Exploring Educational Opportunities in Expanding the Role of Emergency Physicians in Emergency Management

An Information Paper

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A workgroup of the 2014-15 ACEP Disaster Preparedness & Response Committee was assigned to create this information paper, "Explore and promote an expanded role between the practicing emergency physician and local/regional disaster emergency management planning."

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Scope and Purpose:

This document addresses the role of the practicing emergency physician in local and regional disaster emergency management planning and is intended for planning purposes. It was prepared in response to ACEP's 2014-2015 Disaster and Preparedness Committee objective #4: "Explore and promote an expanded role between the practicing emergency physician and local/regional disaster emergency management planning." It further enhances a similar objective completed last year.

Background:

There has been substantial and increased interest in public health and healthcare systems with physician input and involvement with disaster preparedness and response activities. The emergency physician should have an important role during the planning and execution of preparedness plans. Hospitals and emergency management often plan for natural and man-made events, but with little input from emergency physicians who are expected to lead the healthcare team. There are barriers to integration during planning, as emergency preparedness, the emergency physician, public health, the hospitals, fire/rescue, law enforcement, and the communities are not accustomed to working and interfacing together during large-scale events. Expanding the role of the emergency physician in applicable areas of emergency management could serve to open communication, foster development of best practices, reduce silos and provide expertise into the planning process at the local and regional levels of disaster preparedness and response.

The Joint Commission defines a disaster as a "high order-event by complexity, scope or duration. Disaster threatens capabilities, which are bolstered by surge capabilities for care, safety, or security."

A recent national poll of 1600 physicians (SteelFisher G) examined physicians' views of disaster preparedness and response. This poll showed that 56% of the physicians felt equipped to manage a natural disaster, large outbreak of airborne infection, and a major foodborne illness. Over 75% of hospital-based physicians felt that the hospital and staff were equipped to manage these events.

However, several deficiencies were noted from this poll. Most physicians identified that the hospital and/or staff was not adequately prepared for a chemical, biological, radiological, nuclear, or explosive (CBRNE) event. It also revealed gaps in physician awareness of preparedness at their institution. Specifically, 44% of the in-hospital physicians and 37% of the non-hospital affiliated physicians were unfamiliar with the written emergency response plan.

This poll by Dr. SteelFisher suggests that physicians undertake several actions. These actions include: 1.) increase all-hazards training related to emergency preparedness for physicians and their staff; 2.) increase awareness of emergency management operations and activities across inpatient and outpatient settings, and; 3.) incorporate disaster preparedness and response education into routine clinical evaluations.

As funding for disaster preparedness decreases annually federal agencies, state agencies, public health systems, hospitals, and the healthcare systems are forced to compete for this diminishing federal funding. Active involvement by Emergency Medicine (EM) physicians ensures representation. Ensuring optimization of healthcare is a key role that each of these systems expounds. Physician involvement helps ensure care which best assists the victims of these events. Active engagement by practicing physicians is essential to optimize individual and population medical care and outcomes during disaster planning and events.

Methods:

Committee members formally and informally met with individuals representing the National Association of Emergency Medical Services Physicians (NAEMSP), institutions of higher learning, Counsel of Residency Directors (CORD), Emergency Medical Residents Association (EMRA), Society of Academic Emergency Medicine (SAEM), and the American College of Emergency Physicians (ACEP).

Based on these discussions, it was determined that there are two levels of providers that this group should address, the learner (e.g. resident), and the early career emergency physician as well as the mid-career physician. Different activities were suggested to encourage and enhance the opportunities for these physicians with disaster preparedness and response activities.

A survey from the previous year's workgroup was also reviewed incorporating the two-tier emergency physician concept. The previous year's survey elicited input from the ACEP Disaster Medicine Section and the ACEP EMS Section. The results of survey are below.

Results:

The discussions with representatives from NAEMSP, institutions of higher learning, CORD, EMRA, SAEM, and ACEP were enlightening and are still ongoing. The theme of targeting two different physician levels was developed from the objective group meetings and the meetings with the other representatives.

The suggested two different emergency physician groups to be targeted for increased involvement in planning and execution of disaster plans include the learner (i.e. resident, EMS fellows), and the early career emergency physician as well as the mid-career physician. Some the topics explored with the learner were a future development of a focus group with members of EMRA, CORD, SAEM, and the ACEP Education Committee to evaluate the resident curriculum. Consideration of incorporation of focused topics on disaster preparedness may pique the interest of the learner to continue these activities throughout the learner's career while providing the fundamental knowledge needed to support operations during an actual event. Another explored topic was evaluation of an education course as part of the resident curriculum. A formal classroom class or an on-line class available covering preparedness topics when convenient for the learner would enhance the preparedness education without schedule limitations. An example of an on-line course might be a partnership between the National Disaster Life Support Foundation (NDLSF), CORD, SAEM and the ACEP Education Committee in the development of this on-line course. Similarly, the EMS fellows could also incorporate this type of educational activity into their curriculum, which may similarly pique this learner's interest to continue these activities throughout his/her career. Incorporation of offsite courses (e.g. The Center for Disaster Preparedness in Anniston, Alabama) as part of the EMS fellow curriculum would potentially enhance their education experience as well. A curriculum focus group with the ACEP Education Committee, NAEMSP, and other stakeholders could develop specific recommendations for incorporation of activities to enhance the EMS fellowship activities.

For the early career emergency physician and mid-career emergency physician, encouraging involvement with the Medical Reserve Corps (MRC), Citizen Emergency Response Team (CERT), regional healthcare coalitions, and the Disaster Medical Assistance Team (DMAT) was discussed within the objective #4 committee. Development and promulgation of these opportunities via an electronic medium was suggested (e.g. ACEP website, partnering public health website, etc.). Similarly, training opportunities at the state level and national level for preparedness courses (e.g. Basic Disaster Life Support, Advanced Disaster Life Support, Center for Disaster Preparedness/FEMA, etc.), could be promulgated through the same medium. Collaboration between the ACEP Education Committee, the Disaster Preparedness Committee, and NAEMSP in regular offering of courses at ACEP Scientific Assembly and the annual NAEMSP meeting will provide CME in addition to encouraging the physician to remain engaged with disaster preparedness activities.

Our workgroup specifically suggests input on the following from CORD, EMRA, SAEM, and the ACEP Education Committee through joint focus groups:

1) Courses which both the new emergency physician and seasoned emergency physician can readily participate to obtain foundational knowledge of emergency management/disaster preparedness
2) Other educational opportunities in which the new and seasoned emergency physician can obtain foundational knowledge of emergency management/disaster preparedness
3) Educational opportunities in which the emergency physician can maintain up-to-date knowledge of emergency management/disaster preparedness
4) Networking and collaborative opportunities which would encourage interest and sustained interest in emergency management/disaster preparedness

Development of a focus group with ACEP and our federal partners in funding opportunities to encourage emergency physician involvement would also entice involvement early in his/her career and continued support for preparedness

activities. Funding was identified in the previous year's survey as an issue given the competing non-paying activity requirements on emergency physicians (see survey below)

One of the likely future recommendations this workgroup will make is that this objective be continued into the future. A suggestion this workgroup had was splitting this objective into multiple objectives. For example, develop an objective on the targeting of different levels of providers (e.g. learner, as well as early and mid-career physician) in education and activities. Another objective might examine preliminary and sustained funding streams to support emergency physician input into preparedness activities giving their important role in actual events.

Discussion and Recommendation:

The objective #4 working group raised an interesting point that the providers being appealed to may be unique depending on their level of training and where that emergency physician is in his/her career. The discussions generated some unique opportunities and identified the need for collaboration between the various stakeholders to foster active emergency medicine physician participation in preparedness activities.

The results are enlightening but really only provide early information and recommendations to address this objective. Further elucidation is required. The committee objective workgroup members recommend that this objective be further refined and evaluated in the future in collaboration with several focus workgroups

The survey generated a good response on this important topic about exploring emergency physician involvement with disaster preparedness. Many individuals wrote in comments and suggestions regarding the survey questions. One of these in particular was the topic of funding. A critically important future objective might also examine funding streams for education and physician involvement.

All these responses, if explored further, will require collaboration with the various stakeholders to address funding, education, and political support to create sustainable programs to encourage and cultivate emergency physician involvement with disaster preparedness activities. Use of this information and survey results can be a starting platform to initiate the communication with these stakeholders and cultivate the impetus to address these important points.

ACEP, Disaster Preparedness and Response Committee
Exploring opportunities in expanding the role of Emergency Physicians in emergency management
Results - 119 Respondents – 4/24/14

Q2 Your Age

Counts Analysis % Responses	Base	Your Age					
		18-26	27-36	37-5	46-55	56-65	Over 66
	119	-	24	30	30	28	7
	100.0%	-	20.2%	25.2%	25.2%	23.5%	5.9%

Q3 Employment Affiliation (choose all that apply)

Counts Analysis % Responses	Base	Employment Affiliation (choose all that apply)						
		Government (non-military)	Hospital	EMS Medical Director	Military	Acedemic	Tribal	Other
	239	25	88	57	6	52	1	10
	100.0%	10.5%	36.8%	23.8%	2.5%	21.8%	0.4%	4.2%

Please explain Other:

- Battelle memorial Institute p Physician Advisor
- Emergency Physician Group.
- Independent Group contracted through hospital
- Law Enforcement
- Partner in emergency medical group
- Private, Nonprofit disaster center director
- Regional Healthcare Coalition Coordinator
- rural clinic

Q4 Years involved in disaster work

Counts Analysis % Responses	Base	Years involved in disaster work						
		Never have been involved	0-1 Yrs.	2-4 Yrs.	5-8 Yrs.	9-15 Yrs.	15-25 Yrs.	Over 26 Yrs.
	119	4	10	16	19	25	27	18
	100.0%	3.4%	8.4%	13.4%	16.0%	21.0%	22.7%	15.1%

Q5 Which of the following would you recommend to get more Emergency Physician involvement with Emergency Preparedness activities? (Choose all that apply)

Counts Analysis % Responses	
Base	447 100.0%
Which of the following would you recommend to get more Em...	
Contact and participate with local Emergency Management	80 17.9%
Contact and participate with the Hospital Disaster Response Committee	101 22.6%
Create and implement a multi-physician group within your hospital system that integrates with the Hospital Disaster Preparedness Committee	60 13.4%
Contact and participate with Regional Emergency Management/Disast-er Preparedness	86 19.2%
Contact and participate with State Emergency Management	58 13.0%
Contact and participate with the local Medical Reserve Corp	46 10.3%
Other	16 3.6%

Please explain Other:

- Contact and participate with local fire/EMS
- Create funding to pay for MD's time. This is a job that requires professionals, not amateurs. The government pays for everyone else's time as professionals. They need to pay for ours. Otherwise, they don't value our expertise. The old adage is true: it is worth what you paid for it.
- dmat
- DMAT Member
- Encourage employers to allow physicians to volunteer
- Get formal training in disaster medicine.
- get residents in training to participate
- Implement & apply national & international unified protocols and guidelines for disaster management (DM). Collaboration of National frame work organization for DM, such as FEMA, NDMS and others. Avoid fragmentation in the application of such projects. Unification of training, education, certification and credentialing in DM.
- Involvement with national level disaster response (i.e. DMAT/HHS)
- National involvement through DMAT/NDMS
- Ndms

- Outreach to rural community health centers which will be obligated to begin at minimum 4 hours of preparedness training, table top exercises etc... this will be a new requirement for many rural community health centers
- Participate in hospital disaster exercises; cover for physicians wanting to deploy with NDMS, or actually sign up with local DMAT
- Participate in international disaster preparedness
- Participate in National Disaster Management Policy making
- Utilize role of local County Medical Societies in response & communication

Q6 Which of the following preparedness activities would you encourage Emergency Physician involvement?

(Choose all that apply)

Counts Analysis % Responses	
Base	787 100.0%
Which of the following preparedness activities would you ...	
Disaster Exercise Planning	99 12.6%
Disaster Exercise Execution	105 13.3%
Business disaster p-reparedness/planni-ng/implementation	36 4.6%
Attend NDLS classes (e.g. BDLS, ADLS)	64 8.1%
Attend Center for Disaster Preparedness (CDP) courses in Anniston, AL	58 7.4%
Attend state offered disaster preparedness courses	72 9.1%
Hospital Disaster Planning	108 13.7%
Medical Reserve Corp	47 6.0%
State Disaster preparedness teams (e.g. Georgia Defense Force, etc)	57 7.2%
Disaster Medical Assistance Team (DMAT)	82 10.4%
Urban Search and Rescue (USAR)	53 6.7%
Other	6 0.8%

Please explain Other:

- LEPC for hazmat planning, airport emergency planning, local business groups
- Local agency/municipal city/county PH planning via local medical societies

- Local fire EMS
- Preparedness exercises with EMS personnel particularly outreach to volunteer EMS organizations. It's important for ER physicians to understand the challenges many of these selfless serving, dedicated volunteers endure in order to keep access to emergency services in place. It's a great opportunity to give back and it is in the best interest of ER's to do this outreach to help proper triage and transfer of patients. Outreach doesn't often happen for volunteer organizations by physicians. It is more often a train the trainer approach --medic to medic. That is fine, but in the places in most need of well-trained ems providers, these are often the same places dependent on solely on-line or book training. This will be some of the most rewarding of experiences for ER physicians.
- The first step is training. Without training in ICS and disaster medicine, the general emergency physician, no matter how well intentioned, will get in the way of disaster management.
- Update and integrate new guidelines, protocols & procedures in disaster management, in courses such as ADLS and others.

Q7 Additional Comments:

- All these options have been available for decades. Issue of willingness to work after hours on disaster drills, without being reimbursed, when there is so little time to be with families, appears to be a major issue, and no one wants to ask Hospital administrators to pay physicians to do required exercises, but they should.
- At our hospital we have a Disaster Medicine Division within the Dept. of Emergency Medicine which coordinates with the hospital emergency management committee.
- Does training mean readiness?
- EP's are closely associated with the Disaster preparedness and response. As a specialty EM provides a basic understanding of handling MCI and disasters. So we should work as a team and help each other to gain expertise by resource sharing and exchange program between countries for training purposes.
- Have taken CDP courses and interacted with DMAt teams during emergencies. Very useful
- I believe it is especially important that EM Physicians at least get educated at the state level.
- I would not expect the Emergency Physician to do all the items, but select one or two and be active in the planning and execution to ensure there is reality in the thoughts on medical response. I also suggest the same for nurses.
- In Michigan, we need to support local, regional and State EMS roles and participate with our non-physician colleagues.
- It is crucial to the United States that all physicians (not just EM) be involved in emergency preparedness at the local and hospital level. Without that participation the country will not be and is not prepared.
- It is imperative for ED docs to get trained and educated in disaster preparedness and response prior and concurrently with their involvement. They need to understand that they don't know much (unless they have a fellowship) and that they only hurt the specialty and the preparedness efforts when they show up acting like the experts and leaders they are not.
- It seems hard sometimes to get EP's involved in local EMS issues that affect them on a daily basis. Even harder to get them involved with disaster preparedness. Some of the things I have learned have increased my own and my family's preparedness although they groan when they get survival matches and headlamps in their Christmas stockings! Would it be possible to try to involve EP's on a more personal level of protecting themselves and their families and then get their appetite whetted to participate on a

community and regional level instead of leaving up to the local EMS Director an assume that the job is getting done.

- I've done international disaster work for 10 years
- Most of my involvement with disaster prep has been through Central Ohio Trauma System and local EMA I then bring this info back to our disaster committees at the hospitals. Continuity is very important.
- none
- One reason more physicians in general don't get involved is the embarrassing and unprofessional attitudes and behaviors of other physicians and 'leaders' who like to protect their turf. they want to be the leader and while they want others to come play, they do not encourage and if fact discourage others from assuming higher levels of leadership and a more functional role. There are too many whose egos preclude them from seeing physician volunteers as competitors (the 'out to take my job' philosophy) rather than willing to strengthen their position. It's a sad commentary on people who should know better. People who would rather protect their position rather than work with those around them...sounds like a few hundred people that most people dislike in Washington, DC.
- perspective: I am an community emergency physician and serve in the National Guard
- Physician involvement in planning & preparation for disaster response is essental to being ready when disaster occurs.
- physicians should be reimbursed for all of these activities
- Still a participating member IMERT Illinois Medical Emergency Response Team the medical component of the IL Disaster Response Plan
- Strongly encourage use of local county medical societies as collaborative partner in all these efforts
- Thanks for this opportunity.
- The best way for emergency physicians to get active is to participate regularly with local fire EMS and hospital major event preparedness. That will allow them to understand and participate in a variety of local community and business activities, which are of value to them and their community
- The days of docs being uninvolved with anything other than speaking the phrase of the patient diagnosis are, i sincerely hope, going away. Because the people steering the ship for us now have a pattern of respect for other goals over patient care.
- Too often ER docs try to re-invent the wheel because they are not involved, or even knowledgeable, about local and regional plans. It wastes time and resources.
- Unification of training, education, certification and credentialing in disaster management throughout the local, regional, state and national level.
- We've been struggling for many years with how to better engage emergency physicians in disaster medicine. It is VERY difficult to get attending emergency physicians to get involved. Increasingly I'm coming to believe that the target population should be residents. We've recently added B/ADLS to our residents' curriculum. This should accomplish at least 2 things. 1) provide a common foundation for all of our grads in Disaster Medicine that will hopefully stay with them for their careers. 2) Potentially light a fire in some residents to get further involved after graduating. We've also had a number of residents attend CDP in AL with very positive feedback.

- While tradition disaster preparedness and management have been in the realm of many MPH experts, administrators, and other professions, one of the fundamental objectives of disaster preparedness and response is PRESERVATION OF LIFE. I feel we have as physicians delegated too much to non-clinicians who may be great administrators but lack some fundamental knowledge on this function we perform daily. I understand that for most EP's, their role will be in a clinical setting engaged in direct patient care. However, there is a role for EP's to engage in the planning and preparedness functions that we too often pass to another to do. I am excited to see this survey since I feel we do need to have more physician engagement in some non-clinical areas as well as other specific preparedness/response activities that we are so well suited to function in.