



# NEWS

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*Professionally Speaking*

## Waiting for the Other Shoe to Drop

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*Professional Member-at-Large*

To borrow from Charles Dickens, "It was the best of times; it was the worst of times." This sentiment sums up the past 18 months better than any other that comes to mind.

Out of the horror of September 11, 2001, countless acts of selflessness and service were exhibited by my EMS and public safety colleagues at the World Trade Center and the Pentagon, and in a field in southwestern Pennsylvania. The awareness of sacrifice (or potential for same) by public safety personnel (fire, police and EMS) dawned bright and pure in the consciousness of a nation even as its heart was breaking. No one will ever look at those professions in the same light again.

Slowly in the months that followed, things returned to normal, or what became the new normal. The dead were buried, the missing memorialized, but everyone kept waiting; waiting for the other shoe to drop. The tributes and accolades waned over time until the anniversary approached, but then rose again, briefly. The anniversary came and went, and everyone kept waiting; waiting for the other shoe to drop.

Here in the Washington, DC, metropolitan area where I've lived and worked for more than a dozen years, "the other shoe" came in October 2002, in the form of the sniper that terrorized the area for the longest three weeks that anyone can remember. First one community, then another was hit. This was no made-for-TV movie that was neatly wrapped up in 90 minutes. There seemed to be no pattern – the victims were diverse in age, ethnicity

and gender; the attacks happened in daylight and in darkness, at gas stations, parking lots and school yards. Pumping gas was transformed into an odd ballet of evasive maneuvers and continuous surveillance designed to not call attention to one's self just in case the sniper was near. Children stayed inside for recess if they went to school at all. Then, as suddenly as it began, it was over. The indicted perpetrators now await trial and things have returned to that new normal and waiting for the other shoe to drop.

Over the course of the past 18 months, our security threat level has been orange and then yellow, and then orange again, based on perceived validity of the "intel" regarding threats – foreign or domestic. A strange kaleidoscope of color triggering different actions and reactions for each of us, personally and professionally. We have changed how we do business. Doors at police and fire stations that were once left open are now always kept locked. Pre-plans for emergency operations have been reviewed and revised as the call lists are updated. We've been advised to develop and test emergency evacuation plans and create "safe rooms" in our homes. Who could have forecast that duct tape would be as scarce as gasoline that costs less than \$1.70 per gallon? Smallpox vaccination education programs have been designed and drills have been conducted to test our readiness for implementation. Community emergency response teams are being trained at the same time that our friends and family members are being called up for active duty either here or abroad. Things are again back to the new

"normal" and we're back to waiting for the other shoe to drop.

Through it all, my EMS and Emergency Medicine colleagues continue to run calls and see patients. Occasionally a baby is born or a cardiac arrest victim is resuscitated, but most days, nothing particularly remarkable happens – oxygen is given, IVs are started and transports are done; for that, we are grateful that the "other shoe" has not dropped.

As I write this, Operation Iraqi Freedom is 10 days old and if some pundits are to be believed, then perhaps it is not merely one "other shoe" that drops, but many shoes. And if that happens, you can be sure that EMS will be in the front lines and the headlines once again helping our communities to manage the new reality that passes for normal. Stay safe and continue to take good care! ★

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## EMS and Public Health: A Critical Partnership

During the Shanaberger lecture at the NAEMSP annual meeting in 2000, former American Public Health Association (APHA) Executive Director Dr. Mohammad Akhter challenged us to redefine the relationship between EMS and public health. While their approaches may differ, EMS and public health both have the same goal of improving the health of the community. With support from the National Highway Safety Administration, Dr. Akhter established a forum to study this issue. The proceedings from the forum are available at [http://www.nhtsa.dot.gov/people/injury/ems/ems\\_publichealth/EMSPublicHealth.pdf](http://www.nhtsa.dot.gov/people/injury/ems/ems_publichealth/EMSPublicHealth.pdf). I encourage you to download and review this important document.

Dr. Akhter has always been known as a visionary, but little did we know how insightful his address would be. Since his 2000 address, multiple events have forced both the EMS and the public health communities to reconsider their traditional roles. With the specter of a potential terrorist attack on the United States, EMS has had to consider its role in detection and surveillance, as public health has had to consider its role as a community responder. Shortly after September 11<sup>th</sup>, NAEMSP, the National Association of State EMS Directors, and the APHA met once again, this time to develop a joint memorandum of understanding on emergency medical and public health response to terrorism. This document is available at <http://www.apha.org/news/press/2001/emsmou.htm> and is built on the principles developed during the

forum. There are many important recommendations in the MOU, three of which I would like to highlight, but I highly recommend that you review the entire document.

In order to assure prompt notification to Public Health agencies of clustered illnesses identified by EMS responders, and for EMS responders to receive notification of Public Health alerts, a communication infrastructure needs to be established that connects them. This infrastructure should allow communication from ambulance-to-ambulance, hospital-to-hospital, ambulance-to-hospital, and Public Health-to-all EMS components. Such a system will ensure that the most important EMS resources, its volunteer and career providers, will receive vital notifications and shared intelligence that will help them to protect themselves and their families, and to permit them to continue providing essential EMS services to their communities.

While this recommendation was intended to apply to a terrorist attack, it is just as important in addressing the recent SARS outbreak. The Centers for Disease Control (CDC) has been very good in developing and distributing guidelines to healthcare providers and recently developed recommendations specifically for EMS providers. They have also welcomed input from the EMS community in developing them. We must however, strengthen and formalize this process not just at the national level, but also at the state and local levels as well. Additionally, EMS needs to improve our communications systems and ensure interoperability between systems, both of which must be priorities for current Federal anti-terrorism funding.



Robert Bass, MD, FACEP

Leadership from state and local EMS and Public Health agencies should meet and establish regular contact and working relationships immediately.

The roles of EMS and public health have never been more closely aligned and it is essential that dialogue occur and that relationships form before a major event. Based on my experience in Maryland and from what I am hearing from my colleagues around the country, a lot of meaningful dialogue is occurring between EMS and public health officials as they both struggle to help each other adapt to new and unfamiliar challenges and roles. What we have seen is two disciplines that have traditionally not had a close working relationship come together to address a common challenge. At the local, state, and national level, EMS and public health personnel are engaged in many cooperative efforts.

Leadership from EMS and Public Health should develop mechanisms to rapidly assimilate and distribute "best practices" from EMS and Public Health collaborations in the medical/public health response to terrorism.

The CDC has recently asked NAEMSP to assist in this task. NAEMSP President-elect Dr. Bob O'Connor and Dr. Tom Blackwell, Chair of the Terrorism Subcommittee have already begun work on this effort. This is an important project that will enable all EMS systems to benefit from the experiences of successful EMS and public health collaboration efforts around the country.

Most of us are busy enough with our day-to-day responsibilities, so taking on new challenges is not something we relish. I would, however, once again ask you to review the two previously mentioned documents. The tasks that are mentioned in the MOU and the principles in the bulletin are vitally important issues to the health of our communities, and issues that we must find the time to address. ★

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

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

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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.

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#### **Copy Deadlines**

July/August issue: May 30, 2003  
September/October issue: October 3, 2003

# A Note from the Editor

NAEMSP for many years has used traditional forms of communications through the newsletter and its journal to keep members abreast of professional and scholarly issues. We are proud of the continuing enhancements we have seen in these products in the last few years. With the recent updating of our website overseen by Greg Mears, we also have an internet presence we can be very proud of. The reality of the communications environment has progressively demanded instantaneous communication on emerging and rapidly evolving events. Paper and mailed products cannot hope to keep pace with the rapidity with which many issues develop, in part because those issues are driven by ever faster means of communication.

However, as many members have attested, there is still a strong perceived and real value in "hard copy." Obviously the value of PEC speaks for itself. On the other hand, the newsletter, which formerly was the primary means of notifying members of more urgent developments, cannot be expected to serve as the most timely means of communication for time-

sensitive events. For that reason, we have decided to depend primarily on broadcast e-mails, many of which you are now receiving on a regular basis, to inform you of rapidly emerging developments and important deadlines (deadlines related to formal NAEMSP-related business and membership will continue to be transmitted through traditional mail, by letter and/or newsletter for the time being).

NAEMSP News, therefore, will continue to be a major form of communication for less urgent discussion. It will continue to be the primary vehicle for special interest topics, editorials, letters to the editor or leadership, committee reports and other issues that are not extremely time-sensitive. We intend for the newsletter to continue to serve as a forum for thoughtful expression on topics related to EMS and medical direction. We urge you to use it as a means to communicate your valuable expertise and viewpoints to other readers. For that reason, we hope you will consider submitting a topic of special interest to you for the benefit of the entire membership.

Please remember, it is extremely important that we have your current e-mail address on file. NAEMSP has been sending, on average, several broadcast e-mail announcements per month to members. If you have not been receiving them, we do not have your correct e-mail address. Please be sure to update our office with any changes or you will continue to miss valuable time-sensitive information. Almost all of you have an e-mail account (we know this through our member surveys). However, if you are unable to receive e-mail, please let our staff know of your preferred means of contact for special announcements. We will make every effort to accommodate your needs.

As always, feedback on our communication products is extremely important. Let us know if we are meeting your expectations.

Wishing you well,

Cai Glushak, MD FACEP  
Editor, NAEMSP News  
Chairman, Communications Committee

## Rural Affairs Committee Envisions Educational Resource for Rural Medical Directors

Douglas F. Kupas, MD

*Chairman, NAEMSP Rural Affairs Committee*

Many rural EMS medical directors are not able to attend national or even state-sponsored medical director courses. The NAEMSP Rural Affairs Committee identified a need for an educational resource that addresses the unique issues related to providing medical direction to rural EMS services. To address this need, the committee has begun work on a project to produce a one-day rural EMS medical director course on an easily distributed CD. The committee is currently pursuing grant funding to accomplish this goal.

The Rural Affairs Committee had a very productive meeting in Panama City Beach this January. The highlight of the meeting was the opportunity to discuss rural EMS system and medical director needs with Mr. Evan Mayfield and Ms. Cheryl Anderson from the Health Resources and Services Administration (HRSA) of the U. S. Department of Health

and Human Services. Mr. Mayfield serves with the HRSA Office of Rural Health Policy. The dialogue was productive, and we hope to continue this important relationship with HRSA and other potential partners.

In many cases, it is difficult to identify rural EMS medical directors. The committee hopes to do this by targeting these individuals through their EMS providers. To this end, Dr. Greg Frailey presented a lecture entitled "The Care and Feeding of Your Medical Director" at the annual JEMS conference in Philadelphia last month. Dr. Frailey is leading a committee effort to publish an article regarding rural medical direction issues in one of the EMS trade magazines.

Last year, the Rural Affairs Committee continued its efforts to assure that rural topics are included in the annual meeting program. Over the last few years, topics presented at the annual

meeting have included lectures on issues of rural medical direction, agricultural emergencies, and wilderness EMS. The committee plans to continue its efforts to provide rural tracks for the annual meeting.

NAEMSP has many resources to offer to rural medical directors, and the Rural Affairs Committee realizes that this group may not be able to attend the committee meeting at the annual conference. For this reason, we believe that our listserv is an important resource for committee communication. NAEMSP members that are interested in rural EMS issues and would like to become a member of the committee are encouraged to contact the NAEMSP office at 800/228-3677. Committee membership provides an excellent opportunity to network with EMS medical directors who share similar interests and challenges. We need you. ★

# The Emergency Department Major Incident Center

## A Model for Community Investment in Regional Emergency System Preparedness

By Jim Augustine, MD, Vice Chair, Clinical Operations,  
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The time has come to request capital support for the emergency services in America. There are a variety of options to seek that support, but I ask that you consider support in the form of capital investment in the physical plant of the nation's Emergency Departments (EDs). The time-sensitive need for structural upgrade is to modernize the EDs to receive and process in patients from a major community disaster. All EDs in all communities in the country need physical and process changes to deliver "all hazards" preparedness to the citizens served by American hospitals. Hospital preparedness means all Americans have access to critical medical services at a time of need.

The simple beauty of a capital infusion in EDs now is the opportunity to benefit from that investment every day. There is a pressing need for Emergency Department capacity expansion right now. There is a cascade of events following shortages in bed availability for inpatients; this backup then results in ED patients being held awaiting admission then ED beds get saturated; then the ED must go on diversion. American EDs have historically faced capacity crises during periods of peak viral load in the region. But in the past three years, many American hospitals (two-thirds by one survey), in our busiest EDs in our metropolitan areas, this is now a weekly or daily occurrence.

The American health care system faced a similar need for capital investment in a prior time. After World War II, American communities were growing rapidly, health sciences had dramatically improved medical treatment, and American leaders feared disasters on American soil with the beginning of the Cold War. The Federal government considered these needs, and crafted an infrastructure funding program.

The *Hill-Burton Act* became law on August 13, 1946, as Public Law 725. The official title is, "Hospital Survey and Construction Act," and the document is nine pages in length. The chief sponsor was Sen.

Lister Hill (D-Ala.). The act was an amendment to the Public Health Service Act, which authorized grants to the states for surveying their hospitals and public-health centers and for planning construction of additional facilities, and it authorized grants to assist in such construction.

The purpose of this Act delineates a set of needs that is remarkably similar to the challenges American health care faces in 2002.

The purpose of this title is

(a) to assist the several States in the carrying out of their programs for the construction and modernization of such public or other nonprofit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to all their people;

(b) to stimulate the development of new or improved types of physical facilities for medical, diagnostic, preventive, treatment, or rehabilitative services; and

(c) to promote research, experiments, and demonstrations relating to the effective development and utilization of hospital, clinic, or similar services, facilities, and resources, and to promote the coordination of such research, experiments, and demonstrations and the useful application of their results.

*The following are excerpts from 42U.S.C. §291 et seq., which are, at present, incorporated into current U.S. law by the Hill-Burton Act.*

### 291c. General Regulations

The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe

(a) **Priority of projects.** The general manner in which the State agency shall determine the priority of projects based on the relative need of different areas lacking adequate facilities of various types for which assistance is available under this part, giving special consideration

(1) in case of projects for the construction of hospitals, to facilities serving areas with relatively small financial resources and, at the

option of the State, rural communities;

(2) in the case of projects for the construction of rehabilitation facilities, to facilities operated in connection with a university teaching hospital which will provide an integrated program of medical, psychological, social, and vocational evaluation and services under competent supervision;


(3) in the case of projects for modernization of facilities, to facilities serving densely populated areas;

(4) in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area;

(5) to projects for facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(6) to facilities which will provide training in health or allied health professions; and

(7) to facilities which will provide, to a significant extent, for the treatment of alcoholism;

Communities are seeking ways to invest in their emergency preparedness systems. The Federal government is searching for methods to prepare communities for mass casualty and other major incidents. These recent efforts have been heightened by the fact emergency departments are facing overwhelming challenges in delivering care at today's routine daily patient volumes, much less patients from major incidents. Hospital inpatient beds are in short supply in most American metropolitan areas, a problem that then backs patients up into the ED. Hospitals are under increasing budget constraints, and under new fiscal pressures in the form of reductions in reimbursement and accelerating staffing costs. Finally, post-September 11 the American public is concerned about its access to emergency care, and wants to contribute to rescue agencies that provide its safety net services. 

Where should this preparedness effort find fertile and productive ground? A major investment in the nation's community emergency departments. This investment would occur in both the process of emergency care, and the physical facilities where emergency department staffs provide care. This investment should upgrade the facilities needed for disaster care, by building the new areas needed to accommodate large groups of patients presenting for care at the same time. Simultaneously, this space would serve the critical needs of daily crises. Conceptually, this new space could wrap around the existing emergency department to create the new areas needed for reception, monitoring, and initial care.

This project should be a joint and mutual investment, funded and facilitated by the Federal, state, and local government; then carried out in conjunction with the many business, charity organizations, and individuals who want a new level of emergency preparedness in their community. If we wish to pour money into the community disaster systems, we should make sure it helps to rebuild a system of routine emergency medical care. After all, a very effective disaster response system must be built on a foundation of effective day-to-day emergency care.

There are approximately 3,900 EDs currently in the country, servicing about 110 million patients per year for all forms of illness and injury. Virtually all of these EDs need to be re-fitted for a new role in community surveillance and major incident medical care. These same emergency departments have been strained beyond the ability to provide timely care in most American metropolitan areas, due to a reduction in funding, closure of more than 1000 hospitals and emergency departments, and a steady increase in the number of patients seeking care from the emergency system. This problem is now manifest in the issue of Emergency Department crowding and saturation, which leaves our nation's emergency departments unable to meet demands for day-to-day emergency care.

A reinvestment program is needed in essentially all of the existing EDs. This would include the Level One Trauma Centers, who provide many critical care services to a regional group of patients. But this group of Trauma Centers cannot accommodate all the community needs, either on a day-to-day basis, or in the event of a major crisis. All hospitals are now responsible for developing plans to prepare for victims from any type of crisis, from trauma, to contagious disease, to

radiation exposure or burn. With this background, it is critical to rebuild the country's emergency system to accommodate day-to-day, and disaster, medical needs.

## Background on Capital Funding of the Community Health Care System

The current community hospital system, with 24 hour emergency medical resources, was founded in the post World War II era. It was built to satisfy the mutual needs of a growing population; World War II and Cold War fears of major casualties on US soil; the growing availability of emergency care specialists; and funding programs of the Federal Government. This is not dissimilar to the situation in which we find ourselves in 2002!

The funding program of that era was the Hill-Burton Act. One might be tempted to call this new funding program the "Hell to Bin Laden Act". The foundation of the ED "re-fit" is a capital program to update every ED in the country, to fulfill uniform requirements for emergency medical care, medical response to disasters, and community surveillance for communicable illnesses and preventable injuries.

Post September 11, 2001 the Federal government has new responsibilities for the civilian emergency preparedness systems. Uniform requirements exist across the country for

- Appropriate supplies, equipment, and disposable patient care items
- Appropriate facilities for the management of major incident casualties
- A consistent manner for patient check-in, symptom evaluation, triage, and processing into the emergency department. The EMS providers need to use a similar system, so that a regional picture of unscheduled care patient presentations can be developed. This combined data would feed...
- A syndrome surveillance system, with uniform immediate data feed to...
- A regional coordination center, with experts watching incoming data and detecting patterns of injury or illness, which may require immediate management, public safety or public health activation. The utility's industry should provide the models for regional surveillance, coordination, and major incident management.

- The victim reception area should facilitate the containment of any contamination problem, whatever the agent. No further spread into the hospital should take place from any hazard incident.
- The victim reception area should facilitate the work of law enforcement personnel, in the event of a major incident
- The victim reception area should have immediate contact with the regional coordination center, the regional fire and EMS agencies, and all media outlets. This contact system will allow victim care personnel to be up to date with information coming from outside the hospital.
- The Federal government has downgraded its military health system. The civilian ED Major Incident Centers must be capable of caring for military victims, and also must serve as the training sites for those providers who will provide care in the military emergency system.
- The Federal government must prepare for the potential of very large events occurring either in this country or abroad. This includes the scenarios of a California earthquake, a dangerous military action overseas, or a nuclear device explosion.
- The Federal government will prepare to take a large emergency response force out of the country, to support operations there. This must not compromise the ability to care for major incidents occurring simultaneously inside the country.

## A winning formula to accomplishing Federal, and community objectives

The Federal government convenes an expert body to design the components of an American Emergency Department of the future. The critical design components are:

- facility design friendly to communities and patients
- information systems linked with a regional healthcare coordination center
- major incident preparedness elements
- safe management of patients contaminated (or exposed to hazardous substances)
- links to the community's out-of-hospital emergency system

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## The Emergency Department Major Incident Center

### A Model for Community Investment in Regional Emergency System Preparedness

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The Federal government prepares a blueprint for the "ED Major Incident Center". This center "wraps around" the hospital's existing emergency department, and provides a consistent approach to greeting incoming emergency patients, for routine patients and in the event of a major incident. The system for greeting patients is designed to safely manage incoming EMS or ambulatory patients, facilitate the systems, which must survey for syndromes related to natural outbreaks of disease or heralding terrorist or criminal activity. The Center would house the supplies needed for multiple casualty incidents throughout the community, including the new wave of detection systems needed to identify hazardous chemical, biological and radioactive agents.

The Federal government provides seed funding, and then establishes a variety of incentives to encourage investment in the Center by progressively more vested parties to an expert local emergency system.

State governments provide capital funding, with a potential payback from the Federal government in the form of increased Medicaid funding.

Local governments provide additional funding, and more importantly, the regulatory and utility support needed to expand and enhance the local ED. This is a critical need, since a sizable number of hospitals and EDs are landlocked and surrounded by roads, utilities, and other geographic barriers.

Local governments also oversee the partners in Emergency Medical care and major incident response. These are local fire department, EMS, and law enforcement agencies. Those communities that provide support for the ED project and facilitate joint preparedness programs should be eligible for enhanced funding for other local projects.

The local government contribution then should package together support for necessary roadway changes, zoning approvals, movement (and upgrading the durability) of public utilities that surround and feed the hospital, and cooperation with local public safety agencies in performing necessary community emergency medical preparedness planning.

Hospitals provide the space and customized design to incorporate the Major Incident Preparedness Center. The

Hospital will then be capable of expanding the area of the existing ED to accommodate more patient care area and more areas to buffer tight inpatient resources.

National businesses, foundations, and service organizations should contribute to, and be recognized for, the development of a uniform approach to community emergency medical preparedness. The elements needed to organize a system exist in other industries, and those industries should be incentivized to contribute expertise that will be disseminated nationwide. There is a need to develop a methodology to recognize those community organizations and corporations that contribute to this new model of community preparedness.

This new model of emergency care for the community needs a friendly and effective technology base. Information technology has been slow to develop in the American health care system, for many reasons. This effort to integrate information solutions to solve a major community preparedness need should be encouraged. The Federal government is the only entity with the resources and jurisdiction to facilitate this action. Given the new constraints (and implementation costs) of HIPPA, a Federal government approved system of registering, collecting, appropriate surveillance information, and then reporting that information may be necessary.

### Designing the Emergency Department Major Incident Center

The key elements will facilitate the day-to-day and the Major Incident Preparedness functions in the community. This design begins in the approach to the Emergency Department.

### Outside the Walls of the ED Major Incident Center

- The design of the ED should facilitate incoming EMS traffic
- The ED should be recognizable immediately as a community emergency center. As such, the building design should support a red neon stripe around the top of the structure, with a

large visible "E". This or another design should become the designating symbol of an ED Major Incident Center.

- There should be a storage center outfitted for major incident supplies and equipment, available for the hospital, the EMS, fire, and police agencies. This would become the community storehouse for crisis supplies.
- There should be a large electronic message board on an outside wall, configured so that messages could be given to incoming EMS units, ambulatory victims, emergency workers, or the general public. The board would be used in major incidents to give timely instructions to victims and rescuers.
- Major incidents are always going to require that initial victim care take place outside the ED. If there are incidents involving contamination, that is where all incoming victims will be cleaned. The entrance area needs to be configured to incorporate portico shelters, victim triage areas, ambulance unloading, and washdown areas. As such, it should have lighting, a sound system, drainage, warm fresh water outlets, phone cell repeaters, and a supply center to support this mission.
- The entire entrance area to the ED Major Incident Center needs to be equipped for videomonitoring. This will facilitate monitoring of the area on an everyday basis by the hospital. But in a major incident, the area can be monitored by whatever Federal agency will be responsible for regional system management. The everyday entrance to the ED will need the same videomonitoring capability.

### Inside the Walls of the ED Major Incident Center

- Capable of managing victims who arrive by EMS vehicle, or by ambulatory means
- Capable of videomonitoring inside the facility, and by regional or Federal authority
- A separate air handling system from the remainder of the ED, and the hospital. Any damage can then be isolated to this area.
- The entrance area should be capable of "sniffing", for any hazardous substances that detectors become available for. Victims can be processed through those detectors, to check for any hazards that have detection capability. We expect there will be a grow-



ing number of these, for chemicals, radiation, biological agents, explosives, and other weapons.

- Decontamination areas inside the building, to continue the cleaning process that is initiated outside, but needs to be continued where care can simultaneously occur.
- A uniform greeting, triage, and patient tracking system. This would be fed live to the regional or Federal Coordination Center, which includes the syndrome surveillance monitors. This system would have to be based in a Federal mandate, to assure consistent and immediate data feeds.
- A robust communications system, to coordinate the ED with regional sources of information, and the EMS providers.
- Counseling and coordination areas, for families, law enforcement officials, public health authorities, and social support agencies. This area needs to be capable of providing a broad range of support functions, regardless of the type of incident.

The ED Major Incident Center will be the new heart of a community preparedness plan. It will simultaneously serve as a community based health management center, fully integrated with the overall health system and the community's emergency response system.

This concept should be developed by experts in the ED and EMS systems, and then presented to Federal authorities who are seeking global approaches to community emergency preparation.

### Integration with Federal and Military Major Incident Plans

The concept presented here relies on retrofitting the current emergency care system to meet a new and present danger. Who else will contribute services in Major Casualty scenarios? The military. They have some permanent structures, hospitals, for the day-to-day operations of their healthcare system. But for disasters, they have mobile, temporary structures, with central command and control. An infectious disease carried into the hospitals puts the entire rest of the population at risk of spreading whatever misery will be delivered in a mass casualty or terrorist incident. It would be beneficial to do modeling and test various scenarios (ex. small pox, nuclear, etc.) with military care models.

This new ED Major Incident Center should be prepared to work with military units in hospital parking lots, sport/convention arenas, and National Guard armories for major events. These mobile care facilities will work to keep disaster victims OUT of the main hospitals. With these plans, some patients who have been triaged, decontaminated, and initially stabilized (including field surgery) would be sent to hospitals for specialized care (perhaps ICU or specialized procedures). This is particularly critical for large numbers of patients with contagious diseases, who might create a community crisis by contaminating existing hospitals. Patients of terrorist activities that involve contagious diseases will need to be managed outside the hospitals, and the areas

adjacent to the ED need to be established as triage points.

### Summary

It is time to ask the Federal government to embrace and lead a program that will deliver Twenty First Century health care in America. It is the opportunity for hospital and emergency services leaders to provide a pathway for our leaders to make this critical investment, and then for the providers to deliver to their communities an effective and

friendly system of care. We need to coordinate and support this recommendation to our Federal government leaders, then have the wisdom to provide clear guidance in its implementation. We have the opportunity to "Think Big, to Deliver Local". I look forward to working with you on this effort. ★

## Have you considered the Base Station Course

The Base Station Physicians' Course is designed to be of use to all physicians who provide on-line medical direction to prehospital providers. It is a modular course that can be used in its entirety as the basis for a formal base station course, or on a section-by-section basis to augment other educational programs and learning.

The sections include:

- History of EMS
- Prehospital Providers (including levels of certification, training and skills)
- Communications
- Base Station Physician Interaction with EMT-B's (in keeping with the revised DOT EMT-B curriculum)
- Medical-Legal (aspects of medical direction and base station operations).

The course is available on CD-ROM. Contact the Executive Office at (913) 492-5858, ext. 448 if you have any questions on the Course.



### Mark Your Calendar

## 2004 Annual Meeting

January 8 – 10, 2004  
Hilton El Conquistador  
Tucson, Arizona

## 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.

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**ABSTRACTS MUST BE SUBMITTED ELECTRONICALLY.** To do so, visit NAEMSP's website at [www.naemsp.org](http://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](mailto: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.

National Association of EMS Physicians • 2004 Annual Meeting  
January 8 - 10, 2004 • Hilton El Conquistador Resort, Tucson, Arizona

## 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.

**ABSTRACTS MUST BE SUBMITTED ELECTRONICALLY.** To do so, visit NAEMSP's website at [www.naemsp.org](http://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](mailto:info-naemsp@goAMP.com).

### ELECTRONIC SUBMISSION RULES

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  - 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 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](http://www.mhf.net/opensource), or contact Mic Gunderson at [mic.gunderson@healthanalytics.net](mailto:mic.gunderson@healthanalytics.net).

## Commemorating EMS Week

We at the Executive Office, commend you — *all of you*, our members, for the life-saving work that you do in EMS, not just during EMS Week, but every day of the year. We welcome and encourage you to submit any photographs you have of your local EMS Week activities for publication in the July/August issue of *NAEMSP News*. Please send in your submissions with a brief description for the photo caption.

## Call for Nominations

Richard C. Hunt, MD, FACEP

Two Physician Member-at-Large positions will be vacant for the NAEMSP Board of Directors as of January 10, 2004. *Nominations are being solicited now for individuals interested in running for these positions.* The NAEMSP Nominations Committee will hold a conference call to name the nominees in July. If you are interested in running for one of these positions, would like to nominate someone, or need more information, please contact me at [huntr@upstate.edu](mailto:huntr@upstate.edu).

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## 2003 Membership Drive

NAEMSP is once again having a membership drive for 2003. Each time a current member recommends NAEMSP to a colleague who then becomes a member, the current member will have their name placed in a drawing to be held during the January 2004 Annual Meeting. For example, if you refer three new members, your name will be entered in the drawing three times. The winner will receive his/her choice of either complimentary membership for one year (up to \$250 value) or complimentary registration to the annual meeting (up to a \$455 value). Just be sure the individual you refer includes your name on his/her membership application so we can enter your name in the contest. Help your professional organization to grow by encouraging others to join while you benefit at the same time!

# News From the Executive Office

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

## Introducing Jerrie Lynn Johnston

Jerrie Lynn Johnston is NAEMSP's new association manager replacing Jennifer Kimzey. Jerrie Lynn relocated from Louisville, Kentucky recently after spending two years as Membership Director for the Professional Clubmakers' Society (PCS). Prior to her work with PCS, Jerrie Lynn was associated with the Golf Course Superintendents Association (GCSAA) located in Lawrence, Kansas for over 10 years. We welcome Jerrie Lynn to NAEMSP!

## Member Listserv and the NAEMSP Website

Have you been to our website [www.naemsp.org](http://www.naemsp.org)? We are grateful to Dr. Greg Mears for developing the members' only listserv. We hope that you have personalized your settings and are valuing the communication you are receiving. Please give us your feedback at [info@naemsp.org](mailto:info@naemsp.org). If you haven't visited the website lately, do you know what you are missing? Come visit and find out what updates have been made and what resources are available!

## 2004 Annual Meeting

We're looking forward to the 2004 Annual Meeting and working with Dr. Debra Perina and Dr. Ted Delbridge on the program coming up on January 8 – 10, 2004. This year's event held at the Hilton El Conquistador in Tucson, Arizona should not be missed. Here at NAEMSP Headquarters, we are improving the abstract submission, reviewing and rating process through use of new software/vendor. Look for the new system on the website soon.

## Board of Directors Activities

To further communication with related organizations, NAEMSP's officers are meeting with the American College of Emergency Physicians (ACEP) officers in May at The Leadership and Legislative Issues Conference.

The Mid-Year Board of Directors meeting is being held June 1<sup>st</sup> in conjunction with the Society for Academic Emergency Medicine's (SAEM) annual meeting in Boston.

## NAEMSP Welcomes New Members



James Apesos, MD, FACS

Gregory Bell, MD, FACEP

Boris Bergus, MD

James Bovienzo, DO, FACEP

Cynthia Cibiras, FNP

Robert Cibiras, PA-C

Joe Couey, ARNP, EMT-P

Mark Davis, MD, EMT-P

A. Kyle Donne, EMT-P

Janice Elliott

William Etling, NREMT-P

R. Scott Jacobs, MD

John Jardine, MD

Sandy Kinkade, RN, MSN

Ryan Kramer, MD

Ken Lavelle, BS, MICP

Ian Leber, MD

Thomas Long, BS, RN, EMT-P

Michael Magoon, MD

Edward Morrison, DO, FACOEP

Michael Rogan, MD, FAAEM

Joseph Salomone, III, MD

Juliette Saussy, MD

Christopher Schmidt, MD

Mark Schultz, DO, FACEP

Charles Sheppard, MD, FACEP

## 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](mailto: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 article and advertising submissions for July/August 2003 issue of NAEMSP News is May 30, 2003.

# EMS Calendar

**May 22-25, 2003:** Rallye Rejviz. Location: Zlate Hory, Czech Republic. Contact: [www.rallye-rejviz.cz](http://www.rallye-rejviz.cz).

**May 29 – June 1, 2003:** Society for Academic Emergency Medicine 2003 Annual Meeting. Location: Boston, MA. Contact: (517) 485-5484 or [www.saem.org](http://www.saem.org).

**June 2-6, 2003:** 2<sup>nd</sup> Annual Southern California EMS Conference. Location: Palm Springs, CA. Contact: [www.creativeeventsolutions.net/ems](http://www.creativeeventsolutions.net/ems).

**June 6-8, 2003:** EMS Facilitator Workshops on the National Guidelines for Educating EMS Instructors. Location: Washington, D.C. Contact: [www.naemse.org](http://www.naemse.org).

**June 11-14, 2003:** IAFF 7<sup>th</sup> Biennial "EMS in the Fire Service" Conference. Location: Hollywood, FL. Contact: (202) 824-1594.

**June 14-19, 2003:** American Medical Association Annual Meeting. Location: Chicago, IL. Contact: [www.ama-assn.org](http://www.ama-assn.org).

**July 10-13, 2003:** ClinCon 2003. Location: Orlando, FL. Contact: (800) 766-6335 or [www.femf.org](http://www.femf.org).

**June 23-24, 2003:** Networking Neurons: Making Connections. Location: Madison, WI. Contact: [jerickson@wccf.org](mailto:jerickson@wccf.org).

**June 23-27, 2003:** Tactical Paramedic-EMS Training Seminar: The University of Cincinnati Special Operations Institute and the Task Force One Tactical Medical Support Division announce a tactical medicine course for firefighters, paramedics and emergency medical service providers serving on law enforcement related Tactical Response Teams. For more information, visit the website [www.tiger4life.com](http://www.tiger4life.com).

**August 20-23, 2003:** FEMF Symposium by the Sea. Location: Ponte Vedra, FL. Contact: (800) 766-6335 or [www.femf.org](http://www.femf.org).

**August 21-24, 2003:** Pediatric Emergency Medicine Leadership Conference. Location: Albuquerque, NM. Contact: [www.pedialink.org](http://www.pedialink.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](mailto:Thomas.Stephen@mg.harvard.edu).

**September 9-14, 2003:** NAEMSE/CoAEMSP Annual Symposium & Trade Show. Location: Nashville, TN. Contact: [www.naemse.org](http://www.naemse.org).

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

**September 15-17, 2003:** Disease Specific "State of the Art" Emergency Medical Conference. Location: Atlantic City, NJ. Contact: (800) 628-0099.

**September 18-20, 2003:** ENA Scientific Assembly. Location: Philadelphia, PA. Contact: [www.ena.org](http://www.ena.org).

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

**October 2-4, 2003:** American Academy of Family Physicians Annual Meeting. Location: New Orleans, LA. Contact: [www.aafp.org](http://www.aafp.org).

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

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

**October 22-24, 2003:** NCED Congress of Champions. Location: Washington, D.C. Contact: [www.early-defib.org](http://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](http://www.btls.org).

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

**November 27-30, 2003:** 3<sup>rd</sup> Asian Conference on Emergency Medicine. Location: Hong Kong. Contact: [www.acem2003.com](http://www.acem2003.com).

**December 7-12, 2003:** The Institute for Emergency Medical Education Current Concepts in Emergency Care. Location: Maui, Hawaii. Contact: [www.ieme.com](http://www.ieme.com).

**January 8-10, 2004:** NAEMSP Annual Meeting. Location: Hilton El Conquistador, Tucson, AZ. Contact: [www.naemsp.org](http://www.naemsp.org) or [info-naemsp.org](mailto:info-naemsp.org).



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