ED Management

Best Practices – Patient Flow – Federal Regulations – Accreditation

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ED managers' responsibilities will increase with meaningful use rule

Getting emergency physicians onboard is crucial

The world of the ED manager changed significantly in July, when the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology released the final rule for the definition of the term "meaningful use."

Those standards are part of the Health Information Technology for Economic and Clinical Health (HITECH). Act, itself part of the American Recovery and Reinvestment Act of 2009 (ARRA). The rule outlines how electronic health records, or EHRs, must be used to qualify for Medicare and Medicaid financial incentives under the HITECH Act.

"Prior to this final rule, ED orders were excluded under the guise they were part of outpatient services, but such huge numbers of com-

ED Management features management tips patient flow successes, and awards Gold Star

This month we are adding new features to *ED Management*. We want to recognize those ED management teams that go "above and beyond" to dramatically improve performance through unique and creative approaches. From time to time, we will formally recognize their excellence by bestowing a "Gold Star Award," which will be indicated at the top of their story. In this issue, we have given our first Gold Star to the ED team at Akron (OH) Children's Hospital, which created a separate behavioral health unit. Behavioral health is an ongoing challenge for ED managers. Their creative approach to research, planning, design, and financing of the unit establishes a compelling model for others.

Also newly added this month, some of our ED leaders will be sharing management tips — creative strategies and best practices they use to improve the performance of their departments. Also, given the ongoing challenge of ED crowding, we regularly will feature articles illustrating successful patient flow solutions.

If you have strategies and solutions you'd like to share, please send them to Steve Lewis, senior managing editor, at steve@wordmaninc.com.

ments really wanted to include the ED," says **Patricia Daiker**, RN, vice president of marketing for Medhost, a Wakefield, MA-based provider of healthcare throughput software.

In the interim rule, Daiker says, Department of Health and Human Services officials said that hospitals were required to show that 10% of all orders were placed in an EHR, including lab reports and radiology reports. "Now they've just narrowed the scope to medication orders, and increased the percentage to 30%," she explains.

Because such a large percentage of admitted patients go through the ED, note observers, overall hospital compliance should be much easier. It certainly will raise the profile of the ED. **Todd Rothenhaus**, MD, FACEP, senior vice president and CIO of Caritas Christi Healthcare in Boston, says, "If their CIO never paid attention to them before, they are now. It is a bit of a game-changer."

Know your terms

ED managers must understand some critical terms to help their facilities comply with the standards, says **James McClay**, MD, FACEP, associate professor of emergency medicine at the University of Nebraska Medical Center in Omaha.

"First of all, in the phrase 'meaningful use of certified information,' there are two loaded definitions: 'meaningful use' and 'certified,'" McClay says.

The term "certified" refers to the vendors of the systems used by the ED, he says. "If the ED is not using a certified vendor and is still doing documentation on paper, they are not contributing to compliance," says McClay. "If they are working with the hospital EHR vendor and they're using the built-in module, it's up to the vendor to certify the module."

However, most EDs operate on a departmental system in some form or other, so if they are going to contribute to the hospital's meaningful use compliance, their departmental system would have to be certified, he says. The government has established certifying bodies that will make that determination, McClay adds.

The ED manager has to sort out all of this by first asking the vendor representatives if the system they have installed is going to be certified, he says.

EXECUTIVE SUMMARY

Now that the final rule on the meaningful use standard has included patient encounters in the ED, managers will have added responsibilities in the areas of documentation, IT system evaluation, and physician participation.

- Learn and understand the difference between the terms "meaningful use" and "certified."
- Find out which pharmacies are participating in e-prescribing.
- Follow a systematic approach to the selection of an electronic system.

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Editor: **Steve Lewis** (steve@wordmaninc.com).
Executive Editor: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Neill L. Kimball.**

Editorial Questions
For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

"Also, they may only be certified for a particular version of the software. You may be on version 6, and the vendor is certified on version 7," he says. "In that case, you'd have to upgrade."

The ONC web site contains specific information on the meaningful use requirements. *(Go to http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204, and click on "meaningful use.")*

Rothenhaus says, "The hospital and the CIO need the ED to really participate now in helping achieve meaningful use. For example, they will be asking physicians to use CPOE [computerized physician order entry] and electronic prescribing. If you have a system rolled out and you're not using it, you have to, and if you do not have one, you will have to put in a plan. Some hospitals will have to scramble." *(Rothenhaus says compliance should be earned in three stages. See the story, below. He also recommends a team approach, which is described in the* Management Tip, *p. 124.)*

E-prescribing a challenge

Electronic prescribing is complicated, says McClay.

"If you're doing this, you're transmitting information from your system directly to the pharmacy," notes McClay, adding that not all pharmacies are participating, "You need to know all those things," he says.

In addition, to do e-prescribing, you have to go through an intermediary, McClay says. Your software vendor for your system is not also the broker for transmission of transcription. "Ideally, your vendor would provide you tooling" to communicate with this third party, McClay says. "The first-tier vendor generally either builds this into the reports you can generate or sends someone who can provide that service for you." ■

Meaningful Use Standards

The Core Set
- Record patient demographics.
- Record vital signs/chart changes.
- Maintain current and active diagnoses.
- Maintain active medication list.
- Maintain active allergy list.
- Record adult smoking status.
- Provide patient clinical summaries.
- Provide electronic health information copy on demand.
- Generate and transmit prescriptions electronically.
- Use computerized physician order entry for drug orders.
- Implement drug-drug/drug-allergy interaction checks.
- Be capable of electronic clinical information exchange.
- Implement one clinical decision support rule.
- Protect patient data privacy and security.
- Report clinical quality measures to CMS or states.

The Menu Set
- Implement drug formulary checks.
- Incorporate clinical lab test results.
- Generate patient lists by condition.
- Identify patient-specific education resources.
- Perform medication reconciliation between care settings.
- Provide summary of care for transferred patients.
- Submit electronic immunization data to registries.
- Submit electronic epidemiology data to public health agencies.
- Send care reminders to patients.
- Provide timely patient electronic access to health information.

Source: The Centers for Medicare and Medicaid Services.

Earn compliance in three stages

In seeking compliance with meaningful use standards, there are three stages the ED manager must go through, says **Todd Rothenhaus**, MD, FACEP, senior vice president and CIO of Caritas Christi Healthcare in Boston.

"The first is developing a strategy for choosing a system, whether it's a 'best of breed' or an enterprise module," Rothenhaus says. "The second is getting it configured for meaningful use, and the third is getting people to use it."

Set up is a 'pretty key piece,' he adds, due to the complexity of triage notes and nursing documentation for metrics. "There are some 'un-ED-like' requirements such as smoking cessation questionnaires, which may be counter-productive for throughput," Rothenhaus notes. "Accordingly, you have to choose what meaningful use objectives you want to be measured on and build that data capture into your system." The meaningful use objectives are broken into a "core set" of 15 that all hospitals must meet and a "menu set" of 10 procedures from which you can choose five to defer. *(See list, above.)*

"Each hospital gets to choose how they want to be scored, so there have to be some meetings between inpatient and ambulatory folks as to which ones from the menu set they want to report on," says Rothenhaus. ■

Management Tip

Create a team for compliace

When it comes to meeting meaningful use standards, "the first thing ED leadership needs to do is create a team that will strategize on helping the hospital meet them," says **Todd Rothenhaus**, MD, FACEP, senior vice president and CIO of Caritas Christi Healthcare in Boston. "It should not be a very big group, but it should be collaborative, including nursing, physician leadership, and administration."

In addition, you should have someone from IT supporting the plan, Rothenhaus says. "In most organizations, meaningful use criteria will be driven a little more by IT than by some other types of measures like pay for performance, which are driven and collected by quality and safety and administration folks," he explains. ■

Expectations exceeded in productivity gains

'Rolling forecast' budgeting yields quick dividends

When the University of Michigan Health System, Ann Arbor, instituted a "rolling forecast" approach to budgeting, its administrators established a target to improve labor productivity by 2% in fiscal 2010. While the health system far exceeded this goal, boosting overall productivity by 4.7%, the ED at the University of Michigan Medical Center, also in Ann Arbor, took the prize with productivity gains in excess of 7%.

"We had 7.6% improvement in FTE per 10,000 units of service [visits]," says **Jennifer G. Holmes**, RN, BSN, MHSA, CEN, the ED's director of operations. For fiscal 2009, Holmes notes, the department used 38.1 FTEs per 10,000 units of service, and in FY 2010 there were 35.07, yielding the 7.6% reduction. "When we think of productivity, we think of how many patients were seen per doctor and per hour," she explains.

More specifically, leadership achieved reductions of two FTEs in clerical, two FTEs of overtime usage in allied health (ED techs), and two FTEs of nursing overtime, she says. "With folks from industrial engineering, we looked at all arrival data, occupancy data, staffing data, nursing ratios, and built them into a model that could show us where to move people around to optimize productivity," Holmes says. "We found we had more people than we needed in the early morning hours, so we worked to optimize that. We added them where we needed without any incremental expense. We began training interns we would need later on rather than having open positions and then having to backfill them."

Jon Fairchild, MS, RN, CEN, the ED manager, adds, "In the past, because of that need to increase staff, we were never really caught up."

What is a "rolling forecast," and how does it work? In past years, Holmes explains, building a budget meant a significant amount of activity around budget time — January and February — and then waiting until it was approved to take any new actions. "Your fiscal year started July 1, and you spent the rest of the year arguing around that budget. If things changed during the course of the year, there was not an effective mechanism to address it," she recalls. "You probably carried a variance, because the hospital could not anticipate or hold off on things until the next budget year."

Now, Holmes says, the team considers whether anything is going to change in their practice. For example, what service lines might be added or subtracted? "We now look out four to six quarters," says Holmes, noting that these projections are updated quarterly, thus the "rolling" aspect. The team considers issues such as input and staff-

EXECUTIVE SUMMARY

The ED at the University of Michigan Health Center in Ann Arbor exceeded expectations when their system adopted a "rolling approach" to budgeting. The department boosted productivity by more than 7%, compared with a target of 2% and a systemwide average of 4.7%.

- Data on arrivals, occupancy, nursing ratios, and other areas were studied to determine precise staffing requirements.
- Nursing interns were trained early so they would be available to fill staffing needs.
- Planning involved "cohorts" that included other units with which the ED regularly interacts.

ing needs, and team members view the budget more "globally" and plan for potential changes in partnership with other departments.

"We developed some cohorts of groups whose activities directly or indirectly impact each other," Holmes explains. So, for example, surgery, orthopedics, and EDs are all interrelated. "If orthopedics plans some new procedures, that may generate more transfers. There could be more cases to us," says Holmes. In such a case, she explains, future ED activity predictions would be based on projections and historical data. *(Your processes should be continuously reviewed, says Holmes. See the Management Tip on p. 126.)*

"If things are known ahead of time, they can be planned for," Holmes says. "For example, can we plan for beds that will not be used by other departments?" These issues previously were not talked about much, until these cohorts started to look ahead, she says. "Now, we can with better accuracy know what we'll be creating and what others may be generating for us," Holmes says. *(For a more detailed look at the "rolling forecast" process, see the story below.)* ■

Detailed budget helps predictions

A detailed budget is one of the keys to success in the "rolling forecast" approach, says **Jennifer G. Holmes**, RN, BSN, MHSA, CEN, director of operations in the ED at University of Michigan Medical Center in Ann Arbor.

"We started at a baseline, where each of our FTEs is designated," Holmes explains. She also includes how many patients she expects to admit, revenue projections based on activity, what will be spent in salary and wages, and commodities. "We don't submit every name and quarterly variance explanation, such as adding more techs and fewer nurses. Those kinds of changes would generate red flags in previous years because we would be over or under budget," Holmes says.

Now, managers are held to the bottom line, she says. "The administrators recognize that directors and managers are in the best position to make decisions about how to manage resources, with the expectation that they will do so within the overall budget," says Holmes. In addition, she points out, projections are updated along the way. "Last year, for example, we had higher acuity and thus higher charges, and we let senior management know in September that by January we would have several million dollars more in revenue," Holmes says.

While this updating is formally done quarterly, all budget components are looked at on a monthly basis, she says. ■

Productivity focus is liberating

One of the challenges from administration at University of Michigan Medical Center in Ann Arbor was to improve efficiency by 2%, says **Jennifer G. Holmes**, RN, BSN, MHSA, CEN, director of operations in the ED.

"In the past, that meant you needed to get expenses down," Holmes says. "But the focus on productivity frees you up on how to do that."

Holmes' ED is process-oriented, and when managers are considering a metric they think they could improve, they use Lean processes. "We look at how we could do things differently, at the root causes of variability, how we staff different areas by time of day and day of the week," she explains.

So, for example, when it came to the clerical area, a staffer had been doing the schedule. The employee basically wanted to make everyone happy and set aside specific times per their requests. "We changed that responsibility to an administrative assistant who considers who is here, what shifts we have, how they interplay, and what staffing we need, so we now have the closest match to what the unit needs," says Holmes.

Previously, she says, although the unit need is 14 clerks, there would be 17 working on some days. The unit would be short on some other days because staffers were not assigned to shifts appropriately, Holmes says. ■

Management Tip

Continuously review your ED processes

"You should constantly be looking at your processes for opportunities to improve," says **Jennifer G. Holmes**, RN, BSN, MHSA, CEN, director of operations in the ED at University of Michigan

Medical Center in Ann Arbor. "Try new things — even if you have never done them before — and involve your staff in the review."

Holmes recommends using small tests of change and pilots, and being open to staff suggestions — even if you've considered or tried them before. "The time may now be right to implement the idea and achieve real improvements," she explains.

This approach can yield real results, she says. "We have an overall goal to reduce length of stay by one hour, and we have reduced the time from arrival to room by 43 minutes with our most recent process improvement designed by our ED Arrival Team," says Holmes. She emphasizes the importance of listening to your staff. "You can't tell the staff 'this is how we're going to do it,'" Holmes says. *(The ED team uses Lean thinking to inform their process improvement initiatives. An illustration of this approach can be found with the online issue of* ED Management.*)* ■

Gold Star
AWARD

Pediatric ED opens behavioral health area

Improved security for agitated patients

Behavioral health issues present an ongoing challenge for ED managers in pediatric as well as adult facilities. To address these challenges, the ED leadership at Akron (OH) Children's Hospital has built a separate area within the department to treat patients with such issues.

"We have seen mental health and behavioral health issues escalating in the ED, and we did not feel we could safely care for these patients in a regular setting," says **Helen Raub**, BSN, MBA, RN, the ED nursing director. For example, Raub points out, "there were many things they could harm themselves on — monitors and other equipment — and there was the risk of flight for children in crisis."

In addition, she says, patients in crisis might be yelling and screaming next door to a 2-year-old being treated for an earache, and there had been instances when teenagers had attacked staff.

EXECUTIVE SUMMARY

In response to a number of acts of violence and out of concern for the privacy of other patients, the ED at Akron (OH) Children's Hospital decided it was necessary to create a separate behavior health unit. Here are some of the strategies they used:

- Rooms were designed (i.e., lighting and sound) to minimize the risk of escalation in agitated patients.
- Out of concern for patient safety, there is no heavy equipment or medical gasses in the rooms.
- ED leadership solicited input from patients' parents before finalizing their plans.

Security officers and nurses had been injured.

Timothy Lee, MD, medical director of the facility's main campus, says, "We wanted to create a space where, for example, there were no wires hanging from the ceilings. And like any peds ED, we see some pervasive developmental disorders like autism and Asperger's syndrome. Even just the bright lights of the ED and noise levels can escalate agitation." *(Tours of other facilities helped the ED team with the design of the unit. See the story on p. 127.)*

Fortunately, Lee says, there were generous donors in the community who were willing to underwrite the $500,000 unit, which is located within the ED.

Raub says, "It is a secure five-bed unit that is locked and monitored with security cameras. It is designed to be safe. There is no heavy equipment, and there are no medical gasses." *(Raub says Lean principles were used in the planning of the unit. See the Management Tip on pg. 127.)*

Each room has a cot, a couple of chairs, a TV behind a clear acrylic wall, locked cupboards, no sharp corners, and dimmer lights.

"The doors on the rooms swing outward, which means that patients cannot barricade themselves in," Raub adds. "There is a large interview room where nurses and social workers can talk to the family, as well as a family waiting room." Sometimes the family is in as much crisis as the child, she notes, and they need a quiet, safe area where they can collect themselves.

After patients present, the triage nurse determines if they require treatment in the behavioral health unit — for example, if they are threatening suicide or are otherwise agitated. "If the nurse determines there are exclusively mental health issues involved, they take them straight back where they are seen by a nurse, a mental health worker, a social worker, and an ED physician who will make sure that there is nothing medically wrong with them," says Raub.

If the patient is relatively calm, the parents can walk them over to the unit themselves, where they press a button to gain entry. The nurses can see them through a security camera.

If they are not cooperative, the nurse will go over with them or, if necessary, they will call security.

The unit is working well, says Lee. "We had one patient in particular who was agitated, but all it really took was to allow them to walk the hall [in the separate unit], and they de-escalated," he recalls. "That sort of thing would never have been feasible in our other space."

Raub says, "It's going great. On our first day we saw seven patients in the unit. The parents really appreciate it, and it's absolutely done what we expected in terms of safety." *(For more information on behavioral health in the ED, see* ED Management*, September 2008: "'Psych ED' relieves main department," p. 106, and "Separate area in the ED relieves pressure," p. 106.)*

Facility tours help with unit design

To plan the design of a behavioral health unit within its ED, leaders at Akron (OH) Children's Hospital toured several other facilities that already had such units.

"We belong to the National Association of Children's Hospital's ED focus group," says **Timothy Lee**, MD, medical director of the facility's main campus. "All of its members travel to different hospitals and observe operations."

One of the facilities was Kosair Children's Hospital in Louisville, KY, which had a separate behavioral health unit. "The staff they utilized was a lot more psychologically focused. Mental health techs and psych nurses seemed to make a big difference," Lee notes.

Helen Raub, BSN, MBA, RN, the ED nursing director, says, "I see things totally different than how a parent would see them. Another thing we did well was to involve families with children who could potentially be in the ED and find out what they would need."

Initially, she says, she consulted with a parent who is also on a countywide advisory board and advocates for children. "She met with the multidisciplined hospital planning committee," she shares. "We talked about key design issues and met with her several times."

Then, prior to the opening, she invited a group of about six people from the Family Center Care Council, a hospital council that includes parents, and asked them if they had any concerns. "We wanted to know that they would feel comfortable with the unit, its design, and the security equipment, if they brought their child in," Raub explains. "We also asked them how we should present ourselves to the community; after all, we did not want to let people think there would be a psychologist here 24/7."

All of this preparation was valuable, says Raub. "We've found it really helpful since we were going with a brand new site, facility, staff, and processes," Raub says. "We put on that 'green belt' and looked at it from a Lean perspective, focusing on the patient's needs." ■

Management Tip

Use Lean techniques when planning unit

Whenever you're planning a new unit or a physical change to your department, you should employ Lean Six Sigma techniques, advises **Helen Raub**, BSN, MBA, RN, the nursing director of the ED at Akron (OH) Children's Hospital, which recently added a separate unit for behavioral health patients.

"We've found it really helpful since we were going with a brand new site, facility, staff, and processes," Raub says. "We put on that 'green belt' and looked at it from a Lean perspective, focusing on the patient's needs."

During such an initiative, you have to get away from a "we've always done it this way" attitude and examine those approaches that best utilize your available resources, she says.

So, for example, the staffing mix was changed. "Instead of all RNs, as we have in the ED, we added mental health technicians, which was getting away from how we did things in the past," says Raub. In addition, she notes, in the past when children came into the ED in crisis and out of control the first thing the staff did was medicate. "Now, we first use de-escalation techniques to get the child under control and only go to medication or restraints as a last resort," Raub says. ■

Cell phone pix: A new diagnostic tool

Photos taken by patients help speed flow

Initial data on the use of cell phone photos of injuries, taken by the patients themselves in the ED at The George Washington University Hospital in Washington, DC, offers the promise that they might have the potential to speed treatment without sacrificing diagnostic accuracy.

The patients send their pictures to a secure e-mail account, where they can be downloaded by ED physicians. "You look at a patient who comes in with a slice injury, for example, and sometimes you're not sure if they need stitches or not," notes **Neil Sikka**, MD, an assistant professor of medicine at the George Washington University School of Medicine and chief of the Section of Innovative Projects. "When the patients present, we enroll them in the study, they take a picture of their wound, fill out a questionnaire [which covers their history and symptoms], and the doctor will look at the pictures to see if in fact they need stitches." *(If the pictures are of poor quality, notes Sikka, diagnosis is hindered. See the* Clinical Tip *on p. 129.)*

A research assistant helps the patient with the consent process, as well as the questionnaire and a survey that asks their opinion of the process. "They also help them shoot the close-ups from one or two feet away," says Sikka, noting that up to four photos may be used to show different angles on the injury.

The study is "very focused," looking only at patients who come in with acute lacerations or soft tissue infections, he says.

Sikka says that thus far, he has data from 125 patients after several months. He is encouraged by the results. The accuracy rate for determining whether acute lacerations require stitches is in the "high 80% range," Sikka reports. In terms of whether, upon follow-up, patients are getting better or worse, the rates are similar to those of patients who did not participate in the program. "Where we are not as good is in determining management of soft tissue infection," says Sikka, adding that the accuracy rate there is in the upper 60s. "This is probably limited by the fact that we only have 2-D pictures, which can't tell depth or level of swelling," he says.

Sikka also believes the rate could be improved by asking better questions of the patient. "History is the majority of medicine," he says.

Leena Salazar, RN, BSN, director of emergency services, was quite interested in the study when Sikka began it. "From a nursing perspective, it seemed very worthwhile," she says. "Anything that can help to alleviate long waits in the ED and still get the same quality treatment patients expect is a definite plus." *(For more on the reaction of nurses and patients, see the story below.)* ■

EXECUTIVE SUMMARY

The ED at The George Washington University Hospital in Washington, DC, has been participating in a study in which patients use cell phones to photograph wounds or tissue infections. The data indicates that for the most part, diagnoses have been accurate.

- After patients take the picture and complete a questionnaire, the photos are reviewed by an ED physician.
- Research assistants help patients with the consent process.
- If the photos show patients do not require stitches, they can be treated and discharged without waiting for hours.

Nurses, patients like new approach

Nurses and patients in the ED at The George Washington University Hospital in Washington, DC, have responded positively to a new study that allows patients to e-mail cell phone photos of their injuries to ED physicians prior to their treatment.

"Most of our nurses are of the techno-savvy generation, so anything that brings technology into patient care and attempts to streamline things, they are all for," says **Leena Salazar**, RN, BSN, director, emergency services "They're excited about the things that it can do, and if the study pans out — and I don't see why it wouldn't — it will help their triages to know what to expect, since the patients will already have sent the pictures to the physician."

As part of the study, surveys are given to all of the patients for their opinions on convenience, time saved, and improved communication with the provider. **Neil Sikka**, MD, an assistant professor

of medicine at the George Washington University School of Medicine, whose researchers conducted the surveys, says, "They have indicated really good acceptance. People are open to it and interested in the use of technology."

Salazar predicts that in the future, this approach "would definitely improve satisfaction" because it streamlines the treatment process. "Patients do not have to wait hours to be triaged, only to then go back to see a doctor and be told they do not need stitches," she explains. Initial patient survey comments indicate they agree this approach can save time while improving communications with the physician. ■

CLINICAL TIP

Poor image quality hinders diagnosis

When seeking to assess patient injuries such as acute lacerations and soft tissue infections by using cell phone camera photos, "the quality of the image plays a large role" in the accuracy of diagnosis, notes **Neil Sikka**, MD, an assistant professor of medicine at the George Washington University School of Medicine, Washington, DC, who is conducting a study using cell phone photos taken by ED patients.

"Over 50% of inaccurate diagnoses come from poor image quality," says Sikka, adding that he recommends using camera phones with at least three megapixels, auto flash, and autofocus. ■

Actual legal risks if you did it, but didn't document

Any information could be critical

Despite the adage, "If it wasn't documented, it wasn't done," not everything that ED nurses and physicians do is actually documented. The fact is, documentation omissions and errors do occur. The question is, what piece of information is likely to become crucially important from a legal perspective?

Steven J. Davidson, MD, MBA, FACEP, FACPE, chairman of the Department of Emergency Medicine at Maimonides Medical Center in Brooklyn, NY, says that in his opinion, the conventional wisdom of "if it wasn't documented, it wasn't done" is really a consequence of the breakdown of trust between patients and physicians.

"This is a real phenomenon I've observed over my 35 years in the ED," Davidson adds.

Video recordings of the ED patient encounter would be one remedy to the issue of documentation on the medical record, says **Andrew Garlisi,** MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH. "Short of this, the only reliable way to support, confirm, or authenticate the completion of a task is through documentation of the medical record," Garlisi says.

Memories fade and cannot be relied upon in a courtroom situation months or years after an encounter with a patient. "But the medical record can stand as de facto evidence of the truth," says Garlisi. "After all, why would a physician falsely document the medical record in real time, since he or she would have no knowledge that a lawsuit would be forthcoming?"

In reality, there are constraints to documentation of the ED medical record. One is that the expectations and responsibilities for emergency physicians "have seemingly exponentially expanded," says Garlisi. He points to "time is muscle" and "time is brain" initiatives, computerized physician order entry (CPOE), 30-minute guarantees by EDs, and "one-hour door-to-door" fast track initiatives.

"All of these have placed pressure on emergency staff to see patients faster and complete the evaluations and treatments in shorter time frames," says Garlisi.

An ED physician might be deluged with several patients simultaneously, with unstable or critical care patients in the mix. In that scenario, it is difficult for the physician to document every phase of each encounter accurately and precisely, if at all, in real time.

"Documentation takes a back seat to the task at hand: managing the sick and dying patients in a safe manner," says Garlisi. "The emergency staff is under the proverbial gun to deliver faster care and achieve a score of 5 on Press-Ganey patient satisfaction surveys, all in the face of staff cuts and

Essential Elements of Documentation

- Presenting symptoms and complaints
- Care rendered prior to arrival (self-medication or emergency medical services medications or treatments)
- Pertinent positives and negatives relative to the history of the present illness
- Pertinent positives and negatives relative to the physical examination
- Review of ancillary data (EKG, arterial blood gas, blood panels, radiology studies, etc.)
- Discussion with patients and family members regarding treatment plans and options
- Reassessment of the patient's response to therapies and interventions
- Decisions regarding why treatments were not rendered, as with "do not resuscitate" situations
- Discussions with primary care and consultants
- Procedure notes
- Any unusual occurrences such as elopements, leaving against medical advice, disruptive behaviors, or refusal of suggested procedures such as lumbar puncture for severe, sudden headache
- Acknowledgment of review of vital signs, recheck of abnormal vital signs, and interventions of patient education or instructions provided for follow-up of abnormal vital signs
- Explanations of unexpected results, with explicit instructions on when, how, and with whom to follow up. These include high creatinine, suspicious nodule on chest X-ray, proteinuria, low hemoglobin, heme occult positive stool, abnormal EKG, abnormal liver functions, and hypokalemia
- Reasons for transfer (or not to transfer) to another facility
- Psychiatric patients in general — children and adult, suicidal patients, forced detention issues, and restraints

Source: Andrew Garlisi, MD, MPH, MBA, VAQSF, University Hospitals Geauga Medical Center, Chardon, OH

dwindling resources."

At the same time that demands on the emergency physician have increased, there might be insufficient staff and other resources. "It is easy to understand why documentation can be, and often is, substandard, even with the template documentation systems which are in widespread use," says Garlisi. "Unfortunately for the emergency physician, any and all aspects of documentation could be a critical piece of information which could make or break the defensibility in malpractice case."

To the question "which piece of documentation is critically important?" Garlisi responds, "The critically important piece is the one not done properly or missing completely from the medical record," he says. "In my experience, almost every aspect of medical record documentation can be subjected to scrutiny and be a significant determining factor in a medical malpractice decision."

Gabor D. Kelen, MD, director of the Department of Emergency Medicine at The Johns Hopkins University in Baltimore, says that there is no doubt that good document can "save the day" in the event of a malpractice lawsuit alleging poor ED care. "But I would like to seriously challenge that documentation is everything," he says. "I've seen some cases saved by lack of documentation, and I've seen some cases flushed down the toilet, rightfully so, because of documentation."

Kelen has also seen charts where the documentation was lacking, but the ED physician "fell on their sword." "They said that they were lousy documenters, but it doesn't mean they didn't do the right thing. Then they testify as to what really happened."

In that situation, it comes down to who is more credible: the plaintiff who claims the doctor ignored them, or the doctor who says he or she gave good care but just didn't document it.

"The physician may say, 'I had a lot of patients to see. I didn't shortchange this patient, but I didn't get around to documenting everything I did.' If they give a credible account of what happened, often the case either settles for a much smaller amount than it otherwise would have, or they win in court," says Kelen. ■

COMING IN FUTURE MONTHS

- Does "over-triage" result in unnecessary costs?
- New test allows TB diagnosis in under two hours
- Improved communications boost throughput, satisfaction, and safety
- Will budget cuts put emergency department nurses in peril?

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 this activity with the March issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter 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. Which of the following would allow you to contribute to your hospital's compliance with the meaningful use standards, according to James McClay, MD, FACEP, associate professor of emergency medicine at the University of Nebraska Medical Center?
A. Using a paper system for record-keeping
B. Working with a pharmacy that does not participate in e-prescribing

8. How often do she and her staff review budget projections, according to Jennifer G. Holmes, RN, BSN, MHSA, CEN, director of operations in the ED at University of Michigan Medical Center?
A. Monthly
B. Quarterly
C. Every six months

9. Which of the following safety features were included in the new behavioral health unit, according to Helen Raub, BSN, MBA, RN, the ED nursing director at Akron Children's Hospital?
A. Doors that open only outward
B. No sharp corners
C. No heavy equipment in the rooms
D. All of the above

10. According to Neil Sikka, MD, an assistant professor of medicine at the George Washington University School of Medicine and chief of the Section of Innovative Projects, the diagnostic accuracy of cell phone cameras taking pictures of soft tissue infections is limited due to:
A. Patients not being able to hold the camera phone sufficiently still.
B. Poor lighting in the ED.
C. The fact that the pictures are only 2-D.

11. Even with an electronic medical record (EMR), it took seven years to customize the system at Barnes-Jewish Hospital to include documentation by consulting physicians who come down to the ED, according to Darryl Williams, RN, BSN, ED clinical manager. Why was it such a challenge?
A. The consulting physicians refused to use the EMR.
B. The consulting physicians were each using their own documentation sheets.

12. Besides the ED, who should be part of a "team approach" to meet medication reconciliation requirements, according to Diana S. Contino, RN, MBA, FAEN, senior manager of health care with Deloitte Consulting?
A. Pharmacists or PharmD students
B. Primary care physicians
C. Inpatient staff
D. All of the above

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PS Form 3526, September 1998 (Reverse)

CNE/CME ANSWERS

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

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Where do EDs remain challenged? Record keeping and egress integrity

Even an electronic medical record does not guarantee accurate documentation

Every summer The Joint Commission issues a list of those standards hospitals find most difficult to comply with. Among those challenging standards are three that experts say most directly impact the ED:

• DC.02.03.01: The laboratory report is complete and is in the patient's clinical record.

• RC.01.01.01: The hospital maintains complete and accurate medical records for each patient.

• LS.02.01.20: The hospital maintains the integrity of the means of egress.

Compliance with the first two standards is made much easier if the ED is fortunate enough to have an electronic medical record, or EMR. "We have an EMR, and really and truly it solves a lot of problems," says **Darryl Williams**, *RN, BSN, clinical manager of the ED at Barnes-Jewish Hospital in St. Louis, MO. "It has a direct interface with the lab. Their system talks with ours, and the results go directly into our system."*

Results are flagged and posted to the record, Williams adds. "The icon turns red, yellow, and then green when it's posted," he notes. "For any critical results, they still call the doctor."

But having an EMR doesn't guarantee compliance, insists **James Augustine**, *MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "There is still an issue between the 'in' computer and guiding patient care with somebody knowing the results," Augustine says. "In the medical records for patients, it should be clear that somebody has reviewed the results and dealt with any discrepancies."*

For example, he notes, when it comes to cultures, specimens are obtained in the ED, but the initial result might come back a day later. "The results can be sitting in the computer, but they do not do you any good unless a decision-maker acts on it," he says. Some computerized systems now have prompts to trigger the staff to review results of important lab work that comes back later, he says.

Diana S. Contino, *RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles, says, "The lack of compliance may be the result of policies not keeping up with technology or practice. If your organization uses an electronic system to review lab results, and staff go to this system rather than using printed copies, then define an 'active chart' as encompassing the electronic lab reports in the lab or results reporting system."*

EXECUTIVE SUMMARY

Among those standards The Joint Commission reports offer the most difficult compliance challenges for hospitals, the three that have the greatest impact on EDs involve complete lab records, complete and accurate patient records, and egress.

- Install an electronic medical record, and verify that results have been reviewed.
- If you use a paper system, ensure that all final printed results are filed in the paper record.
- Involve clinicians who understand the standards in the selection of equipment.

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Senior Managing Editor Joy Dickinson, Author Steve Lewis, Nurse Planner Diana S. Contino, and Executive Editor 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 that he is a consultant for The Abaris Group and conducts research for Ferno Washington.

If a surveyor then pulled an active chart during a visit, the staff would be expected to describe this process and be knowledgeable of policy and procedures. "Organizations using paper charts are expected to define time frames when a chart is complete," Contino says. "In these cases, the organization needs to ensure that all final printed results are filed in the paper record."

Amend your action plan

If your ED hasn't been able to achieve this standard, there are several items that should be in your action plan, says Contino.

"First, map out the steps of this process, and identify a streamlined approach that minimizes handoffs and multiple persons being responsible for similar actions," she recommends. "One process that has been successful for some organizations is to implement automated 'final results reporting.'"

You should generate "final summary" reports from the lab system at the time that the chart is considered closed, says Contino. "These reports could even be printed on a different color paper, creating a visual queue that all labs are final and ready to file," she suggests. The outcome in this case is "one" easily identifiable report to be filed, as opposed to staff looking for multiple individual sheets.

The third step "should be the implementation of an EMR, which ultimately enhances the process of integrating the results with the patients' record, improving compliance with the standard around 'filing a laboratory result in the medical record' as well as meeting many other regulatory standards," Contino says. (Contino says clinicians should be involved in planning for all of these difficult standards, especially egress. See the story, right.)

Augustine says, "If you do not have an EMR, then you have to have a very sophisticated process of getting lab tests back to the emergency physicians or a responsible nurse, and make sure the results are managed appropriately."

Williams says, "If you do not have an EMR, you either have to have a paper from the lab delivered to you when resulted, or you have to take a read back; the lab calls you, and you give it." This process can be complicated, he concedes, because many people "turn numbers around" even when they read them, and handwriting these results also can cause mistakes.

Williams adds that even with an EMR, it can take quite a while to attain compliance with the second standard. "We've been working with our EMR for seven years now and customizing it, but it's just now achieved completeness," he says. Each consulting service that came down to see patients in the ED had its own consulting documentation sheet, Williams recalls.

"We eliminated that problem by creating templates in our system for them to use," he says. Another piece of paper "people chase all over the world" is the EKG, Williams says. "As soon as it is taken here, our secretary can scan it into the EMR, so our record is a complete record," he says. The accuracy of the system allows the EKGs to be read in a timely manner, including the signature of the physician who wrote the note, Williams says. ■

SOURCES

For more information on complying with standards from The Joint Commission standards:

- **James Augustine**, MD, FACEP, Director of Clinical Operations, Emergency Medicine Physicians, Canton, OH. Phone: (330) 493-4443. E-mail: JAugustine@emp.com.
- **Diana S. Contino**, RN, MBA, FAEN, Senior Manager of Health Care, Deloitte Consulting, Los Angeles. Phone: (949) 683-0117. E-mail: dcontino@deloitte.com. Web: www.deloitte.com.
- **Darryl Williams**, RN, BSN, ED Clinical Manager, Barnes-Jewish Hospital, St. Louis, MO. Phone: (314) 362-4349. E-mail: mdw9207@bjc.org.

Involve clinicians in egress plans

There are any number of reasons why an ED and its hospital would have difficulty complying with The Joint Commission standard regarding egress, says **Diana S. Contino**, *RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles.*

"These include space limitations for the volume of patients, an inability to efficiently manage patient flow, and selecting equipment without the input of clinicians or concern for regulatory standards," Contino says.

Involving clinicians who understand the standards in the selection of equipment improves the ability to incorporate equipment that is useful and

efficient, she says. "It is the clinicians who understand the impact of three large vital sign monitors on poles for 12 rooms. All three poles usually end up in the hallway," she notes. "One medication cart with one barcode reader for 12 rooms usually results in a cart remaining in the hallway."

The involvement of clinicians facilitates the selection of the ideal process/procedures and equipment to meet the egress standards, Contino says. "For example, many clinicians have encouraged the use of asset tracking systems," she says. "These systems create real-time visibility of all equipment or tagged assets, allowing staff to put them in storage areas to maintain egress, while enabling rapid location." Other clinicians have conducted Lean projects to document mounting vital sign and computer equipment in the rooms, which saves staff time and reduces loss — justifying the costs of the additional equipment, she says.

"The bottom line is that clinicians should be actively involved in the selection of equipment and processes to maintain egress, as well as the accountability to adhering to the standards," says Contino.

There are other approaches ED leaders can take to help improve egress, adds **James Augustine**, *MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "Many hospitals have come to use new storage systems that allow them to more efficiently store supplies for the ED and have more space available for large pieces of equipment like EKG machines and computers on wheels," he says.*

When it comes to the boarding of patients, Augustine says, "Hallway egress is a common cause of problems. That requires us to more effectively predict our volumes and create care spaces so that patient management can occur in a room as opposed to a hallway." Part of that process involves efficient movement of admitted patients to the floors, he says.

Barnes-Jewish Hospital in St. Louis, MO, has created an 18-bed transition unit away from the ED that takes just ED patients waiting for admission, reports **Darryl Williams**, *RN, BSN, clinical manager of the ED. "That has really helped us maintain integrity of egress," Williams says.*

When it comes to compliance with all Joint Commission standards, Contino adds this reminder for ED managers: "There are many ways to achieve the standards. The Joint Commission doesn't tell you 'how' to do it, but they define 'what' you need to do." ■

Medication reconciliation: Another change planned

Standard may be released in a few months

As The Grateful Dead might say if asked to describe the various iterations of the National Patient Safety Goal (NPSG) for medication reconciliation, "what a long, strange trip it's been." In the latest installation of the saga, The Joint Commission announced in the Aug. 4, 2010, issue of Joint Commission Online that it would be "presenting a revised requirement — based on the field review comments" to its Standards and Survey Procedures Committee in October.

In fact, as of this writing, The Joint Commission already has submitted proposed revisions to the Joint Commission Hospital Professional and Technical Advisory Committee, chaired by **James J. Augustine**, *MD, FACEP, director of clinical operations, Emergency Medicine Physicians, Canton, OH. "By the end of the year I believe we will have a new standard in place," Augustine predicts. However, according to The Joint Commission, it would not become effective until at least July 2011.*

The Joint Commission concluded revisions were needed following the field review responses. "Many respondents noted that compliance is a challenge because it involves critical issues beyond the organization's control, particularly the reliability of patient reporting of current medications," said the Joint Commission Online report.

Maureen Carr, *MBA, project director for The Joint Commission, says, "People did point out*

EXECUTIVE SUMMARY

Once again The Joint Commission is revising its standard for medication reconciliation. Responses to field reviews indicated some of the key challenges had not been resolved. Experts offer these suggestions for addressing the challenges and for how to proceed while waiting for the revised standard:

- Use your existing medication reconciliation process, and particularly for patients for whom you have a good list of existing medicines, use your best clinical methods to ensure you're giving medications that don't have potential reactions.
- Recognize that The Joint Commission's position is that you should make your best efforts to get an accurate list, but it will not hold you accountable for areas you do not have control over.
- A new standard would not take effect until July 2011 at the earliest.

that sometimes the patient is not a good historian, so that represents a challenge. It's the issue that appeared the most often. However, our position all along is that you should make your best efforts to get an accurate list, but that we would not hold you accountable for things you do not have control over."

Carr adds that "medication reconciliation compliance would not count in terms of accreditation, but we still expect facilities to meet the requirements. People should still be doing all they can to comply."

Margaret Montgomery, *RN, MSN, practice management manager with the American College of Emergency Physicians in Irving, TX, says, "What is clear is that the physician can only address the information that is available, whether it is a medication list provided by the patient or from the medical record from a previous visit. Many patients do not know the names or doses of the medication that they are taking. Patients frequently describe their pills by color or shape and have no idea of the dosage."*

The lack of accurate information about the patients' medication makes the medication reconciliation process difficult at best, adds Montgomery, noting that even having an electronic medical record does not guarantee accuracy. "It is only as reliable as the information that has been entered," she says.

Diana S. Contino, *RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles, says, "Meeting medication reconciliation standards continues to challenge many organizations. Some of the main reasons include: a lack of access to accurate information — the single owner of the information, the patient, is not responsible to, or may not be capable of, sharing it [the medication list] with others — and the lack of standardized data formats and a 'single source of truth' for patients' medication lists."*

Organizations are working to create secure ways to share information between pharmacies, health systems, and insurers, and the solutions often include health information exchanges (HIE), she says. "They have the potential of incorporating demographics, medications, and results, increasing the efficiency of accessing information, and reducing the redundancy of care," says Contino, referring to repeated tests.

Montgomery says, "I think everyone is in agreement that an accurate list is best, but obtaining one in the real world is difficult. If the standard is to make a good faith effort to obtain the information, then that is realistic."

The best goal is to come up with a standard that recognizes the unique aspects in different care environments such as the ED "and provides realistic parameters to ensure appropriate care for patients and meet the standard," she says. In addition, Montgomery notes, "while The Joint Commission will not be factoring in their survey findings on the medication reconciliation NPSG until a new goal is developed, they will be looking at how hospitals are addressing medication reconciliation." ■

Adopt a team approach for med reconciliation

What should ED managers be doing while they wait for The Joint Commission to publish a new standard for medication reconciliation? Take a team approach, recommends **Diana S. Contino**, *RN, MBA, FAEN, senior manager of health care with Deloitte Consulting in Los Angeles.*

"This includes encouraging/educating patients to maintain medication lists either electronically or on paper," Contino says. "The ED is responsible for collecting the initial information and for making the best effort to accurately list medications so the discharging physician can note the continuation or discontinuation of the medications."

As for the other team members, the pharmacists often assist in reviewing and noting other options for medications or doses, she says. Some EDs have pharmacists on staff to assist with the reconciliation process, and others incorporate PharmD students. Inpatient staff and the discharging physicians assist in ensuring the patient leaves with instructions for the appropriate medications. The primary care physician works with the specialist to ensure that all the patients' medications are optimal.

"Since this is a process that crosses many domains, it requires a collaborative approach closely linked with the overall care coordination strategy, which for many organizations includes new programs like medical home," Contino says.

James J. Augustine, *chairman of the Joint Commission Hospital Professional and Technical Advisory Committee, says, "In the meantime, ED leaders should be use their existing medication reconciliation process, and particularly for patients for whom we have a good list of existing medicines, we should use our best clinical methods to ensure we're giving medications that don't have potential reactions with existing medications."* ■

A Quick Summary of Lean Thinking

- Do our work every day in a standard way that we created
  - *Not just the way the work evolved!*
- Be alert to things going wrong
  - *They always do!*
- Fix the problem now
  - *For this patient or co-worker*
- Find and fix the root causes of the problem
  - *So it never happens again!* **Modified after Spear; Billi**

- *Solving problems:*
  - *1. Go and See*
  - *2. Ask why 5 times*
  - *3. Respect people* *Mr. Cho*

jbilli@umich.edu **www.med.umich.edu/mqs** **www.lean.org**

Lean Thinking is just…

…**simple and practical, consistently solving real problems in real time, at the source, at all levels.**

…not jumping to solutions.

…fixing the problem now.

…hard on the problem, easy on the people.

…leader saying, "Follow me. Let's look at it together".

…leading by being knowledgeable, fact-driven, expert negotiator, strong willed (for organization's goals) yet flexible; leading by influence and persuasion.

…not telling people exactly what to do.

…having individual responsibility clear.

John Shook

Lean Thinking: Troubleshooting Guide

1. What is the problem?
2. Who owns the problem?
3. What is the plan?
4. What is the current status of the plan? How will it be monitored?
5. What worker training is needed?
6. How does this problem relate to the organization's most important goals?*
7. What leader development is needed?

Adapted from John Shook. Ask questions in order.
***As a variation, 6 may be asked second. J Billi**

We know half the plan is wrong, we don't know which half. We have to watch it unfold, detect normal from abnormal right now, and fix it.

- Traditional companies think of a plan
  - as a prediction of what will happen.
- Lean companies think of a plan
  - as an experiment to be conducted
  - to tell us what we didn't know about the work
    - Paraphrase of Steven Spear , Fixing Healthcare… HBR'05

Plans are useless, planning is essential. (Eisenhower)