MATERNAL HEALTH COMPACT

Rural health care centers have been essential for patients, but many of these smaller hospitals have shut down their maternity services. For a patient in a rural setting, frequent severe weather and long distances may impede access to a larger hospital. Is it reasonable that we can do more to support obstetrical practitioners in remote settings?

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth services can provide real-time specialty expertise to lower-resource care settings approach.

A Maternal Health Compact could be created linking lower-resource hospitals with specialists, with the goal of transporting patients to the appropriate facility when possible and making care as safe as possible locally when transport is not an option. Telehealth services in obstetrics can help to bridge the gap in three ways: facilitating transport of patients, supporting care provided remotely, and assisting in local quality-improvement activities. Under a Maternal Health Compact, a tertiary care hospital provides services to its referring lower-resource hospitals for high-risk patients. Smaller hospitals also benefit from increased collaborations in which, for instance, the tertiary care hospital runs simulations of obstetrical emergencies and assists with quality-improvement activities such as implementation of hemorrhage-treatment algorithms. Such collaborative work can be done in person or through telemedicine connections.

With better preparation and planning through a Maternal Health Compact, hospitals could be ready for these crises. Through a Maternal Health Compact, physicians and nurses are made available to lower-resource hospitals through a video link can help manage on-site obstetrical emergencies. Telehealth programs, may for example, house under one roof a variety of medical departments — ICU, pharmacy, emergency, and others — to provide continual specialty care to partner care facilities. This kind of coordination is invaluable to patients.

Pregnant woman in rural communities cannot afford to lose access to local hospitals; rather, we need to make the care they receive as safe as possible.

Team training and simulation of emergencies are common tools of the patient-safety movement, and electronic connectivity and broad implementation of a Maternal Health Compact are the next logical steps for improving patient care, retaining rural care facilities, and recruiting and supporting practitioners in the field. Read more at http://www.nejm.org/doi/full/10.1056/NEJMp1700485
MONTANA CONFERENCE ON SUICIDE PREVENTION

Where: Best Western Gran Tree Inn (1325 N 7th Avenue, Bozeman, MT)

When: Friday, July 14th from 9:00-4:00 PM

Why: This conference brings together advocates and professionals in learning about suicide prevention and equips attendees with strategies in reducing suicide.

The conference is free, but registration is required. CEUs are available. Learn More

MANY CHILDREN NEEDLESSLY DIE IN HOT CARS EACH YEAR - SUMMER BRINGS EXTREME RISK FOR THESE TRAGEDIES

On June 7, 2017, U.S. Representatives Tim Ryan (D-13th OH), Peter King (R-2nd NY) and Jan Schakowsky (D-9th IL) introduced the Helping Overcome Trauma for Children Alone in Rear Seats Act (HOT CARS Act of 2017, H.R. 2801), a critical piece of legislation that would prevent children from being needlessly killed and injured when unknowingly left alone in vehicles.

The bi-partisan effort has already received widespread support from more than twenty of the nation’s leading public health, consumer and safety organizations, as well as an expert in neuroscience and the brain memory system, along with families who have lost their child or were seriously injured due to child vehicular heatstroke. The timing of the bill’s introduction coincides with the kickoff of the National Vehicular Heatstroke Prevention Campaign by the National Highway Traffic Safety Administration (NHTSA).

“No child should endure the tragedy of dying while trapped in a hot vehicle. The unfortunate reality is that even good, loving and attentive parents can get distracted. Studies have shown that this can happen to anyone, anywhere.

Our cars can already alert drivers when they leave their keys in the car, their lights on, or their trunk open – none of which are life threatening. It is not unusual for the government to mandate safety features to protect lives. Cars are mandated to have seat belts, interior trunk-releases, and rear backup cameras. Our legislation would move us one step closer to getting this inexpensive technology in every car on the road to help save the lives of children nationwide,” said Congressman Tim Ryan (D-13th OH).

The HOT CARS Act would require the U.S. Department of Transportation to issue a final rule requiring cars to be equipped with a system to alert the driver if a passenger remains in the back seat when a car is turned off. “Since 1990, nearly 800 children have died from heatstroke in vehicles,” said Rep. Schakowsky (D-9th IL). “My colleagues Rep. Tim Ryan, Rep. Peter King and I are introducing the HOT CARS Act today in hopes of bringing that number down to zero. Even the most attentive parent can get distracted and forget a child in the back seat of their car. To prevent these tragedies, our bill would require all new vehicles to be equipped with an alert system to remind the driver to check the back seat. A simple alert can save lives.”

“We commend Congressman Tim Ryan, Ranking Member Jan Schakowsky, and Congressman Pete King for their leadership on this very important safety issue. GM is committed to protecting the safety of children in and around our vehicles and has already deployed an industry-first Rear Seat Reminder on many of our 2017 and 2018 models. The Rear Seat Reminder is a simple feature that is intended to do exactly what it says: remind the driver to look in the rear seat before exiting the vehicle, said Dan Turton, vice president of GM North America Public Policy.

ELECTRONIC MEDIA MATERIALS CAN BE DOWNLOADED HERE:
Click here to download the bill.
Click here to download an infographic, state-by-state statistics and the memorial photo wall graphics.
Click here for the speaker statements.
Heatstroke Deaths of Children in Vehicles

**By the Numbers**

- **10** the minutes it takes for a car to reach deadly temperatures on an 80 degree day
- **38** the average number of children who die from vehicular heatstroke in the US each year
- **57** the lowest known outside temperature at which heatstroke can occur

**By Circumstance**

- Of those left in vehicles:
  - **27%** Playing in vehicle
  - **73%** Left in vehicle
  - **18%** Unclear
  - **27%** Intentionally left in vehicle
  - **54%** Forgotten in vehicle

- Boys accounted for:
  - **3 in 5** left deaths
  - **3 in 4** playing deaths

**By Age**

- **80%** of these deaths were children ages **2 and under**
- **34%** <1 year
- **23%** 1 year
- **23%** 2 years
- **15%** 3 years
- **5%** ≥4 years

Children ages:
- **≤2** were more likely to be left by a caregiver
- **≥3** were more likely to be playing in the car

View the full infographic at: https://www.childrenssafetynetwork.org/infographics/heatstrokeinfographic
CAR SEAT SAFETY TIPS

All children under 13 should ride in the back seat, according to the National Highway Traffic Safety Administration. Here are some additional tips the agency recommends:

**Rear-facing seats:** The American Academy of Pediatrics recommends children remain in rear-facing car seats until at least age 2.

**Forward-facing seats:** When kids outgrow rear-facing seats, they should ride in forward-facing child safety seats placed in the back seat of vehicle (until the age of 4 or reaching a weight of 40 pounds.)

**Booster Seats:** Kids (4 to 8 years old who are less than 4 feet 9 inches tall) may use booster seats located in the back seat of vehicles.

**Seat Belts:** Children may begin to use adult seat belts in the back seat once they reach the age of 8 and are at least 4 feet 9 inches tall.  
Source: *Child Passenger Safety: A Parent's Primer*, NHTSA

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NEW FUNDING OPPORTUNITY FROM THE OFFICE OF MINORITY HEALTH (OMH):
EMPOWERED COMMUNITIES FOR A HEALTHIER NATION INITIATIVE

Deadline: Monday, July 31, 2017 at 5:00pm Eastern

The U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) administers grant programs to support projects that implement innovative models to improve minority health and reduce health disparities. In keeping with this support, OMH has released a new funding opportunity announcement (FOA): Empowered Communities for a Healthier Nation Initiative.

The Empowered Communities for a Healthier Nation Initiative will seek to reduce significant health disparities impacting minorities and disadvantaged populations through the implementation of evidence-based strategies with the greatest potential for impact. The program will serve residents in counties disproportionately impacted by the opioid epidemic; reduce the impact of serious mental illness at the primary care level for children, adolescents and/or adults; and reduce obesity prevalence and disparities in weight status among disadvantaged children and adolescents.

Click here to learn more about this Funding Opportunity Announcement (F.O.A).  
Source: *Office of Minority Health*
In the United States each year approximately 4,300 children die from sepsis emergencies, often due to missed or delayed diagnosis. As an EMS provider you play a decisive role in the identification and early treatment of these critically ill children.

This program will show EMS providers how to identify, assess, and begin treatment for pediatric patients with sepsis as well as how to coordinate care with emergency department and critical care staff. This program is intended for both advanced and basic providers whether working or not your EMS system currently has formal sepsis alert protocols.

**Learn the latest updates and take home the knowledge of how you can make the biggest difference for our littlest patients.**

This event was originally broadcast on May 31, 2017 and is now available for on-demand viewing. You will need to register and then you will have access to the archived presentation, please click on the following link: 
[https://event.webcasts.com/starthere.jsp?ei=1147006&tp_key=3a8c15c517](https://event.webcasts.com/starthere.jsp?ei=1147006&tp_key=3a8c15c517)

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**NEW PEDIATRIC PROTOCOL REDUCES MISSED SEPSIS DIAGNOSES BY 76 PERCENT**

An electronic sepsis alert using a combination of vital signs, risk factors and physician judgment to identify children in a pediatric emergency department with severe sepsis reduced missed diagnoses by 76 percent.

The results of the study were published online in *Annals of Emergency Medicine* ("Improving Recognition of Pediatric Severe Sepsis in the Emergency Department: Contributions of a Vital Sign-Based Electronic Alert and Bedside Clinician Identification" and "Between the Devil and the Deep Blue Sea: Use of Real-Time Tools to Identify Children with Severe Sepsis in the Pediatric Emergency Department").

"Sepsis is a killer and notoriously difficult to identify accurately in children, which is why this alert is so promising," said lead study author Fran Balamuth, MD, PhD, MSCE, of Children's Hospital of Philadelphia, in Philadelphia, Pa. "Identifying the rare child with severe sepsis or septic shock among the many non-septic children with fever and tachycardia in a pediatric ER is truly akin to finding the proverbial 'needle in a haystack.'

This alert, especially with the inclusion of physician judgment, gets us much closer to catching most of those very sick children and treating them quickly. Researchers built a two-stage alert (ESA) and implemented it into the hospital's electronic health record (EHR).

The first-stage alert is triggered when an age-based elevated heart rate or hypotensive blood pressure is documented in the EHR at any time during the emergency visit. If the patient also has a fever or risk of infection, the alert triggers a series of questions about underlying high risk conditions, perfusion and mental status.

The second-stage alert triggers if there is an affirmative answer to any of these questions. When patients have positive first- and second-stage alerts, a "sepsis huddle" is triggered, which is a brief, focused patient evaluation and discussion with the treatment team, including the emergency physician.

This ESA advances the field of sepsis recognition by integrating vital sign anomalies, comorbidities that increase a child's risk for sepsis, and clinical judgment into a tool that is both more sensitive and specific than prior alerts as well as less prone to alert fatigue.

From Silica Gel to Opioids and Everything In Between: Interactive Online Tool Provides Immediate Advice to the Public for Poison-Related Emergencies

The American Association of Poison Control Centers (AAPCC) has launched a new interactive online tool, www.poisonhelp.org, to provide quick, expertly vetted answers to questions about poisoning -- the leading cause of injury-related death in America.

There is an alarming trend of poison-related deaths and injuries – especially in children – directly linked to the increased prevalence and use of opioids and other prescription pain relievers, coupled with emerging poisoning hazards such as marijuana edibles, liquid nicotine, and single use laundry detergent packets increasingly found in homes, nationwide.

Now more than ever, Americans need immediate access to a credible source of poisoning information and treatment advice—in a poisoning emergency, every second counts. The new tool provides critical, lifesaving poison information from any computer or smart device. The nation’s 55 poison control centers, collectively known as “poison control,” are staffed by specially-trained physicians, pharmacists, and nurses who are experts in toxicology, poisoning information, prevention, and treatment—many of these same experts created and vetted the new online tool. Now, free, confidential “poison control” can be easily accessed by:

- CALLING 1 (800) 222-1222, the national Poison Help hotline
- VISITING www.poisonhelp.org, AAPCC’s new interactive online poison information tool; no app download necessary.
- TEXT “poison” to 797979, and add poison control contact information – the online tool and the hotline – to your smartphone. AAPCC advises that this is the best way to be prepared in the event of a potential poisoning emergency.
- Download the Infographic.

BLAST OFF INTO CONCUSSION SAFETY WITH CDC HEADS UP ROCKET BLADES!

3-2-1 Blast Off! CDC’s Injury Center has developed a mobile game app on concussion safety for children aged 6 to 8. Through a futuristic world of galactic racing adventures children can learn the benefits of playing it safe and smart!

The app aims to teach children:
- The different ways the brain can get hurt during sports activities.
- How important it is to tell a coach, parent, or other adult when an injury occurs.
- The importance of taking time to rest and recover if they have a concussion.

Download the HEADS UP Rocket Blades at no cost. (The app is currently only available in the Apple App Store. An Android version of the app is coming soon.)

Concussion Safety and Rocket Blades

Parents and Coaches: Kids want to hear from parents and coaches about concussion safety.

- Download a handout on concussion to share with your kids [PDF – 4 MB](https://www.cdc.gov/headsup/pdfs/resources/RocketBlades_TalkingPoints-a.pdf)
- Get tips for talking to your kids about concussion [PDF – 5 MB](https://www.cdc.gov/headsup/pdfs/resources/RocketBlades_HandoutforKids-a.pdf)
Male and female high school athletes have moderate levels of knowledge about concussion symptoms, but the boys are much more likely to not report concussions for fear of seeming weak, a small U.S. study suggests. The reasons boys gave for not wanting to report a concussion tended to center around not wanting coaches or teammates to think they were weak or to "get mad," researchers report in the Journal of Athletic Training.

"Although males and females have similar concussion symptom knowledge, we still see a negative stigma" with reporting them, lead author Jessica Wallace told Reuters Health. "Especially within male dominated sports, we are seeing that many male athletes are not reporting because they are highly sensitive to how their peers and coaches view them," said Wallace, an athletic trainer and researcher at Youngstown State University in Ohio.

Better concussion education programs are needed to teach kids the dangers of continuing to play with a concussion. Concussion symptoms can include headache, dizziness and difficulty concentrating or sleeping. In all, 22 concussion symptoms are typically included in sport-related concussion education programs, the study team writes. Athletes who continue to play with a concussion risk re-injury and a longer recovery time.

To determine how well high school athletes recognize these symptoms and how likely they are to report a concussion, as well as why they wouldn't, the researchers enrolled 288 athletes (198 boys and 90 girls) at three Michigan high schools. The participants answered a single survey that included a test of recognition of concussion symptoms. The survey also asked whether the student had ever experienced a concussion, how many concussions they had reported to a trainer, coach, parent or other authority figure, and reasons for not reporting the symptoms. Of the 58 participants who had sustained a concussion, 25 reported having had two or more. Knowledge of symptoms was similar between the sexes, with scores ranging from about 11 to 18 out of a possible 21 on the test.

The top reason for both boys and girls to not report a concussion was because they did not think it was serious. Other common reasons included not wanting to lose play time and not wanting to let the team down. The boys were anywhere from four to 11 times less likely than girls to report concussions, for reasons having to do with how they were perceived by peers and coaches.

It is important for athletes, parents, and coaches to understand that concussion is a treatable injury, but an athlete has to report the injury for it to be treated. If an athlete fails to report the injury and continues to play while symptomatic, it can either delay recovery or potentially result in a catastrophic outcome. Coaches need to emphasize that concussions are serious and that reporting concussion symptoms is expected. Barriers to concussion reporting by athletes need to be resolved, with an emphasis not only on education and knowledge, but also the pressures that athletes face from peers, adults, and their own perceptions.


PREVENTABLE CHILD & TEEN DEATH

"Montana has the Highest Child and Teen Death Rate in U.S., Study Shows"  The newly released Kids Count study, produced by the Annie E. Casey Foundation, which advocates for data-based public policy, ranks Montana 47th in the nation for overall child health. It shows Montana lagging behind the rest of the country in key health indicators like insurance rates, obesity rates and death rates. Most concerning is the child and teen death rate.

The leading cause for preventable death for Montana children and teens is motor vehicle crashes. Right behind it is suicide. Of concern to public health advocates is that the number of child and teen deaths had been dropping in recent years. Then in 2015, the last year complete data was available for the study, it jumped back up dramatically.

In 2011, there were 92 child and teen deaths in the state; by 2014 it had dropped to 70. Then in 2015 the number of deaths climbed to 103. Of those deaths, 76 were considered preventable.

Broken down a little further, of the 76 preventable deaths, 29 were in motor vehicle crashes and 18 were suicides. Fourteen of the suicides were completed with a firearm.

Link to Article
WHY USE CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (C.L.A.S.) THROUGHOUT A DISASTER?

Have you experienced a time when you did not know how to best serve individuals from diverse cultural and linguistic backgrounds before, after, or during a disaster? Did you know that racial and ethnic minorities are more likely to suffer worse outcomes than the general population during every phase of a disaster?

- **Course 1** provides an introduction to CLAS and its relevance to disaster preparedness and crisis response.
- **Course 2** covers how to provide CLAS during the preparation phase of a disaster, including conducting a community needs assessment.
- **Course 3** covers how to provide CLAS during the response phase of a disaster, including meeting physical and mental health needs.
- **Course 4** covers how to provide CLAS during the recovery phase of a disaster, including rebuilding neighborhoods.
- This set of courses is designed to help deliver culturally and linguistically competent services in disaster situations. Cultural and linguistic competency is the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations. Cultural and linguistic competency can help improve the quality of the care you deliver to individuals from diverse cultural backgrounds. **This free e-learning program from the HHS Office of Minority Health** is accredited for up to 9 continuing education credits, at no cost, for emergency medical personnel/first responders, emergency managers, psychologists, psychiatrists, and social workers, any disaster or emergency response personnel interested in learning more about culturally and linguistically appropriate services and up to 12 hours for dentists.

This e-learning program is grounded in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. These Standards are intended to advance health equity, improve quality, and help eliminate health disparities. The National CLAS Standards provide you with a blueprint for increasing your cultural and linguistic competency.

REPLACING HIRMS

The MT EMS System is replacing the existing Health Information Resource Management System (HIRMS) with a new ePCR, service licensing and data collection system. The new system, **ImageTrend is ready to use.** All licensed EMS agencies will be required to update their EMS agency license information within the new ImageTrend System. All service licensing will be done through ImageTrend beginning with the 2017 renewals.

The ePCR (Elite) is currently available for use. The ePCR is NEMSIS 3.4 compliant. All agencies currently using HIRMS for their ePCR and/or data collection system will need to move to Elite as soon as possible. HIRMS ePCR will no longer be available for use after December 31, 2017.

WebEx sessions were conducted in June and onsite trainings will be conducted over the next 6 months to ensure all agencies are able to make a smooth transition from HIRMS to ImageTrend. **Your agency will not be able to use the ImageTrend ePCR until you have completed the agency licensing section.**

There are master trainers throughout the state to assist you with the transition to ImageTrend ePCR. Once you have completed the agency licensing update please contact EMSTS to schedule a master trainer to assist you with ImageTrend ePCR training. We will also provide WebEx training on the ePCR. We look forward to providing you a better tool for patient care reporting and agency licensing. Our Service Manager **Workshop scheduled for September 13, 2017 in Kalispell will focus on ImageTrend reporting functionality.** This workshop will assist your service with using ImageTrend to its full potential.

**For further information please contact Shari Graham 406-444-6098 sgraham2@mt.gov or Francine Janik 406-444-3896 fjanik@mt.gov.**
EMERGENCY PEDIATRIC CARE COURSE (EPC)

The NAEMT Hybrid Course is designed to help providers with common pre-hospital emergency pediatric encounters. This program is for prehospital practitioners committed to providing quality care for pediatric patients. Course lectures and interactive sessions address assessment; airway, breathing and circulation; understanding and caring for children; hypoperfusion and shock; cardiac emergencies and congenital cardiac defects, common medical emergencies, trauma, newborn resuscitation, vascular access, care team management, spinal motion restriction, children with special health-care needs, identification of life threats, scene choreography, transport decisions, and child abuse and neglect. The EPC is offered free through funding provided by the MT EMS for Children/Child Ready MT Program--16 hours of accredited pediatric contact time on course completion.

Students must complete the 8 hours of online training prior to the scheduled day of skills and simulation. Access to the online course will be E-mailed to students within three days of course registration. A $75.00 deposit is required to reserve a space in the course—you are not charged if you attend the in-person skills class.

If you would like to host an EPC course in your area, email rsuzor@mt.gov for more information. This is a great opportunity for FREE PEDIATRIC EDUCATION (16 hours of accredited pediatric contact time)

SEPTEMBER 8, 2017: LAUREL AREA  Scheduling EPC classes for fall dates now. To register go to http://www.bestpracticemedicine.com/emergency-pediatric-care/

SAVE THE DATE:
SEPTEMBER 14-15, 2017 FOR THE ROCKY MOUNTAIN TRAUMA SYSTEMS SYMPOSIUM

THIS YEAR THE SYMPOSIUM WILL BE HELD IN KALISPELL AT THE RED LION MOTEL. REGISTRATION IS OPEN WITH UP TO 11.25 CONTACT HOURS AVAILABLE.

TRIVIA
Answer the trivia and win a 2017 Broselow Tape -to the first 5 to email answers to Robin -rsuzor@mt.gov NOT to the listserve. (FYI: Broselow tapes are on back order.)

1. What is Montana's rank for child health?
2. How many minutes does it take a vehicle to reach 80 degrees?
3. At what age/size can children start in booster seats?
4. What is C.L.A.S.?
5. When is the RMTS Symposium?