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Best Practices – Patient Flow – Federal Regulations – Accreditation

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ED quality performance moves into the public reporting arena

'Top performers' are named — What does that really mean?

HealthGrades, a Golden, CO-based health care ratings organization that provides the public with ratings on more than 750,000 physicians and 5,000 hospitals, has just released a study it claims "evaluates hospital emergency medicine for the first time."

The report, which HealthGrades says is the first annual "HealthGrades Emergency Medicine in American Hospitals" study, examined more than 5 million Medicare records of patients admitted through the ED at 4,907 hospitals from 2006 to 2008. It identified hospitals that performed in the top 5% in the nation in emergency medicine.

HealthGrades then compared those top performers with the other facilities and found a 39% lower risk-adjusted mortality rate and a faster rate of quality improvement. HealthGrades postulated that if all hospitals performed at that higher level, 118,014 more patients potentially could have survived their emergency hospitalization.

The study examined these 11 conditions:

- bowel obstruction;
- chronic obstructive pulmonary disease;
- diabetic acidosis and coma;
- gastrointestinal bleed;
- heart attack;

EDM special focus: Health care reform

Our October issue of *ED Management* will focus on how ED managers are preparing for the anticipated onslaught of patients under health care reform. It will include reports from the recently held meeting of the American College of Emergency Physicians and comments from experts on both sides of this all-important issue. Don't miss this special issue of *ED Management*!

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- pancreatitis;
- pneumonia;
- pulmonary embolism;
- respiratory failure;
- sepsis;
- stroke.

HealthGrades also ranked the states according to overall performance. Ohio, Arizona, and Michigan had the best rankings, while Mississippi, Alabama, and Hawaii ranked lowest. (*For information on how to obtain a copy of the study, see the Resource Box on p. 99.*)

What does it mean?

Emergency medicine proponents, even some whose facilities received high rankings, were critical of HealthGrades' methodology.

"HealthGrades basically looked at mortality on the inpatient side," says **Rick Bukata**, MD, clinical professor of emergency medicine at the Los Angeles County University of Southern California Medical Center. Bukata recently retired after serving as ED director at San Gabriel (CA) Medical Center for 25 years.

Although he says his facility ranked among the top 10% in the country, Bukata he notes that "any ED doc who's honest with themselves knows that if we had a patient for two hours before admitting them, in most cases nothing could have been done to change the ultimate outcome." To take credit or blame for whether an admitted patient lives or dies after a six-day hospital stay "is absolutely nutty," he says.

Jon Mark Hirshon, MD, MPH, associate professor in the Department of Emergency Medicine, Department of Epidemiology and Preventive Medicine, the National Study Center for Trauma and EMS, Baltimore, MD, agrees. "They call this an 'emergency medicine excellence award,' but it's not necessarily related to emergency medicine," Hirshon says. "The issue I have is the fact that they looked at in-hospital mortality and said that was a marker for how good an ED is."

The fact remains, however, that this study is just the latest in a growing number of public reports that include a focus on the ED. For example:

- The National Quality Forum (www.quality-

EXECUTIVE SUMMARY

As an ED manager, you face the growing challenge of your performance data being shared with the public and with hospital administration.

- Be sure to share the good news with your administration, so they can use it to help market the hospital.
- When adverse rankings appear, you have two options: Seek additional resources to improve performance, or challenge the data.
- Use an automated system to access "real-time" data on your department's performance, so you will always be ready to defend your ED.

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The HealthGrades study of emergency medicine can be downloaded free of charge at www.healthgrades.com/business/img/HealthGradesEmergencyMedicineStudy2010.pdf.

forum.org) reports on quality improvement and covers care in the ED.

• Medicare's Hospital Compare service (www.healthcare.gov/compare) offers a condition-by-condition rating of how hospitals care for their patients, and it recently began adding data on ED care.

• The Physician's Quality and Reporting Initiative (PQRI, www.cms.gov/pqri) offers doctors an opportunity to earn payment incentives by reporting on and meeting specific quality measures, including some that apply to the ED.

Bukata argues that in many cases, the methodology used can be questioned, but ultimately that might not matter. Administrators are paying more and more attention to these reports, he says. "My most candid view is that the methodologies are generally poor," Bukata says, but Bukata adds that "CEOs love this stuff when your marks are good and use it to promote the hospital and give themselves 'attaboys.'"

When the numbers are bad, of course, they become concerned that the facility will be perceived by the community with less favor than they would like, he says.

Responding to the rankings

If your ED receives a poor ranking, you have two options, Bukata says.

"I would tell the administration that we need more resources to achieve higher rankings, because one of the ongoing stresses of being a medical director of an ED is the inordinate emphasis that the hospital administration puts on keeping the staffing lean in the ED," he says.

The other option, which Bukata does not favor, is to challenge the numbers. "Most people are not going to take your challenge very seriously, even if it is totally legitimate," he says. "It looks like sour grapes to criticize the methodology, even though it is absolutely legitimate in the majority of these cases."

Hirshon takes a different tack. "If someone came to me and asked why we did not get an award of excellence, I'd say this is an in-hospital metric," he says. "You may call it emergency medicine, but the bottom line is what are you doing to do to improve the metrics in your hospital?"

To support any criticism of methodology, he says, "Have an epidemiologist or statistician look at your data, or someone who understands how to do research — someone who understands the population being studied, where the data came from, how it was analyzed, and whether the results support the conclusion." (*For more on the importance of data collection, see the story below.*)

Of course, if you receive a favorable ranking, the path is much clearer. "Frankly, when I like our numbers, I think the surveys are terrific," Bukata says. "However, we should have no delusion that what is being measured really matters." If administration doesn't know about the report, he will let them know, he adds, "but they subscribe to most of them, like the patient satisfaction surveys."

Hirshon says the overall message for ED managers is this: "We need to recognize that we live in a time when a large amount of information is being disseminated, and that gives attention to real problems." While he has an issue with how HealthGrades performed its study, he says, "It's a good thing that people are paying attention to emergency medicine." ■

Managers paying attention to data

In light of the growing trend toward public reporting of performance, an increasing number of ED managers are seeking better ways to track their data, says **Mark D. Crockett**, MD, FACEP, president of the Emergency Care Division at Picis, an information solutions provider based in Wakefield, MA, and an attending ED physician at Morris (IL) Hospital.

"From my perspective, we have a large number of EDs that report anything from wait times to their latest performance," he says. "We see requests from customers to put those kinds of metrics into our software."

With the growing emphasis on reporting quality performance, "you'd better have data," Crockett says. If you don't understand the data behind your ED's processes, the time to understand them is *not* after you've been questioned by administration, he says. "You can't say 'I'll go look into that and see what is going on,'" Crockett says. "You need a ready answer."

This preparation is particularly important for "global" data such as time in the department or door-to-doc time, he says. "It also applies to PQRI [Physician's Quality and Reporting Initiative] measures like time to antibiotics," he says. "And this is tied to better outcomes. It's not just administrators being annoyed for no reason."

Having an automated system to collect such data is becoming a "must" for EDs, says **Jon Mark Hirshon**, MD, MPH, associate in the Department of Emergency Medicine, Department of Epidemiology and Preventive Medicine, the National Study Center for Trauma and EMS, Baltimore, MD. "Personally, I think you *need* some form of automated system," Hirshon says. "With government requirements for electronic health records going forward, that may allow us to have a more automated system for collecting information."

While the fact that these metrics are reported on publicly by private and government organizations frequently can put other areas of performance in the background, it's important that an ED manager maintain focus on all areas of patient care, cautions Rick Bukata, MD, clinical professor of emergency medicine at the Los Angeles County University of Southern California Medical Center, who recently retired after serving as ED director at San Gabriel (CA) Medical Center for 25 years.

SOURCE

For more information on collecting data on ED performance, contact:

• **Jon Mark Hirshon**, MD, MPH, Associate Professor, Department of Emergency Medicine, Department of Epidemiology and Preventive Medicine, the National Study Center for Trauma and EMS, Baltimore, MD. Phone: (410) 328-7474.

"The emphasis others put on specific measures does not mean we should not concentrate on those things that not measured," he says. "After all, those measures are very limited. They shouldn't distract us from other things." The real issue, from a medical point of view, is that "all we can really measure is our processes," he says. "We can't measure outcomes." ■

EDs trying not to let the bed bugs bite

Decontamination is a common procedure

The headlines of late might well have blared their own version of Paul Revere's warning: "The bed bugs are coming! The bed bugs are coming!" TV networks have run special reports on how bed bugs have been "invading" U.S. hospitals, and as the front door to these facilities, EDs have had their share of challenges.

Infestations became so widespread, in fact, that Bell Environmental Services, a pest control company based in Parsippany, NJ, has formed a Bed Bug Division that targets health care facilities, nursing homes, and animal research labs. "We've worked with many EDs," says **Jennifer Erdogan**, director of the division. "We got one call where a patient walked in with 200 bugs inside their wallet." (*Be proactive. See the story on p. 101.*)

But even a single bed bug can, and should, engender a prompt response from an ED. **Rosamond Payne**, RN, is the administrator for the ED at Kings County Hospital Center in Brooklyn, one of the busiest EDs in New York City, with more than 106,000 visits in 2009. "Recently, a patient arrived and appeared to have a bed bug on

EXECUTIVE SUMMARY

As bed bugs have emerged as a growing problem for EDs, managers have developed strategies for prevention and decontamination. Here are some of the approaches they have shared with ED Management:

- Educate your staff on what they should look for on patients and in rooms that would indicate the presence of bed bugs.
- Be proactive. Have an exterminator examine your ED on a regular basis.
- A decontamination room on the outside of the building will prevent the spread of these bugs in your ED.

them," Payne recalls. "Our triage nurse was very alert and took the precaution of placing the bug in a specimen cup for examination." The nurse then followed hospital protocol and these steps were followed:

1. The nurse contacted the environmental services staff, who called the facility's pest control company. The pest control company responded within 30 minutes.
2. As a safeguard, the affected triage area was exterminated with appropriate chemicals.
3. Newly arriving patients were seen in an uninterrupted triage area nearby.
4. Triage was never closed, and the hospital was not put on diversion.
5. As per directions of the pest control company, the affected triage area was closed for two hours and then re-opened to resume services.

Terri Martin, RN, BSN, MBA, the ED nurse director at Mercy Hospital in Anderson, OH, says, "It almost seems like we have some experience [with bed bugs] weekly. The way we started to manage it is if a patient comes in with just a bite, we do not take any special precautions, but if we see the bugs we do."

Martin notes that the bugs do not live on patients, but they can come in on belongings or clothing. "If we see bugs, we take the patient through to the 'decon' room, undress them, wash them, and keep them on the outside of the building," says Martin. The room has a separate outside entrance door. If the patient already is in an examination room when it is determined he or she is contaminated, housekeeping staff come in to clean the room after the patient leaves, using Rid 60 by Chandler, AZ-based Prochem or Misty Dualcide P3 by Amrep of Marietta, GA, she notes.

"The downside is that the room is closed off for 24 hours, so it's better if we can discover the bugs in triage and then take the patient to the decontamination room," Martin says. "In that case the nurse, perhaps with the assistance of a tech, will go out of the hospital and then back into that room from the outside."

If the bugs are discovered after the patient is in a room, in addition to cleaning the room, any staff members who have been infected have to change into hospital-provided scrubs and launder their clothes at the hospital. "If bugs are running around, we assume they are exposed," says Martin. "Everyone's pretty nervous about them and no one wants to take them to their homes."

The bottom line is that "we just try to keep the environment safe for everyone else in the department," she says. (*See protocol with the online issue of ED Management.*) ■

SOURCES

For more information, contact:

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- **Rosamond Payne**, RN, ED Administrator, Kings County Hospital Center, Brooklyn, NY. Phone: (718) 245-3131.

Be proactive about bed bugs

The best way to minimize bed bug problems in your ED is to be proactive, says **Jennifer Erdogan**, director of the Bed Bug Division at Bell Environmental Services, a pest control company based in Parsippany, NJ.

"ED managers should know what to look for," says Erdogan, whose company provides inservices for that purpose. "For example, you can do routine dog inspections with dogs trained to sniff for bed bugs and viable eggs," she says. In addition, you can look for fecal droppings, which are little black specklings, or "cast skins," which are the exoskeletons that the bugs periodically shed, Erdogan adds.

"You should also look in cracks and crevices, such as joints in the furniture," she says. "The bugs do not like to be out in the open." ■

'Triage center' takes pressure off EDs

Referral facility for behavioral health patients

The creation of a new area to quickly assess homeless and uninsured individuals, many requiring behavioral health services, has helped ease pressure on EDs in the Lee Memorial Health System in Fort Myers, FL. It has also earned the system a 2010 AHA NOVA Award for "Community-Based Alternatives to the Emergency Room."

EXECUTIVE SUMMARY

Behavioral health care is a major concern for EDs. Lee Memorial Health System helped relieve the ED burden with a shelter for homeless and uninsured individuals.

- A former director of emergency services provided ED-specific input into the planning process.
- A contracted nurse with ED experience provides the initial assessment of patients referred to the shelter.
- System EDs now have a referral option for patients with behavioral health issues and no longer have to discharge them "onto the street."

In the 18 months since the program was established, 705 duplicated (multiple visits) and 474 unduplicated individuals were referred to the Lee County Behavioral Triage Center, the formal name of the new shelter. One-third was from hospitals, and two-thirds from law enforcement. Of those patients, 30% were referred to another emergency shelter or supported housing, and more than 15% entered inpatient substance abuse treatment.

"This absolutely frees up ED beds and internal hospital beds, since you do not have someone laying on an ER stretcher for several hours," notes **Jennifer Higgins**, RN, MSN, CEN, director of emergency and transport services at Lee Memorial Hospital.

In addition, Higgins says, it has been a morale booster for the staff. "They're just really happy there's an alternative for these patients, instead of them being put back out on the street," she explains. "Sometimes in the past there was a mission to refer them to if we got lucky and then we knew they'd be safe, but otherwise when they were discharged in the past they'd either walk out or have to be jailed if they had done something in the community." Sometimes, she adds, these patients would end up being admitted "for no other reason than they had no place to go."

A community effort

The shelter got its impetus in 2007, when the Lee Memorial Health System board of directors convened 38 community leaders representing business, public education, higher education, government, non-profit organizations, clergy, and health care professionals in all sectors of the system's primary service area of Lee County. The goal was to create the Community Health Vision for 2017 by making specific recommendations to improve the health status of residents and the health care delivery system.

There were 11 partner agencies involved: the Lee County Board of County Commissioners, Lee Memorial Health System, Lee Mental Health Center, Southwest Florida Addiction Services, The Salvation Army, United Way of Lee County, National Alliance of Mental Illness of Lee County, Fort Myers Police Department, Cape Coral Police Department, Lee County Sheriff's Office, and Florida Department of Children and Families, Substance Abuse and Mental Health Program.

Chief Administrative Officer **Lisa Sgarlata**, RN, MSN, CEN, says, "Together we applied for and received a $3 million grant [from the state] for three years."

A small area of space was donated by the local Ruth Cooper Center (a part of Lee Mental Health), she says, and The Salvation Army agreed to run the shelter and provide a case manager. "We provide part of the food cost and staffing from a nursing perspective," says Sgarlata. As former director of emergency services, she was well positioned to represent the ED's interests and contribute input into the handling of the patients.

When patients are referred to the shelter, by the police or the ED, they are seen by a contracted nurse with an ED background. "We make sure they do a minimal screening, using inclusionary and exclusionary criteria," says Sgarlata, who notes these screenings are not subject to EMTALA. "If they need to be seen by an ED, we call the EMS through 911," she adds.

ED managers interested in creating a similar program in their communities should be sure to "get everyone at the table at the same time," says Sgarlata. "There needs to be a willingness for everyone in the community who touches that patient to be committed."

Higgins says, "They all have something to benefit, and they all have the patient's best interests in mind. We knew there were other alternatives, and we owed it to our community to find a better solution." ■

SOURCE

For more information on creating a facility for behavioral health care patients, contact:

• **Jennifer Higgins**, RN, MSN, CEN, Director of Emergency and Transport Services, and Lisa Sgarlata, RN, MSN, CEN, Chief Administrative Officer, Lee Memorial Hospital, Fort Myers, FL. Phone: (239) 332-1111.

Information exchange yields better decisions

Redundant tests curtailed, drug seekers ID'd

The Wisconsin Health Information Exchange (WHIE), which has enabled EDs in the Milwaukee area to electronically access patient data for about three years, has helped the participants save time and make better-informed patient care decisions, according a recent study from the Medical College of Wisconsin in Milwaukee.[1]

The study, which was based on data from 10 EDs and several outpatient facilities, found that:

- Physicians using WHIE spent 42% less time gathering data.
- Use of the WHIE resulted in changed workup or treatment of patients 42% of the time.
- WHIE helped reduce decision-making time 50% of the time.

"We decided that a collaboration of all the health systems in Milwaukee was required to come up with a solution for patients who are coming to several different hospitals," says **John Whitcomb**, MD, FACEP, an ED physician and medical director for patient access at Aurora Sinai Hospital, one of the founding participants. "That results in fragmented medical care, which is often not to the patient's advantage and is also expensive."

At the time of his interview with *ED Management*, Whitcomb was seeing one patient who had had 200 visits to 11 Milwaukee EDs in 2010. "Another has had 40 visits to five hospitals, and none of the 13 doctors in my group had ever seen this patient before," he says. "Nobody gets to the bottom of what their core problems are, and it's extraordinarily expensive to keep repeating CT scans and other costly tests because you have no way of knowing how many prior tests had been given." (*Patients with multiple ED visits might be drug seekers. See the story on p. 105.*)

When a patient enters the ED of a participating facility, registrars print a "face sheet" that provides information on previous ED visits in the area, explains **Marlene D. Melzer-Lange**, MD, medical director of emergency services at Children's Hospital of Wisconsin. "It's almost like having another abbreviated medical record," Melzer says. "You can't see the full record, but you can see when they were at other EDs and why they came." So, for example, if a child comes in with injuries that lead the physician to suspect child abuse, they can look in the electronic record to see if there had been previous injuries of concern. "Sometimes that's not such an easy decision to make — i.e., calling a social worker — so this helps by giving you more information than you would normally have had," Melzer says.

Each facility is required to have a dedicated computer and space in the ED. "Finding a place to put the computer can be complicated," Whitcomb says. "And you have to have the staff committed to training on flow."

For the system to be effective, the doctor has to have the sheet put in his or her hands, Whitcomb says. "Someone has to be trained to pull it out and put it there," he says. "It has to become part of the culture."

Melzer says, "We needed to change processes in the ED. We decided it was best to print out a list of other ED visits every time a patient came in so it became part of the standard registration process." At her facility, she says, that task is performed by the registration clerk.

WHIE has definitely led to a decrease in testing, Melzer says. "Dad or Mom may not always know all the tests their child has had," she explains.

Melzer also believes it has improved outcomes. "We need to study that in a more scientific way, but there have been a few instances where it encouraged me to report child abuse, and a few others when teenagers told me they were not sexually active but I saw that they had been to Planned Parenthood." One of the systems' reproductive health clinics is part of the system. This type of information provides more insight and enables her

EXECUTIVE SUMMARY

A new study from the Medical College of Wisconsin shows that the Wisconsin Health Information Exchange has not only saved time for the EDs participating, but has helped them make better-informed patient care decisions.

- EDs in the Milwaukee area are linked to the system with a dedicated computer housed in a separate area of the department.
- Once registration enters the patient's name into the system, basic information appears about the previous ED visits at all facilities in the city.
- ED staff can also obtain additional patient information if the need arises.

to give such a patient better care, Melzer says.

REFERENCE

1. Kolbasuk McGee M. Health information exchange enhances decision making. *Information Week June 16, 2010*. Accessed at www.informationweek.com/news/healthcare/clinical-systems/showArticle.jhtml?articleID=225700387&cid=RSSfeed_IWK_News. ■

WHIE uncovers drug seekers

One of the key benefits of the Wisconsin Health Information Exchange (WHIE), which has enabled EDs in the Milwaukee area to electronically access patient data for about three years, is that it can help ED physicians identify drug seekers, according to **John Whitcomb**, MD, FACEP, an ED physician and medical director for patient access at Aurora Sinai Hospital, one of the founding participants.

"We prescribe narcotics in good faith to take care of patients in pain," Whitcomb says. "Some patients use that mandate to put us in the position of providing the drugs."

Now, he says, when he sees someone who has been treated at five hospitals for five painful conditions, "it gives me a feeling for their character, as opposed to someone who has gone to one doctor or health system and follows a specific plan of care."

If you see a patient with ED visits for non-identifiable painful conditions three times in the last year, says Whitcomb, *please* don't give them narcotics. "Insist on their seeing someone else who can vouch for their medical care." ■

SOURCES

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• **John Whitcomb**, MD, FACEP, Medical Director for Patient Access, Aurora Sinai Hospital, Milwaukee. Phone: (414) 491-8315.

EDIS yields $1.3 million in new gross revenue

Infusion revenues increase $400,000 a month

Computer systems might be costly, but they can also save you a good deal of money in a short time. For example, the computer system installed at Beaufort (SC) Memorial Hospital and implemented in December 2009 recouped its costs of about $500,000 in just three months.

"Gross revenues went up $1.3 million, or 72%, the first month," says **ED Ricks**, MHA, the chief information officer, who adds that the ED has increased infusion revenue by $400,000 per month. What's more, he adds, "we had been spending $20,000 a month on dictation transcription. That's completely gone." Ricks estimates that the system [Emergency Department Information System (EDIS) from Addison, TX-based Medhost] will yield about $2 million in net cash received annually. (*For more information on Medhost, see the resource box, p. 105.*)

Beaufort's ED Director, **Kevin Kremer**, RN, BSN, says, "We already had a system, but it was used primarily by the nurses. The doctors still dictated and put in all orders by hand." This system was labor intensive for the ED physicians, Kremer says. "We were looking for something that would be a universal approach that could be used both for CPOE [computerized physician order entry] and physician documentation," he notes. Kremer wanted something that was easy to use, efficient, and provided guidance to ensure regulatory requirements were followed, and research found the Medhost system to be the best fit.

"I was primarily looking for improved documentation efficiency," Kremer says. "This system

EXECUTIVE SUMMARY

The ED at Beaufort (SC) Memorial Hospital saw revenues increase $1.3 million, or 72%, in the first month after installation of an information system. The hospital also is realizing $20,000 in savings each month on dictation transcription. The system has been able to pay for itself in three months.
- Prior to installation of this system, physician documentation had not been automated.
- Pop-up messages remind the user when documentation is incomplete.
- IV infusion stop time is now much easier to document and track.

was designed as a touch-screen, which made for easy, succinct documentation." It provides pop-up messages for nurses when there is incomplete documentation and a similar interface for physicians, he says. "We were able to improve charge capture through this more thorough process," Kremer says.

One of the areas where he knew his department was losing revenue was in IV infusion time. "With the old system it was very difficult to find "stop time," and you can't bill unless you have that," Kremer says.

The old system did not provide automatic reminders, so nurses had to be reminded to go back into the system if they had not recorded the stop time, he says. "You could be in the middle of something minor, and then a critical patient would come in," says Kremer. The nurse would forget to go back into the system. With Medhost, only two touches of the screen are required to record that information. "And when the nurse finishes documentation, if she did not enter stop times for *any* infusion, it reminds her she has to do it before she can close the charts," he says. ■

"The assistant director and I took every chart and graded them — much like a school teacher would grade a test, with letter grades and comments — so they could see where documenting was done properly and where it wasn't."

EDIS training has two phases

Before a new computer system could be implemented at Beaufort (SC) Memorial Hospital, two phases of training had to take place, says ED Director **Kevin Kremer**, RN, BSN.

"Four staff members — one physician's assistant, two ED nurses, and one IS clinical support person — went to Dallas for three days of training," he recalls. The system is Emergency Department Information System (EDIS) from Addison, TX-based Medhost.

There they were taught to use the manufacturer's toolkit, which enables the user to build documents and change documentation, he says. Following that training, 10 "super users" in the ED received 4.5 hours of training with the manufacturer so that they could help train the remaining staff. RNs and physicians then received 3.5 hours of training. Hospitalists received 2.5 hours, and ancillary personnel received 90 minutes.

The staff training took place in November 2009, about a month before the system went live. "We gave them time to complete 10 parallel charts — old and new — over a two-week period," Kremer says. "The assistant director and I took every chart and graded them — much like a school teacher would grade a test, with letter grades and comments — so they could see where documenting was done properly and where it wasn't." In all, he says, 700 charts were graded.

"This made 'go-live' almost seamless," he says. "It was so incredibly smooth, with no major issues." For the first three days, the manufacturer shadowed the users for 20 hours. "After 30 days we did not feel like we had ever used anything else," says Kremer. ■

SOURCES/RESOURCE

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COMING IN FUTURE MONTHS

- Hospital Compare web site adds data on ED, outpatient care
- Cardiac MRI in ED cuts costs, admissions for chest pain patients
- "Rolling forecast" approach to budgeting yields quick dividends
- Why are EDs pushing for Propofol exemption?

'No wait' policy has broad goal

Improved community care is sought

There's no doubt that when the Bon Secours system in the Hampton Roads area of Virginia launched a new "no wait" policy for its EDs, it was hoping to improve its brand and attract more patients. However, its goal was broader. After all, it already was successfully fulfilling its guarantee of seeing all patients within 30 minutes. As part of that guarantee, the ED sent any patient who did not see the provider within 30 minutes an apology letter and two movie tickets. That policy continues under 'no-wait.'

"What we really wanted do was to push the communities in which we were located in emergency care as a whole while building loyalty," says **Jeff Doucette**, RN, MS, CEN, vice president of emergency services for Bon Secours Hampton Roads. The strategy of pressuring other EDs in the area seems to have worked, he says. "In Richmond, where we have had the program in place the longest [six months], other facilities now post their wait times on the Internet," he says.

Doucette says that the new system was created in-house, with the assistance of its emergency physicians group. "We brought the plan to the table with the belief that we could provide a no-wait experience, and we certainly have done that," he says.

Basically, says Doucette, the system involves placing an RN right inside the ED entrance. "The nurse is standing up and greets the patients as they come through the door," he says. "She asks the patient their chief complaint, and the only question she has to ask herself is whether they should go to the main ED or to our Quick ER." Once that is determined, the patient is taken directly to the appropriate care area.

Prior to these changes, patients who came into the ED would be met by a greeter, says **Carl F. Wentzel**, MD, the ED medical director at Bon Secours Harborview Medical Center in Suffolk. Bon Secours has three hospital EDs and one free-standing ED. "They would write down initial complaints, take some basic information, and then if a triage room was available, they would go there, where the triage nurse would do a more extensive assessment," says Wentzel, who notes that his ED sees about 30,000 patients a year.

Because the RNs who now greet the patients are the more seasoned ED nurses, "they can tell quickly if the patient needs to go to a critical care room or if they need minor care," he says. A computerized system shows here where beds are available, he adds.

What happens if several patients come in at once? Can the "no-wait" guarantee still be fulfilled? It can, insists Doucette. "We have a process that includes float positions, and those people can immediately come up front," he explains. "In the past we would have been backed up, but now the nurse up front just gets on the phone." The float RNs work throughout the ED assisting primarily with throughput when they are not needed in the front, he says. When they are called up front, they perform the same duties as the "greeting" RN.

If there is not a room available, he adds, the care team comes up front and follows a series of protocols that "have been streamlined and are very specific," says Doucette. For example, he points out, the protocol for abdominal pain formerly had about 15 items; now it has only about five. (*For more on the streamlined protocols and other processes, see the story on p. 107.*)

"What we've done is not earth-shattering on the front end," admits Doucette, and yet the new system has achieved significant improvements. For example, average throughput in the EDs used to be about 3.5 hours and now it is down to two hours, with most patients being discharged within

EXECUTIVE SUMMARY

A combination of staffing and process changes have enabled the EDs of the Bon Secours system to deliver on a "no-wait" promise to patients.
- All patients are now greeted by an RN. Floaters provide backup if several patients present at once.
- Protocols were streamlined to aid in the speedup of patient flow.
- Patients are provided an information folder that gives them contact information for their comments on the new system.

SOURCES

For more information, contact:

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- **Carl F. Wentzel**, MD, ED Medical Director, Bon Secours Harborview Medical Center, Suffolk, VA. Phone: (757) 867-6687.

90 minutes. As for bed placement, "what typically took 30 minutes is now down to six or seven," he adds.

In the last six weeks, Doucette continues, total volumes in the EDs are now 110% over the plan budget. "We're now averaging about 116 patients a day in the freestanding ED and about 145 a day in the hospital EDs," he says. ■

Process changes lay foundation

While the most visible change in the EDs in the Bon Secours Hampton Roads (VA) system is an RN who greets all patients when they enter the department, the system could not be meeting its new "no-wait" guarantee without having first laid the foundation with several process changes, says **Jeff Doucette**, RN, MS, CEN, vice president of emergency services.

"It took us six months to prepare for the new program," says Doucette. "To get to this point, we had to enhance all we do." For example, he says, every patient is now given an information folder, which includes his contact information so that they can provide feedback on the new system.

In addition, he says, all of the ED protocols have been streamlined. Protocols for the "Quick ER," for example, formerly encompassed 20 pages; they have been reduced to five. "We've proven that overall we can provide high-quality emergency care and do it quickly," Doucette says. (*A copy of the "before" and "after" versions of the protocols is available with the online issue of ED Management. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.*)

The patients seem to agree, given the comments he has been getting. "I get 10 to 15 calls a day complimenting our service, where I used to receive 10-15 complaints a day," he reports. "The staff is more satisfied as well." ■

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 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 this 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 QUESTIONS

31. According to Rick Bukata, MD, clinical professor of emergency medicine at the Los Angeles County University of Southern California Medical Center, the best strategy to take if your ED receives a low ranking in a public report is to:
    A. Point out other reports in which your department has received high rankings.
    B. Say your department requires more resources in order to perform at a higher level.
    C. Point out the flaws in the methodology used in the study.
    D. Say the ranking is due to faults in hospitalwide processes and not the ED.

32. At Mercy Hospital, if bed bugs are discovered after a patient has been in a room:
    A. Housekeeping is asked to clean the room.
    B. Staff members that have been infected must change into hospital-provided scrubs.
    C. Staff members that have been infected must launder their clothes at the hospital.
    D. All of the above.

33. Creating a separate facility for referring behavioral health patients can provide much needed relief to EDs, but such an effort requires getting "everyone at the table at the same time," according to Lisa Sgarlata, RN, MSN, CEN, chief administrative officer at Lee Memorial Hospital. Based on how she conducted the process in Fort Myers, "everyone" includes:
    A. The county board of commissioners.
    B. The Salvation Army.
    C. The Florida Department of Children and Families.
    D. All of the above.

34. Patients with previous ED visits at several facilities for non-identifiable painful conditions should be a "red flag" for possible drug abuse, says John Whitcomb, MD, FACEP, an ED physician and medical director for patient access at Aurora Sinai Hospital. At what point does he recommend that you not provide a patient with narcotics?
    A. If they have had such ED visits five times in the last year.
    B. If they have had such ED visits four times in the last year.
    C. If they have had such ED visits three times in the last year.
    D. If they have had such ED visits twice in the last year.

35. According to Kevin Kremer, RN, BSN, the ED director at Beaufort Memorial Hospital, several groups of employees required training on the new Emergency Department Information System (EDIS) before it could be implemented. Which of the groups required the greatest amount of training?
    A. The "super users"
    B. Physicians
    C. Nurses
    D. Ancillary services

36. Jeff Doucette, RN, MS, CEN, vice president of emergency services for Bon Secours Hampton Roads health system, says that the system's EDs can fulfill their "no-wait" promise to patients even if more than one patient presents at that same time. That's because the RN who is always present to greet patients is backed up by:
    A. Physicians' assistants
    B. A phone system for "on-call" nurses
    C. Floaters in the ED
    D. Nurses from other units

CNE/CME ANSWERS

31. B 32. D 33. D 34. C 35. A 36. C.

BON SECOURS
VIRGINIA EMERGENCY SERVICES

Policy and Procedure Manual

Title:	**Med Express GUIDELINES**	**Policy Number:**	
		Origin Date:	
Entity:	Bon Secours Hampton Roads	**Revision Date:**	
Division:	Emergency Services	**Review Date:**	
Category:		**Approved by:**	J. Doucette

POLICY: The following criteria are to be used as Guidelines for triage of patients to Med Express. These criteria are in no way intended to replace the clinical judgment of triage nurses, but to provide a consistent approach to Med Express patients.

PROCEDURE:

GENERAL CONSIDERATIONS:

- Expected total treatment time of one hour or less.
- Patients are without serious underlying medical conditions that may be expected to worsen as a result of their current complaint.
- That adequate staffing and equipment necessary to meet treatment goals is available at all times.
- X-Rays: Patients presenting with extremity injuries may go to x-ray before going to Med Express. The nurse will be responsible for initiating the protocol.
- Med Express is open 12 hours daily. Hours may change during census fluctuations.
- Please follow guidelines, and ask when you have questions.

Items in the "Yes" column are considered appropriate for Fast Track.
Those in the column "No" column is NOT considered appropriate.

HEENT	YES	NO
Headache	• Sinus Origin • Migrane with previous history	• New Onset Migranes • Neurologically associated deficits
Head Injury	• Lacerations • No Loss of Consciousness	• Adult or child with loss of consciousness, vomiting or altered mental status
Earache	• Infection • Foreign Body	
Toothache	• Pain	
Eyes	• Corneal Abrasions • Localized infections • Foreign bodies • Chemical Splashes	• Obvious globe injury • Periorbital cellulitis

Nose	• Foreign Body • Nosebleed from minor trauma or sinus infections	• Significant nosebleed
Throat	• Infection	• Trismus • Drooling or stridor

CHEST	YES	NO
Cardiovascular	• Minor trauma to chest • Pleuritic pain • Chest pain associated with upper respiratory infection • Asymptomatic hypertension SBP<180	• No Chest Pain that is not clearly musculo-skeletal
Pulmonary	• Cough • Mild asthma with RR < 30 and normal SPO2.	• Symptomatic SOB • SPO2 less than 93%
Trauma	• Muscular Strain • Uncomplicated rib injury	• Suspected pneumothorax

GI	YES	NO
Gastrointestinal	• Hemorrhoids • Vomiting < 2 times within past 12 hours • Diarrhea < 2 times within past 12 hours	• Actively vomiting • Diarrhea • Ingestion • Abdominal Pain
Genitourinary	**MALE** • Frequency, Urgency or Dysuria • Penile discharge (No voided sample until evaluated by provider) **FEMALE** • Frequency, Urgency or Dysuria • Vaginal discharge, itching or irritation • Pain or bleeding with intercourse	• Abdominal or pelvic pain • Testicular complaints • Suspected kidney stone • Fever or vomiting with flank pain • Problems with pregnancy • Vaginal bleeding –

	• Vaginal Bleeding – Non-preg. • Bartholin Cyst	known pregnancy • Threatened AB

MUSCULO-SKELETAL	**YES**	**NO**
Back Pain	• Trauma – Ambulatory patient • Acute minor strain or injury • Chronic back pain	• Non-ambulatory • Neurological Deficit • Fever
Lacerations	• Simple facial, trunk or extremities • Suture removal • Wound Rechecks • Puncture wounds	• Complex lacerations* • Requested Plastic/Facial MD
Extremity Trauma	• Puncture wounds • Sprain/Strain • Needle sticks • Contusions • Abrasions • Superficial foreign body removal • Joint pain associated with trauma • Ingrown toe nail • Blood and body fluid exposure	• Severe extremity deformity • Shoulder Dislocation • Vascular compromise
Burns	• 1st degree burns • 2nd degree burns if less than 5% of body surface area and not on children	• Any 3rd degree burns • Circumferential burn of hand or fingers/toes/feet • Facial burns greater than 1st degree
Skin	• Insect bites • Localized cellulitis • Rash without significant systemic symptoms • I & D's • Animal or Human Bites	• Skin reactions with SOB

PEDIATRICS	YES	NO
	Children who fit the Adult Criteria may be seen in FT.	• No children < 90 days of age with fever > 100.

GENERAL CONSIDER-ATIONS	YES	NO
	• Suspected influenza • Medication Refills • EMS arrivals appropriate for FT after triage.	• Psychiatric complaint
Waiting Times	• Overflow from ED side can be seen on FT side if deemed reasonable by FT Provider. • Overflow from FT side can be seen on ED side if deemed reasonable by ED Provider.	
Triage Discretion	Any condition that potentially can be addressed and disposition made within one hour.	

EXCEPTIONS:

REFERENCES:

RELATED POLICIES:

AUTHOR: Valerie Sommer, RN (MIH); Updated: Deb Delaney MS RN CEN (DMC)

Source: Jeffrey N. Soucette, Bon Secours Hampton Roads, Hampton Roads, VA.

BON SECOURS
VIRGINIA EMERGENCY SERVICES

Policy and Procedure Manual

Title:	QuickER Care Exception Guidelines	**Policy Number:**	ESCTS030
		Origin Date:	6/10
Entity:	Bon Secours Hampton Roads	**Revision Date:**	6/10
Division:	Emergency Services	**Review Date:**	6/10
Category:	Provision of Care, Treatment and Services	**Approved by:**	J. Doucette

POLICY: All patients should be evaluated for treatment in QuickER Care. The following are absolute exceptions to a patient being treated in QuickER Care:

1. Patients who require cardiac monitoring
2. Patients who must remain in a supine position, and cannot sit or stand on their own.
3. Behavioral Health patients requiring medical clearance and mental health evaluations
4. Sexual assault cases
5. Child Protective services cases requiring medical clearance
6. All children < 30 days of age

All other patients may be assessed in the QuickerER Care area first and if deemed necessary after initial assessment by the ED physician or MLP provider, moved to the Main treatment area for appropriate monitoring.

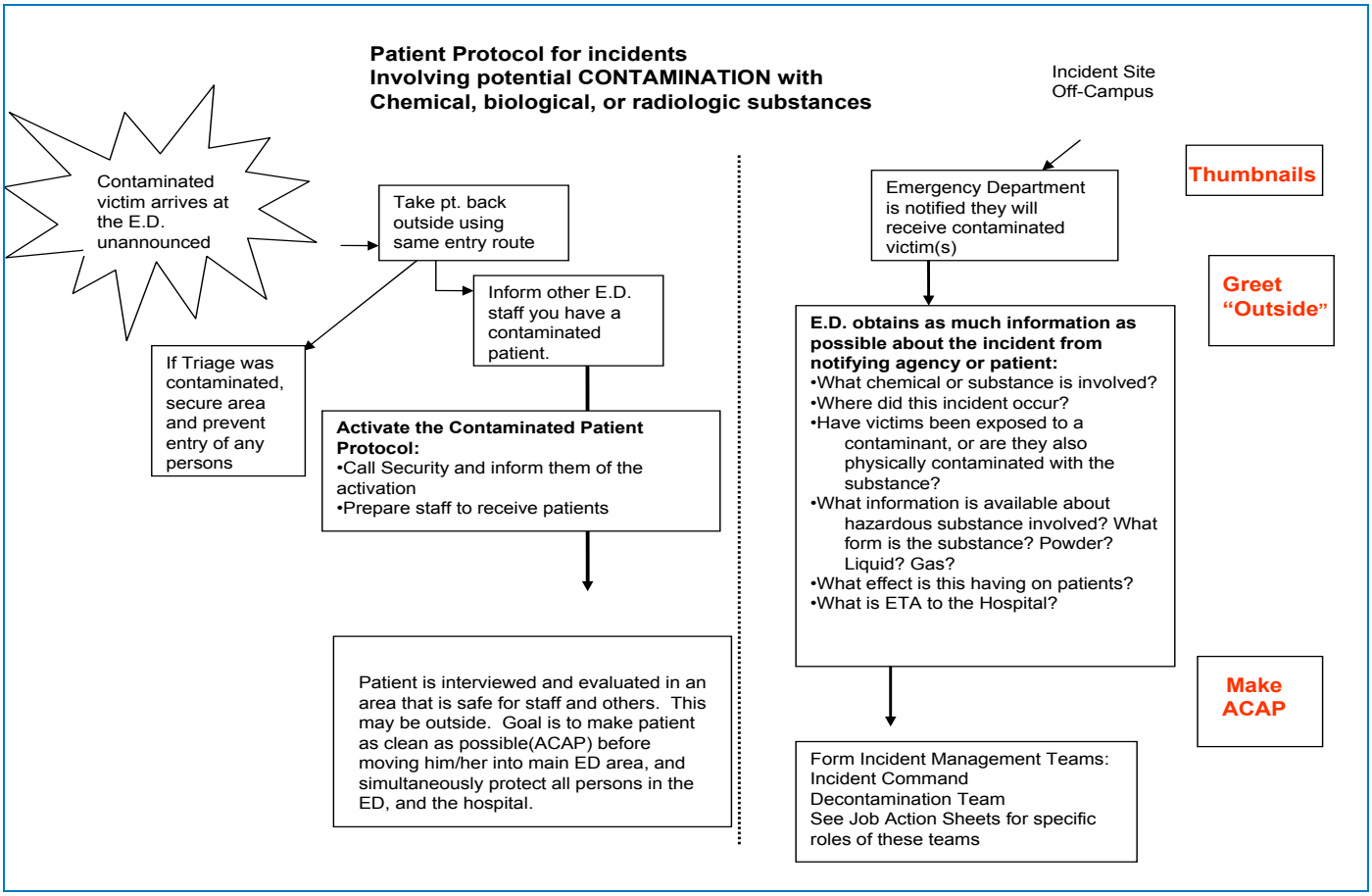
EXCEPTIONS: None

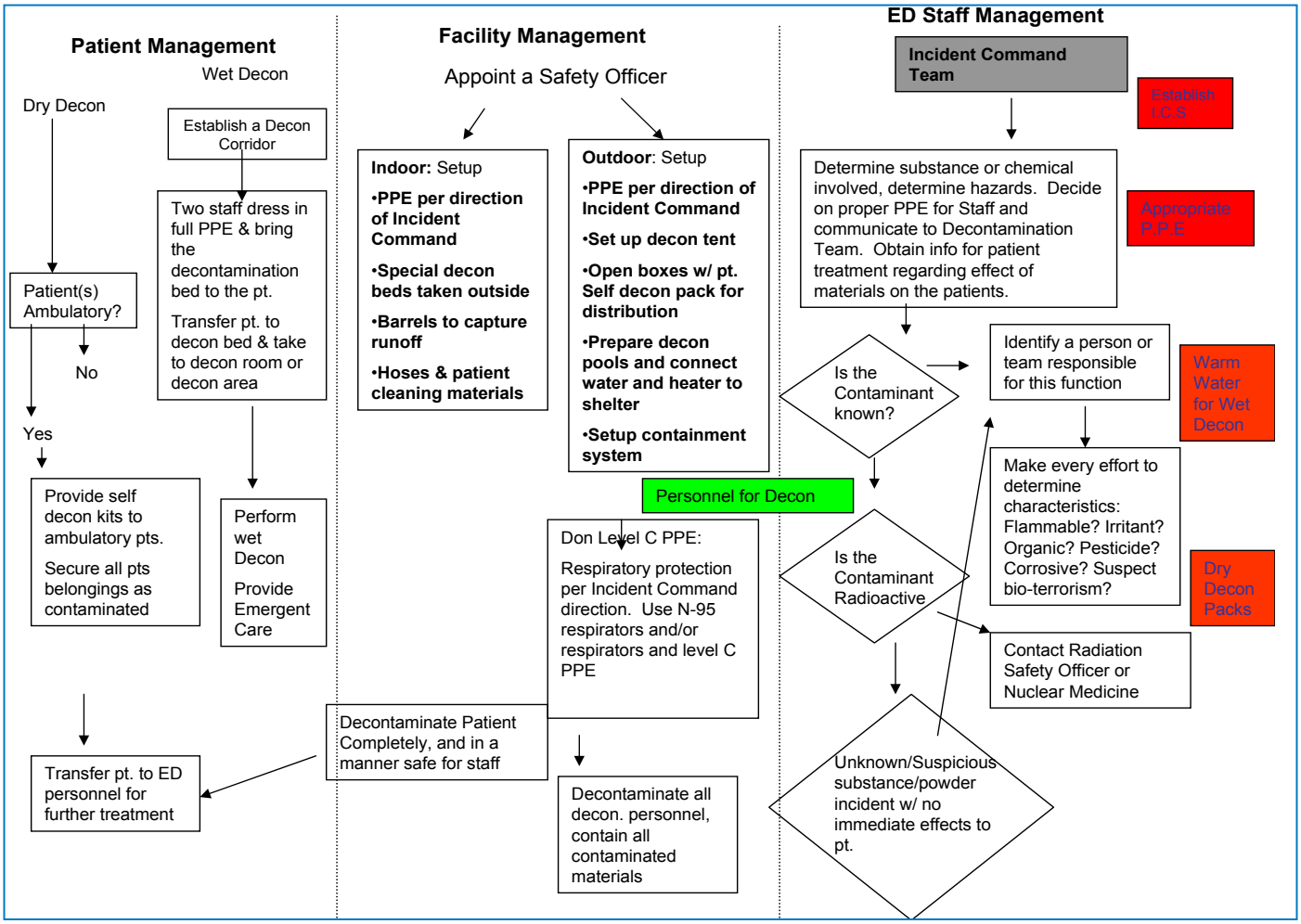
REFERENCES: None

RELATED POLICIES: None

AUTHOR: Jeffrey N. Doucette, RN, MS

Source: Jeffrey N. Doucette, Bon Secours Hampton Roads, Hampton Roads, VA.


Patient Protocol for incidents
Involving potential CONTAMINATION with
Chemical, biological, or radiologic substances
Incident Site
Off-Campus
Contaminated victim arrives at the E.D. unannounced
Take pt. back outside using same entry route
Inform other E.D. staff you have a contaminated patient.
If Triage was contaminated, secure area and prevent entry of any persons
Activate the Contaminated Patient Protocol:
•Call Security and inform them of the activation
•Prepare staff to receive patients
Patient is interviewed and evaluated in an area that is safe for staff and others. This may be outside. Goal is to make patient as clean as possible(ACAP) before moving him/her into main ED area, and simultaneously protect all persons in the ED, and the hospital.
Emergency Department is notified they will receive contaminated victim(s)
Thumbnails
Greet "Outside"
E.D. obtains as much information as possible about the incident from notifying agency or patient:
•What chemical or substance is involved?
•Where did this incident occur?
•Have victims been exposed to a contaminant, or are they also physically contaminated with the substance?
•What information is available about hazardous substance involved? What form is the substance? Powder? Liquid? Gas?
•What effect is this having on patients?
•What is ETA to the Hospital?
Make ACAP
Form Incident Management Teams:
Incident Command
Decontamination Team
See Job Action Sheets for specific roles of these teams


Patient Management
Wet Decon
Dry Decon
Establish a Decon Corridor
Two staff dress in full PPE & bring the decontamination bed to the pt.
Transfer pt. to decon bed & take to decon room or decon area
Patient(s) Ambulatory?
No
Yes
Provide self decon kits to ambulatory pts.
Secure all pts belongings as contaminated
Perform wet Decon
Provide Emergent Care
Transfer pt. to ED personnel for further treatment
Facility Management
Appoint a Safety Officer
Indoor: Setup
•PPE per direction of Incident Command
•Special decon beds taken outside
•Barrels to capture runoff
•Hoses & patient cleaning materials
Outdoor: Setup
•PPE per direction of Incident Command
•Set up decon tent
•Open boxes w/ pt. Self decon pack for distribution
•Prepare decon pools and connect water and heater to shelter
•Setup containment system
Personnel for Decon
Don Level C PPE:
Respiratory protection per Incident Command direction. Use N-95 respirators and/or respirators and level C PPE
Decontaminate Patient Completely, and in a manner safe for staff
Decontaminate all decon. personnel, contain all contaminated materials
ED Staff Management
Incident Command Team
Establish I.C.S
Determine substance or chemical involved, determine hazards. Decide on proper PPE for Staff and communicate to Decontamination Team. Obtain info for patient treatment regarding effect of materials on the patients.
Appropriate P.P.E
Is the Contaminant known?
Identify a person or team responsible for this function
Warm Water for Wet Decon
Make every effort to determine characteristics: Flammable? Irritant? Organic? Pesticide? Corrosive? Suspect bio-terrorism?
Dry Decon Packs
Is the Contaminant Radioactive
Contact Radiation Safety Officer or Nuclear Medicine
Unknown/Suspicious substance/powder incident w/ no immediate effects to pt.