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Chest pain patients in crowded EDs suffer more post-admit complications

'Dysfunctional' hospitals at fault, but EDs must do their part

Patients with heart attacks and other forms of chest pain are three to five times more likely to experience serious complications after hospital admission when they are treated in a crowded ED, according to a new study published online in the journal *Academic Emergency Medicine.*[1]

The study followed 4,574 patients who were admitted to the Hospital of the University of Pennsylvania in Philadelphia for symptoms of chest pain over an eight-year period. Ultimately, 802 were diagnosed with an acute coronary syndrome; of those, 273 had a true heart attack. There were 251 complications that occurred in the hospital after initial ED treatment. Complications included serious events, such as heart failure, delayed heart attacks, dangerously low blood pressure, heart arrhythmias, and cardiac arrest.

When the ED was at its highest occupancy and waiting room census, patients with acute coronary syndrome (ACS) were three times more likely to experience complications in the hospital. When the patient hours were highest, they were more than five times more likely to have a complication. "Most of these complications occurred long after the patients left the ED, but while they were still in the hospital," notes **Jesse M. Pines**, MD, MBA, MSCE, assistant professor of emergency medicine and epidemiology at the hospital and lead author of the paper.

The authors noted that these complications were not explained by what is or is not happening in the ED in terms of specific treatments and timing, such as giving

Executive Summary

A new study concludes that the ED alone cannot be blamed for the fact that chest pain patients in crowded EDs are at greater risk for post-admission complications. However, the lead author argues there are steps ED managers can take to improve outcomes for these high-risk patients.

- Patients have to be seen quickly and diagnosed appropriately.
- Medication reconciliation and transfer of information to the hospital electronic medical record is even more important for these patients.
- Processes for handover to the inpatient team must be made more seamless.

IN THIS ISSUE

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patients aspirin or a timely EKG. Instead, they said, it pointed to a "dysfunctional" hospital.

Jim Horn, MD, FACEP, medical director of ED at the Mercy Hospital Fairfield (OH), says, "One thing I take away from this study is that expected basic quality care measures were received. I don't know if this is a marker of a 'dysfunctional' hospital, but when patients are at their sickest, you potentially see a higher rate of complications, and when the ED is at its highest capacity, you often see patients with higher acuity."

Nevertheless, the authors noted, the findings underscore the need for action on the part of hospital administrators, policy-makers, *and* emergency physicians.

What can ED managers do to minimize these "downstream" complications? "Patients have to be seen quickly and diagnosed appropriately," Pines says. "There must be a good review of their old medical records; and the medications the patient is currently on have to be put into the system. Once the patient is to be admitted, the inpatient team has to come down, and there has to be a smooth transition of care from the ED team."

Horn says, "I agree these are all things that we strive for."

Still, says Pines, a different approach must be taken in light of the study's findings. "ED managers need to realize that these particular patients are at higher risk," he says. "They must communicate with their physicians that during crowded times, even though it is very easy to focus on only the most critically ill patients, those with chest pain are at higher risk for having complications when the ED is crowded — regardless of whether or not they have ACS [acute coronary syndrome]." Thus, Pines says, at these times there must be an even greater focus on the different processes of emergency care.

Horn says, "We're always concerned when volume is high, but our goal is still to see every patient quickly and diagnose them appropriately but quickly. In my place, the [chest pain] patient gets an EKG as soon as he hits the door." **(For suggestions on meeting the additional improvements recommended by Pines, see the story on p. 87. For more recommendations on treating chest pain patients, see the "Clinical Tip" on p. 87.)**

Reference

1. Pines JM, Pollack CV Jr., Diercks DB, et al. The association between emergency department crowding and adverse cardiovascular outcomes in patients with chest pain. *Acad Emerg Med* 2009; June 22. Epub ahead of print. Doi: 10.1111/j.1553-2712.2009.00456.x. ■

Sources

For more information on treating chest pain patients in the ED, contact:

- **Jim Horn**, MD, FACEP, ED Medical Director, Mercy Hospital Fairfield (OH). Phone: (513) 227-4551.
- **Jesse M. Pines**, MD, MBA, MSCE, Assistant Professor of Emergency Medicine and Epidemiology, Hospital of the University of Pennsylvania, Philadelphia. Phone: (215) 662-4050.

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Med reconciliation, transfers are key

While a recent paper in the journal *Academic Emergency Medicine* showed that patients with heart attacks and other forms of chest pain are three to five times more likely to experience serious complications after hospital admission when they are treated in a crowded ED, the authors do not place the blame on the ED, but rather on "dysfunctional" hospitals.[1] Nevertheless, there are a number of areas ED managers can focus on to do their part to reduce those complications, says **Jesse M. Pines**, MD, MBA, MSCE, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania, Philadelphia, and lead author of the paper.

"One of the major and most common complications is when patients go into heart failure after their ED stay, so ensuring that patients receive the medications they are on regularly, that that information is correct, and that they get on those regular meds early on is important," says Pines. "We think having early meds reconciliation could potentially prevent some of these complications."

Jim Horn, MD, FACEP, medical director of the Mercy Hospital Fairfield (OH) ED, says, "In my shop, I've not heard of any issues of meds reconciliation as volume picks up. When we get crowded, we have an admissions nurse whose job it is to manage the meds reconciliation issue."

Transitions of care, in particular from the ED to inpatient status, are much more difficult when the ED is crowded, notes Pines, because there are fewer resources available. "That transition of care, a high-risk time for patients, happens at a time when you have the fewest resources to make sure that happens smoothly," he says.

One of the approaches his department has taken to improve transitions is standardization, Pines says. "Typically in EDs there is a verbal transfer of care between doctors and nurses," he says. "Our policy is that this has to happen with *every* patient, because it can potentially make the transfer less safe when it does not happen."

Horn adds, "This piece definitely needs to be pursued." In his facility they are working on ways of having the boarded patient considered more like an inpatient. "There may not be beds available upstairs, but an inpatient-type nurse can still take care of them in an inpatient way," Horn explains. ■

Reference

1. Pines JM, Pollack CV Jr., Diercks DB, et al. The association between emergency department crowding and adverse cardiovascular outcomes in patients with chest pain. *Acad Emerg Med* 2009; June 22. Epub ahead of print. Doi: 10.1111/j.1553-2712.2009.00456.x. ■

CLINICAL TIP

Chest pain patients need meds reconciled at arrival

When a patient presents to your ED with chest pain, medication reconciliation "should occur as soon as the patient arrives," advises **Jesse M. Pines**, MD, MBA, MSCE, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania, Philadelphia.

In addition, he says, ED managers "should make a concerted attempt to ensure that the patient's correct meds are put into the [electronic] system and that in particular there is no delay in getting patients put back on diuretics, which we think could be causing heart failure." If necessary, he says, the ED should change procedures to ensure this step occurs early on. ■

ED practices 'golden rule' with hospital staff

Expanded scope of practice eases burden of others

"Every doctor in our group tries to put themselves in the shoes of the medical staff, and ask themselves what they would want done prior to admission and how they would want their patients treated," says **Ben Johnston**, MD, president of the emergency physician group at Morris (IL) Hospital.

It is that attitude that helped the ED receive the Top Performer Award for Emergency Services in the medical staff perception category from Professional Research Consultants (Omaha, NE) for the second consecutive year. This award means Morris Hospital & Healthcare Centers received the highest score for quality of care in the ED when compared to other hospitals across the country using the same physician satisfaction survey tool.

Johnston is convinced that while the category speaks of "staff perception," there is a "one-to-one"

Executive Summary

One of the reasons that the ED at Morris (IL) Hospital won an award for staff perception of the quality of care they provide is that the staff constantly strive to anticipate the needs of the rest of the hospital staff and address those needs in the ED.

- Specialists are called and consulted on performing tests in the ED that could make admission unnecessary.
- If a patient presents with an extremity fracture that can be reduced, the orthopedic surgeon is never called.
- General surgeons are not called unless the patient is going to the OR.

relationship between that perception and the delivery of quality care. **Carol Havel**, RN, MS, vice president of patient care services, agrees. "We have good quality scores all along if you look on Hospital Compare" at www.hospitalcompare.hhs.gov, she says.

John Williamson, DO, an ED physician, says one of the things they do particularly well is initial work-up and assessment. "We get things started on the right path as far as diagnosis and work-up and communicating with the attendings," Williamson says.

"Our initial assessment of the patient, work-up, treatment in the emergency department, and discussion with the attending physicians helps to start the patient on the appropriate treatment path," he explains. "I feel that taking the time to listen to our patients helps to develop a trusting relationship with the patients and their families, and the emergency department's caring attitude toward our patients also helps to establish that trust."

How does this "Golden Rule" approach by the ED staff play out? "You have to take things from the perspective of the medical staff," says Johnston. He gives the hypothetical example of a patient presenting with belly pain at 4 p.m. Recognizing that "surgeons want to go home," he will call them up and ask if they want a CT scan. "Clinically, I may not have enough information to know if it's an 'appy' [appendectomy] or not," he says. "If I'm a surgeon, at least I want the option [to do a scan first]."

Chest pain patients often end up getting admitted, but, says Johnston, "If I can call the cardiologist and get a stress test, we might be able to send the patient home. If you're on the other end of the phone, that's how you want to be treated."

Johnston says a broad scope of practice also enables his staff to ease the burden of specialists in the hospital. "I talked to a friend mine of mine who's an internist at Northwestern, and he was shocked by our scope of practice," he shares. For example, if the ED gets a patient with an extremity fracture that can be reduced, the orthopedic surgeon is never called. "This also moves things along very fast," says Johnston, adding that his staff also are "comfortable with procedural sedation." The hospital's orthopedic surgeons "are very comfortable with our procedures," he says.

In addition, Johnston says, "We do not call in plastic surgeons unless there's an underlying problem. We are very comfortable with closures." A general surgeon, he adds, is not called unless the patient is going to the OR.

Nurse/doc rapport boosts quality

Johnston says excellent communication between ED physicians and nurses was a key contributing factor to his department receiving the Top Performer Award for Emergency Services in the medical staff perception category from Professional Research Consultants (Omaha, NE) for the second consecutive year.

Havel agrees. "The doctors are very knowledgeable and also approachable," she says. "They're willing to teach and share information — not only with other doctors, but they are also good mentors to the nursing staff."

Johnston adds, "We think of nurses as colleagues, not people who should do what we tell them. From our perspective, doctors may have all this book knowledge, but nurses have been doing this for years, too, and they are extremely good at pattern reactions — spectacular, in fact, at gut feelings — and I want to hear about that."

Havel says, "From a nursing perspective, it's important to do a good assessment and then share it with the physician. What they don't know they can't act on."

Williamson recalls several cases where the patient was going to discharge, and a nurse would pose an important question. "Instead of blowing them off, we reassessed the patients," he says.

Johnston recalls one particular instance in which a charge nurse questioned his diagnosis of deep vein thrombosis. She asked him if he wanted to order an ultrasound as a precaution, and he did. "If we hadn't done that, the patient would have been sent back to the nursing home with a pulmonary embolus," Johnston says. Instead, he notes, they were admitted and received good care.

Because of instances like these, he explains, the physicians encourage nurses to practice medicine in the full scope of their capabilities. "I never want

Sources

For more information on developing good relationships with hospital medical staff, contact:

- **Carol Havel**, RN, MS, Vice President of Patient Care Services; Ben Johnston, MD Emergency Department; or **John Williamson**, DO, ED physician, Morris (IL) Hospital. Phone: (815) 942-2932.

nurses shut down," he says.

In fact, Johnston says, if someone is not interacting properly with the nursing staff, there will be a discussion with that physician about treating nurses with respect. What's more, he says, "We do not hire a physician we do not feel will interact well with the nurses. If I saw someone who gave great care but did not treat others in a collegial manager, I would not hire that person." ■

Education reduces peds asthma readmits

Experts say programs can be provided by ED

The medical literature shows that educating children and their parents about asthma can reduce return visits to the ED as well as hospital admissions, and experts say that the ED may well be the best place to provide that education.

The Cochrane Library, a London-based publication of The Cochrane Collaboration, an international organization that evaluates health care research, recently reviewed 38 randomized controlled trials involving 7,843 children.[1] The authors concluded that educational interventions were effective in reducing the risk of subsequent ED visits by just more than 25% and that educational intervention also resulted in fewer unscheduled doctor visits.

"I think it's great that there is evidence to support this," says **Joseph Zorc**, MD, an associate professor of pediatrics and emergency medicine and attending physician at The Children's Hospital of Philadelphia. "So many patients come to the ED with their asthma not well managed."

Vincent Wang, MD, associate director of the division of emergency and transport medicine at Children's Hospital of Los Angeles, agrees. Wang adds that the need is even greater today because primary care physicians simply don't have as much time as they did formerly for educating their patient.

Wang and Zorc agree that a one-size-fits-all approach to education will not work. Wang says, "It needs to be customized. There can be some generalization, but every patient has different needs." So, for example, common issues such as causes of asthma and asthma triggers could be made into a single education module, but medications, individual exacerbations, and the method used to teach the patient and the family must be customized. **(For more information from Wang on the treatment of these patients, see the "Clinical Tip" on p. 90.)**

"Basically, when patients come to the ED, they are in different stages of their disease, as is true with any chronic disease," adds Zorc. "They also have different levels of understanding. Many times younger children are just learning, or their parents may just be coming to grips with the fact that their child needs regular preventive medicine. Not everyone is comfortable with that."

The best way to determine those specific needs is to assess the family, he says. How do you make that assessment? "You do it the same way a lot of great clinicians have always done," Zorc says. "You talk to the family and ask a few questions about what they're doing and what they think their child's needs are."

Education given in the ED

Zorc and Wang provided asthma education in their EDs; in fact, Zorc's department has an entire section devoted to asthma treatment. There are six rooms reserved for asthma patients, and they are staffed by respiratory therapists (RTs) and nurse practitioners (NPs). The department also has an observation unit where kids can go for 12-24 hours.

"This is a team approach," Zorc explains. "The RTs

Executive Summary

Education programs for children with asthma and for their parents can significantly reduce the likelihood of ED readmissions, according to several studies. As an ED manager, you should consider providing such programs in your department.

- Do not use a one-size-fits-all approach. Customize the education to each patient and his or her family.
- Establish a separate area in your department where children with asthma can be treated and where they and their parents can receive the educational intervention.
- A short video or a packet of materials on the causes of asthma and common triggers can provide a foundation upon which your specialized patient education can be built.

Sources

For more information on education children with asthma and their families, contact:

- **Vincent Wang**, MD, Associate Director, Division of Emergency and Transport Medicine, Children's Hospital of Los Angeles. Phone: (323) 361-1856.
- **Joseph Zorc**, MD, Associate Professor, Pediatrics and Emergency Medicine, The Children's Hospital of Philadelphia. Phone: (215) 590-1000.

spend time with the family, especially focusing on devices and inhalers. The NPs handle the assessments and education."

The department also has created a 10-minute video that patients and their parents can watch in their room. The video addresses common misconceptions about therapies and side effects. "One of the key messages for the ED is that with this disease, you need to go back regularly to your doctor to get good outcomes," says Zorc.

Wang's facility has an asthma action plan — a packet of general information about asthma and specific care the patient has received. Every packet has several common components, and the rest is filled out by the provider based on what the patient requires for immediate care and in the future. "We do not provide inhaled steroids, but we will make a recommendation," notes Wang.

The bottom line, says Zorc, is that "in some sense, an ED visit is a teachable moment, where the family might be open to moving along [in terms of their education]. Your department should do whatever it can do to assess the patient and family and get them back to their regular provider."

Reference

1. Haby MM, Waters E, Robertson CF, et al. Interventions for educating children who are at risk for asthma-related emergency department attendance. *Cochrane Database Syst Rev* 2009; Issue 1. Art. No.: CD001290. Doi: 10.1002/14651858.CD001290. ■

CLINICAL TIP

Follow-up critical for peds asthma

When treating children with asthma, it's important to remember that follow-up is critical, says **Vincent Wang**, MD, associate director of the division of emergency and transport medicine at Children's Hospital of Los Angeles.

Ensuring follow-up entails "recognizing the need for maintenance therapy, and potentially recommending it," he says. However, he advises, an ED manager should caution physicians against taking the place of primary care physicians. "I do not like to start those meds myself," Wang adds. "I prefer to recommend them." ■

D-to-D slashed 85% — in seven weeks!

ED manager, consultant, CEO a powerful team

The ED at Twin County Regional Hospital in Galax, VA, succeeded in cutting its door-to-doc time from 121 minutes to 19 minutes in just seven weeks — while annual volume was climbing from 19,000 to about 30,000 — by combining a process improvement plan designed by a health care consulting firm, the leadership of the hospital CEO, and the ED's medical director. The plan, which totally eliminated the ED waiting room, was implemented by Ryerson Management Associates in Akron, OH.

The consulting firm's initial assessment, begun in January 2009, indicated specific areas of need. "We had our physician and nursing consultant come in and look at quality of care, and both said it was very good," recalls **Peter Ryerson**, MBA, president and CEO. "We looked at patient satisfaction and felt it could be better, and most of that is built on turnaround time."

In the new process, patients who present to the ED are met by a greeter (usually an RN). "They stand at eye level to the patient and greet them the way our parents taught us: 'Good morning. What brings you to Twin County Regional Hospital today?'" he says. "They do a quick registration and bring them back to a room." Available rooms are indicated on a tracking board.

Hugh Jenkins, MD, FACEP, the medical director, says, "As they walk down the hall, the greeter uses our radio system to tell the doctor and nurse assigned to that room that they have a patient, and they provide the primary complaint. By the time they get there, the nurse is usually there."

If the nurse assigned to the room is tied up, he adds, the greeter nurse will start triage. "At the same time

Executive Summary

Who says culture change in the ED has to be slow and painful? The ED at Twin County Regional Hospital in Galax, VA, cut its door-to-doc time from 121 minutes to 19 minutes in just seven weeks as part of a rapid-cycle process improvement effort. Here are some of the keys to success:

- The waiting room was eliminated. A greeter does a quick registration and gets the patient back to a room almost immediately.
- Physicians are alerted about the patient even before the patient has arrived in their room.
- Other hospital departments streamlined their operations as well.

we put a chart with the room number in the doctor's slot," Jenkins says. "A lot of times everyone will get there at the same time."

Several services are provided at the same time, via the trauma model of care, Jenkins says. "Basically it is a team effort of coordination, where the patient is seen essentially simultaneously by the nurse and the doctor," he explains. "Sometimes the doctor will see the patient before the nurse, and sometimes the other way around, but the same services and documentation are completed by the end of the visit."

Patient satisfaction for the ED has improved from 74.7% in February 2009 to 81.7% in May 2009. The "true" current rating might be higher than that, argues Ryerson. "So many people have had poor experiences in the past, can still remember from what they experienced several visits ago, and may not rate the ED as it currently is," he explains.

The ED would not have succeeded in these efforts without a significant change in culture, not only in the department, but throughout the hospital, says Jenkins. While The Ryerson Group might have had its focus on the ED, the entire hospital had to be involved in making things happen.

Culture change is notoriously difficult to accomplish in a health care setting. How was Twin County able to do it, and so quickly? "When you move quickly, people do not have a chance to kick back," says Ryerson. "We told them they did not want be high on leadership's radar screen."

Speaking of leadership, Ryerson says "We got great leadership from the CEO, who was the change champion. If he says, 'We move,' they move."

In addition, notes Jenkins, there is a benefit in having an outside consultant involved in such cultural changes to "ride herd" on the staff. In fact, changes were made in every unit of the hospital, from room cleaning to lab and X-ray. "All those processes had to be examined. And Peter was able say to them, 'OK, how are you going to do this? What steps will you take to accomplish this goal?'" says Jenkins. "They had to write down the specific steps they would take and on what date the goals would be accomplished."

Through this process, for example, admission was streamlined. "All patients must be on the floor within 30 minutes of the decision to admit," Jenkins says. "That's unheard of!"

This admission deadline was accomplished with the implementation of several changes, says Ryerson. "First, we set up a system to identify when the room was vacant," he says. "We designed a system to get housekeeping to the room and have it cleaned within 25 minutes, and we then faxed the ED orders to the floor and transported the patient to the floor without any phone calls from the ED."

The following improvements were accomplished within four months:

- Laboratory tests for patients in the ED are all below 30 minutes from request (order by physician) to result.
- Results from diagnostic radiology procedures usually are received in 15-20 minutes.
- The environmental services department maintains the ED, with a level of cleanliness of more than 95%.
- For treat-and-release patients, the average time for arrival to discharge time has decreased from two hours and 50 minutes to one hour and 39 minutes.

Jenkins notes that Ryerson was able to counter the natural skepticism of the staff. "Even if the CEO had gone down personally to the lab, it would not have been as good as Peter coming in and saying, 'I've done this 50 times before,'" he explains. "When a staff member says something can't be done, and he says he's already done it, it's very hard to have resistance." **(For more on EDs with no waiting room see "Manager: Not all EDs ready to convert to no-wait status, *ED Management*, January 2008, p. 4.)** ■

Sources

For more information on improving door-to-doc time, contact:

- **Hugh Jenkins**, MD, FACEP, ED Medical Director, Twin County Regional Hospital, Galax, VA. Phone: (276) 236-8181.
- **Peter Ryerson**, MBA, President and CEO, Ryerson Management Associates, Akron, OH. Phone: (330) 867-8800. E-mail: pryerson@rmasolutions.com.

Personal communications can be discoverable

Even incident reports aren't always protected

Physicians' personal notes about a patient's care. Incident reports if a patient is harmed. Information given verbally or in writing to the hospital's risk managers. Conversations or e-mails with ED physicians about the patient's care. E-mails or conversation with physicians who don't work in your ED. Personal correspondence with noninvolved parties.

All of these items are potentially discoverable, according to **Steven D. Davidson**, JD, a partner with Omaha, NE-based Baird Holm. "All notes, conversations or e-mails with colleagues, whether inside or outside the ED, are typically subject to discovery," says Davidson. "The same is true for incident reports and conversations with risk management where facts about the event are being gathered."

There are two general exceptions, however. The first includes any information provided to an attorney, or to others when an attorney is present to give legal advice. "For that reason, we often advise that a lawyer be involved promptly after a significant adverse event, so that conversations and information can be protected by the attorney/client privilege," says Davidson.

The second exception is conversations and information provided for a peer review committee. States treat the peer review privilege differently. For example, in Nebraska, according to **Joseph J. Feltes**, JD, a partner with Buckingham Doolittle in Canton, OH, if a physician provides information or creates documents in connection with an evaluation of the event by a formally recognized peer review committee, which is acting within its function to evaluate and improve care, a privilege exists that protects the information from discovery in a later malpractice action involving the same event. However, again in Nebraska, this privilege does not reach incident reports or communications with risk managers who are gathering information about an event in the normal course of their job duties, and not in connection with a particular peer review activity.

Davidson says, "This privilege does not prevent access to the underlying facts about the event, but rather the evaluative activity of the peer review committee." ■

Source

For more information, contact:

- **Joseph J. Feltes**, JD, Buckingham, Doolittle & Burroughs, Canton, OH. Phone: (330) 491-5225. E-mail: JFeltes@BDBLAW.com.

Do's and don'ts for physicians who are sued

According to **Ken Braxton**, JD, a health care attorney at Dallas-based Stewart Stimmel, ED physicians, when notified of a possible lawsuit or claim, should avoid all of the following actions:

• Never alter documentation when notified of a possible lawsuit or claim.

"The patient's attorney probably already has the medical records, so any alteration or addendum will be immediately used to allege a coverup," says Braxton.

• Never call the patient or their attorney to try to talk them out of the lawsuit.

"This amounts to free discovery for the attorney, who will more than likely let the ED physician 'spill their guts,'" says Braxton.

• Never talk to other providers involved with the care to the patient without an attorney present, other than in a peer review setting.

Braxton cautions, "All nonpeer review and nonattorney conversations with other providers are subject to discovery."

Here are three things that Braxton recommends ED physicians do if they are sued:

1. Immediately notify their insurance carrier to get advice on how to respond upon receipt of the notice.
2. Tell the director of the ED, so that the medical records are secured.
3. Create a personal file that includes the ED physician's correspondence and lawsuit documents and a copy of the patient's chart. ■

ACEP releases H1N1 strategic plan

'No area of the United States would be spared'

Two out of the three pandemics in the 20th century made a first pass and then returned in a more virulent "second wave." Give that historical precedent, EDs departments should prepare for a surge of patients with respiratory symptoms this fall as H1N1 novel influenza A takes a shot at North America during a traditional flu season.

"No area of the United States would be spared from the spread of novel H1N1," the American College of Emergency Physicians (ACEP) warns in a new report. "Although the weather may affect transmission rates, no emergency department is exempt from the risks of an outbreak. If the transmission rates double from the spring 2009, more than 30,000 cases can be expected over the fall and early winter. Emergency departments could see 150% of normal volume of respiratory complaints. This may even be true in communities where the novel H1N1 virus is not yet widely present due to increased levels of concern by the public regarding any respiratory related illness."

The American College of Emergency Physicians (ACEP) is making public a "National Strategic Plan for Emergency Department Management of Outbreaks of Novel H1N1 Influenza" to help the nation's EDs and first responders plan for and manage the surge in H1N1 flu cases that might arrive as early as September (*Editor's note: A copy of the plan is available at tinyurl.com/klb2ss.)* The plan, which was produced under the Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Emergency Care Coordination Center (ECCC), includes the following key components:

- threat awareness;
- protection and prevention;
- surveillance and detection;
- response and recovery.

Second, more virulent waves occurred in the fall in the pandemics of 1918 and 1957, ACEP points out. "Should a second wave occur in the early fall, a vaccine is unlikely to be available," the report states. "Without vaccine, the best defense the nation will have in reducing transmission would be community mitigation strategies. Since case rates are highest in school-aged children, school closures would likely be one of the first strategies employed. This would result in parents needing to remain home with their children and the consequent loss of workplace productivity. This would include health care workers, reducing the ability of emergency departments and hospitals to function at peak efficiency."

ACEP recommends that emergency departments make the following planning assumptions:

- The behavior of the virus is not predictable but is likely to return in the fall of 2009 and persist into 2010, complicating usual seasonal flu management.
- The fall 2009 wave will follow the pattern of pandemics of the 20th century by having greater virulence than the initial wave.
- Children and young adults will experience the highest attack rates.
- Adults older than 65 will have lower attack rates due to previous influenza exposures.
- The onset of the fall wave will not be detected until after it has begun.
- A well-matched vaccine will not be available until mid-October 2009 at the earliest and will not be effective until weeks after the final doses.
- Community mitigation measures can be effective to slow disease transmission and will be the only tool available for prevention.
- Mass antiviral chemoprophylaxis will not be recommended.
- Continuing sensitivity of H1N1 to antiviral medications is unknown.
- Emergency medical and hospital planning for an H1N1 pandemic will be successful only if it is interoperable with emergency management and public health.

The release of the plan "[s]hould encourage people — if they haven't already — to start their planning process and identify other groups they have to work with," says **Stephen V. Cantrill**, MD, FACEP, an emergency physician at Denver Health Medical Center and a member of the task force that developed the plan. "As you know, we tend to think of ourselves as 'stand-alones,' but the ED needs to work with hospitals, state and local health departments, local, state, and federal government, and emergency medicine partners throughout the country," Cantrill says.

Among the goals of the plan was the development of a capabilities list — a "starting place" for ED managers and others for determining the capabilities they would have to have to deal effectively with a potential

WHO issues H1N1 patient care checklist

The World Health Organization (WHO) has developed a new free Patient Care Checklist for Influenza A (H1N1) for use by hospitals worldwide for the treatment of suspected or confirmed cases of the virus.

"All hospitals are being encouraged to use the checklist and, where appropriate, to modify it to suit their local practice," says a statement from WHO.

WHO recommends disseminating the checklist "as soon as possible," since "[t]his is critical for health management, as well as clinical practice, to ensure the fullest possible uptake."

WHO adds that the checklist is currently being evaluated "to improve usability" and an updated version will be posted on the web site when completed.

The checklist can be downloaded at: www.who.int/patientsafety/activities/ah1n1_checklist/en. The web page also includes a brief summary of the checklist and how WHO suggests it be used. ■

pandemic outbreak, he says. Those capabilities will vary from hospital to hospital and town to town, Cantrill says. For that reason, the plan is designed as a foundation upon which emergency planners will build their own customized plan.

"Our goal is always to provide good patient care, and this will optimize those opportunities," Cantrill says.

Once the emergency response planners have taken the ACEP plan and molded it into their own institutional plan, it must be shared with staff, he says. "They need to know what is expected of them in terms of things like personal protective equipment and absenteeism policies," Cantrill notes. "For example, while you may want to come in to work, we do not want you to work when you are sick."

As in any pandemic, staffing would be one of the biggest challenges, says Cantrill, citing the importance of ED managers being aware of many possible sources of staffing help. "For example," he poses, "do you have a list of volunteer retired caregivers? It's not something you want to spool up when the need arises, but rather give thought to it ahead of time." **(The World Health Organization has issued a patient care checklist for H1N1. See story, p. 93.)** ■

Proposed OPPS rule offers 1%-2% pay updates

The Centers for Medicare & Medicaid Services' (CMS) proposed payment policies and payment rate updates for services furnished to beneficiaries during calendar year 2010 in hospital outpatient departments under the outpatient prospective payment system (OPPS) should have no major impact on ED managers, according to **Barbara K. Tomar**, federal affairs director of the American College of Emergency Physicians, Washington, DC.

"In scanning the NPRM [notice of proposed rule making], I didn't see much that was exciting new policy or anything that would appear to have a negative impact on EDs," she says. "For the most part, there are small 1%-2% payment updates for ED APCs [ambulatory payment classifications].'"

Tomar did note that this year CMS proposes to add a Level V in the Type B visit series ($248 vs. $330 for Type A Level V). "Last year, Type B level V was paid the same as Type A Level V," she observes.

There is still no proposal for facility coding for ED visits, "and we are good with that," Tomar says. In addition, she points out, proposed payment for the relatively new APC 0618, critical care with trauma activation, is slated for a 14% reduction. "While that seems bad, one has to remember that payment went from $330 in 2008 to $935 in 2009, and $800 proposed for 2010," she explains. "That's probably based on additional claims and new median cost computations."

CMS will accept comments on the proposed rule until Aug. 31, 2009, and will respond to comments in a final rule to be issued by Nov. 1, 2009. To access the proposed rule, go to http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&item ID=CMS1224005&intNumPerPage=10. If you wish to comment on the proposed rule, go to: www.regulations.gov/fdmspublic/component/main?main=SubmitComment&o=09000064809e7edc. ■

TJC to improve top 4 challenging requirements

The Joint Commission (TJC) is conducting an extensive review of its National Patient Safety Goals (NPSGs) to identify how to increase the value of the requirements in helping organizations provide safe, quality care. According to recent field input on the NPSGs and the standards, the four most challenging requirements are:

- **NPSG 8**, medication reconciliation;
- **The Universal Protocol**, in particular, the site marking requirement;
- **NPSG.02.03.01**, reporting of critical tests, results and values;
- **Standard PI.04.01.01**, staffing effectiveness.

Initial suggestions from the field for improving these requirements include making them less prescriptive and using clearer language. Specific feedback on the critical test results requirement included suggestions for a more limited scope. Feedback on the staffing effectiveness standard revealed that implementation is difficult and costly for organizations while yielding little value.

The Joint Commission will engage focus groups on these issues and will invite field comment on proposed revised requirements via web-based surveys. ■

TJC participates in safety alliance

A public-private alliance of safety officials and technical experts known as the Commercial Aviation

Safety Team (CAST) has significantly improved aviation safety since its creation in 1997.

CAST is now working to create a similar alliance among health care stakeholders, including The Joint Commission (TJC), that could reduce medication and device errors and wrong-site surgeries, according to **Peter Pronovost** MD, PhD, professor in the Department of Anesthesiology and Critical Care Medicine, Johns Hopkins University School of Medicine, and co-author of an article on this topic published recently in the journal *Health Affairs*.[1]

Pronovost and his colleagues are working to establish a health care counterpart to CAST, which they call Public Private Partnership to Promote Patient Safety (P5S). Other stakeholders in addition to The Joint Commission include the Agency for Health Care Research and Quality (AHRQ), the Food and Drug Administration, U.S. Pharmacopeia, the ECRI Institute, insurers, and more than 15 large health systems. Initial planning is under way with a grant from the Robert Wood Johnson Foundation and another grant has been submitted to AHRQ. The planning group is co-chaired by Pronovost; Jerod Loeb, PhD, The Joint Commission's executive vice president of quality measurement and research; Eric Campbell, PhD, associate professor of medicine, Harvard Medical School; and Sara Singer, PhD, assistant professor of health care management and policy, Harvard School of Public Health.

Reference

1. Pronovost P, Goeschel CA, Olsen KL, et al. Reducing health care hazards: lessons from the commercial aviation safety team.. (A proposed public-private partnership to help the health care community emulate the successes of CAST in commercial aviation.) *Health Affairs* 2009; 28:w479-w489. ■

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 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 *questions*

25. According to Jesse M. Pines, MD, MBA, MSCE, ED managers can help reduce the number of post-admission complications in patients presenting to the ED with chest pain by addressing:
A. rapid and appropriate diagnosis.
B. the transition from the ED to inpatient status.
C. medication reconciliation.
D. All of the above

26. Ben Johnston, MD, says because of an expanded scope of practice, his staff often avoid can calling in a surgeon. In which of these situations *does* the staff call a surgeon?
A. When a patient is headed to the OR.
B. When a patient has an extremity fracture that can be reduced.
C. When there is no underlying problem in a plastic surgery case.
D. When procedural sedation is required.

27. According to Vincent Wang, MD, when educating pediatric patients and their families about asthma, some types of information must be customized. Which of the following does *not* need to be customized?
A. Medications
B. Common triggers
C. Individual exacerbations
D. How to reach out to the patient

COMING IN FUTURE MONTHS

■ Pandemic exercise uses parking deck for "drive-through" triage

■ ED takes "reservations" through an online service

■ Coalition of 13 hospitals develops strategies to improve flow

■ Rolling out systemwide ED screening program

28. According to Hugh Jenkins, MD, FACEP, a new greeting/triage/assessment process has helped reduce the door-to-doc time in his department from 121 minutes to 19 minutes. Under this new process, the doctor will see the patient:
A. before the nurse does.
B. after the nurse does.
C. at the same time.
D. Any of the above

29. According to Amy Wilson-Stronks, MPP, what finding surprised a 25-member panel of experts reviewing requirements for communication, culture, and patient-centered care?
A. There are not enough interpreters available in EDs.
B. When patients go to the hospital and have mobility issues, there aren't always ways to accommodate them.
C. That EDs face different challenges than other departments.
D. That religious needs are more difficult to accommodate than cultural ones.

30. Experts say ED managers have some misconceptions about The Joint Commission's Strategic Improvement Initiative. According to Donise Mosebach, RN, MS, CEN, which of the following is true?
A. The intent of some standards has been changed.
B. Several new standards have been introduced
C. The language of standards has been simplified.
D. The survey process has been changed.

CNE/CME answers

25. D; 26. A; 27. B; 28. D; 29. B; 30. C.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Joint Commission proposed requirements on culture, communication out for field review

Patient-centered care also included in Joint Commission proposals

After months of anticipation, The Joint Commission has released its "proposed requirements to advance effective communication, cultural competence, and patient-centered care" for field review. If approved, they will represent some significant new challenges for ED managers.

Keys areas likely to affect the ED include:

• identifying the method the patient would prefer to use to communicate;

• making sure the patient is aware of his or her right to have an interpreter provided free of charge;

• documenting the fact that a language or communication need exists;

• using tools such as teach-back or read-back during patient education;

• accommodating cultural differences, in comparison with the current standard that says "respecting";

• ongoing staff training about cultural differences and their role in patient care. *(Editor's note: Go to www.JointCommission.org/Standards/FieldReviews/field_ecccpc to review all of the proposals.)*

The Joint Commission is taking steps to ease the transition to these new requirements, notes **Amy Wilson-Stronks**, MPP, project director for health disparities in the Division of Standards and Survey Methods. "Part of our work has involved developing an implementation guide, which will come out at the same time the standards are finalized in January 2010," she shares. "It will give some specific examples of resources and tools that can be used to meet the requirements." The earliest date that new requirements would be expected to be implemented is January 2011.

Executive Summary

The Joint Commission's new proposed requirements on communication, culture, and patient-centered care hold many implications for ED managers. If the proposed requirements are adopted as written, you'll need to do the following:

- Determine the three largest ethnic groups among your patients, and be sure you and your staff will be able to meet their needs;
- Remember that special patient needs are not restricted to language. Some patients might need hearing aids, while others might need help to walk (i.e., a cane).
- Recognize that you will be required to accommodate, not merely "respect," patients' cultural and personal beliefs.

Challenges to the ED

When developing these proposed requirements, a 25-member panel of experts followed the care processes for hypothetical patients. "That really allowed us to understand how these issues can impact care, but for the ED there are lots of specific challenges because the work there is very quick and very acute, and the only thing we can add is that we certainly try to be sensitive to the fact that these standards mean different things to different departments," says Wilson-Stronks.

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"The leadership needs to provide their department with the resources and tools they require**." (Wilson-Stronks shares additional thoughts on what The Joint Commission expects of ED managers in the story, below.)**

Staff education might be one of the most challenging of the requirements, but **India Owens**, MSN, CEN, director of emergency services at Clarian West Medical Center in Indianapolis, says there are keys to meeting that challenge. "You have to make the education relevant to your department and the patient demographics," she advises. "If the staff does not understand why these things are being required, they won't absorb the information."

Get to know your 'target'

Owens says the release of the proposals "prompted me to look at the demographics here." She notes that her catchment area includes more than just her hospital's home county, which increases patient diversity. "You have to know the target," Owens explains. "Part of the challenge involves understanding which groups are represented, so I know how to train my staff."

All patients are registered electronically, she says. "Out computer gurus can capture religion and ethnicity, so I can write a report that tells me the top three religious preferences, the top three ethnicities, and so forth," says Owens. Since this is aggregate information, she adds, there is not a privacy issue involved. "All I want to know is what my top three groups are that I need to educate my staff about," she says.

Since the standard is new, she continues, "I have not taken the step to determine this information relative to creating an educational plan. However, I ran it just for fun and found that our top three ethnicities are Caucasian, African-American, and Hispanic."

Owens says most of her education is done online, including post-competency exams, "So, the staff can do it at their leisure, day or night." ■

What does TJC want from ED managers?

While The Joint Commission generally seeks to avoid proscriptive language in its standards, it still has a number of expectations for ED managers and other health care leaders when it comes to its "proposed requirements to advance effective communication, cultural competence, and patient-centered care," says **Amy Wilson-Stronks**, MPP, project director of health disparities in the Division of Standards and Survey Methods.

For example, Wilson-Stronks notes, when it comes to effective communication, "The point we are trying to emphasize is that patients present with various communication needs that should be considered." These needs, she points out, might not only include language interpreters; they might include devices such as hearing aids. "If you're serving a large population of non-English-speaking patients, you should make sure your triage and floor nurses and doctors are aware of how to access language services," Wilson-Stronks adds. **(For more information on language services, see the following stories in *ED Management,* September 2008: "Majority of emergency patients don't understand discharge instructions, p. 97, "Be proactive about improving communications, p. 98, and "Non-English speakers present special problem, p. 99. In *EDM,* June 2007, see "Translation technology fills important niche," p. 65.)**

Patients also must be made aware of those services. Placing "I speak [insert language]" cards at the triage desk is one effective strategy, says Wilson-Stronks. "The other piece ED managers might want to think about is making sure the staff is aware of how to determine the need for an interpreter," she adds. Make sure your staff is trained on accessing interpreter services when a patient is limited English proficient and identifies another spoken language. It also is important that ED staff are trained on how to use the services.

A patient advocate

India Owens, MSN, CEN, director of emergency services at Clarian West Medical Center in Indianapolis, goes a step farther in her department. "We have bilingual staff that can register patients and record their chief complaint, but our goal is always to get a medical-grade interpreter who is the patient's advocate and not the hospital's advocate," she says. "You can't expect the provider to present care options; you need that advocate."

Interpreters can be found through the International Medical Interpreters Association (www.imiaweb.org/default.asp). "Some interpreters contract individually, but most work through some sort of collaborative to enhance availability," Owens explains.

According to the Bureau of Labor Statistics (BLS), medical interpreters' salaries can range from a low of under $9.88 hourly to a high of $30.91 hourly, "which equates to just over $60,000 for someone working full-time," she says. The average salary is $17.10 hourly, which is a bit more than $34,000 annually. These data, she adds, are based on BLS information for 2006,

which is the most recent information readily available.

As far as documenting the need for communication assistance, says Wilson-Stronks, that can take place during admission or assessment. What is new about the documenting proposal is that documentation would be expected to be used for planning purposes by gathering aggregate data, she says.

An interesting new distinction involves patients' cultural and personal beliefs and religious and spiritual practices. Formerly, notes Wilson-Stronks, providers were required to "respect" those differences; now they must "accommodate" them. "This can involve issues like death and dying, or certain rituals," she explains. "You look for a point of reasonableness, but there are ways of making accommodations for these beliefs even when on the face of it they may appear to be unusual."

One example Wilson-Stronks cites involved the preference of the Gypsy population to have a light put underneath the bed, usually a burning candle. "Obviously, you do not want to have a candle burning under a hospital bed," Wilson-Stronks observes. "One hospital has used a flashlight, which appeased the patient and the family, but did not cause a safety issue."

Because the new requirements address patient-centered care, the 25-member expert panel that developed them explored a broad range of issues. "One thing that surprised us was when patients go to the hospital and have mobility issues — for example, they are very large, and unable to get up and access the exam table — there aren't always ways to accommodate them," notes Wilson-Stronks. "Or, they may walk with the assistance of a cane, but when they were moved from the ED to radiology, the cane does not follow them." This inability to accommodate patients also could impact the assessment process (if the patient has trouble walking), she adds.

Finally, says Wilson-Stronks, the education requirement has been broadened to include patients and staff. "The Joint Commission has proposed making the staff education requirement dealing with orientation related to cultural sensitivity more specific to include sensitivity on the cultures of patients and staff," Wilson-Stronks explains. "Training that helps employees better understand different beliefs and perspectives and promotes behavior that is respectful and nonjudgmental is important for both relationships between staff and patients and among staff." ■

SII simplifies language, structure of standards

Initiative doesn't include intro of new standards

While ED managers have awaited the results of The Joint Commission's Strategic Improvement Initiative (SII) with some trepidation, their fears by and large might have been unfounded based on some early comments. In fact, the introduction of the revised standards might actually help dispel some mistaken beliefs.

For example: SII does *not* introduce any new standards that need to be followed, says **Donise Mosebach**, RN, MS, CEN, field director, Division of Accreditation and Certification Operations. "The purpose of SII was to clarify the standards, to delete any redundancies and make language easier for the field to interpret," Mosebach explains. "Within SII, there are no new standards included, and the survey process do not change — just the language of the standards."

In other words, the intent and requirements of the standards have not changed, she says. Organizations need to evaluate patient flow concerns from a systems perspective, in addition to the unique processes within an individual patient care unit, department, or service line, Mosebach says. "This is incorporated into our survey process and will be evaluated while conducting the on-site accreditation survey," she says.

Welcome news

This news should be welcomed by ED managers, says **Michael Carius**, MD, FACEP, chairman of the

Executive Summary

While The Joint Commission's Strategic Improvement Initiative (SII) does not involve the development of any new standards, the language of some standards has changed and in some cases single standards have been divided into two standards. Since this new language is part of the accreditation manual, there are some things you should be aware of:

- The intent of the standards has not changed. The language has been simplified to clarify expectations.
- Be wary of the language that applies to boarding. It could be interpreted by your hospital in a way that is detrimental to your department.
- The previous single Element of Performance (EP) on assessment and reassessment has been changed into two EPs. Familiarize yourself with both of them.

Two EPs may be better than one

As The Joint Commission's Standards Improvement Initiative has unfolded, most of the changes have involved simplifying the language of the individual standards. However, in some cases a single element of performance (EP) has been split into two EPs to improve clarity. Here's an example involving assessment and reassessment:

• **2008 Standard:**

— **PC.2.20 EP1.** The organization's written definition of the data and information gathered during assessment and reassessment includes the following: the scope of assessment and reassessment activities; the content of the assessment and reassessment; and the criteria for when an additional or more in-depth assessment is done. For example, nutritional or functional risk assessments may be defined for at-risk patients. In such cases, nutritional risk criteria should be developed by dietitians or other qualified individuals, and functional risk criteria should be developed by rehabilitation specialists or other qualified individuals.

• **2009 Standard:**

— **PC.01.02.01 EP 1.** The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. (See also RC.02.01.01, EP 2.) Note: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.

— **PC.01.02.01 EP 2.** The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. (See also PC.01.02.07, EP 1; PC.01.02.03 EPs 7 and 8.) Note: Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.

"This reworking of the standard is good," says **Michael Carius**, MD, FACEP, chairman of the Department of Emergency Medicine at Norwalk (CT) Hospital and past president of the American College of Emergency Physicians. "It takes excess verbiage out, but still says you have to redefine the scope and planning of assessment and reassessment." Making two EPs out of one "simply works better," Carius adds. "This may be seen as beneficial for ED managers." ■

Department of Emergency Medicine at Norwalk (CT) Hospital and past president of the American College of Emergency Physicians. "I don't know how widespread the knowledge of the changes is in the ED community," he says. "This will actually help to dispel some of the concerns people might have about The Joint Commission and the direction they are going in."

Mosebach, who was an ED manager before joining The Joint Commission, adds, "The biggest part of SII is that it should make the intent and purpose behind the standards clearer for ED managers and help them understand what the expectation is."

Carius agrees the language has been simplified. "The thing that strikes me when I compare [the old and new] standards is that the 2009 revisions seem to be less wordy, a little easier to understand, and a little less proscriptive," he says.

However, Carius isn't sure that's always a good thing. For example, he is concerned about the simpler language in the standard that covers boarding. Here are the old and new standards:

• **2008 Standard: LD.3.15 EP 2.** Planning encompasses the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations, for example, post-anesthesia care unit and emergency department areas.

• **2009 Standard: LD.04.03.11 EP 2.** The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post-anesthesia care unit or the emergency department.

"Whether this is good or bad for EDs will really be subject to how it's interpreted," says Carius. "If hospitals feel the heat is off and they can do pretty much what they want, it will be bad for EDs."

What Carius means is that in the past administrators at some hospitals have "paid lip service" to the fact that boarding is a systemwide or hospitalwide problem, but they still consider it as an ED problem. "In many respects ED's have looked to The Joint Commission to help us convince administrators that boarding is a systems problem," he notes. "Whether this will make a difference in the right direction is not clear, because the language seems be a little more benign in terms of direction." **(Other changes include taking a single element of performance and splitting it into two "EPs" for more clarity. See the story, above.)** ■