Program Managers' Toolkit

Introduction

Welcome to the Program Managers' Toolkit. This toolkit provides information and resources to help new program managers learn about the Emergency Medical Services for Children (EMSC) Program, the emergency systems of care in which they will be working, and their role as a State Partnership (SP) program manager. Additionally, helpful tools, tips, and best practices are provided for managers of all experience levels to assist with a specific project or simply to hone their EMSC State Partnership management and leadership skills.

The Program Manager's Toolkit updates and replaces the series of guides often informally referred to as the "Rainbow Series," which included *Getting Started and Moving Forward: An EMSC Toolkit for New State Partnership Managers; EMSC Project Management and Leadership Guide;* and *Best Practices: A Guide for State Partnership Grantees on the Implementation of EMSC Performance Measures.* The toolkit also incorporates the updated interactive version of *Public Policy Primer: A Guide on the Legislative Process and Impacting Change at the Federal, State, and Local Levels.* Additionally, this toolkit is directly linked with *Getting Started, Staying Involved: An EMSC Toolkit for Family Representatives.*

The Program Manager's Toolkit is designed to be intuitive and interactive to allow the user to proceed in a step-by-step fashion through each section or to navigate quickly and easily to specific sections or resources on an as-needed basis. It is divided into six sections as follows:

Section I: *Getting to Know the EMSC Program* provides an overview of the Program, including the history of EMSC and a description of currently funded EMSC Programs.

Section II: *Understanding Emergency Systems of Care* (EMS) describes emergency medical service (EMS) systems and provides a variety of resources to help the manager better understand and navigate these systems.

Section III: *Understanding Emergency Systems of Care* (Hospitals) describes hospital systems and provides a variety of resources to help the manager better understand and navigate these systems.

Section IV: *About Federal EMSC Grants* is a tutorial on federal EMSC SP grants under the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Here managers can find valuable resources and detailed instruction on all aspects of SP grant administration. Covered topics include: registration and submission of funding proposals in Grants.gov, the life cycle of a State Partnership grant, the Funding Opportunity Announcement and Notice of Grant Award, navigation of the HRSA Electronic Handbooks (EHBs) and required grant reporting.

Section V: *A Guide to Managing the State Partnership Grant Program* outlines the roles and responsibilities of SP program managers and provides tools and resources to guide them in their work. Included is a detailed discussion of the EMSC Program performance measures and MCHB Discretionary Grant performance measures. The remainder of the section focuses on the development of leadership and management skills that characterize effective SP program managers, including: building effective partnerships and coalitions; engaging the EMSC Advisory Council; and helpful tips and resources for project planning, implementation, and evaluation.

Section VI: *Public Policy Primer: A Guide on the Legislative Process and Impacting Change at the Federal, State, and Local Levels* will help program managers navigate the world of public policymaking. Specifically, grantees will learn how Congress is structured, how a federal bill becomes law, and how the EMSC Program fits into the federal decision-making process. Managers will also learn about the federal grant restrictions on lobbying and how to communicate with elected officials.

Section VI: *An EMSC Toolkit for Family Representatives* will assist EMSC family representatives in their efforts to support the EMSC Program. This section contains information on how family representatives get started and stay involved in the planning and implementation of state EMSC activities.

Section VII: *Tapping Into Resources* provides a categorized list of helpful resources and links.

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Section I: Getting to Know the EMSC Program

A Brief History of the EMSC Program

More than 30 years ago, emergency medical service (EMS) systems were created to provide rapid intervention for sudden cardiac arrest in adults and rapid transport for motor vehicle crash victims. Experiences from the Korean and Vietnam Wars demonstrated that survival rates of seriously injured soldiers could be dramatically increased by stabilizing them and providing them with immediate transport to a well-equipped trauma center. Attempting to duplicate the success in communities across America, the EMS system was created.

Calvin Sia,

Initially, the medical community failed to recognize that children required specialized emergency care. The most glaring deficiency in past emergency care for children among emergency workers is simply being unaware of the pediatric population's special needs.

In 1972, Calvin Sia, MD, president of the Hawaii Medical Association, urged the American Academy of Pediatrics (AAP) to develop EMS systems that would decrease disability and death among children. Dr. Sia worked with Senator Daniel Inouye who later was joined by Senators Orrin Hatch and Lowell Weicker in sponsoring the first Emergency Medical Services for Children (EMSC) legislation, which passed in 1984. This landmark legislation provided federal grant funds starting in fiscal year 1985 to help states improve the emergency care given to children suffering from a life-threatening illness or injury. EMSC funding was and continues to be secured largely due to the work of the AAP and other national organizations that continue to advocate for EMSC.

Senator Daniel

The Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) has been the administrating government agency for the EMSC Program since the passage of the legislation. EMSC's mission is to reduce child and youth mortality and morbidity resulting from severe illness or trauma. It is the only federal program that focuses specifically on improving the quality of emergency care for children. The Program aims to enhance currently existing EMS systems with a pediatric focus.

Throughout the 1990s, the EMSC Program continued to utilize federally designated funds, which ranged from $19 million to $20 million, and made grant funds available to states and territories to address the needs identified by the 1993 HRSA-sponsored Institute of Medicine (IOM) report. The EMSC Program initiatives addressed such areas as: injury prevention, development of clinical protocols and practice guidelines, creation of training curricula and products, data collection and analysis to support injury surveillance and quality improvement in pediatric emergency care, pediatric facility designation guidelines, hospital recognition

programs, pediatric equipment standards for ambulances and emergency departments (ED), model patient transfer agreements, model regulations, and demonstration programs for special populations.

Although much progress continued to be made, the EMSC Program was part of an overall fragmented EMS system. In 2004, the IOM studied the broader spectrum of emergency care infrastructure in the United States. This led to the "Future of Emergency Care" series published in 2006. The series included *Emergency Medical Services at the Crossroads*, *Hospital Based Emergency Care: at the Breaking Point*, and *Emergency Care for Children: Growing Pains*. The reports comprehensively described the system of emergency care with emphasis in the pediatric report on the "uneven" nature of emergency care for children.

Into the second decade of the new millennium, appropriations for the EMSC Program have remained even. However, guided by the "Future of Emergency Care" reports, the Program has continued to grow. Currently 58 states, territories, and freely associated states are funded under the State Partnership Grant Program with the most recent addition of Palau, The Republic of the Marshal Islands, and the Commonwealth of the Northern Mariana Islands. The Program continues to leverage partnerships with federal agencies and national organizations to develop new programs and products; conduct novel research; publish hundreds of articles; provide education and training for thousands of emergency care providers; and improve access to safe, effective, efficient, timely, equitable, family-centered emergency care for all children. For additional information about the history of the Program, read EMSC: An Historical Perspective.

> Fast Facts:
> - Children comprise about 27% of the U.S. population and present special challenges for emergency care providers when they have a medical emergency.
> - Children account for 20% of all hospital emergency department visits.
> - About 13% of all EMS transports involve pediatric patients.
> - Although children are often thought of as "little adults," their unique physical, behavioral, and emotional responses require special considerations when providing emergency care. For example, equipment such as oxygen masks, endotracheal tubes, and IV catheters need to be specifically sized to match the anatomic uniqueness of children. Young children are also unable to provide information about their identity, their symptoms, or previous medical history.

Funded Programs

In an effort to continually address gaps identified in the IOM reports and other key data sources, the categories of grant funding have changed throughout the years. Currently, the EMSC Program directly funds three grant programs, including State Partnership (SP) grants, Targeted Issue (TI) grants, and State Partnership Regionalization of Care (SPROC) grants. Additionally, the Program supports the Pediatric Emergency Care Applied Research Network (PECARN). The EMSC National Resource Center (NRC) and the National EMS Data Analysis Resource Center (NEDARC) are also funded under cooperative agreement and support the Program and its grantees.

State Partnership. The purpose of the EMSC SP Program is to assist states in expanding and improving their capacity to reduce and ameliorate pediatric emergencies, taking special care to include children with special health needs, culturally distinct populations, and historically underrepresented groups, including the U.S. territories, the freely associated states, and American Indian/Native Americans. This will be accomplished using existing research-based knowledge, state-of-the-art systems development approaches, and the experience and products of previous EMSC grantees. SP grants are intended to solidify the integration of a pediatric focus within state EMS systems. States are guided by Standards of Achievement through Program-defined performance measures. The performance measures are the primary goals, objectives, and priorities of the EMSC SP Program.

Targeted Issue. TI grants are intended to address specific needs, concerns, or topics in pediatric emergency care that transcend state boundaries. Typically, the projects result in a new product, resource, or demonstrate the effectiveness of a model system component or service of value to the nation. Ideally SP Program managers are aware if their state also has a TI grant as they may be asked to participate in a TI grant activity at varying levels. The EMSC Targeted Issue Database provides an overview of TI grants awarded in individual states. Descriptions for the most current TI grant projects also are available.

State Partnership Regionalization of Care. SPROC grants are the newest of the EMSC grant programs. These grants were established for the development of regionalized systems of pediatric care that encompass the sharing of resources and improve access to emergency care for children and families in tribal, insular, and rural areas of the country and to develop models of inclusive care that may be replicated in other regions where access to specialized pediatric medical treatment is limited due to geographical distances or jurisdictional borders. A fact sheet details the first six SPROC grant funded projects.

Pediatric Emergency Care Applied Research Network. PECARN is the first federally funded, multi-institutional network for research in pediatric emergency medicine. It is comprised of six research centers that work collaboratively with Hospital Emergency Department Affiliates (HEDAs) to develop and submit nodal research proposals to PECARN and conduct PECARN-approved research at their respective institutions. Together, the represented EDs serve 1.2 million pediatric patients annually.

In 2013 an EMS research center was added to PECARN to test the feasibility of conducting effective prehospital research (read about the Wisconsin-Medical College of Wisconsin: Development of the Charlotte, Houston and Milwaukee Prehospital (CHaMP) Research Node on the fact sheet Targeted Issue Grants, 2013). A list of peer-reviewed publications and abstracts generated through PECARN research is available on the PECARN website.

Resource Centers
EMSC National Resource Center. In 1991, MCHB established the EMSC NRC under a cooperative agreement with Children's National Health System in Washington, DC. Working under the purview of the federal EMSC Program, the EMSC NRC historically has offered

technical expertise to states and territories with EMSC funding in the areas of project development, needs assessment, coalition building, public policy, community engagement and long-term sustainability. Today, the EMSC NRC continues to assist the federal EMSC Program in:

- promotion of EMS system development at local, regional, and national levels;
- provision of consultation and resource development to nearly 100 grantees across all funding categories;
- facilitation of effective transfer of knowledge among all relevant constituents and stakeholders, including state program managers, EMS directors, health care providers, clinical researchers, family representatives, as well as federal partners and national professional organizations; and
- coordination and support of the EMSC Family Advisory Network.

The EMSC NRC also hosts the EMSC Program Meeting, coordinates and facilitates multiple other meetings including quarterly PECARN, SPROC, and TI meetings and teleconferences, and conducts various special meetings for grantees and workgroups as needed. One of the most important tasks of the EMSC NRC is to build and maintain strong partnerships and working collaboratives with national professional organizations and federal agencies.

The EMSC NRC staff represents a range of experience and expertise including:

- pediatric emergency medicine and prehospital pediatrics;
- trauma and acute care;
- trauma systems and regionalized systems of care;
- hospital categorization and inter facility transfer guidelines;
- EMS systems and EMS education;
- disaster preparedness and response;
- childhood injury prevention;
- public policy and public health policy;
- organizational development and coalition building;
- strategic planning and program evaluation;
- research analysis and dissemination;
- family and consumer-centered outreach;
- product design and development;
- communications; and
- meeting planning and coordination.

National EMS Data Analysis Resource Center. Located at the University of Utah School of Medicine, NEDARC was created through a cooperative agreement with MCHB in 1995. NEDARC provides technical assistance to state and territory EMSC program managers and EMS state office directors and other staff to develop capabilities to collect, analyze, and utilize EMS data. Through building these skills in EMSC program managers, NEDARC aims to

strengthen their capacity and equip them with tools and resources that will ultimately enhance the emergency care system for children in their states, territories, and regions.

The NEDARC team is comprised of individuals with diverse backgrounds, including clinical, educational, statistical, communications, public health, technical, and research expertise. Staff provide grantees with technical assistance in the follows areas:

- data collection,
- data analysis,
- data communication,
- research,
- program evaluation,
- grant writing,
- survey methods,
- print and design services,
- meeting facilitation, and
- program promotion (social media and website development).

In addition to one-on-one technical assistance, NEDARC supports EMSC program managers and other EMSC stakeholders through a variety of educational offerings including workshops and webinars and other resources related to data issues.

While all team members are available as a resource to EMSC program managers, each state/territory has a NEDARC staff member assigned to serve as their technical assistance (TA) representative. Visit the map to determine your NEDARC TA representative.

Section II: Understanding Emergency Systems of Care (EMS)

Before attempting to make program improvements, it is important for program managers to understand the EMS system in which Emergency Medical Services for Children (EMSC) operates. A strong and sustainable state program is dependent on the EMSC manager's knowledge of the EMS system and his/her willingness and capability of working with EMS leadership. This chapter provides an overview of the major structural and operational issues in EMS systems that are important to understanding the foundation of the EMSC performance measures.

Where EMS Systems Are Today

The EMS industry has recently been described as being in its adolescence. This description may be particularly well suited to EMS considering its increasing struggle to be recognized as an independent allied health profession and its rebellion against conforming to national standards. Despite important advancements made over the first 40 years of organized EMS in the U.S., the 2006 Institute of Medicine (IOM) report *Emergency Medical Services at the Crossroads* cited serious systemic problems, including:

- highly fragmented, poorly coordinated emergency care,
- highly variable response times,
- a lack of agreed-upon measures for EMS quality,
- insufficient disaster response training,
- divided professional identity, and
- limited evidence base.

In 2011, the National Highway Traffic Safety Administration (NHTSA) released the results of the National EMS Assessment, a comprehensive report of the U.S. EMS system. Today, there are more than 21,000 EMS agencies staffing over 81,000 vehicles with 826,111 EMS professionals licensed and credentialed within the United States. Additionally, a total of four expert panels (two for EMS and two for emergency management) were used to better identify and define trends and industry patterns currently immeasurable with any existing data source. NHTSA is currently conducting reassessments of a number of states. Notably, the National EMS Assessment includes 2010-2011 EMSC performance measure data and 2007 Indian Health Service Tribal EMS pediatric assessment data.

Defining EMS

Prehospital EMS has traditionally been defined as the evaluation and care of patients with acute trauma or medical conditions in the out-of-hospital setting and transport to a hospital emergency department for definitive care. However, as described in the in the following sections, the EMS industry is redefining itself to more accurately reflect divergent models of practice and its evolving role in the overall health care system. Because EMS systems and definitions vary widely within and across states, EMSC program managers must have a good

understanding of EMS systems in their respective states as well as the underlying current of the ongoing EMS systems development regionally and across the nation.

Structure and Function of EMS Systems

Initially, EMS was established to respond to traffic-related morbidity and mortality. As the field of EMS evolved, EMS providers were responding to other emergency calls in addition to traffic-related injuries, such as cardiac events in private homes, playground injuries, and other acute illness. Additionally, emergency and non-emergency transfer services became a significant component of the EMS industry and may be integrated into primary EMS emergency response agencies or operated as stand-alone transfer-service agencies. Today, EMS in a growing number of communities is expanding its scope to include specialty-care transport services (including pediatric and neonatal transport), non-emergent community-based mobile health, preventative care, and patient navigation services. Furthermore, EMS has become an important element of the public health system as the front line in health surveillance, research, and health education. As such, EMS as a field continues to struggle with its identity, operating at the crossroads between health care, public health, and public safety as depicted in below diagram. For more information about EMS, read the **History of EMS**.
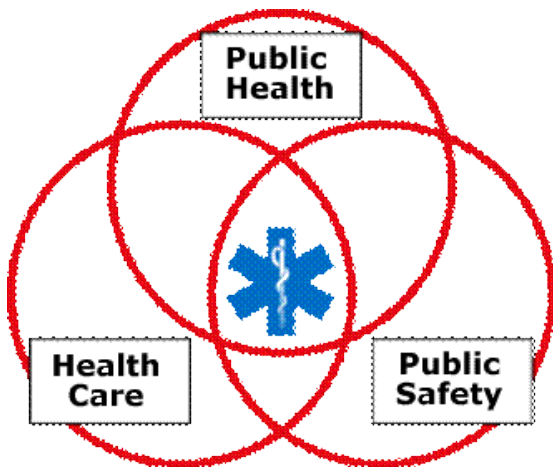
EMS does not exist in isolation, but is integrated with other services and systems intended to maintain and enhance the community's health and safety. As seen in the graphic here, EMS operates at the crossroads between health care, public health, and public safety. A combination of the principles and resources of each is employed in EMS systems. Since EMS providers work in the community, they are often the first to identify public health problems and issues. The emergence of significant health problems is often heralded by its arrival in the emergency department and it arrives via EMS. Since EMS providers respond to all kinds of emergencies and all kinds of hazards, they often work shoulder-to-shoulder with public safety colleagues in law enforcement and fire services.

EMS Operations

EMS is governed through a State Office of EMS. Typically, The EMS Office is housed within state government, either in the Department of Health, Department of Public Safety, or Emergency Management Office. However, in 2011 six states reported that their Office of EMS was operated as a free-standing EMS commission, other independent EMS commission, or some other business model. Interestingly, only 11 states report having statutory responsibility to assure the provision of EMS services. This authority is most commonly held at the local community or EMS agency level. Debates are ongoing throughout the industry about the creation of a federal Office of EMS and Trauma[1,2] and identifying EMS as an essential service[3].

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[1] National Association of Emergency Medical Technicians Field EMS Bill. Accessed January 30, 2015 from.
[2] National EMS Advisory Council. Position Paper on the Role of a Lead Federal Agency for Emergency Medical Services. 2011. Accessed January 30, 2015.

For a comprehensive overview of EMS systems in the US and a breakdown of the components by state, see the 2011 National EMS Assessment.

The diagram to the right illustrates the complexity of an EMS system. In the diagram, the large circle represents each system element as it is activated in response to an incident. The "brown arrowed" elements within the circle represent the specialty care areas within EMS. The list within the circle represents the elements acting behind the scenes to support the system. In order to be "ready every day for every kind of emergency," an EMS system must be as comprehensive as the one pictured above. Developing and maintaining such a system requires thoughtful planning, preparation, and dedication from EMS stakeholders at the local, state, and federal levels.
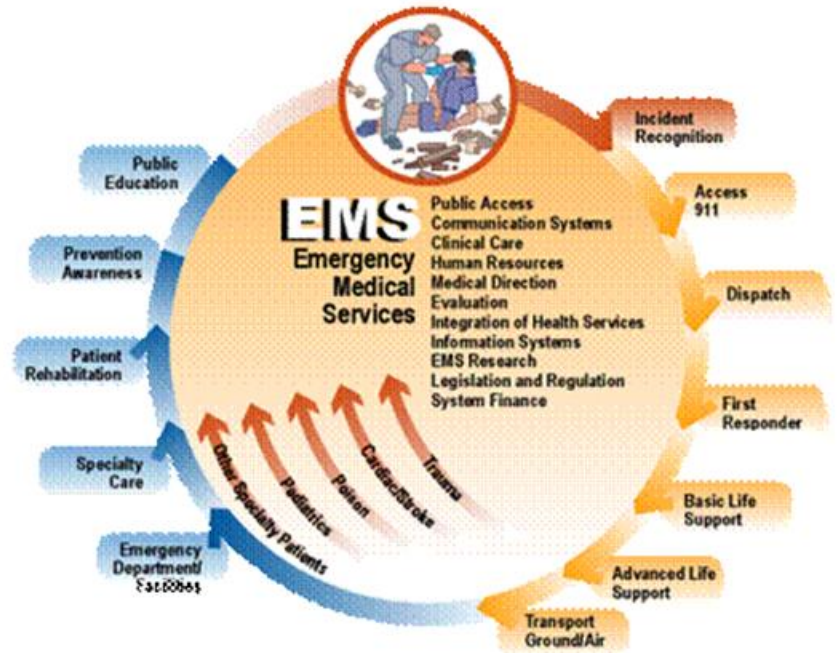
Responsibilities of the Office of EMS
The Office of EMS oversees the following:

- certification and recertification requirements for emergency medical technicians or EMTs (usually regulated by the state). These requirements detail testing requirements for initial certification, required continuing education for recertification credentials, and the number of years before needing to recertify.
- training of EMS providers (usually done locally) to assure that EMTs meet initial certification and recertification requirements.
- scope of practice and medical direction (can be done locally, regionally, or statewide).
- EMS service licensing rules, including ambulance equipment and inspection requirements (can be done locally, regionally, or statewide). EMS licensing rules not only regulate who can operate as an EMS service, but also the minimum requirements for operating the various types and levels of response apparatus. Many states specify, either in statute or rule, the types, sizes, and quantities of equipment to be carried on ambulances and most states have some process for periodic inspection for compliance. The decision of which equipment to carry can rest with the state,

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[3] National EMS Advisory Council. EMS as a Public Good: An Update on Discussions from the NEMSAC Systems Committee. 2012. Accessed January 30, 2015.

regional, or local jurisdiction and is often determined by medical direction and scope of practice.

Delivery of EMS

EMS agencies are most commonly licensed by the state to service a local response area as small as a single EMS station. In any state, broad coverage of EMS services is dependent on a network of EMS agencies across a geographical area. In some state, gaps in ambulance services still remain in some rural and frontier regions.

EMS agency level of service is based on EMS provider certification level and scope of practice as determined by the medical director. Advance Life Support (ALS) services offer EMT-Paramedic level care while Basic Life Support (BLS) services are staffed with EMT-Basic level providers. Some states also license EMT-Intermediate or Advanced EMT providers and may be considered either ALS or BLS services depending on agency, regional, or state scope of practice and state rule or statutory language. Only 24 states license Emergency Medical Responder, or First-responder, level services.

Organizational structures from which EMS agencies operate can be divided into governmental or non-governmental organizations. Governmental organizations can be further divided into fire-based, non-fire-based, and tribal.

An issue germane to EMSC is the pediatric equipment and supplies that ambulances are required to carry, such as oxygen masks, endotracheal tubes, and IV catheters that accommodate the unique anatomy of children. Using incorrectly sized equipment can result in an inability to provide life-saving care to children. The *Joint Policy Statement, Equipment for Ground Ambulances* provides a recommended core list of supplies and equipment that should be stocked on ground ambulances to provide the accepted standards of care. This policy statement is used as the standard for EMSC Performance Measure #71, Equipment on Ambulances and was collaboratively produced by:

- American Academy of Pediatrics,
- American College of Emergency Physicians,
- American College of Surgeons Committee on Trauma,
- Emergency Medical Services for Children,
- Emergency Nurses Association,
- National Association of EMS Physicians, and
- National Association of State EMS Officials.

Fire-based systems operate within a fire department. In a fully-integrated system, personnel are cross-trained as both fire-fighters and EMS providers and may function on an ambulance, rescue squad, or as a first-responder on a fire apparatus. Some fire-based EMS systems operate as separate divisions under a common fire department administration and personnel may not be cross-trained as firefighters or have the ability to transfer from one division to another within the department.

The largest benefit of an integrated fire and EMS system is its economic infrastructure. Firehouses around the country are geographically positioned to serve the local population. These physical structures provide an equivalently strategic location for EMS services. Fire departments also have the administrative infrastructure to manage personnel, provide training, and purchase and maintain equipment and supplies. Further, fire services often have

an existing relationship with the community that makes the acceptance of EMS services by the public easier. Forty percent of EMS agencies in the continental U.S. are fire-based.

Non-fire-based, governmental organizations are commonly referred to as a "third-service" (non-fire and non-police) agency and may be administered by a rural health care district, municipality or county service, a private service under contract with a governmental organization, or any other non-fire-based government entity.

A significant advantage of a third-service EMS system is that it has dedicated personnel who are engaged in professional EMS services without the market competition seen in some non-government organizations. The major challenge to these systems is the cost of providing a third public safety service. Ambulance services under contract may also suffer if disputes occur between a municipal agency and its contracted EMS service. Twenty-one percent of EMS agencies are non-fire-based, governmental organizations.

There are approximately 102 tribal EMS agencies across 19 states. Tribal EMS services are not state entities and are not regulated by the state in which they operate. However, some tribal EMS services seek credentialing by states in order to collect reimbursement from the Center for Medicare and Medicaid Services (CMS). Although 911-based tribal EMS responses account for less than 1% of all EMS events in the U.S., access to specialized pediatric emergency care across geographical and jurisdictional boundaries poses unique challenges for many tribal EMS systems. For information on what the EMSC Program is doing to address these challenges, read the fact sheet EMSC SPROC Grants, 2012.

Medical Direction

Medical direction is the provision of medical guidance and oversight for all aspects of prehospital emergency medical care provided in the field. A medical director is a physician responsible for the provision of medical direction for an EMS system or individual agency. The EMS Agenda for the Future strongly recommended that each state have a designated statewide medical director charged with broad responsibilities to assure uniformity in policies, safe and appropriate medical practices, and coordination of care with community physicians. State medical directors are responsible for EMS system improvements, coordination, and leadership throughout the state EMS system. However, the 2011 National EMS Assessment reported that only 37 states have a statewide medical director for EMS and, of those, only 19 are given statutory authority by the state for the provision of medical oversight in an official capacity, while the remaining 18 are in an advisory capacity only.

Medical direction can be divided into two categories: on-line (direct) and off-line (indirect) medical direction.

On-line medical direction (often called medical control) refers to real time consultation, via two-way radio or telephone, between the EMS provider and a healthcare professional that can provide guidance and direction during on-scene care and transport of an ill or injured patient. This medical consultation is most often provided by a physician, but may also be

administered by a mid-level provider (physician's assistant or nurse practitioner), a nurse, or even a paramedic or EMT with special training following specific guidelines.

Most often, the receiving hospital provides on-line medical direction for patients en route to their emergency department (ED). However, consultation may also be provided by a specially designated hospital regardless of transport destination, a central telemetry office, or the EMS agency medical director or his or her designee.

On-line medical direction allows prehospital providers an opportunity to report on the patient's condition to facilitate ED preparation as well as to seek additional treatment guidance within the purview of their offline protocols. On-line medical direction may also serve important quality assurance and data collection functions.

Off-line or indirect medical direction commonly refers to standard written protocols that EMS providers are responsible for knowing. These outline general treatment guidelines and often define the scope of practice for EMS providers (i.e. what they are and are not allowed to do in the field). Because there has been a dearth of evidence for the development of prehospital care guidelines, many adult and pediatric protocols and guidelines in place today were developed anecdotally or by expert consensus. However, the EMSC Program has led the way in the creation of evidence-based guidelines (EBGs) for the

> EMSC Performance Measure #72, *The percentage of prehospital provider agencies in the state/territory that have offline pediatric medical direction,* is specifically referring to the availability and accessibility of written pediatric prehospital care protocols.

development of prehospital protocols, publishing some of the very first EBGs and conducting multi-state implementation studies.

It is important to note that off-line medical direction encompasses much more than just written protocols. In fact, the vast majority of all medical direction and oversight falls into this category and includes quality assurance and quality improvement efforts, education and training of EMS providers, policy development, systems design and implementation, and much more. This often overlooked aspect of off-line medical direction is vital to the development, implementation, and evaluation of safe and effective prehospital pediatric protocols.

Systems for off-line and on-line medical direction are local in nature. Some states have statewide off-line protocols that all local EMS agencies utilize. Other states allow local jurisdictions to define the protocols based upon the local medical director's leadership. Similarly, guidelines for when to call for on-line medical direction and the choice of hospital destination vary by state.

> *Important EMSC Side Note: Most EMTs and paramedics do not run sufficient numbers of pediatric calls to maintain their skills. Thus, pediatric-specific medical direction is very important for providers as it gives them necessary guidance and assistance during emergency treatment. Visit the State Partnership Performance Measure page to access the most recent national data on EMSC Performance Measure #71, the percent of prehospital provider agencies in the state/territory that have on-line pediatric medical direction available for dispatch through patient transport to a definitive care facility and EMSC Performance Measure #72, the percentage of prehospital provider agencies in the state/territory that have off-line pediatric medical direction.*

EMS Workforce

The 2011 EMS Workforce Agenda for the Future noted that differing types and practice levels of EMS certification and licensure available across the states creates a confusing picture and that workforce data is limited. Practice levels are defined in the Emergency Medical Services Workforce Data Definitions as the EMS level at which an individual is providing EMS services and includes none, Emergency Medical Responder (also called first responder), Basic EMT, EMT-Intermediate*, Advanced EMT, and paramedic. Scopes of practice and EMS education requirements at each level also varies widely within and across states. Some states recognize additional levels of certification or graduated steps within a certification category, such as Paramedic 1, Paramedic 2, and so on in which scopes of practice or more advanced skills are based.

*EMT-Intermediate is being phased out as a recognized level as states transition to the EMS Scope of Practice Model.

EMS Provider Education

Initial and continuing education for EMS providers is regulated by state EMS offices and varies widely. However, the 2000 EMS Education Agenda for the Future: A Systems Approach laid out a vision to improve the structure and efficiency of the national EMS education process. The document proposed an education system built on five integrated primary components:

- National EMS Core Content
- National Scope of Practice Model
- National EMS Standards
- National EMS Education Program Accreditation
- National EMS Certification

> According to the 2012-2013 EMSC Reassessment of EMS agencies, pediatric-specific continuing education is required for recertification/re-licensure of BLS providers in 43 states/territories and of ALS providers in 45 states/territories. Mandated pediatric continuing education contact hours ranged from 0 – 10 (mean 4) and 0 – 16 (mean 7) for BLS and ALS providers, respectively. (*see EMSC Performance Measure #78: The adoption of requirements by the state/territory for pediatric emergency education for license/certification renewal of BLS/ALS providers.*)

Currently, 46 states require National EMS Certification by the National Registry of Emergency Medical Technicians (NREMT) for initial certification, although many states do not require providers to maintain National Registry Certification for recertification or re-licensure. Since January 1, 2013, all paramedic-level applicants for NREMT National EMS Certification must graduate from a program accredited by the Commission on Accreditation of Allied Health Education Programs. However, EMS educational program accreditation is not yet required for EMT Basic and Intermediate or Advanced EMT-level providers who comprise 70% of the EMS workforce.

The National Association of EMS Sate Officials (NASEMSO) 2011 EMS Industry Snapshot indicates that, while more than 90% of states required some level of continuing education (CE) for recertification or re-licensure of EMS providers, at least three states have no requirement for CE at any level, and less than one-third of the states require CE for emergency medical dispatch or medical responder-level EMS providers.[4] The required number of CE contact hours varies from zero to more than 40 hours annually and increase with the level of EMS certification.

In 2013, NASEMSO convened an expert panel with representatives from several national stakeholder groups, including the EMSC Program, to help address cognitive, psychomotor, and affective learning needs of EMS providers related to the care of pediatric populations. The goals of the panel were to identify evidence-based knowledge and skills that lead to improvements in the delivery of EMS care for pediatric populations, increase input and enhance communication among EMS partner groups on pediatric education issues, and increase pediatric competency for all EMS practitioners. The resulting document, Pediatric Considerations for Implementing the National EMS Education Standards was created to help identify focus areas for ongoing pediatric education and competency efforts.

EMS Data Systems (Revisions by Clay Mann, PhD, MS, NEMSIS PI University of Utah)
EMS systems vary from state to state and there is no comprehensive blueprint describing how EMS agencies are structured at the local level. In the past, state EMS systems were not often duly recognized partially due to a lack of systematic EMS data collection in the United States.

Much of the EMS literature cites the need for better data systems. Notably, the EMS Agenda for the Future has outlined the need for integrated data systems. EMS experts believe that in order to evaluate system performance, national, state, and local EMS databases need to be aligned to allow analysis of topics pertinent at each level of administration.

The five main purposes of EMS data collection described in the literature are to:
- provide a patient medical record;

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[4] National Association of State EMS Officials and University of North Carolina. NASEMSO 2011 EMS Industry Snapshot, as cited in 2011 National EMS Assessment, U.S. Department of Transportation, National Highway Traffic Safety Administration, Office of EMS and Federal Interagency Committee on EMS. 2011. Accessed January 30, 2015.

- provide administrative information for billing or reimbursement;
- determine patient outcomes of evidence-based practices;
- system evaluation and improvement; and
- research.

In 1993, NHTSA convened a panel to identify a common EMS data set. The panel listed 81 elements of which 49 are considered "essential" and 32 are "desirable." A 2004 study by Mann et al compared data elements from all states with a statewide prehospital data collection system. Of the 43 states with statewide EMS data collection systems, only six states collect all 81 elements. Thirty-five of the states collect 73% of the essential elements and 56% of the desired elements. Only eight (10%) of the 81 uniform data elements are collected by all 43 participating states.

In response to this growing need for a unified EMS data set, NHTSA organized the National EMS Information System (NEMSIS) project. NHTSA funded a technical assistance center to help states submit data to this national EMS database. As of 2013, 46 states and territories have harmonized local and state EMS data collection systems and submit EMS response records to the national EMS database. Approximately 21 million 9-1-1 initiated EMS responses are submitted annually. These data are available to develop nationwide EMS training curricula, evaluate patient and EMS system outcomes, facilitate research efforts, determine national fee schedules and reimbursement rates, address resources for disaster and domestic preparedness, and provide valuable information on other issues or areas of need related to EMS care.

Although the NEMSIS effort has standardized EMS data collection systems, the ultimate responsibility for reforming and improving patient data collection lies with individual EMS jurisdictions (or the state EMS agency that has regulatory authority). The relative slowness of EMS to embrace data analysis as part of regular performance review is not only a challenge for NEMSIS but also for the implementation of the EMSC performance measures.

The Contributions of EMSC
While the EMSC Program focuses specifically on pediatrics, EMS systems infrastructure as a whole continues to benefit from the research and demonstration projects funded though EMSC grant programs. For the past 30 years, EMSC and its federal partners have taken many important steps to respond to persistent challenges and promote the continued improvement of the EMS industry. Since 1984, with funding from HRSA, Maternal and Child Health Bureau (MCHB), EMSC has supported the development of the EMS system through leadership in prehospital research, development of national performance measures, educational standards and resources, model guidelines, and evidence-based protocols.

Recent landmark changes for the EMS industry are promising, and EMSC continues to be on the leading edge. In response to recommendations from the 2001 National EMS Research Agenda and the 2006 IOM reports, the National EMS Advisory Council (NEMSAC) Committee on Medical Oversight and Research (CMOR) created The National EBG Model Process

outlining a structured model process for the development, implementation, and evaluation of EBGs for EMS systems. The EMSC Program used this model to develop an EBG on pediatric seizure management, which led the way for EBGs on EMS helicopter utilization and prehospital pain management.

In 2012, NEMSAC CMOR followed up with The Next Steps for Prehospital Care Evidence-Based Guideline (EBG), and the NEMSAC Systems Committee concurrently published Evidence Basis for EMS Systems Design. These advisories laid the foundation for a transition to an evidence-based model in prehospital emergency medicine and EMSC continues to be on the front lines. The most recent Targeted Issue (TI) awards include projects to develop and implement EBGs in multiple states and to build a prehospital research node within the Pediatric Emergency Care Applied Research Network.

Also in 2012, the EMSC Program tasked the National EMSC Data Analysis Resource Center to facilitate the development of the next generation of EMSC performance measures. These measures will focus on EMS: pediatric written protocols, pediatric equipment and supplies carried on ambulances, and EMS provider pediatric education requirements for recertification. The project is currently underway with plans to launch nationwide in 2016.

In 2013, EMSC took a leading role in the research and development of an EMS community health services model with a TI grant awarded to Andrew Stephens, M.D. at Indiana University. Treat the Street: Prehospital Pediatric Asthma Intervention Model to Improve Child Health Outcomes involves the utilization of a novel pediatric community paramedicine program to address identified gaps in pediatric asthma care, reduce ED recidivism rates for children with asthma, improve pediatric health outcomes, and enhance paramedic provider roles in the delivery of patient care.

The Program's long-standing partnership with NHTSA, the National Association of Emergency Medical Technicians, NASEMSO, the Federal Interagency Committee on EMS, NEMSAC, NAEMSP, the National Association of EMS Educators, and other agencies and organizations actively engaged in the EMS industry have propelled the EMS industry forward, achieving a number of recommendations from the EMS Agenda for the Future (see Table 2.2 for a description of some of the major national organizations partnering with EMSC).

Where EMS Systems Are Headed

Building on the NEMSIS data set and the creation of the first evidence-based guidelines for prehospital care, efforts are underway to "ensure a more standardized approach to the practice of prehospital care"[5] for EMS systems moving forward. In partnership with the National Association of EMS Physicians (NAEMSP), NHTSA, and the Health Resources and Services Administration (HRSA), NASEMSO is currently developing the first EMS performance measures intended to provide industry benchmarks and develop national standards for EMS

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[5] National Association of State EMS Officials, Medical Directors Council. National Model EMS Clinical Guidelines. October, 2014. Accessed January 30, 2015.

systems. This follows the 2014 release of the National Model EMS Guidelines developed by the NASEMSO Medical Directors Council and funded by NHTSA and the EMSC Program.

The EMS Agenda for the Future describes a vision in which EMS "will be community-based health management that is fully integrated with the overall health care system." Industry leaders are now saying that dramatic changes in the EMS delivery model away from an emergency transport service to a community-based mobile health system is inevitable. New models are emerging across the nation, such as community paramedicine and mobile integrated healthcare, that expand the roles of the EMS workforce and focuses on the delivery of community health services and alternative patient navigation protocols while continuing to be the public's emergency medical safety net.

Table 2: EMS Related Agencies and Organizations:

National Highway Traffic Safety Administration (NHTSA), Emergency Medical Services
Consensus-building, collaboration, and supporting significant national projects are the hallmarks of NHTSA's contributions to EMS system development. An efficient EMS system is integral to reducing injury and mortality on and off our Nation's highways, and is key to ensuring prompt emergency response to any type of illness or injury. The Nation's best preparation for any incident, large or small, is a comprehensive EMS system, ready every day for every emergency. NHTSA's mission is to reduce death and disability by providing leadership and coordination to the EMS community in assessing, planning, developing, and promoting comprehensive, evidence-based emergency medical services and 9-1-1 systems.

Federal Inter-agency Committee on EMS (FICEMS)
FICEMS was established in 2005 by the U.S. Department of Transportation Reauthorization, Public Law 109-59 (Section 10202), to ensure coordination among federal agencies involved with state, local, tribal, and regional emergency medical services and 9-1-1 systems. NHTSA, in cooperation with the Heath Resources and Services Administration and the Assistant Secretary of Health Affairs at the Department of Homeland Security, provide administrative support to the Interagency Committee, including scheduling meetings, setting agendas, keeping minutes and records, and producing reports. FICEMS employs a Technical Working Group (TWG) comprised of interagency staff-level employees who met monthly to provide support to several ongoing EMS projects. The TWG has six standing committees each with two-year work plans that help guide the efforts of FICEMS.

National Association of EMS Educators (NAEMSE)
NAEMSE is a 501 (c) non-profit educational association that has been incorporated since 1995. It is a professional membership organization that is made up of more yhan 3,000 EMS educators, both nationally and internationally, that include instructors, program directors, deans, training officers, EMS physicians, EMS nurses, and EMS state officials. It is governed by a board of directors and the home office is headquartered in Pittsburgh, PA.

National Association of EMS Physicians (NAEMSP)
In 1984, insightful emergency medical service leaders from a cross-section of the U.S. came together to form a new organization for the EMS physician responsible for medical care in the out-of-hospital setting. Their vision was to create a peer group organization to serve as a resource and advocate for EMS physicians and other EMS personnel. In the following months, a national steering committee and advisory board, comprised of well-known academic and community leaders in out-of-hospital care, established the groundwork for NAEMSP.

National Association of Emergency Medical Technicians (NAEMT)
Formed in 1975 and more than 32,000 members strong, NAEMT is the nation's only organization solely dedicated to representing the professional interests of all EMS practitioners, including paramedics, emergency medical technicians, emergency medical responders, and other professionals working in prehospital emergency medicine. NAEMT members work in all sectors of EMS, including government service agencies, fire departments, hospital-based ambulance services, private companies, industrial and special operations settings, and in the military.

National Association of State EMS Officials (NAEMSO)
NASEMSO is the lead national organization for EMS, a respected voice for national EMS policy with comprehensive concern and commitment for the development of effective, integrated, community-based, universal, and consistent EMS systems.

National EMS Advisory Council (NEMSAC)
NEMSAC was formed in April 2007 as a nationally recognized council of EMS representatives and consumers to provide advice and recommendations regarding EMS to NHTSA. NEMSAC does not exercise program management or regulatory development responsibilities, and makes no decisions directly affecting the programs on which it provides advice. NEMSAC provides a forum for the development, consideration, and communication of information from a knowledgeable and independent perspective.

National Registry of Emergency Medical Technicians (NREMT)
NREMT is a non-profit organization established in 1970 as a direct result of recommendations made by President Lyndon Johnson's Committee on Highway Traffic Safety regarding the establishment of uniform standards for training and examination of EMS personnel. Its mission is to serve as the national EMS certification organization by providing a valid, uniform process to assess the knowledge and skills required for competent practice by EMS professionals throughout their careers. Currently, 46 states utilize the National Registry exam for the initial certification of one or more levels of EMS provider.

Section III: Understanding Emergency Systems of Care (Hospital)

A working knowledge of emergency departments (EDs) and the hospital/state systems in which they operate is essential information for Emergency Medical Services for Children (EMSC) program managers. Hospitals and EDs are important components of the continuum of emergency care for children as defined by the EMSC Program. Thus EMSC managers are tasked with assuring that the needs of children are well integrated into this part of the emergency care system as well. This section will:

- describe important considerations in hospital emergency care in the U.S. focusing upon hospital capacity and capabilities, as well as licensing/accreditation processes influencing ED requirements;
- identify important partners to assist in leading and integrating essential pediatric emergency care components into hospital EDs in your state; and
- provide links to key resources to enhance one's knowledge regarding the role of hospitals in the emergency care of children, as well as the achievement of the EMSC performance measures and overall improvement of ED readiness for pediatric patients.

Where Hospital Systems are Today
ED care in the U.S. is strained. An ever-growing population coupled with a decline in the number of hospitals has led to overcrowding. Additionally, the ED often serves as the primary care provider for many and has become the safety net for those with no or inadequate insurance or poor access to primary or specialty care. This leads to high costs incurred by the ED with relatively low rates of reimbursement. Furthermore, overcrowding of the hospital often leads to boarding, or holding patients in the ED for extended periods of time until beds become available. Boarding creates numerous problems for the ED: lack of staff and lack of beds for those patients needing emergency care. A back-up in the entire emergency care system can then occur, often spilling over to EMS.   Ambulances can be detained in busy EDs while waiting for an available room or may even be diverted from the facility altogether forcing transport of the patient to another facility. Definitive care is prolonged and the transporting ambulance is kept out-of-service which, in turn, prolongs response times to the next 9-1-1 call. These delays are often exacerbated for pediatric patients due to fewer, more distant facilities with pediatric beds or pediatric-trained medical staff. For more on access to pediatric specialty care, see the Pediatric Regionalization of Care Primer.

Defining Hospital-based Emergency Care
Hospital EDs and, increasingly, stand-alone emergency centers provide an array of urgent and emergent care services. Most EDs operate 24-hours a day, seven days a week and have immediate access to diagnostic services including diagnostic imaging and laboratory services. Large, high-volume EDs may care for thousands of patients a week and are staffed by highly-trained emergency providers and on-call specialists in almost every field. Smaller community hospitals often have more limited specializations immediately accessible, and some rural and

frontier hospitals may depend on a local on-call physician for immediate stabilization and transfer to definitive care. In many communities, the ED also functions as primary care and may be the last resort for patients with no or limited insurance. Importantly, rural areas have the highest rate of ED visits at 502 per 1,000 population compared to 319 visits per 1,000 population in metropolitan counties.[6]

Differentiating Hospital Capabilities

Today, approximately 5,700 hospitals exist in the United States. According to the American Hospital Association (AHA), just over 3,000 are classified as urban community hospitals, 1,971 are rural community facilities, and the remainder are federal government facilities, psychiatric hospitals, and long-term care hospitals.[7] Of these, more than 1,300 are designated as critical access hospitals (CAHs) and serve an important role in rural/frontier areas. CAHs are specially designated rural facilities that meet certain federal Medicare requirements; they must be located in states that have a rural health plan for the State Flex Program, maintain no more than 25 beds, furnish 24-hour emergency care services, and be 35 miles from any other hospital.[8]

Other classifications and systems of hospitals and ED care have evolved over time. Identification of time sensitive diagnoses has led most states to develop sophisticated systems of emergency care for these patients– i.e. trauma and perinatal systems. Recent time-sensitive systems developed in many states include stroke and cardiac, or STEMI[9], centers. It is important for EMSC managers to know and understand the systems of care that exist in their state, the requirements and the capabilities of hospitals participating in these systems, the lead agencies for these systems, and their potential impact on the emergency care of children. Each of these systems and the hospitals participating in the system bring resources that are potentially valuable to children. Though all systems, excluding perinatal, were developed originally for the adult patient, it is important to recognize that these systems provide validation of the need for advance preparations and specific requirements for facilities when providing care to high risk, low volume emergency patients. For most community hospital general EDs, critically ill and injured children are both low volume and at high risk, necessitating a system of care that assures initial capacity to provide appropriate care as well as access to resources, including processes for inter-facility transfer.

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[6] *Weiss AJ, Wier LM, Stocks C, Blanchard J. Overview of Emergency Department Visits in the United States, 2011. HCUP Statistical Brief #174. Rockville, MD: Agency for Healthcare Research and Quality. 2014*

[7] *American Hospital Association. Fast Facts on US Hospitals. [Online]. Accessed February 24, 2015.*

[8] *U.S. Department of Health and human Services, Health Resources and Services Administration, Health Information Technology. What are critical access hospitals? [Online]. Accessed February 24, 2015.*

[9] *Cardiac centers are commonly referred to as STEMI centers for S-T Elevation Myocardial Infarction, a specific type of cardiac emergency that can be treated effectively with rapid treatment in a cardiac catheterization lab.*

Summary of Common Hospital Types Providing Emergency Care for Children			
Hospital Type and Important Characteristics	**Number in U.S**	**Categorization Responsibilities**	**Care Provided to**
Critical Access Hospitals (CAH) Primary hospital provider in rural/frontier locations. >Located are least 35 miles from another community hospital. >Staff available 24/7. >Facilities have no more than 25 beds >Average length of stay is less than 96 hours. >Transfer agreements required to assure ability to move patients to additional care.	1,331	Center for Medicare/Medicaid Services	Community citizens
Trauma centers are part of state tiered systems of care for the injured.

Pediatric Trauma Centers, Level I and II Capabilities of each tier are often defined in state statute. Transfer agreements are part of the essential criteria for all trauma centers as well as trained staff in trauma resuscitation and the collection of data for performance improvement. | Level I = 190 Level II = 255 Level III = 258 Level IV number not available Pediatric Trauma Centers - 170 | States primarily regulate, though some states do not have state standards but utilize a voluntary process. American College of Surgeons may partner with states to verify trauma center capabilities. | Severely injured patients |
| Perinatal centers are also part of a tiered system for high risk mothers and babies and includes: Level I – low risk Level II – Specialty Care Level III – Subspecialty Care Level IV – Regional Resource Center | Specialty Centers = 148 Subspecialty Care = 809 Resource | States regulate | Newborns and premature infants |

	Centers (NA*)		
Burn centers (May be stand-alone centers or part of a medical center.)	127	American Burn Federation designates	Severely burned adults and children

(*NA – data not available. To learn more about hospital types and capabilities see "Hospital Types and Defining Characteristics" in the Pediatric Regionalization of Care Primer.)

Important Considerations in Pediatric ED Care

EDs often serve as a gateway to definitive care through triage, assessment, stabilization, and transfer to the most appropriate resources, either internally within the hospital or inter-facility transfer to another hospital. The complexities of providing emergency care to children are a reflection of the unique physiological, psychosocial, and emotional needs of the pediatric patient. These unique considerations change regularly and often as the child grows and develops, thus impacting equipment and policies of care. It is also important to realize that children and adolescents access the emergency care system for different reasons than do adults. Pediatric patients have different diseases and injuries than adults, and many children will have chronic diseases necessitating frequent ED visits.

Children comprise 27% of the U.S. population and account for approximately 20% of all hospital ED visits. They are often described as portable, presenting at their local community ED by private car, being brought in by a parent or caretaker, and not by ambulance. Data shows that 90% of emergency pediatric visits take place in a local general hospital rather than a facility with pediatric specialization or expertise. But few hospitals have all the specialty resources pediatric patients sometimes need and which often contribute to optimal outcomes of critically ill/injured children. The Institute of Medicine describes pediatric emergency care as being uneven in America as a result of the inequity of available pediatric care resources. Transfer of the pediatric ED patient to specialty facilities for children is thus common.

Important EMSC Side Note: Specialty pediatric hospitals or children's hospitals comprise only about 5% of all American hospitals and do not exist in every community or in every state. In response to the unevenness of pediatric emergency care resources, the EMSC Program established specific performance measures aimed at improving access to quality emergency care in EDs while assuring EDs are well prepared to provide an appropriate level of care for pediatric patients. PM #74 and #75 measure *the percentage of hospitals with an ED recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical and trauma emergencies*. Additionally, the EMSC performance measures #76 and #77 address inter-facility transfer guidelines and agreements; important considerations that should be planned proactively and available in every ED. See performance measures #74 – #76 in EMSC Performance Measures Implementation Manual for State Partnership Grantees.

As early as 1996 professional organizations, recognizing the unique care needs of children, developed pediatric guidelines for EDs. These guidelines have been reviewed and revised over time incorporating consensus evidence. The most recent revision, Joint Policy Statement: Guidelines for Care of Children in the Emergency Department, authored by EMSC partners, the American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), has also been endorsed by 22 professional organizations. These guidelines serve as the foundation of essential components that should be available in every ED providing care to sick and injured children. Hospitals meeting these guidelines are often referred to as being "pediatric ready."

Pediatric Readiness
Recognizing that most children experiencing an emergency will be initially treated at a community ED, it is imperative that a foundation of care be assured for all children in every hospital ED. Guidelines for care of the pediatric patient in the ED were first drafted by the American Medical Association in 1996. In 2001, AAP and ACEP partnered to update these guidelines – *Care of Children in the Emergency Department: Guidelines for Preparedness.* In 2003, the federal EMSC Program provided funding for the Guidelines Project Steering Committee to conduct a survey of all U.S. hospitals to determine compliance with the 2001 Guidelines for Preparedness. Study results revealed that most hospitals were unaware of the national guidelines and few hospitals had all of the equipment in the recommended guidelines.

In 2009, AAP, ACEP, and ENA released the aforementioned *Joint Policy Statement: Guidelines for Care of Children in the Emergency Department* to replace the 2001 Guidelines for Preparedness. The *joint statement* offers recommendations for essential equipment, medications, personnel training, and key policies necessary for optimal pediatric emergency care. In the fall of 2012, the EMSC Program, in partnership with these organizations and the EMSC State Partnership grantees, initiated the National Pediatric Readiness Project (Peds Ready). Peds Ready is an ongoing quality improvement (QI) project designed to promote optimal care of children in all EDs. The primary purpose of Peds Ready is three-fold: (1) to establish a composite baseline of the nation's capacity to provide care to children in the ED, (2) to create a foundation for EDs to engage in an ongoing QI process that includes implementing the *"Guidelines for the Care of Children in the Emergency Department,"* and (3) to establish a benchmark that measures an ED's improvement overtime. More than 4,100 ED facilities (83% of America's hospitals) participated in the assessment to determine their readiness to care for children. Visit the State Results section for assessment results and project information.

With the assessment completed, Peds Ready partners are active in phase two activities:
- the analysis of collected data,
- the dissemination and sharing of important data findings, and
- the creation of new and additional resources and tools to engage the health care community and effect change.

Important EMSC Side Note: Aggregate data for each state is displayed on the Pediatric Readiness website's State Results pages. Many State Partnership Programs also have the raw assessment data that can be further analyzed for QI and resource development. National focus on this project has brought forth many EMSC partners and champions who have expressed interest in providing support to hospitals. If your state has not focused much attention on your Pediatric Readiness data and efforts to increase hospital readiness scores, it may be an excellent opportunity to share your state data and forge partnerships with representatives of some or all of the following groups:

- State Departments of Hospital Licensure and Regulations, if one exists in your state
- State chapters of the national partners of this initiative: AAP, ACEP, and ENA
- State systems of care leaders specifically impacted by non-pediatric ready EDs, i.e. trauma managers/coordinators
- State disaster and hospital preparedness leaders
- State hospital association leadership
- Office of Rural Health, if large numbers of rural or frontier (CAH) community hospitals exist in your state

Inter-facility Transfer Processes

Research has shown outcomes for critically ill and injured children are optimized at hospitals having specific pediatric resources and expertise, such as a pediatric specific critical care area or pediatric intensive care unit (PICU). Yet, only 10% of all hospitals have PICUs. Scarcity of pediatric specific resources, including pediatric medical specialists for critically ill and injured children, requires today's providers and medical systems to plan for inter-facility transport of pediatric and neonatal patients. More than 10,500 severely injured children were transferred to specialty care resources and services in 2012. Moving a very sick or critically injured infant or child from one facility to another facility is complex and stressful for the child, family, and staff. Preplanned processes reduce the strain of unfolding events, ensure that the handoff of the pediatric patient's care is smooth, and increase transfer safety.

Guidelines and agreements for transfers of critically ill and injured children from receiving EDs to hospitals with specialty resources need to be well thought out, organized, and are essential for every hospital to have in place. Inter-facility transfer guidelines and agreements are encompassed in EMSC performance measures (#76 and #77, respectively) and are also identified in the *Joint Policy Statement "Guidelines for Care of Children in the Emergency Department."*

Some states have well-defined regulations addressing the need for agreements for those services for which a hospital cannot provide care, such as burns. They may also require specific guidelines for the transfer, including pediatric patients. But these states are few and initial studies have found that even with these regulations or requirements in place, a lack of enforcement often limits the availability or efficacy of transfer guidelines and agreements. Systems of care focused on time sensitive diagnoses such as trauma, stroke, and STEMI may also require transfer guidelines and agreements since transfer to appropriate resources is

typically a component of these systems. It may be feasible to build upon these specialty-care systems to establish universal hospital transfer processes that include pediatric patients or adjust the language to address patients of all ages. EMSC managers may also find it helpful to work with coordinators of these programs to identify practices facilitating availability of guidelines and agreements for transfer. For more information on inter-facility transfers, see the Inter Facility Transfer Toolkit for the Pediatric Patient.

ED Operations, Licensure, and Accreditation

Like prehospital EMS agencies, there are wide variations in the ways hospital and stand-alone EDs are accredited and licensed across states and territories. Many organizations and entities have a role in hospital regulation, licensing, and accreditation depending on the type and level(s) of service(s) provided. Hospital licensure and accreditation of EDs seldom resides in the same department or division as prehospital EMS systems and thus EMSC managers may need to collaborate and work with unfamiliar departments and hospital accreditation organizations to best understand systems of ED care in their states. The Pediatric Regionalization of Care Primer, Section 4: Hospital Regulations, Mandates, and Standards Influencing Regionalization, provides additional information to further your understanding of hospital operations.

EMSC Contributions to ED Hospital Care

For three decades, the EMSC Program has been a driving force in the ongoing efforts to improve pediatric emergency care across the continuum of care including the ED. The Program's mission to assure that all children, no matter where they live, play or go to school, have access to high-quality emergency care continues to be a driving force for all involved in EMSC. EMSC performance measures specific to hospitals, as well as the National Pediatric Readiness Project, have defined specific recommendations and opportunities to improve the process for delivery of pediatric ED care. Since most EMSC managers are often within divisions/departments of EMS, the continuum of care focusing upon hospitals and EDs can be perceived as more difficult to address. However, State Partnership grantees across the country have worked with the hospitals and stakeholders in their states and territories to implement change and improvements and positively impact outcomes of pediatric emergency care. Periodic assessments of EMSC Program performance measures and hospital pediatric readiness are conducted. Upward trends of improvements are evident from this data (see Aggregate National Data for EMSC Performance Measures). Thus, state EMSC programs and their stakeholders can take credit for actualizing these improvements, but also know that opportunities for improvement continue to exist and their work is not done.

In 2013, the EMSC National Resource Center collaborated with ENA and the Society of Trauma Nurses (STN) to develop the Inter Facility Transfer Toolkit for the Pediatric Patient, a comprehensive resource to assure that hospitals and providers can better address important components of the transfer processes. Resources included in the toolkit support efforts in establishing agreements/memorandums of understanding to facilitate transfer of children to specialty resources when needed. Additionally, the toolkit aides in the development of

pediatric transfer guidelines to assist staff as they work to ensure safe and timely inter facility transfer.

Other EMSC-funded initiatives impacting pediatric care in the ED include the Pediatric Emergency Care Applied Research Network (PECARN), Targeted Issue (TI), and State Partnership Regionalization of Care (SPROC) grant programs (see Section I for more information on these programs). To date, PECARN has published more than 100 manuscripts and/or abstracts providing a solid foundation for evidence-based pediatric emergency care in the ED. TI grants have also contributed a wealth of primary knowledge, as well as novel tools and resources to improve the care of children in the ED. Finally, the SPROC program brings both the performance measures and pediatric readiness together to facilitate development of regionalized pediatric systems of care for children and families in tribal, territorial, insular, and rural areas.

Where Hospital Systems are Headed

Dynamic changes in the U.S. healthcare system, underscored by passage of the Patient Protection and Affordable Care Act, will have a major impact on hospitals and the broader systems of care in which they operate. Payment structures are now based on accountability, efficiency, and improved health outcomes. Greater transparency of physician and hospital outcomes data will continue to drive changes in delivery models for emergency care.

Incentives to develop or enhance systems of care intended to deliver higher-quality care and lower costs, such as accountable care organizations and health care coalitions, will stimulate collaboration, coalition building, and regionalized systems of care. The use of telehealth and telemedicine will continue to expand with improvements in technology, changes in reimbursement policies, and increased pressure to reduce costs. As this technology advances and increases in use, the ability to provide pediatric specialty care should be enhanced. Finally, hospitals are continuing to move toward a system of electronic health data interoperability to provide safe, effective, efficient, and timely care with the most current patient information, as well as to vastly improve data for continued quality improvement and outcomes research.

Section IV: About the Federal EMSC Program

The Emergency Medical Services for Children (EMSC) State Partnership (SP) Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) through the Maternal and Child Health Bureau (MCHB), Division of Child, Adolescent and Family Health (DCAFH), EMSC and Injury Prevention Branch. This Program is authorized by the Public Health Service Act, Title XIX, §1910 (42 U.S.C. 300w-9), as amended by the Patient Protection and Affordable Care Act, §5603 (P.L 111-148).

The purpose of the EMSC SP Program is to assist states, territories, and freely associates states in the expansion and improvement of emergency medical services for children. The missionis to reduce the prevalence of pediatric morbidity and mortality. Specifically, the program aims to ensure that

- state of the art emergency medical care is available for the ill and injured child or adolescent;
- pediatric service is well integrated into an emergency medical service system backed by optimal resources; and
- the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, is provided to children and adolescents as well as adults, no matter where they live, attend school or travel.

Performance Measures

SP grants generally fund activities that enable states to meet current federal EMSC Program performance measures, as well as MCHB Discretionary Grant performance measures specific to the EMSC Program. These performance measures were created to ensure compliance with the federal Government Performance Results Act (GPRA), a Congressional mandate designed to hold federal agencies accountable for achieving program results. As the performance measures are implemented into state EMS systems, data collected by grantees will provide a mechanism for documenting activities and accomplishments of the EMSC Program nationally.

Each performance measure is hyperlinked to HRSA's Discretionary Grant Information System (DGIS). The DGIS contains the most recent reporting data for each performance measure. Data is supplied in aggregate form only. Note that all EMSC performance measures align with Healthy People 2020 objectives (see Healthy People 2020 Crosswalk to EMSC Performance Measures).

For more in-depth discussion of the EMSC and MCHB performance measures, see Section V: A Guide to Managing a State Partnership Grant.

SP Grant Lifecycle

Each state, territory, or freely associated state is eligible for one SP grant, and state governments and accredited schools of medicine are the only eligible applicants for funding under the EMSC Program. SP grants typically have a four-year lifecycle. Approximately three months prior to each new grant cycle, HRSA will post a Funding Opportunity Announcement (FOA) for "new" and "competing continuation" grants. Federal funding for the SP grants, however, is awarded on an annual basis from March 1 to February 28 and is contingent on the successful submission and review of the Non-Competing Continuation Progress Report each year (see "Reporting Requirements" available below).

- New grants are either State Planning grants (Category I) or Implementation grants (Category II). A State Planning grant is one awarded to a state, or an organization within the state, that has never had an SP grant before and is intended to allow for state self-assessment and planning. An Implementation grant (Category II) is intended for states that have received a State Planning grant and are ready to initiate a full-scale implementation project. Competing Continuation grants (Category III) are awarded to states that have already successfully implemented SP grant programs to improve the emergency medical services system capacity to address the particular needs of children and are looking to continue their work for another four years.

- A Non-Competing Continuation Progress Report must be submitted to receive funding for each subsequent year (years 2-4). This report provides HRSA project officers with state progress on both MCHB and EMSC Program performance measures, and information on project achievements, challenges, and any changes since the beginning of the grant cycle.

Funding Opportunity Announcement

The FOA is a vital resource for SP program managers. It not only provides information about the grant funding opportunity, but also serves a step-by-step grant guidance on everything from how to register and submit a proposal through Grants.gov to what the proposal should include, how it should be formatted, and directions on the submission and notification process. Additionally, the FOA includes helpful templates and links to online resources, post-award reporting requirements, and contact information. The FOA and the grant application itself should be the primary resources when planning and implementing the SP work plan and will be especially valuable for those managers who were not involved in the preparation of the initial grant application, as well as those tasked with preparing the next Competing Continuation (see *HRSA-13-201 for an example FOA).*

Registration. All organizations applying for HRSA grants must register through three separate systems: The Data Universal Number System (DUNS), the System for Award Management (SAM), and Grants.gov. In some states, registration, grant submission, and Federal Financial

Reports (FFRs) are done by a centralized office that oversees all grants and contracts for the agency or organization.

In other states, the EMSC manager is primarily responsible for all aspects of grant management, including registering the organization and submission of grant applications, progress and performance reports, and FFRs. All SP managers need to coordinate closely with their grants and contracts office, know their roles and responsibilities, and assure necessary access to various systems for reporting, information verification, and assurance of timely submission of applications and reports.

Notice of Grant Award

Each applicant submitting a successful application receives a written notification in the form of a Notice of Grant Award (NGA). The NGA may require state grantees to respond to "conditions" placed on their application by a specific date (usually 30, 60, or 90 days after the release of the NGA). Funds will not be released until all conditions have been met to the satisfaction of the EMSC Program. Some examples of conditions include:

- Please provide a detailed explanation for costs associated with "Consultants" within 30 days.
- Please provide a revised budget that includes funding for three representatives to attend the EMSC Program Meeting within 60 days.

The NGA may also include "recommendations" that the reviewers have identified as potentially being helpful for project implementation. Grantees do not need to respond to these recommendations. Recommendations are actions to be considered by the grantee in order to facilitate the achievement of the grant goal(s) and objectives.

Pay attention to both conditions and recommendations for future grant applications as they represent areas where your application can be improved. Review the NGA to familiarize yourself with the format. For example:

- The grant project period is listed in Box 6 and the budget period is in Box 7.
- The NGA is typically sent to the director listed in Box 10.
- The grant award number, which is used for communications with the federal program officers, can be found in Box 4A.
- Electronic Handbook (EHB) requirements and information are found on page two.
- Grant specific conditions that the applicant must respond to within the defined designated period, if applicable, will be noted under the section "Terms and Conditions."

Reporting conditions and contact information for grant management questions can also be found in the NGA.

Electronic Handbooks

EHB is HRSA's on-line grants management system. All competing and non-competing continuation grant submissions and other required reports, as well as requests for changes in grant conditions and carryover of unused funds, must be submitted through EHB. Users wishing to work on any official grant submissions, including progress and performance reports, must be registered in EHB. Depending on the organization, SP program managers may be authorized to view, edit, and submit all reports or they may be given limited authorization that may restrict their ability to edit or submit reports. Access must be requested through the EHB and granted by an "authorizing official" as listed on the NGA and in the EHB User's List for the EMSC State Partnership Grant. Step-by-step instructions for registering and navigating in HRSA's EHB are located on the HRSA website on the *Manage Your Grant* page.

> **Fast Fact:** HRSA's YouTube channel features several **Electronic Handbook video tutorials** that provide a great way to learn about navigating and using the on-line reporting system.

Reporting Requirements

Successful applicants for the SP grant are required to submit various reports at specific stages during the funding life cycle (see the following PowerPoint for a list of reports due and their deadlines). Program managers often share this responsibility with the organization's grants and contracts office, although in some states the manager submits all reports as previously described. At a minimum, managers in most states and territories are responsible for completing the Progress Report, Performance Report, Prior Approval Requests for carryover of unused funds, and the Final Report. Financial reports including the FFR and associated Quarterly FFR Cash Transaction Report are commonly submitted through an office of grants and contracts or financial services department within the grantee organization.

Additional requirements include Office of Management and Budget (OMB) Circular A-133 Audit for organizations that receive more than $500,000 in federal funds and Tangible Personal Property Reports for federally-owned property and durable equipment with an acquisition cost of $5,000 or more per unit. A detailed description of each of these reports with schedules and deadlines can be found in the FOA.

Support

For questions about registering in the Electronic Handbook, contact HRSA's Call Center, Monday-Friday, 9 am-5:30 pm, Eastern Time, at 877-Go4-HRSA/877-464-4772; 877-464-4772; or 301-998-7373; 301-998-7373.

For questions about registering at Grants.gov, contact the Grants.gov Call Center Monday-Friday, 7 am- 9 pm, Eastern Time, at 1-800-518-4726; 1-800-518-4726.

Any additional questions should be directed to either the state's federal project officer or the HRSA grants management specialist for each grant type: State Partnership, SPROC, Targeted Issue or PECARN.

Every step of the way, from registration to completion of the grant life cycle, program managers have access to HRSA and resource center staff. Questions related to budgets, reporting, and other administrative requirements should be directed to the grants management specialist listed on page two of the NGA. Typical issues include those related to the NGA, response to a condition placed on the NGA, preparation for Prior Approval Requests, and the FFR. For programmatic issues, such as project goals, scope, or requests for consultation and resource materials, managers should contact their federal project officer. Additionally, HRSA federal project officers may refer you to the EMSC NRC or NEDARC to assist with specific consultation and resource development needs.

Section V: A Guide to Managing the SP Grant Program

To achieve sustainable and meaningful improvements in pediatric emergency care, State Partnership (SP) managers must become strategic leaders. A strategic leader is an individual who thinks, acts, and influences others in specific ways to bring about enduring change. Strategic program managers are focused on the mission and vision of the Emergency Medical Services for Children (EMSC) Program, keeping long-range goals in mind while working to accomplish short-term objectives. They are keenly aware of the interdependence of their organization within complex systems and actively engage partners and stakeholders to advance the mission of the Program while, at the same time, engaging with others to strengthen the emergency care system as a whole.

Strategic leaders not only develop and follow a strategic plan, but carefully consider every decision made as the plan is enacted. Finally, strategic leaders have a clear understanding of where their program is, where they want it to go, and how they plan to get it there, translating strategy into action and continually evaluating progress, learning. and adapting along the way.

Program Manager Roles and Responsibilities

The primary role of the SP manager is to coordinate and manage all aspects of the EMSC SP program to ensure that the emergency care needs of children are well integrated throughout the entire continuum of care, from illness and injury prevention to bystander care, dispatch, prehospital EMS, definitive hospital care, rehabilitation, and return to community. The program manager is the lifeblood of the SP program and is often recognized as the leading champion for pediatric emergency care throughout the state or territory. Additionally, he or she serves as the primary liaison to the federal EMSC Program providing the vital conduit for the flow of information between the Program and the state or territory.

EMSC SP programs vary from state to state in their organizational structure and method of operation. Most SP programs are housed within a governmental office, such as the State EMS Office or Ministry of Health and are managed by government employees. Some grant programs are held by academic institutions employing managers within the school of medicine or an affiliated children's hospital. Still others encompass a combination of the two in which the SP grant is held by one entity and the management of the grant is contracted to another. To learn more about the organizational structure and management of other states and territories and much more state-specific program information, visit the EMSC State and Territory SnapShot Database Tool. .

Likewise, program managers have widely varied backgrounds, each bringing unique skills and experience to the program as well as diverse learning needs. Regardless of the organizational structure, method of operation, or experience, there are specific roles and responsibilities for managing a SP grant, as well as common characteristics of an effective program manager. For

an example of an EMSC program manager job description, see *EMSC State Partnership Program Manager Job Description and Detailed Scope of Work.*

Table IV-1: Common Characteristics of an Effective EMSC Manager

An Effective EMSC program manager
    • is a champion for children and families;
    • maintains a central focus on EMSC performance measures;
    • understands program constraints and knows how to effectively work within them;
    • builds relationships with key stakeholders;
    • engages their state's EMSC Advisory Committee;
    • develops and follows a strategic plan for the program;
    • utilizes a timeline to plot activities leading to achievement of defined grant objectives;
    • monitors all program activities and project budgets;
    • leverages all available resources to achieve objectives;
    • communicates with their project officer and the EMSC resource centers regularly;
    • complies with all Federal Program requests and conditions in a timely manner.

Implementing the Performance Measures

At the core of each state EMSC program are the performance measures. The EMSC performance measures were developed as a mechanism for documenting activities and accomplishments of the EMSC Program in improving the delivery of emergency care to children. They establish a clear pathway for ensuring each state's EMS system is prepared for and delivers the best possible care to all acutely ill and injured children. The overarching goal of the performance measures, and the primary focus of the program manager's position, is to effectively incorporate nationally recognized pediatric care guidelines into EMS systems in all states and territories across the country resulting in consistent and predictable quality of emergency care for our nation's children.

In 2006, these measures became the basis for all EMSC SP grants, requiring collection and reporting of data, as well as defined plans for achieving each measure. Specifically the measures:

- provide an ongoing, systematic process for tracking progress towards meeting 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 SP 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 Health Resources and Services Administration (HRSA), Congress, and other stakeholders.

The measures were developed through an extensive consensus building process that included input from EMSC grantees, EMSC stakeholders, and pediatric emergency medical experts. The performance measures represent the best thinking of the EMSC Program and its partners. They have also been validated by the Institute of Medicine report *Future of Emergency Care in the United States*.

Baseline performance measure data was collected in 2007-2008, 2010-2011, and 2013-2014 grant cycles. SP managers are responsible for imputing their state performance measure data into HRSA's Electronic Handbook (EHB) as part of their annual performance report. At the state level, performance measure data is expected to be used to periodically evaluate the status of pediatric emergency care and focus efforts on addressing gaps identified. Aggregate data for the EMSC SP program is submitted to the Discretionary Grant Information System (DGIS). National data can also be found on the National EMSC Data Analysis Resource Center (NEDARC) website.

> Based on the achievements in implementing the EMS-related performance measures, in 2013 NEDARC was charged with assembling a multidisciplinary Performance Measure Advisory Committee (PMAC) to begin the consensus process to develop the next generation of EMS performance measures. The new measures will build on the work that has been done and take the performance measures to the next level. More information about the next generation of EMS performance measure will released in 2016.

In addition to EMSC performance measures, SP grantees must report data on five of the 41 Maternal and Children Health Bureau (MCHB) Discretionary Grant Performance Measures. These measures are specifically assigned by the MCHB to EMSC based on their applicability to the Program. For each MCHB Discretionary Grant Performance Measure, SP managers will provide annual objectives and report the indicators against these objectives in their annual performance report.

Health Resources and Services Administration, Maternal and Child Health Bureau Discretionary Grant Performance Measures Specific to the EMSC Program

Number	Performance Measures Title
PM07	The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.
PM10	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training.
PM24	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.

PM33	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
PM41	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.

Achieving the EMSC performance measures can be challenging. Managers should use the performance measure data along with the needs assessment and work plan from the original grant application and past performance reports to prioritize their state's performance measure goals. The _EMSC Performance Measures Implementation Manual_ is a great place to start. Additionally, managers should work closely with their EMSC Advisory Committees, State EMS Offices, family representatives, partners, and stakeholders to help guide performance measure priorities and implementation strategies. Managers should also communicate regularly with their project officers and with the EMSC National Resource Center (NRC) and NEDARC to assist with performance measure implementation goals.

Building Partnerships and Collaboratives
Achieving any statewide quality improvement initiative is a monumental task. Moreover, for a SP program manager, the prospect of changing state healthcare policies or standard industry practices can be daunting. However, successful implementation of the performance measures and other pediatric emergency care quality improvement initiatives can be achieved through effective utilization of multi-agency and multi-disciplinary partnerships and collaboratives.

Partnerships and Collaboratives Defined. A partnership is defined as "a relationship between individuals or groups that is characterized by mutual cooperation and responsibility for the achievement of a specified goal." A collaborative is defined as "to work jointly with others or to work together, especially in an intellectual endeavor." While partnerships and collaboratives are similar in that they are both built with the intent of meeting a common goal, partnerships are characterized by sustained relationships and individual commitment to the interests of the group. Partnership may also be formally acknowledged through written agreements such as a memorandum of understanding or letter of support. Successful collaborative projects often lead to long-lasting partnerships.

Strategic Partnerships. Identifying and cultivating partnerships and developing effective collaboratives are essential EMSC manager responsibilities. Managers must identify partners who have diverse experiences and perspectives, who are knowledgeable, and who have a mutual interest in improving access to quality emergency care for children. In general, a good partner is one who has visibility, authority, and influence, and is capable of affecting change. In many situations, partnerships are strategically designed and orchestrated to address an identified need or to improve support of a key group of stakeholders..

Family Advisory Network Representatives. One of the most important strategic partnerships is between the program manager and their Family Advisory Network (FAN) representative. No one has more at stake in the assurance of high-quality pediatric emergency medical care than

the parents and family members of children whose lives, at any given time, may be placed into the hands of their local EMS provider. FAN represents the consumer's perspective, and the involvement of local community-based family representatives in EMSC will help to integrate the practice of family-centered care into the EMS system. SP managers should involve FAN representatives in all aspects of the SP program and seek out ways to tap into their passion, unique skill sets, and grass-roots community networks to help guide and implement EMSC priorities.

The EMSC Advisory Committee. Another vital partnership is the one between the SP program and their EMSC Advisory Committee or Council. While having an advisory committee that meets regularly is a requirement of SP grant funding, building a strong and effective advisory committee that will help move mountains should be a leadership priority. The EMSC Program specifies that the committee or council include the following eight core members strategically designed to provide vital input from key disciplines:

- a nurse with emergency pediatric experience;
- a physician with pediatric training (pediatrician or pediatric surgeon);
- an emergency physician;
- a currently practicing emergency medical technician (EMT)—basic or paramedic;
- an EMS state agency representative (state medical director, administrator);
- the EMSC SP director;
- the EMSC SP manager; and
- a family representative.

The selection of the individuals to fill these seats should be carefully deliberated. Partnering organizations and key stakeholder groups are often the first places to look, but it is also important to consider other important concerns, such as cultural and linguistic diversity, youth participation, and geographical or regional representation. Members must also be willing and able to commit to meetings and to provide additional support to the program between meetings as determined by the committee.

In addition to the required positions, others may be added. Factors to consider are costs involved in gathering the group for meetings, ability to manage and engage the group, and difficulty in achieving a quorum. However, positions may also be strategically created to cover specific program needs or to shore partnership relations. For example, a key partnership with the state hospital association may be strengthened by inviting a representative of that organization to participate in the advisory committee. Furthermore, it may not be wise to "load" the committee with pediatric champions to the exclusion of other stakeholders, such as professional EMS or hospital management association leaders who may not always agree that EMSC priorities are in the best interest of their constituents. Effective managers have learned to include adversaries in the process to develop trust and foster collaboration. This is a prime example of strategic leadership.

Casting a Wide Net. The old expression "It is not what you know but who you know" is only part of the story. When attempting to affect statewide change in pediatric emergency care, it comes down to not only who you know, but who they know as well and if you can effectively impart what you know on them. This is networking. Everyone works within multiple networks at home, at work, and in their community. A successful program manager understands the value of networks and actively seeks to take advantage of them. An important element of strategic partnering is to be able to look at the big picture and identify partners within a network of networks. For example, an emergency physician on an advisory committee would have more reach if he or she is active in one or more professional associations, such as the [American College of Emergency Physicians](#) (ACEP), is affiliated with the state chapters of those organizations, and is involved in state or regional committees or coalitions.

On the other side of the coin is who knows you. It is impossible for one individual to get face time with every potential stakeholder across multiple organizations, and by nature people are reluctant to trust someone they do not know. This makes it difficult to: get the message out about the SP program goals and objectives, get a foot in the door for potential partnerships, or get responses to a request to complete a survey or questionnaire for EMSC data collection. Strategically, partnering helps by having recognized leaders in multiple organizations lend the SP manager credibility and support within their organizations and networks and helps open doors to otherwise inaccessible groups.

Preparing Budgets and Finance

Accurate and well-planned operational and project budgets are key to securing essential resources, and managers are responsible for utilizing grant funding efficiently and effectively. It is also critical that federal grant funds are expended within the funding period and that all required financial reports are submitted on schedule. A detailed description of required financial reports with schedules and deadlines can be found on the [Funding Opportunity Announcement (FOA)](#).

Overall Operational Budget. An overall budget is required as part of the SP grant application. This is the official project budget, which will account for each year of the four-year grant lifecycle and includes an itemized budget organized by category, as well as a budget justification narrative explaining the details of the itemized budget. Awards, on a competitive basis, will be for a one-year budget period from March 1 to February 28. Funding for each subsequent year is based on availability of funding and successful progress as demonstrated through progress reports and other required submissions. Common budget categories are listed below.

Budget Justification. The budget justification is a narrative document that clearly describes how each item in the budget will support the achievement of proposed activities. All applicant categories (I, II, and III) must include a budget justification in their funding proposal. Specific requirements that are to be included in the budget for each category, such as a reassessment to evaluate progress, are listed in the FOA. For Category II and III applicants, budgets must reflect a clear focus on achievement of the performance measures. However,

up to 10% of the budget may be allocated to other pediatric related activities, such as disaster preparedness or injury prevention. Managers who have any questions about projects beyond the performance measures, including what other activities are acceptable, should contact their project officer or grants management specialist.

Carryover of Unobligated Funds. It is recommended that the SP funds for each year be expended within the funding period. Unused or unobligated funds left over at the end of the funding period are not guaranteed to carry over into the next funding period. Furthermore, this could reflect poor planning or management and will be scrutinized by the Program during review of the Annual Progress Report. However, unexpected events, such as personnel changes leaving a budgeted position vacant for a part of the year, may leave the budget with a balance at the end of the period. When this occurs, a carryover of unobligated funds must be requested through a Prior Approval Request in the EHB, (see Section IV: About the Federal EMSC Program for information about submitting reports and requests in the EHB).

Carryover requests must be submitted within 30 days after the Federal Financial Report (FFR) has been accepted by HRSA. The request must include an official letter explaining why the funds were not spent, how they will be used (a budget justification), the full dollar amount to be carried over, and the Standard Form 424a (from the Progress Report in the EHB). Carryover funds may not be used for new project goals or objectives but must be used to continue or build upon work started in the previous funding period. Funds not requested through the prior approval process within the submission deadlines may offset future funding. For example, if a grantee reports $20,000 in unobligated funds at the end of the funding period and does not submit a Prior Approval Request for carryover within 30 days of the FFR, the following year's requested dollar amount may be reduced by $20,000. For questions regarding budgets and carryover, managers should contact their grants management specialist. An example of a budget and budget justification is available for download.

Contractual Agreements. The SP manager may contract for specific tasks, such as seeking the services of an outside vendor to provide a series of pediatric continuing education courses throughout the year. Other examples include contractual services for a cultural liaison or FAN representative. However, as the grantee, the EMSC manager assumes responsibility for the contractor's work, ensuring that the contractor stays on task and completes all assignments on time as written in the contract. In addition, the grantee is responsible for ensuring that all contractors are notified that they must be registered in the Data Universal Number System (DUNS) and System for Award Management (SAM), (see Section IV: About the Federal EMSC Program for registration instructions).

Common Budget Planning Categories

Budget Category		Cost Considerations
Direct Costs (Costs that are directly related to achieving program objectives)	Personnel	Amount of staff time devoted to the program, their responsibilities, their salaries, and additional funds needed for program support.
	Fringe	A rate for benefits that is typically determined by the state or agency.
	Travel	Costs associated with required meetings (both in-state and out-of-state), including: travel, lodging, and per diem. Note: the grant guidance details required meetings, such as the EMSC Grantee Meeting or other meetings are designated by HRSA.
	Equipment	Cost of essential equipment required for work plan implementation. Equipment is tangible nonexpendable personal property charged directly to the award having a useful life of more than one year and an acquisition cost of more than $5,000. Note that a computer costing less than $4,000 would be considered a supply.
	Supplies	Any items that do not meet the threshold for equipment are considered supplies. This includes office supplies such as paper, stamps, and printing as well as projectors, phones, or computers needed to achieve project objectives that have acquisition costs of less than $5,000.
	Other	All costs that do not fit into any other category. Examples would include rent or utilities not included in an approved indirect rate, or stipend funds to reimburse FAN representatives for attendance at meetings.
	Contractual	An example of a contractual cost includes one required to develop educational materials, conduct assessments, etc. All sub-contractual services require a separate detailed budget and justification.
	Consultants (advisory committee members,	Monies planned for advisory committee member meeting attendance, payment to state IT office for services related to data retrieval and/or analysis, etc. Grantees cannot pay speaker fees but may pay

	meeting facilitator, etc.)	consultant fees and honorariums for a speaker.
Indirect Costs (Costs necessary to the operations of the organization)	Facilities and Administration	The costs associated with the operating and maintaining facilities, depreciation, and administration salaries. For the EMSC State Partnership Program, the indirect cost rate refers to "Other Sponsored Programs/Activities" rates rather than research or education rates. See the FOA for complete details on applicable indirect rates.

Strategic Planning and Quality Improvement

In order to know where the SP program is, where it is going, and how it is to get there, strategic program managers should work with their team to craft a written strategic plan. Strategic planning provides an opportunity to critically look at the SP organization and the current status of the pediatric emergency systems of care in the state, to develop or revise program goals based on these assessments, and identify strategies for reaching those goals. Strategic plans are essentially roadmaps that will guide the program to success. For examples of EMSC State Partnership Program strategic plans, see the Tennessee EMSC 2010-2013 Strategic Plan and the Colorado EMSC Strategic Plan.

Many models for developing strategic plans exist, but most agree on including the following basic elements:

Step 1: Conduct EMS System Assessment and SWOT Analysis

An EMS system assessment provides a review of the emergency care environment in your state; environmental driving forces; changing demographics; political, social, and economic conditions, as well as available and missing resources. This step is often referred to as a SWOT analysis. It looks at the Strengths, Weaknesses, Opportunities and Threats that could potentially impact achieving the performance measures.

The baseline data collected for each performance measures can provide valuable information regarding the status of your system. The baseline data provides a foundation for the development of your program's goals and objectives, and can be used for evaluating progress towards achieving these goals. Once baseline data has been collected and analyzed, a SWOT analysis can be a useful tool to identify strategies to make improvements in each of the performance measures. For example, you may have found through collection of baseline data that only 20% of your state's hospitals have written agreements and guidelines regarding the transfer of children to higher levels of care. By conducting a SWOT analysis with key stakeholders, your program can help identify root causes and ways to overcome barriers. Conversely, a SWOT analysis could be conducted with EMS training coordinators, state EMS office administrators, and others to assess the adequacy of current pediatric training requirements for EMS providers and how these requirements might be strengthened.

Some of the important aspects of conducting an effective SWOT analyses include:

- process is facilitated by an outside or neutral party;
- planning includes representation from all parties or organizations with a stake or interest in the outcome;
- all parties and their input will be regarded equally;
- discussion stays focused on the "system" rather than on individual people;
- discussion does not drift into unrelated topics; and
- plans developed from the SWOT analysis are done by the group, and any revisions to the plans are done with input from the group,

SWOT results can specifically be used to develop goals and objectives to address barriers identified and make system improvements in performance measure areas. There are a number of excellent resources for conducting SWOT analyses and facilitation techniques (see the SWOT Analysis Template).

Step 2: Define Goals

Goals are broad value statements of desired outcomes. Define goals for your program which address the gaps identified in your assessment. Examples of goals related to the performance measures include:

- *By 2016, assure access to quality pediatric emergency care for all children in every region of the STATE.*
- *By 2017, improve the operational capacity of STATE to provide pediatric emergency care.*

Step 3: Develop Objectives

Objectives facilitate achievement of the goals. They should be specific and flow from specific goals developed for the state. They also should be measurable, quantifiable, and achievable in the timeframe specified in your goals.Example objectives include:

- *Provide pediatric training for 90% of BLS providers in STATE every two years.*
- *Ensure that 100% of the hospitals in STATE have pediatric emergency transfer guidelines that include all of the required components of transfer by 2016.*

Using the **SMART** approach is a helpful framework for developing your project goals and objectives. Goals and Objectives should be

S	Specific
M	Measurable
A	Attainable
R	Results oriented/Relevant
T	Time bound

For more information on writing goals and objectives, see Establishing Goals and Objectives and Tips for Writing Goals and Objectives.

Step 4: Identify Strategies

Clear strategies and activities are essential for setting out detailed work plans that will achieve the desired outcomes set out in project goals and objectives. Strategies are broad concepts or approaches to achieve the project objectives while activities are actions that are undertaken within these strategies. For each of the project objectives, create a list of major strategies, specific activities for each strategy, the individual or group responsible for implementing the activity, and a timeline for completion. Strategies should also be written to pass the SMART test. SMART strategies allow strategic managers to monitor the progress and outputs of the project and increase the likelihood of meeting objectives and effecting positive change.

When writing activities, use 'active' verbs and be very clear on what needs to be done. Be sure to include time to review your strategies and activities with your stakeholders. For more information, see Developing Strategies and Activities.

Step 5: Develop a Timeline

Program milestones should be plotted on a timeline. Timelines assist in outlining tasks to be worked on and specific accomplishments to be achieved within a proposed time frame.
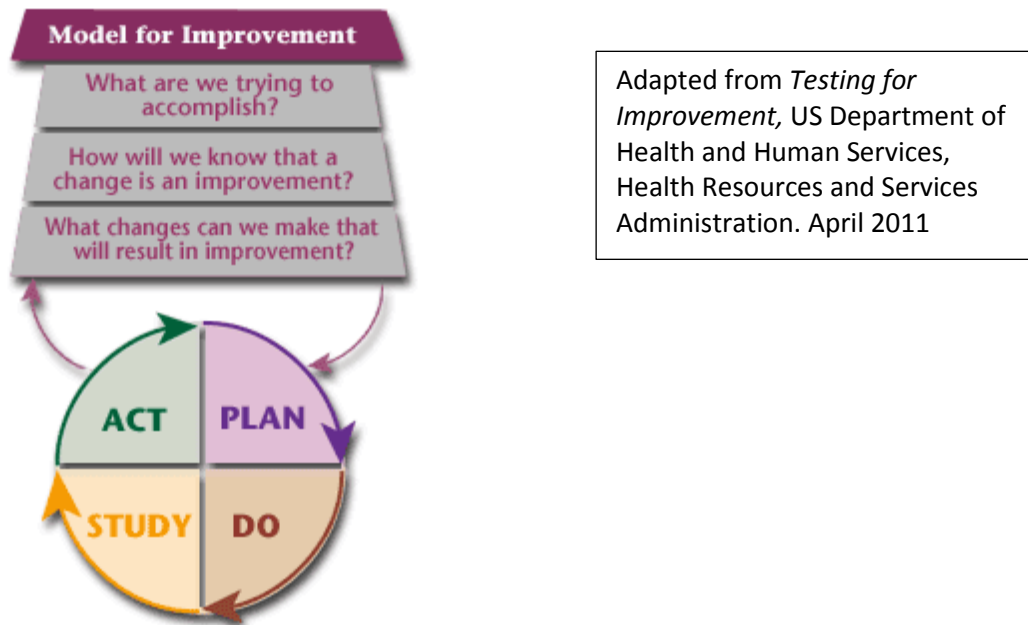
A program timeline could also include essential grant activities that must be adhered to with your funding award (e.g. plotting the date by which updated data must be recorded into the EHB; plotting attendance at the annual grantee meeting). To have multiple successful outcomes occurring within the same time frame may be unrealistic. Often this multiplicity of activities may not be recognized until plotted on a timeline reflecting the numerous tasks and proposed outcomes. Timelines should be constructed with all activities listed and responsible individuals indicated for each activity. A Sample Program Timeline is available for download.

Step 6: Evaluation

Evaluation is a critical part of any strategic plan. Evaluation provides a mechanism for celebrating success while identifying areas where action steps failed to fully actualize the desired changes. Reflection on well-crafted SMART objectives easily facilitates measures of success by focusing on process, degree of change, and outcome. Did the planned action steps facilitate achievement of the objective? Was the objective achieved in total or in increments necessitating further work? If the objective was achieved, what was the actual outcome resulting from achievement. For an example of how to put it all together, see the Project Plan Template.

For example, your objective is to assure that all hospitals have written inter-facility transfer agreements in place and that children are transferred to appropriate resources. In year one, only the eight designated trauma centers are noted to have such in place. Your objective is to devise a plan with your state hospital association and the regional hospital preparedness program to ensure that all hospitals in the state have written agreements in place. Collecting data on this measure in subsequent years will aid you in determining the success of this plan. Further success of the plan can be measured by looking at the number of children actually transferred to the appropriate facility and resources.

Model for Improvement. The Model for Improvement provides a framework for developing, testing, and implementing change, and it is a powerful tool for accelerating improvement. The Model for Improvement is used to successfully improve care processes and outcomes by numerous health care organizations. A Model for Improvement template is provided for grantee use. The model comprises two equally important parts:

Adapted from *Testing for Improvement,* US Department of Health and Human Services, Health Resources and Services Administration. April 2011

Part 1 presents three fundamental questions that are essential for guiding improvement work:

- ***What are we trying to accomplish?*** An organization's response to this question helps to clarify which improvements it should target and their desired results.
- ***How will we know that a change is an improvement?*** Actual improvement can only be proven through measurement. An organization should think about how it wants things to be different when it has implemented a change and agree on what data needs to be collected for measuring. A measureable outcome that demonstrates movement toward the desired result is considered an improvement. For example,

showing how the service that patients receive will improve, or how an organization's processes might change.

- ***What changes can we make that will result in improvement?*** Improvement occurs only when a change is implemented, but not all changes result in improvement. One way to identify which change will result in improvement is to test the change before implementing it.

Part 2 involves the Plan-Do-Study-Act (PDSA) cycle that tests and implements a change in real-work settings.

One of the most common tools for improvement is the Deming (or Shewhart) Cycle. This method is also known as Plan-Do-Study-Act (PDSA) and it is well suited for many improvement projects. The PDSA cycle is shorthand for *testing a change* — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.
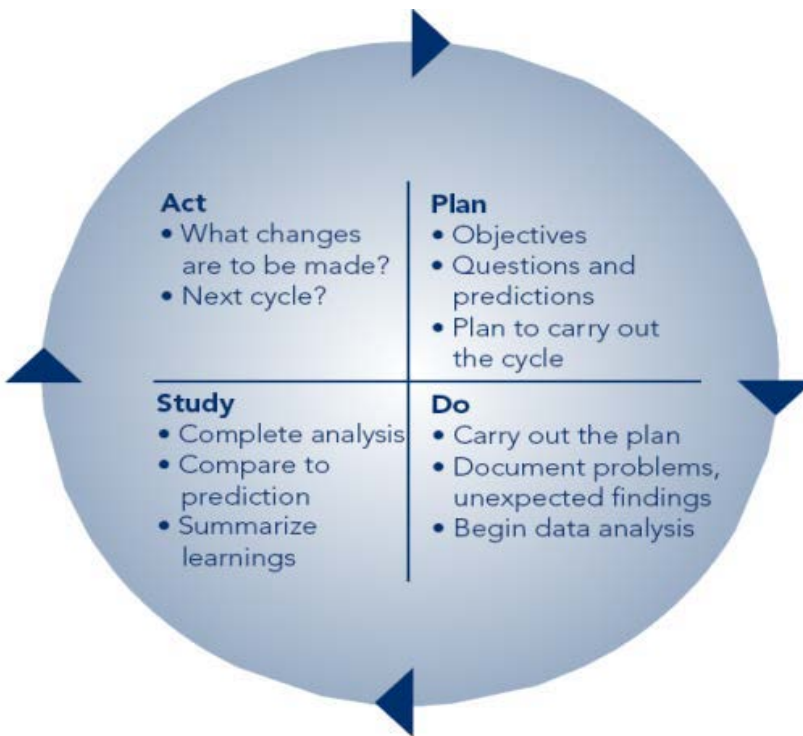
The use of multiple test cycles helps an organization improve upon each test of change. Most system changes require more than one PDSA cycle.

Managing Time Effectively

One of the most important jobs of an EMSC manager is to monitor project initiatives and tasks that lead to successful and timely achievement of the stated grant objectives. To ensure

that grant projects move forward efficiently, a detailed timeline is essential (see Sample Program Timeline). Timelines allow the strategic leader to monitor important grant milestones and deadlines while ensuring timely completion of grant requirements.

To help define weekly work priorities, the manager should refer to this timeline at the start of each week. The timeline will also assist in identifying the need for new strategies if initiatives are not moving forward as originally planned. Monthly monitoring of progress and challenges is recommended and often can be done when meeting with internal agency partners. The EMSC Advisory Committee meetings also provide an excellent opportunity to review the progress made toward achieving performance measure milestones. Committee members can assist with verifying successes or identifying barriers related to project initiatives. Remember to adjust the timeline when the work plan changes.

In addition to developing a timeline with defined milestones for each grant objective, managers should consider these common time management strategies:

- Develop a "to do" list daily and monthly; group things by priority not due dates.
- Use a daily/weekly planner to log appointments, classes, and meetings, or use an electronic calendar such as a Microsoft Outlook® calendar with integrated reminders for meetings and to help organize project due dates.
- Develop a monthly chart to aid in long-term planning. Group similar tasks together.
- Arrange regular times each day for handling repetitive tasks associated with the job, such as reading emails, making follow-up telephone calls, setting up meetings, discussing routine matters with colleagues, etc.
- Immediately provide clarification for any tasks poorly defined or carried out.
- When running a meeting, make sure it starts and ends on time.
- Do not postpone unpleasant tasks, they rarely get better with time.
- Finish the main task of the day prior to going home.

Promoting Activities and Accomplishments

Communicating the need for and goals of the EMSC program in your state is essential. Every individual with whom you come in contact is a potential advocate for children and their unique needs. By educating those unfamiliar with EMSC and enhancing the knowledge of those who are vaguely familiar with EMSC you are gathering the much needed support that is essential for system change in your state.

Listed below are several best practices from other states to help enhance your communication strategy. Remember, any product or presentation created and disseminated using SP grant funding, must acknowledge the fedearl EMSC Program using the following HRSA acknowledgement:

"This project is supported by the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Emergency Medical Services for Children (EMSC)

State Partnership grant program, Grant No. XXXXX for $xxx,xxx. This information or content and conclusions are those of the author and should not be construed as the offical position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

State EMSC Fact Sheet. A state-specific fact sheet that includes details about children and emergency care in your state, grant priorities, initiatives, and successes can be an important communication tool for state EMSC programs. Fact sheets have been found helpful as state managers and others meet with department heads and organizations to gather support for EMSC in states. It is best if the fact sheet can be limited to one page though it can be double sided; and it is critical that it contain the EMSC manager's contact information for further questions and /or follow-up (see Sample State Fact Sheet).

Fact sheets typically:

- acknowledge linkage to the federal EMSC Program;
- address the specific emergency care needs of the children in the state, integrating assessment data when available;
- describe the present state emergency care system, gaps for children, and state EMSC program plans as defined in the grant for addressing the gaps;
- provide a brief listing of previous state EMSC success stories or grant achievements; and
- identify valued state program partnerships.

State EMSC Newsletter or Listserv. Many states have found a state EMSC newsletter or listserv to be an effective tool for disseminating program information. A state newsletter/listserv can be sent to emergency health care professionals on a regular basis to share a program's accomplishments and information on upcoming activities. This communication strategy can lead to additional support for the important work you do.

Key content for EMSC newsletters may include:

- information about major initiatives;
- updates on performance measures;
- upcoming Advisory Committee meetings and proposed agenda;
- dates of regional meetings (if appropriate);
- professional organization highlights from Advisory Committee representatives;
- pediatric emergency education course scheduled in your state;
- federal EMSC Program news (reprint information from the national newsletter *EMSC QuickNews*);
- updates on national pediatric emergency care initiatives (e.g. the development of EMS education standards);
- special recognition day information, such as EMSC Day, EMS Week, orTrauma Week;
- contact information for the EMSC office and EMSC manager; and
- names and contact information for EMSC Advisory Board members;

Today, it is easy and cost effective to prepare and distribute a newsletter electronically. Common programs such as Microsoft Word or Publisher include newsletter "templates" that already have a design laid out; you only have to add content. An electronic newsletter allows you to convey important EMSC program information to a large audience. A newsletter is also an effective way to direct readers to your website. Note, convert the newsletter to a PDF before distributing so that it is easily viewable by all.

State EMSC Website. Many state EMSC programs have developed websites where others can go to obtain program information. Content included on these websites often includes:

- program mission;
- national and state EMSC program information;
- contact information for your state;
- Advisory Committee member names and contact information;
- Advisory Committee meeting minutes;
- updates on performance measures progress;
- important information regarding pediatric practice issues related to emergency care professionals;
- pediatric educational programs, including electronic education programs;
- calendar of EMSC events;
- funding opportunities for EMS and other professionals; and
- resource documents or links to important EMSC materials.

Social Media. Social media outlets have become major formats for communicating with large and diverse audiences within the state and nationally. Platforms such as Facebook and Twitter have revolutionized the way many states communicate with their stakeholders. In 2012, NEDARC and the EMSC NRC published Using Social Media Professionally to Promote EMSC: Social Media Guidelines and Best Practices for EMSC Grantees. This guide is designed to assist and provide information to EMSC grantees on the requirements for planning, design, and best practices for participating and engaging on the social networking sites Facebook and Twitter.

State Results Page on Pediatric Readiness Website. Another tool available for SP program managers is the State Results page on the Pediatric Readiness website. This page provides a summary of the state's Pediatric Readiness Assessment data along with any other information that the manager wishes to share with stakeholders, such as new Pediatric Readiness resources, state quality improvement initiatives, or meeting notifications. To add or update your State Results page, contact the EMSC NRC.

State News Section of EMSC QuickNews.
Each issue of EMSC QuickNews, the official biweekly newsletter of the federal EMSC Program, includes a "State and Territory Updates" section for disseminating state news nationally and

to share with other grantees. Should a state have news to share with their peers in other states, please send this information to the EMSC NRC.

Section VI: Public Policy: A Guide on the Legislative Process

About Congress

The House of Representatives and the Senate
The U.S. Congress was established by the Constitution as one of the three co-equal branches of the U.S. government. This legislative body is divided into two chambers: the House of Representatives, often referred to as the House, and the Senate. There are 435 voting members of the House, who are called Representatives or Congressmen and Congresswomen, and 100 voting members of the Senate, who are called Senators. Additionally, the House includes six non-voting members representing the District of Columbia and the territories of American Samoa, Guam, Northern Marianas Islands, Puerto Rico, and the U.S. Virgin Islands.

The number of Representatives serving in the House from any given state is determined in proportion to a state's population, with each state apportioned at least one member. Each Representative is elected to serve a specific congressional district, or geographical area, within the state. In less populous states, the district may encompass the entire state. Districts are reapportioned every 10 years in accordance with population findings available from the U.S. Census. For example, after the 2010 Census, it was found that Illinois had lost population; therefore, the number of districts, and thus the number of Representatives, from the state decreased from 19 to 18.

While reapportionment can result in an increase or decrease in the number of Representatives from any given state, the total number of voting members of the House is set by law and cannot change from 435.

The number of Senators per state remains fixed at two, regardless of population. Unlike Representatives, Senators are elected to office to represent an entire state, not a district. Therefore, each Senator from any given state must answer to the entire state's population.

The Legislative Cycle and Terms of Office
As previously noted, the term "Congress" can refer to the House of Representatives and the Senate combined. It can also be defined, however, as the two-year legislative period that occurs between elections.

Members of the House are elected to two-year terms, with each Representative up for reelection every two years, while members of the Senate are elected to six-year terms, with one-third of the Senators up for reelection every two years (see Table 1).

Between these biennial elections, Congress meets for a period of legislative activity. These periods are referred to by number and divided into two, one-year sessions; for example, the 113th Congress convened from January 2013 to December 2014, with the first session lasting

from January 2013 to December 2013 and the second session lasting from January 2014 to December 2014. Bills that are introduced but not passed by Congress (the legislative body) within this two-year time frame must be reintroduced in the following Congress (the two-year legislative period).

Table 1: Terms of Office					
	Voting Members	Non-voting Members	Represent	Term of Office	Electoral Cycle
House of Representatives	435	6	districts, or a defined geographical area, within a state	two-year term	all up for reelection every two years
Senate	100	0	state	six-year term	one-third up for reelection every two years

Just as the legislative cycle changes with each election, so does the composition of Congress. Members of Congress may choose not to run for reelection or may lose to the opposing candidate. As a result, the number of Representatives and Senators affiliated with a specific political party may increase or decrease. The political party with the greatest number of members forms the majority party and the political party with the least number of members forms the minority party. This occurs individually in each chamber of Congress.

The majority party holds the most power in each respective chamber, controlling the legislative agenda, setting the legislative calendar, and filling committee chairmanships and other key leadership positions. The larger the majority is, the greater their ability to enact their agenda. Since both parties often have different priorities, however, if the majority party changes hands after an election, so may Congress' priorities. This may increase or decrease the likelihood that particular legislation will be considered by Congress.

Leadership Positions and Committee Chairs
Several key leadership positions exist within Congress, including Speaker of the House, House Majority Leader, House Minority Leader, Senate Majority Leader, and Senate Minority Leader. These individuals control the legislative agenda, set the legislative calendar, make committee assignments, and appoint committee chairman, among other duties (see Table 2).

According to the U.S. Constitution, the Vice President of the United States functions in the capacity as President of the Senate. While the role of the President of the Senate is primarily ceremonial, with rank and file Senators often presiding over the Senate in the Vice President's place, the Vice President is called upon to cast his or her vote in the event of a tie. Also, in the event that membership in the Senate is split evenly among the political parties, such as with 50 Republican members and 50 Democratic members, the party of the Vice President would be considered the majority party.

Congressional Committees with Jurisdiction over Health Care Issues

House of Representatives
House Committee on Energy and Commerce – This committee, and specifically the Subcommittee on Health, has jurisdiction over public health and quarantine; hospital construction; mental health; biomedical research and development; health information technology, privacy, and cybersecurity; public health insurance (Medicare, Medicaid) and private health insurance; medical malpractice and medical malpractice insurance; the regulation of food, drugs, and cosmetics; drug abuse; the Department of Health and Human Services; the National Institutes of Health; the Centers for Disease Control; Indian Health Service; and all aspects of the above-referenced jurisdiction related to the Department of Homeland Security.

House Committee on Ways and Means – This committee, and specifically the Subcommittee on Health, has jurisdiction over federal programs providing payments for health care, health delivery systems, or health research. Popularly, the committee is known for having jurisdiction over Medicare.

Senate
Senate Committee on Health, Education, Labor, and Pensions – This committee has jurisdiction over matters related to health, biomedical research and development, and public health. The committee has original jurisdiction over some of these matters; however, the Subcommittee on Primary Health and Aging is responsible for community health centers, The Health Resources and Services Act, oral health, health care disparities and Alzheimer's disease.

Senate Committee on Finance – This committee, and specifically the Subcommittee on Health Care, has jurisdiction over health programs under the Social Security Act and health programs financed by a specific tax or trust fund. Popularly, the committee is known for having jurisdiction over Medicare, Medicaid, and the Children's Health Insurance Program.

Congress' agenda is also influenced by the committee system. House and Senate committees are organized by and have jurisdiction over a specific subject area. For example, health care issues are considered by the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor, and Pensions. Committees hold hearings to debate

legislation, review the administration of existing federal programs, and investigate allegations of wrongdoing by public officials, among other responsibilities. Additionally, some committees are further divided into subcommittees that are focused on even more specific issues. For example, the House Committee on Energy and Commerce includes a Subcommittee on Health.

Taking into consideration their own legislative interests as well as the prestige of each committee, Members of Congress bid for committee assignments. Appointments are made by party leadership, with each party allotted a certain number of committee seats based on their status as the majority or minority. Typically, the most senior member of the majority party on the committee is appointed committee chair. Each chairman sets the agenda for his or her committee and decides what issues will be addressed and what bills will be considered. Therefore, as the chairmanship changes hands, so can the committee's priorities. This may increase or decrease the likelihood that particular legislation will be considered by the committee.

Table 2: Leadership Positions				
	Speaker of the House	**Majority Leader**	**Minority Leader**	**Majority and Minority Whip**
House of Representatives	Leader of the House Sets the legislative agenda Presides over the House when in session Influences the selection of committee and subcommittee chairs Leader of the majority party in the House Elected to the position by his or her fellow majority members Second in the line of succession to the Presidency Position created by the Constitution and is unique to the House	Second ranking official of the House Sets the schedule for consideration of legislation Responsible for the majority's legislative strategy Promotes party unity Serves as a spokesperson for the majority Elected to the position by his or her fellow majority members	Leader of the minority party in the House Responsible for the minority's legislative strategy Promotes party unity Serves as a spokesperson for the minority Elected to the position by his or her fellow minority members	Each party has its own whip Keeps tallies on how party members intend to vote on a piece of legislation Rallies party members to pass or defeat a piece of legislation
Senate		Leader of the majority party in the	Leader of the minority party in the	Each party has its own whip

		Speaker of the House	Majority Leader	Minority Leader	Majority and Minority Whip
			Senate Sets the legislative agenda and schedule Responsible for the majority's legislative strategy Promotes party unity Serves as a spokesperson for the majority Elected to the position by his or her fellow majority members	Senate Responsible for the minority's legislative strategy Promotes party unity Serves as a spokesperson for the minority Elected to the position by his or her fellow minority members	Keeps tallies on how party members intend to vote on a piece of legislation Rallies party members to pass or defeat a piece of legislation

Table 2: Leadership Positions

The Public Policy Process

The Federal Legislative Process
Both the House of Representatives and the Senate play an important role in the existence of all federal programs, including the EMSC Program. Congress follows a set procedure when considering federal legislation.

How a Bill Becomes a Law

Step 1 – Legislation is introduced in the House and/or Senate and assigned a number.

- Any Member of Congress may introduce legislation, which is commonly referred to as a "bill."
- Each bill is assigned a number; this numbering system is sequential but distinct for the House and Senate.
- Each bill number is preceded by "H.R." in the House and "S." in the Senate. H.R. stands for House Resolution.

Step 2 – Legislation is referred to the House or Senate committee of jurisdiction.

For example, an education bill would be referred to the committee handling education issues.

- The bill can be further referred to a subcommittee; for example, a bill on elementary education might be referred to a subcommittee on elementary education.

Key Committees Important to the EMSC Program	
Senate – Committee on Health, Education, Labor, and Pensions (HELP), Subcommittee on Primary Care and Aging	House – Committee on Energy and Commerce, Subcommittee on Health

Step 3 – The House or Senate committee of jurisdiction may hold a hearing on the legislation and/or a "markup session," during which it edits the bill. Ultimately, the committee votes on the bill and, if approved, reports it out, or passes it on, for consideration by the entire House or Senate.

- Although most times the public can attend a committee hearing, they cannot make comments at the hearing. Only invited witnesses are allowed to testify on the bill for purposes of information.
- If the committee does not report out the bill before the end of the two-year congressional session, the bill "dies." To receive consideration again, the bill must be reintroduced in the next congressional session, where the process starts over again.

Step 4 – The House or Senate may debate, amend, and vote on the bill. If the bill passed on the floor of the House or Senate, it is referred to the other chamber for consideration. Unless the other chamber already has a similar measure under consideration, the bill is referred to committee.

- If both the House and Senate do not debate and vote on the bill before the end of the two-year session, it dies.
- If the bill is voted down by either chamber of Congress, the bill may die. Sometimes a bill is sent back to committee for further amending, after which it may be considered again on the floor.

Step 5 – If both the House and Senate pass the same bill, it is sent to the President for his signature.
- If the House and Senate pass different versions of the bill, each chamber appoints members to a conference committee. The conference committee works out the differences between the two versions of the bill and drafts a "conference agreement" or compromise version of the bill. The House and Senate then vote on the conference agreement. If it passes both chambers, it is sent to the President for his signature.

Step 6 – The President either signs the bill into law or vetoes the bill.

- If the President vetoes the bill, two-thirds of the House and Senate can vote to override the President's veto. If the veto is overridden, the bill becomes law.

Authorizing Legislation

For a federal program to exist, Congress must approve a program's authorization as well as its annual federal appropriation. Legislative committees are responsible for authorizing legislation related to the agencies and programs under their jurisdiction. The appropriations committees of the House and Senate have jurisdiction over appropriations measures.

Authorizing legislation establishes a federal agency or program and provides guidance regarding the appropriate amount of funds needed to carry out the authorized activities of the agency or program. However, authorizing legislation does not provide the funding itself or guarantee that the program will be funded will be at that level through the federal appropriations process.

Authorizing legislation not only establishes a program in name, but it also delineates in statute what a program is and it is not allowed to do. This is often referred to as a program's scope of authority. For example, the legislation authorizing the EMSC Program defines the entities eligible to receive EMSC grants (states/territories or academic medical centers), the duration of each grant, and how many EMSC grants a state may receive at one time.

Federal programs, including the EMSC Program, are usually authorized to exist for a finite amount of time, typically three to five years, at which time Congress must renew the program's authorization through the legislative process. This is commonly referred to as "reauthorization." Congress can make changes to a program's scope of authority when it is reauthorized.
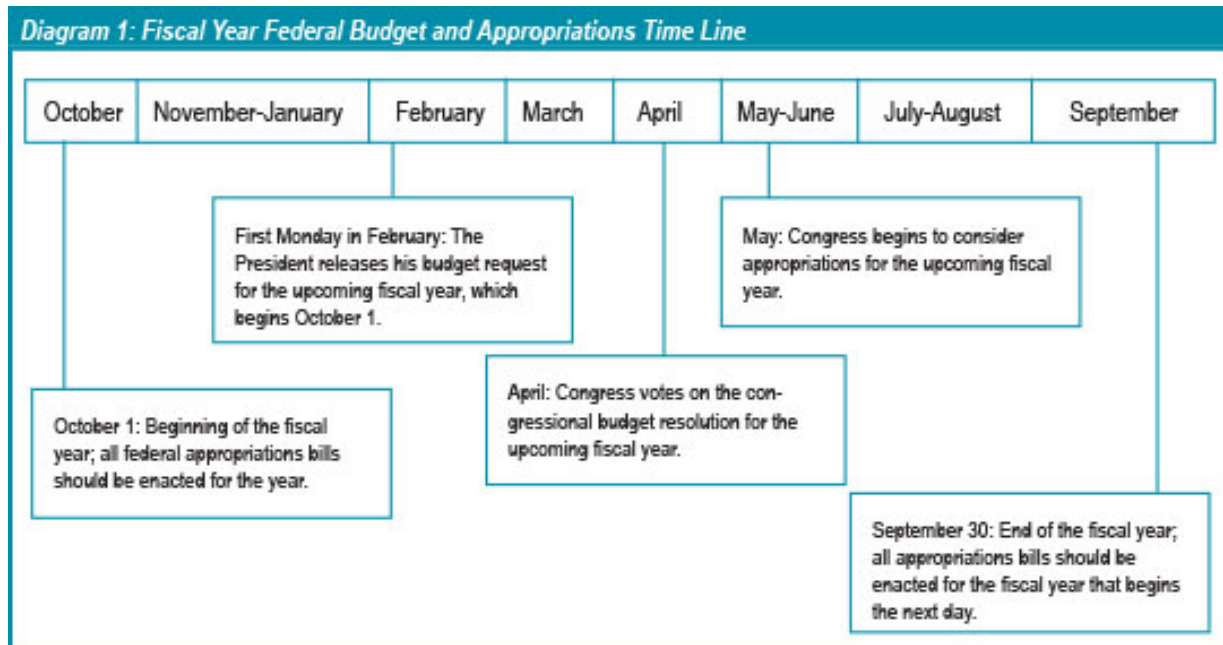
Federal Budget and Appropriations
While authorizing legislation recommends funding levels for federal agencies and programs, it does not provide funding itself. Actual program funding is accomplished through the federal budget and appropriations process.

Congress must complete the budget and appropriations process each federal fiscal year; the federal fiscal year begins on October 1 and ends on September 30 (see Diagram 1). This means that, as a general rule, federal agencies and programs receive funding one year at a time. The amount of funding a program receives can change from year to year, depending upon how much money Congress decides to allocate to it. Based upon federal policy and budget priorities, a program may receive a funding increase, a funding decrease, or level funding.

In theory, federal agencies and programs must be authorized in order to receive an annual appropriation. In practice, however, Congress regularly appropriates funding to programs whose authorization has expired. It may take Congress several years to reauthorize a program

through the legislative process; during this time, Congress often chooses to continue funding the program, despite the fact that its authorization has lapsed.

Diagram 1: Fiscal Year Federal Budget and Appropriations Time Line

The Budget and Appropriations Process

Step 1 – The President's Budget. Each year, on or before the first Monday in February, the President releases his budget request for the upcoming fiscal year (FY). For example, the FY 2016 (October 1, 2015 to September 30, 2016) budget was released in February 2015. The President's budget is a non-binding proposal that sets forth the executive branch's budget priorities and contains detailed funding recommendations for federal agencies and programs for the next fiscal year. It does not have the force of law and does not appropriate funding.

Step 2 – The Congressional Budget Resolution. Each year, Congress drafts a budget resolution, which outlines its financial priorities for the coming fiscal year and sets general spending limits on federal activities. For example, the resolution sets a spending limit for the entire Department of Health and Human Services; it does not recommend specific funding levels for individual programs within the department, such as the EMSC Program. These spending limits serve as a fiscal guideline for the federal appropriations process.

The congressional budget resolution often varies from the President's budget request. Although Congress votes on the budget resolution, typically in April, it is not signed into law by the President.

Step 3 – The Appropriations Process. Appropriations bills provide funding for federal agencies and programs. Each fiscal year, Congress considers approximately 12 appropriations bills; a single appropriations bill may provide funding for multiple agencies and programs (e.g., the

Departments of Labor-Health and Human Services-Education (L-HHS) appropriations bill funds programs within those three departments). The total amount Congress can appropriate to all federal agencies and programs within a given department is defined by the congressional budget resolution's spending limits.

In considering the L-HHS appropriations bill, which includes funding for the EMSC Program, Congress follows a slightly varied legislative process.

- Step A – The L-HHS Subcommittee of the House Appropriations Committee introduces the appropriations bill. The Subcommittee marks-up, or edits, the bill. The Subcommittee then votes on the bill and reports it, or passes it on, to the full House Appropriations Committee. This process is supposed to begin in May.

- Step B – The House Appropriations Committee marks-up, or edits, the bill. The Committee then votes on the bill and reports it to the House of Representatives.

- Step C – The House debates, amends, and votes on the bill. If the bill is passed, it is referred to the Senate, specifically to the L-HHS Subcommittee of the Senate Appropriations Committee. This is supposed to be completed by June.

- Step D – The Senate Subcommittee marks-up, or edits, the bill. The Subcommittee then votes on the bill and reports it to the full Senate Appropriations Committee.

- Step E – The Senate Appropriations Committee marks-up, or edits, the bill. The Committee then votes on the bill and reports it to the Senate.

- Step F – The Senate debates, amends, and votes on the bill.

- Step G – If both the House and Senate pass the same version of the bill, it is sent to the President for his signature.

  If the House and Senate pass different versions of the bill, which is often the case, each chamber appoints members to a conference committee. The conference committee works out the differences between the two versions of the bill and produces a conference agreement (a final, compromise version of the bill). The House and Senate then vote on the conference agreement. If it passes, it is sent to the President for his signature.

- Step H – The President either signs the bill into law, ideally in time for the beginning of the fiscal year on October 1, or he vetoes the bill.

  If the President vetoes the bill, two-thirds of the House and Senate can vote to override the President's veto. If the veto is overridden, the bill becomes law. If the

veto is not overridden, Congress must revise the bill and send the revised version to the President.

Again, appropriations bills are the one legislative item that must be enacted each year. Since federal agencies and programs receive funding one fiscal year at a time, they would shut down if they did not receive an appropriation before the beginning of the next fiscal year.

Many times, however, all of the appropriations bills are not signed into law by the beginning of the fiscal year on October 1. In this situation, Congress may pass a continuing resolution (CR). A CR funds agencies and programs, usually at the previous year's level, for a defined amount of time or until the appropriations bills are enacted.

Tracking Federal Legislation
The public may track federal legislation through the Library of Congress-administered U.S. federal legislation information website. The database houses all bills that have been introduced in the current two-year session of Congress. Legislation introduced in past two-year sessions of Congress can also be found by selecting 'All Legislation' from the left search box's drop down menu.

For example, H.R. 4290, the Wakefield Act, a bill reauthorizing the EMSC Program introduced in the 113th Congress, can be found using the following steps:

1. Access the U.S. federal legislation information website.
2. Select "All Legislation" from the left search box's drop down menu
3. In the right search box, enter:
   • "H.R. 4290" to search by bill number,
   • "Wakefield Act" to search by bill title, or
   • "Emergency Medical Services for Children" to search by key word.
4. When redirected, select the resulting bill that was introduced in the 113th Congress, as indicated.

After selecting the legislation in question, individuals will be redirected to a page with information on the bill's summary and status, including the text of the legislation; the names of any cosponsors; and a list of all Congressional action. This information is updated as the bill passes through the legislative process.

Once initial results are retrieved, the search can be refined by source (e.g., legislation, Congressional Record, or committee report), two-year session of Congress, bill type, status of legislation, subject, chamber, committee, and bill sponsor or cosponsor, among other factors. These options may be selected from the menu boxes on the left hand side of the results page. For more information on conducting searches, select "Tips" to the right of the search boxes on the top of the http://congress.gov homepage.

Note that when looking for the text of any legislation, several versions of the bill may be presented. In order of advancement through the legislative process, these include:

- Introduced – The version of the bill as introduced in either the House or the Senate.
- Reported – The version of the bill as considered and passed by the committee to which it was referred.
- Engrossed – The version of the bill as debated and passed by either the House or the Senate.
- Referred – The version of the bill as referred to the House or Senate after passage by the other chamber.
- Enrolled – The version of the bill as passed in identical form by both the House and Senate and sent to the President for his signature.

Be sure to choose the correct version. When in doubt, select the most recent version, which is usually the last one listed.

The Federal Regulatory Process

Complementing the federal legislative process is the federal regulatory process. Congress sometimes passes laws that purposefully lack detail, leaving it to the various executive branch agencies to issue rules and regulations defining how the laws are to be implemented. For example, Congress may pass a law giving the Department of Health and Human Services broad authority to improve vision care for newborns; the Department then drafts specific initiatives to improve such care.

Executive agencies publish proposed regulations in the *Federal Register* and allow for a public comment period. At the end of that period, an agency will consider the comments and publish a final regulation on the issue. Note that Congress can overturn a regulation through the legislative process within 60 days of it being made final.

The State Legislative and Regulatory Process

EMSC State Partnership grantees are required to meet several federal performance measures. Measure 80 requires that EMSC priorities be integrated into state mandate (e.g., state statute, regulation, or other policy). Having a basic understanding of the state legislative and regulatory process is the first step towards successfully meeting this measure.

State governments function similarly to the federal government, operating with legislative, executive, and judicial branches; the former two are most important in supporting the state's EMSC Program. The activities of these branches are regulated by a state constitution and therefore differ from state to state. While general information on state legislative and executive branches is outlined below, consider speaking with a state department chief or the department's legal counsel or an academic institution chief or institution's legal counsel for more information on a state's specific legislative and regulatory processes.

State Legislative Branch

All states but one have legislatures that are bicameral, or that consist of two chambers: the House of Representatives, sometimes referred to as the House of Delegates or the Assembly, and the Senate. Legislators may be called Representatives, Delegates, Assemblymen and Assemblywoman, or Senators. Only Nebraska's legislature is unicameral, consisting of one chamber with all members referred to as Senators.

States follow a legislative process very similar to that of the federal government. Legislators introduce bills, which are then referred to and considered by a relevant committee. After committee approval, both legislative chambers must consider the bill. If both chambers pass the same version of the bill, it is presented to the Governor.

Most state legislatures' websites include a tool that allows the public to track state legislation. To locate a state legislature's website, search for 'name of state' and 'legislature,' 'House,' 'Assembly,' or 'Senate.' Note that if searching by 'name of state' and 'legislature', the result may be the homepage for the House, the Senate, or both.

On the homepage, find the menu option or search tool titled "legislation," "bill search," "bill lookup," "bill finder," or something similar. Some sites allow searches for legislation by year, bill name, bill number, or keyword. Keep in mind that a website for a state House may only store information on legislation introduced in that chamber; the opposite may hold true for a state Senate website. Therefore, in order to track legislation introduced in the both the House and the Senate, search for, find, and visit the websites for both chambers.

State Executive Branch
The executive branch is run by a Governor, who, as the chief executive officer of the state government, oversees numerous agencies, commissions, and boards. As with the federal system, state legislation is approved or vetoed by the Governor.

The executive branch also oversees the state regulatory process. As with the federal legislature, state legislatures sometimes pass laws that are purposefully lacking in detail, leaving it to the state's various executive branch agencies to come up with the specifics of the law through rules and regulations. For example, a state legislature may pass a law giving the state's Department of Health broad authority to improve vision care for newborns; the department then drafts specific initiatives to improve such care.

Executive agencies publish proposed regulations in a public document, sometimes called a register or administrative bulletin, and allow for a public comment period. (To locate an online version of this document, search for "name of state" and "administrative register," "government register," or "administrative bulletin.") At the end of this period, an agency will consider the comments and publish a final regulation on the issue. Note that state legislatures may be able to overturn a regulation through the legislative process.

Influencing The Public Policy Process

Prohibition on Lobbying with Federal Grant Dollars
To lobby is to seek to influence the introduction, passage, amendment, or defeat of legislation. Keep in mind that federal law prohibits federal grantees, including EMSC grantees, from using their grant dollars to lobby legislators. Using grant dollars means a grantee cannot lobby during work hours; identify him/herself as acting, writing, or speaking on behalf of the grant program when lobbying on personal or non-EMSC funded work time; or use resources and supplies (e.g., a computer or telephone) paid for solely with grant dollars to assist with lobbying activities that occur on personal or non-EMSC funded time.

Two main types of lobbying, both of which are prohibited under the law, include:

Direct Lobbying	Grassroots Lobbying
Direct lobbying is any attempt to influence legislators in the introduction, passage, amending, or defeat of legislation through personal contact. Direct lobbying activities may include written correspondence with, telephone calls to, or a face-to-face meeting with a legislator or the legislator's employee. Other examples of direct lobbying include providing testimony on legislation before a committee or subcommittee and preparing a written report or fact sheet that includes an opinion in support of or against legislation.	Grassroots lobbying is any attempt to encourage the general public to influence legislators in the introduction, passage, amending, or defeat of legislation.

For more information, see Attachment B, Section 25 of Office of Management and Budget Circular No. A-122.

Acceptable Communication with Policymakers
While it is imperative that EMSC grantees follow these rules, they are not meant to bar participation in the public policy process. EMSC grantees may communicate with legislators by following the general guidelines provided below. Keep in mind that grantees may be further limited by rules established by their employer. Be sure to understand the employer's limitations and adhere to their guidelines for lobbying activities.

Educating and Informing versus Lobbying

Grantees can participate in the legislative process during EMSC-paid work hours by educating and informing their legislators. When educating and informing, grantees are not expressing a

view about legislation and are not asking a legislator to introduce, support, or oppose legislation. Instead, grantees are strictly providing factual information on a particular topic. Examples of educating and informing include:

- providing factual information on a particular topic to help policymakers or the general public form an independent opinion about the topic;
- providing factual testimony or technical advice and assistance to a committee or subcommittee, when invited to do so; and
- communicating with government officials for purposes other than influencing legislation, such as commenting on regulations.

IMPORTANT: Before conducting activities designed to educate and inform, grantees should check with their employer to be sure they do not have limitations on such activities.

Grantees Whose Salaries are Paid in Part by non-EMSC Program Funds

Grantees who work full-time but whose salaries are paid in part by their employer may be able to lobby during their non-EMSC working hours. For example, if 20 percent of a grantee's salary is paid for by a medical center, then 20 percent of that person's work time may be used to lobby for the center. A grantee must identify him/herself as an employee of the medical center when conducting these activities; do not identify yourself as acting, writing, or speaking on behalf of the grant or use resources solely paid for with grant dollars to assist with lobbying activities (e.g., a computer or telephone).

IMPORTANT: The institution paying part of a grantee's salary may have its own rules regarding allowable lobbying activities. It is important to check what limitations exist before engaging in such activities.

Lobbying as a Private Citizen

A grantee may lobby on any legislation on his/her own time as a private citizen as long as he/she does not use federal grant resources. Again, be sure to keep the following in mind:

- Do not identify yourself as acting, writing, or speaking on behalf of an EMSC grant.
- Do not use state EMSC program letterhead or your employee email account when writing to legislators.
- Do not write, e-mail, or call during EMSC-paid work hours.
- Do not use employees of the grant during paid work time to prepare lobbying materials.
- Do not use any resources or supplies paid for solely with grant dollars (e.g., a computer or telephone).

Lobbying as a Member of a Professional Organization

If a grantee is a member of a professional or other interest-oriented organization -- such as the Emergency Nurses Association, the National Association of EMTs, or Family Voices – he/she may be able to lobby on any legislation representing him/herself as a member of that organization. Before doing so, check with the organization to ensure the activities comply with their own priorities and practices. Remember, EMSC grantees must lobby on their own time in that group's name, not the grant's name or with grant resources.

Identifying Federal Legislators
To effectively communicate with federal legislators, know who they are.

Identifying Representatives	Identifying Senators
1. Go to the "Find Your Representative" page on the U.S. House of Representatives website.	1. Go to the "Senators" page on the U.S. Senate website.
2. Enter your zip code in the search box and click on 'Find Your Rep by Zip'	2. From the "Choose a State" drop down menu, select a state to be redirected to a page that lists the names of both senators, as well as the address and phone number of their Washington, DC, offices. Link to each Senator's website by clicking on their respective names.
3. A page that includes the name of the Representative, as well as the addresses, phone numbers, and fax numbers for his or her offices will be displayed. Link to the Representative's website by clicking on his or her name.	

Note: If the name of the Representative is already known, access his or her website directly by visiting the U.S. House of Representatives website, and choosing his or her name from the "Representatives' Web sites" drown down menu. Locate his or her contact information in the appropriate section on his or her website.

Those without internet access should be able to identify their legislators by searching the government section of the phone book or consulting one of many congressional directories, which can be found at a local library. Another option is to contact the U.S. Capitol Switchboard at (202) 224-3121; operators should be able to help identify legislators and will transfer calls to a legislator's office.

Legislators maintain a Washington, DC, office and one or more offices within their districts or states. When discussing federal legislative issues with Senators and Representatives, contact their Washington, DC, offices. District offices generally assist constituents having problems with federal agencies, such as a lost Social Security check or delays in obtaining a visa, and handle community outreach activities, such as town hall meetings or visits to local businesses.

Being an Informed Constituent
One of the greatest benefits of communicating with legislators is the opportunity to build mutually beneficial, professional relationships with them and their staff. First, however, grantees must earn their respect and trust as an informed constituent. This is easily accomplished by conducting a little research prior to the visit, telephone call, email, or letter.

Knowing the background and legislative interests of a Member of Congress is of critical importance, especially for an in-person meeting, as it will help determine if the legislator has a personal or professional interest in a particular issue. Each legislator's website will likely contain press releases, lists of bills sponsored or cosponsored, committee and caucus assignments, and other information that will reveal their legislative stance. For example, if a Representative serves on the House Energy and Commerce Committee, which has jurisdiction over EMSC, it would increase their stake in the Program. If he or she is a member of the Congressional Children's Health Caucus or introduced legislation related to children's health that would indicate he or she may be sympathetic to the issue of EMSC.

Biographical or other personal information posted on his or her website can be just as telling. In terms of EMSC, he or she may be a board member at a local children's hospital; be a physician, nurse, or other health care professional by training; or may reveal some other piece of personal information that indicates where his or her interests lie.

It is also important to understand where Congress and others stand on the issue in which you are interested. Research whether or not legislation has been introduced on the topic; if so, know whether or not the legislator has cosponsored the bill and where the bill is in the legislative process. Learn which groups or influential individuals support or oppose the issue and why. If there is something you do not know, do not be afraid to admit it, but be sure to follow-up with the information.

IMPORTANT: Remember that grantees may only provide factual information on a particular topic. They may not express a view about legislation or ask a legislator to introduce, support, or oppose legislation.

Communicating with legislators for the first time can be a daunting task. Keep in mind, however, that for the most part legislators are generalists, meaning they know a little about a lot of issues. They rely upon others to provide them with the specifics on any given topic. When it comes to pediatric emergency medical care, a grantee, a practicing health care professional, or a family member of a child who uses the EMS system, is the expert. Talk

about the difference EMSC has made in the state, to patients, or in the family. This will help you gain the legislator's respect and trust in you as an informed constituent.

Types of Communication
The easiest means of communicating with a legislator is by telephone, email, and writing letters; however, scheduling an in-person meeting can have the greatest impact. Each of these options is discussed below.

Telephone Calls

Telephone calls are an efficient way of sharing information related to a particular issue. When calling, ask to speak to the legislator or the staff member who handles health care issues. More than likely grantees will be asked to leave a message with whomever answers the phone.

Keep the message brief and specific, and if calling about particular legislation, mention the bill number or title. Provide a personal perspective; do not simply read talking points or from a "script." Members of Congress and their staff are more likely to provide a thoughtful response to a thoughtful message.

When calling, identify yourself as a constituent, as Members of Congress tend to respond only to those they represent. If speaking to the legislator or to the staff member who handles health care issues, be sure to thank him or her for his or her time and consider following up with a thank you email or letter. Consider sending the legislator or staff member additional information, if appropriate.

Letters versus Electronic Mail

Legislators receive a large amount of mail. All mail sent to the U.S. Congress is irradiated, leading to a delay in delivery. Therefore, unless it is absolutely necessary, email is the preferred communication vehicle.

Although emails or letters are less personal than a telephone call or in-person meeting, they can be very influential if they are thoughtful and well written. Remember to keep the message clear and concise, and try not to address more than one issue per letter or email. As with telephone calls, if writing about particular legislation, be sure to mention the bill number or title. Finally, close the letter/email by thanking the legislator for his or her attention.

Sometimes organizations will circulate a form letter or email on a given subject where the sender simply fills in the name of his/her legislator in the salutation and signs his/her name. Avoid using these templates if at all possible,. Either write a separate letter or email or edit the template to include personal points of view. Legislators will appreciate letters or emails that share personal thoughts and experience.

When addressing a letter or email, be respectful of the office the legislator holds and use the proper salutation and address (see Table 3). In return, the sender should provide his or her name and contact information so that the legislator may return the correspondence. Note that many legislators respond only to correspondence from their constituents, or those living in their state or legislative district.

Table 3: Addressing Federal Legislators	
Representatives	**Senators**
The Honorable _____ United States House of Representatives Washington, DC 20510 Dear Representative _____:	The Honorable _____ United States Senate Washington, DC 20515 Dear Senator _____:

In-Person Meeting

A personal meeting with a legislator is perhaps the most effective way to convey a message. If a legislator is unavailable, ask to meet with the staff member responsible for health care issues. Do not underestimate the importance of a meeting with a legislative aide. While they are often young, they are usually intelligent, motivated, and capable. They conduct research, draft legislation, write speeches, and brief officials on a regular basis. In short, legislators rely upon them when making policy decisions.

As previously mentioned, being an informed constituent is critical to the success of a meeting. When speaking to a legislator or his or her aide, be clear and concise. Most in-person meetings are short, no longer than15 minutes, be sure you are prepared to convey your message and leave time for discussion within that timeframe. Be prepared to answer questions. If you are unable to answer a specific question, do not be afraid to admit it, but be sure to follow-up with the information.

In the case of EMSC, mention how the federal grant has benefited pediatric emergency medical care within the legislator's state. Thank the legislator for his support of the Program in general and your work in particular, if applicable.

In addition, prepare an information kit to leave with the legislator. This could include, but not be limited to, fact sheets, national and local statistics, and articles. Be sure to include a business card or contact information. Legislators and their staff have busy schedules and often take many meetings throughout the day; leaving materials will help ensure that your concerns are not forgotten.

Working with a Group

To increase the impact of a message, consider visiting the policymaker as part of a group. In the case of EMSC, state advisory committee members may be willing, and able, to assist in these efforts and will add additional viewpoints. Group members with a wide breadth of backgrounds and experience provide a more complete picture of the issue and a more accurate representation of the number and types of individuals with a stake in EMSC (see "Suggested Group Members for a Legislative Visit"). For example, the skills and experience of a physician or nurse can help accurately emphasize the clinical importance of EMSC while a family representative can speak very personally of the benefit of improved pediatric emergency care. Such personal stories often are more compelling than facts and figures.

Suggested Group Members for A Legislative Visit

- State chapter of the American Academy of Pediatric or physician with pediatric training;
- State chapter of the American College of Emergency Physicians or an emergency physician;
- State chapter of Emergency Nurses Association or nurse with emergency pediatric experience;
- State chapter of the Society of Trauma Nurses or a nurse with trauma experience;
- Emergency medical technician (EMT) or paramedic, possibly a member of the National Association of EMTs;
- State or local ambulance association representative;
- State or local coalition of Safe Kids USA or injury prevention specialist;
- School nurse;
- Parent teacher association representative;
- Hospital association and local or State children's hospital representative;
- Individual or association with expertise in pediatric disaster preparedness;
- All EMSC grant recipients within the State – State Partnership Principal Investigator, Grant Manager, and Family Representative; Targeted Issues Principal Investigator, if applicable; PECARN members, if applicable;
- State EMS agency representatives, including the EMS medical director, EMS administrator, trauma manager, and EMS training representative; and
- Public safety representatives, including highway safety representative, police representative, and fire-based EMS representative.

Tips and Tactics For Educating and Informing Legislators

General Tips

- Do not assume that the legislator or aide is familiar with EMSC activities. Remember, you are the expert.
- Keep the message short and simple.
- Always be respectful and courteous, even if the legislator's actions run contrary to personal belief.

Tips for Telephone Calls, Emails, and Letters

Make sure your name and address are clearly written in the email or letter.
Make sure to provide your name and contact information on the telephone call.
Ask for a response in which the legislator's position or action is stated.

Tips for In-Person Meetings

- Schedule an appointment with the legislator regarding EMSC grant activities. If the legislator is not available, request an appointment with the staff member responsible for health care issues. Most of the information that a legislator relies on comes from his/her staff, therefore it is important to convince the aide to see things your way.
- Before a visit, research the legislator (e.g., party affiliation, committee assignments, legislative interests, personal or professional affiliations).
- Prepare a fact sheet or compile other information on EMSC grant activities to leave with the legislator or aide.
- Be prompt – a few minutes early, if possible.
- Do not assume that the legislator or aide is familiar with EMSC activities. Discuss the value of the state's EMSC program, its accomplishments to date, and the difference the program has made in the state's system of care for children. The basic message is that EMSC grant activities are improving the health and well-being of all children by addressing the special needs of children.
- Plan what will be said in advance, keeping the message simple, direct, and brief.
- Prepare a condensed version of key points in case the meeting time gets cut short.
- If visiting with a legislator as a group, designate a chief spokesperson and an order of speaking. Ensure that all members of the group have a role. Plan in advance what each person will say to ensure consistency and avoid repetition.
- Lead with a personal story; tell the legislator or aide what EMSC means to you, your family, and your community.
- Listen carefully to the legislator's comments and questions.
- Take brief notes on any questions that went unanswered for future follow up.
- Ask for a response in which the legislator's position or action is stated.
- After the visit, write a thank you note, and follow-up with requested information.

Best Practices On Public Policy

Perhaps the best way to understand the public policy process is to engage in it. Listed below are two examples from EMSC grantees on affecting policy change.

Washington, DC EMSC State Partnership Grant Manager
Cynthiana Lightfoot, NREMT-P is the EMSC State Partnership Grant project manager for Washington, DC. She formerly served as the District's EMSC family representative. DC EMSC, as it is known, has had the privilege of testifying before the DC City Council on prioritizing pediatric needs in emergency care. In addition, Ms. Lightfoot has been invited to testify before the council regarding Automated External Defibrillators (AEDs) and car booster seat safety. While testifying before legislators can be a daunting experience, Ms. Lightfoot has learned a few rules that can make the experience seamless and rewarding. These rules include:

EMSC grantees must learn "the rules" of advocacy. If a grantee's salary is paid for entirely by a federal grant, he/she will only be able to testify as a content expert when invited to do so by a legislative committee, council, or other legislative body. A content expert is someone who simply shares his or her knowledge on a particular issue. They cannot speak in support of or against a specific piece of legislation. Family representatives, EMSC advisory committee members, and others whose salary is not paid for by grant dollars may be able to take a stand on a legislative issue. These individuals should be used to supplement or enhance testimony.

To become a content expert first form a relationship with your policymakers. In DC, Ms. Lightfoot made appointments with city council members and/or their staff and educated them about her issues of interest. In the states, grantees should identify the legislators who serve on the committees that have jurisdiction over their issues of interest. An initial meeting with a legislator can be as simple as introducing yourself, thanking the legislator for his or her service, and informing them about your issue. Continue to contact your legislator on a regular basis; following up on any outstanding issues from your initial meeting, providing him or her with information on your issue or updates on your activities, or thanking him or her for supporting children's issues. Over time a mutually beneficial relationship will be established.

Working with a coalition can increase the impact of your testimony. When working on car booster seat safety, Ms. Lightfoot met with Safe Kids USA and other injury prevention groups, the DC Department of Transportation, and Children's National Medical Center to determine a plan to advance the issue. Whether a member of a professional (e.g., a physicians or nurses association), consumer (e.g., Family Voices or the PTA), or injury prevention organization (e.g., Safe Kids USA), or volunteer at a local school or hospital, these groups can provide grantees with an introduction to their legislators and help them prepare their testimony.

When preparing testimony, know the maximum length of time allowed to testify. At both the federal and state level, this can be as short as three to five minutes. Given the potential time constraints, it is imperative to prepare a concise statement, focusing on three or four main points. When testifying on AEDs, for example, Ms. Lightfoot focused on the public health outcome of the use of AEDs as well as the legislative and fiscal outcomes of the council passing legislation related to defibrillators. To supplement her oral testimony, she also prepares written testimony that is submitted to the council and entered into the record. Since written testimony is usually longer in length than oral testimony, use it to expand upon the points in the oral statement.

Challenges

- Legislators do not always have a sufficient understanding of children's needs and priorities.
- Working with a group can be beneficial, but make sure members of the group do not lose focus and prioritize their individual needs above those of the group.

Lessons Learned

- Content experts must always be learning. Do not rely on your current level of expertise. Do your homework and your research.
- Make sure that the legislator that is presenting your issue or bill at a legislative hearing has the information needed to understand the issue. Consider writing a brief introduction for him or her that explains both the issue and any related legislation.
- Review any budget concerns and know if the legislation has any fiscal impact. In short, know your numbers and be prepared to discuss this aspect.
- After a bill you have supported is introduced in the legislature or brought up for a committee or council hearing, thank everyone involved and be present for the hearing, even if you are not testifying.
- Aim to secure as many legislators in support of your issue or bill as possible. Do not rely on one champion.
- Testifying on an issue is only part of the process. To truly impact change, be involved from before legislation is introduced until after it becomes law.

While testifying before legislators can be a daunting experience, Ms. Lightfoot would like to share a few rules she has learned that can make the experience seamless and rewarding.

Advertise your expertise. Even if your salary is paid for entirely by a federal grant, you can still take part in the public policy process. Make it known that you are available to serve as a content expert. A content expert is someone who simply shares his or her knowledge on a particular issue. Content experts cannot speak in support of or against a specific piece of legislation. In DC, Ms. Lightfoot made appointments with city council members and/or their staff and educated them about her issues of interest. It wasn't long after that she was invited by a legislative committee to serve as a content expert.

Make use of family representatives, EMSC advisory committee members, and others whose salary is not paid for by grant dollars. They may be able to take a stand on a legislative issue; supplementing or enhancing a grantee's testimony.

Work with a coalition to further your legislative pursuits. When working on car booster seat safety, Ms. Lightfoot met with Safe Kids USA and other injury prevention groups, the DC Department of Transportation, and Children's National Medical Center to determine a plan to advance the issue. Whether you are a member of a professional (e.g., a physicians or nurses association), consumer (e.g., Family Voices or the PTA), or injury prevention organization (e.g., Safe Kids USA), or volunteer at a local school or hospital, these groups can introduce you to legislators and help prepare testimony.

Supplement oral testimony with a written statement. At both the federal and state levels, the time allotted for your testimony can be as short as three to five minutes. Given the potential time constraints, Ms. Lightfoot found that it is imperative to prepare a concise statement,

focusing on three or four main points. To supplement her oral testimony, she also prepares written testimony that is submitted to the council and entered into the record. Since written testimony is usually longer in length than oral testimony, grantees should use it to expand upon the points in your oral statement.

Tennessee EMSC Program Executive Director

As executive director of Tennessee's EMSC program, Rhonda G. Phillippi, RN, BA, has had several years of experience in meeting with her policymakers on issues related to improving pediatric emergency medical care. Until recently, Ms. Phillippi's position was funded 100 percent by federal dollars, so she focused her efforts on educating and informing. She meets with as many members of the Tennessee congressional delegation as possible, both Senators and Representatives, and has found that while meeting with the legislator can be rewarding, meeting with each legislator's health care aide is the most productive use of time.

Even if a grantee is permitted to lobby because his/her position is paid for, in part, by non-Federal dollars, Ms. Phillippi believes that educating and informing legislators can be an invaluable learning experience. Use the time to build relationships with the policymaker and his/her staff. Become a trusted expert before "asking" or "lobbying" them to take a stance on an issue.

Through her efforts, Ms. Phillippi has learned the value of working with a group. She invites the EMSC grant's principal investigator, physicians, and a PTA representative or a consumer, among others, to accompany her on each legislative visit and attempts to recruit these individuals from different parts of the state. Each person brings a varying perspective to the table and may be able to lobby even when a grantee cannot.

In advance of each legislative visit, Ms. Phillippi meets with the group to ensure that everyone understands the issue being discussed, their role in the process, and the desired outcome. She also confers with other organizations that have an interest in EMSC, such as the American Academy of Pediatrics. These organizations may be able to provide additional information related to the cause and help craft a clear, unified message. She emphasizes that the message does not need to be complex; keep points brief.

At each visit, Ms. Phillippi begins by thanking the legislator and his/her staff for taking the time to meet with the group, provides background information on her organization and their interests, explains what the state has been able to accomplish with federal EMSC funding, and talks about the positive difference EMSC has made for children across the country. She stresses that the money the state receives is being put to good use. Ms. Phillippi makes a special point of thanking each policymaker for supporting EMSC. She noted that legislators are often pleasantly surprised by this, as many of them have indicated that few people make an effort simply to thank them.

Oftentimes, the legislator or a staff member will ask a question that Ms. Phillippi and her colleagues can't answer. When this occurs, be forthright and say that you don't have an

answer, but will look into it. As soon as possible, send the requested information in an email, once again taking the opportunity to thank the legislator or staff member for taking the time to meet with the group. Follow up with a telephone call to ensure the office received the information.

Ms. Phillippi's experience in educating and informing has provided her with many chances to help change the pediatric emergency care infrastructure across the United States. Although grantees may have limited time to meet with their policymakers, that time is crucial. Each telephone call, letter, email, and office visit is beneficial to the grantee, to the constituents, to the program and to the issue.

Challenges

- Be proactive, especially when dealing with logistics, such as scheduling appointments.
- A legislator often changes his/her priorities from season to season. Even though he/she may be a champion of an issue one year, the following year may be different. This does not mean the legislator is opposed to the issue, just that it is not a top priority for the current legislative session.

Lessons Learned

- Be flexible. A legislator's schedule often changes. Don't get disappointed if a meeting is cancelled or delayed. Note that not every legislator will agree to an office visit.
- Even if a grantee is new to EMSC, more than likely he/she will know more about the issues being discussed than will the legislators and their staff.
- Most legislative office visits are limited to 5 to 15 minutes. Make those minutes count by planning carefully and using your resources and experts wisely.
- Educating and informing is just as important as "lobbying." It only takes one office visit, one telephone call, or one email to get the process started.

Section VII: An EMSC Toolkit for Family Representatives

For more information about Emergency Medical Services for Children (EMSC) family representatives download Getting Started, Staying Involved: An EMSC Toolkit for Family Representatives.

Section VIII: Tapping into Resources

Section VII: Tapping into Resources

The Program Manager's Toolkit is only one of many resources available to Emergency Medical Services for Children (EMSC) program managers. The Health Resources and Services Administration (HRSA), the EMSC National Resource Center (NRC), and the National EMSC Data Analysis Resource Center (NEDARC) have created a number of resources to assist State Partnership program managers in running their EMSC Program and implementing the performance measures. Additionally, resources from other State Partnership managers, as well as the many partner agencies and organizations are available. Following is list of just a few of the tools program managers can tap into.

HRSA Website. This website has many resources on health- and healthcare- related topics. In addition to detailed information about the *EMSC Program* and each of the funded programs under its umbrella, the HRSA website includes information about adolescent health, autism, Family to Family programs, and cultural competence, just to name a few.

EMSC NRC Website. The EMSC NRC website is a tremendous resource for program managers. The website is updated daily and includes important contact information, a searchable resource library, an EMSC research portal, current and archived news items and important events, educational opportunities, and a section for Family Advisory Network representatives. Additionally, the EMSC NRC website includes 14 *EMSC Toolboxes*, a collection of information and resources on specific topics currently of interest to the EMSC community.

NEDARC Website. The NEDARC website primarily focuses on data systems, data collection, data analysis, and data utilization as it relate to EMSC and the Program's performance measures. Resources on this website include national performance measure data, information on upcoming workshops, and self-guided tutorials and other tools to assist program managers with such topics as statistical analysis, data dissemination, and grant writing.

Pediatric Readiness Website. The pediatric readiness website was created as part of the National Pediatric Readiness Project, an ongoing, multi-organization quality improvement project aimed at providing tools and resources to ensure that all emergency departments are ready to provide quality pediatric emergency care. Included on this site are aggregate national and state assessment results from the 2012-2013 Peds Ready assessment of hospitals, a Readiness Toolkit, and the State Partnership Portal for program managers.

EMSC State and Territory SnapShot Database Tool. This tool allows State Partnership program managers to view and filter results from the 2015 EMSC State Partnership SnapShot Survey. It is designed by and for program managers as a way to share best practices and help identify other states with similar programs or challenges.

NASEMSO PECC Council. The Pediatric Emergency Care Council (PECC) is a council of the National Association of State EMS Officials (NASEMSO). The council formulates recommendations on policies and positions specific to EMSC.

Health Resources on Children in Disasters and Emergencies. This site was created through a partnership between the federal EMSC Program, the Assistant Secretary of Preparedness and Response, the EMSC NRC, and the National Library of Medicine Disaster Information Management Research Center. It is a compendium of resources related to medical and public health issues of children in disasters and emergencies. Links are provided to both journal articles and to other documents and materials that may be useful in preparedness, mitigation, response and recovery activities.

Resources available through the EMSC NRC website include:

Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies. This checklist is intended as a tool to facilitate discussion while supporting hospital administrators and leadership as they incorporate essential pediatric considerations into existing hospital disaster policies.

Pediatric Regionalization of Care Primer: This primer is intended to assist those interested in improving access to pediatric specialty care through an organized sharing of resources, especially in regions where access to pediatric medical treatment is limited due to travel distances or jurisdictional boarders.

Inter Facility Transfer Toolkit: This toolkit provides guidance on specific components associated with interfacility transfer. Not only will it help State Partnership program managers understand interfacility transfer guidelines and agreements, but it also can be used as a resource for hospital leaders to assist them in developing and implementing transfer guidelines and agreements.

PECARN Primer: A Guide for Research Coordinators in the Pediatric Emergency Care Applied Research Network: The purpose of this toolkit is to orient research coordinators to the EMSC Program, the Pediatric Emergency Care Applied Research Network (PECARN), and their role within PECARN. It is divided into the following four sections: Brief History of EMSC and PECARN, Introduction to Research and Resources for the Researcher, Setting Up and Running a PECARN Study, and PECARN's Internal Communication Structure.

Definitions for Frequently Used Terms and Acronyms in EMSC