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Accreditation Update

We want to send a big congratulations out to our Executive Editor, James Augustine, MD, who was elected to serve on the Board of Directors for ACEP, and to our guest columnist Caral Edelberg, who received the Honorary Membership Award for her service to ACEP as well as to her profession. We are so proud!

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Nurse care managers, new programming aim to provide more outpatient care alternatives for ED patients on the margin

Initiative shifts the focus from ED utilization to admission vs. discharge decisions

The debate raging over whether it is wrong or right for lawmakers to be looking at ways to limit ED utilization may be missing the more important discussion, according to **Timothy Peterson**, MD, an assistant professor of emergency medicine and medical director for the population health office at the University of Michigan Health System in Ann Arbor, MI. He argues that while the ED is clearly a high-value place for people to receive care, policy makers and emergency providers themselves should be thinking more about the downstream impact that ED physicians have. "We

EXECUTIVE SUMMARY

The University of Michigan Health System is developing clinical programming and deploying specially trained care managers as part of an initiative aimed at eliminating unnecessary hospital admissions.
- The ED-based care managers will assess every patient who comes to the ED, but focus their time on developing outpatient care alternatives for patients on the margin when physicians are making admission vs. discharge decisions.
- The initial focus of the program will be on patients placed in observation, but developers plan to expand the program to include slightly more complicated patients as physicians become more comfortable with outpatient treatment alternatives.
- While the care managers are already being deployed in the ED, program developers are working with community partners to create a toolbox of outpatient care alternatives such as a visiting nurse program that can be activated by ED referral.
- Illustrating the potential for such a program, one new study showed that in a sampling of Medicare patients who underwent six common surgical procedures, nearly one in five of these patients had an ED visit within one month of their hospital stay, and more than half of these patients ended up back in the hospital.

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make very expensive decisions for patients. And that admissions vs. discharge decision is one of the most expensive decisions that ED physicians are responsible for," states Peterson.

What's needed, according to Peterson, is programming and resources so that ED physicians will feel comfortable sending some patients who they now tend to hospitalize home, knowing they will receive the kind of care they need in an outpatient setting. It's a care model that Peterson and colleagues are planning to have in place within the next six to nine months at the University of Michigan Health System. The process is beginning with the deployment of specially trained nurse care managers throughout the hospital and the ED setting.

First, focus on observation

The ED-based care managers will be tasked with at least assessing every patient who comes through the door, but the degree of intervention is going to vary, explains Peterson. "There are going to be those cases where a patient is clearly going to need to be in the hospital, and their degree of assessment is only going to be to help transition that patient up into the hospital and to set expectations for the admission, length-of-stay, and those sorts of things," he says. "The majority of that work will be handed off to an inpatient care manager."

Similarly, for those patients who are clearly going to be headed home, the intervention by care managers is going to be minimal because these patients will already have discharge plans in place that their physicians are comfortable with, says Peterson.

Where the care managers will have most impact is on those patients who are on the margin. Physicians may be inclined to admit them, observes Peterson, but it will be up to the care managers to help to create outpatient plans that would be equally efficacious and safe for the patients outside of the hospital. "That is where most of their work will be, but we think the absolute number of these patients will be relatively small," he says. "If we can put a resource in place to help physicians feel more comfortable with an outpatient treatment program, where it is appropriate, I think we can have an impact on our readmission rate."

To make such a program work, there has to be what Peterson refers to as a toolbox of alternatives that care managers and physicians can tap into. Already in development is a visiting nurse program from the ED, where patients can get assessment in the home and services delivered to the home, with someone coordinating all of this care with an ED referral, he explains.

"We are also working with some of our skilled nursing facility partners to develop similar programming to help prevent ED admissions," says Peterson. "Fully developing this toolbox is probably going to take another five to seven months. We

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have to understand what the need is, we have to find partners, and then build those programs out."

Peterson fully anticipates that it will take time for the physicians to become comfortable working with the care managers on cases. "A little bit of tension is going to be natural because we're going to be taking physicians who are accustomed to a current mode of practice and asking them to think about the difficulty and adjust to a different operation," he says. "We expect some people to have some degree of reservation, but our goal is to put together the clinical programming needed in order for physicians to feel comfortable with alternative treatment plans."

To ease this transition and allow time for the development of effective outpatient treatment options, the care managers will first focus on what Peterson sees as the most straightforward cases: patients who are currently on observation stays. "These patients are defined by payers as folks who don't need to be in the hospital in the first place," he says. "We think this is the group most amenable to being transitioned out of the hospital and back to home, and receiving the medical care they need in that setting."

Over time, Peterson intends to grow the program to the point where patients with slightly riskier or complicated cases can be safely and comfortably treated at home, but further development of the program will depend on several factors. "On the one hand we have to actually turn on the programming and get the care managers doing the work and assessing the patients, and on the other hand we have to develop that toolbox that we believe people are going to need to be able to tap into," he says. "I don't believe for a second that ED physicians are admitting people to the hospital for no good reason. They feel there is a lack in the outpatient environment that can't be met in any other way except by putting the patient in the hospital."

Own the discharge vs. admission decision

Rather than viewing the ED as a high-cost center, policy makers and hospital administrators should, instead, look at how they can better leverage the ED to improve care and potentially reduce readmissions, according to **Keith Kocher**, MD, assistant professor of emergency medicine in the Department of Emergency Medicine at the University of Michigan Health System. Kocher recently completed a study on hospital and ED utilization among a sampling of 2.4 million Medicare patients who underwent six common surgical procedures over a three-year period. He and his research colleagues found that nearly one in five of these patients had an ED visit within one month of their hospital stay, and more than half of these patients ended up back in the hospital.[1]

The findings suggest that health care teams need to find better ways to keep surgery patients from experiencing emergencies after they leave the hospital. However, Kocher notes that the data also illustrate the role that EDs can potentially play in preventing readmissions. "You have a huge opportunity to address a lot of the needs that might have caused a patient to feel like they needed to seek out unscheduled care," he observes. "You won't be able to prevent all readmissions, certainly, and I think it would be unfair to expect that, but you certainly have the opportunity to really try to coordinate some potential alternative plans to readmission."

It is not a matter of putting further pressure on EDs to fix these problems, emphasizes Kocher. "That is not going to get you anywhere meaningful because a lot of these problems are not just clinical," he says. "You are talking about trying to navigate a potentially complex web of social and family concerns."

Improvements at this stage require a system-level perspective and approach to the problem, adds Kocher. "There are certainly going to be lessons that are generalizable and universal, but probably everyone is going to have to struggle with the details of a solution that works in their own environment," he says. "There is not one solution."

Kocher is happy to see care managers being deployed in the ED at the University of Michigan Health System, but he expects a fair amount of trial and error as the intervention is fine-tuned. "I think there is going to be a lot of experimenting going on as far as how to enlist their help. Ideally, you want the care managers to be proactive so it is not the emergency provider who has to constantly generate a discussion or figure out alternatives," he says. "I think it is going to take some time to figure out how best to integrate them into the management of patients, and particularly into the flow of the ED, which is chaotic and time-dependent."

At the same time, emergency physicians need to fully engage in the process, adds Peterson. "If you are thinking about where health care reform is headed on a federal or even a commercial level, we as emergency physicians need to think about owning that admission vs. discharge decision," he

says. "The more we can do to begin to shape what that looks like for our patients, I think the more successful we can be. That is really what we are focused on here with this type of program." ■

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Lean-driven improvements eliminate waste, boost patient satisfaction in a matter of weeks

Administrators credit front-line staff participation, top-level support for success

With anemic demand for emergency services and suboptimal patient satisfaction scores, administrators at North Adams Regional Hospital in North Adams, MA, knew they needed to do something to change the status quo. "The region we are in is shrinking in population, but the population is aging so we should have been seeing about a wash where [the volume of] ED visits was about the same," explains **Brent Drennan**, MBA, the director of lean transformation at the hospital. "The aging should have offset the population decline, but we were actually seeing shrinking ED visits."

To address the problem, Drennan, whose background is in manufacturing, assembled a team consisting of representatives from all the key service areas that impact ED operations, ranging from clinical and administrative functions to housekeeping and patient relations. In August of this year, the team huddled, putting the hospital's ED processes under a microscope to figure out what could be done to improve efficiency as well as the patient experience.

Participants in this process admit they were surprised at all the built-in delays patients encountered when seeking emergency care. But perhaps most surprising was the speed with which team-driven improvements were able to be implemented. Within six weeks of the original team meeting — referred to in lean parlance as a kaizen event — average wait times in the ED were down to six minutes, less than half what they were before the improvement process. And average door-to-physician times stood at 19 minutes, a reduction of eight minutes from the ED's performance in July.

Now, a few months into the improvement effort, it's clear that the approach is driving continued progress. Volume in the ED is on the upswing with average visits per day increasing from 42 to 54, the hospital's left-without-being-seen rate — which was hovering at 1 to 2 patients per day before the improvement process was implemented — is now close to zero, and the ED's standing in terms of patient satisfaction on Press Ganey surveys is at the 96th percentile, a jump of more than 25 points since the improvement process began. *(**Also see: "Management Tip: When implementing lean-driven solutions, have a plan in place for staff communication," p. 139**)*

EXECUTIVE SUMMARY

To address declining volumes and suboptimal patient satisfaction in the ED, administrators at North Adams Regional Hospital used lean techniques to eliminate waste and streamline the triage process.
• A few months into the new approach, administrators say that average daily visits to the ED have increased from 42 to 54, and patient satisfaction scores have jumped 25 points on Press Ganey surveys.
• Participants also report the approach has resulted in improved cooperation among ED staff and lower noise levels.
• Participants on a lean improvement team implemented a three-step triage process that connects patients with a provider quickly. The approach enables non-essential data gathering to take place later in the visit.
• The team also divided the ED into pods so that nurses can be assigned to three or four contiguous rooms. This approach eliminates unnecessary movement and makes it easier for physicians to find a patient's assigned nurse.
• The hospital is now leveraging the same improvement process to work on ED-to-hospital admissions and a process for handling unexpected patient surges.

Streamline triage

Team members acknowledge that even that before the kaizen event, they understood that wait times were a problem, but they didn't realize just how cumbersome the process of seeking emergency care was for patients. "We weren't aware of how many steps there were in the process or of all the built-in delays [that would occur] in getting the patient from the front door to the treatment room," explains **John Aufdengarten**, RN, MSN, MBA, the interim director of the ED. "We were surprised at how many hard stops there were."

For example, there were more than 50 questions and 50 fields that needed to be filled in during the triage process, notes Aufdengarten, so this was an area that team members quickly targeted for an overhaul. To streamline the process, team members designed a three-stage triage approach that is focused on getting patients back into a treatment room quickly.

"The first part is what we are calling 15-second triage. This is what the charge nurse does in the triage room right before she walks the patient to a [treatment] room," explains **Cheryl Ericson**, RN, the ED nurse representative on the improvement team. The nurse will ask the patient what he or she is there for, and then based on this information, as well as a quick assessment of how the patient appears to be doing in terms of color and other immediate indicators, the nurse will either walk the patient to a treatment room or take the patient there by wheelchair, she explains. "This is a big change, in that before [the new process was implemented] we would stop in the triage room, sit down for five to 10 minutes and assess why the patient was there, and get their medical history and vital signs before transporting them to a treatment room," adds Ericson.

During the second stage of triage, called quick triage, either the charge nurse or a nurse who is assigned to the room will retrieve what they consider to be critical information for the physician such as vital signs, allergies, and other aspects of the patient's medical history," explains Ericson. "They are able to get [this information] right to the doctor, especially if the doctor is waiting to see the patient," she says.

The third stage of triage, called data triage, involves retrieving all the information that wasn't necessarily critical for the physician to have right when he or she walked into the room, explains Ericson. For example, information about a patient's smoking or social history would typically be retrieved on the back end of the quick triage stage, or at some later point during the visit if the physician is waiting to see the patient.

"We have tried to make this as dynamic as possible so that when the patient is being walked to a room, triage continues," explains **Fernando Ponce**, MD, an ED physician who served on the lean improvement team. "The doctor also tries to be part of it by going into the room as soon as the patient arrives. Both the doctor and the nurse who are going to be taking over the patient continue the patient questioning in order to minimize having to go over [the same] questions again and again."

Minimize movement

In addition to streamlining the triage process, team members also decided to divide the ED into different sections that correlate with nursing assignments. "We have 14 rooms, and now we have pods where a nurse is responsible for three or four contiguous rooms," explains Ericson. "Before [this change], a nurse might have a room on one end of the ED and another patient in a room on the other end."

With the old approach, nurses tended to feel isolated, and they were less informed about what was happening in adjacent rooms. "[Consequently], they were less likely to help another nurse who might need an extra pair of hands because they didn't really know what was going on," observes Ericson.

The physicians struggled with the old system as well, reporting that it was difficult to find a nurse when staffers were randomly assigned all over the department. "The pod assignments saved a lot of steps for the nurses and saved a lot of steps for the physicians as well," says Aufdengarten.

Further, where the ED used to have rooms that were specified for particular types of problems, the team members decided to change the system so that almost any patient can now be brought to any room, notes Ericson. "I think, with time, people are starting to realize to some degree that the way we always did things doesn't have to be the way we always do them," she says. "But it has taken time."

Ponce agrees, but despite some initial resistance to the process changes, he sees clear evidence of improved efficiency in the department, including lower noise levels and enhanced

cooperation. "It is more of a team effort from all areas," he says. "I am less tired by having less wasted motion during my shift. Similarly, I can say that when this works smoothly, there is a sense from the nurses with whom I am working that they [feel] they are taking care of the patients in a more satisfactory fashion rather than feeling that they are rushed to do things at a time when mistakes could be made and safety could be compromised."

Refine improvement process

While refinements continue on the front end of the process, administrators are now also applying the lean approach to other areas that need work. For example, Drennan observes that while the ED has a good process in place for handling expected volume, an improvement team has now been tasked with developing a better approach for handling unexpected patient surges. "The other day, by 7 a.m. all of our rooms were full. And it was on a day in the middle of the week when there is normally low volume, so we weren't staffed for that," he says. "We don't have a method to allow us to bring in additional staffing or to respond quickly to that sort of a spike, so that will definitely be [the target] of one of our next [kaizen] events. And we have found that this is not just a problem in the ED, but throughout the hospital."

Another issue affecting the ED but requiring hospital-wide attention is a painfully slow process for admitting patients to the hospital from the ED. Drennan has already staged a second kaizen event to identify opportunities to improve this process. "We were trying to figure out how to get patients from the ED up to the inpatient units faster, so that was one side of the equation because we were focusing a lot on the ED," he explains. "But the other side of the equation was nurses on the inpatient units who were frustrated with how laborious the inpatient process was themselves, so we actually came at it from two different sides."

It is too early to report outcomes from this program, but Drennan notes that early indications are that the improvement team members involved with this process will be able to deliver the same types of gains as the earlier effort. Further, the more hospital administrators and staff work with lean-driven methods, they are becoming more adept at using the process, he adds.

Be inclusive, narrow focus

For example, one of the lessons learned from the first effort is that it is important to insure that there is strong staff nurse representation on the improvement team. Aufdengarten praises the contributions of Ericson, who served as the sole staff nurse on the first improvement team, but he suggests that she would have had an easier job selling the proposed changes to her colleagues if more of them had been included on the team. "She did a spectacular job of communicating with the nurses in the department, but there would have been a multiplier effect [if she had had help from other nurses]," he says.

Drennan agrees with this point. "If we had had another nurse or two on the team, I don't know that we would have necessarily come up with a different plan, but I think that it would have been easier for the nursing staff to accept the changes," he says.

Nonetheless, participating in the process had a motivating influence on Ericson. "You sort of own it, so you become part of it," she says. "I do believe that the more staff you have involved, the more they will buy in, and the more they will get behind it."

Aufdengarten advises colleagues interested in using a similar process to drive improvement to narrow their focus to one area to start. "We didn't look at throughput or the outcomes part because you can't address it all at one time," he says. "But you will become more aware of the barriers to change [in your organization], whether they are [related to] equipment, processes, or people."

A primary key to eventual success is support from the organization's leaders, stresses Drennan. "If the top person doesn't buy into it, the effort will falter," he says, noting that hospital executives at North Adams made it clear to all staff that change was coming, and that they needed to adapt or leave. "That was a tough message for some people to receive, but it was received." ■

SOURCES

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Management Tip

When implementing lean-driven solutions, have a plan in place for staff communication

Hospitals employing lean techniques for process improvement often use "kaizen" events, where front-line personnel get together and identify wasteful practices or other problems, and then devise proposed solutions. However, key to making any changes stick is a good mechanism for communication and enforcement of these changes to the rest of the staff, according to **Brent Drennan**, MBA, the director of lean transformation at North Adams Regional Hospital in North Adams, MA.

Drennan advises that the way a lean improvement team at his hospital communicated changes to the ED's triage process that were devised during a kaizen event was by having a staff nurse who participated in the event take charge of making sure her colleagues were thoroughly apprised of what was expected of them when the changes went live. "She worked the first day of the experiment, not as a nurse but as a coach for the charge nurse and the pod nurses to get them through this," he explains. "She came in and worked with every shift and communicated the message to them over several days."

A similar approach was employed with the physicians, says Drennan, and the changes have now become part of the ED's standard operating procedures. ■

New program set to intervene to prevent readmissions, repeat ED visits due to acute exacerbations of asthma

Program is first to apply community paramedicine to pediatric population

As health care reform continues to unfold and performance-based payment models make more headway, emergency providers are pushing the boundaries beyond what the market has traditionally expected from this field of expertise. The latest example of this is taking place in Indianapolis, where emergency medicine faculty at Indiana University School of Medicine (IUSOM) hope to improve the way asthma is managed in children through the use of a community paramedicine program.

Under the program, dubbed Treat the Streets: Pre-Hospital Pediatric Asthma Intervention Model to Improve Child Health Outcomes, children who have either visited the ED or been

EXECUTIVE SUMMARY

Faculty at Indiana University School of Medicine are set to launch a community paramedicine program aimed at preventing repeat hospital and ED visits for acute exacerbations of asthma in children. Under the program, all children who are treated in the hospital or ED for asthma will receive home visits by specially trained paramedics within a few days of discharge. Paramedics will conduct a comprehensive assessment and make referrals as necessary for follow-up care.

- Nearly 30% of children who have been hospitalized for asthma require readmission to the hospital not long after discharge, and as many as 25% of children who have been treated in the ED for asthma will return to the ED within 30 days for another asthma-related visit.
- The one-time home visits will be comprehensive, enabling EMS providers to initiate stop-gap measures so that if a child is starting to get sick, paramedics can make sure the appropriate medicines are started and that acute care needs are met.
- Developers will monitor 30-day, 90-day, and one-year readmission metrics among patients who have received home visits. They hope that resulting cost-savings will sustain the program beyond the initial period, which is being funded through a grant from the Department of Health and Human Services.

admitted to the hospital for asthma will receive home visits by specially trained paramedics who will be empowered to assess for potential triggers in the environment and make any needed referrals for social services or medical follow-up. The idea is to improve outcomes and reduce recidivism among this highly vulnerable population.

There is plenty of room for improvement. Statistics show that nearly 30% of children who have been hospitalized for asthma require readmission to the hospital not long after discharge, and as many as 25% of children who have been treated in the ED for asthma will return to the ED within 30 days for another asthma-related visit. Further, experts say that asthma is one of the leading causes for ED visits among children.

While Treat the Streets is narrowly focused on a single county in Indiana, and it specifically targets asthma-related admissions or ED visits to Riley Hospital for Children in Indianapolis, developers hope to create a model than can effectively be deployed to improve outcomes and cut costs in many other communities across the country.

Consider the home environment

Elizabeth Weinstein, MD, FAAEM, FACEP, FAAP, assistant professor of clinical pediatrics and emergency medicine at IUSOM and deputy medical director of pediatrics at Indianapolis EMS, observes that emergency medicine providers have a vested interested in how the health care infrastructure cares for children with asthma. "We are the place where people go when they are having an acute event, so we catch a lot of these kids as they enter the system," she says. "More importantly, we are situated at a place where we can intervene in ways which may prevent them from having relapses or a failure to complete the course of therapy that they need to get better."

Weinstein, who is a co-investigator for Treat the Streets, explains that the approach is based, in part, on years of research on how to make a difference with the pediatric asthma population. "There have been a lot of different interventions to try and reduce the [recidivism] rate, and the ones that seem to have the most impact are those that get into the home and into the environment of the family, and work with the families through the barriers that they have," she explains.

Weinstein emphasizes that it is not just a matter of telling children to take their medicine. Many families struggle to pay for the medicine or to even pick up the medicine regularly at the pharmacy. Learning how to administer the medicine correctly is likewise a challenge in asthma care. "There is also the issue of reducing a child's exposure to triggers, which may include smoking or cockroaches or mold in the home," she says.

Establish a curriculum

Leveraging paramedics or pre-hospital providers in a more proactive community health role is not unique; the approach was developed in Minnesota and has been used in the western mountain states, explains **Andrew Stevens**, MD, the principal investigator for Treat the Streets, an assistant professor of emergency medicine, and medical director of paramedic sciences at IUSOM. But he believes this is the first time the approach has been used in an urban setting to address pediatric asthma. "We took what has been a movement in the last five years to use paramedics in a different way, and came up with a novel program that really applied to us here in Indianapolis," he says.

In fact, another community health program that uses paramedics to help prevent readmissions among adult patients with congestive heart failure (CHF) is already ongoing in Indianapolis, so the new program has a ready source of seasoned paramedics who are accustomed to this type of role, says Stevens. Further, since a paramedic training curriculum is already in place for the CHF program, developers have a vehicle they can use to train paramedics for the asthma program.

"What we are doing is adding to the curriculum that we already have for [the CHF] program," says Stevens. While paramedics are already equipped with the training to monitor and treat asthma so that it does not become life-threatening, the new content includes aspects of pediatric social work, pediatric public health, pediatric environmental care, and the basics of medicine in pediatric respiratory disease related to asthma. "We have broken [the information] down into a month and a half of a fully enveloped, hands-on curriculum that tries to be all encompassing from all of those different disciplines. It is basically an advanced practice curriculum for [the paramedics]," he adds.

To handle the demands of both the CHF and the asthma programs, three paramedics have been tapped to serve as full-time community

medicine paramedics. "The expectation is that this will become part of their career experience, and that it will allow them to do this job while also still functioning as street-level paramedics," says Stevens.

Establish comprehensive home visits

When Treat the Streets debuts, first as a three-month pilot in January of 2014 with full implementation of the program to follow in the spring, any visit by a child to the ED or the hospital for an acute asthma exacerbation will be a trigger for a follow-up home visit by one of the community medicine paramedics. At least initially, the prompt for these visits will be manual, explains Weinstein. "We have people working on this everywhere. We have several people situated with EMS, and several people at Riley Hospital — both in the ED and within the division of pulmonology," she says. "Their social workers are on board, and their nurses are on board, so by the time we launch this out into the community, there will be a streamlined process for manual triggering [of the home visits] as soon as kids are admitted."

The home visits will be put on the calendar before patients leave the hospital, and discharge planners will endeavor to schedule the visits within a few days of the hospital visit. "The intention is that this will be a one-time home visit, that the visit will be comprehensive, and that it will enable the EMS provider to initiate stop-gap measures so that if a child is starting to get sick, he or she can make sure the appropriate medicines are started and that the acute care needs are met," says Weinstein. "But [the intention] is also to identify ongoing issues, and then activate appropriate referrals for continued management and care, so public health nursing might be one thing that is triggered by that home visit."

As part of their training, the paramedics will be equipped with resources that they can tap into for specific problems or issues. For example, if paramedics find that there is a cockroach infestation in the home, they will have a specific number they can call to arrange for removal of that infestation, explains Stevens. Similarly, paramedics can take steps to link families with a primary care provider or a high-risk asthma clinic for follow-up. "They can make decisions, and they have the ability to do any necessary medical interventions or basic pharmacology," he says.

Monitor utilization, qualitative factors

Information gathered during the home visits will go toward the construction of an asthma registry that will provide better insight into the barriers that prevent families from achieving more effective asthma control, says Stevens. In addition, he stresses that investigators will be keeping a close eye on 30-day, 90-day, and one-year readmission metrics. While utilization statistics are most important, investigators will also monitor qualitative measures related to parental and family satisfaction with the intervention, and provider approval as well.

Treat the Streets is being funded with an $899,700 grant that IUSOM's Emergency Medicine Division of Out of Hospital Care received from the U.S. Department of Health and Human Services in Washington, DC. However, Stevens is hopeful that the program will be sustained over the long term with payment reforms that move away from fee-for-service models.

"I feel that with these kinds of programs hospitals are starting to buy into [the concept] of accountable care organizations and [payment models based on] episodes-of-care," says Stevens.

With the risks posed by bounce-back admissions, programs like Treat the Streets may be viewed as a way to reduce utilization or to identify ongoing risk factors, he says.

Perhaps boosting the program's chances for success is the fact that participating groups are already pretty well integrated, observes Stevens. "We have a unique partnership in that the EMS system is part of the city/county government, which is also very intertwined with the [Indiana University] School of Medicine, IU Health, and the county health system." ■

SOURCES

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ED Coding Update

A closer look at the two-midnight rule, what it means for ED providers

[This quarterly column is written by ***Caral Edelberg****, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates, Baton Rouge, LA.]*

Soon we will have the final coding and payment changes for Medicare locked in, so it promises to be a long winter. There are a number of worrisome changes affecting emergency medicine, which we will discuss in future columns. This month we will describe one that will redefine admission criteria and payment for hospital inpatient stays. Effective October 1, the implementation period began for defining hospital admissions as those that cross over two midnights, with specifications for admission that will assure the following are met:

• Admission must be supported by a documented order in the medical record and supported by admission and progress notes. The order for inpatient admission certifies the medical necessity for admission. The order must be provided at the time of or before the time of the admission. If admission for a surgical procedure is not included in the "inpatient only" procedure list, a diagnostic test or any other treatment, the physician must expect the admission to cross over two midnights or it will be deemed inappropriate for admission regardless of the time the patient came to the hospital or the length of time the patient used a bed.

• Appropriateness of admission should be based on: (a) patient history and comorbidities; (b) severity of signs and symptoms; (c) current medical needs and risk of an adverse event. All must be documented in the medical record. If an unforeseen circumstance, such as beneficiary's death or transfer, results in a shorter stay than the initial expectation of at least two midnights, the patient may be considered appropriately treated. Patients admitted with the expectation of a two-midnight stay that leave against medical advice would still be considered an appropriate admission.

The starting point for the two-midnight benchmark is when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services are provided. Also to be considered, are factors that may result in an inconvenience to a beneficiary or family, and would not justify an inpatient hospital admission. Admission assumes the factors leading to admit will be based on "clinical expectation, and are significant clinical considerations which must be clearly and completely documented in the medical record."

Timing of the admission may be critical to the appropriateness of the admission. The decision to admit should be based on the cumulative time spent at the hospital, beginning with the initial outpatient service. Thus, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay.

For example, if the patient has already passed one midnight as an outpatient observation patient or in routine recovery following outpatient surgery, the physicians should consider the two-midnight benchmark met if the patient is expected to require an additional midnight in the hospital. This anticipates that the patient would not spend a second midnight prior to writing the admission order.

Medicare expects this revision to "virtually eliminate the use of extended observation" and to limit beneficiary cost-sharing for outpatient services. Outpatient services often carry higher co-pays than inpatient services, so this rule is expected to reduce patient expenditures. Further, Medicare charges patients for utilization days. A patient who is admitted just before midnight and discharged three hours later is currently charged two utilization days, while the patient admitted just after midnight is charged one day. Medicare

COMING IN FUTURE MONTHS

- Concussion care in the ED
- What really works for reducing unnecessary ED utilization
- ED-based interventions for prescription drug abuse
- Screening for hepatitis C in the ED

believes that the two-midnight concept will simplify the concept for its beneficiaries in assessing the appropriateness of their status, coverage, and the impact.

Condition Code 44

When a patient status is changed from inpatient to outpatient following utilization review and after the patient has been admitted, condition code 44 must be affixed to the claim form to indicate that the patient status was changed and approved by the admitting physician. As this has always applied to the unexpected change of patient status following utilization review, Medicare holds that patients who are appropriately admitted with the two-midnight expectation would not require conversion to outpatient. Rather, the patient would remain an inpatient with the expectation that the admission was appropriate and the patient unexpectedly improved and was discharged, not changed in status from inpatient to outpatient.

Medicare proposes that all hospitals, long-term care facilities and critical access hospitals, with the exception of inpatient rehabilitation facilities, will be included in the final policies for two-midnight admission.

Medicare has addressed the expectations for medical review following implementation of the two-midnight rule by establishing medical review policies: (1) a two-midnight presumption; and (2) a two-midnight benchmark. Under the presumption, claims with lengths of stay greater than two midnights after formal admission will be considered appropriate and will not be the focus of medical review unless evidence indicates inappropriate gaming, abuse, or delays to exceed the two-midnight threshold. Medical review will focus on inpatient stays that do not meet the two-midnight threshold. In these cases, documentation must support why the decision was made to admit the patient and why the patient was deemed medically fit to be discharged prior to the second midnight.

Issues Related to ED Boarding

Specific to the emergency department, patients who are "boarded" in the ED until a bed becomes available after the admission order has been written present a special problem. The expectation is that the ordering physician may consider time the beneficiary spent receiving outpatient services (including observation, treatments in the ED, and procedures provided in the operating room or other treatment area) for purposes of determining whether or not the two-midnight benchmark is expected to be met; thus, inpatient admission is generally appropriate.

The starting point for medical review purposes will be from the time the patient starts receiving any services after arrival to the hospital, including the ED. However, the time prior to admission is not considered part of the admission stay, but will be considered for determining whether or not the patient should be admitted. An important consideration is if the physician is unable to make an evaluation and expectation of length of stay when the patient presents for treatment, it is appropriate to monitor the patient in observation or continue to perform diagnostics in the outpatient area.

If patient condition after one midnight as an outpatient dictate the need for an additional midnight receiving medically necessary care, the physician may consider the case in the outpatient setting when making the admission decision. Medicare review contractors would apply the two-midnight benchmark for all time spent within the hospital in evaluation of the claim. Hospitals can expect prepayment audits of 10-25 claims to determine appropriateness of billing.

Of note, based on actuarial data from FY 2009-2011 claims data, "Medicare expects approximately 400,000 encounters would shift from outpatient to inpatient, and approximately 360,000 encounters would shift from inpatient to outpatient, resulting in a net reduction of 40,000 outpatient encounters." ■

CNE/CME QUESTIONS

1. According to **Timothy Peterson**, MD, newly deployed ED-based care managers will first focus their attention on:
A. patients with mental health care needs
B. patients who require home health care
C. patients on observation
D. all of the above

2. Peterson also states that the ED-based care managers will be tasked with:
A. assessing every patient who walks through the ED door
B. identifying cases at triage
C. finding ways to assist ED physicians
D. eliminating the need for follow-up visits

3. What takes place during quick triage, the second stage of the newly redesigned triage process at North Adams Regional Hospital in North Adams, MA?
A. A nurse will conduct a thorough medical history.
B. A nurse will ask the patient for his/her name and chief complaint.
C. A nurse will retrieve what she or he considers to be critical information for the physician.
D. The physician will begin examining the patient.

4. According to **John Aufdengarten**, RN, MSN, MBA, dividing the ED into pods:
A. saves a lot of steps for physicians and nurses
B. provides physicians and nurses with more clarity
C. eases congestion during patient surges
D. makes the ED care process less confusing for patients

5. The idea behind "Treat the Streets," a community paramedicine program in Indianapolis, IN, is to:
A. improve outcomes and reduce recidivism among children with asthma
B. help families learn how to manage asthma
C. reach disadvantaged children with asthma care
D. connect families with asthma specialists

6. According to **Elizabeth Weinstein**, MD, FAAEM, FACEP, FAAP, research shows that interventions that have the most impact on children who have asthma are those that:
A. are managed by hospital systems
B. get into the home and family environment
C. utilize paramedics
D. include patient education and provider resources

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Prepare for enhanced scrutiny on infection control as regulators clamp down on unsafe practices related to health care-associated infections

Forget about skimping on infection-control resources, say experts

Regulatory agencies have put hospitals on notice that infection control will be a high-priority item in the coming months. The Centers for Medicare and Medicaid Service (CMS) has indicated on numerous occasions that it intends to make unannounced visits to inspect for infection-control practices, and there is a long list of potential pitfalls that can leave facilities financially vulnerable and put patients at risk.

While it is not clear what inspectors will be looking for during these visits, a good guess is that they will rely on CMS' revised worksheet on infection control, a 42-page document that reflects new requirements in the agency's interpretive guidelines, as well as issues of importance to accrediting agencies such as The Joint Commission (TJC), according to **Sue Dill Calloway**, CPHRM, CCMSCP, BSN, MSN, JD, president, Patient Safety and Healthcare Consulting and Education, in Dublin, Ohio. Calloway often delivers presentations to health care professionals on regulatory issues and standards. *(For more information on the survey and certification process, see www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOFPage.)*

Calloway advises hospital administrators to establish a committee to review the worksheet and to perform mandatory education for every nurse in the hospital about the different tracers involved. "I would also make sure that the infection preventionist (IP) on the committee is up to speed on all this," she says. "Infection preventionist" is a new term that CMS uses to refer to infection-control professionals.

EXECUTIVE SUMMARY

Government regulators are stepping up efforts to reduce harm from health care-associated infections (HAI) in 2014. This is expected to include unannounced visits to hospitals by inspectors from the Centers for Medicare and Medicaid Services (CMS). Experts recommend that hospitals prepare for such visits by thoroughly reviewing the agency's revised worksheet for infection control, which reflects the latest guidelines and revisions. Further, administrators need to insure that staff are adhering to core best practices.

- The Centers for Disease Control (CDC) says there are 1.7 million HAI every year, resulting in 99,000 to 100,000 deaths.
- The Department of Health and Human Services has devoted $1 billion toward cracking down on the problem in 2014. As a result, hospitals should expect surveyors who are more knowledgeable about infection control than in the past.
- ED administrators need to pay particular attention to the CDC's Guide to Infection Prevention for Outpatient Settings.

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Prepare for better-informed surveyors

There is good reason for the hypervigilance around infection control. Calloway points to statistics from the Centers for Disease Control (CDC) showing that there are 1.7 million health care-associated confections (HAI) every year, resulting in 99,000 to 100,000 deaths.

The Department of Health and Human Services has devoted $1 billion toward cracking down on the problem in 2013, says Calloway. As a result, hospitals should expect surveyors who are more knowledgeable than in the past, she says. "Infection control is one of the key areas that people should focus on. And the thing is, if you don't do it right, it can cost hospitals money," she says.

"If I have open heart surgery and I get a wound infection, CMS will not pay for that, if I am a Medicare patient. If I have knee surgery and I develop an infection, they are not going to pay for that either," she says. "It used to be completely the opposite. It used to be if I had pneumonia, they would pay for that, and then if I developed a central line infection, they would pay for that, so there was no financial incentive to do anything different. Now there is because [CMS] is simply not going to pay. You are going to eat that cost."

While some hospitals have been known to provide scant resources to infection control departments, Calloway advises that it is definitely time for a change in strategy. "My advice is to have enough FTEs [full time employees] to do infection control," she stresses. "In the past, hospitals didn't see this as a moneymaker, but now it is a moneymaker."

For example, Calloway recalls the case of one hospital that by state law had to have one IP for every 100 beds. As a result of this law, the hospital had to hire an additional IP when it grew to 215 beds. The results from this extra set of hands were immense, according to Calloway. The lead IP at the facility reported that hand hygiene compliance went from 50% to 74%, the number of urinary tract infections was reduced by half, and central line infections all but disappeared.

Calloway advises hospital administrators to review whether they have enough manpower to effectively handle infection control, and to make sure the employees taking charge of this responsibility are appropriately qualified to do the job. They also need to be equipped with ongoing training to keep them abreast of new threats, guidance, and techniques, she adds.

Rely on core practices

Calloway notes that ED administrators need to pay particular attention to the CDC Guide to Infection Prevention for Outpatient Settings (www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html). The CDC also provides an infection-control checklist designed for providers in outpatient settings (www.cdc.gov/HAI/settings/outpatient/outpatient-settings.html?source=govdelivery).

While there are unique challenges in the emergency setting, **Ruth Carrico**, PhD, FSHEA, RN, CIC, an associate professor in the Division of Infectious Diseases at the University of Louisville in Louisville, KY, stresses that administrators need to rely on many of the same core practices that are important to all health care settings. These include everything from good hand hygiene and employing safe injection practices to appropriate staff education, administrative support, and performance monitoring.

"I think sometimes we get caught up in trying to be more and more sophisticated in our approach, and in doing that we sometimes move away from those basic practices that are non-negotiable that have to be in place every day, every time we touch a patient," notes Carrico. "What we keep finding is that repeatedly when we have failures in infection prevention, it is because the breaches were of a basic nature."

When staff members fail to comply with basic infection-control practices, a key question for administrators to determine is whether the individuals involved couldn't perform as expected for some reason or they simply refused to do so. "In my experience, the people who won't perform and won't adhere to best practices related to hand hygiene are the same people who don't adhere to best practices with regard to other aspects," says Carrico. "These are people who I don't want on my care team. Not everyone is cut out to be a health care worker, so maybe this is not the best job for them." ■

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The Joint Commission aims for high-reliability health care, unveils framework to move hospitals toward zero harm

Developers cite transparency in error reporting as key to progress

EXECUTIVE SUMMARY

To move hospitals toward what it terms high-reliability, The Joint Commission (TJC) is urging administrators to use a framework that it has developed to push their organizations through stages of maturity, ultimately creating environments in which there is zero patient harm. To get to this point, TJC leaders say hospitals will have to commit to transparency, promote and reward error reporting, and seize upon opportunities to improve.

- The Joint Commission has tested its high-reliability framework in seven hospitals, and it is now working on an assessment tool that will enable hospitals to measure their level of maturity across the framework's 14 components.
- The accrediting agency is urging hospitals to use a combination of Six Sigma, lean, and change management to make improvements that can be sustained.
- At some hospitals, entrenched practices of intimidation are dissuading staff from reporting unsafe practices and interfering with quality improvement efforts, according to TJC.

Far from content with the way things stand in terms of patient safety, The Joint Commission (TJC) is urging hospital administrators and providers alike to set much more ambitious goals, and to make the necessary changes to move their organizations toward what TJC refers to as high-reliability health care.

In a lengthy and detailed article published in *The Milbank Quarterly*, TJC leaders propose a framework that hospitals can use to progress from what the authors describe as the beginning stages of organizational maturity to the point at which these organizations approach high reliability, where there is zero patient harm.[1] *(Also, visit TJC's website to download the article in full at http://www.jointcommission.org/high-reliability_health_care_getting_there_from_here/.)*

The accrediting agency has already tested its high-reliability framework in seven hospitals, and it is now working on an assessment tool to enable hospitals to measure their level of maturity across the framework's 14 components. However, while the work continues, TJC leaders are encouraging hospitals to use the framework to push for improvements.

"The model is now public … and it is pretty descriptive about the things hospitals ought to do, from the board commitment to how physicians are engaged," explains **Charles Mowll**, MPH, FACHE, executive vice president at TJC.

In particular, Mowll stresses how important it is for hospitals to be willing to share their quality improvement indicators, and to encourage staff to come forward with reports of adverse events or safety challenges. "Exemplar organizations are more and more transparent about how they publish these results among the physicians and staff in the hospital, but also in terms of sharing these results with the public," he says.

This is a big hurdle, given that health care safety experts maintain that errors, sentinel events, and other problems are severely under-reported. However, Mowll emphasizes that there are pockets of excellence in this area. "There are a number of hospitals around the country that have figured this out, and created a safety culture … that really stimulates, encourages, and facilitates the active reporting of events," he says.

Encourage, reward reporting

As an example, Mowll points to Nationwide Children's Hospital in Columbus, OH, which posts on its website the progress it has made in decreasing the number of serious safety events that have occurred in its facilities. "There is a growing number of hospitals that are creating this culture, recognizing that there are ways to report events and maintain the confidentiality of the patients and caregivers while still learning from the events so that you are making sure that the events don't recur."

A big piece of the solution, according to Mowll, is having senior leaders who are willing not only to encourage reporting, but also to take immediate action on proven opportunities for improvement. "If you don't come back to the staff and thank them for

reporting [an error or safety problem] … and you don't take action on putting an improvement in place, then the staff is probably going to give up, concluding that they have known about this problem for years and no one ever does anything about it."

There are certain entrenched behaviors that are preventing some hospitals from making more progress toward high reliability, according to TJC. In particular, the authors of *The Milbank Quarterly* article describe practices of intimidation that can dissuade or prevent hospital staff from speaking up when there is a problem. "Changing culture is about changing the attitudes, beliefs, and behaviors of the folks on the front lines of health care," says Mowll. "And it is very hard to change behaviors if one or more of the teammates on the care team are constantly exhibiting intimidating or disruptive behaviors."

This can include everything from not returning a call to yelling, screaming, or even throwing instruments, explains Mowll. "This is about everyone on the team showing respect to each other, and just like the flight crew on an airplane, being able to question each other about an unsafe condition," he says.

Leverage quality-improvement tools

Specific quality-improvement tools can help hospitals move toward high reliability, according to TJC. In particular, the organization is urging administrators to use a combination of Six Sigma, lean, and change management — a group of strategies TJC refers to as robust process improvement.

"Lean is a methodology that eliminates waste from a process. Six Sigma is really a set of tools to improve a process — to look at the defects and inefficiencies in a process and improve it in a robust way, with much more sustainable results than with some of the less rigorous methods that hospitals have used in the past," explains Mowll.

When hospitals have a problem, they have a tendency to resort to putting people in a room to come up with a quick solution, and sometimes that works, says Mowll. "However, most of our problems in health care haven't been resolved by using these less sophisticated improvement methods," he observes. "I think what we have proven here at The Joint Commission, and what several other organizations have proven, is that if you use a combination of lean, Six Sigma, and change management, then your results are going to be better and more sustainable over time."

Why hasn't health care reached the same level of high reliability as other industries such as aviation or manufacturing? "One of the reasons is because adverse events tend to happen one at a time in the hospital setting; the impact of a jetliner crashing is much different," observes Mowll. "If the American public was more highly aware of the level of harm that hospitals are collectively doing, I think there would be a much louder public outcry about the level of safety in American hospitals."

Further, while health care reform will force hospitals to pay closer attention to many types of errors that can cause harm, Mowll laments the need for such legislation. "We should have found better solutions long before this," he says. "But absent good health care solutions, legislation kicks in to prevent HAIs [health care-acquired infections], preventable readmissions, and on and on." ■

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