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Institute of Medicine to overwhelmed ED managers: 'You're not alone'

Many problems caused by flaws in system, landmark reports say

"*Emergency health care in crisis.*"
"*High demand overcomes inadequate system capacity.*"
"*Overcrowding, boarding, diversions are major challenges.*"

ED managers who read these headlines in the three Institute of Medicine (IOM) reports on emergency care probably will feel as though they could have written them themselves.

What *is* different about these reports is that it's not the ED managers pointing out the problems in the system, but a major organization that carries substantial clout. And the report's emphasis on regionalization and system processes clearly demonstrate that problems such as ED overcrowding are not ED problems, but system problems. In the case of overcrowding, for example, that means it's a hospital problem.

"First of all, the IOM calls this a national crisis," says **Mike Williams**, MPA, HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. "I think this report is a major reinforcement to ED providers that the system is broken, and that the IOM feels your

ED Management Special Report: IOM issues landmark report on emergency medicine

In 1999, the Institute of Medicine (IOM) published a report, "To Err is Human: Building a Safer Health System," that led to a radical shift in the way health care organizations and agencies address patient safety. Now the IOM has turned its attention to the nation's emergency care system. Its three-year "Future of Emergency Care" project, just completed, has resulted in the publication of three reports totaling more than 800 pages.

The reports — on hospital-based emergency and trauma care, emergency medical services (EMS), and pediatric emergency care — were derived from 11 studies commissioned by recognized experts in emergency care.

See **IOM report**, continued on page 77

pain. But they reinforced that with the message that hospitals, for example, have not done everything they can do."

The findings of the IOM "absolutely rang true," Williams says. They report, for example, that hospitals went on diversion a half-million times in 2003, he says. "I think the report documents a very grim situation, painting a picture of a very unstable and de-compensating health care system as it relates to emergency care."

The IOM's Future of Emergency Medicine Committee wanted to address a lot of the fragmentation in the continuum of emergency care, explains **Benjamin K. Chu**, MD, MPH, regional president of southern California for the Kaiser Foundation Health Plan and Hospital in Pasadena and a member of the committee. "We want a much more coordinated system — one that is seamless and regionalized, so the patient gets to the right place at the right time — and a system that is accountable," he says.

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People outside the ED, Chu contends, are blinded to the lives of those within the ED. "They don't push for maximum efficiency, and just figure things will be taken care of," he says. However, that belief is a fallacy, he maintains. "The one place you don't want fatal errors is in the ED, but when you're overcrowded and rushed like that, how can you avoid it?" he says.

Fellow committee member **Arthur Kellerman**, MD, MPH, professor and chairman of the department of emergency medicine at the Emory School of Medicine in Atlanta, says that the report describes in detailed and hard-hitting terms the ever-widening mismatch between the demands placed on the emergency care system and its resources. Also, the report highlights "the attendant, unmistakable signs of distress: diversion, an increased risk of errors, high levels of stress, burnout, and our failure to deliver on our promise to the American people that we will be there when they need us," he says. "It's really hard to respond to a flu pandemic or some other major disaster in that context."

With its focus on systemwide change, it is not surprising that most of the IOM's recommendations also were targeted to systems: hospitals, state and federal governments, and health care organizations.

Kellerman says he has three top recommendations:

• On the federal level, he wants the creation of a lead agency responsible for improving the delivery of

Executive Summary

ED managers can make a difference, even though forces beyond your department impact your operations, according to just-released landmark reports from the Institute of Medicine. They suggest these changes to help offset the effects of those forces:

- Become involved in system design and communication issues.
- Performance indicators for EDs are coming. Make sure you have mechanisms in place for training, compliance, and evaluation.
- Consider implementing a clinical decision unit to combat overcrowding in your ED.

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emergency care. "Currently these responsibilities are widely scattered in many agencies," Kellerman says.

• Second, the states should take an active role in regionalizing delivery of pre-hospital care, including the designation of hospital capability to ensure the right patient goes to the right hospital at the right time, he says. Also states should manage the system "so you will not find ambulances wondering around," he says.

• Third, hospitals have to end the practice of boarding of admitted patients and end the widespread practice of ambulance diversion, Kellerman says.

The Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare & Medicaid Services should work to develop positive incentives to hold hospital administrators accountable for that third goal, he says. "It's just stupid that we allow the most time-critical parts of the emergency system to gridlock because the larger system is unwilling to do what it needs to do," Kellerman says. "You have to have a system that pulls patients out of the ED into inpatient units."

Calling all ED managers

The fact that many of the recommended solutions are systems solutions does not mean they should not involve ED managers, Chu emphasizes. For example, when it comes to coordination, "an ED manager really needs to be involved in the overarching design of the system," he says. "You have to be at the table when we talk about trying to get EMS people to communicate with hospital people."

He says one of the coordination pieces that the report discusses is regionalizing and defining different "tiers" of EDs so each tier is adequately trained for the levels of services being offered and being delivered, according to evidence-based protocols. "Each manager has to pay attention to what services their ED is capable of delivering," says Chu. "If you are a Level I trauma center, you have to make your surgeons, radiologists, and neurologists are properly trained and adhere to evidence-based protocols."

In terms of accountability, the committee called for a panel to be convened by the Department of Health and Human Services to develop evidence-based indicators of emergency care system performance. "The ED manager will likely have to worry about making sure that the indicators that are chosen are reasonable and that they can adhere to them," Chu advises. Once EDs have the indicators, the manager will have to work to optimize them, he says. "It will be their job to track them and to embed the department in overall improvement processes as a way to achieve them," he adds.

Managers also must be aware of strategies that are already addressing these problems, adds Williams. "We always cry about boarding, but the first thing I ask a client is, 'Do you have a clinical decision unit?'" he offers.

Williams defines it as "a unit established around an observation medical model, state of the art, with protocol-driven care with the goal of moving all patients through the system in 14 hours." Less than one in 40 EDs has one, he says, "But it's clearly a well-publicized best practice." **(For more on observation units, see these *ED Management* stories: "Desperate to stop the flow of red ink, Level I trauma center will deny transfers," March 2005, p. 25; "Number of freestanding EDs up, helping ease overcrowding, serving rural areas," September 2005, p. 98; and "Some chest pain patients may be discharged early," December 2005, p. 136.)**

Get the best-trained EMS

ED managers will be affected by the IOM's reports on EMS and pediatric emergency medicine as well, says Chu. "If you are a good ED manager, you will take a larger system view and make sure the EMSs associated with you are the best trained and are supervised by ED docs who really know what to do," he advises.

The pediatrics report recommends a family-centered approach, Chu says. "The committee observes that children do better when parents are involved," he says. A lot of hospital inpatient areas have begun letting parents stay overnight, but in a busy ED, it's not always easy to accomplish that, he acknowledges. "In a crowded ED, the manager might have to advocate for a separate area for children and families," Chu says. ■

Sources

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When it comes to IT, ED managers lag behind

Only 30%-40% of EDs have IT systems

The Institute of Medicine (IOM) report is all about the future. However, when it comes to information technology and ED managers, "the future really means catching up with the past," says one expert.

That's because only 30%-40% of the EDs in this country have *any* kind of information system in place, according to **Larry Nathanson**, MD, director of emergency medicine informatics at Beth Israel Deaconess Medical Center in Boston. "The first place for the rest to start is to get one," he advises.

Nathanson is a co-author of a report on information technology commissioned by the IOM, the findings of which have been incorporated into the larger reports. In it, the authors emphasize the value of technological advantages such as ED dashboards, or tracking systems, in a variety of areas, from safety and quality to prioritizing ED activities. **(For more information on tracking systems, see these *ED Management* stories: "Virtual beds' lower flow times, boost satisfaction," December 2005, p. 138; and "EDIS helps shrink door-to-doc times," March 2006, p. 29.)**

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"Certainly from an ED management standpoint, the [report on] technology reviews the tools one needs to put in place in the ED to ensure high-quality, maximum throughput, so you don't have patients coming in, tests being ordered, yet no one knows where they are or what's being done," says **John Halamka**, MD, MS, chief information officer of the Beth Israel Deaconess ED, a practicing emergency physician, and Nathanson's co-author. "I am a strong believer in metrics, and unless you put them in place you will *never* improve the management of the department."

Executive Summary

Information technology (IT) can lead to improvements in throughout, patient safety, quality, and patient satisfaction.

- ED managers now can be accessible when they are on the floor or even if they are at home.
- Having real-time information available allows managers to spot and react proactively to small problems before they become large ones.
- By establishing and tracking metrics, an IT system will enable you to obtain an accurate evaluation of your department's performance.

Sources

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How IT helps

One of the greatest advantages of a dashboard — so named because, as in a car, all your vital information is visible directly in front of you — is that you can react to potential problems before things begin to spiral downward, says Nathanson.

"With an automated tracking system, when things get busy, they are even *more* effective," he says. "Now you know what's going on, if you're getting into trouble, if there is a bottleneck developing." You can be proactive, he explains.

From an administrative point of view, an automated tracking system allows ED managers to be effective while on the floor — or even do from home, he says. "They can page you at three in the morning, you can log in, and instead of a nurse trying to describe a problem, you can look at the screen and see all the same data the nurse sees," Nathanson observes. "This is an important component in communication and ties in to patient safety as well."

Having such a system in place can be a big help when administration wants to review the ED's performance, adds Halamka. "If someone asks what your length of stay [LOS] is, of how long it takes for a patient to get a bed upstairs, what are you going to tell them? That you don't know?" he poses.

His board members are deeply concerned about LOS in the ED, Halamka says. "They think of it as an incredible proxy for the quality of care we deliver," he says. The lesson they have learned is that by having good management tools based on IT, they can achieve higher levels of patient satisfaction, higher throughput, a better business outcome, and higher quality of care "Everyone wins!" he adds.

In addition, electronic documentation can be "a tremendous tool" for training, education, and

simulation, Nathanson says. "Why not run doctors and nurses through simulated codes?" he suggests.

Beth Israel Deaconess launched its system five years ago, and Nathanson admits he was nervous about how well it would be accepted. "We had whiteboards in the background just in case, but they took one look at the system and saw the patient care benefits would be tremendous," he recalls. "When it's done well, it takes off by itself."

So, what are the keys to doing well? "We recommend a priority approach," Nathanson says. First, focus on patient flow, he says. "Then, move to continuity of care across other medical realms, such as getting information on your patients from primary care docs," Nathanson says. "Next, focus on decision support tools and preventing errors."

One of the latest developments involves public health surveillance, he says. "For example, if you can scan all of the area's ED records, you might see you're about to have a big flu outbreak or the Norwalk virus is in town," Nathanson notes. To quantify such a development in nonelectronic EDs would require sifting through stacks of charts, he says. "Now, you can press a key, and there's a bar graph in front of you."

As we move closer to a national electronic information system, EDs will contribute to the creation of Regional Health Information Organization Systems (RHIOS) to allow the exchange of data over large geographic areas, he says.

The bottom line, says Halamka, is this: "In the context of the IOM report, you will have to have both an ED background *and* technology to run the ED of the future." ■

System issues are at the heart of flow woes

IOM calls for a halt to ED boarding, diversions

As the Institute of Medicine (IOM) addressed the issue of patient flow, "system" was once again the magic word.

"I think for the EDs to function in the communities in which they exist, the thing of primary importance is that they not be places where admitted patients are boarded because there is not enough space in the hospital," notes **Peter Viccellio**, MD, FACEP, vice chairman of the department of emergency medicine in the School of Medicine at State University of New York at Stony Brook, and clinical director of the ED at Stony Brook University Hospital. "If you eliminate that, you eliminate ED crowding and ambulance diversion." This is exactly what the IOM called for in its report: that hospitals simply stop going on diversion. The IOM also recommended that federal

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IOM report

Continued from cover

Many of them are quoted in this issue. They share the same overriding themes, perhaps the most pervasive being, "We're all in this together." That is, EDs are not islands unto themselves, but departments that are part of larger systems: hospitals, communities, and regions.

Because these recurring themes were so broad, and because many of the IOM's recommendations were directed toward these systems, we thought it was important for our readers to "drill down" and examine the impact of these reports on ED managers. In addition to our cover story, which will provide a broad overview of the reports, this special issue will include articles on information technology, patient flow, patient safety and quality, and the emergency care work force. We cover what the reports say and what ED managers must do *now* to prepare for the future envisioned by the IOM committee.

We hope you find this issue to be a valuable analysis of the forces that will impact your profession in the years to come. As always, we welcome your comments — both on this month's edition of EDM and on the critical (and sometimes controversial) issues raised in the IOM reports. **[Editor's note: Copies of the IOM reports are available with the on-line version of *ED Management.* If you're accessing your on-line account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." If you already have an on-line subscription, go to www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "ED Management," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the July 2006 issue. For assistance, call Customer Service at (800) 688-2421.]** ■

Executive Summary

ED managers should be proactive in seeking to achieve Institute of Medicine report goals and in tackling patient flow from within, even before systems improvements are made.

- Change the "conversation" about flow, and address it in all meetings as a hospitalwide problem.
- Got no room for new patients? Try moving your admitted patients to the inpatient floor.
- Determine which areas "own" which part of the flow process, and then hold them accountable.

programs revise their reimbursement policies to reward hospitals that appropriately manage patient flow and penalize those that fail to do so.

Viccellio repeats the mantra that this is a hospital problem, not an ED problem. "As ED managers, if nothing else, we have to change the language of the discussion," he says. "We should use this in all settings: Any time we are boarding patients, it should be viewed as an institutional situation."

When his ED is holding admitted patients and has no space to see new patients, "we start to move admitted patients to the inpatient floor — regardless of whether there is a normal bed or available or not," he shares. "They are placed in hallways, the solarium, and so forth."

He got administrative buy-in for this approach, he says, only after having tried for several years to find other solutions. "It just didn't get fixed," he recalls, "But we were afraid the approach we were considering was against state regulations."

He called the senior person at the state health department and learned no such regulation existed. "Once you're overcrowded and people are lying around, what difference does it make if they are here or there?" he poses. **(For more on this strategy, see "Diversion crisis eases, but strategies still critical," *ED Management,* May 2004, p. 55.)**

Viccellio has one major bone to pick with the report. "I was disturbed in the preamble when they talked about unnecessary visits," he says. "We aren't on diversion because we have too many sprained ankles; it's because there are too many seriously sick people."

For example, Viccellio notes, a sore throat might not be considered a serious symptom. "We just had a resident conference on a patient with a cough, a rash on their elbow, and we diagnosed Lyme disease," he relates. "If they had been discharged with a cold, the visit would have been called 'unnecessary.'"

The report's emphasis on accountability makes a lot of sense, says **Diana S. Contino**, RN, MBA, CEN, FAEN, manager of public services-healthcare for Costa Mesa, CA-based BearingPoint, which provides strategic consulting, application services, technology solutions, and managed services for clients in public services (including health care), commercial services, and financial services. "The IOM report is an excellent summary of the key operational flow issues we should be assessing," she says. "The system approach is critical, as is the importance of the process owner — who should own and be accountable for their entire process."

For example, she continues, the admitting units should own the "time from admit request" to the "time of arrival on the unit." "They should be in their [key performance indicators], and you should post them publicly, and their process improvement efforts should be focused on creative ways to decrease these times," says Contino.

The laboratory and radiology departments, she adds, should own the "time order placed" to "time result delivered to the provider," she adds. "If they own and are held accountable for improving this full process, they have the incentive and motivation to critically evaluate the data and work collaboratively to decrease the processing times," she explains. Recently, she notes, the *Wall Street Journal* reported laboratories using Lean and Six Sigma techniques to make significant improvements in the turnaround times and the quality of their tests results.[1]

While the IOM was correct in saying hospitals need to align incentives to improve flow, "we can't wait for incentives to be aligned to make improvements," insists Contino.

"Managers who are grappling with long turnaround times and minimal staffing resources, and who don't have the necessary automated data resources, can't go wrong if they focus initial improvement efforts on several key issues that impact flow," says Contino. They are:

- decreasing practice variation;
- eliminating unnecessary steps;
- matching the right clinical resources (registered nurse, licensed practical nurse/licensed vocational nurse,

Sources

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technician, physician assistant/nurse practitioner, and doctor) to the patient's acuity (clinical needs);

• implementing rapid improvement events. (No longer can you wait months for change. Why not just do it now?)

"Using the IOM report and leading practices at other facilities can expose managers to the tools and methodologies used to identify and focus on the improvements that will produce the biggest results," Contino concludes.

Reference

1. Landro L. Hospitals move to cut dangerous lab errors. *Wall Street Journal,* June 14, 2006. Accessed at www.post-gazette.com/pg/06165/698180-114.stm. ■

Staffing is one element of safety, quality trials

As outlined in the Institute of Medicine report, there are three major issues that are hindering patient safety and quality in our nation's EDs, says **Mary M. Jagim**, RN, BSN, FAEN, internal consultant for emergency preparedness planning at MeritCare Health System in Fargo, ND. Jagim, who until a month ago was the manager of the MeritCare emergency center, identifies these issues as environment, staffing, and competency.

"Overcrowding and boarding issues make the ED a place in which errors would easily occur, whether they are medical errors, missing changes in a patient's condition, or a misdiagnosis because some X-ray or lab was not read in the chaos, or someone left before they could read it," she says. "It's a recipe for disaster."

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The problem with staffing, she says, is that appropriate staff levels are not always being achieved. "If you do not provide appropriate levels of staffing, this will be a safety issue," she asserts. One of the reasons there is a shortage of ED nurses goes back to the environment, she says. "If you feel you can't care for a patient appropriately, if patients swear at you and swing at you, why would you want to work there?" she poses.

The study also points out that there are varying levels of competency across EDs — whether it be nurses, physicians, nurse practitioners, or physician assistants. "If you care for a population with certain needs, you have to demonstrate a core level of competency for caring for them," says Jagim. "The vision of this report was that we create a system that is coordinated, regional, and accountable, and core competency is part of accountability."

Executive Summary

Moving toward improved quality and patient safety requires that the ED manager address three key issues: environment, staffing, and competency.

- "Rub your hospital's nose in the boarding problem," advises one ED manager.
- Make sure the competencies of your staff match the needs of the specific populations they serve.
- Develop a method for determining the most appropriate levels of nursing staff.

Crowding, being understaffed, and an often striking lack of access to informatics contribute to a reputation of the ED as an unsafe environment, says **Arthur Kellerman**, MD, MPH, professor and chairman of the department of emergency medicine at the Emory School of Medicine in Atlanta. "The report also points out understandable distractions: interruptions, acuity, and other factors that conspire to undermine the kind of safety we want," he says.

Learn flow techniques

Looking to the future, Jagim has several recommendations for ED managers. "If managers don't have knowledge in flow management techniques, they need to learn them," she asserts. "If they don't have a good method for determining the most appropriate level of nursing staff, they need to learn that." **(The Emergency Nurses Association has a program that addresses this issue. See resource box, p. 80.)**

Another of the report recommendations is the development of core competency standards for emergency staff, says Jagim. Even before they are developed, however, ED managers still must focus on this important issue. "As an ED manager, I looked at the populations I served," she shares. MeritCare Health System is a Level II trauma center, so Jagim looked for staff who had taken the Trauma Nursing Core Course. In pediatrics, she wanted them to have taken the Emergency Nurse Pediatric Course. For emergency response, she looked for training in areas such as HazMat awareness.

Kellerman adds that ED managers must have access to decision support systems and monitoring technology — "communications systems that don't require you to leave the department to get your results. Elements of that sort can significantly improve quality," he asserts.

Also, your ED should *not* be turned into a holding department on top of your mission to assess incoming

Sources/Resources

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The Emergency Nurses Association offers a system containing guidelines for ED staffing. Go to the ENA web site www.ena.org. Click on "Marketplace." Then, in the search box, type "ENA Guidelines for Emergency Department Nurse Staffing." The program is $100 for members (plus $20 for shipping and handling) and $500 for nonmembers (plus $65 for shipping and handling.)

emergency patients, Kellerman maintains. "That is a mission placed on many EDs by default, perhaps because we've been dumb enough to accept it."

Rub your hospital's nose in the boarding problem, adds **Robert L. Wears**, MD, professor of emergency medicine at the University of Florida (UF) College of Medicine and director of medical informatics at UF Emergency Medicine, both in Jacksonville. "The report gives a lot of support for the contention that nothing of value can be accomplished until the ED boarding problem is resolved," he says. "It should be raised in every venue and at every opportunity until some action occurs."

In addition, ED managers can look for "mini-catastrophes" that can be publicized to dramatize the issue, he says. This strategy is potentially risky, and might be best employed internally, Wears advises. "But there is a need to counterbalance the feeling that, yes, there are lots of complaints, but no one is dying," he says. "For example, one might begin reporting overcrowding episodes as sentinel events to [the Joint Commission on Accreditation of Healthcare Organizations] or state reporting systems."

The one report recommendation that will really help ED managers in the short run is the "command" to stop boarding patients in the ED, and to stop ambulance diversions, says Wear. "However, saying 'stop it now' is not much good without providing some sort of mechanism to actually do it." ■

ED work force appears stretched to its limits

The Institute of Medicine (IOM) report outlined three major dynamics — a shortage of primary care physicians, a disconnect between growing ED patient demand and shrinking capacity, and a shortage of on-call specialists — that are converging to create a dire situation for the emergency medicine work force.

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"We know we are in an environment where we have severe physician work force shortages across the board in all specialties," says **John C. Moorhead**, MD, FACEP, former head of the department of emergency Medicine at Oregon Health & Science University, Portland, and a practicing emergency physician. "I've been working with the Association of American Medical Colleges, and they predict a probable shortage of 20% or more that will likely persist for at least 10 years."

Shortage of physicians contributes

With a shortage in primary care physicians, he explains, patients who normally could access such a physician turn to the safety net, which includes EDs. "We feel good that people can come to us, but this contributes to the overall ED crowding issue that's well described in the report," says Moorhead.

The second key point, he continues, is that despite a decrease in the number of EDs in the country, volume continues to increase and looks to continue in the foreseeable future. "As part of the solution, we are going

Executive Summary

There are steps ED managers can take *now* to position their departments to better handle the staffing demands of the future.

- Turn to physician assistants for support in preliminary screening, diagnosis, and treatment of patients.
- Take a regional leadership approach to coordinating a system of care for facilities in your area.
- Initiate discussions with administrators on potential short- and long-term solutions to staffing problems.

to have to advocate for some additional funding for the work force and graduate medical education, and we believe a good portion should be devoted to emergency care," Moorhead notes.

The third key issue is the shortage of on-call specialists. "What this means to patients is that we can't assure them we'll have access to the services we'd like to provide them," Moorhead declares.

An 'innocuous' report

To a practicing ED manager, these findings are "pretty innocuous," says **Gregory Henry**, MD, FACEP, risk management consultant with Emergency Physicians Medical Group in Ann Arbor, MI. "The real key issue they have *not* addressed is who's giving out the care," he says. "You don't hear anything about using PAs [physician assistants] or techs instead of nurses."

The military has used corpsmen (soldiers able to give first aid) effectively and efficiently since World War II, Henry reports. "My own group uses 65,000 hours a year of PA time," he shares. "They can do a huge amount of preliminary screening, diagnosis, and treatment of patients." They check with physicians on certain diagnoses, and the more complicated cases are turned over immediately to the doctor, "but a huge number of cases they handle particularly well," Henry asserts.

Over the years, Henry contends, the PAs have had higher patient satisfaction rates and fewer malpractice suits against them than physicians. "When we do quality reviews on their charts, they actually do better in terms of adequately and accurately completing the charts than the docs do," he says.

One IOM recommendation Henry does agree with involves having Congress take a close look at malpractice liability. "We need to get closer to the British system, where they have one panel of experts that looks at each question," he says. "It's not an argument of paid experts, but of people who actually know what to do."

Regional call panels

One practical solution the IOM does propose involves the establishment of regional call panels — which Moorhead supports.

"We need to take a very calculated and thoughtful approach to what the solutions should be, but on a *regional* basis," he says. "I think we should encourage ED leaders to think not only in terms their ED, but to take a leadership approach to coordinating a system of care for the region."

Such an approach can help EDs jointly provide direction for patients to those hospitals with the resources that are needed, Moorhead says. "We have a computerized system in Portland that monitors the capability of the different hospitals," he shares. So, for example, if a hospital has a cardiac surgeon available, patients in need of cardiac surgery are sent to that facility.

Coordination across a regional system, he explains would at least allow acute care patients in ambulances to be sent to hospitals where they have the needed resources on a consistent basis.

Managers should act

Moorhead recommends that ED managers take a proactive approach starting today.

"Emergency department directors need to take what's in this report, walk into the hospital administrator's door, and begin a discussion on how we can address these issues in the short and long term," he asserts. "And we need to recruit assistance not only from administration, but from our colleagues in other specialties as well."

A lot of questions need to be raised, adds Henry. "Everyone believes they need more education, more space," he says. "Tell me, who doesn't?" Henry notes that the point is, there are things ED managers must do regardless of current conditions. For example, he notes, the IOM has called for significant congressional allocations for emergency care:

- an initial infusion of $50 million to help offset the costs of uncompensated emergency and trauma care;
- $88 million for projects to test ways to promote coordination and regionalization;
- $37.5 million each year for the next five years to the Emergency Medical Services for Children Program to address deficiencies in pediatric emergency care.

However, that recommended influx of cash may not be forthcoming, Henry says. "Then what are you gonna do?" he challenges.

Still, Henry is optimistic about the future. "The smart guys will always survive. They will figure it out," he says. "But until we are willing to challenge our thought processes, we will have the 'same-old, same-old.'" ■

Source

For more information on ED staffing strategies, contact:

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New patient safety goal: Involve your patients

Another new goal targets patient suicides

ED managers could be impacted by one newly announced National Patient Safety Goal and an extension of an existing goal, says **Richard Croteau**, MD, executive director for patient safety initiatives at the International Center for Patient Safety at the Joint Commission on Accreditation of Healthcare Organizations. The new Goal, 15/ 15A, states:

"The organization identifies safety risks inherent in its patient population. The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]"

The extension is for Goal 13/13A, which previously did not apply to hospitals. It reads:

"Encourage patients' active involvement in their own care as a patient safety strategy. Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so."

In terms of the new goal, says Croteau, "the requirement is that these patients be assessed for risk of suicide, and based on that assessment, that appropriate precautions be taken." Usually, he says, these precautions involve continuous observation and checking for any kind of contraband, such as pills or knives.

Richard Bukata, MD, FACEP, medical director of the ED at San Gabriel Valley Medical Center in Sierra Madre, CA, responds: "I think we do that now. If people come in with some indication there has been self-harm — they've taken some pills, or cut their wrists — all those patients are assumed to be suicidal."

In those cases, he says, after the physicians evaluate them, there often will be a consult from the psychiatric evaluation team. "We often have a guard placed by the room so they cannot elope or leave before it is determined whether they are a danger to themselves." **(For more information on handling these patients, see policy on "Initial Management of Potential Suicidal/Homicidal or Potentially Violent Patients," *ED Management,* July 2003, supplement.)**

As for Goal 13, "The patient needs to be advised as to how they can express concerns about their safety," Croteau explains. "If they observe anything they think is unsafe, they need to be able to report that, so the ED needs to provide those means and encourage them to do it."

He suggests that the triage nurse might say, if appropriate, something like this: "Here at 'St. X Hospital,' we are very concerned about safety. We want everyone and anyone to be alert and to help us keep everyone safe — including you." Accordingly, Croteau continues, the patient can be advised that if they see something that doesn't look right or appears hazardous, they should tell the first nurse or doctor they see. "You don't want the patient to feel you are transferring the responsibility for their safety to them, but you should state your philosophy of safety and engage the patient and family as part of that philosophy," he emphasizes.

The family's involvement is especially important if the patient is unconscious, adds Croteau. "It could be a significant other, a close friend — whoever they want by their side as an advocate," he says.

But, warns Bukata, "The devil's in the details. How are you supposed to comply?" For example, he notes, one possibility might be to have signs all over the ED saying, "If you see something that's not safe, talk to your nurse." ■

Executive Summary

The 2007 National Patient Safety Goals may impact ED managers, but many diligent managers will find they already are in compliance.

- Encourage patients to speak up if they are concerned about safety issues in your department.
- Signage and scripts for nurses can help inform patients how to proceed when they have safety concerns.
- Make sure protocols are in place to take proper precautions when patients are deemed a suicide risk.

Sources

For more information on the 2007 National Patient Safety Goals, contact:

- **Richard Bukata**, MD, FACEP, Medical Director, Emergency Department, San Gabriel Valley Medical Center, 227 W. Orange Grove Ave., Sierra Madre, CA 91024. Phone: (626) 836-3700. Fax: (626) 836-3702. E-mail: wrbukata@aol.com.
- **Richard Croteau**, MD, Executive Director for Patient Safety Initiatives, Joint Commission International Center for Patient Safety, Phone: (401) 855-0281.

Boost communication for emergency preparedness

A new study from the Joint Commission on Accreditation of Healthcare Organizations finds that community-based preparation for — and response to —

Sources

For more information on emergency preparedness, contact:

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disasters will require more effective communication and planning among hospitals, public health agencies, and community first responders such as fire, police, and emergency medical services, than currently exists. The study also found that national benchmarks are needed to measure and promote emergency preparedness planning.

The study — "Integrating Hospitals into Community Emergency Preparedness Planning" — appears in the June 6 issue of *Annals of Internal Medicine.* (To view the complete study, go to www.annals.org/cgi/content/full/144/11/799.) It found that most acute care hospitals are involved in communitywide drills, analyze threats and vulnerabilities with community first responders, and are in communities which have plans for mobilizing necessary supplies, equipment, and decontamination facilities that would be required in an emergency. However, it recommends drills and exercises that more truly simulate the stresses created by emergency conditions that persist over time.

"Drills and exercises should be designed to stress the communitywide response over a substantial period of time and should demonstrate the ability for an effective, collaborative response at any time of day or night," advises. **Barbara Braun**, PhD, Health Policy Research Project Director, Division of Research, Joint Commission on Accreditation of Healthcare Organizations and one of the study's authors. "Drills should address event notification, communication, resource allocation, and patient management."

Robert Suter, DO, MHA, FACEP, immediate past president of the American College of Emergency Physi-cians and chair of the ED at Spring Branch Medical Center in Houston, says the paper is valuable in that it illustrates two very common issues: "One, that hospitals are essential to any preparedness for disasters and emergencies; and two, hospitals need to ensure that they are part of any communitywide disaster and emergency plan."

For ED managers, this survey shows is that there is room for improvement in the way you conduct your drills, Suter says. "One of the keys is for hospital ED managers to go to their community resources such as the fire and police departments and EMS, and show them the data and what will *really* happen in a true disaster," he says. "That, for example, the majority of patients will end up in the ED *first* — and not necessarily with EMS."

It's far more efficient for the police and fire departments to ensure the hospital nearest the disaster has the resources to provide security, decontamination, and triage than it is for them to respond to a scene that may be several miles wide, Suter explains. "If a mass disaster spreads over 10-30 miles, you can't send a fire truck to every patient — but you know people will try to go to the nearest hospital — you have to have those agreements up front so they understand their priority is to focus on the ED." ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME objectives

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

COMING IN FUTURE MONTHS

■ JCAHO's meds reconciliation standard: The battle is joined

■ New Orleans: With two EDs, things have hardly gotten better

■ Transferring inpatients in trouble *to* the EDs

■ When docs ask to resign limited clinical privileges

CE/CME *questions*

19. According to Benjamin K. Chu, MD, MPH, ED managers can respond proactively to the findings of the Institute of Medicine report on emergency medicine by:
A. Getting involved in the design of regional systems.
B. Preparing for the establishment of national emergency medicine standards.
C. Ensuring that emergency medical services (EMS) are well supervised by knowledgeable ED physicians.
D. All of the above

20. According to Larry Nathanson MD, what is the first issue an ED manager should address with an information technology system?
A. Continuity of care
B. Patient flow
C. Decision support
D. Materials management

21. According to Diana S. Contino, RN, MBA, CEN, FAEN, ED managers without electronic information systems can still make four key patient flow improvements. Which of the following did she *not* name?
A. Decrease variation
B. Eliminate unnecessary steps
C. Align incentives
D. Conduct rapid improvement events

22. According to Mary M. Jagim, RN, BSN, FAEN, ED managers can improve patient quality and safety by:
A. learning flow techniques.
B. develop a system to determine appropriate nurse staffing levels.
C. align staff competencies with specific patient populations.
D. All of the above

23. Based on his personal experience, Gregory Henry, MD, FACEP, says physician assistants have been shown to outperform physicians in:
A. accurately completing charts.
B. accurately diagnosing patient conditions.
C. handling screenings more rapidly.
D. treating patients more effectively.

24. According to Richard Croteau, MD, ED managers seeking to comply with National Patient Safety Goal 13/13A should *not:*
A. involve family in safety activities.
B. transfer responsibility for safety to the patient
C. tell the patient who to contact if they have a safety concern.
D. follow a script when discussing the hospital's safety philosophy.

CE/CME answers

19. D; 20. B; 21. C; 22. D; 23. A; 24 B.