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EDs struggle with increased demand from patients with behavioral health concerns

Culture, education, and community links are key to positive outcomes

Already burdened with increased demand for medical services, EDs across the country are also seeing a spike in the number of patients who present with behavioral health issues. There are multiple factors involved, but **Rachel Glick**, MD, clinical professor of psychiatry and director of Psychiatric Emergency Services at the University of Michigan Medical School in Ann Arbor, MI, believes that much of this increase is directly related to the nation's fragile economy. "People are uninsured, people are more stressed, and people are unemployed. They are down and out, and when they have a crisis, the ED is their only option," she says. "It is really analogous to what we are seeing in the medical ED world. Folks

EXECUTIVE SUMMARY

Busy EDs across the country are being challenged by spikes in patients presenting for care with behavioral health problems. Some hospitals have dealt with this issue by building separate units or areas within the ED designed to meet the needs of this patient population; however, experts suggest there is ample room for improvement in the way most EDs care for patients with behavioral health needs.

- Clinicians and staff need to accept responsibility for caring for patients with behavioral health issues, and they need to be appropriately educated and prepared for this task.
- Noting that one in every 10 suicides involves someone who has been seen in the ED within two months of dying, experts stress that suicide prevention training should be a top priority for EDs.
- Create a room or area within the ED that is away from the noise and lights so that it will have a soothing impact on patients who are highly distressed or agitated. Also, consider getting feedback from patients on steps that would make the ED more welcoming to clients with behavioral health issues.
- Look for model programs to learn from and consult with regarding strategies for improving behavioral health care in the ED.

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don't have a lot of resources, so they go to the resource of last resort."

This is straining the capabilities of EDs that have been built, staffed, and equipped to manage medical emergencies. And further compounding the pressure on EDs is the fact that despite the increased demand, financially strapped states are slashing funds for mental health services.

For example, just this past February, Alabama announced plans to shut most of the mental health hospitals in the state and to lay off nearly 1,000 mental health employees by 2013. Other states have initiated similar, if less dramatic, cutbacks. The result of such cutbacks is that patients are being inappropriately unloaded onto hospitals and EDs.

"In the past three years, there has been something like a 17% reduction in mental health services for the safety net," explains **Stuart Buttlaire**, PhD, MBA, regional director of Inpatient Psychiatry and Continuing Care, Kaiser Foundation Health Plan Northern California, Oakland, CA. "In addition to that, we are seeing more and more psychiatric hospital closures across the country. Part of that is because of low reimbursement. The other part is because hospitals are reorganizing, and when they reorganize, they find it more valuable to put in medical-surgical beds than psychiatric beds."

The upshot of all of these forces is that EDs are being left with the challenge of meeting the needs of increasing numbers of patients with behavioral health needs. And this tends to be an uneasy fit for many ED providers. "These are hard patients to deal with. They are complicated. Often, to do a really good job, you need to get corroboration, which isn't always easy in an emergency setting," says Glick. "Also, the patients can be dangerous. From their agitation, they may lash out and hurt you. All of these things make it uncomfortable for a lot of physicians and other health care providers to deal with acute psychiatric issues."

The situation becomes even more difficult when patients require specialized inpatient care because, oftentimes, such beds are in short supply. "Inside the ED, you have to work with your psychiatric colleagues in order to ensure that patients get appropriate care while they are waiting for a bed," explains **Leslie Zun**, MD, chair of the Department of Emergency Medicine, Mount Sinai Hospital, Chicago, IL. "So you have limitations on what you can do in the ED if you don't have a psychiatric unit, an acute stabilization unit, or community resources to send these patients to."

There are no quick or easy solutions for EDs that are struggling with these types of challenges, but experts suggest there are steps that hospitals and department leaders can take to not only ease the strain on their facilities, but also improve the care and overall experience that patients receive when they present to the ED with behavioral health problems.

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Editor: **Dorothy Brooks** (dobr@bellsouth.net).
Executive Editor: **Shelly Morrow Mark**
(352) 351-2587 (shelly.mark@ahcmedia.com).
Managing Editor: **Leslie Hamlin**
(404) 262-5416 (leslie.hamlin@ahcmedia.com).

Editorial Questions
For questions or comments, call **Leslie Hamlin**, (404) 262-5416.

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First, look in-house for improvements

The Institute for Behavioral Healthcare Improvement (IBHI), a membership-based organization focused on identifying and developing quality improvements in the behavioral health space, has been looking at the challenges faced by busy EDs for several years. This has included a number of initiatives, including a multi-hospital learning collaborative aimed at establishing better methods for meeting the needs of patients who present to the ED in psychiatric distress or with underlying behavioral health issues, explains **Peter Brown**, the executive director of IBHI.

One of the key observations from this group is that while establishing links with community resources is critical to both connecting patients with appropriate care as well as maintaining effective patient flow in the ED, it is important for a hospital to look in-house for improvements, at least initially.

"If a hospital goes to the trouble of developing a better internal operation, it gives it significant credibility with the rest of the service package in this area," says Brown. "It does a number of important things: It improves the hospital's own operation, it reduces time-to-treatment, it improves the likelihood that the hospital won't have to hospitalize somebody, and it gives the hospital the opening to go to other organizations and say that the hospital has done its homework and now it is time for the community at large to respond to this."

What are some common problem areas for EDs? One of the biggest issues that IBHI's multi-hospital collaborative picked up on was that patients who present to the ED with behavioral health issues do not commonly have good things to say about their experience. "By and large, they feel like their problems aren't respected," says Buttlaire. "Part of the cultural shift that needs to take place in the ED is that [staff and clinicians] need to see that part of their mission is taking care of and treating behavioral health clients in ways they may not have had to before."

Hire appropriate staff, educate ED staff on management practices

This is not an easy transition for many traditional health care providers, explains **Larry Phillips,** DCSW, program manager, St. Anthony Hospital, Oklahoma City, OK. "One of things we found is that most of the people who go into emergency medicine are not prepared to deal with mental health patients. That is not their desire, it is not their interest, and it is not their focus," he says. "So from the very beginning, starting with the job interview and orientation, we start discussing that 10% to 12% of the population here at our ED are mental health patients, and about 25% to 30% of the patients who go through the ED and are admitted to the hospital are mental health patients." *(Also, see "Create a welcoming, soothing environment for patients with behavioral health needs," p. 41.)*

The objective is to make sure that new employees fully understand what the hospital's expectations are and how they will need to prepare. "What we have to do is make our ED staff — including the techs, the nurses, and registration — aware of the fact that there is a large population of mental health patients who are going to come into our system, and they need to know that before they accept a position here," says Phillips. "They need to understand that and be willing to get training, starting with some special modules in orientation."

Using information gained from the IBHI collaborative, Phillips and colleagues at St. Anthony developed some of their own education modules, but they also got some help from the community. "Working with the Oklahoma City Police Department Crisis Intervention Team, we created a module called EDIT, which stands for emergency de-escalation intervention training," explains Phillips. "It is a two- to three-hour module that is required of everybody who deals with mental health patients, including the mental health triage professionals, and everyone is required to be re-certified [through this module] on an annual basis."

This type of training helps clinicians and other ED personnel learn how to calm patients and develop techniques for speaking with people who are agitated or are experiencing emotional distress, explains Buttlaire, noting that Kaiser provides training on a series of behavioral health issues as well. "We train all of our physicians in how to recognize depression and what to do about it once you have recognized it," he says.

Make suicide prevention for behavioral health patients a top priority

Most standard community EDs have a process for managing patients safely, but these practices do not always match the different needs of a mental health population. This doesn't mean that EDs have to change their entire process, but they do need to develop safe areas and dedicated

staff to manage these patients. In cases involving behavioral health issues, clinicians can often avoid difficulties by simply interacting with people in a slightly different way, says Buttlaire. For example, he explains that many people with mental health disorders have a background of physical or sexual abuse. "The idea of disrobing in front of someone can be a lightning point for these individuals," he says. "ED personnel need to approach people with psychological problems in ways in which their responses will be more positive rather than making things worse."

One high-priority issue for ED personnel should be training in how to recognize patients who are suicidal, and then how to appropriately care for such individuals, stresses Buttlaire. "We know that one in every 10 suicides is someone who has been seen in the ED within two months of dying," he says. "A lot of people who work in the ED are concerned about asking a patient about suicide because they don't know what to do about it if a patient answers yes."

A strategy that can be particularly helpful to hospitals and EDs is to have behavioral health specialists available to consult with clinicians about a suicidal patient or any other behavioral health issue that is of immediate concern, explains Buttlaire. Hospitals that have in-house psychiatrists or other mental health professionals may have an easier time setting up this type of arrangement, but hospitals without in-house expertise can establish links with consultants in the community. Sometimes, all that is required is a phone consult or video conference.

"Having collaborations between EDs and crisis lines can make an enormous difference," adds Buttlaire. *(**Also, see "Study: Cause for concern regarding care of young patients who present to the ED following an episode of deliberate self-harm," p. 42.**)*

One simple intervention that can have great impact with patients at risk for suicide is to reach out to them by phone after their ED visit just to check in on how they are doing, says Buttlaire. "That can make a big difference in whether the patient continues to seek services and continues to stay alive," he says. "This is the type of thing that EDs may not think about."

Start with culture

Change for the better doesn't happen overnight, but opening up the conversation about behavioral health to stakeholders in the community can lead to new resources and improved systems of care for behavioral health patients. "There is a cumulative process that we can point to in places like San Antonio, TX, Akron, OH, Pittsburgh, PA, and Southern California, where hospitals have worked effectively to advance the larger system of care," says Brown. *(**Also, see Management Tip: "To improve behavioral health care, find model-programs to learn from," p. 41.**)*

However, Brown emphasizes that crucial to the success of such endeavors is the culture of the originating organization. "If the culture is closed, authoritarian, and not open to changing the way it does business, the process won't work, so the first stage in the overall process of improving care is to look at the culture of the hospital and the culture of the ED," he says.

Brown advises that one way to assess hospital culture is through the *Hospital Survey on Patient Safety Culture*, a tool available through the Agency for Healthcare Research and Quality (http://www.ahrq.gov/qual/patientsafetyculture/userged.htm). While the tool has a safety focus, it will provide hospitals with a level of evaluation for the culture of the organization, and that is a start, says Brown. "Getting through that initial step is an opening for change at the hospital level, and then you can expand the concept of improving the practice of care throughout the community by having other organizations connected informally to the hospital." ■

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- **Jeffrey Bridge**, PhD, Principal Investigator, the Center for Innovation in Pediatric Practice, Nationwide Children's Hospital, Columbus, OH. E-mail: jeff.bridge@nationwidechildrens.org.
- **Peter Brown,** Executive Director, Institute for Behavioral Healthcare Improvement, Castleton, NY. E-mail: peter@ibhi.net.
- **Stuart Buttlaire**, PhD, MBA, Regional Director, Inpatient Psychiatry and Continuing Care, Kaiser Foundation Health Plan Northern California, Oakland, CA. E-mail: stuart.buttlaire@kp.org.
- **Rachel Glick**, MD, Clinical Professor of Psychiatry and Director of Psychiatric Emergency Services, University of Michigan Medical School, Ann Arbor, MI. E-mail: rglick@med.umich.edu.
- **Larry Phillips,** DCSW, Program Manager, St. Anthony Hospital, Oklahoma City, OK. E-mail: larry_phillips@ssmhc.com.

• **Leslie Zun**, MD, Chair, Department of Emergency Medicine, Mount Sinai Hospital, Chicago, IL. E-mail: zunl@sinai.org.

Management Tip

To improve behavioral health care, find model programs to learn from

For hospitals that are just getting started on a process of improving the way they care for behavioral health patients, it can be very helpful to identify models that they can look to for guidance and assistance, advises **Stuart Buttlaire**, PhD, MBA, Regional Director, Inpatient Psychiatry and Continuing Care, Kaiser Foundation Health Plan Northern California, Oakland, CA. "EDs tend to listen to other EDs," he says, noting that this was a vital element in a learning collaborative that the Institute for Behavioral Healthcare Improvement (IBHI) sponsored so that hospitals could learn from other organizations on ways to better manage the care of patients who present to the ED with behavioral health concerns. The IBHI (www.ibhi.net) can be a source for hospitals or EDs that would like to link up with a model program or join a learning collaborative.

In addition, ED leaders should consider attending an annual conference that focuses exclusively on issues involving the care of behavioral health patients in the ED environment. The *National Update on Behavioral Health Emergencies Conference* will be held in December 2012. For more information about this event, visit the conference website at http://www.behavioralemergencies.com. ■

Create a welcoming, soothing environment for patients with behavioral health needs

In an ideal world, every ED would have a specialized psychiatric emergency services unit available to it so that patients who present with behavioral health issues would have ready access to the kind of care that they need. That, at least, is what **Rachel Glick**, MD, clinical professor of psychiatry and director of Psychiatric Emergency Services at the University of Michigan Medical School in Ann Arbor, MI, sees as the optimal set-up for both patients and providers. And she feels fortunate that this is the kind of care environment that she works in on a daily basis.

"We are adjacent to the main ED. Patients can come directly to us, and many of our patients know we are here, and know if the issue is psychiatric, that they should come directly to us. However, we also get transfers from the medical ED," explains Glick. The arrangement works well because when a patient's medical assessment is completed and there are no active medical issues, then he or she can be quickly transferred over to the separate, but adjacent psychiatric unit where specialized care can commence, and throughput to the main ED is optimized, adds Glick.

In fact, with demand for psychiatric emergency services growing, the unit was recently renovated and expanded with the specialized needs of behavioral health patients in mind. "We designed a nursing station with three rooms that could be used for seclusion, restraint, or even just for patients to quietly rest, but the rooms have lots of windows with built-in shades so if a patient doesn't need to be observed, we can shut the shades so they have that privacy," explains Glick. "Having enough space so that people aren't crowded in together, and having clear lines of observation so that you can keep everyone safe, are [key features] of the space."

Many of the patients the unit receives from the main ED are people who have physical complaints, but also depression, anxiety, substance abuse, insomnia, or some other behavioral health issue that the ED provider believes can more optimally be addressed in the psychiatric unit, but the patients don't always agree, says Glick.

"Sometimes the ED will call and ask one of us to come over and talk to a patient for a few minutes to see if we can talk him into getting some help, so we try to be flexible about that," she says. "There are patients who we simply can't convince to come into our setting, but having staff [nearby] who can help ED physicians who are busy taking care of medically sick patients … can at least open the door for these patients to get help, even if it is not sending them down the hall, but rather getting them a referral for care out in the community."

Demand for emergency behavioral health ser-

vices continues to increase, says Glick. "When we first built the space 10 years ago, we would sometimes have eight or nine patients a day, and now we see 20 or 30 patients a day," she says.

Get feedback from behavioral health patients

Having a separate space and staff for patients with behavioral health issues may not be an option for most EDs. After all, most were not built to manage large volumes of these patients, and they must take care of medical emergencies as a first priority. However, administrators should, nonetheless, think about accommodations for the behavioral health population, observes **Stuart Buttlaire**, PhD, MBA, regional director of Inpatient Psychiatry and Continuing Care at Kaiser Foundation Health Plan Northern California, Oakland, CA. "Emergency departments are not the optimal space for behavioral health clients," he says. "There is lots of noise and lights and people running around, but what you want is some place that helps people become soothed, settled down, and calm."

Buttlaire says some EDs have addressed the issue by designing one room or perhaps a corner that is away from all the action. Also helpful is a quick triage process so that patients with behavioral health needs can be identified and connected with appropriate care quickly, he says.

While most EDs are not in a position to build a brand new unit or even to launch a major redesign, it can be helpful to ask patients who have spent time in the ED with behavioral health issues about the existing environment and what changes might be helpful, advises **Peter Brown**, executive director of the Institute for Behavioral Healthcare Improvement (IBHI). "Have a small group of people who have been ED users for behavioral health purposes give their impressions of what might be done," he says. "Another alternative is to have a member of the ED staff go through the process of becoming a patient. These types of things will give you an idea about how your ED is affecting people when they become consumers there, and it will open up a conversation about what changes or modifications might be helpful."

Buttlaire adds that any ED can improve the environment for behavioral health clients by "thinking through how you can make the ED more welcoming and comfortable for people who are in heightened states psychologically."

While having a distinct area designed with the needs of behavioral health patients in mind can be helpful, Brown cautions that it is not a good idea to have the psychiatric or behavioral health component completely removed from the general health setting. "You need to have the potential for dealing with serious physical issues for the behavioral health population," he says. "You still need to have the capacity to deal with the physical aspects of whatever the issue is." ■

Study: Cause for concern regarding care of young patients who present to the ED following an episode of deliberate self-harm

A common reason for a visit to the ED by a young person is deliberate self-harm, and experts say that the vast majority of these patients meet the criteria for at least one psychiatric disorder. However, a national study of Medicaid data suggests that a high percentage of these patients leave the ED without a mental health assessment, and a similar percentage of patients receive no follow-up outpatient care within a month of the ED visit.[1]

The study, conducted by researchers at Nationwide Children's Hospital in Columbus, OH, suggests that strategies need to be developed to promote ED mental health assessments, and that physician training should be strengthened with regard to pediatric mental health, according to **Jeffrey Bridge**, PhD, the lead author of the study and the principal investigator at the Center for Innovation in Pediatric Practice at Nationwide Children's Hospital. In addition, Bridge says that it is clear from the findings that coordination between ED services and outpatient mental health care is often inadequate.

"The reasons for this troubling pattern are not clear. However, providing specific outpatient appointments rather than contact information, short waiting times between ED discharge and the initial outpatient mental health appointment, and telephone reminders of the outpatient appointment may improve this aspect of care," says Bridge.

Of particular concern is the association between

incidents of self-harm and suicide. Bridge explains that deliberate self-harm is the main risk factor for completed suicide, and the greatest risk for suicide occurs in the period immediately after an episode of self-harm takes place. "Emergency departments can play an active role in suicide prevention by routinely assessing the mental health of youths who present with deliberate self-harm, and helping them get the care they need after they are discharged from the ED," adds Bridge.

In the study, Bridge and colleagues reviewed 2006 Medicaid Analytic Extract files from all 50 states and Washington, DC, pertaining to youth between the ages of 10 and 19 who presented to the ED for care following an episode of deliberate self-harm. They found that most of these patients were discharged to the community rather than referred for inpatient care, but that only 39% of the patients who were discharged to the community received a mental health assessment while in the ED.

Bridge observes that the findings suggest that decisions about whether to conduct a mental health assessment are determined more by staffing patterns or established ED evaluation protocols than by the clinical characteristics of individual patients. ■

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Use routine chart reviews, training, and careful staffing decisions to root out under-triage in the ED

Make sure nurses handling triage have the instincts, skills to think beyond triage tools

Under-triage, or assessing patients as being less ill than they actually are, can lead to treatment delays and adverse outcomes, including serious injury and even death. Despite such dire consequences, however, **Lisa Wolf**, PhD, RN, CEN, FAEN, a clinical assistant professor nursing at the University of Massachusetts in Amherst, MA, believes that under-triage is occurring in ED environments across the country. Why? Wolf believes that part of the problem is that triage decisions are not always based strictly on a patient's condition.

"A lot of clinical decision-making is affected by the people around you — the nurses, the volume, the lengths of time that patients wait in the waiting room, and the presentation of the patient," she says. Further, Wolf suggests that the people charged with making triage decisions are not always equipped with the high-level capabilities needed to be able to differentiate between Emergency Severity Index (ESI) level 2 patients, who are typically seen right away, and ESI level 3 patients, who are deemed stable enough to wait.

An under-triage problem is not always obvious, but routine chart reviews can give ED leaders clues as to whether their triage process is working effectively and whether the right clinicians are handling triage. Then it is up to ED leaders to devise appropriate corrective steps to improve triage accuracy.

Consider implications of triage designation

Wolf has been observing clinical decision-making in EDs across different regions for years, but recently participated in a study to identify what factors most impact transfer times between the ED and the intensive care unit (ICU.)[1] In the

EXECUTIVE SUMMARY

Experts say under-triage is a serious problem in EDs across the country, and the issue has serious implications for patient outcomes. For example, patients who are deemed urgent but stable can deteriorate quickly if they are more ill than the triage nurse initially determined. This can lead to delays in needed care and worse outcomes or even death.

- One small study found that patients who were designated as Emergency Severity Index (ESI) level 3 were often under-triaged.
- Routine chart reviews can help ED nursing leaders determine whether under-triage is a problem, and which nurses may need added training in triage to improve their skills.
- Rather than rotating all emergency nurses through the triage role, ED leaders should carefully evaluate which nurses have the high-level skills needed to make accurate triage decisions.

study, which was conducted at a 142-bed community hospital, data was collected on 75 patients who were transferred from the ED to the ICU. The researchers found that more than half of these patients (58.7%) spent more than four hours in the ED before being transferred, and that the strongest factor impacting transfer times in these cases was the initial ESI triage assignment.

Perhaps not surprisingly, patients designated as ESI 3 were well-represented in the delayed group. In fact, 19 of the 25 patients designated as ESI 3 had delayed transfers, making up more than 40% of all the patients who had delayed transfers. This highlights the difficulty many triage nurses can face, trying to discern whether a patient is potentially unstable, which would match the ESI 2 assignment, or urgent but stable, which is in line with ESI 3. However, Wolf stresses that the difference between these two triage designations has important implications for how these patients will be cared for in the ED.

"The triage designation sets the tone and the trajectory for the entire visit. When a patient is triaged as urgent but stable, the nurse is less likely to go to that patient first if she is busy because the patient is stable. That is what ESI 3 tells you. This patient can wait a half hour," she explains. "However, when somebody gets triaged as potentially unstable or unstable, the nurse will go to see that patient first, so things will be picked up faster with a higher triage."

In Wolf's study, cases of sepsis were the most likely to be under-triaged, but she observes that there are many conditions that require higher-level skills to assign accurately. "There is a whole category of well-appearing ill people out there who get ignored, and their treatment gets delayed. It is really problematic," says Wolf.

Further, in a tricky case, a triage nurse may be reluctant to follow her instincts in an environment that she senses will not be supportive of her decision. "We ignore the fact that clinical decision-making takes place within a social context rather than on a piece of paper," says Wolf. "It is really hard for people to put forward their clinical decisions in the face of resistance."

Given the stakes involved with an incorrect triage assignment, Wolf is concerned about attempts to speed up or simplify the triage process in the interest of faster throughput. "The whole point of triage is to get people the resources they need as quickly as they need them rather than just to put bodies in chairs or in beds," she says. "It is an assessment decision, not a task."

Assign the right nurses to triage, if physician in triage is not an option

More than anything else, getting triage right boils down to making sure that the right people are doing the job, according to **Jeff Solheim**, RN, BRE, CEN, CFRN, a triage expert, consultant, and frequent speaker at emergency care conferences around the world. "There are a lot of ED leaders who look at triage as just another assignment, but it isn't. It is a very unique place that needs to be staffed by the right people," he says. "Not everybody is going to be a good charge nurse or manager, and if they don't have the skills they shouldn't be there. I think triage is the same. It requires a certain subset of skills that I am not convinced every emergency nurse has."

Some facilities use a staffing process that insures that everyone gets rotated through triage, but Solheim believes that ED leaders should put a lot more thought and effort into determining which personnel can do the job well. "Some EDs have clinical ladders, and one of the levels that a nurse can reach is triage," he says. "I think that is a very powerful way of making sure the right people — people who have met the requirements — climb the ladder."

It's an objective process, although it still allows for an educator or ED leadership to have some input on who handles triage and who doesn't, says Solheim. This is important because the best triage nurses can pick up on things that triage tools cannot.

"This is one of the reasons why I like the Emergency Severity Index. It allows the nurse a little bit more subjectivity in decision-making than some of the other triage systems that are out there," says Solheim. "Some of the tools are great. They make people think, but ultimately the tool always has to allow for nurse subjectivity, and that is why you want the right nurse out there."

Solheim adds that some people just have those great decision-making skills where they can think outside the box or outside the tool, and that is what makes a good triage nurse. "Those who don't have that same critical thinking process may stick too close to the tool," he says. "Tools can be good and bad, but if the right person is out there they can use a tool to reinforce their triage, and ultimately know that they are making the right decision."

Make nurse training a priority

In addition to selecting the right people to handle triage, Solheim says ED leaders should

prioritize training so that personnel fully understand the basics of triage as well as the particular process that is being used in the facility. Too often, ED leaders will tell someone that it is their day to triage, and then they will take 10 minutes to show them how to do it, he says. "That does not establish a good triage nurse," adds Solheim.

Further, to reinforce training, Solheim advises nursing leaders to establish procedures for good quality control, where a certain percentage of each nurse's charts are regularly audited to determine whether she or he is triaging to the correct level, or under- or over-triaging. "When thresholds of a certain percentage fall out, then the nurse needs to be retrained or reevaluated to determine whether [this individual] should even be doing triage," he says, noting that a triage nurse should be making accurate assessments about 95% of the time. "If this isn't happening, then it is a good opportunity to help the nurse go back and look at what she is doing."

"Sometimes we get into bad habits, even as triage nurses. Sometimes people forget the initial training. Quality control audits can help to keep the training in mind and keep triage at the right level," says Solheim.

There are different ways to conduct chart audits. Staff nurses can even conduct some of these audits themselves if department leaders want to increase the number of charts reviewed, says Solheim. However, he says an ED leader or an educator should complete some of these audits, or at least review them to bring some objectivity to the process.

Make sure nurse triage assignment is used appropriately

One other issue that ED leaders should consider is how the initial triage decision is being used. Why? Because like Wolf, Solheim has seen instances in which the triage assignment is used inappropriately throughout a patient's stay in the ED. "Whatever is initially assigned should be there, but you can assign a new level if the patient's condition changes," says Solheim. "A lot of times EDs are surprised to hear that."

Further, Solheim emphasizes that once a patient is in a bed, there should be no need to reassign a triage level. "Triage is all about who comes into the treatment area first, but once a patient is in the treatment area, the triage assignment should be put away," he says. "It really shouldn't be used in any further decision-making. Once a patient gets to the back, other tools should be used to determine urgency."

Solheim says that EDs that continue to rely on the triage priority as their assessment in the back are perverting what triage is meant to do. "It is not meant to continue throughout a patient's stay," he says. "Once a patient is in the back, there should be a new system defined for how urgent a patient is viewed." ■

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Jeff Solheim, RN, BRE, CEN, CFRN, Solheim Enterprises, Keizer, OR. E-mail: jeff@solheimenterprises.com.
Lisa Wolf, PhD, RN, CEN, FAEN, Clinical Assistant Professor of Nursing, University of Massachusetts, Amherst, MA. E-mail: noblewolf3@aol.com.

Study: Reconsider the use of CT scans for patients who present with dizziness

A thorough history and exam can yield more information, save costs

When patients present to the ED with dizziness, oftentimes the provider will order a computed tomography (CT) scan to rule out serious medical problems, such as intracranial bleeding or stroke. However, a new study suggests that such scans may not be worth the expense in the vast majority of cases.

According to researchers at Henry Ford Hospital in Detroit, MI, their findings suggest that it may be much more cost-effective for hospitals to implement stricter guidelines for ordering CT scans of the brain and head for patients who present with dizziness. Such a move would not only cut costs, but also limit radiation exposure to patients from

CT scans, say researchers. *(**Also, see "Study: New imaging efficiency measure for ED use of CT for headaches not reliable or accurate," p. 47.**)*

Narrow in on a differential diagnosis

The study, which was presented at the annual Triological Society's Combined Sections Meeting in Miami Beach, FL, on January 26, involved a retrospective review of 1,681 patients who were experiencing dizziness or vertigo when they entered a Detroit ED between January 2008 and January 2011. Nearly half of these patients received a CT scan of the brain and head. However, less than 1% of these scans (0.74%) revealed significant underlying conditions requiring intervention, according to researchers. Furthermore, the total cost for the CT scans over the three-year period was $988,200.

Syed Ahsan, MD, the lead author of the study and a neuro-otologist in the Department of Otolaryngology-Head & Neck Surgery at Henry Ford Hospital, explains that while dizziness can be a signal for intracranial bleeding or stroke, it is much more commonly related to dehydration, anemia, a drop in blood pressure with standing, inflammation or other problems of the inner ear, Meniere's disease, or vestibular neuritis. He says a more thorough evaluation can help providers narrow in on a differential diagnosis.

"Proper evaluation should include information such as the duration of dizziness/vertigo, the triggers of the dizziness (positional, activity), and associated symptoms [such as] migraine, headaches, dysarthria, ataxia, unilateral weakness, hearing loss, and tinnitus," explains Ahsan. "Also, in the elderly, we must be aware of polypharmacy (more than four drugs) as a common cause of dizziness and lightheadedness."

In the Henry Ford study, the patients who had some abnormal findings on CT scans had severe headaches or some neurological deficits, notes Ahsan. "It is important to perform a thorough, but directed, physical exam," he says. "Check for orthostatic hypotension, perform an ear exam, evaluate the cranial nerves, look for spontaneous or positional nystagmus, and most importantly, perform a Dix-Hallpike test to assess for BPPV (benign paroxsmal positional vertigo) and a head thrust test or HTT to assess for vestibular deficits."

Ahsan explains that a positive Dix-Hallpike test would suggest BPPV as the cause, and a simple positioning maneuver performed by an otolaryngologist could be employed to treat the problem. Alternatively, he explains that a positive HTT would suggest vestibular neuritis or labyrinthine dysfunction. "Rarely does cerebellar infarction or hematoma cause a positive HTT," says Ahsan.

Consider the probabilities

As a general rule, if a patient presents with isolated dizziness, light-headedness, or positional vertigo without any other symptoms, the likelihood of finding an acute, life-threatening abnormality on a CT scan is quite low, advises Ahsan. "If a patient has a severe, new onset headache, along with dizziness, or if there is ataxia and/or dysarthria, then a CT of the brain may be helpful," he says. "But if the practitioner is concerned with cerebellar stroke or bleed, then an MRI is indicated since CT does not give a good picture of the posterior fossa region."

EXECUTIVE SUMMARY

Researchers at Henry Ford Hospital in Detroit have found that CT scans rarely show evidence of serious underlying conditions in patients who present with dizziness, yet they are frequently ordered by ED providers. In a study conducted over three years, researchers found that less than 1% of CT scans performed in patients with dizziness yielded significant results. Instead, in most cases, experts say a thorough history and evaluation can help providers narrow in on a differential diagnosis without the expense or radiation exposure associated with CT.

- The cost of the CTs over the three-year study period was $988,200.
- In the study, the patients who had some abnormal findings on CT scans had severe headaches or some neurological deficits along with the dizziness.
- For patients presenting with isolated dizziness, lightheadedness or positional vertigo without any other symptoms, the likelihood of finding an acute, life-threatening abnormality on a CT scan is quite low

COMING IN FUTURE MONTHS

- Culture change in the ED
- Flood of patients seeking dental care in the ED
- A new-age, regional warning system for emergency response
- A new role for EDs in trauma prevention

The bottom line is that a good history and exam will indicate that most cases of dizziness, even when they are coupled with mild headaches, are not urgent, says Ahsan. "In a patient presenting with dizziness after a fall or head injury, and with a physical exam ruling out BPPV or labyrinthine dysfunction, then a CT would be helpful in ruling out an intracranial bleed."

Acting on the results of this study, Henry Ford Hospital plans to implement the use of routine Dix-Hallpike, HTT, and orthostatic BP evaluations, and the evaluation of nystagmus in the ED to see whether these measures decrease the rate of CTs performed while also improving diagnostic accuracy, explains Ahsan. "We hope to decrease the time spent in the ED and the overall cost of evaluation," he says. ■

SOURCE

Syed Ahsan, MD, Neuro-otologist, Department of Otolaryngology-Head & Neck Surgery, Henry Ford Hospital, Detroit. Phone: 1-800-436-7936.

Study: New imaging efficiency measure for ED use of CT for headaches not reliable or accurate

A new study suggests that there are serious problems with the Centers for Medicare and Medicaid Services' (CMS) new imaging efficiency measure for ED use of computed tomography (CT) for headaches. The study, which was published in the *Annals of Emergency Medicine*, concludes that the measure, OP-15, is not reliable or accurate, and that it produces misleading information about hospital ED performance.[1]

The measure, which is included in the hospital outpatient quality reporting program for calendar year 2012, uses Medicare billing records to assess whether CTs are clinically appropriate for headache patients. However, when study researchers reviewed medical records for headache patients whom CMS concluded had inappropriate brain CT scans in a trial run of the measure, they found that more than half (65%) of these CT scans actually complied with CMS' measure, and that there were valid reasons for the CT scans in another 18% of patients.

The authors are calling on CMS to remove OP-15 from any calculations pertaining to the outpatient prospective payment system or value-based purchasing. And the American Hospital Association opposes use of the measure as well, noting that the measure has not been endorsed by the National Quality Forum as a valid and reliable measure of care. ■

REFERENCE

1. Schuur J, Brown M, Cheung D, et al. Assessment of Medicare's imaging efficiency measure for emergency department patients with atraumatic headache. *Ann Emerg Med*. Feb. 23, Epub ahead of print.

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent 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

1. **Rachel Glick**, MD, believes that one of the main reasons why EDs are seeing increasing numbers of patients with behavioral health issues is:
A. patients are reluctant to seek care from mental health practitioners
B. the nation's fragile economy
C. trauma cases have a mental health component
D. drug abuse is on the rise

2. The Institute for Behavioral Health Improvement has found that a common problem area for busy EDs is that:
A. Patients who present to the ED with behavioral health issues do not commonly have good things to say about their experience.
B. They aren't interested in understanding the needs of behavioral health clients.
C. They refuse to work with community resources.
D. Case managers don't have time to deal with the needs of behavioral health patients.

3. **Stuart Buttlaire**, PhD, MBA, says that EDs should place a high priority on making sure clinicians and staff are educated about:
A. depression
B. suicide prevention
C. domestic violence
D. drug abuse

4. In her studies of triage, **Lisa Wolf**, PhD, RN, CEN, FAEN, has found that the strongest factor impacting delayed transfer times for patients between the ED and the intensive care unit is:
A. the initial Emergency Severity Index (ESI) triage assignment
B. staffing levels
C. patient volume
D. the experience level of ED providers

5. According to **Jeff Solheim**, RN, BRE, CEN, CFRN, more than anything else, getting triage right boils down to:
A. good quality control
B. having effective tools
C. having the right people doing triage
D. having enough staff on hand

6. **Syed Ahsan**, MD, explains that a common cause of dizziness in the elderly is:
A. dementia
B. polypharmacy
C. headaches
D. low blood pressure