



News

JUNE 2011

Vol. 20 NEWSLETTER OF THE NATIONAL ASSOCIATION OF EMS PHYSICIANS®

No. 1



In This Issue:

- President's Corner 2
- New Editor 3
- NIH Funds Two Active
NAEMSP® Members in EMS
Study Evaluating Prehospital
TBI Guidelines 3
- EMS Research, Aussie
Style 4
- Committee Updates 5
- Committee on Tactical
Emergency Casualty Care . . 5
- New Interstate Disaster
Medical Cooperative
(IDMC) 5
- NAEMT Announces New
AMLS Textbook and
Course 6
- EMS Trauma Coalition Joint
Response to FICEMS –
Press Release 7
- 2011 NAEMSP® Call for
Nominations 15
- 2012 Award Nomination
Form 16
- 2012 Call for Abstracts. . . . 17
- NAEMSP®-ZOLL EMS
Resuscitation Research
Fellowship. 18
- NAEMSP® Liaison Assumes
Leadership of CECBEMS. . 20
- Update on JC and Cardiac
Arrest: Where Are We? 20
- New Members 22
- EMS Calendar 23

25 YEARS IN THE MAKING: The EMS Subspecialty

*Debra G. Perina, MD
Immediate Past President, ABEM*

As NAEMSP® celebrated its 25th anniversary in 2009, another birth occurred—EMS Subspecialty designation. It was borne out of recognition that EMS physicians had different needs and skill sets distinct from other emergency physicians. The initial 100 members banded together and set about defining EMS as a distinct medical practice. In 1992, a task force created by the American Board of Emergency Medicine (ABEM) and led by Dr. Harvey Meislin, then ABEM Immediate Past President, explored the possibility of subspecialty designation. The task force consisted of members from ABEM (Harvey Meislin), ACEP (Peter Pons, John C. Johnson), CORD (Debra Perina), EMRA (Paula Willoughby), NAEMSP® (Jon Krohmer), SAEM (Max Koenigberg, Robert Swor), and the RRC-EM (Louis Ling). All shared a common vision that EMS practice was unique.

The task force attempted to define the subspecialty, identify a unique body of knowledge, the scientific basis of the practice, and the number of fellowships and graduates. task force members also tried writing examination questions should recognition ultimately occur. The task force spurred efforts in scientific publications and resulted in a landmark publication¹ further defining the subspecialty. Also published was a list of EMS fellowships and graduates. The task force struggled with defining EMS as a primary direct patient care subspecialty. At that time, EMS practice was thought to be largely administrative with minimal direct patient care and few significant scientific underpinnings.

These facts proved to be insurmountable obstacles, and the official task force disbanded in 1996.

This was not the end. The vision of one day achieving subspecialty recognition endured. EMS physicians and NAEMSP® never wavered in their desire to achieve it. Loosely organized efforts continued the growth of the subspecialty. In 2002, efforts intensified again to achieve recognition, largely promoted by NAEMSP® through the Physician Certification Task Force under the leadership of Jon Krohmer. Many talented EMS physicians contributed toward this goal. Through their efforts, EMS continued to mature, scientific manuscripts, books and journals devoted to EMS medicine increased. Dedicated EMS physicians increased in number and fellowship programs grew.

By 2005, enough growth in the EMS medical practice had occurred that renewed interest in achieving subspecialty recognition led NAEMSP®, together with the ACEP EMS Committee then chaired by Bob Bass and subsequently Bill Jermyn, to combine efforts to draft a subspecialty application for ABEM. This application needed to address the required ABMS subspecialty criteria: demonstration of a unique scientific body of knowledge, unique core knowledge in training and practice, the presence of adequate numbers of fellowships, graduates, and physicians identifying a significant portion of their practice in EMS, and the primarily direct patient care practice of the sub-specialist. Pieces of a draft application emerged, finished

continued on page 2

Ronald G. Pirrallo, MD, MHSA NAEMSP® President, 2009-2011



Thank you for allowing me to serve as your President for the ensuing 2 years. My term has begun at a most opportune time. The Program Committee designed an invigorating meeting that was one of the best attended in NAEMSP®'s history. The preconference courses, NAEMSP®'s National EMS Medical Directors Course and Practicum® (our three-day course), the Advanced Topics in Medical Direction™ course and the CONTOMS course, sold out. Clearly all this success was due to the dedicated hard work of our members before I took office. I guess I will take credit for the Florida sunshine that welcomed all those who traveled through the winter storm to attend the meeting. It has been an easy start.

The strength of all professional organizations is built on the work of its members. I would be remiss not to acknowledge the accomplishment of my immediate predecessor, Dr. Ted Delbridge. His vision and suave ushered in a new era for NAEMSP® as the American Board of Medical Specialties approved Emergency Medical Services as American Board of Emergency Medicine's (ABEM) sixth subspecialty. He too would acknowledge that although the president may be given credit for the organization's success, it was accomplished only through many hours of members' volunteer work. Thank you all.

NAEMSP®'s priorities for the next year are two-fold. First is to continue the EMS subspecialty certification work with ABEM and ACGME. This includes establishing eligibility for grandfathering of EMS physician candidates, developing ACGME accredited EMS Fellowship sites, and preparing the certification examination - all tasks already underway. Second is to continue to define and grow NAEMSP® membership. Our international membership and state chapters are promising ways to accomplish this goal. Members are our greatest asset. Attracting new and keeping current members is paramount.

The most important factor to our organizational well-being is to ensure members receive value in their membership. EMS folks are not shy or easily deterred. Get involved in your organization and let us know how to improve it for you. I am confident the incoming Board of Directors and Committee Chairs will vigorously pursue your ideas and that will add value to your membership. I am looking forward to a wonderful first year. *

25 YEARS IN THE MAKING: The EMS Subspecialty

continued from page 1

by Sandy Bogucki and me at the 2008 NAEMSP® Annual Meeting. ABEM accepted this application and approved it with edits in 2009. The draft was submitted to the American Board of Medical Specialties (ABMS), beginning the 18-month approval process. As ABEM President, it was my distinct honor to defend this EMS application through various stages of the ABMS approval process.

Just over 25 years in the making, thanks to the efforts of NAEMSP® and so many committed EMS physicians, EMS finally became a subspecialty at the ABMS meeting on September 23, 2010, where by *unanimous* vote of representatives from all 24 medical specialties the decades long struggle finally ended. The vision of the founding members was achieved and validated. *

¹ Krohmer J, Swor R, Benson N, Meador S, Davidson S, Prototype Curriculum for a Fellowship in Emergency Medical Services, Prehosp Disast Med, Jan-Mar 1994, 73-77.

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®).

Opinions expressed in articles in NAEMSP® News are those of the authors and not necessarily those of NAEMSP® nor the editor of NAEMSP® News. Reproduction in whole or part is strictly forbidden without prior consent of the editor.

Copyright © 2011. The National Association of EMS Physicians®.

Correspondence and inquiries should be sent directly to:

NAEMSP® Executive Office, P. O. Box 15945-281, Lenexa, KS 66285-5945
(913) 895-4611; (800) 228-3677; Fax: (913) 895-4652
Email: info-NAEMSP@goAMP.com; Website: www.NAEMSP.org

Articles for inclusion in the newsletter must be submitted by email (Word). To submit material for publication, contact the editor by telephone or email.

NAEMSP® News Editor, Joseph DeLucia: (314) 422-1244.
Email: jlinde001@charter.net

NAEMSP® Staff Contact, Stephanie Newman, Email: snewman@goAMP.com

New Editor

Joseph A. DeLucia, DO, FACEP, EMT-T proudly accepts the position of *NAEMSP® News* Editor. DeLucia started his emergency services career in the 1970s as a Fireman/Paramedic. He became a RN, and worked as an Emergency Department Nurse before going to medical school. Currently DeLucia practices Emergency Medicine at St. Louis University Hospital's Trauma Center.



"I hope to see *NAEMSP® News* become the source of information for all emergency services personnel," states Dr. DeLucia, "I also hope to hear from colleagues throughout the multiple venues of my career".

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

On a personal note, DeLucia enjoys motorcycling, bicycling and do-it yourself projects.

To contact DeLucia email jlinde001@charter.net or telephone 314-422-1244. *

NIH FUNDS TWO ACTIVE NAEMSP® MEMBERS IN EMS STUDY EVALUATING PREHOSPITAL TBI GUIDELINES

Daniel Spaite, MD, FACEP

Daniel Spaite, MD, Professor of Emergency Medicine, University of Arizona and **Ben Bobrow, MD, State EMS Medical Director, Arizona Department of Health Services** have received a \$2,800,000, 5-year research grant from the National Institutes of Health to evaluate the impact of implementing the EMS traumatic brain injury (TBI) guidelines vetted by the NAEMSP® and the Brain Trauma Foundation.

According to Drs. Daniel Spaite and Ben Bobrow (co-principal investigators and active members of NAEMSP®), the Excellence in Prehospital Injury (EPIC) Project may be the largest specific implementation of the *prehospital* guidelines that has occurred since they were first published by the NAEMSP® in 2000.

The impact of TBI on society is immense. Annually in the U.S., 1.4 million victims of TBI visit emergency departments and, of those, 50,000 die and 235,000 are hospitalized. The CDC estimates that at least 5.3 million Americans, approximately 2% of the U.S. population, have a long-term need for help to perform activities of daily living because of brain injury. Direct medical expenditures and indirect costs of TBI total over \$60 billion in the U.S. annually.

Half of those who die from TBI do so within the first 2 hours. There is strong and growing evidence that the care provided in the *first few minutes* has a powerful impact on survival. The idea that the outcome of TBI is determined by the care occurring after arrival at the hospital has been dramatically challenged. Due to the profound effect of hypotension, hypoxemia, and post-intubation hyperventilation, there is now strong evidence that providing guideline-based treatment in the *prehospital* setting may double survival. This is now being called, 'The Platinum 10 Minutes of TBI.'

The EPIC Project is intended to identify the effectiveness, the *real world* affect, of the EMS TBI guidelines across a vast population of varied demography and EMS system deployment. It is hoped that this information will spur on the universal implementation of guideline treatment in the EMS systems throughout the nation.



EMS RESEARCH, AUSSIE STYLE

David C. Cone, MD

David C. Cone, MD, Past President of NAEMSP® 2007-2008, is currently on a four-month mini-sabbatical as an Honorary Research Fellow at Ambulance Service of New South Wales (ASNSW), Ambulance Research Institute (ARI) through an academic appointment at the University of New South Wales.

The ASNSW is a single EMS agency serving the entire state: approximately 1 million calls and 800,000 transports per year, covering a population of nearly 7 million, over an area of 800,000 km², ranging from the largest city in Australia (Sydney) to extremely remote regions. With a staff of about 3600, and a fleet of roughly 1000 ambulances and close to 20 aircraft, ASNSW is likely the third largest EMS agency in the world.



The ASNSW Ambulance Research Institute (ARI) was founded in 2008, and began its operations in 2009, with the objective to “improve patient outcomes by optimizing and maximizing the impact of interactions between the Ambulance Service and its patients.”

Dr. Paul Middleton, who is ARI Director and ASNSW Medical Director, as well as a long-standing NAEMSP® member, has many research projects. These include a randomized controlled trial of CPAP for acute cardiogenic pulmonary edema, and study of elderly fall patients that is in the process of moving from an observational to an interventional trial, and a randomized trial of two different LMA devices.

Many excellent research projects have come out of EMS systems throughout Australia. ARI has the potential to be a real leader in prehospital research. The ability to electronically link dispatch, EMS, and hospital data across such a large system gives ARI a substantial advantage in conducting many different types of research. We will be seeing many abstracts at the NAEMSP® Annual Meeting and papers in the pages of *Prehospital Emergency Care* from ARI. We will see increasing collaboration with our Australian colleagues and increasing involvement of Australians in NAEMSP®, and the possibility of both ASNSW and ARI hosting “rotating” U.S. EMS fellows may be one such collaboration. *

EXECUTIVE OFFICE STAFF LISTING

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

General Email address to reach staff: info-NAEMSP@goAMP.com

Executive Director,
Jerrie Lynn Kind
Association Manager /
Grants Project
Manager,
Stephanie Newman

Meeting Planner,
Megan Finnell
Administrative Assistant
Diane Conner

COMMITTEE FOR TACTICAL EMERGENCY CASUALTY CARE

E. Reed Smith, MD

To fully develop and grow the doctrine of tactical emergency casualty care (TECC), the Inaugural Committee on Tactical Emergency Casualty Care (C-TECC) has been formed. The mission of C-TECC, as the advisory body, will be to examine the science, evidence, and practice of tactical combat casualty care (TCCC), and extrapolate the germane elements to guidelines and procedures for civilian pre-hospital and operational practice. The doctrine of TECC will not only impact daily and tactical operations, but will revolutionize civilian medical response to mass casualty of any kind with emphasis on explosive and ballistic trauma.

The success on the battlefield of the military medical doctrine of TCCC has been publicized in the medical literature. Returning soldiers have brought it back to the civilian community as they integrate back into civilian police, fire, and EMS agencies. Due to its success and simplicity, TCCC is proposed as appropriate for civilian application on a national level.

The first meeting of the C-TECC was held in Washington, DC, in May 2011, and brought a wide range of players to the table (fire, EMS, education, feds, tactical) to develop the appropriate TECC civilian adaptation of the military TCCC guidelines. The Board of Directors as well as our Board of Advisers includes members of Seattle Medic 1, FDNY, Wake Med, Johns Hopkins, Harvard, Dallas Fire, and other high-volume, well-respected, pre-hospital agencies.

For more information on the C-TECC, please contact Dr. E. Reed Smith of Arlington County Fire Department at rsmith@arlingtonva.us. *

Committee Updates

NAEMSP® RURAL EMS COMMITTEE LISTSERV

The Rural EMS Committee has established a listserv (RuralEMS@jcems.net) to enhance communication among EMS medical directors in rural regions. Its purpose is to have moderated quarterly discussions of issues related specifically to rural EMS medical supervision. Jonnathan Busko, EMS Medical Director in Maine, has initiated the first discussion. The topic is Systems of Care in rural regions.

Those who have attended a Rural EMS Committee meeting in the last few of years are already subscribed with the email address provided at the meeting sign-in. The link to join the listserv is on the NAEMSP® website.

I look forward to your participation. *

Paul Rostykus, MD, MPH
NAEMSP® Rural EMS Committee Chair

New Interstate Disaster Medical Cooperative (IDMC)

Brian Froelke, MD, FACEP, President, CMO IDMC

The new Interstate Disaster Medical Cooperative (IDMC) has made much effort to strengthen its infrastructure. One of the major changes will be transitioning from an organization that relies solely on sporadic donations of time and effort to one that will rely on grants. This new structure can provide a more reliable and improved environment for collaboration and cooperation among our members and our partner organizations.

The new IDMC is working in collaboration with Missouri 1 DMT, Illinois Medical Emergency Response Team, Village of Western Springs Medical Reserve Corps (IL) and the Microsoft Cooperation. The coalition is testing new disaster communications software developed by Microsoft. Testing includes the Azure Portal that provides mass communications and collaboration between agencies, and citizens during disasters. The portal, which resides in the 'cloud,' has the benefit of managing local data and communications based out of a

remote and secure location, untouched by any disruptions to infrastructure or systems in the impacted area.

The system will be used to share critical response information in real time with local, state, and EMAC medical teams, routing information, event information and track the progress of MO-1 and IMERT staff or equipment. Agencies will be able to share Incident Action Plans, routing instructions, threat and counter measure information regardless of individual software used.

MOI-DMAT, IMERT and The Village of Western Springs (Illinois) pilot tested the functions of this application during the national level earthquake exercise in May 2011.

Please email Tim Conley at tconley@isdmc.net if you have any questions. *

NAEMT Announces New AMLS Textbook and Course

Sarah Seiler, RN, EMT-P, AMLS Chair
and
Vince Mosesso, MD, EMT-P, AMLS Medical Director

The National Association of EMTs (NAEMT) is proud to announce the NEW 1st Edition of *Advanced Medical Life Support* (AMLS). The course had been actively taught since 1999. This 1st edition results from the new publishing relationship with Mosby/Elsevier, Inc. Now both PHTLS and AMLS can be purchased from the same publisher.

AMLS is excited to continue to support improving all levels of healthcare providers' assessment skills for improving patient outcomes by using an efficient, yet comprehensive, assessment process. AMLS is being taught across the United States and 12 countries abroad.

What Remains the Same?

- The interactive lecture presentations and practical stations remain case study based. The lectures have been shortened. They directly correlate with the book.
- BLS and ALS Pre- and Post-Tests will remain available to Coordinators when registering a course. Course registration continues to be online through the NAEMT website.
- Lectures, scenarios and textbook utilize internationally recognized measurements for diagnostic information.
- The textbook serves as a reference book, paramedic course ancillary book, as well as for the AMLS course.
- NAEMSP® provides a content review and continues to endorse the AMLS book and course.

What is NEW?

- Expanded scope of U.S. and international health care providers, educators and physicians serve as writers and reviewers for the book and scenarios.
- The AMLS Logo.
- Defined AMLS Assessment Pathway Algorithm will offer a template to the assessment-based process.

- Expanded content throughout the nine textbook chapters:
 - Three new chapters include Endocrine, Metabolic & Environmental Disorders, Infectious Disease, Toxicologic Emergencies; and Hazardous Materials and WMD.
 - Each chapter references specific issues related to bariatric, geriatric and special needs patients.
 - Transport decisions and initial emergency department interventions discussed.
- The assessment process identifies key components of the patient's cardinal presentation, pattern recognition and critical thinking skills.
- Increased use of evidence-based assessment, diagnostic tools and management strategies.
- Expanded appendices include The AMLS Assessment Pathway, 12-Lead Electrode Placement Review, Normal Lab Values, Rapid Sequence Intubation/Airway, Drug Profiles and Answers to Chapter Quiz questions.
- All textbooks include a laminated, quick-reference guide that includes the AMLS Assessment Pathway, 12-Lead Electrode Placement, Common Laboratory Values and Common Toxidromes.
- Lecture presentations are on eight chapters as well as a patient assessment video.
- Improved course forms, including the Evaluation Station format.
- Focus on a dynamic, versus a linear, approach to assessment and management using the AMLS Assessment Pathway.

The AMLS Committee encourages you to check out the amls.org and Elsevier.com websites for further information on the AMLS course and products. Implementation of this course in your continuing education sessions and inclusion in a primary paramedic education program build on the foundational knowledge of all levels of health care providers to support better outcomes in the patients we serve. *



American Association of Neurological Surgeons



April 18, 2011

Alexander Garza, M.D. EMT-P, Chair
Federal Interagency Committee on EMS
c/o Office of Emergency Medical Services
1200 New Jersey Avenue SE, NTI-140
Washington, DC 20590

Dear Dr. Garza:

The Emergency and Trauma Care Coalition consists of several organizations that advocate collaboratively on issues of mutual interest in promoting trauma and emergency care across the spectrum of services. The undersigned organizations appreciate the opportunity to provide stakeholder input to the Federal Interagency Committee on Emergency Medical Services (FICEMS) regarding its assessment of the current and future role of the Federal government in emergency medical services (EMS) and its evaluation of options for establishing or designating a Federal lead office or agency for EMS.

The Coalition believes fundamentally and firmly that emergency medical services are health care services first and foremost, and should be viewed within that health care framework. While EMS intersects with public safety on every emergency call and is an essential component of the first responder community, EMS providers and practitioners are, whether in the field or in the hospital, primarily responsible for providing health care to our patients. Further, while EMS must be fully prepared for catastrophic events, natural disasters and other mass casualty incidents, the most critical function of EMS is the provision of health care to emergency and trauma patients across the continuum of care, including field, trauma, and hospital based care 24 hours a day, 365 days a year.

As FICEMS considers the appropriate federal role and options for a lead federal agency, the Coalition believes that FICEMS should be guided by the 2006 Institute of Medicine report *Emergency Medical Services: At the Crossroads*.¹ Over the past year, organizational members of the Emergency and Trauma Care Coalition have debated and discussed all these issues. The undersigned organizations have come to collectively believe that the IOM analysis and recommendations should serve as the primary foundation for answering the question about the appropriate federal role in emergency and trauma care, and how that role should be manifested organizationally within the federal government.

Challenges Facing Emergency and Trauma Care

The IOM and other entities have identified systemic problems that undermine the ability of the emergency and trauma care system to protect the public in their greatest hour of need.¹ These

challenges must be addressed by the Federal government; failure of the federal government to provide the requisite investment in leadership since the 1970's has greatly contributed to the current fragmented and fragile state of emergency and trauma care in the United States.

In many areas, **field EMS services** are highly fragmented, poorly equipped, and insufficiently prepared for day-to-day operations, let alone natural or man-made major disasters.¹⁻⁹ Federal funding in the 1970's fueled the initial development of EMS systems at the state and local levels.¹⁰⁻¹³ Yet, in the 1980's the withdrawal of comprehensive federal funding led to haphazard growth and implementation of EMS systems across the country.^{12, 14} A 2007 GAO report noted that Medicare payments for Field EMS are 6% below the average cost per transport in urban areas and 17% in rural and super-rural areas.¹⁵ Other systemic problems identified by IOM include: insufficient coordination among EMS providers, disparities in response times, uncertain quality of care, lack of readiness for disasters and inadequate federal funding for disaster preparedness, divided professional identity of EMS personnel, and significantly, a limited evidence base of emergency medical interventions.¹

The IOM report found that **hospital emergency departments** and trauma centers are severely overcrowded and emergency care is highly fractured.¹ Every second of every day, at least 35 patients are transported by ambulance to hospital emergency departments (EDs).¹⁶ Hospital EMS is challenged by overburdened hospital emergency departments – from 1993-2003, 703 ED's closed while ED visits rose by more than 18% in the same period.^{27, 28} As noted by the IOM, crowded EDs resulted in a half million diverted field EMS transports in 2003 creating accessibility issues for emergency ambulance services.¹ More recently, in December 2008, the American College of Emergency Physicians released *The National Report Card on the State of Emergency Medicine*,²⁶ which found that our nation's emergency care system is in serious condition, with numerous states facing critical problems. The overall grade for the nation is a C-, with 90 percent of states earning mediocre or near-failing grades. This Report Card found that the biggest problems facing emergency departments (EDs) are boarding of patients in EDs; lack of adequate on-call specialists; inadequate reimbursement; and high rates of uninsured individuals. Six years ago, the IOM called for a complete overhaul of our nation's emergency and trauma care by creating a coordinated and regionalized system of care. As evidenced by the Mexican Hat Bus Crash mass casualty incident,²³ regionalization of emergency care must be a high priority in all areas of the nation.

The public's expectation that **trauma care** will always be available to them wherever they reside or travel, just as it was on the January 8 shooting in Tucson, has yet to be met. Over the past decade at least 23 trauma centers have closed, including St. Vincent's in Manhattan, which treated the 848 patients on 9/11/01. Due to higher medical liability exposure and the lack of reimbursement for uncompensated care, critical surgical specialists are often unavailable to provide emergency and trauma care.²² According to the CDC,²⁰ 45 million Americans lack access to Level I trauma centers -- the level of care provided to the victims of the 2011 Tucson shooting. The challenges facing trauma centers, trauma systems and physicians who put people back together again are profound. Trauma is the second costliest medical condition¹⁹ and the leading cause of death²⁰ under age 44 -- more than stroke and AIDS combined. Further, 35 million people are treated each year for traumatic injuries²⁵ -- 1 person every 90 seconds, and 1 person every 15 minutes requiring hospitalization. Severely injured trauma patients treated at

Level I trauma centers have a 25% reduction in mortality.^{20, 21} Yet, while studies clearly show the value and cost-effectiveness of trauma care compared to other health interventions,²⁴ the federal government has yet to make the necessary investments to ensure access for all Americans, and, as a result, a fragile trauma and EMS system is faltering.

The lack of federal focus, leadership and funding for emergency and trauma care remains extremely problematic and is an impediment to improving the quality, accessibility and capability of emergency and trauma care. While there is \$224 million in **authorized** federal funding for trauma care, no federal funding is currently **appropriated** to ensure the availability of trauma care for all Americans. A federal investment of the entire \$224 million amounts to 71 cents per person to ensure system readiness to protect the public and save lives. While fire and police first responders have several targeted federal support programs, there is **no** dedicated federal funding stream for field EMS responders to ensure their capability to respond to medical emergencies as part of a coordinated emergency care system. Federal grant funding for *other components* of EMS (such as hospital preparedness) falls within a variety of programs with multiple responsibilities and competing priorities.¹⁷ Accordingly, federal funding for emergency and trauma care is fragmented, limited, and all too often is overlooked in favor of other needs.¹⁷

Vision for Future of EMS -- Forging a Path Beyond the Crossroads

The 1996 EMS Agenda for the Future¹⁸ outlined the following vision for EMS:

"Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to the treatment of chronic conditions and community health monitoring. This new entity will be developed from the redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net."¹⁸

Similarly, the IOM *EMS At the Crossroads* report envisions a system in which all communities will be well served by well-planned and highly coordinated emergency care services that are accountable for their performance.¹ From the patient's point of view, delivery of services for every type of emergency will be seamless. The delivery of all services will be evidence based and innovations will be rapidly adopted and adapted to each community's needs. To achieve that vision, the IOM recommended:

- *Federal Home for EMS* -- the establishment of a lead Federal agency for emergency and trauma care at the Department of Health and Human Services with primary programmatic responsibility for the full continuum of emergency medical services and emergency and trauma care for adults and children, including medical 9-1-1 and emergency medical dispatch, prehospital emergency medical services (both ground and air), hospital-based emergency and trauma care, and medical-related disaster preparedness. FICEMS would continue to serve in a coordinating capacity among all federal agencies with a role in EMS.

- *System Finance* -- that CMS evaluate reimbursement for EMS and make recommendations with regard to readiness costs and permitting payment without transport;
- *Regionalization* -- the development of evidence based categorization systems for EMS, emergency departments and trauma centers based on capabilities as well as evidence-based model prehospital care protocols for treatment, triage, and transport of patients;
- *National Standards for Training and Credentialing* -- adoption among the States of a common scope of practice for EMS personnel with state licensing reciprocity and acceptance of national certification as prerequisite for state licensure and local credentialing of EMS providers and national accreditation of paramedic education programs;
- *Enhanced medical direction* -- medical oversight and direction should be provided by physicians that meet standardized minimum requirements for training and certification;
- *Coordination* -- Dispatch, EMS, emergency department and trauma care providers, public safety and public health should be fully interconnected and united in an effort to ensure that each patient receives the most appropriate care, at the optimal location, with the minimum delay;
- *Communication and Data Systems* -- develop integrated and interoperable communications and data systems. Integrate prehospital EMS into design deployment and financing of National Health Information Infrastructure.

This vision for the future of emergency and trauma care and these recommendations cannot be achieved in the absence of the lead federal agency called for by the IOM.¹ In recommending the establishment of a lead federal agency, the IOM indicated that a lead federal agency could --

- ❖ Create unified accountability for the performance of the emergency and trauma care system;
- ❖ Rationalize funding across various aspects of emergency and trauma care to optimize allocation of resources in achieving system outcomes;
- ❖ Coordinate programs to eliminate overlaps and gaps in current and future funding;
- ❖ Provide consistent federal leadership on policy issues that cut across agency boundaries;
- ❖ Create a large combined federal presence, increasing the visibility of emergency and trauma care within the government and among the public;
- ❖ Provide a recognizable entity that would serve as a single point of contact for stakeholders and the public, resulting in consolidated and efficient data collection and dissemination and coordinated program information;
- ❖ Enhance the professional identity and stature of emergency and trauma care practitioners;
- ❖ Bring together multiple professional groups and cultures, creating cross-cultural and interdisciplinary interaction and collaboration that would model and reinforce the integration of services envisioned by the IOM.

The IOM further articulated objectives of the lead agency,¹ including --

- ❖ Enhancing the performance of the emergency and trauma care system as a whole;
- ❖ Improving the performance of various components thereof including field EMS, hospital-based emergency care, trauma systems, pediatric emergency and trauma care, prevention, rural emergency and trauma care and disaster preparedness;

- ❖ Setting the overall direction for emergency and trauma care planning and funding, serve as the primary collector and repository of data in the field and the key source of information about emergency and trauma care for the public, federal government and practitioners themselves;
- ❖ Allocating federal resources across all of emergency and trauma care to achieve system wide goals and accountability for the performance of the system and its components.

The undersigned organizations agree with the IOM's recommendations in establishing a lead federal agency, in locating it within the Department of Health and Human Services (HHS), and in meeting the articulated objectives by IOM for the following reasons:

- ⇒ The multi-jurisdictional nature of emergency and trauma care, currently spread among many federal agencies without a primary leader or home, is a significant obstacle to achieving the public expectation of a high quality, safe and coordinated emergency, public/community health, and trauma care system that serves all patients with emergency and trauma conditions across the continuum of services.
- ⇒ A lead federal agency will provide a needed champion within the federal government and the leadership needed to promote and improve emergency and trauma care. Establishing the lead federal agency at HHS will facilitate the integration of emergency and trauma care across the continuum within the context of the larger health care system, including efforts to reform it, and promote quality and medical oversight, improvement of practice patterns and service delivery, and standardization of field EMS practitioner credentialing. Efforts to coordinate services across multiple agencies have not and are not likely to achieve that purpose.
- ⇒ There are a number of existing emergency and trauma care programs within the Department of Health and Human Services, with the largest bulk of programs already existing in the Health Resources & Services Administration (HRSA) within various Bureaus. There are other programs in other areas of HHS, such as within ASPR and CDC. We believe that consolidating these HHS programs into a Bureau of Emergency and Trauma Care, within HRSA as the primary programmatic agency, would meet the objectives identified by IOM and better serve the interests of patients with emergency and trauma conditions.
- ⇒ Establishing a lead federal agency will promote setting, coordinated implementation, and ongoing evaluation and realignment of strategic national priorities for emergency and trauma care. A lead federal agency is needed to develop a strategic plan for emergency and trauma care at the national level, to advocate for the implementation of that plan at every level, and to advocate for the proper resourcing to make that plan a reality.
- ⇒ A lead federal agency that is statutorily created is necessary not only to provide a federal home, but to ensure that the federal home will transcend Administrations and provide the crucial level of consistent leadership and accountability throughout the years that is needed to be successful. Accordingly, we believe that statutory authorization must be achieved, particularly with regard to consolidating certain existing grant programs within HHS, which requires enactment by the Congress.
- ⇒ A lead federal agency is essential to efficiently administer coordinated federal grant programs in alignment with the established, unified strategic plan, and to make the most effective use of federal dollars for everyday operations and preparedness. A lead federal

agency will be able leverage programs and federal grants for more effective national progress in the areas of standardization, safety, workforce development, disaster preparedness and EMS research and innovation. A lead agency is best prepared to create a streamlined approach that encompasses the diverse needs of the entire spectrum of emergency and trauma care, regardless of geographic location, system structure, or other linked but essential component of the system as a whole.

- ⇒ We recognize and appreciate NHTSA's guardianship and nurturing of EMS up to this point in time. EMS has reached a point now to be fully integrated into the entire emergency and trauma care spectrum and should be primarily overseen by the agency that oversees the health service it delivers, rather than being defined by the conveyance in which that service is rendered. Accordingly, we believe that a lead federal agency within HHS is best positioned to understand and speak authoritatively on the central health component of emergency and trauma care and allow for the growth of EMS into the future in ways suggested by both the IOM and existing national initiatives, such as the EMS Agenda for the Future, which have not been fully realized due to the existing fragmented structure for EMS within the federal government. Such integration will also promote the ability to pursue efforts that reframe how emergency and trauma care are delivered within the healthcare continuum in a way that is synchronized with other health and public safety entities to achieve maximum patient benefit and system efficiencies.
- ⇒ While we advocate for the primary lead federal agency to be located at HHS, we recognize that essential EMS functions will continue to be carried out in multiple federal agencies, necessitating the ongoing need for FICEMS.

We thank you for the opportunity to provide feedback to FICEMS and for your consideration.

Sincerely,

Advocates for EMS

American Association of Neurological Surgeons

American College of Emergency Physicians

Association of Air Medical Services

Association of Critical Care Transport

Illinois State Ambulance Association

National Association of EMS Educators

National Association of EMS Physicians

National Rural Health Association

Trauma Center Association of America

Cc: The Honorable Tim Walz

The Honorable Sue Myrick

Richard Reed, Special Assistant to the President and Senior Director for Resilience

References:

1. Institute of M. Emergency Medical Services at the Crossroads. Washington, DC: The National Academies Press; 2006.
2. Knott A. Emergency medical services in rural areas: the supporting role of state EMS agencies. *J Rural Health* 2003;19 492-6.
3. Behenna L. Emergency medical services 'at a crisis point'. *Bigfork Eagle* 2007.
4. Montesano N. Mac ambulances running in the red. *News-Register* 2006.
5. Mellott K. Staff shortage has ambulance license in peril. *The Tribune Democrat* 2007.
6. Voravong S. County's volunteer fire companies confront growing challenges. *Journal & Courier* 2006.
7. Gray J. Paramedics' ranks decline in rural areas. *The Birmingham News* 2005;Sect. 1A-2A.
8. Pennsylvania Emergency Medical S. PRESS RELEASE: Pennsylvania Emergency Medical Services Issues Statewide 'Code Blue' to Increase Staffing Levels. In; 2005.
9. Minnesota Department of H. A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk. St. Paul, MN; 2002.
10. Rockwood CA, Mann CM, Farrington JD, Hampton OP, Motley RE. History of emergency medical services in the united states. *J Trauma* 1976;16 299-308.
11. Harvey JC. The Emergency Medical Services Systems Act of 1973-history and potential consequences. *Bull Am Coll Surg* 1975;60 19-22.
12. Post CJ. *Omaha Orange: A Popular History of EMS in America*. Boston, Massachusetts Jones and Bartlett Publishers; 1992.
13. Stewart RD, Brennan JA, Krohmer JR. History of EMS: Foundations of a System. In: *Principles of EMS Systems*. Sudbury, MA: Jones and Bartlett Publishers; 2005:2-16.
14. Office USGA. *Health Care: States Assume Leadership Role in Providing Emergency Medical Services*. Washington, D.C.: Government Accountability Office; 1986. Report No.: GAO-HRD-86-132.
15. Office USGA. *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly*. Washington, D.C.; 2007. Report No.: GAO-07-383.
16. Pitts SR, Niska RW, Xu J, Burt CW. National Hospital Ambulatory Medical Care Survey: 2006 emergency department summary. *Natl Health Stat Report* 2008;6:1-38.

17. Mohr PE, Schoenman JA. Federal Funding for Emergency Medical Services: Final Report. Bethesda, MD: NORC Walsh Center for Rural Health Analysis; 2002.
18. Committee EMSAftFS, Delbridge TR, Bailey B, et al. EMS Agenda for the Future: Where We Are... Where We Want To Be. *Prehosp Emerg Care* 1998;2:1-12.
19. Soni, Anita. *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population*. Statistical Brief #248. July 2009. Agency for Health Research and Quality, Rockville, MD.
20. Injury Prevention & Control: Trauma Care. www.cdc.gov/traumacare. Centers for Disease Control & Prevention, Atlanta, GA.
21. MacKenzie EJ, et al. The National Study on Costs and Outcomes of Trauma. *J Trauma*. 2007;63: S54-S67.
22. Rao, Mitesh, et al. The Shortage of On-call Surgical Specialist Coverage: A National Survey of Emergency Department Directors. *Academic Emergency Medicine* 2010; 17:1374-1382.
23. Kaminski, Ronald. Survival Factors Group Factual Report, NTSB File # HWY-08-MH-012. National Transportation Safety Board, Office of Highway Safety, Washington, DC.
24. MacKenzie, EJ, et al. The Value of Trauma Center Care. *J Trauma*. 2010;69: 1-10.
25. National Trauma Institute. www.nationaltraumainstitute.com. San Antonio, TX.
26. National Report Card on the State of Emergency Medicine, <http://www.emreportcard.org/> and <http://www.acep.org/content.aspx?id=43614>. American College of Emergency Physicians, Irving, TX.
27. American Hospital Association. AHA Hospital Statistics. 1994-95 edition. Chicago, IL: Health Forum, LLC; 1994.
28. American Hospital Association. AHA Hospital Statistics. 2005 edition. Chicago, IL: Health Forum, LLC; 2005.



Nomination for 2011 Awards

Due Date: October 3, 2011

Candidate's Name: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Your Name: _____

Telephone: _____ Email: _____

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, and Dr. Debra G. Perina.

■ **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, and Dr. Brian Schwartz.

■ **Friends of EMS Award**

This award is presented to an 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), and Gary Freeman (ZOLL Medical Corporation).

REASON FOR NOMINATION (attach separate page if necessary):

Please submit form by October 3, 2011 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 3, 2011.

Call for 2012-2014 Board of Director Nominations

Theodore R. Delbridge, MD, MPH – Immediate Past President

The Nominations Committee is conducting the Call for Nominations for the 2012-2014 Board of Directors slate. The positions that will be elected by the membership in 2011 are: three Physician Members-at-Large positions and one Professional Member-at-Large position. The individuals elected for the offices will each serve a two-year term.

The criteria for the open positions are 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 15, 2011, 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 email 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.

PROFESSIONAL MEMBER-AT-LARGE (One position available)

- Nominee must be a professional member in good standing of NAEMSP®.
- Prior 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.

Call for Abstracts 2012

National Association of EMS Physicians

January 12-14, 2012

JW Marriott Starr Pass Resort & Spa

Tucson, 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* 2012 Annual Meeting: in Tucson, 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 participate.

All abstracts will be peer reviewed in a blinded fashion by NAEMSP* Research Committee members. Abstracts will be selected for oral or poster presentation. The exact numbers in each category will be determined by the number of submissions, time and space limitations at the meeting venue, etc. All accepted abstracts will be published in *Prehospital Emergency Care*, the official journal of NAEMSP*. Manuscript submission to *PEC* is encouraged, but 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 be 10-minutes, followed by five minutes for discussion. A moderated session will supplement the poster display. 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 2011.

★ ★ ★ **DEADLINE: Friday, August 19, 2011** ★ ★ ★

THE ABSTRACT DEADLINE IS FRIDAY, AUGUST 19, 2011. Abstracts must be received electronically by 12:00 Noon Eastern Daylight Time, on **Friday, August 19, 2011**. 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 **Friday, August 19, 2011**. 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
5. In order to be considered for an award, a PDF of the poster presentation is due by 5pm Eastern Daylight Time on 12/31/11.



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.



NAEMSP® Liaison Assumes Leadership of CECBEMS

Liz Sibley, Executive Director, CECBEMS

At the Continuing Education Coordinating Board of Emergency Medical Services (CECBEMS) Spring Board meeting held in Ft. Lauderdale, FL, on April 30, 2011, Juan March, MD, FACEP, was elected Chair of the Board of Directors. Dr. March is the first NAEMSP® liaison to serve in the role as the Chair for CECBEMS. He will serve a two-year term ending in April 2013.

Dr. March is Professor with the Department of Emergency Medicine at East Carolina University; in Greenville, NC, and he is also the EMS Medical Director for Pitt County, NC. Serving on the CECBEMS Board since 2004, Dr. March has a long-time commitment to CECBEMS and to providing quality continuing education (CE) for EMS professionals. He was quoted as saying, "I have seen CECBEMS mature as an accrediting organization alongside the evolution of EMS as a health care discipline. Readily available, high quality CE is a vital part of placing EMS professionals on equal footing with other health care professionals."

During the next two years, Dr. March will emphasize the importance of peer-reviewed CE to EMS medical directors. As an EMS medical director, he knows that when an EMS professional has CE certificates that are CECBEMS accredited, there is an assurance of comprehensive standards for quality. "I want to communicate to all my medical director colleagues the quality, dependability, consistency, and cost effectiveness that comes with CECBEMS accredited CE," says Dr. March.

Dr. March also plans to underscore the value of the CECBEMS Accreditation Management System (AMS) database which contains more than two million CE records. One goal for this database will be to assist NREMT, state EMS agencies, training coordinators, EMS providers, and EMS medical directors who can access an individual student's record of completed CECBEMS accredited CE. To obtain access, requests can be made via mail or email to CECBEMS headquarters, www.cecbems.org. In the past, access

to this database has proven to be very helpful to state regulators in validating CE reported by EMS professionals.

CECBEMS has received inquiries from several international EMS organizations and has recently accredited London Health Care Sciences Center in London, Ontario. Dr. March has appointed Jack Allison, Jr., MD, MPH, FACEP, to serve as Chair of the International Committee with the goal of reaching out to EMS organizations outside of the United States that view CECBEMS accreditation as a mark of quality and credibility. "This committee will mentor international applicants and recommend ways in which CECBEMS can address their diverse needs," says Dr. March.

"I foresee a busy and productive term as CECBEMS Chair," Dr. March predicts. "With the help of my fellow Board members, my EMS medical director colleagues, and input from the broader EMS community, we can accomplish much both nationally and internationally." *

Update on JC and Cardiac Arrest: Where Are We?

Preeti Dalawari, MD

On April 22, 2009, the Joint Commission (JC) convened a National Stakeholder Panel to discuss the need for a performance measure set for sudden cardiac arrest (SCA). With 350,000 deaths annually and a lack of evidence-based guidelines and consistency among organizations, the JC recommended the development of performance measures for inpatient and emergency department care, as well as a monograph for community-based initiatives in the prevention and treatment of SCA.

In spring 2010, the JC placed a call for candidate measures (defined as structure, process or outcome measures) and abstracts related to community-based programs related to this topic. The technical advisory panel included nine potential

performance measures which were revised down to six measures in the spring of 2011:

1. Time to defibrillation
2. Confirmation of endotracheal tube placement
3. Patient selection for therapeutic hypothermia
4. Temperature maintenance during therapeutic hypothermia
5. Outcomes for patients receiving therapeutic hypothermia after cardiac arrest outside the hospital
6. Outcomes for patients receiving therapeutic hypothermia following cardiac arrest occurring in any setting

Testing of these measures start in June and July 2011, and the project expects to conclude in February 2012.*



Yale University School of Medicine,
Department of Emergency Medicine



EMS MEDICAL DIRECTOR

The Department of Emergency Medicine at the Yale University School of Medicine is currently seeking an EMS Medical Director to oversee the 12-town, 20-agency EMS system serving the greater New Haven area through the New Haven Sponsor Hospital Program (NHSHP). Approximately 200 paramedics and 500 EMT-Basics receive medical oversight through NHSHP, which is a joint operation of Yale-New Haven Hospital and the Hospital of St. Raphael.

The EMS Medical Director will be appointed to the Department of Emergency Medicine academic faculty, and will work clinically in the Yale-New Haven Hospital ED (an urban, Level I trauma center with approximately 77,000 visits per year) and the Yale-New Haven Shoreline Medical Center ED (a suburban, freestanding ED with approximately 25,000 visits per year). The EMS Medical Director will join a well-established EMS leadership team with a commitment to continuous quality improvement, providing efficient care, and improving patient and provider satisfaction. The EMS Medical Director will serve on the New Haven SHARP Team (the only licensed physician response team in CT), and will have expectations of academic productivity in the Section of EMS, as well as teaching obligations in the Section's EMS fellowship program, which will seek accreditation through ACGME as this process becomes available, and at NHSHP, which runs the largest paramedic training program in the state.

Candidates must be emergency medicine trained and board certified; and EMS fellowship training is preferred. A field provider background is preferred due to the intense operational nature of the position. The successful candidate must demonstrate excellence in clinical, interpersonal, and administrative skills.

For more information, contact Dr. Gail D'Onofrio at (203) 785-4404 or gail.donofrio@yale.edu. To apply, please forward your CV and cover letter via fax at (203) 785-4580, email: jamie.petrone@yale.edu, or mail at Yale University School of Medicine, Department of Emergency Medicine, 464 Congress Ave, P.O. Box 208062, New Haven, CT 06519-1315.

Yale University is an affirmative action, equal opportunity employer and women and members of minority groups are encouraged to apply.

**FELLOWSHIP IN EMERGENCY MEDICAL SERVICES
AND DISASTER MEDICINE AT UCSF**

University of California, San Francisco, Department of Emergency Medicine is seeking applicants for a fellowship in Emergency Medical Services and Disaster Medicine for July 1, 2012. Fellows will serve as HS Clinical Instructors at San Francisco General Hospital, a Level 1 Trauma Center with 65,000 visits yearly and a fully implemented 4 year Emergency Medicine residency.

This fellowship offers both 1 and 2 year options. The program combines EMS with Emergency Management/Disaster Medicine while working with the SF EMS Agency. There are opportunities to work with externally funded faculty as well as take part in the EMS education of local paramedics and the UCSF EM residents.

The two year program offers a master's degree, typically in Public Health or Clinical Research among others. Salary is commensurate with PGY level. Completion of an ACGME accredited EM residency is required prior to start. Send CV, Statement of interest and three letters of recommendation by September 1, 2011 to:

Karl Sporer, MD
c/o Eve Phongsasavithes
Department of Emergency Medicine
505 Parnassus Avenue, Room M-24
Box 0203
San Francisco, CA 94143-0203
Karl.Sporer@emergency.ucsf.edu



Welcome New Members

Anwar Al-Awadhi, MD
Nicolas Albert
Gerard Ashbeck, DO
David Austin, MD
Mark Bacigal, DO
Doug Baggs
Judson Barkhurst
Sean Baskin
Solomon Behar, MD
Jennifer Bengston, MD
Joshua Bobko
Tiffany Bombard, NREMT-P
Matt Boutte
Mark A. Brandenburg, MD
Bruce Brink
Brian K. Buhke, DO, FAAFP
Shayla Cammarata
Shawn Carby
Philip Carmona
Craig Carter, DO
Thomas E. Charlton, MD
Timothy Chizmar
Jonathan E. Clarke, MD
Larry Coleman Johnson, MD
Mark Collins
Joy Crook
Donald M. Dawes, MD
Sherri Dean
Joseph E. Deese, MD
Matthew Deluhery
Gerard DeMers
John Dery, DO
Brian K. Dockery, MD, FACC
Elizabeth Donnelly
Dave Duncan, MD
Don Eby, MD
Timothy Fallon
Kristy Follmer
Steve Frisbie
Kelly Gahan
Joseph Giorgione, EMT

Regina Godette-Crawford
Erin K. Gonzalez, MD
Eric Greenfield
Amy Groen
David R. Gustafson, DO, BCEM
Joseph Hansen, MD
Greg Harrington
David Hassard
Jesse Hatfield
Jon Howell
Mark S. Howerter, MD
Rosidah Ibrahim
Angus M. Jameson
Jason Jaronik
Eric Johnson, PA-C, EMT-P, MS
Drew Juergens
Stephen J. Kaplan, BS, EMT-P
Jung Eun Kim
Michael L. Kloep, MD
Mary Knight, MICP
Lazeni Koulibali
Ashu Kumar
Brian Lanier
Taesik Lee
Won Kyung Lee
Yu Jin Lee
Timothy Lenz, EMT-P
Julie Leonard
Jarrad Maiers
Sameer Mal
Doug Martin, MD
Trevor Maslyk
Michael McGrath
Sylvie Michaud
Pete A. Morassutti
Deborah Morse
Jeffrey M. Mulholland, MD
Jimm Murray
Samar Muzaffar
Choi Myeong Jae
Paul Myre

Ramy M. Z. Nasr, MD, EMT-T
Wren Nealy
Cindy Nicholson
Chris H.O. Olola, PhD
John Pacini
Kyle Paschal
Michael Pearlman
Neha Puppala
Weilun Quan
Paul Raftis
Ali Raja
Mario L. Ramirez, MD
Christopher T. Richards, MD
Michael T. Rothermich, MD
Steve Rowe
Wendy Ruggeri
Rebecca Schulman, MD
Hulbert Silver, BSc, MS, MD
Ron Slagell
Samuel J. Slimmer
James Smith
Howard Snyder, MD
Clyde Sullivan
Lindsay Tawa
Robert Tober
William Tollefsen
Lee Van Vleet
Giuseppe Ventre
Amy Vertin
Gregory Vogelaar
Jim Walery, MD
Michelle Walters
David Wampler, PhD
Scott Wander
Elizabeth Weinstein, MD
Ian Weston
Mark D. Wolcott
Ro Youngsun
Robert Zuckswert

EMS *Calendar*

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

July 4-6, 2011 – Asian Conference on Emergency Medicine (ACEM) 2011, Centara Grand & Bangkok Convention Centre at CentralWorld, Bangkok, Thailand, <http://acem2011.org/>

November 3-7, 2011 – Wilderness Medical Society (WMS) Desert Medicine Conference, Tucson, AZ, www.wms.org/conferences

January 12-14, 2012 – NAEMSP® Annual Meeting, Specialty Workshops, Scientific Assembly and Trade Show, JW Marriott Starr Pass Resort and Spa, Tucson, AZ, www.naemsp.org

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






2012
ANNUAL MEETING
SPECIALTY WORKSHOPS,
SCIENTIFIC ASSEMBLY
AND TRADE SHOW

SAVE THE DATE
JANUARY 12-14, 2012 TUCSON, AZ