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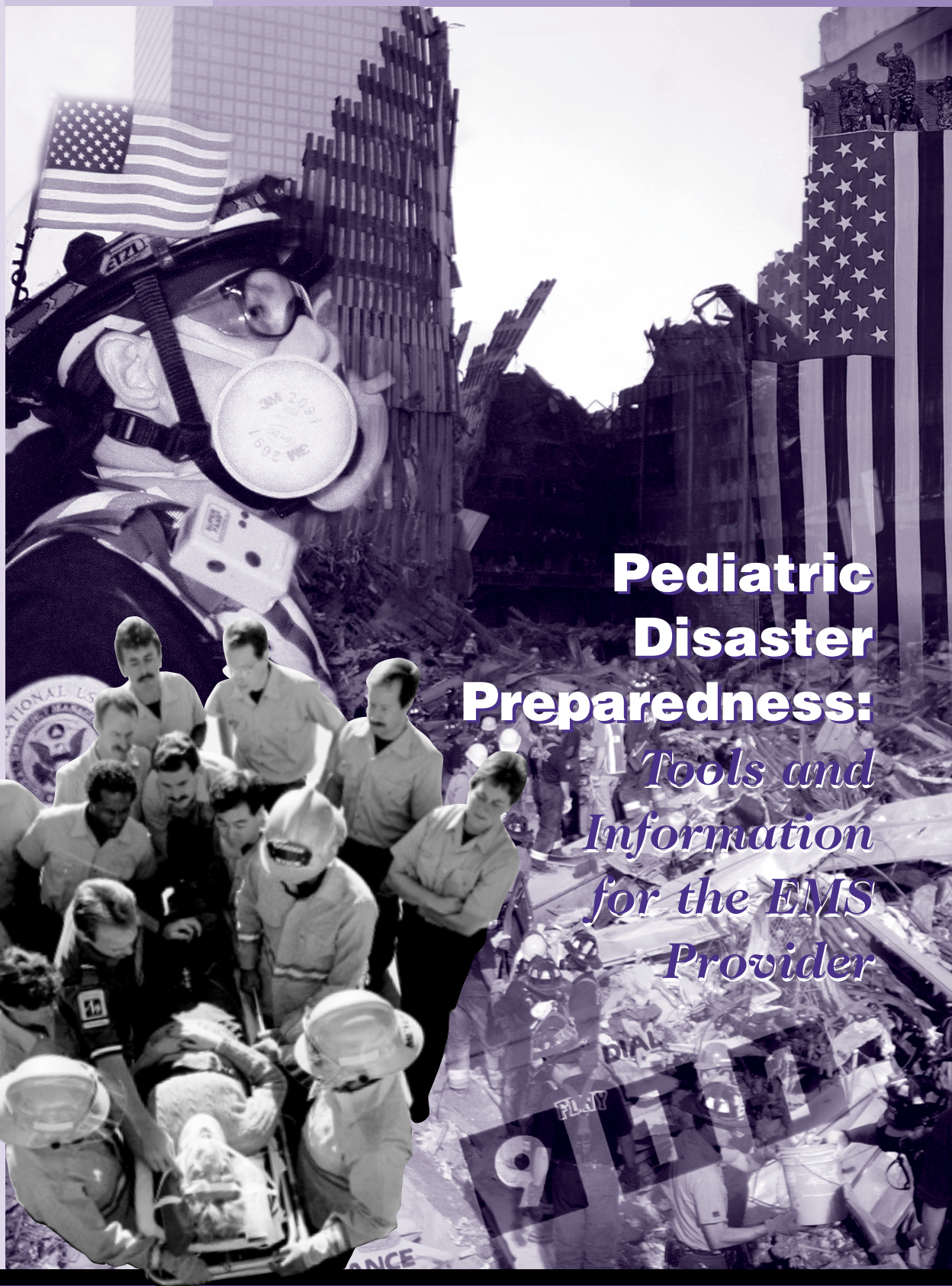
EMSC news

Emergency Medical Services for Children *Newsletter*



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EMSC news

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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.

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Preparing EMS for Acts of Violence/Terrorism Involving Children

by Richard Aghababian, MD

Acts of terrorism are horrible events aimed at innocent and unsuspecting victims that are intended to create fear, insecurity, panic, and chaos within a society. Some of these acts are identifiable immediately, bombings and hijackings for example. Others are more insidious, such as those involving biological, chemical, or radioactive agents.

Unfortunately, individuals who are inclined to plan terrorist activities are just as likely to include children as victims. It might even be argued that the most vicious terrorist groups could intentionally target children. It is therefore critical that emergency/disaster medical professionals play a pivotal role in detecting, planning, and managing the consequences of terrorism.

One such tool already available to the emergency response community is the Pediatric Disaster Life Support (PDLS) course, which was developed to enable physicians, nurses, and emergency medical technicians (EMTs) to better care for children victimized by disaster.

History of PDLS

The impetus for the PDLS course was a workshop sponsored by the Emergency Medical Services for Children (EMSC) Program in September 1995. The workshop focused on the problems of managing children during disasters. A set of recommendations developed by the attendees included the need for a course that would heighten awareness that children require different medical care and emotional support during and after experiencing a disaster.

For the inexperienced responder it was felt that children are difficult to accurately assess because they respond differently than do adults to the types of injuries and illness associated with catastrophic events. While the PDLS course focuses heavily on the impact of natural disasters on children, a portion of the course is devoted to school violence and intentional disasters. For example, the Columbine School shootings serve as a case study in one of the course workshops. Several of the lectures also addressed the injuries and the psychological impact that the bombing of the federal building in Oklahoma City had on the children who were in day care centers in and around the building. Like the Oklahoma City tragedy, the events of September 11 have once again heightened our awareness of the vulnerability of children to acts of terrorism.

Future Directions for PDLS

Future directions for the PDLS course and other training activities sponsored by EMSC must take into consideration the heightened risk of terrorist activity. The U.S. emergency/disaster response network must be better trained and supplied to handle pediatric needs, because an inadequate response to an event involving large numbers of children will produce the panic and chaos sought by the terrorist perpetrators.

Specifically, the PDLS course should be revised to include greater emphasis not only on the physical impact of terrorism on children but on the psychological impact as well. Many new lessons have been learned from the events of September 11, and old lessons revisited. As with the Oklahoma City bombing, many children in New York City and Washington, DC, lost a parent. The children had no opportunity to prepare for their loss, or the mammoth publicity surrounding these events during which many parents perished.

Disasters affect a child's psychological well being in a number of ways. I personally learned new lessons while assisting with the care of postal workers in New York City who had been exposed to anthrax spores. As we counseled the individuals who were at risk for exposure in the use of the antibiotics, I began asking if they truly intended to use the medication. Some parents said that they intended to give the antibiotic, which was Cipro in most cases, to their children to protect them from anthrax. Clearly antibiotics were not indicated for the children of the postal workers, nor was the use of Cipro well advised for their children. Some workers also feared hugging or touching their children when they returned from work for fear of transmitting the anthrax. Contact avoidance by a parent would clearly have a psychological impact on a child unable to understand the reasoning behind the parent's behavior.

Revisions for School Disaster Plans

Greater emphasis should also be placed on revising school disaster plans to make them more adaptable to any situation that involves mass illness or injury, including acts of violence or terrorism. For example, we must pay particular attention to the early identification and management of biological attacks, such as the use of salmonella, E. coli 0157:H7, or other hazardous agents that could be used to contaminate the school food supply. Release of a nerve gas in or near a school would put a sudden strain on the emergency medical system. Airway equipment, pediatric intensive care beds, and pediatric doses of the antidotes 2-PAM and atropine would be rapidly depleted at the local level.

School plans should include mutual aid arrangements, interfacing with fire, law enforcement, and public health agencies. Crisis response teams should also be available to manage the psychological needs of the victims and rescuers.

Clearly much work remains to be done in preparing our country to adequately respond to deliberate attacks by terrorists as well as all other potential disaster scenarios. Perhaps EMSC should plan another workshop to assess the adequacy of our preparedness to handle the needs of children in disaster now as compared with 1995. I would be happy to see the PDLS course revised to address the deficiencies in our knowledge or preparedness that would be identified through such a meeting.

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About the Author: Richard Aghababian, MD, is the chairman of the Department of Emergency Medicine for the University of Massachusetts Medical School (UMMS) in Worchester, MA. He also is the former president of the American College of Emergency Physicians. For information about Dr. Aghababian's two-day PDLS course, contact UMMS at (508)856-4101.

JumpSTART: A Disaster Preparedness Tool for the Times

by Lou Romig, MD

Disasters are on our minds more than ever these days. The events of the past year have made us very aware of our national, organizational, and personal vulnerabilities. Any tool that can help us deal with any aspect of natural, industrial, or intentional disasters is a hot commodity, not only in street-based emergency medical services (EMS) but also in all areas where EMS may have to be rendered.

One such tool is JumpSTART, a system modeled after the widely recognized START (Simple Triage and Rapid Treatment) program, which is designed to help rescuers quickly and accurately categorize pediatric patients into treatment groups. The program was developed to assist in maximizing outcomes for the greatest number of multicasualty incident patients by addressing the unique anatomy and physiology of children. By providing age-specific guidelines, JumpSTART also helps to counter the negative emotional aspects of pediatric triage decision-making.

Current Progress of JumpSTART

The JumpSTART program was progressing well and garnering significant support before September 2001; now it's hard to keep up with the requests for information. By year's end, JumpSTART will have been presented at six national conferences and at multiple regional and statewide conferences. At least three states have mandated or strongly recommended that their EMS constituents use JumpSTART, and interested agencies in five

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JumpSTART...(cont.)

other states have requested information about the program.

JumpSTART is also included in the curriculum for the Pediatric Disaster Life Support course and a soon-to-be-released National Association of School Nurses school emergency course. A year ago, it was made into a video by the Virginia EMSC program. In addition, it is our hope that JumpSTART will be distributed with the color-coded pediatric disaster medication guide currently being developed by Jim Broselow, Bob Luten, and others.

Future Challenges to JumpSTART

Like many new concepts it is only through validation that we can ensure a program's impact and usefulness at the local and national levels. An effort must be made to validate the techniques used in JumpSTART—a most difficult task in the triage arena where there is no "gold standard." We must also look at skills and knowledge acquisition and retention.

In addition, in the face of chemical and biological terrorism, can/should JumpSTART (and START) include agent-specific triage systems for incidents involving weapons of mass effect?

In conclusion, let us remember that disasters are equal-opportunity destroyers, with effects reaching far beyond any Ground Zero. To believe that our children will not be affected is simple ignorance and denial. Indeed, our children may be more vulnerable and more tempting as targets than any of us want to think. We no longer have any excuse to ignore children's issues in disasters, not on organizational levels and certainly not within our own families.

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About the Author: Lou Romig, MD, is the medical director for the South Florida Regional Disaster Medical Assistance Team. For more information about her JumpSTART program, contact Dr. Romig at louromig@bellsouth.net.

EMSC Sponsors IDMC Preconference on Pediatric Disasters

On January 31, 2002, the Maternal and Child Health Bureau's (MCHB) EMSC Program and the Florida Department of Health's EMSC project sponsored Pediatric Disasters, a preconference workshop to the 23rd Annual International Disaster Management Conference (IDMC), at the Rosen Plaza Hotel in Orlando, FL. More than 45 participants attended the conference to learn about the unique needs of children who are involved in natural or intentional disasters. An overview of each speaker's presentation is provided below.

Dan Kavanaugh, MSW, EMSC project officer for MCHB, and Phyllis Stenklyft, MD, principal investigator for the Florida EMSC project, opened the workshop and provided an overview of the Program's most recent EMSC disaster-related initiatives. These include the Pediatric Disaster Life Support course, "After the Emergency Is Over: Post-traumatic Stress Disorder in Children and Youth" fact sheet, the 1998 Consensus Statement on Children's Emergencies in Disasters, and the recently funded targeted issue grant, "Model Pediatric Component for State Disaster Plans."

Tom Lawrence, NREMT-P, EMSC project coordinator for Rhode Island and deputy team leader for the Rhode Island Disaster Medical Assistance Team (DMAT), provided a summary of the new Rhode Island Disaster Initiative, a well-funded state initiative to improve overall state disaster preparedness. As both the EMSC coordinator and deputy commander for DMAT, Lawrence is able to ensure that the needs of children are integrated into state disaster planning.

According to Lawrence, the following pediatric needs should be addressed in a state's disaster preparedness plan:

- Pediatric-sized equipment and medication doses;
- Pediatric-sized protective equipment for personnel;
- Child care for the children of disaster response workers;
- Plans for the decontamination of pediatric patients;
- Training for the triage of pediatric patients in mass-casualty events; and
- Disaster shelters for children with special health care needs.

The Rhode Island EMSC program is devoting approximately 25% of its effort to developing disaster preparedness plans for pediatric issues.

Following Lawrence's presentation, Lou Romig, MD, medical director for the South Florida Regional DMAT, presented on pediatric issues in terrorism. Dr. Romig informed workshop participants that children are often found in large groups, such as in child care centers, which are frequently located in or close to places of business. According to Dr. Romig, children are at an increased risk of injury in case of a terrorist attack because they may not understand what's happening and may be physically or developmentally unable to rescue or protect themselves. In addition, the extreme emotional responses of the public and rescuers to an attack involving children may affect the ability of rescuers to do their jobs. Dr. Romig also provided an overview of the JumpSTART Rapid Pediatric Training System. This triage tool is designed for use in multicasualty disasters that include large numbers of children. The tool is applicable to children aged 1 to 8 years.

During the next presentation, entitled "Addressing the Diverse Needs of Families During Disasters," Florida Institute for Family Involvement Executive Director Connie Wells provided valuable information on how the EMS community can effectively integrate

families into disaster planning. According to Wells, to help prepare families for a disaster EMS professionals must be able to:

- recognize and understand the factors that contribute to family diversity,
- learn how to strengthen a family's knowledge of and reaction to disasters, despite diversity; and
- identify necessary approaches to successfully engage diverse familes.

Her presentation segued nicely into a discussion of family-centered care by Tommy Loyacano, MPA, NREMT-P, chief of operations for the East Baton Rouge EMS Department. Loyacano took a lead role in helping the National Association of EMTs to develop recommendations for implementing family-centered care within the prehospital environment. For more information about these recommendations, read "NAEMT Develops Recommendations for Family-centered Prehospital Care," published in the January/February 2001 issue of *EMSC News* or visit www.ems-c.org.

The Pediatric Disasters Workshop also included a presentation on a unique EMS outreach program for children with special health care needs (CSHCN) based at Children's National Medical Center (CNMC). Betsy Smith, RN, NREMT-P, said the purpose of the CNMC program is to keep EMS providers informed about the unique medical needs of CSHCN. "Informed EMS providers are much more capable of responding to children with chronic illnesses or physical disabilities," said Smith.

The closing workshop speaker was Cheryl Gurley, LCMH, NCC, from the Devereux Mental Health Services for Children in Orlando, FL. Gurley discussed the impact disasters have on a child's mental health and the common signs and symptoms associated with development of mental health issues in children.

EMSC Comrades Help NYC Victims: Reflections on the 9/11 Disaster

Daniel Kavanaugh, MSW, LCSW-C
EMSC Program Project Officer, MCHB

On September 16, Lieutenant Commander Daniel Kavanaugh was deployed to New York City to provide mental health support to federal personnel responding to the World Trade Center (WTC) disaster.

Kavanaugh is a member of the Department of Health and Human Services' Commissioned Corps Readiness Force (CCRF), a cadre of United States Public Health Service (USPHS) officers who can be mobilized in times of disaster or other public health emergency.

Upon arrival in New York City (NYC), Kavanaugh was detailed to the USNS *Comfort* and worked alongside the Navy's Special Psychiatric Rapid Intervention Team (SPRINT). The mission of the USNS *Comfort* was to provide logistical support and services to emergency relief personnel.

Following are some of Kavanaugh's thoughts and reflections about his 15-day experience.

"Every day, hundreds of police officers, firefighters, and government workers came aboard the ship for meals, a place to sleep, and, most importantly, support. The 11-member SPRINT team showed great flexibility, changing from what they thought would be the initial focus of their mission—caring for the wounded from the WTC attack—to caring for the needs of the relief workers who were working at Ground Zero. The USNS *Comfort* became a place where the relief workers could get physical and emotional nourishment in the midst of their very difficult work.

"On day four a need was identified for mental health support at the Office of the Chief Medical Examiner, where approximately 150 members of the Disaster Mortuary Operational Response Team (DMORT) had been deployed to assist the city in its efforts to rapidly identify the victims of the disaster. DMORT is a federal-level response team consisting of medical examiners, forensic pathologists, mental health specialists, funeral directors, dental assistants, and DNA specialists.

"As one can imagine, the activity level at the Medical Examiner's office had increased dramatically as a result of the WTC disaster. DMORT personnel were divided into two groups, each covering a 12-hour shift. I covered the day shift (7:00 a.m.–7:00 p.m.) while a colleague, Lieutenant Beth Henson, covered the night shift (7:00 p.m. – 7:00 a.m.). With this arrangement, a mental health specialist was available around the clock for consultation or support.

"The provision of mental health services within this environment takes on a very different form than what is traditionally provided within an office or hospital. Those working in this environment are typically well-functioning people who may be struggling with the disruption and stress caused by the disaster. It is important not to pathologize their feelings, but rather to help them see that the stress they are experiencing is a normal reaction to a traumatic event. I saw my role as three-pronged: to provide a safe place for personnel to talk about the events; to "cruise the halls" to see if people were getting sufficient sleep, food, and break time; and to assist in problem solving any areas of concern. We were also available to provide debriefings for those who were returning home.

"This is the first time that I have worked on the victim identification side of a disaster. I was impressed by the DMORT's teamwork, camaraderie, and willingness to take on any tasks needed to assist the people of New York City. I learned that the task of victim identification is one that does not get a lot of press, but it is a critical need in a mass casualty event. Through identification of victims, families who have experienced a horrible loss can gain some sense of closure and lessen the uncertainty that they may have felt when they were living in the state of not knowing."

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EMSC Comrades...(cont.)

Betty Hastings, MSW
Traumatic Brain Injury Program Director, MCHB

On September 22, Lieutenant Betty Hastings was deployed by the Office of Emergency Preparedness (OEP) to provide mental health and emergency medical treatment at Ground Zero in New York City. Hastings is a member of the USPHS's Public Health Service-1 Disaster Medical Assistance Team (PHS-1 DMAT). Following her eight-day tour of duty, Hastings submitted a report to her superiors. The following excerpts are from that report.

"Being deployed to Ground Zero was the saddest and the greatest honor ever bestowed upon me. Words, photographs, and television cameras will never capture what it was like to have stood in the wreckage. The smell, endless billowing smoke, noise, and immeasurable human spirit I witnessed will stay with me forever.

"Some days I still can't believe this really happened. The magnitude of this event forbids me from being able to wrap my heart and mind around it, as I believe we are not built to process this type of devastation all at once.

"As I stood in the temporary West Street Morgue, waiting to give emergency workers a good-will basket of Vicks Vapor Rub and Hall's cough drops—which was to help with the smell and prevent nausea—word came from the 'pile' that the bodies of 15 firefighters had just been uncovered. The bodies were being brought up one-by-one. It was at that moment, when I saw the first stretcher with a body wrapped in the American flag being carried by five or so firefighters, that I realized I was standing in the presence of the spirit of America's bravest and most courageous public servants. To have served my country as a public health service officer, among such great heroes, is an honor that I will never forget.

"A month later, on October 22, I was deployed to DC General Hospital in Washington, DC, to help test individuals for anthrax. The testing consisted of swabbing both nostrils, recording contact information and potential location of exposure, and education. From the swabbing station, the participant was then sent to an onsite pharmacist to receive a 10-day supply of the appropriate antibiotic and/or to an onsite physician for further evaluation, if desired. This too was a remarkable experience that made me appreciate how so many people, who once seemed to have such different functions, could come together in a time of great difficulty."

N. Clay Mann, PhD, MS
National EMS Data Analysis Resource Center

On September 11, 2001, approximately 86 investigators associated with the Public Access Defibrillation (PAD) Trial gathered at the Brooklyn Marriott Hotel in New York City for a PAD Steering Committee Meeting. Clay Mann was one of those who attended the meeting. Below is a description of what he saw and did to help the victims of the World Trade Center.

"When the strike happened the meeting attendees were evacuated into the streets of Brooklyn. We all witnessed the burning and eventual collapse of the WTC Towers from the Brooklyn promenade.

"In terror and grief, the physicians, nurses, and other meeting participants sprang into action, demonstrating fearless control and true humanity as they attempted to respond to the enormity of the disaster. Within the hour, local fire personnel attending the conference commandeered a city bus and requested that conference attendees travel to Manhattan Island to set up an initial treatment center near Ground Zero through which patients could be triaged to local hospitals. As the bus began its journey toward Ground Zero, countless people pushed their way in the opposite direction trying to escape the fire and dust inferno that had engulfed the Island.

"Once the triage center location was established, countless ambulances arrived, providing much-needed medical supplies. Conference tables served as makeshift treatment and surgical suites. The triage center remained active until late into the night. At one point, the center was quickly evacuated as the dust plume rising from the collapse of World Trade Center building #7 pushed past the volunteer medical team.

"PAD investigators remained at the Brooklyn Marriott Hotel for several days following the terrorist attack offering first aid, food, and shelter to displaced Manhattan residents in a large ballroom provided by the hotel. When a window of opportunity opened up for attendees to finally leave New York City, most chose to drive home rather than face the apprehension of flying.

"Among the most heroic PAD attendees was Thomas Holohan, an organizer of the New York PAD meeting and a New York firefighter who gave his life in service to his city on that day. It is our hope that this life-changing experience (and our memories of it) will honor the heroic men and women of the New York Fire Department and Police Department who willingly sacrificed all to protect the citizens of New York City on that day."

Tom Lawrence, NREMT-P, I/C
EMSC State Coordinator for Rhode Island and Deputy Team Leader for the Rhode Island Disaster Medical Assistance Team

"My day on September 11 began as any other, but like all other Americans, it changed suddenly at 8:48 a.m. Within one hour of the first attack on the World Trade Center, I along with other members of the Rhode Island Disaster Medical Assistance Team (RI-1 DMAT) was placed on high alert. We immediately began activating other team members, ordering vans and trucks to transport the team and its equipment, and looking after all

of the details of a major mobilization.

"DMATs are part of the National Disaster Medical System (NDMS). Twenty-four level one DMAT teams currently exist in the federal system. Level one status is reserved for those teams that are staffed, equipped, and ready to deploy with 6 to 12 hours notice. A deployed DMAT team is composed of 35 physicians, nurses, paramedics, EMTs, other health care providers, and support personnel, and is able to provide health care in an austere environment for up to 72 hours without resupply.

"By 10:30 p.m. on September 11, 57 members of the RI-1 DMAT left our sponsoring Rhode Island Hospital in 11 vans and two large trucks for Stewart Air Force Base (AFB) in Newburgh, NY. We were escorted by state police cars at the front and rear of the convoy due to the tight restriction on travel into New York City. We arrived at Stewart AFB at 5:00 a.m. and were directed to a very large airplane hanger that would be home for several days. We were quartered with other DMATs, military personnel, and other responding agencies.

"The next morning, 120 members from four DMAT teams left Stewart in another escorted convoy, this time to Ground Zero. During the next two days, we set up five field hospitals around the 'pile,' and treated nearly 8,000 disaster workers during the next two weeks.

"Field hospitals were set up in the courtyard at Manhattan Community College, a delicatessen on Liberty Street, tents at Church Street and One World Financial Plaza, and the lobby of the American Express Building. Injuries involved those to the eyes, soft tissue, respiratory system, and musculoskeletal system. About 180 patients were treated in a typical 8- to 12-hour shift.

"The first teams in to Ground Zero were rotated out and replaced with other teams after 15 days. The Rhode Island team returned home on the afternoon of September 26."

Ambulance Crash Testing for the Safe Transport of Children Draws International Interest

PED-SAFE-T, a targeted issue grant awarded by EMSC for the purpose of conducting ambulance crash safety tests to observe the performance of these vehicles and a variety of occupant and equipment restraint practices currently available or in use for pediatric transport, has seen some major milestones in this last year.

"Since relocating the project to Columbia University in New York City, the project has attracted the attention of many colleagues both nationally and internationally," said Nadine Levick, MD, the grant's principle investigator. "In the last year, I have presented to several EMS, pediatric, injury, and engineering audiences both in the U.S. and abroad." Most recently Dr. Levick served as a keynote speaker at the Swedish National EMS Congress and as a speaker at the Australian Military Automotive Safety and Emergency Services Conference.

Her work has been featured in three peer-reviewed engineering publications and on the Discovery Channel. The most significant event, however, was her involvement in the coordination of an international symposium on EMS vehicle safety under the auspices of the Society of Automotive Engineering (SAE). The symposium was such a success that Dr. Levick was nominated for SAE's Woman of the Year award.

EMSC would also like to congratulate Dr. Levick for being named the director of pediatric emergency services at Harlem Hospital Center in New York City, the director of the Harlem Hospital Injury Prevention Program and the principle investigator of one of five cooperative grants for the Network Development Demonstration Project, an EMSC Program award funded by MCHB.

For more information about the PED-SAFE-T targeted issue grant, please contact Dr. Levick at nadine.levick@columbia.edu.

What's New? *An EMSC Product Update*

Guidelines for Providing Family-Centered Prehospital Care *by the National Association of Emergency Medical Technicians (2000)*

This product, the result of a consensus panel meeting, presents guidelines and recommendations for family-centered care practices in the prehospital setting, including family presence during out-of-hospital care and transport and child and family member safety during transport. The guidelines also address effective methods for communicating with family members and how to deal with prehospital healthcare provider stress. This product is available on-line, free of charge, at www.ems-c.org/downloads/doc/Guidelines.doc.

After the Emergency Is Over: Post- Traumatic Stress Disorder in Children and Youth *by the EMSC National Resource Center (2001)*

This two-page fact sheet defines post-traumatic stress disorder (PTSD), lists common symptoms of PTSD, and provides tips on how to help children and youth who have suffered a traumatic event. The product is available on-line, free of charge, at www.ems-c.org/downloads/pdf/ptstress.pdf. The cost per 100 hard copies is $5. Request product #901.

To obtain hard copies of these products, contact the EMSC Clearinghouse at (703) 902-1203 or access the online order form through the EMSC web site at www.ems-c.org. Once there, click on "Products and Resources."

Six Targeted Issue Grants Awarded in FY 2002

In January 2002, the Maternal and Child Health Bureau awarded six new EMSC targeted issue grants, each of which addresses a specific pediatric health care need or concern and has regional and/or national significance. These three-year grants typically yield new products, data and research findings, clinical practice guidelines, and model programs.

The objectives of each new grant are listed below by grant title, organization, and principal investigator.

Pediatric Continuous Quality Improvement (CQI) Model Project; Michigan State University, Kalamazoo Center for Medical Studies; *William Fales, MD*

The objectives of this grant are to:
- Create a pediatric-focused CQI model and determine its impact on protocol compliance;
- Develop and pilot-test the pediatric-focused CQI Program (PCQI);
- Implement the PCQI in randomized agencies throughout Michigan; and
- Measure protocol compliance before and after the implementation of PCQI.

For more information about this grant, contact Matthew Wilton, EMT-P, at wilton@kcms.msu.edu.

Basic Emergency Lifesaving Skills in Schools—A Model for Replication in WI, MN, ND, and SD; Wisconsin Department of Health and Family Services; *William Perloff, MD, PhD, and Leslie Oganowski, PhD*

The objectives of this grant are to:
- Increase the number of high school graduates in Wisconsin, Minnesota, North Dakota, and South Dakota who are proficient in cardiopulmonary resuscitation, first aid, automatic external defibrillators, safety skills, and knowledge;
- Ensure that the programs are offered using current, interactive, age-appropriate curriculums that are culturally competent;
- Establish a community safety network that supports the delivery of these skills in schools and continued awareness and use of these skills in everyday life; and
- Support the implementation of an efficient Emergency Preparedness Plan in school districts.

For more information about this grant, contact Mary Jean Erschen at erschmj@dhfs.state.wi.us.

Model Pediatric Component for State Disaster Plans; Harlem Hospital, Columbia University –College of Physicians and Surgeons; *David Markenson, MD*

The objectives of this grant are to:
- Build a coalition of experts from the fields of pediatrics, disaster planning, emergency medicine, emergency response, trauma, and mental health;
- Utilize the expertise of the coalition to build a consensus as to the appropriate methodology for the development of a model assessment method of both state disaster plans and recent disaster incidents that are inclusive of the specific needs of children; and
- Use the information gained from the assessment models to develop a Model Pediatric Component (MPC) for use in state disaster planning.

For more information about this grant, contact David Markenson, MD, at dsm2002@columbia.edu.

Screening and Secondary Prevention for Psychological Sequelae of Pediatric Injury; University of Pennsylvania School of Medicine; *Flaura Winston, MD, PhD*

The objectives of this grant are to:
- Refine, validate, and disseminate a screening protocol;
- Develop and pilot-test multiple secondary prevention modules; and
- Create and disseminate practical evidence-based guidelines for EMS providers.

For more information about this grant, contact Susan Passante at passante@mail.med.upenn.edu.

Model Training for Safe Transportation of Children with Special Health Care Needs; Connecticut Children's Medical Center; *Eileen Henzy, MPH*

The objectives of this grant are to:
- Describe the challenges faced by families regarding safe transportation of their child with special health care needs;
- Develop a model training program for rehabilitation specialists that addresses selection and basic use of special needs restraint systems; and
- Implement and evaluate the efficacy of the model training program for product dissemination.

For more information about this grant, contact Eileen Henzy, MPH, at ehenzy@ccmckids.org.

Beyond the Barriers: Project EQUIP; University of Iowa; *Dianne Atkins, MD*

The objectives of this grant are to:
- Develop a pediatric cardiac arrest quality improvement program for prehospital providers;
- Establish reporting methods to disseminate information from the quality assurance program to the Iowa Bureau of EMS and EMS providers;
- Develop education methods to convey information from objectives one and two to EMS providers; and
- Analyze the impact of data analysis and instructional programs on long-term outcomes.

For more information about this grant, contact Dianne Atkins, MD, at dianne-atkins@uiowa.edu.

Seven Regions Receive EMSC Symposium Supplemental Grants

Seven EMSC coalitions will receive awards of up to $50,000 each to develop a regional meeting and to help support activities that encourage collaboration and resource sharing. The funding period for these one-year EMSC Regional Symposium Supplemental Grants is February 1, 2002, through January 31, 2003. The tentative dates and topics for each meeting are listed below by region/coalition name:

Heartland EMS for Children Coalition (HECC)

Member states: Iowa, Kansas, Minnesota, Nebraska, North Dakota, and South Dakota *Meeting dates:* September 12-14, 2002, in Minneapolis, MN. *Topics to be addressed:* Trauma/EMS, injury prevention, poison control centers, grant writing, rural health, systems development, Basic Emergency Lifesaving Skills, and family-centered care.

For more information about the HECC Meeting, contact Claudia Hines at claudia.hines@childrenshc.org.

Southeast EMSC Regional Council (SERC)

Member states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. *Meeting date:* Fall 2002 in Orlando, FL. *Topics to be addressed:* Mass casualty planning, communication during a disaster, trauma system assessment, and pediatric issues in state disaster plans.

For more information about the SERC Meeting, contact Rhonda Phillippi at rhonda.phillippi@mcmail.vanderbilt.edu.

New England EMSC Region

Member states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. *Meeting dates:* January 4-5, 2003, at Ascutney Mountain Resort, in Ascutney Mountain, VT. *Topic to be addressed:* Regional informational sharing.

For more information about the New England Meeting, contact William Clark at wclark@vdh.state.vt.us.

Intermountain Regional EMSC Coordinating Council (IRECC)

Member states: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. *Meeting dates:* September 11-14, 2002, in Park City, UT. *Topics to be addressed:* Information sharing on such topics as suicide and injury prevention, data systems, technology-driven systems, and training/education

For more information about the IRECC Meeting, contact Breck Rushton at brushton@doh.state.ut.us.

Southcentral EMSC Region (SEC)

Member states: Arkansas, Louisiana, Oklahoma, and Texas. *Meeting date:* September 2002 in San Antonio, TX. *Topics to be addressed:* EMS and emergency department protocols and guidelines for pediatric patients, EMSC data collection, system design and analysis, family-centered care, and integration of EMSC into EMS

For more information about the SEC Meeting, contact Ron Hilliard at ron.hilliard@tdh.state.tx.us.

Mid-Atlantic Regional EMSC

Member states: Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Virginia, and West Virginia *Meeting dates:* October 10-11, 2002, in Baltimore, MD. *Topics to be addressed:* Data collection and research, injury prevention and control, clinical models of excellence in the emergency care of children, and systems and policy development

For more information about the Mid-Atlantic Meeting, contact Cynthia Wright-Johnson at cwright@mdems.umaryland.edu.

Center of America Regional EMSC (CARE)

Member states: Illinois, Indiana, Michigan, Missouri, Ohio, and Wisconsin. *Meeting date:* October 2002 in Indianapolis, IN. *Topics to be addressed:* Information sharing and exchange

For more information about the CARE Meeting, contact Denise Giddens at dmgidden@iupui.edu.

In addition, the following territories will take part in these regional symposia:

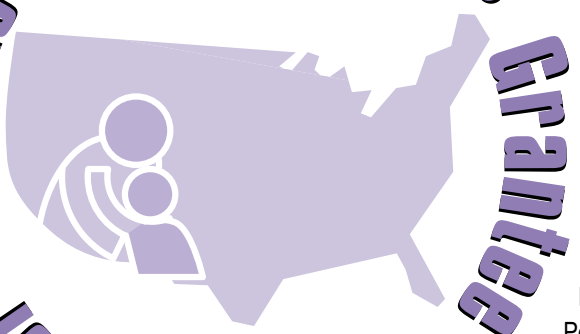
- Puerto Rico will attend the SERC Regional Symposium.
- American Samoa will attend the HECC Regional Symposium.
- Guam and the Northern Mariana Islands will attend the IRECC Regional Symposium.

New Web Page for Children and Youth with TBI Now Available

The Traumatic Brain Injury Technical Assistance Center (TBI TAC), funded by the Health Resources and Services Administration's Maternal and Child Health Bureau, invites *EMSC News* readers to visit its new Children and Youth with TBI web page located within the TBI TAC web site at www.tbitac.org. Once there, click on the Tool Box section.

This new page is part of the Center's children and youth with TBI initiative, which is designed to help states improve the integration of children and youth into their existing TBI projects and initiatives. It features information on emerging TBI and disability-related education issues; successful strategies for implementing TBI initiatives; and new products and resources for families, teachers, and other school personnel.

State of the States • Grantee Update Corner •



Florida

Florida EMSC is delighted to announce that it has published its statewide EMSC needs assessment. It is available on the web at www.doh.state.fl.us/emsc. Based on the needs assessment findings, Florida is drafting a three-year EMSC plan with the help of an ad hoc committee composed of representatives from EMSC-related disciplines, as well as family advocates. On January 31, Florida's EMSC program co-sponsored a Pediatric Disaster Module at the Florida Emergency Management Foundation's 23rd Annual International Disaster Management Conference.

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

Iowa

Blank Children's Hospital in Des Moines, IA, has been selected as a pilot site to conduct one of the six Prehospital Pediatric Care courses. The course was developed by the National Association of EMTs and is considered an in-depth study of the care needed for the pediatric patient in the out-of-hospital setting. An intended audience of out-of-hospital providers, school nurses, emergency room personnel, and critical care unit providers will take part in this lecture and scenario-based training.

In other news, a snowball effect has been created due to the successful kickoff of last year's Pediatric Patient Care — It's In The Bag project. Numerous EMS services have partnered with local Kiwanis organizations in an effort to increase their knowledge and equipment base for pediatric patient care. To date, 11 services in Iowa have received the equipment and training. Successful treatment of a pediatric patient has been attributed to usage of the bag.

For more information about either of these activities, contact Katrina Altenhofen at KAltenho@ health.state.ia.us.

New York

The New York State EMSC program has released its EMSC Prehospital Pediatric Care course, a continuing education course for statewide use. Developed for EMSC by the Fire Department of New York City, EMS Training Division, the course contains eight lessons, including one on children with special health care needs. The course is designed to be used by EMS agency training officers in order to reach as many field providers as possible.

For more information, contact Gloria Hale at ghc08@health.state.ny.us.

Utah

The Utah EMSC program reports the following:

- On November 29 and 30, 2001, the Great Western Pediatric Symposium was held in Salt Lake City. The conference focused on trauma with tracks in EMS and intensive care.
- JumpSTART triage and children with special health care needs continue to be topics of interest at statewide EMS seminars and conferences, at the university, and at local hospital and agency events.
- The Bureau of EMS is now accepting the American Academy of Pediatrics' Training in Pediatric Education for Prehospital Professionals (PEPP) — Advanced Life Support (ALS) course as well as the American Heart Association's Pediatric Advance Life Support course for paramedic pediatric certification requirements.
- In the last year, the Utah EMSC Program completed nine "before PEPP" PALS Plus courses, 11 PEPP-ALS courses, and two Coordinator Orientations courses.
- With the award of the three-year EMSC Enhancing Pediatric Patients Safety Grant, Dale Maughan, RN, EMT-P, will join the program in 2002.

For more information, contact Peter Morris at pmorris@doh.state.ut.us or contact Bryony Orwick at bnorwi0@uky.edu. As always, we look forward to receiving any additional comments or suggestions.

Washington

Cardiopulmonary resuscitation (CPR) is a skill that can save lives. In 1999, Washington State EMSC made it an objective to develop successful approaches to increase the number of Washington State high school students who receive CPR training prior to graduation. To that end, the Washington State EMSC project has developed a resource manual for high school administrators, parents, and teachers to use in developing CPR student training programs.

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CPEM to Release Paramedic *TRIPP*, Initiate Pediatric Research Projects

The Center for Pediatric Emergency Medicine (CPEM), a joint program of the New York University School of Medicine and Bellevue Hospital Center, was established in 1985 to improve emergency medical care for children in New York City and across the United States. With its interdisciplinary staff and access to a national network of experts in the field, CPEM is involved in a variety of projects that will have a positive national impact on the health care of children in the prehospital setting. A few of their most current projects are highlighted below.

Paramedic TRIPP

After delaying release in order to update the resource with the latest American Heart Association (AHA) guidelines, the advanced life support version of the *Teaching Resource for Instructors in Prehospital Pediatrics (TRIPP)* will be available on CD-ROM in April 2002. CPEM will provide all attendees of the National Congress on Childhood Emergencies with a copy of the Paramedic *TRIPP.* Approximately 50 copies will also be distributed to each state EMS director and/or training coordinator. Additional CD-ROM copies of this 1,400-page resource will be available at $10 each. The resource can also be downloaded, free of charge, from the CPEM web site at www.cpem.org. More than 20,000 copies of the original national award–winning *TRIPP* have been distributed in the U.S. and in 38 countries around the world.

Research

Pediatric PreHospital Arrest Survival Evaluation (PHASE)

In collaboration with the Fire Department of New York City (FDNY), Division of EMS, and the New York Academy of Medicine, CPEM is helping to conduct an out-of-hospital cardiac and respiratory arrest study in New York City. FDNY is replicating a prospective data collection methodology created back in 1989, when the New York Heart Association funded the original PHASE study. Specially trained paramedic data collectors provide 24/7 coverage, interviewing field personnel immediately following the call to eliminate recall bias. CPEM is overseeing the MCHB–funded pediatric component of the project. The hypotheses being considered are as follows: (1) Ventricular fibrillation in children experiencing cardiopulmonary arrest is a more frequent occurrence than was previously thought; (2) After adjustment for initial rhythm, the outcome of cardiac arrest in children is different than that of adults; and (3) Patients in respiratory arrest who are "adequately treated" demonstrate no difference in outcome if they are treated with bag-valve-mask vs. endotracheal intubation.

In addition, the study will seek to address the epidemiologic elements, causes, locations, timing, interventions (by bystanders, family, and EMS personnel), initial cardiac rhythm, and outcomes of all children younger than 18 years of age who suffer cardiac or respiratory arrest.

National Child Protection Education Project

In October 2001, a Blue Ribbon Panel of national experts in EMS, EMSC, and child protection was convened to review the results of a nationwide survey of what EMTs and paramedics know about child abuse and neglect. The survey, which had a return rate of 43%, was developed and distributed by CPEM with the assistance of the National EMSC Data Analysis Resource Center, the National Registry of EMTs, and 15 state EMS offices. The proceedings of this meeting will be published simultaneously in *Pediatric Emergency Care, Prehospital Emergency Care, and Annals of Emergency Medicine.* A resource for prehospital providers will also be developed based on the gaps in education revealed by the national survey.

For more information about these projects, contact Marsha Treiber at Treiber@cpem.org.

State of the States…

(cont. from page 10)

A downloadable copy of the manual is available at www.washingtonemsc.org. Once there, click on "CPR Student Training." A very limited number of hard copies is also available by contacting Rachel Thompson at rlt500@att.net.

Comments and suggestions for improving the manual are welcomed. For more information, contact Sheri Reder at sreder@chmc.org.

Wisconsin

The Wisconsin EMSC Program combined education with family fun on October 14 and 15, 2001, with the success of the Second Childhood Emergencies: Prevention and Management Conference. It was held at the Kalahari Resort and Conference Center in Wisconsin Dells, WI. Approximately 350 attendees — including physicians; nurses; advanced practitioners; social workers; pharmacists; first responders; EMTs; paramedics; firefighters; law enforcement officers; child passenger safety technicians; administrators, educators, and staff of Wisconsin schools; child care providers; parents; and grandparents — enjoyed the indoor water park and many excellent presentations on clinical pediatric care, school health, child passenger safety, injury prevention, and much more.

Governor Scott McCallum proclaimed the week of the conference "Childhood Emergencies Week" to encourage all citizens to assume an active role in the promotion and improvement of injury prevention and emergency services for children and to applaud the work of our emergency care providers and educators.

Plans are underway for the 2002 conference, which will be held September 16-17, at the Kalahari Resort.

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

Important Dates *to Remember*

April 8-9
American College of Emergency Physicians
Emergency Medicine Connection
Las Vegas, NV
Contact: Stephanie Batson at
(800) 798-1822, ext. 3274

April 10-13
American Association of Suicidology
Annual Conference
Bethesda, MD
Contact: (202) 237-2280

April 15-17
Emergency Medical Services for Children
3rd National Congress on
Childhood Emergencies
Dallas, TX
Contact: Heather Crown at (202) 884-6881

April 20-23
American Trauma Society
Annual Meeting
Arlington, VA
Contact: (800) 556-7890

May 6-8
International Association of Fire Chiefs
Annual Meeting
Las Vegas, NV
Contact: (703) 273-0911

May 19-22
American Pediatric Surgical Association
Annual Meeting
Phoenix, AZ
Contact: Michele Stevens at (847) 480-9576

May 22
National EMSC Day
EMSC National Resource Center
Contact: Millree Williams at (202) 884-6843

May 19-25
National EMS Week
American College of Emergency Physicians
Contact: Denise Fechner at (800) 798-1822

June 15-18
General Federation of Women's Clubs
Annual Meeting
Kansas City, MO
Contact: (202) 347-3168, ext. 144

June 21-25
Kiwanis International
Annual Convention
New Orleans, LA
Contact: Susie Goens at
(317) 875-8755, ext. 134

June 30–July 1
National Association of School Nurses
Annual Conference
Lake Buena Vista, FL
Contact: Gloria Durgin at (877) 627-6476

July 22-28
National Conference of State Legislatures
Annual Conference
Denver, CO
Contact: Lean Hoff at (202) 624-5400

EMSC National Resource Center
Children's National Medical Center
111 Michigan Avenue, N.W.
Washington, DC 20010

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