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IN THIS ISSUE

Iowa collaborative achieves improvement across the board

Hospital-physician cooperation leads to success

Collaboratives have sprung up all over the country, and many boast impressive results. However, few can lay claim to as many accomplishments in a relatively short period of time as the Iowa Healthcare Collaborative (IHC).

On the occasion of its fifth anniversary, the IHC issued a statement summarizing those accomplishments, which included the following:

- 62% of Iowa hospitals have fully implemented rapid response teams;
- 84% of Iowa hospitals fully implemented the acute myocardial infarction (AMI) care bundle;
- 84% of Iowa hospitals fully implemented the surgical-site infection bundle;
- 76% of Iowa hospitals fully implemented the methods to high-alert medications;
- 79% of Iowa hospitals fully implemented the pressure ulcer care bundle;
- 90% of Iowa hospitals fully implemented the heart failure care bundle.

According to the IHC, fewer than 20% of Iowa hospitals had implemented any of these in 2006. And that's not all:

- In 2007, 68% of health care workers had received influenza vaccination; in 2010, that figure was 91%.

KEY POINTS

- Participants learn from each other, sharing successes and failures.
- Founders of collaborative embrace public reporting.
- Initiatives have different levels of engagement.

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• Hysterectomy surgical-site infections have been reduced by 25%, and there has been a seven-fold reduction in central line infections variation.

• Compliance with the Centers for Medicare & Medicaid Services (CMS) AMI bundle of services has increased from 86% in 2005 to 94% in 2009, from 85% to 90% for pneumonia, and from 73% to 90% for surgical care.

• More than 50% of Iowa hospitals use Lean methodology.

A 'professionalism' model

How has the IHC been able to engender so much success in so many areas?

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EDITORIAL QUESTIONS

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"We really have based our initiatives on a professionalism model," says **Thomas C. Evans**, MD, president of the IHC. "Our two founding partners, the state hospital association and the physicians, are about promoting 'hospital-ness' and 'doctor-ness.' They focus on their members, and we built a concept that...it's our responsibility as providers to be providing care. We took the tack of 'What if we assumed leadership?' — and we did."

With that "naïve" perspective, says Evans, a former CMO for the largest hospital system in the state and president of the state medical society, he began what he describes as an experiment. "We tried it out, and we said if it worked we'd roll it into a 501(c)(3) — and we did it in a year and a half," he reports.

Evans says the IHC has three cornerstones for improvement:

• **Aligning and equipping providers:** This involves assessing where Iowa hospitals are and where they need to be, looking at national challenges and opportunities for improvement, and offering information through tool kits, conferences, etc.

• **Responsible public reporting:** "We said from the beginning that if we're the ones to deliver care, then we really need to embrace transparency," says Evans. "As scientists we should assume responsibility for statistical reliability; we're the public reporting entity."

• **Raising the standard of care:** "We need to constantly improve care if we want to stay in the game," Evans says.

"We're one big PDSA [plan, do, study, act]," he continues. "We do small tests of change and look at what the data say. We have 100% reporting across the state for our 118 hospitals."

At present, he says, there are 74 measures for public reporting, "re-packaged" from Hospital Compare, the state inpatient data set, and tools from the Agency for Healthcare Research and Quality.

On all cylinders

A model is one thing, but it also requires action on the part of many hospitals to successfully improve in so many areas. Evans takes some of the "blame" for that. "I'm a little manicky. I'm a family doctor by training," he says. "It seemed like every time we started something, another imperative got added to the list. We started with the [Institute for Healthcare Improvement's]

100,000 Lives campaign. We looked at that and asked how much of that should we not be doing, and decided we should be doing it all, so we started a statewide initiative with the expectation that everyone would do everything." So, in March 2006, hospitals were asked to voluntarily report to IHC quarterly on their deployment of bundles. After that, six more bundles were added from the 5 Million Lives campaign.

"In the first campaign, 11% of the hospitals reported full deployment of all six bundles in the beginning, and we're now around 70%," Evans says. "The second campaign started at 22%, and now we're around 70%-80%."

There were times, he says, when he had to "chase" hospitals. "We'd tell them they hadn't reported and that they were, say, one of only 10 hospitals in the entire state that hadn't," Evans says. "No one wants to be an outlier."

Subsequently, he says, IHC added its hospital-acquired infection portfolios, a separate statewide project with an independent reporting vehicle. "Next, we adopted Lean manufacturing techniques," Evans says.

The latest project is medical home. "With that, we can begin to work on transitions of care and re-admissions," he explains.

Working together

"We try to do these initiatives together," says Evans. "The hospital association does not lead these initiatives; they found it more effective to stay off to the side. We're the convener and PI coach across the state."

While IHC launches the initiatives, he continues, one of the founding partners is usually who communicates it to the hospitals. "They're told we're creating a statewide paradigm, and that they should be there," Evans explains.

Once an initiative has been selected, he continues, "We build the case for change — what is the current state, what should it be, and what penalties/incentives exist for getting there," says Evans. "Then we identify a series of actions, activities, or steps people should do, and we always try to tie in some objective measures of effectiveness." Wherever possible, he adds, IHC tries to build a return on investment (ROI) strategy as well.

IHC usually builds a "learning community" to help engender success. "We may build a toolkit available to all hospitals, to establish a general context; the learning community is where innovators can opt to participate," Evans explains. "We usually use the 'breakthrough series' model from IHI. We meet and discuss what we're going to do, folks go back to work, we give them more content, they go back to work, we talk about what we've accomplished."

The trick, says Evans, is finding and identifying innovators. "Sometimes we establish innovator workgroups and have them convene regularly by phone," he says.

As initiatives begin moving forward, Evans notes, there are different levels of engagement. "For example, our HAI work group is made up of a few well-equipped infection control professionals who do strategic thinking. Then, we have a monthly conference call for all infection control professionals; we have 70 people on it." The conferees learn about state-of-the-art approaches to preventing HAIs, and where things currently stand; then they are given a set of action items. "We have discussions where people share what they've done, and how they did it," notes Evans. "Those little huddles keep everyone on the same page."

"There are a number of different ways to participate," adds **Steve Gibson**, RN, manager of clinical performance improvement at Trinity Regional Medical Center in Fort Dodge, IA. "You can be fully involved in all conference calls, which occur at different intervals depending on the nature of the collaborative. You can meet in person at least once, sometimes twice a year, and always communicate by telephone at least once a month. Everyone has the opportunity to relate what happened in their independent institutions, going around the table, or call in and share what they do, how they managed the program, and what kinds of processes they're following. They share checklists, and talk about what has and hasn't worked for them." This has proved successful, says Gibson, because "you learn from each other."

In addition, he says, the collaborative provides the opportunity to formally benchmark with the other hospitals. "You can see who's doing well," he notes. "Tom might pick up the phone and say that you're at the top on a certain initiative, and ask if you'd like to give a presentation at the next meeting. If so, that becomes part of the agenda for the collaborative."

Inside an initiative

Gibson offers a closer look at an initiative with which his facility has had "pretty good success" — ventilator-associated pneumonia (VAP). "We've not had one incident for two years now,"

Charge Nurse Checklist

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
All admits/discharges logged on assignment sheet. Admits: arrived from and time. Discharges: dc'd to and time.							
Assure proper patient room assignment of patients (i.e., confused/ combative patients close to N5, 6, 7, 8, 9 clean rooms free of infection.							
Check that Met Pager is on and functioning. Assign to RN. Change Battery every Monday.							
Complete daily review of line necessity.							
Complete catheter bundle.							
Ventilator bundle completed when Ann not here and Sat./Sun.							
Check for accurate patient charges and forward to unit clerk.							
Crash cart check and fridge temp completed and documented.							
Condition Alert tab completed on all admits.							
Wounds staged on all admits and present on admission documented and signed by physician.							
Multiple care parameter - Braden and falls completed on all patients. Initiate falls (>50) and SOS (<17).							
Turn clocks for all q2h turns.							
Restraint orders daily on all patients in restraints. Restraints reflected in plan of care.							
Round on all patients. Marker boards updated with patient specific goal that is consistent with caregraph documentation. Rounding note completed on all patients that includes patient family involvement in discharge plans and cargraph goals.							
Assist with procedures and be sure TIME OUT and bundle checklist is completed with every procedure. Forward copy to Jen.							
Peminic follow up - follow up completed within 24 hours for all hospital-acquired wounds and patient falls.							

Source: Trinity Regional Medical Center.

he reports.

The VAP initiative at Trinity Regional started a little more than three years ago, says Gibson. "It came out of an IHI bundle adopted by IHC," he says. "They took the initiative statewide and offered hospitals the opportunity to participate. We focused on the bundles, implemented them, and monitored our process to make sure we were following the bundle until we were up to 100% bundle use."

The progress was monitored in a number of ways, says Gibson. "Part of the process is behavioral driven; for instance, the way you provide oral care, or a ventilator 'vacation,'" he notes. "We had the charge nurses on the [critical care unit] monitor the performance of the nurses caring for the patients to make sure those bundles were in place for each patient on a ventilator. That was the key." *(Gibson says his team used a checklist to monitor the bundle. See the sample this page.)*

Gibson says he has learned some valuable lessons about getting staff on board. "If you approach things from the standpoint that when

you take into account the human characteristic side of the equation, you try to eliminate all variables a practitioner would face when trying to do the right thing," he shares. "You try to put processes in place that make it very natural and easy to do the right thing."

So, for example, if the barrier to providing proper oral care is that it is done at a difficult time of day, "maybe you have to move that to a different time of day," Evans says. In fact, he says, that lesson came out of the VAP initiative.

Checklists are valuable, he continues, because "people can't remember everything, so you say, 'Here are the four, five, or six things you need to do for this bundle. We even went so far as to have reminders on the ventilators themselves that the bed should be in a certain position, so when you walk in the room, if the bed is not at a 45-degree angle, you have a reminder. We actually had little gauges built into the beds eventually. "

Another key to success, he says, is that "the lab is actually the bedside, and in a collaborative you have shared, real experiences — results of processes are shared, and you can adapt and adopt processes from different hospitals. In fact, I think the sign for bed elevation was developed by someone else."

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Readmission rates for HF reduced by 30%

Transitional care model, self-management keys

DMC Sinai-Grace Hospital in Detroit has been recognized by the Institute for Healthcare Improvement (IHI) for reducing its heart failure readmission rate by 30% this past year. Sinai-Grace was one of the first hospitals to participate in the IHI's State Action on Avoidable Rehospitalizations (MI STAAR) initiative.

KEY POINTS

- Continuity of care a critical consideration.
- Advanced learning assessment conducted within 24 hours of admission.
- "Teach back" method employed with patients, family members.

"We received a letter in 2009 stating that IHI and the Michigan Hospital Association were doing a joint venture on reducing hospital readmissions," says **Peggy Segura**, FNP-BC, nurse practitioner and the day-to-day leader for the STAAR project. "Our president and my boss decided this was something they were interested in."

While the initiative offered guidelines, she says, "we picked what we wanted to work on first." The project leaders looked at the highest-impact areas, processes that were in place, and what could be improved upon with the greatest impact. "For us, congestive heart failure had a significant readmission rate; in fact, most participants have selected it because it's one of the highest DRGs," says Segura.

Transitional care focus

The key component of the initiative, says Segura, was the transitional care model. "That involves providing a high level of service — whether from the acute facility to home or rehab, or back to the primary care provider," she explains. The other key element, which supports the first, involved improving the self-management of patients with chronic diseases.

"We found the most important activity was finding who the learner was; sometimes it's not the patient, but a family member or caregiver; sometimes it's a combination," says Segura. "If the patient is not the one who's going to the store and purchasing food or meds, we need to make it a joint venture."

Within the first 24 hours of admission, an advanced learning assessment is conducted by the nursing staff, the case management staff, or Segura herself. "We educate the patient by teach back; we identify the key points we want to teach them about their disease process and communicate with them at a 5th grade reading level," she says.

The goal, she says, is to make sure the patient/learner understands who the primary care provider

is, what his or her medications are, and how frequently they should be taken. "We also teach them what they're used for, and that they have to have two lists of medications — one with them and one at home," Segura adds. "For this disease process, we also wanted to teach signs and symptoms of their condition worsening — identifying when they are going into heart failure, and what they need to do if it happens. And, we teach them about follow up."

Teach back, she explains, is a "non-shaming" way of teaching patients. "Studies have found if you ask close-ended questions, they give you close-ended answers," says Segura. "We tell them at the end of the session that we want them to teach the information back us to be sure we both have an understanding."

Other improvements implemented

The program involved several other process improvements, including post-discharge follow up. "We have a call center in the hospital, so upon discharge we provide patients with a request for a follow-up appointment to be made within five days," says Segura. "We make sure they have available transportation, and that it works within their schedule."

Initially, she says, her team would call the patients on days seven, 14, 21, and 28 post-discharge to make sure all was going well — that they had followed up with their primary care doctor, and that they were taking their medications. "We also verified the teach back," Segura adds.

However, they found that a number of readmissions were occurring within the first 13 or 14 days, so the call program was rescheduled for days three, eight, 13, and 25. "At the end of 30 days, we turn the patient over to the corporate call center nurses, who call the patients at home twice a month for six months," says Segura.

Improved coordination of care, she continues, goes hand in hand with the post-discharge follow up. "We make sure to facilitate getting the patient back to their primary care provider," says Segura. "If they're from another system outside of ours, we still make every attempt to do follow up. We also work closely with home care and we partner with the Visiting Nurse Association on telephone monitoring, and they call me if the patient is in trouble."

If patients do not have a primary care provider and they are insured, the team asks them who they want to follow up with. "Most of the time they choose to see their [Sinai-Grace] doctor if they have an office outside the hospital," she says. "If they're uninsured, I see the patient in our primary care clinic, and they see me at no charge."

Finally, says Segura, medication reconciliation also has been improved. "We have an EMR, and the medical history is obtained by a nurse at the point of entry," she explains. "Then, whoever provides the care will reconcile the medications. We do an admission reconciliation, and they verify with the patient that those are the meds they're on. If they're transferred to another unit, a transfer reconciliation is obtained, and a discharge medication reconciliation is completed at discharge on a written form."

As most prescriptions come with a label, she continues, "I try to teach my patients to take that label and put it on a loose-leaf piece of paper along with the name of the person who wrote the prescription, where it gets filled, and the last time it was filled."

Keys to success

The project could not have succeeded, says Segura, without the support of top administration. "It had to come from the top down," she says. "Once they decided to support the initiative, they allowed my boss to hire 1.5 people and a QI specialist [Segura came on board about three weeks before the project was implemented]. Once the plan was formulated, I worked with a unit to pilot on, along with unit managers and the administrative director." The team, she says, included a member from pharmacy, primary care clinic managers, social workers, two QI specialists, and a nurse educator, all of whom went to the "kickoff" to get educated on the total program.

When she came on board, Segura went through the process herself. "I went to the floor and educated patients for a month," she recalls. "Then I started bringing in nurse champions for each unit; I educated them, and we worked with the patients. Once they were comfortable, we expanded to teaching on the floors."

Another key to success, she says, is having someone who is very knowledgeable and practice driven — in this case, her boss. "She looked at the project and defined the process, and developed a process map," she says. "We looked at who was responsible for each process; it's really a matter of putting the right people in the right place."

Segura says she is convinced that facilities that have not been as successful "did not have a defined process, or a defined leader." ■

Where do EDs remain challenged?

An EMR 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."

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."

KEY POINTS

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.

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.

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

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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," according to the *Joint Commission Online* report.

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

ized 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." ■

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."

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.)* ■

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.

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"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 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. ■

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