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Circular Letter: DHCQ 09-09-522

TO: Acute Care Hospital Chief Executive Officers  
Emergency Department Directors  
Chief Nursing Officers

FROM: John Auerbach, Commissioner, Department of Public Health  
Jean Pontikas, Interim Director, Bureau of Health Care Safety and Quality

SUBJECT: (1) Reducing or Eliminating the Need for Boarding of Patients in the  
Hospital Emergency Department, and  
(2) Authorization and Guidelines for Use of Alternate Space for Treatment  
of Ambulatory Patients Presenting with Influenza-like Illness (ILI)

DATE: September 25, 2009

This flu season may prove to be especially challenging for all health care practitioners and facilities. As part of ongoing statewide preparations and to address the potential influx of patients with Influenza-like Illness (ILI) to hospital emergency departments (ED), the Department of Public Health (DPH) is issuing this guidance to acute care hospitals. Hospitals are reminded to review, test and update as necessary all applicable emergency management/disaster plans and protocols. To protect the essential functions of the ED to assess, stabilize and care for the acutely ill or injured, such protocols should include a plan to reduce or eliminate the need for boarding patients in the ED, and to triage stable flu patients to alternate space on the hospital premises for evaluation and treatment when volume necessitates.

Hospitals also should establish, test and update as necessary plans and mechanisms for ongoing communication with patients, health care providers, and state and local agencies to promote and increase situational awareness of ILI in Massachusetts and elsewhere. Hospitals also should consider establishing a "Flu Hotline" to help provide patient advice/direction and to avoid unnecessary visits to the ED.

## (1) Reducing or Eliminating the Need for Boarding of Patients in the Hospital Emergency Department

A hospital's full census and emergency management/disaster plans and protocols should ensure timely discharge of inpatients, expedite the movement of admitted ED patients to alternative holding areas or hallway beds as necessary with appropriate coordination, and provide for the appropriate transfer of patients to other facilities and rescheduling of elective admissions and surgeries as the situation requires. In addition, each hospital is expected to test and be prepared to activate a protocol (referred to as "Code Help" policy) as directed in previous communications from DPH dated December 18, 2002.<sup>1</sup> The Code Help policy is intended to optimize patient flow throughout the hospital by redeploying staff and resources with the goal of moving all admitted patients out of the ED within thirty minutes.

DPH's Boarding and Patient Flow (formerly Diversion) Task Force continues to work with hospitals toward the goal of reducing and ultimately eliminating boarding of admitted patients in the ED in Massachusetts hospitals. A "boarder" is defined as a patient who remains in the ED two hours after the decision to admit has been made. With a growing body of literature documenting the negative impacts of ED boarding, admitted patients should only be allowed to board in the ED when no inpatient option exists, the ED has capacity and capability to provide care for boarded patients consistent with Joint Commission, CMS and DPH requirements, and continuing to provide care for those patients does not interfere with the ability to provide appropriate, timely care for other patients in the hospital's ED.

Hospitals should define Code Help activation triggers in their Code Help policy. 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 should implement its appropriate emergency management/disaster plans and protocols to create additional inpatient capacity.

Over the past several years, DPH has issued letters to hospital administrators regarding best practices for helping to reduce patient boarding in the ED and to maximize patient flow throughout the hospital. Although earlier correspondence refers to ambulance diversion, which is no longer allowed in Massachusetts except under "code black", i.e. when a hospital is closed due to an internal emergency, there are many useful resources included in these documents. These letters can be accessed via the Division of Health Care Quality's web pages at [www.mass.gov/dph/dhcq](http://www.mass.gov/dph/dhcq).<sup>2</sup>

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<sup>1</sup> From [www.mass.gov/dph/dhcq](http://www.mass.gov/dph/dhcq) click on *Health Care Facilities and Programs*, then *Hospitals*, then *Information for Emergency Departments*, then *Saturation and Gridlock Emergency management Plan*.

<sup>2</sup> From that homepage, click on *Health Care Facilities and Programs*, then *Hospitals*, then *Ambulance Diversion*, then *Information for Emergency Departments* and/or *Changes to Ambulance Diversion Policies*.

(2) Authorization and Guidelines for Use of Alternate Space for Treatment of Ambulatory Patients Presenting with Influenza-like Illness (ILI)

DPH has received a number of inquiries from hospitals regarding the use of space not currently licensed for ED or outpatient use, on the hospital campus, to temporarily establish influenza-screening areas for the screening, evaluation and treatment of stable ambulatory patients in the event of a surge in patients presenting to the ED or outpatient clinics. As part of the hospital's emergency management/disaster planning, DPH encourages each hospital to identify appropriate, alternate space to accommodate a surge in patients requiring influenza screening. Hospitals may identify and use existing non-patient care space, or other outpatient or inpatient care space, for flu screening, evaluation and treatment, consistent with this letter and enclosed Guidelines.

DPH has developed the attached *Guidelines for Use Of Alternate Space for Treatment of Ambulatory Patients Presenting with ILI*, hereinafter referred to as Guidelines (Attachment A) when a hospital has available space located on the hospital's campus that can be used for screening, evaluating and treating ambulatory patients who are presenting to the hospital with influenza-like illness (ILI) during the 2009-2010 influenza season. (September 25, 2009 through June 30, 2010). The Guidelines outline the conditions for temporary use of alternate space at the hospital to screen, evaluate and provide treatment to stable, ambulatory patients with influenza-like illness in the event such a need arises at your hospital. Each hospital should use the Guidelines to identify appropriate alternate screening space(s), if available. **Through this letter, DPH authorizes use of alternate space(s) selected by the hospital for screening of influenza patients during the 2009-2010 influenza season (9/25/09 through 6/30/10), provided that the hospital complies with the Guidelines.** DPH is not requiring hospitals to submit a copy of their written plan for use of alternate space at this time. A hospital must, however, provide DPH with written documentation of its compliance with these Guidelines if requested by DPH.

Also, please refer to the attached Fact Sheet published by the Centers for Medicare & Medicaid Services (CMS) which provides important information concerning *Emergency Medical Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Department (ED) Services During a Pandemic*. The fact sheet is available on the CMS website at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/> click "policy and memos to states" S&C-09-52 issued 8/14/09.

Additional Resources and References

National Quality Forum (NQF) "National Voluntary Standards for Emergency Care Phase II: Hospital Based Emergency Department Care:  
[http://www.qualityforum.org/Publications/Emergency\\_Care.aspx](http://www.qualityforum.org/Publications/Emergency_Care.aspx)

American College of Emergency Physicians (ACEP) 2008 Task Force Report on Boarding, "Emergency Department Crowding, High Impact Solutions":  
<http://www.acep.org/WorkArea/downloadasset.aspx?id=37960>

Emergency Department Performance Measures  
<http://urgentmatters.org/media/file/EDBA.pdf>

BU Management of Variability Program, Eugene Litvak, Director:  
<http://www.bu.edu/mvp/>

Institute for Healthcare Optimization: <http://www.ihoptimize.org/>

Institute for Health Care Improvement: <http://www.ihc.org/IHI/Topics/Flow/>

Stony Brook University Hospital (Stony Brook, NY) full capacity protocol:  
<http://www.hospitalovercrowding.com/policyFCPword.doc>

Massachusetts Department of Public Health Influenza info:  
[www.mass.gov/dph/flu](http://www.mass.gov/dph/flu)

Please share this information with the appropriate staff at your hospital. We appreciate the efforts Massachusetts hospitals have been making to improve patient flow and the commitment of all hospital staff as they work to continuously provide safe and appropriate care to all patients and to meet the current challenges associated with novel H1N1 influenza. If you have any questions about this information, please contact:

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Email: [gail.palmeri@state.ma.us](mailto:gail.palmeri@state.ma.us)

or

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Attachment A: Guidelines for Use of Alternate Space for Treatment of Ambulatory Patients Presenting with Influenza-like Illness (ILI)

Attachment B: CMS Fact Sheet, *Emergency Medical Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Department (ED) Services During a Pandemic.*

## ATTACHMENT A

### Guidelines for Use of Alternate Space for Treatment of Ambulatory Patients Presenting with Influenza-like Illness (ILI)

(Effective 9/25/09 through 6/30/10, unless rescinded, amended or superseded)

**Purpose:** Alternate use space is provided as an option to more efficiently evaluate and provide care to ambulatory individuals who present to the hospital ED or outpatient clinic(s) with ILI. **The alternate space is limited to use for influenza screening during the 2009- 2010 influenza season. The hospital must ensure that the following conditions are met:**

The hospital must have written guidelines that address the following:

- 1) Criteria to activate use of identified alternate-use space and to de-activate use of the space
- 2) A staffing plan with staff qualifications, including appropriate orientation and training
- 3) Protocols defining patient selection criteria for screening in alternate space: inclusions/exclusions
- 4) Patient flow systems addressing triage, screening exam, treatment, transport to ED/inpatient, etc.
- 5) Policy for security of patients, facilities, supplies, pharmaceuticals / crowd management

The physical space must conform to the following requirements:

- 6) Limited to on-campus locations only
- 7) Limited to existing non-patient care space, or inpatient or outpatient care space
- 8) Limited to use by ambulatory care patients only
- 9) Space cannot be accessed through inpatient units
- 10) Minimum four-foot aisles maintained between patient exam chairs
- 11) Convenient access to waiting areas and toilet facilities

- 12) Immediate access to hand wash sinks or other forms of hand hygiene
- 13) Reasonably sized workspace with privacy considerations for patient screening examination and treatment
- 14) Provision for environmental cleaning, sanitization and appropriate decontamination
- 15) Access to supplies, including emergency supplies, as necessary
- 16) Space, cabinets or carts for storage of supplies and specimens
- 17) Provision for medical recordkeeping, including measures to ensure patient confidentiality
- 18) Conveniently accessible communication systems
- 19) Considerations for fire safety e.g., egress not obstructed, staff trained in fire evacuation plan
- 20) Signage to direct patients to the alternate use space

If you have any questions regarding these guidelines, please contact:

Gail Palmeri, DPH Division of Health Care Quality

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# Attachment B

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Service  
7500 Security Boulevard, Mail Stop S2-12-25  
Baltimore, Maryland 21244-1850



## FACT SHEET

### Emergency Medical Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Department (ED) Services During a Pandemic

#### I. What is EMTALA?

- EMTALA is a Federal law that requires all Medicare-participating hospitals with dedicated EDs to perform the following for **all** individuals who come to their EDs, regardless of their ability to pay:
  - An *appropriate* medical screening exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC). If there is no EMC, the hospital's EMTALA obligations end.
  - If there is an EMC, the hospital must:
    - + Treat and stabilize the EMC within its capability (including inpatient admission when necessary); **OR**
    - + Transfer the individual to a hospital that has the capability and capacity to stabilize the EMC.
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

#### II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)

##### A. *Hospitals may set up alternative screening sites on campus*

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
  - The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

##### B. *Hospitals may set up screening at off-campus, hospital-controlled sites.*

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI). *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*

- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

**C. Communities may set up screening clinics at sites not under the control of a hospital**

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.
- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

**III. EMTALA Waivers**

- An EMTALA waiver allows hospitals to:
  - Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the MSE.
  - Effect transfers normally prohibited under EMTALA of individuals with unstable EMCs, so long as the transfer is necessitated by the circumstances of the declared emergency.
- By law, the EMTALA MSE and stabilization requirements can be waived for a hospital **only if**:
  - The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act ; *and*
  - The Secretary of HHS has declared a Public Health Emergency; *and*
  - The Secretary invokes her/his waiver authority (which may be retroactive), including notifying Congress at least 48 hours in advance; *and*
  - The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.
- CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies.
- Duration of an EMTALA waiver:
  - In the case of a public health emergency involving pandemic infectious disease, until the termination of the declaration of the public health emergency; *otherwise*
  - In all other cases, 72 hours after the hospital has activated its disaster plan
  - In no case does an EMTALA waiver start before the waiver's effective date, which is usually the effective date of the public health emergency declaration.