Joint Report to the
General Welfare, Health and Human Resources Committee
Of the Senate
Health and Human Resources Committee
of the House of Representatives, and the
Select Committee on Children and Youth

Report On the Status of Emergency Medical Services for Children

A Report to the 105th Tennessee General Assembly

Tennessee Department of Health
July 2010

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
220 ATHENS WAY, SUITE 104
PLAZA 1 METROCENTER
NASHVILLE, TENNESSEE 37243
615.741.8402 office
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BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

July 1, 2010

The Honorable Rusty Crowe, Chair
Senate General Welfare, Health and
Human Resources Committee
321 War Memorial Building
Nashville, Tennessee 37243

Dear Senator Crowe:

As required by Tennessee Code Ann. §68-11-251 and §68-140-521, we are pleased to submit the annual report on the Emergency Medical Services for Children (EMS-C) program; the Board for Licensing Health Care Facilities and the Emergency Medical Services Board collaborated with the Committee on Pediatric Emergency Care (CoPEC) in preparation of the report. The EMS-C program focuses primarily on pediatric pre-hospital and hospital care, with consideration for injury prevention, disaster preparedness, and quality improvement. This report reflects activities and accomplishments of the Board for Licensing Health Care Facilities and the Emergency Medical Services Board in meeting national EMS-C objectives.

Improving the availability and quality of children's health care is a major goal for the State of Tennessee and the Department of Health. Our boards help coordinate the role of Tennessee's medical facilities and emergency medical services in providing appropriate pediatric emergency care.

Respectfully submitted,

Larry Arnold, M.D., Chair
Board for Licensing Health Care Facilities

Jackie W. Wilkerson, Chair
Emergency Medical Services Board

C: Susan R. Cooper, MSN, RN, Commissioner
Tennessee Department of Health

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BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

July 1, 2010

The Honorable Sherry Jones, Chair
Select Committee on Children and Youth
320 Sixth Avenue, North
Rachel Jackson Building, 7th Floor
Nashville, Tennessee 37243

Dear Representative Jones:

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BOARD FOR LICENSING HEALTH CARE FACILITIES
EMERGENCY MEDICAL SERVICES BOARD

July 1, 2010

The Honorable Joe Armstrong, Chairman
House Health and Human Resources Committee
21 Legislative Plaza
Nashville, Tennessee 37243

Dear Representative Armstrong:

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Emergency Medical Services Board

C: Susan R. Cooper, MSN, RN, Commissioner
Tennessee Department of Health

Joint Annual Report of
The Board for Licensing Health Care Facilities
And the
Emergency Medical Services Board
To the
Tennessee General Assembly
General Welfare Committee of the Senate
Health and Human Resources Committee of the House of Representatives
Select Committee on Children and Youth
On the Status of
Emergency Medical Services for Children

July 1, 2010

I. Requirement of the Report

Tennessee Code Annotated 68-11-251 requires that the Board for Licensing Health Care Facilities and the Emergency Medical Services Board in collaboration with the Committee on Pediatric Emergency Care shall jointly prepare an annual report on the current status of emergency medical services for children (EMS C) and on continuing efforts to improve such services beginning July 1, 1999.

II. 2010-2013 Strategic Planning for Committee on Pediatric Emergency Care (CoPEC)

The past chair, Rita Westbrook, MD, and the current chair, Barry Gilmore, MD, MBA lead a year long process of creating a strategic plan for EMSC future activities. The process was extremely through, democratic and guided by their dedication to keeping focus on what is best for children in their state. The mission statement was explored and modified to read, "To ensure that every child in Tennessee receives the best pediatric emergency care in order to eliminate the effects of severe illness and injury." The vision statement is: "To be the foremost advocate for children throughout the continuum of care in Tennessee and the nation."

Six major goals were established with strategies, leading indicators of success, and 3 year performance targets. The six goals include:

1. Develop specific communication tools to drive and promote TN EMS'S mission to our members and communities.
2. To expand membership orientation and leadership capacity to address the various components of TN EMSC including CoPEC.
3. To develop and integrate a statewide disaster plan for children
4. Use education (including publications) to support, develop, and disseminate current best practice for emergency medical services for children.

5. Secure diverse funding sources to increase revenues by 50%. (Currently, the only grant funding is provided by the federal HRSA program through the State Partnership grants and a CDC grant.)
6. Exceed the national EMSC performance measures.

Appendix A contains the complete strategic plan.

III. National Emergency Medical Services for Children Site-Visit Report for Tennessee Emergency Medical Services for Children State Partnership Grant

Traditionally, the national EMSC program has conducted periodic site visits to State Partnership grantees to assess their progress in meeting the federal performance measures. During the 2010 grant cycle an additional category of site visits was introduced where the primary objective of the visit to acknowledge the state's stellar performance and progress made in meeting the national performance measures.

Tennessee was chosen as the initial "best practice" site visit because of the strength and leadership of its program. The Federal EMSC program hopes to share best practices utilized by Tennessee to assist other states in making strides especially the four more difficult performance measures which Tennessee has already accomplished.

Appendix B contains the complete EMSC National Report.

IV. Star of Life Awards Ceremony and Dinner

This year was the 2nd annual awards ceremony held to honor the accomplishments of EMS personnel from all regions of Tennessee who provide exemplary life-saving care to adult and pediatric patients. The ceremony includes the presentation of the actual adult or pediatric patient scenarios and reunites the EMS caregivers with the individuals they treated. Recipients are chosen from each of the eight EMS regions in the state. This is the premier event that will kick of EMS week within the state to recognize and honor our excellent pre-hospital providers.

EMS Region 1 Award Winners – Eastman Chemical Company Emergency Services

EMS Region 2 Award Winners – Morristown Hamblen EMS and East Tennessee Children's Hospital Pediatric Critical Care Transport Team

EMS Region 3 Award Winners – Bradley County EMS and Erlanger Life Force

EMS Region 4 Award Winners – Putnam County EMS and Baxter Fire Department

EMS Region 5 Award Winners – Montgomery County EMS and Vanderbilt LifeFlight

EMS Region 6 Award Winners – Wayne County EMS and Vanderbilt LifeFlight

EMS Region 7 Award Winners – Hardin County EMS and Air Evac Lifeteam

EMS Region 8 Award Winners – Bellevue Baptist Church Medical Services Ministry and City of Memphis, TN – Division of Fire/EMS

Legacy Awards were presented as the concluding awards at the EMS Star of Life on May 11, 2010.

The following people were chosen for this award because they were the "founding fathers" for improving the care for critically ill and injured children in Tennessee during the implementation of the principles of Emergency Medical Services for Children in Tennessee and continue to support its efforts.

Joseph B. Phillips, Richard Land, and Donna Tidwell
The first legacy award is presented to Joseph B. Phillips, Richard Land and Donna Tidwell from the Department of Health, Division of EMS. The partnership between TN EMS for Children and the Division of EMS in improving care for children is often highlighted by the national EMSC program.

Jeff Davis
The second legacy award is presented to Jeff Davis. Jeff was present at the first strategic planning event at Fall Creek Falls in 1996 and has continued to advocate for the care of children throughout his career and as an EMS board member.

Craig Becker
Craig Becker, CEO and President of Tennessee Hospital Association is receiving a Legacy Award for his longstanding partnership with TN EMSC and for ensuring that hospitals throughout Tennessee have the right equipment and training to care for the needs of children.

Kevin Churchwell, M.D.
Dr. Kevin Churchwell, CEO, came to Tennessee as a new faculty member at Monroe Carroll, Jr. Children's Medical Center about the same time as the initial activities began for TN Emergency Medical Services for Children. He has championed TN EMSC since the beginning and has continued to be an advocate by balancing relevance, profit, and people.

Bob Duncan
Bob Duncan, position, has tirelessly advocated for TN EMSC whether it was in the halls of Congress or our state capital. He has been a true champion for children and will be greatly missed as he begins his new position at Children's Hospital and Health Systems of Wisconsin as executive vice president of Community Services.

Jay Deshpande, M.D.
It is difficult to put into a sound byte the significance of the next legacy award recipient. His actions are a living example of a quote by Billy Graham. "Our days are numbered.

One of the primary goals in our lives should be to prepare for our last day. The legacy we leave is not just in our possessions, but in the quality of our lives. What preparations should we be making now? The greatest waste in all of our earth, which cannot be recycled or reclaimed, is our waste of the time that God has given us each day." Dr Jay Deshpande spends his time making a difference in the lives of those he encounters; whether it is performing life saving procedures on a child, sitting at a conference table addressing the issues at hand; or being a friend to a colleague. Dr. Deshpande is one of the original four principal investigators for the grant that funded an emergency medical service for children pilot program in Tennessee back in the early 90's. Dr. Deshpande is often cited as a visionary leader for developing a system of care for critically ill and injured children in Tennessee. His time of daily hands-on participation in activities of the TN-EMS-C is missed, but he is and always will be a trusted friend and treasury of wisdom.

V. The Needs of the State Committee on Pediatric Emergency Care

- Since 1994, CoPEC members have provided their own travel and per diem expenses. In light of the current fiscal environment, the members are willing to continue to provide travel and per diem as in-kind support. If in the future funding is more available, CoPEC, would like to have this position reconsidered.

- Support from the Department of Health to accomplish the strategic plan in Appendix A.

VI. Conclusion

The Board for Licensing Health Care Facilities and the Emergency Medical Services Board work cooperatively with other programs of the Department of Health to improve the quality of health care and medical services available to the citizens of Tennessee.

Stated in the National EMSC Report (Appendix B) "Tennessee EMSC Program is a leader amongst EMSC programs in the nation. They have worked diligently and effectively to incorporate legislation on behalf of pediatric patients in the state, to promote adoption of pediatric EMS protocols, interfacility transfer agreements, and facility recognition throughout the state. Tennessee is one of only a few states, and one of the first to incorporate a regionalized hospital recognition system resulting in a model system that is currently being reviewed and incorporated by other states."

We hope to further describe the impact of the rules on pediatric emergency care by utilizing data collected in our next report on July 1, 2011.

This report was reviewed by the respective boards on June 23, 2010 and June 30, 2010 and approved for presentation to the designated committees of the Tennessee General Assembly.

See Appendix A for 2010-2013 Strategic Planning
See Appendix B for National Emergency Medical Services for Children Site-Visit Report

TN EMSC - 2010-2013 STRATEGIC PLAN

MISSION: To ensure that every child in Tennessee receives the best pediatric emergency care in order to eliminate the effects of severe illness and injury.

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GOAL #1: Develop specific communication tools to drive and promote TN EMSC's mission to our members and communities Committee members: Sue Cadwell, and Paula Denslow Co-Chairs, Barry Gilmore , Eric Clauss and Donna Graham()					
STRATEGIES	**LEADING INDICATORS OF SUCCESS**	**3 YEAR PERFORMANCE TARGETS**	**YEAR 1 (10-11) ACTION PLANS & LEAD**	**YEAR 2 (11-12) ACTION PLANS & LEAD**	**YEAR 3 (12-13) ACTION PLANS & LEAD**
1. Develop a marketing plan with a focus on public awareness of TN EMSC	1. A marketing plan has been secured, implemented, increased awareness and has sustained funding for continue public relations.	1. Increased awareness of the public to the existence and function of TN EMSC	1a. The committee will Secure marketing group that will provide pro bono services for purposes of: -Determining Baseline Awareness of TN EMSC by the Public -Propose a marketing plan to include a budget estimate for deployment, • Identifying a distribution and implementation pattern for the marketing proposal The committee will then: -Propose the estimate to the finance committee who will then give us potential resources for funding	1. Launch marketing plan Establish indicators of success; website traffic, increased funds Data collection of educational outreach CRPCs	1. Evaluate success of plan Refine plan based on awareness Follow-up survey to measure public awareness Identify ongoing partners for sustained funding

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			1b. Create an EMSC information slide or slides providing a description of EMSC, its history and accomplishments for members and other committees to add to their presentations. Eric Clauss to develop draft for January.		
2. Communicate strategic plan in support of the TN EMSC mission to our members, member organizations and the public	2. Website organization alignment with strategic plan. Member commitment is demonstrated by signing the "Eric Wall of Commitment" and member activities are in alignment with strategic plan.	2. Recognition of TN EMSC plan by members and member organizations	2a. Provision of the Strategic plan for each member by: -Posting strategic plan on website by Kristi by May 11, 2010 -The CoPEC chair will review strategic plan and progress toward annual goals at each meeting	2. Yearly awareness survey for members and member organizations	2. Yearly awareness survey for members and member organizations

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			-Perhaps in conjunction with other committees, a yearly awareness survey for members and member organizations in order to gauge awareness of both the strategic plan itself as well as toward annual goals by October, 2010. 2b. The TN EMSC / CoPEC staff will Create, post, and have members sign "Eric Wall of Commitment" on May 11, 2010 2c.Kristi and Rhonda will seek permission to post "Meet Eric" (the TN Star of Life story about Eric) on youtube.com by April 30, 2010.		

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GOAL #2: To expand membership orientation and leadership capacity to address the various components of TN EMSC including CoPEC

Committee: Rita Westbrook, and Debi Tuggle Co-Chairs, Carolyn Jackson, Diana Eckroth, Kate Copeland, Debi Tuggle, Jennifer Radtke

STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
1. Develop member orientation to increase knowledge capacity of CoPEC and TN EMSC	100% participation in orientation of existing (em) and new members (nm)	<table><tr><td></td><td>10</td><td>11</td><td>12</td></tr><tr><td>em</td><td>100</td><td>100</td><td>100</td></tr><tr><td>nm</td><td>100</td><td>100</td><td>100</td></tr></table>	Orientation PowerPoint content: 1. History updated by Debbie and Jennifer by August, 2010 2. Funding structure PowerPoint: Carolyn and Diana completed by Carolyn and Diana by August 2010 3. Organization /flow chart completed by - May 2010-Rita 4. Introduction to leadership/work groups slide-completed by Rita August 2010 5. Expectation of members: to be pulled from bylaws –Jennifer by Aug 2010.	Continue to offer quarterly orientation-by task force members	Web based orientation Membership committee

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			6. Update and arrange photo directory by regions completed by Kristi 7. Brief review of strategic plan-Compiled from all of the various task forces and Rita by August 2010. 1b .Development of a Big Brother/Sister program-guideline development by Dianne August 2010	Implement plan of assigning big brothers/sisters- Dianne and chairs of Membership	Evaluation of program via evaluations from both parties -Dianne

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<tr>
<td>2. Member development</td>
<td>Completion of all training sessions by 80 % of the members</td>
<td>
<table>
<tr><th></th><th>10</th><th>11</th><th>12</th></tr>
<tr><td>LE</td><td></td><td></td><td>90%</td></tr>
<tr><td>RR</td><td>50</td><td>60</td><td>80</td></tr>
<tr><td>Civic</td><td>50</td><td>60</td><td>80</td></tr>
<tr><td>***</td><td>%</td><td>%</td><td>%</td></tr>
<tr><td>Call</td><td></td><td>10</td><td>20</td></tr>
<tr><td>Letter</td><td></td><td>10</td><td>20</td></tr>
<tr><td>Visit</td><td></td><td>10</td><td>20</td></tr>
</table>
*LE: leadership exercise
RR: Roberts Rules of Order
baseline from survey
</td>
<td>Education Robert Rules of Order.
4 sessions:
1. Definitions/call to business-Jennifer August 2010
2.Classifications of motions-Kate October 2010
3.Committees and informal actions- Diane Feb. 2011
4.Debates and voting/order of business and agenda-Carolyn –May 2011

Sessions to be given over 1 year and repeated every 2 years. To be given at quarterly meetings by task force.</td>
<td>Complete sessions for 1st cycle, evaluate with survey/evaluations

Development of education on the legislature process; Rhonda and Carolyn Feb. 2011</td>
<td>Development of new leaders and to offer a leadership workshop

How do we determine the new leaders:
Input from current chairs:
Members who express interest

Responsible person: Membership committee

Continue education on RR and Civic course</td>
</tr>
</table>

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<tr><td></td><td></td><td></td><td>Evaluate sessions by Bi-annual survey

Civic/Law assessment: Obtain base line on current members knowledge with survey –Carolyn Jackson with help form Kristi and survey Monkey. Have survey out by August 2010</td><td>Encouragement of increased civic participation through call, letters ad legislative visits</td><td>Reassess members participation via survey

Arrange field trips for members to capital hill

Responsible party Rhonda and committee members</td></tr>
<tr><td>3. Professional update</td><td>100% compliance of work group chair responsibility completed</td><td><table><tr><th></th><th>10</th><th>11</th><th>12</th></tr><tr><td>TFR</td><td>85</td><td>90</td><td>90</td></tr><tr><td>EOR</td><td>85</td><td>90</td><td>90</td></tr></table>TFR –task force written report to EMSC office

EOR-EMSC Office report to members</td><td>Work group chair to provide written report/minutes 2 weeks before CoPEC meeting – responsibility of each chair

EMSC office to mail report to membership one week prior to meeting-Kristi and Rhonda</td><td></td><td></td></tr>
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	90 % of members attend 75% of quarterly meetings 100% of quarterly meetings have legislative update from Executive Director	**ATT**: 10: 85 %; 11: 90 %; 12: 90 % **EDR**: 10: 100 %; 11: 100 %; 12: 100 % EDR-EX.DIRECTOR REPORT	Send nomination letters for membership to each professional org or CEO represented on CoPEC – completed and return date is May 1, 2010 Present nominations to nominating committee and BLHCF and EMS board August 2010		Send nomination letters for membership to each professional org or CEO represented on CoPEC – by TN EMSC office return date is May 1, 2012 Present nominations to nominating committee and BLHCF and EMS board May 2012

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GOAL #3: To develop and integrate a statewide disaster plan for children

Co-Chairs: James O'Donnell, Angie Bowen Members: Marvin Hall, Anne Haston, Joe Holley, Mark Meredith, Gregg Mitchell, Joe Phillips, Ann Rutherford Reed, Patti Scott, Sheri Smith

STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
1. Integrate and interface TN EMSC disaster issues into Tennessee's established disaster system Lead: Angie Bowen	1a. Complete by July 1, 2010. 1b. Begin July 1, 2010 with completion by Dec.31, 2010. **Opportunities to share information with various agencies/organizations may present themselves and sharing information will be ongoing.	2010: Obtain written state plan (ESF 8) and other pertinent existing information, and disseminate to committee. (Angie Bowen) Done	1a. Develop graph of agencies involved in disaster management in Tennessee and the relationships between each. Obtain contact information for each agency. (Angie Bowen) ** Patti Scott to obtain School Disaster Plan. Joe Phillips to obtain TEMA Plan with graph of interagency connection.		

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			1b. Utilize above information to share information about TN EMSC and inquire as to needs of each agency in relation to pediatrics (All committee members based on specialty and geographic region, coordinated by Angie Bowen and James O'Donnell) *Include RMCC/CRPC interface		

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2.Write pediatric disaster addendum to Tennessee's state disaster plan. Lead: James O'Donnell	2.Completion of written plan by December 31, 2011. Initial step: Obtain previous work done by Dr. Abramo by December 31, 2009. (James O'Donnell) Done Review of other state plans and work previously completed by December 31, 2010.	2010: Review of plans and work previously completed. Include altered standards of care. 2011: Completion of written plan. 2012: Submission of plan to state for acceptance into existing state disaster plan.	2.Obtain copies of other state plans and begin review. Sheri Smith James O'Donnell *Reference: Karen Ketchie All committee members to review and submit feedback.	2. Completion of written plan. James O'Donnell Angie Bowen	2. Submission of plan to state for acceptance into existing state disaster plan. James O'Donnell Angie Bowen Joe Phillips

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3.Compile information and resources for dissemination/ready availability Lead: Angie Bowen	3. Material review by December 31, 2010. Resource compilation by December	2010: Material gathering and review 2011: Resource compilation	3. Materials gathered and reviewed. See assignments year 2.	3. Compilation of resources to include: -Pediatric treatment guidelines (Gregg Mitchell: Private Practice, Joe Holley: EMS/ED) -Educational modules (Patti Scott, Marvin Hall, Anne Haston) -Clearing house for classes with disaster/pediatric care components (PALS,PEPP, PITLS) (Angie Bowen) -References (books, web/web-based links, DVD) (James O'Donnell) -State and regional conferences (Mark Meredith)	

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				Unless otherwise stated, all committee to research current availability. Angie Bowen to compile as a whole.	
4.Develop tool for local pediatric disaster resources across the state. Lead: James O'Donnell	4a. Survey tool completed by December 31, 2010. 4b.Hurtz information obtained by May 31, 2010. 4c. Map developed county by county by Dec. 31, 2011.		4a. Develop survey tool for: -EMS (Joe Holley, Angie Bowen) -Hospitals (Mark Meredith, Sheri Smith, Anne Rutherford Reed) -Private practitioners (Gregg Mitchell, Patti Scott) 4b. Obtain information re: HURTZ system from state EMS office (James O'Donnell to obtain from Joe Phillips or Donna Tidwell by May 31, 2010.)	4. Create resource map of the state county-by-county: -ED care levels -Hospital resources: Inpatient services Bed availability/type Surgical/subspecialty (especially ortho) -Health Depts/clinics -Pediatricians -Family Practice -Transport and referral patterns (RMCC)	

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STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
		**Mark Meredith to present to committee on SMART triage next meeting. Donna Tidwell or Joe Phillips to present on Hurtz system.		Angie Bowen and James O'Donnell to create from survey information obtained.	
5 .Organize statewide pediatric disaster drill Lead: James O'Donnell	5. Completion of drill by December 31, 2012	5. 2012: Statewide disaster drill completed with data collected re: performance		5. Lay foundation for drill: -Type - Scenario - Literature/handouts/ evaluation - Agency approval All committee members.	5.Completion of statewide drill All committee members

TN EMSC - 2010-2013 STRATEGIC PLAN

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GOAL #4: Use education (including publications) to support, develop and disseminate current best practice for emergency medical services for children

Marisa Moyers and Lee Blair, Co-Chairs Kaye Stewart, Lee Blair, Yvette DeVaughn, Donna Tidwell , Michael Wallace, Trey Eubanks, Christy Cooper, Sandra Castro, Rick Collier, Ken Holbert, Data co-chair Paulette Johnson, Brad Strohler

STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
1. Explore the implementation of a QI tool to be used statewide in identifying problematic EMS and inter-facility transports.	1a.Increase participation and possible utilization of the QI process by CRPC facilities by 200% before July 2013. 1b.Decrease number of problematic transports by 50% before July 2013.	<table><tr><th></th><th>10</th><th>11</th><th>12</th></tr><tr><td>**# of CRPC participation**</td><td>1</td><td>1</td><td>2</td></tr></table> <table><tr><th></th><th>10</th><th>11</th><th>12</th></tr><tr><td>**ETCH**</td><td></td><td></td><td></td></tr><tr><td>**LeB**</td><td></td><td></td><td></td></tr><tr><td>**MCCH**</td><td></td><td></td><td></td></tr><tr><td>**TC T**</td><td></td><td></td><td></td></tr></table> Baseline by CRPC region <table><tr><td>**ETCH**</td><td></td></tr><tr><td>**Le Bonheur**</td><td></td></tr><tr><td>**MCCH@V**</td><td></td></tr><tr><td>**TC Thompson**</td><td></td></tr></table>	1a. Coordinators and nurse managers to gather current QI data elements utilized at their CRPC institution and bring to coordinator meeting before August 12, 2010 CoPEC meeting. b. Establish general standards for problematic transfers (CRPC coordinators) Sept. 30 c. Establish rating score for problematic transports (CRPC coordinators) Sept 30 d. Each CRPC region establish problematic	1a.Review problematic transfers from all 4 CRPCs and establish priority list of top five problems interventions by Feb 11, 2011 1b. Develop simulated intervention by May 2011 1c. 1st draft of publication regarding problematic transports to peer reviewed journal by Jan 2011 Final draft Feb. 2011 Target publication submission Feb. 2011.	Investigate the development of a strategy to expand QI tool at 4 general level pediatric facilities by June 2012 Complete simulated intervention development of #6-10 problematic transfers by June 2012

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			d. Review redcap database to identify problematic transfers and cross-reference with transfers from identified hospitals by June 2010 (Paulette lead, Barb, Mark, Rhonda, and Sue C.) e. Identify patients that received resuscitative measures at a non CRPC hospital and was not subsequently transferred from identified hospitals by June 2010 f. IRB generated between Vanderbilt and identified hospitals by June 2010 (Paulette and Sue C)2a.Task force members and CRPC coordinators, review materials from Susan Hohenhaus that were emailed from Rhonda	1d 1st draft of publication to peer reviewed journal by Sept 2011 Final draft Oct. 2011 Target publication submission Feb. 2011. Define early, on time, and late transfers (Paulette – lead plus task force members) by March 2011 Identification of early, on time and late transfers to Vanderbilt by May 2011	Lead for Strategy # 1 CRPC coordinators, ED nurse managers, and Paulette Johnson

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<tr>
<td>2. Develop Pediatric Simulation scenarios that will provide consistency in educational training.</td>
<td>2. Each hospital facility that has an emergency department / EMS services with an education agreement will be offered a pediatric simulation annually by CRPC coordinators</td>
<td>
<table>
<tr><th></th><th>10</th><th>11</th><th>12</th></tr>
<tr><td>ETCH</td><td></td><td></td><td></td></tr>
<tr><td>LeB</td><td></td><td></td><td></td></tr>
<tr><td>MCCH</td><td></td><td></td><td></td></tr>
<tr><td>TC T</td><td></td><td></td><td></td></tr>
</table>
Baseline by CRPC region
<table>
<tr><td>ETCH</td><td></td></tr>
<tr><td>Le Bonheur</td><td></td></tr>
<tr><td>MCCH@V</td><td></td></tr>
<tr><td>TC Thompson</td><td></td></tr>
</table>
</td>
<td>2a.Kaye, Lee, Donna and Stan plus the CRPC coordinators, review materials from Susan Hohenhaus that were emailed from Rhonda
b.CRPC coordinators identify scenarios problematic for all regions
c. Develop uniform curriculum used by each CRPC coordinator for scenario education that includes recognition of ill child, preparation for transfer, and appropriate handoff (CRPC coordinators and this task force) Feb 2011</td>
<td>2. Take information learned from above research and add to curriculum previously developed by Aug. 2011</td>
<td>2. Publish initial pilot, written by CRPC coordinators and submitted to peer reviewed journal by Aug. 2012.

Lead for Strategy 2 Kay, Lee, Donna T., *Stan, CRPC Coordinators and Sandra Castro</td>
</tr>
</table>

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			d. Develop standardize evaluation tool to critic scenario (CRPC coordinators and this task force) First draft Oct 2010 Final Feb. 2011 e. Develop evaluation tool for EMS and emergency department to complete following educational experience (CRPC coordinators and this task force) First draft Oct 2010 Final Feb. 2011		

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<tr><td>3. Survey education tool for EMS</td><td>3.The CoPEC education/data task force's pre hospital education survey will be disseminated to 100% of ambulance services in TN with a 50% response to survey</td><td><table><tr><th colspan="3">Survey Response Rate</th></tr><tr><td>June 20%</td><td>July 30%</td><td>Aug 50%</td></tr></table></td><td rowspan="2">3. Develop EMS education survey (Donna, Ken, Rick) Encourage response to receive 50%
a. Donna Tidwell to distribute survey through the EMS consultants
b. CRPC coordinators to disseminate and tabulate survey in their respective regions and report results to task force by August 2010
c. Task force comprised of Donna, Rick, Lee and Ken
4. Develop basic pediatric emergency care presentations (ABC) in the format requested in survey by October 2010
Develop pre and post test standardized presentations (all members of committee)</td><td rowspan="2"></td><td>Lead for Strategy 3 Donna T., Rick Collier, and Ken Holbert</td></tr>
<tr><td>4.Basic pediatric emergency care presentations ABC</td><td>4. A basic pediatric emergency care presentation will be viewed by 75% of EMS agencies by 2012.</td><td><table><tr><th colspan="4">Basic care presentation</th></tr><tr><td></td><td>10</td><td>11</td><td>12</td></tr><tr><td>Goal</td><td>25%</td><td>50%</td><td>75%</td></tr><tr><td>ETCH</td><td></td><td></td><td></td></tr><tr><td>LeB</td><td></td><td></td><td></td></tr><tr><td>MCCH</td><td></td><td></td><td></td></tr><tr><td>TC T</td><td></td><td></td><td></td></tr></table></td><td>4. Refine presentation using evaluation results by May 2011</td><td>Lead for Strategy 4: Christy Cooper, *Kaye, and Sandra Castro, Rick Collier</td></tr>
</table>

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<tr>
<td>5. Surveyor education</td>
<td>5. An orientation to the BLHCF surveyors regarding the pediatric emergency care rules and regulations will be attended by 75% of surveyors in 2011</td>
<td>
<table>
<tr><th>% Attended</th></tr>
<tr><td>2011</td></tr>
<tr><td>75%</td></tr>
</table>
</td>
<td>5. An offer to assist with orientation will be made to the BLHCF by the chair of the Exceeding the Performance Measure task force and/or CoPEC chair at the Sept. 2010 meeting.</td>
<td>5. Orientation developed by Marisa and Yvette to surveyors will be presented at their annual meeting by the chair of the Exceeding the Performance Measure task force and/or CoPEC chair</td>
<td>5. Orientation will be offered annually.

Lead for Strategy 5: Yvette and Marisa</td>
</tr>
<tr>
<td>6. EMS and BLHCF invited to observe mock code</td>
<td>6. 100% of (EMS board) EMS Directors and Trainers and BLHCF will be offered to observe a mock code and 75 % will observe mock code</td>
<td>
<table>
<tr><th></th><th>11</th><th>12</th></tr>
<tr><td>Goal Invite</td><td>100</td><td>100</td></tr>
<tr><td>ETCH</td><td></td><td></td></tr>
<tr><td>LeB</td><td></td><td></td></tr>
<tr><td>MCCH</td><td></td><td></td></tr>
<tr><td>TC T</td><td></td><td></td></tr>
</table>
</td>
<td>6. Invitation will be made to EMS board members that are not retiring June 2010 by CRPC coordinator and Rick for the region in which the EMS board member resides and 50% will observe a mock code by Sept. 2010.</td>
<td>6a. Invitation will be made to EMS board members that are new since June 2010 by CRPC coordinator and Rick for the region in which the EMS board member resides and 50% will observe a mock code by December 2011
6b. Invitation will be made to BLHCF that are not retiring June 2010 by CRPC coordinator for the region in which the board member resides and 50% will observe a mock code by Dec 2011.</td>
<td>Lead for Strategy 6 CRPC coordinators and Ric Collier</td>
</tr>
</table>

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	11	12
Goal	50%	75%
ETCH		
LeB		
MCCH		
TC T		

	11	12
Goal	50%	75%
ETCH		
LeB		
MCCH		
TC T		

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GOAL #5: Secure Diverse Funding Sources to Increase Revenues by 50% (150,000 to 240,000)

Committee: Michael Carr and Bob Roth, Co-Chairs Leslie Phelps, Foundation board)

STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
1. Establish matrix and standardized funding streams.					

	2010	2011	2012
Current Grants	75%	66%	62%
FF	4	5	5
LW	2	2	3
D	1.5	2	4
CG	0	2	4
GE	2.5	5	6
FR	4	4	5
Dues	2	1	1
SL	1	2	3
EC	8	11	7
	100%	100%	100%

Baseline
Current grant funding = $150,000 81%
Fall Fundraiser = FF $ 15,000 9%
LW= Letter Writing - $0
Donations = D - $3000
CG=Corporate Giving - 0
GE=Grant expansion - $0
Dues $3,000
SL = Star of Life (-$2000)
EC= Ed Conference - $15,000 9%

	2010
Current Grants	150K
FF	8K
LW	4K
D	3K
CG	0
GE	5K
FR	8K
Dues	2K
SL	1K
EC	26.4K

	2011
Current Grants	150K
FF	12K
LW	5K
D	5K
CG	5K
GE	10K
FR	9.5K
Dues	2K
SL	2K
EC	30K

	2012
Current Grants	150K
FF	11.5K
LW	6K
D	10K
CG	10K
GE	15K
FR	11K
Dues	2K
SL	7K
EC	30K

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<tr>
<td></td>
<td>1A) Educational conference has achieved increase in attendance and funds raised by 14% cumulative for optimal organizational stability. Rolling average of last 5 years plus 10%

1B) The letter writing campaign "Friends of TN EMSC" has achieved participation from 100% of board members and 25% of TN EMSC colleagues in 10 followed by 10% cumulative annually.</td>
<td>
<table>
<tr><th></th><th>2010</th><th>2011</th><th>2012</th></tr>
<tr><td>#'s</td><td>180</td><td>205</td><td>235</td></tr>
<tr><td>$</td><td>26.4K</td><td>30K</td><td>30,K</td></tr>
<tr><td colspan="4">Baseline 2009
Attendees 139
Amount raised 20,400</td></tr>
</table>
<table>
<tr><th></th><th>10</th><th>11</th><th>12</th></tr>
<tr><td>% Bd.</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>% Part</td><td>10</td><td>20</td><td>25</td></tr>
<tr><td>% FG</td><td>2</td><td>2.2</td><td>2</td></tr>
</table>
Bd=Board Memb.
Part=Participants
FG=Funding Goal
</td>
<td>1A) Identify a chairperson by July 1.
2A) Committee to start work by Jul 1.
3A) Event date and venue selected by Sept 1 MC to talk w Barry and Ryan.

1B) Enlist personal letter writing campaign by Michael at Aug meeting (draft by MC and BR by Jul1)
• 100% of board members
• 10% of TN EMSC colleagues
2B) Draft letters presented by 100% of board members and 10% of TN EMSC colleagues by Oct.
3B) Letters mailed by November 1st.Incorporate "Giving" Thermometer into B and C by GS&F</td>
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<tr>
<td></td>
<td>1C) Achieve individual giving by 100% of board members and 40% of TN EMSC colleagues</td>
<td>
<table>
<tr><th></th><th>10</th><th>11</th><th>12</th></tr>
<tr><td>% BD</td><td>100</td><td>100</td><td>100</td></tr>
<tr><td>% TN EMSC Friends</td><td>20</td><td>30</td><td>40</td></tr>
</table>
</td>
<td>1C) Enlist 100% of board members to make annual gift.

2C) Enlist 20% of TN EMSC colleagues to make annual gift.

3C) Implement record keeping process to record activity.

4C) Establish goal of each board member giving $1000 as a result of Personal activity.</td>
<td>1C) Enlist 100% of board members to make annual gift.

2C) Enlist 30% of TN EMSC colleagues to make annual gift.

3C) Implement record keeping process to record activity.

4C) Establish goal of each board member giving $1000as a result of personal activity.</td>
<td>1C) Enlist 100% of board members to make annual gift

2C) Enlist 40% of program participants to make annual gift

3C) Implement record keeping process to record activity

4C) Establish goal of each board member giving $100 as a result of personal activity.</td>
</tr>
</table>

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	1D) Achieve corporate giving.	<table><tr><th></th><th>2010</th><th>2011</th><th>2012</th></tr><tr><td>CG</td><td>0</td><td>5000</td><td>10,000</td></tr><tr><td></td><td>100%</td><td>100%</td><td>100%</td></tr></table> Baseline CG=Corporate Giving - 0	1D) Compile list of possible funding for program dollars from corporations. 2D) Investigate United Way/Community Giving to determine feasibility of participation in each region of the state by Rhonda Aug metg 3D) Identify corporations that have a matching program by TN EMSC Friends.	1D) Compile list of possible funding for program dollars from corporations. 2D) Participate in United Way/Community Giving to if feasibility indicates participation. 3D) Ten percent increase for number of donors of that have a matching program. 4D). Nascar project to secure 3-5 years of financial commitment Carr, Staff	1D) Compile list of possible funding for program dollars from corporations. 2D) Participate in United Way/Community Giving if warranted to continue. 3D) Ten percent increase for number of donors that have a matching program

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<tr>
<td></td>
<td>1E) Achieve expansion of grant funding.

1F) Expand number of fundraising activities.

1G) Dues structure evaluation</td>
<td>
<table>
<tr><th></th><th>10</th><th>11</th><th>12</th></tr>
<tr><td># of applications</td><td>2</td><td>4</td><td>4</td></tr>
<tr><td># Awarded</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Amt $</td><td>5k</td><td>10k</td><td>15k</td></tr>
<tr><td></td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
Baseline
GE-Grant expansion - 0
</td>
<td>1E) Staff to identify possible grantors and timelines for submission.

2E) Investigate ghost grant writer.

1F) Add one additional anchor funding activity that raises $5,000.

1G) Increase individual member dues to $40 per person</td>
<td>1E) Staff continues to identify possible grantors and timelines for submission.

2E) Enlist persons to write grants.

1F) 2010 anchor increase funding activity that raises $9500.

1G) Increase board membership dues to $150 per member</td>
<td>1E) Staff continues to identify possible grantors and timelines for submission.

2E) Enlist persons to write grants.

1F) 2010 anchor increase funding activity that raises $11,000

1G) Evaluate dues structure and make recommendations to Board</td>
</tr>
</table>

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	1H) Star of Life		1H) Increase net proceeds by $ 1000	1H) Increase net proceeds by $4000	1H) Increase net proceeds by $7000
	1I) Fall Fundraiser		1I) Increase net proceeds by the rolling average of the past four years plus 10%	1I) 1I) Increase net proceeds by the rolling average of the past four years plus 10%	1I) 1I) Increase net proceeds by the rolling average of the past four years plus 10%

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GOAL #6: Exceed the National EMSC Performance Measures

Statement of Direction: EMSC performance measures are part of the foundation for providing quality pediatric emergency care.

Task Force Members: Kevin Brinkmann, Barbara Shultz, Deena Kail, Randall Kirby, Joel Dishroon, Joe Holley

<table>
<tr><th>STRATEGIES</th><th>LEADING INDICATORS OF SUCCESS</th><th>3 YEAR PERFORMANCE TARGETS</th><th>YEAR 1 (10-11) ACTION PLANS & LEAD</th><th>YEAR 2 (11-12) ACTION PLANS & LEAD</th><th>YEAR 3 (12-13) ACTION PLANS & LEAD</th></tr>
<tr>
<td>PM 71: The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.</td>
<td>Increase from 85% to >90% the number ALS and BLS pre-hospital agencies that will have on-line pediatric medical direction from dispatch through patient transport to a definitive care facility by 2011.</td>
<td>
<table>
<tr><th></th><th>09</th><th>10</th><th>11</th></tr>
<tr><td>71</td><td>85%</td><td>>90</td><td></td></tr>
<tr><td>72</td><td>85%</td><td>>90</td><td></td></tr>
<tr><td>73</td><td>11%/29%</td><td>>90</td><td></td></tr>
<tr><td>74</td><td>96%</td><td>>90</td><td></td></tr>
<tr><td>75</td><td>96%</td><td>>90</td><td></td></tr>
<tr><td>76</td><td>96%</td><td>>90</td><td></td></tr>
<tr><td>77</td><td>96%</td><td>>90</td><td></td></tr>
<tr><td>78</td><td>NO</td><td>YES</td><td></td></tr>
<tr><td>79</td><td>100</td><td>100</td><td></td></tr>
<tr><td>80</td><td>7/8</td><td>8/8</td><td></td></tr>
<tr><td>CAH</td><td></td><td></td><td>yes</td></tr>
</table>
CAH-congenital adrenal hyperplasia
</td>
<td>Obtain data of 2010 survey of ALS and BLS pre-hospital provider agencies. Work with EMS CIC and EMS regional consultants to educate/ensure the provision of on-line pediatric medical direction for pre-hospital providers that do not have a plan for this in place.

Completed by R. Phillippi and CRPC coordinators by October 2010

<u>Responsible Members:</u>
<u>Joel Dishroon</u>
<u>Randall Kirby</u></td>
<td>Identify those ALS and BLS pre-hospital provider agencies that have not provided for on-line pediatric medical direction and continue to work with the EMS CIC and regional consultants to improve this.

Address possibility of adding on-line medical direction into the inspection reports.

<u>Responsible Members:</u>
<u>Joel Dishroon</u>
<u>Randall Kirby</u></td>
<td>Report to CoPEC and EMS CIC those ALS and BLS agencies that have not ensured on-line pediatric medical direction. Further work with EMS CIC to ensure this support is available.

Project to be completed by July 2011.

<u>Responsible Members:</u>
<u>Joel Dishroon</u>
<u>Randall Kirby</u>

<u>Link to Education Goal</u></td>
</tr>
</table>

TN EMSC - 2010-2013 STRATEGIC PLAN

MISSION: To ensure that every child in Tennessee receives the best pediatric emergency care in order to eliminate the effects of severe illness and injury.

VISION: To be the foremost advocate for children throughout the continuum of care in Tennessee and the nation.

STRATEGIES	LEADING INDICATORS OF SUCCESS	3 YEAR PERFORMANCE TARGETS	YEAR 1 (10-11) ACTION PLANS & LEAD	YEAR 2 (11-12) ACTION PLANS & LEAD	YEAR 3 (12-13) ACTION PLANS & LEAD
PM 72: The percent of pre-hospital provider agencies in the State/Territory that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.	Increase from 85% to >90% the number ALS and BLS pre-hospital agencies that will have off-line pediatric medical direction from dispatch through patient transport to a definitive care facility by 2011.		Obtain data of 2010 survey of ALS and BLS pre-hospital provider agencies. Work with EMS CIC and EMS regional consultants to educate/ensure the provision of **off-line** pediatric medical direction for pre-hospital providers that do not have a plan for this in place. Completed by R. Phillippi and CRPC coordinators by October 2010 Responsible Members: Joel Dishroon Randall Kirby	Identify those ALS and BLS pre-hospital provider agencies that have not provided for off-line pediatric medical direction and continue to work with the EMS CIC and regional consultants to improve this Confirm that off-line protocols are addressed in the inspection reports. Responsible Members: Joel Dishroon Randall Kirby	Report to CoPEC and EMS CIC those ALS and BLS agencies that have not ensured on-line pediatric medical direction. Further work with EMS CIC to ensure this support is available. Project to be completed by 2011 Responsible Members: Joel Dishroon Randall Kirby

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PM 73: The percent of patient care units in the State/Territory that have the essential pediatric equipment and supplies as outlined in national guidelines.	Increase from 11% to >90% the number of BLS and 21% to >90% ALS ambulances that will have all the essential pediatric equipment and supplies necessary to provide quality pediatric emergency care by 2011.		1. Review the current National Guidelines and compare to current Tennessee equipment requirements for ALS and BLS ambulances. 2. Discuss/approve equipment changes in Task Force conference calls. 3. Present proposed equipment changes to CoPEC in 2010. 4. Dr. Brinkman to make recommendations to the EMS CIC in 2010. Ensure pediatric rep on EMS Task Force rewriting rules and regs. 5. Dr. Holley to make recommendation for rulemaking changed at the Dec 2010 or March 2011 Board meeting to be in compliance with the National EMSC Performance Measure.	Equipment changes presented to the EMS Board. Equipment Rule changes communicated to the EMS agencies through the Regional EMS Consultants. Responsible Members: Dr. Brinkmann Dr. Holley	Ongoing review of updated National EMS equipment guidelines and future revision of Tennessee Rules as needed.

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			EMS Board Dates **2010** March 24-25, 2010 June 23-24, 2010 September 22-23, 2010 December 1-2, 2010 **2011** March 30-31, 2011 June 22-23, 2011 September 28-29, 2011 December 7-8, 2011		

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PM 74: The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric **medical** emergencies.	All healthcare facilities that have the potential to stabilize and/or manage pediatric medical and/or traumatic emergencies are in compliance with their self-designated level of pediatric care as defined by the PECF Rules and Regulations.		Data will be collected utilizing the national EMSC performance measure survey from greater than 80% of facilities capable of PM 74 and PM 75 by R. Phillippi and CRPC coordinators by Summer 2010. Need to assess if the remaining 4% are facilities that are capable of meeting these requirements (i.e. are those facilities primarily research hospitals such as St Jude Children's Research hospital) and document that Tennessee has met these performance measures to the greatest ability. Deena Kail responsible. She will work with CRPC Coordinators to complete this PM by 2011.	Continue follow-up with facilities and document compliance with the National EMSC guidelines.	

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PM 75: The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric **traumatic** emergencies.	For PM 74 and 75, on the last survey 96% of Tennessee's health care facilities satisfy this requirement. The national goal is for 25% by 2017 for PM 74 and 50% for PM 75.				

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PM 76: The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: (see reference) PM 77: The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.	Tennessee health care facilities will have transfer agreements that cover pediatric patients and will have transfer guidelines that include all the components of transfer as recommended by National EMSC. Currently 96% of Tennessee health care facilities meet both of these performance measures.		Data will be collected utilizing the national EMSC performance measure survey from greater than 80% of facilities capable of PM 76 and PM 77 by R. Phillippi and CRPC coordinators by Summer 2010.	PECF Rules and Interpretive Guideline Review and Revision: Kevin and Barbara to review the PECF Interpretive Guidelines documentation of the necessary components of the transfer guidelines. Propose amendments to the interpretive guidelines as needed to be clear of these requirements by the end of 2010. Review with CoPEC any additional changes to the PECF Rules and/or Interpretive Guidelines and finalize any proposed changes for presentation to the BLHCF by 2011.	Universal Pediatric Transfer Agreement: Kevin and Barbara to communicate with the CRPC and THA legal representatives regarding development of a universal pediatric transfer agreement in 2010. Communicate with this legal group the components of transfer as per PM 76 to be included in this new universal transfer agreement in 2010. Communicate with the legal group the potential for improving statewide disaster planning with a universal agreement. Continue to follow and support the legal teams as able with proposed completion of project in 2011.

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			Identify the health care facilities that currently do not have all the necessary components of the transfer agreement. Communicate with those facilities the needed components for their written transfer guidelines. Barbara and Deena to contact CRPC Coordinators for facilities with agreements that don't have all guidelines. CRPC Coordinators to educate those facilities in 2010 and 2011. Further identify if the 4% of Tennessee health care facilities that did not meet these PM in the last survey are capable of meeting these PM. Provide support to these facilities if they are able to meet these PM, otherwise document that Tennessee has met these PM to the greatest ability.		

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PM 78: The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.	Approval by the EMS Board for this requirement.		Collaborate with TEMSEA, EMS CIC and EMS Education committee/Scope of Practice Committee on adoption of requirements for pediatric emergency education for license renewal of BLS and ALS providers. At 8/9/07 COPEC meeting, motion was passed that 20% of EMS CEUs for recertification be in pediatrics -- communicate this to above stakeholders. This is benchmarked to be completed in 2010 with a deadline for completion in 2011. Plan to follow-up with the EMS Board and provide support as needed to ensure this change in rules. Consider having the CRPC coordinators invite EMS Board Members to attend a mock code at one of their local EMS agencies. Joel, Trisha, and Randall to lead these discussions.	Follow through with the changes in rules with the EMS Board to ensure adoption of requirements for pediatric emergency education for license renewal of BLS and ALS providers. Joel and Randall to communicate with EMS regional consultants to communicate changes to EMS providers.	Rules in place that provide for 100% compliance for this performance measure. Link with Education committee

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PM 79: The degree to which Tennessee has established permanence of EMSC in the State EMS System	PM 79: Permanence of EMSC in the State system is defined as: a. EMSC Advisory Committee has the required members as per the implementation manual. b. EMSC Advisory Committee meets at least 4 times a year. c. By 2011, pediatric representation will have been incorporated on the State EMS Board d.By 2011, TN will mandate requiring pediatric representation on the EMS Board. e.By 2011, one Full time EMSC Manager that is dedicated solely to the EMSC Program will have been established		Continue to maintain compliance with all 5 objectives.		

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PM 80: The degree to which the State/Territory has established permanence of EMSC in the State/Territorial EMS system by integrating EMSC priorities into statutes/regulations.	TN EMS will have understanding of the National EMSC Performance measures and the need for establishing permanence of EMSC in Tennessee's EMS system by integrating EMSC priorities into statutes/regulations. 1.Key stakeholders are able to demonstrate knowledge of EMSC performance measures and access them as needed. A plan of action will have been completed by May 2011		EMSC Performance Assessment 1. Annual report card of TN achievement of EMSC performance measures to key stakeholders. Color coded, easy to read report card distributed to each region ends a statewide goal. (Barb and Deena)		Present score card to National EMSC office for further implementation/distribution. Link to Communication tools task force

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2. Committee will have reviewed and developed action plan for children with congenital adrenal hyperplasia			This PM 80 will be complete with the completion of PM 78. Committee will then work on an annual report card. This report card will be sent to COPEC Marketing (Goal #4 Communication) to be sent to stakeholders. 2. Emphasize performance measures that TN does not currently meet. Information will be gathered from CARES as well as other states regarding plans for children with CAH- task force members Action plan will be presented to CoPEC at August 2010 meeting If approved, action plan proposed to Clinical Issues Committee of EMS Board by Dr. Brinkman at September 2010 meeting.		Link with Education task force

National Resource Center

NEDARC
The National EMSC Data Analysis Resource Center

EMSC NRC and NEDARC

Site-Visit Report

for

Tennessee EMSC State Partnership Grant

May 11-13, 2010

Prepared by:

Jocelyn Hulbert
Outreach Coordinator, EMSC National Resource Center

Ian Weston
Director, EMSC National Resource Center

Mike Ely
Director, National EMSC Data Analysis Resource Center

Kent Page
Statistician, National EMSC Data Analysis Resource Center

Site Visit Participants

Tennessee EMSC Program Team

- Rhonda Phillippi, EMSC Program Manager

EMSC Federal Program

- Tina Turgel, Nurse Consultant, HRSA/MCHB/EMSC Program

EMSC Program Site-Visiting Team

- Tasmeen Singh Weik, Executive Director, EMSC NRC
- Ian Weston, Director, EMSC NRC
- Jocelyn Hulbert, Outreach Coordinator, EMSC NRC
- Mike Ely, Director, NEDARC
- Kent Page, Statistician, NEDARC

Introduction

Throughout the course of the EMSC Program it has been customary for the EMSC National Resource Center (NRC) and the National EMSC Data Analysis Resource Center (NEDARC) to conduct periodic site visits to State Partnership grantees to assess their progress in meeting the federal performance measures, and to assist with strategic planning to overcome barriers to meeting the performance measures.

During the 2010-2011 grant cycle an additional category of site visits has been introduced where the primary objective of the visit is to acknowledge the state's stellar performance and progress made in meeting the EMSC performance measures. This is accomplished when members of the federal EMSC program, along with NRC and NEDARC representatives observe first-hand the components of the state's EMS system that evidence best practices in pediatric pre-hospital emergency medicine.

The Tennessee site visit was the first site visit of this type to be conducted. Tennessee was chosen as the initial "best practices" site visit because of the strength and leadership of their State Partnership grant manager, Rhonda Phillippi, and the many accomplishments and impressive collaboration of Ms. Phillippi and her many colleagues in the Tennessee EMS system. The Federal EMSC Program hopes to share select best practices utilized by Tennessee to assist other states in making strides toward meeting the EMSC performance measures.

The primary focus of this site visit was Tennessee's accomplishments specific to the four EMSC hospital-based performance measures. These are considered to be the more difficult performance measures to meet, and Tennessee has met all four.

Performance Measure #74: The percentage of hospitals with an emergency department recognized through a statewide, territorial, or regional standardization system that are able to stabilize and/or manage pediatric medical emergencies.

Performance Measure #75: The percentage of hospitals with an emergency department recognized through a statewide, territorial, or regional standardization system that are able to stabilize and/or manage pediatric traumatic emergencies.

Performance Measure #76: The percentage of hospitals with an ED in the state/territory that have written interfacility transfer guidelines that cover pediatric patients and that contain 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); and
- plan for transfer of patient information (e.g. medical record, copy of signed transport consent), personal belongings of the patient, and provision of directions and referral institution information to family.

Performance Measure #77: The percentage of hospitals with an ED in the state/territory that have written interfacility transfer agreements that cover pediatric patients.

Background

Extracted from the 2009 Tennessee EMSC State Partnership grant

The State of Tennessee (TN) is a long and narrow state that is bordered by eight states which is more than any other state in America. This is significant since each of these states utilize the medical and trauma system of the comprehensive regional pediatric centers in Tennessee. It is a mostly rural state of 95 counties with 5 of these counties being urban. The entire state is 42,244 square miles with differing topography. The west borders the Mississippi River and is flat land, Middle TN has rolling hills, and East TN is mountainous and includes the Great Smokey Mountains. Driving distance from upper east TN to Memphis is twelve hours. The population of TN is 6 million with 57.5% comprised of rural citizens and 25% of the population under the age of 18.

The Tennessee Department of Health, Division of Emergency Medical Services is granted authority to oversee the State's Emergency Medical Services System The Division of Emergency Medical Services (EMS) in TN is housed in the TN Department of Health in the Bureau of Licensing. The EMS structure is set up through an eight regional system with central oversight including licensure and regulations for ambulances as well as EMS provider certification. Providers are licensed at the Emergency Medical Technician Emergency Medical Technician IV (EMT-IV) and Emergency Medical

Technician Paramedic (EMT-P) level. Requirements for education of the pre-hospital providers are instituted in the state EMS Division through previously established rules and regulations. Currently, Tennessee has pediatric education requirement to acquire a license but no pediatric specific continuing education is required for re-licensure.

For Ambulances, the minimum staffing is at least one Emergency Medical Technician and a licensed driver with CPR training, as referenced in Medicare standards. For the 80th to 90th percentile of emergency responses in TN, the crew is Advanced Life Support (ALS) ALS, consisting of at least one paramedic, and an EMT-IV as vehicle operator. Each of the eight regional offices oversees the EMS services in their section of the State. The regional director is responsible for conducting the yearly ambulance services inspection. As a part of this inspection, the equipment is reviewed on each ambulance. Currently, Performance Measure (PM) 73 has not been achieved because all the pediatric equipment on the national equipment list is not required by Tennessee rules and regulations.

Each EMS service is required to have a medical director that approves off line medical control (protocols) and a system for on-line medical control. These are established both by law and by regulation. The State EMS Medical Director provides protocol guidelines but each ambulance service is responsible for adopting or creating their own protocols.

The State EMS Board has twelve specific seats, comprised of representatives from various organizations that are appointed by the Governor. The incorporation of a pediatric representative on the State EMS board, PM 79 has been achieved.

Tennessee has received EMSC Partnership funding since 1994 and primarily has used it to focus on EMSC institutionalization in the state and to improve the quality and availability of pediatric emergency care. By utilizing the EMSC continuum of care model and the National EMSC Performance Measures as templates, strategic initiatives were enacted that have furthered the institutionalization of EMSC within Tennessee.

Prior to legislation in 1998, the EMSC project was politically situated as a sub-committee under the Trauma Care Advisory Council that only reports to the Board for Licensing Health Care Facilities. This structure prevented reporting the pediatric emergency care needs regarding hospital facilities and EMS agencies directly to the appropriate boards. Instead, the Trauma Care Advisory Council could choose to not act on the reports submitted by the Subcommittee on Pediatric Emergency Care

To alter the reporting structure, strategic initiatives including the state legislature unanimously passing the TN EMSC legislation in 1998 and revised in 2007 created a standing committee on pediatric emergency care (CoPEC) which serves as Tennessee EMSC Advisory committee. This legislation requires CoPEC to report directly to both the Board for Licensing Health Care Facilities (BLHCF) and the Emergency Medical Services Board (EMSB). These laws also mandated minimum preparedness for pre-hospital and hospital emergency departments and required both a medical (PM 74) and trauma hospital (PM 75) recognition system, far in advance of the PM requirement. The rules and regulations that establishes this system also mandates written pediatric inter-facility guidelines (PM 77) and agreements (PM 78) for every hospital with an emergency room in TN.

In response to the legislation and CoPEC recommendations, the BLHCF and EMS Boards have promulgated rules and regulations to ensure compliance with the law. These rules include a requirement to promote a family focused approach to the care of the child, including children with special healthcare needs, as well as accounting for ethnic diversity. TN established the rules that included specific pediatric equipment, drugs, and education for physicians, nurses, and pre-hospital providers prior to the creation of Performance Measures by HRSA.

CoPEC, which acts as the state EMSC advisory committee, convenes quarterly with the eight required members as established by PM 79. The eight core members represent the following professional associations: TN American Academy of Pediatrics (TN AAP), TN Emergency Nursing Association (ENA), TN American College of Emergency Physicians (TN ACEP), TN College of Surgeons, TN Ambulance Service Association, the EMS medical director as well as the EMS division director. In addition, the program director, Bradly Strohler, MD, MSCI, the full time equivalent EMSC program manager (PM 79), Rhonda G. Phillippi, RN, BA and three organizations represent families on CoPEC.

The expertise on CoPEC is further complimented by additional members including Rural Health Association of TN, TN EMS Educators Association, and personnel from each level of care in the facility recognition system, TN Association of School Nursing, and TN Chapter of the American Academy of Family Physicians.

The activities of CoPEC are accomplished through the task force committeés. CoPEC just completed the process of developing a strategic plan that includes the national performance measures.

The Division of EMS within the Tennessee State Department of Health has worked with the Committee on Pediatric Emergency Care (CoPEC), and Vanderbilt School of Medicine to administer the Tennessee EMSC Project.

Day 1
Tuesday, May 11, 2010

Our visit to Tennessee was comprised of meetings, discussions with public and state officials, tours of both rural and urban EMS services, and a tour of Monroe Carell Jr. Chilren's Hospital at Vanderbilt. During each of our meetings and tours there was time for extensive discussions with representatives from many aspects of the state's EMS system, and additionally, a pediatric trauma center emergency department.

The following will detail the site visit team's agenda, observations and impressions.

Tuesday, May 11, 2010:

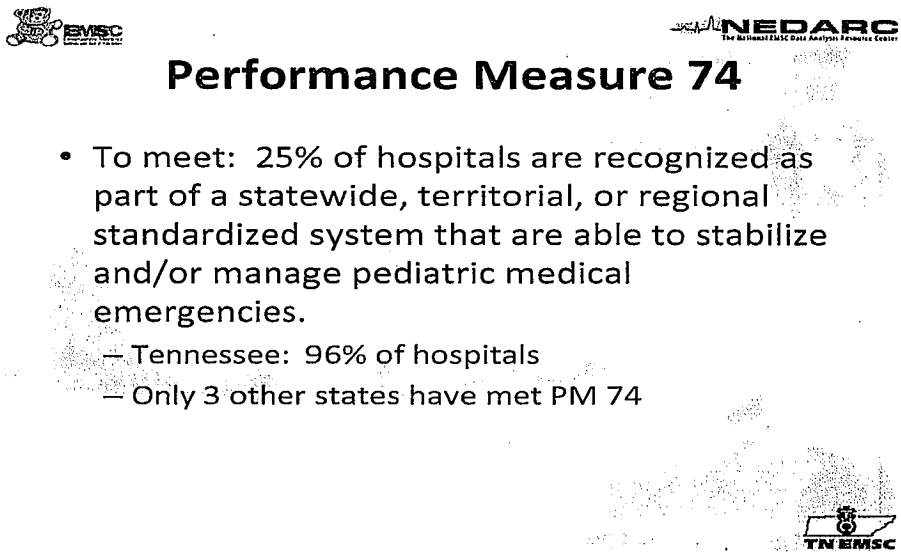
As previously mentioned, the Tennessee EMSC Advisory Committee is named the Committee on Pediatric Emergency Care (CoPEC). This group is comprised of the 8 core members required by performance measure 79, and many additional members (65 total membership) with far-reaching expertise on the issues and needs of pediatric patients in the state. The committee structure is based on membership from across the state, with representation of a medical director, pediatric physicians, pediatric nurses, pre-hospital providers, hospital emergency department personnel and physicians, trauma surgeons, ICU specialists, ambulance and fire department management and personnel, family physicians, and parents. There is also active representation from each of the four Comprehensive Regional Pediatric Centers (CRPC's) across the state, whose collaboration on the behalf of the children in Tennessee should serve as model of successful partnering to ensure the

best possible emergency care. The larger committee also includes representation from partner organizations such as the state chapter of AAP, the state hospital association, and others.

The EMSC site visit team was invited to attend the CoPEC meeting (as observers) while they concluded their year-long process of creating a strategic plan for EMSC future activities. Tennessee's CoPEC is a very active and engaged committee of professionals and parents who work around the year both in full committee, and smaller sub-committees. During the meeting, led by a professional facilitator, the entire CoPEC membership engaged in a leadership training on 'how to run effective meetings and conference calls, while holding people accountable'. The second half of the meeting focused on the finalization of their strategic plan for EMSC. The process they underwent was extremely thorough, democratic and guided by their dedication to keeping focus on what is best for the children in their state. They repeatedly invoked the name of a Tennessee child, "Erik" who was saved by exemplary emergency medical care after a traumatic injury, as a reminder of their guiding principle on standards of care. This is particularly effective when difficult decisions or differing opinions could potentially derail their progress as a team. "Erik" stands for all that could and should be done to ensure the best possible emergency care for children in their state. This has proven to be a very successful method for all members of the team as it keeps them focused on their larger task at hand and lessens the likelihood of individual differences preventing consensus for the group as a whole.

The EMSC site visit team had the opportunity to present some of the data results for how well Tennessee has done in meeting the hospital performance measures, and how they currently compare with other states in the Nation. CoPec's membership were gratified to see some of the results of their hard work.

Following are several of the data slides shared with CoPEC;



Performance Measure 75

- To meet: 50% 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.
  - Tennessee: 96% of hospitals
  - Only 14 other states have met PM 75

Performance Measure 76

- To meet: 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.
  - Tennessee: 96% of hospitals
  - Only 1 other state has met PM 76
  - Nationally: 23% of hospitals

Performance Measure 77

- To meet: 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
  - Tennessee: 96% of hospitals
  - Only 3 other states have met PM 77
  - Nationally: 43% of hospitals

It was the opinion of the site visit team that Tennessee's committee structure and process are an example of an extremely well developed committee approach that far exceeds the requirements of the performance measure. Having equal and appropriate representation from each EMS region ensures that all aspects of the EMS and hospital systems that impact pediatric care are present and available to share the specifics of their region's demographics as they relate to protocols and delivery of emergency care.

At the conclusion of the CoPEC meeting, the site visit team met briefly with the CEO's and medical directors of the four comprehensive regional pediatric centers (CRPC's) in Tennessee. Tina Turgel gave a brief presentation to the group outlining the successes of the Tennessee EMSC Program with regard to the performance measures, again with particular focus on those involving hospital care. Much of the progress that Tennessee has made with the four hospital-based performance measures was enabled by the involvement, support and collaboration of the leadership of the four CPRC's working together with TN EMSC. Without their support and willingness to work together, much of what the state has accomplished would not have been possible. The site visit team had the opportunity to emphasize the unique nature of the collegial partnership between EMS and the hospitals in Tennessee, and how effective they have been at moving their EMS for children program forward. Their state is considered a leader in this realm and will be offered as a model of best practices between public and private enterprise as it relates to the best practices for pre-hospital to hospital care for children.

At the conclusion of the first day, the site visit team was invited to attend the annual "Star of Life" dinner and awards ceremony, which was conceptualized, organized and orchestrated by the TN EMSC program. Each year this awards ceremony is held to publicly acknowledge the stellar performance of EMT's, paramedics and other rescue personnel in Tennessee, who have performed beyond the call of duty during an emergency involving both children and adults in Tennessee. Family members, recovered patients, firefighters, EMT's, paramedics and hospital personnel were in attendance for this very uplifting evening that served as a reminder of dedication of all of the rescue personnel who work in tandem to ensure the best possible outcomes for the citizens in their state.

Wednesday, May 12, 2010:

On day two of the site visit, members of the site visit team were privileged to tour the Monroe Carell Jr. Children's Hospital at Vanderbilt. During the tour, we were able to talk with several key emergency physicians, nurses, PA's and other key emergency department personnel who explained in detail their methods for providing, improving and maintaining requisite EMS training for providers in the field. Tennessee has developed an outstanding network of physicians and EMS medical directors and providers who work together to constantly conduct performance improvement, discuss gaps in care or knowledge, needs for system and communication improvements and the like. The emergency physicians at Monroe Carell actively pursue input from EMS providers, and go out into the community to provide crucial training to the EMS community. Their lines of communication are excellent and far reaching, including not only the urban ambulance services, but extending out to the rural critical access hospitals and EMS/Fire services throughout the state.

After our tour a few members of the site visit team were able to meet with Ms. Christy Allen, Assistant Commissioner for the Bureau of Health Licensure and Regulation for Tennessee. The goal of our meeting was to highlight and share the accomplishments of the Tennessee EMSC program, and to present the outstanding results (see data slides previously shown) compiled to compare Tennessee's performance with the country as a whole. Ms. Allen was very pleased to hear about the success of the EMSC Program and pledged her continuing support to work with Rhonda Phillippi and CoPEC to continue their improvements to the EMS system in Tennessee.

The site visit team then traveled to Lafayette, Tennessee to tour a rural EMS service. Macon County EMS responds to both BLS and ALS calls, and in 2008 was at the forefront of dealing with a tornado that included mass casualties of both pediatric and adult patients. We viewed a presentation of the aftermath of that disaster and how the rescue and recovery efforts were orchestrated. Once again, the excellent communication between rural ambulance services, the critical access hospital, and other pertinent state agencies was evident, and directly impacted the speed and effectiveness of their response with minimal down time. We toured both the ambulance agency that houses several ambulances, fire apparatus, and one helicopter for med evac, along with the nearby critical access hospital, who were also very instrumental in the smooth triaging and transport of critical patients during the tornado disaster.

Thursday, May 13, 2010:

The day began with a meeting with Bob Duncan of the Governor's Office of Children Care Coordination. Mr. Duncan has been a longtime advocate of the EMSC program and has a distinguished background in healthcare. During our meeting we discussed the Tennessee EMSC program's success in meeting some of the more difficult performance measures, and were able to engage Mr. Duncan on his thoughts regarding best practices for success when collaborating within a state to move initiatives such as EMSC forward. His recommendations were helpful and will be shared in the form of technical assistance provided by the EMSC NRC and NEDARC when working with states.

The team next met with members of the Tennessee Hospital Association, where we once again shared the successes of the Tennessee EMSC program, and sought their insights on how we can guide other state's to work effectively with their hospital association representatives. The perspective of the group was that many hospital association members do not truly understand the nature of EMSC. They recommended that in order to ensure active participation by a states' hospital association, it is imperative to enlist the help of three or four dedicated physicians from the surrounding hospitals. They emphasized the importance of beginning the conversation (about what changes need to occur within a system to ensure the best pediatric care) at the physician level and obtaining their buy-in first, and then letting the physicians lead the effort to involve all of the necessary individuals (including the hospital association representative). They stressed that without the buy-in from trauma surgeons and other emergency physicians it would be difficult to engage the hospital association as they are often pulled to work on other issues.

We concluded our site visit with a tour of an urban EMS services in Nashville. The Metro fire department is located in downtown Nashville and services a portion of the downtown region. We discussed EMS training issues, pediatric equipment and pediatric protocols. They shared their protocols with us, allowing us to see how they delineate the adult and pediatric protocols for providers.

Conclusions:

The Tennessee EMSC Program, managed by Rhonda Phillippi, is a leader amongst EMSC programs in the nation. They have worked diligently and effectively to incorporate legislation on behalf of pediatric patients in the state, to promote the adoption of pediatric EMS protocols, interfacility transfer agreements, and facility recognition throughout the state. Tennessee is one of only a few states, and one of the first to incorporate a regionalized hospital recognition system resulting in a model system that is currently being reviewed and incorporated by other states.
They have generously offered to share their best practices with the EMSC program on numerous occasions in order to assist other states' in their efforts with improving their EMS systems as they relate to the care of children in their state.

The Federal EMSC program, the EMSC National Resource Center and the National EMSC Data Analysis Resource Center would like to thank the state of Tennessee, the members of CoPEC, Dr. Michael Carr, Dr. Barry Gilmore, Dr. Tom Abramo, Dr. Mark Meredith, Mr. Randall Kirby, Ms. Barb Shultz, Mr. Eric Clauss, Mr. Lee Blair, Dr. Jay Deshpande, Dr. Brad Strohler, Mr. Bob Duncan,
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EMSC Program Staff Rhonda Phillippi and Kristi Rush
for their time, support, and dedication
to the EMSC Program and all children in the State of Tennessee.

We look forward to continued progress and success in the State of Tennessee.