ASPR Health Care Readiness Cooperative Agreements All-Recipient Webinar Transcript
August 30, 2023
Call Transcript

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Megan Wassef: I will now pass it over to Jennifer Hannah, who will open up today's call.

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Jennifer Hannah: Thank you, Megan. Good afternoon, everyone. Thank you all for joining us today. As Megan already stated, I'm Jennifer Hannah and I'm the Director of the Office of Health Care Readiness here at ASPR. Before I hand it over to our first presenter, I would like to provide a brief overview of what we will cover today. Next slide, please.

So, today's meeting will focus on emergency medical services, or EMS, and pre-hospital care. I will begin by providing a few updates relating to ASPR's Health Care Readiness Programs. Next, Rachel Lehman, the Acting Director of ASPR TRACIE, will provide an overview of ASPR TRACIE's pre-hospital care and EMS related resources. Afterwards, Dr. Richard C. Hunt, the Senior Medical Advisor for the Office of Health Care Readiness, will lead a panel discussion on pre-hospital care. Finally, we will leave some time at the end for general questions from all of you. Next slide, please

I'd like to begin today's webinar with a few administrative updates. As a reminder, hopefully you will refer to the Health Care Readiness Bulletin that was that was released on Monday. Please refer to the Bulletin for any upcoming recipient webinars, as well as any upcoming performance measures deadlines. Next slide, please.

We recently published four new Health Care Readiness Stories from the Field. Stories from the Field highlight your hard work and accomplishments.

From New York City to Arizona, these new stories are examples of the diversity of support that ASPR funding offers you and your sub-recipients as you bolster emergency preparedness and response. To read these stories and explore others, head to the Stories from the Field page on aspr.hhs.gov. For your reference, a member of our team will share the Stories from the Field page link in the chat momentarily.

I will now pass it over to Rachel Lehman to provide an overview of ASPR TRACIE's pre-hospital care resources.

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Rachel Lehman: Thank you, Jennifer, and thank you for featuring ASPR TRACIE on today's All-Recipient Webinar. It is always such a privilege to present on these calls. Next slide.

As Jennifer said, I'm going to give you a quick overview of ASPR TRACIE's pre-hospital resources. As you can see, we have developed a wide variety of resources with our subject matter experts, in response to and in anticipation of incidents. Next slide.

ASPR TRACIE created the EMS Infectious Disease Playbook in 2017, and since its release it has become one of our most popular resources. We comprehensively updated the playbook earlier this summer. The goal of this document is to unify multiple resources of information and

a single, concise planning document, addressing the full spectrum of infectious agents for EMS agencies developing their service policies.

The first section covers dispatch and responder actions. It includes a screening and on-scene assessment algorithm. The rest of the Playbook is organized by precaution, such as contact, droplet, and airborne. The last section covers special considerations, such as hand hygiene, pandemic specific precautions, pediatric issues, and occupational health. Next slide.

The Paradigms and Pitfalls document was created to help EMS medical directors, EMS system planners, and hospital emergency planners plan for mass violence events where the scene is dynamic, the number of patients far exceeds the usual resources, and the usual triage and treatment paradigms may fail. It focuses more on the principles of triage versus the actual process, including: doing the greatest good for the greatest number of patients with the resources available; gaining rapid access to living casualties in evaluating them from the hazard area; providing basic lifesaving interventions as soon as it is safe to do so; transporting the injured to the appropriate hospital as rapidly as possible; when necessary prioritizing resources to those who are most in need and are salvageable with current resources in re-triaging patients as the surge situation continues to change over time.

Moving forward, the Mass Violence and Active Shooter Tip Sheet is part of a suite of mass violence tip sheets ASPR TRACIE created after the Las Vegas Harvest Festival shooting. In this tip sheet we provide EMS providers with pre-event considerations, steps to take during the initial response to a mass casualty incident, and how to transition to supporting hospitals once patient transport is complete. Next slide

We are in the process of having subject matter experts comprehensively review our two updated pre-hospital topic collections: the Pre-Hospital Collection and the Pre-Hospital Mass Casualty Triage and Trauma Care Collection. And you can see, while they share some of the same categories, these collections differ in both in scope and focus. We will be releasing the updated versions of these in September, so keep an eye on your inbox. Next slide.

Next, I wanted to give you a quick overview of some of our recent releases. So, in addition to Version 2.0 of the EMS Infectious Disease Playbook, we released some additional resources this summer that you all might be interested in. Lessons Learned in Health Care Communications Article is based on a roundtable ASPR TRACIE hosted in Spring 2023, which featured speakers representing a wide range of health care stakeholders and jurisdiction types, sharing how they integrated lessons learned from the COVID-19 pandemic and recent incidents into current and future responses. Topics covered in the article include channels used for outreach and continued engagement, strategies for reaching different community cultural groups, tracking and countering rumors, and working with partners to create complementary messaging.

The Health Equity Officer Job Action Sheet is modeled after the Hospital Incident Command System Job Action Sheets. Health care planners can tailor the Job Action Sheet to their system, to incorporate a dedicated health equity officer position. We also recently recorded a presentation moderated by the California Department of Public Health, featuring panelists from public health departments and health care systems in California, sharing their experiences with preparedness and response efforts for planned and unplanned power disruptions. We released another speaker series recording recently which was a demo of our Mass Casualty Hospital Capacity Expansion Toolkits. And that toolkit itself was actually released this spring. Lastly, we

added air quality resources to our Climate Change and Health Care System Considerations Topic Collection, and we updated our Healthcare Facility Onboarding Checklists and our Solar Eclipses: Planning Resource documents. Next slide.

And please just never hesitate to reach out to the APSR TRACIE assistance center. We are here to provide you personalized technical assistance and to answer your questions. And that is all I have for today, unless anyone has any questions.

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Jennifer Hannah: Thank you, Rachel. And just as a reminder for everyone, if you have a question, please enter it into the chat feature here in Zoom, or raise your hand and ask your questions, live. Thanks for that overview, Rachel.

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Rachel Lehman: Thank you, Jennifer.

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Jennifer Hannah: I'm not seeing any questions in the chat, or anyone raising their hand, so we'll now pass it over to Dr. Richard Hunt.

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Dr. Richard Hunt: Shoot Jennifer, I wasn't even gonna wait. So my name is Richard Hunt. I'm the Senior Medical Advisor for the Office of Health Care Readiness here at ASPR. For today's panel discussion we have invited individuals that represent the federal, state, and local levels of pre-hospital care coordination. I'm joined by: Dr. Carol Cunningham, the State Medical Director for the Ohio Department of Public Safety EMS Division, Terry Crammer, the Chief of Disaster Response at the Los Angeles County EMS Agency, and Kate Elkins, an EMS and 911 Specialist from the National Highway Traffic Safety Administration's Office of EMS Services.

We're really excited to have each of you on the call today. Appreciate that. And we're looking forward to hearing your unique perspectives and experience in pre-hospital care. While we're getting the panel set up here, I'm going to start by going over the logistics for this panel discussion. For the panelists - I will read each discussion question and invite one of you to start the conversation and feel free to add on to what another panelist and shared, even if you've already spoken. For those of you in the audience, please enter any questions in the chat during the panel. We hope to address questions, time dependent, during the Q&A portion of today's webinar.

For the purposes of today's discussion, let's talk about EMS broadly to encompass 911, EMS response to medical emergencies, calls to 911, and those EMS agencies response, and inter facility air and ground medical transport, including noncritical care and critical care interfacility transport. So broad spectrum. With that in mind, let's go ahead and get started. We're going to start by discussing EMS membership and representation in our Office of Health Care Readiness programs.

We have a number of programs in our office, and we really want to address and discuss that membership and representation of EMS. EMS is key partner and member for several of our ASPR health care readiness programs and activities. For example, the Hospital Preparedness

Program and the Regional Disaster Health Response System require EMS to be a core member, as does medical transport and special pathogens; however, we have seen that there is an underrepresentation and inconsistent involvement of EMS organizations for a variety of reasons, including variation in EMS structures throughout the nation.

So teeing this up, Kate, you're gonna go first for this one. Have you seen any opportunities or noted practices that could address the challenges or barriers for EMS to participate and collaborate in health care preparedness and emergency response programs? From your experience, what are those challenges or barriers for EMS to participate and collaborate in health care preparedness and emergency response programs?

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Kate Elkins: Excellent question. Well, EMS and 911 systems grow locally and originate at the state level, they're regulated that way, so sometimes it can be really complicated to get their engagement, especially in pre-planning. When your hair is on fire, and you have a whole million things to do in the current moment, it's hard to step aside and go to meetings for planning. So I think one of the strategies that I would strongly recommend that people participate in is to start with your state offices and engage those state offices who understand the complexity and the nuances of the local and the regional systems within your state, and engage that partnership to really leverage the resources that they bring to bear within your community, within your region, within your state, and then have them help you to build those critical relationships early, to engage, recruit, and have participation in all phases of this engagement.

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Dr. Richard Hunt: Thanks, Kate. Terry, your perspective on this?

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Terry Crammer: Yeah. As Kate mentioned, I think it all starts with reaching out to different agencies. I can only give you a perspective of what we do in Los Angeles County, which I understand does not apply to some other areas, but one of strategies we've used is where we have, basically a pre-hospital policy manual, which dictates how things are done in the pre-hospital environment. And with that we have different collaborative groups that we've had for over 40 years, which are a provider agency group, an LA County area ambulance group, a hospital group, pediatric group, etcetera. And we engage them based on that specialty and that expertise. And so we engage them at that level, but also because of our size and complexity of our county, of 4,000 square miles and 10 million people trying to eat an elephant all at once is very challenging. So we broke up our county into nine different regions, what we call disaster resource regions, and we have a hub and spoke model where we can, for example, make the fire department a little bit smaller and maybe in a smaller community, feel like they have better engagement from a local level, versus looking at this big complex system we call LA County. So they engage at those more regional, local levels to make it more pertinent, how they have an impact on their community where many of them live in and serve, versus looking at a bigger picture of LA County, where they may not see that value because of our size.

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Dr. Richard Hunt: Thanks, Terry. I especially appreciate that with LA County, it's local but it's big local. Carol, how about you? From a State EMS Medical Director perspective, what is stopping people from being engaged?

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Dr. Carol Cunningham: Well, I think it starts out with an invitation. I can tell you that when I started, a lot of the other departments in Ohio didn't even know there was a State EMS Medical Director, and I just went out and kind of introduced myself. But you know, 20 years later, it is so much better. I think that as Kate mentioned, you have to have a strong relationship with your state EMS office, but it's a two-way street. I really cringe when we're invited to a project as an afterthought. EMS really should be on the ground floor of every planning initiative and with the committees you have within your EMS Agency, you should at least invite the folks from public health, mental health, whatever you need to the table. And likewise, since we've done that, it's a two-way street and we're invited now to many of the critical committees again at the ground level with our health care response agencies. One new thing that we have just started this summer is a state agency medical director's forum. So, all the medical directors, whether it's mental health or whatever, get together once a month. It’s been amazing to hear about the shared troubles and solutions that we come up with.

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Dr. Richard Hunt: Yeah, I think the clip from the news feed on this would be “it starts with an invitation.” I like that. I appreciate that, Carol. Have an open-door policy. Next question.

We have recipients of our Office of Health Care Readiness awards, so you know, the Regional Disaster Health Response System, the Hospital Preparedness Program-supported coalitions, and then again you know, medical transport, special pathogen patients as an additional area. And so how, beyond the invitation, how do you think, we can specifically, from your perspective, improve recruitment and inclusion of EMS agencies in health care preparedness planning and emergency response? Let me start with Terry on this one.

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Terry Crammer: Yeah, I think that's a great question. And the challenge, I believe, is that you know you look at the health care perspective and you have a lot of regulatory bodies, right? You have the Joint Commission, you have CMS, you have a lot of people that hold us accountable to do engagement and that's kind of how you look at a lot of ESF-8. But when you look at ESF-4, which in our system, all our 911 are fire-based so it's a little bit of a different challenge because then, what is their regulatory body? I don't know. And that's kind of the point. They got the National Highway Traffic Safety Administration, and you have some others, but they're not regulatory. They're kind of more guidance type of things right? You see NHTSA there. So that's a challenge right there, because their mission and our mission are kind of incongruent, and to try to get them to see the collaboration ahead of time is hard. We never have issues in the response phase, right? Everybody buckles down and helps each other.

But in that planning stage, they’re worried about fires, they're worried about other things such as health care. And so again, I present it as a prize. There's a participation thing. We participate in their drills. We invite them to our drills. There's a regulatory piece that we don't always want to force people to do things, but there are benefits to some regulatory, that basically at a local

EMS level you have to do. So one of the things we've done with our ambulances is if they want to get that exclusive operating transport contract, they're signing up to be helping in a disaster to move patients and you're gonna be participating in meetings to plan for those types of disaster. So there is a regulatory piece. Incentivizing, or looking at things that benefit them. During COVID, if you were engaged with us on these meetings, we had a better understanding of what your need was for PPE. So there was a prize there. If you participated, you could give us a better idea of what the situation was for your department, so you may get a higher percentage of the PPE that was being distributed. Because now we had an idea. And if you weren't engaged, then, obviously, we didn't know that. And then I think the key for us is there's it's a two-pronged approach, you know. You have this at a local level, engaging at that smaller captain, maybe battalion chief level by participating in those regional type of meetings that I discussed a little earlier, but then there's also engagement with the chiefs, the big chiefs, the assistant chiefs, the department chiefs. So engaging that leadership and approaching it from the ground level, worker or boots on the ground person, saying what the benefit is to know what's going on locally, but then also from a systems approach from the high-level to get their buy in that this is important. You can't just do one or the other, because the boots on the ground may feel it's important, but they haven't had that engagement with the higher leadership which may not see that its important. So that's gonna take executives at the CEO-level at a hospital, EMS level, public health level, high leadership engaging with the chiefs, because the chiefs aren't engaging with just the regular emergency manager, they're going to want to engage at that high, executive level. So those are things that have worked for us and seem to have benefited us in, especially in in big responses like train derailments, earthquakes, and recently hurricanes. So that's what I have.

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Dr. Richard Hunt: Terry, you bring up some really important points for all of us. Okay, LA County being fire-based, I mean I can name a city on the East coast that's very fire-based, like New York City. So it's I think it's important, as you pointed out, that we don't just have a "one size fits all" on EMS these volunteers. And probably more so, that provides a challenge. Yet, as I reflect back on Carol's comment about how you have to have an invitation and what incentivizes somebody to actually be there? And is better planning and the potential to actually improve our capability and capacity save lives and continue to operate - is that sufficient or is there something, a near tangible that you need for the planning piece? I don't know the answer to that.

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Terry Crammer: Well let me give you one example of an incentivization too. We get HPP funding and we're part of a health care coalition, so if you're part of that coalition, one of the things that we've tried to do is break out some of that money that's not just hospital based. So, we learned a lesson from the Vegas shooting where one of the ambulance companies threw out tourniquets. It was in a disorganized way, but it was organized in a sense that they knew that there were military personnel, off duty police officers, off duty fire personnel, and boy scouts and girl scouts that knew how to apply tourniquets. So what they did is just throw them out there randomly and let them do their thing, instead of having people take off their belts and shirts to make these improvised tourniquets. So the incentive now is, we're working on a project where we're going to create these what we call "trauma throw bags" that will be on supervisor vehicles. So we're engaging that leadership. We're engaging the paramedic, the boots on the ground guy

who's allowed to now throw a bag out in the crowd and allow other people in the community to do what they know best. I mean there's a lot of nurses off duty, and I always feel like, you know, my hands are tied, because I don't have my tools. I have the knowledge of what to do, but I don't have the tools with me. So, this will help provide the tools to those people that know how to use them out there. And that's an incentive because it now doesn't have to be part of their budget, right? We're providing it outside of their budget. So that's just one example that can try to help incentivize.

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Dr. Richard Hunt: Thanks, Terry. So Terry, right now there are three million people in the United States, members of public trained in wound control. So it's not what we had at Las Vegas. It's better. How about Carol? Any perspectives from you on this? And Terry, really appreciated your comments there.

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Dr. Carol Cunningham: Yeah, sure. I think that, again, opening the table, making people feel valued is important. In Ohio, we have fire-based EMS, we have private EMS, but we also have like a third of the state that's served by rural and volunteer agencies. And I've always told them that they are a valuable asset, because they are at an arm’s length to the community. When you look at the different response patterns, you know, everybody wants to live. So regardless of what kind of assets are available, it's the community that's going to use resources that they have and come up with a solution. But again, you know, and I look at the state office like “what can we do to help?” In our committees we actually make an active effort to make sure we have representation from a volunteer EMS agency or rural EMS agency. Cause you can't have the big cities running everything. It just doesn't work that way. I remember I was appalled when CHEMPACK came out and there were some assets that could be distributed and there was a program where people can actually get antidotes outside of CHEMPACK. They were supposed to distribute them throughout the Homeland Security Agency, and I had them one metropolitan area, which I won't name, you know, one of the guys was just like, where's ours? Oh, we'll just bring it to you. Well, you know the toxin killed. Everybody would be dead by then. And that's the kind of you know, control and mindset that we have to have to get rid of. And you know again, like I said, you need to not be so prescriptive with the plans. The other important link that I need to mention is that a lot of these areas border on other states. When there's a mass casualty event, does the patient really care which level of provider, you know, who is intubating them? They need an airway. So, we need to work together and make sure that we're both familiar with the variations and scopes of practice and create disaster plans again that are going to mesh well for the client who is our patient.

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Dr. Richard Hunt: Thanks, Carol. Hey, Kate anything to add?

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Kate Elkins: Yeah, I just want to echo that I love Dr. Cunningham's remarks to not neglect the volunteers in the rural communities. I think it's really important when you're engaging with EMS, they don't have the same health care centered corporate culture, or they don't have the same work hours necessarily, and if you really want them to engage, you need to make it something

that they can engage. Make it something where they can physically get there. Make it so that there are virtual options if the virtual options will work for them. Make it also something where they recognize the benefit and participation. And I mean that from the sense of, if they have engaged in the past and then were ignored, or not considered, or their input wasn't taken in why are they gonna invest their most valuable resource, which is their time and energy, in your project or in your program? And I think it's really important that we have their engagement because there are a lot of assumptions that are made, and when you get to the response time, you want to make sure that you're not working on an assumption that isn't valid per se. I know during COVID we had a lot of challenges where EMS, and especially volunteer EMS and rural EMS, were stepping up and filling a lot of safety net features for their communities. And you know when the volunteer agency in your rural community has only two ambulances - and all of a sudden, they've reached a point where they're no longer staffing that second ambulance, but that second ambulance is critical to your hospital decompression of a critical access hospital - everybody in that community now has a problem. So, making sure the invitation is there that they can make it to the table that they feel like they can speak up and be engaged at the table is incredibly important.

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Dr. Carol Cunningham: And just to add on to what Kate mentioned. An example also is if there's something they need to know, take it to them. Don't wait for them to come to you. You know we had an issue with pediatric intubations - how often do they get to intubate? Well, a couple of years ago we got all the pediatric hospitals together, and we had teams that actually went out and went to them. A volunteer can’t take off from work, doesn't have the resources to go to a big conference, and again, I think it really made them feel valued, and it helped their community cause in that scenario that’s a hot topic. You got to know what you’re doing on something that you don't do very often.

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Dr. Richard Hunt: Great examples and really appreciate that sentiment; it's not banker’s hours, especially for us or for the hospital too. But they can still have the nine to five people come and represent, and so forth. So great points.

Next set of questions. There's a couple of questions that’re related to medical surge. And EMS, indeed, plays a really critical role in mitigating surge. Mitigating surge is defined as events where health care entities care for an increased volume of patients exceeding normal operating capacity. The entire nation saw medical surge, so it’s not new to us. Realizing the differing capabilities and capacities for EMS at state and local levels, as well as between urban, rural and frontier communities.

First question would be: from where each of you sit, what are the critical capabilities you see EMS bringing to the table to help with patient movement and load balancing during an emergency? What challenges do you see that are preventing EMS from supporting preparedness and response? How about we go with Carol first.

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Dr. Carol Cunningham: Okay, this is great topic. I think that we're using telehealth more, but we also have to trust our EMS providers. Just because you call 911, doesn't mean that you

need an ambulance. Just because you call 911, doesn't mean that you need a hospital. For the folks on the ground, they need us to set up other care areas or resources where we're really focusing on taking true emergencies that need to be at the hospital there, but also giving resources to people that we decide to shelter in place or to send them to an urgent care. Or like during a blackout in 2003, people just needed electricity. We opened up a high school gym, and then, you know anybody who needed oxygen generators were plugged in. In terms of barriers, unfortunately, some of the legislation can put people in trouble. I love states that have crisis standard of care plans, where they get additional liability protection for making these types of decisions. If you live in a litigious state that can really be the scary thing. As any type of patient refusal, as you know, Dr. Hunt, it can be dicey. But again, with telehealth, we could use that as a resource. I also think that particularly in the volunteer areas, make sure that your scope of practice is being utilized in the most efficient way. When you don't have paramedics, and people still have needing Naloxone. Yeah, they need it, but what can the state do to help? One thing that we did is we made an agreement with the drug companies that we could get wholesale prices for Naloxone, again to increase access, so that EMRs who don't have can start IVs or use other routes and save these overdose patients. The world's our oyster. We just have to think about errors and get rid of them.

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Dr. Richard Hunt: You know, Carol, you make me think about the extraordinary adaptability of EMS and doing some really hard problem solving during COVID with the examples that we saw. Things like administration of monoclonal antibodies. I mean lot of the telemedicine piece and then trying to figure out how stay alive. The challenges that some of the regulations have, we're confronted with, and they make it really difficult for us to respond to medical surges in ways that we might otherwise. How about you, Kate? Your thoughts on this.

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Kate Elkins: So excellent points, Dr. Cunningham, and I think that what's really important is, we are in the community, for the community. We are that safety net system for the everyday, and when there is a crisis or an emergency, we oftentimes are just asked to rise to that situation. I would highlight that your 911 centers and your emergency medical dispatchers are key components to managing surge, empowering not just your EMS clinicians, but your emergency medical dispatchers, through your medical director to be able to follow protocols. And how many of these calls can go to nurse triage? How many can go to telehealth? How many can have a delayed response? Maybe your community paramedics or mobile integrated health care team can step in and do some of this work in collaboration with your local primary care, urgent care, and other alternate destinations. How can we on the front end, really use these clinicians who are in our communities and leverage their expertise? They practice at the intersection of public health, public safety, emergency management, and health care every day. How can we leverage that expertise and empower them to be that frontline provide that we need and reduce the number of unnecessary trips into that hospital system? And then making sure that they're taking those patients who do need to go to the right place, empowering them not only through protocol and clinical expertise and training, but we're gonna have to talk about that elephant in the room which is finances, and the ability to actually pay for that kind of care, which we know that our system can do, but it currently very much struggles to be funded or be reimbursed for.

So, when we're thinking about planning, are we planning so that we can actually leverage all of that expertise? Or have we still pigeonholed EMS as patient transport where we're not necessarily thinking about them as the ability to get vaccinations into our communities, into our senior centers, or that, you know tribal nation that actually use their paramedics and home health care to do antibody infusions of elders without moving them from their homes. Leveraging those opportunities to care where our patients are, in our communities, with cultural competence, is incredibly valuable. I think it's gonna be important that we have the engagement of our state EMS offices and of all of our medical directors, to empower them to do this amazing health care that they're able to do, but also working on those regulatory challenges. You know, county lines and state lines shouldn't be a barrier, especially in a crisis, but nor should financial systems for reimbursement. And so that's something that's really challenging. And I don't have the solution. I'm just pointing it out as a challenge.

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Dr. Carol Cunningham: We also have to educate our community. I'd encourage everybody to go to the division website. Early in the pandemic, my own fire chief called me said “we're getting killed with calls and we produced a “be a part of the solution” video that we put out on the TV as a public service announcement that educated the community on what kind of symptoms really needed to go to the hospital. But in that video, we also showed the community everything that EMS had to do to get the vehicle ready. They got to see how it got cleaned, and it wasn't like you just drive and go back. It really had a positive impact on making people think about what's appropriate.

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Dr. Richard Hunt: Yeah, thank you. Educating the community is a huge challenge, especially with the numbers of people we have. Hugely important. Terry, how about your perspective? I'm familiar with some of the things that LA County did during the pandemic, with reference to surge but want to hear your perspective on this.

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Terry Crammer: Well, I'm not gonna repeat what Kate and Carol said. I think they brought up very valid points that I concur with. One of the things I’d like to kind of highlight in regard to what Kate was pointing out, is, you know, since Medicare and Medicaid haven't increased their rates since 1998, that makes it very challenging for small EMS departments that are not fire-based to continue operating. And as I heard one of my colleagues that works in the ambulance industry say, “if we're not transporting, we're not making money.” And so, looking at the challenges in supporting preparedness, it's not that they don't want to support preparedness, they just don't have the luxury of having additional funds to attend meetings when they're not getting paid to do that. They have to be out in the field. And when they are out in the field, they're getting pennies to the dollar on what it's actually costing them, for a variety of reasons. I don't want to get into all the politics of living wages and everything else, but you know I have heard an EMT say, “it's hard to work for a company where you put your life on the line going Code 3, expose yourselves to individuals that are ill, maybe contagious, and you're making only two dollars more than the guy that works in McDonald’s, on an hourly basis.”

Those are the kinds of challenges our EMS providers are facing in the private sector. The fire sector is a little bit better, because obviously they're publicly funded, and they have a little bit

more resources in those funding streams. So, on our fire side, having those challenges is a little less because they do get paid to attend meetings, they do get paid to come to that, because that's part of their work environment, to interact with us as an EMS agency, to follow procedures and protocols, and to be part of the solutions that we come up with. But I can see the private sector versus the public sector, and obviously for those areas around the country that are volunteer based, that just compounds it. I mean, they're doing it from their heart, not because of any financial gain that's gonna come from it. So, I think there's pros and cons to all these different types of EMS providers. Again, I do concur with everything they said about the question regarding challenges. Those are just my additions, thank you.

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Dr. Richard Hunt: Thanks, Terry. I think we've touched on some of what would have been responses to the fourth question. So, I'm gonna cut to the chase and go to the last question. The last question is: with the diminished number of EMTs and paramedics as compared to pre-pandemic levels, how can EMS adapt to best respond to the wide range and severity of disasters we face? So, I want to start with Terry for this one.

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Terry Crammer: Of course you would. This is probably the most challenging question of today, right? Cause again recruitment of EMTs. We have plenty of schools, we're just seeing enrollment down. And again, it's because people do their research and go “well, this is how much I'm going to make, and this is how much I'm not going to make.” Some do it because it is a steppingstone. So, this is a challenge we're still faced with, and I don't have a clear answer to this.

Looking at LA County, we have challenges from our public health which the county right next door, has a different operating picture where there are mandates for vaccines and masks and certain things that we may be facing in our county under certain situations, but a county next door isn't requiring the same thing. So, we're losing our EMTs to other counties because of personal beliefs or say these COVID mandates. So that's been a challenge for us because we where we are surrounded by. People have the opportunity to make choices and they tend to go somewhere where there's not as much government influence on what is dictated or required to be an EMT in this county. At the same time, like I said, when you have pay of people that are doing, you know, in some opinions, maybe less critical work, and are almost making comparably the same amount of money, it makes it more challenging to recruit people when there's no financial benefit, with a little bit, maybe higher risk. And quite honestly, you know, more training. I mean, for EMTs and paramedics there's quite an extensive amount of training that goes into what they do. Not everybody's altruistic that they're gonna come out there and do it for free, or at a decreased rate, because they got to put food on the table and feed their families, too. So, yeah, this is a challenge, and I'd love to hear from my colleagues on the panel here, on what their approach has been to this.

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Dr. Richard Hunt: Terry, you know when you're talking about the recruitment challenges, yet from what I'm hearing, it's not like in two months' time we're gonna, have the same workforce levels. So how you adapt. But actually, in your very first response to the very first question I threw out there, you talked about that Las Vegas thing where they had “throw kits”, and they

threw kits out to the public. And so in in many ways, that's like a microcosm of this “we don't have enough to respond to this.” So, they leveraged sort of a force multiplier and really, you know, it was first time I heard of it, but it was pretty effective. So, I mean, I think you actually answered part of the question in your earlier responses. Kate, how about you?

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Kate Elkins: Well, I'm gonna shout out to North Dakota training ranchers in remote parts of the state with the basics of Naloxone administration, Stop the Bleed, and CPR, and giving them some AEDs. Forced multipliers. When you don't have a lot of ambulances, don't have enough volunteers, you are thinking outside of the box. How can you get your community education and engagement to buy you time to get there? I think that's important. So, I am a volunteer paramedic. I still volunteer. I still respond to calls. So how do you keep people once you have them? What are you doing for retention? What are you doing for their mental health? What are we doing to manage the stressors that are in our personal operational challenges in a department? How do we manage the challenge of when I was paying for grad school, as a paramedic years ago, it actually would have been financially beneficial to work at a different venue as I would have made more money? How do we overcome some of those challenges?

But another thing that's really important is we had to shut down the educational pipeline during COVID, for a period of time. A lot of our training programs still struggle to get clinical hours in hospital settings. How can we engage public health, health care, emergency management, and public safety partners to shore up and give us the support that we need to make sure that our educational system is thriving and that when we do recruit people, we are able to retain them. I would love for us to have really robust mental health resources for all first responders, but that's a passion of mine. I think it's also really important that, just because somebody's volunteering and they're not doing it for money, doesn't mean that they don't have a reason that's investing them in doing it. How do we harness those people who are doing it because it's their community or doing it because their family could be the ones calling? How do we recognize some of those driving factors and find out how do we recruit more of those people? It's not as often, now, that we're seeing people having the time to volunteer because they have to have two jobs just to put food on the table, or you have to have multiple things. So, I think it's a really complicated situation, but I would call out things we can do easily are facilitating the educational system and supporting them. Maybe thinking about regulation in the federal space. You know, you can't take out student loans necessarily for a paramedic program. Why isn't that? Why don't we have some of those opportunities there? So, thinking through, how can we make it easier for our communities to train people at all levels, not just the highest level? And how do we find the right people who want to do the work and engage them to stay?

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Dr. Richard Hunt: Yes, thanks Kate. One quick question for you, Kate – from what you're hearing in the office, are you hearing an increase in young people coming in? Or not really right now.

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Kate Elkins: I think it really depends on where you are. There are some regions, some places, some locales that are doing really great. I have a colleague in a rural ambulance service that had two brand new people walk in and she's like “I didn't have to chase them down; they walked

right in my doors and join my department." But you know there's a community in Alaska that is doing a remote EMT course for their community, and they don't have a hospital. So, you know, in those places it's really important. I think in some ways we need to take a lesson from positive psychology. How do we look at the outliers that are positive? Not the doom and gloom outliers where we're losing catastrophic numbers of our workforce to other fields because they can make more money, but why are you retaining your people? How are you keeping your people in some of these places that are more challenged? And I'm optimistic that we'll learn something from that. I will say we are hearing concerning things about agencies shutting down, or volunteer departments where the volunteers are significantly older than would make you comfortable for succession planning. And even where I volunteer, you know there is a challenge of not only getting the volunteers to come in, but what do you do with the person who's twenty-five and doesn't drive a car? How do you get those ambulances moving? If your volunteers don't actively drive yet? So, there's gonna be a lot of things that we're gonna have to address.

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Dr. Richard Hunt: Yes, thanks Kate. Well said. Carol, you get the final word on this one.

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Dr. Carol Cunningham: Yes, so much to be said. You know my biggest fear is that, you know, this isn't just happening in EMS, it's happening in all medical professions. We also have the most experienced people retiring and leaving earlier, doing nonpatient care. So, we have to really ramp it up to make sure we have quality leadership in the future. We really need to create EMS scholarships. People get scholarships to go to college, why do they not get scholarships to be EMS providers? We often look at how to get more paramedics, so let's not forget about the EMR level. We can get people exposed to EMS, and, you know, start out as an EMR, then go to EMT school. We have an EMT program for high school kids. They get college credit through the paramedic program that I'm the medical director for. It's a local community college, and that's very attractive because it doesn't cost them anything. We went to the community, and they actually funded that. And then the one thing I that Kate mentioned, and I was only able to do it at one school, but during COVID, when everybody was doing their education virtually, and not doing their clinical time, we have to always remember: medicine is a people business. I went to our dean, and you know that the school was shut down, and I said, it doesn't have to be mandatory, but for those kids who want to come out, the paramedics are already giving mass vaccinations anyway. As long as there's a paramedic with them, why not have the student come out and be part of it? Not only is that increasing the manpower, but we've got kids coming out that weren't alive during 911. They don't know the satisfaction it gives to be part of the solution and part of that team. I can tell you that the students who participated loved it. The paramedics who are doing the vaccination clinics loved it too, because they had more manpower. And again, you can't teach compassion through a computer. Sometimes you have to hold somebody's hand, and that's the best medicine that that they could have. So, we need to work on that, make it attractive, but really, finances are big. There's no reason why somebody should have to go to school and not be offered a scholarship when you can get a full ride playing basketball and doing something else.

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Dr. Richard Hunt: Yeah and seeding on your example of the experience of being gratified by being part of the solution, at least in my experience. I spent more time with patients in the field

as an EMT, per patient, than I ever did as a physician in the emergency department. Just like, actual time spent, and it is extraordinarily gratifying.

I really appreciate the input from you, Carol, Kate, and Terry. You've been great panelists with a lot of great insights from really quite different perspectives. You know, the National Office of EMS, and then Carol with the state, and Terry with LA County. So, I really appreciate your input and hopefully, some of those who've been on this call have really benefited in some really specific, but also general ways about how we can do a much better job of incorporating EMS into our programs here at the Office of Health Care Readiness. So, with that for those who are on the call feel free to submit questions or comments. I think there have been some already. And at this point I'm gonna go ahead and turn this over to our Office Director, Jennifer Hannah.

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Jennifer Hannah: Thanks, Rick. And I want to certainly thank our panelists. I mean what a great discussion! I think I would describe that as Wow! Wow! Wow! So certainly, as Rick has stated, you know, this is an opportunity for any of our attendees to ask any questions of our esteemed panelists. I mean, while we got them captured here in their in their Hollywood square, if you have a question, you know, please be sure to drop that in the chat, or to raise your hand and ask a question of any of our panelists. I've been watching some of the chat some of the comments in the in the chat, and people have really responded and a lot of what was stated and discussed has resonated. So as stated, if you have a question, please drop it in the chat or raise your hand. So, we'll pause here, and this is also an opportunity if you have any questions for Rachel, or any general questions that you might have in the last couple of minutes that we have on today's call. Again, want to certainly thank our panelists and thank our moderator as well. And thanks to Rachel for providing a great review of the resources that are in ASPR TRACIE.

And Kate just dropped in the chat that they have some resources on their website, as well. So please make sure that you capture that information. If folks are reading the chat also, we'll make sure that we share information as well, following this meeting, along with the with the recording.

So, I'm not seeing any additional questions, or any and additional comments, but you can certainly keep them coming, you know, as always, you can send any comments or questions that you may have to our hpp@hhs.gov resource mailbox. Dr. Cunningham has also provided information about how you continue to continue to engage. Really appreciate our panelists' time, as well as our speakers, for today's call, and also your willingness to continue to serve as a resource. I want to also thank the audience for your active participation. As a reminder, we invite you to share any stories regarding how you are using ASPR funding to make a positive impact on your communities. If you have a story to share, please fill out our Stories from the Field submission form or reach out to your field project officer for more information. A member of our team will drop the Story from the Field submission form link in the chat for easy reference.

We certainly look forward to hearing about the great work that all of you are doing. I want to thank our panelists, our speakers, our moderator, and especially all of you. We hope everyone has a great day. Thank you very much.