healthcare system for the past decade, yet the factors leading its commencement, its evolutions over this time, the current model of service delivery have not been widely published.

Aeromedical service provision may vary significantly from country to country and may also vary regionally within countries. Health systems necessities, capacity and maturity, the level of state, corporate, private or community investment and capacity of the contracted service provider are all factors that influence the service provision.

**Method:** This research provides a descriptive analysis of the historic factors leading to the implementation of HEMS during an era of healthcare reform, its key evolutions and current model of service delivery.

**Results:** Health system reform in a time of global financial recession led to a unique collaboration between the Irish Defense Forces and civilian Emergency Medical Systems (EMS) to provide a sustainable foundation of primary scene landing Helicopter Emergency Medical Services for the Irish state. This sharing of professional knowledge, logistics and operational experience lead to many further system reforms and will inform future aeromedical service provision.

**Conclusion:** Over the past decade the Irish health system has undergone significant reconfiguration and centralization of services, leading to increased demands on emergency medical ground and aeromedical services. Future advancements in aeromedical service provision require an innate understanding of the current model.

This research will add to the knowledge base and inform policy makers and support decision making surrounding Helicopter Emergency Medical Services reform and enhanced service provision in the Irish state.

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## Immediate Medical Care Rendered by U.S. Law Enforcement Officers After Officer-Involved Shootings – An Open-Access Public Domain Video Analysis

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**Introduction:** After officer-involved shootings, rapid delivery of emergency medical care is critical but may be delayed due to scene safety concerns. The purpose of this study was to describe medical care rendered by law enforcement officers (LEO) after lethal force incidents.

**Method:** Retrospective analysis of open-source video footage of officer-involved shootings (OIS) occurring between 2/15/2013 and 12/31/2020. Frequency and nature of care provided, time until LEO and emergency medical services (EMS) care, and mortality outcomes were evaluated. The study was deemed exempt by the Mayo Clinic Institutional Review Board.

**Results:** 342 videos were included in the final analysis. LEOs rendered care in 172 (50.3%) incidents. The average elapsed time from the time of injury to LEO-provided care was 155.8 + 198.8 seconds. Hemorrhage control was the most common intervention performed. An average of 214.2 seconds elapsed between LEO care and EMS arrival. No mortality difference was identified between LEO vs EMS care ($p = 0.1631$). Subjects with truncal wounds were more likely to die than those with extremity wounds ($p < 0.00001$).

**Conclusion:** LEO rendered medical care in half of all OIS incidents, initiating care on average 3.5 minutes prior to EMS arrival. Although no significant mortality difference was noted for LEO versus EMS care, this finding must be interpreted cautiously, as specific interventions, such as extremity hemorrhage control, may have impacted select patients. Future studies are needed to determine optimal LEO care for these patients.

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## Developing Prepositioned Burn Care-Specific Disaster Resources for a BMCI

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**Introduction:** Disaster planning and preparedness for a burn mass casualty incident (BMCI) must consider the needs of those who will be directly involved and support the response to such an event. An aspect of developing a more comprehensive statewide burn disaster program included meeting (regionally) with healthcare coalitions (HCC) to identify gaps in care and deficiencies.

**Method:** Regularly scheduled (quarterly) HCC meetings are held around the state linking stakeholders representing local hospitals, health departments, emergency medical services (EMS) agencies, and other interested parties. We were able to use the HCCs regional meetings to serve as a platform for conducting focus group research to identify gaps specific to a BMCI and to inform strategy development for a statewide approach. Additionally, we held engagement meetings with state emergency response network (a state agency that coordinates the movement of ambulances to appropriate destinations) and the Burn Medical Directors findings were vetted from the focus groups.

**Results:** One of the deficiencies identified, included a lack of burn-specific wound care dressings that could support the initial response. Relying on this same process, a consensus was attained for equipment types and quantities, including a kit for storage. Furthermore, a maintenance, supply replacement,

and delivery to the scene processes were developed for these kits of supplies that could augment a BMCI response.

**Conclusion:** Focus group feedback reminded us that outside of the world of burn care, many report an infrequent opportunity to provide care for patients with burn injuries. Several types of burn-specific dressings can be expensive, and with the occurrence being infrequent. EMS agencies and rural hospitals alike reported that it was unlikely their agency/hospital would have more than a minimal stock of burn injury supplies. Developing supply caches that can be quickly mobilized and deployed to the impacted area was one of the deficiencies we addressed.

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