EMS for Children (EMSC) Committee Meeting
Virginia Office of EMS
Embassy Suites, 2925 Emerywood Parkway, Richmond, VA 23294
February 2, 2023
3:00 p.m.

Core Members Present:	OEMS Staff:	Guests:
Patrick McLaughlin, Chair (EMS Advisory Board, Pediatric Emergency Medicine VCU)	**Wanda Street** (VDH Office of EMS, Secretary Senior)	**Craig Bride** (Bon Secours Southside)
Heidi M. Hooker, Executive Director, Old Dominion EMS Alliance (ODEMSA)	**Chris Vernovai** (VDH Office of EMS, EMSC Planner)	**Kate Davenport** (CHKD Trauma)
David P. Edwards, EMSC Program Manager (VDH, Office of EMS)	**Michael D. Berg** (VDH Office of EMS, Grants Manager)	**Nicole Laurin** (CHOR Trauma)
Petra Connell, EMSC Family Advisory Network (FAN) Representative	**Greg Woods** (SVEMS Executive Director)	**Greg Neiman** (VCU)
Michael Watkins, Nurse with Pediatric Emergency Experience (VCU), Deputy Chief, Goochland Fire & Rescue)	**Ron Passmore** (VDH Office of EMS, Regulation and Compliance Division Director)	**Jennifer Farmer** (Lakeside Volunteer Rescue Squad
Tanya Trevilian, Peds Trauma Program Manager (Carilion Children's of Roanoke)	**Charles Feiring** (CSEMS)	**Michael Clark** (Carilion Trauma)
Patricia Dusty Lynn, Pediatric EMS Educator, UVA	**Scott Winston** (VDH Office of EMS, Asst. State EMS Director)	**Dr. Alix Padget-Brown** (UVA)
	Cierra Brown (VDH Office of EMS)	**Sam Bartle** (VCU, Pediatric Emergency Medicine)
	Tatiana Pedroza (REMS) (REMS)	**George McDaniel** (Pediatric Electrophysiologist)
	Michelle Ludeman (NVEMS)	**Steve Bell** (Rockingham Co.)
	Linda Harris (REMS)	**Whitney Pierce** (CHKD Trauma)
	James Larrick CSEMS)	
	Charles Feiring (CSEMS)	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to order:	The meeting was called to order at 3:02 p.m. by the chair, Patrick McLaughlin.	
Introductions:	Everyone around the room introduced themselves.	
Approval of the minutes from November __ 2022 meeting:	The minutes were approved as submitted.	**The minutes were approved as submitted.**
Chair Report – Patrick McLaughlin:	Dr. McLaughlin welcomed all, provided a brief overview of the planned meeting today, and then yielded the floor over to Scott Winston and Ron Passmore for the OEMS report.	
OEMS Report: Scott Winston, Ron Passmore	Scott Winston (OEMS Assistant Director): Scott referred the group the comprehensive OEMS Quarterly Report that is posted on the OEMS website. He mentioned that the General Assembly is	

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	approaching the "crossover" during their session, and that OEMS is tracking a number of bills and will continue providing a weekly legislative grid and report accessible to all. Ron Passmore (OEMS-Regulations and Compliance Director): Ron noted that the final draft of the new EMS Regulations (Chapter 32) was approved last month (by the Rules and Regulations Committee). It will be an action item at the May 5, 2023, meeting of the State EMS Advisory Board and if approved at that meeting, it will go the Board of Health at their September 2023 meeting for approval. Once approved, it will then officially enter stage two of the regulatory process and begin the executive branch review. Once that portion is complete, then it will go out for public consumption and 60 days of public comments before we get it back. The input that was requested and received from the EMSC Committee (about wording for the proposed regulations) remains in the final draft, so no more kids will be riding in wheel wells once the new regulations get adopted.	
EMSC Program Report – Dave Edwards:	David Edwards (OEMS-EMSC Manager): David gave a brief oral report of highlights, referring members to the written report that had been distributed at the beginning of the meeting: *(see full report at end of minutes)* • 2023 nationwide EMS Agency Survey will end March 31st. Virginia currently sits at a 37% response rate. Regional EMS Council Directors and their staffs are assisting in soliciting submissions, and our goal is to exceed an 80% response. • There is a new national EMSC collaborative for hospital emergency departments that focuses on pediatric suicide—three Virginia hospitals are participating. • Jeremy Wampler recently led two PEPP (Pediatric Education for Prehospital Providers) courses supported by EMSC funding (at Wintergreen and Browder's). More courses are planned for Shenandoah Valley EMS Expo in March, Reston College in June, and sometime after that at Augusta County Fire Rescue. • We have distributed all the current inventory of child restraint systems, but a new shipment is on order and should arrive shortly. Once here, they will be available to volunteer EMS agencies with need; agency leaders should contact David Edwards if interested. Restraint systems are also an excellent choice for RSAF grant applications. • NASEMSO's Pediatric Emergency Care (PEC) Council will be meeting in person as part of the NASEMSO Annual Meetings June 11-15, 2023, in Reno, Nevada. • An application for a new EMSC State Partnership Grant was submitted to the HRSA (Health Resources and Services Administration in early November. If successful, this grant will be for four years (2023-2027) with a possibility of a one-year extension. • The Virginia EMSC program looking for volunteers for several internal work groups (see full report).	**Full EMSC Program Report attached at end of these minutes.**

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	The full EMS for Children Program Report presented February 2, 2023, is appended at the end of these minutes.	
EMSC Family Representative Report	No report today. Petra Connell was unable to attend.	
Securing Children in Ambulances:	A spirited discussion ensued about the need for EMS providers to secure children appropriately during ambulance transport. A significant number of EMS providers in Virginia are still found to be placing a child in a parent's lap during transport, despite efforts to date to discourage this. Once the new EMS regulations (Chapter 32) are in force there will be impetus to correct this beyond what is available today. Options for securing children were discussed (car seats, patient car seats, built-in ambulance car seats, commercially available 5-point restraint systems, etc.). Statewide teaching and educational opportunities/campaigns were discussed, including partnering with Safe Kids, which already performs a heavy lift by sponsoring car seat technician courses. Discussion turned to (in the future) requiring that EMS agencies designate a Pediatric Champion or PECC to advocate at the EMS agency level. Data are needed to prove the need, as this option has been resisted every time it had been considered, yet the data quality at this point is not solid. Some providers still believe that a child is secure if in Mom's lap. Dr. McLaughlin suggested we shelve the idea of mandating agency Pediatric Champions for now as we pursue other options.	
EMS Agency Survey: Heidi Hooker	Heidi Hooker (ODEMSA Exec. Director): We are helping EMSC with the EMS Agency Survey—right now we are at 37 or 39 percent response. We have not started calling agencies yet, as we wanted to give them the first 30 days to just see how many would respond to the emails. Next month we should see the number really start to pop up because we will be calling the ones who have not yet completed one.	**Survey response percentage will be available at next EMSC Committee meeting.**
Medical Direction Committee: Sam Bartle **Trauma Triage**	Dr. Sam Bartle (VCU Pediatric Emergency Medicine): Medical Direction brought on the trauma triage issue that they were reviewing at their last meeting. It was discussed today at the Prehospital committee. We are trying to point out that the criteria (they call it the red criteria) for critically ill kids that would hopefully get them to a pediatric trauma center or a level one trauma center for the pediatric ones in reasonable proximity is the compensated shock issue with kids. They are trying to break it down according to the age of the patient you are seeing bringing in, pointing out that you need to be aware of and consider tachycardia and profusion for the trauma criteria. And that if you are, that is the biggest part, and the criteria should take you to a pediatric trauma hospital if it's in the region. And if it is not in a region, at least take them to a level one- or two-level trauma center. So, I can give you more details about the criteria, but, it's just adding those few lines. It is still in process and will need to go	**Update will occur at next EMSC Committee meeting.**

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	back to the Medical Director's Committee for approval when finished, but it is at least being addressed. They also decided to create a task force looking at the specific needs and issues for pediatric patients in a disaster. Hopefully, they will get the major pediatric centers together discussing what they have, what they can do, and how to say (like the RSV issue); instead of reacting to it, planning for it. We know pediatrics is different and it is not the large numbers that the adult population has. Trying to figure out how to handle something like that again the next time it occurs. Dr. McLaughlin: "I think our last committee meeting we were in the throes of "surge", and we gave some space to vent about what we were dealing with. But I love the fact that the Disaster Committee is considering that as a true disaster versus the way that we think of disaster." Dr. Bartle: Sam mentioned that it in the meeting it was suggested that there are different viewpoints; MCI's (multi-casualty events) being an ***event*** versus something that sort of slowly builds up…	
2023 Symposium	The presentation portal for the 2023 Virginia EMS Symposium as closed. Submissions that were proposed will now be reviewed by the Symposium Planning Committee.	
BRUE (Brief Resolved Unexplained Event) and Patient Refusals	Jennifer Farmer (Lakeside Volunteer Rescue Squad): We are implementing our pediatric protocol for refusals, starting with patients under one. We had to start somewhere, and we had talked about it before our OMD (operational medical director) graciously, willingly allowed himself to be the first call for us, because we do not have this worked out on a more regional basis. So, I guess that what I am looking for is your input—in the case our provider has a patient that's 28 days old, when Mom says she thought they looked blue. We get there, they are fine, they want to refuse, and who do we call? Right now, it is our OMD, but that is not the standard. I do not call my OMD for anything else, I would call the hospital to speak to a physician, but that is not happening on a regional level here. So, we are hesitant to have our providers do that because then if the providers on the other end, call you, Dr. Bartle, you might say "what do you mean--what are you calling me for?" So, I just do not know how we can push this forward on a bigger level because I don't think it's reasonable. It works for us—we had only 72 pediatric calls last year--but for Henrico County, they can't call Dr. Ferguson every time they get a pediatric patient. I am just not sure how we can push this forward at a bigger level. I think they do it at UVA; TJEMS has a protocol where they call in to UVA. A question came up. Some are saying they can't take the patient if the parent's not wanting them to take them. It is considered kidnapping. How do you all get around that?	

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	Jennifer Farmer: We don't. It is considered kidnapping. I can't just take somebody's kid. And it is not that we're trying to get around that. I think the purpose of the call-in is for our provider to talk to a physician, because this is a low volume situation compared to adults. But our providers are not going to be as well versed as Nichole, say, on this 30-day-old baby and what potentially could be wrong. So, if our provider calls in and tells them what they have told the family and the provider says you explained this to them, and we think the child doesn't look that bad, and he really doesn't need to go… Dr. McLaughlin: Right, so they should say that. And that is what we are trying to prevent. Sure, well, if we make a difference, then we'll see it in the percentage of calls that happen. it is going to be very low. But from that, if we were able to alter just five, ten percent—I mean, that could be important. Dusty Lynn (pediatric educator): In Maryland we were working on that, this very thing. This is back in the day (a while ago). For refusals, pediatric refusals, and just talking to the agencies, how many people felt comfortable with recognizing BRUE or possible situations like that. But the EMS providers themselves were not comfortable and did not know the stats with a BRUE, so we educated them with that and then made some protocols that were very empowering. But you are exactly right, it's how you say things. If Mom says, oh, it might have just been the light, I am really just fine with that. and being able to say, you know that something really did scare you enough that you called, let's take him to the ER and let the professionals check him. Or call the local ER--they do also have the protocol and understood and realizing if EMS is getting them to call to talk to the parent and they're on the exact same thing, you know. "I am concerned that you were so concerned. I can't see your child and evaluate them over the phone, so let's bring him in." We found it was very successful and our rates of refusal really dropped. But it is about that education, and how you say what your educator tells you. Dr. Padget Brown: I was going to say, I don't exactly know what the TJEMS protocol. What I've been telling providers is you can talk, like Dusty said, directly to the parent. The EMS provider who's there, or the paramedic who is there is describing to me these kinds of behaviors that you witnessed. Or, you know, "even though your kid looks fine now, this is why they are concerning to me. This is why I am worried that what you saw before could be a prelude to something much worse." (And generally speaking, it is like you are introducing them.). "Hi, I am Dr. Paget-Brown, I hear that this is what happened earlier, and the EMS providers described (whatever they described). What did you see when this event happened? Great, okay, I understand and I'm happy that the baby's better now, but these are my concerns." And having the person identify themselves as Dr. so-and-so seems to have weight. Dr. McLaughlin: And, you know, what we are trying to pinpoint and prevent are children staying home who truly need an evaluation. But	

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	there are intricacies to those diagnoses that we can't expect an EMS provider to cover, so instead of just saying, "yeah, I think you're right, Mom, the kid does look better", keep in mind that the person may or may not remember that a fever in a child less than 60 days is 100.4. Or they think it is 101 or they think it's 99. It does not matter. I do not want those decisions to happen on the street at the house. It is easier if you (I) get called. And this all stemmed from several abuse cases. In fact, not these very obvious reasons why kids can be admitted to a hospital—or at least evaluated. I cannot expect someone to recognize that a child who is three months old should not weigh four kilos. Just should not, right? So that is something that I need to have "eyes" on. With that three-month-old, Mom called because the kid was vomiting, and then she said he is not vomiting anymore, but the provider saw the child and said, "yeah, you're right, looks pretty good". And then the kid shows up a week later, almost dead. And why are we not on her? So, it stems from those types of cases, which unfortunately are not few and far between. But we have a great platform for education. I am really, really excited that you were able to get approval (meaning Jennifer Farmer). Because once we see what your pilot has created as far as numbers, then we can potentially take it elsewhere. Or we take it to the group at VCU, or whatever it is and say this is what other folks are doing—we need to do this. The discussion continued for some time along these lines. Dr. McLaughlin: I think any self-respecting physician that picks up the phone and says to an EMS provider that says I'm a little worried about this kid and I don't know what to do, you're going to say, okay, tell me what's going on. Hopefully. And the nice thing is, it's not always an either/or. Like sometimes the parent could know (especially in Metro D.C.) what that would mean, coming to the ER and waiting six hours in a waiting room full of sick, sick kids, and you have this three-month-old that you want to bring. Sometimes the parents would describe a very strong relationship with their PMD and make an appointment and call and come the next morning or something. And at least that was something instead of a refusal.	
Committee Member Organization Reports:	Whitney Pierce (Children's Hospital of the Kings Daughters-CHKD): We have an Eastern Pediatric Conference coming up May 19th. Registration will be open soon, but it is completely pediatric focused. Tanya Trevilian (Carilion Medical Center): In southwest Virginia we have started an outreach program for our outlying facilities. We just went to bring Rockbridge two four-hour sessions of pediatric-specific education (assessment, lecture, hands-on with equipment, and scenarios). I am a scholar with the Pediatric Pandemic Network (PPN). I was one of six chosen and I get to work on a peds disaster project; waiting now to connect with a national mentor, then I will write a report as it grows. It is a one to two-year commitment to make something lively happen in southwest Virginia.	

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	Heidi Hooker (ODEMSA Exec. Director): Yesterday at the Regional Council Directors meeting we spent part of the time discussing House Bill 2165. This is a bill that would allow an assessment of needs for EMS and funding. So, there are a lot of *especially rural* EMS agencies that are in crisis mode right now as far as funding. They don't have the providers. The County could possibly provide them, but they don't have the funding to pay for what they need. It is our understanding that this bill would not touch "Four-for-Life" or the source where Fire gets their income from, but to open additional sources for EMS. We voted to support that bill. Greg Woods (SVEMS Exec. Director): Our regional council is putting on what we call the *Shenandoah Valley EMS Expo* March 9th, 10th, and 11th. It is being graciously hosted by Blue Ridge Community College at the Weyers Cave campus. We have many excellent subject matter experts that will be providing many quality courses. It is $25 for all the education that you can take, and you will also get a T-shirt—and meals are included with that. This is our second year of doing it and it was just our council, and now we're bringing in our two surrounding councils to help us pull this off. We hope to continue this tradition off cycle from the EMS symposium to provide a regional education CE program for nursing as well as EMS providers. So, it is not aimed just at EMS folks; nurses can also get CE that they can take back and post to their nursing boards for their continuing education. **SVEMS.org** is the web site. The registration is open, you can sign up and pay electronically, and when you show up, you'll get a T-shirt for your time--and we'll feed you.	
Unfinished/Old Business:	**a. 2022 Symposium** – Pediatric Track was successful and discussed. The presentation portal for the 2023 Symposium has closed.	
New Business:	**b. Future Meeting Dates – S**ee below. **c. Other**	
Public Comment:	None.	
Adjournment:	The meeting adjourned at approximately 4:30 p.m. **2023 Meeting Dates:** May 5, August 4, November 17 **Location:** Embassy Suites **Time:** 3:00 p.m. to 5:00 p.m.	

Below (on the next page) is the full version of the EMS for Children program written report presented by David Edwards and provided as a handout at the 2/2/23 EMSC Committee meeting:

EMS for Children (EMSC) Program Report (2/2/2023)

More Child Restraints on the Way…

The Virginia EMSC Program has distributed all its current inventory of grant-funded child restraints to volunteer EMS agencies, but more will soon be available.

EMS agency leaders with a legitimate need for these vital tools should contact the EMS for Children program (david.edwards@vdh.virginia.gov) with their requests to be put on a waiting list. For those agencies who need more than one or two child restraint systems, we recommend applying through the Rescue Squad Assistance Fund (RSAF). The appropriate restraint of children being transported by ground ambulance in Virginia is considered a priority issue. Also, EMS agencies are strongly encouraged to adopt safety policies and procedures requiring the use of child restraints by their providers, and the Virginia EMSC program is available to assist in this.

(Funding for the child restraint systems was through the EMSC State Partnership Grant [H33MC07871] via the Health Resources & Services Administration [HRSA] and administered by the Maternal and Child Health Bureau [MCHB] Division of Child, Adolescent and Family Health.)

Annual EMS Agency Survey *(IN PROGRESS)*

The annual national EMSC EMS Agency Survey is underway, hosted online by the EMSC Data Center (EDC). The goal of the annual survey is to improve understanding of EMS agencies' ability to care for children by collecting data on two specific EMSC performance measures:

- EMSC Performance Measure 02 (assesses if an agency has access to a pediatric emergency care coordinator (PECC))
- EMSC Performance Measure 03 (focuses on an agency's process for skill-checking on pediatric equipment)

The EMSC program is benefitting from significant assistance provided by EMS Regional Councils in targeting this year's survey goal of an 80% response rate. It is very likely that several Councils will actually achieve a 100% response from their agencies.

Last year more than seven thousand EMS agencies responded to the EMS for Children Survey, from more than 58 states and territories. Results of the 2023 assessment will be shared with EMS agencies, the state EMS Advisory Board and the EMSC Committee once the 2023 data has been processed. The survey portal (*emscsurveys,org*) will be open through March 31, 2023.

New EMSC State Partnership Grant Pursued

An application for a new EMSC State Partnership Grant was submitted to the Health Resources and Services Administration (IHRSA) in early November. If successful, this grant will be for four years (2023-2027) with a possibility of a one-year extension at the end. Every state in the U.S. is eligible to receive one EMS for Children grant, as well as nine U.S. protectorates. It is

anticipated that the grant will be funded at a level of $205,000 per year (an increase of more than 36% over previous years' funding). If funding is awarded it will be applied in several specific areas in Virginia:

- Fund the designated Pediatric Track at the annual Virginia EMS Symposiums.
- Support increased number of regional pediatric training courses (NRP, PEPP, ENPC, Handtevy, etc.).
- Provide training for EMS agency Pediatric Champions.
- Facilitate EMS agency acquisitions of ambulance child restraints–purchase and disseminate child restraints as funds allow to volunteer EMS agencies.
- Purchase of pediatric simulation manikins, support for pediatric skills checking.
- Develop a voluntary hospital facility recognition program (EDs).
- Develop an EMS agency pediatric readiness recognition program.
- Support travel of OEMS leadership to NASEMSO meetings (and Pediatric Council).
- Expand role of Family Advisory Network (FAN) representative(s).
- Facilitate pediatric disaster planning with hospitals and EMS agencies.
- Assess hospital EDs for current level of pediatric readiness (upon request and free).

EMSC Program Work Groups

If you have passion and/or expertise concerning pediatric emergency care issues, the Virginia EMSC Program can use your assistance. Works groups are forming as described below. If you are interested in helping, please contact David Edwards (david.edwards@vdh.virginia.gov).

- Facility Recognition Work Group to explore creating a voluntary recognition program for hospital EDs that can demonstrate a specified basic readiness level in caring for children (medical).
- Emergency Transfer Guidelines and Agreements Work Group to develop templates for written *hospital emergency transfer guidelines and agreements* that specifically refer to pediatric patients. These would be intended as a technical resource available to Virginia hospitals.
- Pediatric Champions Work Group to support developing EMS Agency Pediatric Champions (also sometimes referred to as Pediatric Emergency Care Coordinators—PECCs.
- Child Transport Policies & Procedures Work Group to develop template(s) for suggested EMS agency policies and procedures appropriate for restraining children during ground ambulance transport.

***Continuing* Request of Virginia Hospital Emergency Departments**

Aggregate analysis of the last two National Pediatric Readiness Project (NPRP) assessments (of hospital EDs) resulted in specific recommendations to address pediatric readiness gaps:

- Please weigh and record children in kilograms (to help prevent medication errors).
- Please Include children specifically in hospital disaster/emergency plans.

- Please designate a Pediatric Champion (Pediatric Emergency Care Coordinator--PECC). *(This is the single most important item a hospital can implement to ensure pediatric readiness, including patient safety.)*
- Please ensure pediatric patients are included in the quality improvement process.
- Please review and adopt pediatric safety policies (radiation/medication dosages, abnormal vital signs).

Two Virginia Hospitals Join New National Collaborative

At least two Virginia hospitals have joined a new national EMSC venture called the *"Emergency Department (ED) Screening and Treatment Options for Pediatric (STOP) Suicide Quality Improvement (QI) Collaborative"*. The Emergency Medical Services for Children Innovation and Improvement Center (EIIC) notified the Virginia EMSC Program of this and encouraged collaboration with the hospitals in pursuing their objectives.

Pediatric Emergency Care (PEC) Council to Meet at NASEMSO Annual Meeting

The PEC Council will be meeting for two days as part of the *NASEMSO Annual Meeting* (June 11-15, 2023) in Nevada. These meetings are especially designed for the maximum benefit of its primary members who are key personnel in state offices of EMS. It is also an ideal venue for federal, association, and business partners whose mission relates to emergency medical services, specialty systems of care (trauma, stroke, STEMI, overdose), disaster preparedness and related matters.

Suggestions/Questions

Please submit suggestions or questions related to the Virginia EMSC Program to David P. Edwards via email (david.edwards@vdh.virginia.gov), or by calling 804-888-9100. The EMS for Children (EMSC) Program is a part of the Division of Community Health and Technical Resources (CHaTR), within the Virginia Office of Emergency Medical Services (OEMS). If you have any difficulty connecting with David Edwards, please contact Tim Perkins via email (tim.perkins@vdh.virginia.gov) or by phone (804-888-9100).

The Virginia EMSC Program receives significant funding for programmatic support through the EMSC State Partnership Grant (H33MC07871) awarded by the U.S. Department of Health and Human Services (HHS) via the Health Resources & Services Administration (HRSA) and administered by the Maternal and Child Health Bureau (MCHB) Division of Child, Adolescent and Family Health.