,23,24
45:16 46:7 49:5	89:18 90:6 92:7,8	division 4:16	donna's 109:16	82:4,21 85:12,24
52:16 78:1 86:17	110:5 124:8	27:13 31:10,12 (4)		86:20 87:7,12,13,2
88:19,20,22 92:23	126:25 (25)		door 4:2	0,21,22,23 88:1,4,
94:6,7 97:6		doctor 3:7 79:15		5,8,13,15,19
98:20,24 114:10	discussed 17:23	97:17	doug 4:17,17	89:1,7,15,19,22
121:8 122:25	56:1 71:6 86:15			90:12,22
123:5 124:23 (27)	100:19 115:12 (6)	document 29:15	down 23:4 25:5	91:2,4,14,15,16,19
		41:19 70:4,20	40:7 74:20 77:21	92:7,8,12,19
differently	discussing 21:3	72:16,22 73:22	113:6 119:17	93:2,4,17,22,25
112:19	45:6	76:19 77:12 84:18	125:2 129:7,13	94:3,5,18,20,21,25
		107:20 110:13,16	(10)	95:4,6,8,10,18,24
difficult 36:18	discussion 11:18	116:20,21 (15)		96:1,6,7,15,21,25
97:3,8	17:25 19:15 33:25		downtown 5:13	97:3,9,11,25
	34:5 40:4 42:22	documentation		98:7,14,22 99:2
digest 9:2 71:5	45:17,23 47:2	28:6	dr 3:1,4 5:9,10,19	100:13
	49:20 50:1 51:23		6:3,8,15,20	101:1,11,18 102:9
dinged 124:17	57:9,17 60:9	documented 7:19	17:3,8,15,17,20	103:8,12,22
	66:19 67:12 70:22		18:5 19:24 20:2	104:2,3,6,11,15,21
dinova 1:15	71:8,8,18 73:13	documenting	27:23 28:2	105:1,5,10,17,21
5:23,23 63:15	75:6 79:23 83:10	8:17 39:16	35:17,23 36:12	106:6,11
75:22 76:20 79:25	90:8 92:15 99:13		37:2,17	109:12,16 110:12
80:12 98:2,9	103:25 106:16	documents 2:24	38:16,17,23	111:8,17,17,17,18,
101:7,14 119:6	107:1 115:6	8:9 14:5	39:5,13,18,23	19,23,23,23,23,24
1	1	1	1	1

ORIGINAL

112:12	easily 101:19	65:5	entertaining	estimate 20:19
112:12		05.5	111:11	108:14
			111.11	100.14
117:25 118:2,6,10,	east 121:6,6	embody 31:9	1: 00 5 47 00	
14,16,17,24			entire 23:5 47:20	evaluate 26:16
119:2,3,20	eastern 52:7	emergency 4:12	68:3,8 70:5 109:9	
120:5,15,21 122:8		5:10 12:9	114:5 (7)	evaluating 97:12
124:10,18,22	easy 77:9	19:13,14 25:16,17		
125:1,14 129:1	92:21,25 107:12	27:2 33:6,8,9,11	entirely 87:6	evening 69:25
(286)	(4)	41:7 64:3		
		74:14,14,23 (17)	entity 14:19,21	event 131:17
draft	edit 49:24 64:5		80:17	
8:6,6,10,25,25 9:2	76:1 83:6 (4)	employee 30:19		events 11:25
14:16,17 28:9		131:14,15	environment	12:15 114:14
29:2,18 30:1	edits 50:14,21	,	18:8 65:3 90:17	
39:13,18 53:19	54:16,23 67:24	empowers 21:8		eventually
56:3 71:3,3 72:15	70:7 71:9 75:19	F	envisioned	112:20
99:24 100:7 117:4	117:6 (9)	emsac 53:4,5	117:20	
(22)		118:6,16 126:4,8	11/120	ex 63:24
(22)	effect 102:16	(6)	eog 104:10	CA 05.21
drafts 15:2,3	CHECT 102.10		tug 104.10	exactly 18:24
28:5,10 29:5 83:6	effective 76:15	enacted 22:7	equal 43:5	21:7 44:9 64:20
,	enecuve 70.15	enacteu 22.7	equal 45.5	72:1 (5)
(6)	atabet 11.2 52.14	24.11		72.1 (3)
draw 56:2	eight 44:2 52:14	encourage 34:11	equally 26:1	42.22
draw 50:2	1.4.10.17	22.22	•	example 43:22
1	elect 12:17	encourages 23:23	equipment	56:14 98:16,24
drawing 41:24		1.641 1	98:16,17,18	104:21 118:10 (6)
120.12	elected 10:6	endoftheroad	10.0.06.10	1 14 1 50 2
drive 130:13		78:20	err 18:2 36:10	exceed 14:1 59:3
	electronic 14:6			108:11
driving 86:6		enforcement	especially 15:10	
	elements 29:9	81:15 114:7	18:7 36:22	excellent 51:13
drop 64:13	100:10			58:14 64:8 83:2
		engage 11:14	esq 1:20	107:3 112:1,2
drove 3:15	elias 1:17			115:3 (8)
	5:9,10,10 35:17,23	engaged 33:3	essentially 22:21	
due 20:16 21:9	81:23,24 82:4,21		31:2,18	except 57:12
104:1 106:23 (4)	118:10 (11)	enhance 25:13		115:13
		31:12 74:11	establish 21:19	
dumb 56:6	eligible 32:4		22:1 27:18 36:21	exception 11:16
		enjoy 4:4,8	(4)	
duplicative 123:4	elizabeth 1:23			exceptions 10:15
	131:5,23	enlarge 23:10	established 24:8	13:17
during 34:7 52:6			43:18 67:22	
117:18 120:3	email 7:24	ensure 13:5 23:8		excited 2:2,4 6:1
126:5 (5)	14:8,23 15:14,22	25:24 26:13 32:25	establishes 25:6	20:9 128:14
	18:15,16,22 28:14	60:18 90:25 91:10	27:5	129:23 130:9 (7)
duties 9:11 31:24	48:5 130:12 (11)	118:9 (9)		
			establishing	exciting 126:7
ear 47:19	emails 11:15 14:7	ensuring 28:16	24:23	6
	15:7,9,24 107:6			exclusive 80:18
easier 28:15	(6)	entails 88:10	establishment	
46:22 50:13			23:21 24:15	excuse 34:3
108:19 109:13 (5)	embarrassing	entertain 39:3,14		52:2,3 53:15,25

68:11 117:19 (7)	faced 116:22	fcot 80:1 81:10 118:6,14 119:6	finalize 9:3	fl 1:32940
executive 7:2 56:17 104:8	facilitate 19:7,11,22 20:18	120:19,21 122:19 123:10 (9)	finalized 8:15	flights 63:10
105:14 119:8 (5)	32:12,25 33:1,18 36:19 85:2 92:15	fcot's 119:8	finally 84:20	floated 2:23
exercise 70:10	118:12 125:12 (13)	fear 17:20	financially 131:16	floor 40:3 43:11 49:1,4,6 66:14
exhaustively				88:2 (7)
95:11	facilitating 31:19 52:21 117:14	feasible 88:11 100:5	findings 23:19 25:2 105:23	florida
exist 14:6 existence 15:17	facilities 21:23 78:20,21,22 97:2	february 102:12	fine 14:2 16:17,20 26:11	1:1,2,32940 2:3 3:19 5:24 6:11,19,24 7:12
73:8	(5)	federal 82:16	51:11 65:2 69:23 72:12 90:10 103:4	10:2,3,20 12:11 17:3,8 21:4,15,18
existing 25:16 74:13,23 75:4,4	facility 3:3 98:10,20 129:4 (4)	fee 95:6	(10)	22:8,9,10 24:17 25:6,12 26:5 30:8
122:6 (6)	fact 46:5 78:22	feedback 32:3 55:23	fined 13:22	32:9 33:10 36:12 37:1 57:12 79:21
exists 15:14	factfinding 10:16	fees 16:14 97:4	finish 101:19 104:3	80:4 81:3 87:1 88:6,7 89:2 91:21
expand 87:8,17,24 90:19 (4)	facts 23:12	felt 31:9 52:20	finished 85:4	92:24 96:4 98:13,15,25 99:2,3,5,9 112:24
expanding	fail 30:25	few 2:1 37:4,8 94:17 104:11	finite 9:1	114:12,24 121:10 128:10,17,18
100:20	failing 51:24 53:22	121:3 (6)	fire 5:17,17 121:5 128:24 (4)	130:2 131:2,6,8,20 (61)
expect 90:1,1	fair 17:25	fha 75:23	fired 41:12	florida's 10:1
expectation	fall 9:22 14:21	fhs 75:22	G monogono 121.6	flowidiana 120.15
56:22 expected 71:22	77:9 81:15 105:6 113:11 (6)	fifty 47:5	firerescue 121:6 first 2:3 3:4 5:3	floridians 129:15 flowing 21:24
	113.11 (0)	fight 99:10	8:3,21 16:23	nowing 21.24
experience 6:5	falls 106:2	figure 99:11	21:11 23:16,18 30:5 35:13 37:2	focus 129:24
expertise 83:19 108:24	familiar 9:16 16:3 31:16 81:25	122:20	51:7 52:17 57:23 59:4 66:7 84:21	focused 130:8
explain 15:18	(4)	figured 120:19	91:4 108:11,12 122:3 (22)	focuses 129:15
expressed 55:20	far 2:21 12:23 52:21 56:14 65:25	file 14:8	firstdegree 16:19	focusing 77:16
extend 8:20	87:8 96:24 100:9 107:3 108:17 110:21 114:9	filing 16:12 26:25 27:1	fit 28:18 116:24	folks 2:1 8:7 56:16 78:9 80:20 81:5 85:23
extends 121:4	116:10 117:10,14 119:15 122:3	filled 59:22 84:25	five 34:25 43:16 108:12	94:14,17,22 116:21 123:5,10
external 77:21	125:13 (18)	final 8:25 14:16 50:15 99:24 100:7	fix 127:15	126:4 128:1 (15)
extreme 23:18	fashion 82:13	(5)	fixed 79:3	follow 10:18 24:13 48:5,7,7,9

|--|

(6)	16:23	future 75:4,5	govern 9:14	99:7,20 111:20
		119:15 122:3	20:13,24 22:10 (4)	112:3 125:14 (13)
followup 110:19	four 85:7	125:18 (5)		
123:14 130:12	120:13,14	gainesville 6:13	government 9:24 10:1,9 16:23 17:9	guidance 87:10
force 82:12 86:6	fourth 64:10	gamesvine 0.15	36:14 46:25 85:4	guide 24:19
10100 02.12 00.0		gardens 121:12	(8)	27:16 35:7
forces 24:25	fpr 1:23	Surveins 121.12		27.10 33.7
		gathered 11:4	governmental	guidelines 24:7
foregoing 131:9	frame 76:3,12,13	0	10:4	97:13
	,17,25,25 77:6	gathering		
foremost 23:16	83:9,10,23,24 (11)	82:8,18	governor 22:8	guiding 73:22
			30:15 64:21 75:18	
foreseeable 11:5	frames 76:22	general 1:20 4:16	102:2 (5)	guilty 13:21,23
foregood by 26.2	framework	9:12 12:7 13:9 15:21 18:14 22:11	a a van an la	16:16
foreseeably 36:3	94:5,8,25	23:8 40:25 56:17	governor's 41:17,20 42:3,8	gun 67:6
forgot 96:15	74.5,0,25	57:4 58:25 104:22	84:17 85:5 (6)	gun 07.0
101800 20110	fran 1:3	105:6,17 106:1		guys 3:22 8:2
forgotten 83:1		115:14 121:1	gracious 3:3	9:22 18:8,11
C	free 116:23	123:4 124:3,20		19:7,17,20 20:6,19
form 14:6,16		(22)	grant 23:1	31:4,11 32:2
46:13 82:13	frequently 124:4			33:21 35:11
107:23 (5)		generally 12:10	grants 26:7	38:3,9 39:8 48:25
formal	friday 123:23,23	13:19 14:12 34:24 121:2,23 (6)	gray 41:22 73:5	49:21 50:23 51:9 52:25 53:9 56:3
11:8,10,12 18:9	front 4:2 8:3 29:2	121.2,23 (0)	gray 41.22 73.3	66:5 73:6,19
32:21 57:7,8 (7)	53:9 67:8 118:15	generic 54:20	great 28:21 42:16	75:10 83:4 86:7
021210111,0(1)	(6)	63:19 75:14	59:7 61:19 83:5	89:8,11,15 92:16
formalities 19:5			84:7,19 95:18	94:11 99:20
	ftsac 30:9,10	geographically	112:1,11	100:10 103:21
formalize 14:13	51:10	115:2	127:15,21 129:1	110:1,18 113:24
15:5		(• 1 114 10	130:10 (14)	116:6,25 117:15
forprofit 129:12	fulfill 91:3	geospatial 114:18	greatest 31:15	118:10 123:11 124:1,6 125:5
Torprofit 129.12	full 48:24 82:6	given 10:23 16:6	greatest 51.15	124.1,0125.5
forth 86:10	99:25 115:4 (4)	31:21 46:13 85:25	ground 114:6,18	128:16 (53)
130:10		86:16 122:24 (7)	ground 11.00,10	
	fully 22:16 23:7		group 18:16,19	hallway 85:19
forum 29:4 92:3		glad 3:8 114:1	19:1,2,2 25:23	
	function 8:5 10:9		36:8 41:21 50:22	hand 4:9,17
forward 2:12,19	12:25 35:15 (4)	gleaned 38:7	61:21 62:22 73:10	27:15 77:16 87:20
8:1 9:4,7,18 28:17 40:11 54:19 59:13	functions 11:7,8	glenn 1:16 5:19	78:2,5,5,13 85:11 87:7 95:1,13,17	131:19 (6)
63:18 71:10 91:10		greini 1.10 J.17	108:6,24 112:14	handing 28:4
95:3 100:6 111:3	funding 82:16	glenn's 94:3	121:9 123:1,24	
115:8 (17)			125:10 126:9 (29)	handle 114:12,15
	funds 26:12	goal 25:18 38:23		
foster 22:3 23:24			growth 74:24	handling 25:22
f or f or f or f = 10.0	funnel 57:4	goals 8:3	anaga 4.00 5.11	handa 4 20-19
fostering 18:8	funny 87:14	goodness 3:16	guess 4:22 5:11 37:9 46:25 61:7	handout 29:18
foundation 8:4	101111y 07.14	goouness 5.10	62:19 80:5 86:21	hands 97:16
-Summerium Off				

103:18 111:15	held 12:19 13:18	holmes 7:14	119:19 120:13,14	immediate 16:11
b and d w i 4 i a i 1 4 . 7	18:10 115:16	holzon 7.11.11	123:20 129:9 (10)	immediately
handwritten 14:7	120:19 121:3,15	holzer 7:11,11	house 20:6 21:5	immediately 77:22 117:22
hana 14.22	127:10 131:7 (9)	home 69:25		//.22 11/.22
hang 44:23	h . h. 20.15 15	128:7	86:14 102:2 (4)	·····
b 5,22,10,11	help 32:15,15	128:7	h 110-2	impact 86:4
happy 5:22 19:11	65:16 73:6 78:1	1	huge 110:2	
58:1 99:4 104:20	88:11 123:18	homes 82:6		impacted 78:14
(5)	124:3 125:12		hurricane	
	129:19 (10)	homework	65:13,17,19	implement 23:9
hard 97:16		21:9,12		
106:17	helpful 16:24	1 4 64 05	hypothesis	implemented
	59:19 95:22	honest 64:25	85:25,25 87:10	23:11
harder 88:17		86:18,18	91:15,17 (5)	
	helps 77:15,20			implements
hart 119:9	78:13	honestly 86:2	hypothetically	22:12
			123:22	
hb 73:8	hereby 131:6	hope 3:14 30:2,4		important 9:25
		33:2 35:12	ibrahim 1:10	12:2 25:22 73:15
head 35:3 87:22	herself 3:2	109:12,15 (7)	6:20,20 17:3,17	81:20 84:10
	1 1 1 10		18:5 51:3,4 79:11	105:25 112:25
headed 34:24	hesitate 41:18	hopefully 8:25	81:12,13	114:3 129:3,5 (11)
		9:22 38:1	111:17,23 (13)	
health 1:2 3:2	hi 5:23	65:22,24 87:11		importantly 8:18
6:12,15,21 7:7,13		124:13 (7)	idea 31:9 33:13	
21:16 23:23 26:15	high 66:6		50:3 119:23 (4)	impose 23:12
30:19 32:8,9 33:9		horsetrade 86:24	••••••••	110.15
70:24 73:17 74:13	higher 65:9 69:3		ideally 84:24	improve 112:15
80:9,19 81:8,24	99:9	horsetraders	120:17	
82:1,1,4,9,19,23		96:15		improved 120:21
85:21 89:20,23	hinted 15:1		ideas 2:23 25:24	•
99:21 100:2 104:4		hospital	29:14,24 81:6	improvement
106:4 114:21 (35)	history 86:8	5:14,24,25	85:3 (6)	23:25 24:2 26:21
	128:23	6:4,13,167:3,11		30:11 (4)
health's 63:18	1.4 70 01	82:15 89:6 (10)	identified 77:14	•
	hit 78:21	1 1 1 1	84:10 107:2	improvements
healthcare 7:2	hadren ad	hospitalized 47:12	116:17 (4)	22:4
hear 55.22 (0.7	hodgepodge	4/:12	identif- 77.1	inoudible 12.10
hear 55:23 69:7 70:6 130:6 (4)	109:6	hospitals 5.10	identify 77:1	inaudible 13:10 119:10
/0:0 150:0 (4)	h - LJ 49.17 00.10	hospitals 5:12	78:4,9 84:7,8,11	119:10
hoond 12.2	hold 48:17 99:19 104:19 117:18	21:21 26:23	91:13 94:14 110:5,9,9,23,25	incident 114:17
heard 13:2	104:19 117:18	80:20,23 82:6 (6)		
38:7,16 45:17,17		hast 2.0.22	111:6 (14)	incidente 114.12
50:17,18,18 55:13	123:10 125:16 (8)	host 3:9,22	;; 5.20 6.1 0 00.6	incidents 114:13
89:8 (10)	holding 50.12	hotel 118:19	ii 5:20 6:1,9 88:6	include 12.21
hooring 16.11	holding 50:12	HOLEI 110:19	(4)	include 12:21 13:24 25:24 54:5
hearing 16:11 23:5 38:10	hole 50:4	hour 19:10 33:12	iii 88:7	13:24 23:24 34:3 55:14 81:16 82:25
23.3 30.10	101e 30.4	99:15,20 117:23	III 00./	83:5 93:20 123:15
hearings 57:8	holiday 85:9	118:7 124:2,16 (8)	imagination	(10)
86:15 102:17	nonuay 03.9	110./ 124.2,10(8)	106:17	
00.13 102.17	holidays 100:1	hours 16:14 18:6	100.17	included 11:6,12
heart 5:19	nonuays 100.1	48:17,20 64:3	imagine 23:7	77:23 81:13 82:24
1 IICALL J.17		+0.17,20 04.3	magnie 23.1	11.23 01.13 02.24

87:3 (6)	information 9:18 18:18 23:13 42:17	institute 35:15	introductions 5:2 19:25	117:19 121:1,3 126:3 (9)
includes 10:6 14:4 18:22 128:19 (4)	75:11 78:8 79:6 95:19,22 104:16 114:23 118:20,21	institution 60:25 61:3 92:20 95:11 97:4 (5)	investorowned 6:11	job 71:24
including 9:14	122:24 123:14 126:14 (16)	integral 10:9	invites 80:7	joe 6:20
11:8,15 12:6 24:7 74:15 114:6 (7)	informationally 17:21	intended 77:13	125:9 involved 70:13	joseph 1:10 joseph's 5:25
inclusive 21:19 23:21 24:23	informed 78:11	intends 9:7	81:17	journey 79:3
25:13,18 52:21 74:11,20 (8)	infraction 13:22 16:17	intent 23:19 25:2 59:8 105:23 106:4 (5)	issue 33:23 38:7 41:22 45:23 46:24 47:17,25 48:18	judge 1:3
inconvenient 40:6	infrastructure	intentions 66:7	49:11 50:14 61:2 68:14 90:4,9	judicious 122:7
incorporate 49:24 50:14 54:17 61:14 108:6 109:8 (6)	25:17 74:15 infrastructures 74:24	interest 7:17 18:7 19:18 28:6,15 88:21 126:9 (7)	93:22 94:1 (16) issues 11:4 17:5 22:24 28:13 36:3 44:24 45:16 48:23	july 30:4 35:13 53:5 117:20,21,25 118:4,5,16,23 119:15,20 120:23 121:1,19
incorporated 29:24	initial 46:3 76:14 80:21	interested 78:9 79:1 131:16	58:13 60:6 90:2 96:25 97:1 98:14 107:13 128:13	125:13,16,17 126:3,16 (20)
	initiated 85:22	interfacility 27:4	(16)	jumps 124:2
incorporating 106:22	injured 23:22 55:7	interference 118:9	item 52:17 85:12,21 98:20	june 131:20
incorrectly 44:5	···· ······ 70.7	····	101:15 (5)	justifiable 47:23
indeed 34:3 61:5	injury 79:7 83:19,21 128:20 129:18 130:2 (6)	interim 4:16 internally 77:21	itemize 92:17	kate 1:21 4:14 20:22 21:2 39:16
indiana 78:17	input 29:2,13	interpret 13:16	items 13:5 31:9 39:17 70:6 92:17	(5)
indianapolis 6:16	30:2 35:12 48:3,23 (6)	17:20	101:3,14,21 (8)	katekocevar 7:24
indicated 21:5,8	insert 38:13 51:5	interpreted 15:14	iterate 47:20	kathy 7:11
indicates 25:11	inside 33:19	interprets 22:12	iu 6:15	keep 19:11 20:16 24:1 34:19 73:12
individual 18:17	insight 86:14	intricate 66:3	jackson 6:3	77:20 83:13 91:9 92:12,13,13 99:14
individuals 97:23	inspected 16:5	introduce 3:1	jacksonville 5:11,13,17 89:5	111:2 112:5 126:2 127:7 (16)
inform 103:3 129:19	inspection 10:24	4:14 7:10	(4)	keeps 77:15
informal 11:8 33:15,25 34:8 (4)	instance 41:6 47:3	introduced 5:5 20:1 85:22 102:23 (4)	jail 18:3 jamieson 1:3	kemp 1:9 6:23,23 36:13 51:24 53:16,20 54:13
informally 33:16	instead 41:8 106:15 127:3	introduction 5:6	january 21:10 102:11,19 111:1,5	56:8 59:6,19,24 65:2 82:23 92:17
		1		
96:17 102:16,20	21:1,2 27:25	lawsuit	119:4,8,22,25 120:	light 26:11 64:22
---	-----------------------------------	----------------------------------	-------------------------------------	--------------------------
114:1 120:25 121:16,18 (22)	96:9,12 (9)	89:7,10,17,19,22 (5)	6,8,10,14,16,23 121:13,17	lighten 42:8
	language 27:5		122:2,13 123:2	
kendall 20:3 89:21,22,24 90:3	28:9 53:24,25 54:21 55:18 56:3	lay 8:18	124:15 125:12,20 126:7,23 127:19	likelihood 65:10
(5)	60:16 63:3,19 64:5 66:18 74:20	lays 51:16	(79)	likely 52:11
kept 12:14	75:14 85:22,23	lead 11:11	left 4:1 75:17	limit 13:5 87:5
кері 12.14	86:3,9,11,17 93:6	115:10,11	78:5 117:9 (4)	
key 20:10 91:8,12	110:21 113:19			limited 10:14
	(23)	leadership 25:23	legacy 130:1	26:21 57:9
kind 5:4 8:2 13:9		56:18		
16:22 17:19 20:24	large 5:12 13:7		legal 8:7 29:8	line 7:18 19:21
21:13 22:22 24:18	121:5 131:6 (4)	leah 1:18 3:5	42:13 56:19 72:9	31:23 33:13
25:8,9,21 32:18		4:5,10,12 44:23	(5)	40:10,12,12
34:21 39:21 40:2	larger 114:3,12	106:12 (7)		64:6,10 70:8
51:16 53:1,12			legislation 86:22	74:21 107:14
54:20 57:3 63:19	largest 5:17	least 2:15 19:12	102:16 103:10	109:25 127:25
65:7 72:15		32:19 33:19		(14)
73:4,6,10	larry 1:11 6:15	52:17,23 53:3	legislative 23:19	
77:13,14,19,24	50:10 87:8 (4)	65:25 66:24 80:3	25:2 61:6 86:4	lined 77:15
78:13 81:14 82:10	las 114:17	88:25 94:5 95:19	103:5 (5)	lines 62:4 64:12
85:3 88:16,24 90:20 91:7,9	las 114:17	113:7 115:17 117:17 119:15	legislatively	78:7 80:16 83:22
92:18,19 94:11	last 37:20 57:19	124:6 126:1,3 (20)	57:13 106:21	103:6 111:2
95:11 97:21 99:24	67:21 68:1 83:18	124.0 120.1,3 (20)	57.15 100.21	105.0111.2 127:22 (8)
100:1,8 109:6,9	86:7,8 93:18	leave 8:15 19:21	legislators 90:16	127.22 (0)
112:3,7 115:14,16	107:22 121:3	53:21,23 54:7	103:9	link 52:20
116:3,14,15	128:9 129:1 (12)	69:13,18,19	100.0	
121:20		75:9,13 80:25	legislature 22:8	lisa 1:15 5:23
122:4,18,22	lastminute 37:4	92:14 127:8 130:1	56:23 57:3 101:25	75:21 101:6
123:7,16 124:3,5		(14)	105:3,6 (6)	111:18,24 (6)
126:2,13 (67)	late 103:17			
		leffler 1:22 4:19	length 13:7	list 14:4 58:6
kinds 32:17	laughter 62:18	5:1 29:10,17		83:7 93:17 94:3
78:20	95:7	34:6,15 35:20,24	leon 6:23	114:2 125:15 (7)
Imaging 66.1	loundry 14.4	36:9,25 37:14 38:2 39:6 42:18	less 123:7	listed 72:21
knowing 66:1	laundry 14:4	43:10 47:7 52:16	less 125.7	74:21 79:17
knowingly 13:23	law	55:22 57:5,16	letters 14:5	/4.21 /9.1/
16:17	10:1,5,12,18,19,25	59:15 60:12,24		listen 33:17 38:5
10.17	11:2,14,20 13:18	61:11,24 62:2	level 5:20	89:25,25 (4)
knowledge 14:14	14:10,20	63:24 65:18	6:1,7,9,22 88:6,6,7	
15:5	16:3,11,18 22:7,12	66:14,25 68:6,11	98:25 129:5 (10)	listing 57:22
	23:11 37:12 76:4	70:3,16,18 71:12		91:20
known 24:25	81:15 96:3 114:7	89:3 92:15 93:18	levels 88:20	
26:16 27:5	(23)	95:21,25 98:21		literally 56:9
		102:1,7 105:16	liaison 105:15	
knows 97:9	laws 9:14,20	107:11,22		litigation 89:14
	13:16 97:12	108:9,16	liaisons 11:13	
kocevar 1:21	115:19 (5)	110:14,16 117:12		live 6:18 70:7
4:14 7:24 20:22		118:1,3,8,18,21	liberally 13:17	92:1 115:15 (4)

14	6
----	---

[
lives 67:4	31:25 39:10 52:23	management	19:24 20:2,2	91:1 119:20,22
IIVES 07.4	53:13 67:1,9	79:6 81:5,14	40:5,11,18 44:14	
	,	79:0 81:3,14		121:1 126:4 (10)
lobby 3:25	87:10 90:10 91:19		52:13 54:15	
	96:2,3,24 98:2,4	manager 1:22	56:6,9	meeting 2:4,14
local 3:23 22:1	100:10 102:22	40:19	58:4,15,18,19	3:4 5:4 7:19 8:3
24:15 81:19 (4)	108:17 109:17		65:1,13 66:10	11:19
	110:2,3,21 112:23	managers 6:14	67:20 89:19	12:9,14,15,19
localregional	113:1,7,9	81:10	93:17,22,25	13:4,13,15
81:21	119:16,18 121:13	01110	104:3,6,11 111:19	17:4,7,9,12 28:25
01.21	126:15 (33)	mandate 87:4	117:25	31:6 32:10,21,21
locals 82:17	120.13 (33)	129:20	117.25	33:14,22 34:4
10Cais 02.17	Lasha 0.1	129.20		
10.10	looks 2:1		125:1 (34)	36:20 39:1 42:1
location 12:12	93:21,21 99:12 (4)	mandated 57:13		43:19 47:14
14:8 121:15			md 1:7,10,11,13,	48:2,2 49:23
	lorenzo 95:21	mandatory 19:19	14,16,17 (7)	52:24 53:3,7,12
locked 83:13				59:9 62:11 63:9 6
122:16	losing 41:8	manual 16:24	mds 75:25 76:2	5:5,11,15,20,22,24
		61:8		66:19
logic 23:12	love 130:6		mean 38:6 46:22	67:6,11,13,17
logic 23.12	1000 150.0	maps 14:5	74:8 85:24 86:7	70:21,23 76:14
	hunch 100.7	maps 14.5		-
logical 90:20	lunch 128:7	1 100 7 17	87:9 93:4	99:22 110:19
		march 102:7,17	97:16,19 99:7	112:7 115:20 117:
logically 84:25	ma'am 18:13	111:5	101:20,21 102:18	10,12,15,18,22
			105:20 121:16	118:3,4,25
longterm 78:19	mac 6:23 53:14	maria 3:1	(15)	119:2,16 120:3
	59:5,23 113:25			121:3,10,21,25
longtime 81:4	118:9 (6)	mark 1:7 20:2	meaning 47:16	122:1,3,3,12,18,25
			74:9	123:11,14
look 2:14 3:18	main 6:6 56:8	mason's 61:8		125:13,17,17,18
8:12,23			means 13:11	126:1,11,16,19,25
21:10,13,20,23	maintain 21:19	mass 40:18	22:7,11 43:6	127:3,5,6,9
22:14,16 24:1		114:14	115:17 (5)	130:11,15
29:1 30:3 35:11	maintaining 02.0		113.17 (3)	130:11,15
	maintaining 93:9 99:8	material 14:13		131.7,11 (99)
50:11 53:2 61:11	99.0	material 14.15	measures 27:10	
63:21 66:8 67:7	. 04.12		. 061	meetings 2:6
83:9 94:6 95:15	major 84:13	materials 14:14	measuring 86:1	3:22,23
99:7,17 100:22	94:17 100:8 123:3	66:23		10:21,22,23 11:21
101:9 107:5 108:4	(4)		mechanism	13:18 14:14 17:5
,5,7,13,17,23,25		matter 12:7	78:10	18:17,20
111:1,9	majority 38:13	108:24 114:15		31:2,18,19 32:15,1
112:14,20,22	39:25 43:9,20	123:6 129:13 (5)	media 13:11	7,18,20,22,24
114:5,16,24 115:5	56:7 58:24			33:5,6,8,11,24
122:25 123:7	60:21,23 64:9	matters 11:16	mediate 90:9	34:7 36:10,21,22
122:25 125:17	67:23 68:2,3 69:7	12:2 16:12		40:5,22,23
(48)	75:8 (14)	12.2 10.12	medical 4:13	52:6,7,14 53:23
	13.0 (14)	movimize 25.16		
		maximize 25:16	5:12,13,16	60:7 64:1,2,3,3,4
looked 29:22	malcolm 1:9	74:13 122:7	6:6,17,21 7:14	66:1,20,22 67:14
78:19 92:20,21			20:2 25:17 27:2	94:20 99:20,23
95:11 100:15	manage 56:18	maximizes 74:23	74:14 82:8,14	112:4 115:16
112:17 117:12 (8)	76:24		86:21 121:19 (16)	117:14,16
		maximum 98:1		119:15,19 121:1
looking	managed 78:25		meet 22:2 23:22	122:15,19,20
2:12,19,22 30:2		mckenney 1:7	30:4 32:19 50:22	123:3,8,20 124:16
, ,		v		, ,
1	1	1	1	1

125:15 126:17,23	messages 14:7,23	127:7 (8)	58:21,23	49:4,6,11,12,18
(67)	15:24,25 (4)		61:22,24,25	53:18,20 54:12
		minds 128:16	62:6,11,15,24 63:5	58:1,2,4,5,16
meets 27:20	messaging 78:3		(17)	59:23 60:12 62:25
52:18 120:12	94:19	mine 75:22		63:11 66:14 69:19
			moderator's	74:18 87:7,16,24
melbourne	methodist 6:16	minimal 66:24	62:21	88:2 111:3 115:7
131:19		118:9		(37)
	miami 89:6		modernization	
member 6:4 12:1		minimum 67:2	109:18,24 111:22	motions 70:6
34:24 35:1,2	michael 1:22	97:25		87:16
40:15 42:1,9,9	4:19 29:10 58:20		modernizations	
59:18 70:15 (11)	64:2 93:5	minor 92:25	109:21	motto 25:21
	95:1,1,16 108:4			
members 5:7,8	(10)	minority	modified 61:13	move 8:1 9:4,18
9:15 11:3,6,23,25		55:12,19,20 56:4	115:22	28:24 71:9,17
12:17 13:22 28:17	michael's 47:19	58:6 (5)		75:8 81:3 115:7
30:14,25 32:4			modify 23:10	117:11,24 118:24
33:2,16 35:23,24	michelle 7:13	minutes 10:23		(12)
37:11 40:7 42:24		12:14,17 60:18	molly 95:21	
43:2,19,23	microphone	71:13 116:1 117:9		moved 54:13
45:10,11,12,21	50:12 98:21	124:3 (8)	moment 112:6	
46:23 47:11,13				moves 121:10
48:3,6,10,23 51:24	microphones	miracles 104:12	monday 123:24	
53:22 64:9	2:9,10		125:4	moving 9:6 54:19
68:17,24 71:21	·•	misdemeanor		58:17 63:18 64:1
73:19 75:17 76:20	microscope	13:24,25 16:20	money 95:9	74:19 77:19 91:10
77:18 80:7 111:15	98:25	miss 40:21 116:4	month 100:1	100:6 117:8 (10)
115:14,25 119:5 (49)	might 8:24 37:9	124:14	101:19	multiple 49:1
(49)	46:13 49:9	124.14	101.19	multiple 49.1
membership	50:13,15 70:13	missed 111:18	monthandahalf's	must 10:21,23,23
30:13,14,16 40:1	75:7 76:5	116:24	120:18	11:18,23 12:8
42:24 43:5 51:15	78:8,10,14 81:6	110.24	120.10	13:1 23:1,2,11
54:18 57:13 68:16	102:11 108:19	mission	months 65:25	25:24 54:7 (12)
71:20 (11)	111:4 122:10	73:14,16,18,20,25	124:5	
/1.20(11)	123:8,9 124:14	74:4,17,19,19	12110	mystery 86:21
memorandum	126:21 (21)	75:16 (10)	morning 3:15 7:1	
12:15			9:23 21:1 29:17	nah 111:3
	mike 29:16 123:2	missions 34:20	120:12 123:23 (7)	
memorial 6:4				nailed 119:17
7:2,3	miles 3:13	mix 15:22	mornings	
			124:11,18	name 4:12 6:8
men's 3:25	milestone 91:8	mode 63:9		21:1 30:9,10,11
			most 4:13 30:10	41:23 42:4
mentioned 15:3	milestones	model 29:6 91:5	52:20 65:4 103:14	51:7,8,12 (11)
58:21 91:15	106:18		107:23 122:7	
128:19 (4)		moderating	129:2,5 (9)	names 76:21
	million 108:11	62:12		
mentioning			motion	namias 1:14
128:25	mind 19:11	moderator	39:3,15,18,20,23	6:3,3 17:8,15,20
	77:20,22 82:3	31:17,17 50:10	40:3 42:20	27:23 28:2 36:12
message 19:1	99:15 112:5,12	52:1,3 53:15,24	45:4,9,20 48:25	37:2,17 38:17,23

				-
39:5,18,23 40:17	109:4 122:15	28:24 34:16 35:12	nontrauma 5:12	ntdb 26:21,25
41:4,15 42:7,20	10,11122.10	41:10 42:18 50:22		1100 20121,20
43:6,13 44:9,18	necessary 38:3,9	51:22 52:23	normal 31:20,24	nuances 36:7
45:2,7,11,15,19,22	73:2 117:2 126:24	53:3,6 66:8 67:11	128:22	
46:10,21 47:3,6,8	(5)	70:22 71:17 73:14		number 12:21
48:12,20		74:17 75:17 76:16	north	19:21 25:5
49:3,8,12,15,19	need 8:22 14:16	77:5 83:14,16	121:18,21,22	55:4,16 58:6 61:6
50:1,9 51:11,17,20	18:9,12 19:8,9,23	84:3 102:6,7,25		78:1 88:24 91:11
52:5,15 53:4,14,17	29:5 32:1,20 33:1	111:7 112:13	notary 131:5	95:5 102:3 115:21
54:2,25 55:3,21	34:19 35:15,25	113:21 117:17		(13)
57:11 60:19 61:18	36:5,20,20 37:9	120:3,5 121:16	note 39:15	10.0
63:8 64:6,10,18,24	39:15 43:9,25	123:17 124:4	115:16,19 125:22	numbers 40:8
67:25 68:2,12,21	44:8 46:5,11,14,16	125:14,17 (41)	(4)	86:25 88:16 94:9
69:3,10,21,23 70:12,17	47:6 50:4 51:11 60:10 63:21 64:4	nice 3:10 4:7	noted 25:13	95:8 (5)
74:8,16,22 76:3,11	68:19 75:18 77:25	106:18	Hoteu 23.13	nurse 3:6 7:6
79:19 80:3 85:12	78:2,8,9 82:24	100.10	notes 10:13	97:17
86:20	84:12 85:11 87:12	nicholas 1:14	15:2,3 38:12	57.17
87:7,13,21,23	88:11,13		115:25 116:3,5 (7)	nursing 80:10
88:1,8,15	91:12,13,14,15	nick 6:3 62:12		82:6
89:1,7,15,22 90:12	92:8,8,16,18 93:15		notforprofit 6:6	
91:2,16 92:7,12	94:6 101:8,22	nicklaus	129:12	objecting 50:3
94:20 96:1,7,15	104:13,19 108:7	89:3,6,20,23 90:3		• •
97:11 99:2 101:1	109:4,6 111:25	(5)	nothing 30:20	objection 118:23
102:9 103:8,12,22	112:20 114:5		51:18 65:7,11	
104:2	115:11,20 116:13	night 129:1	74:24 109:21 (6)	obligations
105:1,5,10,17	122:25 124:4		10.00	118:25
106:11 109:12,16	127:14,15,23	nine 43:24 44:7	notice 10:22	
110:12	128:16 (73)		12:6,10,20 13:14	obtain 78:10
111:8,17,23 113:3,16 118:6,16	needed 2:11	nobody 18:3 104:20	17:13 18:10,18 19:12 23:6 32:24	93:12,14
119:2 120:15,21	76:24 86:23	104.20	33:4,24 35:25	obtained 93:10
122:8 124:10,18	104:23 (4)	nonattendance	36:9 48:18,21	95:20
125:14 (134)		47:16	65:21 120:18 (19))5.20
	needs 3:24 12:11			obtaining
naming 30:7	19:1 22:2 23:22	noncriminal	noticed 7:19	93:9,11,11 95:20
	35:1 36:4 42:9	13:22 16:16	18:19 32:22 34:4	(4)
national 24:7	46:15 79:4 91:17		36:5 46:15	
26:20 80:4 81:9	107:19 112:8	nondangerous	48:2,14 65:5	obviously 33:1
96:7 97:15 (6)	113:4 114:7 (15)	109:25	66:22 92:3 (11)	34:8 59:18 89:13
				90:16 94:22 96:21
nationalverified	negotiating 19:6	nondisruptive	notices 12:8	(7)
6:10		13:12	32:11	
52.00	net 7:4,11	10.17	4 · C ·	ocala 6:9
natural 52:20		none 18:17	notification	12.24
nature 78:3	neurosurgeons 80:6	127:12 129:12	12:23	occur 13:24 114:7,13
	00.0	nonmembers	november 99:25	114.7,13
navigating 19:6	neurosurgery	11:13	100:7 101:10	october
	99:1	11.1.5	100.7 101.10	103:16,16 104:16
nearest 129:4		nonprofit 6:14	102:10	105:10,10 104:10
	next 2:15 8:19			119:16,18
necessarily 20:12	9:8 20:5 24:3	nonsense 130:9	np 3:6	121:2,14,18,20
·			-	
			1	1

	1	1	1	1
122:9 123:1	operating 47:13	org 105:6	(7)	57:5 79:4,20,20
126:19,19 127:3,3,	98:25	VIS 103.0		85:22 86:23 88:8
	90.23	ananination	outsider 36:13	
4,6,8,10,10 (22)		organization	outsider 30:15	90:7 96:20 106:7
	operational	80:11		108:16,17 109:19
offhand 9:18	29:15		overlapping	112:25 (31)
		organizational	92:25	
office 1:20 4:16	operationally	105:1		participants
9:13 29:8	8:13		oversight 1:18	116:6
41:17,21 42:3,8		organizations	4:13 34:21 41:25	
84:17 85:6 (10)	opinion	10:8	(4)	participate 17:24
	55:12,19,20 56:7			26:20 30:18 33:17
officer 3:2 32:6	64:20 (5)	organized 106:19	overview 8:2	34:11 54:25
61:22			16:22	115:13 118:11 (8)
	opinions 56:4	organizers 119:6		
officers 13:21	58:7 88:19 127:14		own 34:18 94:15	participates
31:14,17,25 32:2,5	(4)	orienting 9:11		17:16
58:20,24 59:1,5			packets 72:14	
61:20 63:17 (12)	opportunities	orlando 6:20	-	participation
	19:8 36:22 108:14	7:13 118:18	page 51:7 57:19	12:20 34:7 80:7
official 5:4 11:9		121:19 (4)	68:1 77:3 81:14	124:16 (4)
13:2 14:11 15:8	opportunity 7:20		93:18 (6)	
33:15 46:4 62:8	13:1 18:11	orthopedists 80:6		particular 9:19
120:4 122:2 (10)	19:20,25 30:11		pages 131:9	23:20 29:12 40:3
	31:12 32:25 33:15	otherwise	puges to the	54:24 66:9 73:15
officially 49:21	34:1,2,8,23 46:16	30:19,22 58:22	palatable 100:4	76:19 78:13 86:9
officially 19.21	53:9 104:23	63:5 67:22 125:10		90:9 106:2 128:3
officio 63:24	119:25 (17)	(6)	palm 7:7	(13)
	119.25 (17)		121:12,12,13 (4)	(13)
omc 1:22	opposed 80:11	ourselves 22:18	121.12,12,13 (1)	parties 89:19
	110:13	102:11 103:12	pamphlet	131:14
once 8:15 28:8	110.15	102.11 103.12	107:8,17	151.14
41:16 57:25 69:25	optimistically	outcome 100:24	107.8,17	parties' 131:15
70:5,10 72:22	109:12	130:3	(6)	
77:8 84:2 88:16	109.12	150.5	(0)	partly 86:21
92:13 95:16 99:18	option 47:17	outcomes 26:24	panhandle 5:21	party 00.21
	90:13	outcomes 20.24	paintanule 3.21	nontrong 91.5
104:24 124:9 (16)	90:15	41 0.0 24.14		partners 81:5
26.17		outline 9:9 24:14	paramedic 129:8	82:22 83:21 118:8
onerous 36:17	options 65:23	75:19 84:4,5 (5)		(4)
50.1	122:14		parameters	4 00 17 00
oneyear 59:1	1 1 1 1 1	outlined 20:17	99:13,18 100:12	party 89:17,22
	order 16:14	27:10 30:14 31:8	1 00 17	
ongoing 89:14	27:18 28:21 30:5	63:20 76:19 (6)	parks 90:17	pass 2:9 39:24,24
	31:25 35:14			43:9,12,25 44:7
online 16:25	39:1,24 57:22	outlines 51:16	parliamentarian	45:12,21 50:5
	59:10 60:20,25	73:14 83:16	59:7,15,18,22	68:23 (11)
open 3:21 7:18	61:13 71:17 85:7		60:13,19 61:16,20	
10:21,24 13:10	102:23 108:6	outlining 84:6	63:23 (9)	passcodes 12:22
19:21 38:4,8	109:3,23 115:22			
127:22 (9)	(20)	outreach 7:6	part 9:11,25	passed 20:7
			10:11,24 18:5	
openly 17:17	orderly 13:5	outside 13:25	21:6,18,21,25	passes 38:6
		18:19 30:20 32:21	26:8,9 34:5 37:10	
operate 8:8 40:19	ordinance 14:10	39:21 50:11 57:9	45:4,5,7 51:20	passing 82:16
			I	

				100
past 78:18	49:5,7,8,10,17	personnel 25:17	placed 12:13	popped 77:22
121:11	52:4 65:16 70:13	74:15 91:24 97:2		popped 77.22
121.11			mlan 2.15 9.10	monuloted 76.1
	71:23 76:6 86:17	(4)	plan 2:15 8:19	populated 76:1
path 9:6	95:14 107:7		21:18 24:22 57:20	97:22
	122:10 128:16	persons 34:25	58:10 66:1	
patient 26:17	129:2,10,11,11	35:1 55:7	72:17,24 77:11	population 22:2
114:4,24,25	130:1 (41)		83:15,16 125:16	
128:20 129:9 (6)		perspective	(13)	port 4:4
	per 30:17,23 97:9	114:24 115:1		
patient's 79:2	108:19 129:20 (5)	117:1,13 128:25	planned 41:7	position 6:18
		(5)		31:3 41:9,9 46:13
patientcentric	percent		planning 24:20	60:10 61:17 63:1
128:11,18	37:15,18,21,24	pete 89:5	55:6 122:4	(8)
120.11,10	38:9,12,17,20	pere 05.5	55.0 122.1	
patients 26:24	43:12 47:5 (10)	phase 106:7,10	plans 24:4,23	possession 14:20
1 -	43.12 47.3 (10)	phase 100.7,10	plans 24.4,23	possession 14.20
78:24 90:3,6	6 4 67 0	1.11. 41.05	1 4 110.0	
114:14 129:3 (6)	perfect 67:3	philip 41:25	plates 110:8	possibility 15:14
		104:21 105:21		
pay 71:25	perform 10:9		play 10:9	possible 32:24
72:8,10,11 97:23	70:10	phone 2:8		33:5,20 52:22
126:6 (6)		7:17,18,23,25	pleasing 30:10	60:4 67:1 104:12
	perhaps 18:3	14:24 18:22		116:5 126:2 (9)
payments 26:10	106:6	40:7,10,11,12,13	pleasure 21:3	
		44:14,16,16,20		possibly 31:12
pdf 110:13	period 45:21	46:17 47:16 51:25	pledge 4:23,24	125:15
-	-	54:5,10 62:11		
pediatric 5:20	permissible	64:7 127:22,25	plus 37:15,18,21	post 28:3,7 72:23
6:1,5 21:11 24:4	18:18	128:2 (26)	38:17,20 47:5,6,7	1
27:11 77:8 85:15			(8)	posted 12:12
87:18 88:6	permit 16:5 61:5	physical 14:6		27:23
89:1,5,11		64:6,13,16	pm 130:15	27.25
90:2,6,18 91:4,11	permitted 34:5	67:14,15 (6)	P m 150.15	potentially 102:9
93:9 95:19 96:6,8	permitted 54.5	07.14,13 (0)	pocket 71:22	122:12
97:14 98:3,10,11	permutation	physically 12:12		
102:3 103:23	87:19	31:1 44:15 51:25	nodium 17.12	normana 21.20
	87:19		podium 17:12	powers 31:20
104:2 106:21,23		53:22	• • • 10 10 0	6 11 40 00
114:20 120:2	permutations	54:4,4,7,9,11	point 9:19 19:8	preferable 48:22
126:18 (34)	88:23	96:10 (11)	40:3 42:7 46:11	
			51:22 62:22 65:19	prehospital
pediatrics 27:9	perpetuate 14:13	physician 3:6	66:9 70:14 71:7	128:25 129:10
	15:5	5:11	82:18 85:17 93:3	
peds 101:18			112:13,22 118:22	premeeting
	person 16:4,19	physicians 3:6	128:3 (18)	125:13
penalties 13:16	42:15,15 62:5,17	80:10		
	128:2 (7)		points 38:5 55:23	preparedness
pensacola 5:20		pick 125:5		81:7
-	personal	-	policies 13:4 55:6	
people 2:8 21:17	15:1,7,9,23,23	piece 98:18	-	prepopulate
33:1 35:21	129:25 (6)	-	policy 22:13	73:17
37:8,25 38:1,23		place 12:6 37:19	93:14	
41:5 43:7,16,16,16	personally	65:15 75:24 94:7		prepopulated
,16,24 44:6,7,8	121:22 123:4	95:14 97:22,22	politics 46:25	73:1
46:4 47:22 48:5		115:18 123:3 (10)	r miles in 20	

	-			
prescribed 23:3	priorities 2:18,20	131:7,11	88:13	13:1,4,10,11,21
Prostince 25.5	9:9 57:21,22			14:3,9,14,15,18,25
prescribes 22:12	58:12 72:19,20,20	process 10:10	protocols 27:3,7	15:3,6,8,11,12,13,
	76:18 77:1,14,16	23:3,3,5 24:17	33:23 89:12 (4)	15,19,20,22,24
presence 31:23	84:6,6 101:5	26:4 57:10 59:13		16:2,3,4,11,15,18
presence erize	107:4 112:10	85:6,15 87:1,2	provide 10:3	17:6,9,13 18:18
present 1:6,18	115:4,6 116:12	91:20,21,23 93:11	25:23 27:19	23:6 28:6,17
11:24 17:12,21	(21)	95:20 106:13	32:10,23 33:13	32:11 33:8
31:1 39:25 40:12		108:22 109:11	34:13 35:12 55:4	34:4,6,13 35:25
44:3,4,20 45:10	prioritization	116:7 (21)	59:17 61:1 70:1,4	48:2 66:22 70:20
49:5 51:25 53:22	58:13 101:21		74:1 80:10,20	72:18 127:19,23
54:4,4,7,9 68:4		produced 116:1	93:5 95:21 97:12	131:5 (59)
69:16 (21)	prioritize		105:2 119:13	
	88:21,22,23	product 85:4	128:5 (22)	publication
presentation		97:11 130:8		12:23
9:12 11:1	prioritized 90:14		provided 22:24	
	••••	program 4:20	37:3 56:5 58:8 (4)	publicly 7:18
presentations	prioritizing	6:14 40:19 60:17		18:11,19 34:4
86:16	90:23	79:7 81:10 (6)	providers 27:2,6	36:5 48:2,13,21 65:5 92:3 116:20
nmagantly 12.2	priority 84:7,9	nnognogg 01.0	80:9,13,15,19,23 81:1,11	
presently 12:3	90:25 101:20	progress 91:9 128:11	82:6,8,15,19,23	(11)
preside 63:4	110:6,10,24	120.11	113:2 (15)	publiclyheld
preside 05.4	113:15 (8)	prohibit 13:12	115.2 (15)	11:19
president 7:2	115.15 (0)	30:21	provides 34:1	11.19
102:2	prison 14:1 16:20	20121	105:3 119:10	publish 115:20
	17:21	promote 25:13		Province 110.20
presumably		74:10	providing 37:4	published
103:8	private 10:8		55:15 74:12 95:22	12:8,10
	14:19,21 15:15 (4)	promoting 74:19	(4)	
pretty 19:5 36:19				publishes 16:23
63:3 83:17	privy 86:2,12	promulgation	provision 22:3	
92:21,25 116:4		56:21 57:10	23:24	pull 71:2 92:9
127:17 (8)	pro 61:25 63:6	108:7,15,16,22		97:8 114:22 (4)
		109:1,11 (8)	provisional	
prevent 32:6	proactive 2:10	50.10	89:4,4	pulled 54:21
	nuchless 49:12	proper 59:12	02.11	10.16
prevention 83:19,21	problem 48:12 113:8	nnonorly 21.24	provisions 23:11	purpose 10:16 16:1,6 31:8
03.19,21	113.0	properly 21:24 66:22	proxies 41:14	54:19,20 74:5,9,10
previously	procedural 11:22	00.22	66:13	91:11 101:24
121:15	12:5	proposals 93:14	00.15	105:7 111:19 (13)
141.15	14.0	116:15	proxy 17:22	
primarily 2:13	procedure		40:22 41:3,9,19	purposes 2:7
5:13 9:5	33:7,10 38:18	propose 103:2,22	42:10,10,10,14	26:22 73:13 104:7
	,	123:8	46:19 (10)	110:19 111:22
primary 86:5	procedures 24:5			116:9 118:22
93:22	115:10,15,18 (4)	proposed 126:15	prq 91:22	122:4 126:24 (10)
prime 85:8	proceed 18:2	proposing 53:14	public 2:2	pursuant 14:10
	59:10,19	103:5	7:21,23	
printed 17:1			10:4,21,22,24,24	pursuing 95:23
	proceedings 10:4	pros 55:9 87:12	11:20,20 12:12	
1	1			

nuch 56.17	questions 17.2	reach 82:14,18	received 14:10	records 10:25
push 56:17	questions 17:2			
103:12,17 116:14	18:4 27:22 28:20	114:18,19 119:9	72:14 127:24	11:20 14:6,9,20,25
(4)	35:16 40:4 44:10	(5)		15:7,12,12,13,18,1
	60:9 72:13 77:17		receiving 2:19	9,23,25
pushing 37:5	82:20	reached 78:12		16:2,3,7,11,18
	104:21,22,23		recent 78:18	26:3 28:17 (21)
put 28:23	105:22,24 107:1,7	read 25:10 76:5		
32:14,15 33:4	117:4,6 126:10	93:6,17 (4)	recently 112:18	red 26:11
55:12,17 56:13	127:11 (22)			
66:18 70:5 76:21		reading 85:13	recognition 4:19	redact 94:22
77:21 79:13,14	quick 83:9	reading 05.15	56:1	95:4,4,8 (4)
,	quick 05.7	real 40:15 128:11	50.1)),+,+,0 (+)
80:18,23 92:22		real 40:15 128:11		
94:6,8 95:9	quickly 67:1		recognize 55:9	redacted 95:6
100:8,9,11,13		realigned 79:12	_	106:25
107:18 109:2	quite 107:23		recommend	
112:21 113:18,19		realize 25:22	38:25 123:24	redactions 95:16
122:5 126:11 (30)	quorum 11:23	75:25		
	31:23 37:10,14		recommendation	redefining 40:2
puts 38:20	40:1,2 42:23 43:2,	really 3:13 9:5	13:20 18:1 38:14	
	5,8,8,11,13,14,15,	21:7 23:6 37:21	55:14,24 56:15	reed 1:11 6:15,15
putting 28:6	18,23,25 44:4,6	38:20 41:5 44:24	58:1,23 59:16	38:16 39:13
I B B	45:1,3,5,14,24	47:18 50:2 64:21	62:9 68:6 74:7	47:11,15,25
qualifier 28:23	46:4 47:4 48:1	65:13 75:12	80:8 83:2 90:24	48:10,22 49:16
quanner 20.25	50:17 60:23	76:13,17 77:13,19	106:9 108:4	50:4,24 58:13
qualify 76:16	64:18,19,23 65:4,6	78:18 79:14,23	111:12 126:20	60:10,14 62:10,16
quality 70.10	66:18 67:17	83:7,9 86:2 93:7	(19)	66:13 67:13,17
analifying 72.5		· · ·	(19)	,
qualifying 73:5	68:14,18,21 (40)	99:10,12,16		68:14,18 72:3
		105:10 108:9	recommendation	74:3,4,9 75:2,4
quality 26:3,21	rabbit 50:4	109:7,19 110:20	s 2:20 10:16	78:16,17 85:24
		112:12,17	11:5,9 12:18	87:12 88:5,13
qualitydriven	rabbithole 49:15	115:9,11 116:4	25:15 27:19 38:11	91:4,15,19 92:8
128:12		128:14,14,16	39:10 54:23	93:2 94:3,18
	radar 112:22	129:2,22 (42)	55:4,10,15	95:4,8,18,24
quandary 44:17	113:11 115:5		56:5,8,19 58:7	96:6,21,25 97:9,25
	116:16 (4)	realm 106:3	69:1,15 73:3,10	98:14,22 100:13
quantify 93:1			74:12 75:7 79:10	101:11,18
97:4	raining 70:1	reappointed 31:4	83:8,17 84:16,17	111:17,23 118:24
	8	59:2	108:21 109:17,21	119:20 120:5
quantitate 92:22	rainy 3:11 4:7		(31)	124:22 129:1 (63)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		reason 16:6		
quarterly	raise 4:17 111:15	37:18 47:23 65:4	recommended	reevaluate 83:11
32:19,21 115:17	laise 4.17 111.13	90:18 109:4 (6)	117:6	reevaluate 03.11
· · · · · · · · · · · · · · · · · · ·	mainag 97.20	90.18 109.4 (0)	117.0	nof error of 26,14
122:20 (4)	raises 87:20		10.14	reference 26:14
17.10	104.00	reasonable 10:22	reconvene 13:14	67:16
question 17:18	random 124:22	12:6 13:1,3,6	71:14,16	
18:14 28:2 34:3,6		16:14 53:15 (7)		referenced 72:16
35:17 37:14	ranges 97:25		record 4:14	
41:2,13 42:16,20	_	reasonably 37:25	14:4,14,15,15,18 1	referring 23:16
43:11 44:18 47:15	rather 60:3,5		5:3,6,8,16,17,18,1	
51:23 56:6 58:17	123:6	recap 81:1	9,20,22 16:5,5,15	reflect 63:22
62:19 71:18,19,23			71:12 72:18 (20)	
85:12 86:20	rdstf 24:25 82:11	receive 30:19		reflecting 12:15
91:3,25 101:6 (26)		71:21 127:24	recordings 13:12	

Г		T		т
refuse 105:18	reintegration 128:21	reporter's 4:11 116:3	24:14,21 26:4,14,19 32:19	reviewers 97:7
magand (0.2	120.21	110.5		
regard 60:2	1 4 20 15 25		98:13,13,15,25	reviewing 26:18
66:21	relate 20:15,25	reporting 1:23	(11)	105:21
regarding 11:15	related 15:7	reports 11:16	reschedule 65:17	revise 28:8
35:17 63:17 67:12	36:10 55:6 90:2	55:10 80:2		
(4)	93:13 96:25 97:1		rescue 5:17,17	revision 107:22
	98:14 126:8 (9)	represent 5:11		
regardless	<i>y</i> (<i>y</i>)	6:10,24 7:3,7 43:2	residents 5:21	revisit 51:9 83:14
14:5,7,24 55:24	relates 34:16		Testuents 5.21	110:10
, ,		(6)		110.10
108:22 (5)	47:15		resolution 38:6	
		representation	43:12	revote 48:19
regional 6:9	relating 120:2	5:6 69:16 75:20		
7:3,14 22:1			resource 16:24	rhetorical 86:21
24:15,20,25 25:1	relative 76:25	representative		
82:11 (9)	131:13,15	5:24 44:17 57:15	resources 98:17	rid 63:6
	,		116:10 117:14	
regions 24:21	relatively 109:25	represented 56:4	122:6,7 (5)	rise 4:23
82:12		58:7		
02.12	relay 28:9	50.7	respond 126:13	risk 38:20 43:21
magistar 12.11	1 elay 20.9	nonvocanting	respond 120.15	115K 30.20 43.21
register 12:11	1107.17	representing 5:21 6:13		
•	relook 107:17	5.21 0.15	response	rmis 79:6
registry	100 5 6	. 15 10	15:18,20	1 < 10 15
26:8,9,18 27:1	remarks 128:5,6	request 15:19		rn 1:6,12,15
78:23 79:6		92:16	responsibilities	
129:16,18,18 (9)	remember 26:25		9:16,25 20:15	road 1:24 113:6
	28:5 76:4	requestor 16:6	42:9 91:3 106:3	
regular 19:17			115:10,12 122:10	rob 7:14
31:2 32:18,20	remind 105:1	requests 127:24	(9)	
33:5 53:23 64:2				robert 1:11
66:22 117:17 (9)	removal 16:19	require 23:22	responsibility	
	i chiovar 10119	33:21 37:25 60:21	32:14 46:12 64:21	robert's 31:24
regularly 18:7	remove 54:6,11	(4)	52.11 10.12 01.21	39:1 59:10
regularly 10.7	80:22	(4)	responsible	60:20,22,24
	00.22			
regulations 97:13	1.04.5	required 2:17	31:18 63:20	61:5,13 115:22 (9)
	renewal 24:5	10:11 12:16,21		
regulatory 106:3		16:8 23:13 29:8	rest 88:24 115:9	rockets 4:4
108:10,13,18 (4)	repeat 44:4	32:22 106:21	125:18	
		116:14 124:16		role 6:6,21 10:9
rehabilitation	report 11:19	(11)	restate 109:16	21:16 31:22
78:19 79:6 81:4	26:23 55:12 56:24			32:8,13 59:13
128:21 (4)	57:2 100:3,18,24	requirement	restroom 3:24	60:11 62:6 63:18
	101:25 102:21	56:24		(11)
reimburse 30:17	103:9 105:2,20		revenues 26:12	
	106:5 129:21	requirements		roles 20:8 21:20
reimbursed	131:7 (16)	10:19 11:22 12:5	review 14:17	115:10,11 (4)
30:22,23		14:21 23:12 27:6	15:11 104:6,7	
	reported 123:5	30:25 93:8 97:2	106:25 111:22	room 7:10,22
reimbursement	reported 123.3	98:23 99:4,5	116:6 (7)	121:8,9 127:25 (5)
30:21	reporter 1:23	102:4 (13)	110.0(7)	121.0,7127.23 (3)
50.21	2:5,7 39:16 131:1	102.4 (13)	reviewed 79:3	rounds 124:14
noinstated 6.2	,	noguinog 22.20	116:1	1001105 124.14
reinstated 6:2	(5)	requires 23:20	110.1	

routine 57:3	schedule 33:7,11	secretary 1:19	sent 19:3 66:23	113:1 120:23
	36:21 40:6 52:6	4:18		123:17,19,25
row 41:11	53:2,3,12 65:22,24	31:17,22,22,24	sentence 57:19	124:2 125:8
42:11,11	66:2 117:10,13,15	58:21,23		126:16,18 127:12
12011,11	118:12 119:14,18	60:3,7,13,16,17	sentenced 14:1	(39)
royale 118:19	122:4 124:23	128:4 (14)	Sentenceu 11.1	(37)
	125:4,18	120.4 (14)	separate	sets 79:9
rule	126:1,11,23,24	section 10:2,20	44:18,25 48:1	Sets 19.9
22:11,21,22,25	(25)	16:4 23:20 24:3	63:10 80:17 81:18	setting 2:12
23:2,4,6,9 25:8	(23)	26:10,19 27:9	90:24 91:1	31:20 32:11 65:22
37:12 54:25	scheduled 41:6	28:25 54:24 56:16	101:8,14,15 (11)	99:22 112:4 (6)
56:14,20,21	53:4,5 67:6 (4)	75:17 84:4 96:3,4	101.0,14,15 (11))).22 112.4 (0)
57:7,10	33.4,3 07.0 (4)	100:14 116:23,24	separately 68:22	seven 12:8 19:12
107:9,10,11	schedules 46:16	127:20 (19)	81:16	32:23 47:7,8,9
107.9,10,11	67:4	127.20 (19)	01.10	66:24 (7)
108.7,15,10,22,25	07.4	2000 11 11 21.25	contombor	00.24 (7)
109.4,3,11,12 (20)	ashaduling 21.5	security 24:25 41:25 82:12	september 103:18,22	annal 7.16 17.4
las 0.16 12.4	scheduling 31:5	41:23 82:12	· · · · · · · · · · · · · · · · · · ·	several 7:16 17:4
rules 9:16 13:4	32:11	see 4:3 14:4	104:1,17 106:12,15 (6)	29:23 99:19
20:12,13,14,15,23 21:4,22 22:13,15	scientific 87:9	See 4:3 14:4 19:24 21:15 23:25	100.12,13 (0)	111:15 (5)
23:2,10,11,12	scientific 07.9	24:9 27:9 28:18	serious 36:14	severely 55:7
23.2,10,11,12 24:18 27:14 28:20	scope 77:15	29:3 32:1 48:4	serious 50.14	severely 55.7
31:24 34:12 35:15	scope 77.15	79:12 96:12	serve 22:3 23:24	shall 16:5 31:2
38:18 39:1 40:20	scorecards	101:18 106:17	32:4 38:23 42:1	56:4 57:19
43:15 55:5 59:10	27:11,11	116:24 (16)	59:1,17 60:13	58:7,10 61:12
60:20,22,24	27.11,11	110.24 (10)	62:2,20 79:14 (11)	71:20 (8)
61:1,5,13 97:12	scoring 27:8	select 122:23	02.2,20 79.14 (11)	/1.20(0)
115:14,22 (36)	scoring 27.8	select 122.23		
			corvod 5.16	chande 6.13
113.14,22 (30)	second 13.14	selected 12.1	served 5:16	shands 6:13
	second 13:14	selected 42:4	served 5:16 115:1	
run 32:18	39:15 42:21 44:23	selected 42:4 58:24	115:1	share 5:14
run 32:18	39:15 42:21 44:23 50:24 51:2,3	58:24	115:1 service 1:23 24:3	
run 32:18 running 59:8	39:15 42:21 44:23 50:24 51:2,3 54:14,15		115:1	share 5:14 94:10,11
run 32:18	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25	58:24 selection 26:2,4	115:1 service 1:23 24:3 27:2 128:24 (4)	share 5:14
run 32:18 running 59:8 104:8	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15	58:24 selection 26:2,4 senate 86:14	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17	share 5:14 94:10,11 shelf 102:14
run 32:18 running 59:8	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23	58:24 selection 26:2,4	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10	share 5:14 94:10,11
run 32:18 running 59:8 104:8 rural 82:23 97:22	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16	58:24 selection 26:2,4 senate 86:14 102:2	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8</pre>
run 32:18 running 59:8 104:8	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18	58:24 selection 26:2,4 senate 86:14	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5)	share 5:14 94:10,11 shelf 102:14
run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3</pre>
run 32:18 running 59:8 104:8 rural 82:23 97:22	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8</pre>
run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37)	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6)	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4)</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37)	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree 13:23,25	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4)</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 satisfy 87:4 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree 13:23,25 seconded 74:22	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24 (24)	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree 13:23,25 seconded 74:22	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23 38:18,19 60:25	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12</pre>
 run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 satisfy 87:4 	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) secondegree 13:23,25 seconded 74:22 88:3	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24 (24)	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23 38:18,19 60:25 65:9 66:5 71:1 78:17 91:13 97:6	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12 show 10:14 37:11</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 satisfy 87:4 savings 108:14</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) secondegree 13:23,25 seconded 74:22 88:3	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24 (24) sends 40:22	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23 38:18,19 60:25 65:9 66:5 71:1	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12 show 10:14 37:11</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 satisfy 87:4 savings 108:14</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree 13:23,25 seconded 74:22 88:3 seconds 51:4	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24 (24) sends 40:22	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23 38:18,19 60:25 65:9 66:5 71:1 78:17 91:13 97:6 99:15,24 100:5	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12 show 10:14 37:11 sic 16:16 38:4</pre>
<pre>run 32:18 running 59:8 104:8 rural 82:23 97:22 rush 9:1 rushed 104:14 sacred 5:19 safety 7:4,11 33:9 sake 44:24 90:15 satisfy 87:4 savings 108:14 scattered 82:10</pre>	39:15 42:21 44:23 50:24 51:2,3 54:14,15 58:3,15,16 59:25 60:1,14,15 61:16,18,23 63:14,15,16 66:16 69:22 74:16,18 87:21,23 88:4 100:19 102:4 103:24 106:7,10,11 113:16 115:7 (37) seconddegree 13:23,25 seconded 74:22 88:3 seconds 51:4	58:24 selection 26:2,4 senate 86:14 102:2 senator 86:5,10 send 7:23 19:2 28:14,16 42:10 56:10 70:4,14,17,23 83:6 94:22,25 95:15 104:24 106:24 118:20,21 123:13 125:8,15,19,20,24 (24) sends 40:22 senior 122:9	115:1 service 1:23 24:3 27:2 128:24 (4) services 25:17 26:13 74:14 80:10 96:8 (5) serving 38:1 session 12:10 39:2 102:5,12,23,24 (6) set 2:18 8:4 13:3 18:6,7 19:3,10,16,18 24:12 35:14 36:23 38:18,19 60:25 65:9 66:5 71:1 78:17 91:13 97:6 99:15,24 100:5 101:8,20,22	<pre>share 5:14 94:10,11 shelf 102:14 shenanigans 86:8 shoot 56:3 shooters 114:8 short 30:10 51:8,9 126:12 (4) shortened 30:9 shortly 130:12 show 10:14 37:11 sic 16:16 38:4 side 18:2 36:10</pre>

92:22,22 (6)	sole 15:2	119:10 121:8	60:11,17 118:12	state 3:19,22 4:20
	SOIC 15.2	122:25 (8)	119:4 (9)	5:18 6:10,11,17,18
sidebar 18:17	solicit 23:13			10:6 13:25 20:6
		speaker 7:21	staffed 60:17	22:6 23:14
sign 95:4	solid 101:3	34:13 102:1		24:17,20,22,22
			staggered 76:8	26:14 27:1 33:10
signature 131:22	solidify 2:14	speaking 103:13		37:12,20 55:5
		121:2	stahl 3:1,4,5	57:21 58:25 65:14
silly 59:7	solidly 83:17			72:4,6 82:4,10,16
	10.00	special 4:19	stakeholder	85:4 86:9 91:21
similar 29:6	someone 19:22	32:22 33:5 35:4	78:5,5 79:24	93:10 95:18,24
100:21,24 101:1	35:2 52:2 59:12,13 (5)	64:3 67:13,14,17 119:19 126:23	86:23 88:20 109:10 (6)	97:6,9,14,14 107:16 112:23
(4)	39.12,13 (3)	(10)	109.10 (0)	114:11 115:19
simple 73:5,12	sometime 130:14	(10)	stakeholders	131:2,6,20 (48)
simple voie,12		specific 9:13 22:2	25:14,24 34:8	10112,0,20 (10)
simply 29:2	sometimes 12:16	23:11 39:21	74:12 77:19,20	state's 106:1
33:25 75:19 103:2	18:15 21:17 28:13	42:14,15 48:18	78:9 82:22	
(4)	40:5 66:6 77:9	56:24 68:25 69:8	83:4,18,20 86:11	statedesignated
	121:21,21 (9)	72:10 81:6 82:25	(12)	98:5
sit 21:6 23:4		89:14 90:8		
36:12 40:19 65:6	somewhat 57:8	94:14,23 98:24	standalone 85:15	statement 12:7
111:3 (6)	L 14.0	108:18 129:20	87:3,18 89:1	22:11 55:15 59:4
site 37:1	somewhere 14:9 55:3 121:11	(20)	90:17 96:1,3,4,13,18,20	61:12 67:22 73:11 (7)
Site 57.1	55.5 121.11	specifically 23:13	(11)	
sitting 90:16	soon 33:4 42:19	25:10,12 126:25	(11)	statements 73:5
128:8	104:18 117:5	(4)	standard 2:6	
	130:14 (5)		22:19 38:19 39:22	stateverified
situation 11:4		specifies 99:1	108:18 111:13 (6)	26:12 98:4
	sorry 10:13			
situations 14:19	28:22 43:4 62:8	specify 98:17	standards	statewide 24:23
atra 21.0 42.25	67:25 84:3 101:5	spectrum 82:6	21:4,22 22:16	90:10 112:16
six 31:9 43:25 44:3,8 47:6 52:14	121:17 (8)	spectrum 82.0	24:6,10,11,12 27:14,20 97:13	statute 2:16 9:8
65:25 128:9 (8)	sort 11:11,18	spend 74:16	99:9 110:4	20:18 21:7
	13:2 37:3	spena / 1.10	111:12,16 (14)	22:7,14,24 23:1,15
sky 129:21	50:10,11 59:11	spinal 79:7	-,()	25:10 26:8
	79:12 85:10 94:3	129:17	standpoint 82:2	30:8,14,16 32:9,19
slant 60:4	100:1 123:6			33:7 51:16,17,21
	128:21 (13)	spivey 7:14,14	start 2:24 40:7	54:21 63:20 72:7
slides 21:13	1.50.7	4 104 7	51:6 53:10,12	73:175:9,13
27:23	sound 59:7	spot 124:7	84:25 95:14	85:13,14,18 86:3,5
sm 20:3	sounds 49:8	spouse 62:17	100:23 101:23 102:17,21 110:25	87:4,15 88:24 90:12 93:7,23
5111 20.3	100:5	spouse 02.17	102.17,21 110.23	96:2,5,9,16,17
small 40:8		squeeze 120:20	126:14 (17)	97:11 100:15
	south 121:10,21			107:8 122:5
smart 129:2		stabilization	started 4:22	128:15 129:21
	southern 52:10	129:4		(48)
smoother 109:11			starting 5:8 93:3	
and 11:05	space 4:4 13:8	staff 5:5 12:24	stanta 100.7	statutes 10:2,20
social 11:25	32:10 33:14 99:22	13:11 59:17,22	starts 102:7	20:12,14,24

11:4,1:8,1:8,22:9,14 stuck 59:20 submitting 78:22 112:12 113:13 survey 97:10 23:17,18 27:14 study 20:19 subsequent 118:25 (38) surviving 62:17 82:0 55: 59:32:0 stuty 20:19 21:11 77:8 79:21 subsequent sunday 106:13 surviving 62:17 81:10:17 87:45,59.24 substance sunshine 9:20.24 sustainal 101:15,12,18,19 22:20,21 23:9 92:12,18 96:7 substantial 107:23 108:13 11:2,14 13:16,18 sustainable 22:20,21 23:9 92:12,18 96:7 substantial 107:23 108:13 11:2,14 13:16,18 sustainable 130:8 104:21 067:21,122 108:2 35:19,22 36:16 system 1:1,21 130:8 104:21 067:21,122 108:2 35:19,22 36:16 system 1:1,21 130:8 studying 109:19 stuff 29:21 36:24 support 60:11 26:62 20:8 37:11,24 110:7 subcammittee 55:6 67:171:2 sufficient 65:21 support 60:11 26:22 30:8 37:11,24 110:7 subcommittee 35:3,20 36:2,67 60:7 61:6 86:13 support 10:12 26:6 22:15 store 127:12 subcommittees 3 35:3,20 36					
23:17,18 27:14 118:25 (38) 120:2 28:20 55: 59:20 study 20:19 subsequent 133:12 sunday 106:13 surving 62:17 statutorily 23:3 87:45:99.24 subsequent 123:12 sunday 106:13 surving 62:17 statutorily 23:3 87:45:99.24 subsetantial sunny 3:10 sustain 130:2 22:02 1 23:9 92:12,18 96:7 90:81.4[19 107:23 108:13 112:14 13:16.18 sustaine 9:20.24 stay 27:13 28:13 104:106:7.21.23 subsetantial 107:23 108:13 112:214 13:16.18 sustainable stay 27:13 28:13 104:106:7.21.23 subsetantive 33:19 34:2 27:22 3:10.11 27:22 3:10.11 stap 125:14 100:11.20 103:23 subsetantive 33:19 34:2 27:22 3:10.12 27:23 19:41:5 stap 125:14 126:25 (40) successfully 92:11 15:19 (25) 27:23 19:41:5 27:23 2:10:23:1 24:32.22,24 (7) 8:412 127:12 sufficient 65:21 99:22 105:13 52:21 7:31:1,24 26:62 2:308 37:1 27:17.23 3:14 26:62 2:308 37:1 27:11.24 26:62 2:308 37:1	21:4,15,18 22:9,14	stuck 59:20	submitting 78:22	112:12 113:13	survey 97:10
98:16 (17) 21:11 77:8 79:21 123:12 sunday 106:13 surving 62:17 statutorily 23:3 87:4,5.9,9.24 substance sunshine 9:20,24 sustain 130:2 statutory 11,15,16,16,17 substantial 101:5,12,18,19 112:14 131.618,18 sustain 130:2 25:18 26:14 56:24 92:1,2,18 96:7 substantial 101:723 108:13 112:14 131.618,18 sustainable 30:8 100:11,20 103:23 substantive 33:19 34:2 sustainable 120:19,22 16:24 129:14 30:8 100:19,22 113:4 126:25 (40) succassfully 92:1 115:19 (25) 72: 15:10,11 step 125:14 studying 109:19 suchandsuch surpermajority 22:10 23:21 24:32,22:24 34:12,13 91:8 stuff 29:21 36:24 sufficient 65:21 99:22 105:13 72:22 100 3:21 stick 102:13 126:18 127:12 suggest 15:25 support 60:11 22:10 23:61 22:10 23:61 stick 102:13 126:18 127:12 suggest 15:25 support 60:11 29:12 13:04 77:22 20:5,10 stil 15:11 18:10 26:62 17:71 71	23:17,18 27:14			118:25 (38)	
85:24 substance summary sustance summary sustance sustance <th< td=""><td>28:20 55:5 93:20</td><td>study 20:19</td><td>subsequent</td><td></td><td></td></th<>	28:20 55:5 93:20	study 20:19	subsequent		
statutorily 23:3 87:45.9.9.24 88:8.15.22 917.9. substance 108:10.20 suny 3:10 suspension 16:18 statutory 22:20.21 23:9 92:1.2.18 96:7. 92:1.2.18 96:7. substantial 107:23 108:13 101:1.5.1.18.19 102:1.4.18 96:7. 52:18 26:16 56:24 92:1.2.18 96:7. substantive 100:1.1.20 103:23 substantive 33:19 34:2 sustainable 14:20.22 16:24 129:14 30:8 109:19.22 113:4 108:12 51:19.22 36:16 system 1:1.21 30:8 109:19.22 113:4 126:25 (40) successfully 207:21 92:1 115:19 (25) 72:12 10.3:21 step 77:3 studying 109:19 supcersolution support 60:11 26:22 20:2 34:10 10:7 support 60:11 26:22 0:23 37:11 27:7.12,13,14,19 10:7 suggest 15:25 38:3 48:15 55:8 support 60:11 29:22.10 26:8.9 28:22 subcommittee 35:20 36:2,6,7 60:21 115:8,12.73 70:16 86:13 support 105:14 129:14 131:8 (47) 40:23 41:10 62:16 53:5.20 36:2,6,7 70:111:8,12.13 52:5 25:6 82:15 storm's 65:4 4:10,7,18,20,22,2 52:5 52:5 <t< td=""><td>98:16 (17)</td><td></td><td>123:12</td><td>sunday 106:13</td><td>surviving 62:17</td></t<>	98:16 (17)		123:12	sunday 106:13	surviving 62:17
statutory 22:20,21 23:9 22:12,18 26:14 56:24 95:14,20 (8) $88.8,15.22$ 91:7.9 97:12,21 100:11.20 103:23 100:11.20 103:23 substantive 130:8 100:11.20 103:23 100:21 06:7.21.22 108:2 35:19,22 36:16 35:19,22 36:16 35:19,22 36:16sustainable 112:14 13:16,18 112:14 13:16,18 112:14 13:16,18 112:24 13:16,18 112:24 13:16,18 112:24 13:16,18 112:24 13:16,18 112:24 13:16,18 112:24 13:16,18 12:24 13:16,18 12:24 13:16,18 12:24 14 12:25 14sustantial 					
statuory 22:20,21 23:9 25:18 26:14 56:24 75:14,20 (8) 11,51,61,61,7 92:1,218 96:7 97:12,21 substantial 107:23 108:13 102:23 108:13 sustain 130:2 101:1,51,18,10 107:23 108:13 sustain 130:2 101:1,51,18,10 11:2,14 13:16,18 14:20,22 16:24 130:8 sustain 130:2 101:1,20 103:23 100:11,20 103:23 100:11,20 103:23 100:12,20 103:23 100:21,22 103:24 126:25 (40) substantive 108:2 sustain 131:24 11:2,14 13:16,18 14:20,22 16:24 129:14 sustain 130:2 10:1,51,18,10 20:32 108:13 step 125:14 104:2 106:7,21,22 109:19,22 105:14 successfully 20:7,21 supermajority 20:7,21 system 1:1,21 20:8,22 21:2,19 step 125:14 studying 109:19 84:22 92:1 94:19 100:6,8,14 125:13 sutficient 65:21 83:14 100:7 supermajority 99:22 105:13 supermajority 22:10 23:12 25:7,21,3,14,19 20:6,2,22 40:8 37:11 99:22 105:13 stick 102:13 126:18 127:12 100:6,8,14 125:13 support 60:11 83:14 15:55 support 60:11 99:22 105:13 52:21 73:11,24 74:11,12,20 78:18 still 15:11 18:10 subcommittee 90:25 121:4 66:20 11:8,12,13, 103:4 112:5 support 100:14 129:14 13:8 (47) storm's 65:4 41:10,17,18,20,22,2 90:51 suppose 17:9,22 53:57,18 (8) supgestion 61:7,22 52:5 suppose 17:9,22 52:5 suppose 17:9,22 52:5 suppose 17:9,22 52:6 82:15 strictly 13:17 40:20 41:10 16:18,20 28:7 59:9 summary 12:15 103:14 122:8 <	statutorily 23:3			sunny 3:10	suspension 16:18
$\begin{array}{c c c c c c c c c c c c c c c c c c c $			108:10,20		
25:18 26:14 56:24 97:12,21 107:23 108:13 11:2,14 13:16,18 sustainable 75:14,20 (8) 99:8,14,19 100:11,20 103:23 substantive 13:19 34:2 129:14 130:8 104:2 106:7,21,22 108:2 35:19 32:2 36:16 system 1:1.21 23:23 21:9 4:15 130:8 126:25 (40) successfully 20:7,21 supermajority 23:10 32:21 step 125:14 studying 109:19 suchandsuch 87:11,13 24:3,22,22,24 84:12,13 91:8 stuff 29:21 36:24 110:7 supermajority 22:10 23:08 37:11 100:8 110:22,22 65:6 71: 71:2 support 60:11 26:6,22 30:8 37:11 25:7,12,13,14,19 100:6,8,14 125:13 sufficient 65:21 99:22 105:13 52:21 73:11,24 79:7,22 90:5,10 111:1 109:6,8,14 125:13 supgest 15:25 support 60:11 26:6,22 30:8 37:11 28:10,12,17,18 26:8,9 28:22 subcommittees 3 66:7: 17:7 support 105:14 129:14 13:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suppose 17:9,22 25:6 82:15 still 15:11 18:10 supermites 3 66:21 75:7 87:17 supose 57:15 s					sustain 130:2
75:14,20 (8) 99:8,14,19 100:11,20 103:23 14:20,22 16:24 33:19 34:2 129:14 130:8 109:19,22 113:4 126:25 (40) 108:2 35:19,22 36:16 48:8,9,13 70:14 ystem 1:1,21 2:322 3:19 4:15 step 125:14 126:25 (40) successfully 20:7,21 92:1 115:19 (25) 72:15:10,11 20:8,22 21:2,19 steps 77:3 stuff 29:21 36:24 84:12,13 91:8 stuff 29:21 36:24 110:7 successfully 20:7,21 successfully 20:7,21 22:10 23:21 22:10 23:21 (7) 84:22 92:1 94:19 109:6,8,14 125:13 sufficient 65:21 83:11 support 60:11 99:22 105:13 26:22 3:08 37:1 22:10 2:13 (7) 84:22 92:1 94:19 109:6,8,14 125:13 sufficient 65:21 83:11 support 60:11 22:13 26:6,22 3:08 37:1 22:10 2:13 (14) suggest 15:25 38:3 48:15 55:8 support 105:14 129:14 13!8 (47) (14) suggestion 61:21 80:20 21:75 78:71 suppose 17:9,22 52:5 systems 22:1 22:68 2:15 storm's 65:4 4:10,17,18,20,22,2 53:57,18 (8) supgestion 61:21 80:58 1:9 93:13 surgeon 6:17,22 57:4 58:25 104:21 talks 30:7 58:9 stricty 13:17 40:20 41:10 summarize 15:18 surgeon 6:17,22 57:4 58:25 104:21 talks 30:7 58:9 stricty 13:17 40:20 41:10 summarize 15:18 surgeon 6:17,22 57:4 5	· · · · · · · · · · · · · · · · · · ·				
100:11.20 103:23 stay 27:13 28:13 130:8 104:2 106:7,21,22 104:2 106:7,21,23 subtantive 108:2 33:19 34:2 35:19,22 36:16 system 1:1,21 23:2,2 3:19 4:15 130:8 104:2 106:7,21,22 126:25 (40) 108:2 35:19,22 36:16 system 1:1,21 23:2,2 3:19 4:15 step 125:14 126:25 (40) successfully 20:7,21 92:1 115:19 (25) 7:2 15:10,11 step 125:14 studying 109:19 suchandsuch 100:8 110:22,22 stuff 29:21 36:24 110:7 26:6,22 30:8 37:1 100:8 110:22,22 65:6 67:1 71:2 84:22 92:1 94:19 sufficient 65:21 support 60:11 26:6,22 30:8 37:1 (7) 84:22 92:1 94:19 sufficient 65:21 support 60:11 26:6,22 30:8 37:1 stick 102:13 126:18 127:12 suggest 15:25 support 100:14 129:14 131:8 (47) 10:24:14 (11) 16:20 2111:8,12.13, 16:20:21 11:24,7 suggestion 61:21 supports 105:14 129:14 131:8 (47) storm's 65:4 subjeet 11:20, 53:7,18 (8) suggestion 52:1 systems 22:1 22:68 2:15 strictly 13:17 90:20 15:11 16:18,20 28:7 suite 1:24 surgeons 24:8 suppose 57:15 table 5:5 44:25 <t< td=""><td></td><td></td><td>107:23 108:13</td><td>· · · ·</td><td></td></t<>			107:23 108:13	· · · ·	
stay 27:13 104:2 106:7,21,22 108:2 35:19,22 35:11 35:11 35:22 35:22 35:22 35:22 36:11 35:22 35:22 36:11 35:22 35:22 35:22 35:21 35:32 35:25:3 36:32 35:20:36:2,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7 35:32,03:62,6,7	75:14,20 (8)				129:14
130:8 109:19,22 113:4 126:25 (40) successfully 20:7,21 48:8,9,13 70:14 20:7,21 25,22 3:19 4:15 7.2 15:10,11 step 125:14 studying 109:19 successfully 20:7,21 21:115:19 (25) 22:10 23:21 steps 77:3 stuff 29:21 36:24 110:7 supermajority 24:3,22,22,24 24:3,22,22,24 stuff 29:21 36:24 sufficient 65:21 support 60:11 26:6,22 30:8 37:11 22:17,21,13,14,19 100:8 110:22,22 65:6 67:1 71:2 sufficient 65:21 support 60:11 26:6,22 30:8 37:11 22:17,21,11,24 stick 102:13 126:18 127:12 suggest 15:25 support 60:11 26:6,22 30:8 37:11 22:17,21,31,44,19 26:8,9 28:22 subcommittee (14) 38:3 48:15 55:8 support 105:14 128:10,12,17,18 26:8,9 28:22 subcommittees 3 supposet 15:25 supposet 57:15 table 5:5 44:25 storn 127:12 subcommittees 3 supgestion 61:21 supreme 55:21 supreme 55:21 talks 30:7 58:9 strick 13:17 90:9 108:24 (10) summary 12:15 surgeon 6:17,22 surgeons 24:8 41:14:28 99:9 108:24 (10) summary 12:15 103:14 122:8 tangible 84:14 104:15 surgeons'	4 07 10 00 10	, ,			
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$			108:2		
step 125:14 studying 109:19 20:7,21 permajority 20:8,22 21:2,19 84:12,13 91:8 stuff 29:21 36:24 110:7 suppremajority 87:11,13 24:3,22,22,24 84:12,13 91:8 stuff 29:21 36:24 110:7 support 60:11 26:6,22 30:8 37:1 100:8 110:22,22 65:6 67:1 71:2 sufficient 65:21 99:22 105:13 52:21 73:11,24 (7) 84:22 92:1 94:19 sufficient 65:21 99:22 105:13 52:21 73:11,24 stick 102:13 126:18 127:12 suggest 15:25 support 20:312 128:10,12,17,18 26:8,9 28:22 subcommittee 60:7 61:6 86:13 support 105:14 129:14 131:8 (47) 90:25 121:4 66:20 111:8,12,13, 16:20,21 112:4,7 suggestion 61:21 suppose 17:9,22 systems 22:1 storm's 65:4 4:10,17,18,20,22,2 50:21 suppose 57:15 table 5:5 44:25 story 78:24 suggestions surgeon 6:17,22 57:4 58:25 104:21 tag 122:20 123:9 strictly 13:17 40:20 41:10 summarize 15:18 41:5 52:9 79:19 tallahassee 3:15 strike 96:19 <td>130:8</td> <td></td> <td>e 11</td> <td></td> <td></td>	130:8		e 11		
studying109:19supermajority22:1023:21step77:3stuff29:2136:24 $37:11,13$ 24:3,22,22,24stuff29:2136:24110:7 $37:11,13$ 24:3,22,22,24100:8110:22,2265:667:171:2support60:1126:6,22(7)84:2292:191:2199:22105:1352:2173:11,24(7)84:2292:191:22105:1352:2173:11,24stick102:18127:12suggest15:25support20:1312:11,12,20(14)suggest15:25support103:4114:5512:8:10,12,17,1840:2341:1062:0011:8,12,13suggest52:1103:4112:9:14124:14(11)(14)suggestion61:21suppose17:9,22systems22:12storn 's65:44:10,17,18,20,22,2suggestion52:1suppose52:2212:8:(4)storn's65:44:10,17,18,20,22,257:4suppose57:17suppose17:9,22story78:24subject11:10suggestionssurgeon61:7,22sup 12:2212:22stricty13:1710:740:2041:10105:5,17106:18,02105:5,17106:18,02105:5,17stricty13:1710:24100:3summary12:15105:5,17106:18,02106:12sup 52:5strike96:19submission100:3 <td< td=""><td>atom 125.14</td><td>120:25 (40)</td><td></td><td>92:1 115:19 (25)</td><td></td></td<>	atom 125.14	120:25 (40)		92:1 115:19 (25)	
steps 77:3 84:12,13 91:8 (1) stuff 29:21 36:24 85:6 67:1 71:2 65:6 67:1 71:2 84:22 92:1 94:19 109:6.8,14 125:13 84:22 92:1 94:19 109:6.8,14 125:13 84:22 92:1 94:19 109:6.8,14 125:13 83:11 87:11,13 24:3,22,22,24 25:7,12,13,14,19 26:6,22 30:8 37:1 52:21 73:11,24 stick 102:13 126:18 127:12 (14) suffcient 65:21 83:3 48:15 55:8 60:7 61:6 86:13 (7) support 60:11 29:7,22 90:5,10 52:21 73:11,24 74:11,12.20 78:18 79:7,22 90:5,10 stick 102:13 126:18 127:12 (14) suggest 15:25 38:3 48:15 55:8 60:7 61:6 86:13 (7) supports 105:14 15:8,20,21 112:4,7 (14) supports 105:14 15:25 103:4 114:5 128:10,12,17,18 102:14 131:8 (47) storn 127:12 subcommittee 35:7,18 (8) suggestion 61:21 66:21 75:7 87:17 117:17 124:15 (6) suppose 17:9,22 52:5 systems 22:1 25:6 82:15 storn's 65:4 4:10,7,1,8,20,22,2 53:5,7,18 (8) suggestion 5 50:21 suppose 57:15 52:22 128:8 (4) table 5:5 44:25 52:22 128:8 (4) strictly 13:17 40:20 41:10 99:9 108:24 (10) summarize 15:18 80:17,24 83:18 80:17,24 83:18 surgeons 24:8 41:5 52:9 79:19 80:17,24 83:18 surgeons '122:12 82:12 tampa 5:25 82:12 strike 96:19 submit 8:6 25:15 66:13 100:17 80:17,24 83:18 surgeors '122:12 80:17,24 83:18 80:17,24 83:18 80:17,24 83:18 surgeors '122:12 82:12 task 24:25 53:8 82:12 strike 5:14	step 125:14	studying 100.10	20:7,21	annormaiority	
84:12,13 91:8 100:8 110:22,22 (7) stuff 29:21 36:24 55:6 67:1 71:2 84:22 92:1 94:19 109:6,8,14 125:13 126:18 127:12 (14) 110:7 support 60:11 92:22 105:13 127:13 (4) 25:7,12,13,14,19 26:6,22 30:8 37:1 92:22 105:13 122:17 31:1,24 stick 102:13 109:6,8,14 125:13 126:18 127:12 (14) sufficient 65:21 38:3 48:15 55:8 60:7 61:6 86:13 38:3 48:15 55:8 60:7 61:6 86:13 supported 23:12 122:10:21 12:4,7 16;20,21 11:8,12,13, 122:14 (11) supcommittee 60:7 61:6 86:13 (7) supported 23:12 suppose 17:9,22 52:5 systems 22:1 25:6 82:15 store 127:12 subcommittee 53:57,18 (8) suggestion 61:21 66:21 75:7 87:17 (14) suppose 17:9,22 52:5 systems 22:1 25:6 82:15 storry 78:24 subject 11:20 53:57,18 (8) suggestions 66:21 75:7 87:17 117:17 124:15 (6) supreme 55:21 105:5,17 106:1 (8) 105:5,17 106:1 (8) 81:5 81:9 93:13 talks 30:7 58:9 14ks 30:7 58:9 stricty 13:17 40:20 41:10 104:15 summarize 15:18 104:15 surgeons 24:8 82:12 tanpa 5:25 82:12 strike 96:19 submit 8:6 25:15 69:2,9,18 submit 8:6 25:15 51:9,197:55,43:1 104:15 surgery 52:8 82:12 taskings 106:20 107:2 strike 96:14 104:5,19 105:15 123:2 (8) surgery 52:8 82:12 taskings 106:20 107:2 strike 5:14 104:5,19 105:15 123:2 (8)	stong 77.3	studying 109.19	guahandguah		
100:8 110:22,22 65:6 67:1 71:2 sufficient 65:21 support 60:11 26:6,22 30:8 37:1 (7) 84:22 92:1 94:19 sufficient 65:21 99:22 105:13 52:21 73:11,24 stick 102:13 126:18 127:12 (14) suggest 15:25 support 60:11 26:6,22 30:8 37:1 still 15:11 18:10 26:8,9 28:22 subcommittee 38:34 55:8 support 60:14 79:7,22 90:5,10 20:25 121:4 66:20 111:8,12,13, 128:10,12,17,18 support 105:14 129:14 131:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suggestion 61:21 supports 105:14 129:14 131:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suggestion 61:21 supports 105:14 129:14 131:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suggestion 61:21 suppose 17:9,22 systems 22:1 store 127:12 subcommittees 3 66:21 75:7 87:17 suggestion 61:21 suppose 57:15 table 5:5 44:25 storm's 65:4 4:10,17,18,20,22,2 57:4 58:25 104:21 155:17 106:1 (8) surgeon 24:8 122:20 123:9 strictly 13:17 40:20 41:10 summarize 15:18 surgeons 24:8 <t< td=""><td></td><td>stuff 20.21 26.24</td><td></td><td>07.11,13</td><td></td></t<>		stuff 20.21 26.24		07.11,13	
			110.7	support 60.11	
109:6,8,14 125:13 83:11 127:13 (4) 74:11,12,20 78:18 stick 102:13 126:18 127:12 suggest 15:25 supported 23:12 103:4 114:5 still 15:11 18:10 26:8,9 28:22 subcommittee 38:3 48:15 55:8 supported 23:12 103:4 114:5 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suppose 17:9,22 systems 22:1 90:25 121:4 16:20,21 112:4,7 16:21,75:7 87:17 suppose 17:9,22 systems 22:1 storn's 65:4 4:10,17,18,20,22,2 50:21 suppose 57:15 suble 5:5 44:25 story 78:24 subject 11:20 50:21 57:4 58:25 104:21 table 5:5:10:21 strictly 13:17 90:24 (10) summarize 15:18 surgeon 6:17,22 57:4 58:25 104:21 99:9 108:24 (10) summarize 15:18 surgeons 24:8 41:5 52:9 79:19 80:75,17 106:1 (8) summers 1:6,16 5:19,19 7:5,5 43:11 103:14 122:8 tangble 84:14 104:15 submit 8:6 25:15 5:19,19 7:5,5 43:11 surgeons' 122:12 82:12 strike 96:19 submit 8:6 25:15 5:19,19 7:5,5 43:11 surgeons' 122:12 82:12 strike 96:19 submit 8:6 2	,		sufficient 65.21		
stick 102:13 126:18 127:12 (14) suggest 15:25 38:3 48:15 55:8 60:7 61:6 86:13 supported 23:12 128:10,12,17,18 129:14 131:8 (47) still 15:11 18:10 26:8,9 28:22 40:23 41:10 62:16 90:25 121:4 124:14 (11) subcommittee 35:3,20 36:2,6,7 66:20 111:8,12,13, 16(20,21 112:4,7) suggest 15:25 38:3 48:15 55:8 60:7 61:6 86:13 supports 105:14 129:14 131:8 (47) store 127:12 subcommittee 35:57,18 (8) suggest 06:121 66:21 75:7 87:17 117:17 124:15 (6) suppose 17:9,22 52:5 systems 22:1 25:6 82:15 storm's 65:4 4:10,17,18,20,22,2 53:57,18 (8) suggestion 61:21 66:21 75:7 87:17 117:17 124:15 (6) suppose 57:15 suppose 57:15 table 5:5 44:25 52:22 128:8 (4) storm's 65:4 5:10,71 714:20 15:11 16:18,20 28:7 suite 1:24 surgeon 6:17,22 57:4 58:25 104:21 105:5,17 106:1 (8) tag 122:20 123:9 strictly 13:17 40:20 41:10 108:24 (10) summarize 15:18 surgeons 24:8 41:5 52:9 79:19 80:5 81:9 93:13 tag 122:20 123:9 strike 96:19 submit 8:6 25:15 66:13 100:17 summary 12:15 103:41 122:8 103:14 122:8 103:14 122:8 82:12 tags 24:25 53:8 82:12 stroke 5:14 104:15 50:17,24 83:18 89:21 92:19 93:4 102:5,8;10 93:24 surgecol 6:5 52:0,10 tasks 8:18 123:2 (8) structure 29:12,13 100:3 submits 56:23 97:10:24 97:3 98:7 101:24 104:15 106:6,12 surgical 6:5 52:10,10 tasks 8:18					
still 15:11 18:10 (14) suggest 15:25 supported 23:12 103:4 114:5 26:8,9 28:22 subcommittee 38:3 48:15 55:8 supports 105:14 129:14 131:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suppose 17:9,22 systems 22:1 124:14 (11) 16,20,21 112:4,7 suggestion 61:21 suggestion 61:21 suppose 17:9,22 systems 22:1 storn 127:12 subcommittees 3 4:10,17,18,20,22,2 117:17 124:15 (6) supgest 65:21 52:22 128:8 (4) storn's 65:4 4:10,17,18,20,22,2 53:7,18 (8) suggestions surgeon 6:17,22 52:22 128:8 (4) strenth 7:13,13 12:7 14:20 15:11 16:18,20 28:7 suite 1:24 surgeon 6:17,22 talks 30:7 58:9 strictly 13:17 40:20 41:10 summarize 15:18 surgeons 24:8 tallahassee 3:15 99:9 108:24 (10) summary 12:15 103:14 122:8 tallahassee 3:15 strike 96:19 submit 8:6 25:15 66:17,12 surgeons' 12:12 task 24:25 53:8 99:9 108:24 (10) summary 12:15 103:14 122:8 task 24:25 53:8 strike 96:19 submit 8:6 25:15 66:17,124	stick 102.13		05.11	127.13(1)	
still 15:11 18:10 38:3 48:15 55:8 11 26:8,9 28:22 subcommittee 38:3 48:15 55:8 supports 105:14 128:10,12,17,18 40:23 41:10 62:16 35:3,20 36:2,6,7 60:7 61:6 86:13 supports 105:14 129:14 131:8 (47) 90:25 121:4 16:20,21 11:8,12,13, 16:20,21 11:8,12,13, suggested 38:16 suppose 17:9,22 systems 22:1 storm's 65:4 4:10,17,18,20,22,2 5 35:7,18 (8) suggestion 61:21 suppose 57:15 table 5:5 44:25 story 78:24 subject 11:20 50:21 17:17 124:15 (6) supreme 55:21 tag 122:20 123:9 strenth 7:13,13 12:7 14:20 15:11 16:18,20 28:7 suite 1:24 suite 1:24 talks 30:7 58:9 strictly 13:17 40:20 41:10 summarize 15:18 surgeons 24:8 talp 5:25 talp 5:25 strike 96:19 submitsion 100:3 summary 12:15 103:14 122:8 tangible 84:14 stringent 66:13 100:17 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 structure 29:12,13 100:3 submits 56:23 97:19:24 surgical 6:5 tasks 8:18 102:5,8,15 103:24 97:3 98:7 101:24 97:3 98:7	50CK 102.15		suggest 15:25	supported 23:12	
26:8,9 28:22 subcommittee 60:7 61:6 86:13 supports 105:14 129:14 131:8 (47) 40:23 41:10 62:16 35:3,20 36:2,6,7 (7) suppose 17:9,22 systems 22:1 90:25 121:4 16;20,21 11:8,12,13, 16;20,21 11:24,7 suggested 38:16 suppose 17:9,22 systems 22:1 stone 127:12 subcommittees 3 66:21 75:7 87:17 suppose 57:15 table 5:5 44:25 storm's 65:4 4:10,17,18,20,22,2 117:17 124:15 (6) supreme 55:21 tag 122:20 123:9 story 78:24 subject 11:20 50:21 57:4 58:25 104:21 talks 30:7 58:9 strictly 13:17 40:20 41:10 108:24 (10) summarize 15:18 surgeons 24:8 tallahassee 3:15 strike 96:19 submission 100:3 summarize 15:18 41:5 52:9 79:19 tampa 5:25 strike 96:19 submit 8:6 25:15 5:19,19 7:5,5 43:1 surgeons' 122:12 task 24:25 53:8 strike 96:19 submit 8:6 25:15 5:19,19 7:5,5 43:1 surgeons' 122:12 task 24:25 53:8 strike 96:19 submit 8:6 25:15 5:19,19 7:5,5 43:1 surgeons' 122:12 task 24:25 53:8 strike 96:19 submit 8:6 25:15 5:19,19 7:5,5 43:1	still 15:11 18:10			supported 20112	
40:23 41:10 62:16 90:25 121:4 124:14 (11) 35:3,20 36:2,6,7 66:20 111:8,12,13, 16,20,21 112:4,7 (14) (7) suppose 17:9,22 52:5 systems 22:1 25:6 82:15 stone 127:12 subcommittees 3 (14) suggested 38:16 66:21 75:7 87:17 (14) supposed 57:15 52:22 128:8 (4) table 5:5 44:25 52:22 128:8 (4) storm's 65:4 4:10,17,18,20,22,2 5 35:7,18 (8) 117:17 124:15 (6) supreme 55:21 table 5:5 44:25 52:22 128:8 (4) storm 78:24 subject 11:20 5 35:7,18 (8) suggestions 50:21 surgeon 6:17,22 57:4 58:25 104:21 105:5,17 106:1 (8) talks 30:7 58:9 strictly 13:17 40:20 41:10 106:18,20 28:7 suite 1:24 surgeons 24:8 41:5 52:9 79:19 80:5 81:9 93:13 tallahassee 3:15 strike 96:19 submission 100:3 104:15 summary 12:15 103:14 122:8 103:14 122:8 124:12,19 (11) task 24:25 53:8 82:12 strike 5:14 104:5,19 105:15 123:2 (8) 80:17,24 83:18 80:17,24 83:18 102:5,8,15 103:24 surgeons' 122:12 82:12 taskings 106:20 107:2 structure 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 97:3 98:7 101:24 surgical 6:5 52:10,10 tasks 8:18 102:5,8,15 103:24		subcommittee		supports 105:14	
90:25 121:4 124:14 (11) 66:20 111:8,12,13, 16,20,21 112:4,7 (14) suggested 38:16 suppose 17:9,22 52:5 systems 22:1 25:6 82:15 stone 127:12 subcommittees 3 4:10,17,18,20,22,2 5 35:7,18 (8) suggestion 61:21 66:21 75:7 87:17 17:17 124:15 (6) suppose 57:15 table 5:5 44:25 52:22 128:8 (4) storm's 65:4 4:10,17,18,20,22,2 5 35:7,18 (8) suggestions surgeon 6:17,22 57:4 58:25 104:21 talks 30:7 58:9 strenth 7:13,13 12:7 14:20 15:11 16:18,20 28:7 suite 1:24 surgeon 6:17,22 50:21 stree 5:17 106:1 (8) tallahassee 3:15 strictly 13:17 40:20 41:10 104:15 summarize 15:18 surgeons 24:8 41:5 52:9 79:19 tampa 5:25 strike 96:19 submit 8:6 25:15 66:13 100:17 5:19,19 7:5,5 43:1 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 structure 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 104:15 106:6,12 surgical 6:5 task 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 surgical 6:5 task 8:18					
124:14 (11) 16,20,21 112:4,7 (14) suggested 38:16 (14) 52:5 25:6 82:15 stome 127:12 subcommittees 3 (14) suggestion 61:21 66:21 75:7 87:17 supposed 57:15 table 5:5 44:25 52:22 128:8 (4) storm's 65:4 4:10,17,18,20,22,2 5 35:7,18 (8) 117:17 124:15 (6) supreme 55:21 tag 122:20 123:9 story 78:24 subject 11:20 50:21 50:21 57:4 58:25 104:21 105:5,17 106:1 (8) talks 30:7 58:9 strictly 13:17 40:20 41:10 108:24 (10) sutte 1:24 surgeons 24:8 41:5 52:9 79:19 tampa 5:25 strike 96:19 submission 100:3 104:15 summarize 15:18 66:13 100:17 summers 1:6,16 5:19,19 7:5,5 43:11 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 82:12 stroke 5:14 104:5,19 105:15 123:2 (8) suit 7.24 83:18 89:21 92:19 93:4 123:2 (8) surgery 52:8 97:3 98:7 101:24 102:5,8,15 103:24 102:5,8,15 103:24 taskings 106:20 107:2 structure 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 102:5,8,15 103:24 surgeal 6:5 52:10,10 tasks 8:18				suppose 17:9,22	systems 22:1
(14) suggestion 61:21 66:21 75:7 87:17 117:17 124:15 (6) supposed 57:15 supposed 57:15 table 5:5 44:25 52:22 128:8 (4) storm's 65:4 4:10,17,18,20,22,2 535:7,18 (8) suggestions suggestions surgeon 6:17,22 50:21 surgeon 6:17,22 57:4 58:25 104:21 105:5,17 106:1 (8) strenth 7:13,13 12:7 14:20 15:11 16:18,20 28:7 suite 1:24 surgeons 24:8 41:5 52:9 79:19 tampa 5:25 strictly 13:17 40:20 41:10 108:24 (10) summarize 15:18 surgeons 24:8 41:5 52:9 79:19 tampa 5:25 strike 96:19 submission 100:3 104:15 summers 1:6,16 5:19,19 7:5,5 43:11 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 82:12 strike 5:14 104:5,19 105:15 123:2 (8) submit 8:6 25:15 97:3 98:7 101:24 102:5,8,15 103:24 surgeons' 122:12 task s8:18 123:2 structure 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 102:5,8,15 103:24 surgeal 6:5 52:10,10 tasks 8:18	124:14 (11)	16,20,21 112:4,7	suggested 38:16		
subcommittees 3 66:21 75:7 87:17 52:22 128:8 (4) storm's 65:4 4:10,17,18,20,22,2 53:7,18 (8) suggestions surgeon 6:17,22 tal 12:20 123:9 story 78:24 subject 11:20 suggestions surgeon 6:17,22 57:4 58:25 104:21 talks 30:7 58:9 strictly 13:17 40:20 41:10 suite 1:24 surgeons 24:8 tallahassee 3:15 strike 96:19 submission 100:3 summarize 15:18 surgeons' 122:15 tanpa 5:25 stringent submit 8:6 25:15 5:19,19 7:55 43:1 surgeons' 122:12 task 24:25 53:8 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 structure 99:21 92:19 93:4 92:19 93:4 surgeing 65:16 submits 56:23 97:3 98:7 101:24 struggling 65:16 submit 20:21 104:15 106:6,12 surgeal 6:5 tasks 8:18		(14)			
storm's 65:44:10,17,18,20,22,2 5 35:7,18 (8)117:17 124:15 (6)supreme 55:21 tag 122:20 123:9story 78:24subject 11:20 12:7 14:20 15:11 16:18,20 28:7 40:20 41:10suggestions 50:21surgeon 6:17,22 57:4 58:25 104:21 105:5,17 106:1 (8)strictly 13:1740:20 41:10 16:18,20 28:7 40:20 41:10suite 1:24surgeons 24:8 80:5 81:9 93:13strike 96:19submission 100:3 104:15summarize 15:18 80:5 81:9 93:1341:5 52:9 79:19 80:5 81:9 93:13tampa 5:25stringent 69:2,9,18submit 8:6 25:15 66:13 100:17summers 1:6,16 5:19,19 7:5,5 43:1 44:2 60:1 64:13surgeons' 122:12 80:21 92:19 93:4 62:6task 24:25 53:8 82:12stroke 5:14104:5,19 105:15 123:2 (8)submits 56:2397:3 98:7 101:24 104:15 103:24surgeond 6:5 52:10,10task 8:18 tasks 8:18strugling 65:16submitted 20:21104:15 106:6,12surgecal 6:5 52:10,10task 8:18 tasks 8:18	stone 127:12		suggestion 61:21	supposed 57:15	table 5:5 44:25
story 78:24 5 35:7,18 (8) suggestions surgeon 6:17,22 tag 122:20 123:9 strenth 7:13,13 12:7 14:20 15:11 50:21 57:4 58:25 104:21 talks 30:7 58:9 strictly 13:17 40:20 41:10 suite 1:24 surgeons 24:8 tallahassee 3:15 strike 96:19 submission 100:3 summarize 15:18 41:5 52:9 79:19 tampa 5:25 stringent 66:13 100:17 summers 1:6,16 103:14 122:8 talgebre 84:14 69:2,9,18 submit 8:6 25:15 5:19,19 7:5,5 43:1 surgeons' 122:12 82:12 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 107:2 92:92:12,13 100:3 submits 56:23 97:3 98:7 101:24 surgical 6:5 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 surgical 6:5 tasks 8:18		subcommittees 3	66:21 75:7 87:17		52:22 128:8 (4)
story 78:24 subject 11:20 suggestions surgeon 6:17,22 talks 30:7 58:9 strenth 7:13,13 12:7 14:20 15:11 10:18,20 28:7 suite 1:24 105:5,17 106:1 (8) talks 30:7 58:9 strictly 13:17 40:20 41:10 suite 1:24 surgeons 24:8 tallahassee 3:15 99:9 108:24 (10) summarize 15:18 surgeons 24:8 tallahassee 3:15 strike 96:19 submission 100:3 summary 12:15 103:14 122:8 tangible 84:14 stringent 66:13 100:17 44:2 60:1 64:13 surgeons' 122:12 82:12 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 107:2 97:3 98:7 101:24 102:5,8,15 103:24 52:10,10 107:2 struggling 65:16 submitted 20:21 104:15 106:6,12 surgical 6:5 52:10,10	storm's 65:4		117:17 124:15 (6)	supreme 55:21	
subject 11:20 50:21 57:4 58:25 104:21 talks 30:7 58:9 strenth 7:13,13 12:7 14:20 15:11 suite 1:24 105:5,17 106:1 (8) talks 30:7 58:9 strictly 13:17 40:20 41:10 suite 1:24 surgeons 24:8 talkassee 3:15 strike 96:19 submission 100:3 summarize 15:18 41:5 52:9 79:19 tampa 5:25 stringent submit 8:6 25:15 66:13 100:17 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 structure 94:5,21,25 95:6,10 97:3 98:7 101:24 surgical 6:5 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 surgical 6:5 tasks 8:18		5 35:7,18 (8)			tag 122:20 123:9
strenth 7:13,13 12:7 14:20 15:11 16:18,20 28:7 suite 1:24 105:5,17 106:1 (8) tallahassee 3:15 strictly 13:17 40:20 41:10 summarize 15:18 surgeons 24:8 41:5 52:9 79:19 tampa 5:25 strike 96:19 submission 100:3 104:15 summarize 15:18 41:5 52:9 79:19 tampa 5:25 stringent submission 100:3 104:15 summers 1:6,16 103:14 122:8 task 24:25 53:8 69:2,9,18 submit 8:6 25:15 5:19,19 7:5,5 43:1 surgeons' 122:12 82:12 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 surgical 6:5 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 tack 5:21	story 78:24			, U	
16:18,20 28:7 40:20 41:10 99:9 suite 1:24 tallahassee 3:15 strictly 13:17 99:9 108:24 (10) summarize 15:18 surgeons 24:8 41:5 52:9 79:19 80:5 81:9 93:13 tallahassee 3:15 strike 96:19 submission 100:3 104:15 summarize 15:18 summary 12:15 103:14 122:8 103:14 122:8 tampa 5:25 stringent 69:2,9,18 submit 8:6 25:15 66:13 100:17 summers 1:6,16 5:19,19 7:5,5 43:1 44:2 60:1 64:13 surgeons' 122:12 task 24:25 53:8 82:12 stroke 5:14 104:5,19 105:15 123:2 (8) 80:17,24 83:18 89:21 92:19 93:4 94:5,21,25 95:6,10 97:3 98:7 101:24 102:5,8,15 103:24 surgical 6:5 52:10,10 tasks 8:18 102:5,8,15 103:24 struggling 65:16 submitted 20:21 104:15 106:6,12 tasks 212			50:21		talks 30:7 58:9
strictly13:1740:20 41:10summarize15:18surgeons24:899:9108:24 (10)summarize15:1841:5 52:9 79:19tampa5:25strike96:19submission100:3summary12:15103:14 122:8tampa5:25stringent104:15summers1:6,16124:12,19 (11)task24:25 53:869:2,9,18submit8:6 25:155:19,19 7:5,5 43:1surgeons'122:1282:12stroke5:14104:5,19 105:1580:17,24 83:18surgery52:8taskings106:20123:2 (8)89:21 92:19 93:494:5,21,25 95:6,1062:6107:2107:2structure94:5,21,25 95:6,1097:3 98:7 101:24surgical6:5tasks8:18102:5,8,15 103:24104:15 106:6,12104:15 106:6,12tach52:10	strenth 7:13,13			105:5,17 106:1 (8)	
99:9108:24 (10)summarize 15:1841:5 52:9 79:19 80:5 81:9 93:13tampa 5:25 tangible 84:14strike 96:19submission 100:3 104:15summary 12:15103:14 122:8 124:12,19 (11)tangible 84:14stringent 69:2,9,18submit 8:6 25:15 66:13 100:17summers 1:6,16 5:19,19 7:5,5 43:1 44:2 60:1 64:13surgeons' 122:12task 24:25 53:8 82:12stroke 5:14104:5,19 105:15 123:2 (8)80:17,24 83:18 89:21 92:19 93:4 94:5,21,25 95:6,10surgery 52:8 62:6taskings 106:20 107:2structure 29:12,13 100:3submits 56:2397:3 98:7 101:24 104:15 106:6,12surgical 6:5 52:10,10tasks 8:18 tasks 8:18			suite 1:24	24.9	tallahassee 3:15
strike 96:19 submission 100:3 summary 12:15 80:5 81:9 93:13 tangible 84:14 stringent 104:15 submit 8:6 25:15 6:13 100:17 104:5,19 105:15 summers 1:6,16 1:22:12 task 24:25 53:8 stroke 5:14 104:5,19 105:15 5:19,19 7:5,5 43:1 44:2 60:1 64:13 surgeons' 122:12 82:12 stroke 5:14 104:5,19 105:15 80:17,24 83:18 surgery 52:8 taskings 106:20 structure 94:5,21,25 95:6,10 97:3 98:7 101:24 94:5,21,010 surgical 6:5 52:10,10 struggling 65:16 submitted 20:21 104:15 106:6,12 52:10,10 teach 5:21	e e			0	tommo 5:25
strike96:19submission100:3summary12:15103:14122:8tangible84:14stringent104:15summers1:6,16124:12,19 (11)task24:2553:869:2,9,18submit8:625:155:19,197:5,543:1surgeons'122:1282:12stroke5:14104:5,19105:1580:17,2483:18surgery52:8taskings106:20structure94:5,21,2595:6,1097:398:7101:24surgical6:5107:2struggling65:16submitted20:21104:15106:6,12tasks8:18	99:9	108:24 (10)	summarize 15:18		tampa 5:25
stringent 69:2,9,18104:15summers 1:6,16 5:19,19 7:5,5 43:1 44:2 60:1 64:13124:12,19 (11)task 24:25 53:8 82:12stroke 5:14submit 8:6 25:15 66:13 100:17 104:5,19 105:155:19,19 7:5,5 43:1 44:2 60:1 64:13 80:17,24 83:18 89:21 92:19 93:4 94:5,21,25 95:6,10 94:5,21,25 95:6,10 97:3 98:7 101:24 102:5,8,15 103:24surgeons' 122:12 62:6task 24:25 53:8 82:12structure 29:12,13 100:3submits 56:2397:3 98:7 101:24 104:15 106:6,12surgical 6:5 52:10,10tasks 8:18 tasks 8:18	strika 96.19	submission 100.3	Summory 12.15		tangible 81.11
stringent 69:2,9,18submit 8:6 25:15 66:13 100:17summers 1:6,16 5:19,19 7:5,5 43:1 44:2 60:1 64:13surgeons' 122:12task 24:25 53:8 82:12stroke 5:14104:5,19 105:15 123:2 (8)80:17,24 83:18 89:21 92:19 93:4 94:5,21,25 95:6,10 97:3 98:7 101:24 102:5,8,15 103:24surgeons' 122:12 62:6task 24:25 53:8 82:12structure 29:12,13 100:3submits 56:2397:3 98:7 101:24 104:15 106:6,12surgical 6:5 52:10,10tasks 8:18 tasks 8:18	Strike 50.15		Summary 12.15		
69:2,9,18submit8:6 25:155:19,19 7:5,5 43:1surgeons'122:1282:12stroke5:14104:5,19 105:1580:17,24 83:18surgery52:8taskings 106:20123:2 (8)89:21 92:19 93:462:6107:2structure94:5,21,25 95:6,1097:3 98:7 101:24surgical 6:5tasks 8:1829:12,13 100:3submits56:2397:3 98:7 101:2452:10,10tasks 52:10struggling65:16submitted20:21104:15 106:6,12tasks52:10	stringent	10 110	summers 1:6.16	122,19 (11)	task 24:25 53:8
66:13 100:17 44:2 60:1 64:13 stroke 5:14 104:5,19 105:15 104:5,19 105:15 80:17,24 83:18 123:2 (8) 89:21 92:19 93:4 94:5,21,25 95:6,10 62:6 107:2 107:2 structure 94:5,21,25 95:6,10 29:12,13 100:3 submits 56:23 struggling 65:16 submitted 20:21 104:15 106:6,12 52:10,10 teach 5:21	Ũ	submit 8:6 25:15		surgeons' 122:12	
stroke 5:14 104:5,19 105:15 123:2 (8) 80:17,24 83:18 89:21 92:19 93:4 94:5,21,25 95:6,10 97:3 98:7 101:24 surgery 52:8 62:6 taskings 106:20 107:2 structure 29:12,13 100:3 submits 56:23 97:3 98:7 101:24 102:5,8,15 103:24 surgical 6:5 52:10,10 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 52:10,10 teach 5:21			, ,		
structure 123:2 (8) 89:21 92:19 93:4 62:6 107:2 structure 94:5,21,25 95:6,10 94:5,21,25 95:6,10 107:2 submits 56:23 97:3 98:7 101:24 surgical 6:5 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 52:10,10	stroke 5:14			surgery 52:8	taskings 106:20
29:12,13 100:3 submits 56:23 97:3 98:7 101:24 surgical 6:5 tasks 8:18 struggling 65:16 submitted 20:21 104:15 106:6,12 52:10,10 teach 5:21		,	· · · · · · · · · · · · · · · · · · ·		0
struggling 65:16 submitted 20:21 102:5,8,15 103:24 52:10,10 teach 5:21	structure		94:5,21,25 95:6,10		
struggling 65:16 submitted 20:21 104:15 106:6,12 teach 5:21	29:12,13 100:3	submits 56:23			tasks 8:18
				52:10,10	
	struggling 65:16		,		teach 5:21
105:14 111:17,18,24,24 surprising 72:7		105:14	111:17,18,24,24	surprising 72:7	

r	I	1	1	1
team 3:2 56:18	threehour 117:21	24:9 28:4,8 36:21	14:11	106:22 111:13,16
73:7		37:6 40:10 50:11	17.11	112:15,23 113:17
13.1	three or out and		trangarintian	,
	threequarters	53:1 62:22	transcription	114:2,2,4,4,5,13,1
technical 12:5	43:24 44:7 64:25	127:18,22 128:2	131:10	4,14,20,20,25
	66:10,15,17 67:20	130:13 (20)		117:24 119:12
telephone	68:15,21 (9)		transcripts 12:16	121:9 126:4,8
11:6,21 33:13		together 3:18	60:6	128:10,12,17,18 1
	threeyear 76:6	11:4 32:13,15		29:3,5,8,11,11,14,
telephonic 54:8		34:19 35:13 37:11	transfer 5:15	18 131:8 (179)
	thrilled 129:9	71:2 79:9 86:11	27:4	
tem 61:25 63:6		92:2,5,6 122:6		traumas 5:15
	thrilling 9:21,21	128:15 (15)	transfers 26:24	
template 29:7	un ning 9.21,21	120.15 (15)		traumatic 130:2
106:25	throughout	tomorrow 4:6	transmit 105:16	
100.23	throughout	tomorrow 4.0	transmit 105.10	A
	26:14 82:10			travel 30:17,23
temporary 62:1		took 64:16 113:6	transport	46:17 63:9 71:25
	throwing 123:22		27:3,3,7 33:23	72:8 126:6 128:7
term 31:2 59:1	126:22	tool 129:16	89:12 90:5 129:8	129:24 (9)
			(7)	
terms 32:3 59:3	thrown 52:4	tools 114:21		triage 27:8
92:22 94:23			trauma 1:1,21	
112:18 (5)	thursday 117:24	top 28:13 66:2	2:3,21 3:19	tried 47:19 77:21
	v	70:6 79:13 81:4	4:15,20 5:20 6:1,5	86:7
text 14:7,23	tie 79:8	107:18 114:2 (7)	,7,8,9,11,14,17,21,	
15:24,25 (4)			22 7:5,6,8 17:4,8	triggers 11:2
15.21,25 (1)	tight 52:15	topic 9:21 24:5	20:8,22,25	
texts 15:24	ugnt 52.15	55:9	20:0,22,25	true 131:10
ICAIS 13.24	time 7:17,18	55.9	21:2,19,20	uue 151.10
the ultracitying	9:1,19 12:6 13:6	toning 22,17		4
thanksgiving		topics 23:17	23:21,22,24 24:3,4	truly 31:9 57:15
85:9	19:3,8 24:1 32:1	1 110.04	,4,7,11,13,15,20,2	
	36:20 42:18 47:21	torch 113:24	1,22,22,24 25:1,5,	try 2:10 8:14 9:6
theoretically	52:14 58:4 62:10		6,12,13,14,16,19 2	28:13 32:23 65:25
57:14	66:23 67:5,6	total 31:1 53:23	6:2,3,5,7,10,12,13,	66:2,25 73:12,17
	70:25 76:3,12,13,1		17,18,19,20,22,23,	75:12 79:8 98:21
thinking 2:24	7,22,25,25 77:6	totally 43:3	24 27:1,3,3,4,6,7,8	104:14 118:9
18:16 59:11 78:7	83:9,10,14,23,23		28:3 30:8 33:3,22	120:20 122:20
107:25 (5)	85:8,9 107:17,24	touch 10:25	37:1 40:19 41:5	126:1,3,5 (20)
	109:20 111:9	16:10	52:5,7,9,21 56:16	
third 47:10 64:6	118:2 120:7,19		73:10,24	trying 42:8 43:10
	121:10 126:5,13	tough 124:12	74:11,12,13,20,23	46:9 47:1 49:1
thoroughly 29:7	127:1 128:3,20	6	75:5	53:2 82:12 86:18
	129:3,24 130:4,10	tourniquet	78:17,21,23,24	90:9 95:12 103:1
three 17:23 26:6	(52)	114:10	79:2,16,24 80:1,10	109:8 112:15
31:1 34:25 35:18	()		,12,15,18,19,20,22	113:1 (14)
37:11 53:23 74:17	timing 119:7	towards 128:11	,12,13,10,19,20,22	
76:8 77:7 112:10		wwarus 120.11	19,21 85:15 86:8	tsa 25:6
113:6 (12)	tips 15:21	tpm 97:18	87:2,18,19,25	15a 23.0
113.0 (12)	ups 13.21	chm 31.10	87.2,18,19,25	ttp 27:5
threadow A.C.	title 22.20 24.5	traffic 26.11		up 21.3
threeday 4:6	title 23:20 24:5	traffic 26:11	89:1,12 90:2,18,20	4
	51:8,9 (4)		93:10 95:19,23	tuesday 125:4
threefourths		training 114:7	96:8 97:14	
68:9,10	today 2:5,13,14		98:11,11,15,23	turn 59:12 85:5
	3:11,12 8:4 21:6	transaction	100:20 103:4,14	

ORIGINAL

				158
turnover 76:8	ultimately 29:25	46:13 47:20	vascular 99:5	visitors 79:13
	32:13 117:15	48:5,7,8,9,25	vasculai 77.5	81:3
turns 109:5	52.15 117.15	52:16,25 56:2,3	vegastype 114:17	01.5
ums 109.5	unable 48:11	57:4,24 59:9	vegastype 114.17	voice 41:8
twice 41:11		60:25 64:12	vehicles 63:10	VOICE 41.0
42:11,11	unavoidable	65:14,22 66:5	venicies 03.10	void 13:18
42.11,11	47:15 48:11	70:11 71:1,4	verbatim 12:16	VOIU 13.10
two 11:2 31:1,17	47.13 40.11	77:15 78:17	verbaum 12.10	volumes 26:17
34:25 35:18,21	uncomfortable	81:5,8 87:6,19	verification 24:6	88:15
37:11 40:21,23	29:4	90:1,2,4,7,17 92:9	79:22 87:1,2	00.15
41:12 43:15 44:24	29.4	99:15,22 100:5	91:19,21	voluntary 30:16
45:16 47:10 53:22	under 10:19	101:16 103:12,17	93:9,12,12,13,15	71:21
59:3 76:7 77:6	11:20 14:21 15:11	101:10 103:12,17	107:15,16 (13)	/1.21
79:9 85:7 91:20	16:3 31:24 32:9	104.9,13,20	107.13,10 (13)	volunteering
101:2,3,19,21	67:5,13 71:19	112:4,6 113:1	verified 79:20	3:18
101:2,3,19,21	75:22 76:10,20	112:4,0 113:1	96:24	5.10
113:7 124:25	81:15 83:20 92:1	123:17,19,25	J0.24	volunteers
129:9 (31)	100:16 115:18	124:2 125:8 126:1	version 17:1	111:14
	(18)	129:23 (84)		
twothird 69:7	(10)		versus 68:15	vote 13:3 30:6
	underserved	upcoming 121:14	71:22 79:21 87:1	35:10 37:11 38:13
twothirds 35:10	83:1		99:9 (5)	40:12 41:3,9
37:23 38:16 39:24	00.1	update 76:24	<i>уу.у</i> (3)	42:2,21,23
40:2 42:23,24 43:	understood	77:8,10,10 (4)	vetted 29:7	43:3,6,20,21
2,3,4,7,9,12,20,25	42:12	//.0,10,10(1)	Vetteu 29.7	44:1,13,21 45:13
44:8 45:9,12,17,20	12.12	updated 28:10	via 127:24	46:4,22 47:17 48:
46:5,7 47:8	undertaken	84:2	Via 127.21	3,12,13,16,20,24
49:3,4,5,6,10,17	78:15	01.2	vice 7:2	49:3,9,16,17,21
50:5,24 64:22,22	,	updates 73:23	100 112	50:5,23 58:24
67:23 68:2,3,7,17,	underway 27:15	108:1	victims 23:22	67:8,23
18,22,24 69:10			27:4	68:15,22,23 69:7
(42)	unfortunately	utilization 88:15		70:7,8,11 122:2
	10:14 21:11		view 38:5 55:24	127:5 (47)
twoyear 83:15		valuable 129:24	65:19	
	unique 92:24			voted 37:18 68:3
type 23:6 39:1	116:22	value 65:11	violate 13:21,23	
91:16 100:25		93:15 99:8,8 (4)	16:10	votes 11:9 12:18
113:6 (5)	unlawfully 16:15			41:19 48:4,23
		variable 88:5	violated 16:18	65:7,15 (7)
types 66:20	unless 12:9 19:13			
88:1,5,10 91:20	71:7 92:2 (4)	variation 87:3	violation 13:18	voting 37:21 43:9
97:7 99:23 100:20				45:11,13,21 47:25
106:22 112:20	unlimited 129:22	varies 96:21	violations 13:24	48:8 49:7,8,10
114:10,12 (12)			16:16	50:6,18 67:10
	up 2:12 10:14	varieties 87:18		68:4,17,24
typically 8:19	11:11 13:22 14:2		virtue 6:18	69:15,16 (18)
18:25 28:12 47:4	16:17 17:6 18:6,7	variety 82:14,19		
77:7 116:19 (6)	19:3,10,16,18		visibility 104:9	walk 28:8 29:19
	20:23 22:24 24:13	various 86:11		51:6 53:2 67:10
typo 75:23 96:20	30:4,9 33:16	95:23	vision 52:18	73:4 99:16 (7)
	34:24 35:3,14			
uf 6:12	36:23 37:11	vary 97:21	visions 32:2	wall 104:14
	39:6,8 42:18			

wants 18:3 22:4	wickham 1:24	worry 51:11	zeff 1:8 7:1	1:32940,32940
50:2		76:23		1.529 10,529 10
	wide 82:14,19		286 10:2,20	39540 23:19
watch		wreck 52:2		
86:16,16,17	willing 3:18		300 124:13,20	201866 96:3
wayside 116:15	wish 7:23 85:20	writing 16:9	125:5,6 (4)	395401 24:3
wayshee 110.15	wish 7.25 05.20	written 11:14,19	321 1:25	393401 24.3
web 71:4	withheld	25:10		395402 25:2
	16:13,16		395 21:18 22:9	
website 12:13	101.10	y'all 19:23 66:1	23:15	395404 26:19
16:25 27:24 28:3,7 72:23	witness 131:19	91:8 108:5 (4)	400 124:13,21	2598500 1:25
28:3,772:23 94:19 (7)	wolfson 89:4,4	vear 2:15	125:5,6 (4)	2598500 1:25
<i>y</i> 1.1 <i>y</i> (<i>t</i>)		8:19,20,21,24 9:8	125.5,0 (1)	3954015 24:20
websites 86:15	women's 4:1	16:20 20:17	500 119:24	
91:23		52:17,23 65:25	120:8,15	3954025 26:2
J	wonder 21:17,24	66:8,8 72:24	574 76.14	2054026 26:10
wednesday 117:21 125:5	wonderful	76:9,11,15,16 77:5 83:10,11,12,13,14,	524 76:14	3954036 26:10
117.21 125.5	3:17,20 21:3	15,16,25 84:1,21	900 1:5 120:12	3954045 27:2
week 9:3 107:6		86:7 102:6,7		
117:19 123:20	woodlief 4:17	107:5 108:11	1045 71:14	
124:1,9,22,24 (8)	1.54.6	111:5 112:13,13	11(5.05.2.72.0	
week's 48:18	word 54:6 64:13,16 67:15	116:18 121:2,4,11,11	1165 25:3 73:8	
week 5 40.10	87:8 96:16	123:17 125:18	1200 120:12	
weekly 19:17	110:13,16 (8)	(44)		
125:10			1208 130:15	
	wording 68:20	year's 113:21	1500 100 4 6 05	
weeks 35:12 37:4 85:7 104:11	words 23:25	years 26:6 37:20	1509 108:4,6,25 111:22 (4)	
126:12 (5)	worus 23.23	77:7 86:9 108:12	111.22 (4)	
120112 (0)	wordsmithing	113:6,7 121:3	2010 107:22	
weigh 114:11	74:17	128:10,24 (10)		
			2018 1:24 100:18	
welcome 3:8,17 4:3,9 29:15 (5)	workgroup 39:2 66:20 94:16 99:20	yesterday 3:11	131:20	
4.5,9 29.15 (5)	(4)	york 1:12 6:12,12	2019 21:10 111:1	
welfare 33:10		44:12 46:2 54:3,9	112:24	
	workgroups	63:6 69:25 70:25		
west 121:11	34:17 35:3,8	71:19 72:1,9,12	2020 26:6 112:24	
western 52:7	39:11 100:5 (5)	75:1 76:10 79:12 97:19 107:6,12,25	113:4,20 (4)	
western 52.7	workload 116:16	120:13 126:16,22	2555 1:3	
whatsoever		127:1,4 (26)		
65:12	works 57:14 65:2		8195 1:24	
	123:21	young 86:5,5,10		
whispered 47:19	workshops 56:20	yourself 65:16	11509 24:10	
whole 18:16	57:7	yoursen 05.10	11907 16:4	
19:15 45:18 85:6		yuck 3:12		
(4)	world 87:14		32940	