Illinois Emergency Medical Services for Children

Pediatric Facility Recognition Renewal Educational Session
Educational Session Agenda

- Emergency Medical Services for Children (EMSC) Overview
  - National
  - Illinois
- Pediatric Facility Recognition Program
  - History of Illinois program
  - Recognition levels
  - Hospital participation
  - Hospital requirements/criteria
- Application Process
- Site Survey Process
- Conclusion
INTRODUCTION
One Million Children receive Emergency Care each year in Illinois

24% of ED visits are children 0 -15 y/o

Is Your Hospital Prepared?
Illinois Demographics

- Population: 12.9 million in 2015
  - 5th most populous state
- Over 2.6 million children age 0-15
  - 625,000 age 3 and younger
- Emergency Health System Resources
  - 11 EMS Regions
  - ~185 hospitals with ED’s
  - ~15 PICUs
  - 27 NICUs (3 located in St. Louis, MO)
  - 66 Level I/II Trauma Centers
    - 4 Pediatric (2 in St. Louis, MO)
    - 6 Pediatric/Adult
- Hospital utilization
  - 24% of ED visits are children 0-15y/o
  - 14% of inpatient admissions 0-15y/o
Began development in the late 1960's - early 1970's

Based on medical advancements
- Vietnam War
- American Heart Association

Primarily designed for adult trauma/cardiac patient

Unintentionally overlooked the needs of children
Gaps in the System

- No widespread availability or dissemination of pediatric healthcare emergency care education
- Lack of pediatric emergency care treatment standards/protocols
- Lack of appropriate pediatric sized equipment in ambulances and emergency departments
- Others
Studies identified that children had higher mortality rates than adults in certain similar emergency situations.
Pediatric Emergency Challenges

- Chance for medical error is greater
  - Appropriately sized equipment/supplies
  - Medication dosages are calculated by weight vs standard dose for adults
  - Critical emergency care interventions are performed infrequently
  - Stages in their physiologic, emotional and behavioral development affect their responses to medical care and risk of injury and illness
Emergency Medical Services for Children

- National EMSC Program established in 1984 through federal legislation
- Jointly sponsored by
  - Maternal & Child Health Bureau
  - National Highway Traffic Safety Administration
- Funding provided to 59 states and U.S. territories to enhance the pediatric component of their emergency medical services system
Federal EMSC Performance Measures

Performance Measures
- Implemented in 2005
- Defined areas of priority
- Data collection/assessment

EMS Focused
- Online Medical Control
- Offline Medical Control
- Pediatric Equipment on Ambulances
- Pediatric Education Requirements for EMS License Renewal

Hospital Focused
- Pediatric Facility Recognition System
  - Medical emergencies
- Pediatric Recognition System
  - Trauma emergencies
- Written Inter-Facility Transfer Guidelines
- Written Inter-Facility Transfer Agreements

Program Focused
- Permanence of EMSC program
- Integration of EMSC priorities into state statutes/regulations
EMSC Performance Measure #74

The percent of hospitals recognized through a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies.
EMSC Performance Measure #75

The percent of hospitals recognized through a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric traumatic emergencies.
EMSC Performance Measure #76

Percentage of hospitals in the State with written pediatric inter-facility transfer guidelines that specify:

- Roles/responsibilities of referring facility and referral center (including responsibilities for requesting transfer and communication)
- Process for selecting appropriate care facility
- Process for selection of transport service based on patient acuity
- Process for patient transfer (including 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
EMSC Performance Measure #77

Percentage of hospitals in the State with written **inter-facility transfer agreements** that cover pediatric patients
How Pediatric Prepared Are We?

Joint Policy Statement – Guidelines for Care of Children in the Emergency Department (October 2009)

- American Academy of Pediatrics
- American College of Emergency Physicians
- Emergency Nurses Association
- Endorsed by 22 organizations including American Heart Association, American Medical Association, Joint Commission, Society of Trauma Nurses, among others

Guidelines address

- Administration and coordination of care of children
- Physicians, Nurses, Other Healthcare Providers who staff the ED
- Quality Improvement/Performance Improvement
- Pediatric patient safety
- Policies, procedures and protocols
- ED support services
- Equipment, supplies and medications
How Pediatric Prepared Are We?

2013 National Pediatric Readiness Survey Project
- National online survey to measure ED pediatric readiness
- Conducted by National EMSC Program with collaboration
  - American Academy of Pediatrics
  - American College of Emergency Physicians
  - Emergency Nurses Association
- Assessment of hospitals based on *Guidelines for the Care of Children in the Emergency Department*

National Hospital Participation (with EDs) = 4,143
- Median Score = 69

Illinois Hospital Participation = 181 (97.8%)
- Median Score = 82.5 (all hospitals)
- Median Score = 88.8 (PCCC/EDAP/SEDP hospitals)
- Median Score = 64.9 (non-recognized hospitals)
### Breakdown of Illinois Hospital Scores by Hospital Pediatric Volume

<table>
<thead>
<tr>
<th>Category</th>
<th># of Hospitals</th>
<th>Average Score</th>
<th>Median Score</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (&lt;1800 patients)</td>
<td>56</td>
<td>65.3</td>
<td>66.3</td>
<td>29</td>
<td>100</td>
</tr>
<tr>
<td>Medium (&lt;1800-4999)</td>
<td>51</td>
<td>77.8</td>
<td>83.8</td>
<td>44</td>
<td>99</td>
</tr>
<tr>
<td>Medium High (&lt;5000-9999)</td>
<td>39</td>
<td>78.4</td>
<td>85.6</td>
<td>36</td>
<td>99</td>
</tr>
<tr>
<td>High (&gt;=10,000)</td>
<td>35</td>
<td>89.9</td>
<td>91.9</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>Grand Total</td>
<td>181</td>
<td>76.4</td>
<td>82.5</td>
<td>29</td>
<td>100</td>
</tr>
</tbody>
</table>
## Sample of Illinois Scores Linked to Facility Recognition Requirements

<table>
<thead>
<tr>
<th>Scored Item</th>
<th>Illinois Score</th>
<th>National Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Coordinator</td>
<td>75.7%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Physician Coordinator</td>
<td>65.7%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Nurse Competency</td>
<td>72.4%</td>
<td>66.7%</td>
</tr>
<tr>
<td>ED has a pediatric patient care review process</td>
<td>68.5%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Weigh in kilograms</td>
<td>72.9%</td>
<td>67.8%</td>
</tr>
<tr>
<td>If weigh in kilograms, also record in kilograms</td>
<td>82.6%</td>
<td>75.3%</td>
</tr>
<tr>
<td>Hospital disaster plan addresses issues specific to the care of children</td>
<td>78.5%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Inter-facility transfer guidelines</td>
<td>81.2%</td>
<td>70.7%</td>
</tr>
</tbody>
</table>
2013 National Pediatric Readiness

- Demonstrated improvement in pediatric readiness of EDs compared with previous reports.
- Validated that having a Nurse Pediatric Emergency Care Coordinator (PECC) is strongly correlated with improved emergency department readiness for children.
- Presence of both a Physician Pediatric Emergency Care Coordinator and Nurse Pediatric Emergency Care Coordinator is associated with improved compliance with the published Guidelines for the Care of Children in the Emergency Department.
  - 2006 Institute of Medicine Report identified that only 18% of EDs had a Physician PECC and only 12% had a Nurse PECC.
  - 2013 PedsReady assessment identified that 47.5% of EDs have physician PECCs and 59.3% have nurse PECCs.
- Illinois scores show 65.7% of EDs have a Pediatric Physician Champion and 75.7% of EDs have a Pediatric Quality Coordinator.
Hospital disaster plan addresses issues specific to the care of children:

- National Score = 46.8%
- Illinois Score = 78.5%
- Illinois scores based on Facility Recognition Level:

<table>
<thead>
<tr>
<th>Facility Recognition Level (total #)</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDAP (87)</td>
<td>6</td>
<td>75</td>
</tr>
<tr>
<td>SEDP (13)</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>PCCC/EDAP (10)</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Not Recognized (75)</td>
<td>32</td>
<td>45</td>
</tr>
</tbody>
</table>
Illinois Emergency Medical Services for Children (EMSC)

Established in 1994

Illinois Department of Public Health
Division of EMS & Highway Safety

Illinois Department of Human Services
Office of Family Wellness

Loyola University Chicago
Department of Emergency Medicine
Illinois EMSC Areas of Priority

- Enhance Healthcare Professional Pediatric Education and Training
- Develop Practice and Care Standards/Guidelines
- Develop a Pediatric Data Surveillance System
- Promote Pediatric Injury Prevention Initiatives
- Assist with pediatric disaster preparedness
- *Develop a process to assure Emergency and Critical Care preparedness for the pediatric patient – Pediatric Facility Recognition*
ILLINOIS EMSC PEDIATRIC FACILITY RECOGNITION PROGRAM
Illinois Pediatric Facility Recognition

Process to identify the readiness and capability of a hospital and its staff to provide optimal pediatric emergency and critical care

GOAL: To decrease childhood morbidity and mortality by ensuring the availability of appropriately trained personnel, along with appropriate emergency department resources and capabilities in order to effectively manage the critically ill and injured child.
History of the Illinois EMSC Facility Recognition Program

1994 – Convened Facility Recognition Task Force
Development of criteria that facilities need to meet to receive recognition (using other state models and national guidelines)
Developed an implementation process
  Voluntary/inclusive process
  Tiered recognition
    SEDP - Standby Emergency Department for Pediatrics
    EDAP - Emergency Department Approved for Pediatrics
    PCCC – Pediatric Critical Care Center
  Designation authority – Illinois Department of Public Health
1998 - Piloted process (EDAP/SEDP) in 2 regions (urban/rural)
1999 – Began statewide implementation
2002 – Rolled out PCCC level
2005 - Mandatory participation by EMS Resource Hospitals
Ongoing – Facility Recognition & QI Committee provide oversight; recommend revisions to the requirements/regulations; develop resources
Facility Recognition Committee Membership

- Illinois Chapter, American Academy of Pediatrics
- Illinois College of Emergency Physicians
- Illinois Academy of Family Physicians
- Illinois Council, Emergency Nurses Association
- Illinois Hospital Association
- Illinois Perinatal System
- Illinois Trauma System
- ED Nurses, ED Physicians, ED Nurse Manager, EMS Coordinator, Clinical Nurse Specialist, Pediatric Nurse Practitioner, Physician Assistant, Pediatric Intensivists, PICU/Pediatric Nurses, PICU/Pediatric Nurse Manager, Transport Team representatives
# Pediatric Facility Recognition Levels

<table>
<thead>
<tr>
<th>SEDP</th>
<th>EDAP</th>
<th>PCCC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals that have the capabilities to recognize the child in trouble, initiate resuscitation and arrange transfer to a higher level</strong></td>
<td><strong>Hospitals that provide comprehensive ED care and may have some pediatric inpatient services</strong></td>
<td><strong>Hospitals that provide pediatric intensive care and pediatric specialty services</strong></td>
</tr>
<tr>
<td>Standby or Basic ED</td>
<td>Comprehensive ED</td>
<td>Comprehensive ED that is an EDAP</td>
</tr>
<tr>
<td>May not have 24 hour physician coverage in the ED</td>
<td>24 hour ED physician coverage</td>
<td>Dedicated PICU</td>
</tr>
<tr>
<td>Typically does not have inpatient pediatric capabilities</td>
<td>Able to provide more specialized pediatric services</td>
<td>Range of pediatric specialty services and inpatient resources</td>
</tr>
<tr>
<td>Criteria aims to assure capabilities to initially manage/resuscitate patient</td>
<td>May have inpatient pediatric capabilities</td>
<td>Coordinate transfer agreements with referral facilities</td>
</tr>
<tr>
<td>Transfer agreements</td>
<td>Transfer agreements</td>
<td>Transport team or affiliation with transport system</td>
</tr>
</tbody>
</table>
111 hospitals (~60%) recognized as a PCCC, EDAP or SEDP (represents > 90% of pediatric inpatient admissions in Illinois)

Database created to assist with tracking
- Facility Recognition status and history
- Renewal application summary
- Survey observations
- Other

List of recognized hospitals are on IDPH and Illinois EMSC websites
- [www.idph.state.il.us](http://www.idph.state.il.us)
- [www.stritch.luc.org/emsc](http://www.stritch.luc.org/emsc)

Illinois Hospitals Participating in Facility Recognition (as of 10/2016)

**In 2015**

- Hospitals in Illinois with EDs = 185
- Total pediatric ED visits = 947,144
- Inpatient admits via the ED = 27,175
- Recognized hospitals = 110 (includes 5 out-of-state hospitals)
- Pediatric ED visits = 745,718 (79% of total)
- Inpatient admits via the ED = 25,892 (95% of total)
Facility Recognition Criteria

- Physician/Advanced Practice Provider/Nursing staff requirements
- Policy/procedure and treatment guidelines
- Equipment/supplies/medication requirements
- Quality improvement
- Pediatric disaster preparedness
Physician/Advanced Practice Provider/Nursing Staff Requirements
Physician Qualifications/Requirements

**EDAP**
- 24/7 coverage of the ED by at least one physician with Board Certification
  - ABEM, AOBEM, ABP, AOBP, ABFP, AOBFP
- Current AHA-PALS or APLS for non-emergency medicine board certified physicians
- Waiver option – not available after 12/31/2017 (replace with Alternate Criteria
  MUST HAVE WAIVER APPROVAL LETTER DATED PRIOR TO 12/31/2017)

**SEDIP**
- Licensed physician
- Training in care of pediatric patients thru residency training, clinical training or practice
- Current AHA-PALS or APLS

**EDAP/SEDIP**
- 16 hrs CME in pediatric emergency topics every two years for ED and Fast Track physicians
- Availability of telephone consultation capabilities with physician board certified in pediatrics or pediatric emergency medicine
- ED Back-up physician within 1 hour for critical situations, increased surge
- On-site response time guidelines for on-call physicians

*All APLS and PALS must include both cognitive and practical skills evaluation*
Physician Qualifications/Requirements: PCCC

**PICU Medical Director**

1) Board Certified in Pediatrics by ABP or AOBP, and Board Certified or in the process of certification in Pediatric Critical Care Medicine by ABP or Pediatric Intensive Care by AOBP; or

2) Board Certified in Pediatrics by ABP or AOBP and Board certified in a pediatric subspecialty with at least 50% practice in pediatric critical care; or

3) Board Certified in Anesthesiology by ABA or AOBA, with practice limited to infants and children and with a subspecialty Certification in Critical Care Medicine;

4) Board Certified in Pediatric Surgery by ABS with a subspecialty Certification in Surgical Critical Care Medicine by ABS.

**NOTE:** In situations 2, 3 & 4 above, a Board Certified Pediatric Intensivist, certified by ABP, shall be appointed as Co-Director.
A Board Certified Pediatric Intensivist, certified by ABP or AOBP, or in the process of certification by ABP or AOBP, who is available within 30 minutes in-house after determination is made that they are needed and who is responsible for the supervision of those listed below. When the intensivist is not in-house, one of the following must be in-house:

- Board Certified Pediatrician, certified by ABP or AOBP or in the process of board certification;
- A resident of PGY-2 or greater under the auspices of a Pediatric Training shall be in the unit, with a PGY-3 in-house.

All of the physicians listed above shall successfully complete and maintain current recognition in AHA-PALS or APLS.

Availability of physician specialists

Pediatric Inpatient Unit Hospitalists

Maintain AHA-PALS or APLS
Physician Qualifications/Requirements: PCCC

Physician Specialist Availability

- Pediatric proficiency as defined by the hospital credentialing process;
- Board/sub-board certification in their specialty;
- 10 hours/year of pediatric CME (category I or II) in their specialty
- 60 minute in-house response time for the following with pediatric proficiency: surgeon, anesthesiologist and neurosurgeon (or transfer agreement)
- Subspecialists with pediatric proficiency available in-house or by phone consultation within 60 minutes after determination is made that they are needed, i.e., orthopedics, neurologist
- Access to other physician specialists as outlined in Section 515.4020 c, 2
Advanced Practice Provider Qualifications: EDAP/SEDJP

Nurse Practitioners/Physician Assistants

- Credentialing reflects orientation, ongoing training, specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process
- Current recognition in APLS, ENPC or PALS
- Nurse Practitioner
  - Pediatric NP; or
  - Emergency NP; or
  - Family Practice NP; or
- Waiver option – not available after 12/31/2017 (will be replaced with Alternate Criteria) MUST HAVE WAIVER APPROVAL LETTER DATED PRIOR TO 12/31/2017
- 16 hours CEU/CME in pediatric emergency topics every two years

All APLS and PALS must include both cognitive and practical skills evaluation
Advanced Practice Provider Qualifications: PCCC

Nurse Practitioners/Physician Assistants (providing direct patient care in the PICU)

**PICU Nurse Practitioner**
- Completion of a Pediatric Nurse Practitioner program or Pediatric Critical Care Nurse Practitioner Program. Certification as an Acute Care Pediatric Nurse Practitioner

**PICU Physician Assistant**
- Current Illinois Physician Assistant licensure

**NPs & PAs**
- Credentialing that reflects orientation, ongoing training and specific demonstrated competencies in the care of the critically ill and injured pediatric patient as defined by the hospital credentialing process
- Current recognition in APLS, PALS or ENPC; and 50 hours continuing education in pediatric critical care topics every two years
Alternate Criteria – replaces waiver

**Physicians**
- Physicians who do not meet defined board certifications (ABEM, AOBEM, ABP, AOBP, ABFP, AOBFP), need to apply for a waiver by 12/31/2017.
- Obtain waiver approval letter from IDPH (dated within 1/1/2014 – 12/31/2017) automatically grandfathers these physicians into meeting EDAP physician qualifications. Must continue to meet below requirements:
  - Need to have worked in an ED prior to 1/1/2018, completed 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60 month period; have current APLS or PALS; complete 16 hours of pediatric CME every two years.

**Nurse Practitioners**
- NPs who have not completed one of the following NP programs need to apply for a waiver by 12/31/2017: pediatric NP program, emergency NP program or family practice NP program.
- Waiver approval letter from IDPH (dated within 1/1/2014 – 12/31/2017) automatically grandfathers these NPs into meeting EDAP and SEDP nurse practitioner qualifications. Must continue to meet below requirements:
  - Need to have worked in an ED prior to 1/1/2018, completed at least 2000 hours of hospital-based emergency department or acute care as a NP over the last 24-month period that includes the care of pediatric patients; have current APLS, ENPC or PALS; complete 16 hours of pediatric CE every two years.

**NOTE:** Waiver option will no longer be available after December 31, 2017.
Staff Nursing Qualifications: EDAP/SEDP

One RN per shift responsible for direct care of the child in the ED with current recognition in:
- APLS, or
- ENPC, or
- PALS

All ED nurses need to maintain recognition in APLS, ENPC or AHA-PALS within 2 years of hire

**EDAP**: 8 hours of pediatric emergency/critical care CE every two years for all nurses

**SEDP**: 8 hours of pediatric emergency/critical care CE every two years for one nurse per shift

*All APLS and PALS must include both cognitive and practical skills evaluation*
**Staff Nursing Qualifications: PCCC**

- **PICU Nurse Manager**
  - 3 years of clinical critical care experience with a minimum of one year in clinical pediatric care
  - Maintains APLS, ENPC or AHA-PALS recognition

- **Pediatric Unit Nurse Manager**
  - 3 years pediatric experience
  - Maintains APLS, ENPC or AHA-PALS recognition

- **Advanced Practice Nurse (CNS/NP)**
  - Clinical leadership/educator role in the management of pediatric patients
  - Completed a Pediatric Nurse Practitioner program or Pediatric Clinical Nurse Specialist Program, and certification as a Pediatric NP or Pediatric CNS
  - Current Illinois Advanced Practice Nurse License
  - Current APLS, PALS, ENPC
  - 50 hours of continuing education in pediatric critical care topics every two years

- **PICU and Pediatric Unit Staff Nurse**
  - Maintains APLS, ENPC or AHA-PALS recognition
  - 16 hrs pediatric emergency/critical care continuing education every 2 years
Policy and Procedure Requirements
Policies and Procedures: EDAP/SEDP

Interfacility Transfer Agreements

“The transfer agreement shall include a provision that addresses communication and QI measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer and patient outcome.”

Interfacility Transfer Guidelines (shall include)

- Process for initiation of transfer, including role and responsibilities of the referring hospital and referral center;
- Process for selecting the appropriate care facility;
- Process for selecting the appropriately staffed transport service to match the patient’s acuity level;
- Process for patient transfer (including obtaining informed consent);
- Plan for transfer of patient medical record information, signed transport consent and transfer of belongings;
- Plan for provision of directions and referral hospital information to family
Policies and Procedures: EDAP/SEDP

- Suspected Child Abuse and Neglect Policy
  - Address identification (including screening), evaluation, treatment and referral to DCFS of victims of suspected child abuse/neglect

- Latex-Allergy Policy
  - Address assessment of latex allergies.

- Pediatric Treatment Guidelines
  - The facility shall have guidelines, order sets or policies/procedures addressing initial assessment and management for its high volume/high risk pediatric population (i.e. fever, trauma, respiratory distress, seizures)
  - Encourage linking newly developed guidelines with QI monitoring

- Disaster Preparedness
  - The hospital shall integrate pediatric components into the hospital Disaster/Emergency Operations Plan
Policies and Procedures: PCCC

- Admission/discharge criteria policy
- Nursing staffing policy based on patient acuity
- Managing psychiatric/psychosocial needs of the PICU patient
- Protocols/order sets/guidelines for management of high/low frequency diagnoses
- Transfer/transport policy that addresses the special needs of the pediatric population during transport
  - Provide consultation to hospitals with established transfer agreement
  - Provide feedback as well as quality review to hospitals on the transfer and management process
  - Have or be affiliated with a transport system and team
- Others
Equipment/Supplies/Medications

- EDAP/SEDP and PCCC
  - Various equipment items, supplies and medications
- Dosing device (length or weight based system for dosing and equipment)
- Weighing scales in KILOGRAMS ONLY
- Access to the 1-800-222-1222 Illinois Poison Center helpline

NOTE: Illinois Hospital Assn Group Purchasing Services can assist with vendor identification of required items and/or required sizes (312-906-6122)
Quality Improvement
Quality Improvement: Emergency Department (EDAP/SEDP)

- Multidisciplinary QI committee/process with documented monitors addressing pediatric care
- **Must minimally address ALL of the following monitors:**
  - Pediatric ED deaths,
  - Pediatric inter-facility transfers
  - Child abuse and neglect cases
  - Critically ill or injured children in need of stabilization (e.g. respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure)
- Identify other pediatric quality and safety QI priorities of the institution.
Quality Improvement: Available QI Tools

**Required monitors:**
- Pediatric Death or Resuscitation Review Tool
- Pediatric Interfacility Transfer Review Tool
- Child Abuse and/or Neglect Injury Screening Tool

**Other:**
- Pediatric Pain Assessment Tool
- Pediatric Pain Management Tool
- Pediatric Asthma Management Tool
- Pediatric Prehospital Respiratory Distress Tool
- Pediatric Seizure Management Tool
- Pediatric Prehospital Seizure Assessment and Management Tool
- Transferred Patient Hospital Feedback Form

Utilize your QI Committee to define the loop closure process

Communicate QI findings to both administration and staff (i.e. via staff meetings, meeting minutes, huddles, bulletin board postings)

*Positive findings* – recognize staff/team

*Opportunities for improvement* – identify education/changes/strategies to address the issue(s)

Implement changes as needed

Re-evaluate QI findings after changes implemented to identify any improvement

Document follow-up in meeting minutes
Quality Improvement: Emergency Department

Pediatric Quality Coordinator (PQC)

Designation of a Pediatric Quality Coordinator:

“A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator.”

Job description that includes the allocation of appropriate time and resources by the hospital

Works with the Pediatric Physician Champion to:

- Assure documentation of pediatric continuing education requirements
- Coordinate data collection for identified clinical indicators/outcomes
- Review selected pediatric cases transported to the hospital by prehospital providers and provide feedback to the EMS Coordinator/System
- Participate in regional QI activities and attend meetings. One representative to report to the Regional EMS Advisory Board
Role of Pediatric Quality Coordinator

- Work with the Pediatric Physician Champion
- Attend & participate in regional meetings
  - Send representative if unable to attend a meeting
- Participate in regional/statewide and ED/hospital pediatric QI projects
- Share data findings with your Pediatric Physician Champion, colleagues, ED administration, EMS Coordinator, ED QI committee/process, others (as applicable).
- Collaborate with ED/EMS staff to implement positive changes in pediatric care
- Work with ED administration to ensure compliance with PCCC/EDAP/SEDP requirements (esp. related to CE requirements)
- Be aware of and offer suggestions for prehospital pediatric monitors
- Share pediatric information/continuing education opportunities with colleagues

*Advocate for your pediatric patients!!*
A physician appointed by the ED Medical Director to champion pediatric quality improvement activities.

Works with and provides support to the Pediatric Quality Coordinator

- Quality Improvement
- Education
- Liaison to ED Medical Director and physician staff on pediatric issues
- Assist with loop closure process
Quality Improvement: PCCC-PICU/Inpatient Pediatric Unit

- Multidisciplinary Pediatric QI Committee
- Focused outcome analyses of PICU services and other pediatric inpatient unit services, including:
  - Pediatric deaths
  - Pediatric interfacility transfers
  - Pediatric morbidities or negative outcomes as a result of treatment rendered/omitted
  - Pediatric quality metrics that examine process of care
  - Child abuse cases (unless performed by another hospital committee)
  - Readmissions within 48 hours after discharge from ED or inpatient that result in admission to the PICU
  - All potential and unanticipated adverse outcomes
- Provide feedback/quality review to transferring facilities on transfer and management process
Pediatric Disaster Preparedness
Hospital Pediatric Preparedness Checklist

Revised in 2015
- Based on recommendations from hospitals
- Ensure consistency with National EMSC guidelines

Key changes:
- Clarification of components that frequently caused confusion
- Provide more guidance to hospitals regarding requirements
- Expanded options to meet exercise requirements
- New Recovery component
- Checklist part of a Toolkit, not just free standing document
Components of Hospital Pediatric Preparedness Checklist

- Overall Emergency Operations Planning
- Surge Capacity
- Decontamination
- Reunification/Patient Tracking
- Security
- Evacuation
- Mass Casualty Triage/JumpSTART
- Children with Special Health Care Needs/Children with Functional Access Needs
- Pharmaceutical Preparedness
- Recovery
- Exercises/Drills/Training
Overall Emergency Operations Planning

- Pediatrics integrated into the hospital Emergency Operations Plan (EOP)/Disaster Plans
  - Separate considerations or under “at risk” population category
  - Recommendation only

- Population assessment of children in hospital service area and incorporate findings into HVA
  - Schools
  - Child care centers
  - Recreational centers/parks
  - Juvenile detention centers
Overall Emergency Operations Planning

- **Staff with pediatric focus** consulted when developing and updating the EOP/Disaster Plan
- Staff with pediatric focus regularly attend hospital emergency preparedness committee meetings and continue to contribute to overall hospital preparedness
- **Staff with pediatric focus encouraged to take courses such as FEMA IC 100, 200 & 700**
  - Recommendation only
- Staff with pediatric focus integrated into hospitals ICS/EOC as indicated by type of event
- Disaster preparedness coordinator regularly attend/participate in regional healthcare coalition meetings
Surge: Planning

- Designate pediatric surge areas/space
  - Alternate treatment sites
  - Pediatric safe areas
- Processes in place to address the needs of children, pregnant women and newborns (e.g. equipment, surge areas, care guidelines)

- Surge resources/capabilities
  - Cribs/beds/isolettes/mattresses
  - Access to pediatric equipment/supplies
    - Pediatric isolation equipment, pediatric face masks
    - Newborn supplies
  - Ventilators
  - Infant/child nutritional needs
    - Age appropriate foods/formula
    - Number of hours of stockpile on site
  - Hygiene needs
    - Infants/toddlers
  - Distraction devices/toys
  - MOUs with external vendors
Surge: Staffing

- Pediatric staff
  - Review call rosters
  - Ensure access to translators
  - Staff assistance:
    - Child, elder and pet care
  - Identify staff who can address psychosocial needs
    - Child Life Specialists
    - Mental Health Professionals
    - Social Workers
    - Chaplains and Hospice Staff
    - Community Clergy
- Identify other options for accessing staff in times of disasters
  - Illinois Helps
Decontamination

- **Water**
  - Low pressure/high volume water
  - Warmed water: 98° F-110° F (36.6° C - 43.3° C)
  - How temperature of water will be monitored during decon

- **Supplies**
  - Soft decon brushes
  - Small gowns/clothing
  - Warming devices/supplies
    - At risk for hypothermia
Process to safely transport/move children through decon shower system
  - Slippery
  - May be uncooperative due to fear

Exercise/drill/training
  - Conducted decon exercise/drill/training within the last 12 months that has included pediatrics and method to decon infants/young children

Keep family unit together!
Reunification/Patient Tracking

- Identify methods for patient identification and tracking
  - Triage tags
  - Surgical marking pens/waterproof markers
  - Wrist/ankle bands
  - Camera with printer
- Develop protocol/process for reuniting/releasing children with parents/caregivers
  - Verification of guardianship
- Link with social services and community partners
  - National Center for Missing & Exploited Children
  - Local law enforcement
  - American Red Cross
- Reunification process tested in exercise/drill/training
Security

- Keep families together
- Develop lock down or secure access procedures
- Test hospital infant and child abduction procedures within the last 12 months
- Unidentified/unaccompanied children
  - Designate holding area/pediatric safe area
  - Address security needs/staffing guidelines
  - Address issues of verifying guardianship
Evacuation

- Ensure all staff are familiar with evacuation procedures designated evacuation routes
- Adequate supplies and equipment for evacuation
  - Pediatrics, nursery, med/surg unit that admits pediatric patients
- Predesignate evacuation staging areas that can be secured
  - Stockpiled supplies including resuscitation equipment
- Prepare unit specific evacuation plans for pediatric areas
  - ED, newborn nursery, pediatric unit, med/surg unit that admits pediatric patients
- Conduct unit specific evacuation exercises/drills-training
Mass Casualty Triage/JumpSTART

- **START** – Simple Triage and Rapid Treatment and JumpSTART
  - Mass casualty triage systems approved for use in Illinois
  - Assesses Respirations, Perfusion and Mental Status
  - Utilizes four triage categories

- JumpSTART addresses physiological/developmental differences of children

- Train staff:
  - Minimal: ED staff
  - Ideal: ED and pediatric inpatient staff

- JumpSTART included in exercise/drill/training within the last 12 months
23% of U.S. households have at least 1 child that meets criteria
15.1% of U.S. kids meet criteria
Illinois: 452,574 kids (14.3%)
Systems in place to handle CSHCN/CFAN during a disaster, especially for hospitals that typically transfer these children to pediatric specialty centers (e.g. MOUs to obtain extra medications, ventilators, care guidelines, etc.)
Encourage use of the Emergency Information Form (EIF)
Pharmaceutical Preparedness

- Medication distribution plan or process
- Process outlined within plan for converting pills to liquid for:
  - Amoxicillin
  - Ciprofloxacin
  - Doxycycline
  - Tamiflu
- Access to medication instructions specific to children
Recovery

- Process to work with primary providers, social services, public health or other health services to provide screening, primary prevention and treatment for behavioral health for children and CSHCN
- Process to provide parents information resources to address needs of children after disaster
- Process to assist staff with self care/mental health needs after disaster
Exercises/Drills/Trainings

- Practice, Practice, Practice!!
- Mock codes:
  - Utilize pediatric resuscitative equipment
  - Calculate and draw up dosages
Exercises/Drills/Trainings

Incorporate children of all ages and CSHCN/CFAN into exercises/drills/trainings:
- Infants
- Toddlers
- School age children
- Adolescents
- CSHCN/CFAN

Exercises/drills/trainings required for:
- Evacuation
- Surge
- JumpSTART
- Reunification
- Decon
- Infant and child abduction
Exercises/Drills/Trainings

Possible sources for “victims” during drills:
- Local schools
- Employees’ children
- Boy scout/girl scout troops
- Manikins
- Dolls
- Paper victims (Flat Stanley)

Types of exercises/drills/trainings:
- Tabletop
- In-service
- Annual training/review
  - Need to track age groups used in training
- Functional
- Full Scale
Resources

http://ssom.luc.edu/emergency-medicine/children/disasterpreparedness/
RENEWAL APPLICATION
Renewal/Application Instructions

- Carefully review the application packet
- Obtain and review your previous PCCC/EDAP, EDAP or SEDP renewal application
- Review the PCCC/EDAP, EDAP and SEDP requirements
  - Some new requirements have been added
  - Revisions have been made in some requirements
- Revise policies/guidelines/scope of practice/other documents accordingly to assure consistency with requirements
- Verify supplies/equipment/medications
- Using the Pediatric Renewal Plan Checklist, begin to pull together the required documentation

**NOTE:** Development of the Pediatric Renewal Plan should be a **multidisciplinary effort**
## EDAP & SEDP Renewal Pediatric Plan Checklist

### Instructions:
Complete an updated EDAP or SEDP Pediatric Plan for your facility using the guideline below and the EDAP or SEDP criteria located in this application. See pages 7-12 (EDAP) and 13-17 (SEDP).

Use the tabs provided by the EMSC office to organize your application.

For each requirement outlined below, select the response(s) as directed and attach supporting documentation.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosed is an organizational chart identifying the administrative relationships among all departments in the hospital, including the Emergency Department and Department of Pediatrics.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is an organizational chart identifying the organizational/reporting structure of ED physician, nursing and ancillary services. Include the reporting structure for the ED Medical Director (to whom he/she reports)</td>
<td></td>
</tr>
</tbody>
</table>

**Review the criteria in section 515.4000 a, 1 and 2 or 515.4010 a, 1 and 2 for the physician staff qualifications and continuing medical education and submit each of the below.**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosed is a policy (s) that incorporates the physician qualifications and CME requirements.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is a completed <strong>CREDENTIALS OF EMERGENCY DEPARTMENT PHYSICIANS</strong> Form.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is a completed <strong>CREDENTIALS OF FAST TRACK PHYSICIANS</strong> Form.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is the curriculum vitae for the ED Medical Director.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is a current one-month physician schedule for the ED.</td>
<td></td>
</tr>
</tbody>
</table>

**Review the criteria in section 515.4000 or 515.4010 a, 3, for the ED Physician coverage and submit one of the below.**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosed is a previously approved policy. There are no changes.</td>
<td></td>
</tr>
<tr>
<td>Enclosed is a revised policy for approval. (Necessary if any ED physicians have a waiver).</td>
<td></td>
</tr>
</tbody>
</table>

**Review the criteria in section 515.4000 or 515.4010 a, 4, for ED Consultation and submit the below.**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosed is a one month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians.</td>
<td></td>
</tr>
</tbody>
</table>
Renewal/Application Instructions

- There needs to be submission of formal documents that incorporate the requirements, i.e., policies, procedures, scope of practice/care, bylaws, etc.

- Use the provided credentialing forms to list physicians, nurses, nurse practitioners and physician assistants.

- Assure continuing education files (physician and nursing), tracking mechanisms and any other back-up documentation is available.

- Illinois EMSC has developed an electronic continuing education tracking resource tool.

  PC and network versions along with instructional guidelines available per Dan Leonard at dleonar@luc.edu
What You Need to Submit

The original signed *Request for Re-recognition of PCCC/EDAP, EDAP or SEDP* form and the Pediatric Plan comprised of:

- Completed PCCC/EDAP, EDAP or SEDP Pediatric Plan Checklist
- Supporting documentation (follow checklist format)
- Completed Physician, Nursing and Nurse Practitioner and Physician Assistant credentialing forms
- Completed PCCC, EDAP or SEDP equipment checklists
- Completed Pediatric Hospital Preparedness Checklist
What You Need to Submit

- Use tabs provided by EMSC to organize your application
- Number of copies to submit for renewal
  - 1 original copy (with tabbed page dividers)
  - 3 additional copies
- Submit single-sided format and unstapled.
- Maintain a copy for your files (with tabbed page dividers)
- Confirm the application due date
- Mail the above copies to the IDPH Springfield office by the due date noted on the application

**NOTE:** If there are dates that you would like us to avoid when scheduling your site survey - include a memo in your application or send an email to Evelyn.Lyons@illinois.gov. We will try to avoid those date(s).
Renewal/Application Tips

Forms are available electronically on the EMSC website – www.stritch.luc.edu/emsc (Click on Facility Recognition link).
- Credentialing forms, equipment checklist and disaster checklist
- Physician and Nurse Practitioner waiver application form and information

Equipment/supply waivers must be submitted in a letter format and identify how waiver will not result in any compromise in care. A waiver for an equipment/supply item should identify:
- The item requested for waiver
- Where the item is currently stored
- How easily/quickly the item can be accessed in an emergency situation
- Identify how care will not be compromised or harm occur by not having item located in the ED

Do not hesitate to contact EMSC for any questions!!
SITE SURVEY PROCESS REVIEW
Opening Session

- **Who should be present?**
  - List of individuals outlined in survey letter

- **How long should it be?**
  - EDAP/SEDP - Approx 30 min
  - PCCC – Approx 45 min

- **What should be reviewed?**
  - SWOT related to pediatric emergency care capabilities (PCCCs should include pediatric inpatient/PICU capabilities)
  - Demographics
  - QI processes overview and inclusion of pediatrics
  - Interfacility transfer process
  - Pediatric disaster preparedness and pediatric surge capabilities
The Tour

- **Who should be present?**
  - Individuals key to the areas being toured
  - Emergency Department
  - Fast Track
  - Radiology/CT scan
  - Pediatric Inpatient Unit(s) or unit where pediatric patients are admitted
  - Disaster supply area(s), decon area/capabilities, pediatric surge areas

- **How long will it last?**
  - Approx 45-60 minutes

- **What will be looked at?**
  - Will be reviewed over next several slides
First Stop on the Tour: Point of Patient Entry
Next Stop on the Tour: Triage Area

**PAIN MEASUREMENT SCALE**

- **No Hurt**
- **Hurt a Little Bit**
- **Hurt a Little More**
- **Hurt Even More**
- **Hurt Whole Lot**
- **Hurt Worst**

**Non-verbal Pain Scale**

**Movement**
- 0 = Positive response to interaction and touch
- 1 = Starting, guarding, generalized tension
- 2 = Thrashing, restless squirming

**Position**
- 0 = Restful position, joints relaxed, hands open
- 1 = Finger curled, initial resistance to position change
- 2 = Clenched fists, knees pulled up, strong resistance to positioning

**Facial Cues**
- 0 = Placid expression, smile, relaxed jaw
- 1 = Frown, fearful expression, brow lowering
- 2 = Scowling, clenched jaw, stern look

**Emotion**
- 0 = Pleasant, serene, cooperative, sleeping
- 1 = Uncooperative, anxious, confused
- 2 = Irritable, combative

**Verbal Cues**
- 0 = Agreeable responses, humming, singing to self, quiet
- 1 = Moaning, groaning, monotone, muttering
- 2 = Screaming, screaming, crying
The Tour Continues: Emergency Department
Emergency Department: Crash Cart Review
Emergency Department: Equipment/Supply/Medication Review
Next Stop on the Tour: Pediatric Inpatient Areas
Tour of PCCC Hospitals

- Two separate teams during the tour
  - One team focuses on the emergency department
  - Other team focuses on the PICU/Pediatric Unit
Additional Focus of the Tour: Pediatric Disaster Review
Additional Focus of the Tour: Pediatric Disaster Review
Document Review
(Approx 60-75 min)
Documents to have present for review:

- Requested information outlined in survey letter
- Quality improvement documentation/manuals with monitor tools (for the required QI monitors), follow-up/loop closure documentation (current two calendar years)
  - Emergency Department
  - PICU/Inpatient Pediatric Unit documentation (for PCCC hospitals)
- Multidisciplinary QI meeting minutes
- One ED patient medical record for each of the four required QI monitors (Pediatric Quality Coordinator and Pediatric Physician Champion discuss QI review process):
  - Pediatric deaths
  - Pediatric interfacility transfers
  - Suspected child abuse/neglect cases
  - Critically ill or injured children in need of stabilization
Documents to have present for review:

- Documentation identifying Pediatric Quality Coordinator participation on regional QI Committee, participation in regional QI activities
  - Meeting minutes
  - Regional monitor activities/findings/process
- Policy and procedure manuals
  - Emergency Department
  - PICU and pediatric unit policy and procedure manuals (for PCCC hospitals)
- Transfer log
- Documentation related to mock code conduction
- Continuing education files for physicians, advanced practice providers and nurses
Documents to have present for review:

- Physician and Nursing staff meeting minutes
  - Emergency Department
  - PICU and pediatric unit minutes (for PCCC hospitals)
- Disaster plans/policies/procedures
  - EOP
  - Decon
  - Evacuation
  - Surge
  - Security
  - Reunification
  - Pharmacy
  - After action reports/training summaries
- Will review previous site survey’s Improvement Plan
Exit Session

Who should be present?
- Key individuals outlined in survey letter

What will be reviewed?
- Survey team observations
- Identification of strengths
- Identification of opportunities for improvement
- Identification of additional documentation/corrective action plans needed

How long is it?
- 15-45 minutes
Common Site Survey Issues:

**Education**

- Non-American Heart Association sponsored PALS courses
  - Courses need to include both cognitive and skills evaluation
    - Some online PALS courses do not meet this
      
      NOTE: online AHA courses do have a skills component

- Lack of conduction of pediatric mock codes
  - Multidisciplinary; incorporate utilization of crash cart
  - Incorporate into quality improvement process
  - EMSC Pediatric Mock Code Toolkit and resources available
  - PALS scenarios can be used as a resource

- Non-compliance or documentation/tracking issues with pediatric CE/CME requirements
  - Ongoing pediatric continuing education is essential for ALL practitioners who take care of children
  - On-line CME is available and easy to access
  - Need alerting/trigger process when staff nearing PALS/ENPC expiration

Note: Continuing Education Tracking Tool for hospital personnel developed thru EMSC is available.
PublicHealthLearning.com (Free CE)

NOTE: PowerPoint presentations are also available at: www.stritch.luc.edu/emsc
Common Site Survey Issues: Policies/Documentation

- Requirements need to be incorporated into policy or other formal documents
- Interfacility transfer agreements
  - Assure that agreements address communication/feedback requirement
- Lack of pediatric treatment guidelines or lack of protocols/guidelines/clinical pathways that address high volume or low volume/high risk diagnoses
- Pediatric guidelines not consistent with current practice standards (e.g., use of Demerol for pain; use of Thiopental in moderate sedation policy)
- Lack of a pediatric pain scale addressing infant and non-verbal child
  - Most hospitals use Wong-Baker FACES scale (appropriate for age 3 and older)
  - Need scales based on physiologic criteria for younger and non-verbal children (e.g., FLACC, NIPS, etc.)
Common Site Survey Issues: Quality Improvement

- Need to have a formal process for monitoring:
  - **SEDP/EDAP**: pediatric deaths, interfacility transfers, suspected child abuse/neglect, and critically ill or injured children in need of stabilization
  - **PCCC**: all above; additionally pediatric morbidities or negative outcomes as a result of treatment or omission; re-admissions within 48 hrs after discharge from ED or inpatient unit that results in PICU admission; pediatric quality metrics that assess process of care

- Inconsistent or lack of attendance at regional QI meetings

- Varied or lack of support/allocation of time provided to the Pediatric Quality Coordinator role for monitor review, data collection, quality improvement activities
Quality improvement documentation doesn’t include thorough follow-thru or loop closure

Lack of sharing of quality improvement findings with physician and nursing staff (e.g., staff meeting minutes)

Feedback loop/communication process to referral hospitals on transferred patients (PCCC hospitals)

Building on previous/current pediatric quality improvement efforts
Common Site Survey Issues: Equipment/Supplies/Medications

- Old Poison Center phone # posted
  - National Poison Hotline 1-800-222-1222
- Expired drugs/equipment trays
- Stocking of medications that are no longer recommended (e.g., Ipecac)
- Consider high-alert labels on look-a-like drugs (e.g., 25% and 50% Dextrose; 4.2% and 8.4% Sodium Bicarb
- All OB Kits should contain a bulb syringe
- Missing smaller airway supplies (i.e., nasal cannula, nasal airways, pediatric Magill forceps)
- Availability of warming devices
- Scales need to be **locked out** to weigh in **kg only**
Common Site Survey Issues: Equipment/Supplies/Medications

- Pediatric crash cart issues
  - Poor organization or difficulty finding items
  - Lack of first-line resuscitation drugs stocked in crash cart or immediately available
  - Outdated Broselow tape and/or outdated dosing booklets/information (i.e. inconsistent with current AHA guidelines)
  - Broselow cart stocking that is not consistent with the color coded tape
  - Cart check system not consistently documented
  - Crash cart not locked
  - Pediatric crash carts not standardized within the institution

- Inpatient Pediatric Unit
  - Need for emergency airway supplies in treatment room
  - Need for pre-printed weight based resuscitation medication dosing forms available at the patient bedside or on chart

NOTE: Investigate mechanisms to group purchase items that aren’t utilized often and can be ordered in bulk
Rapid Response Teams: pediatric education should be required for team members (i.e. PALS)

Security measures/drills should be in place re potential child abduction

Child abuse/neglect screening processes in place

Documents requested prior to the survey need to be available for the survey team

Lack of administrator or designee presence during site survey making it difficult to determine administrative support

Lack of sharing resources/expertise between pediatric unit/department and emergency department

ED Physician contract groups: compliance issues with requirements, especially out-of-state physician groups. Requirements should be outlined in their contract.
CONCLUSION
A Measure to Evaluate Effectiveness of Facility Recognition

- Using hospital discharge data, mortality rates per 1,000 inpatients were calculated for 0 - 15 year olds who were admitted with an injury related diagnosis.

- Records were restricted to facilities that obtained recognition at any level from 1994 - 2015.

- Mortality rates were evaluated.
Pre/Post-Recognition Comparison

The pre-recognition mortality rate was 12.2 deaths per 1,000 inpatients with an injury-related diagnosis.

The post-recognition mortality rate was 9.9 deaths per 1,000 inpatients with an injury-related diagnosis.

This difference is statistically significant.

NOTE: Decreases in mortality can likely be attributed to multiple factors, one of which may be the increased awareness and attention to pediatric emergency care needs emphasized through facility recognition.
Ongoing/Future Plans

- **New National EMSC Resource Center - July 1, 2016**
  - *EMSC Innovation & Improvement Center (EIIC)*
  - Greater utilization of quality improvement processes

- Continue emphasis on Pediatric Quality Improvement in emergency department (EDAP/SEDP) and PICU/pediatric inpatient areas (PCCC/EDAP)

- Continue ongoing renewal of PCCC/EDAP, EDAP and SEDP status every four years

- New Illinois EMSC website [www.stritch.luc.edu/emsc](http://www.stritch.luc.edu/emsc)
New Updated IL EMSC Website – www.stritch.luc.edu/emsc

Illinois Emergency Medical Services for Children

Illinois Emergency Medical Services for Children (EMSC) is a collaborative program between the Illinois Department of Public Health and Loyola University Chicago, aimed at improving pediatric emergency care and disaster preparedness within our state. Since 1994, the Illinois EMSC Advisory Board and several committees along with organizations and individuals within the EMS, pediatric and emergency management communities have worked to enhance and integrate pediatric policy development, education, standards, injury prevention and data initiatives into the Illinois EMS system. The goal of Illinois EMSC is to assure that appropriate emergency medical care is available for ill and injured children at every point along the continuum of care.

RESOURCES
- Regional Pediatric Resource Directory
- PublicHealthLearning.com
- Ron W. Lee, MD, Excellence in Pediatric Care Awards

Note: If your link to the EMSC page does not have this appearance, try refreshing the browser
Resources

Technical assistance with Facility Recognition requirements and renewal process
- Paula Atteberry: 217-785-2083 or Paula.Atteberry@illinois.gov
- Evelyn Lyons: 708-327-2556 or Evelyn.Lyons@illinois.gov

Pediatric disaster preparedness resources
- Laura Prestidge: 708-327-2558 or lprestidge@luc.edu

Pediatric education/quality improvement (QI) resources
- Dan Leonard: 309-451-1763 or dleonar@luc.edu

Data resources
- Dan Leonard: 309-451-1763 or dleonar@luc.edu
- Ruth Kafensztok: 708-327-9019 or rkafens@luc.edu

National EMSC website
www.childrensnational.org/emsc

Illinois EMSC website
www.stritch.luc.edu/emsc

Illinois Department of Public Health website
www.idph.state.il.us
Remember: PCCC/EDAP/SEDP renewal is a team effort!