Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Iowa Department of Public Health

Time Critical Conditions – Systems Planning

Summary of summer 2015 statewide meetings

November 24, 2015

Summary

Ken Sharp-Acute Disease Prevention, Emergency Response & Environmental Health (ADPER&EH) Division Director and Rebecca Curtiss, Chief, Bureau of Emergency and Trauma Services (BETS) made 6 stops with 12 meetings around the state in late summer of 2015 to discuss the Preparedness Program, the American College of Surgeons Statewide Trauma Assessment and the National Highway Transportation Safety Administration Statewide EMS Assessment.

DATE	LOCATION	TIME
28-July	Cherokee	3:00 pm-5:00 pm and 6:00 pm-8:00pm
4-August	Johnston	3:00 pm-5:00 pm and 6:00 pm-8:00pm
11-August	Mason City	3:00 pm-5:00 pm and 6:00 pm-8:00pm
17-August	Atlantic	3:00 pm-5:00 pm and 6:00 pm-8:00pm
27-August	Ottumwa	3:00 pm-5:00 pm and 6:00 pm-8:00pm
1-September	Marion	3:00 pm-5:00 pm and 6:00 pm-8:00pm

Recommendations were received by our national partners to create more efficient systems of care, system development and planning for response. Once the most recent bureau activities and national recommendations were summarized by Ken and Rebecca the following discussion points were raised:

- General concerns regarding response networks (areas)
- Coordination challenges
- Communication
- Funding
- Quality evaluation and performance improvement

Attendees by Profession

Location	Public Health	Hospital/Trauma	EMS	EMA
Northwest Iowa-Cherokee	15	9	7	5
Central Iowa-Johnston	26	9	12	9
North Central Iowa-Mason City	12	4	17	6
South West Iowa-Ottumwa	12	7	20	3
South East Iowa-Atlantic	11	6	11	6
Eastern Iowa-Cedar Rapids/Marion	26	23	26	9
Total Attendance-253	102	58	93	38

Summary of Most Recent BETS Activities

General

1. The Bureau of EMS (now BETS) has not had a Medical Director since 2005.
2. The Bureau of EMS had not had a full time chief since March of 2011, until January 2014 with the formation of BETS.
3. The Division of Acute Disease Prevention and Emergency Response was merged with the Division of Environmental Health Services to create ADPER&EH. The Bureau of EMS was merged with the Center for Disaster Operations and Response which is now called the Bureau of Emergency and Trauma Services
4. The EMS and Trauma programs at IDPH experienced a significant reduction in resources from approximately 2003 through 2013.

Emergency Medical Services

Significant media coverage of the EMS system in 2010 – 2013 increased awareness and focus on efforts by IDPH to work with stakeholders in addressing system needs. During the 2013 and 2014 calendar years, IDPH met with many different stakeholders to seek input on what additional support was needed for EMS. Three key needs were identified: Medical Director Position for EMS/Trauma, more Technical Assistance/Customer Service, and better use of data to inform system improvement decisions.

During this same time, key advisory groups were calling for increased efforts on the part of IDPH to provide additional support for these important systems. In response to these calls for action, IDPH initiated efforts in 2014 and 2015 that resulted in key wins:

1. $150,000 was appropriated by the 2014 General Assembly, and IDPH has worked with ImageTrend to roll out a new trauma and EMS data registry (s) in the spring and summer of 2015.
2. In the 2013 Iowa Strategic Safety Plan, the need for an EMS assessment was identified to establish a baseline for Iowa' EMS system and identify future needs. Funding for the assessment were provided by the Department of Transportation. The assessment was carried out by the National Highway Traffic Safety Administration (NHTSA) in April 2015. NHTSA has provided a final report with EMS System recommendations.
3. IDPH and the Governor's Office requested a reallocation of underutilized funding within IDPH budget, and transferred $200,000 into the EMS and Trauma programs. This reallocation was approved by the 2015 General Assembly and will enable IDPH to create three new positions. First, a contractual Medical Director will be selected to provide direction and medical oversight to the EMS and Trauma programs. Second, an additional EMS Coordinator will be hired with a primary focus on providing technical assistance to EMS services and providers in achieving standards of care. Third, a statistical analyst will be hired to engage in better use of EMS and Trauma data and provide support to systems development.

Trauma

Based on the recommendation from the Trauma Systems Advisory Council (TSAC), IDPH requested funding from the 2014 General Assembly to support a formal review of Iowa's Trauma System by the American College of Surgeons (ACS). The funding was not appropriated. BETS worked within the bureau programs to find funding for the review. The ACS review occurred in February 2015, and a final report of recommendations for Iowa's Trauma Systems was published in April. BETS staff have, in cooperation with TSAC, taken the ACS recommendations and formulated a comprehensive work plan. BETS and local partners have established several subcommittees to review and evaluate the entire trauma system in Iowa, as well as strategies to implement key components of the ACS report.

Preparedness Background

Since 2002, IDPH Center for Disaster Operations and Response (now BETS) has received and distributed federal grant dollars to support emergency preparedness efforts across Iowa. The ultimate purpose of this grant program is to develop emergency preparedness and response capabilities for an all-hazards approach. In 2012, the Centers for Disease Control and Prevention (CDC) and the Assistant Secretary for Preparedness and Response (ASPR) introduced the public health and hospital preparedness capabilities. These capabilities include a heavy focus on medical and public health systems, coalitions and the need for these systems to work together in the time of disaster. IDPH has witnessed a wide range of efforts by our local partners to engage with the medical community and emergency management and to a lesser extent with EMS.

Related to preparedness efforts, in the fall of 2014 and 2015 the nation has seen the threats of Ebola to both foreign and domestic locations. In response to those concerns, IDPH worked extensively with public health, laboratory, hospitals, and EMS to create a system of care for suspect Ebola patients. This work has been successful with the engagement of all partners, it has been carried forward to a permanent effort to ensure a system of care for any highly infectious disease. This work also realized the value in engaging a full system discussion that included EMS in ways we have not seen before. This engagement of EMS ensures a timely and safe transport of a patient while at the same time creating efficiencies for the EMS system in reducing the burden by not expecting that every EMS service and hospital are resourced to transport or treat individuals with highly infectious disease.

Common Themes from National Assessments

1. The recommendations from the ACS report for Iowa's Trauma System include coalition and community support work, system planning, system integration, financial & human resource considerations, system coordination, and disaster preparedness.
2. The recommendations from the NHTSA report for Iowa's EMS System include financial & human resource considerations, system integration with trauma and EMS, system planning and development, better utilization of data, and communication system coordination with EMS.

3. The preparedness capabilities and the work performed through Public Health and Hospital preparedness funding efforts include expectations such as community preparedness (including medical systems), community recovery (including medical systems), emergency operations coordination, fatality management, mass care, medical countermeasures, and medical surge.
4. Lessons learned from Ebola demonstrate that a well-coordinated and planned system of care for highly infectious diseases incorporates planning that includes public health surveillance and investigation activities, transportation of patients in a safe and low-risk manner (EMS engagement), appropriate levels of medical care for patients who exceed public health services, and laboratory capabilities to ensure expedient and accurate analysis of specimens. These planning efforts have also engaged emergency management, law enforcement, mortuary sciences, and others to ensure a comprehensive systems planning effort.
5. The system challenges for EMS, trauma, and public health preparedness are strikingly similar as noted in the recommendations from the ACS and NHTSA reports, as well as the preparedness capabilities. Each of these systems has touch points between the systems, and public/patient health outcomes that align closely.
6. Each of the systems (expanded to include Stroke, STEMI, and other "time critical condition" systems) have been largely developed in a silo without seemingly meaningful discussions about how to leverage and engage in solutions to problems across systems.

Discussion Points-Questions for Regional Meeting Attendees

1. ADPER/EH & BETS believes there is an opportunity to be more intentional about addressing the system challenges ACROSS system lines rather than within each individual system. For example, rather than establishing coordination efforts based on geographical county boundaries, is there better efficiencies to be found in developing systems based on factors such as patient referral patterns, EMS response capabilities, trauma system capabilities, etc.?
2. In 2017, BETS will be submitting a new competitive grant application for preparedness funding; and we are looking at that as an opportunity to be more intentional on how to better engage and incorporate all of these systems in better coordination. What are the suggestions from the group regarding what that might look like? There is no predetermined plan at this time.
3. EMSAC and TSAC are moving forward to develop work plans to implement recommendations from the ACS and NHTSA reports, the information gathered from these regional meetings will be used to inform and develop strategies that best align with the needs of our stakeholders.
4. The intent of these regional meetings was to gather input and guidance on concerns and potential solutions. With this information BETS plans to develop a draft recommendation on future efforts to improve system coordination among programs that include LPHA, Hospitals, Trauma, and EMS.
5. We would like to have a draft recommendation ready for public comment in 6-12 months that will help us plan for the future.

Regional Meeting Challenges-Themes by Region

Northwest:

Aging staff in all service programs
Volunteer numbers declining
Lack of sustainable funding
Lack of Medical Director Engagement
Image Trend training has been insufficient
Difficult to get EMS to coalition meetings
PSAP lacks coordination not enough medical dispatch programs
Coalitions lack unified efforts in local areas
Need local "champions" to unify and coordinate regional efforts
EMS as an essential service

Central:

There are no system response efforts-coalitions are planning endeavors
EMS must be an essential service
TCC system building barriers: territorialism, legal agreements among partners are difficult to navigate
Need more technical assistance directly to local partners
State should designate TCC areas and requirements/expectations as related to funding

North Central:

EMS as essential service
Resource limitations: staff/funds
EMS Education standards are very high, difficult to find volunteers to successfully complete courses
24/7 availability of staff is challenging
Lack of direction and clear expectations from IDPH to local coalitions
EMS provider level transition is a barrier to having adequate numbers of trained providers

Southwest:

Preparedness coalitions offer slow solutions as only capability focused, not response in previous form. New efforts should be response based areas based on patient referral patterns
Frequent turn over in positions-all programs
Lack of regional organization has slowed collaborative efforts
Preparedness capabilities are not achievable

Southeast:

Majority of the system development funds are spent on training, not developing a local system or coalition
Fire based services are restricted to fire jurisdiction, imposes on system development
Data analysis is not used to drive decisions
Emergency medical dispatchers are not required, this leaves the first line of EMS vacant
Lack of volunteers/staff
Slow development pace of community para-medicine/mobile integrated health
Lack of state collaboration between IDPH and HSEMD related to capabilities/ESF, planning and exercises
Data submission requirements are not enforced and local partners are unable to get useable data in return

East:

No access to system development training, poor understanding of expectations or how to implement without direction from IDPH
Lack of understanding regarding training requirements for EMS and Coalitions
Unable to find quality candidates for EMS training
Local services need more funding
EMS must be an essential service
Not enough technical assistance for single entities for day to day efforts much less system development
No multi-entity coordination for system development
There are no models for engaging different systems of care

Local Partner Recommended Solutions to Challenges (listed in no particular order)

Submission of data-EMS should be required to submit all PCR within 30 days of end of month so data can be extracted and actionable
IDPH should design the jurisdictional boundaries to assure an appropriate response and improve outcomes-designed using STEMI/STROKE/TRAUMA from 911 data only.
Must be standards of performance; measurements must be critical benchmarks for coalition authorization
Must begin to benchmark EMS reaction times, response times and patient outcomes
Emergency Medical Dispatch is critical
Programs/Service should bid on area jurisdictions for system building
Private services should be inspected differently than 911 response services
Each coalition should designate a reporting authority to access data for system sharing
Must have good data for system assessment-Data must tell a story
Data has to be pushed back to the services-IDPH must develop better reporting mechanisms
Collaboration through coalitions and CHNA-HIP
Provide education related to system wide data use and quality improvements

Provide statewide summit focused on all response agencies
EMA should serve as leadership and collaboration champion
Prioritize problems then search for long term sustainable funding solutions
IDPH to retain some of the system development funds to provide admin and education for TCC system building
Leverage resources at the local level, prioritize critical problems.
System Development funds should be utilized by volunteer services only due to lack of other incentives
Increase funds to local partners
Retain % of statewide civil penalties to support IDPH and local systems
Increase technical assistance to locals regarding system building
IDPH to provide education through a periodical newsletter-one page-priority information
Provide data by county geographic areas
IDPH should assist in volunteer recruitment efforts
IDPH needs to provide staff or funding for additional coalition mediation/development
IDPH should transition coalition leadership back to larger regional area
Share local successes as models
Legislation to hold each BOS accountable for EMS/911 services in each county
IDPH to provide more practical examples and templates for work to be completed
IDPH needs to provide staff or funding for additional coalition mediation/development
Determine additional medical care providers that can be exempted such as LPN, radiological techs
IDPH provide a forum to share success stories
IDPH to take more active role in the development of community para-medicine/mobile integrated health
Require coalitions to include EMS from all services
Requiring BOH/LPH to administer system development funds, has served as a good model
Improve collaboration between IDPH and HSEMD on capabilities, planning and exercise requirements
Increase opportunities to interact and share best practices, such as statewide conference
Brand TCC and coalitions as outcome based community service not money
Link PSAP and data submission software
Conduct a preparedness and pre-hospital to hospital gap assessment as related to capabilities in all TCC's
Determine additional medical care providers that can be exempted such as LPN, radiological techs to serve as EMS providers
IDPH to provide regionally based training specifically for TCC
IDPH to force system standards and development-develop smarter deliverables and assign local responsibility
System Development and Preparedness funds to go through LBOH, LPH to serve as TCC champion
IDPH to require a minimum of quarterly coalition meetings with all TCC partners in attendance

IDPH to develop web pages for best practices and model projects
Develop TCC based only on patient referral patterns
IDPH to provide joint coalition/EMS technical assistance staff to facilitate multi-system/partner meetings
Utilize the school consolidation model for TCC development. Legislate and complete.

Next Steps

1. Prepare and distribute summary of the TCC statewide meetings to key stakeholders.
2. IDPH/BETS will employ two new FTEs before January 1, 2016 to provide additional technical assistance for EMS systems development and compliance with EMS system standards; and to enhance BETS capability to review, analyze, interpret, and distribute EMS, Trauma, and preparedness data.
3. IDPH/BETS will seek applications for re-establishing a part-time Medical Director for the EMS and Trauma systems.
4. Consult with Emergency Medical Services Advisory Council, Preparedness Advisory Council, and Trauma Systems Advisory Council to seek input on strategies to enhance "system" planning strategies for cross sectional engagement from EMS, Trauma, Public Health Preparedness, and Hospital Preparedness programs.
5. IDPH/BETS will by July 1, 2016 present to key stakeholders a draft proposal for system development strategies to better engage cross-disciplinary efforts to improve Iowa capacity and capability for Time Critical Conditions. This plan will include at a minimum, a proposed organizational structure, resource allocation plan, and prioritization of capabilities development.
6. IDPH/BETS will repeat the statewide meeting schedule during the summer of 2016 to receive feedback and input on the system development strategy proposal for final decision making with a goal of implementation of new strategies by July 1, 2017.