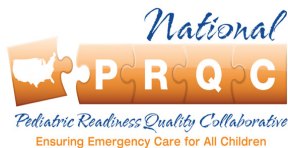


PRQC Newsletter

The latest news and events from the collaborative

Issue: 5

March 16, 2020



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.

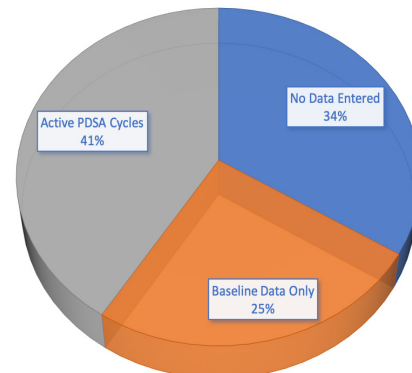
In addition to celebrating your successes and planning for sustainability, this newsletter will detail the remaining asks from the collaborative. This includes the final team presentations, final site visits and exit survey as well as completion of the Pediatric Readiness Assessment. Once your site has 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

PRQC DATA ENTRY STATUS
TOTAL ACTIVE SITES: 112
16-MARCH-2020



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Learning Sessions

11:00 - 1:00 PM CT

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!



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](#).

Final Team Presentations

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.

April 7th 11:00 – 1:00 CT Slide Deadline: April 3rd	April 21th 11:00 – 1:00 CT Slide Deadline: April 17th
Eight is Enough ETCH LifesavERs Pediatric Peaches Pediatric Pit Crew WISPR	Lone Star Kids Longhorn Kids MOKAN Rocks New England EMSC Oregon Pediatric Readiness Remoc’s Minions Wrangler for Kids Fight or Flight Response Team

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 were purely for the collaborative participants. We asked 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 did not 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.

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.

ED personnel who wish to obtain a copy of their facility's assessment results should contact their local State Partnership Manager. To find his or her contact information, please visit our EMSC Grants Database. Select "State Partnership" from the type dropdown as well as your state and check the "current" radio button. Click "View Grant Details" to see the contact information for your state.

Final Site Visits & 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.

ASSESSMENT 2020

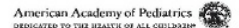
National Pediatric Readiness Project (NPRP)
Ensuring Emergency Care for All Children

GET PEDSREADY

The unique needs of children and their families are often left out of hospital disaster plans. To integrate pediatric disaster preparedness into your ED, download the EMSC Disaster Preparedness Checklist: <https://tinyurl.com/PedsReadyDisasterPreparedness>

Prepare now to be PedsReady before taking the assessment starting in June 2020. pedsready.org

Supported by:



Supported in part by the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Emergency Medical Services for Children (EMSC) Program (cooperative agreement number U54MC20024).

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 at 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

Why should we work on this?



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

Metrics: Clinical Quality Review, July-August 2019

Metric	Goal	Jan-Mar 2019	April 2019	July-Aug 2019
% of children receiving LET gel (if needed)	> 95%	50%	85%	100%
% of children (<5 yo) receiving at least one intranasal medication	> 90%	12%	14%	75%
% of children receiving injectable lidocaine	< 5%	25%	28%	0%
“Appropriate” management	100%			100%

- Pain Management/ Laceration Care – Chart Audit Themes
 - 20 cases meet review criteria, 16 charts audited (4 with no lac repair)
 - **Great adoption of the use of LET gel**
 - **No one with inappropriate injectable lidocaine!**
 - **KUDOS: Duncan & Jackson (high adoption), Flores (complicated case)**
 - 4 kids on the border to consider intranasal. *Ideas in 5-6 year old category?*

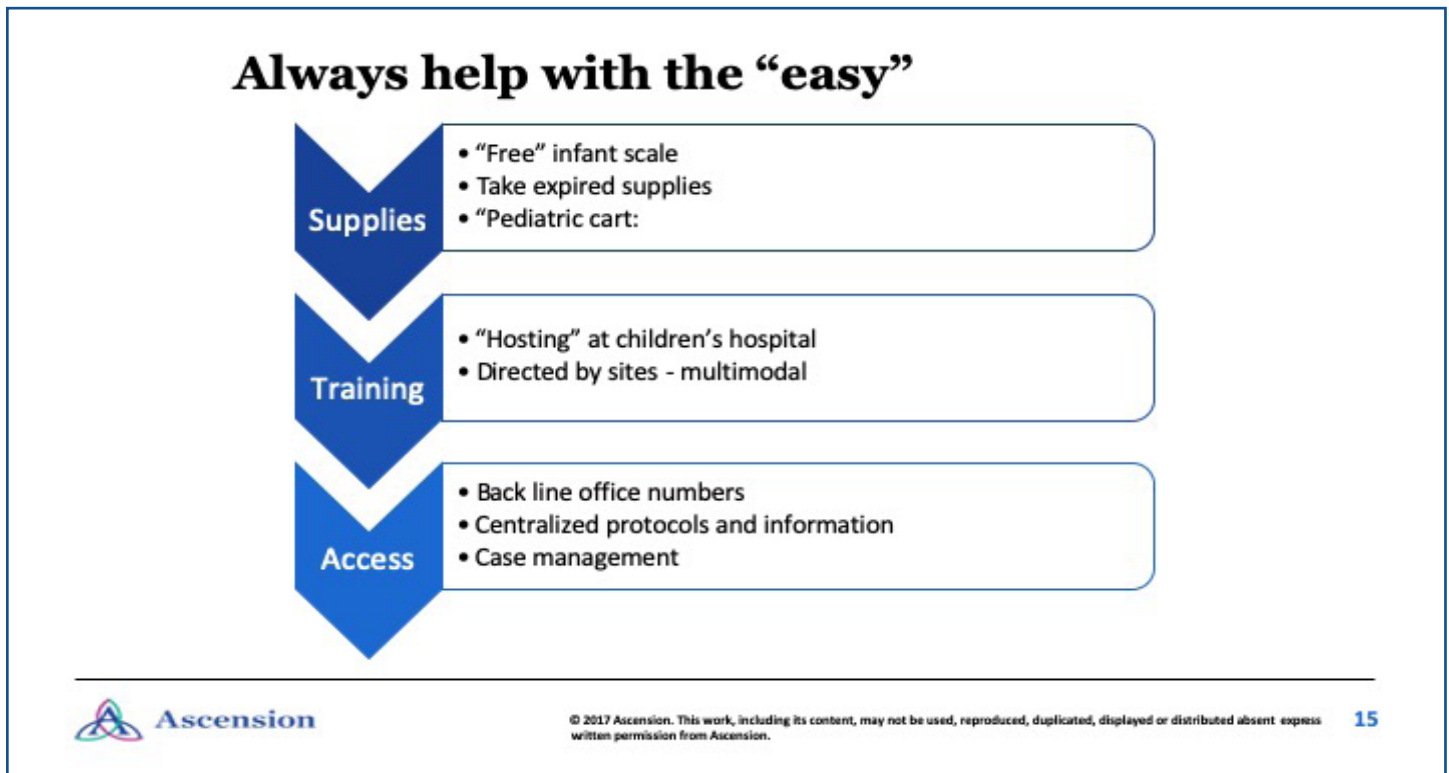
authority for that person. Because turnover has been a major challenge, work to get leadership to commit to maintaining this role when there is turnover.

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 bedside 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.



Sujit Iyer, MD

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Associate Professor, Department of Pediatrics
Associate Program Director, Pediatric Emergency Medicine Fellowship
UT Austin Dell Medical School

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.

<p style="text-align: center;">Weight in Kilograms</p> <p>Scales that lock in kilograms</p> <ul style="list-style-type: none"> • Health o Meter® #600KL: Pediatric and Adult Scale; Lockout to Metric Unit • Cardinal® Detecto Baby Scale Model: Metric-only infant scale <p>Staff Education Leadership support</p>	<p style="text-align: center;">Interfacility Transfer</p> <p>Establish minimum criteria for transfer</p> <p>Interfacility Transfer Toolkit Family Transfer Packets</p> <p>Establishing a process to receive feedback from receiving hospital</p>
<p style="text-align: center;">Abnormal Vital Signs</p> <p>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</p>	<p style="text-align: center;">Disaster Preparedness</p> <p>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</p>

New In Press:**Trends in Capability of Hospitals to Provide Definitive Acute Care for Children: 2008 to 2016**

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 between 2008 and 2016 and found that over the course of time, most hospitals and particularly those that saw a low-volume of pediatric patients, decreasingly provided definitive pediatric acute care choosing instead to transfer pediatric patients to higher-volume urban centers. The authors—[along with a commentary by PRQC SME Marianne Gausche-Hill, MD](#)—cautioned that as pediatric care becomes concentrated in fewer centers we endanger access to definitive pediatric care, particularly in rural areas.

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.](#)