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Growing trend of identity theft poses safety and billing loss threats

Prevention particularly difficult in emergency setting

Just as identify theft has been steadily increasing in the general populace, so has it grown in the medical setting, with the ED perhaps feeling the greatest impact of all. At CoxHealth, which operates three hospitals and more than 50 clinics in Springfield, MO, 1-2% of the system's patient population have an identity theft issue, and most of the incidents of medical identity theft come through the ED, says **Betty Breshears**, MHA, the vice president of corporate integrity.

John Archer, RN, director of the ED in Cox South Hospital in Springfield, says, "We have seen a rising problem in the last five years of folks trying to use other folks' insurance. For example, they might hand us a relative's card."

Archer says identify theft poses a dual threat in the ED. First, of course, is the potential loss of revenue. Breshears points out that in non-profit hospitals, the facility in most cases would care for these patients anyway, even if they had given their true identifies. Therefore, she says, it doesn't alter the financial result to a significant degree.

The more serious concern involves the actual care of the patient, Archer says. "Think about someone who checks in with another ID and who has a long history of health problems," he says. "We'll do our tests under that name and the records of that other person, and we could potentially kill someone if we give them a drug they're allergic to or if we perform the wrong type and cross of blood." Another situation is the

EXECUTIVE SUMMARY

Identity theft is more than just a legal issue. Patients with improper identification are at risk for receiving potentially harmful treatment.
- Have registration department require photo identification from all patients.
- Ask additional questions, such as the patient's date of birth.
- Ask staff members to be the "eyes and ears" of registration and security, and ask them to report anything suspicious.

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inability to reach the patient with a follow-up call to inform them of a negative test result, he says.

Beyond these issues is the added pressure of the "Red Flags Rule," a Federal Trade Commission (FTC) policy that many businesses and organizations, must implement a written identity theft prevention program designed to detect the warning signs, or "red flags," of identity theft in their day-to-day operations. Fortunately for ED managers and other health care leaders, the FTC has delayed its compliance deadline until Dec. 31, 2010, to consider complaints that physicians should not be held to the same standards as other creditors in guarding against identify theft.

The physician complaints are well-founded, says **Darria Long Gillespie**, MD, MBA, a resident in the Department of Emergency Medicine at Yale University in New Haven, CT. Such a program will be extremely complicated in the ED, "as patients purposefully give us incorrect information frequently for many reasons aside from identity theft, so it would be even more difficult to differentiate one from the other," Long Gillespie says.

One common reason for giving invalid information is that they are not legal citizens and don't want the ED to be able to track them, she says. "Another very common reason is that patients don't want to pay the bill and don't want to be tracked down for the bill of the ED, so they purposefully give incorrect phone numbers, addresses, and so on," Long Gillespie says.

Given these factors, "we're totally accustomed to patients lying about their demographic information," she says.

Proceeding with plans

Notwithstanding these challenges and the delay of Red Flag Rule implementation, several EDs are proceeding quickly with their own plans to combat identity theft.

At Cox South, "a photo ID is now required by the registration folks to confirm their identification," says Archer. "If they can't provide it — although it will not delay or effect treatment — they will be flagged as such and will need to confirm their identity at a later time." After the patients show their IDs, they also are asked to confirm they have some knowledge about things such as their date of birth or the last four digits of their social security number, he says. *(Archer played a key role in the development of the ED policy. See the story on p. 87.)*

The ED at St. Joseph Hospital in Bangor, ME, just recently started to ask for positive ID, adds **Charles F. Pattavina**, MD, chief of emergency medicine and a member of the public relations committee of the American College of Emergency Physicians. "For a long time there was a general feeling that, especially at a patient's time of need, we did not want to press too hard for things like a driver's license or ID or give them the impression

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other things are as important as their care," he says, "But now it's become apparent that people are trying to use other individuals' health care benefits."

At Cox South, there are discussions under way about adding a new policy that would involve taking a photograph of every patient who registers in the ED for the first time, Archer says. "Some EDs in larger cities have gone to that level, and I see it happening in the next two or three years here or even sooner," he says. The process is not complicated, Archer says. "The registrar would take the picture, not unlike the process you go through when you open a new bank account. They hold up the camera next to the computer and snap," he explains.

That idea is probably a good one, says Pattavina, "especially if you explain to the patient that you're trying to prevent somebody coming in and claiming to be them." ■

Manager, registrar develop policy

Fitting best practices into the system

The new identity theft program for the ED at Cox South Hospital in Springfield, MO, was a team effort between the ED manager and the registrar, says **John Archer,** RN, director of the ED.

"We worked on the changes collaboratively," Archer says. "As best practices come up, we sat down and talked about how to fit them into our system and operational flow."

The clinical staff is involved in the new process, which includes requesting a photo identification of all patients, only when patients arrive by ambulance, he says, so the new policy did not involve a significant amount of training. "However, they are our eyes and ears," Archer says. "If they see or hear something that just doesn't fit, they bring it to the attention of the registration staff or security — as they have already had to do several times."

What are some of those things that "just don't look right?" **Beth Keith** is manager, health care provider consulting, at Affiliated Computer Services in Dearborn, MI, a company that performs Red Flags Rule assessments and will help health care organizations put policies and procedures in place to deal with the issue. "The cases I have been involved with have mostly had to do with a birth date being off," Keith says. Other common tip-offs include non-existent social security numbers or addresses, photo IDs that have been altered or don't match up with the person, or cases in which patients say they have left their photo IDs at home. *(For information on how to detect non-existent Social Security numbers, see the resource box, below.)*

Whatever policy you develop to detect possible identity theft, it's imperative that the ED manager be heavily involved, Archer says. "All things that happen in the ED — no matter who is involved — ultimately come back to me," he explains, "so while it may not be my number one focus, I have to make sure people do the right things to protect our patients." ■

SOURCE/RESOURCE

For more information on protecting your ED against identity theft, contact:

- **Beth Keith**, Manager, Healthcare Provider Consulting, Affiliated Computer Systems, Dearborn, MI. E-mail: beth.keith@acs-inc.com.

- Information about invalid Social Security numbers and the structure used for assigning numbers is available at www.usrecordsearch.com/ssn.htm.

Pharmacists in ED benefit clinical care

[Editor's note: This is the second in a two-part series on placing pharmacists in the ED. In our last installation, we examined the performance improvements that the University of Rochester (NY) Medical Center achieved as the result of placing a pharmacist inside the ED. In addition, we discuss how a pharmacist's recommendations to dispense a medication orally instead of using an IV enabled the ED to save a considerable amount of money while at the same time improving patient safety. In this issue, we look at additional benefits these pharmacists offer, from the perspective of ED nurses and physicians.]

Having a pharmacist in the ED offers many benefits, especially for the most seriously ill and injured patients, notes **Rollin J. (Terry) Fairbanks**, MD, MS, FACEP, assistant professor of emergency medicine and of community and preventive medicine at the University of Rochester (NY) School of Medicine and an ED physician at the University of Rochester Medical Center. For that reason, the pharmacist's office at University of Rochester Medical Center is located in the critical care/resuscitation area of the ED.

"It's where we feel their help is most useful. It's where we give the most dangerous meds with the most potential to hurt people if they are given the wrong dose or meds that can have harmful side effects," says Fairbanks, who works closely with the ED pharmacist. "The other reason is that it's where we need to give the timeliest meds, where there's a need for urgency. We find pharmacists are crucial in those situations."

Nicole M. Acquisto, Pharm D, BCPS, the emergency medicine clinical pharmacy specialist, says, "It's faster because with a multi-discipline team, you have someone focused just on meds, safety, and expediting administration. You have an extra person just focused on meds while the nurse is packaging the patient up and the doctor is reviewing the therapy."

Nurses and physicians voice different, but equally important, reasons to appreciate the pharmacist, says Fairbanks. "Physicians have lot of expertise and they prescribe many drugs, but this is all the pharmacists do, and they are truly the experts," he says. "When there's a trauma alert, for example, and we're taking care of patients and worried about getting them blood, often the pharmacist may suggest a pain medication we perhaps did not think about."

Fairbanks considers the ED pharmacist a clinical consultant and advisor. "They're much more than a dispenser of meds," he says.

As for nurses, they love the notion that the pharmacists can anticipate the needs of the team and have everything ready when needed, Fairbanks says. He was particularly struck by the quote of one nurse who commented for a staff survey he was conducting. "She was overwhelmed one time when she was the only nurse in the CT scan area and had a critical trauma peds patient," he says. The doctor had written orders for multiple drips of three medications, Fairbanks says.

"She was trying to process the order and figure out how she could possibly get it all together, when the pharmacist walked in with an IV pump and all three orders filled," he says. "All she had to do was press start." ■

SOURCES

For more information on pharmacists in the ED, contact:

• **Nicole M. Acquisto**, Pharm D, BCPS, Emergency Medicine Clinical Pharmacy Specialist, University of Rochester (NY) Medical Center. Phone: (716) 310-0504.
• **Rollin J. (Terry) Fairbanks**, MD, MS, FACEP, Assistant Professor of Emergency Medicine, University of Rochester School of Medicine. Phone: (585) 463-2920. E-mail: Terry.fairbanks@rochester.edu.

15-minute policy results in few refunds

Payouts are for waits of 20 minutes or so

Representatives at Emerus Emergency Hospitals, a licensed emergency specialty hospital company based in The Woodlands, TX, have been telling patients at several of its "24-hour EDs" for months now that if they are not seen by a physician within 15 minutes, the hospital will pay for their $1,000 visit. So far, the new policy is working quite well, say Emerus representatives.

"In the first six weeks at two facilities we saw 1,500 patients, and only four left without a bill," says **Randy Park**, MD, director of the facility in Aubrey, TX. "All

EXECUTIVE SUMMARY

Emerus Emergency Hospitals, a licensed emergency specialty hospital company in Texas, has taken the bold step of guaranteeing patients they will be seen by a physician within 15 minutes or their visit is free. In the first six weeks of the policy, the deadline was missed only four times.

- Patients in distress are sent right back to a nurse. Complete registration takes only a few minutes.
- Nurses are cross-trained so that they often do not have to wait for others to complete labs or other tests.
- The radiology technician is in the ED and accountable to ED leadership.

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of those patients were seen in less than 20 minutes, but it was still more than 15 minutes."

If anything, such "failures" serve to strengthen patient satisfaction, says **Hemant Vankawala**, MD, FACEP, who is a partner and medical director of the Emerus facility in McKinney, TX. "If you wait only 17 minutes and the visit is free not only are you not upset, but you're impressed that we did what we said we would do," Vankawala says.

Park says, "We were looking for ways to let the public know about the changes we have made in our practice of emergency medicine and how it might benefit them. In looking at our performance, it appeared we could make this claim with minimal risk to ourselves because we were already meeting it."

When a patient comes into the ED, front office staff registers them. "If they look like they're in distress, they will page back to the nurse, and they will immediately go to the back," Park says. "If they're relatively stable, they will formally register in the waiting room and wait to be called to the back, but even a complete registration process is only a few minutes."

The offer is made to all patients, regardless of insurance status. When the registration process is complete, the patient is given a stopwatch to time how long it takes to see a physician, he says.

There are several aspects of the Emerus approach that make it easier to deliver on the 15-minute promise. For example, Park notes, Emerus employs a significant amount cross-training. "Our work environment is good, and people will do other chores, which eliminate a lot of time losers," he says.

In a traditional ED, the doctor sees a patient, orders labs and EKGs, and a different person performs each of those tasks, Park points out. As a result, you have to wait for one person to finish a test before the next one can be conducted. "We cross-trained our nurses so that one nurse does all those things, and there's no waiting between the order and the steps," he says. "Those handoffs and waiting for ancillary persons to arrive are critical in a lot of EDs."

In a large traditional hospital, each department such as the lab is separate from the ED, notes Vankawala. The focus of those departments is to run inpatient services, he says. The radiology tech is accountable to the department of radiology, and the nurse is accountable to the nursing department, he says.

"In our facilities everyone is immediately accountable to the corporate vision, which is to provide high-quality ED care," Vankawala says. "Everyone reports up through the ED."

Park adds, "Our radiology tech is right in the department with us." Park and Vankawala are experienced, board-certified ED physicians who have worked in a variety of clinical settings, from busy trauma centers to tents in New Orleans for Hurricane Katrina.

From a practice standpoint, says Vankawala, he actually had to re-set his "internal clock" in the new environment. "In a traditional setting, if you saw someone in abdominal pain, you'd order labs and CAT scans, and that would take four to six hours," he notes. In that time, most patients would get better or stay worse and be admitted, Vankawala says. "In our ED, I get them back every 45 minutes," he says. "That's a good problem to have."

Because of that system, "the average dwelling time in our department is less than 50 minutes," Park says. In addition, he acknowledges, the Emerus facilities do not have to cope with poor bed availability on the inpatient side. (*The compensation program for physicians allows for a lighter patient load, notes Park. See the story below.)* ■

Charging holds is key to staffing

The reimbursement policy used by Emerus Emergency Hospitals, a licensed emergency specialty hospital company in Texas, impacts its staffing policy and is one reason it's able to guarantee patients will be seen by a physician within 15 minutes, says **Randy Park**, MD, director of the facility in Aubrey, TX.

"In most hospital-based EDs, the charging is done in two areas: the facility side charge and the physician charge," Park says. "The hospital bills for the facility side charges include ancillary services, while the doctor only bills for what he does."

Such a policy means that out of the $1,000 the average patient pays for a visit, the physician

SOURCES

For more information on seeing ED patients quickly, contact:

- **Randy Park**, MD, Director, Emerus 24-Hour ED, Aubrey, TX. Phone: (972) 347-2525.
- **Hemant Vankawala**, MD, FACEP, Partner and Medical Director, Emerus 24-Hour ED, McKinney, TX. Phone: (972) 908-2383.

receives less than $200, he says. This system, in turn, puts pressure on the doctors to see about four patients per hour to achieve the compensation they require. "If you imagine I am able take care of four patients per hour, when 12 patients come in, the other eight have to wait," says Park, pointing to that issue as one of the causes of ED crowding.

By involving physicians in the ownership of the EDs, "we've been able redistribute those funds," he says. "We recognize the traditional approach as a misuse of funds, and we want to give those funds to the people who actually do the work."

Accordingly, he adds, "we do not staff down to keep doctors busy all the time." Thus, when an abnormal number of patients present, the ED has enough reserve capacity to see them.

Hemant Vankawala, MD, FACEP, who is at the facility in McKinney, TX, says, "We actually operate under our capacity most of the time. In most traditional hospitals, they operate at or near their capacity continually, so when they do get a surge they are overrun. When we get a surge, it is well within our reach."

In most EDs, they aim for 10 acute care beds or so, Park says. "In ours, the most beds we have in one facility is eight, and we generally use four as primary and the other four are extra," he says. ■

ED Coding Update

What every ED manager needs to know about RACs

[This quarterly column on coding in the ED is written by Caral Edelberg, CPC, CCS-P, CHC, president of Edelberg Compliance Associates, Baton Rouge, LA. If there are coding issues you would like to see addressed in this column, contact Edelberg at phone: (225) 454-0154. E-fax: (225) 612-6904. E-mail: caral@cedelbergcompliance.com.]

Living with payer audits has been a reality of practicing medicine for a long time. Most of us have a plan in place to perform internal audits to identify any risk areas that might present a problem when audited by a payer. But things have been kicked into a new dimension with the implementation of federally mandated audits by Recovery Audit Contractors (RACs) that are sure to put you on the audit radar in the near future.

Simply speaking, RACs are working with Medicare to audit problems and risk areas identified through data mining or several additional initiatives designed to protect the federal government from fraud. The auditors that work for these organizations are incentivized to find problems, as they are paid based on the money they bring back to the Medicare program. To be sure you and your RAC are on the same page, you should be monitoring the web site of your regional RAC contractor, where they list the actual codes and procedures they are auditing, as well as the resources they use to make their recovery determinations. *(For information on regional RAC contractors, see resource box, p. 91.)*

The RAC is required to examine all evidence used in making individual claim determinations. A RAC's authority for determining the accuracy of your coding depends on written Medicare policy, Medicare articles, or Medicare-sanctioned coding guidelines that are to be used to determine if coding is accurate.

Examples of Medicare-sanctioned coding guidelines that are used include CPT statements, CPT Assistant statements, and *AHA Coding Clinic* statements. *(See resource box, p. 91.)* These are resources that you will need to review prior to returning your claims to the auditor to ensure that you can address your code determinations accurately.

The RAC doesn't target a claim solely because it is a high dollar claim, but it might target a claim because it is high dollar AND contains other information that leads the RAC to believe it is likely to contain an overpayment (over-utilization, un-bundling, and so forth). RACs review claims on a post-payment basis and use the same Medicare policies as carriers, fiscal intermediaries, National Coverage Determinations (NCD), Local Coverage Determination (LCD), and Centers for Medicare

and Medicaid Services (CMS) manuals. Two types of reviews are used by RACs to identify problems with your claims: automated, with no medical record needed, and complex, with a medical record required.

Timing is everything

RACs will not be able to review claims paid prior to Oct. 1, 2007, and will be able to look back three years from the date your claim was paid. To ensure there is clinical expertise used in determining whether you submitted your claim correctly, RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician medical director.

Because timing is everything in a RAC audit, you will have 30 days from the date of the demand letter to notify that you plan to appeal the RAC determination — no exceptions. You then have 120 days to file your appeal on each claim that was audited. To ensure the RAC demand letter makes it to you or the individual charged with responding, each RAC provides a contact form that allows you to designate the individual in your practice or hospital who will receive all RAC-related communication. Once notified, you must pay the amount assessed by the RAC or the amount will be RAC deducted from Explanations of Medicare Benefits (OMBs).

Of course, you need to appeal the RAC findings. Many errors can be made by RAC auditors who might not be familiar with the unique rules that apply to emergency medicine. And when you win these appeals, your money will be returned with interest accrued, so it's important to appeal all RAC findings unless you identify a clear billing error. Of those hospitals and providers that appealed, 34% of the appeals were won by Part B providers, and 33% were won by Part A providers. If you don't appeal, you lose! And the success of ED appeals might be higher, as it's more difficult for auditors to review ED claims, particularly evaluation and management (E/M) levels, due to differences rules for the ED setting. *(You can determine whether you are a prime target for an audit by collecting comparative data on your coding patterns and comparing them to the patterns for your region. See the story, below.)* ■

RESOURCES

The following are the web addresses of the region RACs:
- A, Diversified Collection Services (DCS): www.dcsrac.com.
- B, CGI Federal: racb.cgi.com.
- C, Connolly Healthcare: www.connollyhealthcare.com/RAC.
- D, HealthDataInsights: racinfo.healthdatainsights.com.

For more information on CPT statements and CPT Assistant statements, go to www.ama-assn.org. Select "bookstore."

AHA Coding Clinic is available at www.hospitalconnect.com. Click on "HospitalConnectSearch Online Store."

Medicare Learning Network (MLN) articles at www.cms.gov/MedlearnMattersArticles often refer to these articles as they relate to Medicare policy.

Check patterns of RAC audits

By **Caral Edelberg**, CPC, CCS-P, CHC
President
Edelberg Compliance Associates
Baton Rouge, LA

All audits aren't created equal, but many are the result of "data mining," or comparing your coding patterns to those of your regional peer group.

You can determine whether you are a prime target for audit by collecting comparative data on your coding patterns and comparing them to the patterns for your region. Data on your evaluation and management (E/M) level distribution, codes 99281-99285, and critical care 99291, should be monitored for your facility and professional coding patterns.

If you have payers that represent more than 10% of your revenue, ask for their "coding/audit tool" and request written clarification on how it's used. Many post a general statement about coding guidelines on their web site, but this doesn't guarantee how they are used. NEVER sign a provider contract with a payer that doesn't address these important factors. Payers who audit you with their own special criteria can easily find you lacking in the coding and documentation required to support their audit findings. When this occurs, you are open to significant recoveries, fines, and penalties, so be proactive.

To stay on track with Recovery Audit Contractor (RAC) program hotspots, know where previous improper payments have been found. Look to see what improper payments were found by the RACs by starting with the demonstration findings at www.cms.hhs.gov/rac. Permanent RAC findings will be listed on the individual RACs' web sites. You may also look to see what improper payments have been found in Office of Inspector General (OIG) reports at www.oig.hhs.gov/reports.html and Comprehensive Error Rate Testing (CERT) reports at www.cms.hhs.gov/cert. Currently RACs are not looking at E/M services; however, they soon will. Hospitals are being audited on several procedures including infusions, a common service in the ED.

Take steps to prepare your ED

There are some steps you can take NOW to better prepare. Bring the expertise and strengths of your ED and emergency practice together on a routine basis to discuss differences and commonalities. Be sure you are looking at your ED and practice E/M utilization and ensuring accurate coding of all E/M levels. Keep an eye on nursing and physician documentation to be sure it supports medical necessity thorough entries made by clinical staff documenting the chief complaint, ED course, interventions, differential diagnoses, and disposition. Look closely at how timed procedures and services are billed, as well as those services that are age-related. These services includes critical care, observation, and conscious sedation.

If you haven't done so already, implement an audit program that is supported by written policies and procedures. If you look at only 50 records per calendar quarter, you'll find areas that need attention. Ensure that you have a corrective action plan in place to address any problems or billing errors that are identified.

As with all programs that measure or evaluate clinical or financial performance, ensure that your ED providers participate by including them in discussions and reviews of audit findings and coding or billing performance. Most physicians and ED nurses are well-versed in the responsibilities of coding and billing as they relate to documentation and medical necessity and can help keep documentation of each of these critical audit areas on track. By tracking and documenting improvements, you succeed in minimizing problems and ensure that you are prepared for the audit that is coming your way. ■

Is 'boarded' care viewed as substandard?

Your ED patient's bad outcome might have nothing to do with the fact that he or she was held in the hallway while awaiting an inpatient bed. However, it could impact the outcome of subsequent litigation against the ED.

"I know that patients and families think that 'boarded' care is substandard to inpatient care. I would think the jury may think the same," says **Matthew Rice**, MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

Sandra Schneider, MD, professor of emergency medicine at University of Rochester (NY) Medical Center, says that the best way to reduce liability is to "get the admissions out of the ED as soon as possible. We know that boarding is the number one patient safety concern of emergency physicians." She believes risk increases with very prolonged boarding times as the patient is handed off to subsequent providers who often are not aware of the details of the patient's case.

According to the Centers from Disease Control and Prevention report "Estimates of Emergency Department Capacity: United States, 2007," there are 500,000 ambulance diversions annually in the United States, and 62.5% of EDs board admitted patients for more than two hours. **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County (OH) EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH, says the report contains "few, if any, surprises to nurses and emergency physicians who regularly work in the trenches."

Stop dangerous practices

S. Allan Adelman, JD, a health law attorney with Adelman, Sheff, & Smith in Annapolis, MD, says the most dangerous practices regarding ED boarding involve "anything that makes continuous supervision and monitoring of the patients more difficult."

Adelman isn't not aware of any specific evidence, such as studies or literature, showing that holding patients increases an ED's legal risks. "But you cannot ignore the fact that being left in a hallway is not going to create an impression of well-organized health care," says Adelman. "That alone may make patients much more willing to believe

they were not properly cared for."

Adelman says that he firmly believes "that an unanticipated bad outcome coupled with dissatisfaction with some aspect of the care provided are the primary ingredients of a malpractice claim." He recommends the following:

- Be sure that sicker patients whose condition could deteriorate more rapidly are kept in locations where they can be more readily and regularly observed.
- Be clear regarding who is responsible for the boarded patient, both with regard to the nursing staff and physicians.
- Make regular contact with the patients and their families, and explain to them why the patient is being boarded.
- Make an effort to provide privacy.
- Have a good explanation of why boarding was necessary readily available. ■

GUEST COLUMN

ED handoffs to inpatient: Patient safety at stake

By **N. Beth Dorsey**, RN, Esq.,
and Timothy A. Litzenburg, Esq.,
Hancock, Daniel, Johnson & Nagle
Richmond, VA.

The practice of emergency medicine is unique in that an emergency medicine physician acts as a gatekeeper. While treatment of a patient might be brief, initial examination and assessment often will dictate the course of the patient's treatment after admission to the hospital. Thorough, efficient communication between the emergency department (ED) and the hospital floor is essential to continuity and quality of care. This article addresses handoff pitfalls, pertinent law, and ideas for improvement.

"Handoff" or "handover" refers to transition of care, when control of, or responsibility for, a patient passes from one health care professional to another. Handoff occurs at many stages in the hospitalization of a patient. In the ED setting, the main transition episodes are presentation to the ED (particularly if by emergency transport), shift changes within the ED, and admission to inpatient care. This article focuses on handoffs at the time of hospital admission.

Historically, there has been a dearth of research and literature on the subject of handoffs. In recent years, however, interest in the subject has increased significantly. In 2006, The Joint Commission named as one of its National Patient Safety Goals the following: "Implement a standardized approach to 'hand off' communications, including an opportunity to ask and respond to questions."[1]

The World Health Organization also launched its "Action on Patient Safety:

High 5s" initiative, naming "communication during patient care handovers" as one of the five pillars.[2] Indeed, patient safety is always at stake during a handoff, and it is crucial that no information be lost during the transfer. The ED-physician-to-admitting-physician handoff presents unique challenges in that, as opposed to shift or location changes, it is a cross-specialty transfer. Due to the nature of shift changes in the ED, there is more of an established procedure for handoffs to the oncoming physician. Admission handoffs represent a change in three domains: provider, department, and physical location.[3]

In general, the handoff process begins with the emergency physician's assessment of the patient's stability and acuity. Following that, the emergency physician will contact an admitting physician. At this point, it is important that a core of information passes between the physicians, whether by phone or in person. This information includes, at a minimum: chief complaint, past medical history, history and physical, reason for admission, any abnormal findings, lab and radiology results, the course of treatment in the ED, and whether the patient is stable.[4]

Handoff pitfalls

Errors in ED-to-hospital handoffs can result in dire, but preventable consequences. Failure to timely and accurately pass on important information can lead to a delay in diagnosis or treatment, or worse. There are societal dangers as well, with handoff fumbles leading to higher healthcare costs, public dissatisfaction, longer hospital stays, and a higher rate of return visits.

In one study, 29% of physicians reported that one of their patients had experienced an adverse event or a "near miss" because of inadequate communication between the ED and admitting physician.[5]

A situation that often leads to handoff problems is the practice of "boarding," or keeping a patient

physically in the ED after he has been technically admitted to the hospital as an inpatient. This scenario arises when a hospital experiences a temporary bed shortage. The emergency physician has signed out the patient, and while he still bears some responsibility for the patient, often mentally "moves on," and considers the patient's care to be the admitting physician's responsibility. Particularly in a case where an admission is done over the phone, a patient who is being "boarded" can have a significant and dangerous gap in treatment simply because each physician thinks the other one is handling patient care.

Problems in handoff communication do not always originate with the physician making the handoff. When there is imperfect communication between the patient and the initial emergency physician or between emergency physicians at a shift change, this problem communication often will carry forward past admission, contributing to errors in diagnosis, treatment, and disposition.[6]

One key area rife with problems is lab results. Often, results of lab draws taken in the ED are returned after the patient has been admitted to the floor. If the results come back to the ED instead of being sent to the floor or the admitting physician, they might not make it into the hands of the doctor who is treating the patient. If it is unclear after a transition which physician is to follow up on certain studies, there is a danger that no physician will follow up. One study found that in one of six cases of missed diagnoses, test results had failed to reach the proper clinician.[7]

As an ED becomes busier, the attentions of the health care professionals become, by definition, more divided. When the provider responsible for signing out a patient is carrying a heavy workload, this workload inevitably can lead to faulty transitions. Not surprisingly, the likelihood of omission of information is higher when the handoff is rushed.

Likewise, an ED physician caring for a great number of patients may be operating based on, and reporting, information that is not current at the time of handoff.[8] Another less concrete area in which handoff problems originate is physician bias. Some doctors see their specialty as superior to others, or they are dismissive of another doctor's opinions or recommendations. Bias can create holes in the handoff, as the receiving physician practices selective listening. For example, an internist might not trust the ED staff's ability or judgment.

Similarly, there can be a dogmatic divide of responsibilities. Some internists expect that emergency physicians will produce definitive diagnoses and provide complete treatment, while some emergency physicians think that their role is to stabilize and dispose of the patient.[9]

Finally, technology can complicate matters related to the handoff. Medical record format is often the partial culprit in improper information exchanges. As hospitals move toward electronic records, part of the record is often electronic and part is still paper. When a receiving physician sees only one or the other, he can make treatment decisions based on an incomplete picture. Furthermore, reliance on electronic records tends to reduce the "cognitive load" of physicians, making quick recall more difficult.[10]

Pertinent law

At first glance, the requirements of EMTALA appear to end once a patient has been admitted to the ED and stabilized.[11] If, however, the patient cannot be "stabilized" in the ED, EMTALA might require admission. In a 2009 federal decision, the Sixth Circuit Court of Appeals ruled that there is a continuing obligation for a hospital to treat a patient after admission, for however long until "no material deterioration of the condition is likely" upon the patient's release.[12] Depending on a patient's condition, EMTALA might require an ED physician to not only treat a patient, but to effect a handoff to an admitting physician. However, it is the position of the Centers for Medicare and Medicaid Studies that a "boarded" patient is outside of the scope of EMTALA.[13]

State laws require physicians to comply with the standard of care, which is generally defined as what a reasonably prudent physician would do in like or similar circumstances. Poor handoffs are specifically implicated in 24% of malpractice claims involving the ED.[14]

Communicating a clear division of responsibil-

ity, as well as other information, as part of patient handoff can prevent tragedy and costly malpractice litigation. ED physicians should communicate all vital information, but also clearly delineate responsibility and plan for information exchange after the moment of transfer. These simple steps can prevent adverse consequences and improve patient care.

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AHC Media publication wins national competition

Healthcare Risk Management, published by AHC Media, the publisher of *ED Management*, took first place honors in the best instructional reporting category of the Specialized Information Publishers Association's annual journalism awards announced recently.

Healthcare Risk Management, which focuses on ideas, strategies, and recommendations for reducing hospital risk and liability, was honored for a special report in two issues last year on the risks associated with the use of medical helicopters. The award goes to the long-time HRM editor, Greg Freeman, along with Russ Underwood, executive editor, and Karen Young, managing editor, who worked with him on the series. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the September issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME OBJECTIVES

1. Apply new information about various approaches to ED management.
2. Discuss how developments in the regulatory arena apply to the ED setting.
3. Implement managerial procedures suggested by your peers in the publication. ■

CNE/CME QUESTIONS

25. According to John Archer, RN, ED director, CoxSouth Hospital, if presenting patients at his facility cannot provide registration with photo ID, they will:
    A. Be asked to immediately provide alternative pieces of identification.
    B. Be denied treatment until a friend or relative can come to the ED with identification.
    C. Be revisited by registration personnel following treatment.
    D. Be asked to give their date of birth instead.

26. According to Rollin J. (Terry) Fairbanks, MD, MS, FACEP, assistant professor of emergency medicine and of community and preventive medicine at the University of Rochester School of Medicine, the benefits of having a pharmacist in the ED include:
    A. Having an expert oversee proper dosage of potentially dangerous medications.
    B. Fulfill the ED's need for urgency and timely administration of medications.
    C. Suggesting medications the physician might not have considered.
    D. All of the above.

27. According to Hemant Vankawala, MD, FACEP, of Emerus, having a radiologist in the ED enables him to receive results of scans within:
    A. 45 minutes

B. 60 minutes
C. 70 minutes
D. 90 minutes

28. According to Caral Edelberg, CPC, CCS-P, CHC, president of Edelberg Compliance Associates, how long does an ED manager have from the date of a demand letter to notify that they plan to appeal the Recovery Audit Contractor (RAC) determination?
A. 15 days
B. 30 days
C. 60 days
D. 90 days

29. Bonnie Coalt, RN, the nursing director of the ED at Miami Valley Hospital, says an interdisciplinary team recommended about 20 changes in violence prevention practices when it was determined the policy need to be revamped were significantly revamped. The changes include:
A. Reducing the number of entrances to the ED.
B. Placing a greeter and campus policeman just inside the ED entrance.
C. "Wanding" patients who come by ambulance.
D. All of the above.

30. According to The Joint Commission's new policy on response to a sentinel event, it will consider the organization's efforts before changing its accreditation status if the organization has:
A. Begun a root cause analysis.
B. Made "measurable and observable" efforts to improve and mitigate a risk of recurrence.
C. Informed The Joint Commission of the event.
D. Dismissed the responsible party(ies).

CNE/CME ANSWERS

25. C; 26. D; 27. A; 28. B; 29. D; 30. B.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

Sentinel Event Alert says access control holds the key to reducing ED violence

Manager must interact with internal and external security personnel

[Editor's note: This is the third in a three-part series on reducing violence in the ED. In the first article, our experts discussed the importance of a "zero tolerance" policy. In last month's article, we outlined key steps recommended by government agencies for reducing violence and discussed the importance of having clear procedures when it comes to dealing with patients and their families. This month we examine the Sentinel Event Alert *recently published by The Joint Commission, which discusses why the ED is particularly susceptible to episodes of violence, outlines leading causal factors, and provides additional guidance for violence prevention.]*

"Once considered safe havens, health care institutions today are confronting steadily increasing rates of crime, including violent crimes such as assault, rape and homicide," asserts The Joint Commission in *Sentinel Event Alert* 45, "Preventing violence in the health care setting," issued June 2, 2010.

"As criminal activity spills over from the streets onto the campuses and through the doors, providing for the safety and security of all patients, visitors and staff within the walls of a health care institution, as well as on the grounds, requires increasing vigilant attention and action by safety and security personnel as well as all health care staff and providers."

The ED, says The Joint Commission, "is typically the hardest area to secure." How can that challenge be overcome? "A key to providing protection to patients is controlling access," said **Russell L. Colling**, MS, CHPA, a health care security consultant based in Salida, CO, and the founding president of the International Association for Healthcare Security and Safety, Glendale Heights, IL, in the *Alert*.

Detective **William M. Rogers**, MD, FACEP, pharmaceutical diversion group supervisor/investigator for the Drug Abuse Reduction Task Force (DART) and a practicing ED physician in Cincinnati, OH, says, "Teleologically that stands to reason, in that the ED is the gateway to the hospital. It is typically responsible for a third of the admissions, and you are going to have a mix of families and patients from diverse backgrounds with diverse expectations and all coupled under high stress."

When it comes to improving access control, says Rogers, the first thing that needs to be done is a threat assessment. This assessment involves steps such as a look at the population served and the most prevalent crimes. Rogers same these are some of the questions that must be asked: Do you see a lot of domestic assaults or gang violence? What caliber

Executive Summary

A new Joint Commission Sentinel Event Alert notes that EDs are the most vulnerable area of the hospital when it comes to violence and that access control is a key to preventing that violence. * Perform a risk assessment, so you know where your greatest threats lie.
• Examine physical control barriers, and consider access control products such as keypads.
• Position security personnel in the greeting area of the ED.

Financial Disclosure:
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weapons are used on the street? Is there a history of violence spilling in to the ED? The threat assessment should be conducted by ED managers and security staff, and it requires buy-in from the administration, he says. "If they don't buy into the validity of the assessment, they will not fund what needs to happen," Rogers explains.

Physical control barriers also must be examined, he says. "In addition, you can control access with keypads at the EMS entrance, the walk-in entrance, and from other parts of the hospital, so if someone gets in from another part of the hospital, they still can't get into the ED," Rogers says.

There are also basic skills that can be taught to your staff, he says. "They can be as simple as staff learning how to walk through a doorway, learning angles and geometry so when they walk into a room they can see it, rather than looking down at the chart," he explains. "Some very simple prevention does not cost money, just training time."

Key role for manager

Once a threat assessment is completed, says Rogers, "it falls under the ED manager to be the driving force" behind implementation of the access control strategy, in cooperation with appropriate security personnel.

"You may find out that your hospital security staff is underfunded and understaffed, and may not be able to handle a crisis," he says. "In that case you need to partner early with law enforcement." Rogers adds that "after the assessment, the ED manager needs to be part of the all-hazards response plan."

In concert with security, plans to meet threats should be divided into immediate actions, intermediate (6-18 months) strategic needs, and long- range plans that require capital budgeting and must be brought to administration, he says.

ED managers should be aware of all the resources available in the community, Rogers says. "For example," he says, "law enforcement may be able to direct the officers that patrol the area to not be in uniform." If there is drug activity in the area, for example, Rogers says these officers would be better able to observe activity. If an event occurs, he adds, "you can more readily send someone in for observation."

If for some reason law enforcement does not respond enthusiastically, "you can go to the chief prosecutor's office about strategies," Rogers suggests. "They would be only too happy to be proactive. They don't want another case file, and it would be a political feather in their cap if they are able to put out a 'stop the violence' program."

The ED manager also should establish relationships with key people in the community, he says. "It's always good to know the key players before something happens," Rogers says.

ED, community group join forces

One example of just such cooperation with the community occurred at Loyola University Medical Center in Maywood, IL, where "street justice" was prevented following a gang-related incident. The ED collaborated with Maywood CeaseFire, a violence-prevention group that uses street-savvy people to mediate disputes and quell conflicts between high-risk youths and their families and friends.

The collaboration between Loyola and CeaseFire began in May 2009. Interventions now begin soon after victims of violence arrive at the hospital for treatment, explained the Loyola system in a news release.[1]

Victims and their families are screened by Loyola trauma staff, chaplains, and social workers for possible referral to the CeaseFire Hospital Response team, who are specially trained to effectively intervene when emotions are running at their highest. The team is comprised solely of CeaseFire volunteers. Some are chaplains, while others are just concerned members of the community.

Thomas Esposito, MD, chief of the division of trauma, surgical critical care, and burns in the Department of Surgery at Loyola Stritch School of Medicine, says, "The solution to street violence needs to be multi-faceted, multidisciplinary, and community-based." *(ED managers must collaborate with security to develop a good violence prevention plan. See the story below)*

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ED and security team up, create plan

Several years ago the security plans for the ED at Miami Valley Hospital in Dayton, OH, were significantly revamped. The process required strong teamwork between ED leadership and hospital security.

"Several years ago we gathered together in response to staff concerns about the continuing amount of disruption in the ED," recalls **Bonnie Coalt**, RN, the nursing director of the ED. A team of about 20 people was put together, including mental health assessment, registration, campus police, nurses, and physicians, Coalt says.

"We held brainstorming sessions to identify what people thought were good ideas, and came up with almost 40," she says. "We probably implemented 20 in one shape or another."

All the recommendations were put in one document and then priced out, says Coalt. "The team picked the top 10 we wanted to take forward with immediately: triage area improvements, lockdown process, metal detectors, the ability to 'wand' patients who come by ambulance, panic buttons, and incident debriefing," she says.

Perhaps the most important change involved a revamping of the triage area, Coalt says. "We developed a construction plan and redid the area," she says. "We created four private triage rooms, each with an exit door so the triage nurse has a way to escape, and each room has a panic button," she says. Now there are only a limited number of "in" and "out" ED doors, Coalt says, because "we had way too many ways to get into the ED."

Processes also were changed. Now, presenting patients see a greeter and a campus policeman before they even reach a nurse.

Lt. **LaMark Davis**, operations manager security officer, says that in addition to having a steady dialogue with the ED on the new plan, "we communicate on an as-need basis. And whenever an incident occurs in the ED, we get together and debrief on how things could have been handled differently. We communicate well together."

Communication is enhanced by the placement of security personnel, adds Barbara Johnson, vice president of operations. "The campus police command center is located in the heart of the ED, which we think is very important," Johnson says. "And, on the recommendation of our security consultants — who provide a new assessment yearly — we set up a second one because we were missing redundancy." In other words, if there was an event and there was only one command center and it was disabled in some way, the facility would lose command over the situation. That second center is in a building right across from the main facility, she says.

There are now formalized internal safety and external safety committees, she adds. "We interface not only with campus police, but with town police officers," Johnson says. "We've partnered with the local police department to help with perimeter security, and they sit in on meetings with us." ■

Joint Commission suspends 'auto' adverse decision

The Joint Commission has suspended its policy that triggers an "automatic" adverse decision if an organization fails to complete an acceptable root cause analysis in response to a sentinel event or its related measure of success within a specified time frame. The change is retroactively effective as of Jan. 1, 2010.

Under the new policy, if an organization makes "measurable and observable" efforts to improve and mitigate a risk of recurrence, The Joint Commission will consider the organization's efforts before changing its accreditation status.

"It is no longer automatic that an organization will be placed into provisional status, which puts them on the path to other actions — up to and including an adverse accreditation decision — based on some part of the process on which they did not completely hit the mark," explains **Anita Giuntoli**, BSN, RN, MJ, associate director of the Office of Quality Monitoring at The Joint Commission. "So, for example, if they have done a really good root cause analysis, but when they implemented and measured their new processes it did not hit the thresholds that were set, we will work with them on what the obstacles are and what steps will make this process more effective for them."

In the case of an ED, for instance, the remedy might have been education of the ED staff. "That's something you can measure, like the percentage of

Executive Summary

The Joint Commission's revision of its policy on root cause analysis puts greater attention of something that, quite frankly, some ED managers might not have been aware of. The ED manager plays an important role when events occur in the department, such as:

* knowing who the main Joint Commission contact is in the hospital, and making them aware of a potential adverse or sentinel event that has occurred;
* participating in the root cause analysis to identify what ED processes might need improvement;
* making sure the remedial activities recommended can be measured, so The Joint Commission can see an active attempt is being made to improve.

nurses for whom education had to take place within three months," Giuntoli says. In that example, perhaps the ED had set a target of 95% of the nurses being educated within three months but they had only reached 85% because the educators had not yet educated the night shift, she says.

"We'll ask what they're going to do now to tweak their plan, and we look to them to be responsive," says Giuntoli. "Perhaps they'll decide to assign two more nurses to cover the night shift or have a 'learn at breakfast' session."

If the changes seem to give them a reasonable chance of meeting expectations, The Joint Commission might suggest they touch base again in a few weeks or a couple of months "to see if things are moving along a constructive path." If, on the other hand, there had been no substantive effort toward implementing the plan and measuring what occurred — i.e., 'we scheduled a lunch and learn but nobody showed up' — "then we would say that might trigger a cascade of more serious discussions," Giuntoli adds.

Who does the reporting?

The direct reporting of an adverse or sentinel event to The Joint Commission is not handled by the ED manager, even if the event occurred in the ED, notes **Mary Anne Morris**, MS, RN, senior director of accreditation services for Cincinnati Children's Hospital Medical Center.

"That responsibility resides in a position like mine, or it may be done through the legal department," Morris says. "You're required to report an event if it becomes public knowledge, for example, if something appears in the paper."

She adds that because The Joint Commission uses a service that saves news reports, the agency certainly will know about it. In that case, even if the event occurred in the ED, someone in her position would make the report directly. However, if an ED patient is given the wrong dosage of a medicine and there is an adverse outcome, it might not be immediately apparent to people outside the ED, Morris says. Then, she says, it is the ED manager's responsibility to "notify the internal stakeholders" as to what occurred. "There should be an internal incident reporting policy, and you would probably want to escalate the knowledge you have and participate in a root cause analysis," Morris suggests.

Giuntoli says, "If the event happened in the ED, what we've seen is the root cause analysis process involves the individual at the bedside and also the people who oversee that area." However, there is a point person in the organization who is the identified "owner" of how the facility does root cause analyses, she says. *(The Joint Commission hopes this new policy will encourage reporting. See the story below.)* ■

TJC hopes change aids transparency

The Joint Commission is hoping that its suspension of a policy that triggers an "automatic" adverse decision if an organization fails to complete an acceptable root cause analysis in response to a sentinel event or its related measure of success within a specified time frame will encourage more self-reporting and advance root cause analysis activities.

"Certainly when an organization has an event, it's devastating for the clinicians and the organization," notes **Anita Giuntoli**, BSN, RN, MJ, associate director of the Office of Quality Monitoring at The Joint Commission. "We respect the journey they're on to sort out where they go from here, and in looking at their processes for improving patient safety, we feel if we dialogue about the issue and if we collaborate, we will continue to improve together."

Giuntoli says she hopes this change will cause providers to be more alert in the future to incidents that might lend themselves to a sentinel event alert or a national patient safety goal. "We know there are issues of liability and that organizations do have to think carefully when choosing to self-report," she says. "They need to know that all the information we have is extremely confidential. We feel that concern can be taken away."

In addition, there have been concerns that the organization's accreditation status might be impacted by the sharing of the event, Giuntoli says. "Now, we feel we may have taken away one of the barriers. We will not do that in an arbitrary, automatic way, but actively look to earnestly engage in patient safety with them," she says.

However, **Mary Anne Morris**, MS, RN, senior director of accreditation services for Cincinnati Children's Hospital Medical Center, is not so sure that by publicizing the policy change, the Joint Commission won't achieve the opposite effect. "In the past, people may have reported events without knowing it could affect their accreditation status," she says. "More people may now be aware of the potential cost." ■