



NEWS

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The Spirit of HIPAA Is EMS There?

Sandy Bogucki, MD, PhD

The regulatory mandates of the Privacy Rule associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) took effect April 15 of this year. It's probably safe to say that most of us in emergency medicine and EMS grudgingly studied another set of federal guidelines, altered our procedures, trained, and documented in order to implement the new requirements over the past year. It's probably also safe to say that our approach to HIPAA compliance has centered on addressing the issues that our legal advisors interpreted as essential in limiting our exposure to sanctions, including criminal penalties, or litigation under the Act. EMS agencies and providers might also now consider taking the opportunity to transcend the letter and, where feasible, approach the spirit of the HIPAA legislation.

Basic outlines of the HIPAA requirements were widely disseminated to the public by the print, broadcast and electronic media around the time of the implementation deadline. The 'spin' was generally very positive; the press hailed this affirmation of patients' right to minimize access to their personal medical records or, more broadly, protected health information (PHI). In EMS, we know very well the premium placed on privacy. When members of our agencies have medical emergencies at home, it is common practice to request landline or coded dispatch of fire apparatus or ambulances, silent approach, and abbreviated or no radio traffic associated with the call. Surely we understand that, given the option, most of the citizens we serve would also elect these courtesies. Accommodating the clear public value articulated in HIPAA

even beyond current interpretations of essential EMS compliance, merits consideration. Local initiatives will, of course, be both driven and limited by EMS system configuration, embedded technologies, applicable statutes and ordinances, economic constraints, and staffing patterns.

The present discussion will not focus on legal interpretations or potential ramifications of the definitions of 'covered entities,' 'business associates,' or 'reasonable measures; these will likely evolve over the life of the Act and its Privacy Rule. That evolution may also move toward the 'Spirit of HIPAA' as the regulators and public gain familiarity with ways to protect medical information associated with EMS. This discussion will simply encourage voluntary evaluation of local dispatch and other radio protocols that could fairly easily enhance the privacy of our patients' PHI without compromising the safety or effectiveness of the medical care we provide.

Radio scanners are widely used by the public. In areas that depend upon volunteer responses for fire, rescue and medical emergencies, responders frequently rely on scanners with or without other alert devices for notification of alarms. More commonly, the 'scanning public' monitors transmissions of public safety agencies out of interest in community news or for entertainment. Obviously, scanner use should not provide individuals who are not otherwise so entitled access to our patients' PHI.

During an EMS call, PHI is typically broadcast at three separate junctures: dispatch, updating second tier responders, and hospital notification. In many systems, radio communication is also required for on-line medical control, and represents a fourth circumstance under which PHI is

sometimes broadcast. In defense of the status quo, some have argued that there is no breach of confidentiality associated with such transmissions as long as patient names are not used.

The standard set in the Privacy Rule, itself, however, protects health information that includes demographic particulars other than names by which a patient's identity may be surmised. Dispatching EMS units over the air to a specified address for a patient of specified age and sex and a specified medical complaint or condition clearly falls short of the intent of HIPAA as long as scanners are inexpensive, readily available, and provide excellent radio reception. Likewise, updates provided by first responders to transport services, direct hospital notification or 'patches' transmitted over Med channels by medical communications services, and on-line medical control all involve divulging patients' histories, current problems, and treatment provided. All of these communications are routinely monitored over the same scanners that originally captured the identifying demographics during dispatch.

Current federal guidance indicates that EMS is not expected to fundamentally alter its operations in order to achieve

continued on page 4

IN THIS ISSUE:

President's Corner	2
National Center for Early Defibrillation (NCED) Update	3
EMS Medical Directors Call for Nominations	3
Important Notice for ABEM Members	4
NEMSIS Completes Significant Milestone	5
Call for Abstracts and Submission Rules	6
Grants Update	8
NCED Survivor's Summit	9
NAEMSP 2004 Annual Meeting Information	9
New Members	11
News From the Executive Office	11
EMS Calendar	12

President's Corner

Still Penny Wise But Pound Foolish After Twenty Years of Progress

I received an email from a state medical director this past week. He let me know that his position had been eliminated due to state budget cuts. At the same time, I heard from another state medical director who had been replaced by a physician with no EMS background, but who is under contract with the state to support their WMD program. Apparently the state felt that they could get a "two-for" out of the deal. It is not my intention to sound flippant about this issue, but after being a member of NAEMSP for the past 20 years and advocating for the need for quality medical oversight, it still amazes me how little people know about EMS and especially the role of an EMS medical director. That knowledge deficit is not limited to government officials. Some of our own colleagues in medicine, even emergency medicine, have yet to fully appreciate the benefit of a well-trained, knowledgeable and experienced EMS physician. In fact, many physicians believe that EMS is no more than an extension of hospital care, so what applies there applies to out of hospital care. It follows, therefore, that they would not appreciate the not so subtle differences of practicing in the field or the litany of special skills and knowledge required to do it right. Physicians who know these differences and who know how to ensure that an EMS is providing care in a safe and effective manner should be an essential part of any local, state or national EMS system, but we know that is not the case. Clearly we have made progress in the past 20 years, but as

we are about to celebrate this milestone anniversary, we must look forward to the challenges we still face.

We must continue our efforts to establish EMS as a subspecialty of an established ABMS board. In order to accomplish this, we must make the case that there is a body of knowledge and clinical skills that is unique to EMS and the out of hospital environment, and that physicians who possess that knowledge and those skills are an essential part of any quality EMS system. Unless and until we have some process to certify EMS physicians, as far as many are concerned, any willing physician will do as a medical director. Physicians who successfully complete an EMS fellowship should be able to obtain the reward of subspecialty certification for their training and expertise. In turn this certification would enable them to compete more effectively for paid medical director positions, especially in larger or more sophisticated EMS systems.

We must advocate for fair and reasonable compensation for an EMS medical director's time. No one I know expects to get rich being an EMS medical director, but providing a fair wage for the services rendered by an EMS medical director is a significant step towards ensuring quality EMS. It's not that they are mercenary; the reality is that compensation would enable many medical directors to dedicate more quality time without having to juggle conflicting schedules and family responsibilities while losing sleep in the process. Sure, I did it for many years, but I know that in many



Robert Bass, MD, FACEP

meetings I attended I had less than my best to give, particularly after working a 12-hour night shift. There are many places where EMS is still provided by volunteers and where a lack of resources precludes compensating the medical director. In such situations, one should not expect the medical director to be paid when no one else is. However, where it is feasible, providing compensation for an EMS medical director is the best way for a system to ensure that the medical director has the necessary time to commit to the task.

We must continue our efforts to define and expand the knowledge base that is unique to EMS and its medical directors. Certainly, that is what NAEMSP has done very well over the years and both our textbook, *Prehospital Systems and Medical Oversight*, and our journal, *Prehospital Emergency Care*, are considered to be authoritative sources of information. However, as recently pointed out in the *EMS Research Agenda*, there is much that we still do not know and a lot that we can do to improve that knowledge base. NAEMSP does that with every annual meeting and with every new edition of the textbook and the journal. Nevertheless, we must all consider the importance of research and the significant role that all of our systems and us can play in contributing. Every system has something to offer. Whether it is an opportunity to do research, a clinical observation, or a best practice to share, we all should be contributing.

We must continue to strengthen and mature the relationship between EMS systems and the medical director. Clearly that has been happening as the concept of medical control has given way to a more collegial approach of medical oversight. With rising concerns about errors in medicine and the need for better quality improvement systems, the role of the

continued on page 8

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 bimonthly newsletter of the National Association of EMS Physicians (NAEMSP).

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Correspondence and inquiries should be sent directly to: **NAEMSP Executive Office**, P.O. Box 15945-281, Lenexa, KS 66285-5945; (913) 492-5858; (800) 228-3677; Fax: (913) 599-5340, E-mail: info-naemsp@goAMP.com, Website: www.naemsp.org

Articles for inclusion in the newsletter must be submitted by e-mail or on diskette (WordPerfect or Word). To submit material for publication, contact the editor by telephone or e-mail.

NAEMSP News

Cai Glushak, MD, Editor
(773) 702-9502 • Fax: (773) 702-7182
E-mail: cglushak@medicine.bsd.uchicago.edu

Jerrie Lynn Johnston, NAEMSP Staff Contact
E-mail: jljohnston@goAMP.com

Copy Deadlines

September/October issue: August 1, 2003
November/December issue: October 3, 2003

NCED CONTINUES TO CHALLENGE SUDDEN CARDIAC DEATH

By Vince N. Mosesso, Jr, MD, NAEMSP Board Member-at-Large and NCED Medical Director

The National Center for Early Defibrillation (NCED) continues to challenge the nation's leading cause of death through a variety of activities. Each year NCED targets an area that is particularly timely and important. This year the focus is on Automated External Defibrillator (AED) programs in schools.

NCED believes that schools are an important target for implementation of AED response programs and CPR and AED training. While the incidence of sudden cardiac arrest (SCA) among persons under 18 years of age is 1/100,000, a seemingly small figure compared with the number of adults who experience SCA, the total years of life lost from those "few" young victims rivals that for adults. Placing AEDs in schools affects many more than just the student victims of SCA. A large number of parents and other adults frequently gather at schools for sporting events, plays, other school functions and community events. It is not uncommon for one of these visitors to experience SCA. Perhaps most importantly is the anticipation that learning CPR and how to use an AED, and seeing AEDs hanging on the walls like fire extinguishers, will ultimately lead to a cultural change. Our hope is that young people who grow up in this environment will become adults who understand the importance of and are willing to take *immediate bystander action* when someone collapses in SCA.

To this end, NCED has been working hard on a number of projects related to schools. In January 2003, in conjunction with the NAEMSP Annual Meeting, NCED held its third issues forum: "Automated External Defibrillators (AEDs) in the Schools." Parents of young sudden cardiac arrest victims, emergency medicine and cardiology experts, representatives of the American Heart Association, the American Academy of Pediatrics, the EMS for Children National Resource Center, the National Association of School Nurses, AED manufactur-

ers, and national training organizations gathered to share their interest and efforts in promoting CPR and AED training in the school setting. Participants also discussed successful implementation strategies, legal and liability issues, pre-participation screenings for teen athletes, funding for school-site AED programs, training and data collection. Key recommendations of the forum were:

1. All schools should provide CPR-AED training for all students. Ideally, this would be done with age-specific courses several times before graduation.
2. All school systems should establish CPR-AED response programs.

The NCED website, www.early-defib.org, will feature a new section dedicated to SCA among young people and information on school-based defibrillation programs, including links to many organizations active in this area, survivor stories and model programs.

NCED is also developing two new products for the school initiative. An educational supplement on the problem of SCA and the solution of early CPR and defibrillation will be distributed this fall with a number of professional journals read by school board members, principals, health and physical education teachers, and school nurses.

The second product is an interactive CD-ROM designed for high school students, and secondarily their teachers and parents. The CD will include a video demonstrating the Chain of Survival in action, an interactive

NCED CONGRESS OF CHAMPIONS AND SURVIVOR SUMMIT

When? Wednesday, October 22–Friday, October 24, 2003

Where? Hyatt Regency on Capitol Hill, Washington, D.C.

Who? Champions and "Champions-in-the-Making" of quality early defibrillation programs, including initiators, implementers and monitors of community-wide programs and on-site programs in locations such as schools, businesses, health and fitness clubs, golf courses, doctors' offices, hotels, railways and highways

How much? Conference Registration Fees: Early bird: \$295; On-time: \$325; On-site: \$350; Hotel room rates: \$149 Single/Double

Why? *Because so many more can survive!*TM

For more information, visit www.early-defib.org, or contact NCED at info@early-defib.org, or 1-866-AED-INFO (toll free).

"game" in which users have three minutes to save a SCA victim, and educational background material about SCA, CPR, defibrillation and advanced care. This product will be available for distribution by the fall.

Finally, NCED recently announced its first national conference, the NCED Congress of Champions, which will be held on October 22-24, 2003, in Washington D.C. The conference, targeted to champions and champions-in-the-making of community-wide and on-site early defibrillation programs, will focus on program implementation and enhancement. A Survivor Summit for invited survivors of SCA and an educational session for legislators will be held in conjunction with the NCED Congress of Champions. Please see the adjacent insert for more details.

The National Center for Early Defibrillation was founded in 2000 as a non-profit organization based at the University of Pittsburgh. Staff include: Vince Mosesso, MD, Medical Director; Paul Paris, MD, Associate Medical Director; Mary Newman, Executive Director; and Kristin Hanson, Programs Specialist. ★

Nominate Your Fellow for the **NAEMSP Fellowship Recognition Award**

The NAEMSP EMS Fellowship Recognition Award recognizes those physicians who have demonstrated commitment to prehospital emergency care by having completed a bonafide fellowship in emergency medical services.

To be eligible for the recognition award, the physician must have completed the EMS fellowship after **June 30, 2000** and be nominated by his or her fellowship director. Nomination forms may be obtained from the NAEMSP Executive Office by calling (800) 228-3677, ext. 4448, or by e-mailing your request to info-naemsp@goAMP.com. Using this form, fellowship directors must indicate that the graduated fellow has acquired expertise in several areas of EMS medical direction and has fulfilled a research requirement. Additionally, both the fellowship director and the EMS fellow must be members of NAEMSP.

Now is the time to look toward our January 2004 annual meeting, when NAEMSP hopes to acknowledge several soon to graduate EMS fellows. Fellowship directors should be guiding fellows toward completion of projects and ensuring that last year's graduates fulfill leftover obligations.

Again, nomination forms can be obtained from the NAEMSP Executive Office. The submission deadline for the January 2004 awards is November 21, 2003.

continued from page 1

compliance with the Privacy Rule. Furthermore, although the problem of radio transmission of PHI by EMS is acknowledged, available technological solutions such as the use of encrypted radio, cellular or hybrid systems are considered attractive if feasible, but are not mandated since the cost could be prohibitive in many jurisdictions. These opinions are reassuring in that our EMS agencies do not appear likely to be penalized or sanctioned under the HIPAA Privacy Rule for our current radio protocols.

If, however, it is clear both that privacy is highly valued by our patient populations, and that radio transmission of PHI represents a significant breach of patient confidentiality, should we not look more closely at our current practices and evaluate some alternatives, even without the immediate threat of criminal or civil prosecution? For each of the four typical examples of EMS radio transmission of PHI, it is important to ask whether the benefits from transmission of that information outweigh the negative effects on the patient as well as whether there is a feasible, cost-effective alternative means of communicating the truly critical information.

There are some EMS systems in suburban and rural settings where the name associated with the telephone from which the 911 call originated is broadcast to assist volunteer responders in identifying the incident location. This practice should be summarily discontinued. Where possible, conversion of dispatch and operational radio systems to more secure modalities should be considered. Admittedly, any form of broadcast can be intercepted by unintended recipients with sufficient technological sophistication and funding. Communications security is, however, incrementally enhanced by use of trunking, cellular, digital formats, encryption, and other methods. In the interim, until improved hardware can be budgeted and installed, dispatch protocols should be reviewed with an eye toward minimizing broadcast of patient information. For example, can the incident location be broadcast along with the units needed to respond without giving the age, sex and chief complaint of the patient involved over the radio? Is it possible to convey this more sensitive (though certainly important) information to text pagers, cell phones, or video monitors in the responding units?

Similar alternatives should be considered for updating sequentially tiered responders en route. Broadcast of the medical situation found over low or high band VHF, UHF or untrunked, 800 MHz frequencies that don't 'hop' should be a last resort. If the situation is not critical, first responders can indicate this without providing further specifics. If it is important for those on scene to provide additional information, radio transmission should include only essential information and not all aspects of the medical report that will be given face-to-face when care of the patient is turned over to the next response tier. Cellular communication with a radio feature has been particularly useful for this purpose in some systems.

Notification of destination hospitals that ambulances are inbound with patients widely occurs via radio, and detailed medical reports of patient condition and treatment are frequently provided. The Med channels used to 'patch' reports to hospitals in many systems are UHF bands in the 450 MHz range that are readily monitored on any radio scanner. The vast majority of routine radio notifications to destination hospitals do not contribute to the quality of care received by transported patients, so it can be argued that the potential breach in confidentiality is not warranted. This is the area that may be most immediately amenable to improved patient privacy. If notification is considered essential to prepare an ED location for the patient, low priority transports might notify hospitals only that they are en route with a stable adult

medical/trauma patient. If possible, dispatch or medical communications centers can notify hospitals of incoming patients electronically, by fax or voice landline, eliminating direct radio communication between hospital and ambulance in these low acuity patients.

For higher acuity transports, and for contacting medical control, radio communication on monitored channels should still be a last resort. Once again, more secure alternatives such as cellular or digital communications deserve consideration. It should be noted that one potential problem with such alternatives is maintaining the current practice of recording the communications between providers and OLMC or destination hospitals. While it can be argued whether the recording is necessary, it does serve a useful purpose, and can readily be accomplished by adding this capability to the receiving telephone lines, or by digital archiving by a variety of techniques.

Implementation of the HIPAA Privacy Rule has focused our attention on the importance of protecting our patients' health information from public scrutiny. According to current federal and legal interpretation of the Rule, EMS compliance will not immediately require major overhaul in operational medical communications. This interpretation gives us time to optimize our local responses to an unequivocal articulation of what we intuitively know needs improvement. It should not be an excuse for entrenchment of our tradition of broadcasting demographically identifiable, federally protected, patient health information. ★

Important Notice to

Current and Former ABEM Diplomates

- ❖ Emergency Medicine Continuous Certification (EMCC) will begin in 2004.
- ❖ All Diplomates who want to maintain their certification with ABEM beyond the current expiration date must participate fully in the EMCC program.
- ❖ Effective 2004, the licensure requirement for all Diplomates will change. Diplomates will be required to continuously maintain a current, active, valid, unrestricted and unqualified license in at least one jurisdiction in the United States, its territories, or Canada, and in each jurisdiction in which they practice. Inactive medical licenses voluntarily held by physicians are in compliance with the *Policy on Medical Licensure*.
- ❖ Physicians eligible for ABEM recertification under current rules will maintain eligibility under EMCC. The written recertification examination as it currently exists will be offered for the last time on November 2, 2003.
- ❖ A special option will be available only from 2004-2006 for former Diplomates to regain their Diplomates status through participation in EMCC. Former Diplomates must begin their participation in EMCC in 2003 to take advantage of this option.

A full description of EMCC including details of Diplomates' participation requirements are available on the ABEM website at www.abem.org. Questions should be directed to American Board of Emergency Medicine, 3000 Coolidge Road, East Lansing, MI 48823; 517/332-4800; emcc@abem.org.

National Emergency Medical Systems Information System (NEMSIS)

Completes Significant Milestone

Continued Exciting Progress Toward NEMSIS Implementation Phase

Submitted by Greg Mears, MD, *Principal Investigator*

The National EMS Information System (NEMSIS) project has reached a significant milestone over the past several months. This progress is due to the extraordinary efforts and vision of the National Association of State EMS Directors and the Federal funding partners; Health Resources Services Administration's (HRSA) Maternal Child Health Bureau's Trauma and EMS Program, Emergency Medical for Services for Children (EMSC) and Department of Transportation's National Highway Traffic Safety Administration's (NHTSA) EMS Division. The 1993 NHTSA Uniform Pre-Hospital Dataset Version 1.0 has been revised and expanded to version 2.0, which is a comprehensive dataset, descriptive of an entire EMS event. This revision represents the work of the NEMSIS Task Force comprised of a dedicated and tireless group of federal program and organizational representatives. Organizations comprising the NEMSIS Task Force include:

American Ambulance Association (AAA)
American College of Emergency Physicians (ACEP)
American College of Surgeons: Committee on Trauma (ACS-COT)
American Heart Association (AHA)
Emergency Medical Research Outcomes Project (EMSOP)
International Association of Fire Chiefs (IAFC)
International Association of Fire Fighters (IAFF)
National Academy of Emergency Medical Dispatch (NAEMD)
National Association of EMS Physicians (NAEMSP)
National Association of EMS Quality Professionals (NAEMSQP)
National Association of State EMS Directors (NASEMSD)
National Emergency Number Association (NENA)
National EMSC Data Analysis Resource Center
NHTSA's EMS Division
Center for Disease Control (CDC)
Federal Emergency Management Administration (FEMA)
Emergency Medical Services for Children (EMSC)—HRSA
Office of Rural Health Policy (ORHP)—HRSA
Trauma/EMS Systems Program—HRSA

Accomplishments of the NEMSIS Task Force and Development of the National EMS Dataset

Not only has there been detailed input by NEMSIS Task Force, but public comment has also been an integral component of this important project. In 2002, under the leadership of the NASEMSD Data Committee Chairperson, Jim Craig (Mississippi State EMS Director), members of the NEMSIS Task Force were charged with revising the NHTSA Uniform PreHospital Dataset, Version 1.0. In November of 2002, an initial draft of the proposed NHTSA Uniform PreHospital Dataset, Version 2.0, was posted on a central website with name and definition only for public comment. During the past two years, this group of dedicated EMS professionals have labored hours over detailed and

intricate data points. This group, by intentional design, vision and direction, created a smaller subset of the comprehensive NHTSA Uniform PreHospital Dataset, known as the National EMS Dataset. The National EMS Dataset will be the foundation for the National EMS Data Registry. This registry will be a national repository of EMS data, defining and describing systems, personnel, and services. The National EMS Dataset will represent the minimum data elements that states will collect and submit to the proposed National EMS Data Registry. The steadfast vision of the NEMSIS project is to facilitate the accurate reporting of EMS services at the local, state and national levels. Through the aggregation of this data at the state and national levels, policy makers and our EMS leadership can identify, support and promote EMS initiatives.

Vision for the Future—Implementation of the National EMS Dataset

Dialogue with Federal and professional entities and organizations has commenced to explore a sound fiscal business plan toward successful implementation of the National EMS Dataset. EMS systems are encouraged to evaluate their current EMS system and data needs to migrate or adopt Version 2.0 of the NHTSA Uniform PreHospital Dataset, including the National EMS Dataset. This will assist in documentation of EMS services, and clinical care. This will in turn provide critical structure and information for EMS quality management programs.

In the future, EMS Medical and System Directors, advisors and advocates should consider the following key points in the implementation of the NHTSA Uniform PreHospital Dataset:

- Evaluate your EMS system and determine which of the NHTSA Version 2.0 Data Elements would be helpful in quality management and oversight activities.
- Adjust your current EMS system to collect data using the NHTSA Version 2.0 Data Elements.
- Encourage EMS systems to migrate or adopt the NHTSA Version 2.0 Data Elements in order that EMS system, personnel, and clinical care can be documented and evaluated in a standardized and consistent national format.
- Encourage vendors, software developers, and medical device manufacturers to migrate and adopt the NHTSA Version 2.0 Data Element definitions.
- Go to www.nemsis.org for detailed information on how to migrate or initiate a data system utilizing the NHTSA Version 2.0 Data Elements.

Please stay tuned to the National EMS Information System Project. The future of EMS can only be realized through using standardized information systems, which in turn will provide an accurate description and justification of EMS services and delivery. ★

Call for Abstracts and Submission Rules

GENERAL INFORMATION

The National Association of EMS Physicians is now accepting abstracts for review for oral and poster presentations at the NAEMSP 2004 Annual Meeting: Specialty Workshops, Scientific Assembly, and Trade Show in Tucson, Arizona. Authors are urged to submit original work involving EMS or resuscitation research. The full spectrum of out-of-hospital and resuscitation research will be considered including basic science, clinical, health services research, epidemiological, operational, economic, and educational studies. Physicians, research scientists, out-of-hospital care providers, and administrators are all encouraged to submit their work.

All abstracts will be reviewed and scored in a blinded fashion by a subcommittee of the NAEMSP Research Committee. Papers will be selected for oral and for poster presentation, with 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 in any format and may not have been presented at a national meeting.

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. Cash awards will be given for Best Resident/Fellow Presentation, Best Scientific Presentation, Best Poster Presentation, Best EMS Provider Research Presentation and Best Cardiac Arrest Research Presentation. Awards will be presented at the Awards Luncheon at the annual meeting.

Call for Pediatric Abstracts and Submission Rules

GENERAL INFORMATION

The National Association of EMS Physicians is now accepting pediatric abstracts for review for oral and poster presentations at the NAEMSP 2004 Annual Meeting: Specialty Workshops, Scientific Assembly, and Trade Show in Tucson, Arizona. Authors are urged to submit original work involving pediatric emergency medical services including basic science, clinical, health services research, epidemiological, operational, economic, and educational studies. Physicians, research scientists, out-of-hospital care providers, and administrators are all encouraged to submit their work.

All abstracts will be reviewed and scored in a blinded fashion by a subcommittee of the NAEMSP Research Committee. Papers will be selected for oral and for poster presentation, with 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 in any format and may not have been presented at a national meeting.

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. A cash award, airfare, hotel lodging for three nights and complimentary registration to the 2004 Annual Meeting will be given for the Best Pediatric Presentation. Awards will be presented at the Awards Luncheon at the annual meeting.

ABSTRACTS MUST BE SUBMITTED ELECTRONICALLY. To do so, visit NAEMSP's website at www.naemsp.org.

Abstract Deadline is Friday, September 5, 2003. Abstracts must be received electronically by 12:00 Noon Central Daylight Time, on Friday, September 5. 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.
2. Without exception, submissions must be received at the NAEMSP Executive Office in Lenexa, Kansas by **12:00 Noon, Central Daylight Time on Friday, September 5, 2003**. 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 other brief introductory material as needed.
 - b. Statement of methods, to include such information as design, setting, participants/subjects, interventions/observations, etc. as needed to clearly demonstrate how the study was carried out.
 - 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 if needed.

Call for International Posters

GENERAL INFORMATION

The National Association of EMS Physicians is now accepting abstract submissions for review for an international poster session at the NAEMSP 2004 Annual Meeting to be held at the Hilton El Conquistador Resort in Tucson, Arizona. The purpose of this poster session is to educate attendees about various models of EMS delivery, encourage networking and information exchange among EMS professionals from various countries, and provide a venue for dissemination and discussion of information about innovative EMS projects. Authors are encouraged to submit abstracts describing large (national or regional) non-U.S. EMS systems for consideration for presentation. All abstracts will be reviewed and scored in a blinded fashion by a subcommittee of the NAEMSP Program Committee, and submissions will be selected based on content, educational value, and space limitations at the meeting venue. Following the standard editorial review process, and as space permits, selected abstracts may be published in the January 2004 issue of *Prehospital Emergency Care*, the official journal of NAEMSP. Presenting authors will be responsible for all costs including: transportation, meals, lodging and registration.

STRUCTURE

The abstract may be a general description of an EMS system, or may focus on a specific aspect of the system, such as medical oversight, integration with the overall health care system, or development of a unique program. The usual research abstract format (objectives, methods, results, conclusions) is not required, and authors are requested instead to format the abstract in such a way as to provide maximal organization and information to the reader. There are no required section titles or subheadings, but general information in the following categories is requested:

1. Essential parameters of your nation/region: Estimated population and demographics, and a brief description of the geography, including square kilometers covered by the EMS system.
2. Basic description of the prehospital care system: Number and type of ambulance services and ambulances, number and levels of training/certification for prehospital personnel, annual call volume, medical direction and involvement of EMS physicians, and legislation or regulation of the system. A more detailed template of information required on the poster is attached; however, only the more abbreviated information listed above is required to appear in the abstract.

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 - b. Statement of methods, to include such information as design, setting, participants/subjects, interventions/observations, etc. as needed to clearly demonstrate how the study was carried out.
 - 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 if needed.

CALL FOR SUBMISSIONS

The Open Source EMS Initiative (OSEMSI) has issued three calls for submissions including Indicator Formats, System-Level Indicators and Cardiac Related Indicators. The OSEMSI's purpose is to create and continuously update superb versions of commonly used EMS system documents that virtually every EMS system has (or will need) to develop, maintain, access or purchase. For more information, visit the OSEMSI website at www.mhf.net/opensource, or contact Mic Gunderson at mic.gunderson@healthanalytics.net.

GRANTS Update

National Research Agenda

The National Highway Traffic Safety Administration and Maternal and Child Health Bureau have awarded NAEMSP with the National EMS Research Agenda Cooperative Agreement. You can read the National EMS Research Agenda online by visiting www.naemsp.org and going to the "Grants" section. In addition, the EMS Research Agenda is available for download in PDF format. The National EMS Research Agenda was also published as a supplement to the July/September issue of *Prehospital Emergency Care*, Volume 6 Number 3. This phase of the Research Agenda Grant has been completed.

National Research Agenda Priority List

A Scope of Work and budget has been prepared for another phase of the National Research Agenda – Modification No. 5. This phase involves the concept of the creation of a research priority list for EMS. The agreement discusses that (1) The consensus process involved in developing a timely priority list for EMS will encourage individual agencies to develop common goals for EMS research; (2) Priority lists can be useful to agencies and organizations that provide grants or other funding opportunities; (3) Provision of a list of topics of interest to the community of EMS could serve to direct researchers to areas of broader interest; and (4) The process of creating and promoting a common agenda will create a unity of purpose within the field of EMS and among many different individuals, organizations and agencies that have related goals of fostering EMS research. We anticipate that the award will be made before July 1st.

National EMS Core Content

The National Highway Traffic Safety Administration and Maternal and Child Health Bureau have contracted with NAEMSP and ACEP to develop a National EMS Core Content describing the entire domain of out-of-hospital medical care. The first meeting of the Core Content Task Force was held in Arlington, Virginia, on March 22, 2002, with participation by 11 organizations. The second Core Content Meeting was held on November 4th, at which time the group worked on the second draft of the National EMS Core Content. The third and final meeting of this group was held February 10-11, 2003. The Writing Team is now in the process of completing their report. The original contract expired on May 16, 2003, but we have filed for an extension of the contract until January 31, 2004. We expect to be granted that extension and should hear the results sometime in June.

Neely Conference

The Neely Conference was held to develop a medical necessity criterion for EMS research derived

from peer-reviewed literature and expert judgment that can be used in research protocols studying triage systems and EMS systems. The one-day conference, which was named in honor of Keith Neely, PhD, MPA, EMT-P, who passed away in 2001, was held on Wednesday, January 15, 2003, in Panama City, Florida, in conjunction with the NAEMSP annual meeting. The conference attendees learned to be aware of the current criteria that are being used in studies of EMS triage and to develop a consensus set of research criteria for EMS response and ambulance transport. The Writing Team is in the process of preparing their final report of the conclusions reached during this conference.

Pediatric and Adolescent Mental Health Emergencies

EMSC funded this project through a Partnership for Children grant. The final report has been prepared by Dr. John D. Hoyle Jr., and was published in the January 2003, issue of *Prehospital Emergency Care*, as well as in an article in the *NAEMSP News*.

Partnership for Children

The next meeting of the EMS Partnership for Children Consortium will tentatively be held in Washington, D.C. on October 2-3. Michael P. Flanagan, CAE, NAEMSP's Grants Project Director, represents NAEMSP. One other representative from the association will attend. The purpose of these meetings is to provide the group with an opportunity to gather and share information and advance the goals of PFC which encourages the development and distribution of best clinical practices guidelines along with educational and research programs related to emergency medical services for children. The Consortium is currently undergoing some reorganization and the scope of these meetings may change significantly with the next meeting. We should be notified of those changes sometime this summer.

Pediatric Emergency Care Research Workshop

The Emergency Medical Services for Children (EMSC) has awarded NAEMSP with a new Cooperative Agreement effective September 1, 2002. The purpose of the contract is to develop a two-day workshop that will be held in conjunction with the NAEMSP annual meeting. The workshop will focus on pediatric emergency care research and will be held in January in Tucson, Arizona. The Principal Investigator for the workshop is Kathleen Brown, MD, and the Steering Committee consists of Lynn White, MS; and Brooke Lerner, PhD, EMT-P.

The layout of the workshop has not been completed at this point in time, but the original concept was that the first day of the workshop would be customized and the second day would consist of breakout sessions that would be specific to pediatric emergency care research and would run concurrently and be integrated with the NAEMSP annual meeting general sessions. The second day of the workshop would also include attendance at the oral abstract presentations. Following the pediatrics

workshop, the Steering Committee would prepare an evaluation summary and preparations for future enhanced pediatric emergency care research workshops.

Interactive Information Systems for Responding to Acts of Terrorism Grant

NAEMSP has been awarded a Cooperative Agreement with the Center for Disease Control and Prevention. The contract calls for NAEMSP to work with federal, state and local public health agencies to design and conduct a national needs assessment survey to identify currently functioning interactive informational systems between public health agencies, emergency departments and EMS systems as well as the characteristics of those systems and to identify linkages of acute care and emergency medical services to state and local injury prevention programs. Following the needs assessment survey, a writing team will be developed to analyze the data collected and to prepare preliminary conclusions. There will also be a one-day congress convened to assist in the identification of opportunities for the rapid exchange of information. The objective is that interactive information systems between EMS physicians and public health agencies would strengthen day-to-day operations and better prepare systems for catastrophic events. The end result will be a White Paper on Interactive Information Systems. The Principal Investigator for this project is Robert O'Connor, MD, MPH.

The Steering Committee has been conducting conference calls and a congress was scheduled to be held in Washington, D.C. on July 9th. The group is also working with the CDC on a joint White Paper. ★

President's Corner, continued from page 2

medical director is more important than ever. However, the older monolithic "captain of the ship" style of leadership will not work as it has in the past. Today's medical director plays a key leadership role in the team of providers, administrators, educators, politicians, and others that it takes to provide quality EMS. Medical directors must be better educated and better prepared to assume this vital role.

The final, and not the least, challenge that we face in the future is the need for better advocacy for EMS. If the public and our politicians do not know about EMS, we can't expect them to be willing to do much to support it. An EMS medical director's leadership role is not limited to the EMS system; they must be effective leaders in the community as well. Individually and collectively we need to be making the case for better support of EMS and its role as an essential public safety service.

We have come a long way in twenty years, but we still have a long way to go. ★

Developing Research Criteria to Define Medical Necessity in EMS

Keith Neely, PhD, was an active member of NAEMSP who advocated for and performed research on alternative EMS delivery systems. Before his untimely death in 2001, he and others realized that this research was being hampered by a lack of a standard set of research criteria that could be used to determine that the patient needed a specific EMS response. To address this need, "The Neely Conference: Developing Research Criteria to Define Medical Necessity in EMS," a working conference, was held on 15 January 2003, as a pre-conference to the National Association of EMS Physicians Annual Meeting in Panama City Beach, Florida.

Dave Cone, MD, the project principal investigator, along with Terri Schmidt, MD, and N. Clay Mann, PhD, organized the conference. We are indebted to Jeff Michael and Susan McHenry of the National Transportation Safety Administration for their support and assistance, as well as to Michael Flanagan, Grants Project Manager of the National Association of EMS Physicians executive office staff, for developing and managing the meeting logistics. We are also indebted to the meeting facilitators: Lawrence Brown, MD, EMT-P; James Dunford, MD; Jay M. Goldman, MD; Jon R. Krohmer, MD; Greg Mears, MD; Lori Moore, DrPH, EMT-P; Robert Norton, MD; Ronald G. Pirrallo, MD, and participants who performed the actual work of the conference. The conference convened approximately 30 EMS physicians, researchers, administrators, providers, and representatives of interested federal agencies. Proceedings of the conference will appear in a future issue of *Prehospital Emergency Care*.

We all know that not all patients who call 911 need an emergency EMS response, and not all patients for whom EMS arrives need ambulance transport to the hospital. What is not clear is how to safely determine who needs which type of response and transport or even if it can be determined. Currently, research studies have sought to evaluate the value of tiered responses of various configurations, the benefits of certain deployment strategies, and the role for certain system and clinical interventions. Further, some research has been done attempting to determine when and if it is safe to triage callers to a dispatch center or patients for which an EMS response has been sent to alternative resources.

With no standard to use in judging which patients "need" an EMS response of a certain type, the existing research has been difficult to compare. The situation is somewhat analogous to the state of cardiac arrest research

prior to the establishment of the Utstein Criteria. This has resulted in a variety of research efforts that cannot be compared to each other, because each has used a different set of criteria to determine the need for an EMS response or ambulance transport. The ability to compare studies and decide about how these studies might impact system designs would be greatly enhanced by a single set of criteria so studies can be compared side by side. This was the lofty goal of the Neely Conference. Bringing the experts together in a structured setting was a great beginning. Now the hard work of formalizing the criteria is underway. The criteria will be based on these agreed upon principles:

1. Any dispatch or field triage system that is developed must be designed to offer patients alternatives to EMS, not to refuse care to patients.

2. It is theoretically possible to develop a set of clinical criteria for need. Some groups of patients (major trauma) will clearly need traditional EMS response and some will not, but this has yet to be defined.
3. In addition to clinical criteria, certain social and other non-clinical criteria may be used to justify a response.
4. Communication barriers, patient age, special needs and other conditions complicate patient assessment but should not exclude patients from consideration.

The proceedings from the conference are being completed and plans are being considered for how to move the process forward from here. The conference organizers are interested in ideas and feedback from members of NAEMSP. ★

The NAEMSP 2004 Annual Meeting

Promises Diverse and Cutting Edge Information

Debra Perina, MD, *Program Committee Chair*

Mark your calendars now for January 8-10, 2004, and plan to join us at the NAEMSP 2004 Annual Meeting for a stimulating educational experience! Samplings of presentations include pre-conference workshops on legal aspects of EMS systems management, a pediatric research essentials workshop sponsored by EMS-C, a CONTOMS course, and a hands-on Fireground 101 operational exercise.

Didactic topics will include the medical director's role in preparing EMS response to infectious disease – the SARS story, statistical process control in quality management, problem solving for rural medical directors, comparing patient outcomes across EMS systems, and common avoidable errors in EMS.

Panel discussions on RSI airway control issues and incident debriefing will stimulate thoughtful discussions. Results from the recently completed PAD trial will be presented in the research forum. Other included topics are technological advances in EMS, pediatric issues and public health initiatives in EMS.

An international disaster presentation will focus on response issues in the recent multiple earthquakes in Turkey. The System Showcase will highlight EMS systems with interesting or unique qualities that might be beneficial to other agencies, while the NAEMSP Photo Contest gives members a chance to exhibit their interesting and unusual photographs.

The program also includes many thought provoking and educational oral and poster research presentations. In addition, 2004 is NAEMSP's 20th anniversary, so you won't want to miss the special celebration activities that are being planned!

Call for Photographs



Many of us involved in EMS have great action photos depicting various elements of prehospital systems. You now have the opportunity to show off your best!

Once again, NAEMSP will sponsor a photo contest at the 2004 annual meeting in Tucson, Arizona. The NAEMSP Program Committee would like to encourage all interested members to submit EMS-related photos for the contest. Approved entries will be displayed in the poster hall during the entire meeting. First, second and third place winners will be selected by a subgroup of the program committee, and the winners will be announced at the Awards Luncheon.

Please remember that these photos will be publicly displayed. Any patient identifiers should not be visible without the written consent of the patient or their immediate family member. Photo captions may be included, although this is not mandatory. It must be understood that these photos are for public display and all captions must be professional in content.

If you have photos you wish to submit, please send an 8 x 11 copy no later than November 14, 2003, to: Dr. Ted Delbridge, Department of Emergency Medicine UPMC-Presbyterian CL-06, 200 Lothrop Street, Pittsburgh, PA 15213.

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2002 Fellowship Recognition Award Recipients

Michael J. Casner, MD
Bethany A. Cummings, MA, DO
David P. Hostler, PhD, EMT-P

NAEMSP Welcomes New Members



Kathleen Crawford, EMS I/C	Christopher Prince, MD
Damon Darsey, EMT-P	Terri Sabina
Margaret De Grace, MA	Jeffrey Schroeder
Javier Escobar, MD	Kelly Trakalo, EMT, RRT
Mike Grill, BS, NREMT-P	Clifford Turen, MD
Andrew Hawk, MD	Michael Ward, DO
Richard Hoyer, PhD, MD, EdD	Michael Young, MD

News From the Executive Office

Dede Gish-Panjada, MBA, *Executive Director* and Jerrie Lynn Johnston, *Association Manager*

Get Involved!

Are you interested in becoming involved in NAEMSP? Committee and task force participation is an excellent way to do this. Our experience is that individuals who get actively involved in their professional association have a higher degree of job satisfaction, remain on the leading edge of their practice, and are motivated to perform at higher levels than those who are not involved. If you are interested in being more involved with a committee, or becoming a committee chair, please contact Monica Frihart, staff liaison to the Membership Committee at mfrihart@goAMP.com or contact Jerrie Lynn Johnston, Association Manager at jljohnston@goAMP.com.

Research Agenda Website

We have been experiencing difficulties with the Research Agenda website (www.researchagenda.org). Until a solution is found, the information has been linked with our main page, www.naemsp.org. We apologize for the inconvenience this has caused.

Showcase Your Scientific Research

The 2004 "Call for Abstracts" submission information is included in this issue. The abstract deadline is **Friday, September 5, 2003 at 12:00 noon CDT**. This year, we are again using the electronic-submission-only format, with the exception of overseas submissions, which may be faxed to the NAEMSP Executive Office. Again this year, a special Pediatric Call for Abstracts had been developed with the support of the Maternal and Child Health Bureau (MCHB), Emergency Medical Services for Children (EMSC). The "Call for International Posters" continues to grow and evolve and is also included in this issue. Please note that if your abstract is chosen for consideration, you must register for the 2004 Annual Meeting. See pages 6-7 for complete submission details on the Call for Abstracts, Call for Pediatric Abstracts and Call for International Posters, or visit the NAEMSP website at www.naemsp.org.

EMS Medical Director of the Year Award Nominations Due August 1

The National Association of Emergency Medical Technicians (NAEMT) is accepting nominations for a new award recognizing outstanding leadership in EMS medical direction. The Richard Ferneau EMS Medical Director of the Year Award carries a \$1,000 prize and is sponsored by Ferno-Washington, Inc. It will be presented at NAEMT's Annual Awards Banquet on September 25, 2003, in Las Vegas.

"The EMS medical director is a vital component of EMS and provides the medical and legal empowerment for EMS workers to care for the sick and injured," said NAEMT President John Roquemore. "Over the last three decades, the role of EMS medical director has evolved into a well-defined practice of medicine and, in many of the best EMS systems, it is the medical director who sets the tone for the quality of services delivered. NAEMT wants to honor those people who do it best."

The award is named for Richard (Dick) Ferneau, founder of Ferno-Washington, Inc., a global leader in the manufacturing and distribution of professional emergency medical, therapy and mortuary equipment products and a longtime supporter of emergency medical services. In 1955, Richard Ferneau founded Ferno Manufacturing in Stauton, Ohio. Ferneau teamed up with El Bourgraf and, in 1957, they moved the business to Greenfield, Ohio, where they began manufacturing a one-man mortuary cot. In 1961, Ferno purchased the Washington Mortuary Supply Company, and the corporation changed its name to Ferno-Washington, Inc. In 1972, Ferno-Washington moved to Wilmington, Ohio, where it is located today.

The Richard Ferneau EMS Medical Director of the Year Award recognizes an EMS Medical Director who demonstrates:

- Exemplary local leadership in the provision of Emergency Medical Services;
- Outstanding dedication to continually improving the quality of local prehospital emergency medical care;
- Exceptional ability in motivating, encouraging, and supporting EMTs and Paramedics; and
- Recognized innovation in system development and clinical care.

Any practicing medical director of a local EMS system is eligible.

Nominations are due August 1, 2003, and should include letters of recommendation from both inside and outside the nominee's EMS system. Winners will be chosen by NAEMT's Awards Committee. Nomination forms may be obtained from the NAEMT website at www.NAEMT.org, or by calling the NAEMT headquarters at (800) 34-NAEMT.

NAEMT is an international association of paramedics and EMTs that represents career and volunteer EMS workers worldwide. NAEMT's goal is to serve its members through educational programs, information services, membership benefits, effective representation, and recognition of the professionalism and dedication of the men and women who provide pre-hospital medical care.

EXECUTIVE OFFICE STAFF LISTING

The NAEMSP Executive Office and staff e-mail address information is listed below for your reference.

General E-mail Address to reach staff: info-naemsp@goamp.com
Executive Director Dede Gish-Panjada, MBA
Association Manager Jerrie Lynn Johnston
Meeting Manager Joyce K. Miller, CMP
Grants Project Director Michael P. Flanagan, CAE
Administrative Assistant Monica Frihart

The deadline for EMS Calendar submissions for October/November 2003 issue of NAEMSP News is August 1, 2003.

EMS Calendar

August 20-23, 2003: Florida Emergency Medicine Foundation Symposium by the Sea. Location: Ponte Vedra, FL. Contact: (800) 766-6335 or www.femf.org.

September 4-6, 2003: Setting the Healthcare Agenda for Emergency Air Medical Transport. Location: Salt Lake City, UT. Contact: Thomas.Stephen@mg.harvard.edu.

September 9-13, 2003: National Association EMS Educators Annual Meeting. Location: Nashville, TN. Contact: www.naemse.org.

September 11-14, 2003: Firehouse on the Road: Atlanta, GA. Contact: (800) 827-8009 or www.firehouseontheroad.com.

September 14-17, 2003: Second Mediterranean Emergency Medicine Congress. Location: Barcelona, Spain. Contact: 1414-276-3349.

September 18-20, 2003: ENA Scientific Assembly. Location: Philadelphia, PA. Contact: www.ena.org.

September 21-25, 2003: EMS Expo. Location: Las Vegas, NV. Contact: (877) EMS-EXPO or www.emsmagazine.com.

September 23-25, 2003: Technologies for Public Safety in Critical Incident Response 5th Annual Conference & Expo. Location: St. Louis, MO. Contact: (888) 475-1919.

October 2-4, 2003: American Academy of Family Physicians Annual Meeting. Location: New Orleans, LA. Contact: www.aafp.org.

October 2-4, 2003: Sand Key EMS Summit 2003; Sunstar EMS/Florida Emergency Medical Foundation. Location: Clearwater, FL. Contact: 800-766-6335; www.femf.org.

October 12-16, 2003: American College of Osteopathic Emergency Physicians Scientific Assembly. Location: New Orleans, LA. Contact: (800) 521-3709 or www.acoep.org.

October 12-15, 2003: American College of Emergency Physicians Annual Meeting. Location: Boston, MA. Contact: (800) 798-1822 or www.acep.org.

October 15-18, 2003: Firehouse on the Road: Fort Worth, TX. Contact: (800) 827-8009 or www.firehouseontheroad.com.

October 22-24, 2003: NCED Congress of Champions. Location: Washington, D.C. Contact: www.early-defib.org.

November 6-8, 2003: Basic Trauma Life Support International Conference. Location: York, England. Contact: (800) 495-BTLS or www.btls.org.

November 12-15, 2003: Firehouse on the Road: Albuquerque, NM. Contact: (800) 827-8009 or www.firehouseontheroad.com.

November 15-19, 2003: National Fire Protection Association Fall Educational Conference. Location: Reno, NV. Contact: (617) 770-3000 or www.nfpa.org.

November 27-30, 2003: 3rd Asian Conference on Emergency Medicine. Location: Hong Kong. Contact: www.acem2003.com.

January 8-10, 2004: NAEMSP Annual Meeting. Location: Hilton El Conquistador, Tucson, AZ. Contact: www.naemsp.org or info@naemsp.org.

Mark Your Calendar



Don't miss the

2004 Annual Meeting

January 8 – 10, 2004

Hilton El Conquistador

Tucson, Arizona

Preliminary education program brochures will be mailed to all NAEMSP members and posted on the website in late September. Make your reservations now! Be sure to mention NAEMSP to secure the **special group room rate of \$184** plus tax. Call: 520-544-5000.

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



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