ED Management®
Best Practices – Patient Flow – Federal Regulations – Accreditation

March 2013: Vol. 25, No. 3
Pages 25-36

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Virulent influenza fills EDs across the country, prompting hospitals to launch emergency plans

Experts: Have surge capacity ready in case demand for care spikes

After a few mild seasons, the flu packed a wallop this year, straining resources in hospitals across the country and forcing some EDs to go on diversion during peak periods.

Particularly hard hit was Boston, MA, where the mayor declared a public health emergency in the second week of January. By January 13, Massachusetts General Hospital (MGH) reported that it had already identified 618 cases of flu and had admitted 196 patients.

EXECUTIVE SUMMARY

Hospitals across the country have been straining to meet high demand from patients exhibiting symptoms of influenza. In early January, the mayor of Boston declared a public health emergency, as hospitals there reported a huge increase in the number of flu patients over last year's mild season. Public health officials in New York also declared a public health emergency, as many hospitals across the state launched emergency flu surge plans. In Illinois, as many as 11 hospitals went on diversion on January 7 because demand from flu patients was so intense.

- By January 13, Massachusetts General Hospital in Boston had already identified 618 cases of the flu and had admitted 196 patients. This prompted the hospital to initiate its flu surge plan, which extended the hours of primary care practices to take pressure off the ED.
- In New York, more than 15,000 cases of flu had been reported by January 10, nearly a three-fold increase over last year, and hospitalizations from the flu were up by 169%.
- To meet high demand from flu patients seeking care in the ED, some community hospitals have leveraged personnel from other hospital departments to perform non-clinical tasks such preparing rooms and bringing in meals for busy providers.
- To limit transmission of the flu, EDs are providing patients with masks, and they are scheduling extra staff so that wait times don't become excessive.

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"In addition to the large numbers of patients coming to the ED with flu-like illness, we have had members of our clinical staff (nurses, physicians, NPs, and PAs) fall ill, leading to staffing challenges in the midst of the increased volume," explains **David Brown**, MD, associate chief and vice chairman of the Department of Emergency Medicine at MGH. "In response to this, MGH has initiated its flu surge plan, in which primary care practices, both adult and pediatric, extend their hours into the evening and leave slots open during the day for ill patients seeking medical attention, in order to ease the burden on the ED."

In addition, Brown says the ED activated its own internal surge plan, which calls for an additional attending physician and PA to come in and work when the ED reaches threshold levels of crowding. "This occurred several times during the last week in December and the first few days of January," he adds. *(Also see, "For debut this spring: A user-friendly tool to predict flu activity," p. 28.)*

Public health officials in New York State also declared a public health emergency as hospitals there were besieged by patients with symptoms of flu. In early January, Montefiore Medical Center in New York City noted that as many as 40% of the patients seeking care with symptoms of flu in the ED were testing positive for influenza, and the situation was similar in many other EDs. By January 10, more than 15,000 cases of flu had been reported across the state, nearly a three-fold increase in flu cases over 2012. And hospitalizations from the flu were up by 169%.

In Illinois, the flu emergency appeared to reach a peak on January 7, 2013. That's when at least 11 hospitals began diverting patients from their EDs because they were so overwhelmed with patients exhibiting flu-like symptoms.

Take steps to reduce wait times

Overall, the Centers for Disease Control and Prevention in Atlanta, GA, reported that the number of flu cases had more than doubled from last year, and that most states were seeing moderate to severe activity. While epidemiologists noted that this year's flu vaccine was roughly 60% effective against the virus, some noted that the flu strain largely responsible for the surge in patients this year was unusually aggressive. At the same time, they observed that EDs were also seeing a large number patients suffering from a new type of norovirus or stomach illness, which is also highly contagious.

While the halls of many large, urban EDs were filling up with flu patients, smaller community hospitals faced challenges as well. For example, after admitting more than 100 patients in a single week in early January, Lehigh Valley Hospital-Cedar Crest in Salisbury Township, PA, erected a surge tent in the hospital's parking lot to treat lower acuity patients.

Fairview Medical Center in Wyoming, MN, has

ED Management® (ISSN 1044-9167) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to **ED Management**®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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Approved by the American College of Emergency Physicians for a maximum of 15.00 hour(s) of ACEP Category I credit.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

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been straining to meet high demand as well. The level III trauma center operates a conjoined ED and urgent care center, but since all patients go through the same triage point to determine where they should go for care, the surge in flu patients has been bogging things down.

"We have had to be creative in sending out a second triage person so that we don't have people waiting for extended periods of time," explains **David Milbrandt**, MD, the medical director of the ED at Fairview. "We are doubling and in some cases tripling our urgent care volumes. Our ED volumes are heavy also. They are a little over what they would normally be, but our urgent care volume is way above normal. And our admission rate is higher as well."

The surge in flu cases began at Fairview just before Christmas, prompting the hospital to implement its command center shortly after the holidays. Inpatient capacity and ICU capacity have both been stressed at times, explains Milbrandt. But he reiterates that most of the pressure was on the urgent care center.

"We added extra resources to facilitate taking care of these patients in a more timely fashion because we were getting to the point where there were four-hour waits in the urgent care center," he says.

Leverage non-clinical personnel

In addition, for the first time, the hospital administrators tried a new tactic: They leveraged personnel from non-clinical areas to help with patient surges. "What we found was our providers were getting sick as well, so we would have a lower number of people able to do the work," says Milbrandt.

Of course, non-clinical personnel couldn't perform medical tasks, but they did help out in other ways. "We had our environmental services people come in and help us turn over rooms. That is not typically their responsibility, but they were very willing to step in, realizing that everyone else was working really hard," explains Milbrandt.

People from nutrition also took steps to make sure the providers on duty had access to meals. Many of the physicians, nurses, and techs were so busy taking care of patients that they couldn't take breaks, so having food brought from the cafeteria down to their work site was very helpful, says Milbrandt.

"We also had some of our facilities personnel go out and help guide people to where they needed to go, so we tried to unload some of the workload from the ED staff, and the people who actually took on that work were really happy to do it," says Milbrandt. "It was some really good teamwork."

Should demand for care accelerate further, Fairview has plans in place to set up two flu clinics, one within the hospital and another at an outlying site in a heavily populated area.

The clinics would be used to take some of the pressure off the ED, primarily by handling the surge of lower-acuity patients. "There would be nurse-initiated protocols rather than having physicians have to man these centers," says Milbrandt.

One tool that has already proven useful this season is Zipnosis, a web-based service that connects people with minor medical issues with a clinician online. "People put in their complaints and, at the end of it, they will get a response from a provider within 30 minutes," observes Milbrandt. The service relies on established protocols to determine who would benefit from anti-viral medications like Tamiflu. For any serious symptoms, such as shortness of breath, for example, the patient will immediately be directed to go the ED.

"As we have tried to decrease the cost of care, there are some things that people don't need to physically show up for. And this creates another alternative way for people to receive care, especially during the flu season when you don't want a bunch of people sitting in the waiting room, infecting people who don't have the flu," says Milbrandt.

To limit such transmissions from taking place, ED staff have attempted to separate patients exhibiting flu symptoms from other patients in the waiting room, and they are providing them with masks, adds Milbrandt.

Keep the ED free for acutely ill patients

At press time, it was clear that not all areas of the country were experiencing the same kind of stress from flu as the Northeast and Midwest. At the University of Miami Hospital in Florida, for example, 4-5% of patients were presenting to the ED with flu-like illness, explains **Robert Levine**, MD, chief of the University of Miami School of Medicine's Division of Emergency Medicine and director of the ED at the University of Miami Hospital (UMH).

"I don't get the sense that we are being overwhelmed. In fact, we are not admitting a lot of these patients," says Levine. "The illness we are seeing is mild to moderate, not similar to the overwhelming flu we have sometimes seen in the past that results in lots of ICU admissions."

Levine has only been at University of Miami Hospital for a year, but he notes that he has witnessed flu seasons that were much more severe than the current one. "In Houston, where I used to work, we had some years where we would have a quarter or a third

of the patients in the ICU on life-support who were flu victims," he says. "That's a lot of patients, and many of them had very life-threatening illness."

Levine cautions that the number of flu cases was still trending upward in the ED at UMH, but he says there is no need as of yet to implement emergency plans. "Our biggest challenge is that we ran out of swabs to test for flu, but that has not been a big encumbrance," he says. "We are just treating patients empirically as they are doing in the Northeast. If someone comes in with an influenza-like illness, we will just treat them."

While the length and severity of this year's flu season is not yet clear, Levine stresses that it is important for any ED to have mechanisms in place to quickly ramp up if patients complaining of flu begin to overwhelm the department. "You need to have a way to open up additional pods to see patients, and some clinics to direct patients to if the need arises," he observes. "And as far as inpatients go, we have had to sometimes expand our ability to take care of critically ill patients by opening up additional areas in the hospital."

It can also be helpful to dedicate one area of the ED to taking care of flu patients. "Then dedicate personnel to try to process these patients rapidly," he advises. "Depending on how sick the patients are, they can really overwhelm an ED, especially when the virus is particularly severe. When flu patients are really sick, it can take four to six hours to see them and get them stabilized."

During peak periods of demand, it is important to try to keep the ED free for those patients who are acutely ill, stresses Levine. "We tell staff, as well as patients, to stay home, drink plenty of fluids, and to try to see their private physician unless they are really sick," he says. "You can't be perfect, and our general tendency is to err on the side of telling people that if they feel ill and are worried, they should come to the ED. But people with no fever, who are able to eat and drink, can generally go to their family physician."

However, symptoms such as shortness of breath, feeling weak or dizzy, or high fever are red flags to tell the patient to come in right away, adds Levine. ■

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For debut this spring: A user-friendly tool to predict flu activity

The early arrival and severity of this year's influenza season may have caught some ED administrators off guard, but it did not come as a surprise to **Andrea Dugas**, MD, an emergency medicine research fellow at Johns Hopkins University in Baltimore, MD. "I had suspicions that this was probably going to be a more severe influenza season just because of the cyclical nature of influenza," she says, pointing out that last year's flu season was "incredibly mild."

Another tip-off to the nature of this year's flu season came in September. That's when Dugas observed that flu activity began picking up on Google Flu Trends, an Internet-based tool that monitors search traffic for influenza. "That provided a clue that influenza season was coming early this year," she says.

Dugas has been consumed with such data for months as she and colleagues toil away on a predictive model intended to help hospital and ED administrators better anticipate the levels of staff and resources they will need to handle flu-related patient volume in future weeks. The work is funded by a grant from the Department of Homeland Security, but is being carried out by the National Center for the Study of Preparedness and Catastrophic Event Response (PACER), an independent center that works in conjunction with Johns Hopkins University.

While EDs already have plans in place to handle flu-related patient surges, experts say they don't have a great way to predict when, precisely, to launch these plans. What often happens as a result, they say, is severe crowding in the ED and long patient wait times during the height of flu season.

A tool is in the works

Early on in the quest to develop a better predictive method, researchers validated that Google Flu Trends did, in fact, present an accurate picture of current flu-related activity, at least on a city-wide

basis. They then tested a number of predictive models to see how well the instruments could forecast *future* flu-related activity.

"The model that performed the best was actually an auto-regression that was based on the number of influenza cases seen in the ED," says Dugas. "You could watch the trend and see how the number of flu cases increased, and then use that information to predict what the next point was going to be."

This particular model performed even better when researchers added the Google Flu Trends data to it, explains Dugas, so the researchers have been fine-tuning an algorithm that crunches data regarding the number of flu cases seen over time with Google Flu Trends values for a particular location over time. "That gave us the best model, the most accurate model, to predict what was going to happen the following week in a particular ED," adds Dugas.

Currently, the researchers are in the process of validating the tool regionally to make sure that the predictive model will work across regions and throughout the United States. "In conjunction with that, we are also developing a tool for ED administrators and hospital planners to use," says Dugas.

It is going to be a free, Internet-based tool in which ED directors can log in, create an account, and enter their own hospital data pertaining to the number of flu cases seen per week over a period of time, explains Dugas. "The tool will then pull in the Google Flu Trends data [for the region], and in the background run this algorithm and predictive model, and just give them an idea of what to expect," she says. The tool will then store the data so that administrators can make use of it in subsequent flu seasons.

More trials planned

Given the virulent nature of the current flu season, Dugas wishes she could have had the tool up and running earlier. But at this point, she feels confident that hospital administrators will have access to the tool before next year's flu season begins to kick in. In fact, she is hoping to debut the website where the tool will be housed as early as this spring. "Then we are hoping to do some trials, get some feedback, and see if we can optimize this," she says.

Dugas isn't recommending that EDs act on information from the tool in isolation, but she does think it will be helpful as an additional weapon in their arsenals. "We are still experimenting and validating to make sure this will be accurate, but take a look at it and see if it helps with decision-making," she advises. ■

Taking a new tack, MetroHealth System welcomes super-utilizers of the ED, equips them with care coordinators

Care plans give ED providers a roadmap to follow when patients with complex needs present for care

The emergency medicine community has pushed hard against complaints that too many patients with non-urgent needs are being seen in the ED, but there is little doubt that so-called super-utilizers — patients who come to the ED regularly for one reason or another — are not receiving the kind of care they need in the most appropriate setting. Further, in cases in which there are finite emergency resources, such patients are taking time and space away from patients with urgent and acute care needs.

Addressing this problem cost-effectively is complicated in a fee-for-service environment that rewards volume, but as health care organizations inch toward different payer models that reward quality and satisfaction, new solutions are emerging that can help transition super-utilizers of the ED toward more effective, ongoing care pathways.

For example, the Red Carpet Care program, developed by the MetroHealth System in Cleveland, OH, is addressing super-utilizers by turning a common response to these patients on its head. Rather than viewing them as a nuisance when they present to the ED for the umpteenth time, the aim of this program is to roll out the "red carpet" to these patients by offering them easy access to care coordinators and other resources to help them connect with the kind of care and resources they really need.

Devise care plans

The program is actually just one component of larger efforts that have been going on at MetroHealth for more than two years, explains **Alice Petrulis**, MD, FACP, the medical director of managed care at MetroHealth and the clinical champion of the Red Carpet Care program. Beginning in 2010, the ED at MetroHealth Medical Center began sending the names of super-utilizers to Petrulis with the idea that she could set up a care plan for these often complex patients so that the

ED would have guidance to follow when they come in for care.

For each patient, Petrulis tracked down the primary care provider (PCP), if there was one, and any other care providers involved with the individual's care, and they mapped out a care plan that was fairly rudimentary. "It would include things that the ED needed to know," says Petrulis, noting that the plan would point out what tests and procedures the patient had already undergone, whether the patient needed to be referred to his or her PCP, and whether the patient was a narcotic seeker.

Petrulis, who works out of the MetroHealth Medical Center, then entered the care plan into the health system's electronic medical record (EMR) under a special code, so that it would be flagged whenever the patient presented to the ED for care. "When the patient's name was pulled up by the ED physician, the name would be in red, and the provider would be prompted to click on the name to bring the care plan up," explains Petrulis.

This approach worked well, and was consequently enlarged for a project MetroHealth devised with the state's Medicaid program. "We took a handful of patients from each of the three Medicaid payers, and did the same thing," says Petrulis. "We put in care plans that would alert the ED, and we did intensive case management via the case managers at each of the three plans."

During the Medicaid project, Petrulis sat down with representatives from the three Medicaid payers every month to review each of the patient cases, update their care plans, and assess what impact the approach had made over time. "In a year, we were able to reduce ED utilization by 39% [among the super-utilizing Medicaid patients]," observes Petrulis, explaining that the statistics were calculated by comparing utilization before and after the care plans were initiated. "Indeed, many of the patients had stopped using the ED, and they were actually quite grateful. They didn't know they could just call their PCP or get an appointment that easily."

The approach delivered many success stories, but it did not work well in every case, notes Petrulis. "Patients who were alcoholics were the toughest to get a hold of, and some others were difficult to find, too," she says. "They didn't answer their phones and didn't come to clinic appointments."

However, the approach was successful enough that Petrulis is continuing this work with two of the Medicaid payers. "Every four to six weeks we go over all of the patients who are on our list, update their care plans, and talk about how to better care for these patients, improve the quality of their care, and keep their ED utilization down," she says.

Take a welcoming approach

Further, the work has formed the basis for the Red Carpet Care program, which is being funded, in part, by a grant from the Robert Wood Johnson Foundation. Building on the earlier efforts, MetroHealth has hired two nurse practitioners (NP) to serve as care coordinators and contact persons for the super-utilizing ED patients who are identified for the program.

"They actually give the patients cell phones if they don't have a phone, and the NPs tell the patients that they can call them at any time. That way, the patients are not on the phone lines waiting in some sort of tree in order to get a hold of someone they can speak with to make an appointment," explains Petrulis. "It is the same face every time so the patients can establish a relationship with that NP."

Developers have based many of the program's elements on input they received from previous patients who were super-utilizers. "We did a focus group with them before we started with recruitment for the new program," notes Petrulis. "They wanted the same face every time and they wanted someone to take care of them who would give them good care, but also like them for who they are. It was very reassuring to hear that, so we thought the phrase 'red carpet care' would be a very successful name for this project."

As with the earlier efforts, the Red Carpet Care program relies on the ED at MetroHealth Medical Center, a level I trauma facility that sees 100,000 patients per year. Emergency providers identify patients who would be good candidates for the pro-

EXECUTIVE SUMMARY

MetroHealth System in Cleveland, OH, has developed the Red Carpet Care program to address patients who keep coming back to the ED for care, often because they have complex needs that could be met better in other care settings. The program takes a welcoming approach toward these patients, and pairs them with care coordinators to help them better navigate the health care system. The program is just getting started, but it builds on earlier efforts at MetroHealth that have reduced ED utilization by 39% among super-utilizing patients.

- ED providers identify candidates for the Red Carpet Care program when they come to the ED for care.
- In consultation with a patient's care providers, program managers assemble care plans for program participants that can be quickly pulled up on the health system's electronic medical record system when these patients come to the ED for care.
- Nurse practitioners serve as contact persons for program participants to quickly link these individuals to needed resources.

gram. **Jonathan Siff**, MD, MBA, FACEP, the director of informatics and associate director of emergency medicine operations for MetroHealth, has taken the lead in coordinating the Red Carpet Care program in the emergency setting.

"I am the person who the ED folks come to when they have someone to nominate for the program, and I communicate with Dr. Petrulis," explains Siff. "Sometimes the patients meet her criteria, but we communicate back and forth to identify patients who can benefit from comprehensive case management at the hospital level."

Target patients with complex needs

Siff adds that while there are no "hard and fast" criteria that patients must meet to qualify for the program, it is generally designed for patients who use the ED frequently and who have problems or issues that are beyond the scope of the ED to address.

"These patients are generally very challenging if for no other reason than they do use the ED so frequently, and that often creates frustration for patients and for providers," he says.

Having access to the care plans is a plus for everyone involved, adds Siff. "It is better for the patients because they know what to expect," he says. "And it is better for the providers because they have a very clear roadmap of how to address the patient's usual needs without having to try and reach a PCP at 3 o'clock in the morning, and without having to spend hours trying to review a very complicated and lengthy chart."

It can be very difficult to get all the parties involved in a patient's care in the same room or involved in the same email trail to come up with a final cohesive plan, so it often takes time to get a care plan in place, notes Siff. Social workers or case managers often need to be heavily involved because many of these patients have social issues such as language barriers or financial problems.

"Sometimes there needs to be investigation," says Siff. "We may need to call the patient and talk to him, or involve social services to go to the home and see what the situation is, so it can get very complicated," he observes. "But ultimately, I think it always improves care for the patient."

For example, through this collaborative approach, the Red Carpet Care program can make sure patients are getting their medicines and that they have access to a physician who speaks their language. "They do whatever can be done ahead of time," says Siff, referring to the care planners involved with the program. "Then if a patient re-presents to the ED, for whatever reason, the program provides us with an easy link to a plan of action that we can follow."

In addition to identifying patients who might be good candidates for the program, emergency physicians also play a role in developing the care plans. However, Siff says there has been no resistance to the approach because it helps providers deal with many of the more complex patients. "It improves our ability to deal with these patients in an appropriate and expedient fashion," he says.

Furthermore, patients are responding well to the program, too. "They have been educated by the case managers, so they have an understanding of what they can expect to have done when they come to the ED," says Siff. "Prior to the program, I think many of these patients had expectations that were unrealistic or that were fostered by some of the barriers."

Since many of the barriers have already been addressed ahead of time when these patients come in to the ED, the patients receive better care coordination, stresses Siff. "The whole idea of the red carpet approach is that we want to roll out the red carpet for these patients and put them in the control seat," he says. "If they understand what their care plan is and if they are learning the tools to help manage their own care, they are going to be healthier and more satisfied." ■

SOURCES

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Ergonomic considerations loom large as hospitals and other health care organizations rapidly adopt IT tools

Ergonomic experts warn of a flood of repetitive strain injuries among providers

Health care has lagged behind other industries when it comes to leveraging the power of infor-

mation technology (IT). However, in the race to catch up, which has been accelerated by $20 billion in federal stimulus dollars, ergonomists warn that hospitals and other health care entities are not giving adequate consideration to the potential for IT-related musculoskeletal injuries. In fact, these injuries are already happening, according to **Alan Hedge**, PhD, CPE, director of the Human Factors and Ergonomics Laboratory at Cornell University in Ithaca, NY.

Hedge recently unveiled the results of a study in which 179 physicians were queried about their computer use and musculoskeletal discomfort. He found that a majority of female doctors and more than 40% of male doctors reported suffering from upper-body repetitive strain ailments on at least a weekly basis.[1]

"We didn't anticipate that we would already see such high levels of musculoskeletal discomfort, so the alarm bells went off," explains Hedge. While the physicians queried in the study worked in outpatient settings, Hedge notes that the same types of issues are impacting providers in hospitals and EDs. And he stresses that 90% of hospitals are still not intensively using their electronic medical record (EMR) systems. "It is going to get even worse as EMRs get rolled out and people spend even more time using computers as part of their daily work," he says.

Consider how, where technology will be used

Health care organizations are following in the footsteps of most other industries that went through computerization in the 1980s and 1990s, but Hedge says there is little evidence that the people who are leading the health care IT charge have learned from earlier missteps.

"Companies purchased computers en masse, and then in the 1990s we had an epidemic of injuries," he says. "Now we've got that under control because there are ergonomic programs in place. Further, ergonomists are involved with making choices about how technology is going to be used, what furniture is needed to support that, and what work practices you need to ensure that people don't get injured. However, in health care that isn't happening."

Without a rapid change in course, Hedge says health care organizations, including hospitals, EDs, and clinic settings, can expect to see neck, shoulder, arm, and wrist injuries related to poor environmental layouts and improper use of computer devices. And Hedge emphasizes that the current surge in the use of mobile devices comes with its own set of risks.

"A lot of health systems are thinking that they will just give all of their physicians a laptop or a tablet and they can just walk around and capture all of the data, but it is not that simple," says Hedge. "If you don't actually think about how they are going to be using the device, you are just going to create a lot of injury problems for those individuals."

For example, one new phenomenon that Hedge has observed is what he calls "iPad neck." "This develops when people spend a lot of time with their head in a forward inflection," he says. "It puts a lot of strain on the muscles in the back of the neck and shoulders."

Recently, Hedge has been working with people in the ED, and he has found that resorting to laptops or tablets in this setting is particularly problematic for providers. "You don't want them carrying a laptop or tablet or anything like that," he says.

A more workable alternative to consider for the ED, says Hedge, is a cell phone-based system. "With this approach, physicians have their hands free, and data is sent to them via a cell phone that they can easily have in a pocket while they are actually moving around in the space," he says. "There are lots of configurations and information out there. It is really a matter of putting the issue on the radar screen before new systems are implemented."

Too often, IT departments drive the implementation of new systems without proper consideration of how or where the technology will be used, says Hedge. ■

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EXECUTIVE SUMMARY

Unless hospitals and other health care organizations change course, they can expect to see a steep rise in repetitive strain injuries among providers related to the adoption of electronic medical record (EMR) systems and other IT tools, according to ergonomic experts. They urge hospital and ED administrators to consider how and where technology will be used when planning IT installations, and to take steps to ensure that workstations, mobile devices, and other IT tools are used properly, with minimal provider discomfort.

- Researchers queried 179 physicians about their computer use, finding that a majority of female physicians and more than 40% of male physicians were suffering from upper-body repetitive strain ailments on at least a weekly basis.
- Ergonomic experts say that hospitals and other health care organizations need to heed the missteps of other industries that computerized in the 1980s and 1990s, resulting in a flood of repetitive strain injuries.

SOURCE

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ED Coding Update

Avoid common missteps when billing for the services provided by teaching physicians

[This quarterly column is written by ***Caral Edelberg***, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates, Baton Rouge, LA.]

Billing for the services provided by teaching physicians (TPs) continues to create problems for providers, coders, and compliance professionals due the many faces of documentation provided through electronic medical records (EMRs), template records, and handwritten charts. To better understand the elements of service and documentation required for the TP to bill independently for services provided in collaboration with a resident, it might be helpful to review some common definitions.

Definitions

A **teaching physician** is a physician (other than another resident) who involves residents in the care of his or her patients.

A **resident** is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the financial institution. **Receiving a staff or faculty appointment or participating in a fellowship does not, by itself, alter the status of "resident."** Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.

A **student** is an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. **Medicare does not pay for any service furnished by a student.** (*See E/M service documentation performed by students.*)

Being **physically present** is when the TP is located in the same room (or a partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the TP and/or resident performs a face-to-face service.

Documentation requirements

When notes are dictated by a resident and/or TP or others as outlined in the specific situations below, Medicare documentation guidelines are as follows:

- Documentation may be dictated and typed or handwritten, or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Documentation must identify, at a minimum, the service furnished, the participation of the TP in providing the service, and physical presence of the TP to assess the patient and participate in the plan of care.

Dictation "macros" are acceptable for attestations in the context of an electronic medical record. When using an EMR, it is acceptable for the TP to use a macro as the required personal documentation if the TP adds it personally in a secured (password-protected) system. **In addition to the TP's macro, either the resident or the TP must provide customized information that is sufficient to support a medical necessity determination.** The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. According to Medicare, it is insufficient documentation if both the resident and the TP use macros.

Medicare Teaching Physician E/M Documentation Requirements

E/M services billed by TPs require personal documentation of at least the following:

- Personal performance of the service or documentation of physical presence during the key or critical portions of the service when performed by the resident; and
- The participation of the TP in the management of the patient.

Note: When assigning codes to services billed by TPs, coders should combine the documentation of both the resident and the TP for selecting the appropriate E/M service.

A Medicare example of minimally acceptable documentation by the TP is: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that the picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Each attestation or addendum ***must*** be patient-specific and identify that the TP was physically present and evaluated the patient or had involvement with planning the patient's care. If the TP attestation or addendum isn't dictated/documented, then services are not separately billable by the TP. (Medicare considers funds provided to the hospital on the Part A side appropriate reimbursement for the teaching duties of the TP, so separately billing for services that do not include a personal involvement and face-to-face visit with the patient would be considered inappropriate.)

Medicare examples of unacceptable documentation by the teaching physician include:

- "Agree with above," followed by legible countersignature or identity;
- "Rounded, reviewed, agree," followed by legible countersignature or identity;
- "Discussed with resident. Agree," followed by legible countersignature or identity;
- "Seen and agree," followed by legible countersignature or identity;
- "Patient seen and evaluated," followed by legible countersignature or identity; and
- Legible countersignature or identity alone.

Such documentation is not acceptable because the documentation does not make it possible to determine whether the TP was present, evaluated the patient, and/or had any involvement with the plan of care. In cases in which there is no direct TP involvement and documentation of content of that personal involvement, the record is unbillable.

Resident E/M documentation requirements

Residents can document all components of an E/M service under the supervision of the TP. Resident notes and TP notes can be dictated separately. When determining E/M level, coders *must* combine both resident and TP documentation. However, services without a TP attestation of personal involvement or addendum indicating personal involvement with the patient are unbillable.

Medical student E/M documentation requirements

When the TP is billing separately for services provided with the assistance of medical students, only the following can be performed by the medical student and, if reviewed and agreed to by the TP, can be counted as part of the TP's service:

- Review of systems; and
- Past, family, and social history.

Medical students often document in ED records. However, in order for medical students to document the above items, the TP and/or resident *must* be *physically* present to qualify for TP services.

The TP may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the TP **must verify and re-document the history of present illness,** as well as **perform and re-document the physical exam and medical decision-making activities** of the service.

Teaching physician documentation requirements for time-based E/M services

According to Medicare rules for Critical Care Services, the TP must be present for the period of time for which the claim is made. None of the time spent by the resident unaccompanied by the TP can count toward critical care. For example, code 99291 requires 30-74 minutes spent evaluating a critically ill or injured patient. Although it is common for the resident to be involved in managing critically ill patients, the TP must be physically present with or without the resident for 30- 74 minutes to report Critical Care Service code 99291. Time spent by the resident alone cannot count toward critical care time billed separately by the TP.

Examples of Critical Care Attestations:

Unacceptable Example of Documentation:

"I came and saw (the patient) and agree with (the resident)."

COMING IN FUTURE MONTHS

- A new look at telemedicine in emergency care
- Point-of-care testing in the ED
- What emergency providers need to know about sickle cell disease
- Early analysis of Washington state's effort to curb non-urgent ED visits

Acceptable Example of Documentation:

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Teaching physician surgical procedure documentation requirements

In order for TPs to bill for minor procedures performed by residents in the ED, the TP must be present during the entire procedure, even for those that take only a few minutes to complete. These procedures are defined as taking five minutes or less (e.g., simple suture), and involve relatively little decision-making once the need for the operation is determined. For more complicated procedures, the TP must be present for the entire procedure to bill independently for a procedure involving a resident. For more complex procedures, the TP must be present for the "key" portions, determined by what the TP considers "key" and based on the type of procedure.

Procedure notes can be documented by the resident. However, the TP must dictate an attestation or addendum stating that he or she was present during the *entire* procedure for minor procedures and for the "key" elements for more complex procedures by documenting the key portions of the procedure for which he or she was present.

Interpretation of diagnostic radiology and other diagnostic tests

Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a TP. If the TP's signature is the only signature on the interpretation, Medicare assumes that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the TP must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with or edits the findings. **Medicare does not pay for an interpretation if the TP only countersigns the resident's interpretation.**

Documentation Tip: If using macros, TPs should have two different attestations: One for E/M services and the other for Procedures performed in the ER.

Teaching Physician E/M & Procedure Coding and Billing Tips

• Resident notes *must* have a TP attestation or addendum. If not, the service is unbillable.

• Resident notes *must* have a signature by the TP to meet federal and facility policies, whether or not the TP personally provided a billable service. You must differentiate the physician attestation, which illustrates review and agreement with the resident's service from the separately billable service provided and billed separately by a TP. All resident charts must be reviewed and signed by the supervising TP, but that alone does not demonstrate performance of a separately billable service by the TP.

• If E/M or procedure meets Medicare TP guidelines (Medicare/ Medicare HMO only) **— GC** modifier must be appended to each service line item that residents participate in.

• When coding Critical Care Services, only time spent by the TP is counted toward billable critical care time. ■

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME OBJECTIVES

1. Apply new information about various approaches to ED management.
2. Discuss how developments in the regulatory arena apply to the ED setting.
3. Implement managerial procedures suggested by your peers in the publication. ■

CNE/CME QUESTIONS

1. To meet high demand from patients exhibiting symptoms of flu, **David Milbrandt**, MD, explains that the hospital tried which new tactic this year?
A. They hired more providers.
B. They opened two flu clinics outside of the ED.
C. They referred patients to their primary care providers.
D. They leveraged personnel from non-clinical areas to help.

2. At Fairview Medical Center, to limit the transmission of flu in the ED waiting room,
ED staff are:
A. telling lower-acuity patients to go home
B. segregating patients with flu symptoms from other patients
C. providing patients with masks
D. both B and C

3. **Andrea Dugas**, MD, is working on a new flu prediction tool to help ED administrators:
A. track flu severity from year to year
B. better anticipate the levels of staff and resources needed
C. coordinate care with other local providers
D. determine when antiviral medication is needed

4. According to **Jonathan Siff**, MD, MBA, FACEP, the Red Carpet Care program is primarily designed for patients:
A. who use the ED frequently and have needs beyond the scope of the ED to address
B. who frequent the ED with non-urgent problems
C. who do not have primary care providers
D. who have mental health problems

5. Siff also notes that a key strength of the Red Carpet Care program is:
A. its ability to achieve buy-in from emergency providers
B. its ability to identify narcotic-seeking patients
C. having nurse practitioners serve as care coordinators
D. the fact that it doesn't cost very much

6. Without a rapid change in course, **Alan Hedge**, PhD, CPE, says health care organizations, including hospitals, EDs, and clinic settings can expect to see what type of problems related to poor environmental layouts and the improper use of computer devices?
A. neck, shoulder, arm, and wrist injuries
B. increased inefficiency
C. a dramatic increase in errors
D. increased patient dissatisfaction

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Use of the Universal Protocol in the ED: Clarifications and recommendations for enhanced procedural safety

Expert advice: Adapt the UP to fit the risk profile of the ED

Since mid-2004, The Joint Commission (TJC) has held all accredited hospitals to task for enforcing use of the Universal Protocol (UP), a practice designed to improve procedural safety by having clinicians go through a three-step process to insure that when they perform a procedure, they are performing the right procedure, on the right patient, in the right place.

While the UP applies to the ED, many emergency providers find the practice to be less applicable to their work environment than to surgical settings. **Jesse Pines**, MD, MBA, MSCE, FACEP, director of the Center for Health Care Quality and an associate professor in the Departments of Emergency Medicine and Health Policy at George Washington University in Washington, DC, and colleagues discussed these views and made some recommendations for future work on procedural safety in the ED in a recent paper published in *The Joint Commission Journal on Quality and Patient Safety*.[1]

"The perception by emergency physicians is that the UP is something that was retrofitted for the ED from the operating room (OR), and that the importance or salience of the UP to a lot of procedures in the ED is not really there," says Pines.

The main issue is that while the UP has been shown to provide an extra level of safety in preventing surgeons from operating on the wrong patient or the wrong site, it mainly serves this purpose with respect to patients who have been anesthetized, which is not the way procedures are typically carried out in the ED, explains Pines. "If someone comes in with an abscess, you are probably never going to drain the wrong abscess because the pathology is obvious," he says, noting that the patient is also fully conscious in this situation.

In the course of reviewing this paper, Pines explains that TJC reviewers clarified that their intention is for the UP to be applied only in the case of invasive procedures. While this still leaves some procedures open to interpretation, Pines suggests

EXECUTIVE SUMMARY

Emergency medicine providers have found that the Universal Protocol (UP), a safety procedure designed to ensure that providers perform the right procedures, on the right patients, in the right place, is more suited to the operating room than the ED. However, when adapted for the risk profile of the ED, the UP can enhance safety. Because of the unique characteristics of the emergency setting, experts suggest that ED leaders need to look beyond use of the UP to further strengthen procedural safety.

- The Joint Commission maintains that the Universal Protocol should be used for all invasive procedures performed in the ED, and that the "emergency exception" should not be a common occurrence.
- The Universal Protocol is important for ED procedures that feature an element of care that is not completely obvious to the patient.
- Some safety issues, such as a poor layout or not having the right equipment in place, are not captured by the Universal Protocol.

Financial Disclosure:
Managing Editor Leslie Hamlin, Author Dorothy Brooks, Nurse Planner Diana S. Contino, and Executive Editor Shelly Morrow Mark report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses that he is a stockholder of EMP Holdings.

that he would not consider a simple incision and drainage to be an invasive procedure.

On another matter, however, TJC reviewers tightened the reins. Regarding the "emergency exception," a provision that enables providers to bypass the UP when life or limb is threatened, the reviewers made clear that such exceptions should not be a common occurrence. "The Joint Commission still expects the UP to be performed in almost all invasive procedures," says Pines. With this understanding, providers performing run-of-the-mill intubations, for example, could not say that these are "life or limb" emergencies that fall under the emergency exception provision, he explains.

Use UP for elements of care

James Augustine, MD, FACEP, director of clinical operations at Emergency Medicine Physicians in Canton, OH, and a co-author of the paper, adds that the UP is important for ED procedures that still feature an element of care that is not completely obvious to the patient. In the case of a patient who has a laceration that requires sutures, he notes that the provider might communicate the following:

"I am here to perform a closure of the wound on your right arm with plastic sutures. I will be using an iodine cleaning solution and bupivacaine numbing medicine, both of which you said you are not allergic to. Is that correct, Mr. Smith?"

Another procedure in which use of the UP clearly applies is the insertion of a chest tube. "A safety-based protocol would include the need for the physician to identify — with the patient's help, if he/she is able — which side is the correct one for insertion, and which is the incorrect side," says Augustine.

"There are procedure-related complications that have occurred in EDs through the years that have been similar to those in other parts of the hospital," adds Augustine. "There is an opportunity to improve quality and insure patient care in the ED through the same applications of the UP. However, the application of the UP should be modified to the risk profile of the ED."

Look beyond use of the UP

While there are instances in which use of the UP will improve safety, Pines stresses that ED leaders interested in improving procedural safety need to look well beyond this tool. "There are a lot of errors that can happen in the ED that aren't captured with the Universal Protocol," he says.

For instance, Pines says that a poor layout, or not having the right equipment in place when it is actually needed in an emergency situation is a real safety issue not covered by the Universal Protocol. When a direct laryngoscopy doesn't work, it is critical to have a difficult airway box available in the ED, he says. Similarly, Pines notes that not having the right person in place to do a procedure is a safety issue as well.

"A lot of the issues related to procedural safety in the ED have very little to do with the UP, so ED leaders who really want to improve procedural safety have to think about their own local issues related to their hospital and related to emergency care," says Pines.

One issue deserving of particular attention in emergency care is the reality that emergency physicians are commonly called upon to perform procedures that they may have done only once or twice in their careers. "A cricothyrotomy or a transvenous pacer are all part of the ED scope of practice, but these are things that we don't perform very often," says Pines. "This can be an issue with procedural safety because you will have this person in extremis who needs a procedure, and the person who is doing it may not have a lot of experience actually doing that procedure."

How can EDs respond to this challenge? Ongoing quality improvement efforts are important, but it may also make sense to require regular simulation exercises just to make sure that all the providers can do these procedures, says Pines. "In this specialty, we are asked to do these uncommon invasive procedures," he says. "These are high-risk procedures that we are expected to do with a high level of competence that we don't do every day."

Another issue of high importance to the ED is the process of monitoring patients. Augustine stresses that this needs to be done in a reliable manner as procedures are being performed. "The ED is the site of care for patients with high acuity, and there is little opportunity for preparing patients in the same manner as a conventional operative site," he explains. "Active monitoring is very important related to procedural safety."

Augustine adds that ED leaders are responsible for modifying workplace factors that impact patient safety to allow rapid application of the Universal Protocol. "Technological solutions will enhance patient safety and facilitate rapid documentation," he says. "The proper placement of tools like capnography, airway intervention carts,

and cardiac monitoring systems will improve quality as well as the application of the Universal Protocol." ■

REFERENCE
1. Pines J, Kelly J, Meisl H, Augustine J, et al. Procedural safety in emergency care: A conceptual model and recommendations. *The Joint Commission Journal on Quality and Patient Safety* 2012;38:516-526.

SOURCES

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• **Jesse Pines**, MD, MBA, MSCE, FACEP, Director, Center for Health Care Quality, and Associate Professor, Departments of Emergency Medicine and Health Policy, George Washington University, Washington, DC. E-mail: pinesj@gwu.edu.

New standards make hospital leaders accountable for managing patient flow, nurturing relationships

While new requirements are not always welcomed in the ED, to be sure, managers and front-line providers do have reason to feel optimistic about new standards, unveiled by The Joint Commission (TJC), regarding how hospitals manage patient flow.

EXECUTIVE SUMMARY

Recognizing that patient backlogs in the ED are a hospital-wide issue, The Joint Commission (TJC) is taking steps to make hospital leaders more accountable for this issue. The new standards are designed to encourage hospitals to nurture relationships with other providers in the community, especially organizations that care for patients with behavioral health issues. The goal is to facilitate care for patients in the right setting while minimizing the need for boarding in the ED.
• Already in place are standards requiring a written plan for the care and treatment of patients who present to the ED with emotional or substance abuse issues.
• Behavioral health patients require constant monitoring, extra care considerations.
• On-site surveyors will be checking to make sure ED providers and staff are complying with their own written policies and procedures.

Recognizing that patient flow does not necessarily begin and end in the ED, the accrediting agency is taking firm steps to hold hospital leaders accountable for measuring all the components of the patient flow process, and for setting goals for improvement. Further, beginning in 2014, hospital leaders have been put on notice that they need to have referral options in place for the care of patients who present to the ED with behavioral health emergencies.

"Hospital leaders are going to have to establish relationships with community resources so that the ED can treat these patients and then move them to more appropriate settings," explains **Jeannie Kelly,** RN, MHA, LHRM, an expert on risk management and quality assurance at Soyring Consulting in St. Petersburg, FL. "You have to have these relationships at a higher level going on, so that all the parties can communicate and work with each other, and get out of the silos they are in now."

By providing hospital leaders with a year to gear up for these standards, it is clear that TJC recognizes that it will take time to forge relationships with other community providers**.** However, Kelly notes that it is also clear that the agency recognizes what busy EDs are up against on a daily basis.

"These people who work in the ED are overworked and stressed, and they are trying to shovel against the tide. There is a never-ending flow of people and problems coming in, and they are doing the best they can with what they have," she says. "I think The Joint Commission realizes this, so they are elevating the responsibility [for patient flow] and making hospital leadership more accountable."

Kelly adds that TJC is also being realistic about the time it takes to nurture ties with other provider organizations in a community. "The agency recognizes that physicians, nurses, and social workers can't just pick up the phone and establish this kind of community relationship. That has to come at a higher level."

Take note of added considerations

Already in place, as of January 1, 2013, are standards requiring hospitals to have written plans in place for the care and treatment of patients who present to the ED with emotional or substance abuse problems. "There are several things that have to happen," says Kelly. "ED providers have to

assess these patients for their medical and psychological problems, and they have to determine what kind of placement or treatment they might need."

In addition, while these patients await discharge or transfer to another facility, they need to be in an environment that is safe and well-monitored so that there is no danger of a patient hurting him- or herself or others. "ED providers can generally not leave these patients alone or out of sight, so there is a lot that is required above and beyond a typical patient who might be boarded in the ED for one reason or another," adds Kelly. "They need a lot of extra care and extra considerations."

The sooner such patients can be transferred to a care environment that meets their needs, the better, says Kelly. This is where the community relationships become so important. "Knowing what kinds of resources are out there, and where these patients can be properly placed is paramount to the success [of these standards]," says Kelly. "Hospital leaders need to start initiating these relationships today."

While EDs are still struggling with the challenge of caring for behavioral health patients, Kelly observes that many clinicians and hospital administrators are encouraged that the issue is getting more attention by the public as well as accrediting organizations. "The reports of shootings by people who were unstable and didn't have access to community mental health resources have focused more attention on this," she says. "If we can get people the kind of health care they need, whether it is physical or mental health care, that will be a really good thing for the country."

Clear away barriers

Kelly notes that TJC surveyors will certainly want to document that hospitals have written policies and procedures in place regarding patient flow practices; however, she notes that the tougher test will be whether the hospitals are adhering to these procedures. "There can be barriers in place, such as crowding or not enough psych beds," she says. "It could be that someone has not been trained; they don't know what the psych resources are or they don't know what the plan is."

These are issues hospital leaders should consider when developing plans for complying with the patient flow standards. "There are many different barriers, and some of them are not real. Some are just perceived," says Kelly, noting that it is not uncommon for a busy nurse or case manager to say that there are no beds available without thoroughly checking whether that is really the case.

Beginning in 2014, accredited hospitals will need to measure and set goals for mitigating and managing the boarding of patients who come through the ED. Further, TJC is recommending that patients be boarded for no longer than four hours, based on safety and quality. ■

SOURCE

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