

## **MCHB/DPSWH 2004 Webcast.**

### **MCHB Poison Prevention and Control: Collaborative Opportunities for Programs**

#### **Serving Children - Part 2**

July 1, 2004

MAXINE JONES: I'm Maxine Jones. Thank you for tuning into our webcast. We'll only hear and see the presenters today, we will not have slides. Just a couple of things for the new commerce, the ones that didn't get a chance to tune in yesterday, as far as the question and answering, you may ask questions any time during the presentation by clicking on the questions for speaker scroll. Scroll down, type out your question and hit send. You can do this any time during the presentation. Unfortunately we aren't able to answer your questions today but we will answer them if you can just -- we'll have those answered to the next two weeks or so. On the left interface of the video window that's where you would adjust the screen with the volume control slider button. Those of you at the beginning of your registration, if you selected accessibility features, there will be captioning underneath the video window and that's about it for the webcast users.

At the end of the broadcast we will have an online evaluation. If you could fill that out to help us prepare for future webcast presentations. Your first speaker will be Sue Kell on outreach and education.

SUE KELL: Good morning. Our group discussed education and outreach and our members included Daniel, Jim Murray, William, Jen, Katie, Rose Ann and myself. Our

group members came from many different backgrounds. We had the Department of Health safe kids. American Academy of Pediatrics. The American Association of Poison Control Center and Maternal and Child Health Bureau so we had a variety of folks in our group looking at education and outreach. Maxine has asked me to give a definition of education outreach, which I'll do. And this is the transfer of poison prevention and awareness to groups of all ages and stages. And all socio-economic and cultural groups. So the education outreach group did not address each IOM or Battelle recommendation but rather we were given a set of questions and provided input on each of these questions. Here they are. Number one, what are some additional outreach and education programs that will cost little or no money? Two, how can we identify best practices in the area of collaborating on education and outreach? Number three, how do we successfully coordinate our centers with public health entities. Number four, how can education and outreach address cultural competency issues? I hate to complain, but this was really hard.

As you probably all know, injury prevention is a very difficult thing to measure. I recall reading an abstract recently that was evaluating abstracts from the World Health Organization and it said that less -- had outcome evaluations at all. And so I think in the injury prevention field when we look at positive outcomes, they are very few and far between and really difficult to measure. It takes years to realize the yield of prevention programs. I think we're all committed and dedicated and know that education is a good thing. But it's just difficult to measure. Wouldn't it be great if we could teach children from a very early age to be poison safe so that we wouldn't have to continually educate them

through all of their stages of life? We teach kids successfully to brush their teeth, have good manners and keep clean. Why not teach them to be poison safe as well?

Our topic was very hard because poisoning is a much bigger problem than anyone realized. Maybe even bigger than some of the poison folks realized, actually. When you look at the E-codes and count up all the poison deaths and injuries we find that poisoning is the second most common injury category. So when we were looking at our first question about trying things for little or low cost, additional programs that would have little or low cost, we started to list things and we had to sort of do time out. Let's talk about just for a few minutes who poison educators already do. So I'll give you just a little short background. Poison educators and Poison Centers transfer their messages to the public in four ways. Number one, they perform public education presentations. And this includes health fairs, talks, and workshops. Number two, they promote media contacts. So media of all types, newspapers, radio, TV, magazines and whatnot.

Number three, they mail education materials out to many groups and individuals for their own personal use and for distribution. And number four, they maintain poison center websites so these websites have downloadable information sheets, they have contact information and in some cases online learning. A little more background here. Many Poison Centers have regular contact with agencies. So they contact service areas hospitals in their region, health departments, safe kids coordinators, Red Cross, libraries, public schools, police, fire and rescue, insurance companies, pediatricians and family medicine physicians, nurses organizations including school nurses, childcare providers,

nursing homes, senior centers and extension agents. I'm sure there are many more but that's the list we came up with. In answering question number one, because poison center educators have been faced with low funds for so many years, we have done many programs that actually cost little or no money already. The low-hanging fruit has already been picked. And things like including education materials in someone else's large mass mailing.

Using areas in physicians offices in emergency departments and using public service announcements. They aren't paid to -- we don't have to pay for the public service announcements. It does cost to develop them, but, you know, of course, the air time is not what we would like all the time. So our group started to talk about things that we might be able to do. And one was train the trainer program. Do you remember the movie, "pay it forward" where a good deed was done and then that person goes out and does good deeds for three people and those three people go out and do good deeds and on and on it goes? It really multiplies and moves forward. And that's the basic concept with the train the trainer program. These programs could be very useful and are used already in many Poison Centers. These could be used for training other injury prevention coordinators in the injury field. They could be used to train new poison educators and bring them into a baseline knowledge of what poison center outreach is all about. We could have these programs developed in a number of formats so that they could be conducted live, online, in print or even through video. And, of course, we would really want these programs to be valid from an education model. We probably would need to have an instructional

designed professional develop these programs with the input from the other programs that are already out there.

There are many very good ones. And I think it's very important our group discussed to have programs that have been evaluated up front so that we don't -- we can avoid some of the mistakes of performing a program that hasn't really been tested. Number two, the second question we looked at was how to identify best practices in the area of collaborating on education and outreach. So really why reinvent the wheel? There are many wonderful poison education programs already in existence. And we have started an archive of some of these programs already. But we certainly need to continue that archiving process. Our group felt like best practices could be identified in this way to take chunks out of the programs that are really wonderful and put them together into a program that could be used on a national basis. And we're looking at programs for all ages and stages again. And we still do need local materials. There is no doubt about that. The problems that we might have in Florida differ from those in Arizona, for example.

So we really do need local programs but we need some national programs as well and we certainly have started on that. We have many wonderful national materials. Another thing is to link educators to other educators who have had success in the area of injury prevention. We might look to experts in these fields, folks with the heart association, diabetes, the health department. Some other ways to identify best practices, some of these actually are answers to some of the other questions. It was hard to really separate some of these out. We might use television more. There was a national group that

looked at -- a focus group, that's what I was trying to think of -- where the participants in the focus group suggested that we use TV more.

As you all know, television is a very powerful thing. It's expensive, though. When we're talking about low cost, television is not that. I think that we haven't really tried a national television campaign and that would be something to definitely work on. And it's on our wish list. Also we might look at gaining some information from a national survey like the national household survey. I know it takes time to get questions on that survey, but we could find out some really good information that way. And another thing that came up was in states where Poison Centers don't exist and they contract services from other states, it would be nice to have a checklist of baseline poison prevention activities so that these states who receive phone coverage, but not necessarily have education coverage, would know exactly what really needs to be done in a baseline education provides on prevention program.

OK, our third question was how do we successfully coordinate our centers with public health entities? We just wanted to say that our group really wants to embrace any type of partnership with public health because partnerships work. It's a great way to spread our messages. One thing that I think that we could do to help this would be to have a shared language. Public health injury prevention specialists have a language that poison prevent educators don't necessarily have. And we might pull together, you know, folks to come to the national meeting at the North American Congress of clinical toxicology to share with the educators. We already have some folks in this area within our group of poison

educators but really focus in on that a lot more. And also I think we need to keep abreast of high-risk areas. We certainly have focused a lot of education on kids under six years of age. And certainly calls to the Poison Centers involve that age group in about 50% of all the calls. But we know that morbidity and mortality is highest in other groups. So we need to really make sure that we are identifying those groups and targeting them. And our last question was how can education and outreach address cultural competency issues?

We discussed the national materials and even local ones and when we asked the question, are current national materials or local ones culturally competent for the most part we say no because the language translations don't always address all dialects of a given language and so, you knowing it's hard to address everyone. We really need to first start with identifying primary language needs. And I think the other thing is to have awareness built among educators and other members in the poison world. And we recently had a meeting in New York, actually, the northeast regional educators meeting, where cultural competence was discussed. And I think that we have touched on this at our national meetings but we certainly want to keep looking at that issue and raising awareness and moving forward from there.

So that's really the end of my presentation. But I wanted to let folks know, who are listening today, that now is the time for you to put your input in on these four questions. Please let HRSA know your input. Our group did the best that we could in the time allowed and it was really wonderful working with this group. They were all very helpful and we're a team now and we did some good work. But it's not complete. And we hope

that the folks out there listening will help us to complete this. Thank you very much. Are there questions?

MAXINE JONES: I have the Mike and I'll ask you to repeat the question, Sue.

SUE KELL: Did you have a question?

MAXINE JONES: Sue, when you talked about culture all competency and what you could recommend for HRSA to move that forward. In addition to putting materials in different languages, did you also talk about that cultural competency encompasses more, such as making sure that if you understand a different group, that the way that they receive information might be different so you would have to not only change the words on the materials, but perhaps change the way the message is delivered?

SUE KELL: Well, it's hard to get really in depth on some of this. The question really was did we address cultural competency in written materials, in changing the wording, not just -- is that-

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MAXINE JONES: Not just the wording but how –

SUE KELL: [inaudible] Yes, yes. How a group receives the materials and how that relates to cultural competency. We did discuss that and how it might be nice to have a video

rather than printed materials in some situations. Can you think, Sam? This is our question answerer here.

SAM: We really did try to address that, although certainly the limited time didn't allow us to drill down very far. But the recommendation to increase awareness among poison center educators and begin the discussion of what all the aspects of cultural competence are, that really went to that. We didn't get down to detail but felt that the need to begin a very long discussion about addressing issues of cultural competence needed to start with increasing understanding and awareness among the educators and that was one of the issues that we recognize needs to be addressed. Well, we didn't get down to talking about the need for resources but clearly we felt that I think one of the recommendations that the group came up with was that there needs to be education provided to poison center educators in the form of maybe a workshop at the North American Congress of clinical toxicology this morning.

Our group didn't get a chance to get to this level of detail. Information in the newsletter that specialists in -- that health educators use also in an ongoing information through some other format, web base, possibly, recognizing you are not going to -- you are not going to resolve even the issue of educator awareness and understanding of the issues with one four or eight hour workshop at a national meeting.

SUE KELL: As sort of an additional comment, I think these recommendations kind of fit together. We did discuss a little bit the observation that the variety of cultural approaches

even down to the neighborhood level is something that is going to be very hard to achieve from just the poison center educators' direct intervention but that many state and local health departments and hospitals and other entities have outreach workers and educators that may relate to a particular Dominican community or southeast Asian community or another community in that neighborhood so they have Co-oping that and getting that message to that community, at one removed. I would just like to also emphasize the conversation we had about the household surveys. BRFSS is the most obvious but there are several other opportunities. Because that is an established and really very powerful capacity to measure current State of knowledge about poisonings, about access, etc. And to measure the effectiveness of what we do, at least over time in the different states and jurisdictions and we think that's an opportunity that could be captured fairly easily with a couple of standardized questions and I suspect our member from the CDC national center world will talk about that, too.

STACY HARPER: I'm Stacy Harper from the CDC. When we're talking about low cost it might not be the way to go. Some may not be aware that every question costs money on that. When you add questions, just for our own education here, since we're in that group, every one of those questions that is added costs money. It's not an inexpensive thing to do. I've been in several centers throughout my career in CDC where we didn't have the money to add questions or could only add three. Just as an educational point.

>> Thank you for your presentation. I was particularly interested in the collaboration issue with state and county health departments and what your vision was in terms of addressing

the IOM point regarding what they thought was the importance and utility of the collaborations. And particularly, I would like to hear perhaps from some other here. Are Poison Centers supposed to knock on the county and health department's door to foster collaboration or should we wait for the county and health departments to knock on our door? How do we foster that? And can the recommendation of the IOM be met? I realize there has been a lot of discourse about that, a lot of concern among the poison center community particularly about their recommendation in public education. It's not my sense that in the past the county or state health departments have been knocking on poison center's doors saying please collaborate with us and educate us. The message now is somehow to make this better we need to collaborate with them. And how do we do that? How do we even go in that direction? How can HRSA help, if at all?

SUE KELL: All right. The question is about how the collaboration with the public health entities would work. And I don't know the answer to that question. But I know a lot of people have ideas about how that would work. And, you know, certainly we do -- poison educators routinely contact public health departments. Sometimes even in local poison center train the trainer programs there are individuals from the health department at the train the trainers. I see myself, my personal opinion, I see a collaboration there. Not to get rid of one or the other, but to work together. And as our committee discussed, we embrace this partnership. Can only get stronger through that. There are things that the health department does very well that we're not doing. Or maybe not doing as well as they do. And they can certainly learn from us the things that we know about poisoning. So, you know, that it is a larger problem. Maybe, you know, as we have seen a lot of

agencies don't realize what the big problem it is. And, you know, that may have been way back when, why Poison Centers actually got going and were a separate entity from everyone else because it was kind of a specialized injury.

>> Sue, you did a nice job in illustrating all the different groups that Poison Centers work with. That's an important message. I think a lot of the anxiety I've seen over this issue has more to do with distribution of the message and getting it out to the public and so I think a very important role that was overlooked and maybe the most important role that was overlooked by educators is development of programs. And I think -- I really think the responses, you've kind of cut yourself short. This is not a criticism, just a comment, but I think you failed to really let people know all the work that educators do in really developing programs. I don't think dissemination of the message is as important as developing the message. And I think that's the most important thing that educators can do and then to facilitate dissemination of the message. That to me is the core of the educators, from my perspective.

SUE KELL: And I think, you know, many times people don't realize what goes into developing a program. You're absolutely right. It's a very systematic approach to program development where you look at the needs of the target population, their testing pre and post. There is lots of work that goes on which I was reminded of last night when I was putting my Power Point together. Not that that's anything comparable but we really do need to use a systematic best practices approach to developing programs, you're absolutely right. And that's what the public education committee conference is all about.

When we have our annual meetings at the North American Congress of clinical toxicology we talk about how to develop programs, how to evaluate them, how to do needs assessment, how to do surveys, how to analyze data, all kinds of things like this. So thank you for bringing that up.

>> Sue, you mentioned targeted audiences. And I guess, you know, when you're in a government agency cost benefit is the big buzz and assessment of that. So the effectiveness of the message. Did the group talk about who are the targeted audience where you can get the best bang for your buck? You talked about suggestions, half the calls being children under six but did you get into that where you think the primary education should go in order to be most effective?

SUE KELL: The question concerned targeted audiences and the cost benefit issue. And how we would identify the audiences we wanted to target. We did talk about that a little. You know, certainly as we said, half of the calls to Poison Centers are about kids under six. We don't want to lose that audience. We don't want to lose that population that is calling the poison center because it is an important audience to work with parents and, you know, as we said, to make children aware from a very early age so they can take that knowledge on with them to adulthood and senior citizenship. So we talked about that. We also talked about where the highest morbidity and mortality rates were and targeting those audiences. Do you have anything to add on that, Sam?

SAM: Sue, I guess we didn't have a chance to drill down quite that far once again. As Sue said we addressed some of the more global question but recognize the needs in New York City, Washington and Los Angeles and New York City may be different from Ames, Iowa and differences at the individual state or whatever region is covered.

>> I have one quick question. You mentioned you have four common roles and Ed gave us an additional role that has been overlooked. Are there any other roles that educators have that may be overlooked and that we should know about?

>> Yes. This was a question about the roles of educators and the four areas that I identified are products. So we didn't really even list what goes into developing those products. So there are many roles that the educators do that we just -- it would take us a while to even get into all of that. We certainly, you know, could discuss that.

>> Again, this is a little anecdotal but again speaking for the New England regional poison center. The educator who was most involved in expanding outreach and education in our part of the country has since become effectively the center manager. So that if you redefine the activity as more than just managing a struggling little component of a hospital and make it a significant piece of a much wider world relating to practice and to public health and such, the educators often seem to have much to contribute to that.

MAXINE JONES: Thank you. Well, we have pretty much run out of time for the first presentation. Sue, we thank you so much for a great presentation. And the next presenter will be Rich Weissman presenting information from the certification group.

RICH WEISSMAN: Good morning. I would like to welcome the folks from the west coast. I'm among those in the room recognizing that you guys have just realized slightly after 6:00 a.m. in the morning. So that for those of you with us, we are most appreciative. I would like to start out by thanking HRSA for convening this stakeholders meeting. It has been a wonderful opportunity to exchange a lot of very interesting concepts with colleagues from throughout the United States. Our particular questions had to do with certification and the committee, which included myself, Paul, Jessica, Milt and Chris had a very interesting discussion about certification and certification issues. And certainly you probably all recognize from those that know us that it was not a particularly concordant group. We had a lot of discussion and disagreement but we had discussion and agreed upon some very basic concepts.

The first question we addressed is should HRSA encourage an alternative certification process for Poison Centers and if so, how? I tell you, what a difficult question to really answer. I think that most of us believe that an external type of certification would be an extremely good thing. What we did was, we took a look at the current certification process that is run by the American Association of Poison Control Center and took a look at its history and it dated back to the early 1980's when there was a need to separate out Poison Centers that were nothing more than a telephone and a book in an emergency

department from this new entity that was different. A room with health professionals that were 100% dedicated to provide answers to public and health professionals. What needed to be done was to be able to recognize that there was a level of competency that was needed for someone to call themselves a Poison Control Center.

As many programs that grew up through the American Association of Poison Control Centers. It had a problem. Because it was an organization of poor Poison Control Centers. They had to do their certification process basically on a shoestring. And that is often what we have at present is a group of people that work extremely hard but are very much volunteers. And it is a peer review process. We were talking about moving to a totally different type of certification with an external group. Someone that was no longer affiliated with the Poison Control Center. Someone not linked to any of the board of trustees of the organizations. However, as we began to discuss this, we realized that there were a couple of problems that would be very, very difficult to overcome. Number one is that this would be an extremely expensive proposition because what would be required would be to travel people, to get them together, to probably pay for their time and this could be a fairly costly operation. So that the conclusion that we said is that yes, external certification is a very good thing, but it should not in any way reduce the current or future federal funding that is going to be coming to Poison Control Centers. What this would require would be one of two things. If it is going to happen prior to 2009 when our current reauthorization runs out is that this would actually require an amendment that would allow for an additional authorization of dollars to be put back into the system that could pay for this external certification. We would also want that in the future legislation

that hopefully will go forward and fund Poison Centers that this is going to have to include money for an authorization that would be above the \$100 million. If you take a look at the IOM study, certification is not one of the core competencies. We would need to have money above the \$100 million authorization before we can really get into external certification. When we were finished, the majority of the committee concurred with the IOM study that external certification was certainly a desirable process and that we should move in that direction. As a committee, we had some difficulty in trying to work through some of the nuts and bolts. And the small group that we were really were unable to identify a group that we felt would be qualified at present to be an external certification body. One of the recommendations that we would offer up to HRSA was that we believe that research should be conducted to determine if a qualified group exists, or if possible, if this group can be found, to have them brought before or to present or discuss at one of the future stakeholders group. If we are correct and there doesn't appear to be a qualified certification body, then it may be necessary to form a totally independent group. And we went through and began to look at some of the characteristics that we believe would be very desirable for members of this new certification committee. We thought that the committee size should probably be around ten people and that the majority of members should have extensive Poison Center experience. It will be very difficult for someone not involved with Poison Centers for a fairly large or long period of time to relatively understand the complexity of why things are being done at present the way they are. Many of the things that drive Poison Centers are financial and many of the steps or changes that have occurred have been based upon best practices that have been determined over a period of about 20 years. We felt that other members on the

committees should be predominantly healthcare professionals. People that might be users of the Poison Control Centers or people that have intimate contact with the activities of the Center. We also felt that one of the major advantages of getting an external certification body would be to reduce any possibility of conflict of interest or bias. And we felt that it would be important to stipulate that no member of the current board of trustees of any professional organization that has any affiliation with poison control centers should be allowed to serve on this certification process. The second question that we were asked, we felt was a lot easier and could be answered very briefly, and that is should HRSA increase its effort with the certification grantees, which would be the non-certified centers in the remaining funding months. The answer to this was a clear yes. The certification grantees have all had to develop a timeline and a plan for achieving certification. It's in everyone's best interest for the certification grantees to succeed in achieving certification. We need HRSA to work with them to make sure they stay on time and at the end of their road do become certified as quickly as possible. At this point I'll entertain any questions.

>> Thank you very much for that. My question has to do with question number one, and while we don't have that back to actually look at, I'm a little unclear as to why an outside certification process might have the potential of taking funds away from existing centers. I'm not sure if the implication is that an outside certification process might cause for centers to lose that certification with an outside process and therefore they would not be eligible for funding, or if it was just simply that each of the centers would lose some money if they had to put money into the certification process starting up.

RICH WEISSMAN: The current cost of getting a poison center certified in the United States is approximately \$500. This is a relatively inexpensive amount of money considering that the certification lasts for five years, roughly \$100 a year. If you take a look at what it would cost to bring together a panel of ten experts, probably on four or five different occasions during a year in which you have to certify approximately one-fifth of the group each year, recertify them based upon reviewing their annual report every year, we're talking about a considerable amount of time and a considerable amount of travel. One of the things that the American Association of poison control centers has been exploring over the last couple of years are the benefits that would be derived from on-site visits by this inspection group. And we feel that if we're going to change the certification process, it would be best to change it to what we believe would be the best possible way of certifying centers and that would be to move from a paper application to a combination of a paper application and then having a panel of two or three people travel to that center, meet with the directors, see the functionality of that particular center, and then offer an evaluation report back.

If you take a look at just some rough cost estimates of what this would be, it's probably in excess of \$200,000 to \$300,000 annually. That's a fairly large amount of money to what is presently being spent. This money would have to come either from Poison Control Centers that are currently fiscally strapped and unable in many circumstances to come up with this money, or it will have to come from the new dollars that hopefully will result from the IOM study. Now, the IOM study did not have certification listed as one of its core

competencies. It would have to be dollars put into the legislation above that of what has already been allocated. And I think that what one of the feelings of the small group we met with is that certification is a very important component of running a Poison Center community within a country, making that that certification process is as polished as possible is going to be critical for the valid -- validity of that process. It doesn't come inexpensively and it will require a significant infusion of new dollars.

>> As a follow-up question or comment, I completely agree with you that excellence and validation does cost money. One model that folks may want to look at is what the ambulance industry throughout the United States did 15 years ago when they elected not to allow their trade association to start up a national accreditation process to allow units of government to contract with perhaps the better ambulance services. They started an independent commission on accreditation of ambulance services and it has many of the features that you and your committee have talked about. Trained, on-site reviewers. Staff that conduct off-site reviews and a panel of commissioners who meet several times a year and make the judgments. That might be a model to look at. It does seem to fall in line with exactly what you and your group envisioned yesterday.

RICH WEISSMAN: I think one of the things that is kind of an important concept is that throughout this meeting we've been looking at ways of doing things as inexpensively as possible. This is an area where you clearly do not want to cut costs. It is an area where you want to make sure that you're putting your best foot forward. That you're doing the job at the highest level you possibly can because the implications of either certifying a

center that should not be certified, or even worse, not certifying a center that should be is really devastating to the community that is served by that Poison Center and clearly this is an area where all the money is needed to do the job directly needs to be invested.

>> Rich, actually, your last point was a good segue to my question. Did the group grapple at all -- I use that word because I think that's what you would do -- with the issue that although there are significant costs, that setting those funds aside would actually have such significant downstream benefit that it's worthwhile to take them from an existing appropriation or even within the recommended \$100 million recommendation?

RICH WEISSMAN: I think that there are really two possible answers to that question.

Clearly, if and when the \$100 million appropriation becomes available, if it's the only appropriation that is received, will probably enhance the funding streams at the level of the local poison center to the point where a substantial increase in certification costs could be passed on to the Poison Centers and the Poison Centers would be able to bear that cost. If we were to take a look at today's finances in the Poison Control Centers where it really is a day-to-day existence. Where survival is often measured in days as opposed to years based upon the number of dollars that are available, if one were to take a look at the implications of charging \$25,000, or \$50,000 to certify a center, what we're talking about is an FTE. What that FTE translates into is that center often being able to stay open or not. So that I think with the current authorization and appropriation of dollars, there clearly is not a mechanism that would allow this to be funded that would improve upon the system as it exists today. We clearly need to be looking forward to future authorizations and

appropriations and to make sure that this is a component and that it's dollars that are put aside but certainly not dollars that right now are taken out of a wallet that is virtually empty, which is our Poison Centers today.

>> Again, thank you for the informative presentation. Regarding the question of whether HRSA should continue to work with the non-certified centers in seeking certification, I think we all agree that it's very important that we continue that and we've talked in depth about the importance of certification. But did the committee consider an endpoint to that support for centers that continue to not meet the certification obligations?

RICH WEISSMAN: As part of the current legislation, Poison Centers had a finite period of time in which, upon receiving the grant, they had to meet certification criteria. Clearly, unless there is some prevailing reason why that was not able to be accomplished, if a center at the end of their certification grant fail to comply with at least the current certification criteria they have, in essence, defaulted with their commitment in that certification grant. I can speak of the kind of difficult situation we've had during the past legislative session when we went for reauthorization of the current Poison Center law. A lot of people objected to the fact we had in our initial go through Congress defined a finite period of time for three years for these centers to become certified and all of a sudden we're going back and saying let's add another two. Well, we felt that was necessary because when the dollars were authorized it was very different from when they were appropriated. We initially asked for \$28.6 million to be paid and it wasn't even until the last year of that appropriation that we even approached \$22 million. The first year the

centers received only a tiny percentage of the amount of money they were supposed to get and it was very, very late in the cycle. The second year they received slightly more but it clearly did not give them the full opportunity of three years of funding to move forward. So that we felt that by adding an additional two years and maxing it out at five, that this was a reasonable period of time for a non-certified center to be able to achieve the minimum criteria to become certified. So that again, our committee didn't spend a whole lot of time on this question, but felt that it was very important and would encourage HRSA to provide all the aid and assistance they can to the non-certified centers so that they're able to comply with the terms of their grant and at the end of that time period become certified.

>> I have a quick question, Rich for clarify indication. You believe the cost is \$500 and that covers what exactly?

RICH WEISSMAN: That's the certification application to have the center certified once during that five-year cycle.

>> OK. And does that include any cost to travel your experts in or for your peer review?

RICH WEISSMAN: It does not. The way that the American Association of Poison Centers have been doing this is one of the major certification meetings is held concurrently with the North American conference of clinical toxicology so often the experts and Poison Centers are there. The certification committee usually meets at one other time during the

year. Often to coincide with the mid-winter board meeting so a lot of the individuals are there and then the only travel that is required is to be -- to bring the non-board members that are members of the certification committee together. So that it's been a very, very difficult and often awkward system because they are trying to do it on a shoestring. And I think that people are beginning to realize that when you cut costs invariably you'll cut quality. I think there is a definite need to move forward and to do the job correctly.

>> Your group suggested we pick a group of ten people. How many people currently sit on the panel?

RICH WEISSMAN: I'll ask for some help on that. Ten.

>> Why is ten the optimal number? Before you proceed with that, does that include a certain amount of toxicologists and others, or is it just something that—

RICH WEISSMAN: In the design that we proposed, we recommended that a majority of the people that are on the certification panel, or certification group, be individuals that have extensive knowledge in the workings of Poison Control Centers. Now, this was not to be at the exclusion of all others. We use felt that one less than the majority of people on that should be individuals that are knowledgeable of the healthcare or public health system. The so-called users of the Poison Control Centers and these people might have the ability to bring to the table expertise in areas that are outside of the four walls of the Poison

Control Centers so we felt that this would be a definite advantage to improve upon the system to bring in outsiders. The so-called stakeholders of a poison center, the users of a poison center as part of that evaluation panel.

MAXINE JONES: OK. Thank you. I'm going to ask the people on that side of the room.

[Inaudible]

MARK: Rich, good morning. As a -- I am often charged with delivering an orientation to new healthcare professionals that come to the poison center where I'm at and give them an overview when they're there for whatever reason, some orientation or a residency or fellowship or even just a rotation. And often when I get to the point of certification and certified centers versus non-certified centers I often illustrate that by the comparison of using the hospitals that are level one trauma centers versus those that are not. And both of us -- both Poison Centers and hospitals that are level one trauma centers must meet a number of criteria and if you fail to meet one of those criteria you aren't a level one trauma center. The American College of surgeons who does that, that would be another model for us to follow again. They also use three surgeons to do their site visits. And that would also allow us to envision or have an understanding of just what the cost is to go do those site visits. So again we aren't reinventing the wheel but using our colleagues as well.

RICH WEISSMAN: Thanks, Mark, good comments.

>> Rich, thanks good for a good presentation. Did your committee consider, in light of what I think is one of our missions here, is to think outside of the box. And two, to obviously be aware of cost, did your committee discuss or consider at all putting people who are impartial at this current process, who are impartial but yet have knowledge of a Poison Center, into the present process. Putting into the current committee perhaps three people who have retired from Poison Center work but still have no current stake in or conflict of interest in current certification so that we begin to gain some outside impartiality into the current process while we're looking forward to the future to a goal of perhaps moving it outside of the trade organization that we currently have?

RICH WEISSMAN: I guess the answer -- the simple answer is no because we were within the limits of about an hour and a half of getting together and going through a fairly difficult concept of even evaluating the benefits of external versus internal. Clearly, if two years from now or three years from now HRSA and the federal government are not able to come up with additional funding for certification process, the American Association and the board of directors of that organization have already defined as one of the areas that they are evaluating at present, the certification process. And clearly, if the dollars don't become available the American Association of Poison Centers will continue on a move to try to redefine and better the certification process, even without dollars. I think this is an ongoing process. So I think that all of these thoughts and recommendations can and will be shared with the certification committee and with the board of trustees or the board of directors and they begin to look at a better way of certifying centers. That's an ongoing process.

>> Thank you, Rich. That's been excellent. It was a good segue into my comment. The American Association of Poison Control Centers has begun the process to look at the entire certification process to see if that is something we should be continuing, something we shouldn't, something we should change. We need to look at that. We have been certifying centers for decades and it's time to step back and evaluate the entire program. That process has begun and I would welcome the input and participation of any of the stakeholders that have an interest in certification, please come and talk to me, talk to Kathy, we would love to hear your input and get you involved in the process as we move forward. Thank you for helping me with that. The question I had, though, was the Institute of Medicine study talked about both certification of centers and certification of specialists. Did your committee have a chance to talk about specialists at small

RICH WEISSMAN: We only talked about certification of specialists for a few minutes. It was a small microcosm of that. Clearly as we move to an external certification process, we would also move the housing and administration of that exam to that same group. We recognize that much of the question writing would probably still remain at the level of the local poison center and the final construction and evaluation and certification of that exam would then move forward to this new external body.

ROSEANNE: I have one quick follow-up to a response to an earlier question about the composition of the current certification committee. The current peer review process. For those of you who aren't familiar with our process I just want to emphasize the certification

committee right now a carefully constructed so that it represents the three professional disciplines that operate in Poison Centers, nursing, pharmacy and medicine. It includes the four primarily functional areas of poison center operation so it includes directors, medical directors, educators and specialist in poison information and it is additionally constructed so there is geographic representation as well. Thank you.

RICH WEISSMAN: Thanks, Roseanne. That was a great addition. I think we're just about out of time so thank you very much.

MAXINE JONES: My pleasure to introduce Doug Borst, the current president of the American poise centers.

DOUG BORST: Recommendations on data within the Institute of Medicine report. We were given some questions to get our discussion going that we worked through and as a result of working through those questions we were able to go back to the specific recommendations made by the Institute of Medicine and make some comments based on that. That's what we'll go through today. I apologize to everyone here. I don't have a nice Power Point presentation. I decided it was too much work last night at 9:00 to do a Power Point so you get a word document instead. Before I get started I want to thank Maxine for putting this group together. I really appreciate being asked to be part of it and I'm sure I could speak on behalf of the other poison representatives that are here. Thank you for having us here. I will say to the folks that are in Poison Centers taking part in the webcast that are watching this, that we will be reviewing this entire two-day meeting and you'll be

hearing about this either from -- directly from me in emails from me through poison line and on the association website, we'll be getting pieces of this throughout the next few weeks. We'll keep you informed so you don't have to freak -- you don't have to be scrambling to write notes over everything that is being presented today. We'll get it out to you.

So the first thing we were asked to do -- here is our data group. You can see the participants, Susan from the consumer product safety commission, Jerry from the EPA. MONIKE. Stacy Harper and Dennis Christian son from the CDA. Toby and myself from the AAPCC. And these are all a group that became apparent immediately that everybody in this group is very passionate about data and the value of the data that we have and very passionate about the need for good data in poisonings. We had a very, very spirited discussion and a very wide ranging discussion on all sorts of data at all different levels so it was enjoyable to be part of it. I want to thank the members of the break-out group for all their hard work. So thank you. The first thing we were asked to do as part of our charge was to define -- we should have a definition of what data is and what we're working with. We thought it was appropriate to go to the World Health Organization and define what surveillance is because it's what we're trying to do. The definition of what we're doing is the systematic, ongoing collection of data for analysis and dissemination. It is coming from each Poison Center, collected and systematically throughout the country collected nationally where it is analyzed and then disseminated.

I think we are working to meet that and we go back to that as we answer some of the questions. The first recommendation made by the Institute of Medicine is the CDC working with HRSA and the states should continue to build an effective infrastructures including bioterrorism and chemical terrorism. In the IOM report it's their recommendation number four. And one of the activities that is specifically mentioned by the IOM is that we do a structured review of tests and that -- we'll mention that as we go. We did come up with three bullets as part of our discussion. The first is that as I mentioned, this entire group was very passionate about data and we as a group support the Institute of Medicine recommendation of all hazard surveillance. All hazard meaning morning chemical terrorism or bioterrorism. It's important that we do environmental surveillance, it's important that we do consumer product surveillance, that we do all hazard surveillance. Like I mentioned, one of the specific activities that is mentioned in the Institute of Medicine report is to did a structured review. A structured review was performed by CDC staff performed last summer in 2003. That has been completed and filed with the CDC and it followed the structured review process that the CDC uses that has been published. And it is a recommendation of this group that that review process should be repeated as our surveillance efforts change in advance.

The surveillance that we do today with tests is different than what we did a year ago because we've made such advances so rapidly. And it's important that that review is repeated. So one recommendation is to go ahead and ask the CDC to repeat that at an interval that is appropriate for CDC. The second recommendation that was put towards us from the Institute of Medicine was that the secretary of HHS should instruct key agencies

to convene an expert panel to develop a definition of poisonings that can be used in surveillance activities including tests and ongoing data collection. That's the Institute of Medicine recommendation number nine. The IOM panel made the point the problem of accidental injury due to poisoning is far, far greater than what we're currently measuring and part of that problem is the very inconsistent definitions of poisonings that are in different measurement pieces throughout government and industry. So it's very difficult to get your whole arms around the problem because we all measure it differently and have different definitions and as the IOM stated yesterday, if we really looked at this and had a much broader definition of poisonings than we currently use, that there would be nearly as many accidental injuries due to poisonings as there are due to motor vehicle accidents which greatly elevates the need and importance for what we do every day. So the specific question we've been given and we did go forward and ask that HRSA, we've been asked to give direction to HRSA, that HRSA ask the NCHS and WHO to redefine poisoning. To work together so we can get a joint definition of poisoning and that HRSA further identify other stakeholders to include in that process, those other stakeholders would include the other government bodies, it may include researchers that are using poison data or injury data. It would include people in insurance industry that are interested in injury data. It would include the drug companies and other industries that may be interested in poisoning and injury data.

It's important we bring in as many stakeholders as we can as we define that. One modeled mentioned by the CDC is the traumatic brain injury program and also mentioned by the Institute of Medicine yesterday that they had a different process in defining brain

injury and it's maybe a model we can follow. That's a big issue, though. The third question that was posed to us is the Department of Health and Human Services should undertake a targeted education effort to improve health provider awareness of poisoning data collection as it relates to Health Insurance, Health Insurance Portability and Accountability Act on poison center consultation including follow-up. The Institute of Medicine recommendation number 10. And this is a HIPAA and the entire privacy issue is a thorn in every poison specialist, every tox -- toxicologist or people working at Poison Control Centers recognizes this. We're glad we're asking for some direction. What we'll ask HRSA to do is they should write a letter to each Poison Center that receives funding through our contract arrangements and designate each one of those Poison Centers as a public health authority. They can use that with local hospitals. In addition to that the CDC has been working on a frequently-asked questions about HIPAA, privacy and Poison Centers. They should complete that work that they're doing and that should be posted to benefit us. Then HRSA should communicate both of those, the letter that they're writing to Poison Centers and the frequently asked questions to every U.S. Hospital as well as working with other stakeholders like the American hospital association and posted on their own website so that the information that Poison Centers are not covered under all the strict privacy and HIPAA rules that are interpreted to our negative impact that we can remove some of that burden from us. Those would be our recommendations to HRSA.

The fourth point we were given is the director of the CDC should ensure that surveillance data generated by Poison Control Centers currently reported in tests are available to all appropriate local, state and federal public health units and Poison Control Centers on a

realtime basis for no additional cost to users. IOM number 11. Our group agrees that the poison data should be widely available to whoever wants it. The more it is used, the greater benefit it is to all of toxicology and Poison Centers. We want that shared and we want that to go out as much as we can. The biggest concern that we have is the burden, the current burden of data collection lies within the center and specifically on the specialists that answer those calls and input that data. And right now that purchase den - - burden is not recognized and we need to recognize it as we go forward especially in the area of financial instability of centers. So the recommendations we've made are first, that all test data should be fully available to local, state and federal public health units as well as all Poison Centers in all forms and in realtime. That there are some barriers to availability and the barriers include the inaccurate and inconsistent product database. We have trouble getting specific products at specific formulations to match up within our data. That the time and resources dedicated by Poison Centers to the collection of data is not being recognized. And the resources needed for maintenance, QA and development of the national database, that's another barrier that has to be recognized.

So the recommendations and policy changes that are needed is we feel there should be some legislation that require the notification of product formulations to some federal depository. The federal government needs to fund that database. We need to find additional outside funding to centers for the accurate collection of data. There have been time motion studies that show that about 25% of Poison Center time is put into collecting data. If we use the IOM recommendation of \$100 million and this is one of their core functions that translates to \$25 million should be put into this. That's additional dollars

over of course what we're already getting. Naturally that has been to be verified by additional time/motion studies. And then HRSA would be able to, in their contracts, be able to require data quality and some kind of QA on behalf of the centers submitting data. We need to find additional funding for the ongoing maintenance and QA of the national database. Our fifth charge was federally funded research should be provided for studies on the epidemiology of poisoning. The treatment and prevention of drug overdose. Health services access and delivery.

Strategies to improve regulations and facilitate researchers input into regulatory procedure and five the cost efficiency of new poison prevention and control system for general and specific poisonings. The Institute of Medicine recommendation number 12. We believe that more research is needed and needs to be done on all levels. The Institute of Medicine made that very clear and anybody that has worked in toxicology for any number of years recognizes that also. Our recommendations at HRSA should work with the CDC to help secure additional outside funding to conduct that research and CDC has been willing to conduct some broad based research on the epidemiology of poisoning and take the lead to that. The last thing we were asked to do is to prioritize our feeling or our points which was data in the bigger picture of all the other points. And we're looking at this as the most important thing for a Poison Center for us to look at in how we are prioritizing is the organizational management that we haven't heard yet this morning because we need to have the funds to financially stabilize Poison Centers, both today -- we need to focus today on the short-term but we also need to focus long term.

So number one in our priority list from our committee is the financial stability of Poison Centers. It's difficult to go out to get those dollars and difficult to prove we're doing a good job without the data ya. the second thing most important behind the financial stability is we need to have good, high quality, accurate data to perform public health surveillance and demonstrate our performance. It is important that we financially stabilize the center but nearly as important we need high quality data to show the benefit to the public. That's the end of our group's presentation. I want to thank our group for all their input and if anybody has questions I would be happy to answer them.

>> Doug, I have one question. You mentioned earlier one of your recommendations was to make the data available -- widely available to everyone who wants it. Did you mean for a price or for free?

DOUG BORST: What we would prefer is data is available to all -- anybody that does public health and to all Poison Centers because we should be part of the public health fabric for free for their own use any way they can use it and improved benefit to the public health. I think everybody in our group recognizes that and agrees with that. In order to get there, we also have to recognize the cost there is of producing that data and the burden that is currently being absorbed by centers and the personnel that is taking that data. The individual specialists and the time they put into it. So yes, that should be widely available. But at the same time we have to look at who is collecting that and the financial burden put on those centers to try to take care of that, too.

>> I think I would like to reinforce that point. As a public health person, I think the infrastructure costs of maintaining good data and making it accessible are blissfully ignored by the wider world in general and you all are a prime example. You wind up with very -- there is an awful situation where the national breastfeeding rates are known only through the Ross lab survey. That's not the way to go. (No audio at the present time)  
(No audio at the present time)

DOUG BORST: OK, everyone, can everyone take a seat? We're going to start back up. Can everyone take a seat? We're about to start.

>> We need to get started.

DOUG BORST: Is everyone ready?

MAXINE JONES: Excuse me, could everyone take their seats, please? The webcast is running.

ROSEANNE: Good morning. My name is Mark Johnson and I'm here representing the state and territorial injury prevention directors association. And our work group got the integration of services. The members of the work group included Joe Phillips, representing the National Association of state inspectors, Loren from the association of state and territorial health officials. Tommy from the American National Association of EMTs thank you to Tommy for helping me put this together. Kathy from the American

Association of Poison Control Centers. In the Institute of Medicine report, they discussed integration of services, including coordination of poison control centers with other public health entities. They said that meeting the ambitious national objectives for poisoning prevention set by the U.S. Department of Health and Services and Healthy People 2010 with the central burden of biological and chemical attacks requires combined efforts of public health agencies and a proposed regional system of Poison Control Centers. One of the questions that we were asked was what is HRSA's role?

Our group answered that with collaborate with state stakeholders and we used some examples of putting the Association of State and Territorial Health Officials, and Directors Association, National Association of State Emergency Medical Technicians and others. We also from posed that there needed to be a greater effort to educate the general public about the magnitude, the poisoning issue in the United States and we believe that that's probably not very well appreciated. And educate the public about the role of the Poison Control Centers which we also think may not be fully recognized at the moment. HRSA's role could include demonstrate current and future linkages with homeland security. There is an organization within HRSA that is doing that. And highlight federal, state and local levels. Know about the federal grant program but we believe that there could be other options for leveraging funding and that that could be explored further. We suggest the possibility of surveying Poison Centers and state health departments for examples of integration. The question was asked earlier about who should be knocking on whose door. And I think that that could be facilitated with some of the organizations that I mentioned previously.

I think there are examples -- and I know in my state we have a memorandum of agreement when the state health department and the Poison Center and those examples could be shared with Poison Centers in other states. HRSA could help identify and develop best practices for integrated regional poison control systems. And I believe that that also could result in a work group that could be convened for that purpose. We discussed the possibility of requiring documentation of partnerships with public health agencies in stabilization and enhancement grant but it was the concern of some members that that not require additional funding or not take funding away from the stabilization of the Poison Centers that are currently having financial difficulties. We could -- HRSA could encourage Poison Centers to collaborate with public health for outreach and public education. As was stated earlier, we do not see this as an either/or. We see this as leveraging what Poison Centers are doing, hopefully as states become more aware of the magnitude of the problem as identified by the Institute of Medicine report, there will be more support for broadening the efforts in poison outreach and education and injury prevention. And groups like the state and territorial injury prevention directors association could help facilitate some of that.

HRSA could work with CDC, Poison Centers and states to evaluate the effectiveness of outreach education and other services. It was pointed out earlier, evaluation is difficult but it can be done and there are evaluation specialists in health agencies that I think could be very helpful in designing and implementing evaluation programs for this overall effort. How can HRSA encourage collaboration? One suggestion is they could develop and

disseminate a guide showing examples of successful collaborations using state and Poison Center and other collaborations that currently exist. Encourage data sharing. And this would include Poison Centers and health departments. There could be opportunities for state epidemiological support to Poison Centers. Although as was stated previously, there are problems with definitions of poisoning, which complicate data collection efforts and surveillance, there could be opportunities to -- and already are, to combine the test system, toxic -- what is that test?

Exposure, surveillance system? With state vital statistic death reports, with medical examiner data, with hospital discharge data, other sources as available, whether it be emergency department data, EMS data, combining these sources because as was pointed out in the IOM report, a lot of the poison deaths don't show up in the test system. And this would give a more comprehensive picture of the magnitude of the problem and help agencies and organizations target population groups and prevention efforts. How can HRSA encourage collaboration? Other opportunities may include encourage the integration with state and local emergency management organizations, identify the role of Poison Centers in the state Incident Command System. Maternal and Child Health Bureau and the hospital preparedness program already do, by the way, but could emphasize the Poison Center's role in the homeland security grants that are targeted to hospitals. They could encourage collaboration with the schools of public health and help identify the roles of poison centers and occupational medicine.

At the state level, for example, there are groups like state emergency response commissions and regional local emergency planning committees that could be involved in this process. Applying experience from other areas to Poison Center program development. We discussed there is a program that is sponsored by the national highway traffic safety administration for emergency medical service technical assistance teams. Most states in the United States have had one of these teams review their statewide emergency medical service system at least once. Several states have had this more than once. There is a similar program sponsored by the state and territorial injury directors association for state technical assessment teams for comprehensive statewide injury and prevention control programs. These are one-week programs where teams of approximately five or six experts go into the state, use consensus standards and develop reports on the strengths and weaknesses of the programs. A similar process could be developed for comprehensive regional poison control systems. Model EMS integration and public -- model EMS integration with public safety, acute care, public health and emergency management could be looked at as an example of another program area where integration succeeds, as well again as injury prevention programs, which collaborate with other public health programs and there is a document put out by the state and territorial injury prevention directors association called the states safe model which could be used as a model for developing consensus standards for a regional integrated comprehensive poison control system.

Possible next steps include contact with a national organization to convene a consensus panel to develop a model regional poison system based on best practices. And then use

the model program guide to develop a technical assistant team modeled to evaluate existing programs. Participants should include Poison Center staffs, public health officials, injury prevention professionals, emergency medical service providers, homeland security and emergency management, and other government and other representatives. We were asked to try to estimate how much something like this would cost and that's difficult to do and we didn't have a great deal of time. But based upon experiences with some of these other programs and using voluntary participation, we believe that the model could be developed for under \$100,000. Some may disagree with that but that's my best guess. Technical assistance team reviews based upon, again, the national highway traffic safety administration and the other programs about \$10,000 to \$15,000 for state or region. If this is done the states could potentially be asked to provide matching funds to help defray the costs. The costs to educate the public about the magnitude of the problem is an unknown but it needs to be done and partnerships with state and local health agencies can probably make that happen.

Policy changes. Basically understanding the current crisis and needing to stabilize financially stabilize Poison Centers the policy change should evolve following the Institute of Medicine's recommendations from the emphasis on stabilization, hopefully beyond that to the development of the regional poison control systems. And that basically concludes the recommendations of our work group. I would invite other members, if I left something out. Questions?

>> Thank you for an interesting presentation. I realize we have several members from state health departments here in the audience and perhaps yourself and others could put in a couple words about this. This report is clearly asking the Poison Center group to integrate themselves, perhaps, or get better integrated with state health departments. What is the state health department sponsor perception?

MARK JOHNSON: They aren't coming to the Poison Center saying will you play with us. The mandate is for the poison centers to play and work and integrate with the state health departments. Is there desire and demand on the state health department side to integrate Poison Center services into what they do?

>> Well, I come from the State of Alaska. Before the passage of this act we didn't have a poison system. We actually reached out and we have a memorandum of agreement with the Oregon Poison Center and they answer all of our calls. In that agreement they share data with us, they help us with the educational materials and the outreach and professional training. So at least one state has gone to the Poison Centers and asked for help but I would be happy to help facilitate that as a representative of a state health department. I could at least encourage my colleagues from other states that this would be appropriate. Obviously we all have the problem of limited resources and too much to do and not enough resources to do it. But I do believe that there could be at least an opportunity to sit down and have some discussions and that doesn't cost money.

MARK JOHNSON: I think one of the reasons that some of us are here representing organizations on the public health in the broad spectrum of public health for this is that we do realize and increasingly I think are documenting the importance of this. Many of us have experience of how messy it gets politically and otherwise if you screw it up. Or drop it or whatever. Which is not a very good reason but it's sort of a strong negative reason to get involved. But I think we're all pretty candid that the range of performance and responsiveness and such among public health authorities is at least as broad as it is in Poison Centers. There are some that care a lot about this and everywhere in between. You have to try. It's one of those things that we don't do it together, we'll wind up doing something less productive to each other.

>> I think the other thing is with -- a demonstration of the magnitude of the problem. Because I can tell you that when we started getting the data, we were surprised. We didn't think it was as big a problem as it turns out to be. That may be true with many of my colleagues.

>> I guess to echo what has already been said not only from my state but from the national organization of state health officials, I think there is no question that state health departments view the importance of poison education and poison prevention as an integral part of injury control which is an integral part of public health which is a mandated function of government on behalf of its citizens. I likewise think that you'll find the involvement or coordination or collaboration between centers and their respective health departments at probably every stage of a continuum. I think that our state and others I'm

aware of have a wonderful working collaborative relationship with their Poison Center in some cases this is done contractually with an exchange for money and deliverables sometimes it's the national collaboration that occurs and the respective center and perhaps in some states there is not perhaps that level of intense coordination. I think there is always room for improvement in every state and in every collaboration. Certainly communication is a two-way street. I have no idea why the IOM couched that recommendation as they did. But I can tell you that our organization nationally and the respective health departments I think universally view poison prevention critically important.

I think what has been brought up in the last couple days is, perhaps, we under recognized the size and seriousness of the problem. I think that the success of Poison Centers in efficiently and effectively handling this area has perhaps caused some health departments to not pay as much attention to it because they know it is being handled efficiently and effectively to their citizens and devote their time and energy to other problems that aren't that well handled but there is room for additional dialogue, collaboration and ensuring that there are no gaps and that there is really a seamless delivery system. And they will be sharing back and forth of resources, whether that be human or financial.

MARK JOHNSON: Sometimes through discussions you find opportunities you didn't know existed. So it's good to have those collaborative discussions, I think.

>> I just wanted to add a little more to the state health discussion. Unfortunately my colleagues jumped in first and wanted to state that each state health department is different and that there are great examples of some states working well together. We heard in our group yesterday that during West Nile virus and smallpox in Colorado that the state health agency saw the Poison Control Center had a 24 hour hotline capacity and were able to bridge that relationship. So I wanted to state that it is a two-way street. People need to be talking with each other and certainly the national organizations can help foster that. But some states have really had a headache with the Poison Control Center and it failed and the state had to be the safety net for it. Each relationship is different where things have started off on a good foot or a bad foot and we need to help continue to make sure it's always a good foot forward.

MAXINE JONES: Any other questions? The next presenter will be Donna Seiger. Thank you.

DONNA SEIGER: My group was asked specifically to address organizational management. Our group consists of Kevin, David, Ed and myself. We looked at operational structures and the -- our discussion was based on two comments from the Battelle report and one from the IOM. What we tried to take into consideration were the areas of have Poison Centers been able to hire and retain qualified staff? Has there been improvement in financial stability? Then we looked a little more in depth at the IOM recommendation about commissioning a systematic management review that would focus on the organizational determinants of the Poison Center that looked at cost, quality and

staffing. Starting with our first question, should HRSA convene a task force or should a task force be convened to look at innovative staffing solutions?

>> I think what always happens with groups is you come up with ideas that you would never have if you just sat by yourself and tried to think these through which is always the benefit of a group process. We started talking about task force and innovative staffing and came to the conclusion that within a PCC was certainly the knowledge to be able to look at staffing solutions but we didn't think it was a staffing solution problem. We thought it was a money problem. There wasn't one person at the table that didn't think if we didn't have enough money to hire competitively we couldn't fill any staff position in our Poison Center at that time. Our conclusion was we didn't need innovative staffing. We needed to be able to give competitive pricing. The second aspect that we looked at was the recommendation that came under retaining and hiring qualified staff was should we develop distance learning versus webcast programming to train and increase the level?

Once again this brought quite a spirited discussion because what we concluded was that we didn't want to shorten the course of the training of these certifications. We thought that would actually decrease the level of expertise we were trying to maintain. There wasn't anything better to educate than sitting in a Poison Center and answering the call the training courses and web-based courses we felt would be an excellent opportunity for new recruits and people we might want to do continuing medical training and it would develop a consistency in training, an Internet-based learning module was recommended.

The third aspect under that retention of staff was to consider creating assistant director, senior positions. I was a little surprised at the overall discussion with this. It came out to be a very positive aspect. It actually expanded rather than looking at just senior spies, but that we should have external and internal fellowships. Where people could actually climb career ladders from the position of a spy would actually be very beneficial. The second question we looked at, has there been an improvement in the financial stability of Poison Control Centers?

DONNA SEIGER: The answer is yes. That wasn't even discussed and for the reasons that we have -- that have been listed and that we've all discussed earlier today. But the concern is we need to concern ongoing federal grants and we need to look at strategic planning. It is hard to look at strategic planning if you don't have dollars to deal with. With some financial stability it is important that strategic planning go ahead. It was very strongly felt that there should be technical assistance as well as a meeting of Poison Center groups to share information and discussion of how centers have succeeded financially. We need to reframe our services of fee or service. The recommendation was to consider a business training course for people in Poison Centers.

That there is clearly a difference in degree of expertise in the business and management of centers and that we may be able to look at some opportunities to give everybody a baseline from which to start. We then looked at the HRSA -- the IOM recommendation about commissioning a systematic management review and this area drew our greatest amount of discussion by far. We first decided we need to defined what systematic

management review was. We defined it as a global review from a multidisciplinary group. We felt it was important that there be able inside and outside the Poison Center in the composition of the IOM study. When we looked at what the analysis should include we went fairly specifically into their recommendations.

So the analysis they thought should look at new indicators of quality. We thought that was very important. And we thought that what we haven't proven is the quality with which Poison Centers do anything, in that one of our strong recommendations was that a study should be commissioned that determines if Poison Center managed patients have a better outcome. We haven't shown anybody that what we do makes a difference. Along with the indicators of quality and looking at Poison Centers, some of the issues of staffing have to be addressed in terms of the quality of how the Poison Center runs. Two issues we wanted to look at in staffing is the role of providers, do they save money and is the quality of information acceptable? What is the acceptable ratio of providers to SPIs?

The second area we wanted to look at was within the certification requirement that looks at the criteria for the number of calls of staff per FTE. Current recommendations don't take into account information calls, account acuity or follow-up. We need to determine a baseline minimum and severity score to determine acuity. These were all studies we thought -- commission studies that should be used to try and get this information as an indicator of quality. The next thing we looked at in terms of this analysis was the organizational structures. What became clear is how many different organizational structures there are within this group of Poison Centers. That was clear when the IOM

tried to look at it and one of their concerns was each Poison Center had such different organizations it was very hard to make a comparison. The many different structures clearly affect the staffing issues, the cost and positive and negative aspects of each.

What we felt needed to be defined is what the Poison Centers have in common. The things that they have different and there needs to be a profile done of the Poison Centers from the aspect of organizational structures. In doing that, it may help us determine what the number of FTEs are required exposure. Whether on site medical -- what the business and financial guidance is in each center. It was also added that data collection instruments should be addressed and incorporate the staffing profiles, more accurate assessments of acuity and outcome if we're going to be able to make these outcome and assessment based measures. The role of center size has a difference. There was consensus there is a critical number of calls that affects the quality of care. There may be a critical number per FTE and a critical number per center. We need to define that in terms of both maximum and minimum.

Human exposures is not an accurate enough indicator. The impact of regional differences on Poison Center operational costs clearly there are differences in costs per call which may be regional. However, the operational approach may be affecting the cost per call as much as the cost of living or economic differences. And until we have all this data that looks at the operational function of each Poison Center we will not be able to determine that. Which leads us to the need for an economic evaluation. Specifically the questions that were asked in terms of how we implement these suggestions. I think our most

important recommendation for HRSA in terms of recommendation and implementation was to divert dollars to research and outcome data, operational approach and organizational structures, safe and Poison Center services. This could be done in the form of incentive grants or contracts to look at studies that quality impact and cost effectiveness of different Poison Center system models.

We haven't yet shown what we do with cost effective and a benefit to society. We're developing guidelines to optimize care that we haven't shown as beneficial. We need outcome data on the system, the economy of scale and the organization. Evidence-based medicine principles are behind patient management. We need the same principles to manage Poison Centers and staffing. That was our most important recommendation. The second recommendation was to consider strategic planning for financial stabilities and to educate ourselves on that. The third was to consider supporting an external fellowship and SPI growth and development. I would be able to take any questions and turn them over to the people in my group if I can't answer them.

MAXINE JONES: Thank you, Donna, for the great presentation. I have a couple of quick questions. The -- your recommendation is that HRSA should go ahead and do the whole systematic management review of the program and I think the points that you made to look at the staffing, organizational structures are looking at commonalities are wonderful and really need to be studied especially looking at the defining -- doing studies to define the value of what we do and do we really make impact I think is terrific. And to add more data and more validity to some of the numbers we quote can only benefit all of us. I

missed at the end, though, when you were talking about how this was going to be -- how HRSA should pay for this. Are they supposed to find outside dollars? I missed that.

DONNA SEIGER: We put it in terms of incentive grants or actually RFPs is the way we thought it would be looked at. We've already got some data within our data system but we'll have to categorize and get all the data and I think we'll have to look at the data to do a formal analysis.\

MAXINE JONES: Thank you, Donna. Very nice presentation. I totally agree with you in terms of not needing to address innovative staffing solutions. That's not what is required. It's the money that's required and one of the -- one of my concerns about some of the Battelle presentations yesterday was cut costs, cut costs. Working in a system that has been bare bones to begin with, how do we cut costs? We need more funding so we can continue to provide the services that we're providing. I don't know whether you addressed this specifically in your discussion, a presentation yesterday suggested the ongoing federal funding be from set asides from Maternal and Child Health Bureau and preventive block grants. We also heard yesterday that may not be the way to go. That may be a dead end in itself. And so if what Battelle is recommending is potentially a dead end, where do we go? What are your recommendations or recommendations for HRSA to pursue if the Battelle recommendations are a non-starter based on other considerations?

DONNA SEIGER: Well, I'll ask the help from the committee. I'll give a personal thought. I think we're going to have to think outside the box and use what we have in terms of

collaboration from within our centers. I still think there is an awful lot we can learn from each other in our centers. I think things like this are a start in the right direction. I don't think there is any centers that once again this is a personal opinion, that aren't using money wisely. It is not like we've got money we're throwing around. I think that there are marked difference in expertise in different centers between how they're structured, and how people are paid. We may need to re-look at the whole organization of how we have organized centers in the past. You know? It worked ten years ago. It may not work now. We may need to re-look at that. And I think that doing some type of cost analysis within the centers that takes into consideration regional variations. It came out of this group discussion. There was a lot of variation. Kevin, Ed, do you have anything more to add to that?

>> Just to further comment on that. I think the one thing we talked about a lot was diversion of pre-existing funds. Maybe there are dollars within the program that are not being expended as well as they could be expended in our opinion. The guidelines issue came up as a discussion that it was the opinion of most of us take we didn't think that this is a lot of money being spent for something that maybe isn't all that beneficial to us and maybe we should divert some of those dollars to study some of these other issues that perhaps are a lot more important than developing guidelines.

DONNA SEIGER: Good point.

>> Maybe I missed a piece of the comment but did the group give attention to the organizational context in which Poison Centers historically have existed? I think there is a widespread opinion in the public health world that hospitals in general and academic hospitals in particular are very problematic in terms of efficient staffing and management and overhead costs and all of that. And that certainly is tradition for Poison Centers but there may be other possibilities.

DONNA SEIGER: Well, yeah. I think what certainly came out of that was what the variation was from hospital to hospital. I mean, even in the group around the table the variation of how the Poison Centers were structured and the hospital requirements were very different. I think that's a bunch of data that is there that we need to look at that can help each one of us to determine how we could better run it within our hospital. A lot of Poison Centers are considering a complete restructuring which is what we did. I think that once again we need to look at what we need to be doing now organizationally within each Poison Center compared to ten years ago and I expect it is going to be different.

MAXINE JONES: Any additional questions? If not -- Thank you, Donna. At this point in time let me say thank you to all of our presenters, all of the people who stepped in and volunteered to be our facilitators, all of those who -- all of you who worked in the group. And gave us your opinion in regards to how we can go about implementing these recommendations. Thank you. I think you all did a wonderful job in fully outlining what HRSA should do with these recommendations. At this point in time on the agenda we're scheduled to take general questions and answers regarding all of the group presentations.

Are there any additional questions regarding previous presentations today? If none, then what we're going to do is say thank you to all of our participants on the webcast. I'm so happy to report that today approximately 50 people -- 50 people logged onto the webcast today and about 20 minutes ago I was told that there were 30 something people still logged on. Yesterday we had 20 participants who logged on so this means that these are sites logging on and we're happy you participated via webcast and we'll look into doing this in the future again for some of our other stakeholder meetings. So thank you. And now we'll move to the part of the agenda where we'll just go -- if this is OK with everyone I'll modify the agenda the best way possible. Instead of coming back after lunch, it's like almost 11:00 now. What we can do is start the discussion that we were going to have at 2:00 today for the stakeholder feedback and we'll extend that as long as possible or to the completion of it and then if you hand us your evaluation forms we all may leave early depending on where we fall within that discussion.

>> If someone could send us an email of access for that we can disseminate it not only to the organizations we represent at this table but also to the Poison Centers we represent as well.

MAXINE JONES: OK. Great.