#NHCPC24

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Visions of Progress: Sustainable Strategies for Emergency Preparedness & Resilience

Presented By:

MESH

Healthcare Coalitions and EMS

Leveraging new alliances with old partners

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Housekeeping

- My opinions are my own and are based on
  - Case studies and other research
  - Operational experience
- If while I am making observation you feel like I am picking on you
  - I probably am, but know I am also picking on me
- You are free to disagree

Background

- Paramedic for 30 years
- Masters in EM
- Doctorate in Health Science
- Research interests in crisis decision making and EMS response
- Healthcare Preparedness SME
- ED for South Dakota HCC

EMS

- Originated as a hospital-based response model
- The first healthcare professionals that disaster patients interact with
- Is inappropriately included in the same category as Fire and Law Enforcement while it has much more in common with healthcare and hospital service

Why should HCC's focus on EMS as a primary partner?

- Fire and LE move from dispatch to scene to available
- EMS moves from dispatch to scene to hospital
- EMS operates within the healthcare discipline daily
- In large scale events, EMS may assist with decompression
- In mass casualties, EMS is the extension of the ED

Ongoing case study

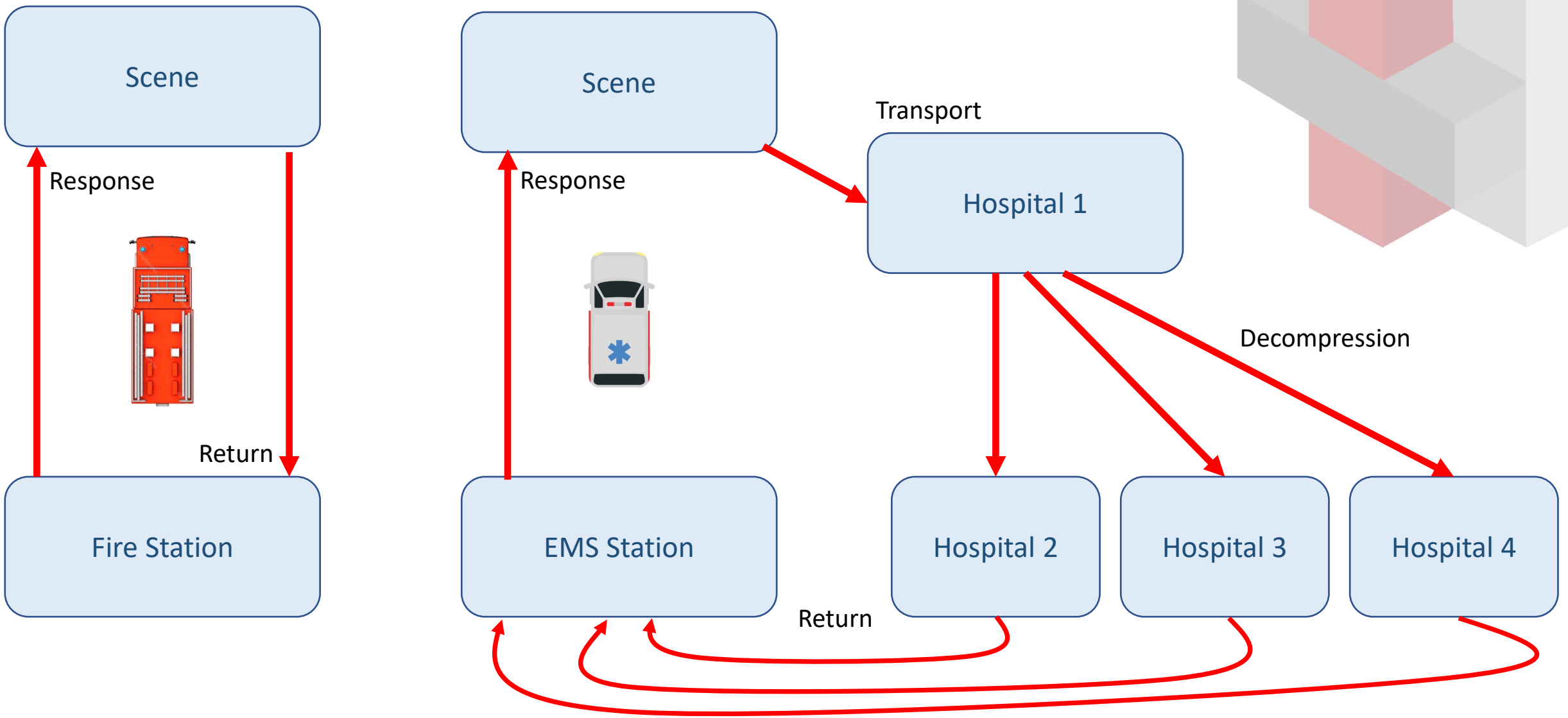
- Research large event responses
- Identify similarities in response issues
- Determine causative factors
- Implement change

- 1993 WTC
- 1995 OKC
- 1995 Tokyo
- 2001 WTC
- 2003 Toronto
- 2003 Jerusalem
- 2004 Madrid
- 2004 Beslan
- 2005 London
- 2013 Boston*
- 2017 Las Vegas

Case study findings

- EMS encounters a mostly dynamic situation
  - Patient loads demand immediate action
  - Medical Branch Operations are time consuming
  - Responder stress and the demand for help (victims)
- HCC’s communicate during events
  - EMS Communications with HCC’s may not be existent

Incident life cycle



NIMS

- NIMS doctrine is focused on not changing what we do everyday
- ICS changes EMS operations to an unfamiliar model
- NIMS training and exercises do not prepare EMS providers for large scale chaotic scenes where “organization” may take several hours

Training

- EMS gets minimal training in MCI management
- EMS has a core-based training related to closest hospitals
- MRSE confirms how long it takes to move patients with actual resources
- Regular training may focus on more day-to-day operations and clinical approaches to patient care and not coordination with HCC's, MCI, and facility decompression
  - This is a performance GAP between HCC's and EMS Partners

Exercise inefficiencies

- **EMS is typically not included in healthcare exercises**
- Independent EMS (non-fire based) is typically not included in first responder exercises
- Volunteer and rural EMS have daily staffing issues that prevent exercise participation

Is EMS on our primary exercise invite list?

THE VISION

Healthcare systems, including EMS, are fully integrated with each other and with the communities in which they operate. Additionally, local EMS services collaborate frequently with their community partners, including public safety agencies, public health, social services and public works. Communication and coordination between different parts of the care continuum are seamless, leaving people with a feeling that one system, comprising many integrated parts, is caring for them and their families.

EMS Agenda for the Future - 2050

Healthcare coalition exercises

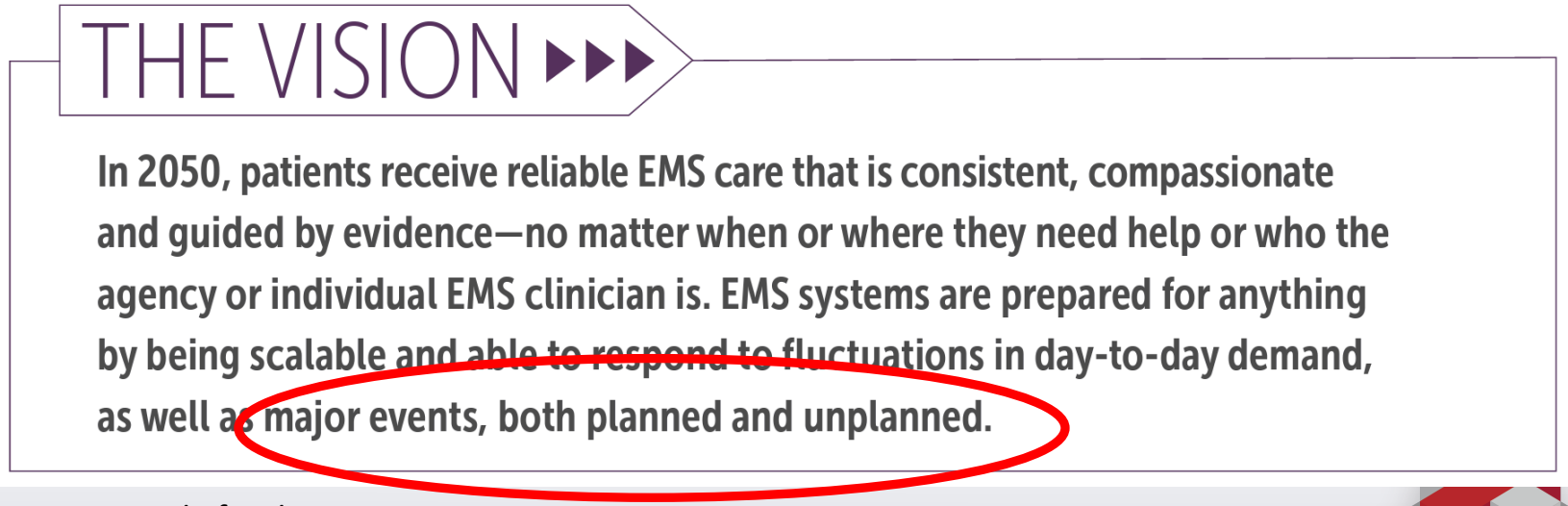
- EMS is not a typical participant in healthcare exercises
- Hospitals “discuss” expectations and assumptions related to EMS
  - Assumption based planning is regularly skewed
  - Often overestimate EMS capabilities
- Local providers are rarely at the planning table
  - Especially in overtaxed areas

New cycle expansion

- What is the ratio of membership?
  - Appendix Z partners
  - **EMS partners**
  - EM partners
  - Public Health partners
  - ESF-8 Partners
  - At-Large partners
- EMS has leadership roles and clear voice
  - EMS comes in many forms

HCC Planning

- Is there EMS representation on planning committees?
  - Threat assessments
  - Involvement in plans and annexes
  - Response structure
    - Ability to activate coalition during crisis
  - After action reporting



EMS Agenda for the Future - 2050

Modification of response processes?

- Do we reconfigure the response structure to the geography?
- Are there alternative options for EMS response?
  - If Medical Branch Operations are cumbersome, what isn't?
  - Especially true in rural and frontier
- Define, and then exercise options
  - EMS needs to be at the table

HCC involvement

- EMS coalitions and memberships
  - SDAA and SDEMA
  - Transportation plan
  - EMS involved in Ebola and other specialty planning
    - No continuity after that
    - COVID?
  - Some positive examples
    - Decon training in SD
      - Decon-triage-transport cross training

Gap analysis

- Big gap in knowledge between coalitions and EMS
  - In planning priorities
  - In regulatory issues
  - In C-Suite awareness
  - In healthcare communities

Have we asked our EMS partners what they need?

Adding a second floor

- EMS advisory group
  - Paid ALS service
  - Volunteer ALS service
  - Hospital Based ALS Service
  - Hospital Based BLS service
  - Fire Based service
  - State EMS Director
  - SDHCC Executive Director
  - Volunteer BLS Service

Goals of EMS advisory

- EMS – Healthcare Summit
  - Rural EMS
  - Healthcare planners
  - C-Suite execs
- Adding tiered membership positions for EMS leadership
  - SDEMSA
  - SDAA
  - EMS-C

New concept

- HAVBed
  - Facilities report staffed beds
  - Can EMS report staffed units?

Final thoughts – Combining goals

- ASPR HPP Cycle (work plan)
- National Healthcare Security Strategy
- EMS Agenda for the Future
- ASPR NACSD/NACCD/NACIDD
- Appendix Z
- Joint Commission

Questions


SOUTH DAKOTA HEALTH CARE COALITION
SD
Partners in Preparedness