

**Abstract:**

The experience of the federal Emergency Medical Services for Children program over the past 30 years illustrates many of the challenges facing those who advocate for programs that serve special populations or targeted purposes. Even programs that are well run and successful may find themselves targeted for budget cuts or elimination if they do not have committed champions, a readily identifiable constituency, and a range of resources at their disposal. The long campaign to preserve the Emergency Medical Services for Children program has yielded valuable lessons for advocates working at any level of government.

**Keywords:**

emergency care; trauma; children; emergency medical services; advocacy

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# The Little Program That Could: Saving Emergency Medical Services for Children

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*Editor's Note:*

It has been a little over three years since the publication of this manuscript in the March 2014 issue of CPEM. The proposed elimination of the HHS/HRSA EMS for Children program in the Trump Administration's budget proposal, "The Foundation for American Greatness," will hopefully mobilize that same small but highly motivated constituency of key stakeholders (pediatricians, emergency physicians, nurses, surgeons, family physicians, hospitalists, intensivists, advanced practice providers, paramedics, emergency medical technicians, etc) who endeavor on a daily basis to provide the best possible care to acutely ill and injured children and aspire to achieve optimal outcomes. Over the past three years, with fairly modest funding, EMS for Children has continued to engage emergency care providers and promote steady progress in pediatric emergency readiness in prehospital and hospital-based settings, and beyond. The funding provided to

the National EMSC Data Analysis Resource Center has provided state and local EMS providers with the vital tools necessary to measure performance metrics and examine the impact of interventions intended to improve performance. The fairly small funding investment made in 2001 by EMS for Children in the creation of an infrastructure for the Pediatric Emergency Care Applied Research Program (PECARN) has resulted in close to 100M in grant funding and over 120 publications, an impressive return on investment. This research has informed efforts transforming care provided to children in emergency departments across the nation. The recent evolution of the EMSC National Resource Center into an Innovation and Improvement Center has positioned the program to infuse quality improvement science into existing and new projects at local, state and national levels, further improving outcomes. While three years old, this manuscript remains incredibly relevant to current events. It offers a concise and thoughtful analysis of the program's 'political history'. This historical account certainly merits reading by all providers of pediatric emergency care. Even more important is the analysis offered in the second half of this manuscript, where the authors theorize why this small yet clearly impactful program was targeted for elimination, and despite that, how it managed to survive. This exploration offers a very timely and pragmatic playbook for emergency care providers who recognize how EMS for Children has informed and improved their care delivery for this vulnerable population, as well as other individuals or groups who simply care deeply about the well-being of children, as to how we may again be successful in advocating on the behalf of children and in educating elected and appointed officials about the value of EMS for Children and the remarkable multi-disciplinary and multi-specialty coalition it has generated and sustained since its inception in 1985. I want to thank my co-authors, Cynthia Pellegrini and Joseph Wright, not only for their collaboration on this manuscript, but for their leadership contributions as part of the coalition, led by the American Academy of Pediatrics (AAP), that saved EMS for Children. Cindy's affiliation remains the same as it was in March 2014, as has mine. My colleague Joe Wright is now the Department Chair and Professor of Pediatrics and Child Health at the Howard University College of Medicine, and serves as Chair of the AAP Committee on Pediatric Emergency Medicine. It is our hope that this article will inspire our readers to take action.

Steven E. Krug, MD  
Editor, CPEM

**M**odern-day emergency medicine has its roots in the battlefield. Physicians serving during the Korean and Vietnam Wars and, more recently, during the conflicts in Iraq and Afghanistan, brought home with them techniques for saving critically wounded soldiers, translating these skills from treating blast and gunshot wounds to auto crashes and acute medical emergencies.<sup>1,2</sup> As the field of emergency medicine grew, however, astute practitioners soon began to observe disparities in the treatment outcomes of adults and children. Disturbing trends emerged wherein adults survived while children with similar injuries or illness severity could not be saved.<sup>3-5</sup> Experts in the field attributed these outcome differences to critical gaps in equipment, training, and level of care delivered to these children by prehospital and hospital-based emergency care providers.<sup>4</sup>

## THE EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM

These trends soon came to the attention of policymakers, driven by the efforts of visionary pediatricians like past president of the Hawaii Pediatric Society Dr. Cal Sia, who brought these concerns to the late Senator Daniel Inouye (D-HI). In 1984, the Emergency Medical Services for Children (EMS for Children) program was created by Senators Inouye, Orrin Hatch (R-UT), and Lowell Weicker (I-CT) to direct federal resources toward improving emergency medical care for children.<sup>6</sup> These senators recognized that emergency care for children would likely never rise to being a top priority for any single institution or state; rather, a national focus was necessary both to leverage resources and to disseminate research and best practices across all states.<sup>7</sup>

The program was initiated in 1985 with a scant \$2 million in funding. Over the next 15 years, program funding grew slowly but steadily at an average of about \$1 million per year, rising from \$2 million in 1987 to \$15 million in 2001. Although neither the Reagan nor Bush Administrations requested funding for the program in the years immediately after its creation, the program enjoyed bipartisan support in both the House and Senate Appropriations Committees. The program was renewed with little fanfare in 1987,<sup>8</sup> 1990,<sup>9</sup> 1992,<sup>10</sup> and 1998<sup>11</sup> as part of larger pieces of legislation.

In response to emergency department (ED) overcrowding and growing evidence of distress within emergency medical services (EMS) systems, the Institute of Medicine (IOM) commissioned a study of the US emergency care system in 2004. The IOM panel released its 3-part report, *Future of Emergency Care in the US Healthcare System*, in 2007. One part of the report,

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