

EMSC/CHILD READY CONNECTION NEWSLETTER

August 2015: VOLUME 3, ISSUE 8



A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation*) is provided to children and adolescents, no matter where they live, attend school or travel.

THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME WITH THE RIGHT RESOURCES!



Child Ready Montana- State Partnership of Regionalized Care (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

Exciting news and events are going on this month!

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E-CIGARETTE POISONINGS ON THE INCREASE! SEE PAGE 3.

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PEDIATRIC TRAUMA COURSE FOR EMS OPPORTUNITY. SEE PAGE 8.

WIN A FREE REGISTRATION TO THE PEDIATRIC EMERGENCY & TRAUMA SYMPOSIUM IN BILLINGS AUGUST 27-28TH BY ANSWERING THE TRIVIA (SEE CRITERIA) PAGE 9!



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CONGRATULATIONS AND GREAT WORK TO PHILLIPS COUNTY HOSPITAL !

Phillips County Hospital has been formally recognized with the Montana EMSC/Child Ready MT Project for being a **Pediatric Capable Facility**.

Phillips County Hospital has also been named one of the 2015 Top 100 Critical Access Hospitals. We commend Phillips County Hospital for achieving top performance among your peers and earning this National recognition. The facility has also been recognized as the 20th highest ranked Critical Access Hospital in the country, determined by the iVantage Health Analytics and recently announced by the National Rural Health Association (NRHA).



CHILD READY MONTANA

Child Ready Montana is a State Partnership Regionalization of Care Grant (SPROC) funded by the Federal Health Resource and Services Administration (HRSA). Montana is one of 6 states to be awarded this grant with the Montana Emergency Medical Services for Children (EMSC) Program.

Top six patient centered care needs for treating pediatric patients and their families.

Listening to and respecting each child and his or her family. Honoring racial, ethnic, cultural, and socioeconomic background and patient and family experiences and incorporating them in accordance with patient and family preference into the planning and delivery of health care.

Ensuring flexibility in organizational policies, procedures, and provider practices so services can be tailored to the needs, beliefs, and cultural values of each child and family and facilitating choice for the child and family about approaches to care.

Sharing complete, honest, and unbiased information with patients and their families on an ongoing basis and in ways they find useful and affirming, so that they may effectively participate in care and decision-making to the level they choose. Health information for children and families should be available in the range of cultural and linguistic diversity in the community and take into account health literacy. In hospitals, conducting physician rounds in the patients' rooms with nursing staff and family present can enhance the exchange of information and encourage the involvement of the family in decision-making.

Providing and/or ensuring formal and informal support (eg, peer-to-peer support) for the child and family during each phase of the child's life. Such support is provided so that Health Insurance Portability and Accountability Act and other relevant ethical and legal guidelines are followed.

Collaborating with patients and families at all levels of health care: in the delivery of care to the individual child; in professional education, policy making, program development, implementation, and evaluation; and in health care facility design. Patients and families can serve as members of advisory councils, committees, and task forces dealing, for example, with operational issues in health care facilities; as collaborators in improving patient safety; as participants in quality-improvement initiatives; and as leaders or co-leaders of peer-support programs. In the area of medical research, patients and families should have voices at all levels in shaping the research agenda, in determining how children and families participate in research, and in deciding how research findings will be shared with children and families.

Recognizing and building on the strengths of individual children and families and empowering them to discover their own strengths, build confidence, and participate in making choices and decisions about their health care. (AAP Pediatrics Vol. 129 No 2 February 1, 2012)

Child Ready MT and EMSC are partnering to complete site reviews for the Pediatric Criteria throughout Montana. Please contact Kassie Runsabove or Robin Suzor to schedule your site review.

E-CIGARETTE POISONING



Nicotine is an acute toxin



Liquid nicotine can be harmful if **swallowed** or **absorbed through the skin**

E-cigarettes contain a liquid nicotine solution that can be poisonous. These products come in bright colors and appealing flavors and scents, making them particularly attractive to young children.

More than half of these exposures occurred in **children ages 5 and under**



Symptoms include:

- Nausea
- Vomiting
- Increased heart rate
- Increased blood pressure
- Seizures
- Death



Poison control centers reported a **145% increase** in calls involving e-cigarettes and liquid nicotine between 2013 and 2014



The National EMSC Data Analysis Resource Center (NEDARC) has created an [infographic](#) based on data from the Pediatric Readiness Assessment. The infographic states the importance of weighing children and recording the weight in kilograms, based on a patient safety recommendation from the 'Guidelines for Care of Children in the Emergency Department.'

The Pediatric Readiness Assessment revealed that half of the hospitals in the nation do not weigh and record in kilograms, which is a concern because it can lead to medication dosing errors.

Having a Pediatric Emergency Care Coordinator is the single most important item that hospitals can implement to ensure pediatric readiness including patient safety.

The
MOST IMPORTANT SAFETY INITIATIVE for **CHILDREN**

Hospitals should

WEIGH & RECORD
children in
KILOGRAMS

only **1** in **2**
Hospitals Weigh and Record in Kilograms*

Not Weighing and Recording in KG can lead to
Drug Dosing ERRORS

Having a
PEDIATRIC Emergency Care Coordinator

is the single most important item that hospitals can implement to ensure pediatric readiness including patient safety.*

www.pediatricreadiness.org

* Gausche-Hill M, Ely M, Schmuhl P, Telford R, Remick K, Edgerton E, Olson L. A National Assessment of Pediatric Readiness of Emergency. *JAMA Pediatrics*. Published online April 13, 2015. doi:10.1001/jamapediatrics.2015.138.

INITIATION OF A MEDICAL TOXICOLOGY CONSULT SERVICE AT A TERTIARY CARE

A recent [article](#) published in *Clinical Toxicology* describes the creation of a pediatric medical toxicology consultation service and the impact of the service on the medical toxicology fellowship program and regional poison center. Presently, 10% of board-certified medical toxicologists are pediatricians but over 50% of poison control center calls involve children less than 6 years of age. Prior to formation of the service, medical toxicology consultations were performed over the phone by a regional poison center. In collaboration with Departments of Pediatrics and Emergency Medicine, regional poison center, and toxicology fellowship, study investigators established a toxicology consulting service at a tertiary care children's hospital.

A total of 139 consultations were performed during the first year of service among patients ages 1 month to 18 years. Of these, 14 (10%) were ED consultations, 62 (45%) were inpatient consultations and 63 (45%) were critical care consultations. Furthermore, the primary exposures were as follows: polypharmacy (24), analgesics (22), antidepressant/antipsychotics (15), altered mental status (12), antimuscarinic (9), envenomations (7), and botulism (1).

The consultation service generated 13 consultations in the first month and 11 consultations per month thereafter. Additionally, the service increased the number of pediatric patients seen by the medical toxicology fellowship program from 30 to 94 in the first year.

Investigators found that the medical toxicology consultation service filled a clinical need by: allowing medical toxicologists to gather more accurate history and detailed physical information, identifying clinical trends and facilitating access to complete laboratory data; improving house staff and student knowledge of exposure, ingestion and envenomations; and allowing toxicology fellows to fulfill the new ACGME pediatric toxicology consultation requirements. <http://www.ncbi.nlm.nih.gov/pubmed/25686099>

Childhood Adversity linked to Adult Migraines

Studies have shown a most surprising finding of a link between exposure to parental domestic violence and migraines. Even after accounting for variables including age, race, socioeconomic status, history of depression and anxiety, and childhood physical and sexual abuse, **men and women who had witnessed parental domestic violence had 52% and 64% higher odds of migraine**, respectively, compared to those without such a history. <http://www.sciencedaily.com/leases/2015/06/150624071024.htm>

FEMA'S POST-DISASTER REUNIFICATION OF CHILDREN- A NATIONWIDE APPROACH

The Federal Emergency Management Agency (FEMA) developed a document which reflects the Nation's first attempt to establish a holistic and fundamental baseline for reunifying children separated as a result of a disaster and aims to assist local, state, tribal, territorial, and insular governments and those responsible for the temporary care of children, such as educational, child care, medical, juvenile justice, and recreational facilities, in enhancing the reunification elements of existing emergency preparedness plans and/or conducting new all-hazards reunification planning.

Includes information on: Concept of Operations Guidance; Minor Separated from Parent or Legal Guardian; Child Reported Missing by Parent or Legal Guardian; Unaccompanied Minor Identified as Deceased; Supplemental Checklist; Preparedness; Evacuation Support; Shelter Operations; Reunification Mechanisms; and Public Information and Outreach.

<http://www.fema.gov/media-library/assets/documents/85559>

HELP NHTSA SPREAD HEATSTROKE PREVENTION AND AWARENESS

The summer is heating up and the National Highway Traffic Safety Administration's (NHTSA) heatstroke prevention and awareness efforts are in full swing. This marks the fourth summer that NHTSA has spread awareness about the dangers of child heatstroke in hot cars, while urging parents and caregivers to think, "**Where's Baby? Look Before You Lock.**"

Since 1998, over 630 children in America have died from heatstroke. Over half, 53 percent to be exact, were forgotten in vehicles; 29 percent gained access by themselves and became trapped; and 17 percent were left intentionally by adults not fully aware of the dangers. Already, eight children this year and more than 30 children in 2014 lost their lives from heatstroke after adults left them in unattended vehicles.

Heatstroke tragedies are 100-percent preventable, which is why NHTSA is looking for every opportunity to educate consumers on the importance of making sure that children are neither unintentionally locked in, nor able to gain access to (and become trapped in) unattended vehicles. NHTSA is asking highway traffic safety partners to ramp up activities this summer to augment the national effort. NHTSA is offering tools to assist in communicating with the public.

This **resource** includes information on:

- Using the Latest Campaign Materials;
- Using Social Media to Get the Word Out; and
- Upcoming Opportunities for Your Calendar.

More information can be found at:

English: www.safercar.gov/parents/InandAroundtheCar/heat-involved.html



Look Before You Lock

Make it a habit to look before you lock, and try these [tips to avoid putting children at risk of heatstroke](#).



TAKE ACTION if You Notice a Child Alone in a Car!

Protecting children is everyone's business—learn [what to do if you see a child alone in a car](#).



Never Leave a Child Alone in a Car

Think heatstroke can happen on a cloudy day? Find out—take this [quiz to test how much you know about preventing child heatstroke](#).



Get Involved

[Find and share campaign information](#) for parents, caregivers, schools and organizations, and remind everyone to **Look Before You Lock!**

SUMMER MONTHS CAN BE VERY UNCOMFORTABLE, EVEN DANGEROUS, FOR PETS.

As with children, never leave pets in a parked car. On a warm day, temperatures inside a vehicle can rise rapidly to dangerous levels.

On an 85-degree day, for example, the temperature inside a car with the windows opened slightly can reach **102 degrees within 10 minutes**. **After 30 minutes, the temperature can reach 120 degrees**. Pets may suffer irreversible organ damage or death.



WHY DOES HEALTH LITERACY MATTER?

It's easy for those of us in the field to forget how many people out there don't understand how crucial health literacy is.

These facts make a pretty good quick pitch:

- Only 1 in 10 U.S. adults have the skills needed to use health information that is routinely available in health care facilities, retail outlets, and the media.
- People with poor health are 5 times more likely to have below basic health literacy skills than people in good health. (This reality is compounded by the fact that health literacy skills decrease when you're stressed or sick.)
- People with limited health literacy skills often get worse care and have more medication errors, longer hospital stays, and higher death rates.

It's no abstraction. Health literacy — or the lack of it — has a direct impact on people's well-being and health. The good news is that by making health information easier for everyone to understand, we can improve health outcomes.

DID YOU KNOW?



Fully 20 percent — 1 in 5 — of children ages 13-18 currently have and/or previously had a seriously debilitating mental disorder. Dr. Thomas Insel, Director of the National Institute of Mental Health, offers a tour of [mental illness by the numbers](#) in a recent blog post.

While the numbers alone are compelling, the personal stories of families and individuals affected by mental illness complete the picture of why finding ways to prevent and treat mental illness is such an urgent need.

http://www.nimh.nih.gov/about/director/2015/mental-health-awareness-month-by-the-numbers.shtml?utm_source=Youth.gov&utm_medium=email&utm_term=NMHM15%20&utm_campaign=newsletter

A CONSENSUS-BASED CRITERION STANDARD DEFINITION FOR PEDIATRIC PATIENTS WHO NEEDED THE HIGHEST-LEVEL TRAUMA TEAM ACTIVATION

A recent article published in *The Journal of Acute Care and Surgery* defines a consensus-based standard definition criterion for the highest-level pediatric trauma team activation. Utilizing a modified Delphi technique, a panel of 10, representing local and national experts in emergency medical services, emergency medicine, and trauma, convened to develop the criterion standard definition.

The initial Delphi survey was developed based on existing literature on trauma team activations. Panelists reviewed the outcomes and the criteria utilized in those studies; then voted to add, keep, remove, or modify the outcome criteria during each of the five rounds of voting.

Twelve criteria were identified for inclusion in a consensus-based standard definition for the highest-level pediatric trauma team activation by the expert panel. Investigators concluded that the development of the consensus-based standard definition for the highest-level pediatric trauma team activation is an opportunity to determine the accuracy and efficacy of highest-level pediatric trauma team activation procedures.

http://www.ncbi.nlm.nih.gov/pubmed/25710438?utm_

Meet Carla.

She just found out she is pregnant. She is also reluctant to cut back on her alcohol use.

*How can you help her **reduce her risk** of having a child affected by prenatal alcohol exposure?*

Learn how to apply **Brief Motivational Interviewing** techniques to address Carla's drinking and encourage her to choose to cut back on her alcohol use during this [free 15-minute CE-accredited case study](#).

For more resources on preventing prenatal alcohol exposure, visit www.arhp.org/FASD

FAMILY PRESENCE IN THE EMERGENCY DEPARTMENT

The EMSC National Resource Center developed a course that **PRIMARILY TARGETS EMERGENCY DEPARTMENT NURSES**, and includes **THREE MODULES**:

- ⇒ Evidence for family presence (FP),
- ⇒ Introduction to FP, and
- ⇒ Implementation of a FP program.

http://www.emscnrc.org/CHEXWizards/family_presence_in_the_emergency_room/index.html

PEDIATRIC TRAUMA COURSE FOR EMS PROVIDERS.

This course targets EMS providers and offers an overview of pediatric trauma, the leading cause of injury and death in American children.

EMS providers will have the opportunity to learn about the scope of pediatric trauma, revisit the keys of their pediatric patient assessment, review the benefits of specialized trauma center resources, and examine how trauma pre-planning tools can assist them in making the best transport decisions for their patients.

EMS personnel must make a number of critical decisions when they arrive on the scene of a pediatric injury, not the least of which is where to ultimately transport the patient.

Trauma is among the leading causes of injury and death in American children; accordingly, it is essential that EMS providers possess a firm understanding of how to evaluate their pediatric patients as well as the resources available to them to assist in making the best transport decisions.

This course is designed to review the EMS prehospital management of pediatric trauma through the following topics:

- **Defining the impact of pediatric trauma – the size and cost of the problem, who is most affected and who is at the greatest risk, what can be done to prevent it;**
- **Reviewing the fundamentals of the pediatric patient assessment;**
- **Considering the benefits of the advanced care offered by trauma centers;**
- **Examining the utility of a trauma triage and destination pre-planning tool in making consistent transport decisions.**

www.emspic.org/news/pediatric-trauma-course-ems-providers



TRIVIA CONTEST:

The first 5 facilities or services to have at least 4 staff answer the trivia, could WIN one free registration (value \$100) for the August 27-28, 2015 Emergency & Trauma Outreach Symposium sponsored by the Children's Hospital Colorado and in collaboration with St. Vincent's Health Care in Billings. Check out the agenda at www.childrenscolorado.org/ce or see topics below. (12.5 CEUs) Email rsuzor@mt.gov (1st 5 facilities or services to answer trivia receives one MT EMSC sponsored registration)

1. What is the percentage increase in E-cigarette poisonings in 2014?
2. What is one of the important safety initiatives for children?
3. Why does health literacy matter?
4. What does FP stand for?
5. What are the three modules for FP?

TRAINING RESOURCES:

2015 EMERGENCY & TRAUMA OUTREACH SYMPOSIUM -This symposium offers physicians, nurses, pre-hospital providers and other healthcare team members the latest guidelines for pediatric practice through patient-centered presentations and hands-on skills training. (12.5 CEUs)

TOPICS INCLUDE • Pediatric-specific patient assessment and pediatric responses to illness & trauma; Identify appropriate pediatric pain assessment tools and pain relief modalities; Pediatric response to shock and pediatric resuscitation techniques; Common respiratory conditions in children and those requiring emergent intervention; Methods utilized to calculate the Total Body Surface Area of a burn wound, differentiate between the depths of burn wounds and identify pediatric burn injuries that are due to non-accidental trauma; Pediatric neurological compromise due to injury and appropriate interventions; the developmental, anatomic and physiologic characteristics of a child with a traumatic injury and/or burn wound; Differentiate between types and causes of abdominal pain in children. **AND MUCH MORE!**

NOW AVAILABLE: PEDS READY DATA WEBINAR CONVERTED TO ON-DEMAND LEARNING MODULE

The EMSC-hosted webinar *Pediatric Readiness Data: An Opportunity to Improve Quality of Care in Your Emergency Department* (originally aired in December 2014), is now available as an [on-demand online learning module](#). The module defines quality improvement; highlights key components of the quality improvement process, and discusses how to apply essential quality improvement methodologies to improve pediatric emergency care using the National Pediatric Readiness data.

Charles Macias, MD, MPH, and Kate Remick, MD, discuss the importance of quality improvement in pediatric emergency care, a key quality improvement framework, and potential for quality improvement projects using the National Pediatric Readiness data. Evelyn Lyons, RN, MPH, illustrates the real life application of quality improvement in pediatric emergency care.

This educational event targets hospital emergency department (ED) Pediatric Readiness respondents. Content is appropriate for all ED leaders, including ED medical directors, managers, education specialists, quality improvement coordinators, as well as hospital leadership, quality improvement department staff, EMSC program managers, and state departments of health/hospital regulatory staff. **Continuing CEUs are available for those that complete the module, the evaluation, and score a 70% or higher on the post-assessment.** For more information see http://emscnrc.org/EMSC_Resources/CME_Training/Pediatric_Readiness_Data.aspx?utm_

