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Best Practices – Patient Flow – Federal Regulations – Accreditation

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IN THIS ISSUE

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Robot saves ED stroke patients, addresses subspecialist shortage

Neurologists in another facility speak through robot, guide care

When a patient presents at Frankfort (KY) Regional Medical Center with neurological symptoms, a "code neuro" is called. In addition to ED staff jumping into action, the lab, radiology, and additional nursing help are alerted.

"It tells the CAT scanner we will quickly do an EKG, start an IV, and that they have to clear the way so we can get the scan done and read by radiology within 15-20 minutes," says **Mike Presley**, MD, FACEP, medical director of the ED.

Meanwhile, the robot swings into action.

That's right, robot. Provided by University of Louisville Healthcare, NELSON (Neurological Evaluator for Lowering Stroke Outcomes Nationwide) stands about 5 feet 6 inches tall and glides across the floor on unseen wheels. He allows neurological specialists at Louisville to communicate via wireless broadband Internet with the Frankfurt ED staff. His "face" is a 21-inch computer screen, on which the head of the consulting neurologists appears and speaks to the ED staff.

But NELSON is more than just a rolling computer screen. His movements are controlled by the team in Louisville. So, for example, when the patient or family member has a question, he will turn his head. The distant physician will speak directly to the questioner.

EXECUTIVE SUMMARY

It isn't quite "2010 ED Odyssey," but the handling of stroke victims at Frankfort (KY) Regional Medical Center with the aid of a robot is certainly cutting edge. The University of Louisville Healthcare is making the robots and neurological consultants available at no cost. ED managers considering such a program can learn from the experiences at Frankfurt:

- Develop or amend your stroke code response to be used with the robot and the outside consultants.
- Have your staff go through a demonstration before implementing the program.
- Visit a facility using the program so you can see it in action.

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What's more, NELSON has his own voice. Once treatment has been completed, for example, he is supposed to be plugged into an electrical outlet. If that fails to happen, NELSON's computer will detect that failure and a computer voice will say "Please plug me in."

Louisville makes NELSON and its staff available free of charge in exchange for Frankfurt deploying the program.

"We've gotten nothing but positive feedbacks from patients and clinical staff," reports Presley. "I was concerned that patients would get 'freaked out,' but the technology we're using actually blows people away."

Eliminating call problems

The decision to try the program grew out of the frustration of having stroke patients come into the ED and not being able to find the resources to take care of them in a timely manner, says chief nursing officer **Sammie Mosier,** RN, BSN, MA, CMSRN, NE-BC, who helped initiate communication with Louisville.

"We had a lack of neurology coverage, especially on a 24-hour basis, and we were even to the point where EMS services would not bring patients to us because they did not know if we had coverage, and with stroke patients you have a window of time in which they need immediate treatment," Mosier says.

In the past, notes Presley, these patients had to be transferred to another facility, which could have negatively impacted outcomes if the transfer took too long. "This allows us to keep more of the neuro patients at our facility," he explains. "We have hospitalists that can admit and care for patients from a general medical sense, but we need special care by neurologists."

Mosier adds, "It's definitely increased the intensity level and care we can provide for patients. Delay is bad for their care, and it's scary not to have the service you need. With this relationship the patient gets treatment immediately, and if they need surgery and we can't do it, they are put on a direct route to Louisville."

Mosier went to Louisville to observe the program in action. "We learned all the things they could offer patients, and they also had a track record," she says. "We would not be the first facility to use the program."

There are 11 other facilities in Kentucky that are using the program, including Louisville.

Among the key deciding factors, were the 24/7 availability of consultants and their expertise, she says. *(There was little formal training of ED staff required. See the story on p. 15.)* Now the ED physicians perform a quick assessment of new patients, and if they determine it could be a potential stroke, they initiate a call to Louisville and the robot is initiated, Mosier says.

"The on-call doc at the U of L activates the

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SOURCE

For more information on using robots in the ED for stroke victims, contact:

• **Sammie Mosier**, RN, SN, MA, Chief Nursing Officer, and **Mike Presley**, MD, FACEP, ED Medical Director, Frankfort (KY) Regional Medical Center. Phone: (502) 875-5240.

robot, brings it to the bedside, works with the nurse or doctor, and starts doing the neural assessment immediately," she says. "There's no way, even if we had coverage, that the patient could be seen any faster."

NELSON also wears a stethoscope around his "neck" for the physician to use at the request of the neurological consultant.

The examination is a complete one, says Presley, who explains that the assessment must be completed before a decision is made about whether to administer a thrombolytic. "Most of the neurologic exam is done by asking the patient to perform a certain task, such as holding both hands out with palms extended and then opening their eyes. The specialist can assess the patient's strength by having them hold their arms up for a period of time and their reflexes by how fast they move their arms."

In addition, says Presley, the neurologist can "zoom in" on the patient's eyes while the Frankfurt caregiver shines a light in the eyes, so they can see how the pupils react. "It's amazing how much they can do," he says. ■

Robot requires little training

15-minute demo training provided

There was minimal training required to prepare the ED staff for the implementation of a robot-aided stroke care program at Frankfort (KY) Regional Medical Center, says Medical Director **Mike Presley**, MD, FACEP.

"The robot is very user friendly, says Presley.

The staff went through a 15-minute demo training at the request of **Kerri Remmel**, MD, PhD, stroke team leader for University of Louisville Healthcare, which provides the robot. "We linked with her, and she show us how it moves, how it can see the room, and how it can talk clearly with us, the patient, and the family," says Presley.

He notes that it is really the consulting neurologist in Louisville who speaks through the robot. "The only thing we need to remember is to plug it back up when it's done," Presley says.

One change was made in the program after it had been in place for a while, adds Presley, who notes that the robot is also being used by the intensive care unit (ICU).

"We found that they not only do a lot of ED consults, but they are also in the ICU, seeing people on the floor. So rather than training every doctor or nurse that might use, it we decided to train the house supervisors, and one is always in the house," Presley explains. "So if one of our hospitalists needs a consult from ICU, the house doctor can hook them up." ■

Trauma patients feted by staff

Event provides closure, camaraderie

Unless they are return patients, it's a rare event for ED providers to see the individuals they treat after they've been discharged. But at Loyola University Medical Center, Maywood, IL, leaders of the facility's Level I Trauma Center recognized that because the staff usually sees the patients when they are in the worst shape, it would be of great benefit to re-connect with those who have recovered and see living proof of their successes.

They decided to bring their former patients back for a special event to honor them for their survival and to let them re-connect with the staff and meet other patients with similar experiences. The event, called Fall Festival of Life: Honoring Our Trauma Patients, took place on Oct. 17, 2010, and is planned as an annual event.

"We get to see the fruits of our labor," explains **Tom Esposito**, MD, MPH, chief of

EXECUTIVE SUMMARY

Members of the trauma center staff at Loyola University Medical Center in Maywood, IL, believe that patient care doesn't end with discharge. They recently held a special event to celebrate their survivors, and they plan to make it an annual affair.

- Invitations were sent out to all survivors who had had Injury Severity Scores of 17 or above.
- Several opportunities were created to enable staff and patients to interact.
- Patients were invited to tell their stories, which can be an important part of the healing process.

the Division of Trauma, Surgical Critical Care, and Burns, noting that such an event is a good morale booster. "We thought it would be a nice idea to bring them back to honor them and in a small way pat ourselves on the back and see that the hard work we put in to try and save these people really does pay off."

"We see a lot of sad stories in a trauma center, but we also see some success stories in terms of people who have be seriously injured and then recovered," Esposito says. "We thought it would be nice to recognize their courage and perseverance as survivors of the leading cause of death in the 1-34 age group."

Jan Gillespie, RN, trauma program manager, says, "When you look at all that trauma centers are doing, it's important to look at our patients who survive and really celebrate their success — and our success."

Esposito adds such an event has PR value as well. "In terms of creating good will, absolutely; it's good for the community to know we're here when they need us," he says. "But by definition the trauma system takes in patients based on how they appear in the field, so we were not trying to increase market share, but just let them know trauma makes a difference."

A three-hour event

The celebration crammed a lot of activity into three hours, says Gillespie, who says that the event was held in the cafeteria of the Stritch School of Medicine on the campus of Loyola University Medical Center. The event began with an introduction from Esposito, who talked about the importance of trauma care and trauma systems.

"We had several families come up and tell their stories and what they're doing today," she says.

An invitation was extended to other patients to come up and share their stories, and several who hadn't expected to talk did so. "Many survivors brought pictures of themselves during the course of their stay," adds Gillespie, who says the event concluded with a picnic-type lunch and a cutting of the cake honoring the patients.

There were also opportunities for staff to interact with patients during check-in. "Before we sat down to eat, everyone went around to all the tables where the patients were, talked with them, and made sure they felt welcomed," adds Gillespie. *(Patients received personal invitations to the event, and staff was notified and asked to attend. See the story, right.)*

SOURCE

For more information on events to celebrate surviving patients, contact:

• **Tom Esposito**, MD, MPH, Chief of the Division of Trauma, Surgical Critical Care, and Burns, and Jan Gillespie, RN, Trauma Program Manager, Loyola University Medical Center, Maywood, IL. Phone: (708) 2072.

Gillespie saw the event as "a healing time" for the patients. "Nobody goes out and decides to have a trauma. It happens very suddenly and unexpectedly, and changes lives forever," she notes. "There are different stages of healing. One is to go back, see where you were, talk about those who took care of you about how they viewed your experience."

Patients also want to thank the staff, Gillespie adds. "Many trauma patients simply go through their stay, then rehab, then go home, and do not get to interface with us after rehab," she says.

For some of these patients, it's the first time they've ever talked in public about what they went through, Gillespie says. "Sometimes it's very helpful if you know you're not the only one out there who has had such an experience," she says.

Esposito labels the even a success. "The feedback that we got from the patients was that they were appreciative of us doing this," he says. In addition, he notes, a "survivor's group" has been spawned as a result of the event, to enable other patients to share their experiences. Details are still being worked out. "For a lot of these patients it was the first time they met each other, and many had similar injuries and similar feelings and they felt they should share their experiences more often," Esposito explains. ■

Attendees chosen for trauma reunion

To generate attendance at the first annual Fall Festival of Life: Honoring Our Trauma Patients, the leadership of the Level I trauma center at Loyola University Medical Center, Maywood, IL, made sure that patients and staff could put the event on their calendars by giving them advance notice.

"We sent invitations to all trauma patients who had had Injury Severity Scores of 17 or above in the previous two years, as well as several other families who had been with us for a long time,"

says **Jan Gillespie**, RN, trauma program manager.

Invitations also were sent out to members of a local group called Cease Fire, with whom the center has worked closely. "After a violent situation in the neighborhood, with the patient's permission they will go into the neighborhood and try to stop retaliation," Gillespie explains.

All residents rotate through trauma, and so residents, attending physicians, nurses, and social workers were asked to attend, she says.

About 50 people — former patients and staff — attended, says Gillespie, "But we have gotten many calls after event from people who missed it and asked us to be sure to include them next year, and we received many 'thank yous' from those who came and want to come back."

Tom Esposito, MD, MPH, chief of the Division of Trauma, Surgical Critical Care, and Burns, says, "We'd like to have seen more, but this is our first effort. We've also talked about adding something more enduring like a tree planting or a trauma garden." ■

Patient Flow
SOLUTIONS

ED leaders reverse poor flow trends

Satisfaction ranking: From 'worst to first'

How's this for a turnaround? A few years ago, patient satisfaction levels in the three EDs of the Cambridge (MA) Health Alliance were in the lowest decile in Massachusetts, and now they are consistently in the top quartile. In fact, adds **Assad Sayah**, MD, FACEP, chief of emergency medicine for the system, "In the last couple of months, we've been in the first or second percentile in the state."

This turnaround in patient satisfaction is the result of broad-based undertaking to improve patient flow and the patient experience in the EDs, which has achieved several other impressive results. For example:

- Door-to-doc time has been reduced from 90 minutes to 12 minutes.
- The rate of patients who have left without being seen (LWBS) has fallen from 4.8% to less than .5%.
- The average length of stay has decreased by 13% to 2.5 hours.
- The EDs, which used to be on diversion 8% of the time, have not gone on diversion in four years. During those four years, the total volume for the three EDs has risen from about 80,000 patients a year to 100,000 patients a year.

Shortly after he arrived, Sayah recalls, the ED leadership was put in charge of a multi-disciplined group whose task was to improve flow in and out of the ED. "When I got here, things had been done the same way for a very long time," says Sayah.

Sayah says he had a lot of support from the administration. The group he headed represented not the ED, administration, radiology, the lab, and admissions. It included nurses and physicians, including hospitalists. Recommendations for improvement came from many different areas. "One person cannot affect change. You have to own flow as an institutional problem, not just the ED's problem," he says. *(Leadership was critical to the culture change required to accomplish this improvement.* *See the story on p. 18.)*

Still, it was the ED that had to lead the way, says **Luis Lobon**, MD, MS, FACEP, the site chief of emergency medicine at the Cambridge Hospital campus, who came on board shortly after Sayah did. "What was very clear from the beginning was that we needed to clean our own house," he says. "We were not expecting miracles from the other departments."

So, the ED "pioneered" the change by eliminating diversions two years before such a practice was mandated statewide. Lobon says, "By doing things of that nature, it sent a clear message that we were dedicated to changing the experience of the patient."

Still, says Sayah, the "biggest piece" of the process centered around the other departments. "You can do all you want to upfront, but if you can't decompress the ED from boarded and admitted patients, you are fighting a losing battle," he says. "Three of the five teams addressed these issues: doctor-to-doctor handoffs, nurse-to-nurse hand-

EXECUTIVE SUMMARY

A concerted effort by the Cambridge (MA) Health Alliance has slashed door-to-doc time in its three EDs from 90 minutes to 12 minutes, cut the rate of patients who left without being seen from 4.8% to less than .5%, and decreased the average length of stay 13% to 2.5 hours.

- "Patient partners" greet all patients and speak to them in their own language.
- The system pioneered the "no-diversion" approach in Massachusetts.
- Staff and space were merged to improve efficiency and increase flow.

offs, and early patient discharges."

Adding a "partner"

In terms of new process changes "up front," one of the most notable was the creation of the position of "patient partner." This is a non-clinical individual who Sayah likens to the host/hostess who first greets you when you enter a restaurant.

"They are helpful PR people who can answer your questions in more than one language," notes Sayah. On two of the campuses, that position is staffed 12 hours a day, and on the third that position is staffed 18 hours a day, he says.

"When the patient comes to the door, the first person that meets them is the patient partner," says Sayah. "He speaks to them in their language. If they cannot, we have a translation phone that answers immediately." *(For more on telephone translation services, see "Translation technology fills important niche,"* ED Management, *June 2007, p. 65.)*

The patient partner asks the patient three questions — name, date of birth (or social security number), and chief complaint. "They do a 'mini-reg' which take 30 seconds, after which that information is accessible by computer to all of us, so we can order tests and produce a chart," Sayah explains. "The patient partner creates the initial chart, puts the bracelet on the patient, and brings them to the ED immediately so there is no sitting involved."

There is no waiting room. In fact, Sayah adds, the reception areas ultimately might be converted to clinical use. Lobon says, "The most important principal involved here is that the patient comes to the ED to see a physician. They do not come to watch TV, or see a triage nurse, or talk to registration about insurance. They want a physician, and that's what we give them."

Most of the patients (those requiring sub-acute care) are taken to the rapid assessment area. "Historically this area was occupied by express care, [ED] administration, and triage," says Sayah. "We merged the space together and the staff together."

For example, notes Sayah, the department previously had one triage nurse and two express care nurses. Now it has three rapid assessment nurses. "There is no bottleneck," he says. "Two EDs have five rapid assessment rooms, and one campus has nine, all of which have nurses and PAs; the doctors have been moved to the acute side."

Sayah says that 40% of patients never move out of the rapid assessment area. Registration personnel will perform a bedside registration using a wireless mobile registration station. "The patient is discharged right from the same room," says Sayah. ■

SOURCES

For more information on improving patient flow, contact:

- **Luis Lobon**, MD, MS, FACEP, Site Chief of Emergency Medicine, Cambridge (MA) Hospital. Phone: (617) 665-1712.
- **Assad Sayah**, MD, FACEP, Chief of Emergency Medicine, Cambridge Health Alliance. Phone: (617) 665-2356.

Management Tip

Secret to making a culture change

The dramatic improvements achieved in patient flow at Cambridge (MA) Health Alliance could not have been possible without culture change, says **Assad Sayah**, MD, FACEP, chief of emergency medicine for the system.

"Culture change starts from the leadership setting the expectations for everyone else and being available and willing to support the ED," Sayah says. "It's easy to dictate to people what to do, but you really have to lead by example and work harder than anyone else, and be available 24/7 and help the staff whenever they need it."

Such change also requires teamwork, Sayah says. "We work hand in hand with nursing leadership and the ED administrator; we look at leadership of the department as a tripod," he notes. "All three of us work hand in hand to be on the same page, making it possible for everyone across disciplines to sing the same song before implementation of new processes begins." ■

Expectations for tPA is pathway to litigation

"It's too bad someone didn't give you thrombolytics, because you probably wouldn't be paralyzed now." Whether it's a nurse, doctor, or someone else making that statement to a stroke patient cared for in your ED, you could end up named in a lawsuit.

"There seems to be more and more litigation surrounding not giving thrombolytics," says **Matthew Rice**, MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. "People's expectation is that this is a magic drug. So, one of the risks for EDs is not giving it when people believe it should have been given."

Victoria L. Vance, JD, a health care attorney with Tucker, Ellis & West in Cleveland, OH, agrees that there is a public perception that tissue plasminogen activator (tPA) is a "magic bullet." Vance is former senior counsel and director of litigation for The Cleveland Clinic Foundation. "The law lags science. Presently, the allure of the 'clot-busting' drug remains high," says Vance. "There are many reported settlements and verdicts arising out of the failure to give tPA to a stroke patient in the ED."

Silverman, Thompson, Slutkin & White in Baltimore has successfully handled several cases involving stroke patients who presented to the ED. Most of the lawsuits involved failing to administer tPA. "It is well known that time is the enemy after any stroke," says **Jamison G. White**, an attorney at the firm. "In our experience, one of the most powerful pieces of evidence in a case against an ED physician where the issue is failure to timely diagnose and treat a stroke patient is the failure of the ED physician to order a stat blood draw and/or stat CT scan of the brain in a patient who presented within the 'golden window' of treatment with the recent onset of stroke symptoms."

This situation is particularly damaging when subsequent CT scans demonstrate that the patient suffered a non-hemorrhagic stroke. "In short, failing to treat a stroke patient with tPA within the golden window when no contraindications existed, runs contrary to the prevailing standard of care today," says White.

He says other strong evidence against EDs would be the failure of the ED staff to timely triage and/or have a patient who presented with the acute onset of stroke symptoms be seen by a physician, within the golden window for treatment. "Common errors that we see in this setting appear to be a failure of ED personnel to appreciate the true nature of a patient's complaints, a mix-up with one patient temporarily confused with another which delays treatment, and overall over-crowding in the ED," notes White.

The ED records might reveal the lag time between when a patient is triaged and when the appropriate stroke treatment is initiated has pushed a patient from inside to outside the treatment window. "We have the ability to subpoena the ED's records to see how many patients were triaged and/or treated during the time period that the plaintiff was in the ED, to see if the ED was essentially overwhelmed and this particular patient fell through the cracks, so to speak," says White. "What we allege in these lawsuits is a simple failure to timely diagnose and/or treat the patient."

Even with overcrowding, the ED must operate a successful triage function to identify patients with conditions that are "time dependent" with regard to therapy, says John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA. "Fortunately, there are not many truly time-dependent therapies. Acute myocardial infarction would of course be the classic example," says Burton. "Treatment of ischemic stroke with tPA has effectively evolved, and been represented, as another."

Don't misuse tPA

The current legal atmosphere is clearly that you are more likely to be sued for failing to give tPA than giving the drug, says **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta.

A typical lawsuit involving damage after giving tPA might involve allegations that the patient's blood pressure was uncontrolled, the risks weren't explained, and there is a bad outcome. Although a blood pressure documented in the patient's chart is difficult to dispute, medical decision making can be more of a grey area. "These cases always come up after several years and your memory is poor. You don't remember exactly what your thinking is," says Gross. "So if you don't give tPA, you need to describe very clearly why it's contraindicated."

In this legal climate, an ED physician might be tempted to err on the side of giving tPA, especially when family members or the patient are demanding it. "But there are risks with tPA treatment, to be sure," says Vance. "These can also have adverse legal, as well as medical, consequences." (*See five tips to avoid a lawsuit, below.)*

Want to avoid a suit? Follow these 5 tips

Victoria L. Vance, JD, a health care attorney with Tucker, Ellis & West in Cleveland, OH, recommends the following to reduce risks with tis-

sue plasminogen activator (tPA):

• Follow your ED's stroke and/or tPA protocol.

"Educate your staff on the protocol," says Vance. "Remember, protocols are not inflexible. These must be written as a guide to clinical judgment. Protocols should not be mandatory or so prescriptive as to foreclose case-by-case decision making."

• Remember that even if tPA is given, lawsuits still can arise from the perceived failure to administer the drug quickly enough.

The window of opportunity to administer tPA recently has been expanded from 3 hours to 4.5 hours.

"In a tPA-related claim, the legal retrospective will focus on time," says Vance. "It is advisable to document the timeline of your workup."

Vance says to note the time when the neurologist consult was called, when labs were drawn and results returned, when the patient was sent for and received CT imaging, as well as all nursing interventions and all physician orders and actions.

While some institutions wait for all laboratory results to come back before giving tPA, this waiting is not the practice of **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta. "Unless I suspect an abnormality, I don't wait for the lab results. We just move on to tPA," Gross says. "The big emergency medicine policymakers generally suggest leaving it up to the individual institutions. However they make their protocols, that will be the standard they'll be held to."

• Retain your ED's census records, trauma logs, and duty rosters.

Vance says, "If a patient-plaintiff ever asks about staffing and acuity levels while questioning the speed of treatment of a particular patient, you will be prepared to respond."

• Obtain and document an accurate history as to the time of onset of symptoms, to determine if the therapeutic window is still available.

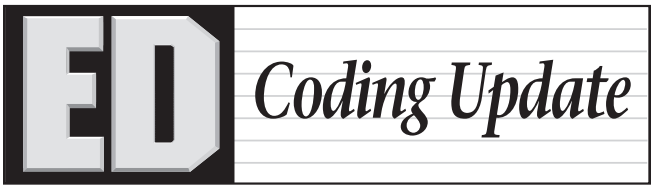
A patient might tell you upon arrival at 3 p.m. that her symptoms began at noon, which is carefully documented in the chart. Minutes later, an ED staff member finds out from a family member that the patient's symptoms in fact began hours earlier, so tPA cannot be given. If the time of onset is not corrected in the chart, says Gross, you might later have a hard time defending your decision not to offer the drug.

"Seek out family members, knowledgeable witnesses, or a foreign language translator, as necessary, to get the most accurate and complete history and timeline of pertinent events," says Vance. These might include onset and progression of symptoms, recent head injuries, bleeding problems, bleeding ulcers, trauma, hypertension, and pregnancy.

• Carefully document the patient's clinical course in the emergency department.

"If patients are improving, they often do not qualify for tPA," adds Vance.

However, this situation is not always the case. "Some folks will make the argument 'the symptoms are improving,' so tPA was not given, but that is kind of a vague point," says Gross. "If you have a patient who is rapidly improving, but still seems to park at a fairly high number, most of those folks we will continue to treat. If the patient still has a pretty bad deficit, I would proceed on giving it, and document exactly that." ■



You can optimize revenues, compliance

[This quarterly column on coding in the ED is written by ***Caral Edelberg****, CPC, CPMA, CAC, CCS-P, CHC, president of Edelberg Compliance Associates, Baton Rouge, LA. If there are coding issues you would like to see addressed in this column, contact Edelberg at phone: (225) 454-0154. E-fax: (225) 612-6904. E-mail: caral@cedelbergcompliance.com.]*

Much has been written about the best practices for increasing ED revenue in such a compliance-driven, audit-rich environment. However, there are still many opportunities to maximize revenue and compliance, particularly as ED volumes and acuity continue to increase. Maximizing revenue requires focus on documentation, codes, charges, and revenue cycle management. Perfecting one without attention to the others prevents achieving revenue goals.

Consider the following for your compliance/revenue improvement program in 2011:

• Use medical decision making (MDM) as an indicator of documentation improvement.

Identify how many records are down-coded to levels lower than the level of MDM. As MDM is a true indicator of ED professional acuity, any evaluation and management (E/M) coded lower

than the MDM level is an indication that your ED providers need inservice on the required elements of history and physical examination.

• Initiate documentation reporting for your providers.

Although you might be closely monitoring your physicians and mid-level providers for documentation omissions, few facilities track nursing documentation problems. Omissions of nursing documentation of repeat assessments, orders, and times procedures (critical care, observation, infusions, and injections) can cost hospitals hundreds of thousands of dollars in lost revenue. Design a tracking and report system for nurses to elicit their support in documentation improvement.

• Compare your ED professional acuity distribution to your facility acuity distribution.

If the facility distribution doesn't meet or exceed the professional distribution, you might need to step back and re-evaluate the criteria you are using to assign facility levels. Facility E/M levels include resources of ED staff used to support the ED physician as well as consultants who come to the ED. The consultant support might be significant but not recognized by your facility assessment criteria.

• Ensure correct billing of ED procedures.

Can you be sure all procedures performed in the ED are listed on your facility chargemaster? Frequently missed procedures include complex laceration repairs, orthopedic procedures, foreign body removals, burn management, and incision and drainage. How can you ensure you are capturing them? Compare billing of these services between the ED providers and the hospital. If ED physicians are billing more procedures than the hospital, something is amiss, and it might be costing you significant revenue. The facility should be billing the same number of surgical procedures billed by the ED MDs, in addition to infusions, injections, and other services performed by consultants.

• Review your ED fees.

Do your charges meet or exceed the Medicare payment amounts? Have you checked to be sure your charges meet or exceed other contracted payer fee schedules? Your charges should, at the very least, meet contracted fee amounts.

• Are you using mid-level providers in your ED?

The rules for documentation and supervision differ between Medicare, Medicaid, and private payers and might differ for certain types of services. It's a good idea to revisit these rules to be sure your documentation supports the services of the supervising physician and to ensure your billing is being performed correctly. Medicare requires personal involvement of the "supervising" physician to support billing by the physician. If no personal involvement is documented, Medicare pays only 85% of the Medicare Fee Schedule. From a compliance perspective, you need to ensure coding accurately reflects who performed what! (*Improved documentation can sometimes create new challenges. See Edelberg's column, below.)* ■

Differentiate your coding levels

More tips for revenue enhancement

By **Caral Edelberg,** CPC, CCS-P, CHC
President
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Baton Rouge, LA

As a specialty, emergency physicians have vastly improved documentation. As a result, the intention of the Centers for Medicare and Medicaid Services to differentiate 99284 "moderate" medical decision making (MDM) from 99283 "moderate decision making" by the level of history and physical examination no longer works!

The vast majority of ED records score out at the 99284 moderate decision making level, and with history and physical examination at detailed (99284) or comprehensive (99285) levels, you might be coding too many 99284s. Remember that medical necessity still counts. Consider differentiating your 99283 MDM from 99284 MDM with the combination of the presenting problem(s) and the interventions documented during the ED course. This should help to determine which level of moderate MDM you provided.

Here are some other recommended revenue enhancement techniques:

• Closely monitor revenue when transitioning from your dictated/template medical record to an electronic format.

Services performed with inaccurate or incomplete documentation cannot be billed. These services include procedures without orders and orders performed by nurses but not documented. The combination of the two account for significant losses but can be easily corrected with a tracking and documentation improvement program.

• Are your bills going out quickly and with correct information? Are the units of each service billed correctly?

Make sure coding audits are performed with a review of codes and additional areas of the claim form that often result in denials. If you can't list the top five reasons for denials in your practice or hospital ED billing, you can guarantee your revenue is compromised.

• When was the last time you saw a report that scored each of the areas we have discussed here?

Do you routinely receive a report for your practice or ED department that lists documentation deficiencies, frequent coding problems, chargemaster problems and resolutions, and frequent denials by percent of total claims? If you have to request special programming each time one of these problems are identified, chances are you aren't able to analyze and address issues fast enough. Consider designing a summary that tracks key issues on a monthly basis. ■

Staff pray with patients? Don't fear lawsuits

Practitioners should tread carefully

If highly religious nurses or physicians feel that it is appropriate to pray with patients and to share their faith, some patients will appreciate this, while others might not. However, it's unlikely this practice will lead to a lawsuit.

Lawrence B. Stack, MD, associate professor of emergency medicine at Vanderbilt University in Nashville, TN, and other legal sources say they know of no lawsuits involving praying in the ED. "There has been one case of a nurse suspended because a patient complained that she offered to pray for him, but there has been no legal action that I can tell," Stack says.

The one caveat that he offers is that "spiritual health care" in the ED should be treated like any other health care information and is subject to patient privacy regulations.

Stack says that several hospital chaplains informed him that their organizations had no specific policy regarding praying with patients. "It has not been an issue, at least in our hospital," he says. "Prayer in the ED is not necessarily discouraged or encouraged."

Stack has prayed with patients several times in the ED, usually at their request. "If you ask the patient, there is always risk of offending somebody, but it is highly unlikely for a lawsuit to occur when offering help for the spiritual component of their lives," he says.

Jonathan D. Lawrence, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, says it would be difficult to prove damaged if an ED staff member prayed for a patient.

"It would be more of a nuisance suit," says Lawrence. "A patient could conceivably sue the physician or the facility for infliction of emotional distress, but I am not aware of any suit where that's actually happened."

Lawrence says that while there's nothing wrong with praying with a patient, the physician should not initiate it. A clinician's attempts to proselytize are an "unprofessional and ethically abhorrent abuse of power," he says. "The reason it's an abuse of power is because of the unequal relationship. The patient is a dependent of the physician in their relationship. The same would be true if you tell a patient to vote Democrat. It is probably not illegal, but it is unethical."

Lawrence says that ED nurses and physicians should tread carefully in this regard. "This is why hospitals have pastoral care divisions," says Lawrence. "Hospitals are in the business of providing medical treatment, but recognize that for a lot of people, that includes a spiritual component." It is always helpful if the physician is the same religious background as the patient, adds Lawrence.

ED physicians should be sensitive to the patient's desire, or lack thereof, to have prayer brought into their care, says Lawrence. Also, a passive role, not an active one, should be taken by the physician, saying "Amen," but not leading the prayer, for example, he says. "I've been asked by patients and families if I would mind praying with them. I respectfully stand there, but I don't participate in an active way," says Lawrence.

Employees may offend

Chris DeMeo, JD, a health care attorney with Munsch Hardt Kopf & Harr in Houston, TX, says that it is more likely that if a patient or family

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member is offended by a care provider's religious expression, he or she will complain to the hospital rather than file suit.

"This puts the hospital in the position of balancing between patient satisfaction and its employee's religious freedom," says DeMeo. "Misapplying that balance can and does lead to litigation."

DeMeo says that the legal risks of praying with patients, with respect to professional liability or malpractice, should be "relatively minimal." This minimal risk is assuming the religious expression does not interfere with the quality of patient care.

A physician or nurse praying with a patient or family, or otherwise expressing their faith, will not cause physical injury to the patient. "Most states do not recognize a cause of action for mental anguish absent a physical injury, unless the conduct causing the mental anguish is extreme and outrageous," says DeMeo. "Someone in the ED praying with a patient or sharing their faith wouldn't reach this level."

Conceivably, a patient could have a case if an ED staff person did something egregious, like telling a patient or family member that a terrible injury or death is a punishment from God. "Short of that, there is not much exposure to lawsuits from

(continued on p. 24)

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

25. According to Mike Presley, MD, FACEP, of Frankfort Regional Medical Center, the demonstration of the "NELSON" robot program showed staff the following:
A. How the robot moves
B. How the robot can see the patient's room
C. How the robot can talk clearly with staff, the patient, and the family
D. All of the above

26. According to Jan Gillespie, RN, of Loyola University Medical Center, the staff decided to invite former patients to a celebratory event based on their Injury Severity Scores (ISS) at the time of admission. Their cutoff point was an ISS of:
A. 6 or higher
B. 12 or higher
C. 17 or higher

27. According to Assad Sayah, MD, FACEP, of the Cambridge Health Alliance, a revamping of the intake process enables the system's three EDs to handle a large number of patients in the rapid assessment area. How many of the patient population never have to leave this area before discharge?
A. 40%
B. 35%
C. 30%

28. According to Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, omissions of nursing documentation for certain activities can cost hospitals hundreds of thousands in lost revenue. These activities can include:
A. Nursing repeat assessments
B. Management of patient related orders
C. The timing of medical procedures
D. All of the above

29. Maureen Carr, MBA, of The Joint Commission, says that although the National Patient Safety Goal that governs medication reconciliation has been formally revised, the old standard will remain in effect until:
A. March 2011
B. July 2011
C. October 2011

30. According to Dina Cicillini, RN, Director, PCS, of the Steven and Alexandra Cohen Children's Medical Center of New York, the same critical elements should be covered in handoffs:
A. Between any providers
B. Between any nurse in the ED and a nurse in another department
C. Between any two nurses in the ED

(continued from p. 23)

patients and families in this regard," says DeMeo.

DeMeo says that a bigger liability concern for EDs is in dealing with employees whose religious expressions might offend patients, families, or coworkers.

As an employer, the ED could have exposure under Title VII of the Civil Rights Act for taking adverse employment action against an employee for exercising his or her freedom of religious expression. An adverse employment action generally means termination, demotion, a material loss of benefits, or significantly diminished material responsibilities, says DeMeo.

An employer is required to make a reasonable accommodation for the religious expression that does not cause undue hardship. "That being said, an employer is not required to allow an employee to impose his or her religious beliefs on others," says DeMeo.

Therefore, if patients, families, or coworkers are offended by an ED provider's religious expression, or such expression is otherwise disruptive, the ED might be justified in disciplining the employee and curtailing the offensive or disruptive behavior. "Each case will depend on its specific facts," says DeMeo. ■

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CNE/CME ANSWERS

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

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Finally! The Joint Commission revises NPSG for medication reconciliation

Difficulty of taking accurate history in ED acknowledged

At long last, The Joint Commission has completed the revision process for the National Patient Safety Goal (NPSG) that governs medication reconciliation. The new goal, which was finalized on Dec. 3, 2010, can be found at http://www.jointcommission.org/npsg_reconciling_medication.

"In January 2009, The Joint Commission took action to reduce the burden of the NPSG on medication reconciliation for organizations and determined that survey findings would not be factored into the organization's accreditation decision until a revised NPSG was developed," said the commission in a released statement. "The revised NPSG underwent a field review in the second quarter of 2010; the review reaffirmed that medication reconciliation is an important patient safety issue that should continue as a NPSG." The statement also noted that NPSG.03.06.01 replaces Goal 8 (08.01.01, 08.02.01, 08.03.01 and 08.04.01) and its related elements of performance (EPs).

James J. Augustine, MD, FACEP, chair of the Joint Commission Hospital Professional and Technical Advisory Committee, which reviewed the proposed revisions, says, "The idea of medication reconciliation is a very sound one and important across all healthcare entities, but in the outpatient setting, where most EDs function, it is sometimes extraordinarily difficult to figure out what medications people are on and reconcile them with the medications given in the ED and added as they are treated and released." Augustine also is director of clinical operations, Emergency Medicine Physicians, Canton, OH.

It was this difficulty that was among the major issues addressed in the revised goal, notes

Maureen Carr, MBA, project director, Department of Standards and Survey Methods at the Joint Commission, notes that the old NPSG will remain in effect until July 2011, but it will not count against accreditation. "We addressed the issue to the extent that we could, recognizing that the problem is going to still be there as people are people," says Carr. She is referring to the complaints The Joint Commission received from emergency medicine representatives who noted that many ED patients cannot provide their list of medications at all or cannot provide complete and accurate lists.

"What we have instructed, and noted in a note to EP 1 in the goal is that we recognize it is often difficult to make sure you have accurate and complete information," says Carr. The note says the following: "It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered

EXECUTIVE SUMMARY

The revised National Patient Safety Goal (NPSG) for medication reconciliation has several elements of performance that have important implications for ED managers.

- A good faith effort must be made to obtain complete information about the medications the patient is taking.
- ED staff should make it a point to explain the importance of managing medication information to the patient when he or she is discharged.
- The old NPSG will remain in effect until July 2011, but it will not count against accreditation.

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as meeting the intent of the EP."

In other words, Carr clarifies, "in terms of compliance, a good faith effort will be considered as complying." And what might be construed as a "good faith" effort? "It might involve trying to see if the patient was carrying a list or had a family member with them who could provide one," she says.

Augustine adds, "In terms of the ED, what The Joint Commission has asked in improving quality and safety is for the staff to make their best efforts at determining what comprehensive list of medicines exist and reconciling the medications the patient is going to go home on. That will be compliant with the standard."

In some cases, the patient will have a drug store or a primary care provider who would have an accurate list of the medications the patient is using on an ongoing basis, he says. In those cases, "the staff should utilize those resources even if it means an extra phone call for the ED," Augustine says. However, he adds, "the reality of the situation is that some people arrive in the ED under totally unplanned circumstances, and all they know is that they are on a blue pill, a red pill, and a green pill, and they've gotten them from different doctors and don't know where they get them filled." In those instances, he says, "the staff will not have the ability to develop an accurate list."

Providing consultation

A new EP (number 5) that is included in the revised goal also has significant implications for EDs. It reads as follows: "Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter." A note adds the following: "Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations."

Carr notes, "Counseling the patient about how important it is to keep accurate information at all times is important. It helps ensure that if they enter the system again they will be prepared to provide accurate information. While it will still continue to be an issue, hopefully over time it will improve."

While this could take place in the context of discharge instructions, Carr notes that The Joint Commission is not just talking about formal education about the drugs. "This is not so much about taking them, but about emphasizing how important it is to keep this information up to date," she explains.

Augustine says, "Many of our new ED electronic records give staff the opportunity to send patients home with a list of medications when they are discharged, as well as those they are known to be on regularly. With both the input of the staff and some medication information software programs, you are able to make sure there are no immediate medication safety issues that need to be addressed and are then able to give patients something that is able be used for future care and future interaction of that patient with the healthcare system."

It's also key for the staff to verbally remind the patient that this information is important and should be carried with them, he says. For those ED leaders who also oversee interactions with the EMS, Augustine says, be aware that practices such as the "vial of life" are being used in the field. "That's a program where they ask patients to take a small plastic container and put important healthcare documents in their freezer or refrigerator at home copies of your medications, durable power of attorney, living will, or DNR," he says. "EMS providers are then asked to look in the refrigerator/freezer for those documents." The refrigerator/freezer is designated because it's convenient and frequently used. *(Under the revised goal, EDs can define the types of medication information to be collected. See the story below.)* ■

SOURCES

For more information on the medication reconciliation National Patient Safety Goal, contact:

- **James Augustine**, MD, FACEP, Director of Clinical Operations, Emergency Medicine Physicians, Canton, OH. Phone: (330) 493-4443. E-mail: JAugustine@emp.com.
- **Maureen Carr**, MBA, Project Director, Department of Standards and Survey Methods, The Joint Commission, Oakbrook Terrace, IL. Phone: (630) 792-5000.

ED can define meds information

Another section of the revised National Patient Safety Goal (NPSG) on medication reconciliation that is of special significance to ED managers is EP 2, which says the following: "Define the types of medication information to be collected in non–24-hour settings and different patient circumstances."

A note following the EP includes the ED as an

example of a non–24-hour setting. "Right now in the medication reconciliation goal, part 804.01 talks about areas in which medications are minimally used to prescribe for short duration," notes Maureen Carr, MBA, project director, Department of Standards and Survey Methods at the Joint Commission.

James J. Augustine, MD, FACEP, chair of the Joint Commission Hospital Professional and Technical Advisory Committee, which reviewed the proposed revisions, adds, "It's reasonable for the ED to have a process for evaluating the effect of those short-term medications in regard to side effects on long-term medications the patient is taking. This generally involves blood thinners."

Finally, he says, ED leaders must make sure the paperwork or electronic documentation the staff uses allows them to most easily reconcile existing lists. In addition, they should "update staff on the processes being used to collect information, educate the patient or family, and send patients to the next type of care with the best information available," Augustine says. All of this information should be covered in an inservice, he says.

"This also contributes to 'meaningful use' of systems," he says. "And the reality is that many of the new EHR programs allow you to do a very convenient medication reconciliation." ■

Defective handoffs reduced by 52%

Participants focus on their EDs

Using solutions targeted to the specific causes of an inadequate hand-off, organizations participating in an initiative headed by The Joint Commission Center for Transforming Healthcare that fully implemented the solutions achieved an average 52% reduction in defective handoffs. Of the 10 organizations that participated, seven have addressed the transition from the ED to patient floors.

The initiative involved the use of "Robust Process Improvement," a process improvement approach that uses the tools of Lean, Six Sigma, and change management, according to **Klaus Nether,** MT (ASCP) SV, a Black Belt with the center. "It's a systematic approach to problem solving," Nether explains.

One of the participating facilities, the Steven and Alexandra Cohen Children's Medical Center of New York, in Glen Oaks, originally began with a "pass the baton" tool, but modified into a more sophisticated handoff tool. **Dina Cicillini**, RN, director of Patient Care Services of Pediatric Emergency Services. "We basically constructed a tool for handoffs that covered all the important points of care provided to the ED patients and translated it in a comprehensive way to the inpatient providers who were now going to take care of the patients. We also mimic the tool when we give handoffs internally, because the same critical elements should be covered in any transfer." The tool includes such information as patient's name, gender, date of birth, diagnosis, procedure, initial assessment upon presentation, interventions and lab results, and status.

Cicillini says the major barrier that was addressed by the form was being able to make a meaningful connection with the provider receiving the patient while both sides of the handoff are multi-tasking and have a small amount of time to focus on the handoff.

The staff was not happy with the original handoff form and re-designed it, she says. Now, Cicillini says, they gather all the necessary information, sit in as quite an area as they can find, and complete the report in standard format so that the receiver knows exactly what they should be receiving and can easily identify what's missing because the sender and receiver have the same number of elements to look for.

"At the end of the handoff I'm looking at the same tool. It's standardized communication with a built-in double-check," Cicillini explains. *(In developing such a form, it's essential to have the frontline staff involved, says Cicillini.* *See the story on p. 4.)*

More information to come

Nether says more information soon will be made available. He notes, for example, that five of the 10 participating hospitals still are implementing solutions and will report their progress

EXECUTIVE SUMMARY

A group of hospitals participating in a program sponsored by The Joint Commission Center for Transforming Healthcare has succeeded in achieving an average 52% reduction in defective handoffs. Here are some of the discoveries made during the project that impact EDs:

- The same critical elements should be covered in any transfer, whether it's from the ED to another department or between two providers within the ED.
- Forms should be standardized so that the giver and receiver of information are expecting to see the same types of information.
- Information being transferred might include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes in any of these.

SOURCES

For more information on improving handoffs, contact:

- **Carol Mooney**, RN, MSN, Senior Associate Director, Standards and Interpretation Group, The Joint Commission, Oakbrook Terrace, IL. Phone: (630) 792-5900.
- **Klaus Nether**, MT (ASCP) SV, Black Belt, The Joint Commission Center for Transforming Healthcare, Oakbrook Terrace. Phone: (630) 792-5297.

in the coming weeks.

"They will then implement their control plans to monitor improvement, as well as sustaining it over time, which is a unique part of this program," Nether says. "We will then start piloting the process as well as the targeted solutions in demographically diverse hospital and healthcare systems."

One reason for the pilot programs, he explains, is that the criteria for choosing the participants included a requirement that they already had experience with these tools. "As we go to pilot, we want to make sure that any organization, regardless of size or experience, will be able to follow this step-by-step process," Nether explains.

All the tools and the measurement system will be shared with the pilot participants, so that they will be able to measure their current baseline performance and identify and validate their specific root causes. "There isn't a single root cause," notes Nether," and they differ from organization to organization."

In the second half of 2011, he says, this information will be available on the Web (www.centerfortransforminghealthcare.org.) free of charge. "You'll be to go in and follow the process step-by-step, the way the participating hospitals did," he says. *(An outline of the proper handoff process is also found in a Joint Commission standard. See the story below.)*

Standard outlines handoff process

The proper process for handoffs is outlined in The Joint Commission standard PC.02.0201. EP2, notes **Carol Mooney**, RN, MSN, senior associate director at the Standards and Interpretation Group, who adds that they formerly were covered under a National Patient Safety Goal.

"Typically when we move a goal into the chapter, it is because we have brought attention to it and the education was out there and there was more compliance, but we didn't want to eliminate our focus on it," she explains.

In fact, she notes, compliance levels for the standard are about 99%. So why would The Joint Commission Center for Transforming Healthcare involve numerous hospitals in an initiative to improve their handoffs? **Klaus Nether,** MT (ASCP) SV, a Black Belt with the center, says, "Studies have shown that in a typical hospital there are 4,000 patient handoffs every day. If you are doing a really good job 95% of the time that's about 200 failures a day, and the consequences of these can be serious: anything from inappropriate treatment to delay of treatment to extended lengths of stay and increased healthcare costs."

Mooney says that Element of Performance (EP) 2 under the standard states that the process for the handoff "provides for the opportunity for discussion between the giver and receiver of patient information." She adds that a note in the EP states that such information might include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes in any of these.

Mooney notes that "just the setting itself" in the ED makes compliance a challenge. One way to ensure success, she says, is "to develop a standardized process so that various disciplines, such as nursing, know how to report off to the nurses on the units when the patient gets transferred up to the floor." ■

Management Tip

Involve staff in new tools

When developing a new tool, such as a handoff form, it's critical to have your frontline staff involved in that process, says **Dina Cicillini**, RN, director of Patient Care Services of Pediatric Emergency Services at the Steven and Alexandra Cohen Children's Medical Center of New York.

"They are the ones that will be using the tool, and it has to make sense for their workflow," Cicillini says.

In addition, she says, you should be sure to have an "exclusive" rollout for such a tool. "There are lots of things going on in the ED, so make this a focused rollout so you can sustain and maintain it," Cicillini says. "You have to give it your full attention." ■