

What's Inside?

- * Federal Corner
- * Good Clinical Practice Tip from the DCC
- * Study Updates
- * Nodal News

Contact us:

P.O Box 581289
Salt Lake City, UT 84158
Phone (801) 213-3205
Fax (801) 581-8686

Or visit us online at:
www.pecarn.org



In a nutshell

“We’ve come a long way, babies...: A Brief History of PEM”

Walton O. Schalick, III, MD, PhD, PRIME/University of Wisconsin

February 3rd, 1951: Millions of Americans tuned into the weekly radio detective show, *The Saint*. Vincent Price played Simon Templar, the rakish hero who solved crimes with whimsy and panache. This episode, “The Carnival Murder,” has several markers for the history of Emergency Medicine. A circus performer, has been poisoned. Another is saved by a doctor called to her side. There was no ambulance, ED or even an ER. Rather, a doctor paid an emergency house call, or in this case a circus-tent-call. The process was familiar to listeners across the country, because ERs and Emergency Medicine had not been created.

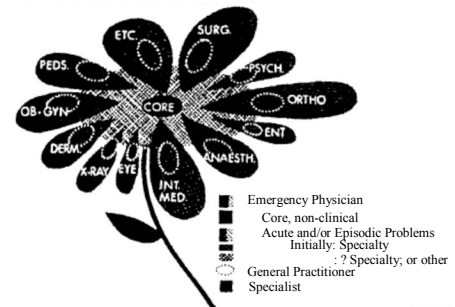
So where was EM and PEM? It was still years in the future. But to see that, we need to look further back. The first pediatric in-patient hospital in the English-speaking world was the Great Ormond Street Hospital (GOSH). At GOSH’s founding in London in 1852 there was an explicit exclusion:

children suffering from accidents or external injuries or their immediate effects are not in general eligible for admission as inpatients, the Hospital ... intended for children suffering from diseases peculiar to, ... their early age.

The success of this inpatient model spread rapidly throughout Europe, and the US. Following Ives at Yale and Jacobi in New York, Pediatrics rapidly achieved specialty milestones. It focused on what Jacobi called, “not ... miniature men and women,” but a field with “its own independent range and horizon;” Pediatrics became very attractive. From 1923-62, the total number of American physicians increased by 76%; pediatricians increased by 1,425%. The field had taken off.

But with success came growing pains. In the mid-twentieth century, generalism wavered. In particular, the number of house calls declined without a change in physicians’ office hours. Consequently, hospitals created a ‘room’ where substitutive, if competitive, care could be provided. By 1962, *Medical Economics* reported on the expanding phenomenon: “Our enemy: The emergency room,” strangling the livelihood of generalists. Admissions, it argued, should be restricted to the “bona fide emergency cases;” local practitioners should get the rest.

A more mobile post-war America saw a rise in trauma; GIs had experienced complete medical care in the military and expected a similar cradle-to-grave civilian experience. Equally, emerging third-party reimbursement, growing expectations of middle-class appetites, and accelerating, large-technology-dependent medical care all impelled the wild expansion of health care, pediatrics and eventually EM, symbolized by Robert Dailey’s “Emergency Medicine Flower” in 1976.



Other changes supported these shifts. In 1966, the NAS/NRC released a landmark report, *Accidental Death and Disability: The Neglected Diseases of Modern Society*, stressing that trauma care was deplorable. That year, Congress created NHTSA, encouraging ambulance and EMS training/research; simultaneously CPR recommendations emerged. The 1960s and early ‘70s saw corporate liability, taxation and Good Samaritan laws restructured, which encouraged EM services and burgeoning hospital emergency care.

But American emergency medical care was uneven. Following Congress’ efforts in 1965, the 1973 EMSS Act created ~300 regional EMS organizations. Reporting on Labor Day 1977, *The New York Times* noted that ambulance teams tended 20,000 victims of MVCs and 40,000 other urgent injuries/illnesses over the holiday weekend, but their care and success were still highly variable. Training was the answer, and academia responded. From 1971 to 1999, the number of academic EM Departments rocketed from 2 to 57; residencies followed suit, varying between two and four years in length. And adult EM was not alone.

Continued on pg. 2

Continued from pg. 1

PEM emerged from the nexus of forces and again, the military played a role, with Emergency Maternal and Infants Care (1943-48). These structures spread beyond the military. From 1956-61, non-inpatient services at The Children's Hospital, Boston had stagnant growth except for the emergency program that more than tripled; by 1967, it had increased by 950%.

By the late 1970s, Martha Bushore-Fallis and Jerry Foster at the Columbus' Children's Hospital began teaching PEM. Intriguingly, pioneers of PEM like James Seidel and David Jaffe, entered via general pediatrics rather than EM. In 1981, the AAP formed a PEM section, chased by the first edition of Ludwig/Fleisher in 1983, and by the mid-90s, fellowship-styled, sub-boarding through ABEM became the norm. Endowed chairs in PEM followed in 2000, as did chairs of Pediatrics and of Emergency Medicine who were PEM specialists.

Echoing the '73 EMSS, the late US Senator Daniel Inouye

with Senators Orrin Hatch and Lowell Weicker, sponsored the first EMSC legislation in 1984, achieving passage in 1985 and distribution to four states for EMSC services in 1986.

PEM has also benefited from The Saint's investigatory determination. PECARN is a perfect example. While Pediatric research dates to the beginning of medicine, a real acceleration occurred after the founding of American Pediatrics in New York. The PEM field joined its predecessors from oncology to neonatology in creating a transnational collaborative network. As an apotheosis, PECARN represents a validation of the needs of our constituency. Those excluded from GOSH more than 160 years ago are now included in the remit of children's hospitals and actively embraced in the knowledge generation so desperately needed to ameliorate/prevent their conditions.

Just as The Saint constantly looked out for the little guy, so too has PEM done for the youngest amongst us, with equal success.

Data Safety Monitoring Boards (DSMB) for Clinical Trials

T. Charles Casper, PhD

Every so often in PECARN's randomized trials, the DCC pushes sites to get data entered and queries resolved because "there's going to be a DSMB meeting." Data and Safety Monitoring Boards, or DSMBs, are a part of the majority of randomized trials. The purpose of these groups is to minimize the risks to study participants and to repeatedly reassess the risk-to-benefit ratio of interventions. The NIH requires DSMBs for all multicenter clinical trials of interventions that entail potential risk to subjects. But, what does the DSMB actually do? What goes on behind those closed doors?

A DSMB typically consists of an odd number (3-7) of experts, including at least one statistician. The remaining members will have expertise in the disease/condition, methods, or outcomes being studied in the trial. In PECARN studies, for example, areas of expertise might include biostatistics, emergency medicine, and pediatric critical care. Having both statistical and clinical judgment is essential. The DSMB must be independent of the trial sponsor, principal investigators, and participating sites. The frequency of DSMB meetings throughout a trial will depend on the particular trial design and duration, and is also, in part, up to the discretion of the DSMB. Usually, meetings are between 6 and 12 months apart, but the schedule is driven by the DSMB and the funding agency.

Prior to a DSMB meeting, a screening cutoff is established. This will define the population for which data will be discussed at the meeting. All data discrepancies must be resolved, so that the DSMB reviews data that accurately represent the current state of the trial. It is for this reason that the DCC data and project managers must follow up with each site until all data issues are resolved. The DSMB reviews baseline data about the trial in the Open Session of the meeting. The Closed Session of the DSMB is open only to the DSMB members and presenting statisticians. This closed session begins by reviewing baseline characteristics similar to the Open Session, but this time by randomized treatment arm. Next, data associated with intervention are explored. For example, in MAGiC, this includes looking at the number of infusions given (out of 6 possible), the duration of each infusion (supposed to be 20

minutes), and the time between infusions (ideal is 8 hours). Primary and secondary outcomes are examined, followed by specific safety concerns, as well as all adverse events. Following the Closed Session, the DSMB may have an Executive Session (without DCC statisticians), and then recommendations are given.

These DSMB recommendations are given to the trial PIs and the sponsor (e.g., NIH). A wide variety of recommendations are possible, and these may be study-wide or site-specific. Recommendations may include modification of eligibility criteria, dropping an arm of the trial, or stopping the trial altogether. If a trial is enrolling slowly, the DSMB may suggest removing an exclusion criterion that would increase the number of eligible patients. The DSMB could also recommend dropping an entire treatment arm, for example, if results were indicating that a particular arm was causing a lot of adverse events. Stopping a trial completely can be recommended for several reasons. Stopping for efficacy might occur if interim results show a very clinically and statistically significant difference between arms. If a lot of serious adverse events are showing up on one arm, the trial could be stopped for safety. When results indicate that an intervention has little or no effect compared to control (or seems to have a negative effect), and there is a very low likelihood of ending up with a significant difference at the end of the trial, the trial may be stopped for futility. Stopping for feasibility issues, such as very slow enrollment, is a common DSMB recommendation. The DSMB may also recommend stopping a trial due to poor patient/site compliance with the protocol. The DSMB might even make very site-specific recommendations, e.g. that a site demonstrate improvement in post-discharge follow-up rate, protocol compliance or enrollment rate.

Clearly, DSMB recommendations can have a serious impact on trial design and conduct. The DSMB protects study subjects and helps ensure that a trial's results will be meaningful, regardless of whether or not any treatment effect is observed. For the DSMB to make effective, well-informed decisions, it is essential for the data presented to be as up-to-date and complete as possible.



EMSC Advocate David Heppel, MD, Retires

David Heppel, MD, Director, Division of Child, Adolescent and Family Health in the Maternal and Child Health Bureau at the Health Services and Resources Administration, has retired after 35 years of service. Dr. Heppel's career involved prior service within the Indian Health Service and the National Institute of Mental Health. Dr. Heppel was the first program officer for the Federal Emergency Medical Services for Children (EMSC) Program. It was his vision that led to the creation of the Pediatric Emergency Care Applied Research Network (PECARN) in 2001. The EMSC Program would like to sincerely thank Dr. Heppel for his leadership and visionary direction over the years.

New Director Appointed to OECR

Jeremy Brown, MD, has been appointed the new Director of the Office of Emergency Care Research (OECR) (<http://www.nigms.nih.gov/About/Overview/OECR/>) housed within the National Institute of General Medicine. Dr. Brown has extensive clinical and research experience, including authoring more than 30 peer-reviewed articles and three books. In his new role, Dr. Brown will coordinate and promote collaboration to advance research in the field of emergency medicine. His contact information is Jeremy.Brown@nih.gov.

NICHD Advances Opportunities for EMSC Research

Lynne Haverkos, MD, MPH, at *The Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), championed the following program announcement that calls for research proposals in the area of emergency medical services for children as a R21 or RO1 mechanism. More information can be found at <http://grants.nih.gov/grants/guide/pa-files/PA-12-142.html>.

Newly-Funded EMSC Targeted Issues Grants

On September 1, 2013, HRSA invested \$5.4 million over the next three years to support six Targeted Issue grants focusing on pediatric prehospital care.

Brooke Lerner, PhD is leading one of the new grants, an EMS Research Network, CHaMP. This network brings together three EMS affiliates (EMSAs) to establish the infrastructure and test the feasibility of pediatric emergency care research in the prehospital setting. CHaMP will partner with PECARN's research nodes to build upon its success. CHaMP's EMSAs are:

1. Houston Fire Department, led by Keith Gates, MD, site PI, and Manish Shah, MD, academic advisor;
2. Milwaukee EMS, led by Lorin Brown, DO, site PI, and David Brousseau, MD, MS, academic advisor; and
3. Mecklenburg EMS led by Jonathan Studneck, PhD, EMT-P, site PI, and Stacy Reynolds, MD, academic advisor.

The addition of CHaMP provides an opportunity to continue improving pediatric emergency care through increasing the availability of quality pediatric prehospital research and the ability to gather statistically significant sample sizes of pediatric prehospital data.

Additional EMS Targeted Issue Grantees:

Scott Rodi, MD is leading "Innovating and Improving Pre-hospital Pediatric Care in Rural New Hampshire and Vermont: The Center for Rural Emergency Services and Trauma (CREST) Network for EMS Providers" based at the Geisel School of Medicine and Dartmouth-Hitchcock Medical Center

Robert Silverman, MD, MS is leading "Pre-hospital Oral Steroids for the Treatment of Status Asthmaticus in Children (POSTSAC) Study" based at Hofstra North Shore-LIJ School of Medicine at Hofstra University

Mary Fallat, MD is leading "Compassionate Options for Pediatric EMS (COPE)" based at University of Louisville Research Foundation

Andrew Stevens, MD is leading "Treat the Street: Pre-hospital Pediatric Asthma Intervention Model to Improve Child Health Outcomes" based at Indiana University

Manish Shah, MD is leading "Pediatric Evidence-Based Guidelines Assessment of EMS System Utilization in States" based at Baylor College of Medicine and Texas Children's Hospital.

For more information about each new grant, read "Health Resources and Services Administration's EMSC Targeted Issue Grants, 2013". For additional information about the program or to access an online searchable database of all past and current targeted issues grantees, go to:

http://www.childrensnational.org/EMSC/GrantPrograms/Targeted_Issues.aspx.

Federal Contact Information:

Elizabeth "Beth" Edgerton, MD, MPH
Scientific Advisor
eedgerton@hrsa.gov

Theresa Morrison-Quinata
Program Officer
tmorrison-quinata@hrsa.gov





Q: What are some helpful tips when obtaining documentation of informed consent from study participants?

A: Each year, informed consent-related issues are among the most commonly cited deficiencies in CDER's GCP compliance inspections of clinical trial investigators and sites. Informed consent-related issues can include (but are not limited to):

- Individuals obtaining consent are not approved to obtain consent from study participants
- Obtaining consent on an informed consent form that is an outdated version
- Study procedures occurring before consent has been obtained
- Consent forms dated by study personnel rather than the participant, parent or LAR
- Time of consent not documented, when required on the consent documents
- No documentation that a copy of the signed/dated consent document was provided to the subject
- Non-English speaking individuals signing informed consent documents that are written in English

Many of the violations stated above can be prevented by documenting the informed consent process using informed consent checklists that are provided for most studies. In addition, listed below are some tips on obtaining complete and accurate informed consent documentation:

- Print each version of the consent documents on different colors of paper (for example, v1 consent documents printed on orange, v2 consent documents printed on red, etc.).
- Use colored paper for original, signed consent documents. Print copies on white paper for subjects/parents.
- Highlight or put sticky "Sign Here" notes on all signature, date, time, and initial lines.
- Review the consent documents in their entirety with the subject/parent, before any study procedures begin. Train your investigators and RAs to do the same.
- Include an AM/PM designation as part of your consent document template to better identify the time of consent.
- Update stockpile of consent documents with new versions as soon as they are available.

Source: 2010 Good Clinical Practice: A Question and Answer Reference Guide. May 2010

Submitted by: **Heather Gramse**



The Research Coordinator Advisory Committee

Since its inception last Spring, the PECARN Research Coordinator Advisory (RCA) Committee has garnered much support and interest...most of which has revolved around a recurring theme: what are the PECARN "Best Practices?" This question was first posed internally during our first RCA meeting. We decided to investigate how work was being accomplished at each site. The result was our first RC project, a poster presentation at a PECARN Steering Committee meeting describing HEDA infrastructure. At that same PECARN meeting, the Steering Committee received a report on performance metrics. Afterward, the RCs were again asked to evaluate best practices, this time in an effort to identify strategies for improving site performance. Our efforts to mobilize RCs led us to recognize limitations in communication, and we have been working toward implementing an RC blog and Facebook page in order to provide some forum in which we can communicate. We have also been looking at ways in which we use terminology and discussing how we might be able to standardize terms between the HEDAs (and even create some new terms to help describe nuances in the enrollment process). In these ways we are working to increase collaboration between HEDAs, as well as to draw from one another's strengths and experiences. As a new committee, we have many successes to report, but not without a few stumbling blocks. The major struggle is balancing commitment to the RCA committee with commitment to our busy daily research responsibilities. The positive message herein is this: RCs are so busy dedicating themselves to their sites' excellent performance of PECARN research that they are struggling to find additional time to commit to the committee.



Save the Date

Winter/Spring 2014 In-Person Meeting:
Tuesday, February 25 – Wednesday, February 26, 2014
Hyatt Regency, Chicago, IL



TBI-KT

The study entitled “Implementation of the PECARN Traumatic Brain Injury Prediction Rules for Children Using Computerized Clinical Decision Support (CCDS): An Interrupted Time Series Trial” is funded by the American Recovery and Reinvestment Act—Office of the Secretary (ARRA OS): Grant #S02MC19289-01-00. The overall goal of the study is to promote the appropriate use of cranial CT for children with blunt head trauma by creating a generalizable model to translate the PECARN Traumatic Brain Injury (TBI) prediction rules into clinical practice.

We are currently in year four of the project. Since our last update, we have continued data collection in the clinical trial using the electronic health record blunt head injury data collection tool, with overall enrollment of approximately 20,000 eligible patients. We have successfully implemented the CDS at all sites. One site has transitioned from vendor-specific CDS to web-services based CDS; another site will also transition to web-services based CDS in the near future. With CDS implemented, we will now assess whether there is a change in the use of CT for children with minor blunt head injury.

A manuscript on the sociotechnical analysis for design of clinical decision support has been accepted to The Journal of Biomedical Informatics. Several other manuscripts on the development of the CDS are in process.

Biosignatures Study

After six years of enrollment, our beloved Biosignatures study has concluded its enrollment at the end of May this year. Over 6,000 patients were consented, with a total of 4,735 Biosignatures and 1,937 PCT samples collected! That represents a tremendous amount of dedication and hard work from the 26 contributing sites. As the DCC continues to review and clean study data, sites may receive periodic queries. One paper has been submitted while progress on remaining primary and secondary manuscripts is underway!

FLUID

FLUID, a prospective randomized clinical trial using a factorial design, will determine whether variations in the rate of administration and sodium content of rehydration fluids during pediatric DKA treatment are associated with differences in neurological outcomes. This NICHD-funded study will enroll 1,510 DKA patients and 400 non-DKA patients over five years at 13 PECARN centers. We have enrolled 606 DKA patients to date. All new sites are currently enrolling and doing a great job! We have also enrolled 87 “non-DKA” comparison patients – children with type 1 diabetes who have never had DKA. Our “Methods” manuscript was recently published in *Pediatric Diabetes*. Investigating biomarkers of cerebral injury has shifted to the forefront of focus for our ancillary studies, which are currently under review at the NIH.

PECARN Registry

This project is to establish a data registry from electronic health records at four PECARN sites (CHOP, CCHMC, CNMC, Children's Hospital Colorado) to collect and report quality measures of emergency care provided to children. Measurable benchmarks will be established and a clinician feedback intervention will be implemented to improve performance. The project will allow systematic and widespread collection and reporting of performance and outcomes and is critical to allow clinicians and emergency care stakeholders to improve care beyond the local level. Currently data from 2012 is being transmitted to validate extraction processes and assess the de-identification algorithm. Ongoing transmission of data to populate the Registry is upcoming. There will be an expert panel convened to determine ideal benchmarks for the quality measures. Performance measure report cards will be generated and delivered to practitioners and sites in mid-2014.

TBI

We continue to analyze data and publish manuscripts from the TBI project. We have now published 12 manuscripts from this study, and currently have two manuscripts under review at journals

(*The Association of Scalp Hematomas and TBI; Risks of Sedation for Children Undergoing CT; and Isolated Vomiting and Risk of TBI*). Two others have been submitted to GAPS (*Practice Variation of CT Use; Isolated LOC and TBI*), and the final ~8 manuscripts are close to circulation to collaborators. This will eventually bring the total productivity of manuscripts for this project to well over 20. The TBI Public Use Dataset has been released, and there are some projects being developed from that as well.

Quality of Care

The long term objective of the study is to create a generalizable instrument to measure quality of ED care that can be used to improve the quality of care provided to children in the ED. We will accomplish this by applying and further validating a previously developed implicit review instrument that measures quality of care delivered to children in EDs. Data collection at the performance sites is now completed. Physician reviewers completed all quality assessments and scoring. A Nurse Researcher completed the review process for the Gausche-Hill instrument for the purpose of validating the quality of care instrument. The study PIs are working with the data center on analysis for the first manuscript.

Patient Safety

Various manuscripts are currently being written for the Patient Safety study and NYS Patient Safety study. A manuscript on Radiology errors has been submitted to “Academic Emergency Medicine” while a manuscript on near-miss and unsafe conditions, which was presented at PAS 2013, is currently being written for submission to a journal this Fall. Additional manuscripts on diagnostic errors, laboratory errors, process variance errors and the NYS Patient Safety data are in various stages of writing and/or review.



Conducting High Priority,
High-Quality Research in
Pediatric Emergency Care



PECARN Core Data Project

The PECARN Core Data Project (PCDP) is an observational descriptive study to identify basic epidemiological information on all ED visits from each participating hospital within PECARN. These data have been instrumental in hypothesis generation and grant acquisition for PECARN. The PCDP database has complete data for 2002-2012. The PCDP Demographic Reports have been generated to reflect 2002 – 2012 data and are available through the DCC SharePoint site at <https://sp.utahdcc.org>. PCDP data from 2002 – 2012 are currently available in the cubes, which can be accessed at <https://www.utahdcc.org/reportportal>. Information about using the cubes, is available in the PCDP eRoom. If you need help with access, please contact Andi Thomas at the DCC. For preliminary analysis of PCDP data, PECARN members can use the cubes or complete a data request form, found in the PCDP eRoom. **April 15, 2014** is the deadline for data submission from all sites for 2013 data. For any questions, please contact Libby Alpern at ealpern@luriechildrens.edu.

MAGiC

Enrollment in the MAGiC study continues. As of the end of August, we have enrolled 186 (89%) of our needed 208 patients. Routine interim site and pharmacy monitoring is complete and analysis of the biomarker samples is scheduled to begin this month. If enrollment at our current rate continues, we will finish this year. Thanks to all sites and the DCC for their strong work over these past 3 years!

ASSESS

We are happy to report that all 16 sites participating in ASSESS are actively screening and enrolling patients! As of September 7, 2013 we had enrolled 462 participants. Monthly research coordinator conference calls are underway and study updates are being sent out on a regular basis. Thank you for all of your hard work getting the study up and running!

THAPCA

The Therapeutic Hypothermia After Pediatric Cardiac Arrest (THAPCA) Trials continues to recruit In-Hospital subjects. (The out-of-hospital arm closed December 31, 2012 after reaching its target accrual rate!). The IH trial has screened a total of 2147 subjects; 536 were eligible and 229 were enrolled. The 35 participating sites have shown true commitment to the study and we thank everyone for their work on the project.

IAI

We continue to analyze and prepare abstracts/manuscripts from the IAI database. The primary paper (Prediction Rule for IAI in Children), the inter-rater reliability paper, and the normal abdominal CT scan paper were recently published. Two additional manuscripts are currently under review and five manuscripts are in preparation for submission. Two additional abstracts are in preparation for submission in November 2013. Finally, an additional two more manuscripts are being planned for future submissions.

Seizure

Data analysis for the Lorazepam Study is complete and the results indicate that there is no significant difference between Lorazepam and Diazepam in treating pediatric seizures. Both drugs are considered safe for use in children and neither is considered more effective than the other in stopping seizures for children in active status epilepticus. Most sites are in the process of sharing these results with their respective communities through public disclosure. All public disclosure activities are expected to be fully complete at all sites by December 2013.

EMS

The Prehospital Infrastructure Project manuscript has been accepted for publication in Prehospital Emergency Care and the project is now complete.

C-Spine Injury (CSI) in Children

C-Spine Injury (CSI) in Children: A 17-center, 5 year retrospective cohort of 540 children with CSI and 3 control groups of children who sustained blunt trauma and were found to be without CSI on cervical spine imaging. This study has resulted in several publications all of which can be found on the PECARN website.

EMS Participation in Prehospital Research: A multi-center study which used focused interview and focus group methodology to identify the barriers and facilitators to EMS prehospital provider participation in research aimed to limit immobilization to children who are at non-negligible risk for C-spine Injury. This study resulted in the publication of an overall assessment of EMS prehospital provider participation in research:

A qualitative assessment of factors that influence EMS partnerships in prehospital research. Acad Emerg Med 2012;19:161-173.

We anticipate two follow-up manuscripts describing EMS prehospital provider beliefs regarding cervical spine immobilization in children and EMS prehospital provider beliefs regarding participation in pediatric research.

Future Directions: An R21 was submitted to the NICHD to fund a HOMERUN pilot aimed at prospectively refining, validating and implementing a Pediatric C-Spine Injury Risk Assessment Tool in the pre-hospital and ED settings. The grant scored at the 1st percentile with an impact score of 10. **This is a perfect score!** We anticipate funding to start December 2013.

IAF-Appendix

The manuscript "Computed Tomography With Intravenous Contrast Alone:

The Role of Intra-abdominal Fat on the Ability to Visualize the Normal Appendix in Children" was published in Academic Emergency Medicine in August 2013.



Conducting High Priority,
High-Quality Research in
Pediatric Emergency Care



CHAMP E-RNC



Dr. E. Brooke Lerner is a tenured professor of emergency medicine and pediatrics at the Medical College of Wisconsin as well as the mother of 2 year old Olivia and 4 year old Lucas. She is an injury epidemiologist and a former EMS field provider who has dedicated her career to improving prehospital care through research. She has nearly 20 years of EMS related experience, has received several million dollars in federal funding for EMS research and has authored over 80 peer-reviewed publications.



Brittany Farrell is the new Nodal Administrator of CHaMP. Brittany graduated from the University of Wisconsin with an emphasis in public health and communication, and completed her M.S. in Communication from the University of Wisconsin-Whitewater. She serves as a Program Coordinator in the Department of Emergency Medicine at the Medical College of Wisconsin. A sports fanatic, Brittany also enjoys watching and recounting the latest episodes of *The Daily Show*.

HOMERUN

Cincinnati

Immediately following the October PECARN meeting, Venita Robinson will be traveling with Give Back Cincinnati to Peru to help in a local community by volunteering. Give Back Cincinnati is an amazing organization that organizes international service trips.

Milwaukee

Mark Nimmer, lead coordinator for the MAGiC study at MCWI, has been accepted into a work/study program at the Medical College of Wisconsin in pursuit of a secondary degree in IT Programming/Analysis. Mark is expected to graduate in December, 2013. Clinical Research Assistant Maura Coffey was promoted from a CRA 2 to a CRA 3 in recognition of her outstanding work. Maura is applying for medical school in the fall of 2014.

St. Louis

Mike Reeves joined the PECARN team in June 2013 as a Research Patient Assistant working with the MAGiC, FLUID and ASSESS studies. He previously worked as a Research Assistant in the Clinical and Translational Research Department at Washington University in St. Louis. Mike enjoys spending his free time cycling and golfing.

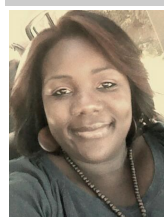


GLEMSCRN



Angie Thelen is a new Research Coordinator at the University of Michigan. Angie started working with PECARN in May 2013 after graduating from U of M with a degree in Microbiology and a minor in Medical Anthropology. In the future, she hopes to attend medical school to become a physician and clinical researcher. When she's not in the ED enrolling patients, she enjoys travelling, hanging out with friends and family, and baking!

NRC



Sametria McCammon, MSPH, recently joined the EMSC National Resource Center as a Program Coordinator working with the PECARN and Targeted Issues grant programs as well as other EMSC-related research activities. Sametria has a Bachelor's degree in Biology from Fisk University and a Master's degree in Public Health from Meharry Medical College. She has research experience in disaster preparedness, diversity in the healthcare workforce, workforce retention and utilization of the emergency room for primary care. She has a passion for public health issues such as access to quality health care and maternal and child health.



Angela D. Mickalide, PhD, MCHES, is the Executive Director of the HRSA-funded EMSC NRC. She earned her Bachelor of Arts degree in psychology from Colby College and her doctoral degree in behavioral sciences from The Johns Hopkins School of Hygiene and Public Health. Dr. Mickalide has published 90 articles, book chapters and research reports, as well as delivered numerous keynote presentations and print and broadcast media interviews. She was appointed recently to a four-year term on the CDC National Center for Injury Prevention and Control's Board of Scientific Counselors and is a board member of the Society for the Advancement of Violence and Injury Research.



PRIME CHOP



The PRIME node would like to announce a change in PECARN leadership at The Children's Hospital of Philadelphia (CHOP). Joe Zorc will assume the role of HEDA PI at Children's Hospital of Philadelphia (CHOP), effective in October. Joe has been involved in PECARN for many years, particularly as a lead investigator in the Bronchiolitis study. Joe is Director of Emergency Information Systems at CHOP and his primary research interests are asthma and bronchiolitis.



Also new to the node is Allison "Allie" Mak, a CRC at CHOP who has taken over primary responsibility for coordinating the FLUID study there (with many other secondary responsibilities). Allie has hit the ground running!



PRIME PCMC



J. Dillon Stephens BS has been working as a Research Coordinator for the University of Utah Department of Pediatrics since March 2013. Before that he worked for the department as a research assistant in the Primary Children's ED beginning January 2012. Dillon graduated from the University of Utah May of 2012 with a biology degree and chemistry minor. Dillon enjoys outdoorsy stuff and sports almost as much as a good nap. His vices of choice include Sour Patch Kids, Twinkies, and Mountain Dew. He also loves motorcycles; even more than the leg they cost him. *He does have 2 eyes and one robot foot.*



Michael Dela Cruz has recently joined the Division of Pediatric Emergency Medicine as a Research Coordinator this year. He has participated in several Pediatric studies in the Emergency Department of Primary Children's Hospital and is currently one of the assistant coordinators for the DKA Study. Michael has graduated from the University of Utah with a BA in Middle Eastern Studies and is one of the first students to receive a Pediatric Research Minor. Michael moved from Saudi Arabia 11 years ago and has a passion for languages, CrossFit, and Game of Thrones.

PRIDENET

PRIDENET would like to congratulate Dr. Robert Hickey on the imminent October arrival of his first grandchild! Hasbro RC, Rosalie Berrios-Candelaria, has a new nephew whom she adores! Speaking of new additions, the node welcomes three new RAs: Anthony Sciulli of UPMC and Shivany Pathania and Darin B. Chheng of Hasbro. Anthony is a sophomore at the University of Pittsburgh studying physical therapy. He is also a certified EMT. Anthony started with PECARN as a student and became such an integral part of the team that we invited him back! Shivany is a recent graduate of Boston University. She plans to attend medical school in the future. Darin is a graduate of the University of Rhode Island with a double major in Biology and Kinesiology and plans to become a PA.



Shivany Pathania



Anthony Sciulli



Darren Chheng



PEM-NEWS



Rakesh Mistry, MD, MS recently joined the Children's Hospital Colorado, as Associate Research Director for the Section of Emergency Medicine. He chairs the PEM Interest Group at the SAEM, and is a member of the Steering Committee for the PEM Collaborative Research Committee. His personal interests include skiing, hiking, cooking, and football; he is a 20-year season ticket holder and die-hard fan of the Rutgers Scarlet Knights football team.



Eric Sasine, BA is an RC at Children's Hospital Colorado this July. Eric has collected data for five studies at Denver Health as part of a seminar through the University of Colorado - Boulder. Eric graduated from the University of Colorado - Denver in 2011 with a bachelor of arts in history. Having finished his pre-med coursework this May, Eric is now applying to medical schools for 2014. When not studying or working, he enjoys hiking, camping, long-distance cycling, and spending time with his fiancée and family.



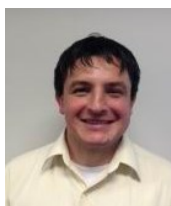
Hang Phan, BS has worked as a research assistant at Children's Hospital Colorado since 2013. Previously she worked and interned at the Barbara Davis Center for Childhood Diabetes with the TEDDY (The Environmental Determinants of Diabetes in the Young) and DAISY (Diabetes AutoImmunity Study in the Young) studies. Hang enjoys hiking, camping, playing guitar, and watching football.



Paul Pokrandt, BS is a new research assistant at Children's Hospital Colorado. Paul studied Economics and Chinese at the University of Colorado in Boulder, and he aspires to be a physician specializing in pediatrics. Prior to working at CHCO, Paul spent three years working in finance. In his free time, Paul enjoys fishing, hiking, running, snowboarding and reading.



Jennifer Arsego, BS is an RC at Columbia University Medical Center, and has previously helped screen and enroll patients into PECARN studies. Originally from Connecticut, Jen completed her bachelor's degree in business at Seton Hall University and moved to New York City five years ago. To de-stress, Jenn loves running and recently completed a half marathon. Jenn is currently a post-baccalaureate student at Columbia University and is working on the ASSESS study.



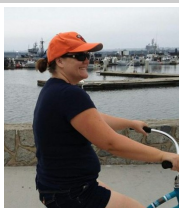
Erick Villarreal is a new RC at Texas Children's Hospital. Being a Medical Doctor from Bolivia, Erick has worked in the clinical research field for several years. He is passionate about medical field advances and is especially interested in infectious diseases. In the future, he hopes to apply to a residency program. He trains and competes in Brazilian Jiu Jitsu, is an avid reader and chess FIDE ranked player. He enjoys a good brew with great Texas BBQ, all without leaving behind his roots of a fantastic South American "parrillada".



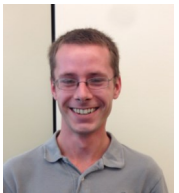
Paul Johnston, MPH is a new RC at Columbia, working primarily on the TBI-KT project. Paul hails from Memphis, Tennessee, but has been in New York for two decades. His favorite thing about NYC is being able to walk just about everywhere – which usually involves finding pizza. Paul hopes to attend medical school and possibly specialize in Emergency Medicine. Paul's hobbies include SCUBA diving, competitive shooting, motorcycle riding, and baking (he makes key lime pies for upscale restaurants in the NYC suburbs).

See *THIS* Edition of the
PECARN Newsletter online at:

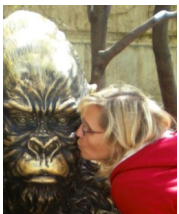
www.pecarn.org

Data Coordinating Center

Marci Fjelstad is a new (again) Project Manager with the DCC. She left the DCC about a year ago for a different position inside the University of Utah & is now thrilled to be returning to the DCC & PECARN. Marci will be leading Probiotics and Registry. In her free time, Marci chases her dog Molly around, hikes, snowboards, kayaks when she can, and laughs a lot.



Tim Simmons, MStat, has been with the DCC since 2011 and began working full-time as a statistical analyst there in May. Within PECARN, he is involved in the Biosignatures, MAGiC, KT and ASSESS studies. Aside from statistics, Tim enjoys traveling and improvising on the piano.



Amy Watson is another new Project Manager with the DCC. She has been with PECARN as a research coordinator at Primary Children's for over three years & is now thrilled to walk the rest of the way down the hall to work with the DCC. Amy will be leading FLUID and TBI KT II. Outside of work Amy is very busy with her large family. If Amy ever has any extra time after juggling all her family's extracurricular activities, she also enjoys hiking, reading, paddle boarding, and soaking up the sun!

WBCARN

Dom Maican originally joined the CNMC PECARN staff in May of 2012 as a Research Intern and was promoted to a CRA position in Fall 2013 to coordinate the ASSESS study. He currently attends the University of Maryland where he studies Chemistry and will graduate in May. When not at CNMC or school, he is very involved in the DC and NYC classical music scene and frequents the DC area parks with his two dogs – a Siberian Husky and a German Shepherd.



Jackie McKesey recently joined the CNMC Staff in June of 2013 as the Research Coordinator for the Fluid Therapy in DKA Study. She graduated from UCLA in 2012 with a Bachelor's in Physiology and Minor in Spanish. She recently received her Masters of Science in Physiology and Biophysics from Georgetown University and is currently attending Georgetown to receive her Medical Degree. She has a 3 year old daughter who she enjoys playing with in her down time. She also loves to cycle, bake cookies, and spend time planning her upcoming wedding.



Joanna Westerfield joined the CNMC PECARN staff as a Clinical Research Assistant in August 2013. Though she graduated from the University of Pennsylvania with a BA in Modern European History and an unexpected love for the liberal arts, Joanna has always had her mind set on a career in healthcare and one day hopes to become a Physician's Assistant. In her free time, she loves kickboxing, discovering coffee shops, and trying new recipes. Joanna is the primary research coordinator at CNMC for the MAGiC study.



Kim Wells joined Lurie Children's Hospital in Chicago as a Research Associate in June 2013. Kim is a graduate of Bryn Mawr College and a recent transplant from Philadelphia where she got her first taste of PECARN as an Academic Associate at CHOP. Kim lived in Japan after college and enjoys traveling, rock climbing, and exploring her new city.



Laura Turner joined the Lurie Children's Hospital as a Clinical Research Assistant in June 2012. Laura is a graduate of Florida State University and is currently pursuing a Masters of Public Health in Epidemiology at the University of Illinois at Chicago. In her free time, she loves backpacking, playing kickball, and exploring the many amazing food establishments in Chicago.