Update on EMSA Initiatives

Howard Backer, MD, MPH, FACEP
Director
Emergency Medical Services Authority

EF 8 Update from EMSA

Howard Backer, MD, MPH, FACEP
Director, California Emergency Medical Services Authority
EMSA Responsibilities

- **Disaster**
  - Coordination medical response
  - Disaster Medical Volunteers
  - Mobile field medical program
- **Specialty care**
  - Trauma, Stoke, STEMI, EMS for Children
  - Poison Control
- **Prehospital care**
  - Coordinated 2-tier structure with local EMS agencies to develop, regulate, monitor and improve EMS systems
  - Scope of practice for all EMS
  - Paramedic licensure

Health and Medical Disaster Needs

- **Acute medical care**
  - Injuries/illnesses related to event
  - Usual medical emergencies
- **Existing patients in health care facilities**
- **Community-dwelling chronic illnesses**
  - Maintain community health services to protect acute care facilities
  - Power-dependent, medication, evaluation and treatment
- **Mental health**
- **Public health**
  - Needs assessment
  - Preventive: Immunization, food and water, outbreaks
  - Environmental: toxic spills (With EF 10)
Health and Medical (EF 8) Integration
Health and Safety Code 1797.150-153

- Medical health operational area coordinator (MHOAC)
- Regional disaster medical and health coordinator (RDMHC and RDMHS)
- Mobilize mutual aid resources and coordinate emergency medical services using SEMS and assisting OES
Update/Revision of EOM: expanded topics

• Multi-Agency Coordination
  – Model after fire service: operational system to prioritize incidents and allocate scarce resources

• Response to Catastrophic Incidents
  – Changes in joint State/Federal planning for catastrophic incidents

• Alerting and Notification
  – Changes to the CAHAN system with new infrastructure platform
  – Need to sign up again

Update/Revision of CA Public Health and Medical EOM

New Topics

• Mental health, behavioral health and substance use disorder

• Emergency powers of health officials

• BioWatch

• Safe drinking water (to account for shift in agency responsibility)
Where is HICS currently used?

**Current users**
- United States
- Colombia
- New Zealand
- Puerto Rico
- Taiwan
- Kenya
- Pakistan
- Iran

**Plan to implement**
- Japan
- Syria
- Afghanistan
- Tanzania
- India
- Tajikistan
HICS 2014 Revision

- Application to small and rural hospitals
- Additions
  - A Patient Family Assistance Branch
  - An Employee Family Care Unit Leader
  - Job action sheets and job aids for new positions
- New Incident Planning Guides (IPGs) and Incident Response Guides (IRGs)
  - Active Shooter, Mass Casualty Incident, and Wildland Fire
- Forms in both Adobe “fillable” PDF format and Word

Key Factors for Successful Implementation of Hospital Incident Command System

1. Executive and Administrative Support
2. Planning and Tailoring
3. Training and Retraining
4. Activations and Exercise
5. Communication
6. Coordination with Community/External Partners

Based on analysis of responses from Stanford University Hospital (averages 30 HICS activations per year)
L. Schoenthal, Masters thesis in Homeland Security
MCI (Hwy 5N, Glen Co)
10 dead, > 30 injured

Asiana Air Crash
Napa Earthquake

California Fires 2015
State Role in Medical Surge

- Monitor health care system stress
- Support continuity of operations
- Coordinate mutual aid for health care
  - Equipment and stockpiles
  - Medical volunteers and health teams
- Distribute patient load
- Allocation of scarce resources
- Occupational healthcare issues
Principles for catastrophic response

- EF 8 must respond rapidly and deploy substantial resources
- Need to integrate EF 8 into early priority/decision making
- Large federal presence
- Bundled mission assignments

3 overall medical strategies

- Support existing, functional facilities
- Augment facilities and personnel
- Evacuate patients to decompress facilities and reduce demand
Catastrophic event response

• SOC moves to Joint Field Office
• REOCS collapse into SOC
• EF 8 participates early in Unified Command Group
• Use bundled mission and resource request
• Move health care teams directly to operational area rather than stage
Catastrophic event response
Bundled resource request for catastrophic earthquake
- 4 250-bed Federal Medical Station (FMS) Caches
- 8 50-bed FMS Caches
- 4 FMS Strike Teams
- 5 Type I Disaster Medical Assistance (DMAT) (50 person)
- 6 Type II DMATs (35 person)
- 3 Type III DMATs (24 person)
- 2 International Medical Surgical Response Team (IMSURT)
- 2 NVRTs with equipment (Veterinary Teams)
- 2 Applied Public Health Team (APHT)
- Patient movement support package (18 teams plus equip)
- Rapid deploymnet force team (125 public health personnel)
- 2 Mental health teams (26 PHS each)
- 2 DMORT teams with centers

Disaster Healthcare Volunteers
(As of September 2015)
- 2387 Physicians
- 7829 Nursing Services
- 2571 EMS
- 1113 Pharmacy Service
- 901 Hospital Ancillary
- 706 Animal Service
- 461 Social Services
- 1229 Mgmt & Support Services
DoD Health Surge Resources
Statewide Patient Movement Plan

• For large events that exceed Op Area’s resources
• Learn from other states’ plans, e.g., New York (SuperStorm Sandy), Louisiana, Texas
• Integrate California assets
  – Ambulance Strike Teams
  – CAL-MATs
• Coordinate with Federal Response Partners
  – National Disaster Medical System (NDMS)
  – National ambulance contract
  – DoD

Challenges for Patient Movement Plan

• Lack of standardization for data, communications, patient tracking
• Capabilities for packaging and evacuation of patients in “no-notice” event
  – What information must accompany patients?
  – How do we prioritize patients for evacuation?
  – How are patients and equipment tracked?
• Little planning for large regional event
• EMS surge
Patient Movement and Tracking
In the field to facilities and interfacility

EMS surge

- Tiered Dispatch
- Coordinated Transport to Alternate Destinations
- Modified Transport and Treatment Strategies
- No patient off-load delays

CDC, ORISE: Framework for Expanding EMS System Capacity during Medical Surge (Draft 2014)
Behavioral health

- DHCS assuming lead for planning
- Reinstating workgroup
- Review current state and recommendations for prior process 2012-13
- Move forward on elements of operational plan

DHV
- Disaster Healthcare Volunteers (DHV) access to patient records from alternate care sites

EMS
- Hospitals, physicians, labs, imaging, pharmacies
- Search
- Alert
- File
- Reconcile

PULSE+EHR-Link
Patient Unified Lookup System for Emergencies
CA controversies
• N-95 or PAPR
• Fluid resistant or fluid impermeable

Patient Isolation Ambulance
Ebola

- Still monitoring at least 30 people/week and no longer includes travelers from Liberia
- Regional Infectious Disease Center in California
- ConOps for transport of infectious patients being developed by RDMHS and RDMHC
  - May be limited or all EMS providers
  - Based on existing emergency response and mutual aid
  - Infectious precautions at a minimum will follow CDC recommendations.

Thank you for your attention and for all you do to prepare our healthcare system for emergencies.

Howard Backer, MD, MPH
Director@emsa.ca.gov
Questions?