The US Emergency Care Coordination Center

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Editor's Note: *This article is part of a series that describes the many ways that the Department of Health and Human Services interacts with the emergency care system. The Department of Health and Human Services includes many divisions that are well known to the health care world, including the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the National Institutes of Health, and the Agency for Healthcare Research and Quality. The goal of the series is to increase the visibility of federal emergency care–related activities within the emergency care community.*

INTRODUCTION

The federal government's role in the delivery of emergency care in the United States is complex. Although emergency care is delivered within the Department of Veterans Affairs, Indian Health Service, and Department of Defense, primarily for eligible beneficiaries, the majority of it is delivered in the private sector rather than as part of a federal program. This is, of course, true of the rest of health care as well; chronic disease management, routine screening examinations, and elective surgeries take place almost exclusively in a private marketplace. The role of the federal government in regulating this market has been debated and is beyond the scope of this article, but it is clear that because of the significant proportion of health care paid for through the Medicare and Medicaid programs (20% and 16% of 2014 national health expenditures, respectively),[1] the federal government plays a significant role in health care delivery by using regulatory and payment levers to ensure the delivery of high-value medical care.

Emergency care, however, does not exist in a typical health care marketplace. In many ways, emergency care sits at the intersection of the public sector (public health, police, and fire) and the private health care sector. In fact, Americans perceive emergency care for injuries as a public good akin to police and fire services as much as a part of the health care system. The idea that no one would be turned away from an emergency department (ED) became the law of the land with the passage of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986, requiring all hospitals that receive federal payment for health care services to provide medical screening examinations and stabilization to anyone presenting to an ED, regardless of ability to pay.[2]

As a universally accessible gateway from the community into the health care system, EDs need to be ready for anything that may come through the doors at any time, ranging from social and mental health crises to life- and limb-threatening injury and illness. Beyond this, local, state, tribal, and federal agencies have an important role in ensuring that communities are able to respond to the health consequences of naturally occurring and man-made events. In large-scale disasters and public health emergencies, the US health care system is expected to be prepared to respond immediately to complement emergency management and public health efforts of local, state, and regional disaster teams. When the emergency care system is under chronic stress, surge capabilities in the health care system are compromised and patient- and population-level health outcomes may deteriorate. It is through this lens that the Emergency Care Coordination Center approaches the integration of emergency care into the broader health care system.

THE US EMERGENCY CARE SYSTEM

The always-available and always-ready posture of the ED is a point of pride for emergency providers, but constant readiness comes with relatively high fixed costs that have created tension between consumers and payers (including the US government) about the management of low-acuity conditions in a high-fixed-cost environment. Although the ED has been celebrated as the "hub of the [health care] enterprise,"[3] it has simultaneously been targeted as a high-cost center, referred to as an unfunded mandate (because patients cannot be turned away because of inability to pay), and dialogue about "inappropriate," "avoidable," or "unnecessary" visits abound. Significant delivery system reform efforts have targeted reduction in ED utilization as a cost-saving measure.

Many of the forces that have driven emergency care use over time are a part of societal demographic changes and

shifts in how health care is delivered in the United States. Key demographic factors include the aging of the US population, the increase in independent living among older adults, and a shift in perspective about health care delivery at the end of life. The effect of American consumer culture on health care delivery cannot be overstated. More than ever before, health care is seen as a consumer good. This has been reflected in governmental efforts focused on increasing transparency around the cost and quality of care delivered, as well as in private sector health care efforts focused on maximizing market share. Finally, it is critical to examine how trends in health care delivery affect the emergency care system.

Advances in health care allow Americans to live long lives despite multiple chronic medical problems. Health care economics, patient preferences, and scientific advancement have resulted in a shift from inpatient- to outpatient-based health care, even for complex surgeries or treatments (eg, chemotherapy). These driving forces have created a public expectation that, whether for convenience, preference, fragility (acute exacerbations of chronic problems), or severity of illness, the ED will serve as the health care safety net. More than a third of annual patient visits in the United States—354 million—are for acute unscheduled care, ranging from exacerbation of chronic diseases to unplanned occurrences, such as motor vehicle crashes.[4] Although researchers have estimated that between 13.7% and 27.1% of patients treated in EDs could be managed in alternative settings, ED visits continue to increase annually. ED claims data have been used to understand the unmet needs in the primary care or outpatient health care system, but primary care–based alternatives have not emerged.[5] The evolving role of emergency care in the US health care system has been thoroughly examined in detail elsewhere.[6]

Despite efforts to prevent the need for care or to move care to lower-cost settings, ED visits have been steadily increasing. The emergency care system represents a critical access point, delivery system hub, and ultimate backup plan for the remainder of the health care system. In addition, emergency care can never be a pure marketplace, given the public sector's reliance on it to be ready in times of need. Delivery system reform efforts focused on maximizing just-in-time efficiency need to be balanced with the just-in-case capacity and capabilities expected by the American public. The Department of Health and Human Services believes that a high-performing emergency care system is the foundation for a prepared overall health care system and a resilient nation. The mission of the Emergency Care Coordination Center is to lead the US government's efforts to create an emergency care system that is:

- patient and community centered;
- integrated into the broader health care system;
- high quality; and
- prepared to respond during public health emergencies.

Although the center works with other Department of Health and Human Services and federal departments during emergency response situations, the center primarily focuses on providing guidance and coordinating policy initiatives to strengthen the day-to-day operations (eg, capacity, capabilities) of acute unscheduled care facilities so they are prepared for responses.

CREATION OF THE EMERGENCY CARE COORDINATION CENTER

The Emergency Care Coordination Center is within the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response. *Annals* readers were introduced to the Assistant Secretary for Preparedness and Response's mission in a previous HHS Highlights article.[7] The Assistant Secretary for Preparedness and Response was authorized under the 2006 Pandemic and All Hazards Preparedness Act,[8] and reauthorized in March 2013, "to improve the Nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural." In response to a series of reports released by the Institute of Medicine (IOM) in 2006, the Emergency Care Coordination Center was created in January 2009 and placed within the Assistant Secretary for Preparedness and Response office to improve the delivery of daily emergency care in the United States.

The 2006 IOM Committee on the Future of Emergency Care in the US Health System released 3 reports: *Hospital-Based Emergency Care: At the Breaking Point,*[9] *Emergency Medical Services: At the Crossroads,*[10] and *Emergency Care for Children: Growing Pains.*[11] These reports describe an emergency care system that is "overburdened," "underfunded," "highly fragmented," and "increasingly unable to appropriately respond to the demands placed upon it each and every day." Recognizing the precarious state of emergency care in the United States, the IOM recommended the development of "regionalized, coordinated, and accountable emergency care systems throughout the country." IOM further recommended that Congress "establish a lead agency for emergency and trauma care…housed in [the Department of Health and Human Services]." After the IOM report in 2007, Homeland Security Presidential Directive 21 mandated the creation of a Department of Health and Human Services office to "address the full spectrum of issues that have an impact on care in hospital emergency

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