

The following lists outline the **major** changes to the performance measures implementation manual from the 2007 version. Note that this implementation manual is considered “DRAFT”. A final version will be released in the Spring of 2009. This manual goes into effect March 1, 2009. Until then, the 2007 manual should be used.

 **Overall:**

- An exemption from data collection or a request to use an alternative data collection method should be directed at the Federal Program Contacts.
- **EHB** tables for all performance measures have been updated along with the instructions for EHB entry.
- List of members for the Performance Measures Advisory Committee (PMAC) (page 156)

 **New Grantee Requirements:** (page 5)

- The EMSC Program is allowing flexibility for grantees in performance measure implementation by dividing the performance measures into those that all grantees are required to work on and those that are optional. Note: all grantees are required to report data in EHB for all performance measures listed below (see EHB note under optional measures).

All grantees are required to continue meeting targets for the following measures:

- 66a—online and offline medical direction
- 66b—pediatric equipment on patient care units
- 66c—hospital recognition for trauma
- 67—pediatric education requirements during recertification
- 68a—EMSC advisory committee with 8 required members and 4 meetings per year
- 68b—pediatric representation on EMS board
- 68c—full time EMSC manager
- 68d—integration of priorities into statute, rule, regulation, or other policy issued by a legally authorized entity with enforcement rights to ensure compliance

The following measures are optional for grantees to meet targets as state resources allow:

- 66c—hospital recognition for medical emergencies
  - 66d—interfacility transfer guidelines
  - 66e—interfacility transfer agreements
- If you do not work on the optional measures above, you will still need to enter data into EHB each year. The EHB data entry can reflect data collected in previous years.

**EMSC Program Contacts:** (page 6)

- AK, AS, AZ, CA, CO, GU, HI, ID, IL, IA, KS, CNMI, MI, MN, MO, MT, NE, NV, ND, OH, OR, SD, UT, WA, WI, WY please refer to: Dan Kavanaugh.
- AL, AR, CT, DE, DC, FL, GA, KY, LA, ME, MD, MA, MS, NH, NM, NJ, NY, NC, OK, PA, PR, RI, SC, TN, TX, VT, VI, VA, please refer to: Tina Turgel.

**Hospital Definition Updated:** (page 8)

**Hospitals:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured. Military and Indian Health Service hospitals are not required for data collection, but may be helpful in assuring all children in the state/territory have access to needed resources. A state/territory can obtain information from these hospitals if they are able to do so.

**Patient Care Unit Definition Updated:** (page 8)

**Patient Care Unit:** A patient care unit is defined as a vehicle staffed with EMS providers (BLS and/or ALS) dispatched in response to a 911 or similar emergency call AND responsible for transporting a patient to the hospital. Examples include an ambulance, or other type of transporting unit. This definition excludes non-transport vehicles (such as chase cars) to provide additional personnel resources, air ambulances, exclusively defined specialty care units, water ambulances/units.

**General Data Considerations:** (page 9)

The changes to the performance measures are in effect starting with the 2009 state Partnership cycle (March 1, 2009 to February 29, 2010). Prior to beginning data collection all states/territories should contact NEDARC. EHB entry will occur in approximately July of each year. Data must be collected as specified by this manual for each performance measure; the EMSC Program is interested in measuring change for these performance measures over time.

**Survey Consideration:** (page 9)

The following was deleted: Grantees must conduct annual surveys in order to report on yearly progress. This means that the same individuals may need to be re-surveyed each year. If grantees wish to conduct a random sample of the surveys they must consult NEDARC.

**Performance Measure 66A: Online and Offline Medical Direction**

**Updated Definitions:** (page 12)

**On-line pediatric medical direction:** An individual is available 24/7 to EMS providers who need on-line medical direction when providing care to a pediatric patient. This person must be a medical professional (e.g., nurse, physician, physician assistant [PA], nurse practitioner or EMT-P) and must have a higher level of pediatric training/expertise than the EMS provider to whom he/she is providing medical direction.

For survey purposes, if the EMS provider does not know the training level of the person providing medical direction, the EMS provider should answer based on his/her confidence in the information given by the medical professional.

### **Performance Measure 66B: Pediatric Equipment**

Overall—all references to the 1996 ACEP list were updated to now include “national guidelines” to be published in the final version of the implementation manual.

### **✚ Exemption from Data collection Requirements Changed to the Following:** (page 31)

Note: all 3 requirements must be met:

- The state/territory must have an inspection process that verifies a 1:1 match with the national list (for all equipment and supply sizes; excluding out-of-scope equipment/supply). Remember to verify with the NRC if a piece of equipment can be legitimately considered “out-of-scope.”
- The inspection process must be regular (as defined by the state/territory; this typically occurs every year or every two years) and must cover all patient care units in the state/territory in the given inspection cycle.
- A documented enforcement process (as defined by the state/territory) to ensure that missing equipment will be replaced.

### **Performance Measure 66C: Hospital Recognition**

#### **✚ Data Collection Methods:** (page 45)

Note that the grantees will be required to enter data separately for medical versus trauma emergencies.

### **Performance Measure 66D/E: Hospital Interfacility Guidelines and Agreements**

#### **✚ List of Required Guidelines:**

The following was deleted

Process for return transfer of the pediatric patient to the referring facility as appropriate.  
There are now only 5 guideline requirements.

#### **✚ Updated Definition:** (page 52)

- The paragraph starting with “All hospitals”...the following was deleted, “Tertiary care centers capable of taking all pediatric needs do not need to have guidelines for transferring children.”

### **Performance Measure 68B: EMS Board**

#### **✚ Updated Definition:** (page 88)

**EMS Board:** The EMS Board within the state/territory refers to the state/territory governing entity or body that provides oversight for emergency medical services and that has the primary responsibility and authority of advising on EMS issues in the state/territory, which ultimately affects the decision-making process. The EMS Board may have different names in different states/territories. The structure of EMS oversight could be referred to as an EMS advisory committee or similar reference. If the state/territory does not have an EMS Board, please consult the NRC.

## **Performance Measure 68C: Full-time EMSC Manager**

 **Updated Definition:** (page 91)

**State/territory, Federal, and/or other-funded:** State/territory-funded refers to any funds provided by state/Territorial government organizations or the state/territory legislature (e.g., line item in the state/territory budget) to support the EMSC manager position. Federal funding refers to any funding received from a Federal governmental agency. Other funding refers to any funding received from other sources, such as professional, private, and/or philanthropic groups (e.g., foundations, non-profits).

**Solely:** The EMSC manager is to dedicate 100% of his/her effort to the EMSC Program, EMSC activities, or other EMSC-related projects. The EMSC manager could have other responsibilities from the performance measures, but they should be EMSC-related priorities. Grantees need one individual that is designated as the FTE for EMSC and responsible for the program. If the position is split between multiple individuals, it is easy for EMSC activities to be prioritized lower than other activities.

## **Performance Measure 68D: Integration of Priorities**

 **Strategic Planning:** (page 98)

Added section titled “Writing Points for Drafting Legislation and Examples of Statutes Mandating EMSC Priorities” is new in addition to new information on legislation in other states.