



News

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In This Issue:

- President's Corner 2
- AMR Appoints Leading EMS Physician As New CMO 3
- SCAA to Address Advancements in Prevention and Treatment for Nation's Leading Cause of Death at Annual Meeting 4
- Crystal Clear Vision 5
- NAEMSP® Board of Directors Elections 6
- EMS Sub-Specialty Update 6
- The Wilderness Medical Society 7
- Blast Injury Preparedness and Response Information . 7
- Grant from the Duke Endowment News Release 8
- NAEMSP®-ZOLL EMS Resuscitation Research Fellowship 10
- Nominations for 2010 Awards 12
- New Members 13
- EMS Calendar 13

TEMS A Trial by Fire

by Keith Murray, MD

Emergency Medicine Physician, Austin Medical Center, Austin, MN
Team Physician, NIPAS EST, Cook County Sheriffs Police HBT

I never imagined that in my third year of emergency medicine residency at the University of Chicago Medical Center that I would be running in 30 pounds of body armor, carrying a collapsible ladder, and heading toward a house with a known criminal inside. I had been working for the past year with the Cook County Sheriffs Police Department (CCSPD) Hostage, Barricaded, Terrorist team (HBT), but this was the first time I was in one of the forward elements. We had received intelligence that a known felon was selling firearms and narcotics out of his home, and we had been granted a search warrant to investigate. The approach was simple; 12 of us, fully armored and riding on the outside of our ballistics van, were to deploy once we came to a complete stop in front of the house. The only sound that could be heard as the van hopped the curb and came to rest was of 24 boots hitting the ground and breaking into the three teams that would comprise the assault elements. My team ran the gauntlet as we split the other two teams providing lethal cover for us and sprinted to the 'D-David' side of the house. The four of us split yet again and the first and last man in my group stepped left and right respectively to provide closer lethal cover as I came around to the lead with the collapsible ladder. I spun, coming to an abrupt halt as my back struck the house and began to deploy the ladder. Glass rained down on me as the third man in my team began to 'break and rake' the window just to the side of my position. The command, "ladder," was given and I placed it on the left aspect of the now empty window socket so that my right-handed shooter could move into position to provide inside cover for the other two teams about to make entry. Two flash-bang grenades and 10 seconds later, the house was



Dr. Dennis (left) and myself, Dr. Murray

secure and three bad guys were safely in custody – with no shots fired and no injuries to my guys.

This was the culmination of my one-year long senior project working in conjunction with Andrew Dennis, D.O., FACOS, DME Trauma Surgery/Burn/Critical Care at The Cook County Trauma Unit. Dr. Dennis is a sworn peace officer for Des Plaines, Medical Director for the SWAT team, and an attending trauma surgeon at Cook County Trauma. We used the University of Texas Southwestern's tactical medicine fellowship curriculum as a skeleton and created the outline of a tactical medicine fellowship for Cook County, as well as a 28-day "awareness level" rotation that would be open to senior level residents in both emergency medicine and surgery who were interested in tactical medicine. I was the guinea pig. My first exposure to true tactical medicine was the 28-day rotation with multiple SWAT teams in the Chicago-land area. The next several months of training were centered on putting in my dues, getting to know the members of the two separate teams and earning their respect. In conjunction,

continued on page 3

Theodore Delbridge, MD, MPH NAEMSP® President, 2009-2011

Summertime can be tough in terms of driving toward significant goals. That is, of course, unless they relate to improving a golf swing, perfecting a barbeque recipe, hiking a mountain, or finding some R&R. Nevertheless, over the past two months, the fields of EMS and NAEMSP® have both cleared major hurdles that were next steps in their development.

As members of NAEMSP®, whether we are physicians or professional members, we recognize the inherent need for quality medical direction of EMS systems. We understand that medical direction is as integral to EMS delivery as the providers in the field. When it is done well, by individuals with knowledge, skill, and commitment, EMS systems achieve meaningful goals for the benefit of their communities and patients. When qualified physicians with knowledge and skills are lacking, EMS systems are more likely to struggle to deliver state-of-the-art care and achieve the sorts of results that are otherwise possible for their patients.

We and others have worked long to achieve deserved recognition for those physicians who prepare themselves and then dedicate meaningful portions of their careers to deliver quality health care to their communities via the EMS systems they help lead. We are now one step closer. Weeks ago the American Board of Medical Specialties (ABMS) committee with jurisdiction over such matters voted to move the issue of EMS sub-specialization to the full ABMS Assembly for a final vote. This is huge! It was only possible because of NAEMSP®'s leadership manifest through several hard-working members, collaboration with the American College of Emergency Physicians (ACEP), and the support of the American Academy of Emergency Medicine (AAEM) and Society for Academic Emergency Medicine (SAEM). But, for the past 15 months the ball has been carried with resolve and political agility by the American Board of Emergency Medicine (ABEM). Having received the proposal crafted by NAESMP® and ACEP, the leadership of ABEM, including President Debra Perina, made the issue of EMS sub-specialization a priority, shepherding it first through the approval processes for ABEM and now ABMS.

The ABMS will consider the issue at its meeting in late September. We will, of course, be standing by with great anticipation. Should it pass, EMS will become a subspecialty of Emergency Medicine, and ABEM will immediately begin work to develop the tools and testing necessary for implementing the paths to subspecialty certification.



In July, the NAEMSP® Board of Directors took a step to help the organization grow to serve its members in a new way. Frequently NAEMSP® members have common interests or objectives with regional foci. They could benefit from the strength of organization, but it can be difficult for a national/international association such as NAEMSP® to responsibly engage on that level. Thus, there is a role for regional chapters of NAEMSP® to help members network and address issues they have in common. The Board has approved a process through which NAEMSP® members can now develop chapters of the association.

The policy and a handbook to help members pursue chapter charters are available on-line at the NAEMSP® website. Members may organize themselves on statewide bases, regional bases (parts of states or multiple states) and national and multi-national bases outside the United States. NAEMSP® is prepared to assist with start-up costs for each chapter, and hopes to charter four as pilots during this fiscal year. Again, among the many possible benefits is the opportunity to use the influence of NAEMSP® to positively affect EMS in more regional ways and help members connect with each other for causes they share.

Certainly, this has been a busy summer. As we look forward over the next few months, we will have much to celebrate at our annual meeting in Bonita Springs, Florida. In the meantime, do not hesitate to be in touch with committee chairs to see how you can be making a difference at NAEMSP® so that NAEMSP® can be making a difference for you. *

The National Association of EMS Physicians® is an organization of physicians and other professionals partnering to provide leadership and foster excellence in out-of-hospital emergency medical services.

The NAEMSP® newsletter is designed to inform members of interesting developments in the field of EMS. Members are encouraged to send information which may be of interest to others reading this publication.

NAEMSP® News is the official newsletter of the National Association of EMS Physicians® (NAEMSP®).

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AMR Appoints Leading EMS Physician As New CMO

From Business Wire | Tuesday, July 27, 2010

GREENWOOD VILLAGE, Colo. – American Medical Response (AMR) today announced the appointment of Edward Racht, M.D. to the newly created position of Chief Medical Officer. Dr. Racht has been an emergency medical services physician and educator for more than 20 years. A widely recognized leader and frequent keynote speaker, Dr. Racht received his medical degree from the Emory University School of Medicine and completed his residency at the Medical College of Virginia. Dr. Racht will join AMR effective September 20, 2010.

Prior to joining AMR, Dr. Racht served as Vice President of Medical Affairs and Chief Medical Officer for Piedmont Newnan Hospital in metro Atlanta. He has served as the Medical Director of the Austin / Travis County Emergency Medical Services System (Texas), Co-Medical Director of the Richmond Ambulance Authority (Virginia) and in multiple career and volunteer EMS organizations in Texas and Virginia. Dr. Racht is a Clinical Associate Professor of Emergency Medicine at the University of Texas Southwestern Medical School in Dallas, and is an active member of the Medical Director's Course faculty for the National Association of EMS Physicians. In 1999, he was appointed as the first Chairperson of the State of Texas EMS & Trauma Advisory Council, and served as Chair until 2008.

Dr. Racht has been extensively involved with the American Heart Association and has been active in international healthcare, serving as a consultant to the World Bank and as the American founder of the Vladivostok and Moscow, Russia, EMS Training Centers. Dr. Racht serves on multiple national and local committees and advisory boards, and is a frequent educational and keynote speaker on acute healthcare and the complexities of medical practice in the streets. He is well known for his "operationalizing medicine" initiatives and his passion for building integrated systems of care.

Mark Bruning, AMR President, said of Dr. Racht, "I am truly pleased to welcome a physician leader of Ed's caliber to the AMR family. In his new role, he will work closely with our paramedics and EMTs, medical directors, clinical services professionals and operations leaders to advance our clinical commitments to excellence and the provision of quality emergency medical care. He will lead our efforts in delivering to our employees the training, education and clinical standards to ensure that the patients and communities we serve continue to receive the highest-quality level of pre-hospital services." *

TEMS A Trial by Fire

continued from page 1

I was interfacing with the various EMS elements on these two teams collectively referred to as our Tactical EMS or TEMS elements. They largely consisted of full-time firefighters and/or police officers who had certifications as paramedics and were also involved with the SWAT team. Dr. Dennis and I would set up training centered on mission specific objectives (focusing on the 'bleeding and breathing' paradigm) that could be expected on certain "call-out" situations, drill the TEMS providers in the various areas, and then integrate these situations into the full team-training days.

My senior year also gave me a new found respect for the EMS personnel working in the field. I had done several ride-alongs in my first year of residency, but never appreciated the breadth and depth that these guys were trained. I found myself teaching medical topics on lecture days, and I inversely learned from my guys in the field to be solely responsible for gaining IV access, priming IV lines, mixing drugs and administering these drugs. I knew how to do these things in a safe and contained situation but not in an austere environment with the possibility of coming under direct fire. To begin training for these situations, we embraced the "practice how you play" paradigm. All of our simulations worked on this principle. To carry this further we have several exciting projects that we are working on for next year. Dr. Dennis and I are currently negotiating with the Chicago Fire Department and are planning on using its "Simulation Alley" for further TEMS training. It is a working city block equipped with smoke buildings, water, electricity, breachable doors and windows. We will be able to incorporate individual training into larger team exercises. Combining this larger scale simulation exercise with a new simulation fellow (affiliated with Evanston Hospital, part of the NorthShore University HealthSystem), we plan to design core competency skill sets with drills first in the simulation lab and then moving to field exercises where we can measure competencies. Skill sets would include hemorrhage control with IBDs and CATs, carries, drags, field intubations and back-up airway use, ACLS, ATLS, needle thoracostomy, etc.

The future of tactical medicine in the Chicago area is only limited by our imagination. I believe that the enthusiasm, EMS support, law enforcement support and university residency support is there and only needs to be harnessed. *





Sudden Cardiac Arrest Association to Address Advancements in Prevention and Treatment for Nation's Leading Cause of Death at Annual Meeting

Media Contact: Jill Talley
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Washington, DC (July 2, 2010) – October is National Sudden Cardiac Arrest Awareness Month, and the Sudden Cardiac Arrest Association (SCAA) will raise awareness about the nation's leading cause of death through a variety of educational sessions and advocacy events at its Annual Meeting, October 8-10, 2010, at the Pittsburgh Marriott City Center in Pittsburgh, Pennsylvania.

The three-day program begins with a Medical Education Conference on Friday, October 8, 2010, featuring some of the country's leading experts in cardiology and electrophysiology who will address the latest advancements in preventive care, in-hospital post-resuscitation care and EMS/out-of-hospital treatment, and provide insight on the prevalence of sudden cardiac arrest in youth and athletes. Attendees also will learn of positive patient outcomes directly from SCA survivors. Sponsored by the Heart Rhythm Society, SCAA and University of Pittsburgh Medical Center (UPMC), the Medical Education Conference affords professionals the opportunity to earn 6.5 continuing medical education credits.

"In recent months, we've seen death rates due to cancer drop in areas throughout the country, but sadly the cases of sudden cardiac death and heart disease-related illnesses continue to rise," said Robert Schriever, Chairman of SCAA and an SCA survivor.

"This is all the more reason we must continue to raise awareness among the general public on the importance of CPR and automated external defibrillators (AEDs) and expand training and educational opportunities for professionals in the medical field so that we all can collaboratively increase survivability of SCA, and the Annual Meeting is a unique and timely opportunity for us to do just that."

Festivities also include a Survivor Celebration on Friday evening, where SCA survivors from across the country will gather and be recognized for their efforts in increasing awareness of SCA. And the 2010 SCAA Awards Dinner will take place on Saturday, October 9, honoring community advocates, first responders, corporate citizens and medical leaders for their continued efforts to raise awareness of SCA, prevent sudden cardiac death and improve cardiovascular health. *

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About the Sudden Cardiac Arrest Association

SCAA is the nation's largest non-profit advocacy organization exclusively dedicated to SCA awareness and prevention. For more information, please visit www.suddencardiacarrest.org.

EXECUTIVE OFFICE STAFF LISTING

The NAEMSP® Executive Office staff and email address information is listed below for your reference.

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Crystal Clear Vision

Commentary by Troy M. Hagen

The crystal ball has been used to “see” the past, present, and future since 500 AD. The accuracy and reliability of clairvoyant visions can certainly be argued, but what if we were able to use such a tool to “see” where EMS has been, where it is currently, and what it will become in the future.

There was little question in 1966 about the efficacy of a robust emergency care system when the National Academy of Sciences (NAS) published *Accidental Death and Disability: The Neglected Disease of Modern Society* that documented widespread deficiencies across the US. This white paper spurred Congress to pass laws that helped usher in a modern EMS. Apparently, the crystal ball was lost in the early 1980s when federal leadership lost its focus and sent states and local EMS agencies on their merry way to develop their own EMS systems. If one could have seen the future, they certainly would not have taken the actions they did. It appears the crystal ball was replaced with a spinning dartboard with a very small bullseye.

One does not need special tools to witness the state of EMS today across the country. It is widely diverse with multiple models, organizational structures, funding mechanisms, scopes of practice, and competencies. However, even with all these disparate systems, there are pockets of excellence and EMS has made an impact to the health care delivery system. The push for evidence-based medicine has challenged many previous cornerstones of medical care, but overall, EMS has been shown to make a difference. The National EMS Advisory Council (NEMSAC) documented the EMS impact with its white paper: *EMS Makes a Difference: Improved Clinical Outcomes and Downstream Healthcare Savings* (www.ems.gov/nemsac/index.html). NEMSAC reviewed over 400 articles to evaluate the current state of EMS research and determine whether conclusions can be drawn when taken from a global view. While we may still argue whether ALS makes a difference in critical trauma, there is little question that EMS makes a difference within the trauma system of care. The same can be stated for STEMI and stroke care. Within these systems of care, EMS has found a place in the healthcare system where its true impact can be measured, analyzed and continually improved from both patient outcomes and financial perspectives.

So what is next for EMS? It is time to throw out the dartboard, grab the crystal ball, and embrace the visions that can become reality in the near future. The simple decision to act will define the next generation of EMS.

My crystal ball portrays EMS greatness. In the future, EMS will:

- Become recognized as an essential service for every community
- Be an integral part of the health care system. Community paramedics and advanced practice paramedics will continue to expand the role and scope of EMS in emergency care, prevention, and public health activities
- Be funded for the delivery of health care services and no longer only a transportation benefit
- Resolve disputes between different model types with sound governance and good public policy

- Play a significant role in local, state, and federal emergency preparedness and mass care activities and the recipient of appropriate grants to fulfill this mission
- Have a lead federal agency advocating for EMS on Capitol Hill and with other federal agencies
- Have defined core competencies, an accredited curriculum, and a national credentialing system for EMS providers, instructors, field training officers, supervisors, managers, and executives
- Become recognized and fulfilling as a career and not a stepping stone into other disciplines or roles
- Improve its safety record to safeguard its most precious resources – the EMS providers and the communities they serve
- Have universities and foundations dedicated to EMS research
- Have established a national standard setting body

How do we make all this happen in a few short years from now? EMS providers and leaders must be engaged at all levels. One cannot sit back and wait for others to do this for us. The country is going through rapid change in nearly every industry, nothing more prevalent than health care. EMS needs a seat at the table as the next evolution of health care is created. Everyone involved in EMS must be an advocate for the EMS providers, the EMS system, and the patients we serve.

All EMS leaders and EMS providers must:

- Get involved!
- Ensure quality and excellence by continuing to learn and improve our medicine and processes to increase value to the public we serve
- Provide additional proof that EMS makes a difference
- Educate policy makers, the medical community, and the general public about EMS and the impact we make.
- Advocate for sound public policy at all levels of government
- Change the way EMS is financed through congressional action
- Understand the entire system of care and lead EMS into arenas where we can make the most difference to the most amount of people

Once accomplished, EMS will no longer be just a medical taxi but a full-service health care, public health, and public safety entity.

It all starts with you and getting engaged. Without you, the vision in the crystal ball will be just smoke and mirrors. *

About Troy Hagen

Troy M. Hagen, MBA, Paramedic, is the Director for Ada County Paramedics in Boise, Idaho. He has been involved in EMS for 21 years. He sits on the Board of the National EMS Management Association and is the official Board Liaison to NAEMSP®. He also is a member of the NEMSAC and served as primary author for the (*EMS Makes a Difference*) whitepaper.

NAEMSP® Board of Directors Elections

**For Terms January 2011 –
Annual Meeting January 2013**

The NAEMSP® Nominating Committee, chaired by Immediate Past President David C. Cone, MD, is pleased to present you with the following exceptional candidates for the open positions on the NAEMSP® Board of Directors.

The NAEMSP® Board of Directors candidate slate is as follows:

President-Elect

Ritu Sahni

Secretary/Treasurer

Jane Brice

John McManus

Physician Member-At-Large (three positions available)

Doug Floccare

David Tan

Kevin Mackey

Karen Wanger

Ron Roth

Allen Yee

The candidates listed above are members in good standing with NAEMSP® and have agreed to serve the membership and the best interests of the association if elected.

In the case of a tie in voting, a subsequent election will be held for those candidates involved in the tie. If a tie results after two elections, the NAEMSP® Board of Directors shall determine the winner by a simple majority vote of the members of the Board.

IMPORTANT! The NAEMSP® election will be conducted on-line again this year. Each eligible voting member with an active email in the NAEMSP® database will be receiving email instructions and a link to the election website with a unique identifier. Each member may only cast one ballot.

Members for whom we either do not have an email address in the NAEMSP® database or the email address does not work, will receive a postcard at the physical mailing address we have on file. The postcard will provide detailed instructions about accessing the voting website.

Voting will be open from September 15 – October 31, 2010 at 5:00 p.m. Eastern Time. No votes will be accepted after this time. If you have any questions, or have not received notification about voting via email or postcard, please contact NAEMSP® at (913) 895-4611 or by email at info-naemsp@goAMP.com.

Voting is open to all physician, professional, international, resident and fellow members of the NAEMSP® in good standing. Medical students and honorary members are not eligible to vote.

Thank you for taking time to place your vote for your NAEMSP® Board of Directors. *

EMS Sub-Specialty Update

David C. Cone, MD
Jane H. Brice, MD, MPH

As most of our members are aware, our EMS Physician Certification Task Force, supplemented with additional members from the American College of Emergency Physicians (ACEP), spent most of 2008 writing an application for formal recognition of EMS as a physician subspecialty. A group of eight subcommittees assisted in the writing of the application, which was handed off to the American Board of Emergency Medicine (ABEM) for a first review in February 2009. Following additional discussion and edits, ABEM submitted the application to the American Board of Medical Specialties (ABMS) in August 2009.

In February 2010, the ABMS Committee on Certification, Subcertification and Recertification (COCERT) reviewed the application, and Dr. Debra Perina (immediate past-ABEM president, and former NAEMSP® board member) answered a number of COCERT's questions. In March, ABMS sent a letter to ABEM asking for additional information on five aspects of the application, and the replies to that letter have been drafted. COCERT met again in late July, at which time Dr. Perina presented the replies to the questions and answer any additional questions that arise. COCERT did, at its July meeting, vote to move the application to the ABMS Assembly for consideration at its September meeting.

In parallel, the Accreditation Council for Graduate Medical Education (ACGME) has begun reviewing the application, with specific attention to program requirements for EMS fellowship programs. Dr. Lynne Meyer, the executive director of the emergency medicine Residency Review Committee (RRC-EM), indicates that a minimum of 1.5 to 2 years will be needed for ACGME to develop the program requirements and the needed documentation; thus, credentialing of fellowship programs is still several years away. Similarly, it will take a number of years for ABEM to create a certification exam, which will likely be a half-day exam of roughly 200 multiple-choice questions. It is never too soon, however, for existing fellowship programs and others who are considering establishing a fellowship to start examining the draft new fellowship curriculum that was submitted as part of the application. Please visit the NAEMSP® web site for the current draft fellowship curriculum, as well as the PowerPoint slides of our presentation at the Society for Academic Emergency Medicine Annual Meeting held in Phoenix in early June. We will continue to provide updates in this newsletter, and will present additional details at a didactic session at the NAEMSP® annual meeting next January in Bonita Springs, Florida. *

The Wilderness Medical Society

is organizing an international delegation of specialists in wilderness EMS/Search & Rescue to travel to China. The trip will be in October of this year.

EMS personnel (physicians or non-physicians) with particular interest and training in wilderness medicine make ideal delegates and would be strongly encouraged to apply for inclusion on this delegation.

The trip leader will be Section member Seth Hawkins, and a strong showing of NAEMSP® delegates would be fantastic.

A smaller and more generalized delegation last year enjoyed a number of unique experiences. Highlights included rescue training on an unreconstructed (non-tourist) portion the Great Wall of China with the Blue Sky mountain rescue group; visiting with villagers in rural communities to learn cultural differences in conceptions of health and illness; tours of mainstream and TCM Chinese hospitals and EMS centers; and extraordinary Chinese meals, including the mandatory Peking Duck and more exotic items like scorpions, firewater and intricate dumpling dishes.

This year a more prehospital-intensive program plans similar activities with even more specialized focus, including the opportunity to:

- Participate in **high-level, bilateral exchanges** with leading Asian mountain rescue/SAR groups and individuals
- **Share techniques, equipment, training and management principles** with Chinese counterparts
- **Challenge yourself and your perspectives** as you witness firsthand China's wilderness medical, rescue and prehospital systems
- **Create connections** with your fellow delegates and Chinese counterparts that generate lasting professional and personal benefits
- **Earn 15 hours** of continuing medical education
- Enjoy ample time for **touring highlights of Chinese culture**, one of the oldest civilizations in the world. This trip also grants 15 hours of continuing education and has ample time for touring highlights of Chinese culture as well as professional activities.

More information and an application form is available at: www.peopletopeople.com/lorengreenway.

Questions can be directed to trip leader Seth Hawkins at hawk@aya.yale.edu, Wilderness Medical Society leader Loren Greenway at loren@wms.org, or People to People Ambassador Program at 877.787.2000 or info@peopletopeople.com. *



Be Ready in a Moment's Notice: Blast Injury Preparedness and Response Information



CDC wants to help you and your staff to be ready in a moment's notice to treat and receive patients after a terrorist bombing.

Why is this important? Terrorist bombings have the potential to inflict multi-system and life threatening injuries on many persons simultaneously. In addition, they present profound surge capacity challenges, affecting health systems and capabilities.

To this end, CDC has developed two new mass casualty and emergency response documents:

- ***In a Moment's Notice: Surge Capacity for Terrorist Bombings***, download a free copy at: <http://emergency.cdc.gov/masscasualties/surgecapacity.asp>.
- ***Interim Planning Guidance for Preparedness and Response to a Mass Casualty Event Resulting from Terrorist Use of Explosives***, download a free copy at: http://emergency.cdc.gov/masscasualties/terrorist_explosives.asp.

In these documents, health care providers and systems will gain knowledge about the critical steps needed to prepare for and respond to a terrorist bombing, including:

- Discipline-specific and practical solutions for the surge challenges of multiple patients at the scene and after a terrorist bombing, and
- Guidance for health systems and policy leaders on how to prepare for and respond a terrorist bombing

For more information and resources related to the treatment of blast injuries or on surge capacity after a terrorist bombing, please visit: <http://emergency.cdc.gov/BlastInjuries>.



State of North Carolina
Department of Health and Human Services

For Release: Immediate
Contact: Jim Jones, (919) 733-9190

Date: June 29, 2010

**Grant from The Duke Endowment provides
critical ambulance cardiac resuscitation equipment**

RALEIGH – North Carolina patients with a life threatening illness or injury will have a better chance of survival through a \$2.15-million grant awarded this month by The Duke Endowment to the N.C. Department of Health and Human Services.

Each year, EMS systems provide emergency care to more than 1.1 million people in North Carolina, of whom 7,500 will have suffered a cardiac arrest and another 100,000 will have a condition that could develop into cardiac arrest or require aggressive treatment and monitoring. Across the county-based EMS systems in North Carolina, cardiac arrest survival rates vary from as low as 5 percent to as high as 40 percent. The national average survival rate for an out-of-hospital cardiac arrest is less than 7 percent.

This grant will provide medical devices to EMS agencies and assist EMS professionals in rapidly identifying patients who are experiencing a life threatening event as well as provide vital information guiding the correct treatment. These devices also can assist EMS in identifying which patients require hospitals specializing in heart, stroke, trauma, or intensive care.

Currently one-third of North Carolina's 1,000 on-duty EMS ambulances and response vehicles do not have capnography equipment – which monitors carbon dioxide in a patient's breath – and one-fourth do not have 12-lead electrocardiogram (ECG) devices which monitor the heart. This grant will close that gap by providing funding to enable local EMS agencies to purchase the needed devices. The end result will be improved response, care and outcomes for patients experiencing life threatening illness, injury, or cardiac arrest. Funding will focus on in-service units that need the equipment.

"We are grateful to The Duke Endowment for providing these critically needed funds," said Lanier M. Cansler, secretary of the Department of Health and Human Services. "We're also grateful to our partners at the EMS Performance Improvement Center at the UNC-Chapel Hill Department of Emergency Medicine for their support in helping us to recognize the need. Once this specialized equipment is in place, it will greatly increase the chances of survival for cardiac arrest patients in their service areas."

Gene Cochrane, president of The Duke Endowment, said that through all of its health care grants, the Endowment is committed to projects that will enhance the lives of individuals in our region.

(MORE)

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Renee McCoy
Director



(Grant from The Duke Endowment, Page Two)

“When more response vehicles have access to this important equipment, more people in crisis situations will receive quality care,” he said. “We are pleased to play a role in strengthening emergency medical services in North Carolina.”

The funds will be made available through the N.C. Office of Emergency Medical Services (OEMS), which is part of the Division of Health Service Regulation, and the EMS Performance Improvement Toolkit – Cardiac Arrest Program.

Drexdal Pratt, chief of the N.C. OEMS, said there will be an application process for those needing the equipment. All EMS agencies submitting an application for funding that have in-service vehicles currently not equipped with these devices will be provided the funds necessary to meet the need.

The grant could provide as many as 282 electrocardiogram devices and up to 350 of the devices that measure carbon dioxide levels in exhaled breath. “It is an indicator of how well the patient is breathing and how well the patient is metabolizing, internally,” Pratt said. “It is considered the standard of care for EMS systems in the placement and monitoring of airways that are used to ventilate or breathe for patients who cannot on their own.”

The North Carolina College of Emergency Physicians has strongly recommended that the N.C. OEMS require both devices to be present on every in-service EMS vehicle in the state and the equipment has been part of the state’s EMS treatment protocols for the past eight years.

The Duke Endowment, located in Charlotte, N.C., seeks to fulfill the legacy of James B. Duke by improving lives and communities in the Carolinas through higher education, health care, rural churches and children’s services. Since its inception, the Endowment has awarded nearly \$2.7 billion in grants.

#



NAEMSP®—ZOLL EMS Resuscitation Research Fellowship



In recognition of the need for trained researchers specializing in prehospital resuscitation and the need for improving the care of patients requiring resuscitation, the National Association of EMS Physicians® and ZOLL have collaborated to create the NAEMSP®-ZOLL EMS Resuscitation Research Fellowship.

Purpose:

The purpose of this two-year fellowship is: 1) to prepare and train individuals for a career in prehospital resuscitation research and to serve as a stepping stone for individuals to become independent prehospital resuscitation researchers; 2) to expand the commitment of academic institutions to prehospital resuscitation research; and 3) to expand the field of prehospital resuscitation research.

This fellowship will support the development of research skills and the completion of a resuscitation research project under the supervision of an experienced mentor. Completion of this fellowship should prepare individuals to become independent with sustained extramural funding.

Eligibility: The Resuscitation Fellowship consists of the Applicant, the Mentor, and the Institution. All three must meet basic criteria:

Applicant —

The applicant for the Resuscitation Fellowship must be a junior faculty member (position below Associate Professor, within 10 years of completing residency or fellowship training, and have no R01-level or similar awards) and hold a terminal degree (MD, DO, PhD, PharmD, etc). Preference will be given to residency trained Emergency Medicine physicians, but non-physicians and physicians not trained in Emergency Medicine may also apply.

Mentor —

Mentorship is a critical component of this Research Fellowship and a well-qualified mentor must be identified. The mentor should be an accomplished investigator in resuscitation research, with a track record in publishing studies, obtaining grant funding, and mentoring. A primary mentor should be identified who will, with the applicant, be responsible for planning and completing the Research Fellowship. Co-mentors may be identified as appropriate. Mentorship committees are strongly encouraged due to the interdisciplinary nature of prehospital resuscitation research, but a primary mentor must be identified.

Institution —

Any institution in the United States or Canada may apply for the Research Fellowship as long as it 1) is university-based or linked to an academic institution; 2) has an active prehospital resuscitation research program; and 3) sponsors an ACGME- or Royal College of Physicians and Surgeons of Canada- approved Emergency Medicine residency program. Institutions that can demonstrate a track record of extramural competitive grant funding; dedicated funds, space, and support staff; and interdisciplinary research will receive preference.

Details and Expectations of the Award

The NAEMSP®-Zoll EMS Resuscitation Research Fellowship is a two-year award (July 1-June 30) that makes available up to \$80,000 per year. None of these funds may be used for facilities and administrative costs (“indirects”). A maximum of 75% of the funds (\$60,000 per year) may be allocated for salary and benefits support for the fellow. The remainder should be used to support research such as supplies, equipment, research assistant, education and travel costs. No funds may be used for mentorship salary, secretarial support, renovations. A complete budget must be submitted with the application.

The resuscitation research project should be identified and clearly described in the application for the Fellowship. For guidance, applicants should review the National EMS Research Agenda, the EMS Outcomes Project, the EMS-C Five-Year Plan, and other published priority-setting consensus documents to identify aspects of resuscitation in need of research.

During the fellowship, the recipient of the award will be expected to:

1. work no more than 12 hours per week on clinical activities;
2. attend the NAEMSP® Annual Meeting each year of the fellowship;

During or within one year of completion of the fellowship, the recipient of the award will be expected to:

1. submit an abstract for review and presentation at the NAEMSP® annual meeting;
2. submit at least one manuscript from the research project to Prehospital Emergency Care.

The recipient of the award will submit progress reports every six months during the fellowship period and one year after completion of the fellowship to the NAEMSP® Research Committee. Completion of these requirements are the responsibility of the applicant, mentor(s), and institution. Failure to adhere to these expectations can lead to termination of the award.

Funds will be distributed annually based upon the progress reports submitted to NAEMSP®.

Selection Guidelines

Nominations will be reviewed and selections made by NAEMSP®. A review committee will be selected from the NAEMSP® Research Committee and will be appointed by the Chair of the Research Committee and approved by the NAEMSP® President. This group will review the application based on the following:

1. merit and feasibility of the proposed research;
2. impact of the study on resuscitation;
3. the applicant’s interest in pursuing a career in prehospital resuscitation research;
4. the strength of the mentor(s);
5. the strength of the institutional support;
6. the strength of the research environment;
7. appropriateness of the budget request.

The recommendations of the review committee will be submitted to the NAEMSP® Board along with written critiques of each application. The Board will make the final award decision based on the review committee’s recommendation.



Application Process

The application will be due to NAEMSP® by November 20, 2011 for the award to start on July 1, 2012. Only electronic submissions will be accepted. Submissions can be emailed to info-naemsp@goamp.com. The PHS 398 forms (available at www.nih.gov, revised 4/2006) will be used for the application, using the instructions for the K-Awards, with the modifications listed here.

1. Under Section II of the PHS 398 form, 1A-1D and 4A-4D combined must be no longer than 20 pages.
2. Of the three letters of reference submitted with the application, one must come from the applicant’s current department chair.
3. The appropriate departmental chair or dean for the applicant institution must authorize the letters of institutional support and departmental support.
4. The Checklist page does not need to be submitted.
5. The Other Support page should be submitted for the primary mentor.



Nomination for 2010 Awards

Due Date: October 1, 2010

Candidate's Name: _____

Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Your Name: _____

Telephone: _____ E-mail: _____

NOMINATION FOR THE FOLLOWING AWARD:

■ **Ronald D. Stewart Award**

This award is given annually to a person who has made a lasting, major contribution to the EMS community nationally. This is often considered a lifetime achievement award. Recent recipients have included Dr. Daniel Storer, Dr. Mickey Eisenberg, Jim Page, Dr. Jon Krohmer, Dr. Edward Cain, Dr. Roger White, Dr. William Jermyn, Dr. Daniel Spaite

■ **Keith Neely Outstanding Contribution to EMS Award**

This award is presented to an active or past member of NAEMSP® (physician or non-physician) who has provided significant leadership to the Association. Recent recipients have included Lawrence Brown, EMT-P, Dr. Ray Fowler, Dr. Rick Hunt, Dr. Ted Delbridge, Dr. Juliette Saussy, Dr. David Persse, Beth Adams, Dr. Robert O'Connor, Dr. Douglas Kupas

■ **Friends of EMS Award**

This award is presented to a individual who has been an advocate to further NAEMSP®'s mission nationally through influencing or implementing public policy. The award is typically given to a governmental individual or organization, EMS organization, or congressional leader. Recent recipients have included Mr. Robert Niskanen, the Laerdal Family, Dr. Jeff Runge (NHTSA administrator), Drew Dawson (NHTSA EMS Chief) and Dr. Richard Carmona (Former U.S. Surgeon General) and Dan Kavanaugh (EMSC), Susan McHenry(NHTSA), William Ball (GM OnStar)

REASON FOR NOMINATION (attach separate page if necessary):

Please submit form by October 1, 2010 to:

NAEMSP®, Attn: Stephanie Newman at SNewman@goamp.com or Fax: (913) 895-4652

NAEMSP® is also soliciting applications for the **EMS Fellowship Recognition Awards**. Criteria for this recognition, and submission forms, are available on the NAEMSP® website under Fellowships. Submissions are due by October 1, 2010.



Welcome New Members

John J. Ahern, II
Pushpal R. Banerjee, DO
Michael T. Barr, MD
Eric H. Beck, DO, EMT-P, CCEMT-P
Steven Blyth, MD
Douglas T. Boyce, EMT-P, SEI
Douglas Clark, CCEMT-P
Benjamin L. Cornett, MD
Fabrice Dami, MD, MBA
Richard W. Dandridge, EMT-P
Denise H. Daudelin, RN, MPH
Eric G. Davis, AS, NREMT-P
William Dick, MD
Christopher L. Dunnahoo, MD
James F. Goulding, MD
Larry R. Handlin, DO

Jeff Hawkins, AAS, EMT-P
Attila J. Hertelendy, PhD, NREMT-P
Garrett Herzberg, EMT-P
Gregory A. Ingram, MD, EMT-B
Richard R. Kimball, MD
Elizabeth A. Kubota, EMT
James S. Lee, BMSc
JiHun M. Lee, DO
David P. Lehrfeld, MD
Paul R. Leslie, ACP
Renee S. MacPhee, PhD
Elizabeth B. Murray, DO, MBA
Patrick M. O'Neill
Kevin M. Payne, EMT-P/IC
Phillip Rawlings, BS, EMT-P
Jose A. Rubero, MD

Rebecca Rupp, DO
Stephan Samoyloff, MD
Jordan B. Schooler, PhD, EMT-E
Manish I. Shah, MD
Anthony Shields, MD
Michael Smialowski, MD
Nicholas Sparrow, MBBS, BSc, MRCCP
Michael R. Underwood, MD
Jaya Uppal, MD
Jessica B. Van Voorhees, EMT, MD
Jonathan Wendell, MD

EMS Calendar

*Mark your calendar and
make plans now to attend!*

October 14, 2010 – Update on Tactical Medicine: Concepts and Controversies, Texas Health Research & Education Institute, Dallas, TX, www.TexasHealth.org/CME, (866) 295-3269

October 29-31, 2010 – American Academy of Neurology, 2010 Fall Conference, Encore at Wynn, Las Vegas, NV, <http://www.aan.com/view/fc>, Early Registration Deadline: October 6, 2010

December 8-11, 2010 – Emergency Cardiac Care Update (ECCU 2010), Citizen CPR Foundation, San Diego, CA, www.eccu2010.com, (703) 538-3548

January 13-15, 2011 – NAEMSP® 2011 Annual Conference, Hyatt Regency Coconut Point, Bonita Springs, FL, www.naemsp.org

July 4-6, 2011; ACEM – Asian Conference for Emergency Medicine 2011, Thai Association for Emergency Medicine, Centara Grand & Bangkok Convention Centre at CentralWorld, Bangkok, Thailand, <http://www.acem2011.org>

Be sure to check out the most updated version of the EMS Calendar at www.NAEMSP.org