Oregon Emergency Medical Services for Children Advisory Committee Meeting Minutes

2022 Quarter 2 | April 7, 2022
Chairperson Matthew Philbrick
Vice Chairperson Christa Schulz, MD

Appointed Committee Members		
Committee Member Name	**Committee Position**	**Present, Absent or Vacant**
Tamara Bakewell	Family representative	Absent
Andrea Bell	Nurse with pediatric experience	Present
Jeffrey Dana	At-large member	Present
Jackie Desilva	Hospital Trauma Coordinator	Present
Carl Eriksson, MD	Pediatric Emergency Preparedness representative	Present
Jennifer Eskridge	Injury Prevention representative	1st Meeting July 2022
Brent Heimuller, MD	Physician with pediatric training	Present
Matthew House	EMT/Paramedic currently practicing, ground level provider	Present
Kelly Kapri	Highway Traffic Safety representative	Present
Erik Kola	Behavioral Health representative	Present
Todd Luther	Emergency Department Manager	Joined after roll call
Danielle Meyer	Hospital Association representative	Joined after roll call
Matthew Philbrick	EMS Patient Transport representative	Present
Dana Pursley-Haner	EMS Educator	Present
Justin Sales, MD	Emergency Physician	Joined after roll call
Christa Schulz, MD	Pediatric Hospitalist	Present
Vacant	Tribal EMS representative	Vacant

HRSA EMSC Grant Required Committee Members		
Committee Member Name	**Committee Position**	**Present, Absent or Vacant**
Rachel Ford, MPH	Oregon EMSC Program Manager	Present
Elizabeth Heckathorn	OHA EMS Representative - Secondary	Present
David Lehrfeld, MD	OHA EMS Representative - Primary	Absent
Dana Selover, MD	HRSA EMSC Grant Point of Contact	Present

Oregon Health Authority EMS & Trauma Systems Program Staff
Peter Geissert, Julie Miller, Ammara Molvi

Guest Speakers and Members of the Public
Matt Hansen, MD (Oregon Health & Science University), Chelsea Holcomb (OHA), Beth Holliman (OHA), Brian Pitkin (OHA), Linda Sheffield (Santiam Hospital), Brittany Tagliaferro-Lucas (Oregon Center for Children & Youth with Special Health Needs)

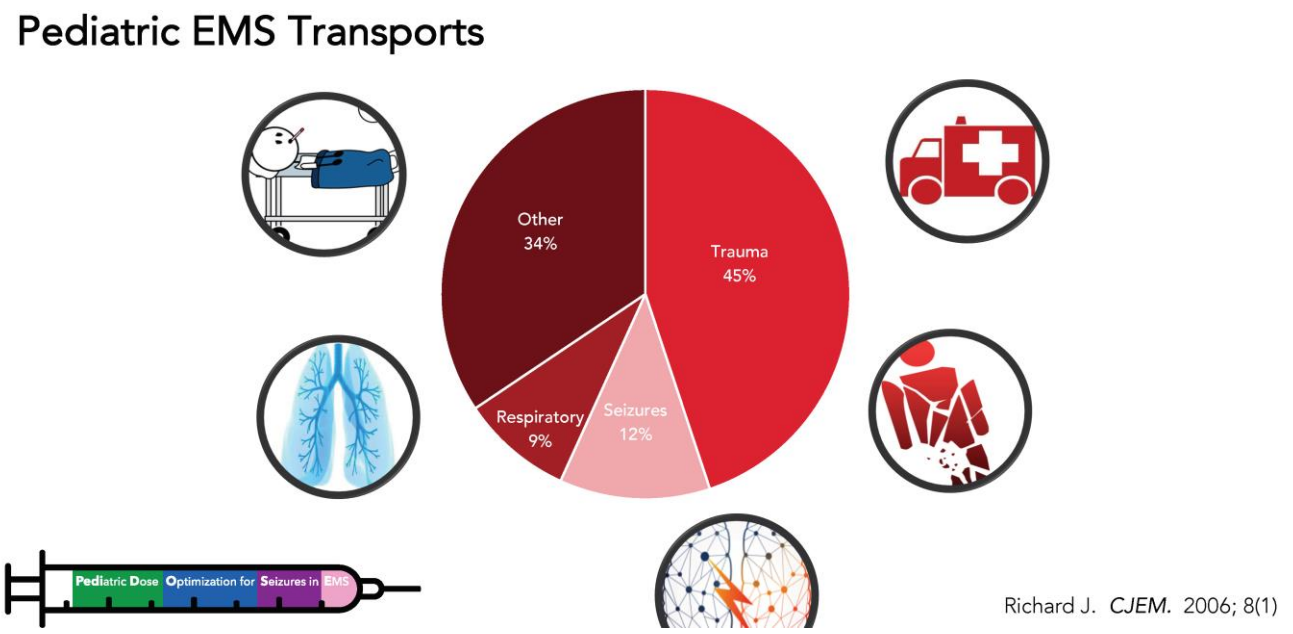
Call to Order | Matthew Philbrick, Chairperson
Start Time 9:03 a.m.

Minutes | Chairperson
January 2022 Minutes were reviewed. No changes noted. Motion to approve minutes as written: Jackie Desilva. Second: Dr. Christa Schultz. None opposed. Motion carried.

Committee Membership | Chairperson
Resignations: Anna Stiefvater served four years (4/1/2018-3/31/2022) as the Injury Prevention representative. Many thanks to Anna for their service! Jackie Desilva, Hospital Trauma Coordinator, is leaving Asante Rogue Regional and starting a new job. Today is her last EMSC Advisory Committee meeting. **Appointment**: Jennifer Eskridge was appointed to serve as the new Injury Prevention representative, 4/1/2022-3/31/2026. Jennifer is the Community Outreach Educator for the Oregon Poison Center at OHSU. Jennifer's first meeting will be July 7, 2022. **Reappointments**: Danielle Meyer was reappointed for a 2nd 4-year term and Tamara Bakewell was reappointed for a 3rd 4-year term. Danielle and Tamara – thank you for your continued service and advocacy, and for representation of these critical Committee positions. **Vacancies**: The Committee is seeking applicants for Hospital Trauma Coordinator, Tribal EMS representative, and Behavioral Health representative. The Committee needs your help identifying candidates to fill these positions. All applications will be reviewed, but to support committee member representation across Oregon, consideration will be given to applicants who live and/or work in the following counties: Baker, Malheur, Morrow, Umatilla, Union, and Wallowa. Committee Member Application: LINK

Pediatric Research: Pedi-DOSE Study | Dr. Matthew Hansen, Oregon Health & Science University
Dr. Hansen is a physician scientist at Oregon Health & Science University and is a researcher affiliated with the Pediatric Emergency Care Applied Research Network (PECARN). The Pediatric Dose Optimization for Seizures in EMS study is the first true emergency medical services (EMS) clinical trial

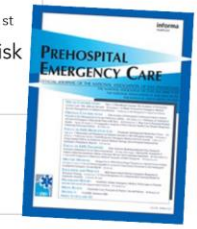
that is being conducted in PECARN and probably the first multi-center prehospital pediatric trial done in the last 20 years.



- Seizures are one of the most common medical reasons why EMS are requested for a child and account for 10-12% of all pediatric EMS transports based on various studies and the EMS affiliate-based data in PECARN.
- When seizures are not stopped quickly, they can lead to neurologic morbidity, respiratory compromise, and increased mortality.
- Timely delivery of the right dose of a benzodiazepine using an ideal route is essential to treat pediatric seizures effectively and safely in the prehospital setting.

Evidence-Based Seizure Guidelines

DO	DON'T
Check blood glucose	Give rectal medication
Give dextrose IV/IO (D10, 5ml/kg) or glucagon IM for hypoglycemia (<60 mg/dL)	Place an IV/IO initially
Give IM/IN benzodiazepines as first line treatment (midazolam 0.2 mg/kg)	Require medical control for the 1st two doses of medication (apnea risk after two doses)
IV/IO benzodiazepines (0.1 mg/kg) can be given for subsequent doses	



Shah MI. *Prehospital Emerg Care*. 2014; 18(1)

Intramuscular (IM) More Effective Than Intravenous (IV): IM takes effect quicker than having to wait for an IV line to be put in. Percentage of patients seizing on ED arrival: 26% IM midazolam, 36% IV lorazepam.

Paramedic Adherence After a Pediatric Seizure Protocol Change: 50% → 70% preferred routes; 61% → 71% received midazolam; 61% ~ 56% correct dose given.

Opportunities to Optimize Pediatric Seizure Management: Of those giving the incorrect dose, the most common error was underdosing primarily because providers were afraid to give too much medicine to a pediatric patient. Average time to receive the medication was 14 minutes. Potentially faster ways to measure for dosage.

System Changes are Required: Standardized dosing based on age rather than length. Only 4 dose amounts used. Makes it faster for the Paramedics faster to give the dose. Save time by using chart. Paramedics should not calculate the dosage. EMS Arrives on scene → determine patient's age → administer the dose to give in mL via the intranasal or intramuscular route.

PediDOSE Conceptual Model: This will be faster resulting in less delays in midazolam administration and fewer cases of underdosing, which would result in fewer patients seizing upon arrival to the emergency department and less respiratory failure and neurological morbidity.

- Aim 1 = Effectiveness: To compare the impact of standardized EMS midazolam dosing relative to conventional dosing on pediatric seizure cessation upon ED arrival.
- Aim 2 = Safety: To compare the frequency of respiratory failure after implementation of standardized EMS midazolam dosing for pediatric seizures.

Inclusion Criteria + Age De-Escalation: Required by the FDA. Enrolling kids 2 years and older, then later will enroll younger ages. Patients 6-months to 13-years who are actively seizing while in the care of

a paramedic (regardless of seizure type/duration). Transported by participating EMS agency to participating emergency departments.

Exclusion Criteria for Study and Analysis: Benzodiazepine allergy, pregnancy, severe growth restriction, traumatic head injury in past 24 hours, history of psychogenic non-epileptic seizures, ventilator dependence, ingestion of a toxic substance in past 24 hours, and absence of seizures during EMS or emergency department care.

Other study details: Protection of human subjects, data safety monitoring, and study sites across the country. The Principal Investigator is Manish Shah, MD, MS.

Stepped-wedge Design: Unique part of the study. Every site starts by providing usual care, then two sites at a time are randomly selected to switch to the new protocol, and this how get the comparative results.

EMS Seizure Protocol: Flow chart described actively seizing patient with advanced life support (ALS) paramedic on-scene and outcomes.

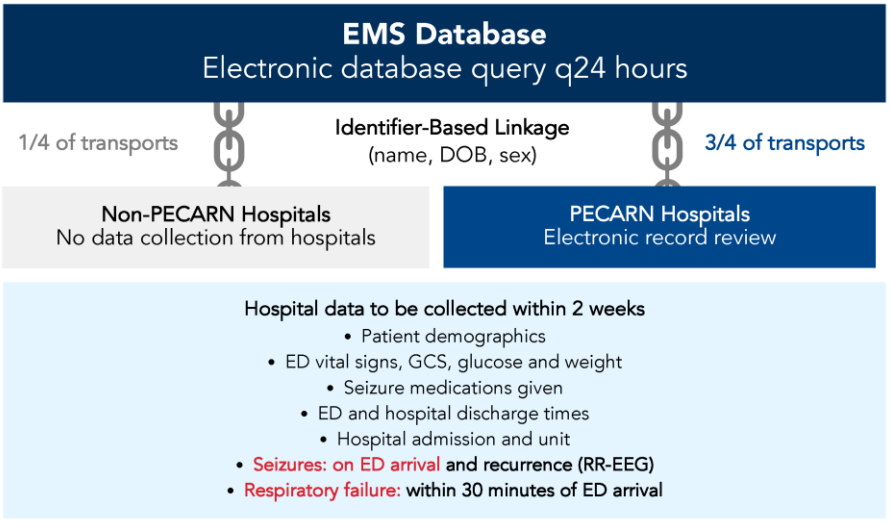
Training to Maximize Adherence: Case-based, video, interactive format and supporting tools are provided to EMS Agencies for this study. The participating emergency departments, Providence St. Vincent, Randall Children's, and Oregon Health & Science University will use a headband EEG device called ceribell that helps to determine if patients are still seizing.

Study Outcomes: Will include primary, secondary, exploratory, and safety data. Data will be captured through EMS database and verbal reports.

Questions/Comments:

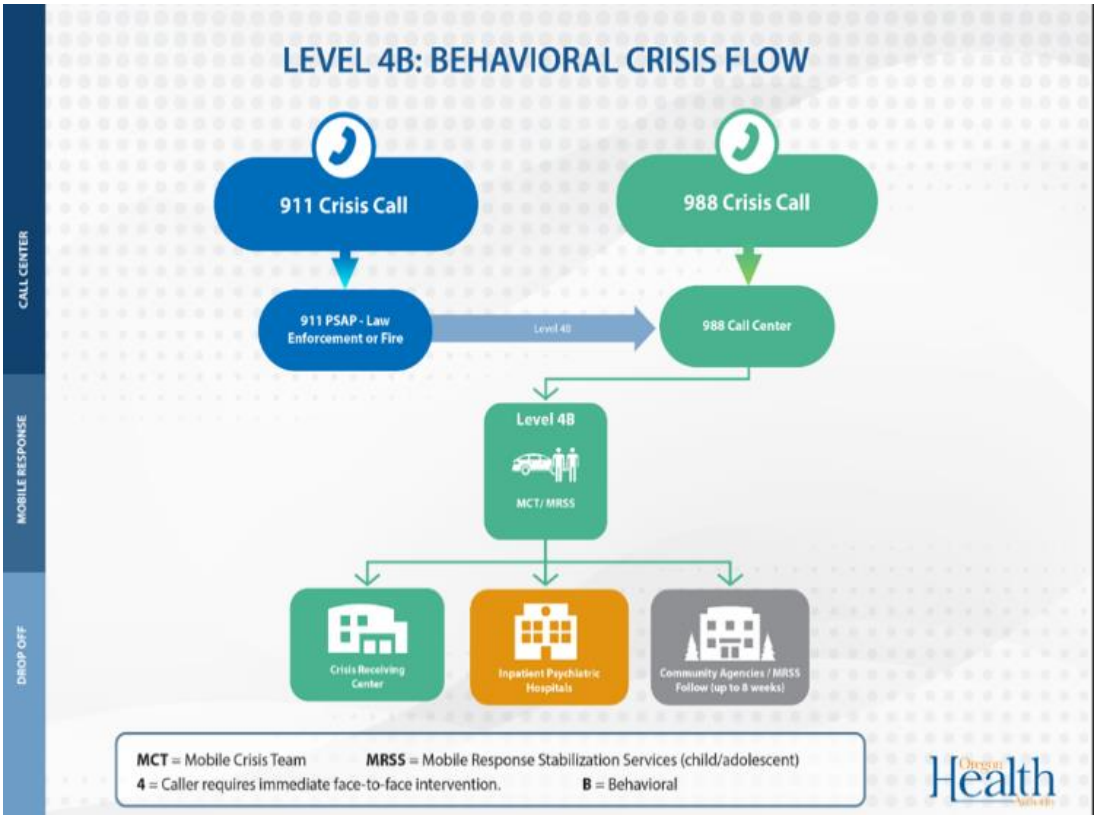
- Dr. Carl Eriksson - This study helps us to move forward and am excited that we are a part of this study.

Data Collection



988: Transforming the Crisis System for Children, Youth, Young Adults, and their Families | Brian Pitkin, OHA Children's 988/Mobile Response and Stabilization Services Coordinator

2020 marked a step forward towards the establishment of a 988 national line to serve as a call center to respond to those in crisis. 988 and 911 will work collaboratively to ensure an appropriate response.



Feedback: The community and those with lived experience highlight the need for a crisis response system that is tailored to meet the unique needs of children and families in crisis. Emergency departments are often the front door for the emergencies.

- ED not equipped for addressing crisis in children and families.
- Children and families not feeling heard.
- Need the ability to work collaboratively with providers towards solutions.

House Bill (HB) 2417: Passed July 2021. Will stand up 988 as an alternative to 911 for all Oregonians across lifespan. Will expand the current mobile response services across the state. Will create stabilization services and community resources that include the development of comprehensive, sustainable, and effective home- and community-based services for children, youth, young adults, and their families. Will expand and promote crisis services customized for children, youth, young adults, and their families.

HB 2417, OAR 309-019 (6-9) and Service Element (SE) 25: Govern crisis response. Intended to be a lifespan program, so will need to update to include children and family-specific response.

National Resources, Research and Models for Children's Crisis Services: National push for guidelines. Reviewed national best practices on crisis response for youth and families. OHA consultation with national expert Liz Manley. Building on national supports that are already in place. Mobile Response and Stabilization Services (MRSS) national best practices guide the implementation of Oregon 988/MRSS.

Comparison of Crisis and Transition Services (CATS) and MRSS:

Crisis and Transition Services (CATS)	Mobile Response and Stabilization Services
• Referrals from emergency departments across 11 Counties	• Youth can access services without going to the emergency department
• Face-to-Face Response within 3 hours	• Face-to-Face Response within one hour (up to three in rural)
• Team includes both clinical staff and Family Support Specialists for 45-90 days	• Youth and families define what they need and when they need it; does not have to be an acute mental health crisis
• Crisis and Safety Planning	• Access to a variety of services and supports for up to 2 months
• Mental Health Assessment/Service Planning	• Team includes access to Qualified Mental Health Professionals, Qualified Mental Health Associates, and both Youth Peer and Family Support Specialists
• Team meeting scheduled with family within 72 hours of discharge from ED	
• Team assists families in connecting with community support and resources to ensure a warm handoff	

- 988/MRSS expands on older CATS program by implementing services statewide, removing emergency department as the point-of-contact, and decreasing response time.

MRSS Teams + Youth and Family: Addressing additional needs, tying into the resources that are already in place and focus on providing wraparound care at a local level that relies on numerous and varied resources.

Three Pillars of 988/MRSS:

1. Someone to Call: 988 Call Center going live in July 2022 for all of Oregonians. 988 access to immediate behavioral health support, for Oregonians across the lifespan and their families, and call center staffed by Lines for Life.
2. Someone to Respond: Customized Mobile Response and Stabilization Services (MRSS) 2-person teams with specialized training working with children and youth will provide face-to-face response. Teams include Family Support Specialists, Youth Peer Support Specialists, Qualified Mental Health Professionals, and Qualified Mental Health Associates.
3. Community of Support: MRSS Teams provide local resources and systems of care for children, youth, and their families for up to 8 weeks. This includes child and youth-centered tools.

Next Steps:

- Update Oregon Administrative Rules, billing codes and Service Element 25 to include MRSS specific to children, youth, and families for 2023.
- Training staff.
- Build out community resources and develop expedited pathways to care.
- MRSS Community Conversations and Learning Collaboratives.

Questions for the Committee:

- In your experience, what is needed to make mobile crisis response effective for children, youth, young adults, and their families?
- What community resources are needed to address the Want to find from you the needs of children, youth, young adults, and their families?

Questions/Comments:

- Erik Kola shared words of appreciation and acknowledgement of the need for 988.
- Dr. Christa Schulz: Is there a plan for recruiting more staff for this? What process will be used for referral? Any discussions where this would put the inpatient care needs? **Answer**: Workforce issue is very cumbersome. The program is aware of the workforce needs and are looking at hiring. Looking at telehealth options. Starting these discussions to partner with emergency departments. Hope there will be an ability to partner with mobile response teams. CATS has been an opt-in for the counties, and now will be a requirement to provide the stabilization services. This will spread CATS/MRSS from 11 counties to 36 counties.
- Dr. Justin Sales: Is there dedicated funding coming from the state to support this and the growth of the external partners? Limitations of crisis care is lack of space for crisis care and outpatient referral. Is there funding for providing these services? **Answer**: HB2417 came with $30 million dollars in general funds and have divided $10 million to the existing county response teams to meet the requirements. The kids program part of this has approximately $18 million for getting the mobile response trained on child specifics and there is a match to that amount. CMS is doing enhanced rates for the crisis response and the state is in the middle of a state plan amendment for billing and CMS is offering enhanced rates for crisis codes for the first several years of this project to get it moving. Will be working with reimbursement pathways. This is insurance neutral so open to all types of health insurance. Are distributing funds to counties that need it the most in an equitable manner.

- Dr. Brent Heimuller shared outpatient clinical experience. Kids are sitting in emergency department for days. At clinic struggling to keep up with the need. **Answer**: New model will provide quicker access to mental health assessment and other services.
- Dr. Dana Selover: In addition to interfacing with the primary care behavioral health system and emergency departments, can you talk a little about your Patient Safety Answering Point (PSAP) and the 911 services and the EMS services? How are you doing outreach and interfacing? How can OHA EMS participate and play a role? **Answer**: Meetings with 988 and 911 PSAPs involve a collaborative effort. If call requires emergency medical care, then will dispatch EMS. If risk or harm are and issue, then dispatch law enforcement. Lines for Life and Northwest Human Services have a procedure that they follow when they receive a call, and transfer calls to 911 as needed. 911 will transfer calls to 988 as needed. It will be a symbiotic relationship. Working to make sure that child, youth, and young adult needs are heard.
  Action: Brian Pitkin and Beth Holliman will take this back to see what discussions are happening at local level and will get information back to Rachel Ford.
- Dr. Dana Selover: Are the triage protocols for 911 and 988 done and implemented across the state? Considered that EMS availability in rural areas may not be as available? Clear about what may happen and ready for that? Opportunity to give webinars and outreach to EMS services. This could overwhelm rural EMS. **Answer**: A majority of the discussions with PSAPs have centered around law enforcement and not EMS.
  Action: Brian will bring this back and discuss.
- Liz Heckathorn: There has not been any training offered to EMS that are currently working with public health and behavioral health systems. There is great effort to collaborate with PSAPs. Conversation for PSAP call takers and dispatchers. EMS is an integral part of the 988 systems moving forward. It is important to share training and information with EMS. Liz offered to be a resource for 911 and 988.
- With 988 going live mid-July, is there any component of the work that you have been doing that will start immediately or will it run up over time into 2023? **Answer:** Still have to go through Rules Advisory Committee. Once the Rules are in place, the counties will know minimum requirements. The MRSS teams will be out there. CATS is going to stay in place as-is until end of the year. After Rules solidified will start working with the counties on the transition.
  Action: Committee will stay in contact and welcome a future 988/MRSS presentation.

Suicide Prevention Project: Letter & Next Steps | Chairperson

Background: Peter Geissert has presented at the past several Committee meetings showing that suicide rates in the state of Oregon are increasing, with pediatric suicide being the leading cause of death in Oregon and second leading cause of death nationally. Knowing that Oregon was trending in the wrong direction, the Committee engaged with partners to gather resources and tools. At the last meeting, Committee members discussed and drafted a letter.

Committee Objectives: Share general resources, raise awareness and/or provide trainings.

Mental Health & Crisis Support Resources: The Committee requests to add resources to the EMSC website have been completed and the contact lists were updated.

Letter: *Youth Mental Health Letterhead Draft* has been shared with the Committee. The letter provides an overview of state suicide data and resources and takes a neutral approach to the topic. The requested changes to the letter have been completed, including referencing the EMSC Program. Prior to the April meeting, eight Committee members approved the letter.

Questions/Comments:

- Dr. Justin Sales: Is the letter or the EMSC website needing to reflect the 988 number or resources they are going to be promoting in July? **Answer**: This is worth discussing and can be added if decided. Suggestion was made to add to the EMSC website.
- Erik Kola: How or who is going to be handling the feedback from this letter? How will the feedback get accumulated, evaluated, and assessed? Appreciate the Committee taking this on and starting the conversation. **Answer**: Rachel Ford has her email at the bottom of the letter. Can take input and create as actions items for the Committee and how they can assist. Once we get feedback, will take the next step.
- Conversation about collective group of contacts to send letter to: EMS, schools, media, etc. What is the priority?
  Dr. Christa Schulz: Appropriate to send out to same EMS agencies contacts as the pediatric readiness information?
  Erik Kola: Resource to EMS providers and potentially emergency departments (EDs). The resources in the letter are a great starting point. Schools, EDs and family resources are another layer. Advocating for a narrowed first outreach.
  Action: Rachel Ford will send to the EMS Pediatric Emergency Care Coordinators contact list.
  Action: Outreach to EDs and family advocacy organizations.
- Carl Eriksson: Suggestion was made to remove the names of Committee members' organizations from the letter. Might look like representing organizations from an official capacity.
  Action: Formally ask Oregon Pediatric Society and others if they will support this effort and co-brand the letter.
- Dr. Brent Heimuller: For outreach to the schools, would want to include the Counselors, Principals, and Special Education Directors. For outreach to local clinics, most clinics have a psychologist so could send to behavioral health contacts.
  Action: Outreach to schools, clinics, and other mental health advocacy groups. Brent could inquire about centralized contact.

Motion to approve the *Youth Mental Health Letterhead Draft* letter with the edits afore mentioned by Jeffrey Dana. Second by Dr. Brent Heimuller. None opposed. Motion carried.

Pediatric Suicide Data | Peter Geissert, OHA EMS & Trauma Systems Program

Project Status: Meeting weekly to reconcile discrepancies between coding of records. There are about 150 records left to review. Will reach out internally for clinical/EMS perspectives on coding. Once the inter-rater reconciliation is completed, will begin definition development.

Process includes:

- Inter-rater reliability
- Beginning with discrete variables (codes)

- Parsing the narrative - feature selection: the process of identifying key words and combinations of key words strongly associated with a category
- Deterministic vs. Probabilistic definitions
- Assessing performance - Sensitivity, Specificity, and Receiver Operating Characteristic (ROC) Curve

Revised Timeline:

- December 2021: Coding completed
- January 2022: Present preliminary findings
- February - April 2022: Inter-rater agreement assessment
- May - June 2022: Definition development
- July 2022: Present candidate metrics/definitions

Questions/Comments: None

Health Emergency Ready Oregon (HERO) Kids | Brittany Tagliaferro-Lucas, Oregon Center for Children & Youth with Special Health Needs

The HERO Kids Registry provides medical information to EMS before arriving on the scene and for clinicians to view in the Emergency Department Information Exchange (EDIE). Looking to launch HERO Kids Registry this fall.

Committee was provided a visual walkthrough of the online HERO Kids Registration site. Some field are required, but most are optional. Includes: Demographics, Contacts, Clinical Details, Alerts and Instructions, Upload Documents (Emergency Protocol Letter, POLST, etc.). Once completed, the registry can be printed.

Will continue to collect feedback from providers about functional edits.

Questions/Comments:

- Dr. Christa Schulz: Does the form allow for multiple medical conditions? **Answer**: In the primary diagnosis field they can enter as much information as they want. The PDF can expand depending on the complexity of the record.
- Dr. Carl Eriksson: For some patients there is a need to give very concrete guidance. Example: This child has a Blalock-Taussig (BT) shunt. Please do not give more than 40% oxygen. How do you envision this will show in a very clear way for providers? Have concerns how the parent would navigate putting this level of clarity into the Registry. **Answer**: Will be relying on this being included in the Emergency Protocol Letters. There is a free text field where information can be included. Revisions to the Registry are not complete and there will be more fine tuning before this goes live. Will be developing a step-by-step PowerPoint presentation for families with instructions, tips, best practices, and examples.
- Dr. Brent Heimuller: An expandable form to include all medications would be great. **Answer**: Yes, that section of the Registry allows for multiple entries.
- Dr. Carl Eriksson: Will there be an ability for proxy entry? Some patients may need the primary doctor to enter the information. **Answer**: Currently HERO is parent and young adult owned. The

recommendation will be to work with medical providers when a young adult or child has special health needs. Clinicians cannot complete or edit a registration, but the family can ask the medical provider for assistance.

- Dr. Dana Selover: What is the expectation that the parents have? Is the information on the Registry relevant to an emergency or is it for all their medical history? How will this be used? Are you encouraging families to work with their local EMS? **Answer**: The expectation is that HERO Kids Registry is to provide information to EMS and emergency department providers in an effort to receive more informed care. There will be no training for EMS about how to manage medical conditions but will hopefully lessen stress on both the family and provider side. Encouraging families to visit local EMS with their child or young adult to introduce them to EMS and provide the HERO Kids ID Registry number to EMS.
- Dr. Carl Eriksson: Some of the information will need to come directly from clinicians. Does it make sense for provider access to the Registry? ED feedback has been that medical information needs to be short and bulleted. Need to figure out how to enter information for the success for EMS and emergency departments. **Answer**: Provider-to-provider direct communication will be in phase 2 of the HERO Kids Registry. Will develop a portal for the completion of Emergency Protocol Letter.

For additional questions or comments, herokids@ohsu.edu.

AmeriCorps VISTA Member Project | Ammara Molvi, OHA EMS & Trauma Systems Program

Lake County Community Meeting: Wrapping up the project with Lake County. Hosted a community meeting that included Lake County project participants, as well as Rachel Ford, Robert Edwards, Ammara Molvi, and Liz Heckathorn from the OHA EMS & Trauma Systems Program and Sarah Anderson from the Oregon Office of Rural Health. Survey results were reviewed during the meeting and participants shared feedback and information about agency operations.

Project Reports: Created a project report that provides an overview of the project and the results. Each EMS agency received a report with agency-specific data compared to the average for Lake County.

Toolkit: The EMS Resource Toolkit can be found by searching "OHA EMS Resource Toolkit" on the web or visiting the OHA EMS website. Share the EMS Resource Toolkit flyer.

- Added items requested by Lake County. New additions include Billing Resources, Community Resources, Initial and Continuing Education, Patient Care Guidelines, and Policies and Procedures Guidebook.

This is Ammara's last EMSC Advisory Committee meeting. Last day of service is Monday, April 11th. Huge shout out to Rachel Ford, Liz Heckathorn and the OHA EMS & Trauma Systems Program team.

Questions/Comments:

- Liz Heckathorn: We will continue to develop and update the Toolkit and hopefully figure out a means to count how many people access the Toolkit.
- The Committee shared appreciation for Ammara's year of service.

PEDS-03 Project | Rachel Ford & Peter Geissert, OHA EMS & Trauma Systems Program

Overview - Rachel Ford

Letters: Letters were mailed to all EMS transport agencies on March 30th. They were provided their individual stats as compared to all agencies in the state.

Feedback:

- Several EMS agencies asked if there a way the state could make weight a required field in ImageTrend Elite, as this would dramatically increase compliance.
- Agency said that they must have missed this message in October of 2021. However, they will get this out to their crews immediately.
- Agency is going make the weight a mandatory field on all patients that they transport so that should fix the problem.
- Agency appreciated getting the statistics and they are going to work on fixing the problem.

Next Steps Recommended by Committee:

- **Letters to emergency departments regarding documentation of weight in kilograms:** Rachel checked with the EMS & Trauma Systems Program data team, and it sounds like the weight in kgs information is available for trauma hospitals in the Oregon Trauma Registry. For the non-trauma hospitals, the team will be checking the Emergency Department Data Set. This could be shared at a future State Trauma Advisory Board meeting, through regular Pediatric Readiness Program communication or other means.
- **Regular distribution and/or updates to scorecard/dashboard with key metrics, not pediatric specific, for all EMS agencies:** The EMS & Trauma Systems Program data team stated that this is absolutely part of the vision. There is some groundwork that needs to be laid to make that happen. The team has the pediatric quality measures coded up, so once they have the platform to host agency and hospital specific dashboards, the performance measures will be included.
- **Grants:** HRSA Targeted Issues Grant and similar grant opportunities were reviewed. The current EMSC Targeted Issues grant cycle is 2019-2022 and Oregon Health and Science University is one of the recipients. Their project is *A Multi-State Evaluation of Emergency Department Pediatric Readiness: Guideline Update and Association with Quality, Outcomes, and Cost*. The Principal Investigator is Craig D. Newgard, MD, MPH. The Oregon Office of Rural Health is interested in funding some EMS quality improvement projects and there has been some discussion about opportunities. The Committee will be kept informed of future conversations.

Pediatric-03 Data Update - Peter Geissert

EMS data is always a snapshot. The metric can shift with reporting:

- Documentation of weight associated with time to record completion.
- Documentation of weight associated with documentation of Unit Notified Date/Time.

Shared graphic representation of NEMSQA Pediatric-03 metric for each month of 2019 - 2022.

Shared graphic representation of Q3 (July - September 2021) and December 2021 - February 2022. This was for all patients, both pediatric and adult. There is a lot of movement from the pre-period to the post-period. Reorganizing these data points to form a curve, the distribution of agency percentage documentation is very similar in the pre- and post-periods. The Kolmogorov-Smirnov (KS) Test was used

to look at whether there was a statistical difference between these distributions. The KS Test is a non-parametric test, meaning it is not sensitive to non-normal data. The two-sample variants of this test can test for difference between two empirical cumulative distribution functions. The test statistic is quite small, and the p-value is .992. There is no statistically significant difference here.

Shared graphic representation of Q3 (July - September 2021) and December 2021 - February 2022. This was for pediatric patients only. Some movement in both directions between the pre- and post-periods. There are fewer agencies represented here because there are some agencies that did not have pediatric calls. Reorganizing these data points to form a curve, the distribution for the pre- and post-periods for agency percentage documentation is very similar. In the post period it is rising a little higher and faster. When reviewed last quarter, there was a larger gap between the two curves suggesting there might be a shift. Remember, with additional data submitted and perhaps more complete data, the two curves are tucked in closer to one another. The test statistic is small, and the p-value is .991. There is no statistically significant difference here.

Questions/Comments:

- Matt Philbrick: Is there an opportunity to repeat this data analysis mostly because we sent an updated letter with a call to action? Recognizing that the changes might be slow and/or incremental, we would like to see if the intervention (agency-specific letter) sparked any sort of positive change especially with Rachel Ford's targeted outreach. What is the workload to repeat a similar report in 6 months to see if there is sustained improvement? **Answer**: The script is built so it is easier to perform this analysis again. Have heard the interest of the Committee in being able to monitor this on a month-to month basis, so I am working on having the script setup to quickly pull a near real-time metrics. Can repeat this again for the next meeting and/or following meeting as appropriate.
  Action: Peter will work towards monthly data reporting, and at a minimum will pull data for July and October meeting.

Wrap-up - Rachel Ford

Peter has agreed to keep pulling data. Would like to send agencies a second letter in a few months to provide feedback on their efforts.

Questions/Comments:

- Dr. Carl Eriksson: No problem sending another letter. Good idea to keep up the communication and the pressure. This is an important initiative.
  Action: Rachel will request data from Peter and send letter to agencies in approximately three months.

Next steps:

- Request time on Oregon chapter of National Association of EMS Physicians meeting agenda
- Use the Prehospital Guidelines Consortium's draft Prehospital Evidence-Based Guideline Implementation Toolkit (see January meeting file).
- What other steps would the Committee like to pursue?

Questions/Comments:

- Dr. Carl Eriksson: NAEMSP is a great idea and communicating with the agencies in as many ways possible with the information and the ask is key. Is there someone who can present this to the NASEMSP? It would be great coming from an EMS Medical Director. **Answer**: Dr. Lehrfeld is the chair of NAEMSP. Rachel Ford will ask Dr. Lehrfeld to take this to the group.
  Action: Rachel will meet with Dr. Lehrfeld to discuss NAEMSP presentation.

EMSC Program | Rachel Ford, EMSC Program Manager

National Association of State EMS Officials (NASEMSO):

- **Defibrillator Pad Incompatibility**: On January 27th, the Defibrillator Pad Incompatibility memo from the NASEMSO Pediatric Emergency Care Council was emailed to all Oregon EMS Operations Officers and EMS Medical Directors, as well as posted on the OHA EMS website. It was identified that EMS services and/or personnel had been utilizing incorrect pediatric defibrillator pads with various manual monitor/defibrillators and AEDs. This results in the inability to deliver therapy across all age and weight ranges. Emergency medical services, fire, and other public safety agencies have been encouraged to read the memo and double-check all monitors and AED units to ensure they have the correct manufacturer recommended pads. For questions, please refer to the manufacturer instructions for the device or contact the manufacturer.
- **Other Activities**: Pediatric Emergency Care Council and NASEMSO West Region meetings. Developing the agenda for the June 2022 Pediatric Emergency Care Council Annual Meeting. Participating in the Pediatric Emergency Care Council Welcome Packet Workgroup with the assigned deliverables of a resource list by state and topic and an EMS-specific acronyms list.

Pediatric Readiness Program (PRP): www.pedsreadyprogram.org

- **Education Sessions:** There are 23 education session recordings and slides, including the two latest, *Bronchiolitis is Back* and *Pediatric Toxicology*, that can be accessed in the Education section of the Pediatric Readiness Program website. Future sessions include Pediatric Trauma, Pediatric DKA (diabetic ketoacidosis), and Mental Health and Collaborative Problem-Solving. CME/CE is available for the quarterly live and recorded education sessions thanks to a formalized CME/CE agreement with Legacy Health.
- **New!** The Pediatric Readiness Program is now sharing Pediatric Grand Rounds information from Providence Health & Services Oregon Region, Providence Sacred Heart Children's Hospital, Randall Children's Hospital, and Doernbecher Children's Hospital through the listserv. CME/CE is available. There are also several national sources of free CME, continuing education, and pediatric case review available in the Shared Resources section of the Pediatric Readiness Program website.
- **Workshop**: Learn fundamentals and advanced skills for productive quality and value projects through the University of Continuous Quality Improvement (CQI) Workshop. Lead by Dr. Joe Kaempf, these workshops are free, fun, interactive and open to all providers and caregivers. Teams learn common CQI tools and language. For more information, visit the Quality Improvement section of the Pediatric Readiness Program website.
- **Other News:** The Weight in Kilograms QI Collaborative concluded. The PRP team continues to meet and will review the 2021 NPRP assessment results to determine future quality improvement efforts.

National Pediatric Readiness Project Assessment (NPRP):

- **2021 State Report**: The 2021 NPRP Assessment State Frequency Report was shared with Committee members. Rachel Ford is reviewing the results and curating resources to address technical assistance needs identified in questions 82-90. Rachel requested feedback from the Pediatric Readiness Program Team on the resource list.
- **Request for Information**: In May, the OHA EMS & Trauma Systems Program will send a request to hospitals to update their contact information. This will include a few new contact fields: Nurse and Physician Pediatric Emergency Care Coordinator and Emergency Department Educator. These contacts will be used to build relationships and share resources with hospitals.
- **2021 Regional Reports**: Rachel Ford received 2021 NPRP Assessment Regional Reports and will be working with the National EMSC Data Analysis Resource Center to prepare them for posting on the Oregon EMSC website.

EMSC Innovation & Improvement Center (EIIC):

- **Pediatric Emergency Care Coordinator Workforce Development Collaborative**: Participation continues and part two of the collaborative will include the implementation of a project plan to create a hospital Pediatric Emergency Care Coordinator/Champion contact list and improve communication with Coordinators/Champions. This Collaborative supports the work to address technical assistance needs identified in the NPRP Assessment.
- **National Pediatric Readiness Quality Collaborative**: Meetings continue with members of the EIIC team and several EMSC State Partnership Program Managers to assist with the rollout of an improved version of the collaborative. The EIIC is looking for a few hospitals to complete the field testing. Rachel Ford shared this with one Oregon hospital she thought would be interested.
- **Trauma Improvement Sprint**: Two sessions focused on hospital pediatric readiness and the new American College of Surgeons pediatric requirements. Rachel Ford will be following up with Madeleine Parmley, OHA Trauma Coordinator, about changes to the trauma rules.

Annual EMS Survey: The 2022 EMS Survey launched on January 5th and closed on March 31st. The email-based communication was completed as scheduled but did not call the EMS agencies and fire departments out of respect for the challenges being faced . As of April 1st, the final response rate was 39.8% (128/322) EMS agencies and fire departments. Will work to achieve a 70-80% response rate in 2023.

EMS Pediatric Emergency Care Coordinators: Newsletters were sent in January and March, as well as additional outreach regarding the National Rural EMS and Care Conference Scholarships and Compassion Fatigue & Self-Care Course.

Health Resources and Services Administration (HRSA) Grant: Received a Notice of Award on February 28th for the April 1, 2022 - March 31, 2023 grant year. It is a partial award (38.63%) because Congress had not provided a full budget to HRSA. On March 16th, Oregon EMSC received notice that the federal government's fiscal year 2022 Appropriations were approved by Congress, which included fiscal year 2021 ceiling funding for the EMSC Program. As a result, the HRSA EMSC Program expects to issue the balance of grant funds requested for this fiscal year over the next few months.

Questions/Comments: None

State EMS & Trauma Systems Program: EMS Modernization & 2022 Quarter 1 Report | Dr. Dana Selover & Elizabeth Heckathorn, OHA EMS & Trauma Systems Program

2022 Quarter 1 Report - Liz Heckathorn

Thank you for all the Committee is doing.

Website: Have statement on website that will also go out in a memo. With the emergency declaration ending April 1, 2022, the Emergency Initial Provider License (EIPL) is no longer offered. The current EIPLs can continue to work in Oregon until their EIPL expires. Some will qualify for renewal.

Renewal: In renewal season. Currently renewing 1330 Emergency Medical Responders. Renewing all EMS Ambulance Services and Vehicles.

Staffing: Robbie Edwards promoted to CS1 position. It is a permanent position, and this is a big win as we do not lose the historical information, skills and experience that Robbie has brought to the team. Have the two AS1 positions on fast track and moving forward.

EMS Provider Exams: Changes are coming for educational system and psychomotor exams for EMS providers. As a result of National Registry making some changes, OHA EMS is working with the Community Colleges for a smooth transition.

Trauma System: Hired Trauma Program Coordinator Madeleine Parmley. They are getting the trauma surveys back on track.

EMS Modernization - Dr. Dana Selover

Thank you to Jackie DeSilva for the many years of Committee service and Ammara for her hard work on the VISTA project.

2021 session and 2022 short session: In 2022 not too many bills. State Bill 1549 is for temp staffing agencies that staff healthcare providers. There will be a conversation about cost setting. House Bill 2359, Healthcare Interpreters, was reopened. Race Ethnicity Age Language and Disability Data Collection, HB 2417 Crisis Care for Behavioral Health.

Looking at 2023: Transfer Guidelines specifically around Pediatrics (2022) and EMS Modernization. ODOT is very busy with spending and funding and watching how that will impact the post-crash analysis.

Questions/Comments: None

Committee Roundtable | Chairperson

Rachel Ford: Happy to see so many today. Welcome back!

Matt Philbrick: Thank you for the active participation! Great discussion today!

Public Comments | Chairperson

- None

Meeting Adjourned: 11:58 a.m.

Next meeting is July 7, 2022