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INSIDE

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With strengthened guidelines for health care workers, the CDC ups its game against the deadly Ebola virus

Nursing organizations collaborate to identify gaps, make system improvements

As the Centers for Disease Control and Prevention (CDC) scrambles to get in front of the fast-moving Ebola crisis with strengthened guidance for health care workers and a new dedicated response team, there is no question that hospitals are on edge. The fervently reported missteps in Dallas, where two health care workers contracted the disease

EXECUTIVE SUMMARY

Informed by the cases of two nurses who contracted Ebola virus disease (EVD) while caring for a patient with the disease in Dallas, TX, the Centers for Disease Control and Prevention (CDC) in Atlanta, GA, has unveiled strengthened guidance for health care workers. Further, nursing organizations are pledging to work together to identify gaps and make system-level improvements to protect both patients and caregivers.

- The CDC's new recommendations emphasize rigorous training for health care workers in how to put on and take off personal protective equipment (PPE), and they state that this activity should always be carefully supervised by a monitor.
- The guidance also states that health care workers should use either an N-95 respirator mask or a powered air purifying respirator (PAPR) when they are providing care to a patient with Ebola.
- Experts stress that the new guidance does not change the fundamental issue that Ebola is transmitted through contact with infectious substances from patients.
- Nursing organizations are pledging to work together to identify problems and improve safety for both caregivers and patients.

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while caring for a patient with Ebola virus disease (EVD), have clearly highlighted kinks in this country's fragmented health care system. Further, some experts are questioning whether the country is really prepared to deal with an epidemic of infectious disease, let alone a handful of cases. However, it is also clear that these unfortunate early experiences with the first EVD cases to be diagnosed in this country have gotten the attention of everyone who works on the front lines in health care — especially ED leaders and the many layers of diverse personnel that keep patients moving through the system. (Also see: "State, local authorities in the driver's seat for much of the Ebola response," p. 136.)

More protection, training urged

The CDC's new updated guidance for health care workers regarding personal protective equipment (PPE) emphasizes three core principles:

- health care workers need to undergo rigorous training on how to put on and take off PPE;
- there should be no skin exposed when PPE is worn;
- all workers need to be supervised by a trained monitor whenever PPE is put on or taken off. (See full updated guidelines on the use of PPE equipment here: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html.)

While the appropriate use of PPE is critically important, it is only one aspect of preventing the spread of EVD, according to **Arjun Srinivasan**, MD, the associate director of health care-associated infection prevention programs at the CDC.

"We have all recognized this fact. It is the [aspect] that tends to get attention because it is something that is visible that people can see," said Srinivasan, when speaking about the new guidance during a webinar sponsored by the *New England Journal of Medicine* on October 22. "But there are other aspects of infection control — including aggressive screening and evaluation, and then appropriate disinfection — that are also critically important to preventing the spread of Ebola."

Srinivasan emphasized that the CDC's recommended infection-control strategies for preventing the spread of Ebola are based on the "fundamental issue" that Ebola is transmitted through contact with infectious substances from patients. However, he also acknowledged that the earlier guidance needed to be amended based on the initial early experiences that providers have had in caring for patients with Ebola in the United States.

"It is important to note the previous guidance that the CDC had issued for the care of patients with Ebola in the U.S. was based exclusively on experience — albeit extensive experience — from groups like Medicins Sans Frontieres, Doctors Without Borders, and with CDC experience in dealing with Ebola, and all of that experience had come from Africa," said Srinivasan. "We had not cared for a patient with Ebola in the U.S. As has been pointed out, we now do have some degree of clinical experience managing patients with Ebola in the United States, and we thought there was a need to update the guidance with that clinical experience."

Use N-95 or PAPR respirators

One notable change in the new guidance deals with the type of respiratory protection that the CDC is recommending. "The new guidance recommends that health care workers use either an N-95 [respirator] mask or a powered air purifying respirator (PAPR) when they are providing care to a patient with Ebola," explains Srinivasan. "This recommendation is not because we think the route of Ebola transmission has changed. Ebola is not spread through an airborne route. However, we understand from some of the experts we have been consulting in the U.S. that there are times when the level of care and the need to perform an aerosol-generating procedure in a patient with Ebola might change unexpectedly, and there may be some need to do something that could generate an aerosol."

The thinking behind this more stringent standard is that health care workers shouldn't have to leave the room of an Ebola patient they are caring for to put on the proper equipment to perform a needed procedure, noted Srinivasan. "We need them to be prepared for the potential for aerosol generation at all times, and that is why we have gone this route. It is an issue of preparation."

Srinivasan added that the specialized bio-containment unit at the University of Nebraska has been utilizing N-95 respirators, and the specialized unit at Emory University has been using PAPRs. "There is successful experience with providing safe care using either one of these types of protection," he said.

Another change in the new guidelines is that during the removal of PPE, the CDC is now recommending steps to provide for the disinfection of any visibly contaminated PPE or gloves. This is to further increase the margin of safety, said Srinivasan.

The safe utilization of PPE is so important that the CDC is emphasizing that health care workers need to be trained carefully on the proper procedures before they take care of any patients with Ebola, and they need to practice those procedures until they are confident in them, stressed Srinivasan.

"Training on the use of PPE is not something that we have focused on previously in U.S. hospitals," emphasized Srinivasan, noting that even he hasn't received this kind of formal training even though he is an infectious disease specialist. "We need to do more to train personnel on how to directly use PPE, and these guidelines highlight that fact."

Prioritize screening

While some regions have quickly moved toward a strategy of designating specific centers that are best equipped to care for patients with Ebola, Srinivasan stated that all hospitals have to be prepared to evaluate a patient with potential Ebola and to provide immediate care. "We don't know where a patient with Ebola might present for care or what hospital he might present to in the U.S.," he observed. "But we also believe that it may be preferable to have a smaller number of hospitals that are providing the full course of treatment for Ebola — hospitals that are well-equipped and well-prepared to provide the full and very complex course of care for a patient with Ebola."

There are still many challenges and unanswered questions, acknowledged Srinivasan. "One of the big ones is how we manage and handle the evaluation of suspect cases in the ED setting and, even more challenging perhaps, in the outpatient setting," he said. (*See CDC algorithm for managing patients with suspected Ebola in the emergency setting, p. 137.*)

However, Srinivasan added that in more than 400 instances where the CDC has been called upon to work through an evaluation of a suspected case of EVD, the disease has been ruled out in the vast majority of cases, with testing required in fewer than 10% of these patients. Further, in the cases that required a test, only one case — the index case involving a man from Liberia, Thomas Eric Duncan — turned up positive, he noted.

Duncan later died from the disease at Texas Health Presbyterian Hospital in Dallas, TX. Two of the nurses who cared for Duncan contracted EVD, but have since recovered from the disease. Also, an American physician who spent time in West Africa caring for Ebola patients before returning to the United States has since been diagnosed with EVD and is undergoing treatment at Bellevue Hospital in New York City.

"I think it is important to emphasize that while we need to make sure that there are aggressive screening programs in place, we need to balance our recommendations for PPE during screening with the needs of all of you who are providing frontline care to be able to provide that care effectively," said Srinivasan. "That is something we are working on right now. We are working in partnership with a number of organizations."

Collaborate for improvement

Amid sharp criticism by some nursing unions that hospitals and public health officials aren't doing enough to protect frontline personnel from the risks posed by EVD, three of the nation's largest nursing organizations have pledged to work together to identify problems and improve safety for both caregivers and patients. The Emergency Nurses Association (ENA), the American Association of Critical Care Nurses, and the American Organization of Nurse Executives have committed to collaborate in identifying resources and system gaps that have the potential to harm patients or caregivers, explains **Deena Brecher**, MSN, RN, APN, ACNS-BC, CEN, CPEN, president of the ENA.

"We are actively seeking out information about where we could do better, and we are going to work together as quickly as possible to put solutions in place that will prevent the spread of disease," says Brecher. "We are going to commit to our patients and their families that they will receive excellent care regardless of where they are."

Brecher notes that the ENA website already has a page devoted to EVD. "It is a one-stop shop for resources and information, the current recommendations, and some translation of the CDC information into ED-speak," she says. "We have heard from some of our members that they want a quick and easy resource, so that would be the first place to look. At the same time, we need them to partner with their nursing leadership, their ICU colleagues, and their infection control and infectious disease partners in their hospital and come up with a plan." (See Editor's note below for CDC and ENA resource information.)

Speaking about the missteps in the handling of the first Ebola case in Dallas, TX, Brecher says that there was no single person to blame. "The system failed, and what we need to do is learn from that, see where our own systems in our own hospitals need to be improved, and improve them," she stresses.

Further, Brecher notes that while all clinicians have a professional responsibility to keep themselves informed about new threats or risks, hospitals have a responsibility to provide the appropriate education and training. "We have an opportunity to provide real-time, just-in-time, hands-on training to every nurse who is going to be caring for a patient who could or does have Ebola, and that is something that we probably haven't done before because we weren't faced with something like this," she explains. "This is one of those things that is constantly going to be changing. The more information we get, the more the recommendations are going to change, and the more information we are going to have to safely treat these patients. It is ever-evolving and it is going to continue to evolve because we don't really have an evidence base for this." ■

Editor's note: Visit the CDC's website on Ebola virus disease to access a full range of resources for health care providers: http://www.cdc.gov/vhf/ebola/. Also, access the ENA webpage to find more resources specifically geared to emergency nurses: http://www.ena.org/about/media/ebola/Pages/default.aspx.

SOURCES

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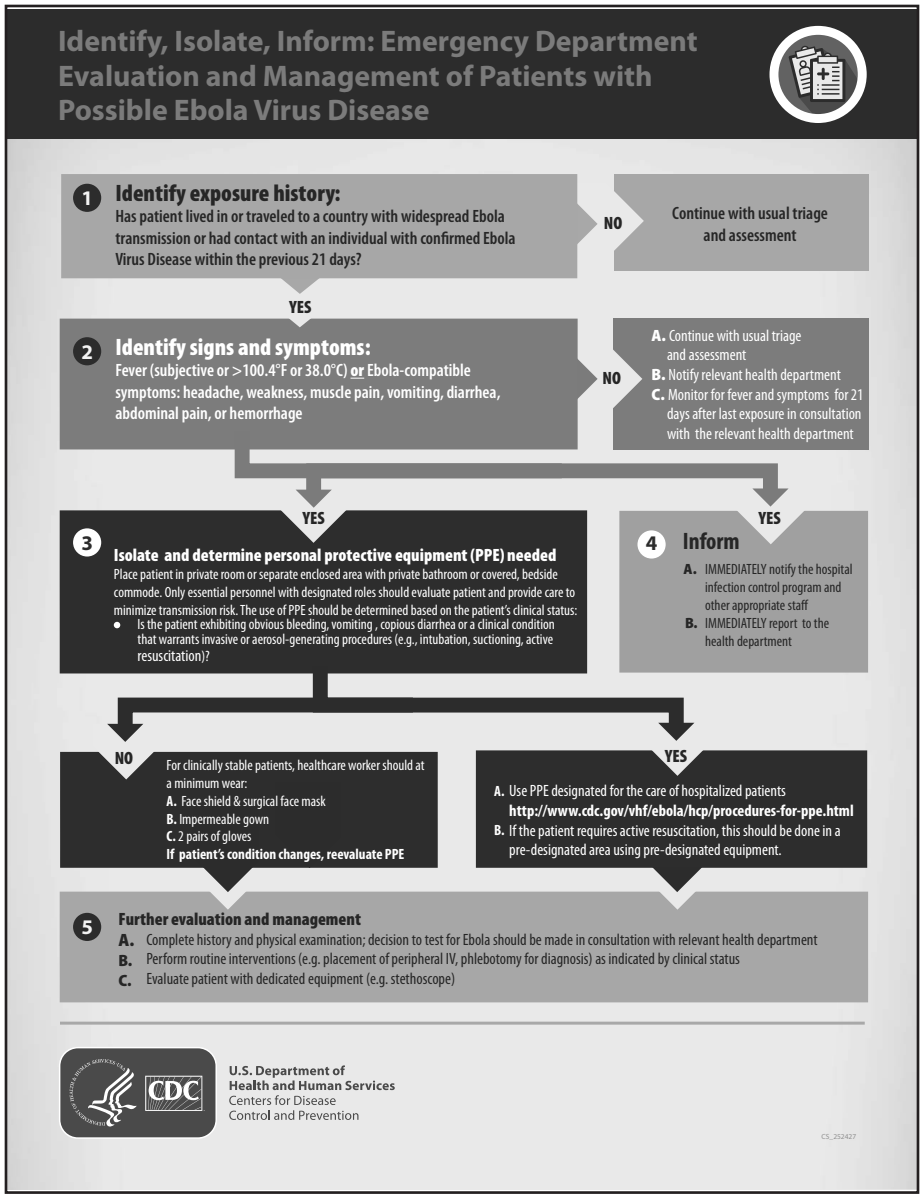
State, local authorities in the driver's seat for much of the Ebola response

When it first became clear that a hospital in Dallas, TX, had initially missed the diagnosis of Ebola virus disease (EVD) in a patient from West Africa, criticism was swift, not only of the hospital, but also of public health authorities such as the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. The heat on federal health agencies grew even more intense when it took days for a clean-up crew to arrive at the patient's home, and for the loved ones of the patient to be relocated to



a safe location while they remained in quarantine for 21 days. However, much of this criticism stemmed from a lack of understanding of how the health system is set up in this country, according to **Mark Rothstein**, JD, director of the Institute for Bioethics, Health Policy and Law at the University of Louisville in Louisville, KY.

"Public health response is mostly a matter of state law," observes Rothstein. "The CDC has limited jurisdiction. It provides guidance, consultation, laboratory services, and other things, but the CDC is limited to preventing the importation of infectious diseases and the interstate spread of infectious diseases. Everything else is the primary responsibility of the state and the localities."

Further, even within a particular region, there is a variety of different players and actors involved with public health response, including EMS personnel, county public health officials, law enforcement, epidemiologists, and others, notes Rothstein. "The thing that the Dallas episode really demonstrated is that it is unfortunately easy to drop the ball, and the consequences can be very grave," he explains. "We need systems in place and redundancies to make sure [these mistakes] don't happen again. And I am not necessarily sure that all of the players nationwide would necessarily do better in the next case, and that is a great concern."

Laws differ from state to state

Emergency personnel have an obligation to identify someone who presents with EVD, isolate the person, and immediately notify public health authorities, but then local and state public health authorities need to take the next steps, explains Rothstein. "They have to engage in contact tracing, perhaps with the help of the CDC; they then need to make sure that people who need to be quarantined are in fact quarantined, and to obtain orders to quarantine if people indicate that they are not going to obey the quarantine," he says.

It is also the responsibility of state or local authorities to arrange for a bio-hazard crew to clean up an area that may put the public at risk, to arrange for the monitoring of people who are under quarantine to ensure that someone who shows signs of having EVD is immediately identified, and to make sure that people who are under quarantine receive needed food, medicine, or other services, explains Rothstein. "There are a lot of details that need to be worked through, but these are not the responsibility of the hospital or the ED after they do those first basic steps," he says.

Still, each state has different laws governing how and when emergency personnel should contact public authorities. "For instance, in some states there is an obligation to report

all gunshot wounds. In every state there is a responsibility to report cases of suspected child abuse. When you get to infectious diseases, the schedule for how soon you have to report them depends on what the disease is," says Rothstein. "With something that is so contagious or where mortality is so high [such as with EVD], immediate notification should be second-nature to emergency folks."

The patchwork of differing state laws has become particularly evident with the range of policies being employed with respect to the quarantining of health care workers returning from West Africa. Some states, including New York, New Jersey, and Connecticut, are requiring 21-day quarantines for all returning health care workers, regardless of whether they have any potential symptoms of EVD. Such policies go well beyond what federal health authorities recommend. In fact, officials are concerned that such policies will discourage health care workers in this country from volunteering their time to fight the epidemic in West Africa, thereby increasing the risk to Americans. Further, health care workers themselves are strongly critical of such measures.

In an effort to make such policies more uniform and consistent with the science regarding EVD, the CDC has unveiled guidance for the "Monitoring and Movement of Persons with Ebola Virus Exposure" that is based on five risk categories, but as Rothstein explains, the agency cannot force states or localities to follow the recommendations. (See CDC's guidance for returning health care workers here: http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html.)

Dallas episode offers lessons

While it is clear that the public health response to the initial case in Dallas was not optimal, other communities can learn from these early missteps. "I am hoping that the experience with the Dallas situation is the alarm bell that other folks around the country are hearing," observes Rothstein. "Sometimes you need something like this to shake the complacency of the system."

The lessons should apply well beyond the current Ebola outbreak, but Rothstein is concerned that the focus on preparedness will fade when the public health risks from EVD in this country subside. "In 2004, my institute and I were asked to do an assessment of the lessons learned from the SARS [Severe Acute Respiratory Syndrome] epidemic, and we concluded that we were just not ready for this. We don't have in place the necessary surge capacity in hospitals," he says. "If we had a pandemic flu situation, which would require many more hospitalizations than Ebola is likely to require, many more people would be needing respirators, and they just weren't there."

During the 2004 exercise, investigators found that hospitals in some other countries had entire floors equipped with beds and equipment that they were not allowed to use unless there was a declaration of an emergency, at which point administrators could just turn on the lights, explains Rothstein.

"We don't have that. We've got lots of hospitals, but they are 70% occupied, so it is not clear that we have all the facilities ready to go, and it's certainly not clear that the needed coordination is in place," says Rothstein. "The greatest challenge of the American health care system is that it is very fragmented and legal responsibility rests with the federal government, the state governments, the county governments, municipal governments, and then in various agencies across the board. It is not always clear who is calling the shots. If we work it out, that would be the best response that we could have to this Dallas episode." ■

Hospitals prepare plans, drill staff to ensure that potential Ebola patients are identified, isolated, and managed safely

Even before the Centers for Disease Control and Prevention (CDC) unveiled its strengthened guidelines on the identification and management of patients with Ebola virus disease (EVD) in mid-October, hospitals around the country were already in drill mode, in some cases trying to play catch-up after events in Dallas, TX, exposed what can happen if a hospital is caught unprepared to safely handle a suspected EVD case. However, even for major academic medical centers that are accustomed to preparing

for large medical emergencies and threats, there has been some added urgency to their EVD preparations.

For instance, on October 17, Ronald Reagan UCLA Medical Center in Los Angeles, CA, held an "Ebola preparedness exercise" designed to test the hospital's policies and procedures for identifying and managing a patient with EVD. "We're working with our Los Angeles Department of Public Health as well, our colleagues at other University of California medical centers, and we are basically critically evaluating all of our protocols and making sure that they are appropriate," explains **Robert Cherry**, MD, chief medical and quality officer at UCLA. "We have only one chance to get this right, so we want to make sure now — while we don't have a patient — that our protocols are effective."

Part of the exercise involved actually going through the process of identifying a patient suspected of having EVD, isolating the patient in a designated room, and deploying protocols for both the safe treatment of this type of patient and the bio-containment of any waste. "We have exceeded the CDC recommendations for personal protective equipment (PPE), and we are trying to really lock down the processes to make sure that all of our patients and staff are as safe as possible," observes **Zachary Rubin**, MD, the medical director of infection prevention at the medical center.

Prepare PPE kits for staff

Another step UCLA took to stay ahead of the outbreak: The hospital prepared PPE kits based on the practices developed at Emory University Hospital, which has thus far had the most experience in this country in caring for patients with EVD. During the Ebola exercise drill, clinicians donned PPE under the watchful eye of a designated safety officer, they transferred the simulated patient with EVD to the ICU, performed the requisite blood tests, and engaged in waste removal activities. Eventually, clinicians removed the PPE — also while being observed by the safety officer to ensure that the PPE was being removed in a way that prevented any opportunities for contamination.

"We know from both [the University of] Nebraska and Emory that they have been able to care for patients safely with appropriate safety gear, and that's exactly what we are trying to do — to make sure that UCLA is prepared in exactly the same way as Emory and Nebraska are," notes **Daniel Uslan**, MD, a UCLA clinical professor of infectious diseases and public health. "The likelihood of us seeing a patient with Ebola at any given hospital in the United States remains very low. It is still a very rare disease … and there has still only been a handful of cases in this country, but the likelihood of us seeing patients who might have Ebola is fairly high, so we want to be prepared because we won't know until tests come back whether a patient truly has Ebola or not. We have to be prepared as if they truly do."

Under UCLA's response plan, health care workers cannot enter or leave an EVD treatment room without a safety officer's approval. Officials say such precautions are in line with both CDC standards and standards set by California's Division of Occupational Safety and Health. Officials add that these are the same precautions that health care workers use when caring for any patient with a potentially infectious disease.

As part of its Ebola preparations, the UCLA Health System has adjusted its medical record system so that a red flag is placed on the electronic medical record [EMR] of any patient who has recently traveled

EXECUTIVE SUMMARY

Hospitals around the country have stepped up their efforts to train staff and implement procedures to ensure the safe identification and management of any patients with signs of Ebola virus disease (EVD). Ronald Reagan UCLA Medical Center in Los Angeles, CA, held an "Ebola preparedness exercise" to give staff an opportunity to walk through the hospital's protocol for handling a simulated patient with EVD. The University of Alabama at Birmingham (UAB) Medical Center has held similar exercises, and is now holding twice-weekly meetings of its leadership team to make sure that all new developments in the Ebola outbreak are communicated.

- UCLA Medical Center has prepared PPE kits based on the practices developed at Emory University Hospital, which has thus far had the most experience in this country in caring for patients with EVD.
- The UCLA Health System has adjusted its medical record system so that a red flag is placed on the electronic medical record [EMR] of any patient who has recently traveled to a high-risk area.
- UAB Medical Center has incorporated what had been a paper-and-pencil screening tool for EVD into its electronic medical record.
- Training on PPE as well as EVD screening is being provided to first-responders and 911 call center dispatchers in the UAB system.

to a high-risk area. Further, blood testing on any patient suspected of having EVD will be conducted in a mobile, in-room lab rather than the medical center's regular laboratory. This will insure that blood samples do not leave the patient's room, according to the hospital.

William Dunne, the UCLA Health System's director of emergency preparedness, safety and security, says the Ebola patient tracer exercise will help the medical center identify both the strengths in the medical center's response plan as well as areas in need of improvement. "We'll take those lessons learned … as well as things learned from other institutions and other agencies … to make sure that we provide an even safer practice and more effective patient care," he notes.

Streamline EVD screening at triage

The University of Alabama at Birmingham Medical Center in Birmingham, AL, began stepping up its preparations for potential EVD cases nearly three months before the first case was diagnosed in the United States, explains **Sarah Nafziger**, MD, an associate professor in the Department of Emergency Medicine at UAB and the assistant state emergency medical services medical director for the Alabama Department of Public Health. "We were watching developments in West Africa with the current outbreak and saw that it was larger than any previous outbreak, so we began looking at our processes, pulling out our plan, and started thinking about what steps or preparations we needed to make," says Nafziger.

Similar to the exercise at UCLA, staff at UAB have been running through their EVD response plans with simulated patients, and they have practiced putting on and taking off PPE. "There is a lot of value in working things out on paper in a tabletop setting, but there is even more value when you physically walk through your process," observes Nafziger.

Further, even before the CDC began to emphasize stronger policies with respect to PPE, protective gear for health care workers figured prominently in UAB's response plan. "We have always looked at PPE as an essential piece in taking care of these patients [with EVD]," says Nafziger. "The PPE was really at the forefront for us in our interpretations of the [earlier] guidelines, but maybe that is because we have been thinking about this for a long time."

At press time, UAB had not yet seen a patient who tested positive for EVD, but staff did encounter several patients who had risk factors that required more intensive screening and questioning. "After talking with the patients, we figured out that they did not indeed have Ebola … but we walked through our process of screening and that was very helpful for us," says Nafziger.

In fact, as a result of these early experiences with suspected patients as well as the ongoing practice sessions, the hospital has made a few improvements in its protocol for EVD. "One of the tweaks is we decided to add another piece of PPE to our PPE ensemble, a hood that covers the neck," notes Nafziger. "We found that some of our PPE was a little bit scratchy and just uncomfortable, so we added another layer to make it more comfortable."

The hospital has also digitized what had been a paper-and-pencil screening tool for EVD. "We have been able to incorporate that now into our EMR [electronic medical record] system so that it is computerized just like everything else is in our triage process," notes Nafziger. "These are small things that we have been able to streamline into the process to make it work more smoothly."

Train first-responders, 911 dispatchers

Nafziger acknowledges that the news that two nurses contracted EVD while caring for a patient with the disease in Dallas has heightened concerns about staff and patient safety. "As health care providers, we understand that there is some risk of exposure to infectious diseases, but the bottom line is nobody wants to go to work and have it cost them their life," she observes. "I think the solution for that is to arm ourselves with knowledge about how the disease is spread and how to use our protective equipment."

The evidence base from people who have taken care of patients with EVD in Africa during the past 20 years is that PPE does work when it is used appropriately, stresses Nafziger. "That is really what we are focused on: making sure everyone has the proper information," she adds, noting that this policy extends to the EMS personnel who work in the field.

"In the EMS setting, our crews most likely would be the first health care providers to encounter an Ebola patient. That scenario is very likely, so not only have they been trained in the use of PPE, but we have to make considerations for how to make sure that we … have processes in place for decontaminating the interior of the ambulance, so we certainly have had to make preparations in that regard," explains Nafziger. "In addition, we have had to make preparations with our public safety answering points — our 911 call centers — to make sure they are screening patients for

Ebola risk factors so that we have that information prior to the arrival at the scene of an emergency."

Making sure that all members of the health care team are communicating effectively — with each other as well as members of the public — becomes particularly important when there is an outbreak of infectious disease, notes Nafziger. "One of the worst things that can happen in a situation like this is hysteria, and something that you frequently see happen in these situations is partial or incorrect information gets conveyed from person to person, and that can create some very undesired results," she observes.

"Let's be very specific in the information we share with one another so that we don't induce exaggerated responses," notes Nafziger. "We have to look at those risk factors [for EVD] before we come to conclusions."

One way UAB is keeping hospital leadership informed about the EVD outbreak as well as the medical center's preparations for potential cases is by holding meetings twice a week at a minimum, says Nafziger. "Hopefully our preparations won't be needed, but we are all thinking about this very intently, we are following the guidance on a minute-to-minute basis, and continuously checking for new updates and information," she explains. "The information and guidance we are getting has been very fluid, and we are trying to keep up with that."

While many organizations are looking to the CDC to make sure that the American health care system is prepared to handle EVD patients, there is only so much that the agency can do, notes Nafziger. "Everyone is going to have to take the initiative for preparedness. It is not going to be handed to you. Each individual hospital and each individual provider has to take that initiative to make sure they are ready." ■

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ED CODING UPDATE

From the trenches — finding lost ED revenue

This is the first of a two-part series on recovering lost ED revenue

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

There are many ways an ED practice can lose revenue. Today's complex medical payment systems require constant monitoring and analysis to stay ahead. Without a flexible data management tool/dashboard to identify outliers and compare provider productivity and quality, it may be difficult to manage your ED appropriately. However, while you determine the best approach to overhauling your ED coding and revenue management processes, here are a few quick things you can do to determine whether you will need a deep dive or surface look at how your ED is performing.

Infusions and injections

Emergency departments can easily lose in excess of $1 million when start and stop times for ED nursing infusions aren't documented by nursing staff. Sounds like an easy fix, right? But depending on the EMR system you are using to capture nursing services, it may not be as easy as it looks to assure each infusion start and stop time is addressed via ED documentation.

First, physician orders must be clearly stated in the record in an easy-to-identify orders section. Some EMRs permit physicians to enter

free text anywhere on the chart, so it's not unlikely to find bits and pieces of orders buried in sections other than the "orders" section of the record. Second, nurses need in-service in order to understand to which procedures they need to apply start and stop times. All infusions are not created equally. Piggy-backs with multiple meds, hydration, and multiple lines all require a detailed understanding of how the start and stop times are used to assign the billing codes.

In the ED, the highest hierarchy or priority code determines which service is primary and which is secondary. Infusions are primary to injections and both are primary to hydration. Although chemotherapy doesn't apply in the ED, it still is considered the highest priority/hierarchy of the infusion/injection services. However, we are not including these valuable services in our discussion of ED services.

Assume a patient receives a normal saline infusion, an antibiotic infusion (not concurrent), and an IV push during the same episode of care, all in the same vein. The category for the initial code will be from the injections/infusions category, which is primary to the hydration category. Then within the injections/infusions category, the nurse would identify the antibiotic infusion as the initial code because infusions are primary to pushes. The hydration code would be considered an add-on service and not an initial service. Only one initial code may be used per encounter per vein. In order to bill these appropriately, as each is a timed service, the start and stop time of each must be documented. Without this documentation, the infusions would be classified as an IV push, which is a significant loss of revenue.

Critical care

Facilities often fail to clearly identify and/or code for the services that qualify for critical care. Critical care is a timed service and in the ED setting it requires summarization of the bedside time spent by clinical providers as required by CMS/Medicare. Without that documentation, critical care is downgraded to an Evaluation and Management level (99281-99285) according to each individual ED's facility Evaluation and Management (E/M) criteria. This results in significant lost revenue.

In addition, for those facilities that bill Trauma Activation, the Trauma Activation service would be billable, as it must be billed in addition to Critical Care (99291) for qualify for payment. To remedy any problems you may be experiencing with appropriate assignment of critical care, consider adding a field to your EMR that requires nursing to summarize bedside time spent providing critical care to your ED patient. In addition, be sure coders all recognize the content of critical care by providing a table of critical interventions, drugs, procedures, and presenting problems (PP)/diagnoses that indicate critical care has been provided. Audit frequently to identify any areas where coding staff and clinical staff disagree on content of the critical care service.

Emergency departments provide significantly more critical care than is actually billed out to payers, and now is a good time to begin the process of correcting any errors. Emergency department acuity data is critical to understanding appropriate ED staffing, acuity mix, and cost of providing services. If critical care is not captured appropriately, your ED acuity will be flawed. Most, if not all, of this data generally comes from the coding process, so it must be accurate and capture services appropriately.

Medical necessity

Increasing payer denials are being generated from medical necessity audits. Although the work may be appropriately documented, the reason for it can be subjectively judged as "not medically necessary" by payer auditors who do not fully understand the "what and why" of ED care. When appealing these claims, the volume of which is climbing significantly, your ED must connect the dots from the chief complaint/presenting problem (PP) through the identification and acuity of risk factors to the overall medical decision-making process in order to justify the service. Be cautious of EMR systems that provide a drop-down menu to assign the CC/PP as they are generally not nearly as inclusive as required to address the intricate details of a patient's complaint.

Recording the patient's own words, followed by the information provided by the clinical provider upon questioning is the best combination of information to support the services that are provided. Providers should be careful to list differential diagnoses as well, as they provide support for the tests and interventions. Differential diagnoses can underscore the range of problems being considered, but generally require documentation of additional testing to rule out the problem list. The differentials should be correlated to the diagnostic studies in order to be effective for determining medical necessity.

Evaluation and management (E/M) distribution/acuity

Closely monitor how your evaluation and management criteria are performing by monitoring the ED evaluation and management distribution for your facility. If the majority of your patients are falling into ED levels 1-3 (99281-99283), you may want to have an outside auditing firm take a look. ED acuity is on the increase as more and more patients are moved to outpatient settings, and have no primary provider and/or insurance. So, be sure you are assigning the ED service levels accurately. This is an area that can result in significant financial losses to your institution. Medicare permits each hospital to design its acuity criteria individually, so yours should accurately reflect the type of services you provide as well as demonstrate the acuity managed in your ED. ■

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- Ebola: mitigating fear among front-line health care providers
- The challenge of recognizing domestic violence in the emergency setting
- Another look at over-used procedures in the ED
- Salary trends for nurse/physician leaders

ED MANAGEMENT

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To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log on to www.cmecity.com to take a post-test; tests are taken after each issue. 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 test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE/CME QUESTIONS

1. **Arjun Srinivasan, MD, says that the CDC's recommended infection-control strategies for preventing the spread of Ebola virus disease (EVD) are based on the "fundamental issue" that:**

   A. frontline health care workers are at high risk of contracting EVD
   B. Ebola is transmitted through contact with infectious substances from patients
   C. personal protective equipment (PPE) is the sole key to preventing the spread of EVD
   D. a patient with EVD could present to any hospital at any time

2. **Srinivasan also states that in more than 400 instances in which the CDC has been called upon to work through an evaluation of a suspected case of EVD, the disease has been ruled out even before requiring a test in all but what percentage of cases?**

   A. 20%
   B. 15%
   C. 10%
   D. 5%

3. **The patchwork of differing state laws has become particularly evident with the range of policies being employed with respect to:**

   A. the quarantining of health care workers returning from West Africa
   B. the way bio-hazard cleanup crews are deployed
   C. the way frontline personnel triage patients suspected of having EVD
   D. isolation procedures in hospitals

4. **Under UCLA's EVD response plan, health care workers cannot enter or leave an EVD treatment room without**

   A. a safety officer's approval
   B. first disinfecting their PPE
   C. a colleague to accompany them
   D. all of the above

ED ACCREDITATION UPDATE
COVERING COMPLIANCE WITH JOINT COMMISSION STANDARDS

TJC: Plan and prepare for the transition to new tubing connectors to minimize the risk of dangerous misconnections, clinician frustration

Phased-in transition to new tubing connectors set to begin early next year

Finally, the International Organization for Standardization (ISO) is rolling out new tubing connector standards designed to reduce the risk of accidental tubing misconnections. While such problems may not be on the radar screens of busy frontline health care providers, patient safety professionals are only too familiar with the risks posed by a misplaced connector.

"It is serious and it has been a problem for a long time because of the Leur connector that is shared by various types of tubing that access different body sites," explains **Michael Cohen**, RPh, MS, ScD, president of the Institute for Safe Medication Practices (ISMP) in Horsham, PA. "We have a medication errors reporting program, and every once in a while we get a report about a misconnection. This goes back many, many years."

The Joint Commission (TJC) is well acquainted with the problem as well. In fact, in August, TJC issued a Sentinel Event Alert noting that the risk for a tubing misconnection is high in hospital settings when you consider that most patients who are admitted to a hospital receive intravenous infusions of one type or another over the course of their stay. Further, the accrediting agency is putting health care organizations on notice that they need to be vigilant in managing the risk posed by these misconnections during the transition to the new ISO connector standards, which will be phased in over time.

Consider multiple types of misconnections

The most common type of tubing misconnection

EXECUTIVE SUMMARY

To reduce the risk of dangerous tubing misconnections, the ISO is rolling out new tubing connector standards that will eventually make it nearly impossible for tubing associated with one delivery system to be connected to a delivery system that serves a different purpose. Experts welcome the change, noting that tubing misconnections that cause injury and even death have been happening for years. However, TJC has issued a Sentinel Event Alert, warning that health care organizations need to be vigilant in managing the risk posed by these misconnections during the phased-in transition to the new connectors.

- Experts explain that tubing misconnections occur because many different types of tubing utilize the same Leur connector, making it possible for a clinician to mistakenly connect a tube to the wrong delivery system.
- The most common type of tubing misconnection reported to the ISMP is when a clinician wants to administer something to a patient through a feeding tube, but accidently administers the substance through an IV tube instead.
- The first new connector, called the ENFit, is going to be for enteral feeding tubes. It will not connect to IV tubing, making that type of misconnection unlikely. The new connector should be available early next year.
- Since hospitals will continue to use older tubing until their supplies are exhausted, manufacturers will temporarily provide adapters capable of making new administration sets compatible with older tubing.

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reported to ISMP is when a clinician wants to administer something to a patient through a feeding tube, but accidently administers it through the IV tube instead, explains Cohen. "Unfortunately, the tubing for administering [the feeding substance] that connects with the tubing in the patient is very much like IV tubing. It has the same connector," he explains. "So every once in a while [a clinician] prepares the feeding substance and … unfortunately, they connect it to an intravenous line — a central line catheter where it fits perfectly, and then it starts infusing."

This creates two types of problems, advises Cohen. "One, the level of sterility [in the feeding substance] may not be as great as you would see with IV fluids," he says. "And the second problem is that some of the feeding materials we use are very thick … and they wind up in the pulmonary capillaries. Given enough quantities, this could affect breathing."

Another type of misconnection that can have particularly dire consequences occurs when a clinician accidently injects intravenous fluids into the spinal canal or epidural space. Cohen explains that this type of misconnection can lead to a fatality in some cases.

Cohen adds that one of the oddest misconnections — and one that has been reported to ISMP several times — involves the use of automatic blood pressure (BP) monitors. "The nurses set these up so that every 15 minutes or half hour or so the patient's BP cuff will inflate, check the patient's BP, and then that [reading will] register on the monitor," observes Cohen. "The monitor sends air to pump up the BP cuff so that it can do the reading."

However, sometimes clinicians inadvertently connect the BP monitor to a needleless IV system so that when the air pumps into what is supposed to be a BP cuff, it is actually being pumped into a patient's vein, says Cohen. "Enough quantity of air can [create] an air embolus where a whole bolus of air gets into the heart chamber and blood does not pump out," he says. "This can be very dangerous. Given a large enough quantity of air, it can kill someone. We have had some deaths reported from this in the past."

While many of these tubing misconnections tend to happen on a hospital's upper floors, there are also risks in the emergency setting. "Emergency departments are by their very nature hectic, chaotic places. Medical professionals are often hurried, harried, and running from place to place, trying their best to get patients the care they need," explains **Jeannie Kelly**, RN, MHA, LHRM, a quality assurance consultant at Soyring Consulting in Tampa, FL. "Tubing can become disconnected when transferring a seriously ill patient to diagnostic imaging. A nurse may misconnect the tube in haste."

> "… THE SECOND PROBLEM IS THAT SOME OF THE FEEDING MATERIALS WE USE ARE VERY THICK … AND THEY WIND UP IN THE PULMONARY CAPILLARIES."

Another more common type of misconnection does not even involve clinicians. "When a patient gets up to use the bathroom or turns in his bed, tubing can become disconnected," notes Kelly. "The patient or a family member, trying to be helpful, may then misconnect the tubing."

Guard against confusion/frustration

To prevent all of these types of misconnections, the ISO has developed new international manufacturing standards for connectors that will make it nearly impossible to connect a tube from one delivery system to a delivery system that serves a different function. "The ISO has been hearing about these reports all these years, so they have come up with different fittings for these connectors besides the Leur," explains Cohen.

The first new connector, called the ENFit, is going to be for enteral feeding tubes, explains Cohen. "It will not connect to an IV line, so you will no longer be able to give an IV infusion of these feeding substances," he explains. "It is going to be a very systematic implementation over several months, starting in January [2015]. It will involve the [enteral feeding] administration set, the feeding tube which only accepts the new connection, and the syringes to give medications through a port that will be on the side that will have the same fitting so that it can only be used for gastrointestinal purposes."

The new connectors were originally supposed to be rolled out in the fall of 2014, but their debut has been delayed because [at press time] the FDA had not yet approved the application from the manufacturers to produce the connectors, explains Cohen. "No one has actually gone ahead and produced the product yet,

so there are no samples out there for people to handle and talk about," he says.

Nonetheless, as TJC points out in its Sentinel Event Alert, clinical leaders need to be prepared for the changes, and mindful of the risks that will accompany the gradual transition to the new connectors.

Kelly agrees, noting that while the changeover to the new, safer connectors is long overdue, there is likely to be some initial confusion and frustration.

"One thing to remember is that nurses are resourceful and will always find a work-around," observes Kelly. "The goal of training should be to emphasize the risk inherent in using the old connectors, and the benefit of the new connectors. [Once they are available from the manufacturers], let the staff handle them and get used to them in training sessions prior to roll out. Challenge them to find the work around if they can, and educate again on the danger of the old connectors."

Complicating the transition to the new connectors is the reality that hospitals will still have some inventory of the older tubes that they will continue to use until supplies run out, and many patients will have the older tubes already in place even as the new connectors are phased in. To accommodate this reality, manufacturers will make available an adapter that will make the new administration set compatible with the old tubing, explains Cohen.

"These tubes can stay in place for a long time. [Clinicians] are not going to take a patient in for a surgical procedure just to make the change to the new tubing, so we have to have these [adapters] to make the new administration sets compatible," says Cohen. "Eventually, [manufacturers] will remove the [adapter] when it is no longer needed, but it is going to be available for at least a year."

Stay on top of needed supplies

One potential problem that administrators need to guard against during the transition to the new connectors is the possibility that clinicians may resort to jerry-rigging when a tubing connection does not fit. "I think you have to remind people on your staff that if something doesn't connect properly there is probably a reason for it. Check it out; don't just go ahead with it," observes Cohen. "This [message] is particularly important for young, inexperienced professional staff members who may not have run into this issue before. I think there will be a lot of learning."

Also, materials management supervisors are going to have to make room for new products as the new connectors and any temporary extension pieces or adapters get phased into use. Ordering the new items properly and making sure that the hospital does not run out will be an added challenge, says Cohen.

Other unanticipated challenges could arise as well, as hospitals adapt to the new connectors, but this is an important change that has been a long time coming, stresses Cohen. He adds that the changes are being phased in very slowly and systematically "all in the hope that any downside will be minimized or eliminated."

Make use of resources, tools

While the new ISO connector standards grew out of a collaborative effort involving manufacturer groups, clinicians, regulators, and others, the roll out of the new connectors is being managed by the Global Enteral Device Supplier Association (GEDSA), a non-profit trade group based in Columbus, OH. As part of this effort, GEDSA has created a website to keep health care providers informed about the rollout: www.stayconnected2014.org.

The ISMP is also making a resource available to health care providers to help them prepare for and manage the transition to the new connecters. A comprehensive "Tubing Misconnections Self-Assessment for Healthcare Facilities" form is available for download at www.ISMP.org. Click on the "tools" link in the upper right-hand section of the website's front page, then scroll down until you reach the "self assessments" link. Click on this link to find the tubing self-assessment form. Users will be asked to sign up for the form, but it will then be available for download immediately.

The Joint Commission says it does not have any current plans to introduce new accreditation or certification standards related to the new connector standards, but it is participating in GEDSA's Stay Connected committee, and it is strongly urging health care organizations to assess their risks regarding tubing misconnections, and establish processes and protocols to insure the safe transition to the new ISO connectors. ■

SOURCES

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- **Jeannie Kelly**, RN, MHA, LHRM, Quality Assurance Consultant, Soyring Consulting, Tampa, FL. E-mail: Jeannie.kelly@soyringconsulting.com.

Seize upon mistakes/errors as opportunities for system improvement

To pick up on any problems related to the new tubing connector standards or the transition to these standards, it is important to nurture an environment that encourages error reporting. However, this is a continuing challenge for health care organizations, observes **Jeannie Kelly**, RN, MHA, LHRM, a quality assurance consultant at Soyring Consulting in Tampa, FL. "Most adverse events are under-reported, and in a punitive culture under-reporting will continue," she says.

> "IF [THEY] SEIZE UPON THESE TYPES OF EVENTS AS OPPORTUNITIES TO IMPROVE THE SYSTEM, STAFF WILL BE AWARE OF THE RISKS AROUND THEM.".

Consequently, rather than punishing or suspending personnel who are involved in an error or adverse event, Kelly advises administrators to make an example of how staff can learn from the misstep. "Don't just focus on providing more training. Do a root-cause analysis to determine what in the system contributed to the error," she explains. "Was a nurse stressed due to the ED getting slammed? Was staffing adequate? Were staff members working as a team?"

Taking a larger view can pay multiple dividends, notes Kelly. "If administrators seize upon these types of events as opportunities to improve the system, staff will be aware of the risks around them and work as a team to design and maintain safe systems."

TJC: Standards apply to the safe and effective management of Ebola patients

The Joint Commission has signaled to health care organizations that their readiness to safely receive and manage suspected Ebola cases is very much within the purview of surveyors on several fronts. The accrediting agency has highlighted accreditation chapters that it says are "focal" to identifying any strengths or weaknesses in a healthcare organization's response plans as well as its ability to care for patients with Ebola virus disease (EVD) while "minimizing the risk of transmission" to others. The highlighted chapters include the following:

- Leadership (LD) 04.01.01,04.01.07
- Environment of Care (EC) 02.02.01,03.01.01
- Emergency Management (EM) 02.01.01,02.02.01,02.02.03,02.02.05,02.02.07
- Human Resources (HR) 01.04.01,01.05.03,01.06.01
- Infection Control (IC) 01.03.01,01.05.01, 01.06.01,02.01.01,02.01.01,02.03.01
- Nursing (NR) 01.01.01,02.03.01
- NPSG.07.01.01 ■

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