

Access to Optimal Emergency Care for Children

Committee on Pediatric Emergency Medicine

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

Millions of pediatric patients require some level of emergency care annually, and significant barriers limit access to appropriate services for large numbers of children. The American Academy of Pediatrics has a strong commitment to identifying barriers to access to emergency care, working to surmount these obstacles, and encouraging, through education and system changes, improved levels of emergency care available to all children.

INTRODUCTION

Millions of infants, children, adolescents, and young adults seek emergency care every year in the United States. Many individuals may not receive appropriate acute care in a timely fashion because of numerous obstacles. Emergency departments (EDs) are the nation's safety net. EDs provide comprehensive acute care 24 hours a day, 7 days a week.¹⁻³ Factors that weaken this safety net disproportionately affect vulnerable populations. Access to appropriate pediatric emergency medical care is important for children, because substantial morbidity may occur if care is delayed.

Problems That Restrict Access to Care

- A. Lack of universal understanding and application of a definition of "emergency."
- B. Lack of reasonable access to alternative sources of health care so that the ED is left as the only place that will see everyone.
- C. ED crowding and diversion of emergency medical services (EMS).
- D. Lack of universal access to enhanced or basic 911 services and wireless 911 service for cellular phones, with reliance in some areas on local 10-digit emergency telephone numbers.
- E. The misconception that freestanding urgent care centers provide comprehensive emergency services and that all EDs are equally equipped to care for children.
- F. Variability in the availability of appropriate equipment, supplies, and medications in emergency departments for children of all ages.⁴
- G. Variability in pediatric training and experience among physicians and nurses staffing EDs.
- H. Lack of pediatric training and experience for prehospital EMS and interhospital transport personnel.

www.pediatrics.org/cgi/doi/10.1542/peds.2006-2900

doi:10.1542/peds.2006-2900

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Key Words

access to care, emergency readiness, emergency medical services for children

Abbreviations

ED—emergency department
EMS—emergency medical services
AAP—American Academy of Pediatrics
EMSC—Emergency Medical Services for Children

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2007 by the American Academy of Pediatrics

- I. Lack of evidence-based guidelines for care efficacy and safety within all levels of emergency medical services for children.
- J. Lack of access to pediatric emergency medical care in many regions of the country.
- K. Lack of reliable access to pediatric medical subspecialists, pediatric surgical specialists, and mental health professionals.
- L. Lack of, or failure to initially identify, the medical home, or failure to return the child to the medical home after ED discharge.
- M. Lack of or inadequate reimbursement for primary care for large numbers of children.
- N. Managed care protocols that bypass regional emergency services for children.
- O. Managed care protocols designed to reduce the use of emergency facilities without providing appropriate alternatives for care.
- P. Failure by payers to use the “prudent-layperson” standard for definition of emergency.
- Q. Retroactive denial of third-party payment when diagnostic signs and/or symptoms suggest an emergent condition but the final diagnosis (often established after evaluation and treatment) is “nonemergent.”
- R. Denial of payment for services to insured patients for any reason (eg, preexisting or chronic conditions).
- S. Increasing legislation and managed care initiatives related to emergency access for children that often require complex and time-consuming telephone calls and documentation.
- T. Fears borne by families of ill or injured children regarding immigration issues, social service agency intervention for child custody concerns, and other legal or financial concerns.
- U. Language and education barriers to understanding appropriate utilization of less emergent sources of care.

Since the American Academy of Pediatrics (AAP) published the original policy statement on access to emergency care in 1992⁵ and a revision in 2000,⁶ several substantial advances have occurred.

Advances That Promote Access to Emergency Care

- Significant increases in the number of emergency medicine residents and residency programs that include specific training and experience in pediatric emergencies.
- Development of dual pediatrics-emergency medicine residency training programs.

- Significant increases in pediatric emergency medicine fellowship programs.
- Increased availability of physicians with specific training and certification in pediatric emergency care.
- A substantial and ongoing increase in the presence of board-certified emergency medicine physicians in EDs throughout the country.
- Increasing numbers of providers at all levels taking pediatric emergency courses such as Pediatric Advanced Life Support (PALS),⁷ Advanced Pediatric Life Support (APLS),⁸ the Neonatal Resuscitation Program (NRP),⁹ and the Emergency Nursing Pediatric Course (ENPC).¹⁰
- Improvements in pediatric education for EMS providers and the Pediatric Education for Prehospital Professionals (PEPP) program.¹¹
- Many available resources covering school and child care emergencies^{12,13} (see additional publications at <http://bolivia.hrsa.gov/emsc> and www.aap.org and courses at www.nasn.org).
- Publication of the Institute of Medicine 1993¹⁴ and 2006³ reports on pediatric emergency care.
- Development of models and educational materials on access to pediatric emergency medical care through the Emergency Medical Services for Children (EMSC) program of the Health Resources and Services Administration’s Maternal and Child Health Bureau (see <http://bolivia.hrsa.gov/emsc>).¹⁵
- Publication of new manuals and texts that provide education and information about access to pediatric emergency care.¹⁶
- Publication of statements and guidelines for pediatric facility categorization, emergency centers, office preparedness, urgent care centers, and prehospital and interfacility transport^{17–20} (including a policy statement currently in development from the AAP on preparation of the offices of pediatricians and pediatric primary care providers).
- Institutional adoption of pediatric facility standards, such as Emergency Departments Approved for Pediatrics [EDAP], through legislation or voluntary participation.²¹
- Development of model legislation for emergency care for children.
- Formation of the Pediatric Emergency Care Applied Research Network (PECARN) as a means to promote evidence-based approaches to care.²¹

Despite this progress in access to emergency care, more advances are needed.

RECOMMENDATIONS

The AAP recommends that every child in need have access to quality pediatric emergency medical care. Efforts must be made at local, state, and federal levels to:

1. Improve prompt and appropriate access to pediatric emergency medical care for all children regardless of socioeconomic status, ethnic origin, immigration status, type of insurance, location, or health status.
2. Increase public, professional, and government awareness about the magnitude of the problem of access to pediatric emergency medical care for children.
3. Fund, support, and promote the further development and improvement of EMS for children at federal, state, and local levels.
4. Improve awareness, dissemination, and use of the large body of resources available through the Health Resources and Services Administration's Maternal and Child Health Bureau's EMSC program and provide ongoing funding support for future resource development, education, research, and outcomes evaluation by the EMSC program, as recommended in the 2006 Institute of Medicine report.³
5. Improve optimal emergency care for children throughout every aspect of the EMSC continuum, from injury prevention to tertiary-level pediatric emergency and critical care to rehabilitation, and ultimately coordinate emergency care through the medical home.
6. Promote the development of evidence-based guidelines and other strategies, such as medication dosing guidelines, to improve care consistency and quality and to reduce errors in the emergency care of children.
7. Fund, support, and further develop research efforts directed at all aspects of pediatric emergency care to provide the foundation for evidence-based standards for efficacious and safe patient care.
8. Encourage the implementation of enhanced (emergency-access) 911 systems and wireless 911 services for cellular phones.
9. Improve collaboration between schools, child care facilities, mental health professionals, medical homes, and local EMS to facilitate easy access into the EMS system.
10. Encourage collaborative efforts by emergency care physicians and primary care physicians to identify a medical home for every child. If a medical home is not identified, the ED should initiate the process of locating a medical home for follow-up and ongoing care after discharge.
11. Encourage the use of the emergency information form (EIF) published by the AAP and American College of Emergency Physicians (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/4/e53>) for children with special health care needs.
12. Encourage all EDs to establish transfer agreements with facilities with higher levels of pediatric care to ensure timely access to pediatric emergency and subspecialty tertiary care for critically ill and injured children.
13. Encourage state and local EMS system and ED preparedness for pediatric emergencies and care of children in disasters.
14. Encourage the availability of existing pediatric medical subspecialists, pediatric surgical specialists, and mental health professionals who have special skills and expertise that are required for comprehensive and optimal care of critically ill and injured children.
15. For pediatric surgical specialists and pediatric medical subspecialists who are in short supply, encourage the expansion of training programs to ensure the future availability of these professionals necessary to provide specialized pediatric care.
16. Support and facilitate the practice of telemedicine to optimize the delivery of care for services that can be delivered via telemedicine.
17. Encourage managed care organizations to accept the prudent-layperson definition of an emergency and to provide reimbursement for services mandated by the Emergency Medical Treatment and Active Labor Act (42 USC §1395dd).
18. Payers should cover the expense of language-translation services required to provide emergency care.

The AAP membership and leadership, as advocates for children, can and should make a strong commitment to assist pediatricians and families in making decisions about seeking timely and appropriate emergency care.

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Pediatrics 2007;119;161
DOI: 10.1542/peds.2006-2900

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Committee on Pediatric Emergency Medicine
Pediatrics 2007;119;161
DOI: 10.1542/peds.2006-2900

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