



**Testimony of  
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**Fiscal Year 2009-2010 Performance Oversight Hearing  
District of Columbia Fire and Emergency Medical Services (EMS)  
Committee on Public Safety and the Judiciary  
Council of the District of Columbia**

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Children's National Medical Center, a 283 bed not-for-profit academic medical center located at 111 Michigan Avenue, NW, has provided hope to sick children and their families for more than 140 years. With Children's Hospital, seven primary care facilities, one outpatient center, two facilities providing specialty care services, and two pediatric practices located in the District of Columbia, Children's National is proud to provide convenient, high quality pediatric primary and specialty care to the District's children and families.

**Pediatric Emergency Services at Children's National**

The Division of Emergency Medicine at Children's National provides emergent medical and trauma care for the approximately 130,000 children who live in the District of Columbia and also a large regional catchment area. Last year, the Emergency Medicine and Trauma Center (EMTC) at Children's National provided care for more than 85,000 children. Approximately 56 percent of the children who seek care at our Emergency Department reside in the District. Because of the large number of visits, Children's National's EMTC can be, on any given day, the busiest emergency department of any type in the city, and is one of the busiest pediatric emergency departments in the country.

The EMTC is an American College of Surgeons verified Level I Pediatric Trauma Center and serves as such for the District of Columbia and the State of Maryland. The EMTC is also designated by the Maryland Institute for Emergency Medical Services Systems as a pediatric base station. The District of Columbia does not have a similarly codified designation as part of its emergency medical services system, but through Children's National's Emergency Communications and Information Center, emergency medical technicians and paramedics from any EMS system, including the District, have access to a board-certified pediatric emergency medicine attending physician 24 hours a day, seven days a week.

In 1980, simultaneous with children's hospitals in Kansas City and Philadelphia, Children's National Medical Center was the first to offer a subspecialty training program in pediatric emergency medicine. The attending faculty who constitute the Division of

Emergency Medicine and staff the EMTC are graduates of this subspecialty training and, per medical staff requirement, are certified by the American Boards of Pediatrics and Emergency Medicine.

The Division of Emergency Medicine at Children's National is a recognized national leader in the development of best practices in emergency medical services and pre-hospital pediatrics. Dr. Joseph Wright, a long-standing member of the Division of Emergency Medicine, has served on the Mayor's Emergency Medicine Advisory Committee, is the EMS Medical Director for Pediatrics for the State of Maryland, and also appeared before and submitted recommendations to the Task Force on Emergency Medical Services, which was created as part of a settlement agreement with the family of David E. Rosenbaum. Through Dr. Wright and a number of other faculty members in the Division of Emergency Medicine, Children's National has been deeply invested and involved in emergency medical services for children in the District of Columbia for more than 25 years.

### **The Continued Need for an Emergency Medical Services for Children Program**

Early EMS systems were designed to provide rapid intervention for sudden cardiac arrest in adults and rapid transport for motor vehicle crash victims. However, as identified in the 1993 Institute of Medicine report entitled *Emergency Medical Services for Children*, adult systems do not meet children's specialized needs. Children suffer from different diseases and injuries and react differently - physically, psychologically, and emotionally - to traumatic illness and injury. Additionally, when it comes to medical supplies and equipment, there is no "one size fits all" for children.

In response, pediatricians and pediatric surgeons, identifying poor outcomes among children receiving emergency medical care, became advocates on behalf of their patients. They sought to obtain for children the same positive results that EMS had achieved for adults. Through their advocacy, federal legislation passed in 1984 to establish the Emergency Medical Services for Children (EMSC) program. Since then, EMSC grants have helped all 50 states and the District of Columbia to improve emergency care for children.

Children's National has played a key role in facilitating the EMSC program across the country and in the District. Children's National houses the EMSC National Resource Center (NRC), which was established in 1991. The NRC works with states to identify the resources needed to organize and implement EMSC activities throughout the nation. These include providing guidance in securing funding, developing injury prevention plans, building coalitions, shaping public policy, training pre-hospital and hospital care providers, producing educational resource materials, and much more.

Children's National commends Councilmember Mendelson and the Committee on Public Safety and the Judiciary for their leadership in the enactment of Law 17-0357, the "Emergency Medical Services Act of 2008." While many of the provisions of this bill

were enacted in response to the Rosenbaum family tragedy, the bill also formally recognized the District's EMSC program for the first time. Currently, at least 29 other states and Puerto Rico have statutes either institutionalizing EMSC through the establishment of a state-level EMSC program or allow for pediatric input into an EMS-related board. Through the enactment of this bill, the District has joined many other states in recognizing the EMSC program as an institutional part of its overall governmental structure.

In order to measure the effectiveness of federal grant programs, the Health Resources and Services Administration (HRSA), which is part of the U.S. Department of Health and Human Services, requires states and the District to report on specific performance measures related to their grant-funded activities. These measures were created to drive the programmatic direction of the funding. The District has made progress towards meeting these measures, particularly over the last few years. An example of this progress is the fact that emergency medical technicians (EMTs) are now required to maintain National Registry certification. Maintaining National Registry certification requires the completion of pediatric continuing education. We appreciate that, over the last two years, we have received improved support from the District's Fire and EMS (DCFEMS) Department as a partner as we strive to meet these measures. We have also received support from DCFEMS for other projects that we are working on through our federal grant including the creation of an electronic registry for Children with Special Health care Needs in the District. Our goal is to integrate this registry into the 911 and emergency dispatch system to allow pre-hospital providers to be better prepared when called to the home of a child with special health care needs.

However, there are still performance measures that we are unable to meet. These include ensuring pediatric representation on the Emergency Medical Services Advisory Committee (EMSAC). Since the EMSAC has not been convened, we are unable to meet this requirement.

Another performance measure requires the provision of pediatric offline medical direction for EMTs (pre-hospital protocols). The current pediatric pre-hospital protocols in use were drafted in 2001. Recently, the pre-hospital protocols were revised under the direction of the former Director, Dr. James Augustine. During this process, we were informally asked to review and edit the pediatric portion of these protocols. We appreciate being given this opportunity. However, these protocols are still not in effect and there is no established process for ensuring that they are maintained and updated on a regular basis.

Additional measures that we have not been able to meet include:

- The development of a system for recognition of facilities that are prepared to manage pediatric medical and traumatic emergencies;
- The presence of inter-facility transfer guidelines for medical emergencies: Transfer guidelines help to facilitate a well-coordinated system that encompasses

- procedures for getting children to the best treatment facility as quickly as possible; and
- Compliance with nationally-recommended equipment guidelines for ambulances: These guidelines recommend essential pediatric equipment and supplies needed to adequately treat and transport pediatric patients.

These are examples of areas in which a legislative mandate may help improve the ability of the District's EMS system to provide excellent care for children. It is our experience that if children's needs are not explicitly included in legislation and policies, they are implicitly excluded.

### **Historical Timeline**

To frame the issues of current concern, it is critical to understand the chronology of several important points in time:

- **1997** – HRSA approached Children's National Medical Center to seek assistance in facilitating application by the Government of the District of Columbia for procurement of state partnership funding through the federal EMSC program. The District was the only jurisdiction among 50 states and 5 U.S. territories not to have applied for designated funding in this state partnership category expressly targeted at improving emergency medical services for children at the local level. Although not a block grant, the intent of the federal program was clearly to get these funds into states, territories and the District through a competitive grant process. Despite active solicitation, this non-application on the part of the municipal government persisted for several years before Children's National was approached.

Children's National was not successful in convincing the then-Emergency Medical Health Services Administration of the Department of Health (DOH) to be the primary applicant for this funding as specified in the grant guidance. The federal program, with permission of the then-Director of DOH, agreed to allow Children's National to apply for this category of funding in lieu of the District government.

- **1998-2003** – As successful state partnership grant holders, Dr. Wright and the EMSC leadership team from Children's National Medical Center are actively engaged participants on the Mayor's Emergency Medical Services Advisory Committee (EMSAC), which was managed and overseen by the Emergency Health and Medical Services Administration of the DOH with active participation and input from the Fire and EMS Department. There were a number of noteworthy accomplishments achieved during this period, including a complete revision of the pediatric pre-hospital protocols, which, along with the rest of the EMS protocols, were more than a decade out of date and obsolete. Also, Children's National offered pediatric training and continuing education expressly to DC Fire and EMS personnel, which at that time were well-subscribed and supported by Fire and EMS leadership. One of the specific training modules developed during this period on the care of children with special

health care needs received national recognition as Product of the Year by the federal EMSC program.

- **2004** – EMSAC was inexplicably disbanded and has yet to be re-seated. With the loss of this oversight function, coordination of EMSC activities with the municipal stakeholders became much more difficult and active participation of governmental partners began to wane significantly.
- **2006–present** - The District of Columbia EMSC State Partnership grant is awarded its third competitive renewal in 2006 and its fourth competitive renewal in 2009 with Children’s National as the applicant. One of the performance measures calls specifically for the establishment of a regulatory presence and permanence of EMSC in the municipal governance structure.

### **The RAND Report on Health and Health Care in the District of Columbia**

Several findings from the RAND report released in 2008 highlight the concerns that Children’s National has about the quality of pre-hospital emergency medical services for children in the District of Columbia:

- **“Inconsistencies between the EMS training curriculum and actual EMS protocol”** – In the pediatric pre-hospital protocols that Children’s National revised for the District of Columbia in 2002, we were very adamant about the fact that paramedics need to have the pharmacologic capability in their formulary to treat a seizing patient of any age, especially a child, where prolonged status epilepticus can lead to hypoxia and brain injury. We wrote the use of benzodiazepines into the protocols, highlighting how out-of-step with current pre-hospital practice the District was by not providing this basic level of care to its citizenry. To date, this discrepancy has not been rectified and remains a major disparity in care. Children on one side of Eastern, Southern and Western Avenue’s who are seizing uncontrollably receive a nationally-recognized standard of care for this condition while enroute to Children’s National, while those inside the District boundaries receive a sub-standard level of care in the back of a DC Fire and EMS ambulance.
- **“Despite indications that changes to protocols would be supported by both DC FEMS and HEPRA, there does not appear to be an established process in place for this purpose”** – Under the previous advisory structure, i.e. the Mayor’s EMSAC run by HEPRA’s precursor, the Emergency Health and Medical Services Administration, we had a highly functional, multi-disciplinary body composed of individuals from every component of the emergency medical services continuum dedicated to working together to improve the system. The interests of public safety, hospitals, government, health and the citizenry were all represented around the table. The work of the EMSAC was supported by a very active subcommittee structure, and we were able to address all aspects of system operation and function. Protocol assessment, development and revision was successfully managed, albeit briefly, through this process.

Unfortunately, EMSAC has not been convened since 2004. Because of the absence of a functioning EMSAC, the protocol process is, once again, falling into obsolescence with the most recent revision dating back to 2002. This is a function that requires constant tending and expert oversight.

Children's National is appreciative to Mayor Adrian Fenty and his administration for issuing Mayor's Order 2007-174, which re-establishes EMSAC and defines its composition and operations. We commend the Committee for including language in Law 17-0357 that formally recognizes the EMSAC program. We also commend the Committee for including language in Law 17-0357 requiring pediatric representation in EMSAC. As already mentioned, emergency services provided for children are much different than those provided for adults. Thus, EMSAC will be better prepared to meet the needs of all residents of the District of Columbia if there is a voice that represents pediatric trauma care. Despite these actions, however, EMSAC has not been convened by the Mayor since 2004.

- **“Few opportunities for continuing education currently appear to be available”-** Children's National has long been committed to pre-hospital education and training. Through our Institute for Pre-hospital Pediatrics and Emergency Research, we have regularly offered continuing education courses, such as Pediatric Advanced Life Support (PALS) and Pediatric Education for Pre-hospital Providers (PEPP). We have also, in the past, offered dedicated training to DCFEMS both at the training academy and at Children's National. Among the most disappointing challenges that we've faced over the last decade in working with the District is the lack of a consistent commitment to pediatric continuing education. We have offered a number of courses with reserved slots for DCFEMS personnel that have gone under-subscribed or completely unattended. The most common explanation that we've received is that management can't afford or is unwilling to cycle personnel out of active duty shifts for continuing education; and that medics are not willing to receive such education “off the clock.” In the last two months, we were able to offer tuition-free PALS courses for 16 DCFEMS paramedics. These courses are taught by Children's National staff with specific expertise in pediatric emergency care. We will continue to offer these classes. However, the availability of this funding is sporadic and, as noted above, does not cover the real costs of the training to DCFEMS or Children's National. A more consistent commitment of resources is needed to maintain a pre-hospital work force that is prepared to recognize or care for critically ill or injured children in the field.

In 2009, Children's National released its Pediatric Health Needs Assessment, which was conducted by the RAND Corporation. The report, “Health and Health Care among District of Columbia Youth,” is a comprehensive study of the health and health care of the youth who reside in the District of Columbia. According to the study, a disproportionately large amount of children who are publicly insured utilize the ED. Additionally, a substantial amount of children who do not utilize a medical home utilize the ED for their primary care. Although many of these children are not transported to the

ED through DCFEMS, it is still critically important that the District's EMS system be appropriately equipped to care for the sizeable amount of children who continue to utilize the ED.

## **Recommendations**

Unlike other emergency departments in the District, the issue at Children's National is not ED diversion; in fact, as cited in the RAND report, despite being the only hospital operating at or near full capacity, we are able to employ a 'no diversion' policy such that no child in the District of Columbia or anywhere in the surrounding region will ever be diverted away from Children's National's expert care. Our main concern centers around the quality of services delivered to children in the pre-hospital setting and the government's role in ensuring access to safe and equitable care.

As such, Children's National recommends the following:

- A renewed commitment to pediatric pre-hospital continuing education and training among EMS personnel;
  - Children's National can commit to providing a practical rotation in our ED during which EMTs can develop and improve their skills in assessing pediatric patients.
  - Children's National will continue to offer content experts to assist in training and continuing education of EMTs.
  
- A renewed commitment that EMSAC will reconvene so that a highly functional, multi-disciplinary body can continue to discuss all aspects of EMS system operation and function;
  
- Codifying the following procedures so that the District government maintains its commitment to the EMSC program:
  - Regular review and maintenance of pre-hospital care protocols that includes the input of pediatric experts;
  - A process for designating facilities that are capable of handling pediatric medical and traumatic emergencies;
  - A statute/regulation for written inter-facility transfer guidelines and agreements that cover pediatric patients; and
  - Maintenance of appropriate pediatric equipment as recommended by a group of national professional organizations on all patient transport vehicles.

Children's National remains committed to working with all governmental and municipal stakeholders in developing the best Emergency Medical Services system in the country. Children and families in the District of Columbia deserve an EMS system that is well-versed in pediatric protocols and prepared to deliver the highest quality care to our most vulnerable citizens.