

MEMORANDUM

March 3, 2009

TO: Public Safety Committee
Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst *LMC*
Minna Davidson, Legislative Analyst *MD*

SUBJECT: **Discussion: Emergency room diversion and patient care records,
opportunities for collaboration**

On November 25, 2008 the Council approved a \$1.595 million special appropriation to fund an electronic patient care reporting system (ePCR) the Fire and Rescue Service (MCFRS) must implement within the next year to meet State standards. A patient care record must be generated for every patient contact performed by MCFRS and, for each patient transported to the hospital, MCFRS must provide the hospital with a patient care record as well as providing data to the Maryland Institute for Emergency Medical Services Systems (MIEMSS). Copies of records must also be provided when requested by insurance companies, lawyers, and patients and their families. A summary of the ePCR is attached at © 14-21. The PS Committee is receiving regular updates on the implementation of this system.

At the November session, Councilmember Leventhal asked how the ePCR might or might not be coordinated with or linked to electronic patient care systems being developed for the Montgomery Cares clinics and by the county's hospitals.

As follow-up to Councilmember Leventhal's request, Council staff met with representatives of MCFRS, the Department of Health and Human Services (DHHS), and the Primary Care Coalition to discuss the ePCR system. At the meeting, MCFRS explained the features of the system they are procuring and discussed with staff from the Primary Care Coalition whether the clinic system and ePCR might have opportunities for interoperability. While the initial assessment was that the systems would not be directly linked, the discussion then moved into a broader discussion about emergency room transports and diversions and whether MCFRS provides emergency response to patients who might not require emergency care if they had regular primary medical care.

At this session, the joint Committee will have an opportunity to be briefed on ongoing discussions between Montgomery Cares (DHHS and Primary Care Coalition) and MCFRS, which have included a briefing to MCFRS staff on the Montgomery Cares program. In addition, MCFRS will brief the joint Committee on ambulance diversions (when an emergency room closes and an ambulance must be diverted to another facility) and representatives from the Primary Care Coalition will provide the joint Committee with an overview of emergency room diversion (reducing emergency room demand by providing care through primary care settings) and a grant they have recently received to study this issue and develop solutions.

An example of a case where opportunities for collaboration might result in better outcomes for the entire system might be the identification of the patient who requires emergency transport and emergency department care for diabetes only because the patient does not have a primary care home where they can receive regular monitoring of their condition and medication. Are there ways to identify these types of situations and refer the patient to Montgomery Cares to determine if they might be eligible for Montgomery Cares, Medicaid, or another program? If there are other reasons the patient cannot access medical care (such as transportation) is there a way to address this need?

Attached at © 1-6 is data that shows the magnitude of the problem when demand for emergency room services are greater than capacity. Circles 1-2 provide definitions for the five categories: Red Alert, Yellow Alert, Blue Alert, Mini Disaster Alert, and Hospital Re-Route and © 7-13 provide the operational policies. The following table summarizes the data included at © 2-4.

Hospital	Number of Times Ambulance Diversion was required in the last five years	Number of Hours that ER was in an alert status during the last five years
Holy Cross Hospital	1,182	12,557
Montgomery General Hospital	1,003	5,669
Shady Grove Adventist Hospital	623	5,176
Washington Adventist Hospital	908	4,958
Suburban Hospital (non-Trauma)	793	3,768
Suburban Hospital (Trauma)	451	846
TOTAL	4,960	32,974

Question 1:

Definitions of the alert status codes for ambulance diversions -“Code Red”, “Code Yellow”, etc. (Does the County use the definitions for Region 5 on the MIEMSS website? If so, we can include the definitions in the packet.)

Yes we currently use/follow the current MIEMSS policy and definitions:

Red Alert:

Definition - The hospital has no ECG monitored beds available and requests that patients who are likely to require this type of care, not be transported to their facility. ECG monitored bed is defined as any adult in-patient critical care bed, including specialty critical care units and telemetry beds. The hospital requests that all priority II and III ECG monitored patients are transported to the next closest appropriate hospital.

Yellow Alert:

Definition - The Emergency Department temporarily requests that absolutely no Priority II or III patients are transported to their facility. Yellow alert is initiated because the Emergency Department is experiencing a temporary overwhelming overload such that priority II or III patients may not be managed safely.

Blue Alert:

Definition - When an EMS jurisdictional system is temporarily taxed to its limits in providing pre hospital care and ambulance transportation due to extraordinary situations such as multi-casualty incidents, snow, icing, or flooding or other circumstances that contribute to high demand for ambulance service, the jurisdiction may declare blue alert status which suspends yellow alert.

Mini Disaster (Alert):

Definition - A Mini Disaster Alert will be called when a hospital's emergency department experiences an unexpected, in house physical plant problem such as: water or power outages, hazardous materials incidents, bomb scares or other situations that threaten the life/health of patients and providers. (Critical care overloads are not considered justification for mini disaster alerts.) It may also be called for because of scheduled shut down of key services such as power or oxygen systems or at the request of the Secret Service. While on mini disaster alert the hospital will receive no patients regardless of priority.

Hospital Re-Route:

Definition - This policy provides guidelines for both emergency medical services (EMS) and emergency medical dispatch (EMD) personnel when a basic or advanced life support unit is being held at a hospital emergency department because a bed is unavailable. Patients should be accepted by the emergency department staff and transferred from the ambulance stretcher to a hospital gurney in a reasonable time frame.

This policy does not replace Yellow Alert, nor does it cancel or override it. If a hospital is on Yellow Alert prior to a hospital "Re-Route" being declared, it will remain on Yellow Alert after the cancellation of the "Re-Route" or until the Yellow Alert is cancelled by the hospital.

See the Attached **MIEMSS Region V Alert Status System Document**

Question 2:

Summary information about the number of times the five hospitals in the County experienced ambulance diversions over the past five years.

To the best of our ability we were able to gather the following Data:

Holy Cross Hospital:

<u>Alert Status</u>	<u>Number of Times</u>	<u>Number of Hours</u>	
Yellow Alert	614	4,091.5	hours
Red Alert	535	8,412.48	hours
Mini Disaster	1	.54	hours
Re-Route	32	52.17	hours
Total:	1182	12,556.69	hours

Montgomery General Hospital:

<u>Alert Status</u>	<u>Number of Times</u>	<u>Number of Hours</u>	
Yellow Alert	659	3,348.72	hours
Red Alert	314	2,258.44	hours
Mini Disaster	7	17.88	hours
Re-Route	23	44.10	hours
Total	1003	5,669.14	hours

Shady Grove Adventist Hospital:

<u>Alert Status</u>	<u>Number of Times</u>	<u>Number of Hours</u>	
Yellow Alert	393	2,410.11	hours
Red Alert	178	2,658.93	hours
Mini Disaster	7	13.82	hours
Re-Route	45	93.61	hours
Total	623	5,176.47	hours

Suburban Hospital:

<u>Alert Status</u>	<u>Number of Times</u>	<u>Number of Hours</u>	
Yellow Alert	579	2,387.83	hours
Red Alert	181	1,315.42	hours
Mini Disaster	9	20.78	hours
Re-Route	24	43.72	hours
Trauma By-Pass	451	846.16	hours
Total w/o Trauma	793	3,767.75	hours
Total w/ Trauma	1244	4,613.91	hours

Washington Adventist Hospital:

<u>Alert Status</u>	<u>Number of Times</u>	<u>Number of Hours</u>	
Yellow Alert	776	4,476.24	hours
Red Alert	43	261.22	hours
Mini Disaster	9	29.85	hours
Re-Route	80	190.96	hours
Total:	908	4,958.27	hours

Question 3:

Factors that create the need for ambulance diversions.

There are a number of factors that would cause the need for ambulance diversions. The primary reason is too many patients. This can manifest its self in the form of too many total patients or it could be too many patients of one type or another. (Trauma or in need of monitoring)

On a rare occasion there will be an event localized to the hospital that will prevent the otherwise ok hospital from accepting patient's. This includes routine situations such as water or power outages as well as fires or possible criminal/terrorist events.

Question 4:

The impacts of ambulance diversions on the delivery of EMS services

There are a number of direct impacts on the EMS service when an ambulance is diverted:

- Longer Transport Times
- Longer Committed to call Times
- Longer Return to Service Times
- Less units in service for a longer time
- Increased Response Times
- More Units on additional calls
- Higher Fuel Costs
- Higher Mileage (increased wear and tear on vehicles)

M.I.E.M.S.S.

REGION V

ALERT STATUS SYSTEM

**Approved by the
Maryland Region V EMS Advisory Council
January 28, 1999
Amended
November 16, 2000
Reprinted with Corrections
January 16, 2001**

Note:

Patients destined for transport to trauma and specialty referral centers are not governed by these policies. They should be transported to facilities as per Maryland Medical Protocols. If a question arises in reference to these patients, trauma consultation should be requested.

Principles of Ambulance Diversion

- ◆ EMS Systems need open, uncomplicated, and unrestrained access to hospitals. In principle ambulance diversion is against the best interests of the EMS System and the patient but its existence in some situations is a necessity.
- ◆ Resource hospitals (i.e. trauma centers, burn centers, smoke inhalation centers, centers with labor and delivery services, and pediatric centers) have a special obligation to the community as do geographically isolated hospitals.
- ◆ There are times in which hospitals have a shortage of resources that render them temporarily unable to care for additional patients. During those times, it may be in the best interests of the patient to be transported to another hospital. The EMS system may establish a mechanism whereby hospitals can acknowledge their inability to provide optimal care (i.e. alert status). Final determination of patient destination however, must rest with the provider actually caring for the patient. This provider, acting according to medical protocols and with the ability to seek medical consultation, has the most direct knowledge of the patients condition and conditions effecting transport including road conditions, weather etc.
- ◆ Diversion policies must be unselective with regard to the patients ability to pay and conform to COBRA requirements.
- ◆ All decisions by a hospital to request ambulance diversion must be made with patient care paramount: no hospital can divert patients unless an appropriate other hospital exists to receive that patient.
- ◆ Our goal is early reliable notification of a serious patient so that the receiving hospital can gather the necessary resources.
- ◆ A diversion system must be as simple as possible.
- ◆ The criteria for ambulance diversion alert must be written down and agreed to by hospitals and EMS system leadership. There must be a clear mechanism for a hospital to request such an alert, for a hospital to be placed on alert and for such an alert to be communicated to the EMS system.

Alert Status System of Region V

I. Red Alert Policy

- A. Definition - The hospital has no ECG monitored beds available and requests that patients who are likely to require this type of care, not be transported to their facility. ECG monitored bed is defined as any adult in-patient critical care bed, including specialty critical care units and telemetry beds. The hospital requests that all priority II and III ECG monitored patients are transported to the next closest appropriate hospital.
- B. Declaration of a Red Alert - The hospital will notify EMRC via the hospital console. EMRC will:
1. notify the appropriate jurisdictions
 2. note time on log sheet
 3. track time used
- C. Override of Red Alert - A red alert will automatically be disregarded for any of the following conditions:
1. a blue alert
 2. a priority I monitored patient from the hospital's normal catchment area
 - a. hospital will receive those patients for initial stabilization then transfer to another facility for admission.
 - b. if an open hospital is 2-3 minutes further, it may be advisable to transport to that facility.
 - c. if an open hospital is less than 15 minutes further, the provider may divert if it is in patients best interest following physician consultation/approval.
 3. the diversion of an ECG monitored priority II or III patient would take an additional 15 minutes or more. (consultation recommended)
 4. adjacent facility (ies) also on red alert.
- D. Maximum Duration - Red Alert is granted for four hours. It may be extended once. No hospital may be on alert more than 8 hours in a twenty four-hour period beginning at 12:01 am.
- E. Red Alert at Adjacent Hospitals - If the two closest hospitals are on red alert, the provider will transport to the closest. If one of the closest is on red and one on yellow alert, the patient will be transported to the hospital on red alert.
- F. Termination - The facility shall notify EMRC via the console. EMRC shall:
1. note time of termination

2. notify appropriate jurisdictions
- G. Documentation - EMRC will maintain a computerized log of all activity.
- H. Problem Incidents - EMRC should be advised of any problem incident immediately.
1. EMRC will notify the Regional Administrator.
 2. Regional Administrator will investigate and document any problems the next working day.
 3. Findings will be forwarded to the Region V EMSA Council.
 4. Council will review and recommend actions as appropriate.

II. Yellow Alert Policy

- A. Definition - The Emergency Department temporarily requests that absolutely no Priority II or III patients are transported to their facility. Yellow alert is initiated because the Emergency Department is experiencing a temporary overwhelming overload such that priority II or III patients may not be managed safely.
- B. Declaration of a Yellow Alert - The hospital will notify EMRC via the hospital console. EMRC will:
1. notify the appropriate jurisdictions
 2. note time on log sheet
 3. track time used
- C. Override of Yellow Alert - A yellow alert will automatically be disregarded for any of the following conditions:
1. a blue alert
 2. a priority I patient from the hospital's normal catchment area (Hospital will receive those patients for initial stabilization then transfer as necessary - provider may consult with hospital and divert if in patients best interest and less than 15 minutes further)
 3. the diversion of a priority II or III patient would take an additional 15 minutes or more. (consultation recommended)
 4. adjacent facility (ies) also on yellow alert.
- D. Maximum Duration - Yellow alert may not exceed 8 hours during a 24 hour period beginning at 12 a.m. (midnight).
- EMRC will maintain the time records and verify yellow alert status ever 2 hours. Exceeding the 8 hour threshold shall be documented as an occurrence.

- EMRC will remind hospitals of the maximum allowable duration section of this policy when the 8 hour threshold has been reached within a 24-hour period beginning at 12 a.m. (midnight).
- E. Yellow Alert at Adjacent Hospitals- If the two closest hospitals are on yellow alert, the provider will transport to the closest.
- F. Termination - The facility shall notify EMRC via the console. EMRC shall:
1. note time of termination
 2. notify appropriate jurisdictions
- G. Documentation - EMRC will maintain a computerized log of all activity.
- H. Problem Incidents - EMRC should be advised of any problem incident immediately.
1. EMRC will notify the Regional Administrator.
 2. Regional Administrator will investigate and document any problems the next working day.
 3. Findings will be forwarded to the Region V EMSA Council.
 4. Council will review and recommend actions as appropriate.

III. Blue Alert Policy

- A. Definition - When an EMS jurisdictional system is temporarily taxed to its limits in providing pre hospital care and ambulance transportation due to extraordinary situations such as multi-casualty incidents, snow, icing, or flooding or other circumstances that contribute to high demand for ambulance service, the jurisdiction may declare blue alert status which suspends yellow alert.
- B. Declaration of a Blue Alert
1. the jurisdiction's senior EMS officer or his designee shall declare a blue alert
 2. the emergency communications center shall notify EMRC when the jurisdictions goes on or off blue alert
 3. if EMRC workload permits, they will notify hospitals
- C. Maximum Duration - Blue alert will continue until the jurisdiction cancels it.
- D. Termination - The jurisdiction shall notify EMRC of end of blue alert. EMRC shall:
1. note time of termination.
 2. notify appropriate hospitals if workload permits.

- E. Documentation - EMRC will maintain a computerized log of all activity.
- F. Problem Incidents - EMRC should be advised of any problem incident immediately.
 - 1. EMRC will notify the Regional Administrator.
 - 2. Regional Administrator will investigate and document any problems next working day.
 - 3. Findings will be forwarded to the Region V EMSA Council.
 - 4. Council will review and recommend actions as appropriate.

IV. *Mini Disaster Alert Policy*

A. Definition - A Mini Disaster Alert will be called when a hospital's emergency department experiences an unexpected, in house physical plant problem such as: water or power outages, hazardous materials incidents, bomb scares or other situations that threaten the life/health of patients and providers. (Critical care overloads are not considered justification for mini disaster alerts.) It may also be called for because of scheduled shut down of key services such as power or oxygen systems or at the request of the Secret Service. While on mini disaster alert the hospital will receive no patients regardless of priority.

- B. Declaration of a Mini Disaster - The hospital will notify EMRC via the hospital console if appropriate. EMRC will:
- 1. notify the appropriate jurisdictions
 - 2. notify the Regional Administrator
 - 3. note time on log sheet
 - 4. track time used

If the jurisdiction becomes aware of a disaster situation in a hospital which has not notified the EMRC, the highest EMS Officer or his designee may unilaterally declare a mini disaster and inform the hospital of such. In such a circumstance the hospital will be required to demonstrate that it is safe to terminate the mini disaster.

- C. Duration - Mini Disaster alert will continue until the hospital cancels it. No patients will be transported to the hospital during the mini disaster alert.
- D. Termination - The hospital shall notify EMRC of the end of the mini disaster. EMRC shall:
- 1. note time of termination
 - 2. notify appropriate jurisdictions

- E. Documentation - The hospital shall explain the mini disaster in writing to the Region V EMS A Council.
- F. Problem Incidents - EMRC should be advised of any problem incident immediately.
 - 1. EMRC will notify the Regional Administrator.
 - 2. Regional Administrator will investigate and document any problems.
 - 3. Findings will be forwarded to the Region V EMSA Council.
 - 4. Council will review and recommend actions as appropriate.

V. Hospital Re-Route Policy

- A. Definition - This policy provides guidelines for both emergency medical services (EMS) and emergency medical dispatch (EMD) personnel when a basic or advanced life support unit is being held at a hospital emergency department because a bed is unavailable. Patients should be accepted by the emergency department staff and transferred from the ambulance stretcher to a hospital gurney in a reasonable time frame.

This policy does not replace Yellow Alert, nor does it cancel or override it. If a hospital is on Yellow Alert prior to a hospital "Re-Route" being declared, it will remain on Yellow Alert after the cancellation of the "Re-Route" or until the Yellow Alert is cancelled by the hospital.

- B. Reasonable is defined as twenty (20) minutes from the arrival of the patient at triage, to the placement of the patient either in a wheelchair or on a hospital stretcher.
- C. Delayed Medic Unit Responsibilities - If the patient has not been placed in a wheelchair or on a hospital gurney within the twenty (20) minute time frame, and it does not appear that such placement will happen within the next ten (10) minutes, EMS Personnel shall . . .
 - 1. Contact the E. D. Charge Nurse to discuss if they will be able to place the patient within another 10 minutes. If this will not be possible, EMS personnel will proceed with "2" below.
 - 2. Notify the EMS Duty Officer (or appropriate County level officer such as EMS Chief) of the situation.
 - a. Remain with patient at all times and continue patient care as necessary until the patient has been transferred to a hospital wheelchair or gurney. Report must be given to the person assuming responsibility for the patient.

- b. Assist the hospital staff in any way that will assist in clearing a bed for the patient. This will expedite patient's transfer from stretcher.
Maintain a professional demeanor and avoid direct conflicts with hospital staff, patients, or patients' family regarding the delay.

D. Responsibilities of EMS Duty Officer

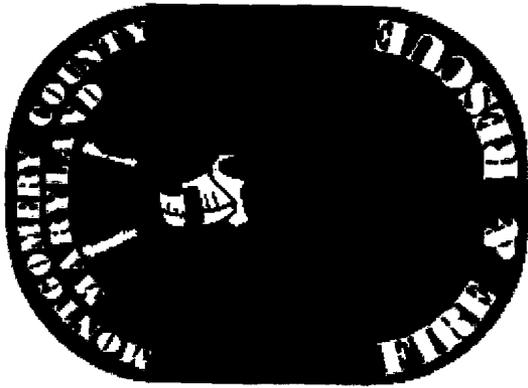
1. The EMS Duty Officer should contact the ED charge nurse to discuss when they will be able to place patient on hospital gurney or wheelchair.
2. The Duty Officer will also assess County and region wide activity to determine if this is a county or systemwide overload or at a single hospital. (Recommend consult / review with EMRC)
3. If other hospitals are open Duty Officer shall place hospital on Reroute. The duty officer will notify the hospital, County Dispatch Center and EMRC of their actions.

E. When a basic or advanced life support unit is advised of a hospital "Re-Route," they will:

1. Re-route all priority 2 and 3 patients to the next closest hospital.
2. Take Priority 1 patients to the closest appropriate hospital unless otherwise directed by a consulting physician.
 - a. Advise the consulting physician of the closest hospital's re-route status due to a lack of beds in the emergency department.
 - b. Follow the consult physician's direction.
3. Patients requiring transport to a specialty referral service located at a hospital on "Re-Route" should be taken to a hospital as directed by a consulting physician.
 - a. Have EMRC place both the intended Specialty Center and receiving emergency department on line.
 - b. Advise the consulting physician of the closest hospital's "Re-Route" status due to a lack of beds in the emergency department.
 - c. Follow the consult physician's direction.
4. Advise the patient of the reason for their re-route only if they ask, or specifically request transport to the hospital in question.
 - a. If the patient refuses transport to the next closest hospital, contact the hospital in question via EMRC. Inquire as to length of the wait before a bed or wheelchair will be available, and advise the patient.
 - b. If the patient still refuses transport to the next closest hospital, transport the patient to the hospital on "Re-Route." Advise the hospital of your ETA and the patient's chief complaint or injury.

F. Hospital on Re-Route will be monitored by the Duty Officer to determine when status should be removed.

- G. Local Dispatch Center Responsibilities - When contacted by their units about a "Re-Route" status change the Local Dispatch Center shall . . .
1. Notify the proper Local EMS Officials of the status change
 2. Change the hospital's "Re-Route" status.
 3. Advise all their EMS personnel of the hospital's status in the same manner as any other hospital status change.
 4. Notify the Emergency Medical Resource Center (EMRC) of the hospital's "Re-Route" status change.
- H. EMRC Responsibilities - When notified of hospital "Re-Route" status changes, EMRC will . . .
1. Notify all appropriate Local Dispatch Centers that a hospital's "Re-Route" status change was requested by the posting jurisdiction.
 2. If time allows, confirm that the hospital is aware of their "Re-Route" status change.
- I. Documentation
1. All basic and advance life support units being held at a hospital for thirty (30) minutes (or more) will forward a "Re-Route" Report to the Local EMS Official. This report should include
 - a. Hospital
 - b. Date
 - c. Maryland Ambulance Information System (MAIS) or County runsheet number
 - d. Times from arrival to release
 2. EMRC will enter changes in status to the County and Hospital Alert Tracking System (CHATS).
 3. All concerns or complaints regarding this policy will be directed in writing to the Local EMS Official or designee.
- J. "Re-Route" At Adjacent Facilities
1. If the two closest hospitals are on "Re-Route", the prehospital provider shall take direction from their local EMS official as to the appropriate destination.
 2. The Local EMS Official may cancel the "Re-Route" for any cause regardless if units are still delayed.



ePCR Project

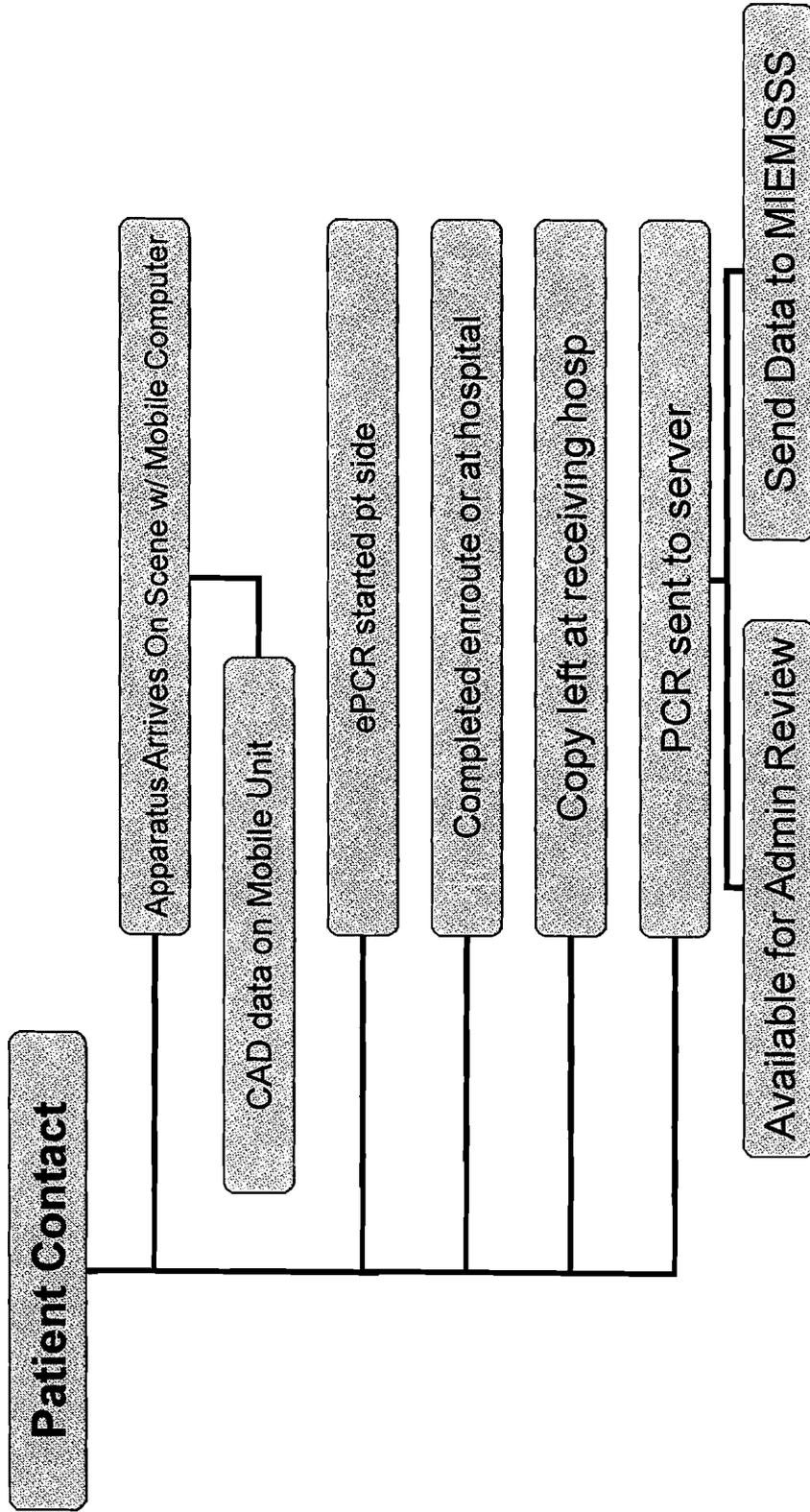
Patient Care Record Requirements

- Patient care record (PCR) frequency
 - PCR copies
 - Receiving hospital requirements
 - State requirements
-

Problems with Present Patient Care Reporting System

- Storage Needs
 - Illegible writing
 - Missing PCRs
 - Statistical data
 - Quality Improvement
 - PCR processing
 - State data transfer
-

ePCR Operational Process



ePCR Proposal Components

- ePCR Software
- Mobile computers
- Wireless communication hardware
- Database storage and security
- Interface configuration
- Hospital printers
- Personnel

Data Possibility Preview

- Demographic Reports
 - EMT & Paramedic Skill Proficiency Reports
 - Operational Reports
 - Performance Reports
-



ePCR Benefits

- Budget need predictions
 - Inventory and supplies
 - Performance Data
 - Individual personnel performance
 - Statistical reports
 - Storage
 - Accuracy and legibility
 - Processing
-



Benefits cont'd

- Lost data
- Quality improvement
- Prompt delivery of PCR copies
- State Data delivery

PS/HHS COMMITTEE #1
March 5, 2009

ADDENDUM

MEMORANDUM

March 4, 2009

TO: Public Safety Committee
Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst *JMMC*
Minna Davidson, Legislative Analyst *MD*

SUBJECT: **Discussion: Emergency room diversion and patient care records,
opportunities for collaboration – Additional Information from Primary Care
Coalition**

Attached at © 1-2 is summary information from the Primary Care Coalition on the Emergency Department Diversion Grant they recently received. PCC will provide the joint Committee with an overview of the grant at the session.

Project Summary: Emergency Department Diversion Grant from the State to the Primary Care Coalition and partners (3.5.09)

Project background

- Emergency room visits are rapidly increasing nationally and within the County.
- As many as half of all emergency department visits could be avoided by care in other settings (NYU algorithm).
- Excess use of non-urgent emergency department care represent a national cost saving opportunity of \$21.4 billion annually.
- Reduction in avoidable visits will reduce the incidence of emergency room temporary closure or by-pass.

Project Description: A two year, \$700,000 grant, to implement a comprehensive approach to reducing avoidable emergency department visits at Montgomery County hospitals for uninsured (self-pay and charity care) County residents.

- A coordinated referral process with electronic health information exchange between emergency rooms and community clinics.
- An eligibility/enrollment system directing uninsured emergency department patients to Medicaid or Montgomery Cares for adults and M-CHIP or Care for Kids for children.
- Establishment of a “care coordination unit” which will utilize navigators/care coordinators to facilitate enrollment and referral procedures.
- Identification and implementation by clinics of 3-5 “tests of change” to divert patients from emergency departments to more appropriate care venues.
- Establishment of a steering committee including representatives from each of the five hospitals, Montgomery Cares participating clinics, and Montgomery County Department of Health and Human Services.
- Participate in Institute for Healthcare Improvement’s Avoidable Emergency Department Visit Reduction Prototyping initiative.

Project Goal

- Reduce avoidable visits to Montgomery County hospital emergency rooms for uninsured patients by 30 percent, or 3010 visit per year and costing \$1.4 million.
- Develop coordinated referral processes between hospitals and clinics.
- Develop coordinated eligibility procedures for Medicaid, M-CHIP, Montgomery Cares, and Care for Kids for uninsured emergency room patients.
- Implement “3-5 tests of change” to divert uninsured patients to more appropriate care venues.

