

The Inextricable Relationship of Emergency Care, National Health Security/Preparedness, and Health Care Reform

Nicole Lurie, MD, MSPH

0196-0644/\$-see front matter

Copyright © 2013 by the American College of Emergency Physicians.

<http://dx.doi.org/10.1016/j.annemergmed.2013.05.017>

[Ann Emerg Med. 2013;62:509-510.]

Editor's Note: *This article is the introduction to a new series that describes the many ways that the Department of Health & Human Services (DHHS) interacts with the emergency care system. DHHS includes many divisions that are well known to the health care world including the Center for Medicare & Medicaid Services, the Health Resources and Services Administration, the National Institutes of Health, and the Agency for Healthcare Research & Quality - as well as many that while perhaps less well known, impact the day to day operation of the emergency care system. The Office of the Assistant Secretary for Preparedness & Response has become a primary contact within DHHS for emergency care related issues, and in this first in the series Dr. Nicole Lurie describes the many ways that her office interacts with the emergency care system.*

Editor's Capsule Summary

What is this article about?

This article provides an introduction to the new *Annals* series "HHS Highlights" and an overview of the office of the Assistant Secretary for Preparedness & Response (ASPR), the central home for public health emergencies.

How does this affect our patients?

Given the critical role of the emergency care system in the response to public health emergencies, the office of the ASPR focuses on improving day to day emergency care and coordinates many federal entities that support the civilian emergency care system in times of crisis.

As the Assistant Secretary for Preparedness and Response for the US Department of Health and Human Services (HHS), I have a unique view of the intersection of the private health sector and the federal partners when it comes to emergency and disaster care. In my time in this role, I have seen the critical role that the civilian emergency care system plays in the preparedness

for, response to, mitigation of, and recovery from disasters and public health emergencies. In responses as diverse as hurricanes, widespread power outages, tornados, pandemics, bombings, and explosions, I have witnessed firsthand the dedication, ingenuity, and deep commitment of emergency physicians, nurses, and emergency medical services (EMS) professionals who have gone above and beyond the call of duty to provide care to their community in the most trying of circumstances. And I have witnessed time and time again the critical roles played by bystanders and other community members who felt compelled to help. Preparedness and response to such events rests on the back of strong day-to-day systems. The emergency care system is one of the hallmark systems that we have come to count on in times of need. I and the people of this country take comfort in knowing that there is an emergency care system that is ready to respond at a moment's notice, 24 hours a day, 365 days a year, and that we can count on it in times of crisis. It is my pleasure to write the first in a series of articles that will introduce *Annals* readers to the emergency care activities of the Department of Health and Human Services.

The office of the Assistant Secretary of Preparedness and Response was created as a lesson learned after Hurricane Katrina, with a goal of bringing together a disparate set of activities and creating a single point of accountability. It was authorized by the Pandemic and All-Hazards Preparedness Act in 2006 and reauthorized earlier this year. The office's mission is to ensure that the country is prepared for public health emergencies, including those caused by bioterrorism, and to respond to them when local and state resources are overwhelmed.

The Assistant Secretary for Preparedness and Response office has 3 operational components: the Office of Emergency Management; the Biomedical Advanced Research and Development Authority, which is responsible for the advanced development and procurement of medical countermeasures; and the Office of Policy and Planning. Contained within these offices are familiar entities, including the National Disaster Medical Service, which deploys medical, veterinary, and mortuary assets to communities when needed during disasters; the National Hospital Preparedness Program, which provides funding to prepared the health care system to deal with emergencies; and the Emergency Care Coordination Center.

The Assistant Secretary for Preparedness and Response office is responsible for supporting public health and medical aspects of disasters and coordinates frequently with the Federal Emergency Management Agency, as we did during the tornados in Joplin and most recently during Hurricanes Irene and Isaac and Superstorm Sandy. Because of our mission, we have always had a lot of emergency care expertise, including emergency medical technicians, nurses, and emergency physicians. During the past few years, I have made a concerted effort to expand on these capabilities by recruiting talented individuals with diverse emergency medicine and public health backgrounds. Many of our current leaders have spent much of their professional lives in emergency care and bring impressive and wide-ranging experience to HHS.

During the course of my career, I have been a primary care physician (and still volunteer in a community clinic once a week), a researcher in academia and in a think tank, and in leadership roles in state and federal government. This background has allowed me to see the emergency care system from a variety of perspectives and has informed my understanding of how essential it is that we strategically insert emergency care and principles of emergency preparedness into every aspect of the health care system. *Annals* readers are well aware of the Institute of Medicine's assessment that the nation's emergency care system is "fragmented, overburdened, and underfunded." Unfortunately, 5 years after the release of the "Future of Emergency Care" series, emergency department crowding and the accessibility of primary care has worsened in many communities. I am optimistic that access and coverage expansion provided through the Patient Protection and Affordable Care Act will ultimately relieve many of these problems, although I recognize that in the short term the stress on the health care system, including the emergency care system, may increase as we provide greater access to the previously uninsured. Throughout this transition, my office has and will increasingly be focused on ensuring high-quality care, integrating emergency care into the larger health care system, and coordinating emergency care across health systems. A high-functioning emergency care system is a critical component of a prepared overall health care system and a prepared country. If the system is under chronic stress, it will have difficulty responding to surges in demand from weather emergencies, pandemic infectious diseases, terrorist attacks, a bus crash, or a busy Friday night. How we balance health care reform initiatives with the day-to-day function of our emergency care system will in many ways define our health security and preparedness. As I have said over and over again, if we cannot do it day to day, we will not be able to do it on game day.

Within the Assistant Secretary for Preparedness and Response office, the Emergency Care Coordination Center is now a component of the Office of Policy and Planning. At my direction, it is increasingly focused on the intersection of routine emergency care and preparedness, as well as better integration into our reforming health care system, as emphasized in the Institute of Medicine reports. For example, in the last year the

Emergency Care Coordination Center evaluated the effect of alternative funding models for EMS, worked with the American Burn Association to develop a framework for burn surge, and supported the Association of State and Territorial Health Officers to develop a toolkit to help EMS agencies and hospitals cope with shortages of emergency medications. We will continue these activities, as well as our collaboration with federal and community partners, to support and strengthen state and local emergency care systems. But as many readers know, the Department of Health and Human Services involvement in emergency care spans nearly all of the HHS components. As a part of a recent inventory of emergency care activities within the department, one thing that has become clear to us is how many of our programs that are not under the emergency care banner touch the emergency care system in one way or another.

Using the HHS Highlights mechanism, we plan to bring you some of the stories of how HHS interacts with the emergency care community. Everything that we do at HHS, including support of electronic health records, training grants for health professional training, paying for health services through Medicare/Medicaid/Children's Health Insurance Program, funding medical research, preventing outbreaks of infectious diseases, and deploying the National Disaster Medical System, affects emergency care. There are few, if any, major activities within HHS that do not affect the emergency care system in some way. Conversely, any major issue facing the emergency care community will have significant influence on preparedness, as well as on achieving the overarching goals of the Patient Protection and Affordable Care Act.

I am excited to be able to share with you some of the exciting things going on at HHS that will affect emergency care and your practice. I appreciate that the editors of *Annals* have provided us with this important opportunity to communicate with the emergency care community and look forward to working together to implement the Patient Protection and Affordable Care Act and in the process increase our nation's health security and improve day-to-day emergency care for every American.

Supervising editor: Brendan G. Carr, MD, MS

Author affiliations: From the Office of the Assistant Secretary for Preparedness and Response, Department of Health and Human Services, Washington, DC.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The author has stated that no such relationships exist.

Address for correspondence: Nicole Lurie, MD, MSPH, E-mail aspr@hhs.gov.
