AMERICAN HEALTH CONSULTANTS

ED Management

The monthly update on Emergency Department Management

Vol. 13, No. 2

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Diversion decision diagram

February 2001

Are you putting patients in danger? You need to reduce your diversion rates

Diversion is putting EDs 'on the verge of crisis' nationwide

Is your ED going on diversion throughout the entire year instead of just the flu season? Are your diversion rates at an all-time high? When your ED is not able to go on diversion, do you feel that the overcrowded conditions are potentially unsafe for patients?

If your answers to these questions are "yes," circumstances in your ED reflect a growing trend that can endanger patients, says **Alan C. Woodward**, MD, FACEP, chief of emergency services at Emerson Hospital in Concord, MA.

"The system is under significant duress and on the verge of crisis," Woodward warns. "This is going to continue to get worse and worse."

Despite taking steps to address the problem, ED managers report record increases in diversion rates.

You can't stop patients from coming

"Last summer, our diversion rate was almost as high as the previous winter," says Woodward. "In the last eight months, there were only three days when not a single hospital in eastern Massachusetts was on diversion."

The ED at Massachusetts General Hospital in Boston is on ambulance divert up to 45 hours per week, says **Alasdair Conn**, MD, FACEP, chief of emergency medicine.

However, ambulance divert merely slows but does not stop the flow of patients into the ED, he notes. "Physicians continue to ask patients to come to the

Executive Summary

High diversion rates are a crisis nationwide, with many EDs reporting high diversion rates throughout the year that cause potentially unsafe conditions for patients.

- To avoid diversion, length of stay must be reduced not only in the ED, but hospitalwide.
- Patients will continue to come to the ED during diversion, so be prepared.
- Have an effective diversion policy and an expeditious process to implement it when needed.

ED for evaluation and management."

When more than three hospitals are on ambulance divert, the 911 center opens all of them, says Conn. "This really puts a strain on the ED and is putting patients in danger," he adds.

Often, even though the situation in the ED is recognized as unsafe due to overcrowding, hospitals are being denied diversion or are told they must go off diversion, because there is no place to divert patients to, Conn says.

The nursing shortage has compounded the problem, adds Woodward. "The shortage is particularly acute here. Even though we have closed half of the hospital beds in the state, most hospitals can't even fully staff the remaining beds they have," he says.

Here are effective practices implemented at EDs to address the problem of diversion:

• Decrease patients' overall length of stay.

Do everything possible to process patients faster, which makes room for the next patient, urges Conn. "We have analyzed patient delays to find out where the road blocks are," he reports.

At Massachusetts General's ED, a satellite lab was opened to improve lab turnaround times, with the goal of staffing it around the clock, he says. "Also, radiology was identified as a bottleneck, so a second helical CT scanner was installed," Conn adds.

However, the ED can't solve the problem alone — length of stay must be decreased hospitalwide, advises Conn. "Every one-tenth of a day decrease in overall length of stay opens up 12 new beds," he says. Conn recommends transferring patients to subacute facilities when appropriate and hiring additional nurses for the intensive care unit.

• Use hard data as leverage to add additional staff.

At Massachusetts General, nursing and physician workloads were analyzed with a national benchmarking database from the San Rafael, CA-based QuadraMed Corp., reports Conn. "This is a tool that is used elsewhere in the hospital and by many other hospitals in the U.S., so we are able to use the data for benchmarking," he notes.

It was determined that the ED nurses were putting in a workloads equivalent to 150% of the nursing workload at similar institutions, says Conn. "We were working at a 'high risk' percentage," he says. "It's no wonder we had a high turnover rate."

To bring the percentage down, the ED added 20 more FTEs, including two ED physicians, says Conn. "We argued that one cannot add nurses without adding more administrative positions —- we asked for 22 but were given eight — and more physicians," he adds.

Conn also has used work-related value units (WRVUs) to compare the physician workload with benchmarks from the Lansing, MI-based Society for Academic Emergency Medicine. "Although provisional, the annual benchmarks for emergency medicine are about 4,000 WRVU per year," he notes. "Our physicians are working at over 6,000."

• Redirect physician responsibility.

The ED at Massachusetts General has a trauma acute area with 10 beds, a general area with 16 beds, five pediatric beds, and a fast-track area. Recently, a rapid diagnostic unit with six monitored beds opened.

"We asked that the attending physicians for our other areas now cover these additional monitored beds," says Conn.

Patients are now triaged as needing a monitored bed in the waiting room, says Conn. "Although emergencies, these are not usually life threatening —

Resources

Guidelines for Ambulance Diversion are available from the Dallas-based American College for Emergency Physicians (ACEP). The guidelines were published in October 1999 as a policy resource and education paper (PREP) to supplement ACEP's January 1999 policy statement on ambulance diversion. Single copies are free. To order a copy of the policy statement or the PREP guidelines, contact:

- **American College of Emergency Physicians**, 1125 Executive Circle Drive, Irving, TX 75038-2522. Telephone: (800) 798-1822, Ext. 6 or (972) 550-0911. Fax: (972) 580-2816. E-mail: pubsorder@acep.org. Web: www.acep.org. For the January 1999 policy statement, click on "Policies/Resources" and then "ACEP Policy Statements." Click on "List all policy statements" and scroll down to "Ambulance Diversion." For the October 1999 guidelines, click on "PREP available."

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abdominal pain with stable vitals, for example," he adds. "We may have 10 or even 20 patients at a time in this category. So there is a risk that they may have to wait for many hours and become unstable."

The additional ED physician resources are used to relieve the other attending staff, treat the patients in the rapid diagnostic unit, and also to manage these patients at triage, says Conn. "This new position can also initiate labs or X-rays and provide screening exams," he explains.

• Use an algorithm.

Using a "diversion decision diagram" enables you to focus on necessary activities when you are already very busy, says Augustine. "You must have a policy, and you must have an expeditious process to carry it out," he stresses. **(See diversion decision diagram, inserted in this issue.)**

Augustine recommends including the following key points in your policy:

— What group of patients is being diverted?

— Are they being diverted to someplace in particular?

— How long will it last?

— Is this diversion consistent with hospital policy and justified by patient care needs (and therefore not an Emergency Medical Treatment and Active Labor Act [EMTALA] issue)?

— When and how will diversion status end?

• Address diversion as a hospital problem.

In the Boston area, the number of acute care beds has decreased by 35% over the last 10 years, so hospitals are running at very high occupancies, reports Conn.

Because of high diversion rates, a Massachusetts state task force on diversion developed a series of best practices that area hospitals have adopted. Here are some examples that affect the ED, but involve other departments:

• implementing written hospital operational procedures for identifying, monitoring, and managing ED diversions;

• establishing plans and systems for tracking and maximizing the utilization of beds and staff;

• listing specific hospital contacts authorized to convey information regarding status of ED diversions and transfer receiving capability;

• establishing communication and coordination agreements or protocols with other hospitals and prehospital providers in the service area.

To reduce diversion rates, the ED requires buy-in from administration and other departments, Conn insists. "Our hospital CEO realizes that this is a hospital problem, not an ED problem," he says. ■

Sources

For more information about diversion, contact:

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Avoid diversion by looking outside of your ED

If you really want to avoid diversion, look outside the four walls of your ED.

"You need to know how busy the paramedics are and what the status is at other EDs,' says **Edwin Homansky**, MD, FACEP, chief of staff for the ED at Valley Hospital in Las Vegas. "ED managers must know what's going on at the other facilities to know how busy you're going to get."

Much better use of available information and demand planning systems is needed, says **James J. Augustine,** MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting. He recommends using a system for bed status management, utilized by the hospitals, the major payers, and the general medical community.

"This would allow the regional health system to operate at a more efficient level while still enabling the community to access excellent care at peak demand times," Augustine says.

A bed status management system has been successfully introduced in several metropolitan areas, reports Augustine. "The status of key community resources is communicated to providers," he explains.

Here are ways to avoid diversion by increasing awareness of community resources:

• Address underlying problems with EMS and ED capacity.

When developing a strategy to reduce diversion, answer the following questions about ED and EMS

capacity, recommends Augustine:

— Are these two resources able to manage demand for services 95% of the time?

— Would greater capacity in one or both be able to buffer demands so that diversions are not necessary?

— Can the hospital better manage existing capacity or resources (for example, the CT scanner) so that those resources will be available when peak demands occur?

— Can more of the tightest resources, such as cleaning staff to prepare rooms between patients, be strengthened?

— Can the hospital use information systems to predict peak times and then staff for them?

— Are there regional pools of resources that can be used more effectively?

• Defer patients or get them to alternative environments.

Some patients who are going to be admitted might be able to be managed with home care or direct admission to a nursing facility, suggests **Alan C. Woodward**, MD, FACEP, chief of emergency services at Emerson Hospital in Concord, MA.

"We use our transitional care unit to place patients in nursing homes," he says. "The thresholds change as it gets more desperate."

Shortages of hospital beds might need to be addressed by utilizing a broader base of beds in the community, says Augustine. "This pool of beds would have to be staffed by a competent and flexible set of hospital employees, who would be providing services in a nontraditional environment," he says.

The hotel and extended care facilities in a community may be the best source of excess capacity for the acute health care system, suggests Augustine.

At the peak of the viral season three years ago, the Dayton area had many of its hospitals at or near diversion status, with EMS units held in the field waiting to find which hospital was open to take a patient, recalls Augustine.

"The EDs were thrust into a leadership position," he says. "My first calls were to the local Marriott hotel for their availability of beds in their hotel or into their local extended care facility."

Under this type of crisis scenario, ED managers must take on leadership responsibilities, stresses Augustine.

• Use EMSystem.

In the Kansas City metropolitan area, EDs have worked with the pre-hospital community to implement EMSystem, a computerized tracking of the system's availability, which is accessible 24 hours a day.

Dennis Allin, MD, medical director of the Kansas City Emergency Medical Services (EMS) system and director of emergency medicine at the University of Kansas Medical Center, says, "This system delineates the type of diversions recognized in our community. It also gives the pre-hospital personnel, hospitals, and dispatch centers up-to-the minute knowledge of

Excerpt from EMSystem diversion policy

With EMSystem, the definition of hospital status is standardized across the entire Kansas City metropolitan area. However, EMS providers or emergency medical systems should continue to follow their local policies and procedures regarding the determination of hospital destinations. It is the position of the EMSystem Task Force that no operational policy or direction is given as a part of this document. It is up to each EMS agency to determine what they will do with the status information on EMSystem and further communicate their operational plans to their respective hospitals of interest. EMSystem provides standardized information to facilitate patient routing decisions.

Hospitals should attempt to avoid ambulance diversion. If diversion becomes necessary, however, emergency departments must update their status (i.e., open, resource alert, closed to ambulances, and out of service) on EMSystem.

Emergency departments must update their status in accordance with the defined intervals listed on the Kansas City region EMSystem Web site. EMSystem will prompt these updates with an audible tone and on-screen message. See the EMSystem Users Manual for the specific information required to update diversion status.

Emergency departments that are unable to update their status on EMSystem must contact their EMCC and the EMCC must update emergency department status.

Dispatch centers, or EMCCs, must ensure that EMS units in the field are informed of the status of hospitals in their zones so that patients can be routed to the most appropriate facility.

Air ambulance services must update their status in accordance with the defined intervals listed on the Kansas City region EMSystem Web site to ensure EMCCs are aware of the availability of air ambulance resources. ■

Source: Mid-America Regional Council Emergency Rescue Committee, Kansas City, MO.

Sources

For more information on diversion and community resources, contact:

- **Dennis Allin**, MD, FACEP, University of Kansas Medical Center, Emergency Services, 3901 Rainbow Blvd., Kansas City, KS 66160. Telephone: (913) 588-6504. Fax: (913) 599-6437. E-mail: DALLIN@kumc.edu.
- **Edwin Homansky**, MD, FACEP, Doctors Medical Services, 2915 W. Charleston Blvd., Suite 10, Las Vegas, NV 89102. Telephone: (702) 259-1228. Fax: (702) 259-1252. E-mail: boxdoc7@aol.com.

For more information on EMSystem, contact:

- **Infinity HealthCare**, 1251 W. Glen Oaks Lane, Mequon, WI 53092. Telephone: (888) 290-6710 or (414) 290-6770. Fax: (414) 290-6780. E-mail: info@emsystem.com. Web: www.emsystem.com.

available resources."

It is critical that all hospitals in an EMS system have a relationship with each other, he stresses. "The pre-hospital component allows for a discussion of what resources are available and a consensus on what types of diversion will be allowed and how these will be communicated," Allin says.

Community protocols were developed in the Kansas City metropolitan area to establish policies for the use of EMSystem, notes Allin. EMSystem is a Web-based, real-time hospital ED diversion and mass casualty incident reporting system manufactured by Infinity HealthCare in Mequon, WI. **(For contact information, see source box, above. See excerpt of the diversion policy for EMSystem, p. 16).** "Through this system, a hospital is held more accountable for how often they divert and for what reasons, since this is tracked throughout the community," he adds. ■

Reduce 'boarder' patients in your department

If you want to avoid diversion, you need to move admitted patients upstairs quicker, urges **Alan C. Woodward**, MD, chief of emergency services at Emerson Hospital in Concord, MA.

"Patients are coming to us sicker and need to be admitted, but there are insufficient beds," he says. "We are now bedded and staffed for the valleys. The norms are a stretch, and the peaks are unattainable."

The ED acts as a "buffer" for many of the busiest units of the hospital, says **James J. Augustine,** MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting.

"The ED staff manage the patients and do rapid decision making for patients who need services when that unit of the hospital is tied up," he adds. "We hold and manage patients waiting for an open operating room, critical care bed, dialysis unit, cardiac cath lab, invasive radiology intervention room, or CT scanner."

Here are ways to reduce overcrowding and avoid diversion:

• Bring solutions to administration.

Step forward and take the opportunity to solve the problems of "tight bed flow" in the upstairs units, advises Augustine.

"ED patients are best served when we can rapidly evaluate and then send the patient to an appropriate unit with an open bed," he says. "ED leaders are often masters at efficiency and major incident planning. The hospital will benefit from the addition of these skill sets."

• Act promptly when the ED is backlogged.

At Valley Hospital in Las Vegas, a Divert Activation Response Team (DART) is called in when the ED is overcrowded, reports **Edwin Homansky**, MD, FACEP, the ED's chief of staff. The team includes a representative from nursing administration, the administrator on call, the admitting supervisor, housekeeping supervisor, and the ED charge nurse, he says. **(See the hospital's diversion plan, p. 18.)**

The team does the following:

— determines if the ED needs more nurses or aides;

— determines where beds are available in the hospital;

— determines if there are patients in critical care areas that can be stepped down to the floor so that patients can be admitted to critical care areas;

— determine if any elective surgeries need to be cancelled.

It's key to act as soon as you see a problem developing, says Homansky. "If the ED is heating up at 3 on Friday afternoon, then by 7 that night you're going to have a real problem," he stresses. "You need to start addressing that soon."

• Start the admission process earlier.

At Valley Hospital, the admission process is started as soon as it's determined that a patient will be admitted, which saves 30 to 45 minutes, says Homansky. "For example, we will start admission procedure on an obvious unstable angina patient before any tests are back, knowing from the history and EKG that this patient is going to be an admit," he explains.

• Build flexibility into other departments.

Develop a consistent method of communication

between the unit coordinator in the ED and areas such as the OR and the ICUs, urges **Dennis Allin**, MD, medical director of the Kansas City Emergency Medical Services system and director of emergency medicine at the University of Kansas Medical Center. At University of Kansas, there are separate medicine, pediatric, neurosurgery, and surgery ICUs, along with a intensive care burn unit, he says.

"The unit coordinators on these units will communicate and cooperate with each other, allowing us to

Desert Springs Hospital Diversion Plan 2000-2001

The Emergency Department sees approximately 35,000 patients yearly with an admissions rate of 24%. The national average admission rate is reported at 17% to 18%. This may suggest the acuity at Desert Springs Hospital is greater than the average ED. This higher than average admission rate coupled with inefficiencies in patient flow, shortage of ICU beds and staff, has caused the ED to back up, necessitating the need for the ambulance service to divert patients to other facilities. The number of hours on emergency divert has increased from 18% to 32% and from 31% to 77% for critical care divert. The following recommendations are suggested to streamline the admission process and decrease the length of stay of admitted patients in the Emergency Department, thereby reducing the number of hours on divert:

A. Facility recommendations.

1. Expand critical care by 12 beds. Project to be complete and operational by Dec. 1, 2000.
2. Utilize outpatient holding area for post-percutaneous transluminal coronary angioplasty (PTCA) recovery to allow additional capacity in Intermediate Care. Intermediate Care currently has 22 beds, and many of them are utilized for post-PTCA patients.
3. Utilize lounge chairs in pre-op for discharged patients waiting for transportation.
4. Utilize the flow behind the back section of the Emergency Department for overflow, mental health, and inebriated patients.

B. Patient flow recommendations.

1. Divert Avoidance Response Team (DART) to be activated prior to the Emergency Department necessitating divert. Criteria: 3 ICU/CCU holds and/or 10 admitted holds in any level of care combination. DART includes administrator on call, medical director, nursing supervisor, admit nurse, housekeeping supervisor, case manager, ED manager and/or ED physician. The goal of DART is to take a proactive approach to divert avoidance and change the culture of diverting first and then attempting to alleviate the backlog.
2. Develop a standardized short order sheet for initial orders to allow for quick initiation of the admission process. Currently, the time difference between the decision to admit the patient and actually completing the initial orders is 60-75 minutes. The admission process begins once the initial admission orders are recorded, NOT when the ED physician decides to admit the patient.
3. Work with managed care companies to expedite the admission process. Patients are currently held for several hours in the ED waiting for admission assessment by the managed care physician.
4. Implement a nurse/transporter team to facilitate the admission from the Emergency Department to the nursing unit. This team would transport the patient, perform initial orders, and perform the orientation of the room and nursing unit to the patient. This process would eliminate delays due to staff nurse unavailability at the time the admission is required.
5. Implement protocols to expedite routine testing to begin at point of triage.
6. Identify a gatekeeper to meet and greet ambulance upon arrival.
7. Implement bedside registration with short form registration for ED patients to expedite initial assessment process.
8. Enforce ICU/CCU and Intermediate Care admission criteria to ensure appropriate patient placement.
9. Radiology to transport patients from the ED instead of ED staff.
10. Laboratory to draw patients in Radiology instead of waiting for return to ED to expedite processing of lab tests.

C. Equipment recommendation.

1. Rent monitors and ventilators to prevent unavailability experienced last year.

D. Staffing recommendations:

1. The nursing/tech schedule in the ED has traditionally been static with no swing shifts coinciding with busier times in the department. Schedules are being restructured with additional swing shifts to increase staffing during busier hours.
2. Continue to recruit RNs and CNAs to meet staffing standards.
3. Work with statewide nursing recruitment task force to change regulations to allow paramedics to function in the ED.

Source: Desert Springs Hospital, Las Vegas.

stay open," Allin says.

For example, the medicine ICU might be full, but a sick patient can be placed in any of the other ICUs, he explains. "We can do this because our critical care nurses are all trained in the same core competencies," he says.

• **Immediately move patients out of the ED when the ED is overcrowded.**

Key policy makers must be able to open up closed units, move patients expediently out of critical care beds to step-down or general units, cancel elective cases, and communicate with medical staff members, says Augustine. "You need to do this at the instant when bed resources become tight," he adds. ■

How to communicate your diversion message

Not all diversions are alike, according to **James J. Augustine**, MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting.

"Each cause of diversion should have a unique communication associated with it," he states.

Bringing a cardiac arrest or unstable trauma patient to an urban ED that has lost electrical power clearly could endanger the patient, Augustine explains. "Therefore, the reason for diversion should be communicated with the diversion message," he stresses. "If an ED is on diversion due to internal safety issues, that ED should not be utilized except in the most dire circumstances."

You must communicate your "diversion message" to the prehospital system effectively, says Augustine. **(See communication of a diversion message, p. 20.)**

The EMS system can become dysfunctional when facilities begin to reroute, and chaos grows as more EDs come to diversion status, warns Augustine. "The EMS system has a difficult job in understanding and conveying the diversion message," he says.

Here are ways to do this effectively:

In some areas, it's mandated that an unstable patient still must be taken to the closest facility, even if that hospital is on diversion, says Augustine. "That can be a real problem, if the hospital is on diversion because of safety problems within the ED," he adds.

When diversion is needed for safety reasons, explain those reasons to EMS, Augustine advises. He reports that the Dayton, OH, area has diverted patients from hospital EDs during the following incidents:

• a bomb threat that forced a hospital to evacuate completely for 24 hours;

• a major hazardous materials release that formed a toxic cloud around two hospitals for 18 hours;

• a fire in the ED;

• a series of lightning strikes during a storm, which knocked out primary and secondary power systems in a hospital for several hours.

In all of these circumstances, patient care could not be provided, and all ambulance and ambulatory patients were diverted. In several cases, a medic unit was placed at the ED doors to transport away any patient brought by other means to the hospital, Augustine says.

The ED staff, working outside at these incidents, provided initial evaluation and stabilization, documented the interaction on paper, and referred the patient to another specific hospital, he explains. "In the hazardous materials incident, no vehicle traffic was permitted into the area of the hospital, so no incoming patients were possible at all," he adds.

When patient safety is at risk, such as loss of utilities at the hospital, you must announce that risk very clearly so that EMS will not deliver patients to you, stresses Augustine. Another goal is for walk-in patients to make the decision to drive to another hospital, he says.

Patient care is compromised if the patient has an unstable medical condition that cannot be managed by the EMS crew, says Augustine. "An airway that cannot be captured, IV access that cannot be obtained, antibiotics that are not available, or other lifesaving procedures may be time-delayed if the EMS crew is diverted around the closest ED," he says.

In these circumstances, the rerouting message, which explains that a hospital has been incapacitated and cannot safely receive patients through the ED, should go out through the electronic media to the general public, Augustine advises. "That ED might only be able to manage patients in the back of an ambulance, performing life saving stabilization procedures," he adds.

Other diversion messages should go to EMS providers, with instructions to divert certain types of patients to other facilities, he says.

Diversion also can be caused by shortages of available staff, equipment, or beds. Augustine suggests using the term "Potential Care Compromise Situations." Here are examples of this:

The hospital has full census and must divert all EMS transport patients to avoid compromising patient care.

The hospital ED is overwhelmed for some reason and cannot accommodate further emergency transport

(Continued on page 21)

Communication of a Diversion Message

When communicating your diversion message, the following questions must be answered, according to **James J. Augustine**, MD, FACEP, CEO of Premier Health Care Services, a Dayton, OH-based physician management group that provides ED staffing and consulting.

Why is the diversion occurring? It could be due to:
- ☐ safety reasons;
- ☐ ED compromised;
- ☐ certain hospital services unavailable;
- ☐ CT scan;
- ☐ monitored beds;
- ☐ critical care beds;
- ☐ dialysis, etc.;
- ☐ labor and delivery;
- ☐ a "nearby" hospital not compromised in its ability to deliver care.

Who is diverted? This list might include:
- ☐ all patients;
- ☐ care can take place temporarily in "parking lot" with rendezvous with on-site transport vehicles;
- ☐ no care can occur. Facility and ED staff fully compromised;
- ☐ message must go out by EMS channels plus to the general public through the media;
- ☐ EMS patients;
- ☐ all EMS patients;
- ☐ patients who have an identified need that EMS personnel can recognize;
- ☐ all monitored patients;
- ☐ all trauma patients;
- ☐ all critical care patients
- ☐ all patients who may require CT scan (strokes, head injury);
- ☐ all patients utilizing a special hospital service, such as dialysis and labor and delivery, which is compromised.

How large a population and EMS system will be affected?
- ☐ Diversions from a regional referral center, such as the children's hospital, the trauma center, or the burn center, will need to be communicated widely.
- ☐ A hospital isolated in a large geographic area will be more difficult to divert.

What are the legal implications?
- ☐ Care compromise is not as defensible if uncompromised care is available for a patient within a reasonable transport time.
- ☐ Diversion policy must be developed and applied consistently and not subject to real or perceived financial motivation.
- ☐ Diversion, rendezvous, and transfer incidents each have EMTALA implications. Documentation should support medical judgment, clear communications, consistency, and lack of financial motivation.

How long will diversion last? It could last:
- ☐ a foreseeable and predictable time frame that is short (hours);
- ☐ an unknown but short time frame (hours);
- ☐ an unknown and lengthy time frame (structural collapse from an earthquake).

How will message be communicated and to whom? Communication could include:
- ☐ other surrounding EDs (by phone, fax, radio, or electronic interchange);
- ☐ local EMS;
- ☐ regional EMS;
- ☐ general public media;
- ☐ physician offices.

Is the ED physician medical control able to override the diversion decision? Options include:
- ☐ no, as in situations in which the ED is unsafe;
- ☐ yes, when the ED physician can assist in patient care in locations such as the parking lot;
- ☐ yes, when the ED can accommodate the patient, then arrange transport to another hospital;
- ☐ yes, when the ED physician can arrange a rendezvous with a skilled transport vehicle (helicopter or mobile intensive care unit);
- ☐ yes, when the patient will be evaluated in the ED and then further disposition decisions are made.

Is there a specific site to divert to? Options include:
- ☐ yes, (all children under the age of 14 are being diverted to _____ hospital);
- ☐ no, but call us and we may be able to help make decisions with you;
- ☐ no, and we cannot help make decisions (phones, radio and/or staff are unavailable).

Is rendezvous in the parking lot an option?
- ☐ The ED and/or hospital is compromised, but the parking lot available to transfer patients to another hospital with a higher level of care.
- ☐ A vehicle is placed in the parking lot with appropriate staff to perform rendezvous.
- ☐ ED staff available in the parking lot to assist in evaluation, urgent treatment, and the destination decision.
- ☐ EMTALA implications are addressed by good documentation.

patients. This might occur when there is a sudden overwhelming high acuity patient volume.

The hospital is unable to accommodate patients requiring a particular set of services. Most commonly, this is for critical care beds, cardiac telemetry, or pediatric services.

The hospital has temporarily lost a key piece of diagnostic equipment that is available at another nearby hospital. This is typically the CT scanner, at hospitals which have only one scanner that has planned or unplanned downtime. Because the CT scanner is needed for immediate diagnosis of a growing number of ED patients (head trauma, stroke, and abdominal pain), the hospital administrators might think timely care is compromised, says Augustine.

The dispatch centers might need significant clarification of what form of diversion is taking place, how long it will last, and how to effectively communicate the message to units in the field, says Augustine.

"Many dispatchers are police or civilian personnel and must be given an explicitly worded message to deliver," he adds. ■

EMTALA Q&A

[Editor's note: This month's issue includes the first of an ongoing series that will address reader questions about the Emergency Medical Treatment and Active Labor Act (EMTALA). If you have a question you'd like answered, contact Staci Bonner, Editor, ED Management, *280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciBonner@aol.com.]*

Q: When the ED calls for a consult, can the on-call physician send his or her physician assistant (PA)?

A: Not unless the hospital puts the PA on the on-call list, if appropriate from a medical point of view, according to **Gloria Frank**, JD, president of EMTALA Solutions, an Ellicott City, MD-based consulting firm and former lead enforcement official on EMTALA for the Baltimore-based Health Care Financing Administration (HCFA).

The hospital would have to delegate specific responsibilities to the PAs for screening and stabilization when medically appropriate, based on the patient's symptoms and condition, says Frank.

"The delegation would have to be in the bylaws or other document approved by the hospital governing body," she adds. "They would have to be careful about any state law restricting PA practice."

If a physician is on call and sends a PA instead, the hospital should have written policies regarding what kind of discipline will result, such as referral to peer review, Frank advises.

"If the hospital has to transfer the patient because the on-call physician did not come in, the hospital must report the name of the on-call to the receiving hospital," she says. "The receiving hospital, in turn, must report the incident to HCFA."

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Point/Counterpoint

ED managers: Do not stop restocking

By **Robert Suter**, DO, MHA, FACEP
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(Editor's note: In December 2000, the Department of Health and Human Services Office of Inspector General [OIG] issued an anti-kickback statute safe harbor to protect certain arrangements involving hospitals that restock drugs and medical supplies without charge for ambulance suppliers transporting emergency patients to the hospitals. [For details, see ED Management, *September 2000, p. 97.] In this issue,* ED Management *presents opposing viewpoints on this controversial issue.)*

Unfortunately, by bringing attention to EMS, this action has triggered a great deal of hand wringing and concern over any and all interactions between hospitals and EMS. Most of this concern is unwarranted.

If some consultants are believed, allowing EMS to drink a cup of coffee out of the employee lounge is an illegal kickback for referrals and will subject the ED director to major fines or hard time in the federal penitentiary. This approach is ridiculous. We should not apologize for or be afraid of advocating the interests of our EMS patients! Taking reasonable action to support EMS is not criminal.

Let's remember that the anti-kickback laws were developed by Pete Stark (D-CA) to prevent inducements that would result in greater utilization of services and corresponding expense to the government. They do not prevent entities from engaging in activities that only influence selection of providers. If they did, all health care advertising would be illegal. Marketing activities that trigger increased utilization are illegal; marketing activities that do not are not.

When a family physician has a relationship with a cardiologist, the physician has a large degree of discretion about when and if a patient is referred for specialty evaluation or re-evaluation. This constitutes control over utilization. This control is effectively expanded given that such a referral could lead to increased testing as well. Therefore, this referral could be expected lead to further expense. Thus, inducements between the cardiologist and family physician easily could be seen as problematic or in some cases clearly illegal.

Not so with EMS. Our EMS crews are not cruising the streets and dragging patients into ambulances to take them to the hospital. EMS initiates service only when called by the patient. Patients control utilization, not EMS crews. Decisions to transport are nearly always determined by community protocol and not provider discretion. Once the patient is in the ambulance, it is inevitable that the patient will receive services.

While EMS providers arguably might, in some cases, have some selection of who will provide services, they have no ability to influence the utilization of services. This is a key point, since these circumstances create a clear and nearly insurmountable obstacle that prevents interactions with EMS providers from crossing over the line between selection and utilization.

One cannot refute the legal advice that refraining from anything that could be perceived as an inducement is the safest approach. The logical corollary to this is that the best way to avoid injury is to not get out of bed in the morning! Or, an alternative approach might be to close the ED. That also will guarantee compliance.

The fact is that many of the things that the cynical view as "inducements" clearly constitute efforts to improve EMS care or preparedness. When they do so, pursuing the best interests of our patients gives us an obligation to continue them. Educational programs improve performance. Ambulance restocking programs improve preparedness. A cup of coffee or a sandwich that fuels a tired medic for the next call does as well.

These are not criminal acts under the anti-kickback laws and regulations. They are actions in the community interest and support the hospitals' mission to serve the community. Furthermore, many of them are similar to courtesies extended by most hospitals to medical staff, which have not been found problematic by the Health Care Financing Administration, in spite of much higher risks of being so.

Rejecting the personal and professional needs of our EMS colleagues, even in the interest of "compliance with the law," is detrimental to our patients. Respecting these needs improves relationships and enhances communication between EMS and hospital providers. Improved communication results in better transmittal of clinical information and better continuity, thereby improving patient care.

Concern about how our interactions with EMS relate to anti-kickback laws is appropriate. Fear is not. Doing the right thing is not illegal, nor do policy makers want it to be. The creation of "safe harbors" by the Office of Inspector General clearly shows that this is true.

Hospitals should not shy away from the obligation to support their EMS system and providers. Know the anti-kickback laws. Stay within them. Don't stop appropriate activities. Don't be afraid.

[This column is the opinion of the author and does not constitute legal advice or the position of any organization. Contact Suter at QuestCare, 101 E. Park Blvd., Suite 911, Plano, TX 75074. Telephone: (972) 881-8353. Fax: (972) 422-2208. E-mail: r.suter@questcare.com.] ▼

EDs should not be resupplying

By **Mike Williams**
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The Office of Inspector General's (OIG's) published proposed safe harbor for ambulance restocking (*Fed Reg* 65(99):32060-32065 [May 22, 2000]) and a recent separate final safe harbor (Dec. 21, 2000, OIG Advisory Opinion 00-9) has created some controversy about its intent and limitation. I believe hospital emergency departments should be out of the business of resupplying ambulances.

The safe harbor makes it clear that the OIG considers it improper to restock ambulances at a discount or for free unless the arrangement meets seven very specific conditions set forth in this safe harbor. (There are several other safe harbors published by the OIG on this subject during the past two years). Not only is it considered improper by Medicare to restock ambulances at a discount or for free, it is unnecessary.

Hospitals began many years ago providing support services for ambulances and their staff. Some of the early support was necessary to establish and monitor prehospital programs. During the 1970s, early paramedic programs received key services from hospital coronary care units (CCUs) to mobile intensive care units. Yes, in these infancy days of paramedic programs, many paramedics received their training, medications, and even on-line direction from CCUs. Quickly, these programs matured to developing links with professionally run EDs, where the paramedics and some EMTs received instructions from ED physicians or mobile intensive care nurses.

In these early days, the only place a paramedic ambulance company could obtain its medications and supplies was from these EDs. Because these programs were so new, there was also a need to provide more direct supervision. Resupply was one way to do this.

I also remember when sandwiches and drinks were made available to me in the ED and resupply was another way to "attract" ambulances to use a particular ED when there was a choice. Frankly, it worked. During my early days in EMS, I, like many other EMTs, worked hard and got paid little. Often my lunch or dinner depended on whether the hospital ED had food for us. Ambulance resupply was just another excuse to go to that ED even if we did not have a patient.

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

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For questions or comments, call Joy Daughtery Dickinson, (229) 377-8044.

Statement of financial disclosure: To reveal any potential bias in this publication, and in accordance with the Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Auer (editorial advisory board member) is a stockholder in Lynx Medical Systems; Dr. Bukata (advisory board member) is president of the Center for Medical Education and is the developer of EDITS software; Dr. Mayer (advisory board member) is a stockholder in Emergency Physicians of Northern Virginia Ltd. and Patient Care and ED Survival Skills Ltd.; Dr. Yeh (advisory board member) serves as a consultant to Dynamics Resource Group, a spokesperson for Medic Alert, and a member of the board of directors for Vital Solutions and MassPRO.

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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 "How to get out the message" in this issue.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See "EMTALA Q&A" and "EDs should not be resupplying.")
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

A lot has changed since then, but I am sorry to say there are still EDs out there trying to attract ambulances to bring patients to them. I am not talking about good customer service or strong clinical links; I am referring to incentives designed to induce.

Paramedic and EMT-run ambulances have other ways to legitimately resupply themselves without relying on the hospital. These include purchasing the supplies and drugs directly from reputable medical supply companies or perhaps from a hospital but at fair market value.

It is also known that payers generally will reimburse ambulances for these costs. Even Medicare in most communities pays for most prehospital drugs and supplies and in others, the Medicare payment has been adjusted upward as these costs are considered "wrapped" into the base cost. Even the new draft Medicare fee schedule provides a global rate for all services to include supplies and drugs, and therefore the ambulances will be repaid for these costs. We might not agree that the proposed rate of payment by Medicare is sufficient, but the intent is there to cover these costs.

Getting resupplied by the hospital at no cost or below actual cost has the potential of allowing an ambulance provider to "double dip." Medicare's new fee schedule, which is expected to begin in the spring of 2001 but will be phased in over four years, is still paying most ambulance companies based on specific drugs and supplies used.

Don't get me wrong. A close working relationship between hospitals and all prehospital providers is an important and necessary feature of quality EMS systems. Rural providers that do not have the resources or the funds to conduct their own resupply now have a series of OIG safe harbors that provides guidance on how to structure a hospital resupply program without risk.

Hospital resupply has the potential to be an actual or potential inducement Ambulance providers have opportunities to be resupplied in other appropriate ways that don't put quality-coordinated EMS systems at risk. Those that do not use these methods risk stiff fines and other penalties and put the local EMS system at risk. I recommend that the practice be eliminated in all but the most extreme circumstances.

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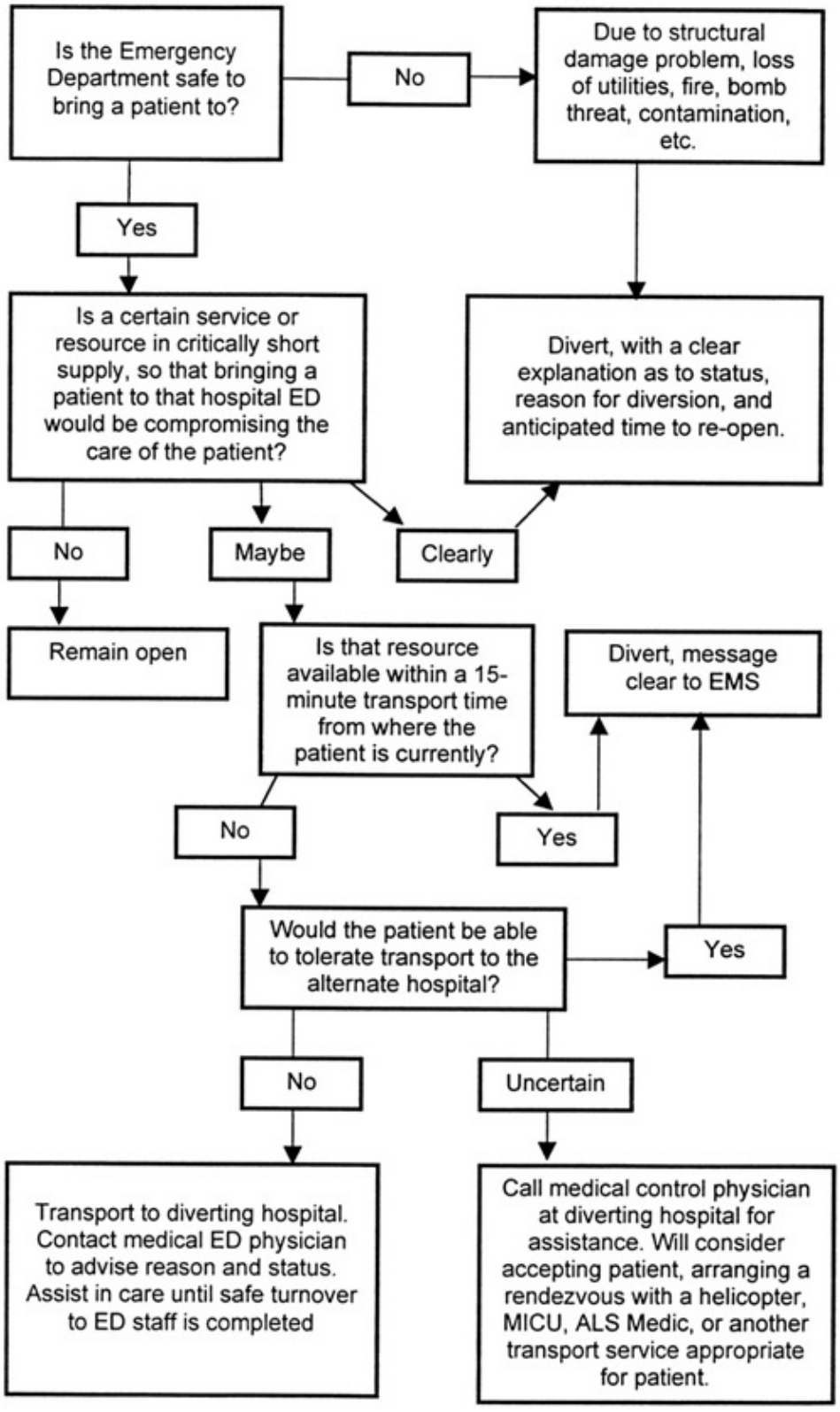
Diversion Decision Diagram



Source: Premier Health Care Services, Dayton, OH.

The Communication of a Diversion Message

Why is diversion occurring?

- Safety reasons
- ED compromised
- Certain hospital services unavailable
  - CT scan
  - Monitored beds
  - Critical care beds
  - Dialysis, etc.
  - Labor and delivery
- A "nearby" hospital not compromised in its ability to deliver care

Who is diverted?

- All patients
  - Care can take place temporarily in "parking lot" with rendezvous with on-site transport vehicles
  - No care can occur, facility and ED staff fully compromised
  - Message must go out by EMS channels plus to the general public through the media
- EMS patients
  - All EMS patients
  - Patients who have an identified need that EMS personnel can recognize
    - All monitored patients
    - All trauma patients
    - All critical care patients
    - All patients who may require CT scan (strokes, head injury)
    - All patients utilizing a special hospital service, such as dialysis and labor and delivery, which is compromised

How large a population and EMS system will be affected?

- A regional referral center, such as the children's hospital, the trauma center, or the burn center, will need to be communicated widely
- A hospital isolated in a large geographic area will be more difficult to divert

What are the legal implications?

- Care compromise is not as defensible if uncompromised care is available for a patient within a reasonable transport time
- Diversion policy must be developed and applied consistently, and not subject to real or perceived financial motivation
- Diversion, rendezvous, and transfer incidents each have EMTALA implications. Documentation should support medical judgement, clear communications, consistency, and lack of financial motivation

How long will diversion last?

- A foreseeable and predictable time frame that is short (hours)
- An unknown but short time frame (hours)
- An unknown and lengthy time frame (structural collapse from an earthquake)

How will message be communicated and to who?

- Other surrounding ED's (by phone, fax, radio or electronic interchange)
- Local EMS
- Regional EMS
- General public media
- Physician offices

Is the ED physician medical control able to override the diversion decision?

- No, as in situations where the ED is unsafe
- Yes, where ED physician can assist in patient care "in the parking lot"
- Yes, where ED can accommodate the patient, then arrange transport to another hospital
- Yes, where ED physician can arrange a rendezvous with a skilled transport vehicle (helicopter or MICU)
- Yes, where the patient will be evaluated in the ED and then further disposition decisions are made

Is there a specific site to divert to?

- Yes, (all children under the age of 14 are being diverted to _____ hospital)
- No, but call us and we may be able to help make decisions with you
- No, and we cannot help make decisions (phones, radio and/or staff are unavailable)

Is rendezvous in the parking lot an option?

- ED and/or hospital compromised, but parking lot available to transfer patients to another hospital with a higher level of care
- A vehicle placed in parking lot with appropriate staff to perform rendezvous
- ED staff available in parking lot to assist in evaluation, urgent treatment, and then destination decision
- EMTALA implications addressed by good documentation