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The monthly update on Emergency Department Management

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Inside

In this issue:
Three ambulance restocking forms; patient transportation protocol; admitting process flowsheet and feedback form; admission report; initial assessment record; and ED patient satisfaction survey

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Ambulance restocking could violate federal law, despite safe harbor

Follow rules closely to avoid violating federal anti-kickback laws

Do you give paramedics meal vouchers? Do you restock supplies for one local ambulance company but not another? Do you offer paramedics free educational services? You probably will be surprised to learn that those common ED practices could constitute a violation of federal anti-kickback laws, according to a proposed rule from the Office of the Inspector General (OIG) in Washington, DC. **(See box, p. 98, for information on obtaining a copy of the May 22, 2000, rule.)**

The primary concern raised by the OIG is that hospitals might inappropriately influence the destination of ambulances by offering "free" medications and supplies when other hospitals might not offer such items, says **Douglas M. Wolfberg**, Esq., an attorney with Page, Wolfberg, & Wirth, a national EMS, ambulance, and medical transportation law firm in Mechanicsburg, PA.

The OIG concluded that those perks might constitute "illegal remuneration," which is prohibited under the federal anti-kickback statute, explains Wolfberg. The OIG's recently published proposed rule will establish a safe harbor for EDs that restock ambulances, he notes.

The safe harbor doesn't guarantee you are in the clear, however, warns **Robert Suter**, DO, MHA, FACEP, regional medical director of the North Texas region for Questcare Emergency Services in Dallas. "You are still at risk for violating federal law," he says. "The fines are potentially unlimited, up to the amounts received by the hospital from Medicare."

Executive Summary

A proposed rule to create safe harbors for EDs that restock ambulances was published by the Office of the Inspector General, but EDs are still at risk for violations.

- Even common practices such as providing free food, waiving education tuition, and restocking ambulance supplies could violate federal anti-kickback laws.
- Violations of the anti-kickback statute place a hospital at risk of losing its Medicare status.
- The proposed rule gives EDs seven criteria to qualify for safe harbors for ambulance restocking.

The proposed rule gives EDs seven criteria to qualify for safe harbors for ambulance restocking, explains **Michael Williams**, president of the Abaris Group, a consulting firm in Walnut Creek, CA, specializing in emergency services. "But this doesn't exonerate EDs. Rather, this provides a carefully proscribed template for you to follow," he says. "If followed precisely, it should provide protection." **(See story on how to ensure compliance with the seven criteria for safe harbors established by the OIG, p. 99.)**

Still, you might follow the seven criteria and be guilty of a kickback if the OIG concludes the restocking event was intended to induce a referral, Williams says. **(See story on avoiding giveaways, p. 100.)**

The restocking issue has opened many ED providers' eyes to practices and behaviors that could be risky from a fraud and compliance standpoint, he emphasizes. "It pays to be alert and informed."

Experts: Don't stop restocking

Although no EDs have been cited or fined for violations of the ambulance restocking rule yet, the threat of penalties and fines is real, warns Williams. "The practice of restocking ambulances by hospitals has been widespread and common practice. However, it is only recently that the OIG has begun to alert providers of this issue."

Under federal fraud statutes, hospitals that practice restocking are at great risk of a citation or fine and have been for many years, he stresses. "Remember, each restocking event is a potential violation."

Still, many ED management experts insist that ambulance restocking is in the best interest of patient care. "If an ambulance brings you patients, then gets another call and hasn't made it back to the station yet to get supplies, what happens then?" asks Suter. "They can't carry unlimited supplies on an ambulance."

Ambulances need to have their par levels of supplies, especially in the case of a community disaster with multicasualties, says Suter. "Not restocking because you are afraid of HCFA [Health Care Financing Administration] is not in your community's best interest," he says. It's true that never giving anything to EMS is the absolute safest thing to do, he says. "But that's similar to saying the best way to not commit malpractice is to not see any patients. You need to make sure you are restocking in a legal way."

Here are ways to comply with the safe harbors established by the OIG for ambulance restocking:

• **Address the issue at a system level.** Unless you charge ambulance providers fair market value for restocked items, make sure that your restocking program is part of a coordinated EMS council program, says Wolfberg. **(See sample agreement for ambulance restocking, inserted in this issue.)**

Rather than putting the onus of ambulance restocking on individual hospitals or EDs, address decisions regarding restocking issues at a system level, urges **Linda Honeycutt**, EMT-P, EMS programs coordinator for Providence Hospital and Medical Centers in Novi, MI. All hospitals in a region should meet with the area's EMS agencies to adopt a regional policy, she suggests.

Copies of rule available

A copy of the proposed safe harbor rule is available on the Office of the Inspector General's (OIG) Web site (www.hhs.gov/oig/). Click on "OIG Electronic Reading Room," and then "OIG Regulations." The regulation is listed as a May 19 publication.

The special advisory bulletin was published by the OIG in the May 22, 2000, *Federal Register*. The *Federal Register* is available at many libraries and from the *Federal Register* on-line database through GOP Access, a service of the U.S. Government Printing Office. The address is www.access.gpo.gov/su_docs/aces/aces140.html.

A paper copy of the May 22 *Federal Register* may be purchased for $8. Specify the date of the issue and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or MasterCard number and expiration date. Contact: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Telephone: (202) 512-1800. Fax: (202) 512-2250. ■

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Also, ED managers should work closely with legal counsel to implement an ambulance resupply program, Wolfberg recommends. The program should comply with the hospital's legal obligations and address the significant community benefits from ambulance restocking arrangements, he says.

• **Create a specific list of items to be restocked.** You'll need a paper trail of what was restocked and how it was paid for, says Williams. "You can't restock ambulances by just taking items off the shelves without telling anyone," he emphasizes.

Adhere to a list of specific items that are allowed to be restocked, Honeycutt advises. "In our area, a list of exchangeable items was developed by ED representatives and EMS providers through the EMS medical control authority," she says. The only supplies on the exchange list are IV equipment and supplies, and pillows when a patient is wearing one as a splint, Honeycutt says. **(See "Oakland County Medical Control Authority IV Ancillary Supply Exchange List," inserted in this issue.)**

The group ensured that the ambulance services were not already being reimbursed for the listed items, says Honeycutt. "This standardized list, as well as drug boxes, are the only exchangeable items that are sanctioned. Consequently, hospitals are not perceived to be competing with one another for ambulance business." **(See story on billing for restocked supplies, p. 101.)**

• **Use patient transportation protocols.** Use patient transportation protocols to direct the EMS crews in choosing the patient's destination facility, recommends Honeycutt. **(See Oakland's transportation procedure, inserted in this issue.)**

Basically, her facility's protocols state that unstable patients will be transported to the closest appropriate facility, explains Honeycutt. Stable patients will be transported to the facility of their choice. "If they have no preference, the patient then goes to the closest appropriate facility," she says.

• **Develop a policy for restocking.** According to Suter, your ED policy for ambulance restocking should clearly state the following:

— whether supplies are replaced;
— if that restocking includes drugs;
— what "high cost" supplies are included;
— which agencies are eligible;
— how staff should do charge capture or accounting. **(See "Drug Box Exchange Program Standing Orders," inserted in this issue.)**

• **Be consistent with restocking.** Don't engage in a unilateral restocking arrangement with select ambulances, advises Wolfberg. "You should not be restocking for the purpose of outdoing other hospitals' restocking program as a competitive tool for admissions."

Sources

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Don't discriminate between EMS agencies on any basis, warns Suter. "At one point, the draft guidelines made distinctions between public and private, profit and nonprofit, volunteer and paid services," he says. "This language has been dropped."

Above all, don't replace supplies for your local 911 provider and not replace them for the regional private transport service, Suter advises. "Don't play favorites," he says. "Enter into agreements with all or none to avoid the appearance of courting favor with agencies capable of referring patients to you and not to others." ■

How to meet 7 criteria for safe harbor

The safe harbors for ambulance restocking proposed by the Office of the Inspector General (OIG) in Washington, DC, clarify existing regulations, according to **Robert Suter**, DO, MHA, FACEP, regional medical director of the North Texas region for Questcare Emergency Services in Dallas.

In late 1997, the OIG issued an advisory opinion stating that an ambulance restocking arrangement violated the anti-kickback statute, says Suter. The following year, the OIG issued three advisory opinions that differed significantly from the 1997 opinion, he notes. Those proposed the establishment of a safe harbor for ambulance restocking. The OIG said restocking serves a public interest by ensuring that ambulances are fully

stocked with current medications, sanitary linens, and other supplies that are compatible with equipment used in local EDs, he explains.

On May 22, 2000, the OIG published a proposed rule that would establish those safe harbors, Suter reports. "Under the proposed rule, ambulance safe harbor restocking must meet the conditions of one of two categories." Those categories only pertain to emergency ambulance services, not routine ambulance transports, he emphasizes. They are:

• ambulance providers paying the hospital fair market value for the replenished drugs or supplies used for the transport of an emergency patient;

• arrangements made between the hospital and emergency provider in which the hospital contemporaneously restocks drugs and supplies used during the transport of an emergency patient.

Under the first scenario, commercially reasonable and appropriate payment arrangements must be made in advance, notes **James Augustine**, MD, FACEP, chief executive officer of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting. Nonprofit receiving facilities can sell to a nonprofit ambulance provider at cost, he notes.

Some hospitals have "apothecary" arrangements for sales of certain medications and supplies to local physician offices and other health care delivery agencies, in compliance with state pharmaceutical laws, notes Augustine. "With this apothecary relationship, the hospital could sell supplies and medications to local emergency service providers," he says.

Follow 7 criteria to the letter

Suter says the second category contains seven criteria you must meet to qualify for a safe harbor:

1. Hospitals must restock on an equal basis for all ambulance providers that bring emergency patients to the receiving facility.

2. Restocking arrangements must be part of a comprehensive and coordinated effort to improve the EMS delivery system in the relevant service area. They must be open to all emergency ambulance providers and hospitals in the area and must be implemented with and monitored by a regional EMS council or equivalent.

3. Restocking arrangements must be in writing.

4. The hospital must not bill any federal health care program or beneficiary for the restocked drugs or supplies or write off the cost of the drugs or supplies as bad debt.

5. Ambulance providers may not bill any federal health care program or beneficiary separately for the replenished drugs or supplies.

6. The hospital and ambulance supplier must maintain records of the restocked drugs and supplies and make the records available to the secretary of the Department of Health and Human Services upon request.

7. The hospital and ambulance supplier must otherwise comply with all federal, state, and local laws regulating emergency medical care and the provision of drugs and medical supplies, including the laws relating to the handling of controlled substances.

Even token giveaways could put you at risk

Giving paramedics meal vouchers and waiving tuition for educational events might seem harmless, but examine these practices carefully to avoid violations of federal anti-kickback laws, advises **Michael Williams**, president of the Abaris Group, a consulting firm specializing in emergency services based in Walnut Creek, CA.

"Even the *potential* for inducement to refer could be a violation," Williams adds.

Potential violations include educational activities above and beyond contractual obligations or for programs commonly available elsewhere in the market, he says.

"I don't think ED managers need to wholesale get rid of practices such as education," he says. "Rather, you should make sure they are grounded in clear legal or contractual obligations, such as a hospital contract with the state EMS agency."

An actual inducement does not have to happen, he notes. "Do not be lulled into the perception that if you are the only hospital in town or the ambulance service does not have a choice, that you could not be guilty of a kickback. If it looks, acts, or smells like an inducement — regardless of intent — this could be a violation."

It is the intent that matters, not the amount of incentive or whether it actually had an effect, Williams emphasizes. "Deep down we really know what is being done here," he says. "Historically, we can honestly say that some EDs do this to encourage ambulances to come to their ED. It is as simple as that."

If there is even an implication of intent, it is a violation of one or more statutes, he says. "It does not matter if it is for one or many ambulances, if there is actual or potential intent to induce." ■

To ensure compliance with the criteria, follow these steps:

• **If you don't have a restocking program in place, work with a regional EMS organization to develop one**. The agencies should form an oversight entity, commonly called a regional EMS council, with a written plan of organization and a written restocking program, Augustine advises. "Then a plan for restocking should be developed, placed in writing, and signed by all involved agencies," he says. "Ideally, all hospitals in a region will participate."

The EMS agency must be a member of the EMS delivery system in the area and must comply with the OIG's criteria and other relevant laws, Augustine notes. "The hospital may want to create a file of signature forms which state these components and are signed by an appropriate representative of the EMS agency," he suggests.

• **Develop a coordinated record-keeping program for all items that are distributed to ambulance providers.** Keep a list of agencies that have signed the restocking agreement, Augustine advises. "Also, maintain some record of EMS agencies that rarely come to that hospital to transport patients but are not part of the regional arrangement. This does happen at times and is not a huge issue for hospitals."

Consider a restocking form

Implement an exchange or restocking record, he suggests. "Many hospitals currently use a restocking form, which is completed by the EMS agency that transported the patient. EMS personnel complete the form, restock, and go back in service. The hospital uses the form to track drug distribution, inventories, costs, and shortages."

Larger hospitals may want to designate a supply technician who oversees the restocking during busy times, says Augustine. "The hospital will likely want to summarize the supplies used into regular reports, and keep either the reports or the stack of completed resupply forms on file," he explains.

The ambulance agency will need to maintain records of which hospitals resupplied which items, he says. ■

Source

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Don't bill Medicare for restocked supplies

Under the May 22, 2000, proposed safe harbor rule published by the Office of the Inspector General, you won't be able to bill Medicare for items you restock ambulances with, so there will be no way to recover those costs, notes **Michael Williams**, president of the Abaris Group, a consulting firm in Walnut Creek, CA, specializing in emergency services.

That's bad news for ED managers, especially coupled with the implementation of ambulatory payment classifications (APCs) and other revenue-limiting trends, emphasizes Williams.

You can't change beneficiaries

It appears that the hospital must absorb the cost of all medications, supplies, and linens provided to Medicare beneficiaries, says **James Augustine**, MD, FACEP, chief executive officer of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting. The hospital and EMS agency also can't charge the beneficiary for the cost of any drugs or supplies, he explains.

Payments to ambulance agencies for emergency ambulance transport services typically include the cost of supplies used, which could include those restocked at a hospital, says Augustine. "But the hospital cannot bill for any of those medicines or supplies," he says.

That restriction can be a significant economic burden for the hospital, because many Medicare beneficiaries might require the use of medicines, linens, or supplies during their care and transportation, Augustine says. "The hospital will have to absorb these costs, with fixed reimbursements for admitted Medicare patients through DRGs and for other patients through APCs."

The hospital can bill non-Medicare patients, commercial third-party payers, and Medicaid for restocked supplies, medications, and linens, he says.

If there is any possibility that an EMS agency will charge a patient for supplies used in the field, you should have procedures to prevent billing the Health Care Financing Administration (HCFA) for those same supplies, warns **Robert Suter**, DO, MHA, FACEP, regional medical director of the North Texas region for Questcare Emergency Services in Dallas.

In addition, the hospital needs to have accounting procedures so if you are not billing for the supplies, you also are not writing the cost off as "bad debt," because that also is partially reimbursed in HCFA calculations, Suter notes. ■

Help indigent patients and see return visits drop

Improve staff morale and help your community

When a homeless patient comes to the ED at Bellevue Hospital Center in New York City, he or she leaves not only with appropriate medical treatment, but also with clothing and a meal, reports **Lewis Goldfrank**, MD, director of emergency medicine.

"We give out tens of thousands of coats, pants, and shirts on an annual basis," he says. "This allows the person on the street to achieve some level of dignity upon discharge."

Such charitable practices benefit the patients and ED staff, says **Norman C. Christopher**, MD, director of pediatric emergency medicine at Children's Hospital Medical Center of Akron (OH).

"The reward we see, in addition to our own satisfaction, is that we are able to develop a tremendous 'loyalty' by families and agencies in our area," he notes.

Acts of charity also boost staff morale, according to Christopher. "It is uplifting to the staff to participate in projects that benefit our patients, their families, and the community at large," he says.

Here are ways to help indigent patients in your ED:

• **Give free starter prescriptions.** At Children's ED, "starter" packs are given to patients, with a prescription to be filled at a more convenient time. "The goal is to reduce return visits and worsening of conditions because of the inability to fill a prescription," Christopher says.

This service most often is offered in the middle of the night, on weekends, or for out-of-town patients and isn't directed specifically at the indigent, he notes.

Executive Summary

Programs that address the needs of indigent patients benefit the community, boost staff morale, and decrease return visits to the ED.

- By giving "starter" packs of prescriptions to patients, you can reduce return visits caused by the inability to fill a prescription.
- Consider providing transportation home for families involved in motor vehicle crashes.
- Donate car seats for infants and young children.
- Provide a range of social services that address specific needs of patients, such as shelter referrals and substance abuse interventions.

"However, when a family appears to be 'needy' or expresses that type of need, we also invoke this approach," he says.

Sometimes, patients come in for a specific chief complaint but seem to have problems that aren't easily defined, notes Goldfrank. "These are ideal patients to talk with about general health care understanding, potential for domestic violence, fear of immigration issues, or psychosocial needs," he says. Blaming the patient for using the ED inappropriately is the wrong attitude, he contends. "We fill the gaps in our society for particularly needy individuals such as the . . . impoverished American or immigrant."

"In our setting, a plan is established for immediate follow-up, regardless of the patient's financial resources."

• **Offer a wide range of social services.** Your ED needs an ongoing social services effort that focuses on the specific needs of your community, stresses Goldfrank. "It is essential to understand the educational and income needs of the people we serve."

Immigrants receive targeted services

The Bellevue ED has a diverse patient population with 25% immigrants, many of whom have never had basic health care, he reports. The ED's services focus on crime victims, including victims of sexual assault and domestic violence; shelter referrals; substance abuse interventions; ambulance discharge from the ED; child placement and assessment; HIV testing; and home care referrals, he says.

In addition, referral to a social worker is available 24 hours a day, seven days a week, to assist patients with services such as job placement and lodging, he explains.

A large percentage of the ED's patients have a household income under $20,000, notes Goldfrank. To address the fact that many patients have income limitations, patients with conditions that require follow-up care such as pneumonia or congestive heart failure are given free medication and a primary care appointment, he says. "In our setting, a plan is established for immediate follow-up, regardless of the patient's financial resources." That plan often avoids a return ED visit, he notes.

The ED also sees significant numbers of patients whose reading levels are below the third grade, says Goldfrank. Educational and discharge materials that

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are appropriate for those patients are available.

At Children's Hospital Medical Center of Akron, social service representatives are available in the ED 24 hours a day. For six of those hours, the representatives are on call from home.

"This expert staff is always available to provide support services for families," Christopher says. For example, shelter referrals can be made for victims of domestic violence. Several support groups are available for families with special needs children, such as premature infants or children with chronic diseases, he notes.

• **Adopt families during the holidays.** Used toys, books, clothing, and coats are provided to needy families during the winter season, particularly at holidays, Christopher says. "Several families are also 'adopted' by the ED every Christmas and Thanksgiving season. We provide them with meals, age-appropriate presents, and clothing."

The ED also has a standing arrangement with a local organization to provide baseball tickets for families who can't afford them. "This is a nicety that is appreciated greatly by families here," Christopher says.

• **Provide transportation.** The ED provides transportation home for patients who are able to document a real need, he notes. "For example, a family with only one vehicle was involved in a motor vehicle crash," he says. "There are other less dramatic scenarios where we would provide this service as well."

• **Donate car seats.** The ED provides car seats for families leaving with infants and/or younger children who are without them. "We always hope to get the seats back [when the family purchases one of their own], but we never really expect to," says Christopher.

The ED is active in this area because the hospital is the only pediatric resource in the immediate area, he notes. "I really feel that this is a responsibility we have to meet." **(See story on the ED's role as a "safety net," at right.)** ■

Reports conclude: ED safety net is in danger

The ED functions as a health care safety net, but that role is in danger, warns **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY.

"Through EMTALA [the Emergency Medical Treatment and Active Labor Act], ED care is an entitlement available to the entire U.S. population and all U.S. visitors," says Davidson. "For those without insurance or other means of obtaining care, they're assured of at least a screening exam and stabilizing care. But the safety net is fraying."

According to a new report from the Washington, DC-based Institute of Medicine (IOM), *America's Health Care Safety Net: Intact but Endangered*, rising numbers of uninsured patients, changes in Medicaid policies, and cutbacks in government subsidies are putting unprecedented pressure on EDs.[1] **(For details on how to order the report, see box, p. 104.)**

A similar report issued by the Dallas-based American College for Emergency Physicians (ACEP) last year, *Defending America's Safety Net*, echoes those concerns.[2] **(See box, p. 104.)**

ED staff soon may be unable to care for the growing numbers of uninsured, says ACEP president **Michael Rapp**, MD, FACEP, an ED physician at Arlington (VA) Hospital. "This is especially true for the nation's EDs, which are the most vital components of the nation's safety net. The ED is the portal of entry for as many as three out of four uninsured patients admitted to U.S. hospitals."

The IOM report says the growth of Medicaid managed care, elimination of subsidies that help defray the costs uncompensated care, and a growing demand for charity care make it increasingly difficult for EDs to

ACEP conference: Preserving the safety net

The American College of Emergency Physicians (ACEP) is hosting a National Congress on Preserving America's Health Care Safety Net in Washington, DC, on Sept. 19. More than 200 federal policy-makers, physician leaders, and health care regulators will convene to address the problem of health care coverage for the uninsured. For details, contact ACEP's Washington, DC, office. Phone: (202) 728-0610, ext. 3006. ■

Where to find the reports

The Institute of Medicine report, *America's Safety Net: Intact But Endangered,* is available for $42.95 plus $4.50 shipping charge. To order, contact: National Academy Press, 2101 Constitution Ave. N.W., Lockbox 285, Washington, DC 20055. Phone: (888) 624-8373 or (202) 334-3313. Fax: (202) 334-2451. E-mail: zjones@nas.edu. Web: www.nap.edu.

The American College of Emergency Physicians report, *Defending America's Safety Net,* describes trends in health care that threaten the nation's ability to delivery emergency care. The report is available for $15, including shipping. To order a copy of the report, contact: American College of Emergency Physicians, Customer Service, P.O. Box 619911, Dallas, TX 75261-9911. Phone: (800) 798-1822, ext. 6, or (972) 550-0911. Fax: (972) 580-2816. E-mail: gwestbrook@acep.org. Web: www.acep.org. ■

Sources

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survive. Roughly one in five Americans is uninsured. Between 1988 and 1998, the number of uninsured increased by almost 20%, Rapp notes.

The IOM report recommends the creation of a new government body to monitor and assess the condition of safety net providers and to review the impact of federal and state policies on the system, he says.

A national prudent layperson standard for emergency medical services is needed, Rapp adds. ACEP will host a national conference this month to address the issue of the uninsured, he reports. **(See "ACEP conference: Preserving the safety net," p. 103.)** Rapp recommends a series of incremental reforms that don't undermine employer-sponsored programs.

The ability to meet the needs of indigent patients is a cornerstone of emergency medicine, emphasizes Davidson. "Compassionate care of people regardless of their means is a personal, professional, and ethical credo for all I know and esteem who work in the ED."

A recent study showed that despite current economic prosperity, poverty and hunger are commonplace among ED patients at the University of Minnesota in Minneapolis.[3] "We found that our patients are often forced to make choices between buying food and buying prescription medications," says **Margaret Kersey**, MD, principal investigator. "Often, this directly leads to potentially preventable ED visits and hospital admissions." The study showed that lack of access to a reliable food source can have a direct and indirect impact on patient health, says Kersey. "Hunger and food insecurity should be routinely addressed as health care issues, particularly in the urban ED setting where they are likely to be very common."

Several studies have found that the populations most likely to use the ED for their primary care are often disenfranchised and need social services in other aspects of their lives, says Kersey.[4-5] "Therefore, in some ways the ED is actually an ideal place for intervention," she says.

Although ED medical staff don't have time or resources needed to evaluate the social service needs of every patient thoroughly, there are simple steps EDs can take, says Kersey. For example, screen patients about access to medical care, food, and safe shelter, she recommends. "This practice would catch many people who would otherwise fall through the cracks."

Although the short-term cost of increasing social services in the ED might seem high, the potential benefits could be substantial, she says. "There are both financial benefits and improvements to patient quality of life."

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ED Benchmarking Success

ED gets patients upstairs in 60 minutes or less

Getting floor nurses to accept patients without delay is a major roadblock for almost every ED, but specific steps can be taken to avoid this problem, according to **James Espinosa**, MD, FACEP, medical director of the ED at Overlook Hospital in Summit, NJ. **(For more on getting patients admitted faster, see *ED Management,* July 2000, p. 80.)**

There is no chance of reducing delays in the ED unless the admission cycle time is decreased, argues Espinosa. "If you block the receptor sites to accept new patients in ED by holding patients excessively, then the functional capacity of the ED is essentially eaten up," he says.

At Overlook's ED, the admission cycle time ranged from 3½ to four hours, according to **Linda Kosnik**, RN, MSN, CS, chief nursing officer for the ED. The ED set a goal of reducing the time from "decision to admit," to "transfer to unit bed" to less than 60 minutes, she says.

Here are the changes made to achieve that goal:

1. Delays were measured. First, baseline data were collected in "bite-size pieces," says Kosnik. The following times were measured: when the decision is made that the patient will require a bed; when the patient is assigned a bed; and when the patient actually leaves the ED. Each time period was broken into more components, so that specific obstacles could be identified.

Executive Summary

The ED at Overlook Hospital in Summit, NJ, reduced admission cycle times from 3½ to four hours to less than 60 minutes.

- Although nursing staff members are encouraged to resolve problems on their own, the "czarina of bed control" serves as a point person in the ED to resolve significant problems.
- A housekeeping staff member is assigned to clean the beds on each unit in order of priority.
- ED staff have access to real-time information about patients being discharged from the floors.

Now that the goal of a 60-minute turnaround time has been reached, admission cycle times are routinely collected in real time as part of the ED tracking system, says Kosnik. "If it goes over 60 minutes, we immediately evaluate what the holdup is, whether it's someone not sending report or the ED not sending the patient upstairs." **(See "Admitting Process Flowsheet/Feedback Form" and "Admission Report," inserted in this issue, and ED admission flowchart, p. 106.)**

2. Bed control was brought under the ED's authority. Bed assignments were made part of the ED tracking system so ED staff are kept informed as beds become available, Kosnik reports. "The reason you need that is because 40% to 60% of admissions come from the ED," she says. "So the only way the ED can control the flow is by having a visual picture of what is going on through the whole hospital."

That makes the ED aware of admissions coming from other areas, says Kosnik. "There is a tendency to blame the inpatient side for everything," she adds. "Admissions discharges tend to appear in a lump-sum total, and this allows you to watch for that." It also keeps the floors from hiding beds, Kosnik adds. "This way, you know who is going in and who's going out."

3. The role of "czarina of bed control" was created. Kosnik serves as the point person in the ED to resolve any problems that arise. "The goal is to find the beds to put patients in," she notes. A bed controller follows up on bed availability, she explains. The bed controller at Koznik's ED is a secretary, she says.

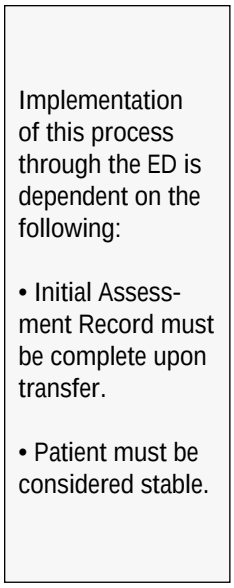
The "czarina" ensures that things are moving along and supports the bed controller. "We still allow the nursing staff on the units to assign the beds," she says. "I only get involved if the bed controller is meeting resistance."

The ED tracking system measures cycle times (giving a continuous visual display in 15-minute data points with bar graphs) to make sure they fall within certain limits, says Kosnik. "If we are not meeting those parameters, then the czarina is called and asked to intervene. But we've only had to do that a couple of times. Eventually, the units realized we meant business."

Interventions usually are handled at a staff level, Kosnik stresses. "We don't want this to be a hierarchical program," she says. "We want the core process to be at the staff level so they can converse with each other when problems arise."

4. Registration and housekeeping were decentralized. Registration for all direct admits is now handled on the floor, Kosnik says. "That's a significant patient satisfaction component, because the patient goes directly to the floor and is given a bed assignment, as opposed to waiting in the ED."

Admission Process for Direct and Emergency Department



Source: Overlook Hospital, Summit, NJ.

A common excuse from the floors was that beds weren't ready, so a housekeeping staff member is assigned to clean the beds on each unit as his or her primary responsibility, she says. "As a result of that, we can turn beds around much more quickly now."

Previously, a core group of housekeeping staff cleaned beds throughout the institution, not in any order of priority, explains Kosnik. "There might be four beds to clean on the 10th floor, but we need beds on the second floor." Now, the resource nurse on each unit prioritizes bed cleaning, she says. "They know where the assigned beds are located. This way, beds are cleaned on each unit as soon as they are empty."

5. Discharge holding was eliminated. Holding patients who are being discharged from units can slow the process, says Kosnik. "This tends to happen in most facilities unless somebody is watching, because it's a matter of convenience for the nursing staff."

Now the ED can access a list of patients who are being discharged in real time. "If we see there are 12 discharges from one unit at once, we know there is a problem, because they should be discharging patients in real time," says Kosnik. "The floors should not be waiting until a change of shift to put discharges into the system. That's a way of hiding beds." ■

Give floor nurses reasons to accept patients

The major barrier to reducing admission delays is to motivate floor nurses to take patients more quickly, stresses **Linda Kosnik**, RN, MSN, CS, chief nursing officer for the ED at Overlook Hospital in Summit, NJ.

"You have to ask yourself, 'what's in it for them?' It's a one-way street, so you need to create motivation," she says. "Getting human beings to cooperate is the whole problem. Otherwise, the floors have no reason to take the patients."

Here are four incentives given to floor nurses at Overlook Hospital so patients are accepted without delay:

1. Patient surveys and performance appraisals address delays. Patient satisfaction is a strong motivator for nursing staff, says Kosnik. "Patients who sit in the ED for extended periods of time will be very unhappy for their entire stay," she explains.

If a patient is received from the ED, the patient satisfaction survey includes a question about the admission process. "So it is in the floor nurse's best interest to take patients quickly and efficiently," Kosnik says. "A good turnaround time looks good for them, and patient satisfaction will be higher." **(See *Emergency Department Survey*, inserted in this issue.)**

Reducing admission cycle times was identified as a hospitalwide initiative and put into the performance appraisals of floor nurses, she says. "You can't do this alone in the ED. You need administrative support. Reducing admission cycle times needs to be a concern to everybody, not just the ED."

2. The ED documents initial assessment. A documentation tool was created that facilitates documentation for the floor nurses. "One of the barriers to the floors taking admissions was the time it took the floor nurses to complete a four-page admission form," notes Kosnik. "It turned out that the form had the same information that was already collected in the ED."

A checklist format was created, which allows the ED to do the initial documentation for the floors. "This was part of the initial assessment which we were doing anyway, and it's a real plus for the floors to get that done before the patient goes upstairs," she explains. **(See "Initial Assessment Record," inserted in this issue.)**

3. ED nurses give nonverbal reports so floor nurses don't have to stop what they are doing to take reports. The ED no longer gives a verbal report to the floors. Instead, the ED sends reports by pneumatic

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CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See in this issue *Benchmarking Success: ED gets patients upstairs in 60 minutes or less; Reports conclude: ED safety net is in danger*.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See in this issue *Don't be fooled by safe harbors for restocking ambulances: ED managers are not off the hook;* and *Even token giveaways could put you at risk*.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.

tubes. "That way, the floors have all the information they need to take care of the patient right away," says Kosnik.

Previously, the time it took for ED nurses to give report ranged from five to 30 minutes, she says. "Our staff would have to call multiple times for the floor nurse to take the report," she recalls.

The floor nurses also had to stop what they were doing to take report, so they are very satisfied with the nonverbal reporting system, says Kosnik. "The floor nurse is given half an hour to evaluate the report. They notify us if they have any immediate questions or problems. Otherwise the patient is sent up directly," she explains.

The ED allows 30 minutes before sending the patient upstairs in most cases, says Kosnik. "But if the floor nurse knows they are getting an OR patient in half an hour, they might ask us to send up the patient right away. Likewise, if there is a code going on, they may ask us to delay the patient for awhile. But there are not many excuses that we will accept."

4. The ED accepted responsibility for occasionally holding patients. In reality, it's not just the units that cause delays, Kosnik says. "We are just as guilty of holding patients as the inpatient units are," she acknowledges.

Sometimes admissions were delayed at Overlook because ED nurses were holding them in the rooms, she says. "That might be because they are having difficulty giving a report, or so they didn't have to take another patient."

There were also times when the ED would want to admit a patient, and the nurse would call to give report, and the floors would say to send the patient upstairs, says Kosnik. "Then, the ED physician would say the patient needs a CT scan first, and we wouldn't notify the floor."

The floor staff need to plan their day and don't want surprises like those, says Kosnik. "If we tell them to expect a patient upstairs within a half-hour, and the patient doesn't come for two hours, by that time, the floor nurse could have three postoperative patients to take care of," she explains. "So the next time, that nurse will be less likely to take a report on a patient." ■