September 2007

Dear _____,

We are writing to update you on the challenge of Emergency Department crowding in Baltimore City.

Last year, the Baltimore City Task Force on Emergency Department Crowding met to review data showing a dramatic increase in crowding from 2002 to 2005. Participating hospitals in the Task Force included Bon Secours, Good Samaritan Hospital, Harbor Hospital, Johns Hopkins Hospital, Johns Hopkins Bayview Hospital, Maryland General Hospital, Mercy Hospital, Sinai Hospital, St. Agnew Hospital, Union Memorial Hospital, and the University of Maryland Medical Center.

In June 2006, the Task Force made 15 recommendations to improve inflow, throughput, and outflow in Baltimore City hospitals.

One of these recommendations called for better communication between the EMS system and Emergency Departments. With your assistance, this recommendation has been implemented. The Baltimore City Fire Department now utilizes EMS Supervisors and Fire Battalion Chiefs to directly communicate with emergency room staff, speeding up the process of releasing the medic units. In addition, additional medics have been placed in service, and patients are rerouted by the EMS system to less crowded facilities.

Recently, we surveyed all city hospitals to about implementation of some or all of 11 key recommendations. The survey found that hospitals are generally implementing most of the recommendations, with some major steps taken in the last year.

We also reviewed 2006 data related to Emergency Department crowding. These data show that the problem has held relatively stable in Baltimore last year.

Thank you for your continued attention to this public health challenge. In the coming weeks, we will share hospital-specific data with you. The rest of this letter explains our recent findings in more detail.

Measures to Reduce Crowding

In June of last year, the Task Force on Emergency Department Crowding recommended that hospitals:

1. **Increase Access to Primary Care,** because poor access to primary care in Baltimore City contributes to unnecessary use of emergency departments.
2. **Consider Triage Bypass.** This system brings patients directly to beds, skipping the formal "triage station" at times when there are open beds in the emergency department.
3. **Consider Short Stay Units.** These units facilitate rapid admission and discharge for more routine medical problems.
4. **Consider Electronic Bed Tracking.** This step may require shifting bed control to a bed flow coordinator for the hospital.
5. **Consider a Hospital-Wide Flow Team.** Effective teams have enthusiastic participation of all levels of hospital staff.
6. **Promote Increased Efficiency of Transfers to Hospital Floors.** Using "tele-paks" allows the conversion of any bed to a monitored bed.
7. **Consider Adopt-A-Boarder.** Having patients wait for beds on hospital floors, not just in the Emergency Department, can reduce crowding.
8. **Consider a Standardized Throughput Measure.** Agreeing to a standardized measure improves hospitals' ability to review efficiency.
9. **Increase Efficiency of Discharge.** Early discharge and transfer to assisted living facilities increases the number of beds available.
10. **Increase Inpatient Bed Capacity.** Hiring new nurses or increasing facilities can make more beds available quickly.
11. **Review Elective Surgery Scheduling.** This review might identify hidden reasons for Emergency Department crowding.

Earlier this year, the Health Department surveyed each of the city hospitals to understand more about how these recommendations were – or were not – being implemented around the city.

The survey found that out of 11 hospitals:

1. **Eight hospitals report trying to increase access to primary care.** Three hospitals have clinical or case managers in their emergency departments. Four make primary care referrals to sites within the hospital or to community health clinics.
2. **Nine hospitals report practicing triage bypass.**
3. **Four hospitals report using active short stay units.** One additional hospital reported opening an extra 16-bed unit when needed to accommodate patient influx.

4. **Seven hospitals report using electronic bed tracking.** .
5. **Eight hospitals report use of flow teams.** Six of those hospitals have identified continued bottlenecks in patients being discharged too late in the day, rooms not being cleaned quickly enough, or nursing staff not being ready to "take report" on patients quickly enough.
6. **One hospital reports expanded use of portable telemetry.** Two additional hospitals report expanded permanent monitored bed capacity. Four hospitals have not expanded use of "tele-paks" because of not enough or insufficiently trained nurses.
7. **Two hospitals report boarding patients in areas outside the Emergency Department.**
8. **Ten hospitals report having standardized throughput measures.** All ten track multiple time-based parameters such as door to triage, triage to departure, or door until seen by doctor. Five hospitals report adjusting staffing levels to match patient flow
9. **Six hospitals report adopting early discharge policies.** The other five hospitals are reorganizing their staffing to more closely march patient flow.
10. **Ten hospitals report trying to increase inpatient bed capacity.** The hospitals report hiring new nurses and/or increasing facilities.
11. **Seven hospitals have reviewed elective surgery scheduling.** Out of those, two have implemented improvement programs to reduce the impact of surgery scheduling on Emergency Department crowding.

Emergency Department Crowding in 2006

Last year's Task Force report examined the period from 2002 to 2005 and found that the number of city ambulance transports increased by 8% and the total number of patients in city emergency departments increased by 11%. Yet over this same period, our previous report found:

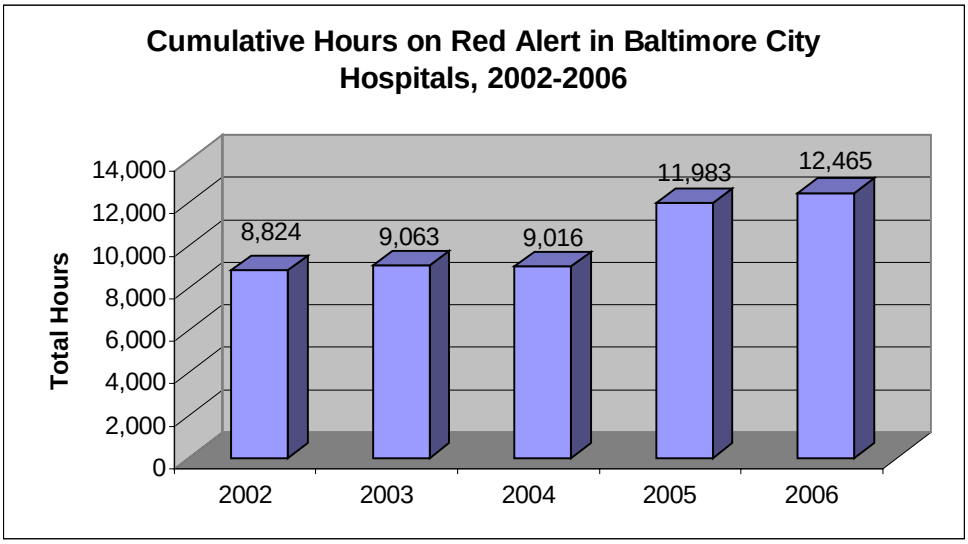
- The total hours of hospital time without available EKG-monitored inpatient beds (red alert) increased by 36%;
- The time that ambulances waited at hospitals to return to service increased by 45%; and
- The total hours that the EMS system placed hospitals on "re-route" status increased by 165%.

This increase in emergency department crowding was part of a decade long trend.

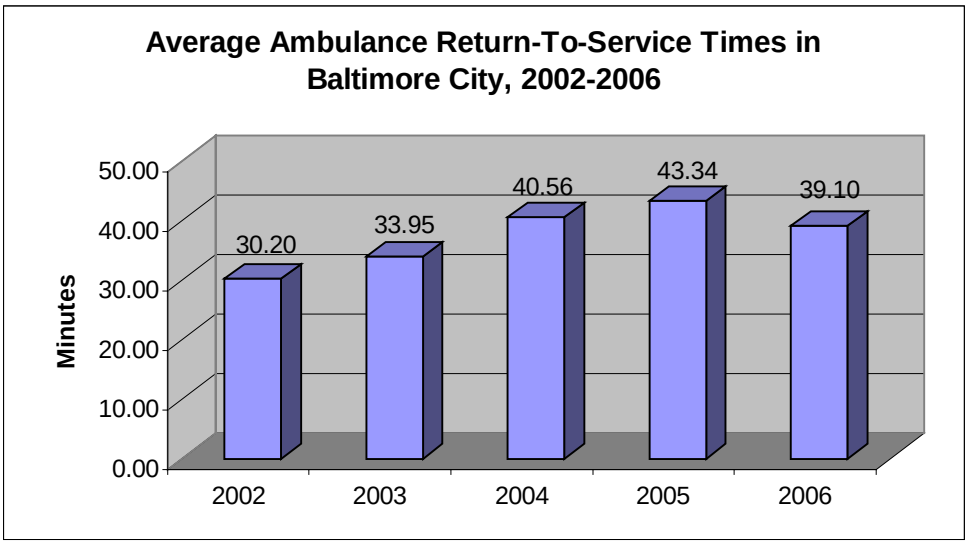
To update the report, we looked at the period from 2005 to 2006. This review finds that Emergency Department crowding has remained fairly stable.

City ambulance transports decreased by 1.6% and patient visits to emergency departments increased by 3.2%. Over this period:

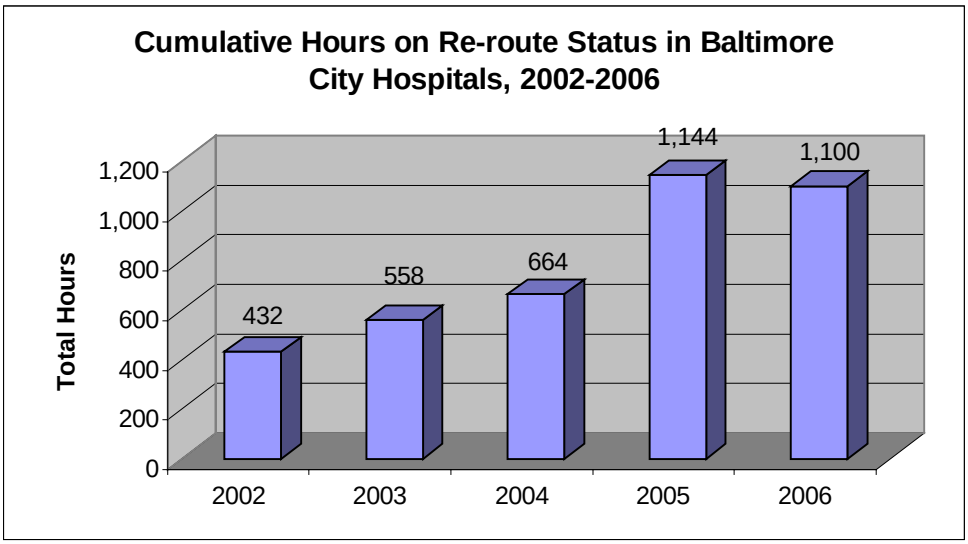
- Total hours of hospital time without available EKG-monitored inpatient beds (red alert) increased by 4.0%.



- The time that ambulances waited at hospitals decreased by 9.8%.



- Total hours that the EMS system places hospitals on "re-route" status decreased by 3.8%.



All of the data in the above analyses come from the Maryland Institute for Emergency Medical Services Systems (MIEMSS).

Conclusion

Emergency Department crowding remains a serious challenge for Baltimore City. We very much appreciate the effort the city's hospitals have made to both make and then follow recommendations aimed at addressing this challenge. We also support your assistance in enhancing communication between EMS and Emergency Departments. Such efforts may be one explanation for the stable results in 2006.

We must aim for further progress. We have no doubt that many of the same pressures that have led to increased Emergency Department crowding are still bearing down on our system. We urge you to review your hospital's efforts to follow the Task Force's recommendations and make additional changes if indicated.

Please do not hesitate to contact either one of us if we can be of assistance in this effort.

Sincerely,

William J. Goodwin, Jr.
Chief
Baltimore City Fire Department

Joshua M. Sharfstein, M.D.
Commissioner
Baltimore City Health Department