EMSC news
EMERGENCY MEDICAL SERVICES FOR CHILDREN NEWSLETTER
VOLUME 14, NO.4, JULY/AUGUST 2001

HRSA Announces New Trauma/Emergency Medical Services Program

The 106th Congress appropriated $3 million to the Health Resources and Services Administration (HRSA) for fiscal year (FY) 2001 to "improve the nation's overall emergency medical system, including the joint efforts between HRSA and the National Highway Traffic Safety Administration (NHTSA) to assess state systems and recommend improvements to the current system." HRSA's Maternal and Child Health Bureau (MCHB) and Office of Rural Health Policy (ORHP) and NHTSA will co-administer this effort. The goal is to promote a comprehensive system for the delivery of high-quality trauma care services nationwide.

The principal activities to be conducted during FY 2001 include:

1. Conduct a State-by-State Trauma Systems Needs Survey;
2. Organize and staff a national stakeholders group on trauma/EMS systems;
3. Focus on the special needs of rural communities by fostering relationships with the State Offices of Rural Health and Offices of EMS, as well as by conducting a demonstration project on rural access to automatic external defibrillators;
4. Conduct a national public awareness initiative; and
5. Facilitate the creation of or enhance an existing comprehensive trauma/EMS data system.

Continue on page 3

INSIDE THIS ISSUE

EMSC Welcomes New Federal Staffer


Dan Kavanaugh

The Maternal and Child Health Bureau recently hired Dan Kavanaugh, MSW, LCSW-C, as a project officer for the Emergency Medical Services for Children (EMSC) Program. His primary responsibility will be to work closely with EMSC Program Director Cindy Doyle, RN, in providing the highest level of customer service and technical assistance to EMSC grantees. His hiring is a part of an overall effort to ensure that professionals in EMSC have the skills, knowledge, and resources necessary to provide quality care to those experiencing a crisis.

According to Kavanaugh, his main challenge in taking this position is applying the clinical knowledge that he's gained over the years to the larger public health system. "Coming as I did from the largest biomedical research facility in the world, one has to quickly learn how to negotiate many complex systems and how to help families negotiate these same systems," said Kavanaugh.

Kavanaugh began his health care career in 1991 at the University of Maryland Medical Systems providing clinical social work services to pediatric patients and their families. The following year, he entered the U.S. Public

Continue on page 2

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

ABC News Consultant John Nance to Keynote 2002 National Congress

The third National Congress on Childhood Emergencies, scheduled for April 15-17, 2002, in Dallas, TX, will feature internationally recognized air safety analyst and advocate John Nance as the keynote speaker for the Opening General Session. Nance is best known to North American television audiences as the aviation analyst for the ABC television network and as the aviation editor for *Good Morning America.*

Nance will provide an exciting presentation on the comparison between improving airline safety and patient safety. This presentation will be an excellent way to launch the conference theme Taking Action, Saving Lives.

Before joining ABC, Nance had delivered more than 3,000 newscasts on radio and television, including three years with ABC affiliate WFAA in Dallas. He has also appeared *on MacNeil-Lehrer News Hour, CBS Evening News, Nova, Oprah, Larry King Live*, and many other local and national shows.

In addition to his broadcast career, Nance is an author of 10 books and two editorials for *The Los Angeles Times* and *USA Today*. Six of his books are bestsellers, including *Final Approach, Scorpion Strike, Phoenix Rising, The Last Hostage, Pandora's Clock*, and *Medusa's Child*. The latter two both aired as major, successful two-part miniseries on television.

John Nance

Nance is a decorated Air Force pilot and a veteran of Vietnam and Operation Desert Shield/Desert Storm. He serves as a lieutenant colonel in the Air Force Active Reserve, and remains involved in flight safety education for the Air Force. Nance has extensive flight experience, having piloted many jet aircraft, including Boeing 727s, 737s, 747s, and Air Force C-141s. He has logged more than 13,000 hours of flight time in his commercial airline and Air Force careers.

Nance is one of several featured speakers scheduled to present at the 2002 Congress. Information about other speakers and conference programming will be featured in future

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EMSC News welcomes articles on people, programs, and procedures related to emergency medical services for children. All manuscripts, artwork, or photography should be submitted to Suzanne Sellman at the EMSC National Resource Center.

U.S. Department of Health and Human Services
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New Federal Staffer, *from page 1*

Health Service as a commissioned officer and subsequently worked at the National Institutes of Health's (NIH) Clinical Center in Bethesda, MD. During his tenure at NIH, his primary role was the provision of psychosocial services to patients and their families participating in clinical trials. In this position, Kavanaugh's emphasis included working with children diagnosed with rare genetic illnesses, most of whom had multiple, complex needs and frequent interaction with various health care systems. He helped to ensure that the health care needs of these children were being managed well in their local community.

Kavanaugh was instrumental in developing the NIH Clinical Center's Department of Social Work Education Forum, and received the NIH Clinical Center Director's Award for his work as a member of the Head and Neck Cancer Interdisciplinary Care Team. In addition, he has spoken locally and nationally on utilizing a strengths-based assessment approach in the area of psychosocial patient care.

Kavanaugh can be reached at (301) 443-1321 or dkavanaugh@hrsa.gov.

EMSC to Assist Organizers of 2002 Winter Olympics

Recently, Utah's Brian Garrett, director of the EMS and Fire Office for the 2002 Winter Olympics, approached the Emergency Medical Services for Children (EMSC) Program to request assistance in preparing the state's prehospital providers and volunteers to respond to potential medical emergencies involving children during the Winter Games.

"We will have thousands of children at the various venues. Some of them will be competitors and others observers," said Garrett. "Our medical staff and the hundreds of volunteer EMS personnel need to be adequately prepared to treat ill or injured children of all ages."

Utah EMSC Project Coordinator Breck Rushton and his co-workers have been extremely aggressive in educating the International Olympic Committee, the U.S. Olympic Committee, and the Utah Olympic Committee about the special training needed to prepare health care providers for pediatric medical emergencies. Utah's EMSC program has rallied the resources of the EMSC National Resource Center to help conquer this endeavor.

With the Center's help, Rushton and his staff carefully reviewed the EMSC Product Catalog to determine the best products to meet the specific parameters of the task. Approximately 20 different products were selected on topics ranging from assessment and airway management to trauma and disaster preparedness. Fifty copies of each product were shipped to the Utah Department of Health, the home to both the Utah EMSC program and the 2002 Utah Olympic EMS and Fire Office.

Utah's EMSC program will assist in disseminating the products and conducting training sessions throughout the state. "We are very excited to receive the additional resources," said Rushton. "We have such a short time frame to train these providers." The resources—most of which are designed as self-paced learning tools (i.e., CD-ROMs)—will enable Utah's EMSC program to reach those who are unable to attend the training sessions.

"Providers of all levels can use many of these resources on their own time as long as they have access to a computer," said Rushton.

New Trauma/Emergency Medical Services Program, *from page 1*

Trauma Systems Need Survey

Currently, work is underway to develop a 15- to 20-question needs survey tool for states to use to collect baseline data on trauma system development. Emergency Medical Services for Children (EMSC) grantees that are interested in utilizing this survey and realize the importance of integrating trauma services into the delivery of care nationwide are eligible to receive $35,000 - $40,000. The funding is designed to help EMSC grantees convene a meeting involving representatives from their state EMS agencies, Office of Rural Health, and trauma community for the purpose of collaborating on the implementation of the assessment survey.

Information collected from the survey will be used to help develop federal funding strategies to assist states in their efforts to enhance trauma care, to assure access to trauma services in rural and geographically-isolated areas, and to encourage system development and collaboration.

An official notice of funding is expected to be available in late July or early August. The grant guidance is now available from MCHB's web site at www.mchb.hrsa.gov. To facilitate the application award process, MCHB has received permission to supplement existing EMSC grants. It is anticipated that the Notice of Grants Awards will be available in late September 2001.

For questions regarding technical and program issues, eligibility, or assistance in preparing a request, contact MCHB's Rick Smith, MS, at (301) 443-5372 or rsmith@hrsa.gov; ORHP's Jennifer Riggle, JD, at (301) 443-7530; or NHTSA's Jeff Michael, EdD, at (202) 366-4299 or jmichael@nhtsa.dot.gov. For assistance with grant management aspects of your application, requirements and budgets, contact Ms. Mickey Reynolds at (301) 443-0724 or mreynolds@hrsa.gov.

Editors Note: *Within MCHB, the Injury/EMS Branch is responsible for the following programs: Traumatic Brain Injury, Injury/Violence Prevention, Poison Control Centers, Trauma Care Systems, and EMSC. This article is featured in this edition of EMSC News because of its timely nature and the issues of mutual concern to the EMSC program and our grantees.*

National PIE Campaign Moving Forward

The Emergency Medical Services for Children (EMSC) Program's National Public Information and Education (PIE) Campaign has taken another step toward reaching its national goal of educating the general population—especially parents—about the importance of being prepared for a pediatric emergency.

Last Fall, EMSC, in cooperation with a range of government, national, and professional organizations, launched its three-year campaign with the release of the Pediatric Emergency Care Resource Kit for emergency medical services (EMS) professionals. The comprehensive kit was designed to give professionals the tools they need to provide state-of-the art pediatric emergency care. It was also designed to help evaluate and bring organizations, communities, and states into compliance with accepted standards for pediatric emergency care. The kit, produced in CD-ROM format, contains more than 2,000 pages of critical information on pediatric injury and illness prevention, treatment, and rehabilitation.

Following the kit's successful release, EMSC began to implement phase two of the campaign: gauging public awareness of and preparedness for effectively handling pediatric emergencies. This phase will focus on reaching out to parents, caregivers, and children. It will emphasize prevention methods and preparation for pediatric emergencies, such as identifying illness warning signs, choosing the most appropriate hospitals for pediatric emergencies, and implementing guidelines for treating ill or injured children.

To this end, a series of 12 one-hour focus groups were conducted to assess the levels of awareness and preparedness among parents regarding pediatric emergencies. The focus groups—eight in general markets and four in Hispanic markets—were conducted in six U.S. cities: New York City, NY; Chicago, IL; Jackson, MS; Seattle, WA; Minneapolis, MN; and Tampa, FL.

The general market participants included a mix of ethnicities reflective of the general population, and the Hispanic market included a mix of countries of origin. Each group had approximately six to eight participants of both sexes and varying ages and income levels, with at least a high school degree or general equivalency degree (GED), one child under age 16 at home, as well as a set of other key demographic parameters.

The participants tested a range of messages and concepts to determine which would resonate. Would messages laced with guilt be more effective than ones with a positive spin? Would participants be most responsive to messages related to parenting skills? Should the messages be quick, concise, and proactive? Would radio or television be more or less effective in certain communities? Which would be more successful, print or broadcast advertising?

Although all messages seemed to motivate interviewees to create a preparedness plan for emergencies related to their children, most participants leaned toward those that use a positive approach and provide more specific references to the concept of "preparedness."

There were mixed feelings about statements that hinged on guilt as a motivating factor. Whereas some admitted that guilt does provoke parents to act, many felt that a positive message would do a better job. Focus group results also indicated that many people thought they were prepared for an emergency but in reality were not. Questions such as "Do you know your child's blood type?" and "Do you know which hospital(s) in your community is most capable of treating children?" served to open participants' eyes to the components of a detailed plan.

The EMSC Program is currently reviewing the preliminary results of the focus groups. The next step is to turn this research into a range of communication strategies, tactics, and tools that will be most effective in educating a national audience about this very critical issue.

Information on the next step in this effort will be forthcoming.

Study Finds Children Admitted to Hospitals Lacking Pediatric Expertise

A study published in the June 2001 issue of *Pediatric Emergency Care* found that the majority of hospitals that usually admit pediatric patients do not have separate pediatric facilities. According to Jean Athey, PhD, lead author of "Ability of Hospitals to Care for Pediatric Emergency Patients," nearly 10% of hospitals without pediatric intensive care facilities admit critically injured children to their own facilities. Likewise, 7% of hospitals routinely admit pediatric patients known to require intensive care to their adult intensive care units rather than transferring these patients to a facility with pediatric intensive care services.

The Emergency Medical Services for Children Program funded the study—using the Consumer Product Safety Commission's National Electronic Injury Surveillance System (commonly referred to as NEISS)—to help evaluate hospital preparedness on a national basis.

Other findings include:

- Less than half (47%) of hospitals without pediatric intensive care units have written transfer agreements with facilities containing pediatric intensive care units.
- Approximately 76% of U.S. hospitals care for pediatric emergencies in the adult/pediatric combined emergency department (ED), 18% in the adult ED, and 7% in a separate pediatric ED.
- Only 23% of U.S. hospitals reported that they had a pediatric emergency physician in-house or on call 24 hours a day. However, pediatricians were available in 64% of EDs.
- Equipment for infants and children was more likely to be missing than adult-sized equipment; for example, 43% of hospitals indicated that they did not have cervical collars for infants, whereas only 5% did not have adult-sized cervical collars.

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Have You Moved?

The editors of *EMSC News* want to make sure you don't miss a single issue. If you have recently moved or the contact person for your organization has changed, please let us know by completing the below *EMSC News* Subscription Update Request and mailing it to: Leslie Green, Communications Assistant, EMSC National Resource Center, 111 Michigan Avenue, NW, Washington, DC 20010.

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Delaware Develops Innovative Program to Enhance Paramedics' Pediatric Skills

Last year, Delaware paramedics responded to approximately 30,000 advanced life support calls. Of those, only 3,000 were pediatric related. According to State Paramedic Administrator Steven Blessing, prehospital providers throughout the state, especially those serving rural areas, do not see enough children to feel comfortable in treating them. "It may be months between pediatric contacts," said Blessing.

To improve comfort levels in assessing ill and injured children, Delaware paramedics will be breaking ground in a new clinical setting. Starting this September, paramedics will rotate through local pediatrician offices to get "hands-on" pediatric experiences for recertification. This innovative initiative, known as the Pediatric Clinical Assessment with Pediatricians (PCAP) program, guarantees that prehospital providers will have direct clinical contact with children. Historically, emergency departments (EDs) served as the pediatric training ground for paramedics. In Delaware, however, pediatric interactions during clinical time in the ED are a hit-or-miss prospect.

To ensure success of the program, Delaware's Division of Public Health is working in collaboration with the Alfred I. duPont Hospital for Children. The hospital has a network of 10 pediatric primary care practices in medically underserved areas throughout the state. Delaware's Emergency Medical Services for Children (EMSC) program is working with these practices to implement its Office Preparedness program, a performance improvement project that includes mock codes, policies for standardizing emergency equipment and medications, and model emergency care protocols.

"The plan is for the paramedics to spend four hours with a pediatrician or nurse practitioner, completing actual histories and physical assessments, and honing their communication skills with a variety of age groups," said Delaware EMSC Project Coordinator Marie Renzi, RN. "With the high volume of children in the pediatric office, prehospital providers can be assured they will have direct contact with at least four or five children during this time period."

The program, which will begin on a voluntary basis, will help paramedics meet their required biannual 72-hour continuing education requirement. Parents who agree to participate in the program will be required to sign a consent form. Paramedics will not be allowed to perform any invasive procedures in the physician's office.

For more information about PCAP, contact Renzi at (302) 739-6637 or mrenzi@state.de.us.

MCHB to Award Pediatric Patient Safety Grants

In May, the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) announced it would be awarding two Enhancing Pediatric Patient Safety (EPPS) demonstration grants to support the assessment and/or implementation of an existing strategy or tool with the potential to improve patient safety in pediatric emergency care delivery in multiple prehospital and hospital emergency department settings. A total of $500,000 has been set aside to fund the two projects for up to a three-year project period.

The issue of patient safety has generated much concern since the publication of the Institute of Medicine's (IOM) report *To Err Is Human* in November 1999, and subsequent articles in medical journals and the mass news media. The IOM report highlighted one critical aspect of health care quality—the ability of the system to render care to the patient without causing injury in the process. The report synthesized the available evidence on patient safety and noted that medical errors are a leading cause of death and injury.

Currently, there are few well-tested strategies for improving patient safety for children receiving emergency care. One tool MCHB is interested in testing is the pediatric color-coded system, which allows access to accurate precalculated medication doses and equipment sizes and emergency treatments for critically ill and injured children.

More information about the EPPS grants, which will be awarded on September 26, will be featured in a future issue of *EMSC News*.

Plan to Celebrate International Walk to School Day

It began as an idea. It's become a movement. On October 2, 2001, the world celebrates International Walk to School Day. It's a chance to teach kids and their parents to think of walking as both a form of exercise and a safe means of transportation.

The Evolution

In 1997, the Partnership for a Walkable America sponsored the first National Walk Our Children to School Day in Chicago, IL. Back then, it was simply a day to bring community leaders and children together to make a community more walkable. Last year, 2 million children, parents, teachers, and community leaders in cities and towns around the world had celebrated the first International Walk to School Day.

The Issue

The reasons for walking have grown just as quickly as the event itself. Thanks to lifestyles that favor convenience over activity, children have become increasingly sedentary. This holds particularly true in the U.S. where one child in four is obese. Exercise habits formed in childhood are likely to carry over into adulthood, so children should begin forming healthy habits now.

Children are also some of the most vulnerable users of our streets. For example, in the U.S. children less than 15 years of age represent only 15% of the population but make up 30% of pedestrian injuries. Instilling good safety skills, such as looking both ways before crossing the street, obeying street signs, and walking on sidewalks, teaches children not only to become better pedestrians, but also to become pedestrian-considerate motorists when the time comes.

Getting Started

If you are interested in sponsoring a Walk to School Day event in your community, begin planning now. First, choose your school(s) and get your event partners lined up. Recruit the participation of key community leaders, sports figures, or other spokespersons. Second, register your event on the Walk to School web site (www.walktoschool.org) to obtain regular e-mail updates. While at the site, take the time to download the free resources available to help make your event a success. Last, and most important, spread the word. Let everyone in your community know about the event and the importance of their participation.

Whether your concern is healthier habits, safer and improved streets and sidewalks, or cleaner air, Walk to School Day events are aimed at bringing forth permanent change to encourage a more walkable America—one community at a time. For more information, contact Laurie Flaherty at the National Highway Traffic Safety Administration's Office of Communications and Outreach at (202) 366-2705 or lflaherty@nhtsa.dot.gov.

. . . Public Policy Network . . .

Congress Approves Fiscal Year 2002 Budget Outline

The Senate and the House of Representatives have approved a budget resolution containing nearly $2 trillion in federal spending for fiscal year 2002 (FY02), which begins on October 1, 2001. The broad budget plan calls for a 4% increase in spending for FY02 and permits $1.35 trillion in tax cuts over the next 11 years. The budget outline adopted by both chambers closely resembles what President George W. Bush proposed in his budget on April 9, 2001.

The budget resolution, H.Con.Res. 83, does not require the President's signature and, therefore, lacks the force of law. Essentially, it is a non-binding planning tool that sets boundaries for tax and appropriations legislation this year. Congress may ignore its budget blueprint, however, and exceed limits on spending and taxes.

Sustaining Access to Vital Emergency Medical Services Act of 2001

On March 21, 2001, Senator Kent Conrad (D-ND) introduced the Sustaining Access to Vital Emergency Medical Services Act of 2001. The bill (S.587) seeks to uphold access to vital emergency medical services in rural areas. Additionally, S.587 would award grants that would improve EMS training and equipment assistance in rural areas and require the prudent layperson standard for emergency ambulance services under Medicare and Medicaid.

The bill, which has six co-sponsors, was referred to the Committee on Finance where it awaits further action.

If you have questions about these or other legislative matters, contact a member of the EMSC National Resource Center's public policy staff at (202) 884-4927.

Pediatric Expertise Helps Alesha Beat the Odds

Ten percent of all pregnancies result in premature birth. Unfortunately, four out of five women arrive at the hospital too late for treatment. The risk of death for infants at the gestational age of 23-24 weeks is 50%. And, for those who survive, there is still a chance that the infant will have a significant disability or handicap, including brain abnormalities, chronic respiratory problems, or blindness.

In 1998, with the help of Prince George's Hospital Center in Cheverly, MD, I overcame the odds when I gave birth 24 weeks into my pregnancy. I often wonder what the outcome would have been if the hospital staff had not been trained in advanced life support for infants. It was a great comfort to know that when our baby's birth suddenly became an emergency, high-quality care was available.

As I recall, the last minutes were like a freight train of pain ripping through my body as I lay in the hospital delivery room. The neonatologists on duty had just finished preparing me for the outcome of my baby's premature delivery. They said that my baby had only a 50/50 chance of survival because her lungs were not fully developed. I had experienced a previous miscarriage, and was petrified at the thought of losing another baby.

The doctors advised me against pain medication so that the baby would have a fighting chance. I was, however, given an injection of Betamethasone, a steroid medication to promote the development of her lungs. Moments later, I pushed and could hear the faint cries of my little angel. There was sigh of relief as my husband and I looked at each other and then at our daughter, whom we named Alesha Imani. The relief quickly turned to panic as a herd of nurses and doctors rushed into the delivery room. The doctors shouted out instructions, codes, numbers, and medical terms as they quickly administered oxygen to my helpless baby and whisked her away to the Neonatal Intensive Care Unit (NICU).

Later that day, our doctor explained that Alesha was doing well for an infant her size, which, at the time was only 1 pound 7 ounces. She was every bit of a miracle. The staff made sure that my husband and I understood that Alesha would have to stay on oxygen in the hospital for a least another three months. Her condition was stable, but could change from better to worse at any time, and it did.

During the ensuing, exhaustive weeks, my family and I would make daily trips to the hospital — sometimes twice each day. Faith, the support of family and friends, and the expertise of the hospital personal got me through those rough times, even when our daughter experienced a collapsed lung.

The staff was very accommodating, supportive, and empathetic to our situation. They always gave us the hard facts in a caring and supportive way— even an occasional hug.

With the exception of a few minor scars from lifesaving medical procedures, our daughter finally came home weighing a hefty four pounds. I carefully dressed her in a pink-flowered dress that her grandmother handmade. My husband and I thanked the NICU staff and bundled up our little angel to take home.

Today, Alesha's development is where it should be, both physically and mentally. We have the professionalism and caring at Prince George Hospital Center to thank for that!

—Leslie Green, *communication's assistant, EMSC National Resource Center*

Roving Reporter

Fernando Daniels, MD, medical chief of EMS for DC Fire addresses staff, parents, and emergency personal during an event celebrating the first National EMSC Day held at Children's National Medical Center in Washington, DC.

EMSC Systems Scoop

From the initial grant that established the Emergency Medical Services for Children (EMSC) Program to the present, one of the most difficult challenges facing all pediatric emergency care advocates is visioning for the future. Like the proverbial "snowball," we must continue to work diligently to be sure the snowball neither comes to rest at the bottom of the hill nor breaks up into smaller, less effective pieces. With the help of many talented individuals from throughout the nation the process continues at an impressive tempo.

Some of the highlights nationally include:

The Emergency Information Form (EIF).

Jointly developed by the American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP), the EIF is designed to furnish health care providers with needed medical information about a child who has a special health care need. Although the form has been available for several years, the overall implementation of the form has been less than either group anticipated. In an effort to increase its utilization nationally, the EMSC Program sponsored a meeting of vested organizations. From all accounts, the meeting brought forth significant discussion and produced a number potential recommendations. These recommendations will assist AAP, ACEP, and EMSC in their objectives regarding how to best serve medically fragile children.

The EMSC Research Network.

The EMSC Research Network is a $1.8 million initiative designed to create regional "hubs" or "nodes" that will work collaboratively to gather evidence-based pediatric research information from around the nation. Although many details continue to be defined, a formal announcement about the initiative is expected shortly.

Clinical Practices in Emergency Departments (EDs).

In June, experts in pediatric emergency care came together to begin the process of determining how to continue to improve the clinical practices in EDs caring for children. Using the foundational work from AAP's *Children in the Emergency Department: Guidelines for Preparedness*, efforts will be directed at moving pediatric and adolescent clinical practice guidelines in the ED to the next level. This effort will evolve into another funded initiative slated for release in early 2002.

National EMS Database Feasibility Study.

This new initiative is designed to assist with the collection and utilization of emergency medical services (EMS) data on a national scale. Currently, no such collaboration nor repository exists by which prehospital and ED information can be analyzed. The National EMSC Data Analysis Resource Center is working closely with the federal EMSC Program and the EMSC National Resource Center to develop this initiative and bring it to fruition.

Trauma/EMS Program.

The Maternal and Child Health Bureau's Injury and EMS Branch is working with the Office of Rural Health Policy and the National Highway Traffic Safety Administration to develop a new Trauma/EMS Program.

The principle activities to be conducted by the new program include:

- A State-by-state Trauma Systems Needs Survey;
- Organizing and staffing a national stakeholders group on trauma/EMS systems;
- Focus on the special needs of rural communities by fostering relationships with the State Offices of Rural Health and Offices of EMS as well as by conducting a demonstration project on rural access to automatic external defibrillators;
- Conducting a national public awareness initiative; and
- Facilitating the creation of or enhancing an existing comprehensive trauma/EMS data system.

For more information about these initiatives, read the corresponding article on page 1 or contact Rick Smith, MS, acting program director for EMS/Trauma, at (301) 443-5372 or rsmith@hrsa.gov.

State of the States • Grantee Update Corner •

Florida

Springtime is a busy time for the Florida Emergency Medical Services for Children (EMSC) program. On March 21, 2001, in commemoration of Florida's Emergency Medicine Day, EMSC project staff exhibited at the state capitol. On April 30 and May 1, staff members provided *Risk Watch* implementation training to six county *Risk Watch* coalitions. *Risk Watch* is a school-based injury prevention curriculum created by the National Fire Protection Association.

To help celebrate May 23, 2001, as the first National EMSC Day, a copy of the recently released Pediatric Emergency Care Resource Kit and the Broselow Pediatric Emergency Tape were sent along with a quiz to each Florida prehospital service.

For more information about these activities, contact Melissa Bassett at Melissa_Bassett@doh.state.fl.us.

Hawaii

Hawaii reports that its paramedics and emergency medical technicians (EMTs) commemorated EMS Week and EMS for Keiki (Children) Day in the true spirit of aloha. It began with the mayor's recognition of outstanding personnel and included a bicycle helmet giveaway event, a Keiki identification booth, informational displays, ambulance demonstrations, medical screenings, and a hands-on emergency vehicle exhibition.

Entertainment included Hawaii's unique cardiopulmonary resuscitation hula and performances by talented emergency medical service (EMS) musicians.

For more information, contact Lois Sugai at lasugai@mail.health.state.hi.us.

Mississippi

The Mississippi EMSC program is currently in its third year of implementation. Since funding became available, EMSC project staff have trained more than 800 health professionals using the Training in Pediatric Education for Prehospital Professionals (PEPP) course and approximately 1,500 health professionals using the Basic Trauma Life Support course. Both courses have been offered at no cost to participants.

On the injury prevention front, Mississippi is collaborating with the state's Department of Education and Trauma Care System in an effort to increase awareness of the *Risk Watch* curriculum and its availability to schools. More than 20 schools are now using *Risk Watch* at no cost. In addition, EMSC staff are collaborating with the Mississippi Poison Control Facility to collect pediatric-specific poison data that will be used to develop targeted poison prevention messages and activities.

For more information about these activities, contact Keith Parker at kparker@msdh.state.ms.us.

On March 21, 2001, in commemoration of Florida's Emergency Medicine Day, EMSC state project staff exhibited at the state capitol.

New York

On October 10-11, 2001, the Center for Pediatric Emergency Medicine's (CPEM) National Child Protection Education Project will hold a meeting in Washington, DC, to bring together the EMSC and child protection communities. Based on data analyzed from CPEM's national survey of EMTs and paramedics, participants will create an educational blueprint to train prehospital providers in the recognition, treatment, and reporting of child abuse and neglect.

In other news, the Paramedic TRIPP (Teaching Resource for Instructors in Prehospital Pediatrics) will be available this Fall. For further information, go to www.cpem.org.

Ohio

Ohio reports that it has conducted two PEPP courses and several PEPP instructor courses. The new instructors are charged with institutionalizing PEPP within their hospitals and providing regularly scheduled courses.

Ohio also reports that the revised Emergency Guidelines for Schools is now available through its web site. Through its EMSC partnership grant Ohio is providing 18 EMS agencies with funds to implement community-based injury prevention projects. In addition, project staff have recently completed regional injury prevention trainings for EMS providers in five locations throughout Ohio.

For more information on these projects, go to www.state.oh.us/odps/division/ems/ems_local/emsc/EMS-ForChildren.htm or contact Christy Beeghly at cbeeghly@dps.state.oh.us.

South Dakota

On April 19, 2001, the Heartland EMS for Children Coalition (HECC) held its Annual Meeting in Bismarck, ND. The meeting was hosted by the North Dakota EMSC and held in conjunction with the North Dakota EMT Conference.

Highlights of the meeting included state project reports from Nebraska, North Dakota, South Dakota, Minnesota, Iowa, and Kansas; program updates from the Maternal and Child Health Bureau and the EMSC National Resource Center; and informational presentations on collaborating with school nurses and family advocates.

For more information about this meeting or HECC, contact Dave Boer at (605) 333-6652 or boerd@siouxvalley.org.

Wisconsin

The Wisconsin EMSC program collaborated with the state's Bureau of EMS and Injury Prevention and Bureau of Transportation Safety on a statewide children's drawing contest to commemorate EMSC Day 2001.

EMS services, fire services, law enforcement agencies, nurses, physicians, parents, grandparents, and anyone involved in the care of children were encouraged to work with their local schools and child care centers to have children of various ages draw pictures related to emergency care, injury prevention, and transportation safety.

The drawings will be used to develop products to decorate the walls and tables at the Second Annual Wisconsin Childhood Emergencies Conference to be held at the Kalahari Resort and Conference Center from October 14 -15, 2001.

For more information about this activity, contact Mary Jean Erschen at (608) 266-7457 or erschmi@dhfs.state.wi.us.

Statistic of Importance

Estimated number of nonfatal injuries treated in hospital emergency departments, by age, U.S., 2000

Age Group (years)	Nonfatal Injuries (Percent of total population)
0–4	2,587,021 (8.4%)
5–9	2,411,708 (7.8%)
10–14	2,696,014 (8.8%)
15–19	3,327,434 (10.8%)
20–24	3,071,245 (10.0%)

STATISTIC OF IMPORTANCE

Question Corner

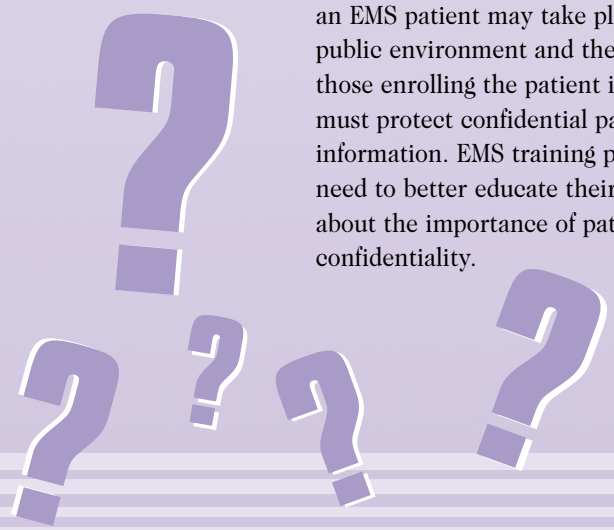
Q: I'm starting a new research project and would like information about general principles guiding the informed consent process. Can you help?

A: According to staff from the Emergency Medical Services for Children (EMSC) Program, informed consent is more than just signing a form. It is a process of information sharing, comprehension, and an individual's voluntary agreement to participate in a study. Research participants must be given sufficient information to make an informed choice.

"The manner and context in which the information is conveyed is as important as the information itself,"said Isabele Melese d'Hospital, PhD, research specialist for the EMSC Netional Resource Center. It is necessary to adapt the presentation of the information to the participant's capabilities, and the investigator is responsible for ascertaining if the participant has comprehended the information.

An agreement to participate in a research study is only valid if it is voluntary. The element of informed consent requires conditions that are free of coercion and undue influence. Potential participants also must not feel like their treatment will be compromised if they do not participate. For example, if a physician asks a patient if they would like to participate in a research they are doing and the patient declines, they should not feel as if their right to good and competent care is compromised in any way.

One particular concern about obtaining written informed consent in EMS is the nature of emergency situations that are not conducive to paperwork. The Code of Federal Regulations, CFR 21 Part 50, section 50.24, specifies the requirements for exception from informed consent for emergency research. The Federal Drug Administration recently released a draft document providing guidance for implementing the rules. In those circumstances in which waiver of the written consent requirement is not appropriate, other strategies for streamlining the consent process might be possible. The consent form does not necessarily need to be a multi-page document.



Some researchers have had success with a two-step process involving a structured verbal consent in the field followed by formal written consent once the patient arrives at the emergency department.

It is important to note that some patients, such as those in coma, in extremis, and in the pediatric age group, will never be able to give informed consent. Further, those patients who may be able to give informed consent may still be unduly influenced by the emergent nature of their condition. Researchers must work with their Institutional Review Boards and within the federal regulators to develop consent mechanisms that account for these issues and protect these patients while not unfairly excluding them from the research process and the potential benefits of those efforts.

Many areas of prehospital care in need of research involve patients who are competent and not in extremis. Obtaining consent from such patients should be comparable to obtaining consent from patients in any other clinical setting. One difference is that the process of obtaining consent from an EMS patient may take place in a public environment and therefore those enrolling the patient in research must protect confidential patient information. EMS training programs need to better educate their students about the importance of patient confidentiality.

TBI Center Provides Focal Information

A traumatic brain injury (TBI) occurs every 21 seconds. Even more surprising is the fact that brain injuries are more likely to occur than a heart attack or cancer and are the number one cause of death and disability among children and young adults. In fact, experts are now saying that everyone probably knows someone with at least a mild traumatic brain injury.

Recently, writers for *EMSC News* had the opportunity to sit down with specialists from the TBI Technical Assistance Center (TAC) to discuss the causes, consequences, and misconceptions of traumatic brain injuries.

What is a TBI and how does it differ from a brain attack?

A traumatically induced brain injury occurs when the head hits something, something hits the head, or something penetrates the brain. A brain attack is the preferred term for a stroke. Although there is no cure for TBI, there is treatment and rehabilitation.

A brain injury is not contagious, although victims are often ostracized. Brain injury is the only disability that can mimic or replicate any other disability. Because computed axial tomography (CAT) scans do not always reveal a brain injury, patients are often misdiagnosed and given the wrong treatment or none at all.

What are the leading causes of TBI?

Currently, the number one cause of TBI is motor vehicle crashes, although in some countries violence is becoming the leading cause. Other causes may include shaken baby syndrome, a gunshot, wounds, falls, sport activities, and surgical episodes. The results can be devastating.

What happens to a person who experiences a TBI?

A person may experience changes in behavior, emotions, communication, memory, mobility, energy, decision-making abilities, eating and sleeping patterns, performance of tasks, or relationships. TBIs have also resulted in death.

The TBI TAC is making great strides in raising awareness of TBI. This past Spring, the Center launched the TBI web site, which features resources, grantee information, and search functions. In addition, new fact sheets and a leadership guide are being created for local and national distribution. TAC is also working collaboratively with the Brain Injury Association of America (BIAA) to identify other ways to increase awareness and build strong partnerships with other related organizations.

For more information about TBI, contact a TAC specialist at (202) 884-6802 or visit www.tbitac.com.

TAC Specialists Donna Davidson and Sandra Knutson present information about TBI at a recent training program.

Latest Library Additions

- American Academy of Pediatrics; Committee on Pediatric Emergency Medicine; American College of Emergency Physicians; and Pediatric Committee. "Care of Children in the Emergency Department: Guidelines for Preparedness." *American Academy of Pediatrics*. 107, No. 4 (2001): 777-81.
- American College of Emergency Physicians. "The Role of Emergency Physicians in Emergency Medical Services for Children." *Annals of Emergency Medicine.* 37, No. 4 (2001): 428.
- Babl, Franz; Vinci, Robert; Bauchner, Howard; and Mottley, Lawrence. "Pediatric Pre-Hospital Advanced Life Support Care in an Urban Setting." *Pediatric Emergency Care.* 17, No. 1 (2001): 5-9.
- Bernardo, Lisa Marie; Gardner, Mary Jane; and Seibel, Karin. "Playground Injuries in Children: A Review and Pennsylvania Trauma Center Experience." *Journal of the Society of Pediatric Nurses.* 6, No. 1 (2001): 11-20.
- Cvijanovich, Natalie; Cook, Lawrence; Mann, Clay; and Dean, Michael. "A Population-Based Study of Crashes Involving 16- and 17-Year-Old Drivers: The Potential Benefit of Graduated Driver Licensing Restrictions." *Pediatrics.* 107, No. 4 (2001): 632-37.
- Dayie, Amofah; Aronson, S.; Jansen-McWilliams, L.; and Kelleher, K. "Use of a Statewide System to Improve Health and Safety in Child Care Facilities." *Ambulatory Pediatrics.* 1, No. 2 (2001): 73-78.
- Farmer, Janet and Muhlenbruck, Laura. "Telehealth for Children with Special Health Care Needs: Promoting Comprehensive Systems of Care." *Clinical Padiatrics.* 40, No. 2 (2001): 93-98.
- Junkins, Edward Jr.; Knight, Stacey; Olson, Lenora; Lightfoot, Amy; Keller, Patricia; and Corneli, Howard. "Analysis of School Injuries Resulting in Emergency Department or Hospital Admission." *Academic Emergency Medicine.* 8, No. 4 (2001): 343-48.
- Melnyk, Bernadette; Moldenhauer, Zendi; Veenema, Tener; Gullo, Sharon; McMurtrie, Madelyn; O'Leary, Elaine; Small, Leigh; and Tuttle, Jane. "The KySS (Keep Your Children/Yourself Safe and Secure) Campaign: A National Effort to Reduce Psychosocial Morbidities in Children and Adolescents." *Journal of Pediatric Health Care.* 15, No. 2 (2001): 31A-4A.
- Niermeyer, Susan; Van Reempts, Patrick; Kattwinkel, John; Wiswell, Thomas; Burchfield, David; Saugstad, Ola; Milner, Anthony; Knaebel, Stefanie; Perlman, Jeffrey; Azzopardi, Dennis; Gunn, Alistair; Boyle, Robert; Toce, Suzanne; and Solimano, Alfonso. "Resuscitation of Newborns." *Annals of Emergency Medicine.* 37, No. 4 (2001): s110-125.
- Quan, Linda; Bennett, Elizabeth; Cummings, Peter; Henderson, Peter; and Del Beccaro, Mark. "Do Parents Value Drowning Prevention Information at Discharge from the Emergency Department?" *Annals of Emergency Medicine.* 37, No. 4 (2001): 382-85.
- Rivara, Frederick; Thompson, Diane; and Thompson, Robert. "Bicycle Helmets: It's Time to Use Them: The Evidence That They Reduce Head Injuries Is Too Strong to Ignore." *BMJ.* 321, No. 7268 (2000): 1035-36.
- Smith, Elizabeth; Singh, Tasmeen; and Adirim, Terry. "A Prehospital Notification System Makes a Difference for Special Needs Children." *JEMS.* 26, No. 5 (2001): 48-55.
- Sobo, Elisa; Andriese, Steve; Stroup, Craig; Morgan, Dana; and Kurtin, Paul. "Developing Indicators for Emergency Medical Services (EMS) System Evaluation and Quality Improvement: A Statewide Demonstration and Planning Project." *Journal on Quality Improvement.* 27, No. 3 (2001): 138-54.
- Stein, Ruth; Johnson Silver, Ellen; and Bauman, Laurie. "Shortening the Questionnaire for Identifying Children with Chronic Conditions: What Is the Consequence?" *Pediatrics.* 107, No. 4 (2001): e1-5.
- Woodward, George and Fleegler, Eric. "Should Parents Accompany Pediatric Interfacility Ground Ambulance Transports? Results of a National Survey of Pediatric Transport Team Managers." *Pediatric Emergency Care.* 17, No. 1 (2001): 22-27.
- Zideman, David; Zaritsky, Arno; Carlo, Waldemar; Osmond, Martin; Gausche-Hill, Marianne; Hazinski, Mary; Rasmussen, Gail; and Nadkarni, Vinay. "Airways in Pediatric and Newborn Resuscitation." *Annals of Emergency Medicine.* 37, No. 4 (2001): s126-36.

If any interesting publication or product (written or produced within the last 18 months) has crossed your desk that you would like to share, please contact the EMSC National Resource Center Medical Librarian, Kathryn Willis, at (202) 884-6835 or kwillis@emscnrc.com.

Satcher Unveils Suicide Prevention Initiative

Surgeon General David Satcher recently unveiled a "National Strategy on Suicide Prevention" that is aimed at reducing both the number of suicides and the stigma of mental illness.

Speaking at the University of Pittsburgh's graduation, Satcher said that mental illnesses, including depression, cause 80% to 90% of the 30,000 suicides that occur each year in the U.S., adding that "social stigma" contributes to suicide by "keeping people from seeking treatment."

Satcher added that the new initiative, "18 months in the making" would have a threefold focus: an attempt to make Americans more aware of the magnitude and nature of the problem of suicide, improve ways to diagnose and treat mental illness to prevent suicides, and increase the amount of research on suicide. "If we are able to recognize and diagnose depression early, we should be able to prevent many of the suicides that are taking place today," Satcher said. (Barnes, *Pittsburgh Post-Gazette*, 4/30).

News from NEDARC

One common barrier to establishing an effective data collection system is getting key personnel to buy into the importance of data collection. Some don't want to budget the time or the money for data collection; others don't understand the value of acquiring data. To establish a successful emergency medical services (EMS) data system, it is important for providers, agencies, and administrators to understand the many benefits of data collection.

Why Collect Data?

- It is the only reliable way to evaluate the responsiveness and effectiveness of EMS.
- It identifies service areas that need improvement or further evaluation.
- It allows for dissemination of accurate public information.
- It encourages the development of meaningful education and prevention programs.
- It promotes decision-making and resource allocation based on solid evidence rather than on isolated occurrences, assumption, emotion, and politics.
- So you can know what you don't know!

Data can be used to:

- Improve quality of emergency care and procedures;
- Stimulate new organizational ideas;
- Draw public and media attention to a community issue;
- Influence legislative policies and regulations;
- Provide justification for an existing program or illustrate a need for a new program;
- Help obtain grant funding;
- Promote initial and continuing education and research efforts;
- Allocate state or agency resources effectively; and
- Help those in the EMS community see the value of their work.

Data professionals at the National EMSC Data Analysis Resource Center (NEDARC) are available to help you improve your data collection systems and the quality of your Emergency Medical Services for Children programs. If you have questions, contact Michael Ely at (801) 585-9761; Michael.ely@hsc.utah.edu or visit NEDARC's new web site at www.nedarc.org.

Congratulations to Our EMSC Heroes Award Recipients

On June 4, 2001, at a special luncheon held during the Annual EMSC Grantee Meeting, the following individuals, organizations, and products were recognized with a National EMSC Heroes Award. Additional information about each recipient will be featured in the September/October issue of *EMSC News*.

EMSC Project Coordinator of Distinction Award

Katrina Altenhofen (Iowa)
Claudia Hines (Minnesota)

EMSC State Achievement Award

State of Maryland

Outstanding EMS Provider of the Year

Keith Harris, EMT-P
(North Carolina)

EMSC Parent Volunteer of the Year

E. Murney Rinholm (North Carolina)

EMSC Community Partnership of Excellence Award

Indiana District Kiwanis, Kids for Riley (Indiana)

Innovation in EMSC Product Development

Pediatric Emergencies for Prehospital Providers (American Academy of Pediatrics)

Important Dates to Remember

July
National March of Dimes
Mothers March
Summer Campaign
Contact: Lisa DíAgostino Leahy at
(914) 997-4451

July 18-20
National Association of
Hispanic Nurses
Annual Meeting
San Antonio, TX
Contact: Cary Jo Lederman at
(410) 749-3200

July 22
National Parent's Day
Parents' Day Council
Contact: Gary Jarmin at
(703) 548-4904

July 22-27
World Federation of Mental Health
World Assembly
Vancouver, CAN
Contact: (604) 681-5226

July 27
Burn Children Recovery Foundation
Summer Ice Event Gala
Indianapolis, IN
Contact: Shawn Tabor at
(317) 803-2876

August 3-5
American Medical Women's
Association
International Conference
Cleveland, OH
Contact: Julie Dogil at
(703) 838-0500

August 8-12
National Black Nurses Association
Annual Conference
Los Angeles, CA
Contact: Millicent Gorham at
(301) 589-3200

August 15-18
IRECC Conference
(Intermountain Regional EMS for
Children Coordinating
Council, Inc.)
Big Sky, MT
Contact: (406) 994-6683

August 24-28
American Psychological Association
San Francisco, CA
Contact: Jodi Ashcraft at
(202) 336-5565

September
Baby Safety Month
Contact: Juvenile Products
Manufactorers at
(856) 231-8500

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Washington, DC 20010

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Maternal and Child Health Bureau

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U.S. Department of Transportation
National Highway Traffic Safety Administration