EMSC ADVISORY COMMITTEE

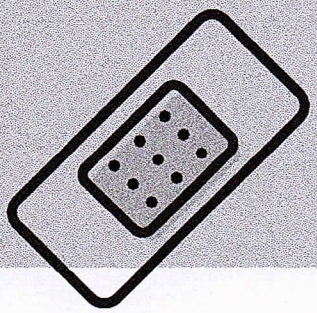
PROPOSED TIMELINE FOR STRATEGIZING WORK PLAN TO ACHIEVE PERFORMANCE-MEASURE OUTCOMES

for EMSC Grant Year 3 - 4/1/20 to 3/31/21

NOTE: The PM Implementation Manual states "most recent resources...are available... *emscimprovement.center/measurement*." However, no such page on their website: 404 error.

as of 4/16/2020

Work Plan Priority	Performance Measure	Summary Description of PM	Goal: by Year	Goal: Percent	Status of Nevada	QRTR MEETING for Planning (3rd Thursday)	STRATEGIES	Implementation Notes
#1	02	Pediatric Emergency Care Coordinator (PECC)	**2020**	**30%**	**TBD.** NEDARC 2020 agency-survey completed 3/31/20. 100% response-rate for Nevada EMS agencies, but "data not yet cleaned." Estimate 10/54 agencies have a PECC = **18.5 %. Need 17,** i.e., **7 add'l PECC's,** to assure PM's successful outcome by end of 2020.	**Thursday, April 16 2020** (teleconferenced)	See excerpt from PM Implementation Manual (attached), page 28	**7.5 months left in 2020 for implementation; next annual data collection in January, 2021**
			2023	60%				
			2026	90%				
	03	Use of Pediatric-Specific Equipment	**2020**	**30%**	**TBD.** NEDARC 2020 agency-survey completed 3/31/20. 100% response-rate for Nevada EMS agencies, but "data not yet cleaned."		See excerpt from PM Implementation Manual (attached), page 36. Also, develop and adopt revised Skills Verification Sheet.	**7.5 months left in 2020 for implementation; next annual data collection in January, 2021**
			2023	60%				
			2026	90%				
#2	06	Interfacility-Transfer Guidelines	2021	90%		**Thursday, July 16 2020** (Carson City)		
	07	Interfacility-Transfer Agreements	2021	90%				
#3	04	Hospital Recognition for Pediatric Medical Emergencies	2022	25%	**TBD.** NEDARC 2020 hospital-survey postponed UFN. Last data available is from 2017.	**Thursday, October 15 2020** (Las Vegas)		
	05	Hospital Recognition for Pediatric Trauma	2022	50%				
#4	08	Permanence of EMSC	Each year	Full List	**(1) EMSC Advisory Committee meets regularly.** (2) Pediatric Rep on EMS Board. (3) Full-time EMSC program manager.	**Thursday, January 21 2021** (Carson City)		(2): EMSC program manager will be proposed for membership on EMS Board. (3) Currently EMSC program manager is not a permanent employee, but is a contractor ("temp").
#5	09	Integation of EMSC Priorities into Statutes or Regulations	2027					Synchronize efforts with Nevada's 81st Legislative Session, normally starting in February, 2021.
	01	Submission of NEMSIS-Compliant Version 3.x-Data	2018	baseline data	**2020: 96% of Nevada's EMS agencies are compliant.**			
			2021	80%				



EMSC 02

PEDIATRIC EMERGENCY CARE COORDINATOR (PECC)

SEE "STRATEGIC PLAN," PAGE 28

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

Goal for this measure is that by 2026:

Ninety percent of EMS agencies in the state or territory have a designated individual who coordinates pediatric emergency care.

Significance of Measure:

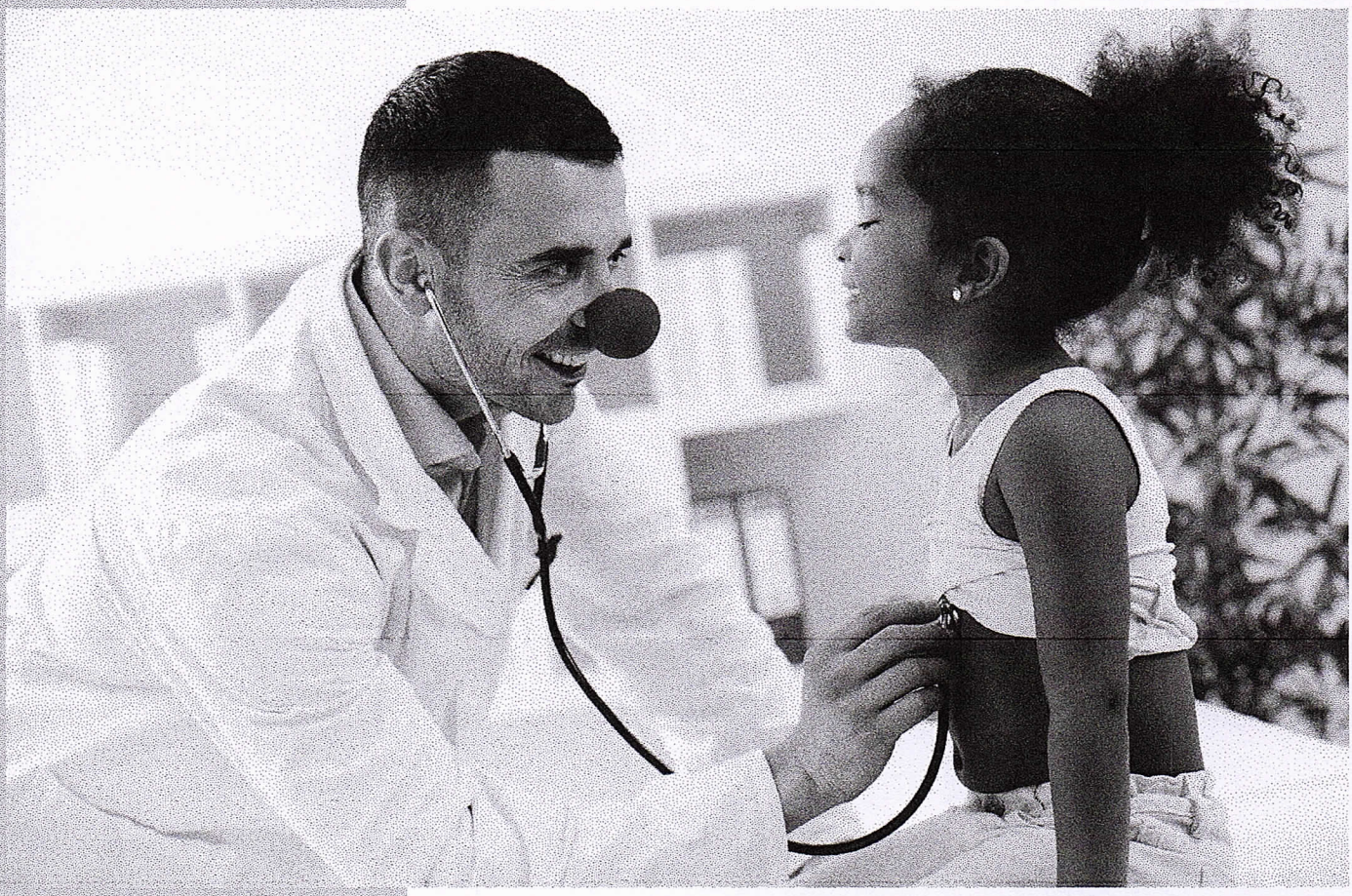
The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains"[1] recommends that EMS agencies and emergency departments (EDs) appoint a pediatric emergency care coordinator to provide pediatric leadership for the organization. This individual need not be dedicated solely to this role and could be personnel already in place with a special interest in children who assumes this role as part of their existing duties.

Gausche-Hill et al.[2] in a national study of EDs found that the presence of a physician or nurse pediatric emergency care coordinator was associated with an ED being more prepared to care for children. EDs with a coordinator were more likely to report having important policies in place and a quality improvement plan that addressed the needs of children than EDs that reported not having a coordinator.

The IOM report further states that pediatric coordinators are necessary to advocate for improved competencies and the availability of resources for pediatric patients. The presence of an individual who coordinates pediatric emergency care at EMS agencies may result in ensuring that the agency and its providers are more prepared to care for ill and injured children.

1 Institute of Medicine Committee on the Future of Emergency Care in the U.S. Health System (2007). Emergency care for children: growing pains.

2 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.



The presence of an individual who coordinates pediatric emergency care at EMS agencies may result in ensuring that the agency and its providers are more prepared to care for ill and injured children.

The Pediatric Emergency Care Coordinator (PECC) should be a member of the EMS agency and be familiar with the day-to-day operations and needs at the agency. However, some states or territories may use a variety of models to coordinate pediatric emergency care at the county or regional levels. If there is a designated individual who coordinates pediatric activities for a county or region, that individual could serve as the PECC for one or more individual EMS agencies within the county or region.

Some of the roles that the individual who coordinates pediatric emergency care might oversee at an EMS agency include:

- Ensuring that the pediatric perspective is included in the development of EMS protocols.
- Ensuring that fellow providers follow pediatric clinical-practice guidelines.
- Promoting pediatric continuing-education opportunities.
- Overseeing pediatric-process improvement.
- Ensuring the availability of pediatric medications, equipment, and supplies.
- Promoting agency participation in pediatric-prevention programs.
- Promoting agency participation in pediatric-research efforts.
- Liaises with the emergency department pediatric emergency care coordinator.
- Promoting family-centered care at the agency.

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.

EMSC 03

USE OF PEDIATRIC-SPECIFIC EQUIPMENT

SEE "STRATEGIC PLAN", PAGE 36

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.

Goal for this measure is that by 2026:

Ninety percent of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

Significance of Measure:

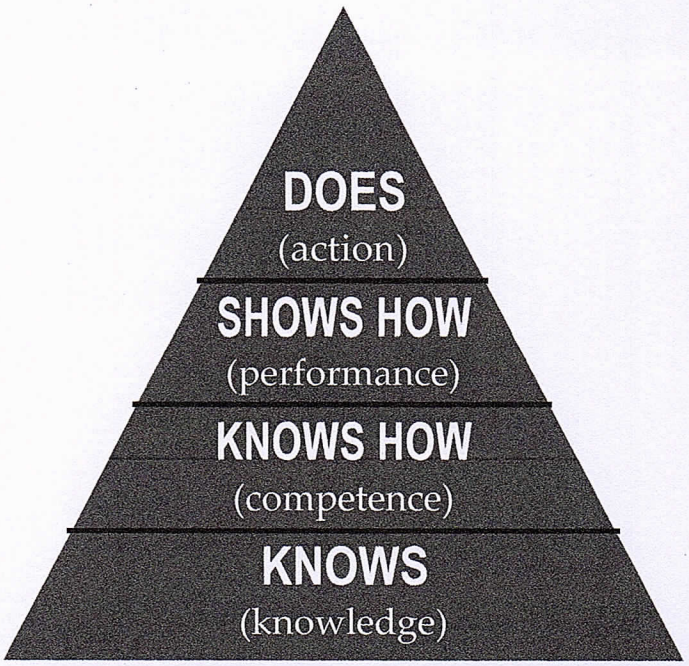
The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains"[1] states that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. For example, Lammers et al.[2] reported that paramedics manage an adult respiratory patient once every 20 days compared to once every 625 days for teens, once every 958 days for children, and once every 1,087 days for infants. As a result, skills needed to care for pediatric patients may deteriorate. Another study by Su et al.[3] found that EMS provider knowledge rose sharply after a pediatric resuscitation course, but when providers were retested six months later, their knowledge was back to baseline.

Continuing education such as the Pediatric Advance Life Support (PALS) and Pediatric Education for Prehospital Professionals (PEPP) courses are vitally important for maintaining skills and are considered an effective remedy for skill atrophy. These courses are typically required only every two years. More frequent practice of skills using

1 Institute of Medicine Committee on the Future of Emergency Care in the U.S. Health System (2006). Emergency care for children: growing pains.

2 Lammers, R. L., Byrwa, M. J., Fales, W. D., & Hale, R. A. (2009). Simulation-based assessment of paramedic pediatric resuscitation skills. *Prehospital Emergency Care*, 13(3), 345–356.

3 Su, E., Schmidt, T. A., Mann, N. C., & Zechnich, A. D. (2000). A randomized controlled trial to assess decay in acquired knowledge among paramedics completing a pediatric resuscitation course. *Academic Emergency Medicine*, 7(7), 779-786.



Framework for clinical assessment

different methods of skill ascertainment are necessary for EMS providers to ensure their readiness to care for pediatric patients when faced with these infrequent encounters.

Demonstrating skills using EMS equipment is best done in the field on actual patients, but in the case of pediatric patients, this can be difficult given how infrequently EMS providers see seriously ill or injured children. Other methods for assessing skills include simulation, case scenarios and skill stations. In the absence of pediatric patient encounters in the field, there is no definitive evidence that shows that one method is more effective than another for demonstrating clinical skills. But, Miller's Model of Clinical Competence[4] posits via the skills complexity triangle that performance assessment can be demonstrated by a combination of task training, integrated skills training, and integrated team performance. In the EMS environment this can be translated to task training at skill stations, integrated skills training during case scenarios, and integrated team performance while treating patients in the field.

Resources:

The most recent resources and tools available to support the implementation of the EMSC performance measures are available within the "Measurement" section of the EIIC's website. Visit emscimprovement.center/measurement to find the resources available to support your efforts to implement the performance measures in your state or territory. This section is updated as resources related to each performance measure become available.

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4 Miller, G. E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine*, 65(9), S63-7.

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.