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A Call to Action: The Institute of Medicine Report on Emergency Medical Services for Children

Jane F. Knapp, MD, Editor

ABBREVIATIONS. EMS-C, Emergency Medical Services for Children; IOM, Institute of Medicine; EMS, Emergency Medical Systems; ED, emergency department; BLS, basic life support; EMT, emergency medical technician.

INTRODUCTION

Emergency Medical Services for Children (EMS-C) must be recognized as a public responsibility; the "market" cannot be relied on to produce the kind of planning and cooperation required to make services available to all who need them.1 The Institute of Medicine (IOM) Report on Emergency Medical Services For Children.

Each year millions of American children become seriously ill or injured in emergency encounters. A child who did not receive the medical care they needed or deserved under these circumstances you understand what EMS-C is all about. The familiar adage, "Children are not small adults," emphasizes that their care must be an integral part of a system not an afterthought once the adults have been addressed. The achievement of the desired level of competence for EMS-C in the larger system is hampered by many factors. These include lack of organization, equipment, training, and a lack of understanding of the child's unique problems and needs.

In response to these needs, Congress approved a demonstration grant program in 1984. The purpose of the program was threefold: to expand access to EMS-C, to improve the quality available through existing Emergency Medical Systems (EMS), and to generate knowledge and experience that would be of use to all states and localities seeking to improve their system.

Continuing interest prompted the formation of the Committee on Pediatric Emergency Medical Services by the IOM. This 19-member committee Chairled by Dr Donald N. Medearis, Jr released their report in the summer of 1993. The IOM report entitled Emergency Medical Services for Children is available in both a soft cover 25-page summary and the full text (see Appendix).

As with any work similar in nature to Emergency Medical Services for Children, dissemination of the existence and importance of the information in the report is critical. The purpose of this supplement to Pediatrics is to help disseminate the findings of the IOM report and to personalize these findings for pediatricians, surgeons, subspecialists, nurses and others involved in the care of children. As the IOM report notes, there has been a tendency in the past for discussions of emergency care to concentrate on the principal providers. To make real strides in system development it is imperative that we recognize that EMS-C is much, much more than prehospital services, emergency departments (EDs), and hospital inpatient settings. For instance, it is well documented, that office-based physicians and nurse practitioners encounter emergency conditions among their patients. Sixty-two percent of Chicago area pediatricians from one study reported seeing at least one child a week who required hospitalization or urgent treatment.2 Going beyond the office to the home, it has been argued by pediatric emergency medicine physicians that parents should be devoting at least as much time to learning pediatric Basic Life Support (BLS) as they do to childbirth preparation. This level of parental education and involvement requires organization and effort at all levels of pediatric practice. Furthermore, it embodies the philosophy that emergency medical care cannot be treated as a process unrelated to a child's routine health care needs. The connections between primary care, emergency care, tertiary (ie, specialty care), and rehabilitation should be as seamless as possible (see the Figure). Therefore, the articles in this the supplement were chosen to help physicians in various settings whether it be urban or rural, subspecialty or primary care, recognize how EMS-C relates to their practice. This supplement should enhance, not replace, the need for reading some form of the IOM report. The summary should be required reading for anyone who has responsibilities in the medical care of children; familiarity with the entire report should be mandatory for all who are involved in emergency care.

Contained herein are eight articles by a distinguished panel of authors. Dr George Foltin, Director of Pediatric Emergency Medicine at Bellevue Hospital Center/New York University Medical Center, thoroughly examines Critical Issues in Urban Emergency Medical Services For Children. Indeed, there appear to be many challenges in our cities. Particularly in major urban areas there is an increasing demand for services, often in circumstances in which emergency care resources are scarce or overburdened. In some areas of the country, the call for ED and inpatient care exceeds the capacity of the hospitals in question, making it difficult for them to provide optimal care.

How can EMS-C address the needs of children who live in counties with more cattle than people? In the second article, Dr Jerome Hirschfeld, Director of Pediatric Education at the Family Practice Residency of Idaho addresses issues relating to EMS-C in rural and frontier America.

Surgeons play a critical role in EMS-C. A passage from the report states that, "For the surgical specialties, surgeons-in-training in pediatric subspecialties not involving trauma should receive an adequate grounding in trauma; those training in trauma should be expected to spend time in settings that include care for pediatric patients." In their commentary The Surgeon and EMS-C, Drs Arthur Cooper and Barbara Barlow from the Division of Pediatric Surgery Harlem Hospital Center/Columbia University

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Figure. The connections between primary care, emergency care, tertiary care, and rehabilitation.

Note: Horizontal axis indicates time

Vertical axis indicates utilization

* adapted from EMS-C: A Report to the Nation
Critical Issues in Urban Emergency Medical Services for Children

George L. Foltin, MD, FAAP, FACEP

ABSTRACT. In order to be effective those wishing to improve emergency care of children in an urban environment must be aware of barriers as well as resources. Urban children are at high risk for requiring emergency care as a result of both illness and injury. These children face a dangerous environment resulting from the problems of poverty, homelessness, overcrowded living conditions, drug abuse, and a shrinking tax base. They face this nation's highest rates of violent injury (intentional and unintentional), immunization delays, and preventable infectious diseases such as TB and measles. In addition, they have poor access to quality primary health care and suffer the greatest morbidity rates from chronic diseases such as asthma and diabetes. On the other hand, there is great opportunity to ensure that urban children receive quality emergency health care. The urban environment is rich in "centers of pediatric excellence," which often have paid full-time EMS systems in operation, and is the locale in which the majority of pediatric emergency medicine specialists and prehospital advanced life support providers practice. The child advocate must work to ensure that the urban child can benefit from these resources.

INTRODUCTION/BACKGROUND

Emergency medical services for children (EMS-C) is envisioned as consisting of six phases (Table 1). These phases should be integrated into the child's medical home. Within these phases are contained all the components of a fully functioning emergency medical services (EMS) system. The EMS System comprises primary health care providers, ambulance services, receiving hospitals, interhospital transport services, and subspecialty referral centers. These components often operate independently, may not interface well or at all with the other components, or may not exist. This situation varies on a region to region basis.

The landscape that forms the backdrop in which urban EMS-C exists includes many problems associated with poverty. Forty percent of urban children live below the poverty level.1 Many are homeless and many more are exposed to the detrimental effects of drug trafficking. The environment of the urban child is dangerous. The incidence of penetrating trauma to children is rising in every urban center and is not limited to the adolescent age group. In some urban centers, the morbidity and mortality rates from...