

Florida EMSC Advisory Committee Meeting September 29, 2021

*Phyllis L. Hendry, MD, FAAP, FACEP
Professor of Emergency Medicine and Pediatrics
Associate Chair for Research, Department of Emergency Medicine
University of Florida College of Medicine/Jacksonville
Florida EMS for Children Medical Director*





Welcome and Call to Order

Roll call of committee members and liaisons

(please email confirmation of your attendance with name/org./contact info to pedready@jax.ufl.edu or via chat box)

Security and Recording

Please mute your phones and do not put on hold!

*6 to mute or unmute

If hacked a new invite will be sent to committee members only.

Welcome members, liaisons, visitors and PECCs

FL EMSC and PEDReady Contact Information

Medical Director: Dr. Phyllis Hendry

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(904) 244-4986 (office)

FL EMSC Program Manager: Lori JeanJacques

Lorrianna.JeanJacques@flhealth.gov

850-558-9500

FL EMSC Program Director : Melia Jenkins

melia.jenkins@flhealth.gov

(850) 558-9532

Group email:

pedready@jax.ufl.edu

Key Websites:

<https://www.emlrc/flpedready>

<https://emscimprovement.center>

<http://www.floridahealth.gov/provider-and-partner-resources/emsc-program/index.html>

New/Reappointed EMSC Advisory Committee Members

Term ends: 07/10/2022

- Jennifer N. Fishe, MD

- Physician with Pediatric Experience
- Associate Medical Director for Pediatrics, Nassau County Fire Rescue

- Barbara Tripp RN, EMT-P

- Emergency Medical Technician/Paramedic
- Rescue Division Chief, City of Tampa Fire Rescue

- Nichole Shimko, RN, MSN, CCRN, CPN, C-NPT

- Nurse with Emergency Pediatric Experience
- Nurse Supervisor, Golisano Children's Hospital of Southwest Florida

- Marshall Frank DO, MPH, FACEP, FAEMS

- Emergency Physician
- Medical Director, Sarasota County Fire Dept.

- Felix Marquez BA, RN, EMT-P

- EMS Education Manager
- President/CEO of Orlando Medical Institute, Paramedic/Firefighter for City of Orlando

- Sandra Nasca, RN

- FAN Representative
- Retired ED Nurse, Forensic Medical Investigator

EMSC Advisory Committee Liaisons

- Michael Rushing, NRP, RN, BSN, CEN....
 - FL ENA
 - AHA Coordinator, Baptist Healthcare
- Tracey D. Vause, MPA, CPM, EMT-P
 - Rural EMS
 - EMS Chief, Walton County Fire Rescue
- Ernest (Sonny) Weishaupt EMT-P
 - PECC (EMS/ED)
 - EMS Liaison, Arnold Palmer Hospital for Children
- Julie Downey
 - Disaster
 - Fire Chief, Davie Fire Rescue
- Meryam Jan, MD
 - FL PEDReady pediatric resident liaison
 - 3rd yr Pediatric Resident at UFCOM – Jacksonville
 - Website reviewer and PE²ARL editor

- Jeremiah Rabish, PMD
 - PECC (EMS)
 - Operations Captain and PECC, Sarasota County Fire Dept.
- Sarah Weed
 - PECC (EMS)
 - Rescue Lieutenant /FF/CCP-FPC, Alachua County Fire Rescue
- Lauren Young, LCSW
 - Mental health
 - Medical Social Work & MIH Coordinator, Palm Beach County Fire Rescue
- Lisa Nichols, MBA, BSN, RN, CCRN-K
 - Trauma program manager
 - Pediatric Trauma Program Manager at Wolfson Children's Hospital
- Adding critical care/PICU liaison

EMSC/DOH BEMO Advisory Staff

- Melia Jenkins

- EMSC Project Director

- Lorrianna Jean-Jacques

- EMSC Project Manager

- Steve McCoy

- Bureau Chief, Bureau of Emergency Medical Oversight at Florida Health

- Jane Bedford

- Rural EMS Coordinator

- Kate Kocevar

- Trauma Administrator

- Michael Hall

- EMS Administrator; Florida DOH
Bureau of Emergency Medical Oversight

- Kenneth Schepcke, M.D.

- FL EMS Medical Director

- Phyllis L. Hendry, MD, FAAP, FACEP

- FL EMS-C Medical Director

Opening Announcements

- Welcome Joseph A. Ladapo, MD, PhD, new State Surgeon General
- Congrats to Kenneth Scheppke, MD, FAEMS, 2021 NAEMT/Bound Tree EMS Medical Director of the Year Award
- **Thank you to Melia Jenkins for 24 years of dedicated service to Florida EMSC program**

Melia Jenkins

Social Services Manager/EMSC Project Director

- Started with the EMSC program in 1997, started working with Dr. Hendry in 1999!
- Coordinated the development of EMSC federal partnership grant resulting in approximately \$2.9 million in grant funds since the program's inception
- Fun fact: I am only 4 foot 10 $\frac{3}{4}$ inches tall and love my high heel shoes!
- Favorite food: salty snacks
- Favorite book: anything from John Grisham



Presentations and Special Topics

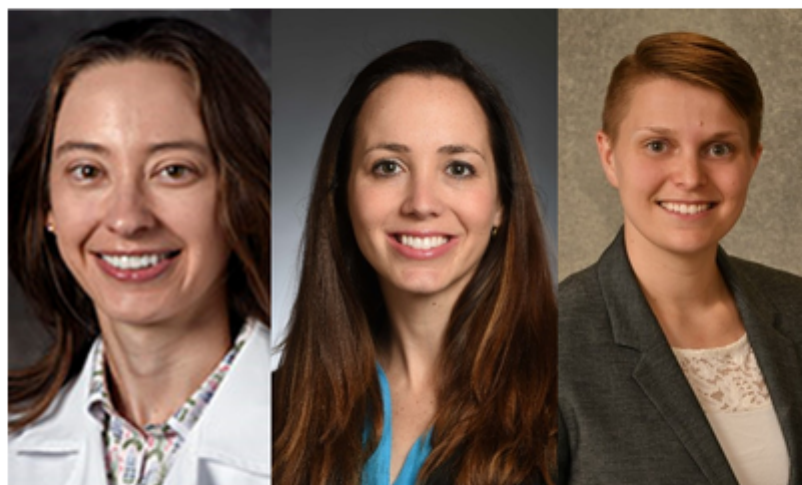
Dr. Jen Fishe: Focus on Pediatric EMS Research

- -Harris MI, Crowe RP, Anders J, D'Acunto S, Adelgais KM, Fishe JN. Applying a Set of Termination of Resuscitation Criteria to Paediatric Out-Of-Hospital Cardiac Arrest. Resuscitation. 2021 online ahead of print. <https://pubmed.ncbi.nlm.nih.gov/34555488/>
- -Collaboration with PECARN
- <https://emscimprovement.center/news/pecarn-study-exploring-oral-steroids-for-asthma-in-ambulance-settings/>

PECARN study exploring oral steroids for asthma in ambulance setting

Published August 30, 2021

Cincinnati Children's Hospital Medical Center and local Cincinnati EMS agencies from the [Pediatric Emergency Care Applied Research Network \(PECARN\)](#) [↗](#) midwestern research node, HOMERUN, are a major site in a national study of the efficacy of EMS administration of oral steroids to children with asthma exacerbations. The "Early Administration of Steroids in the Ambulance Setting: An Observational Design Trial" or "EASI AS ODT" study is a pragmatic trial using a stepped wedge design, where each site introduces the intervention at a different period in time, rather than all at once. Using this approach, the study is looking at pediatric patient outcomes before and after EMS agencies introduce an oral steroid option for the treatment of asthma attacks. The study is led by Principal Investigator Jennifer Fishe, MD, a pediatric emergency medicine physician and pediatric EMS medical director from the University of Florida College of Medicine-Jacksonville, and is funded by a five-year National Heart, Lung, and Blood Institute K23 award.



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New Regional Pediatric Pandemic Network will partner with EIIC to build on EMSC disaster preparedness efforts

August 30, 2021

Improving access to care through the Telehealth Collaborative

August 30, 2021

State successes: Wisconsin EMSC receives \$520,000 workforce development grant

August 30, 2021



Responding To Children In Disasters

www.CLDisasterRelief.org

CLDR

Mission:

To empower and support children and families in crises by integrating child life professionals' services into impacted communities. Through individualized direct services, community outreach, education, and research, Child Life Disaster Relief mitigates the effects of traumatic events on children and families.

Vision:

To develop a coordinated and global network to ensure that children in disasters and crises have the tools and support needed to promote positive coping and resilience.



Children are Resilient . . .

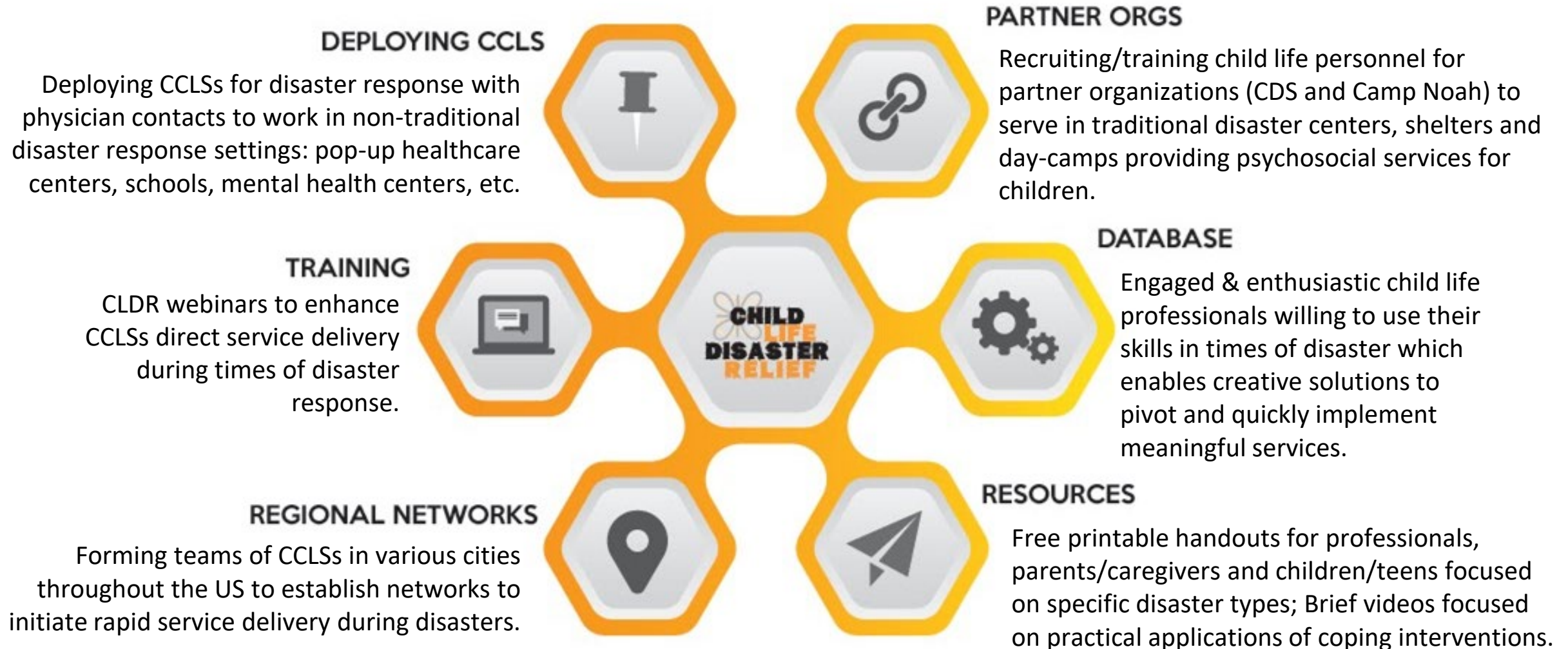
Yes, children are typically more **resilient** (*ability to recover quickly*) than adults.

However, children are also more **vulnerable** (*susceptibility to being hurt*) to negative long-term impact from major life events.

Studies on Adverse Childhood Experiences shows the link between traumatic events in childhood and significant emotional, mental, and physical negative outcomes in adulthood.

Mitigation in the moment of need by trained professionals is essential.

CLDR Initiatives



CLDR Current SCOPE OF SERVICE

*To ensure **consistent** and **reliable** service-delivery, CLDR has the capacity currently to focus on the following:*

- **Natural disasters:** hurricanes, tornados, floods, wildfires, derecho, volcanoes, avalanches, tsunamis
- **Incidents of mass violence impacting communities:** shootings, terrorism, influx of war-torn refugees/evacuees
- **Large fires/accidents displacing multiple families** -5 or more families
- **Biological/chemical:** pandemic, oil spills

Responses

Child Life Specialists have responded to **48** disasters to-date:
40 natural and 8 man-made

With over **15,000** child-encounters

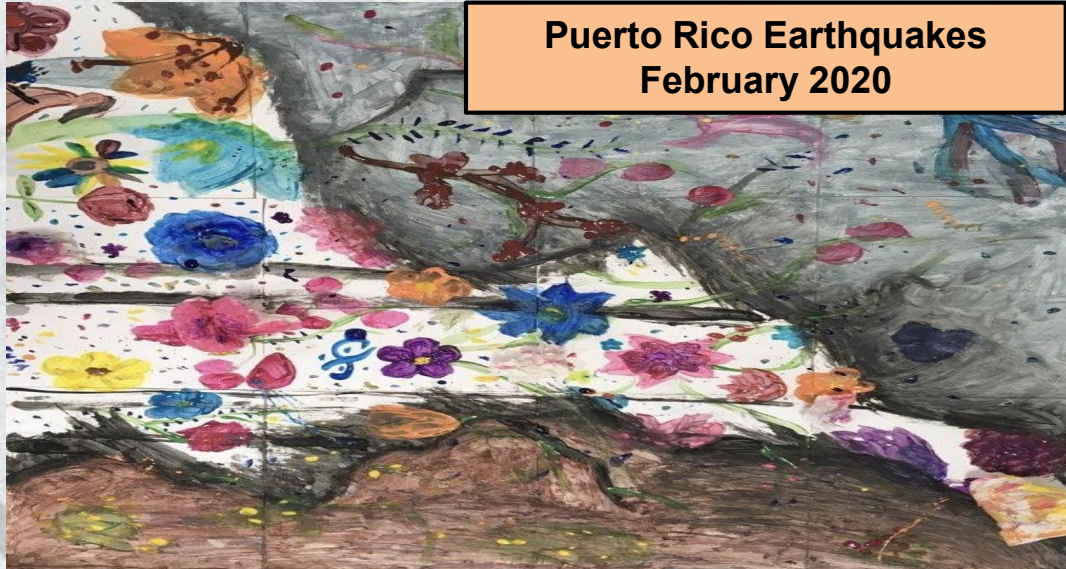
Florida-Specific Responses Include:

- Surfside Condominium collapse, Summer 2021
- Hurricanes Irma & Michael (2017, 2018)
- Pulse Nightclub Shooting (2016)

Child Life Specialists' Professional Expertise

- Experts in lifespan growth and development
- Trained to mitigate stress and trauma for children/teens during a crisis
- Provide developmental and coping assessments
- Provide appropriate play and therapeutic interventions to support coping and resilience
- Trained to assess children's and family's responses to stress, trauma and/or significant life experiences
- Utilize evidence-based practice

Child Life Specialists' Professional Expertise



Puerto Rico Earthquakes
February 2020

Dear Earthquakes,

Can y'all leave us alone? Like bro we are tryna live.
I swear these days have been the worst days of my life. Just disappear
or go to the Bermuda Triangle.

Dear Earthquakes, Can y'all leave us alone? Like bro we
are tryna live. I swear these days have been the worst
days of my life. Just disappear or go to the Bermuda
Triangle.

“As child life specialists
our goal is to provide spaces
for children and families
to **learn, grow and develop**
through challenging life
events”

- Genevieve Lowry MS.Ed., CEIM, CCLS

Dear Dorian,

I really did not know that this story was going to be this bad.

- * When the storm came I was very sad.
- * It made me feel very forgotten.
- * Dorian made me feel like I was going to die.
- * Dorian was so bad that every person in that house was shocked.
- * Dorian killed a lot of people.
- * Dorian killed a lot of my friends and their family.
- * Dorian made a lot of people feel like they was all ~~ate~~ by there self.



Dorian this letter is to you

Why did you do this to Labarre and Granddaddy

This letter is to Dorian from: [redacted]

to you



Disasters can and will **vary**.

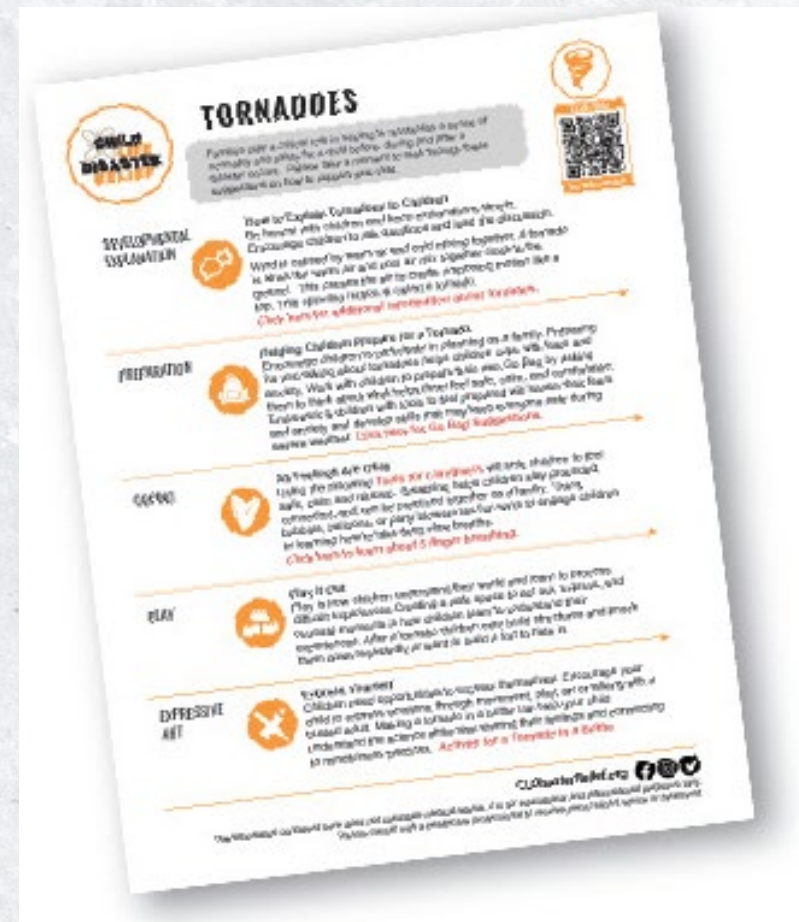
The need for children to have play to help foster positive coping and resiliency is **always essential**.



Fall 2019 Hurricane Dorian Deployment, Bahamas

Community Resources

- **Trainings** -Tailored to Communities
- **Virtual Webinars**
- **Disaster-Specific Resources**
 - Focused on developmentally appropriate explanations
 - Practical application of coping techniques in the moment of stress
 - Easily accessible online



PARTNER ORGANIZATIONS

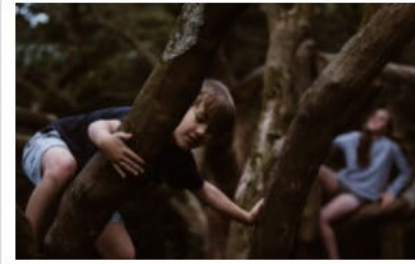
[American Academy of Pediatrics](#), [American Red Cross](#); [Children's Disaster Services \(Church of the Brethren\)](#); [Federal Emergency Management Agency](#); [National Association for the Education of Young Children](#)

[National Child Traumatic Stress Network \(NCTSN\)](#); [National Institute for Trauma & Loss in Children \(TLC\)](#); [Save the Children](#); [SAMHSA Disaster and Distress Helpline](#)

[SAMHSA National Helpline](#), [National Suicide Prevention Lifeline](#)



5 Essential Needs for
Children Following
Disasters



Disaster Specific



COVID-19



Parents / Caregivers



Research



Organizations

The Child Life Disaster Relief backpack grant is almost complete! We have gone from a year long process of a proposal, acceptance, research, ordering, an Amazon warehouse of over 70 boxes and a 200 pound pallet on my back porch to over 10,000 developmentally appropriate items sorted and stuffed into 150 backpacks. I'm so incredibly grateful to these amazing women, CLDR board, Northeast Florida Healthcare Coalition for Emergency Management, two four-legged assistants and another supervisor who was sleeping on the job!





Email: info@CLDisasterRelief.org

Website: www.CLDisasterRelief.org

New Educational Resources and Literature

Podcasts:

-Reel Emergency vodcast: Featuring Drs. Peter Antevy, Mark Piehl and David Spiro on interactive vodcasts (adult and pediatric topics) <https://reeldx.com/news/reel-emergency-vodcast>

-CHOP PEM Podcasts: <https://www.chop.edu/pempodcast>

JEMS recent pediatric articles

- <https://www.ems1.com/inside-ems/articles/dr-peter-antevy-talks-head-up-cpr-whole-blood-use-by-ems-VXicVAUclsXnNFwh/>
- <https://www.ems1.com/ems-products/neonatal-pediatric/articles/out-of-hospital-pediatric-cardiac-arrest-management-UliXiY8VS39Nnw0N/>
- <https://www.ems1.com/ems-products/neonatal-pediatric/articles/pre-hospital-pediatric-cardiac-arrest-should-children-be-treated-like-small-adults-wi1o1MAfUtB7NAj9/>

DKA: Increase in nonpediatric teams transporting pediatric DKAs during COVID, especially new onset

-Managing Diabetic Ketoacidosis in Children

[https://www.annemergmed.com/article/S0196-0644\(21\)00160-8/fulltext](https://www.annemergmed.com/article/S0196-0644(21)00160-8/fulltext)

Diagnosis of DKA

Criteria: hyperglycemia + acidosis + urine/serum ketones

Clinical features: polyuria, polydipsia, weight loss, abdominal pain, vomiting, headache, Kussmaul respirations, altered mental status

Initial Management

Clinical assessment: ABCs, vital signs, neuro exam with GCS

Obtain IV access (if possible, 2nd line for serial blood draws)

Laboratory studies: glucose; serum electrolytes, creatinine, beta-hydroxybutyrate; venous blood gas; urinalysis

Signs of cerebral edema?

Yes

No

Assess ABCs

Elevate head of bed to 30°

Mannitol (0.5-1 g/kg) **or**

3% NaCl (5 mL/kg) IV

over 20 minutes

Reduce IV fluid rate

Fluid Resuscitation

Administer 10 mL/kg NS bolus

Repeat bolus for persistent tachycardia, prolonged capillary refill, cool extremities, or other signs of hypoperfusion

IV fluid Administration

0.9% or 0.45% NaCl to replace deficit over 36-48 hrs plus maintenance fluids

Add 40 mEq/L potassium once serum K < 5 mEq/L (5 mmol/L) as KPhos, KAcetate, or KCl

Add 5-10% dextrose, if serum glucose < 300 mg/dL (16.7 mmol/dL)

Do not administer sodium bicarbonate

Avoid intubation

Unless unable to protect airway or poor effort

Intubation/ventilation are high-risk procedures in children with DKA

Insulin Administration

Start IV insulin infusion at 0.05-0.1 unit/kg/hr

Do not administer insulin bolus

Ongoing Monitoring

Q1 hour: vital signs, blood glucose, neurologic checks with GCS

Q2-3 hour: Electrolytes and VBG

New Educational Resources and Literature

Autism: approximately 1 in 54 children in the U.S. diagnosed with an autism spectrum disorder (ASD), boys 4 times more likely to be diagnosed than girls. EMS and ED management challenges

- Resources and information to assist with early assessment, diagnosis and intervention for infants and toddlers presenting with symptoms of autism spectrum disorder (ASD).
<http://www.toddlertracks.org/>. <https://vimeo.com/532444189/ddbcd2d9d1>

Fever: Evaluation and Management of Well-Appearing Febrile Infants 8 to 60 Days Old. Pediatrics August 2021, 148 (2) e2021052228; DOI:
<https://doi.org/10.1542/peds.2021-052228>

<https://pedemmorsels.com/pediatric-fever-update-febrile-infants-8-to-28-days-old/>

- Bottom line for EMS= transport all pediatric fever

Toddler Tracks Ambassador – join us!

Be a Toddler Tracks Ambassador in your community, directing families to resources and participating in education and brainstorming sessions! Contact us to learn more.

Name

Email Address

Contact

Toddler Tracks Community Partners



Educational Webinar Series
Presented by Global Partnership for Telehealth



Toddler Tracks
Pathways to Tackling Autism

March 25, 2021
12:15 p.m. EST
Free CEU Offering



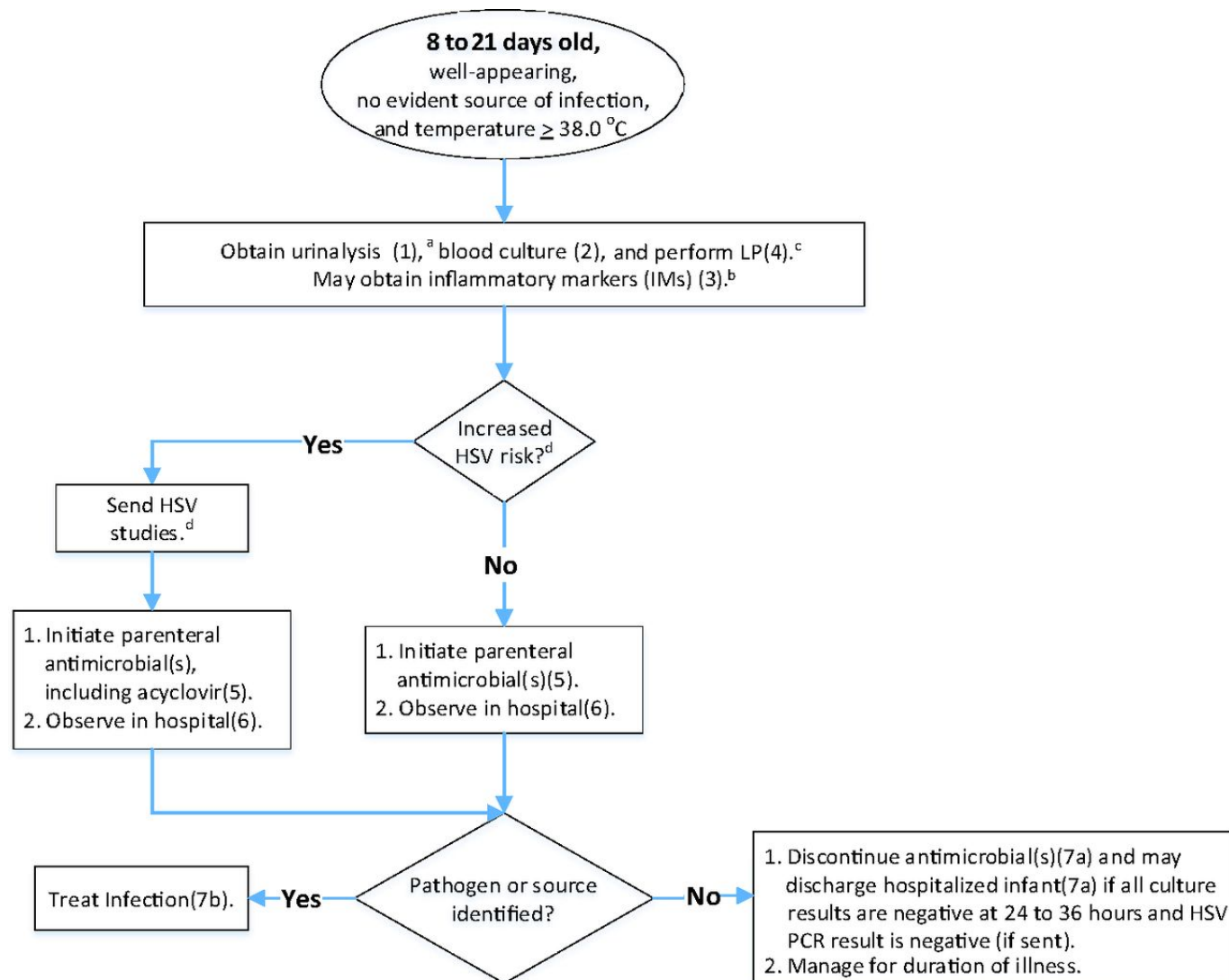
Boyd H. Mark, MBA
Founder, Pediatric Telemedicine of America

Learn about these free online resources for families and healthcare professionals addressing early autism diagnosis and intervention.



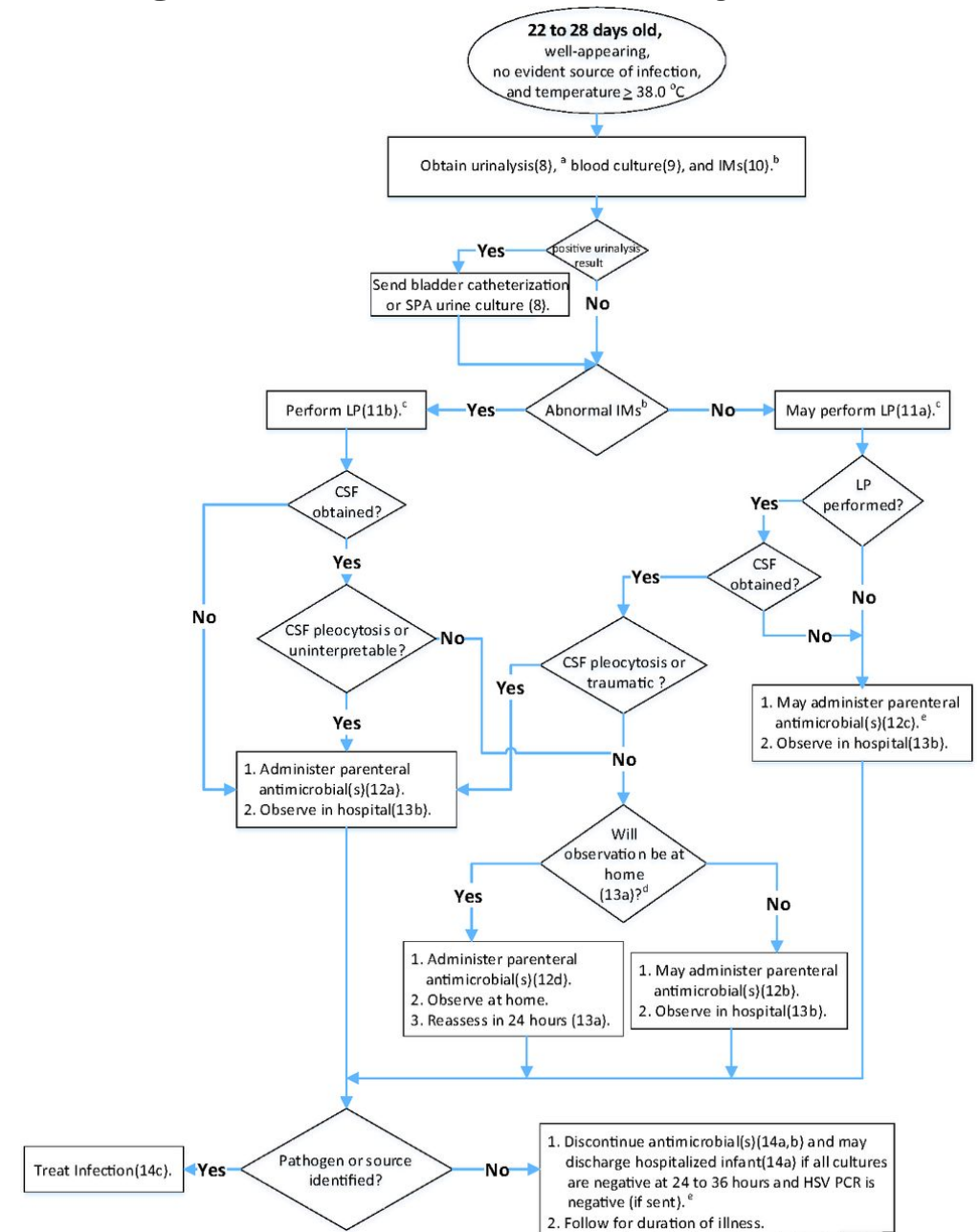
Laboratory values of inflammation are considered elevated at the following levels: (1) procalcitonin >0.5 ng/mL, (2) CRP >20 mg/L, and (3) ANC >4000 to 5200 per mm³. Although we recommend all infants in this age group have a complete sepsis workup, receive parenteral antimicrobial agents, and be monitored in a hospital, knowing IM results can potentially guide ongoing clinical decisions. c Send CSF for cell count, Gram stain, glucose, protein, bacterial culture, and enterovirus PCR (if available) if pleocytosis is present and during periods of increased local enterovirus prevalence. d HSV should be considered when there is a maternal history of genital HSV lesions or fevers from 48 hours before to 48 hours after delivery and in infants with vesicles, seizures, hypothermia, mucous membrane ulcers, CSF pleocytosis in the absence of a positive Gram stain result, leukopenia, thrombocytopenia, or elevated alanine aminotransferase levels. Recommended HSV studies are CSF PCR; HSV surface swabs of the mouth, nasopharynx, conjunctivae, and anus for an HSV culture (if available) or PCR assay; alanine aminotransferase; and blood PCR.

Algorithm for 8- to 21-day-old infants



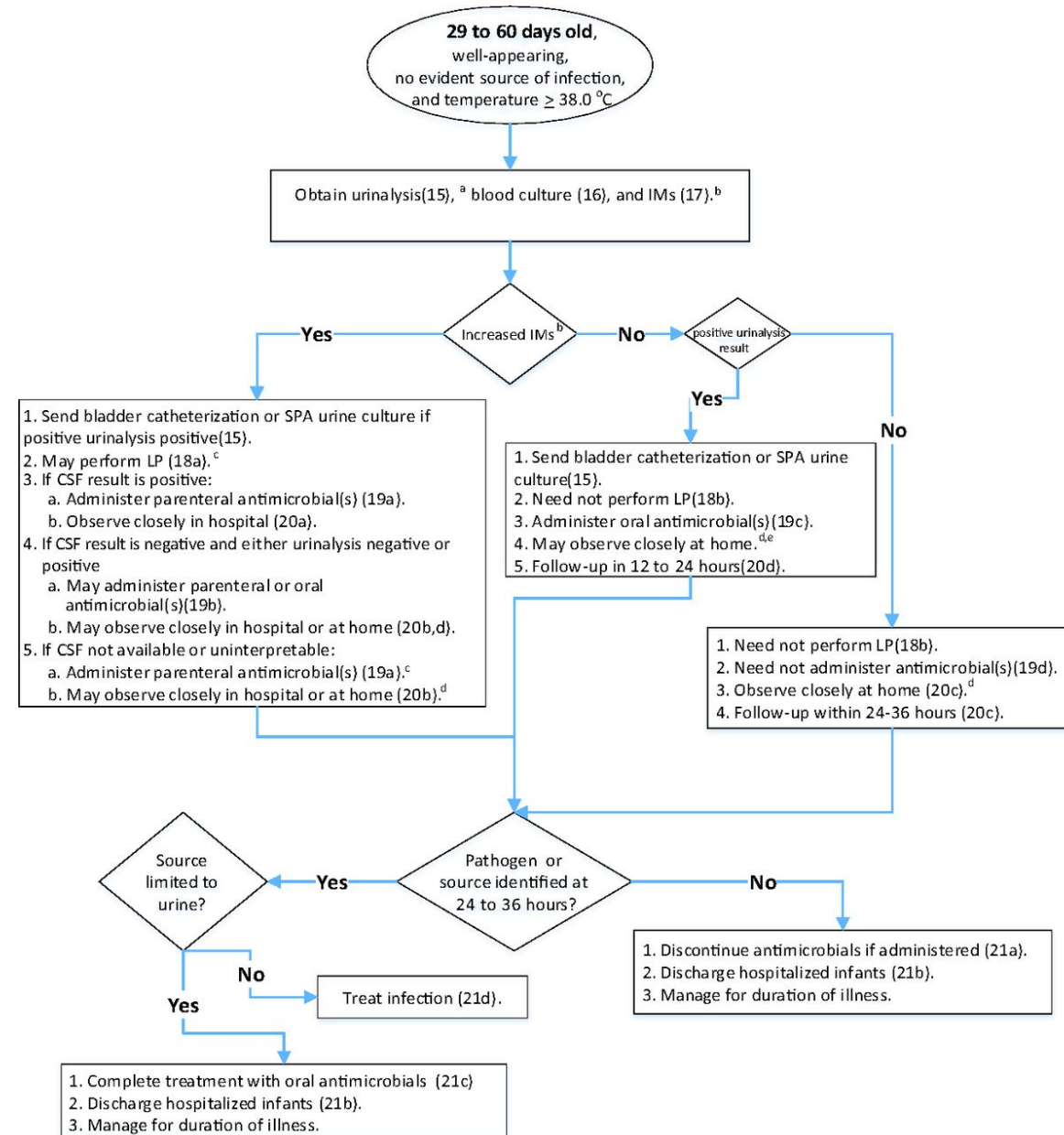
If available, procalcitonin should be obtained along with ANC or CRP. If procalcitonin is unavailable, both ANC and CRP should be obtained, and a temperature $>38.5^{\circ}\text{C}$ is considered abnormal. IMs are considered abnormal at the following levels: (1) temperature $>38.5^{\circ}\text{C}$, (2) procalcitonin $>0.5\text{ ng/mL}$, (3) CRP $>20\text{ mg/L}$, and (4) ANC $>4000\text{ }5200\text{ per mm}^3$. ^c LP is recommended before administration of antimicrobial agents because interpreting CSF after the administration of antimicrobial agents is difficult. However, the risk of meningitis in 22- to 28-day-old infants is lower than that in infants <22 days old in several studies. Therefore, in some circumstances, clinicians may elect to defer an LP and initiate antimicrobial agents, recognizing the potential risk of partially treated meningitis. Send CSF for cell count, Gram stain, glucose, protein, bacterial culture, and enterovirus PCR (if available) if pleocytosis is present and during periods of increased enterovirus prevalence. HSV can occur in this age group. HSV should be considered in infants with vesicles, seizures, hypothermia, mucous membrane ulcers, CSF pleocytosis in the absence of a positive Gram stain result, leukopenia, thrombocytopenia, or elevated alanine aminotransferase levels. Recommended HSV studies: CSF PCR; HSV surface swabs of mouth, nasopharynx, conjunctivae, and anus for HSV culture (if available) or PCR assay; alanine aminotransferase; and blood PCR. ^d Infant may be managed at home if parent and clinician agree that the following are present: reliable phone and transportation, parent willingness to observe and communicate changes in condition, and agreement to the infant being reevaluated in 24 hours. ^e If CSF is positive for enterovirus, clinicians may withhold or discontinue antimicrobial agents and discharge at 24 hours, provided they meet other criteria for observation at home.

Algorithm for 22- to 28-day-old infants

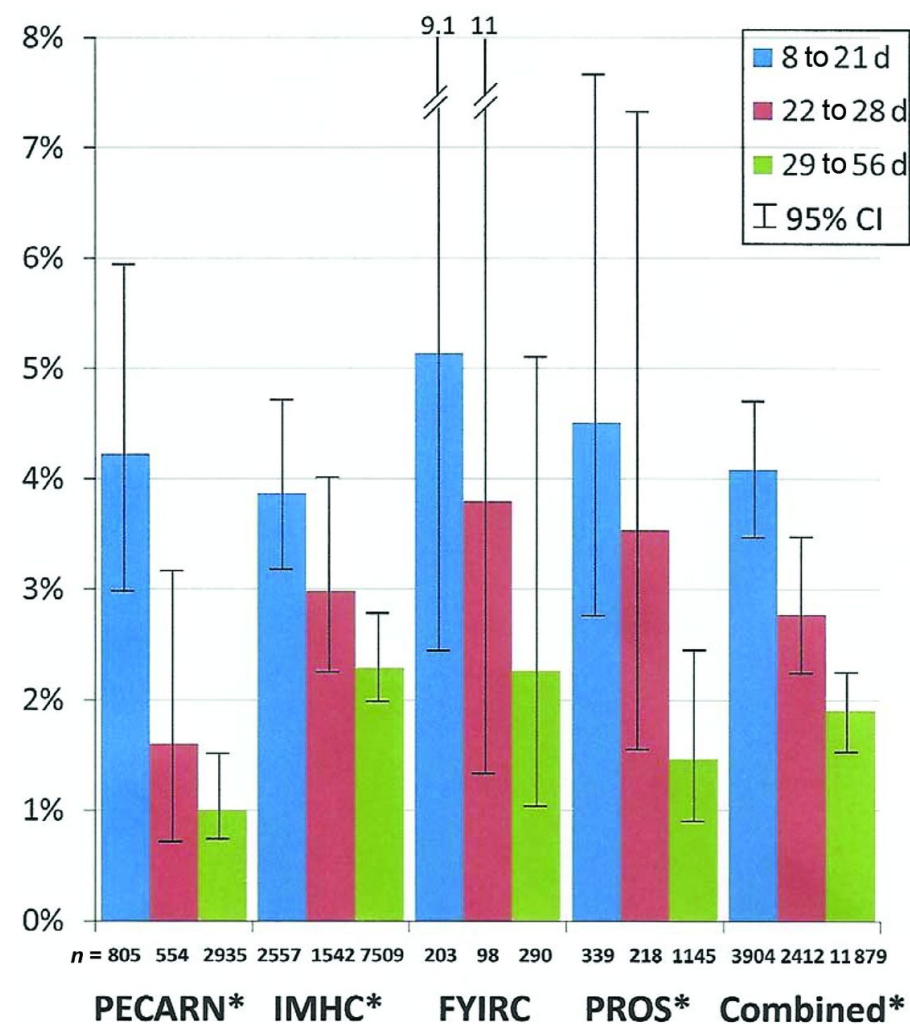


b If available, procalcitonin should be obtained along with ANC or CRP. If procalcitonin is unavailable, both ANC and CRP should be obtained, and a temperature $>38.5^{\circ}\text{C}$ is considered abnormal. IMs are considered abnormal at the following levels: (1) temperature $>38.5^{\circ}\text{C}$, (2) procalcitonin $>0.5\text{ ng/mL}$, (3) CRP $>20\text{ mg/L}$, (4) ANC >4000 to $5200/\text{mm}^3$. c Send CSF for cell count, Gram stain, glucose, protein, bacterial culture, and enterovirus PCR (if available) if CSF pleocytosis is present and during periods of increased local enterovirus prevalence. Although rare in this age group, HSV should be considered when there is a maternal history of genital HSV lesions and in infants with vesicles, seizures, hypothermia, mucous membrane ulcers, CSF pleocytosis in the absence of a positive Gram stain result, leukopenia, thrombocytopenia, or elevated alanine aminotransferase levels. Recommended HSV studies are If CSF is unobtainable or uninterpretable, there are insufficient data to make a specific recommendation. Options: observe without treatment of a period of time and, depending on infant clinical condition, repeat LP and/or laboratory markers; begin empirical antimicrobial agents and reassess in 24 hours on the basis of infant response and results of blood culture; if CSF is bloody or antimicrobial agents have previously been started, analysis by multiplex PCR can add additional information; consult with local a pediatric infectious disease specialist. d Infant may be managed at home if parent and clinician agree that the following are present: reliable phone and transportation, parent willingness to observe and communicate changes in condition, and agreement to the infant being reevaluated in 24 hours. e Most 29- to 60-day-old infants with negative IM and urinalysis results may be observed at home. However, hospital observation is an option for infants when there are barriers to follow-up.

Algorithm for 29- to 60-day-old infants



Rate of bacteremia by age groupings. * χ^2 for trend: $P < .001$.



Robert H. Pantell et al. Pediatrics 2021;148:e2021052228

PEDIATRICS

New Educational Resources and Literature

New *simulation scenarios*: <https://www.acepsim.com/>

Sanford *Pediatric Critical Care*: <http://www.learnpicu.com/home>

AAP Section on *EM case scenarios*: <http://emergiquiz.com/>

Gaps in pediatric trauma care: <https://www.generalsurgerynews.com/In-the-News/Article/07-21/Gaps-in-Pediatric-Trauma-Care-Meeting-the-Demands/64042>

- ACS partnership with EMSC

The Casey Foundation *2019 KIDS COUNT Data Book*:
<https://assets.aecf.org/m/resourcedoc/aecf-2019kidscountdatabook-2019.pdf>; <https://datacenter.kidscount.org/data#FL/2/0/char/0>

- Florida still in lower quartile of states

TABLE 2

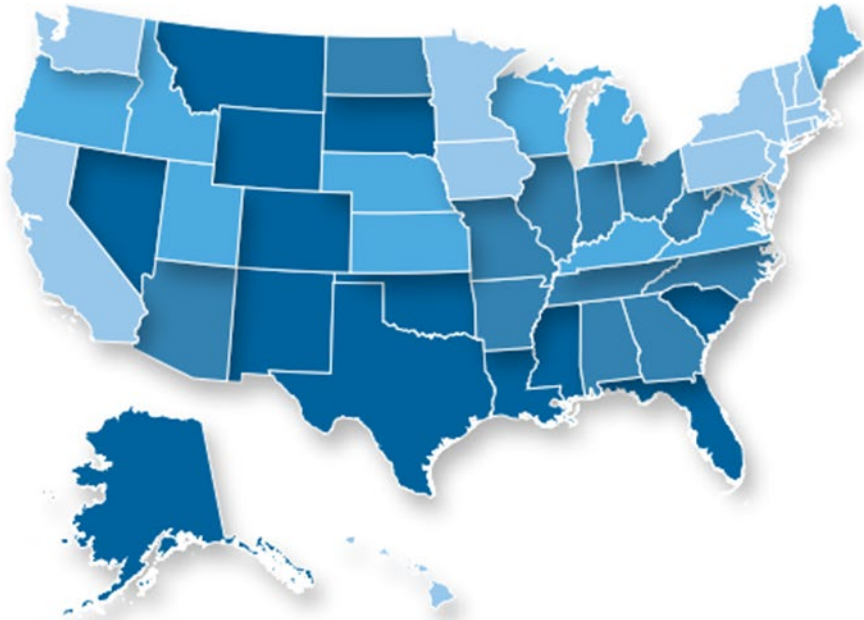
California, Florida and Texas Account for Half of the Nation's Recent Child Population Growth

Change in the Number of Children by Location: 1990–2017

Location	Number of Children: 1990	Number of Children: 2017	Change in Number of Children	Percentage Change
United States	64,218,512	73,655,378	9,436,866	15%
Alabama	1,050,041	1,095,473	45,432	4%
Alaska	177,502	184,928	7,426	4%
Arizona	1,006,040	1,633,490	627,450	62%
Arkansas	620,933	705,540	84,607	14%
California	7,980,501	9,060,136	1,079,635	14%
Colorado	881,640	1,261,833	380,193	43%
Connecticut	752,666	743,826	-8,840	-1%
Delaware	165,628	204,484	38,856	23%
District of Columbia	112,632	124,492	11,860	11%
Florida	2,988,807	4,201,983	1,213,176	41%
Georgia	1,747,363	2,514,698	767,335	44%
Hawaii	279,983	305,744	25,761	9%
Idaho	313,373	443,792	130,419	42%
Illinois	2,940,837	2,897,185	-43,652	-1%
Indiana	1,437,209	1,573,409	136,200	9%
Iowa	719,366	731,947	12,581	2%
Kansas	662,641	712,538	49,897	8%
Kentucky	945,951	1,010,539	64,588	7%
Louisiana	1,205,984	1,108,403	-97,581	-8%
Maine	308,066	252,634	-55,432	-18%
Maryland	1,180,426	1,347,506	167,080	14%
Massachusetts	1,353,806	1,369,955	16,149	1%
Michigan	2,459,633	2,176,649	-282,984	-12%
Minnesota	1,176,680	1,298,657	121,977	10%
Mississippi	733,660	713,567	-20,093	-3%
Missouri	1,316,423	1,382,971	66,548	5%
Montana	223,677	228,889	5,212	2%
Nebraska	430,068	475,733	45,665	11%
Nevada	316,406	685,463	369,057	117%
New Hampshire	277,454	258,773	-18,681	-7%
New Jersey	1,018,187	1,979,018	960,831	9%
New Mexico	453,538	488,080	34,542	8%
New York	4,281,643	4,154,497	-127,146	-3%
North Carolina	1,625,804	2,302,346	676,542	42%
North Dakota	170,920	175,772	4,852	3%
Ohio	2,778,491	2,605,235	-173,256	-6%
Oklahoma	841,715	959,285	117,570	14%
Oregon	742,436	873,619	131,183	18%
Pennsylvania	2,799,168	2,664,515	-134,653	-5%
Puerto Rico	N.A.	656,796	N.A.	N.A.
Rhode Island	225,823	207,332	-18,491	-8%
South Carolina	921,041	1,104,674	183,633	20%
South Dakota	199,453	214,856	15,403	8%
Tennessee	1,220,200	1,507,502	287,302	24%
Texas	4,906,220	7,366,039	2,459,819	50%
Utah	627,122	926,699	299,577	48%
Vermont	143,296	116,825	-26,471	-18%
Virginia	1,520,670	1,869,176	348,506	23%
Washington	1,301,545	1,645,816	344,271	26%
West Virginia	436,797	369,718	-67,079	-15%
Wisconsin	1,302,869	1,282,644	-20,225	-2%
Wyoming	136,078	136,483	405	<.5%

FL 41% increase

A STATE-TO-STATE COMPARISON OF HEALTH: 2019



RANKINGS AND KEY

1. Massachusetts	14. Wisconsin	26. Indiana	38. South Carolina
2. New Hampshire	15. Maryland	27. Illinois	39. Texas
3. New Jersey	16. Maine	28. North Carolina	40. Florida
4. Rhode Island	17. Virginia	29. Ohio	41. Colorado
5. New York	18. Michigan	30. North Dakota	42. Louisiana
6. Minnesota	19. Nebraska	31. West Virginia	43. Oklahoma
7. California	20. Oregon	32. Missouri	44. Montana
8. Iowa	21. Utah	33. Tennessee	45. South Dakota
9. Vermont	22. Delaware	34. Georgia	46. Nevada
10. Hawaii	23. Idaho	35. Arizona	47. Mississippi
11. Washington	24. Kansas	36. Alabama	48. New Mexico
12. Pennsylvania	25. Kentucky	37. Arkansas	49. Wyoming
			50. Alaska

Updates from Other Committees and Constituency Groups

FL EMS 2022 – 2026 State Plan

• # **Strategy** **Objective** **Owner**

Strategic Priority 3: EMS System Infrastructure and Finance

Goal 3.1: Attract, recruit, and retain a prepared, diverse, and sustainable EMS workforce in all geographic areas of Florida

Enhance pediatric pre-hospital care: Increase percentage of EMS agencies with a PECC (Pediatric Emergency Care Coordinator or Champion) to 35% by 2022 with a subsequent increase of 10% per year

- Other plan objectives

- Pending synchronization with other state plans

Updates from Other Committees and Constituency Groups

- Medical Care Committee
 - Drs. Marshall Frank and Dr. Tony Gandia, Co-Chairs
 - Focus on STEMI, Stroke, Sepsis, CA, Trauma
 - Resuscitation academies and dispatcher training
 - CARES

Emergency Medical Services for Children Program

- **Mission: to reduce childhood morbidity and mortality due to severe illness or trauma.**

- Administered by the Health Resources and Services Administration (HRSA), within the Department of Health and Human Services
- Authorized by Congress in 1984
- Focus on enhancing the pediatric capability of existing EMS systems



HRSA-EMSC Programs



Emergency Medical
Services for Children

EMSC Innovation
and Improvement
Center (EIIC)



EIIC

Emergency Medical Services for Children
Innovation and Improvement Center

National EMSC Data
Analysis Resource
Center (NEDARC)



State Partnership
Programs

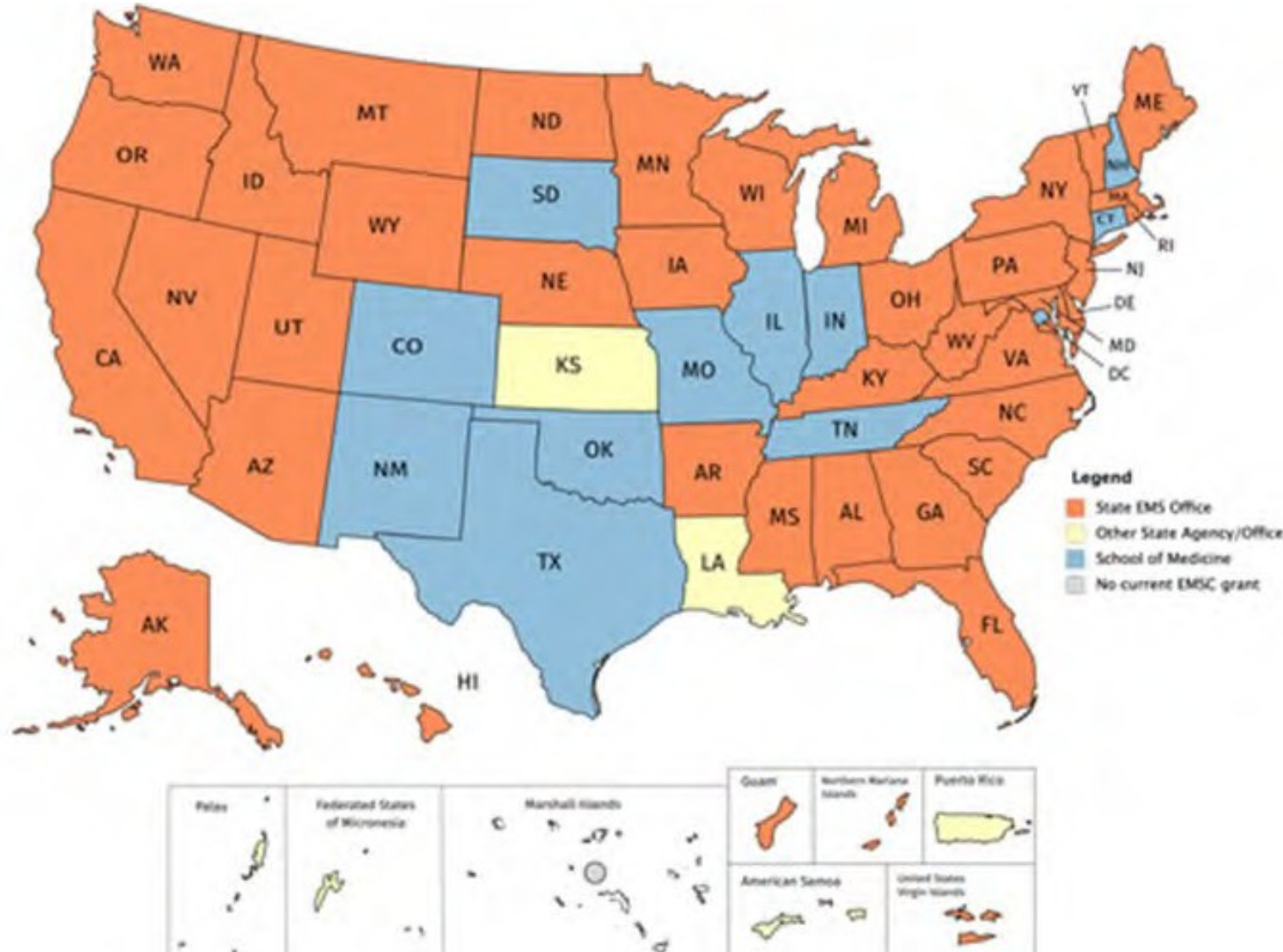


Pediatric Emergency Care
Applied Research Network
(PECARN)



EMS for Children State Partnerships

State Partnership grants were first introduced in 1996 to help states improve, refine, and integrate pediatric care within the state EMS system.



National EMSC Related Updates



NEDARC EMSC 2021 EMS Agency Survey results for performance measures 02 and 03

- FL response rate 50.8% (99/195) vs 44.6% national
- % PECCs increased; use of pediatric specific equipment decreased
- Analysis of NEDARC state level data in Tableau

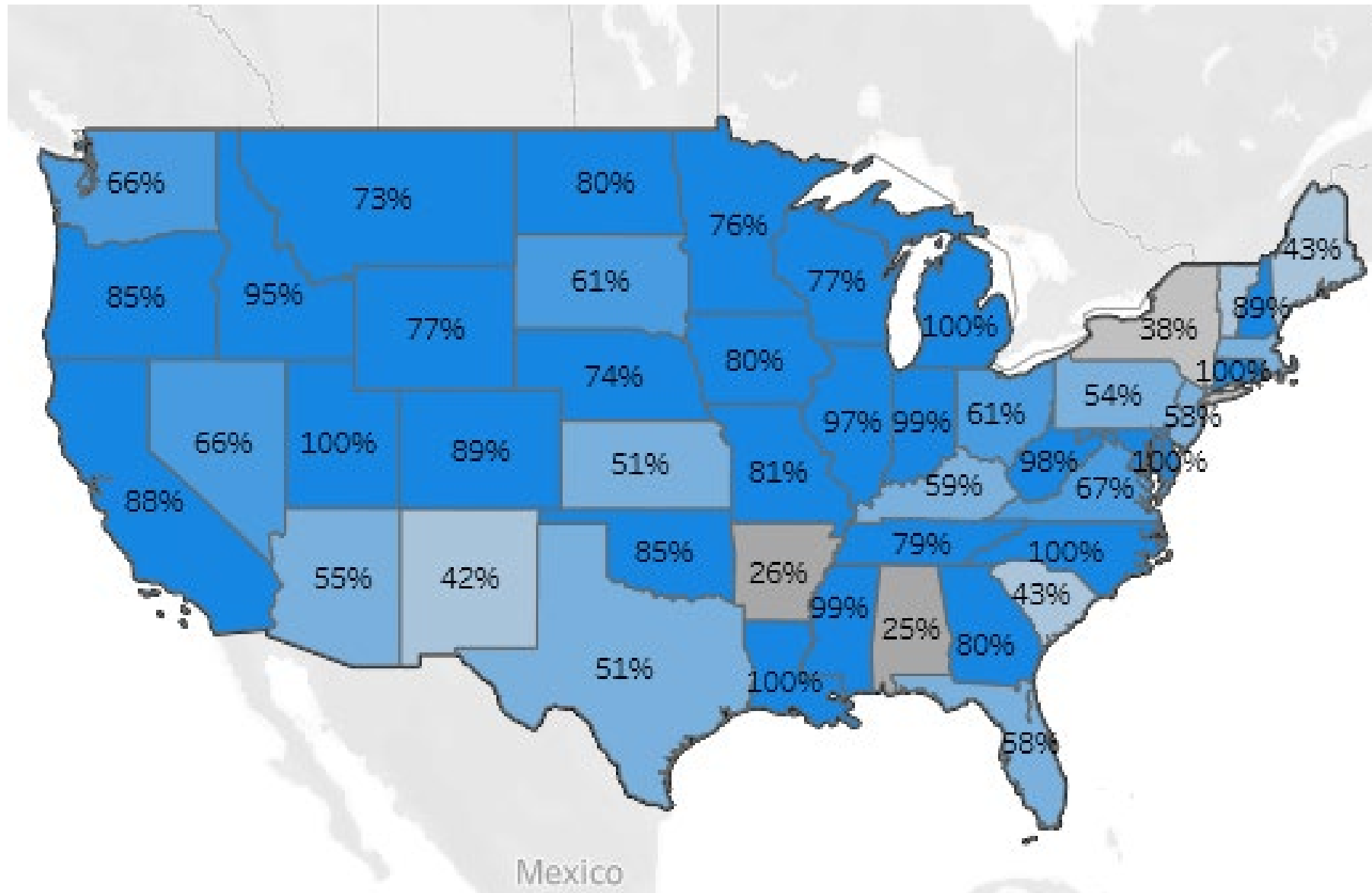
2021 NPRP Assessment (ED pediatric readiness) closed: FL 58% response rate, results pending

- <https://pedsready.org/>.

EIIC Prehospital Pediatric Readiness Toolkit and Checklist:

https://media.emscimprovement.center/documents/Prehospital_Pediatric_Readiness_Checklist_Final.pdf

2021 NPRP Assessment (ED pediatric readiness)



National EMSC Related Updates



EIIC Prehospital Pediatric Readiness Toolkit and Checklist:

https://media.emscimprovement.center/documents/Prehospital_Pediatric_Readiness_Checklist_Final.pdf

EIIC Pediatric Readiness for EDs- checklists **updated 2021**

- https://media.emscimprovement.center/documents/NPRP_Modified_Interactive_Checklist_Final.pdf
- https://media.emscimprovement.center/documents/NPRP_Checklist_Final_Apr2021.pdf



Prehospital Pediatric Readiness EMS AGENCY CHECKLIST



This checklist is based on the 2020 joint policy statement “[Pediatric Readiness in Emergency Medical Services Systems](#)”, co-authored by the Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), National Association of EMS Physicians (NAEMSP), and National Association of EMTs (NAEMT). Additional details can be found in the AAP Technical Report “[Pediatric Readiness in Emergency Medical Services Systems](#)”.

Use this tool to check if your EMS agency is ready to care for children as recommended in the Policy Statement.

Consider using resources compiled by the Health Resources & Services Administration’s Emergency Medical Services for Children (EMSC) Program when implementing the recommendations noted here, to include the [Prehospital Pediatric Readiness Toolkit](#).



EDUCATION & COMPETENCIES FOR PROVIDERS

- ☐ Process(es) for ongoing pediatric specific education using one or more of the following modalities:
 - Classroom/in-person didactic sessions
 - Online/distributive education
 - Skills stations with practice using pediatric equipment, medication and protocols
 - Simulated events

Process for evaluating pediatric-specific competencies for the following types of skills:

- ☐ Psychomotor skills, such as, but not limited to:
 - Airway management
 - Fluid therapy
 - Medication administration
 - Vital signs assessment
 - Weight assessment for medication dosing and equipment sizing
 - Specialized medical equipment
- ☐ Cognitive skills, such as, but not limited to:
 - Patient growth and development
 - Scene assessment
 - Pediatric Assessment Triangle (PAT) to perform assessment
 - Recognition of physical findings in children associated with serious illness
- ☐ Behavioral skills, such as, but not limited to:
 - Communication with children of various ages and with special health care needs
 - Patient and family centered care
 - Cultural awareness
 - Health care disparities
 - Team communication

EQUIPMENT AND SUPPLIES

- ☐ Utilize national consensus recommendations to guide availability of equipment and supplies to treat all ages
- ☐ Process for determining competency on available equipment and supplies

PATIENT AND MEDICATION SAFETY

- ☐ Utilization of tools to reduce pediatric medication dosing and administration errors, such as, but not limited to:
 - Length based tape
 - Volumetric dosing guide
- ☐ Policy for the safe transport of children
- ☐ Equipment necessary for the safe transport of children

PATIENT- AND FAMILY-CENTERED CARE IN EMS

Partner with families to integrate elements of patient- and family-centered care in policies, protocols, and training, including:

- ☐ Using lay terms to communicate with patients and families
- ☐ Having methods for accessing language services to communicate with non-English speaking /non-verbal patients and family members
- ☐ Narrating actions, and alerting patients and caregivers before interventions are performed

Policies and procedures that facilitate:

- ☐ Family presence during resuscitation
- ☐ The practice of cultural or religious customs
- ☐ A family member or guardian to accompany a pediatric patient during transport

POLICIES, PROCEDURES, AND PROTOCOLS (TO INCLUDE MEDICAL OVERSIGHT)

- ☐ Prearrival instructions identified in EMS dispatch protocols include pediatric considerations, when relevant, such as, but not limited to:
 - Respiratory distress
 - Cardiac arrest
 - Choking
 - Seizure
 - Altered consciousness
- ☐ Policies, procedures, and protocols include pediatric considerations, such as, but not limited to:
 - Policy on pediatric refusals
 - Pediatric assessment
 - Consent and treatment of minors
 - Recognition and reporting of child maltreatment
 - Trauma triage
 - Children with special health care needs
- ☐ Direct medical oversight integrates pediatric-specific knowledge
- ☐ Protocols (indirect medical oversight) include pediatric evidence when available
- ☐ Destination policy that integrates pediatric-specific resources

QUALITY IMPROVEMENT (QI)/ PERFORMANCE IMPROVEMENT (PI)

- ☐ PI process includes pediatric encounters
- ☐ Pediatric-specific measures are included in the PI process
- ☐ Submission of EMS agency data to the state’s prehospital patient care database
- ☐ Submitted data is compliant with the current version of NEMSIS (version 3.x or higher)
- ☐ Process to track pediatric patient centered outcomes across the continuum of care, such as, but not limited to:
 - Transport destination
 - Secondary transport destination
 - ED and hospital disposition
 - ED and hospital diagnoses
 - Survival to hospital admission
 - Survival to hospital discharge

INTERACTION WITH SYSTEMS OF CARE

Policies, procedures, protocols, and performance improvement initiatives involve ongoing collaboration with:

- ☐ Pediatric emergency care
- ☐ Public health
- ☐ Family advocates

Plans and exercises for disasters or mass casualty incidents include:

- ☐ Care of pediatric patients, such as, but not limited to:
 - Pediatric mental health first aid
 - Pediatric disaster triage
 - Pediatric dosing of medications used as antidotes
 - Pediatric mass transport
- ☐ Tracking of unaccompanied children
- ☐ Family reunification
- ☐ Collaborate with external personnel or have internal staff focused on enhancing pediatric care, such as, but not limited to:
 - Pediatric emergency care coordinator (PECC)
 - Regional PECC
 - Pediatric advisory council(s)
 - Medical director with pediatric knowledge and experience

- ☐ Understand pediatric capabilities at local and/or regional emergency departments for children with the following types of conditions:
 - Medical emergency
 - Traumatic injury
 - Behavioral health emergency
- ☐ Policies and/or procedures for transfer of responsibility of patient care at destination

Revised May 20, 2021

To provide feedback on this checklist, please email pprp@emscimprovement.center

For additional information on the Prehospital Pediatric Readiness Project (PPRP), visit:
<https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness>





Pediatric Readiness in the Emergency Department

Resources and Tools – Interactive Modified Checklist

This document, based on the **Pediatric Readiness in the Emergency Department Checklist**, provides direct links to Toolkit resources, where applicable. This interactive document is *not* the Checklist in its entirety. The full version of the Checklist, the Pediatric Readiness in the Emergency Department joint position statement, and all Toolkit materials can be found [here](#).

In an effort to connect the checklist with the most relevant resources found in the Readiness Toolkit, the EMSC Innovation and Improvement Center (EIIC), together with the two Pediatric Disaster Care Centers of Excellence—the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) and the Eastern Great Lakes Pediatric Consortium for Disaster Response (EGLPCDR), developed the following document for use by hospital emergency departments.

Administration and Coordination of the ED for the Care of Children

Checklist Item	Specific Resources for Individual Items
☐ Physician Coordinator for Pediatric Emergency Care (PECC)	Role Responsibilities: Physician Coordinator for Pediatric Emergency Care
Board certified/eligible in EM or PEM (preferred)	EM / PEM
☐ Nurse Coordinator for Pediatric Emergency Care (PECC)	Role Responsibilities: Nursing Coordinator for Pediatric Emergency Care
- CPEN/CEN (preferred) - Other credentials (e.g., CPN, CCRN)	CEN / CPEN CPN / CCRN
General Resources	
Is Your ED Ready for Children? Pediatric Emergency Care Coordinators Lead the Way to Readiness! (webinar recording)	
Importance of the Pediatric Emergency Care Coordinator	

Physicians, Advanced Practice Providers (APPs), Nurses, and Other ED Healthcare Providers

Checklist Item	Specific Resources for Individual Items
☐ Healthcare providers who staff the ED have periodic pediatric-specific competency evaluations for children of all ages. Areas of pediatric competencies include:	
Assessment and treatment (e.g., triage)	Physical Assessment Skills Checklist (Pediatric)

Physicians, Advanced Practice Providers (APPs), Nurses, and Other ED Healthcare Providers

Checklist Item	Specific Resources for Individual Items
- Device/equipment safety - Critical procedures - Resuscitation - Disaster drills that include children	Equipment Competency Validation Record Clinical Practice Pathways AHA: PALS and PEARS Lurie Children's Hospital Disaster Exercises
Team training and effective communication	Orientation Knowledge and Skills Checklist for the RN SBAR Tool TeamSTEPPS
General Resources	
Orientation Knowledge and Skills Checklist for the RN	

Guidelines for QI/PI in the ED

Checklist Item	Specific Resources for Individual Items
☐ The QI/PI plan includes pediatric-specific indicators:	
- Data are collected and analyzed - System changes are implemented based on performance - System performance is monitored over time	HCA Pediatric Readiness Gap Analysis (Example) Rapid-Cycle Improvement Controlling Change Pediatric Readiness Data: An Opportunity to Improve Quality of Care in Your ED (webinar recording)
General Resources	
Check Your Pediatric Preparedness (Site Assessment & Checklist) Quality Improvement Concepts Example QI Plan: Illinois EMSC Pediatric Mild Traumatic Head Injury	

ED Policies, Procedures, and Protocols

Checklist Item	Specific Resources for Individual Items
Policies, procedures, and protocols for the emergency care of children. <i>(These policies may be integrated into overall ED policies if pediatric-specific issues are addressed.)</i>	
☐ Illness and injury triage	Direct Link to Toolkit
☐ Pediatric patient assessment and reassessment	Direct Link to Toolkit
☐ Identification and notification of the responsible provider of abnormal pediatric vital signs	Direct Link to Toolkit
☐ Immunization assessment and management of the under-immunized patient	Direct Link to Toolkit

ED Policies, Procedures, and Protocols

Checklist Item	Specific Resources for Individual Items
☐ Sedation and analgesia, for procedures including medical imaging	Direct Link to Toolkit
☐ Consent, including when parent or legal guardian is not immediately available	Direct Link to Toolkit LA PedsReady Example
☐ Social and behavioral health issues	Direct Link to Toolkit LA PedsReady Example
☐ Physical or chemical restraint of patients	Direct Link to Toolkit
☐ Child maltreatment reporting and assessment	Direct Link to Toolkit
☐ Death of the child in the ED	Direct Link to Toolkit LA PedsReady Example
☐ Do not resuscitate (DNR) orders	Direct Link to Toolkit
☐ Children with special health care needs	Direct Link to Toolkit
☐ Family and guardian presence during all aspects of emergency care, including resuscitation	Direct Link to Toolkit LA PedsReady Example
☐ Patient, family, guardian, and caregiver education	Direct Link to Toolkit
☐ Communication with the patient's medical home or primary care provider as needed	Direct Link to Toolkit
☐ Telehealth and telecommunications	Direct Link to Toolkit

All-Hazard Disaster Preparedness

Checklist Item	Specific Resources for Individual Items
The written all-hazard disaster-preparedness plan addresses pediatric-specific needs within the core domains	
☐ Pediatric surge capacity for injured and non-injured children	ASPR TRACIE Pediatric Surge Annex
☐ Decontamination, isolation, and quarantine of families and children of all ages	AAP Decontamination REMM: Decontamination of Children (video)
☐ Minimization of parent-child separation	Location for Family Reunification Checklist for Locating Families
☐ Tracking and reunification for children and families	Family Sign-In and Tracking Form Unaccompanied Minor Tracking Form
☐ Disaster drills include a pediatric mass casualty incident at least every two years	Disaster Planning: Preparing for Pediatric Surges

All-Hazard Disaster Preparedness

General Resources
Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies
LA County Family Assistance Center Plan

Evidence-Based Guidelines

Checklist Item	Specific Resources for Individual Items
☐ Evidence-based clinical pathways, order sets or decision support available to providers in real time	PECARN Publications TREKK (Translating Emergency Knowledge for Kids) AHA Pediatric Resuscitation AHA Neonatal Resuscitation

Inter-facility Transfers

Checklist Item	Specific Resources for Individual Items
☐ Written pediatric inter-facility transfer agreements	Interfacility Transfer Toolkit
☐ Written pediatric inter-facility transfer guidelines	Interfacility Transfer Toolkit Example

Guidelines for Improving Pediatric Patient Safety

Checklist Item	Specific Resources for Individual Items
Pediatric patient and medication safety needs are addressed	
☐ Children are weighed in kilograms only	eBroselow System
☐ For children who require emergency stabilization, a standard method for estimating weight in kilograms is used (e.g., a length-based system)	Pediatric Resuscitation and Emergency Medications - Excel Calculator
☐ Infants and children have a full set of vital signs recorded	Quick Reference Code Cards Vital Sign Assessment Policy Example
☐ Process for safe medication delivery that includes: • Prescribing • Administration • Disposal	

Guidelines for ED Support Services

Checklist Item	Specific Resources for Individual Items
☐ Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions for children	SAMPLE Imaging and Radiology Policy Template
General Resources	
ACR Appropriateness Criteria® Suspected Physical Abuse—Child Radiation Risk to Children From Computed Tomography Children With Minor Blunt Head Trauma Presenting to the Emergency Department	

National EMSC Related Updates

- EMSC Grantee meeting August 31-September 2 (recordings available soon)
Hendry, Dully and Nasca presented on Child Abuse During the Pandemic: Up, Down or Different?”
EMSC Communications: How to Share our Successes (Hendry representing EMSC state partnerships); FL PEDReady newsletter highlighted
- PECC workforce <https://emscimprovement.center/collaboratives/pwdc/>
September 1, 2021 – June 30, 2022
- -EMSC Pulse monthly newsletter: main means of national communication
<https://emscimprovement.center/news/>
- -NAEMSP Policy Statements coming soon on Pediatric Airway Management in the Prehospital Setting

Child Abuse During the Pandemic: Up, Down or Different?

Dr. Phyllis Hendry, FAAP, FACEP

Dr. Kathleen Dully, FAAP

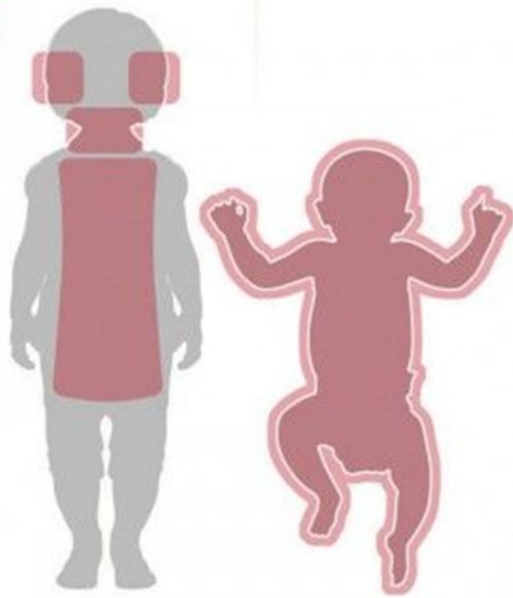
Sandra Nasca, RN

Don't Forget: TEN 4 FACES

BRUISING RULES

Torso Ears Neck
4 years & under

OR ANY BRUISING ON AN INFANT
4 MONTHS OR YOUNGER



ABUSE: TEN 4 FACES P

Any bruising to the:

Torso, Ears, or Neck

4 yrs or under

Frenulum, Angle of jaw, Cheek, Eyelid, Sclera

Pattern

Or ANY bruising *4 months or under*

is a significant indicator of child abuse.



EMSC

Emergency Medical
Services for Children

#EMSC2021meeting

Pierce MC, Kaczor K, Lorenz DJ, et al. Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics. JAMA Netw Open. 2021;4(4):e215832. doi:10.1001/jamanetworkopen.2021.5832

New Regional Pediatric Pandemic Network will partner with EIIC to build on EMSC disaster preparedness efforts (HRSA)

\$9,700,000 per year/five-year grant

The five children's hospitals are:

- UH Rainbow Babies and Children's Hospital (lead center)
- University of California San Francisco-Benioff Children's Hospital
- University of Louisville School of Medicine-Norton Children's Hospital
- University of Utah, Primary Children's
- Saint Louis University-Cardinal Glennon Children's Hospital

PIs: Charles Macias, MD, MPH, Executive Director of the EMSC Innovation and Improvement Center and Chief Quality Officer at Rainbow Babies and Children's, and Christopher Newton, MD, FACS, FAAP, Medical Director of the Trauma Care Center and Pediatric Surgery Department at Benioff Children's.

Florida EMSC/PEDReady Updates



-State Awards

-PEDReady website: <https://emlrc.org/flpedready/>

-Report on recent educational sponsorships and meetings

- EMSC Sponsorship of 2021 Symposium by the Sea in August
 - Pediatric Cardiac complications: COVID-19 & MIS-C by Drs. Zeretzke-Bien and Swan
 - Sudden Cardiac Arrest in Young Athletes by Dr. Carmen J. Martínez Martínez
- - FCEP's 50th Anniversary Celebration during Symposium by the Sea, "50 Years, 50 Voices" project: <https://fcep.org/50years/>



Our Mission

Advancing Patient Safety by Training Clinicians to Use Existing Devices, Procedures, and Drugs Better via Simulation and Re-Designing Devices, Procedures, and Drug Delivery.



Taking the "Trauma" out of Florida Pediatric Trauma Preparedness and Management: A Multidisciplinary Educational State Initiative

Florida *PED*TraumaReady



FLORIDA

PEDReady



Overall Goal

All Florida EDs and EMS agencies are

PEDTraumaReady

Funding:

University of Florida JHMHC Self Insurance Program

UF W. Martin Smith Interdisciplinary Patient Safety Awards

Learning Objectives

- Describe pediatric trauma epidemiology and trends
- Understand unique anatomic, physiologic and psychologic characteristics of the pediatric age groups that affect response to injury and management.
- Identify current challenges and priorities in managing and transporting pediatric trauma patients
- Review current pediatric trauma protocols, guidelines, literature, and resources to use for advanced preparation
- Discuss and complete interactive pediatric trauma and burn case scenarios



FL TRAUMA PEDReady

Need updated list of trauma centers with contact phone number, address, directions:

https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/reports/Hospital_ER_Services.pdf

Burn centers in FL: <https://floridacot.org/florida-burn-centers>

Risk of Traumatic Brain Injuries in Infants Younger than 3 Months With Minor Blunt Head Trauma

- The PECARN traumatic brain injury low-risk criteria accurately identified infants <3 months old at low risk of clinically important traumatic brain injuries. However, infants at low risk for clinically important traumatic brain injuries remained at risk for traumatic brain injuries on CT, suggesting the need for a cautious approach in these infants.
- [https://www.annemergmed.com/article/S0196-0644\(21\)00298-5/fulltext](https://www.annemergmed.com/article/S0196-0644(21)00298-5/fulltext)

Risk of Traumatic Brain Injuries in Infants Younger than 3 Months With Minor Blunt Head Trauma. Zaynah Abid, MD, MPH, Nathan Kuppermann, MD, MPH, Daniel J. Tancredi, PhD, Peter S. Dayan, MD, MSc

Annals of Emergency Medicine
Volume 78 Issue 3 Pages 321-330.e1 (September 2021)

Absence of:

Glasgow Coma Scale score < 15

Other signs of altered mental status

Palpable skull fracture

Scalp hematoma (excluding frontal)

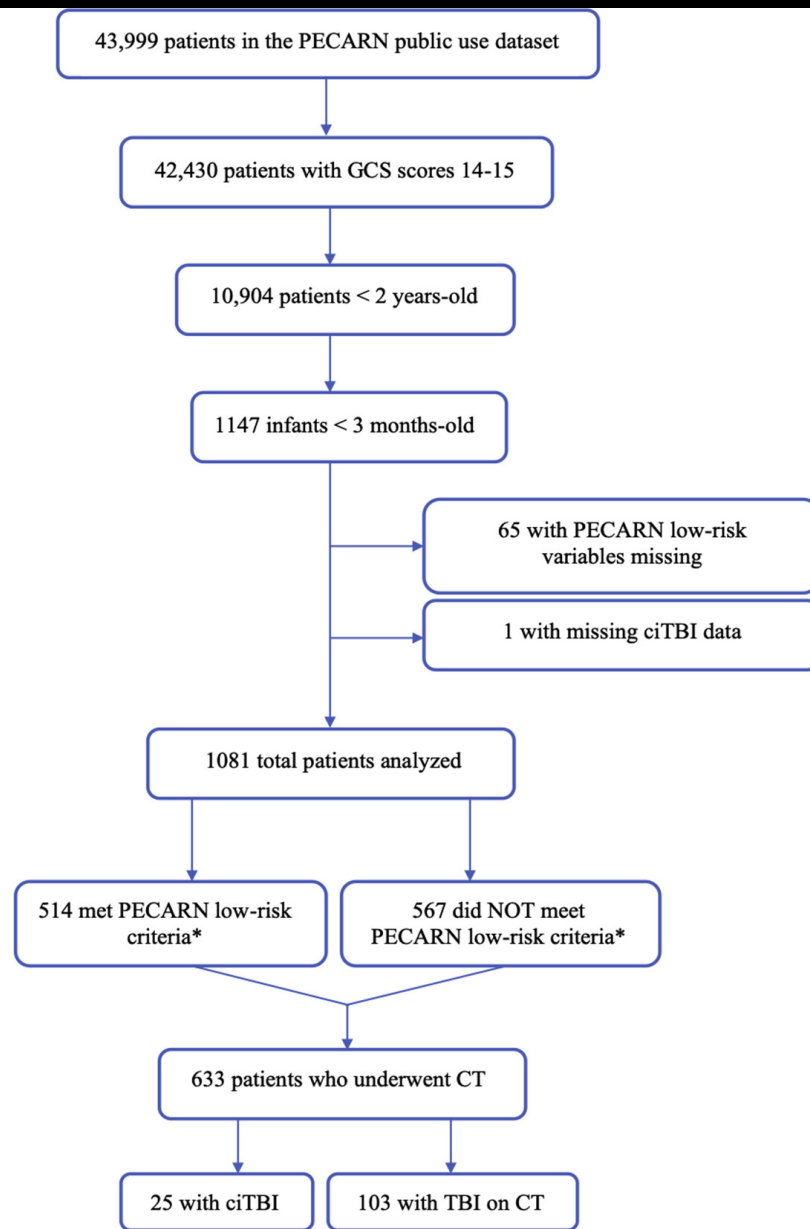
Loss of consciousness $\geq$ 5 seconds

Not acting normally per parent

Severe mechanism of injury

- ◆ Fall > 3ft
- ◆ Motor vehicle crash with patient ejection, death of another passenger or rollover
- ◆ Pedestrian or bicyclist without helmet struck by motor vehicle
- ◆ Head struck by high impact object





*PECARN criteria were not established at the time of parent study; CTs obtained at the discretion of treating clinician

Florida EMSC/PEDReady Updates



- May 2022 EMSC Day plans
- Rural update (Bedford)
- Florida FAN Report (Nasca)
- FCEP Pediatric EM Committee Update
- Request for badge buddies with pediatric VS, etc.
 - EDs that don't see children often

EMSC Committee: 4 PEDReady Work Groups

Pediatric Resuscitation

- -CARES update
- -FL Resuscitation Academy with pediatric add on
- -Other updates

Safe Pediatric Transport

PECCs and Pediatric Equipment Education

- National collaborative
- -Trauma Program Managers added upon request
- -Felix Marquez and VR: <https://www.youtube.com/watch?v=UhcHFv1X9fl>

Pediatric Mental Health and Disaster

- JumpSTART badge buddy updates
 - Eastern Great Lakes Pediatric Consortium for Disaster Response (EGLPCDR) educational modules on JumpSTART
- TEEEX Pediatric Disaster Response and Emergency Preparedness Course
- -Mental health- EIIIC toolkit in progress
<https://emscimprovement.center/education-and-resources/peak/pediatric-suicide-screening-mental-health/>
- -AAP pediatric mental health minute series:
<https://www.aap.org/en/patient-care/mental-health-minute/>

START Modified ADULT

(size, + 2° sex characteristics)

Move the Walking Wounded

MINOR

No Respirations after Head Tilt

EXPECTANT

CONTROL BLEEDING

Respiratory Distress (> 30/min)

IMMEDIATE

Perfusion (No Radial Pulse)

IMMEDIATE

Mental Status

IMMEDIATE

(Unable to Follow Commands)

Normal RPM, Follows Commands

DELAYED

CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

FL MCI LEVELS

MCI Level 1: 5-10 victims

MCI Level 2: 11-20 victims

MCI Level 3: 21-100 victims

MCI Level 4: 100 -1000 victims

MCI Level 5: Over 1000 victims

July 2021

IMMEDIATE

Red

DELAYED

Yellow

MINOR

Green

EXPECTANT

Black

JumpSTART Modified

(Newborn to Young Adult*)

Move the Walking Wounded

MINOR

No Respirations and No Peripheral Pulse

EXPECTANT

Respiratory Rate: > 45/min, < 15/min
or ↑Work of Breathing, obvious distress

IMMEDIATE

No Respirations with Peripheral Pulse
Give 5 Ventilations via Barrier Device
Spontaneous Respirations Resume
after 5 Ventilations

IMMEDIATE

No Spontaneous Respirations Resume
after 5 Ventilations

EXPECTANT

CONTROL BLEEDING

Perfusion (No Palpable Pulse)

IMMEDIATE

Mental Status**

Unresponsive or not localizing pain

IMMEDIATE

Alert, responds to voice, localizes pain

DELAYED

*Presence of 2° sex characteristics; **Consider developmental level
July 2021 with permission ©Lou E Romig MD. emlrc.org/flpedready/

CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

Pediatric Mental Health and Disaster

Concussion season: A third of children and adolescents develop a mental health problem after a concussion!

- HEADS UP to Schools: Online Concussion Training for School Professionals (CDC)

Infographic from Michigan and Ohio:

https://media.emscimprovement.center/documents/FINAL_HVA_and_Children.pdf

New federal funding for pediatric mental health

- <https://mchb.hrsa.gov/maternal-child-health-initiatives/mental-behavioral-health/arp-pediatric-mental-health>

Contacting guardians of minor baker acts and incarcerated children

**New HEADS UP Concussion Training for School Professionals.
Plus, new reports from CDC's Traumatic Brain Injury Team**



The [HEADS UP to Schools: Online Concussion Training for School Professionals](#) is designed to help classroom teachers (grades K-12), school administrators, paraprofessionals, teachers' aides, and other staff who work with students understand:

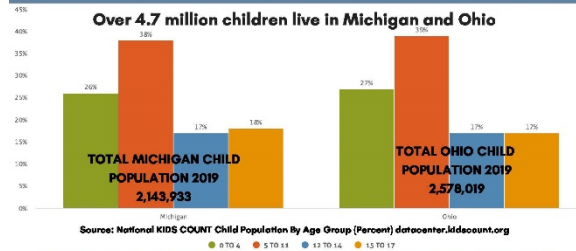
- How a concussion may affect a student's learning, emotions, and behavior.
- How to identify and monitor signs and symptoms of concussion.
- How to help students successfully return to school and recover from a concussion.

This free training will take about 45-60 minutes to complete. It features easy-to-follow information with knowledge checks and illustrated case studies that showcase a variety of scenarios to help you apply the information presented and achieve the key learning objectives of the course.

Check out the [CDC HEADS UP](#) trainings on concussion:

Children and Disaster

Emergency Management: Threat Assessment, Hazard Identification, and Risk



Children are a high-risk vulnerable population and are consistently left out of hospital & regional threat and hazard assessments.

Including children in threat and hazard assessments creates opportunities to avoid, control, and reduce community impacts as well as promote whole community engagement & capability



National pediatric readiness scores for hospitals in Michigan/Ohio was 66/67 out of 100 in 2014. While these scores fall within the national average, higher scores are known to be associated with improved pediatric care outcomes.



A Center for American Progress 2020 analysis reported that 30% of the Ohio/Michigan Health Care workforce have children <14 years old. Planning with childcare and schools preserves local and regional health provider workforce.



According to KIDS COUNT Data Center in 2019 18% of Ohio and Michigan children live in poverty. Planning for children is essential for shelter & food assistance programs. Disaster events increase the need for food and shelter assistance and have lasting community impacts.

Child-Centric Disaster Readiness

Sources: American Academy of Pediatrics, FEMA & CDC



- Community resilience begins with teaching children to be disaster ready.
- Children are able to engage parents in disaster readiness learned in schools.
- Children & youth are capable to become disaster leaders.
- Children & families who are disaster ready experience less long term impacts.

Pediatric Disaster Readiness = Whole Community Readiness



This publication was made possible by Award Number (U59CE000151-01) from the Office of the Assistant Secretary for Preparedness and Response (ASPPR). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of ASPPR or the Department of Health and Human Services.

Children and Disaster

Emergency Management: Threat Assessment, Hazard Identification, and Risk

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Regional Healthcare Coalition 2020 Top 5 Hazard Vulnerabilities



1 Blizzard Snow

- Awareness:** Children are at greater risk of injury and death due to severe weather events. Pediatric admissions to hospitals associated with frostbite, hypothermia, and carbon monoxide poisoning should be anticipated.
- Preparedness:** Workforce with children may travel long distances to and from their children impacting their ability to respond to disasters.
- Response:** Families with children who are dependent on medical devices are known to seek assistance from 911 and hospitals during a severe weather power outage.
- Mitigation:** Children rely on their families, childcare providers, and schools to prepare and gather supplies prior to freezing winter storms.



2 Active Shooter

- Awareness:** There were 70 school shootings in Michigan and 55 in Ohio in 2020. Most shootings occur within proximity to schools.
- Preparedness:** Active shooter drills in schools were associated with a 42% increase in anxiety & stress and 39% in depression. The American Academy of Pediatrics recommends that drills be conducted in a manner that does not traumatize children.
- Response:** PsySTART triage assists providers in allocating mental health resources to children and adults after the event. Limiting children's media exposure when an incident occurs reduces anxiety. Practice age-appropriate community messaging to reassure children.
- Mitigation:** Stop-the-bleed training is for everyone, including middle and high school students. Hospitals need to ensure there is a practiced plan for family reunification and unaccompanied children.



3 Chemical Exposure

- Awareness:** Children have a greater risk of respiratory failure and acute toxicity. Children breathe more air per kilo and have a higher body surface area that increases the absorption of toxins. Agents of the highest concern include nerve, blistering, asphyxiants, and disabling agents.
- Preparedness:** Childcare, schools, and families should have plans for sheltering in place. Prehospital providers and hospitals decontamination equipment and PPE.
- Response:** Anticipate the decontamination of children within a short period of time. Prevent hypothermia using warmed water for decontamination. Prepare for pediatric medical countermeasure administration.
- Mitigation:** Communities should have reliable mechanisms to alert the community to a toxic exposure and how to shelter in place.



4 Mass Casualty

- Awareness:** Only 13% of communities have a mass casualty plan that includes children. Trauma accounts for approximately 20% of pediatric EMS encounters under normal conditions. Children are at greater risk of blunt chest and abdominal trauma, including traumatic asphyxia.
- Preparedness:** Adopting a single standard for pediatric triage such as JumpSTART or SALT improves on-scene triage between responders.
- Response:** Children with critical trauma or burns require a regional coordinated system of response. EMS transport mutual aid, including air transport to distant pediatric regional centers, should be anticipated.
- Mitigation:** Promote Stop-the-Bleed Programs. Place stop-the-bleed kits with public access defibrillators.



5 Cyber

- Awareness:** Every year thousands of children become victims of cybercrime. The National Center for Missing and Exploited Children (NCMEC) CyberTipline reports included over 69 million images, videos, and other files related to child sexual exploitation.
- Preparedness:** Secure computer networks in schools, libraries, and other areas where children gather. Train caretakers in the signs of child cybercrime.
- Response:** As children move to online learning the need to monitor and report cybercrime events against children through appropriate law enforcement channels including the NCMEC.
- Mitigation:** Promote programs known to reduce the risk of cybercrime of children from the FBI and National Center for Missing and Exploited Children.

PECCs and Pediatric Equipment Education

- Need section on website
- EIIIC Collaborative
- Updates and ideas from PECCs

<https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/>

“225,978 child COVID-19 cases 9/9/21-9/16/21 (5,292,837 to 5,518,815) and children represented 25.7% (225,978/878,977) of the weekly reported cases”

Children and COVID-19: State Data Report

A joint report from the American Academy of Pediatrics and the Children's Hospital Association

Summary of publicly reported data from 49 states, NYC, DC, PR, and GU

Version: 9/16/21

** Note: The numbers in this report represent cumulative counts since states began reporting. The data are based on how public agencies collect, categorize and post information. All data reported by state/local health departments are preliminary and subject to change and reporting may change over time. Notably, in the summer of 2021, some states have revised cases counts previously reported, begun reporting less frequently, or dropped metrics previously reported. For example, due to several changes on their dashboards and the data currently available, AL, NE, and TX data in this report are not current (cumulative data through 7/29/21, 6/24/21, and 8/26/21 respectively). Readers should consider these factors. States may have additional information on their web sites.*

<https://abc13.com/houston-coronavirus-11-month-old-girl-with-covid-baby-treated-at-hospital-150-miles-away-hospitals-running-out-of-space-for-patients/10933199/>

<https://files.asprtracie.hhs.gov/documents/aspr-tracie-pediatric-lessons-learned-from-covid-19-immediate-and-future-implications.pdf>

Drug-related 911 calls for youth jumped 43% in 2020 (NEMSIS):

<https://www.reuters.com/article/us-health-coronavirus-trauma-specialreport/idUSKBN2FE14C>

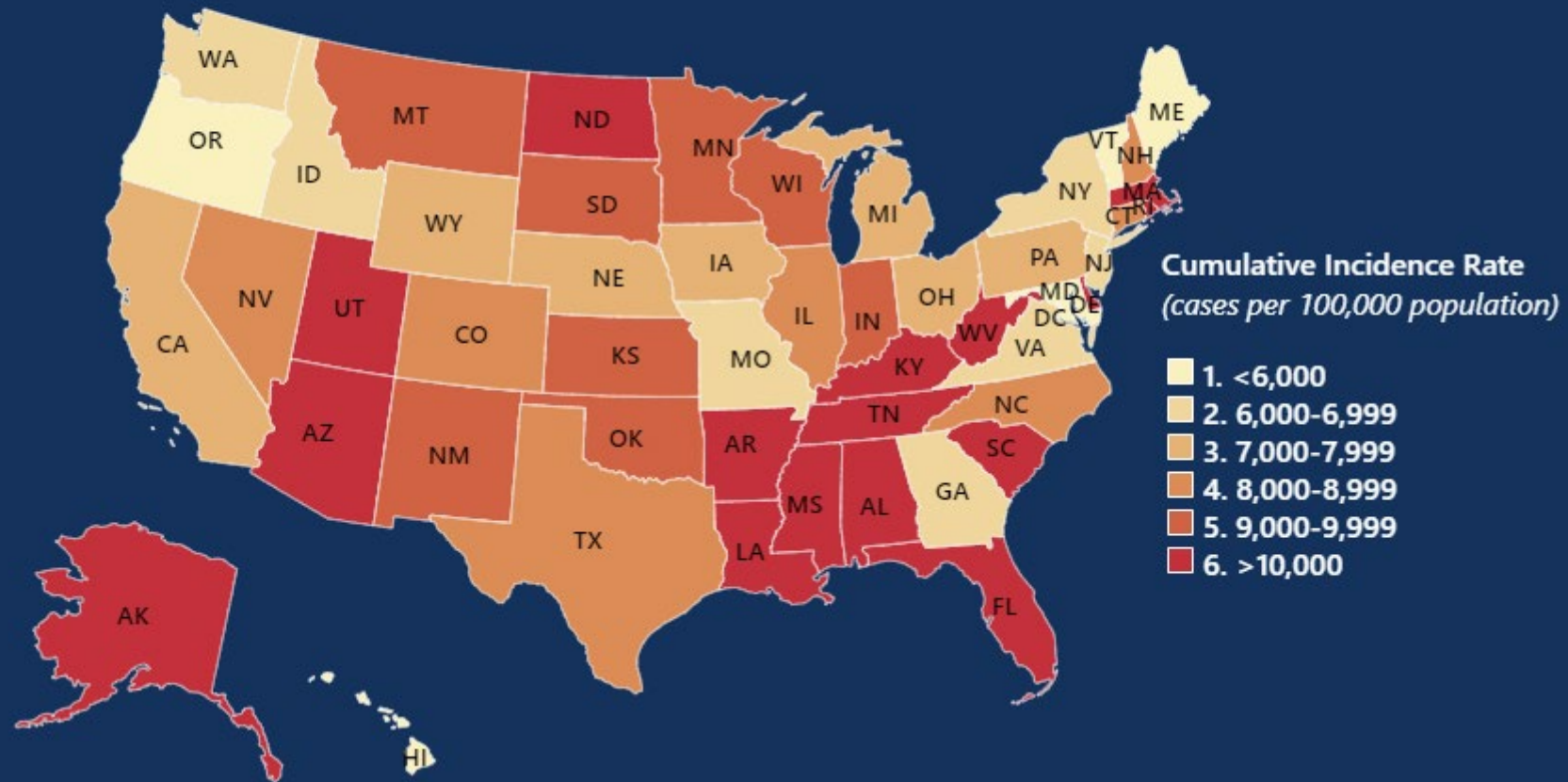
https://www.cdc.gov/mis/mis-c/hcp/provider-resources/index.html?s_cid=misc-006&utm_source=CDC+COCA+Newsletter&utm_campaign=MISC

<https://www.covkidproject.org/>

Cumulative Incidence of COVID-19 in Children and Teens

Reported cases per 100,000 Population

www.covkidproject.org Updated **09/17/2021** @covkidproject

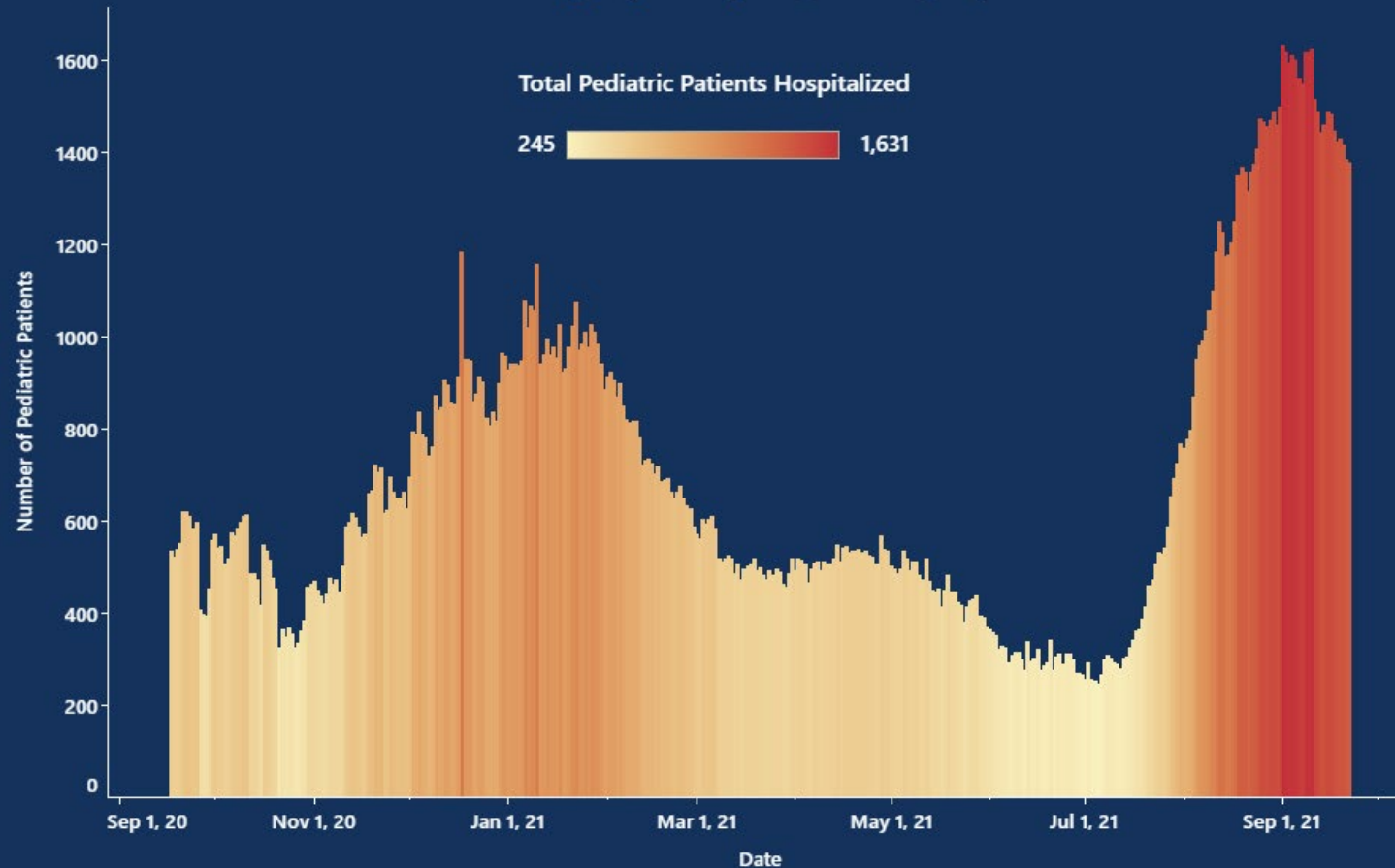


COVID-19 Hospitalizations Dashboard

Scroll down or select: **National** or **State**

Pediatric Patients Currently Hospitalized with Confirmed COVID-19
United States **9/17/2020** to **9/22/2021**

www.covkidproject.org [@covkidproject](https://twitter.com/covkidproject)



Upcoming Meetings of Interest

- Next EMSC Advisory Committee meeting
proposed for week of January 17-21st in Daytona (Fire East)
- FAEMSMD (<https://faemsmd.org/>) next meeting TBD
 - FL EMS Update + Eagles Webinars Tuesday's - 11:00 AM to 12:30 PM
- Next Resuscitation Academy ?
- Handtevy Pediatric Pre-Hospital Instructor Course-EMS World Oct. 5th
- ? Others

Thank You!

Sears Catalog, 1961 🤖



Auto Strap for front-seat tots

\$1.88

Guards your child as you're busy driving through traffic. Lets him sit, stand, kneel or sleep without disturbing driver. Prevents spills from sudden stops. Heavy web harness attaches to safety strap that snaps to car seat frame. Removes easily. Also use as walking harness. For 1 to 10-year olds. Fits any car. Shpg. wt. 9 oz.

460 SEARS 3PCBKM

49 G 7945.....\$1.88

- New Business
- Questions
- Announcements



The 9 National EMSC State Performance Measures

Pre-hospital

- **Availability of EMS pediatric patient care data**
- **Coordination/advocacy for pediatric emergency care within EMS system
PECC or Champion**
- **Proficiency of EMS providers in the use of pediatric-specific equipment**

Hospital

- Facility recognition programs (pediatrics, trauma, etc.)
- Guidelines and interfacility agreements for transfer of pediatric patients

Program sustainability

- EMSC advisory committee • Pediatric representation on EMS board
- Integration of EMSC priorities into state/territorial law or regulations

2021 National EMS for Children Survey Results

 **15,768**
EMS agencies
were sent survey

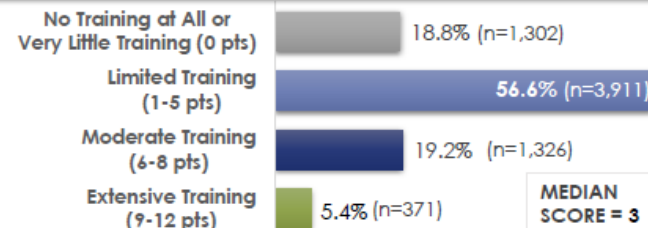
Types of Methods for Physically Demonstrating Correct Use of **PEDIATRIC- SPECIFIC** Equipment



Percent & Type/Method Skill Checking Reported



Frequency of Skill-Checking on Pediatric Equipment



[Click here](#) and go to page 35 to see how the skill-checking points were calculated.

Significance

The processes & frequency of skill-checking evaluations for EMS providers has long been established as important for the maintenance of skills when treating patients for improved patient outcomes.¹⁻³ Miller's Model of Clinical Competence provides a framework for clinical evaluation that theorizes that competency for clinical skills can be demonstrated for EMS through a combination of skill stations, case scenarios & simulations, & real-life field observations with a frequency of at least twice a year.³⁻⁴

1. Lammert, R. L., Byrwa, M. J., Fales, W. D., & Hale, R. A. (2009). *Simulation-based Assessment of Paramedic Pediatric Resuscitation Skills*. Prehospital Emergency Care, 13(3), 345-356.
2. Su, E., Schmidt, T. A., Mann, H. C., & Zechin, A. D. (2000). *A Randomized Controlled Trial to Assess Decay in Acquired Knowledge Among Paramedics Completing a Pediatric Resuscitation Course*. Academic Emergency Medicine, 7(7), 779-786.
3. Miller GE. *The Assessment of Clinical Skills/Competence/Performance*. Acad Med 1990; 65:563-67.
4. National EMS for Children Data Analysis Resource Center (NEDARC). *EMS for Children Performance Measures: Implementation Manual for State Partnership Grantees*. Salt Lake City, UT: NEDARC; 2017.

Resources

- [Pediatric Readiness in EMS Systems](#) (joint policy statement)
- [Prehospital Pediatric Readiness Toolkit](#)
- [Simulation-based assessment of paramedic pediatric resuscitation skills](#) (abstract)
- [Use of Pediatric-Specific Equipment](#) (video)
- [State EMS for Children Program Manager List](#) (online database)

Prepared by the **National EMS for Children Data Analysis Resource Center (NEDARC)**, located at the **University of Utah School of Medicine**. July 2021 www.nedarc.org

This report is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of the Emergency Medical Services for Children Data Center award totaling \$3,000,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

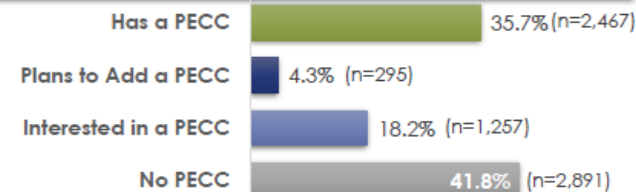
2021 National EMS for Children Survey Results

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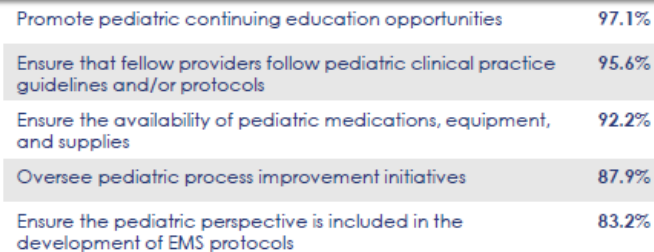
What is a PECC?

 A designated individual(s), often called a **Pediatric Emergency Care Coordinator** or **PECC**, who is responsible for coordinating and **championing PEDIATRIC-SPECIFIC** activities for an EMS agency. This individual(s) could serve as the PECC for one or more EMS agencies.

PECC at Agencies



Agencies who Have a PECC – Top 5 Reported PECC Duties



Resources

- [Pediatric Readiness in EMS Systems](#) (joint policy statement)
- [Pediatric Emergency Care Coordinator Learning Collaborative](#) (webpage)
- [Pediatric Emergency Care Coordinator](#) (video)
- [Prehospital Pediatric Readiness Toolkit](#)
- [State EMS for Children Program Manager List](#) (online database)

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Florida EMS for Children Program

2021 EMS Agency Survey Results

Florida Data Collection Numbers:

Number of Respondents: **99**

Number Surveyed: **195**

Response Rate: **50.8%**

Number of Records in Dataset (after data cleaning)*: **99**

*Data cleaning includes removing agencies that do not respond to 911 and duplicates, etc.

Performance Measures EMSC 02 and EMSC 03:

Number of Records Used in Performance Measure Calculation (see below): **98**

Performance Measure Exclusions*:

Indian Health Services or Tribal Agencies Participating: **0**, Military Facilities

Participating: **1**, Air-Only Agencies: **0**, or Water-Only Agencies: **0**.

*The agencies listed above are excluded from any final calculations related to the Performance Measures (see below). However, all states and/or territories were given the opportunity to survey these agencies for additional reporting based on state interest and need. Therefore, information from these agencies is included in all other data points.

**Pediatric Emergency
Care Coordinator (EMSC 02):**

48.0%
(47/98)

**Use of Pediatric-Specific
Equipment (EMSC 03):**

23.5%
(23/98)

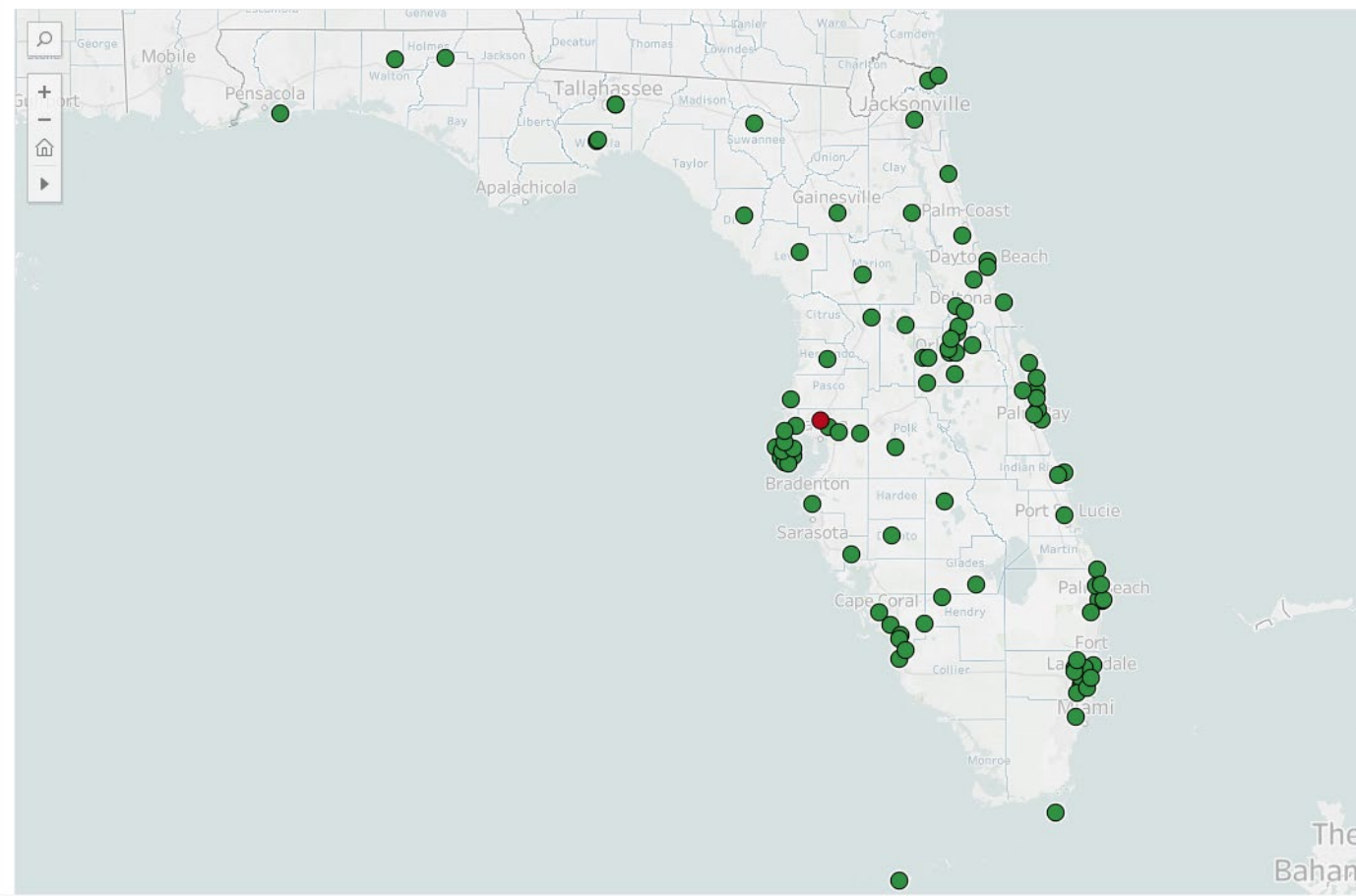
Overview Agency Map of Respondents EMSC 02 Trending EMSC 03 Trending Demographics PECC Overview Skill Checking Overview

Florida EMS Agency Respondents Location by Highest Licensure - 2021

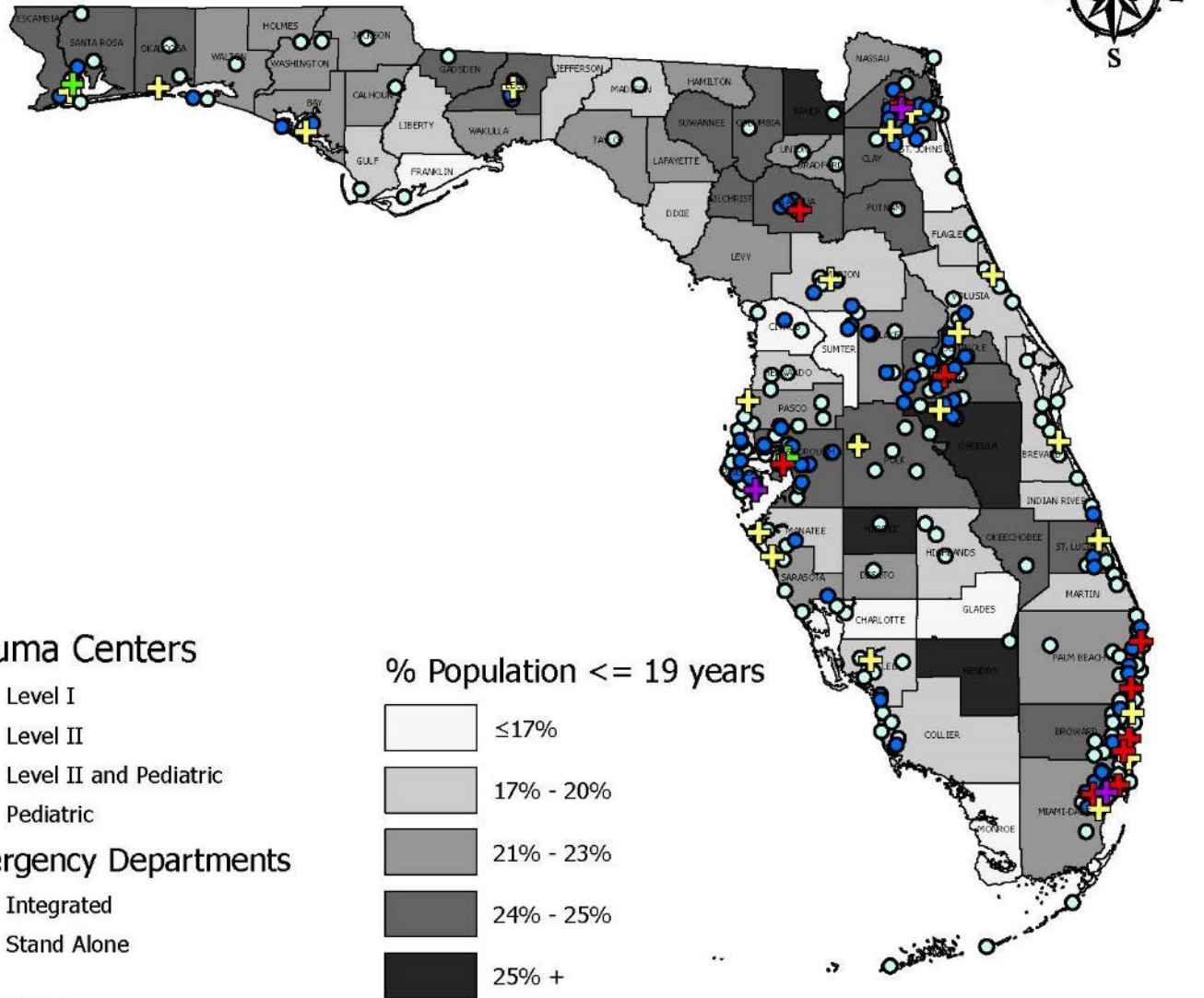
Survey Year: 2021 County: (All) Urbanicity: (All) EMSC 02: (All) EMSC 03: (All) Pediatric Volume: (All) Agency Type: (All)

Legend:

Basic Life Support (BLS)
Advanced Life Support (ALS)



11/20/2020- need 2021 update



11/20/2020
Florida Department of Health
Division of Emergency Preparedness and Community Support
Bureau of Emergency Medical Oversight



*Percent of Population
Ages <= 19 In
Relation to Trauma
Centers and
Emergency Departments*

Disclaimer: This thematic map is for reference purposes. Any reliance on the information contained herein is at the user's own risk. The Florida Department of Health and its agents assume no responsibility for any use of the information contained herein or any loss resulting there from.

Now up to 308 EDs

**299 EDs: 215
Integrated ED's, 84
Stand Alone (AHCA)**
87 Off-Site EDs as of
02/01/2021

~286 EMS agencies

17 CH

15 TC w/ peds

**4 Burn Centers
w/ped capability**