

STATE OF NEW YORK
DEPARTMENT OF HEALTH

EMS for CHILDREN ADVISORY COMMITTEE
Meeting

CHAIRMAN: ARTHUR COOPER, M.D., M.S.
DATE: September 18, 2012
TIME: 1:00 p.m. to 4:15 p.m.
LOCATION: Troy, New York

1 Advisory Committee, 9-18-2012
 2 ATTENDEES
 3 Sharon Chiumento, B.S.N. E.M.T.-P
 4 Arthur Cooper, M.D., M.S.
 5 Director of Pediatric Surgical Services
 6 Harlem Hospital Center
 7 Robert Kanter, M.D. (Telephonically)
 8 Professor, Dept. of Pediatrics
 9 Director Critical Care and Inpatient
 10 Pediatrics
 11 SUNY Upstate Medical University
 12 Rita Molloy, R.N. (Telephonically)
 13 Mary G. Clarkson School Nurse
 14 Janice Rogers, M.S., R.N. C.S. C.P.N.P.
 15 N.Y.S. Emergency Nurses Association
 16 Elise van der Jagt, M.D., M.P.H.
 17 Professor of Pediatrics and Critical Care
 18 Children's Hospital at Strong
 19 Lee Burns, B.S. E.M.T.-P
 20 Department of Health
 21 Director of Emergency Medical Services
 22 Martha Gohlke, B.A., E.M.T.-B
 23 HPA-I, Coordinator, E.M.S.C. Program
 24 N.Y.S. Department of Health
 25 Bureau of Emergency Medical Services
 Linda Tripoli, R.N.
 HPA-I, Trauma Program Coordinator
 N.Y.S. Department of Health
 Bureau of Emergency Medical Services
 Hope Plavin
 H.A.P.
 N.Y.S. Department of Health
 Sandy Haff
 N.Y.S. Department of Health

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1 Advisory Committee, 9-18-2012
 2 (The meeting commenced at 1:00
 3 p.m.)

4 **DR. COOPER:** I'd like to welcome
 5 everyone to the -- the September 18, 2012 meeting
 6 of the New York State Emergency Medical Services
 7 for Children Advisory Committee. We're -- we're
 8 short on physical presence today, but we are long
 9 on -- on -- on participation. Bob Kanter, our vice
 10 chair, is on the phone with us. We're expecting
 11 Danielle LaRaue to join us and a couple of others.
 12 So Rita Malloy, I believe, is joining us online.

13 And Martha, is there anyone else
 14 who we're waiting for. Bob is here, Danielle, and
 15 Rita, and isn't there someone else who is joining
 16 us online?

17 **MS. GOHLKE:** Dr. Bass, I think,
 18 is joining us.

19 **DR. COOPER:** Yes, right -- right.
 20 Okay. Dr. Bass and maybe a couple of others. So,
 21 yeah, this is -- it's a very tough time of year
 22 with the religious holidays and -- and so on and so
 23 people were unable actually to travel, but -- but
 24 we're going to have, I think, a fairly robust
 25 turnout on the telephone, so I hope we'll all feel

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1 Advisory Committee, 9-18-2012
 2 Nancy Agard
 3 N.Y.S. Department of Health
 4 Colleen McLaughlin
 5 N.Y.S. Department of Health
 6 David Brick
 7 N.Y.S. Department of Health
 8 DOH - Bureau of Health Care Research and
 9 Information Services
 10 Pamela M. Lawrence, Program Research
 11 Specialist II (Syracuse Office)
 12 DOH - Division of Quality and Patient Safety
 13 Lisa McMurdo, R.N., M.P.H., Director

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1 Advisory Committee, 9-18-2012
 2 as though we're in good company even though we may
 3 not see some of our -- some of our friends in
 4 person today.

5 My name is Art Cooper. I'm chair
 6 of the committee. I'm a pediatric surgeon from
 7 Columbia University in Harlem Hospital. We have a
 8 very full agenda. We have lots of really, really,
 9 really great updates for you and news to report in
 10 terms of -- in terms of the work of the committee,
 11 but we also have an awful lot of new faces with us
 12 today and guests who are going to hopefully make
 13 our -- our work today really focus in on some new
 14 directions. So starting at my left with Sharon
 15 Chiumento, who does tons and tons and tons of work
 16 behind the scenes for this committee, I'd like to
 17 have everyone introduce themselves so that we all
 18 know who each other is.

19 Sharon?

20 **MS. CHIUMENTO:** Sharon Chiumento,
 21 I'm from the Monroe County area. I'm a paramedic
 22 and a retired nurse and a member of SEMAC.

23 **MS. ROGERS:** I'm Jan Rogers. I'm
 24 a nurse practitioner, pediatric nurse practitioner
 25 in the pediatric emergency department at Strong

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1 Advisory Committee, 9-18-2012
 2 Hospital in Rochester.
 3 **DR. VAN DER JAGT:** I'm Elise van
 4 der Jagt. I'm a pediatric critical care physician,
 5 also at University of Rochester, at Golisano
 6 Children's Hospital.
 7 **MS. HAFF:** I'm Sandy Haff, from
 8 the Division of Certification and Surveillance.
 9 **MS. TRIPOLI:** Linda Tripoli, New
 10 York State Trauma Program Manager.
 11 **MS. SPERRY:** Sarah Sperry,
 12 Epidemiologist with the Injury Prevention Program.
 13 **MS. GOHLKE:** Martha Gohlke,
 14 E.M.S. for Children Coordinator.
 15 **MS. BURNS:** Lee Burns, Director
 16 of E.M.S. Bureau.
 17 **MS. McMURDO:** Hi; Lisa McMurdo,
 18 Director of Division of Quality Patient Safety.
 19 **MS. LAWRENCE:** Pamela Lawrence, I
 20 work for the Bureau of Health Care Research and
 21 Information Systems.
 22 **DR. BRICK:** Hi; I'm David Brick.
 23 I'm a pediatric cardiologist in New York and I'm
 24 going to be presenting some information on an
 25 updated NIST guideline.

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1 Advisory Committee, 9-18-2012
 2 **MS. McLAUGHLIN:** Hello. I'm
 3 Colleen McLaughlin. I'm a research scientist with
 4 the Patient Safety Center at the State Health
 5 Department.
 6 **MS. PLAVIN:** Good afternoon.
 7 Hope Plavin, I'm newly with the new office of
 8 Quality and Patient Safety in the State Health
 9 Department.
 10 **MS. AGARD:** I'm Nancy Agard. I
 11 work for the Patient Safety Center in the Health
 12 Department.
 13 **DR. KANTER:** Bob Kanter, Peds
 14 Critical Care in Syracuse.
 15 **DR. COOPER:** Anyone else on the
 16 phone at this point?
 17 **MS. MALLOY:** Rita Malloy, I'm the
 18 past president of the New York State Association of
 19 School Nurses and public relations chair. Is there
 20 a way to put the volume up to the phone
 21 participants?
 22 **DR. COOPER:** Well I'll tell you
 23 what. We'll do our best to have everyone be sure
 24 that they press the red button --
 25 **MS. MALLOY:** Okay.

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1 Advisory Committee, 9-18-2012
 2 **DR. COOPER:** -- on their
 3 microphone when they speak. I think that's been
 4 part of the -- part of the problem.
 5 **MS. MALLOY:** Okay. Thank you.
 6 **DR. COOPER:** You're welcome.
 7 Welcome, Rita.
 8 **MS. MALLOY:** Thank you.
 9 **DR. COOPER:** Anybody else? Okay.
 10 Well, we will hope that as people join us that they
 11 will be announcing their presence volubly so that
 12 we know that they are there. So just to begin
 13 the -- begin the -- begin the agenda today, of
 14 course, we're going to be focusing, as usual, on
 15 reports from the Bureau of E.M.S. and the E.M.S.
 16 for Children grant. We're then going to focus on
 17 some new business, focusing -- or chiefly regarding
 18 some patient safety issues. Before updating you on
 19 where we are in terms of the 405 hospital code
 20 revision and the emergency preparedness activities
 21 and then as usual we will conclude with the updates
 22 from our sister advisory committees and -- and
 23 D.O.H. partners.
 24 I -- I do want to just begin the
 25 meeting by sharing with everyone that we had a

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1 Advisory Committee, 9-18-2012
 2 really excellent meeting with the commissioner on
 3 August 23rd past. The commissioner was gracious
 4 enough to accommodate Bob Kanter and I, as chair
 5 and vice chair of the Committee to speak about the
 6 future directions for the Committee over the coming
 7 months and years. And I think that there were
 8 three major themes that emerged from that meeting.
 9 I think that those of us that were there in
 10 addition to myself and Bob, namely Martha and Lee
 11 and Lisa, will all agree that it was a really very,
 12 very productive meeting and very useful in terms of
 13 the directions that we might be taking.
 14 First and foremost, of course, on
 15 our -- on our agenda is completion of our task of
 16 getting the regulatory package brought forward.
 17 Suffice it to say that the commissioner was
 18 extremely positive about continuing to move in that
 19 direction and gave us some guidance as to where we
 20 might go in the -- in the next month or so with
 21 that, with the expectation that at this point
 22 unless another issue arises between now and then,
 23 is expected to be on the agenda for the Codes
 24 Committee of the Public Health and Health Planning
 25 Council on November 15th. And to all of you who

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1 Advisory Committee, 9-18-2012
 2 have participated in the Committee for all these
 3 many years and been through our time together in
 4 terms of moving toward this day, this is really
 5 going to be a terrific -- you know, a terrific
 6 undertaking once it -- once it goes forward, which
 7 we expect that it will with the Commissioner's
 8 support on that date.
 9 In addition to that, and we'll
 10 give you an update about that a little bit later in
 11 terms of the details, we focused on emergency
 12 management, disaster medicine, public health
 13 preparedness, in terms of this Committee's role
 14 in -- in advancing that particular field within
 15 the -- within the scope of our work. Bob Kanter,
 16 as -- as is usual, was particularly compelling in
 17 terms of his advocacy for the -- the involvement of
 18 this Committee in the work of the Department
 19 respecting emergency preparedness. And as a result
 20 of that, thanks to, again, Martha, Lee and Lisa, we
 21 had an opportunity to meet with Mr. Nick Ntarogen
 22 (phonetic spelling), if I'm pronouncing that
 23 correctly, who is the Deputy Director of the -- of
 24 the Preparedness Program within the Department
 25 which we learned this morning combines the -- the

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1 Advisory Committee, 9-18-2012
 2 public health emergency preparedness grants --
 3 grant from C.D.C. and the hospital preparedness
 4 grant from the -- from the ASPR, the assistant
 5 secretary for preparedness and response. We came
 6 up with -- with some very useful directions to
 7 pursue in the immediate and -- and midrange future
 8 and will again comment on those briefly a little
 9 bit later in the meeting.
 10 Last, but in my view certainly
 11 not least, the commissioner expressed his hope that
 12 this Committee would assist him in -- in his
 13 quality safety agenda. And of course, we have our
 14 friends from the -- from the Patient Safety Center
 15 within the Department with us today to sort of open
 16 the discussion on that issue. But we heard the
 17 commissioner utter the D word during our meeting,
 18 dashboard, and -- and I think that this represents
 19 a really, really incredible opportunity for our
 20 Committee to begin to work, you know, on a quality
 21 safety agenda and emergency care for children
 22 statewide as we move into the future. Of course,
 23 we have spent the last decade or so really
 24 preparing, you know, for this time, laying the
 25 groundwork in terms of, you know, a -- a regulatory

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1 Advisory Committee, 9-18-2012
 2 basis for the work that -- that -- that is done on
 3 behalf of emergency care for children and of course
 4 the next phase is focusing on improving the safety
 5 and quality of that work to ensure that it really
 6 meets the needs of our -- of our youngest citizens.
 7 Now many of you may not know that
 8 one of our very longest serving members, Elise van
 9 der Jagt, from -- from Rochester, actually
 10 pioneered work in this area on one of the very
 11 first two E.M.S.C. grants in New York State back in
 12 the mid-1980s. He was at that time developing an
 13 emergency registry and looking to develop some risk
 14 adjusted outcome metrics based upon the data that
 15 he collected. And I had a chance to briefly speak
 16 with Elise and Elise has graciously accepted the
 17 opportunity to really focus the work of the
 18 Committee on this aspect of -- of -- of emergency
 19 pediatric care as we move forward in the next -- in
 20 the next months and years.
 21 So, Elise, I really want to thank
 22 you for that. It's going to be a huge undertaking,
 23 but vitally important to the -- to the work of this
 24 Committee, the Department, and of course public
 25 health at large in New York State and so thank you

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1 Advisory Committee, 9-18-2012
 2 so much for your agreeing to take that on.
 3 Obviously, those of you who wish
 4 to work with Elise on that very, very, very
 5 important project that the commissioner has
 6 indicated really has his very strong support,
 7 please let -- let me know and him know and, you
 8 know, we'll be moving forward in that -- in that --
 9 in that endeavor as -- as we go forward throughout
 10 the next several months and years.
 11 So that, sort of, by way of an
 12 intro as to what's been taking place over the last
 13 few months since we last meet and I think it's
 14 really, really, really exciting. And once again, I
 15 want to thank Martha and Lee and Lisa publicly, as
 16 I so often do privately, for all the incredible
 17 work that they do on behalf of the children of New
 18 York State behind the scenes when we are, you know,
 19 thinking about more pressing issues such as taking
 20 care of those kids when they come to our -- come
 21 to -- come to our -- come to us for -- for help.
 22 So at this point, I'm going to --
 23 I'm going to turn the agenda over to Lee Burns, who
 24 is going to give us a little bit of an update as to
 25 where things stand with -- with the Bureau.

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1 Advisory Committee, 9-18-2012
2 Lee?
3 **MS. BURNS:** Well we are in the
4 midst of implementing the new E.M.T. curricula.
5 It's a monumental task. Basically, for those of
6 you who are not E.M.S. people, there are five
7 levels of E.M.S. certification in New York State.
8 At the national level, in 19- -- or excuse me --
9 2009 at the national level the E.M.T. level --
10 actually all of them, were updated and changed.
11 For us in New York, it lengthens the course time.
12 There are some funding issues. We are in the -- it
13 was -- it was published as a guideline, so there
14 were no objectives to it, so we've been working
15 with our -- your sister councils and other states
16 on developing objectives so that our instructors
17 can teach the curricula and that there are testing
18 elements. So that is -- that's -- again, it's a
19 monumental task. We have a group of people in the
20 City now looking at exams.
21 The budget process is starting
22 again. Actually, I guess it never goes away
23 really. So we're working with the Department on
24 budgeting. I would be remiss if I didn't utter
25 these three words, travel reimbursement issues. I

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1 Advisory Committee, 9-18-2012
2 look at my -- most of you are Health Department
3 people, so you have -- you understand the magnitude
4 of the -- of the problem. The -- the State, not
5 just the Health Department, implemented something
6 they call the State Fiscal System, the S.F.S. Many
7 of us have other words to fit into the S.F.S., but
8 not for publication. As a part of that, the
9 advisory councils, the travel reimbursement has
10 shifted away from really what has historically been
11 a paper process. I think you will be doing paper
12 and we will be submitting it electronically. I
13 know that our councils are not getting paid on a
14 timely basis. We have many, many outstanding
15 vouchers. We do -- we can tell you that every
16 voucher that we had in the Bureau has been
17 processed, the last of them fairly recently. So
18 the -- as all us who are using the S.F.S. can
19 attest, they're beginning to -- it's a learning
20 curve for us to use it and they're beginning to --
21 they're starting to actually reimburse us so that's
22 kind of encouraging. So I -- I beg your indulgence
23 and forgiveness. I know that it's -- it is -- you
24 know, it comes out of your personal finances to get
25 here and I apologize on behalf of the Department

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1 Advisory Committee, 9-18-2012
2 and the State. Again, it's very frustrating and
3 we're sorry.
4 Sure?
5 **MS. CHIUMENTO:** We were supposed
6 to get a vendor number at some point in time and I
7 haven't submitted my recent vouchers because I've
8 been waiting for the vendor number and have never
9 received it, so are we still going that direction?
10 Shall we submit the vouchers?
11 **MS. BURNS:** I'll check because
12 there's a -- there's a bureau in the Department
13 called Council Operations and those -- and they --
14 they're -- our -- we've gone round and round about
15 something called a Netcard and when I -- I'm a
16 simple person, unlike most of you, but I asked what
17 is a Netcard and everyone looks at me and says we
18 really are not actually sure. So I'll check on
19 the -- I know that our core sponsors and the
20 ambulance services, anybody seeking reimbursement
21 for our contract work has to have a vendor I.D.
22 **MS. McMURDO:** Yeah. The little
23 bit that I understand is they will be requiring a
24 vendor I.D. in the future, but currently the old
25 system of the paper is still standing and we only

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1 Advisory Committee, 9-18-2012
2 recently were told that in the last week or so. So
3 I would think, we can verify, but I think you
4 should submit things by paper.
5 **MS. LEE:** I think you have paper
6 for them; don't you, for --?
7 **MS. GOHLKE:** Yes. My
8 understanding is we were supposed to fill in your
9 vendor I.D. number when we get it. That was the
10 last word I had heard.
11 **MS. LEE:** The answer to your
12 question, clearly, is we don't know. We'll get
13 back to you on that.
14 **MS. CHIUMENTO:** But at least now
15 I know that I can send the stuff to you and let you
16 deal with it.
17 **MS. LEE:** I'm not sure I'd
18 encourage that behavior either, but you know,
19 we'll -- we'll -- I think a big part of the
20 frustration, and I say this to all -- with all my
21 Health Department colleagues that are going to do
22 this, is that it changes pretty regularly, so once
23 we think we know what we're doing, the whole system
24 changes. Did I miss anything? So -- but we --
25 we're lobbying for you. We -- we understand that

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1 Advisory Committee, 9-18-2012
 2 it comes out of your, you know, personal budgets.
 3 We appreciate your participation. We implore you
 4 to keep participating and we are doing everything
 5 we can to make our finance, as Marjorie Geiger once
 6 said, our finance colleagues -- this is the part
 7 she wouldn't have said -- miserable. So we bug
 8 them to death so.
 9 We are in the last year of a
 10 four-year grant, which Martha has really led the
 11 charge on with regard to electronic pre-hospital
 12 patient records. She has dragged Linda, our Trauma
 13 Coordinator, kicking and screaming so that we
 14 include trauma records in --.
 15 **MS. GOHLKE:** It's called sharing
 16 the pain.
 17 **MS. BURNS:** Okay. Into an
 18 electronic platform. We have -- have had a lot of
 19 success with -- with pre-hospital stuff and the
 20 trauma stuff. I'm looking at Pam since it causes
 21 her -- yes, she has a pain right here thinking
 22 about particularly the trauma. So the information
 23 we're getting is very exciting and we're -- on the
 24 bright side, we -- while probably about forty
 25 percent of our E.M.S. services across the state are

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1 Advisory Committee, 9-18-2012
 2 submitting data electronically, it represents over
 3 two-thirds of our overall call volume. So that --
 4 and that number grows weekly because services are
 5 switching over to electronic patient records. And
 6 I tell you this so you understand because you're
 7 health professionals, there is no financial
 8 incentive for our pre-hospital care providers to
 9 submit electronically from the Department.
 10 However, more and more ambulance services are
 11 billing their patients. And their ability to
 12 collect those dollars is much better when they're
 13 using electronic patient records. So that is
 14 compelling.
 15 Dr. van der Jagt?
 16 **DR. VAN DER JAGT:** I have the
 17 question about the database that generates. Is
 18 this a Web-based electronic record, that they can
 19 go to the Web and they can also download their own
 20 data to see how they're doing? This is -- again,
 21 I'm thinking about a quality safety perspective.
 22 Like the trauma, I think, now is Web-based. Isn't
 23 that right? When you --.
 24 **MS. HAFF:** Facilities have the
 25 ability to purchase the ImageTrend software, which

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1 Advisory Committee, 9-18-2012
 2 is the vendor, so that it would be a live Web-based
 3 repository, but for the most part I think most of
 4 the trauma centers want to continue to use their
 5 current vendors will download into the ImageTrend
 6 system and then our goal, just like on the P.C.R.
 7 side, will be for the regions to access aggregate
 8 data to do some quality improvement activity.
 9 **DR. VAN DER JAGT:** So the -- so
 10 the answer to that is that currently it's not a
 11 Web-based tool that they can -- it's just an
 12 electronic data form. Is that correct?
 13 **MS. GOHLKE:** Well the E.P.R. --.
 14 **DR. VAN DER JAGT:** Could you
 15 explain maybe a little bit about it? That would be
 16 really helpful.
 17 **MS. GOHLKE:** It's on the Web, but
 18 it's not a live repository, or it's not -- you see
 19 one patient and you enter it in. It's -- you
 20 download once a month or once a day if you want to
 21 do it that frequently. And the State only collects
 22 the data that they want to look at on a statewide
 23 basis. So it's not a legal patient record that
 24 E.M.S. services can retrieve in that sense of the
 25 word of a live repository, but it is Web-based.

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 2 You do upload through the Web. Does that make
 3 sense?
 4 **DR. VAN DER JAGT:** It does make
 5 sense. The question then is, is the data that the
 6 agency collects on an individual patient, is all of
 7 that data put in or is it only select data fields
 8 that are on that form?
 9 **MS. GOHLKE:** Only the identified
 10 data that we at the State choose to retrieve.
 11 **DR. VAN DER JAGT:** And who
 12 decides what fields have been put into that?
 13 **MS. GOHLKE:** What we -- we
 14 brought it to the State E.M.S. Committee Council
 15 and they participated in what data that they
 16 thought would be good to collect on a statewide
 17 level and then the data that the State had
 18 collected previously, we've put in there. It grew.
 19 We were collecting ninety-something elements and
 20 now we collect two hundred and forty-something
 21 elements. So it's a much bigger database than we
 22 had before.
 23 **MS. LEE:** I suggest you can blame
 24 Sharon because it's hers. But she was very
 25 instrumental in developing the pre-hospital

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1 Advisory Committee, 9-18-2012
 2 dataset, but it's Nemsys compliant. The other
 3 piece to this is that while a service can look at
 4 their data on ImageTrend, it's not real time and
 5 one would presume that they can look at their own
 6 data because they're using either ImageTrend
 7 software or another vendor. There's -- there's
 8 forty gold compliant and silver compliant vendors.
 9 And in New York State we have found probably the
 10 vast portion of our services are using ZOLL, E.M.S.
 11 charts, Sansio, the small -- actually small numbers
 12 are looking at ImageTrend, although I think one
 13 region has chosen ImageTrend, which is very
 14 exciting. So while it's not live real time data,
 15 from our perspective, it's monumental improvement
 16 because we just released our 2008 data. We're
 17 hoping to be able to release 2009 and '10 before
 18 the end of -- of two thousand -- what year is this?
 19 '11 -- oh -- '12? And so while, you know, it's
 20 certainly -- our data's not syndromic surveillance
 21 valuable, we really -- the increased dataset and
 22 the timeliness that we can, you know, see what's
 23 going on will give us some really good insight on,
 24 you know, protocols and patient treatment. The
 25 other thing is that it -- it's matchable to SPARCS.

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1 Advisory Committee, 9-18-2012
 2 So we're hoping to be doing some -- some looking at
 3 SPARCS with our pre-hospital data.
 4 **MS. GOHLKE:** It's been a huge
 5 undertaking that's taken four years to get to where
 6 we are now, which is we're just starting to get
 7 data into the system through this method.
 8 **DR. VAN DER JAGT:** I just think
 9 it's phenomenal and I just -- it goes back to the
 10 opening statement of trying to be put in chart, I
 11 guess in some way for the quality and safety
 12 metrics for -- for E.M.S.C., is that the linkage
 13 between the pre-hospital dataset and the SPARCS
 14 dataset is critical and how to do that exactly. So
 15 this sets us up very nicely for being perhaps able
 16 to do that.
 17 I have one more question if I
 18 can -- you can bear with me. It's a question of
 19 you mentioned, Lee, that forty percent of ambulance
 20 agencies are basically submitting electronic
 21 P.C.R.s but that that accounts for sixty percent of
 22 the population basically. Could you divide it into
 23 upstate versus downstate because upstate is very
 24 rural, largely volunteer and I'm just wondering how
 25 that compares to downstate New York City, which is

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2 a very different place.

3 **MS. BURNS:** I can run numbers for
 4 you actually if you're interested and send them to
 5 you. It -- in the -- in the metropolitan New York,
 6 FDNY, in the nine-one-one system does about a
 7 million point six calls. So FDNY and all of the
 8 voluntary hospital providers are all submitting
 9 electronically. Some of the peripheral, the
 10 volunteers, it's all in the verbiage, the
 11 voluntaries are the hospitals. The small volunteer
 12 ambulances, I don't think any of them are
 13 submitting electronically, but they're doing a very
 14 small call volume. Upstate, there are pockets
 15 where E.P.C.R.s are very, very heavy. Your world,
 16 for example, Monroe Livingston, again thanks to the
 17 small woman at the end of the table, is -- is --
 18 you're probably ninety-eight percent electronic,
 19 would you say, Sharon?

20 Once you get out into the
 21 hinterlands, it's a little less, but it's growing.
 22 The Finger Lakes Region has an E.P.C.R. program and
 23 they are signing in services daily, including
 24 non-transporting basic life support response, which
 25 is very exciting. They're not statutorily required

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2 to submit data and, yet, they are which gives us a
 3 lot, a really deep view.

4 The other Susquehanna region, the
 5 Binghamton area, has been submitting electronically
 6 forever, almost as long as Monroe Livingston
 7 actually. They are just switching over to what we
 8 fondly call the homegrown system, to a commercially
 9 prepared system. Just financially, they couldn't
 10 support continuing to build their own program,
 11 especially in light of the options.

12 And then the Albany area, the big
 13 services, are -- are primarily electronic -- well,
 14 that's not altogether true. We're working on that.
 15 The larger ambulance services are electronic. Some
 16 of the municipals, it's a little -- because there's
 17 an expense involved, it's a little more -- you
 18 know, it's like pulling hen's teeth sort of thing.
 19 But I can -- we know who they are. We know how
 20 many calls they do. I just need to actually get
 21 the data. So if you want it, send me a note.

22 **DR. VAN DER JAGT:** Thank you very
 23 much.

24 **MS. GOHLKE:** And I just want to
 25 add, as Lee says, it's all really driven by

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2 reimbursement. If the ambulance company is billing
3 the patient, they're probably using an E.P.C.R.
4 system because that facilitates that.

5 **MS. BURNS:** We also know that the
6 numbers of ambulance services submitting for
7 reimbursement also grows routinely because our --
8 our friends in the Medicaid, you know, whatever
9 they are, O something or other, they -- we are in
10 touch with them when they issue a Medicaid permit
11 number. So we're aware of that. And I -- you
12 know, the economy has driven that also.

13 I want -- without throwing Linda
14 under the bus, but just to spend two minutes
15 talking about the trauma and A.C.S., which is very
16 dynamic and lively and important to you all, too.

17 **MS. TRIPOLI:** We had sent out a
18 letter of intent to all of the hospitals in New
19 York State, explaining to them that the
20 commissioner had made the decision to adopt the
21 American College of Surgeons Committee on Trauma
22 Standards and Verification Process, to outline for
23 them what that would mean, which basically was two
24 more tiers of designation. We would go from a
25 designation of regional and area to level one, two,

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2 three, four, which would allow for a much more
3 inclusive trauma system. So we sent out a letter
4 requesting intent. We've gotten some -- a great
5 response. All of the facilities currently in the
6 trauma system have responded, some a little
7 obtusely because, certainly, decisions have to be
8 made. But we got probably fifteen more hospitals
9 who -- many whom -- of whom are looking for the
10 level four or rural trauma center designation,
11 which is very exciting. Some of those folks I've
12 hooked up with their regional, especially in the
13 Rochester area, so that they can start attending
14 regional meetings and start getting used to be
15 included in the system.

16 The next STAC meeting is in
17 October. The Chair of the American College of
18 Surgeons Committee on Trauma and the Chair of the
19 Verification Process will be attending and
20 observing and will be present at a dinner the night
21 before to answer questions and resolve some of the
22 anxiety.

23 We've had three -- four
24 consultative visits to date. We have a fifth about
25 to be conducted and a sixth scheduled. The letter

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2 that was composed by the Bureau and signed by our
3 administrative staff lays out the timeline now for
4 seeking a consultative visit and the timeline for
5 verification. So that has been sent out and
6 certainly generating a lot of buzz.

7 Again, doing a lot of work on
8 beefing up our regional trauma advisory committees,
9 hopefully encompassing more of our E.M.S. community
10 in those efforts and I know we're meeting with FDNY
11 in October to begin the discussion in New York City
12 of really pulling them into the system and
13 explaining to them the verification process and
14 hopefully also pulling them into the regional
15 quality improvement efforts. And we're offering
16 the topic course in November. We have tentative
17 dates and now we're just waiting to solidify those
18 and that will be held in Nyack -- at Nyack
19 Hospital.

20 **DR. COOPER:** Thank you. Lee, do
21 you have anything further for us? Is that it?

22 **MS. BURNS:** That's it.

23 **DR. COOPER:** Lisa, anything from
24 the Department?

25 Okay. Martha?

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2 **MS. GOHLKE:** Not too much to
3 report. This is a competitive grant cycle year for
4 the next four years. So I had the pleasure of
5 going through a full grant application, which we're
6 at the very end of now and it's been a long ordeal,
7 as anybody knows who writes a grant. But -- so
8 hopefully we'll have another four years of fun in
9 New York State and all signs show that we will
10 unless something changes drastically that we don't
11 know about, but it looks good.

12 Vetting, apparently in June or
13 July, I can't remember, the Governor's Office sent
14 out required paperwork to the members to complete.
15 I think it had to do with your tax forms. I'm not
16 sure because they don't tell me. And in order to
17 get through the vetting process, if you didn't jump
18 through that hoop and sign the completed paperwork,
19 release forms, whatever it was that they asked you
20 to do, you need to do that. The only person that
21 has been vetted at this point is Allan Filler, who
22 couldn't be here today, from the Iroquois Hospital
23 Association. We have not heard from the rest of
24 the Committee members yet about the vetting
25 process. So if you are unaware of what it is that

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2 you were supposed to do and you can see me
3 afterwards and I'll try and get you hooked up with
4 that paperwork. Like I said, they don't include me
5 in on that. All I know is there's an e-mail and a
6 date that went out from somebody, but I can access
7 that person and that date for you to look in your
8 e-mail, spam file most likely if you didn't get it.

9 So the other thing is the
10 pediatric readiness survey that we were told it was
11 going to be deployed this fall, I had distributed
12 the survey at the last meeting. This is a national
13 kind of report card, assessment that they're doing
14 about E.D. pediatric readiness. We're now being
15 told that New York -- New York State is going to be
16 deploying this survey in March of next year. And
17 we're also being told that -- originally, it was
18 they were hoping that coordinators like myself
19 would get involved and distribute the survey and
20 make sure it gets complete. But now we're being
21 told you are going to do it and you should be
22 excited about it.

23 We just got a letter from HERSA.
24 One of the ways they're making sure that we're
25 involved is they're now rolling in our own survey

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2 questions that we have to have answered for the
3 grant into the pediatric readiness survey. So if
4 we want to get that data for our grant, we need to
5 follow through and process this whole survey. So
6 we'll talk more about this at our -- at our future
7 meetings. I'm going to -- I'm going to need your
8 help getting the surveys answered at your
9 facilities and at the surrounding facilities next
10 spring when we're told to go forward and I'll have
11 more information about that. And if you want to
12 see the actual survey, just send me an e-mail and
13 I'll resend it out. It's a very long document,
14 very long survey which we've been told it's been
15 shortened considerably. But it went from maybe an
16 hour and a half survey to probably an hour survey.
17 I don't know.

18 So that's on the horizon and I'll
19 leave this towards the end of the meeting because
20 we do have guest speakers that we want to get to,
21 but we'll talk about attendance at the meetings and
22 maybe how to change the formats of this meeting or
23 try and encourage better attendance in the future.
24 We're trying to balance between the cost of these
25 meetings, in-person meetings and not in-person

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2 meetings, but we need to meet everybody's needs and
3 we'll talk more about that towards the end of the
4 meeting and see what people want to do for the
5 future.

6 **DR. COOPER:** Questions for
7 Martha? Well, Martha, thank you so much for all
8 the work you've done, particularly on the grant.
9 We all know that that grant is underpinning many,
10 if not most, of our activities and we're deeply
11 grateful for all that you've done and the support
12 you've gotten from the Department in getting that
13 grant off the ground.

14 We've had at least one person
15 join us. Deb, would you say hello for everyone so
16 folks on the phone know who you are?

17 **MS. SOTTOLANO:** Hi; this is Deb
18 Sottolano, Department of Health, O.H.S.M.

19 **DR. COOPER:** Deb is our liaison
20 from the disaster preparedness world.

21 I know Bob and Rita are on the
22 telephone. Has anyone else joined us by telephone
23 in the interim? We are still expecting a couple of
24 folks, so I will hope they speak up when -- when
25 they arrive.

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2 Okay. Well one of the things
3 that -- that we spoke of a little earlier, namely
4 moving toward a quality safety agenda for -- for
5 emergency care and children, sparked our interest
6 in reaching out to the Safety Center to hear about
7 some of their activities as they pertain to -- to
8 children. And at this point I'm going to ask
9 Colleen McLaughlin -- Dr. Colleen McLaughlin from
10 the Department of Health to -- to introduce some of
11 the issues regarding pediatric patient safety in
12 the emergency care realm. And -- and she, I
13 believe, has asked Dr. David Brick from N.Y.U. to
14 speak about medication safety, which is one of
15 their key initiatives. I might point out that
16 medication safety is one of the -- one of the
17 important points that is included in the regulatory
18 package that's going forward in a very general way.
19 So this is really right up -- right up there in
20 terms of our -- of our priorities.

21 So Colleen, I'll turn it over to
22 you at this point. Thank you.

23 **DR. McLAUGHLIN:** Thank you very
24 much. I'd like to, first of all, thank Lisa for
25 connecting the dots for us. We had prepared this

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2 article that's been distributed about pediatric
3 medication errors and she -- you know, it went
4 through her for the usual, you know, Department
5 sign-offs and whatnot and, you know, said hey, this
6 looks just like the regs that they're passing, so
7 why don't you guys hook up. So she told me to talk
8 to Martha and that's how this eventually grew. So
9 Martha is loading the presentation.

10 Martha, how am I going to change
11 the slides from here? Okay.

12 **DR. McLAUGHLIN:** So -- there we
13 go. Thank you. So what I did is I -- the
14 newsletter that we prepared has been distributed.
15 I just have to ask. It says please do not
16 redistribute. We anticipate that it will be going
17 out soon. It will have lots of pretty pictures and
18 be nicely formatted and go out on the Web, but
19 until we actually get the sign-off from the Public
20 Affairs group I'd appreciate it if you didn't
21 redistribute it from what I'm sending you. And so
22 what I'm doing now with this presentation is I just
23 want to give you a brief kind of introduction to
24 what's in the newsletter, but you can peruse the
25 newsletter on your own time.

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2 Sorry. I have no idea how to
3 work this apparently. Okay. Okay. I think I
4 figured it out. All right. Sorry about that. So
5 I am -- now, I'm -- I can't look at the slides and
6 talk in the microphone so.
7 Okay.
8 So what I'm going to be
9 presenting is a descriptive analysis of medication
10 errors among pediatric patients. We -- we
11 undertook this analysis as part -- as part of a
12 pharmaceutical safety grant that the Patient Safety
13 Center had received to do a number of initiatives
14 related to medication safety. We used the data
15 that came into the Health Department from the --
16 from NYPORTS. NYPORTS is the New York Patient
17 Occurrence Reporting Tracking System. This system
18 is required by law for Article 28 facilities to
19 report adverse occurrences. The report -- the
20 adverse occurrences include both patient safety
21 events and other events that happen in a hospital
22 such as loss of services in the hospital, you know,
23 if the telephones go down and things like that.
24 And it's the warning system for the State Health
25 Department for hospital-wide events, for example,

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2 and then also the reporting for these serious
3 safety events.

4 So we pulled out of NYPORTS
5 serious medication errors among patients aged
6 nineteen years of age and younger, spanning the
7 timeframe that NYPORTS really -- it launched in
8 2001, but we -- you know, the very early cases were
9 less detailed, so we started in 2002 to 2011 is the
10 analysis period that we used.

11 Here's a little bit of background
12 about NYPORTS. Among the things that are
13 reportable to NYPORTS are patient death or
14 impairment related to the health care process but
15 not the natural course of disease. So you know,
16 it's kind of legalese language and the question is
17 how do you interpret that. We -- we -- they used
18 this term, unexpected deaths. What does it mean to
19 have an unexpected death? So in the regulation
20 changes that happened in July 2011 -- the
21 regulation changes happened before that, but were
22 implemented in July 2011. The NYPORTS system
23 adopted the National Quality Forum definition for
24 serious safety event. And for medication errors
25 that is a -- no, I don't have that -- sorry --

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2 patient death or serious injury associated with
3 medication error. So they have definitions for
4 what is a medication error, what is a serious
5 injury.

6 Prior to July '11, hospitals
7 could also voluntarily report medication errors,
8 even if they didn't result in serious injury or
9 death. Those voluntarily reported events are in
10 the data that I'll be presenting. We're no longer
11 collecting those, but an example might be a
12 medication error in an infant that required, say,
13 dialysis. Well, now, that's not a good example.
14 May have required dialysis but didn't require
15 dialysis -- required additional monitoring is a
16 better example. May not have actually resulted in
17 an injury -- any injury to the child, but the event
18 itself was of enough significance to the facility
19 that they voluntarily did a request analysis and
20 made a submission about it.

21 So the -- the stories that I'm
22 presenting today, the data I'm presenting include
23 the bulk of them are these -- are serious injuries
24 or deaths, but there also are some serious events
25 that did not actually result in patient harm.

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 2 So the NYPORTS data is largely
 3 just a textual description of the event. And what
 4 we're collecting is the description of the event,
 5 the summary, and then a summary of the timeline of
 6 the event, the root cause statements and executive
 7 summary from the root cause analysis. So the
 8 facility takes the -- the medical record, the
 9 interviews with the providers, they get the root
 10 cause analysis team in a room. They do a cause
 11 analysis process and then submit the results of
 12 that process as a narrative to the Health
 13 Department. So that narrative should describe what
 14 happened, why it happened, what the outcome for the
 15 patient was, and how the facility is correcting the
 16 root causes that led to that event happening, what
 17 they -- the risk reduction strategies they are
 18 implementing to specifically address the root
 19 causes, and -- and how they're going to monitor
 20 those risk reduction strategies that -- that are
 21 implemented.
 22 So over the course of the
 23 approximately ten years that we had data for, there
 24 were eighty pediatric occurrences reported to
 25 NYPORTS. Now first of all, you'll -- you'll

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 2 immediately say well there's no way there were only
 3 eighty children in the state that had medication
 4 errors or even serious injury from medication
 5 errors. And so you have to understand that we
 6 realize that that reporting into NYPORTS, although
 7 it's mandated by law, is not necessarily one
 8 hundred percent compliance. And I'll just, you
 9 know, leave it at that. The -- the -- the upside
 10 of that is that the data that are in there are
 11 really, really good for the type of thing that I'll
 12 be presenting today. So that -- so we have to take
 13 it for what it is. We've got eighty stories of
 14 what happened that we can learn from.
 15 Among those eighty reported
 16 occurrences of medication errors among pediatric
 17 patients, seventeen deaths were either directly
 18 attributable to the medication error or the
 19 medication error probably contributed to the death.
 20 I mean that's a difficult thing to determine, so
 21 the -- we -- sometimes it's -- that's really
 22 unknown.
 23 There were an additional
 24 forty-one injuries that required either increased
 25 monitoring or intervention to sustain life.

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 2 Sometimes that intervention was rescue medication.
 3 Sometimes it was a procedure, such as dialysis.
 4 Sometimes it was advanced life support or -- or
 5 intubation or a -- you know, an admission to the
 6 PICU or something like that.
 7 About fifty percent of the
 8 reports were among infants. This is consistent
 9 with the proportion of pediatric patients who are
 10 hospitalized. Fifty percent of hospitalizations
 11 among pediatric patients are newborns or infants,
 12 so that -- that's not an unusual occurrence. It's
 13 not -- there's no reason to believe that infants
 14 are necessarily at high risk for having a
 15 medication error occurring. They may be at higher
 16 risk for having a serious harm should a medication
 17 error occur.
 18 Yes?
 19 **DR. VAN DER JAGT:** Could I ask a
 20 question about that? Were -- could you -- did you
 21 break it down into infants that were in NICUs
 22 versus infants that were on general floors because
 23 they're different kinds of populations?
 24 **DR. McLAUGHLIN:** Yeah. In the
 25 stories that I have, I indicate whether or not it

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 2 was a NICU or a PICU or a newborn nursery. And in
 3 the newsletter we do -- that's a little bit
 4 difficult to sometimes determine because a lot of
 5 times the error doesn't necessarily even happen
 6 where the -- where the -- at the -- in the unit
 7 that the patient is actually admitted to.
 8 Sometimes the error happens in another location in
 9 the hospital, for instance, the specialty
 10 procedural error or something, so trying to -- the
 11 location in the hospital is sometimes difficult.
 12 That's the type of thing that we can look at more
 13 closely, but in terms of the infants, most of them
 14 were either -- were in the NICU.
 15 **DR. VAN DER JAGT:** The other way
 16 to look at that would be by gestational age if
 17 that's included in your dataset.
 18 **DR. McLAUGHLIN:** Not necessarily
 19 consistently. Again, this dataset is primarily a
 20 narrative and we could get the days of life for the
 21 newborns or the NICU patients, but gestational age,
 22 it depends on whether or not it was included in the
 23 narrative.
 24 So one of the things that we did
 25 with the data is we coded the data to the age

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 2 formats and I'm not going to get all data geeky
 3 here, but essentially it's just a coding system
 4 that we started to apply to the NYPORTS data. As I
 5 said, the NYPORTS data coming in text form, we're
 6 trying to put some codes on it so that it can
 7 actually be analyzed. So one of the data elements
 8 we coded was the stage of medication process in
 9 which the event originated. Now those of you who
 10 are familiar with medical care know that an event
 11 can originate in -- at one stage and perpetuate
 12 through the process until it actually reaches the
 13 patient. So the event might occur -- the actual
 14 error might occur in the pharmacy and then is not
 15 caught and eventually reaches the patient. The
 16 error can occur in the pharmacy and be caught prior
 17 to administration. It's still an error, but it
 18 doesn't reach the patient. So one thing about this
 19 is all these errors reached the patient.
 20 Because they're errors that reach
 21 the patient, they're more heavily weighted toward
 22 administration errors than -- than the actual
 23 distribution of all the errors that can occur.
 24 Okay? So an error occurring in prescribing or
 25 preparing, for example, has more opportunities to

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 2 be caught than an error that originates at the
 3 administration stage. So although this is
 4 interesting, it's not the whole story because it
 5 doesn't tell you how many errors occurred and were
 6 stopped. But it does tell you that -- that even
 7 with all those checkpoints, prescribing is still
 8 the number one source of the origination of the
 9 error. So those were errors that were made at the
 10 prescribing stage and were not caught until some
 11 point after the administration stage.
 12 And then I'm sorry for the small
 13 text. Again, this is in the hard copy that we
 14 distributed. We also looked at the process of
 15 care. This is the age or acute term for this
 16 variable so I'm not that fond of the term process
 17 of the care here, but that's what they call it.
 18 And here more than one thing can happen so the sum
 19 is not equal to the eighty errors that actually
 20 occurred. For example, you could have an incorrect
 21 overdose that might occur because of an incorrect
 22 rate, for example. So it's both an overdose and an
 23 incorrect rate. So what we see from this is that
 24 among the -- among the errors that were reported to
 25 NYPORTS, overdoses were the predominant form. And

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 2 that would follow from the idea that these were
 3 errors that predominantly caused harm. It's harder
 4 to detect harm from undertreatment than from an
 5 overdose. It's harder to ascribe harm and -- and
 6 more difficult for the facility to pick it up and
 7 report it when -- when the event is an underdose
 8 compared to an overdose. So again, this is not
 9 really the distribution of errors, it's the
 10 distribution of errors that -- for the most part,
 11 errors that caused harm, detectable harm and
 12 reported harm.
 13 One thing that I -- the other
 14 little point that I want to put in here is that
 15 monitoring, most of the monitoring issues that are
 16 picked up in NYPORTS are issues where it's a high
 17 alert medication that requires some sort of
 18 monitoring. Specifically for pediatric patients,
 19 it's often opioids that are administered and
 20 require monitoring and the child might have a
 21 respiratory -- an adverse -- which should be just a
 22 drug reaction, but turns into a medication error
 23 because of inadequate monitoring causes harm to the
 24 patient that should have been prevented with better
 25 monitoring of the patient's condition after the

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 2 opioid administration.
 3 Another example of monitoring
 4 might be, for example, if there's critical lab
 5 values that were not monitored prior to the
 6 administration of the next dose and that
 7 anticoagulants are a good example of that, although
 8 those aren't really represented in this pediatric
 9 population as much as they are in the adult
 10 population. So that may not -- again, that's --
 11 that's an area that can occur even after
 12 administration in some cases, when it's a
 13 monitoring of the patient's condition or prior to
 14 administration if it's monitoring of the patient's
 15 lab values or something that should inform the
 16 administration process.
 17 Okay. So what I'm going to do
 18 from this point forward -- and I want to be
 19 somewhat brief in this because you do have the
 20 newsletter and I would like to get to Dr. Brick's
 21 presentation because I think that that's really
 22 very interesting. I'm just going to go really
 23 briefly through a few of the stories from the
 24 NYPORTS and talk about some high leverage
 25 strategies to prevent medication errors and some of

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 2 the reg changes that -- that you all have been
 3 working on.
 4 So the first one is -- this is a
 5 kind of story that there's a lot of rumors about
 6 this issue with -- not just rumors, but truth in
 7 some cases, where weight in kilograms versus
 8 pounds. This is one of the reg changes that you
 9 made, weight must be weighed and recorded in
 10 kilograms. In this instance, the emergency room --
 11 emergency department, the nurse asked the parents
 12 what the child's weight was. The parents said
 13 forty-two. The nurse put it into the electronic
 14 medical record in the wrong field. There were two
 15 fields available, one for pounds, one for
 16 kilograms. She entered forty-two into the kilogram
 17 field, not the pound field. The dose was -- dose
 18 of anesthetic was calculated based on forty-two
 19 kilograms. The child weighed forty-two pounds. It
 20 was a two point two time overdose because of that.
 21 And again, I just want to point out we did change
 22 some details of these stories to keep the -- the --
 23 just to the story but to protect confidentiality.
 24 So the issue was the triage
 25 system allowed both pounds and kilograms in

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 2 separate fields. The root cause analysis team then
 3 started to look at all the places that a child's
 4 weight was recorded in the hospital and they found
 5 eighteen difference occurrences, sometimes pounds,
 6 sometimes kilograms, sometimes not specified. And
 7 the other part of the story is that the clinicians
 8 assumed the parents were reporting weight in
 9 kilograms, which, you know, those of us who went
 10 through school in the 1970s and were told that we
 11 were going to go to metric, I understand you
 12 clinicians have, but I haven't and I would not
 13 report pounds -- I mean weight in kilograms, even
 14 if I knew it was going to be safer because I don't
 15 know my children's weight in kilograms. So that
 16 was -- you know, it was -- it was kind of a narrow
 17 way of -- of interacting with the parents to assume
 18 that they were reporting weight in kilograms.
 19 So the other part of what I'm
 20 doing here is the Institute for Safe Medication
 21 Practices had a collaborative with us over the
 22 course of the past year as part of this
 23 pharmaceutical safety initiative. They had a
 24 medication safety self-assessment for facilities.
 25 It was released and available in 2011. The tool is

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 2 still available and they will work with facilities
 3 if the facilities would like to use it. About --
 4 Nancy can correct me if I'm wrong, but fewer than
 5 forty percent of facilities in New York actually
 6 submitted to the I.S.M.P. self-assessment. It's a
 7 very good tool to find out where they stand on
 8 medication safety in terms of state of the art.
 9 It's very long and detailed and it takes a lot of
 10 effort on the part of the facility to complete it,
 11 but it's a good exercise. And if the facility is a
 12 champion who can get it done and then actually use
 13 the results from it to implement changes in the
 14 facility, it's an excellent idea.
 15 So I -- for all these stories, I
 16 pulled out an I.S.M.P. self-assessment item that
 17 addressed the issue at hand. And in this
 18 particular one, all weights and heights are
 19 measured and documented in electronic systems and
 20 in written forms in metric units, for example. You
 21 do not allow non-metric units in your electronic
 22 medical records or paper forms. That's just the --
 23 the I.S.M.P. self-assessment gives you a scale of
 24 one to five. One, being you haven't done anything
 25 about it. Five is it's fully implemented in one

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 2 hundred percent of the facility in one hundred
 3 percent of the cases. And then there's some range
 4 in between.
 5 The next story --
 6 **DR. COOPER:** May I just interrupt
 7 for one sec? Relating to a regulatory package, I
 8 just want to raise the issue with my colleagues
 9 from the Department of Health and perhaps our
 10 suggestion should be broader than merely weight,
 11 that maybe we should be speaking about height or
 12 maybe even body surface area but that we should be,
 13 you know, using metric units and, you know, to be
 14 consistent with the I.S.M.P., you know, and --
 15 N.Q.F., you know, direction. Just a thought as we
 16 move forward.
 17 **MS. McMURDO:** We did think -- we
 18 did agree with that thought, Art, and we did
 19 broaden -- if you recall the regulation only
 20 applied to peds and we basically said you have to
 21 do weight in metric for all -- for all. I get to
 22 your point. I think that's definitely consistent
 23 with what we were thinking and I think we have to
 24 have some conversations with the pharmacy community
 25 about is it -- it does seem to make sense to go

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 2 metric. When -- when -- the one thing that struck
 3 me with some meeting I was at, at the I.S.M.P.,
 4 they pointed out that countries that do not --
 5 foreign countries don't have these problems in
 6 medication error on the systems because they use
 7 the metric system, which is kind of startling when
 8 you think so many of our problems are related to
 9 pounds versus kilograms when other places don't
 10 have it. If we just would use metrics, so maybe we
 11 should just start requiring people to use metric.

12 **DR. COOPER:** I'll leave the
 13 details to you and our experts at the Patient
 14 Safety Center. My only point was simply to say
 15 that maybe we wanted to be a little bit broader
 16 than simply weight in the -- in the package that
 17 we're proposing.

18 **DR. VAN DER JAGT:** I would
 19 definitely agree with that. I think, however, it
 20 is not as simple as saying all they can record is
 21 in kilograms or centimeters because if you would
 22 look at the way the questions come, it would not
 23 have prevented that particular mistake because if
 24 the parent -- if you're thinking kilograms and just
 25 had one slot to put kilograms in, and the parent is

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 2 thinking pounds and there's not that connection of
 3 oh, they're thinking pounds, I'm thinking
 4 kilograms, that actually -- it has to do more with
 5 human factors analysis. How do you actually work
 6 that process? Even though I totally agree that it
 7 should all be kilograms. It should all be
 8 centimeters. Probably B.M.I. should be in there as
 9 well. But the process is not as simple as just
 10 making it mandatory --

11 **DR. McLAUGHLIN:** Yes, absolutely.

12 **DR. VAN DER JAGT:** -- using only
 13 metrics.

14 **DR. McLAUGHLIN:** There were two
 15 problems here. One was the recording in the
 16 electronic medical record made it confusing and
 17 that confusion may not have been there had the
 18 conversation needed to happen before entering it.
 19 The other was the assumption of what the parents
 20 were reporting. And neither of those are in
 21 isolation. And the human factors issue is exactly
 22 what David's presentation is going to be about.

23 So -- so the next story is -- is
 24 just the overdose -- it's an adult vial versus
 25 pediatric vial, similar to the stories that we've

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 2 heard in the media. In this case, it came out of
 3 pharmacy. The adult concentration had been used to
 4 prepare a pediatric. The adult and pediatric
 5 medications were stored side by side. They looked
 6 alike. The -- they could not determine whether or
 7 not it was that the pharmacist had grabbed the
 8 wrong -- grabbed from the wrong bin or the previous
 9 use of the adult med had been restocked into the --
 10 had been put back into -- or if it was an original
 11 stocking issue. They just know that -- that it was
 12 the -- the wrong vial was used. It was noticed
 13 later when the pharmacist was cleaning the work
 14 area and realized that it was the wrong vial.
 15 Products both look alike. Drug names or packaging
 16 that are known to be problematic for confusion are
 17 segregated and not stored alphabetically. This --
 18 I.S.M.P. recommendations are not specific to
 19 pediatric, so for pediatric medications another
 20 high leverage strategy is to make sure not to stock
 21 adult vials in pediatric care areas. That wasn't
 22 the issue here, but obviously it's part of the
 23 story.

24 The next story was -- this one's
 25 a little bit complicated. You can read about it,

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 2 but essentially the nurse was setting up a T.P.N.
 3 infusion pump, got distracted, went back to the
 4 pump, didn't check to make sure all the connections
 5 were made, and had also engaged in some at-risk
 6 behavior by loosening the free flow prevention
 7 clamp, allowing a T.P.N. infusion at -- at a faster
 8 rate than it should have happened and causing some
 9 harm to the infant. The nurse checked the pump
 10 settings, which is kind of the electronic end part
 11 of it, but didn't follow the trail of the bag to
 12 the patient, and as I said, had that at-risk
 13 behavior of bypassing a safety system that was
 14 built into the pump design, the line design. The
 15 I.S.M.P. recommendation is really long. I'm not
 16 going to read it, but essentially it's that
 17 everybody knows how to use a pump and follows the
 18 procedures.

19 So that one's pretty
 20 straightforward. In this case, it was a human
 21 error coupled with some at-risk behavior on the
 22 part of the nurse in a situation in which that
 23 at-risk behavior was not normal for that nurse. So
 24 it wasn't -- it wasn't an ongoing problem. So to
 25 kind of put in the just culture spin on this, the

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 2 nurse needed some -- some coaching on
 3 appropriate -- avoiding that kind of bypassing of
 4 the safety system, but then the entire -- this was
 5 in a NICU. The entire NICU, they wanted to go back
 6 and make sure all the nurses knew what to do.
 7 This one is another one that's
 8 related to an E.M.R. in a pediatric emergency
 9 department. The parents reported that the child
 10 had an allergy to penicillin. The doctor
 11 mistakenly entered no known allergies, N.K.A., on
 12 an order for morphine, not related to antibiotics,
 13 but just didn't see the allergy to penicillin on
 14 the triage sheet. That no known allergies in the
 15 E.M.R. then got picked up by the pharmacy and the
 16 later care providers who then ordered penicillin
 17 for the child. The child was wearing an allergy
 18 armband, but the nurse missed the allergy armband
 19 at the time that they -- the penicillin was
 20 administered to the child.
 21 **DR. VAN DER JAGT:** While you're
 22 on the subject of allergies, have you included food
 23 allergies, because food allergies, particular milk
 24 allergy, is huge and causes anaphylaxis. And we've
 25 actually had that in our hospital numbers of years

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 2 ago. We've had it over the years, but we've
 3 actually separated out that we actually ask about
 4 medication allergies and food allergies are
 5 separate.
 6 **DR. McLAUGHLIN:** You know, that's
 7 an interesting point. First of all, I think a food
 8 allergy would not be reportable to NYPORTS.
 9 **DR. VAN DER JAGT:** It's currently
 10 not. But should it be?
 11 **DR. McLAUGHLIN:** That's a whole
 12 other ball of wax in terms of what should be
 13 reported, because at this point because they've
 14 adopted the National Quality Forum of reportable
 15 events, I don't think a food allergy or any
 16 allergy -- I don't even think latex allergy issues
 17 are reportable to National Quality Forum as serious
 18 safety events. It's -- at this point I think
 19 allergies are limited to medication.
 20 **DR. VAN DER JAGT:** I guess I'm
 21 just wondering. I don't know that process here,
 22 but having -- I mean I do -- I was the chief
 23 quality safety officer for Children's Hospital for
 24 twenty years and I cannot begin to tell you how
 25 many patients had serious life threatening

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 2 anaphylaxis from being given milk in the hospital,
 3 milk -- milk in something, and it is truly a major
 4 issue and may even be more common than medication
 5 allergy. So I would just -- I don't know how to
 6 bring it to the --.
 7 **DR. McLAUGHLIN:** Like put it on
 8 somebody's agenda.
 9 **DR. VAN DER JAGT:** Exactly. And
 10 just because it's not part of the National Quality
 11 Forum, it's not written into the NYPORTS, it
 12 doesn't mean that it's not valuable. And I think
 13 this is more common for pediatric patients than it
 14 really is for adult patients. I mean pediatric
 15 patients, the latex allergy and the milk allergy,
 16 especially, or food, you know, allergies is huge
 17 and I cannot over emphasize that, compared to
 18 adults.
 19 **DR. McLAUGHLIN:** I -- I think
 20 that your point is very relevant given the national
 21 media attention right now to allergies and allergy
 22 interventions in, you know, specific to the
 23 Epi-Pens being available in schools and whatnot.
 24 So I don't know.
 25 Lisa? I don't even know how we

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 2 would go about --?
 3 **MS. McMURDO:** Well I do think it
 4 would probably be a discussion that would be better
 5 if it started at the N.Q.F. so they would
 6 incorporate that into the national model as opposed
 7 to -- because that's kind of how we've gotten into
 8 a problem with NYPORTS is creating our own little
 9 world.
 10 **DR. McLAUGHLIN:** In terms of
 11 reporting, but we could -- you know, we could put
 12 it on as -- as one of the things that we might want
 13 to just think about in terms of addressing it
 14 for -- in other areas, but you know.
 15 **DR. VAN DER JAGT:** And I think --
 16 I don't want to belabor this. I don't take up all
 17 this time here, but obviously I'm quite zealous
 18 about this particular one, because children in
 19 hospitals or E.D.s is a vulnerable population. And
 20 the parents are considered to be the ones who are
 21 the advocates and defenders of them because kids
 22 cannot speak for themselves, frequently. So if the
 23 parent is not there to say oh, no, no, no, he's
 24 allergic to that, you know, that is a huge issue.
 25 So it really falls under, almost like you know kids

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2 are special needs, kids are vulnerable, these are
3 people that we need to really pay attention to
4 these kids with these high allergic propensities.
5 **DR. McLAUGHLIN:** Yeah -- yeah.
6 In this particular instance, I'm going to kind of
7 skip over the -- what happened with the -- well the
8 E.M.R. system. The issue -- I'm just going to skip
9 ahead two slides here. The R.C.A. that came in
10 from the facility said deficit knowledge is --
11 knowledge deficits, ineffective communication, and
12 a failure of leadership in culture were at the root
13 of this event.
14 Totally separate from the issue
15 with the E.M.R. not being recorded on the -- the
16 allergies not being recorded on the E.M.R. and on
17 the triage sheet, in this instance it was the
18 pediatric E.D. was not compliant with the
19 hospital-wide policy on recording allergies and
20 were not being forced to be in compliant by the
21 hospital leadership, were allowed to use a
22 paper-based system that had pre-dated the C.P.O.E.
23 system and the pharmacy was enabling that behavior
24 by entering allergy information for them on the --
25 from their paper-based system. And this event

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2 caused them to re-evaluate their leadership in
3 terms of -- of the pediatric E.D. in, first of all,
4 getting them to be compliant with the hospital-wide
5 C.P.O.E. and E.M.R. systems as well as appointing
6 nursing leadership specific to the pediatric E.D.
7 So I picked out this story for
8 you guys because I think it's a really illustrative
9 story of the issues of culture and patient safety
10 that is just not an electronic system in this case.
11 They had an electronic solution in the facility.
12 So the I.S.M.P. -- when an event
13 involves staff who cut corners, breach policy, and
14 did not follow a procedure, the conditions that led
15 to these at-risk behaviors are investigated to
16 uncover system-based incentives that encourage the
17 behavior and or system-based disincentives that
18 discourage safe behaviors. So this is about taking
19 the event that occurs and finding out why --
20 whether or not it was at-risk behavior and what
21 were the incentives and disincentives to having
22 correct behavior, given that -- the way the
23 facility expects their -- their staff to operate.
24 And you know, the regulatory changes that you guys
25 have proposed in terms of pharmacy services also

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2 address this Q.I. type of issue.
3 I think this is the last story
4 that I have. This one is -- it was just an
5 ordering error. The doctor picked the wrong
6 antibiotic from the pick list in the C.P.O.E. The
7 issue wasn't that they picked the wrong antibiotic;
8 it's that they -- the doctor in this case chose to
9 use the manual -- manually calculate the dose
10 instead of using the E.M.R. built in C.P.O.E.
11 weight-based decision making. And when the nurse
12 went to administer it, she could not tell whether
13 or not the doctor had manually calculated the dose
14 or whether or not the decision support had been
15 used. The nurse should have recalculated the dose.
16 There's no doubt about that, but she didn't have
17 the information needed to know that this -- that --
18 well, she should have recalculated the dose. If
19 she had known that the dose had been manually
20 calculated, that may have happened more effectively
21 than it did. So this is an instance, again, where
22 there's a -- there is an electronic solution, but
23 the doctor could bypass it. And the doctor
24 choosing to use the manual order entry instead of
25 the weight-based decision making built into the --

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2 the ordering, caused the overdose because they had
3 picked the wrong antibiotic. They used -- they
4 calculated it right, just with the wrong formula
5 because they used the formula for the antibiotic
6 they thought they were picking.
7 So in this case, there was also
8 sub-optimal communication, which -- which again, is
9 getting at this culture issue in terms of -- this
10 was a -- you know, as I said in the story, this was
11 a busy, hectic night shift. This team normally did
12 not have sub-optimal communication and in this
13 particular instance, you know, the circumstances
14 led to less than optimal patient care.
15 So you know, you guys have in your regs the
16 instructions for weight-based dosing, but again,
17 this is a story that illustrates the fact that, you
18 know, even with the references and whatnot, we
19 still have to build safe systems and safe cultures.
20 So at this point I'd like to turn
21 the microphone over to -- sorry -- Dr. Brick.
22 **DR. COOPER:** Just before we
23 proceed, Dr. Brick, I just wanted to comment
24 that -- that these are stories that are all too
25 common in -- in medical and nursing practice, but

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 2 I -- I would feel myself to be remiss if I didn't
 3 point out two important themes that have been
 4 consistently annunciated by the Institute for
 5 Health Care Improvement. The first by Paul
 6 Batalden, one of the senior members of that
 7 organization and a member of their Board, that
 8 every system is perfectly designed to achieve the
 9 result -- the results that it gets. And second,
 10 the statement attributed to Albert Einstein that
 11 definition of insanity is to keep doing the same
 12 thing over and over again and expecting a different
 13 result. The Institute for Health Care Improvement
 14 has -- has made it very, very, very clear that --
 15 that the typical response to medication errors,
 16 which is to find those who -- who made the errors
 17 and discipline them in some way, or to write a new
 18 policy that has even more steps than the old policy
 19 that led to the -- that led to the problem in the
 20 first place, you know, are not effective solutions
 21 to the workarounds that everyone adopts when the
 22 system is too crazy or complicated to -- to make it
 23 work under any and all circumstances.
 24 So I think as -- as we move
 25 forward, the regulatory basis is critically

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 2 important, but as we move forward into our brave
 3 new world of quality and safety, I think we really
 4 have to, you know, keep in mind that our goal
 5 really needs to be to assist our colleagues
 6 statewide in -- in -- in designing systems that --
 7 that, you know, really make it almost impossible
 8 for errors to be committed by mistake, but that
 9 those systems have to be simple and straightforward
 10 so that people -- so that, you know, fallible human
 11 beings cannot break them without -- without undo
 12 difficulty.
 13 Dr. Brick?
 14 **DR. BRICK:** Thank you. That's a
 15 really good presentation. Thank you. Do you have
 16 a laser?
 17 (Off-the-record discussion)
 18 **DR. BRICK:** Okay. So I'm David
 19 Brick. I'm a pediatric cardiologist in New York.
 20 Today we're going to be talking about unique
 21 usability challenges in designing electronic health
 22 records used for the care of children. And
 23 essentially -- so basically, we're going to be
 24 talking about human factors, which is basically how
 25 a human being interacts with a machine. And if you

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 2 were to go -- fly to California and rent a car, you
 3 would want to make sure that the -- well, you could
 4 be assured that the gas is on the right and the
 5 brake is on the left and the steering wheel is in
 6 front of you. And although you may not be able to
 7 use the satellite radio right away, there's certain
 8 things that you want to be able to use without
 9 having to figure it out.
 10 And of course, we all kind of
 11 have this image in our mind when we think of
 12 children and it just helps realize there's a huge
 13 dramatic difference between grown-ups and kids. So
 14 the goals today are we're going to talk about why
 15 the pediatric patients have different needs for
 16 their charts, what those different needs translate
 17 into different functions, and how those functions
 18 can malfunction or be difficult to use and cause
 19 errors and human factor solutions.
 20 And this talk is based on a
 21 document by NIST. And I didn't know what NIST is
 22 so I'm going to tell everyone what it is. The
 23 National Institute of Standards and Technology is
 24 part of the Commerce Department and they are a
 25 scientific group that studies lots of things,

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 2 including human factor design of different systems.
 3 And they have a group that looks at human factors
 4 designs of electronic health records. And one of
 5 the projects we did was specifically looking at
 6 pediatric patients.
 7 And what's important to know as
 8 we go through this is that these are -- these are
 9 only things that are specific to kids. So there's
 10 lots of things that aren't in here that are in
 11 other papers that they've done related to patients
 12 in general. And you can download this document at
 13 NIST dot gov.
 14 So I know --.
 15 **DR. COOPER:** Dr. Brick, will you
 16 be able to provide us with a copy of your
 17 presentation?
 18 **DR. BRICK:** Definitely. I think
 19 I e-mailed it, but maybe it got bumped.
 20 **DR. COOPER:** Okay. Thank you.
 21 **DR. BRICK:** It might have gotten
 22 spammed out, so I'll send it again.
 23 **DR. COOPER:** Thank you.
 24 **DR. BRICK:** Absolutely. So
 25 basically, you know, we all know this, but

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2 pediatric patients are different than grown-up
3 patients in one major way, that they develop over a
4 time continuum. And if we start here with the
5 fetus, the fetus has its own physiology, its own
6 diseases, and patients now can have fetal
7 surgeries, fetal cardiac catheterizations, fetal
8 blood transfusions, and so the fetus has a
9 completely different set of needs than other
10 pediatric patients.

11 And then when you're born, you
12 have the neonatal patient. As we discussed, the
13 neonate has a very different physiology than older
14 kids. They have their own immune systems, their
15 own cardio-vascular systems, their own respiratory
16 systems, they have different unique needs.

17 As the child gets older and you
18 get a pediatric patient, that's again a different
19 situation. The adolescent patient, as anyone who
20 knows, who has a teenager knows, that their brains
21 are very different than other people and this has
22 been shown by functional M.R.I.s.

23 And now we have the adult
24 congenital patients. So if a -- if a baby is born
25 with a congenital heart disease and lives to --

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2 lives into adulthood, that patient has a completely
3 different need than someone going to see an adult
4 cardiologist. It's a completely different set of
5 functions that they need, that the doctor needs,
6 and the patient needs.

7 And I'm going to put this into a
8 concept which I did not create, but kind of
9 dimensions of care. So normally, you have
10 different settings, outpatient, urgent care, E.R.,
11 ward and you can include E.M.S., right, it's a
12 different place to see a patient. And then you
13 have different specialties, primary care,
14 cardiology, pulmonology. And this is a two
15 dimensional lattice. And it's kind of like Connect
16 Four. You know, you only have two dimensions,
17 whereas the pediatric patient, you have to take
18 that same lattice work and put it into a third
19 dimension, which is time. So each one of these
20 two-D planes from the pre-natal patient, to the
21 neonate, onto adult congenital has its own lattice
22 work. And this is more like a Rubik's cube, but
23 it's more like this kind of Rubik's cube, because
24 there are just so many variables that the doctor
25 has to deal with.

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2 And we're going to talk about
3 these, but basically, you have all sorts of
4 variables that you're using for calculations,
5 weight, height, body surface area, you mentioned
6 gestational age. These are all critical and -- and
7 they are things that are changing obviously over
8 the time continuum.

9 So what are the specific things
10 that should be in pediatric charts that are
11 different than adult charts? So we're going to go
12 through these one by one. So first the growth
13 chart. So this is really a critical component of
14 any chart and it allows the doctor to check for
15 proper growth at a glance. But the other thing it
16 does is that we talked about medication errors and
17 if someone enters forty-four pounds instead of
18 forty-four kilos, a graphic display of that would
19 instantly make it obvious that the patient was --
20 was incorrectly entered. So here is the Center for
21 Disease Control. This is the standard growth chart
22 that we use. And the way this works is pretty
23 simple, and this has been around for a long time.
24 As the patient comes in, let's say here the patient
25 is three months old and they're going to plot the

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2 weight -- the height and the weight and the doctor
3 keeps doing that over time for each visit and then
4 you get something that looks like this. If a
5 patient comes in and they have, for instance, heart
6 failure, which is something I see, immediately you
7 notice that this curve looks different because the
8 weight here has fallen off the percentile, but the
9 height has kept going. Other common patterns,
10 here's a patient with something called
11 constitutional growth delay, for instance, a
12 genetic syndrome. And the pediatrician, before
13 even walking into the room, is immediately alerted
14 there is something going on because the height and
15 weight are falling off in parallel.

16 Now the E.M.R. growth chart,
17 instead of sitting at the front of the chart, it's
18 often very difficult to get and the pediatrician
19 often has to do multiple clicks, even ten or twenty
20 clicks to get all the data and then you get to the
21 growth chart. And right away, you see some things
22 that are different. For instance, this growth
23 chart only has the weight. Notice the height is
24 not displayed on the same page. And all of these
25 colors and percentiles are kind of arbitrary. They

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2 don't match up with the C.D.C. growth chart. The
3 colors, they don't really mean anything. In
4 addition, you notice up here that the data is all
5 smushed together and you can't really see what it
6 says.

7 So here's a growth chart of a
8 patient. And as anyone who has taken seventh grade
9 science will recognize, human beings, really
10 there's no system that works like this. This
11 patient is giant and then shrinks down to a tiny
12 little baby for several months and then grows to a
13 giant baby for several months and vice versa. And
14 what's interesting is this growth chart was not
15 seen by the doctor because it was kind of hard to
16 access and the patient was in for various reasons.
17 And what this is caused by -- and notice here this
18 chart allows pounds and kilograms. But what
19 happened here is when the doctor entered ten space
20 pounds, the system recorded ten pounds but if the
21 doctor put ten pounds without a space, it recorded
22 ten kilos. And of course this can create tragic
23 errors, even if the person intending it, they
24 actually wrote the right thing, ten pounds. So in
25 this growth chart, it's pretty obvious.

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2 you're going to have an area where you're going to
3 convert, make sure it's accurate. Single click
4 navigation to access the growth chart and to
5 display the height and weight on the same chart.
6 One of the other recommendations is to prevent mode
7 errors. And a mode error would be where you think
8 you're entering pounds and you're entering
9 kilograms or you think you're entering ounces and
10 you're entering C.C.s, so there's a bunch of them
11 but you can see them in the paper which I'll send
12 you that with -- with the slides.

13 Here's obviously the one we just
14 talked about, milligram per kilogram dosing.
15 There's a lot of reasons it's more complicated in
16 kids. So here is amoxicillin clavulanate. If
17 you're an adult doctor, it's very simple. You
18 basically are not going to give eight hundred and
19 seventy-five milligrams twice a day. But in kids,
20 it's more complicated because the dose is going to
21 range from twenty to a hundred milligrams per
22 kilogram per day. And again, we talked about in
23 kids pediatric dosing can be based on weight,
24 gestational age, age, body surface area, so it's
25 much more complicated. But the other thing is

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2 But I'm going to give an example
3 where it might not be. Here's a patient who is
4 kind of large for their age and then I'm going to
5 blow up some of the key things. This patient
6 weighs five point four kilos, so if this patient
7 came to see me for heart failure, I would multiply
8 the weight times ten and I'd put this patient on
9 fifty micrograms per day of a medicine called
10 digoxin. It's a standard dose. It's extremely
11 safe and as a doctor you're reassuring the patient
12 that this is the right dose and your baby's going
13 to be fine. Unfortunately, and this is a
14 hypothetical case, it did not happen, the patient
15 dies from an overdose that wasn't caught by anyone
16 until people go back and realize that the patient
17 was actually tiny, not big, and the patient only
18 weighed five point four pounds. So these errors,
19 especially if it's the first time you're seeing a
20 patient, are very hard to catch.

21 So the NIST group of scientists
22 came up with a few suggestions. One is to -- well,
23 actually if you go back, there is the first one.
24 Do not permit changes to pounds or kilograms -- I
25 don't know why it -- why did I do that. So but if

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2 there's more room for error. So for the
3 amoxicillin clavulanate, most -- there's really
4 only two formulations that adults use and the most
5 we use is eight hundred and seventy-five. But in
6 pediatrics, there's thirteen formulations based on
7 whether you're giving a liquid, tabs, or chewables.
8 And then in Europe, I mean and they can become
9 available here, there's two more. So in this case,
10 you could imagine one of the things we're going to
11 show is truncation errors. If you just say
12 amoxicillin clavulanate, there's going to be
13 thirteen different ways you can give this, with
14 different concentrations of the components.

15 Here is four neonates,
16 vancomycin, just as another example of how complex
17 it is, that the dosing instead of just being a
18 standard dose, is based on the post-natal age, plus
19 the weight in this algorithm. So here if you are a
20 five hundred gram baby, your dose is going to be
21 seven point five milligrams every twenty-four
22 hours, whereas a hundred kilo teenager is going to
23 get fifteen hundred milligrams every six hours. So
24 if the computer doesn't catch the mistake, it's two
25 hundred times the dose, which of course, can be

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2 lethal or cause severe harm.

3 And this is an interesting thing
4 in pediatrics, that we use liquid formulations a
5 lot. And for the parents sometimes it's hard
6 because the pharmacy mixes it and the parents
7 really can't even go back and check that they're
8 giving the correct thing. So here's two drugs.
9 One is called amlodipine and one is called
10 amiodarone and even in adults they're lookalike
11 drugs. But if you're an adult patient and you've
12 been on amlodipine and the pharmacist accidentally
13 gives you amiodarone, one thing is both of these
14 are taken in adults so it's not -- it may not be
15 that harmful if you take it plus the tablet looks
16 very different. So adults use both these drugs,
17 but kids amiodarone is used and it's pretty safe,
18 but amlodipine in infants is lethal. So the stakes
19 are much higher.

20 And again, just to give you an
21 example of how hard these are, here's a system that
22 has truncated the data. And you could see one of
23 these is amlodipine and one is amiodarone, but
24 because the I looks like the L, these are very hard
25 to tell part. And just to give you an idea, if

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2 you're a pharmacist and you're doing, you know, a
3 hundred patients and amiodarone and amlodipine
4 really could start to look alike as you're looking
5 at kind of lists that aren't properly formatted.
6 In addition, again, once it's turned to liquid
7 formulation, the parent has no idea that they're
8 even giving the wrong medication until there is
9 a -- until there is a side effect.

10 Sometimes the adult doses can
11 actually be large -- I mean the pediatric doses can
12 be larger so in this case because it's weight
13 based, the child will get a thousand milligrams
14 whereas the adult will only get eight hundred and
15 seventy-five milligrams. This is a really
16 unfortunate thing that happens which is the E.M.R.
17 can actually change the dose, so in this case the
18 patient was ordered penicillin twice a day and the
19 E.M.R. changed it to every six hours because the
20 E.M.R. thought the doctor had made a mistake and
21 this was the dose that was faxed to the pharmacy.
22 And a lot of E.M.R.s have kind of these -- they're
23 supposed to be safety features which correct the
24 dose and make sure it's correct, but actually
25 they're not correcting it.

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2 So some of the guidelines we came
3 up with is, again, protecting against mode errors
4 for -- for what mode you're in, milligram per
5 kilogram versus just milligrams, do not permit
6 automated defaults into adult doses, support custom
7 formulations for liquid medications. This is a
8 huge one to avoid truncation of medication names
9 and dosages. And to display the normal ranges for
10 medication doses and lab values so that the doctors
11 can see that something is falling outside the
12 range.

13 So vaccines are another
14 challenging part of pediatric medicine and there's
15 lots of things -- lots of vaccine errors. You can
16 get the wrong dose, you can get the wrong vaccine,
17 it can be expired, in the wrong place. The most
18 common one is actually getting the wrong vaccine.
19 And these -- as I show you the list of vaccines,
20 you can see why this happens because some of them
21 sound a lot alike, like T.D.A.P. and D.T.A.P. and
22 adacel and daptacel are different. And as a
23 pediatrician, you're looking at this giant list of
24 vaccines which with three-letter abbreviations --
25 and you could see that they're combined in

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2 different ways so this vaccine T.D. -- D.T.A.P.
3 which is diphtheria, tetanus, and pertussis can
4 actually be combined with hepatitis, the polio
5 vaccine, and it can be combined with HIB, with
6 haemophilus influenza, so there's lots of different
7 variations.

8 In addition, based on the age of
9 the patient, the doctor is going to decide which to
10 give in which combination. And then there are
11 these little caveats which is small and it's not
12 meant for you to read, but just to realize how
13 complex it is. Then when you're a little older,
14 you go to this graph which is again has the same
15 set of caveats. And then if you fall behind,
16 there's another graph the C.D.C. publishes with all
17 the same kind of timelines and caveats. And then
18 if there's a vaccine shortage the C.D.C. publishes
19 those caveats and guidelines. So you can see it's
20 a tremendous amount of information and cognitive
21 bandwidth for the pediatrician to use and the
22 E.M.R. should help the doctor, but often it hurts
23 them.

24 So here's a case where in this
25 case the patient got D.T.A.P. and hepatitis B and

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 2 polio, but in this case the patient got the
 3 hepatitis, the polio twice, but these are actually
 4 the exact same data for the computer but it's
 5 truncated so the doctor has -- or the nurse has no
 6 way of knowing that there was an I.P.V. here.
 7 Here's a list of vaccines, so
 8 your kid goes to the doctor and this is what the
 9 doctor has to look at. And keep in mind that each
 10 one of these vaccines is a combination so T.D.A.P.
 11 is three different vaccines and then it's combined
 12 with other vaccines. And this particular E.M.R.
 13 only allows the doctor to sort by the first name --
 14 by the first initial of the first component of this
 15 multi-component vaccine. And so if you're trying
 16 to do catch up, you could see how easy it would be
 17 to miss vaccines that the kids were getting.
 18 So some of the guidelines we came
 19 up with, which is to support the display and
 20 tracking of components of vaccines and to allow
 21 sorting of vaccines by multiple fields.
 22 Age-related normals, so in kids the -- what's
 23 considered normal changes with their age, their
 24 body surface area, and their gestational age. And
 25 as one example there's something called an L.V.E.D.

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 2 which is -- if you've ever been to a cardiologist,
 3 you've had this. It's basically the doctor
 4 measures the size of your heart and diastole. And
 5 it's pretty simple. The doctor just makes sure
 6 it's about less than four point five centimeters.
 7 But if you go see the pediatric cardiologist it's
 8 much more complicated because it's based on height,
 9 weight, and body surface area. So if you go to see
 10 a little baby, we would use this chart. But if you
 11 go to see a bigger kid, we would use this chart.
 12 And again I'm not expecting anyone to follow this
 13 inasmuch as it's meant to show how complex it is.
 14 Then the doctor has to go and calculate the body
 15 surface area. Then he takes the body surface area
 16 and he plugs it into this graph which gives him the
 17 value. And this has to be repeated for each value
 18 over and over again for each measurement the doctor
 19 is taking.
 20 Something as simple as a blood
 21 pressure, if you're in the field and you have to
 22 know what a normal blood pressure is for a kid,
 23 adults it's pretty straightforward, a hundred and
 24 twenty over eighty. But in kids the normal value
 25 is a little more complicated. And the doctor has

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 2 to do this every time and most of the E.M.R.s don't
 3 support this. So first you go to this N.I.H. chart
 4 and you find the page that applies to your kid.
 5 Then you have to go back to the growth chart and
 6 get the height percentile. Then you go back to the
 7 N.I.H. chart, plug the height percentile and the
 8 age in and then it gives you the systolic and
 9 diastolic blood pressure. So here it's
 10 ninety-seven over fifty-three. So every time a
 11 pediatrician goes to see a child, if they're
 12 following the guidelines, they have to do this
 13 calculation every time. And if the E.M.R. doesn't
 14 support it, it makes it more difficult. It's
 15 wasting a lot of time and the doctor can be doing
 16 other things. So we would like the E.M.R. to
 17 enable us seeing where the normal ranges originated
 18 from and what the normal ranges are, basically.
 19 And I guess that's good for any data you're looking
 20 at, to know where it came from.
 21 Privacy, so for teenagers they
 22 have special rights to their charts that -- that
 23 other people don't have. And a teenager can -- can
 24 ask that their parents not be able to look at
 25 certain parts of their charts. But if you open up

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 2 an E.M.R., you're going to see things, depending on
 3 which E.M.R. you're using, called private notes,
 4 confidential notes, secure notes, internal notes,
 5 and sticky notes and all of these things mean
 6 different things in different E.M.R.s. And
 7 actually, they all behave differently so you may
 8 give a copy of something to the -- to the parent
 9 that's actually protected information because it
 10 was impossible for you to know how to stop the
 11 parent from getting that information.
 12 So basically one of the things
 13 here is, and again, in any chart, you want to make
 14 it visible what the rules are that describe what
 15 information can be viewed and printed and
 16 transferred and define what all these things mean.
 17 Newborns, again, very special.
 18 When a baby is born, they don't have a medical
 19 record number and sometimes some nurses have told
 20 us that they have a hard time getting blood
 21 transfusions because the blood bank won't give them
 22 a transfusion until after they have a medical
 23 record number. The prenatal history is special
 24 because a lot of it comes from the mom's chart.
 25 And also, a newborn is very special how breast milk

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 2 is handled. Again people don't want to use
 3 their -- waste their breast milk and they don't
 4 want to get other people's breast milk. It's
 5 almost like a medication in that sense.
 6 Here is a report by the
 7 immunization active -- sorry -- action coalition.
 8 In -- in one of the series they cited, these are
 9 three babies that got hepatitis B because it was
 10 incorrectly recorded. So even though the mom said
 11 she was positive, the baby got -- didn't get the
 12 hepatitis B immune globulin and the baby got
 13 hepatitis, which is obviously a tragic thing when
 14 it's completely preventable.
 15 So again for newborns, a baby can
 16 already -- a newborn baby can have had surgery, a
 17 cath, and blood transfusions, but yet, many --
 18 despite this complex history, a lot of nurses and
 19 doctors are reporting a lot of workarounds to get
 20 the post-natal blood transfusion because the baby
 21 doesn't have a medical record number and isn't
 22 properly entered into the system.
 23 So some of our guidelines for
 24 newborns is create a system for efficient creation
 25 of the newborn record, support efficient processes

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 2 for the administration of breast milk including
 3 labeling and matching the mother to the baby and to
 4 the milk, and support connecting the prenatal data.
 5 Again, if you have extensive and important prenatal
 6 data, it's no good to you if the baby transfers
 7 hospitals via E.M.S. and no one has that data.
 8 Radiology issues, kids are often
 9 sedated and intubated for radiology procedures.
 10 The ionizing radiation they get can be more
 11 important because they have rapid cell growth and
 12 they have an entire lifetime to have that effect.
 13 The dose of the contrast agents is based on -- is
 14 based on milligrams per kilogram. In addition, as
 15 you know, there's more variation in what we
 16 typically order when you -- when you order a CAT
 17 scan; it's for a much more varied reasons. And we
 18 need to keep track of this radiation exposure so
 19 that as kids are going from hospital to hospital,
 20 there's one place that you can store it. So we're
 21 recommending to support physician radiologist
 22 communications to clarify which scan variations are
 23 needed to support alerts for a contraindicated
 24 procedures, for instance if you have a pacemaker
 25 and you're going to get an M.R.I. And cumulative

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 2 radiation exposure over time.
 3 Patient I.D., obviously very
 4 important. And again, in newborn babies it's much
 5 more complicated because if you walk into a NICU,
 6 you might see all these baby names and they change.
 7 For instance, Baby Girl Martinez can become Sarah
 8 Rabinowitz. Baby Girl Doe can become Baby Girl
 9 Harrison, can become Amanda Clough, and this can
 10 lead to errors because there's a lot of shift
 11 changes and people may not be aware that the baby's
 12 name changed. So a couple of the things we
 13 recommended are including photographs of the
 14 newborns with their primary caregivers for patient
 15 identification and also including extra
 16 identifiers, such as age -- oops, how did I do
 17 that? Sorry.
 18 (Off the record)
 19 **DR. BRICK:** Okay. So in summary,
 20 pediatric patients do have special requirements and
 21 those requirements lead to special functions in the
 22 E.M.R. And as they are if they're absent,
 23 difficult to use or malfunctioning, they can cause
 24 errors but there are human factor solutions to
 25 these issues.

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 2 I want to thank all the people at
 3 NIST, the C.D.C., and O.N.C. for helping with this.
 4 And I also want to say when you think about this,
 5 this is just for pediatrics, but you could have
 6 another one just for E.M.S., another one for
 7 surgery, another one for radiology because each of
 8 these areas has their own kind of intense special
 9 functions that they do. But once you realize that
 10 these solutions are out there, it's very good. All
 11 right. Thank you.
 12 **DR. COOPER:** Thanks so much, Dr.
 13 Brick. It's such a huge issue that -- you know,
 14 that you and Dr. McLaughlin have, you know, really
 15 focused on that we're really, really indebted to
 16 you and grateful to you for coming. You know, as
 17 we follow the Commissioner's direction and embark
 18 on a course of patient safety, I -- you know, I --
 19 I am hoping that we can continue to count on
 20 your -- you know, your continuing to work with us,
 21 perhaps with Martha's and Lee's and Lisa's
 22 permission invite someone from your shop to
 23 participate in our meetings on a regular basis. I
 24 know that Foster Gesten is an old friend of all of
 25 us here and, you know, as the -- as the, you know,

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 2 medical director, perhaps that's something that --
 3 that he might want to become involved with. I
 4 don't know. We'll certainly leave that to all of
 5 you as to who would be the best person to represent
 6 you here, but I -- I do think that with the
 7 information you brought to us and the system that's
 8 been set up with the Department and Dr. van der
 9 Jagt's extensive experience in this area that we
 10 can do some good work together. So I'm really
 11 pleased that you were able to join us.
 12 We'll just ask if Nancy Agard has any -- anything
 13 to add since you're from that area?
 14 **MS. AGARD:** Not a thing.
 15 **DR. COOPER:** Not a thing. Okay.
 16 Thank you, Nancy.
 17 Any questions for either Dr.
 18 McLaughlin or Dr. Brick? Okay. Elise?
 19 **DR. VAN DER JAGT:** Just a
 20 clarification. Whenever you say we have
 21 recommended, I'm not sure what the context is and
 22 I'm not sure what you mean.
 23 **DR. BRICK:** I might not be -- I
 24 might not be saying everything exactly legally
 25 correct, but NIST is part of the Commerce

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 2 Department and they only make -- they do guidance.
 3 **DR. VAN DER JAGT:** Okay.
 4 **DR. BRICK:** So it would be up to
 5 some other regulatory group to say we would like
 6 to -- you to follow that guidance.
 7 **DR. VAN DER JAGT:** I see. So
 8 it's a recommendation from NIST?
 9 **DR. BRICK:** It's guidance on.
 10 It's kind of a --
 11 **DR. VAN DER JAGT:** But it's not a
 12 regulatory --
 13 **DR. BRICK:** -- that's right.
 14 **DR. VAN DER JAGT:** -- it's not
 15 like we have done this in New York State or
 16 anything like that.
 17 **DR. BRICK:** It's -- it's a bunch
 18 of -- that's right. It's a bunch of scientists
 19 getting together and saying these are solutions to
 20 these problems, these are guidance and usability
 21 things that we recommend.
 22 **DR. VAN DER JAGT:** Right.
 23 **DR. McLAUGHLIN:** And that really
 24 gets at the heart of why, you know, we -- Dr. Brick
 25 and I have been communicating over the past year or

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 2 so is, okay, so what do we do with this? What --
 3 what now? Because, you know, the role of the
 4 E.M.R. vendors, the role of the Health Department
 5 and OHIT, the role of the Patient Safety Center, in
 6 figuring out how to get some of these
 7 recommendations implemented and, you know, where we
 8 go from here with these ideas.
 9 **DR. VAN DER JAGT:** Right. Right.
 10 **MS. SOTTOLANO:** I thought that
 11 the Office of the National Coordinator for the
 12 E.M.R. vendors had a -- in order for them to be
 13 able to even be certified to -- to be a vendor,
 14 there were certain standards that they had to meet.
 15 And I'm surprised to see incompatibility of
 16 vocabulary such as you mentioned on the notes,
 17 different types of notes. That really stands out
 18 if they're supposed to meet these -- these
 19 standards. So I was curious about that -- you
 20 know, that process for certification.
 21 **DR. BRICK:** Right. So I think in
 22 the latest meaningful use guidelines, they
 23 recommended that E.M.R. vendors use user centered
 24 design, but they -- and although they mentioned
 25 that the NIST guidelines exist, they didn't say

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 2 that they have to follow them. So basically user
 3 centered design, it's up to the vendor to decide
 4 what that means.
 5 **DR. VAN DER JAGT:** Can you use
 6 the mic, please?
 7 **MS. SOTTOLANO:** I'm sorry. It
 8 just seems to be a big change from the original
 9 policy on E.M.R.
 10 **DR. BRICK:** The interesting
 11 thing, too, is that one of the concepts in human
 12 factors design, which is cognitive bandwidth, you
 13 know, which is how much you can process at once.
 14 And so you know all of these guidelines and the
 15 pediatric guidelines and the human factor
 16 guidelines that they have done for E.M.R. charts in
 17 general, when you think about the nurse who is
 18 being overwhelmed and entering all these things.
 19 And the nurses I talked to, you know, sometimes
 20 it's not that one specific guideline, but it's the
 21 fact that your brain is frazzled with twenty
 22 patients and you're being forced to remember things
 23 to go from one system to the other and it becomes
 24 overwhelming.
 25 And again, that concept is for

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2 each one of these systems that you make better, you
3 decrease your cognitive bandwidth and the whole
4 system runs better so.
5 **MS. ROGERS:** I have a question
6 and an observation. Has anybody compared the
7 incidence of errors when we were on paper systems
8 versus the E.M.R.?
9 **DR. McLAUGHLIN:** That's a really
10 good question. There's -- there's this issue --
11 there's a little bit of literature about errors
12 caused by electronic, but again, that's not
13 necessarily reportable to any -- it's -- it's
14 even -- even F.D.A. because they're not devices.
15 Errors caused by devices are reportable to the
16 F.D.A., but E.M.R.s are not considered devices. So
17 those studies have been relatively narrower in
18 scope than being able to compare incidents. You,
19 at the best, would be able to compare before and
20 after. Certainly, the -- the belief is that these
21 systems have made health care safer. It's one of
22 the overriding -- when -- when the -- when they
23 take about the reason for implementing E.M.R.s and
24 C.P.O.E. and all the other technologies, is safety.
25 And then, you know, quality is hopefully part of

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2 it, too, but in terms of measuring that and in
3 terms of -- that it actually has gotten safer or
4 not and then also separately from that, measuring
5 the errors that are due to these systems and then
6 comparing that to errors that were due to not
7 having the system, there really isn't that much
8 work being done in that, other than in specialized
9 studies.
10 **MS. ROGERS:** My observation, and
11 this is just my own personal observation, is that
12 we've exchanged a different set of problems from
13 paper to E.M.R. And quite honestly, I -- I am
14 appalled every day on some of the ordering problems
15 in the E.M.R. system as far as mgs. per kg.,
16 popping in -- I ordered fluids the other day for a
17 neonate and it popped in a thousand milliliter
18 bolus. It didn't even give me the option of twenty
19 C.C.s per kilogram. There -- I mean the system is
20 rampant with this and the overrides that they have
21 are -- I don't even look at them anymore. I mean
22 it tells me that if I order a hundred sixty
23 milligrams of -- or Tylenol, that I'm overdosing
24 the patient because I should only give one
25 fifty-seven. So I mean the more you read those

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2 ridiculous, you know, kind of --
3 **MR. McLAUGHLIN:** Alerts.
4 **MS. ROGERS:** -- alerts, thank
5 you, the -- you just don't even pay attention to
6 them at all. So that's why I wondered if there's a
7 comparison. I just think we just have a new set of
8 problems.
9 **MS. TRIPOLI:** To piggyback on
10 what she had said, one of the beauties of the prior
11 system was you didn't have values auto-populate
12 throughout the medical records. So whereas in
13 emergency room someone might not have picked up an
14 allergy, the admitting nurse did and so she altered
15 the record. My concern would be with
16 auto-population people, it's all taken care of and
17 you don't have this checks and balances which come
18 from conversations and these questions being asked.
19 I think people -- okay, that's settled. So that's
20 a concern that I have. And as an investigator in
21 my prior life, the other issue with computerized
22 medical records is every record looks the same. So
23 if you're looking at an incident, you really can't
24 determine the events that led up to the incident
25 because everything is so homogenized, protocol is

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2 followed, and that's all you get out of it. Well
3 and an example would be I was at a facility three
4 times for decubitus ulcers and couldn't track
5 what -- what broke down in that system because the
6 protocols were checked as having been, you know,
7 enforced, so it's -- I agree with you a hundred
8 percent.
9 **DR. BRICK:** I think those are
10 really good observations and I've heard those many
11 times exactly like that, which is part of the
12 reason, you know, that we did this. But it's a big
13 issue.
14 **DR. COOPER:** I -- I think that --
15 you know, that the comments that have been made are
16 really right on target. The -- we've learned that
17 with respect to, you know, operations and so on
18 that -- and blood transfusions and major
19 interventions like that, that we need to, you know,
20 use two specific different unrelated patient
21 identifiers to ensure that we have the right
22 patient. Given the fact that we know that there
23 are always numerous errors with -- you know, with
24 manual systems and that the electronic systems
25 which were supposed to make our lives so much

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2 easier have created their own set of problems,
3 perhaps as we move forward in the future we should
4 be considering, you know, two different ways to
5 ensure that the medication dose is, you know, in
6 the five rights, you know, right patient, right
7 dose, right, you know, et cetera, et cetera, that
8 they are followed, you know, every time. Just a
9 thought as we think more about, you know, moving
10 forward in terms of drug delivery in our hospitals.
11 Elise?

12 **DR. VAN DER JAGT:** Yeah, just a
13 comment, again, having done quality for such a long
14 time. I think that there's just been a change in
15 the kinds of problems that we see. I'm not so sure
16 that they are worse. And -- and case in point is
17 that we -- where I am, we were very serious about
18 preventable medication errors and we tracked for
19 over two decades -- before all this E.M.R. came on,
20 we had tracked in the pharmacy every order that had
21 been incorrectly written. And there were many,
22 many, many orders. And there were a number of
23 those that actually were executed, you know, and
24 the patient did actually receive those doses. The
25 particular kinds of errors that were reflected in

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2 those long listings of errors and orders, those
3 errors are not there anymore. You know, they were
4 often related to legibility, they related to
5 decimal points, you know, those errors are really,
6 by and large, not there. But there are other kinds
7 of errors that have crept into this because of the
8 vehicle. And I think that the learning curve is a
9 very steep one. You -- I mean I've learned over
10 the years, we have -- we have electronic medical
11 records -- we've had C.P.O.E. for quite awhile, but
12 the electronic medical record we just only have had
13 now, what, a year and a half or so. And the
14 learning that occurs with that, what works, what
15 doesn't, what you have to double check on, not to
16 accept a note that just looks like it's written
17 when it's all dubbed in sort of, you know, I mean
18 those are things you learn that those are the
19 weaknesses of the system. You know, so I think
20 that -- I think what this has been helpful with is,
21 again, to point out how -- what seems like a very
22 simple thing can result in very complex outcomes
23 and very serious outcomes because of a minor, minor
24 looking kind of thing. And that's the thing that
25 we have to figure out. And as I'm thinking ahead

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2 with this, the quality and safety sort of
3 initiative that I guess I have just accepted is
4 that I think it's trying to look for those things
5 that are prone to result in errors and then try to
6 figure out is not only the outcomes in general for,
7 you know, all the way pre-hospital into hospital
8 and beyond, but also whether the vehicle that we're
9 using to assess those errors is -- is that, in
10 itself, the problem, you know, in some areas, at
11 least. So that if the E.M.S. provider, let's say,
12 in a pre-hospital care area had gotten a weight,
13 let's say -- I'm just taking this out of thin air,
14 has gotten away from the family, has recorded it
15 wrong, and somehow that electronic record, which is
16 not translated and hooked up to the in-patient
17 record, now that's an error that came out of the
18 E.M.S. because of the software that's used for that
19 and the human factors that are causing the problem
20 and now it tracks it all the way, you know, into
21 the hospital because the kid's never weighed until
22 the third week into the hospital or whatever. You
23 know, I'm just grabbing something here. Those are
24 the kinds of errors that we should look at, process
25 errors and then there's outcome errors that we have

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2 to look at, both.
3 **DR. BRICK:** I think the other
4 issue is -- is that a lot of times the other errors
5 when you would discover a process error,
6 operational error on paper, you could get together
7 with a group of people and say we're going to
8 implement these things, but you have giant hospital
9 systems and you might identify an area that's
10 important to you and to get the vendor to change,
11 even to move -- like in the truncation errors where
12 you couldn't tell the difference between amlodipine
13 and amiodarone, they -- you may not be able to put
14 that high on their list to just be able to stretch
15 over so you can see the whole drug. So that
16 becomes a -- it's harder to fix sometimes.

17 **DR. VAN DER JAGT:** Yes. And I
18 work very closely with one of our medical record
19 architects, who is also in quality and safety
20 and you know, it's really interesting. You look at
21 your own narrow area and you say this has to be
22 fixed now. If you only did this thing to it, that
23 would make it totally simple. But then it's so
24 intertwined and interconnected that if you make
25 that little change, then it sort of blows up the

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 2 system in a whole different area that you weren't
 3 aware because they were all connected.
 4 **DR. BRICK:** Right.
 5 **DR. VAN DER JAGT:** And now you've
 6 taken out that little thread, and now the whole
 7 thing unravels in someone else's area. You know,
 8 and that's a real difficulty and it's a learning
 9 thing. I think it's -- you know, it's like
 10 technology. It's a blessing but you have to learn
 11 how to use the blessing so that you don't end up
 12 being cursed. You know so.
 13 **DR. BRICK:** And a lot of these
 14 concepts can be implemented in the -- in the
 15 formation process. So they're building the E.M.R.s
 16 out, the next build they can actually look at the
 17 guidelines and -- and the other guidelines that
 18 NIST has published to figure out what things are
 19 important to prevent these errors so.
 20 **DR. COOPER:** Once again, I'd like
 21 to really thank our colleagues from the Patient
 22 Safety Center for coming and Dr. Brick
 23 particularly --
 24 **DR. BRICK:** Thank you for
 25 inviting me.

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 2 **DR. COOPER:** -- for making the
 3 trek from New York to present this -- this really
 4 important information.
 5 UNIDENTIFIED FEMALE SPEAKER: In
 6 the rain.
 7 **DR. COOPER:** In the rain,
 8 absolutely, yes -- yes -- yes. Well dodging those
 9 rather large raindrops in the New York State
 10 Thruway does present its own quality safety
 11 problems. So we're very grateful for your time and
 12 your -- and your input to the process.
 13 And -- and once again, Dr.
 14 McLaughlin, I would be delighted to have one or
 15 more of your colleagues with us in the future
 16 meetings if that's acceptable to the Bureau staff.
 17 **MS. BURNS:** We'll -- we'll
 18 discuss it.
 19 **DR. COOPER:** Thank you. Thank
 20 you so much. Okay. You are absolutely welcome to
 21 stay to -- you know, for the rest of our agenda,
 22 but I'm sure you have other things that you need to
 23 get done, such as dodging a few more raindrops.
 24 **DR. McLAUGHLIN:** Thank you for
 25 the offer, but we'll --.

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 2 **DR. COOPER:** And I think at this
 3 particular point, it might be useful if we took a
 4 very, very short break. So we'll be back in five
 5 minutes.
 6 (A recess was taken.)
 7 **DR. COOPER:** Okay. I would like
 8 to call the meeting back to order following our
 9 brief recess. We do have a fair amount of business
 10 yet to cover. And just by way of wrapping our --
 11 our previous discussion, Elise van der Jagt is
 12 going to work with Martha and we'll set up, you
 13 know, an initial conference call to begin to
 14 brainstorm some of the issues about where we might
 15 want to take the -- you know, take the Committee
 16 down the first step toward development of some kind
 17 of a dashboard as the Commissioner has suggested.
 18 And so we'll try to get that done sometime before
 19 our next meeting in December.
 20 So moving on to old business, the
 21 first item of old business has to do with the 405
 22 hospital codes revisions. I don't want to say too,
 23 too much about this at this particular point in
 24 time. What I will say once again is that we're
 25 deeply grateful to the Department for, you know,

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 2 continuing to support this initiative. We did meet
 3 with the Commissioner on August 23rd. There were
 4 two issues I think that were of particular concern
 5 to the -- you know, to the Commissioner. The first
 6 had to do with the issue of -- of nurse to patient
 7 staffing ratios in the pediatric intensive care
 8 unit. There's some fairly extensive literature,
 9 you know, pointing out that the better the
 10 staffing, the higher the -- the higher the safety
 11 and, you know, trying to figure out exactly where
 12 and how to draw a line in terms of -- in terms of
 13 quality safety issues in the unit with respect to
 14 staffing, you know, is -- is the tough nut to
 15 crack, particularly in an environment where
 16 hospitals, you know, are facing the same financial
 17 pressures that -- that we -- we are all aware of.
 18 So the final language in the -- in the draft regs
 19 has yet to be approved by Department staff or
 20 developed or approved by Department staff and --
 21 and with respect to the staffing ratios. And you
 22 know, we'll hold further discussion on that until
 23 such time as -- you know, as -- as it seems
 24 appropriate.

The other issue that was of some

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2 concern had to do with the inclusion of
3 tele-medicine in the -- you know, in the -- in the
4 regulatory package. There's been quite a bit of
5 discussion about how tele-medicine might be used
6 to, you know, broaden the reach of the -- you know,
7 our existing pediatric resources. I just heard
8 this morning that the Department has made a
9 decision that although tele-medicine is going to be
10 part of the future, that it probably does not make
11 sense to include a specific tele-medicine component
12 as part of this particular regulatory package at
13 this time.

14 So I think those were the two big
15 issues. I think that the Commissioner was
16 extremely positive about -- about the -- the -- the
17 meeting, as were we. I think he was very, very
18 pleased that we presented him with -- with solid --
19 a solid evidentiary basis for the recommendations
20 that we were making. And once again, he made it
21 clear that his office was most concerned with
22 ensuring that whatever, you know, guidance is put
23 into regulation or policy, that it be evidence
24 based and that there be a strong quality safety
25 component. So I think that it's fair to say that

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2 those were the -- the major issues that emerged
3 from the meeting.
4 And what I'll do at this point is
5 I'll ask Martha and Lee and I think Lisa is not in
6 the room at the moment. Oh, she left for another
7 meeting? Oh, okay. And Sandy, if they have any
8 additional comments to make at this time.
9 **MS. BURNS:** No -- no.
10 **DR. COOPER:** Did you hear a
11 little bit of use of that cognitive bandwidth that
12 we were hearing about --
13 **MS. BURNS:** I have a very narrow
14 cognitive bandwidth, so I would say to you --.
15 **DR. COOPER:** -- in the -- in that
16 long pause between the question and the answer? I
17 think there was a large cognitive bandwidth there.
18 Okay. So I'm hearing that we
19 have no further comments at this time. So we'll
20 keep you updated as to where that's going.
21 Bob, are you still on the line?
22 **DR. KANTER:** Yep.
23 **DR. COOPER:** Bob, do you want
24 to -- would you like to talk about the emergency
25 preparedness activity update?

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2 **DR. KANTER:** Sure, just a very
3 short update. The New York State Task Force on
4 Life and the Law is continuing to think about
5 guidelines for triage allocation for ventilators in
6 a pandemic or in some other overwhelming situation.
7 It's a difficult issue because the -- the group
8 would like to provide practical operational
9 suggestions. However, there aren't good data to
10 back up any operational suggestions and we go
11 around in circles trying to make the language
12 precise enough to use it to apply principles in
13 making decisions and, yet, we are up against the
14 lack of data every step of the way.

15 The other update is from this
16 morning's meeting with -- let me get my notes out
17 here -- with Nick Ntarogen from the Office of
18 Health Emergency Preparedness. And he outlined for
19 us some of the projects that that agency is working
20 on. The gist of our discussion with him was the
21 notion that our Advisory Committee probably could
22 contribute to their work in a very useful way. The
23 point we made was that the E.M.S.C. Advisory
24 Committee is a uniquely qualified
25 inter-disciplinary group that provides maybe a

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2 better perspective on pediatric issues than maybe
3 any other group, any other agency in the whole
4 system. And we have -- and we feel that we could
5 contribute more than we have up until now. So
6 there were a few issues that we discussed that
7 might be -- that might warrant our input.
8 It remains to be seen whether
9 we're going to receive an assignment to any one of
10 these, but mass prophylaxis in a pandemic or
11 infectious disease threats, building on ideas about
12 more effective coalitions to carry out disaster
13 preparedness and responses, trying to develop -- to
14 identify and give roles to pediatric champions at
15 the local level in every county across the state
16 for emergency preparedness, and a whole area that
17 we didn't discuss enough for me to understand it
18 completely, but having to do with human services
19 planning, things like mass care shelters, providing
20 food in shelter situations, environmental health
21 issues, housing, temporary and restoring housing
22 after a public health emergencies. And every step
23 of the way, reality was sort of emphasized. This
24 is not a great time to take on any new roles
25 because public budgets are short, but it probably

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2 is a very good time to make the best use you can of
3 your inexpensive experts who might be able to
4 further the work that's -- that's very difficult to
5 do. And -- and the good news for everyone is that
6 our Committee is interested in helping.

7 I think those are the main
8 things, Art, unless you can think of something
9 else.

10 **DR. COOPER:** Only that, Bob, you
11 know, your -- your strong expertise in emergency
12 mass critical care I think will be especially
13 useful in helping along with some of the planning
14 that's -- that's been ongoing.

15 Any other -- any other issues
16 with respect to the disaster update?

17 Okay. I have two additional
18 issues. First, of course, Deb Sottolano is our
19 liaison from the -- the Hospital Preparedness
20 Program or the Health Care Preparedness Program, I
21 should say, and wondered if she had any additional
22 thoughts that she wanted to add at this point?

23 **MS. SOTTOLANO:** Right now, one of
24 the big efforts that's going forward, as Dr. Kanter
25 did mention briefly, is the idea of establishing

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2 office so I think that is a great -- kind of a
3 great bridge between this group and -- and -- and
4 the OHIP efforts.

5 **DR. COOPER:** Great. One final
6 note, as Bob indicated during his remarks a moment
7 ago, the -- this Committee, given the depth and
8 breadth of its expertise, its continuity and so on,
9 and really frankly, deep involvement in disaster
10 preparedness and public health emergency
11 preparedness activities over the years, in many
12 ways is uniquely positioned to assist the
13 Department in focusing on some of the issues with
14 respect to children. And to that end, and in terms
15 of the -- you know, bringing the expertise of this
16 group to the -- you know, to the -- to the health
17 care coalitions that are going to be formed, it
18 made sense for us to think about providing not
19 merely a list of our membership, but perhaps short
20 bios for each of us that sort of focuses explicitly
21 on our expertise with respect to -- particularly
22 with respect to, you know, disaster preparedness,
23 but also, of course, our general areas of expertise
24 so that, you know, the -- the folks who are reading
25 this -- this information will say, ah, okay, maybe

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2 health care coalitions around the state. And I
3 know, too, that I've been working a little bit with
4 New York City, Kate Uranica just left, but --.

5 **DR. KANTER:** I'm sorry, Deb; I'm
6 having a hard time. You're breaking up.

7 **MS. SOTTOLANO:** I'm sorry.
8 I'm --.

9 **DR. KANTER:** I don't know if you
10 have a microphone right there, but I'm having a
11 hard time hearing you.

12 **MS. SOTTOLANO:** Yeah, I do, I'm
13 sorry. I have too low a voice. But what I was
14 saying was is that one of the big projects for the
15 Office of Health Emergency Preparedness, as you
16 mentioned, Dr. Kanter, is this idea of regional
17 health care coalitions that they're kind of
18 establishing. And I know New York City is also
19 interested in working with some of the upstate
20 coalitions as far as regional pediatric planning
21 for disasters, too. And so we -- we had a project
22 and in fact I'm going to -- I spoke to Martha about
23 showing some of my data from my survey. And we're
24 hoping to continue that project through the
25 coalitions. I've been talking with the regional

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2 these are folks we could learn something from.
3 So -- so I'm going to ask each of the Committee
4 members to provide us with a short bio that, again,
5 describes basic areas of expertise, but also
6 focuses on -- on, you know, one's disaster
7 preparedness activities. I was thinking something
8 fairly short, you know, ten lines or so, no more
9 than that, that would, you know, really be, you
10 know, useful to the Department's folks in helping
11 to get our -- our -- our expertise out there to the
12 health care coalition community. So I'll ask
13 everyone to do that.

14 So any other questions or
15 thoughts about disaster preparedness activities?
16 All right. Hearing none, we'll move to some
17 updates from some of our sister advisory committees
18 and D.O.H. partners. And before I call on Sarah
19 Sperry, I know that Pam Lawrence is with us today,
20 but she's not officially on the agenda.

21 Pam, did you want to make any
22 comments at all?

23 **MS. LAWRENCE:** (inaudible
24 response)

25 **DR. COOPER:** Okay. There's

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 2 nothing the matter with that. Okay. We're all
 3 here for that reason, as well.
 4 Sarah, can you give us an update
 5 with respect to the Bureau of Injury Prevention
 6 activities?
 7 **MS. SPERRY:** Sure. Okay. I
 8 think this is up to me now. I -- I asked our
 9 office and I told them all that I was coming here
 10 and if anyone had anything that they needed or
 11 wanted me to relay. I do want to throw out that
 12 especially in relation to the work with the School
 13 Nurse's Association, pertinent to you, that there
 14 are the new concussion guidance documents and all
 15 of that up. They're accessible on the website.
 16 And but what -- the only ones I officially got
 17 stuff for are upcoming week events. This week is
 18 National C.P.S. Week, September 16th through the
 19 22nd. October 1st through the 5th is -- I'm sorry.
 20 **UNIDENTIFIED FEMALE SPEAKER:**
 21 C.P.S. means?
 22 **MS. SPERRY:** I'm sorry. Child
 23 Passenger Safety.
 24 Yeah. No. In -- in my world,
 25 I'm sorry, it's child passenger safety, you know,

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 2 car seats. Drive Safely to Work, October 1st
 3 through 5th. September 19th, later this week, is
 4 No Text on Board Pledge Day. October 14th through
 5 the 20th is National Teen Driver Safety Week. And
 6 that's what I have and I have little write-ups of
 7 everything. I'll pass that out.
 8 **DR. COOPER:** Thank you.
 9 **MS. SPERRY:** You're welcome.
 10 **DR. COOPER:** Thank you so much.
 11 **MS. SPERRY:** And that's all for
 12 me.
 13 **DR. COOPER:** Well I -- I -- far
 14 be it from me to add anything to this outstanding
 15 report, but -- but I think there is one important
 16 thing that is taking place one week from today.
 17 **MS. SPERRY:** Oh, yeah. Sorry.
 18 We're -- we are. We're -- a week from today is our
 19 I.C.P.G. meeting, which is our injury prevention --
 20 no -- injury community prevention group. Sorry.
 21 The acronyms are -- I'm full of them and not always
 22 full of what they're for. But the I.C.P.G. is a
 23 group of community partners from various levels of
 24 state governments, local governments,
 25 practitioners, and so forth, that are very involved

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 2 in injury prevention. And they come -- we bring
 3 them together to help guide us in the focus of our
 4 injury prevention efforts in the state. We had a
 5 meeting this fall -- no, not fall -- spring I
 6 believe -- spring. I'm -- it's just occurring to
 7 me that it is actually fall now. But we're --
 8 **DR. COOPER:** Is that a cognitive
 9 bandwidth issue, Sarah?
 10 **MS. SPERRY:** Most definitely a
 11 cognitive bandwidth issue.
 12 No, not another acronym. But so
 13 at any rate, we -- we met in the spring. And
 14 the -- the project that I'm spearheading with this
 15 is a state injury action plan which is turning out
 16 to be a monstrous document of what it is that, you
 17 know, the leading -- what are injury problems, data
 18 and background, on all of them, what it is in
 19 loosely C.D.C. smart objective format, which are
 20 basically measurable, reasonable, and attainable
 21 goals to combat these problems. They have
 22 additional resources, other things that are usable
 23 and good and promise -- promising or proven
 24 strategies that we're not using but they're there
 25 in case someone else wants to use them. So it's --

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 2 and we're doing it for all of injury, so this is
 3 getting to be a very, very big task I've taken on.
 4 Also, there are -- there's child
 5 policy which is focusing, I believe, on lighters,
 6 not just any lighters, on working on bringing
 7 people's awareness to and pushing towards
 8 prohibition of novelty lighters, which if anybody
 9 hasn't seen them, are -- really, really look like
 10 toys, like I've heard that a bunch of times and
 11 said, yes, okay, it's a lighter that looks like a
 12 toy. But at our last meeting --
 13 **DR. COOPER:** And in fact is a
 14 blowtorch.
 15 **MS. SPERRY:** Yeah. At our last
 16 meeting, they brought them in -- people from Office
 17 of Fire Safety brought them in, examples that
 18 they've bought online. And being thirty-three
 19 years old, I couldn't tell that that was a lighter
 20 and how you would make something light, or some of
 21 them you could. But they're still kind of scary --
 22 really scary and there's -- what else? Fall
 23 prevention in older adults, which doesn't impact
 24 you all nearly so much, although --
 25 **MS. SPERRY:** Okay. Yeah. But --

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 2 you know, that's -- fall day is coming up the first
 3 day of fall. And what else? No, it is. The
 4 National Fall Prevention Awareness Day is the first
 5 day of autumn. And let's see. That -- I know I'm
 6 forgetting things.
 7 **MS. MALLOY:** Can I just interject
 8 something about concussions?
 9 **MS. SPERRY:** Go for it.
 10 **DR. COOPER:** Please. Who is on
 11 the line? Is that Rita?
 12 **MS. MALLOY:** This is Rita -- Rita
 13 Malloy.
 14 **DR. COOPER:** Hi, Rita. Thanks.
 15 **MS. MALLOY:** So when you were
 16 speaking about the concussion guidelines and school
 17 nurses, one of the things I wanted to mention was
 18 in discussions, you know, amongst ourselves as --
 19 as school nurses, one of the things that has been,
 20 you know, concerning is that the impact program
 21 that's been, you know -- are you familiar with the
 22 impact program, where there's -- there's
 23 preliminary testing, like baseline testing done
 24 with athletes, and then there's some kind of
 25 collaboration done with hospitals and the schools

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 2 to monitor, you know, kids for concussions. But
 3 one of the things that was discussed was the
 4 manipulation of the test by -- by the athletes so
 5 that they would underscore, understanding that they
 6 would be re-tested and held to a certain standard
 7 and they want to still play, so they're -- they're
 8 testing down intentionally. They're manipulating
 9 the variables themselves. That was one thing. And
 10 the other thing was that a lot of the
 11 collaborations are being done with orthopedists,
 12 instead of neurologists. And it's you know -- our
 13 nurses did raise concerns that are the right people
 14 looking at this particular subject. So you know,
 15 sometime in the future, we might want to take a
 16 look at that since it's kind of new to us, that
 17 these, you know, guidelines are being formulated or
 18 encouraged for schools and some loose affiliations
 19 are being formed between hospitals and schools. So
 20 we might just want to have our ear to the ground
 21 and -- and take a look at that at some point when
 22 some data is starting to be collected.
 23 **MS. SPERRY:** Absolutely. And
 24 I -- I guess it makes total sense that the athletes
 25 would test down just to make it easier, but you

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 2 know, this is -- I'm a data person. I'm not one of
 3 our program people. But this -- these are -- are
 4 fabulous points that I'm making myself notes of to
 5 bring back now to the people that work with our
 6 concussion stuff and working with the Brain Injury
 7 Association and all of those -- those partnerships
 8 that we have and have going on. I think that those
 9 are points that need to get brought forward.
 10 **DR. COOPER:** Rita, I'd like to
 11 discuss this issue with you a little bit more
 12 off-line because this is a -- I think you're
 13 raising a really, really important issue and this
 14 is an area that I think our Committee could at
 15 least perhaps, you know, act to, you know, raise
 16 the attention of others about this problem and, you
 17 know, maybe in collaboration with our own bureau
 18 and Sarah's bureau, the brain trauma people and
 19 perhaps the Brain Trauma Foundation people and your
 20 own organization perhaps maybe, you know, think of
 21 a way that we might begin to address this
 22 particular issue. So I'll be in touch with you
 23 afterwards about how we might move forward in this
 24 area. Is that all right with you?
 25 **MS. MALLOY:** Great. Thanks.

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 2 **DR. COOPER:** Okay. Great.
 3 **MS. SPERRY:** Thank you. Those
 4 were -- were really good points to -- to have and
 5 to, you know, be taking away.
 6 **DR. COOPER:** Anything else,
 7 Sarah, at this point?
 8 **MS. SPERRY:** Trying to -- to
 9 think. We're in -- I had mentioned to Lee earlier,
 10 we've been in this flux of moving for several
 11 months now. Well, they had originally told us we
 12 were moving in, like, May but we got the most
 13 definitely you have to be packed and ready to go
 14 Tuesday at the end of August and we're still in our
 15 office and heard today that we're -- we're likely
 16 to still be there in October. So we're living out
 17 of boxes and very disheveled and disorganized, but
 18 our -- hopefully, we'll be squared away soon and so
 19 that's also taking up some of my cognitive
 20 bandwidth, just you know, remembering life. But --
 21 so I think that's everything I have.
 22 **DR. COOPER:** Fortunately, far
 23 more of those musty dusty old files are -- are
 24 electronic now than paper, so hopefully, you know,
 25 we're still making forward progress.

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 2 **MS. SPERRY:** We're still making
 3 forward progress.
 4 **DR. COOPER:** Very good. Jan and
 5 Sharon, it's been a while since SEMAC met, as I
 6 recall. We have a meeting coming up soon-ish.
 7 Perhaps you can -- I think -- in fact, I think we
 8 met since the last meeting of SEMAC, but correct me
 9 if I'm wrong, Sharon.
 10 **MS. CHIUMENTO:** You are exactly
 11 right. We met in June and they last met in May.
 12 So I don't have anything specific from that, except
 13 that on our conference call probably didn't have
 14 much chance to mention that almost all of the
 15 protocol recommendations that we had made to -- not
 16 protocol -- standard recommendations we made to
 17 SEMAC and Medical Standards were accepted. So we
 18 made several corrections, specifically on things
 19 like dosages in milligrams per kilograms, rather
 20 than in stated standard doses, and other things
 21 that relate definitely to safety.
 22 And then the other thing was that
 23 during the summer, I'm actually -- have continued
 24 to move forward with a couple projects. One is
 25 taking these standards and putting them into a much

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 2 There was a relatively important issue that arose
 3 during the last SEMAC meeting regarding the
 4 pediatric protocols. And that is how do we define
 5 the child? This of course is the age old question
 6 that we all -- we all struggle with. And the
 7 Department chose, at the last meeting, to, shall we
 8 say, not get into the weeds on that issue at that
 9 particular meeting. But I do think that it's
 10 probably worthwhile for us to think about -- since
 11 we do represent emergency medical services for
 12 children, it's probably useful for us to think
 13 about what we might want to do in terms of saying
 14 what we mean by child And you know, if -- if -- if
 15 not adopting a position, at least lay out the
 16 various, you know, concerns that are involved in
 17 terms of thinking about -- about differences
 18 between adults and -- and -- and children.
 19 So I'm going to leave that on
 20 the -- on the -- on the burner to simmer until the
 21 next meeting. But what I am going to do in the
 22 interim is ask Martha to remind me to get together
 23 a conference call among the Committee members who
 24 have an interest in this particular area as to how
 25 we might want to move forward in terms of

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1 Advisory Committee, 9-18-2012
 2 more usable format so that they can be put on the
 3 Web or done in another method. So I sent that off
 4 to Andy Johnson.
 5 The other thing I've been working
 6 on is the standard -- the curriculum, the standards
 7 for the education, especially for the basic E.M.T.,
 8 and working for -- putting those into modules
 9 because it was kind of -- before we had done it
 10 based on what our old objectives were. I've now
 11 taken the objectives and put them into the modules
 12 to match the federal modules. And the one thing of
 13 note for us here is that pediatrics is everywhere
 14 through those modules. It's not -- there's not
 15 only a pediatric module, pediatrics is of course
 16 very heavily involved in the life span module.
 17 There's a whole new life span module. In addition
 18 to that, just about every other module has an
 19 objective at the end that says discuss differences
 20 in -- age related differences in pediatrics and
 21 geriatrics. So pediatrics is very heavy in the new
 22 national standards -- educational standards.
 23 **DR. COOPER:** Thank you. And I
 24 also appreciate your jogging my memory. I'm having
 25 one of those cognitive bandwidth issues myself.

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1 Advisory Committee, 9-18-2012
 2 recommending to our peers within the E.M.S. arena
 3 broadly defined as to how we think, you know,
 4 children ought to be handled within an E.M.S.
 5 system, broadly defined in terms of who is a child,
 6 who is an adult.
 7 So sometime during October,
 8 Martha, let's see if we can't set up a call and
 9 begin to have that discussion so we can get
 10 something in writing, you know, if not a position
 11 paper, just at least some kind of statement, if you
 12 will, from the Committee at least laying out the
 13 arguments. But I don't think we should take a
 14 position on it at it, certainly, at this moment or
 15 maybe even at the next meeting, but I think we need
 16 to think about it a little bit since this is an
 17 issue that's vexed everyone from time immemorial.
 18 Elise?
 19 **DR. VAN DER JAGT:** Yes. I -- I
 20 think -- again, looking at the broad spectrum and
 21 the scope of E.M.S.C. which includes not only
 22 E.M.S. but also hospitals, the discussion about
 23 pediatric age cannot be made independently, E.M.S.
 24 versus hospital. And the spectrum includes also
 25 the primary care physician, who sees -- who

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1 Advisory Committee, 9-18-2012
 2 considers what that pediatric age might be. So I
 3 was just making a plea, I guess, as we think
 4 through this process, which is very complicated and
 5 certainly very varied among many different
 6 stakeholders, we can -- we have to make sure that
 7 the E.M.S.C. comprehensive model all the way from
 8 primary care all the way through rehab, which is a
 9 E.M.S.C. model, that we not break the continuum of
 10 that by selecting one age for one area and one age
 11 for another area.
 12 **DR. COOPER:** Well stated. So
 13 we'll think a little bit more about that before we
 14 do anything more about it, but that is -- that was
 15 an area of some contention at the last SEMAC
 16 meeting. The recommendations we made were not, but
 17 to whom they should apply was fairly contentious.
 18 So that's an issue that we'll come back to. And,
 19 Sharon, I'll ask you to report at our next
 20 meeting -- the next meeting of SEMAC, that we have
 21 taken this on as a project and we'll get back to
 22 the -- we'll get back to them about it and
 23 hopefully that will, you know, allow SEMAC some
 24 breathing room in terms of having to focus on that
 25 issue in the immediate future.

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1 Advisory Committee, 9-18-2012
 2 Okay. STAC, Linda Tripoli has, I
 3 think, had to leave us. I think it is fair to say
 4 that the -- she already covered the major issue
 5 that's before the STAC.
 6 Elise, were you at the last STAC
 7 meeting? I -- I don't think -- I don't think you
 8 were, yeah. Yeah. And you know, the major issue
 9 was and continues to be the issue of the A.C.S.
 10 verification process. There were presentations by
 11 a couple of the -- of the trauma program managers
 12 from the state who have had extensive experience,
 13 both of long standing and of recent vintage, with
 14 the A.S.C. verification process. They gave us
 15 their views of how the process went, how it was to
 16 be laid out. The STAC did vote to recommend to the
 17 Commissioner, or to the Department really, that --
 18 that -- that individual facilities have one year
 19 from the date of the STAC meeting to contact the
 20 American College of Surgeons to arrange for a site
 21 visit and -- and then had -- or a consultation site
 22 visit, I should say, and then had one year after, I
 23 believe, the report was received, if I'm not
 24 mistaken, to -- to arrange for a verification
 25 visit. So a letter was recently distributed from

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1 Advisory Committee, 9-18-2012
 2 the Department indicating that that recommendation
 3 had been adopted, although I believe the date that
 4 was set forth in the letter was May 10th, 2013 to
 5 be the final date by which hospitals had to notify
 6 the Department -- or had to, excuse me, formally
 7 request from the American College of Surgeons a --
 8 a -- a date for a consultation visit.
 9 Obviously, you know, the
 10 hospitals will need to notify the Department that
 11 they have made such a request in writing at the
 12 appropriate time. But it does appear that things
 13 are moving forward at this point. As -- as Linda
 14 indicated, there have been up to fifteen facilities
 15 who are seeking designation at -- you know, as
 16 Level Three or Level Four facilities, which is a
 17 good thing, you know, and something that hopefully
 18 will make our trauma system, in the end, more
 19 inclusive.
 20 So there was some work done in
 21 addition on -- on the -- the -- the definitions to
 22 be included in the -- the trauma registry
 23 dictionary. Suffice it to say at this point as
 24 time moves forward, our own data dictionary is
 25 getting closer and closer and closer in detail to

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1 Advisory Committee, 9-18-2012
 2 the national trauma data dictionary that's also
 3 promulgated by the American College of Surgeon's
 4 national trauma databank subcommittee. So I think
 5 those were the major issues.
 6 I don't think that there's
 7 anything of any great note in addition to come out
 8 of that -- that -- those discussions at this
 9 particular point in time. A great deal of
 10 discussion is going forward to the executive
 11 committee regarding, you know, some issues in and
 12 around whether folks with hip fractures should be
 13 included in the registry or not. It's a major
 14 subject of discussion at the present time. But
 15 that concerns more the elderly population than the
 16 younger population at this point so it ties in very
 17 nicely with Sarah Sperry's fall day; right, on the
 18 first of fall? So that -- that I think will cover
 19 most of the issues with respect to our sister
 20 advisory committees and D.O.H. partners.
 21 Now moving forward, we do have a
 22 meeting in December, but -- but, but, but, but I
 23 know Martha wants, she indicated at the beginning
 24 of the meeting, to take a few minutes now to think
 25 about how we might you know further the work of the

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1 Advisory Committee, 9-18-2012
2 Committee through our regular face-to-face
3 meetings, but as well through conference calls and
4 perhaps -- conference calls and perhaps other forms
5 of electronic meeting so we can get the work done.
6 And I'll turn it over to Martha at this point to
7 facilitate that discussion.

8 **MS. GOHLKE:** As far as the grant
9 goes, the feds say that we can -- well we need to
10 meet four times a year and we also have that in
11 statute in New York State. But two of those --
12 half of those meetings can be done electronically
13 and half face to face, so as -- and that's kind of
14 what we went to with conference -- two conference
15 calls a year and then two in-person meetings a
16 year. As far as our bylaws, our bylaws say that to
17 be concerned an active member, you have to attend
18 at least two meetings a year. The D.L.A.,
19 Department of Legal Affairs of in D.O.H. says that
20 phone meetings, people on the phone cannot be
21 verified so they can't vote and in a sense they're
22 not attending the meeting because they -- you can't
23 verify who they are. So it's really -- so like
24 today, for example, if we had any issues to bring
25 to vote, we wouldn't have a quorum and we couldn't

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1 Advisory Committee, 9-18-2012
2 reasons and -- so -- but, we can't conduct
3 business, though, I guess over the phone.

4 **DR. COOPER:** Let me ask the --
5 let me just ask the Department staff, just to begin
6 this -- this brief discussion. What, if anything,
7 can be done about arranging for some kind of
8 Web-based facility where there was visual
9 recognition that allowed an individual to be
10 clearly verified as being present, you know, by
11 sight, as well as by voice which would presumably
12 meet the requirements of the -- you know, of the
13 state for, you know, the open meetings law?

14 **DR. KANTER:** You know, it's not
15 just visual recognition, but there's all kinds of
16 security around passwords and such. A lot of very
17 important business gets conducted electronically
18 using passwords.

19 **DR. COOPER:** That's one other,
20 you know, way to do it.

21 **MS. GOHLKE:** Being an open
22 meeting, though, it has to be done in an open
23 meeting venue so -- so the public can attend and
24 honestly express their opinion. So that's -- also
25 you got to take that into the picture, as well.

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1 Advisory Committee, 9-18-2012
2 vote. So it's an issue if people can't make an
3 in-person meeting for that one reason alone and
4 then our by-laws saying that you have to be an
5 active member in attending at least fifty percent
6 of the meetings a year.
7 So the electronic or, in our
8 case, we don't have webinar access but we have the
9 conference call. It's convenient in many ways and
10 it saves cost of these meetings when we do them by
11 phone, so that's a plus. But on a downside, you
12 know, it makes it hard for people that have
13 emergencies who can't attend those two in-person
14 meetings to meet the -- the voting requirements and
15 the by-law requirements of the meetings. So we're
16 at the point, we do have December 18th on the
17 calendar for our next meeting, but I need to set up
18 meetings for 2013 and I wanted to ask what the
19 Committee thought about the number of in-person
20 meetings versus phone meetings, how are things
21 working for people, what do -- do you think we
22 should go to more in-person meetings? What do you
23 think? Because today and the last meeting, we're
24 getting -- it's getting harder and harder to get
25 people here at the meeting. And that's for various

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1 Advisory Committee, 9-18-2012

2 **DR. KANTER:** No, but my point is,
3 it's a public -- publicly open meeting, no
4 different than what we've got now, but for
5 conducting the business where you need to verify
6 the identity of a voter, it's easy to verify that
7 electronically. There's any number -- you know,
8 there's just a large amount of the business that
9 gets conducted on a daily basis is done
10 electronically using passwords.

11 **DR. COOPER:** Lee, I don't know
12 where to go with this. Is there -- is there -- can
13 we get any -- any -- any relief under the current
14 system? You know, I'm sure that we're not the only
15 group, you know, affiliated with state government
16 that's having these types of challenges.

17 **MS. BURNS:** I -- I think it's --
18 it's very confounding. As you know from last
19 year's law, attempts to change the law, small
20 advisory councils do not appeal to the current
21 state government. So they've not really made it
22 easier to conduct business. So right now,
23 there's -- we don't -- we don't have access or
24 ownership of technology that would allow these
25 meetings to be open electronically and as Dr.

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1 Advisory Committee, 9-18-2012
 2 Kanter suggests, you know, signing in, in order to
 3 vote. With that said, though, I think, you know,
 4 yesterday as we were trying to figure out what was
 5 going to happen today and we knew that -- we knew
 6 Martha and Dr. Cooper and I were going to be here,
 7 the question for us is do we cancel these meetings
 8 because while the meeting space exists because
 9 we're contracted, the expenses -- all the other
 10 expenses don't. So we're really at a crossroads
 11 here. You know do you hold face-to-face meetings
 12 and conduct business or do you -- you know, do you
 13 hold electronic meetings and have you know small --
 14 really smaller than four face-to-face meetings to
 15 hold your business at. There's no easy answer to
 16 this. But I think if you don't chose -- if the
 17 Committee itself, I mean, you know, doesn't, you
 18 know, chose to participate in its own Committee,
 19 we're going to lose you, and I'm afraid of that, or
 20 you're going to be consolidated into a larger
 21 advisory body, all of which is not off the table,
 22 by the way.
 23 **DR. COOPER:** I want to underscore
 24 what -- what Lee has -- Lee has stated. We fought
 25 very, very very hard to get this Committee

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1 Advisory Committee, 9-18-2012
 2 established under law so that we would have the
 3 statutory authority, you know, to provide the kind
 4 of advice that we're now speaking about providing
 5 to our friends in the Quality Safety Division, to
 6 our friends in the -- in the hospital preparedness
 7 area, and so on. And you know, I just, you know,
 8 with all my heart, you know, urge all of us to, you
 9 know, set aside what other business we have, you
 10 know, to come to these meetings. You know, if we
 11 get subsumed into some other committee or disappear
 12 altogether, I assure you that the voices of
 13 children will -- will never be heard amongst the
 14 din of the needs of all the rest of the world. We
 15 have got to step up no matter what the issues are
 16 and just make it our business to be here. You
 17 know, I don't know what else to say about that and
 18 we need to, you know, work with our colleagues in
 19 state government to figure out how we can make this
 20 happen in a way that's, you know, that -- that
 21 falls within in law, yet, you know, meets, you
 22 know -- you know, the needs of the current
 23 generation in terms of, you know, electronic
 24 meeting and so on when feasible. But we must
 25 really step up to the plate and meet our

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1 Advisory Committee, 9-18-2012
 2 responsibilities to the public. We all raised our
 3 right hands and said that we would do this and we
 4 need to do it.
 5 **DR. VAN DER JAGT:** Art, if I
 6 could respond to that? I mean this is really very
 7 complicated. I do understand it. But I'm
 8 wondering if we look back at the meetings that
 9 we've had in these last several years, how many of
 10 those meetings have we actually required a vote on
 11 something? And so I'm wondering if -- if we're not
 12 voting very frequently or maybe not every meeting,
 13 I'm wondering if we could do the two and two. You
 14 know, we have two meetings and that those are
 15 clearly targeted for business, decisions, have to
 16 have a quorum, you have to be here, and that the
 17 other two meetings are reserved for discussion, for
 18 F.Y.I., for, you know, brainstorming for thinking
 19 through some of the concepts, short of a decision.
 20 And the reason I say that is --
 21 is in many of the councils and different committees
 22 I'm on, it is not unusual to present a proposal at
 23 one meeting that is not voted on and then wait
 24 until the following meeting to vote on that
 25 proposal, you know, so that there is some time to

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1 Advisory Committee, 9-18-2012
 2 consider and think about it, so that it's not
 3 presented and then immediately you vote on it
 4 before even thinking about it all that much, but
 5 that you actually delay it. And that could perhaps
 6 work into a system like this where discussion --
 7 **MS. GOHLKE:** Well by default,
 8 that's what we've been doing because --
 9 **DR. VAN DER JAGT:** But I'm saying
 10 making it more formal that there are actually
 11 specific -- like this meeting and this meeting,
 12 whatever, you know, those are the ones you have to
 13 be here. And I have to agree with -- with Dr.
 14 Cooper that if one cannot make those meetings, then
 15 maybe that person should not be on the Committee.
 16 I mean I really hesitate to say that because
 17 there's always like well what if we lose somebody
 18 or lose four or five people and then the Committee
 19 is defunct. But I -- on the other hand, you can't
 20 have a committee work with people not here.
 21 **MS. GOHLKE:** Well that also leads
 22 to another issue, is that we still have vacancies
 23 in that we need to figure out a way how we're going
 24 to fill that because that will take pressure off of
 25 other people who may have an emergency and can't

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1 Advisory Committee, 9-18-2012
 2 show for a meeting and we can still meet quorum.
 3 So that is another added variable to the numbers of
 4 people in this room right now that are voting
 5 members.
 6 **DR. VAN DER JAGT:** Right.
 7 Martha, may I also ask about --?
 8 **DR. COOPER:** Elise, I might just
 9 add that part of our issue, this particular meeting
 10 is the fact that two of our members resigned really
 11 one about a month ago and one a couple of days ago.
 12 And of course, we are still waiting for individuals
 13 to be vetted to fill positions that were vacated
 14 over a year ago, you know, so, you know, those are
 15 part of -- those are -- those are issues as well.
 16 I mean this is not an issue that's solely limited
 17 to -- you know, to us, you know, in terms of not
 18 making the meetings, but -- you know, but we are
 19 part of the problem as all these other issues are
 20 part of the larger problem. But set aside all of
 21 that, we have got to find a way to keep this --
 22 keep the work of this Committee going. I mean
 23 look -- just look at what we -- the business we
 24 transacted today and, you know, the work that we've
 25 brought before the Commissioner and so on, you

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1 Advisory Committee, 9-18-2012
 2 know, culmination of ten -- twelve years of effort
 3 on all of our part. And you know, to lose that,
 4 you know, that opportunity would be tragic in my
 5 view.
 6 **DR. VAN DER JAGT:** Dr. Cooper,
 7 could I ask a bit about the vetting process --
 8 maybe Martha, the vetting process because when you
 9 say that there is still -- there are still people
 10 out there who are in the process of being vetted,
 11 where -- we all are. So my --
 12 **MS. GOHLKE:** Allan Filler. All
 13 the rest here have now been re-vetted.
 14 **DR. VAN DER JAGT:** But is the
 15 vetting, where is the barrier for that? Is it
 16 here? Or is it somewhere else?
 17 **MS. GOHLKE:** Well apparently,
 18 it's some people haven't filled out the required
 19 paperwork which may have slowed the process down
 20 for those individuals. I don't -- it didn't slow
 21 the whole Committee down. I don't actually know
 22 why Allan --
 23 **DR. VAN DER JAGT:** I mean once
 24 the paperwork is done --
 25 **MS. GOHLKE:** -- why Allan got

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1 Advisory Committee, 9-18-2012
 2 through and the rest of you didn't who did the
 3 paperwork.
 4 **DR. VAN DER JAGT:** Yes. Okay.
 5 Once the paperwork is done by the people who are to
 6 be vetted, where are the barriers? Because that's
 7 beyond the control of the Committee members. I
 8 mean that's a hard thing to deal with.
 9 **MS. GOHLKE:** I don't actually
 10 think that's why people aren't attending the
 11 meetings.
 12 **DR. VAN DER JAGT:** Okay.
 13 **MS. GOHLKE:** I mean maybe the
 14 individuals that have -- there's one individual
 15 that resigned before she got vetted. And I didn't
 16 ask her specifically if it had to do with her
 17 frustration of waiting. I don't think it was, to
 18 be honest. But it could have been. But I think --
 19 I don't really think that's -- I don't think people
 20 are, I don't know, frustrated with the vetting
 21 process and not coming because of that.
 22 **DR. COOPER:** I don't think that's
 23 the issue, but it does impact upon our ability to
 24 make quorum.
 25 **DR. VAN DER JAGT:** Oh, I'm sorry.

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1 Advisory Committee, 9-18-2012
 2 One question I had, Martha, is what constitutes a
 3 quorum? Is it more than fifty percent?
 4 **MS. GOHLKE:** It's the majority.
 5 **DR. VAN DER JAGT:** It's -- that's
 6 more than fifty percent. Fifty-one percent or
 7 more. Okay. Thank you.
 8 **DR. COOPER:** Right. But it's the
 9 majority of what. Okay?
 10 **MS. GOHLKE:** Right now -- yeah,
 11 right. We now -- right, exactly. The bylaws say
 12 and the intent behind the statute is that you serve
 13 until your seat is filled. So technically, Dr.
 14 Lewis and some of the other members that have
 15 resigned are still technically part of the
 16 Committee until we fill their seat. So if they're
 17 counted into the quorum or not, you know, we have
 18 eight vetted voting members that are active and we
 19 have four here today. So if that's -- if that's
 20 the number we're working with, we didn't meet
 21 quorum today.
 22 **DR. VAN DER JAGT:** Could you tell
 23 us again, refresh our memories of which positions
 24 are still vacant?
 25 **DR. COOPER:** Pediatric

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1 Advisory Committee, 9-18-2012
 2 physiatrist, pediatric primary care physician,
 3 pediatric emergency medical services physician,
 4 parent of ill or injured child, pediatric
 5 behavioral specialist. Some -- some of those
 6 positions are -- you know, have individuals, you
 7 know, that have been recommended for appointment
 8 that are, you know, awaiting a formal appointment.
 9 UNIDENTIFIED FEMALE SPEAKER: Who
 10 are those and which are those?
 11 **MS. GOHLKE:** I think it's only
 12 Danielle LaRaue for the primary care. I think
 13 that's what we slated her for.
 14 **DR. COOPER:** Okay.
 15 **MS. GOHLKE:** But the other ones
 16 are -- there's no candidate for the other.
 17 **DR. VAN DER JAGT:** The -- the
 18 question of the pediatric physiatrist is a
 19 difficult one because there are very, very few of
 20 those. I don't know about New York City, but in
 21 upstate New York there is probably one or two at
 22 the most. So that is a limitation of the -- of
 23 the --.
 24 **MS. GOHLKE:** Yes. It's in
 25 statute. It's also in -- I think they took it out

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1 Advisory Committee, 9-18-2012
 2 of the federal requirements. I'd have to double
 3 check, but it may still be in federal requirements.
 4 **DR. VAN DER JAGT:** And one
 5 question I have there is when we say pediatric
 6 physiatrist, is it still consistent with the -- the
 7 statute or the regulations here --
 8 **MS. GOHLKE:** Yes.
 9 **DR. VAN DER JAGT:** -- whether you
 10 could have a physiatrist with an interest in
 11 pediatrics versus a pediatric physiatrist because a
 12 pediatric physiatrist is a sub-specialty within --.
 13 **MS. GOHLKE:** It says pediatric
 14 physiatrist in the -- in the statute. So I don't
 15 know, however that's interpreted.
 16 **DR. VAN DER JAGT:** But I'm just
 17 wondering if that would be an acceptable -- if we
 18 find a general physiatrist.
 19 **MS. GOHLKE:** I would think that
 20 would be all right.
 21 **DR. VAN DER JAGT:** You know, a
 22 physiatrist, you know, and that person says you
 23 know I am really interested in pediatrics, would
 24 that be acceptable?
 25 **MS. GOHLKE:** As far as -- as far

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1 Advisory Committee, 9-18-2012
 2 as the feds are concerned, not that that's the rule
 3 here, but as far as meeting the requirements of the
 4 grant, they just want to make sure it's a
 5 practicing clinician.
 6 **DR. VAN DER JAGT:** Correct.
 7 **MS. GOHLKE:** Not somebody who did
 8 it at one point in time.
 9 **DR. VAN DER JAGT:** No -- no, I
 10 understand that, yes. Thank you.
 11 **DR. KANTER:** I'm sorry, Martha.
 12 I need to sign off. I've got another thing I've
 13 got to do right now.
 14 **MS. GOHLKE:** Okay. Thank you,
 15 Dr. Kanter.
 16 **DR. COOPER:** Bob, thank you so
 17 much for coming and for your participation this
 18 morning and this afternoon.
 19 **DR. KANTER:** Good.
 20 **DR. COOPER:** Take care.
 21 **DR. KANTER:** Thanks.
 22 **DR. COOPER:** Well I think that,
 23 you know, we have indicated the importance of this
 24 issue, you know, to ourselves and our colleagues
 25 and I know Martha and I and Bob and Lee will be

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1 Advisory Committee, 9-18-2012
 2 thinking about this over the -- over the next
 3 couple of months, but I do ask that all -- all of
 4 you set aside December 18th to be here for sure.
 5 Jan?
 6 **MS. MALLOY:** It's an in-person
 7 meeting?
 8 **MS. ROGERS:** I think you're
 9 preaching to the choir right here with us three and
 10 so I'm asking how this important message will be
 11 communicated to the rest of the Committee.
 12 **DR. COOPER:** It will be. It will
 13 be. Okay. I've already communicated with a couple
 14 of the members personally.
 15 And Rita, can you make it on
 16 December 18th?
 17 **MS. MALLOY:** I'll put it on my
 18 calendar. There are ten of us listed as vetted
 19 members online.
 20 **MS. GOHLKE:** Oh, yeah, you assume
 21 that the online is up to date.
 22 **MS. MALLOY:** Yes.
 23 **MS. GOHLKE:** The other thought --
 24 we -- us individuals don't have control over what's
 25 online. That goes through a process, as you can

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1 Advisory Committee, 9-18-2012
 2 imagine.
 3 **MS. MALLOY:** But when you were
 4 talking about a quorum, I was just looking to see
 5 if I could see, you know, what might be, you know,
 6 perceived as half of us. But --.
 7 **MS. ROGERS:** I'm happy to ask one
 8 of our pediatric emergency physicians if they are
 9 interested. However, I feel like Rochester is
 10 overrepresented and I think it would be better --.
 11 **MS. GOHLKE:** Well that is an
 12 issue. They do want geographic and we don't need
 13 an emergency medicine physician. We need an E.M.S.
 14 **MS. ROGERS:** Oh, E.M.S.
 15 **MS. GOHLKE:** Yes.
 16 **DR. VAN DER JAGT:** And again,
 17 very few of those.
 18 **MS. ROGERS:** Excuse me, yes.
 19 **MS. GOHLKE:** Well Dr. Halpert was
 20 really kind of that niche before because he was --
 21 you know, he was doing -- he was a medic for -- he
 22 was also qualified as a medic, kept his --.
 23 **MS. ROGERS:** What qualifies a
 24 E.M.S. physician?
 25 **MS. GOHLKE:** Well he was a

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1 Advisory Committee, 9-18-2012
 2 paramedic, as well as being an M.D. So that
 3 worked.
 4 **DR. VAN DER JAGT:** There is an
 5 evolving -- evolving sub-specialty of pediatric
 6 emergency medicine or emergency medicine that is
 7 actually called E.M.S. emergency medicine
 8 physicians and those are now people who have
 9 actually done a fellowship in E.M.S. as part --
 10 after they go -- become certified in either
 11 emergency medicine or in pediatric emergency
 12 medicine.
 13 **MS. ROGERS:** The ones that I know
 14 have done that, though, are focused on adults.
 15 **DR. VAN DER JAGT:** That is
 16 correct.
 17 **MS. ROGERS:** There also is
 18 pediatrics?
 19 **DR. VAN DER JAGT:** Well that's --
 20 it's an evolution -- it's an evolution as I
 21 understand it, at least.
 22 **DR. COOPER:** That's right. There
 23 are no actual pediatric E.M.S. fellowships of which
 24 I'm aware. There are E.M.S. fellowships and there
 25 are some pediatric emergency medicine physicians

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 2 who have chosen to pursue that in addition to
 3 pediatric emergency medicine.
 4 **MS. GOHLKE:** The requirements for
 5 membership came from the grant long ago and then
 6 the feds realized, I think, some of these seats
 7 were hard to fill and they took out, I just looked,
 8 the physiatrist. They took out the E.M.S.
 9 physician. They took out -- they took out --
 10 before we had two parent reps and they brought it
 11 down to one. But we have it in New York State
 12 statute, all these, so that's the downside of
 13 putting things in regulation.
 14 **MS. CHIUMENTO:** I'm wondering
 15 if --?
 16 **DR. COOPER:** That's something we
 17 can work on, as well. But right now we need to
 18 focus on getting our work done, which means we have
 19 to be here.
 20 **MS. CHIUMENTO:** I have -- I was
 21 wondering if possibly if a physician who is a
 22 medical director for an E.M.S. service could
 23 qualify to fill that position? And that would be a
 24 whole lot easier because, you know, every ambulance
 25 service has to have an E.M.S. director.

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1 Advisory Committee, 9-18-2012
 2 **DR. COOPER:** All right. Well
 3 hopefully not to be continued. Hopefully, we'll
 4 get this problem solved in short order. But in any
 5 event, we are to be continued on December 18th.
 6 Unless there's any other new business, I think
 7 it -- Elise?
 8 **MS. GOHLKE:** Right now that's
 9 slated to be a phone meeting. That's what we
 10 originally had set it up. So I mean, so I just
 11 want to put that in.
 12 **DR. COOPER:** Okay. All right.
 13 Well --.
 14 **MS. MALLOY:** Is it going to be a
 15 phone meeting? That's what I want to know.
 16 **MS. GOHLKE:** Well there's a
 17 contractual issue with the hotel, so if -- you
 18 know, we'd have to look at that if -- if the
 19 Committee really decided that it should be an
 20 in-person meeting.
 21 **DR. COOPER:** So it is not
 22 scheduled to be at this hotel on December 18th. Is
 23 that correct?
 24 **MS. GOHLKE:** That's correct.
 25 **DR. COOPER:** Okay. All right.

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1 Advisory Committee, 9-18-2012
 2 Well --
 3 **MS. GOHLKE:** Which is why we made
 4 it a phone meeting.
 5 **DR. VAN DER JAGT:** So, Dr.
 6 Cooper, could I bring up just a suggestion for an
 7 agenda item for our next meeting?
 8 **DR. COOPER:** Please.
 9 **DR. VAN DER JAGT:** I just had the
 10 opportunity to be at the E.C.C.U. conference in
 11 Florida. The E.C.C.U. conference is Emergency
 12 Cardio-vascular Care Update conference which comes
 13 out every two years. It is put out by the Citizen
 14 C.P.R. Foundation. And as I came back from that, I
 15 was at a workshop or something, but as I came back
 16 from that, it struck me again having been immersed
 17 again into the importance of bystander C.P.R.,
 18 A.E.D., trying to prevent cardiac arrest, both
 19 adult and peds, respiratory arrest, but
 20 particularly cardiac arrest, and then thinking
 21 about emergency events, coming to this meeting, it
 22 just seems to me that this is an area that we
 23 should be looking at. If we are really calling
 24 ourselves emergency medical services for children
 25 and remembering that we are looking at the spectrum

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1 Advisory Committee, 9-18-2012
 2 of pre-hospital, E.D. hospital, et cetera,
 3 emergency events that occur in all areas and how we
 4 can best provide care to them, not only the
 5 pre-hospital care, it just seems to me that
 6 emergency events in the hospital, which are by and
 7 large respiratory arrests and cardiac arrests in
 8 pediatric patients, that that should also be on our
 9 agenda, is how can we do that better. And so that
 10 raises things like the -- the bill that, again,
 11 that didn't pass in New York State about C.P.R. in
 12 the schools which is an educational thing which I
 13 know that a number of people have been trying to
 14 get that through as an educational way of
 15 preventing mortalities in pediatric patients on the
 16 outside. It brings up to mind the -- the
 17 dysfunctioning of how cardiac arrests and to some
 18 degree also respiratory arrests are managed
 19 in-hospital, the significant dysfunction of that.
 20 That raises the issue of first responder response
 21 in-hospital, which is essentially the primary care
 22 team and then secondary responders which are rapid
 23 response teams to prevent death from occurring.
 24 Anyway, there's a lot of aspects
 25 to this. I just want to bring this up as a

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1 Advisory Committee, 9-18-2012
 2 discussion point because we do -- I mean we
 3 represent the kids who are dying out there, both
 4 outside and inside hospitals, homes, facilities,
 5 and we should be speaking for them and speaking to
 6 those very concrete issues which are perhaps a
 7 little bit easier to manage than some of the, you
 8 know, just general sort of care, you know, that
 9 kids are who were sick. So anyway, I bring that up
 10 as a -- as a -- an agenda item that I wondered if
 11 we could speak about and find out what our -- and
 12 again, with this sort of looking now at quality
 13 safety kinds of issues across the spectrum, how can
 14 you look at one part of that and not the other, the
 15 spectrum. And that fits with regionalization. It
 16 fits with a lot of other things, with the most sick
 17 kids that we have in our system. So that's just
 18 what I just wanted to --.
 19 **DR. COOPER:** And we stand
 20 adjourned and we will meet again on December 18th
 21 by telephone with a couple of conference calls in
 22 between on specific areas of -- of work that we've
 23 agreed to undertake and thank you all for coming.
 24 (The meeting adjourned at 4:15
 25 p.m.)

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1 Advisory Committee, 9-18-2012
 2 I, G. Michael France, do hereby certify that
 3 the foregoing was taken by me, in the cause, at
 4 the time and place, and in the presence of
 5 counsel, as stated in the caption hereto, at
 6 Page 1 hereof; that before giving testimony
 7 said witness(es) was (were) duly sworn to
 8 testify the truth, the whole truth and nothing
 9 but the truth; that the foregoing typewritten
 10 transcription, consisting of pages number 1 to
 11 150, inclusive, is a true record prepared by me
 12 and completed by Associated Reporters Int'l.,
 13 Inc. from materials provided by me.

G. Michael France, Reporter

Date

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