Joint Commission beefs up patient flow rules

By: MARY ELLEN SCHNEIDER, Family Practice News Digital Network

01/15/13

The Joint Commission is putting hospital leaders on notice that boarding in the emergency department requires a hospital-wide solution.

In performance standards that went into effect on Jan. 1, the Joint Commission is requiring hospitals to set specific goals to improve patient flow, which include ensuring the availability of patient beds and maintaining proper throughput in laboratories, operating rooms, inpatient units, telemetry, radiology, and the postanesthesia care unit. The Joint Commission is also calling on hospitals to ensure the efficiency of nonclinical services such as housekeeping and transportation and to maintain access to case management and social work.

Dr. Frederick C. Blum

The standards specifically name the medical staff, the chief executive officer, and other senior hospital managers as having a responsibility to take action when patient flow goals are not met.

"We wanted to make sure that organizations were looking at patient flow hospital-wide, even if the manifestation of a flow problem seemed to be in the emergency room," said Lynne Bergero, project director in the division of health care quality evaluation at the Joint Commission.
"The emergency department isn't an island," she added, "so looking at how everything interrelates is going to produce better flow for patients overall and better outcomes for the patient in terms of not having as much boarding."

The Joint Commission has had standards for patient flow in place for several years, but they weren't specific about the need for hospital leaders to set goals for improvement. Without specific direction, most hospitals weren't following through. "We just wanted to be much more explicit and say, ‘You need to set goals,’ " Ms. Bergero said.

The updated patient flow standards also include some brand new elements, though the new requirements won't go into effect until Jan. 1, 2014. Under the new rules, hospitals must measure and set goals for curbing the boarding of patients in the ED. The new requirement defines boarding as the "practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made." Boarding goals should be based on patient acuity and best practice, the Joint Commission wrote, but it recommended that boarding times should not exceed 4 hours.

Hospitals won't be scored on the 4-hour guideline during their surveys, Ms. Bergero said. The expectation is that hospitals will set their own time limits for boarding and they will be scored based on their own goals. Joint Commission surveyors, however, will question hospital leaders about what conditions require boarding times beyond 4 hours, she said.

While setting a time limit for ED boarding has been controversial, Dr. Frederick Blum said that he sees it as a move in the right direction. Dr. Blum, associate professor of emergency medicine at West Virginia University, Morgantown, was president of the American College of Emergency Physicians in 2005. At the time, he was working with regulators, including the Centers for Medicare and Medicaid Services, to establish a 4-hour boarding limit similar to that in place in the United Kingdom.

"The big frustration that emergency physicians all over the country have is that the ED is viewed as infinitely able to take care of patients, where everybody else has a hard limit," Dr. Blum said. "All of us realize there are limits to what we can do. So things like crowding and boarding need to be hospital-wide problems, not just ED problems."

The 4-hour guideline will be especially important for hospitals with prolonged boarding times, said Dr. Robert I. Broida, an emergency physician in Canton, Ohio, and an ACEP representative to the Joint Commission's hospital professional and technical advisory committee.

As for those hospitals that are already top performers, Dr. Broida said that it's unlikely to impact their performance. "If they're already performing at that level, they'll likely stay there."

The Joint Commission also set new rules for boarding related to behavioral health emergencies. A new requirement, which also takes effect on Jan. 1, 2014, calls on hospital
leaders to work with behavioral health providers in the community on better care coordination for these patients.

Ms. Bergero said that the requirement recognizes the larger problem of limited community resources for mental health. "The pie isn’t going to get any bigger for a long time in a lot of communities and we recognize that," she said. "The idea is, how do you work more strategically with the resources and with the partners that are there to provide for a better continuum of care for these patients?"

Addressing this issue is critical, Dr. Blum said, because patients with mental health emergencies can get stuck in the ED for days, not hours, as ED staff scramble to find dwindling placements. The new requirement brings hospital leadership into the process as partners with the ED. "While hospitals can’t solve this issue by themselves, it will at least pull them into the boat with us and give us a larger voice in trying to develop the community resources that we need to care for these folks," he said.

Additionally, the Joint Commission released a new requirement that hospitals provide patients who are awaiting care for emotional illness or substance abuse with a safe, monitored location. Hospitals are also required to provide training to clinical and nonclinical staff on caring for these patients, including medication protocols and de-escalation techniques. These requirements took effect on Jan. 1, 2013.

m.schneider@elsevier.com