



→ INSIDE

Twin initiatives accelerate patient flow and nurture collaboration 27

Initiate medication-assisted treatment and connect patients with ongoing care without adding resources 30

Use these steps to handle pushback on plan to tackle opioid addiction in the ED 33

Community ED facilitates throughput with innovative model 33

ED Accreditation Update: Storytelling can help reduce serious safety events; revisiting the domains of high reliability



RELIAS
MEDIA

MARCH 2020

Vol. 32, No. 3; p. 25-36

First Case of Coronavirus Confirmed in United States

Experts see similarities to MERS and SARS, other pathogens that produced difficult-to-contain outbreaks

U.S. ED staff already had their hands full treating patients presenting with influenza; now, there is another pathogen to be concerned about: a novel coronavirus.

This pathogen has sickened hundreds of patients with pneumonia in Wuhan City, China, a significant transportation hub about 700 miles south of Beijing. Several patients there have died from the illness since the pathogen was identified in recent weeks

On Jan. 21, the CDC confirmed the first case of coronavirus in the United States. The agency reported a resident of Washington state was hospitalized with the illness after returning from a trip to Wuhan City. The man, described as being in his 30s, is reported to be in good condition, and health authorities are investigating whether there are any additional exposures related to this first case.

Days before the CDC confirmed the first U.S. case, **Nancy Messonnier**, MD, director of the agency's National Center for Immunization and Respiratory Diseases, addressed why this

outbreak is of particular concern. "We have faced this challenge before, first with SARS [Severe Acute Respiratory Syndrome Coronavirus] and later with MERS [Middle Eastern Respiratory Syndrome Coronavirus]. Both outbreaks were complex and required a comprehensive public health response," she said during a Jan. 17 telebriefing. "Because of that experience, we know it is crucial to be proactive and prepared."

Messonnier said any time there is a new virus or pathogen emerging in a population that has not experienced it before, that population has not built immunity, and there are no specific treatments or vaccines to address the bug.

"Understanding that this pathogen looks, at least from a genetic perspective, like [MERS and SARS] makes us especially worried," she said. "It doesn't take much for a virus in general to go from being worrisome to being extremely worrisome because [viruses] tend to morph and mutate a lot. That's why in this class of viruses, we are especially worried, and we're taking a very

ReliasMedia.com

Financial Disclosure: Physician Editor **Robert Bitterman**, MD, JD, FACEP, Nurse Planner **Nicole Huff**, MBA, MSN, RN, CEN, Author **Dorothy Brooks**, Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Editorial Group Manager **Leslie Coplin**, and Accreditations Manager **Amy M. Johnson**, MSN, RN, CPN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.



ED MANAGEMENT®

ED Management (ISSN 1044-9167) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *ED Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421
customerservice@reliamedia.com
ReliasMedia.com

ACCREDITATION

Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 1.25 AMA PRA Category 1 Credit(s)™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Dorothy Brooks
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

© 2020 Relias LLC. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner.

cautious and proactive approach.” While it is rare for animal coronaviruses to infect people and for the illness to then spread between people, that is what happened in the case of SARS and MERS. There are indications that the newly discovered coronavirus has followed a similar pathway, according to Messonnier.

“Most of the patients in the outbreak have reportedly had some link to a large seafood and live animal market, which does suggest an animal to human spread,” she explained.

While the market was closed in early January for disinfection and cleaning, new cases involving the novel coronavirus continue to be identified, Messonnier indicated. She added that reports from China suggest some patients have become seriously ill from the coronavirus, while others have recovered and are feeling better.

The response to this newly discovered pathogen is early, but Messonnier said the CDC does have some information with which to work in preparing for new cases.

“Our laboratory is using genetic sequences [of the coronavirus] provided by the Chinese, and already has the ability to identify this pathogen,” she said. This testing was conducted within a day in the case of the individual diagnosed with the illness in Washington state.

The genetic sequence has been made available to scientists around the world, which is how cases in Thailand, Japan, and South Korea were confirmed, Messonnier noted.

Investigators in those countries compared the genetic sequences they found in samples from their patients to the sequence the Chinese collaborators shared.

The CDC is working on a more specific diagnostic test that it will be

distributing to state health departments and others soon.

The CDC has begun screening most passengers arriving in the United States on direct and connecting flights from Wuhan City. This screening is taking place at John F. Kennedy International Airport in New York City, San Francisco International Airport, and Los Angeles International Airport. These three airports receive the vast majority of travelers from Wuhan City, noted **Martin Cetron**, MD, director of the CDC's Division of Global Migration and Quarantine, during the Jan. 17 telebriefing.

Plans also have been established to begin screening patients at Hartsfield-Jackson International Airport in Atlanta and O'Hare International Airport in Chicago.

Any passengers who raise concerns based on their symptoms, temperature, and link to Wuhan City will be moved to a tertiary screening process. During this further investigation, quarantine medical officers will ask questions about exposure to family members and others. Also, individuals who are ill will undergo further evaluation at predesignated facilities that can perform a diagnostic workup. This includes collecting specimens that will be sent to the CDC for reference testing for the novel coronavirus.

“We have been through this type of protocol before in 2014 and 2016 during Ebola entry screening, which lasted many months,” Cetron noted. In a similar fashion, individuals requiring further evaluation will be transported safely without exposing others, and they will be evaluated under CDC guidance for infection control precautions and recommendations, he added.

Considering all this is happening in the middle of respiratory virus

season, Cetron stressed that it will be much more likely that travelers identified for further evaluation actually will be suffering from influenza, parainfluenza, or respiratory syncytial virus.

“We have been in contact with some of our partners that are screening in other countries, and it is our understanding that they had screened thousands before they found [cases involving the novel coronavirus],” he explained. “We are expecting this is going to be a triage scenario, and there is the capability in these referral centers for doing rapid diagnostics for the other causes of respiratory illness.”

Cetron added that the symptom-based entry screening process at U.S. airports is just one aspect of a multilayered response that also includes alerting the country’s public health and healthcare delivery systems.

“When used with other public health measures already in place for

the rapid detection of ill-arriving travelers, we can slow and reduce the spread of disease into the United States,” he explained.

The CDC has issued a Health Alert Network (HAN) message containing interim guidance for healthcare providers regarding the outbreak and when they should consider the novel coronavirus in patients who present with fever and respiratory symptoms. Recent travel to Wuhan City or exposure to someone who has recently visited the area should raise suspicions that the novel coronavirus could be the cause of a patient’s illness.

Some hospitals are reportedly already implementing electronic prompts to question patients about recent travel to China, or association with any people who have recently visited the country. The HAN alert provides instructions regarding infection control procedures, specimen collection, and how to report such cases to the CDC. *(Editor’s Note:*

Much more information can be found online at: <http://bit.ly/2TPrr3d>.) “We are preparing across the public health and healthcare [delivery] system to prevent, detect, and respond to this novel coronavirus,” Cetron reported. “The earlier we detect a case, the better we can protect the public and the more we can understand about this virus and its risk for spread.”

Cetron cautioned it is still early in this outbreak, and more guidance and details likely will be forthcoming soon.

“While we have experience with SARS and MERS, humility is important,” he said. “As we learn more about this newly emerging virus, CDC will adjust its screening and response procedures appropriately.”

(Editor’s Note: As of Jan. 27, there have been five confirmed coronavirus cases in the United States, with dozens of other pending cases under review. Updates and more information is available from the CDC online at: <http://bit.ly/3aLTVB3>.) ■

Internal Process Improvements, Focus on Early Discharges Help Relieve Throughput Pressure

Instead of small fixes, examine the entire process as a whole, from patient arrival to discharge

In 2017, the administrative and clinical leadership in the ED at University Hospital in San Antonio, TX, knew they would need some help from inpatient staff to address all their throughput challenges. But first, ED leaders knew they had to put their own house in order.

“I can talk to hospital administration, and we can work together to try to come up with solutions, but [the hospital] is not my house,” says **Christina Bird, DO**, explaining the mindset of leaders in 2017. “The ED is my house, and that is what

we had to try and fix.” The need for change was clear in the ED’s operational metrics at the time. Bird, who now serves as medical director of the department of emergency medicine, notes the overall average length of stay (LOS) was about 475 minutes, and the total LOS in the ED for admitted patients was 625 minutes.

Further, the time between a decision-to-admit order in the ED and the designated inpatient bed becoming occupied was well over 200 minutes. Excessive boarding was an issue. However, it quickly became

clear that nibbling around the edges was not going to fix the problem, Bird observes.

“We tried to siphon off the fast-track patients, but we were not running that as efficiently as we probably could have. Then, we put an advanced practice provider [APP] in triage to try and improve our door-to-provider time,” she explains. “It helped with our leave-without-being-seen rate, but then our left-without-treatment-complete rate went up. Patients would be seen by our provider who would order a

workup, but then patients would go back to the waiting room and they would wait for hours.”

Many patients would leave in frustration because there was no room to put them in, Bird explains. “It was like we were trading one metric for another,” she says. “We did small Band-Aids here and there that we thought were doing something, but they really weren’t.”

Ultimately, ED leaders concluded a complete overhaul of the intake process was needed. Dubbing this effort the “power up” initiative, department leaders created a true split-flow model, dividing the ED into sections based on acuity.

“Looking at our data, we realized we really didn’t have a lot of fast-track patients, our ESI [Emergency Severity Index] 4s and 5s,” Bird notes. “We were only seeing about

20 to 25 fast-track patients a day. That wasn’t enough to justify the amount of resources we were using for our fast track.”

Consequently, model developers replaced the fast track with a new area dubbed the “power pod,” designed to manage ESI level 5, 4, and so-called “vertical 3s,” or patients designated as ESI level 3 who can remain seated and most likely will be discharged. “The other stream of flow is our ESI level 1s, 2s, and the horizontal or sicker level 3s,” Bird adds.

Under this configuration, patients designated as ESI level 1 or 2 will go directly to a bed in the ED’s main treatment area. Patients designated as ESI level 4 or 5 will go to the power pod for care. Then, ESI level 3 patients will be seen by a physician in triage who will determine

which space is best and begin the appropriate workup.

“That is our highest volume of patients,” observes Bird, referring to the ESI level 3 designees.

In place since May 2018, the approach has proven to provide a more efficient use of space and resources, Bird reports, noting the department’s former 12-bed fast-track area has been transformed into a power pod with 23 treatment spaces to accommodate both fast-track and what she refers to as mid-track patients.

While ED leaders were working with frontline staff on the front-end overhaul, they also began working to optimize their connections with the other hospital departments and services the ED relies on in caring for patients.

“We brought together all of the stakeholders from multiple ancillary services,” Bird explains. “We also had hospital administration be a part of it.”

The idea was to demonstrate the ED was doing everything possible to fix what it could internally, but that it now needed the hospital’s active involvement to work on the ED’s boarding problem — an issue that was beyond the ED’s full control.

By this point, the ED had made significant progress on its operational metrics. As of December 2018, Bird notes the leave-without-treatment-complete rate was down to 5.1%, the left-without-being-seen rate was at 1.1%, the door-to-provider time was 29 minutes, and the ED’s discharge LOS stood at 348 minutes.

To make further progress, beginning in January 2019, hospital administration initiated its own “power through” initiative, aimed in part on relieving throughput pressure on the ED. “We had already been working on this for a year, so [the

EXECUTIVE SUMMARY

Through two related initiatives, University Hospital in San Antonio, TX, has significantly improved throughput in the ED and communications with other hospital services and departments. First, the ED tackled its own internal operations, overhauling its intake process and expanding the number of treatment spaces. Then, the ED began working with the inpatient side to ensure beds were available in time to accommodate admissions from the ED and reduce the need for boarding.

- The ED instituted a true split-flow model, dividing patients into two flow streams based on acuity.
- To facilitate this transition, a 12-bed fast track was transformed into a “power pod” area with 23 treatment spaces.
- Patients designated as Emergency Severity Index (ESI) levels 3, 4, or 5 are sent to the power pod for care while more acute patients (ESI levels 1 or 2) receive care in the ED’s main treatment area.
- In addition to the internal process improvements, the ED worked with inpatient staff on discharge scheduling to better accommodate daily admissions from the ED.
- The hospital’s push to facilitate discharges by noon has made a significant dent in the time between bed request and bed occupied or boarding time in the ED. Administrators note this number had dropped from 240 minutes before the improvements were made to 120 minutes in October and November 2019.

inpatient side] was using some of our data and some of our suggestions,” Bird shares. “They decided to hone in on [facilitating] discharges before noon ... because our arrival curve starts to pick up between 9 a.m. and 11 a.m. By the time these ED workups are finished, that is when admissions really start to [increase].”

In the push to bring all inpatient units on board with earlier discharges, the “power through” team members began holding weekly lunches to review data and any ongoing challenges or issues that cropped up.

“In April or May [2019], they invited [ED representatives] to begin attending the lunches to try to bring us into the conversation more and also so that we could present some of our data,” Bird recalls. “They could see how what they are doing impacts what we are doing.”

During these sessions, the ED nursing director typically takes charge of presenting the relevant metrics from that area, and then the panel talks through what is or is not working, Bird shares. However, there is no question the concerted push to facilitate earlier discharges is paying off.

“In the last three or four months, we have had a significant drop in our boarding,” Bird observes. “At our worst, the time between bed request to bed occupied was about 240 minutes ... and in October and

November 2019, [that number] was down to 120 minutes.”

To be sure, there have been some months when boarding times in the ED have surged, but the overall trajectory of the effort is positive. Still, the “power through” team is pushing for continued progress.

The goal is to shorten the bed-request-to bed-occupied time to 45 minutes for patients admitted from the ED, Bird offers.

While the “power up” and “power through” initiatives have not solved all the throughput challenges, there have been some additional benefits beyond reduced boarding levels.

“When we started [the power up] initiative, because of how collaborative it was and how much time we all spent together ... it really created this awesome teamwork aspect,” Bird shares. “It really kind of regenerated a lot of people.”

Several champions were identified to drive the various aspects of the overhaul, and the ED leadership stayed involved.

“We took point on a lot of the smaller group sessions ... and I reviewed all of the workflows when we revised them,” Bird notes.

Further, Bird says that standards for work were established to describe what the expectations for each job or role in the new workflows were. The team developed guidelines and restrictions regarding which patients can be sent to the power pod area.

To keep the team on track, leaders follow up on any staff complaints regarding patients who are placed in the power pod for care even though they do not meet the appropriate criteria.

“We review [these cases], and then we talk to the team. We also do frequent messaging,” Bird reports. “Any time you create new processes and protocols ... a lot of it is just continuing to message people, to remind them of the guidelines.”

Bird acknowledges that sustaining the improvements is a continuing challenge. “People can slip back a little bit, but also when you become more efficient and you do things well, you in turn get a higher volume of patients,” she says. “Every month, we have beaten our volumes from last year.”

Bird’s advice to other ED leaders planning efforts to address throughput challenges is to first gather good data.

“That is something we struggled with in the beginning, not really knowing what our numbers represented and whether they were correct,” she says. “If you can’t trust the metrics, you are going to have a hard time making improvements on them.”

Also, do not get caught up trying to fix little issues here and there; look at the whole process, from patient arrival to patient disposition, Bird advises.

Assess • Manage • Reduce Healthcare RISK

Listen to our free podcast!

Episode 4: Reflections of a Nurse: What Made Me Stay or Leave?

www.reliasmedia.com/podcasts



“We had tried lots of smaller Band-Aids, and they all failed,” she says. “We had to make everything work together in unison. We couldn’t just fix one small part of it.”

Bird adds that it is critically important to bring all stakeholders to the table to achieve meaningful improvement. One might be surprised what is revealed.

“Even though we had radiology and the lab [on board] right from the

beginning, we realized they weren’t aware of some of our targets and our initiatives,” she explains.

For instance, radiology always tended to queue imaging tests based on patient acuity, where the sicker patients always received X-rays first. However, in some cases, the ED needed tests performed on lower-acuity patients first.

“We realized that we weren’t telling [radiology] when we needed

those tests done,” Bird notes. Today, the ED is in the process of figuring out a better way of queuing needed services, and how the department can most effectively work with allied services.

“I think really engaging with all the parties is what you need to do,” says Bird, adding the effort has proven worthwhile there. “We are routinely now having zero patients in the waiting room.” ■

EDs in Smaller Communities Can Initiate Medication-Assisted Treatment Without Additional Resources

A reliable treatment center partner is critical to quickly take over the care of patients initiated on such treatment

There are many reasons why EDs may choose to keep patients who present with opioid use disorders at arm’s length, preferring to hand them off to an addiction or behavioral health specialist whenever possible. One of the more frequent refrains is that they simply do not have the resources or expertise to treat addictions.

However, the results of an intriguing new study suggest that not only can larger, urban EDs with plentiful resources respond to this need effectively, but EDs in more rural settings can act, too.

Investigators conducted a small, prospective, observational study at Arnot Ogden Medical Center (AOMC) in Elmira, NY. It grew out of many years of frustration experienced by **Frank Edwards, MD, FACEP**, emergency medicine residency director at AOMC.

“For many years working in this region, on a reasonably regular basis I would have patients come into the ED in opioid withdrawal who didn’t have any significant hookup with treatment options, [and they] were asking for help,” Edwards recalls. “Other than giving them Tylenol,

Zofran, and treating their symptoms with an alpha-blocker, clonidine, or something that might help a tiny bit, there wasn’t too much else to do.”

Edwards would give these patients the phone number for a local treatment center and hope they would follow up.

“We here in Elmira are one of the hotbeds for opioid use disorder,” he shares. “It is sort of a rural, economically deprived area with not enough Suboxone providers to go around, so we needed to address this.” Edwards came across the pioneering work of Gail D’Onofrio,

Assess...
Manage...
Reduce...

Healthcare RISK

Listen to our free podcast!

Episode 12: Provider Burnout When Treating Opioid Use Disorder

www.reliasmedia.com/podcasts



MD, MS, the physician-in-chief of emergency services at Yale-New Haven Hospital. She and colleagues documented the benefits associated with a new model of care for patients who present to the ED with symptoms of opioid withdrawal.¹

“[They] showed you can treat these folks with buprenorphine in the ED and give them a warm handoff to a treatment center, and [these patients] have much better follow-up rates,” Edwards explains. “That only makes sense.”

To date, most EDs that have implemented the type of approach spelled out in D’Onofrio’s study are in larger urban centers where resources tend to be more plentiful.

Nonetheless, Edwards researched the issue further. He believed developing such a program at AOMC could provide not only a feasible solution for the community, it could form the basis of a good, scholarly educational project for the hospital’s residents to tackle.

“After discussions with some toxicologists about the use of buprenorphine ... we decided to [do the program] here,” Edwards says. “It also coincided with the hospital’s development of a task force to help deal with the opioid crisis as well.”

When staff initiate medication-assisted treatment (MAT) in the ED, it is important to work with a partner in the community that can continue providing Suboxone to patients once they leave the ED. Consequently, Edwards contacted CASA-Trinity of Chemung County, an outpatient drug and addiction treatment facility staffed by peer counselors, nurses, and Suboxone providers. “We are the only substance use treatment provider in Elmira other than some private [practitioners], but we are licensed by the state. We were the logical

EXECUTIVE SUMMARY

The results of a study conducted in the ED at Arnot Ogden Medical Center in Elmira, NY, provide a roadmap for how EDs in smaller, less densely populated areas can help their communities address the opioid epidemic. Without taking on any additional staff, investigators found it is feasible for emergency providers in such settings to initiate patients on buprenorphine and then refer these patients to a local treatment center for continued medication-assisted treatment (MAT).

- When the study was conducted, the ED advertised that patients in withdrawal could be treated there and then linked to a treatment provider for ongoing MAT.
- Key to the approach was a good working relationship with a local treatment center that agreed to see patients started on buprenorphine in the ED within three days.
- Results from the 12-month study showed that out of 62 patients who were evaluated for the program in the ED, 53 met the criteria to receive buprenorphine in the ED and were initiated on treatment. Of this group, 46 were compliant with their initial appointment to receive MAT at the addiction treatment clinic. Forty-three of the original 62 patients who were referred to the treatment center for care still were receiving MAT at 30 days, and 33 patients still were engaged in MAT at 90 days.

entity to be at the table for this,” explains **Ann Domingos**, LCSW-R, CASAC, CADC, the CEO of CASA-Trinity, which maintains three other addiction treatment clinics in New York and two clinics in Pennsylvania. “[Edwards] called everybody together and talked about how we could address this.”

Edwards and Domingos came up with a working relationship whereby any patient who agreed to begin MAT in the ED would be seen whenever possible in the CASA-Trinity clinic within three days.

This time frame fit within Drug Enforcement Administration rules, which allow non-X-waivered physicians to administer buprenorphine for up to 72 hours, enabling the ED to continue providing the drug to patients up until their scheduled appointment at the treatment facility.

The facilities created a communication system and

developed relevant paperwork. Whoever is treating a patient in the ED can call the clinic to set up a guaranteed appointment.

“If this was during off hours, there would be a voicemail system plus some paperwork that the patient would take with him or her to the treatment center at the next-available time and day when it was open,” Edwards notes.

While Domingos welcomed the effort, there were some initial challenges on her end.

“We had not yet developed a robust outreach and warm handoff component to our program. Systems were changing at that time to include that type of thing,” she recalls. “It was an interesting process to be able to free up staff to be able to go to the ED and meet [patients there] if at all possible.”

Domingos notes this was at a time when peer recovery specialists,

individuals who are in recovery from substance use disorders themselves, were first certified by the state to provide counsel and support to new patients seeking treatment.

“[Peers] can go over to the ED to meet patients and let them know they will see them when they come over to the clinic,” she says.

Nonetheless, the process was new to Domingos and AOMC ED staff. “Some of the challenge was intersecting differently both with other providers and [individuals] in our own system,” she explains.

Once all the intricacies of the process were worked out with CASA-Trinity, Edwards made sure nurses, physicians, and advanced practice providers were fully educated about how the program would work. This happened through presentations, emails, and printed materials spelling out the protocol and other relevant details, according to investigators.

During the 12-month period when the program was under study (March 15, 2018, through March 15, 2019), the ED advertised to the community that people in withdrawal could come in for immediate treatment with buprenorphine and a rapid referral for ongoing MAT services. This outreach was conducted through flyers, press releases, and interviews on local TV, according to investigators.

“One of the thrusts of the program was that if we let the community become aware of this option for getting treatment, they wouldn’t necessarily have to just call the treatment center and get an appointment at some time in the future,” Edwards shares. “If they were in withdrawal and wanted treatment right then, then they could come on in. In a nonjudgmental fashion, we would treat them and get them linked up [with a MAT provider].”

While there were some logistical hurdles, Edwards notes the study showed this type of program is feasible without the need for additional resources.

“We did have a study coordinator who worked with us for one year and basically kept track of the patients’ data so we could compile our statistics,” he says.

However, other than for data tracking and collection, no additional staff members were required. Further, the results demonstrated the benefits of initiating MAT in the ED.

OTHER THAN
FOR DATA
TRACKING AND
COLLECTION,
THIS MODEL
REQUIRED NO
ADDITIONAL
STAFF MEMBERS.

Investigators reported that during the study period, 62 patients were evaluated for buprenorphine criteria, 53 of whom met the criteria to receive buprenorphine in the ED, and then were referred to the treatment center for follow-up. Of this group, 46 patients were compliant with their initial appointment to receive MAT at the addiction treatment clinic.

Of the nine patients who did not meet the required criteria, or were not in sufficient withdrawal, to receive buprenorphine in the ED but were nonetheless referred to the clinic for treatment, four patients appeared for their initial MAT appointment at the treatment

facility. Forty-three patients still were receiving MAT at 30 days, and 33 still were engaged in MAT at 90 days.²

While the AOMC ED no longer advertises to the community, patients in withdrawal still can be initiated on MAT in the ED and then be referred to CASA-Trinity for continued care. It is an option patients still pick, Edwards observes.

“That second piece is really key to making this [program] make sense,” he says, referring to the need to develop a working relationship with an outpatient treatment center that can take over the care of patients on MAT.

Domingos, who has since established similar relationships with other EDs, adds that another critical piece is designating a champion in the ED who is 100% behind the approach and will push for the needed changes.

“Some of it is educating the emergency physicians and nurses on addiction. It is also getting everybody around the table from the very beginning before you are going to do this to talk about how you can do it,” she says. “There is a lot of up-front work that really needs to happen before this type of project can be successful. That is really what makes or breaks it.” ■

REFERENCES

1. D’Onofrio G, O’Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment of opioid dependence: A randomized clinical trial. *JAMA* 2015;313:1636-1644.
2. Edwards F, Wicelinski R, Gallagher N, et al. Treating opioid withdrawal with buprenorphine in a community hospital emergency department: An outreach program. *Ann Emerg Med* 2020;75:49-56.

Arriving at 'Yes' on Providing Treatment, Referral for Opioid Use Disorders

Bringing emergency physicians on board with the idea of initiating patients on medication-assisted treatment (MAT) for opioid use disorders can present challenges, acknowledges **Frank Edwards**, MD, FACEP, emergency medicine residency director at Arnot Ogden Medical Center (AOMC) in Elmira, NY.

“The perceptions that a lot of physicians have is that these are patients they don’t want to deal with,” he says.

However, Edwards stresses physicians must understand they are going to encounter these patients one way or the other.

“These are patients who would otherwise be coming in to hit you up for a prescription for Percocet for their back pain ... or they would be coming in with abscesses from shooting up,” Edwards shares. “We have a problem, and the medical profession is partly responsible, so we should step up to the plate and help.”

Edwards has found this message resonates, at least with most emergency physicians in his own ED. Residents in particular enthusiastically support AOMC’s policy of providing buprenorphine to patients who present with opioid withdrawal symptoms and referring them a local treatment center for continued care.

While one of seven attending physicians in the ED expressed some skepticism of the idea that providing treatment for patients in withdrawal should be part of an emergency physician’s scope of practice, most were at least open to the idea once they learned more about buprenorphine, Edwards recalls.

“It is a very safe medicine, and many physicians are frankly scared of buprenorphine or Suboxone,” Edwards observes. “It is the lack of familiarity and the fact that the DEA has it in a special category right now.”

Ann Domingos, LCSW-R, CASAC, CADC, the CEO of

CASA-Trinity, agrees that a lack of familiarity with buprenorphine often is behind emergency provider resistance to taking on patients with opioid addictions.

“Without a lot of experience in the field ... they get concerned about providing this medication,” she says.

Educating providers about buprenorphine or Suboxone can remedy this problem, but this often requires ongoing persistence, Domingos observes.

“The challenge is that doctors rotate so often that sometimes the information doesn’t get to them,” she adds.

Fortunately, Domingos sees more emergency physicians coming around to the idea that they can play a role in the treatment of opioid addiction, and they are more open to new approaches in the ED.

“There has been a lot of work [in this area] over the past four years,” she notes. “It really makes it impossible for people to bury their heads in the sand.” ■

Rapid Assessment Zone Re-Engineers Patient Intake Process, Expedites Care

In the continuing quest to minimize wait times and enhance operational efficiency, clinicians and administrators have developed many patient flow models, most of which tend to work best in EDs with specific characteristics or patient populations.

Sometimes, a unique model emerges that is worth considering for ED leaders who suspect there is more they could do to optimize their resources and serve patients

more efficiently. For instance, recent research suggests the development and implementation of a rapid assessment zone (RAZ) model has produced positive benefits for the ED at St. Luke’s Hospital in New Bedford, MA, a busy, community ED that averaged about 90,000 patients a year as of 2017, the period during which the RAZ model was first implemented.

In a retrospective before-and-after study, investigators found the RAZ

approach enabled the ED to cut the average arrival-to-provider time in half, trim overall length of stay (LOS) by 32 minutes, and reduce the leave-without-being-seen rate by 84%.¹

It is an ongoing journey for the St. Luke’s ED, but the results suggest the RAZ model may be an approach that other similar departments may find useful as they examine their own operational metrics and pressure points.

The St. Luke's development team members did not start from scratch when designing their own approach. They borrowed elements from other front end optimization models, but also looked closely at their own data to devise a solution best suited to facilitating throughput, given their environment, staff, and patient population.

Jennifer Pope, MD, a co-author of the study and an emergency medicine physician affiliated with both St. Luke's and Beth Israel Deaconess Medical Center in Boston, explains there are two main components to the RAZ model: an up-front triage decision and the RAZ space itself.

"[A] rapid split was developed in response to an analysis of [the ED's] old process, which found there was a lot of time lost performing a detailed triage process up front," she notes. "The ED had been trying to compensate by using a lot of nursing-driven triage protocols, which can be very helpful when short on clinical space, but also [can]

lead to overtesting." Consequently, the RAZ model essentially eliminates traditional triage from the intake process and employs a "pivot nurse" to quickly determine whether patients can remain ambulatory or likely will require more intensive resources. This determination is based on the nurse's clinical judgment, a patient's age, and primary complaint. The decision is made before any vital signs are taken or an Emergency Severity Index Score designated.

The pivot nurse's determination is used to split the flow of patients between the main ED, a 49-bed area that receives patients who will likely require more resources, and the RAZ, a space that includes 18 rooms equipped to manage the patients who can remain ambulatory.

"The RAZ space and its function [have] both planned and organic components," Pope observes. "St. Luke's is a relatively large-volume ED, but has a low volume of true [lower acuity] patients." Further,

Pope notes the large waiting room in the original ED offered an opportune space from which to carve out additional ED care spaces.

"We created one large patient care space as opposed to multiple small ones, which meant [the area] would need to care for a broader acuity of patients than a fast track [typically would]," she says.

Once patients are placed in the main ED or RAZ, they will undergo a provider assessment, vital signs will be taken, and a full nursing triage assessment will take place. The idea is for these actions to occur as concurrently as possible to remove unneeded extra steps and minimize serial assessments, according to investigators. Further, bedside registration is completed when it does not conflict with patient care.

In most cases, patients sent to the RAZ will be diagnosed and treated while ambulatory. Patients sent to the RAZ who are identified as requiring more resources than originally determined may be transferred to the main ED, although their care can begin in the RAZ.

When space is not available in the main ED, the RAZ can be flexed to include some acute care space. Typically, the pivot nurse, in concert with the ED lead nurse, makes such determinations.

During the intervention study period, which began in June 2017, the RAZ was operational every day between 9 a.m. and 11 p.m. and staffed by four nurses, three clinical technicians, a physician, and two advanced practice providers. Notably, the approach did not require the onboarding of any additional staff.

To assess the impact of the model, investigators compared data from the six months before the intervention began with data compiled for six months following implementation of

EXECUTIVE SUMMARY

To reduce bottlenecks, a development team at St. Luke's Hospital in New Bedford, MA, developed a rapid assessment zone (RAZ) model aimed at minimizing unneeded steps and expediting care. The approach has proved beneficial, enabling the ED to make improvements in several operational metrics without the need to take on additional staff.

- Administrators note there are two main components to the RAZ model: an up-front triage decision and the RAZ space itself.
- Soon after presentation to the ED, a pivot nurse determines whether patients should be sent to the RAZ for assessment and treatment or to the main ED. This determination is made primarily based on the nurse's clinical judgment, a patient's age, and the chief complaint. It takes place before vital signs are taken or an Emergency Severity Index score is assigned.
- Generally, patients who can remain ambulatory go to the RAZ, while patients who will require more intensive services go to the main ED.
- In a retrospective before-and-after study, investigators found the approach enabled the ED to significantly reduce the average arrival-to-provider time, overall length of stay, and the leave-without-being-seen rate.

the RAZ. Both the pre- and post-intervention periods included more than 43,000 patient visits to the ED. Investigators reported the RAZ model produced improved outcomes on all metrics studied. This included an overall median ED LOS decline from 203 minutes to 171 minutes, a decline in the median arrival-to-provider time from 28 minutes to 13 minutes, a decline in the leave-before-treatment completed rate from 1.0% to 0.8%, and a decline in the leave-before-being-seen rate from 3.1% to 0.5%.

While the intervention proved successful, one early hurdle concerned creating a “greeter” position. The person fulfilling this nonclinical role is responsible for managing a quick preregistration and recording each patient’s primary complaint upon presentation to the ED.

“A major challenge was getting the greeter team comfortable with the role,” shares Pope, explaining that the greeter and an ED tech are the first employees to see incoming patients. “The pivot nurse is often able to make the decision [regarding] patient flow without seeing many of these patients.”

To assist with this task, Pope notes that the development team created a ‘trigger’ mechanism that the greeter can use for patients who require immediate attention. For instance, the greeter would call “trigger” for any patient in obvious distress, someone who is unresponsive, or someone who has been stabbed.

The authors stated the model includes flexibility for patients who present with certain complaints such as chest pain. In that instance, for example, a patient will receive an ECG before the pivot nurse’s decision regarding placement in the RAZ or main ED. Also, they noted

plans are in place to adapt the RAZ model in the event of patient volume surges.

Considering the pivot nurse plays a key role in the RAZ, the individuals chosen to serve in this

FOR OTHER ED LEADERS WHO FACE SIMILAR CHALLENGES, FRONT-END IMPROVEMENT WILL PRODUCE FEW DIVIDENDS IF THE PROCESS HAPPENS IN ISOLATION.

position initially were experienced nurses who were well-versed in rapid triage, Pope explains.

“Some had been part of the RAZ development team,” she says. “Over time, we have seen the role performed successfully by a broad cross-section of nurses who have rotated into the role and who have received training from nurses experienced with the model.”

Pope adds the RAZ team continues to examine the model for new iterative changes that might further enhance performance.

“[This includes] taking a closer look at the pivot [nurse] role and improving the process for moving patients out of the RAZ when they are more complex/sick, and main department beds are limited,” she shares. “Any major change should be accompanied by a regular examination of data, discussion with front-line staff regarding challenges and barriers, and the understanding that healthcare demands flexibility and agility in navigating a field that changes constantly.”

For other ED leaders who face similar throughput challenges, Pope cautions that a front-end improvement will produce few dividends if the process happens in isolation.

“There was a lot of work done prior to [implementation of] the RAZ focusing on internal and back-end ED operational processes and metrics,” Pope explains.

These improvements focused on things such as lab and radiology turnaround times and streamlining the admission process.

“These other processes need to be examined and optimized thoroughly to best understand what front-end process a department needs,” Pope adds. ■

REFERENCE

1. Anderson JS, Burke RC, Augusto KD, et al. The effect of a rapid assessment zone on emergency department operations and throughput. *Ann Emerg Med* 2020;75:236-245.

COMING IN FUTURE MONTHS

- Improving the emergency environment for patients with autism and other sensory deficits
- A new emphasis on the social determinants of health in the ED
- A push to move pediatric readiness beyond the ED and into the prehospital environment
- How this year’s flu season has arrived with added complexities for frontline providers



ED MANAGEMENT

PHYSICIAN EDITOR

Robert A. Bitterman, MD, JD, FACEP
President
Bitterman Health Law Consulting Group

NURSE PLANNER

Nicole Huff, MBA, MSN, RN, CEN
Clinical Manager
Santa Ynez Cottage Hospital
Emergency Department
Solvang, CA

EDITORIAL ADVISORY BOARD

Nancy Auer, MD, FACEP
Vice President for Medical Affairs
Swedish Health Services, Seattle

Kay Ball, PhD, RN, CNOR, CMLSO, FAAN
Professor of Nursing
Otterbein University
Westerville, OH

Larry Bedard, MD, FACEP
Senior Partner
California Emergency Physicians
President, Bedard and Associates
Sausalito, CA

Richard Bukata, MD
Medical Director, ED, San Gabriel (CA) Valley Medical
Center; Clinical Professor of Emergency Medicine, Keck
School of Medicine, University of Southern California
Los Angeles

Diana S. Contino, RN, MBA, FAEN
Executive Director, Accountable Care Organization
Memorial Care Health System
Fountain Valley, CA

Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC
President, Edelberg Compliance Associates
Baton Rouge, LA

Gregory L. Henry, MD, FACEP
Clinical Professor, Department of Emergency Medicine
University of Michigan Medical School
Risk Management Consultant
Emergency Physicians Medical Group
Chief Executive Officer
Medical Practice Risk Assessment Inc.
Ann Arbor, MI

Marty Karpel, MPA, FACHE, FHFMA
Emergency Services Consultant
Karpel Consulting Group Inc.
Long Beach, CA

Thom A. Mayer, MD, FACEP
Chairman, Department of Emergency Medicine
Fairfax Hospital, Falls Church, VA

Larry B. Mellick, MD, MS, FAAP, FACEP
Vice Chairman, Academic Affairs
Interim Section Chief, Pediatric Emergency Medicine
Assistant Residency Director
Professor, Emergency Medicine
University of South Alabama
Mobile, AL

Robert B. Takla, MD, FACEP
Medical Director and Chair
Department of Emergency Medicine
St. John Hospital and Medical Center, Detroit

Michael J. Williams, MPA/HSA
President, The Abaris Group
Walnut Creek, CA

Interested in reprints or posting an article to your company's site? There are numerous opportunities for you to leverage editorial recognition for the benefit of your brand. Call us at (800) 688-2421 or email us at reprints@reliamedia.com.

Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliamedia.com or (866) 213-0844.

To reproduce any part of Relias Media newsletters for educational purposes, please contact The Copyright Clearance Center for permission:

Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. Under the working relationship established between the ED at Arnot Ogden Medical Center and the CASA-Trinity treatment center in Elmira, NY, patients initiated on medication-assisted treatment in the ED will be seen at CASA-Trinity within:
 - a. one day.
 - b. two days.
 - c. three days.
 - d. seven days.
2. Public health authorities are especially worried about a novel coronavirus that has emerged from China because, from a genetic standpoint, it looks similar to:
 - a. measles.
 - b. HIV.
 - c. swine flu.
 - d. MERS and SARS.
3. In their redesign of the patient flow process in the ED at University Hospital in San Antonio, TX, a team transformed a 12-bed fast track area into:
 - a. an on-site lab.
 - b. a power pod with 23 treatment spaces.
 - c. an enlarged waiting room.
 - d. an observation area.
4. Under a revamped intake process implemented at St. Luke's Hospital in New Bedford, MA, who determines whether patients can remain ambulatory or will require more intensive resources?
 - a. An advanced practice provider
 - b. A physician
 - c. A pivot nurse
 - d. A charge nurse

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;
3. Implement managerial procedures suggested by peers in the publication.

Hartford HealthCare Touts Benefits of Storytelling in Quest to Reduce Serious Safety Events

This approach requires a commitment to transparency, sharing the good and the bad at all levels to become better

The term “high reliability” had not come into focus when the quest to become a high reliability organization (HRO) began a decade ago for Hartford HealthCare.

That is when Hartford, a seven-hospital system based in Connecticut, adopted its H3W operating model, according to **Rocco Orlando**, MD, FACS, the health system’s chief academic officer, who spoke about the health system’s journey at the Institute for Healthcare Improvement’s national forum in December 2019.

“It’s really about culture and respect. It’s about how we get along with one another. We thought that platform was essential to the high reliability part of the journey,” Orlando noted.

However, over time, health system leaders have layered on additional aspects to the operating model, such as Lean quality improvement techniques, the creation of new metrics, and organized rounding.

“We were incrementally adding to the capabilities of our model over time because we think it is essential that you can’t drive your people crazy,” Orlando explained. “You have to keep the lessons simple and straightforward. You have to really convince folks that [new steps] are really part of an organic process.”

However, the explicit “high reliability” piece of Hartford’s journey really began in 2013. That is when leaders committed to eliminating medical errors, Orlando

recalled. Fortunately, leaders were not walking this path alone. Hartford joined the Connecticut Hospital Association and its member facilities in committing to the same goal. “It was really a commitment to cultural change,” Orlando added.

Since then, Hartford has used techniques to enhance reliability processes, with a keen focus on systems thinking and preventing errors before they occur.

“We have paid more attention to detection,” Orlando reported. “We are looking at our near-misses, we are looking at our precursors to safety events, and we are really harvesting that data to look for trends to find times when we might be able to head off something at the pass.”

Hartford’s leaders also have focused on the organization’s approach to root cause analysis to examine serious safety events and ensure lessons learned are shared widely.

“Our serious safety events and our high-risk near-misses are shared ... at all of our leadership groups, and then again cascaded down [to staff],” Orlando explained. “There is a richness in those experiences that needs to be shared.”

As part of this effort, Hartford has focused on ensuring staff use the same process to assess and document harm, Orlando observed.

“We make sure that the way we categorize serious safety events, precursor safety events [that reach the

HARTFORD HAS USED TECHNIQUES TO ENHANCE RELIABILITY PROCESSES, WITH A KEEN FOCUS ON SYSTEMS THINKING AND PREVENTING ERRORS BEFORE THEY OCCUR.

patient but cause minimal or no harm] and near-misses ... is the same across the entire organization,” he added.

To facilitate this process, the health system maintains a centralized quality structure in which adverse events and near-misses are reviewed to ensure a consistent approach is used in categorizing and analyzing the cases. This helps keep data reliable, Orlando said.

“We are using our electronic reporting systems to harvest and mine these data,” he shared. “We are presenting this [information] in dashboards so that we have data and trends that we can then feed back to all of our system members to help in the improvement process.”

Use Case-Based Learning

All these techniques have paid dividends. In five years, Hartford has reduced serious safety events by more than 70%. But with improvements plateauing in recent years, leaders

reached for a new approach to their operating model that would help them continue the march toward high reliability.

They concluded that any new approach should begin with broad buy-in from the entire leadership team, including Hartford’s board and CEO, and that it should become part of the rounding process, Orlando explained.

“We have to make it tangible when we are meeting with staff, whether in informal meetings or in rounding,” he said.

Ultimately, in 2019, the leadership team concluded they needed to re-educate using case-based learning or storytelling to illustrate how errors occur.

“We were really feeling that we needed staff to engage in questions and learning and really probe what we should be doing differently,” shared **Stephanie Calcasola**, MSN, RN-BC, CPHQ, vice president for quality and safety at Hartford HealthCare. “Our quality and risk manager leaders created 27 case-

based sessions based on our harm events, not our proud moments.”

These cases were categorized by specialty. For instance, some involved heart or vascular events, while others pertained to inpatient transitions, ambulatory care, or medical diagnostic errors, Calcasola explained.

“We then created a standard one-hour template program with all credentialed HRO trainers,” she added.

Thus far, the training sessions have been deployed to Hartford sites throughout Connecticut, engaging more than 1,500 clinical leaders. “Our goal was to rearticulate what high reliability behaviors are,” Calcasola noted.

For instance, the sessions include a review of how to use the Stop, Think, Act, Review (STAR) mnemonic. “The other major cultural commitment was [for attendees] to understand their role as a leader in modeling high reliability, particularly for our numerous staff,” she said.

There also is an emphasis on empowering staff to use “red alerts” if they need to express a safety concern, Calcasola noted.

“That flattens the power base, and we have another chain of command that we follow for that,” she observed.

Revisit Harm Events

Each case session provides an opportunity for participants to conduct their own root cause analysis to figure out what went wrong.

For example, one case involved a 53-year-old patient who was brought to the ED suffering a stroke. There was bleeding in his brain, and it was determined that he required a

EXECUTIVE SUMMARY

After several years of progress, Hartford HealthCare, a seven-hospital system based in Connecticut, is using case-based learning to move beyond a plateau regarding its reduction of serious safety events. This new effort is part of the health system’s commitment to eliminate medical errors.

- Leaders created a curriculum that includes learning sessions based on more than two dozen cases of harm or medical error that actually occurred in the Hartford system.
- The specific cases used have been selected from various disciplines, ranging from incidents that involved heart or vascular events to harm that transpired because of hospital transitions or diagnostic errors.
- Administrators note these sessions create powerful learning opportunities whereby clinicians and staff perform their own root cause analyses before discussing how the errors can be prevented moving forward.
- The sessions are used to enforce high reliability behaviors and to encourage staff at all levels to raise safety concerns.

hemicraniectomy, where part of his skull would be removed to relieve pressure on one side of his brain, Orlando observed.

Luckily, one of the health system's best neurosurgeons would be performing the operation, supported by an excellent team. The patient was brought to the operating room, there was a time out taken before the procedure began, and the surgery was completed, Orlando reported.

However, when the neurosurgeon immediately reviewed a post-operative CT scan of the patient's brain to assess the results, he realized he had operated on the wrong side of the brain.

Hartford leaders are using this incident as a case-based opportunity for learning. A relevant multidisciplinary group will work to figure out what went wrong and how another similar situation can be prevented. In this instance, the patient had dark skin. The purple marker the surgeon

used to label the side of the brain requiring surgery was not visible, Orlando explained. The surgeon marked the correct side, but later turned the patient's head to the wrong side, resulting in the wrong-site surgery.

**IN FIVE YEARS,
HARTFORD HAS
REDUCED SERIOUS
SAFETY EVENTS BY
MORE THAN 70%.**

This is despite the fact the team went through the time out and the verification process that is part of operating room procedure. "This tells you that it really wasn't a good time out," Orlando observed.

In this case, investigators discovered that there was an inappropriate deference to authority. Everyone was

thinking that the surgeon was the smartest guy in the room, that he is never wrong, Orlando explained. "We are all wrong [sometimes], and we need our teams to help us," he added.

Listening to clinicians in the room reliving that event through the case study, Calcasola was impressed hearing how each participant rethought what he or she might have done in that situation, and whether that event could have happened to them, she explained.

"It indirectly supports some of our just culture work, recognizing that errors happen to all people, and what we could we do differently as a way to even support that practitioner because of that error," she said. "That kind of learning is quite powerful."

Storytelling is about not fearing transparency, Orlando added. "[It's] being out there and sharing the good and the bad with the team in the drive to get better," he explained. ■

Revisiting the 5 Domains of High Reliability

For the past several years, there has been a keen focus in health-care on high reliability, the idea of operating in such a way as to prevent or avoid serious harm or mistakes. But how does the concept translate into actions that clinicians and administrators can use to make progress?

Erika Sundrud, a vice president at Premier Inc., a healthcare consulting firm headquartered in Charlotte, NC, addressed this question during the Institute for Healthcare Improvement's national forum in December 2019.

"We hear boards saying 'no harm, that is our vision' ... but [healthcare

organizations] struggle at times to operationalize it," she noted. "What does it look like for the nurse manager every day in a no-harm environment? What do his or her job duties look like every day as they move forward?"

To learn the answer, it can help to review what the five domains of high

**Assess • Manage • Reduce
Healthcare RISK**

Listen to our free podcast!

Episode 11: Recognizing Safety Risks as Healthcare Systems Expand

www.reliasmedia.com/podcasts



reliability are and what they really mean, Sundrud observed.

“If these [five domains] are proven to create a safe environment ... we have to go back and [ask] what does this mean for us, how do we operationalize all five of these things every day, and then continue to have a mindful presence of [high reliability] every day,” she said.

• **Stay preoccupied with failure.**

Every adverse event that happens and every near-miss that one catches sends the message that there are further improvements to be made, according to Sundrud.

“I have never met an organization in my 18-year career that does not have any [adverse] events or near misses,” she shared. “For all of us, this is a journey. We need to seek to understand these near-misses [and adverse events], to know them better and move forward.”

• **Resist the temptation to simplify.** When a mistake or near-miss occurs, it is not uncommon for people to immediately reach the conclusion that the problem was miscommunication, the fact that someone lacked the proper skill set, or some other fairly straightforward conclusion.

There is a tendency to oversimplify failure so that a quick fix can be implemented, Sundrud explained. However, in many cases, there are numerous contributing factors to a mistake or adverse event.

For instance, Sundrud recounted the experience of one health system that wanted to understand why patients were experiencing excessive lengths of stay.

“Patients were getting hung up in the ICU, and then they were getting hung up in the step-down unit,” she recalled. “We were wondering what was happening here, what was wrong.”

In that instance, the chief medical officer, the hospitalists, and even the intensivists concluded the problem was due to the fact that the organization had just hired new nurses.

“Is that a good explanation? It could be, but is it the only explanation? Absolutely not,” Sundrud stressed. “Sometimes, the most simple answer coming forward for some of the events going on in your system is right there in front of you, but [the root cause] can be much more complex than given credit for,” she cautioned

• **Be sensitive to operations.** It is important for leaders and staff to understand what is happening on the frontlines. This includes the specific work, processes, and the system that affects patient care every day, Sundrud said.

“You would think that this would be the easiest thing that we can do because we all know what is happening in every process and every system in our organization

that is impacting patient care,” she explained. “Yet, often we are finding that a simple piece alone has variation in it. Understanding that [variation] is important.”

• **Commit to resilience.** Even if there are one or two failures, if an organization can continue avoiding big failures, then employees have achieved something important. Still, leaders must keep pushing, Sundrud noted.

“Our job is to uncover things early and often, and to continue to work on them,” she said.

This means periodically fine-tuning or redesigning processes so they work more effectively. “Often, we are finding that [this work] slips through the cracks,” Sundrud shared. “That resilience is often very difficult.”

• **Defer to expertise.** “In healthcare, we defer to physicians all the time, which we should, but this is when leaders are deferring to people that know [a specific] process,” Sundrud explained. “They are trusting the insights of people who understand their process and their situation, and then move forward from there.” ■

RESOURCE

- Premier Inc. *Creating a Culture of Optimal Care Delivery*. Charlotte, NC; 2018. Available at: <http://bit.ly/2RF8WvI>. Accessed Jan. 22, 2020.

Assess • Manage • Reduce Healthcare RISK

Listen to our free podcast!

Episode 9: Limiting Liability Risks in Pediatric Emergency Care

www.reliasmmedia.com/podcasts

