July 8, 2010

TO: Acute Care Hospital Chief Executive Officers, Chief Operating Officers, Chief Nursing Officers, Chief Compliance Officers, Chief Medical Officers, Presidents of Medical Staff, Emergency Department Directors and Directors of Quality and Safety

FROM: Alice Bonner, RN, PhD
Director, Bureau of Health Care Safety and Quality

RE: Hospital Code Help Plans

The purpose of this letter is to request the resubmission of revised hospital Code Help Plans by October 1, 2010.

This letter is the third in a series of letters the Department has issued addressing Code Help policy. The purpose of a Code Help policy is to move all admitted patients out of the ED within 30 minutes when its licensed capacity is reached/exceeded. The Department has previously requested that all hospitals update, implement and test their plans. Most recently, in the February 25, 2010 circular letter, the Department requested a copy of each hospital’s plan. The Department received 60 plans, covering 71 emergency department locations.

With the assistance of an advisory group of three clinicians and administrators involved with emergency department operations and patient flow throughout the hospital, the Department reviewed the plans. From this review, it is clear that hospitals have been working diligently to develop plans to improve patient flow and ease the burden of crowded emergency departments. However, many of the plans lacked the specificity defined in the previous DPH letters and necessary procedures to ensure successful restoration of ED outflow and capacity within the defined time frame.

What is in the Code Help Plan?
The Code Help policy is one focused part of a broad continuum of patient flow policies, procedures and efforts to reduce ED crowding. The specific components/criteria of an acceptable Code Help policy are defined in the DPH letters of September 25, 2009 and February 25, 2010 (links provided below) and must include:
1. **Purpose** - The policy clearly states its purpose is to move all admitted patients out of the ED within 30 minutes of activation.

2. **Triggers** - The policy clearly states it will be activated when the ED is unable to care for existing patients in a licensed treatment space/area or is unable to accept any new patients into a licensed treatment space/area and there are admitted patients waiting in the ED for an inpatient bed. (These triggers should be clear and concise, allowing clinical staff on duty to readily identify those situations in which Code Help activation is required.)

3. **Activation Process** - The policy clearly states the chain of command for activating the policy when the trigger thresholds are reached. (This must be an efficient process, initiated by the ED, with a minimum number of required calls, notifications or steps, in order that the policy can be implemented within minutes when and if required. An alternate initiative may be implemented, such as opening an additional floor or surge unit, prior to activating Code Help, if it will off load the admitted patients from the ED in 30 minutes.)

4. **Next Steps** - The policy clearly states that if Code Help implementation does not eliminate the burden of admitted patients in the ED in a defined time (e.g., 1-2 hours), or if the severity of the initial situation warrants, then the hospital will activate the appropriate emergency management/disaster plans and protocols to create additional inpatient capacity. (Re-activation of Code Help is not an adequate Next Step.)

5. **Testing and Evaluation** - The policy states that Code Help is to be periodically tested on a regular basis (e.g., every 3-6 months, unless activated in the interim.) Activations of the plan must be followed in a timely fashion with an after-action review, for purposes of quality improvement and refinement of each institution’s Code Help plan.

**Resubmission of Code Help Plans**

With this information in mind, we ask you to review your plans, revise as necessary to incorporate these five specific criteria, fully implement and test them, and resubmit them by **Friday, October 1, 2010** via email to: DPH.DHCQ@massmail.state.ma.us, unless your institution is notified by DPH in an attachment to this letter that the hospital’s current policy meets the stated criteria.

For organizations with multiple hospital sites, we request a policy for each campus, as one ‘umbrella policy’ may not adequately address the unique environment of each hospital site. Thus, hospital systems must submit a Code Help plan for each campus. Please be sure to include contact information, including an email address, for the person at your hospital to whom questions about the plan may be directed.

**Boarding**

To reiterate the Department’s position on boarding of patients in the ED as stated in the letter of September 25, 2009, a “boarder” is defined as a patient who remains in the ED two hours after the decision to admit has been made (by the Emergency Physician or the first physician evaluating the patient who determines the patient requires admission). A growing body of literature documents the negative impacts of boarding. Thus, admitted patients should only be allowed to board in the ED when:
• A patient’s medical condition requires continued emergency department care, or
• All of the following conditions apply:
  1. no inpatient option exists,
  2. the ED has the capacity (licensed clinical space\(^1\) for patient examination and/or treatment) and capability to provide care for boarded patients consistent with CMS, DPH, and hospital accreditation requirements, and
  3. continuing to provide care for boarded patients does not interfere with the ability to provide appropriate, timely care for patients who come to the ED.

**DPH surveyors may assess boarding of admitted patients in the emergency department and review Code Help plans as part of the hospital survey and complaint review process.**

**Additional Resources**
The Massachusetts Hospital Association (MHA) is holding their 12\(^{th}\) annual Emergency Medicine Conference on July 16, 2010, from 9:00 a.m. to 2:30 p.m. in Waltham and will focus on patient flow and best practices. At the conference, MHA plans to discuss how they will be collecting and posting on its website, hospital “patient flow” and Code Help policies in an effort to assist hospitals to share best practices. Further details will be provided at the conference. **Go to [www.mhalink.org](http://www.mhalink.org) and click on Education and Events for more information about registration.**

As mentioned in previous letters, in the event you or your ED staff have concerns about unusual situations related to boarding in the emergency department, a phone line is available 24 hours a day for consultation with or reporting to the Department at 800-424-4666. Please ask for the clinician on call.

The two most recent DPH circular letters regarding Code Help are here:
September 25, 2009 Circular letter No. DHCQ 09-09-522
February 25, 2010 Circular letter No. DHCQ 10-02-531

We would like to take this opportunity to thank MHA for the support it has provided as well as commend the hospitals for all of their efforts to address the issues related to crowding in emergency departments. Through our collaborative efforts we will continue to work toward reducing and ultimately eliminating boarding in emergency departments throughout the Commonwealth.

If you have questions about this letter please contact Nancy Murphy in the Division of Health Care Quality at nancy.murphy2@massmail.state.ma.us

\(^1\) Clinical areas previously approved by the Department as part of a licensure survey or plan review.