Innovation and Improvement Center
EIIC
Emergency Medical Services for Children

EMSC*Pulse*

An online digest of EMSC Program News and Activities from the EIIC

EMSC and the Blueprint for Children

Established in 1984, Emergency Medical Services for Children (EMSC) is a federal initiative designed to improve emergency medical services (EMS) and reduce death and disability for critically ill or injured children. Since its inception, EMSC has increased awareness and resources to support the unique needs of children in the EMS system.

EMSC awards grants to improve pediatric EMS, provide pre-hospital and acute care training in pediatric emergency care, develop new programs, and promote public awareness of the vulnerability of children in the EMS environment. These grants funds have led to the establishment of EMS guidelines, protocols, and equipment list; formation of advisory committees and national/state partnerships; and identification of quality improvement strategies for children in the EMS system.

In "*Blueprint for Children: How the Next President Can Build a Foundation for a Healthy Future*", the American Academy of Pediatrics' (AAP) highlights EMSC as a priority area for the incoming federal administration. The AAP recommends the administration "support and expand the existing EMSC program using as a basis the 2015 comprehensive assessment of pediatric readiness of emergency departments and the positive effect of pediatric emergency care coordinators on readiness".

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EMSC All Grantee Program Meeting | Arlington VA | August 15-17, 2017

ECHO Act Signed into Law

On December 14, 2016, the President signed the Expanding Capacity for Health Outcomes Act (ECHO Act, https://www.govtrack.us/congress/bills/114/s2873) which tasks the Secretary of Health and Human Services with studying telehealth models and summarizing the analysis of how these technology enabled learning and capacity building models address disease management, health care workforce, public health, health care delivery in rural, remote and medically underserved areas, and barriers to the utilization of telehealth. The Secretary must also list models that have been funded, recommendations to reduce barriers, opportunities to increase adoption and application of models to life-long learning.

Although often used interchangeably, the terms telehealth and telemedicine have somewhat different intent and meaning. Telemedicine, a more restrictive term, is the provision of clinical services using technology assistance, whereas telehealth is more inclusive including clinical care, health education (of patient and providers), public health and health administration.

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My Days as an EMSC State Partnership Grantee – Morgan Scaggs of Kentucky

The activities of an EMSC State Partnership (SP) Grantee are NEVER the same, by day or by location. In recent issues, the EMSCPulse has featured SP Program Managers describing activities in their territory. This article is the result of an interview with Morgan Scaggs, AA, NRP, EMSC Program Director for Kentucky.

Hello from the Bluegrass state! In 2011, I began looking for a new challenge and an opportunity to relocate from South Carolina to Kentucky (KY) to enable both my 2 year old son and myself to be closer to family. By that time my career had included work in pre-hospital EMS, the fire service, hospital emergency department, critical-care transport, injury prevention programs, and EMS education. When I stumbled across the job posting for the EMSC Project Director position in KY, I realized I had a great foundation for the job. Luckily for me, the hiring committee agreed and I began my work here in July of 2011.

Settling into the Kentucky Board of EMS (KBEMS) office, I found support for the program but was quick to recognize colleagues had little understanding of day-to-day responsibilities, challenges or opportunities I would face in this position. Fortunately, Dr. Mary Fallat (the driving force behind EMSC in KY for many years) served as an amazing resource and mentor. Attending national meetings and interacting with other program managers was an invaluable source of information and support as I learned more about my new role.

Building relationships can be a slow process. I have come to realize that it is the key to everything I do. Many days, time is spent attending meetings and working on projects that do not seem to be the central focus of my position; but those activities are investments that pay off in the future.

Working with the KBEMS Education Committee allowed me to influence education standards and regulations while helping to identify future members for my Advisory Committee and work groups for special projects such as the pediatric recognition program for EMS agencies.

Teaching a class for Kentucky EMS instructors on Pediatric Abusive Head Trauma led to greater interagency recognition that Kentucky EMSC can be a resource for pediatric emergency care needs. I receive phone calls and emails weekly from training officers and agency directors looking for guidance on pediatric education, protocols, and QI activities. Recently, a request was received from an agency director who had an employee struggling after a difficult pediatric call and was seeking advice on how to help.

Attending meetings of the Trauma Advisory Committee and the Health and Medical Preparedness Advisory Committee has led to closer relationships with individuals working with the KY Hospital Association, the Hospital Preparedness Program, and our two children's hospitals. These relationships have been crucial in building a statewide coalition to work on pediatric readiness and facility recognition while participating in the EMSC Facility Recognition Collaborative. As an EMS provider, I enjoyed direct patient interaction and felt I had made an impact in a number of patients' lives.

MORGAN SCAGGS, AA, NRP, EMSC PROGRAM DIRECTOR FOR KENTUCKY

As an EMS Educator, I missed patient contact, but I realized that by shaping the knowledge, skills, and attitudes of many individual EMS providers, I was potentially improving the care of many more patients than I could reach alone. Now, my work is further removed from the bedside; but I have the opportunity to shape the emergency medical system to improve care for children statewide. Interpersonal relationships and collective effort make the system more than the sum of its parts. It is never a waste of time to cultivate connections with people and organizations… those connections are the bridges you need to reach your goals!

ECHO Act *continued from page 1*

Three models are as follows, including two with EMS for Children funding:

1. **Project ECHO**, a global program developed at the University of New Mexico (UNM), began as a provider to provider consultation service to co-manage the care of Hep-C patients. It has expanded to a global program encompassing a variety of diseases and provider audiences. Direct patient care is not included in this model.
2. **University of California-Davis** has a well-developed telemedicine clinical service providing direct patient care by pediatric intensivists regionally to rural hospitals. Dr. James Marcin, a leader in the field, has received two EMS for Children, State Partnership Regionalization of Care (SPROC) Grants for the project.
3. **UNM- The Child Ready Virtual Pediatric Emergency Department (Child Ready-VPedED) Telehealth network** provides both direct patient care and provider education across this regional network of rural, remote and tribal facilities. It was grown from the HRSA EMS for Children-SPROC and the Office Rural Health Policy Grant programs.

Blazing Trails in Prehospital Care through Targeted Issues Grants

HRSA and the EMSC Program present a webinar updating two of the 2013 Targeted Issues projects **on January 31, 2017, 1-2:30 pm ET. Blazing Trails in Prehospital Care through Targeted Issues Grants:** The Center for Rural Emergency Services and Trauma (CREST) Network for EMS Providers & Pediatric Evidence-Based Guidelines Assessment of EMS System Utilization in States (PEGASUS).

Speakers will be Drs. Tom Trimarco & Manish Shah, principal investigators for each grant. Diane Pilkey, RN, MPH will moderate.

This webinar is approved 1.5 credits through the Commission on Accreditation for Pre-Hospital Continuing Educations (CAPCE) and for 1.58 continuing nursing education credits through Texas Children's Hospital at no charge.

Registration is required: Click here for info and registration.

HRSA Welcomes New EMSC Public Health Analyst

The HRSA MCHB Division of Child, Adolescent and Family Health, Emergency Medical Service for Children (EMSC) Program would like to introduce Lorah Ludwig; newest addition to the staff. Lorah joins HRSA as a Public Health Analyst from the United States Peace Corps where she served as a Community Health Specialist. She lived and integrated at the community level in Peru to successfully collaborate with local, regional and national institutions to design, plan, manage, and evaluate two principle programs addressing community health priorities. Lorah also served as a gender equality committee representative/liaison for the northern region of Peru for all gender-related projects, resources, and activities.

Before her work with the United States Peace Corps, Lorah was a licensed Emergency Medical Technician and worked for the Gift of Life Donor Program as an In-House Tissue and Organ Transplant Coordinator. In this position, she collaborated with hospitals, surgeons, tissue processing agencies, state organ procurement organizations, and transplant teams to coordinate hundreds of life saving organ and tissue donations. Lorah obtained her degree in Health Science/Public Health from Boston University. She is originally from Philadelphia and recently moved to Friendship Heights, Maryland. Her interests include travel, yoga, nature, philosophy, and she loves macaroni and cheese.

LORAH LUDWIG -- NEW EMSC PUBLIC HEALTH ANALYST

In her new role, Lorah will serve as a Project Officer overseeing EMS for Children grant programs. Please help us welcome Lorah to HRSA. You may reach Lorah by email at LLudwig@hrsa.gov.

EMSC*Pulse* welcomes articles about people, programs, and initiatives related to emergency medical services for children. Submit to EMSCInnovation@TexasChildrens.org

EMSC Publications

- National Association of EMS Physicians. **Physician Oversight of Pediatric Care in Emergency Medical Services.** *Prehosp Emerg Care*. 2017. 21(1): 88, DOI: http://dx.doi.org/10.1080/10903127.2016.1229826
- Remick K, Gross T, Adelgais K, Shah MI, Leonard JC, Gausche-Hill M. **Resource Document: Coordination of Pediatric Emergency Care in EMS Systems.** *Prehosp Emerg Care*. 2017; early online publication ahead of print. http://dx.doi.org/10.1080/10903127.2016.1258097
- Genovesi AL, Olson LM, Telford R, Fendya D, Schenk E, Morrison-Quinata T, Edgerton EA. **Transitions of care: The presence of written interfacility transfer guidelines and agreements for pediatric patients.** *J Pediatr Emerg Care.* At press.

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The assessment, "National Assessment of Pediatric Readiness of Emergency Departments", published in JAMA Pediatrics, provides the initial findings of the Peds Ready assessment by EMSC. The AAP also recommends funding increase in order to "promote the quality of care provided in the pre-hospital and hospital setting, reduce pediatric mortalities due to serious injury and support rigorous multi-site clinical trials."

Reducing pediatric death and disability is a shared priority for both the AAP and EMSC. With a new administration in office and potential changes in health policy priorities, it is important that EMSC continue to be a voice for vulnerable children in order to improve care and outcomes for children in the EMS system.

Save the Dates!

- **TI Grantee Webinar** — Two 2013 Targeted Issue (TI) grant recipients will present a webinar ***January 31, 2017, 1-2:30pm ET***. Continuing education credits will be provided to those who attend the live presentation. You **must register** to attend. See page 3 of this issue for more information.
- **EMSC Town Hall Webinar** --Quarterly update from HRSA for all State Partnership grantees has been changed to ***February 21, 2017 4-5 pm ET***. HRSA will provide web conference information to attendees.
- **Introducing Stop the Bleed to the EMSC Community**—A webinar presentation by Dr. Mary Fallat, Dr. Lenworth Jacobs, and Rick Patrick of U.S. Department of Homeland Security. ***March 29, 2017, 3-4pm ET***. Registration will be posted on EIIC site under "Webinars."
- **2017 American Academy of Pediatrics Section on Emergency Medicine/Section on Hospital Medicine, Leadership Development Conference**. ***April 7-9, 2017*** in St. Petersburg, FL, Conference for PEM and PHM providers, including those from community and children's hospital settings, experienced leaders and leaders-in-the-making and learners of all levels of training. Registration now open!
- **EMSC All Grantee Program Meeting** will be held in Arlington VA on ***August 15-17, 2017***. More details and targeted meeting dates by program to come soon!
- Join safe sleep experts in Pittsburgh, PA, ***April 25-28, 2017*** for the **5th National Cribs for Kids® Infant Safe Sleep Conference: "Beyond the Safe Sleep Message – Cultivating Community Collaborations"**. This conference addresses the need to further reduce infant mortality rates locally and nationally by: targeting and utilizing existing program resources; creating partnerships through community leadership collaborations; providing organizations with the tools needed for a unified infant safe sleep effort. Register here.

Resources Available within HHS

The Assistant Secretary for Preparedness & Response (APSR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) ListServe sign up here: https://asprtracie.hhs.gov

Welcome to the EMSC

Kansas — Tracy Cleary is returning as the Kansas EMSC Coordinator. She can be reached at tracy.cleary@ks.gov or 316-337-6050.

Ohio — Christina J. Wedding has joined the OHIO team a part of the Family Advisory Network. You can reach her via email at cwedding@icloud.com .

Job Opportunity

New Hampshire is seeking a new **EMSC Program Manage**r. To view the position description / submit an application, click here and use 'EMSC' as the key word.

CDC Report Shows Costs of Fatal Injuries for States in 2014

Text from the CDC National Center for Injury Prevention and Control, Division of Violence Prevention Announcement

Injuries created a significant economic burden on states in 2014, according to a Morbidity and Mortality Weekly Reports (MMWR) released January 12, 2017 by the Centers for Disease Control and Prevention (CDC). The report is the *first study on the state-level economic burdens of injuries*. Numbers and rates of fatal injuries, lifetime (medical and work-loss) costs, and lifetime costs per capita were calculated for each of the 50 states and the District of Columbia (DC) and for unintentional injuries and violence, including suicide and homicide.

Key Findings

- Injury death rates and economic states and DC.
- The 5 states with the highest lifetime costs per capita were New Mexico ($1,233, death rate 101.9 per 100,000), West Virginia ($1,162, death rate 98 per 100,000), Alaska ($1,091, death rate 85.8 per 100,000), Louisiana ($1,041, death rate 77.5 per 100,000), and Oklahoma ($1,040, death rate 88.8 per 100,000). The 5 states with the lowest lifetime costs per capita were New York ($491, death rate 40.2 per 100,000), New Jersey ($533, death rate 44.4 per 100,000), California ($538, death rate 44.9 per 100,000), Massachusetts ($550, death rate 47.4 per 100,000), and Minnesota ($557, death rate 54.3 per 100,000).
- For unintentional injuries, West Virginia had the highest ($815) and Maryland had the lowest lifetime costs per capita ($261).
- For suicides, Alaska had the highest ($338, death rate 22.0 per 100,000) and New Jersey had the lowest lifetime costs per capita ($107, death rate 8.3 per 100,000).
- For homicides, DC had the highest ($273, death rate 13.2 per 100,000) and Hawaii had the lowest lifetime costs per capita ($24, death rate 2.3 per 100,000).
- New York, New Jersey, and California ranked among the 5 lowest lifetime costs per capita for fatal injuries. In contrast, New Mexico ranked among the 5 highest lifetime costs per capita for fatal injuries.

Increasing Incidence and Economic Burden of Injuries Call for Effective Prevention Strategies

The total lifetime medical and work loss costs of fatal injuries in the United States was $214 billion in 2013. From 2005 to 2014, the number of unintentional fatal injuries increased from 117,809 to 136,053 and unintentional injury moved up from the 5th to the 4th leading cause of death. Similarly, the number of suicides rose from 32,637 to 42,773 and suicide moved from the 11th to the 10th leading cause of death.

The Injury Center empowers and equips states with the resources and information to address the most

pressing injury and violence issues including prescription drug overdose, child abuse and neglect, traumatic brain injury, motor vehicle crash injury, suicide, and intimate partner/sexual violence. Visit our funded programs web page to learn how the Injury Center works with states to help implement and promote life- and cost-saving injury and violence interventions.

Learn More

- Read the article in MMWR.
- Visit the CDC Injury Center web site for information about injury prevention and cost of injuries.

Call for Speakers --New Jersey Statewide Conference on EMS

-- Proposals accepted through 3/15/17

The NJ EMS Conference Committee is seeking experienced speakers from the EMS, hospital, and preparedness community to deliver a variety of presentations.

To submit a proposal for the 2017 NJ Statewide Conference on EMS, please visit: www.NJEMSConference.com