PRQC Newsletter

The latest news and events from the collaborative

Issue: 5 *February 14, 2019*

National PRQC
Pediatric Readiness Quality Collaborative
Ensuring Emergency Care for All Children

In this Issue

Learning Sessions

11:00 - 12:30 PM CDT

March 3
April 7
April 21

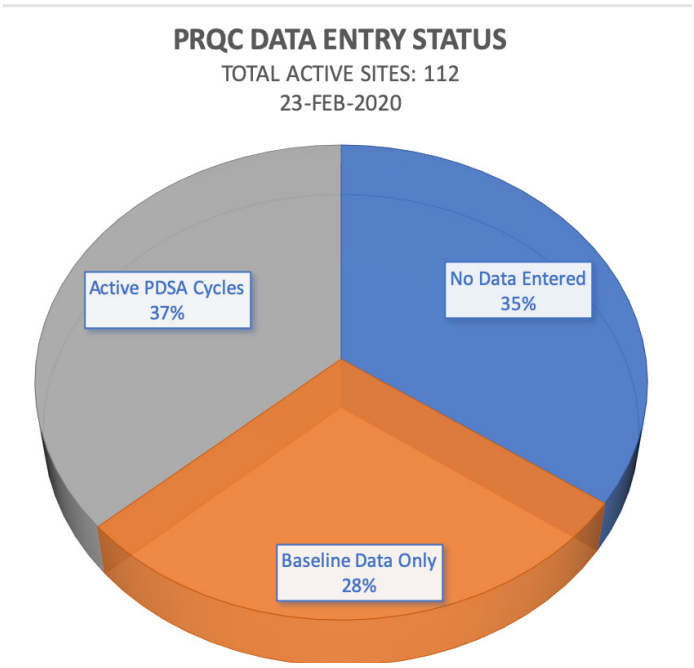
Join in!

Yammer is an online collaboration tool available through Microsoft Office 365. Our PRQC members-only page is open to all to post questions and share resources. Click here to join the conversation!

Follow the EIIC!

Dear PRQC Participants,

Progress, progress, PROGRESS! We want to begin with congratulating you all on the progress you have made. We have been continuously impressed by the successes you all have shared over the past several learning sessions. The improvements in pediatric care that you all have made over a relatively short period of time is extremely impressive. With three months left in the collaborative, there is still plenty of time to move the needle even more.



Along with implementing final change strategies and ensuring all data is entered, we want each of you to reflect on the progress you've made over the past year. What change strategies impacted your institution the most? What were your challenges and how did you overcome these challenges? We have structured the exit survey to be completed during your final site visits (in-person or virtual) to help you reflect on your progress and strategize on how to sustain your progress. You will find more details on this process at the end of the newsletter.

In addition to celebrating your successes and planning for sustainability, this newsletter will detail the remaining asks from the collaborative. This includes team presentations for the March and April Learning Sessions, final site visits and exit survey as well as completion of the Pediatric Readiness Assessment. Once your site has completed these tasks, we will mail you a certificate of recognition signed by HRSA for display in your ED.

Completion of these tasks will conclude your participation in the collaborative. However, we don't want that to mean that the work is done. A significant portion of this newsletter is devoted to sustainability planning. How do you continue the work of pediatric readiness after the formal close of the collaborative? During our January Learning Session, Dr. Sujit Iyer, a pediatric emergency medicine physician from Dell Medical Center Children's Hospital in Austin, TX and team trainer for the Longhorn Kids, shared strategies for keeping leadership engaged and detailed the role that the regional children's hospital can play in supporting pediatric champions in community EDs and offering support such as supplies and training.

Warm regards,

The PRQC Admin. Team

Want More News from the EIIC?

The EMSC Pulse is published about every 4 weeks and includes information on all EMSC activities as well as news and events from our partners. Read the latest issue here.

Best Practices

SUCCESS SIDEBAR

Collaborative

Percent of patients weighed in kilograms only:
Baseline: 62%, Feb 2020: 83%

Percent of patients for whom a full set of vital signs was obtained:
Baseline: 60%, Feb 2020: 76%

Percent of patients with abnormal vital signs identified and included in an early notification process:
Baseline: 31%, Feb 2020: 65%

Individual Sites

Went from 0% of weights being obtained in kilograms only (were obtained in both lbs and kgs) to 72% compliance

Reached 61% total compliance in obtaining a full set of vital signs, up from 35%

Went from 43% to 93% total compliance in obtaining a full set of vital signs in all pediatric patients with an ESI triage level of 1, 2, or 3.

Created go bags for children to minimize stress during a disaster.

Went from 70% to 93% compliant on obtaining a blood pressure on all children.

Collecting a complete set of vital signs went from near 0% to over 90%.

Able to incorporate the weight in kilograms bundle into their hospital QI plan.

The table below summarizes the best practices that have been shared by participating hospitals during the Learning Sessions. Some of these practices, like staff education and leadership support crosscut across all bundles while others, such as blast text messages for disaster notification, are bundle specific. If there is a best practice that you have had success with and do not see listed, please email Meredith at mrodriqu@bcm.edu.

Weight in Kilograms

Scales that lock in kilograms
- Health o Meter® #600KL: Pediatric and Adult Scale; Lockout to Metric Unit
- Cardinal® Detecto Baby Scale Model: Metric-only infant scale

Staff Education
Leadership support

Interfacility Transfer

Transfer packets

Abnormal Vital Signs

Badge buddies
Room charts
Pediatric supply cart
Kanga bands
Supply exchange program with regional center
Staff Education (in-services, 1:1 coaching) Performance emails and reviews
Reverse site visits
Pediatric committees
SBAR tools
Pediatric skills day
Monthly newsletter
Policy changes
Develop a core pediatric nurse internship
Empowering staff to speak up
Leadership Support

Disaster Preparedness

Engaging with a regional coalition and pediatric annex
Communication modes: blast text messages
Downtime charts and quick triage forms
Triage tags
Tracking floaters and tracking forms
Pediatric go-bags to reduce stress
EMR (Epic) disaster integration

Learning Sessions

We acknowledge that it takes a good deal effort to put together a team presentation for the Learning Sessions and we sincerely appreciate the effort you all have put into these presentations. These presentations are essential for the success of the collaborative. Sharing of best practices and collective troubleshooting of problems is what defines a quality improvement collaborative and sets us apart from a didactic-focused implementation project. It is our hope that in these final months you continue to discover best practices and achieve successes that can be shared with the rest of the collaborative. This is why we asked each of you to present again in January and March and why you will present one more time in April. Team assignments for these dates are listed in the table below.

There are important differences in the nature of your presentations between the January/March Learning Sessions and the final presentations in April. The January and March Learning Sessions are purely for the collaborative participants. We want you to share what change strategies you are currently working on, what is working well for you to drive change within your organization and where your challenges occur. These presentations don't have to be especially long or formal.

The final Learning Sessions will be open to a larger audience and we strongly encourage you to invite your hospital leadership. We want you to showcase the totality of the work of you have done. Perhaps summarize all the change strategies you employed and indicate the degree to which each strategy impacted change. We especially want you to highlight your successes. How did this work truly impact your organization? However, this doesn't mean we want you to shy away from your challenges. With senior leadership in attendance, we hope they are taken aback by the progress you all have made and will be interested in hearing how this work can continue beyond the close of the collaborative and what obstacles may need to be overcome.

March 3
Lone Star Kids
Longhorn Kids
MOKAN Rocks
New England EMSC
Oregon Pediatric Readiness
Remoc's Minions
WranglER for Kids

April 7
Eight is Enough
ETCH
Fight or Flight Response Team
LifesavERs
Pediatric Peaches
ReTEE for Kids
WISPR

April 21
Lone Star Kids
Longhorn Kids
MOKAN Rocks
New England EMSC
Oregon Pediatric Readiness
Pediatric Pit Crew
Remoc's Minions
WranglER for Kids

Remaining Requirements

Pediatric Readiness Assessment

The primary aim of the collaborative is that by April 2020, teams will collectively improve their pediatric readiness score by 10 points. As we come to a close, each of you must complete the 2013 Pediatric Readiness Assessment. You will note that the Assessment looks familiar. The Assessment is the SAME one you took when the collaborative began (the 2013 National Pediatric Readiness Assessment). It is extremely important that the same assessment is utilized for comparison to facilitate measuring your ED's pediatric readiness improvements post change strategy implementation. Because of the length of the assessment, it is advised that you print a paper copy of the assessment, complete the paper version by hand and then return to the portal to complete the electronic version using your handwritten copy. Unfortunately, a post assessment report on existing gaps in pediatric readiness at your institution will not be available at the conclusion of this assessment. An updated gap analysis for pediatric readiness will be available upon completion of the new 2020 National Assessment.

Note that the 2020 National Assessment will roll out across the country June 2020. The 2020 assessment will be different in that it will reflect the changes included in the 2018 National Pediatric Emergency Department Readiness Guidelines. We STRONGLY encourage you to take the 2020 assessment to measure your ED's compliance with the updated Pediatric Readiness Guidelines and to receive an updated gap analysis. An updated Pediatric Readiness Toolkit is also under development to provide assistance, guidance and resources to aid 2020 assessment participants in addressing identified gaps in Pediatric Readiness. The new toolkit is slated to be done by roll out of the 2020 National Assessment of Pediatric Readiness.

Hospitals interested in obtaining a copy of their facility's 2013 assessment results should contact Patricia Schmuhl (patricia.schmuhl@hsc.utah.edu) at the National EMSC Data Analysis Resource Center (NEDARC) where the Peds Ready data is held. Please note that individual hospital data is confidential and protected under Institutional Review Board (IRB). Therefore, there is a process by which facilities can obtain their own results, and Ms. Schmuhl can help facilitate this process.

Final site visits and exit survey

Our team trainers conducted site visits at the beginning of the collaborative to establish connections and gain an understanding of your hospital. As the collaborative comes to a close, we're asking each trainer to conduct final site visits. These can be either in-person or virtual. The aim of these site visits is to review progress, celebrate successes and—most importantly—make a plan for sustained improvement. During our January Learning Session, Dr. Iyer suggested several ways in which a local children's hospital can support community hospitals. Please see the sustainability planning section below for a summary.

Once you have taken some time to review your success and establish a sustainability plan with your trainer, we're asking every hospital to complete the exit survey. This will be conducted through RedCap (no login required) and will be approximately XX questions. The goal of this exit survey is to help us understand the elements that you felt helped make the collaborative successful and what we could do better in future collaboratives. Completion of this survey is required to formally close your site's participation in the collaborative.

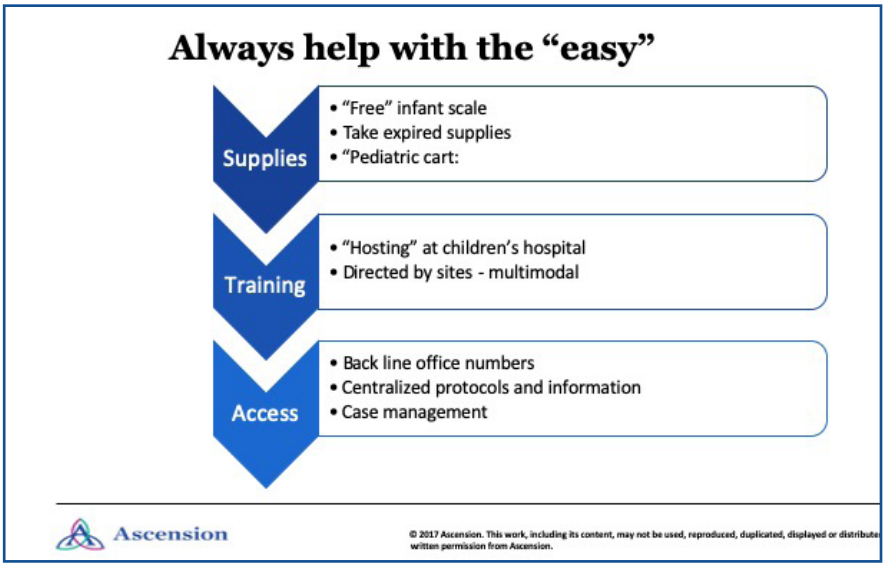
Certificate of Appreciation

In recognition of your efforts in the collaborative, each hospital will receive a certificate of appreciation. This certificate will list individuals at your hospital who contributed to this work (as identified by the exit survey) and will signed by leadership at the Department of Health and Human Services, Health Resources and Services Administration (HRSA). This certificate is meant to be displayed in your ED as a symbol of your hospital's commitment to enhance the quality of care for children. Please note, the certificate of appreciation will not be sent until you have completed both the NPRP Assessment and the Exit Survey.

Sustainability Planning: Engaging Hospital Leadership

Our January 28th Learning Session was kicked off with a presentation from Dr. Sujit Iyer, a pediatric emergency medicine physician at Dell Medical Center Children's Hospital in Austin, TX and team trainer for the Longhorn Kids. Dr. Iyer has been working for several years with community hospitals in the Seton (now Ascension) network on improving pediatric care delivery and offered useful advice on how to engage hospital leadership to sustain improvement efforts. His presentation is summarized below.

Gaining Leadership Support



Over 50% of the 24 million pediatric visits to EDs in the US occur in low or medium volume EDs. Children represent a minority (20-25%) of the overall ED population with <5% requiring tertiary care, therefore, for a given facility, critically ill or injured children are seen relatively infrequently making it a challenge to meet an individual child's immediate needs without an effort to sustain readiness. Furthermore, a lack of financial incentives for the pediatric population (e.g. the Medicare Readmission Reduction program) has resulted in lack of prioritization of pediatric-specific needs. However, a recent study (Ames et al) demonstrated a 4-fold difference in mortality among critically ill and injured children evaluated a low versus high-pediatric ready EDs. Thus, the risk of not maintaining pediatric readiness is high.

Show the Numbers

- Current pediatric volume and potential market share: Hospital leadership is often not fully aware of how many pediatric patients are actually passing through the ED. Relate these numbers (e.g. how many children do you see, what percentage of your volume do they account for, what is their level of acuity) to the number of children who are potentially impacted in your network helps give a sense of the potential market share. You could also add here that improvement in pediatric quality metrics could be marketed to pediatricians to drive referrals and increase the hospital's market share in pediatrics.
- Number of transferred patients: What percentage of your pediatric patient volume is ultimately transferred to another institution? The goal of this work is to keep patients that do not need to be transferred. Can you illustrate for your leadership that some of these transfers are potentially avoidable if staff is equipped with the proper supplies and training?

Social Media Reviews

Hospital leadership is usually attuned to the communities' opinion of the hospital. Finding social media reviews (e.g. Google, Yelp, Facebook), can help give a sense of how many parents might be driving past their hospital in favor of a pediatric urgent care or another facility that specifically markets pediatrics.

Safety Issues / Case Study

Safety is top of mind for almost all hospital executives. Are there specific safety issues or known gaps that could be addressed by pediatric-focused QI work? A case study works really well here to illustrate these gaps. You might also show your hospital's pediatric readiness score to demonstrate your gap areas and how the hospital compares to the national average.

Here is where you can demonstrate the potential for improvement. Dr. Iyer spoke on the call about an

Sustainability Planning: Engaging Hospital Leadership

albuterol administration program for asthma that they implemented in their community EDs. Eventually, the community hospital beat the children's hospital in all metrics. Also important to note, is that when this community hospital lost the pediatric champion, their numbers went back to how it was before.

Staff Feedback

According to Dr. Iyer, hospital leadership in the community hospitals that he worked with were particularly receptive to comments from the staff indicating that they were uncomfortable treating children because they lack the proper equipment, supplies or training. Share feedback from bedside nurses on their comfort level with treating pediatric patients. Are there specific areas for improvement and can they help identify possible solutions?

Financial Concerns

While a more detailed analysis of this concern is currently underway by the EMSC program, it appears that there is very little financial cost to becoming pediatric ready. In fact, the majority of sites have all of the equipment and supplies. Rather, it is about ensuring that processes are working well and that risk of harm to the pediatric population remains low.

Managing Expectations

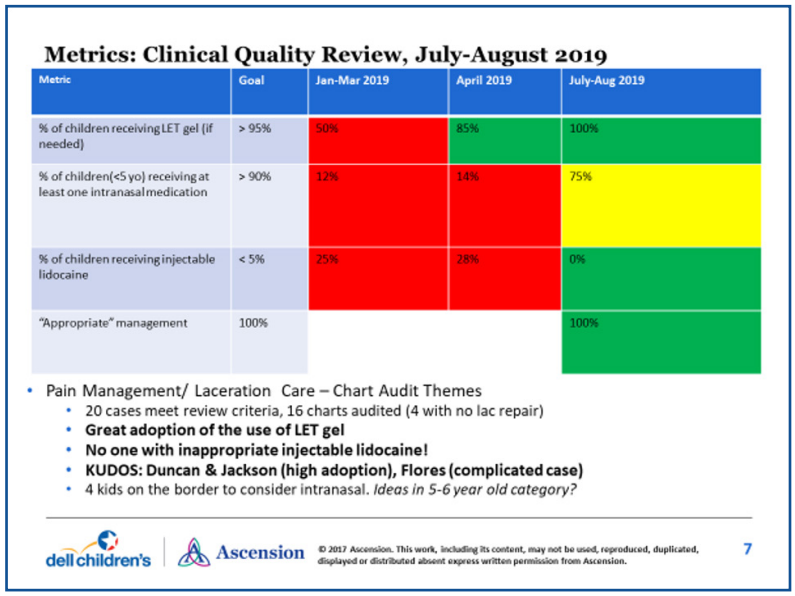
Some CEOs might be concerned that participation on a pediatric readiness program will turn into a requirement to meet certain criteria (similar to a state trauma designation). There are currently 15 states with pediatric readiness recognition programs – nearly all of which are voluntary. The goal of the pediatric readiness effort is to foster and support improvements to increase access to high quality emergency care for children. We recognize that costly verification and designation processes can hinder access when facilities choose not to participate. For that reason, our focus is on providing resources to empower facilities to engage in pediatric readiness efforts.

Keeping Pediatrics on the Radar

Update Leaders Regularly on Performance and Wins

Prioritizing pediatrics when there are so many priorities demanding attention is a challenge. Create a dashboard or report that gets emailed to senior leadership on a regular basis. This report should not only include patient volume, transfer numbers and quality/performance metrics but also a list of barriers and action plans. Below you will see an example of what this report looked like for Dr. Iyer's team.

To avoid this becoming another initiative that comes and goes, it is important to integrate the pediatric champion into the organizational chart and establish a title for the position to create leadership and



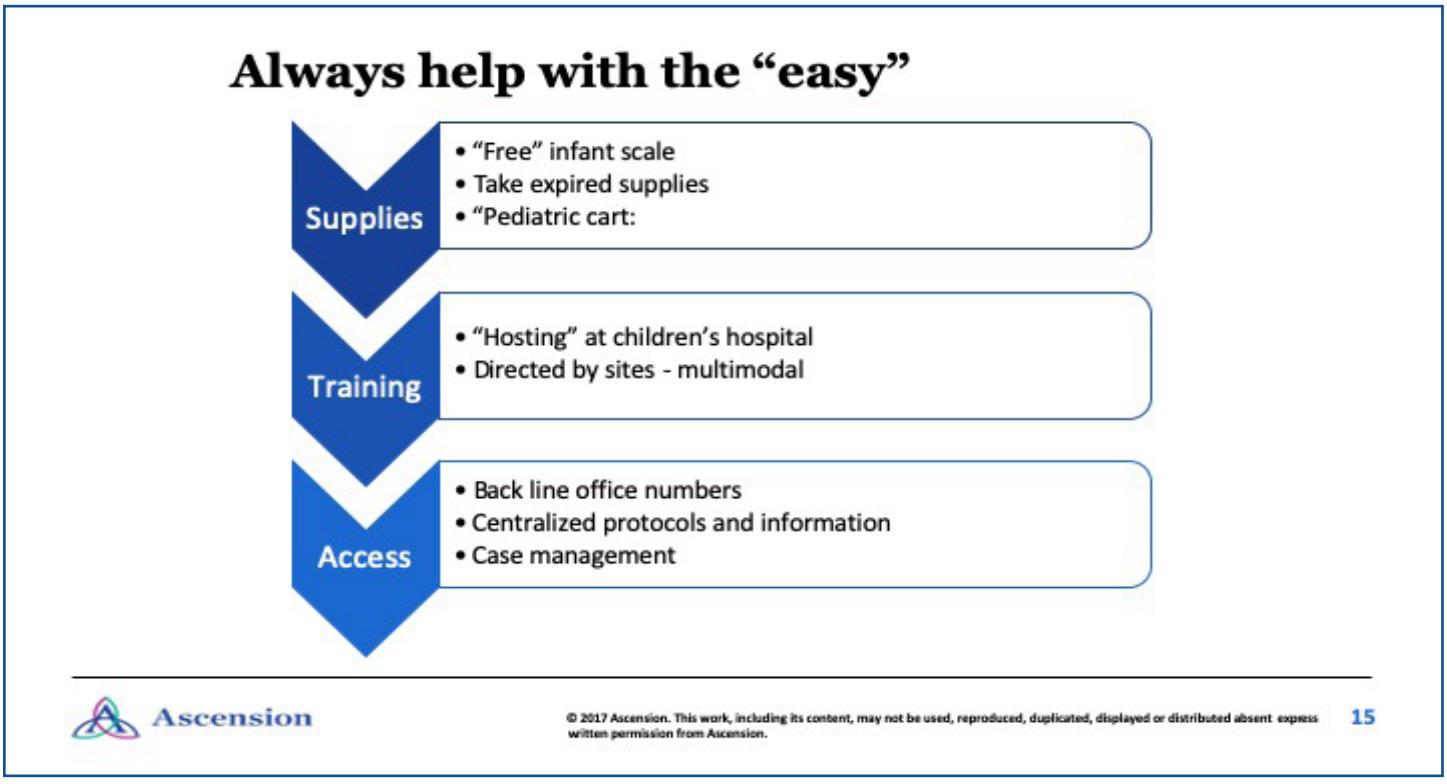
authority for that person. Because turnover has been a major challenge, work to get leadership to commit to maintaining this role when there is turnover.

The Role of Local Children's Hospital

Dr. Iyer and Dell Children's hospital saw it as their duty to invest in the community hospitals in their network. This included not only providing access to resources—see the diagram to the right—but also serving as an advocate for the local pediatric champion to their own managers. This included helping to draft the data summaries and performance reports for hospital leadership.

Dr. Iyer worked with beside nurses at the community hospitals to understand their needs and tailored the content and delivery mode. In many cases, this meant starting small. They began with taking the Pediatric Readiness Assessment and ensuring each site had the proper equipment and training. They then worked with each hospital to establish goals and implementing change. The key to successes was to avoid seeming patronizing. This was truly a partnership with the common goal of improving care for kids.

It is important to note that although Dr. Iyer's work was enabled by being part of a network, however a partnership like this can be established through other channels such as this collaborative or pediatric disaster coalitions and pediatric annexes.



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New In Press:

Trends in Capability of Hospitals to Provide Definitive Acute Care for Children: 2008 to 2016

PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Kenneth A. Michelson, Joel D. Hudgins, Todd W. Lyons, Michael C. Monuteaux, Richard G. Bachur and Jonathan A. Finkelstein

Pediatrics January 2020, 145 (1) e20192203; DOI: https://doi.org/10.1542/peds.2019-2203

In this article, Michelson and colleagues analyzed ED visits by children bewtween 2008 and 2016 and found that over the course of time, most hospitals and particularly those that saw a low-volume of pediatric patients, decreasinly provided definitive pediatric acute care chosing instead to transfer pediatric patients to higher-volume urban centers. The authors--along with a commentatry by PRQC SME Marianne Gausche-Hill, MD--cautioned that as pediatric care becomes concentrated in fewer centers we endanger access to definitive pediatric care, particulary in rural area.

Intalere and National Rural Health Association (NRHA) to Partner

Intalere and NRHA are proud to announce a new partnership recognizing Intalere as the exclusive group purchasing partner of NRHA. Group Purchasing Organizations (GPOs) such as Intalere help health care providers realize savings by aggregating purchasing volume of members and using that leverage to negotiate discounts on behalf of their members with manufacturers, distributors and suppliers. Intalere works with health care providers to save money on virtually everything they buy. Intalere helps rural health care facilities through:

- A customized approach to cost savings utilizing a portfolio of tools, resources and contracting solutions focused on the rural healthcare market. Intalere brings significant savings by analyzing your daily spend and providing you with workable and actionable information to effectively manage costs.
- Expert guidance, resources and unparalleled customer service through supply chain experts, clinical and facility specialists focused on helping rural facilities deal with their unique challenges.
- Linking NRHA membership to best practices for rural health care providers in the areas of financial, clinical and operational efficiencies.

Intalere shares NRHA's mission of improving the health and well-being of rural Americans, and has the expertise and tools to collaborate on customized initiatives to improve margins and enhance health care quality for the entire 21,000 NRHA membership base.

Course: Pediatric Disaster Response and Emergency Preparedness

Upcoming Dates Nationwide

This course prepares students to effectively, appropriately, and safely plan for and respond to a disaster incident involving children, addressing the specific needs of pediatric patients in the event of a community based-incident. Pediatric specific planning considerations include mass sheltering, pediatric-triage, reunification planning and pediatric decontamination considerations. This is not a hands-on technical course, but instead a management resource course for stakeholders like pediatric physicians, emergency managers, emergency planners, and members of public emergency departments like EMS, Fire, Police, Public Health, and Hospitals in field of disaster response and preparedness work. Learn more.