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The monthly update on Emergency Department Management

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Emergency Department Pharmacist Activities

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Ready for HIPAA? Take steps to protect patient privacy before it's too late

You'll need strategies to avoid being fined for noncompliance

Patient records left on a desk in full view. Interviewing a sexual assault patient in full earshot of others. Answering a caller's question about whether a certain individual is being treated in your ED.

These may be common occurrences in your ED, but as of April 2003, they also may be violations of the Health Insurance Portability and Accountability Act (HIPAA).

"It's this year's Y2K," says **Jeanne McGrayne**, director of emergency department strategies for VHA Consulting Services, a nationwide network of community-owned health care systems, based in Charlotte, NC.

"Ultimately, we're all going to have to comply, just like with the Joint Commission [on Accreditation of Healthcare Organizations]," she says. "And the bottom line is: It's the right thing to do."

ED managers: Unprepared

Many ED managers interviewed by *ED Management* admitted they have done little or nothing to comply, but most are very concerned about the effect HIPAA regulations will have on their EDs. **(To obtain a copy of the proposed regulations, see resource box, p. 88.)**

Violations of HIPAA are a major concern, especially since the criminal penalty for disclosing patient information without malicious intent is up to $50,000 plus one year in prison.

Don't miss conference replay opportunity

American Health Consultants is offering a replay of one of its most popular audio conferences — **Put It in Writing: Keys to Effective Documentation** — at the subscriber-only rate of $149. Don't miss out on this special opportunity to educate your entire staff at your convenience for one low facility fee. The replay includes handouts, additional resource materials, and free CE for your entire staff.

(Continued on page 94)

Executive Summary

The Health Insurance Portability and Accountability Act (HIPAA) will become effective April 2003 and will require you to address patient privacy issues throughout your ED.

- Use sign-in sheets that conceal the patient's name.
- Give patients beepers instead of calling out names in the waiting room.
- Use a special code to give patients additional privacy.

The biggest challenge for ED managers, says **Jonathan Kent**, RN, CEN, assistant director of the emergency center at Medical Center of Central Georgia in Macon, is protecting privacy in a crowded, noisy ED.

"Patients have as much desire for the world to know their medical complaints as they have to show them the color of their underclothes, but we are still not perfect at protecting the privacy of our patients," he says.

Here are effective ways to comply with HIPAA requirements for patient privacy:

• Protect patient records from view.

You will need to have a secure place for all patient records in your ED, McGrayne says. "This is something you have to pay attention to," she emphasizes.

She gives the example of digital X-ray systems that list patient names at the bottom and may be viewed at various workstations. "You need to consider where you put those screens and ensure that the patient's name is not visible," she says.

She notes that one hospital has a practice of delivering medical records to the ED for all patients being treated. "This is a best practice because it's better for the patients if their clinical history is available to providers."

However, HIPAA will require records to be secured, she says. "Right now, they are laying all over the place," she says. "Anyone could walk through the ED, pick up one of the records, and walk away with it. It can be very serious."

The front page of a patient's chart may be visible, since many EDs keep charts at the bedside or the front desk, McGrayne says.

She offers the following solutions:

Use This Checklist and Ensure Patients' Privacy

The emergency department staff at Medical Center of Central Georgia in Macon are regularly inserviced on the following instructions to ensure patient privacy:

- ✔ Do not share any information with friends or family members of the patient or other employees who do not have a "need to know" to adequately perform their jobs.
- ✔ Do not attempt to access any information on a patient that *you* do not have a need to know for your job.
- ✔ Do not have discussions about patients in hallways, elevators, cafeteria, or outside the organization while off-duty.
- ✔ Do not use your code to look up information for anyone else. They should have their own code that allows them access they need.
- ✔ Always log off before leaving a workstation unattended.
- ✔ Never share your password with others or allow them to use a workstation logged on with your password.
- ✔ Never take any information outside the organization, including photocopies, printed pages, or faxed pages.
- ✔ Use cover sheets on all charts and clipboards.

— Centralize records.
— Put a cover page over demographic information.
— Use binders that protect patient information.
— Scan and automate access to old records.

• Use a sign-in sheet that conceals the patient's name.

Medical Center of Central Georgia's ED uses a triage sign-in sheet consisting of a multipart form with individual tear-off tickets. As each patient signs in, a list that is concealed behind a cover sheet is generated with the name, time, and chief complaint.

The form includes a place to write a telephone contact number, should the patient decide to leave prior to being seen by the triage nurse, Kent adds.

• Limit what other patients can hear.

COMING IN FUTURE MONTHS

- ■ Effective strategies for psychiatric patients
- ■ Obtain reimbursement for 'hold' patients
- ■ How to ensure oral privacy in your ED
- ■ Lessons in efficiency from other industries

McGrayne warns against the common practice of ED physicians dictating patient outcomes in open workstations, which discloses sensitive information to those standing around the desk. "If planning for a new facility, ensure there is adequate space for dictation or telephone discussions to allow for privacy," she says.

Another solution McGrayne offers is investing in automated documentation features that eliminate verbal dictation altogether. She suggests using the HIPAA requirements as leverage to obtain this resource from administrators.

Calling out names of patients waiting to be seen is another potential problem, McGrayne says. She refers to her own consulting experiences, when asked to pose as a patient to evaluate ED processes firsthand.

"When I have done 'mystery patient visits' and someone yells out my name while I'm sitting in a crowded waiting room, I cringe," she says. "Regardless of HIPAA requirements, I feel it's very inappropriate."

To address this concern, ED patients at Gunderson Lutheran Medical Center in La Crosse, WI, are given pagers by the triage nurse so they can be contacted confidentially, says **Stephanie Swartz**, RN, administrative director of emergency medical services. **(For the ED's protocol for use of patient pagers, see box, at right.)**

There also is an added benefit because patients can leave the ED waiting room area and wait in the lobby, cafeteria, or outside, Swartz says.

She notes that the cost for a pager is $140, including the charger units and transmitters, and she says the ED has not had much of a problem with the loss of pagers.

"Our customer feedback shows that patients like the privacy and the increased mobility," Swartz says.

• Give staff inservices specifically about privacy.

The way you educate staff about privacy requirements will be the biggest factor in determining whether you are HIPAA-compliant, according to Kent. "They are the ones who control information at the outset," he emphasizes. **(See checklist of privacy practices the ED staff is instructed to use, p. 86.)**

All ED staff are required to complete an annual competency assessment on privacy issues and receive regular inservices on this topic, he says.

• Dispose of health information properly.

Kent recommends placing receptacles wherever a document with the patient's name or other identifying information is produced. He suggests using a document-destruction company to empty them.

Staff are instructed to dispose of all protected health information, including floppy disks, CD-ROMs, plastic identification cards, embossers, and name bands, in one of the 10 locked receptacles.

ED Protocol for Patient Pagers

GOALS

- To maintain confidentiality of patients in the waiting room of the Trauma and Emergency Center.
- To be able to call family members back to the treatment area, allowing them more mobility during extensive waits.

1. The triage nurse will give each patient a pager after he or she has been triaged.
2. The number of the pager will be written on the nurse's note in the upper right area of the form.
3. Patients and family members present will instructed on the use of the pager such as: "The pager is used to let you know when we are ready to take you back to the treatment area to see the doctor. The pager will make a buzzing (or vibrating) sound. We are using them so that we do not announce patients' names in the waiting room, and that provides privacy for you."
4. Patients will be instructed to come toward the registration desk to meet the staff who will take them back to the treatment area.
5. Patients in wheelchairs will be instructed to raise their hand in acknowledgement so that the staff member can then wheel them to the treatment area.
6. The pager then can be given to a family member/friend with instructions for that person to come to the treatment area when the pager buzzes to rejoin the patient.
7. The staff person should introduce him/herself to the patient and family and explain that he or she is going to take the patient to a room to see the doctor.
8. Do not use the patient's name until you are out of the public area. Using the patient's name then is important to ensure proper identity of the patient.
9. Pagers will be returned by placing them in the basket on the registration desk or by placing them back in the charger.
10. Pagers will be wiped off with a disinfectant after patient use, as needed, and all pagers will be cleaned once a day.

Source: Gunderson Lutheran Medical Center, La Crosse, WI.

Sources/Resources

For more information on how to protect patient privacy, contact:

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Proposed changes to the "Standards for Privacy of Individually Identifiable Health Information," part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), were published in the March 27, 2002, *Federal Register*. To view the proposed rules and a side-by-side comparison of this new proposal, go to: www.aishealth.com/Compliance/HIPAARegs032202.html. A final rule will be published later this year. To order a copy of the *Federal Register* with the proposed rule, contact New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date requested. Credit card orders also can be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $10. The *Federal Register* is available at many libraries and on the web: www.access.gpo.gov/nara/index.html.

Kent notes that it's very important to place a receptacle at the automated medication dispenser. "If a receipt is generated and not used for documentation, it must be destroyed, as it has the patient's name and drug listed on it," he says.

• Use a special code for increased privacy.

Kent says that ED patients at his facility are offered a "No Press, No Info" (NPNI) special code. "Patients under this designation will have their presence in our facility neither confirmed or denied by phone or in personal contact with visitors," he says.

He explains that if any ED staff member feels a patient may desire increased privacy, such as a community "VIP" or a victim of violence, the "NPNI" designation is offered. "The patient can choose to have zero information available even regarding his or her presence in the hospital, except on an absolute need-to-know basis for caregivers," Kent says.

• Make every attempt to increase privacy by shifting the location of patients.

Kent says his ED staff make every possible effort to ensure audio and visual privacy for all patients, including shuffling placement in rooms and holding at least one room open for private interviews and exams.

He notes that staff may be used to needing a private space for physical examinations to protect a patient from being exposed to onlookers, but it's important they understand that interviews also may require the same level of privacy.

"It is difficult at times to make these arrangements, but we do it to the absolute limit of our capability," he says. ■

ED Benchmarking Success

Cut medication errors in half with ED pharmacist

By the time emergency medical services arrived at University of Texas Southwestern Medical Center in Dallas with a 2-year-old boy who had ingested his mother's ramipril and labetalol, the ED's pharmacist already had prepared detailed information sheets for the nurse and physician.

Those sheets listed the care pathway for each agent involved, appropriate evidence-based management, potential side effects, necessary lab tests, and

Executive Summary

Using a dedicated pharmacist in the ED can drastically cut costs and medication errors.

- The pharmacist is a valuable resource for physicians, who can obtain current information about complex drug interactions.
- Nurses receive regular inservices about medication administration.
- Monthly costs were cut by $61,000 due to more appropriate utilization of medications.

complications that might occur.

This type of scenario now occurs in the ED on a daily basis, due to the use of a dedicated on-site pharmacist in the ED, says **Paula J. Mialon**, PharmD, the facility's clinical pharmacist for emergency medicine.

This individual responds to codes, reviews medications before administration, and educates staff on important issues related to risks and alternatives, says **Robert A. Wiebe**, MD, FAAP, FACEP, professor and director of the division of emergency medicine and department of pediatrics at the facility.

Although the program started only a year ago, there have been dramatic results, Wiebe says. "This program is still maturing, but we have some preliminary data that show a 50% reduction in medication errors since the pharmacist has been on site," he reports.

This alone has been enough justification for hospital administrators to allocate this resource for the ED with 24-hour coverage, he says. He reports that four clinical staff pharmacists soon will be providing coverage for more than 95% of the patients seen through the ED.

Here are some benefits of having a dedicated pharmacist in the ED:

• Staff are assisted with complex medication issues.

Mialon serves as the link between the central pharmacy and the ED for drug delivery and administration and acts as a resource for the medical and nursing staff. She gives inservices on drug calculations, toxicology, and rapid sequence induction pharmacology to ED nurses.

As a result, clinicians are freed from having to worry about dosages, drug interactions, complications, and routes of administration, Wiebe says. "It isn't just a convenience," he says. "This allows us the luxury of devoting our time and energy to other critical patient care issues."

Wiebe notes that new drugs are appearing daily, and each new drug has pharmacokinetic issues that create problems for the clinician. "The pharmacist is the expert in drug delivery, interactions, and complications," he says.

Mialon explains that she reviews the patient's entire list of medications, including herbal products or teas, over-the-counter drugs, and vitamins. She notes that any of these may cause clinical symptoms that may imitate or mask another disease.

She also points to patients on complicated drug regimens at home, such as a patient who comes to the ED with active seizures. "He takes Tegretol at home, and we run a level, and it is critically low. The next question is — how much do we give him to get him controlled again?" she asks. In this case, Mialon would calculate his pharmacokinetic parameters, make clinical recommendations based on the results, and review the patient's history to rule out potential adverse drug interactions.

Next, Mialon provides nurses with information about preparation and delivery of the medication and potential side effects. "Should a side or adverse effect occur, the pharmacist is there to help with management," she says.

• Medical errors are reduced.

Orders are reviewed for appropriateness, dose, route, and frequency, and determining if the agent is the best, most cost-effective, and safest agent available, Mialon says. "Common errors such as incorrect decimal points are intercepted," she adds.

'Curbside' educational opportunities

Mialon says there is plenty of "curbside" education that takes place. "Any question we are asked, we find the answer for," she says.

She uses other hospital pharmacists as a resource. "If a patient presents to the ED with a complex cardiac issue, I can call my cardiology pharmacist, who specializes in this area, for consultation." The other pharmacist may be familiar with a specific patient's history, Mialon adds. "She may know details such as the best vancomycin dose the patient tolerates, which saves someone else from starting over completely," she says.

She adds that the ED pharmacists attend all traumas and codes in the ED to assist with dosing and drawing up of medications, preparing drips such as epinephrine or dopamine, and assisting with administration. "This frees up the nurse to do other things, such as procedures and charting," Mialon says.

She stresses that every drug provided by the pharmacist is labeled.

"Not one syringe leaves the hands of the pharmacist

Sources

For more information on the benefits of a dedicated emergency department pharmacist, contact:

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to be given to the patient without a label and at least one second check by another member of the team," Mialon says.

• Costs are reduced.

In a one-month pilot test with just one pharmacist on eight-hour days, $61,000 was saved in direct costs, she reports, by switching to less expensive but equally effective agents and recommending "judicious use" of laboratory draws, particularly for drug levels. "And that's not including 'potential' reductions based on errors such as legal fees," Mialon adds. **(See "Emergency Department Pharmacist Activities," in this issue.)** ■

ED managers react to smallpox vaccine update

A Centers for Disease Control and Prevention (CDC) advisory committee has recommended that smallpox vaccinations be made available to first responders and pre-designated hospital personnel, but not the general population or other health care workers.

Although it has not been determined whether the recommendations will be implemented, the CDC's Advisory Committee on Immunization Practices (ACIP) says the potential benefits of vaccination fail to outweigh the risks and complications of the vaccine. **(See key recommendations, at right.)**

The CDC committee discussions indicated that some 15,000 first responders and health care workers may be immunized. However, officials at the Dept. of Health and Human Services later indicated that number could go as high as 500,000 people. While the issue remains under discussion, here are some reactions of ED managers regarding immunization:

• Individuals most likely to be exposed should receive immunizations.

Denny Swick, RN, CEN, EMT-P, EMS coordinator for emergency services at Columbus (OH) Children's Hospital, argues for protection of groups who could be exposed without advance notice, such as ED staff.

In contrast, he notes that any team members responding to a suspected outbreak presumably would not need immunization in advance, as they would know they are potentially going into an infectious zone.

• Some ED staff say it should be their decision.

Many ED managers view the decision not to vaccinate health care workers as appropriate, because they have no desire to risk the potential side effects of the vaccine, and they have no guarantees such a risk would result in the appropriate immunity,

Executive Summary

In updated recommendations, a Centers for Disease Control and Prevention advisory committee says that a small group of predesignated personnel should receive smallpox vaccinations, but not the general public or other health care workers.

- Some managers insist that any group who could be exposed without advance notice should be vaccinated.
- There is a concern about time off for vaccination if an exposure occurs.
- The risk of side effects is a concern.

CDC's Key Recommendations

Below are key recommendations from the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices regarding smallpox vaccination:

- Smallpox vaccination is recommended for selected personnel in facilities pre-designated to serve as referral centers to provide care for the initial cases of smallpox.
- Smallpox vaccination is recommended for those pre-designated by the appropriate bioterrorism and public health authorities to conduct investigation and follow-up of initial smallpox cases that would necessitate direct patient contact.
- State bioterrorism response plans should designate initial smallpox isolation and care facilities. In turn, these facilities should pre-designate individuals who would care for the initial smallpox cases. Additional personnel should be identified and trained to care for smallpox patients to ensure adequate staffing.
- Specific teams at the federal, state, and local levels should be established to investigate and facilitate the diagnostic work-up of the initial suspected case(s) of smallpox and initiate control measures. These smallpox response teams might include people designated as medical team leader, public health advisor, medical epidemiologists, disease investigators, diagnostic laboratory scientist, nurses, personnel who would administer smallpox vaccines, and security/law enforcement personnel. Such teams also may include medical personnel who would assist in the evaluation of suspected smallpox cases.

Source: Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices, Atlanta.

according to **Bettina Stopford**, RN, CNE, chair of the national Weapons of Mass Destruction work group for the Des Plaines, IL-based Emergency Nurses Association.

Still, many would like the choice to be their own, says Stopford, noting that health care professionals are the first line of defense in the identification of a biological agent release.

"After 9/11, I have changed the way I view issues, both personally and within the ED," says **Brian Miluszusky**, RN, BSN, director of nursing for the ED at New York (City) Presbyterian Hospital.

"I personally don't know if I would take the vaccine, but I think that all ED and hospital staff should be able to take the vaccine, and so should their families," he points out.

There is a concern about time off if mass vaccinations are needed.

Miluszusky points to current CDC recommendations that health care workers who are vaccinated, particularly those who work around immunocompromised patients, not return to work for up to two weeks after vaccination to prevent inadvertent transmission of the virus.

"Can you imagine what would happen if there was even one unrecognized case in the ED?" he asks. "Anyone in contact would have to get the vaccine, including nurses, doctors, clerks, and registrars. Think about how crippling this would be."

• The possibility of side effects is acknowledged.

Eric Lavonas, MD, FACEP, emergency physician and toxicologist at Carolinas Medical Center in Charlotte, NC, says he believes that most people would choose to be vaccinated for the peace of mind.

"However, I work for a hospital system with 27,000 employees," he says. "If I was the CEO, I'm not quite sure what I'd say to my employees who got seriously ill because they worked for me and chose the vaccine."

• The bottom line is EDs remain vulnerable.

Stopford says that EDs remain vulnerable. She points to the absence of the following:

— active surveillance system;

— appropriate education to recognize suspicious syndromes;

— appropriate level of personal protective equipment;

— readily available local supply of pharmaceuticals;

— rapid access to the Atlanta-based National Pharmaceutical Stockpile. The stockpile is a component of the CDC's Bioterrorism Preparedness and Response Initiative that supplies vaccines, pharmaceuticals, and medical supplies as needed.

The ED still is a primary site in which to identify and treat victims infected with a potentially lethal biological agent, Stopford says, and she notes that EDs have varied response capabilities, dependent upon resources allocated to their preparedness.

• There is a need to have a mass vaccination plan in place if needed.

Lavonas notes that, due to side effects, a mass vaccination campaign of health care workers or the general public would cause illness instead of preventing it.

He adds that if intelligence agencies learn that terrorists have acquired a supply of smallpox virus, then mass vaccination would make sense. "The ACIP guidelines take this into account," he says.

Lavonas says that vaccination after a smallpox exposure is still believed to be effective during the incubation phase. "Also, the same droplet isolation procedures we use to prevent the spread of tuberculosis in the hospital setting will work for smallpox," he says. "We are not defenseless."

While Lavonas thinks the ACIP recommendation to vaccinate some health care workers who can provide immediate care in the event of a rapid mass vaccination program is appropriate, he says it's even more important to have a "Plan B" if needed.

"We need to develop the capability to vaccinate a large population within 24 hours of the appearance of smallpox, so that we could stop an outbreak in its tracks," he says. ■

Sources

For more information about the recommendation, contact:

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For the complete text of the *Draft Supplemental Recommendation of the ACIP Use of Smallpox (Vaccinia) Vaccine, June 2002,* go to: www.cdc.gov/nip/smallpox/supp_recs.htm.

Learn how bioterrorism bill will affect your ED

If you're like most ED managers, you're eager to find out how the newly enacted Public Health Security and Bioterrorism Response Act will impact your ED.

Sources interviewed by *ED Management* unanimously agreed that the new law will result in better preparedness. "Legislation that encompasses the entire health care system, with public health as the foundation, is a welcome event," says **Ann Stangby**, RN, CEM, emergency response planner for San Francisco General Hospital.

Stangby adds that the resources allocated will benefit your ED's operations in general, not just in terms of preparation for terrorism. "It looks like much of what is being recommended is going to enhance the health care system overall," she says.

Here are key components of the legislation, along with reactions from experts in ED management and disaster planning:

• A national bioterrorism surveillance network will be established. The newly created Emergency Public Information and Communications Advisory Committee will track outbreaks of infectious diseases.

Stangby says this early warning system will benefit you not just in cases of terrorism but also during disease outbreaks, pointing to her ED's annual struggles to meet the demands of the flu season.

• Training will be provided. ED physicians and other health care providers will be trained to recognize and treat victims of biologic agents and other weapons of mass destruction. However, she says a key concern is lack of standardized training for all health care providers, including those in large and small hospitals, rural health centers, freestanding clinics, and urgent care sites.

"I think there needs to be one approved curriculum for health care providers. It can be customized, but the basic content should be consistent," Stangby adds.

Standardized disaster training should be in the curriculum for students in medicine, nursing, pharmacy, and respiratory care, she says, and refresher training should be given periodically. "Providing certification is an excellent foundation, as it will help to maintain competencies," she says.

• Funding will be allocated. The legislation allocates $1.6 billion in grants to states for hospital preparedness. "It's certain that this will translate into a large amount of funds for ED preparedness," predicts **Rich Klasco**, MD, chief medical officer for Micromedex and an ED physician at Swedish Medical Center in Englewood, CO.

Sources

For more information about the implications of the bioterrorism law, contact:

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Micromedex, a provider of databases and integrated support tools covering drug, disease, patient education, toxicology, alternative medicine, regulatory, and chemical information, is based in Greenwood Village, CO.

Klasco argues that you should take a proactive stance regarding funding. "Instead of just waiting to see what comes to you from the federal government, have a plan in your mind for what constitutes bioterrorism preparedness in your setting."

He recommends going to hospital administrators armed with a list of needed resources. "Everyone is waiting to be handed their 'tool kit,' so to speak. We all need to make some decisions about our needs," he says.

Betty Karas Bartolini, RN, emergency preparedness coordinator at Waterbury (CT) Hospital, takes that a step further, recommending that you meet with local or national politicians to lobby for your ED's needs. She reports that representatives from her hospital recently met with Sen. Joseph Lieberman (D-CT) to discuss the bioterrorism law. "We expressed that we would like to see ongoing training available to staff members in the ED, and a disaster medical assistance team available to respond quickly in the event of a hazard," she says.

Klasco underscores the need to put information into the hands of first responders with handheld computers. "It's necessary to have the full spectrum of information technology available, because we don't know where the target is going to be in our information chain," he argues.

Bartolini says that funding is needed to improve the ability of EDs to decontaminate patients. "We see many patients leaving the scene of a potential hazardous materials incident and making their way to the ED before they are decontaminated," she says. ■

EMTALA Q & A

[Editor's Note: This column is part of an ongoing series that will address reader questions about the Emergency Medical Treatment and 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.]*

Question: There are clinics and private offices in the same building as our freestanding ED. If an ED patient requires an orthopedist or ophthalmologist, and there is a specialist available upstairs, can the patient be sent to that office for treatment, or do we have to follow the on-call schedule?

Answer: There is no EMTALA requirement to follow a particular call schedule, according to **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"It is perfectly appropriate to discharge/transfer a stable patient to any physician's office to continue or complete the care started in the ED," he says. He adds that once the screening exam is performed and stabilizing treatment provided, transfer or discharge is the next step.

The specialist's office may the most appropriate place for the completion of care, Lawrence notes. "Some government field offices looking into EMTALA violations have not understood this and have charged violations, though I think this is a diminishing problem as they begin to understand how the system works in real life," he says.

Lawrence says that, as always, careful documentation of the screening exam and a description of the patient's stability (no reasonable likelihood of deterioration as a result of transfer or discharge) will protect the practitioner.

Question: If a sick child is examined in a pediatrician's office and sent to the ED with written orders for lab work, X-rays, and an intramuscular injection of an antibiotic, is a medical screening examination (MSE) required?

Our ED physicians believe that because of the physical absence of the pediatrician in the ED at the time of service, they are obligated to perform an MSE. The pediatricians disagree, because they have just examined that child in the office and have written orders accompanying them.

Answer: The ED physicians are correct, Lawrence says. He explains that the pediatricians have the capability of sending these children for outpatient lab tests and X-rays without involving the ED and can administer antibiotics in their own offices. If the children are being sent to the ED, they are there for emergency care and must receive an MSE like any other patient, he points out.

Lawrence concludes that the pediatricians must be educated on EMTALA requirements. "There is plenty of literature to show them from the federal government addressing exactly this type of situation," he says.

"The pediatricians must either conform to EMTALA or make other arrangements for these children," he explains.

Question: If an accepting physician tells us to send the patient to the ED and verbally agrees to see the patient there, do we still need to get acceptance from the accepting ED and give report?

Answer: No, according to Lawrence, explaining that EMTALA allows acceptance on behalf of a hospital by the physician who intends to take care of the patient. "Whether we like it or not, that may not be the emergency physician, and the patient may end up in a busy ED with no beds available," he says.

Lawrence underscores that separate acceptance by the receiving ED is not required. "Also, no formal oral report is required from the sending ED to the receiving ED," he says.

He notes that EMTALA *does* require the sending hospital to make and send copies of all charts, labs, X-rays, electrocardiograms, and other diagnostic tests. Lawrence adds that common courtesy requires good communication between all parties: the sending ED and ED physician, the receiving ED and ED physician, the accepting physician, and nursing personnel. ■

Source

For more information about EMTALA, contact:

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JOURNAL REVIEWS

Amey AL, Bishai D. **Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey**. *Ann Emerg Med* 2002; 29:631-638.

According to this study, sexual assault victims are not receiving complete treatment as recommended by Centers for Disease Control and Prevention Guidelines.

Researchers from Johns Hopkins Bloomberg School of Public Health in Baltimore analyzed seven years of data reported to the National Hospital Ambulatory Medical Care Survey by a nationally representative sample of EDs. Although the number of rapes reported by EDs for the years 1992 through 1998 is consistent with the number of rapes reported to law enforcement, the study found that a large portion of the patients were not given appropriate treatment.

Here are key findings:

• Although Centers for Disease Control and Prevention guidelines recommend screening for sexually transmitted diseases (STDs) and HIV for sexual assault patients, 65% of patients were not screened for STDs, and 77% were not screened for HIV. Of adult patients 18 and older, 21% received neither screening nor treatment.

• Fewer than half of eligible women received emergency contraception, although this is recommended by the American College of Obstetricians and Gynecologists for women at risk of pregnancy.

"On the basis of our evidence, there are a significant number of adult women who do not receive proper screening and treatment to prevent pregnancy and STDs after sexual assault," write the researchers.

"This points to a need for hospital EDs to develop better programs for medical management of patients experiencing sexual assault or to refer patients to other hospitals that have developed this expertise," they explain. **(For more information on this topic, see "Do sex assault victims receive adequate care? If not, you risk fines, violations," *ED Management*, June 2002, p. 61.)** ▼

Thornquist L, Biros M, Olander R, et al. **Health care utilization of chronic inebriates**. *Acad Emerg Med* 2002; 9:300-308.

County programs can reduce ED use for most chronic inebriates, but serious medical illness or injury in a small group of these patients had a major impact on resource utilization, says this study from the Hennepin County Medical Center in Minneapolis.

The facility's ED receives approximately 4,500 visits each year, or 12 per day, for patients with acute alcohol intoxication or altered mental status due to alcohol. To address this problem, the county developed three programs to reduce ED utilization, including a housing program and intensive street case management.

The study looked at 92 chronic inebriates, seven of whom had severe illness or injuries. The researchers found significant reductions in the numbers of yearly medical visits for this group of patients.

However, the mean charge for medical care of this group did not decrease, due to a small number of catastrophic medical events for a few study patients that skewed the overall results for the group as a whole.

"Although it is tempting to disregard these outliers in the final medical cost-savings analysis, they are a medical reality in this patient group," the researchers conclude.

They recommend the following to manage chronic inebriates:

• developing a countywide system to promote appropriate use of the ED, while still providing a medically safe environment for patient;

• involving the ED in development of programs to address the medical and social needs of this group;

• developing programs that address current health needs of these patients, with the awareness that a significant number will not respond to rehabilitation. ■

(Continued from cover)

Put It in Writing: Keys to Effective Documentation, will be replayed from Aug 20-21 starting at 8:30 a.m. and concluding at 5:30 p.m. Aug. 21. The need for thorough and accurate documentation is crucial in health care. Inadequate documentation can result in claims denials, lawsuits, and even criminal investigations.

Learn the keys to effective documentation and how it can benefit your facility. The conference is presented by Deborah Hale, CCS, president of Administrative Consulting Services, and Beverly Cunningham, RN, MS, director of case management at Medical City in Dallas.

To sign up for the replay, or to get information on upcoming live audio conferences, call American Health Consultants' customer service department at (800) 688-2421. You will be given a dial-in number and conference call access code. Conference material will be available on-line once you register. When ordering, please refer to this effort code: 62001. ■

CE/CME questions

For more information on the CE/CME program, contact the customer service department at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

25. Which of the following is recommended to comply with patient privacy regulations, according to Jonathan Kent, RN, CEN, assistant director of the emergency center at Medical Center of Central Georgia?
    A. separate interview rooms for all patients
    B. use of sign-in sheets at triage
    C. avoiding any confirmation of a patient's presence in the ED
    D. use of locked receptacles to dispose of documents with patient information

26. Which of the following resulted when a dedicated pharmacist position was added to the ED, according to Robert A. Wiebe, MD, FAAP, FACEP, professor and director of the division of emergency medicine and department of pediatrics at University of Texas Southwestern Medical Center at Dallas?
    A. Medication errors were reduced.
    B. Staff turnover decreased.
    C. Direct costs of medications increased.
    D. Patient satisfaction increased.

27. Which of the following groups is included in current recommendations for smallpox vaccination?
    A. health care workers
    B. pre-designated hospital personnel
    C. ED staff
    D. emergency medical services personnel

28. To comply with EMTALA, what must the sending hospital do after an accepting physician accepts the patient verbally, according to Jonathan D. Lawrence, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center?
    A. Obtain separate acceptance by the receiving ED.
    B. Provide a formal oral report.
    C. Make and send copies of the patient's chart including diagnostic tests.
    D. Obtain written consent before the patient is transferred.

29. Which of the following is provided by the recently passed bioterrorism preparedness legislation?
    A. All trauma centers will receive updated decontamination equipment.
    B. Rural facilities will receive the majority of funding.
    C. Only facilities in urban areas will receive funding.
    D. Training will be provided to ED physicians to recognize and treat victims of biologic agents and other weapons of mass destruction.

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30. Which is true regarding medical treatment for sexual assault victims, according to a study published in *Annals of Emergency Medicine*?
    A. Most sexual assaults were not reported to law enforcement.
    B. A significant number of women were not screened for sexually transmitted diseases.
    C. Almost all eligible women received emergency contraception.
    D. All women were screened for HIV.

CE/CME objectives

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

1. Name one effective way to protect patient privacy in the ED. (See "*Ready for HIPAA? Take steps to protect patient privacy before it's too late*.")
2. List one result of having a dedicated pharmacist in the ED. (See "*Cut medication errors in half with ED pharmacist*.")
3. Name one group included in the CDC recommendation to receive smallpox vaccine. (See "*ED managers react to smallpox vaccine update*.")
4. Cite one requirement of the sending hospital when a patient transfer occurs, to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA). (See "*EMTALA Q&A*.")
5. Identify one finding of a study on sexual assault victims. (See "*Journal Reviews*.")
6. Name one resource provided by newly passed legislation on bioterrorism preparation. (See "*Learn how bioterrorism bill will affect your ED*.") ■

Emergency Department Pharmacist Activities

The following activities are performed by the Emergency Department Clinical Pharmacist. They are presented in order of importance, with the most important activity presented first.

- Continuously seek out interventions by making rounds in the medical, trauma, and observation units. Clinical pharmacist offers suggestions and assists in preventing medication errors from occurring.
- Suggest appropriate medication and/or dose recommendations where necessary.
- Assist in drip calculations and medication dosing and drip compatibility, particularly in code/trauma situations.
- Perform pharmacokinetic dose checks and make recommendations on dose adjustments for anti-epileptic medications, phenytoin, theophylline, digoxin, and aminoglycoside orders, and TDM of other meds as necessary.
- Serve on medical and trauma code response teams. Attend all incoming transport patients until deemed stable or transferred to another area.
- Aid in the management of the poisoning/toxicology patient, including review of toxin and its appropriate treatment. Aid with recommendation and utilization of appropriate antidotes to common poisons.
- Inform on adverse medication events/reactions, document occurrence. In conjunction with other members of the ERC team, design and implement plans for elimination or minimization of errors.
- Inform on medication side effects, interactions, and incompatibilities.
- Answer drug information questions from ERC staff and patients.
- Enter physician orders after review. Facilitate rapid turnaround time from pharmacy.
- Inform on drug-drug or drug-disease interactions.
- Fill emergency department outpatient prescriptions for difficult-to-find after-hours emergent prescriptions.
- Document clinical and cost-saving activities/interventions as well as routine provision of information.
- Educate medical staff on costs of comparable medications (e.g. outpatient formulary concerns), and assist prescribing habits (review of individual patient's insurance formulary to provide best possible discharge care). May include assistance in acquisition of medications from drug companies for indigent patients.
- Responsible for all pharmacy distribution issues in the ERC. Serve as liaison between pharmacy and ERC to improve medication delivery and turnaround time.
- Facilitate transfer of patient to floor/ICU by notifying floor/ICU pharmacist of situation and immediate medication needs after arrival.
- Recommend alternate drug entities during drug shortages as needed.
- Perform formal/informal consultations as needed to ERC staff as requested.
- Identify unknown medications (by name or medication itself).
- Provide and attend physician, nursing, and pharmacy inservices on emergency medicine-related topics.
- Recruit, maintain, and educate ERC pharmacy staff.
- Recommend alternate routes of administration when appropriate.
- Inservice physician and nursing staff as requested.

Note: TDM — Therapeutic drug monitoring
ERC — Emergency Referral Center
ICU — Intensive care unit

Source: University of Texas Southwestern Medical Center, Dallas.