https://emscimprovement.center/programs/partnerships/family-advisory-network/

Family Advisory Network

In 1999, the EMSC Program created the Family Advisory Network (FAN) to facilitate the inclusion of family representatives in state EMSC programs. Today, the FAN membership includes family representatives from most states and U.S. territories.

FAN members contribute to their state program activities in numerous ways, including, but not limited to: serving as members, chairs, and co-chairs of their state EMSC advisory committee; coordinating special community outreach projects; assisting with the development and implementation of EMSC policy objectives; and helping to plan, present, and promote educational offerings within their state.

Family representatives are also involved at the national level. Several FAN members sit on the federal EMSC Strategic Planning Committee and are involved on the EMSC Program Meeting Planning Committee.

In addition, members share resources and information through the EIIC electronic updates.

Family Advisory Network

Resources

Webinars

Members List

Members Only

Helping to Improve Pediatric Emergency Care

This 14-minute video captures the compelling stories of nine Family Advisory Network (FAN) representatives and highlights the work they are doing to improve pediatric emergency care at the local and state levels.

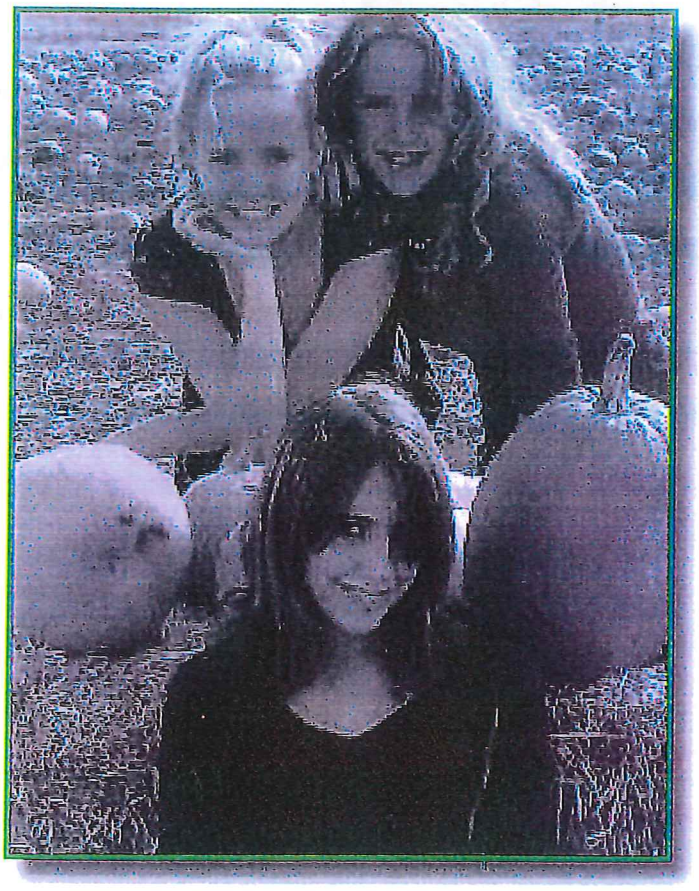
Chapter 2 What Is A Family Representative?

An EMSC Toolkit for Family Representatives

Family representatives are individuals selected by the state EMSC advisory committee and/or the state EMSC project manager to represent the needs of families in the community. The state EMSC advisory committee guides state EMSC grantees toward meeting the EMSC performance measures. Members of the EMSC advisory committee assist grantees in strategic planning, obtaining buy-in from the state/Territory leadership to effect system change, and assure that family issues are not overlooked. The state EMSC project manager is the person responsible for the day-to-day grant activities.

Section I: Qualifications and Criteria

Qualifications to be a family representative, if any, are determined by the state EMSC program. The basic standard for recruiting and selecting a family representative is to identify a parent from the community who is interested in improving the health care system for their child. An EMSC family representative is usually a leader in the community who exemplifies volunteerism.



Becoming an EMSC family representative does not require an individual to have a background in EMS. However, the role does require that the individual be passionate about the healthcare needs of children and have some knowledge about the EMS system within their local community. This knowledge may be based on a personal experience or that of someone close to them. Knowledge of the local EMS system is necessary in order to provide a consumer's perspective during EMSC program planning, development, and implementation – particularly when developing patient- and family-centered systems of care.

Often a state's EMSC advisory committee or the EMSC project manager will choose a family representative based primarily on his/her willingness to dedicate their time and share their knowledge. Current EMSC family representatives have diverse backgrounds and expertise; for example, some are homemakers, consultants, teachers, or students.

When selecting a state EMSC family representative, the NRC recommends that the individual be:

1. a parent, legal guardian, or caregiver;
2. willing to learn and become familiar with the local, state, and national EMS system, as well as the EMSC Program through orientation and training;
3. able to commit time and effort to the project for at least one year; and
4. able to tactfully and professionally communicate and is reflective when listening to issues regarding emergency care and children.

10/7/2019
https://emscimprovement.center/programs/partnerships/performance-measures/

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Performance Measures

Performance Measures are the primary goals of the SP Program and serve as standards of achievement for the state/territory grantees. In accordance with the Government Performance Results Act, grantees are required to regularly report on their progress to the Health Resources and Services Administration (HRSA).

The original set of performance measures was developed in 2005 and included: 1) availability of online and offline pediatric medical direction in EMS systems, 2) availability of pediatric equipment on ambulances, 3) pediatric training for prehospital care providers, 4) development of statewide systems for categorizing pediatric trauma and medical capabilities of hospitals, and 5) presence of interfacility transfer guidelines and agreements. After achieving significant progress in these areas, the EMSC created a new set of performance measures.

This set of performance measures was jointly developed by HRSA, the National EMSC Data Analysis Resource Center (NEDARC) and subject matter experts. Following two rounds of public comment, the following performance measures became active in 2017.

Chapter 4 | Achieving EMSC Performance Measures

An EMSC Toolkit for Family Representatives

The EMSC Program has developed and is expecting all EMSC State Partnership grantees to achieve defined performance measures. These measures steer all grantees toward a common goal of better pediatric emergency care.

This chapter will clarify each performance measure and explain a family representative's role in moving the measure forward. Keep in mind, that a family representative's personal experiences with the EMS system provide a pathway to reach health care professionals, the general public, and public officials. Note that many of the terms referred to in this chapter (i.e., BLS and ALS providers, patient care units, facility recognition, etc) are defined in Appendix B: Frequently Used Terms and Acronyms in EMSC.

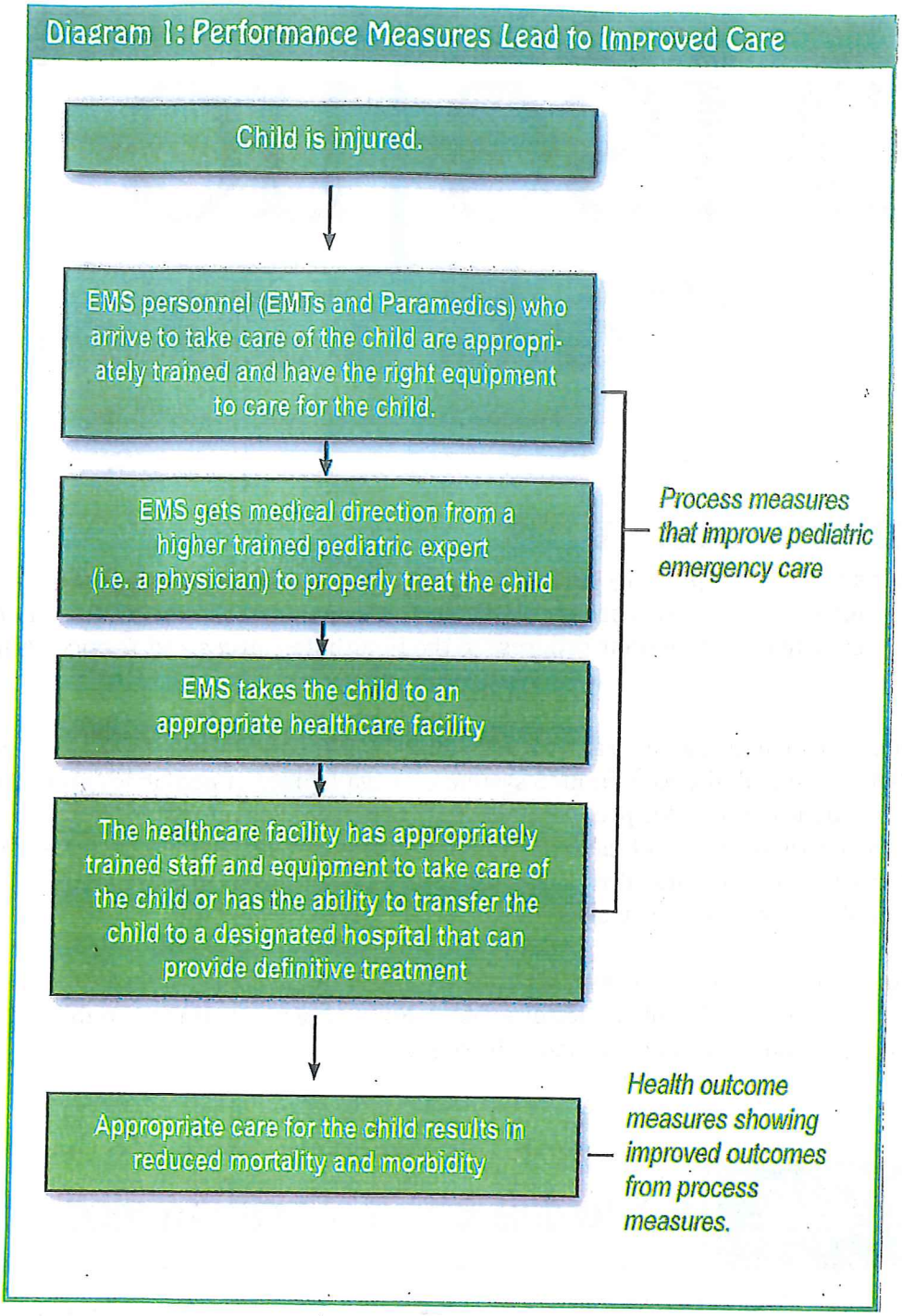


Diagram 1: Performance Measures Lead to Improved Care
Child is injured.
EMS personnel (EMTs and Paramedics) who arrive to take care of the child are appropriately trained and have the right equipment to care for the child.
EMS gets medical direction from a higher trained pediatric expert (i.e. a physician) to properly treat the child
EMS takes the child to an appropriate healthcare facility
The healthcare facility has appropriately trained staff and equipment to take care of the child or has the ability to transfer the child to a designated hospital that can provide definitive treatment
Process measures that improve pediatric emergency care
Appropriate care for the child results in reduced mortality and morbidity
Health outcome measures showing improved outcomes from process measures.

NOTE –

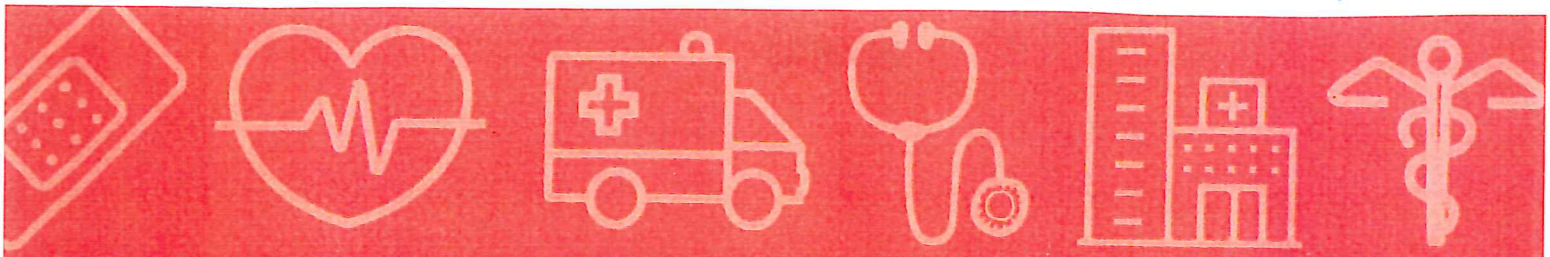
The following section is a cut-and-paste combination of functional material that explains the roles and responsibilities of a member of the Family Advisory Network (FAN) pertaining to the EMSC Performance Measures:

(1) The current 9 EMSC Performance Measures, extracted from *the Implementation Manual for State Partnership Grantees*, which was released in 2017 (and is still in effect) by the U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), entitled "**EMS FOR CHILDREN PERFORMANCE MEASURES**," and is available on the website of The National EMSC Data Analysis Resource Center (NEDARC) –

http://www.nedarc.org/performanceMeasures/documents/EMS%20Perf%20Measures%20Manual%20Web_0217.pdf

(2) The details of a Family Representative's crucial role in moving forward these specific Performance Measures, to "steer grantees toward a common goal of better pediatric emergency care," extracted from ***"An EMSC Toolkit for Family Representatives,"*** which is available on the website of the EMS for Children Innovation and Improvement Center (EIIC) –

https://emscimprovement.center/programs/partnerships/family-advisory-network/



EMS FOR CHILDREN PERFORMANCE MEASURES

Implementation Manual for State Partnership Grantees

Effective March 1st, 2017

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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.

Section I: Pediatric Medical Control

Overview of the Performance Measure	*Why Is This Important?*
Ensure the operational capacity of the State EMS system to provide pediatric emergency care by ensuring prehospital provider agencies have on-line and off-line pediatric medical direction at the scene of an emergency for BLS and ALS providers.	Children are not little adults. Without appropriate pediatric medical direction, a prehospital provider could underestimate the pediatric patient's condition, make a medication dosing error, or be incapable of effectively triaging multiple pediatric patients.

Family Representative Role

If off-line (i.e., written) protocols already exist in the state, family representatives should review each to determine whether patient- and family-centered care procedures and policies are included. An explanation of family-centered care systems is included in Chapter 2, Section IV. If written protocols are not in place, family representatives can contribute to their development by providing feedback on the importance of ensuring that all EMS providers follow specific procedures that keep a family appraised of their child's medical condition.

apprised

Note that family representatives are not expected to be familiar with the medical terminology within the pediatric protocols.

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.

Section II: Pediatric Equipment and Supplies

Overview of the Performance Measure	*Why Is This Important?*
BLS and ALS patient care units in the State/Territory will have the essential pediatric equipment and supplies, as outlined in national guidelines.	Children come in different sizes. Without the right sized pediatric equipment, a pediatric airway cannot be managed, an IV cannot be established, a cervical spine (c-spine) cannot be immobilized, and appropriate medication doses cannot be delivered.

Family Representative Role

A family representative can help to ensure all patient care units responding to a 911 call have the pediatric equipment and supplies needed to save the life of a child. First, talk with the state's EMSC project manager to find out what equipment and supplies the patient care units in the state have and what equipment is missing. Second, work with the project manager to determine what can be done locally to ensure all the equipment and supplies are available on the units.

Partnership development is one strategy grantees have used with great success to help meet this performance measure. For example, the Indiana EMSC program partnered with the Indiana District of Kiwanis through its Young Children Priority One (YCPO) initiative to provide pediatric equipment bags to more than 32 counties in the state. In recognition for its support, the Indiana District of Kiwanis received a 2001 EMSC National Heroes Award for Community Partnership of Excellence.

Since 2000, the Nebraska/Iowa Kiwanis Foundation has partnered with the EMSC Program to provide needed basic level pediatric equipment and education to EMS services in Nebraska and Iowa. In 2005, the General Federation of Women's Clubs' Oconomowoc (WI) Junior Woman's Club (OJWC) worked with the Wisconsin EMSC state project to distribute the Broselow-Luten tape to all 32 fire departments in Waukesha County. Thanks to a $24,000 grant OJWC received from a private foundation, all Waukesba County ambulances now also have ALS and BLS pediatric bags.

Partnering with local civic and community-based organizations is ideal. These types of organizations often make donations to benefit the unmet needs of the community, such as purchasing pediatric medical equipment. For more information on partnership development, see Chapter 3, Section IV, "Building Coalitions and Establishing Community Partners."

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Section V: Pediatric Training of Prehospital Providers

Overview of the Performance Measure	Why Is This Important?
States/Territories will adopt requirements for pediatric emergency education prior to recertification of BLS and ALS providers.	Nationally, 10% of ambulance emergency runs are for sick or injured children. It is estimated that of that 10%, only one-tenth of the cases are for critically ill and/or injured children. Information gained from national surveys show that, due to their limited exposure to pediatric emergencies, most prehospital providers often feel inadequate and poorly prepared to provide care to children. Continuing education helps ensure that prehospital providers are ready to take care of a pediatric patient in the field. Continuing education also improves the quality and effectiveness of pediatric emergency care, and thereby, improves pediatric outcomes (e.g., reduced morbidity and mortality).

Family Representative Role

Family representatives can help ensure all EMS providers receive pediatric training before they are recertified/relicensed in the state. Talk with the EMSC project manager to learn whether pediatric education is a standard requirement prior to recertification. Determine the type of pediatric training received and how often. Should pediatric training not be required, strategize with the EMSC project manager in partnership with the state EMSC advisory committee to combat existing barriers. Discuss the challenges and determine how family representatives can help.

Ask the project manager whether a family representative can contact the local EMS agencies to discuss their pediatric training programs and determine the issues that prevent the EMS agency from providing and requiring pediatric education prior to recertification. After identifying the issues, work with the state advisory committee to strategize solutions.

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.

Section III: Hospital Recognition

Overview of the Performance Measure	*Why Is This Important?*
Establish a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.	Without a pediatric emergency healthcare facility recognition process, access to appropriate critical care, trauma care, or burn care could be delayed. Delays can result in negative patient outcomes.

Family Representative Role

Family representatives can help to ensure the establishment of a statewide, territorial, or regional standardized system that recognizes hospitals by their capability to stabilize and/or manage pediatric medical emergencies and trauma. Talk with the EMSC project manager to find out whether a standardized system exists. If so, ask what hospitals have been designated, which have not, and why. If a system does not exist, learn more about the importance of a recognition system – especially its affect on EMS providers – then work with the state EMSC advisory committee to develop a system. As a parent/guardian, it is important to know which hospitals in the state are capable of managing pediatric emergencies and trauma. If the system merely directs pediatric emergencies to the closest hospital regardless of its capacity to care for children and their unique needs, timely access to urgent specialized care may be jeopardized.

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.

Section IV: Transfer Agreements and Guidelines

Overview of the Performance Measure	*Why Is This Important?*
Hospitals in the State/Territory will have written pediatric interfacility transfer agreements and guidelines.	The most severely ill and injured children sometimes require specialized care that is only available in select hospitals. Without effective interfacility transfer agreements and guidelines, the timely and appropriate transfer of patients to the right level of emergency care is placed in jeopardy. These delays could result in negative patient outcomes.

Family Representative Role

Health insurance status and other factors, such as a receiving hospital's patient capacity, often prevent the immediate transfer of a patient to an institution equipped to provide specialty medical treatment. Family representatives can help ensure timely patient transfers by working with their state's EMSC advisory committee and project manager to ensure all hospitals in the state have interfacility transfer agreements and guidelines in place. Talk with the project manager to determine if interfacility transfer agreements and guidelines exist and whether they are in place with all hospitals in the state. Learn how to work with the hospitals and review the current interfacility guidelines to ensure patient- and family- centered procedures are incorporated during transfers.

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.

EMSC 08 Performance Measure
Permanence of EMSC

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.

Section VI: EMSC Permanence

Overview of the Performance Measure	*Why Is This Important?*
Permanence of the EMSC Program will be established in the State/Territory EMS system.	Integration of pediatric priorities into existing EMS rules and regulations ensures that your EMS system changes will be permanent. An EMSC Program that has permanence includes a dynamic advisory committee, pediatric representation on the State EMS Board, and a full-time EMSC project manager. These components will lead to successful EMS improvements for pediatric patients should the Federal EMSC grant program end.

Family Representative Role

The preceding performance measures must be adopted and integrated into state statute or regulation. A family representative is in a position to educate state policymakers regarding the importance of the state EMSC project's initiatives and the performance measures. In particular, a family representative may want to share with the policymaker his/her personal experiences with the EMS system; sharing such real-life experiences reminds others about the importance of EMSC in the community. For more information on the legislative process and a family representative's involvement in it, see Chapter 5.