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April 2001

Warning: Are you using nonphysicians for MSEs? Rethink this risky practice

Common procedure is linked to adverse outcomes and federal violations

(Editor's note: This is the first of a two-part series on nonphysicians and medical screening examinations [MSEs]. This month, we cover how to comply with EMTALA while using nonphysicians for MSEs, and liability risks. Next month, we'll cover what to include in protocols for this practice.)

It's every ED manager's nightmare: When an ED nurse sent a feverish, lethargic 2-year old girl to a private physician without a medical screening examination by a physician, there were tragic results. Several hours later, the child returned, dead from meningitis.

The child was given only an initial triage, not the scope of assessment required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

"The ED was unable to obtain prior approval for the visit from the gate-keeper physician in the patient's Medicare plan," explains **Stephen Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance.

The hospital was cited by the Baltimore-based Health Care Financing Administration (HCFA) for failure to have proper policies and procedures in place and for allowing a nurse to discharge a patient without being seen by a physician for an MSE, Frew notes. The nurse and outside physician also were named in malpractice counts, and the confidential settlement was seven figures, he reports.

"From the HCFA enforcement end, this case is typical of cases for non-physician MSE citations," he warns.

Avoid lawsuits and violations

Don't let this scenario occur in your ED, urges Frew. Use of nonphysicians for MSEs has resulted in numerous citations and significant litigation, he notes. **(See checklist, p. 39.)**

"Typically, the problems arise from an assumption that nurses can simply be assigned to triage, and that triage classifications are sufficient for medical screening," he explains.

Executive Summary

Using nonphysicians to give patients medical screening examinations (MSEs) has resulted in numerous lawsuits, EMTALA violations, and adverse outcomes, yet the practice is common in EDs.

- EMTALA experts advise against using nurses to perform MSEs.
- Educate staff that triage is not a substitute for an MSE.
- Follow protocols strictly and document the adequacy of the scope of the MSE.

Although adverse events or poor outcomes certainly increase the probability that HCFA will be notified and an investigation will follow, under HCFA standards, a bad outcome is not required for a violation to be cited, Frew emphasizes. "They also state that a bad outcome does not necessarily mean a violation occurred, but it increases the index of suspicion," he adds.

Violations will be cited if HCFA determines that the system is not sufficiently documented, if protocols are not followed, or if the surveyor thinks that, in retrospect, the patient needed physician involvement that was not provided, warns Frew. **(See excerpts of HCFA regulations pertaining to MSEs, inserted in this issue.)**

By using nonphysicians for MSEs, you also risk an EMTALA violation due to inconsistent treatment, says **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix, AZ.

"Invariably, there will be some disparity, where some patients see a physician and others get a less qualified individual," he explains. "This could be construed as disparate care, which is prohibited by basic EMTALA principles."

Practice is common

Despite the obvious risks of using nonphysicians for MSEs, the practice is surprisingly common. A recent study found that 37% of EDs at academic medical centers use nonphysicians for MSEs at least occasionally.[1] A third of these centers reported poorer clinical outcomes than expected from ED care as a result of the nonphysician MSE.

This practice is common in small communities that do not have a full-time physician in the ED and in fast-tracks in larger ED's, reports Frew. "Some hospitals have flirted with this practice, thinking they can cut costs," he adds. "But where the issue is financial, they usually end up violating in multiple manners."

As a result, hospitals are frequently cited for failure to properly designate staff to perform MSEs, and failure to provide appropriate protocols, Frew says. **(See related story on liability risks, p. 40.)**

Here are ways to avoid EMTALA violations when using nonphysicians for MSEs:

• **Avoid using nurses to perform MSEs.**

Using nurses to perform MSEs is a *very* risky practice in the ED, warns **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC.

Never use nurses to conduct MSEs in the ED, Bitterman advises. "HCFA always determines that the patient was too sick or too complicated for the nurse alone to screen the patient and that the patient should have been seen by the emergency physician," he says.

• **Never substitute triage for an MSE.**

The triage examination is *not* an MSE, but merely a tool by which the ED determines the order in which the MSE will take place, says **Jonathan D. Lawrence**, MD, JD, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

Every patient who presents must receive triage and a complete MSE, says Frew. "This generally amounts to a full ED visit," he acknowledges.

• **Address the use of nonphysicians at remote sites.**

Realize that the obstetrical department, outpatient clinics, psychiatric assessment units, urgent care clinics, and all off-site locations operating under the new outpatient prospective payment system (OPPS) *also* must address MSEs and authorization of appropriate personnel if the MSE is not done by a physician 100%

(Continued on page 40)

COMING IN FUTURE MONTHS

- Effective techniques for airway management education
- You must comply with new patient safety standards — Here's how
- Dramatically improve your quality assurance program
- Boost revenues significantly with patient financial counseling

EMTALA Compliance Checklist

☐ Create a written statement defining why you believe it will be advantageous to utilize nonphysicians for provision of medical screening exams.
☐ Create a cost analysis to determine cost-effectiveness of the proposal.
☐ Have risk management do a risk analysis to determine secondary costs/exposures. (Does the expected benefit justify the risks of administrative and civil liability and possible perceived reduction in standard of care?)

If the above still looks like the project is worth the effort, then define the way you intend to use the nonphysician screener in a draft policy

[ ] For all presenting patients
[ ] For non-urgent or specific triage categories only

(REMEMBER: Medical screening is not a glorified triage. It is essentially a completed ED visit, including necessary testing.)

[ ] For certain types of presentations — What kinds?

Define individual's authority in a draft policy

[ ] Able to order tests? Which ones?
[ ] Able to interpret tests? Which ones?
[ ] Authority to discharge patients?
[ ] Physician sees prior to discharge?
[ ] Physician does NOT see prior to discharge (affects Medicare reimbursement)

Define limits of nonphysician role in draft policy.

[ ] When MUST a physician conduct the MSE?
[ ] When must a phone or verbal consult with MD occur?
[ ] Are certain types of patients or degrees of triage NEVER appropriate for nonphysician MSE?
[ ] May the nonphysician begin workup awaiting physician?
[ ] What lab values trigger physician involvement?
[ ] By known scope of practice limitations in the state

☐ Verify scope of acceptable practice with state licensure boards by having them review and give a letter of approval, if possible. If necessary, adjust to meet their requirement/limitations.

Prepare a list of necessary competencies in draft policy form.

[ ] Training/credentials required
[ ] Experience required
[ ] Demonstrated competencies
[ ] Necessary approvals from nursing and medicine leadership

☐ Define additional training, orientation, or certification to be completed upon approval and prior to assuming the role (in draft policy form).
☐ Assemble into a hospitalwide policy on nonphysician authority for medical screening.
☐ Prepare a draft departmental protocol that provides detailed instructions to those approved as screeners on how to handle the medical screening exam, forms to use, examples of situations, etc., in draft form.
☐ Create continuous quality improvement (CQI) indicators and criteria to monitor EMTALA compliance issues under the plan, compliance with protocols, and quality of care.
☐ Threshold of compliance for EMTALA is "zero error" tolerance. Policies should designate the individuals responsible for CQI monitoring, the frequency, the method by which it is handled for nonphysicians, the reporting chain, and the individuals responsible for discipline or enforcement.
☐ Create/assemble orientation materials and training program for designated screeners, and assign responsibility for implementation.
☐ Create a plan and assign responsibility for ongoing education for screeners.
☐ Submit the entire package to legal counsel experienced with the Health Care Financing Administration (HCFA) plans of correction in EMTALA citation situations for review and approval.
☐ [OPTIONAL] Submit the package to the regional HCFA office with a request that they review and comment on whether they find it acceptable as written.
☐ Implement plan AS WRITTEN. No deviations are safe.
☐ Watch VERY closely for situations that are not addressed by the plan, or that produce risky results not intended by the plan, so that immediate adjustments can be made.

Source: Stephen Frew, JD, Frew Consulting Group, Rockford, IL.

of the time, Frew stresses. **(See sample policy for nurse performance of medical screening examinations in the obstetrical department, enclosed in this issue.)**

Off-site locations without physicians will be at high risk for violations if they fail to have policies and procedures for assessment of presenting unscheduled patients and proper designation of medical screening personnel, says Frew.

In the case of OPPS sites, the policies also must provide a determination of when the patient needs to be transferred to the home facility or nearest available facility, as a physician might not be available on-site to meet the requirements, notes Frew.

• **Allow only qualified individuals to perform MSEs.**

The basic rule is that nonphysicians may perform the MSE in areas where they are properly designated, says Frew.

"HCFA guidelines specifically indicate that this is similar to 'credentialing' a person for a role, in that it is a formal designation and may not be one that changes frequently," he says.

Frew notes that HCFA considers the following six factors to decide whether the designation process is adequate:

1. There must be formal designation by the governing board of the hospital as a "qualified medical person" or qualified screener.

2. The individual must be acting within the scope of practice for the individual level of licensure. The MSE must be sufficient to reach a diagnosis by exclusion; in other words, no emergency medical condition, as defined by the law, is present.

3. The individual must be acting under written protocol.

4. The individual must be acting within a written job description that includes training and competency standards.

5. There must be designation of whatever requirements there are for contact with a physician. Some states only allow nurses in contact with a physician to function under protocol for a medical screening exam.

6. There must be objective criteria for determining when the presenting condition exceeds the scope properly delegated to a nonphysician and when a physician must come in to complete the screening exam.

• **Document carefully.**

If you use nonphysician screeners, you must maintain careful quality assurance documentation, cautions Frew.

"This must cover adequacy of the medical record and adequacy of the scope of the MSE," he says. "Particular concern should be given to scope of practice and return visits."

Reference

1. Beddingfield FC, Uner AB, Kwon H, et al. A survey of nonphysician medical screening examinations in academic emergency medicine. *Acad Emerg Med* 2000; 7:61-65. ■

Sources

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Using nonphysicians for MSEs: 'Is it worth it?'

There's no question that Emergency Medical Treatment and Active Labor Act (EMTALA) regulations permit medical screening examinations (MSEs) by nonphysicians, says **Jonathan D. Lawrence**, MD, JD, ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"The use of nurse practitioners and physician's assistants saves tremendous time in a busy ED," he acknowledges.

But, Lawrence adds, the real question you should be asking is, "Is it worth it?"

"Since nearly every 'emergency medical condition' discovered during an MSE is going to have to be seen by a physician anyway, what is the advantage of nonphysicians doing MSEs, unless the institution's policy is to turn away patients with non-emergency conditions for care elsewhere?" asks Lawrence.

The practice should not be done in the ED, except

in limited circumstances such as a fast track staffed by a physician's assistant (PA) or nurse practitioner (NP), according to **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix.

"Even then, there is a requirement for a physician to countersign the chart on every patient transferred and possibly every patient that is discharged," Taylor says. "Although this is not explicitly stated in the regulations, a 'discharge' is equivalent to a 'transfer,' so it could be construed."

Here are some of the reasons experts advise against the use of nonphysicians to perform MSEs in the ED:

• **Adverse outcomes are more likely.**

Lawrence points to several examples of conditions that are notoriously difficult to diagnose, even for skilled ED physicians. "These include myocardial infarctions with atypical presentations, pulmonary emboli, and early meningitis," he says. "Not all emergency medical conditions fit into neat guideline rules."

• **Patient satisfaction is lower.**

Patients turned away for care elsewhere because they don't have an emergency medical condition are likely to be dissatisfied customers, says Lawrence. "Consider all the consequences that dissatisfaction brings," he advises.

The time and resources used for a nonphysician to perform a proper MSE could be better spent by having an ED physician, or NP/PA under EP supervision actually treat the patient, argues Lawrence.

"Not only will the patient be happier, but also the hospital and EP will not miss another 'revenue enhancing opportunity,'" says Lawrence. "The additional time to actually treat the patient after the MSE is performed and diagnosis is made is minimal."

• **The guidelines and policies needed for nonphysician MSEs increase liability risks.**

Having to follow strict protocols to the letter lays the hospital wide open for liability when an investigation takes place by state or federal authorities, says Lawrence.

"Anyone who has done policy audits knows that no institution can follow its policies 100%," he warns. "The more detailed the policies, the more likely an investigation will find a deviation from them, subjecting the hospital to the range of EMTALA sanctions."

• **Nonphysicians can't be billed for an ED visit under Medicare.**

The professional service portion of care cannot be billed for an ED visit under Medicare, if a physician does not see the patient, notes **Stephen Frew**, JD, president of the Rockford, IL-based Frew Consulting Group, which specializes in EMTALA compliance.

An alternative used by some hospitals is to have all patients seen briefly prior to discharge by a physician, so that the screening is ultimately approved by a physician, signed by a physician, and billable under Medicare, Frew notes.

• **There is a lack of defense for malpractice cases.**

Although adverse events or poor outcomes can occur with any medical encounter, including those with board-certified ED physicians, the problem with nonphysician MSEs is defending what occurred when a physician did not see the patient, Taylor explains.

"This is not so much a problem with EMTALA as it is with the malpractice case that nearly always follows," he says.

Some courts have only held the provider to the standard of care commensurate with their training, Taylor notes. "Others have use the 'captain-of-the-ship' theory and assume that the highest available standard — a physician — is the standard to which anyone doing such care will be held," he warns.

Lawrence contrasts the scenario of a patient given an MSE by a nonphysician to that of a patient first seen by a nurse practitioner, then seen by an ED physician for review before the patient is discharged. In the former situation, the nonphysician is working independently of any physician, says Lawrence.

"The blame for any mistakes made in the MSE will fall squarely and solely on the hospital if such a patient is sent for care elsewhere and an untoward event occurs," he emphasizes.

In the second situation, the ED physician is acting as a "quality control" of the physician extender and sharing in the treatment decisions as well as the downside if a mistake is made, says Lawrence. ■

Update your ED staff on AHA guidelines

Are your staff up to date on the *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care* from the American Heart Association (AHA)? You'll need to update them immediately, urges **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance.

You may increase your liability risks if your practice is not consistent with the guidelines, warns **Michele Wolff**, RN, MSN, CCRN, professor of nursing at Saddleback College in Mission Viejo, CA.

"I would challenge any medical professional who does not follow the guidelines," she says. "How would a nurse or physician answer the question, 'What evidence do you have that led you to implement an intervention that is contrary to the AHA guidelines and standard practice?'"

You have a professional responsibility to ensure your staff are practicing according to current policy, protocols, and community standards, Wolff says. "Based on this, a clinician who does not follow the latest AHA guidelines would have a difficult time using the 'I didn't know' defense," she says.

Encourage staff to take responsibility for teaching the new skills to each other, advises **Teresa Ostler**, RN, ED educator and pediatric advanced life support (PALS) coordinator at Primary Children's Medical Center in Salt Lake City.

"The shared learning approach takes some of the responsibility off of the manager and places it with the individual learner, where it really belongs," she says.

Here are effective ways to update staff on the new guidelines:

• **E-mail.** Use e-mail to alert staff where to download information about the guidelines or how to obtain copies, advises Gausche-Hill. **(See resource box for this information, p. 43.)**

Gausche-Hill also recommends attaching a lecture handout on the important changes to the guidelines for staff to review.

"I am doing this now for our staff for the PALS changes," she reports.

• **Courses.** All regional AHA offices are providing updates on the new guidelines, with many national rollouts, says **Mary Fran Hazinski**, RN, MSN, senior science editor for the AHA's emergency cardiovascular care committee and clinical specialist in the division of trauma in the departments of surgery and pediatrics at Vanderbilt University Medical Center in Nashville, TN.

Contact your local AHA regional representative for information about rollout courses, Hazinski recommends.

• **Guest lecturer.** "This can be extremely helpful," Hazinski advises. "However, be sure that the person that provides the inservice is very familiar with the topic and can answer questions."

She suggests contacting your AHA regional representative and inviting her to speak at a grand rounds or nursing inservice.

Gausche-Hill acknowledges that it can be difficult to get staff to participate in these meetings. "Offering continuing education credit is a must," she advises. "You also need to supply refreshments and make the program available at times when it is easy for staff to attend." For example, mornings are often less hectic in the ED, she notes. She suggests having several sessions, so that every staff member is able to attend one of the updates. **(See story on guest speakers, p. 43.)**

• **Mock codes.** Use "mock codes" to present a patient scenario and have staff manage that patient at the bedside, says Gausche-Hill.

Mock codes should be given when the ED is not hectic, with a physician or nurse acting as moderator, says Gausche-Hill. "A case is presented, and the team has to work through the case," she explains. "A rhythm simulator can be used to simulate the rhythm changes, and the moderator can give feedback during or after the code."

For example, the respiratory therapist might begin doing bag-mask ventilation on the patient, a nurse could attempt an IV and place the patient on the monitor, and the physician could intubate and run the code, Gausche-Hill suggests.

• **Educational materials.** "There is a wealth of resources and references available to AHA instructors," says Hazinski. She recommends that all ED managers subscribe to *Currents in Emergency Cardiovascular Care* and obtain a copy of the guidelines from one of the AHA distributors for the department. **(See resource box for ordering information, p. 43.)**

ED nurses should schedule a "journal club" to discuss a different chapter of the guidelines each week or month, Hazinski suggests.

• **Posted algorithms.** Make sure the new algorithms are easily visible, says Ostler. "We post the PALS and ACLS [advanced cardiac life support] algorithms in a laminated color form on each crash cart for easy reference," she reports.

• **Newsletters.** Write articles for your ED's newsletter reviewing the new medications, routes of administration, and side effects, recommends Ostler.

• **Distribute learning packets.** The ED at Primary Children's is developing a "learning unit" or self-

Executive Summary

To improve patient care and avoid liability risks, you must ensure your staff are practicing according to new guidelines from the American Heart Association.

- To increase staff participation in inservicing, offer continuing education credit, provide refreshments, and hold several programs.
- Use e-mail to alert staff about the new guidelines and how to obtain copies.
- Hold mock codes for nurses, physicians, and respiratory therapists to manage patient scenarios.

paced packet of information for the new PALS information, notes Ostler. The packets include a sheet that states the objectives and directions for completing the learning unit, current clinical articles, policies and handouts, a clinical skill checklist, and a post-test.

• **Mini-inservices.** At each staff meeting, educate staff about a single aspect of the new guidelines, suggests Ostler. "For example, teach everyone about vagal maneuvers and practice the 'straw technique,'" she says. ■

Get guest speakers at no cost to you

Would you like a guest speaker to update staff on the American Heart Association's *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*? If you're like most ED managers, you don't have the financial resources needed to pay a lecturer.

Here are some suggestions for low-cost or free lecturers, recommended by **Marianne Gausche-Hill**, MD, FACEP, FAAP, director of emergency medical services at Harbor-University of California at Los Angeles Medical Center in Torrance:

• **Local physicians**. "Often, a local physician is willing to review and critique the guidelines and offer this to staff," Gausche-Hill says. Check with your hospital's public relations department to find out which physicians might be available, she suggests.

• **Speakers at major universities.** These individuals might be willing to speak at no charge, Gausche-Hill advises. She suggests contacting the public relations offices at the universities to ask for suggestions for speakers.

• **Volunteer organizations.** These groups may agree to assist financially or with supplying refreshments, she says. Contact the volunteer office at your facility or your local chamber of commerce to get the names of volunteer groups and contact people, she suggests.

• **Local hospitals.** Partnering with a local hospital to share the cost of a guest speaker will reduce costs significantly, suggests Gausche-Hill.

• **Drug companies.** You may be able to obtain financial assistance for guest lecturers, Gausche-Hill says. "However, be aware that some physicians and nurses may not be comfortable with drug company sponsorship. Some EDs may have rules about the use of these types of funds," she notes. Gausche-Hill points out that having a drug company representative as a speaker might also affect whether you can offer CME. ■

Sources

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Resources

The *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care* were published in the Aug. 22, 2000, issue of *Circulation*, the official journal of the American Heart Association (AHA). Reprints are available for $20 plus $7 shipping and handling. To order, contact:

- **Channing L. Bete**, 200 State Road, South Deerfield, MA 01373-0200. Telephone: (800) 611-6083 or (413) 665 7611. Fax: (800) 499-6464 or (413) 665 2671. E-mail: aha@channing-bete.com. Web: www.channing-bete.com.

Key changes are outlined on the AHA web site (www.cpr-ecc.americanheart.org). Click on "What's New" and "Guidelines Released."

The Fall 2000 issue of *Currents in Emergency Cardiovascular Care* contains a 28-page summary of the new guidelines. Individual copies are available for $5. To order a copy or to subscribe, contact:

- **Currents OnLine.com**, 27500 Interstate 45 N., Suite 124, Spring, TX 77386. Telephone: (888) 999-4210 or (281) 419-1992. Fax: (281) 419-8238 ext. 110. E-mail: info@currentsonline.com.

EMTALA Q&A

[Editor's note: This column is 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 Kusterbeck, Editor, ED Management, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck@aol.com.]

Q: If a patient is discharged from the ED and is referred to an on-call physician for treatment the next day, is the physician bound by EMTALA to see the patient?

A: This is a very controversial question and a gray area, according to **Gloria Frank**, JD, owner 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).

"Some people think that the physician is bound if the hospital telephones the physician to notify him or her that the patient will be there the next day [or whatever time period]," she explains. "The counterargument is that once the patient is stable for discharge, no further EMTALA obligations attach to the physician or the hospital."

The arguments for imposing a continuing obligation on the *hospital* are as follows, says Frank:

• The patient is not truly stable for discharge if the hospital knows or has reason to know that the patient's condition eventually will deteriorate because of lack of follow-up care.

• HCFA imposes an obligation to provide a patient who is stable for discharge with a plan for follow-up care. Again, if the hospital knows or has reason to know that the follow-up care will not be provided, then there is no effective plan.

According to **Grena Porto**, ARM, CPHRM, director of clinical risk management for VHA, a Berwyn, PA-based alliance of community-owned health care organizations, the key to whether EMTALA applies is whether an emergency medical condition exists. "In this scenario, it sounds like the emergency medical condition no longer exists, so EMTALA no longer applies," she says.

Q: What are the EMTALA implications if a hospital does not have the resources to provide ED patients with a certain test, such as echocardiography, in the off hours? While most clinical situations will be able to be resolved with alternative testing such as chest X-rays or nuclear medicine, there may be occasions where the only appropriate test would be an echocardiography that would not be available in the middle of the night.

A: This scenario involves three issues, says Porto:

• What services is the hospital required to provide under EMTALA?

• Is it required to provide definitive treatment?

• Can the hospital make adjustments to availability of services based on resource constraints?

To answer the first question, consider the original basic requirements of EMTALA, says Porto. "Under EMTALA, the hospital is required to provide a medical screening exam to determine whether or not an emergency medical condition exists," she notes.

Stabilize or resolve condition

If such a condition exists, the hospital must offer sufficient treatment to stabilize or resolve the emergency medical condition, Porto says. "Once that happens, EMTALA no longer applies," she explains.

If it seems as though echocardiography is not required to determine whether an emergency medical condition exists or to stabilize the patient because other alternatives are available, "it would not be required under EMTALA," says Porto.

Regarding whether the hospital is required to provide definitive treatment, Porto points to the example mentioned. "Echocardiography may be 'state of the art' or definitive diagnostic testing, but that is not required under EMTALA," she says.

Porto also offers a different example: If a patient presents with a dissecting aneurysm of the aorta, but the hospital does not have bypass capability, does the hospital violate EMTALA by not doing the treatment? "The answer is no," she says. "The hospital need only screen, treat, and stabilize. Again, once the emergency has passed, the hospital has no further

Sources

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obligations under EMTALA."

The answer to the third question, as to whether the hospital can make adjustments to availability of services based on resource constraints, is yes, according to Porto. "As long as the hospital treats all patients the same, within its capability to provide care, then there is no violation of EMTALA," she says.

Thus, if there is no neuroradiologist available at night or on certain days, that is not a violation of EMTALA, provided all patients are treated the same, Porto clarifies. "Under these circumstances, the hospital would be required to stabilize, and then transfer the patient to a facility that has the necessary capabilities to treat the emergency medical condition," she says. ■

Senate confronts the nursing shortage

If you're like most ED managers, you're struggling with high vacancy rates and a lack of qualified nurse candidates to staff your ED. The nationwide nursing shortage has become so severe that the U.S. Senate has formed a subcommittee to find solutions.

The shortage is exacerbated by the fact that fewer people are choosing nursing as a career. According to government projections, the United States will need 1.7 million nurses by 2020; however, only 600,000 will be available.

The shortage is especially severe in the ED because of overcrowding that occurs when there are either no beds available to admit ED patients, or a lack of staff to open those beds, says **George D. Velianoff**, RN, DNS, CHE, executive vice president of nursing for the Emergency Nurses Association in Des Plaines, IL.

"This causes a backup in the ED, and we are left caring for patients that belong in the critical care units, while still keeping our doors open to everyone else," he says. "With these conditions, staffing does become strained."

Velianoff notes that although overall vacancy rates nationally are around 14%, this number is quickly rising to 30% in some areas. "We are especially concerned about the next 10 years, when those ranks continue to diminish with no new faces coming into the ED," he adds.

Sen. Tim Hutchinson (R-AR), chair of the subcommittee, said senators would introduce a plan in the next few weeks that would include grants for nursing scholarships and training programs. Legislation has also been introduced by Sens. Jim Jeffords, (R-VT), and John Kerry, (D-MA) to provide training, incentives, and higher wages to current and prospective nurses.

The Senate subcommittee will help put the nursing shortage in the public spotlight where it belongs, according to **Diana Contino**, RN, MBA, CEN, CCRN, president of Emergency Management Systems, a Monarch Beach, CA-based consulting firm that specializes in staffing issues.

"Raising awareness is always a step in the right direction," Contino says. "Look at how awareness has impacted domestic violence. People have a better understanding, and it is less tolerated."

Here are ways to combat the nursing shortage in your ED:

• **Pay for conferences.**

Conferences can be a huge morale-booster and also improve the care nurses give in the ED, says **Michelle Myers-Glower**, RN, MS, former director of emergency and trauma services for Elmhurst (IL) Hospital. Myers-Glower is currently a consultant in Glencoe, IL, who specializes in nursing staffing and recruitment.

"I don't send my staff to Hawaii, but I will pay if anyone wants to go to the local ENA [Emergency Nurses Association] convention or conferences pertaining to their job," she says.

• **Promote the profession.**

Emergency nursing leaders need to find new ways to promote the profession, urges Contino.

"Right now, the ED is viewed as an exciting place for nurses to work because of the television show 'ER,'" she says. "As with all television shows, someday 'ER' will no longer be popular. What will be our plan for future promotion?"

• **Give nurses an opportunity for growth.**

New career paths are needed to bring nurses into the profession, Contino argues.

"We need to provide incentives for them to increase their education and skills, and move from the lower-level support positions to nursing levels," she says.

Nurses are looking toward their goals and future employment, and security is crucial for many, says Myers-Glower. "I offer nurses to be on committees such as restraint, conscious sedation, and new products, and they enjoy being a part of a team," she says.

• **Carefully assess your staffing.**

Sources

For more information about the nursing shortage, contact:

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Do an intensive benchmarking review to see if your staffing is adequate for your ED, advises Contino. "Having adequate staffing often decreases turnover," she says.

• Decrease nursing workloads.

Delegate tasks to the laboratory, transporters, and radiology wherever you can, says Contino. "Look at the respiratory therapy staff and LVN/LPN staff to see if they can assist in an expanded role," she recommends.

• Provide adequate orientation.

Another recruitment strategy is defining the orientation program, says Myers.

"Nurses want to know there is a structure in place with a designated preceptor," she says. "They will go to the institution that offers this before one that doesn't."

• Offer free education.

Nurses cannot afford to keep up with all the renewals and new certifications, says Myers-Glower.

"I pay for them after they have worked in our ED six months," she says.

Offer on-site classes, Myers-Glower recommends. "Nurses love this, especially if you can provide an opportunity for instructor status," she says. "There may be an opportunity for your hospital to make money on holding these classes on-site. This advertises to nurses that the hospital is involved in continuing education and that you care about them as a nurse." ■

Sobie JM, Gaves D, Tringali A. **ED "hold" patients: Is their care also being held?** *J Emerg Nurs* 2000; 26:549-553.

Patients who are "held" in the ED because of an unavailable inpatient bed had their blood pressure, pulse, respiratory rate, and oxygen saturation recorded with greater frequency than patients who were directly admitted, according to this study from William Beaumont Hospital in Troy, MI, and St. John's Hospital in Detroit. The researchers audited 104 medical records of patients with pneumonia to compare the care received by "ED hold" patients and 52 "ED direct admit" patients. Here are key findings:

• Directly admitted patients had their intake, output and temperature noted with greater frequency.

• A higher percentage of ED hold patients (30.8%) did not have a temperature recorded than the direct admit group (1.9%).

• More hold patients (36.5%) did not have breath sounds assessed, compared with 1.9% of the direct admit group.

ED nurses did not adhere to the standard of recording temperature and breath sounds, but assessment was more timely in hold patients compared with direct admits, which surprised the researchers. "We expected that the prioritization of care for newly arrived patients in the emergency department would supersede the care of patients who had already been admitted and were waiting for a bed," they write. "As a result, we thought the care of the patients being held would be less timely." ■

CE/CME questions

[Editor's note: Beginning this month, ED Management will print CE/CME questions in each issue. At the end of the six-month semester, we'll include a Scantron form and envelope in the issue so that you can answer the questions and return the answers to us. This change means you'll need to keep your issues for at least six months so that you can refer to those issues and write down your answers when you receive your answer sheet. Also, if you already are a participant in our CE/CME program, you'll find the test for the previous semester enclosed in this issue. If you have any questions, please contact Joy Dickinson, managing editor, at joy.dickinson@ahcpub.com. Telephone: (229) 377-8044.]

1. According to regulations for the Emergency Medical Treatment and Active Labor Act (EMTALA),

which of the following is true regarding designation of individuals to perform medical screening examinations?

A. Formal designation by the hospital's governing board is not required.

B. Written protocols are not required.

C. Written job descriptions are required, but don't need to include training and competency standards.

D. Protocols must include requirements for contact with a physician.

2. Which of the following is true regarding EMTALA violations for nonphysicians and MSEs, according to Stephen Frew, JD, president of the Frew Consulting Group?

A. Most citations have involved the substitution of triage for an MSE.

B. An adverse event is required for a violation to be cited.

C. An adverse event ensures that a violation will be cited.

D. Violations will not be cited unless it is determined that the patient needed physician involvement that was not provided.

3. Which of the following is true regarding liability risks and following the Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care from the American Heart Association (AHA)?

A. If clinicians do not practice according to the new guidelines, they can be sued for malpractice, but the hospital would not be liable.

B. If staff practice is not consistent with the new

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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 Update your staff on new ED guidelines.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See Warning: Are you using nonphysicians for medical screening exams? Rethink this risky practice, Using nonphysicians for MSEs: 'Is it worth it?', and EMTALA Q&A.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

guidelines, the hospital could be held liable.

C. If staff do not practice according to the guidelines, ignorance is an effective defense, since the guidelines were recently published.

D. Because the AHA guidelines are not yet standard practice, they would not be used to support a patient's malpractice suit.

4. When is the use of nonphysicians for MSEs appropriate, according to Todd Taylor, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center?

A. when the ED is on ambulance diversion

B. only in limited circumstances such as a fast track staffed by a nurse practitioner

C. always, unless the patient requests to see a physician

D. never, under any circumstance

5. Which of the following is true regarding patients who are "held" in the ED because of an unavailable inpatient bed, according to a study published in *Journal of Emergency Nursing*?

A. ED "hold" patients were not assessed as often.

B. ED "hold" patients were assessed more often than "direct admit" patients.

C. ED "hold" patients had temperature and breath sounds noted more frequently.

D. There was no difference between the care given to the two groups.

6. To comply with EMTALA, is a hospital required to provide ED patients with a specific diagnostic tests, such as echocardiography, 24 hours a day, according to Grena Porto, ARM, CPHRM, director of clinical risk management for VHA?

A. only if the diagnostic test is required to determine whether an emergency medical condition exists or to stabilize the patient

B. always

C. only if the patient requests it

D. never ■

ED Management
The monthly update on Emergency Department Management

Bioterrorism Fax-Back Survey

Dear *ED Management* Subscriber:

The threat of biological warfare is of growing concern to many who work in emergency departments. Please take a few minutes to tell us your thoughts on this potential threat. When you have completed this short survey, please fax it to Jean Griffiths at (800) 850-1232. Thank you for participating.

1. Does your facility's disaster plan include procedures for what do in the event of a suspected biological event?

Yes No

2. How would you rate your facility's preparedness to handle a biological emergency?

Not at all prepared Somewhat prepared
Well-prepared Extremely well-prepared

3. Have you or your staff received training in handling suspected biologic emergencies?

Yes (If yes, what form of training did you receive?) _____
No

4. How confident are you that you would identify the use of a biological agent in a group of patients presenting with similar symptoms in a short period of time?

Not confident Moderately confident Very confident

5. Would you and your staff be interested in participating in a teleconference on how to plan for and handle a biologic crisis?

Yes No

Thank you again for your participation. **Please fax your completed survey to Jean Griffiths at (800) 850-1232.**

Model Policy: Registered Nurse Performance of Medical Screening Examinations in the Obstetrical Department

(Must be Approved by the Hospital's Governing Board)

1. Registered nurses with demonstrated clinical competency in obstetrics may perform medical screening examinations on persons requesting or requiring this type of emergency medical services.
2. The specific tasks that registered nurses may perform as part of the medical screening examination include, but are not limited to assessing: fetal heart tones, the regularity and duration of uterine contractions, fetal position and station, cervical dilation/effacement, and status of uterine membranes, (i.e., ruptured, leaking, intact).
3. "Demonstrated clinical competency" means the ability to conduct the tasks listed in Section (2) as demonstrated by: [successful completion of the hospital's skill validation process and departmental orientation at the time of the nurse's hire, successful completion of an advanced fetal monitoring course; successful completion of a neonatal resuscitation program; other]. The registered nurse's personnel file should reflect documentation of the nurse's continued competency.
4. Registered nurses who perform medical screening examinations must consult with a physician at an appropriate time before the patient's disposition. The physician is responsible for obtaining pertinent information from the nurse, ordering appropriate diagnostic tests, analyzing the results of those tests and determining the appropriate disposition of the patient; and countersigning the [EMTALA certification for transfer form] within a reasonable time after the transfer.

When a patient requires diagnostic or treatment services that are beyond the registered nurse's scope of practice, demonstrated competency, or comfort level, the registered nurse will:

— request that the patient's attending physician or on-call physician come to the hospital to further evaluate and treat the patient; or

— refer the patient to another appropriate area within the hospital for further screening, evaluation, or treatment; or

— transfer the patient to another facility, at the direction of a physician, when (s)he determines that the benefits outweigh the risks.

The physician is responsible to come to the hospital or send an appropriately credentialed practitioner with hospital privileges if the nurse performing the medical screening examinations determines that the physician's presence is necessary. When the attending or on-call physician refuses to come to the hospital when requested by the nurse, or the nurse has concerns about the physician's medical management of the patient which cannot be resolved with the physician, the nurse will contact [his or her supervisor, risk management, hospital administrator, department chair, other].

A registered nurse may not discharge or transfer a patient from the hospital until he or she has:

1) performed a medical screening examination;
2) consulted with a physician who has authorized the discharge or transfer of the patient;
3) completed and signed the appropriate EMTALA certification for transfer form, if applicable; and
4) documented the screening examination, interventions, physician orders, disposition of the patient, and if applicable, discharge instructions.

The hospital's quality assurance process will include random and periodic reviews of OB records to evaluate the appropriateness of screening examinations, interventions, and patient dispositions.

Source: Arizona Hospital and Healthcare Association, Phoenix, AZ, and Coppersmith Gordon Schermer Owens and Nelson, PLC, both of Phoenix.

Excerpts from Emergency Medical Treatment and Active Labor Act (EMTALA) Manual

3.3 Who is Qualified to Perform the Medical Screening Examination?

A physician or other "qualified medical person" may perform the medical screening examination. The hospital must state in its bylaws or governing body approved rules and regulations who the hospital deems to be "qualified medical persons" for purposes of providing the medical screening examination. According to the Health Care Financing Administration (HCFA):

- While it may be prudent for a hospital to require a physician to conduct a screening examination in every instance, there may be hospitals, especially rural primary care hospitals, in which a physician is not available to provide a medical screening examination. Even when physicians are present in the hospital, there may be circumstances that are so clearly not emergency medical conditions that other qualified medical personnel may conduct the initial screening examination. However, it is up to the hospital to determine under what circumstances a physician is required to perform an appropriate medical screening examination. [59 *Fed. Reg.* 32086, 32099, (June 22,1994)]
- A "physician" is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he performs such function or action. If state law permits podiatrists, dentists, optometrists, or chiropractors to provide the health care services that are a necessary part of a medical screening examination for a particular person, then they too may be deemed to be physicians for purposes of the EMTALA medical screening examination.
- Other "qualified medical persons" may include physician assistants, nurse practitioners, and registered nurses. "Qualified medical persons," however, must be capable of determining whether an emergency medical condition exists and ordering any necessary diagnostic procedures, without exceeding the scope of their professional licenses. These persons must be able to order whatever diagnostic procedures may be necessary to assess the person and be capable of interpreting the results to the extent necessary to determine whether the person has an EMTALA-defined emergency medical condition. In addition, a qualified medical person must have access to and be capable of using all of the hospital's resources, including ancillary services available to the emergency department.
- Registered nurses, without advanced training or resources, generally do not meet the above criteria. If the hospital would like to use registered nurses to conduct limited medical screening examinations (e.g., obstetrical nurses), the hospital should consider adopting specific written policies addressing the education and training required and circumstances under which the registered nurse must consult with a physician. (Note that only a physician may make transfer decisions or determine whether a pregnant woman having contractions is in false labor — the latter a determination which ends the hospital's EMTALA obligations.)
- Although hospitals may designate and use non-physician personnel to conduct medical screening examinations, there are risks in doing so. HCFA has reserved the right to "second guess" a hospital's designation of "qualified medical personnel." HCFA has stated:
- Although we are requiring the hospital to specify. . . who is a "qualified medical person" for purposes of providing an appropriate medical screening examination, this does not mean HHS [the Department of Health and Human Services] must accept the hospital's specification when determining whether an appropriate medical screening examination was done. So, for example, if a hospital specifies that a nurse is always the "qualified medical person" who should do the medical screening examination, HHS may, in some instances, determine that there was not an appropriate medical screening examination because the condition of the individual required the expertise of a physician to determine whether the individual had an emergency medical condition. [59 *Fed. Reg.* 32086, 32099 (June 22, 1994)]

Thus, if a non-physician does not identify an emergency medical condition and transfers or discharges a person without meeting the EMTALA requirements, HCFA may conclude that the hospital violated EMTALA by failing to provide an appropriate medical screening examination. If the person is injured due to the lack of an adequate screening, the person may bring suit against the hospital for both a violation of EMTALA and negligence under state malpractice laws.

8.2 Formulating EMTALA and Emergency Department Polices

Because hospitals have obligations to persons requiring emergency medical services under both state and federal law, the hospital's governing body should review and understand the law, regulations, and standards applicable to

the hospital's provision of emergency services and consider formulating and adopting a policy or set of policies that incorporate these various obligations. If possible, the policy (or policies) should be included as part of the hospital's compliance program or, at a minimum, periodically assessed through the hospital's quality assurance system.

The governing body should consider including the following elements in its emergency department and EMTALA policies:

1. education of hospital personnel regarding the hospital's EMTALA obligations and a system (preferably confidential) for personnel to report suspected violations to hospital administration;
2. monitoring systems to detect non-compliance with EMTALA and the related emergency department policies;
3. the hospital's emergency services capabilities and procedures to be followed at those times the hospital cannot meet its full capabilities;
4. mechanisms to ensure that emergency department physicians and personnel have appropriate qualification and training;
5. the definition of "qualified medical personnel" who may conduct medical screening examinations and provide stabilizing treatment, including the education, training, scope of practice, and licensure standards for non-physicians who meet this definition;
6. requirements for hospital physicians and staff to document compliance with EMTALA (e.g., medical record documentation, certification forms, transfer forms); and
7. a process to track education efforts, monitor compliance, identify instances of non-compliance, provide for the evaluation and investigation of incident reports and other quality of care complaints, and ensure meaningful sanctions and other corrective actions related to the hospital's emergency department policies.

With the support of the medical staff, the hospital may want to consider including:

1. a requirement that those who are granted hospital privileges affirm in writing that they understand and will support and uphold the hospital's policies concerning persons with emergency conditions, including the duty to serve call and to timely respond to the emergency department when requested; and
2. a policy and the necessary procedures to suspend, pending the outcome of the hospital's peer review process, the privileges of any physician who refuses to be placed on the call list or who fails or refuses to attend a person in the emergency department when on call.

Source: Arizona Hospital and Healthcare Association and Coppersmith Gordon Schermer Owens & Nelson, PLC, both of Phoenix.

Emergency Medical Treatment and Active Labor Act (EMTALA) Regulations on Medical Screening Exams (Excerpt)

*** Title 42 — Public Health — Code of Federal Regulations (CFR)**

Sec. 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) General.

In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examinations must be conducted by individuals determined qualified by hospital bylaws or rules and regulations and who meet the requirements of Sec. 482.55 concerning emergency services personnel and direction.

(d) Restricting transfer until the individual is stabilized —

(1)(ii)(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (d)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

* Health Care Financing Administration EMTALA State Operations Manual — May 1998

Tag A406: Interpretive Guidelines: §489.24(a)

This delegation should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform these examinations may be set forth in the rules and regulations, instead of placing this information in the hospital bylaws.

It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

Tag A409: Interpretive Guidelines: §489.24(d)(1)(ii)(B)

Section 1861(r) of the Act [EMTALA] defines physicians as:

(i) A doctor of medicine or osteopathy. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under state law or a state's regulatory mechanism);

Tag A409: Interpretive Guidelines: §489.24(d)(1)(C)

Individuals other than physicians may sign the certification of benefits versus risks of a transfer. These individuals must be identified in hospital bylaws, rules and regulations, or another board-approved document.

If a certification of benefits versus risks was signed by a qualified medical person, a physician's countersignature must be present. Hospital bylaws or policies and procedures will describe the maximum amount of time allowed to obtain physician countersignatures on hospital documents.

Source: Health Care Financing Administration, Baltimore.