

Share and Learn Conference Call

Date: September 8, 2008
Time: 2:00p.m. to 3:30p.m. EST
Topic: Performance Measure PM 66a (On-line and Off-line Medical Direction)
Facilitator: Diana Fendya, MSN (R), RN, EMSC NRC Trauma/Acute Care Specialist

Participating Grantees:

1. Alabama, Ann Klasner
2. Alaska, Raj Maskay
3. Delaware, Marie Renzi
4. Illinois, Susan Fuchs
5. Maryland, Cynthia Wright-Johnson
6. Massachusetts, Deborah Clapp
7. Minnesota, Kristi Berg
8. New Hampshire, Janet Houston
9. New York, Martha Gohlke
10. North Dakota, Kelli Rice
11. Ohio, Joe Stack
12. Pennsylvania, Beth McAteer
13. Pennsylvania, Steve Mrozowski
14. Puerto Rico, Wanda Arbelo
15. South Dakota, Amy Marsh
16. South Dakota, Dave Boer
17. Tennessee, Rhonda Phillippi
18. Wisconsin, Joyce Andersen
19. Wyoming, Carol Zorna

NEDARC Attendees:

Mike Ely, Andrea Genovesi, Patty Schmuhl, Craig Hemingway and Kent Paige

NRC Attendees:

Tasmeen Singh, Diana Fendya, Jocelyn Hulbert, Gayathri Jayawardena and Theresa Morrison-Quinata

Pennsylvania's Offline Pediatric Protocols

Beth McAteer, EMSC Program Manager for the state of Pennsylvania explained the process used to develop and distribute standardized EMS protocols throughout the state.

Pennsylvania is divided into 16 regions with each having their own EMS council and EMS director. As a result, 16 different sets of protocols existed which guided the off-line practice of EMS providers in the state. Providers serving in urban and rural locations and the distances involved in transporting and providing care for pediatric patients complicated the development of one standardized set of protocols to meet the needs of all providers in the state. However, the state's EMS regulations require that all protocols be developed in consultation with the regional medical advisory committee and they must be approved by the EMS Department; therefore, this required process was utilized to standardize the EMS protocols.

In November of 2004 Pennsylvania began phasing in statewide protocols for off-line medical direction. The first step was to develop the statewide BLS protocols and then integrate the pediatric components; these went into effect in July of 2005. During the initial roll out, 20,000 providers took part in an online class at a state conference held in August of that year. The following year efforts focused on the development of statewide ALS protocols, again with integrated pediatric sections.

In 2007, as EMS providers applied for EMT re-licensing, the Pennsylvania EMSC program sent out a pocket guide of protocols to each provider with their renewed license. Both sets of protocols are also posted on the Pennsylvania EMS website. Pennsylvania protocols are updated every two years. Having consistent pediatric BLS and ALS statewide has worked well and has assured consistency of care for all children across the state.

To learn more about Pennsylvania's pediatric EMS medical direction, contact Beth McAteer at bmcateer@state.pa.us.

Maryland's Online and Offline System

Cynthia Wright-Johnson, EMSC Program Manager for the state of Maryland, shared how the EMS system has evolved over the years.

Maryland has statewide pediatric protocols for both on- and off- line medical direction. In the late 90's pediatric components were integrated into all protocols. At present, online medical direction is provided by designated EMS base stations which have evolved over a 10-year period. Each base station must comply with state regulations that include application, participation in a standardized base station course and site visits which occur on a 5-year cycle. All base stations utilize the same statewide BLS and ALS EMS Protocols for online medical direction. Statewide pediatric medical direction for both trauma and medical emergencies is provided by two pediatric base stations which were defined in the mid 1990s. Pediatric base stations also provide consultation for community hospitals.

Offline EMS protocols are revised on an annual basis. Each year, new protocols are provided to all hospitals via a DVD with an accompanying teaching program covering all changes. To reach EMS personnel, protocols and their changes are posted on the Maryland EMS website and webcasts are held which provide an opportunity for feedback on the changes.

During pediatric trauma and medical emergencies, Maryland EMS providers are instructed to call the pediatric base station for online medical direction and parents are directed to call the local hospital and/or the children's hospital. Pediatric EMS base stations are codified into law and must be specialty centers for pediatrics.

To learn more about Maryland's pediatric EMS medical direction, contact Cynthia Wright-Johnson at cwright@miemss.org.

Illinois' Online and Offline System

Susan Fuchs, MD, FAAP, FACEP, the state of Illinois, Associate Director of Pediatric Emergency Medicine, Children's Memorial Hospital, explained how pediatric protocols were developed in the state.

Illinois formed a prehospital committee in 1994. The first pediatric-specific prehospital protocols were developed in 1997 (18 were developed originally). Prior to that time each agency only had one or two pediatric specific protocols. Recently efforts were undertaken by a multidisciplinary group to update the original 18 protocols and add an additional 5 new protocols, including a pediatric AED protocol. These protocols are used by all levels of EMS providers (EMT-B, EMT-I and EMT-P) including the Emergency Medical Responders (EMR). Protocols are set-up in an algorithm format for ease of use onto one page.

Dr. Fuchs also added that creating and implementing a statewide document that included input from numerous individuals and organizations emphasized the need for vital collaborations with key individuals in numerous agencies, associations, and other entities. Obtaining consensus among these groups was critical.

To learn more about Illinois' pediatric protocols, contact Dr. Susan Fuchs at s-fuchs@northwesterns.edu

Participant Questions & Comments

Question 1: How are states educating providers as protocols are updated?

Maryland indicated that they have a roll out process for protocol update that includes trainings at the agency level.

Pennsylvania regularly reviews and updates their protocols and utilizes service/regional medical directors to assist with dissemination. They have also found it successful to utilize processes that get the information out directly to the providers – informing the grassroots. Initially the small pocket editions of all ALS and BLS protocols with the integrated pediatric components were provided to all providers as they applied for re-licensure. All protocols with identified changes are also posted on their state EMS website for both providers and directors.

Question 2: How do we keep up with the education requirements for small town ambulance services with small pediatric call volumes?

Potentially you could have providers and medical directors track specific skills that one assumes improve with increased frequency i.e. “number of intubations having been performed in the last year” and use that as a measurement of whether or not they need to update their skills in intubation. Keep in mind though that at this time there are no standards, based on evidence, supporting a particular number or opportunities of skills to verify proficiency.

Comment 1:

Statewide pediatric protocols could provide a basis for pediatric performance improvement initiatives in states – i.e. pediatric medication protocols could facilitate monitoring the appropriate utilization and dosage of medications for specific diagnoses. Such information could then be utilized to plan remedial education on protocols and processes that were not implemented appropriately.

Comment 2:

Our state has statewide protocols but since “access” is defined as being available on the EMS provider or patient care unit 24/7, the state is not in compliance with the measure. The cost of photocopying these paper protocols is very expensive. The hospitals have the hardcopy and providers have the pocket reference cards. It is also not always feasible to have the protocols available in rural areas because of the limited technology and limited access to computers.

When feasible, having web base access to protocols available is very helpful. Many services/providers have gone to protocols being downloadable to a PDA which is carried on the rig or by the provider.

Comment 3:

A binder with all the protocols for BLS and ALS listed in them could be monumental in size, especially if the state also includes hospital information in the binder. Consideration should be given to protocols separated into algorithms, medication dosages, and patient care, and consider excluding the list of all the hospitals in order to remain efficient. Therefore it may be easier to update and reprint only individual sections as they are regularly reviewed and revised.

Comment 4:

The 2009 grantee meeting should offer a forum for medical directors to gather and hear success stories on performance measure achievement.

Comment 5:

To review and update protocols regularly, a multidisciplinary approach may be helpful.

**Next Share and Learn Conference Call
Monday, October 20th
PM 66b – Pediatric Equipment - Mark Your Calendars Now!**