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This year, surveyors to look for patient flow problems: Identify bottlenecks now

You'll need to monitor improvements in any problem areas

Are patients on gurneys in hallways a typical sight in your organization's emergency department (ED)? The growing problem of ED overcrowding is potentially dangerous to patients, resulting in the new leadership standard on managing patient flow from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The standard, effective Jan. 1, 2005, appears in the leadership chapter of the 2005 Hospital Accreditation Manual.

You'll need to develop and implement plans to identify and mitigate obstacles to efficient patient flow throughout your organization, using specific indicators to measure components of the patient flow process and monitor capacity for areas that receive patients.

"This is a big safety issue, because many hospitals are running out of surge capacity," says **Carol J. Gilhooley**, director of survey methods development in the JCAHO's division of standards and survey methods.

During 2005 surveys, surveyors will be looking for indications of problems with patient flow throughout the organization, such as overcrowding in the ED or patients being boarded while awaiting inpatient beds.

"If they see those kinds of things, they will want to hear how the organization plans to alleviate them," she says.

By analyzing data to reveal bottlenecks in patient flow, you will have powerful evidence to present to hospital leaders, Gilhooley emphasizes. "It's hard to run from your own data — it's very convincing," she says. "This helps people brainstorm and come up with solutions."

Not just an ED problem

"I hope that the JCAHO standard will bring these patient care barriers to the forefront and assist organizations in identifying issues across the organization, not just in the ED," says **Toni G. Cesta**, PhD, RN, FAAN, vice president of patient flow optimization at the North Shore-Long Island Jewish Health System in Great Neck, NY.

The lack of available inpatient beds is the root of the problem, says Gilhooley. "I think the word has gotten out that it's not just an ED problem, and there is a lot of good research to show this. There must be a place

for patients to go once the decision has been made to admit," she says. "Boarding issues are what we are trying to get at with the standard. It would be ideal if no patients were boarded, but this isn't always realistic."

Work as part of a collaborative

Gwinnett Hospital System in Lawrenceville, GA, recently began participating with the Boston-based Institutes for Healthcare Improvement (IHI)'s patient flow collaborative. "The goal is not just to meet the JCAHO standards but to have a better flow process throughout the system," says **Wendy Solberg**, CHE, director of quality resources.

The organization has three primary goals: getting an ED patient to a room within an hour after the decision is made to admit, decreasing the number of discharges after 3 p.m. by 50%, and transferring every intensive care unit (ICU) patient to an inpatient bed within four hours from the time the patient is deemed ready to move from ICU.

"We've got a team with strong leadership support from our vice president of operations," says Solberg. "We're using about nine key measures provided by IHI, as well as using rapid cycle improvement to change one process at a time."

Scottsdale (AZ) Healthcare also is participating in IHI collaboratives on patient flow, reports **Sylvia Bushell**, consultant for organizational effectiveness. "We have two projects under way: one on inpatient flow and one on operating room [OR] flow," she says.

The organization is using a new hospital diagnostic tool developed by IHI, which looks at the number of bed turns in a facility. The tool "diagnoses" patient flow by calculating bed turns based on variables such as length of stay (LOS), case-mix index, number of functional beds, and number of admissions.

"The tool helps us to focus our improvement efforts and also meets the JCAHO requirement for measurement and reporting for patient flow," Bushell says. "We are starting to use this tool to compare our hospital with other hospitals in the collaborative and share plans to improve."

To ensure compliance with JCAHO's patient flow standard, consider the following:

- **Choose indicators carefully.**

Gilhooley recommends looking at outcome and process indicators throughout the organization, such as length of stay and peak volumes in the ED, and balancing indicators such as patient and staff satisfaction and readmission rates. "Those kinds of things will help leadership to assess patient throughput."

Surveyors will want to see that you have done some analysis based on your findings and acted on this, she adds.

Another valuable indicator is transfer times from the ED or post-anesthesia care unit (PACU) to inpatient floors, Gilhooley notes. "The ED and the OR are frequently competing for the same ICU beds, so smoothing out an OR schedule can often help the ED," she says. "We know that hospitals

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can't control the volume of patients in the ED, but you can control your OR schedule."

The new JCAHO standard requires you to define mechanisms for identifying and dealing with periods of overcapacity. "The ways in which this might be defined is up to the specific organization," Cesta says.

The indicators being used at her organization are percent of total occupancy, number of ED bed holds and type of beds, patient acuity level, PACU holds, diversion status, and anticipated discharges. **(See the organization's patient flow scorecard, p. 4.)**

Cesta worked with nursing and bed management to identify these indicators. "You have to consider where your organization's bottlenecks are. For most organizations, it is the ED, coupled with potentially available beds on the nursing units," she says. "If you are at 100% occupancy and are expecting less discharges than you have patients on hold in the ED, then clearly you have a capacity issue."

While monitoring patient flow indicators, you should continue looking at other quality measures, such as rate of readmission for both the ED and inpatients and the number of ED patients leaving without being seen, Solberg recommends.

- **Make small changes and monitor the impact**.

"Rather than trying to fix the entire problem at once, find out where the bottlenecks originate and get at them one at a time," Gilhooley advises.

"We are suggesting that organizations test something for a couple weeks to see if it has an impact," she notes.

- **Be sure to involve physicians.**

The JCAHO standard specifically requires the involvement of medical staff. Physician champions are selected for each patient flow project at Scottsdale Healthcare, and their input and feedback is solicited on a regular basis, Bushell adds.

"They are key stakeholders," she points out. Physician involvement was key in a project to improve OR flow, with patients being followed from the time they are scheduled for surgery in the physician's office until a month after discharge.

"This included going into the surgery with them, rounding with the physicians, and going to follow-up appointments," Bushell says.

- **Make sure your data are valid**.

Gwinnett's physicians weren't consistently documenting the time for when the decision was made to admit a patient, Solberg notes. "As a result, we had a tough time trying to figure out exactly when the decision was made," she says. "We defined the 'decision to admit' time as when all the data and lab results are back and there is an order for admission from the admitting physician, and the physician talked to the admitting division. Clear definitions are key."

- **Find creative ways to turn beds quicker.**

"There are a lot of creative things that can be done to get beds turned around more quickly," Gilhooley says. She gives examples of working with discharge planning, involving physicians, and creating a person who is accountable for the beds in the organization.

A daily bed huddle takes place at Gwinnett, with a group of clinicians from each floor giving reports on the number of available beds to representatives from surgery and the ED.

"The bed huddle is our biggest patient flow initiative right now," says Solberg. "When an ED patient becomes ready for admission, we want to have a spot to put them."

A bed coordinator is responsible for the bed tracking system and patient flow, says Solberg. "Her focus is making sure the beds are there when we need them and facilitating the daily bed huddle," she says.

Plans also are under way to invest in a bed tracking board and scheduling discharge times to tie with peak volumes in the ED, Solberg reports.

- **Give boarded patients the same level of care they would receive as inpatients**.

Your organization should identify a location to safely house and care for overflow patients and should be prepared to staff the area appropriately as well as provide for medications and food, Cesta advises.

In response to questions from organizations about what constitutes "appropriate and adequate care" for boarded patients as required by the standard, JCAHO pulled together a group of experts, including representatives from the Irving, TX-based American College of Emergency Physicians, to create a list of 12 elements to address.

"We listed those things that organizations should be concerned about when they are boarding patients in a temporary location," Gilhooley explains.

"So surveyors will be talking to leaders about that, too — what planning they have done to make all those things that are important to their care available," she adds.

(Continued on page 5)

Patient Flow Scorecard

Initiative Specific Metrics	Target	Baseline	Frequency	YTD Actual	Status
Length of Stay					
Reduction in length of stay/excess days	YTD Case Mix Adjusted LOS		Monthly		
Reduction in avoidable/variance days by DRG, facility, and practice	Reduce to Zero		Monthly		
Perioperative Services Capacity and Throughput					
Reduction in Number of OR Cancellations within 24 hours of Scheduled Surgery	Reduce to Zero		Monthly		
Reduction in Number of OR Holds	Reduce to Zero		Monthly		
Reduction in PACU LOS	Reduce Average from Baseline		Monthly		
Reduction in Number of PACU Patients Held Overnight with Bed Assignment	Reduce to Zero		Monthly		
Reduction in Turnaround Time From Bed Request to Bed Assignment	Reduce to 1 Hour		Monthly		
Reduction in Turnaround Time From Bed Assignment to Bed Placement	Reduce to 1 Hour		Monthly		
Fewer Case Start Delays	Reduce from Baseline		Monthly		
Reduction in Time From OR Schedule Request to Time on OR Schedule (inpatients)	Reduce from Baseline		Monthly		
Inpatient Capacity and Throughput					
Increase in Occupancy Rate	Increase from Baseline		Monthly		
Reduction in Clinical Denials***	Less than 5% of Patient Days		Monthly		
Reduction in 3rd party pay or denials (all)***	Less than 3% of Patients Days		Monthly		
Reduction in EMS Ambulance Response Time	Reduction from Baseline		Monthly		
Reduction in Turnaround Time for Tests/Treatments/Procedures/Consults***	Reduce from Baseline		Monthly		
Discharge Plan in Medical Record Within 24 Hrs of Admission	100%		Quarterly		
ED Throughout and Capacity					
Reduction in Time from Triage to Disposition	<120 Minutes		Monthly		
Reduction in Time from Disposition to Bed Assignment	<40 Minutes		Monthly		
Reduction in Time from Bed Assignment to Placed in Bed	<60 Minutes		Monthly		
Reduction in ED LOS (admitted patients)	Reduce from Baseline		Monthly		
Reduction in ED LOS (treat and release patients)	Reduce from Baseline		Monthly		
Reduction in LWOBE Rate	Reduce to Zero		Monthly		
CAP — Time to First Antibiotic	< or equal to 4 hours		Quarterly		
AMI — Aspirin Received Within 24 Hours of Arrival	Assessed on Admission and Prescribed as Appropriate		Quarterly		
AMI — Beta-Blocker Received Within 24 Hours of Arrival	Immediately Upon Arrival if Appropriate		Quarterly		
Reduction in diversion rate	Reduce to Zero		Monthly		

***These metrics are dependent on the availability of a Case Management software application.

*To be prioritized by the teams

Source: North Shore-Long Island Jewish Health System, Long Island Jewish Medical Center, Great Neck, NY. Not to be reproduced without permission.

The list includes life safety code issues such as avoiding blocked corridors, ensuring patient privacy and confidentiality, providing appropriate access to ancillary services, staffing the area with appropriately privileged practitioners, and ensuring access to other practitioners who may be necessary for consultation or referral.

"Access to medical assistance in an emergency is also important — if a patient is on a gurney in the hallway, does he have a call button, or a way to access help if he needs to go to the bathroom?" asks Gilhooley.

To alleviate pressure on Gwinnett's ED, an admissions unit was created so that patients could be moved into an intermediate holding area until a bed becomes available.

"It is essentially equivalent to an inpatient unit. Patients get the initial nursing assessment and the same level of care that a patient would receive on the floor," Solberg says.

- **Use a multidisciplinary approach.**

To comply with the standard, interdivisional teams need to work together, says Gilhooley.

"Even lab turnaround time might have an important impact on patient LOS in the ED," she continues. "Some hospitals now have a phlebotomist working right in the ED, so patients don't have to wait an extra 15 minutes for a phlebotomist to get from the lab to the ED."

- **Have a single person responsible for patient flow.**

Consider having a single leader responsible for coordinating all patient flow initiatives, as the process is very complex and labor-intensive, Cesta advises.

As one of the only vice presidents for patient flow in the country, Cesta's role is to identify and correct any patient flow barriers across the 17-hospital system, at the input access points, such as admitting and ED; inpatient throughput including pharmacy, laboratory, radiology, transport, housekeeping, case management, bed management, and physician practice issues; and output, including access to continuing care services, discharge planning, and barriers to timely discharge.

"The benefits to having this position include the opportunity to have systemwide processes that are consistent and effective and to ensure that each process represents best practice," Cesta notes.

"By having one person in charge, barriers to improvement are broken down because I do not belong to any one department or hospital," she adds.

[For more information on JCAHO's leadership standard for managing patient flow, contact:

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ACCREDITATION
Field Report

Medications, life safety are focus during survey

A recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey at Medical City Dallas Hospital was "extremely educational," with surveyors taking extra time to educate staff, reports **Rosemary Rouse**, RN, BSN, the organization's survey coordinator.

"Staff were more comfortable with this type of process because it focused on how their roles impact patient care. They were able to elaborate about the things they do every day."

Before the survey began, surveyors announced they wanted the process to be a partnership and an educational experience for everybody, with the focus being on patient care as opposed to policy review, Rouse adds.

Here are key areas of focus during the survey:

- **Environment of Care and Security.**

Surveyors incorporated Environment of Care evaluations on every unit they visited, continually checking for safety hazards during patient tracers. "That was different — in the past, that was not as much of a focus," she adds. For example, during a patient tracer, a surveyor would go into a room, check the intravenous pump, and ask to see the maintenance history on that pump.

Surveyors also looked for compliance with

new Environment of Care standards related to controlling egress, Rouse explains. "They spent time in the newborn and pediatric areas looking at the entry and exit ports to assess how well they were secured, the alarm sensitivity, and who had access to certain elevators," she says.

The focus was on making sure pediatric populations were secure. "For areas with camera-monitored access, they checked to see that it was monitored 24 hours a day, seven days a week, to ensure the safety and security of patients."

- **Medication management**.

"The medication management standards seemed to be a big focus area, and they reviewed this on every unit they visited," Rouse notes.

Surveyors reviewed the pharmacy's overview of medications before they were administered, pain management, documented need for a medication in the record, and unapproved abbreviations, and asked about the read-back process for verbal orders.

The surveyors also looked at how pain management orders were written and how nurses selected the appropriate medication to give if multiple orders were present.

"For example, if a nurse had two pain medication orders, they wanted to know how the nurse made a decision to choose one over the other," Rouse says.

- **Communication.**

Surveyors wanted to know how patient information got communicated from one shift to another, or one discipline to another, to ensure a smooth continuum of care.

"They would follow a patient down to radiology for a CT scan and monitor to see what information was transferred from point A to point B," she explains. For example, they wanted to see if the patient record and orders went along with the patient, and if the orders were reviewed prior to doing the procedure.

- **Physician documentation.**

The physician surveyor did pull charts to assess handwriting legibility, but there was always a nurse who could read or interpret the physician's writing, Rouse says.

"The surveyor's definition of legibility was that somebody who didn't read it every day would be able to read it quickly to promote patient safety," she notes.

If the surveyors found charts missing an element of documentation, they would ask for additional charts from medical records to make sure they had an adequate sampling.

"If everything looked good in those records, then everything was fine," Rouse adds.

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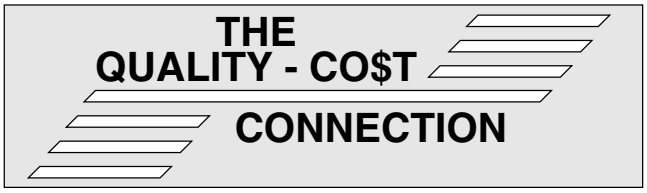

Plan now for those high-census situations

Review and update protocols

By **Patrice Spath**, RHIT
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Forest Grove, OR

Is your hospital prepared for a pandemic or any clinical crisis circumstance that results in an unusually high rate of admissions?

The influenza vaccination shortage in fall 2004 served as a reminder of the need to constantly review and update protocols for handling high utilization situations.

For health care institutions, a high rate of hospitalizations could tax an already overburdened system. Many hospitals already have emergency preparedness plans that could be adapted to high census planning. If your organization has not already done so, now is the time to reevaluate protocols for handling high-census situations. Special consideration should be given to several areas.

The greatest challenge of treating patients during a pandemic is the real possibility of reduced staffing levels due to employee illness. Ideally, all staff members, physicians, and their families receive a flu immunization.

However, this might not have been possible because of the vaccine shortage. So be prepared for higher than normal illness rates among staff,

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HMSA case managers are patient advocates, not UMs

System promotes collaboration, not competition

Case managers with the Hawaii Medical Service Association (HMSA), a nonprofit medical indemnity association, follow a practice model that differs significantly from that used at most other insurance companies, says **Melissa Bojorquez**, ACBSW, MBA, CCM, supervisor for the HMSA case management program.

That difference may have something to do with why HMSA — the independent licensee for Blue Cross Blue Shield for the state — was chosen to receive the March of Dimes Franklin Delano Roosevelt Award for Distinguished Community Services. A video, *Circle of Healing,* which was made in connection with the award, depicts HMSA's handling of four different cases in which its members were faced with devastating illness.

"In some settings, case managers are also utilization managers," Bojorquez notes, "but it's difficult to represent the patient if you're playing that role. In our model, we don't place case managers in that position. Our case managers aren't necessarily the decision makers, but rather the facilitators."

Case managers serve as patient advocates, she explains, working toward the best possible plan of care. Decisions on whether to cover a particular treatment are made by the HMSA medical director, Bojorquez adds.

"Sometimes, our case managers have to deliver not-so-good news," she points out, "but we try to move beyond what's not payable to, 'How can we access the care we need for the patient? Do we need to transition to another community funding source, another program?' It's important for us to say to the patient, 'Here is the outcome, and I know it isn't what you expected, but can we move forward?'"

Through such efforts, she notes, "our organization has played an important role in making health care affordable from a member and an employer group perspective."

Another advantage of having health plan case managers, Bojorquez points out, is that they can follow members from multiple locations. "They can follow a member from the hospital to a rehab facility to home care to independent living or assisted living," she adds, "an advantage that case managers in specific facilities or settings do not have."

One of the cases cited in the March of Dimes award involved an infant who was born with a nonfunctioning bowel and ultimately had to be sent to a West Coast facility for a small bowel transplant, Bojorquez says.

"That took a lot of coordination, with a member going out of state who had to be supported in an unfamiliar area," she says. "The case manager was there to support the family throughout the process."

The case manager worked with utilization management to preauthorize the treatment, which involved determining that the facility was a "Blue Quality Center for Transplant" under the Blue Cross Blue Shield "center of excellence" requirement, Bojorquez continues. "There was a lot more coordination and research than with organs like livers or hearts that are more commonly transplanted."

In addition to being a conduit of information for issues within HMSA, she says, the case manager worked with outside payer sources to seek coverage under other programs for which the child might be qualified. For example, it costs between $35,000 and $50,000 to transport a critically ill patient from Hawaii to the mainland, Bojorquez explains. In this case, that expense was covered by another agency.

That child's care is ongoing, with trips back and forth between facilities in Hawaii and California, she says. "The family is very appreciative of the case manager. They think of her as a friend, someone to call for advice."

What makes Hawaii unique

One of the factors that makes Hawaii's health care environment unique, Bojorquez explains, is that the state's Prepaid Health Care Act requires employers to provide insurance to any person working 20 hours or more per week, she adds.

Because of that requirement, it is not uncommon for case managers to have to coordinate care and services that have coverage by several insurers, Bojorquez says. When a case involves coverage by more than one health plan, she adds, the coordination of benefits can be complicated.

The unique nature of the HMSA model allows case managers to take a cooperative approach when it is necessary to navigate between two plans, she points out.

"It might be two competitors — HMSA and Kaiser, for example — working together, but the issue is how best to coordinate the patient's care, not to try to avoid being the one to pay for the care."

In many cases, Bojorquez notes, "[the other insurer] covers part of the care, and we cover part of it." Because of the universal nature of coverage in Hawaii, she adds, "there is no need to be adversarial. We can work collaboratively."

With about 60% of the market and 670,000 members out of a population of nearly 1.3 million, HMSA is the largest insurer in the state, she says. "Kaiser is next, and union plans or third-party administrators have the rest."

HMSA has been part of the Blue Shield Association since 1946, and since 1990, has been the independent Blue Cross Blue Shield plan for the state of Hawaii, Bojorquez explains. The case management program has been in place since 1988, she notes, sparked in part by needs associated with the AIDS epidemic.

With advances in medical technology that support home care of the complex medical patient, she says, "there needed to be a unit that assisted members with these types of catastrophic treatments. We needed a program to review the appropriateness of home services that were in lieu of being in the hospital."

In seeking to fill those needs, the HMSA program evolved from individual benefit management to a more focused care management model, adds Bojorquez, "always with the intent of helping members with complex care needs."

HMSA was founded in 1938 as what is known as a mutual benefit society, she explains. "It was started by social workers, teachers, and nurses because of the need for affordable health care in the community. We now have different types of benefits, but a lot of our role is navigating members on how best to use their benefits."

Members pay dues to the nonprofit organization, Bojorquez explains, and it is managed by a 27-member community board that serves without compensation. "Insurance is the primary product, but there is a range of other programs for which HMSA has been the catalyst. We still have the mission of bringing quality, affordable health care into Hawaii."

Among other services, HMSA provides disease management, preventive health, health education, and screening programs, she notes. In some instances, Bojorquez says, the organization's role is bringing in or helping providers to develop services that aren't in the community, and establishing a reimbursement model.

Nurses were the basis of the case management program when it started, she points out, but the agency progressed to a nurse/social service or care coordination model. "That was because a lot of the need was not always for treatment of the disease but for the coordination of resources and services."

What happens today

Now the case management program refers to and coordinates with HMSA's disease management program for the education and management of chronic health conditions, she says, as the HMSA case management staff focuses on members with serious and/or chronic long-term illness, those with complex placement/social needs, and children or elderly patients who are medically fragile, among others.

"We are addressing the needs of the patients,

but we are also putting a lot of effort into assisting the families, because they are the caregivers," Bojorquez adds. "We look at what is needed to help maintain the patient at home. Another program might be more concerned with clinical aspects, compliance with protocols. We look beyond that."

Palliative care, education of advance directives, and transition to hospice care are among the program services, she notes. "Our highest volume is oncology, and we have a lot of patients who are at the end stages of disease or who are suffering from life-limiting disease.

Once the patient is taken care of by the appropriate providers, the issue is, 'How do you support the family? Are they at risk of breakdown? Do they need respite care?'"

In addition to Bojorquez, the case management staff includes **Linda Dullin**, RN, senior case manager, and four social work case managers, she says, as well as the medical director.

Dullin performs the first level of clinical review for all referrals. The referrals, which come by telephone, fax, or e-mail, are fielded by an HMSA intake specialist, who takes the information on the referral, checks eligibility, puts the appropriate medical and plan/benefit documents together, and sends them to Dullin.

Most referrals come from within the organization, Dullin says, whether from a member, a member's family, or another facet of HMSA, such as the disease management program. Physicians account for the smallest volume of referrals, she adds, but HMSA hopes those numbers will increase.

"Usually, our members have far more contact with a physician than with HMSA, and the physician is aware when someone has a particular need," she notes. "Who better to get that information from than somebody who's right in the thick of it?"

Physicians sometimes think of case management as being utilization management, Bojorquez says, and because they fear case managers will take an adversarial approach, they are reluctant to seek their help. "They shouldn't be," she adds. "We want to be an adjunct to their care of the patient."

The program would welcome more referrals from hospitals that are providing care to HMSA members, Dullin notes.

"Case management technically is a benefit, but most members don't realize that," she points out. "We might be able to say, 'This person has skilled nursing benefits. Rather than discharging the patient to a home that may be unsafe, why don't we send him to short-term rehabilitation facility so he can get stronger and have physical therapy?' A lot of times that was never thought of."

Once a referral comes in, Dullin explains, she reviews the material available, and if she can't make a determination, requests additional information. "If it's, say, a premature infant, with potential special-needs coordination, I will ask the hospital to send admission history and physical and consultation notes."

If a physician is making the referral, and Dullin has the information on the recent hospital stay but knows there were pertinent care events before that, she will contact previous providers.

"Because we're part of an insurance company, we don't run into as much difficulty with HIPAA [the Health Insurance Portability and Accountability Act] privacy requirements as some might think. When a person is admitted, part of the [privacy notice that is signed] allows release of their information."

Interestingly, she often has to "remind the provider that we are the insurance company," Dullin says. "I don't hesitate to put the request in writing, just to reassure the provider. We also send a copy to the member, because one of the things you're supposed to be able to do under HIPAA is go to the insurance company and find out to whom your medical information is being released."

Empowering patients to reach their goals

After looking at the clinical implications of the additional information she has requested, Dullin says, she sometimes still needs to talk with the member or his or her family to determine, for example, if there is home care of any kind or a private caregiver.

"If we're talking about getting community resources, I want to find out what they already have in place," she says. "We want to empower them as much as possible.

"Our case management is to help them navigate and coordinate and maximize benefits, but we also work with them on what they want to accomplish," Dullin points out. "Unless we ask what they want and they tell us, the goals become our goals and not those of the members."

When she completes her evaluation of the case and determines that the person is appropriate for case management, Dullin gives the assignment to one of the social work case managers, she says.

Rather than just handing over a file, Dullin adds, "I try to give the case manager an overview of the case. All the information is in the hard copy, but I give them a highlight, something to put a face on it."

It's a team effort

A team approach extends throughout the HMSA organization, Bojorquez notes.

At the intake level, Dullin looks closely at cases to determine if they should be diverted to the disease management or behavioral health programs. "Our whole intent is not to duplicate something that is already in place," she says.

"It's not unlikely that we might have a member who is diabetic, has congestive heart failure, and is at risk for end-stage renal disease and depression," Bojorquez says. "Is that person going to have four case managers?"

Representatives from the different programs meet monthly to discuss complex cases, decide who has the best relationship with the member, and make that person the lead for the case, she says.

"The others take a back seat, and she becomes the primary contact," Bojorquez explains. "The patient might remain on other caseloads, but to avoid duplication of services, those case managers don't touch the case without coordinating with the lead case manager."

Meanwhile, the entire case management staff meet weekly for "case management rounds," she continues. "We present cases and give each other feedback. It's a vital piece of the program."

If a case is complex, or there may need to be a referral outside the network, Bojorquez adds, someone from HMSA's clinical review area may join the discussion.

The smallness of the unit engenders a strong camaraderie, Dullin says, with staff members often asking each other, "Have you ever had to deal with this?" or "What's your recommendation?"

"Our work in case management is hard at times, but in the majority of cases, the results are favorable for both patients and family. The job provides a real sense of satisfaction," she points out.

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CE *questions*

1. Which is true regarding a new leadership standard on managing patient flow from the Joint Commission?
   A. All organizations should use the same indicators to assess patient flow.
   B. Only organizations with severe ED crowding must monitor patient flow.
   C. Surveyors will be looking at patient flow within the ED only.
   D. Organizations are required to identify and mitigate impediments to efficient patient flow throughout the hospital.

2. Which is recommended to improve patient flow?
   A. Involve only ED staff in the process.
   B. After bottlenecks are identified, make small changes and monitor their impact.
   C. Avoid including physicians when initiatives are implemented.
   D. Have a single department address throughput organizationwide.

3. During a Joint Commission survey at Medical City Dallas Hospital, what was the physician surveyor's definition of legibility?
   A. Any staff member must be able to read a physician's order without difficulty.
   B. The physician must be able to read his own order.
   C. At least one nurse must be able to read the order.
   D. As long as nurses can read the order, it's considered legible, even if pharmacists can't decipher the handwriting.

4. Which is true regarding a new accreditation process for chest pain centers?
   A. The criteria conflict with Joint Commission requirements.
   B. Organizations must meet or exceed a set of criteria and complete on-site evaluations.
   C. Only larger facilities may obtain accreditation.
   D. Accreditation only is given to facilities which offer percutaneous coronary interventions.

Answer Key: 1. D; 2. B; 3. A; 4. B

(Continued from page 6)

physicians, or their family members. To ensure adequate staffing during high utilization, your facility's time-off policies and procedures should address staffing needs adequately.

Unplanned absences or previously scheduled vacations may need to be denied or cancelled to achieve adequate staffing during times of clinical crisis.

Facility policies and employee union contracts should be flexible to ensure sufficient staff coverage so that safe care can be given to the larger than usual emergency department (ED) or inpatient populations. It may be necessary to use RNs or other health care professionals in administrative roles for patient care activities; however, the current clinical competence of these people must be considered.

Make sure your ED is prepared to handle high patient volume. Urgent care or fast-track areas in or adjacent to the ED may need to be converted to patient treatment areas.

Appoint a triage officer

If you don't already have a triage officer to manage patient flow, consider appointing one during times of high utilization. This person can make appropriate patient referrals to local physicians' offices or community health centers when ED treatment is not required.

Recheck your transfer procedures. It may be necessary to send patients to other hospitals when your ED is experiencing unusually heavy patient volumes or when your facility is in danger of exceeding inpatient bed capacity.

Review your policies for admitting and scheduling elective procedures. How and when will your facility implement contingency plans such as limiting elective admissions or canceling scheduled surgeries?

If a high number of flu-related admissions occur, it may be necessary to control elective utilization of your facility. Such limitations not only allow for redistribution of staff and equipment, but also reduce the risk of elective patients contracting influenza from already hospitalized patients.

Of course, your facility should have isolation plans for patients admitted with complications of influenza or any other contagious disease. Under ideal circumstances, patients with suspected or diagnosed influenza should be in a private room.

During a time of high census, private rooms are unlikely to be available, and containment of infection may be difficult. Some patients are dependent on certain health care procedures or treatments (e.g., dialysis) that must continue during high-census situations. For these patients, it is especially important that they receive an annual influenza vaccine and are cared for by health care workers who have been immunized.

Consider performing elective or necessary procedures or treatments in an outpatient area or ambulatory care unit to reduce the chance that these patients are exposed to inpatients infected with the influenza virus.

Effective utilization management activities are critical during periods of high census. If your facility has ineffectual physician advisor support for utilization problems, consider appointing temporary medical triage officers to manage patient flow.

The medical director or service chiefs could function in this role. Be sure a sufficient number of triage officers and case managers are allocated to the appropriate units to facilitate timely discharge or transfer of patients to home, a skilled nursing facility, or other facilities.

Careful monitoring of critical care bed utilization is especially important to ensure patients are expeditiously transferred out of these units. When inpatient utilization is high, consider creating a patient discharge holding area or discharge lounge to free up bed space.

The committee responsible for utilization management must be actively involved in recommending and enforcing procedures for dealing with high-census situations. Start by confirming there are adequate protocols for bed management across the organization.

These protocols should address how and when the decision will be made to admit, transfer, and discharge patients. During the period of high census, the director of case management should monitor utilization and bed availability carefully.

The following types of data should be gathered at least daily and reported to triage officers, the medical director, utilization committee chairman, and senior leaders:

- average number of available intensive care unit beds (adult and pediatric);
- average number of available medical ward beds (adult and pediatric);
- average number of available ED beds;
- average waiting time for nonambulatory patients to be seen in the ED;

- average waiting time for ambulatory patients to be seen in the ED;
- average number of patients in the ED waiting to be seen;
- average number of patients waiting for inpatient beds (in ED, clinics, post-anesthesia recovery, etc);
- average number of area hospitals on ED diversion.

After the bed utilization crisis is over, the natural response is to breathe a sigh of relief and ease back into the business-as-usual mode. However, don't relax quite yet! As soon as possible following the end of the crisis is a perfect time to evaluate how your facility did at managing the large volume of patients. Some systems or protocols may not have worked well and need redesigning. Don't overlook the opportunity for this hindsight analysis. Evaluation of lessons learned from the high-census situation will assist in responding to future crises.

The utilization committee should coordinate this evaluation, asking questions such as:

- Was the high-census procedure activated appropriately to free up or add patient beds to accommodate multiple admissions? Was it activated too soon or too late?
- Did all departments effectively assess and triage patients to the appropriate level of care?
- What could the medical staff have done to facilitate transfer of patients to the most appropriate level of care?
- Was the hospital able to efficiently procure necessary resources (e.g., supplies, equipment, staffing, holding beds)?
- Were scarce resources adequately and appropriately rationed?
- What additional resources and mechanisms are needed to procure the needed supplies, equipment, and staff during the next utilization crisis?
- Were nonmedical resources (i.e., security, sanitation, water, and transportation) sufficient during times of unusually heavy patient volume?
- Were infection control practices adequate to maintain patient safety?
- Did the physician clinics have an efficient communication mechanism to alert the hospital of incoming patients?
- What other resources does the hospital require to ensure patients are adequately cared for during times of high census?
- What recovery and mitigation efforts can be taken now to reduce problems during the next surge of patients?
- What community resources would help to reduce the burden of unusually high admissions?
- What nonmedical resources may be needed in the event (e.g., security, law enforcement, sanitation, water, transportation)?

Insights without implementation produce no results. Where opportunities for improvement are identified, the committee should spell out action plans to harness the ideas that result from the lessons learned discussions.

The impact of the high-census debriefing depends on making clear decisions on how to use the insights gained. That includes spelling out who is responsible for seeing that each insight is disseminated quickly and put into practice. The utilization committee should receive regular feedback on the progress of protocol or procedure revisions. Don't wait until the next bed utilization crisis to find out that nothing has changed. ■

Does your chest pain care deserve accreditation?

Number of accredited centers is growing fast

Would you like your organization's care of patients with chest pain to be something to brag about? Consider obtaining accreditation from the Columbus, OH-based Society of Chest Pain Centers (SCPC).

Accreditation will demonstrate to physicians, patients, and the community that you follow the highest standards in caring for chest pain patients, according to **Mary Sharp**, chief nursing officer at Southern Hills Medical Center in Nashville, TN.

"Following evidence-based protocols helps us achieve the best patient care outcomes and consistent practice," she adds.

The accreditation process is a powerful performance improvement tool, enabling you to measure the quality of the care you are giving to patients with acute coronary syndrome (ACS), says **Lynnette Boyer**, ARNP, administrative officer for ambulatory care and coordinator of the chest pain center at North Florida/South Georgia Veterans Health Care System in Gainesville, FL.

Heart attacks are the leading cause of death in the United States for both men and women, with more than 5 million Americans visiting hospitals each year with chest pain.

The SCPC uses a protocol-driven approach to reduce time to treatment during the critical early stages of a heart attack, when treatments are most effective, and better monitor patients when it is not clear whether they are having a coronary event.

Surveyors don't play 'gotcha'

To receive accredited status, your organization must meet or exceed a set of stringent criteria and complete on-site evaluations by a review team, but the process is more educational than punitive, Boyer says.

"The goal is to see that every single piece of the puzzle is being done correctly, and as efficiently and time-sensitively as possible," she explains. "This is not like JCAHO [the Joint Commission on the Accreditation of Healthcare Organizations]; this is not 'gotcha.' They are going to come in and advise you how to facilitate improvement. They want to see that you are sincerely trying to improve the care you give."

You must document key elements and metrics that indicate your chest pain center has processes in place to consistently evaluate and treat patients presenting with chest pain, and that hospitals routinely follow their treatment results via ongoing quality improvement initiatives, explains **Matthew T. Roe**, MD, MHS, principal investigator for Crusade, a national quality improvement initiative to increase the practice of evidence-based medicine for patients with diagnosed non-ST-segment elevation acute coronary syndromes, coordinated by Duke Clinical Research Institute in Durham, NC.

"This recognizes hospitals that have a commitment to uniform, high-level care of chest pain patients," he says.

The steering committee of Crusade has agreed to work with the SCPC in the accreditation process and will recommend that all 400 Crusade hospitals accredit their chest pain centers.

To receive accreditation, your chest pain center must demonstrate expertise in the following areas:

- integrating the emergency department with the local emergency medical system;
- assessing, diagnosing, and treating patients quickly;
- effectively treating patients with low risk for ACS and no assignable cause for their symptoms;
- having a functional design that promotes optimal patient care;
- ensuring chest pain center personnel competency and training;
- maintaining organizational structure and commitment;
- continually seeking to improve processes and procedures;
- supporting community outreach programs that educate the public to promptly seek medical care if they display symptoms of a possible heart attack.

Once an organization is accredited, the team returns for a site visit every three years to ensure you have achieved their recommendations for improvement. A $15,000 fee covers the site visit and consultation.

You can use your organization's accredited status as a marketing tool, and it is a bonus during JCAHO surveys, Boyer explains.

"JCAHO loves this — when they come out to do a survey and you've already got accreditation from the SCPC, it's obvious you care about quality." There may soon be another powerful incentive, she adds.

"When 26 states use an accreditation, it becomes a standard, and 23 states currently have SCPC-accredited hospitals," Boyer says. "Medicare will probably start to require it. Just like with trauma center accreditation, you will have chest pain center accreditation."

At Community Health Partners Regional Medical Center in Lorain, OH, the SCPC's criteria were used as a framework to assess processes and systems, says **Jane M. Jones**, CPHQ, director of quality systems. Current practices were compared with the criteria in the accreditation manual, and changes were made to improve care.

After an application was submitted along with supporting documentation such as order sets, policies, and guidelines, a four-hour site visit was scheduled.

This consisted of a visit to the chest pain unit followed by a review of the accreditation tool with team members including cardiologists, the chest pain medical director, chest pain coordinator, emergency department director and educator, quality personnel, and administrators.

"This approach was well-received by all members of the team and especially by the physicians," Jones says.

The tool reviews the entire continuum of care for ACS patients and, therefore, requires the organization to take a systems look at its patient care processes, she continues.

"When this occurs, gaps in the delivery of care

can be identified and action plans developed to improve the quality and safety of patient care," Jones says.

Quality role is key

The quality manager is key in achieving accreditation and should be the one to complete the application for accreditation, Boyer stresses.

"This is a data-driven accreditation program — without the data you'll never get accredited," she says. "You'll need buy-in from upper administration, the emergency department, and cardiology, but data are everything."

The quality manager should be responsible for the following, according to Jones:

- Establish the process and outcome measures to identify how well systems and processes are functioning.

"This includes nationally known ACS quality measures such as EKG within 10 minutes of arrival or thrombolytics within 30 minutes, but may include unique process measures specific to an individual organization," she adds.

- Identify methods for data collection, preferably concurrent instead of retroactive chart review.
- Identify measurement goals for the organization, as well as best practice benchmarks.
- Aggregate data and analyze them for patterns and trends. "This may require some segmentation of the data into various shifts, days of week, and providers," says Jones.
- Develop a quality scorecard to report the measurement results and compare these against the organization's goals and benchmarks.

"Ensure the results are communicated to appropriate individuals within the organization, reviewed for improvement opportunities and actions taken as necessary to either improve or sustain high-quality outcomes," Jones explains.

- Cycle this process on a regular basis.

"Do you get that EKG within 10 minutes of arrival, do you get those troponins drawn within 60 minutes, and do you get those thrombolytics on board in less than 30 minutes?" Boyer asks. "The quality manager measures to make sure all of that is happening."

This can be done in a variety of ways, such as monitoring a percentage of patient charts, but without these data, there will be no accreditation, she notes.

"If you can't monitor your improvement process, how do you know you improved?" Boyer asks.

"The data points are not difficult — anyone with an Access database could design a template for this," she continues.

At Boyer's system, 100% of ACS charts are audited to check that all performance measures are met. "And if they don't find it in there, it didn't happen," she explains.

At Southern Hills, quality managers aggregate, oversee, analyze, and set in place methods to improve clinical outcomes and satisfaction with care.

Here are steps that occur:

- Data are collected and entered into several databases, on both a concurrent and retrospective basis.
- A registered nurse and the cath lab director abstract the data, and they are reviewed in appropriate committees for opportunities to improve performance.
- The core measures nurse provides education as needed on a concurrent basis to ensure practice guidelines are followed consistently.

Process is saving lives

Chest pain is the leading cause of malpractice lawsuits alleging misdiagnosis, says Boyer. "So the quality manager's job is twofold: One, that the patient gets the care they need in a timely fashion, and secondly, to reduce litigation," she adds.

The accreditation process has improved outcomes dramatically at her facility, according to Boyer. "It's a wonderful way to improve your process of care. I would encourage even the smallest hospital to take a look at it — in fact, especially the smallest hospitals. This says they're giving the same level of care as all the other hospitals — that little old VA is doing a standard of care similar to Cornell," she adds. "It's a great way to keep the institution cutting edge."

Here are examples of improvements made at the North Florida/South Georgia Veterans Health as a result of the SCPC accreditation process:

- **Cases are reviewed collaboratively with emergency medical services (EMS).**

"Previously, we did not have as close a relationship with EMS as we have now," says Boyer. "Thanks to the process, we now help them with their quality reviews, by doing ACS case reviews to see where we can improve."

The organization also is planning drills coordinated with emergency medical services (EMS) to find improvement opportunities.

As a result, EMS now is giving better documentation about when aspirin was given, routinely provides 12-lead EKGs, and in turn, receives feedback about care provided in the field and follow-up information on patient outcomes.

- **Faster troponin results are obtained**.

"We never got the troponins done in a timely fashion," says Boyer. "Now we have point-of-care troponin so we know within five minutes if the result is positive or negative," she says.

- **Two dedicated observation beds in the ED were added for ACS**.
- **New algorithms were developed**.

"Ours were way out of date," Boyer notes. "We are also looking at new competencies for nurses."

- **A technician was added at triage.**

"The triage process didn't work very well before, so we put a tech there who is instantly ready to do the EKG," says Boyer. The VA also is considering purchasing a new EKG machine that can be transmitted down to cardiology instantly.

- **Signage was improved.**

All signage inside and outside is being changed to better direct patients to the point of care. "Our signage was terrible outside, and we didn't realize it — it was embarrassing," she says. "We didn't think about it from the patient's point of view, and a delay in care can cost a life."

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To obtain a manual including an application for accreditation, which costs $150, go to the SCPC web site at www.scpcp.org. Click on "Accreditation of Chest Pain Centers," "Accreditation Manual Request Form." Or contact the SCPC, 3000 W. Broad St., Box 9, Columbus, OH 43204. Phone: (614) 274-9710. Fax: (614) 274-9716. E-mail: info@scpcp.org.] ■

NEWS BRIEFS

New CMS data key tool to identify shortcomings

Newly updated data now are available at the Centers for Medicare & Medicaid Services' Hospital Quality Initiative web site (www.cms.hhs.gov/quality/hospital), from hospitals participating in the Hospital Quality Alliance, the initiative led by the American Hospital Association and other organizations with the goal of sharing hospital quality information.

COMING IN FUTURE MONTHS

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- ■ Controversy over pay-for-performance programs
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More than 4,000 hospitals currently share data through the initiative, which assesses how often caregivers follow 10 clinical care steps proven to improve outcomes in heart attack, heart failure, and pneumonia patients.

Nearly 3,900 hospitals were eligible to receive a full Medicare inpatient payment update for reporting their performance on these measures.

In addition, approximately 200 small rural facilities also volunteered to share their data, though they were not eligible for the incentive.

"Quality managers should review how their facility's performance looks in relation to facilities nationwide," says **Patrice L. Spath**, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "Now, even small critical access hospitals have data they can use to evaluate performance."

Use the information as a springboard for improvements, Spath recommends. "Even if the data show your facility's performance is as good or even better than other facilities, remember the old adage, 'Everything can be improved,'" she says. "Achieving 100% compliance with recognized standards of care should be everyone's ultimate goal." ▼

JCAHO issues guidelines for pay for performance

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued a set of principles to guide the development of health care pay-for-performance programs.

According to JCAHO's board of commissioners, pay-for-performance programs should place the highest priority on patient-centered efforts to improve health care quality and patient safety. Currently, more than 100 pay-for-performance programs exist nationwide.

JCAHO's guidelines are designed for use by policy-makers, third-party payers, health plans, purchasers, and others who are involved in programs that provide incentives for achieving performance benchmarks.

JCAHO is urging that new models for payment give specific attention to aligning incentives among patients, practitioners, provider organizations, purchasers, and payers.

The guidelines emphasize the need for collaboration among stakeholders, evidenced-based measures, transparency and openness, and investment in subthreshold performers.

To view the Principles for the Construct of Pay-For-Performance Programs, go to the JCAHO web site at www.jcaho.org. Click on "News Room," "Joint Commission News Releases," "Joint Commission Establishes National Principles to Guide Pay-For-Performance Programs," "View the full set of principles." ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

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