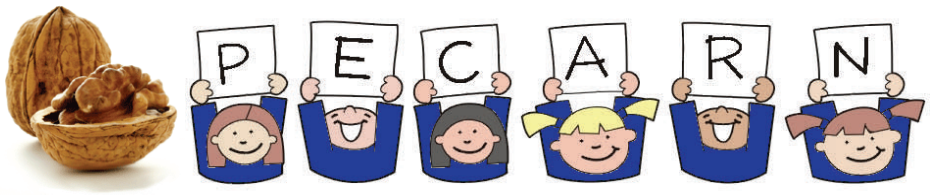
PECARN Newsletter

Fall
2010



In a nutshell

What's Inside?

Randomization in Multicenter Clinical Trials

By Sally Jo Zuspan RN MSN, CDMCC Program Manager

PECARN is implementing two randomized, controlled clinical trials in the next several months. Both the Fluid Therapy and Cerebral Injury in Pediatric Diabetic Ketoacidosis (DKA) and the Intravenous Magnesium for Sickle Cell Vasoocclusive Crisis (MAGiC) trials will use randomization systems to assign treatment groups.

A randomized, controlled trial (RCT) is the 'gold standard' of research. Randomization uses a standardized method to allocate the intervention or treatments to study subjects. When a study is set up to be randomized, it means that treatment or intervention being studied is assigned by a random process instead of by the researcher. Random assignment removes potential sources of bias by taking the decision out of the hands of the investigator. Randomization also can account for pre-specified baseline characteristics of the subjects by assigning patients in a manner such that the study groups are similar with respect to those characteristics. This will help assure that any observed differences in outcome were due to the treatment rather than baseline differences between the study group and the placebo group. A double-blind trial means that neither the researcher, nor the clinician, nor the study subject knows which treatment is assigned. This helps eliminate bias that might result from thinking that a patient is getting better because they received the study drug. In the MAGiC trial, the research subjects will be assigned by randomization to receive either the study drug or placebo and clinicians will not be able to tell which treatment their patient received. In other studies, like DKA, treatment is not blinded; clinicians and research coordinators will know which treatment arm the patient is assigned to and which fluid treatment they will receive but because of the randomization process, the clinician will not be able to predict which treatment arm will be coming next for any given patient. This helps maintain equipoise and minimize clinician bias. Regardless of whether the study is blinded or not, it is still important to have a process to randomly select the treatment so that treatment decisions remain unbiased. This is accomplished by randomization.

The randomization process can occur centrally or locally. Local randomization means that study assignments occur at the clinical site and are provided to the site in the form of a list or a sealed envelope. Central randomization means that a site accesses the randomization service by internet or telephone, and the treatment assignment is provided based on information provided by the clinical site. The central approach is often the preferred method for large, multicenter clinical trials because there are fewer opportunities for accidental disclosure of the randomization scheme and so that future treatment schedules will not be revealed.

Randomization can be accomplished using several systems. A common method is an interactive telephone system where the site coordinator accesses the randomization system via a telephone. Site coordinators enter

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Contact us:

P.O Box 581289
Salt Lake City, UT 84158
Phone (801) 581-6410
Fax (801) 581-8686

Or visit us online at:
www.pecarn.org

Next PECARN meeting: January 19-21, 2011 in Miami, FL

Mark your calendars

Supported by Grant U03MC00008, Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services

Continued from page 1

site-specific and patient information via the keypad on the phone. Treatment assignments are provided directly to the sites. This system then faxes a confirmation to the site and to the CDMCC. Other methods include web-based randomization systems and the old stand-by, the paper envelope. In this last scenario, a site coordinator opens an envelope that contains the treatment assignment. The site generally remains blinded to whether the treatment is drug or placebo; the randomization process tells them simply to select "vial number 27".

While the process of randomization seems simple to understand, implementing randomization correctly and consistently can be difficult in the real world. Randomization schemes can sometimes be complicated, making them vulnerable to error. Decisions about randomization may have to be made under time constraints and in some cases with unforeseeable circumstances. If any errors are made during the process, the integrity of the study can be compromised.

Several types of human errors can occur during the randomization process. Randomization often requires that clinical site investigators or research coordinators enter specific information that is necessary for stratification. For example, if the study data will be stratified by age, clinical site or a clinical score, this information must be correctly entered by the site. If entered incorrectly, then the treatment assignment may be incorrect or come from the wrong block. This can disrupt the anticipated groupings of subjects. Another error is that the randomization system could direct the clinical site to select vial number 27 (the study drug) but the staff at the site erroneously selects vial number 28 (placebo) instead. This kind of error will almost certainly be discovered during analysis, but getting the subject into the right group can be more difficult than it sounds. A strict interpretation of the intention-to-treat principle would require placing the subject in the active drug group (since he was supposed to receive vial number 27). However, if the error was truly accidental, it might make sense to count the subject in the placebo group (since he actually received vial number 28). In most cases, the analysis is unlikely to be affected much by the placement of a single subject in one group or the other, but a few errors like this could be devastating to the integrity of a trial.

Other human errors include forgetting to randomize entirely. In one situation, the coordinator enrolled but failed to randomize the patient. The coordinator simply selected a vial at the site, bypassing the randomization system. In this case, the site perceived an urgency of getting the study drug to the patient as quickly as possible. This is, of course, a serious protocol violation and must be reported to the IRB and the data center. Randomization should never be bypassed. If there are problems randomizing, sites should follow their protocols to access help.

Accidental randomizations have occurred when coordinators were testing the randomization system and "accidentally" randomized a patient or called prematurely to randomize a patient that was never consented. All of these result in confusion, disrupted number sequences and other regulatory problems. When these types of problems occur, it is essential that clinical sites communicate directly to the CDMCC so that the problem can be corrected and appropriate reports can be made.

MAGiC and DKA will have 3 methods of randomization to assure that randomization is always available to clinical sites. The first step will be to contact the telephone randomization service. If, for some reason, the system is unavailable, the next step is to access the web-based system. If the web system cannot be accessed, then the last option is to use the paper randomization system at the local site. These steps will be specified in the study procedures so that clinical site coordinators are aware of how to access each one appropriately.

Tips For Randomizing Correctly

- All staff should make a practice call to become familiar with the system
- Use the script every time you make a call to avoid errors
- Double check the randomization confirmation form to verify data entered
- Have letter-conversion chart handy when making calls
- If you make an error, call the CDMCC for help

Reference: Downs, M., Tucker, K., Christ-Schmidt, H., Wittes, J. Some Practical Problems in Implementing Randomization. Clin Trials. 2010:7(3):235-45.

PECARN

EMSC Legislative Update:

In February, the President released his fiscal year 2011 budget request, recommending level funding, or $21.5 million, for the EMSC Program for the coming fiscal year (October 1, 2010 through September 30, 2011). In July, the Senate Committee on Appropriations passed their version of the fiscal year 2011 Departments of Labor, Health and Human Services, and Education appropriations bill. The committee recommended an appropriation of $22.5 million for the EMSC Program for the upcoming fiscal year. This is a $1 million increase over the current (fiscal year 2010) level and the President's fiscal year 2011 budget request. Next, the Senate will consider and vote on the legislation. Recall that the House of Representatives must also consider its respective version of the appropriations legislation, and the two legislative chambers will have to come to an agreement on a final bill before it can become law.

EMSC Federal Program Increases Staffing

Federal Staff for the EMSC Program has increased from 2 to 6 with the addition of Jocelyn Hulbert, Theresa Morrison-Quinata, Yolanda Baker, and Tasmeen Weik. Jocelyn and Theresa transitioned from the National Resource and will join Yolanda working primarily with Tina Turgel as project officers for the EMSC State Partnership Grants. Tasmeen will primarily be the project officer for the PECARN cooperative agreements as well as other research-related activities of the EMSC Program.

PECARN Investigator Wins EMSC Heroes Award for Outstanding Research

The EMSC Program would like to congratulate ACORN's Principal Investigator, Nathan Kuppermann, MD, MPH, for receiving the EMSC 2010 Hero's Award for ***Outstanding Research Project Award*** as principal investigator on the study "Identifying Children at Very Low Risk of Clinically Important Traumatic Brain Injuries after Blunt Trauma."

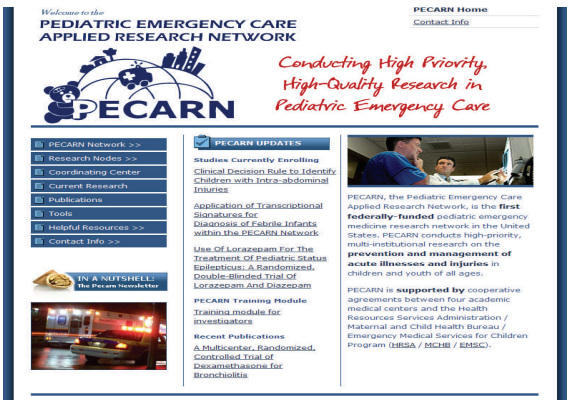
HRSA Announces 2010 EMSC Targeted Issues Grants

HRSA/MCHB EMSC Program awarded 9 new Targeted Issues Grants for FY2010. "Progesterone for Traumatic Brain Injury in Children: Planning a Safety and Efficacy Trial, "University of Michigan, Rachel Stanley, MD, will be conducted within PECARN. The 2010 Targeted Issues Fact Sheet highlighting the projects of the successful applicants will be released through Researcher in the next few weeks.

NEMSAC Appointments

The U.S. Transportation Secretary Ray LaHood has recently announced the appointment of 23 leaders to serve on the National Emergency Medical Services Advisory Council (NEMSAC). The council provides expert EMS advice to the department and its federal partners. The council also makes recommendations on key issues in the EMS field, including recruitment and retention of EMS personnel, quality assurance, federal grants for emergency services, and preparation for multi-casualty incidents. Those who have worked closely with EMSC that have been selected to serve on the Council include:

- Dia Gainor, Idaho's state EMS director and past president of the National Association of State EMS Officials;
- Arthur Cooper, MD, MS, a professor of surgery and director of trauma and pediatric surgical services at Columbia University's Medical Center in affiliation with the Harlem Hospital Center; and
- Joseph Wright, MD, MPH, a pediatric emergency physician at Children's National Medical Center in Washington, DC and acting executive director of the EMSC National Resource Center.



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

www.pecarn.org

Biosignatures Study

Sites are currently enrolling at a pace of approximately 64 samples per month and over 530 samples have been collected since January 2010. The study principal investigators have identified the samples with proven bacterial infections and proven viral infections collected during year two and sample analysis is underway. A grant proposal titled 'RNA Biosignatures in the Emergency Evaluations of Febrile Infants' was funded by the National Institute for Child Health and Human Development (NICHD) and will extend the Biosignatures study for an additional two years. Under the new grant, sites will continue to collect samples to create the diagnostic biosignatures and will collect an additional sample to evaluate the newer screening test, procalcitonin. A training session is scheduled in conjunction with the January 2011 PECARN Steering Committee Meeting in Miami, FL

C-Spine Injury (CSI) in Children

This study identified 540 children with CSI and compared them to children who experienced blunt trauma but did not sustain CSI. The main manuscript which presents the results of the case-control analysis was accepted with revisions for publication in Annals of Emergency Medicine. Manuscripts are being written for five secondary analyses: Description of CSI Patterns in Children, AARS, Utility of Plain Films in the Diagnosis of CSI in Children, Method of Spinal Immobilization in Children <2 Years Old at Risk for Cervical Spine Injury and CSI Transport. Additionally Dr. Prashant Mahajan will present an abstract titled 'Spinal Cord Injury without Radiologic Abnormality (SCIWORA) in Magnetic Resonance Imaging (MRI) Era' at the AAP conference on Friday, October 1 at 1:30 PM.

EMS Focus Group

This study used focused interview and focus group methodology to identify the barriers and facilitators to EMS participation in research aimed to limit immobilization to children who are at non-negligible risk for C-spine Injury. Focus groups and focused interviews with all echelons of EMS leadership were completed in St. Louis, Milwaukee, Salt Lake City, Buffalo, Rochester, DC and Baltimore. All transcripts were reviewed and comments were categorized into topics such as qualities, beliefs, barriers, motivators and suggestions. The manuscript presenting the main findings from this study was reviewed by GAPS and the consensus was to approve with minor revisions and return to the GAPS chair before submission.

IAF Appendix Study

The Intra-abdominal Fat and Appendix CT Study has completed enrollment. Thank you to all sites that participated. We are currently analyzing data and plan to submit abstracts to upcoming national research meetings. The study results will contribute to defining the standard of practice for imaging children suspected of having appendicitis.

IAI

The Intra-abdominal Injury (IAI) study was funded by the Centers for Disease Control (CDC) in October 2006. The goal is to develop a clinical decision instrument to determine the indications for abdominal CT use in children with blunt torso trauma. Patient enrollment began in May 2007 and ended in January 2010. We enrolled 12,044 patients with a capture rate of 80.9%, including 762 patients with an IAI. Data cleaning is wrapping up and decision rule generation and analysis has begun. Thanks to everyone for all their hard work over the past three years!

Patient Safety and New York State Patient Safety

We have collected over 13,000 incident reports in a three year period. Reviewers are analyzing and categorizing the first year of incident reporting data into a database. The pilot study that took place in New York state has completed the data collection phase. Data analysis is in progress. In this pilot study, all incident reports for the participating sites were reviewed and over 3200 ED charts were reviewed by a study RN at the CDMCC.

PECARN Core Data Project

Please plan to submit calendar years 2009 and 2010 PCDP data to the CDMCC by April 1, 2011. Updated data submission instructions may be available in the late Fall but data fields remain the same as previous years.

All locked PCDP Data for 2002 – 2008 are now available in the cubes. For preliminary analysis of PCDP data, you can use the cubes or complete a data request form (found in the PCDP eRoom). The cubes can be accessed at (https://www.utahdcc.org/reportportal)

Contact: Drew DeMarco (andrew.demarco@hsc.utah.edu)to obtain or reset your cube login and password. For any questions, please contact Libby Alpern at: (alpern@email.chop.edu)

Performance Measures

The three year PEM Performance Measures project is nearing its completion. A prioritized list of 60 performance measures, balance across multiple dimensions, and a subset of 15 measures chosen for immediate testing have been defined. We have submitted our first manuscript, and three others are under way. We are working with the EMSC program to further disseminate our results through web resources and a webinar to be held in October or November, 2010.

Pre-hospital Infrastructure

This study collected data for 521,239 runs from fourteen EMS agencies for the years of 2004-2006 through HEDA partnerships with the agencies. These fourteen submitted data sets consist of varying size, amount of missing data, and format. Twenty-two EMS agencies ultimately participated in the study, with eight unable to submit data. Data collection is complete and the fourteen unique data sets from each agency have been combined into one study database. Analysis and paper writing is on-going.

Federal Corner

Seizure

The Pediatric Seizure study (The Use of Lorazepam for Pediatric Status Epilepticus: A Randomized, Double-Blinded Trial of Lorazepam and Diazepam) has 11 participating sites actively enrolling: including newly recruited Children's Hospital Denver who is approved to enroll only preconsented patients at this time. Three new additional sites are of coming aboard to increase patient enrollment: Baylor College of Medicine (Houston) has completed their community consultation and is awaiting approval from their IRB to consent Cohort 2 patients, and 2 Canadian sites: Alberta Children's Hospital (Calgary), and Children's Hospital of Eastern Ontario (Ottawa) have completed community consultation and are awaiting ERB review of the findings. All sites have received formal site initiation visits. With a total of 209 patients enrolled, we have now met over 75% of our projected enrollment numbers.

TBI

The TBI project continues to reap the benefits of all the time and investment of the TBI investigators. All four abstracts submitted for the 2010 PAS/SAEM meetings were accepted and presented. One was presented at the PAS Presidential Plenary session (*Clinician Judgment versus the Prediction Rule*, presented by Shireen Atabaki), and a second one, presented by Lise Nigrovic was awarded the SAEM Best Young Investigator Presentation (*Clinical Observation before the Decision to Obtain a Computed Tomography (CT) for Children with Blunt Head Trauma).* This brings the total to 17 completed and presented abstracts (none have been turned away!), on top of 3 published manuscripts.

We have submitted another manuscript for publication, another 2 to GAPS for review, and are finishing drafts of a handful of other TBI manuscripts. We are currently working on approximately 10 more TBI substudies/manuscripts. We hope to have all substudies submitted for publication over the next 1-2 years. Next TBI projects actively being prepared: 1) knowledge translation of the prediction rule (Peter Dayan PI), and 2) progesterone for serious TBI (Rachel Stanley PI) – funded by and EMSC Targeted Issues Grant.

Magnesium in Crisis (MAGiC)

The magnesium (MAGiC) study, funded by NICHD, will enroll approximately 250 children from 4 sites (3 nodes) within PECARN. Our primary outcome is length of stay for sickle cell pain crisis. We are currently working through IRBs, and anticipate a training session in late Fall, with study enrollment beginning soon after. The CDMCC is currently developing the database.

DKA

DKA, a prospective randomized clinical trial, will determine whether variations in the rate of administration and sodium content of rehydration fluids during DKA treatment are associated with differences in neurological outcomes of DKA. The NICHD -funded study will enroll 1,510 patients over five years and will include ten PECARN sites. Dr. Nathan Kuppermann and Dr. Nicole Glaser, Study Principal Investigators, are excited to get started with the study training late September, 2010.

THAPCA

The Therapeutic Hypothermia After Pediatric Cardiac Arrest (THAPCA) Trials are closely approaching their one year anniversary! To date, the study has screened a total of 931 subjects, 183 were eligible and 86 have been randomized. The protocol has been amended several times this year to assist sites with enrollment.

The second study training was held in July in Deer Valley, UT and included the Vanguard sites as well new sites that are coming on board this fall.

The Vanguard sites have done an excellent job enrolling subjects, and we expect even more enrollment with the additional sites.

The other big THAPCA development over the summer was the migration electronic data capture system. We anticipated an original OC roll out in January 2010, however, we discovered that it took more time that anticipated to get the system up and running. Fortunately, OC was released to the sites on August 23, 2010 and data entry has begun using the new system! Thanks to everyone for their hard work and commitment to the THAPCA Trials!

Good Clinical Practice Tip:

Q: Can copies of electronic documents that are maintained in a computer system be used as primary source documents?

A: Yes, copies of electronic documents can be used as a primary source as long as it is a "certified copy". The definition of a "certified copy" is, "a copy of original information that has been verified, as indicated by dated signature, as an exact copy having all of the same attributes and information as the original". Therefore, when you are using a print out of an electronic document as a primary source, you must verify that the copy matches all aspects of the original electronic record. Once you have verified the accuracy of the copy, you must sign and date the document.

Source: Mathieu, M.P. (2010). *Good Clinical Practice: A Question & Answer Reference Guide,* ED.). Needham, MA: Barnett Educational Services.

Submitted by Hai Le, BS, CCRP
CDMCC Clinical Research Coordinator

Research Week!

A collaborative effort by the CARN Research Staff

By: Bahiyyah Jackson RC, CARN

The typical PECARN emergency department (ED) is not the idealized environment shown on TV (unless you're watching TLC or the Discovery Channel). It is a high stress environment that requires unique personalities to meet its challenges, particularly when it comes to introducing research into the ED clinical workflow. Ladies and gentlemen introducing the PECARN RCs! Yes, the PECARN RCs are the individuals who present the exciting PECARN research protocols to our EDs and are frequently met with the questions "What is this study all about ?" or even more common "Why are we doing this study?" Many of us have experienced these exact responses, but the question remains, how do we get our staff excited and committed to PECARN research?

Welcome to research week (or month, if you dare)! Research week has been implemented for the past 2 years within the CARN sites. You ask, what IS Research Week? Research week is a full week dedicated to events that remind, retrain, and reinvest ED staff in ongoing PECARN research. Events may include, a game of trivia in the ED break room (MDs versus RNs) aimed at reminding staff about a specific aspects of the protocol (particularly those that are frequently misinterpreted or missed), a skit performed in the ED highlighting a particular study or, mini- trainings in conjunction with a staff meetings. Research week is a good opportunity for the RCs to create fun and inventive ways to keep the ED staff invested in PECARN studies. As the old saying goes, "The proof is in the pudding". Anecdotally, we have found a generalized increase in enrollment, a decrease in missed eligible patients, RCs getting paged for studies more consistently, as well as a decrease in protocol deviations following Research Week. This suggests that research week may have a positive impact on study awareness in the ED. In addition, the research outreach is well received because the staff is learning or being refreshed in a fun and informative way which results in a more collaborative dynamic in the ED. When the staff is happy, we're all happy.

Suggestions for Research Week

Some studies are quite daunting, but it is the RC's job to make them fun and exciting to be a part of. A little food for thought - if you aren't excited about the research you are involved in, then how do you expect others to respond? Here are a few approaches to encouraging staff "buy-in":

1. Remind ED staff or physicians how great they are doing (positive reinforcement yields the best results) in person and via email to the entire staff (to promote healthy competition). (RC/PI)
2. Quiz their knowledge on current studies. Who doesn't enjoy a piece of chocolate or tasty snack for answering a quiz question correctly? (RC/PI)
3. Provide an opportunity for Q&A. This also lends time to refresh enrollment procedures and give study updates. Try to spend at least 30 minutes a day in the ED (RC). Your presence demonstrates another level of commitment and dedication (RC/PI).

Here are some of the fun ways CARN celebrated Research Week 2010!

- Light Refreshments were provided during Q&A session updates.
- PECARN Study Jeopardy (doctors vs. nurses)
- Single question quiz for candy of your choice.
- Roll out of new study posters
- A humorous, but informative skit involving interns/research staff reenacting an ideal enrollment
- Trivia! Nothing gets staff more involved than seeing a leader board with the daily scores. At the end of the month the staff celebrated at University of Maryland with a luncheon.

Research week/month creates a resounding buzz about PECARN. The staff become more aware of who we are and not just "those research folks" crowding inboxes with study-related emails. So, ask yourself, is your site going the extra mile to promote PECARN research? If the answer is a cold "no" or even a lukewarm "yes" or even if it is a resounding "yes!" consider putting on a "research week". Remind, retrain, and reinvest your site in PECARN research.

HAPPY RESEARCH WEEK!

PECARN

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

ACORN

The ACORN node would like to congratulate Dr. David Brousseau from MCW on the award of his NIH grant to study the addition of IV magnesium to standard care for sickle cell pain episodes (MAGiC Trial). We would also like to congratulate Drs. Nate Kuppermann and Nicole Glaser on the award of their NIH grant to study fluid therapy regimens for pediatric diabetic ketoacidosis. Finally, we'd like to congratulate Drs. Marcin, Dharmar and Kuppermann on the presumed award of their AHRQ grant to validate an implicit review instrument for measuring the quality of care in pediatric emergency medicine.

Rich Ruddy from Cincinnati Children's won the 2010 Jim Seidel Distinguished Service Award, which will be presented to him at the American Academy of Pediatrics (AAP) meeting in October, 2010 in San Francisco.

CDMCC

Congratulations to Hai Le, BS, CCRP who recently took the Society of Clinical Research Associates (SoCRA) exam and passed the test with a high score. He is now a Certified Clinical Research Professional (CCRP). Way to go Mr. SoCRA!

CARN

CNMC's Biosignatures guru/ RC Julie Smith married her boyfriend of 6 years, Joseph Jennings on August 21st in Bethesda, Maryland. The wedding was attended by family, friends and CARNies alike! The groom is currently in medical school, and maybe someday will be a PECARN PI, or at least a doctor willing to help out RCs! Gooooo CARN!

GLEMSCRN

Congratulations to Prashant Mahajan, Octavio Ramilo and Nathan Kuppermann who received funding for their project *RNA Biosignatures in the Emergency Evaluation of Febrile Infants* from the DHHS, NIH Eunice Kennedy Shriver National Institute of Child Health and Human Development.

Congratulations also to Rachel Stanley and Nathan Kuppermann who were awarded funding for their Targeted Issues Grant *Progesterone for Traumatic Brain Injury in Children: Planning a Safety and Efficacy Trial,* from HHS/ HRSA/ MCHB, Emergency Medical Services for Children.

New Faces to PECARN

CDMCC

Jun Wang is a CDMCC Statistician. She began working as a statistical analyst for the CDMCC in May. She is currently working on the TBI study and the MAGIC study. Jun graduated from Brigham Young University with a M.S. in Statistics. She and her husband are originally from China and enjoy spending time with their lovely two-year- old daughter.

New Faces to PECARN

CARN

Vanessa Grant is the new Clinical Project Assistant at Children's National Medical Center (CNMC). Vanessa is no stranger to the CARN family—she started working for CARN as a research intern in the summer of 2009. An aspiring physician, Vanessa is interested in pediatric emergency medicine, especially emergency medicine research. During her leisure, she enjoys reading and is addicted to Zumba. Vanessa is delighted to be back with PECARN and is excited about working with the CARN team, as well as expanding her experience in pediatric emergency medicine research. Goooooo CARN!

Vanessa (bottom center) with her brothers and sister.

GLEMSCRN

Kristina Galaska joined the staff at Nationwide Children's Hospital in July, 2010. She recently graduated from the University of Dayton with a BA in Psychology and minors in Sociology and English. Kristina enjoys the outdoors and her favorite vacation spot is Myrtle Beach, South Carolina. She loves watching football and cheers for the Pittsburgh Steelers. Kristina is thrilled to be a part of the research team at NWCH.

Jake Stremers has joined the staff at Children's Hospital of Michigan in Detroit. Jake graduated from Michigan State University in the spring with a B.A. degree in Anthropology and Pre-Med studies. Jake currently lives in Port Huron and commutes to Detroit every day, and enjoys sailing and cycling. He is presently very busy applying to medical school and is looking forward to the upcoming MSU football season. Lastly, he is thoroughly enjoying working at the CHOM ED and is looking forward to learning more about our research and the research process.

PEDNET

Michelle Strong is a new Research Coordinator at Bellevue Hospital. She is originally from Oakland, California and has completed her undergraduate degree at Dartmouth College. At Dartmouth College she obtained a degree in Sociology with a certificate in Women and Gender Studies. Upon graduation she entered the Premedical Post-Baccalaureate Program at Columbia University. While in the Post-Baccalaureate Program she volunteered as a research assistant for PECARN at Columbia Presbyterian Hospital. She enjoyed these experiences and is happy to have been brought on as a research coordinator for Bellevue Hospital. She is currently applying to medical school and hopes to begin in the Fall of 2011.

CDMCC

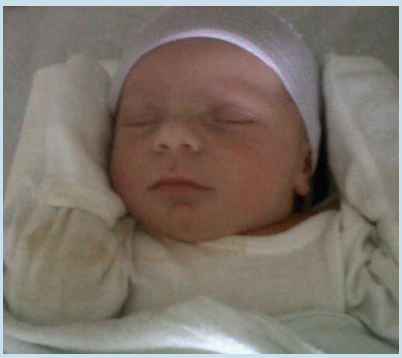
Tomohiko Funai joined the CDMCC Statistician team in July 2010. He is a recent graduate from Brigham Young University with an M.S. in Statistics. He is currently working on PCDP, Patient Safety Project, and Pre-hospital Infrastructure Project for PECARN. Tomohiko was born in Japan but he also lived in Switzerland, Singapore and United Kingdom while growing up. He enjoys running, oil painting, ballroom dancing, saxophone, and spending time with his wife and son.

This newsletter was compiled by Emily Stock, Secretary of the CDMCC

New Jr. Faces to PECARN

PEDNET congratulates Mikhail Berlyant and his wife Yulia Rozendent on the birth of their daughter. Her name is Sofia Mikhail Berlyant! She was born on May 9 at 4am - on Russian "V" day and was a great present for her mom on Mother's Day. She weighted 7 lbs 11 ounces and was 54 cm long at birth. She has brought great joy to her parents.

ACORN-
Jamie Chalfin and her husband, Nick, welcomed a baby boy a few weeks ago.
Benjamin Hyde Chalfin
Born 8/5/10 at 8:25am
7lb 14oz; 20.5 inches



CDMCC-
Anna Davis and her Husband Keller, welcomed a baby boy a few weeks ago.
Emmett Davis
Born 6/30/10 at 8:50pm
8lb 4oz; 25.5 inches