

Maryland Hospital & EMS Emergency Department Overload Mitigation Plan

Introduction and Background

Across the nation emergency department overcrowding is being recognized as a developing crisis in health care delivery. An objective measure of ED overcrowding in Maryland is the amount of yellow alert hours required by hospitals.

Maryland has experienced a dramatic increase in hospital emergency department yellow alerts, primarily between December and February. As seen on the attached graph, the trend is continuing to rise. Initially, the emergency department overcrowding increase was observed predominantly in Region III (central Maryland), however, the trend has quickly expanded to the rest of the state as well. The increasing trend raises concern about hospitals' ability to accommodate patients needing urgent medical care, as well as critically ill patients, and to respond effectively during a mass casualty incident or epidemic. Although the incidence of emergency department overcrowding is highest in the early winter, recent data continues to show an increase during the rest of the year as well.

Proposal

It is recommended that state health agencies (DHMH, MHCC, MIEMSS), local health agencies, hospitals, healthcare providers, and emergency medical services (EMS), adopt a collaborative and cooperative approach to provide short-term and intermediate mitigation solutions that will effectively deal with critical levels of emergency department overcrowding. Realizing that regional needs vary, we believe that participation in the Plan by the affected entities in each region is essential. Consequently, the operational portions of the Plan may be implemented and adjusted as necessary, utilizing input from regional subcommittees, hospitals, healthcare providers, and EMS providers in each geographic region.

Geographic Scope: The Plan's geographic breakdown corresponds to the regional and jurisdictional approach used by the statewide EMS system, as well as the approach used for county health departments. The following regions and jurisdictions are proposed:

1. Region I: composed of the jurisdictions of Garrett and Allegany counties.
2. Region II: composed of the jurisdictions of Washington and Frederick counties.
3. Region III A: composed of the jurisdictions of Baltimore City and Baltimore County.
Region III B: composed of the jurisdictions of Harford, Carroll, Howard, and Anne Arundel counties.
4. Region IV: composed of the jurisdictions of Cecil, Kent, Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Somerset, and Worcester counties.
5. Region VA: composed of the jurisdictions of Montgomery and Prince George's counties. Region V B: composed of the jurisdictions of Charles, Calvert, and St. Mary's counties.

Within each jurisdiction, hospitals may be further sub-grouped based on geographic proximity, if necessary.

The successful implementation of this Plan is dependent upon the cooperation and support of all parties involved including EMS, hospitals, healthcare providers, and state and local health agencies. The Plan strategies are to be used as guidelines for consideration and should not be considered all-inclusive. Events that require strategies beyond this Plan, will be managed utilizing the state disaster plans for WMD, etc.

Pre-Event; Preparatory; Normal

State Health Agencies

- Develop committees within the EMS Regional Councils, to include the Local Health Officers and hospitals, that will track yellow alerts and recommend to MIEMSS and DHMH the implementation and termination of the “Regional EMS Overload” and “Extended Regional EMS Overload” strategies.
- MIEMSS in conjunction with the regional committees, to determine and distribute uniform, acceptable guidelines for hospital placement on yellow alert status.
- MIEMSS in conjunction with regional committees to develop contingency plans for patient destinations.
- MIEMSS (regional administrators) to review when hospitals are on yellow alert and/or re-route for more than 6 hours in a 24 - hour period.
- MIEMSS to identify and notify hospitals of alert utilization to ensure hospitals’ awareness.
- With MHA, initiate efforts to compile and distribute hospital “best practices”.
- Encourage communication and collaboration among affected hospitals to facilitate the development and implementation of cooperative short-term and long-term solutions.
- DHMH Mental Hygiene Administration and MHA to educate state and private psychiatric facility staff regarding system-wide impact of delays in emergency department patient transfers.
- DHMH Mental Hygiene Administration to continue to work with emergency departments to facilitate the transfer of uninsured psychiatric patients.
- MIEMSS to develop alternative destination criteria for ambulance patient transports.
- DHMH to work with nursing homes to expedite appropriate patient transfers to and from the hospital and to address transfer delays extending beyond 6 hours.

- DHMH in conjunction with the Nursing Home Associations, to develop a plan to evaluate patients, without transfer to an emergency department, whenever possible.

Hospitals

- Each hospital with an emergency department to develop a formal plan to effectively handle emergency room admissions in the event of emergency department / critical care / hospital saturation.* Individual plans may be collected by the Best Practices Committee and distributed to other hospitals within the geographic area and to the Yellow Alert Taskforce. The plans shall include:
 - ◇ a monitoring system to track patient flow in the ED and criteria to identify pre-yellow alert situations and plans to prevent yellow alert requests.
 - ◇ a list, including names, of all hospital officials that have the authority to call a yellow alert; the list shall include senior clinical staff;
 - ◇ the procedure to call yellow alert; and
 - ◇ specific procedures for implementing overload strategies.

*("Saturation": all stations or beds are filled to capacity and/or traditional staffing to patient ratios are at maximum under the hospitals written staffing plan.)

- Utilize available "best practices" to eliminate delays in discharge or transfer of patients.
- Utilize available "best practices" to maximize availability of critical care beds, by eliminating delays in transfer of patients to step-down or other beds.
- All hospitals within the affected area encourage direct admissions that bypass the ED when clinically appropriate.
- Encourage hospitals to offer flu immunizations within their catchment area.
- Establish liaisons with outpatient facilities to provide expedited post-emergency follow-up.

EMS

- EMS to determine feasibility of alternative ambulance destinations meeting MIEMSS criteria, and to develop plans for implementation.
- EMS operational programs to prepare contingency plans for staffing and resources.
- All EMS providers required to abide by alert policies according to regional policies.
- Commercial EMS encouraged to respond within two hours for hospital discharges.

Agencies, Hospitals, EMS

- Implement physician education regarding referrals of patients to emergency departments and system-wide impact of such referrals.
- Implement and / or reinforce public education regarding:
 - ◊ importance of obtaining flu immunization and infection control strategies; and
 - ◊ appropriate use of “911”, the EMS system, and hospital ED.

Regional EMS Overload

Regional coordinating committees shall consider implementation when hospitals within a defined geographic area are on yellow alert status more than 35% of the total collective time (this means a 35% reduction in ED availability), for a period determined by regional committees until total yellow alert time drops below 25% for a period determined by regional committees.

State Health Agencies

- MIEMSS and DHMH alert all state and local health agencies of Overload implementation.
- Issue public service announcements directing sick individuals to seek non-emergent care from primary care providers.
- CDC and DHMH epidemiology/tracking/management teams.

EMS

- EMS transports stable (priority 3) patients to alternative ambulance destinations meeting MIEMSS criteria when possible.
- Jurisdictions within the affected geographic region(s) attempt to increase EMS provider staff.

Hospitals

- Hospitals attempt to schedule non-emergent[?] surgeries at times of low incidence of hospital bypass.
- Hospitals within the affected geographic region attempt to increase staff.

[?] Includes procedures requiring overnight admission or 23 hour stay that may be rescheduled without risk of physical harm to the patient.

- Hospitals review infection control procedures and augment as necessary.

Extended Regional EMS Overload

(Regional coordinating committees shall consider implementation after 30 days on regional EMS overload).

State Health Agencies

- Expand public service announcements from Overload to press releases/health alerts, if necessary. Respiratory precaution requirements may be included here.
- Temporary, centralized patient routing to maximize hospital resources and minimize patient care delays.
- Allow participation of retired /inactive nurses and physicians in health care delivery.

DHMH Local Health Departments

- Establishment of local screening centers and activation of volunteer services for “walking ill” evaluation and triage, prior to going to emergency department (coordination through DHMH with local emergency managers and local health officers).

Hospitals

Hospitals encouraged to implement or prepare to implement appropriate portions of individual internal disaster plans to include:

- Reporting bed availability (staffed and unstaffed) to MIEMSS every 6 or 12 hours.
- Conversion of all available bed space to patient management areas.
- Scheduling efforts to maximize utilization of staff on a twenty-four hour basis.
- Conversion of surgical recovery areas into critical care units.
- Cancellation of all elective and non-emergent[?] surgery.
- Conversion of outpatient facilities into primary treatment centers with potential inpatient service capabilities.

Nursing Homes

[?] Includes procedures requiring overnight admission or 23 hour stay that may be rescheduled without risk of physical harm to the patient.

- DHMH requests nursing home maximization of nursing staff to allow patient admissions on a 24-hour basis.
- DHMH requests nursing home medical directors to schedule on-site physician coverage as necessary to manage patients in the facility and minimize referrals to hospitals.
- DHMH requests conversion of nursing homes associated with existing hospital-based programs, into in-patient health care facilities where feasible.

EMS

- Encourage jurisdictions to increase staffing to maximize utilization of staff on a twenty-four hour basis.
- EMS providers authorized to select alternate destinations for priority 3 patients.
- EMS providers may refer patients requesting emergency department transport, to a non-emergent treatment facility if patients meet the referral protocol.