AHC Media

Everything the Joint Commission Wants You to Know About Patient Flow

Tuesday, March 17th, 2015

Speaker

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Learning Objectives

1. Identify TJC changes to the patient flow standards in 2013 and 2014.
2. Discuss the TJC patient flow tracer evaluated by surveyors.
3. Describe the four-hour rule for getting patients to their room when admitted.
4. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
5. Evaluate compliance requirements and penalties.

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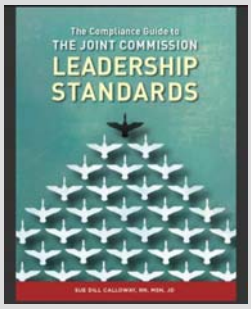
Speaker is Author of TJC Leadership Book



- Speaker is author on book on the TJC leadership standards
- The Compliance Guide to the Joint Commission Leadership Standards
- Chapter where patient flow standards are located
- Published December 2014 by HCPro

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Objectives

- Recall that the Joint Commission has changes to the patient flow standards that went into effect in 2013 and 2014
- Discuss that the Joint Commission has a patient flow tracer that is evaluated by surveyors during a survey
- Describe the four hour rule (goal) on getting patients to their room when admitted

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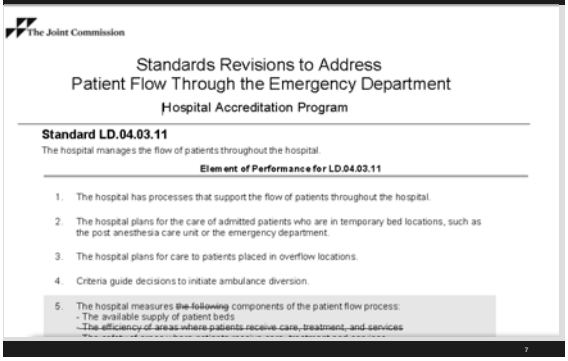
TJC Amends Patient Flow Standards



The Joint Commission

Standards Revisions to Address
Patient Flow Through the Emergency Department

Hospital Accreditation Program

Standard LD.04.03.11

The hospital manages the flow of patients throughout the hospital.

Element of Performance for LD.04.03.11

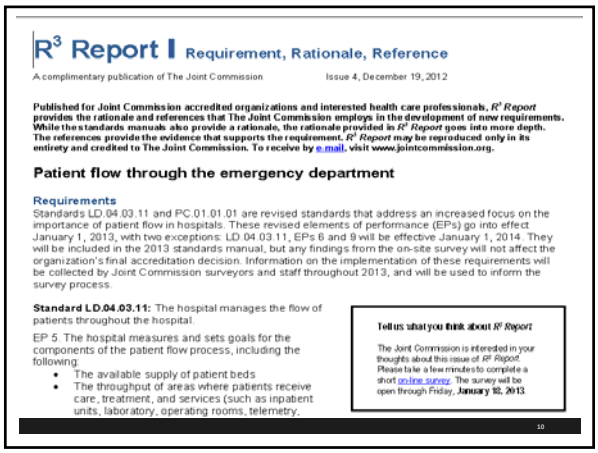
1. The hospital has processes that support the flow of patients throughout the hospital.
2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post anesthesia care unit or the emergency department.
3. The hospital plans for care to patients placed in overflow locations.
4. Criteria guide decisions to initiate ambulance diversion.
5. The hospital measures ~~the following~~ components of the patient flow process:
   - The available supply of patient beds
   - ~~The efficiency of areas where patients receive care, treatment, and services~~

TJC Issues R3 Report

- Published December 19, 2012 and is 5 pages
  - Provides rationale, requirements, and references used
- Can be downloaded off TJC website at www.jointcommission.org/r3_report_issue4/
- Discusses LD.04.03.11 and PC.01.01.01 changes
  - LD.04.03.11: The hospital manages the flow of patients throughout the hospital (Revises EP 5, 7, and 8)
  - PC.01.01.01: The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs (EP 4 and 24)
- LD EP 6 (4 hour time frame) and 9 (boarding behavioral health patients) effective Jan 1, 2014

R3 Report Patient Flow Thru the ED

www.jointcommission.org/r3_report_issue4/



R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission — Issue 4, December 19, 2012

Published for Joint Commission accredited organizations and interested health care professionals, *R³ Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in *R³ Report* goes into more depth. The references provide the evidence that supports the requirement. *R³ Report* may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, visit www.jointcommission.org.

Patient flow through the emergency department

Requirements

Standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals. These revised elements of performance (EPs) go into effect January 1, 2013, with two exceptions: LD.04.03.11, EPs 6 and 9 will be effective January 1, 2014. They will be included in the 2013 standards manual, but any findings from the on-site survey will not affect the organization's final accreditation decision. Information on the implementation of these requirements will be collected by Joint Commission surveyors and staff throughout 2013, and will be used to inform the survey process.

Standard LD.04.03.11: The hospital manages the flow of patients throughout the hospital.

EP 5 The hospital measures and sets goals for the components of the patient flow process, including the following:

- The available supply of patient beds
- The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry,

Tell us what you think about *R³ Report*

The Joint Commission is interested in your thoughts about this issue of *R³ Report*. Please take a few minutes to complete a short on-line survey. The survey will be open through Friday, January 18, 2013.

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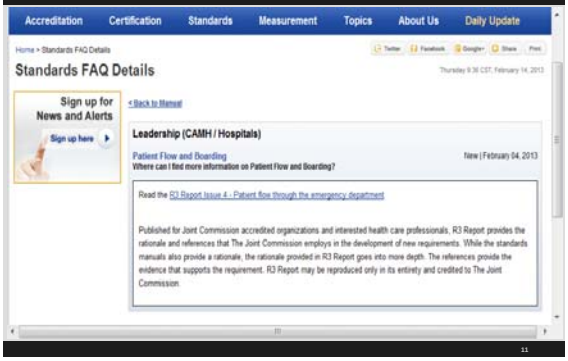
TJC FAQ References R3 Report



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Crowding and Boarding

- The patient flow standards are part of the leadership chapter
- Leadership chapter completely rewritten in 2009 and amended every year since
- TJC standards on patient flow are to prevent overcrowding and boarding especially in emergency department (ED) patients
  - Also boarding of patients in other temporary locations
- TJC first implemented patient flow chapter standards in 2005

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Patient Flow Revisions

- Revisions include leadership use of data and measures to identify and mitigate and manage patient flow issues and management of ED throughput as a system wide issue
- Revisions include safety for boarded patients and leadership communication with behavioral health providers so care of boarded patients is coordinated
- TJC also revised **PC.01.01.01** because of safety issues of boarding behavioral health patients especially in the ED

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Use of Data

- TJC revised EPs 5, 7, and 8 to be consistent with current practices regarding the use of data and metrics
  - This is used to identify, monitor, manage and improve patient flow throughout the hospital
- Most hospitals reported that leaders are reviewing the patient flow data on a monthly or quarterly basis
- Have used Lean, Six Sigma or other change management to make changes and improve outcomes
  - Attention to culture and operations were found to be as important as concerns about technology & data

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Overcrowding and Boarding

- Crowding and boarding has been a problem for many years for hospitals
- It has been a top issue for organizations like the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA)
- One study found that ED crowding is growing twice as fast as visits
- In fact, ED crowding is rising to unsustainable proportions (Pines, Annals of EM, 2012)

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Overcrowding and Boarding

- The number of ED visits increased by 1.9% per year over an eight year study period
- This calculated to a rate that increased 60% faster that the population growth
- Crowding grew by 3.1%
- ACEP and Urgent Matters are an excellent source of articles on solutions and ideas to deal with the issue of overcrowding and boarding

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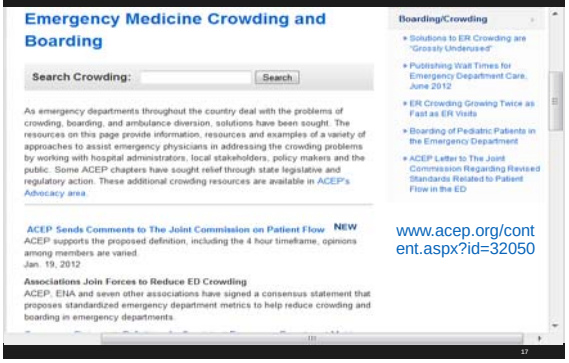
ACEP Resources on Crowding and Boarding



www.acep.org/content.aspx?id=32050

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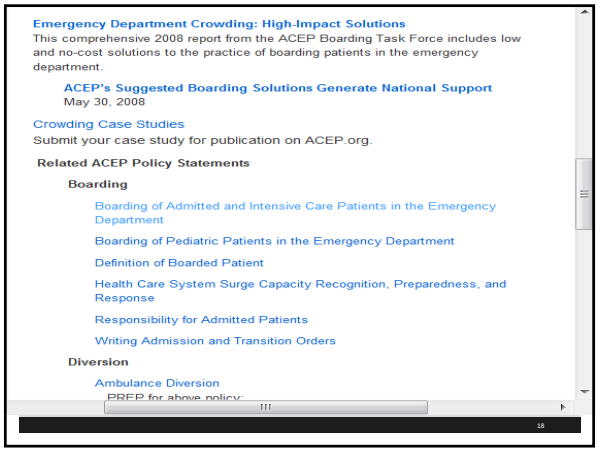

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Urgent Matters

http://urgentmatters.org

Consensus Statement for ED Metrics

- ACEP, ENA, AAEM, AAP, ANA, ED Practice Management Association, and others have joined forces to reduce ED crowding
- Total 9 organizations
- Signed a consensus statement to standardize ED metrics so everyone is measuring things in the same way
- Defines ED arrival time, ED transfer time, ED contact time (time to see the physician or LIP), admission time, disposition to discharge, ED LOS, etc.

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Consensus Statement for ED Metrics

CONSENSUS STATEMENT

DEFINITIONS FOR CONSISTENT EMERGENCY DEPARTMENT METRICS

The emergency department (ED) has become the "portal to the community" and the entry point where most patients are introduced to the health care system. It is also a logical place to expedite needed reform to ensure universal access to essential health care services. This situation has led the undersigned stakeholder organizations to develop metrics that will aid in helping to alleviate the critical situation facing our emergency departments in the care of their patients.

www.acep.org/clinical---practice-management/consensus-statement--definitions-for-consistent-emergency-department-metrics

DEFINITIONS – TIME STAMPS

EMERGENCY DEPARTMENT
A dedicated location serving an unscheduled patient population requesting emergency assessment.

EMERGENCY DEPARTMENT ARRIVAL TIME*
The time that the patient first arrives at the institution for the purpose of requesting emergency care should be recorded as the arrival time. This is the first contact not necessarily registration time or the triage time.

*Emergency Medical Services (EMS): EMS vehicle arrives at emergency department door.
*Ambulatory: A patient requests care, or is asked by ED staff if they are here to receive emergency care.

EMERGENCY DEPARTMENT OFFLOAD TIME

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Crowding is a Patient Safety Issue

- Crowding is caused by boarding
- Research has shown that this is a patient safety issue and impacts patient outcomes
- Boarding increases
  - Waiting times and ambulance diversions
  - Length of stay (LOS)
  - Medical errors and sentinel events
  - Malpractice claims
  - Patients who leave without being seen
  - Financial losses, mortality and other related issues

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Crowding and Boarding Mortality Rate

- Article published in December 2012 in Annals of Emergency Medicine found patients who came through a crowded ED had a **5%** greater chance of dying in the hospital
- Likely caused from challenging doctors' resources
- Crowding delays treatment of MI, pneumonia and painful conditions, increased LOS and costs
- Average ED rate now 58.1 minutes (Up from 46.5 minutes between 2003 and 2009, CDC)
- Looked at 995,379 ED visits from 187 hospitals

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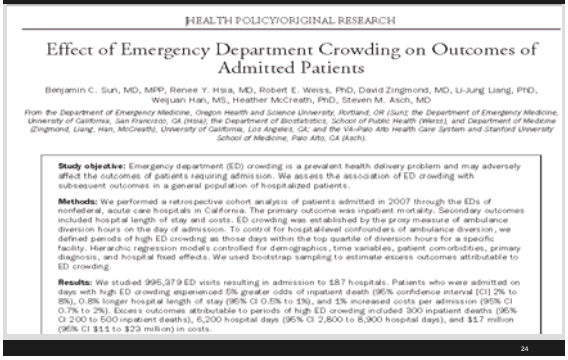
5% Greater Odds of Dying in Crowded ED



HEALTH POLICY/ORIGINAL RESEARCH

Effect of Emergency Department Crowding on Outcomes of Admitted Patients

Benjamin C. Sun, MD, MPP, Renee Y. Hsia, MD, Robert E. Weiss, PhD, David Zingmond, MD, Li-Jung Liang, PhD, Weijuan Han, MS, Heather McCreath, PhD, Steven M. Asch, MD

From the Department of Emergency Medicine, Oregon Health and Science University, Portland, OR (Sun); the Department of Emergency Medicine, University of California, San Francisco, CA (Hsia); the Department of Biostatistics, School of Public Health (Weiss), and Department of Medicine (Zingmond, Liang, Han, McCreath), University of California, Los Angeles, CA; and the VA-Palo Alto Health Care System and Stanford University School of Medicine, Palo Alto, CA (Asch).

Study objective: Emergency department (ED) crowding is a prevalent health delivery problem and may adversely affect the outcomes of patients requiring admission. We assess the association of ED crowding with subsequent outcomes in a general population of hospitalized patients.

Methods: We performed a retrospective cohort analysis of patients admitted in 2007 through the EDs of nonfederal, acute care hospitals in California. The primary outcome was inpatient mortality. Secondary outcomes included hospital length of stay and costs. ED crowding was established by the proxy measure of ambulance diversion hours on the day of admission. To control for hospital-level confounders of ambulance diversion, we defined periods of high ED crowding as those days within the top quartile of diversion hours for a specific facility. Hierarchic regression models controlled for demographics, time variables, patient comorbidities, primary diagnosis, and hospital fixed effects. We used bootstrap sampling to estimate excess outcomes attributable to ED crowding.

Results: We studied 995,379 ED visits resulting in admission to 187 hospitals. Patients who were admitted on days with high ED crowding experienced 5% greater odds of inpatient death (95% confidence interval [CI] 2% to 8%), 0.8% longer hospital length of stay (95% CI 0.5% to 1%), and 1% increased costs per admission (95% CI 0.7% to 2%). Excess outcomes attributable to periods of high ED crowding included 300 inpatient deaths (95% CI 200 to 500 inpatient deaths), 6,200 hospital days (95% CI 2,800 to 8,900 hospital days), and $17 million (95% CI $11 to $23 million) in costs.

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Patient Flow

- Is an issue that needs to be solved by hospital leadership
- It is not necessarily an ED issue even though it impacts the ED
- The revised standards recognize that the causes may be multi-factorial and stem from other areas in the hospital
- If the surveyor identifies problems with patient flow, the surveyor will interview leadership about their shared responsibility with the Medical Staff

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Managing Patient Flow Rationale

- This standard has a rationale that discusses that managing the flow of patients throughout the hospital is essential to prevent overcrowding
- Overcrowding undermines the timeliness of care and affects patient safety
- System-wide programs should be effectively managed that support patient flow
- This includes processes for admitting, assessment, treatment, patient transfer and discharge
- Improving these can lead to useful strategies

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State Ban on ED Diversions

- Massachusetts became the first state to ban ambulance diversion in 2009
  - Concern was this would increase ED over crowding and boarding
- 2012 study found this was not the case and actually found it led to shorter average ED wait times
- ED traffic increased in nine hospitals 3.6% but LOS dropped 10.4 minutes for admitted patients
  - Ambulance diversion has little impact on crowding
  - Operational changes improved patient flow such as streamlining handoffs and reducing occupancy level

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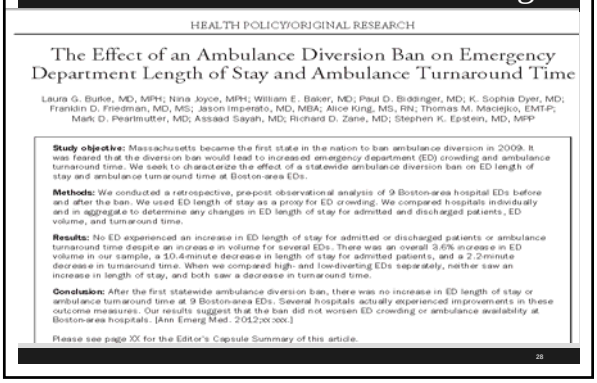
Ambulance Diversion & Crowding



HEALTH POLICY/ORIGINAL RESEARCH

The Effect of an Ambulance Diversion Ban on Emergency Department Length of Stay and Ambulance Turnaround Time

Laura G. Burke, MD, MPH; Nina Joyce, MPH; William E. Baker, MD; Paul D. Biddinger, MD; K. Sophia Dyer, MD; Franklin D. Friedman, MD, MS; Jason Imperato, MD, MBA; Alice King, MS, RN; Thomas M. Maciejko, EMT-P; Mark D. Pearlmutter, MD; Assaad Sayah, MD; Richard D. Zane, MD; Stephen K. Epstein, MD, MPP

Study objective: Massachusetts became the first state in the nation to ban ambulance diversion in 2009. It was feared that the diversion ban would lead to increased emergency department (ED) crowding and ambulance turnaround time. We seek to characterize the effect of a statewide ambulance diversion ban on ED length of stay and ambulance turnaround time at Boston-area EDs.

Methods: We conducted a retrospective, pre-post observational analysis of 9 Boston-area hospital EDs before and after the ban. We used ED length of stay as a proxy for ED crowding. We compared hospitals individually and in aggregate to determine any changes in ED length of stay for admitted and discharged patients, ED volume, and turnaround time.

Results: No ED experienced an increase in ED length of stay for admitted or discharged patients or ambulance turnaround time despite an increase in volume for several EDs. There was an overall 3.6% increase in ED volume in our sample, a 10.4-minute decrease in length of stay for admitted patients, and a 2.2-minute decrease in turnaround time. When we compared high- and low-diverting EDs separately, neither saw an increase in length of stay, and both saw a decrease in turnaround time.

Conclusion: After the first statewide ambulance diversion ban, there was no increase in ED length of stay or ambulance turnaround time at 9 Boston-area EDs. Several hospitals actually experienced improvements in these outcome measures. Our results suggest that the ban did not worsen ED crowding or ambulance availability at Boston-area hospitals. [Ann Emerg Med. 2012;xx:xxx.]

Please see page XX for the Editor's Capsule Summary of this article.

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State Ban on ED Diversions

- Hospital may only divert if on Code Black such as fire, flooding, contamination or other disasters
- Study found the major factor of ED crowding is boarding of admitted patients in the ED
- Inadequate staffing also lead to ED crowding
- Massachusetts hospitals have been leading the way to reduce ambulance diversions and focus on patient flow
- IOM says diversions can lead to catastrophic delays for seriously ill or injured patients

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Key Interventions

- Code Help implemented
- Inpatient bed dashboard
- Establish threshold to deploy physicians at triage
- Establish 10 bed surge pod on inpatient unit to care for boarded ED patients
- Use nontraditional space for boarding such as PACU, off hour procedure unit, etc.
- Twice daily rounds
- Internal medicine coverage of admitted patients waiting for inpatient bed, etc.

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Manage Patient Flow LD.04.03.11

- The standard: The hospital manages the flow of patients throughout the hospital
- This standard has 9 elements of performance (EPs)
- EP1 states the hospital has a process that supports the flow of patients throughout the hospital
  - What are some things a hospitals could do to meet this standard?
  - Many hospitals have a policy of no direct admits to the ED
  - Some hospitals go on diversion when there is a critical shortage of beds or staff

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Manage Patient Flow LD.04.03.11

- EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)
  - Some hospitals have instituted processes to support the flow such as stat cleans of room by environmental services when a patient is waiting in the ED
  - Some hospitals have posted ED physicians or NP at triage to expedite care in the ED
  - Some ED have direct boarding where patients arriving go immediately to an ED bed if one is open (pull to full)
  - Others keep ambulatory patients vertical when their condition allows this

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Manage Patient Flow LD.04.03.11

- EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)
  - Some hospitals have a revised process in which each of the departments accepted one overflow patient
  - The thought being it was easier for a department to take care of one additional patient then to have 12 boarded patients in the ED
  - Some hospitals require daily rounds be made by a specified time so current patients are discharged home timely freeing up beds for patients who are being boarded

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LD.04.03.11 Manage Patient Flow

- EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)
  - Patient flow problems most frequently occurred on Mondays and Tuesdays
  - Some hospitals have ensured that adequate services are available on the weekend so surgeons will not just schedule elective cases on Monday or Tuesday but can space elective cases throughout the entire week
  - The literature is full of research and strategies that hospitals that do to improve and support patient flow throughout the hospital

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LD.04.03.11 Plan Patient Care

- EP2 Addresses the need for the hospital to plan and care for the patients who are admitted and whose bed is not ready or a bed is unavailable
  - Patient may be in a temporary area such as the ED or PACU
- EP3 Addresses the need for the hospital to plan the care for patients who are placed in an overflow location
- So what does these two standards mean?

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EP 2 and EP 3 LD.04.03.11

- For example, an ICU patient is admitted and is currently residing in the ED
  - It is the ICU standard of care-does an ICU nurse come down to care for the patient?
- How does the patient get their assessment done, lab tests, medications administered and other ICU care?
- How does the hospital ensure that the patient is getting the same standard of care?
- How do you ensure that nursing staff are competent to care for patients?

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LD.04.03.11 Diversion

- EP4 Discusses that criteria guide decisions to initiate ambulance diversion
  - Hospitals should have a policy and procedure on diversion
  - One state recently passed a law forbidding ambulance diversions but other safe guards were put into place
  - Diversion is an EMTALA issue
  - EMTALA CoP, page 38, states that "a hospital may divert individuals when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time"

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LD.04.03.11 Diversion

- EP4 discusses that criteria guide decisions to initiate ambulance diversion (continued)
- If ambulance disregards the hospital's instructions and brings the patient to the hospital, the ED must do a medical screening exam (MSE) to determine if the patient is an emergency medical condition (EMC)
- ED should consider documenting dates and times for diversion
- Case law exists regarding diversion

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EMTALA Manual

State Operations Manual
Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3- Record Review
VI. Task 4- Interviews
VII. Task 5-Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendixtoc.pdf

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

§489.20 Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities

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So What's in Your Policy?

DIVERT POLICY

PURPOSE

To define the term "divert" as it applies to our hospital.

To provide and protect patient safety

To establish an organized response to fluctuation in clinical acuity or resource availability, thereby ensuring appropriate medical screening, stabilization, and/or initiation of treatment, and/or transfer to a facility equipped to provide an equal or higher level of service.

SCOPE

Hospital-wide
External services, as individual situation would require

DEFINITION

Divert is that situation whereby it is temporarily necessary to direct patients to another service area or another facility for care.

SITUATIONS NECESSITATING DIVERSION

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DIVERT NOTIFICATION CHECKLIST

DATE:_____ **TIME INTIATED:** _____ **TIME CANCELLED:**_____ **TOTAL:** _____

AUTHORIZED BY:_____ **following consultation with: Unit Manager**_____

Medical Director_____ **Administrator on Call**_____

Type of Divert: ____ **Individual patient**
____ **Specific type of patient (explain)**_____
____ **Unit/department (specify)**_____
____ **Hospital-wide**

SITUATION NECESSITATING DIVERSION (check all that apply)
____ **Medical Command decision Reason:**_____

____ **Appropriate bed unavailable:**
____ Security room
____ Monitored beds
____ Capacity maximized

____ **Staffing/personnel issue:**
____ Acuity/staffing ratio
____ Support services unavailable
____ Specialty physician not available

____ **Equipment problem:**
____ Utility outage (specify) _____
____ Capacity in service

____ **Disaster:**
____ Severe weather
____ Fire
____ Manmade (type) _____

NOTIFICATIONS (check all that apply)
____ Appropriate Service Areas
____ Local Ambulances (via radio)
____ County Communications (911)
____ Other Facilities: specify_____
____ Department of Health (If greater than 8 consecutive hours or 12 hours in a 24 hour period.) *Refer to ADM39*

BRIEF SYNOPSIS OF EVENTS LEADING TO DIVERT

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LD.04.03.11 Measurement and Goals

- EP5 Requires the hospital to measure and set **goals** for the components of the patient flow process
  - This EP was revised January 1, 2013 and includes additional things that must be measured
- Hospital leaders will need to use data and metrics in a more systematic process
- Measurement includes:
  - The available supply of patient beds
  - Access to support services such as case management and social work

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LD.04.03.11 Measure the Following

- Measurement includes (continued):
- The safety of areas where patients receive care and treatment
- Throughput of areas where patients receive care which could include inpatient units, lab, PACU, OR, telemetry, radiology, and telemetry
- Hospitals must also measure and set goals for the efficiency of non-clinical services that support patient care such as transportation and housekeeping

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LD.04.03.11 Boarding and the 4 Hour Rule

- The hospital must measure and set goals for mitigating and managing the boarding of patients who come through the ED
- EP6 EP went into effect January 1, 2014
- It is recommended that patients not be boarded more than **4 hours**
- This is important for safety and quality of care

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LD.04.03.11 Boarding and the 4 Hour Rule

- TJC defines boarding as the "The practice of holding patients in the ED or a temporary location after a decision to admit or transfer is made."
- The hospital should set its goals with attention to patient acuity and best practices
- The four hour window has lead to a lot of discussion in the emergency medicine community
- The four hour window is a recommendation and not a requirement but all hospitals should strive to not keep patients boarded more than 4 hours

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LD.04.03.11 Review Measurement Data

- EP 7 Requires the staffs or individuals who manage the patient flow processes to review the measurement results
  - EP7 went into effect January 1, 2013
- This is done to assess if the goals made were achieved
- Data required was discussed in EP 5

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LD.04.03.11 Data Guides Improvements

- EP8 Requires leaders to take action to improve patient flow when the goals were not achieved
- EP8 revision went into effect January 1, 2013
- Leaders who must take action involve the board, medical staff, along with the CEO and senior leadership staff
  - References PI.03.01.01, EP 4, which states that the hospital takes action when it does not achieve or sustain planned improvement

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LD.04.03.11 Data Guides Improvements

- There are certain delays that are known as patient flow problem triggers
- Data will prompt surveyors to have discussions with the hospital and the role of the Medical Staff in resolving these
- This includes delays in patient assessment, blood draws, radiology studies, handoff communication and reporting, cleaning rooms, taking report from the ED, and delays in the getting patients to the operating room can signal that patient flow problems exist.

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LD.04.03.11 Boarding of Psych Patients

- EP 9 States that the hospital determines if it has a population at risk for boarding due to behavioral health emergencies
- EP9 was new standard effective January 1, 2014
- Hospital leaders must communicate with the behavioral health providers to improve coordination and make sure this population is appropriately served
- There is a shortage of behavioral health beds in this country leading to times where these patients have camped out in the ED sometimes for days

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Boarding of Behavioral Health Patients

- Patient flow problems pose a significant and persistent risk to the quality and safety of behavioral health patients
- Some hospitals have added up to 5 or 6 beds in a locked unit in the ED for behavioral health patients to keep them safe
- Often staffed by behavioral management staff and not ED staff
- Often have video and audio to observe patients and ensure their safety

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Boarding of Behavioral Health Patients PC

- Hospitals should also be familiar with two sections of PC.01.01.01 under EP4 and EP24
- EP 4 Hospitals that do not primarily provide psychiatric or substance abuse services must have a written plan that defines how the patient will be cared for which includes the referral process for patient who are emotional ill, or who suffer from substance abuse or alcoholism
  - This means that hospitals that do not have a behavioral health unit or substance abuse unit, how do you care for the patient until you transfer them out?

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Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24 (new in 2014)
- EP 24 requires boarded patients with an emotional illness, alcoholism or substance abuse be provided a safe and monitored location that is free of items that the patients could use to harm themselves or others
- Hospitals often use sitters and have a special safe room
- EP24 requires orientation and training to both clinical and non-clinical staff that care for these patients

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Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24 (Continued)
- This includes medication protocols and de-escalation techniques
- Assessments and reassessments must be conducted in a manner that is consistent with the patient's needs
- Free guide on how to create a safe room called the Design Guide for the Built Environment of Behavior Health Facilities, 2014, at https://www.naphs.org/index

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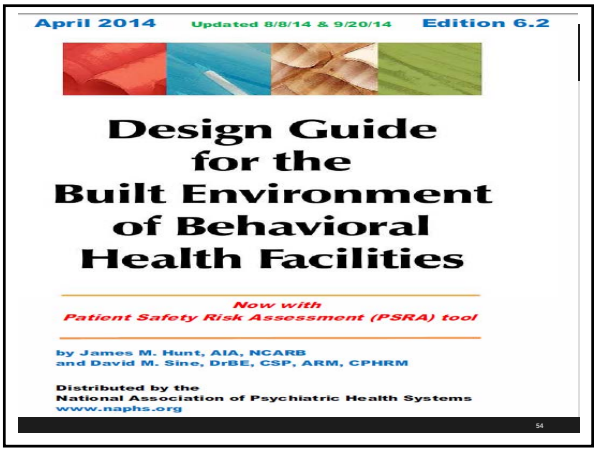

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Methods of De-escalation

- Active listening
- Validate feelings such as “you sound like you are angry”
- Some organizations have personal de-escalation plan that lists triggers such as not being listened to, feeling pressured, being touched, loud noises, being stared at, arguments, people yelling, darkness, being teased, etc.

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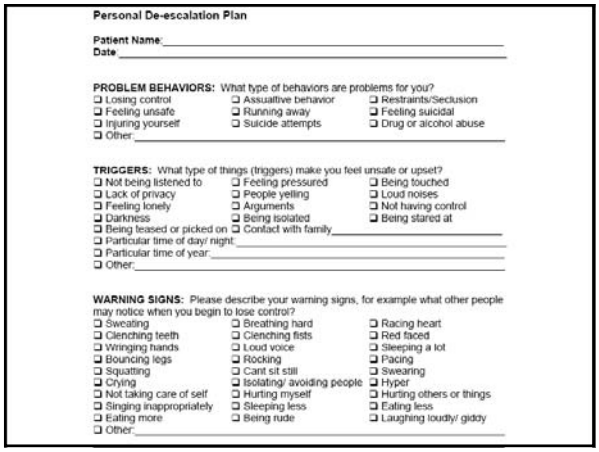

Personal De-escalation Plan

Patient Name:_____
Date:_____

PROBLEM BEHAVIORS: What type of behaviors are problems for you?

❑ Losing control	❑ Assualtive behavior	❑ Restraints/Seclusion
❑ Feeling unsafe	❑ Running away	❑ Feeling suicidal
❑ Injuring yourself	❑ Suicide attempts	❑ Drug or alcohol abuse

❑ Other:_____

TRIGGERS: What type of things (triggers) make you feel unsafe or upset?

❑ Not being listened to	❑ Feeling pressured	❑ Being touched
❑ Lack of privacy	❑ People yelling	❑ Loud noises
❑ Feeling lonely	❑ Arguments	❑ Not having control
❑ Darkness	❑ Being isolated	❑ Being stared at
❑ Being teased or picked on	❑ Contact with family_____	

❑ Particular time of day/ night:_____
❑ Particular time of year:_____
❑ Other:_____

WARNING SIGNS: Please describe your warning signs, for example what other people may notice when you begin to lose control?

❑ Sweating	❑ Breathing hard	❑ Racing heart
❑ Clenching teeth	❑ Clenching fists	❑ Red faced
❑ Wringing hands	❑ Loud voice	❑ Sleeping a lot
❑ Bouncing legs	❑ Rocking	❑ Pacing
❑ Squatting	❑ Cant sit still	❑ Swearing
❑ Crying	❑ Isolating/ avoiding people	❑ Hyper
❑ Not taking care of self	❑ Hurting myself	❑ Hurting others or things
❑ Singing inappropriately	❑ Sleeping less	❑ Eating less
❑ Eating more	❑ Being rude	❑ Laughing loudly/ giddy

❑ Other:_____

Psych Boarders in the ED

- There are 53 million mental health related visits to the ED
- This is an increase from 4.9% to 6.3% from data 1992-2001
- 19.4% of patients with mental health issues are admitted
- This is why ACEP and the American Academy of Pediatrics recommend increasing resources related to mental health

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Psych Boarders in the ED

- 2010 Survey of Hospital ED Administrators found:
- 86% of EDs are unable to transfer patients
- 70% reported that patients are boarded in the ED because of the shortage of beds for more than 24 hours
- 10% reported patients are boarded more than 1 week
- 90% reported that boarding psych patients reduced the availability of ED beds for ED patients

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Psych Boarders in the ED

- Study found that 67% of ED doctors reported that there was a decrease in behavioral health beds
- 23% reported sending patients home without seeing a mental health professional due to a lack of resources
- This included that 31% of the time there was not a psychiatrist available
- Perhaps the telemedicine law will make it easier to contract with a group of psychiatrist to ensure all patients are seen by a psychiatrist

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Tracer Methodology

- The surveyors follow actual experience of a sample of patients as they interact with their health care team
  - The surveyors evaluate the actual provision of care provided to these patients
- Looks at how the individual components of the hospital interact to provide safe, high quality patient care
- The proof is in the pudding and this makes great sense
- Patient flow tracer updated with guidance in January 2014 and new discussion topics in LD session

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2015 Survey Activity Guide

The Joint Commission

www.jointcommission.org/assets/1/6/Organization_SAG.pdf

Survey Activity Guide
For Health Care Organizations

2015

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Survey Activity Guide Tracers Page 49

During survey – Sessions are generally in order of the survey agenda		
Surveyor Arrival	All	32
Surveyor Preliminary Planning Session	All	33
Opening Conference	All	34
Orientation to Your Organization	All	35
Initial Surveyor Planning	All	37
Individual Tracer Activity	All	38
Program-Specific Tracers: **(conducted during Individual Tracer Activity)**		
• Continuity of Care	AHC	43
• Elopement	BHC	44
• Continuity of Foster/Therapeutic Foster Care	BHC	45
• Violence	BHC	46
• Suicide Prevention	BHC, HAP	47
• Laboratory Integration	HAP, CAH	48
• Patient Flow	HAP, CAH	49
• Staffing	NCC	50
• Equipment & Supply Management	HME	51
• Fall Reduction	OME	52
• Hospital Readmission	OME	53
Special Issue Resolution	All	54
Team Meeting/Surveyor Planning	All	55
Daily Briefing	All	56
Competence Assessment and Credentialing/Privileging	AHC, BHC, NCC, LTC, OBS, OME	57

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Patient Flow Tracer

Applicable Programs
CAH, HAP

Program Specific Tracer – Patient Flow

Joint Commission Participants
Surveyor

Organization Participants
Staff involved in patient care, treatment, or services throughout the hospital and leaders responsible for the planning, development and oversight of related systems, as available

Logistical Needs
This focused tracer occurs during time designated for Individual Tracer Activity

Objectives
The surveyor will:
- Look for organization awareness and improvements in patient flow
- Evaluate process issues throughout the hospital contributing to patient flow concerns

Overview
Growing concerns from the health care field about increasing patient congestion continue. Poorly managed patient flow most often impacts vulnerable areas in the hospital first, such as the emergency department, critical care units and surgical areas, but these are not always the causative factors and answers lie throughout the hospital. Treatment delays, medical errors and generally, unsafe practices thrive in the presence of patient congestion; these are precursors to and contributing factors in negative sentinel events. Many hospitals have improved their flow of patients through due diligence. Joint Commission accredited hospitals are required to

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Introduction to Patient Tracers

- Purpose is to evaluate compliance with the standards as they relate to the care and treatment of a patient [1]
- Tracers are integral to the on-site survey process and often referred to as the **corner stone** of the Joint Commission survey (no longer called JCAHO)
- Practicing tracers are a great way to prepare for your survey
- Tracers can provide you with information and ability to increase patient safety and improve clinical outcomes

1 Tracer Methodology: Tips and Strategies for Continuous System Improvement, 2nd edition, TJC

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TJC Patient Flow Tracer

- Surveyor instructed to look and listen throughout the survey for clues that may be indicative of patient flow concerns along with awareness in patient flow
- When found the surveyor should perform the program specific tracer for patient flow
- During the orientation to the organization, the surveyor is to ask the leaders how they monitor and manage hospital wide patient flow issues
  - Should document any projects undertaken and reasons
  - Especially medical, surgical and behavioral health patients

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TJC Patient Flow Tracer

- Surveyor may trace the patient affected by patient flow issues
  - Bed availability delays
  - Lengthy boarding experiences
  - Transport delays
  - Transfer delays
  - Delays in performing tests and receiving results
  - Availability of providers
- S

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Patient Flow Interview Questions

- Will ask for dashboard data they review to support system wide decision making
- Will look for cyclical issues or trends
- During the individual tracer, surveyor instructed to look at the data the hospital is collecting
- What patient flow processes are measured?
  - Recall the EP 5 tells the hospital what to monitor
- What other PI measures are in place?
- How is the information used to make improvements and will look at process contributing to concerns

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Patient Flow Interview Questions

- How is the patient flow data circulated and shared with others?
- Surveyor to explore patient flow issues
- Surveyor to check for variability in workload such as staffing during the day and between days of the week
- Will ask about wait times, turn around times, and boarding of patients
  - Will look for delays in stat orders for diagnostic testing, complaints of not enough staff etc.

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Individual Tracer for Patient Flow

- Will assess if improvements to patient flow have been made
- Ask staff what they consider to be the most challenging patient flow problems
  - Especially the ED, OR, medical-surgical units, radiology, lab, housekeeping and transport
- Surveyor told to reference the program specific tracer for patient flow
- Surveyor to ask staff about timing of assessments and reassessments

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Patient Flow Interview Questions

- Also availability of consulting providers such as behavioral health, oncology, surgery, neurology, and ob/gyn
- Surveyor to ask about the rounding of the consultants and the qualified mental health staff
- Ask the staff about the frequency of rounding on boarded patients with behavioral health emergencies
- There is a program specific tracer for patient flow for hospitals including critical access hospitals that is very detailed

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Patient Flow Interview Questions

- May ask about the volume and types of patients seen in the ED
- How ED throughput is monitored?
- How are patients presenting with conditions outside the scope of services managed such as a mental health patient who is a trauma patient?
- Will ask about patient boarding
- Unsafe practice thrive in the presence of patient congestion

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Patient Flow CAH and HAP Programs

- Duration is 60 to 90 minutes
- Surveyor to identify if there is any evidence of any patient flow problems
- Surveyor to evaluate the process issues that are present throughout the hospital that can contribute to patient flow issues
- The **triggers** indicative of a patient flow problem are assessed by direct observation, by reviewing PI data and reports, and by interviewing staff
- Will select a patient who had an extended delay or stay

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Triggers Indicative of Patient Flow Problems

- Increase length of stay in the ED
- Insufficient support and ancillary staffing
- Misuse of ED for low acuity patients and direct admits
- Patients experiencing delays with transfers
- Indicators such as MI get ASA and beta blockers on arrival and fibrinolytic with 30 minutes and PCI within 90 minutes
- Pneumonia patients blood cultures and antibiotics timely?

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Triggers Indicative of Patient Flow Problems

- Assessment delays
- Delay in blood draws or x-rays
- Delay in communication such as reporting handoff from one area to another
- Delay in discharge due to discharge processes
- Delay in OR scheduling
- Hospital process that stop flow of patient in ED such as work up in ED or housekeeping protocols
- Misuse of ED for direct admits

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Patient Flow Tracer

- Can locate a patient to trace through looking at the ED log or on surgical units where problem getting a bed into a bed
- Will look for a behavioral health patient in the ED needing an inpatient bed
- Will look for delays in transferring the patient to an inpatient bed
- Surveyors may interview staff
- Will look at what patient flow processes are being measured

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Patient Flow Tracer

- If the patient is delayed will look at the diagnosis to see if it associated with any of the core measures
- Will look for variances such as not getting thrombolytics within 30 minutes or PCI within 90 minutes
- If patient had pneumonia was blood cultures drawn before the first antibiotic and given within 6 hours of arrival
- Will look for antibiotics timely for patients going in surgery

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Patient Flow Tracer

- Will visit the ED more than once to determine impact and responses to flow at different times of the day
  - Are there patients in hallway beds?
- Will ask leaders what they have done to fix the patient flow problems
- Will ask about shared accountability with the medical staff and leadership
- How are the indicator results reported to leadership and how was it used to improve patient flow

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Patient Flow Tracer

- Will interview staff about the patient flow experience with psyche or substance abuse patients
- Is the staffing, assessment, and care taken to safely manage the behavioral health or substance abuse patients
- Was the space appropriate to safely manage these patients
  - Note that many hospitals have a ED special unit to house behavioral health patients awaiting a bed or transfer
  - Often a locked unit with cameras and audio control and care provided by behavioral health staff

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Patient Flow Tracer

- Will interview the physicians, including surgeons and hospitalists about rounding times, surgery schedule and discharge process
- Note may be looking to see if the hospital modifies the elective surgeries when indicated
- May ask about the MS structure such as teaching or safety net hospital, use of hospitalists, contracted or employed ED physicians and how it impacts patient flow initiatives
- Will ask about delays in patient care
- May still ask about diversion policy and process

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Patient Flow Tracer

- Do the PI measures show any delays in treatment, surgery, discharge to home, or diagnostic testing?
- Will look to see if any delay to getting the patient transferred to their unit
- May ask how the key goals were determined
- Will ask how patient safety and quality are sustained in situations where the hospital's goals are not met
- Surveyor to discuss observations with the organization at the conclusion of the tracer activity

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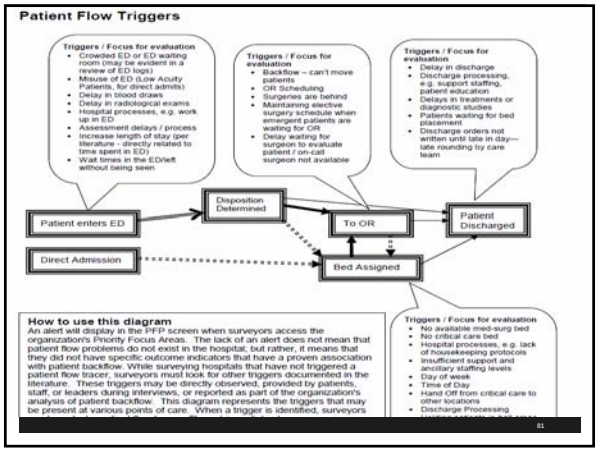

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Patient Flow Tracer Questions Asked in Past

- Looked at how the hospital planned for staffing and how they trained staff about the differences in emergent and hospital care
- Identify temporary holding area such as are patients held in the emergency department or waits for surgery or critical care units
  - Treatment delays, medical errors and unsafe practices can thrive in presence of patient congestion
  - TJC hospitals are expected to identify and correct patient flow issues

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CMS Created and TJC Adopted ED Quality Measures

Last Updated: Version 4.4

EMERGENCY DEPARTMENT
NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

Set Measure ID #	Measure Short Name
ED-1a	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure
ED-1c	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients
ED-2a	Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure
ED-2c	Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients

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CMS ED Throughput Measure

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Emergency Department Throughput Measures Stratification
Numerator/Denominator/Exclusion Calculation Information

	Clinical Quality Measure (CQM)	CQM Subset	Numerator	Denominator	Exclusion
1	ED-1 NQF 0495	1.1 All Emergency Department (ED) patients admitted to the facility from the ED	Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.	All ED patients admitted to the facility from the ED	Observation & Mental Health Patients
1		1.2 Observation ED patient stratification	Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.	ED Observation patients admitted to the facility from the ED	None
1		1.3 Dx stratification ED patients	Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.	ED patients with a Dx of Psychiatric/Mental Health admitted to the facility from the ED	None
2	ED-2 NQF 0497	2.1 All ED patients admitted to inpatient status	Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status.	All ED patients admitted to the facility from the ED	Observation & Mental Health Patients

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The End! Questions??

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Resources

- Pines JM, et al. The financial consequences of lost demand and reducing boarding in hospital emergency departments. *Annals of Emergency Medicine, 2011 Oct;58(4):331-40*
- Institute of Medicine. Hospital-based emergency care at the breaking point, Washington, D.C.: National Academies Press, 2007. http://www.nap.edu/catalog.php?record_id=11621 (accessed February 14, 2013)

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Resources

- www.hospitalovercrowding.org
  - Dr Peter Viccellio
  - Overcrowding power point slides
  - Key points of harm caused by overcrowding
  - Full capacity protocol, etc.

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Thank you for attending!!

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