



ECCC Strategic Plan FY 2012 – FY 2016



ASPR

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Executive Summary

The Emergency Care Enterprise (ECE) in the United States represents a major segment of the overall health care system that is dedicated to the diagnosis and treatment of time-sensitive illness and injury. ECE is primarily made of two critical and interlocking components, the pre-hospital and hospital systems. Both are integral parts of the U.S. health system reliant upon each other to meet the overarching goal of providing excellence in emergency care. The Emergency Care Coordination Center (ECCC) was established in January 2009 within the Office of the Assistant Secretary for Preparedness and Response (ASPR) at the Department of Health and Human Services (HHS). Creation of the ECCC fulfilled the requirements of Homeland Security Presidential Directive #21 (2007) and was a response to recommendations made in the 2006 Institute of Medicine Future of Emergency Care series of reports *Hospital-Based Emergency Care: At the Breaking Point*; *Emergency Medical Services: At the Crossroads*, and *Emergency Care for Children: Growing Pains*. These documents describe our nation's ECE as "fragmented," "overburdened," and "underfunded," and challenged in many ways in its effort to provide high quality emergency care to the public on a day-to-day basis.

In addition to addressing the emergency aspects of the everyday health care needs of our country, the ECE is where our nation's immediate disaster medical response capabilities are grounded. The charter for the ECCC, published in the Federal Register in April 2009 by the ASPR, states that efficient and effective day-to-day functioning of the ECE is necessary for true health care preparedness for disasters. As defined by the *National Health Security Strategy*, released by the Office of the ASPR, "national health security is achieved when the Nation and its people are prepared for, protected from, respond effectively to, and are able to recover from incidents with potentially negative health consequences." Healthy, resilient communities with accessible, scalable, and high quality health care delivery systems are fundamental to achieving this state of security for the Nation.

While some components of the ECE have developed tremendously over the past several decades, significant challenges related to coordination and integration remain. Fragmentation among the essential components of emergency care limits the development of the coordinated, regionalized, and accountable ECE envisioned by the Institute of Medicine. This challenge requires novel approaches to system development, cooperation and coordination in order to achieve the ultimate goal of supporting and improving the delivery of daily emergency care that can also meet the needs of communities in disasters. The ECCC exists to catalyze these improvements through its goals of supporting the nation's emergency care delivery systems, and through its vision of ensuring that exceptional emergency care is available for all people in the United States regardless of geographical location. This is an important capability that serves the overall mission of the ASPR: "Lead the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters by supporting our communities' ability to withstand adversity, strengthening our health and response systems, and enhancing national health security."

The Emergency Care Enterprise

The ECE is a critical and integral part of the US health care system, and refers to the organized delivery system for emergency care within a given area. Emergency care encompasses the full continuum of services and systems involved in the delivery of emergency medical care, including injury prevention, bystander first aid, medical first response, pre-hospital care (EMS), hospital-based emergency department and trauma care, and specialty emergency care. In addition to providing acute, time sensitive emergency care in urgent cases, the ECE is often the primary point of access for general health care for many, and the center of the critical infrastructure and workforce required during the medical response and recovery efforts that follow a catastrophe. From this perspective the ECE represents a network of providers, facilities, resources and organizational supports that link individuals and communities with critical health care resources when and where they are required.

A System in Crisis

The United States' ECE is in crisis. The amount of care provided through the ECE has exhibited a consistent upward trend. According to a 2007 report from the National Center for Health Statistics (NCHS), there were approximately 94.9 million emergency department visits in 1997 (35.6 visits per 100 persons) compared to 116.8 million ED visits (39.4 visits per 100 persons) in 2007. In 2009 the number of ER visits further increased to 136.1 million visits. Despite the increased demand, the number of hospitals operating EDs in the United States declined from more than 5,000 in 1991 to fewer than 4,000 in 2006.

In 2006, the Institute of Medicine's (IOM) Committee on the Future of Emergency Care in the United States Health System released its findings on the state of the US ECE in three volumes. The reports, titled *Hospital-Based Emergency Care: At the Breaking Point*; *Emergency Medical Services: At the Crossroads*; and *Emergency Care for Children: Growing Pains* describe a system that is overburdened, underfunded, highly fragmented, and increasingly unable to appropriately respond to the demands placed upon it each and every day. The IOM report states that there are approximately 114 million visits for emergency department care per year, and the *2011 National EMS Assessment* reports over 31 million responses for pre-hospital emergency medical services (EMS) annually; these numbers continue to increase. Also cited are serious workforce issues such as liability concerns for providers, shortage of medical specialists, and a critical lack of education for pre-hospital providers who are able to deliver emergency care. Recognizing the precarious state of the ECE in the US, within *Hospital-Based Emergency Care: At the Breaking Point* the IOM recommended the development of "regionalized, coordinated, and accountable emergency care systems throughout the country." In its sister report, *Emergency Medical Services: At the Crossroads* the IOM states that pre-hospital care "is often fragmented and disorganized, and the quality of emergency medical services (EMS) is highly inconsistent from one town, city, or region to the next."

Two reports released by the Government Accounting Office (GAO) have served to reflect and complement the IOM's conclusions. In 2003, the GAO found that although two of every three hospital emergency rooms diverted ambulances at least one time during the fiscal year, one in 10 hospitals diverted ambulances a full 20% of the year. A 2009 GAO report noted that patient wait times for immediate and urgent care exceeded their recommended time frames in 74% and 50% of patient cases; the average national wait time for emergent cases was more than twice the maximum recommended time of 14 minutes. In both

studies, patient boarding was cited as a factor. Studies conducted by professional associations such as the American College of Emergency Physicians (ACEP) have also noted the impact of patient boarding on the ECE.

Patient boarding, where admitted patients are kept in the emergency department while awaiting an inpatient bed, has been identified by experts as potentially the most significant problem facing the ECE. Boarded patients frequently do not receive an equivalent level of care to that delivered on an inpatient unit. This practice consumes resources that could otherwise be dedicated to caring for emergency department patients, and furthermore contributes to the problem of diverting patients away from emergency departments. Consequently, boarding negatively impacts preparedness. Boarded patients make it challenging for emergency departments to receive additional patients in response to a mass casualty incident. The elimination of the practice of patient boarding should be considered one of the highest priorities for improving the ECE.

Equitable access to high quality emergency care remains another challenge. As an example, the *Growing Pains* report concluded that there is a significant disconnect between the utilization of the ECE by pediatric patients (approximately 1 in 4 visits) and the resources that are in place to deliver high quality emergency care for children (such as emergency equipment and personnel who are experienced in pediatric medicine). While this is already a significant issue for day-to-day operations, during a disaster this problem will be magnified and likely result in critical shortfalls in the nation's ability to care for large numbers of sick or injured children. According to the National Commission on Children and Disaster report to Congress, Pre-hospital EMS consistently lacks standardized equipment and trainings specific to children thereby reducing the opportunity to provide critical interventions in the pre-hospital environment. Ensuring that children, as well as all other members of society, have access to high quality, adequately resourced ECE is a critical issue to our nation's health security.

Other significant challenges face the ECE such as wide practice and environment variability; workforce recruiting and training; information management and interoperability; and medical error reduction in an environment of increasing system stress and limitations on accountability in the pre-hospital care system. One of the most pressing issues confronting the ECE may be the challenge of making the best use of limited emergency care resources in an age of increasing utilization.

Ideal Emergency Care

In its ideal form, ECE is patient- and community-centered, and integrated into the overall health system. Patient-centered care encompasses the qualities of compassion, empathy, and responsiveness to the needs, values, and preferences of the individual patient, and are just as applicable in emergency situations as in other care settings. Patient-centered emergency care has: 1) respect for patients values, preferences, and expressed needs; 2) coordination and integration of care; 3) information, communication, and education; 4) physical comfort; 5) emotional comfort (relieving fear and anxiety); and 6) involvement of family and friends. Care that is patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones an integral part of the care team collaborating with health care professionals in making clinical decisions. The ideal ECE is seamlessly integrated with a patient's personal care team as described in the consensus document, "Joint Principles of the Patient-Centered Medical Home," released by the Patient-Centered Primary Collaborative in 2007.

While at the individual level emergency care should be patient-centered, the functioning and quality of the ECE must be considered more broadly. Where and how a patient receives emergency care often depends on geography and the population's need for care rather than individual patient preference, needs or previously established relationships with providers. It is thus difficult to consider issues such as access to care or preparedness using the perspective of a single patient or single facility.

Community-centered care focuses on the health needs of the population of specific geographically defined communities. The development of a community-centered ECE involves the creation of a system that appropriately balances population needs and individual requirements in both their time of crisis or in a more generalized community emergency. Emergency care planning from the population's perspective has been embraced by the emergency care community, and is often expressed in terms of the need for regionalized systems, integrated networks, and a web of emergency care interconnected across the US. Community-centered care ensures that the needs of the population are responsibly and efficiently met by existing, and adaptable health care resources.

When compared to most medical care, emergency medical care is often episodic in nature and frequently involves practitioners who do not have a preexisting relationship with the patient and little to no knowledge of the patient's medical history. Leveraging technologies such as tele-medicine and integrated electronic medical records is an increasingly important means to mitigating this information and relationship gap. In rural America, for example, tele-medicine can play an increasing role in addressing some emergency care gaps, allowing advanced practice paramedics, advanced practice registered nurses and physician assistants to treat patients who would not have access to an emergency physician in their time of critical need. However, there remain significant gaps in efficacy and implementation process that reflects how best to operationalize this concept.

The ideal system offers emergency medical care that is of uniformly high quality and accessible to all who require it, acknowledging and addressing the needs of populations with health disparities. This means getting the right care to the patient, in the right time, so they can be delivered to definitive care which reflects the individual's needs in the most efficient manner. The ideal system also highlights the role of prevention as potentially the most cost-effective means of delivering emergency care by avoiding the need for it.

An optimally functioning ECE will be adequately resourced and funded, and will provide high quality care that is able to scale up rapidly in times of increased demand, whether that represents a busy weekend or a large scale disaster. Three key elements of an optimal ECE are regionalized, accountable, and coordinated emergency care. The interrelationship of these elements are illustrated in Figure 1 and discussed in the following sections.

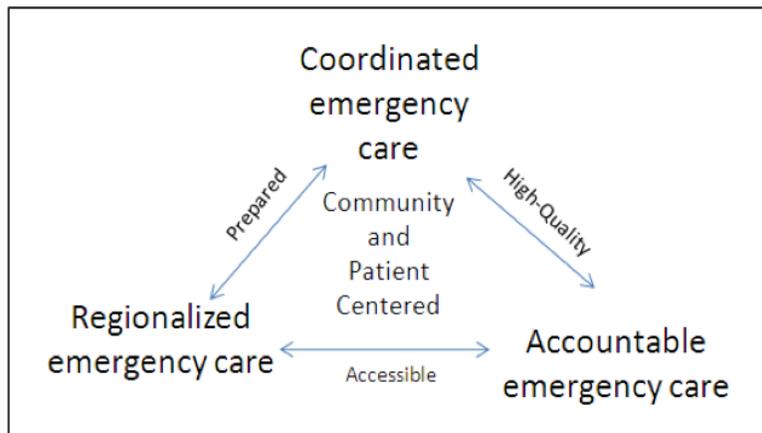


Figure 1: Attributes of Ideal Emergency Care

Given the wide range of professionals and services that impact the optimal functioning of the ECE, an outreach mission with engagement across the full spectrum of emergency medical care is required. The many inputs to the ECE include EMS system leaders, Emergency Medical Responders, EMTs and paramedics, primary care providers and alternative providers of outpatient ambulatory care. Although emergency care providers are often placed at the center of the ECE, true coordination of care requires the participation of ancillary staff, nursing professionals, and sub-specialty consultants in many medical and surgical areas. Finally, services that contribute to the efficient disposition of patients from the pre-hospital and hospital-based environments (including home health care, short and long term care facilities, and innovative alternatives to hospital-based care) have an important stake in the ideal function of daily emergency care and have significant implications for preparedness.

Regionalization

In its three-volume report from 2006 on the critical state of the ECE in the United States (described at the beginning of this section), the IOM recommended that the Federal Government implement a regionalized ECE to improve cooperation. In a regionalized system, local hospitals and EMS providers would coordinate their efforts to be in alignment with patient and community needs. Regionalization should not be confused or interpreted as centralization, the process in which specialized resources and personnel are housed at referral centers and patients are selectively directed to those facilities. Regionalization is an integrated and coordinated approach to ensure that the right patient gets to the right resource, at the right place, at the right time, and that the population's emergency care needs are similarly met. Regionalization is not the sequential delivery of patients to progressively higher levels of care, but rather the process of ensuring that the individual patient and the population in need are treated in the most appropriate location that can provide safe and effective care using the resources available.

Coordination/Integration

Regionalization often requires coordinated resource planning. This can be challenging in a competitive health care environment; however, failure to efficiently allocate resources in a coordinated way, either day-to-day or during population-level emergencies, results in inefficiencies, duplication of effort, increased health care costs, decreased quality and often, inequitable distribution of care. "Co-opetition," where competitors work together to achieve a common goal, is perhaps the model that best captures the concept of regionalization of emergency care resources. The roots of co-opetition lie in game theory and the premise that the act of conducting business does not have to be a win or lose phenomenon. Instead, the theory states that competitors may achieve shared successes in a market space by distributing among them the nonprofitable aspects of business, creating an environment where their return on investment is increased by virtue of the reduction of their redundant, non-profitable burdens. In health care, co-opetition has been a successful model for achieving population health goals in many communities.

The concept of co-opetition is closely aligned with the promotion of healthcare coalitions for preparedness planning through the ASPR Hospital Preparedness Program. A healthcare coalition or HCC is the formal collaboration of the entire spectrum of public health and medical entities within a defined region that serves as a multiagency coordinating group. These coalitions have responsibilities in meeting preparedness, response, recovery and

mitigation activities in support of National Response Framework, Emergency Support Function #8 - Public Health and Medical Services; their functions include regional health care system emergency preparedness planning, resource coordination, interfacing with incident management, and providing situational awareness in a disaster. Healthcare coalitions promote co-opetition as hospitals normally in competition for patients and resources become able to share information that improves the efficiency of their individual health care services, especially by reducing duplicative operations between them. As healthcare coalitions make it easier for individual area hospitals to maximize their operational efficiency, their region's overall quality of care improves. The co-opetition provided by healthcare coalitions also makes it easier to create redundant, interoperable systems to communicate between hospitals, EMS, public health agencies and emergency managers during disaster events.

An example of co-opetition in healthcare

In order to comply with new federal requirements that ensure patient privacy, competing medical insurance companies form a shared organization that leverages technology to increase the efficiency by which claims are submitted. By doing so, they are simultaneously cooperating and competing with each other to advance their overall market.

A highly effective ECE requires commitment from and coordination of a broad range of stakeholders that includes all levels of government, the medical and public health communities, the local and regional EMS resources, and most importantly, citizens. Seamless integration of care across emergency medical dispatch, pre-hospital care systems, inpatient care systems, primary and specialty care systems, and most importantly across hospitals and competing health systems are vital to the success of the ECE as a whole, as well as to the ECCC's mission discussed later in this document. The fundamental tenet of the ECCC holds that an efficient and effective health care delivery system that provides equitable access to efficient routine and emergent care will be better able to support a successful surge response to major public health and medical incidents.

Accountability

ECE accountability may be promoted through the public and transparent reporting of system quality and capability. The development of metrics is integral to establishing accountability in the health care system. Metrics should reflect the entire spectrum of emergency care beginning with citizen response and continuing through the emergency department.

Along with the rest of the health care system, leaders within the ECE are working to develop metrics that are indicators of high quality care to improve accountability for the care that is delivered. Unlike much of health care, however, emergency care is unplanned, therefore metrics must measure effectiveness at the level of the system and community as well as at the level of the individual hospital and provider. The tremendous variance in the structure, quality, sophistication, and integration of ECEs from one community to another must be taken into consideration for any metric that is developed.

Emergency care involves multiple organizations and operations (EMS, suburban emergency departments, inter-facility transfer, tertiary care center emergency departments, specialty

care, etc.) and many transitions of care. It also involves the care of individual patients, as well as the capability of the system as a whole to address population needs in disaster situations. With few consistent performance metrics, it becomes difficult to measure and compare systems from one community to another. In this respect, quality emergency care can be challenging but not impossible, to measure. Quality emergency care is not only about ensuring the quality of each link in the continuum of care, but also ensuring how well handoff occurs between those links for which rapid transfers are necessary.

Emergency care and hospital business practices must be evaluated for those business practices which support high quality patient care and preparedness. These practices need to be considered best practices and disseminated throughout the ECE. Individuals and organizations responsible for providing emergency medical care must be held accountable for implementing these practices.

The Federal Interest in a Strong Emergency Care Enterprise

The Federal Government has a strong interest in supporting the Nation's ECE. Many departments and agencies (for example, the National Highway Traffic Safety Administration within the Department of Transportation, the Federal Communications Commission, the National Security Staff, and the Department of Homeland Security) provide support to various aspects of the emergency care infrastructure to forward such diverse national priorities as reducing highway traffic safety deaths, assuring universal 9-1-1 coverage, and preparing to manage disasters and other catastrophic health events.

Before 1966, federal involvement with EMS was limited to the development of general health resources and services; no specific program to develop EMS existed. In 1966 the National Academy of Sciences released a report entitled *Accidental Death and Disability: the Neglected Disease of Modern Society*. This report highlighted the shortcomings of the management of injuries in the United States and spurred the national development of organized emergency medical systems. In 1966 the Federal Government passed the National Highway Safety Act (NHSA) as part of an overall highway safety program. This act specifically addressed the need to improve emergency medical services related to highway accidents as well as to all other medical emergencies.

Between 1966 and 1973, the Department of Transportation provided over \$48 million for the emergency medical services part of the National Highway Traffic Safety Program. In 1973 the Emergency Medical Systems Act provided over \$300 million in federal funding for early emergency medical services activities, and other federal programs also provided funds which benefited these services. However, a 1976 GAO report stated, "No agency was designated program coordination responsibility, thus the federal program expenditures for the services [were] uncoordinated."

With the rapid expansion of formal systems providing pre-hospital care in the 1960s and 1970s, there was an increasing need for a system to receive and care for such patients in the hospital. Emergency departments began a structural transformation with a dramatic increase in sophistication. Physicians and nurses specially trained in emergency medicine were necessary to perform emergency diagnostics and invasive procedures required for resuscitation and stabilization.

More recent interest in the ECE involves the ability of the nation to ensure timely, effective and high quality care during times of catastrophic disasters. With increasing levels of system stress the balance between resources and need has become inverted, stressing the system to the point where needs far exceed resources and lead to daily system failures such as boarding in emergency departments and ambulance wait times.

The National Health Security Strategy (2009) specifically recognizes these challenges and identifies *fostering integrated, scalable health care delivery systems* as a key strategic area to protect the health and safety of Americans in public health emergencies. This emphasis on scalability fundamentally acknowledges the precept that improvements in the routine day-to-day ECE functions will result in better disaster response.

The Federal Coordination of Emergency Care

HSPD-21, one of the foundational documents behind the development of the ECCC, charged the office to “address the full spectrum of issues that have an impact on care in hospital emergency departments, including the entire continuum of patient care from pre-hospital to disposition from emergency or trauma care.” Given the existence of a number of agencies already involved in emergency care delivery, the office was instructed to “coordinate with existing executive departments and agencies that perform functions relating to emergency medical systems in order to ensure unified strategy, policy, and implementation.”

The charter of the ECCC describes the development of a Council on Emergency Medical Care (CEMC). The CEMC is a coalition of stakeholders representing organizations across the US Government whose mission is to provide policy guidance and facilitate interagency involvement in the development and advancement of the ECE and its priorities (Appendix A).

As stated in the ECCC charter document, the ECCC is to play a collaborative role with the Federal Committee on EMS (FICEMS). FICEMS is administered by the National Highway Traffic Safety Administration (NHTSA) Office of EMS and was established to ensure coordination among all federal agencies specifically relating to pre-hospital emergency medical services and 9–1–1 systems. The ECCC and FICEMS are positioned to serve in a coordinating role for the entire spectrum of both pre-hospital and hospital-based emergency care. Additional information regarding the ECCC is provided in this document starting on page 12.

The Federal – Private Interface

Although the Federal Government has a strong interest in a high-quality ECE, it provides relatively little direct medical care (apart from the Department of Defense, Veterans Administration, Indian Health Service, and the National Disaster Medical System). Since the overwhelming majority of hospital emergency care in the United States is provided in the private sector, the role of the ECCC is to support and assist the private sector in the development of strong emergency care systems through the coordination of federal partners and activities. Pre-hospital emergency care is much more diverse with pre-hospital emergency medical services being roughly split between public, private and volunteer organizations. Therefore, it is essential that the ECCC, in partnership with CEMC and FICEMS member agencies and departments, conduct active outreach and communication with the local, state and private sector emergency medical care providers. The active involvement of this diverse stakeholder community is necessary to achieving the mission of

the ECCC. Appendix C provides a partial list of key government and private partners essential for the development of a 21st century ECE.

Engagement of the private sector will take place using mechanisms familiar to the academic and professional communities of stakeholders. These mechanisms will involve communication of information related to objectives and achievements of federal agencies in the academic literature, in trade publications, and through didactic presentations at national meetings. As required, communication to the private sector will also occur through publication of notices and requests for information in the Federal Register, posting of information on government websites, meetings held in conjunction with organizations such as the Institute of Medicine, and collaboration with existing Federal Advisory Committee Act groups.

Federal-private interfaces will continue to take place in the concrete realm of service provision as well, an important example of a model interface being the Hospital Preparedness Program's healthcare coalitions concept discussed above.

Emergency Care and The Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) (PL 111-148 and 111-152) is expected to have a tremendous impact on the ECE of the future. Broadly speaking, the goals of the ACA can be summarized as: 1) instituting consumer protections; 2) improving quality and lowering cost; 3) increasing access to affordable care; and 4) holding insurance companies accountable. Successful implementation of the ACA will require careful and deliberate attention to all of the provisions of the law as they relate not only to emergency care but also to the integration of care across the full continuum of care (including bystander care, emergency medical dispatch, pre-hospital care, in-hospital emergency department care, specialty care, rehabilitation, and prevention), from daily operations to catastrophic health emergencies.

Section 3504 of the ACA provides the ASPR new authorities to administer grants relating to emergency care. In addition, the ASPR now has the authority and responsibility to advance the ECE through multiple mechanisms. These mechanisms include supporting the development of modern systems of care delivery; sponsoring workshops and conferences; conducting and supporting relevant research, training, evaluations, demonstration projects to advance the ECE; and providing technical assistance to state and local agencies to help enhance trauma and emergency care. The ACA further authorizes the Secretary of Health and Human Services to advance basic science and clinical research efforts in trauma, emergency care and pediatric emergency care.

Assessing the potential impact of the ACA on the ECE is a priority of the ECCC. Opportunities exist to work with federal partners to determine or develop metrics that will be useful in gauging any trends in health care quality, access, and costs.

The Emergency Care Coordination Center

Following the release of the 2006 IOM Future of Emergency Care reports, Homeland Security Presidential Directive 21, paragraph 41 (HSPD-21) tasked the development of an Office for Emergency Medical Care within the Department of Health & Human Services. The charge of this office was to “lead an enterprise to promote and fund research in emergency medicine and trauma health care; promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; promote local, regional, and State emergency medical systems; preparedness for and response to public health events.”

The response to this directive was the creation of the Emergency Care Coordination Center within the Office of the Assistant Secretary for Preparedness and Response. In the charter of the ECCC, the former ASPR, W. Craig Vanderwagen, wrote that “HHS recognizes that the successful delivery of daily emergency care is a necessary foundation for our nation’s emergency preparedness efforts.” Because of the recognition that “improving the resiliency, efficiency, effectiveness, and capacity of daily hospital emergency medical care delivery will strengthen the nation’s state of readiness for public health emergencies and disasters”, the ECCC was charged with supporting the US Government’s coordination of in-hospital emergency medical care activities, and improving the delivery of the nation’s daily emergency medical and behavioral health care.

Since its inception, the ECCC has been funded for initial operating expenses and a limited number of mission-critical projects through existing ASPR appropriations. This startup funding (between \$1-4 million per fiscal year) allowed critical “foot in the door” projects to begin. To be fully successful in meeting the goals and objectives envisioned in this document, a minimum budget of approximately \$20 million per fiscal year will be required; funding less than this amount will require carefully selecting and concentrating on those highest-priority goals and objectives which will achieve the greatest impact. In addition, Section 3504 of The Patient Protection and Affordable Care Act provide ASPR the authority, but not the authorization, to award up to \$24 million for grants to establish programs for improving trauma care in rural areas; competitive grants to improve trauma systems; grants to design and implement regionalized systems for emergency care; and formula grants to modify state trauma plans.

From the ECCC Charter:

“The ECCC will work in coordination with the Federal Interagency Committee on Emergency Medical Services (FICEMS). Whereas FICEMS was established to ensure coordination among the Federal agencies involved with state, local, tribal, or regional emergency medical services and 9-1-1 systems, and specifically focuses on issues relating to pre-hospital care, the ECCC is established to address issues relating to in-hospital emergency department care.

Together, the ECCC and FICEMS will contribute to an Emergency Care Enterprise (ECE) that will coordinate efforts of the USG throughout the broad spectrum of emergency medical care.”

ECCC Organization

The ECCC is uniquely positioned to serve a key role in improving the resiliency, efficiency, effectiveness and capacity of the ECE and strengthen the nation's state of readiness for and resilience to disaster.

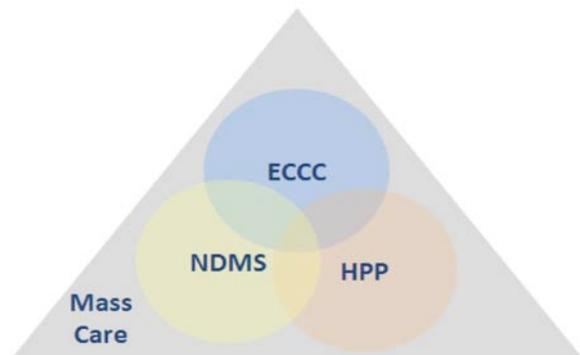


Figure 2: HHS/ASPR/OPEO Division of Mass Care, Preparedness Intersection

ASPR, under which the ECCC has been established, is responsible for developing operational plans, analytical products, and training exercises to ensure the preparedness of the Office, the Department, the Federal Government and the public to respond to domestic and international public health and medical threats and emergencies. ASPR, through its Office of Preparedness and Emergency Operations (OPEO), is responsible for ensuring that the systems, logistical support, and procedures necessary to coordinate the Department's operational response to acts of terrorism and other

public health and medical threats and emergencies are in place. Similarly, through its Division of Mass Care (Figure 2) where the ECCC resides, OPEO has responsibility for the National Disaster Medical System (NDMS) and the Hospital Preparedness Program (HPP), a grants program to strengthen health care systems preparedness in states and territories. While these three programs have different objectives, they have a crucial intersection that serves as a catalyst for public health and medical preparedness.

ECCC Vision, Mission, Principles, & Goals

The ECCC Vision

To enhance the provision of exceptional emergency medical care for all people in the United States.

Mission

To assist and strengthen the USG's efforts to promote federal, state, tribal, local, and private sector collaboration and to support and enhance the nation's system of emergency medical care delivery.

Principles

The activities of the ECCC will be based on the following operating principles, which will guide its actions on a daily basis. These principles will be consistent with the overall strategic plan for the ASPR and its focus on the development of resilient communities and

the Federal Government's leadership role in coordinating, developing, and improving public health and medical emergency preparedness, response, and recovery systems. Other documents influence these principles as well, such as Healthy People 2020, the HHS Strategic Plan, and the National Health Security Strategy (see Appendix A).

Principle #1

Supporting public-private partnership

As most direct clinical emergency care is provided within the private sector, the effectiveness of the ECCC depends on partnership with, and active involvement of, the entire emergency care community.

Principle #2

Developing and using a strong evidence base

Research, evidence and information are the essential underpinnings of effective clinical practice, system performance, readiness and national health security. A primary role of the ECCC will be to expand the knowledge base of ECEs where evidence is insufficient.

Principle #3

Coordinating efforts of federal partners

Emergency care is comprised of a widely diverse spectrum of activities represented among widely divergent federal programs. Coordination of federal efforts is essential to advancing the ECE.

Principle #4

Building systems that enhance preparedness

A fundamental operating principle is that public health emergency preparedness is built on a foundation of strong and effective health systems, public health and daily operations. The ECCC strives to improve preparedness by strengthening health systems.

Principle #5

Promoting the tenants of *accessibility, quality, and scalability* in emergency care

The ECCC supports the development of the provision of excellent patient- and community-centered emergency health care that is available to all who need it, of consistent high quality, and scalable to adapt to fluctuations in need during busy periods or disasters.

The fundamental value of the ECCC lies in its capacity to engage stakeholders, support research, create a federal focus for emergency care, conduct policy analysis and

disseminate knowledge which improves the day-to-day quality of emergency medical care in the United States.

Goals

From 2012 to 2016, the ECCC primary strategic areas of focus are coordination, accountability, and regionalization. The goals listed here represent potential objectives as well as activities that are already in progress. The CEMC and emergency care stakeholders will assist with the evaluation, prioritization, and further refinement of these goals. As with the principles above, these goals are consistent with the ASPR strategic plan.

Goal #1

Lead the coordination of the federal emergency care partners.

Objective 1.1: Provide strategic leadership and administrative support to the CEMC.

Objective 1.1a: Through engagement with the CEMC, serve in the role of an advisory body for any new federal initiative affecting emergency care, including any funding that would come from the ECCC if that mechanism becomes available.

Objective 1.2: Participate in the Federal Interagency Committee on EMS.

Objective 1.3: Participate with partners in developing quality metrics for a high functioning ECE, in conjunction with stakeholders and subject matter expert.

Objective 1.4: Through engagement with stakeholders and subject matter experts work to insure that the capability and capacity of the ECE to care for children is proportional to the adult population.

Goal #2

Support an ECE that is responsive to both the patient and the community.

Objective 2.1: Promote research on health care system management to establish and promote best practices for ensuring that a patient is seen by the right type of provider, at the right time, in the right place, based on their acuity level.

Objective 2.2: Explore and evaluate alternative funding models for emergency care, including pre-hospital care that could enhance accessibility and quality.

Objective 2.3: Encourage improved communication between the ECE and a patient's medical home and public health resources.

Goal #3

Enhance efficiency and promote the appropriate utilization of emergency care

Objective 3.1: Work with stakeholders to identify the causes of boarding and to reduce the practice of boarding patients in the emergency department.

Objective 3.2: Leverage other federal policies to improve the financing and coordination of emergency care.

Objective 3.3: Identify and characterize all patient populations (including special needs and pediatric) and geographical regions that will require higher amounts of resources to deliver high quality emergency care.

Objective 3.4: Work with stakeholders to establish mechanisms to foster cooperation between emergency departments and pre-hospital EMS.

Goal #4

Promote local and regional emergency preparedness.

Objective 4.1: In coordination with HHS or other federal grant programs, develop and conduct exercises or research to identify gaps in emergency care capabilities as well as best practices relating to public health and emergency medical preparedness, response, and recovery.

Objective 4.2: Quantify national and local ECE resources (facilities, providers), modalities (e.g., ventilators) and detail which areas or services are most compromised to serve communities during an emergency response or disaster.

Objective 4.3: Promote community-based opportunities to engage and improve other components of the health system (in particular primary care clinicians, the health care workforce, and community health centers) in public health emergency preparedness, response, and recovery activities related to emergency care.

Objective 4.4: Identify those emergency care business practices that are not compatible with preparedness (examples: ambulance wait times, boarding, competition of hospitals, unnecessary regulatory mandates, liability issues for providers and facilities) and develop methods to minimize their effects on preparedness.

Objective 4.5: Promote the trial and assessment of regionalization agreements/coalitions for emergency care.

Goal #5

Support research to improve emergency care

Objective 5.1: Support the development of evidence based practice guidelines for the ECEs.

Objective 5.2: Support the establishment an ECE research network.

Objective 5.3: Support the establishment of a best practices and evidence clearinghouse to improve clinical care and operational efficiency, using all available information and research.

Objective 5.4: Support research projects describing the comparative effectiveness of regionalizing emergency care with a focus on time-sensitive clinical conditions, pediatric populations, information management, and patient mobility.

Objective 5.5: Support fellowship opportunities for future leaders from across the entire ECE.

Goal #6

Support the integration of emergency care management and clinical information systems and technology into the overall health system.

Objective 6.1: Promote the integration of ECE data systems into health information networks, and ensure the means exist to objectively evaluate this process.

Objective 6.2: Explore the ways in which technology (enhanced 9-1-1 systems, electronic medical records, tele-medicine, etc.) can increase safety, efficiency, and quality in emergency care, with a focus on bridging the existing boundaries between pre-hospital and hospital-based care, as well as between inpatient care and the patient's medical home.

Objective 6.3: Promote the most effective methods to integrate emergency care data into existing health information networks, and ways to make network data available to emergency care providers.

ECCC Achievements & On-Going Projects

In a short period of time, the ECCC achieved significant accomplishments and is in the process of developing several key on-going projects.

ECCC Significant Achievements

Council on Emergency Medical Care (CEMC)

The first meeting of the CEMC was held in December 2008. The CEMC is the federal interagency body of subject matter experts that provide advice relating to issues involving emergency care and the ECE:

- Held meeting with stakeholders in January 2011 with the Assistant Secretary for Planning and Evaluation as a collaborator to examine with key non-federal stakeholders how evolving issues related to health reform may affect emergency care. Issues examined included:
 - The impact of daily emergency care issues on workforce and surge capacity in pandemic or disaster medical situations;
 - Emergency care capacity and crowding;
 - The impact of healthcare reform and insurance on the emergency care enterprise;
 - Emergency care workforce issues; and
 - The medicolegal environment in clinical emergency care practice.

HHS Lead for Institute of Medicine Forum

The ECCC led HHS' sponsorship of Institute of Medicine Forum on Medical and Public Health Preparedness and Response, and sponsored three IOM Emergency Care Workshops:

- Surge Capacity
- The Emergency Care Enterprise
- Regional ECEs

HHS Lead for American Medical Association Forum

The ECCC led HHS' sponsorship of the AMA Third National Conference on Health Systems Readiness.

HHS Lead for Development of FETIG

The ECCC led the development of the Federal Education and Training Interagency Group (FETIG) and co-chaired this interagency group in its development of a work plan for the National Center for Disaster Medicine and Public Health.

Hurricane Katrina Support

The ECCC sponsored a Review of Medical Records of Hurricane Katrina patient care facilities.

H1N1 Pandemic Influenza of 2009 – 2010

The ECCC accomplished several important functions during the global influenza pandemic of 2009 to 2010:

- Led a collaborative effort with the American College of Emergency Physicians to draft and publish the *National Strategic Plan for Emergency Department Management of Outbreaks of Novel H1N1 Influenza*;
- Developed and fielded the web-based triage algorithm for H1N1 in collaboration with Emory University and other federal and non-federal partners;
- Develop a Simulation Model to Evaluate the Economic Impact of H1N1 on Hospitals in collaboration with AHRQ;
- Conducted a National Ventilator Survey in U.S. Acute Care Hospitals:
 - Produced paper published in the AMA's Journal of Disaster Medicine and Public Health Preparedness;
- Sponsored development of H1N1 Self-Evaluation Tool:
 - Adults and peds, posted to Flu.gov;
- Conducted extensive biostatistical analyses of the NHLBI 2009 H1N1 ICU Registry;
- Submitted inter-agency paper on 2009 H1N1 (pediatric cohort), provisionally accepted in *Pediatrics*;
- Submitted inter-agency paper on 2009 H1N1 (adult population), Revisions requested by *Critical Care Medicine*;
- Responded to 7 FDA requests regarding influenza anti-virals based on data from the NHLBI 2009 H1N1 ICU Registry;
- Responded to the DHHS Secretary's request for data regarding the impact of the 2009 H1N1 epidemic on US Hospitals (HiHAT Analyses);
- Sponsored Special Supplement to AMA's [Journal of Disaster Medicine and Public Health Preparedness](#) that focused on Pandemic Influenza to include H1N1:
 - Published an original manuscript on *Implications of EMTALA During Health Emergencies and Alternate Sites of Care*; and
- Sponsored and helped develop Critical Care Cross-Training Course with Society of Critical Care Medicine (SCCM).
- The CEMC also produced a position paper on H1N1 and medical surge capacity and emergency care workforce protection.

Developing Surge Capacity

The ECCC led the development of a contract project with UPMC for Novel Strategies for Situational Awareness of Healthcare System Functioning and Capacity.

The ECCC also sponsored development of prototype of management information system to provide near-real time monitoring of emergency department indicators of performance.

Emergency Physician Fellowships

The ECCC has co-sponsored three fellowships for emergency physicians, and is in the process of co-sponsoring a fourth.

Health Economic Forum Sponsorship

The Health Economic Forum included leading healthcare economists and industry preparedness stakeholders who examined funding for medical surge capacity.

Conference on Regionalized Emergency Care

The ECCC sponsored a conference that focused on developing demonstration projects for regionalized emergency care services. This conference focused on the ways in which regionalization affects various medical specialties, the mechanisms by which it can be made adaptable by location, the identification of available resources, and how the concept can be measured and quantified.

ECCC Key On-Going Projects

Collaboration with the National Quality Forum (NQF)

The ECCC is working with the NQF to develop the foundation for a larger project on quality measures development for Regionalized Emergency Medical Care.

Collaboration with the CDC National Center for Health Statistics

The ECCC is collaborating with the Centers for Disease Control's National Center for Health Statistics to identify enhancements to the NHAMCS-ED in order to prospectively assess the ECE in relation to ongoing health reform efforts.

Emergency Care Research

The ECCC is continuing to collaborate with key federal and academic partners to sponsor a conference to address important issues related to emergency care institutional review boards. This conference is scheduled for September 2011.

Collaboration with CDC Injury Control Center

The ECCC is working with the Centers for Disease Control's Injury Control Center to organize community preparedness conferences for major cities to enhance their response to the terrorist use of improvised explosive devices.

Appendix A: Strategic Context

The goals and objectives of the ECCC strategic plan not only relate to the mission and vision of the ECCC, but also serve broader societal and organizational goals. In particular, Department of Health and Human Services' Strategic Plan, the National Health Security Strategy (NHSS), the ASPR Strategic Plan, and Health People 2020. The chart below highlights select provision of those documents that align with the mission and vision of the ECCC.

HHS Strategic Plan
<p>Goal 1: Transform Health Care. Objective B: Improve health care quality and patient safety. ECCC: All goals and objectives</p>
<p>Goal 2: Scientific Knowledge and Innovation. Objective A: Accelerate process of scientific discovery to improve patient care. ECCC: Goal #5, support research to improve emergency care.</p>
<p>Goal 3: Advance the Health, Safety, and Well-Being of the American People. Objective A: Ensure the safety, well-being, and healthy development of children and youth. Objective E: Reduce the occurrence of infectious diseases. Objective F: Protect American' health and safety during emergencies, and foster resilience in response to emergencies. ECCC: Goal #2, support an emergency care enterprise that is responsive to the patient and community.</p>
<p>Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs. Objective A: Ensure program integrity and responsible stewardship of resources. Objective C: Use HHS data to improve the health and well-being of the American people. ECCC: Goal #3, enhance efficiency and promote the appropriate utilization of emergency care.</p>
<p>Goal 5: Strengthen the Nation's Health and Human Services Infrastructure and Workforce. Objective B: Ensure that the Nation's health care workforce can meet increased demands. ECCC: Goal #4, promote local and regional emergency preparedness.</p>

ASPR Strategic Plan

Goal 1: Promote resilient communities, fostering a nation able to withstand and recover from public health emergencies.

ECCC: Goal #4, promote local and regional emergency preparedness.

Goal 2: Strengthen federal public health and medical preparedness, response, and recovery leadership and capabilities.

ECCC: Goal #4, promote local and regional emergency preparedness.

Goal 3: Promote an effective medical countermeasures enterprise.

ECCC: Goal #5, support research to improve emergency care.

Goal 4: Strengthen ASPR's leadership role in coordinating and developing public health and medical emergency preparedness, response, and recovery policy for the Department.

ECCC: Goal #1, lead the coordination of the federal emergency care partners.

Goal 5: Improve the preparedness and integration of health care delivery systems.

ECCC: Goal #4, promote local and regional emergency preparedness; Goal #6, support the integration of emergency care management and clinical information systems and technology into the overall health system

Goal 6: Improve management of the ASPR organization and investment in its people.

ECCC: Goal #4, promote local and regional emergency preparedness.

National Health Security Strategy

Objective 4: Foster integrated, scalable health care delivery systems.

ECCC: Goal #1, lead the coordination of the federal emergency care partners; Goal #6, support the integration of emergency care management and clinical information systems and technology into the overall health system

Objective 10: Ensure that all systems that support health security are based upon the best available science, evaluation, and quality improvement methods.

ECCC: Goal #5, support research to improve emergency care.

Healthy People 2020

AHS HP2020-4: (Developmental) Increase the proportion of persons who have access to rapidly responding pre-hospital emergency medical services.

ECCC: Goal #2, support an emergency care enterprise that is responsive to the patient and community.

AHS HP2020-8: Reduce the proportion of hospital emergency department visits in which the wait time to see an emergency department physician exceeds the recommended timeframe.

ECCC: Goal #3, enhance efficiency and promote the appropriate utilization of emergency care.

AHS HP2020-5: Increase the number of States and the District of Columbia that have

implemented guidelines for pre-hospital and hospital pediatric care.

ECCC: Goal #2, support an emergency care enterprise that is responsive to the patient and community; Goal #3, enhance efficiency and promote the appropriate utilization of emergency care.

AHS HP2020–3: Increase the proportion of persons with a usual primary care provider.

ECCC: Goal #2, support an emergency care enterprise that is responsive to the patient and community.

Appendix B: Current CEMC Representation

COUNCIL ON EMERGENCY MEDICAL CARE (CEMC)		
Department	Agency	Offices/ Division
Department of Defense (DoD)	USUHS	Center for Disaster and Humanitarian Assistance Medicine Department of Military and Emergency Medicine
Department of Defense (DoD)	Navy	Naval Medical Center, Department of Emergency Medicine
Department of Defense (DoD)	Air Force	Emergency Medicine Consultant to AF SG
Department of Defense (DoD)	Army	Walter Reed Hospital
Department of Defense (DoD)	OASD(HD&ASA)	Health & Medical Defense Support of Civil Authorities
Department of Defense (DoD)	Navy	Navy Emergency Medicine
Department of Health and Human Services (HHS)	Office of the National Coordinator (ONC)	CDR/ Office of Health Information Technology Adoption / Office of the National Coordinator for Health IT
Department of Health and Human Services (HHS)	Administration for Children and Families (ACF)	Captain Roberta Lavin, USPHS, Director, Office of Human Services Emergency Preparedness and Response

Department of Health and Human Services (HHS)	Food and Drug Administration (FDA)	CDR / Office of Counterterrorism and Emerging Threats/ Office of the Commissioner
Department of Health and Human Services (HHS)	Office of Medicare Hearings and Appeals (OMHA)	Office of Medicare Hearings and Appeals
Department of Health and Human Services (HHS)	ASAM	Federal Occupational Health
Department of Health and Human Services (HHS)	Agency for Healthcare Research and Quality Center for Delivery (AHRO)	Emergency Department Research Activities, Organization and Markets
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	National Library of Medicine (NLM)/ Office of the Disaster Information Management Research Center Specialized Information Services
Department of Health and Human Services (HHS)	Assistant Secretary for Planning and Evaluation (ASPE)	Office of Science and Data Policy
Department of Health and Human Services (HHS)	Indian Health Service (IHS)	Emergency Services
Department of Health and Human Services (HHS)	Office of Intergovernmental Affairs (IGA)	Office of Intergovernmental Affairs (IGA)
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	National Institute of Neurological Disorders and Stroke (NINDS)
Department of Health and Human Services (HHS)	US Public Health Service (USPHS)	CDR, Program Support Center, Federal Occupational Health Service (FOH)
Department of Health and Human Services (HHS)	Agency for Healthcare Research and Quality (AHRO)	Patient Safety Portfolio
Department of Health and Human Services (HHS)	Centers for Disease Control and Prevention (CDC)	National Center for Injury Control and Prevention
Department of Health and Human Services (HHS)	Health Research Services and Administration (HRSA)	Emergency Medical Services for Children Program
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	National Institute of Child Health and Human Development (NICHD)

Department of Health and Human Services (HHS)	Center for Disease Control (CDC)	CDC-NCHS-Ambulatory and Hospital Care Statistics Branch
Department of Health and Human Services (HHS)	Assistant Secretary for Preparedness and Response (ASPR)	Office of Preparedness & Emergency Operations National Healthcare Preparedness Programs
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	NIMH / Division of Services and Intervention Research
Department of Health and Human Services (HHS)	Agency for Healthcare Research and Quality (AHRQ)	Director, Public Health Emergency Preparedness Research Program
Department of Health and Human Services (HHS)	Centers for Medicare and Medicaid Services (CMS)	Quality Measurement and Health Assessment Group
Department of Health and Human Services (HHS)	Centers for Medicare and Medicaid Services (CMS)	Physicians Regulatory Issues Team
Department of Health and Human Services (HHS)	Federal Occupational Health (FOH)	Division of Environmental Health Services
Department of Health and Human Services (HHS)	OSD	Office of the Chief Medical Officer
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	Division of Pharmacology, Physiology, and Biological Chemistry NIGMS/NIH/DHHS
Department of Health and Human Services (HHS)	National Institutes of Health (NIH)	National Heart, Lung and Blood Institute National Institutes of Health (NHLBI)
Department of Health and Human Services (HHS)	SAMHSA	OPPD/DPC
Department of Homeland Security (DHS)	Office of Special Health Affairs, Health Resources and Services Administration (OHA)	Office of Special Health Affairs, Health Resources and Services Administration (OHA)
Department of Homeland Security (DHS)	US Public Health Service (USPHS)	CDR/ Office of Health Affairs
Department of Homeland Security (DHS)	Office of Health Affairs (OHA)	Office of Health Affairs
Department of Homeland Security (DHS)	Office of Health Affairs (OHA)	Operational Medicine & Workforce Health Protection Division

Department of Transportation (DOT)	National Highway Traffic Safety Administration (NHTSA)	Office of Emergency Medical Services
Department of Veteran Affairs (VA)	Veteran Affairs	Emergency Medicine Medical - Surgical Services Office of Patient Care Services
White House Homeland Security Council	HSC	Public Health Policy

Appendix C: Government & Private Partners

Government Partners

ASPR	Assistant Secretary for Preparedness and Response
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DOC	Department of Commerce
DOD	Department of Defense
DOL	Department of Labor
DVA	Department of Veterans Affairs
EMS	Emergency Medical Services
EMS-C	Emergency Medical Services for Children
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Administration
FICEMS	Federal Interagency Committee on EMS
HRSA	Health Resources and Service Administration
NCIPC	National Center for Injury Prevention and Control
NEMSAC	National EMS Advisory Council
NIH	National Institutes of Health
NIOSH	National Institute of Occupational Safety and Health
NOA	NHTSA – Office of the Administrator
NTI	NTHTSA Office of Traffic Injury Control
NTIA	National Telecommunications & Information Administration
OSHA	Occupational Safety & Health Administration
OSP	Office of Safety Programs
OST	Office of the Secretary of Transportation

Private Partners

AAP	American Academy of Pediatrics
ACEP	American College of Emergency Physicians
ACS/COT	American College of Surgeons/ Committee on Trauma
AHA	American Heart Association
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality

AAFP	American Academy of Family Physicians
APCO	Association of Public-Safety Communications Officials
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
BTF	Brain Trauma Foundation
CIT	Critical Illness and Trauma Foundation
ENA	Emergency Nurses Association
IAEMSC	International Association of EMS Chiefs
IAFC	International Association of Fire Chiefs
IAFF	International Association of Fire Fighters
NACCHO	National Association of County & City Health Officials
NACHRI	National Association of Children's Hospitals and Related Institutions
NAEMSE	National Association of EMS Educators
NAEMSP	National Association of EMS Physicians
NAEMT	National Association of Emergency Medical Technicians
NAOTM	National Association of Tactical Medics
NEMIS-TAC	National EMS Information System – Technical Assistance Center
NEMSMA	National EMS Management Association
NGA	National Governors Association
NREMT	National Registry of Emergency Medical Technicians
NRHA	National Rural Health Association
NTDB	National Trauma Data Base
PECARN	Pediatric Emergency Care Research Network
SAEM	Society of Academic Emergency Medicine
TJC	The Joint Commission (formerly The Joint Commission on Accreditation of Healthcare Organizations)