



## Town Hall Meeting Conference Call

September 29, 2009 2-3:30 p.m. EST

Led by:

EMSC National Resource Center  
8737 Colesville Road, Suite 400  
Silver Spring, MD 20910  
202-476-4927

[www.childrensnational.org/emsc](http://www.childrensnational.org/emsc)

### Participating Grantees:

Alabama, Ann Klasner	New Hampshire, Janet Houston
California, Donna Westlake	North Carolina, Gloria Hale
Colorado, Lisa Ward	North Dakota, Kelli Rice
Connecticut, Wendy Wheeler	Ohio, Joe Stack
Delaware, Marie Renzi	Oklahoma, Paul Marmen
Illinois, Evelyn Lyons	Oklahoma, Stacy Morton
Indiana, Gurinder Hohl	Puerto Rico, Wanda Arbelo
Kansas, Sarah House	South Carolina, Taffney Hooks
Kentucky, Tom Taylor	South Dakota, Dave Boer
Louisiana, Debbie Huffman	South Dakota, Amy Marsh
Maryland, Cyndy Wright-Johnson	Tennessee, Rhonda Phillippi
Massachusetts, Deborah Clapp	Texas, Anthony Gilchrest
Michigan, Linda Nesbit	Utah, Kristin Lauria Gurley
Minnesota, Kristi Moline	Vermont, Peter Otten
Mississippi, Ashley Adcox	Virginia, David Edwards
Montana, Bobbi Perkins	Washington, Scott Hogan
Nebraska, Debbie Kuhn	
Nevada, Bob Heath	

**Federal Staff:** Tina Turgel, Federal Project Officer

### **NEDARC Staff:**

Michael Ely

### **NRC Staff:**

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

## **Policy Update provided by Karen Belli, Sr. Public Policy Specialist**

As many are aware, the 2009 federal fiscal year will end on September 30, 2009. Fiscal year (FY) 2010 begins on October 1, 2009. Presently, none of the 12 federal appropriations bills for FY 2010 have been enacted, including the Departments of Labor-Health and Human Services-Education (L-HHS) bill, which provides funding for the EMSC Program.

Grantees may recall that the House of Representatives passed their version of the L-HHS appropriations bill in July, which includes \$21 million for EMSC. The Senate Appropriations Committee passed their version of the appropriations bill that same month, recommending \$22 million for the Program. At this time, however, neither version of the L-HHS appropriations bill has been signed into law.

When appropriation bills are not signed into law by the beginning of the new fiscal year, Congress passes a “continuing resolution.” A continuing resolution provides stopgap funding to keep the government operating until Congress is able to complete the annual appropriations process. Remember, the government relies on annual funding to keep running; without funding, federal programs would cease to operate.

Therefore, in late September both the House and Senate approved a continuing resolution. For existing federal programs, including the EMSC Program, this measure provides level, or fiscal year 2009, funding through Saturday, October 31 or until the relevant appropriations bill is enacted. Therefore, during this interim period, the bill provides for an annual funding level of \$20 million for the Program.

### *Reauthorization*

No recent action has been taken on reauthorization of the EMSC Program. Recall that in March the House passed HR 479, the Wakefield Act, to reauthorize the Program. In addition, EMSC Program reauthorization was included in the health care reform bill passed by the Senate Health, Education, Labor, and Pensions (HELP) committee in July. The Senate may combine the HELP committee bill with the health reform bill being considered by the Senate Finance committee. The two committees would have to decide if EMSC reauthorization remains in the bill.

### **NEW 2009 Implementation Manual**

The NEW Implementation Manual with performance measure changes and the new numbering system has been released and is now available on the NRC website at [http://www.childrensnational.org/EMSC/ForGrantees/Performance\\_Measures.aspx](http://www.childrensnational.org/EMSC/ForGrantees/Performance_Measures.aspx). Additionally, all State Partnership grantees will receive two, paper bound copies in the next few weeks.

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.

#### *Inspection Reports*

If grantees propose to use an inspection process, there must be a one-to-one match with pediatric equipment list being used for EMSC performance measure 73. This list is included in the implementation manual.

#### *Demonstrating you have met a performance measure*

Grantees must first communicate with the federal project officer, Tina Turgel, to seek confirmation that they have met a specific performance measure. Detailed instructions on how to seek an official notice from the Program, that a performance measure has been met, are outlined in the Implementation Manual. Grantees may also obtain an exemption from data collection letter (only for performance measures that require data collection). Please submit your request for data exemption prior to March 2010.

#### *Performance Measure 71:*

Performance Measure 71 was originally the first component of performance measure 66a: On-Line Medical Direction. The former measure “at the scene of an emergency” was defined “from dispatch, through patient transport, to a definitive care facility.” The definition has now been integrated into the new measure. The standard is still 90% of BLS agencies 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 indicate 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 for this performance measure will be that ILS or any intermediate service will now be included with BLS agencies. The acceptable data collection methods are surveys. If you plan to use your own survey, you must seek permission from Tina Turgel. Details regarding the specific representatives that grantees may, survey are on page 17, “representative of the EMS agency that has day to day oversight of the agency.” In order to receive an exemption from data collection, a mandate must exist that clearly states, on-line medical direction must be available to all EMS personnel in the state and an enforcement process exists (e.g Base stations that are required to be available to all pre-hospital providers agencies, or licensing requirements that mandate the provision of such medical direction).

#### *Performance Measure 72:*

Performance Measure 72 was originally the second component of performance measure 66a: Off-Line Medical Direction. The former measure, “at the scene of an emergency” was defined “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 indicate 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. If a State classifies their ILS agencies as ALS, please consult NEDARC prior to data collection. The acceptable data collection methods are surveys. If you plan to use your own survey you must seek permission from Tina Turgel. If you are using inspection reports, there must be a written requirement for the protocols to be carried on the ambulances or by the EMS personnel.

*Performance Measure 73:*

Performance Measure 73 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:

[http://www.childrensnational.org/EMSC/ForGrantees/Performance\\_Measures.aspx](http://www.childrensnational.org/EMSC/ForGrantees/Performance_Measures.aspx).

Because the list includes both adult and pediatric equipment, it was not feasible to survey all items. A sub-set of items will now 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:

[http://www.childrensnational.org/EMSC/ForGrantees/Performance\\_Measures.aspx](http://www.childrensnational.org/EMSC/ForGrantees/Performance_Measures.aspx).

The new Implementation Manual details the abbreviated pediatric equipment list and the 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 like 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 reported having 100% of the equipment according to the new list) and a denominator (**# of patient care units that provided 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 a State to be recognized as part of a standardized system, that are able to stabilize and handle pediatric medical emergencies. HRSA requested this performance measure move from “yes” or “no” questions to 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:*

Formerly part of performance 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 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 - progress has been made to develop a system and 5 - 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:*

Formerly part of 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 Medicaid reimbursement issues and therefore was something hospitals could not be asked to address. The denominator will be the total number of hospitals with an emergency department **that provided data/returned surveys** and the numerator is the number of hospitals that reported 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:*

Performance measure 77 was previously performance measure 66e. The denominator will be the total number of **hospitals with an emergency department that provided data/returned surveys**. The numerator is the number of hospitals that reported as having transfer agreements.

*Performance Measure 78:*

Performance measure 78 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:*

Performance measure 79 was previously performance measures 68a, 68b and 68c. The five sub-components remain 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 position 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:*

Performance measure 80 was previously performance measure 68d. This measure remains un-changed, however each of the priorities have been separated. There are now 6 distinct areas in the detail sheets and 8 entries (some of the 6 priorities have been broken down further resulting in 8 bullet points). Legislation for any of these areas will now earn a point and once again help demonstrate progress.

## **REMINDERS**

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

January 5, 2010

**Exemption from Data Collection Requests** – Please contact the federal project officer early to provide sufficient time to review. You may also contact your NRC representative to review the supporting documents and provide guidance prior to sending to Tina.

## **QUESTIONS**

1. Will a hard copy of the Implementation Manual be sent to the grantees?

*Yes, within the next few weeks the NRC will mail a hard copy to all grantees.*

2. Has the grant guidance been released? Do you have any idea when it will be released?

*The guidance has not been released. We will alert all grantees once we are notified that the guidance has been released by HRSA.*

3. The surveys must be approved by Tina or NEDARC?

*The federal project officer, Tina Turgel.*

4. Those of us in the competitive cycle, are we on the same survey cycle as everyone else?

*Yes, everyone will start collecting in March 2010.*

5 When do we receive the surveys from NEDARC?

*NEDARC is currently pilot testing in Indiana and West Virginia and will be working with each state prior to March. We can start prepping late this Fall/early next year.*

6. Can we have integrated protocols?

*If you have protocols that integrate adult and pediatric, that's fine.*

7. Does it matter if they are transport agencies?

*Yes. If the transporting agency transports in response to 911 emergency. Keep in mind, the unit of measurement is "agency" and no longer "provider".*

8. Will we be asked to enter the same information in EHB as in the Manual?

*Yes, you are given 120 days from the time it opens for you. Since grantees are on different grant cycles, please access your EHB profile when prompted by HRSA to do so. The specific requirements due to EHB for your state will be available on your EHB profile. In addition, please work closely with your NEDARC representative for guidance on how to complete the EHB.*

9. Will EHB show our old data?

*No, because previous data is under old numbers.*

10. We have fire departments that first respond with our EMS agencies would they be included in the medical direction PM?

*Consult with NEDARC for a more detailed analysis after better understanding your system.*

11. Please clarify; do we lump ILS with BLS?

*If a State system defines ILS as Advance Life and you feel this level of EMS service fits more appropriately with ALS rather than BLS, you may lump ILS with ALS. However, we encourage you to please work with the NRC and NEDARC to discuss your State system further.*

12. Will performance measures 74, 76, 77 become mandatory in the future?

*At this time we do not know.*