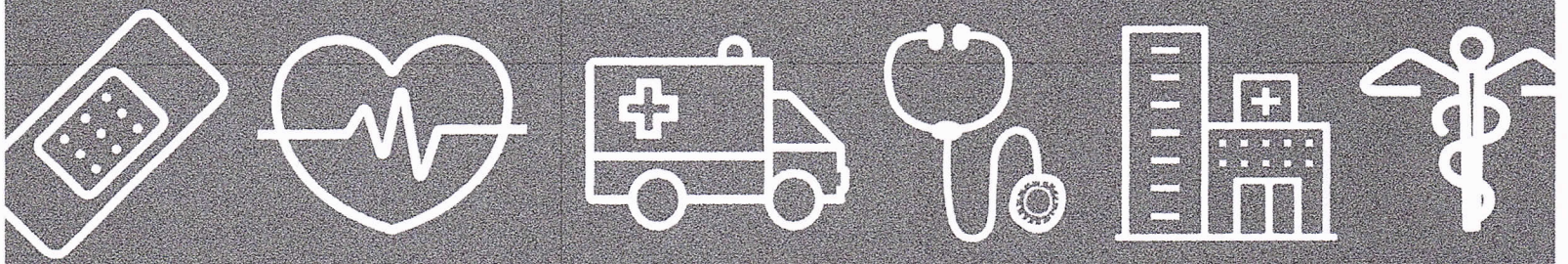

EMS FOR CHILDREN PERFORMANCE MEASURES

Implementation Manual for State Partnership Grantees

Effective March 1st, 2017

9 PERFORMANCE MEASURES

EMSC 01 Performance Measure
Submission of NEMSIS Compliant Version 3.x-Data

The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.

By 2018, baseline data will be available to assess the number of EMS agencies in the state or territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.x-compliant patient-care data to the State Emergency Medical Services (EMS) Office for all 911-initiated EMS activations.

By 2021, 80 percent of EMS agencies in the state or territory submit NEMSIS version 3.x-compliant patient-care data to the State EMS Office for all 911-initiated EMS activations.

EMSC 02 Performance Measure
Pediatric Emergency Care Coordinator (PECC)

The percentage of EMS agencies in the state or territory that have a designated individual who coordinates pediatric emergency care.

By 2020, 30 percent of EMS agencies in the state or territory have a designated individual who coordinates pediatric emergency care.

By 2023, 60 percent of EMS agencies in the state or territory have a designated individual who coordinates pediatric emergency care.

By 2026, 90 percent of EMS agencies in the state or territory have a designated individual who coordinates pediatric emergency care.

EMSC 03 Performance Measure
Use of Pediatric-Specific Equipment

The percentage of EMS agencies in the state or territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

By 2020, 30 percent of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0–12 scale.

By 2023, 60 percent of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0–12 scale.

By 2026, 90 percent of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0–12 scale.

EMSC 04 Performance Measure ***Hospital Recognition for Pediatric Medical Emergencies***	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies. By 2022, 25 percent of hospitals are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
EMSC 05 Performance Measure ***Hospital Recognition for Pediatric Trauma***	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma. By 2022, 50 percent of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.
EMSC 06 Performance Measure ***Interfacility Transfer Guidelines***	The percent of hospitals with an Emergency Department (ED) in the state or territory that have written interfacility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.) • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record. • Plan for transfer of copy of signed transport consent. • Plan for transfer of personal belongings of the patient. • Plan for provision of directions and referral institution information to family. By 2021, 90 percent of hospitals in the state or territory have written interfacility transfer guidelines that cover pediatric patients and that include specific components of transfer.

EMSC 07 Performance Measure ***Interfacility Transfer Agreements***	The percent of hospitals with an Emergency Department (ED) in the state or territory that have written interfacility transfer agreements that cover pediatric patients. By 2021, 90 percent of hospitals in the state or territory have written interfacility transfer agreements that cover pediatric patients.
EMSC 08 Performance Measure ***Permanence of EMSC***	The degree to which the state or territory has established permanence of EMSC in the state or territory EMS system. Goal: To increase the number of states and territories that have established permanence of EMSC in the state or territory EMS system. Each year: • The EMSC Advisory Committee has the required members as per the implementation manual. • The EMSC Advisory Committee meets at least four times a year. • Pediatric representation incorporated on the state or territory EMS Board. • The state or territory requires pediatric representation on the EMS Board. • One full-time EMSC Manager is dedicated solely to the EMSC Program.
EMSC 09 Performance Measure ***Integration of EMSC Priorities into Statutes or Regulations***	The degree to which the state or territory has established permanence of EMSC in the state or territory EMS system by integrating EMSC priorities into statutes or regulations. By 2027, EMSC priorities will have been integrated into existing EMS, hospital, or healthcare facility statutes or regulations.

Supporting Documentation:

Supporting documentation should be available to support EHB entries and may be requested by HRSA at any time. Supporting documentation for this measure includes the following:

- The report with the numerator and denominator generated by NEDARC.
- The complete dataset for this measure.
- Any additional documentation that may be requested by HRSA.

Strategic Plan:

Baseline Data-Collection Phase:
Once performance-measure data have been collected, the results should be presented to the EMS for Children Advisory Committee to evaluate the starting point, discuss target setting, and explore opportunities to implement strategies for growth.

Planning Phase:
Some specific strategic-planning activities that grantees can undertake to effect system change in their state or territory to meet this measure include:

- Reviewing baseline data for the measure, discussing gaps with the EMS director and medical director, and tracking changes in the data after the baseline is collected to monitor quality-improvement efforts.
- Assessing reasons that EMS agencies do not have a designated individual who coordinates pediatric emergency care.

Action and Implementation Phase:

- Engage regional, agency, and medical directors to better understand barriers to designating an individual to coordinate pediatric emergency care.
- Consider systematically evaluating pediatric patient outcomes and comparing EMS agencies with a designated individual who coordinates pediatric emergency care to agencies without.
- Contact the EMS for Children resource centers to identify other states, territories, and freely associated states that have achieved this measure.

Evaluation Phase:

- Collect data.
- Reconcile data and send results to EMS agencies.

You may also be asked the following regarding your response rate:

Numerator: Total number of responding EMS agencies (as defined in the sampling frame above).

Denominator: Total number of EMS agencies (as defined in the sampling frame above) in your state or territory.

Supporting Documentation:

Supporting documentation should be available to support EHB entries and may be requested by HRSA at any time. Supporting documentation for this measure includes the following:

- The report with the numerator and denominator generated by NEDARC.
- The complete dataset for this measure.
- Any additional information that may be requested by HRSA

Strategic Plan:

Baseline Data-Collection Phase:
Once performance-measure data have been collected, the results should be presented to the EMS for Children Advisory Committee to evaluate the starting point, discuss target setting, and explore opportunities to implement strategies for growth.

Planning Phase:
Some specific strategic-planning activities that grantees can undertake to effect system change in their state or territory to meet this measure include:

- Reviewing baseline data for the measure, discussing gaps with the EMS director and medical director, and tracking changes in the data after the baseline is collected to monitor quality-improvement efforts.
- Assessing reasons that EMS agencies do not have a process that requires their EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

Action and Implementation Phase:

- Engage regional, agency, and medical directors to better understand barriers to having a process that requires their EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

- Consider systematically evaluating pediatric-patient outcomes and comparing EMS agencies that have a process that requires their EMS providers to physically demonstrate the correct use of pediatric-specific equipment versus the agencies that do not.
- Contact EMS for Children resource centers to identify other states and territories that have achieved this measure.

Evaluation Phase:

- Collect data.
- Reconcile data and send results to EMS agencies.

Program Targets:

YEAR	TARGET
2020	30 % of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0-12 scale.
2023	60 % of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0-12 scale.
2026	90 % of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of 6 or more on a 0-12 scale.

New Jersey Paramedic conducts an assessment of a pediatric burn patient while comforting the mother during the 2016 New Jersey Statewide Conference on EMS Simulation Competition.

Supporting Documentation:

Supporting documentation for this measure should be available to support EHB entries and may be requested by HRSA at any point. Examples include:

- Facility-recognition application packet for part of the recognition process.
- Criteria that facilities must meet in order to receive recognition as a facility able to stabilize and/or manage pediatric medical emergencies.
- A list of hospitals participating in the pediatric medical emergency facility recognition program and their corresponding categorization, recognition, or designation level.
- Any additional documentation that may be requested by HRSA

Strategic Plan:

The following phases and terminology are used as best practices in developing a facility recognition program (based on the Medical Facility Recognition Collaborative) and will be helpful as you develop your program.

Planning Phase:

- Identify key stakeholders and champions for an improvement team.
- Develop a process map or a fishbone diagram for the state-specific approach to developing a state-approved recognition program:
  - Understand how the state functions.
  - Map the political framework.
- Meet with the EMSC Advisory Committee to discuss framework and additional stakeholders:
  - Identify barriers.
  - Develop action steps.

Research Phase:

Research and review current pediatric medical recognition programs (see the EIIC website emscimprovement.center/measurement):

- Evaluate potential effectiveness in your state.
- Choose characteristics of a recognition program for your state or territory.

Alaska's first Pediatric Emergency Care Facility Recognition, October 6, 2015. Alaska Native Medical Center, located in Anchorage, Alaska, has been recognized as a Comprehensive Pediatric Emergency Care Facility by the Alaska EMS for Children Facility Review team.

Stakeholder Agreement Phase:

- Identify stakeholders and potential host institutions for the recognition program.
- Meet with stakeholders to review and discuss opportunities and barriers.
- Obtain a stakeholder agreement that shows that the following have been reviewed and accepted:
    - Recognition criteria based on the latest release of the "Guidelines for Care of Children in the Emergency Department"
    - Program characteristics (for example, voluntary, single-tier, and so forth)

Implementation Plan Phase:

- Develop a process map to include:
  - Identification of host institution(s) and sustainability plan
  - Application for recognition program and criteria
  - Timeline
  - Tracking system
  - Recognition process
  - Marketing plan
  - Method of recognition

Piloting and Recognition Phase:

- Develop a process map for an initial pilot, including:
  - Selection of participants
  - Evaluation and revision of recognition process
  - Initial recognition

Program Targets:

YEAR	TARGET
2022	25% of hospitals are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.

Supporting Documentation:

Supporting documentation for this measure should be available to support EHB entries and may be requested by HRSA at any point. Examples include:

- Facility-recognition application packet for part of the recognition process.
- Criteria that facilities must meet in order to receive recognition as a facility able to stabilize and/or manage pediatric traumatic emergencies.
- A list of hospitals participating in the pediatric traumatic emergency facility recognition system and their corresponding categorization, recognition, or designation level.
- Any additional documentation that may be requested by HRSA.

Strategic Plan:

Review Current System Phase:

- Review your most current Pediatric Readiness data at the hospital level, which contains many scored elements related to the care of pediatric trauma.
- Meet with your state or territory Trauma Manager. If you do not have state or territory Trauma Manager, you may want to meet with a representative of the hospital association in order to:
  - Review your most current Pediatric Readiness data together.
  - Review the existing statewide or territorial pediatric trauma criteria, looking for inclusion of pediatric trauma criteria.

Champions and Consensus Phase:

- Invite the Trauma Manager or trauma stakeholders to meet with your EMSC Advisory Committee:
  - Discuss the feasibility of a trauma system inclusive of children (whether improving an existing system or developing a similar trauma system).
  - Review or summarize your most recent Pediatric Readiness data.
  - Discuss deficits and gaps.
  - Discuss ways to assist hospitals that are not designated trauma centers to become at least Pediatric Ready.
- Develop a team of experts and champions who can assist you in developing a plan to move forward.

Criteria Phase:

- Work with your team to improve or develop trauma criteria that is inclusive of pediatric patients.
- Review pediatric elements used as criteria for other state or territory trauma systems or from the ACS.

Verifying Body Phase:

- Ensure that your state or territory has a verification body for designated trauma centers.
- Explore the current process for trauma verification.
- Incorporate the new pediatric criteria into the trauma-verification process.
- For nondesignated hospitals, explore ways to verify that they are at least Pediatric Ready.

Program Targets:

YEAR	TARGET
2022	50% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.

EMSC 06

An interfacility transfer guideline ensures that critically ill and injured children receive needed services, that appropriate consultation services are available, and that children are rapidly transported to specialized centers.

Supporting Documentation:

Supporting documentation should be available to support EHB entries and may be requested by HRSA at any point. Supporting documentation for this measure includes the following:

- The report with the numerator and denominator generated by NEDARC.
- The complete dataset for this measure.
- Any additional documentation requested by HRSA

Strategic Plan:

Using the previously collected data, the state or territory should assess its compliance with having pediatric interfacility transfer guidelines. Data should be presented to the EMS for Children Advisory Committee to develop a strategy for meeting the performance measure.

Some specific strategic-planning activities grantees can undertake to effect system changes to meet this measure in their states or territories include:

Planning Phase:

- Review baseline data and discuss gaps in the existence and use of interfacility transfer guidelines for pediatric patients with your EMS director and medical director.
- Review the data to determine which hospitals reported they are in the process of developing interfacility transfer guidelines, and contact hospital officials to see if they need any help, such as developing an interfacility guideline template.
- Review the data to determine which components recommended by AAP, ACEP, and ENA are missing from the guidelines for each hospital, and contact each hospital to discuss adding the missing components to their interfacility transfer document(s).
- Assess the reasons that hospitals do not have interfacility transfer guidelines for pediatric patients. For example, does the language of current guidelines include "patients of all ages"?

Action and Implementation Phase:

- Brief your family representative on the importance of interfacility transfer guidelines, and enlist the representative's assistance as you make plans to meet with hospitals and the hospital association.
- Sponsor a meeting of all hospitals in partnership with the state or territory hospital association to assess the existence and use of interfacility transfer guidelines for pediatric patients among hospitals in the state or territory. Include a discussion of the barriers and challenges to using interfacility transfer guidelines for pediatric patients, and discuss potential solutions.

Supporting Documentation:

Supporting documentation should be available to support EHB entries and may be requested by HRSA at any point. Supporting documentation for this measure includes the following:

- The report with the numerator and denominator generated by NEDARC.
- The complete dataset for this measure.
- Any additional documentation required by HRSA

Strategic Plan:

Using the previously collected data, the state or territory should assess its compliance with having pediatric interfacility transfer agreements. Data should be presented to the EMS for Children Advisory Committee to develop a strategy for meeting the performance measure.

Some specific strategic-planning activities grantees may undertake to effect system changes to meet this measure in their states or territories include:

Planning Phase:

- Review baseline data, and discuss gaps in the existence and use of interfacility transfer agreements for pediatric patients with the EMS director and medical director.
- Review the data to determine which hospitals reported they are in the process of developing interfacility transfer agreements, and contact hospital officials to see if they need any help, such as developing an interfacility transfer-agreement template.
- Assess the reasons that hospitals do not have interfacility transfer agreements for pediatric patients. For example, does the language of current guidelines include "patients of all ages"?

Action and Implementation Phase:

- Brief your family representative on the importance of interfacility agreements, and enlist the representative's assistance as you make plans to meet with hospitals and the hospital association.
- Sponsor a meeting of all hospitals in partnership with the state or territory hospital association to assess the existence and use of interfacility transfer agreements for pediatric patients among hospitals in the state or territory. Include a discussion of the barriers or challenges to using interfacility transfer agreements for pediatric patients, and discuss potential solutions.

Evaluation Phase:

- Collect data.
- Reconcile data and send results to hospitals.

7. There is a statute or regulation for written interfacility transfer agreements that cover pediatric patients.	
8. There is a statute or regulation for pediatric on-line medical direction for ALS and BLS prehospital provider agencies.	
9. There is a statute or regulation for pediatric off-line medical direction for ALS and BLS prehospital provider agencies.	
10. There is a statute or regulation for pediatric equipment for BLS and ALS patient-care units.	
11. There is a statute or regulation for the adoption of requirements for continuing pediatric education prior to recertification and/or relicensing of BLS and ALS providers.	
Total:	

Supporting Documentation:

Supporting documentation should be available to support EHB entries and may be requested by HRSA at any point. Examples of supporting documentation for this measure include:

- Legislation or other structural framework
- Copies of statues or regulations
- State or territory requirements for each priority
- Any additional documentation requested by HRSA

If grantees have not integrated the EMSC priorities into existing statues or regulations, supporting documentation will be required to demonstrate progress made toward such integration.

Strategic Plan:

Some specific strategic-planning activities grantees may undertake to effect system changes in their states or territories to meet this measure include:

- Familiarizing themselves with the processes and schedules for the legislative- and rule-making procedures in the state or territory, especially as they relate to EMS and hospital regulation. These processes vary widely in each state, territory, and freely associated state; knowing the procedural rules is critical to success.

- Reviewing existing state or territory statues and regulations, and discussing gaps in the integration of EMSC priorities with the EMSC Advisory Committee.

- Assessing the reasons that the state or territory has not integrated EMSC priorities into existing statues or regulation.

- Engaging family representatives to brainstorm ideas for educating the public about EMSC priorities.

- Educating and informing state legislators and officials on EMSC priorities and their importance to the community served. When educating and informing, grantees are not expressing a view about legislation and are not asking a legislator to introduce, support, or oppose legislation. Instead, grantees are strictly providing factual information on a particular topic. Examples of educating and informing include:

    - Providing factual information on a particular topic to help policymakers or the general public form an independent opinion about the topic.
    - Providing factual testimony or technical advice and assistance to a committee or subcommittee, when invited to do so.
    - Communicating with government officials for purposes other than influencing legislation, such as commenting on regulations.
    - Contacting Program Managers in other states or territories who have met the measure to discuss how they overcome challenges.

- Engaging state legislators and officials, as well as EMS and hospital stakeholders, to discuss the barriers and challenges to integrating EMSC priorities into existing statutes or regulations, and facilitating solutions with these groups.

- Determining the feasibility of the state or territory to integrate the EMSC priorities into existing statutes or regulations.

- Working with professional organizations and other state pediatric advocates to inform and engage their legislative and advocacy efforts. The following list provides examples of professional organizations with chapters in most states:
    - American Academy of Pediatrics
    - American College of Emergency Physicians
    - American Hospital Association
    - Children's Hospital Association
    - Emergency Nurse Association
    - Family Voices
    - National Association of EMTs
    - National Association of EMS Physicians
    - National Association of School Nurses

Program Targets:

YEAR	TARGET
2027	EMSC priorities will have been integrated into existing EMS or hospital and healthcare facility statutes or regulations.