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Under the gun to act, hospitals in Washington state put their hopes on seven "best practices" to curb non-emergent use of their EDs by Medicaid patients

Hospitals aim to show progress quickly; administrators hope it will be enough to head off draconian cuts

Every day patients flock to EDs with sore throats, headaches, and other non-emergent problems that are more in line with what you would expect a primary care provider (PCP) to handle. It costs more

EXECUTIVE SUMMARY

Hospitals in Washington state are under intense pressure by their state legislature to reduce the non-emergent use of EDs by Medicaid patients. As a result, emergency physicians and the Washington State Hospital Association have put together a plan involving the implementation of seven best practices aimed at educating patients about using the most appropriate setting for their care needs, electronically sharing information across ED sites so that narcotic-seeking patients can be easily identified, and expanding access to primary care resources. The hospitals have pledged to show progress by January of 2013 under the threat that legislators may move to limit the number of non-emergent ED visits that Medicaid patients can have.

- One aspect of the effort involves the creation of a Patient Review and Coordination Program, so that frequent ED utilizers can be identified and tracked wherever they present for care.
- The Washington State Hospital Association is meeting with each of the Medicaid plans in the state to encourage them to establish strong call centers and to reassess the scripting used so that patients are appropriately advised about where to seek care for their complaints.
- Lack of funding for mental health care in Washington state remains an obstacle, as an estimated 85% of high ED utilizers have concurrent mental illness.

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to handle minor problems in an acute care setting, but for a variety of reasons, this type of utilization continues to rise, often times clogging throughput and driving up ED wait times.

While virtually every state is concerned about the costs associated with this problem, legislators in Washington state have put the hospitals there on notice that they aren't going to put up with what they see as overutilization of the state's EDs much longer. After first announcing plans to limit Medicaid payments to EDs for visits or conditions deemed not medically necessary or appropriate in the ED setting, legislators have now backed down on that pledge, and instead have agreed to a proposal put forth by emergency physicians aimed at curbing use of the ED for non-emergent needs.

The plan involves a collaborative effort between ED physicians and hospitals to beef up the sharing of information electronically, deliver education to patients about appropriate use of the ED, and to continually monitor performance on a range of metrics so that significant reductions in ED use can be achieved by January 2013.

While no firm targets have been stipulated, hospital and ED administrators know they are under the gun to make progress quickly. It is also quite clear that colleagues in 49 other states feel like they have a lot riding on the effort as well. *(Also, see "New Jersey effort brings down non-emergent utilization at two demonstration sites, but findings suggest more policy changes are needed," p. 88.)*

'Best practices' take center stage

The heart of the plan consists of seven best practices that were developed by the Washington State chapter of the American College of Emergency Physicians (ACEP), the Washington State Medical Association, and the Washington State Hospital Association (WHSA). "We spent considerable time discerning what we could do to reduce ED visits based upon the literature and also based upon what we see in our hospitals and EDs," explains **Carol Wagner**, the senior vice president of patient safety for the Washington State Hospital Association (WSHA) in Seattle, WA. "There is a strong commitment from the hospitals to design a better way of providing care."

Nathan Schlicher, MD, associate medical director at St. Joseph Medical Center in Tacoma, WA, and a spokesman for the Washington Chapter of ACEP, says that the state's emergency physicians are on board with the plan, and that the approach is moving the state in a "positive direction."

Some of the best practices will take time to fully implement, but hospitals had to indicate their willingness to comply by mid-June. The best practices include:

- Adoption of an electronic information exchange system to share information about ED visits with other hospitals.
- Education of patients about the appropriate

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use of the emergency department.

• Dissemination of lists of patients enrolled in a Patient Review and Coordination Program (PRCP) so that frequent users can be identified when they come into the ED.

• A process to contact a PRCP client's primary care physician when they come into the ED, and to make a follow-up appointment where appropriate.

• Implementation of narcotic guidelines.

• Physician enrollment in the state's Prescription Monitoring Program.

• Designation of staff to review the state's utilization feedback reports and take appropriate action in response to the information contained in the feedback reports.

Primary care access is critical

While the electronic information exchange was fully functional by mid-June, Wagner explains that it will probably be October before all the hospital interfaces for the exchange are completed. Further, to help hospitals with the education requirements, WSHA has developed a brochure that lists what types of conditions should generally be treated in a primary care setting or an urgent care center, and when patients really should go to an ED. "We believe this brochure will be helpful for not only when patients wait in EDs, but also to help reinforce education that is being delivered by the provider," explains Wagner. "The hospitals are very committed to implementing the seven best practices, and to looking for ways that care can be provided in a high quality manner in the most cost-effective setting."

Wagner acknowledges that access to primary care is a complicated problem that requires more than patient education. In fact, WSHA reached out to health care experts in other states to find out what strategies can be helpful in linking frequent-utilizers to primary care, and one recommendation that kept coming up as being helpful is the use of call centers to help patients understand what level of care they need. "[Consequently], WSHA is meeting with each of the Medicaid plans in the state to encourage them to have a strong call center, and also to look at the scripting that is used in the call centers," explains Wagner.

It is not uncommon for call center staff to tell patients that if they are worried, they should visit the ED, but this messaging can be problematic, says Wagner. "There are times when such instructions are helpful, but there are other times when patients could [more appropriately] be instructed to get an earlier appointment with their PCP or to go to an urgent care center."

Community resources differ, so hospitals are using a variety of mechanisms to connect patients to appropriate care. "In some communities there is not enough primary care coverage, so there are clinics being developed and other strategies to try to find resources for these patients when they are not in the hospital," explains Wagner.

Wagner adds that one issue that will require additional solutions, beyond the best practices, is mental health. "Funding for mental health care in Washington state is one of the lowest in the nation, and yet these patients need help and assistance," she says. "When these needs go unattended, a lot of times these patients end up in our EDs. We don't have all the answers around mental health, so it is something we are going to have to continue working on going forward."

Schlicher agrees, noting in published reports that 85% of the high-ED-utilizing patients have concurrent mental illnesses that often go untreated.

Hospitals, EDs must show progress

While connecting patients to primary care is obviously critical to reducing overutilization of the ED, Wagner stresses that it is also important for EDs across the state to be able to share information. "Regardless of where patients go for their ED visits — particularly if they are needing to go to the ED frequently — there will be a consistent plan across hospitals, and also an understanding of how potentially that patient could be treated in a setting that is probably even more convenient," observes Wagner.

Lack of primary care isn't the only reason why patients overutilize EDs. Many patients frequent EDs to obtain access to narcotic drugs, explains Wagner. To address this group, as well as other patients who frequently utilize the ED, the Washington State Health Care Authority has established a Patient Review and Coordination Program (PRCP) to connect high-utilizing patients with a PCP and a hospital so that they can receive more coordinated care for their increased needs, adds Wagner.

The PRCP will provide needed support and resources so that narcotics guidelines, developed by the Washington Chapter of the American College of Emergency Physicians, can be carried out. "The WSHA and the Washington State Medical Association have supported this. It is a great way to insure that the strategy is imple-

mented across EDs so that there is a consistent way to approach narcotic-seeking patients," says Wagner. "There are posters and there are good materials for the clinicians to work from."

At press time, the Washington State Health Care Authority was still in the process of finalizing utilization feedback forms that will include key metrics around such issues as narcotic prescribing, and ED utilization among PRCP patients. These reports are designed to provide hospitals with performance updates around the seven best practices as well as overall ED utilization. "The state is looking for a reduction in ED visits," says Wagner. "The hospitals and EDs in Washington State hope to be able to demonstrate that."

While no specific targets have been publicized, the Washington state Health Care Authority is projecting that the collaborative effort will save more than $30 million in health care costs. With such a short timeline, Wagner is hopeful that the state will be satisfied with progress. "I believe what the state is looking for is a trend in terms of a reduction in ED utilization," she says. "Everybody is committed to providing high quality patient care, and continued access at lower cost. We need a sustainable health care delivery system." ■

SOURCES

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New Jersey effort lowers non-emergent utilization at two sites, but findings suggest more changes needed

Hospitals in Washington state are, arguably, under the most intense pressure to bring down utilization of the ED for non-emergent needs. However, many states are working on this problem, and some solutions have emerged, although funding remains a concern.

For example, in New Jersey, interventions developed by the New Jersey Hospital Association's Health Research and Educational Trust, the state Department of Human Resources, and the New Jersey Primary Care Association, successfully decreased Medicaid recipients' inappropriate use of the ED by more than 20% in a demonstration project that focused on two emergency departments over two and a half years.

Called the Community Partnership for ED Express Care and Case Management, the effort used a $4.8 million grant from the Centers for Medicare and Medicaid Services (CMS) to beef up support services for patients who presented to the ED with non-emergent needs.

"The less acute and less sick patients were split off from the main population or sicker patients," explains **Eric Wasserman**, MD, FACEP, chairman of the Emergency Medicine Department at Newark Beth Israel Hospital in Newark, NJ, one of the two demonstration sites. The other site was Monmouth Medical Center in Long Branch, NJ.

Once these less acute patients were provided with appropriate care for their needs, ED staff took extra steps to make sure they had an appropriate follow-up appointment with their primary care provider (PCP), or if they had no PCP, then they immediately scheduled an appointment with a partnering federally qualified health center. In addition, ED staff took the time to educate patients about the importance of having a medical home for their primary care needs, and they explained what conditions should be dealt with in a primary care setting rather than an ED.

"We had dedicated nurse practitioners who were taking care of these patients, and not only managing their current medical problems, but also focusing on what some of the factors were that made them come to the ED for their given complaint," says Wasserman. "The majority of these patients (89%) were uninsured or on Medicaid."

For patients with additional social needs, case managers were on hand at both the hospitals and participating health centers to arrange for transportation to their medical appointments or to provide other support services. They also followed-up on these patients, making sure they received any needed referrals for specialty care, and that they actually showed up at these appointments. "The additional resources made all the difference," says Wasserman.

New incentives are needed

At the conclusion of the demonstration, analysts found that ED visits for primary care at the two sites decreased by 22% even though overall ED volume increase by 1%. In addition, the reduced ED utilization for primary care needs improved patient flow through the ED, reducing the average patient turnaround time by about 15%, according to a report from the New Jersey Hospital Association (NJHA).

Analysts also found that the peak day for primary care visits in the ED was Monday, and that the peak times for these visits was between 10 am and 1 pm. The timing is important because many experts suggest that the reason patients flock to the ED for non-emergent needs is because federally qualified health centers are closed. These findings suggest there are other reasons.

Indeed, according to the NJHA's report on the demonstration, when patients who presented to the ED with non-emergent problems were asked why they came to the ED, 21% said they thought that they needed emergency care, 20% said their doctor's office was not open, and 12% said their doctor was not available that day.

As a result of the demonstration, the NJHA and the partnering organizations have unveiled several recommendations, most of which will require more work or resources to be fully implemented. For example, they note the need for consumer outreach so that the public is better educated about when to appropriately use the ED, and they also state that federally qualified health centers should make their availability and the quality of their services known to all populations.

The report also emphasizes that incentives need to be created to encourage patients to use primary care settings when appropriate. It's a problem of both access and economics, according to Wasserman. "In urban areas you have a lack of PCPs and limited hours at that, so even though patients sub-triage themselves to EDs, I think they don't necessarily have places to go or the means to pay for care, so there is going to have to be this whole restructuring of the system so that patients are incentivized to go elsewhere and not to the ED," he explains. "A lot of PCPs and sub-specialty clinics ask for payment up front, and if patients can't do that, there is no incentive to go there."

Further, while the interventions developed during the demonstration were effective at reducing inappropriate ED utilization, the grant money is no longer available to pay for the extra support services. "Many people believe that a lot of money can be saved if you see patients in a less costly environment as long as they are receiving care that is appropriate to their needs," says Wasserman. "But it has been left up to the EDs to see everybody who shows up, to try and explain to them that their particular problem could have been handled in a different setting, and hope for the best." ■

Study: To minimize errors, rely on interpreters when caring for LEP patients in the ED

Data show professional interpreter training trumps years of experience on the job

Hospitals that receive federal funds are required by law to offer language assistance to patients with limited English proficiency (LEP). There is good reason for such a requirement because census data suggest that more than 59 million Americans speak a language other than English at home, and more than 25 million have LEP. However, a new study suggests that the type of assistance provided can make a big difference in determining whether

EXECUTIVE SUMMARY

A new study strongly suggests that it is important for EDs to rely on professional interpreters, rather than ad hoc interpreters or no interpreters at all, when caring for patients with limited English proficiency (LEP). The researchers examined health care encounters involving LEP patients at two pediatric EDs, and found that the encounters associated with professional interpreters were associated with far fewer errors of potential clinical consequence than the encounters associated with ad hoc interpreters or no interpreters.

- Experts say the most important first step in minimizing language-based errors is to identify patients with LEP when they present for care.
- Professional interpreters are defined as having at least 100 hours of training.
- Researchers say that when evaluating interpreters, professional training is more valuable in terms of minimizing errors than experience on the job.
- Make sure that interpreters are available to LEP patients throughout the course of their ED visit as well as during any follow-up visits or telephone calls.

or not there are miscommunications that lead to clinical consequences.[1]

Researchers, led by **Glenn Flores**, MD, a professor and director of the division of general pediatrics at the University of Texas Southwestern Medical Center and Children's Medical Center of Dallas, scoured the audiotapes of 57 interactions involving LEP patients at two large pediatric EDs in Massachusetts. They discovered nearly 2,000 errors, 18% of which had potential clinical consequences. However, only 2% of these errors were associated with professional interpreters who had at least 100 hours of training. Interpreters with less training were associated with 12% of the errors, and ad hoc interpreters — typically family, friends, or staff who may be bilingual but have no training in medical interpretation — were associated with 22% of the clinically significant errors. The authors note that the error rate was, in fact, lower (20%) for patients who had no interpreters at all than for the patients who had ad hoc interpreters.

"We have shown in a number of studies that having no interpreters is suboptimal and having ad hoc interpreters is suboptimal because they don't have the training and they are not familiar with medical terminology," says Flores. Further while it may be tempting to make use of a family member who is bilingual, this can present additional complications. "There can be embarrassing issues, particularly when you have a child interpreting for adults," explains Flores. "The adult may not want to talk about domestic abuse or drug abuse, and [he or she] may not want to talk about sexual issues, or depression."

Matthew Wynia, MD, director of the Center for Patient Safety at the American Medical Association and clinical assistant professor at the University of Chicago in Chicago, IL, agrees, noting that the use of ad hoc interpreters is problematic in many respects. "If you use a family member or the janitor, or you just pull someone in who happens to speak the language but who doesn't have any training in how to be an interpreter, not only do you have some of the problems of confidentiality and professional ethics of interpretation, but you also have just plain quality control problems," says Wynia. "They can miss-report what you say to the patient."

Identify patients with limited English

Communicating with the LEP population is challenging in all health care settings, but the ED has some unique characteristics that may heighten the risk for errors. "Even if you speak the same language as your health care provider, when things happen fast and people have serious issues it can be hard to understand what is going on, so when you add a language barrier to the mix, it really magnifies the challenges," says Flores. Nonetheless, he stresses there are things that ED administrators can and should do to minimize the chances that language barriers will lead to errors. ***(Also see, "New tool helps hospital administrators assess their communications climate," p. 92.)***

The first and most important step, says Flores, is to make sure that LEP patients are identified when they present to the ED for care. One way to do this is by asking all patients what primary language is spoken in their home. In cases where English is not the primary language, patients should be asked to rate their ability to speak English: very well, well, not well, or not at all. "Anything less than 'very well' is classified as LEP, and these patients need an interpreter," says Flores. "Don't just ask them if they need an interpreter because you will miss a lot of patients who don't speak sufficient English."

Keep in mind that many critical health care communications occur throughout a patient's visit to the ED, not just while he or she is being seen by a physician. This is where many health care organizations drop the ball, says Flores, noting that interpreters are not always present when they need to be. "Some of the most important communications occur at the end of the visit when the nurse or a medical assistant is signing the patient out," he says. "Also, you can imagine trying to get someone to sit still during an MRI [magnetic resonance imaging] or to get them in the right position for a chest X-ray without an interpreter." ***(Also, see Management Tip: "Have English language resources on hand for LEP patients," p. 93.)***

Written communications, such as prescriptions or patient instructions, need to be printed in the patient's preferred language as well. "Have an option on the prescription pad when you can check off Spanish or some other language that is prevalent in your area so that the pharmacist knows how to print the instructions," says Flores. "Also, make sure that you have all of your patient instruction materials printed out in the most common languages so that people really do understand what they are supposed to do after discharge."

There should be plans in place for phone communications involving LEP patients as well, advises Flores. "Make sure that when patients call on the telephone that there are multilingual operators and phone trees for making appointments and follow-ups," he says.

Wynia agrees, noting that if a patient who does not speak English calls in, it is the hospital's responsibility to get an interpreter on the line. "Many patients just don't call because they know an interpreter isn't readily available," he says. "This is also why patients tend to cluster in [health care] settings where interpreters are available or where the staff speak their language."

Interpreter phone lines offer some advantages

The literature suggests that the best way to communicate with LEP patients is through a professional interpreter or a bilingual provider, says Flores. Consequently, he advises ED administrators to identify staff who are bilingual, consider providing bonuses to personnel who are fluent in other languages, and to do more outreach to and recruitment of bilingual personnel.

While some large EDs have professional interpreters on staff 24/7 who speak Spanish or another language that is prevalent in the community, this is not practical in many settings, and it is impossible to have interpreter coverage for every language in any case. In instances where in-person interpreters are not available, most EDs rely on language lines where they can access trained interpreters via the telephone. "Typically, there are two handset phones that people can use so that both the patient and the doctor can be on the line with the interpreter at the same time," explains Wynia.

The phone lines can be inconvenient and cumbersome to use. And, of course, a phone-based interpreter will not able to pick up on any nonverbal cues or facial expressions that the patient may exhibit, but there can be some advantages to this approach as well, says Wynia. "When people are on the phone they may be willing to say things to the interpreter that they might not be willing to talk about if the interpreter is standing in the same room with them," he says.

In fact, Wynia, who is an HIV specialist, experienced this type of situation first hand with a patient who always refused the assistance of a live interpreter. "Whenever she came in she preferred to not have an interpreter at all, but if there was anything of importance we had to discuss, I would get an interpreter on the phone, and she was OK with that because that interpreter wouldn't know her," he explains. "She was more willing to have that conversation with an interpreter on the phone than she would with a live interpreter."

In a true emergency, Wynia acknowledges that there may not be time to bring in a live interpreter or establish contact with a phone-based interpreter. "In an ideal setting you will have a rapid response way of getting an interpreter there, but regardless, you have to put the patient first and not let the situation get out of hand. You do the best with what you've got," he says. "But that isn't the most common situation in the ED. Most of what we see in EDs is more urgent rather than emergent cases, and in an urgent case you probably can wait 15 to 20 minutes [to establish contact with an interpreter]."

Even in cases where it is inconvenient or inefficient to wait for the services of a professional interpreter, Wynia stresses that the data are very clear that this is a better option than doing without an interpreter or relying on an ad hoc or untrained interpreter.

A word about cost

Professional interpreters can add costs to any health care encounter, and currently only 13 states and the District of Columbia provide third-party reimbursement for interpreter services. While this is certainly an issue for hospital administrators, it should not be a factor for individual providers, stresses Wynia. "The physician who is making the decision on whether to call an interpreter does not face that cost," he says. "Physicians who are convinced that interpreters are important to providing quality care will use interpreters, and those who feel like the inconvenience overrides the relative improvement in quality of care may not use them. But I think you have to acknowledge that is a risky decision because God forbid something happens to a patient after they leave because they did not understand [patient instructions.]"

Where costs can enter into the decision-making equation is if hospitals adopt methods or systems that are not very responsive, hard to use, or particularly inefficient. "If you have to wait a long time [for an interpreter], that will drive up the inconvenience factor," adds Wynia.

When contracting for the services of interpreters or interviewing candidates for interpreter positions, keep in mind that time spent in professional training is more important than years of experience. This, at least, is what Flores discovered in his study, and he believes it makes perfect sense. "If you never received any training, even if you were working on the job as an interpreter

for 30 years, you were probably making the same mistakes over and over again," he says. "I think this really shows how important and powerful the training is."

Unfortunately, there is not yet a universal understanding of precisely what comprises a trained, professional interpreter, although there is a code of ethics for interpreter services which covers things like maintaining confidentiality, and interpreting exactly what the parties say, explains Wynia. Consequently, medical interpreter certification programs are not at a point where it is reasonable or practical for health care organizations to require that medical interpreters be certified. "The vast majority of interpreters aren't yet certified," he says. "They may have very good training, but there just weren't any national certification programs until about 18 months ago." ■

REFERENCE
1. Flores G, Abreu M, Barone C, et al. Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine* 2012 Mar 14. [Epub ahead of print]

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New tool helps hospital administrators assess their communications climate

It is not easy for hospital administrators to determine whether the communications policies and strategies they have in place are effectively meeting the needs of patients with limited English proficiency (LEP), but there are some new tools available that may help. The Communication Climate Assessment Toolkit (CCAT), developed by the American Medical Association's (AMA) Ethical Force Program, consists of a series of surveys, each aimed at different populations within the hospital setting.

"It is a multi-dimensional assessment of communication in a health care organization," explains **Matthew Wynia**, MD, director of the AMA's Center for Patient Safety, and clinical assistant professor at the University of Chicago in Chicago, IL. "So we are not looking just at the communication between the patient and the doctor, we are looking at the whole climate for communication throughout an organization."

For example, the CCAT includes a patient survey, which is available in multiple languages, as well as a clinical staff survey, which queries participants about the availability of interpreters as well as translated materials, explains Wynia. "We also have a survey that goes to non-clinical staff, so we ask people in housekeeping and on the front desk about the care and communications capacities of the organization," he explains.

The CCAT has nine scores that hospitals can receive, each representing a composite of information from patients and from staff, adds Wynia. "One of those scores is for language services, but we also have a score for community engagement, we have a score for engaging patients in care decisions, there is a score for cross-cultural issues, and a score for health literacy."

The surveys are available for download at no charge from the website www.ethicalforce.org. Hospitals can use the surveys on their own, or if they are interested in seeing how their scores compare to scores from other organizations, for a fee they can work with a consultant who has been trained by the Ethical Force group in how to use the surveys, and they can access the group's benchmarking database.

"The CCAT is just coming out of the gates, so we will see how many hospitals are interested in using it," explains Wynia. At press time, about 30 hospitals had already taken advantage of the toolkit, and the instrument was going through the process for endorsement by the Washington, DC-based National Quality Forum. "With a little bit of luck, a large number of hospitals will be using [the CCAT] in the future," says Wynia. "There aren't many measures that explicitly address health disparity issues, and I think communication is a known driver of health disparities."

Management Tip

Have English language resources on hand for LEP patients

Having professional interpreters available for patients with limited English proficiency (LEP) is important, but ED administrators should also consider looking into the resources that are available in their communities to help LEP patients with their English skills. "I have never had LEP family members say that they don't want to learn English," observes **Glenn Flores**, MD, a professor and director of the division of general pediatrics at the University of Texas Southwestern Medical Center and Children's Medical Center of Dallas.

Flores advises health care administrators to make use of www.literacydirectory.org, a website where you can quickly find all the free and low-cost language classes that are available within a particular ZIP code. Then, when LEP patients present for care to the ED, it should be an easy matter to pass along the language resources to them as they are being discharged. While it won't make a difference to their immediate health care concerns, it may help them on subsequent visits to the ED or with any future health care communications. ■

For improved outcomes, connect first-episode schizophrenia patients to comprehensive care quickly

Rapid follow-up is key to preventing subsequent ED visits in patients with mental health concerns

Mental health experts believe that as with many acute medical conditions such as stroke and heart attack, early diagnosis and treatment can make a critical difference for patients with schizophrenia, potentially limiting the severity and progression of the disease. This is important to ED administrators and clinicians because the first opportunity to intervene in many of these cases often occurs in an emergency setting, although getting to a correct diagnosis may be difficult.

"A lot of these patients are extraordinarily anxious and they may be acting kind of odd," explains **Cheryl McCullumsmith**, MD, PhD, division director, Hospital Psychiatry, at the University of Alabama at Birmingham Medical Center (UABMC). "We also see patients who have more of what appear to be depressive symptoms. They may not be getting out of bed or going to school, and their parents are becoming increasingly concerned."

These types of symptoms can be due to substance abuse, intoxication, or other medical conditions, all of which need to be ruled out if this is a patient's first medical encounter, adds McCullumsmith. "It is very important to distinguish between psychosis and schizophrenia. Psychosis is a symptom like fever. Everyone with

EXECUTIVE SUMMARY

For schizophrenia patients, early diagnosis and comprehensive treatment can improve outcomes, according to mental health experts. And the first opportunity to intervene often occurs in an emergency setting.
To help ED staff connect these patients to appropriate care quickly, the ED at the University of Alabama at Birmingham Medical Center has opened the First Episode Schizophrenia Clinic, one of only a few such care settings in the country. While most EDs don't have this type of resource available, experts suggest staff would benefit from regular education about the signs and symptoms of the disease, and they urge ED administrators and clinicians to foster relationships with outside mental health providers so suspected schizophrenia patients can be transitioned to appropriate care quickly.

- Onset of schizophrenia most often occurs during the teenage years.
- Patients may present with depressive symptoms, or they may be acting odd or reclusive.
- Other potential causes, such as substance abuse or alcohol intoxication, need to be excluded before a definitive diagnosis of schizophrenia can be made.
- Experts advise ED clinicians to make sure they communicate effectively with outside mental health providers when making a patient referral. The mental health provider needs to understand what workups were completed in the ED, and what conditions the ED staff are concerned about. Patients often fail to report why they have been referred.

a fever doesn't have pneumonia, and everyone with psychosis doesn't have schizophrenia," she explains. "We have seen youngsters taking diet pills or taking steroids for weight-lifting. They come in and they are psychotic, but that doesn't mean they are schizophrenic."

Consider patient and family needs

However, for new cases of suspected schizophrenia, which is often first observed in teenagers, UABMC now has an added resource available to the ED. The First Episode Schizophrenia Clinic, which opened in May of this year, is set up to initiate aggressive, comprehensive treatment shortly after diagnosis. The goal is to lessen the complications associated with schizophrenia for both patients and family, explains **Adrienne Lahti**, MD, the clinic's director.

"There is data showing that the quicker you can make an intervention with medication, the better the outcome," says Lahti. However, she stresses that effective treatment also depends on how well the family understands the illness.

When there is a first episode of schizophrenia, the patient is not the only one in crisis, the family is in crisis as well, adds Lahti. "You can imagine having a 17-year-old boy who was doing pretty well, and you thought he was going to go to college, and then his grades are falling and he is staying in his room," she explains. "So it is critical to work with the family and let them know there are things they need to do, and the first thing is to be an advocate for their son."

For example, family members are critical to making sure that a patient takes his medication and shows up for medical appointments. "We encourage patients to stay in school and to stay functional," says Lahti. "There are studies showing that the more you can keep people functional the better the outcomes."

The First Episode Schizophrenia Clinic will see patients who have been referred from the ED as outpatients, and it will also work with hospital physicians to transition admitted patients to the clinic once they have been discharged.

Educate staff

The First Episode Schizophrenia Clinic at UABMC is the only such clinic in Alabama, and it is one of only a handful of similar care settings in the country. However, even without this resource, there are steps that EDs can take to improve the care they provide to patients who present with the signs or symptoms of schizophrenia.

Staff education is very important, explains McCullumsmith, noting that she conducts several grand rounds every year with emergency medicine staff. "Also, because we have psychiatry present here, we do a lot of one-on-one [with clinicians] when we are seeing patients. We talk to them about [psychiatric] cases," she says. "If you don't have psychiatry available in your ED, that is more difficult to do."

McCullumsmith advises clinicians to utilize a psychiatric rating scale, such as the Brief Psychiatric Rating Scale (BPRS), for example, when they have a patient who they suspect may be schizophrenic. "It gets into some symptoms of psychosis. It may not pick up on everything for a first episode, so it is not ideal," she says, noting that the instrument is primarily used by mental health care providers. "However, it will provide information about how to ask the questions, and this can be difficult."

When referring a patient with psychiatric issues to an outside provider, make sure that you provide a comprehensive assessment of what is going on with the patient, stresses McCullumsmith. "If you just give patients a referral and tell them to go to the local community mental health center, they are not going to go there and say that they are psychotic," she says. "They may not even know why they have been referred."

Instead, the outside provider should receive a copy of your notes so that he or she knows what workups you have done and what your concerns about the patient are, explains McCullumsmith. Otherwise, it is difficult for the provider to begin treatment.

Arrange for rapid follow-up

Patients who present to the ED with psychiatric problems need to have follow-up appointments

COMING IN FUTURE MONTHS

- What the Supreme Court's ruling means for emergency care
- Connecting ED patients with palliative care options
- Why ED crowding has gotten worse, and what you can do about it
- Could you benefit from ED flow facilitator?

soon after their visit or they are likely to be back in the ED in short order, explains McCullumsmith. "We had trouble getting rapid follow-up, not just for first-break [schizophrenia] patients, but for all patients with mental illness, so we established our own transitional clinic," she says. "We find that if we can actually see people within three days of their ED visit, they don't come back to the ED nearly as often. It takes twice as long for them to come back for a psychiatric reason."

Typically, patients are seen in the transitional clinic a few times before they are transitioned to their eventual mental health care provider. "We are working on showing that it is actually more cost-effective than ED visits," says McCullumsmith.

Not every ED is going to be able to establish a transitional clinic for patients with mental health problems, but McCullumsmith says administrators and clinicians can work toward establishing a means to rapid follow-up by building relationships with outside mental health providers. She is also a strong proponent of having social workers on staff who can work closely with patients who have mental health needs.

"We have a social worker who we have given the task of being our intensive case manager. She works with patients who are in distress and coming in frequently, and can't seem to make that next step of establishing regular care," explains McCullumsmith. "She digs in and finds out more about their history, makes follow-up calls, reminds them about upcoming appointments, and contacts family members to help get them to the appointments."

In some cases, the hospital will provide taxi fares or bus tokens to patients who have no other way to get to their appointments, and staff will also help to get patients established on medication for free. "We do a lot of things from the ED to really help get patients started in a program and to help keep them going," adds McCullumsmith. ■

SOURCES

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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. Hospitals in Washington state are using a variety of mechanisms to connect frequent ED-utilizers with primary care providers. However, **Carol Wagner**, the senior vice president of patient safety for the Washington State Hospital Association (WSHA) in Seattle, WA, says what one problem will require additional solutions?
A. narcotic-seeking patients
B. mental health care
C. the dearth of primary care providers
D. all of the above

2. In a New Jersey demonstration project, analysts found that the peak day and time for primary care visits in the ED was:
A. Friday between 9 pm and 1 am
B. Wednesday between 7 pm and 11 pm

C. Monday between 10 am and 1 pm
D. Saturday between 5 pm and 9 pm

3. Why is it important to rely on professional interpreters when communicating with patients with limited English proficiency (LEP) rather than friends or family who may be bilingual?
A. Friends or family may not understand medical terminology.
B. Friends or family are not bound by the same rules of confidentiality or professional ethics.
C. Patients may not want to talk about embarrassing issues or abuse in front of family or friends.
D. All of the above

4. **Glenn Flores**, MD, professor and director of the division of general pediatrics at the University of Texas Southwestern Medical Center and Children's Medical Center of Dallas, says the first and most important step toward communicating with patients who have limited English proficiency (LEP) involves:
A. identifying these patients as LEP when they present for care in the ED
B. establishing a rapport
C. winning the patient's trust
D. bringing in a professional interpreter

5. Mental health experts believe that early diagnosis and treatment can make a critical difference for patients with first-break schizophrenia. Why is this important to ED clinicians and staff?
A. They see a high number of schizophrenia patients.
B. They lack understanding about the signs and symptoms of schizophrenia.
C. They don't have the resources to manage schizophrenia patients.
D. The first opportunity to intervene in many schizophrenia cases often occurs in an emergency setting.

6. **Cheryl McCullumsmith**, MD, PhD, division director, Hospital Psychiatry, at the University of Alabama at Birmingham Medical Center, says it is important to arrange for rapid follow-up of patients who present to the ED with mental illnesses. Why?
A. Many of these patients don't have access to primary care providers.
B. Patients who have rapid follow-up are much less likely to return to the ED for care.
C. It is important for psychiatric patients to bond with a mental health provider.
D. These patients prefer to seek care in the ED.