Pediatric Readiness in the Emergency Department: Policy Statement

Katherine E. Remick, MD, FAAP, FACEP, FAEMS*; Ashley A. Foster, MD, FAAP, FACEP; Aaron R. Jensen, MD, MEd, MS, FACS, FAAP; Regan F. Williams, MD, MS, FACS, FAAP; Elizabeth Stone, PhD, RN, CHSE, FAEN; Madeline Joseph, MD, FAAP, FACEP; Gregory P. Conners, MD, MPH, MBA, FAAP; Kathleen Brown, MD, FAAP, FACEP; Marianne Gausche-Hill, MD, FAAP, FACEP, FAEMS

AMERICAN ACADEMY OF PEDIATRICS
Committee on Pediatric Emergency Medicine, Section on Surgery

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Pediatric Emergency Medicine Committee

EMERGENCY NURSES ASSOCIATION
Pediatric Committee

AMERICAN COLLEGE OF SURGEONS
Committee on Trauma

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

*Corresponding author. E-mail: kate.remick@austin.utexas.edu.

This is a revision of the previous joint policy statement titled "Pediatric Readiness in the Emergency Department." This is a joint policy statement from the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Surgeons, and the Emergency Nurses Association. These updated recommendations are intended to serve as a resource for clinical and administrative leadership of emergency departments as they strive to improve their readiness for the emergency care of children of all ages. [Ann Emerg Med. 2026;87:e11-e24.]

ABBREVIATIONS: ED: emergency department; EMS: emergency medical services; EMSC: Emergency Medical Services for Children (program); IOM: Institute of Medicine; NPRP: National Pediatric Readiness Project; PECC: pediatric emergency care coordinator; PI: performance improvement., QI: quality improvement.

0196-0644/$-see front matter
© 2025 Emergency Nurses Association, American College of Emergency Physicians, American Academy of Pediatrics and The American College of Surgeons. Published by Elsevier Inc on behalf of Emergency Nurses Association and American College of Emergency Physicians, by American Academy of Pediatrics and by Wolters Kluwer Health, Inc. on behalf of The American College of Surgeons. All rights are reserved, including those for text and data mining, AI training, and similar technologies.
https://doi.org/10.1016/j.annemergmed.2025.11.016

INTRODUCTION

[Ann Emerg Med. 2026;87:e11-e24.]

To meet the immediate physiologic, anatomic, psychological, and developmental needs of children and adolescents, emergency departments (EDs) must maintain appropriate resources, including pediatric-specific equipment and supplies, policies and procedures, competencies for staff, patient safety protocols, continuous quality improvement efforts, and oversight of all administrative aspects of pediatric emergency care. The sum of these elements is termed "pediatric readiness" and represents the foundational infrastructure needed to stabilize and/or resuscitate critically ill or injured children in the ED.[1-3] The ED is a central health care access point for over 30 million children and families.[4] More than 80% of these visits occur in community hospital EDs, most seeing fewer than 10 children per day.[5,6] Outcomes, including survival, for children who seek emergency care are contingent on the availability of these critical and foundational resources. High levels of pediatric readiness are linked to a 76% and 60% decrease in mortality risk for critically ill and injured children, respectively.[7-9] Pediatric readiness also serves as a framework for ensuring equity in pediatric emergency care based on its association with a threefold reduction in disparities for mortality risk.[10] This policy statement describes the components of pediatric

readiness that lead to improved outcomes in critically ill or injured children and are considered the basis for pediatric readiness verification standards.

These recommendations are intended for all EDs that provide care for children, including freestanding EDs, rural emergency hospitals, critical access hospitals, and low-volume EDs. The accompanying "Pediatric Readiness in the Emergency Department: Technical Report" provides additional background and resources to support pediatric readiness efforts.[11]

RECOMMENDATIONS

To promote the infrastructure to support immediate stabilization, resuscitation, and high-quality emergency care for children, the American Academy of Pediatrics, American College of Emergency Physicians, Emergency Nurses Association, and American College of Surgeons believe that all EDs can do the following.

ADMINISTRATION AND COORDINATION

- Appoint a physician and a nurse as pediatric emergency care coordinators (PECCs) to promote adequate pediatric skills and knowledge of ED staff, develop and maintain pediatric policies and procedures, oversee pediatric quality improvement efforts, familiarize staff with pediatric equipment, supplies, and other aspects of pediatric care, liaise with appropriate quality committees within the hospital and trauma system, and oversee all administrative aspects of pediatric readiness.[5,6,12]

Pediatric Competencies for Clinical Staff

- Facilitate baseline and periodic pediatric competency evaluations for all ED staff including neonates, infants, children, adolescents, and children with special health care needs (eg, technology dependence, chronic conditions, and/or medical complexity) that span all phases of ED care (triage, assessment, resuscitation, diagnostics, interventions, and appropriate disposition and follow-up).[13]
- At minimum, the ED medical director has at least 1 physician on staff who is a board-certified emergency medicine or pediatric emergency medicine physician.[5]
- Promote multidisciplinary education among ED staff that incorporates procedural, affective, and cognitive skills in the child's care.

Pediatric Equipment and Supplies

- Have immediately available pediatric equipment and supplies (eg, pediatric resuscitation cart) to assess, treat, resuscitate, and stabilize children and adolescents with diverse clinical presentations. See Table 1.
- Keep a portable pediatric resuscitation cart immediately available in the ED and organized to facilitate rapid identification of age- or weight-based, appropriately sized equipment.
- Have a daily method to verify the proper location and function of pediatric equipment and supplies including restocking as needed.

Pediatric Patient Safety

- Adopt a triage system that is validated for the pediatric patient to identify pediatric patients at risk for clinical deterioration.[14]
- Implement practices to reduce adverse medical events and medication dosing errors, including weighing and recording in kilograms only.[15]
- Adopt tools that decrease the cognitive load with pediatric dosing such as precalculated point-of-care dosing guides for children of all weight categories, computerized physician order entry that integrates upper dosing limits, and a standardized formulary for high-risk and commonly used pediatric medications.[16]
- Promote a culture of safety surrounding pediatric medications, which includes implementing an independent, 2-clinician crosscheck process and family engagement for high-alert medications.[16]

Pediatric Policies, Procedures, and Protocols

- Incorporate evidence-based policies and protocols for screening and treating children with mental or behavioral health emergencies.[17-19] See Table 2.
- Incorporate evidence-based clinical pathways and algorithms (when available) to guide comprehensive emergency care for children of all ages in real time. See Table 2.
- Standardize care for common presentations to overcome implicit bias, language, and cultural barriers and promote cultural competency for clinicians.[20]
- Adopt clinical practice guidelines and decision support tools for common pediatric conditions, including bronchiolitis, asthma, sepsis, fever in the infant, head trauma, seizure evaluation and management, and appendicitis.[21-31]
- Have social workers and/or case managers available, either in person or via telehealth, to address access to care and referral to community pediatric resources when needed.
- Make readily available the contact information for regional poison control centers and/or toxicology experts to facilitate emergent consultation, when needed.

Table 1. Pediatric Readiness Checklist for Emergency Departments (also see Appendix E1, available at http://www.annemergmed.com for printable version)

ADMINISTRATION AND COORDINATION

- Physician Pediatric Emergency Care Coordinator (PECC)[a]
  - o Board certified/eligible in EM or PEM (preferred but not required)
  - o If not board certified in EM or PEM, meets qualifications for credentialing by the hospital as an emergency clinician specialist with special training and experience in the evaluation and management of the critically ill/injured child.
  - o This role may be shared with an advanced practice provider who is credentialed to care for patients in the ED.
- Nurse Pediatric Emergency Care Coordinator (PECC)
  - o Have special interest, knowledge and skill in the emergency nursing care of children.
  - o Certified Emergency Nurse (CEN)/Certified Pediatric Emergency Nurse (CPEN) (desired)
  - o Other credentials (CPN, CCRN)

COMPETENCIES FOR PHYSICIANS, ADVANCED PRACTICE PROVIDERS, NURSES, AND OTHER ED HEALTH CARE CLINICIANS

- Healthcare providers who staff the ED have baseline and interval updates of skills and procedures to maintain pediatric competencies. Continuing education may be used to fulfill certain competencies but interval updates of skills and procedures is strongly encouraged.
- Areas of pediatric competencies and professional performance evaluations may include but are not limited to:
  - o Assessment and treatment (eg, triage, illness and injury, pain, mental/behavioral health emergencies)
  - o Medication administration and delivery
  - o Device/equipment safety (eg, low-volume infusion pumps)
  - o Critical procedures
  - o Resuscitation (neonatal and pediatric)
  - o Trauma resuscitation and stabilization
  - o Patient- and family-centered care
  - o Team training and effective communication

QUALITY IMPROVEMENT/PERFORMANCE IMPROVEMENT

- A defined QI/PI plan that includes chart review of all pediatric deaths and pediatric-specific indicators (please see the guidelines/toolkit for additional details)
  - o Data are collected and analyzed
  - o Process improvement strategies are implemented
  - o System changes are implemented based on performance
  - o Performance is monitored over time

POLICIES, PROCEDURES, AND PROTOCOLS

- Policies, procedures, and protocols for the emergency care of children. (These policies may be integrated into overall ED policies as long as pediatric-specific issues are addressed.)
- Illness and injury triage
- Assessment and reassessment including a complete set of vital signs and frequency of reassessment that also includes:
  - o Documentation of full set vital signs
  - o Weight in kilograms
  - o Identification and notification of the responsible clinician of abnormal vital signs and/or assessment
- Sedation and analgesia for procedures, including medical imaging
- Pediatric transfusion
- Consent of minors, including when a caregiver is unavailable
- Management of caregivers who exhibit verbal or physical abuse toward ED staff
- Assuming temporary protective custody of a child
- Social issues, including food insecurity and home safety
- Pediatric behavioral health, including substance abuse disorders
- Care of child with agitation including pharmacologic management and physical restraint
- Trauma-informed care
- Suicide screening and management
- Child maltreatment assessment and mandated reporting
- Reduced dose radiation for imaging
- Death of the child in the ED
- Family-centered care
  - o Involve caregiver in patient care decision making and medication safety processes
  - o Caregiver presence during all aspects of emergency care, including resuscitation
  - o Caregiver education
  - o Discharge planning and education
  - o Bereavement counseling

Table 1. Continued.

- Communication with patient's medical home or primary caregiver
- Do-not-resuscitate orders
- Children with medical complexity (coordination of care)
- Immunization assessment and management
- Telehealth/telemedicine for subspecialty consults
- Human trafficking screening and management
- Written interfacility transfer agreements and guidelines that include but not limited to the following pediatric components:
  - o Defined process for initiation of transfer
  - o Criteria for transfers (eg, specialty services)
  - o Process for selecting the appropriate facility
  - o Criteria for selection of appropriate transport service
  - o Plan for transfer[b]
- Standardized clinical pathways, order sets or decision support available to providers in real time

PATIENT AND MEDICATION SAFETY

- Pediatric patient and medication safety needs are addressed in the following ways:
  - o Weigh in kilograms only
  - o Record weights in kilograms only
  - o For children who require emergency stabilization, a standard method for estimating weight in kilograms is used (eg, a length-based system)
  - o Obtain and record a full set of vital signs including pain and mental status
  - o End-tidal CO2 monitoring for sedation and critical illness/injury
  - o Processes for safe medication delivery that includes prescribing, administration, and disposal
  - o Promote an environment that is culturally and linguistically appropriate that supports family-centered care
  - o Verifying patient identification
  - o Timely tracking, reporting, and evaluation of patient safety events

Support Services

- Evidenced-based imaging and laboratory testing policies and guidelines (eg, Choosing Wisely[c])
  - o Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions for children
  - o The laboratory has the skills, personnel, and capability to perform laboratory tests for children of all ages, including obtaining samples and the availability of micro technique for small sample size
- All efforts made to transfer completed images and laboratory results when a patient is transferred from one facility to another
- Collaboration with other ED support services to meet the needs of children in the community
- Personnel capable of providing supportive, family-centered, trauma-informed care including specially trained social workers, nurses, chaplains, mental health professionals, or child life specialists

DISASTER[d]

- The written all-hazard disaster-preparedness plan addresses pediatric-specific needs, including:
  - o Triage of pediatric patients
  - o Decontamination, isolation, and quarantine of families and children of all ages
  - o Medications, vaccines, equipment, supplies, and trained providers for children in disasters
  - o Pediatric surge capacity for injured and noninjured children
  - o Minimization of parent-child separation
  - o Tracking, identification of unaccompanied children
  - o Reunification for children and families
  - o Access to specific behavioral health therapies and social services for children
  - o Care of children with special health care needs
  - o Disaster drills include a pediatric mass casualty incident at least every 2 years and drills include pediatric patients

EQUIPMENT, SUPPLIES, MEDICATIONS

- Pediatric-Specific Considerations for Medications
  - o Anesthetics/topical (eg, EMLA [eutectic mixture of local anesthetics], lidocaine 2.5% and prilocaine 2.5%, LET [lidocaine, epinephrine, and tetracaine], L.M.X. 4 [4% lidocaine])
  - o Dextrose (D10)
  - o Oral glucose or sucrose solutions for pain control in infants
  - o Vaccines
  - o Oral suspensions of medications administered orally
- General Equipment
  - o Patient warming device (including for newborn infants)
  - o IV blood/fluid warmer
  - o Restraint device
  - o Weight scale, in kilograms only (no opportunity to weigh or report in pounds), for infants and children

Table 1. Continued.

- o Standardized chart or tool to estimate weight if resuscitation precludes the use of weight scale (eg, length-based tape)
- o Tool or chart that relies on weight (kg) to determine equipment size and correct drug dosing (by weight and total volume)
- o Pain scale assessment tools that are age/developmentally appropriate
- o Rigid boards for use in CPR
- o Pediatric-specific AED pads

• Monitoring Equipment
- o Blood pressure cuffs (neonatal, infant, child, adult arm, and thigh)
- o Doppler ultrasonography devices
- o ECG monitor/defibrillator with pediatric and adult capabilities, including pediatric-sized pads/paddles
- o Pulse oximeter with neonatal, pediatric, and adult probes
- o Continuous end-tidal CO2 monitoring for children of all ages

• Respiratory
- o Endotracheal tubes:
  - uncuffed: 2.5, 3.0, 3.5 mm
  - cuffed: 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, mm
- o Feeding tubes (5F, 8F)
- o Laryngoscope blades (curved: 2, 3; straight: 0, 1, 2, 3)
- o Supraglottic airway devices (eg, i-Gel or laryngeal mask airway [LMA], size 1, 1.5, 2, 2.5)
- o Laryngoscope handle
- o Pediatric Magill forceps
- o Nasopharyngeal airways (neonatal, infant, and child)
- o Oropharyngeal airways (infant and child, sizes 0-3)
- o Stylets for endotracheal tubes (pediatric)
- o Suction catheters (infant 6-8F and child 10-12F)
- o Rigid suction device
- o Bag-mask device (manual resuscitator), self-inflating (infant, child, and adult sizes)
- o Masks to fit bag-mask device adaptor (preterm, neonatal, infant, child, and adult sizes)
- o Simple oxygen masks (standard and nonrebreather) for an infant, child, and adult
- o Nasal cannula (infant, child, and adult)
- o Gastric tubes: infant (8F) and child (10F)

• Vascular Access
- o Arm boards (infant, child, and adult sizes)
- o Atomizer for intranasal administration of medication
- o Catheter over the needle device (14- to 24-gauge)
- o Intraosseous needles or device (neonatal, pediatric, and adult sizes)
- o IV administration sets with calibrated chambers and extension tubing and/or infusion devices with ability to regulate rate and volume of infusate (including low volumes)
- o IV solutions to include: NS; D5 0.9% NS, D5 0.45% NS; lactated Ringer, and D10W

• Fracture Management
- o Extremity splints, including femur splints (pediatric and adult sizes)
- o Cervical collars (infant, child, and adult sizes)

• Specialized Pediatric Trays or Kits
- o Difficult airway supplies/kit
- o Newborn delivery kit
- o Urinary catheterization kits and urinary (indwelling) catheters (infant and child)
- o Hemorrhage control kits, including pediatric-sized tourniquets

ADDITIONAL CONSIDERATIONS

- Alprostadil (prostaglandin E1)
- Central venous catheters (4.0F-7.0F)
- Chest tubes to include infant, child, and adult sizes (infant: 8F-12F; child: 14F-22F; adult:24F-40F) or pigtail catheter kit (8.5F-14F)
- Thermometer with low temperature capabilities
- Inotropic agents (eg, digoxin, milrinone)
- Laryngoscope blade size 00
- Lumbar puncture tray including infant (22 gauge, 1.5") and pediatric (22 gauge, 2.5") sized spinal needles
- Noninvasive ventilation (continuous positive airway pressure or high-flow nasal cannula)
- Salem sump nasogastric tube (6F-16F)
- Self-inflating bag-mask device, pediatric size

Table 1. Continued.

- Tube thoracostomy tray
- Tracheostomy tubes (tube sizes 3.5 mm-5.5 mm)
- Umbilical vein catheters (3.5F and 5.0F)
- Video laryngoscopy

[a]The Physician and Nurse PECC work collaboratively on pediatric readiness initiatives. See the technical report for detailed roles and responsibilities.
[b]https://emscimprovement.center/education-and-resources/interfacility-transfer/
[c]The Choosing Wisely Initiative can be found at https://www.choosingwisely.org/
[d]https://emscimprovement.center/domains/preparedness/disaster-plan-prepare/disaster-checklist/

- Obtain a full set of vital signs on all children, pain and mental status reassessments at appropriate intervals based on facility policy, and repeat vital signs for all children who are admitted, discharged, and/or transferred. Metric units are preferred for all patient measurements (eg, height, length, head circumference), when clinically indicated by the treating clinician.
- Promote patient- and family-centered care that encompasses communication practices, informed consent, medical decision making, bereavement, and support for cultural and faith-based customs and practices.[32]
- Develop and maintain 1) policies for interfacility transfer of children that adhere to standardized criteria based on locally available resources; and 2) decision support to guide the selection of the most appropriately staffed transport service and capable pediatric receiving center.[33,34]

Table 2. Recommended Policies, Protocols, and Clinical Pathways for Pediatric Emergency Care

Pediatric triage for illness and injury[14]
Pediatric patient assessment and reassessment, including complete set of vital signs and frequency of reassessment[26]
Documentation of a full set of vital signs, including weight in kilograms, core temperature, respiratory rate, pulse oximetry, heart rate, blood pressure (including manual confirmation), pain, and mental status, when indicated[21-31]
Identification and notification of the responsible provider for abnormal vital signs (age appropriate)[25,26]
Pediatric sedation and analgesia[41,42]
Pediatric transfusion procedure[43-46]
Consent of minors (including when the caregiver is unavailable)[47]
Management of caregivers who exhibit verbal or physical abuse to staff[48]
Assuming temporary protective custody of a child[47]
Pediatric social issues including food insecurity, housing instability, and home safety[49]
Approach and management of a child with agitation[19,50]
Suicide screening and management[51]
Child maltreatment assessment and mandated reporting[52]
Reduced dose radiation for pediatric imaging[38]
Death of a child in the ED[53,54]
Family-centered care (including medical decision making, presence during resuscitation, discharge planning, education, and bereavement)[55,56]
Communication with the medical home[57,58]
Lack of a medical home[57,58]
Do-not-resuscitate orders[59]
Children with medical complexity (including developmental disabilities and medical dependency) that includes coordination of care with subspecialists and adjustment of care plans as needed[57]
Immunization assessment and management[60,61]
All-hazard disaster preparedness plan includes pediatric-specific needs, including (equipment and supplies, pediatric surge capacity, triage and decontamination, behavioral health during disasters, pediatric patients in drills, and reunification)[35]
Pediatric telehealth/telemedicine for subspecialty consultation[62,63]
Human trafficking screening and management[64,65]
Interfacility transfer guidelines[33]

Table 3. Recommended Quality Measures for Pediatric Emergency Care.[66-70]

Clinical Area of Focus	Phase of Care	Directionality	Quality Measure
Patient assessment and reassessment	Assessment	Increase	Percentage of pediatric patients with weight documented in kilograms only
		Increase	Percentage of pediatric patients with pain assessed
		Increase	Percentage of pediatric patients with vital signs reassessed
	Intervention	Decrease	Median time from collection of first set of vital signs to first intervention (eg, oxygen, medication)
	Disposition	Decrease	ED length of stay (ED arrival to discharge[a])
Interfacility transfer	Disposition	Increase	Percentage of transferred pediatric patients who met the site-specific criteria for transfers
		Decrease	Time from arrival to transport
Blunt head trauma	Assessment	Increase	Percentage of pediatric patients with a full set[b] of vital signs obtained.
		Increase	Percentage of pediatric patients with a Glasgow Coma Scale reassessment
	Diagnostics	Increase	Percentage of patients with a head CT that met evidence-based criteria[c]
	Intervention	Decrease	Percentage of pediatric patients who received inappropriate hypotonic fluids
Seizures	Assessment	Increase	Percentage of pediatric patients with a neurologic reassessment
	Intervention	Increase	Percentage of pediatric patients who received at least one additional class of antiepileptics (for patients requiring ≥2 doses of benzodiazepines)
	Diagnostics	Decrease	Percentage of pediatric patients who underwent invasive diagnostic assessments: blood glucose, blood work, urinalysis, lumbar puncture, and head CT
Respiratory	Intervention	Increase	Percentage of pediatric patients with asthma or croup that received a steroid
		Decrease	Median time to steroids in patients diagnosed with asthma or croup (ED arrival to steroid administration)
		Increase	Percentage of pediatric patients ≥2 years with a diagnosis of asthma that received a beta agonist
		Decrease	Median time to beta agonist administration in patients ≥2 years with a diagnosis of asthma (ED arrival to beta agonist administration)
		Decrease	Percentage of patients who received an antibiotic
	Diagnostics	Decrease	Percentage of patients who underwent unnecessary chest radiography
Vomiting and dehydration	Intervention	Increase	Percentage of pediatric patients who received an antiemetic
		Decrease	Time to first antiemetic (ED arrival to antiemetic administration)
		Increase	Percentage of patients who received oral rehydration
Mental health	Assessment	Increase	Percentage of patients who had a structured suicide screen
		Increase	Percentage of patients with a positive suicide screen who had a structured suicide assessment
	Intervention	Increase	Percentage of patients with a positive suicide screen who had a consultation with a licensed mental health professional
		Increase	Percentage of patients with a positive suicide screen who received a discharge safety plan

[a]For purposes of standardization, discharge is defined to be the moment of physical departure from the ED.
[b]Includes temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, mental status, and pain assessment.
[c]One example is the Pediatric Emergency Care Applied Research Network Head CT Rules.[34]

- Collaborate with hospital and local emergency management personnel to promote disaster drills that include pediatric victims, minimize parent-child separation during decontamination, track and identify unaccompanied children, facilitate family reunification, determine pediatric surge capacity, and provide emergency pediatric behavioral health during disasters.[35]
- Collaborate with 9-1-1 transporting agencies and first responder organizations on regional integration of pediatric readiness across the emergency care continuum.
- Have medical imaging protocols that address age- or weight-appropriate dose reductions for children.[36-38]

Quality and Performance Improvement

- Collect clinical data from pediatric encounters across a core set of pediatric-specific quality measures to identify areas of low performance and implement strategies to improve clinical performance.[39] See Table 3.
- Conduct multidisciplinary review of all pediatric deaths and adverse events to identify opportunities for improvement.

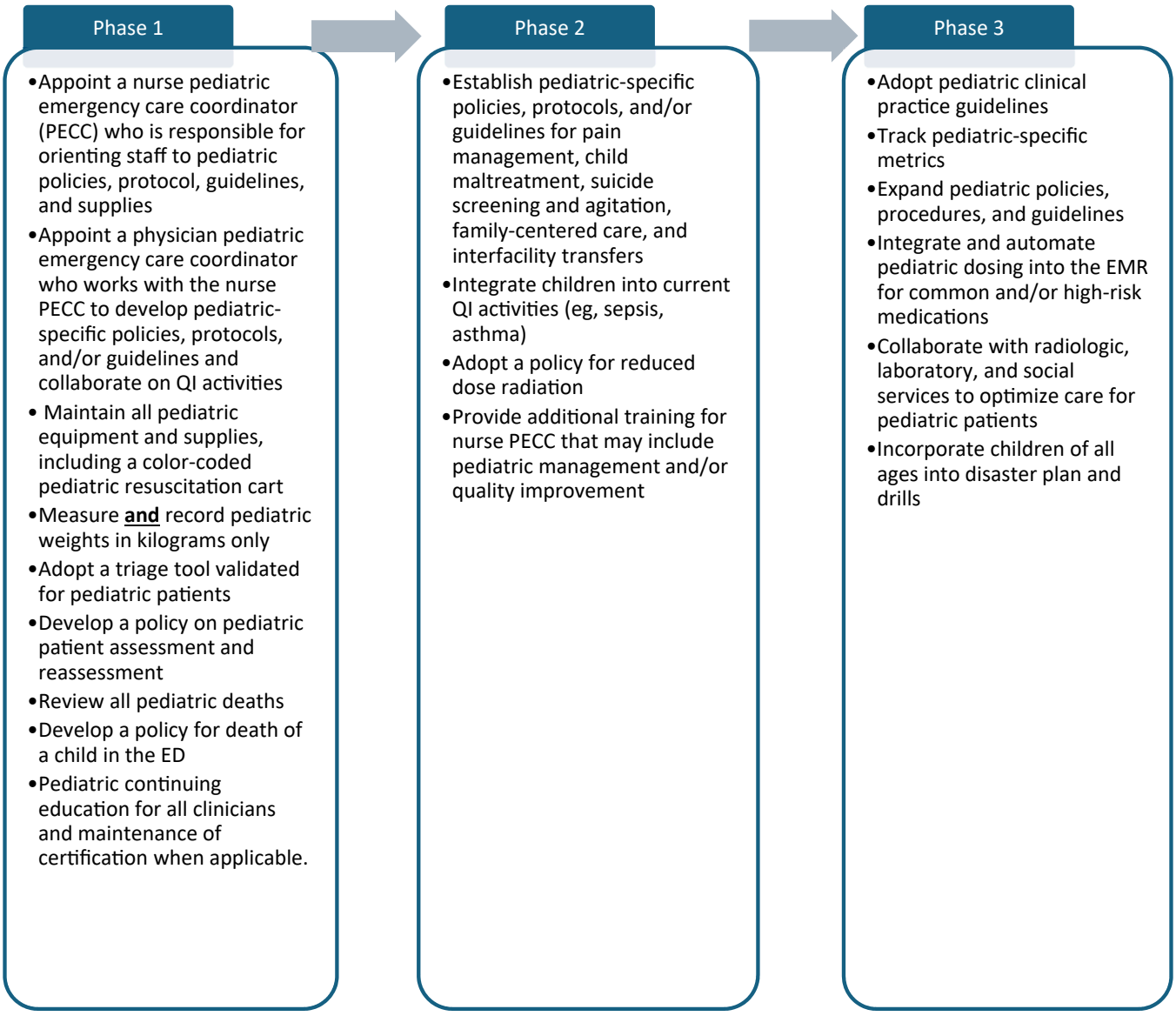

Figure. Pediatric readiness implementation algorithm for the care and resuscitation of the ill or injured child

Sustainability of Pediatric Readiness

- Have ED participate in external verification for pediatric readiness recognition when available.[40]

Recognizing that achieving pediatric readiness is a process, the Figure serves as a suggested stepwise approach for EDs to achieve high levels of pediatric readiness. The National Pediatric Readiness Project Toolkit hosted by the Emergency Medical Services for Children Innovation and Improvement Center is a comprehensive, open-access toolbox that contains sample policy templates and decision algorithms, as well as many other resources (https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/).

CONCLUSIONS

High pediatric readiness is associated with increased survival among critically ill and injured children and adolescents. Appointed PECCs and continuous pediatric quality improvement are the primary drivers of all aspects of pediatric readiness. The infrequent exposure of ED-based health care professionals to seriously ill or injured children is a barrier to the maintenance of essential

pediatric skills and clinical competencies. Engagement in continuous pediatric quality improvement efforts is vital to ensure high-quality emergency care for all children. Recognition of the unique needs of children and the commitment to pediatric readiness through the adoption of these recommendations is an essential first step to achieve the best outcomes for ill and injured children. Resources to assist with implementing all aspects of this document can be found at www.pediatricreadiness.org and in the accompanying technical report.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors, the American College of Emergency Physicians and its Board of Directors, and the Emergency Nurses Association and its Board of Directors.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication. All Rights Reserved.

This paper was jointly developed by *Journal of Emergency Nursing*, *Annals of Emergency Medicine*, *American Academy of Pediatrics*, *The Journal of the American College of Surgeons* and jointly published by Elsevier Inc, American Academy of Pediatrics and Wolters Kluwer Health, Inc. The articles are identical except for minor stylistic and spelling differences in keeping with each journal's style. Either citation can be used when citing this article.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

© 2025 Emergency Nurses Association, American College of Emergency Physicians, American Academy of Pediatrics and The American College of Surgeons. Published by Elsevier Inc on behalf of Emergency Nurses Association and American College of Emergency Physicians, by American Academy of Pediatrics and by Wolters Kluwer Health, Inc. on behalf of The American College of Surgeons. All rights are reserved, including those for text and data mining, AI training, and similar technologies.

Author affiliations: Departments of Pediatrics and Surgery and Perioperative Medicine, Dell Medical School at the University of Texas at Austin, Austin, Texas; Department of Emergency Medicine, University of California San Francisco, and UCSF Benioff Children's Hospitals, San Francisco, California; Department of Surgery, Division of Pediatric Surgery, University of California San Francisco, and UCSF Benioff Children's Hospitals, San Francisco, California; Departments of Surgery and Pediatrics, University of Tennessee Health Science Center and Le Bonheur Children's Hospital, Memphis, Tennessee; School of Nursing, University of North Carolina at Chapel-Hill, Chapel-Hill, North Carolina; Department of Emergency Medicine, University of Florida College of Medicine-Jacksonville, Jacksonville, Florida; Departments of Pediatrics and Emergency Medicine, SUNY Upstate Medical University; Syracuse, New York; Departments of Pediatrics and Emergency Medicine, The George Washington University School of Medicine, and Children's National Medical Center, Washington, District of Columbia; Los Angeles County EMS Agency, Department of Emergency Medicine and Pediatrics, David Geffen School of Medicine at UCLA, Harbor-UCLA Medical Center, Department of Emergency Medicine, Los Angeles BioMedical Research Institute, Los Angeles, California

CONTRIBUTORS' STATEMENT: Dr. Remick, Dr. Foster, Dr. Jensen, Dr. Williams, Dr. Stone, Dr. Joseph, Dr. Conners, Dr. Brown, and Dr. Gausche-Hill were each responsible for all aspects of writing and editing the document and reviewing and responding to questions and comments from reviewers and the Board of Directors.

FUNDING: No external funding.

FINANCIAL/CONFLICT OF INTEREST DISCLOSURE: Drs. Remick, Jensen, and Gausche-Hill receive funding from the Health Resources and Services Administration EMS for Children Program of the U.S. Department of Health and Human Services (HHS), grant # U07MC37471. The remaining authors have indicated they do not have a financial relationship relevant to this article to disclose.

REFERENCES

1. Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine and Section on Surgery; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Pediatric readiness in the emergency department [reaffirmed January 2024]. *Pediatrics*. 2018;142(5):e20182459. https://doi.org/10.1542/peds.2018-2459
2. Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL; American Academy of Pediatrics; Committee on Pediatric Emergency Medicine and Section on Surgery; American College of Emergency

Physicians; Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Pediatric readiness in the emergency department. *Ann Emerg Med*. 2018;72(6):E123-E136. https://doi.org/10.1016/j.annemergmed.2018.08.431
3. Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine and Section on Surgery; American College of Emergency Physicians; Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Pediatric readiness in the emergency department. *J Emerg Nurs*. 2019;45(1):E3-E18. https://doi.org/10.1016/j.jen.2018.10.003
4. McDermott KW, Stocks C, Freeman WJ. Overview of pediatric emergency department visits 2015. In: *Healthcare Cost and Utilization Project (HCUP)* Statistical Briefs [Internet]. August 7, 2018. Agency for Healthcare Research and Quality Statistical Brief #242. Accessed February 18, 2025. https://www.ncbi.nlm.nih.gov/books/NBK526418/
5. Remick KE, Hewes HA, Ely M, et al. National assessment of pediatric readiness of US emergency departments during the COVID-19 pandemic. *JAMA Netw Open*. 2023;6(7):e2321707. https://doi.org/10.1001/jamanetworkopen.2023.21707
6. Gausche Hill M, Ely M, Schmuhl P, Telford R, Remick K, Edgerton E, Olson L. National assessment of pediatric readiness of emergency departments. *JAMA Pediatr*. 2015;169(6):527-534. https://doi.org/10.1001/jamapediatrics.2015.138
7. Newgard CD, Lin A, Malveau S, et al. Emergency department pediatric readiness and short-term and long-term mortality among children receiving emergency care. *JAMA Netw Open*. 2023;6(1):e2250941. https://doi.org/10.1001/jamanetworkopen.2022.50941
8. Melhaldo C, Remick K, Miskovic A, et al. The association between pediatric readiness and mortality for injured children treated at US trauma centers. *Ann Surg*. 2024;280(6):e26-e33. https://doi.org/10.1097/sla.0000000000006126
9. Ames SG, Davis BS, Marin JR, et al. Emergency department pediatric readiness and mortality in critically ill children. *Pediatrics*. 2019;144(3):e20190568. https://doi.org/10.1542/peds.2019-0568
10. Jenkins PC, Lin A, Ames SG, et al. Emergency department pediatric readiness and disparities in mortality based on race and ethnicity. *JAMA Netw Open*. 2023;6(9):e2332160. https://doi.org/10.1001/jamanetworkopen.2023.32160
11. Remick KE, Foster AA, Jensen AR, et al; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine and Section on Surgery; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Pediatric readiness in the emergency department: Technical report. *Pediatrics*. 2025; in press.
12. Foster AA, Li J, Wilkinson MH, et al. Pediatric emergency care coordinator workforce: a survey study. *JACEP Open*. 2023;4(4):e13006. https://doi.org/10.1002/emp2.13006
13. Callahan JM, Baldwin S, Bodnar C, et al. Access to critical health information for children during emergencies: emergency information forms and beyond. *Ann Emerg Med*. 2023;81(3):e27-e36. https://doi.org/10.1016/j.annemergmed.2022.12.005
14. Triage Qualifications and Competency. Emergency Nurses Association Position Statement. Emergency Nurses Association, 2018. Accessed September 12, 2024. https://media.emscimprovement.center/documents/triagequalificationscompetency.pdf
15. Weighing All Patients in Kilograms. Emergency Nurses Association Position Statement. Emergency Nurses Association, 2016. Accessed September 12, 2024. https://media.emscimprovement.center/documents/Weighing_All_Patients_in_Kilograms_ENA_Position_Statement.pdf
16. Joseph MM, Mahajan P, Snow SK, Ku BC, Saidinejad M; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Optimizing pediatric patient safety in the emergency care setting. *Pediatrics*. 2022;150(5):e2022059674. https://doi.org/10.1542/peds.2022-059673
17. Saidinejad M, Duffy S, Wallin D, et al; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. The management of children and youth with pediatric mental and behavioral health emergencies. *Pediatrics*. 2023;152(3):e2023063256. https://doi.org/10.1542/peds.2023-063255
18. US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Critical Crossroads Pediatric Mental Health Care in the Emergency Department: A Care Pathway Resource Toolkit. US Department of Health and Human Services; 2019.
19. Gerson R, Malas N, Feuer V, Silver GH, Prasad R, Mroczkowski MM. Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry. *West J Emerg Med*. 2019;20(2):409-418. https://doi.org/10.5811/westjem.2019.1.41344
20. Cabana MD, Flores G. The role of clinical practice guidelines in enhancing quality and reducing racial/ethnic disparities in paediatrics. *Paediatr Respir Rev*. 2002;3(1):52-58. https://doi.org/10.1053/prrv.2002.0182
21. Ralston SL, Lieberthal AS, Meissner HC, et al. Clinical practice guideline: The diagnosis, management, and prevention of bronchiolitis. *Pediatrics*. 2014;134(5):e1474-e1502. https://doi.org/10.1542/peds.2014-2742
22. Kirolos A, Manti S, Blacow R, et al. A systematic review of clinical practice guidelines for the diagnosis and management of bronchiolitis. *J Infect Dis*. 2020;222(7):S672-S679. https://doi.org/10.1093/infdis/jiz240
23. Kaiser SV, Johnson MD, Walls TA, et al. Pathways to improve pediatric asthma care: a multisite, national study of emergency department asthma pathway implementation. *J Pediatr*. 2020;223:100-107.e2. https://doi.org/10.1016/j.jpeds.2020.02.080
24. American Academy of Pediatrics. VIP Pathways for Improving Pediatric Asthma Care (PIPA): Clinical Pathway for Pediatric Asthma in the Emergency Department Setting [toolkit]. Last updated: December 2015. Accessed September 12, 2024. https://downloads.aap.org/DOCCSA/PIPAEDToolkit.pdf
25. Schlapbach LJ, Watson RS, Source LR, et al. International consensus criteria for pediatric sepsis and septic shock. *JAMA*. 2024;331(8):665-674. https://doi.org/10.1001/jama.2024.0179
26. Weiss SL, Fitzgerald JC. Pediatric sepsis diagnosis, management, and sub-phenotypes. *Pediatrics*. 2024;153(1):e2023062967. https://doi.org/10.1542/peds.2023-062967
27. McDaniel CE, Kerns E, Jennings B, et al. Improving guideline-concordant care for febrile infants through a quality improvement initiative. *Pediatrics*. 2024;153(5):e2023063339. https://doi.org/10.1542/peds.2023-063339
28. Kuppermann N, Holmes JF, Dayan PS, et al. Identification of children at very low risk of clinically important brain injuries after head trauma: a prospective cohort study. *Lancet*. 2009;374(9696):1160-1170. https://doi.org/10.1016/s0140-6736(09)61558-0
29. Corwin DJ, Durbin DR, Hayes KL, Zonfrillo MR. Trends in emergent head computed tomography utilization for minor head trauma after implementation of a clinical pathway. *Pediatr Emerg Care*. 2021;37(9):437-441. https://doi.org/10.1097/pec.0000000000001728
30. Smith DM, McGinnis EL, Walleigh DJ, Abend NS. Management of status epilepticus in children. *J Clin Med*. 2016;5(4):47. https://doi.org/10.3390/jcm5040047
31. Russell WS, Schuh AM, Hill JG, et al. Clinical practice guidelines for pediatric appendicitis evaluation can decrease computed tomography

utilization while maintaining diagnostic accuracy. *Pediatr Emerg Care*. 2013;29(5):568-573. https://doi.org/10.1097/pec.0b013e31828e5718
32. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Ann Emerg Med*. 2019;73(3):e29-e31. https://doi.org/10.1016/j.annemergmed.2018.11.006
33. EMS for Children, Emergency Nurses Association, Society for Trauma Nurses. Pediatric Interfacility Transfer Guide. Revised June 17, 2024. Accessed February 18, 2025. https://emscimprovement.center/education-and-resources/interfacility-transfer/
34. Marcin JP, Sauers-Ford HS, Mouzoon JL, et al. Impact of tele-emergency consultations on pediatric interfacility transfers: a cluster-randomized crossover trial. *JAMA Netw Open*. 2023;6(2):e2255770. https://doi.org/10.1001/jamanetworkopen.2022.55770
35. Emergency Medical Services for Children Innovation and Improvement Center. Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies. August 2022. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/toolkits/pediatric-disaster-preparedness-toolbox/
36. Marin JR, Lyons TW, Claudius I, et al; American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, Section on Radiology; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; American College of Radiology. Optimizing advanced imaging of the pediatric patient in the emergency department: policy statement. *Pediatrics*. 2024;154(1):e2024066854. https://doi.org/10.1016/j.annemergmed.2024.03.023
37. Kanal KM, Butler PF, Chatfield MB, et al. U.S. diagnostic reference levels and achievable doses for 10 pediatric CT examinations. *Radiology*. 2022;302(1):164-174. https://doi.org/10.1148/radiol.2021219027
38. Nelson TR. Practical strategies to reduce pediatric CR radiation dose. *J Am Coll Radiol*. 2014;11(3):292-299. https://doi.org/10.1016/j.jacr.2013.10.011
39. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. The National Academies Press; 2001. https://doi.org/10.17226/10027
40. Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Readiness Recognition Programs. Accessed September 12, 2024. https://emscimprovement.center/domains/recognition-programs/
41. Coté CJ, Wilson S; American Academy of Pediatrics, Section on Pediatric Dentistry; American Academy of Pediatric Dentistry. Guidelines for monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures. *Pediatrics*. 2019;143(6):e20191000. https://doi.org/10.1542/peds.2019-1000
42. Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Education and Advocacy Kit (PEAK): Pain. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/peak/peak-pediatric-pain/
43. Tasker RC, Turgeon AF, Spinella PC. Recommendations on RBC transfusion in critically ill children with acute brain injury from the Pediatric Critical Care Transfusion and Anemia Expertise Initiative. *Pediatr Crit Care Med*. 2018;19(9 Suppl 1):S133-S136. https://doi.org/10.1097/pcc.0000000000001589
44. Noland DK, Apelt N, Greenwell C, et al. Massive transfusion in pediatric trauma: an ATOMAC perspective. *J Pediatr Surg*. 2019;54(2):345-349. https://doi.org/10.1016/j.jpedsurg.2018.10.040
45. Kamyszek RW, Leraas HJ, Reed C, et al. Massive transfusion in the pediatric population: a systematic review and summary of best-evidence practice strategies. *J Trauma Acute Care Surg*. 2019;86(4):744-754. https://doi.org/10.1097/ta.0000000000002188
46. Trappey AF, Thompson KM, Kuppermann N, et al. Development of transfusion guidelines for injured children using a modified delphi consensus process. *J Trauma Acute Care Surg*. 2019;87(4):935-943. https://doi.org/10.1097/ta.0000000000002432
47. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, Committee on Bioethics. Consent for emergency medical services for children and adolescents [reaffirmed April 2020]. *Pediatrics*. 2011;128(2):427-433. https://doi.org/10.1542/peds.2011-1166
48. American College of Emergency Physicians, Protection from Violence and the Threat of Violence in the Emergency Department. June 2022. Accessed September 12, 2024. https://www.acep.org/patient-care/policy-statements/protection-from-violence-and-the-threat-of-violence-in-the-emergency-department
49. Tedford NJ, Keating EM, Ou Z, et al. Social needs screening during pediatric emergency department visits: disparities in unmet social needs [reaffirmed April 2020]. *Acad Pediatr*. 2022;22(8):1318-1327.
50. Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Education and Advocacy Kit (PEAK): Agitation. Last updated July 2024. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/peak/pediatric-agitation/
51. Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Education and Advocacy Kit (PEAK): Suicide. Last updated July 2024. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/peak/pediatric-suicide-screening-mental-health/
52. Emergency Medical Services for Children Innovation and Improvement Center. Pediatric Education and Advocacy Kit (PEAK): Child Abuse. Last updated October 2023. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/peak/child-abuse/
53. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Policy statement: Death of a child in the emergency department [reaffirmed September 2019 and November 2024]. *Pediatrics*. 2014;134(1):198-201. https://doi.org/10.1542/peds.2014-1245
54. O'Malley P, Barata I, Snow S, et al; American Academy of Pediatrics; Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Emergency Medicine Committee; Emergency Nurses Association, Pediatric Committee. Technical report: Death of a child in the emergency department [reaffirmed November 2024]. *Pediatrics*. 2014;134(1):e313-e330. https://doi.org/10.1542/peds.2014-1246
55. American College of Emergency Physicians. Patient- and family-centered care and the role of the emergency physician providing care to a child in the emergency department. October 2020. Accessed September 12, 2024. https://www.acep.org/siteassets/new-pdfs/policy-statements/patient–and-family-centered-care-and-the-role-of-the-ep-providing-care-to-a-child-in-the-ed.pdf
56. Emergency Medical Services for Children Innovation and Improvement Center. Patient- and Family-Centered Care Toolkit. 2019. Accessed September 12, 2024. https://emscimprovement.center/education-and-resources/toolkits/patient-and-family-centered-care-toolkit/
57. Carrier E, Yee T, Holzwart RA. National Institute for Healthcare Reform. Research Brief Number 3. Coordination Between Emergency and Primary Care Physicians. February 2011. Accessed September 12, 2024. https://www.nihcr.org/analysis/improving-care-delivery/prevention-improving-health/ed-coordination/
58. Turchi RM, Antonelli RC, Norwood KW, et al; Council on Children With Disabilities, Medical Home Implementation Project Advisory Committee. Patient- and family-centered care coordination: a framework for integrating care for children and youth across multiple systems

[reaffirmed April 2023]. *Pediatrics*. 2014;133(5):e1451-e1460. https://doi.org/10.1542/peds.2014-0318
59. Silverman A, Batten J, Berkman E, et al. Resuscitate but not intubate? Partial codes in pediatrics. *Pediatrics*. 2023;152(2):e2022058931. https://doi.org/10.1542/peds.2022-058931
60. American College of Emergency Physicians. Immunization of Adults and Children in the Emergency Department. Revised October 2020. Accessed September 12, 2024. https://www.acep.org/patient-care/policy-statements/immunization-of-adults-and-children-in-the-emergency-department
61. Immunizations and the Responsibility of the Emergency Nurse. Emergency Nurses Association Position Statement. Emergency Nurses Association; 2019. Accessed September 12, 2024. https://media.emscimprovement.center/documents/immunizations_lBGUFpB.pdf
62. American College of Emergency Physicians. Emergency Medicine Telehealth. Revised September 2022. Accessed September 12, 2024. https://www.acep.org/patient-care/policy-statements/emergency-medicine-telehealth
63. Saidinejad M, Barata I, Foster A, et al. The role of telehealth in pediatric emergency care. *J Am Coll Emerg Phys Open*. 2023;4(3):e12952. https://doi.org/10.1002/emp2.12952
64. Greenbaum J, Crawford-Jakubiak JE, Chrisitan CW, et al; American Academy of Pediatrics, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3):566-574. https://doi.org/10.1542/peds.2014-4138
65. Chisolm-Straker M, Sze J, Einbond J, White J, Stoklosa H. Screening for human trafficking among homeless young adults. *Child Youth Serv Rev*. 2019;98:72-79. https://doi.org/10.1016/j.childyouth.2018.12.014
66. Remick K, Bartley K, Gonzales L, MacRae K, Edgerton E. A consensus-driven model to establish pediatric emergency care measures for low-volume emergency departments. *BMJ Open Qual*. 2022;11:e001803. https://doi.org/10.1136/bmjoq-2021-001803
67. Hoffmann JA, Johnson JK, Pergjika A, Alpern ER, Corboy JB. Development of quality measures for pediatric agitation management in the emergency department. *J Healthc Qual*. 2022;44(4):218-229. https://doi.org/10.1097/jhq.0000000000000339
68. Johnson TJ, Goyal MK, Lorch SA, et al. Racial/ethnic differences in pediatric emergency department wait times. *Pediatr Emerg Care*. 2022;38(2):e929-e935. https://doi.org/10.1097/pec.0000000000002483
69. Stang AS, Straus SE, Crotts J, Johnson DW, Guttmann A. Quality indicators for high acuity pediatric conditions. *Pediatrics*. 2013;132(4):752-762. https://doi.org/10.1542/peds.2013-0854
70. Emergency Medical Services for Children. National Pediatric Readiness Quality Initiative. Accessed September 12, 2024. https://emscimprovement.center/engage/nprqi/

LEAD AUTHORS
Katherine Remick, MD, FAAP, FACEP, FAEMS
Ashley A. Foster, MD, FAAP, FACEP
Aaron R. Jensen, MD, MEd, MS, FACS, FAAP
Regan F. Williams, MD, MS, FACS, FAAP
Elizabeth Stone, PhD, RN, CHSE, FAEN
Madeline Joseph, MD, FAAP, FACEP
Gregory Conners, MD, MPH, FAAP
Kathleen Brown, MD, FAAP, FACEP
Marianne Gausche-Hill, MD, FAAP, FACEP, FAEMS

AAP COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, 2024–2025
Toni K. Gross MD, MPH, FAAP, FAEMS, Chairperson
Kerry S. Caperell, MD FAAP
Jennifer A. Hoffmann, MD, MS, FAAP
Jennifer E. McCain, MD, FAAP
Sylvia Owusu-Ansah, MD, MPH, FAAP
Christian D. Pulcini, MD, MEd, MPH, FAAP
Mohsen Saidinejad, MD, MS, MBA, FAAP
David Schnadower, MD, MPH, FAAP
Caleb E. Ward, MB BChir, MPH, FAAP
Muhammad Waseem, MD, FAAP

FORMER COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE MEMBER, 2024
Gregory Conners, MD, MPH, MBA, FAAP, Chairperson

LIAISONS
Christopher S. Amato, MD, FAAP, FACEP – *American College of Emergency Physicians*
Sam Shahid, MBBS, MPH – *American College of Emergency Physicians*
Mary E. Fallat, MD, FAAP, FACS – *American College of Surgeons/AAP Section on Surgery*
Cynthiana Lightfoot – *AAP FamilY Partnerships Network*
Charles G. Macias, MD, MPH, FAAP – *EMSC Innovation and Improvement Center*
Elizabeth L. Stone, RN, PhD, CEN – *Emergency Nurses Association*
Tabitha A. Cheng, MD – *National Association of EMS Physicians*
Katherine E. Remick, MD, FAAP, FACEP, FAEMS – *National Association of Emergency Medical Technicians*
Cynthia J. Wright-Johnson, MSN, RN – *National Association of State EMS Officials*

STAFF
Sue Tellez

AAP SECTION ON SURGERY EXECUTIVE COMMITTEE, 2024–2025
Marybeth Browne, MD, MS, FAAP, Chairperson
Elizabeth Beierle, MD, FAAP
Barbara Anne Gaines, MD, FAAP
Saleem Islam, MD, MPH, FAAP, Immediate Past Chair
Marc P. Michalsky, MD, MBA, FAAP
Mehul V. Raval, MD, MS, FAAP
Danielle Saunders Walsh, MD, FAAP

Liaisons
Mary E. Fallat, MD, FAAP, FACS – *American College of Surgeons/AAP Section on Surgery*

Staff. Vivian Thorne

ACEP PEDIATRIC EMERGENCY MEDICINE COMMITTEE, 2024–2025
Madeline Joseph, MD, FACEP, Chair
Kiyetta Alade, MD
Christopher Amato, MD, FACEP
Jahn T. Avarello, MD, FACEP
Steven Baldwin, MD
Isabel A. Barata, MD, FACEP, FAAP
Lee S. Benjamin, MD, FACEP
Kathleen Berg, MD
Kathleen Brown, MD, FACEP
Jeffrey Bullard-Berent, MD, FACEP
Ann Marie Dietrich, MD, FACEP
Phillip Friesen, DO
Michael Gerardi, MD, FACEP, FAAP
Alan Heins, MD, FACEP
Doug K. Holtzman, MD, FACEP
Jeffrey Homme, MD, FACEP
Timothy Horeczko, MD, MSCR
Paul Ishimine, MD, FACEP
Samuel Lam, MD, RDMS
Katharine Long
Kurtis Mayz, JD, MD, MBA
Sanjay Mehta, MD, Med, FACEP
Larry Mellick, MD
Aderonke Ojo, MD, MBBS
Audrey Z. Paul, MD, PhD
Denis R. Pauze, MD, FACEP
Nadia M. Pearson, DO
Debra Perina, MD, FACEP
Emory Petrack, MD
David Rayburn, MD, MPH
Emily Rose, MD
W. Scott Russell, MD, FACEP
Timothy Ruttan, MD, FACEP
Mohsen Saidinejad, MD, MBA, FACEP
Brian Sanders, MD
Joelle Simpson, MD, MPH
Patrick Solari, MD
Michael Stoner, MD
Jonathan H. Valente, MD, FACEP
Jessica Wall, MD
Dina Wallin, MD
Muhammad Waseem, MD, MS, FACEP
Paula J. Whiteman, MD, FACEP
Dale Woolridge, MD, PhD, FACEP

Former ACEP Pediatric Emergency Medicine Committee Members, 2024
Joseph Arms, MD
Richard M. Cantor, MD, FACEP
Ariel Cohen, MD
Carrie DeMoor, MD
James M. Dy, MD
Paul J. Eakin, MD
Sean Fox, MD
Marianne Gausche-Hill, MD, FACEP, FAAP
Timothy Givens, MD
Charles J. Graham, MD, FACEP
Robert J. Hoffman, MD, FACEP
Mark Hostetler, MD, FACEP
Hasmig Jinivizian, MD
David Markenson, MD, MBA, FACEP
Joshua Rocker, MD, FACEP
Brett Rosen, MD
Gerald R. Schwartz, MD, FACEP
Harold A. Sloas, DO
Annalise Sorrentino, MD, FACEP
Orel Swenson, MD
Michael Witt, MD, MPH, FACEP Staff
Loren Rives, MNA
Dan Sullivan
Stephanie Wauson

EMERGENCY NURSES ASSOCIATION PEDIATRIC COMMITTEE, 2024-2025
Julie Cohen, MSN, RN, CEN, CPEN
Lisa Hill, DNP, RN, TCRN, EMT-P I/C
Kimberly MacKeil-White, DNP, RN, CPEN, NPD-BC
Courtney Williams Simmons, MSN, RN, CPEN, TCRN, NPD-BC, CEN, ENA Senior Nursing Content Specialist

Board Liaisons
Maureen Curtis-Cooper, BSN, RN, 2016 Board Liaison
Kathleen Carlson, MSN, RN, 2017 Board Liaison Staff
Marlene Bokholdt, MSN, RN
American College of Surgeons Committee on Trauma, 2024-2025
Jeffrey D. Kerby, MD, PhD, FACS, Chair
Warren Dorlac, MD, FACS, Vice Chair
Lillian Kao, MD, FACS, Chair, Quality Pillar

John Sutyak, MD, FACS, Chair, ATLS Working Group
Brendan Campbell, MD, FACS, Chair, Injury Prevention
John Armstrong, MD, FACS, Chair, Advocacy Pillar
Stephen Barnes, MD, FACS, Chair, Membership
Kristan Staudenmayer, MD, FACS, Chair, Trauma Systems
Scott Sagraves, MD, FACS, Chair, Verification Review Committee
Nirav Patel, MD, FACS, Chair, Global Working Group

https://doi.org/10.1016/j.annemergmed.2025.11.016