TJC’S New Patient Flow Standards: Crowding and Boarding in the ED

September 5, 2013

The information provided in AHC Media Webinars does not, and is not intended to constitute medical or legal advice. Opinions, references and links provided by our speakers are provided for your convenience and do not represent our endorsement of such opinions, products or services.
Speaker

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- Board Member Emergency Medicine Patient Safety Foundation www.empsf.org
- 614 791-1468
- sdill1@columbus.rr.com
Objectives

- Recall that the Joint Commission has changes to the patient flow standards that go into effect in 2013 and 2014
- Discuss that the Joint Commission has a patient flow tracer that is evaluated by surveyors during a survey
- Describe the four hour rule (goal) on getting patients to their room when admitted
TJC Patient Flow Standards

- TJC has revised their standards on patient flow effective January 1, 2013 and 2 changes in 2014
  - Not called JCAHO anymore
- LD.04.03.11 EP 6 goes into effect January 1, 2014 regarding setting a 4 hour window as the goal for boarding of patients in the ED before they get to their bed
- LD.04.03.11 EP 9 goes into effect January 1, 2014 regarding boarding of behavioral health patients in the ED
TJC Amends Patient Flow Standards

www.jointcommission.org/standards_information/prepublication_standards.aspx

Standards Revisions to Address
Patient Flow Through the Emergency Department
Hospital Accreditation Program

Standard LD.04.03.11
The hospital manages the flow of patients throughout the hospital.

Element of Performance for LD.04.03.11

1. The hospital has processes that support the flow of patients throughout the hospital.

2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post anesthesia care unit or the emergency department.

3. The hospital plans for care to patients placed in overflow locations.

4. Criteria guide decisions to initiate ambulance diversion.

5. The hospital measures the following components of the patient flow process:
   - The available supply of patient beds
   - The efficiency of areas where patients receive care, treatment, and services
   - The safety of areas where patients receive care, treatment, and services
The Joint Commission New Patient Flow Standards

By: Sue Dill Calloway RN MSN JD CPHRM
Chief Learning Officer
Emergency Medicine Patient Safety Foundation
July 2012

The Joint Commission is an organization that accredits about 82% of the hospitals in the United States. Any hospital accredited by the Joint Commission must be in compliance with all of their standards. The Joint Commission has standards on patient flow to prevent overcrowding and boarding of patients in the emergency department and in other temporary locations.
TJC Issues R3 Report

- Published December 19, 2012 and is 5 pages
  - Provides rationale, requirements, and references used
- Can be downloaded off TJC website at www.jointcommission.org/r3_report_issue4/
- Discusses LD.04.03.11 and PC.01.01.01
  - LD.04.03.11: The hospital manages the flow of patients throughout the hospital (Revises EP 5, 7, and 8)
  - PC.01.01.01: The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient’s needs (EP 4 and 24)
- LD EP 6 (4 hour time frame) and 9 (boarding behavioral health patients) go into effect Jan 1, 2014
Published for Joint Commission accredited organizations and interested health care professionals, R³ Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in R³ Report goes into more depth. The references provide the evidence that supports the requirement. R³ Report may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, sign up to receive an E-mail Alert.
Published for Joint Commission accredited organizations and interested health care professionals, $R^3$ Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in $R^3$ Report goes into more depth. The references provide the evidence that supports the requirement. $R^3$ Report may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, visit www.jointcommission.org.

Patient flow through the emergency department

Requirements
Standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals. These revised elements of performance (EPs) go into effect January 1, 2013, with two exceptions: LD.04.03.11, EPs 6 and 9 will be effective January 1, 2014. They will be included in the 2013 standards manual, but any findings from the on-site survey will not affect the organization's final accreditation decision. Information on the implementation of these requirements will be collected by Joint Commission surveyors and staff throughout 2013, and will be used to inform the survey process.

Standard LD.04.03.11: The hospital manages the flow of patients throughout the hospital.

EP 5. The hospital measures and sets goals for the components of the patient flow process, including the following:

- The available supply of patient beds
- The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry,
Leadership (CAMH / Hospitals)

Patient Flow and Boarding
Where can I find more information on Patient Flow and Boarding?

Read the R3 Report Issue 4 - Patient flow through the emergency department

Published for Joint Commission accredited organizations and interested health care professionals, R3 Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in R3 Report goes into more depth. The references provide the evidence that supports the requirement. R3 Report may be reproduced only in its entirety and credited to The Joint Commission.
Crowding and Boarding

- The patient flow standards are part of the leadership chapter
- Leadership chapter completely rewritten in 2009
- TJC standards on patient flow are to prevent overcrowding and boarding especially in emergency department (ED) patients
  - Also boarding of patients in other temporary locations
- TJC first implemented patient flow chapter standards in 2005
Patient Flow Revisions

- Revisions include leadership use of data and measures to identify and mitigate and manage patient flow issues and management of ED throughput as a system wide issue.

- Revisions include safety for boarded patients and leadership communication with behavioral health providers so care of boarded patients is coordinated.

- TJC also revised PC.01.01.01 because of safety issues of boarding behavioral health patients especially in the ED.
Use of Data

- TJC revised EPs 5, 7, and 8 to be consistent with current practices regarding the use of data and metrics
  - This is used to identify, monitor, manage and improve patient flow throughout the hospital
- Most hospitals reported that leaders are reviewing the patient flow data on a monthly or quarterly basis
- Have used Lean, Six Sigma or other change management to make changes and improve outcomes
  - Attention to culture and operations were found to be as important as concerns about technology & data
Crowding and boarding has been a problem for many years for hospitals.

It has been a top issue for organizations like the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA).

A recent study found that ED crowding is growing twice as fast as visits.

In fact, ED crowding is rising to unsustainable proportions (Pines, Annals of EM, 2012).
Overcrowding and Boarding

- The number of ED visits increased by 1.9% per year over an eight year study period
- This calculated to a rate that increased 60% faster than the population growth
- Crowding grew by 3.1%
- ACEP and Urgent Matters are an excellent source of articles on solutions and ideas to deal with the issue of overcrowding and boarding
ACEP Resources on Crowding and Boarding

Emergency Medicine Crowding and Boarding

Search Crowding:  

As emergency departments throughout the country deal with the problems of crowding, boarding, and ambulance diversion, solutions have been sought. The resources on this page provide information, resources and examples of a variety of approaches to assist emergency physicians in addressing the crowding problems by working with hospital administrators, local stakeholders, policy makers and the public. Some ACEP chapters have sought relief through state legislative and regulatory action. These additional crowding resources are available in ACEP’s Advocacy area.

ACEP Sends Comments to The Joint Commission on Patient Flow NEW
ACEP supports the proposed definition, including the 4 hour timeframe, opinions among members are varied.
Jan. 19, 2012

Associations Join Forces to Reduce ED Crowding
ACEP, ENA and seven other associations have signed a consensus statement that proposes standardized emergency department metrics to help reduce crowding and boarding in emergency departments.

www.acep.org/content.aspx?id=32050
Emergency Department Crowding: High-Impact Solutions
This comprehensive 2008 report from the ACEP Boarding Task Force includes low and no-cost solutions to the practice of boarding patients in the emergency department.

ACEP’s Suggested Boarding Solutions Generate National Support
May 30, 2008

Crowding Case Studies
Submit your case study for publication on ACEP.org.

Related ACEP Policy Statements

Boarding

Boarding of Admitted and Intensive Care Patients in the Emergency Department
Boarding of Pediatric Patients in the Emergency Department
Definition of Boarded Patient
Health Care System Surge Capacity Recognition, Preparedness, and Response
Responsibility for Admitted Patients
Writing Admission and Transition Orders

Diversion

Ambulance Diversion
PREP for above policy:
URGENT Matters

Announcements

Urgent Matters Conference: Coordinating and Improving Emergency Care in the Era of Reform
October 7, 2012 - 12:45-5 PM

Join Urgent Matters and the American College of Emergency Physicians for a half-day event exploring the new era of health reform and the implications for the emergency department. Multidisciplinary leaders in the field will discuss acute care coordination, resource utilization, patient experience, and quality improvement in the ED. Additionally, the workshop will address the necessity of an appropriate emergency care setting for the growing aging population.

Crowding

Emergency department (ED) crowding has reached epidemic proportions across the country. We all know that crowded EDs lead to longer wait times and lead to poorer patient outcomes. This issue of the Urgent Matters E-Newsletter features two low cost ways to reduce ED crowding and improve patient safety and a review of the Joint Commission’s new patient flow standards.

By focusing on patient intake and using a team approach Dr. Joseph Delucia and his colleagues at Saint Louis University Medical Center were able to reduce left-before-being-seen rates and improve patient satisfaction.

Natalie Schmitz, MMSc., PA-C, SEMPA President and her colleagues discuss how PAs can be utilized to improve ED crowding in this issue’s Best Practices article.

The third article in this issue reviews the Joint Commission’s new patient flow standards. Sue Dill Callaway RN MSN JD CPHRM, from the Emergency Medicine Patient Safety Foundation explains the impact of the revised standards that will go into effect January 1, 2013.

ACEP Scientific Assembly
October 8 - 11, 2012
Join the American College of Emergency Physicians in Denver for the world’s premier emergency medicine conference. Featuring over 300 educational courses, Pre-conference CME opportunities, and the largest exhibit program in the specialty - you can’t miss out on this one-of-a-kind experience!

Approved for AMA PRA Category 1 Credit™

Register Now!

2013 NAEMSP® Annual Meeting
January 10-12, 2013
Featuring specialty workshops, scientific assembly and trade show at the Hyatt Regency Coconut Point Resort and Spa in Bonita Springs, Florida.

Start Planning Your Trip Today
ACEP, ENA, AAEM, AAP, ANA, ED Practice Management Association, and others have joined forces to reduce ED crowding.

Total 9 organizations

Signed a consensus statement to standardize ED metrics so everyone is measuring things in the same way.

Defines ED arrival time, ED transfer time, ED contact time (time to see the physician or LIP), admission time, disposition to discharge, ED LOS, etc.
Consensus Statement for ED Metrics

Consensus Statement
Definitions for consistent Emergency Department metrics

The emergency department (ED) has become the “portal to the community” and the entry point where most patients are introduced to the health care system. It is also a logical place to expedite needed reform to ensure universal access to essential health care services. This situation has led the undersigned stakeholder organizations to develop metrics that will aid in helping to alleviate the critical situation facing our emergency departments in the care of their patients.

Definitions – Time Stamps

Emergency Department
A dedicated location serving an unscheduled patient population requesting emergency assessment.

Emergency Department Arrival Time*
The time that the patient first arrives at the institution for the purpose of requesting emergency care should be recorded as the arrival time. This is the first contact not necessarily registration time or the triage time.

*Emergency Medical Services (EMS): EMS vehicle arrives at emergency department door.
*Ambulatory: A patient requests care, or is asked by ED staff if they are here to receive emergency care.
Crowding is a Patient Safety Issue

- Crowding is caused by boarding
- Research has shown that this is a patient safety issue and impacts patient outcomes
- Boarding increases
  - Waiting times and ambulance diversions
  - Length of stay (LOS)
  - Medical errors and sentinel events
  - Malpractice claims
  - Patients who leave without being seen
  - Financial losses, mortality and other related issues
Crowding and Boarding: Mortality Rate

- Article published in December 2012 in Annals of Emergency Medicine found patients who came through a crowded ED had a **5%** greater chance of dying in the hospital.
- Likely caused from challenging doctors’ resources.
- Crowding delays treatment of MI, pneumonia and painful conditions, increased LOS and costs.
- Average ED rate now 58.1 minutes (Up from 46.5 minutes between 2003 and 2009, CDC).
- Looked at 995,379 ED visits from 187 hospitals.
5% Greater Odds of Dying in Crowded ED

Effect of Emergency Department Crowding on Outcomes of Admitted Patients

Benjamin C. Sun, MD, MPP, Renee Y. Hsia, MD, Robert E. Weiss, PhD, David Zingmond, MD, Li-Jung Liang, PhD, Weijuan Han, MS, Heather McCreath, PhD, Steven M. Asch, MD

From the Department of Emergency Medicine, Oregon Health and Science University, Portland, OR (Sun); the Department of Emergency Medicine, University of California, San Francisco, CA (Hsia); the Department of Biostatistics, School of Public Health (Weiss), and Department of Medicine (Zingmond, Liang, Han, McCreath), University of California, Los Angeles, CA; and the VA-Palo Alto Health Care System and Stanford University School of Medicine, Palo Alto, CA (Asch).

Study objective: Emergency department (ED) crowding is a prevalent health delivery problem and may adversely affect the outcomes of patients requiring admission. We assess the association of ED crowding with subsequent outcomes in a general population of hospitalized patients.

Methods: We performed a retrospective cohort analysis of patients admitted in 2007 through the EDs of nonfederal, acute care hospitals in California. The primary outcome was inpatient mortality. Secondary outcomes included hospital length of stay and costs. ED crowding was established by the proxy measure of ambulance diversion hours on the day of admission. To control for hospital-level confounders of ambulance diversion, we defined periods of high ED crowding as those days within the top quartile of diversion hours for a specific facility. Hierarchic regression models controlled for demographics, time variables, patient comorbidities, primary diagnosis, and hospital fixed effects. We used bootstrap sampling to estimate excess outcomes attributable to ED crowding.

Results: We studied 995,379 ED visits resulting in admission to 187 hospitals. Patients who were admitted on days with high ED crowding experienced 5% greater odds of inpatient death (95% confidence interval [CI] 2% to 8%), 0.8% longer hospital length of stay (95% CI 0.5% to 1%), and 1% increased costs per admission (95% CI 0.7% to 2%). Excess outcomes attributable to periods of high ED crowding included 300 inpatient deaths (95% CI 200 to 500 inpatient deaths), 6,200 hospital days (95% CI 2,800 to 8,900 hospital days), and $1.7 million (95% CI $1.1 to $2.3 million) in costs.
Patient Flow

- Is an issue that needs to be solved by hospital leadership
- It is not necessarily an ED issue even though it impacts the ED
- The revised standards recognize that the causes may be multifactorial and stem from other areas in the hospital
- If the surveyor identifies problems with patient flow, the surveyor will interview leadership about their shared responsibility with the Medical Staff
Managing Patient Flow Rationale

- This standard has a rationale that discusses that managing the flow of patients throughout the hospital is essential to prevent overcrowding.

- Overcrowding undermines the timeliness of care and affects patient safety.

- System-wide programs should be effectively managed that support patient flow.

- This includes processes for admitting, assessment, treatment, patient transfer and discharge.

- Improving these can lead to useful strategies.
State Ban on ED Diversions

- Massachusetts became the first state to ban ambulance diversion in 2009
  - Concern was this would increase ED over crowding and boarding
- 2012 study found this was not the case and actually found it led to shorter average ED wait times
- ED traffic increased in nine hospitals 3.6% but LOS dropped 10.4 minutes for admitted patients
  - Ambulance diversion has little impact on crowding
  - Operational changes improved patient flow such as streamlining handoffs and reducing occupancy level
The Effect of an Ambulance Diversion Ban on Emergency Department Length of Stay and Ambulance Turnaround Time

Laura G. Burke, MD, MPH; Nina Joyce, MPH; William E. Baker, MD; Paul D. Biddinger, MD; K. Sophia Dyer, MD; Franklin D. Friedman, MD, MS; Jason Imperato, MD, MBA; Alice King, MS, RN; Thomas M. Madejko, EMT-P; Mark D. Pearlmutter, MD; Assaad Sayah, MD; Richard D. Zane, MD; Stephen K. Epstein, MD, MPP

**Study objective:** Massachusetts became the first state in the nation to ban ambulance diversion in 2009. It was feared that the diversion ban would lead to increased emergency department (ED) crowding and ambulance turnaround time. We seek to characterize the effect of a statewide ambulance diversion ban on ED length of stay and ambulance turnaround time at Boston-area EDs.

**Methods:** We conducted a retrospective, pre-post observational analysis of 9 Boston-area hospital EDs before and after the ban. We used ED length of stay as a proxy for ED crowding. We compared hospitals individually and in aggregate to determine any changes in ED length of stay for admitted and discharged patients, ED volume, and turnaround time.

**Results:** No ED experienced an increase in ED length of stay for admitted or discharged patients or ambulance turnaround time despite an increase in volume for several EDs. There was an overall 3.6% increase in ED volume in our sample, a 10.4-minute decrease in length of stay for admitted patients, and a 2.2-minute decrease in turnaround time. When we compared high- and low-diverting EDs separately, neither saw an increase in length of stay, and both saw a decrease in turnaround time.

**Conclusion:** After the first statewide ambulance diversion ban, there was no increase in ED length of stay or ambulance turnaround time at 9 Boston-area EDs. Several hospitals actually experienced improvements in these outcome measures. Our results suggest that the ban did not worsen ED crowding or ambulance availability at Boston-area hospitals. [Ann Emerg Med. 2012;xx:xxxx]
State Ban on ED Diversions

- Hospital may only divert if on Code Black such as fire, flooding, contamination or other disasters
- Study found the major factor of ED crowding is boarding of admitted patients in the ED
- Inadequate staffing also lead to ED crowding
- Massachusetts hospitals have been leading the way to reduce ambulance diversions and focus on patient flow
- IOM says diversions can lead to catastrophic delays for seriously ill or injured patients
Key Interventions

- Code Help implemented
- Inpatient bed dashboard
- Establish threshold to deploy physicians at triage
- Establish 10 bed surge pod on inpatient unit to care for boarded ED patients
- Use nontraditional space for boarding such as PACU, off hour procedure unit, etc.
- Twice daily rounds
- Internal medicine coverage of admitted patients waiting for inpatient bed, etc.
The standard: The hospital manages the flow of patients throughout the hospital

This standard has 9 elements of performance (EPs)

EP1 states the hospital has a process that supports the flow of patients throughout the hospital

- What are some things a hospitals could do to meet this standard?
  - Many hospitals have a policy of no direct admits to the ED
  - Some hospitals go on diversion when there is a critical shortage of beds or staff
EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)

- Some hospitals have instituted processes to support the flow such as stat cleans of room by environmental services when a patient is waiting in the ED
- Some hospitals have posted ED physicians or NP at triage to expedite care in the ED
- Some ED have direct boarding where patients arriving go immediately to an ED bed if one is open (pull to full)
- Others keep ambulatory patients vertical when their condition allows this
EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)

- Some hospitals have a revised process in which each of the departments accepted one overflow patient.

- The thought being it was easier for a department to take care of one additional patient then to have 12 boarded patients in the ED.

- Some hospitals require daily rounds be made by a specified time so current patients are discharged home timely freeing up beds for patients who are being boarded.
EP1 states the hospital has a process that supports the flow of patients throughout the hospital (continued)

- Patient flow problems most frequently occurred on Mondays and Tuesdays
- Some hospitals have ensured that adequate services are available on the weekend so surgeons will not just schedule elective cases on Monday or Tuesday but can space elective cases throughout the entire week
- The literature is full of research and strategies that hospitals that do to improve and support patient flow throughout the hospital
EP2 Addresses the need for the hospital to plan and care for the patients who are admitted and whose bed is not ready or a bed is unavailable
  - Patient may be in a temporary area such as the ED or PACU

EP3 Addresses the need for the hospital to plan the care for patients who are placed in an overflow location

So what does these two standards mean?
For example, an ICU patient is admitted and is currently residing in the ED
  - It is the ICU standard of care—does an ICU nurse come down to care for the patient?

How does the patient get their assessment done, lab tests, medications administered and other ICU care?

How does the hospital ensure that the patient is getting the same standard of care?

How do you ensure that nursing staff are competent to care for patients?
EP4 Discusses that criteria guide decisions to initiate ambulance diversion

- Hospitals should have a policy and procedure on diversion
- One state recently passed a law forbidding ambulance diversions but other safeguards were put into place
- Diversion is an EMTALA issue
- EMTALA CoP, page 38, states that “a hospital may divert individuals when it is in “diversionary” status because it does not have the staff or facilities to accept any additional emergency patients at that time”
EP4 discusses that criteria guide decisions to initiate ambulance diversion (continued)

If ambulance disregards the hospital’s instructions and brings the patient to the hospital, the ED must do a medical screening exam (MSE) to determine if the patient is an emergency medical condition (EMC)

ED should consider documenting dates and times for diversion

Case law exists regarding diversion
State Operations Manual
Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3 - Record Review
VI. Task 4 - Interviews
VII. Task 5- Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases
DIVERT POLICY

PURPOSE

To define the term “divert” as it applies to our hospital.

To provide and protect patient safety

To establish an organized response to fluctuation in clinical acuity or resource availability, thereby ensuring appropriate medical screening, stabilization, and/or initiation of treatment, and/or transfer to a facility equipped to provide an equal or higher level of service.

SCOPE

Hospital-wide
External services, as individual situation would require

DEFINITION

Divert is that situation whereby it is temporarily necessary to direct patients to another service area or another facility for care.

SITUATIONS NECESSITATING DIVERSION

...
DIVERT NOTIFICATION CHECKLIST

DATE: ______________ TIME INITIATED: __________ TIME CANCELLED: __________ TOTAL: __________

AUTHORIZED BY: ___________________________ following consultation with: Unit Manager ________________

Medical Director __________________________ Administrator on Call ________________________

Type of Divert:  
_____ Individual patient  
_____ Specific type of patient (explain) ________________________________  
_____ Unit/department (specify) ________________________________  
_____ Hospital-wide

SITUATION NECESSITATING DIVERSION (check all that apply)  
_____ Medical Command decision Reason: ________________________________  

______ Appropriate bed unavailable:  
     _____ Security room  
     _____ Monitored beds  
     _____ Capacity maximized  

______ Equipment problem:  
     _____ Utility outage (specify) ________________________________  
     _____ Capacity in service

______ Staffing/personnel issue:  
     _____ Acuity/staffing ratio  
     _____ Support services unavailable  
     _____ Specialty physician not available

______ Disaster:  
     _____ Severe weather  
     _____ Fire  
     _____ Manmade (type) ________________________________

NOTIFICATIONS (check all that apply)  
_____ Appropriate Service Areas  
_____ Local Ambulances (via radio)  
_____ County Communications (911) | Other Facilities: specify ________________________________

Department of Health (If greater than 8 consecutive hours or 12 hours in a 24 hour period) Refer to ADM 59

BRIEF SYNOPSIS OF EVENTS LEADING TO DIVERT
EP5 Requires the hospital to measure and set goals for the components of the patient flow process

This EP was revised January 1, 2013 and includes additional things that must be measured

Hospital leaders will need to use data and metrics in a more systematic process

Measurement includes:
- The available supply of patient beds
- Access to support services such as case management and social work
LD.04.03.11  Measure the Following

- Measurement includes (continued):
  - The safety of areas where patients receive care and treatment
  - Throughput of areas where patients receive care which could include inpatient units, lab, PACU, OR, telemetry, radiology, and telemetry
  - Hospitals must also measure and set goals for the efficiency of non-clinical services that support patient care such as transportation and housekeeping
LD.04.03.11 Boarding and the 4 Hour Rule

- EP 6 Measurement results are provided to those who manage patient flow (2012 and 2013 standard)
- The hospital must measure and set goals for mitigating and managing the boarding of patients who come through the ED
- It is recommended that patients not be boarded more than 4 hours
- This is important for safety and quality of care
LD.04.03.11  Boarding and the 4 Hour Rule

- TJC defines boarding as the “The practice of holding patients in the ED or a temporary location after a decision to admit or transfer is made.”
- The hospital should set its goals with attention to patient acuity and best practices
- The four hour window has lead to a lot of discussion in the emergency medicine community
- The four hour window is a recommendation and not a requirement but all hospitals should strive to not keep patients boarded more than 4 hours
EP7 Measurement results regarding patient flow processes are reported to leaders (2012)

EP7 effective January 1, 2013

EP 7 Requires the staffs or individuals who manage the patient flow processes must review the measurement results

This is done to assess if the goals made were achieved

Data required was discussed in EP 5
EP8 Measurement guides the improvements in the patient flow processes (2012)

EP8 revision was effective January 1, 2013
- EP8 Requires leaders to take action to improve patient flow when the goals were not achieved

Leaders who must take action involve the board, medical staff, along with the CEO and senior leadership staff
- References PI.03.01.01, EP 4, which states that the hospital takes action when it does not achieve or sustain planned improvement
There are certain delays that are known as patient flow problem triggers.

Data will prompt surveyors to have discussions with the hospital and the role of the Medical Staff in resolving these.

This includes delays in patient assessment, blood draws, radiology studies, handoff communication and reporting, cleaning rooms, taking report from the ED, and delays in the getting patients to the operating room can signal that patient flow problems exist.
EP9 is new and is effective January 1, 2014

EP 9 States that the hospital determines if it has a population at risk for boarding due to behavioral health emergencies

Hospital leaders must communicate with the behavioral health providers to improve coordination and make sure this population is appropriately served

There is a shortage of behavioral health beds in this country leading to times where these patients have camped out in the ED sometimes for days
Boarding of Behavioral Health Patients

- Patient flow problems pose a significant and persistent risk to the quality and safety of behavioral health patients.

- Some hospitals have added up to 5 or 6 beds in a locked unit in the ED for behavioral health patients to keep them safe.

- Often staffed by behavioral management staff and not ED staff.

- Often have video and audio to observe patients and ensure their safety.
Hospitals should also be familiar with two sections of PC.01.01.01 under EP4 and EP24.

EP 4 Hospitals that do not primarily provide psychiatric or substance abuse services must have a written plan that defines how the patient will be cared for which includes the referral process for patient who are emotional ill, or who suffer from substance abuse or alcoholism.

This means that hospitals that do not have a behavioral health unit or substance abuse unit, how do you care for the patient until you transfer them out?
Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24 (new)
- EP 24 requires boarded patients with an emotional illness, alcoholism or substance abuse be provided a safe and monitored location that is free of items that the patients could use to harm themselves or others
- Hospitals often use sitters and have a special safe room
- EP24 requires orientation and training to both clinical and non-clinical staff that care for these patients
PC.01.01.01 EP 24 (Continued)

- This includes medication protocols and de-escalation techniques
- Assessments and reassessments must be conducted in a manner that is consistent with the patient’s needs
Design Guide for the Built Environment of Behavioral Health Facilities

by James M. Hunt, AIA, NCARB
and David M. Sine, ARM, CSP, CPHRM

Distributed by the National Association of Psychiatric Health Systems

www.naphs.org
Methods of De-escalation

- Active listening
- Validate feelings such as “you sound like you are angry”
- Some organizations have personal de-escalation plan that lists triggers such as not being listened to, feeling pressured, being touched, loud noises, being stared at, arguments, people yelling, darkness, being teased, etc.
Personal De-escalation Plan

Patient Name: ____________________________  
Date: ____________________________

PROBLEM BEHAVIORS: What type of behaviors are problems for you?

- Losing control
- Feeling unsafe
- Injuring yourself
- Other: ____________________________

- Assultive behavior
- Running away
- Suicide attempts
- Restraints/Seclusion
- Feeling suicidal
- Drug or alcohol abuse

TRIGGERS: What type of things (triggers) make you feel unsafe or upset?

- Not being listened to
- Feeling lonely
- Darkness
- Being teased or picked on
- Particular time of day/night:
- Particular time of year:
- Other: ____________________________

- Lack of privacy
- Feeling pressured
- Being isolated
- Contact with family
- Being touched
- Loud noises
- Not having control
- Being stared at

WARNING SIGNS: Please describe your warning signs, for example what other people may notice when you begin to lose control?

- Sweating
- Clenching teeth
- Wringing hands
- Bouncing legs
- Squatting
- Crying
- Not taking care of self
- Singing inappropriately
- Eating more
- Other: ____________________________

- Breathing hard
- Clenching fists
- Loud voice
- Rocking
- Cant sit still
- Isolating/avoiding people
- Hurting myself
- Sleeping less
- Being rude
- Racing heart
- Red faced
- Sleeping a lot
- Pacing
- Swearing
- Hyper
- Hurting others or things
- Eating less
- Laughing loudly/giddy
There are 53 million mental health related visits to the ED

This is an increase from 4.9% to 6.3% from data 1992-2001

19.4% of patients with mental health issues are admitted

This is why ACEP and the American Academy of Pediatrics recommend increasing resources related to mental health
Psych Boarders in the ED

- 2010 Survey of Hospital ED Administrators found:
  - 86% of EDs are unable to transfer patients
  - 70% reported that patients are boarded in the ED because of the shortage of beds for more than 24 hours
  - 10% reported patients are boarded more than 1 week
  - 90% reported that boarding psych patients reduced the availability of ED beds for ED patients
Psych Boarders in the ED

- Study found that 67% of ED doctors reported that there was a decrease in behavioral health beds.
- 23% reported sending patients home without seeing a mental health professional due to a lack of resources.
- This included that 31% of the time there was not a psychiatrist available.
- Perhaps the new telemedicine law will make it easier to contract with a group of psychiatrists to ensure all patients are seen by a psychiatrist.
Tracer Methodology

- The surveyors follow actual experience of a sample of patients as they interact with their health care team.
- The surveyors evaluate the actual provision of care provided to these patients.
- Looks at how the individual components of the hospital interact to provide safe, high quality patient care.
- The proof is in the pudding and this makes great sense.
Introduction to Patient Tracers

- Purpose is to evaluate compliance with the standards as they relate to the care and treatment of a patient.
- Tracers are integral to the on-site survey process and often referred to as the corner stone of the Joint Commission survey (no longer called JCAHO).
- Practicing tracers are a great way to prepare for your survey.
- Tracers can provide you with information and ability to increase patient safety and improve clinical outcomes.

1 Tracer Methodology: Tips and Strategies for Continuous System Improvement, 2nd edition, TJC
### Survey Activity Guide  Tracers

<table>
<thead>
<tr>
<th>Individual Tracer Activity</th>
<th>All</th>
<th>37</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program-Specific Tracers:</strong> <em>(conducted during Individual Tracer Activity)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continuity of Care</td>
<td>AHC</td>
<td>42</td>
</tr>
<tr>
<td>• Elopement</td>
<td>BHC</td>
<td>43</td>
</tr>
<tr>
<td>• Continuity of Foster/Therapeutic Foster Care</td>
<td>BHC</td>
<td>44</td>
</tr>
<tr>
<td>• Violence</td>
<td>BHC</td>
<td>45</td>
</tr>
<tr>
<td>• Suicide Prevention</td>
<td>BHC, HAP</td>
<td>46</td>
</tr>
<tr>
<td>• Laboratory Integration</td>
<td>HAP, CAH</td>
<td>47</td>
</tr>
<tr>
<td>• Patient Flow</td>
<td>HAP, CAH</td>
<td>48</td>
</tr>
<tr>
<td>• Staffing</td>
<td>LTC</td>
<td>49</td>
</tr>
<tr>
<td>• Resident Centered Care</td>
<td>LTC</td>
<td>50</td>
</tr>
<tr>
<td>• Equipment &amp; Supply Management</td>
<td>HME</td>
<td>51</td>
</tr>
<tr>
<td>• Fall Reduction</td>
<td>OME</td>
<td>52</td>
</tr>
<tr>
<td>• Hospital Readmission</td>
<td>OME</td>
<td>53</td>
</tr>
<tr>
<td>Special Issue Resolution</td>
<td>All</td>
<td>54</td>
</tr>
</tbody>
</table>
EMPSF Emergency Department Patient Safety Briefing

April 2011
Revised April 2012
Sue Dill Calloway RN BA, BSN, MSN, JD

Joint Commission Patient Flow Tracer
Crowding and Boarding in the ED
Patient Flow: Orientation Session

- Revised patient flow tracer in 2012 and 2013
- In 2013 added content related to the topic of patient flow regarding sources for admissions, ED population details, boarding of patients
- Includes how leadership monitors and responds to these situations
- Enhanced content to cover these new expectations in LD and PC chapters
Patient Flow  Orientation Session

- During orientation to the hospital, the surveyor will ask how leaders monitor and manage patient flow issues
- Will discuss as it relates to medical surgical and behavioral health patients
- Will ask about dashboard data that leaders look at to support system wide decision making
  - Will ask for other reports reviewed by hospital leadership
- Will look for documentation of any patient flow projects
During Individual Tracers Patient Flow

- Surveyor to ask staff on different units what they consider to be the most challenging patient flow problems

- Especially the ED staff, housekeeping, transportation, lab, radiology, OR, and medical surgical units

- Will ask about experience with psychiatric or substance abuse criteria who come to the ED
  - Look at space consideration for safe management of these patients

- See the following on the program specific tracer for patient flow
During Individual Tracers Patient Flow

- Surveyor is supposed to query the staff regarding the timing of assessments and reassessments.
- Also regarding the availability of consulting providers:
  - Such as for behavioral health, oncology, surgery, neurology, ob/gyn.
- Surveyor to ask staff about frequency of boarding patient with behavioral health emergencies.
- Ask about availability and rounding of qualified mental health staff or consultants.
Patient Flow Individual Tracer

- What patient flow processes are being measured?
- What has the hospital learned from the data?
- What did the hospital do to make changes and improvements?
- How is the patient flow information that is collected shared with others?
- Will ask about turnaround times for tests, wait times, boarded patients, will look for delays in stat orders for diagnostic testing, complaints of not enough staff etc.
- Surveyor will determine if improvements are made
Patient Flow  CAH and HAP Programs

- Surveyors are to interview staff during each of the individual tracers on what patient flow processes are being measured
- What other PI measures are in use
- Will visit the ED more than once to determine impact and are there patients in hallway beds?
- How has this data been used to make improvements
- Surveyor will look for variability in workload during the day and between days of the week
- Ask about wait, boarding, and turnaround times
Look at patient flow and back flow issues such as delays in transport

Evaluate process issues leading to back flow

Identify temporary holding area such as are patients held in the emergency department or waits for surgery or critical care units

Treatment delays, medical errors and unsafe practices can thrive in presence of patient congestion

TJC hospitals are expected to identify and correct patient flow issues

Lasts 60-90 minutes
Look at how the hospital plans for staffing and trains staff about differences in emergent and hospital care

What you have done to improve and plan for diversion

Look at past data collection

How do you identify problems and implement improvements

LD needs to share accountability with MS
- If ED goes on diversion frequently ask about staffing plan when on diversion, who made decision, is census a threshold?

- Did the hospital modify the elective surgeries pre-diversion?

- During planning session regarding metrics (EP5) determine if hospital has set performance goals and incremental targets for each of the pt flow process

- Are they benchmarking themselves against external organizations, research initiatives, or collaboratives?
Triggers Indicative of Patient Flow Problems

- Assessment delays
- Delay in blood draws or x-rays
- Delay in communication such as reporting handoff from one area to another
- Delay in discharge due to discharge processes
- Delay in OR scheduling
- Hospital process that stop flow of patient in ED such as work up in ED or housekeeping protocols
- Misuse of ED for direct admits
Triggers Indicative of Patient Flow Problems

- Increase length of stay in the ED
- Insufficient support and ancillary staffing
- Misuse of ED for low acuity patients and direct admits
- Patients experiencing delays with transfers
- Indicators such as MI get ASA and beta blockers on arrival and fibrinolytic with 30 minutes and PCI within 90 minutes
- Pneumonia patients blood cultures and antibiotics timely?
During Conducting a Patient Flow Tracer

- Surveyor to select a patient experiencing a delay
- Such as an ED patient awaiting an inpatient bed
  - Review the patient’s MR for delays
- Will map out the course throughout the hospital
- Will trace the flow through various area and ask staff about how much time the patient spent there
- Suppose to interview MS including surgeons and hospitalists
  - Ask about rounding time, surgery schedules, and discharge process, use of hospitalists, is ED physicians employed or contracted
During Conducting a Patient Flow Tracer

- Surveyor to interview staff about the patient flow issues with ED behavioral health patients and substance abuse patients
- Will look at the staffing assessments done
- Will look at space considerations taken for the safe management of these patients since they often have a longer length of stay
- If issues are identified then will interview leaders about the actions they have taken to mitigate the problems and how they use dashboards and other reports to monitor the situation
Patient Flow Triggers

**Triggers / Focus for evaluation**
- Crowded ED or ED waiting room (may be evident in a review of ED logs)
- Misuse of ED (Low Acuity Patients, for direct admits)
- Delay in blood draws
- Delay in radiological exams
- Hospital processes, e.g. work up in ED
- Assessment delays / process
- Increase length of stay (per literature - directly related to time spent in ED)
- Wait times in the ED/left without being seen

**Triggers / Focus for evaluation**
- Backflow – can’t move patients
- OR Scheduling
- Surgeries are behind
- Maintaining elective surgery schedule when emergent patients are waiting for OR
- Delay waiting for surgeon to evaluate patient / on-call surgeon not available

**Triggers / Focus for evaluation**
- Delay in discharge
- Discharge processing, e.g. support staffing, patient education
- Delays in treatments or diagnostic studies
- Patients waiting for bed placement
- Discharge orders not written until late in day—late rounding by care team

---

Patient enters ED → Disposition Determined → To OR → Bed Assigned → Patient Discharged → Direct Admission
# TJC ED Quality Measures

EMERGENCY DEPARTMENT NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED-1a</strong></td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate</td>
</tr>
<tr>
<td><strong>ED-1b</strong></td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure</td>
</tr>
<tr>
<td><strong>ED-1c</strong></td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Observation Patients</td>
</tr>
<tr>
<td><strong>ED-1d</strong></td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients</td>
</tr>
<tr>
<td><strong>ED-2a</strong></td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate</td>
</tr>
<tr>
<td><strong>ED-2b</strong></td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure</td>
</tr>
<tr>
<td><strong>ED-2c</strong></td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients</td>
</tr>
</tbody>
</table>

Last Updated: Version 4.0
http://www.medicare.gov/HospitalCompare/Data/emergency-wait-times.aspx

Emergency Department Throughput Measures

Long waiting times in hospital emergency departments (EDs) can increase risks for patients, especially those who have serious illnesses. Waiting times at different hospitals can vary widely, depending on the number of patients seen, ED staffing, efficiency, admitting procedures, or the availability of inpatient beds. The measures for Emergency Department Wait Times include:

- ED-1-Average (median) time patients spent in the ED, before they were admitted to the hospital as an inpatient
- ED-2-Average (median) time patients spent in the ED, after the doctor decided to admit them as an inpatient before leaving the ED for their inpatient room

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>ED-1</th>
<th>ED-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY HOSPITAL INC</td>
<td>183 MINUTES²</td>
<td>54 MINUTES²</td>
</tr>
<tr>
<td>805 FRIENDSHIP ROAD</td>
<td>85 PATIENTS</td>
<td>44 PATIENTS</td>
</tr>
<tr>
<td>TALLASSEE, AL 36078</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILTON MEDICAL CENTER</td>
<td>196 MINUTES²</td>
<td>50 MINUTES²</td>
</tr>
</tbody>
</table>
Thank You!

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- Board Member Emergency Medicine Patient Safety Foundation www.empsf.org
- 614 791-1468
- sdill1@columbus.rr.com
Resources


Resources

- www.hospitalovercrowding.org
- Dr Peter Viccellio
- Overcrowding power point slides
- Key points of harm caused by overcrowding
- Full capacity protocol, etc.
This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.
Questions?

Do you have a question that you would like answered during the Q&A session?

Simply follow the instructions below.

- To ask a question, please press *1 on your touchtone phone.

- If you are using a speaker phone, please lift the receiver and then press *1.

- If you would like to withdraw your question, press *1.