EMSC NATIONAL RESOURCE CENTER

Share and Learn Conference Call

Date: October 8, 2008
Time: 2:00p.m. to 3:30p.m. EST
Topic: Performance Measure PM 66b (Pediatric Equipment)
Facilitator: Jocelyn Hulbert, EMSC NRC Outreach Coordinator

Participating Grantees:

1. Alabama, Ann Klasner
2. Alaska, Raj Maskay
3. Florida, Patricia Kenyon
4. Georgia, Tracie Al'Belar
5. Idaho, Rachael Alter
6. Iowa, Katrina Altenhofen
7. Kansas, Sarah House
8. Louisiana, Debbie Huffman
9. Maine, Jan Brinkman
10. Maryland, Cynthia Wright-Johnson
11. Massachusetts, Deborah Clapp
12. Minnesota, Kristi Berg
13. Missouri, Paula Adkison
14. New Jersey, Eric Hicken
15. New York, Martha Gohlke
16. North Carolina, Gloria Hale
17. Ohio, Joe Stack
18. Oklahoma, Paul Marmen
19. Pennsylvania, Jeannette Kearney
20. Puerto Rico, Wanda Arbelo
21. Puerto Rico, Milagros Martin de Pumarejo
22. South Dakota, Amy Marsh
23. South Dakota, Dave Boer
24. Tennessee, Rhonda Phillippi
25. Texas, Beverly Willis
26. Utah, Kristin Gurley
27. Virginia, David Edwards

NEDARC Attendees:
Colleen Cummins, Mike Ely, Patty Schmuhl, Craig Hemingway, and Kent Paige

NRC Attendees:
Diana Fendya, Jaclynn Haymon, Jocelyn Hulbert, Gayathri Jayawardena, and Rinal Patel

South Dakota's Pediatric Equipment Best Practice Initiative

Dave Boer, EMT-P, MBA, EMSC Program Manager for the State of South Dakota explained the process of acquiring and distributing pediatric equipment throughout the State.

In the mid-1990's South Dakota made its first attempt to ensure that EMS ambulances had appropriate equipment to provide emergency care for children. However, it was not until the establishment of EMS regulation equipment changes in 2006 and the establishment of a partnership with the Department of Health (DOH) that the S. Dakota EMSC program was able to target pediatric equipment for all services. South Dakota's plan was to replicate efforts of Iowa and Nebraska who had worked with another partner organization, the Kiwanis, to provide pediatric equipment bags and training to every ambulance service across their states .

South Dakota's EMSC survey results for this measure identified the following gaps:

- Most services had a majority of equipment but were missing a few sizes of specific items (most of which were inexpensive to replace).
- Many services were missing a pediatric mobilization board.
- Almost all the services had pediatric equipment displaced all over the unit and disorganized rather than in one place.

To help EMS be more prepared for children, South Dakota EMSC wanted all ambulances to have an organized pediatric bag with all the recommended essential equipment pieces. The EMSC Program had previously worked with the DOH on other initiatives i.e. the Poison Control Program. The EMSC manager contacted the DOH Director who was willing to partner in the provision of funds for the pediatric equipment bags. This would help with disaster preparedness efforts and planning - ensuring that the needs of special populations, which children are a part of, would be being addressed.

The South Dakota EMSC Program purchased and distributed the equipment bags to all services, one for each ambulance. In addition the EMSC Program put into place a two-year training program, which included a review and proper use of all pediatric equipment in the bag such as the length based treatment tape.

By assuring that all EMS ambulances had a fully equipped bag with pediatric equipment, the EMSC program was then positioned to work with the state's Governor's EMS Advisory Board to pursue rules and regulations requiring the essential pediatric equipment. Initially, there was some hesitancy to impose a financial burden related to equipment purchase on the units; however, when the EMSC program reassured that all essential equipment would be paid for by DOH and EMSC, the writing of regulations -- including required pediatric equipment -- was pursued by the committee enthusiastically. In October 2007, South Dakota was able to get their EMS rules changed to incorporate pediatric equipment.

The data collection process pursued by EMSC allowed the EMSC program to identify the gaps , missing equipment and providers' lack of knowledge of how to use some of

the equipment. Having a partnership was advantageous in making the needed equipment become a reality for providers. Prior work and support with the Department of Health and Poison Control led to this partnership which allowed S. Dakota EMSC to meet performance measure 66a.

To learn more about South Dakota's availability of pediatric equipment, please contact Dave Boer at dboer@usd.edu.

Missouri's Pediatric Equipment Best Practice Initiative

Paula Adkison, EMSC Program Manager for the State of Missouri, explained the process of supporting EMS services in the provision of essential pediatric equipment on all ambulances in her state.

Paula works for the Bureau of EMS under the Department of Health. A pediatric subcommittee that also functions as the EMSC Advisory Committee falls under the EMS State Advisory Committee (SAC). Missouri conducted an informal survey (prior to NEDARC's survey tool) of all EMS services. The survey measured the number of response calls, types of rigs (ALS vs. BLS), availability of education on resuscitation, types of ongoing education, and the specific needs of that unit. Survey results identified the following:

- Equipment age was old,
- Equipment was missing,
- Correct sizes were not always available,
- Providers were often not aware of how to use the equipment.
- A lack of continuing education on pediatric patient care.

In Missouri, patient care protocols are mandatory for all services while equipment is not. The Missouri EMSC Advisory Committee wanted to make sure that all ambulances had the required essential pediatric equipment. EMSC Advisory committee members developed a voluntary pediatric equipment inspection process. The EMSC inspection process proposed had no authority over the services or over the equipment ambulances carried. EMSC Committee members wanted to make sure that the voluntary inspection process was not perceived by agencies as being punitive if a unit did not have the proper equipment. Missouri sought to help these units understand the need for individual equipment requirements while assisting to create partnerships to facilitate funding if needed.

As agencies are inspected, if all required pediatric equipment is available on the ambulances, the inspection team awards the agencies with a sticker for each ambulance in the service. The sticker denotes that these vehicles are prepared for children and pediatric friendly. Also as part of the recognition ceremony, the local media (both news stations and newspapers) is invited to highlight the event. For services with large numbers of ambulances, where inspection of all vehicles would be difficult, the team is reviewing service protocols and the director's list of required ambulance equipment. If the ambulance manager attests to all required equipment being available on all ambulances and agrees to sign an affidavit stating such, then the service is also

recognized with stickers and publicity. This seemed to be the most effective way to go about instituting the inspection process for large services where it would nearly be impossible to look at all the trucks. The sticker program has been well received and many agencies have wanted the inspection team to come and inspect them..

Missouri has 6 regions within the state and one region has already recognized 100 ambulances. For small rural services this has been a big incentive. It has also provided an opportunity for parents and community individuals to recognize and commend the services for being prepared to provide care for children.

Missouri has first focused on making sure that ambulance services have the proper equipment, and later plans to move onto emergency departments as a step towards pediatric medical categorization.

To learn more about Missouri's availability of pediatric equipment, please contact Paula Adkison at Paula.Adkison@dhss.mo.gov.

Participant's Questions and Comments

Question 1:
How many bags did South Dakota give away and how much did it cost?
In addition to supplying equipment to the 147 ambulance services, bags and crash carts were also purchased for the fifty South Dakota Hospital Emergency Department's. Nearly 500 responder bags cost approximately $300,000. The hospital bags and carts were funded by the hospital preparedness fund.

Question 2:
How did you differentiate ALS, ILS and BLS bags?
Primarily BLS bags were given out; although a note and brochure of ALS equipment was also attached. Recipients were provided color coded inserts for missing ALS equipment to be inserted. There was also a reminder to keep bags replenished. In addition, statewide training was provided

Question 3:
Being a state office, was there any concern over the recognition of services since recognition implies that one service was prepared better than another by the state to provide care for children?
No, since this was strictly volunteer based, the state did not appear to have any concerns. Also voids in equipment have been able to be addressed readily by referring the service to the Children's Miracle Network. They have provided lots of assistance in helping reach rural communities and providing missing equipment so that almost all services surveyed have been able to come up to the required standard..

Question 4:
We have been hesitant to start work on pediatric equipment requirements because of the new equipment list that will be coming out next year (2009). Are you concerned about the

reception of the new list?
We have been telling our agencies about the pending updated ambulance list, and informed them that it would be a size range and not as specific as the current list. We don't anticipate it as a problem. We can't imagine it to be the more expensive equipment.

Question 5:
Only transport vehicles may be equipped with ALS equipment, in my state. Should an equipment bag be accessible for both transport and chase vehicles?
First responders typically are not licensed in S. Dakota, so the focus has been more on ambulance, training entities and EMRV. We are trying to help identify gaps (one being different types of responders).

Question 6:
Do you know when the new National Pediatric Equipment List will come out?
Presently the national organizations are reviewing the list and addressing comments from various committees. We have been told to anticipate the new list in early spring 2009.

Question 7:
There are some agencies that do not carry particular items because it is out of their scope of practice, how do you handle these situations when doing the recognition program*?*
Regardless if equipment is missing because of scope of practice issues, we still provide the services with a note of missing items from the recommended equipment list.

Comment 1:
Partnerships are encouraged to leverage funding (e.g. Kiwanis for BLS bags, Federation of Women help supply bears and blankets).

Next Share and Learn Conference Call
Monday, December 1st
PM 66b – Pediatric Facility Categorization - Mark Your Calendars Now!