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Hospital diversion scheme draws ire of national ED organizations

In face of controversy, hospital might reconsider its policy

Several EDs across the country have initiated policies to encourage patients who don't face "true" emergencies to seek care elsewhere in the community and to find "medical homes," but none have been met with the outrage that descended upon the University of Chicago Medical Center recently. The *Chicago Tribune* reported that under a new policy, the hospital was "escalating steps to direct these consumers elsewhere, which it says will allow it to focus on treating the sickest of patients."[1]

Reaction from within the industry was swift and uncompromising. In a prepared statement, leaders of the American College of Emergency Physicians (ACEP) said the university was "dangerously close" to a "patient-dumping" policy that would violate the Emergency Medical Treatment and Labor Act (EMTALA). ACEP said that several emergency physicians and the ED director resigned over the new policy.

The American Academy of Emergency Medicine (AAEM) said the University of Chicago should "re-evaluate its triage and screening examination policies."

As *ED Management* went to press, an internal hospital memo indicated the facility was, indeed, "reconsidering" its policy,[2] but ACEP and AEEM leaders remained skeptical. What's more, they say, such a re-evaluation would not negate some of the actions already taken. They also expressed concern that other facilities, facing growing financial pressures, might consider similar actions.

Executive Summary

The controversy over a new diversion policy at the University of Chicago Medical Center points out the pitfalls that can arise when seeking creative solutions to overcrowding and financial concerns, especially when it comes to compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Here are some warnings offered by the experts:

- Your physicians must participate in all medical screening exams.
- You always can be second-guessed as to whether a case was "urgent."
- When conducting financial analyses, look at what visits actually cost you, not what you charge for care.

IN THIS ISSUE

Financial Disclosure:
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MAY 2009
VOL. 21, NO. 5 • (pages 49-60)

"It's good that they're listening to public constructive criticism, and perhaps even listening to their own ED physicians and nurses, whereas initially this was done without any input from clinical people," notes **Larry D. Weiss**, MD, JD, FAAEM, president of the AAEM, a professor of emergency medicine at the University of Maryland, Baltimore, and an attending ED physician at the University of Maryland Medical Center, also in Baltimore. "Several of our members, who work there, said they were not considered at all — that the policy was developed by administrative personnel," he says. Such an approach is tantamount to "changing the way the operating room works without consulting the surgeons," Weiss adds.

Weiss' objections extend to the new triage policy itself. "It's our understanding that if, during the screening exam, the physician determines the patient to be stable, they are directed to discharge them," he says. "But there are many stable patients who require admission, and the idea that they would turn away stable patients violates national standards of practice." For example, Weiss offers, a patient with a gallstone could be in a lot of pain but not have an infection, or someone with pneumonia might have stable vital signs. "Where do you draw the line?" he asks.

What the University of Chicago was doing went beyond what many other facilities have done, says **Sandra Schneider**, MD, an ACEP vice president. "What they did was, in order to maintain their financial status, they looked at the types of patients that added dollars to the hospital and made inpatient beds available to them while cutting down on the number of beds available to regular emergency treatment," says Schneider, who also is a professor of emergency medicine at the University of Rochester (NY) and an attending ED physician at Strong Memorial Hospital, also in Rochester.

Schneider says such a policy might not violate EMTALA, as long as the patients who are diverted don't have an emergency medical condition. However, there is a moral obligation to see them, she says. (**One legal expert says EMTALA concerns may be real. See the story on p. 51.)** Schneider argues that most of these patients are not 'taking advantage' of the ED, which many assert is the case. "Our literature shows us that many of these people do not go on to get treatment," she says. "Those who choose to come to the ED often do so because there is no other option, either there are no clinics available, or those that are available are not open at

Sources

For more information on policies to address overcrowding and financial pressures, contact:

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ED Management® (ISSN 1044-9167) is published monthly by AHC Media LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***ED Management***®, P.O. Box 740059, Atlanta, GA 30374-9815.

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the times they can get there."

As for the latest news about the hospital, "we do not know what they have come up with, although we're happy they are reconsidering the policy," says Schneider, who adds, "We'd be glad to meet with them and talk about it."

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2. Louden K. Chicago hospital to halt new emergency department policies after criticism. *Medscape Medical News,* March 16, 2009. Accessed at www.medscape.com/viewarticle/589704. ■

Hospital's plan — a bridge too far?

While it's true that many hospitals and EDs have instituted policies that seek to encourage nonurgent patients to find other medical "homes," the policy recently adopted at the University of Chicago Medical Center goes a bit farther than most, says **Sandra Schneider**, MD, vice president of the American College of Emergency Physicians.

"Many hospitals are doing something similar, but perhaps not as overt or as obvious," says Schneider, who also is a professor of emergency medicine at the University of Rochester (NY) and an attending ED physician at Strong Memorial Hospital in Rochester. "Many, for example, will choose to admit patients who have surgical needs to the OR over those from the ED, if there is one bed left in the hospital." She also has seen hospitals continue to take transfer patients even when the facility is full and patients are waiting in the ED, "because transfers usually pay better, have insurance more often, and have more complex issues," Schneider says.

Where the University of Chicago was a bit more overt about it, she asserts, is they began to shrink beds available to patients and the size of the ED, "which artificially reduces your ability to take in patients who cannot pay. It's one way to make sure you do not get those types of patients." What's more, such an approach is based on a misconception, says **Michael Frank**, MD, JD, FACEP, FCLM, general counsel and director of risk management for Emergency Medicine Physicians Management Group, in Canton, OH. "Editorial in the *Chicago Tribune* to support this policy cited average costs of $1,200 for an ED visit to demonstrate that the hospital can't afford nonurgent visits," he notes. "That may be what they charge, but that's not what the visit costs the hospital."

Hospitals, he notes, have many fixed costs, including utilities and salaries. "What it costs to treat someone with a sore throat is trivial," Frank says. "If you divert that patient, you may save $20, not $1,200." ■

Source

For more information on policies directing nonurgent patients to other facilities, contact:

- **Michael Frank**, MD, JD, FACEP, FCLM, General Counsel and Director of Risk Management, Emergency Medicine Physicians Management Group, Canton, OH. Phone: (330) 493-4443.

Beware of EMTALA, warns legal expert

Hospitals and EDs that institute policies similar to the recent approach instituted at the University of Chicago Medical Center would do well to consider that they may be in violation of the Emergency Medical Treatment and Labor Act (EMTALA), warns **Michael Frank**, MD, JD, FACEP, FCLM, general counsel and director of risk management for Emergency Medicine Physicians (EMP) Management Group in Canton, OH.

"You can form a system that will result in ED patients going elsewhere, once it has been determined they do not have an emergency medical condition that will comply with EMTALA, but it's very difficult to do that — and very hazardous — because the standard that is used will be retroactively applied," he says.

EMTALA requires an "appropriate" medical screening exam (MSE), he says. "But the term 'appropriate' has never been defined by CMS [the Centers for Medicare & Medicaid Services] or any other group, so this is a wide-open invitation for CMS to determine after the fact that the diverted patient did have an emergency condition," Frank says. "They could also determine that the screening was not appropriate."

Frank says his understanding is that the facility was doing appropriate triage, but not necessarily an assessment. "I don't think they were only using physicians," he notes. "Under CMS guidelines, the hospital must use 'the full spectrum of its capabilities' in performing a medical screening exam." So, Frank explains, "If you have doctors in the ED, that is part of the 'full spectrum,' it becomes problematic to say you have done an appropriate MSE when it is done with nurses and paramedics and you don't use doctors."

The bottom line is that while such policies can follow the letter of the law, they still are risky, he says. "There's no way to be sure you will not run afoul of EMTALA with such a policy," Frank warns. "All it will take is one complaint, and EMTALA is complaint-driven." ■

'Seniors-only' ED draws raves from patients

Revamping existing space kept down costs

The senior emergency center at Holy Cross Hospital in Silver Spring, MD, may be a rarity, but based on the responses of patients and staff — not to mention our increasingly aging population — perhaps more EDs should consider creating a separate unit for older patients.

"Since we opened [in November 2008], we have averaged between 97% and 99% in patient satisfaction," reports **Bonnie Mahon**, RN, BSN, MSN, senior director of medical, surgical, and senior services. **(The unit was designed by a multidisciplinary team including ED representatives. See the story, right.)**

David Cummings, RN, CEN, the Holy Cross emergency center director, says, "Based on the patient responses, they are very appreciative of being placed outside the general ED population in a quiet area where the staff is more attuned to their specific needs." **(Members of the regular ED staff volunteered to work in this new unit. See the story on p. 53.)**

The senior center is located within the ED itself. The space formerly was used for express care, which has been moved to another floor. The senior center has its own entrance and exit doors. All patients present in the main triage area of the ED. At that point, a set of criteria are used to determine if they should be placed in the senior center. First, they must be age 65 or over. Secondly, their placement is determined by the initial symptoms.

They use a scale of 1 to 5, Mahon explains. "If they are clutching their chest, for example, and are possibly having an MI, they are Category 1 and are immediately taken back to the acute side of the ED," she says. If MI, stroke, and acute bleeding are ruled out, which puts them in Categories 2 to 5, they are eligible for the senior emergency center.

Once the patients are placed in a room, the primary nurse conducts a six-question assessment. The assessment includes issues such as history of falls, the last time they were in an ED, and their current medications. "We want to see if they are at risk for return," Mahon explains.

If a patient responds positively to five or more questions, the nurse puts in a request for a pharmacy consult, Mahon says. "The pharmacist will review all the medications," she says. "We have had several 'saves' since we opened." For example, Mahon recalls a patient who came into the ED after falling. A review of the medications indicated the dosage level was too high, so adjustments were made. "We consider that a save," she says. A score of 2 or more triggers a visit from a social worker, Mahon adds.

Two weeks after discharge, a coordinator in the hospital's office of seniors conducts a follow-up survey. The survey asks patients how well the staff listened to them, if they were kept well informed, how they would rate the care and compassion with which they were treated, what they thought about noise levels, and if they would recommend the facility. ■

Executive Summary

The ED at Holy Cross Hospital in Silver Spring, MD, has created a separate ED specifically dedicated to treating patients who are 65 or older. Here are some of the strategies they used to create the unit:

- Specific criteria were created to determine which patients should be admitted to the senior ED.
- All nurses who work in the department received special training in geriatrics.
- Lights with dimmers, nonslip floors, and warm colors were included in rooms for patient comfort and safety.

Multi-unit team designs senior ED

Once the decision was made in July 2007 to create a senior emergency center at Holy Cross Hospital in Silver Spring, MD, **Bonnie Mahon**, RN, BSN, MSN, senior director of medical, surgical, and senior services, put together a team that included two ED physicians, the chief nurse, the nurse manager, and a director of case management.

Fortunately, there was space available within the ED itself to create a separate department. "We just knocked down a wall," she says. "It had its own nurses' station, six bays, and two rooms."

The team changed the lighting based on the recommendations of elder care expert Bill H. Thomas, MD, and his colleagues from the University of Maryland Baltimore County Erickson School. The school offers

Sources

For more information on creating a senior ED, contact:

- **David Cummings**, RN, CEN, Emergency Center Director, Holy Cross Hospital, Silver Spring, MD. Phone: (301) 754-7000.
- **Bonnie Mahon**, RN, BSN, MSN, Senior Director of Medical, Surgical, and Senior Services, Holy Cross Hospital. Phone: (301) 754-7431.

a major in management of aging services, and it describes itself as "part business school, part aging studies, and part public policy." "Their specialty is aging," says Mahon. Upon their recommendation, the shiny linoleum floors were replaced with nonskid faux wood. Light dimmers were placed in all bays, with switches in the nurses' stations. "Normal fluorescent lighting creates 'hot spots' on the floors that can affect depth perception and cause falls," she explains. The walls were painted in warm colors such as gold, and all rooms or bays have a clock and/or a TV.

The renovations cost a total of $150,000, Mahon reports. "We were very fortunate that in 2007, the hospital fundraiser was dedicated to seniors, so the money raised went toward creating the center," she says.

ED staff volunteer for senior center

Most of the staff in the new senior emergency center at Holy Cross Hospital in Silver Spring, MD, came from the main ED, says **David Cummings**, RN, CEN, the hospital's emergency center director.

"What we have done is find people who really want to work with this population and ask them to work there permanently," he says, noting that it is similar to what happens with a pediatric ED. "In 'peds,' you have mostly pediatric RNs, which is a subspecialty, and we created a subspecialty of nurses who are interested in and understand the needs of the population," Cummings says.

This unit did not leave the main ED understaffed, he says. "This was an area that was previously staffed that we carved out, so people were just differently assigned," Cummings explains.

All the nurses who work in the ED have received special training, says **Bonnie Mahon**, RN, BSN, MSN, senior director of medical, surgical, and senior services. "We used the Geriatric Emergency Nurses' Education program from the Emergency Nurses Association [ENA]," she says. Mahon estimates the total cost of the course was $8,000, which included a fee of several hundred dollars each for the separate modules required for each nurse. "It was really good and comprehensive," she adds. *[Editor's note: ENA sources say the course is currently being revamped and is temporarily unavailable. They estimate that it will be available in its new format by the fall. ENA can be contacted at (847) 460-4123 or education@ena.org.]* ■

New protocol slashes PCI-to-balloon time

Mortality rate 50% lower than that of 'walk-ins'

A new program in Houston that involves tight teamwork between The University of Texas Medical School at Houston, the Memorial Hermann Heart and Vascular Institute — Texas Medical Center, and the Houston Fire Department EMS, as well as an experimental "cocktail" given in the ambulance to patients meeting certain criteria, has dramatically reduced Percutaneous Coronary Intervention (PCI)-to-balloon time and improved survival rates.

The program is named the Pre-Hospital Administration of Thrombolytic Therapy with Urgent Culprit Artery Revascularization (PATCAR). When patients with cardiac symptoms call 911 and the fire department responds, they are asked these quick questions: Do you have cardiologist? If so, at which hospital do they practice? Do you have a provider preference?

"If the patient has a long-standing relationship with

Executive Summary

A new team-oriented process in Houston has enabled caregivers to dramatically reduce the time it takes for a patient to receive balloon angioplasty and, in the process, has vastly improved mortality rates. Here are some of their keys to success:

- As part of a "cocktail" given in the ambulance, the protocol calls for half-doses of retavase to reduce likelihood of reinfarction.
- Cardiologists are called from the ED once the process begins, so they often are in the ED or cath lab when the patient arrives.
- A set of criteria helps determine which patients will receive the new protocol.

another hospital or they prefer another, they are not brought to ours," explains **James McCarthy**, MD, medical director of emergency services at Memorial Hermann — Texas Medical Center. "But if that facility does not have a cath lab and they have STEMI [ST segment elevation myocardial infarction], they do not go there." If the EKG is positive, he continues, one paramedic does a complete assessment and the second one calls the ED's number on a cell phone and sends the EKG.

"A light flashes on my computer and it makes a noise at my receiving station, which is centrally located in the ED," McCarthy says. "I click a mouse, and up pops the screen, and it is either STEMI or not."

How long? About 5 seconds

This process typically takes about five seconds, he says. McCarthy's dedicated phone rings like a siren. "I talk with the paramedic about the patient; they tell me the symptoms, I confirm that I am looking at the right EKG and that it is consistent with STEMI, and review the symptoms and history to see if there is anything that excludes the patient from receiving fibrinolytics," McCarthy says. "If not, we give the patient a loading dose of heparin, clopidogrel, and retavase." (The retavase is given at only half the usual dose, per the Food and Drug Administration's approval after the researchers developing the protocol filed an Investigational New Drug application.)

As soon as McCarthy gives that order, he turns to his secretary and says, "Activate heartbeat," at which point a multipager goes to an interventional cardiologist fellow, a cardiology research nurse, a cath lab nurse and other staff, the business office, the cardiac care unit (CCU), a CCU fellow, the CCU charge nurse, resident, and the operations administrator.

Explaining the importance of contacting the business office, McCarthy says, "nothing happens in a hospital without a medical number. The patient hits the door and is pre-registered."

Staff often wait for patient

McCarthy estimates that about 40% of the time, he and his team get things moving fast enough so that the cardiology staff are actually waiting for the patient. "We take a quick look to make sure they do not need be intubated — that they are awake and talking — and they go straight to the cath lab and are transferred to the table by the Houston fire department," he says. "By the time we are done with paperwork, the case is over."

This process has dramatically reduced the time it takes to treat the patient, says **Richard Smalling**, MD, PhD, head of the PATCAR initiative. "Right now, the typical time from primary PCI onset to balloon is four hours; with us, [the artery is] opened in 165 minutes or less," says Smalling, who is also professor of medicine at UT Medical School at Houston and director of interventional cardiology at Memorial Hermann — Texas Medical Center.

In addition, says McCarthy, "For patients we do this for, there is a 50% reduction in mortality compared to folks who just walk in the ED or who are brought in by an ambulance service that has not called us." ■

Sources

For more information on Pre-Hospital Administration of Thrombolytic Therapy with Urgent Culprit Artery Revascularization (PATCAR), contact:

- **James McCarthy**, MD, Emergency Center Director, Memorial Hermann — Texas Medical Center, Houston. Phone: (713) 704-5007.
- **Richard Smalling**, MD, PhD, Professor and Director of Interventional Cardiovascular Medicine, University of Texas Medical School at Houston, Director of Interventional Cardiology, Memorial Hermann — Texas Medical Center, Houston. Phone: (713) 500-6559.

Inservice given for new protocol

Before the successful implementation of the PATCAR (Pre-Hospital Administration of Thrombolytic Therapy with Urgent Culprit Artery Revascularization) process at Memorial Hermann — Texas Medical Center, a good deal of preparation was required, says **James McCarthy**, MD, medical director of emergency services.

It was the brainchild of Richard Smalling, MD, PhD, professor and director of interventional cardiovascular medicine, University of Texas Medical School at Houston, director of interventional cardiology at Memorial Hermann Memorial Hermann — Texas Medical Center, Houston, and head of the PATCAR initiative. "But we were brought into it early on — in the planning stages," McCarthy recalls. "The initial concerns were what could be done in the back of the ambulance and how to treat a patient we have not seen yet." As soon as he and his staff stepped back from that initial reaction, he says, they realized that in certain cases, it made sense.

"We had to do an inservice on what the protocol was, what the plan was, what testing was required, and

technical stuff on setting up with the staff on how we would be receiving the EKGs from the field, a protocol for making it safe to administer pre-hospital therapy, and working out kinks with the paramedics," McCarthy says. "Then, we worked intensively with the transmission staff, because initially we did not have a strong-enough data line for 12-lead EKGs. We had to switch to cell phone carriers."

Finally, he said, he worked on a multidisciplined approach for the hospital. "We addressed how to get the ball moving once we were notified," he explains. "For example, we had to work with cardiology to relinquish the decision about whether to go to catheterization. That decision now solely rests in our hands."

Now, when McCarthy hits his "panic button" indicating a patient with ST-segment elevation myocardial infarction (STEMI) is coming in, "Smalling just asks how long he has to get to the cath lab," says McCarthy. "I tell him to either go straight to the ED or to the lab." ■

ED Coding Update

Improve your understanding of decision making's impact

[Editor's note: This is the first in a two-part series on the relationship between decision making and documentation. This month, we cover the key components of medical decision making. Next month, the column will address risk as an element of decision making. This quarterly column on coding in the ED is written by ***Caral Edelberg****, CPC, CCS-P, CHC, president of Edelberg Compliance Associates in Baton Rouge, LA. If there are coding issues you would like to see addressed in this column, contact Edelberg at (225) 454-0154. EFAX:(225) 612-6904. E-mail: edelbergeca@earthlink.net.]*

It's funny how things change. This year marks 14 years since the implementation of the Medicare/American Medical Association documentation guidelines. Looking back at that point in time, it seemed a long shot that emergency medicine records could ever contain all of the elements needed for most of the levels, particularly 99284 and 99285.

To a large extent, the guidelines have made the job of coding easier. Coders know what to look for to score each level. Vendors offering documentation tools were given a remarkable opportunity, and many survive to this day with constant upgrades to products to help physicians with the arduous task of documenting each and everything they do.

Physicians have come a long way, too. Their documentation today exceeds our expectations by miles and, more significantly, most emergency physicians today really want to learn the ins and outs of documentation to ensure they are paid properly for their hard work. They often look to coding and billing staff to keep them current on coding and documentation rules.

Of late, more medical records provide documentation for the essential components of the history and physical examination. When missing information, most coding professionals would agree that missing elements of the history most often results in down-coding from the level illustrated by medical decision making. Why? ED physicians don't often understand the intricate rules and correlation between the history/physical and the importance medical decision making. Understanding how medical decision making affects overall level of service within the ED goes a long way toward understanding what to document, with the understanding that documentation merely supports the efforts of the ED practitioner; however, in doing so, it allows coding staff to code at the level of service actually provided.

Docs undervalue their services

If ED physicians have an understanding of the level of complexity of medical decision making they are providing through the case, the checks and balances in place for determining the level of the history and physical examination might easily function properly. Truly, many emergency physicians do what comes naturally when treating ED patients and don't recognize the high complexity of many of the day-to-day services they provide. In doing so, they routinely undervalue their services.

Medical decision making (MDM) was gifted to us by the Centers for Medicare & Medicaid Services and the American Medical Association. It's a label placed on something physicians start the minute they pick up a chart and walk into a patient's examining room. With the documentation guidelines, MDM was put into a format that has now become standard thinking for coding and billing professionals but doesn't always make sense to the physician.

MDM consists of:

• the number of possible diagnoses and/or management *options;*

• the amount and/or complexity of *data* (medical

Number of diagnoses or management options	Points	Amount and/or complexity of data to be reviewed	Points
Self-limited or minor (max = 2)	1	Review and/or order clinical lab tests, radiology tests or tests in CPT medicine section (max = 3)	1 each class of test
Established problem to examiner, stable/improved	1	Discussion of test results with performing physician	1
Established problem to examiner, worsening	2	Decision to obtain old record and/or obtain history from someone other than patient	1
New problem to examiner, no additional workup planned (max = 1)	3	Review, summarize old records and/or obtain history from someone other than the patient and/or discussion of case with another health care provider	2
New problem to examiner, additional workup planned	4	Independent visualization of image, tracing or specimen (not report review)	2

Number of diagnoses or management options points	≤1 (minimal)	2 (limited)	3 (multiple)	≥4 (extensive)
Amount and/or complexity of data to be reviewed points	≤1 (minimal/none)	2 (limited)	3 (multiple)	≥4 (extensive)
Risk of complications and/or morbidity or mortality	Minimal	Low	Moderate	High
Type of decision making	Straightforward	Low complexity	Moderate complexity	High complexity

Source: Edelberg Compliance Associates, Baton Rouge, LA.

records, diagnostic tests, and/or other information) that must be obtained and analyzed;

• the *risk* of significant complications, morbidity, and/or mortality associated with presenting problem(s), diagnostic procedure(s), and/or possible management options.

If we break each element down, we see components that are essential to documentation and coding appropriately. **(See graphic, above.)**

Of note, the content of the diagnoses and management options component clearly recognize many of our ED patients at the multiple or extensive level that correlates to a 99284 or 99285. Most ED patients present to the ED with problems new to the ED physician. Don't think of it as chronic problems being managed appropriately; think of it as acute exacerbation of chronic problems — many poorly managed — and most being new to the ED physician examining the patient.

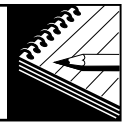
Definition of 'work-up'

The definition of "work-up" planned has never been clearly defined as it relates to the documentation guidelines. However, some payers define it as a work-up by the examiner during the current visit. Others define it as a scheduled work-up following the visit. Either way, our ED patients typically score at the 99284 or 99285 level on this element, as ED problems are either new to the examiner but not requiring a work-up, or new to the examiner who is planning a work-up.

Clearly, diagnostic studies and referrals to consultants for further work-up and treatment constitute a planned, additional work-up. I tend to think that following the history and physical, the emergency physician either plans an additional, more in-depth work-up or determines that no additional work-up is required. If the work-up — generally defined as lab, X-ray, EKG, or additional diagnostic tests — is performed in the ED, it *should* qualify as "additional work-up planned." If referred to another provider, it *definitely* qualifies. Check with your major payers to see how they define "additional work-up."

The amount and complexity of data to be reviewed are clearly an objective determinate, and the level of complexity should be clearly documented. The ordering of lab tests, X-rays, and EKGs is generally easy to identify from the physician notes. However, when the physician fails to document discussion/review of test results with the radiologist or cardiologist or fails to record the personal review of diagnostic tests, the review of old records, or the personal interpretation of diagnostic tests, the documentation fails to provide the higher level of complexity managed by the ED physician. ■

GUEST COLUMN



Tips to succeed in getting sued

By **Bruce David Janiak**, MD, FACEP, FAAP
Professor of Emergency Medicine
Medical College of Georgia
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(Editor's note: Janiak has served as an emergency medicine medico-legal consultant for more than 30 years, and he has reviewed hundreds of malpractice cases. In the process, he has recognized common patterns and mistakes that emergency physicians make that set them up to be sued. With his tongue firmly planted in his cheek, Janiak points out the following potential mistakes and ways that lawsuits are created.)

If you want to get sued, don't bother to explain your approach to the patient's problem or share decision making with the family. Patients would like to hear what you are thinking. This information and communication event gives them an opportunity to express their expectations. Remember that unmet expectations are a root cause of unhappiness in all of life (even if it's too long a wait at a fast-food restaurant).

For example, "I am concerned about your grandfather's fever. We are going to do some labs and a chest X-ray. If these results are all negative, then I believe he will be able to go home, since he looks otherwise OK." Now the plan is set, the relatives have a chance for buy-in, and your pathway should be relatively smooth.

Contrast this approach with the more absolute comment, "The labs are OK, so he has a virus and can go home." If grandfather deteriorates in the next few hours at home, you want a family that shared in the decision making.

Failure to communicate

Another version of the same theme is the failure to recognize their need for communication. Have you ever purposely avoided the eyes of that relative or patient leaning on the doorway into the room? They often want reassurance that they have not been forgotten. Even if the man in Room 6 is not your patient (this refers to both physicians and nurses), take a second to ask, "May I help you?" This gesture might go a long way toward mitigating the building anger or frustration fueled by an unexpectedly long wait. And there is a side benefit when you confirm that you actually did put in a call "30 minutes ago"; some of the building frustration can be shared with the party actually responsible (e.g., the slow consultant). Finally, offering the patient a blanket because he or she is in a frigid room says more than a thousand solicitous words and is an awesome way to communicate to your patients that you care.

A 'lose-lose' situation

• Don't do what the patient requests.

As emergency physicians, we frequently are told, "My doctor sent me in and said you should call her as soon as I arrive." Knowing that we have not yet done an evaluation, it is natural to assume that the primary care physician will want the benefit of our history, physical, and testing results. By following this natural assumption, you may find yourself in a "lose-lose" situation. Refusal to contact the requesting doctor gives the patient evidence of your lack of caring and concern. Furthermore, perhaps the primary care physician (PMD) did want early contact and will facilitate admission, consultation, or provide invaluable background information. If anything goes wrong, the patient will be upset, and the PMD will stand by the patient.

This situation is especially true of the curmudgeonly consultant. (You know and dread him. Calls to him are unpleasant, and every time you speak with him, he treats you like an intern.) This consultant will certainly claim, "I would have come in immediately if the emergency doc had only called. As it was, he waited for the CT result, and it was too late to save your husband." Don't be afraid of conflict. After all, you must be the patient advocate.

• Be sure to overtest, since that will protect you from a successful suit.

This concept is all-pervasive, and we all practice some defensive medicine. The bottom line here is that overly defensive test-ordering makes your defense in a lawsuit more difficult. For example, a patient presents with fever and a negative history and physical examination. You are sure you are dealing with a virus, but order a complete blood count (CBC) just to be sure. The white blood cell count (WBC) is, unfortunately, 18,600 with a slight shift to the left. Because the patient looks great, he goes home only to return with something awful and infectious. You and your defense expert will be grilled on the CBC alone. In truth, these cases are much more defensible when labs are not done. You must ask yourself, "What will I do with abnormal results?" Your expert will have an easier

time saying the tests were not indicated than saying that grossly abnormal results were not a harbinger of the doom that already is evident at trial.

• Place little to no emphasis on the discharge process.

We who practice emergency medicine have done very well with the initial portions of the emergency department (ED) experience. Our triage and registration processes are streamlined, and the clinical evaluations of emergency specialists are light years ahead of what we did 20 years ago. Yet the end point, the discharge process, has changed little. I have seen the scribbled "F/U with PMD PRN" more times than I can count.

Discharge instructions need to be more specific. "See Dr. Hughes within 2 days, or sooner, if worse" is more appropriate, especially if the patient deteriorates unexpectedly. The patient's failure to follow specific instructions will help should litigation ensue.

Conversely, open-ended instructions will weigh against the emergency physician in a similar circumstance. For example, a patient comes to the ED several times over several months with "pneumonia." All of his discharge instructions are vague regarding follow-up. His lung cancer remains undiagnosed, and a lawsuit follows.

• Assume no one is listening (even the dead and dying).

After a prolonged resuscitation, I once pronounced a patient dead, only to have her revive on her own shortly thereafter. Following her discharge from the hospital, she sought me out, declaring, "I heard everything you guys were saying." Although this is an extreme case and, thankfully, all staff members were professional, I was reminded of how vulnerable we can be to off-the-cuff comments.

Patients do not like listening to our vacation stories or comments about our favorite wines when they are in distress. Keep personal comments and stories out of earshot. Bad results combined with comments about our behaviors are supportive of a jury's judgment about our credibility.

• Don't be afraid to mention the word "appendicitis."

We have all heard the relative exclaim, "I know someone who had this same pain and later died of appendicitis." Take the time to address these concerns with an acknowledgment of the patient's impressions and concerns. Indicate that you, too, have thought about this diagnosis and why a particular diagnosis isn't or is included in your differential.

When appropriate, bring up other possible and reasonable scenarios and outcomes that might be associated with a patient's chief complaint and presentation. Counsel him or her that appendicitis is a potentially difficult diagnosis, and that time may have to pass for you to make a definitive diagnosis. Discuss with him or her the pros and cons of the CT scan, including a significant radiation exposure. You might be surprised that some people will opt to return the next day for a repeat examination rather than have the CT scan.

These discussions also can serve to educate the patient's family that a return visit for a repeat evaluation is an acceptable diagnostic approach. In addition, simple reassurance might be another valuable outcome: "Thank you for asking the question. Yes, appendicitis is a possibility, but usually we find the pain associated with appendicitis in the right lower quadrant and not on the left side."

Nevertheless, in the event of a bad outcome, avoiding tough questions such as the proverbial ostrich and refusing to acknowledge their fears or even the possibility that their family member might have a more serious condition can set one up for a lawsuit.

• Ignore complaining patients, and don't call them back.

Having called back many complainers over the years, I have learned much about how we are perceived. While often painful experiences, they are truly opportunities for improvement. The primary issue in almost every situation includes a communication failure. We tend to see a patient, order a test or two, and then return to discuss results. This is acceptable when the department is busy; but when you have the time, just sit (yes, sit) and chat for a few minutes. You may find that the true reason for the visit will be disclosed. It's possible that even though you are practicing good emergency medicine, you are not meeting the patient's expectations.

ED directors can miss an important opportunity to learn about operational problems or staff behaviors that need correcting. In reality, the astute management of a patient's complaint can sometimes turn an unhappy customer into an ardent fan of your service and a return customer.

Finally, patients might complain simply because they feel "no one cared," and by the physician not responding, that feeling is reinforced. Opportunities to defuse a potentially litigious situation or public relations boondoggle might be missed.

We all need to do more communicating and less testing. **(See story about "little things" you can do, p. 59.)** Don't be afraid to ask specifically, "What is your primary concern?" or "What did you expect me to do for you today?" In reality, the best way to get sued is to actively or passively treat patients contrary to how you would like to be treated if you were in their shoes. All the testing you can do will not

overcome the combination of a bad outcome and a perceived bad attitude. ■

'Little things' foster connection with patients

What are the things that physicians who have successful and therapeutic relationships with their patients do more or less consistently? Researchers interviewed 50 medical professionals judged by their peers to be especially good at sustaining excellent patient relationships.[1] In their article published in the *Annals of Internal Medicine*, they summarize the themes that seem to correlate with a healing relationship with patients:

• **Do the little things.** Introduce yourself, greet everyone in the room, shake hands, smile, sit down, make eye contact, give undivided attention.

• **Take time to listen.** Be still, quiet, interested, and present.

• **Be open.** Be vulnerable, and don't avoid the pain. Look for the unspoken.

• **Find something to like, to love.** Think of your family, take the risk, and stretch yourself.

• **Remove barriers.** Acknowledge power differentials, and practice humility. Create bridges, and make welcoming spaces.

• **Let the patient explain.** Listen for fear and anger. Listen for expectations and hopes.

• **Share authority.** Offer guidance. Ask permission. Enable the patient's autonomy.

• **Be committed and trustworthy.** Do not abandon. Invest in trust, and be faithful.

Reference

1. Churchill LR, Schenck D. Healing skills for medical practice. *Ann Intern Med* 2008; 149:720. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **September** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

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 your peers in the publication. ■

CNE/CME *questions*

7. According to Sandra Schneider, MD, the policy recently adopted at the University of Chicago Medical Center to divert nonurgent patients to other facilities is more "overt" than similar policies at other hospitals because:
A. the hospital takes other transfer patients even when it's full.
B. the hospital will admit surgical patients over ED patients.
C. it simultaneously reduced the number of beds in and the size of the ED.
D. its medical screening exams are not appropriate.

8. According to Bonnie Mahon, RN, BSN, MSN, patients discharged from the hospital's senior emergency center receive a follow-up call two weeks later, asking them if:
A. the staff listened to them.
B. if they were kept well informed.
C. if they would recommend the facility.
D. All of the above

9. According to James McCarthy, MD, when the PATCAR process is used, patients arriving in the ED or the cath lab find the cardiologist already waiting for them:
A. 40% of the time.
B. 35% of the time.
C. 30% of the time.
D. 25% of the time.

COMING IN FUTURE MONTHS

■ Guidelines for safety of peds during disasters

■ Newly published research on patient waits

■ Effect of longer-than-expected observation stays on payment

■ ED uses "split-flow" system to help manage patient flow

10. According to Caral Edelberg, medical decision making consists of:
A. the number of possible diagnoses and/or management options two to four days after discharge.
B. the amount and/or complexity of data (medical records, diagnostic tests, and/or other information) that must be obtained and analyzed five to seven days after discharge.
C. the risk of significant complications, morbidity, and/or mortality associated with presenting problem(s), diagnostic procedure(s) and/or possible management options.
D. All of the above

11. According to Louise Kuhny, RN, MPH, MBA, CIC, if your state does not specify a time frame within which a verbal order must be authenticated, the "default" time period is:
A. 24 hours.
B. 36 hours.
C. 48 hours.
D. 72 hours.

12. According to Kirstie M. Tindale, BSN, 100% compliance with the National Patient Safety Goals would only be possible if:
A. patients were better educated.
B. all hospitals and pharmacies were linked electronically.
C. The Joint Commission clarified its requirements.
D. physician and nurse leaders more actively promoted compliance.

CNE/CME answers

7. C; 8. D; 9. A; 10. D; 11. C; 12. B.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Standards on verbal orders rank high among common compliance problems

Among the most challenging standards from The Joint Commission for the first half of 2008 was standard IM.6.50 — "Designated qualified staff accept and transcribe verbal or telephone orders." According to the organization, 40% of hospitals were not in full compliance. **(This standard is now in a new chapter, under "RC" as opposed to "IM." See the story on p. 2.)**

This problem is not surprising to ED managers, who say the hectic pace in their departments can make compliance with this standard quite challenging. "In an emergency setting, you do not take care of one patient at a time; it's not a linear process," notes **India Owens**, MSN, CEN, director of emergency services at Clarian West Medical Center in Indianapolis. "It's a different world than, say, the inpatient world."

Owens offers this hypothetical situation: A patient is vomiting, and the doctor has ordered medication in written format. The nurse goes in to recheck the patient and sees he has continued to vomit. She seeks out the doctor, who is heading to another room where a second patient is having a heart attack. The nurse tells the physician the patient is still vomiting, and he says the dosage should be increased. "This is all done on the go," she says. "The nurse writes down or asks the doctor write down the order when they get the chance."

This is not to say the "transcription" part of the standard is impossible to meet. Owens says she has devised solutions for paper-based and electronic systems. (Her department switched to computerized physician order entry [CPOE] about nine months ago.)

"Prior to the switch, we solved the problem somewhat by having a single sheet that was used by both doctors and nurses," she says. "On one side at the top was the physician order, and at the bottom was the nurse's sign-off."

With this system, she explains, if the nurse wrote the verbal order down, the doctor still had access to that same piece of paper to sign it, and vice versa. "In many places there are two different sheets of paper," notes Owens. "Here, the nurse could just hand the doctor the chart and say, 'Write it on the clipboard.'"

Now that the department has switched to CPOE, "you would not have this problem as consistently with verbal orders because the system 'forces' the doctor to write," Owens says. As soon as a nurse enters a verbal order, she explains, it flows to the physician's inbox for him or her to sign. "If you set your system up well, it closes the gap on this problem," Owens says.

A solid policy will address the issue of having only qualified personnel transcribe the orders, adds **Kathy Hendershot**, RN, ED clinical director at Methodist Hospital in Indianapolis. "We have a policy that verbal orders cannot be taken by anybody except a registered

Executive Summary

The hectic pace of the ED makes it difficult to comply with The Joint Commission's standard on verbal orders, but some nurse managers have been able to increase compliance significantly with proactive strategies. Here are some of the successful approaches they have used:

- ongoing education and communication, including inservices, unit meetings, posters, and mass e-mails;
- incorporating the verbal orders standard into education about the National Patient Safety Goals;
- conducting random chart audits to gauge the level of staff compliance.

Financial Disclosure:
Senior Managing Editor Joy Dickinson, Author Steve Lewis, Nurse Planner Diana S. Contino, and Associate Publisher Coles McKagen report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Executive Editor James J. Augustine discloses he is a consultant for The Abaris Group and conducts research for Ferno Washington.

nurse employed by the hospital," she says.

Documentation also can be a problem, Hendershot says. "It clearly starts with the policies and procedures within your organization meeting the standard; then, you 'teach to the test,'" she says. Once the policy was written and rolled out, Hendershot says, it was "cascaded" through organization management. "It's important to make sure the medical staff understands it," she adds.

Because the hospital still is on a paper system, "unless it is an emergent situation — usually resuscitation — we tell nurses they can't take a verbal order," Hendershot says. "They know now that in case they need an order, they will carry a form with them and ask the physician to write it down."

In cases where verbal orders are used, the nurse is required to call back the order to the physician. "Usually, we document the order on the chart as a read-back a verbal order, or RBVO, and the physician has to sign off on that," she explains.

To help ensure compliance, Hendershot conducts a significant amount of education. "Within our department we've done inservices, unit meetings, posters, mass e-mails, and we've made it part of our National Patient Safety Goal education," she says. **(Nurse managers also use random audits to track compliance. See the story, right.)** ■

Verbal orders placed in new chapter

The Joint Commission (TJC) has noted that its verbal order standard, IM.6.50, has been one of the more difficult to comply with, but "ED managers who now wish to brush up on that standard will have to look elsewhere, says **Louise Kuhny**, RN, MPH, MBA, CIC, TJC's senior associate director of standards interpretation.

"The information management chapter used to have two components — verbal orders and patient information — but we split out verbal orders," she explains. "It really pertains to record of care; so, it is now in a new 'RC' chapter: RC02.03.07."

The standard still addresses the same issues, Kuhny notes. "You need to have a policy that says who can receive verbal orders, and they must be authenticated within the time frame specified," she says.

The latter requirement, she reports, leads to the great majority of requirements for improvement. "[The Centers for Medicare & Medicaid Services] put out a communication about 18 months ago that said if there are no pre-existing state regulations, the default is 48 hours," Kuhny says. "A few states use 24 hours, which is particularly challenging, and others have 30 days; but the vast majority of states go to the default of 48 hours."

What if an ED manager is not sure what the state requirement is? "I recommend they check with the quality folks in the hospital," she replies.

How does Kuhny suggest ED managers ensure compliance? "You need to put systems in place to be sure to prompt providers to sign the order when they next see the patient, and the providers need to be diligent," she advises. "You should put a reminder in your electronic system or a flagging system on your charts to remind the doctor or other allied licensed practitioner." ■

Audits help manager track compliance

Nurse managers say they find chart audits extremely effective in tracking staff compliance with The Joint Commission's standard on verbal orders.

Kathy Hendershot, RN, ED clinical director at Methodist Hospital in Indianapolis, for instance, uses a random, generalized chart audit. **India Owens**, MSN, CEN, director of emergency services at Clarian West Medical Center in Indianapolis, also uses audits to track compliance. While Owens considers her compliance initiative to be a work in progress, she reports that compliance in her department has risen from 30% to about 75%.

"Any time there is a medical error in the ED, we check to see if there was a written or verbal order," Hendershot says. "If it is not signed, we will scrutinize it." If the order is documented as verbal, she will make sure it has been documented correctly.

"Also, we will routinely ask the staff if they understand what the policy is," Hendershot reports. "We will randomly select staff and ask if they understand what an RBVO [read-back verbal order] is. If they fail the test, we will go back and re-educate them."

This is not an easy "test," she says. "When we ask them what it is, they have to say, 'Read back' for the correct answer," Hendershot explains. "When surveyors were coming along, they would ask them, and they'd say, 'Repeat back,' and we'd be 'dinged' on that clarification."

"The way we've done audits is through inpatient admissions: How many of them have their completed meds reconciliation form on their chart from the ED as they go upstairs," Owens explains. In addition, she says, "our secretaries scan every chart into a computerized medical record, and they double-check the charts [for medication reconciliation]. They have been empowered to 'slap nurses around' if it is missing." ■

TJC changes policy on med reconciliation

In the latest move in the continuing saga of the National Patient Safety Goal (NPSG) on medication reconciliation, The Joint Commission has said while it will continue to evaluate compliance with the standard during on-site surveys, "it will not be factored into the organization's accreditation decision and will not generate Requirements for Improvement [RF])." The new policy, announced recently, became effective retroactively to Jan. 1, 2009.

The Joint Commission noted in its announcement "the difficulties that many organizations are having in meeting the complex requirements of NPSG 8."

The shift was good news for ED managers. "I'm excited," says **Kirstie M. Tindale**, BSN, clinical manager of the ED at St. Francis Hospital in Tulsa, OK. "It's helpful to not get 'dinged' on it because it's hard. It's been very difficult to implement." Tindale remains cautiously optimistic. "I'm sure they will change their minds," she predicts. **(For a story about what EDs should do in the meantime, see story, right.)**

That caution is well advised, notes **Louise Kuhny**, RN, MPH, MBA, CIC, The Joint Commission's senior associate director of standards interpretation. "We would encourage continued diligence," she says. "All the experts would agree, and health care workers would agree, that there is risk to patients if medication reconciliation is not carried out appropriately. To omit or duplicate medications or to prescribe something that is contraindicated can have bad consequences."

What The Joint Commission actually reassesses is a department's method of reconciliation — not whether they do it, she says. "Organizations should still be prepared to explain to surveyors what processes they have in place," Kuhny says.

It would be unfair for The Joint Commission to expect total compliance, Tindale argues. "We've made significant headway and we've done better; but until there is a requirement that all pharmacies and hospitals be linked in a [computer] network, actual medication reconciliation will always have less than 100% compliance," she says. "For our ED, our problem is getting that information up front; half of our patients do not remember medication doses or names — they might remember the colors — and we, as ED staff, do not have time to call all their pharmacies."

A couple of St. Francis' ED physicians previously worked in facilities in other states where EDs had access to statewide databanks linked up to every pharmacy. "You just typed in the patient's name and birth date, and you could get a full list of their meds," Tindale says. "That's what *we* need."

Kuhny agrees, to a point. "I think obtaining a list from the patient is definitely one of the most challenging standards for the ED, and an electronic system would be a definitive solution, but it's only one piece of a big puzzle," she says. ■

Executive Summary

The Joint Commission has once again shifted gears on medication reconciliation, announcing that it will no longer be factored into accreditation decisions. While The Joint Commission continues to evaluate its requirements, here are some guidelines for dealing with this ongoing uncertainty:

- If you have plans in place that would positively affect patient safety and quality, then proceed with those plans.
- Keep your focus on tracking medications at each point of change the patient makes in their care.
- Lobby for the establishment of an electronic system linking pharmacies and hospitals.

What should EDs do while TJC 're-evaluates'?

Even as The Joint Commission announced that it would cease to factor compliance with the National Patient Safety Goal on medication reconciliation into its accreditation decisions, it reminded all interested parties that final language on the goal is far from complete.

"The Joint Commission will be evaluating and refining the expectations for accredited organizations pertaining to medication reconciliation," it stated when announcing the policy change.

Where does that leave ED managers? How do they proceed with compliance programs when they're not entirely sure what it is they are supposed to be complying with? **Louise Kuhny**, RN, MPH, MBA, CIC, The Joint Commission's senior associate director of standards interpretation, admits she gets a lot of questions from hospitals about programs they were planning to change or improve. "Our position is that if they had plans in place that required resources and they are convinced those plans would positively affect patient safety and quality, we would encourage them to go ahead with their plans," she says. "But if those plans are being done for the purpose of accreditation, and they are not necessarily convinced those particular changes would improve

patient safety and quality, then we would encourage them to hold off until we make a new decision."

Kirstie M. Tindale, BSN, clinical manager of the ED at St. Francis Hospital in Tulsa, OK, says, "I don't intend to change anything. For myself, I prefer to still consider it something we need 100% compliance on, because we *do."*

Until The Joint Commission more clearly defines what they want, no one will be completely sure what is being evaluated when surveyors visit, she points out. "But any clinical people who sit down and give this serious consideration should know what medication reconciliation should entail — that you do it for every point of change the patient makes in their care," Tindale says. "That speaks for itself." ■

New monograph helps examine hand hygiene

The Joint Commission has released a monograph titled "Measuring Hand Hygiene Adherence; Overcoming the Challenges," to help health care organizations target their efforts in measuring hygiene performance.

The monograph is the result of a two-year collaboration with major infection prevention and control leadership organizations in the United States and abroad to identify effective approaches for measuring adherence to hand hygiene guidelines in health care organizations.

According to The Joint Commission, without standardized approaches to measuring hand hygiene performance, it is impossible to determine whether overall performance is improving, deteriorating, or unchanged as new strategic interventions are introduced. The Joint Commission's National Patient Safety Goals require accredited organizations to follow recognized hand hygiene guidelines; however, studies continue to show that adherence to those guidelines is lacking. This is due, in part, to the variation in approaches to measurement, which makes rates of adherence difficult to compare.

The monograph provides a framework to help health care workers make necessary decisions about when, why, and how to measure compliance with hand hygiene, while systematically reviewing the strengths and weaknesses of commonly used approaches. Examples of measurement methods and tools in the monograph, which also includes references to evidence-based guidelines and published literature, were submitted by organizations through the Consensus Measurement in Hand Hygiene project.

"Measuring hand hygiene adherence is not a simple matter," said **Jerod M. Loeb**, PhD, executive vice president, The Joint Commission's Division of Quality Measurement and Research, in making the announcement. "The monograph can help health care organizations more effectively measure compliance and strengthen improvement activities that save lives and money."

Elaine Larson, RN, PhD, FAAN, CIC, scientific advisor for the project and associate dean for research at the Columbia University School of Nursing, New York City, said, "Monitoring hand hygiene is useful only if the methods are valid and reliable and the results are widely disseminated and used to improve practice. This monograph will be an invaluable resource to institutions struggling to do it right."

Electronic copies of the monograph are available free on The Joint Commission's web site (www.jointcommission.org). Once you're on the home page, type "hand hygiene monograph" in the search box. A free printed copy is available by calling The Joint Commission's Department of Customer Service Center at (630) 792-5800, option 5, or sending an e-mail to customerservice @jointcommission.org. ■

Joint Commission report shows gains in safety

Most managers have been pushing extra hard to improve safety over the last few years, and The Joint Commission says all the hard work is paying off.

Hospitals have steadily improved the quality of patient care over a six-year period, saving lives and improving the health of thousands of patients, according to a recent Joint Commission report. The data come from *Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2008*, an analysis of National Patient Safety Goal compliance and hospital quality measures related to heart attacks, heart failure, pneumonia, or surgical conditions, provides scientific evidence of improved patient care.

There were some dramatic improvements over the six-year period of data collection, especially in providing smoking cessation advice. For example, hospitals provided this advice to 98.2% of heart attack patients in 2007, compared with 66.6% in 2002. Hospitals greatly improved their results from 2002 to 2007 in providing this advice to heart failure patients (from 42.2% in 2002 to 95.7% in 2007) and patients with pneumonia (from 37.2% to 93.7%). Other strong improvements included providing discharge instructions to heart failure patients (from 30.9% to 77.5%) and providing pneumococcal screening and vaccination to pneumonia patients (from 30.2% to 83.9%). ■