

## Share and Learn Conference Call

Date: December 1, 2008  
 Time: 2:00 p.m. to 3:30 p.m. EST  
 Topic: Performance Measure PM 66c (Pediatric Facility Recognition)  
 Facilitator: Diana Fendya, EMSC NRC Trauma & Acute Care Specialist

### Invited Speakers:

Martha Gohlke, New York; Paul Marmen, Oklahoma; and Rhonda Phillippi, Tennessee

### Participating Grantees:

Alabama, Ann Klasner Arizona, Tomi St. Mars Connecticut, Wendy Wheeler Delaware, Marie Renzi Georgia, Tracie Al'Belar Idaho, Rachael Alter Kansas, Sarah House Maine, Jan Brinkman Maryland, Cyndy Wright-Johnson and Allen Walker Minnesota, Kristi Berg Mississippi, Alisa Williams	Missouri, Paula Adkison New York, Martha Gohlke North Carolina, Gloria Hale North Dakota, Kelli Rice Ohio, Joe Stack Oklahoma, Paul Marmen Pennsylvania, Steve Mrozowski South Dakota, Amy Marsh Tennessee, Rhonda Phillippi Texas, Beverly Willis Wyoming, Carol Zorna
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### NEDARC Attendees:

Colleen Cummins, Craig Hemingway, Kent Paige, Andrea Genovesi, Patricia Schmuhl, and Mike Ely

### NRC Attendees:

Diana Fendya, Theresa Morrison-Quinata, Jocelyn Hulbert, and Tasmeen Weik

## New York's Pediatric Facility Recognition Best Practice Initiative

*Martha Gohlke, EMSC Program Manager for the State of New York, shared the state's experience in developing a pediatric trauma recognition system and efforts underway for pediatric medical facility recognition.*

Martha has been with the New York EMSC program for about a year. She credits a lot of the ground work for this initiative to her predecessor, Gloria Hale. She added that the development of the state trauma system and the processes utilized for trauma center recognition in the state have evolved over the last 10 years.

New York's trauma system is voluntary. It includes 43 facilities which have been designated as adult and/or pediatric trauma centers. Twenty-six facilities are classified as level I facilities, 14 are level II, and 3 are pediatric trauma centers. The pediatric trauma centers, because of multiple resource availability, are capable of managing both severely injured children and pediatric medical emergencies. However, trauma regulations specific to pediatrics are brief with few specifics. Fortunately, the trauma rules and regulations are presently under revision. The committee revising the regulations is utilizing many of the guidelines in the American College of Surgeons' Green Book, *Resources for Optimal Care of the Injured Patient, 2006*, including the new pediatric trauma center guidelines. New York's EMS for Children committee is actively involved with the revision process, helping to define and design the trauma system to assure pediatric considerations are included. Their next meeting is scheduled for February of 2009.

An important strategy undertaken by the EMSC Advisory Committee to address the needs of critically ill children was the development of a White Paper specific to the needs of pediatric patients. This paper included background, rationale and evidence for a pediatric medical hospital recognition system. The New York State EMSC Advisory Committee took the lead role in development of the paper. (White Papers typically serve as an authoritative report on a topic of concern and provide a guide or actions to achieve the proposed recommendations.) They began the White Paper by doing an extensive literature search and review of pediatric facility recognition to identify practices and evidence to support a state facility recognition process. However, due to changes in the State's leadership, i.e. new Commissioner of Health, approval of the White Paper and its recommendations has been delayed.

The State has also faced other challenges while trying to move this initiative forward. They include: dealing with common bureaucratic delay, resistance to change due to the perceived competitive environment created by a recognition system, and the global financial crisis that has affected the State of New York.

Collaboration with others vested in the process and building upon the experiences of other states successful in defining a process for facility recognition will be very helpful as the committee moves forward with this performance measure. The State of New York will continue to forge onward. Future plans include a stakeholders meeting to build consensus, a detailed review of other model programs, and finally defining a process that will work best for the state for New York's Pediatric Trauma and Medical Emergencies Recognition System.

*To learn more about New York's efforts to enhance their Trauma System and the development of the White Paper, contact Martha Gohlke at [mag20@health.state.ny.us](mailto:mag20@health.state.ny.us).*

## **Oklahoma's Pediatric Facility Recognition Best Practice Initiative**

*Paul Marmen, EMSC Program Manager for the State of Oklahoma, shared the State's experience in developing a recognition system for pediatric trauma and medical emergencies.*

Oklahoma has had a voluntary trauma system in place for more than 10 years. They utilized the statewide Trauma Advisory Committee, established by the Governor's Task Force, to integrate pediatric medical and trauma needs. The State trauma system mandates require ALL 84 hospitals in the state to be recognized or designated as trauma centers. The designation level is based upon resource availability. The Department of Health assumes responsibility for designating level I, II, III, and IV trauma centers. Less than 20% of facilities are level IV trauma centers, approximately 20% are level III centers, 3 are level II and there is 1 level I trauma facility. Level III facilities treat both pediatric and adult patients. Presently, the one level I trauma center in the State is the Oklahoma University (OU) Medical Center. OU Medical Center is the State's largest comprehensive facility and also houses the only Children's Hospital in the State.

Initially, the Department of Health used the *Emergency Department Approved for Pediatrics (EDAP) Guidelines*, developed in California, to guide the development of pediatric criteria. It should also be noted that the trauma regulations also require all facilities to have transfer agreements and guidelines which should be helpful in meeting Performance Measures 66d and e. However, these regulations are not specific to pediatrics at this time.

Oklahoma's future plans are to continue working with key stakeholders to incorporate language that clearly states "all" or "pediatric" patients into the transfer component of the regulations.

*To learn more about Oklahoma's work to move this performance measure forward, contact Paul Marmen at [Paul-Marmen@ouhsc.edu](mailto:Paul-Marmen@ouhsc.edu).*

## **Tennessee's Pediatric Facility Recognition Best Practice Initiative**

*Rhonda Phillippi, EMSC Program Manager for the State of Tennessee, shared steps she has taken to establish a facility recognition system for both pediatric trauma and pediatric medical emergencies.*

There are approximately 120 licensed hospitals with emergency departments in the State of Tennessee. State facility rules require all hospitals to self-designate their pediatric capabilities. There are four defined recognition levels:

- Basic – requires availability of an RN with pediatric training in the emergency department 24/7;
- Prime – requires 24/7 in-house physician;
- General – requires an in-patient pediatric area and a pediatric department;
- And a Comprehensive Regional Medical Center (CRMC) –requires transfer agreements and guidelines to be in place, ambulances services and specialty physicians.

Tennessee published Trauma Guidelines for Pediatrics in 1995. In 1996 a 3-day consensus meeting with key pediatric stakeholders from across the State was held. The meeting utilized the "Future Search Model" to facilitate discussions and to work on the future system design and scope of EMSC in Tennessee. The three-day meeting ended with plans to develop a White Paper

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[www.childrensnational.org/emsc](http://www.childrensnational.org/emsc)*

and defined steps for institutionalization of EMSC into state statute. In 1996 EMSC legislation was passed unanimously. A Committee on Pediatric Emergency Care was defined in these statutes. This committee is to provide pediatric input to the State Board for Licensing Health Care Facilities and the EMS Division.

### Helpful hints from Rhonda

- Get parents involved
  - Parents hosted a Press Conference and were the key to gaining support from rural legislators for the pediatric recognition program developed in Tennessee.
- Keep potential obstructionist involved
  - Once these individuals begin to understand the importance of EMSC initiatives, they become your greatest asset and advocate.

### **Participant's Questions and Comments**

Question 1:

How did Tennessee deal with the Obstructionists?

*Using a well-trained facilitator is essential. "Future Search" is a process of getting everyone involved and recognizing everyone has value. Help everyone find their individual connection to your EMSC program.*

Question 2:

How did you deal with concerns of competition between hospitals?

*Keeping the parents in the forefront is critical. These key leaders can continue to ask the basic question – "What is best for the children" and thereby force leaders to find solutions.*

Question 3:

What is CRPC?

*A Comprehensive Regional Pediatric Center is required to have transfer agreements with at least one Comprehensive Regional Trauma Center (CRTC). The agreement with a CRTC also includes an educational component to assure continued training and education is provided to providers in the defined region which they are a part of. Each Regional Center must have at least one or two full-time equivalents dedicated to assisting other healthcare professionals access essential educational opportunities to ensure a certain level of care competency including injury prevention knowledge.*

Question 4:

What position in the Department of Health is designated to conducting inspections and how often?

*In Oklahoma, the process is conducted every two years. The process and specific inspection is a private and confidential process. It is part of the hospital licensure process.*

*In Tennessee, it is a part of the inspector's job and the process is conducted with other annual activities to renew hospital licenses.*

Question 5:

Where do funds come from to support the trauma system?

*In Oklahoma it comes from the State driver's license fund. One dollar for each renewal goes toward supporting the system.*

*In New York, there is mandated funding for the Trauma program. However, due to financial issues there has been discussion about moving to possibly a paper self-assessment survey.*

Question 6:

What was your initial relationship with key stakeholders prior to having the Stakeholders meeting?

*Rhonda stated that she had no relationship with the attendees prior to the meeting. It was the parents and the pediatric experts that drove the effort.*

Question 7:

How are you evaluating the system?

*In Tennessee, they have been mapping pediatric medical and trauma conditions over the years and looking for trends in outcome and care i.e. meningitis and closed head injuries in children under 3. One of the measures is determining whether these children get to the right hospital.*

Question 8:

How many States have met this Performance Measure?

*There are 5 States at this time: Tennessee, Oklahoma, California, Illinois, and Utah. Other States have recognition programs within their trauma system for injured children.*

Question 9:

Can State regulations be placed in one spot so that other grantees may find these resources?

*Karen Belli, Senior Public Policy and Partnerships Specialist at the NRC, has done research in this area and this information is available to grantees. For copies of state regulations and statutes related to Performance Measure 66c please go to <http://www.childsnational.org/EMSC/ForGrantees/Performancemeasures>*

Comment 1:

Cyndy Wright-Johnson shared that Maryland has both pediatric trauma centers and perinatal centers. During their development they have had to deal with a large constituency that did not support a pediatric medical emergencies recognition system. She has since gathered support from pediatric and adult medical directors who are helping to circulate and promote all standards.

Words of Advice

Get parents involved, look for new partners, keep in mind that this may take 10 years to come to fruition—be persistent.

**Next Share and Learn Conference Call**

**January 12<sup>th</sup>, 2009**

**PM 66d and e – Inter-facility Pediatric Transfer Agreements and Guidelines – please mark your calendars and plan to attend**