



EMSC
Emergency Medical
Services for Children

EMSC PLAYBOOK

A Guide for State Partnership Program Managers



Table of Contents

Click on a section header to visit that page.

Why Do We Need to Improve Pediatric Emergency Care?	4
Why Do Children Need Specialized Care?	5
EMSC Overview and Background	6
Understanding EMSC's Four Components	7
The Pivotal Role of the EMSC State Partnership Program Manager	9
Who Is Available to Support Your Efforts?	11
How Does All of This Play into Your Program Manager Role?	13
National EMSC Performance Measures by Program Objective for 2023–2027	13
EIIC State Partnership Advisory Committee	13
What Is EMS?	15
What Are the Components of EMS Systems?	16
Who Regulates EMS Agencies and Personnel?	16
What Are the Types of EMS Clinicians?	17
What Is the Structure of an EMS Agency?	18
What Are Hospital Systems and EDs?	20
What Are the Components of EDs?	21
What Are the Different Levels of ED Clinicians?	21
How Do EMS Agencies and EDs Work Together?	22
What Is Pediatric Readiness?	24
Why Does Pediatric Readiness Matter?	24
Pediatric Readiness in EDs Saves Lives	24
Flagship EMSC Pediatric Readiness Projects	24
Pediatric Readiness and Trauma Centers	25
Pediatric Readiness and Disaster Preparedness	25
Administration and Authorization	28
Eligibility and the Application Process	28
Reporting and Other Requirements	29
Support and Contacts	29

The EMSC Innovation and Improvement Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award (U07MC37471) totaling \$2.74M with 0 percent financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. government. For more information, visit [HRSA.gov](https://www.hrsa.gov).



Welcome!



Welcome to the Emergency Medical Services for Children (EMSC) family! Whether you've recently been hired as a program manager/coordinator for the State Partnership Program or have been in your role for some time, this playbook provides important information about EMSC. You'll learn about EMSC's structure, priorities, and expectations and get a better understanding of the systems and networks you will work with, such as emergency medical services (EMS), hospital/emergency departments (EDs), trauma systems, and disaster management.

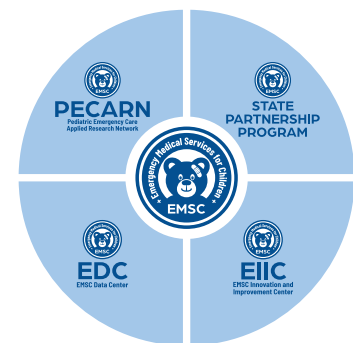
Improving pediatric emergency care is complicated and requires different strategies, approaches, and teams working together.

That's why the EMSC Program can feel complex. There's a lot to unpack, and we're here to help you get started (or help you fill in some blanks). Some managers come into this position without EMS, hospital system, or public health experience, and others arrive without program management experience. We understand that the learning curve is steep, so try not to feel overwhelmed. It will take time for you to digest it all, and we're here to help!

Why Do We Need to Improve Pediatric Emergency Care?

Having their child experience a health crisis is every parent or caregiver's worst nightmare, but 35 million children and families seek out emergency care every year. Even though that's a significant number, most EDs and EMS agencies see children far less often than they see adults. It's even rarer that they see children with a life-threatening illness or injury.

Figure 1: The EMSC Program Arms



As a result, EDs and EMS agencies don't get as much experience with pediatric cases, especially complex ones. And because they have limited—sometimes even strained—resources, they tend to focus on the patients they see more of: adults. As a result, they might not have the specific skills, protocols, equipment, and other components needed to provide high-quality emergency care for children.



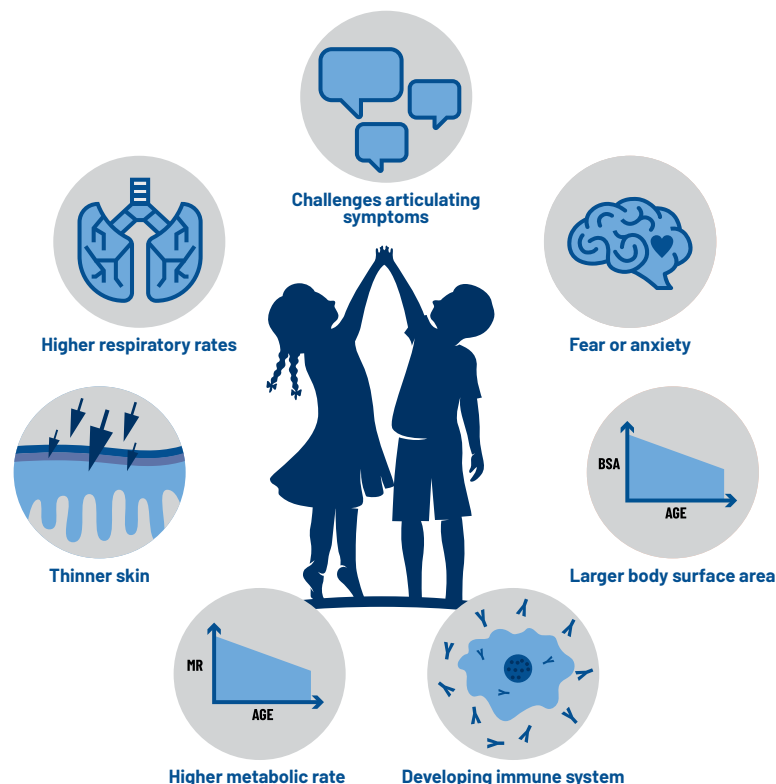
Why Do Children Need Specialized Care?

Children are not simply “tiny adults.” They have unique physiological, emotional, and developmental characteristics that differ from adults. Examples include:

- Physiological differences: larger head in proportion to body size, smaller airway, organs compacted in a smaller space, and differences in heart, respiratory rates, and blood pressure
- Emotional and developmental differences: unable to explain their symptoms like adults can and may be more scared and anxious

These differences make children especially vulnerable in emergencies, so they need pediatric-specific emergency care.

Figure 2: Pediatric Considerations



1. <https://emscdatacenter.org/wp-content/uploads/2023/06/2022-National-EMS-for-Children-Survey-Report.pdf>
2. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807059?resultClick=1>

EMSC Overview and Background

The EMSC Program was established in 1984 after a pediatrician in Hawaii, Dr. Calvin Sia, recognized that the emergency medical care system was not set up to handle the unique needs of children. With support from senators and staff in Connecticut and Utah, Congress passed legislation that established EMSC, which is the only federal program dedicated to children's needs in health emergencies. Learn more about the early history of EMSC in this [short video](#) or the [EMSC timeline](#).

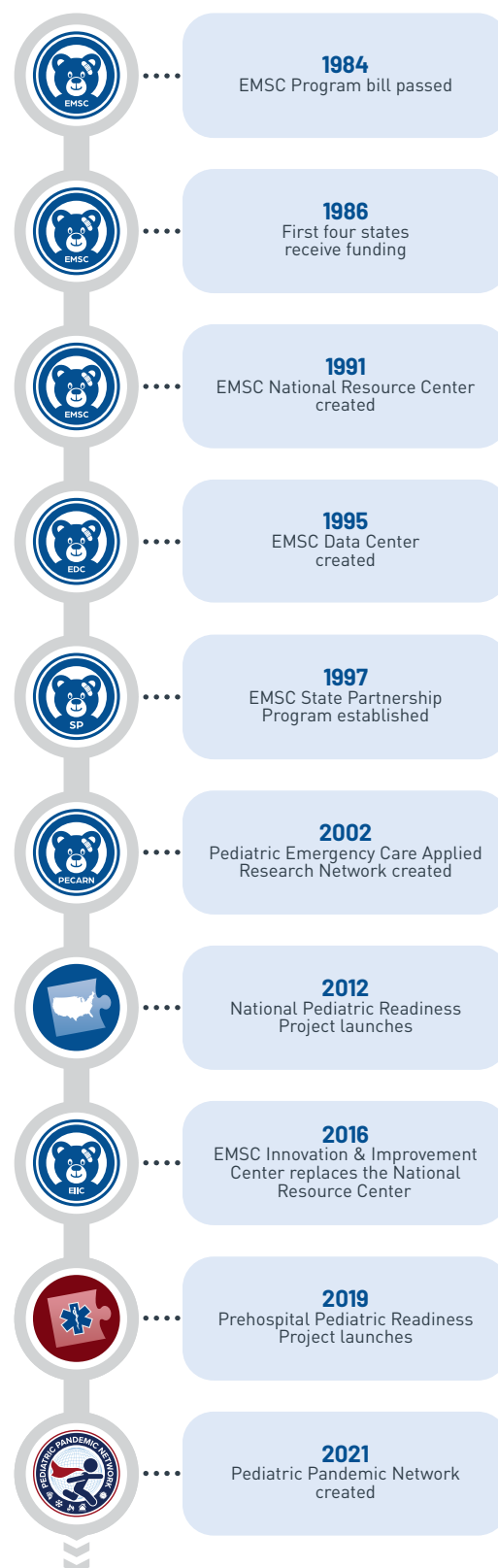
The program is administered through the Health Resources & Services Administration (HRSA), which is part of the U.S. Department of Health and Human Services (HHS), alongside agencies like the Centers for Disease Control and Prevention, the Food and Drug Administration, and the National Institutes of Health. HRSA's programs help the country's most vulnerable patient communities (such as children, pregnant people, rural communities, people with HIV, and transplant patients, among others) get the health care they need.

As part of HRSA's Maternal and Child Health Bureau (MCHB), the EMSC Program works to ensure that all children—no matter where they live—have an emergency care system in their area that provides quality emergency care services. HRSA's MCHB accomplishes this by providing funding to state governments and schools of medicine to work with clinicians, administrators, and other partners to improve pediatric emergency care. While the EMSC Program began by providing a few state grants, today it includes more than 60 grants across four major arms and touches nearly every state, territory, freely associated state, and jurisdiction in the United States (which we call "states" in this playbook).



Learn more about HRSA and MCHB by watching this short video.

Figure 3: EMSC Timeline



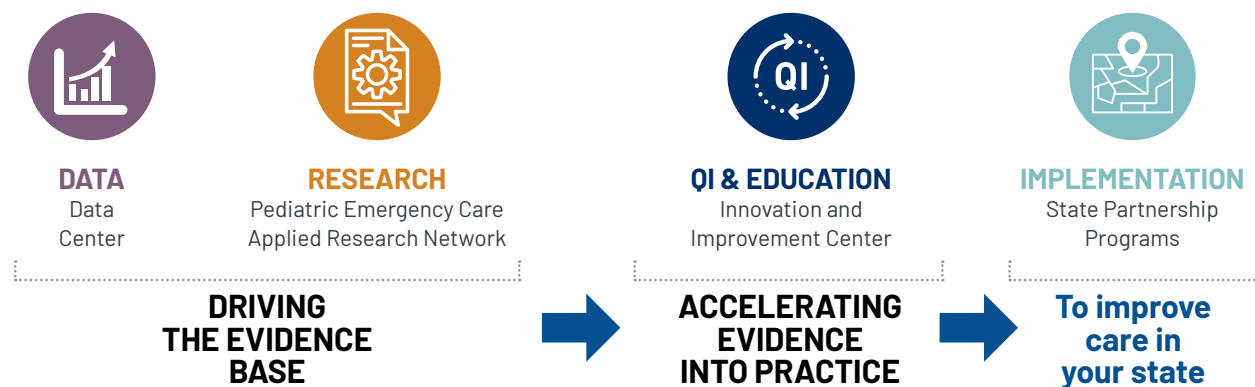
Understanding EMSC's Four Components

The EMSC Program includes the following components or "investments":

- **State Partnership Programs:** focusing on implementation, integration, and infrastructure
- **EMSC Innovation and Improvement Center:** accelerating efforts through quality improvement and education science
- **EMSC Data Center:** creating an evidence base through data collection, analysis, and visualization
- **Pediatric Emergency Care Applied Research Network:** conducting high-quality research to advance clinical knowledge

Each part of the EMSC Program is tackling the challenge of improving pediatric emergency care in a unique and important way. Figure 4 helps explain how the arms work together.

Figure 4: How the EMSC Arms Work Together



This short video explains more about the EMSC resource centers and grants.

Helpful Links

- [HRSA EMSC](#)
- [EMSC Innovation and Improvement Center \(EIIC\)](#)
- [EMSC Data Center \(EDC\)](#)
- [Pediatric Emergency Care Applied Research Network \(PECARN\)](#)
- [State Partnership Programs](#)



State Partnership Program Overview and Background

EMSC State Partnership Program grant funding helps states meet the needs of children within their unique emergency care systems. Programs use strategies that are tailored to their state to achieve the performance measures specified by HRSA MCHB. By developing, implementing, and sharing resources, tools, and other opportunities for emergency clinicians, State Partnership Programs lead the way in improving pediatric patient outcomes.

Introduced in 1997, State Partnership Programs have existed in all states, territories, jurisdictions, and freely associated states. Each program includes a director, manager (you!), and family representative, also known as the Family Advisory Network (FAN) representative. This team works closely with an advisory committee of clinicians, state officials, and other experts to strengthen emergency care systems and achieve performance measures.

These programs vary from state to state in how they are organized, how they operate, and their strategic approach. For example, while most State Partnership Programs are part of their state's EMS office, some are part of a different branch of the state government or an academic institution. Other programs are a combination of the two, meaning that one office or agency holds the grant, and another office or agency manages it (e.g., the state EMS office might receive the grant funds but fund another group to hire the program manager and handle most of the grant requirements).

The Pivotal Role of the EMSC State Partnership Program Manager

The program manager is essential to each State Partnership Program and is often recognized as the leading champion for pediatric emergency care in a state. The key roles and responsibilities of a program manager are as follows:

- Understand and be well versed in current performance measures (described later in this section).
- Coordinate and manage all strategic and operational aspects of the grant while working closely with their project director, FAN representative, and other members of the EMSC Advisory Committee.
- Ensure that the emergency care needs of children in their state are well-integrated throughout the emergency system of care. This is frequently accomplished through strategies such as the development of relationships with EDs and EMS agencies, partnerships with state and local organizations, quality improvement, sharing of educational resources and opportunities.
- Serve as the primary contact to the federal EMSC Program and its two resource centers (the EMSC Innovation and Improvement Center and the EMSC Data Center), ensuring coordination and the flow of information between the federal Program and the state.

We encourage you to review the program manager [Welcome Kit](#), which includes resources you should be familiar with once you are hired, when you reach your three-month mark, and after you've been on the job for six months. Many of the Helpful Links in this Playbook are in the Welcome Kit, but it has other useful resources and recommendations as well.

An effective program manager...

- Is a champion for children and families.
- Maintains a central focus on EMSC performance measures.
- Builds relationships with key partners in their state.
- Engages their state's EMSC Advisory Committee.
- Develops and follows a strategic plan for the program.
- Is a steward of program funding and monitors the budget to ensure resources are used most effectively.
- Puts all available resources to the best use to achieve objectives.
- Communicates with their HRSA EMSC project officer (PO) and the EMSC resource centers regularly.
- Complies with all federal program requests and conditions on time.
- Understands that federal program requests and conditions may evolve as the health care landscape changes.
- Promotes both ED and prehospital Pediatric Readiness initiatives.
- Updates and maintains information in the Contact List Management System (CLMS) to ensure accurate data collection to meet EMSC grant goals.

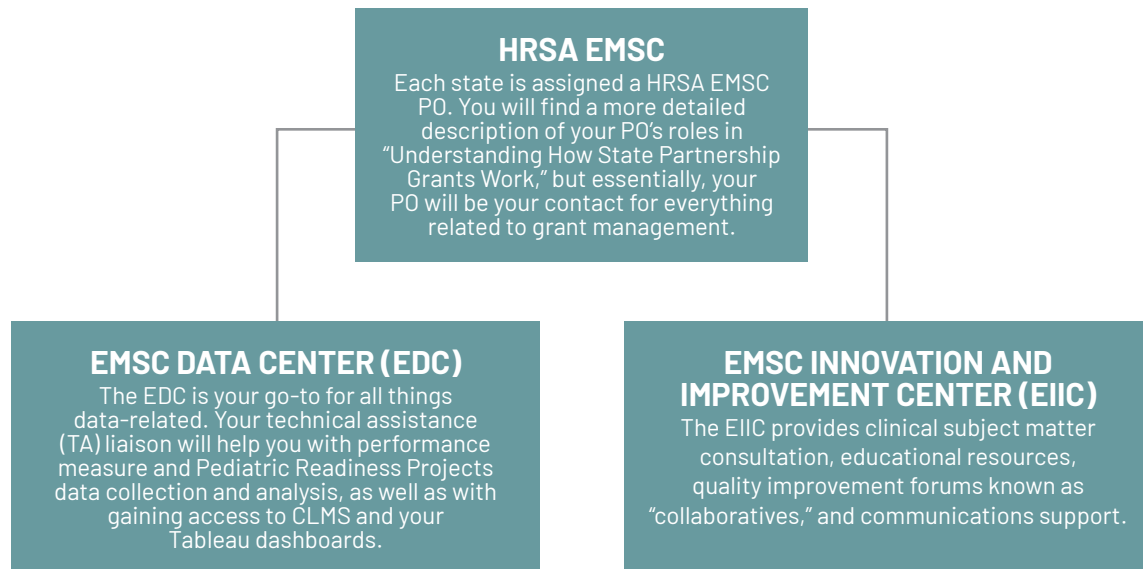
Helpful Links

-  Review the [EMSC Performance Measures 2023 Implementation Manual for State Partnership Grantees](#).
-  Review the [EMSC State Partnership Activities and Tasks Timeline](#).
-  Check out the [EMSC Grants Database](#) to learn more about past grant work in your state.
-  Use the open library of [state-created resources](#) to see what tools and resources other states have developed.
-  Find marketing materials and logos in the [EMSC Branding & Marketing Center](#).
-  Learn how to [build partnerships and collaborations](#) to support your work.
-  Find ways to promote your state's [activities and accomplishments](#).
-  Use the [acronyms reference guide](#) to learn unfamiliar acronyms.
-  If you don't have access to CLMS or Tableau, complete the [Request Active Directory Account](#) form. (The form needs to be filled out by a project director; contact your EDC TA if that's not possible.)
-  Find your list of agencies and hospitals for data collection in the [CLMS](#).
-  Explore data reports from past data collections in [Tableau](#).

Who Is Available to Support Your Efforts?

Figure 5 shows the three entities that can support your work as a program manager.

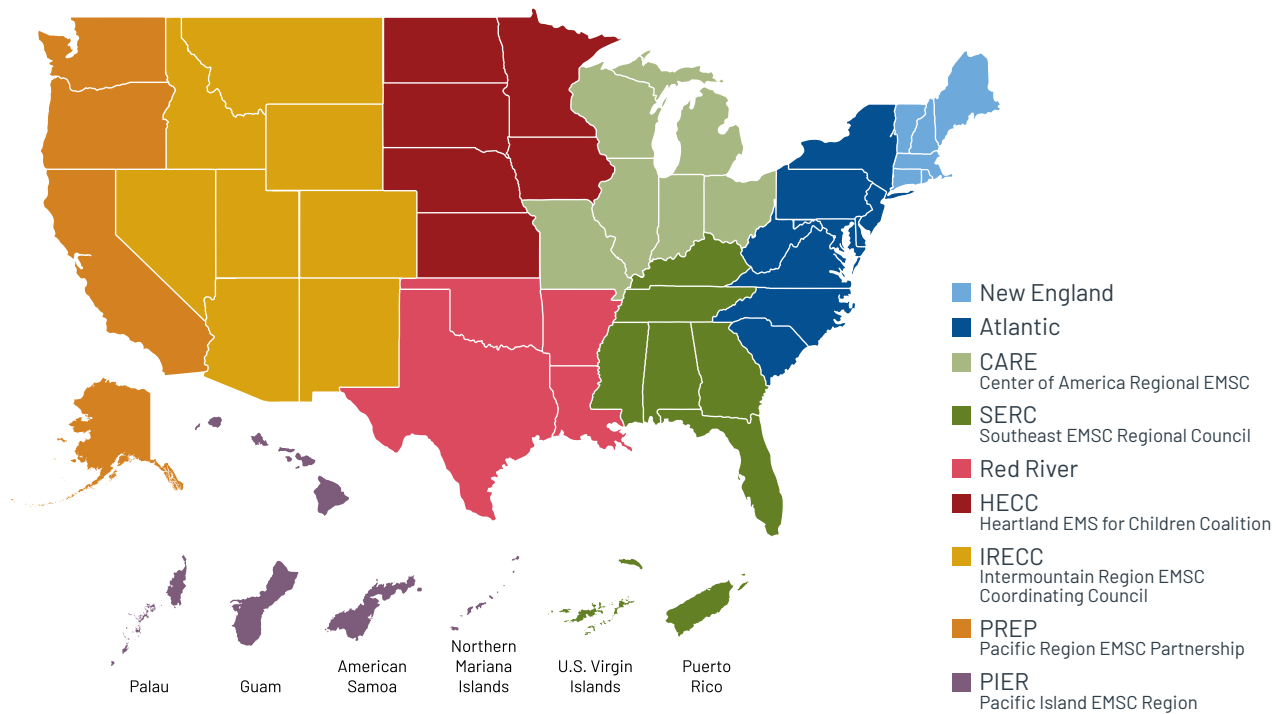
Figure 5: How EMSC Supports Program Managers



Other support opportunities include simply connecting with fellow State Partnership program managers and learning about their work—both successes and challenges. You could start with program managers in your EMSC Region, or if you're looking for help with challenges based on your program location, reach out to managers in similar organizations. Contact information, an EMSC region map, and program locations can be found in the "Helpful Links" box on page 12.

Note on EMSC Regions: While some EMSC State Partnership Regions meet and collaborate on regional projects, such collaboration isn't expected or required. If you're in an active region, you might find it valuable to connect with others in your region to find out if meetings take place.

Figure 6: EMSC Regions



Helpful Links

- 🌐 Locate your PO, EDC TA, and EIIC support staff, including contact information, on the [Technical Support Contacts page](#).
- 🌐 Contact the program managers for other [State Partnership Grants programs](#) for support and advice.
- 🌐 Find your [EMSC Region](#).
- 🌐 Discover where other [EMSC State Partnership Programs are located](#).
- 🌐 Check out this [infographic](#) to find out who to contact with particular questions.
- 🌐 Learn more about the work of the [EDC](#) and [EIIC](#).

How Does All of This Play into Your Program Manager Role?

Though each state does have autonomy, the EMSC State Partnership Program focuses on performance measures as the main objectives and benchmarks for grantees. Performance measures, required by federal law, are the primary goals of the EMSC State Partnership Program and serve as standards of achievement for grantees. The measures ensure consistency, transparency, and accountability as the program progresses toward its goals. Every new grant cycle, HRSA releases new or updated performance measures in a Notice of Funding Opportunity (which is discussed in the “Eligibility and the Application Process” section) and publishes (or updates) a corresponding implementation manual that describes the importance of and expectations and reporting requirements for each measure. Current performance measures center around improving pediatric emergency care in EDs and prehospital settings.

National EMSC Performance Measures by Program Objective for 2023–2027

Table 1 shows the EMSC Performance Measures by program objective for 2023–2027.

Table 1: National EMSC Performance Measures by Program Objective, 2023–2027

PROGRAM OBJECTIVE 1	PROGRAM OBJECTIVE 2	PROGRAM OBJECTIVE 3	PROGRAM PERFORMANCE EVALUATION
Expand the uptake of pediatric readiness in EDs.	Improve pediatric readiness in EMS systems.	Prioritize and advance family partnerships.	Assess program permanence & ensure mandates/statutes are in place.
Four measures focus on: • ED pediatric readiness recognition programs • ED pediatric emergency care coordinators (PECCs) • the need to weigh and record pediatric weight in kilograms • disaster plans	Four measures focus on: • EMS agency pediatric recognition programs, • EMS agency PECCs • pediatric equipment skills checks • disaster plans	One measure focuses on ensuring programs have a Family Representative on their state EMSC Advisory Committee who represents the emergency needs of children.	Two measures focus on: • Permanence of EMSC • Increase integration of EMSC priorities into existing prehospital or hospital statutes/regulations/rules

EIIC State Partnership Advisory Committee

The EIIC provides support to a State Partnership Advisory Committee (SPAC), whose primary purpose is to provide ongoing strategic direction to the EIIC State Partnership support team. SPAC has representation from each EMSC Region (leads and alternates), and ad hoc members from the EDC and FAN. The group meets every other month, and you may hear from your regional lead or alternate with requests for input or feedback on EIIC-related resources and collaboratives. If you have ideas for improvement or resource needs, reach out to your [SPAC representative](#) or [EIIC support specialist](#).

Helpful Links

-  Read about [Current Performance Measures and Resources](#) (including the [Implementation Manual](#)).
-  [Learn more](#) about the development of the EMSC State Partnership Program Performance Measures and past measures.
-  Find your [SPAC representative](#) and learn more about what this group has accomplished.



Understanding Emergency Systems of Care: EMS

While most other medical specialties focus on specific organs or processes (such as cardiology for the heart or obstetrics/gynecology for childbirth, pregnancy, and the female reproductive system), emergency care involves a wide variety of acute illnesses and injuries. This care can include assessing, diagnosing, treating, and managing a patient from the moment he or she is seen at the scene of an incident through hospital admission, discharge, and potentially outpatient care.

The emergency system of care requires a timely and coordinated response that involves a network of teams and entities that manage patients entering the system. An understanding of these systems is essential for your success. The following two sections on EMS and ED care provide an overview of the emergency care systems you will engage with as an EMSC State Partnership program manager.



What Is EMS?

At its core, emergency medical services (EMS) is a coordinated system of care designed to provide urgent medical care and stabilization to individuals experiencing acute medical or traumatic emergencies. This care is typically provided in response to calls to 911. This system—which includes ambulance services, non-transporting EMS and fire-rescue agencies, and helicopters—is also known as prehospital care. EMS clinicians are among the first links in the emergency response system, encompassing a network of trained professionals, resources, and systems working together to benefit both patients and communities. For critically ill or injured patients (like those with blocked airways, cardiac arrest, or severe bleeding), the quick decisions and actions of EMS clinicians can be as crucial to survival as the care provided later at the hospital. These responses can often be the deciding factor between life and death.

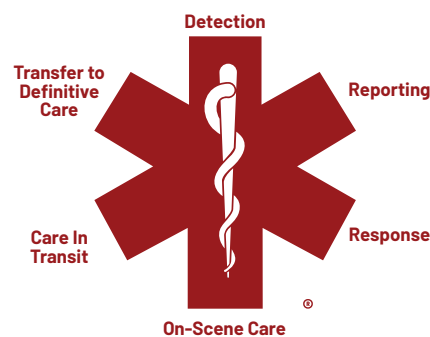


What Are the Components of EMS Systems?

An easily recognizable emblem of EMS is the Star of Life, which symbolizes the six critical components of an EMS system.

1. **Detection.** Early recognition—by the public, the patient, or another public service agency—is key to a patient having the best chance of survival.
2. **Reporting (dispatch).** A call to 911 (or another public safety answering point) activates the emergency response system for those in need of acute medical care. Dispatchers provide instructions to the caller for immediate care and coordinate the deployment of appropriate resources.
3. **Response.** The first-response professionals to arrive on the scene (e.g., police officers, firefighters, and/or EMS) assess the situation and begin interventions. Who arrives first will depend on community needs and resources. While many first-responder agencies provide basic life support (BLS) and do not transport patients (e.g., fire-rescue agencies and quick response units), in rural parts of the country, a BLS agency may be a patient's only option for being transported to their community hospital.
4. **On-scene care.** The EMS clinicians provide life-saving medical interventions and stabilize the patient at the scene. The use of evidence-based and model clinical guidelines is critical. This component could include triaging patients based on the severity of their injuries or illnesses to ensure the appropriate allocation of resources (e.g., during a mass casualty incident).
5. **Care in transit.** Unless patient care protocols indicate that transport is not needed, or a patient refuses transport, the patient will be put into an ambulance (ground or air) staffed with EMS clinicians who provide medical care en route.
6. **Transfer to definitive care.** The patient is transferred to an appropriate health care facility (e.g., emergency department, trauma center, or another specialty care center [pediatric, cardiac, stroke, burn]), where facility staff continue care, further stabilize the patient, and initiate definitive treatment.

Figure 7: Star of Life



EMS doesn't function in isolation; it is an integral part of the broader health care system, collaborating with hospitals; trauma centers; and public health, emergency management, and public safety agencies.

Who Regulates EMS Agencies and Personnel?

Each state has a lead EMS agency with the common objective of protecting the public by setting standards for:

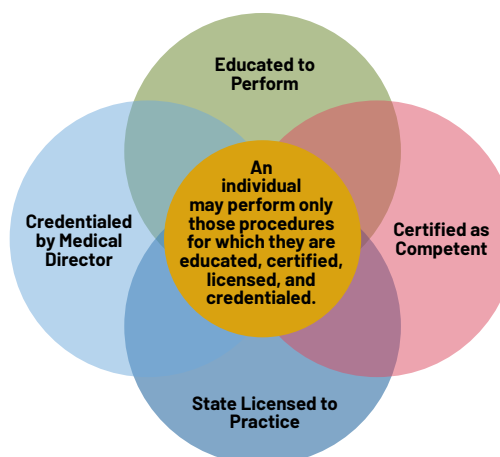
- Ambulance vehicle design,
- Medical equipment and medications, and
- Training of personnel and staffing.

While each state's authority varies, state EMS offices (or bureaus) are generally responsible for the overall planning, coordination, and regulation of the state EMS system. Their responsibilities could include licensing or certifying EMS clinicians, agencies, and ambulances. It is important for you to determine your state's structure and regulatory authority, as this will be essential to your ability to understand how to make progress in the prehospital performance measures (Program Objective 2).

States also have varying requirements for EMS agencies to provide patient care data to both state and national repositories. A subset of the data collected in each electronic patient care record (ePCR) is transmitted to the National EMS Information System (NEMSIS), which is the only national repository used to collect, store, and share EMS patient care data from states and territories. These data are vital for many reasons, including assisting with data-driven decision-making (e.g., improved patient care), research initiatives (e.g., illness trend analysis), and performance improvement (e.g., measuring key performance indicators). EMS patient care data are critical to providing safer, more effective emergency care.

State data submission requirements are included as a federal EMSC Program priority in Performance Evaluation Measure II.

Figure 8: Relationship Among Education, Certification, Licensure, and Credentialing



Adapted from National Highway Traffic Safety Administration (2021). "The relationship among education, certification, licensure, and credentialing."

What Are the Types of EMS Clinicians?

EMS clinicians have different levels of medical capability, each with its own scope of practice and functioning under a specific set of protocols. While the skills of each level vary across states (Figure 8), Table 2 provides a general overview (as outlined in the [National EMS Scope of Practice Model](#)).

Table 2: Types of EMS Clinicians

EMERGENCY MEDICAL RESPONDER (EMR)	EMERGENCY MEDICAL TECHNICIAN (EMT)	ADVANCED EMT	PARAMEDIC
EMRs are trained to begin immediate life-saving care (e.g., CPR, bleeding control, oxygen administration, automated external defibrillator use) while waiting for a higher-level EMS response.	EMTs are trained in the BLS skills necessary to stabilize and transport patients (e.g., airway management and some medication administration). EMTs may assist advanced clinicians with patient management.	Some states recognize an intermediate-level clinician between the EMT and a paramedic. Professionals at this level can use some more advanced airway management techniques, as well as intravenous (IV) therapies, though not as many skills as paramedics have.	Paramedics have the highest level of prehospital training and can perform advanced life support (ALS) interventions. They are trained in administering medications, interpreting electrocardiograms (ECGs), providing advanced airway management, monitoring for cardiac issues, and more.

What Is the Structure of an EMS Agency?

Determinations on how a community provides EMS are decided at the local level, based on resources and needs. EMS agencies are generally defined by what type of service they provide and in what type of organization they are based. Service types include response to 911 calls and interfacility transports. An ambulance service may do one or the other or both. EMS agencies may also respond to 911 calls without transport capability by using vehicles such as fire engines or SUVs. These non-transport EMS agencies are often part of the emergency response in urban areas, as well as in rural areas, where they care for patients until an ambulance arrives from a more distant location.

Here are the **types of organizations** that provide EMS response:

- **Private for-profit:** often provide services via a contract but can operate independently
- **Private nonprofit:** often community- or region-based; can provide services via contract or operate independently
- **Public safety:** owned by a government entity, typically a fire department, and although uncommon, could be a law enforcement agency
- **Fire-based:** can be operated as part of municipal or county government entities
- **Third service:** a stand-alone department within city or county government, operating separately from fire and police
- **Hospital-based:** operated by hospitals or health care systems
- **Public utility:** operating as a public service, similar to water, gas, or electricity

A local EMS agency may be staffed by any combination of the following **types of personnel**:

- **True volunteer:** receives no compensation
- **Compensated volunteer:** receives some form of remuneration, such as a small payment for carrying a pager on call or a stipend for responding to an actual call
- **Part-time worker:** paid hourly wages for part-time work
- **Full-time worker:** receives a standard salary for full-time work

A popular saying in the EMS community is “If you’ve seen one EMS agency, you’ve seen one EMS agency,” which acknowledges the immense variation in the field. Whatever their agency’s specific characteristics, EMS plays a critical role at the front lines of our health care system.





Understanding Emergency Systems of Care: EDs



What Are Hospital Systems and EDs?

A hospital system, also known as a health care system or health system, refers to a network or group of hospitals, clinics, health care clinicians, and sometimes other related facilities that work together to provide coordinated health care services to a particular geographic area or community.

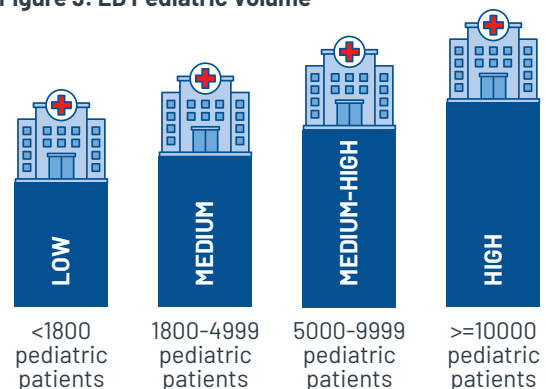
Hospitals can also have different designations or be verified or accredited as specialized centers for various medical needs, including the following:

- **Burn Centers:** verification from the [American Burn Association](#)
- **Critical Access Hospitals (CAH):** **designation** given to eligible rural hospitals by the Centers for Medicare & Medicaid Services
- **Pediatric facilities (children's hospitals):** guidelines and best practices for pediatric hospitals provided by the [Children's Hospital Association](#) (though it is not an accrediting body)
- **ST-Elevation Myocardial Infarction (STEMI):** verification or accreditation from the [American College of Cardiology](#), [the Joint Commission](#), and state or regional health departments
- **Stroke:** verification or accreditation from [the Joint Commission](#), [Det Norske Veritas Healthcare](#), and state or regional health departments
- **Trauma (including centers specializing in pediatric trauma):** verification or accreditation from the [American College of Surgeons Committee on Trauma](#) and state health departments

Often (but not always) located within a hospital system, an ED has as its main objective providing immediate medical care to patients experiencing acute illnesses, injuries, or other urgent medical needs. ED staff assess, stabilize, and treat patients' needs. Typically open 24 hours a day, 7 days a week, EDs provide around-the-clock medical care and cannot deny care for any patient.

As you connect and work with the hospitals in your state, it's important to understand their annual ED pediatric volume. Figure 9 displays a breakdown of the categories of annual pediatric volume. You can find the pediatric volumes for EDs in your state by accessing past National Pediatric Readiness Project (NPRP) assessment scores (contact your [EDC TA liaison](#) if you don't know where to find these). You'll learn more about NPRP in the "Pediatric Readiness" section.

Figure 9: ED Pediatric Volume



What Are the Components of EDs?

- **Triage:** Patients are assessed and evaluated to determine the urgency and/or specialty of care required to meet their medical needs.
- **Diagnostic and treatment capabilities:** EDs have diagnostic equipment and treatment options to assess and manage acute medical conditions, including:
 - **Diagnostic imaging:** X-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI), ultrasounds, and other imaging studies help clinicians diagnose injuries, fractures, internal bleeding, and other conditions.
 - **Laboratory testing:** Blood tests, urine tests, cultures, and other laboratory studies help clinicians diagnose infections, metabolic disorders, and other medical conditions.
- **Admission and discharge:** After treatment in the ED, patients may be admitted to the hospital for further care, transferred to another facility with additional or more specialized resources, or discharged with instructions for follow-up care. Patients requiring hospital admission are typically transferred to an inpatient unit or specialized department.
- **Coordination of care:** Ideally, EDs coordinate care for patients with complex medical needs. This may involve consulting with specialists, arranging transfers to higher-level care facilities, coordinating with social services for vulnerable patients, and ensuring seamless transitions of care between the ED and other health care settings.
- **Education and prevention:** EDs sometimes serve as resources for patient education and illness or injury prevention, especially in rural settings where health care resources can be limited. For example, ED clinicians can provide patients with information on illness or injury in children to help prevent future medical emergencies (e.g., car seat safety, helmet safety, immunizations/vaccinations).

What Are the Different Levels of ED Clinicians?

Table 3 shows the different levels of ED clinicians based on their training and what care they can provide.

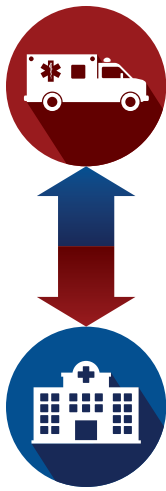
Table 3: Levels of ED Clinicians

PHYSICIANS (MDs or DOs)	ADVANCED PRACTICE PROVIDERS (APP)	NURSES (RNs)	SUPPORT STAFF
Physicians who are certified in emergency medicine or pediatric emergency medicine typically lead the medical care team in the ED.	An APP has advanced clinical training and education and can diagnose and treat medical conditions, often with a degree of autonomy. APPs include nurse practitioners, physician assistants, and clinical nurse specialists.	Nurses provide direct patient care, administer medications, and conduct assessments. Additionally, nurse managers oversee the clinical team and help coordinate patient flow.	A variety of technicians, specialists, and other personnel assist with patient care, diagnostic testing, and overall coordination.

EDs are crucial to the health care system, as they provide rapid, life-saving care for patients experiencing urgent medical issues. They act as a safety net, ensuring access to critical services for all individuals and helping to prevent more severe outcomes by addressing emergencies promptly. Additionally, EDs play a key role in managing public health crises and offering immediate care during natural disasters or accidents.

How Do EMS Agencies and EDs Work Together?

EMS agencies and EDs work together in several critical ways to provide comprehensive emergency medical care, ensuring that patients receive timely, coordinated, and effective care.



Here are the key components of the interaction between EMS agencies and EDs:

- **EMS communication with the ED during transport:** EMS clinicians communicate with the receiving ED about the patient's condition and estimated time of arrival. They keep the ED updated on interventions performed and changes in patient condition; depending on telehealth capacities, they can consult with ED clinicians who can provide additional guidance on patient care in real time.
- **ED preparation:** Based on the information provided by EMS, the ED prepares for the patient's arrival, ensuring that the necessary staff and equipment are ready.
- **Arrival and handoff:** EMS provides a verbal report to the ED staff who take over the patient's care, continuing treatment and conducting further assessments as needed. The EMS crew also shares their ePCR with the ED.
- **Feedback and quality improvement:** EDs and EMS agencies may use feedback and quality improvement processes so they can discuss cases in order to improve future care and coordination.





Pediatric Readiness

What Is Pediatric Readiness?

Children have unique characteristics that require specific care, especially in emergencies. Being Pediatric Ready means that an ED, EMS agency, or fire-rescue agency has pediatric champions, competencies, policies, equipment, and other resources they need to provide high-quality emergency care for children.

Why Does Pediatric Readiness Matter?

- **Prehospital:** Pediatric incidents make up about 10% of all prehospital calls, and more than 81% of EMS agencies encounter fewer than eight pediatric patients each month.³ In addition to being infrequent, these calls can require higher levels of care and cause more stress for all involved. Due to the limited frequency of these interactions, clinicians often are less familiar with and confident in providing quality pediatric care.
- **Hospitals:** 80% of children⁴ receive emergency care in general EDs, which mainly treat adults.⁵ Because they don't treat many as many children as adults, EDs tend to focus on adult needs and may not be well-prepared to care for children, especially in rare cases of severe illness and injury, which are even less common.

Pediatric Readiness in EDs Saves Lives

Research shows that high levels of Pediatric Readiness (>87 points on the NPRP assessment) in EDs is associated with the potential for:

76%
lower mortality rate
in ill children

60%
lower mortality rate
in injured children

2,143
children's lives saved
across the US each year⁶

Research on the impact of Pediatric Readiness in prehospital settings is still in the early stages.

Flagship EMSC Pediatric Readiness Projects

The EMSC Program has two flagship projects that empower emergency care clinicians in the ED and prehospital setting to improve their capability to care for children.

National Pediatric Readiness Project (NPRP)

NPRP is led by the EMSC Program in partnership with the American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP), the American College of Surgeons Committee on Trauma (ACS COT), and the Emergency Nurses Association (ENA). The project is based on **national guidelines**, which offer recommendations for essential equipment, medications, personnel training, and key policies for providing optimal pediatric emergency care. This initiative has grown significantly since the first joint guidelines for the care of children in the ED were published in 2001.



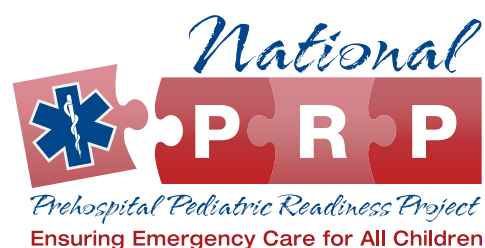
The NPRP has created free and open-access **resources to help EDs address Pediatric Readiness gaps**. As part of the State Partnership grant requirements, NPRP national assessment periods typically occur every five years. The assessment is also **typically open** between national assessment periods so that EDs can assess their progress internally on a regular basis.

3. <https://emscdatacenter.org/wp-content/uploads/2023/06/2022-National-EMS-for-Children-Survey-Report.pdf>
4. https://media.emscimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf
5. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807059?resultClick=1>
6. https://media.emscimprovement.center/documents/Pediatric_Readiness_Impact_Statistics.pdf

National Prehospital Pediatric Readiness Project (PPRP)

Established in 2019, the PPRP parallels NPRP, though its focus is on supporting EMS and fire-rescue agencies. Led by the EMSC Program, more than 30 national organizations, federal partners, and experts support the project via participation in its **Steering Committee**.

The PPRP is informed by **national recommendations**, which, just as with NPRP, led to the development of a checklist, an in-depth assessment, and an online toolkit of resources. The inaugural PPRP assessment launched in 2024 and is also anticipated to occur every five years.



Helpful Links

-  [National Pediatric Readiness Project \(NPRP\)](#)
-  [National Prehospital Pediatric Readiness Project \(PPRP\)](#)

Pediatric Readiness and Trauma Centers

While the NPRP focuses on emergency care for all children in the ED, the program has an impact on the pediatric trauma population in particular. Because fewer than 60% of children live within 30 miles of a pediatric trauma center (PTC), communities can't rely on PTCs alone to provide high-quality initial resuscitative care. Adult trauma centers, Critical Access Hospitals, and community EDs can ensure children have access to high-quality initial resuscitative care by focusing on Pediatric Readiness in all EDs. Unfortunately, trauma centers have not been shown to have high levels of Pediatric Readiness universally. Research suggests that adult trauma centers (low-volume centers that are unfamiliar with how to resuscitate and stabilize children) may benefit the most from targeted efforts to enhance Pediatric Readiness. New optimal standards for caring for an injured patient, which were released in 2022 by ACS COT, include a requirement for trauma centers—adult and pediatric—to assess their own Pediatric Readiness and take steps to address any gaps.

Helpful Links

-  Read the report [Status of Pediatric Trauma System Development in the United States](#) that was released in 2022.
-  [Learn more](#) about the ACS COT Pediatric Readiness standard.

Pediatric Readiness and Disaster Preparedness

The purpose of disaster planning is to establish—before a large-scale event—lines of communication within and across community resources that will function together under a unified protocol before, during, and after a disaster event. This planning includes identifying additional staff to support the ED or EMS agencies (particularly during a surge of pediatric patients) and is critical to disaster preparedness. Without a tested preparedness plan in place, EDs and EMS agencies won't be able to adequately meet the needs of children, who are particularly vulnerable during disasters. Having a disaster plan that addresses children's needs is the first step in ensuring that their unique needs are effectively addressed during disasters.

The federal government has funded multiple projects that focus on pediatric disaster preparedness:



- **Pediatric Disaster Care Centers of Excellence (PDCOE):** The Administration for Strategic Preparedness and Response (ASPR) has awarded three cooperative agreements to pilot the creation of PDCOEs to improve disaster response capabilities in the United States specifically for children.

The centers (WRAP-EM, Region V for Kids, and Gulf 7) are tasked with developing or improving their capability and capacity to provide highly specialized care to pediatric patients within and outside their regions. They work to ensure the needs of all pediatric patients, including children with special health care needs, are considered and integrated into the PDCOE plans and operations. [Learn more about the PDCOEs.](#)

- **Pediatric Pandemic Network (PPN):** Through this network, children's hospitals serve as regional hubs for improving care for all children in pandemics, disasters, and everyday situations. PPN's hospitals work with regional and national programs, academic institutions, community organizations, and individual experts to share pediatric-related information, educational resources, and best practices. The PPN is funded through a separate mechanism from the EMSC Program but is administered through the same branch of HRSA. [Learn more about the PPN.](#)

The work of both the COEs and the PPN is considered to align with the work of the EMSC Program because being ready to care for children in everyday emergencies helps facilitate preparedness for all types of disasters. The initiatives collaborate closely on efforts to improve preparedness across the country.

Helpful Links

- HHS Administration for Strategic Preparedness and Response—Technical Resources, Assistance Center, and Information Exchange: [Pediatrics/Children](#)
- [National Pediatric Disaster Coalition](#)



Understanding How State Partnership Grants Work

Administration and Authorization

EMSC State Partnership Grants are administered by the EMSC Branch of the Division of Child, Adolescent, and Family Health in the Maternal and Child Health Bureau of the Health Resources and Services Administration at the U.S. Department of Health and Human Services.

As a federal program, the EMSC Program must be reauthorized by Congress every five years (i.e. Congress must vote to continue its funding). The EMSC Program is currently 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 (Public Law 111-148).

Eligibility and the Application Process

Each state, territory, or freely associated state is eligible for one State Partnership Program grant. State governments and accredited schools of medicine are the only eligible entities that may apply for an EMSC State Partnership Program grant.

All State Partnership grants have a four-year life cycle. Before the start of a new grant cycle, and after funds have been appropriated by Congress, HRSA posts a Notice of Funding Opportunity (NOFO) for new and competing continuation grants (see the fiscal year **2023 announcement** as an example). In non-competing years (Years 2–4 of the grant cycle), federal funding is awarded on an annual basis. The release of funds to each grant recipient is based on funding availability, sufficient progress to determine continuation is in the government's best interest, and the completion of a Non-Competing Continuation (NCC) Progress Report each year (see the "Reporting and Other Requirements" section for more information).

All organizations applying for HRSA grants must register through three separate systems: **System for Award Management (SAM)**, **Grants.gov**, and **Electronic Handbooks**. 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 program manager is responsible for all aspects of grant management, including registering the organization and submitting grant applications, reporting requirements, and FFRs. All program managers need to coordinate closely with their grants and contracts office, know their roles and responsibilities with registration, and ensure necessary access to various systems so that applications and reports are both timely and accurate.

Each applicant submitting a successful application receives a written notification in the form of a Notice of Award (NOA). The NOA 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 NOA). Funds will not be released until all conditions have been met to the satisfaction of the EMSC Program. The NOA may also include recommendations that the reviewers have identified as potentially helpful for project implementation. Recommendations are actions the grantee should consider in order to achieve the grant's goal(s) and objectives. Grantees should pay attention to both conditions and recommendations for future grant applications, as they represent areas where the application can be improved.

Reporting and Other Requirements

The Electronic Handbooks (**EHB**) is HRSA's online grants management system. All competing and non-competing continuation required reports (e.g., Program and Performance Reports), requests for changes in grant conditions, and carryover of unused funds must be submitted through EHBs. Depending on the organization, program managers may be authorized to view, edit, and submit all reports, or they may have limited authorization, which could restrict their ability to edit or submit reports. Access must be requested through EHB and granted by an authorizing official as listed on the NOA and in the EHB User's List for the grant. If you have an EHB-related issue or question, fill out a **customer support form** or call the Help Desk (1-877-464-4772).

Successful grant applicants are required to submit various reports at specific stages during the funding life cycle. Most program managers are responsible for completing the NCC Progress Report, **Discretionary Grants Information System (DGIS)** Performance Reports (e.g., New Competing Performance Report, NCC Progress Report, and Project Period End Performance Report), and Prior Approval Requests for carryover of unused funds. 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. A detailed description of each of these reports with schedules and deadlines can be found in the NOFO, and the forms can be found in the full DGIS package. Table 4 outlines the reporting requirements for each stage within the grant life cycle, with estimated reporting time frames.

Grant recipients are required by law to acknowledge HRSA when describing projects or programs funded in whole or in part with HRSA funds. The Further Consolidated Appropriations Act (Public Law 116-94) requires acknowledgment of federal funding for a variety of products, such as press releases and other public statements; publications and other documents, including toolkits, resource guides, websites, and visual presentations; requests for proposals; and bid solicitations. Find detailed guidance and examples on **HRSA's website**.

Support and Contacts

Every step of the way, from registration to completion of the grant life cycle, program managers have access to HRSA staff. You have been assigned both a PO and a grants management specialist (GMS). Find your contacts on the **Technical Supports** contacts page.

Your PO is your primary contact for programmatic aspects of your grant. They also:

- Monitor technical and programmatic performance,
- Conduct site visits,
- Ensure proper documentation of deliverables to ensure success, and
- Review and make recommendations for continued federal support.

Your GMS is the primary contact for budgetary aspects of your grant. They also:

- Help explain the regulations, policies, and financial aspects of your award (including FFRs);
- Respond to conditions placed on the NOA;
- Prepare any Prior Approval Requests;
- Explain award and cost principle requirements; and
- Oversee the receipt of all required reports.

Table 4: Reporting Requirements Schedule

GRANT YEAR	REPORT TYPE	AVAILABLE DATE	DUE DATE
1	New Competing Performance Report	Period of performance start date	120 days from the available date
	Non-Competing Continuation (NCC) Progress Report	Determined by federal program	45 days from the release of instructions
2	New Competing Performance Report	Beginning of each budget period (Years 2-5, as applicable)	120 days from the available date
	Federal Financial Report	Beginning of each budget period (Years 2-5, as applicable)	90 days from the available date
	Carry Over Request	FFR approval date	30 days after FFR submission approval
	NCC Progress Report	Determined by federal program	45 days from the release of instructions
3	New Competing Performance Report	Beginning of each budget period (Years 2-5, as applicable)	120 days from the available date
	Federal Financial Report	Beginning of each budget period (Years 2-5, as applicable)	90 days from the available date
	Carry Over Request	FFR approval date	30 days after FFR submission approval
	NCC Progress Report	Determined by federal program	45 days from the release of instructions
4	New Competing Performance Report	Beginning of each budget period (Years 2-5, as applicable)	120 days from the available date
	Federal Financial Report	Beginning of each budget period (Years 2-5, as applicable)	90 days from the available date
	Carry Over Request	FFR approval date	30 days after FFR submission approval
Closeout	Project Period End Performance Report	End date for the period of performance	90 days from the available date
	Federal Financial Report	Beginning of each budget period (Years 2-5, as applicable)	90 days from the available date
	Carry Over Request	FFR approval date	30 days after FFR submission approval

Helpful Links

-  [HHS Grants Policies & Regulations](#)
 - [Grants Policy Statement](#)
-  [SF-424 Application Guide](#) (developed and maintained by HRSA for the preparation and submission of applications through [Grants.gov](#) to HRSA using the SF-424 Workspace Application Package)
-  [Electronic Handbooks](#)
 -  [Customer Support Center](#)
-  HRSA's [Manage Your Grant](#) page



Moving Forward

We encourage you to explore the full range of resources available through this program and take advantage of opportunities to further your understanding and engagement. Whether you're new or experienced, continuous learning is key to maximizing your impact and improving pediatric emergency care in your state.

While this document provides a broad overview of the program, we encourage you to review the **Program Manager Welcome Kit**, which includes additional resources and tips. These resources have been curated to help you navigate your role and succeed as a State Partnership program manager.

Stay Up to Date



Bookmark the **State Partnership Program Dashboard** and visit it frequently.



Read newsletters from the EMSC Program. You will be automatically subscribed but let your **EIIC support specialist** know if you are not receiving it.



Attend quarterly **EMSC Town Halls**.



Appendix: Helpful Links

Introduction to EMSC

- [EMSC Historical Perspectives](#) (timeline)
- [Origins of EMSC](#) (short video)
- [Introduction to HRSA MCHB](#) (short video)
- [Introduction to EMSC Programs](#) (short video)

Program Web Pages

- [HRSA EMSC](#)
- [EMSC Innovation and Improvement Center \(EIIC\)](#)
- [EMSC Data Center \(EDC\)](#)
- [Pediatric Emergency Care Applied Research Network \(PECARN\)](#)
- [State Partnership Grants](#)

State Partnership Programs: Resources and Support

- [Acronyms reference guide](#)
- [EMSC State Partnership Activities and Tasks](#) (timeline)
- [Building Partnerships & Collaborations](#)
- [State Partnership Program Dashboard](#)
- [EMSC Grants Database](#)
- [State Partnership Programs locations](#)
- [EMSC Branding & Marketing Center](#)
- [Open library of state-created resources](#)
- [Performance Measures](#)
- [Promoting Activities & Accomplishments](#)
- [EMSC Regions](#)
- [Request Active Directory Account](#) form (to gain access to [CLMS](#) and/or [Tableau](#))
- [State Partnership Advisory Committee](#)
- [Technical Support Contacts](#)
- [EMSC Town Hall Meeting Archive](#)
- [Welcome Kit](#)
- [What is EMSC & where can I get help?](#)

Grant Management

- [2023 State Partnership Grant NOFO](#)
- [System for Award Management](#)
- [Grants.gov](#)
- [Electronic Handbooks](#)
- [Federal Financial Reports](#)
- [Notice of Award](#)
- [Discretionary Grants Information System](#)
- [HHS Grants Policies & Regulations](#)
- [Grants Policy Statement](#)
- [SF-424 Application Guide](#)
- [HRSA Grants and Electronic Handbooks Customer Support Center](#)
- [Manage Your Grant](#)

Key Federal Agencies and National Organizations

Federal

- **Federal Interagency Committee on EMS (FICEMS)**: ensures coordination among Federal agencies supporting local, regional, State, tribal, and territorial EMS and 911 systems
- **National EMS Advisory Council (NEMSAC)**: a forum for the development, consideration, and communication of information from a knowledgeable and independent perspective
- **National Highway Traffic Safety Administration Office of EMS (NHTSA OEMS)**: advances a national vision for EMS through projects and research
- **U.S. Fire Administration (USFA)**: provides training, research, and outreach to help keep EMS personnel and their patients safe and help prepare fire departments for special EMS operations

National

- **National Association of EMTs (NAEMT)**: represents the professional interests of prehospital clinicians providing out-of-hospital emergent, urgent or preventive medical care
- **National Association of State EMS Officials (NASEMSO)**: supports, equips, and advocates for state, territorial, and tribal EMS officials in their work to improve systems of care and the professionals operating in them
- **National Association of EMS Physicians (NAEMSP)**: serves as a resource and advocate for EMS physicians and EMS professionals

Hospital Systems

- **American Burn Association (ABA)**: promotes and supports burn-related research, education, care, rehabilitation, and prevention
- **Critical Access Hospitals (CAHs)**: designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services
- **Children's Hospital Association (CHA)**: national voice of children's hospitals
- **American College of Cardiology (ACC)**: professional home for cardiovascular clinicians and researchers seeking the latest science, research and education
- **The Joint Commission**: accredits and certifies health care organizations in the United States
- **Det Norske Veritas Healthcare**: international accreditation organization
- **American College of Surgeons Committee on Trauma (ACS COT)**: sets standards, conducts trauma center verification, and advances trauma education, prevention, and research

Trauma Systems

- **Status of Pediatric Trauma System Development in the United States** (report)
- **ACS COT Pediatric Readiness standard** (article)

Disaster Preparedness

- **Pediatric Disaster Centers of Excellence**
- **Pediatric Pandemic Network**
- HHS Administration for Strategic Preparedness and Response—Technical Resources, Assistance Center, and Information Exchange: **Pediatrics/Children**
- **National Pediatric Disaster Coalition**

Pediatric Readiness

- [NPRP: website | checklist | toolkit | assessment](#)
- [PPRP: website | checklist | toolkit | assessment](#)
- [Pediatric Readiness Saves Lives](#) (infographic)
- [Emergency Department Pediatric Readiness and Mortality in Critically Ill Children](#) (article)
- [Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care](#) (article)
- [State and National Estimates of the Cost of Emergency Department Pediatric Readiness and Lives Saved](#) (article)

National Guidelines

- [Pediatric Readiness in the Emergency Department](#) (Joint Policy Statement)
- Pediatric Readiness in Emergency Medical Services Systems
 - [Joint Policy Statement](#)
 - [Technical Report](#)



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