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Reimbursement for end-of-life planning offers dividends to emergency providers

But specialty training, resources are needed to ensure quality service and outcomes

In a move many consider long overdue, the Centers for Medicare and Medicaid Services (CMS) has signaled that it is now prepared to reimburse providers for advance care planning discussions.

Such conversations are already covered when patients first enroll in Medicare, but acknowledging that more flexibility in the timing, and perhaps frequency, of these conversations is needed, CMS is proposing to set up a separate payment system along with advance care planning codes so these conversations can take place at the most appropriate time for patients and families.

While the details regarding any documentation requirements and reimbursement levels are still being worked out, and final approval still must take place, CMS proposes to implement the new policy in January 2016.

That means hospital administrators need to review what resources they have in place to help patients and their families make these important decisions,

and to consider what policy changes may be needed to ensure providers are equipped with the skills and training required to provide this service. (*Also see: "More education, support on end-of-life care issues needed for prehospital providers," p. 100.*)

Further, experts suggest emergency providers in particular may need to up their game with respect to both discussing treatment and palliative care options for patients who present with end-stage diseases and conditions, and interpreting the choices of patients who have already made their wishes known in advance care planning documents.

Advance planning offers dividends

Bernard Hammes, PhD, the director of Medical Humanities and Respecting Choices, an advance care planning program established by the Gundersen Health System in La Crosse, WI, suggests

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emergency providers have much to gain from having this type of payment system in place for advance care planning discussions. “They would then have the likelihood that when patients come [into the ED] in an emergency and have a serious medical problem they will have some clearer direction about who is going to make decisions when the patient can’t and what decisions might be favored or preferred by the patient,” he explains.

Hammes is in a position to know about the impact of advance planning because the Respecting Choices model has been in place in La Crosse, WI, for more than 20 years. “For adult residents of La Crosse County who come and receive care in any care setting at the end of life, 96% of the time we have a written care plan in the medical record,” he says. “It is quite possible that in the ED a decision can be made not to proceed to surgery or not to proceed to the ICU because the medical condition of the patient is so clearly identified and the health care agent is so understanding of the patient’s preferences — [which are] so clear that they are in the medical record. The family and the doctor in those circumstances can say, ‘call palliative care and have them take over management of the care of this patient from this point in the ED going forward.’”

Hammes observes that while advance health care planning should take place long before the patient presents to the ED, it nonetheless impacts emergency services. “It allows the right decision to be made at the right time for that patient and that family,” he says.

Further, while the CMS proposal is a “great first step,” according to Hammes, he notes that more steps are needed. “What Medicare is putting into place is the potential or the

proposal to pay at least some group of providers to initiate and have these conversations, but there are other things that need to be put into place,” he explains. “We have to have a way of capturing that [advance] care plan in the medical record so that it is actually available in the ED, and then we also have to train emergency physicians how to look at, to read, to understand, and then appropriately use that plan in decision-making, even in an emergency.”

Many experts believe emergency providers have been forced into plugging gaps in existing end of life issues, and that the federal effort to improve availability and consistency of this planning process will reduce the burden on the emergency system in significant ways.

Conversations require repetition

Mary Minton, PhD, the associate dean of the graduate nursing program at South Dakota State University in Brookings, SD, is pleased that CMS has plans to reimburse for end-of-life discussions, but having led a team of researchers to investigate what palliative care and end-of-life resources are available in a range of health care facilities in her state, she anticipates a steep learning curve ahead.

“It will require specialty training, because this is not a skill that most of us are equipped with. Some of us intuitively are open to engaging in [end-of-life care discussions], but by and large our medical model, our health care culture, is still rather cure-oriented,” Minton says. “So I love that this is happening, but it must be addressed with a deep amount of intention, planning, and evaluation.”

Minton observes that there

are a number of well-established educational programs that address end-of-life planning and care, including Education in Palliative and End-of-Life Care (EPEC), which offers a range of curricula geared toward different specialty areas, including emergency medicine (www.epec.net), and the End-of-Life Nursing Education Consortium (ELNEC) of the American Association of Colleges of Nursing, which offers programs for nurses (www.aacn.nche.edu/el nec). The Respecting Choices program in La Crosse, WI, also offers education and training in a range of formats (www.gundersenhealth.org/respecting-choices/training-and-certification/online-courses/facilitator-curriculum).

Minton envisions the need for a two-pronged effort aimed at equipping medical providers with the knowledge and skill to both discuss end-of-life care and interpret patient instructions. “We have to focus on our undergraduate and graduate programs, but we also have to equip our practicing providers because they are the ones dealing with the complexity of the health care environment. Sometimes it appears there is no time for this conversation or counseling, which is why intention is so important,” she explains. “To put this as a billable item — that ratchets it up to a place of importance so that it is a line item ... but my concern is that it needs to be lockstep in that we always make sure we address it, but not at a surface level, because this kind of conversation requires repetition.”

Further, Minton stresses that end-of-life planning needs to be an interdisciplinary exercise. “In my work in palliative and end-of-life care, the team is the hub. It is a team process of communication, whether it involves deciding what treatment [options] to choose, considering how to interpret

EXECUTIVE SUMMARY

With the announcement by the Centers for Medicare and Medicaid Services (CMS) that it plans to begin paying providers to engage patients in end-of-life planning discussions, experts suggest emergency providers will need to up their game in terms of both discussing end-of-life care options with patients and families, as well interpreting choices that patients have spelled out in advance planning documents. A final decision on the proposal is not expected until November, but CMS has signaled that it is ready to implement the policy in January 2016.

- Experts suggest the move will ultimately give emergency providers clearer direction on patient preferences when they present for care with end-stage conditions.
- They also agree that more specialty training is needed to educate providers on how to effectively engage patients and families in advance planning discussions.
- Experts also advise hospitals to consider quality control procedures to ensure patient choices regarding end-of-life care are being followed.

patient wishes, or how to manage symptoms,” she says. “It is complex, and despite the documents that might be in place and the discussion that has taken place, at any given moment it can still be a moving target.”

In all of these scenarios, the burden of discussion shifts into the primary care arena, and the practices of physicians who see patients with terminal illnesses will see the most change, and will receive the most reimbursement.

Physicians need to engage

Hammes is eager to get the details regarding how reimbursement would work under the CMS proposal, and he intends to offer suggestions during the comment period that CMS is facilitating regarding who should be having these end-of-life planning discussions with patients.

“These are complex conversations and not everyone has the knowledge or communication skills to do this well, and so if I have a concern about Medicare’s decision, it is that while I

support the concept of providers being paid for this, I think we still haven’t had a conversation about who should be providing this service,” Hammes says. “Our experience in Respecting Choices is that physicians simply do not have enough time, when you look at all their responsibilities and obligations to patients, to have this additional responsibility.”

Hammes also intends to offer input to CMS about the training required to skillfully conduct these advance planning conversations. “We wouldn’t pay a family practice physician to do open heart surgery because they are not trained to do open heart surgery,” he says. “This does take skill, it does take competence, and it does take knowledge, and if people are going to have these conversations, I think they should have the competence to do it, and do it well so that the service we are paying for is actually beneficial to the patient and the family.”

While physicians may not be in the best position to conduct end-of-life planning conversations, they nonetheless need to be involved, Hammes stresses. “The physician has two important roles here. One is to

More education, support on end-of-life care issues needed

Emergency medicine technicians (EMT) and paramedics are, at times, the first medical personnel on the scene of a patient who may wish to not initiate, or to discontinue, life-saving care. But he or she requires education and protocols that direct the process. Further, there may be family conflict over such decision-making, requiring much more from first-responders than what their clinical training has equipped them to provide, according to **Deborah Waldrop**, LMSW, PhD, a professor and the associate dean for faculty development in the School of Social Work at the University of Buffalo in Buffalo, NY, who recently led a team of researchers to explore the role of first responders in dealing with end-of-life situations.¹

“Emergency calls at the end of life are intense and emotional, often engendering more need for family intervention than medical care,” notes Waldrop, who is an expert on advance care planning. “Additional education about the nature of end-of-life calls, family conflict and resolution, family emotions, and clarification of protocols between health care providers (e.g., nursing homes, hospice, and hospitals) is needed.”

Among the obstacles that first responders may encounter is the possibility of ethical challenges when they respond to a call for which there is no paperwork stipulating the patient’s wishes to forgo resuscitation, Waldrop observes. Further, she notes patients and families may not fully understand the implications of specific decisions.

“People often do not know what is involved in resuscitation and what will happen when a loved one who is dying is transported to an ED,” Waldrop says. “They just know that when they need help they will have a response in less than 10 minutes from an EMS team.”

What would also help EMTs and paramedics is more public education about legally binding documents that describe end-of-life care decisions and the need for people to engage in advance care planning before medical crises occur, Waldrop advises. Further, she suggests that all health care providers need to be brought up to speed about what the scope of practice is for prehospital providers, and what they can expect and not expect from EMT teams in the field.

Waldrop believes that the current proposal by the Centers for Medicare and Medicaid Services (CMS) to more liberally pay for advance planning sessions would help address many of these concerns.

“Currently, when conversations about end-of-life wishes do take place, they are often very near death when many important other opportunities [to discuss these matters] have been missed,” she says. “CMS payment for earlier conversations would promote the importance of talking about what is hoped for and what is realistic, helping families and providers know what to do and be as comfortable as possible with that before a medical crisis occurs.” ■

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introduce the topic to the patient, and to say to his or her patient that this is something we routinely do, and we know we can provide better care to our patients and their families when they are willing to engage with us in this planning process,” he says, noting the patient can then be handed off to a specialist who has the time to sit down with the family and have the full discussion. “This kind of motivation or introduction by the physician is really important in engaging the patient.”

The second important role for the physician has to do with answering questions about treatment options, diagnoses, and other medical issues that impact the planning process, Hammes explains. “Facilitators need to be trained so that they work collaboratively with the physician so that when a patient says they have a question about their medical condition or that they don’t know if they understand it well enough, the facilitator knows how then to bring the physician into that discussion to get the information needed by the patient.”

A third area where Hammes plans to offer suggestions to CMS has to do with what specifically should take place in the course of an advance planning session. “Many of us have some very clear, well-researched ideas about what things actually matter and help in these discussions, and what kind of training is required for that assistance to actually be beneficial,” he says. “If it is simply handing a document to someone and saying, ‘let me show you how to fill out the boxes,’ that is not planning. That is filling out paperwork, which we know doesn’t work, and sometimes creates more problems than it solves. So there are some very clear things that need to happen in terms of the planning process.”

Implement quality controls

Once systems and policies are in place to integrate advance care planning into the care process, hospitals need to take steps to ensure quality, Hammes advises. He observes that one way Gundersen Lutheran Medical Center does this is by leveraging the hospital's existing quality infrastructure.

"Like every hospital, we have a peer review committee that reviews the deaths of patients in our hospital to make sure there were no mistakes and that high quality care was provided despite the outcome," Hammes notes. "One of the things that our peer review committee always looks at is whether the patient had an advance directive, and if they did, was it appropriately used by the treating physician in making decisions."

For instance, if the peer review committee found that an emergency physician ignored, misread, or misused a patient's set of preferences, that would be something they would take up with the physician to find out why there is a discrepancy between the patient's wishes and what the physician did, Hammes explains.

"There are lots of things that can happen ... but at our hospital, if in fact the physician does not appropriately use the advance directive in decision-making, we consider that a medical error," Hammes notes. "That would be called out, and there would be some sort of corrective action taken, if needed."

While the next steps may be complex, Hammes urges hospital administrators to acknowledge there is ample room for improvement when it comes to end-of-life planning. "The previous approach, which has involved simply asking patients whether they

have an advance directive, and then giving them a pamphlet about their legal rights — a step required by federal regulation under the Patient Self-Determination Act — has not worked and will not work," he stresses.

The existing federal and Joint Commission standards do not go far enough, Hammes adds. "The only thing we have seen that improves care is these more sophisticated and in-depth conversations that involve the patient and their family," he says. "We know how to do these things now, they do improve care, and I think it is what we should expect out of our health care systems — to deliver to patients as a way of making care better, and really helping families through some of the most difficult moments of their lives."

ONCE SYSTEMS
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Take stock of existing resources

While CMS is not expected to make a final decision about its proposal until November 1, both Hammes and Minton agree hospital

administrators should now be taking stock of their existing infrastructure for end-of-life planning. "Each institution is a little bit different in how they go about this," Minton notes. "Some have palliative care referral teams, which are great. We are seeing more and more of those. And some of this is done informally already. It is important for each institution to first assess what they do have in place, what their strengths are, and where do they need specialty training."

Physicians, in particular, need to be informed by a team, but if they are the ones being reimbursed, they need to be prepared to step up to the plate and initiate these discussions, Minton advises. "It involves being able to look at the horizon of what the patient is going through and saying, 'OK, this is the time when it is appropriate [to have the discussion].' I can't say that is an easy call, but the more you do it, you become better versed in it, and that is where mentoring becomes important," she explains. "We are at a point of saying, 'this is worth reimbursing. This is important. It is meant to improve outcomes, and it is meant to decrease costs.'" ■

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Pediatric emergency care coordinator role associated with improved 'readiness'

Clinicians in this role focus on quality improvement, staff education, and adherence to national guidelines for pediatric care in nation's EDs

A new study suggests that EDs that have a pediatric emergency care coordinator (PECC) — a physician or nurse who is assigned to address staff training, equipment, and policies pertaining to the care of children — are better prepared to meet the needs of young patients than EDs that do not. This is among the findings gleaned from responses to a web-based assessment designed to measure compliance with national guidelines for pediatric readiness.¹

The assessment, which was conducted between January and August 2013, is part of a collaborative quality-improvement initiative of the American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA). Researchers received completed assessments from 4137 EDs for a response rate of 82.5%. They found that pediatric readiness, as defined by a weighted pediatric readiness score (WPRS), has improved markedly since a similar assessment was conducted in 2003. Overall, pediatric readiness increased to 70 out of 100, an increase of 15 points from the 2003 assessment. At the same time, the response rate to the survey greatly improved as well, as only 29% of the EDs queried in the earlier survey responded.

Investigators say the presence of a PECC was associated with higher WPRS measures across all pediatric volume categories, and that a PECC also increased the likelihood an ED possessed all the components for quality pediatric care recommended

in national guidelines.

"We do know that by having [a PECC] you are much more likely to have a quality improvement plan, which, is, in and of itself, a quality measure," explains **Marianne Gausche-Hill**, MD, FACEP, FAAP, the lead author of the research and the director of Emergency Medical Services at Harbor-UCLA Medical Center in Torrance, CA.

Gausche-Hill adds that EDs with a PECC are also more likely to have all the recommended equipment as well as all of the recommended policies in place to care for young patients. "We know from our paper that the likelihood of having all the things that are specified in the guidelines is four times more likely if you have a PECC," she observes.

This focused attention on pediatric care needs is important because while most community EDs see a high volume of adults, and become accustomed to the care needs of adults, they generally see far fewer young patients.

"Sick children are not high-volume for a large majority of hospitals, even though more than 80% of children are seen in non-children's hospitals in emergency settings," Gausche-Hill notes. "So we have to, from a systems perspective, address the needs of children, and really the way we do that is by assigning these [PECC] roles."

Gausche-Hill adds that while much depends on the resources and support that a PECC receives in a given ED, the research shows having a PECC makes a difference, although

just under half of the nation's EDs actually have someone filling this role, according to investigators.

Leverage networking opportunities

The role of PECC was originally created more than 20 years ago in Los Angeles. The precise title given to someone who assumes this role varies from region to region, but in Los Angeles, PECCs are referred to as pediatric liaison nurses, explains **Nancy McGrath**, MN, RN, CPNP-AC/PC, a pediatric nurse practitioner who has assumed this role at Harbor-UCLA Medical Center.

Here, having a pediatric liaison nurse is one of the requirements for having an EDAP designation, signifying the ED is approved to care for pediatric patients. Hospitals in Los Angeles are surveyed every three years to maintain the EDAP designation.

However, beyond the survey, McGrath acknowledges the success of the PECC/nurse liaison role depends both on support from administration and time to do the job.

"We do quality improvement, education for staff, and we attend hospital meetings that pertain to pediatric emergency care," McGrath notes. "We also attend monthly pediatric liaison nurse meetings with the other 46 pediatric liaison nurses for Los Angeles County."

This type of networking helps to insure that advances in quality and safety get disseminated to all

the EDAP facilities quickly. For instance, McGrath recalls that when the ACEP and ENA both came out with position papers stating that all children should be weighed in kilograms, since medication dosages are based on weight in kilograms, McGrath made sure that all the scales in the ED were locked on kilograms. “We had them disabled so that they couldn’t weigh kids in pounds,” she says. “In Los Angeles County, at our monthly meeting of the pediatric liaison nurses, we shared this information, and then all of the facilities did the same thing, so kids in Los Angeles County are not weighed at all in pounds in any of the EDAP facilities.”

In addition to these activities, McGrath sits on a pediatrics advisory committee that oversees all the policies and procedures for the care of children in the pre-hospital arena. “You sometimes have to go the distance to find what is new and what is happening so that you can bring it back to your staff,” she explains.

Facilitate education

Laura Garcia, RN, the pediatric liaison nurse at PIH Health, a community hospital in Whittier, CA, agrees the networking meetings offer tremendous value.

“You don’t have to re-create the wheel every time. Within our pediatric liaison group we share policies, standards, and any new articles that are coming out,” she says. “I work at a community hospital, so I don’t have the resources that a children’s hospital has. I need to find out what they are doing and how I can best meet the same goal of care.”

Garcia spends much of her time doing chart audits and identifying problems so she can then set about

the task of taking corrective action and educating staff on the change process. For instance, when a young pediatric patient who had presented to the ED later developed sepsis, Garcia spearheaded an educational initiative on septic shock for all the nurses and physicians in both pediatrics and the ED, and she worked with colleagues to implement the practice of running an early warning score for sepsis on all patients before they are transferred from the ED to an upper floor.

“In addition to that, we have now changed our practice in the entire ED so that every patient who comes through gets a sepsis screening exam on presentation,” she explains.

In addition to quality improvement activities, Garcia hosts educational conferences on pediatric issues every other year, and she runs through mock codes with nurses so they will be prepared to make use of tools or equipment designed for patients or events that do not occur that often.

“I also keep track of everyone’s education to make sure they are complying with the standards we have,” she explains. “It is a day in and day out type of thing. You have to live this role and not just try to make it about the survey.”

Keeping the focus on readiness

While investigators saw much improvement in pediatric readiness in the latest assessment, the exercise also highlighted areas that require attention. For instance, less than half of respondents (47%) reported having a disaster plan that specifically addresses the needs of children, at least 15% said they lacked at least one specific piece of equipment recommended in the guidelines,

and more than 80% reported facing barriers to the implementation of the guidelines. The most common barriers cited were training costs and a lack of resources.

However, Gausche-Hill observes that simply doing the assessment should spur improvement in many of these areas.

“More than 80% of EDs are now aware these guidelines exist and that perhaps they should follow them,” she says. “We gave [respondents] immediate feedback, including a gap analysis with the top three things they needed to do to improve their readiness.”

In addition, Gausche-Hill notes respondents were also equipped with resources for improvement so that they would not have to start from scratch. She says the goal for the future is to keep re-evaluating and providing feedback so EDs can continue to make strides on pediatric readiness. ■

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Study suggests more training, support for nurses treating patients with behavioral health concerns

Specialized protocols can speed care, put providers and patients on the same page

Caring for patients with behavioral health (BH) concerns presents a number of challenges in the emergency setting. Studies have shown that such patients often experience long lengths-of-stay (LOS) while awaiting care from a specialist or referral to another facility. These problems, in turn, can lead to crowding, boarding, and other issues that ultimately impact non-BH patients in the ED as well.

What can EDs do from a nursing perspective to improve care for this patient population while also eliminating some of the spill-over effects on other patients? A new study from the Emergency Nurses Association (ENA) suggests nurses perceive that more guidance in terms of practice guidelines and

specialized protocols is needed in this area. Further, they voice frustration about what they perceive as a lack of tailored education as well as resources to optimally care for BH patients presenting with mental health crises and concerns.

An analysis of survey data and information gleaned from focus group sessions suggests there are several interventions that, at least from a nursing perspective, could potentially improve the care BH patients receive in the emergency setting and shorten their stay there as well.¹

Address gaps in training

The study involved a combination of self-report surveys and focus group responses on a range of issues not

well covered in the literature, explains **Lisa Wolf**, PhD, RN, CEN, FAEN, the lead author of the study, director of ENA's Institute for Emergency Nursing Research, and a clinical assistant professor of nursing at the University of Massachusetts in Amherst, MA. "There was really not a lot of information on such things as LOS, models of care, or the role of nursing in the care of BH patients," she says. "So we developed a survey to perhaps answer some questions about what kind of care models were being used, what nurses felt in terms of preparation, and what they felt about attitudes toward BH patients."

The 35-item survey was developed in concert with a committee of emergency nurses with expertise in BH care, and it covered topics related to preparation/training, confidence levels, average LOS, the use of protocols, availability of dedicated BH staff, the use of chemical and physical restraints, and dedicated space for BH care.

"We sent out [the survey] and got about 1230 responses, and then we triangulated that data, using focus groups at our annual conference in Nashville in 2013," Wolf explains. "We had about 20 nurses split into two groups ... and we told them to tell us about their experience in caring for BH patients, and really put flesh on the bones of those quantitative [survey] questions."

The survey responses and focus group comments indicate that while nurses want to provide good care to BH patients, they feel they are inadequately prepared to do so, Wolf explains.

EXECUTIVE SUMMARY

A new study involving nurse-level data suggests nurses feel under-prepared to care for patients who present to the ED with behavioral health (BH) concerns, but it also notes that they would be highly receptive to receiving added training and support in this area. Further, researchers stress the need for specialized protocols to standardize the way BH patients are cared for in the emergency setting.

- Researchers found that a huge percentage of nurses had received no BH training beyond nursing school, producing a lack of understanding and frustration.
- Study participants reported that the average length of stay (LOS) for BH patients who present to the ED is 18.5 hours, but researchers found that the presence of a specially trained BH nurse reduced LOS substantially.
- More than half of study participants (57%) noted their hospitals have no inpatient psychiatric unit, and 51% indicated their hospitals have no dedicated treatment area for BH patients.
- Just 35% of respondents reported that their EDs had dedicated BH staff to assist with the management and care of BH patients, and 24% said they did not have a standardized protocol for managing this patient population.

“There is that sense of operating in an informational vacuum a little bit,” she adds. “Plus, our physician colleagues are also not well-prepared to care for these patients. They are very reluctant to do so. They don’t get a lot of training in emergency psychiatry.”

The researchers found a huge proportion of nurses had received no training in BH beyond nursing school. What this means, according to Wolf, is that while a nurse is likely to receive a lot of information about strokes, heart attacks, and similar crises, information about BH crises is not presented in a way that is clinically available. “That lack of understanding produces a lot of frustration,” she says.

For example, while it is quite common in any given ED to find emergency nurses who specialize in trauma, cardiac emergencies, or pediatrics, there also should be nurses trained in caring for people with BH emergencies, Wolf notes.

Employ BH nurses

Study participants reported that the average LOS for BH patients who present to the ED is 18.5 hours, a statistic that is problematic given that studies have shown that such lengthy stays adversely impact care. More than half of the participants (57%) noted their hospitals have no inpatient psychiatric unit, and 51% indicated their hospitals have no dedicated treatment area for BH patients. Just 35% of respondents reported their EDs had dedicated BH staff to assist with the management and care of BH patients, and 24% said they did not have a standardized protocol for managing this patient population.

What factors seemed to make

the biggest difference on LOS? Researchers found the presence of a specially trained BH nurse reduced LOS substantially. “The limitation is that this is nurse-level data, but I would say anyone who uses electronic tracking can look at their board and get a pretty good idea of what the average LOS is in their department,” Wolf observes. “Our finding of 18.5 hours is certainly not outside the realm of plausibility, but using that number, we do see a significant reduction in LOS, given the presence of a nurse trained in BH emergencies.”

Nurses trained in BH do not necessarily have to have prescribing ability to be effective, Wolf says. “When you have someone who has specific training in any given subspecialty of emergency medicine, they know what the plan should be, and they know how to advocate,” she explains. “They can move the care of the patient along and advocate for them in a way that someone without that training might not be able to do.”

Another step that individual departments could initiate is to identify and adopt a protocol so that the care of BH patients is standardized, Wolf offers. “Is everybody doing the same thing when a BH patient comes into the ED from triage to the physician? Is everybody on the same page? Protocols help you to do that,” she says. “I would say the first thing that most departments could probably put into place without an incursion of financial obligations is a protocol to move things along, to have a map for the care of these patients.”

Wolf also advises ED administrators to consider staff training on how to effectively care for patients with BH emergencies. “This can involve the suicidal patient, the

schizophrenic patient who is off his or her medicines, the depressed patient who maybe doesn’t have a plan [for suicide] but you don’t really know for sure, or the potential overdose,” explains Wolf. “How do we keep people safe when there are no external markers?”

Wolf adds that ED administrators should consider implementing a steady dose of in-service training to address such issues. “Dealing with patients with BH crises should be a part of every ED orientation,” she says. “If everyone is on the same page in terms of care, you have less agitation because everyone is clear and everyone is not adrift. They know what happens next — both nurses and patients. That is important.”

A more difficult problem to tackle is the lack of inpatient space for BH patients who are waiting for a bed. Researchers found that this problem certainly leads to extended LOS, but a solution to the problem requires attention at an institutional or societal level, Wolf acknowledges.

Stress education, support

EDs that have effective BH protocols in place as well as a trained BH nurse on site might want to proceed to the next level of care — the use of a psychiatric nurse practitioner, Wolf advises. However, she observes that most EDs still have plenty of room to improve on the implementation of the earlier steps.

“The majority of EDs struggle with this because these long lengths-of-stay tie up beds, contribute to crowding, and reduce the ability of people to care for the other people in the ED,” Wolf notes. “The nurses we spoke to [as part of this study] were passionate in their wish to

provide really excellent care to this population. Nurses want this education. They want to do this well, so if this study goes anywhere towards stressing education, training, and support for the nurses caring for BH patients, then we are on the right track.” ■

REFERENCE

1. Wolf L, et al. U.S. emergency nurses' perceptions of challenges and facilitators in the management of behavioural health patients in the emergency department: A mixed-methods study. *Australas Emerg Nurs J* 2015 Apr 28 [Epub ahead of print].

SOURCE

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ED CODING UPDATE

Heed these advanced coding and documentation concepts for pediatric patients

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

Attempting to use adult coding and documentation criteria for pediatric ED patients can be a costly and challenging process. Diagnosing the problems of infants and small children who can't adequately communicate their problems often requires additional time and expertise but isn't adequately addressed in current coding rules. And trying to sort out Mommy and Daddy's litany of observed problems with Junior requires additional investigation and consideration of a number of potential problems. Documentation requirements for infants and children often require more detail for appropriate documentation of both the medical necessity and the level of medical decision making to support the additional time and effort required.

Below are some of the conditions and interventions that, for infants and children, may require a higher level of medical decision making than for the same problem in an adult:

- Fever
- Discussion with Poison Control, monitoring, observation for ingestion in infant, child

- Charcoal for ingestion of toxic substance
- Pediatric suctioning to clear airway
- Hydration
- Severe pain
- Severe nausea and vomiting
- Pediatric lumbar puncture
- PO challenge
- Observation for response to treatment during ED course
- Bites (human, insect, animal, etc.)
- Sedation for procedures.

As parents become more skeptical about vaccinations, and pediatricians become more careful about use of antibiotics in certain age groups, medical decision making actually increases. This is due in no large part to the number and types of situations and outcomes to consider. Additionally, children with birth defects, terminal conditions, or severe chronic problems who present with either acute exacerbations of their condition or additional problems resulting from treatment of their condition (cancer, diabetes, asthma) may require additional consideration in order to treat effectively.

Complicating factors such as autism, ADD/ADHD, etc. will add to the time and intensity required to treat even minor cuts and bruises.

How can medical necessity be documented to establish the higher level of medical decision making often required to treat pediatric problems? Here are a few tips for documenting appropriately:

1. Be sure to include a complete history of present illness. Ask when the problem first occurred. What made it worse and necessitated an ED visit today? What is the severity of the problem (pain, shortness of breath, treatment-related nausea and/or vomiting, temperature)? What type of home or long-term treatment has been tried and for how long? Is there anything that makes it better or worse? What other problems is the infant/child experiencing?

2. Provide details about each system reviewed that is related to the problem. For example, if it is shortness of breath, provide details about the respiratory, constitutional, cardiovascular, etc., as appropriate with more than just a word or two. And remember, you can't have

a negative review of the system referenced in the history of the present illness as the problem. No negative respiratory for an asthma exacerbation and no negative integumentary for a child with infected insect bites on extremities. For those systems not directly related to the presenting problem and found to be negative, document "All other systems reviewed and negative."

3. Make sure the pertinent elements of past medical, social (living arrangements, school, siblings, etc.), and family history are investigated and documented. In almost all pediatric patients, questions related to a past medical and social history are relevant.

4. Be sure to provide the details of the physical exam for each of the organ systems and body areas examined. Be sure systems related to the chief complaint and any symptomatic systems are referenced with details.

5. Documentation of medical decision making can make or break the payer's view of medical necessity, and it begins with the HPI. Risk factors, past problems, attempts at resolution, and the details about why the parents brought the child to the ED now help support medical necessity. In addition, consultation with the family physician or other specialists, review of available records, or the necessity of obtaining additional history from the parents as the ED course progresses is an indication of the ED provider's concern for problems. With pediatric patients, differential diagnoses and/or provisional diagnoses go a long way toward underscoring the need for diagnostic tests and/or ED treatments. However, emergency physicians may consider these alternatives but decide against them. When this occurs, a discussion of the

considerations for not performing these tests and interventions should be clearly recorded. This is critical in defending payment denials or audits. Also, when parents refuse recommended treatment or disposition, this should be recorded with resulting risks. Kids don't generally get the number and type of diagnostic studies that occur in the adult population, but the risk from their problems can be significant.

6. The diagnosis statement should be precise, and any other problems treated in addition to the primary diagnosis should be listed. For ICD-10 purposes, the more detail about site, type of problem, progression, co-morbidities, surgical treatment provided, diagnostic findings, etc. is essential. For injuries/ trauma, document:

- Cause – what caused the injury?
- Location – where was the patient when the injury occurred?
- Activity/Accidental/Assault? – what was the patient doing?
- Active or Follow-up Treatment – was this the initial or a subsequent encounter?
- Type (contusion, laceration, sprain/strain);

- Detailed location of site;
- Laterality;
- Presence of foreign body.

Finally, watch how you use your documentation templates and voice dictation. The incidence of inappropriate statements and jumbled dictation is becoming more frequent. Check your chart frequently as you complete it and be sure what appears there is what you intended. Auditors find gender-related dictation errors, meaningless text on ROS or PE, and diagnoses containing conditions not referenced anywhere in the record. When this occurs, it calls into question the validity of other information.

Additionally, the failure to document orders that are performed by nursing staff is becoming a common occurrence and is responsible for millions in lost ED facility revenue. If you are ordering meds, IVs, nursing procedures, etc., be sure they are documented appropriately. Documentation defends the treatment provided and the bill you send to the patient or insurer. Be sure you defend your actions by what you write. ■

CME/CNE OBJECTIVES

After completing this activity, participants will be able to:

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

COMING IN FUTURE MONTHS

- Managing sickle cell pain in the ED
- A pathway to improved quality, lower wait times
- It's complicated: HIT vendors
- speak up about technology-related adverse events
- How problematic handoffs continue to compromise patient safety



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CME/CNE QUESTIONS

1. The two important roles for physicians in end-of-life planning are:
 - A. making sure the family is engaged in the process, and overseeing the end-of-life planning discussion
 - B. introducing the topic to patients, and answering medical-related questions
 - C. explaining what end-of-life planning is, and filling out planning documents
 - D. filling out end-of-life planning documents, and signing their names to these documents
2. Sick children are not high-volume for a large majority of hospitals even though more than ____ of children are seen in non-children's hospitals in emergency settings.
 - A. 20%
 - B. 40%
 - C. 60%
 - D. 80%
3. The likelihood of having all of the things that are specified in national guidelines for pediatric are is how much more likely if an ED has a pediatric emergency care coordinator?
 - A. two times
 - B. four times
 - C. six times
 - D. eight times
4. The first thing most EDs could do to improve care for behavioral health (BH) patients without an incursion of financial obligations is:
 - A. provide in-service training for staff
 - B. hire a BH nurse
 - C. implement a protocol for BH care
 - D. designate space for BH care

New practice guidelines aim to put teeth in the root cause analysis process

Experts point to the need for a standardized approach, noting that too often the process means different things to different people

Root cause analysis (RCA) — the process by which health care organizations identify and learn from errors and potential errors — has been a pillar in the U.S. health system for some time, but experts note the results have been inconsistent at best. Hospital medical errors are now the third leading cause of death in this country, according to the Agency for Healthcare Research and Quality.

To find out how traditional RCA processes are falling short, the National Patient Safety Foundation (NPSF) assembled a panel of experts to examine the approach in depth and offer guidance aimed at elevating the RCA process so that it results in accurately identifying what's behind errors or near-misses, and leads to actions that eliminate or drastically reduce the chances that the problem will happen again.

The results of this investigative process are a new set of guidelines aimed at putting real teeth in the RCA process and making sure efforts to identify the causes and potential causes of patient harm lead to sustainable system improvements. In fact, noting that too often RCA efforts fall short when it comes to implementing sustainable solutions, the authors of the guidelines have changed the name of RCA process to Root Cause Analysis and Action or RCA squared (RCA²).

While the complete guidelines are available via the NPSF website (www.npsf.org/RCA2), the co-chairs of

the improvement effort recently held a web conference to answer questions about the process and offer direction on how health care organizations can get a much better return from their error-prevention programs.

Go beyond analysis

INVESTIGATORS OFFERED GUIDANCE TO IMPROVE THE RCA PROCESS SO IT BETTER IDENTIFIES ERRORS AND LEADS TO SOLUTIONS.

James Bagian, MD, PE, project co-chair and director of the Center for Health Engineering and Public Safety at the University of Michigan noted that too often RCA processes have failed because they lack a standardized approach.

“When we even use the term ‘root cause analysis’ it means different things to different people, which causes problems in learning from each other,” he says.

Bagian added that RCA processes often lead to superficial solutions such as telling someone to be more careful, which he noted is not very helpful or sustainable.

“There is often a lack of follow-up even when we have done a good analysis, which often we have not,” he says. “We don’t have good, robust action plans to go along with that.”

One of the primary reasons why the guideline authors decided to enhance the term used for RCA to RCA² is because the former term implies that there is only one root cause, which is not generally the case, Bagian offers. He also suggests the RCA process should be more than

just an analysis.

“If all we do is an analysis, then that doesn’t make any difference to the patient,” he says. “The point is what action do we take, and that is why we call it RCA squared.”

The new process, outlined in the guidelines, also addresses the issue of sustainability and follow-up, Bagian adds. “It is not enough to have good ideas. You must implement them and make sure that they really had the desired effect,” he says. “You also have to make sure you didn’t create new problems with your solution to the current problem.”

Incorporate transparency

A first step toward reducing harm is coming up with a way to identify which problems or errors you are going to put through the RCA² process. Bagian notes that for too many organizations, the prioritization process is based on the level of patient harm that occurred.

“The problem is if you take such a risk-based approach, then by definition you will not be looking at close calls or near misses of a serious sentinel event,” he says. “That is not a good thing, because we first have to actually harm someone before we understand why it happened and do something about it. We don’t live our own lives this way. It doesn’t make sense, and yet, for the vast majority of institutions, that is exactly what they do.”

Instead, it is important to look at the severity of what did or could have occurred, and the likelihood that it might occur, Bagian explains.

“There are studies that show that a close call occurs — depending on the type of event — anywhere from 10 to 300 times more often than the event it is the harbinger of,” he says. “That is 10 to 300 opportunities you have to recognize it as a vulnerability and do something about it.”

The NPSF report offers guidance about how to develop risk matrices that incorporate severity categories and probabilities. However, when

building this model for determining which errors or near misses to address through RCA², the criteria need to be transparent so that there is no need for debate, Bagian advises.

“If you have that, there should be one individual or their backup who makes that determination, because it is a fairly straightforward thing,” he says. “Everybody understands how it is done, everybody should be striving toward the same goal, and you don’t have to dissuade the perception that you are cherry-picking just what you want to look at as an organization.”

Assemble a team

Who should serve on an RCA² team?

“We suggest that at least one of these people be a subject matter expert in the area involved, and one should clearly be competent in the RCA process,” explains **Doug Bonacum**, CSP, CPPS, a project co-chair and vice president for quality, safety, and resource management for Kaiser Permanente in Oakland, CA. “One should be a frontline staff member who does the work but was not involved in the actual event. And — in a new recommendation — one should be a patient representative.”

The patient representative should not be someone involved in the actual event, notes Bonacum, but he adds that the authors thought that having this component would bring value to the investigative process.

“We think this is going to enable the RCA² team to gain a more complete understanding of the circumstances surrounding the event, and may offer additional perspectives on how to reduce the risk of recurrence, which is our goal,” he explains.

The number of team members

EXECUTIVE SUMMARY

While hospitals have been using root cause analysis (RCA) to identify the reasons for problems and errors for many years, experts note that the results of these efforts have been uneven at best. To improve the RCA process, a team of experts from the National Patient Safety Foundation (NPSF) have assembled best-practice guidelines to both standardize the RCA process and guide organizations in their improvement efforts. Further, they have renamed the process RCA squared or RCA² to emphasize the need for action steps once an analysis is completed.

- Report authors say prioritization methods need to be devised so that near-misses and close calls receive more attention from RCA² teams.
- RCA² teams should be nimble, including four to six members, one of whom is a patient representative.
- When problems or errors emerge, the RCA² process should commence within 72 hours, and the RCA² team should complete its investigative work in 30 to 45 days.
- Experts say causal statements should outline what the solutions to a problem or error should be.

should be limited to between four and six members, Bonacum adds.

The idea behind this recommendation is that the group should be nimble and able to overcome organizational inertia, he says.

Further, he notes it takes into consideration the fact that health care organizations have limited resources.

“We feel team members need to be grounded in some basic understanding of human factors and safety science, and they absolutely need a team leader who is not only skilled in the RCA² process, but also in dealing with people, in dealing with emotions, in communicating both in writing and orally as an expert, and, most importantly, staying on task,” Bonacum says.

Graphical descriptions

While many health care organizations like to map processes as they are intended to occur, the report authors recommend RCA² teams also make a graphical description of the event as it actually occurred.

“By mapping what actually happened, causes and corrective actions may be more easily identified, and your goal of implementing sustainable, systems-based improvements more easily achieved,” Bonacum says.

The RCA² team should interview anyone who might know anything about why the event or near miss occurred, but the report authors noted it is important to probe why the event occurred, not just what precisely took place.

Team members should also take advantage of the literature, their own past experience, and any other

resources that might help them in pinpointing the true causes of the problem under investigation, Bagian notes.

When a problem or error emerges that merits analysis, the report authors noted the process should begin within 72 hours, and the investigation should be completed in 30 to 45 days.

“The longer you wait to figure out what the problem is and come up with countermeasures or mitigation actions to implement, the longer your patient population is at risk,” Bagian observes. “It certainly is more than unfortunate to have a problem, and then while you are waiting and not taking action, another patient is harmed.”

It makes sense to have established times when the RCA² teams will meet so that if people are on call, they can take steps to ensure they are available ahead of time.

“Often people who don’t plan ahead and then try to bring up [meetings] in an ad hoc way have trouble getting teams together, and this delays their success,” Bagian says.

“The point is that you want to get your results as quickly as you can and deliver a good, well-thought-out job,” he adds.

Include specifications

When team members are ready to prepare the final causal statements regarding the event, they need to be mindful of the fact they will probably not be the ones who are approving the final implementation of any solutions or funding the necessary resources.

“Those individuals may not have the foresight that you have, so look at [this task] as if you are

writing specifications,” Bagian says. “Describe your causes in a way so that ... it actually lays out for you what the solution would really be.”

What does not work? Using negative descriptors such as saying that someone is poorly trained or that someone failed to act does not spell out a solution, Bagian warns.

“If a physician didn’t know it was [his or her] responsibility [to act], that is not the point,” he stresses. “Why didn’t they know it was their responsibility? Why didn’t [the health care system] set the systems so that they knew that?”

Take action

The authors stressed that the most important part of the RCA² process is what happens as a result of the analysis.

“It is the implementation of actions to eliminate or control system hazards or vulnerabilities that have been identified in those causal statements,” Bonacum explains. “We want to ensure the actions and causes are tightly coupled.”

The NPSF report introduces the concept of an action hierarchy in which several actions may be required, but some are deemed stronger or longer-term than others.

“The action hierarchy is based on human factors and our understanding of error prevention and of systems safety,” Bonacum says.

For example, in the case of a piece of equipment that continually flashes an error code, Bonacum explains that a short-term fix might be to post instructions on how to clear that error code right on the device.

However, a permanent solution would be to work with the manufacturer to change the software

or the device.

“That basically eliminates this thing from ever happening again, and it is the type of systems solution we want for our practitioners and absolutely for our patients,” Bonacum says.

Designate responsibility

To ensure actions or solutions are carried out, it is critical for specific individuals to be made responsible, Bagian advises.

“Committees aren’t responsible for anything. A person is,” he says. “It could be the chair of a committee, the chief medical officer, or a charge nurse ... but the person needs to understand the buck stops with [him or her].”

Bagian adds it is not just a matter of designating who is responsible. There needs to be a specific date for when the action must be accomplished.

“People have to know what is

going to be measured, how it is going to be measured, by whom, and what date,” he says. “Those are really important things. They are methodical things. But most experience will show this is seldom ever done.”

When measuring the effectiveness of RCA²-devised actions, Bagian says it is important to look at both process and outcome measures.

“If you only look at outcome, and the outcome didn’t change, and then you just suppose that people did the process, that is a big assumption,” he notes.

Further, Bagian emphasizes that the results need to be widely disseminated.

“Leadership has to know,” he observes. “The staff should know too because they spent their own blood, sweat, and tears reporting things, and some participated in the investigation or implemented countermeasures. They want to know if they made a difference; same thing with patients and families.”

When people realize that what they did made a difference, it will whet their appetite to do more quality improvement, Bagian observes.

“Celebrate the wins. Everything is not going to be totally successful, but then you learn and make iterative changes to make it work,” he notes. “Only by doing follow-up measurement do you even know about that, so these are really important things to kind of close the loop and make sure that you can continue to do better.” ■

SOURCES

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ED Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely**. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- A. chair
- B. director of emergency services
- C. director of nursing services
- D. medical director
- E. nurse manager
- F. other _____

2. What is your highest degree?

- A. BA
- B. BS
- C. BSN
- D. MA
- E. MBA
- F. MD
- G. MS
- H. MSN
- I. PhD
- J. RN

3. What is your sex?

- A. male
- B. female

4. What is your age?

- A. 20-25
- B. 26-30
- C. 31-35
- D. 36-40
- E. 41-45
- F. 46-50
- G. 51-55
- H. 56-60
- I. 61-65
- J. 66+

5. What is your annual gross income from your primary health care position?

- A. Less than \$30,000
- B. \$30,000 to \$39,999
- C. \$40,000 to \$49,999
- D. \$50,000 to \$59,999
- E. \$60,000 to \$69,999
- F. \$70,000 to \$79,999
- G. \$80,000 to \$89,999
- H. \$90,000 to \$99,999
- I. \$100,000 to \$129,999
- J. \$130,000 or more

6. Where is your facility located?

- A. urban area
- B. suburban area
- C. medium-sized city
- D. rural area

7. In the last year, how has your salary changed?

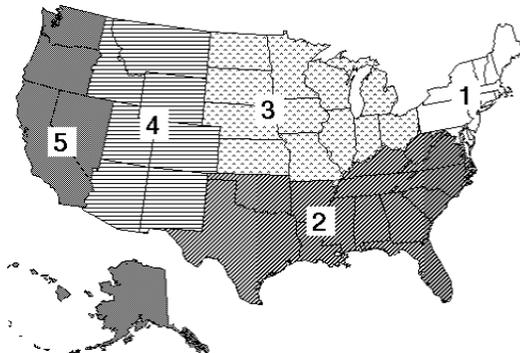
- A. salary decreased
- B. no change
- C. 1% to 3% increase
- D. 4% to 6% increase
- E. 7% to 10% increase
- F. 11% to 15% increase
- G. 16% to 20% increase
- H. 21% increase or more

8. Which best describes the ownership or control of your employer?

- A. federal government
- B. state, county, or city government
- C. nonprofit
- D. for profit

9. Please indicate where your employer is located.

- A. region 1
- B. region 2
- C. region 3
- D. region 4
- E. region 5
- F. Canada
- G. other



10. How long have you worked in your present field?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

12. In the past year, how has the number of employees in your department changed?

- A. increased
- B. decreased
- C. no change

11. How long have you worked in health care?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

13. How many hours a week do you work?

- A. less than 20
- B. 20-30
- C. 31-40
- D. 41-45
- E. 46-50
- F. 51-55
- G. 56-60
- H. 61-65
- I. 65+

14. If you work in a hospital, what is its size?

- A. <100 beds
- B. 100 to 200 beds
- C. 201 to 300 beds
- D. 301 to 400 beds
- E. 401 to 500 beds
- F. 501 to 600 beds
- G. 601 to 800 beds
- H. 801 to 1,000 beds
- I. >1,000 beds
- J. I don't work in a hospital

Deadline for Responses: Nov. 2, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.