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Rear Admiral Nicole Lurie
Assistant Secretary for Preparedness and Response
Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20024

Dear Rear Admiral Lurie:

The Emergency Nurses Association (ENA) appreciates the opportunity to comment on the Emergency Care Coordination Center's ***Request for Information Relevant to the Regionalization of Emergency Medical Care Delivery Systems and Demonstration Model Development*** (74 FR 42673). As the only professional nursing organization with nearly 37,000 emergency nurses across the United States, ENA is dedicated to defining the future of emergency nursing and emergency care. We actively supported the Institute of Medicine study on the ***Future of Emergency Care*** and have participated throughout the dissemination process.

ENA agrees with the IOM's findings that the emergency care system is highly fragmented and variable. Emergency medical services agencies, hospitals, trauma centers, public safety services, and public health agencies lack effective communication systems and often do not coordinate efforts efficiently. **The Emergency Nurses Association supports the IOM's assertion that the emergency care system in the United States needs to be coordinated and regionalized.** In its 2002 ***Mass Casualty Incidents*** position statement, ENA recommended that emergency services be seamless with 911 and dispatch, ambulances, emergency medical services (EMS) personnel, hospital emergency departments, and trauma centers and specialists working in a coordinated manner. The ENA believes emergency care also must be regionalized to help ensure the patient is transported to the right hospital at the right time for the right care. The following comments address the questions posed in the Center's ***Federal Register*** notice.

A. Existing Models

To date, states with well functioning and coordinated trauma systems are the best blueprint for the effectiveness of regionalization. Trauma systems have proven that by coordinating the transport of critical injured trauma patients to specialized trauma centers, morbidity and mortality are reduced. Maryland, one of the original seven states receiving demonstration project funds to develop model EMS trauma systems under the ***Emergency Medical Services Development Act of 1972***, is a prime example of a comprehensive trauma system that coordinates care along the continuum – from injury through rehabilitation. ENA recognizes the necessity of the Trauma-EMS Program, which has been the only federal source available to build a trauma system infrastructure in the United States. When it existed, the Trauma-EMS Program, which lost its funding in FY 2006, provided critical national leadership and leveraged additional scarce state dollars to optimize trauma care through system integration that offered seriously injured individuals, wherever they lived, prompt emergency transport to the nearest appropriate trauma center within the "golden hour."

The Michigan system is another example of how an effective regionalized trauma system improved the coordination of care and positively influenced patient outcomes, particularly for residents in the more rural area of the Upper Peninsula (UP). Michigan's challenges revolved around the fact that the EMS systems of most of its rural areas are characterized by small, volunteer squads that provide medical first response and basic life support services, and by a shortage of advanced life support capabilities. By regionalizing EMS systems – sharing resources across geopolitical boundaries – they were able to increase provider coordination and make better use of scarce resources. In UP, the two largest area hospitals have demonstrated a clear interest in strengthening the local health care system and have worked closely with smaller hospitals and EMS providers. Trauma systems in states with large rural areas have significantly improved the ability of emergency care providers to get the right patient to the right place at the right time. The coordinated "systems" approach enhanced the development of a continuum of care and supporting communications systems as well as the competency of those providing the care. This model can be built upon and expanded for all of emergency care.

B. Analysis of Current Clinical Practices in Regionalized Care

In recent years, many hospitals and health systems have merged and created larger health systems forming, to some degree, a privatized version of regionalized care. Successful systems provide us with an opportunity for evaluation and analysis of those elements that could be transferrable to a broader regionalized care system. Key elements of these health systems that contribute to improved care services include:

- Inpatient and Outpatient Services – Outpatient services include widespread accessibility of primary care and walk in services for unscheduled acute care. Rural or outreach primary care is often provided by nurse practitioners;
- Centralized electronic medical records;
- Resources dedicated to coordination of services for patients throughout the health system;
- Centralization of high cost, high tech services;
- Defined relationships between rural or community facilities and larger urban tertiary centers;
- Well established and defined referral and transfer procedures as well as feedback mechanisms for improving quality of care;
- Inclusion of care within the system for critical specialties: trauma, cardiovascular, neurology, pediatrics, obstetrics, orthopedics, geriatrics, and behavioral health;
- Shared on-call structure within communities with multiple facilities in close proximity;
- Educational resources available throughout the system to support expected competencies across the continuum of care;
- EMS services incorporated within the system either as a direct component or through cooperative agreement;
- Established mechanisms for shared leadership of the system and its components by stakeholders;
- Centralized oversight of system goals, quality measures, regulatory compliance and finances.

Critical to the development of regionalized care will be the participation of all community stakeholders including city and state government leaders in the assessment, organization, and coordination of regionalized care system.

C. Communications Infrastructure

Several data elements currently exist that ENA believes should be incorporated in regionalization systems to provide situational awareness of resource availability. They are:

- An integrated communications system, ideally coordinated in a single regionalized center or through linked statewide regional centers, utilized for day-to-day operations as well as disaster response communications. The system is linked to all stakeholders including public health;
- A communication system that is capable of using and supporting all emergency communications frequency allocations;
- Continuous, redundant, and reliable communication and information technology systems that assure full interoperability and data exchange;
- A system that provides the capability for emergency alerts to agencies and the public through shared systems incident management and situational awareness, patient tracking, and resource management. The goal is to get the right information to the right person in the right form in real time anywhere necessary and to get the response back to the sender in a similar manner.

D. Opportunities and Challenges in Regionalized Care Delivery

Challenges exist that will need to be overcome for the development of a successful, regionalized care system. Some of those challenges are:

- Loss of autonomy of individual entities within the system;
- Perceived loss of revenue related to transfer of patients or loss of higher reimbursed specialty procedures;
- Strain on patient families if tertiary care is now provided farther from home.

However, the development of regionalization also provides us with many opportunities to improve the timeliness, cost effectiveness, and quality of care. These include:

- Creation of an emergency care system based upon getting the right patient to the right place at the right time;
- Development of critical infrastructure to not only improve coordination of day-to-day care but also vastly improve the ability to manage disaster response;
- Reduction of health care cost related to decrease in redundancy of certain services;
- Enhanced communications among entities;
- Public participation and enhanced understanding of emergency care capacity and capabilities;
- The development of electronic health records and their accessibility within a region;
- Structure system design that supports quality care at all levels with financial incentives for participation and attainment of quality outcomes.

E. Evaluation of Regionalized Care Delivery Systems

The evaluation measurements to determine the success of regionalized emergency care systems should be based upon the primary objective of improving patient outcomes thru directing patients to facilities with optimal capabilities for any given type of illness or injury. Evaluation criteria should include:

- Inclusivity of all health care entities within a region;
- Regional assessment and gap analysis regarding continuum of services within the system;
- Planned regional strategies to address system care gaps;
- Interoperability of communications systems;
- Facility compliance with tiered regional facility criteria;
- Patient transfer times from point of dispatch to definitive care at the appropriate facility. Source for this data would be state EMS data;
- Ability to monitor capacity within the system and adjust EMS transports to equalize treatment times;
- Ability of system to respond to surges and disasters including regional plans for transfer of patients and shared resources;
- Compliance with National Voluntary Consensus Standards for Emergency Care as defined by the National Quality Forum;
- Morbidity and mortality data;
- Measurable data collection available for benchmarking system performance and for ongoing feedback regarding system performance and process improvement.

F. Adaptation of Regionalization to Emergency Medical Care

The nation's emergency care system is currently beyond saturation on a daily basis. Consequently, it has limited ability to respond to a surge of patients from a catastrophic event. As the Emergency Care Coordination Center (ECCC) moves forward, it is critical that clear leadership is established in this area and funding support directed to coordinate the functions of emergency care, as well as assist in providing system incentives for non-emergent care delivered in areas outside of the emergency department.

ENA wholeheartedly endorses unencumbered access to quality emergency care. However, EMTALA, the Emergency Medical Treatment and Labor Act ensuring public access to emergency services regardless of ability to pay, has had the unintended effect of increasing visits to the ED for acute and chronic conditions that do not meet the Centers for Medicare and Medicaid Services (CMS) definition of "emergency medical condition". ENA acknowledges an attempt by CMS to lessen the restrictions regarding patients with non-emergent conditions. Despite a CMS clarification, much confusion continues to surround this issue, grounded in fear of possible reprisals for failure to adhere strictly to EMTALA regulations. EMTALA continues to limit an ED's options to manage its patient load by restricting its ability to send non-urgent patients off-site for clinical care, rather than conducting a full medical assessment in the ED. Nurses cannot tell a patient probable wait times or suggest alternatives for care under the current regulations. With severe crowding and ambulance diversions identified as a national crisis, compounded by the increase in patients using the ED for primary care, some flexibility needs to exist for clinical judgment by an ED practitioner (who has experienced an actual encounter with the patient) to identify those patients who do not obviously meet the definition of an emergency medical condition. As regionalized care systems are established, the opportunity is created to institute a best practice for assuring timely patient access to care utilizing a tiered approach.

G. Additional Information

ENA urges the ECCC and the Emergency Care Enterprise to consider the following suggestions regarding the implementation of demonstration projects for the regionalization of emergency care systems:

- Select demonstration projects to provide an array of regional diversity including both highly populated urban regions as well as sparsely populated rural regions. Also, select regions with existing, well-defined trauma systems as well as those without fully functioning systems. This diversity will provide insight into what resources will be needed to facilitate regionalization in different environments.

- Establish consideration criteria that include evidence of engagement of local and state government leaders and plans for public involvement in the implementation.

We applaud your efforts towards emergency care regionalization. If you would like to discuss our concerns in more detail or require additional information, please do not hesitate to contact me or Kathleen Ream, ENA's Government Affairs Director, at 703-241-3947 or via e-mail at kathiream@aol.com.

Sincerely yours,

William T. Briggs, RN, MSN, CEN, FAEN
President