



# Town Hall Meeting Conference Call

July 21 and August 11, 2009 from 2-3:30 p.m. EST

Led by:

EMSC National Resource Center  
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Silver Spring, MD 20910  
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[www.childrensnational.org/emsc](http://www.childrensnational.org/emsc)

## Participating Grantees:

Alabama, Ann Klasner	Montana, Bobbi Perkins
Alabama, David	Nevada, Bob Heath
Alabama, Katherine Hert	New Hampshire, Janet Houston
Alaska, Raj Maskay	New Jersey, Eric Hicken
Arkansas, Addie Grigsby-Roshell	New York, Martha Gohlke
California, Donna Westlake	North Dakota, Kelli Rice
Colorado, Lisa Ward	Ohio, Joe Stack
Connecticut, Wendy Wheeler	Oklahoma, Paul Marmen
Connecticut, Kim Dawin	Oregon, Philip Engle
Delaware, Marie Renzi	Puerto Rico, Wanda Arbelo
District of Columbia, Cynthiana Lightfoot	Puerto Rico, Maria Centeno
Georgia, Tracie Al'Belar	Rhode Island, David Parker
Idaho, Rachael Alter	South Carolina, Alonzo Smith
Illinois, Evelyn Lyons	South Carolina, Taffney Hooks
Indiana, Gurinder Hohl	South Carolina, Greg Kitchens
Iowa, Katrina Altenhofen	South Dakota, Dave Boer
Kansas, Sarah House	Tennessee, Rhonda Phillippi
Kentucky, Tom Taylor	Texas, Anthony Gilchrest
Louisiana, Debbie Huffman	Vermont, Peter Otten
Maine, Jan Brinkman	Virginia, David Edwards
Maryland, Cyndy Wright-Johnson	Washington, Scott Hogan
Michigan, Linda Nesbit	Wisconsin, Joyce Andersen
Minnesota, Kristi Moline	

**Federal Staff:**

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Colleen Cummins, Mike Ely, Andrea Genovesi, Craig Hemingway, Kent Page, and Patty Schmuhl

**NRC Staff:**

Karen Belli, Diana Fendya, Jocelyn Hulbert, Gayathri Jayawardena, Tiffani Johnson, Rinal Patel, Theresa Morrison-Quinata and Tasmeeen Singh Weik

**Policy Update provided by Karen Belli, sr. public policy specialist***Fiscal Year 2009 Appropriations*

Last month the House Appropriations Committee passed the Fiscal Year (FY) 2010 Departments of Labor, Health and Human Service, and Education appropriations bill, which includes funding for the EMSC Program. The committee voted on \$21 million for the Program for the upcoming fiscal year (October 1, 2009-September 30, 2010). This is \$1 million more than the Program received this year.

The full Senate has not yet acted upon the bill however the Senate Committee on Appropriations Report (S Rept 111-66) on the Fiscal Year 2010 Departments of Labor, Health and Human Services, and Education appropriations bill is now available at: [Hyperlink to Calendar 149 Appropriations Bill](#). The committee has requested \$22 million for the EMSC Program for the upcoming fiscal year. For information on the EMSC Program, please see pp 49 and 302. The Senate will likely consider the bill after Labor Day when the chamber returns from the summer recess period. After Congress reconvenes in August, the full Senate will pass their version of the appropriations bill to which we will see \$22 million dollars or perhaps more if someone decides to offer an amendment to increase the funding. Subsequently, both chambers will have to agree on which dollar amount (\$21, \$22 or an amount in between) they would like to vote on. For the first time in many years we are hoping to see an appropriations amount in place before October 1, 2009.

*Reauthorization*

At the Annual EMSC Program Meeting, Jacqueline Rychnovsky (staff member representing Senator Inouye's office), mentioned that the health care reform bill being considered by the Senate Committee on Health, Education, Labor and Pension has integrated the language of the Wakefield Act. The inclusion of the Wakefield Act into this legislation provides an additional means to get Program reauthorization passed this year. The stand-alone version of the Wakefield Act, S 408, could also still be considered as well.

Although legislation was passed in committee, there is still a long way to go before any of the health care reform bills becomes law. In fact, the health care reform legislation introduced in the House of Representatives does not include EMSC reauthorization.

Furthermore, the Senate Finance Committee will introduce its own bill, which may or may not include reauthorization for EMSC.

*President Obama's visit to Children's National Medical Center, Washington, D.C.*



President Barack Obama visited Children's National Medical Center on July 20, to learn more about the unique healthcare delivery challenges children's hospitals and pediatric providers face. President Obama held a closed door, roundtable discussion on healthcare reform with six healthcare professionals from Children's National Medical Center. Concerns of physicians, nurses, and physician assistants were shared with the President including improving access to care and the unique challenges of employing new technologies, such as electronic medical records.

One of the six healthcare professionals involved in the roundtable discussion was Joseph Wright, MD, MPH, Medical Director for the EMSC National Resource Center.

### **EMSC New Numbering of Performance Measures presented by Tasmeen Singh-Weik, EMSC NRC Executive Director**

Detail sheets recently e-mailed to all grantees were provided by HRSA and will be used by the developers of the Electronic Handbook (EHB). The detail sheets summarize the numbering of the new performance measures. The Implementation Manual with performance measure changes and the new numbering system will be released in the near future. The implementation manual continues to be the detailed resource that grantees should use for planning purposes.

Each of the sub-measures are now individual performance measures. This will more accurately reflect the progress of grantees and ensure that credit is received for each of the measures met by State/Territories. Previously, grantees had to meet all the sub-components of any one measure to meet the measure. The new numbering system allows State/Territories an opportunity to demonstrate achievement of a greater number of measures as they meet smaller components.

<b>Performance Measure 71</b> (formerly PM 66a (i))	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
<b>Performance Measure 72</b> (formerly PM 66a (ii))	The percent of pre-hospital provider agencies in the State/Territory that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
<b>Performance Measure 73</b> (formerly PM 66b)	The percent of patient care units in the State/Territory that have essential pediatric equipment and supplies as outlined in the national guidelines.
<b>Performance Measure 74</b> (formerly PM 66c medical)	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
<b>Performance Measure 75</b> (formerly PM 66c trauma)	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
<b>Performance Measure 76</b> (formerly PM 66d)	The percent of hospitals in the State/Territory that have written interfacility transfer guidelines that cover pediatric patients and that include pre-defined components of transfer.
<b>Performance Measure 77</b> (formerly PM 66e)	The percent of hospitals in the State/Territory that have written interfacility transfer agreements that cover pediatric patients.
<b>Performance Measure 78</b> (formerly PM 67)	The adoption of requirements by the State/Territory for pediatric emergency education for license/certification renewal of BLS/ALS providers.
<b>Performance Measure 79</b> (formerly PM 68a,b,c)	The degree to which State/Territories have established permanence of EMSC in the State/Territorial EMS system by establishing an EMSC Advisory Committee, incorporating pediatric representation on the EMS Board, and hiring a full-time EMSC manager.
<b>Performance Measure 80</b> (formerly PM 68d)	The degree to which State/Territories have established permanence of EMSC in the State/Territorial EMS system by integrating EMSC priorities into statutes/regulations.

*Performance Measure 71:*

This was originally the first component of performance measure 66a: on-line medical direction. The former measure “at the scene of an emergency” was defined as “from dispatch, through patient transport, to a definitive care facility.” The definition has now been integrated into the measure. The standard is still 90% of BLS and 90% of ALS agencies will have on-line medical direction by 2011. The EHB will now require a numerator (# of pre-hospital provider **agencies** that indicated they had on-line medical direction according to the survey) and a denominator (# of pre-hospital provider **agencies that provide data**) for **both** BLS and ALS.

One significant change in the new Implementation Manual will be that ILS or any intermediate service will now be included with BLS agencies.

*Performance Measure 72:*

This was originally the second component of performance measure 66a: off-line medical direction. The former measure “at the scene of an emergency” was defined as “from dispatch, through patient transport, to a definitive care facility.” As with PM 71, the definition for “at the scene of an emergency” has been integrated into the measure. The EHB will now require a numerator (# of pre-hospital provider **agencies** that indicated they had off-line medical direction according to the survey) and a denominator (# of pre-hospital provider **agencies that provide data**) for **both** BLS and ALS. Again **ILS** services will be included with BLS agencies.

*Performance Measure 73:*

This was formerly performance measure 66b which refers to the new National Equipment Recommendations for Ambulances. This list can be found on the EMSC website at [Equipment for Ambulances](#). Because this list includes both adult and pediatric equipment, it was not feasible to survey for all items and a sub-set of items will be used for purposes of meeting the performance measures. The list titled “Performance Measure Pediatric Equipment List” is available on the EMSC website. To access the checklist document directly, click on the hyperlink provided - [Equipment Checklist for PM](#). The new Implementation Manual will also detail the abbreviated pediatric equipment list and NEDARC survey templates will use the abbreviated list.

Patient care units are now defined as “a vehicle staffed with EMS providers dispatched in response to a 911 call or similar emergency call AND responsible for transporting a patient.” The next round of surveys will be limited to those patient care units that actually transport patients in response to a 911 call. Certain transport vehicles, such as air ambulances and specialty care units such as med flights, water taxi, or part of a special unit or inter facility transport, will be excluded from surveying.

The EHB will now require a numerator (# of patient care units that claim they have 100% of the equipment according to the new list) and a denominator (**# of patient care units that provide data**) for both BLS and ALS. The denominator will be the number of patient care units totaled from all agencies. For example, if you received 10 surveys and each of those

agencies had 10 patient care units, then the denominator would be 100 patient care units. Of those agencies, if 95 units had some of the equipment and 5 patient care units had 100% of the equipment, the numerator would be 5.

The survey is based on the level of care of each patient care unit, therefore BLS and ALS units will be separated in the survey. ILS units will be lumped with BLS units.

*Performance Measure 74:*

Formerly part of performance measure 66c, this measure specifically focuses on the pediatric medical emergency recognition system. The time frame has been extended to 2017 with 25% of the hospitals in the State to be recognized as part of a regional standardized system that are able to stabilize and handle pediatric medical emergencies. HRSA preferred staying away from “yes” or “no” questions and desired percentages and scales to better document grantee progress. Previously, in the EHB, grantees were asked to answer “yes” or “no” as to whether or not the State/Territory had a system of recognition in place; now grantees will be asked to enter the number of hospitals that are recognized as a part of the system. For PM 74, the denominator will be the total number of hospitals with an emergency department in the State/Territory. The numerator will be the number of hospitals that have been recognized through the State/Territorial system to stabilize and handle pediatric medical emergencies. This is not a data collection measure. Grantees are not expected to survey hospitals. Rather it is anticipated that State/Territories will know if they have a recognition system and the number of hospitals recognized by the system. State/Territories without a recognition system will enter a “0” into the numerator and denote their progress through a scoring scale.

A scoring scale will be provided by EHB to document progress in developing a recognition system. The scoring scale ranges from 0-5: 0→no progress has been made to develop a system and 5 representing the recognition of at least one facility. When “5” is entered for the progress scale then the grantee will also need to enter more than 0 in the numerator. A recognition system can be voluntary as long as it is State- or Territory- wide.

*Performance Measure 75:*

This was also part of former measure 66c, but specifically focuses on pediatric trauma recognition. The time frame for this measure has also been extended to 2017. Previously, grantees were asked to answer “yes” or “no” in the EHB regarding the existence of a trauma recognition system in the State/Territory. Grantees will now need to enter the number of hospitals that have been recognized as a part of the trauma system. The denominator will be the total number of hospitals with an emergency department in the State/Territory. The numerator will be the number of hospitals that have been recognized through the State/Territorial system that are able to stabilize and handle pediatric trauma emergencies. Again, this is not a data collection measure so grantees are not expected to go out and survey hospitals; it is anticipated that grantees will know whether a trauma recognition system exists in their State/Territory and how many hospitals are recognized as part of the system.

A scoring scale in the EHB related to this measure will also be completed by the grantee to reflect the State/Territory's progress in developing a recognition system. Grantees without a recognition system will enter a "0" into the numerator. A scoring scale that ranges from 0-5: 0→no progress has been made to develop a system and 5 where at least one facility has been recognized. When a score of "5" has been entered on the score scale, grantees will then need to enter a numerator and denominator. A pediatric trauma recognition system can be voluntary as long as it is State- or Territory- wide.

*Performance Measure 76:*

This was formerly performance measure 66d. The language has not changed from the draft Implementation Manual. The first five components of the guidelines are exactly as listed in the draft Manual but are now in a bullet format; run-on sentences have also been eliminated. The following guideline component was taken out: " plan for returning the patient back to the referring facility." This proved to be problematic due to issues of Medicaid reimbursement and therefore was something hospitals could not be asked to work on. The denominator will be the total number of hospitals with an emergency department **that provide data/return surveys** and the numerator is the number of hospitals that report having all the transfer guideline components in place.

It is very important that states work with their NEDARC representative as they collect data for this measure. The information collected previously by grantees will need to be reanalyzed and adjusted to **not** include the last component (return transfer).

*Performance Measure 77:*

This was previously performance measure 66e. The denominator will be the total number of **hospitals with an emergency department that provide data/return surveys**. The numerator is the number of hospitals reporting as having transfer agreements.

*Performance Measure 78:*

This measure was formerly performance measure 67 and remains unchanged. The EHB is expected to allow grantees to enter data points for both BLS and ALS requirements for pediatric education. If the answer is yes→enter total number of hours (not classes) required and the total number of pediatric specific hours; and if the answer is no→ details regarding challenges can be inserted by the grantee.

*Performance Measure 79:*

These were previously performance measures 68a, 68b and 68c. The five sub-components are the same. The EHB will allow grantees to enter "yes" or "no" for all of the five components and then tabulate a score between 0-5. For example, if a State/Territory has a pediatric representative on the board but that person is not mandated, the grantee would receive at least 1 point out of the 2 possible points. This ensures that States/Territories receive credit for those components that are in place while demonstrating progress.

*Performance Measure 80:*

This was previously performance measure 68d. This measure has not changed, however each of the priorities have been separated out. There are now 6 distinct areas in the detail sheets and the actual data collection form has 8 entries (some of the 6 priorities have been broken out separately). Legislation for any of these areas will now earn a point and once again helps demonstrate progress.

**Future Town Hall Conference Calls – 2:00pm Eastern Time**

- September 29, 2009
- January 5, 2010

**QUESTIONS**

1. Are these detail sheets which have been used to create the screens in the EHB finalized, approved by HRSA and no more changes can be made? *Correct, we cannot make any substantive changes. However, the implementation manual will provide specifics on how to interpret the meaning of the performance measures.*
2. What is ILS? *ILS stands for Intermediate Life Support Provider; some State/Territories refer to ILS providers as EMT-Intermediates. The EMT-Intermediate provider is trained with more advanced skills than an EMT-Basic but receives less training than paramedics. The training requirements for this EMT-level provider vary by State/Territory and their scope of practice varies as well.*
3. Will we be given the option of “out of scope” pediatric ambulance equipment in the surveys? *The group that worked on the new equipment guidelines felt that ALS services need all the equipment that is on the list and there should not be anything that is out of scope of practice. This is also the reason that ILS is now combined with BLS.*
4. How did the Program determine the 25% threshold for medical recognition; it may be difficult or easy for some states to achieve this measure based on the evolution of state recognition systems and number of hospitals in the state? *Not having any data from previous years to determine how many hospitals had been recognized presented real challenges. The only data available was how many states reported having a recognition system in place. It was from that data that the 25% was derived. Both HRSA and the EMSC Program recognize that the percentage was not based on any baseline data. As the Program looks towards 2017, the goal may be tweaked based on the baseline data gathered. It is also recognized that many states have regional systems crossing state boundaries and therefore this data provides the Program with more information and flexibility to not only report data from the individual hospitals, agencies or patient care units, but also report on a state by state level. As long as the hospitals meet the State defined standard, that would be sufficient since there is no EMSC standard.*

*We realize that the development of recognition systems require years and years of work and effort. Therefore, efforts have been employed to keep the measure broad enough for states to have flexibility in their systems.*

5. Since there is no EMSC standard for hospital recognition, is it correct that states can basically put together any program they want? *That is correct and the reason is because each state has different resources which may affect their ability to meet this measure. Therefore, this allows states to set the standards they feel their hospitals can reasonably meet in order to provide a state-wide recognition system. The recognition system can also be voluntary.*
6. What do we do if our State classifies ILS as an ALS? *Please consult with NEDARC to discuss your specific situation.*
7. Our state has a self-assessment based upon the state standards written, it is not a formal assessment; would this qualify? *If your state has a process by which the hospital does a self-assessment, and you, as the EMSC Program manager verify their self-assessment and determine that they are pediatric capable, this would qualify as a formal assessment. Recognition does not have to be done by the state.*
8. We do have a state-wide trauma system but it does not specify any pediatrics, it's very vague? *This will need to be looked at closely, however, if it says something along the lines of "all ages," it most likely qualifies. ACS standards do have pediatric specific elements. If your state follows ACS guidelines and are verified pediatric capable or pediatric trauma centers, it mostly likely qualifies.*
9. Under inter-facility transfer agreements the definition states that "an agreement that applies to all patients or patients of all ages would suffice, as long as it is not written for only adults; how do states know if it's only written for adults? *If the agreement specifies only for adults or age for consenting adults, it would not be applicable for children. In many states if the agreement states a "person" or "individual" the legal implications are that it is a person of legal consenting age, which is age 18. Thus language around "all ages" or "all patients" is needed.*
10. On the detail sheets under performance measure 78, it states performance measure 68? *This is a typo; it should say "formerly performance measure 67". For performance measure 78 you will enter information for BLS and ALS; ILS will not be captured. For PM71-73, ILS will be combined with BLS and the definition for paramedic will be updated in the Implementation Manual and surveys.*
11. It is my understanding that the new performance measure language for defining pre-hospital provider agencies were those that respond to a 911 call and are transport agencies? *Yes, a patient care unit is now defined as "a vehicle staffed with EMS providers dispatched in response to a 911 call or similar emergency call AND responsible for transporting a patient." The next round of surveys will be limited to those patient care units that actually transport patients in response to a 911 call.*

12. Is there an updated list of recommended equipment? *Yes, the 2009 list can be found on the EMSC website. To access the document directly, click on the following hyperlink provided - [Equipment for Ambulances](#). From the EMSC website [www.childrensnational.org/emsc](http://www.childrensnational.org/emsc), click on "For Grantees" and then click on "SP Performance Measure" and scroll to the "Performance Measure Equipment List."*
13. What should we (9 grantees in a different grant cycle) be prepared to enter in EHB this Fall? *The EMSC NRC advises all grantees, when prompted by HRSA, to view their EHB profile to determine what information may need to be updated. Since not all grantees are on the same grant cycle, each grantee must review their EHB profile for the specific requirements due for their state.*
14. Has there been discussion to utilize performance measure 71 to survey the hospitals rather than the pre-hospital providers since in many cases the pre-hospital provider is unable to determine the level of pediatric education of the person providing on-line medical direction? *The spirit of this measure is trying to assess if pre-hospital providers have access to on-line medical direction and if the provider feels that the person providing on-line medical direction has a higher level of knowledge than they did. The measure is not trying to assess specific training (such as PALS and others) of the individual providing the on line direction but rather their ability to provide additional guidance for the care of the child. If we survey the hospital, they will report that 100% of providers have medical direction. We need to measure this from the perspective of the prehospital provider.*
15. In my state ALS does not transport, they are all chase vehicles, so will they have to be surveyed if none provide transport? *No, they will not have to be surveyed – only transporting providers that respond to a 9-1-1 dispatched call will be surveyed.*
16. In the current Implementation Manual recognition for MEDICAL emergencies is optional, and recognition for TRAUMATIC emergencies is required. Has that changed with these detail sheets? Is medical categorization now required? *Medical recognition is still optional (PM 74). If in the grant proposal a State/Territory indicated that they do not have the resources to work on this particular performance measure, the State/Territory will not need to. However, grantees will still need to provide data on the measure in the EHB. All performance measures will require data in the EHB.*
17. Currently, several parts of performance measure 79 will never be able to get higher than a 3 or 4 on the progress scale in my state. Will this project a negative image of my state and the Program? *If every State/Territory met every measure, performance measures would cease to exist. The concept is to demonstrate progress and if a State/Territory is not progressing because of challenges, it is important to share those challenges in your grant applications. The Program can then use that information to show Congress the gaps and needs of State/Territories.*
18. When will the new detail sheets become effective? *All changes are effective immediately. Most of the implications of these measures are related to data collection methods and EHB entries. Those who have reached 80% will not collect data until next year when the new grant cycle starts on March 1, 2010. EHB will be updated for the Fall 2009 cycle.*

19. What are the rest of the states entering into EHB this Fall? *Previously collected data will be entered with more details. Please contact your NEDARC representative. NEDARC staff is working to have the new national survey ready by January. In addition, the EMSC NRC advises all grantees, when prompted by HRSA to view their EHB profile to determine what information may need to be updated. Since not all grantees are on the same grant cycle, each grantee must review their EHB profile for the specific requirements due for their state.*
20. Can grantees apply for the consultant positions that the EMSC now has available? *Yes, there is no conflict of interest; applications are due September 4, 2009.*
21. Regarding performance measure 80, is there a way to measure progress, even if it does not match exactly with the EMSC performance measure, i.e. can one mark yes if legislation exists that mandates a one-to-one match with the current equipment list? *A fairly loose interpretation exists for performance measure 80. The concept of this measure is that a State/Territory has legislation that directs pediatric pre-hospital care within the arena of the performance measure. Karen Belli has a catalog of State/Territories with rules and regulations addressing the performance measures. This can be found on the website at [http://www.childrensnational.org/EMSC/ForGrantees/Performance\\_Measures.aspx](http://www.childrensnational.org/EMSC/ForGrantees/Performance_Measures.aspx). If you have legislation that is not listed on the website, please send it to Karen for review.*
22. Are 76 and 77 optional? *Yes, as long as it is stated in your grant application that you do not have the resources to work on the performance measure(s). The State/Territory will not have to work on the measure but data will still need to be provided on the measure in the EHB.*
23. Is pediatric still being defined as ages 0-17, but not including 18? *It is 0 up to age 18.*