The NASEMSO Health and Medical Preparedness Council

Annual Meeting Record
Charleston, S.C.
8:00 a.m.-2 p.m. EST
June 21, 2022

Attending: HMPC members and guests.

Call to order/Roll Call: Karen Owens, Chair called the meeting to order at 8:00 a.m.

Federal Partners Update:
NHTSA: Kate Elkins gave updates to include the following:

- FICEMS response paper due out in July (but then needs to go into clearance)
- FEMA/HHS COVID response Prehospital team
- Ems.gov has all the covid response documents including some for mental health. I will be looking at what revisions need to be done to update and maintain a useful resource bank. https://www.ems.gov/projects/coronavirus_covid-19_resources.html
- Federal working group for suicide prevention, White House Interagency policy committee for suicide prevention (3 sub IPCs), SAMHSA working groups all have EMS/911 representation from OEMS
- 988 - https://www.samhsa.gov/find-help/988 multiple recorded webinars on FCC and SAMHSA websites
    - OEMS will host a webinar this summer.
- Mental health and suicide prevention listening session will start in the fall again.
- Collaboration with NIOSH and CDC on suicide among first responders paper that will go into peer review soon but here is the blog https://blogs.cdc.gov/niosh-science-blog/2021/04/06/suicides-first-responders/
- National Roadway Safety Strategy – Safe System Approach
- Post Crash Care – fifth pillar of the safe systems approach – opens up opportunities as we move forward to have increased funding through regional grant program that is in existence
- If EMS and 9-1-1 are represented in state plans through DOT – opportunities will be available to fund improvements
- Systems that reduce time to respond
- Making 9-1-1 more efficient
- In the past – state office of EMS may not have had the best experience with highway safety office

- Signficant changes in how they are being advised and how we hope they will be able to utilize their funding.
- National Roadway Safety Strategy - https://www.transportation.gov/NRSS

Action item: Kate will share information and links to Leslee Stein-Spencer for dissemination to the Council.

U.S. Fire Administration (USFA) Rick Patrick

Emergency Medical Services (fema.gov)

- Statutory charges for USFA – EMS is one of them
- New NFIRS system – contract to write the standards and data sets going forward – no timeline. They are working with NHTSA to make sure new system talks to NEMSIS and other federal reporting requirements
- Working on a research study called EMS needs assessment
- Looking at EMS disaster response partner – Really came to a head of an understanding across the spectrum – EMS recognized in ESF-8 through ESF-4
- Redoing the EMS medical directors handbook
- New EMS response to civil unrest
- Homeland Security Information Network – USFA in charge of the fire/EMS – best way to get best practices - Emergency Services | Homeland Security (dhs.gov)
- Opened specific EMS portal – link on website to request permission and must have government email – If you don't have a government email
- Roadway safety comprehensive study in which they are partnering with NHTSA Multiyear study to understand the highway safety issues from epidemiological study
- Electric Vehicle Study-Partnering with NHTSA to look at EV Fires and impacts to first responders

NFA: National Fire Academy branch of USFA: Mike Stern

- Focused on system management and MCI disaster management
- Competency based practices
- They do have online classes – it is being transitioned – currently no instructor facilitated online programs just yet
- Just started contracting process to do needs assessment/gap analysis – separate from USFA (specific to EMS education, not National Scope of Practice) that fits within NFA
- Classes are not limited to fire service agencies. The classes are open to any student that fits the selection criteria
- Can give access to the system to review the instructor material so we know what is being taught and how it is being presented
- Classes are also being conducted to present the potential for defining careers and upward mobility with a task force of members of each council to better determine education necessary to promote

COVID 19 Lessons Learned:
Members of the Council shared their experiences in their states on COVID 19. Some of the highlights included the following**:**

Areas of Improvement:

- Communication and sharing information; need for contingency planning

Best Practices:

- Weekly/daily meeting with partners went well – ongoing communication; work on educating federal partners on what EMS is
- Posted most current recommendation in Image trend
- State government is smaller – co-located with the office of emergency management early on – Medical Operations Coordination Cell – All hospitals and partners on a call – Problems solved on that call – Use Alertsend (app) – Challenge now is making sure they don't lose the tools and relationships that were built during covid
- EMS is nimble – we were able to make changes on the fly to meet the needs of the residents of our state and our EMS stakeholders
- Data is king – we were able to utilize biospatial to push out just in time data related to COVID hotspots and also EM Resource to survey our agencies weekly on their staffing and PPE needs.
- Training of all EMT and paramedics to do PCR testing and then vaccines
- Used EMS Strike teams as vaccinators
- Our testing and vaccine teams focused on the underserved populations homebound, Latino community
- A building of relationship and role of EMS into the public health
- Medical Operations Coordination Cell **(MOCC):** A cell (group of medical operations experts) within emergency operations centers (EOCs) at the sub-state regional, state-wide, and federal regional levels that can assist in the transferring of patients between healthcare facilities. Able to identify open beds, ICU etc.
- Shared similar challenges with coordination and collaboration – Disaster Medical and Mortuary Team has been responding agent and coordinator for the state COVID response; In recent years, a portion of those resources went to the state to become direct deployed; portion of the resources were created
- IDMC.US-Interstate Disaster Medical Collaborative-Designed to be a mission to support structure
- EMS allowed to transport to alternative care centers including mental health facilities.
- EMS used as staffing in multiple places to include hospitals.
- MIHP staff used to free up beds in hospitals by staffing areas
- Volunteer registry used to help staff areas especially in rural areas.

Areas for Improvement:

- Contingency planning; use of PPE/fit testing – need to be prepared every day
- Longest activation of EOC activation – biggest frustration – solving missions of critically sick patients (dialysis/chronically ill) – solving a challenge with private assets was a foreign concept
- Defining EMS – how much can EMS actually do – benefit and crutch through response – Just because an agency has an EMS provider on staff doesn't make them an expert and should still use EMS office to respond
- EMS not defined in first round of vaccines as a healthcare worker, state allowed them in the definition but when the state mandated vaccines for healthcare workers, EMS was mad and said they weren't healthcare workers.
- EMS office integrated with EOC – became painfully obvious they did not have as loud of a voice as necessary; need a louder voice/dedicated position
- EMS responsible for all critical resources – constant changes in recommendations that came out of federal government
- Communication – information was changing on the daily and sometimes conflicted between state and federal agencies. This affected trust with the public and EMS stakeholders
- No dedicated EMS Preparedness Plan – having a plan in place for the "next" disaster/pandemic will help support our EMS system. The plan must include at a minimum the following: provider safety, medical control authority support, agency support, licensing and regulatory functions, data surveillance, education, general EMS Office functions, other EMS programs support (EMSC, CP, MIH, etc.), and other state and federal preparedness resources.
- Protection of responders with ppe and timely testing needs to be done.
- Coordination of homeless population who tested positive
- Prepared for impact during hurricane season on what to do with shelters and general population
- ICS stood up – Once it grew, they created work screen management; frustrating from the DOH – EMS not included in first round of vaccinations; received lots of calls about exposure, testing, etc. then the requirement for vaccination for healthcare workers turned to anger – created a ton of work by a lot of people that could have been used in more productive ways
- Had to invest time in regulatory manners and definitions
- Structured very differently – have ESF 8 functions in their function as well as trauma and rural health – at the table very early – EMS used to fix issues – RTs in the ICU as needed – EMTs were not a part of ESAR-VIP – dipping toe into community paramedicine prior to COVID – within a month had 5 systems up and running within a month – post-COVID it has proven challenging – how do we demonstrated the sustainability of MIH – all tied together with behavioral health improvements
- Need to identify what falls under the umbrella of MIHP.

- Communication – information was changing on the daily and sometimes conflicted between state and federal agencies. This affected trust with the public and EMS stakeholders
- Legislative action is needed to accommodate public health emergency declarations and define appropriate authorities.
- Informatics to support epidemiological response were limited in capacity; increased support would allow public health officials to translate data more rapidly into actionable information.
- Maximizing new recovery assistance funding streams proved challenging due to limited information to guide state officials on appropriate implementation.
- Area for Improvement: Vaccination efforts for underserved and underrepresented populations
- Vaccination efforts were challenging for those with limited mobility, access and functional needs, and/or lack of access to a computer or mobile device.
- Ensure all mass vaccination clinics meet ADA compliance for wheelchair ingress and egress, as well as services for those with other access and functional needs, including large print paper forms.
- Memorialize strategies for determining fixed sites, strike teams, and at-home processes in a playbook to support the State of Alaska pandemic influenza plan

Executive Board:
President Alissa Williams, President-elect Joe House and NASEMSO's Executive Director Dia Gainor and Deputy Andy Gienapp came to the meeting and addressed the importance of the HMPC and what a key role this council plays in the organization. Andy discussed the Cooperative Agreement # 4 that NASEMSO is working on to include Public Health, Emergency Management, 911 and EMS and guidelines that will be developed. NASEMSO will be conducting a scan of great ideas/tactics/techniques developed over the years
Need five states that can pilot these guidelines. So far the following states have volunteered to be a pilot: – Maine, Nebraska, Michigan, Alaska – Still looking for a southern state

First Net:
Attached is the power point presented by First Net as well as two recommended videos to view:
Dedicated Connectivity During the COVID Crisis: https://youtu.be/U0OD2LMnGMM
DHR Health: Connectivity Critical for Better Patient
Outcome: https://youtu.be/STjdK8Kb460

National Ambulance Contract:
Mike Ragone and Tim Smith gave an overview of the NAC and lessons learned from COVID. Their power point is attached

General Discussion:

- Joe Schmider made a recommendation to submit a resolution concerning an ESF For EMS:
  NASEMSO hereby requests our Federal partners to support and take steps to move forward the recognize EMS as a valuable national system of care and move forward to provide EMS it owns ESF and Community Lifelines as soon as possible
  It was moved and second to proceed with the resolution.
- Discussion on whether or not to change the name of the council and how to encourage involvement by states. It was decided to keep the name as Health and Medical Preparedness and to look at expanding definitions and roles in order to elicit more state involvement with the council.
- Election of Officers:
  - Karen Owens: Chair
  - Jay Taylor: Chair Elect
  - Joe Schmider: Past Chair
  - Regional Reps:
    - South: Joe Schmider
    - East: Jay Taylor
    - Great Lakes: Sabrina Kerr
    - West: Gene Wiseman
    - Western Plaines: Karen Owens will recruit a member