The Future of System Planning

Ken Sharp, Division Director, ADPER&EH

Rebecca Curtiss, Bureau Chief, BETS

Iowa Dept of Public Health

History of PHEP/HPP funding

- Following events of 9/11, funding for preparedness activities distributed to the states.
- Initial distribution used 6 EMA regions, largely a matter of convenience and consistency with existing structure.
- Transitioned to locally driven coalitions in 2011, resulting in 74 coalitions to date.
- Neither model was based on data regarding patient or healthcare patterns.

History of EMS

- Originally established as a separate Bureau within IDPH.
- From early 2000's until 2013 the Bureau experienced an approximately 50% reduction in funding and staff.
- Extensive media and legislative attention refocused IDPH efforts to address EMS system needs.
- 2013 resulted in merger of ADPER & EH
- January 2014 resulted in merger of CDOR and EMS
- Increased resources and staffing support (4.0 FTE) from IDPH has resulted.

History of Trauma

- Trauma system established in 1995, as an inclusive system.
- No dedicated funding from state appropriations to support, and was supported by EMS bureau.
- Experienced similar reduction in support as EMS due to reduction in funding and staffing.
- Resulted in delays in verification of hospitals.
- IDPH addressed trauma system needs as part of the 2013/2014 reorganization efforts.
- Increased resources and staff (.50 FTE) increase since 2013.

2013 Organizational Changes

- Division Director retirement in Health Promotion & Chronic Disease Prevention.
- Opportunity for reducing the # of Divisions and to align similar functions across divisions.
- Acute Disease Prevention & Emergency Response Division and the Environmental Health Division were merged due to similar functions and close interaction.
- Bureau mergers (January 1, 2014)
  - Center for Disaster Operations & EMS Bureau
  - Environmental Health Services & Lead Poisoning Prevention

2014 Legislative Session

- IDPH requests
  - $150,000 system development fund to update the trauma and EMS data registry – passed
  - $75,000 general fund request to pay for ACS & NHTSA assessments - failed
- Image Trend roll out in 2015.
- IDPH reprioritized budget to ensure ACS and NHTSA consultations occurred in February 2015 and April 2015 respectively.
  - Subsequent reports from each visit provided extensive recommendations for system development and improvement.

2015 Legislative Session

- IDPH & IGOV requested a $200,000 reallocation of funding from Chronic Conditions appropriations to support staffing needs for EMS and Trauma – passed
  - Regional EMS coordinator – hired early 2016
    - Provide increased support for local EMS services via technical assistance and compliance
  - Statistical Research Analyst – hired early 2016
    - Oversee and provide support for the use of data from EMS and Trauma system to help drive system improvement efforts.
  - State EMS Medical Director – working with UIHC to coordinate hiring a joint positions to provide Medical Direction to BETS.

2015 Regional Meetings - Themes

- EMS staffing and resourcing challenges
- Grant funding often perceived as a barrier to progress
- System challenges/needs are consistent between EMS, Trauma, Preparedness, and Emergency Management
- Need more dedicated technical assistance and leadership to help shepherd service area focus.

ACS Recommendations - Trauma

- Integration of EMS within the trauma system
- Develop regional destination protocols
- Review patient transport and transfer patterns to identify potential geographic trauma service areas.
- Develop regional advisory councils
- Must be better coordination between Level I and Level II facilities with the Level III and Level IV

NHTSA Recommendations - EMS

- Establish regions for the care of ill or injured patients, based on historic referral patterns that have developed around higher level trauma centers.
- Collaboration and coordination among EMS services and other systems is needed, including PSAPs.
- Improve triage guidelines to optimize patient destination decisions, and develop interfacility transfer guidelines to transfer patients to higher level of care for patients who will benefit.

PHEP/HPP Capabilities

- 1 – Community Preparedness
- 2 – Community Recovery
- 3 – Emergency Operations Coordination
- 4 – Emergency Public Information & Warning
- 5 – Fatality Management
- 6 – Information Sharing
- 7 – Mass Care
- 8 – Medical Countermeasure Dispensing
- 9 – Medical Material Management & Distribution
- 10 – Medical Surge
- 11 – Non-Pharmaceutical Interventions
- 12 – PH Laboratory Testing
- 13 – PH Surveillance & Epi Investigation
- 14 – Responder Safety & Health
- 15 – Volunteer Management

EMS System Development Standards

- System Organization & Development
- Staffing & Training
- Communications
- Response & Transportation
- Facilities/Critical Care
- Data Collection/System Evaluation
- Public Information & Education
- Disaster Medical Response

What does the data say?

- Google Earth Display
- GIS mapping efforts
  - Trauma Facilities (118)
  - EMS Services (900+)
  - PHEP Coalitions (74)
  - Inpatient/Outpatient data (IPOP)
    - Cardiac
    - Trauma
    - Stroke

FY2018 Grant Funding Proposal

- 8-12 regions, largely based on Trauma facilities and patient patterns using the most critical conditions
- Funding support will come from PHEP/HPP/EMS System Development Funds – structured in two streams
  - Non-competitive to support FTE needs of each region
  - Competitive application – 8-12 regional coalitions will be eligible to apply for funding to address regional priorities and needs
  - Funding formulas based on county-by-county allocations will no longer be used.

Using FY16 Budget – Here are some numbers to consider

- Let's Assume 10 Regions (not finalized)
- Total Local Contracts (PHEP/HPP/System Dev): $5,022,594
- Non-competitive Stream: $1,200,000
  - 1 FTE/region @ $120,000
- Competitive Stream: $3,822,594
  - This leaves the potential for an AVERAGE award of $382,226 per region to work on system development and capability completion.

Funding structure/expectations

- RFP posted fall 2016 with application due Spring 2017 to align with CDC grant submission
- Local BOH or BOS will be the eligible applicant
- Every Region will be required to hire 1 FTE using the non-competitive funding, using a consistent position description that will focus on planning/management skills.
- Year 1
  - All regions will be required to address Capability 1 – Community Preparedness
    - Focus on building coalition structure, governance structure, etc
  - Regions may elect to address Capability 3 (Emergency Ops Coordination), 6 (Information Sharing), and 10 (Surge Capacity)
    - Recommendations from ACS and NHTSA align well, in addition EMS System Development Standards also support these capabilities

Discussion

Increased TA Support from IDPH

- What technical support is needed to ensure success in regional coalition structure?
- What TA ahead of RFP posting is needed to help determine appropriate agency in region to support?
- What resources can be made available to help prepare local partners to come together?