U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Emergency Medical Services for Children
Next Generation of Performance Measures (Prehospital Systems)
March 2016

FREQUENTLY ASKED QUESTIONS

GENERAL QUESTIONS:

1. **Are the new EMS for Children performance measures unfunded mandates?**
   The Emergency Medical Services for Children (EMSC) performance measures are not unfunded mandates. The purpose of the EMSC performance measures is to continue to document activities and accomplishments of the Program across all 58 current grant programs in the states, territories and the freely associated states. These performance measures and future performance measures will provide guidance to the Program on future areas for improvement. This set of performance measures will:

   - 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;
   - 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.

2. **Are the new EMS for Children performance measures biased against small, rural, or volunteer agencies?**
   The program requires this data to be collected with a desire to understand how it can assist all EMS agencies, regardless of size, to be better prepared to care for ill and injured children. EMS agencies of all sizes, may face challenges in working on the new EMS for Children performance measures.

NEMSIS-SPECIFIC Performance Measure:

1. **Why can't the measure be "NEMSIS v3 data is being collected on 90% of the call volume in the state rather than from 90% of agencies? "**
   The program did consider using call volume versus percentage of agencies. One of the reasons that the program decided on using the percentage of agencies was that many

states and territories may not know the total call volume but could reasonably know the number of agencies in their state. The program is concerned that if this measure captured the percent of call volume rather than the percent of agencies, the program would not understand what was happening at small agencies. For example, by using call volume, the measure could be considered biased toward rural states with a few urban areas that potentially have 90% of the call volume. This data is important for developing program planning to address the needs of all EMS agencies.

2. **My state may never convert to NEMSIS v3, so can the measure be rewritten to eliminate the version 3 part of the measure?**
   There are many benefits to NEMSIS v3, one of which is Health Level 7 (HL7) compliance feature. The NEMSIS TAC has worked with the Standards Development Organization HL7 to develop transmission standards for the movement of NEMSIS data between entities. Details regarding the importance of HL7 may be heard in the recorded webinar presented by NHTSA's Noah Smith provided here: https://hrsa.connectsolutions.com/p6zocxmzvlb/. In addition, beginning January 1, 2017, the NEMSIS Technical Assistance Center (TAC) will no longer accept NEMSIS v2 data from states and territories. As a result, our Program needs to be current with national standards.

3. **My state does not license EMS agencies; does this mean that I don't have to report data on this measure?**
   Even if your state or territory does not license EMS agencies, you still have to report on this measure. The intent of this measure is to determine how many agencies in the U.S. are submitting NEMSIS v3 data, whether those agencies are licensed at a state, local, or some other level. If the EMS agencies in your state submit NEMSIS v3 data in 2017 (the expected first round of data collection on these new EMS for Children measures) then you should report the number of EMS agencies that submit NEMSIS v3 data to the State EMS office. Your state EMS Data Manager should be able to assist you.

4. **The NEMSIS measure does not go far enough to improve the quality of the EMS data that is being submitted. Can the measure be revised to include a list of pediatric data elements, data validation, and scoring tools?**
   This is definitely the direction the Program is headed and is something that will be considered for development in the future. For the next five years, the EMS for Children program is interested in knowing how many agencies submit v3 data in order to have a baseline of EMS data collection numbers.

5. **This measure is not pediatric-specific and is out of scope of the EMS for Children program.**
   The EMS for Children Program has funded state partnership programs to support the development of EMS data systems since its inception, and believes this is an important area for performance measurement and improvement. Past Funding Opportunities Announcements (FOA) for the State Partnership Grants have allowed grantees to use grant funds to support the EMS data infrastructure in their states, so this measure is in line with past EMS for Children efforts and within the scope of the program. In addition, since NEMSIS collects data on patients of all ages, and does contain pediatric-specific variables, pediatric patients are included.

SKILL-CHECK Performance Measure:

1. **To achieve the skill-checking measure a state would have to reach an '8' on the scale. This score is too high and unrealistic. Can you consider lowering the score for achievement?**
   Yes. After reviewing the measuring scale and supporting evidence, the program has decided that a state/territory would achieve this measure by scoring a '6' or higher on the scale.

2. **The skill-checking measure is too broad. Can it be revised to include the specific pieces of equipment that the program is interested in?**
   At one point in the development process, the measure did include specific pieces of life-saving equipment but as we field-tested the data collection instrument, we learned that there was variability among agencies as to what pieces of equipment were considered out of scope or if the medical director allowed agencies to use that equipment. As a result, the program determined that knowing if a *process* to skill-check, rather than which specific pieces of equipment they tested on, would help to understand how prepared EMS agencies are to care for children. We assume that agencies who invest the resources to skill-check will select the pieces of equipment that are most crucial or very rarely used in the field to care for children.

3. **Our state certifies EMS instructors and only state certified EMS instructors can teach EMS providers, how does this figure into how EMS agencies will respond to the questions in the skill-checking measure?**
   EMS agencies in states which require certified EMS instructors will need to take state regulations into consideration when they respond to the survey questions which ask about the process their agency uses to skill-check.

4. **How do national courses such as PEPP and PALS and certifications like NREMT CCP fit into the skill-checking measure?**
   As long as the course is in-person, an agency would respond in a way that reflects the methods used in the course or certification (i.e. simulation, skill-station) and frequency of the skill-checking activities whether the process occurred via a national course or not.

5. **Does an agency have to use or adopt all three of the methods listed (skill-station, simulation, and field encounter) to meet the measure?**
   No, the measure can be achieved by using only two of the three described methods.

6. **Can HRSA consider using the state's recertification/relicensure period as the time period for when skills check should occur?**
   At this time, a couple of states recertify/relicense annually which would make the performance measure target burdensome. In addition, a couple of states recertify/relicense EMS providers every five years which would include a very long period of time before pediatric skills check would be required. The comment was considered but may not work well for the states with shorter and longer periods of recertification/relicensure.

Pediatric Emergency Care Coordinator (PECC) Performance Measure:

1. **Does the PECC need to be on staff at the EMS agency?**
   No. Ideally, the Pediatric Emergency Care Coordinator (PECC) should be a member of the EMS agency and be familiar with the specific day-to-day operations and needs of the agency. Some states/territories utilize county or regional models of emergency care; if there is a designated individual who coordinates pediatric activities for a county or region, that individual could serve as the PECC for one of more individual EMS agencies within the county or region.

2. **Will there be a toolkit available for EMS agencies which provide a job description for a PECC?**
   Yes, the EMS for Children Program resource centers will develop toolkits, fact sheets, and webinars to assist State Partnership Grantees in the implementation of the new performance measures.

3. **Can you add the word 'injury' to the PECC role so that it reads 'promote agency participation in pediatric injury prevention program'?**
   As written, the specific function does not exclude injury but rather encompasses all types of prevention programs. Injury prevention is just one type of prevention activity that a PECC could engage in—other prevention programs can include asthma or other childhood illnesses so the performance measure is being more broadly defined. In addition, the EMS for Children program wanted to be consistent with what is recommended in the IOM report, "Emergency Care for Children: Growing Pains" (2006).

Pediatric Medical and Trauma Recognition Performance Measures:

HRSA appreciates the comments received related to the current performance measures to assure systems are prepared to stabilize and manage pediatric medical and traumatic emergencies. The comments will be used to begin the discussion as we develop the next generation of Hospital-Based performance measures. The comments were indeed very helpful and we intend to reach out to additional subject matter experts and build a consensus on what should be the next generation of performance measures (hospital systems). We will keep EMSC stakeholders throughout the development of the hospital-based performance measures informed.

If you any additional comments or questions about the new EMS for Children performance measures please contact Theresa Morrison-Quinata, HRSA Acting Branch Chief, EMS for Children Branch at 301-443-1527 or TMorrison-Quinata@hrsa.gov.