PRINCE GEORGE'S COUNTY COUNCIL
EMERGENCY ROOM WAIT TIME TASK FORCE
March 31, 2025

- Members Present

Marina Anwuri, Community Member
Caroline "Caro" Williams-Pierce, Community Member
Karmen Brown, Hospital Representative, Adventist Healthcare
Jeffrey Cooper, Community Member
Bill Miller, Urgent Care
Jibran Eubanks, SEIU 1199, SEIU 1199
Laura Ogle, DNP, CENP, CNE, CEN, Hospital Representative, MedStar Southern Maryland Hospital Center
Terrell Buckson, Assistant Fire Chief
Erica Turner, Special Assistant to DCAO Health, Human Services & Education, Office of County Executive
Dr. Erin Smith, Hospital Representative, Kaiser Permanente

- Members Absent:

Dr. Reginald Brown, Hospital Representative, Luminis Health Department
Delegate Ashanti Martinez, State Delegate, Maryland General Assembly
Dr. Tomeka Archinard, Emergency Room Physician, Capital Region Medical Center
Augustin Amara, Service Employee, SEIU 1199
Zynab Faye, Union Nurse, SEIU 1199
Tiffany Green, Fire Chief
Travis Rickert, Major, PGPD
John Carr, Sheriff
Donalyn Holloway, Executive Assistant, Greater Baden Medical Services
Dr. Chris DeMarco, CEO, Greater Baden Medical Services
Angela Jones Jackson, COO, Greater Baden Medical Services

- Staff Present

Tiffany Hannon, Chief of Staff to Council Member Oriadha
Anya Makarova,

Emergency Room Wait Time
Minutes
March 31, 2025

- **Welcome & Opening Remarks**

Chair Blegay convened the third virtual meeting, continuing its work after a year of community tours and site visits. Chair Blegay stated that Anya will now take the lead on administrative support for the Workgroup and expressed appreciation for Anya's consistent involvement and valuable contributions throughout the process. Chair Blegay indicated that due to the recent focus on tours, some administrative tasks had been delayed

Chair Blegay asked the members to introduce themselves and their affiliation. Attendance was recorded, and the meeting was confirmed to be recorded for reference. The Workgroup then prepared to transition into administrative updates, and a presentation was scheduled for the meeting.

- **Administrative Update**

Chair Blegay reminded the members that recent legislation has extended the Workgroup's timeline by another year, allowing additional time to develop a comprehensive final report. She emphasized that the Workgroup had visited nearly every Emergency Department (ED) in the county. The only remaining location is Kaiser Urgent Care in Largo, which is planned, as it is one of the more advanced urgent care facilities in the region.

Following the completion of these final visits, the Workgroup will host a town hall forum to hear directly from community members about their experience accessing care. After the forum, the Workgroup will shift from site visits to a series of brainstorming sessions to begin drafting the final report. This will include one in-person meeting to work through materials together and several follow-up virtual sessions.

Additionally, all presentations and materials gathered throughout the process, including site visit presentations, the initial hearing report, and today's presentation, will be compiled and shared with members to inform the report-writing phase. Chair Blegay also acknowledged the state's effort to examine healthcare access, and the Workgroup aims to align its work with those broader initiatives.

- **Presentation**
  Megan Renfrew, Associate Director, Policy and Consumer Protection
  Tina Simmons, Associate Director of Quality Methodologies
  Janice Lepore, Chief of Policy and Government Affairs

Ms. Renfrew led the presentation from the Maryland Health Services Cost Review Commission (HSCRC). She was joined by colleagues Tina Simmons, Associate Director of Quality Initiatives, and Janice Lepore, Chief of Policy and Government Affairs. The presentation focused on Maryland's efforts to address ED wait times.

Ms. Renfrew began by outlining HSCRC's role as an independent state agency tasked with ensuring access to high-value health care. The agency achieves this by setting hospital rates, controlling costs, improving care quality, and supporting population health initiatives. She emphasized the importance of system-wide collaboration across various health services, from community-based care to hospital and post-acute care, in order to improve access and outcomes. Ms. Renfrew highlighted the spectrum of healthcare services and the need for integrated efforts from multiple state agencies, including the Maryland Department of Health, Medicaid, and the Maryland Insurance Administration. These partnerships are essential for addressing systemic challenges such as behavioral health needs, data sharing through CRISP (the state's health information exchange), and delays in post-acute discharge due to insurance authorization issues. Ms. Renfrew explained how broader issues in the healthcare system, particularly outside the hospital setting, contribute to ED congestion.

Ms. Simmons led the presentation, explaining that ED overcrowding has been a recognized issue since the 1990s and has remained relatively unchanged over the years. She shared historical data showing the key ED metrics have been flat since they were first tracked in 2012. Due to the discontinuation of national data collection by the Centers for Medicare and Medicaid Services (CMS), Maryland has had to develop its own state-specific measures to continue monitoring ED performance.

Ms. Simmons outlined a timeline of actions HSCRC has taken in response to this issue. Beginning in 2017, the commission began collecting corrective action plans from hospitals that exceeded acceptable ED wait time targets. Additional steps included funding a Mobile Integrated Health pilot program and incorporating ED wait time metrics into the state's pay-for-performance initiatives. In 2021, the state committed $79.1 million to behavioral health crisis services, reinforcing the link between mental health and ED utilization. In 2023, Maryland launched the Emergency Department Dramatic Improvement Effort, a collaborative project involving the Maryland Hospital Association, the Department of Health, and emergency medical services. This initiative emphasized rapid-cycle quality improvement efforts at individual hospitals and the development of targeted strategies, or AIM statements," to reduce ED length of stay.

Ms. Simmons also detailed the launch of the ED Wait Time Reduction Commission in 2024 and the integration of ED length of stay into the state's Quality-Based Reimbursement (QBR) program. This program, which places 2% of inpatient hospital revenue at risk, incentivizes improvements in performance across three domains: person and community engagement, clinical care, and patient safety. ED length of stay is now included in the engagement domain alongside measures such as patient experience and follow-up care, highlighting its elevated importance in system-wide quality evaluations.

Ms. Simmons noted that HSCRC is currently shifting to more robust data collection methods by sourcing directly from hospital case mix data. This will allow for more detailed analysis and better tracking of ED flow. This change, combined with the financial incentives tied to hospital performance, is expected to drive meaningful improvements in reducing ED wait times and alleviating the burden on emergency care services.

Ms. Simmons explained that in addition to QBR, HSCRC provides targeted financial support to hospitals facing acute capacity pressures. This includes funding to alleviate costs related to ED crowding and seasonal surges. In response to a respiratory illness surge in late 2024 and early 2025, $140 million in additional funding was allocated to 22 hospitals heavily impacted by RSV, flu, and pneumonia cases. Another $50 million was provided in 2025 to address overall ED volume and staffing pressures.

She also discussed HSCRC's hospital rate-setting authority. Hospitals may request a full rate review if they experience significant operational or patient-related changes. Over the past two years, these rate reviews have resulted in $130 million in increased funding for hospitals across the state.

Ms. Simmons explained that they establish the rates that hospitals are allowed to charge insurers, and those insurers are then required to pay those rates. The system includes some built-in discounts, such as incentives for prompt payment, and public payers receive a modest discount as well. She said that essentially, they determine the prices that hospitals can bill for their services.

Ms. Simmons noted that HSCRC is currently undertaking a year-long review of its financial policies to better align funding with hospital needs, access to care, and service delivery improvements. Public comment on this review was collected earlier in the year, and revised policies are expected to support broader health system goals, including more equitable access to emergency and primary care.

Ms. Simmons emphasized the persistent challenges contributing to prolonged ED wait times in Maryland. It was expressed that a variety of interrelated factors, both internal and external to hospital systems, affect these delays. Key contributors include staff limitations, bed management practices, organizational structures, and unique hospital characteristics such as teaching status, complexity, and ED size. Maryland hospitals tend to be larger, more complex, and more likely to be teaching facilities compared to other states, which further influences wait times.

A critical determinant of ED delays in hospital occupancy, which itself is influenced by factors such as surgical volumes, inpatient length of stay, end-of-life ICU days, and access to post-acute care. These occupancy pressures are directly tied to the availability of palliative and hospice care services, as well as timely discharge options.

Ms. Simmons highlighted a range of hospital-level and community-level interventions aimed at improving ED throughput. These include Enhancing hospice palliative care access, Improving access to skilled nursing facilities, Expanding behavioral health services within the community, Better planning of elective surgeries and medical admissions to avoid surges that constrain ED capacity, Strengthening primary care infrastructure, including the Maryland Primary Care Program and other advanced care models, and addressing social determinants of health to reduce preventable ED visits.

Ms. Simmons provided an overview of the Maryland Emergency Department Wait Time Reduction Commission, which was established through legislation that went into effect in July 2024. The Commission was formed to address system-wide contributors to prolonged ED wait times by developing strategies and policy recommendations for the state and local agencies, hospitals, and healthcare providers.

She further explained that the Commission is tasked with: Ensuring patients are treated in the most appropriate care setting, Improving hospital efficiency by maximizing ED and inpatient throughput, Enhancing post-discharge resources to support timely discharges, Identifying and recommending improvements in data collection and integration, with an emphasis on bridging current silos to gain a clearer picture across the healthcare continuum, and Facilitating the sharing of best practices across the system.

The Commission's first meeting was held in October 2024, and it will meet through June 2027. Two major deliverables were noted: the First report due November 2025 and the Second report due November 2026. The Commission's focus areas are: Behavioral Health, Post-Acute Care, Primary Care, Hospital Payment Program aimed at improving care quality, increasing transparency, and reducing avoidable ED utilization, and Operational improvements within hospitals to streamline patient flow and optimize the discharge process.

An emphasis was placed on reducing unnecessary ED visits by bolstering community-based resources while also improving hospital operations and discharge efficiency. Workforce challenges were acknowledged as a common issue across all focus areas.

Ms. Simmons emphasized that the Commission's top priority is addressing hospital throughput and ED boarding, which significantly impacts ED operations. Prolonged boarding delays admissions and discharges, creating bottlenecks. Key efforts include: Optimizing capacity across the care continuum, improving care transitions within hospitals to reduce length of stay, and Strengthening transitions to post-acute care, including SNFs, palliative care, and home health services.

Ms. Simmons emphasized the diverse representation within the Commission's subgroups, highlighting that the broad range of expertise has been instrumental in informing the work. The information-gathering process includes regular scheduled full Commission meetings, four

subgroups, and hospital site visits. The Commission also incorporates feedback from hospitals and community partners and conducts extensive data analysis to develop a comprehensive understanding of emergency department wait time drivers.

Ms. Simmons shared a timeline, noting that the Commission was established in July 2024, with the first meeting held in October 2024. The Commission and its subgroups will meet through November 2026, with 54 meetings scheduled for calendar year 2025.

Ms. Simmons continued by outlining the four subgroups: Access to Non-Hospital Care, ED Hospital Best Practices, Data and Hospital Capacity, Operations, and Staffing. She highlighted that these subgroups meet regularly to promote cross-sector collaboration, develop practical solutions, and align efforts with the Commission's overall objectives.

- Access to Non-Hospital Care

This subgroup focuses on improving transitions from hospitals to post-acute and community-based care. It examines barriers to timely discharge, particularly for complex patients, and explores partnerships and resource needs to expand access to behavioral health, primary care, and long-term care services.

- ED & Hospital Best Practices

This group identifies and promotes the implementation of evidence-based strategies to improve patient flow. Focus areas include interdisciplinary rounds, early discharge planning, daily huddles, surge protocols, discharge lounges, and clinical pathways that reduce unnecessary admissions delays.

- Data

The Data subgroup analyzes the length of stay trends and integrates hospital-level case mix and occupancy data to identify capacity opportunities. It is also developing tools like a capacity calculator to quantify potential bed availability and exploring ways to standardize tracking of avoidable inpatient days.

- Hospital Capacity, Operations & Staffing

This team addresses operational challenges that impact throughput and ED wait times. It focuses on staffing models, physical space constraints, and internal workflows, and collaborates with hospitals to develop sustainable surge and staffing strategies that align with patient volume.

Ms. Simmons expressed that the HSCRC plays a critical role in the Best Practices subgroup, particularly because it holds authority over all hospital-related policies in the state. The HSCRC recently approved a policy that mandates that every hospital select and implement two of six best practices aimed at improving patient throughput and reducing length of stay. Hospitals will be required to report on implementation progress throughout the year. At the end of the year, the HSCRC will evaluate the outcomes of these practices to determine their effectiveness. This

assessment will inform the development of a long-term pay-for-performance program, ensuring accountability and sustained impact across hospitals statewide.

Ms. Simmons introduced the six specific hospital best practices under consideration:

- Interdisciplinary Rounds and Early Discharge Planning

Daily interdisciplinary rounds focus on care coordination, early discharge planning, and identifying barriers to discharge. Hospitals must document planning within 48 hours of admission and screen for social determinants of health to ensure appropriate community referrals.

- Standard Daily Shift Huddles

Short, shift-based huddles ensure consistent communication among care teams using standardized formats and huddle boards. Hospitals track and report the frequency and effectiveness of these huddles, including escalation processes for discharge barriers.

- Bed Capacity Alerts

Hospitals implement surge plans triggered by predefined capacity thresholds to manage inpatient flow proactively. Standardized processes and quantitative metrics are used to report activation and response effectiveness.

- Expedited Care Bucket

Hospitals choose from targeted interventions, such as discharge lounges, observation units, or dedicated case managers, to speed up patient care and throughput. At least one initiative must be implemented and tracked for impact.

- Clinical Pathways & Observation Management

Standardized clinical pathways guide treatment for common conditions like COPD and diabetes, potentially reducing unnecessary admissions. These pathways support coordinated care from the ED through outpatient follow-up.

- Patient Flow Throughput Council

Monthly meetings of hospital leaders and frontline staff review data, identify barriers, and implement solutions to improve patient flow. Key performance metrics are shared across teams to promote transparency and accountability.

In response to a request for clarification, Ms. Simmons explained that the Discharge Lounge is a staff area where patients wait after discharge while arranging transportation or other logistics. This frees inpatient beds, improving hospital flow and reducing ED wait times.

Ms. Simmons informed the group that all ED Wait Time Reduction Commission materials, including meeting dates, slides, agendas, and recordings, are publicly available on the HSCRC

website under the designated Commission tab. She reiterated that meetings are open to the public, with opportunities for public comments at the end of each meeting. Upcoming meeting schedules and contact information were also shared for those interested in participating or requesting additional information.

- **Q&A**

A question was raised about how the Workgroup is addressing hospital workforce shortages, particularly regarding environmental services, nursing, and pharmacy staff, and how those shortages contribute to ED wait times. Also, an inquiry was raised about the composition and priorities of the Capacity, Operation, and Staff subgroup.

In response, Ms. Simmons confirmed that the subgroup has not yet met but that Workforce issues are a top priority. She acknowledged that ancillary staff (e.g., EVS and pharmacy support) are not currently captured in standardized reporting, and the group is exploring ways to better reflect and measure this in future analyses.

Discussion also includes leveraging telehealth and virtual nursing as strategies to extend staffing resources statewide.

A question was raised about Prince George's County hospital's performance under QBR measures, particularly regarding ED wait times and the potential loss of hospital revenue (up to 2%) for failing to meet benchmarks.

Ms. Simmons noted that performance varies by hospital and measure. While specific data was not immediately available, she acknowledged that several Prince George's County hospitals have areas for improvement. However, she emphasized the value of the new best practices collaborative, which is fostering cross-hospital learning and performance improvement. Hospitals have begun reaching out to one another to share successful strategies.

A question was raised about Prince George's Hospital compared to others in terms of reimbursement rates.

Ms. Simmons explained that Maryland hospitals operate under global budgets, meaning each hospital has an annual revenue cap set by the commission. This cap accounts for factors such as population growth, quality incentives, and programs addressing community health needs. Prince George's County hospitals have benefited from the HSCRC's regional partnership program, which helped fund the Dyer Care Center through a $79 million statewide behavioral health crisis services investment.

The Workgroup staff expressed interest in following up to review specific hospital performance data and to better understand how local hospitals rank across key metrics. Ms. Simmons welcomed further discussion and offered to provide additional details in a follow-up.

Concerns were expressed about equity in rate setting, particularly in counties like Prince George's that face both limited preventive resources and a higher prevalence of complex health conditions.

Ms. Simmons acknowledged the equity challenges and offered to provide more detailed follow-up on rate transparency and how funding mechanisms are designed to support hospitals in underserved areas.

A question was raised about long-stay patients who are difficult to discharge due to limited post-acute care options. Ms. Simmons confirmed this is a validated issue, with significantly longer hospital stays for such patients. They are currently analyzing data to identify trends by diagnosis, payer, and region to understand infrastructure gaps. Solutions being explored include expanded home health protocols, payer partnerships, and hospital-at-home models, but more data is needed before implementation.

A member noted that the Behavioral Health Administration has been working to improve ED discharge processes, including a bed registry and linking discharge planners to 2-1-1 for rapid patient support. In response to a question about social determinants of health, particularly for unhoused patients, Ms. Simmons confirmed it's a widespread challenge. Some hospitals are testing partnerships and resource platforms to address these needs, and the HSCRC is exploring how successful models might be scaled using population health funding. No definitive solutions yet, but the work is ongoing.

A question was raised about extended hospital wait times impacting EMS and police officers, particularly when officers bring in individuals under emergency petitions and must wait several hours. The member acknowledged the concern and noted that while the issue is recognized, awareness among hospital staff appears limited.

Ms. Simmons confirmed that long wait times for EMS and police are a consistent, longstanding issue. The ED Wait Time Reduction Commission is prioritizing medical and post-acute care issues while partnering with behavioral health commissions already addressing related concerns. EMS wall time data is publicly available through MIMS, but does not include police emergency petition wait times, though that data may exist through behavioral health workgroups.

A member asked if Prince George's County-specific ED data could be provided. The response confirmed that while current ED data is statewide and hospital-specific (including PG hospitals), regional breakdowns are in development. A new access map is expected by April to visualize bed capacity across the state. MIMS reports already provide some regional data, grouping PG County with Montgomery and another county. More regionally segmented reports are planned.

A question was raised about tracking hospital transfer times. The response clarified that while transfer cases are not included in performance metrics, they are reviewed internally for analysis, and hospitals also monitor them.

A question was asked about continued support for Mobile Integrated Health (MIH) programs. The response noted that the pilot funding ended years ago. While MIH is valued for reducing hospital use, current hospital rates don't support it, and hospitals may not prioritize it due to funding constraints.

Ms. Simmons noted past success with hospitals funding MIH through grants or direct support and offered to connect them with others who've built sustainable models.

A member asked if AIM statements for Prince George's hospitals are public. The response noted they likely are, possibly through a Maryland Hospital Association report, and staff will confirm.

A member asked how local governments can support ED wait time efforts. Ms. Simmons offered to connect them with successful county coalition models.

- **Identify Next Steps**

The next meeting will be an on-site visit to Kaiser Permanente Urgent Care in Largo, Maryland.

- **Adjournment**

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