

106-O

Advocating for Children—Become Involved in Your State EMSC Program

Cynthia Wright-Johnson, RNC, MSN; CWRIGHT@miemss.org



Upon completion of this course, the participant will be able to:

1. Describe the federal and state Emergency Medical Services for Children (EMSC) programs;
 2. Describe the impact of the three EMSC Performance Measures on hospital and EMS professionals;
 3. List the core components of the EMSC Strategic Plan;
 4. Implement activities involving both local ENA chapters and state ENA councils that support the EMSC programs; and
 5. Compare and contrast your state or territory's pediatric resources to the federal EMSC goals.
- I. Emergency Medical Services for Children—1984 to 2011
- A. EMSC—first there were four, then eight, and now 56 federally funded programs
 1. Created under federal law Preventive Health Amendments of 1984–PL 98-555
 2. 1985 EMSC Program funds began with \$2 million (Section 1910 of Public Health Service Act)
 3. 2010 EMSC Program funds have been proposed at \$21 million
 - B. EMSC Vision: reduce child and adolescent mortality and morbidity from severe illness or trauma
 - C. EMSC Goals
 4. Ensure that state-of-the-art emergency medical care for the ill or injured child and adolescent
 5. Ensure that pediatric services are well integrated into the existing state EMS systems
 6. Ensure continuum of care is provided to children and adolescents is at the same level as that for adults—primary prevention of illness and injury, acute care, and rehabilitation
 7. Ensure families, children and adolescents are involved in the development and infrastructure of the EMSC program at the state and federal level
 - D. The EMSC program funds:
 1. State Partnership Grants—50 states and 6 territories may apply for three year funding cycles
 2. Targeted Issues Grants—focused areas of program development or research for pediatric care over three years; typically three to four funded each year
 3. PECARN—Pediatric Emergency Care Applied Research Network—four nodes with multiple HEDA reaching 28 hospitals that see 800,000 children in EDs a year
 4. Two national resource centers—NRC in DC and NEDARC in Utah
 5. Interagency federal agreements—NHTSA, IHS, CDC
 6. MCHB Research Grants
 - E. 2007 IOM Report—Emergency Care for Children: Growing Pains
- II. EMSC—Regional and State Activities
- A. EMSC regions—similar to Public Health and NHTSA regions
 1. Regional networks, meetings and symposia
 2. Regional liaisons to resource centers
 3. NASEMSO (has only four regions)
 - B. State EMSC Offices (agency location varies)
 1. Grant requirements of 10 Performance Measures; See additional handout
 2. Coordination and collaboration across state agencies and between hospitals
 3. Injury Prevention and Health Promotion



ENA Leadership Conference 2010

February 17-21, 2010

Chicago, IL

4. FAN—Family Advocacy Network voice
 5. 2009—H1N1 took over our schedules with preplanning, census monitoring, and clinic logistics
- B. EMSC Performance Measures 101: what DID the numbers 66, 67, and 68 have to do with your practice and what content has changed now that they are numbers 71–80
1. Federal performance measures came in 2005 and there are 10 components
 2. Each state's self assessment prioritized their focus on measures
 3. Federal benchmarking data is now available from NEDARC in Utah
 4. Every state has work that needs your input, support and advocacy
 - a) Hospital Medical Direction and EMS Protocols
 - b) EMS Equipment and Training
 - c) Facility categorization
 - d) Interfacility transfers and transports
 - e) Legislation, regulations, and rules that advocate for children and adolescents
- III. ENA Councils and Chapters Partnering with Emergency Medical Services for Children
- A. EMSC Advisory committees are looking for ENA representatives
 - B. Pediatric education is required for BLS and ALS EMS professionals. What is your best lecture or scenario station?
 - C. Regionalization of pediatric care. Where does each hospital fit in? Is there consensus on the guideline? Where do you find the national models?
 - D. Twenty five years later—the priority one is still children and families getting the right care when it counts. Get involved!
- IV. EMSC Resources to help in your practice
- A. MCHB Webcasts: <http://www.mchcom.com/liveWebcasts.asp>
 - B. NEDARC: <http://www.nedarc.org>
 - C. NRC Website toolboxes: <http://www.childrensnational.org/EMSC>
 - D. NRC Publications and resources to order or download
 - E. National EMS for Children's Day in May each year
 - F. State EMSC websites have nursing education training modules
 - G. NEW in 2009: Joint Policy Statements and Guidelines
 1. March 2009 Guidelines for Ambulance Equipment
 2. September 2009 Guidelines for the Care of Children in Emergency Departments

Resources:

Emergency Medical Services for Children National Resource Center. (2009). *Best practices: A guide for state partnership grantees on the implementation of eMSC performance measures*. Retrieved January 11, 2010, from http://www.childrensnational.org/files/PDF/EMSC/PubRes/Best_Practices_Guide.pdf

Emergency Medical Services for Children. (2008). *EMSC strategic plan FY 2008–2010: Recommendations of the partnership for children stakeholders group*. Rockville, MD: Health and Human Resources Administration.

Krug, S. (2005). Twenty years of emergency medical services for children: A cause for celebration and a call for action. *Pediatrics*, 115(4) 1089–1091.

National Academy of Sciences. (2007). *Emergency care for children: Growing pains*. Washington, DC: Author.



ENA Leadership Conference 2010

February 17-21, 2010

Chicago, IL

Tool for learning about your states EMSC program, projects and progress:

Revised Federal EMSC PM	Description	Your States Progress
Performance Measure 71 (formerly PM 66a (i))	The percent of pre-hospital provider agencies in the state/territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.	
Performance Measure 72 (formerly PM 66a (ii))	The percent of pre-hospital provider agencies in the state/territory that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.	
Performance Measure 73 (formerly PM 66b)	The percent of patient care units in the state/territory that have essential pediatric equipment and supplies as outlined in national guidelines.	
Performance Measure 74 (formerly PM 66c medical)	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.	
Performance Measure 75 (formerly PM 66c trauma)	The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.	
Performance Measure 76 (formerly PM 66d)	The percentage of hospitals in the state/territory that have written interfacility transfer guidelines that cover pediatric patients and that include pre-defined components of transfer.	
Performance Measure 77 (formerly PM 66e)	The percent of hospitals in the state/territory that have written interfacility transfer agreements that cover pediatric patients.	
Performance Measure 78 (formerly PM 67)	The adoption of requirements by the state/territory for pediatric emergency education for license/certification renewal of BLS/ALS providers.	
Performance Measure 79 (formerly PM 68a,b,c)	The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by establishing of an EMSC Advisory Committee, incorporating pediatric representation on the EMS Board, and hiring a full-time EMSC manager.	
Performance Measure 80 (formerly PM 68d)	The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by integrating EMSC priorities into statutes/regulations.	
New EMSC PMs	There will be new EMSC PM in the future...Stay tuned.



ENA Leadership Conference 2010

February 17-21, 2010

Chicago, IL