# PRINCE GEORGE'S COUNTY COUNCIL
# EMERGENCY ROOM WAIT TIME TASK FORCE
# July 28, 2025

- Members Present

Wala Blegay, Council Member, Chair
Delegate Ashanti Martinez, Maryland General Assembly
Laura Ogle, DNP, CENP, CNE, CEN, Director of Nursing Professional Development MedStar Southern Maryland Hospital Center
Terrell Buckson, Assistant Fire Chief
Erin Smith, MD, FACEP, Assistant Chief, Acute Care Services, Permanente Medicine
Jibran Eubanks, SEIU 1199
Marina Anwuri, Community Member
Jeffrey Cooper, Community Member
Caroline "Caro" Williams-Pierce, Community Member

- Members Absent:

Dr. Reginald Brown, Hospital Representative, Luminis Health Department
Erica Turner, Special Assistant to DCAO Health, Human Services & Education, Office of County Executive
Karmen Walker Brown, Associate Vice President, Government Relations, Adventist Healthcare
Dr. Tomeka Archinard, Emergency Room Physician, Capital Region Medical Center
Bill Miller, Urgent Care
Augustin Amara, Service Employee, SEIU 1199
Zynab Faye, Union Nurse, SEIU 1199
Fire Chief Thelmetria Michaelides, Fire Department
Travis Rickert, Major, Prince George's County Police Department
Sheriff John Carr, Office of the 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

- Others Present

Daffodil Baez, President, Adventist Fort Washington Medical Center
Zachary M. Olare, Deputy Chief, Prince George's County Police Department
Basirat Uthman
Jenny Abamu
Sherri Cook
WUSA

Emergency Room Wait Time
Minutes
July 28, 2025

- Staff Present

Anya Makarova, Senior Advisor to the Board of Health, Prince George's County Council
David Noto, Legislative Budget and Policy Analyst
Leroy Maddox, Legislative Attorney
Ayana Crawford, Chief of Staff, Council Member Blegay
Rhonda Riddick, Committee Assistant, HHSPS
Eddie Brown, Committee Assistant, General Assembly

- **Welcome & Opening Remarks**

Chair Blegay opened the meeting by welcoming everyone, making sure enough members were present to officially begin, and giving everyone a chance to introduce themselves. Delegate Ashanti Martinez (District 22) joined the call.

Chair Blegay explained that the Task Force is now moving toward finalizing its recommendations. At the last meeting, members shared input based on their visits to the county's emergency rooms. Using that feedback, along with information from hospital presentations, a draft of findings and recommendations has been prepared.

- **Approval of Minutes**

A motion was made, seconded, and the minutes were unanimously approved.

- **Review and Discussion of Draft Report**

**Anya Makarova, Senior Advisor to the Board of Health**

- Report is still in draft form, includes feedback and recommendations gathered so far.
- Provides background on the resolution and task force purpose (reduce ER wait times)
- Overview of emergency services in the county:
    - 6 County emergency rooms (4 hospital-based, 2 freestanding).
    - Limited access to specialty care centers compared to the rest of Maryland.
- Maryland ranks 3rd worst in the nation for ER wait times.
- Prince George's County hospitals perform worse than both state and national averages.
- Data shows wait times are increasing, not improving.
- Causes of long wait times will be further developed in the final draft.
- Current patient volume data is incomplete
    - Freestanding emergency departments (ERs) are missing from the dataset.
    - This gap means the full picture of patient volume is not available.
    - Need to gather complete, multi-year data on all ERs.

**Questions and Answers:**

Question: Asked about the source of ER wait time data and noted improvements at Fort Washington that might not be reflected.

Response: Data came from CMS (Centers for Medicare & Medicaid Services), specifically archived hospital-based data. She acknowledged it may not be the most current (2023 data released in 2025) and welcomed updates or alternative data sources to ensure accuracy before finalizing the report.

Question: Asked whether the report emphasizes the number of hospital beds per 100,000 residents in Prince George's County compared to the state.

Response: Confirmed that the issue will be addressed later in the report. Members were asked to suggest ways to make the section on hospital bed capacity more prominent.

Health Services Cost Review Commission (HSCRC) efforts: (have tried for a decade to reduce wait times, but Maryland remains among the worst in the nation.

- Reason for current Commission: Develop a long-term, more comprehensive strategy.
- Timeline: Commission will release recommendations in November 2025 and November 2026.
- Commission's approach:
    - Looks at hospital factors
    - Seeks to reduce demand for ER services
    - Aims to improve discharge processes and strengthen community care resources
    - Incorporate health equity into its framework
- Subgroups within Commission:
    - Access to non-hospital care
    - ER best practices
    - Data and reporting
    - Hospital capacity, operations, and staff
- Anya suggested the Task Force might expand its review of the Commission's subgroup recommendations to compare with their own findings.
- Safe Staffing Act
    - Coalition of healthcare workers, unions, NAACP, AFT, Medical Society, and others.
    - Passed in the Maryland House but failed twice in the Senate.
    - Supporters:  could reduce ER wait time.
    - Critics: too narrow; mostly sets up committees instead of mandating staffing practices.

- Findings: Capacity & Healthcare Infrastructure
    - Long ER wait times reflect systemwide healthcare gaps, not just hospital inefficiency.
    - Shortages: primary care, specialty care, urgent care, hospital beds, alternative care sites.
- Hospital bed deficit:
    - Prince George's County: 0.8 beds/1,000 residents
    - Montgomery: 1.4 beds/1,000 residents
    - Baltimore City: 6.8 beds/1,000 residents
    - Huron Report identified a 500-bed shortage in Prince George's County.
- Recommendations emerging from findings
    - Expand urgent care centers as buffers between routine care and ERs.
    - Develop alternative treatment sites for lower acuity/specialty conditions (i.e., Dyer Center).
    - Create community health hubs co-locating medical and social services to address social determinants of health.
    - Use upcoming Health Atlas to target resources where social and health needs are greatest.
- Health Disparities & Social Determinants
    - County residents face systemic health inequities, including:
        - Severe health disparities.
        - Social needs tied to housing, income, and education.
        - Impacts of systemic racism
- These inequities drive greater ER demand and worsen already long wait times.
- Adopt a "Health in All Policies" Framework to advance health equity and build a resilient healthcare system.
- Emergency Room Task Force included as one component of the broader framework.
- Funding recommendations:
    - Dedicate a portion of the County budget.
    - Leverage grant funds for one-time expenditures
    - Use general funds for ongoing expenditures.
- Equity tracking and reporting:
    - Establish a public-facing equity dashboard (race, ethnicity, zip code).
    - Publish an annual equity gap report to guide resource allocation.
- Governance and accountability:
    - Appoint a County equity coordinator.
    - Require health impact assessments that evaluate racial equity impacts.
    - Institutionalize community co-governance via a permanent Community Health Equity Council.

    - Require quarterly progress reports from the County Executive to the council and community.
- Overall emphasis:
    - Ensure all initiatives are properly funded.
    - Track and measure outcomes using equity metrics.
    - Promote a systematic, data-driven, community-inclusive approach to health equity.
- Health & Social Determinants:
    - Re-emphasized need to address County demographics and social determinants of health.
    - Recommend full implementation of the already mandated Health in All Policies framework.
- ER & Hospital-Level Practices:
    - Some efficiencies can improve wait times at the ER and hospital level.
    - Task Force assumes hospitals are doing their best within their control.
    - Highlighted potential areas for improvement:
        - Technology: Effective use of telehealth and other innovations.
        - Staffing: Need more discussion on hospital and ER staffing.
        - Care Coordination: Deployment of care navigators to connect patients to community resources.
        - Process Improvements: Streamlined admissions and discharge protocol.
        - Patient Experience: Improve customer service and front desk communication.
- Healthcare Navigation & Public Education:
    - Residents need help understanding when to use ER vs. other options.
    - Recommend public education campaigns covering:
        - ERs, urgent care sites, mobile healthcare programs.
        - Contacting primary care physicians or alternative providers.
    - Goal: Empower residents to make informed healthcare decisions.
- Collective Effort & Stakeholder Responsibility:
    - Reducing wait times is not just the hospital's responsibility; multiple stakeholders involved.
    - Identify roles for state-level stakeholders:
        - Governor, General Assembly, Maryland Health Care Commission, HSCRC
    - Key priorities for advocacy:
        - ER and trauma capacity expansion.
        - Workforce stabilization.
        - State capital funding for facility upgrades and new infrastructure.
        - Dedicated operational funding to support competitive staffing.
- Stakeholder Involvement:

    - Identified Fire and Emergency Medical Services (EMS) as a key local stakeholder.
    - Explore developing a comprehensive list of alternative care sites to divert lower-acuity patients from ERs.
- Mobile Integrated Healthcare Program (MIHP)
    - Connects frequent 911 users to community health resources.
    - Aims to reduce unnecessary ER visits through disease prevention and management.
    - Potential for expansion to further decrease ER use.
- EMS Dispatch Protocols:
    - Plans to follow up with 911 call center and Office of Homeland Security to clarify dispatch protocols.
    - Concern: EMS may be sent for non-urgent or non-acute needs.
- Current Status of Draft Report:
    - Overview includes a mix of findings, observations, and preliminary recommendations.
    - Next step: Finalize the complete list of recommendations.

**Questions & Answers:**

Question: Some visited hospitals have surge plans and surge rooms. Can these be highlighted as best design practices? Could the report identify hospitals implementing vertical approaches to increase space without structural changes? Could PCP doctors commit to seeing patients within three days to reduce non-emergency ER visits?

Response: Surge rooms and surge plans can be included as potential best practices, though naming specific hospitals is not yet standard in the report.

Vertical approaches can be recognized as innovative solutions for managing patient flow.

PCP commitment for three days was not included in the notes or submitted recommendations, so it is not in the draft.

Question: How can we educate the public to choose urgent care versus emergency care, given that patients may not be able to self-diagnose accurately?

Response: Use choice architecture in physical facilities to guide patients: e.g., urgent care > accelerated acute care > ER, all in one location. This approach reduces reliance on patients' self-diagnosis while directing them efficiently to the right level of care.

Integrate education campaigns to reinforce the use of urgent care and alternative sites.

Question: How do we ensure that patient education is integrated into ER and healthcare navigation?

Response: Suggest public education campaigns, signage, and outreach about urgent care, mobile healthcare programs, and primary care access.

Comments: A member focused on staffing and workforce issues as a key driver of ER wait times. It was pointed out that the entire care team, not just nurses (including technicians, nurse assistants, environmental service workers, community health workers and pharmacy staff), affects ER flow.

The Safe Staffing Committee Act is critical; other states with similar acts show much better ER performance.

Maryland's ER wait times have worsened compared to states with safe staffing laws, and it is suggested that recommendations should include wage increases, workforce training expansion, and oversight to enforce staffing ratios.

Question: What do hospital staff think about teleriage (iPads or remote consults in the ER)?

Response: Staff perspectives are mixed. Some departments find it helpful; others have concerns about workflow and clarity on roles. Overall, success depends on having enough staff so teleriage doesn't disrupt their regular duties.

Question: What about surge plans where staff from other hospital units are temporarily sent to the ER?

Response: Moving staff around is risky if they aren't trained for critical care; it can endanger patients and staff licensure. Moving staff should be a last resort, and careful planning is needed for both training and space.

**Anya Additional Questions:**

1. Are there any other efforts, statewide, local, or by specific organizations, aimed at reducing ER wait times that we should include in the report to make that section comprehensive?
2. Regarding the recommendation to increase ER capacity: How is capacity calculated (i.e., number of beds), and do we have data on current capacity? Can we compare it to other hospitals or counties to support the recommendations?
3. Requesting detailed feedback on staffing issues: Is staffing really a problem? If yes, what kind of problem: recruitment, retention, or a specific role/profession? What solutions are being proposed?
4. What about equipment bottlenecks in ERs? Are delays caused by limited access to equipment like MRIs or X-rays? Could this be contributing to long patient wait times?

Response: Other efforts to reduce ER wait times: House Bill 1143 (2024) created the Maryland Emergency Department Wait Time Reduction Commission. This may be connected to HSCRC efforts.

Regarding staff issues: Additional research is needed on worker retention and the use of staffing agencies. Concerns exist because temporary agency staff can earn more, creating workplace tension.

Regarding equipment bottleneck: Capital equipment generally exists, but process issues can delay care. For example, insufficient staff to operate the equipment continuously. Another factor is that radiology reports can be delayed if radiologists aren't available promptly.

Comments: ERs have staffing requirements to remain operational, and data should exist to indicate what is needed. Need more detailed data on which roles are lacking and how that affects ER operations.

Response: Important to identify not just general shortages (e.g., nurses) but also specialty positions needed to operate certain equipment and interpret results. Next steps would be to reach out to the hospital and organizations like nurses' unions to clarify the extent and nature of staffing issues. Determine whether County-level interventions (e.g., workforce pipelines, support programs) could help address gaps.

**Comments – HSCRC:**

A key disconnect between Prince George's County and the state on ER issues. The County sees a critical need for more hospital beds and better staffing to reduce wait times, while the state suggests adding beds may not help and that hospital-level factors mainly drive ER performance. Current formulas for funding and compensation don't account for local challenges, leaving most Prince George's County ERs below the state average in compensation.

Response: The County has repeatedly requested more funding and beds for its hospitals, especially Capital Region and Fort Washington. It appears that state officials have downplayed these needs, partly because many residents seek care outside the County, which the state sees as reducing demand.

Historical structural limitations, like smaller hospital replacements, contribute to current capacity challenges. Prince George's County often feels overlooked in statewide healthcare planning despite being the second-largest jurisdiction. There's ongoing advocacy to adjust statewide needs assessment processes to allow for more responsive local solutions. Early advocacy is key to securing local healthcare improvements.

The Certificate of Need (CON) process can disadvantage certain jurisdictions, like Prince George's County. Some areas, like Laurel, can access care in neighboring counties, which affects how hospital needs are assessed.

There's concern about fully eliminating CON because it ensures hospitals provide a portion of care for uninsured patients (uncompensated care). Overall, while CON can slow expansion, it also guarantees some level of community care, so changes would need careful consideration.

It was suggested to involve a healthcare economist to analyze Prince George's County's population and healthcare expenditures, in order to strengthen the case for local healthcare needs from an economic perspective.

- **Identify Next Steps**

Anya closed the meeting by thanking everyone for their contributions and dedication. She encouraged members to continue submitting feedback, ideas, or additional data to her or Ms. Sandra Eubanks. She noted the importance of aligning on key recommendations, such as expanding ER capacity and adding more beds, since other stakeholders may not fully share the Task Force's perspective.

The next meeting will be held virtually and will include an updated draft of the report for further discussion and finalization.

- **Next Meeting**

  **September 15, 2025**

- **Adjournment**

**The meeting adjourned at approximately 7:36 p.m.**