



EMSC PERFORMANCE MEASURES 66D AND 66E: MAKING TRANSFERS WORK FOR CRITICALLY ILL AND INJURED CHILDREN

A major focus of the Emergency Medical Services for Children (EMSC) Program is to ensure that prehospital providers have the equipment, protocols, and training needed to provide appropriate care for children. It is equally important to ensure that emergency departments (ED) that receive children are also adequately prepared.

Unfortunately, many hospitals – particularly those in rural or remote areas – do not have the specialty resources needed to treat critically ill and injured children. This presents a unique challenge to the EMSC Program since eighty-nine percent of ED visits occur in rural or remote facilities.¹

To help ensure that children have access to needed resources, the EMSC Program dedicated two sub-measures under performance measures 66 to the establishment of interfacility transfer agreements and guidelines. Recent evidence shows that the best outcomes for critically ill and injured children are achieved when treated at facilities most prepared to address their needs.² Effective interfacility transfer agreements and guidelines will ensure the timely and appropriate transfer of patients to the appropriate level of emergency care. Without these agreements care might be delayed or might not even occur. Delays potentially result and/or contribute to negative patient outcomes.

EMSC PERFORMANCE MEASURES 66D AND 66E

66D The percentage of hospitals in the state/territory that have written pediatric interfacility transfer guidelines that include the following components to facilitate the transfer:

- A defined process for the initiation of transfer. This process includes the advance identification of groups or conditions of patients to be considered for transport and defines the roles and responsibilities of both referring and referral centers.
- A selection process for determining the appropriate care facility. Does the referring facility have a facility preference for patients with specific diagnosis or needs? Have the referring facilities established transfer agreements with the specialty facilities for specific services that it cannot provide (i.e. burn care, rehabilitation, etc.)?

HOSPITAL VARIABILITY

- Approximately 27 % of all ED visits are by children younger than 19 years of age.³
- Less than 5% of all hospitals in the U.S. are recognized as pediatric or children's hospitals. Eight-nine percent of pediatric emergency visits are seen in non-children's hospital EDs.¹
- Approximately 53% of hospitals admit children but do not have a separate pediatric ward or department.⁴
- Hospitals have a variety of ED configurations with only 4% of non-children's hospitals having a separate area to treat pediatric patients.¹
- Only 10% of hospitals with an ED have a designated pediatric intensive care unit (PICU).²
- More than 15% of hospitals without a pediatric trauma service do not have written pediatric transfer agreements to send patients to another hospital.⁴
- Only 6% of EDs have all of the recommended pediatric equipment and supplies.¹
- Only 26% of EDs have all 13 pediatric policies recommended by The American Academy of Pediatrics/American College of Emergency Physicians' Emergency Department Pediatric Preparedness Guidelines.¹
- Approximately 52% of the hospitals without a PICU have transfer agreements with facilities that do have a PICU.⁴



- A process for selecting the appropriately staffed transport service to match the patient's acuity. Can the patient travel by basic or advance life support ambulance or does the patient need a specialty transfer team or air evacuation?
- A process for the patient transfer that includes the necessary patient preparation (i.e., securing of airways, venous fluid/blood administration, etc.)
- A plan for the transfer of patient information that includes the requested diagnostic test results. Should the information be sent electronically, by fax, or with the patient?
- A plan for the return transfer of the pediatric patient to the referring facility, as appropriate and/or the provision of follow-up communications to the referring facility.

Some facilities have found it advantageous to develop transfer agreements and guidelines as one integrated document. Such a document clearly defines intent of sending and accepting patients between hospitals as well as the steps needed to facilitate expeditious movement of the patient. A transfer checklist that defines responsibilities of each facility can also be an effective tool to ensure that each component of the guidelines is being effectively addressed.

66E

The percentage of hospitals in the state/territory that have written pediatric interfacility transfer agreements.

Hospitals need interfacility transfer agreements (written formalized arrangements between healthcare facilities) in place that specify alternate care sites for those essential resources not readily available for critically ill and injured pediatric patients. Pre-arranged agreements between facilities expedite the movement of patients to needed care available at specialty facilities. Agreements encourage providers to consider the transport of children to specialty care in advance of critical situations – rather than forcing providers to cope with these issues during crisis events. Many facilities will have transfer agreements in place with several facilities, i.e. a children's hospital, a rehabilitation facility, a burn care unit, etc.

Agreements also provide proactive planning to facilitate ease in transport when surge capacity must be increased due to a mass casualty event. Working with a state's Bioterrorism Hospital Preparedness Programs to build upon mutual aide agreements that may already exist may facilitate the establishment of agreements between hospitals. State hospital associations can and often do play an active role in encouraging the establishment of transfer agreements.

¹ Gausche- Hill, Marianne. "Pediatric Preparedness of US Emergency Departments: A 2003 Survey," *Pediatrics*. (2007). *The American Academy of Pediatrics*.

² *Emergency Care for Children, Growing Pains, Institute of Medicine Report (2006), page 86. National Academies Press, Washington, DC.*

³ *Emergency Care for Children, Growing Pains, Institute of Medicine Report (2006), page 15. National Academies Press, Washington, DC.*

⁴ Middleton, K. "Availability of Pediatric Services and Equipment in Emergency Departments: United States, 2002-2003," *Advance Data (2006). U.S. Department of Health and Human Services.*