News

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Training & Tools for Rural Responders

Information Courtesy of Bethany Cummings, DO

The Nation's rural emergency responders face unique challenges when compared to their urban counterparts. In recognizing the need for consistent, quality training which addresses those challenges, Congress and the Department of Homeland Security (DHS) established the Rural Domestic Preparedness Consortium (RDPC or the Consortium) to develop and deliver relevant all-hazards training in support of rural homeland security requirements. Led by Eastern Kentucky University, the Consortium is comprised of academic partners that possess extensive experience and unique capabilities in serving the rural emergency response community. The RDPC is composed of the following academic partners, as well as other strategic partners who support its mission:

East Tennessee State University
Johnson City, Tennessee

Eastern Kentucky University
Richmond, Kentucky

Iowa Central Community College
Ft. Dodge, Iowa

NorthWest Arkansas Community College
Bentonville, Arkansas

The University of Findlay
Findlay, Ohio

North Carolina Central University
Durham, North Carolina

Courses currently offered include MGT 335 *Event Security Planning for Public Safety Professionals*, AWR 147 *Rail Car Incident Response*, AWR 144 *Port & Vessel Security for Public Safety and Maritime Personnel*, and AWR 148 *Crisis Management for School-Based Incidents – Partnering Rural Law Enforcement and Local School Systems.* **All training delivered by the RDPC is certified by DHS and is offered tuition-free.**

To ensure that training directly reflects the needs of rural emergency responders, the Consortium convenes an annual national rural emergency preparedness summit and completes a bi-annual national survey of rural stakeholders. Data gathered from these activities is used to determine the type of training needs, the extent to which it is needed, and the best methods for delivering it.

Additionally, to ensure that RDPC's activities are validated by the stakeholders it serves, an Advisory Board of practitioners serving in rural areas across the Nation provides guidance and recommendations to the program. The RDPC Advisory Board consists of 19 national organizations and associations representing the Emergency Services Sector, public health, state and local government, the National Guard, and private industry. The Board is currently chaired by the International Association of Directors of Law Enforcement Standards and Training with the National Association of EMS Physicians serving as the Vice-Chairwoman. Vice-Chairwoman, Dr. Bethany Cummings, says, "the Consortium creates a unique opportunity for information sharing in a collaborative and cooperative environment among the emergency response and public safety disciplines and the academic partners, to develop and deliver educational programs which will further emergency preparedness targeted to rural stakeholders."

To find out more information on RDPC, request a course, or find training in your area, please visit www.ruraltraining.org, contact RDPC staff at (859) 622-8106, or email info@ruraltraining.org.

This project is supported by Cooperative Agreement Number 2007-GD-T7-K007 administered by the U.S. Department of Homeland Security (DHS), Federal Emergency Management Agency (FEMA) National Preparedness Directorate (NPD) National Integration Center (NIC), Training and Exercise Integration/ Training Operations (TEI/TO). Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the United States Government. *

President's Corner

Theodore R. Delbridge, MD, MPH

This year marks the 25th anniversary of NAEMSP. It also marks the 25th anniversary of the Emergency Medical Services for Children (EMS-C) program of the U.S. Health Resources and Services Administration.

While children may represent 20% or more of emergency department patients in the U.S., they typically comprise less than 10% of EMS patients. Yet, their needs are often quite specific. The potential benefit of doing the right thing for them can be quite extraordinary. Saving the life of a child or limiting long term disability potentially affects many more quality life years than similar efforts do for adults. Thus, even though the EMS system might encounter proportionately fewer children than adults, the cumulative number of quality life years at stake is significant.

Clearly, we should not be doing less for adult patients, but we must do all we can for our children. That, to my understanding, has been part of the message of the EMS-C program for more than two decades. What's good for pediatric patients is good for the whole of the EMS system. And, if it's good for the EMS system, it ought to be good for children, as well. To its credit, the EMS-C program has focused our attention on the important issues of caring for our children by promoting needed education and training, demonstration projects, and important works of research.

At its recent annual grantee meeting, there was palpable energy. While there was a sense of accomplishment in bringing children's issues to the forefront, there was recognition that there is so much more to be done. Among the attending physicians, nurses, EMS personnel, administrators, educators, researchers, policy makers, and parents there remained extraordinary commitment and a sense of duty and responsibility.

NAEMSP has previously partnered with EMS-C and others to ensure presentation of pediatric content at our annual meetings, to conduct pre-conference workshops regarding EMS research fundamentals, to develop ambulance equipments lists, and to develop model protocols. Of course, NAEMSP looks forward to continuing its support for the initiatives and ideals of the EMS-C program long into the future!

What about out-of-hospital cardiac arrest? We all have them (hopefully)…people in our communities saved by the EMS system (the big system) to survive out-of-hospital cardiac arrest. I recently met two such people. Eddie, from Austin, Texas, is in his 40's with two young daughters. He collapsed at his local health club where there was an AED. Jim was visiting rural West Virginia when he collapsed at a conference center in a large park. Again, there was an AED in the facility. Neither Eddie nor Jim had any prior clue of heart disease. Their stories reminded me of how exceptional it can be when the EMS system, all of its parts, work as intended.

A recent out-of-hospital cardiac arrest summit sponsored by the American Heart Association also reminded me that there are three types of EMS systems: a) those that hope to save out-of-hospital cardiac arrest victims and know exactly how they are doing; b) those that think they save victims of out-of-hospital cardiac arrest but really have no idea; and c) those that generally don't save victims of out-of-hospital cardiac arrest and know it. In fact, they may have given up. We definitely, I believe, ought to be striving to be type "a" communities.

We should be all about translating science, or sometimes just consensus of thought, into practice in the field. As EMS leaders, we should be expected to advocate for systems designed to save out-of-hospital cardiac arrest victims. We should know our success rates, we should be monitoring them, and we should be deploying strategies to improve them. One possibility we cannot overlook is implementation of induced post-resuscitation hypothermia for appropriate patients.

Some would argue that our ability to save victims of out-of-hospital cardiac arrest is an excellent measure of the overall effectiveness of our EMS systems. Others might argue against that presumption. However, for sure, if this is not the measure of success we, in each of our systems, ought to be clear about what is, why, and how we are doing.

Finally, there is a lot going on. It is an exciting time. NAEMSP members, please do not be shy about engaging with your organization by contacting a committee chair and getting involved. ✱

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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.

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Tale of Twelve Cities – Managing Chaos

Preparing for Terrorist Bombings

Cai Glushak, MD, FACEP, NAEMSP® News Editor

In recent years, the Centers for Disease Control, Division of Injury Response, has hosted a series of meetings intended to better prepare the hospital and EMS community for terrorist bombings. The effort has been a progressive process of accumulating the collective wisdom of healthcare leaders and government figures who have had to deal with catastrophic bombings or been in charge of preparing their communities. The first meeting took place in May of 2007, in which representatives of the U.S.' three largest cities, New York, Chicago and Los Angeles, met with leaders from Israel, Spain and the UK – three locations that have had abundant recent experience with such attacks. A meeting in December, 2008 in Bethesda, Maryland expanded this forum to 12 cities, including San Francisco, Boston, Washington, D.C. as well as Islamabad, Mumbai, New Delhi, London, Madrid and the state of Israel.

Hosted by Dr. Richard Hunt, Division Director and Past NAEMSP® President and facilitator Dr. Leonard Marcus, Director of the Program for Healthcare Negotiation and Conflict Resolution at the Harvard School of Public Health, the forum provided a rich exchange of experiences between communities who have faced these tragic events and cities who have made significant preparations, but been tested little by the real thing. In fact, here lay the irony: while the U.S. has arguably devoted the greatest resources to preparing their EMS and hospital systems for terrorist events, most of the lessons learned come from overseas and all too often from cities with less advanced healthcare or EMS systems.

The special international presenters included:

- New Delhi: Dr. Sanjeev Bhoi, Professor of Emergency Medicine and Officer in Charge, JPN Apex Trauma Centre
- Mumbai: Dr. Aparna Deshpande, MS, DNB, Professor, Department of Surgery, Seth G. S. Medical College and King Edward Memorial Hospital
- Islmabad: Dr. Rashid Jooma, FRCS, FRCSEd(SN), Professor, Ministry of Health, Government of Pakistan
- London: Simon Lewis, Chief Superintendent and Head of Emergency Preparedness, Emergency Preparedness Operational Command Unit, Metropolitan Police Service, New Scotland Yard
- Madrid: Fernando Turégano, MD, PhD Head, General Surgery 2 and Emergency Surgery, University General Hospital Gregorio Marañón
- Israel: Isaac Ashkenazi, MD,Director of the Urban Terrorism Preparedness Project, National Preparedness. Dr. Ashkenazi, who serves as a consultant to the forum and to communities dealing with terrorist bombings worldwide, is a former Surgeon General of the Israel Home Front Command (HFC), having extensive experience dealing with numerous bombing incidents.

A number of revelations emerged surrounding the array of special management issues involved in bombing situations: recognition of the unique and diverse pattern of blast injuries; the dynamics of the blast scene; the effectiveness of EMS and law enforcement response and hospital readiness, to name a few.

Knowing What Injuries to Expect

It is clear that a diverse, but distinct pattern of injuries results from bombing incidents and several of the speakers noted that lack of appreciation of these otherwise unusual injuries hampered their management approach. Dr. Deshpande, whose hospital in Mumbai received the largest number of victims in the 2007 train bombings, reported the most frequent injuries as burns, shrapnel and missile injuries, traumatic amputations, long bone fractures; perforated eardrums, and hemo/pneumothoraces. Victims who died tended to be dead on arrival or perished within the first 24 hours. Dr. Turegano-Fuentes described a similar pattern in Madrid as well as a significant number of eye, head and spinal cord injuries. Of note, the presence of tympanic membrane perforation, occurring in 240 of the 512 victims on whom they had complete information, was found to be a sensitive marker of severe blast exposure.

Understanding Patterns and Risk

The distribution and injury pattern of victims will clearly depend on the microenvironment of the incidents. The London, Madrid and Mumbai bombings were dispersed throughout multiple locations creating increased panic, resource deployment challenges and severe communications headaches. It also made it difficult to coordinate hospital destinations as victims converged from multiple sites. Both the London and Madrid experience attested to the increased force of a blast in enclosed spaces, the destruction and casualties being far more significant in train cars that were in confined tunnels. Mr. Lewis described the additional problem of rescue access combined with the effects of smoke inhalation in these confined spaces. In Islamabad, Dr. Jooma stated that the secondary fire that swept through the Marriott hotel resulted in a large number of burn victims as compared to the common blast situation.

Chaos Management

Perhaps the single most recurrent theme was the repeated description of chaos that emergency responders and healthcare leaders had to manage. Chaos struck at every level – EMS response, public reaction, media and responding healthcare personnel. Organized triage and patient distribution were challenging if not impossible as EMS responders converged on usually the closest hospitals with limited coordinated direction from "incident command." In Madrid, two separate responding EMS agencies more or less operated independently, while in other cities, the EMS response was rudimentary, with "responders" with limited training exercising independent decisions. In all situations, walking wounded and the victims transported by private vehicle generally arrived at hospitals before those transported by EMS. As victims with any independent mobility rapidly cleared the scene, "helpful" medical and untrained responders converged on both the incident locations as well as the hospitals. These unmanaged responders presented almost as much of a challenge as taking care of the

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actual victims. Dr. Jooma found one way to deal with some of the louder "helpers" was to have someone of authority assign them discrete tasks in order to focus their attention away from the general confusion. In India and Pakistan, not only were the media a continuous force to contend with, but politicians used the hospitals as "photo ops" on an ongoing basis, thus commanding attention, creating further security concerns and attracting crowds.

It became clear that the challenge in these situations is not that of "organizing" the scene or getting control, but rather preparing for any number of uncontrollable realities and preparing your responders at all levels to deal with it. While the concept of field hospitals and treatment might be useful in specific situations, it seemed rarely practical in the setting of bombings, where the general tendency was to evacuate the scene rapidly and allow forensics and recovery forces to take over. In fact, Dr. Ashkenazi, who persistently counsels leaders to accept the realities of these chaotic scenes, said that in Israel the expectation is that all victims needing hospital treatment will have it started within 60 minutes of the blast and that the scene will be completely cleared within 180 minutes. They attempt to restore the scene to normal activity within 2-4 days, a practice that has served as an emotional deterrent to perpetrators.

Surge and Redistribution

What was a universal reality in all events was that victims will converge on the closest hospitals. This is where privately transported patients, walking wounded and worried well, families, media, law enforcement and even ambulances will all head. Hospitals must assume this and not count on external authorities to head off the first wave of victims. For the U.S., the discussants recognized the challenge will be further compounded by the relatively small size of most U.S. facilities, compared to the frequently huge publically funded hospitals that treated many of the victims in the overseas incidents. Most of these hospitals have thousands of beds and therefore considerably more internal surge capacity and flexibility.

This was not to say that we can do nothing to offset the situation. Better organized EMS response systems may indeed be able to influence the initial distribution of ambulance-transported victims, though this requires greater focus on incident command-to-field communications and monitoring of community bed availability. There has been progress on this front in L.A. and in the distribution of burn beds in N.Y. Real-time bed surveillance remains a challenge in most population centers, however. Participants persistently focused on optimizing patient *re* –distribution potential as a more practical means of re-allocating the burden of hospital care. There was widespread agreement that all communities should place more emphasis on this means of surge planning with stronger inter-hospital planning along with a central coordinating authority and a quick to mobilize interfacility transportation plan.

Many More Lessons

There were many more important considerations, both persisting problems and best practices shared, covering an array of important issues – the group felt palpable progress could be made on many of them with an organized focus: altered triage and an adjusted standard of care; emergency credentialing mechanisms; using drills more effectively and better preparing the public; using uniform terminology; avoiding duplication of training resources; and, not least, a more structured approach to collecting data scientifically on these incidents for future study and preparation.

While Dr. Richard Hunt and the Center for Injury Response are making it a priority to get this rich experience in greater depth to the responder community through various venues, they already make some valuable materials available to get you started. The Division makes its CDC Blast Injury Fact Sheets available by rapid fax to responders to any blast incident. They also have a data extraction form in English and Spanish to help collate information. An instructional CD-Rom is also available, with an updated version due out in the near future.

More information can be obtained about the Tale of Twelve Cities forum as well as the response to bombings and terrorism events at http://www.cdc.gov/injuryresponse/index.html. If you would like more information about the participants or the proceedings, you can also contact Dr. Richard Hunt or the author. ✱

NAEMT's AMLS Course Continues to Grow

Vince Mosesso, MD,
AMLS Medical Director

NAEMSP® has provided medical leadership and endorsement of the Advanced Medical Life Support Course developed and sponsored by the National Association of EMTs since its inception in 1999. This course holds a unique niche among the cadre of "merit badge" courses, filling the gap between ACLS® and ATLS®. AMLS curriculum includes all medical illness and conditions outside of cardiac arrest. What really distinguishes this program is its approach to the content. AMLS takes a symptom-based approach and focuses on critical thinking to work through differential diagnoses, considering life-threats first then other critical and serious conditions. Much of the learning occurs in small group patient simulation scenarios. The numbers of AMLS courses and participants has grown steadily each year, with over 700 courses taught and over 9000 students trained in 2008.

The course is overseen by the NAEMT's AMLS Committee, chaired by Linda Abrahamson, RN, EMT-P. Medical oversight is provided by me and our newly appointed associate medical director, David J. Hirsch, MD, both as appointed liaisons of NAEMSP®. David is currently serving as an EMS fellow with Boston EMS. Other members of the Committee include Rosemary Adam, Ann Bellows, Brad Pierson, and Tony Brunello.

The committee is currently in the process of updating the AMLS course with new educational materials including new course media and a new textbook. Many supplemental resources will be provided for participants. These are slated for publication by the end of 2010.

AMLS should be considered for both initial and continuing education for all prehospital care providers. Many critical care transport and emergency department staff also find the program very beneficial. ✱

Advocates for EMS:

QUARTERLY REPORT *as of March 2009*

To kick off the year, Advocates for EMS Board of Directors met in Jacksonville, Florida during the National Association of EMS Physicians' annual conference to plan its legislative strategy for 2009. Legislative goals for 2009/fiscal year 2010 in addition to funding for NEMSIS include:

- Improve worker protections with the reinstatement of the Ryan White CARE Act language and provide death benefits to non-governmental and volunteer firefighters, ground and air ambulance crew members and first responders;
- Improved first responder grant funding for EMS providers at the Department of Homeland Security;
- Increase the number of members of the House of Representatives in the Congressional EMS Caucus;
- Advocate for the passage of some of the recommendations from the IOM Future of Emergency Care Report recommendations, including improved EMS and enhanced EMS research and a regionalization demonstration program; and
- Build relationships with the new Administration and those agencies that have programmatic and regulatory authority over EMS such as HHS, DHS and NHTSA.

Actions By the New Congress

With the new Congress off to a fast start, Advocates has been as well. Congress started off the year finishing what the 110th Congress could not; the renewal of the Children's Health Insurance Program (CHIP). The new CHIP is estimated to provide health care coverage to 6.5 million more kids than the current program does. The program will be paid for by an increase in the federal tobacco tax.

In addition, the Congress passed the American Recovery and Reinvestment Act of 2009 which contained $19 billion in Medicare and Medicaid incentives plus grants and loans for health care providers. Advocates worked with Congressional staff to ensure that emergency medical services providers (EMS) were included in the list of health care providers who are eligible for grants and loans. Grants and loans will be distributed by states and EMS providers will now have to work with their states to determine how grants and loans will be distributed at the state level. Distribution of funds will begin at the end of 2009 or the beginning of 2010.

In March, Congress passed the remaining appropriations bills that fund agencies for fiscal year 2009. Those agencies include the Department of Health and Human Services and the Department of Transportation. Advocates was successful in working with members of Congress to secure $750,000 for the National Emergency Medical Services Information System (NEMSIS). States such as North Carolina have begun to use NEMSIS data to help advocate at the local level for the purchase of additional ambulances and help address response times. Advocates has worked to support funding for NEMSIS in FY2010.

The House passed an FY 2010 budget resolution that allows $533 billion in non-emergency, non-defense spending. This level represents an 8.8 percent increase over FY 2009 (not including funds provided in the economic recovery package), but is $7 billion below the President's budget request. Such initiatives include a reserve fund to support Medicare physician payment system reforms that "change incentives" to promote efficiency and quality, "improve payment accuracy" (including "appropriate compensation" for primary care), improve care coordination, and make providers "accountable" for quality and utilization. The reserve fund cannot exceed $87.3 billion over 5 years/$285 billion over 10 years. The budget resolution also includes a reserve fund for health care reforms that "may include" quality improvement, cost reduction, and public/private coverage expansions.

The legislation contains budget reconciliation language instructing the House Ways and Means Committee (which oversees the Medicare program) to identify by Sept. 29, $1 billion in savings over 5 years. The House Energy and Commerce Committee (which oversees Medicaid and Medicare Part B) must identify a similar level of savings. Additionally, the budget resolution includes a "Sense of the House on Promoting American Innovation and Economic Competitiveness." The provision states that the "resolution builds on significant funding provided in the American Recovery and Reinvestment Act for scientific research," through funds provided under the "Health" function and other functions of the budget resolution.

The Senate similarly passed an FY 2010 budget resolution that "preserves the major priorities in President Obama's budget." The Senate version permits $525 billion in non-emergency, non-defense spending, a 7.0 percent increase over FY 2009 non-recovery spending, but $15 billion below the President's proposed level.

The Senate's version includes reserve funds for health care reform and changes in Medicare physician reimbursements (levels not specified), but does not contain reconciliation instructions. However Senate Budget Committee Chair Kent Conrad (D-N.D.) urged his colleagues to "insist" that any changes to Medicare physician reimbursement "be paid for." A more detailed version of the President's budget is expected to be released during the first week of May.

The overview also acknowledges funding provided for the National Institutes of Health (NIH) in the American Recovery and Reinvestment Act (P.L. 111-5) and continues to support funding for NIH in 2010 including support for cancer research." The summary further pledges "funding for the Health Professions program and the National Health Service Corps to increase the number of health professionals practicing in medically underserved areas."

Health Care Reform

President Obama on Monday met with House Democrats in closed-door sessions to discuss his fiscal year 2010 budget

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MEMC V Names NAEMSP® a Supporting Society

The National Association of EMS Physicians (NAEMSP®) has endorsed the Fifth Mediterranean Emergency Medicine Congress (MEMC V) and signed on as a Supporting Society of the Congress. MEMC V will be held 14-17 September 2009, at the Palacio de Congresos in Valencia, Spain.

MEMC V is the collaborative effort of the European Society for Emergency Medicine (EuSEM), the American Academy of Emergency Medicine (AAEM), and this year, Sociedad Española de Medicina de Urgencias y Emergencias (SEMES). The mission of the Congress is to promote the practice of Emergency Medicine throughout the world and to provide a forum for information exchange.

We hope to build on the success of the Fourth MEMC in Sorrento, Italy in 2007, where more than 1500 individuals from over 72 countries attended the meeting. Historically, this Congress has been considered by delegates to be the best Emergency Medicine conference they've attended and the "turning point" for the development of Emergency Medicine around the world.

As a member of NAEMSP®, you are eligible to receive discounted registration to MEMC V. Supporting Society members are entitled to a reduced rate of €500, a full €100 off the Non-Member rates!

Registration and abstracts are now being accepted. Log on to www.emcongress.org for information on the preliminary program, a Call for Abstracts, social events and cultural tours.

MEMC V organizers are pleased to invite you to attend! If you have any questions, please contact:

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Advocates for EMS:

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proposal, during which he linked the passage of his budget to the ability to act on major issues including health care reform. President Obama said that the "momentum" of the budget would help Democrats move on reform legislation. However, key Democrats in the Senate oppose using the budget reconciliation process (a way to avoid filibusters) to move health care reform legislation.

Senator Max Baucus (D-MT), Chair of the Senate Finance Committee has stated that he would like to move health care reform legislation through the Finance Committee sometime in June. Senator Kennedy has stated that he would like to have reform legislation move through the Health, Education, Labor and Pensions Committee by the August Congressional recess.

2ND Annual EMS Policy Summit Held at EMS Today

Advocates for EMS (AEMS) hosted the 2nd Annual EMS Policy Summit at EMS Today in Baltimore, MD. The event gathered federal agency leadership from the U.S. Department of Homeland Security, U.S. Department of Health and Human Services, U.S. Department of Transportation, U.S. Fire Administration, the Centers for Disease Control and Prevention and the White House Homeland Security Council to address topics on federal legislative issues that affect EMS providers. The Federal Interagency Council on EMS(FICEMS) Chair, Kevin Yeskey, MD addressed the latest activities of FICEMS. The Summit was a huge success with nearly 100 attendees participating in a question and answer session with federal panelists.

Senate Committees Hold HHS Secretary Nomination Hearings for Sebelius

On Tuesday, March 31st, the Senate Health, Education, Labor and Pensions Committee held a hearing on Governor Kathleen Sebelius (KS) who had been nominated to become the next Secretary of the Department of Health and Human Services (HHS). The Senate Health, Education, Labor and Pensions (HELP) Committee and the Finance Committee, which holds jurisdiction over the Cabinet post, held hearings at the end of March/beginning of April. The Senate Finance Committee is expected to vote on her nomination after the Easter recess. Her confirmation will then go before the full Senate for consideration.

Republican senators asked Governor Sebelius to pledge that the administration won't push for using the budget reconciliation process, which requires a simple majority for passage rather than the usual 60 votes needed to avoid a filibuster, as a means of enacting health care legislation.

NAEMT Hill Day

Finally, on April 2nd, members of the National Association of EMTs Board took to the Hill to discuss Advocates top priorities for 2009. Thank you to those who participated. Hill visits are the most effective way to advance our agenda!

If you will be in Washington in the coming months and would like to visit members the offices of your Congressional delegation to discuss EMS issues, please contact Lisa Meyer at Cornerstone Government Affairs at (202)448-9500 or at lmeyer@cgagroup.com. ✱

Committee Updates

Canadian Relations Ad Hoc Committee Update

Andrew H. Travers, MD, MRc, KRCPC

Check out the Canadian Prehospital Evidence Based Protocols Project!

The ***Canadian Prehospital Evidence Based Protocols Project*** (PEP) has been evolving over the last three years. The PEP project started in 1998, and is a repository of appraised research evidence, categorized according to prehospital protocols. Section Editors assign a Level of Evidence to each research study included in the database. Subsequently, every intervention is given a Class of Recommendation, based on the relevant research. The dashboard of evidence is openly available online for your reference at: http://emergency.medicine.dal.ca/ehsprotocols/protocols/toc.cfm.

Did You Know??

There are 24 EMS physicians and 11 paramedics from across Canada and Ireland who serve as Section Editors with the PEP project.

- There are over 850 articles included in the PEP database.
- We collaborate with the Canadian Cochrane Network and Centre, to ensure Cochrane reviews are included in the PEP. See the Cochrane Corner page.
- If you know of an article that is not currently included in the PEP project, you can submit it on the 'Make a Suggestion' page.
- Section Editors meet semi-annually, at the NAEMSP® conference in the winter and the Canadian Association of Emergency Physicians conference in the summer. Anyone interested to learn about the PEP project, and how it can be used in their EMS service is welcome to attend these meetings.
- A manuscript on the PEP project will be published in Academic Emergency Medicine later this year.
- We have begun to offer Paramedic-Evidence Based Practice courses, which are critical appraisal short courses for paramedics and students. To date, courses have been run in Nova Scotia, Newfoundland and Ontario. The P-EBP program is funded by a Knowledge Translation & Exchange grant from the Nova Scotia Health Research Foundation.

Future PEP Activities

- This summer, a medical student will be helping to get a sub-project started on evaluating clinical practice guidelines that are pertinent to prehospital care. These appraised guidelines will appear in the PEP dashboard on the website later in 2009.
- A Level II Paramedic-Evidence Based Practice course is under development, and will be available for paramedics in 2010. This course will build on the literature searching and critical appraisal skills learned in the Level I course, and will be available through an on-line classroom.

Want to know more? Contact Jan Jensen, PEP project coordinator: jljensen@dal.ca or 902/494-2255. *

Brief Report on the 5th Asian Conference on Emergency Medicine

Sang Do Shin, MD, PhD, Co-chair, NAEMSP® Asian Relations Ad Hoc Committee, Department of Emergency Medicine, Seoul National University Hospital, Seoul, Korea

EMS Medical Direction Overview Course

The Asian Conference on Emergency Medicine was successfully held in Busan, Korea, May 16-19. About 1,200 participants including EM physicians, nurses, and EMTs from many Asian countries attended with the topic of "Challenge, Creation, and Collaboration".

On May 16th, the Korean Society of Emergency Medicine and the National Association of EMS Physicians co-hosted the EMS medical direction overview course. Thirteen instructors (from USA, Japan, Taiwan, Singapore, Thailand, Malaysia, and Korea) lectured on 1) Overview of medical oversight and role of EMS medical director, 2) Comparison of EMS system of Asian countries, 3) Building capacity for EMS-based studies. Dr. Ron Pirrallo and Dr. Ritu Sahni gave lectures on EMS history, system designs, service types, and providers. Dr. Marcus Ong (NAEMSP® Asian Relations Committee co-chair) and colleagues described the EMS systems of Singapore, Japan, Taiwan, Malaysia, Thailand, and Korea. Dr. Mattew Ma and colleagues reported on EMS studies conducted in each country. The number of participants was 48 including EM physicians, nurses, and EMTs. This kind of EMS direction overview course was the first one in Asia, and all attendees expressed great satisfaction with the program.

Asian EMS Council

After the course, a meeting of EMS physicians. Dr. Shin, as the meeting organizer, welcomed all and shared the motivation for forming the group. Dr. Ong proposed that the objective of the group be to promote and advocate for prehospital care/EMS in Asia. The attendees agreed to the formation of the Asian EMS Council (AEMSC), consisting of individual-based, community-focused physicians actively involving in EMS and prehospital care medicine. Dr Shin proposed that board positions be for one-year terms, and to rotate the positions every year. As a guide, the Chair could be the main organizer/host of the annual meeting, the Vice Chair could be the next organizer/host of the meeting, and the Secretary could be from the same country as the Chair. The following were elected to the inaugural board: Chair: Sang Do Shin, Vice Chair: Marcus Ong, Secretary: Jae Kwang Kim, Board members: Pairoj Khruekarnchana, William Woo, Nik H Rahman, Matthew Ma, Hideharu Tanaka; and advisory members: Dr. Ron Pirrallo, Dr. Ritu Sahni, and Dr. David Cone.

The Asian EMS Council will recruit active members from many communities. The first active mission is to complete a comparative study of Asian EMS proposed by Drs. Cone and Shin. The second job will be to devleop and conduct the Pan-Asian Resuscitation Outcome Study proposed by Dr. Ong. To enhance collaboration, Dr. Shin will create a web site for the Council, which will guide the studies, communication, and discussion among members.

The AEMSC will take part in the 2010 International Congress on Emergency

continued on page 8

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Medicine (ICEM) in Singapore, and the 6th ACEM in Thailand in 2011.

The Second Meeting of the NAEMSP® Asian Relations Ad Hoc Committee

The second meeting of the committee was held on May 19th, 7:00 a.m. - 8:30 a.m. Even though it was held very early in the morning, many EMS physicians attended from USA (3), Japan (1), Taiwan (2), Singapore (1), Thailand (2), and Korea (7)

Dr. Shin as co-chair welcomed all and introduced the NAEMSP® Asian Relations Committee, its history, mission, and current issue.

Attendees had discussions about following:

Issues related to the first EMS medical direction overview course

Issues related to attending the NAEMSP® annual meeting

Issues related to collaboration with the NAEMSP® members.

The EMS direction overview course at the 2009 ACEM was very successful. However, to make it a better program, economic barriers should be removed for developing countries' students. Course organizers should consider lower fees, which might be possible with sponsorship by a company or public authorities. Topics were superficial in this course, even considering that this was the first offering. In the next course, perhaps at the 2010 ICEM in Singapore, dividing the course into two levels (basic and for leaders) like previous NAEMSP® EMS direction courses would be beneficial.

Attending the NAEMSP® annual meeting in the US is prohibitively expensive for EMS physicians from many Asian nations. If NAEMSP® can provide scholarships for Asian attendees, this will attract more attendees from Asian countries.

The final issue was related to relationships between EMS physicians from the USA and Asia regarding studying in the USA. Many Asian countries have immature EMS systems, and therefore going abroad and studying in the USA has been a fairly common course for Asian EMS physicians. However, many EMS physicians have suffered from the lack of a close relationship with US institutions. It was discussed that perhaps NAEMSP® can help facilitate linkages between Asian and US programs.

As a member of the ACEM program committee and an organizer of the EMS direction overview course, Dr. Shin noted his appreciation to all attendees and expressed special thanks for the unlimited assistance of NAEMSP®. *

Free Six Month Membership to New Members

It's Not Too Late to Participate!

Join us in our New Member Promotion!

Give a Free Six-month Membership (May 1 – Nov. 30, 2009) Here is an opportunity to share the benefits of NAEMSP® membership with friends and colleagues. Sometimes telling someone about NAEMSP® is not enough. We are providing an opportunity for you to ***show*** someone what NAEMSP® is about. If you have friends or colleagues that work in EMS or otherwise have an academic or professional interest, why not sign them up for a **free trial membership**! **Membership will begin May 1 and last until November 30 of 2009.**

New members will have access to the member's only website, the newsletter, our journal, *Prehospital Emergency Care*, and all benefits of membership exclusive of voting rights. It is simple. Have your colleagues complete the *promotional application* also found on the member's only area of the website and send it in to the office with a cover letter from you (the current member) sponsoring the free membership. In the payment section of the application this free program is referenced.

If you would prefer, contact the office to have an application sent to you. You can sign up as many new members as you would like, but this offer will be limited to the first 200 applications received.

Program rules:

- Any member can give away free 6 month memberships.
- The member is responsible for getting the completed membership application to the NAEMSP® office attached to a letter/email from the current member attesting to his desire to provide the free membership.
- No online applications will be accepted.
- The free promotional membership period will run from May 1 to November 30, 2009. Sign up now to take advantage of the full six months.
- Free memberships will include all benefits of the association except voting rights and annual meeting discounts.
- Individual members are not limited in the number of memberships that they can give away/sponsor however there will be an aggregate Association limit of 200 memberships.
- Free memberships will be first-come, first-served.

Call for Abstracts

National Association of EMS Physicians®
January 7-9, 2010
Pointe Hilton Tapatio Cliffs Resort
Phoenix, Arizona

Call for Abstracts and Submission Rules

GENERAL INFORMATION

The National Association of EMS Physicians® is calling for abstracts to be presented at the NAEMSP® 2010 Annual Meeting: Specialty Workshops, Scientific Assembly, and Trade Show in Phoenix, Arizona. Authors are urged to submit original work involving EMS or resuscitation research. The full spectrum of research will be considered including basic science, clinical, epidemiological, health services, operational, economic and educational studies. Physicians, research scientists, out-of-hospital care providers, and administrators are all encouraged to submit.

All abstracts will be reviewed and scored in a blinded fashion by a subcommittee of the NAEMSP® Research Committee. Abstracts will be selected for oral or poster presentation. The exact numbers in each category to be determined by the number of submissions, time and space limitations at the meeting venue, etc. All selected abstracts will be published in *Prehospital Emergency Care*, the official journal of NAEMSP®. Manuscript submission to *PEC* is encouraged, but right of first refusal is not required. Research submitted for consideration may not have been published previously, though prior presentation within 90 days of the meeting is acceptable.

Oral presentations will consist of a 10-minute platform presentation, followed by five minutes for questions and answers. A moderated poster session will supplement the display of poster abstracts. Awards will be given for Best Scientific Presentation, Best Poster Presentation, Best Resident/Fellow Presentation, and Best EMS Professional Presentation. In addition, ZOLL will sponsor the Best Cardiac Arrest Presentation and the National Disaster Life Support Foundation (NDLSF) will sponsor an award for Best Disaster Research. Awards will be presented at the Awards Luncheon at the Annual Meeting.

ABSTRACTS MUST BE SUBMITTED ELECTRONICALLY through the dedicated submission site. To submit an abstract, visit NAEMSP's website at www.NAEMSP.org. The website will officially open in mid-June 2009.

★ ★ ★ NEW DEADLINE: Tuesday, August 14, 2009 ★ ★ ★

THE ABSTRACT DEADLINE IS TUESDAY, AUGUST 14, 2009. Abstracts must be received electronically by 12:00 Noon Eastern Daylight Time, on **Tuesday, August 14, 2009.** No exceptions will be granted.

Questions can be directed to the NAEMSP® Executive Office at (800) 228-3677 or by e-mail at info-NAEMSP@goAMP.com.

ELECTRONIC SUBMISSION RULES

1. Abstracts must be submitted electronically through the dedicated submission site.
2. Submissions must be received at the NAEMSP® Executive Office by 12:00 Noon, Eastern Daylight Time on **Tuesday, August 14, 2009.** Late submissions will not be considered.
3. To ensure blinding, no identifying information should appear in the abstract.
4. The abstract must include:
   a. Statement of purpose or hypothesis, with brief introductory material as needed.
   b. Statement of methods to clearly demonstrate how the study was carried out; include such information as design, setting, participants/subjects, interventions/observations, etc.
   c. Summary of results presented in sufficient detail to support conclusion, with brief mention of statistics used (p values, confidence intervals, etc) to reach conclusions.
   d. Statement of conclusions reached, with important limitations stated if needed.
   e. Word Count Limit: 350 words

Nomination for 2009 Awards

Due Date: August 31, 2009

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 and Dr. William Jermyn

■ **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. Jullette Saussy, Dr. David Persse, Beth Adams and Dr. Robert O'Connor

■ **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)

REASON FOR NOMINATION (attach separate page if necessary):

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Please submit form by August 31, 2009 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 November 2, 2009.

National Association of EMS Physicians®

Call for 2010-2012 Board of Director Nominations

David C. Cone, MD – Immediate Past President

The Nominations Committee is conducting the Call for Nominations for the 2010-2012 Board of Directors slate. The positions that will be elected by the membership in 2009 are: three Physician Members-at-Large. The individuals elected for the offices will each serve a two-year term.

The criteria for the open positions is listed below. This information will assist you in recommending for nomination the best candidate for the office. The ability to offer more than one candidate for each office is dependent upon receiving a sufficient number of nominations for each office from the membership.

You may recommend yourself or another NAEMSP® member for Board of Directors nomination by completing the electronic submission form. A representative sample of a candidate's biography, which will appear on the ballot, can be downloaded from the nomination submission site. ***All recommendations MUST BE RECEIVED BY July 13, 2009 to be considered for the slate of candidates.***

Recommendations should be submitted electronically to NAEMSP's Executive Office through the link located on the NAEMSP® website. The nominee will receive an e-mail acknowledgement of receipt of the Recommendation for Nomination form within two (2) business days of receipt. If such acknowledgement is not received within that time frame, please contact the NAEMSP® Executive Office at (913) 895-4611. The slate of candidates will be compiled by the Nominations Committee and reviewed by the Board of Directors.

CANDIDATE CRITERIA AND POSITION DESCRIPTIONS

The affairs of the Association are governed, supervised, and controlled by the Board of Directors. The authority delegated to the Board requires that it set policies and make relevant decisions on behalf of the Association's membership; therefore, Board Members should be the most knowledgeable about the activities and needs of the Association's members. The Board's duties include:

- Ensuring that the needs of the membership are met.
- Approving and evaluating plans and policies of the Association.
- Budgetary approval and control.
- Monitoring and reviewing financial objectives.
- Long-term strategic planning.

MEMBER-AT-LARGE (Three positions available)

- Nominee must be a Physician member in good standing of NAEMSP®.
- Prior ad hoc committee/task force involvement preferred.
- Ability to commit to the Board of Directors for a two-year term and act as peer representative of the membership.

NAEMSP® Executive Office
P.O. Box 15945-281
Lenexa, KS 66285-5945

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EMS Calendar

Mark your calendar and make plans now to attend!

August 3-4, 2009, World Research Group's 4th Annual Disaster Planning for Hospitals, Hilton Suites Chicago Magnificent Mile. For more information or to register, please contact the World Research Group toll free by phone at (800) 647-7600 or via e-mail at info@worldrg.com, www.worldrg.com/disaster

August 12-15, 2009, MTBI 2009 – An International Conference on Mild Traumatic Brain Injury, Fairmont Hotel Vancouver, Vancouver, BC, Canada, contact: Meredith Areskoug, 604-685-0450 or 1-877-685-0452; Email: info@mtbi2009.org; Web site address: www.mtbi2009.org

August 18-23, 2009, NAEMSE's 14th Annual Educational Symposium EMS Education: Imagine the Possibilities, Walt Disney World, Florida, http://www.naemse.org/symposium

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

Welcome New Members

Kristen Barr
Jenna Bartz, MD
Thaddeus J. Bishop, AS, EMT-P, NCEE
Thomas G. Chiccone, MD
Patrick Cody, DO
Bradley L. Demeter, BA, EMT-B
Frank Dos Santos, DO
Mark E.A. Escott, MD, MPH
James G. Flaherty, MD, MS
Jason T. Gengerke, MD
Michael Y. Ghim, MD
Edgar R. Goulette, PCP
Jason Heavens, MD, MHA, FACHE
Victor A. Heresniak, DO
Ray K. Jennings, NREMT-P, CCP
Mark Jermusyk, BS, NREMT-P
Jacob B. Keeperman, MD
Patrick D. Lambert
Miatta Nyanforh, EMT-B
Lawrence H. Roberts, MD, FACS
Adrian Robertson, MD, FRCP(C)
Heather Seemann
AlonDuane Selman, DO
Rahul Sharma, BS, NREMT-P
Nathan Stephens, DO
Kenneth J. Sternig, MS-EHS, BSN, EMT-P
Roger Swingle, MD
Joseph Tennyson, MD
Daniel L. Wolfson, MD
Eric R. Wooster, NREMT-P