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AHC Media

MARCH 2016

Vol. 28, No. 3; p. 25-36

## Cleveland hospitals increase capacity, hire additional staff to help end ambulance diversion

*Hospital leaders pledge to make a ban on diversions stick, but some outsiders question whether a voluntary pact will work*

Most EDs have some experience with ambulance diversion, the practice of turning away ambulances for a period of time so that emergency staff can better manage surges in demand. However, while this tactic may help clinicians better care for patients who are already in the ED, few argue with the notion that diversion likely delays care for incoming patients who must now travel to a second- or third-choice facility that may be farther away. Further, there is no question that delays in care can adversely affect outcomes, and cause problems for EMS providers as well as other hospitals in the area that must pick up the slack.

In short, nobody likes diversion, and yet the practice persists in many communities around the country when ED administrators determine that they don't have the capacity or staff to accommodate incoming ambulance traffic. A handful of communities have determined that ambulance diversion is a practice they can do without. At

least some of these efforts have clearly demonstrated that when the issue is addressed collectively as a community, diversion can not only be eliminated, but looking more closely at the problem can also force hospitals to finally address the deeper throughput issues that often prompt the need for diversion in the first place. (See also: "Cleveland can learn from Boston," page 28.)

### Consider effect on incoming patients

Hospital leaders in Cleveland are the latest to come to the realization that ambulance diversion must end, and that they have the tools and the capacity to make it happen.

"Our local emergency transport system called a meeting in late November [2015], and said that this was really not working well for them," explains **Alfred Connors, MD**, chief clinical officer for MetroHealth Medical Center, one of

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## ED MANAGEMENT®

### ED Management®

ISSN 1044-9167, is published monthly by AHC Media, LLC  
One Atlanta Plaza  
950 East Paces Ferry Road NE, Suite 2850  
Atlanta, GA 30326.  
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

### POSTMASTER: Send address changes to:

ED Management®  
P.O. Box 550669  
Atlanta, GA 30355.

### SUBSCRIBER INFORMATION:

Customer Service: (800) 688-2421.  
customerservice@ahcmedia.com.  
AHCMedia.com  
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST

### EDITORIAL E-MAIL ADDRESS:

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### SUBSCRIPTION PRICES:

Print: U.S.A., 1 year with free AMA PRA Category 1 Credits™: \$519. Add \$19.99 for shipping & handling.  
Online only: 1 year (Single user) with free AMA PRA Category 1 Credits™: \$469  
Outside U.S., add \$30 per year, total prepaid in U.S. funds

Back issues: \$82. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.  
GST Registration Number: R128870672.

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

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

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four health systems in the Cleveland metropolitan area. The other three systems are the Cleveland Clinic, University Hospitals, and St. Vincent Charity Medical Center.

According to Connors, EMS providers urged hospitals to unite and craft a system or process that wouldn't be so disruptive to its operations or patients requiring emergency care.

"They pointed out that ... when we were closing [to ambulance traffic] we were thinking about what was best for the patients in our ED right at that point, and they agreed that is important," Connors says. "But their point was that what you don't want to do is a good job for the 50 people in your ED, but then put a larger group in the community at a disadvantage because now it is harder for [EMS] to coordinate and arrange transport for everybody."

It wasn't one thing, but rather the accumulated effect of multiple small things that brought the issue to a head, Connors explains.

"There wasn't enough communication among the systems as we were closing, so we would see that we had a problem and we would close, but we weren't taking into account who else was closed at the time," he says. "What [the EMS providers] wanted was something where we worked together, we communicated with each other, and we did a better job managing this to minimize the effect on the community."

Contributing to the problem is the fact that ED volumes have been on the increase in Cleveland in recent years for many reasons, observes **Jane Dus**, DNP, RN, NE-BC, chief nursing officer at University Hospitals Case Medical Center. "Some of this can be attributed to Medicaid expansion, but we have seen an increase in patients presenting to our EDs,

which resulted in MetroHealth and [University Hospitals] increasing our number of diversion hours so that we could maintain the care of the patients in our EDs," she says. "When that happened, patients would end up at the Cleveland Clinic."

## Collaborate with hospital providers

In response to the discussion with EMS providers, the chief medical officers (CMOs) of all four health systems decided to partner and find a solution. In addition to CMOs, the city commissioner for EMS, the director of safety for the city, and the director of the board of health for the county were invited to participate as well, Dus recalls.

"I was brought along because I manage our ED," she says. "It was an interesting dialogue."

Cleveland is somewhat unique in that there are four hospitals that are all located within a 10-mile radius, Dus observes, adding that an ambulance will always travel to the closest, most appropriate hospital, so if the ambulance is transporting a trauma patient, it will not arrive at the Cleveland Clinic because that is not a trauma facility. However, if the patient is not a trauma patient or not in acute distress, the ambulance will often travel to the patient's hospital of choice — unless, of course, that hospital's ED has closed its doors to new patients. For instance, reports note that University Hospitals logged more than 550 hours on diversion in 2015, and MetroHealth closed its doors to new ambulance traffic for more than 400 hours.

During the meeting, the participants all felt compelled to see what they could do to alleviate the diversion problem, Dus explains.

“We recognize that there are times when, if we are closed and MetroHealth is closed, the squads need a place to go; or if a patient wants to go to University Hospitals and they have to go to the [Cleveland] Clinic because we are closed, they don’t get to go to their hospital of choice,” she says. “We just decided to make an agreement. It is a verbal agreement that by the middle of February [2016], let’s try to not go on diversion hours at all.”

The pact between the hospitals is voluntary. There are no regulations that would force compliance, but participants are convinced they can put an end to ambulance diversion in Cleveland.

“We made the decision collectively that, yes, this is the right thing to do for our patients, and so we are going to do what we need to do to make this happen,” says **Bradford Borden**, MD, chairman of the Emergency Services Institute at the Cleveland Clinic. “It’s just the right time to come together with the other health systems in our city and in our area, and get everybody on the same page.”

## Look at throughput hospital-wide

In fact, as all participants acknowledge, the task will be somewhat easier for the Cleveland Clinic than for the other hospitals involved, given that the Cleveland Clinic has already taken the steps necessary to all but eliminate ambulance diversion on its main campus.

“We were only on diversion for 10 hours in 2015, and so we have already done some things on our end,” Borden notes. “A big thing is that we have great support in our institution [for the concept] that emergency medicine throughput is not just ED

## EXECUTIVE SUMMARY

With pressure from EMS to curb ambulance diversion, the four hospital systems serving metropolitan Cleveland have made a pact to bring diversion to an end. The agreement is voluntary, but all sides were determined to make the ban on diversion stick as of mid-February 2016. To get there, the health systems are increasing capacity, adding staff, and taking steps to tackle deeper hospital throughput issues.

- In 2015, reports noted that University Hospitals logged more than 550 hours on diversion, and MetroHealth closed its doors to new ambulance traffic for more than 400 hours. The Cleveland Clinic went on diversion for only 10 hours last year.
- To prepare for the ban on diversions, MetroHealth is adding more inpatient and ED beds, and it is also hiring additional staff. University Hospitals is taking similar steps while also building on the success of its medical access clinic, a lower-cost setting where patients can be screened, stabilized, and connected with primary care for future low-acuity needs.
- Hanging over the effort in Cleveland: Voluntary efforts to ban ambulance diversion in Boston failed repeatedly. However, once regulators mandated a ban on diversion statewide in 2009, the hospitals all fell into line with few signs of any adverse consequences. The city has now operated diversion-free for seven years.

throughput, it is hospital throughput, so the whole hospital needs to be on same page in terms of trying to make sure we are being as efficient as we can be for all of our beds.”

With this organizational support, the Cleveland Clinic has implemented a number of interventions to improve efficiency. For example, Borden notes that the hospital now holds a series of hospital “huddles” throughout the day to quickly identify and effectively manage any concerns, such as patient surges, that occur.

The hospital also has instituted Saturday morning surgeries so that bed utilization is more evenly spread over seven days rather than just five, and it has begun to make better use of some of the health system’s regional ICUs to ease demand on the main campus.

While Cleveland Clinic is ready to go, other health systems are taking steps to improve efficiency and

build up capacity so that diversion will not be necessary. For example, MetroHealth will soon take over the operation of two additional EDs, which are staffed to manage 20,000 to 25,000 patients a year, Connors explains.

“We think this will unload our main campus ED to a degree,” he says. “We will have more sites to go to if needed.”

The health system is also building a satellite ED in a suburb of Cleveland that should be ready for patients in August, and it will soon complete renovations to the ED on its main campus.

“We have redesigned our waiting room and tried to make it more efficient. We also have added additional exam rooms and evaluation rooms,” Connors says. “We did it so that we could handle additional patients, and with the very idea of trying to improve our

throughput process so that we have fewer people waiting.”

Also, while expanding emergency care capacity, the hospital is adding two floors to its critical care pavilion to create more ICU space and step-down capacity.

“One of the problems that keeps people waiting [in the ED] is that we

get someone who needs an ICU bed, so we need to move someone from the ICU into a step-down unit before we can move [the emergency patient] up to the ICU,” Connors explains. “We are doing this so that we will be more likely to have an open bed so that we can take the patient [up to the ICU] right away and we don’t end

up with backlogs. The [new critical care capacity] will open in July and that will help us in dealing with [the ban on ambulance diversions].”

## Prioritize staffing, efficiency

The construction projects are key, but Connors observes that the most important step MetroHealth is taking to adhere to the new agreement relates to staffing.

“We see about 100,000 to 105,000 patients in our central ED per year. We’ve got a busy ED and ... [the staff] don’t mind being busy,” he says. “Often times when they get backed up, it is not because we don’t have enough beds available in the hospital ... it is because we don’t have enough staffed beds.”

To resolve this problem, MetroHealth hired a sizable number of nurses in the summer of 2015, but the hospital system is only just beginning to feel the effect.

“They are steadily coming out of their orientation and training process,” Connors explains. “They should be ready to staff our EDs and floors so that we will be more likely to flex up our staff easily because we have the people to do it, and we think they will be in place by Feb. 15.”

In just the past few weeks, MetroHealth has further reviewed its human resource pipeline to take care of any other staff shortages that need to be filled to ensure that staffing is optimal, Connors notes.

“We feel pretty confident we will be OK, and as the nurses have come on board we haven’t had to go on diversion very much in the last two months,” he says. “We are feeling that on Feb. 15 we will be ready for this diversion-free agreement.”

University Hospitals is also taking

## Cleveland can learn from Boston

While hospital leaders in Cleveland are steadfast in their determination to end ambulance diversion, it remains to be seen whether the ban on diversion will be sustained. The voluntary route was not successful in ending ambulance diversion in Boston several years ago, although the key driver of the process there was different. “Massachusetts had a Boarding and Diversion Task Force for a long time, and they had been trying to voluntarily eliminate it, and it just wasn’t working by voluntary means,” recalls **Laura Burke**, MD, MPH, an emergency medicine physician at Beth Israel Deaconess Medical Center in Boston.

However, when the task force, which was part of the Massachusetts Department of Public Health, voted to make a ban on ambulance diversion mandatory statewide on Jan. 1, 2009, the hospitals all fell into line. “The [task force] was willing to go out on a limb and do it. They had buy-in from lots of people, but there were also fears that [the ban] would cause harms; that EDs would be overwhelmed with patients, and that patients would die,” Burke says.

Fortunately, such fears did not materialize. Burke co-authored a study on the effect of the diversion ban on nine EDs in the Boston area, concluding that the ban did not exacerbate ED crowding or ambulance availability.<sup>1</sup> “We are going on seven years now that we haven’t had ambulance diversion, and no one talks about putting it back,” Burke says. “Diversion is a crutch, and when hospitals are forced not to use that crutch, they make do. It was a crutch that didn’t work anyway.”

Burke praises Cleveland’s voluntarily ban on ambulance diversion, and she acknowledges that every community is different. However, there is no denying that hospitals in Boston clearly needed to know that they could not back out. Her advice to other health systems and communities that are struggling with diversion problems is to keep the pressure on for change and look for a sympathetic ear among policymakers.

“Find the story that makes people care about this,” Burke advises. For instance, she notes that mass-casualty events have received a lot of attention of late, and people are concerned about an effective emergency response. “Having that policy angle that makes people pay attention to what we know is the right way of doing things probably would help,” she says. ■

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steps to improve efficiency and increase capacity.

“We are in the process of opening new ICU and division beds, because part of our problem [has been] lack of capacity on the inpatient side,” Dus observes. “We are also looking at our throughput through the ED.”

In addition, administrators are hoping to build on the success of the hospital’s medical access clinic, which opened three years ago to screen and stabilize patients.

“We can send patients to the clinic where we can hook them up to primary care, so they don’t even make it to the back of the ED,” Dus explains. “Many of these patients have insurance, but they don’t have access to primary care, so we arrange for them to have primary care, and what we are finding is that 96% of them don’t return to the ED for low-level care needs.”

## Establish a deadline

Dus acknowledges that there are always concerns about patients overloading the ED, but she stresses that the hospital is going to make every effort to abide by the agreement to end diversion by Feb. 15. She adds that there are signs of progress on that front.

“Just by making the agreement, we are already only closing for four-hour increments, and that seems to be going well,” Dus observes. “Instead of going cold turkey, the agreement for Dec. 1 through Feb. 15 was that if any ED needed to close, it could only close for four hours, and then it would need to stay open again for another eight hours.”

While efforts to boost efficiency and add capacity are important, Dus suggests that hospital staff [members] are also realizing that they can handle

more patient volume than they anticipated.

“That is part of it, and also knowing that closing isn’t an option anymore,” she says. “It makes you think a little bit more creatively, and work a little bit differently and proactively.”

“WE ARE GOING TO MAKE SURE IT WORKS BECAUSE THAT IS THE MENTALITY OF THE PEOPLE AT THE TABLE. EVERYBODY BOUGHT INTO THE FACT THAT THIS IS NOT JUST THE RIGHT THING TO DO FOR THE PATIENTS, IT IS THE RIGHT THING TO DO FOR THE COMMUNITY.”

Connors concurs that the agreement has forced each hospital to focus their attention on meeting the goal, but he notes that the hospitals were working on the problem even before entering into the agreement.

“Two facilities, [Cleveland Clinic and St. Vincent Charity Medical Center], were [eliminating diversion] already, and both MetroHealth and University Hospitals had plans in

place to address the issue,” he says. “That is partly what determined the deadline at a time when everyone could do this.”

Also key to the agreement is the fact that competitive issues didn’t enter into the equation, Connors adds.

“The reason this succeeded is we effectively put aside those issues because there is no competitive advantage to closing your ED. Actually, the competitive advantage would be to never close your ED because [that way] patients can always get in,” he says. “We also realized that the things we are doing to fix this problem are also an advantage competitively. It makes it easier for our patients to get in and get services, so there really isn’t an advantage to not doing this.”

Borden has no doubt that the hospitals will succeed in sustaining the ban on ambulance diversion.

“We are going to make sure it works because that is the mentality of the people at the table,” he says. “Everybody bought into the fact that this is the right thing to do. It is not just the right thing to do for the patients; it is the right thing to do for the community.” ■

## SOURCES

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# CMS proposes prioritizing patient preferences, linking patients to follow-up care in discharge planning process

*Emergency medicine clinicians are concerned that the infrastructure is not yet in place to facilitate successful implementation of proposed rule*

The Centers for Medicare and Medicaid Services (CMS) is projecting clear signals that hospital providers soon will need to devote more resources to the discharge planning process. The agency spelled out its intentions in a proposed rule designed to ensure that patients who are discharged from the hospital or the ED have clear follow-up instructions and that they are connected with appropriate resources and follow-up. In addition to acute care hospitals

and EDs, the proposed requirements would apply to long-term care facilities, inpatient rehabilitation centers, and home health agencies. Regardless of the setting, CMS is driving home the message that emergency medicine clinicians should give more weight to patient preferences during the discharge planning process.

When announcing the rule, **Patrick Conway**, MD, deputy administrator and chief medical officer at CMS, said that the rule will put the

patient and caregivers at the center of care delivery.

“Patients will receive discharge instructions, based on their goals and preferences, that clearly communicate what medications and other follow-up is needed after discharge, and pertinent medical information will be communicated to providers who care for the patient after discharge,” he said. “This leads to better care, smarter spending, and healthier people.”

According to CMS, the proposed revisions would update the requirements for discharge planning, making them more consistent with current practice. The agency also stated that the new provisions would improve care and outcomes while reducing adverse events and readmissions.

In addition, the proposed rule would implement the discharge planning provisions within the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which requires hospitals as well as some post-acute care providers to focus on patient preferences during the discharge planning process, and to leverage data on both quality and resource use in their efforts to help patients reach their goals.

However, the proposed rule, which was posted in the Federal Register on Nov. 3, 2015 (<http://federalregister.gov/a/2015-27840>), has sparked strong reactions from hospital providers who maintain that the new requirements will be too expensive to implement. For instance, while

## EXECUTIVE SUMMARY

Hospital providers voice concerns about a proposed rule by the Centers for Medicare and Medicaid Services (CMS) that would require providers to devote more resources to discharge planning. The rule would apply to inpatients as well as emergency patients requiring comprehensive discharge plans as opposed to discharge instructions. CMS states that the rule would ensure the prioritization of patient preferences and goals in the discharge planning process, and also would prevent avoidable complications and readmissions. However, hospital and emergency medicine leaders worry that community resources are not yet in place to facilitate the links and follow-up required in the proposed rule, and that the costs associated with implementation would be prohibitive.

- The proposed rule would apply to acute care hospitals, EDs, long-term care facilities, inpatient rehabilitation centers, and home health agencies. Regardless of the setting, though, CMS is driving home the message that patient preferences should be given more weight during the discharge planning process.
- Under the rule, hospitals or EDs would need to develop a patient-centered discharge plan within 24 hours of admission or registration, and complete the plan prior to discharge or transfer to another facility.
- Under the rule, emergency physicians would determine which patients require a comprehensive discharge plan.
- Both the American Hospital Association and the American College of Emergency Physicians worry that hospitals will have to take on more staff, invest in training, and make changes to their electronic medical record systems to implement the provisions in the proposed rule.

agreeing with CMS' goal for hospitals to deploy comprehensive, multidisciplinary, patient-centered discharge planning processes, the American Hospital Association (AHA) stated that hospitals would likely need to take on additional staff, develop and implement new discharge planning processes, and make changes to their electronic medical records (EMR) systems. The AHA added that such changes would be particularly onerous for community hospitals, many of which operate under very tight budgets.

The American College of Emergency Physicians (ACEP) largely agreed with AHA's position, noting that regulators need to be mindful of the many demands on providers already in place.

"This is just one of many, many documentation requirements and regulations that have come out of this administration since the passage of the Affordable Care Act (ACA)," observes **Barbara Tomar**, MHA, federal affairs director at ACEP in Washington, DC. "

## Train more social workers

Specifically, among the provisions contained in the proposed rule, hospitals would be required to do the following for applicable patients:

- **develop a patient-centered discharge plan within 24 hours of admission or registration, and complete the plan prior to discharge or transfer to another facility;**
- **establish a medication reconciliation process that aims to improve medication management and patient safety;**
- **send relevant medical information to the receiving facility in the case of patient transfers;**

- **create a post-discharge follow-up process.**

The proposed requirements would have a particular effect on inpatient populations, but they would also affect many ED patients. For instance, for the 30% of hospitals that have dedicated ED-based observation units, patients discharged from those units would clearly require comprehensive discharge plans under the proposed rule, explained Tomar. In addition, while the rule isn't entirely clear on this point, complex patients or patients with multiple comorbidities would likely require comprehensive discharge plans as well.

"It sounds like for the purposes of the ED that the physician would identify patients who should have more comprehensive discharge plans as opposed to discharge instructions," Tomar says.

However, given that EDs operate 24 hours a day, seven days a week, EDs would need to make social workers available on weekends and after hours to complete the comprehensive discharge plans, notes **Tiffany Jackson**, MD, an emergency medicine physician at the University of Alabama in Birmingham.

"Then we would also need those community resources that [patients] would reach out to 24 hours a day," she says. "We need to have ways to get patients back into the community, get them plugged in, and to coordinate care, but unfortunately I believe that the infrastructure is not ready yet."

Jackson adds that hospitals would have a tough time finding the staff to implement the comprehensive discharge planning goals implied in the proposed rule.

"Even if we did have all this money to pay for social workers, there is not even a workforce of social workers that could fill all the needs

throughout the country, so there are a lot of infrastructure issues that would need to be addressed," she explains.

Of particular concern to emergency providers, the proposed rule appears to put them on the hook for patients with complex behavioral health needs who arrive in the ED when there is nowhere else to go.

"The housing of psych patients is a big problem across a lot of hospital EDs, and the lack of placement is a big issue, so they just back up in the ED," Tomar stresses. "Clearly [these patients] would be the kind of patients who would need some sort of structured plan, but all the plans in the world aren't going to guarantee that there is a way to implement them."

Jackson agrees with these sentiments, particularly for those patients requiring inpatient mental healthcare.

"If there is no bed for these patients, we can try our best to create a plan, but ultimately what they need is a bed," she adds.

## Consider PDMP limitations

CMS is soliciting comments on the use of prescription drug monitoring programs (PDMPs). In particular, the agency wants to know whether the use of PDMPs should be mandated as part of the discharge planning process, and whether PDMPs should be used in the medication reconciliation process.

Noting that the functionality of PDMPs varies widely from state to state, Tomar says that ACEP believes that the use of PDMPs should not be mandated — at least not yet.

"Some of those systems are tied into hospital EMRs [so that] the information is pushed into the records. In other states, the PDMPs

aren't updated very frequently, and [providers] basically have to stop what they are doing in the ED, go to another computer, and log in [to access the PDMP information]," she explains. "It is very cumbersome in certain states, so we don't want to see [PDMP use] mandated until it is at a level across the [country] that makes PDMPs useful and easy to access."

It is unclear at this point when CMS might unveil final rulemaking on discharge planning.

"With rules like these, the feds have a lot more leeway to final-

ize them at their own pace," Tomar observes. For instance, she notes that some draft rules issued in 2011 were only recently finalized.

"On the other hand, this could be something that the Obama administration wants to push through before they are out of office," Tomar offers. "It is on the horizon, but until [CMS] starts to move to interpretive guidelines, it is hard to say what emergency providers should do."

Tomar adds that in its current form, the proposed rule is more of an issue for inpatient providers than

emergency medicine clinicians.

"We don't really know what the endpoint is, or when this is going to be finalized," she says. ■

## SOURCES

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- **Barbara Tomar**, MHA, Federal Affairs Director, American College of Emergency Physicians, Washington, DC. Email: btomar@acep.org.

# Study: Drug shortages in emergency settings worsen; root causes unknown

*Researchers call for thorough investigation into cause and urge aggressive solutions*

There is new evidence suggesting that not only are drug shortages a significant problem for emergency providers, but that the problem has gotten worse, according to an analysis of 13 years of drug data from the University of Utah Drug Information Service in Salt Lake City. In a study published in *Academic Emergency Medicine*, researchers reported that drug shortages in EDs have more than quadrupled in recent years.<sup>1</sup>

Among nearly 1800 drug shortages reported between 2001 and 2014, investigators reported that 610 involved drugs used in emergency settings. Further, more than half of these drugs used in the ED are life-saving medications are used to treat high-acuity conditions. Among these critical medications, researchers reported that 10% have no available substitute.

While shortages of drugs used in the ED eased between 2002 and 2007, the researchers found that that the number of drug shortages

skyrocketed 435% from 2008 to 2014. In particular, drugs used for lifesaving interventions or high-

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INVESTIGATE THE  
SHORTAGES.

acuity conditions increased by 393% during this period, and shortages of drugs with no substitute spiked by 125%.

The most common reasons cited for a drug shortage were manufac-

turing delays (25%), supply and demand (14%), and scarce raw material (4.4%). However, drug manufacturers did not cite a specific reason for nearly half of all the drug shortages involving medications used in the emergency setting.

Researchers suggested that there is some evidence that the 2008 financial crisis may have contributed to the drug shortages. However, they urged policymakers, drug manufacturers, physician-led organizations, and patient advocacy groups to aggressively investigate the shortages. The researchers note that there is little evidence that legislation passed in 2013 to make it easier for the FDA to ease drug shortages is working. ■

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# New policy changes regarding observation are boon to emergency medicine

The key lies in understanding how the changes affect coding, billing practices

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

Several substantive changes were made to policies for hospital observation in 2016 that benefit emergency medicine. The Centers for Medicare & Medicaid Services (CMS) reimburses hospitals for observation using a “composite” ambulatory payment classification (APC) when the service is provided in conjunction with an appropriate type A or B ED visit, critical care, clinic visit, or a direct referral to observation. This composite APC furthers CMS’ efforts to increase the packaging of related services under the Outpatient Prospective Payment System (OPPS). Under OPPS, observation is defined as “extended assessment and management composite” services. The 2016 payment for observation is \$2,174.14. The observation composite APC is listed with a status indicator of Q3, which is defined as codes that may be paid through a composite APC and includes services that are paid under OPPS.

In the past, when observation care was provided in conjunction with a high-level visit, critical care or a direct referral to observation was an integral part of a patient’s extended encounter of care, and payment was made for the entire encounter through one of two composite APCs. For 2016, observation continues to be paid under a composite APC titled, “Comprehensive Observation Services (COS) (APC 8011).”

To qualify for COS payment, billing must include:

- **Any procedure that is assigned Status Indicator “T”;**
- **Any claim containing eight or more units of services described by**

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EMERGENCY  
MEDICINE.

**HCPCS code G0378 (observation services, per hour);**

- **Claims that contain services provided on the same date of service or one day before the date of service for HCPCS code G0378 and described by one of the following codes:**

- *G0379 (Direct referral of patient for hospital observation care) on the same date of service as HCPCS code G0378;*
- *99281 (ED Level 1);*
- *99282 (ED Level 2);*

- *99283 (ED Level 3);*
- *99284 (ED Level 4);*
- *99285 (ED Level 5);*
- *G0380 (Type B ED visit Level 1);*
- *G0381 (Type B ED visit Level 2);*
- *G0382 (Type B ED visit Level 3);*
- *G0383 (Type B ED visit Level 4);*
- *G0384 (Type B ED visit Level 5);*
- *99291 (critical care);*
- *G0463 (Hospital outpatient clinic visit for assessment and management of a patient);*
- *Claims that do not contain a service that is described by a HCPCS code to which status indicator “J1” has been assigned.*

Observation services are, by definition, outpatient services, so transfer into observation status must be specifically ordered at a time when it is uncertain if an inpatient admission will be necessary (chapter 1, section 50.3.2 of the Medicare Claims Processing Manual). Providers will report the ED or clinic visit code, or, if applicable, G0379 (direct referral to observation) and G0378 (hospital observation services, per hour) and the number of units representing the hours spent in observation (rounded to the nearest hour) for all Medicare observation services.

The Medicare Outpatient Code Editor (OCE) will determine if the service qualifies for reimbursement under a composite APC. To qualify, there must be a physician order to place the patient in observation. For Medicare payment, a HCPCS

Type A ED visit code 99281, 99282, 99283, 99284, 99285, or G0384 Type B ED visit code, critical care (99291), or a G0463 HCPCS clinic visit code is required to be billed on the day before or the day that the patient is placed in observation.

If the patient is a direct referral to observation, the G0379 may be reported in lieu of an ED or clinic code. In addition, the E/M code associated with these other services must be billed on the same claim form as the observation service and the E/M must be billed with a modifier -25 if it has the same date of service as the observation code G0378.

The observation stay must span a minimum 8 hours and these hours must be documented in the “units” field on the claim form. For facility billing of observation, the “clock” starts at the time that observation services initiate in accordance with a practitioner’s order for placement of the patient into observation status. The patient must be under the care of a physician or non-physician practitioner during the time of observation care, and this care must be documented in the medical record with an order for observation, admission notes, progress notes, and discharge instructions (notes), all of which are timed, written, and signed by the physician.

A non-physician practitioner who is licensed by the state and approved by internal credentialing and bylaws to supervise patients in observation may do so. This observation end time is when all clinical or medical interventions have been completed, including the nursing follow-up care performed after the physician’s observation discharge orders are written.

The medical record must include documentation that the physician used “risk stratification” criteria to

determine that the patient would benefit from observation care. (These criteria may be either published generally accepted medical standards or established hospital-specific standards). All related services provided to the patient should be coded in

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addition to the observation code G0378.

For physician payment for observation care under CPT, there are no procedural restrictions or specific preceding visit level requirements similar to Medicare’s policies for facilities. Physician observation services are billed in lieu of Emergency Department or other Evaluation/Management CPT codes, except for certain exemptions (e.g., Critical Care).

Medicare has an 8-hour minimum for physicians reporting the observation same-day-discharge codes 99234-99236. This 8-hour minimum does not apply to an observation stay that spans 2-calendar days (99217-99220). CPT lists typical observation times a practitioner could spend at the bedside and on the patient’s hospital floor or unit as follows:

- **99218: initial observation care per day, 30 minutes bedside/floor/unit time.**
- **99219: initial observation care per day, 50 minutes bedside/floor/unit time.**
- **99220: initial observation care per day, 70 minutes bedside/floor/unit time.**
- **99234: observation or inpatient hospital care, 40 minutes bedside/floor/unit time.**
- **99235: observation or inpatient hospital care, 50 minutes bedside/floor/unit time.**
- **99236: observation or inpatient hospital care, 55 minutes bedside/floor/unit time.**
- **99224: subsequent observation care, 15 minutes bedside/floor/unit time.**
- **99225: subsequent observation care, 25 minutes bedside/floor/unit time.**
- **99226: subsequent observation care, 35 minutes bedside/floor/unit time.**

For 2016, CMS will again pay for a direct referral to observation using code G0379 (now recognized under APC 5013). CMS expects that hospitals will bill this service in addition to G0378 when a patient is referred directly to observation care after visiting a physician in the community. Hospitals should not bill HCPCS code G0379 (APC 5013) for a direct referral to observation care on the same day as a hospital clinic visit,

ED visit, critical care, or after a “T” status procedure that is related to the subsequent admission to observation care. If observation criteria are met, the composite APC 8011 will be paid. If observation time related to direct referral does not meet observation guidelines, the payment for G0379 is \$480.69.

Facilities should report intravenous infusions and injections in addition to observation service for all payers, including Medicare. Most infusion and injection procedures are status indicator “S” procedures and are paid separately. If an infusion begins in the ED or clinic visit preceding observation, subsequent or concurrent hours of infusion may be coded in observation. The initial service codes would not be coded a second time, unless there was an initiation of a second IV infusion site.

CMS directs facility providers to follow CPT rules for coding injections and infusions. Separate payment is allowed for services with status indicators S (significant procedure not subject to discounting) and X (ancillary service) when billed with G0378. The payment policy is the same for many non-Medicare payers.

As in years before, payment in 2016 is not allowed if a surgical procedure or any service that has a status indicator of “T” occurs on the day before or the day that the patient is placed in observation. However, all services related to the observation services should be coded. The OCE logic will determine payment.

• **Composite APC payment is based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.**

• **In other circumstances, payment is made through a separate**

### **APC payment or packaged into payment for other services.**

One of CMS’ goals for OPSS is

**PAYMENT IN 2016 IS NOT ALLOWED IF A SURGICAL PROCEDURE OR ANY SERVICE THAT HAS A STATUS INDICATOR OF “T” OCCURS ON THE DAY BEFORE OR THE DAY THAT THE PATIENT IS PLACED IN OBSERVATION.**

to increase the packaging of interrelated services into a primary service. Packaged services include a limited number of additional ancil-

lary services, in particular certain minor procedures and pathology services, except for cochlear implant and auditory implant programming services. CMS will also package payment for a few drugs that function as supplies in a surgical procedure.

In EDs and clinics, most lab work will be packaged and not paid separately in 2016. In addition, many add-on codes will be packaged in 2016. An add-on code is a procedure performed in addition to a primary procedure and is never reported alone. Examples of packaged add-on codes include: 99292 — critical care, each additional 30 minutes; 99145 and 99150 — moderate sedation codes; debridement add-on codes; removal of nail plate add-on codes; and immunization add-on codes. Injections and infusions are not packaged. Drug administration add-on codes are not packaged. Infusion add-on codes 96368 (concurrent infusion) and 96376 (IV push same drug) continue to be packaged in 2016 under status indicator “N.” ■

## **CME/CE 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**

- Diagnosing chest pain in the ED
- New help for EDs overwhelmed with BH patients
- Pushing the envelope on patient safety
- What emergency clinicians can do to improve EMR usability



## ED MANAGEMENT

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## CME/CE QUESTIONS

1. **Contributing to the problem of ambulance diversion in Cleveland is the fact that:**
  - A. ED volumes have been on the increase in recent years.
  - B. the hospitals compete with each other for patients.
  - C. the chief medical officers of each hospital do not communicate with each other.
  - D. communications with EMS are poor.
2. **The Cleveland Clinic only went on diversion for 10 hours in 2015 because:**
  - A. the hospital expanded its ED to accommodate more patients.
  - B. the hospital added scores of new inpatient beds.
  - C. the hospital hired more emergency nurses and physicians.
  - D. there is institutional support for the concept that emergency medicine throughput is not just ED throughput, but hospital throughput.
3. **When a task force of the Massachusetts Department of Public Health voted to make a ban on ambulance diversion mandatory statewide on Jan. 1, 2009:**
  - A. there were fears that the ban would cause harm and that EDs would be overwhelmed with patients.
  - B. the task force had buy-in from lots of people.
  - C. the hospitals all fell into line.
  - D. All of the above
4. **In a proposed rule on discharge planning, the Centers for Medicare & Medicaid Services is driving home the message that:**
  - A. patient preferences should be given more weight during the discharge planning process.
  - B. emergency providers need to do more to ensure that patients understand discharge instructions.
  - C. medication reconciliation processes need to be overhauled.
  - D. too many EDs ignore the importance of follow-up care.

## Using swarm intelligence to boost the root cause analysis process and enhance patient safety

*The key to the swarming approach is a blame-free environment and rock-solid support from hospital leadership*

The idea of delving deeply into an error so that you can figure out what went wrong makes perfect sense to most people. But in the healthcare environment, such a process, often referred to as root cause analysis (RCA), can easily bog down in political, legal, and bureaucratic concerns. For instance, when frontline providers are not forthcoming about problems or issues because they fear punitive repercussions, it is much harder to see the truth, let alone devise solutions that will actually improve patient safety. Similarly, if an RCA process is designed to meet a requirement rather than to fix problems, it is easy to see how the results may be off the mark or ignored.

With these issues in mind, in 2009 the University of Kentucky Health-Care (UKHC) decided to replace its traditional RCA process with a new approach that relies on swarm intelligence, a concept borrowed from other industries, to quickly assess problems in a blame-free environment and identify fixes that potentially stand a better chance of correcting or improving flawed processes.

Hospital administrators acknowledge that it took time for the process to work, but after seven years, the results are impressive. For example, investigators at UKHC note that incident reporting has increased by 52% and the health system has experienced a 37% decrease in the observed-to-expected mortality ratio.<sup>1</sup> Furthermore, it's an approach that UKHC administrators believe could well deliver dividends at other health systems.

### Don't play blame game

**Paula Holbrook**, RN, BHS, JD, CPHRM, associate general counsel and associate director of risk management at UKHC, recalls how "difficult and unwieldy" the RCA process was at UKHC.

"It was basically reserved mostly for sentinel events. It consisted of one person in quality interviewing people and making notes, going through this huge, onerous ... unintelligible framework that just didn't work," she says.

"It was a boondoggle."

Holbrook credits **Paul DePriest**, MD, who is now the executive vice president and chief operating officer at Baptist Memorial Health Care in Memphis, TN, but at the time was the chief medical officer at UKHC, for recognizing the need for reform and spearheading the effort to rid the RCA process of blame and finger-pointing.

However, Holbrook acknowledges that it was an uphill battle.

"One of the early challenges was trying to explain what [swarming] was," she recalls. "Trying to introduce a new concept into an old culture is difficult."

During swarming, when something goes wrong, the people involved come together as quickly as possible after the problem becomes apparent to figure out a solution, explains **Mark Williams**, MD, FACP, MHM, director of the Center for Health Services Research at UKHC.

"It leverages acute memory and knowledge about what is going on versus looking at the problem much later

"TRYING TO INTRODUCE A NEW CONCEPT INTO AN OLD CULTURE IS DIFFICULT."

when memories fade and they begin to reinterpret their memories based on other activities that are going on or comments by other people,” he says.

However, everyone recognized from the start that the approach would not be successful if the people called on to discuss and solve problems feared they were being pulled into a swarm to be punished, Williams adds. “We heard very clearly from the staff [involved when the swarm approach was first being implemented] that Paul DePriest would step in if there was any attempt by others to point fingers or assign blame,” he says.

As time went on, other leaders fulfilled this role. Trained swarm facilitators also made sure to protect frontline staff members from intimidation or punishment. “That happened so repeatedly that people began to become increasingly comfortable, and they recognized the

effectiveness of these swarms,” Williams notes.

**UKHC STARTED WITH ONLY 22 SWARMS IN 2009, BUT MORE THAN TRIPLED THAT NUMBER IN 2010 AND EVENTUALLY COMPLETED MORE THAN 300 BY THE END OF 2014.**

While reformers started small, they focused on important issues, Holbrook recalls.

“The first reforms had to do with unrecognized clinical decline and chaotic codes, particularly in the

ED,” she explains. “We had to proceed slowly, carefully, and reliably in order to establish some credibility to the process.”

In 2009, the first year of swarming, the health system only completed 22 swarms, but the number of swarms more than tripled in the second year, and by the third year nearly 170 swarms were completed, Holbrook says. She adds that in 2014, the health system completed more than 300 swarms, and she is still tallying the number of 2015 swarms.

In the ED, for example, the approach has been applied to patient flow, triage protocols, assessments, overcrowding, and boarding, Holbrook says.

“This swarm process applies to the very basics of healthcare, and what we have found in the course of swarming ... is that often the basics are lacking,” she says.

For instance, assessment, escalation, communication, and handoffs are critical steps, Holbrook notes.

“The nuts and bolts of care, such as taking vital signs and communicating those or obtaining an accurate weight [on a patient],” are very important, she explains.

“We overcame the challenges by explaining [the concept] and reinforcing it at every swarm. We provided feedback to people, and people learned it well,” Holbrook says. “You have the right people in the right place, you hear the stories, and you hear the perspectives of people who were involved: The people in authority, accountability, and responsibility for that unit, service, or department.”

The insight and understanding gained from listening to different viewpoints on a problem or error reduces finger-pointing and blame, Holbrook adds.

## EXECUTIVE SUMMARY

In an effort to strengthen patient safety, leadership at the University of Kentucky HealthCare (UKHC) decided to replace its traditional approach to root cause analysis (RCA) with a process based on swarm intelligence, a concept borrowed from other industries. Under this process, when a problem or error is identified, staff quickly hold a swarm — a meeting in which all those involved in the incident or problem quickly evaluate why the issue occurred and identify potential solutions for implementation.

- A pillar of the swarm concept is a mandate that there be no punishments or finger-pointing during the swarms. The idea is to encourage staff to be forthcoming to achieve effective solutions.
- Typically, swarms last for one hour and result in action plans designed to correct problems or deficiencies within a specific period of time.
- The ED was one of the first areas where UKHC applied swarms. For example, hospital administrators note that the approach has been used to address issues involving patient flow, triage protocols, assessments, overcrowding, and boarding.
- After seven years, incident reporting at UKHC has increased by 52%, and the health system has experienced a 37% decrease in the observed-to-expected mortality ratio.

“That shared perspective, even if it is different, is helpful,” she says. “As we did more of these, we found a way to develop a more standard process in terms of documentation and communication of the findings ... and doing this in a blame-free environment really helped. People are more honest.”

Holbrook observes that one standardized form that is particularly helpful is a sign-in sheet that reminds all swarm participants that their discussions are privileged under federal law.

“As an attorney, I want to make sure that oral and written communications that are part of the swarm process are protected and privileged so that people have a safe place to be open and transparent,” she says. “We very zealously guard our discussions.”

The commitment from top leadership was key to the successful implementation of the swarm process, adds **Jing Li**, MD, MS, administrative director and an assistant professor at the Center for Health Services Research at UKHC.

“We needed the leadership to set the tone, and then for everyone else to get the same message,” she says. “Another [key] strategy at that time was that there was a designated group to start the process.”

## Add structure to the approach

Over the last seven years, UKHC administrators and staff have continued to refine the swarming process. When problems arise, there are two types of swarms to correct problems or improve processes.

“There might be a local unit-level swarm when an issue doesn’t have system-level implications. In that instance, people will deal with the issue right there by pulling their group

together, led by a unit manager or local area staff,” Williams explains. “Then there are system-level swarms ... which invariably involve a senior leader, such as the chief nursing officer, chief operating officer, or chief medical officer.”

In addition, like many health systems, UKHC has an incidence reporting system. Staff review reported issues on a weekly basis according to established criteria to determine

“THIS SWARM PROCESS APPLIES TO THE VERY BASICS OF HEALTHCARE, AND WHAT WE HAVE FOUND IN THE COURSE OF SWARMING ... IS THAT OFTEN THE BASICS ARE LACKING.”

which issues or problems should be swarmed at the system level.

Once the decision is made to hold a swarm, key staff members who were involved in the incident or issue are contacted, and someone from the patient safety department works to coordinate attendance.

“The [swarms] are routinely scheduled at three particular times, either at noon, 7 a.m., or at 4 p.m. or 5 p.m. so that other issues don’t interfere,” Williams says. “Also, since this is a priority for the organization, managers know that if one of their frontline staff [members] is invited to attend a swarm, it is their responsibility to support their staff being there.”

In fact, typically, when frontline staff members are invited to a swarm, their managers also attend the meeting to support their personnel, even if they were not involved in the episode under discussion, Williams adds.

“[Similarly], when residents are invited to a swarm, the residency program director for that particular specialty is invited to the swarm to support the resident,” he says.

Swarms typically take place in a neutral location where participants have access to the health system’s electronic medical record and a whiteboard to document findings or suggestions. The meetings are designed to last for 1 hour, and involve a review of all the particulars that led to the swarm, an investigation of any underlying systems factors, and the identification of specific areas in need of improvement, which are formulated into an action plan. In addition, specific individuals are tasked with carrying out each of the identified action steps, most commonly within 60 days.

“After this one-hour session, there is still a follow-up mechanism in place ... and there will be one person as the key point of contact for the action items,” Li notes. Further, the health system is now developing a database of all swarms that have taken place so that administrators can quickly identify any swarms that are recurring, indicating that the issue has not been solved.

## Engage leadership

After several successful years of swarming, UKHC is developing a standardized, instructional approach so that other organizations can take advantage of lessons learned. In addition, Holbrook has already begun to

visit other hospitals to help train their personnel to implement the process and offer advice to organizations that are interested in traveling a similar path.

Holbrook stresses that senior leadership must lead and promote swarming initiatives.

“Make sure that you have credible people [taking charge] of the effort on an ongoing basis,” she says. “Don’t relegate the responsibility to a manager. Make sure that the initiative has support from the top down

and that you have engagement from leadership.” ■

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# Improving hand hygiene compliance with new technology

*Web-based application produces big gains in compliance, significant reductions in healthcare-associated infections*

There is new evidence that use of a hand hygiene improvement tool developed by The Joint Commission’s (TJC) Center for Transforming Healthcare can not only improve compliance, but also contribute to significant reductions in health care-associated infections.

Investigators at Memorial Hermann Health System (MHHS) in Houston reported that after implementing TJC’s Web-based Targeted Solutions Tool (TST) for hand hygiene in 150 inpatient units throughout its 12-hospital system, and conducting a process improvement project from October 2010 to December 2014, hand hygiene compliance improved from 58.1% at baseline to 95.6% in the final year of the project, based on 31,600 observations. Further, during this same period, rates of central line-associated bloodstream infections decreased by 49% and ventilator-associated pneumonia in the adult ICU decreased by 45%.<sup>1</sup>

The improvements stem from

MHHS’s participation in TJC’s Center for Transforming Healthcare’s inaugural project in 2009, designed to improve hand hygiene. As part of this effort, MHHS and seven other organizations worked to systematically identify strategies for amassing hand hygiene compliance data. They also identified the root causes and factors related to non-compliance, and then implemented interventions to combat these issues.

The Center for Transforming Healthcare then used the information collected during this phase of the project to develop its TST, an application that is based on robust process improvement methodologies such as Lean, Six Sigma, and change management. Investigators noted that the tool guides organizations through a hand hygiene improvement effort. Four hospitals, including Memorial Hermann’s Northwest Hospital, then pilot tested the tool with all four facilities, demonstrating substantial increases in hand hygiene compliance.

At this point, investigators reported that MHHS elected to implement the TST in all 12 of its hospitals as soon as the tool became available in September 2010. MHHS then commenced a study to measure the effect, which included a baseline period to collect pre-implementation data, an improvement phase during which TST-guided interventions were employed, and a control phase to assess whether the improvements achieved in hand hygiene compliance were sustained. Investigators reported that data show MHHS was able to maintain substantially improved compliance throughout its 12 hospitals for 25 months following implementation. ■

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