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

Advisory Committee, 9-18-2012

ATTENDEES

Sharon Chiumento, B.S.N. E.M.T.-P
Arthur Cooper, M.D., M.S.
Director of Pediatric Surgical Services
Harlem Hospital Center
Robert Kanter, M.D. (Telephonically)
Professor, Dept. of Pediatrics
Director Critical Care and Inpatient Pediatrics
SUNY Upstate Medical University
Rita Molloy, R.N. (Telephonically)
Mary G. Clarkson School Nurse

Janice Rogers, M.S., R.N. C.S. C.P.N.P.
N.Y.S. Emergency Nurses Association
Elise van der Jagt, M.D., M.P.H.
Professor of Pediatrics and Critical Care
Children's Hospital at Strong
Lee Burns, B.S. E.M.T.-P
Department of Health
Director of Emergency Medical Services
Martha Gohlke, B.A., E.M.T.-B
HPA-I, Coordinator, E.M.S.C. Program
N.Y.S. Department of Health
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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Nancy Agard
N.Y.S. Department of Health

Colleen McLaughlin
N.Y.S. Department of Health
David Brick
N.Y.S. Department of Health

DOH - Bureau of Health Care Research and Information Services
Pamela M. Lawrence, Program Research Specialist II (Syracuse Office

DOH - Division of Quality and Patient Safety
Lisa McMurdo, R.N., M.P.H., Director

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(The meeting commenced at 1:00 p.m.)

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

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

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

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

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as though we're in good company even though we may not see some of our -- some of our friends in person today.

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

Sharon?

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

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

Hospital in Rochester.

DR. VAN DER JAGT: I'm Elise van der Jagt. I'm a pediatric critical care physician, also at University of Rochester, at Golisano Children's Hospital.

MS. HAFF: I'm Sandy Haff, from the Division of Certification and Surveillance.

MS. TRIPOLI: Linda Tripoli, New York State Trauma Program Manager.

MS. SPERRY: Sarah Sperry, Epidemiologist with the Injury Prevention Program.

MS. GOHLKE: Martha Gohlke, E.M.S. for Children Coordinator.

MS. BURNS: Lee Burns, Director of E.M.S. Bureau.

MS. McMURDO: Hi; Lisa McMurdo, Director of Division of Quality Patient Safety.

MS. LAWRENCE: Pamela Lawrence, I work for the Bureau of Health Care Research and Information Systems.

DR. BRICK: Hi; I'm David Brick. I'm a pediatric cardiologist in New York and I'm going to be presenting some information on an updated NIST guideline.

MS. McLAUGHLIN: Hello. I'm Colleen McLaughlin. I'm a research scientist with the Patient Safety Center at the State Health Department.

MS. PLAVIN: Good afternoon. Hope Plavin, I'm newly with the new office of Quality and Patient Safety in the State Health Department.

MS. AGARD: I'm Nancy Agard. I work for the Patient Safety Center in the Health Department.

DR. KANTER: Bob Kanter, Peds Critical Care in Syracuse.

DR. COOPER: Anyone else on the phone at this point?

MS. MALLOY: Rita Malloy, I'm the past president of the New York State Association of School Nurses and public relations chair. Is there a way to put the volume up to the phone participants?

DR. COOPER: Well I'll tell you what. We'll do our best to have everyone be sure that they press the red button --

MS. MALLOY: Okay.

DR. COOPER: -- on their microphone when they speak. I think that's been part of the -- part of the problem.

MS. MALLOY: Okay. Thank you.

DR. COOPER: You're welcome. Welcome, Rita.

MS. MALLOY: Thank you.

DR. COOPER: Anybody else? Okay. Well, we will hope that as people join us that they will be announcing their presence volubly so that we know that they are there. So just to begin the -- begin the -- begin the agenda today, of course, we're going to be focusing, as usual, on reports from the Bureau of E.M.S. and the E.M.S. for Children grant. We're then going to focus on some new business, focusing -- or chiefly regarding some patient safety issues. Before updating you on where we are in terms of the 405 hospital code revision and the emergency preparedness activities and then as usual we will conclude with the updates from our sister advisory committees and -- and D.O.H. partners.

I -- I do want to just begin the meeting by sharing with everyone that we had a

really excellent meeting with the commissioner on August 23rd past. The commissioner was gracious enough to accommodate Bob Kanter and I, as chair and vice chair of the Committee to speak about the future directions for the Committee over the coming months and years. And I think that there were three major themes that emerged from that meeting. I think that those of us that were there in addition to myself and Bob, namely Martha and Lee and Lisa, will all agree that it was a really very, very productive meeting and very useful in terms of the directions that we might be taking.

First and foremost, of course, on our -- on our agenda is completion of our task of getting the regulatory package brought forward. Suffice it to say that the commissioner was extremely positive about continuing to move in that direction and gave us some guidance as to where we might go in the -- in the next month or so with that, with the expectation that at this point unless another issue arises between now and then, is expected to be on the agenda for the Codes Committee of the Public Health and Health Planning Council on November 15th. And to all of you who

have participated in the Committee for all these many years and been through our time together in terms of moving toward this day, this is really going to be a terrific -- you know, a terrific undertaking once it -- once it goes forward, which we expect that it will with the Commissioner's support on that date.

In addition to that, and we'll give you an update about that a little bit later in terms of the details, we focused on emergency management, disaster medicine, public health preparedness, in terms of this Committee's role in -- in advancing that particular field within the -- within the scope of our work. Bob Kanter, as -- as is usual, was particularly compelling in terms of his advocacy for the -- the involvement of this Committee in the work of the Department respecting emergency preparedness. And as a result of that, thanks to, again, Martha, Lee and Lisa, we had an opportunity to meet with Mr. Nick Ntarogen (phonetic spelling), if I'm pronouncing that correctly, who is the Deputy Director of the -- of the Preparedness Program within the Department which we learned this morning combines the -- the

public health emergency preparedness grants -- grant from C.D.C. and the hospital preparedness grant from the -- from the ASPR, the assistant secretary for preparedness and response. We came up with -- with some very useful directions to pursue in the immediate and -- and midrange future and will again comment on those briefly a little bit later in the meeting.

Last, but in my view certainly not least, the commissioner expressed his hope that this Committee would assist him in -- in his quality safety agenda. And of course, we have our friends from the -- from the Patient Safety Center within the Department with us today to sort of open the discussion on that issue. But we heard the commissioner utter the D word during our meeting, dashboard, and -- and I think that this represents a really, really incredible opportunity for our Committee to begin to work, you know, on a quality safety agenda and emergency care for children statewide as we move into the future. Of course, we have spent the last decade or so really preparing, you know, for this time, laying the groundwork in terms of, you know, a -- a regulatory

basis for the work that -- that -- that is done on behalf of emergency care for children and of course the next phase is focusing on improving the safety and quality of that work to ensure that it really meets the needs of our -- of our youngest citizens.

Now many of you may not know that one of our very longest serving members, Elise van der Jagt, from -- from Rochester, actually pioneered work in this area on one of the very first two E.M.S.C. grants in New York State back in the mid-1980s. He was at that time developing an emergency registry and looking to develop some risk adjusted outcome metrics based upon the data that he collected. And I had a chance to briefly speak with Elise and Elise has graciously accepted the opportunity to really focus the work of the Committee on this aspect of -- of -- of emergency pediatric care as we move forward in the next -- in the next months and years.

So, Elise, I really want to thank you for that. It's going to be a huge undertaking, but vitally important to the -- to the work of this Committee, the Department, and of course public health at large in New York State and so thank you

so much for your agreeing to take that on.

Obviously, those of you who wish to work with Elise on that very, very, very important project that the commissioner has indicated really has his very strong support, please let -- let me know and him know and, you know, we'll be moving forward in that -- in that -- in that endeavor as -- as we go forward throughout the next several months and years.

So that, sort of, by way of an intro as to what's been taking place over the last few months since we last meet and I think it's really, really, really exciting. And once again, I want to thank Martha and Lee and Lisa publicly, as I so often do privately, for all the incredible work that they do on behalf of the children of New York State behind the scenes when we are, you know, thinking about more pressing issues such as taking care of those kids when they come to our -- come to -- come to our -- come to us for -- for help.

So at this point, I'm going to -- I'm going to turn the agenda over to Lee Burns, who is going to give us a little bit of an update as to where things stand with -- with the Bureau.

Lee?

MS. BURNS: Well we are in the midst of implementing the new E.M.T. curricula. It's a monumental task. Basically, for those of you who are not E.M.S. people, there are five levels of E.M.S. certification in New York State. At the national level, in 19- -- or excuse me -- 2009 at the national level the E.M.T. level -- actually all of them, were updated and changed. For us in New York, it lengthens the course time. There are some funding issues. We are in the -- it was -- it was published as a guideline, so there were no objectives to it, so we've been working with our -- your sister councils and other states on developing objectives so that our instructors can teach the curricula and that there are testing elements. So that is -- that's -- again, it's a monumental task. We have a group of people in the City now looking at exams.

The budget process is starting again. Actually, I guess it never goes away really. So we're working with the Department on budgeting. I would be remiss if I didn't utter these three words, travel reimbursement issues. I

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

and the State. Again, it's very frustrating and we're sorry.

Sure?

MS. CHIUMENTO: We were supposed to get a vendor number at some point in time and I haven't submitted my recent vouchers because I've been waiting for the vendor number and have never received it, so are we still going that direction? Shall we submit the vouchers?

MS. BURNS: I'll check because there's a -- there's a bureau in the Department called Council Operations and those -- and they -- they're -- our -- we've gone round and round about something called a Netcard and when I -- I'm a simple person, unlike most of you, but I asked what is a Netcard and everyone looks at me and says we really are not actually sure. So I'll check on the -- I know that our core sponsors and the ambulance services, anybody seeking reimbursement for our contract work has to have a vendor I.D.

MS. McMURDO: Yeah. The little bit that I understand is they will be requiring a vendor I.D. in the future, but currently the old system of the paper is still standing and we only

recently were told that in the last week or so. So I would think, we can verify, but I think you should submit things by paper.

MS. LEE: I think you have paper for them; don't you, for --?

MS. GOHLKE: Yes. My understanding is we were supposed to fill in your vendor I.D. number when we get it. That was the last word I had heard.

MS. LEE: The answer to your question, clearly, is we don't know. We'll get back to you on that.

MS. CHIUMENTO: But at least now I know that I can send the stuff to you and let you deal with it.

MS. LEE: I'm not sure I'd encourage that behavior either, but you know, we'll -- we'll -- I think a big part of the frustration, and I say this to all -- with all my Health Department colleagues that are going to do this, is that it changes pretty regularly, so once we think we know what we're doing, the whole system changes. Did I miss anything? So -- but we -- we're lobbying for you. We -- we understand that

it comes out of your, you know, personal budgets. We appreciate your participation. We implore you to keep participating and we are doing everything we can to make our finance, as Marjorie Geiger once said, our finance colleagues -- this is the part she wouldn't have said -- miserable. So we bug them to death so.

We are in the last year of a four-year grant, which Martha has really led the charge on with regard to electronic pre-hospital patient records. She has dragged Linda, our Trauma Coordinator, kicking and screaming so that we include trauma records in --.

MS. GOHLKE: It's called sharing the pain.

MS. BURNS: Okay. Into an electronic platform. We have -- have had a lot of success with -- with pre-hospital stuff and the trauma stuff. I'm looking at Pam since it causes her -- yes, she has a pain right here thinking about particularly the trauma. So the information we're getting is very exciting and we're -- on the bright side, we -- while probably about forty percent of our E.M.S. services across the state are

submitting data electronically, it represents over two-thirds of our overall call volume. So that -- and that number grows weekly because services are switching over to electronic patient records. And I tell you this so you understand because you're health professionals, there is no financial incentive for our pre-hospital care providers to submit electronically from the Department. However, more and more ambulance services are billing their patients. And their ability to collect those dollars is much better when they're using electronic patient records. So that is compelling.

Dr. van der Jagt?

DR. VAN DER JAGT: I have the question about the database that generates. Is this a Web-based electronic record, that they can go to the Web and they can also download their own data to see how they're doing? This is -- again, I'm thinking about a quality safety perspective. Like the trauma, I think, now is Web-based. Isn't that right? When you --.

MS. HAFF: Facilities have the ability to purchase the ImageTrend software, which

is the vendor, so that it would be a live Web-based repository, but for the most part I think most of the trauma centers want to continue to use their current vendors will download into the ImageTrend system and then our goal, just like on the P.C.R. side, will be for the regions to access aggregate data to do some quality improvement activity.

DR. VAN DER JAGT: So the -- so the answer to that is that currently it's not a Web-based tool that they can -- it's just an electronic data form. Is that correct?

MS. GOHLKE: Well the E.P.R. --.

DR. VAN DER JAGT: Could you explain maybe a little bit about it? That would be really helpful.

MS. GOHLKE: It's on the Web, but it's not a live repository, or it's not -- you see one patient and you enter it in. It's -- you download once a month or once a day if you want to do it that frequently. And the State only collects the data that they want to look at on a statewide basis. So it's not a legal patient record that E.M.S. services can retrieve in that sense of the word of a live repository, but it is Web-based.

You do upload through the Web. Does that make sense?

DR. VAN DER JAGT: It does make sense. The question then is, is the data that the agency collects on an individual patient, is all of that data put in or is it only select data fields that are on that form?

MS. GOHLKE: Only the identified data that we at the State choose to retrieve.

DR. VAN DER JAGT: And who decides what fields have been put into that?

MS. GOHLKE: What we -- we brought it to the State E.M.S. Committee Council and they participated in what data that they thought would be good to collect on a statewide level and then the data that the State had collected previously, we've put in there. It grew. We were collecting ninety-something elements and now we collect two hundred and forty-something elements. So it's a much bigger database than we had before.

MS. LEE: I suggest you can blame Sharon because it's hers. But she was very instrumental in developing the pre-hospital

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

So we're hoping to be doing some -- some looking at SPARCS with our pre-hospital data.

MS. GOHLKE: It's been a huge undertaking that's taken four years to get to where we are now, which is we're just starting to get data into the system through this method.

DR. VAN DER JAGT: I just think it's phenomenal and I just -- it goes back to the opening statement of trying to be put in chart, I guess in some way for the quality and safety metrics for -- for E.M.S.C., is that the linkage between the pre-hospital dataset and the SPARCS dataset is critical and how to do that exactly. So this sets us up very nicely for being perhaps able to do that.

I have one more question if I can -- you can bear with me. It's a question of you mentioned, Lee, that forty percent of ambulance agencies are basically submitting electronic P.C.R.s but that that accounts for sixty percent of the population basically. Could you divide it into upstate versus downstate because upstate is very rural, largely volunteer and I'm just wondering how that compares to downstate New York City, which is

a very different place.

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

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

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

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

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

DR. VAN DER JAGT: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

MS. BURNS: That's it.

DR. COOOPER: Lisa, anything from the Department?

Okay. Martha?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sorry. I have no idea how to work this apparently. Okay. Okay. I think I figured it out. All right. Sorry about that. So I am -- now, I'm -- I can't look at the slides and talk in the microphone so.

Okay.

So what I'm going to be presenting is a descriptive analysis of medication errors among pediatric patients. We -- we undertook this analysis as part -- as part of a pharmaceutical safety grant that the Patient Safety Center had received to do a number of initiatives related to medication safety. We used the data that came into the Health Department from the -- from NYPORTS. NYPORTS is the New York Patient Occurrence Reporting Tracking System. This system is required by law for Article 28 facilities to report adverse occurrences. The report -- the adverse occurrences include both patient safety events and other events that happen in a hospital such as loss of services in the hospital, you know, if the telephones go down and things like that. And it's the warning system for the State Health Department for hospital-wide events, for example,

and then also the reporting for these serious safety events.

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

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

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

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

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

So the NYPORTS data is largely just a textual description of the event. And what we're collecting is the description of the event, the summary, and then a summary of the timeline of the event, the root cause statements and executive summary from the root cause analysis. So the facility takes the -- the medical record, the interviews with the providers, they get the root cause analysis team in a room. They do a cause analysis process and then submit the results of that process as a narrative to the Health Department. So that narrative should describe what happened, why it happened, what the outcome for the patient was, and how the facility is correcting the root causes that led to that event happening, what they -- the risk reduction strategies they are implementing to specifically address the root causes, and -- and how they're going to monitor those risk reduction strategies that -- that are implemented.

So over the course of the approximately ten years that we had data for, there were eighty pediatric occurrences reported to NYPORTS. Now first of all, you'll -- you'll

immediately say well there's no way there were only eighty children in the state that had medication errors or even serious injury from medication errors. And so you have to understand that we realize that that reporting into NYPORTS, although it's mandated by law, is not necessarily one hundred percent compliance. And I'll just, you know, leave it at that. The -- the -- the upside of that is that the data that are in there are really, really good for the type of thing that I'll be presenting today. So that -- so we have to take it for what it is. We've got eighty stories of what happened that we can learn from.

Among those eighty reported occurrences of medication errors among pediatric patients, seventeen deaths were either directly attributable to the medication error or the medication error probably contributed to the death. I mean that's a difficult thing to determine, so the -- we -- sometimes it's -- that's really unknown.

There were an additional forty-one injuries that required either increased monitoring or intervention to sustain life.

Sometimes that intervention was rescue medication. Sometimes it was a procedure, such as dialysis. Sometimes it was advanced life support or -- or intubation or a -- you know, an admission to the PICU or something like that.

About fifty percent of the reports were among infants. This is consistent with the proportion of pediatric patients who are hospitalized. Fifty percent of hospitalizations among pediatric patients are newborns or infants, so that -- that's not an unusual occurrence. It's not -- there's no reason to believe that infants are necessarily at high risk for having a medication error occurring. They may be at higher risk for having a serious harm should a medication error occur.

Yes?

DR. VAN DER JAGT: Could I ask a question about that? Were -- could you -- did you break it down into infants that were in NICUs versus infants that were on general floors because they're different kinds of populations?

DR. McLAUGHLIN: Yeah. In the stories that I have, I indicate whether or not it

was a NICU or a PICU or a newborn nursery. And in the newsletter we do -- that's a little bit difficult to sometimes determine because a lot of times the error doesn't necessarily even happen where the -- where the -- at the -- in the unit that the patient is actually admitted to. Sometimes the error happens in another location in the hospital, for instance, the specialty procedural error or something, so trying to -- the location in the hospital is sometimes difficult. That's the type of thing that we can look at more closely, but in terms of the infants, most of them were either -- were in the NICU.

DR. VAN DER JAGT: The other way to look at that would be by gestational age if that's included in your dataset.

DR. McLAUGHLIN: Not necessarily consistently. Again, this dataset is primarily a narrative and we could get the days of life for the newborns or the NICU patients, but gestational age, it depends on whether or not it was included in the narrative.

So one of the things that we did with the data is we coded the data to the age

formats and I'm not going to get all data geeky here, but essentially it's just a coding system that we started to apply to the NYPORTS data. As I said, the NYPORTS data coming in text form, we're trying to put some codes on it so that it can actually be analyzed. So one of the data elements we coded was the stage of medication process in which the event originated. Now those of you who are familiar with medical care know that an event can originate in -- at one stage and perpetuate through the process until it actually reaches the patient. So the event might occur -- the actual error might occur in the pharmacy and then is not caught and eventually reaches the patient. The error can occur in the pharmacy and be caught prior to administration. It's still an error, but it doesn't reach the patient. So one thing about this is all these errors reached the patient.

Because they're errors that reach the patient, they're more heavily weighted toward administration errors than -- than the actual distribution of all the errors that can occur. Okay? So an error occurring in prescribing or preparing, for example, has more opportunities to

be caught than an error that originates at the administration stage. So although this is interesting, it's not the whole story because it doesn't tell you how many errors occurred and were stopped. But it does tell you that -- that even with all those checkpoints, prescribing is still the number one source of the origination of the error. So those were errors that were made at the prescribing stage and were not caught until some point after the administration stage.

And then I'm sorry for the small text. Again, this is in the hard copy that we distributed. We also looked at the process of care. This is the age or acute term for this variable so I'm not that fond of the term process of the care here, but that's what they call it. And here more than one thing can happen so the sum is not equal to the eighty errors that actually occurred. For example, you could have an incorrect overdose that might occur because of an incorrect rate, for example. So it's both an overdose and an incorrect rate. So what we see from this is that among the -- among the errors that were reported to NYPORTS, overdoses were the predominant form. And

that would follow from the idea that these were errors that predominantly caused harm. It's harder to detect harm from undertreatment than from an overdose. It's harder to ascribe harm and -- and more difficult for the facility to pick it up and report it when -- when the event is an underdose compared to an overdose. So again, this is not really the distribution of errors, it's the distribution of errors that -- for the most part, errors that caused harm, detectable harm and reported harm.

One thing that I -- the other little point that I want to put in here is that monitoring, most of the monitoring issues that are picked up in NYPORTS are issues where it's a high alert medication that requires some sort of monitoring. Specifically for pediatric patients, it's often opioids that are administered and require monitoring and the child might have a respiratory -- an adverse -- which should be just a drug reaction, but turns into a medication error because of inadequate monitoring causes harm to the patient that should have been prevented with better monitoring of the patient's condition after the

opioid administration.

Another example of monitoring might be, for example, if there's critical lab values that were not monitored prior to the administration of the next dose and that anticoagulants are a good example of that, although those aren't really represented in this pediatric population as much as they are in the adult population. So that may not -- again, that's -- that's an area that can occur even after administration in some cases, when it's a monitoring of the patient's condition or prior to administration if it's monitoring of the patient's lab values or something that should inform the administration process.

Okay. So what I'm going to do from this point forward -- and I want to be somewhat brief in this because you do have the newsletter and I would like to get to Dr. Brick's presentation because I think that that's really very interesting. I'm just going to go really briefly through a few of the stories from the NYPORTS and talk about some high leverage strategies to prevent medication errors and some of

the reg changes that -- that you all have been working on.

So the first one is -- this is a kind of story that there's a lot of rumors about this issue with -- not just rumors, but truth in some cases, where weight in kilograms versus pounds. This is one of the reg changes that you made, weight must be weighed and recorded in kilograms. In this instance, the emergency room -- emergency department, the nurse asked the parents what the child's weight was. The parents said forty-two. The nurse put it into the electronic medical record in the wrong field. There were two fields available, one for pounds, one for kilograms. She entered forty-two into the kilogram field, not the pound field. The dose was -- dose of anesthetic was calculated based on forty-two kilograms. The child weighed forty-two pounds. It was a two point two time overdose because of that. And again, I just want to point out we did change some details of these stories to keep the -- the -- just to the story but to protect confidentiality.

So the issue was the triage system allowed both pounds and kilograms in

separate fields. The root cause analysis team then started to look at all the places that a child's weight was recorded in the hospital and they found eighteen difference occurrences, sometimes pounds, sometimes kilograms, sometimes not specified. And the other part of the story is that the clinicians assumed the parents were reporting weight in kilograms, which, you know, those of us who went through school in the 1970s and were told that we were going to go to metric, I understand you clinicians have, but I haven't and I would not report pounds -- I mean weight in kilograms, even if I knew it was going to be safer because I don't know my children's weight in kilograms. So that was -- you know, it was -- it was kind of a narrow way of -- of interacting with the parents to assume that they were reporting weight in kilograms.

So the other part of what I'm doing here is the Institute for Safe Medication Practices had a collaborative with us over the course of the past year as part of this pharmaceutical safety initiative. They had a medication safety self-assessment for facilities. It was released and available in 2011. The tool is

still available and they will work with facilities if the facilities would like to use it. About -- Nancy can correct me if I'm wrong, but fewer than forty percent of facilities in New York actually submitted to the I.S.M.P. self-assessment. It's a very good tool to find out where they stand on medication safety in terms of state of the art. It's very long and detailed and it takes a lot of effort on the part of the facility to complete it, but it's a good exercise. And if the facility is a champion who can get it done and then actually use the results from it to implement changes in the facility, it's an excellent idea.

So I -- for all these stories, I pulled out an I.S.M.P. self-assessment item that addressed the issue at hand. And in this particular one, all weights and heights are measured and documented in electronic systems and in written forms in metric units, for example. You do not allow non-metric units in your electronic medical records or paper forms. That's just the -- the I.S.M.P. self-assessment gives you a scale of one to five. One, being you haven't done anything about it. Five is it's fully implemented in one

hundred percent of the facility in one hundred percent of the cases. And then there's some range in between.

The next story --.

DR. COOPER: May I just interrupt for one sec? Relating to a regulatory package, I just want to raise the issue with my colleagues from the Department of Health and perhaps our suggestion should be broader than merely weight, that maybe we should be speaking about height or maybe even body surface area but that we should be, you know, using metric units and, you know, to be consistent with the I.S.M.P., you know, and -- N.Q.F., you know, direction. Just a thought as we move forward.

MS. McMURDO: We did think -- we did agree with that thought, Art, and we did broaden -- if you recall the regulation only applied to peds and we basically said you have to do weight in metric for all -- for all. I get to your point. I think that's definitely consistent with what we were thinking and I think we have to have some conversations with the pharmacy community about is it -- it does seem to make sense to go

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

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

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

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

DR. McLAUGHLIN: Yes, absolutely.

DR. VAN DER JAGT: -- using only metrics.

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

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

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

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

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

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

nurse needed some -- some coaching on appropriate -- avoiding that kind of bypassing of the safety system, but then the entire -- this was in a NICU. The entire NICU, they wanted to go back and make sure all the nurses knew what to do.

This one is another one that's related to an E.M.R. in a pediatric emergency department. The parents reported that the child had an allergy to penicillin. The doctor mistakenly entered no known allergies, N.K.A., on an order for morphine, not related to antibiotics, but just didn't see the allergy to penicillin on the triage sheet. That no known allergies in the E.M.R. then got picked up by the pharmacy and the later care providers who then ordered penicillin for the child. The child was wearing an allergy armband, but the nurse missed the allergy armband at the time that they -- the penicillin was administered to the child.

DR. VAN DER JAGT: While you're on the subject of allergies, have you included food allergies, because food allergies, particular milk allergy, is huge and causes anaphylaxis. And we've actually had that in our hospital numbers of years

ago. We've had it over the years, but we've actually separated out that we actually ask about medication allergies and food allergies are separate.

DR. McLAUGHLIN: You know, that's an interesting point. First of all, I think a food allergy would not be reportable to NYPORTS.

DR. VAN DER JAGT: It's currently not. But should it be?

DR. McLAUGHLIN: That's a whole other ball of wax in terms of what should be reported, because at this point because they've adopted the National Quality Forum of reportable events, I don't think a food allergy or any allergy -- I don't even think latex allergy issues are reportable to National Quality Forum as serious safety events. It's -- at this point I think allergies are limited to medication.

DR. VAN DER JAGT: I guess I'm just wondering. I don't know that process here, but having -- I mean I do -- I was the chief quality safety officer for Children's Hospital for twenty years and I cannot begin to tell you how many patients had serious life threatening

anaphylaxis from being given milk in the hospital, milk -- milk in something, and it is truly a major issue and may even be more common than medication allergy. So I would just -- I don't know how to bring it to the --.

DR. McLAUGHLIN: Like put it on somebody's agenda.

DR. VAN DER JAGT: Exactly. And just because it's not part of the National Quality Forum, it's not written into the NYPORTS, it doesn't mean that it's not valuable. And I think this is more common for pediatric patients than it really is for adult patients. I mean pediatric patients, the latex allergy and the milk allergy, especially, or food, you know, allergies is huge and I cannot over emphasize that, compared to adults.

DR. McLAUGHLIN: I -- I think that your point is very relevant given the national media attention right now to allergies and allergy interventions in, you know, specific to the Epi-Pens being available in schools and whatnot. So I don't know.

Lisa? I don't even know how we

would go about --?

MS. McMURDO: Well I do think it would probably be a discussion that would be better if it started at the N.Q.F. so they would incorporate that into the national model as opposed to -- because that's kind of how we've gotten into a problem with NYPORTS is creating our own little world.

DR. McLAUGHLIN: In terms of reporting, but we could -- you know, we could put it on as -- as one of the things that we might want to just think about in terms of addressing it for -- in other areas, but you know.

DR. VAN DER JAGT: And I think -- I don't want to belabor this. I don't take up all this time here, but obviously I'm quite zealous about this particular one, because children in hospitals or E.D.s is a vulnerable population. And the parents are considered to be the ones who are the advocates and defenders of them because kids cannot speak for themselves, frequently. So if the parent is not there to say oh, no, no, no, he's allergic to that, you know, that is a huge issue. So it really falls under, almost like you know kids

are special needs, kids are vulnerable, these are people that we need to really pay attention to these kids with these high allergic propensities.

DR. McLAUGHLIN: Yeah -- yeah. In this particular instance, I'm going to kind of skip over the -- what happened with the -- well the E.M.R. system. The issue -- I'm just going to skip ahead two slides here. The R.C.A. that came in from the facility said deficit knowledge is -- knowledge deficits, ineffective communication, and a failure of leadership in culture were at the root of this event.

Totally separate from the issue with the E.M.R. not being recorded on the -- the allergies not being recorded on the E.M.R. and on the triage sheet, in this instance it was the pediatric E.D. was not compliant with the hospital-wide policy on recording allergies and were not being forced to be in compliant by the hospital leadership, were allowed to use a paper-based system that had pre-dated the C.P.O.E. system and the pharmacy was enabling that behavior by entering allergy information for them on the -- from their paper-based system. And this event

caused them to re-evaluate their leadership in terms of -- of the pediatric E.D. in, first of all, getting them to be compliant with the hospital-wide C.P.O.E. and E.M.R. systems as well as appointing nursing leadership specific to the pediatric E.D.

So I picked out this story for you guys because I think it's a really illustrative story of the issues of culture and patient safety that is just not an electronic system in this case. They had an electronic solution in the facility.

So the I.S.M.P. -- when an event involves staff who cut corners, breach policy, and did not follow a procedure, the conditions that led to these at-risk behaviors are investigated to uncover system-based incentives that encourage the behavior and or system-based disincentives that discourage safe behaviors. So this is about taking the event that occurs and finding out why -- whether or not it was at-risk behavior and what were the incentives and disincentives to having correct behavior, given that -- the way the facility expects their -- their staff to operate. And you know, the regulatory changes that you guys have proposed in terms of pharmacy services also

address this Q.I. type of issue.

I think this is the last story that I have. This one is -- it was just an ordering error. The doctor picked the wrong antibiotic from the pick list in the C.P.O.E. The issue wasn't that they picked the wrong antibiotic; it's that they -- the doctor in this case chose to use the manual -- manually calculate the dose instead of using the E.M.R. built in C.P.O.E. weight-based decision making. And when the nurse went to administer it, she could not tell whether or not the doctor had manually calculated the dose or whether or not the decision support had been used. The nurse should have recalculated the dose. There's no doubt about that, but she didn't have the information needed to know that this -- that -- well, she should have recalculated the dose. If she had known that the dose had been manually calculated, that may have happened more effectively than it did. So this is an instance, again, where there's a -- there is an electronic solution, but the doctor could bypass it. And the doctor choosing to use the manual order entry instead of the weight-based decision making built into the --

the ordering, caused the overdose because they had picked the wrong antibiotic. They used -- they calculated it right, just with the wrong formula because they used the formula for the antibiotic they thought they were picking.

So in this case, there was also sub-optimal communication, which -- which again, is getting at this culture issue in terms of -- this was a -- you know, as I said in the story, this was a busy, hectic night shift. This team normally did not have sub-optimal communication and in this particular instance, you know, the circumstances led to less than optimal patient care.

So you know, you guys have in your regs the instructions for weight-based dosing, but again, this is a story that illustrates the fact that, you know, even with the references and whatnot, we still have to build safe systems and safe cultures.

So at this point I'd like to turn the microphone over to -- sorry -- Dr. Brick.

DR. COOPER: Just before we proceed, Dr. Brick, I just wanted to comment that -- that these are stories that are all too common in -- in medical and nursing practice, but

I -- I would feel myself to be remiss if I didn't point out two important themes that have been consistently annunciated by the Institute for Health Care Improvement. The first by Paul Batalden, one of the senior members of that organization and a member of their Board, that every system is perfectly designed to achieve the result -- the results that it gets. And second, the statement attributed to Albert Einstein that definition of insanity is to keep doing the same thing over and over again and expecting a different result. The Institute for Health Care Improvement has -- has made it very, very, very clear that -- that the typical response to medication errors, which is to find those who -- who made the errors and discipline them in some way, or to write a new policy that has even more steps than the old policy that led to the -- that led to the problem in the first place, you know, are not effective solutions to the workarounds that everyone adopts when the system is too crazy or complicated to -- to make it work under any and all circumstances.

So I think as -- as we move forward, the regulatory basis is critically

important, but as we move forward into our brave new world of quality and safety, I think we really have to, you know, keep in mind that our goal really needs to be to assist our colleagues statewide in -- in -- in designing systems that -- that, you know, really make it almost impossible for errors to be committed by mistake, but that those systems have to be simple and straightforward so that people -- so that, you know, fallible human beings cannot break them without -- without undo difficulty.

Dr. Brick?

DR. BRICK: Thank you. That's a really good presentation. Thank you. Do you have a laser?

(Off-the-record discussion)

DR. BRICK: Okay. So I'm David Brick. I'm a pediatric cardiologist in New York. Today we're going to be talking about unique usability challenges in designing electronic health records used for the care of children. And essentially -- so basically, we're going to be talking about human factors, which is basically how a human being interacts with a machine. And if you

were to go -- fly to California and rent a car, you would want to make sure that the -- well, you could be assured that the gas is on the right and the brake is on the left and the steering wheel is in front of you. And although you may not be able to use the satellite radio right away, there's certain things that you want to be able to use without having to figure it out.

And of course, we all kind of have this image in our mind when we think of children and it just helps realize there's a huge dramatic difference between grown-ups and kids. So the goals today are we're going to talk about why the pediatric patients have different needs for their charts, what those different needs translate into different functions, and how those functions can malfunction or be difficult to use and cause errors and human factor solutions.

And this talk is based on a document by NIST. And I didn't know what NIST is so I'm going to tell everyone what it is. The National Institute of Standards and Technology is part of the Commerce Department and they are a scientific group that studies lots of things,

including human factor design of different systems. And they have a group that looks at human factors designs of electronic health records. And one of the projects we did was specifically looking at pediatric patients.

And what's important to know as we go through this is that these are -- these are only things that are specific to kids. So there's lots of things that aren't in here that are in other papers that they've done related to patients in general. And you can download this document at NIST dot gov.

So I know --.

DR. COOPER: Dr. Brick, will you be able to provide us with a copy of your presentation?

DR. BRICK: Definitely. I think I e-mailed it, but maybe it got bumped.

DR. COOPER: Okay. Thank you.

DR. BRICK: It might have gotten spammed out, so I'll send it again.

DR. COOPER: Thank you.

DR. BRICK: Absolutely. So basically, you know, we all know this, but

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

lethal or cause severe harm.

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

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

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

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

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

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

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

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

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

polio, but in this case the patient got the hepatitis, the polio twice, but these are actually the exact same data for the computer but it's truncated so the doctor has -- or the nurse has no way of knowing that there was an I.P.V. here.

Here's a list of vaccines, so your kid goes to the doctor and this is what the doctor has to look at. And keep in mind that each one of these vaccines is a combination so T.D.A.P. is three different vaccines and then it's combined with other vaccines. And this particular E.M.R. only allows the doctor to sort by the first name -- by the first initial of the first component of this multi-component vaccine. And so if you're trying to do catch up, you could see how easy it would be to miss vaccines that the kids were getting.

So some of the guidelines we came up with, which is to support the display and tracking of components of vaccines and to allow sorting of vaccines by multiple fields.

Age-related normals, so in kids the -- what's considered normal changes with their age, their body surface area, and their gestational age. And as one example there's something called an L.V.E.D.

which is -- if you've ever been to a cardiologist, you've had this. It's basically the doctor measures the size of your heart and diastole. And it's pretty simple. The doctor just makes sure it's about less than four point five centimeters. But if you go see the pediatric cardiologist it's much more complicated because it's based on height, weight, and body surface area. So if you go to see a little baby, we would use this chart. But if you go to see a bigger kid, we would use this chart. And again I'm not expecting anyone to follow this inasmuch as it's meant to show how complex it is. Then the doctor has to go and calculate the body surface area. Then he takes the body surface area and he plugs it into this graph which gives him the value. And this has to be repeated for each value over and over again for each measurement the doctor is taking.

Something as simple as a blood pressure, if you're in the field and you have to know what a normal blood pressure is for a kid, adults it's pretty straightforward, a hundred and twenty over eighty. But in kids the normal value is a little more complicated. And the doctor has

to do this every time and most of the E.M.R.s don't support this. So first you go to this N.I.H. chart and you find the page that applies to your kid. Then you have to go back to the growth chart and get the height percentile. Then you go back to the N.I.H. chart, plug the height percentile and the age in and then it gives you the systolic and diastolic blood pressure. So here it's ninety-seven over fifty-three. So every time a pediatrician goes to see a child, if they're following the guidelines, they have to do this calculation every time. And if the E.M.R. doesn't support it, it makes it more difficult. It's wasting a lot of time and the doctor can be doing other things. So we would like the E.M.R. to enable us seeing where the normal ranges originated from and what the normal ranges are, basically. And I guess that's good for any data you're looking at, to know where it came from.

Privacy, so for teenagers they have special rights to their charts that -- that other people don't have. And a teenager can -- can ask that their parents not be able to look at certain parts of their charts. But if you open up

an E.M.R., you're going to see things, depending on which E.M.R. you're using, called private notes, confidential notes, secure notes, internal notes, and sticky notes and all of these things mean different things in different E.M.R.s. And actually, they all behave differently so you may give a copy of something to the -- to the parent that's actually protected information because it was impossible for you to know how to stop the parent from getting that information.

So basically one of the things here is, and again, in any chart, you want to make it visible what the rules are that describe what information can be viewed and printed and transferred and define what all these things mean.

Newborns, again, very special. When a baby is born, they don't have a medical record number and sometimes some nurses have told us that they have a hard time getting blood transfusions because the blood bank won't give them a transfusion until after they have a medical record number. The prenatal history is special because a lot of it comes from the mom's chart. And also, a newborn is very special how breast milk

is handled. Again people don't want to use their -- waste their breast milk and they don't want to get other people's breast milk. It's almost like a medication in that sense.

Here is a report by the immunization active -- sorry -- action coalition. In -- in one of the series they cited, these are three babies that got hepatitis B because it was incorrectly recorded. So even though the mom said she was positive, the baby got -- didn't get the hepatitis B immune globulin and the baby got hepatitis, which is obviously a tragic thing when it's completely preventable.

So again for newborns, a baby can already -- a newborn baby can have had surgery, a cath, and blood transfusions, but yet, many -- despite this complex history, a lot of nurses and doctors are reporting a lot of workarounds to get the post-natal blood transfusion because the baby doesn't have a medical record number and isn't properly entered into the system.

So some of our guidelines for newborns is create a system for efficient creation of the newborn record, support efficient processes

for the administration of breast milk including labeling and matching the mother to the baby and to the milk, and support connecting the prenatal data. Again, if you have extensive and important prenatal data, it's no good to you if the baby transfers hospitals via E.M.S. and no one has that data.

Radiology issues, kids are often sedated and intubated for radiology procedures. The ionizing radiation they get can be more important because they have rapid cell growth and they have an entire lifetime to have that effect. The dose of the contrast agents is based on -- is based on milligrams per kilogram. In addition, as you know, there's more variation in what we typically order when you -- when you order a CAT scan; it's for a much more varied reasons. And we need to keep track of this radiation exposure so that as kids are going from hospital to hospital, there's one place that you can store it. So we're recommending to support physician radiologist communications to clarify which scan variations are needed to support alerts for a contraindicated procedures, for instance if you have a pacemaker and you're going to get an M.R.I. And cumulative

radiation exposure over time.

Patient I.D., obviously very important. And again, in newborn babies it's much more complicated because if you walk into a NICU, you might see all these baby names and they change. For instance, Baby Girl Martinez can become Sarah Rabinowitz. Baby Girl Doe can become Baby Girl Harrison, can become Amanda Clough, and this can lead to errors because there's a lot of shift changes and people may not be aware that the baby's name changed. So a couple of the things we recommended are including photographs of the newborns with their primary caregivers for patient identification and also including extra identifiers, such as age -- oops, how did I do that? Sorry.

(Off the record)

DR. BRICK: Okay. So in summary, pediatric patients do have special requirements and those requirements lead to special functions in the E.M.R. And as they are if they're absent, difficult to use or malfunctioning, they can cause errors but there are human factor solutions to these issues.

I want to thank all the people at NIST, the C.D.C., and O.N.C. for helping with this. And I also want to say when you think about this, this is just for pediatrics, but you could have another one just for E.M.S., another one for surgery, another one for radiology because each of these areas has their own kind of intense special functions that they do. But once you realize that these solutions are out there, it's very good. All right. Thank you.

DR. COOPER: Thanks so much, Dr. Brick. It's such a huge issue that -- you know, that you and Dr. McLaughlin have, you know, really focused on that we're really, really indebted to you and grateful to you for coming. You know, as we follow the Commissioner's direction and embark on a course of patient safety, I -- you know, I -- I am hoping that we can continue to count on your -- you know, your continuing to work with us, perhaps with Martha's and Lee's and Lisa's permission invite someone from your shop to participate in our meetings on a regular basis. I know that Foster Gesten is an old friend of all of us here and, you know, as the -- as the, you know,

medical director, perhaps that's something that -- that he might want to become involved with. I don't know. We'll certainly leave that to all of you as to who would be the best person to represent you here, but I -- I do think that with the information you brought to us and the system that's been set up with the Department and Dr. van der Jagt's extensive experience in this area that we can do some good work together. So I'm really pleased that you were able to join us.

We'll just ask if Nancy Agard has any -- anything to add since you're from that area?

MS. AGARD: Not a thing.

DR. COOPER: Not a thing. Okay. Thank you, Nancy.

Any questions for either Dr. McLaughlin or Dr. Brick? Okay. Elise?

DR. VAN DER JAGT: Just a clarification. Whenever you say we have recommended, I'm not sure what the context is and I'm not sure what you mean.

DR. BRICK: I might not be -- I might not be saying everything exactly legally correct, but NIST is part of the Commerce

Department and they only make -- they do guidance.

DR. VAN DER JAGT: Okay.

DR. BRICK: So it would be up to some other regulatory group to say we would like to -- you to follow that guidance.

DR. VAN DER JAGT: I see. So it's a recommendation from NIST?

DR. BRICK: It's guidance on. It's kind of a --

DR. VAN DER JAGT: But it's not a regulatory --

DR. BRICK: -- that's right.

DR. VAN DER JAGT: -- it's not like we have done this in New York State or anything like that.

DR. BRICK: It's -- it's a bunch of -- that's right. It's a bunch of scientists getting together and saying these are solutions to these problems, these are guidance and usability things that we recommend.

DR. VAN DER JAGT: Right.

DR. McLAUGHLIN: And that really gets at the heart of why, you know, we -- Dr. Brick and I have been communicating over the past year or

so is, okay, so what do we do with this? What -- what now? Because, you know, the role of the E.M.R. vendors, the role of the Health Department and OHIT, the role of the Patient Safety Center, in figuring out how to get some of these recommendations implemented and, you know, where we go from here with these ideas.

DR. VAN DER JAGT: Right. Right.

MS. SOTTOLANO: I thought that the Office of the National Coordinator for the E.M.R. vendors had a -- in order for them to be able to even be certified to -- to be a vendor, there were certain standards that they had to meet. And I'm surprised to see incompatibility of vocabulary such as you mentioned on the notes, different types of notes. That really stands out if they're supposed to meet these -- these standards. So I was curious about that -- you know, that process for certification.

DR. BRICK: Right. So I think in the latest meaningful use guidelines, they recommended that E.M.R. vendors use user centered design, but they -- and although they mentioned that the NIST guidelines exist, they didn't say

that they have to follow them. So basically user centered design, it's up to the vendor to decide what that means.

DR. VAN DER JAGT: Can you use the mic, please?

MS. SOTTOLANO: I'm sorry. It just seems to be a big change from the original policy on E.M.R.

DR. BRICK: The interesting thing, too, is that one of the concepts in human factors design, which is cognitive bandwidth, you know, which is how much you can process at once. And so you know all of these guidelines and the pediatric guidelines and the human factor guidelines that they have done for E.M.R. charts in general, when you think about the nurse who is being overwhelmed and entering all these things. And the nurses I talked to, you know, sometimes it's not that one specific guideline, but it's the fact that your brain is frazzled with twenty patients and you're being forced to remember things to go from one system to the other and it becomes overwhelming.

And again, that concept is for

each one of these systems that you make better, you decrease your cognitive bandwidth and the whole system runs better so.

MS. ROGERS: I have a question and an observation. Has anybody compared the incidence of errors when we were on paper systems versus the E.M.R.?

DR. McLAUGHLIN: That's a really good question. There's -- there's this issue -- there's a little bit of literature about errors caused by electronic, but again, that's not necessarily reportable to any -- it's -- it's even -- even F.D.A. because they're not devices. Errors caused by devices are reportable to the F.D.A., but E.M.R.s are not considered devices. So those studies have been relatively narrower in scope than being able to compare incidents. You, at the best, would be able to compare before and after. Certainly, the -- the belief is that these systems have made health care safer. It's one of the overriding -- when -- when the -- when they take about the reason for implementing E.M.R.s and C.P.O.E. and all the other technologies, is safety. And then, you know, quality is hopefully part of

it, too, but in terms of measuring that and in terms of -- that it actually has gotten safer or not and then also separately from that, measuring the errors that are due to these systems and then comparing that to errors that were due to not having the system, there really isn't that much work being done in that, other than in specialized studies.

MS. ROGERS: My observation, and this is just my own personal observation, is that we've exchanged a different set of problems from paper to E.M.R. And quite honestly, I -- I am appalled every day on some of the ordering problems in the E.M.R. system as far as mgs. per kg., popping in -- I ordered fluids the other day for a neonate and it popped in a thousand milliliter bolus. It didn't even give me the option of twenty C.C.s per kilogram. There -- I mean the system is rampant with this and the overrides that they have are -- I don't even look at them anymore. I mean it tells me that if I order a hundred sixty milligrams of -- or Tylenol, that I'm overdosing the patient because I should only give one fifty-seven. So I mean the more you read those

ridiculous, you know, kind of --

MR. McLAUGHLIN: Alerts.

MS. ROGERS: -- alerts, thank you, the -- you just don't even pay attention to them at all. So that's why I wondered if there's a comparison. I just think we just have a new set of problems.

MS. TRIPOLI: To piggyback on what she had said, one of the beauties of the prior system was you didn't have values auto-populate throughout the medical records. So whereas in emergency room someone might not have picked up an allergy, the admitting nurse did and so she altered the record. My concern would be with auto-population people, it's all taken care of and you don't have this checks and balances which come from conversations and these questions being asked. I think people -- okay, that's settled. So that's a concern that I have. And as an investigator in my prior life, the other issue with computerized medical records is every record looks the same. So if you're looking at an incident, you really can't determine the events that led up to the incident because everything is so homogenized, protocol is

followed, and that's all you get out of it. Well and an example would be I was at a facility three times for decubitus ulcers and couldn't track what -- what broke down in that system because the protocols were checked as having been, you know, enforced, so it's -- I agree with you a hundred percent.

DR. BRICK: I think those are really good observations and I've heard those many times exactly like that, which is part of the reason, you know, that we did this. But it's a big issue.

DR. COOPER: I -- I think that -- you know, that the comments that have been made are really right on target. The -- we've learned that with respect to, you know, operations and so on that -- and blood transfusions and major interventions like that, that we need to, you know, use two specific different unrelated patient identifiers to ensure that we have the right patient. Given the fact that we know that there are always numerous errors with -- you know, with manual systems and that the electronic systems which were supposed to make our lives so much

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

Elise?

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

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

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

to look at, both.

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

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

system in a whole different area that you weren't aware because they were all connected.

DR. BRICK: Right.

DR. VAN DER JAGT: And now you've taken out that little thread, and now the whole thing unravels in someone else's area. You know, and that's a real difficulty and it's a learning thing. I think it's -- you know, it's like technology. It's a blessing but you have to learn how to use the blessing so that you don't end up being cursed. You know so.

DR. BRICK: And a lot of these concepts can be implemented in the -- in the formation process. So they're building the E.M.R.s out, the next build they can actually look at the guidelines and -- and the other guidelines that NIST has published to figure out what things are important to prevent these errors so.

DR. COOPER: Once again, I'd like to really thank our colleagues from the Patient Safety Center for coming and Dr. Brick particularly --

DR. BRICK: Thank you for inviting me.

DR. COOPER: -- for making the trek from New York to present this -- this really important information.

UNIDENTIFIED FEMALE SPEAKER: In the rain.

DR. COOPER: In the rain, absolutely, yes -- yes -- yes. Well dodging those rather large raindrops in the New York State Thruway does present its own quality safety problems. So we're very grateful for your time and your -- and your input to the process.

And -- and once again, Dr. McLaughlin, I would be delighted to have one or more of your colleagues with us in the future meetings if that's acceptable to the Bureau staff.

MS. BURNS: We'll -- we'll discuss it.

DR. COOPER: Thank you. Thank you so much. Okay. You are absolutely welcome to stay to -- you know, for the rest of our agenda, but I'm sure you have other things that you need to get done, such as dodging a few more raindrops.

DR. McLAUGHLIN: Thank you for the offer, but we'll --.

DR. COOPER: And I think at this particular point, it might be useful if we took a very, very short break. So we'll be back in five minutes.

(A recess was taken.)

DR. COOPER: Okay. I would like to call the meeting back to order following our brief recess. We do have a fair amount of business yet to cover. And just by way of wrapping our -- our previous discussion, Elise van der Jagt is going to work with Martha and we'll set up, you know, an initial conference call to begin to brainstorm some of the issues about where we might want to take the -- you know, take the Committee down the first step toward development of some kind of a dashboard as the Commissioner has suggested. And so we'll try to get that done sometime before our next meeting in December.

So moving on to old business, the first item of old business has to do with the 405 hospital codes revisions. I don't want to say too, too much about this at this particular point in time. What I will say once again is that we're deeply grateful to the Department for, you know,

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

The other issue that was of some

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

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

those were the -- the major issues that emerged from the meeting.

And what I'll do at this point is I'll ask Martha and Lee and I think Lisa is not in the room at the moment. Oh, she left for another meeting? Oh, okay. And Sandy, if they have any additional comments to make at this time.

MS. BURNS: No -- no.

DR. COOPER: Did you hear a little bit of use of that cognitive bandwidth that we were hearing about --

MS. BURNS: I have a very narrow cognitive bandwidth, so I would say to you --.

DR. COOPER: -- in the -- in that long pause between the question and the answer? I think there was a large cognitive bandwidth there.

Okay. So I'm hearing that we have no further comments at this time. So we'll keep you updated as to where that's going.

Bob, are you still on the line?

DR. KANTER: Yep.

DR. COOPER: Bob, do you want to -- would you like to talk about the emergency preparedness activity update?

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

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

better perspective on pediatric issues than maybe any other group, any other agency in the whole system. And we have -- and we feel that we could contribute more than we have up until now. So there were a few issues that we discussed that might be -- that might warrant our input.

It remains to be seen whether we're going to receive an assignment to any one of these, but mass prophylaxis in a pandemic or infectious disease threats, building on ideas about more effective coalitions to carry out disaster preparedness and responses, trying to develop -- to identify and give roles to pediatric champions at the local level in every county across the state for emergency preparedness, and a whole area that we didn't discuss enough for me to understand it completely, but having to do with human services planning, things like mass care shelters, providing food in shelter situations, environmental health issues, housing, temporary and restoring housing after a public health emergencies. And every step of the way, reality was sort of emphasized. This is not a great time to take on any new roles because public budgets are short, but it probably

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

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

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

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

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

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

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

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

MS. SOTTOLANO: I'm sorry. I'm --.

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

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

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

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

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

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

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

MS. LAWRENCE: (inaudible response)

DR. COOPER: Okay. There's

nothing the matter with that. Okay. We're all here for that reason, as well.

Sarah, can you give us an update with respect to the Bureau of Injury Prevention activities?

MS. SPERRY: Sure. Okay. I think this is up to me now. I -- I asked our office and I told them all that I was coming here and if anyone had anything that they needed or wanted me to relay. I do want to throw out that especially in relation to the work with the School Nurse's Association, pertinent to you, that there are the new concussion guidance documents and all of that up. They're accessible on the website. And but what -- the only ones I officially got stuff for are upcoming week events. This week is National C.P.S. Week, September 16th through the 22nd. October 1st through the 5th is -- I'm sorry.

UNIDENTIFIED FEMALE SPEAKER: C.P.S. means?

MS. SPERRY: I'm sorry. Child Passenger Safety.

Yeah. No. In -- in my world, I'm sorry, it's child passenger safety, you know,

car seats. Drive Safely to Work, October 1st through 5th. September 19th, later this week, is No Text on Board Pledge Day. October 14th through the 20th is National Teen Driver Safety Week. And that's what I have and I have little write-ups of everything. I'll pass that out.

DR. COOPER: Thank you.

MS. SPERRY: You're welcome.

DR. COOPER: Thank you so much.

MS. SPERRY: And that's all for me.

DR. COOPER: Well I -- I -- far be it from me to add anything to this outstanding report, but -- but I think there is one important thing that is taking place one week from today.

MS. SPERRY: Oh, yeah. Sorry. We're -- we are. We're -- a week from today is our I.C.P.G. meeting, which is our injury prevention -- no -- injury community prevention group. Sorry. The acronyms are -- I'm full of them and not always full of what they're for. But the I.C.P.G. is a group of community partners from various levels of state governments, local governments, practitioners, and so forth, that are very involved

in injury prevention. And they come -- we bring them together to help guide us in the focus of our injury prevention efforts in the state. We had a meeting this fall -- no, not fall -- spring I believe -- spring. I'm -- it's just occurring to me that it is actually fall now. But we're --.

DR. COOPER: Is that a cognitive bandwidth issue, Sarah?

MS. SPERRY: Most definitely a cognitive bandwidth issue.

No, not another acronym. But so at any rate, we -- we met in the spring. And the -- the project that I'm spearheading with this is a state injury action plan which is turning out to be a monstrous document of what it is that, you know, the leading -- what are injury problems, data and background, on all of them, what it is in loosely C.D.C. smart objective format, which are basically measurable, reasonable, and attainable goals to combat these problems. They have additional resources, other things that are usable and good and promise -- promising or proven strategies that we're not using but they're there in case someone else wants to use them. So it's --

and we're doing it for all of injury, so this is getting to be a very, very big task I've taken on.

Also, there are -- there's child policy which is focusing, I believe, on lighters, not just any lighters, on working on bringing people's awareness to and pushing towards prohibition of novelty lighters, which if anybody hasn't seen them, are -- really, really look like toys, like I've heard that a bunch of times and said, yes, okay, it's a lighter that looks like a toy. But at our last meeting --.

DR. COOPER: And in fact is a blowtorch.

MS. SPERRY: Yeah. At our last meeting, they brought them in -- people from Office of Fire Safety brought them in, examples that they've bought online. And being thirty-three years old, I couldn't tell that that was a lighter and how you would make something light, or some of them you could. But they're still kind of scary -- really scary and there's -- what else? Fall prevention in older adults, which doesn't impact you all nearly so much, although --

MS. SPERRY: Okay. Yeah. But --

you know, that's -- fall day is coming up the first day of fall. And what else? No, it is. The National Fall Prevention Awareness Day is the first day of autumn. And let's see. That -- I know I'm forgetting things.

MS. MALLOY: Can I just interject something about concussions?

MS. SPERRY: Go for it.

DR. COOPER: Please. Who is on the line? Is that Rita?

MS. MALLOY: This is Rita -- Rita Malloy.

DR. COOPER: Hi, Rita. Thanks.

MS. MALLOY: So when you were speaking about the concussion guidelines and school nurses, one of the things I wanted to mention was in discussions, you know, amongst ourselves as -- as school nurses, one of the things that has been, you know, concerning is that the impact program that's been, you know -- are you familiar with the impact program, where there's -- there's preliminary testing, like baseline testing done with athletes, and then there's some kind of collaboration done with hospitals and the schools

to monitor, you know, kids for concussions. But one of the things that was discussed was the manipulation of the test by -- by the athletes so that they would underscore, understanding that they would be re-tested and held to a certain standard and they want to still play, so they're -- they're testing down intentionally. They're manipulating the variables themselves. That was one thing. And the other thing was that a lot of the collaborations are being done with orthopedists, instead of neurologists. And it's you know -- our nurses did raise concerns that are the right people looking at this particular subject. So you know, sometime in the future, we might want to take a look at that since it's kind of new to us, that these, you know, guidelines are being formulated or encouraged for schools and some loose affiliations are being formed between hospitals and schools. So we might just want to have our ear to the ground and -- and take a look at that at some point when some data is starting to be collected.

MS. SPERRY: Absolutely. And I -- I guess it makes total sense that the athletes would test down just to make it easier, but you

know, this is -- I'm a data person. I'm not one of our program people. But this -- these are -- are fabulous points that I'm making myself notes of to bring back now to the people that work with our concussion stuff and working with the Brain Injury Association and all of those -- those partnerships that we have and have going on. I think that those are points that need to get brought forward.

DR. COOPER: Rita, I'd like to discuss this issue with you a little bit more off-line because this is a -- I think you're raising a really, really important issue and this is an area that I think our Committee could at least perhaps, you know, act to, you know, raise the attention of others about this problem and, you know, maybe in collaboration with our own bureau and Sarah's bureau, the brain trauma people and perhaps the Brain Trauma Foundation people and your own organization perhaps maybe, you know, think of a way that we might begin to address this particular issue. So I'll be in touch with you afterwards about how we might move forward in this area. Is that all right with you?

MS. MALLOY: Great. Thanks.

DR. COOPER: Okay. Great.

MS. SPERRY: Thank you. Those were -- were really good points to -- to have and to, you know, be taking away.

DR. COOPER: Anything else, Sarah, at this point?

MS. SPERRY: Trying to -- to think. We're in -- I had mentioned to Lee earlier, we've been in this flux of moving for several months now. Well, they had originally told us we were moving in, like, May but we got the most definitely you have to be packed and ready to go Tuesday at the end of August and we're still in our office and heard today that we're -- we're likely to still be there in October. So we're living out of boxes and very disheveled and disorganized, but our -- hopefully, we'll be squared away soon and so that's also taking up some of my cognitive bandwidth, just you know, remembering life. But -- so I think that's everything I have.

DR. COOPER: Fortunately, far more of those musty dusty old files are -- are electronic now than paper, so hopefully, you know, we're still making forward progress.

MS. SPERRY: We're still making forward progress.

DR. COOPER: Very good. Jan and Sharon, it's been a while since SEMAC met, as I recall. We have a meeting coming up soon-ish. Perhaps you can -- I think -- in fact, I think we met since the last meeting of SEMAC, but correct me if I'm wrong, Sharon.

MS. CHIUMENTO: You are exactly right. We met in June and they last met in May. So I don't have anything specific from that, except that on our conference call probably didn't have much chance to mention that almost all of the protocol recommendations that we had made to -- not protocol -- standard recommendations we made to SEMAC and Medical Standards were accepted. So we made several corrections, specifically on things like dosages in milligrams per kilograms, rather than in stated standard doses, and other things that relate definitely to safety.

And then the other thing was that during the summer, I'm actually -- have continued to move forward with a couple projects. One is taking these standards and putting them into a much

more usable format so that they can be put on the Web or done in another method. So I sent that off to Andy Johnson.

The other thing I've been working on is the standard -- the curriculum, the standards for the education, especially for the basic E.M.T., and working for -- putting those into modules because it was kind of -- before we had done it based on what our old objectives were. I've now taken the objectives and put them into the modules to match the federal modules. And the one thing of note for us here is that pediatrics is everywhere through those modules. It's not -- there's not only a pediatric module, pediatrics is of course very heavily involved in the life span module. There's a whole new life span module. In addition to that, just about every other module has an objective at the end that says discuss differences in -- age related differences in pediatrics and geriatrics. So pediatrics is very heavy in the new national standards -- educational standards.

DR. COOPER: Thank you. And I also appreciate your jogging my memory. I'm having one of those cognitive bandwidth issues myself.

There was a relatively important issue that arose during the last SEMAC meeting regarding the pediatric protocols. And that is how do we define the child? This of course is the age old question that we all -- we all struggle with. And the Department chose, at the last meeting, to, shall we say, not get into the weeds on that issue at that particular meeting. But I do think that it's probably worthwhile for us to think about -- since we do represent emergency medical services for children, it's probably useful for us to think about what we might want to do in terms of saying what we mean by child And you know, if -- if -- if not adopting a position, at least lay out the various, you know, concerns that are involved in terms of thinking about -- about differences between adults and -- and -- and children.

So I'm going to leave that on the -- on the -- on the burner to simmer until the next meeting. But what I am going to do in the interim is ask Martha to remind me to get together a conference call among the Committee members who have an interest in this particular area as to how we might want to move forward in terms of

recommending to our peers within the E.M.S. arena broadly defined as to how we think, you know, children ought to be handled within an E.M.S. system, broadly defined in terms of who is a child, who is an adult.

So sometime during October, Martha, let's see if we can't set up a call and begin to have that discussion so we can get something in writing, you know, if not a position paper, just at least some kind of statement, if you will, from the Committee at least laying out the arguments. But I don't think we should take a position on it at it, certainly, at this moment or maybe even at the next meeting, but I think we need to think about it a little bit since this is an issue that's vexed everyone from time immemorial. Elise?

DR. VAN DER JAGT: Yes. I -- I think -- again, looking at the broad spectrum and the scope of E.M.S.C. which includes not only E.M.S. but also hospitals, the discussion about pediatric age cannot be made independently, E.M.S. versus hospital. And the spectrum includes also the primary care physician, who sees -- who

considers what that pediatric age might be. So I was just making a plea, I guess, as we think through this process, which is very complicated and certainly very varied among many different stakeholders, we can -- we have to make sure that the E.M.S.C. comprehensive model all the way from primary care all the way through rehab, which is a E.M.S.C. model, that we not break the continuum of that by selecting one age for one area and one age for another area.

DR. COOPER: Well stated. So we'll think a little bit more about that before we do anything more about it, but that is -- that was an area of some contention at the last SEMAC meeting. The recommendations we made were not, but to whom they should apply was fairly contentious. So that's an issue that we'll come back to. And, Sharon, I'll ask you to report at our next meeting -- the next meeting of SEMAC, that we have taken this on as a project and we'll get back to the -- we'll get back to them about it and hopefully that will, you know, allow SEMAC some breathing room in terms of having to focus on that issue in the immediate future.

Okay. STAC, Linda Tripoli has, I think, had to leave us. I think it is fair to say that the -- she already covered the major issue that's before the STAC.

Elise, were you at the last STAC meeting? I -- I don't think -- I don't think you were, yeah. Yeah. And you know, the major issue was and continues to be the issue of the A.C.S. verification process. There were presentations by a couple of the -- of the trauma program managers from the state who have had extensive experience, both of long standing and of recent vintage, with the A.S.C. verification process. They gave us their views of how the process went, how it was to be laid out. The STAC did vote to recommend to the Commissioner, or to the Department really, that -- that -- that individual facilities have one year from the date of the STAC meeting to contact the American College of Surgeons to arrange for a site visit and -- and then had -- or a consultation site visit, I should say, and then had one year after, I believe, the report was received, if I'm not mistaken, to -- to arrange for a verification visit. So a letter was recently distributed from

the Department indicating that that recommendation had been adopted, although I believe the date that was set forth in the letter was May 10th, 2013 to be the final date by which hospitals had to notify the Department -- or had to, excuse me, formally request from the American College of Surgeons a -- a -- a date for a consultation visit.

Obviously, you know, the hospitals will need to notify the Department that they have made such a request in writing at the appropriate time. But it does appear that things are moving forward at this point. As -- as Linda indicated, there have been up to fifteen facilities who are seeking designation at -- you know, as Level Three or Level Four facilities, which is a good thing, you know, and something that hopefully will make our trauma system, in the end, more inclusive.

So there was some work done in addition on -- on the -- the -- the definitions to be included in the -- the trauma registry dictionary. Suffice it to say at this point as time moves forward, our own data dictionary is getting closer and closer and closer in detail to

the national trauma data dictionary that's also promulgated by the American College of Surgeon's national trauma databank subcommittee. So I think those were the major issues.

I don't think that there's anything of any great note in addition to come out of that -- that -- those discussions at this particular point in time. A great deal of discussion is going forward to the executive committee regarding, you know, some issues in and around whether folks with hip fractures should be included in the registry or not. It's a major subject of discussion at the present time. But that concerns more the elderly population than the younger population at this point so it ties in very nicely with Sarah Sperry's fall day; right, on the first of fall? So that -- that I think will cover most of the issues with respect to our sister advisory committees and D.O.H. partners.

Now moving forward, we do have a meeting in December, but -- but, but, but, but I know Martha wants, she indicated at the beginning of the meeting, to take a few minutes now to think about how we might you know further the work of the

Committee through our regular face-to-face meetings, but as well through conference calls and perhaps -- conference calls and perhaps other forms of electronic meeting so we can get the work done. And I'll turn it over to Martha at this point to facilitate that discussion.

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

vote. So it's an issue if people can't make an in-person meeting for that one reason alone and then our by-laws saying that you have to be an active member in attending at least fifty percent of the meetings a year.

So the electronic or, in our case, we don't have webinar access but we have the conference call. It's convenient in many ways and it saves cost of these meetings when we do them by phone, so that's a plus. But on a downside, you know, it makes it hard for people that have emergencies who can't attend those two in-person meetings to meet the -- the voting requirements and the by-law requirements of the meetings. So we're at the point, we do have December 18th on the calendar for our next meeting, but I need to set up meetings for 2013 and I wanted to ask what the Committee thought about the number of in-person meetings versus phone meetings, how are things working for people, what do -- do you think we should go to more in-person meetings? What do you think? Because today and the last meeting, we're getting -- it's getting harder and harder to get people here at the meeting. And that's for various

reasons and -- so -- but, we can't conduct business, though, I guess over the phone.

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

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

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

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

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

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

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

Kanter suggests, you know, signing in, in order to vote. With that said, though, I think, you know, yesterday as we were trying to figure out what was going to happen today and we knew that -- we knew Martha and Dr. Cooper and I were going to be here, the question for us is do we cancel these meetings because while the meeting space exists because we're contracted, the expenses -- all the other expenses don't. So we're really at a crossroads here. You know do you hold face-to-face meetings and conduct business or do you -- you know, do you hold electronic meetings and have you know small -- really smaller than four face-to-face meetings to hold your business at. There's no easy answer to this. But I think if you don't chose -- if the Committee itself, I mean, you know, doesn't, you know, chose to participate in its own Committee, we're going to lose you, and I'm afraid of that, or you're going to be consolidated into a larger advisory body, all of which is not off the table, by the way.

DR. COOPER: I want to underscore what -- what Lee has -- Lee has stated. We fought very, very very hard to get this Committee

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

responsibilities to the public. We all raised our right hands and said that we would do this and we need to do it.

DR. VAN DER JAGT: Art, if I could respond to that? I mean this is really very complicated. I do understand it. But I'm wondering if we look back at the meetings that we've had in these last several years, how many of those meetings have we actually required a vote on something? And so I'm wondering if -- if we're not voting very frequently or maybe not every meeting, I'm wondering if we could do the two and two. You know, we have two meetings and that those are clearly targeted for business, decisions, have to have a quorum, you have to be here, and that the other two meetings are reserved for discussion, for F.Y.I., for, you know, brainstorming for thinking through some of the concepts, short of a decision.

And the reason I say that is -- is in many of the councils and different committees I'm on, it is not unusual to present a proposal at one meeting that is not voted on and then wait until the following meeting to vote on that proposal, you know, so that there is some time to

consider and think about it, so that it's not presented and then immediately you vote on it before even thinking about it all that much, but that you actually delay it. And that could perhaps work into a system like this where discussion --.

MS. GOHLKE: Well by default, that's what we've been doing because --.

DR. VAN DER JAGT: But I'm saying making it more formal that there are actually specific -- like this meeting and this meeting, whatever, you know, those are the ones you have to be here. And I have to agree with -- with Dr. Cooper that if one cannot make those meetings, then maybe that person should not be on the Committee. I mean I really hesitate to say that because there's always like well what if we lose somebody or lose four or five people and then the Committee is defunct. But I -- on the other hand, you can't have a committee work with people not here.

MS. GOHLKE: Well that also leads to another issue, is that we still have vacancies in that we need to figure out a way how we're going to fill that because that will take pressure off of other people who may have an emergency and can't

show for a meeting and we can still meet quorum. So that is another added variable to the numbers of people in this room right now that are voting members.

DR. VAN DER JAGT: Right. Martha, may I also ask about --?

DR. COOPER: Elise, I might just add that part of our issue, this particular meeting is the fact that two of our members resigned really one about a month ago and one a couple of days ago. And of course, we are still waiting for individuals to be vetted to fill positions that were vacated over a year ago, you know, so, you know, those are part of -- those are -- those are issues as well. I mean this is not an issue that's solely limited to -- you know, to us, you know, in terms of not making the meetings, but -- you know, but we are part of the problem as all these other issues are part of the larger problem. But set aside all of that, we have got to find a way to keep this -- keep the work of this Committee going. I mean look -- just look at what we -- the business we transacted today and, you know, the work that we've brought before the Commissioner and so on, you

know, culmination of ten -- twelve years of effort on all of our part. And you know, to lose that, you know, that opportunity would be tragic in my view.

DR. VAN DER JAGT: Dr. Cooper, could I ask a bit about the vetting process -- maybe Martha, the vetting process because when you say that there is still -- there are still people out there who are in the process of being vetted, where -- we all are. So my --.

MS. GOHLKE: Allan Filler. All the rest here have now been re-vetted.

DR. VAN DER JAGT: But is the vetting, where is the barrier for that? Is it here? Or is it somewhere else?

MS. GOHLKE: Well apparently, it's some people haven't filled out the required paperwork which may have slowed the process down for those individuals. I don't -- it didn't slow the whole Committee down. I don't actually know why Allan --

DR. VAN DER JAGT: I mean once the paperwork is done --.

MS. GOHLKE: -- why Allan got

through and the rest of you didn't who did the paperwork.

DR. VAN DER JAGT: Yes. Okay. Once the paperwork is done by the people who are to be vetted, where are the barriers? Because that's beyond the control of the Committee members. I mean that's a hard thing to deal with.

MS. GOHLKE: I don't actually think that's why people aren't attending the meetings.

DR. VAN DER JAGT: Okay.

MS. GOHLKE: I mean maybe the individuals that have -- there's one individual that resigned before she got vetted. And I didn't ask her specifically if it had to do with her frustration of waiting. I don't think it was, to be honest. But it could have been. But I think -- I don't really think that's -- I don't think people are, I don't know, frustrated with the vetting process and not coming because of that.

DR. COOPER: I don't think that's the issue, but it does impact upon our ability to make quorum.

DR. VAN DER JAGT: Oh, I'm sorry.

One question I had, Martha, is what constitutes a quorum? Is it more than fifty percent?

MS. GOHLKE: It's the majority.

DR. VAN DER JAGT: It's -- that's more than fifty percent. Fifty-one percent or more. Okay. Thank you.

DR. COOPER: Right. But it's the majority of what. Okay?

MS. GOHLKE: Right now -- yeah, right. We now -- right, exactly. The bylaws say and the intent behind the statute is that you serve until your seat is filled. So technically, Dr. Lewis and some of the other members that have resigned are still technically part of the Committee until we fill their seat. So if they're counted into the quorum or not, you know, we have eight vetted voting members that are active and we have four here today. So if that's -- if that's the number we're working with, we didn't meet quorum today.

DR. VAN DER JAGT: Could you tell us again, refresh our memories of which positions are still vacant?

DR. COOPER: Pediatric

physiatrist, pediatric primary care physician, pediatric emergency medical services physician, parent of ill or injured child, pediatric behavioral specialist. Some -- some of those positions are -- you know, have individuals, you know, that have been recommended for appointment that are, you know, awaiting a formal appointment.

UNIDENTIFIED FEMALE SPEAKER: Who are those and which are those?

MS. GOHLKE: I think it's only Danielle LaRaque for the primary care. I think that's what we slated her for.

DR. COOPER: Okay.

MS. GOHLKE: But the other ones are -- there's no candidate for the other.

DR. VAN DER JAGT: The -- the question of the pediatric physiatrist is a difficult one because there are very, very few of those. I don't know about New York City, but in upstate New York there is probably one or two at the most. So that is a limitation of the -- of the --.

MS. GOHLKE: Yes. It's in statute. It's also in -- I think they took it out

of the federal requirements. I'd have to double check, but it may still be in federal requirements.

DR. VAN DER JAGT: And one question I have there is when we say pediatric physiatrist, is it still consistent with the -- the statute or the regulations here --

MS. GOHLKE: Yes.

DR. VAN DER JAGT: -- whether you could have a physiatrist with an interest in pediatrics versus a pediatric physiatrist because a pediatric physiatrist is a sub-specialty within --.

MS. GOHLKE: It says pediatric physiatrist in the -- in the statute. So I don't know, however that's interpreted.

DR. VAN DER JAGT: But I'm just wondering if that would be an acceptable -- if we find a general physiatrist.

MS. GOHLKE: I would think that would be all right.

DR. VAN DER JAGT: You know, a physiatrist, you know, and that person says you know I am really interested in pediatrics, would that be acceptable?

MS. GOHLKE: As far as -- as far

as the feds are concerned, not that that's the rule here, but as far as meeting the requirements of the grant, they just want to make sure it's a practicing clinician.

DR. VAN DER JAGT: Correct.

MS. GOHLKE: Not somebody who did it at one point in time.

DR. VAN DER JAGT: No -- no, I understand that, yes. Thank you.

DR. KANTER: I'm sorry, Martha. I need to sign off. I've got another thing I've got to do right now.

MS. GOHLKE: Okay. Thank you, Dr. Kanter.

DR. COOPER: Bob, thank you so much for coming and for your participation this morning and this afternoon.

DR. KANTER: Good.

DR. COOPER: Take care.

DR. KANTER: Thanks.

DR. COOPER: Well I think that, you know, we have indicated the importance of this issue, you know, to ourselves and our colleagues and I know Martha and I and Bob and Lee will be

thinking about this over the -- over the next couple of months, but I do ask that all -- all of you set aside December 18th to be here for sure. Jan?

MS. MALLOY: It's an in-person meeting?

MS. ROGERS: I think you're preaching to the choir right here with us three and so I'm asking how this important message will be communicated to the rest of the Committee.

DR. COOPER: It will be. It will be. Okay. I've already communicated with a couple of the members personally.

And Rita, can you make it on December 18th?

MS. MALLOY: I'll put it on my calendar. There are ten of us listed as vetted members online.

MS. GOHLKE: Oh, yeah, you assume that the online is up to date.

MS. MALLOY: Yes.

MS. GOHLKE: The other thought -- we -- us individuals don't have control over what's online. That goes through a process, as you can

imagine.

MS. MALLOY: But when you were talking about a quorum, I was just looking to see if I could see, you know, what might be, you know, perceived as half of us. But --.

MS. ROGERS: I'm happy to ask one of our pediatric emergency physicians if they are interested. However, I feel like Rochester is overrepresented and I think it would be better --.

MS. GOHLKE: Well that is an issue. They do want geographic and we don't need an emergency medicine physician. We need an E.M.S.

MS. ROGERS: Oh, E.M.S.

MS. GOHLKE: Yes.

DR. VAN DER JAGT: And again, very few of those.

MS. ROGERS: Excuse me, yes.

MS. GOHLKE: Well Dr. Halpert was really kind of that niche before because he was -- you know, he was doing -- he was a medic for -- he was also qualified as a medic, kept his --.

MS. ROGERS: What qualifies a E.M.S. physician?

MS. GOHLKE: Well he was a

paramedic, as well as being an M.D. So that worked.

DR. VAN DER JAGT: There is an evolving -- evolving sub-specialty of pediatric emergency medicine or emergency medicine that is actually called E.M.S. emergency medicine physicians and those are now people who have actually done a fellowship in E.M.S. as part -- after they go -- become certified in either emergency medicine or in pediatric emergency medicine.

MS. ROGERS: The ones that I know have done that, though, are focused on adults.

DR. VAN DER JAGT: That is correct.

MS. ROGERS: There also is pediatrics?

DR. VAN DER JAGT: Well that's -- it's an evolution -- it's an evolution as I understand it, at least.

DR. COOPER: That's right. There are no actual pediatric E.M.S. fellowships of which I'm aware. There are E.M.S. fellowships and there are some pediatric emergency medicine physicians

who have chosen to pursue that in addition to pediatric emergency medicine.

MS. GOHLKE: The requirements for membership came from the grant long ago and then the feds realized, I think, some of these seats were hard to fill and they took out, I just looked, the physiatrist. They took out the E.M.S. physician. They took out -- they took out -- before we had two parent reps and they brought it down to one. But we have it in New York State statute, all these, so that's the downside of putting things in regulation.

MS. CHIUMENTO: I'm wondering if --?

DR. COOPER: That's something we can work on, as well. But right now we need to focus on getting our work done, which means we have to be here.

MS. CHIUMENTO: I have -- I was wondering if possibly if a physician who is a medical director for an E.M.S. service could qualify to fill that position? And that would be a whole lot easier because, you know, every ambulance service has to have an E.M.S. director.

DR. COOPER: All right. Well hopefully not to be continued. Hopefully, we'll get this problem solved in short order. But in any event, we are to be continued on December 18th. Unless there's any other new business, I think it -- Elise?

MS. GOHLKE: Right now that's slated to be a phone meeting. That's what we originally had set it up. So I mean, so I just want to put that in.

DR. COOPER: Okay. All right. Well --.

MS. MALLOY: Is it going to be a phone meeting? That's what I want to know.

MS. GOHLKE: Well there's a contractual issue with the hotel, so if -- you know, we'd have to look at that if -- if the Committee really decided that it should be an in-person meeting.

DR. COOPER: So it is not scheduled to be at this hotel on December 18th. Is that correct?

MS. GOHLKE: That's correct.

DR. COOPER: Okay. All right.

Well --

MS. GOHLKE: Which is why we made it a phone meeting.

DR. VAN DER JAGT: So, Dr. Cooper, could I bring up just a suggestion for an agenda item for our next meeting?

DR. COOPER: Please.

DR. VAN DER JAGT: I just had the opportunity to be at the E.C.C.U. conference in Florida. The E.C.C.U. conference is Emergency Cardio-vascular Care Update conference which comes out every two years. It is put out by the Citizen C.P.R. Foundation. And as I came back from that, I was at a workshop or something, but as I came back from that, it struck me again having been immersed again into the importance of bystander C.P.R., A.E.D., trying to prevent cardiac arrest, both adult and peds, respiratory arrest, but particularly cardiac arrest, and then thinking about emergency events, coming to this meeting, it just seems to me that this is an area that we should be looking at. If we are really calling ourselves emergency medical services for children and remembering that we are looking at the spectrum

of pre-hospital, E.D. hospital, et cetera, emergency events that occur in all areas and how we can best provide care to them, not only the pre-hospital care, it just seems to me that emergency events in the hospital, which are by and large respiratory arrests and cardiac arrests in pediatric patients, that that should also be on our agenda, is how can we do that better. And so that raises things like the -- the bill that, again, that didn't pass in New York State about C.P.R. in the schools which is an educational thing which I know that a number of people have been trying to get that through as an educational way of preventing mortalities in pediatric patients on the outside. It brings up to mind the -- the dysfunctioning of how cardiac arrests and to some degree also respiratory arrests are managed in-hospital, the significant dysfunction of that. That raises the issue of first responder response in-hospital, which is essentially the primary care team and then secondary responders which are rapid response teams to prevent death from occurring.

Anyway, there's a lot of aspects to this. I just want to bring this up as a

discussion point because we do -- I mean we represent the kids who are dying out there, both outside and inside hospitals, homes, facilities, and we should be speaking for them and speaking to those very concrete issues which are perhaps a little bit easier to manage than some of the, you know, just general sort of care, you know, that kids are who were sick. So anyway, I bring that up as a -- as a -- an agenda item that I wondered if we could speak about and find out what our -- and again, with this sort of looking now at quality safety kinds of issues across the spectrum, how can you look at one part of that and not the other, the spectrum. And that fits with regionalization. It fits with a lot of other things, with the most sick kids that we have in our system. So that's just what I just wanted to --.

DR. COOPER: And we stand adjourned and we will meet again on December 18th by telephone with a couple of conference calls in between on specific areas of -- of work that we've agreed to undertake and thank you all for coming.

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

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

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