

# Improving Patient Flow for the ED and Beyond



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# Objectives

- Discuss TJC patient flow tracer that is evaluated by surveyors during a survey.
- Describe the four hour rule on getting patients to their room when admitted.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.



**EMERGENCY  
DEPARTMENT**



**EMERGENCY DEPARTMENT**  
Departamento de Emergencias

**01601**

# Objectives

- Recall that the Joint Commission has patient flow standards.
- 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.

# Joint Commission Project Refresh 2016



# Project Refresh

- The Joint Commission deleted **131** requirements that were identified as having become a routine part of operations and clinical practice
  - Or no longer necessary for quality or patient safety
  - Some were covered elsewhere
  - Effective July 1, 2016 and called Project Refresh
  - No changes to the Patient Flow Standards
- Will delete a total of **225** requirements all together
- These deletions were the result of a multi-phased project to improve the accreditation and certification process

# 131 EPs Deleted July 1, 2016



• Issued April 25, 2016 •

## Prepublication Requirements

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit <http://www.jcrinc.com>.



### Standards and Elements of Performance Deletions for Hospital

APPLICABLE TO HOSPITAL

Effective July 1, 2016

#### EC.01.01.01

The hospital plans activities to minimize risks in the environment of care.

Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

#### Elements of Performance for EC.01.01.01

2. Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings.

R	A			
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Rationale: Implicit in EP 1 of this standard

#### EC.02.01.03

The hospital prohibits smoking except in specific circumstances.

# TJC Patient Flow Resources and R3 Report



# TJC Patient Flow Standards



## Standards Revisions to Address Patient Flow Through the Emergency Department Hospital Accreditation Program

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### **Standard LD.04.03.11**

The hospital manages the flow of patients throughout the hospital.

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#### **Element of Performance for LD.04.03.11**

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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
  - The safety 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/](http://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

The screenshot displays the website for The Joint Commission. At the top left is the logo, and to its right are links for "Log In | Request Guest Access" and "Forgot password? | Log In Help". Further right are links for "Contact Us | Careers | JCR Web Store | Press Room". A search bar with a "Go" button is located on the right side. A blue navigation bar contains the following menu items: "Accreditation", "Certification", "Standards", "Measurement", "Topics", "About Us", and "Daily Update". Below the navigation bar, the breadcrumb "Home > Topic Details" is visible. The main heading is "Topic Details" with the URL [www.jointcommission.org/r3\\_report\\_issue4/](http://www.jointcommission.org/r3_report_issue4/) and the date "Wednesday 6:47 CST, January 2, 2013". Social media sharing buttons for Twitter, Facebook, Google+, Share, and Print are present. A sidebar on the left features a "Sign up for News and Alerts" box with a "Sign up here" button. The main content area is titled "Topic Library Item" and features the article "R<sup>3</sup> Report Issue 4 - Patient flow through the emergency department" dated "December 19, 2012". A "Download This File" button is provided. The article text states: "Published for Joint Commission accredited organizations and interested health care professionals, R<sup>3</sup> 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 R<sup>3</sup> Report goes into more depth. The references provide the evidence that supports the requirement. R<sup>3</sup> Report may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, sign up to receive an [E-mail Alert](#)."

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# R<sup>3</sup> 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, *R<sup>3</sup> 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 *R<sup>3</sup> Report* goes into more depth. The references provide the evidence that supports the requirement. *R<sup>3</sup> Report* may be reproduced only in its entirety and credited to The Joint Commission. To receive by [e-mail](mailto:), visit [www.jointcommission.org](http://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 8 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 *R<sup>3</sup> Report*

The Joint Commission is interested in your thoughts about this issue of *R<sup>3</sup> Report*. Please take a few minutes to complete a short [on-line survey](#). The survey will be open through Friday, **January 18, 2013**.

# TJC Patient Flow Resources

- TJC has a website on patient flow resources
- It contains a 3 page resource on the 4 hour recommendation under LD.04.03.11 EP 6
  - [www.jointcommission.org/patient\\_flow\\_standard\\_4hour\\_recommendation/](http://www.jointcommission.org/patient_flow_standard_4hour_recommendation/)
- The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department (ED)
- TJC provides a definition of boarding after researching how hospitals described and defined boarding

# TJC Patient Flow Resources

- Boarding is:
  - The practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made
  - The hospital should set its goals with attention to patient acuity and best practice
  - It is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care
- Time frames, monitoring, and metrics varied widely in the literature from 2 hours or less to 24 hours or more

## Patient Flow Resources [www.jointcommission.org/accreditation/patient\\_flow\\_resources.aspx](http://www.jointcommission.org/accreditation/patient_flow_resources.aspx)

Friday 12:18 CST, July 22, 2016

### Hospital Program

Hospital Home

How to Become Accredited

Integrated Care Certification

Primary Care Medical Home (PCMH) Certification

Performance Measurement

Standards Information

➤ Patient Flow Resources

Pioneers in Quality

Top Performer on Key Quality Measures

Resources and Tools

This web page will highlight resources (articles, reports, case studies, etc.) that can provide helpful information to hospitals as they prepare to implement operational, cultural, and data management changes to improve patient flow in their organizations. The purpose of providing these resources is not to endorse a specific strategy or intervention, but to provide a range of examples for consideration as hospitals design, implement, review, and improve their own approaches to patient flow in their organizations.



#### Joint Commission Content

- The "Patient Flow Standard" and the 4-Hour Recommendation
- Navigating the Challenges of Patient Flow and Boarding in Hospitals - Storyboard

#### External Links

- New tool aims to standardize hand-offs in the ED
- Changes in Patient Flow Among Five Hospitals Participating in a Learning Collaborative
- Right Care, Right Time, Right Place, Every Time
- Improving Pediatric Emergency Department Patient Throughput and Operational Performance
- Pediatric and Adolescent Mental Health Emergencies in the Emergency Medical Services System

# TJC Patient Flow Standards

## The “Patient Flow Standard” and the 4-Hour Recommendation

In September 2012, The Joint Commission published revisions to Leadership (LD) Standard LD.04.03.11, known as the “patient flow standard,” in the *2012 Update 2* to the *Comprehensive Accreditation Manual for Hospitals* (see July 2012 *Perspectives*, page 1). Since the publication of this revised standard, organizations have asked The Joint Commission about the source of the 4-hour time frame for boarding recommended in the Note at Standard LD.04.03.11, Element of Performance (EP) 6:

### Standard LD.04.03.11

The hospital manages the flow of patients throughout the hospital.

6. **This element of performance will go into effect January 1, 2014:** The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPSG.15.01.01, EPs 1 and 2; PC.01.01.01, EPs 4 and 24; PC.01.02.03, EP 3; PC.02.01.19, EPs 1 and 2)

*Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.*

# Crowding and Boarding and TJC Patient Flow



# 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

# 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

# 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

# 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)

# 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 than 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

# ACEP Resources on Crowding and Boarding

## Emergency Medicine Crowding and Boarding

Search Crowding:

Search

As emergency departments throughout the country deal with the problems of crowding, boarding, and ambulance diversion, solutions have been sought. The resources on this page provide information, resources and examples of a variety of approaches to assist emergency physicians in addressing the crowding problems by working with hospital administrators, local stakeholders, policy makers and the public. Some ACEP chapters have sought relief through state legislative and regulatory action. These additional crowding resources are available in [ACEP's Advocacy area](#).

### [ACEP Sends Comments to The Joint Commission on Patient Flow](#) **NEW**

ACEP supports the proposed definition, including the 4 hour timeframe, opinions among members are varied.

Jan. 19, 2012

### [Associations Join Forces to Reduce ED Crowding](#)

ACEP, ENA and seven other associations have signed a consensus statement that proposes standardized emergency department metrics to help reduce crowding and boarding in emergency departments.

## Boarding/Crowding

- » [Solutions to ER Crowding are "Grossly Underused"](#)
- » [Publishing Wait Times for Emergency Department Care, June 2012](#)
- » [ER Crowding Growing Twice as Fast as ER Visits](#)
- » [Boarding of Pediatric Patients in the Emergency Department](#)
- » [ACEP Letter to The Joint Commission Regarding Revised Standards Related to Patient Flow in the ED](#)

[www.acep.org/content.aspx?id=32050](http://www.acep.org/content.aspx?id=32050)

## [Emergency Department Crowding: High-Impact Solutions](#)

This comprehensive 2008 report from the ACEP Boarding Task Force includes low and no-cost solutions to the practice of boarding patients in the emergency department.

### [ACEP's Suggested Boarding Solutions Generate National Support](#)

May 30, 2008

### [Crowding Case Studies](#)

Submit your case study for publication on ACEP.org.

### **Related ACEP Policy Statements**

#### **Boarding**

[Boarding of Admitted and Intensive Care Patients in the Emergency Department](#)

[Boarding of Pediatric Patients in the Emergency Department](#)

[Definition of Boarded Patient](#)

[Health Care System Surge Capacity Recognition, Preparedness, and Response](#)

[Responsibility for Admitted Patients](#)

[Writing Admission and Transition Orders](#)

#### **Diversion**

[Ambulance Diversion](#)

[PRFP for above policy:](#)

# Urgent Matters



An initiative to improve hospital patient flow and reduce emergency department crowding

<http://urgentmatters.org>



[About Urgent Matters](#) [E-Newsletter](#) [Webinars](#) [Toolkit](#) [Resources](#)



## Announcements

**Urgent Matters Conference: Coordinating and Improving Emergency Care in the Era of Reform**

October 7, 2012 - 12:45-5 PM

Join Urgent Matters and the American College of Emergency Physicians for a half-day event exploring the new era of health reform and the implications for the emergency department. Multidisciplinary leaders in the field will discuss acute care coordination, resource utilization, patient experience, and quality improvement in the ED. Additionally, the workshop will address the necessity of an appropriate emergency care setting for the growing aging population.

## URGENT Matters E-Newsletter

Volume 9, Issue 3

Summer 2012

### Crowding

Emergency department (ED) crowding has reached epidemic proportions across the country. We all know that crowded EDs lead to longer wait times and lead to poorer patient outcomes. This issue of the Urgent Matters E-Newsletter features two low cost ways to reduce ED crowding and improve patient safety and a review of the Joint Commission's new patient flow standards.

By focusing on patient intake and using a team approach Dr. Joseph DeLucia and his colleagues at Saint Louis University Medical Center were able to reduce left-before-being-seen rates and improve patient satisfaction.

Natalie Schmitz, MMSc., PA-C, SEMPA President and her colleagues discuss how PAs can be utilized to improve ED crowding in this issue's Best Practices article.

The third article in this issue reviews the Joint Commission's new patient flow standards. [Sue Dill Calloway RN MSN JD CPHRM](#), from the Emergency Medicine Patient Safety Foundation explains the impact of the revised standards that will go into effect January 1,

## What's Happening in Emergency Care

### ACEP Scientific Assembly

October 8 - 11, 2012

Join the American College of Emergency Physicians in Denver for the world's premier emergency medicine conference. Featuring over 300 educational courses, Pre-conference CME opportunities, and the largest exhibit program in the specialty - you can't miss out on this one-of-a-kind experience!

Approved for AMA PRA Category 1 Credit™

[Register Now!](#)

### 2013 NAEMSP® Annual Meeting

January 10-12, 2013

Featuring specialty workshops, scientific assembly and trade show at the Hyatt Regency Coconut Point Resort and Spa in Bonita Springs, Florida.

[Start Planning Your Trip Today](#)



# 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.

# 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](http://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**

# 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

# 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

# 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 \$1.7 million (95% CI \$1.1 to \$2.3 million) in costs.

# 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

# 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

# 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

# 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.

# 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

# 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.

# The TJC Patient Flow Standards



# 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

# 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

# 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

# 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

## 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?

# 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?

# 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”

# 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

# EMTALA Manual

## State Operations Manual

### Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

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*(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](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_Appendixtoc.pdf)

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

§489.20 Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities

# So What's in Your Policy?

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## 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

## DIVERT NOTIFICATION CHECKLIST

DATE: \_\_\_\_\_ TIME INITIATED: \_\_\_\_\_ 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: \_\_\_\_\_

_____ <b>Appropriate bed unavailable:</b>	_____ <b>Staffing/personnel issue:</b>
_____ Security room	_____ Acuity/staffing ratio
_____ Monitored beds	_____ Support services unavailable
_____ Capacity maximized	_____ Specialty physician not available

_____ <b>Equipment problem:</b>	_____ <b>Disaster:</b>
_____ Utility outage	_____ Severe weather
_____ (specify) _____	_____ Fire
_____ Capacity in service	_____ Manmade (type) _____

### NOTIFICATIONS (check all that apply)

_____ Appropriate Service Areas	_____ County Communications (911)
_____ Local Ambulances (via radio)	_____ Other Facilities: specify _____

\_\_\_\_\_ Department of Health (If greater than 8 consecutive hours or 12 hours in a 24 hour period.) Refer to ADM59

.....  
**BRIEF SYNOPSIS OF EVENTS LEADING TO DIVERT**

# 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

# 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

## 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

## 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

## 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

## 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

## 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.

## 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

# 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

# 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?

# 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

# 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, at [www.fgiguilines.org/wp-content/uploads/2015/05/DesignGuideBH\\_7.0\\_1505\\_rev-2.pdf](http://www.fgiguilines.org/wp-content/uploads/2015/05/DesignGuideBH_7.0_1505_rev-2.pdf)



# Design Guide for the Built Environment of Behavioral Health Facilities

[www.fgiguilines.org/wp-content/uploads/2015/05/DesignGuideBH\\_7.0\\_1505\\_rev-2.pdf](http://www.fgiguilines.org/wp-content/uploads/2015/05/DesignGuideBH_7.0_1505_rev-2.pdf)

*Now with  
Patient Safety Risk Assessment Tool*

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by James M. Hunt, AIA, NCARB  
and David M. Sine, DrBE, CSP, ARM, CPHRM

# 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.

## Personal De-escalation Plan

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Losing control    | <input type="checkbox"/> Assaultive behavior | <input type="checkbox"/> Restraints/Seclusion  |
| <input type="checkbox"/> Feeling unsafe    | <input type="checkbox"/> Running away        | <input type="checkbox"/> Feeling suicidal      |
| <input type="checkbox"/> Injuring yourself | <input type="checkbox"/> Suicide attempts    | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Other: _____      |  |  |

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Not being listened to  | <input type="checkbox"/> Feeling pressured | <input type="checkbox"/> Being touched      |
| <input type="checkbox"/> Lack of privacy  | <input type="checkbox"/> People yelling    | <input type="checkbox"/> Loud noises        |
| <input type="checkbox"/> Feeling lonely   | <input type="checkbox"/> Arguments         | <input type="checkbox"/> Not having control |
| <input type="checkbox"/> Darkness   | <input type="checkbox"/> Being isolated    | <input type="checkbox"/> Being stared at    |
| <input type="checkbox"/> Being teased or picked on <input type="checkbox"/> Contact with family _____ |  |   |
| <input type="checkbox"/> Particular time of day/ night: _____   |  |   |
| <input type="checkbox"/> Particular time of year: _____   |  |   |
| <input type="checkbox"/> Other: _____   |  |   |

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

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

# 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

# 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

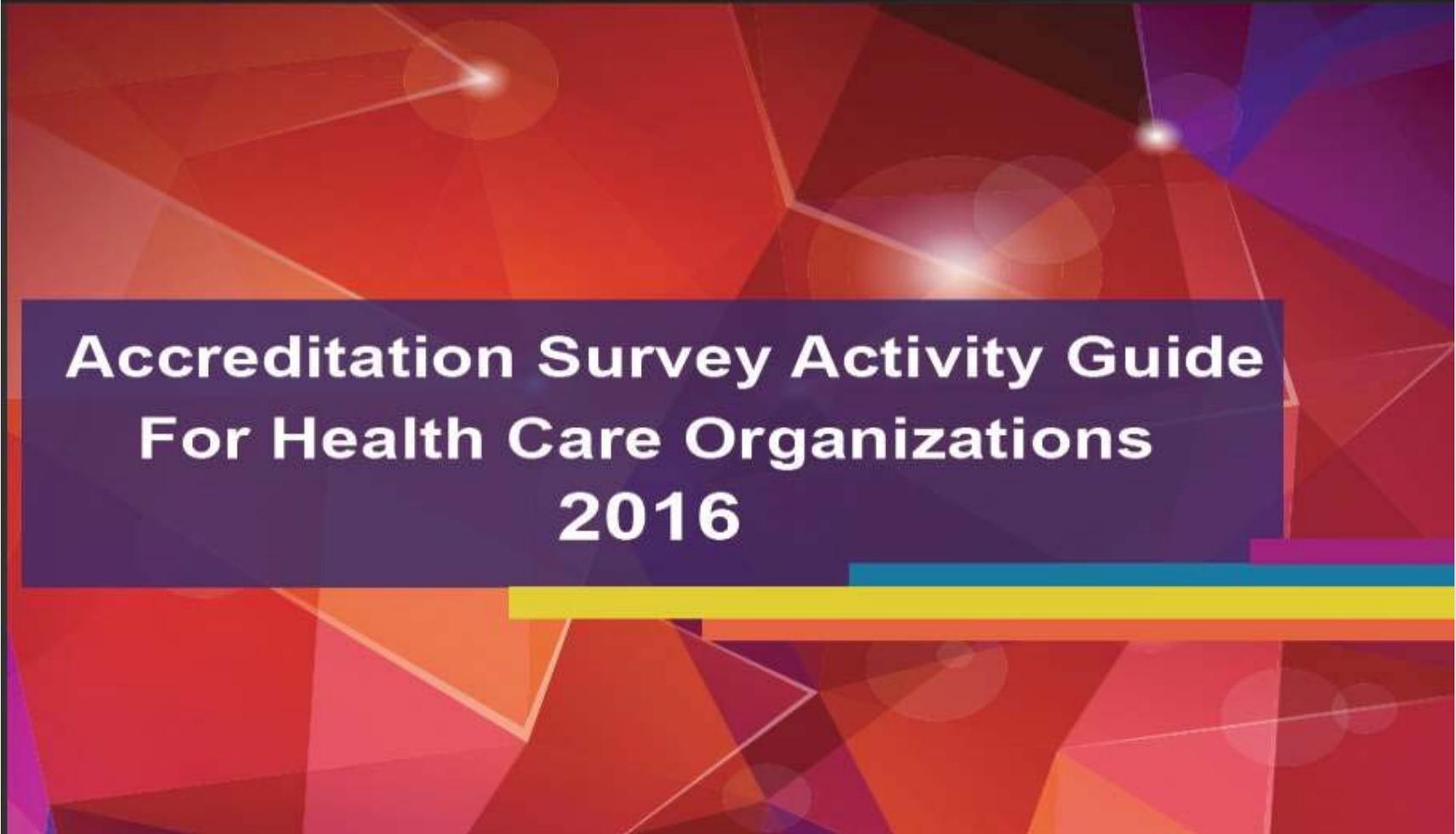
# TJC Patient Flow Tracer



# 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

# 2016 Survey Activity Guide



**Accreditation Survey Activity Guide  
For Health Care Organizations  
2016**

# Survey Activity Guide Tracers Page 49

<b>During survey – Sessions are generally in order of the survey agenda</b>		
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
<b>Program-Specific Tracers: (conducted during Individual Tracer Activity)</b>		
• Continuity of Care	AHC	43
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• Continuity of Foster/Therapeutic Foster Care	BHC	45
• Violence	BHC	46
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• Laboratory Integration	HAP, CAH	48
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Competence Assessment and Credentialing/Privileging	AHC, BHC, NCC, I.T.2, OBS, OME	57

# Patient Flow Tracer

## Program Specific Tracer – Patient Flow

Applicable Programs  
CAH, HAP

**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

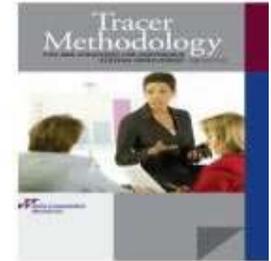
The surveyor will:

- 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 identify and correct patient flow issues throughout their organization. While evidence of patient flow issues

# Introduction to Patient Tracers



- Purpose is to evaluate compliance with the standards as they relate to the care and treatment of a patient <sup>1</sup>
- 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
- <sup>1</sup> Tracer Methodology: Tips and Strategies for Continuous System Improvement, 2<sup>nd</sup> edition, TJC

# 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

# TJC Patient Flow Tracer

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

# 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

# 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.

# 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

# 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

# Behavioral Health Patients Boarded in ED

- Surveyor instructed to review medical records of boarded patients
- To make sure assessments and reassessments done including medical, mental status, and psych assessment
- Consider suicidal risk
- Care planning and identify care providers and family members or others with role in care planning
- Evaluate communication and coordination with other staff such as social work, and psychiatry

# 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

# Patient Flow CAH and HAP Programs

- **Program Specific Tracer:** 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

# 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?

# 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

# 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

# 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

# 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

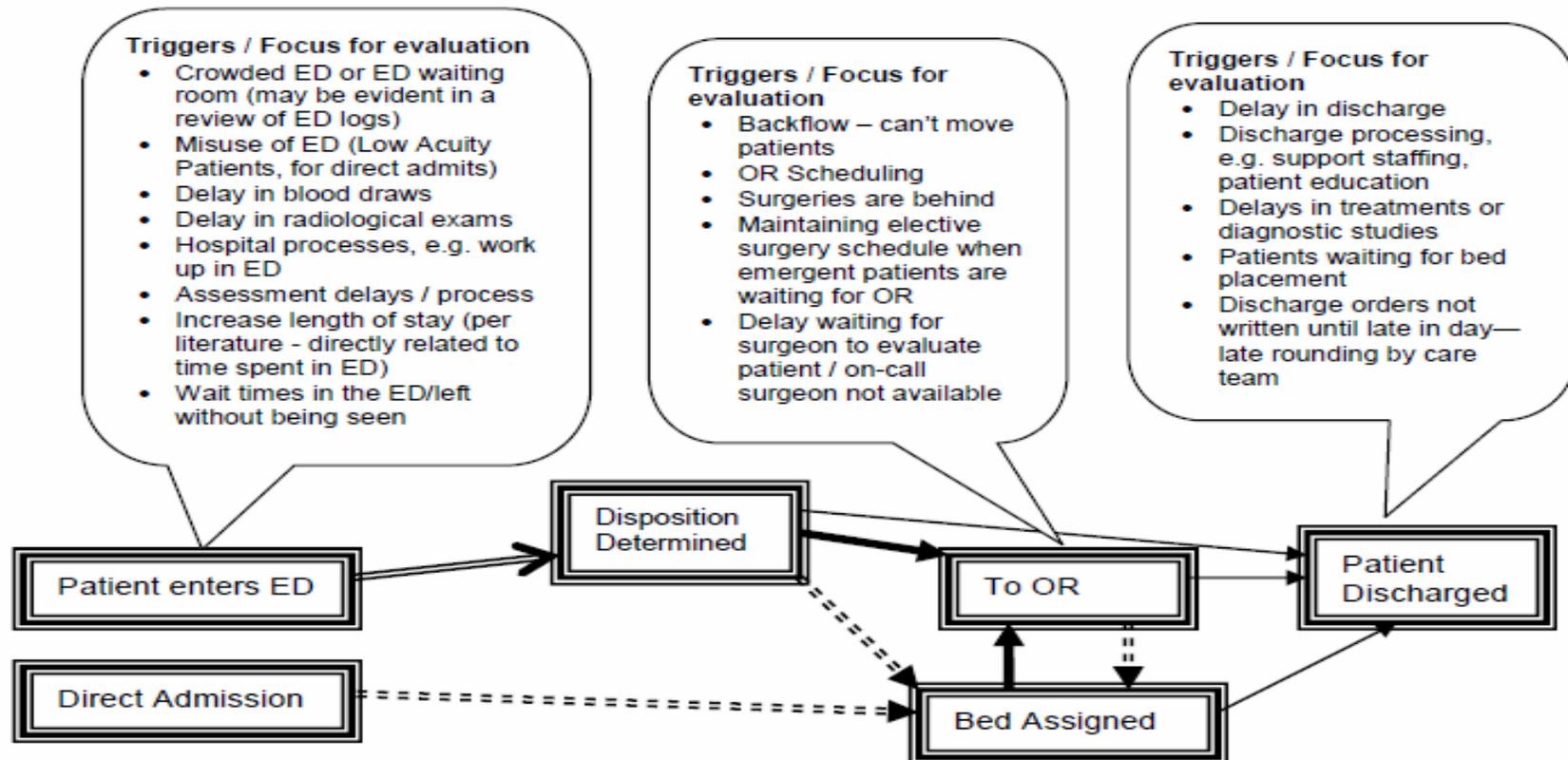
# Patient Flow Tracer

- 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

# 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

## Patient Flow Triggers



### How to use this diagram

An alert will display in the PFP screen when surveyors access the organization's Priority Focus Areas. The lack of an alert does not mean that patient flow problems do not exist in the hospital; but rather, it means that they did not have specific outcome indicators that have a proven association with patient backflow. While surveying hospitals that have not triggered a patient flow tracer, surveyors must look for other triggers documented in the literature. These triggers may be directly observed, provided by patients, staff, or leaders during interviews, or reported as part of the organization's analysis of patient backflow. This diagram represents the triggers that may be present at various points of care. When a trigger is identified, surveyors

### Triggers / Focus for evaluation

- No available med-surg bed
- No critical care bed
- Hospital processes, e.g. lack of housekeeping protocols
- Insufficient support and ancillary staffing levels
- Day of week
- Time of Day
- Hand Off from critical care to other locations
- Discharge Processing

# 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

# Behavioral Health Patients in the ED

- Will ask about the practice of sitters
- How often is care provided to patients
- Will ask if patients placed in hallways when ED bays are full
- What suicide risk reduction actions are taken
- What contacts with community resources
- Ask how care is provided until disposition
- Ask about case management and social worker availability in the ED

# Patient Flow Through the ED

- If surveyor finds out the ED goes on diversion frequently;
  - Will ask to see staffing plan for period they were on diversion
  - Will ask if there is a plan to intervene when census meets a certain threshold
  - How does the OR handle elective surgeries pre-diversion?
  - How does the hospital decide to convert other areas into patient rooms like the PACU

# Planning Session

- During the planning session for metrics regarding EP 5 of LD.04.03.011 regarding the supply of patient beds and the safety of care areas and access to support services
  - Determine if there are performance goals and incremental targets for each of the patient flow processes
  - Ask about the measures that in place
  - How they monitor the data of their performance based on their goals
  - Are they benchmarking themselves against external associations or research initiatives

# 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

# CMS ED Throughput Measure

Medicare.gov

The Official U.S. Government Site for Medicare

Close Window

Print

<http://www.medicare.gov/HospitalCompare/Data/emergency-wait-times.aspx>

About the Data

About Hospital Compare data

Timely and Effective Care measures

Measures of Readmissions, Complications and Deaths

Outpatient Imaging Efficiency measures

Patients' survey

Number of Medicare

## *Emergency Department Throughput Measures*

Long waiting times in hospital emergency departments (EDs) can increase risks for patients, especially those who have serious illnesses. Waiting times at different hospitals can vary widely, depending on the number of patients seen, ED staffing, efficiency, admitting procedures, or the availability of inpatient beds. The measures for Emergency Department Wait Times include:

- ED-1-Average (median) time patients spent in the ED, before they were admitted to the hospital as an inpatient
- ED-2-Average (median) time patients spent in the ED, after the doctor decided to admit them as an inpatient before leaving the ED for their inpatient room

HOSPITAL NAME	ED-1	ED-2
COMMUNITY HOSPITAL INC 805 FRIENDSHIP ROAD TALLASSEE, AL 36078	183 MINUTES <sup>2</sup> 85 PATIENTS	54 MINUTES <sup>2</sup> 44 PATIENTS
CHILTON MEDICAL CENTER	196 MINUTES <sup>2</sup>	50 MINUTES <sup>2</sup>

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

Clinical Quality Measure (CQM)				
CQM Measure (CQM)	CQM Subset	Numerator	Denominator	Exclusion
ED-1 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
	1.2 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
	1.3 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
ED-2 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

# The End! Questions??



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- Dublin, Ohio 43017
- 614 791-1468 (Call with Questions, No emails)
- [sdill1@columbus.rr.com](mailto:sdill1@columbus.rr.com)

# 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](http://www.nap.edu/catalog.php?record_id=11621) (accessed February 14, 2013)

# Resources

- [www.hospitalovercrowding.org](http://www.hospitalovercrowding.org)
  - Dr Peter Viccellio
  - Overcrowding power point slides
  - Key points of harm caused by overcrowding
  - Full capacity protocol, etc.

**This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.**

# Thanks for attending!



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