

EMSC PERFORMANCE MEASURES INSTRUCTION GUIDE FOR CONSULTANTS

INTRODUCTION AND BACKGROUND

PURPOSE OF DOCUMENT

These guidelines have been developed to provide guidance to consultants on the development of the next generation of EMSC Program performance measures for 2011.

EMSC PROGRAM MISSION STATEMENT

The EMSC Program is designed to reduce child and youth mortality and morbidity resulting from severe illness or trauma. It aims to: 1.) ensure that state-of-the-art emergency medical care for the ill or injured child and adolescent is available when needed; 2.) ensure that pediatric services are well integrated into the existing state emergency medical services (EMS) system and backed by optimal resources; and 3.) ensure that the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, is provided to children and adolescents at the same level as adults.

EMSC PROGRAM BACKGROUND

The EMSC Program was established under the Preventive Health Amendments of 1984 (PL 98-555). It is administered by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB). The EMSC Program is the only Federal program whose sole focus is on improving the quality of emergency care for children. The Program is primarily a grant making program to State governments and academic medical centers.

Although the EMSC Program has made significant strides over the years in improving the pediatric emergency care system, more remains to be done to ensure that children receive optimal medical care in an emergency. The Institute of Medicine's study on the Future of Emergency Care in the United States Health System resulted in three reports that were released in June 2006. One of these reports, *Emergency Care for Children: Growing Pains*, highlights the existing gaps in emergency care for children. The EMSC Program seeks to address these gaps in care.

PERFORMANCE MEASURES BACKGROUND

With the implementation of the Government Performance and Results Act (GPRA), public sector agencies are increasingly being held accountable for achieving outcomes. GPRA focuses on a results-oriented approach, requiring Federal agencies to develop performance measures that inform and guide organizational decisions and communicate to a broad constituency about their success. As a result of GPRA, all Federal agencies are obligated to provide information to Congress on the effectiveness of their programs.

In an effort to continue its focus on accountability and performance, the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau's (MCHB) tasked the National Resource Center (NRC) to develop a set of performance measures for the EMSC Program. Performance measures complement activities within the Program's current integrated performance management system.

The purpose of the EMSC Program performance measures is to document activities and accomplishments of the Program in improving the delivery of emergency services to children. Additionally, information from the measures helps to provide guidance to the Program on future areas for improvement.

Specifically, the goal of the performance measures is to:

- Provide an ongoing, systematic process for tracking progress towards meeting the goals of the EMSC Program;
- Allow for continuous monitoring of the effectiveness of key EMSC Program activities;
- Help identify potential areas of performance improvement among the EMSC State Partnership grantees;
- Determine the extent to which the grantees are meeting established targets and standards; and
- Allow the EMSC Program to demonstrate its effectiveness and "tell its story" to the Office of Management and Budget (OMB), Congress, and other stakeholders.

The first set of EMSC performance measures were developed in 2004-2005. At the time, the NRC contracted with an independent consulting group to facilitate performance measure development. The process included a document review of the literature, drafting of measures that were then evaluated by a consensus group of EMSC stakeholders, and beta testing in 3 states. Initially, over 71 measures were drafted. From these, 3 overall measures were chosen as the final measures, 2 of which have additional sub-measures for a total of 10 measures for which grantees are responsible. The first year that States implemented the performance measures was 2006 and data was entered into the HRSA Electronic Handbook (EHB) in July 2007. Initial feedback from States suggested considerable frustration in understanding and implementing performance measures. As a result, the measures were refined effective 2009 with input from grantees and a Performance Measure Advisory Committee (PMAC).

There have been significant challenges on both the State/Territory and Federal side to the implementation of the performance measures. On the State/Territory side, there is difficulty in customizing national performance standards and implementation to the unique infrastructure of the State/Territory. On the Federal side, it has been challenging to come up with meaningful, uniform measures that are applicable for all States, DC and 5 Territories to meet the Federal requirements of standardized reporting. The current performance measures have targets to be achieved by the year 2011 when the measures expire. The Program is currently taking steps to develop the new generation of performance measures with the help of a group of independent special consultants.

AN OVERVIEW OF THE EMSC

INTEGRATED PERFORMANCE MEASUREMENT SYSTEM

An effective performance management system must be integrated at every level of the organization. The following describes the components of the Program's integrated system. The following information will provide direction for the nature of the next generation of performance measures.

PERFORMANCE MEASURE DEVELOPMENT TEAM

The performance measures development will be coordinate by the EMSC National Resource Center. Participants will include:

- Staff from the Health Resources and Services Administration (HRSA) who will approve and oversee the process
 - Staff from the EMSC National Resource Center (NRC) who will coordinate all activities and prepare documents
 - Independent consultants hired by the EMSC National Resource Center
 - Staff from the National EMSC Data Analysis Resource Center (NEDARC) who will provide input into the measures
 - The Performance Measures Advisory Committee (PMAC) of the EMSC NRC
 - EMSC Partnership for Children Stakeholder group
 - Other stakeholders and participants as needed
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SUMMARY OF EMSC STRATEGIC PLAN

The Program's performance measure activities are strongly linked to its goals and objectives, which are outline in our strategic plan outlined below.

The strategic plan can be downloaded from:

http://childrensnational.org/files/PDF/EMSC/PubRes/Public_Version_of_Final_EMSC_Strategic_Plan.pdf

Goal 1: Improve the evidence base for pediatric emergency care through the development of a research infrastructure	
Objective 1.1	Review, update, and implement pediatric emergency care research priorities
Objective 1.2	Develop and support a cadre of new prehospital pediatric emergency care research investigators
Objective 1.3	Encourage the development of high-priority and rigorous prehospital-based pediatric emergency care research studies
Objective 1.4	Make funding available for rigorous and definitive hospital-based pediatric emergency care research studies
Objective 1.5	Disseminate pediatric emergency care research findings and results to health care leaders, policymakers (including Federal, State, and local), and practitioners in all settings
Objective 1.6	Optimize the infrastructure for multi-institutional pediatric emergency care research
Objective 1.7	Foster pediatric emergency care research collaboration among EMSC grantees, stakeholders, and Federal agencies
Objective 1.8	Assist investigators with seeking funding outside of the EMSC Program
Goal 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care	
Objective 2.1	Develop evidence- or consensus-based on-line and off-line pediatric medical direction for basic and advance life support providers
Objective 2.2	Assess the availability of essential pediatric equipment and supplies for basic and advance life support ambulances
Objective 2.3	Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma
Objective 2.4	Develop written pediatric inter-facility transfer guidelines for hospitals
Objective 2.5	Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities
Objective 2.6	Develop and adopt minimum requirements for pediatric emergency education as part of the recertification requirements of all emergency medical service providers
Objective 2.7	Engage EMSC stakeholder organizations in developing strategies to assist States/Territories in improving the pediatric emergency care infrastructure
Goal 3: Identify and disseminate strategies to improve the quality of pediatric emergency care	
Objective 3.1	Assess current resources for pediatric patient care quality
Objective 3.2	Disseminate currently available resources and/or implementation strategies on pediatric patient care quality to EMSC grantees and other relevant stakeholders
Objective 3.3	Make funding available to develop the infrastructure for studying pediatric patient care quality

Goal 4: Establish permanence of EMSC in each State/Territory EMS system	
Objective 4.1	Establish an EMSC Advisory Committee within each State/Territory
Objective 4.2	Incorporate pediatric representation on the State/Territory EMS Board
Objective 4.3	Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program
Goal 5: Improve emergency preparedness and response for children involved in disasters	
Objective 5.1	Review and disseminate guidelines on how to appropriately respond to children and their families before, during, and after a disaster at the national, State, and local levels
Objective 5.2	Encourage States/Territories to incorporate pediatric disaster preparedness training into initial education, continuing education, credentialing, and certification programs for emergency medical service providers
Objective 5.3	Increase the capacity for States/Territories to improve their level of pediatric expertise on Disaster Medical Assistance Teams and other organized disaster response teams
Objective 5.4	Review and disseminate disaster plan strategies that address pediatric surge capacity before, during, and after a disaster for both injured and non-injured children at the national, State, and local levels
Goal 6: Improve State/Territory and national capacity and infrastructure to collect, analyze, and utilize pediatric emergency care data	
Objective 6.1	Make funding available to improve State/Territory and national capacity and infrastructure to collect, analyze, and utilize pediatric emergency care data
Objective 6.2	Provide States/Territories with technical assistance for data collection, analysis, and utilization
Objective 6.3	Provide data management services, consultation, and support to the Research Node Centers of PECARN

ACCOUNTABILITY FOR THE MEASURES

EMSC State Partnership Grantees are required to collect and report data on each of the performance measures. Current partnership grant funding is at \$130,000 per year. Performance measures need to be accomplished within this funding.

CURRENT EMSC PERFORMANCE MEASURES

<p>Performance Measure #71 <i>(Former PM 66ai)</i></p>	<p>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.</p> <p>By 2011:</p> <ul style="list-style-type: none">• 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.• 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
<p>Performance Measure #72 <i>(Former PM 66aii)</i></p>	<p>The percent of pre-hospital provider agencies in the State/Territory that have pediatric off-line medical direction available from dispatch through patient transport to a definitive care facility.</p> <p>By 2011:</p> <ul style="list-style-type: none">• 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.• 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.

<p>Performance Measure #73 <i>(Former PM 66b)</i></p>	<p>The percent of patient care units in the State/Territory that have the essential pediatric equipment and supplies as outlined in national guidelines.</p> <p>By 2011:</p> <ul style="list-style-type: none"> • 90% of basic life support (BLS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for basic life support ambulances. • 90% of advanced life support (ALS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for advanced life support ambulances.
<p>Performance Measure #74 <i>(Former PM 66c medical)</i></p>	<p>The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.</p> <p>By 2017:</p> <ul style="list-style-type: none"> • 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
<p>Performance Measure #75 <i>(Former PM 66c trauma)</i></p>	<p>The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.</p> <p>By 2017:</p> <ul style="list-style-type: none"> • 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.

<p>Performance Measure #76 (Former PM 66d)</p>	<p>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:</p> <ul style="list-style-type: none"> • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family <p>By 2011:</p> <ul style="list-style-type: none"> • 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.
<p>Performance Measure #77 (Former PM 66e)</p>	<p>The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.</p> <p>By 2011:</p> <ul style="list-style-type: none"> • 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
<p>Performance Measure #78 (Former PM 67)</p>	<p>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.</p> <p>By 2011, the State/Territory will have adopted requirements for pediatric emergency education for the recertification of paramedics.</p>

<p>Performance Measure #79 <i>(Former PM 68a, b, c)</i></p>	<p>The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.</p> <p>To increase the number of State/Territories that has established permanence of EMSC in the State/Territory EMS system.</p>
<p>Performance Measure #80 <i>(Former PM 68d)</i></p>	<p>The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.</p> <p>By 2011, EMSC priorities will have been integrated into existing EMS or hospital/healthcare facility statutes/regulations.</p>

PERFORMANCE MAINTENANCE CHECK

In order to maintain and improve an integrated performance measurement system, the EMSC Program is taking steps to develop the new generation of performance measures for fiscal year 2011 with the help of a group of independent special consultants. In evaluating the current performance management system, the Program seeks to answer the following questions:

- Is the current performance management system meeting our organizational needs?
- Is the current performance management system effective?
- Is the current performance measurement system driving improvement?

GUIDELINES FOR CONSULTANTS

OBJECTIVES

1. Development of the next generation of performance measures for the EMSC Program. This process will include:
 - A comprehensive document review of EMSC Program materials to identify a set of potential measures
 - Working collaboratively with the Performance Measurement Team via consensus group meetings and conference calls to refine measures and select a subset of critical few “core” measures for which all grantees will be responsible for reporting as well as a set of “*advanced*” measures that grantees can choose to work on depending on the needs and availability of resources in the State
2. Beta testing of the measures with a representative group of grantees

GUIDELINES/PARAMETERS FOR CONSULTANTS

- Performance measures must be directly linked to or aligned with The EMSC Strategic Plan
 - Measures must be valid, reliable, and have agreed upon definitions
 - Must yield tangible and easily understood results that allow for meaningful trending/analysis and are useful
 - Performance measures must be constructed in a way that ensures compliance with appropriate federal laws and regulations
 - Consultants must identify a data source, and when possible, should rely on existing data systems that serve other purposes
 - Each performance measure must include the following:
 - **Indicators to measure performance:** the performance measure
 - **Significance of Measure:** Explains the importance of the measure and the rationale for implementing the measure. Includes a list of resources, publications, and other scientific references including articles, reports, and expert testimonies.
 - **Definition(s):** Provides clear definitions of key terms in the measure.
 - **Data Collection Methods:** Provides: 1) a description of the appropriate data collection methods for the measure and 2) a description of supporting documentation that may be requested by HRSA and should be made available to support EHB entries.
 - **Gradient:** Defines levels of success including targets or goals with upper and lower control limits, benchmark levels when appropriate
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- Performance measures must pass the **SMART** test:

S = Specific

- Must be clear and consistently defined with no ambiguity

M = Measurable

- Able to quantify and compare to other data (comparison over time or comparison against accepted standards)

A = Attainable

- Measure must be achievable and measurable under the conditions expected

R = Realistic

- Consider cost and feasibility of data collection

T = Timely

- Can reasonably be measured in the specified performance period
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