APPROVED: Standards Revisions Addressing Patient Flow Through the Emergency Department

The Joint Commission approved standards revisions in June that address patient flow through the emergency department (ED) as a hospitalwide concern as well as an issue of safe provision of care for boarded patients. The revisions include enhancements and additions to "Leadership" (LD) Standard LD.04.03.11, known as "the patient flow standard," and "Provision of Care, Treatment, and Services" (PC) Standard PC.01.01.01, which includes expectations that relate specifically to the experience of patients with behavioral health issues. Most of the revised EPs become **effective January 1, 2013**, for **hospitals**; however, two requirements will be deferred for one year.

Revisions to Standard LD.04.03.11 address the following:

- Leadership use of data and measures to identify, mitigate, and manage issues affecting patient flow throughout the hospital
- The management of ED throughput as a systemwide issue
- Safety for boarded patients, which refers to the practice of holding patients in the ED or another temporary location after the decision to admit or transfer has been made
- Leadership communication with behavioral health providers and authorities to enhance coordination of care

For patients who have been boarded because of behavioral health emergencies, revisions to Standard PC.01.01.01 address safety in the following areas:

- Environment of care
- Staffing
- Assessment, reassessment, and the care provided

Patient flow problems pose a persistent risk to the quality and safety of

care despite recent efforts to improve efficiencies, including the launch of The Joint Commission patient flow standard in 2005, expanded ED capacity, and decreased reliance on diversions. The standards revisions recognize that, although patient flow problems often manifest in the ED, their origins may be multifactorial and stem from other areas of the hospital. Highlights of the standard revisions are provided below.

> *The standards revisions recognize that, although patient flow problems often manifest in the ED, their origins may be multifactorial and stem from other areas of the hospital.*

Use of Data and Metrics

Hospital leaders are now using data and metrics more systematically in order to do the following:

- Monitor and manage patient flow throughout the organization
- Identify, anticipate, and mitigate cyclical trends
- Create a shared vision, clear goals, and accountability for improvement throughout the organization

The revised Elements of Performance (EPs) 5–8 at Standard LD.04.03.11 are designed to better reflect these contemporary practices in patient flow management. In addition, the revisions reinforce basic performance improvement expectations for setting goals and taking follow-up action when goals are not achieved.

Boarding

Heightened risks associated with boarding—such as those due to delays in care, compromised outcomes, and excessive demands on staff—mean that boarding can be a possible indicator of a systemic problem in patient flow. The revisions to Standard LD.04.03.11, EP 6, which highlight boarding as a safety risk, require the hospital to set goals for mitigating and managing the boarding of patients in the ED or on another unit of the hospital. Although the Note to the revised requirement recommends that boarding time frames not exceed four hours, this time frame is not a required target. Patient acuity and best practice should govern clinical decision making in the interest of patient safety and quality of care.

Patients with Behavioral Health Emergencies

New EP 24 at Standard PC.01.01.01 addresses the particular challenges facing patients with behavioral health emergencies. Existing standards provide for safe, quality care for all patients; however, patients with behavioral health emergencies who are boarded for extended periods repeatedly receive care that is not consistent with safe, quality practices for their particular needs. In addition to the orientation and training of staff, EP 24 addresses the provision of a safe environment and the assessment, reassessment, and care of these patients. This enhancement focuses attention on a vulnerable patient population—a population that presents the hospital with quality and safety circumstances different from those of the acute medical patients for whom ED space, staffing, and care processes were designed.

Improvements in patient flow for patients with behavioral health emergencies are often confounded by policies and practices in the community that are beyond the control of any individual hospital. The Joint Commission developed new EP 9 at Standard LD.04.03.11 to promote hospital leadership collaboration with behavioral health providers and authorities who serve their communities either as individual hospitals or through hospital systems, state hospital associations, or other partnerships. Initiatives and recommendations from hospitals, hospital associations, and interested stakeholders indicate that collaboration between medical and behavioral health providers and authorities can generate the synergy required to launch new solutions, establish or reinforce a more functional continuum of care, or mitigate inappropriate use of ED services.[1–5]

Support for Implementation

The standards revisions—along with a new Introduction and revised Rationale for the patient flow standard—will appear in the *2012 Update 2* to the *Comprehensive Accreditation Manual for Hospitals*, scheduled for publication in fall 2012,

Continued from page 3

as well as in the E-dition® update scheduled for release in October. In addition, The Joint Commission plans to send an *R³ Report (Requirement, Rationale, Reference)* to the field later in 2012. *R³ Reports* are complimentary electronic bulletins that provide additional information and evidence to help organizations as they implement new requirements. To sign up to receive the bulletin, go to http://www.joint commission.org/ealerts/.

Most of the revised EPs become effective January 1, 2013. However, because two issues are particularly complex (boarding and leadership collaboration for behavioral health patients), the implementation of Standard LD.04.03.11, EPs 6 and 9, will be deferred for a year to provide hospitals with additional time to adopt and test solutions before they affect the accreditation decision. The revisions are shown in the box on page 5, with new text underlined and deletions noted in ~~strikethrough~~.

Questions about the revisions may be directed to Lynne Bergero, MHSA, project director, Department of Standards and Survey Methods, at lbergero@joint commission.org. P

References

1. Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Aff.* 2010 Sep;29(9):1637–1642.
2. American College of Emergency Physicians. State and Local Efforts to Address Boarding and Crowding: An Information Paper Developed by the 2008–2009 ACEP State Legislative/Regulatory Committee. Garritano AM (primary author). Dec 14, 2010. Accessed Sep 22, 2011. http://www.acep.org/WorkArea/showcontent.aspx?id=69866
3. American Hospital Association's Behavioral Task Force. Behavioral Health Challenges in the General Hospital: Practical Help for Hospital Leaders (contains three components: Recommendations, Case Examples, and a TrendWatch issue brief). Accessed Jan 27, 2012. http://www.aha.org/advocacy-issues/mentalhealth/taskforcereport.shtml
4. Illinois Hospital Association. Illinois mental health and substance abuse services in crisis. *Shaping the Debate: Focusing on Critical Illinois Health Care Issues.* May 2011. Accessed Jul 15, 2011. http://www.ihatoday.org/uploadDocs/1/shapingdebatemay.pdf
5. Sowers WE, Rohland B. American Association of Community Psychiatrists' principles for managing transitions in behavioral health services. *Psychiatric Services.* 2004 Nov 1;55(11):1271–1275.

Official Publication of Joint Commission Requirements

New and Revised Requirements for Patient Flow Through the ED

APPLICABLE TO HOSPITALS

Effective January 1, 2013 (unless otherwise noted)

Leadership (LD)

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

Elements of Performance for LD.04.03.11

A 5. The hospital measures and sets goals for the ~~following~~ components of the patient flow process, including the following:
  - The available supply of patient beds
  - The ~~efficiency~~ throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the post-anesthesia care unit)
  - The safety of areas where patients receive care, treatment and services
  - The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)
  - Access to support services (such as case management and social work)

A 6. ~~Measurement results are provided to those individuals who manage patient flow processes. (*See also* NR.02.02.01, EP 4)~~ **This element of performance will go into effect January 1, 2014:** The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (*See also* NPSG.15.01.01, EPs 1 and 2; PC.01.01.01, EPs 4 and 24; PC.01.02.03, EP 3; PC.02.01.19, EPs 1 and 2).

   Note: *Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.*

A 7. ~~Measurement results regarding~~ The individuals who manage patient flow processes ~~are reported~~ review measurement results to ~~leaders.~~ determine whether goals were achieved. (*See also* NR.02.02.01, EP 4)

A 8. ~~Measurement results guide improvement of~~ Leaders take action to improve patient flow processes when goals are not achieved. (*See also* PI.03.01.01, EP 4)

   Note: *At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the glossary for the definition of leader)*

A 9. **This element of performance will go into effect January 1, 2014:** When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population. (*See also* LD.03.04.01, EPs 3 and 6)

Provision of Care, Treatment, and Services (PC)

Standard PC.01.01.01
The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.

Elements of Performance for PC.01.01.01

A 4. Ⓓ Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse. (*See also* LD.04.03.11, EP 6)

C 24. If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:
  - Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others. (*See also* LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)
  - Provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (*See also* HR.01.05.03, EP 13; HR.01.06.01, EP 1)
  - Conducts assessments and reassessments, and provides care consistent with the patient's identified needs. (*See also* PC.01.02.01, EP 23)