



MACEP Pediatric Section Newsletter

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Establishing a Pediatric Emergency Care Coordinator in 100% of Mass EDs

The Pediatric Section of the Massachusetts College of Emergency Physicians (MACEP) is setting the following goals:

1) Establish a physician and/or nursing Pediatric Emergency Care Coordinator (PECC) in 100% of Massachusetts EDs by the national ACEP meeting in October 2017

2) Make it easy for ED leadership to establish this PECC role through web-based resources

3) Use our success as a model for helping other states to expand establishment of PECCs in their EDs.

This program is focused on making it easy for physician and/or nursing leadership in all Massachusetts emergency departments to:

- **Identify** a physician and/or nurse with some passion for pediatric care to take on the role of PECC

- **Provide** web-based training and resources for the PECC so he/she is empowered to make improvements to and serve as a departmental resource for pediatric emergency care

- **Allow** for this PECC to provide variable support to the department, as each department identifies its own needs. This could range from minimal support (e.g., simply serving as a resource) to robust upgrades in care (e.g., establishing pediatric QI metrics, educational training, etc).

In their 2006 report "Emergency Care for Children: Growing Pains," the Institute of Medicine (IOM) recommended that hospitals appoint pediatric emergency coordinator(s) to provide pediatric leadership for improving care for children. In 2009, guidelines were published jointly by the American College of Emergency Physicians (ACEP), the American Academy of Pediatrics (AAP) and the Emergency Nurses Association (ENA) for care of children in emergency departments (EDs),

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Emergency Medical Services for Children (EMSC) Funding for MA

Although children make up approximately 20% of all visits to the ED, 80-90% of children are evaluated in non-children's facilities, and only 2-3% of injured children are treated in a Pediatric Trauma Center. Many hospitals and EMS agencies are not well equipped to handle these patients. ^{1,2,3}

The EMSC Program is a Federal government health initiative administered by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), and the Maternal and Child Health Bureau (MCHB). Its aim is to reduce child disability and death due to severe illness or injury by increasing awareness among health professionals, providers and planners, and the general public of the special needs of children receiving emergency medical care.

In 1973, Congress passed the Emergency Medical Services Systems Act of 1973, providing funding for comprehensive state and local government EMS systems. Since 1985, the EMSC program has provided grants to all states, and established national resource centers and the pediatric emergency care research network (PECARN).

Funding for EMSC comes from the federal **Maternal and Child Care** block grant, which is roughly \$667 million. This funds important programs at the national level. Only around \$20 million of this grant goes to fund EMSC. For Massachusetts, EMSC has received \$130,000 per year for around 7 years. This budget basically supports one staff person (salary, fringe and indirect costs), usually with a small amount left over for training/education or printing projects. It is a very small program that links up with many other areas such as EMS, injury & violence prevention, the child fatality review process, and children with special healthcare needs, among others.

President Trump changed the FY2018 Federal Programs Budget, and cut \$103 million from the Maternal and Child Care grant, including the \$20 million for EMSC. The EMSC grant year starts every March 1, and this year they approved only 57% of the funds. We lost the EMSC Program Manager position for the State of MA largely due to the cuts in the budget, and the State is scrambling to move resources to keep the funding.

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Websites to check out!

Every month we'll share some websites that may be of interest

Mass Pediatric Toolkit- Resources to improve pediatric care: [LINK](#)

EMSC Resources/ Toolkit to improve pediatric readiness in your ED: [LINK](#)

EMS-C Webinars: [LINK](#)

National Pediatric Readiness Project: [LINK](#)

PEM Playbook (excellent and lively podcast on PEM topics): [LINK](#)

Upcoming Events

- **2017 Resident/ Fellow Job Fair**, Sept 14, Framingham: [LINK](#)
- **AAP National Conference, Pediatric Emergency Section**, Sept 16-19, Chicago: [LINK](#)
- **ACEP Annual Meeting**, Oct 29- Nov 1, Washington, DC: [LINK](#)



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including a call for the establishment of a physician and nursing coordinator for pediatric care.

In 2015, Gausche-Hill et al published their landmark survey of over 4,100 EDs, “A National Assessment of Pediatric Readiness of Emergency Departments,” demonstrating that establishment of a pediatric emergency care coordinator was associated with a significant increase in pediatric readiness scores, regardless of pediatric volume. The authors concluded that “creating the role of PECC is the single most important process change that hospital and ED administrators can implement to improve compliance with the national guidelines.”

However, despite the creation of the National Pediatric Readiness Project (NPRP), and an increased national focus on pediatric readiness and the establishment of PECCs, we continue to have significant challenges in obtaining this goal. Gausche-Hill et al estimated the establishment of PECCs in approximately two-thirds of EDs nationally. However, data from Sullivan et al, published in 2013, show only 17% of EDs surveyed having a PECC. More recent data from 2015 show that only 28% of Massachusetts EDs reported having a PECC.

Establishment of a PECC is THE most effective way to achieve a focus on enhancing emergency care for children. We believe that achievement of this goal requires implementation at the local level.

We also encourage you to download the free app *EMNet findERnow*, which shows the distance and directions from your current location to the closest EDs, anywhere in the US. Developed by EMNet researchers at Mass General, this app was recently updated to include a Pediatric Version. Subscribers to this version can access ED-specific pediatric information, including information about whether or not each US ED has a PECC. To learn more, go to www.findERnow.org.

All ED Directors in Massachusetts should have received communication from MACEP about this project. If your ED has not identified a PECC yet, please contact Dr. Emory Petrack at epetrack@tuftsmedicalcenter.org to learn about the free resources available to help your ED improve pediatric emergency care.



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The success of the program really depends on EMSC being able to forge partnerships with hospitals, the Office of Emergency Medical Services, and other programs that may impact children and adolescents. I hope that through this editorial, we help raise awareness of the importance of the EMSC grant for the children of MA.

1 Emergency Care for Children: Growing Pains. Future of Emergency Care. Institute of Medicine. 2007.

2 Gausche-Hill M. Pediatrics 2007; 120:1229-37.

3 Goto T, et al. West J Emerg Med 2017;in press.

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COMET was developed and launched as a pilot study in 2010-2011. **COMET** laid the foundation for a larger collaborative called **ImPACTS** – Improving Pediatric Acute Care through Simulation. We have studied the care of acutely ill children using 4 simulation cases across 58 institutions in the Northeast, identifying gaps in care and systems issues. This work has been published (links below to some of the articles). Our goals are to continue partnerships with community sites using simulation and other modalities as a means to help bridge gaps in care and to be an ongoing resource to those sites. [Please contact me for any interest in our outreach programming!!!](#)

In situ simulations are conducted in actual patient care units using equipment and resources from that unit. High-fidelity simulators present clinical findings (pulses, breath sounds, heart sounds), are connected to a monitor displaying vital signs and a computer displaying the electronic medical record (labs, imaging). Scenarios are programmed into a computer and the simulator's status will change over time and in response to the provider's interventions. Simulations mimic clinical care and facilitate training and assessment in ways that cannot be accomplished in real patient care safety efforts.

Sims will provide a platform for valid and reliable measurement of the quality of care and identify the impact of both human and systems-based safety threats. For the duration of the simulations we will need one room in your department to hold simulations and debrief afterwards. Teams will care for a variety of simulated pediatric patients in a variety of scenarios. The structure, processes and outcomes of care will be evaluated for infant/school aged patients presenting with common life-threatening conditions.

Participants will reflect on their experiences immediately following each simulation. Trained experts will facilitate debriefings using the Army's after action review format to identify failure modes in the work environment and the systems of care. Debriefings will provide perspectives not readily apparent during clinical care and that would not be uncovered using traditional retrospective risk reduction techniques.

We will work with a designated "Pediatric Champion" at your hospital to provide specific feedback on performance and to develop "action plans" to improve the quality of care. Ex: refining pediatric sepsis algorithms, identification of latent safety threats, new pediatric medication dosing systems, pediatric policies, and develop innovative provider competencies.



[Links to Work \(partial list\):](#)

-Disparities in Adherence to Pediatric Sepsis Guidelines Across a Spectrum of Emergency Departments; a multicenter prospective cohort study.

DOI: <http://dx.doi.org/10.1016/j.jemermed.2015.08.004>

-Differences in the Quality of Pediatric Resuscitative Care Across a Spectrum of Emergency Departments. DOI: [10.1001/jamapediatrics.2016.1550](https://doi.org/10.1001/jamapediatrics.2016.1550)

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www.cometmd.com (under construction)