EMS Stakeholder Meeting Proceedings Report November 2011

Disclaimer

This report was prepared by the Office of the Assistant Secretary for Preparedness and Response, Emergency Care Coordination Center. Opinions, conclusions, and findings expressed in this report are those of the authors. The report consists of preliminary findings and does not provide or imply any policy or procedural changes for the U.S. Department of Health and Human Services.

Overview

The EMS Stakeholder Meeting was convened to gain the opinion of stakeholders on how the Department of Health and Human Services (DHHS), in general, and the Office of the Assistant Secretary for Preparedness and Response (ASPR), in particular, can improve the nation's emergency care enterprise (ECE), while recognizing that the ECE is often the doorway into the nation's health care system.

The meeting consisted of a series of exercises in which participants were asked to subjectively rate five aspects of emergency care on a scale of 1 to 10. These were: reimbursement; Emergency Support Function-8 (ESF-8); health information technology; regionalization; and research initiatives. This was followed by a brief from a DHHS SME on the topic and then an open discussion on what needed to be accomplished to improve the score of each ECE aspect. After the open discussion, participants were asked to re-rate the particular aspect were all stakeholder recommendations to be implemented. The presentations by experts were intended to help stimulate participants' thinking about recommendations on the ECE. These recommendations were reviewed by the group following the discussion and form the basis of the deliverables listed at the end of these proceedings.

Introductory Remarks

Richard Reed, Special Assistant to the President from the National Security Staff (NSS), noted the need for better alignment of EMS between federal entities such as ASPR, FEMA, DHHS, DHS, and DOT. He stated that the NSS is developing an executive order for the President's consideration that will attach EMS to one or more federal entities in a manner that will improve sustain and grow the system.

Gregg Lord noted that the discussion was not intended to have an influence on either the EMS executive order or H.R. 3144 - Field EMS Quality, Innovation, and Cost Effectiveness Improvements Act of 2011, which had been introduced into the House of Representatives the month before. Instead, the meeting was held to gain input on EMS issues so that DHHS and ASPR could better understand how to meet their roles across the continuum of ECE, from the time EMS is notified of an emergency to the point where a patient goes through disposition in the emergency department.

Gregg Margolis spoke to the need for better integration of EMS into the nation's health care system, which would strengthen the entire ECE.

Nicole Lurie, Assistant Secretary for Preparedness and Response, noted that the National Health Security Strategy cannot meet its objectives of building community resilience and strengthening the national health system without ECE integration. Emergency care preparedness should be scalable and embrace the whole community, recognizing that health care starts with bystanders. Obstacles to ECE integration lie in its decentralization and variability in which it is organized at the local level across the country. The lack of ECE organization is endemic: even relevant entities within the federal government lack coordination. A goal of the ECCC is to coordinate

the nation's ECE services such that their daily operations are scalable to address large-scale disasters.

Dr. Tinker was introduced as the meeting moderator and facilitator, and began by introducing the core team of experts from the governmental and private EMS organizations who would be participating in the exercises.

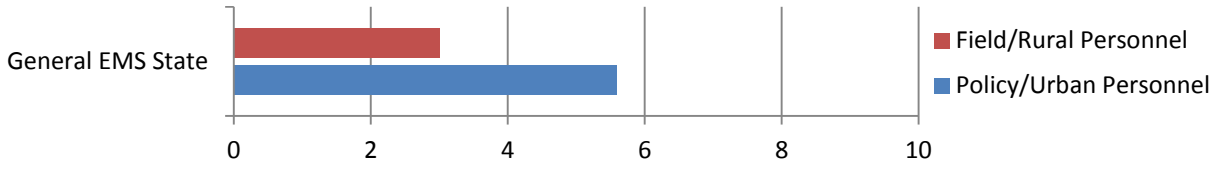
EMS Rating Exercises

The purpose of the EMS rating exercises was to find how to create, model, and replicate opportunities that could serve to develop EMS performance, capability, capacity and infrastructure. Participants began each exercise by considering where on a scale of 1 to 10 an aspect of EMS currently rated. These ratings were subjective and not intended to be a scientific representation. Instead, the ratings were meant to serve as a general baseline for the discussions that followed, which formed the core group of experts' recommendations for improvement.

The open discussions on each EMS aspect were moderated by Dr. Tinker and framed by a generally consistent set of topics: successes, challenges, ideal state, roles, and metrics. The group of experts generated specific ideas for each, presented in these proceedings as bulleted points. As the discussion was free flowing, the participants determined the relevancy and importance among the topics for each aspect, resulting in a slight variance in the record.

At the completion of each open discussion, the core group of experts was polled again on a scale of 1 to 10 for a general determination as to how the EMS aspect would improve were each recommendation enacted.

EMS Rating Exercise: The General State of EMS



At the beginning of the EMS rating exercises, the core group of experts was polled on where they believed the general state of the nation's EMS stood. The group returned a median score of 5 out of 10 (note: unlike the discussions of other aspects, the participants were not polled again at the conclusion of the meeting regarding the general state of EMS).

The group noted that although the median score for all participants was returned at a 5, 9 of 20 scores in this exercise were returned between 1 and 4 (with a median score of 3), and the 12 remaining scores were returned between 5 and 7 (with a median score of 5.6). After examination, the group recognized that the split occurred between experts who represented field

personnel or rural organizations (1 to 4), and those experts representing administrative/policy organizations (5 to 7).

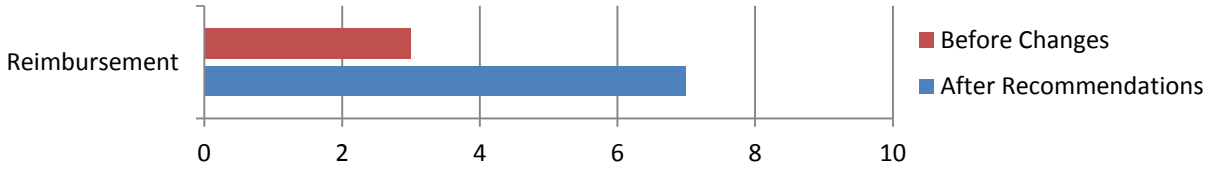
Open discussion

Those experts representing field EMS personnel and predominantly rural organizations cited these reasons for their lower scores:

- Regional disparities
- Personnel lack educational opportunities
- Fragmented nature of systems and services
- Lack of measurable goals
- Inadequate funding
- Rural service has often been constructed as amalgams of available but disparate and uncoordinated resources, versus having been engineered in their entirety as singular systems
- Professional environment that is competitive instead of collaborative

Those experts representing administrative and policy organizations cited many of the same topics, however they identified what in their view was the existence of either progress or positive trajectories regarding these issues having prompted their higher scores.

EMS Rating Exercise: Reimbursement



Initial median rating: 3
Median rating after recommendations for improvement: 7

Dr. William Rogers of the Centers for Medicaid and Medicare Services (CMS) gave a presentation on what CMS may be able to do to foster improvements in EMS. Dr. Rogers began by noting there is a fundamental question which must be decided upon if any core improvements to EMS are to be made: "*Because EMS encompasses elements of both the emergency services system and the health care system, where exactly does EMS fall in a patient's transition between these two systems?"* Future improvements for EMS, and therefore also CMS' reimbursement policies for it, can only be set when it is determined whether EMS is the health care component of the emergency public safety system, or if it is instead the emergency services component of the health care system.

This fundamental question aside, Dr. Rogers said that CMS has a limited ability to innovate of its own accord because its functions are largely dependent on federal statute; for example, adding a

Medicaid reimbursement for preventive screenings is a change that would be dependent on the approval of Congress. Thus, although CMS is able to affect small changes via guidance, proposed rules, and reimbursement fee schedules, creating a pay-for-performance program for EMS would require Congress' approval.

Open discussion

CMS successes:

- As a government health care reimbursement entity, CMS is more efficient than its counterparts elsewhere in the world
- CMS fills a need
- CMS creates silos of care providers

Opportunities for CMS:

- Create demonstration projects
- Primary care extension
- Shape reimbursement to be flexible, adaptable, and scalable
- Streamlined reimbursement processes
- Separate out pre-hospital EMS
- Block grants that pay for preparedness instead of the traditional fee for service approach
- Change administrative contractors about every three years to help ensure high quality of service
- Leverage out-of-hospital downstream capabilities
- Use CMS to create savings that can be invested back into EMS
- Capitates based on population

Ideal future state:

- CMS tests and models innovative programs aimed at improving EMS reimbursement and delivery
- Pre-hospital care is an integrated part of the health care infrastructure
- Routine data collection and analysis of EMS is performed
- Uniform, highly educated EMS workforce exists

ASPR roles:

- Continue to bring stakeholders together
- Act as a unified voice for EMS issues to the public and within the inter-agencies
- Work with CMS-Innovations to establish funding for demonstration projects

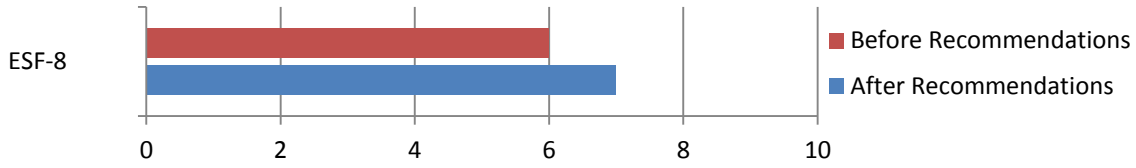
Metrics: How do we know we're succeeding?

- The number of lives saved increases
- Patients are more satisfied with the Emergency Care Enterprise
- Administrative cost savings occur

Three key messages around reimbursement:

- Investing in EMS could improve care and cost savings, but research is needed to validate this concept
- EMS is the single largest health services provider in the United States
- EMS is on the front lines of the nation's disaster response

EMS Rating Exercise: Emergency Support Function-8



Initial median rating: 6
Median rating after recommendations for improvement: 7

Dr. Andrew Garrett presented an overview of ESF-8 and the National Disaster Medical System (NDMS), and noted those issues in day-to-day care involving medical oversight and the lack of standardized competencies present challenges to EMS, and that these issues become compounded during a major response. In addition, differing certifications among states do not always translate to a specific set of skills, presenting the issue of not readily knowing which EMS providers from which states are qualified to perform certain services during a response. An EMS system that is efficient and effective every day, and that is scalable to meet national disasters, is an integral part of preparedness.

An EMS response of national scale requires a great amount of local initiative. Although ASPR coordinates ESF-8 response on the behalf of the federal government, the majority of resources exist at the state, local, and private level, and these must be integrated with federal assets in order to ensure a successful disaster response. This disparity makes it difficult to exactly define the federal role in disaster response. Also, it is a challenge to plan a scalable EMS system that is able to meet both local responses and major national disasters, while at the same time being capable of responding to disasters as diverse as pandemics or hurricanes. Communication is vital in any event, but reliable and effective communications proves difficult when the leadership process of ESF-8 lacks clarity.

Open discussion

ESF-8 successes:
- Comprehensive
- Well documented and organized
- Strong capacity and infrastructure
- Greater alignment

ESF-8 challenges:
- Need for doctrine

- Not well funded

Ideal future state:
- High level of coordination
- Enhanced communication
- Sustainable funding
- Capacity is understood
- Accountability
- Limited federal role, since most response is from the state and local level

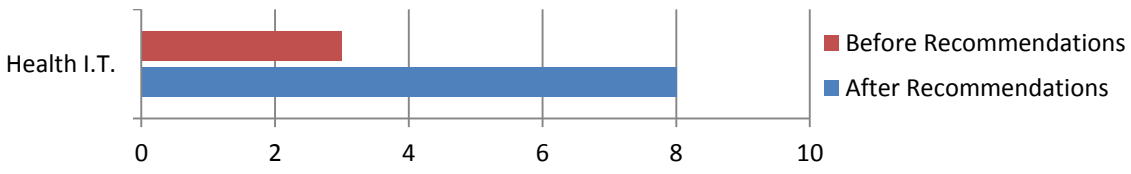
ASPR roles:
- Aligning FEMA and NHTSA grants to support EMS preparedness
- Perform a realistic needs assessment of local communities

Local roles:
- Local governments should know what their needs are
- Educate local and state politicians about EMS

Metrics: How do we know we're succeeding?
- Better services may be delivered with fewer dollars
- Needs and desired outputs are met
- Capacity is developed for local responders to meet large events
- Credentialing of volunteers is rapid and timely
- Ability to track patients across the response continuum
- Communications infrastructure improvements have been developed between responders, government, and the public

Three key messages around ESF-8:
- Coordination and communication starts at the local level
- Effective daily pre-hospital EMS is critical for both community and national preparedness
- Multiple, redundant communications pathways are essential for response

<u>EMS Rating Exercise: Health Information Technology</u>



Initial median rating: 3
Median rating after recommendations for improvement: 8

Gregg Margolis presented an overview of health information technology, with a focus on the development of a national Health Information Exchange (HIE) network. While most of the funding for infrastructure has been directed toward primary and in-patient care due to the fact that is where the overwhelming majority of health records reside, there are considerable emergency care implications for a national HIE. An ideal system will hold patient medical records that are viewable by field EMS personnel at the scene of the incident, allowing for review of all relevant information that could aid treatment and disposition. This capability to bring up the complete medical records of anyone in the back of an ambulance also raises considerable privacy issues. If these can be solved, an HIE network would provide a wealth of data for health surveillance and research, and when combined with tele-health capabilities would be a leap forward for providing health care to rural populations.

The core group of experts noted that although states and the federal government have recognized the value of HIE networks and provided funding for their development, there has been little official recognition in government policies of their benefits as they relate to EMS. Thus, there is a need for stakeholders to ensure that discussions on HIE networks among policymakers center around the concept that extending HIE networks to EMS would result in better integration of the ECE, ultimately benefitting the entire national health care system.

Open discussion

Characteristics of a top HIE network:

- Timely
- Standards compliant
- Compatible with other systems
- Ubiquitous and universally accepted
- Thoroughly searchable
- Secure
- User friendly
- Open, scalable architecture

Challenges to achieving a HIE network:

- Privacy concerns
- Affordability
- Technical support
- Obsolescence
- Accountability
- Local reluctance

Opportunities provided by HIE:

- A fully integrated emergency care enterprise

Ideal future state:

- HIE network is implemented by 2013
- Data sharing is a CMS condition of participation

- Reimbursement incentivizes EMS partners to join HIE networks

ASPR roles:

- Publicly supporting the idea of incorporation of EMS and emergency care into the health information exchange

Local roles:

- Physically implement the systems
- Mandate participation in HIE networks

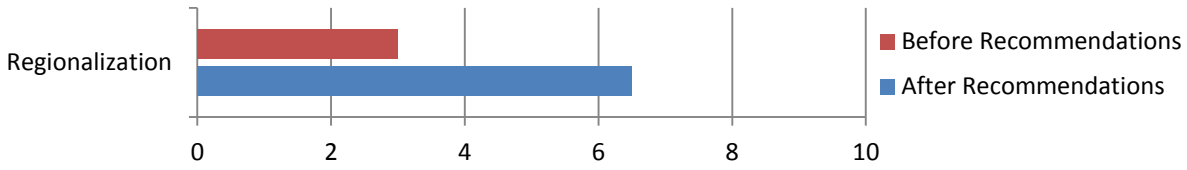
EMS stakeholder roles:

- All stakeholders sign onto a doctrinal statement supporting HIE
- Gain the Joint Commission's support of HIE networks
- Assemble case studies and data supporting HIE implementation as a national policy

Metrics: How do we know we're succeeding?

- All patient encounters are documented into the HIE network
- Data from the HIE network is readily available for research and system improvement

EMS Rating Exercise: Regionalization



Initial median rating: 3
Median rating after recommendations for improvement: 6.5

Gregg Lord presented the regionalization overview to, noting that the concept of a "regionalized, coordinated, and accountable system of emergency care" has existed since the National Academy of Sciences published *Accidental Death and Disability: The Neglected Disease of Modern Society* in 1966 (more commonly referred to as the "EMS White Paper"). However, more than four decades later this vision of regionalized EMS still remains unfulfilled, prompting questions as to what barriers have prevented it from becoming reality.

One barrier to achieving regionalized EMS may lie in how the concept of regionalization has traditionally been understood to include only health care systems and hospitals. This limited focus has thus excluded the role of EMS and the out-of-hospital environment from being properly considered in regionalization planning. By working to expand the concept of regionalization to include EMS, the full continuum of care may be regionalized to the benefit of the hospital and healthcare systems.

Expanding regionalization to include EMS and out-of-hospital care also depends on finding methodologies that reduce expense and response factors. These factors may include the use of paramedics versus emergency medical technicians (EMTs); determining when or when not to transport; and if the decision is made to transport, whether the patient is delivered to a hospital or an out-of-hospital health care facility.

Open discussion

Ideal future state:

- EMT has the authority to decide where to transport the patient
- Closest service responds to call, regardless of its political/geographical jurisdiction
- Standards and metrics are common across the region
- Real time situational monitoring is available across the region
- Region is cooperative and all services' business models align
- Reduction of duplication across region
- Effective communications system
- Common medical direction for system elements

Challenges:

- Determining an equitable funding share among different jurisdictions
- Determining chief authorities across multiple jurisdictions

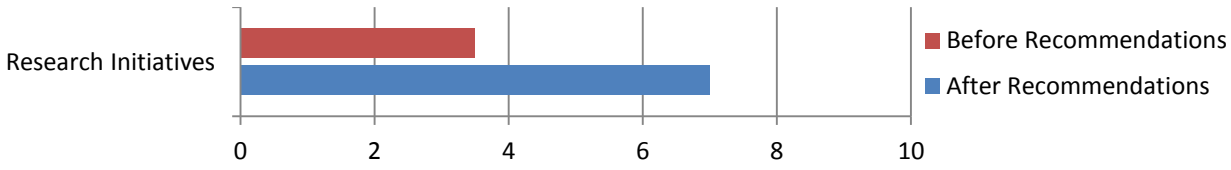
ASPR roles:

- Advocate for incentivizing regionalization
- Assist with the development of models and standards

Local role:

- Agree to change to a regional model

EMS Rating Exercise: Research Initiatives



Initial median rating: 3.5
Median rating after recommendations for improvement: 7

Scott Somers of the National Institute of General Medical Sciences at the National Institutes of Health (NIH) gave an overview of what the Institute is doing with regards to research in the field of emergency medicine (EM). Although the number of studies funded by NIGMS on EM has increased, these studies have not been coordinated because EM research is not a specific charge

of any of the 28 institutes within NIH. NIH is also trying to address a weak EM research infrastructure as well as the lack of qualified EM researchers. Dr. Somers invited the core group of experts to contact him if any member of the group is interested in emergency medicine research.

Ryan Mutter of the Agency for Healthcare Review and Quality (AHRQ) provided an overview of how the agency supports EMS research needs. AHRQ supports research in comparative effectiveness and regionalization in the pre-hospital and EMS delivery systems, and also provides grant funding for EMS research. AHRQ also supports data collection, providing EMS research data through the Healthcare Cost and Utilization Project (H-CUP).

Tasmeen Weik of the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) presented on the Emergency Medical Services for Children (EMS-C) program. EMS-C collects data through its state grant programs, surveys, and collaborations with other agencies and makes it available for EMS research.

Open discussion

Challenges to research:

- Available funding sources are disparate and not clear to researchers
- Importance of EM research is not recognized by providers
- There are few pre-hospital providers who are also researchers
- Few partnerships between researchers and pre-hospital practitioners
- Infrastructure to perform EM research needs to be developed
- The IRB process is paralyzing pre-hospital research

Opportunities for research:

- Initiate dialogue to translate science and research into practice
- Opportunity to gain pre-hospital data
- ACA has specific language in support of EM research

Successes:

- The National Registry is growing its body of EM researchers
- EM research is being applied to the battlefield setting by the Department of Defense

Top EM questions research might answer:

- Can we safely treat patients without transporting them to the ED?
- What are the savings recognized versus patient outcomes of decreasing ICU bed stays, or of intubating or not intubating?
- What are the proper systems of care to deliver during actual interventions in the field?
- Does the "Golden Hour" actually exist and does it change outcomes?

Ideal future state:

- ASPR provides leadership on research and cross-pollination
- A cadre of experienced researchers who can respond to funding opportunities

- Improved EM research infrastructure
- Robust data sources that permits analyses across the expanse of EM
- IRB problem will be solved
- Advocates exist who can advance the research mission

Metrics: How do we know we're succeeding?

- Number of research papers on EMS increases
- Funding awards for EMS research increases
- Evidence demonstrating that EMS research contributed to a policy shift
- Increase in the number of systems collecting uniform data

DHHS Desired Deliverables

At the end of the EMS Stakeholders Meeting, the core group of experts was asked to articulate specific deliverables that DHHS should attempt to achieve.

1. Expand the National Cardiovascular Data Registry's CARE Registry to all 50 states.
2. Perform a joint study on EMS with the CMS Innovation Center.
3. Push for full national adoption of EMS education agenda and scope of practice.
4. Keep referencing EMS at professional meetings to make it topical.
5. Bring together the scientific and operational side of EMS.
6. Have Secretary of DHHS use funds under the ACA for research.
7. Have CMS Innovation Center expand the limited data set linking pre-hospital and hospital care.
8. Make EMS research a focus, and inventory existing EMS research.
9. Plan and launch the EMS and ECE regionalization Agenda for the Future Project.
10. Bring ASPR, CMS, and stakeholders together to discuss incentives and disincentives related to the Medicare Conditions of Participations.
11. Reimburse for EMS readiness, capability and credentialing.
12. Have CMS develop clear guidance on sharing data and the HIPPA concerns
13. Discuss with the Secretary of DHHS about how to tap into discretionary funding to promote EMS agenda.
14. Perform in-depth surveys of EMS professionals in the field on their needs.
15. Expand and improve the culture of Safety Project.
16. Perform meta-analysis of the last 20 years of EMS research to understand what already exists.
17. Work in basic first aid and CPR in high school health classes.

DHHS Efforts

The extensive list above has been reviewed and the DHHS is looking into each item to determine what methodologies can be applied to accomplish the deliverable. As the first step in the process of identifying solutions to each of the issues articulated above the DHHS will need to institute a department wide effort. The Emergency Care Coordination Center (ECCC) has been tasked by the Assistant Secretary of Preparedness and Response (ASPR) to bring together all of the principles who have projects, programs or efforts relating to emergency medical services, emergency care and trauma. The ECCC will provide regular updates on these efforts as well as others currently in development which will provide improved support and engagement to the entire Emergency Care Enterprise.

The ECCC, in conjunction with the other members of the DHHS team, will continue to host opportunities for the entire Emergency Care Enterprise to engage with the DHHS and our Federal partners regularly.

APPENDIX A

Emergency Medical Services &
The U.S. Department of Health and Human Services:
A Listening Session

State Room (7th Floor)
The Elliott School of International Affairs
George Washington University
1957 E Street, NW Washington, DC 20052

8:00 am ****** REGISTRATION ******

8:30 am **OPENING REMARKS**

Gregg Lord, MS, NREMT-P
Emergency Care Coordination Center
Office of the Assistant Secretary for Preparedness and Response

Gregg Margolis, PhD, NREMT-P
Division of Health Systems and Health Care Policy
Office of the Assistant Secretary for Preparedness and Response

9:00 am **ASSISTANT SECRETARY FOR PREPAREDNESS & RESPONSE WELCOME**

Nicole Lurie, MD, MSPH
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services

9:15 am **MEETING OVERVIEW & PROCESS**

Tim Tinker, DrPH, MPH
Center for Risk and Crisis Communication
Booz Allen Hamilton

9:30 am **REIMBURSEMENT ISSUES**

- Aligning Incentives
- Paying for Performance
- Quality Measures

William Rogers, MD, FACEP
Physicians Regulatory Issues Team
Centers for Medicare and Medicaid Services

10:45 am ****** BREAK ******

11:00 am **EMERGENCY SUPPORT FUNCTION-8**

Andrew L. Garrett, MD, MPH
National Disaster Medical System
Office of the Assistant Secretary for Preparedness and Response

12:00 pm ****** LUNCH ******

1:00 pm **HEALTH INFORMATION TECHNOLOGY**

Gregg Margolis, PhD, NREMT-P

Office of the Assistant Secretary for Preparedness and Response

1:30 pm **REGIONALIZATION**
Gregg Lord, MS, NREMT-P
Office of the Assistant Secretary for Preparedness and Response

2:00 pm **RESEARCH INITIATIVES ACROSS HHS**

- Agency for Healthcare Research and Quality
  Ryan Mutter, PhD
  Emergency Department Research Activities

- Health Resources and Services Administration
  Tasmeen Weik, DrPH, NREMT-P
  Emergency Medical Services - Children

3:00 pm ****** BREAK ******

3:15 pm **RESEARCH INITIATIVES ACROSS HHS (CONT.)**

- National Institutes of Health
  Scott Somers, PhD
  National Institute of General Medical Sciences

4:15 pm **OPEN DISCUSSION**

5:00 pm **RECAP AND ADJOURN**

APPENDIX B

Non-Federal Invited Guests

Roy Alson
American College of Emergency Physicians

Tony Baker
International Association of Fire Chiefs

John Bilotas
National Association of Police Organizations

James S. Blumenstock
Association of State and Territorial Health Officials

Scott Bourn
National Association of EMS Educators

J. Robert Brown, Jr.
International Association of Fire Chiefs

Richard Childress
International Association of Flight Paramedics

Jim DeTienne
National Association of State EMS Officials

David Finger
National Volunteer Fire Council – EMS

Dia Gainor
National Association of State EMS Officials

Brad Gruehn
American College of Emergency Physicians

Jim Judge
National Association of EMTs

Thomas Judge
Association of Critical Care Transport

Skip Kirkwood
National EMS Management Association

D. Randy Kuykendall
National Association of State EMS Officials

Daivd Lee
National Rural Health Association

Thomas R. Loyacono
National Registry of EMTs

Gary Ludwig
International Association of Fire Chiefs

Gregory P. Lynskey
Association of Air Medical Services

Kristin McDonald
American College of Surgeons

Jamie Miller
American College of Emergency Physicians

Christine Murphy
Emergency Nurses' Association

Brent Myers
National EMS Management Association

Tony O'Brien
National Association of EMTs

John Osborn
Trauma Centers Association of America

James J. Orsino
Emergency Medical Services Labor Alliance

Gina Piazza
American College of Emergency Physicians

Aarron Reinert
National EMS Advisory Council

George S. Rice, Jr.
Association of Public-Safety Communications Officials – International

Adrienne Roberts
American Association of Neurological Surgeons

Lawrence E. Tan
International Association of EMS Chiefs

Timothy Tinker
Booz Allen Hamilton

Lisa Tofil
Trauma Centers Association of America

Jeff Tremel
Emergency Medical Services Labor Alliance

John J. Walsh, Jr.
International Association of Emergency Managers

Bill Webb
International Association of Fire Fighters

Chris Zalar
Association of Critical Care Transport

Other Non-Federal Participants

Shehnaz Cipulio
Detroit, MI

Jimmy Gambone
Oakland, CA

Kate Gambone
Oakland, CA

Mark Logemann
New Castle, DE

Anthony Weinmann
Pittsburg, PA

Robert Morley
Boston, MA

William Wagner
New Castle, DE

Wisam Zeineh
Detroit, MI

Federal Observers

Tabinda Burney
DHHS/ASPR

Matthew Cogdell
DHHS/ASPR

Drew Dawson
DOT/NHTSA

Elizabeth Edgerton
DHHS/HRSA

Kristin Finne
DHHS/ASPR

Richard D. Flinn
DHS/FEMA

Emily Gabriel
DHS

Andrew Garrett
DHHS/ASPR

George Gentile
DHHS/HRSA

Michael Gerber
DHHS/ASPR

RADM Clare Helminiak
DHHS/ASPR

Lisa Kaplowitz
DHHS/ASPR

Gregg Lord
DHHS/ASPR

RADM Nicole Lurie
DHHS/ASPR

Gregg Margolis
DHHS/ASPR

Matthew McBride
DHHS/ASPR

Ralph Montgomery
DHHS/ASPR

Ryan Mutter
DHHS/AHRQ

Richard W. Patrick
DHS

Richard Reed
National Security Council

William Rogers
DHHS/CMS

Noah Smith
DOT/NHTSA

Scott Somers
NIH/NIGMS

Scott Somers
DHHS/NIH

Heather Strachan
DHS/FEMA

Frances Vaughn
DHHS/ASPR

Tasmeen Weik
DHHS/HRSA

Darielis Williams
DHHS/ASPR

Kevin Yeskey
DHHS/ASPR

APPENDIX C

About the Emergency Care Coordination Center (ECCC)

The Emergency Care Coordination Center is a strategic entity located within the Office of the Assistant Secretary for Preparedness and Response in the Department of Health and Human Services (HHS) in fulfillment of Homeland Security Presidential Directive #21 and in response to the following 2006 Institute of Medicine Reports: *Emergency Care for Children*, *Hospital-Based Emergency Care* and *Emergency Medical Services: At the Crossroads*. ASPR recognizes that the successful delivery of daily emergency care is a necessary foundation for our nation's emergency preparedness efforts. Public health and medical disaster readiness continue to be priorities for the U.S. government. 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.