Florida EMS for Children Advisory Committee Agenda

June 15, 2023, 1-3 pm EST
Seminole Hard Rock Hotel, Hollywood Florida: Terrace D

Join on your computer, mobile app or room device:

Click here to join the meeting
Meeting ID: 278 666 856 723
Passcode: zopEgQ

Call in (audio only):

Phone #: 850-792-1375
Phone Conference ID: 870 012 32#

Welcome, Introductions, & Call to Order

-Welcome committee members, liaisons, visitors and PECCs
-Sign roster or email attendance confirmation with name/title/contact info to pedready@jax.ufl.edu

Florida EMSC State Partnership Program Leadership, EMSC Advisory Committee Members and Liaisons

-Updated roster with new EMSC staff (UF)
-Program administration updates
-Travel
-Website, news, and social media (Facebook)
@floridaemsforchildren (UF)
Current PEDReady website: https://emlrc.org/flpedready/
Developing companion UF Florida EMSC website
PEDReady and FL EMSC news contained in biweekly FCEP news briefs
Restarting quarterly FL EMSC PEARL newsletter
Email pedready@jax.ufl.edu to sign up for news briefs or to have information posted

-Mission, sample tagline: "Partnering with Florida emergency departments, EMS agencies, disaster preparedness organizations, and families in the care of ill and injured children to enhance pediatric readiness across the continuum of care"

BEMO Announcements and Updates

-State EMS Survey (pediatric related results)
-State Strategic Plan

Old Business and Follow-up Information

1. Safe Transport
Slide set and recording being added to website: https://youtu.be/KMP3kxHEoJc
Dissemination of limited numbers of pedimates and neomates to rural agencies
Work with Health Care Coalitions to provide pediatric restraint devices (McManus)
Education and hands on training challenge contests
National updates

2. Button Battery Ingestion Management
   Options for administering honey
   Emmy- Florida Association of Broadcast Journalists Award in Health Reporting and Edward R. Murrow Award: https://www.news4jax.com/news/2022/05/12/child-unsafe-the-danger-of-button-batteries/
   FCOT statement

3. FL PEDReady resource bags
   Contain communication cards, JumpSTART/START revised badge buddies, PALS pocket card, Handtevy badge buddies, Difficult Airway Course pocket card (adult and pediatric), ABC's of Pediatrics Emergencies chart, pain scale cards, EMRA Pediatric ECG card, pediatric acetaminophen/ibuprofen dosing magnets, NRP pocket cards, poison center magnets, etc.

4. Pediatric and neonatal educational needs

5. TXA in Pediatric Trauma

6. Disaster Related Activities and Hurricane Ian outcomes
   a. Hurricane Ian wrap-up and accomplishments. Big thank you to our Health Care Coalitions for prioritizing pediatric needs!
   b. State Handtevy proposal
   c. Debriefing tool
   d. HCC tabletop exercises and EMSC related inquires
   e. Using MIH to prepare families and children for disasters (L Work)

7. Children with Special Healthcare Needs (CSHCN)
   STARS Update: Special needs Tracking and Awareness Response System
   Comfort kits

Pediatric Data and Biospatial EMSC Dashboard

National/State EMSC Performance Measures

1. **Surveys (Required)**
   2023 National EMSC EMS survey (pending results)
   2024 National EMSC Prehospital Pediatric Readiness Survey (long)
   2021 National EMSC ED Pediatric Readiness Survey for EDs: FL 58% response rate. Average FL score 75/100, median 76. Still pending national comparison scores due to wait for publication: https://pedsready.org/

2. **Expand the uptake of Pediatric Readiness in Emergency Departments** where not already done, by establishing a state, territorial, or regional Pediatric Readiness Recognition Program for hospital EDs; designating PECCs in EDs; and ensuring hospital EDs weigh and record children's weight in kilograms.

3. **Improve Pediatric Readiness in EMS Systems** by establishing a state, territorial, or regional standardized Prehospital Pediatric Readiness Recognition Program for prehospital EMS agencies;

increasing PECCs in prehospital EMS agencies; and increasing the number of prehospital EMS agencies that have a process for pediatric skills-check on the use of pediatric equipment.

4. **Increase pediatric disaster readiness in hospital EDs and prehospital EMS agencies** by ensuring that disaster plans address the needs of children.

5. **Prioritize and advance family partnership and leadership** in efforts to improve EMSC systems of care.

Liaison and Constituency Group Reports

a. Rural update (Vause and McManus)
b. Florida FAN Report (Nasca)
c. Trauma: Program managers (Nichols), FTSAC, FCOT
d. Disaster (Downey, etc.)
e. Mental Health (Work)
f. Data Committee, Biospatial (EMSC dashboard)
g. Community Paramedicine/MIH/H.A.R.T. (Health-Access-Resiliency and Telehealth) Section (Bedford)
h. FL ENA (Rushing)
i. EMS Educators
J. PECCs (Rabish, Weed, Weishaupt, Walters)
K. Pediatric and neonatal transport (FNPTNA)
l. Injury prevention (Summers)
m. Children's Medical Services, Child Death, Child Abuse
n. Other

New Business

1. Upcoming courses, resources, national EMSC Collaboratives, etc.
2. Future meetings
3. Trends: congenital syphilis
4. Announcements

pedready@jax.ufl.edu
904-244-4986
https://emlrc.org/flpedready/

Florida EMS-C Advisory Committee Meeting
June 15, 2023, 1-3 pm EST
Seminole Hard Rock Hotel, Hollywood, Terrace D

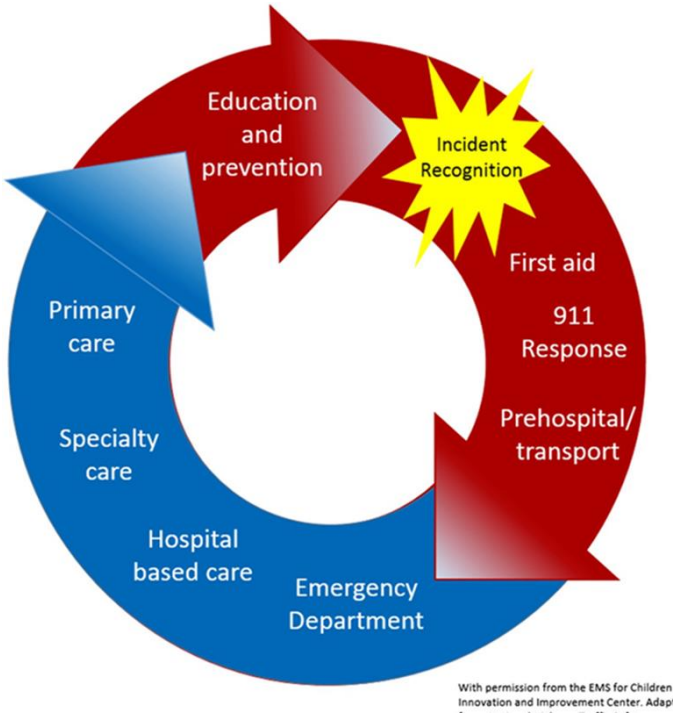
HRSA Maternal & Child Health

FLORIDA PEDREADY

EMSC IIC NEDARC The National EMSC Data Analysis Resource Center PECARN

EMSC IIC Emergency Medical Services for Children | Innovation & Improvement Center

EMSC ensures the continuum of healthcare is *pediatric ready*



EMSC grantees

EMSC Innovation and Improvement Center

Quality improvement

State Partnership

Infrastructure

EMSC Data Center

Accountability

Regionalization of Care

Systems integration

Targeted Issues

Innovation

PECARN Network

Evidence generation

Innovation and Improvement Center
EMSC
Emergency Medical Services for Children

Welcome and Call to Order

- Welcome committee members, liaisons, visitors and PECCs

- Sign roster or email attendance confirmation with name/title/contact info to pedready@jax.ufl.edu

Florida EMSC State Partnership Program Leadership, EMSC Advisory Committee Members, and Liaisons

- Updated roster with new EMSC staff (UF) and introductions
- Program administration updates
- Travel

Emergency Medical Services for Children (EMSC) Advisory Committee Roster (August 2022 - August 2024)

Tricia Swan, MD, M. ED, FAAP, FACEP Associate Professor of Emergency Medicine, University of Florida COM Program Director, Pediatric Emergency Medicine Fellowship Chair, ACEP Pediatric EM Section ***Appointed Position: Physician with Pediatric Experience***	**Nichole Shimko, RN, MSN, CCRN, CPN, C-NPT** Manager, Transport Team, Golisano Children's Hospital of Southwest FL Representative, Florida Neonatal and Pediatric Transport Network Association ***Appointed Position: Nurse with Emergency Pediatric Experience***
Barbara Tripp, RN, EMT-P Fire Chief, City of Tampa Fire Rescue ***Appointed Position: EMT/Paramedic***	**Marshall Frank, DO, MPH, FACEP, FAEMS** Medical Director, Sarasota County Fire Department ***Appointed Position: Emergency Physician***
Sandra Nasca, RN Retired Nurse and Forensic Medical Investigator, Child Advocate ***Appointed Position: FAN (Family Advocacy Network) Representative***	

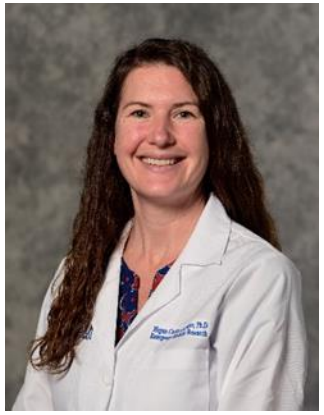
Committee Liaisons	
Michael Rushing, MSN, APRN, NRP, FNP-BC, CEN, CPEN, CFRN, TCRN, CCRN-CMC ***Position: Florida Emergency Nurses Association (ENA) Representative***	**Ernest (Sonny) Weishaupt, EMT-P** EMS Liaison/PECC, Arnold Palmer Hospital for Children ***Position: ED/EMS PECC Liaison***
Tracey D. Vause, MPA, CPM, EMT-P Chief of Emergency Services, Walton County Sheriff's Office Chair, Emerald Coast Healthcare Coalition ***Position: Rural EMS Liaison***	**Sarah Weed, EMT-P** Health & Safety Captain, Alachua County Fire Rescue ***Position: EMS PECC Liaison***
Jeremiah Rabish, PMD EMS Operations Captain, Sarasota County Fire Department, SCFD PECC ***Position: EMS PECC Liaison***	**Marvin Walters, PMD** EMS Chief, Wakulla County Fire Rescue ***Position: Rural EMS PECC Liaison***
Julie Downey, EMT-P Fire Chief, Davie Fire Rescue Chair, EMS Advisory Disaster Response Committee ***Position: Disaster Preparedness Liaison***	**Jennifer N. Fishe, MD** Associate Professor, University of Florida COM-J Director UF Center for Data Solutions PECARN WPEMR Node Affiliate Researcher ***Position: Pediatric Research and Data Liaison***
Lisa Nichols, MBA, BSN, RN, CCRN-K Pediatric Trauma Program Manager, Wolfson Children's Hospital ***Position: FL Trauma Program Manager Liaison (FCOT)***	**Lauren Young Work, LCSW** Medical Social Work, MIH Coordinator Palm Beach County Fire Rescue ***Position: Mental Health Liaison***
Joshua G. Thomas Director, Child Abuse Death Review Unit Division of Children's Medical Services, FDOH ***Position: Child Death and CMS Liaison***	

Florida EMSC Program Staff (UF)	
Phyllis L. Hendry, MD, FAAP, FACEP Professor of Emergency Medicine and Pediatrics Associate Chair for EM Research University of Florida COM – Jacksonville ***EMSC State Partnership Project Director (UF)*** ***Florida EMS for Children Medical Director*** ***Chair, EMS for Children Advisory Committee***	**Katelyn Perl, MS, CHES®** Program Manager I Department of Emergency Medicine University of Florida COM – Jacksonville ***FL EMSC/PEDReady Program Manager***
Megan E. Curtis Gonzalez, PhD Associate Director of Clinical Research Department of Emergency Medicine UF College of Medicine - Jacksonville	**Morgan Henson Campobasso, MPH, CPH, CCRP** Assistant Director of Clinical Research Department of Emergency Medicine UF College of Medicine - Jacksonville
Amy Kennedy Executive Assistant Division of Research Department of Emergency Medicine UF College of Medicine - Jacksonville	

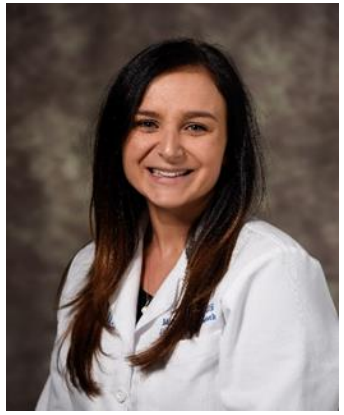
Katelyn Perl, MS, CHES®
Florida EMSC Program Manager
June 2023

Katelyn Perl is joining the Florida Emergency Medical Services for Children (EMSC) Program as the new Program Manager. The program is now housed administratively at the University of Florida College of Medicine - Jacksonville (UFCOM-J) in the Division of Emergency Medicine Research. Ms. Perl has a Bachelor of Science degree in Applied Physiology and Kinesiology, a Master of Science in Health Education and Behavior from the University of Florida and is a Certified Health Education Specialist (CHES®). She is transitioning from her current UFCOM-J position with the Pain Assessment and Management Initiative (PAMI) where she served as Program Manager and educator for a federally funded model Pain Coach Educator and Toolkit Program. Although she will miss her PAMI colleagues and stakeholders, she is thrilled to join the EMSC team!

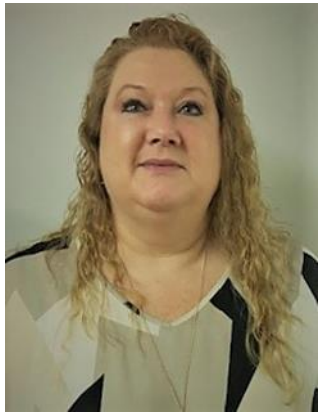
Phone: 904-244-8617
Email: Katelyn.Perl@jax.ufl.edu



Megan Curtis Gonzalez, PhD
Associate Director, Clinical Research
HRSA EMSC Program Reporting & Compliance



Morgan Henson, MPH, CPH, CCRP
Assistant Director, Clinical Research
FL EMSC Biospatial Data Coordinator



Amy Kennedy, Executive Assistant
EMSC “Chaos Coordinator”

Other UF EM Research team members and student interns assist with website development, data, etc.

Florida EMSC DOH State Partners, Committees and Constituency Groups	
Angus M. Jameson, MD, MPH, FACEP, FAEMS ***State EMS Medical Director***	**Steve McCoy** Chief, Bureau of Emergency Medical Oversight Division of Emergency Preparedness and Community Support
Mike G. Hall FL Bureau of Emergency Medical Oversight EMS Section ***EMS Administrator***	**Jennifer McManus, AS, EMT** FL Bureau of Emergency Medical Oversight EMS Section ***Rural EMS Coordinator/Region 6 Coordinator***
Additional Committee Representatives from BEMO Trauma, Data, Operations, Community Paramedicine/MIH; PIER Committee (Public Information Education Relations)	**Florida College of Emergency Physicians, Florida Association of EMS Medical Directors, Florida Hospital Association, Florida Committee on Trauma, and other constituency and stakeholder groups**

Updated 06/07/2023

FLORIDA PEDREADY

Caring for children can be challenging! The goal of Florida PEDReady is to enhance pediatric emergency care, “readiness,” and preparation in Florida EDs and EMS systems.

Visit Florida PEDReady for information, free resources, and educational opportunities:

Website: https://www.emlrc.org/flpedready/

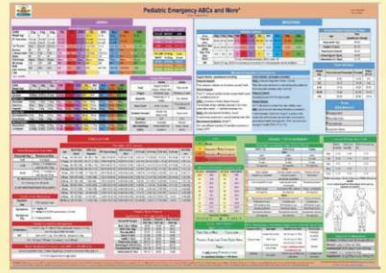
Email: PEDReady@jax.ufl.edu

Funded by Florida EMSC State Partnership Program

JumpSTART Badge Buddies

https://tinyurl.com/2b57jvab

Pediatric Emergency ABCs & More



https://tinyurl.com/mr276ncx

PEDReady Communication Cards

English/Spanish English/Creole

https://emlrc.org/flpedready/

Florida EMSC Programmatic Updates

- Facebook @floridaemsforchildren (UF)
- Current PEDReady website: https://emlrc.org/flpedready/
  Developing companion UF Florida EMSC website
- PEDReady/FL EMSC news contained in biweekly FCEP news briefs
- Restarting quarterly FL EMSC PEARL newsletter
- Email pedready@jax.ufl.edu to sign up for news briefs, to be a PECC, ask questions, or to have information posted
- Logos and branding

Florida EMSC Programmatic Updates

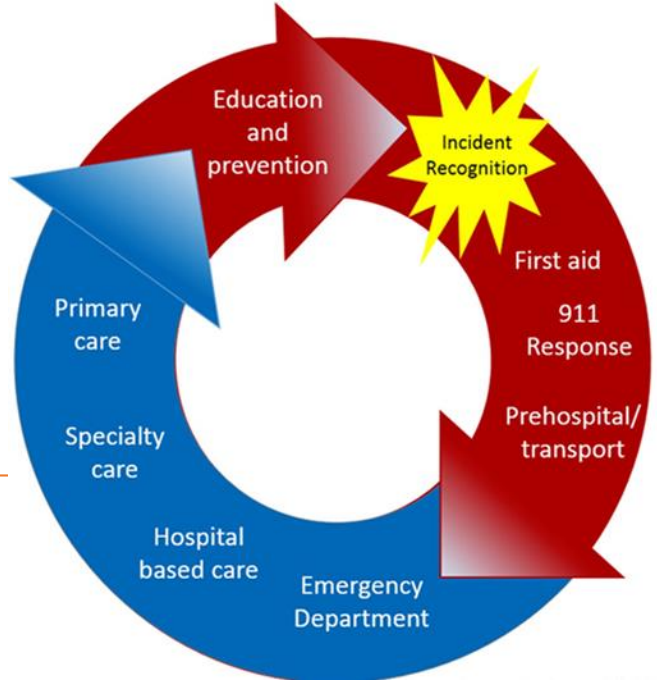
- Travel and budget
  - HRSA EMSC state partnership program funds not fully authorized by congress resulting in decreased budget
  - FL gets same funding as small states
  - UF travel reimbursement information sent to committee members and liaisons, end of fiscal year
  - Currently budgeted for 2 in person meetings per year, may increase to 3 depending on expenditures
  - All travel costs have increased: currently only reimbursing for mileage or rental, limited hotel nights (based on travel distance), no meals ($36/day)
  - Will apply for supplementary grant funding

2023 - 2027 HRSA EMSC State Performance Measures

1. **Establish an EMSC Advisory Committee** with the required core members, convening at least four times each grant year. √
2. **Ensure sufficient oversight of the EMSC grant program** by maintaining one full-time SP program manager that is dedicated solely to the EMSC SP Program.
3. **Support data collection, analysis, and continuous quality improvement**. Include the collection of data from hospital EDs and prehospital EMS agencies, maintain the Program's Contact List Management System for your state/jurisdiction; disseminate information.
4. **Expand the uptake of Pediatric Readiness in Emergency Departments** where not already done, by establishing a state, territorial, or regional Pediatric Readiness Recognition Program for hospital EDs; designating PECCs in EDs; and ensuring hospital EDs weigh and record children's weight in kilograms.
5. **Improve Pediatric Readiness in EMS Systems** by establishing a state, territorial, or regional standardized Prehospital Pediatric Readiness Recognition Program for prehospital EMS agencies; increasing PECCs in prehospital EMS agencies; and increasing the number of prehospital EMS agencies that have a process for pediatric skills-check on the use of pediatric equipment.
6. **Increase pediatric disaster readiness in hospital EDs and prehospital EMS agencies** by ensuring that disaster plans address the needs of children.
7. **Prioritize and advance family partnership and leadership** in efforts to improve EMSC systems of care.

Florida EMSC and PEDReady Mission

"Partnering with Florida emergency departments, EMS agencies, disaster preparedness organizations, and families *in the care of ill and injured children* to enhance pediatric readiness across the continuum of care"



BEMO Announcements and Updates

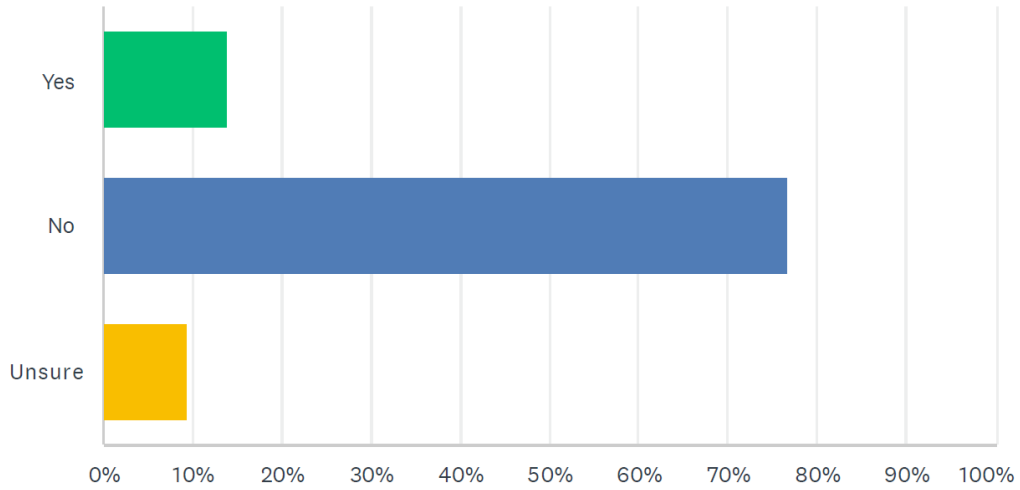
- State EMS Survey (pediatric related results)
- State Strategic Plan
- Other updates: J McManus Education Coordinator, Office of Rural Health (Leffler), Quality First Initiative

Florida HEALTH
Emergency Medical Oversight

Q60 Does your agency have a Pediatric Emergency Care Coordinator (PECC) or Champion?

Answered: 203 Skipped: 17

220 respondents
Answered 203, skipped 17



ANSWER CHOICES	RESPONSES	
Yes	13.79%	28
No	76.85%	156
Unsure	9.36%	19
TOTAL		203

Florida EMS Survey 2022 Results

FL response rate 81%! A lot of calls and work to get this rate
176 respondents

- First year survey was *not* part of the FL annual EMS survey
- National score PECC: 35.8%; **Florida 2022 score: 44.7%**

- National score use of pediatric equipment: 26.1%, Median score 4 points; **Florida 2022 score 32.6%, score 4**

State/Territory: Florida

Survey Year: 2022

Florida EMS for Children Program

2022 EMS Agency Survey Results

Florida Data Collection Numbers:

Number of Respondents: 142
Number Surveyed: 176
Response Rate: 80.7%

Number of Records in Dataset (after data cleaning)*: 142
*Data cleaning includes removing agencies that do not respond to 911, duplicates, etc.

Performance Measures EMSC 02 and EMSC 03:

Number of Records Used in Performance Measure Calculation (see below): 141

Performance Measure Exclusions*:
Indian Health Services or Tribal Agencies Participating: 0, Military Facilities Participating: 1, Air-Only Agencies: 0, or Water-Only Agencies: 0.

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

63 vs 28 on state survey

Pediatric Emergency Care Coordinator (EMSC 02):

44.7%

(63/141)

(Exclusions See Above)

A respondent needed to answer **YES** to "Having a designated individual who coordinates pediatric emergency care" in the survey to meet this measure.

Use of Pediatric-Specific Equipment (EMSC 03):

32.6%

(46/141)

(Exclusions See Above)

See pg. 35 in the "EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017" for an explanation of the scoring.

Survey Year:
2023

National EMS for Children Program

2023 EMS Agency Survey Results

Data Collection Numbers:

Number of Respondents: 8,106
Number Surveyed: 14,546
Response Rate: 55.7%

Number of Records in Dataset (after data cleaning)*: 8,027
*Data cleaning includes removing agencies that do not respond to 911, duplicates, etc.

Performance Measures EMSC 02 and EMSC 03:

Number of Records Used in Performance Measure Calculation (see below): 7,982

Performance Measure Exclusions*:
Indian Health Services or Tribal Agencies Participating: 24, Military Facilities Participating: 8, Air-Only Agencies: 13, or Water-Only Agencies: 0.

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

Note: Official numbers for reporting purposes (below) include responses from all agencies that meet the performance measure criteria; the following tabs/pages demonstrate different ways to look at the data over-time.

Pediatric Emergency Care Coordinator (EMSC 02):

37.2%
(2,970/7,982)
(Exclusions See Above)

A respondent needed to answer YES to "Having a designated individual who coordinates pediatric emergency care" in the survey to meet this measure.

Use of Pediatric-Specific Equipment (EMSC 03):

26.5%
(2,119/7,982)
(Exclusions See Above)

See pg. 35 in the "EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017" for an explanation of the scoring.

Florida 57.4% response rate
101/176 agencies
Detailed state report pending

EMSC 02 - Pediatric Emergency Care Coordinator (PECC) Performance Measure Trending:

Trending Over Time:

There are many ways to measure improvement over time. On this page, you can see how the nation performed for EMSC 02:

1) Trend Over Time - This looks at all respondents from all five survey years to see how the nation's performance measure numbers are changing. The number of respondents may not be the same because response rates often change and the same agencies do not always participate.

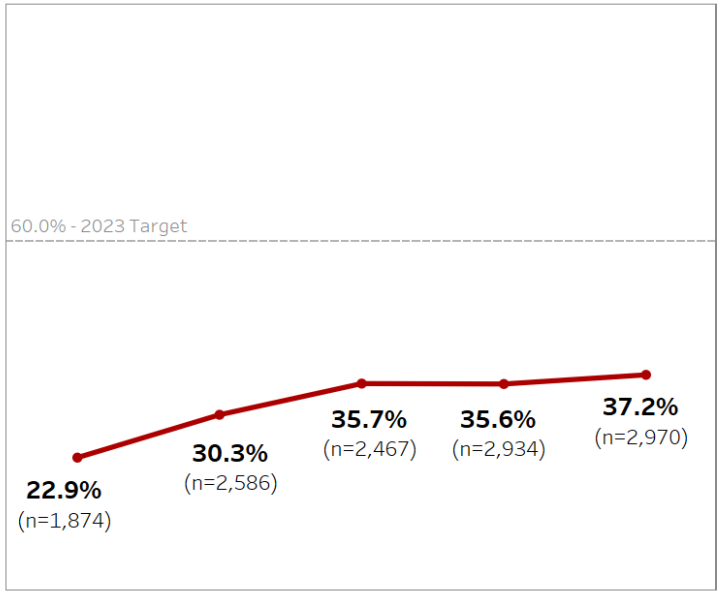
2) Trend Over Time (One to One Analysis) - This looks at only those agencies who participated in all five years of the survey. This type of analysis illustrates collective upward or downward movement with EMSC 02 over time for those agencies who completed the survey in all five years (see number in red box).

NOTE: EHB = Electronic Handbook. These are the official numbers that are reported to the EMSC Program.

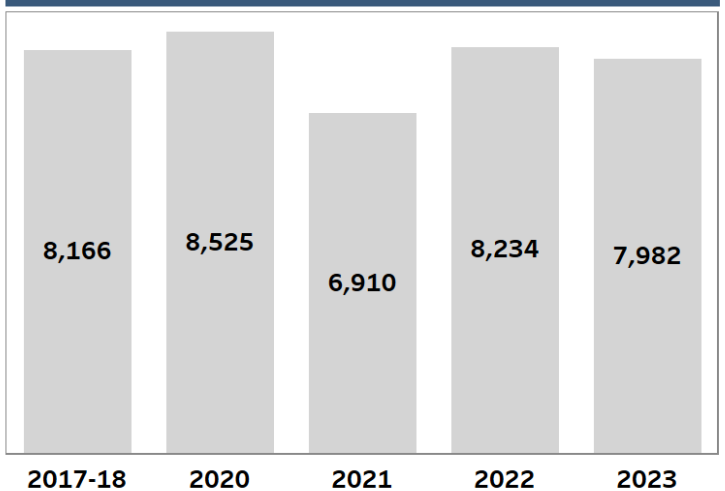
The horizontal dashed gray line in the graphs indicates the EMSC National Target for 2023 which is 60%.

BELOW: Percent and Number of Agencies that Reported Meeting EMSC 02 by Survey Year.

EMSC 02 - Trend Over Time (Met PM - EHB Num):

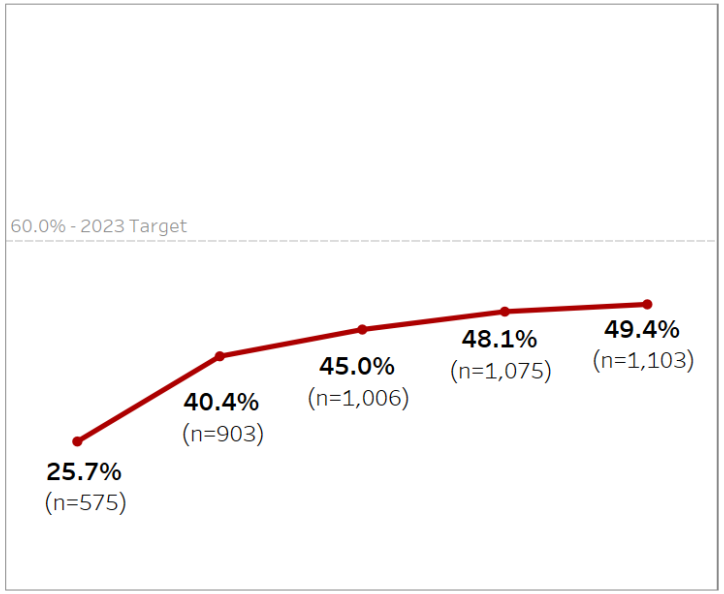


EMSC 02 - # of Agencies that Responded Each Year:

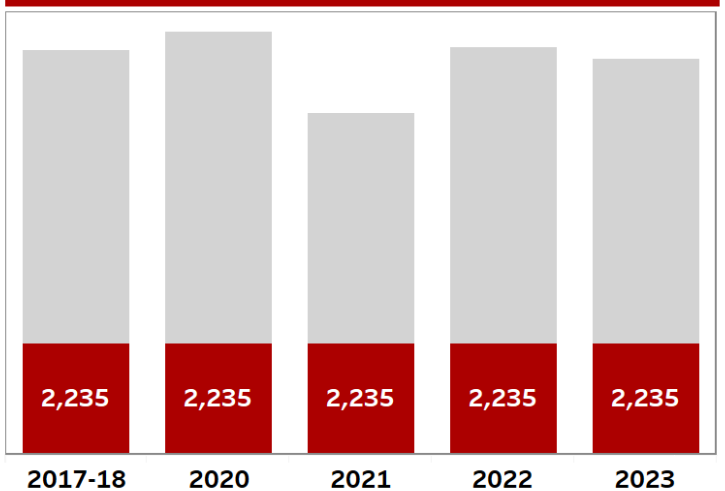


BELOW: Percentage and Number of Agencies Participating in ALL FIVE Survey Years that Reported Meeting EMSC 02.

EMSC 02 - Trend Over Time (Met PM - 1:1 Analysis):



EMSC 02 - # of Agencies that Responded EVERY Year:



Florida Use of Pediatric-Specific Equipment Overview for ALL 2022 Agencies

Pediatric-Specific Equipment Score by Percentage of Agencies and Percentage of PECCs

	% of Agencies	% of Agencies with a PECC
Scored 6 pts or Higher	32.4% (n=46)	54.3% (n=25)
Scored Less than 6 pts	67.6% (n=96)	40.6% (n=39)

Survey Year: 2022

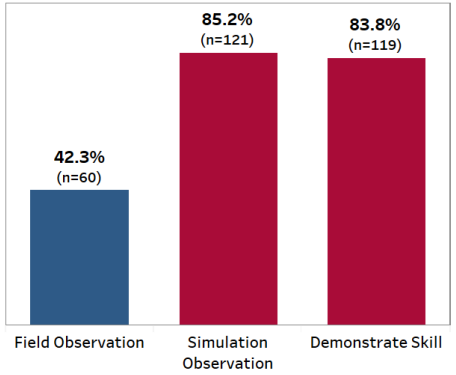
PECC/No PECC: All

County: All

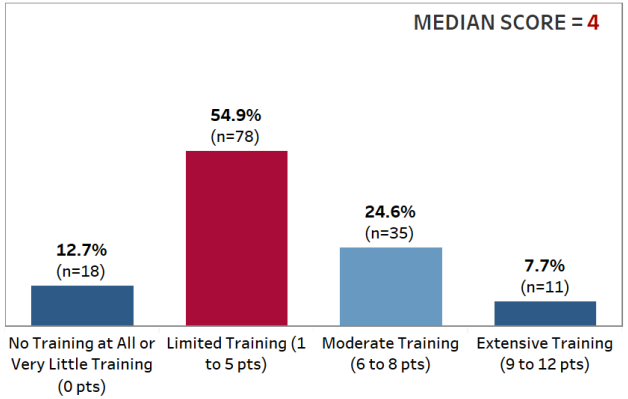
Agency Type*: All

*Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).

Percent by Type/Method of Skill Checking:



Breaking Down the Score = Frequency of Training:



Use of Pediatric-Specific Equipment Matrix:

% of Agencies: 3.5% – 57.7%

	Two or more times per year (4pts)	At least once per year (2pts)	At least once every two years (1pt)	Less frequency than once every two years (0 pts)	None
How often are your providers required to demonstrate skills via a SKILL STATION?	16.2% (n=23)	38.7% (n=55)	25.4% (n=36)	3.5% (n=5)	16.2% (n=23)
How often are your providers required to demonstrate skills via a SIMULATED EVENT?	15.5% (n=22)	38.7% (n=55)	27.5% (n=39)	3.5% (n=5)	14.8% (n=21)
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	11.3% (n=16)	16.9% (n=24)	4.9% (n=7)	9.2% (n=13)	57.7% (n=82)

This matrix was used to score the type of skill demonstration/simulation and the frequency of **occurrence**. A score of 6 pts or higher "met" the measure. The darker the box the higher the percentage of agencies in that group. See pg. 35 in the "EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017" for additional information about this matrix.

Use of Pediatric-Specific Equipment Overview for ALL 2022 Agencies

Pediatric-Specific Equipment Score by Percentage of Agencies and Percentage of PECCs

	% of Agencies	% of Agencies with a PECC
Scored 6 pts or Higher	26.2% (n=2,171)	53.2% (n=1,154)
Scored Less than 6 pts	73.8% (n=6,116)	29.6% (n=1,809)

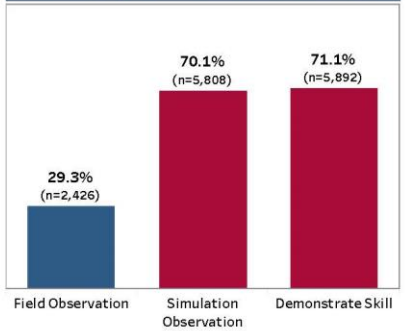
Survey Year: 2022

PECC/No PECC: All

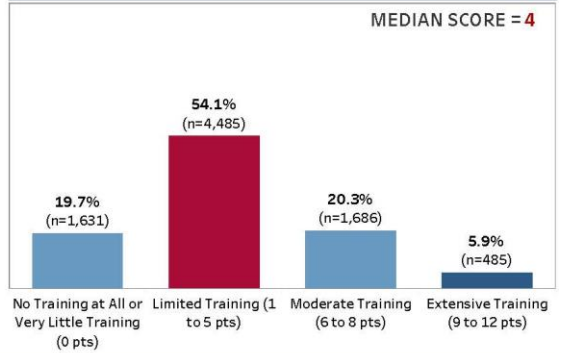
Agency Type*: All

*Agency Type: Default = All Agencies Surveyed. Drop-down the Menu to Filter by Sub-Groups IF Available (IHS/Tribal/Military/Etc.).

Percent by Type/Method of Skill Checking:



Breaking Down the Score = Frequency of Training:



Use of Pediatric-Specific Equipment Matrix:

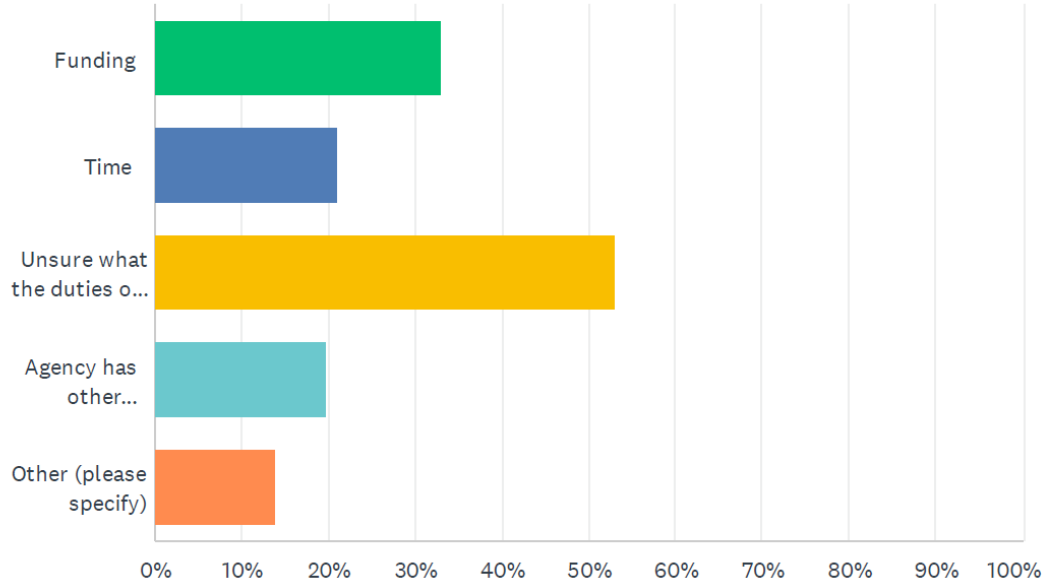
% of Agencies: 2.1% – 70.7%

	Two or more times per year (4pts)	At least once per year (2pts)	At least once every two years (1pt)	Less frequency than once every two years (0 pts)	None
How often are your providers required to demonstrate skills via a SKILL STATION?	15.0% (n=1,243)	42.1% (n=3,488)	11.9% (n=987)	2.1% (n=174)	28.9% (n=2,395)
How often are your providers required to demonstrate skills via a SIMULATED EVENT?	12.1% (n=1,000)	41.0% (n=3,395)	14.2% (n=1,175)	2.9% (n=238)	29.9% (n=2,479)
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	6.9% (n=570)	15.1% (n=1,252)	4.0% (n=333)	3.3% (n=271)	70.7% (n=5,861)

This matrix was used to score the type of skill demonstration/simulation and the frequency of **occurrence**. A score of 6 pts or higher "met" the measure. The darker the box the higher the percentage of agencies in that group. See pg. 35 in the "EMSC for Children Performance Measures, Implementation Manual for State Partnership Grantees, Effective March 1st, 2017" for additional information about this matrix.

Q62 If "No" or "Unsure", what are your agency's barriers to identifying a PECC? (Select all that apply)

Answered: 166 Skipped: 54



ANSWER CHOICES	RESPONSES	
Funding	33.13%	55
Time	21.08%	35
Unsure what the duties of a PECC entail	53.01%	88
Agency has other priorities	19.88%	33
Other (please specify)	13.86%	23
Total Respondents: 166		

EDC
EMSC Data Center

To better understand the EMS system's **readiness** to care for pediatric patients, the **EMS for Children Program** conducted a national survey of EMS agencies. The following are the results of this quality improvement effort. EMS agencies can learn more about their state efforts by contacting their state EMS for Children Program Manager shown in the Resources sections of this 3-page report.

2022 National *EMS for Children Survey* Results

15,309
EMS agencies were sent survey

What is a PECC?

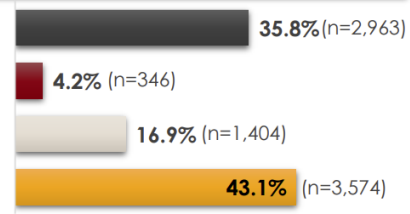
A designated individual(s), often called a **Pediatric Emergency Care Coordinator** or PECC, who is responsible for coordinating and ***championing PEDIATRIC-SPECIFIC*** activities for an EMS agency. This individual(s) could serve as the PECC for one or more EMS agencies.

Resources

- Pediatric Readiness in EMS Systems
  - Joint Policy Statement
  - Technical Report
- Pediatric Emergency Care Coordinator *(video)*
- Prehospital Pediatric Readiness
  - Toolkit
  - Checklist
- Quality Improvement
- Additional PECC Resources
- State EMS for Children Program Manager List *(online database)*

Prepared by the EMS for Children Data Center (EDC), formerly known as NEDARC, located at the University of Utah School of Medicine. ***July 2022*** **www.nedarc.org**

PECC at Agencies



Agencies who Have a PECC – Top 5 Reported PECC Duties

Promote pediatric continuing education opportunities	**96.8%**
Ensure that fellow providers follow pediatric clinical practice guidelines and/or protocols	**94.9%**
Ensure the availability of pediatric medications, equipment, and supplies	**92.5%**
Oversee pediatric process improvement initiatives	**87.3%**
Ensure the pediatric perspective is included in the development of EMS protocols	**83.9%**

Significance

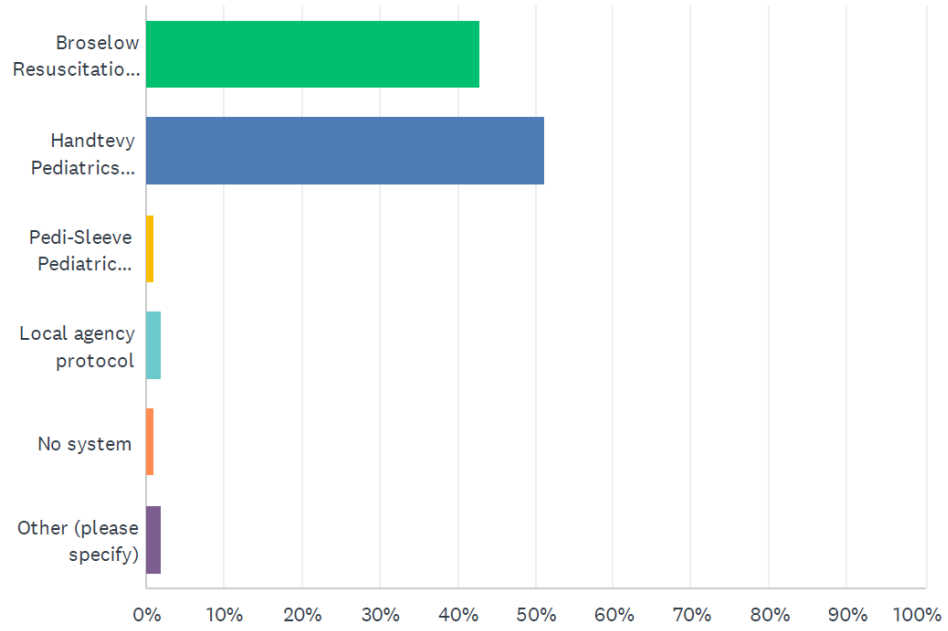
A study of the readiness of hospital emergency departments (EDs) to care for children has shown that EDs are more prepared to care for children when there is a PECC who is responsible for championing & making recommendations for policies, training, & resources pertinent to the emergency care of children.[1] While this study was conducted in EDs, the 2020 joint policy statement,[2] Pediatric Readiness in EMS Systems, states the importance of EMS physicians, administrators, & personnel to collaborate with pediatric acute care experts to optimize EMS care for children to improve outcomes. In further support of the importance of EMS agency PECCs, a recent study "found that the availability of a PECC in an agency is associated with increased frequency of pediatric psychomotor skills evaluations."[3]

1. Gausche-Hill, M., Ely, M., Schmuhl, P., Telford, R., Remick, K. E., Edgerton, E. A., & Olson, L. M. (2015). A National Assessment of Pediatric Readiness of Emergency Departments. *JAMA Pediatrics*, 169(6), 527–534.
2. Moore, B., Shah, M. I., Owusu-Ansah, S., Gross, T., Brown, K., Gausche-Hill, M., Remick, K., Adelgais, K., Lyng, J., Rappaport, L., & Snow, S. (2020). Pediatric Readiness in Emergency Medical Services Systems. *Prehospital Emergency Care*, 24(2), 175-179.
3. Hewes HA, Genovesi AL, Codden R, Ely M, Ludwig L, Macias CG, Schmuhl P, Olson LM. (2021). Ready for Children Part II: Increasing Pediatric Care Coordination and Psychomotor Skills Evaluation in the Prehospital Setting. *Prehospital Emergency Care*, pp.1-8.

This report is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of the Emergency Medical Services for Children Data Center award totaling $3,200,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Q63 What system does your agency use to determine age and weight-based pediatric medication dosing and equipment size selection?

Answered: 203 Skipped: 17

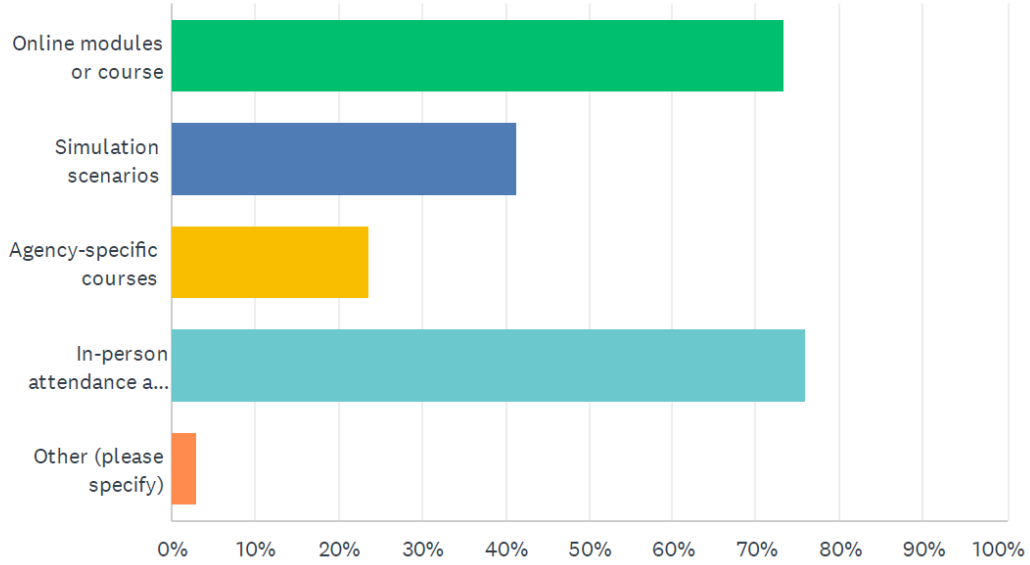


ANSWER CHOICES	RESPONSES	
Broselow Resuscitation Tape	42.86%	87
Handtevy Pediatrics Emergency Standards System	51.23%	104
Pedi-Sleeve Pediatric Dosing System	0.99%	2
Local agency protocol	1.97%	4
No system	0.99%	2
Other (please specify)	1.97%	4
TOTAL		203

Statewide system proposal

Q64 What mechanism does your agency use to meet the need for pediatric continuing education?

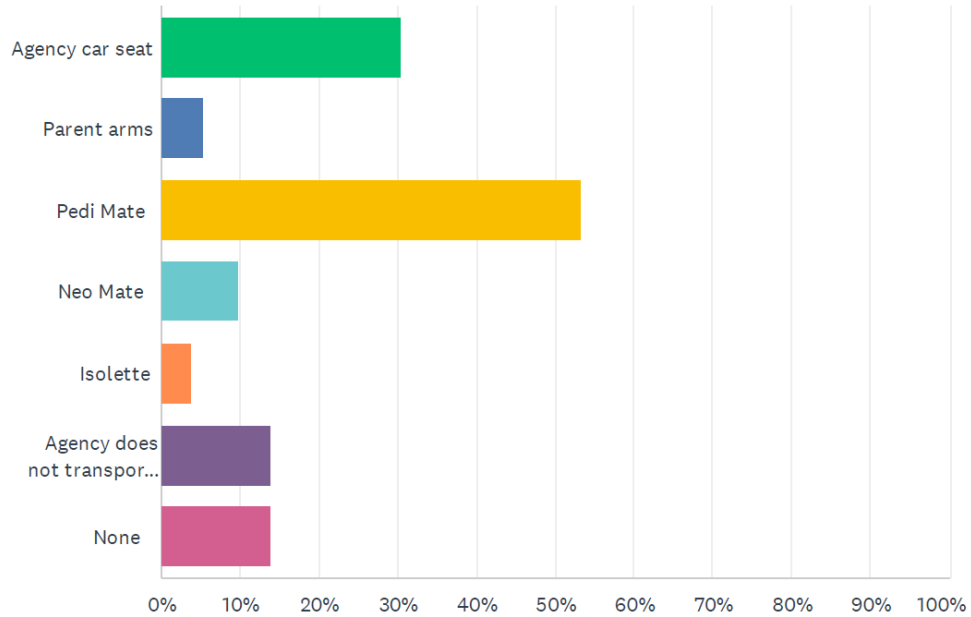
Answered: 203 Skipped: 17



ANSWER CHOICES	RESPONSES	
Online modules or course	73.40%	149
Simulation scenarios	41.38%	84
Agency-specific courses	23.65%	48
In-person attendance at a course (PALS, PEPP, EPC, other)	75.86%	154
Other (please specify)	2.96%	6
Total Respondents: 203		

Q57 Which restraining method(s) are used by your agency to transport patients 4 years of age or less? (Select all that apply)

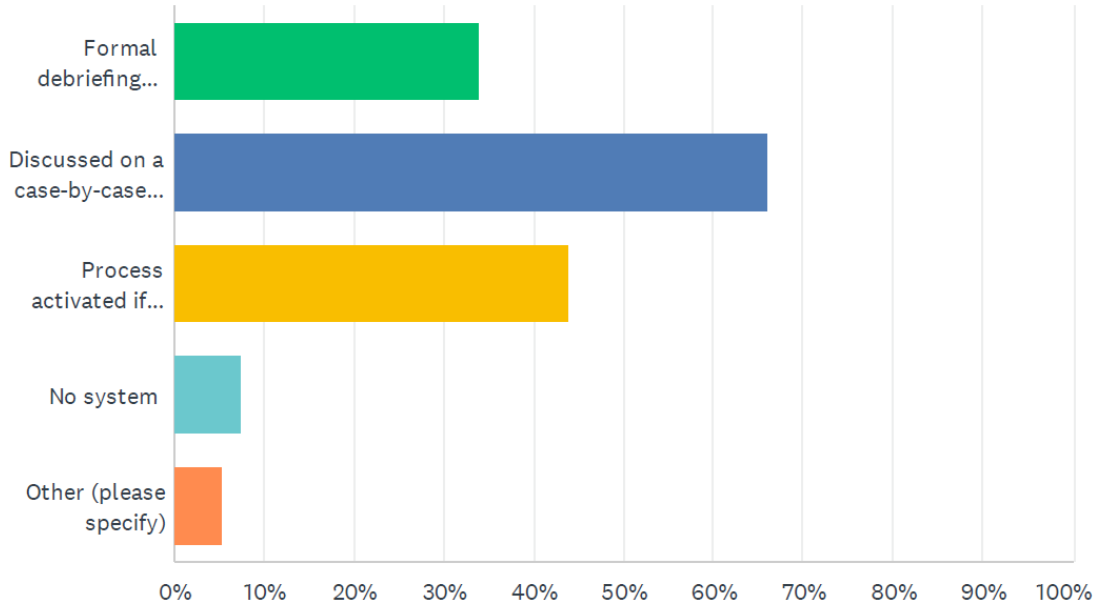
Answered: 203 Skipped: 17



ANSWER CHOICES	RESPONSES	
Agency car seat	30.54%	62
Parent arms	5.42%	11
Pedi Mate	53.20%	108
Neo Mate	9.85%	20
Isolette	3.94%	8
Agency does not transport < 5 kg	13.79%	28
None	13.79%	28
Total Respondents: 203		

Q65 What system(s) does your agency have in place to debrief or discuss a pediatric death or resuscitation? (Select all that apply)

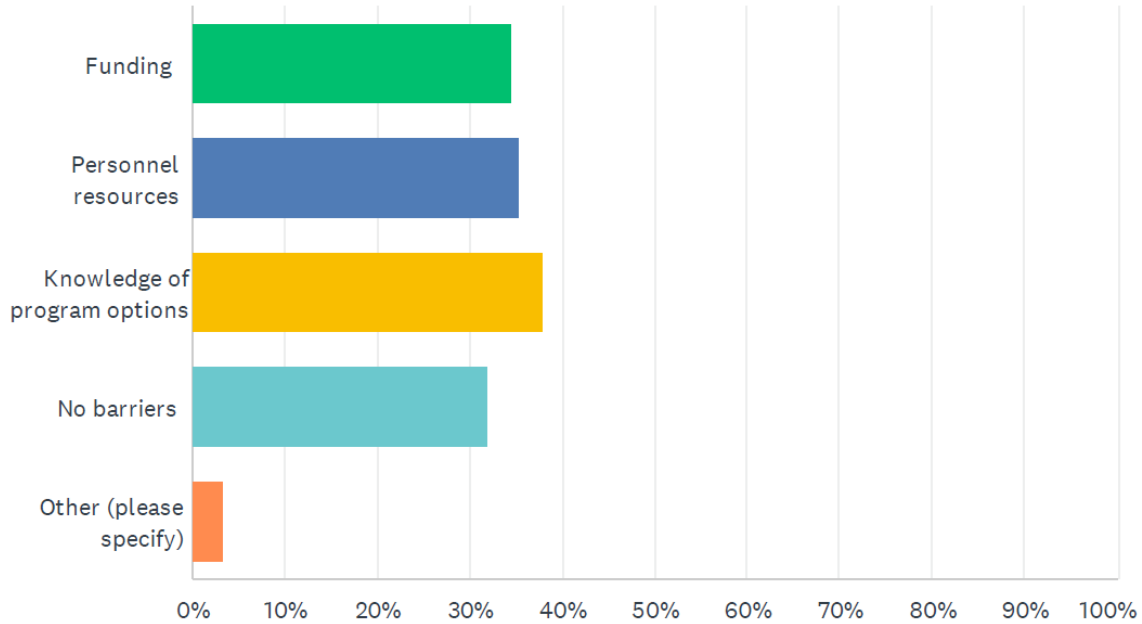
Answered: 203 Skipped: 17



ANSWER CHOICES	RESPONSES	
Formal debriefing process for all pediatric deaths and/or resuscitations	33.99%	69
Discussed on a case-by-case basis	66.01%	134
Process activated if requested by the agency employee	43.84%	89
No system	7.39%	15
Other (please specify)	5.42%	11
Total Respondents: 203		

Q66 Please identify the primary barriers your agency experiences with presenting infant mortality programs. (Select all that apply)

Answered: 203 Skipped: 17



ANSWER CHOICES	RESPONSES	
Funding	34.48%	70
Personnel resources	35.47%	72
Knowledge of program options	37.93%	77
No barriers	32.02%	65
Other (please specify)	3.45%	7
Total Respondents: 203		

BEMO Announcements and Updates

- **State Strategic Plan**: will include children and pediatric data when appropriate, challenge is small % of data compared to adult patients
- **Sample objectives**:

Objective 1.1.B – Increase the number of providers earning Florida State EMS *Quality First* recognition from 0 to 100 by December 31, 2028.

Objective 1.1.J – Increase the percentage of EMS transports originating from 911 requests in which SP02 is documented during and after intubation from 12% to 90% by December 31, 2028.

Objective 2.1.A – Increase the percentage of EMS providers participating in injury prevention and community health promotion efforts from 23% to 50% by December 31, 2028.

Old Business and Follow-up Information

Safe Transport

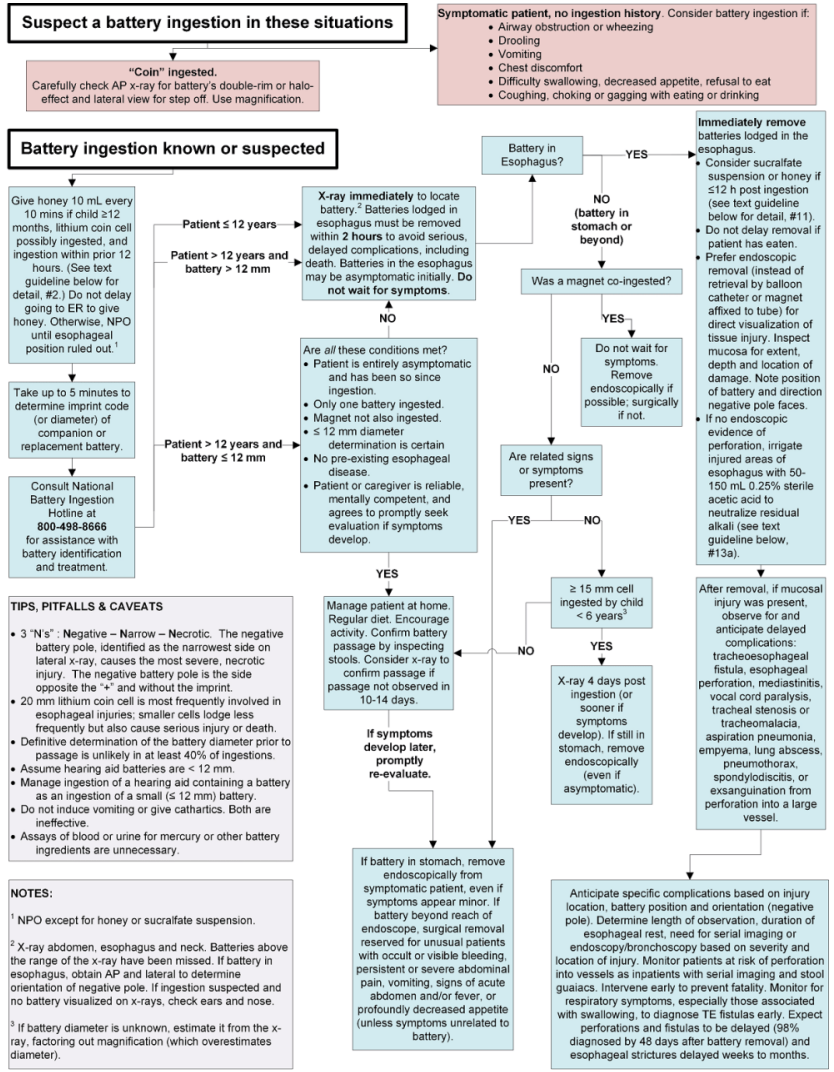
- Slide set and recording being added to website https://youtu.be/KMP3kxHEoJc
- Dissemination of limited numbers of pedimates and neomates to rural agencies (Thank you Jennifer McManus!)
- Program working with Health Care Coalitions to provide pediatric restraint devices
- Education and hands on training challenge contests
- National updates

Old Business and Follow-up Information

Button Battery Ingestion Management

- Options for administering honey
- FCOT statement
- Emmy- Florida Association of Broadcast Journalists Award in Health Reporting and Edward R. Murrow Award: https://www.news4jax.com/news/2022/05/12/child-unsafe-the-danger-of-button-batteries/
- Presentation to be added to PEDReady website

https://www.poison.org/battery/guideline



<u>If battery ingestion is suspected</u>:

1.Do not induce vomiting.

2.Administer honey immediately and while en route to the ER, if:

1.A lithium coin cell may have been ingested (if you don't know what kind of button battery was swallowed, assume it is a lithium coin cell unless it is a hearing aid battery);

2.The child is 12 months of age or older (because honey is not safe in children younger than one year);

3.The battery was swallowed within the prior 12 hours (because the risk that esophageal perforation is already present increases after 12 hours);

4.The child is able to swallow; and

5.Honey is immediately available.

How to dose honey:

1.Give 10 mL (2 teaspoons) of honey by mouth every 10 minutes for up to 6 doses. **Do not worry about the exact dose or timing**.

2.Use commercial honey if available, rather than specialized or artisanal honey (to avoid inadvertent use of large amounts of honey produced from potentially toxic flowers).

3.Honey is NOT a substitute for immediate removal of a battery lodged in the esophagus. Honey slows the development of battery injury but won't stop it from occurring. Do not delay going to an ER.

3.Other than giving honey, keep the patient NPO until an esophageal battery position is ruled out by x-ray.

Search Amazon.com

Description

100 Individual packet of Kraft honey (.31 oz/ 9g, or roughly 1 teaspoon)

Features & details

- Individual packet of Kraft honey (.31 oz/ 9g, or roughly 1 teaspoon)
- Perfect for adding to tea or toast w
go

Add to Cart

Product information

THE COMMITTEE ON TRAUMA

February 7, 2023

Angus Jameson, MD
State Emergency Medical Director
Florida Department of Health
4052 Bald Cypress Way
Tallahassee, FL 32399

Re: Recommendations for the Management of Button Battery Ingestion & Use of Tranexamic Acid in the Field for Pediatric Patients

Dr. Jameson,

The Florida Committee on Trauma (FCOT) provides the attached recommendations for the management of button battery ingestion and the use of tranexamic acid in the field for pediatric patients. These recommendations were formulated by the FCOT Pediatric Trauma Committee, which most recently met on February 3, 2023 to finalize this submission.

Members of the Pediatric Trauma Committee:

- Robert Letton, MD, FACS, Interim Vice Chair, Pediatric Trauma Committee, Wolfson Children's Hospital
- Amy Berger, University of Florida, Shands
- Elizabeth Blevins, Tampa General Hospital
- John Draus, MD, FACS, Wolfson Children's Hospital
- Oliver Lao, MD, FACS, Joe DiMaggio Children's Hospital
- Shawn Larson, MD, FACS, University of Florida College of Medicine
- Leopoldo Malvezzi, MD, FACS, Nicklaus Children's Hospital
- Karen McCauley, Johns Hopkins All Children's Hospital
- Lisa Nichols, Wolfson Children's Hospital
- Kelsey Palladino, Memorial Regional Hospital
- Candace Pineda, Memorial Regional Hospital
- Donald Plumley, MD, FACS, Orlando Health Arnold Palmer Hospital for Children
- Christopher Snyder, MD, FACS, Johns Hopkins All Children's Hospital
- Shakeva Swain, Nicklaus Children's Hospital
- Keith Thatch, MD, FACS, Johns Hopkins All Children's Hospital
- Patsy Williamson, Wolfson Children's Hospital
- Brian Yorkgitis, DO, FACS, University of Florida Health - Jacksonville

On behalf of the FCOT, thank you and the Florida Department of Health for the opportunity to share our collective expertise on these important issues. The FCOT membership is always available to support our emergency medical services (EMS) and Emergency Medicine partners in

Peter A Pappas MD, FACS
Chair, ACS Florida Committee on Trauma
UCF College of Medicine
Winter Park, FL 32789

BUTTON BATTERY INGESTION

Due to the extreme difficulty diagnosing a foreign body ingestion in the field, button battery ingestion should never be an activation from the field. In transfer, however, once a button battery ingestion is identified, it should be transported by EMS as expeditiously as possible, including as a Trauma Activation depending on local guidelines. In addition, we recommend initiating poison control guidelines prior to transfer.
(https://www.poison.org/battery/guideline)

Old Business and Follow-up Information

FL PEDReady resource bags

Contain communication cards, JumpSTART & START badge buddies, PALS pocket card, Handtevy badge buddies, Difficult Airway Course pocket card (adult and pediatric), ABC's of Pediatrics Emergencies chart, pain scale cards, Pediatric ECG card, pediatric acetaminophen & ibuprofen dosing magnets, NRP pocket cards, poison center magnets, distraction tools, etc.

DRUG DOSES

Optimization	Dose/kg	80 kg adult
Fentanyl (HTN Emergency)	3 µg/kg	250 µg

Induction Agent	Dose/kg	80 kg adult
Etomidate	0.3 mg/kg	24 mg
Propofol (Higher doses may be required in younger children)	1.5 mg/kg	120 mg
Ketamine	1.5 mg/kg	120 mg

Paralytic Agent	Dose/kg	80 kg adult
Succinylcholine	1.5 mg/kg	120 mg
Rocuronium	1.5 mg/kg	120 mg

Maintenance	Infusion Rate
Propofol (Higher doses may be required in younger children)	5–100 mcg/kg/min IV
Midazolam	100–200 mcg/kg/hr IV
Fentanyl	50–300 mcg/hr IV

SCH RELATED HYPERKALEMIA

Absolute contraindications to SCh

- History of malignant hyperthermia (MH)
- Burns >3 days — until healed
- Muscle damage (crush) >3 days — until healed
- Spinal cord injury, stroke >3 days — 6 months
- Neuromuscular disease (e.g. MS, ALS), myopathy — indefinitely
- Intra-abdominal sepsis >3 days — resolution of infection

Treatment of Hyperkalemia

- 10% Ca gluconate10–20 cc IV over 2 min.
- $NaHCO_3$ 50–100 mEq IV over 5–10 min.
- Glucose 50 gm, regular insulin 10 units (500 cc D10 W, 10 units regular insulin) IV over 45–60 min.
- Hemodialysis

PEARLS

- During RSI, BMV patient only if saturation drops below 93%
- All drugs are IV push except fentanyl which should be given slowly over 1–2 minutes, monitoring closely for respiratory depression
- Patients with ↑age, ↓cardiac output or hypovolemia/hypotension should receive reduced doses of induction agents
- Sellick's maneuver: We recommend use during BMV to minimize gastric insufflation
- **ELM**: Use optimal **E**xternal **L**aryngeal **M**anipulation to improve view of cords

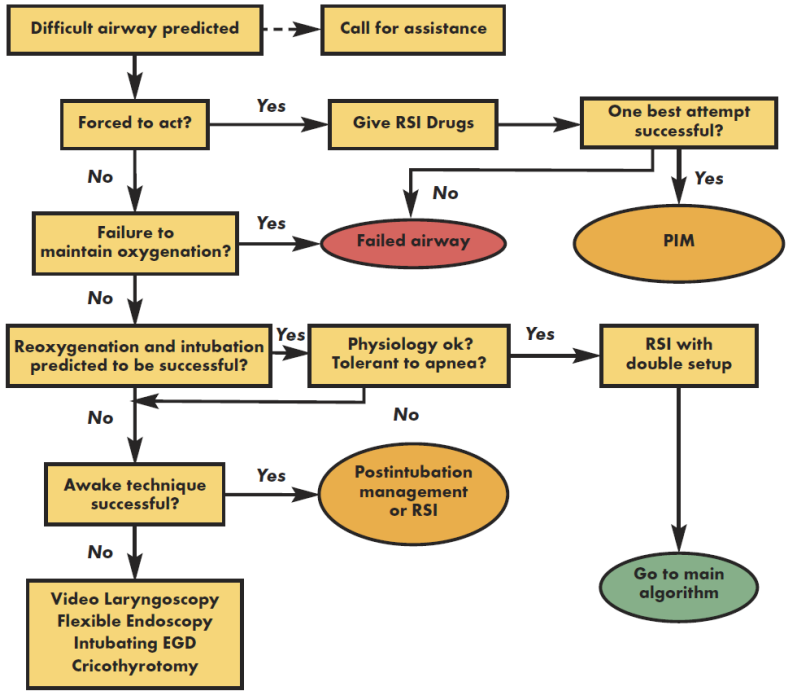
the difficult airway course™

theairwaysite.com

the airway card™

version 5.0

DIFFICULT AIRWAY ALGORITHM



DIFFICULT AIRWAY ASSESSMENT

- **LEMON** (direct laryngoscopy): **L**ook externally (gestalt); **E**valuate 3-3-2; **M**allampati; **O**bstruction/**O**besity; **N**eck mobility
- **ROMAN** (mask ventilation): **R**adiation/**R**estriction; **O**bstruction/**O**besity/**O**SA; **M**ask seal/**M**ale/**M**allampati; **A**ged; **N**o teeth
- **SMART** (cricothyrotomy): **S**urgery; **M**ass; **A**ccess/**A**natomy; **R**adiation; **T**umor
- **RODS** (Extraglottic device): **R**estriction; **O**bstruction/**O**besity; **D**istorted anatomy; **S**hort thyromental distance

INDICATIONS FOR INTUBATION

- Failure to protect the airway
- Failure to oxygenate or ventilate
- Anticipated clinical course
  - Deterioration
  - Transport
  - Impending airway compromise

RAPID SEQUENCE INTUBATION

zero – 10+ min. — Preparation

Monitoring (SpO_2, ECG, BP, $ETCO_2$), IV access

Preoxygenation (highest concentration oxygen)

8 vital capacity breaths or 3 minutes of tidal volume breathing
Flush rate O_2 by NRB mask
Nasal Cannula oxygen 15 lpm for apneic oxygenation
Pediatrics: apneic oxygenation 1-2 lpm/year of age, max 15 lpm

Physiologic Optimization

Normal saline, blood or pressors – for hypotension
BiPAP if still hypoxic
Pediatrics: Atropine optional, used principally for infants < 1 yr

zero — Paralysis with Induction

zero + 15 sec. — Positioning

Position patient optimally for laryngoscopy
Pediatrics: consider shoulder roll for infants < 6 months

zero + 45 sec. — Placement with Proof

Intubate and confirm with $ETCO_2$ or waveform capnography
Secure tube

zero + 1 min. — Post-Intubation Management

Sedation and analgesia
Paralysis only if necessary
Hemodynamic, oxygen, and $ETCO_2$ monitoring
Appropriate ventilator settings

PEDIATRIC TIPS

- Consider shoulder roll for infants <6 months of age.
- Apneic oxygenation is 1-2 lpm/year of age to max of 15 lpm/year of age.
- Consider atropine for pretreatment under 1 year of age.
- Straight (Miller) blades preferred under 2 years of age.
- Use a cuffed tube if appropriate size available.
- Consider marking endotracheal tube at appropriate lip-to-tip distance.

The Broselow Luten zones for PEDIATRIC DRUGS AND EQUIPMENT

the difficult airway course™

theairwaysite.com

INTUBATION CONSIDERATIONS IN CHILDREN

Insertion Depth – *see color chart*
Ventilator Settings
FiO_2: 100%
PEEP: 5 cm H_2O initial
PIP: 20–30 cm H_2O
Inspiratory Time: *see color chart*
Tidal Volume* and RR: *see color chart*
Post Intubation – Secure tube at lip *and* stabilize neck

*Tidal volume of 6–10 mL/kg frequently used, but assess patient to determine there is chest rise and distal air entry on exam. Adequate tidal volume typically requires PIP of at least 15 cm H_2O if lung compliance is normal.

ZONE	3kg	4kg	5kg	PINK	RED	PURPLE	YELLOW	WHITE	BLUE	ORANGE	GREEN
Length (cm)	46–52	52–57	57–61	61–67	67–75	75–85	85–97	97–109	109–121	121–133	133–146
Weight (kg)	3	4	5	6–7	8–9	10–11	12–14	15–18	19–23	24–29	30–36
PRETREATMENT											
Atropine	0.06 mg	0.08 mg	0.1 mg	0.13 mg	0.17 mg	0.2 mg	N/A	N/A	N/A	N/A	N/A
INDUCTION											
Etomidate	0.9 mg	1.2 mg	1.5 mg	2 mg	2.5 mg	3.2 mg	4 mg	5 mg	6.3 mg	8 mg	10 mg
Ketamine	6 mg	8 mg	10 mg	13 mg	17 mg	20 mg	26 mg	33 mg	42 mg	53 mg	66 mg
Propofol	9 mg	12 mg	15 mg	20 mg	25 mg	32 mg	40 mg	50 mg	63 mg	80 mg	100 mg
PARALYSIS											
Succinylcholine	6 mg	8 mg	10 mg	13 mg	17 mg	20 mg	26 mg	33 mg	40 mg	53 mg	66 mg
Rocuronium	3 mg	4 mg	5 mg	7 mg	9 mg	10 mg	13 mg	17 mg	21 mg	27 mg	33 mg
MAINTENANCE*											
Vecuronium	0.3 mg	0.4 mg	0.5 mg	0.7 mg	0.9 mg	1 mg	1.3 mg	1.7 mg	2.1 mg	2.7 mg	3.3 mg
Lorazepam	0.15 mg	0.2 mg	0.25 mg	0.3 mg	0.4 mg	0.5 mg	0.6 mg	0.8 mg	1 mg	1.3 mg	1.6 mg
EQUIPMENT											
ET Tube (mm)	3.5 unc/3.0 cuff	3.5 unc/3.0 cuff	3.5 unc/3.0 cuff	3.5 unc/3.0 cuff	3.5 unc/3.0 cuff	4.0 unc/3.5 cuff	4.5 unc/4.0 cuff	5.0 unc/4.5 cuff	5.5 unc/5.0 cuff	5.5 cuff	6.0 cuff
Lip-Tip (cm)	9–9.5	9.5–10	10–10.5	10–10.5	10.5–11	11–12	12.5–13.5	14–15	15.5–16.5	17–18	18.5–19.5
Suction	8 F	8 F	8 F	8 F	8 F	8–10 F	10 F	10 F	10 F	10 F	12 F
L-Scope blade	1 St.	1 St.	1 St.	1 St.	1 St.	1 St.	2 St./Cvd.	2 St./Cvd.	2 St./Cvd.	2–3 St./Cvd.	2–3 St./Cvd.
Stylet	6 F	6 F	6 F	6 F	6 F	6 F	10 F	10 F	10 F	14 F	14 F
Oral Airway	50 mm	50 mm	50 mm	50 mm	50 mm	60 mm	60 mm	60 mm	70 mm	80 mm	80 mm
NP Airway	14 F	14 F	14 F	14 F	14 F	18 F	20 F	22 F	24 F	26 F	26 F
$ETCO_2$ Detector	PED	PED	PED	PED	PED	PED	PED	ADULT	ADULT	ADULT	ADULT
BVM (min vol mLs)	450	450	450	450	450	450	450	450–750	750–1000	750–1000	1000
LMA	1	1	1	1.5	1.5	2	2	2	2-2.5	2.5	3
VENTILATION											
Tidal Volume mL	20–30	24–40	30–50	40–65	50–85	65–105	80–130	100–165	125–210	160–265	200–330
Frequency (BPM)	20–25	20–25	20–25	20–25	20–25	15–25	15–25	15–25	12–20	12–20	12–20
Insp. time (sec)	0.6	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.8

*Continuous infusions can be used for maintenance of post-intubation sedation. Dosing is on the other side of the card.

START Modified ADULT

(size, + 2° sex characteristics)

Move the Walking Wounded	MINOR
No Respirations after Head Tilt	EXPECTANT

CONTROL BLEEDING

Respiratory Distress (> 30/min)	IMMEDIATE
Perfusion (No Radial Pulse)	IMMEDIATE
Mental Status (Unable to Follow Commands)	IMMEDIATE
Normal RPM, Follows Commands	DELAYED

CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

FL MCI LEVELS

MCI Level 1: 5-10 victims
MCI Level 2: 11-20 victims
MCI Level 3: 21-100 victims
MCI Level 4: 100 -1000 victims
MCI Level 5: Over 1000 victims

July 2021

On PEDReady website

IMMEDIATE	Red
DELAYED	Yellow
MINOR	Green
EXPECTANT	Black

JumpSTART Modified

(Newborn to Young Adult*)

Move the Walking Wounded	MINOR
No Respirations and No Peripheral Pulse	EXPECTANT
Respiratory Rate: > 45/min, < 15/min or ↕Work of Breathing, obvious distress	IMMEDIATE
No Respirations with Peripheral Pulse Give 5 Ventilations via Barrier Device Spontaneous Respirations Resume after 5 Ventilations	IMMEDIATE
No Spontaneous Respirations Resume after 5 Ventilations	EXPECTANT

CONTROL BLEEDING

Perfusion (No Palpable Pulse)	IMMEDIATE
Mental Status** Unresponsive or not localizing pain	IMMEDIATE
Alert, responds to voice, localizes pain	DELAYED

*Presence of 2° sex characteristics; **Consider developmental level

CONDUCT SECONDARY TRIAGE IN THE TREATMENT PHASE

Pediatric Pain and Fever Dosing Guide*

Acetaminophen (Tylenol®) **Dosing Table** (give every 4-6 hours as directed)									
Child's Age	**0-3 mo***	**4-11 mo**	**12-23 mo**	**2-3 yr**	**4-5 yr**	**6-8 yr**	**9-10 yr**	**11-12 yr**	**12+ yr**
Weight (pounds)	**6-11 lbs**	**12-17 lbs**	**18-23 lbs**	**24-35 lbs**	**36-47 lbs**	**48-59 lbs**	**60-71 lbs**	**72-95 lbs**	**96+ lbs**
Weight (kilograms)	**3-5 kg**	**6-7 kg**	**8-10 kg**	**11-15 kg**	**16-21 kg**	**22-26 kg**	**27-32 kg**	**33-43 kg**	**44+ kg**
Liquid 160mg/5mL (mL)	**1.25 mL**	**2.5 mL**	**3.75 mL**	**5 mL**	**7.5 mL**	**10 mL**	**12.5 mL**	**15 mL**	**20 mL**

* **Speak to your doctor before giving Acetaminophen to children under 2 months old**

Ibuprofen (Advil®/Motrin®) **Dosing Table** (give every 6-8 hours as directed)									
Child's Age	**0–6 mo**	**6-11 mo**	**12-23 mo**	**2-3 yr**	**4-5 yr**	**6-8 yr**	**9-10 yr**	**11-12 yr**	**12+ yr**
Weight (pounds)	**0-11 lbs**	**12-17 lbs**	**18-23 lbs**	**24-35 lbs**	**36-47 lbs**	**48-59 lbs**	**60-71 lbs**	**72-95 lbs**	**96+ lbs**
Weight (kilograms)	**0-5 kg**	**6-7 kg**	**8-10 kg**	**11-15 kg**	**16-21 kg**	**22-26 kg**	**27-32 kg**	**33-43 kg**	**44+ kg**
Drops 50mg/1.25mL (mL)	–	**1.25 mL**	**1.875 mL**	**2.5 mL**	**3.75 mL**	**5 mL**	–	–	–
Liquid 100mg/5mL (mL)	–	**2.5 mL**	**4 mL**	**5 mL**	**7.5 mL**	**10 mL**	**12.5 mL**	**15 mL**	**20 mL**

* Ideal dosing is based on **weight**, not age. Use a dosing cup or syringe if possible. 1 teaspoon = 5 mL
mo = months of age; **yr** = years of age

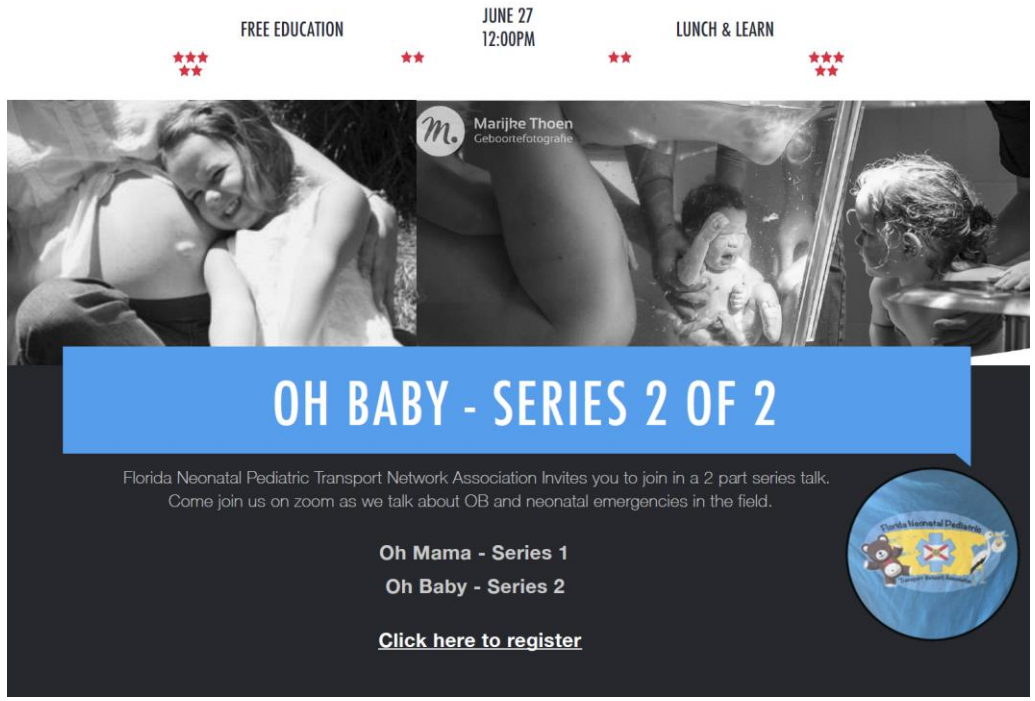
FLORIDA PEDREADY
emlrc.org/flpedready

pami.emergency.med.jax.ufl.edu

PAMI
Pain Assessment and Management Initiative

Old Business and Follow-up Information

Pediatric and neonatal educational needs



SCAN ME

Old Business and Follow-up Information

Prehospital TXA Use in Pediatrics

- Varying viewpoints, remain current on new literature and follow agency medical direction and protocols
- February 2023 statement from FCOT

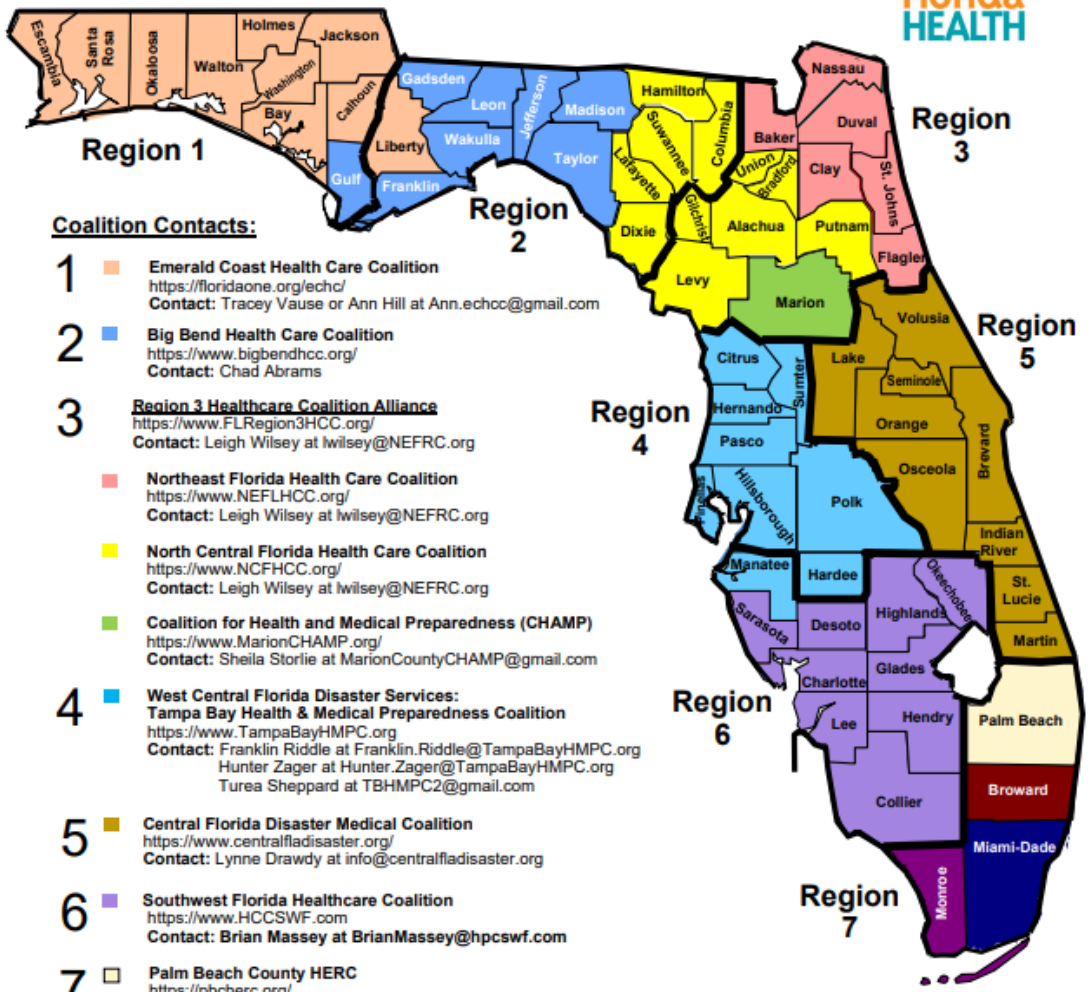
PREHOSPITAL TXA (Tranexamic Acid)

Without advanced coagulation studies such as TEG, the use of TXA in Pediatric Trauma, particularly in the pre-hospital setting, does not currently have evidence-based indications. Numerous questions remain as to the appropriate pediatric dose, timing, and specific indications for the use of TXA in the pediatric trauma population. The one recommendation that the FCOT Pediatric Subcommittee can make is that in an adolescent trauma patient, age 12 or older, (or longer than the Broselow tape), administration of TXA in the field for hemorrhagic shock (especially penetrating mechanism) may be of benefit, and adult dosing is appropriate. Further recommendations will be forthcoming, pending the results of the larger, multi-center PECARN TIC-TOC Trial.

Florida Health Care Coalitions

By Regional Domestic Security Task Force (RDSTF) Region

Updated: March 29, 2023



Coalition Contacts:

1 **Emerald Coast Health Care Coalition**
https://floridaone.org/echc/
Contact: Tracey Vause or Ann Hill at Ann.echcc@gmail.com

2 **Big Bend Health Care Coalition**
https://www.bigbendhcc.org/
Contact: Chad Abrams

3 **Region 3 Healthcare Coalition Alliance**
https://www.FLRegion3HCC.org/
Contact: Leigh Wilsey at lwilsey@NEFRC.org

Northeast Florida Health Care Coalition
https://www.NEFLHCC.org/
Contact: Leigh Wilsey at lwilsey@NEFRC.org

North Central Florida Health Care Coalition
https://www.NCFHCC.org/
Contact: Leigh Wilsey at lwilsey@NEFRC.org

Coalition for Health and Medical Preparedness (CHAMP)
https://www.MarionCHAMP.org/
Contact: Sheila Storlie at MarionCountyCHAMP@gmail.com

4 **West Central Florida Disaster Services:**
Tampa Bay Health & Medical Preparedness Coalition
https://www.TampaBayHMPC.org
Contact: Franklin Riddle at Franklin.Riddle@TampaBayHMPC.org
Hunter Zager at Hunter.Zager@TampaBayHMPC.org
Turea Sheppard at TBHMPC2@gmail.com

5 **Central Florida Disaster Medical Coalition**
https://www.centralfladisaster.org/
Contact: Lynne Drawdy at info@centralfladisaster.org

6 **Southwest Florida Healthcare Coalition**
https://www.HCCSWF.com
Contact: Brian Massey at BrianMassey@hpcswf.com

7 **Palm Beach County HERC**
https://pbcherc.org/
Contact: John James at johnj@pbcms.org

Broward County Health Care Coalition
http://www.bchconline.com/
Contact: Kelly Keys at kkeys@bchcoalition.com
Reshena Clark at rclark@bchcoalition.com

Miami-Dade County Healthcare Preparedness Coalition
https://www.mdchpc.org/
Contact: Marilia VanKeeken at
marilia.vankeeken@smrt7.onmicrosoft.com

Keys Health Ready Coalition
Contact: Cyna Wright at admin@keysready.org

Statewide Contacts

- Florida Department of Health: Pam Tempson at pam.tempson@flhealth.gov
- Florida Hospital Association: John Wilgis at john@fha.org

https://www.floridahcc.org/coalitions/

Old Business and Follow-up Information

Disaster Related Activities and Hurricane Ian outcomes

- Hurricane Ian wrap-up and accomplishments

  Big thank you to our Health Care Coalitions for prioritizing pediatric needs!
- Need a debriefing tool, central repository for documents, etc.
- HCC pediatric tabletop exercises and EMSC related inquires
  - Operation Tots
  - ? About pediatric supplies on BLS mass casualty ambulances
  - Family reunification plans
- Using MIH to prepare families and children for disasters (L Work)

Disaster Related Activities and Hurricane Ian outcomes

- State Pediatric Readiness Concept Proposal

That the Florida Bureau of Emergency Medical Oversight in collaboration with the Florida EMS Advisory Council explore funding options for implementation of a voluntary Handtevy or other equivalent pediatric system in state EMS agencies based on medical director preference with priority considerations for rural agencies, areas where transport to a pediatric capable facility is > 30 minutes, and counties with high pediatric populations. Neonates, children, adolescents, special healthcare needs, and disaster preparedness should be considered in system planning.

For need, background, and proposal scan the code

Florida PEDReady

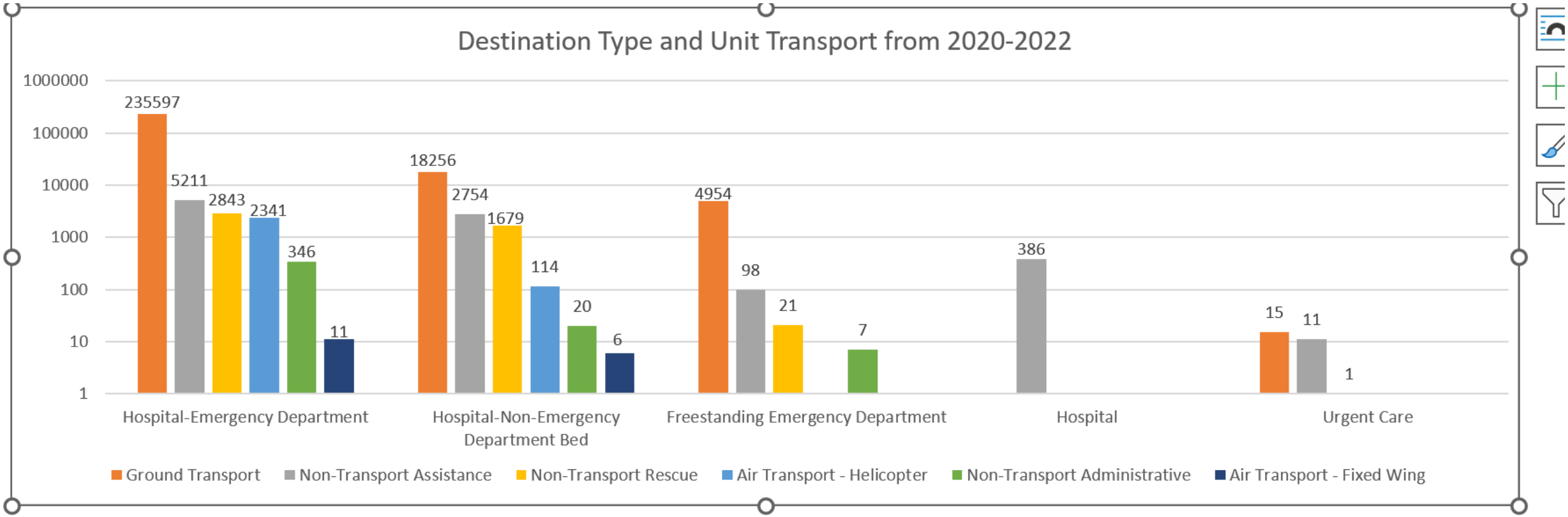
Old Business and Follow-up Information

Children with Special Healthcare Needs (CSHCN)

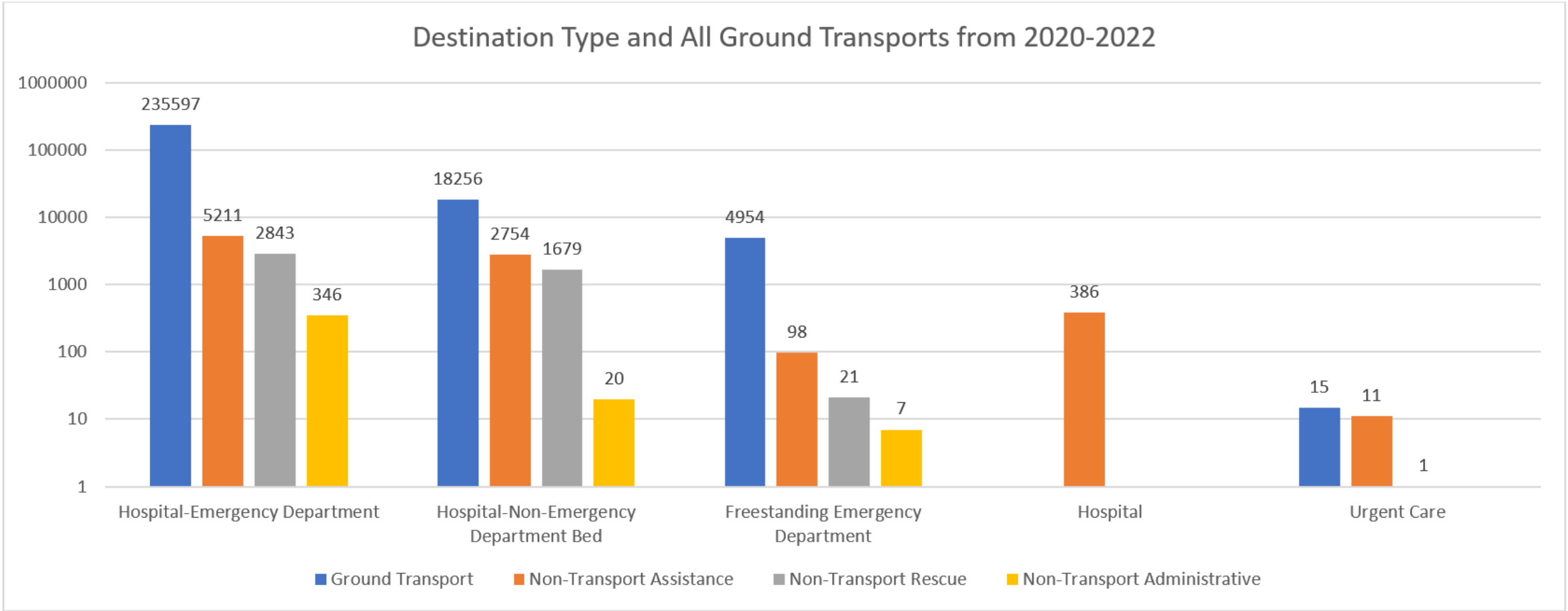
- STARS: Special needs Tracking and Awareness Response System
- Comfort kits

Pediatric Data and Biospatial EMSC Dashboard

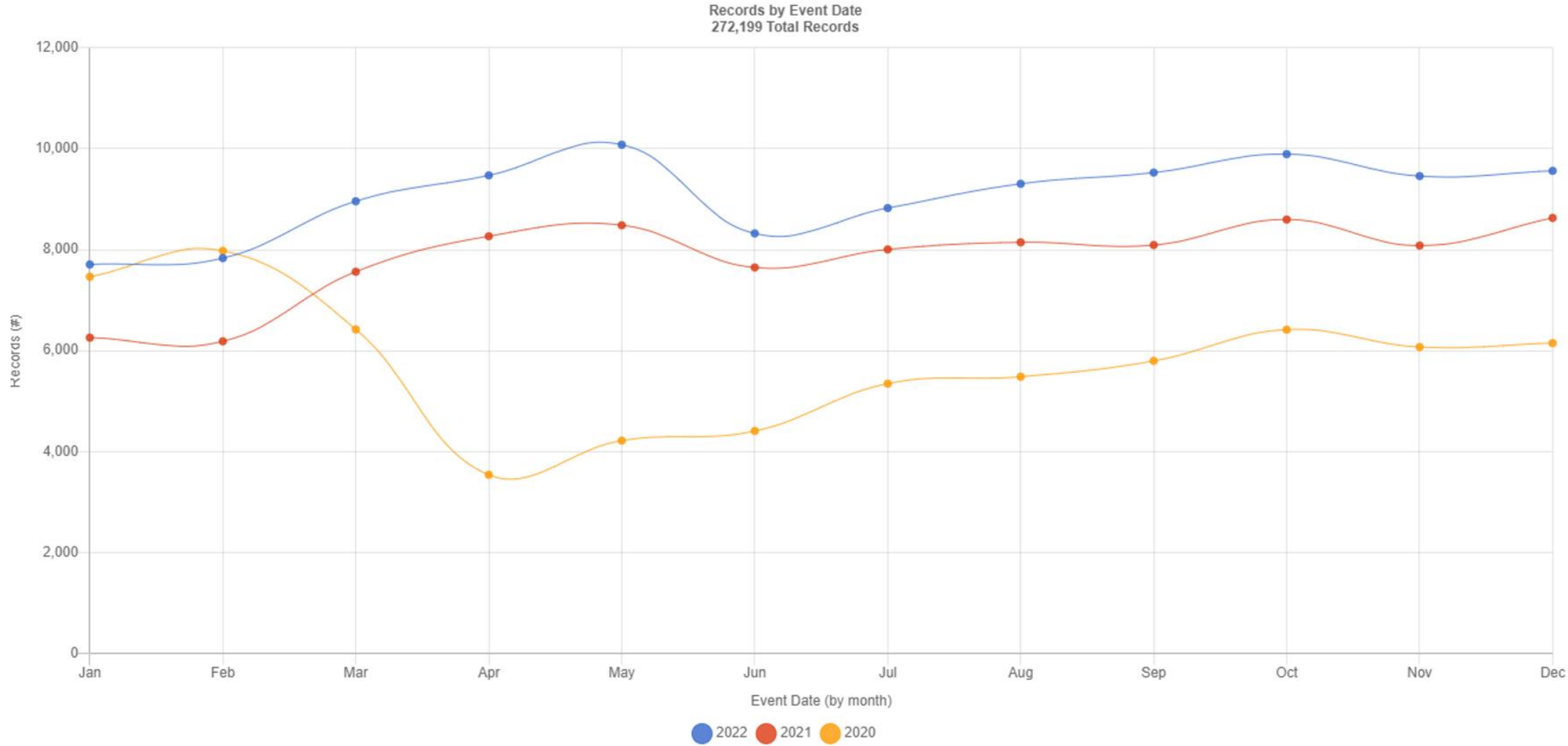
- Currently looking at 2020-2022, **0-18 years**
- What do you want to see??????
- Responses by age categories
- Procedures
- Medications
- Newborn deliveries
- ????????????????



Destination Type	Ground Transport	Non-Transport Assistance	Non-Transport Rescue	Air Transport - Helicopter	Non-Transport Administrative	Air Transport - Fixed Wing
Hospital-Emergency Department	235597	5211	2843	2341	346	11
Hospital-Non-Emergency Department Bed	18256	2754	1679	114	20	6
Freestanding Emergency Department	4954	98	21	0	7	0
Hospital	0	386	0	0	0	0
Urgent Care	15	11	1	0	0	0



Destination Type	Ground Transport	Non-Transport Assistance	Non-Transport Rescue	Non-Transport Administrative
Hospital-Emergency Department	235597	5211	2843	346
Hospital-Non-Emergency Department Bed	18256	2754	1679	20
Freestanding Emergency Department	4954	98	21	7
Hospital	0	386	0	0
Urgent Care	15	11	1	0


Records by Event Date
272,199 Total Records
12,000
10,000
8,000
6,000
4,000
2,000
0
Records (#)
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Event Date (by month)
2022
2021
2020

National and State EMSC Performance Measures

Surveys (Required)

- 2023 National EMSC EMS survey (pending results)
- 2024 National EMSC Prehospital Pediatric Readiness Survey (long)
- 2021 National EMSC ED Pediatric Readiness Survey for EDs: FL 58% response rate. Average FL score 75/100, median 76. Still pending national comparison scores due to wait for publication: https://pedsready.org/

National and State EMSC Performance Measures: Sample activities

Expand the uptake of Pediatric Readiness in Emergency Departments where not already done, by establishing a state, territorial, or regional *Pediatric Readiness Recognition Program for hospital EDs; designating PECCs in EDs*; and ensuring hospital EDs weigh and record children's weight in kilograms. (voluntary)

- Host online focus groups regarding the Florida ED PRRP background, purpose, and benefits to seek input on pediatric readiness recognition criteria and metrics
- Maintain updated contact list of all EDs and hospital system ED pediatric leadership
- Develop PRRP ED dashboard for professionals and families to include ED services, service exclusions, address, map, transfer criteria, transport and contact referral line information

National and State EMSC Performance Measures: Sample activities

Improve Pediatric Readiness in EMS Systems by establishing a state, territorial, or regional standardized *Prehospital Pediatric Readiness Recognition Program for prehospital EMS agencies; increasing PECCs in prehospital EMS agencies; and increasing the number of prehospital EMS agencies that have a process for pediatric skills-check on the use of pediatric equipment.*

- Maintain updated contact list of all EMS agencies, EMS training programs, and PECCs
- Host online and in person focus groups on EMS PRRP background, purpose, and benefits to seek input on pediatric readiness recognition criteria and metrics
- Develop planning committee and process to conduct rural EMSC Pediatric and Disaster Readiness “rodeos” with skill stations

National and State EMSC Performance Measures: Sample Activities

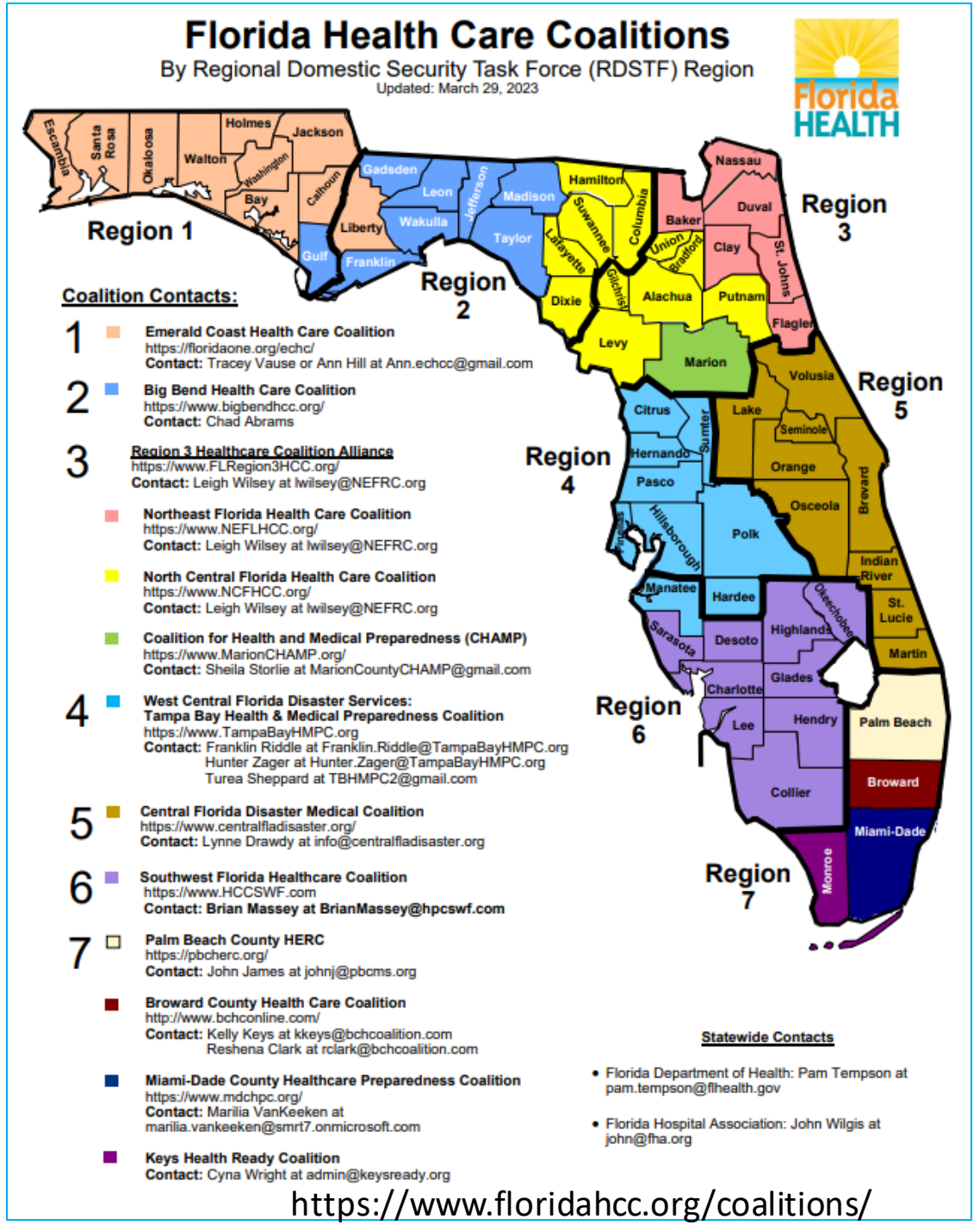
Increase pediatric disaster readiness in hospital EDs and prehospital EMS agencies by ensuring that disaster plans address the needs of children.

Prioritize and advance family partnership and leadership in efforts to improve EMSC systems of care

- Review current EMS and ED pediatric disaster plans, drills, mock scenarios, training materials
- Administer online pediatric readiness disaster needs assessment and surge capacity inventory

Florida BEMO Regional EMS Coordinators

Regions 1, 2: Jeff Guadiana (Health, Safety & Wellness, Workforce)
Region 3, 4, 5: Vacant (Quality and Education)
Region 6: Jennifer McManus (Rural EMS)
Region 7: Tom DiBernardo (Special Projects/CARES)



Coordinator Site Visit Potential EMSC Topics

- Inquire about agency PECC status, pediatric equipment and training, pediatric protocols including disaster and safe pediatric transport restraint
- Ask permission to sign up PECC or pediatric point of contact for PEDReady listserv and for weekly E-News
- Share national and state EMSC & PEDReady resources and website (National equipment list, JumpSTART badge buddies, ABCs of Pediatric Emergencies, distraction and comfort kits, communication cards, pain and fever dosing guides, etc.)
- Ask about pediatric challenges
- Recognize pediatric champions and model programs.

Liaison and Constituency Group Reports

a. Rural update (Vause and McManus)
b. Florida FAN Report (Nasca)
c. Trauma: Program managers (Nichols), FTSAC, FCOT
d. Disaster (Downey, etc.)
e. Mental Health (Work)
f. Data Committee, Biospatial (EMSC dashboard)
g. Community Paramedicine/MIH/H.A.R.T. (Health-Access-Resiliency and Telehealth) Section (Bedford)
h. FL ENA (Rushing)
i. EMS Educators
j. ECCs (Rabish, Weed, Weishaupt, Walters)
k. Pediatric and neonatal transport (FNPTNA)
l. Injury prevention (Summers)
m. Children's Medical Services and Child Abuse
n. Other

New Business:

- Upcoming courses, resources, national EMSC Collaboratives, etc.

  https://emscimprovement.center/collaboratives/prqc/2023/
- Future meetings
- Announcements
- Trends

Saving Lives Through Pediatric Readiness Efforts

The readiness of Emergency Departments (EDs) to meet the needs of children is highly variable, with a national median score of 69 on a 100-point scale. But research shows that scoring 88 points and above is tied to significantly improved outcomes. Integrating children in quality improvement (QI) efforts can improve pediatric readiness by up to 26 points, meaning QI has the potential to significantly reduce the risk of death for children presenting to your ED.

FREE OPPORTUNITIES TO ENGAGE IN QI

National PRQC
Pediatric Readiness Quality Collaborative
Ensuring Emergency Care for All Children

Pediatric Readiness Quality Improvement Collaborative (PRQC)

Leveraging the NPRQI platform, PRQC will provide foundational training and support to help ED-based teams implement pediatric QI efforts. PRQC participants will choose one or more focus areas from four high-priority topics. While sites will have access to the NPRQI platform and dashboard even after the close of the collaborative, participating teams are expected to implement a local QI project during the 18-month time period.

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

National Pediatric Readiness Quality Initiative (NPRQI)

NPRQI is an open-access QI portal designed to support general and low-volume EDs in assessing and improving pediatric emergency care. NPRQI is self-guided and self-paced. Participants have access to a broad menu of clinical areas and associated quality measures. Performance may be compared to similar EDs and across patient demographics.

Understanding PRQC and NPRQI

PRQC participants simultaneously register for NPRQI and will receive support and guidance on NPRQI during the collaborative. However, EDs can also choose to enroll in NPRQI only.

	PRQC	NPRQI
Registration Deadline	June 6, 2023	Open enrollment
Time Period	Ends December 15, 2024; 18 months total	Open participation; No end date
Clinical Focus	Choose 1 or more of 4 areas of focus: Patient Assessment, Patient Safety, Pain Management, and Suicide	Open menu with 7 clinical areas of focus (28 quality measures): Patient Assessment and Safety, Interfacility Transfers, Respiratory Complaints, Blunt Head Trauma, Seizures, Suicide, and Vomiting
Support	Learning sessions, Intervention guides, QI and data literacy training, QI coaching, access to subject matter experts	Reference materials, **User guides**
Continuing Education Credits	CEU/CNE/CME/MOC Part IV	MOC Part IV only, indivudual submission
Required Time Commitment	1-2hrs/wk including monthly 1.5-hr learning sessions	Site-driven
Data Capture and Dashboard Access	NPRQI platform	NPRQI platform
Confidentiality	Yes, Participant Organization Agreement	Yes, Participant Organization Agreement
Cost	Free	Free
Registration Site	https://emscimprovement.center/collaboratives/prqc/2023/	https://sites.utexas.edu/nprqi/

EMSC Emergency Medical Services for Children

The Emergency Medical Services for Children Innovation and Improvement Center (EIIC) is part of an award (U07MC37471) totaling $3M and NPRQI is part of an award (H34MC33244) totaling $1.2M. Both awards have 0% percentage financed with nongovernmental sources and are supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov. NPRQI is a quality improvement effort that has been submitted through the University of Texas IRB and designated exempt.

New Business:

- EMSC Day May 2024 planning
- Future meetings
  - October 3-5 Henderson Beach Resort, Destin
  - Florida Fire Conference January 10-12, 2024, Orange County Convention Center
- Trends: Congenital Syphilis, what are you seeing?

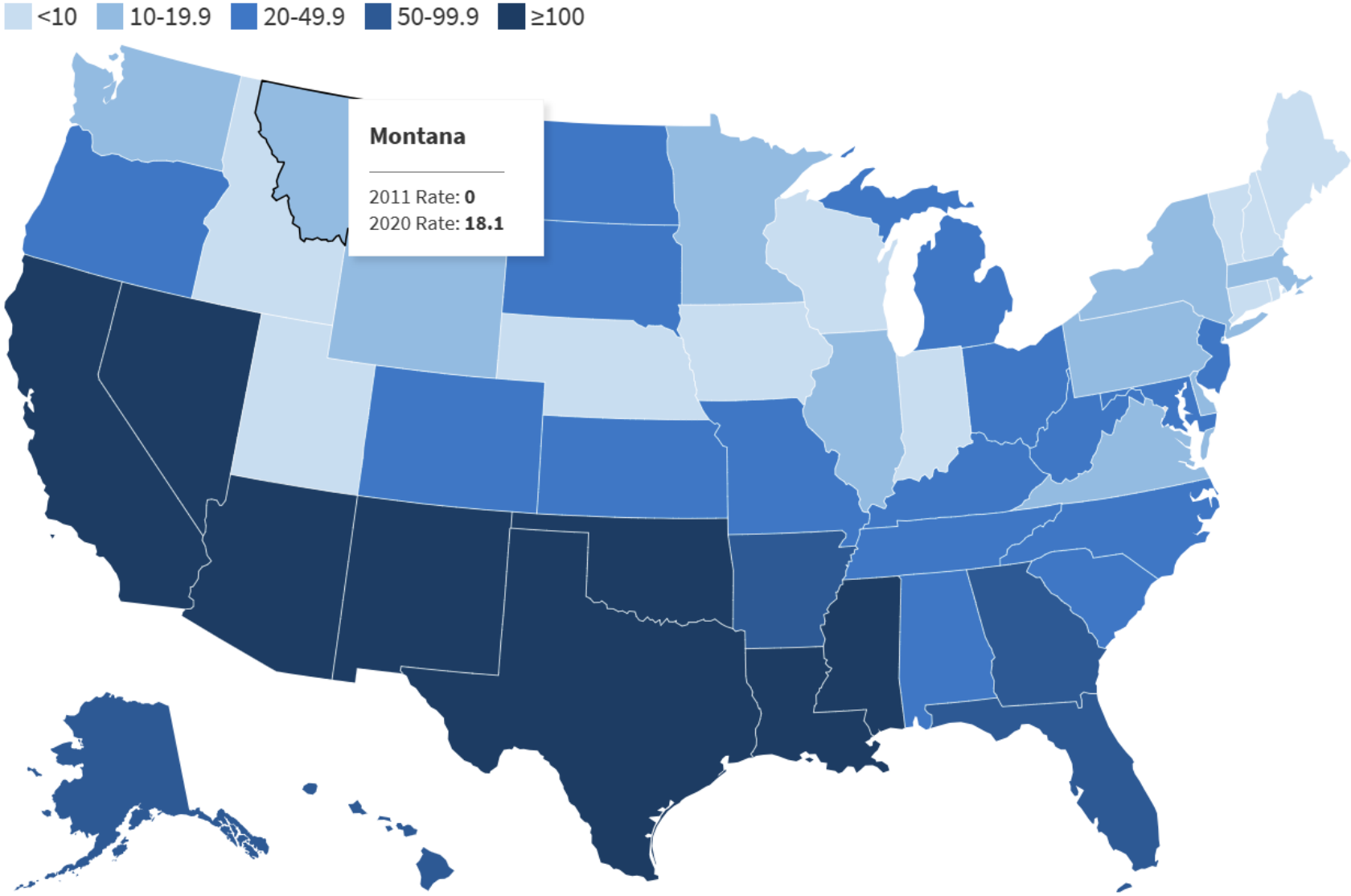
Trends

- Increase in congenital syphilis cases
  - Reported cases of congenital syphilis increased during 2009–2018 in Florida (21 to 108; 414%) and in the US (427 to 1,306; 206%). At the same time, reported cases of infectious syphilis among women increased by 142% in Florida (147 to 356) and 124% in the US (2,232 to 4,995).
  - ED screening
  - https://www.floridahealth.gov/diseases-and-conditions/sexually-transmitted-diseases/std-fact-sheets/congenital-syphilis.html

Congenital Syphilis Rates Are Highest in the West and South

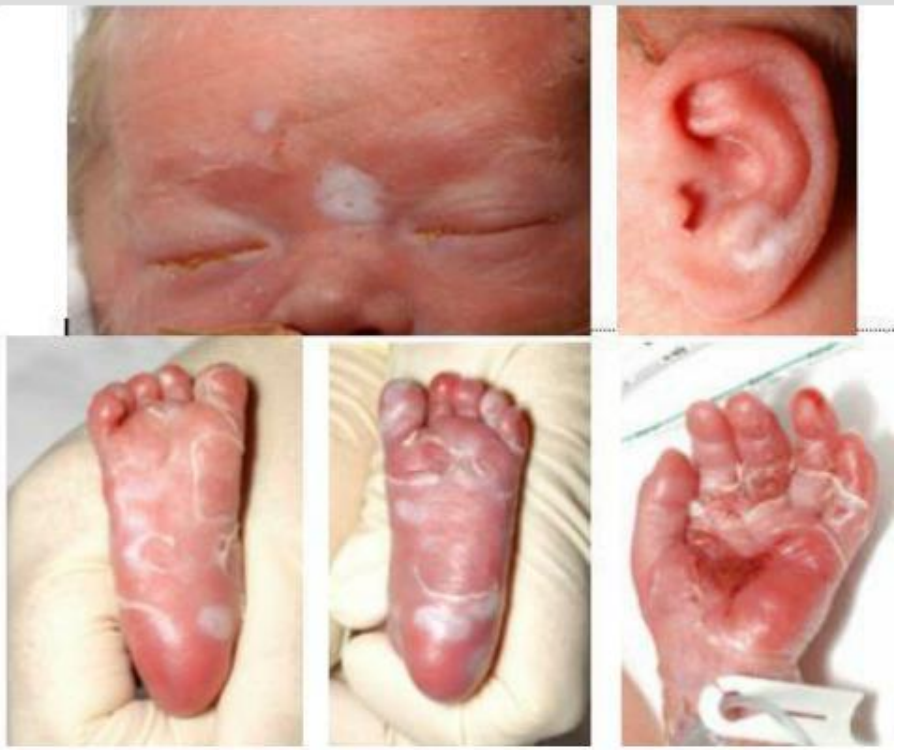
New Mexico, Arizona, Texas, and Nevada had the highest rates of congenital syphilis in 2020. All but three states — Maine, New Hampshire, and Vermont — reported having cases.

Cases per 100,000 live births



Early-onset congenital syphilis (before or at age 2 y)

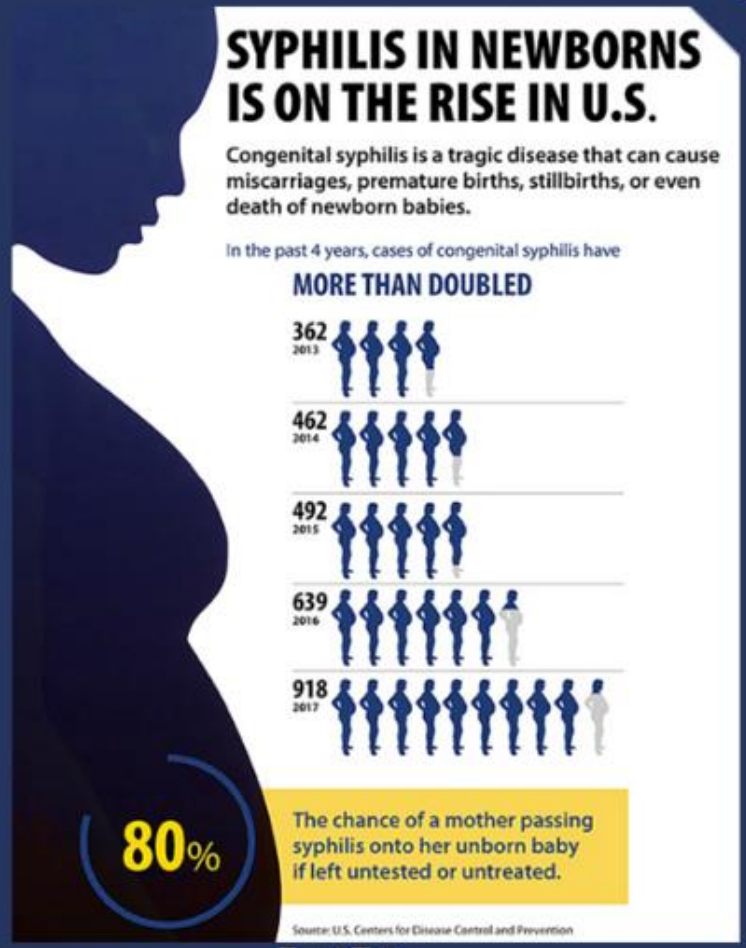
- Maculopapular rash, may involve palms and soles.
- In contrast to acquired syphilis, a vesicular rash and bullae (pemphigus syphiliticus) may develop - highly contagious.
- Mucosal involvement may present as rhinitis ("snuffles") – poor feeding.
- Nasal secretions are highly contagious.



CONGENITAL SYPHILIS (CS)

STUDIES HAVE SHOWN THAT 40% OF BABIES BORN TO FEMALES WITH UNTREATED SYPHILIS MAY BE STILLBORN OR DIE FROM THE INFECTION. THE FOLLOWING CAN OCCUR FOR BABIES BORN WITH CS:

- DEFORMED BONES
- SEVERE ANEMIA (LOW BLOOD COUNT)
- ENLARGED LIVER AND SPLEEN
- JAUNDICE (YELLOWING OF THE SKIN OR EYES),
- BRAIN AND NERVE PROBLEMS, LIKE BLINDNESS OR DEAFNESS,
- MENINGITIS
- SKIN RASHES



Protect your baby from syphilis

Thank You PEDReady Champions!

- Questions, Comments and Announcements
- Send your photos, resources, stories!

pedready@jax.ufl.edu
904-244-4986
https://emlrc.org/flpedready/

Code for presentation

FL EMSC Advisory Committee Attendance and Meeting Minutes

Seminole Hard Rock Hotel, Hollywood Florida: Terrace D

In Person & Virtual (via TEAMS)

June 15, 2023

1:00 pm – 3:00 pm EST

Attendees

State Program Staff	Committee Members	FL DOH BEMO
• Dr. Phyllis Hendry • Katelyn Perl • Amy Kennedy (virtual) • Dr. Megan Curtis-Gonzalez (virtual)	• Dr. Tricia Swan (virtual) • Dr. Jennifer Fishe (virtual) • Nichole Shimko • Sandra Nasca (virtual) • Dr. Marshall Frank • Marvin Walters • Michael Rushing • Julie Downey • Lauren Young Work • Tracey Vause	• Dr. Angus Jameson • Mike Hall • Jennifer McManus • Steve McCoy • Jane Bedford (virtual) • Christina Parmer (virtual)
Other In-Person		
• Joseph Blackwelder • Bari Conte • Dan Moran • Emily Myers • Jeffrey Dierking • Michelle Damron • Brent Allen • Elijah Virgin	• Keith Hernandez • Nicole Smith • Wendy Williams • Shawn Rolquin • Ty Campbell • Cailu Campbell • Brian Berson • Maria Fernandez	• Michael Anderson • Srikireun Botte • Lisa Deboer • Michael Johns • Shana Pender • Michael Austin • Robert Skinner • Andrea Lombardo
Other Virtual		
• Kelsey Palladino • Jordyn Zyngier • Jennifer Lauture • Dr. Joon Choi • Brenna Radigan • Casey Allen • Jeremy Sidlaukas • Kris Hood	• Dr. Sara Cortes • Julio • Sheri Medlar • Steve • Alicia Buck • Amy Perez • David Summers • Penelope Blake	• Elizabeth Blevins • Michael Davis • Tiffany Dunlap

Meeting Commenced

6/15/2023 at 1:03 pm

Presentations

Documents and Announcements Disseminated at Meeting

- Enhancing Pediatric Safety and Preparedness Proposal
- Utilizing Mobile Integrated Health Programs in Florida for Pediatric Disaster Preparedness
- Florida EMS Strategic Plan Draft
- Florida EMSC Program Manager Announcement
- Updated Florida PEDReady Resource Flyer

Welcome, Introductions, & Call to Order

- Welcome committee members, liaisons, visitors, and Pediatric Emergency Care Coordinators/Champions (PECCs)
- See attendance list and email PEDReady@jax.ufl.edu for corrections or additions
- Sample magnetic name badges were shown to committee members. The majority of members were interested in having a Florida EMSC Advisory Committee name badge.

Florida EMSC State Partnership Program Leadership and EMSC Advisory Committee Members and Liaisons

- Reviewed updated committee members and liaisons, EMSC leadership, and state partners
- The FL EMSC State Partnership Program funded by HRSA is required to be located in a state department of health or a college of medicine. A mutual decision was made to have the University of Florida College of Medicine – Jacksonville (Emergency Medicine Research) apply for the 2023 HRSA 4-year grant funding and program administration. The Florida application received a score of 95/100. This award became effective April 1, 2023. The program will remain as a collaborative state program with FL DOH BEMO.
- New EMSC Program Staff were introduced, which include:
    - Dr. Phyllis Hendry (Project and Medical Director)
    - Katelyn Perl, MS, CHES® (FL EMSC Program Manager)
    - Megan Curtis Gonzalez, PhD (HRSA EMSC Program Reporting and Compliance)
    - Morgan Henson, MPH, CPH, CCRP (FL EMSC Biospatial Data Liaison)
    - Amy Kennedy (EMSC Program Executive Assistant)
- The updated Florida PEDReady Resource flyer was disseminated
- The FL EMSC Facebook page is @floridaemsforchildren (UF)
- Current PEDReady website: https://emlrc.org/flpedready/
    - Will maintain current website on the Emergency Medicine Learning Resource Center (EMLRC), however, currently building a UF EMSC Program website
- Quarterly PE^{2}ARL newsletter
    - Restarting quarterly newsletter
    - Continuing to send PEDReady newsletter items to FCEP for biweekly news brief. Email PEDReady@jax.ufl.edu to sign up for news briefs or to have information posted.
- Committee travel reimbursement
    - You need to become a vendor within the UF system
    - Will try to fund three in-person meetings per year (currently funded for 2 in-person meetings per year)
    - Members and liaisons reimbursed for two nights
- New HRSA performance measures reviewed (see presentation slides)

- Mission, sample tagline updated based on new performance measures: "Partnering with Florida emergency departments, EMS agencies, disaster preparedness organizations, and families in the care of ill and injured children to enhance pediatric readiness across the continuum of care." The committee agreed with this updated statement.

BEMO Announcements and Updates

- Jennifer McManus is now the State EMS Education Coordinator. She will continue to work with EMSC and was recognized by the committee for all of her pediatric rural EMSC and safe transport efforts and accomplishments.
- The Office of Rural Health is now under the leadership of BEMO and Michael Leffler
- The Quality First Initiative was discussed and will include pediatric components

National and State EMS Survey Results

- Dr. Hendry reviewed pediatric-related state EMS survey results, including PECCs, age and weight-based pediatric dosing systems, continuing education, safe transport devices, pediatric death and resuscitation debriefing, and infant mortality programs
- The State 2023 EMS Survey indicated only 28 agencies or 14% reported having a PECC, however, the 2022 National EMSC Survey indicated 63 agencies had a PECC. 2023 national results are pending at this time, but it is not anticipated that the number decreased. The 2023 national rate for PECCs is 37.2%. Florida's rate in 2022 was 44.7%. Florida's 2023 National EMSC Survey participation rate was lower than 2022.
    - Agencies that had PECCs had a much higher score for their equipment usage
    - Barriers to a PECC: people are unsure of the duties of the PECC
    - There will be a pediatric readiness and PECC working group for EMS agencies and for emergency departments developed in the upcoming year

State EMS Strategic Plan

- Committee members expressed concerns about the lack of pediatric objectives in the new plan. There was discussion with Dr. Jameson and Mike Hall that the new plan will include children and pediatric data when appropriate. The challenge is the small percentage of pediatric EMS encounters compared to adults.
- Sample objectives:
    - Objective 1.1.B – Increase the number of providers earning Florida State EMS *Quality First* recognition from 0 to 100 by December 31, 2028
    - Objective 1.1.J – Increase the percentage of EMS transports originating from 911 requests in which SP02 is documented during and after intubation from 12% to 90% by December 31, 2028
    - Objective 2.1.A – Increase the percentage of EMS providers participating in injury prevention and community health promotion efforts from 23% to 50% by December 31, 2028

Old Business

- Safe Transport
    - Slide set and recording being added to website: https://youtu.be/KMP3kxHEoJc
    - A limited number of PediMates and NeoMates were purchased with remaining grant funds for rural agencies that were not covered by Health Care Coalitions
    - Program working with Health Care Coalitions to provide pediatric restraint devices to their regions
- Button Battery Ingestion Management
    - Options for administering honey were discussed and demonstrated

- Emmy - Florida Association of Broadcast Journalists Award in Health Reporting and Edward R. Murrow Award: https://www.news4jax.com/news/2022/05/12/child-unsafe-the-danger-of-button-batteries/
- The Florida Committee on Trauma Statement regarding button battery ingestion and transport was reviewed
- National Capital Poison Center Button Battery Ingestion Triage and Treatment Guideline: https://www.poison.org/battery/guideline
- The Florida EMSC button battery ingestion presentation has been updated and is available for others to use (see QR code in presentation slides). Email PEDReady@jax.ufl.edu to request the presentation.
- The importance of making dispatch and transport teams aware of the urgency of transport in these cases was discussed

- FL PEDReady Resource Bags (see images in presentation slides)
  - Contains communication cards, JumpSTART/START revised badge buddies, PALS pocket card, Handtevy badge buddies, Difficult Airway Course pocket card (adult and pediatric), ABC's of Pediatrics Emergencies chart, pain scale cards, EMRA Pediatric ECG card, pediatric acetaminophen/ibuprofen dosing magnets, NRP pocket cards, poison center magnets, etc.
  - If you would like a resource bag, email PEDReady@jax.ufl.edu; limited to one per agency or ED
- Pediatric and Educational Needs
  - Nichole Shimko discussed the upcoming webinar, "Oh Baby - Series 2 of 2," scheduled for June 27 at 12:00 p.m.
- Prehospital TXA Use in Pediatrics
  - Varying viewpoints, remain current on new literature, and follow agency medical direction and protocols
  - February 2023 statement from FCOT regarding pediatric TXA usage was reviewed
    - Waiting for PECARN study to be released
- Disaster-Related Activities and Hurricane Ian Outcomes
  - Hurricane Ian wrap-up and accomplishments were discussed
  - Big thank you to our Health Care Coalitions for prioritizing pediatric needs and purchasing pediatric restraint devices
  - Need a debriefing tool and a central repository for documents
  - Dr. Hendry and other committee members have been attending HCC pediatric tabletop exercises such as Operation Tots. Questions were asked about pediatric supplies on BLS mass casualty ambulances and family reunification plans.
  - Lauren Young Work discussed using mobile integrated health (MIH) to prepare families and children for disasters
    - There are about 51 mobile integrated health programs throughout the state of Florida – maybe more
    - See meeting attachment with information presented by Ms. Work
    - www.ready.gov
  - Will have a working group related to pediatric disaster
- State Pediatric Readiness Concept Proposal for EMS Advisory Council
  - Dr. Phyllis Hendry stated that she has no financial disclosures to make regarding this proposal for the EMS Advisory Council
  - Chief Julie Downey recommended the following motion for voting, which was approved by all committee members: "That the Florida Bureau of Emergency Medical Oversight in collaboration with the Florida EMS Advisory Council explore funding options for implementation of a voluntary Handtevy or other equivalent pediatric system in state EMS agencies based on medical director preference with priority considerations for rural agencies, areas where transport to a pediatric capable facility is > 30 minutes, and counties with high pediatric populations. Neonates, children, adolescents, special healthcare needs, and disaster preparedness should be considered in system planning."
  - Dr. Marshall Frank suggested to clarify what a "pediatric capable facility" means
- Children with Special Healthcare Needs (CSHCN)
  - STARS Update: Special needs Tracking and Awareness Response System
  - Dr. Hendry asked Dr. Jameson to comment on the Special Patient Protocol concept that was discussed at the Florida Association of EMS Medical Directors meeting regarding children with special healthcare needs that require unique medications not typically carried by EMS

agencies. Standing orders are signed by the local EMS medical director. Dr. Jameson will provide a sample to be disseminated with meeting materials.

- Family Advocacy Network (FAN)
  - Would like to have more than one representative and include different geographical regions of the state. This is a performance measure in collaboration with our FAN representative, Sandy Nasca.
  - If you would like to become a FAN or know someone that would like to become involved, please email PEDReady@jax.ufl.edu
- Pediatric Data and Biospatial EMSC Dashboard
  - Morgan Henson is training with Tom DiBernardo to develop pediatric Biospatial dashboards
  - Currently looking at years 2020-2022 and 0-18 years of age
  - The committee discussed data points they are interested in reviewing in a state aggregate level. Responses included need for pediatric mental health calls, newborn deliveries, overdoses, and time on scene. Dr. Jennifer Fishe volunteered to help with this initiative.

New Business

- National/State EMSC Performance Measures
  - Surveys
    - Required
    - Results are pending for the 2023 National EMSC EMS survey
    - 2024 National EMSC Prehospital Pediatric Readiness Survey
    - 2021 National EMSC ED Pediatric Readiness Survey for EDs: FL had a 58% response rate. Average FL score 75/100; median 76. Still pending national comparison scores due to wait for publication: https://pedsready.org/.
  - 1) Expand the uptake of Pediatric Readiness in Emergency Departments where not already done, by establishing a state, territorial, or regional Pediatric Readiness Recognition Program for hospital EDs; designating PECCs in EDs; and ensuring hospital EDs weigh and record children's weight in kilograms.
    - The recognition program would be strictly voluntary
    - Sample activities include:
      - Host online focus groups regarding the Florida ED PRRP background, purpose, and benefits to seek input on pediatric readiness recognition criteria and metrics
      - Maintain updated contact list of all EDs and hospital system ED pediatric leadership
      - Develop PRRP ED dashboard for professionals and families to include ED services, service exclusions, address, map, transfer criteria, transport and contact referral line information
  - 2) Improve Pediatric Readiness in EMS Systems by establishing a state, territorial, or regional standardized Prehospital Pediatric Readiness Recognition Program for prehospital EMS agencies; increasing PECCs in prehospital EMS agencies; and increasing the number of prehospital EMS agencies that have a process for pediatric skills-check on the use of pediatric equipment.
    - Sample activities include:
      - Maintain updated contact list of all EMS agencies, EMS training programs, and PECCs
      - Host online and in person focus groups on EMS PRRP background, purpose, and benefits to seek input on pediatric readiness recognition criteria and metrics
      - Develop planning committee and process to conduct rural EMSC Pediatric and Disaster Readiness "rodeos" with skill stations
  - 3) Increase pediatric disaster readiness in hospital EDs and prehospital EMS agencies by ensuring that disaster plans address the needs of children and 4) Prioritize and advance family partnership and leadership in efforts to improve EMSC systems of care.
    - Sample activities include:

- Review current EMS and ED pediatric disaster plans, drills, mock scenarios, training materials
- Administer online pediatric readiness disaster needs assessment and surge capacity inventory
- Family and patient perspectives will be incorporated into all performance measures

- Florida BEMO Regional EMS Coordinators
  - Regions 1, 2: Jeff Guadiana (Health, Safety & Wellness, Workforce)
  - Region 3, 4, 5: Vacant (Quality and Education)
  - Region 6: Jennifer McManus (Rural EMS, changing to Education)
  - Region 7: Tom DiBernardo (Special Projects/CARES)
- Coordinator Site Visit Potential EMSC Topics
  - Inquire about agency PECC status, pediatric equipment and training, pediatric protocols including disaster and safe pediatric transport restraint
  - Ask permission to sign up PECC or pediatric point of contact for PEDReady listserv and for weekly E-News
  - Share national and state EMSC & PEDReady resources and website (National equipment list, JumpSTART badge buddies, ABCs of Pediatric Emergencies, distraction and comfort kits, communication cards, pain and fever dosing guides, etc.)
  - Ask about pediatric challenges
  - Recognize pediatric champions and model programs
- Liaison and Constituency Group Reports
  - Rural EMS (Tracy Vause and Jennifer McManus)
    - Tracy Vause discussed his work with the Emerald Coast Healthcare Coalition. Initial surveys indicated that of the 10 counties in Region 1, 60% of agencies did not have pediatric transport equipment. This could be due to a variety of factors, including training. This is being successfully addressed by the HCC. The counties had pediatric transport equipment delivered and this continues to be a priority for Florida's coalitions.
  - FAN (Sandra Nasca)
    - Sandra Nasca supports the idea to have regional FANs in Florida, especially in the Southern part of the state. The All Grantee Meeting is in September 2023, where Ms. Nasca plans to discuss PEDReady family outreach and to help others understand PEDReady concepts. She reported on the ECHO series on disaster management with children with special healthcare needs. This series includes different scenarios that bring in children with special healthcare needs and the issues they face. The outreach committee, the PEDReady advocacy sub-committee, and the trauma domain completed the first review of the family toolkit through the education workgroup.
  - Florida Trauma Program Managers (Lisa Nichols)
    - The FCOT, FAEMSMD, and EMS Advisory Council are reviewing the issue of using national versus state Trauma Triage Protocols. This will require legislation.
  - Disaster Preparedness (Julie Downey)
    - NFPA3000 Standard is in for revision. Under that plan and working with others, they would like to remove the word "family" and use the phrase "incident reunification." Ms. Downey was able to add FL PEDReady JumpSTART as a resource. The standard will be open for public comment toward end of the year. There are a few legislative updates, including Senate Bill 250. This legislation provides $1.25 million dollars in funding for Stop the Bleed Kits to public schools and goes into effect July 1, 2023. If you are doing any training, please register at Stopthebleed.org. Bill 543, involves concealed weapons and states that our law enforcement partners will have an active assailant policy and will be trained on it every year; goes into effect July 1, 2023. The active assailant policy will model the draft policy of the Marjory Stoneman Douglas active assailant policy. Ms. Downey encourages you to work with your law enforcement partners and to complete the training with them every year.
    - Dr. Hendry commented that there are many new legislative updates that affect pediatric care. Legislative updates will be shared with committee members and will be added as a standing update for future Liaison and Constituency Group Reports.
  - Mental Health (Lauren Young Work)

- Lauren Work would like to remind everyone that 211 is available. Every 211 system in Florida has a teen help line. There has been an increase in mental health calls in children as young as 8 years-old. 988 is the federal answer to having an integrated suicide help line number. In Florida, almost all of the 988 calls are being answered by your local 211. There is a movement in mobile integrated health using challenge coins. The coins include the 988 on them and are light and affordable. Ms. Work suggested reaching out to your department to request funding for the coins.
- Dr. Hendry mentioned that FL EMSC purchased a Disaster Scenarios in Seconds Kit. After initial training the kit could be available for loan in the future.

- Data Committee and Biospatial (EMSC dashboard)
  - Dr. Hendry discussed that the data committee will be busy with all of the elements related to data in the new strategic plan.
- Community Paramedicine/Mobile Integrated Health (MIH)/Health-Access-Resiliency and Telehealth (H.A.R.T.) (Jane Bedford)
  - Dr. Hendry mentioned there are a lot of exciting things happening with MIH. They are working on getting this data in Biospatial. If you are doing anything pediatric, email PEDReady@jax.ufl.edu.
- Florida Emergency Nurses Association (ENA) (Michael Rushing)
  - On a national level, ENA is having discussion regarding workplace violence, human trafficking awareness, and pediatric readiness with promotion of PECCs. ENPC and NRP courses have been provided to rural area critical access hospitals using rural roads to healthcare grants. EMS courses include tactical medical courses, active shooter courses in schools, and churches with pediatric patients. ENA is promoting the use of pediatric readiness survey results to encourage hospital improvements regarding PECC, pediatric readiness EDs, and EMS communities. Discussion with emergency nurses on button battery ingestion management is consistent with this focus. Mr. Rushing would like to present Dr. Hendry's button battery slides to the ENA group. All nursing licenses in Florida require human trafficking continuing education. Mr. Rushing recommends encouraging human trafficking CEs for EMS providers.
  - Dr. Hendry commented that it would be helpful if the ENA could help with obtaining the point of contact for Florida EDs to help with future surveys.
- EMS Educators
  - Dr. Hendry mentioned that there are efforts to try to improve pass rates for the schools. FL EMSC has worked on obtaining a point of contact for the schools so they can be sent pediatric resources. Many of the schools have reached out for resources to help with education efforts. A PECC is a point of contact; a champion. FL EMSC has loaned out the Scenario in Seconds to some schools throughout Florida. The importance of getting paramedics interested in pediatrics while they're in school was mentioned.
- PECCs (Jeremiah Rabish, Sarah Weed, Ernest Weishaupt, and Marvin Walters)
- Pediatric and Neonatal Transport Network Association (FNPTNA)
  - Nichole Shimko discussed the Safety Summit and CNPT Review will be September 13-14, 2023 in the Clermont area. There is national attention on the FNPTNA disaster and evacuation plan and process used in Hurricane Ian. The organization's work on this has been accepted or presented to five different conferences so far.
- Injury Prevention (David Summers)
  - David Summers discussed that he encouraged his PIER group to partner with schools to complete training on Stop the Bleed. Mr. Summers is promoting EMSC and the safe transport program. One of the areas of interest is in transportation-related injuries. There was discussion around opioid issues throughout the state and CORE. Mr. Summers discussed falls and he will be holding a live session on pediatric falls and injuries.
- Children's Medical Services, Child Death, Child Abuse
  - Brenna Radigan, Prevention Specialist/Program Analyst with Child Abuse Death Review Unit of CMS reviewed her organization's work with fire departments and others on drowning prevention. Dr. Hendry displayed some of the materials. They have done several events this Summer. If individuals are interested, you can reach out to Joshua.Thomas@flhealth.gov or Brenna.Radigan@flhealth.gov. Ms. Radigan discussed that they partnered with 9 different counties who had the highest rates of infant-related sleep death. They have been providing safe sleep bags and education to

parents and hospitals. A sample bag was shown to the committee. To obtain a bag or learn more, reach out to Joshua Thomas and Brenna Radigan.

- EMSC Day 2024
  - For EMSC Day in May 2024, FL EMSC would like to plan an event
- Future Meetings
  - State EMS Meetings on October 4-6, 2023, at Henderson Beach Resort in Destin, Florida
  - Florida Fire Conference on January 10-12, 2024, at Orange County Convention Center in Orlando, Florida
- New Trends
  - Dr. Hendry discussed that there has been a rise in congenital syphilis cases in the past decade. Reported cases of congenital syphilis increased during 2009–2018 in Florida from 21 to 108 (414%) and in the United States (US) from 427 to 1,306 (206%). At the same time, reported cases of infectious syphilis among women increased by 142% in Florida from 147 to 356 and 124% in the US from 2,232 to 4,995. These children do not necessarily present at birth. Symptoms of congenital syphilis and ED screening for congenital syphilis were discussed. Click the link to learn more about congenital syphilis: https://www.floridahealth.gov/diseases-and-conditions/sexually-transmitted-diseases/std-fact-sheets/congenital-syphilis.html.

Contact Information

- Email: PEDReady@jax.ufl.edu
- Phone Number: 904-244-4986
- Website: https://emlrc.org/flpedready/

Meeting Adjourned

6/15/2023 at 3:00 PM

Katelyn Perl, MS, CHES®
Florida EMSC Program Manager
June 2023

Katelyn Perl is joining the Florida Emergency Medical Services for Children (EMSC) Program as the new Program Manager. The program is now housed administratively at the University of Florida College of Medicine - Jacksonville (UFCOM-J) in the Division of Emergency Medicine Research. Ms. Perl has a Bachelor of Science degree in Applied Physiology and Kinesiology, a Master of Science in Health Education and Behavior from the University of Florida and is a Certified Health Education Specialist (CHES®). She is transitioning from her current UFCOM-J position with the Pain Assessment and Management Initiative (PAMI) where she served as Program Manager and educator for a federally funded model Pain Coach Educator and Toolkit Program. Although she will miss her PAMI colleagues and stakeholders, she is thrilled to join the EMSC team!

Florida EMSC and Pediatric Readiness Concept Proposal: Enhancing Pediatric EMS Safety and Preparedness by Implementing a Voluntary System for Medication Dosing, Equipment, and Local Level Protocols

Background

- Pediatric patients (0-18 years) comprise only 6-10% of EMS transports.
- Florida EMS agencies must be prepared to take care of children ranging from a premature newborn to an adult sized adolescent - 24/7/365.
- EMS professionals perform infrequent pediatric critical procedures (<1% of all pediatric encounters) and medication dosing (~20% of pediatric encounters).
- Pediatric EMS calls present a high potential for patient safety events and risks. Pediatric and newborn patients in general present a high risk for liability.
- Children have unique differences in anatomical, physiological, developmental, and injury mechanisms that result in different responses to trauma and medical disorders including disaster settings such as chemical and radiation incidents.
- The majority of children receive initial emergency care in or transport to non-pediatric facilities.
- Pediatric interfacility transfers have increased across the country by approximately 30% in the last decade due to closure of pediatric and OB inpatient units, the rapid growth of free standing EDs, and other factors leading to rural agencies and EDs managing critical ill or injured children and newborns for hours if air services are not available.
- Dealing with pediatric EMS calls presents unique challenges including managing concerned or emotional parents, caregivers, and siblings.
- Pediatric resuscitations or death experiences produce a large emotional burden for prehospital professionals.
- 1 out of 5 children in the US have a special healthcare need (physical, developmental, behavioral, or technology dependent).

All EMS agencies need a system to treat newborns, children, and adolescents based on age, weight, and developmental level.

Models of Age and Weight Based Pediatric Management

- Florida statute requires a pediatric length-based measurement device for equipment selection and drug dosage. The purpose of the device is to give an approximate weight based on length when the actual weight is unknown.
- National pediatric emergency position and policy statements recommend a length and/or weight based system and volumetric dosing guides.

- The Broselow Tape, a color-coded length-based tape, was first developed in 1985 to relate a pediatric patient's height to their *approximate* weight to determine equipment size and dosages of medication during emergencies. This concept expanded into national pediatric resuscitation protocols and algorithms, electronic health systems, and other pediatric emergency management systems.
- The 2023 Florida EMS survey indicates that 51% of agencies employ the Handtevy Pediatric Emergency Standards system to determine pediatric medication dosing and equipment size selection; 43% use a Broselow Resuscitation Tape; 2% use local agency policy; and 1% use the Pedi-Sleeve Pediatric Dosing System
- The Handtevy System has some unique advantages:
    - Use in all ages- pediatric and adult
    - Includes protocols and checklists with the ability to utilize local or model protocols; offers a mobile platform and app
    - Provides medication concentrations, dose, and volume to administer
    - Peer reviewed publications and scientific abstracts demonstrate significant reduction in medication errors, time to drug administration, and cognitive errors along with significant increases in ROSC rates.

State Need

- Florida EMS agencies are requesting funding assistance for the Handtevy system via state EMS matching grants, Florida EMSC, and requests to local healthcare coalitions; however, funds are limited. Recent hurricanes and mass disasters in Florida and nationally demonstrated gaps and needs in pediatric emergency care.
- Several states in the US have funded and deployed the Handtevy System at a state level (VA, Utah, HI, AK, LA).

Proposal Request

That the Florida Bureau of Emergency Medical Oversight in collaboration with the Florida EMS Advisory Council explore funding options for implementation of a voluntary Handtevy or other equivalent pediatric system in state EMS agencies based on medical director preference with priority considerations for rural agencies, areas where transport to a pediatric capable facility is > 30 minutes, and counties with high pediatric populations. Neonates, children, adolescents, special healthcare needs, and disaster preparedness should be considered in system planning.

Let's treat all children in Florida the way we want our own children and family managed in an emergency or disaster situation!

Florida PEDReady

Utilizing Mobile Integrated Health Programs in Florida for Pediatric Disaster Preparedness

- There are 51 programs in Florida.
- MIH is able to facilitate telehealth outreach and/or in home visits.
- MIH personnel are skilled at identifying needs, connecting patients and families to resources, educating, and creating plans in partnership with patients and families.
- MIH personnel are trusted within the community due to the connection with EMS.
- As seen during COVID response, MIH programs can stand up an initiative very quickly and effectively.
- Initiatives could be scaled to community needs and program capacity, from integrating disaster planning questions in to assessment/planning with existing MIH patients/families to providing disaster planning resources offered by FEMA through targeted outreach with specific populations through access points and/or partnerships.

Potential Access Points for MIH to connect to families with children/teens

- ✓ **Crew referrals after 911 interaction**
- ✓ **Existing MIH patients/families**
- ✓ EOC special needs shelter registries
- ✓ Pediatric hospitals
- ✓ Pediatric urgent care centers
- ✓ STARS
- ✓ Hospice agencies
- ✓ CPS partnerships
- ✓ Therapy centers
- ✓ CARD
- ✓ Florida managing entities
- ✓ Special needs childcare centers
- ✓ Childcare centers and preschools
- ✓ School system ESE programs
- ✓ County departments managing youth and family programs
- ✓ County Parks and Recreation Department partnerships
- ✓ County library systems
- ✓ County Health Department
- ✓ Pediatricians
- ✓ 211
- ✓ Community organizations serving children/teens (i.e. YMCA, Healthy Mother's, Healthy Babies, etc.)
- ✓ And more….

Planning Resources & Engagement Tools:

https://www.ready.gov/kids

Need to know more about MIH or learn if your community has any MIH programs? Contact Lauren Young-Work, LCSW at LDYoung@pbcgov.org or Michael Leffler at Michael.Leffler@flhealth.gov

Priority 1: National Leader in Quality Clinical Care

Goal 1.1: Safe and Effective

Objective 1.1.A – Increase the percentage of Emergency Medical Services (EMS) providers participating in the Florida State EMS Quality Coaching Program from 1% to 40% by December 31, 2028.

Objective 1.1.B – Increase the number of providers earning Florida State EMS Quality First recognition from 0 to 100 by December 31, 2028.

Objective 1.1.C – Increase the percentage of data submission quality, specifically fully validated submissions, from 38% to 90% by December 31, 2028.

Objective 1.1.D – Increase the percentage of electronic patient care records (ePCR) submitted to the EMS Tracking and Reporting System (EMSTARS) from 79% to 95% by December 31, 2028.

Objective 1.1.E – Increase the percentage of EMS transports originating from a 911 request for patients with suspected ST-elevation myocardial infarction (STEMI) during which aspirin is administered during or before the EMS encounter from 64% to 90% by December 31, 2028.

Objective 1.1.F – Increase the percentage of non-traumatic cardiac arrest patients who received bystander cardiopulmonary resuscitation (CPR) from 30% to 50% by December 31, 2028.

Objective 1.1.G – Increase the percentage of non-traumatic cardiac arrest patients who achieved a return of spontaneous circulation (ROSC), both prehospital and upon arrival to the Emergency Department, from 22% to 30% by December 31, 2028.

Objective 1.1.H – Increase the percentage of EMS transports originating from a 911 request for patients suffering from suspected sepsis during which a sepsis pre-arrival (Pre-Alert) notification is made from 45% to 90% by December 31, 2028.

Objective 1.1.I – Increase the percentage of EMS transports originating from a 911 request for patients with suspected sepsis in which ETCO2 is documented from 79% to 90% by December 31, 2028.

Objective 1.1.J – Increase the percentage of EMS transports originating from 911 requests in which SP02 is documented during and after intubation from 12% to 90% by December 31, 2028.

Objective 1.1.K – Increase the percentage of advanced airway procedures performed during an EMS response originating from a 911 request in which placement was verified with ETCO2 from 84% to 100% by December 31, 2028.

Objective 1.1.L – Increase the percentage of EMS responses originating from 911 requests for non-cardiac arrest patients who successfully receive advanced airway placement without hypoxia or hypotension on first attempt (FAIR Measure Airway 19) from 26% to 80% by December 31, 2028.

Goal 1.2: Timely and Efficient

Objective 1.2.A – Increase the percentage of patients, ages 35 and up, with initial complaint non-traumatic chest pain/acute coronary syndrome (ACS) symptoms to receive a 12 Lead electrocardiogram (ECG) in 10 minutes or less of arrival or EMS First Medical Contact from 82% to 90% by December 31, 2028.

Objective 1.2.B – Increase the percentage of ST-elevation myocardial infarction (STEMI) alert events, in which the on-scene time is less than or equal to 15 minutes, from 82% to 90% by December 31, 2028.

Objective 1.2.C – Increase the percentage of stroke alert events, in which the on-scene time is less than or equal to 15 minutes, from 84% to 90% by December 31, 2028.

Objective 1.2.D – Increase the percentage of trauma alert events, in which the on-scene time is less than or equal to 10 minutes, from 13% to 50% by December 31, 2028.

Objective 1.2.E – Increase the percentage of incidents where Telecommunicator CPR (T-CPR) was utilized in which compressions were initiated from 67% to 80% by December 31, 2028.

Objective 1.2.F – Increase the percentage of trauma alert patients in which the total time from unit notified by dispatch time to patient arrived at destination time is less than or equal to 60 minutes from 89% to 95% by December 31, 2028.

Goal 1.3: Patient-Centered

Objective 1.3.A – Increase the percentage of providers utilizing patient satisfaction surveys from 46% to 80% by December 31, 2028.

Goal 1.4: Enhance Data Systems and Linkages to Provide the Infrastructure to Facilitate Data Driven Advancement of EMS Care

Objective 1.4.A – Increase the percentage of Health Information Exchange (HIE) outcome data matching to EMS records from 21% to 75% by December 31, 2028.

Goal 1.5: Support Development and Implementation of Evidence-Based EMS Practices

Objective 1.5.A – Increase the number of peer-reviewed EMS-related journal articles to which the Department contributed from 0 to 25 by December 31, 2028.

Objective 1.5.B – Increase the number of evidence-based model resources developed by the Medical Care Committee from 0 to 2 per year by December 31, 2028.

Objective 1.5.C – Increase the percentage of providers using prescriptive learning based upon quality improvement data from 0% to 80% by December 31, 2028.

Priority 2: Improving Community Health

Goal 2.1: Injury Reduction and Community Health Promotion

Objective 2.1.A – Increase the percentage of EMS providers participating in injury prevention and community health promotion efforts from 23% to 50% by December 31, 2028.

Objective 2.1.B – Increase the percentage of EMS providers providing mobile integrated healthcare (MIH) from 16% to 33% by December 31, 2028.

Goal 2.2: EMS Engagement with Substance Use Disorder (SUD) Programs

Objective 2.2.A – Increase the percentage of counties where at least one EMS provider is participating in a community-based SUD program from 13% to 100% by December 31, 2028.

Objective 2.2.B – Increase the percentage of ground EMS providers with the treatment and transportation protocol that addresses SUD patients from 7% to 90% by December 31, 2028.

Objective 2.2.C – Increase the percentage of ground-based 911 EMS providers that participate in the naloxone (Narcan) leave-behind program from 17% to 70% by December 31, 2028.

Priority 3: Sustainable EMS Systems

Goal 3.1: EMS Workforce that Meets the Demands of the System

Objective 3.1.A – Decrease the percentage of licensure attrition rate of certified paramedics from 9% to 4% by December 31, 2028.

Objective 3.1.B – Decrease the percentage of licensure attrition rate of certified emergency medical technicians from 21% to 15% by December 31, 2028.

Objective 3.1.C – Increase the percentage of paramedic first-time National Registry pass rate from the state average of 58% to 80% by December 31, 2028.

Objective 3.1.D – Increase the percentage of emergency medical technician first-time National Registry pass rate from the state of 69% to 80% by December 31, 2028.

Goal 3.2: Improve the Utilization of EMS Resources

Objective 3.2.A – Decrease the percentage of low acuity 911 transports to an emergency department, including free-standing, from 15% to 8% by December 31, 2028.

Goal 3.3: Improve Public Safety Telecommunicator (PST) System Resiliency

Objective 3.3.A – Decrease the percentage of attrition rate certified PST from 27% to 15% by December 31, 2028.

Priority 4: Protecting the Public and Providers

Goal 4.1: Improve Provider Safety and Wellness

Objective 4.1.A – Decrease the percentage of reported incidences of threats or use of physical force against EMS workers that results in or has a high likelihood of resulting in injury, psychological trauma, or stress from 65% to 50% by December 31, 2028.

Objective 4.1.B – Increase the percentage of EMS providers that participate in a Behavioral Health Assistance Program (BHAP) from 56% to 80% by December 31, 2028.

Objective 4.1.C – Decrease the number of annual suicides within the EMS workforce, including PST, from 18 to 0 by December 31, 2028.

Priority 5: Promoting Innovation in EMS

Goal 5.1: Utilize the Department's Data Sources to Advance Patient Care

Objective 5.1.A – Increase the number of EMS research projects that the Department participates in from 3 to 5 by December 31, 2028.

Goal 5.2: Integrate Emerging Technologies to Improve Patient Care Delivery

Objective 5.2.A – Increase the percentage of providers utilizing telehealth from 10% to 70% by December 31, 2028.

Objective 5.2.B – Increase the number of predictive analytical reports from 0 to 10 by December 31, 2028.

Objective 5.2.C – Increase the number of collaborative programs with county health departments bi-directionally exchanging bio-surveillance data with EMS providers to identify emerging health threats from 1 to 67 by December 31, 2028.

Priority 6: Preparedness, Response, and Recovery to Disasters and Emerging Public Health Threats

Goal 6.1: Build and Enhance a Sustainable System for Preparedness, Response, and Recovery for Disasters and Emerging Public Health Threats

Objective 6.1.A – Increase the number of ambulance services pre-registered for response in the ESF-8 state ambulance deployment plan (Ambulance Deployment Standard Operating Guidelines) from 0 to 50 by December 31, 2028.

Objective 6.1.B – Increase the number of EMS pre-staging areas from 0 to 20 by December 31, 2028.

Objective 6.1.C – Increase the percentage of EMS providers who participate in regional healthcare coalition activities from 54% to 75% by December 31, 2028.

Objective 6.1.D – Increase the percentage of licensed 911 ground EMS providers who use an active shooter/hostile events response guideline that is substantially similar to the National Fire Protection Association (NFPA) 3000 standard on for preparedness, response, and recovery from an active shooter/hostile event from 55% to 95% by December 31, 2028.

Goal 6.2: Community Preparedness and Education

Objective 6.2.A – Increase the percentage of licensed 911 ground EMS providers providing public outreach for hemorrhage control programs/tourniquet usage substantially similar to Stop the Bleed from 40% to 80% by December 31, 2028.

Objective 6.2.B – Increase the percentage of EMS providers who have a written agreement with a county health department to provide immunization or public health countermeasure programs from 36% to 75% by December 31, 2028.

CS11 SPECIAL PATIENT PROTOCOL

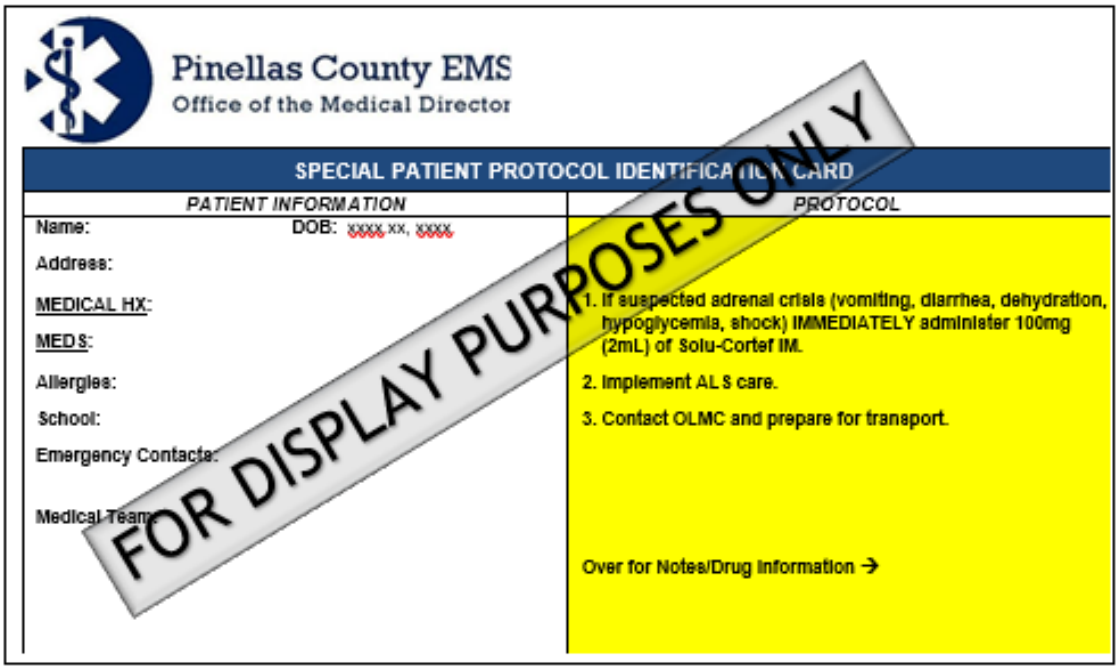
Background:

- From time to time, we encounter a patient who has an unusual medical condition or requires specialized treatment modalities outside of our normal operating protocols
- We cannot write protocols for each of these unusual situations into the Medical Operations Manual (MOM)
- It is important to be able to rapidly identify these types of patients and implement the appropriate specialized care

Policy:

- A patient with an unusual medical condition(s), that requires specialized treatment, will be issued a Pinellas County EMS "Special Patient Protocol Identification Card". The card contains the patient demographics, background information, standing orders and any applicable drug information
- The patient will be instructed to carry the card with them at all times and present to EMS clinicians upon initial contact. Any specialized medications needed, shall be kept by the patient with the card
- Pinellas County EMS Clinicians are authorized to follow the standing orders as printed on the card, upon being presented with such a card, after verifying the patient's identity
- OLMC Physicians retain ultimate discretion in the management of all patients and may be contacted for any clinical guidance or questions or as specified on the card
- This card will have an expiration date and a copy of the card with supporting information will be kept on file. ALS First Responders in areas frequented by such patients (e.g. home, work, school) will be advised when a card is issued and provided with a copy of the card. Additionally, CAD Caution Notes will be added to the home address for these patients

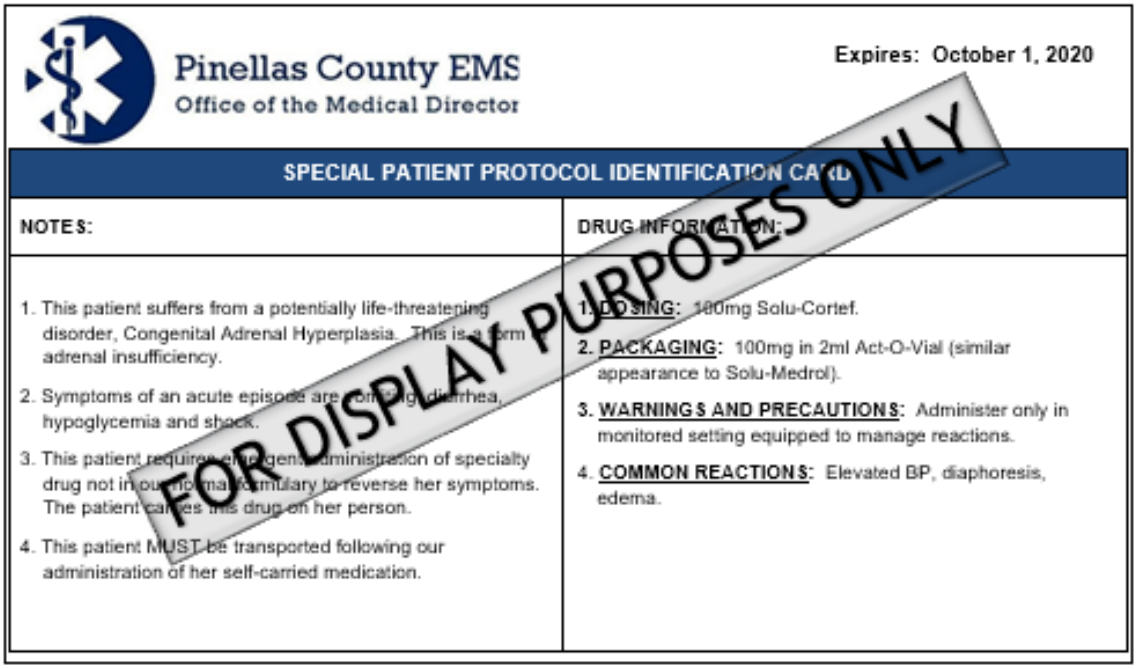
CS11 SPECIAL PATIENT PROTOCOL



Pinellas County EMS
Office of the Medical Director

SPECIAL PATIENT PROTOCOL IDENTIFICATION CARD

PATIENT INFORMATION	*PROTOCOL*
Name: DOB: xxxx xx, xxxx Address: MEDICAL HX: MEDS: Allergies: School: Emergency Contacts: Medical Team:	1. If suspected adrenal crisis (vomiting, diarrhea, dehydration, hypoglycemia, shock) IMMEDIATELY administer 100mg (2mL) of Solu-Cortef IM. 2. Implement ALS care. 3. Contact OLMC and prepare for transport. Over for Notes/Drug Information →



Pinellas County EMS
Office of the Medical Director

Expires: October 1, 2020

SPECIAL PATIENT PROTOCOL IDENTIFICATION CARD

NOTES:	DRUG INFORMATION:
1. This patient suffers from a potentially life-threatening disorder, Congenital Adrenal Hyperplasia. This is a form of adrenal insufficiency. 2. Symptoms of an acute episode are vomiting, diarrhea, hypoglycemia and shock. 3. This patient requires emergent administration of specialty drug not in our normal formulary to reverse her symptoms. The patient carries this drug on her person. 4. This patient MUST be transported following our administration of her self-carried medication.	1. DOSING: 100mg Solu-Cortef. 2. PACKAGING: 100mg in 2ml Act-O-Vial (similar appearance to Solu-Medrol). 3. WARNINGS AND PRECAUTIONS: Administer only in monitored setting equipped to manage reactions. 4. COMMON REACTIONS: Elevated BP, diaphoresis, edema.