State EMS Office Involvement in Domestic Preparedness Efforts

NASEMSO 2010 Status Report

National Association of State Emergency Medical Services Officials

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Introduction and Background

Effective domestic preparedness and response requires cooperation and collaboration between multiple agencies. The nature of a domestic incident or disaster transcends the traditional and rigid hierarchical nature of government organizations, requiring instead a fluid and dynamic capability more closely identified with virtual organizations.

Agencies that do not normally work together under any other circumstances must be ready to work hand-in-hand during a disaster or domestic incident because these systemic emergencies can quickly exceed the resources, expertise and authorities of any single agency.

Prudence requires that all agencies with a conceivable mission in response to a domestic incident or disaster be involved in the planning and preparation efforts. Individual incidents may not require actions or participation by all of the agencies, but each must be prepared for collaborative efforts to respond to those that may.

Human casualties may not constitute the preponderance of some incidents; but to the extent that human lives are at risk in the vast majority of major emergencies, it is both necessary and desirable that state emergency medical services agencies be involved in the planning and execution of domestic preparedness and response.

The National Association of State EMS Officials (NASEMSO) is the professional organization of the administrators of EMS systems in each of the states, territories and the District of Columbia.

State EMS Office Involvement in Domestic Preparedness Efforts is a report based upon a survey of the 56 state and territorial EMS agencies, and is intended to ascertain the extent to which state and territorial EMS offices are represented and supported in ongoing multi-agency coordination for readiness and planning.

The target population consisted of the EMS Directors of the States, Territories[1] and the District of Columbia. Of 56 surveys, 53 were returned, for a 95% rate of return[2].

[1] Territories include Guam, Puerto Rico, American Samoa, the Northern Mariana Islands and the U.S. Virgin Islands
[2] A list of jurisdictions participating in the survey is included in the appendix

I. Response Analysis

Section A: Integration of Preparedness and Response Activities

The purpose of this section of the survey instrument was to gauge the extent to which state and territorial EMS offices are involved in activities related to domestic preparedness and incident response.

Of the 53 respondents, 60% indicated they were somewhat satisfied or very satisfied with the level of state EMS office involvement in domestic preparedness and response activities; however, 40% indicated this area needed improvement.

Seventy-four percent indicated they were somewhat satisfied or very satisfied with the relationships between the state EMS office and partner organizations in the state. 26% indicated this area needed improvement.

Fifty-one percent of respondents indicated the EMS office has a designated position in the state emergency operations center (EOC). Sixty percent of the respondents reported the state EMS office has a designated position in the Public Health EOC. Only 11% of respondents indicated the state EMS office has a designated position in the state fusion center. The types of positions assigned to these duties were eclectic, with no clear plurality of type emerging. In some instances, the Office Chief was assigned to these duties, and in others, another manager or staff member was assigned; in some instances, a rotating schedule was in place. In some other few instances, the type of person assigned would be contingent upon the nature of the emergency.

The functional relationship between the state EMS office and the state Emergency Management Agency (EMA) is described by the nature and extent of their respective roles during an emergency. Seventy percent of respondents indicated the EMA contacts the EMS office for Emergency Management Assistance Compact (EMAC) requests for mobilization of ambulances. Sixty-six percent of respondents indicated the EMA contacts the EMS office for requests to mobilize emergency medical personnel; and 42% indicated EMA contacts EMS for mobilization of other resources or assets.

The state EMA and EMS offices have worked together on initiatives to assure the availability of public ambulances according to 64% of the respondents, and to assure availability of private

ambulances according to 58% of respondents. Sixty-six percent reported such cooperation regarding EMT credentialing; and 44% reported such cooperation relating to initiatives on medical oversight.

It is difficult to gauge the value and efficacy of such preparation unless the plans are put into effect in an actual emergency and after-action reports and evaluations are used to identify gaps. The survey instrument asked respondents whether over the last five years, the state had requested a mutual aid response from another state. Twenty-six percent of the respondents had made such a request for resources from another state. Forty-two percent of respondents indicated a request for assistance from another state had been made through EMAC; and 51% indicated such a request for assistance had been made of them through the National Ambulance Contract.

Fifty-one percent of respondents also indicated that in the past five years, ambulances had left the state to support a mutual aid request from another state without prior knowledge or consent of the state EMS office. Another 24% were unsure whether such an event had occurred; however, 75% of the respondents do not require EMS office notification to leave the state for more than 48 hours to assist in a major incident in another state. While 21% of the respondents indicated they do require notification when ambulances leave the state on mutual aid requests, only 36% of this cohort (a total of four states) report having legislation or regulations regarding such notification.

Ninety-four percent of respondents reported that the state EMS office participates in the coordination of resources such as ambulances or emergency medical personnel, during a major incident within the state.

Asked what would be the primary channel for the request if the state needed ambulances during a major event today, 50% indicated EMAC; 11% indicated a request would most likely be a direct state-to-state request; nine percent indicated the National Ambulance Contract would be the primary resource; 13% indicated some other unspecified resource; and eight percent were unsure. Nine percent indicated it would be unlikely they would request outside assets or assistance.

Sixty percent of respondents indicated that one or more providers in their jurisdictions participate as subcontractors to the Federal Emergency Management Agency's National Ambulance Contract. Nineteen percent of respondents indicated that no providers from their jurisdictions participate; and 21% were unsure.

Emergency medical resources are generally arrayed in such a manner as to meet the usual and customary demand for services. Each ambulance service generally also has a reserve capacity of back-up vehicles and on-call personnel beyond the assets that are in service at any given time in order to meet small-scale spikes in demand. Large-scale disasters can quickly overwhelm these additional resources, necessitating mutual aid responses from other ambulance services and even other states. However, the regular caseload of patients requiring emergency medical services is likely to be unabated during a disaster. In other words, no one is going to re-schedule his or her heart attack simply because there is a disaster going on. Asked what impact National Ambulance Contract compliance would have on day-to-day ambulance operations in their states in the event of a "Katrina-like" catastrophe, 53% indicated it would have little or none. Another 17% indicated it would have a moderate impact on operations, and 15% reported it could have a major impact. Fifteen percent were unsure what impact the event would have.

Coordinating a concomitant request for EMS resources from both EMAC and the National Ambulance Contract is reported by 45% of respondents to be a shared responsibility by state EMS and the state EMA. Seventeen percent of respondents indicated the EMS office would coordinate such a request; and likewise, 17% of respondents were unsure how such coordination would occur. Fifteen percent indicated the state EMA would coordinate the request; and 6% indicated that "no one" was responsible for such coordination.

A registry is maintained of EMS practitioners voluntarily willing to deploy for interstate mutual aid by 64% of respondents. Of these, 91% use the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). This is a federal program to establish and implement guidelines and standards for the registration, credentialing, and deployment of medical professionals in the event of a large-scale national emergency. Nine percent use another type of database for these purposes.

The chaos of a disaster unfortunately provides unscrupulous opportunists the chance to misrepresent their qualifications and standing to provide emergency care. If a provider's license has been revoked, suspended or restricted in some way, the value of their contributions under the most strenuous circumstances would be dubious. The National Practitioner Data Bank (NPDB) is essentially a system for flagging certain health care practitioners' professional credentials. Use of such database information can help agencies in assuring that the persons who show up to assist in a disaster are in fact qualified and in good standing with their home state. This notwithstanding, only 35% of respondents indicated that their own states report EMS practitioners to the NPDB when a practitioner's license has been suspended or revoked.

The instrument asked respondents what contract language requirements FEMA should implement to support states during activation of the National Ambulance Contract. By a large plurality, 45% of respondents indicated the contract should require mandatory notification to the sending state prior to ambulances or personnel leaving for deployment. Twenty-four percent indicated that pre-event negotiated funding for mutual aid response should be included in the contract. Seventeen percent said the contract should require evidence of compliance with the National Incident Management System's 5-year training plan and resource typing models. Another 11% were unsure or had no recommendations.

The Homeland Security Exercise and Evaluation Program (HSEEP) is a capabilities and performance-based exercise program. The purpose of the HSEEP is to ensure exercises and drills conform to established best practices, and promote consistency for exercises at all levels of government. Fifty-four percent of respondents indicated their EMS office was somewhat involved with the state HSEEP; and 25% reported the involvement of the EMS office was very high. However, 21% of respondents reported no involvement at all in this program. With 75% of state EMS offices reporting little or no HSEEP involvement, a review of the program's under-utilization should be undertaken.

Section B: Funding

This section contains information on the degree of engagement of state and territorial EMS offices with federal grant resources for preparedness and response activities. References to eight specific known funding entities/programs and a generic "other" category were included in the survey.

The survey asked each respondent to identify how involved his/her own EMS office was in the application process for these grants. The possible responses were 1. Not applicable (meaning to the respondents' knowledge, the state did not make application); 2. Very involved; 3. Involved; 4. Occasionally involved; 5. Rarely involved; and 6. Not involved.

(Author's note: Not all of the 53 respondents answered the items for each and every funding source. For purposes of clarification, the number of respondents answering for each item is expressed below as n=#.)

Centers for Disease Control and Prevention (n=50)

These preparedness grant programs are largely for upgrading state and local health department preparedness and response capabilities relative to bioterrorism. Funding enables public health departments to have the capacity and capability needed for effective response to the public health consequences of terrorist incidents, infectious disease outbreaks, natural disasters and biological, chemical, nuclear and radiological emergencies.

Forty percent of respondents (20 of 50) indicated no EMS office involvement at all in the application process for these funds; 30 percent indicated only occasional or rare involvement; 24 percent reported the state EMS office was involved or very involved. Six percent of the respondents indicated this grant category was not applicable.

The funding rate[3] for this program was 52% (14 of 27). The total combined funding received by these applicants was **$10,676,440**. The average award amount reported was **$762,603**. The largest award amount reported was **$8,000,000**, and the smallest award amount reported (among those reporting receiving an award) was **$10,000**.

[3] Funding rate is an expression of the percent of state EMS offices that received funding out of all that indicated any level of involvement in the application for funding.

Pandemic Flu Supplemental Funding (n=49)

HHS made available additional grant money to states, territories and 4 metropolitan areas (L.A., D.C., NYC and Chicago) for continued planning, training and acquisition of needed equipment for an effective pandemic response.

About one quarter of respondents (24%) indicated no EMS office involvement at all in the application process for these funds; 34 percent indicated only occasional or rare involvement; 37 percent reported the state EMS office was involved or very involved. Four percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 34%. The total combined funding received by these applicants was **$19,206,125**. The average award amount reported was **$1,600,510**. The largest award amount reported was **$12,000,000**, and the smallest award amount reported (among those reporting receiving an award) was **$18,000**.

Emergency Management Preparedness Grants/HRSA (n=45)

This purpose of this grant program is to assist state and local governments in enhancing and sustaining all-hazards emergency management capabilities.

Sixty percent of respondents indicated no EMS office involvement at all in the application process for these funds; 14 percent indicated only occasional or rare involvement; 15 percent reported the state EMS office was involved or very involved. Eleven percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 15% (two of 13). The total combined funding received by these two applicants was **$100,000**. The larger award amount reported was **$60,000**, and the smaller award amount reported (among those reporting receiving an award) was **$40,000**.

Public Health and Human Services Block Grants (n=49)

These broad grants give the grantees the flexibility to prioritize the use of funds to fill funding gaps in programs that deal with leading causes of death and disability as well as the ability to respond rapidly to emerging health issues.

Forty-five percent of respondents (27 of 49) indicated no EMS office involvement at all in the application process for these funds; 20 percent indicated only occasional or rare involvement; 34 percent reported the state EMS office was involved or very involved. *Zero* percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 48%. The total combined funding received by these applicants was **$4,394,507**. The average award amount reported was **$338,039**. The largest award amount reported was **$732,000**, and the smallest award amount reported (among those reporting receiving an award) was **$40,000**.

Hospital Preparedness Program/Assistant Secretary for Preparedness and Response (n=48)

The purpose of this grant program is to enhance the ability of hospitals and health care systems to prepare for and respond to bioterrorism and other public health emergencies. The HPP program supports priorities identified by the National Preparedness Goal established by the Department of Homeland Security.

Twenty-three percent of respondents indicated no EMS office involvement at all in the application process for these funds; 25 percent indicated only occasional or rare involvement; and 48 percent reported the state EMS office was involved or very involved. Four percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 69% (13 of 27). The total combined funding received by these applicants was **$20,359,757**. The average award amount reported was **$848,323**. The largest award amount reported was **$10,200,000**, and the smallest award amount reported (among those reporting receiving an award) was **$10,000**.

Department of Homeland Security (n=50)

The DHS provides funds to build capabilities at the state and local levels and to implement the goals and objectives included in state homeland security strategies and initiatives in their State Preparedness Report.

Thirty-eight percent of respondents (19 of 50) indicated no EMS office involvement at all in the application process for these funds; 24 percent indicated only occasional or rare involvement; 34

percent reported the state EMS office was involved or very involved. Four percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 31%. The total combined funding received by these applicants was **$3,699,604**. The average award amount reported was **$411,067**. The largest award amount reported was **$1,360,000**, and the smallest award amount reported (among those reporting receiving an award) was **$20,000**.

Urban Area Security Initiative (n=45)

This grant program focuses on enhancing regional preparedness in major metropolitan areas. The program supports the National Priority on expanding regional collaboration in the National Preparedness Guidelines and assists jurisdictions in developing integrated regional systems for prevention, protection, response and recovery.

Fifty-one percent of respondents (23 of 45) indicated no EMS office involvement at all in the application process for these funds; 15 percent indicated only occasional or rare involvement; 20 percent reported the state EMS office was involved or very involved. 13 percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 25% (4 of 16). The total combined funding received by these applicants was **$755,400**. The average award amount reported was **$188,850**. The largest award amount reported was **$315,000**, and the smallest award amount reported (among those reporting receiving an award) was **$15,400**.

Metropolitan Medical Response System (n=47)

The MMRS program supports the integration of emergency management, health and medical systems into a coordinated response to mass casualty incidents caused by any hazard. Successful MMRS grantees reduce the consequences of a mass casualty incident during the initial period of response by having augmented existing local operational response systems before the incident occurs.

Forty-five percent of respondents (21 of 47) indicated no EMS office involvement at all in the application process for these funds; 28 percent indicated only occasional or rare involvement; 19

percent reported the state EMS office was involved or very involved. Nine percent of the respondents indicated this grant category was not applicable.

The funding rate for this program was 9%nine percent (2 of 22). The total combined funding received by these applicants was **$788,000**. The larger award amount reported was **$780,000**, and the smaller award amount reported (among those reporting receiving an award) was **$8,000**.

Other (n=17)

This category includes all federal grant funds (other than those already listed) pursued by states for purposes related to domestic preparedness and response.

Forty-seven percent of respondents (8 of 17) indicated no EMS office involvement at all in the application process for these funds; six percent indicated only occasional or rare involvement; 29 percent reported the state EMS office was involved or very involved. 18 percent of the respondents indicated this grant category was not applicable.

Only six states indicated involvement in the application process, but eight reported receiving funding. It may be that EMS was not the applicant, but was incorporated in the execution functions once the awards were received. The total combined funding received by these eight applicants was **$16,517,338**. The average award amount reported was **$2,064,667**. The largest award amount reported was **$12,400,000**, and the smallest award amount reported (among those reporting receiving an award) was **$65,000**.

Combined, these federal programs made 88 awards to 38 state EMS offices for a total of $76,497,171. On average (of the states that received funding) support came from two different federal sources. The highest number of funding sources reported was seven (out of nine possible program sources).

CHART A

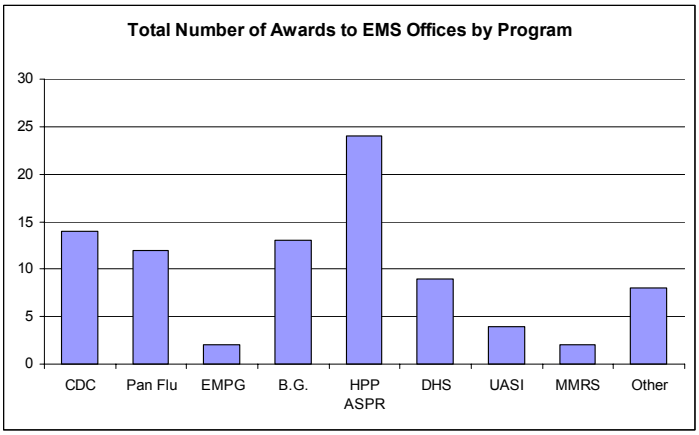

Chart A (left) shows the total number of grant awards to EMS offices by each federal program.

Note that the Hospital Preparedness Program/Assistant Secretary for Preparedness and Response gave the most awards to EMS offices (24). Even so, only slightly more than two-thirds of the state EMS offices that reported being involved in the application for funding from HPP/ASPR reported receiving funding.

CHART B

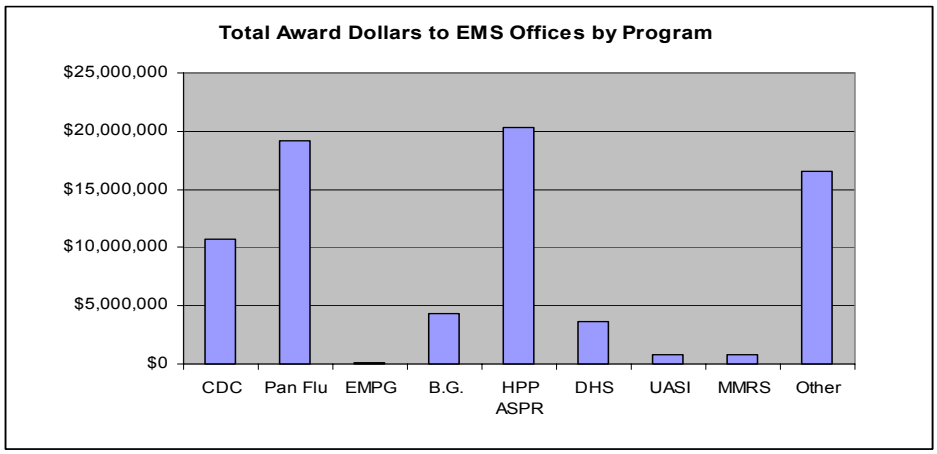

Chart B (left) shows the total dollar amount of grant awards to EMS offices by each federal program. Note that the HPP/ASPR program once again shows the most support for state EMS offices, awarding a total of $20,359,757. The Pan Flu Supplement program places second here, but funded only twelve or exactly half the number of EMS offices that HPP/ASPR funded.

Section C: Homeland Security Grant Program (HSGP)

The HSGP consists of five sub-programs: the State Homeland Security Program (SHSP); the Urban Areas Security Initiative (UASI); Operation Stonegarden (OPSG); the Metropolitan Medical Response System (MMRS): and the Citizen Corps Program (CCP).

The previous section addressed involvement of state EMS offices in the application for this funding. This section deals with specific issues related to the incorporation or representation of EMS in the execution of the programs. The survey queried eight specific areas of potential involvement. Every single area showed a paucity of state EMS involvement.

Eighty-three percent of respondents indicated that no HSGP funds were used to support EMS medical direction. An additional 13% indicated it was unknown whether any HSGP funds were used for these purposes.

The National Emergency Medical Services Information System (NEMSIS) helps states collect more standardized data elements with a goal of eventually establishing an integrated national EMS database. Again, 83% of respondents indicated no HSGP funds were used for NEMSIS implementation.

Sixty-eight percent of the respondents indicated the State EMS office was not involved in reporting the use of funds to the Department of Homeland Security/Federal Emergency Management Agency Grants Reporting Tool (GRT).

Sixty-five percent of respondents reported that the state EMS office is not represented on the Citizen's Corps Council. Fifty-eight percent of respondents indicated no EMS representation of any kind on the Citizen's Corps Council.

Forty-seven percent of respondents (a plurality) indicated that MMRS sub-grantees do not collaborate with state EMS. Only 40% indicated there was some collaboration between MMRS sub-grantees and state EMS.

The State Senior Advisory Committee (or equivalent body) is responsible for coordinating FEMA Grant Programs Directorate (GPD) grants and CDC and ASPR cooperative agreements. Seventy-four percent of respondents indicated that the state EMS director is not represented on the State Senior Advisory Committee (or equivalent). Likewise, 74% of respondents reported that the State Trauma Manager is not represented on the State Senior Advisory Committee (or equivalent).

II. Summary and Conclusion

As the agencies primarily responsible for the architecture of the EMS systems, clearly the state EMS offices have a major role to play in preparedness endeavors. This role is either not fully recognized or adequately supported by preparedness initiatives at the federal and/or state level. The fact that 75%seventy-five percent of state EMS offices report little or no involvement in the Homeland Security Exercise and Evaluation Program (a program that expressly exists to ensure exercises and drills conform to established best practices, and to promote consistency for exercises at all levels of government) should be of some concern. A review of this program's under-utilization should be considered.

It is clear that a large portion of state and territorial EMS offices are not participating fully in the various federal grants aimed at improving domestic preparedness. The Institute of Medicine (IOM) finds that federal funding for EMS has been lagging in comparison to other areas of consideration such as public safety and public health.

In its 2006 report, *"Emergency Medical Services at the Crossroads."* the IOM explores a range of issues that include integration of all components of EMS into disaster preparedness, planning, and response actions. Among the many findings and recommendations in this report:

> "While significant federal funding is available to states and localities for disaster preparedness, emergency care in general has not been able to secure a meaningful share of these funds because they have been folded into other public safety functions which consider emergency medical care a low priority. To address the serious deficits in health-related disaster preparedness, **Congress should substantially increase funding for EMS-related disaster preparedness through dedicated funding streams."** (See page 9, emphasis in the original)

For many years, the federal approach to support state EMS offices has been constituted of multiple small grant programs. This approach has both strengths and weaknesses; but it may be that the potential economies of scale inherent in the consolidation of these various funding mechanisms into a dedicated all-purpose preparedness funding stream would induce greater participation and uniformity of purpose among state EMS offices.

III. Appendix

A. List of Participating States and Territories

B. Sample of Survey Instrument

State & Territorial Offices Participating In Survey

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Territories

District of Columbia
Guam
N. Mariana Islands
U.S. Virgin Islands

A. Preparedness and Response

1. Does the State EMS Office have a designated position in the State Emergency Operations Center (EOC)?

☐ Yes ☐ No

1a. If *yes*, what type of EMS staff person (e.g., training, trauma, medical director, etc…) is so designated?

2. Does the State EMS Office have a designated position in the State Fusion Center?

☐ Yes ☐ No

2a. If *yes*, what type of EMS staff person (e.g., training, trauma, medical director, etc…) is so designated?

3. Does State EMS have a designated position in the State Public Health EOC (if separate from state EOC)?

☐ Yes ☐ No

3a. If *yes*, what type of EMS staff person (e.g., training, trauma, medical director, etc…) is so designated?

4. Please indicate whether your state EMA office contacts the EMS office for EMAC requests for mobilization of any of the following (check all that apply):

☐ Ambulances ☐ Personnel ☐ Other EMS Resources (explain:)

5. Please indicate whether your state EMA office has worked with your state EMS Office for EMAC initiatives for any of the following (check all that apply):

☐ **Ambulance availability (public)** ☐ **Ambulance availability (private)** ☐ **EMT credentialing** ☐ **Medical oversight**

6. In the past 5 years, has your state requested an EMS mutual aid response from another state during a major incident?

☐ Yes ☐ No ☐ Not Sure

7. In the past 5 years, has your state deployed ambulances to support a mutual aid response during a major incident through:

EMAC?

☐ Yes ☐ No ☐ Not Sure

National Ambulance Contract?

☐ Yes ☐ No ☐ Not Sure

8. In the past 5 years, have ambulances left your state to support a mutual aid response during a major incident without the prior knowledge or input of the State EMS Office?

☐ Yes ☐ No ☐ Not Sure

9. Are ambulances and/or personnel permitted to leave your state to assist in a major incident for more than 48 hours without notifying your State EMS Office?

☐ Yes ☐ No ☐ Not Sure

9a. If no, do you have existing legislation or rules requiring notification?

☐ Yes ☐ No ☐ Pending

10. Does the State EMS Office participate in the coordination of EMS resources (ambulances, personnel) during a major incident in your state?

☐ Yes ☐ No ☐ Not Sure

11. If your state needed ambulances during a major incident today, what would be your primary source for the request?

(please select your best answer)

☐ **Unlikely to request outside assets** ☐ **State-to State Agreements in Place** ☐ **Request through EMAC**

☐ **National Ambulance Contract** ☐ **Unsure** ☐ **Other:**

12. Do you have EMS providers in your state that participate as subcontractors to Federal Emergency Management Agency's (FEMA) National Ambulance Contract?

☐ Yes ☐ No ☐ Not Sure

13. What impact do you anticipate the National Ambulance Contract would have on day-to-day EMS services in your state if a "Katrina-like" catastrophe required a national response?

☐ **No Impact** ☐ **Little Impact** ☐ **Moderate Impact** ☐ **Major Impact** ☐ **Not Sure**

A. Preparedness and Response (continued)

14. Who coordinates an EMS resource request if the request is for both EMAC and the National Ambulance Contract?

☐ **State EMS Office** ☐ **State EMA Office** ☐ **EMS & EMA** ☐ **No One** ☐ **Not Sure**

15. Does your state use a volunteer database (such as ESAR-VHP or related state version) to register EMS Practitioners who are willing to deploy for interstate mutual Aid?

☐ Yes, ESAR-VHP ☐ Yes, other: ☐ No

16. Does your state report EMS practitioners to HRSA's National Practitioner Data Bank when an EMS license has been suspended or revoked?

☐ Yes ☐ No

17. What contract language requirements should FEMA implement to support states during activation of the National Ambulance Contract? (Please check all that apply)

☐ Mandatory notification to the sending state prior to ambulances or personnel leaving for deployment

☐ Pre-event negotiated funding for mutual aid response

☐ Evidence of compliance with NIMS 5-year training plan and resource typing models

☐ None of the Above

☐ Not Sure

☐ Other:

18. How involved is the State EMS Office in the State's Homeland Security Exercise and Evaluation program?

☐ Very Involved ☐ Somewhat Involved ☐ Not Involved at All

B. Funding

1. Please indicate below, for each type of grant, how involved the state EMS office is in the application process:

CDC	Choose One	**Pan Flu Supp.**	Choose One	**EMPG**	Choose One
Block Grants	Choose One	**HPP (ASPR)**	Choose One	**DHS**	Choose One
UASI	Choose One	**MMRS**	Choose One	**Other**	Choose One

2. For each type of grant, please indicate the amount received by your state EMS Office for Federal Fiscal Year 2009 (even if the funding was a pass-through to go to local EMS):

CDC	**Pan Flu Supp.**	**EMPG**
Block Grants	**HPP (ASPR)**	**DHS**
UASI	**MMRS**	**Other**

3. How much federal grant funding for preparedness and response activities has been routed through your EMS Office for EMS providers and/or EMS personnel for FFY 2009?

3a. List an example of activities made possible by this pass-through funding:

4. Have EMS providers in your state received any other specific EMS resources (training, equipment, funding, etc…) through other federal grants in FFY 2009?

☐ **Yes** ☐ **No** ☐ **Unknown**

4a. If yes, list an example of what those resources were used to accomplish:

C. Preparedness Activities

1. How would you characterize your satisfaction with State EMS Office involvement in preparedness and response activities:

☐ **Very satisfied** ☐ **Somewhat satisfied** ☐ **Needs improvement** ☐ **Unsure**

2. How would you characterize your satisfaction with State EMS Office relationship with response partner organizations (state EMA, Fire Marshall, Public Health Epidemiology, etc…)

☐ **Very satisfied** ☐ **Somewhat satisfied** ☐ **Needs improvement** ☐ **Unsure**

D. Homeland Security Grant Program (HSGP)

1. Were Homeland Security Grant Program (HSGP) funds used to support:

Medical Direction? ☐ Yes ☐ No ☐ Unknown **NEMSIS Implementation?** ☐ Yes ☐ No ☐ Unknown

2. Did the State EMS Office report use of funds to the DHS/FEMA Grants Reporting Tool (GRT)?

☐ Yes ☐ No ☐ Unknown

3. Was the State EMS Office represented on the State Citizen Corps Council?

☐ Yes ☐ No ☐ Unknown

4. Was there an EMS representative on the State Citizen Corps Council?

☐ Yes ☐ No ☐ Unknown

5. Do MMRS subgrantees in your state collaborate with state EMS?

☐ Yes ☐ No ☐ Unknown

6. The State Senior Advisory Committee (or equivalent body) is responsible for coordinating FEMA Grant Programs Directorate (GPD) grants and CDC and ASPR cooperative agreements. Is the State EMS Director represented on the State Senior Advisory Committee?

☐ Yes ☐ No ☐ Unknown

7. Is the State Trauma System Manager represented on the State Senior Advisory Committee?

☐ Yes ☐ No ☐ Unknown

Acronyms and Abbreviations:

ASPR – Assistant Secretary for Preparedness and Response

CDC – Centers for Disease Control

DHS – Department of Health Services

EMA – Emergency Management Agency (State counterpart to FEMA)

EMAC – Emergency Management Assistance Compact

EMPG/HRSA – Emergency Management Preparedness Grants/Health Resources and Services Administration

ESAR-VHP– Emergency System for Advance Registration of Volunteer Health Professionals

HPP – Hospital Preparedness Program

MMRS – Metropolitan Medical Response System

UASI – Urban Area Security Initiative