Fifty Years Since the Great Alaska Earthquake: The Role of First Responders in Catastrophic Disaster Planning

Roles, Responsibilities Of Emergency Medical Services

Emergency medical services (EMS) responders, are the initial health care providers at the scene of disaster. EMS personnel are often the first to recognize the nature of a disaster and can immediately evaluate the situation and determine the need for resources, including medical resources. The chain of survival starts with *notification* to emergency medical dispatchers. *Response* is provided by various levels of first responders to include emergency medical responders, emergency medical technicians, paramedics and EMS physicians such as this speaker.

It is important to understand that EMS providers may be the *first* to apply crisis standards of care (CSC). We, the dispatch and field providers are integral partners in local, state, tribal and territorial efforts related to the development and implementation of coordinated preparedness and CSC planning. In the case of a disaster in which emergency health care personnel, medical and transport equipment, and hospital beds are scarce, local EMS personnel will be forced to modify their care from conventional to crisis care. This means moving from the usual standards of care, in which the goal is to save everyone, to Crisis Standards of Care, in which as many lives as possible are saved with the resources that are available. Resource shortages include staff, supplies, and equipment, lack of fuel or medicines, limited mutual aid or disruption of coordination and communication functions. Prehospital EMS is not only the *safety net of access to emergency care* on a day-day basis for every one in this audience and for all who are listening in, but in fact during a disaster *EMS is a gatekeeper* of protection to our nation's healthcare infrastructure. EMS is responsible for approximately 1% of the total country's healthcare costs, but such a "small train" drives approximately 40% of our overall healthcare expenditures. While our daily mission is to triage, treat and transport patients to the right medical treatment facility the first time, in the case of a biochemical attack, ambulance crews must recognize and ensure only decontaminated patients arrive at the door of an emergency department. Failure to do so will result in cross-contamination and an infrastructure crisis from hospital closures.

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EMS Integration into Disaster Planning- Lessons Learned from the Capstone Alaska Shield 2014 Exercise

The information gained at the local and state level from federal partners during Alaska Shield could not have been replicated without full-scale play. Forward patient movement from the disaster to casualty collection points, alternate care sites, and disaster aeromedical staging facilities are complex actions involving multiple agencies and are only *understood when practiced*.

We learned for example, that even using every available transportation asset equipped for litters (ambulances, an ambulance bus, and a dual-use vehicle, that we could transport a maximum of 24 patients, when the receiving medical treatment facility could have handled between 35-50 patients.

Bariatric and Special Needs patients will require special transportation knowledge during a disaster as the equipment and care requirements are different and affect maximum throughput for patient evacuation. For example a bariatric patient will be required to lay flat on a military medical transport during the flight with the current arrangements for standard transport of a medically unstable patient. The litters are available but this limits the total number of patients transported on a single flight. The ability for EMS providers and hospital personnel to be aware of these fine distinctions in the triage and resource allocation/destination decision are crucial to the success of the overall mission.

We also learned there are minimal military resources available with specific pediatric capabilities and those require deployment time. Specific funding and training for critical pediatric stabilization and transport must be strengthened in order to respond effectively.

In the small port town of Valdez we clearly illuminated the crisis in *volunteer EMS systems* that struggle to sustain daily operations and do not, I repeat, *do not have the ability to surge.* They uniformly thorough out this nation are the forgotten heroes of EMS. I recommend a concerted effort by all states to access the true value of their volunteer EMS systems, and transform the next generation of EMS to be supported by volunteer labor, but is not exclusively reliant on volunteer labor to provide an essential public service. You wont miss us, until we are gone.

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EMS Integration with Frontier Extended Stay Clinics

Senator Begich, Alaska was the first state to stand up and operate a state-owned former Federal Medical Station, now known as the Alaska Medical Station. The purpose of alternate medical treatment sites are to decompress hospitals and allow access to care for those patients less seriously injured or ill. In this exercise local EMS providers worked side-by-side with military medics, as well as volunteer nurses, physicians, support staff, and the Alaska Department of Health and Social Services. What we learned is that while the roles of a basic responders are clear, anything beyond basic life support demonstrated a lack of interoperability between military and civilian licensed EMS, nursing and medical providers. Support in a catastrophic event and during recovery will be hampered if states are not a part of the proposed Interstate Compact for Licensure of EMS Personnel. [i]

Finally Senator Begich, Alaska's *Frontier Extended-Stay Clinic* Model of 24/7 emergency care on a day-to-day basis as well as in disasters is a best practice model of disaster preparedness for rural and remote areas of our nation. These federally qualified health centers are located in communities in Alaska where the hospitals are not easily accessed and are designed to address the needs of seriously ill or injured patients who, due to adverse weather conditions or other reasons, such as in times of disasters, like the 1964 Earthquake where patients cannot be transferred quickly. These clinics have the ability to monitor and observe patients for up to 48 hours. This not only decompresses the hospitals from receiving rural patients at a time when they are most stressed in the first 48 hours but also is an essential support to rural EMS systems which are dependent on volunteer EMS providers and do not have surge capacity. It is a little known pilot project started in 2003 and is important for the members of your subcommittee who live in rural states to know about.[ii]

Thank you for this opportunity to come from rural Alaska and speak on behalf of the EMS community.

Respectfully submitted,

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[i] The Interstate Compact on the Licensure of EMS Personnel (NASEMSO) Stated Goals:

- Invest all member states with the authority to hold EMS personnel accountable through the mutual recognition of member state licenses;
- Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action and significant investigatory information ;
- Promote compliance with the laws governing EMS personnel practice in each member state;
- Increase public access to EMS personnel;
- Enhance the states' ability to protect the public's health and safety, especially patient safety;
- Encourage the cooperation of member states in the areas of EMS personnel licensure and Regulation;

Support licensing of military members who are separating from an active duty tour, veterans and their spouses.