

Improving EMS Medical Direction for Pediatric Patients, An Internet

Webcast
Tuesday, August 22, 2006
3:00-4:00pm Eastern

Moderator:

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Public Health Service EMSC Program Director

The Emergency Medical Services for Children (EMSC)
Program

and

The Indian Health Services (IHS) Clinical Support
Center (Accredited Sponsor)
Present:

"Improving EMS Medical Direction for Pediatric Patients,
An Internet Webcast"

Accreditation for Continuing Medical Education

- The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.
- The IHS Clinical Support Center designates this continuing education for up to 1 hour of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity.
- This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse-Midwives.
- The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation, and designates this activity for 1.2 contact hours (including 0.6 hours of pharmacology) for nurses.

Disclosure Statement

- *Drs. Wright and Brown have completed the disclosure process. They have declared to have no significant financial relationships with any product or commercial manufacturer that would constitute a conflict of interest.*
- *Additionally, they have indicated that they will identify any experimental or "off-label" uses of any medications, and will use generic names or multiple trade names when discussing medications.*

EMSC Program Performance Measures

Developed to improve EMS system capacity to deliver appropriate pediatric emergency care.

EMSC State Partnership Grantees are required to report annually on three measures (66, 67, and 68).

Overview of Development Process

- Reviewed relevant documentation to identify the “universe” of measures
- Narrowed the “universe” to a working set of 50 measures
- Convened an EMSC Consensus Group Meeting to identify three core measures
- Convened conference calls with various members of the Group to refine the three measures
- Beta-tested the three core measures with three grantees (Colorado, Illinois, New Hampshire)

Performance Measure #66

- The degree to which the State/ Territory has ensured the operational capacity to provide pediatric emergency care.
 - “Operational capacity” comprised of 5 sub-measures (66 a, b, c, d and e.)

Performance Measure #66

- 66 a. The percentage of pre-hospital provider agencies in the State/Territory that have on-line and off-line pediatric medical direction at the scene of an emergency for Basic Life Support (BLS) providers and Advanced Life Support (ALS) providers.

We will discuss this measure in more detail

Performance Measure #66

- 66 b. The percentage of pre-hospital provider agencies in the State/Territory that have the essential pediatric equipment and supplies, as outlined in the American Academy of Pediatrics (AAP)/ American College of Emergency Physicians (ACEP) Joint Guidelines for Basic Life Support (BLS) providers and Advanced Life Support (ALS) ambulances.

Performance Measure #66

- 66 c. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric emergencies.

Performance Measure #66

- 66 d. The percentage of hospitals in the State/Territory that have written pediatric inter-facility agreements.
- 66e. The percentage of hospitals in the State/Territory that have written pediatric inter-facility guidelines.

Performance Measure 67

- The adoption of requirements by the State/Territory for pediatric emergency education for the recertification of paramedics.

Performance Measure #68

- The degree to which the State/ Territory has established permanence of EMSC in the State/Territory EMS system.
 - Measure 68 is comprised of 4 sub-measures (68 a, b, c, and d).

Performance Measure #68

- 68 a. The establishment of an EMSC Advisory Committee within the State/Territory.
- 68 b. The incorporation of pediatric representation on the State/Territory EMS Board.

Performance Measure #68

- 68 c. The establishment of one full time equivalent (FTE) EMSC Manager that is dedicated solely to the EMSC Program.
- 68 d. The integration of EMSC priorities into existing EMS or hospital/ healthcare facility statutes/ regulations.

Improving Offline and Online Medical Direction for Pediatric Patients Details of Performance Measure 66a.

- Goal: By 2011, 90% of pre-hospital provider agencies in the State/Territory will have on-line and off-line pediatric medical direction at the scene of an emergency for BLS and ALS providers.

Performance Measure #66a Definitions

- **Pre-hospital provider agencies:** Licensed/certified/designated agencies with the primary responsibility of delivering care to pediatric patients during an emergency and transporting them to the hospital; unlicensed agencies and air ambulances are excluded.
- **Pediatric:** Persons up to 18 years old.

Definitions: Medical Control

- On line – Medical Direction
- Off line – Protocols

Model Pediatric Protocols

Developed by the National Association of EMS Physicians.

Currently being revised.

Separate pediatric protocols vs. integrated pediatric protocols?

www.naemsp.org

Other Resources

- CPEM TRIPP
- AHA Pediatric Advanced Life Support Guidelines
- EMSCNRC has access to some existing state pediatric models of protocols (i.e. Illinois).

Other Resources

- ACEP and AAP will be available to assist in identifying members in your state to assist in providing guidance with protocols and pediatric medical direction.

- Children's hospitals in your states may be willing to provide support and leadership in developing protocols and identifying individuals in their area as well as referring facilities to assist in provision of pediatric medical direction.

How Can You Assist Your EMSC Grant Program?

- Provide guidance to services/agencies as they begin the process of protocol development.

How Can You Assist Your EMSC Grant Program?

- Provide template language for on line pediatric medical direction agreements that agencies may use without developing their own.

How Can You Assist Your EMSC Grant Program?

- Assist in developing a process for monitoring, i.e.
 - Agency protocol development
 - Adoption and utilization of the protocols
 - Identification of pediatric on line medical directors

How Can You Assist Your EMSC Grant Program?

- Participate in your state EMSC Advisory Committee and provide support for adoption and development of EMSC on-line, off – line medical guideline development and adoption.

How Can You Assist Your EMSC Grant Program?

- Monitor individual agency accountability for both off-line protocol and on line pediatric medical direction
 - i.e. Have agencies submit to office of EMS a copy of their pediatric off line protocols as well as signed agreement for provision of pediatric on line medical direction.

How Can You Assist Your EMSC Grant Program?

- Assure that this topic is integrated into and remains on EMS Board agenda as priority for discussion holding all services in the state accountable for such.
- Once protocols are developed and adopted agencies will need to consider and incorporate changes and updates in guidelines as treatments and evidence evolves.

Methodology for Pediatric Protocol Development: Maryland Institute for Emergency Medical Services Systems (MIEMSS)

- “Champion” identification
- Comprehensive review of published literature
- Review of available EMS jurisdictional protocols
- Consultation with Pediatric Quality Improvement Committee (privileged & confidential)
- Vetted by the Pediatric Emergency Medical Advisory Committee (PEMAC) protocol subcommittee

Methodology for Pediatric Protocol Development: Maryland Institute for Emergency Medical Services Systems (MIEMSS), continued

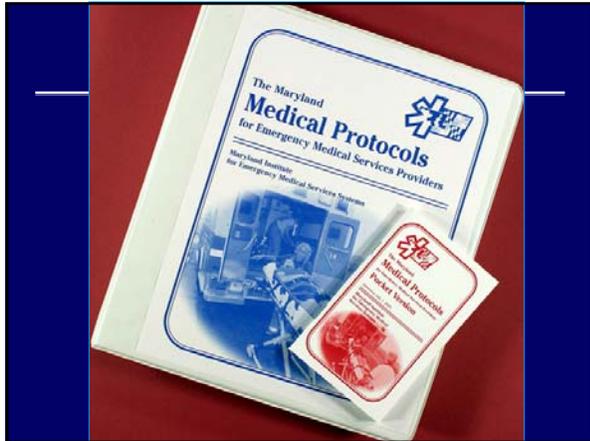
- Consensus within the overall PEMAC
- PEMAC recommendation to the Protocol Review Committee (PRC)
- PRC recommendation to the EMS Board
- Spring protocol roll-out, July publication
- Coordination with PEMAC education subcommittee

Apparent Life-Threatening Event

D. APPARENT LIFE-THREATENING EVENT (ALTE) (NEW '05)



1. Initiate General Patient Care.
2. Presentation
An episode in an infant or child less than 2 years old that is frightening to the observer and is characterized by some combination of the following:
 - a) Apnea (central or obstructive)
 - b) Skin color change: cyanosis, erythema (redness), pallor, plethora (fluid overload)
 - c) Marked change in muscle tone
 - d) Choking or gagging not associated with feeding or a witnessed foreign body aspiration



Integration: Benefits

- An identified “seat at the table”
- Education and training: Less intimidating for field providers
- Pediatric content can’t get lost

Integration: Challenges

- Subject to larger EMS bureaucracy
- May be struggle to be heard, i.e. competition with other constituents
- Constant need to articulate the unique needs of children.

DC-EMSC: State Partnership Grant #2 [March 2000]

Building Capacity for Prehospital Pediatrics:

- Complete review, revision and update of the pediatric pre-hospital treatment protocols, customized from the National Association of EMS Physicians (NAEMSP) Model Pediatric Protocols template.

Prehospital Emergency Care, 2000;4:111

Prehospital Emergency Care, 2004;8:343

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Deputy Director for Medical Affairs
1000 Pennsylvania Avenue, NW
Office of Emergency Health and Medical Services

October 18, 2001

Fire Chief Ronald Finn
Chief of Columbia Fire and EMS
1923 Vermont Avenue, NW
Washington, DC 20001

Dear Fire Chief Finn:

We are pleased to inform you that the Department of Health has approved the pediatric protocols revised for DC Fire and EMS by the Emergency Medical Services for Children (EMSC) partnership project based in the Division of Emergency Medicine and Trauma Services at Children's National Medical Center.

We recommend the Fire and EMS Department make these protocols operational within 30 days of the approval date. The only noted exception to full implementation is the seizure protocol. The addition of Diazepam as a therapeutic modality for the emergency treatment of seizures is pending the introduction of emergency legislation by the Department of Health. Upon passage and promulgation, DC Fire and EMS will have 30 days to introduce Diazepam to the formulary.

The protocols are approved as written by the EMSC partnership project and can not be edited without the approval of the Department of Health. All requests for revision or comments should be directed to the EMSC partnership team at Children's National Medical Center.

Sincerely,
Larry Siegel, MD
Senior Deputy Director for Medical Affairs

cc: Fernando Daniels, MD Medical Director, DC Fire and EMS
Chief Danny Mann, Training Coordinator, DC Fire and EMS
Sherry B. Adams, RN, Executive Director, OEDMS
Joseph Wright, MD Children's National Medical Center
Taraeene Singh, Children's National Medical Center

815 N. Capitol Street, N.E., Suite 1010 Washington, D.C. 20002 (202) 462-5844 Fax: (202) 462-5829

only noted exception to full implementation is the seizure protocol...addition of Diazepam is pending the introduction of emergency legislation by the Department of Health (to the City Council)...

- Pediatric Protocols approved October 2001
- EMSC Partnership team installed as responsible entity for revisions and updates

Separate: Benefits

- Flexibility of autonomy
- Emphasizes unique needs of children
- Pediatric expertise is valued

Separate: Challenges

- May get "lost"
- Training issues
- Ownership
 - May need to be revised at different times

Other Challenges

- Lack of a single unifying agency or system
- Rural/remote areas
- Need for "pediatric presence"
