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Circular Letter: DHCQ 12-12-579

TO: Acute Care Hospital Chief Executive Officers

FROM: Madeleine Biondolillo, MD, Bureau Director
Iyah K Romm, Director of Policy, Health Planning, and Strategic Development

DATE: December 10, 2012

RE: Code Help Plans

With the impending flu season, the onset of winter, and the increase in emergency department (ED) crowding that will likely follow, the Department of Public Health (Department) would like to take this opportunity to remind hospitals of the importance of testing and revising as necessary their Code Help plans. Code Help is a key tool used to alleviate the crowding caused by the boarding of patients in the ED while they await placement in an inpatient bed by optimizing patient flow throughout the hospital through redeployment staff and resources with the goal of moving all admitted patients out of the ED within thirty minutes.

Implementation of these plans requires the commitment, support and cooperation of the entire hospital. For previous letters issued by the Department regarding Code Help, see: <http://www.mass.gov/eohhs/provider/licensing/facilities/health-care-facilities/hospitals/code-help-plans.html>

Code Help activation triggers are defined in all hospital-specific Code Help policies approved by the Department. When an ED becomes saturated to the point where the ED is unable to care for existing patients in a licensed treatment area, or is unable to accept any new patients into a licensed treatment area, and there are admitted patients waiting in the ED, then a hospital must activate its Code Help policy. If implementation of the Code Help policy does not eliminate the burden of admitted patients in the ED in a timely fashion, or if the severity of the initial situation warrants it, then the hospital must implement its appropriate emergency management/disaster plans and protocols to create additional inpatient capacity.

Testing and Revising Your Hospital's Plan

As of October 2011, all acute care hospitals had developed a Code Help plan and had that plan accepted by the Department. Hospitals are expected to fully implement those plans. One of the

requirements of an acceptable plan is a bi-annual Code Help drill. Subsequent to these drills, as well as any live activation, and subsequent After Action Reviews, hospitals are expected to identify areas for improvement and update their plans accordingly to improve effectiveness in reducing crowding.

Survey of Impact of Code Help Plan Implementation

Early last year, the Department, in collaboration with colleagues from Beth Israel Deaconess Medical Center, sent all hospitals a brief, anonymous survey regarding their experiences with implementing Code Help. The survey was sent to four individuals at each facility (Chief Medical Officer, Chief Nursing Officer, ED Chairperson, and ED Nursing Supervisor). Results from the survey suggest that the frequency of ED crowding varies widely among institutions, with the majority of respondents indicating that crowding occurs at least weekly. Nearly 70 percent of the respondents felt that having an established Code Help plan prompted activities to alleviate ED crowding before Code Help triggers were met. However, the survey responses suggest that not all institutions have been activating their Code Help plans when the defined crowding threshold levels have been met. This finding demonstrates that work remains to ensure full implementation of the plans in all hospitals.

Department Surveyor Review

Hospitals should also be aware that Department surveyors who are on site conducting survey or complaint investigation activities anywhere in the hospital may ask staff about Code Help implementation. Surveyors will be receiving a directed refresher training on Code Help, and will be increasing the focus on this important plan to reduce ED boarding. Surveyors on site in facilities may also ask to see documentation related to the implementation of Code Help plans, including drills and After Action Reviews.

Ongoing Activities

To identify outliers and trends by region, hospital size and teaching vs. non-teaching hospital status, the Department continues to monitor the monthly ED data submitted by the hospitals. To date, hospital size and teaching status do not result in significant differences in boarding. There appear to be regional variations, with a high in EMS Region 5 of approximately eighty percent of the boarders remaining in the ED for 12 or more hours who have a behavioral health diagnosis.

The Massachusetts College of Emergency Physicians (MACEP) has secured a grant to collect and analyze 30 metrics relating to behavioral health patients in the ED for two hospitals in each EMS Region. This data will be used to develop necessary interventions to alleviate the extended lengths of stay in the ED experienced by behavioral health patients.

We thank you for your attention to this important issue and are committed to working with all stakeholders to continue to address the problems caused by crowding in Emergency Departments.