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Are family physicians the answer to ED doctor shortage, or 'blasphemy'?

Professional organizations plan meeting to discuss alternatives

The debate has been simmering for a while, but it came to a boil recently when the American Academy of Family Physicians (AAFP) threw down the gauntlet with its recent position paper, "Critical challenges for family medicine: delivering emergency medical care — equipping family physicians for the 21st Century."[1]

"The evidence is clear that EM residency training programs will not meet workforce needs for decades, and family physicians will be needed in the work force,"[1] the AAFP asserted. It went on to note that "[f]amily physicians are trained to provide emergency medical care through residency and post residency education . . ."[1] That might be true, but as one observer put it, many emergency medicine professionals consider suggestions that family physicians join the ED staff to be "blasphemy."

The American College of Emergency Physicians (ACEP) doesn't go that far, but president **Sandra M. Schneider**, MD, FACEP, says "The gold standard for training is ED residency." ED residents spend three to four years training to be emergency physicians, Schneider says. "The family practice resident may spend one, two, or at most three months of training in the ED," Schneider observes. "We feel the difference between three months and three to four years is significant."

Having said that, however, Schneider says that there are some family physicians who have obtained through experience the skills

EXECUTIVE SUMMARY

Some organizations maintain that family physicians have the skills and training necessary to practice in the ED and help combat the current physician shortage, while others maintain their training is inadequate. Here are some issues to take into consideration with such candidates:

- Have they obtained thorough experience the necessary skills to practice in the ED?
- Have they received a significant amount of clinical training in an ED?
- Has their training progress been monitored by a teaching attending?

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necessary to provide emergency care in most situations. She believes credentialing should be based upon an individual's skills. "I also believe that individuals who work in EDs should have those essential skills before they start working," Schneider adds. That requirement is determined by the hospital. "Hospitals generally have a credentialing process where they talk to individuals who have seen this physician work and can state what their competency is with certain procedures and certain types of patients," Schneider says.

Another problem with moving family physicians into emergency medicine is that it might be a case of robbing Peter to pay Paul, she says. "Clearly we need more emergency physicians, but we also need more primary physicians," says Schneider. "Every time we pull one, particularly in a rural area, to work in the ED, they are not available to meet the needed primary care." Observers note that this need will become even stronger under the new health care law.

Kasimir Oganowski, MD, director of physician services for Premier Health Care Services in Dayton, OH, says, "All of us agree that there is this need — a workforce problem stemming from the lack of residency-trained physicians — and we need to find other avenues to bring other physicians into the workforce who can do the work." Oganowski says that he originally was trained in primary care, but now he has more than 21 years' experience in the ED.

"I agree the gold standard is a residency-trained, board certified doctor, but the reality is there are not enough of them," Oganowski says. "I was in a meeting yesterday in West Virginia, and all the EDs represented said they were one to two doctors short."

In an effort to meet that shortage, Premier has created a year-long training program for family physicians who are interested in practicing emergency medicine. Oganowski acknowledges the argument that there is also a shortage of family physicians, but he insists this program is not contributing to the problem. "We are not trying to take every primary care doctor out of their offices to bring them into the ED," he says. "What we are trying to do is accommodate a number of them who for various reasons want to do emergency medicine. We want to make sure as much as we can that they have the skills and knowledge to do that work." *(For more on the Premier program, see the story on p. 3.)*

For Schneider's part, she believes the solution to the ED physician shortage should be addressed by those organizations that represent ED professionals. "There is an ACEP study in process right now, and we will be making recommendations in January after bringing together all emergency medicine organizations to have a summit on this very issue," she says. "We believe we ought to be the ones to fill the need." *(Look to upcoming*

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- **Sandra M. Schneider**, President, American College of Emergency Physicians, Irving, TX. Phone: (800) 798-1822.

issues of ED Management *for coverage of those recommendations.)*

REFERENCE

1. Gerard WA, Staffer A, Bullock K, et al. Family physicians in emergency medicine: new opportunities and critical challenges. *Ann Fam Med* 2010; 8:564-565. ■

Program trains family physicians

Dayton, OH-based Premier Health Care Services, which places emergency medicine physicians and mid-level providers and staffs and manages hospital EDs, has instituted a year-long training program for family physicians interested in working with the ED.

"We were unable to fill a lot of the staffing requirements with experienced, boarded, emergency medicine residency-trained physicians," says **Jerry Tasset**, MD, PhD, FACEP, who runs the program.

Kasimir Oganowski, MD, director of physician services for Premier, adds, "We looked at the crisis, and as a group asked ourselves a question: How can we take care of this?"

The program, which is now in its third year, has two main components, says Oganowski.

"There is a didactic portion one day a week, typically four to six hours," he says. "During those sessions and during the year we use Tintinalli's Emergency Medicine: A Comprehensive Study Guide." In addition, he notes, all students participate in the American College of Emergency Physicians Ohio Chapter's emergency medicine board review course. "We have a procedures lab at Wright State [University, Dayton, OH] where they practice placing chest tubes, central lines, and other procedures," he says.

Tasset says, "We have the lecture piece in the morning and a practicum in the afternoon with fresh cadavers. They spend 36 hours a week working with our emergency physicians in one of our EDs."

The students take a provider course in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS). Oganowski says, "We test the physicians regularly, and evaluate them three times a year." Tasset says, "They have a teaching attending at the clinical sites that also monitor their progress and give feedback to us."

Oganowski believes such a program provides a viable alternative to board-trained emergency physicians when there are an insufficient number of them available. "Our goal is when they finish our program they can go to work in an ED and with confidence take care of anything that comes through the door," says Oganowski. Feedback from ED managers who have hired graduates convinces him that goal has been achieved, he adds. ■

SOURCE

For more information on training family physicians for the ED, contact:

- **Jerry Tasset**, MD, PhD FACEP, Premier Health Care Services, Dayton, OH. Phone: (800) 726-3627.

Alert addresses patient suicides

When the situation warrants it, The Joint Commission will re-visit a topic that it previously has covered in a *Sentinel Event Alert* to look at it from a different point of view. That clearly was the case as it once again has made patient suicide an alert topic, according to **Robert Wise**, MD, medical advisor to the Division of Health Quality Evaluation.

"The [sentinel event] database is a voluntary database, so we don't know what the specific rates are, but when we look at what's reported to us, there are suicides connected to the psych unit and those connected to the ED and the med/surg unit, and the latter two are different kinds of issues," says Wise, who explains that the latest alert focuses on the ED and inpatient units. "What we're trying to get across is that these are different environments, and they need to be thought about separately."

The ED is a rapid-paced, high-volume environment with high acuity patients, Wise notes. "You have a lot of life-and-death situations, and you have personnel really focused on trying to quickly understand what the potentially serious med/surg issues are," he says. A number of these patients also could have suicidal issues associated with their medical problems, Wise points out. "It is a secondary issue, but it could turn out to be a deadly one," he says. "It's easy to sort of miss that secondary one because of how fast things are moving."

An example might be a cancer patient who comes to the ED because he or she is experiencing new pain or shortness of breath that is probably indicative of some spread, Wise says. "You also have a good chance the person is more despondent or feels hopeless," he says. "That's not what they present, with, but it is clearly there also."

What if patients don't volunteer info?

Bill Fiebig, RN, BSN, CEN NREMT-P, the ED manager at the Rose de Lima Campus of St. Rose Hospital in Henderson, NV, agrees. "It's easy to pick up the person who says 'I want to kill myself,' because they have declared," Fiebig says. "But it's very different with people with chronic illnesses, who go through body image or lifestyle changes, who may not be earning the same amount of money any longer or who are unable to work, or who are not functioning in daily life."

EDs do not do a good job of discovering that patients have a previous psychiatric illness when they don't volunteer that information in their history, he says. "We do not pry as much because our environment is so fast-paced," Fiebig says. "The truth is we are most likely the worst place in the world for patients with mental illness to come." Still, he adds, "we have to do a better job in screening patients and looking at their case in a multi-dimensional way."

Offering your staff inservices on this topic as a matter of course might not be all that effective, says Wise.

"Close calls or real events are more likely to be teaching moments," he says. "It becomes valuable then to do a root cause analysis, understand what happened, and then not blame the person in charge but use it as a teaching experience."

If you just do an inservice out of the blue and share the *Sentinel Event Alert*, for example, "People's eyes will glaze over because it does not have any meaning to their reality," says Wise. "However, if you have a near miss or, heaven forbid, a completed suicide, you can *then* bring in the inservice, and the alert is more likely to come alive for the staff," he says.

Fiebig says, "I couldn't have said it better myself. People need to have a relevant explanation given to them. We tend to inservice, inservice, inservice, and all you get are lost messages. If you have a real-life event, the staff is more likely to pay attention." *(It's also important that your staff learn to recognize suicide risk factors. See the story, below.)* ■

EXECUTIVE SUMMARY

The Joint Commission has issued a *Sentinel Event Alert* about patient suicides in the ED and med/surg units because they represent environments that are distinct from that of the psych unit. The ED faces special challenges because of its fast-paced environment.

- Recognize and look for psychiatric issues that might be the result of the patient's reaction to their physical problems.
- Schedule an inservice following a near miss or a successful suicide. It will be much more impactful if staff can relate to an incident.
- Be on the alert for signs of psychological problems in your patients, i.e., agitation manifested by pacing the floor.

SOURCES

For more information on preventing patient suicide in the ED, contact:

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- **Robert Wise**, MD, Medical Advisor, Division of Health Quality Evaluation, The Joint Commission. E-mail: rwise@jointcommission.org.

Recognize risks, take precautions

ED managers and their staffs should be aware of the risk factors for patient suicide, says a recent Sentinel Event Alert from The Joint Commission. Experts agree and add that it's also important to take precautions when you believe patients might be a danger to themselves.

There are two types of patients who might present such a risk, says **Robert Wise**, MD, medical advisor to the Division of Health Quality Evaluation. "Some people have cognitive problems: dementia or other things that might affect

their judgment," Wise notes. "They're a lot more likely to be despondent and make a suicide attempt if they're intoxicated or if they have some sort of dementia because they're not able to grasp or understand the consequences."

The other group of patients is at risk because of the way in which they react to their medical problems, he says. "Suicidality may come from the patient's perception of their illness," Wise says. "You have to understand what the person is perceiving about what you're telling them."

Gregory Henry, MD, FACEP, risk management consultant at Emergency Physicians Medical Group, Ann Arbor, MI, says, "I have never had someone successfully go from looking normal to killing themselves in my department. The crime is concentrating on the wrong thing." ED managers and their staffs should be on guard for subtle signs of problems such as agitation, Henry says. "Look for patients who pace the floor or those who are so monumentally depressed they sit there and say life is not worth living," he advises.

Once you've determined a patient is at risk, you should do the "simple" things that can help avoid a more serious situation, says Henry. "Make sure the patient is in the ED proper, and have them closer to the nursing station," he advises. "Obviously, remove harmful objects from the room." He also says that ED staffs should check for any instruments or materials with which the patient might harm themselves or others, because patients who are suicidal also might be homicidal.

If nurses see warning signs, they should notify the physicians that precautions need to be taken, says Henry. "What's more, get in touch with somebody who's invested in the well-being of the patient," he adds.

Bill Fiebig, RN, BSN, CEN NREMT-P, the ED manager at the Rose de Lima Campus of St. Rose Hospital in Henderson, NV, says, "The big thing is you have to make sure nurses are assessing the psychodynamics of their patients, although it's easier said than done sometimes. We're helped by having chaplains round regularly [because St. Rose is a faith-based health system], and we also do our own rounding in the ED."

If caregivers suspect another dimension to a patient's illness, "we encourage our nurses to get chaplains involved in difficult circumstances and to look at the family dimension as well," says Fiebig. ■

SOURCE

For more information on patient suicide risk factors, contact:

• **Gregory Henry**, MD, FACEP, Risk Management Consultant, Emergency Physicians Medical Group, Ann Arbor, MI. Phone: (734) 995-3764.

Gold Star AWARD

ED targets end-of-life patients

Program offers 'comfort, control and choices'

[Editor's note: ED Management *awards the "Gold Star" to ED teams that go above and beyond the expected to dramatically improve performance through unique and creative approaches. To nominate your ED or another one for a Gold Star, contact Joy Daughtery Dickinson, senior managing editor, at joy.dickinson@ahcmedia.com.]*

An ED program designed to serve the terminally ill? It makes perfect sense to **Mark Rosenberg**, DO, MBA, FACEP, chairman of emergency medicine at St. Joseph's Regional Medical Center in Paterson, NJ. So much so, in fact, that his department recently introduced Life-Sustaining Management and Alternative (LSMA) services. The program is designed to provide comfort, control, and choices for chronic and terminally ill patients and their loved ones.

"St. Joseph's has a large peds ED and a very active ED in downtown Paterson with a fairly large geriatric population that had been continuing to grow," Rosenberg says. "We decided to develop full-circle care in the ED."

Rosenberg says his ED had been seeing 40-60 geriatric patients a day, but it had not really met its goal of providing complete care because it did not have a program to help most of them who had a life-limiting disease.

"In January [2010] we decided to start the program and take care not just of geriatric patients but anyone who had life-limiting illness," says Rosenberg. "We felt management of these patients could be better if it was initiated in the ED and then followed through to the community or the hospital."

The ED leadership was particularly qualified to

develop such a program because both Rosenberg and ED nurse coordinator Ramazan Bahar, RN-BC, had been involved in palliative care over the years. "When a patient has a terminal illness they know they are dying, but often no one wants to discuss it with them," notes Bahar. This approach takes control away from the patient, she says.

Bahar recalls the case of an elderly Dominican woman with metastatic brain cancer. "The children were told she had three weeks to live, but they had not wanted to tell her," she says. "I said, 'I'll tell you something: She knows. Let's let her decide how she wants to spend that time."

The daughters gave their permission, and the ED physician in charge of the case told her. Her response? "I knew." The provider team and the family asked her what she wanted to do. "She wanted to go back to the Dominican Republic," says Bahar, "And we made arrangements for hospice and palliative care." *(Rosenberg takes a non-traditional approach to one specific type of palliative care. See the story, right.)*

A different approach

A program such as this one runs counter to the traditional ED approach to care, says Rosenberg.

"We are usually focused on curing, and sometimes you need to focus on caring," he explains. "We have now created that model in the ED, where you can provide care without curing and give control back to the patient."

A "treat, stabilize, cure, and discharge" approach might work for most patients, Bahar says, "but there is a different type of treatment for these patients. We are here to advocate for them and make sure their wishes are translated to the next level of care."

Rosenberg and Bahar provide a consulting service and are available 24/7 along with another ED physician. Rosenberg says, "Any time a patient is in need of palliative care or has to deal with end-of-life issues, rather than them having to deal with it, they call us. We take the burden away from the emergency physician."

The ED physicians simply have to call his or Bahar's extension. If they're out, it goes to their cell phones, notes Rosenberg. "We've created a whole new level of care for these individuals," he says. *(For an example of a recent case, see the story, below.)* ■

EXECUTIVE SUMMARY

The new Life-Sustaining Management and Alternative (LSMA) services program in the ED at St. Joseph's Regional Medical Center in Paterson, NJ, is designed to offer patients with life-limiting disease greater control over their care choices and also help them contact services such as hospice if they are needed.

- Two ED physicians and one nurse are on call 24/7 for consulting referrals from ED physicians.
- The consultants meet with the patient and their family to review the case and present alternatives.
- The program shifts the traditional ED focus of curing to one of caring.

SOURCE

For more information on treating terminally ill patients in the ED, contact:

- **Ramazan Bahar**, RN-BC, ED Nurse Coordinator, and Mark Rosenberg, DO, MBA, FACEP, Chairman of Emergency Medicine, St. Joseph's Regional Medical Center, Paterson, NJ. Phone: (973) 754-2000.

Case shows hospital met patient's request

A recent case in the ED at St. Joseph's Regional Medical Center in Paterson, NJ, shows the value of its new Life-Sustaining Management and Alternative (LSMA) services, says **Mark Rosenberg**, DO, MBA, FACEP, chairman of emergency medicine and co-creator of the program.

The patient was 56-year-old male with stage IV lung cancer who was having difficulty breathing. He had been through chemotherapy, but it was no longer efficacious. His oncologist had told the family there was nothing more he could do.

Rosenberg met with the patient and his wife and reviewed his history. He also presented them with alternatives. "The hospitalist was going to admit him, probably drain the malignant effusion in his chest, and put him in the ICU, where he may have died," he said. When Rosenberg explained the circumstances to the patient, "he was excited ... happy. He knew he was dying and just wanted somebody to say it and know what was in store for him," he says.

The patient decided he would rather go home. Rosenberg arranged for hospice care. "We also got him to tape record messages for his nieces, who were 1 and 3, and for others, so he could leave a legacy for them," he notes. "We also had family meeting, and to this day the family couldn't be more thankful that we let him have a choice and reach his goals."

The patient died at home three weeks later without medical support. ■

Clinical Tips

Some EOL care is not adequate

Shortness of breath in terminally ill patients is often managed poorly, says **Mark Rosenberg**, DO, MBA, FACEP, chairman of emergency medicine at St. Joseph's Regional Medical Center in Paterson, NJ, and co-creator of its new Life-Sustaining Management and Alternative (LSMA) program.

"The tendency is to put a breathing tube in, but a very good treatment is giving morphine," Rosenberg says. "A lot of people think this will shorten life, but studies show it will actually lengthen life.

Rosenberg adds that ED managers and their staffs have a lot to learn about treating these patients. "My feeling is there is great opportunity for emergency doctors to provide better care by better understanding EOL [end of life] initiatives," he says. "From a clinical point of view, it's a better opportunity to learn how to manage acute chronic pain, narcotics like morphine, methadone, and dilaudid in particular. You can get very skilled."

There are several recommended drugs for EOL care that can help mask symptoms such as dizziness, nausea, vomiting, constipation, and diarrhea, Rosenberg adds. ■

Elderly women get unnecessary UCs

They have higher morbidity with infections

A study conducted in the ED at St. John Hospital and Medical Center in Grosse Pointe, MI, has found that ED staff placed unnecessary urinary catheters (UCs) in nearly half of women 80 or older. The study was published in the November 2010 issue of the *American Journal of Infection Control*.[1]

Such a practice could unnecessarily expose these women to the risk of infection, a hazard of urinary catheterization, notes **Mohamad G. Fakih**, MD, MPH, medical director of infection prevention and control and lead author of the study. *(For his tips on minimizing the risk of infection, see the story on p. 8.)*

Ironically, these findings occurred subsequent to the institution of new catheterization guidelines which, a previous study by Fakih showed, actually reduced overall utilization of urinary catheters.[2] "The first study showed a drop from 14.9% to 10.6% in initially placed catheters," says Fakih. "But there is still a large minority of patients that have urinary catheter placed unnecessarily; 30.3% of all initially placed catheters did not comply with institutional guidelines."

Nonetheless, the guidelines were essential, says **Margarita Pena**, MD, FACEP, the ED director and "physician champion" for the guidelines. "The best thing about them is that you have clear-cut indications and non-indications," Pena says. *[A copy of the guidelines can be found in the online issue of* ED Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

There still is a judgment factor involved, she adds. "It's not specifically mentioned in the guidelines, but if someone comes in drunk and out of it, we're going to put a Foley in them." says Pena.

Given the guidelines, why did so many of these women still receive unnecessary catheters? One problem is that people don't always follow guidelines, says Fakih.

"The more we push to improve quality, the more you dig into each department finding more and more that a lot of people do not follow guidelines," he says. "In this case, 41% of those patients who were catheterized did not have a documented doctor's order," which is a requirement of the guidelines.

Nurses often think the catheter makes the patients more comfortable and insert it as a convenience, Fakih says.

Pena says, "My personal feeling is that number one, people are still not completely aware of or know about the guidelines. We have rotating physicians who come through the department every so often, and the nurse just asks if it's OK to put the catheter in, and they say 'Sure.' Newer nurses may also not be aware of the guidelines." However, she says that the regular nurses are now cognizant that

EXECUTIVE SUMMARY

In a recent study, it was found that more than half of the female ED patients who were 80 or older received unnecessary urinary catheters (UCs). The authors note the following proposed actions to limit these errors:

- Have clear-cut indications and non-indications for the placement of urinary catheters.
- Require that all such procedures have orders from an ED physician.
- Make sure that newer or rotating staff are made aware of your department's guidelines.

they have to have a physician's order before inserting the catheter. *(How can the compliance rate be improved? See the story below.)*

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1. Fakih MG, Shemes SP, Pena ME, et al. Urinary catheters in the emergency department: Very elderly women are at high risk for unnecessary utilization. *Am J Infect Control* 2010; 38:683-688.
2. Fakih MG, Pena ME, Shemes S, et al. Effect of establishing guidelines on appropriate urinary catheter placement. *Acad Emerg Med* 2010; 17:337-340. ■

Feedback is key to compliance

Despite new guidelines for urinary catheter insertion, nearly half of women 80 or older received unnecessary urinary catheters, according to a study conducted in the ED at St. John Hospital and Medical Center in Grosse Pointe, MI. What can be done to improve the compliance rates?

"Giving regular feedback and reminders is very important," says **Margarita Pena**, MD, FACEP, the ED director and "physician champion" for the guidelines. "There has also got to be a cultural change."

Mohamad G. Fakih, MD, MPH, medical director, infection prevention and control, agrees. "What would help is intervening with nurses," Fakih says. "A big component is nurses placing a catheter without orders."

Another strategy would be to target these people who are at high risk, he says. "If you have good electronic records, you can say 'Identify all females 80 or above,' and go look at them and see if they have catheters in and see if they meet the guidelines," Fakih suggests. ■

Clinical Tips

Keep catheter a closed system

"One way to minimize the risk of infection in catheterized patients is to keep the catheter system as a closed system," says Mohamad G. Fakih, MD, MPH, medical director of infection prevention and control at St. John Hospital and Medical Center in Grosse Pointe, MI. "Don't break the system," Fakih cautions. "The catheter is connected to a tube, the tube is connected to a bag. Do *not* disconnect these from each other."

In addition, when placing a catheter, place it under aseptic conditions, he says. "Secure the catheter on the patient's thigh so as to reduce the trauma related to catheterization," Fakih advises. "Then, only keep it in as long as necessary and no longer." ■

Patient Flow SOLUTIONS

'No-wait' ED a five-year success

Wait time to see practitioner cut in half

A true test of the success of a process improvement initiative is whether the results can be sustained, and the ED at Hudson Valley Hospital Center in Cortlandt Manor, NY, has just celebrated the fifth anniversary of its "no wait" process. Most patients skip the waiting room entirely and go right to registration, and then to triage.

"We've cut the wait time to be seen by a practitioner by 50%," says **Ron Nutovits**, MD, FAAEM, chair of the ED. "Most patients are now triaged within five minutes and seen by a practitioner within 20. Within the first month, our rate of patients who left without being seen went from .7% to .33%, and our Press Ganey scores went to the mid-90s." Nuvovits says the 35,000-visit ED was also recognized by Press Ganey for its high staff satisfaction scores.

Maryanne Maffei, RN, MS, director of nursing, explains the process. "When the patient comes in, they sign in at the registration desk. We do a quick registration — name and date of birth — so we can give them a medical record number, and then they have a seat. Their name then appears on our computerized system, and the triage nurse takes them from the waiting room to the triage room." When triage is finished, the patient is taken immediately into the care area, where labs and X-rays can be ordered and treatment begun, Maffei says.

Nuvovits says, "It became a one-way system. Instead of coming in, registering, and going back to the waiting room, now they come in and the greeter gets them into our tracking system, alerts

SOURCE

For more information on reducing wait times, contact:

• **Maryanne Maffei**, RN, MS, Director of Nursing, **Ron Nutovits**, MD, FAAEM, Chairman of the ED, Hudson Valley Hospital Center, Cortlandt Manor, NY. Phone: (914) 734-3247.

the triage nurse; they go to triage and come directly from triage to the main ED." The department has two triage areas, so patients can be treated simultaneously, he adds.

Maffei says, "We really focused on triage in training. If more than two people are in the waiting room, the staff will go there, bring them to a room, and triage them."

It was emphasized to staff that this change would benefit patient safety. "We needed to change the thought process of some of the nurses in the department, so they could see how much safer it was going to be to bring patients immediately into the department for treatment," says Maffei. *(For more on how to work with your staff, see the story below right.)*

Eventually, this approach became "part of the norm," she says. In fact, Maffei shares, there's another hospital nearby that is trying to implement a similar approach. "They were discussing it with one of our nurses, and she told them, 'Don't worry, it's hard at the beginning, but you get used to it,'" she says. *(The transition was also made easier through the use of simulations, which helped ensure that staffing levels matched demand fluctuation. See the story below.)* ■

Simulation helps plan staffing

One of the keys to the success of the "no-wait" ED at Hudson Valley Hospital Center in Cortlandt Manor, NY, was the use of a "virtual ED" simulation model that allowed ED leaders to predict what the resulting performance times would be using different levels of ED physician and nurse staffing, according to **Ron Nutovits**, MD, FAAEM, chair of the ED.

"We analyzed the data to see how many patients would come in at what time of day," Nutovits says. "It showed our staff that if they said 'hello' right away and got the process going, we avoided the negative impact of not only dealing with patients who were irate, but we would not have to explain to patients several times an hour that we'd see them as soon as we could."

Eric Bachenheimer, MHSA, MBA, FACHE, director of ED Solutions, the ED consulting/advisory services firm that developed the "virtual ED," says, "We were also able to predict the number of walkouts, patient-to-nurse ratios, census, and waiting times for patients in the ED. The benefits of this were significant in that we were able to identify the optimal staffing level and be able to understand what type of performance we could expect from employing that approach." *(For more information, contact Bachenheimer at BachenheimerE@alpha-apr.com.)* ■

EXECUTIVE SUMMARY

Not only has the "no-wait" ED at Hudson Valley Hospital Center in Cortlandt Manor, NY, reduced by 50% the time it take for patients to see a provider, but it has maintained that performance for five years.

- After a quick registration, a computer system tells triage nurses the patient is ready to be taken back to triage.
- If more than two people are ever in the waiting room, the staff is trained to bring them to a room and triage them.
- A simulation model helped leaders determine optimal staffing strategies.

Management Tip

Heed staff when making changes

Instituting process changes can be a "culture shock" for your staff. That shock can be eased by adopting an empathetic attitude, says **Maryanne Maffei**, RN, MS, director of nursing in the ED at Hudson Valley Hospital Center in Cortlandt Manor, NY.

"Listen to your staff and try to understand what they're going through," Maffei advises. "If there are little changes you can make that will help them to better adapt and still enable you to reach your goal, then do it."

It's important to make your staff feel they have some control over the changes that are about to take place, she adds. For example, she says, recalls members of the staff were concerned that with the "no-wait" process instituted five years ago, they would become backed up in triage. "They requested that if the greeter saw there were more than two patients in the waiting room that the greeter would call the charge nurse to notify her," she says. "The charge nurse in turn would send

another nurse to triage, which would ease some of the pressure the nurses felt."

As this process was in line with the new direction and did not significantly change the overall process, Maffei explains, it was a change that could easily be made and make the staff members feel that they had some control. ■

Patient Flow SOLUTIONS

Improved flow aids patient safety

Cut wait times, LWBS, boost compliance

If there are any doubts that improving patient flow also enhances patient safety, the recent experience of the ED at Enumclaw (WA) Regional Hospital should dispel them. A new triage and treatment process has dramatically improved flow performance, but it has also garnered the ED the Washington State Medical Association's 2010 William O. Robertson Patient Safety Award.

Richard Dickson, RN, the ED manager, explains why. "Our rate of patients who left without being seen had been 5%, and we dropped it to between .8% and 1.1%," Dickson says. "When we examined the records of the patients who had left before being seen, we discovered that on average they were level three patients." The ED uses a five-level triage classification, with level 1 being the most serious.

A level 3 patient "is someone that needs to be seen," Dickson says. An example is a patient with abdominal pain. "I like to think they went to another hospital, but they also could have gone home and bled out," Dickson notes.

In addition, he says, the department's AMAs (Against Medical Advice) also have dropped, from 1.5% a month to less than .5%. "Patients used to think that what the doctor ordered was either too costly or too time-consuming," Dickson notes. "Since they're being seen much earlier, they tend not to run out before the doctor finishes treating them."

They certainly are being seen more quickly. The door-to-doc time has dropped from an average of 52 minutes to an average of 16 minutes, Dickson reports.

The new process was "borrowed" from a sister hospital, St. Anthony Hospital in Gig Harbor, WA, which implemented its process in March 2009.

EXECUTIVE SUMMARY

The ED at Enumclaw (WA) Regional Hospital has reduced its rate of patients who left without being seen from 5% to between .8% and 1.1% and cut its door-to-doc time from an average of 52 minutes to an average of 16 minutes with the institution of a new triage and treatment process. At the same time, it has improved patient safety and received an award from the Washington State Medical Association.

- When patients present, one of two registration clerks takes down the chief complaint and quickly registers the patient to give them an account number.
- After initial registration, "team intake" staff takes them to a patient room or a triage room.
- A five-tier triage system is used to determine placement of patients.

Enumclaw went live with theirs in early 2010. "It was a brand-new hospital, and we wanted to develop a process that was very patient-centered and designed to meet their needs and expectations," explains **Paul Hildebrand**, MD, regional medical director for emergency services in the Franciscan Health System, which is based in Gig Harbor, WA.

In seeking models, Hildebrand discovered that his group's parent organization, TeamHealth, had developed an effective process for Banner Good Samaritan Medical Center in Phoenix and for Memorial Hermann Hospital in Houston. "We went to Phoenix and observed," he says.

When patients present, says Hildebrand, they are greeted and "brought right back," where they are seen by a physician/nurse team. "They do not spend a lot of time out front or go through the redundant exams you see in a lot of places," he says. Once a treatment plan is created, it is discussed with the patient.

At St. Anthony, says Hildebrand, door-to-doc time is about 10 minutes and LWBS is "essentially zero." If a patient needs to be admitted, a nurse from the inpatient area comes down and takes the patient upstairs. "So our staff is able to continue

COMING IN FUTURE MONTHS

- Are AEDs less effective than traditional defibrillators?
- EDs share keys to improving handoff communications
- ED celebrates recovery with trauma patients
- Ambulance "garage" used to handle patient overflow

seeing new patients," Hildebrand says.

One difference between St. Anthony and Enumclaw, notes Dickson, is that his staff is too small to allow a dedicated triage nurse. "We have two RNs 12 hours a day and three the other 12 hours," says Dickson, adding that they basically take turns as the triage nurse.

When patients present at Enumclaw, one of two registration clerks take down the chief complaint and "quick-reg" the patient to give them an account number. "They then call the team intake [triage], and they come and take them either straight back to a patient room or to a triage room, depending on their triage level," says Dickson.

Level 4 or level 5 patients, who are seen in the triage area, then wait outside the X-ray and lab areas (which are not in the ED), sitting on waiting benches provided for them until their results are back. ■

'Train ticket' tracks patients

In the ED at Enumclaw (WA) Regional Hospital, lower acuity patients are provided with a form that is called a "train ticket," which helps staff keep track of the progress of their care.

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 this activity with the March issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a letter of credit. When your evaluation is received, a letter 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

19. According to Sandra M. Schneider, MD, FACEP, president of the American College of Emergency Physicians (ACEP), the gold standard for ED training is:
A. A minimum of five years working in an ED
B. ED residency
C. At least 250 hours of clinical training
D. Observation by an ED attending

20. According to Mark Rosenberg, DO, MBA, FACEP, chairman of emergency medicine at St. Joseph's Regional Medical Center, skilled use of which drug is an important element of end-of-life care?
A. Morphine
B. Methadone
C. Dilaudid
D. All of the above

21. Gregory Henry, MD, FACEP, risk management consultant for Emergency Physicians Medical Group, cites several actions ED staff should take if they determine a patient is a suicide risk. Which of the following was *not* among them?
A. Remove harmful objects from the room.
B. Check the patient for instruments or materials with which they might harm themselves.
C. Give the patients lots of quiet time without interruption.

22. According to Margarita Pena, MD, FACEP, the ED director at St. John Hospital and Medical Center, what strategies can be used to increase compliance with guidelines such as those recently introduced in the department governing the insertion of urinary catheters?
A. Cultural change
B. Giving regular feedback and reminders
C. Updating new nurses and rotating physicians
D. All of the above

23. According to Eric Bachenheimer, MHSA, MBA, FACHE, director of ED Solutions, simulations enabled the ED managers at Hudson Valley Hospital Center to predict several important factors. Which of the following was *not* among them?
A. Acuity
B. Walkouts
C. Patient-to-nurse ratios

24. The ED at Enumclaw Regional Hospital uses a five-level triage system. According to Richard Dickson, RN, the ED manager, an examination of the records of the patients who had left before being seen indicated that on average, they were classified on what level?
A. Level 1
B. Level 2
C. Level 3
D. Level 4

"As soon as they are done with 'team intake,' or triage, the nurse will check a box indicating triage is complete and ask them to take the form with them, because when they sit on their bench outside of X-ray, where they wait for results, the techs will come and look for people with these pieces of paper in their hands and initial them when the labs or X-rays are completed," notes **Richard Dickson**, RN, the ED manager. *[A copy of the form can be found in the online issue of* ED Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Dickson says the form grew out of a series of weekly interdepartmental meeting that were held as a new patient flow process was being launched. "The key to getting staff onboard is involving the registration department, the lab, and imaging to get buy-in," he says. During the weekly meetings, comments were solicited about the process. "We thought we knew everything, but they threw out the ticket idea and said 'What about this?'" Dickson says. "It's been invaluable." ■

CNE/CME ANSWERS

Answers: 19. B; 20. D; 21. C; 22. D; 23. A; 24. C

2010 SALARY SURVEY RESULTS

ED Management®

Best Practices – Patient Flow – Federal Regulations – Accreditation

Salary 'logjam' breaks, compensation improves although economy does not

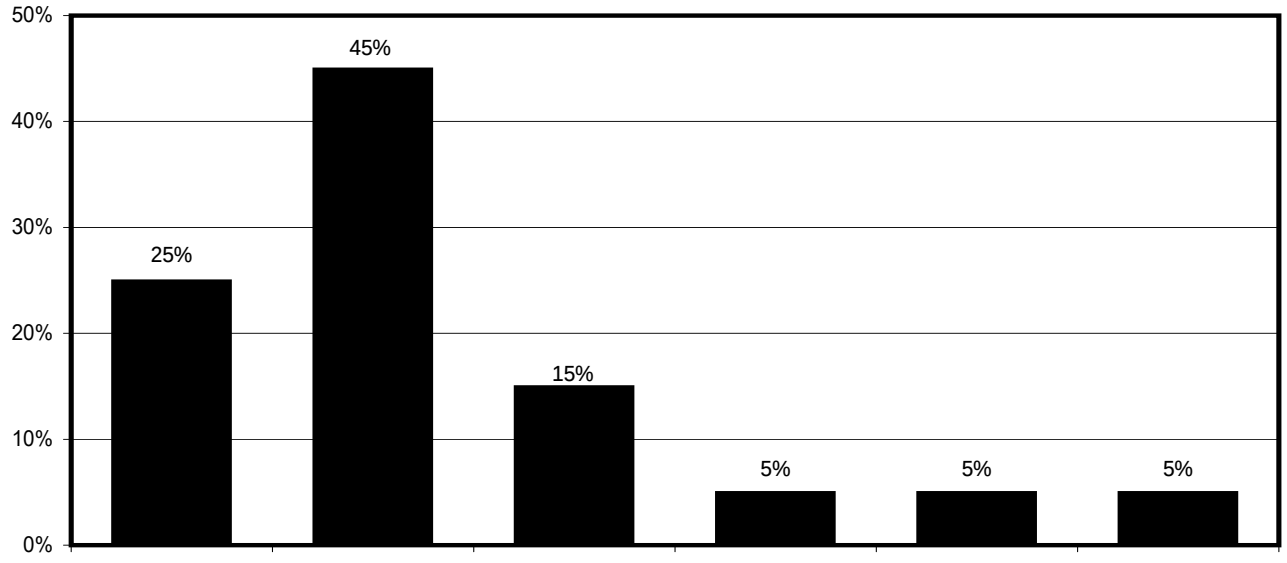
Something had to give. After several years of stagnation or even decline in compensation for ED managers, salaries have begun to improve, according to the *2010 ED Management Salary Survey*.

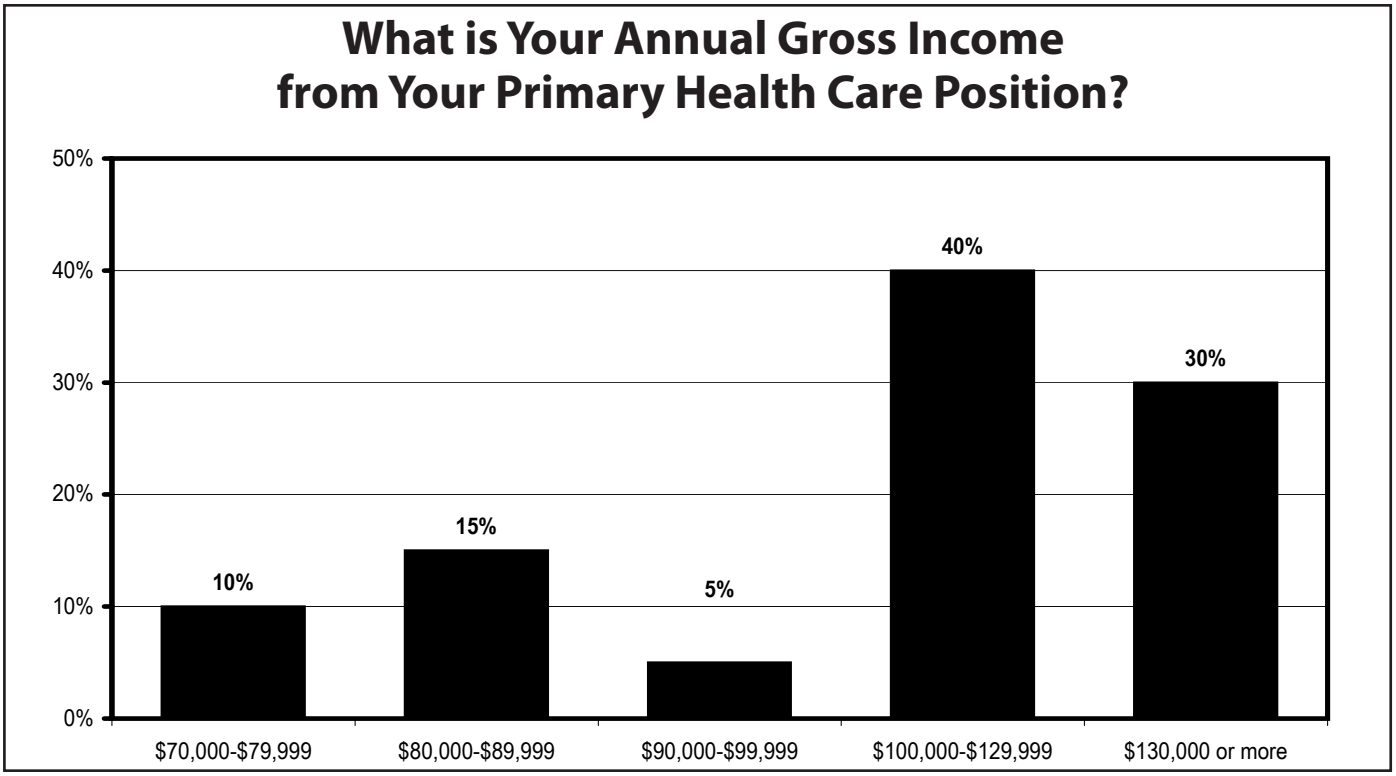
Survey responses indicated that only 25% percent of respondents saw no change in their salary, while the *2009 EDM Salary Survey* showed 36.96% saw their salaries remain the same. Conversely, while only 2.15% of the respondents in the *2009 EDM Salary Survey* said they had received an increase of between 4% and 6%, that figure more than doubled in the *2010 EDM Salary Survey* to 5%. Another 5% reported an 11% to 15% increase in 2010, and 5% more said their increases were between 16% and 20%. (*See the chart below.*)

For the 2010 report, 582 surveys were disseminated. There were 20 total responses, for a response rate of 3.4%.

"Last year everybody pulled back, and finally after another year had gone by they said, 'We have to do something for these people,' so they gave an increase — and that makes sense," says **Michael D. Bishop**, MD, president and CEO of Unity Physician Group, a Bloomington, IN, firm that staffs hospital EDs in Indiana and Kentucky and owns and operates urgent care centers in Indiana. "The market is still tight to get people. To be

In the last year, how has your salary changed?





perfectly honest, the health care reimbursement business has not changed much in the last couple of years, but hospitals just had to do something."

Mike Williams, MPA/HAS, president of the Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services, says "The survey results are almost spot-on with what I'm seeing. I am seeing it largely because of market trends and a demand for capacity."

Sometimes physicians are getting calls asking if they can fill a management position temporarily, Williams says. "In reality, looking at what the market is, you have to either make competitive offers or grow your management team from within, if that's possible," says Williams.

Diana S. Contino, RN, MBA, FAEN, senior manager, Deloitte Consulting, Los Angeles, sees similar trends on the nursing side. "The salary numbers appear to make sense. They follow industry trends," she says, "But let's also look at the staff RN salaries as they relate to the director/managers' compensation. Mean annual salaries for all staff RNs, according to industry national benchmarks, range from $53,000, 25th percentile, to $78,000, 75th percentile."

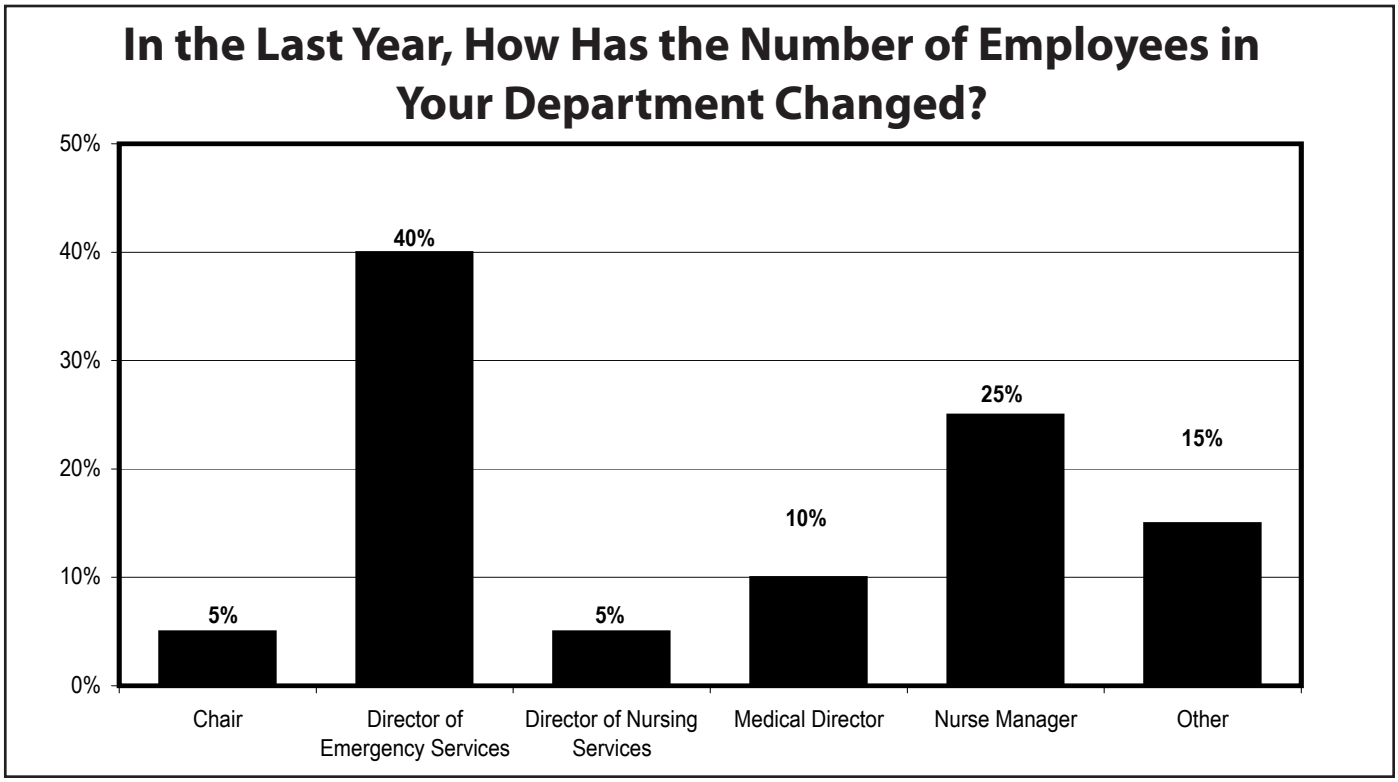
There are also geographical variations, she points out. California, for example is on the high end for RNs with average annual salaries benchmarked at $85,000 (approximately $42 per hour working 40 hours, 50 weeks per year). Nurse director/manager compensation should be higher than hourly staff RN salaries. Ranges are usually commensurate with that compensation.

"As an example, if a director/manager's compensation is $100,000, the difference between the staff RN — CA 75th percentile of $85,000 — and the director/manager is $7.21 an hour," says Contino. "ED directors/managers have to decide if the added responsibilities are worth the compensation differences."

The survey indicates 75% of the respondents work between 46 to 60 hours per week. (*See the chart on p. 4.*) "This actually reduces the director/manager's hourly rate to $43 to $33 respectively," Contino notes. Many individuals feel they have a higher quality of life as an hourly staff nurse as opposed to the manager/director's increased workload, she explains, and equal or lower compensation than staff nurses is less than desirable.

"In my experience the organizations with salary ranges 25% to 50% greater than staff have increased success with filling positions and retaining managers," says Contino. She says that work environment also plays into director/manager recruitment and retention strategies.

Most often the higher salaries are commensurate with the local economic pressures, employer financial stability, and span of responsibilities – e.g. multiple departments, volume, complexity of service, adds Contino. "A nurse director/manager making less money may have fewer direct reports, minimal budget responsibilities, and limited 24-



hour call responsibilities," she says.

Salary increases were especially evident in the higher ranges, according to the survey. For example, 40% of the respondents said they earned between $100,000 and $129,000, compared with 21.28% in the 2009 survey. And 30% reported salaries of $130,000 or more, compared with 10.64% in 2009. This was matched by a corresponding drop in those earning between $90,000 and $99,000, from 14.89% to 5%, as those managers moved into the higher levels. In the $70,000 to $79,999 and $80,000 to $89,000 ranges, where only 25% of the respondents fell, responses for 2009 and 2010 were nearly identical. (*See the chart above.*)

"There are a lot of firms out there recruiting nurse managers or specializing in that work because there is high demand, but not as many nurses are available, and that takes a lot more aggressive recruitment and compensation packages," adds Williams. "We've seen a large number over $125,000, but with what I see, you're talking about mature, experienced people with children in high school or college."

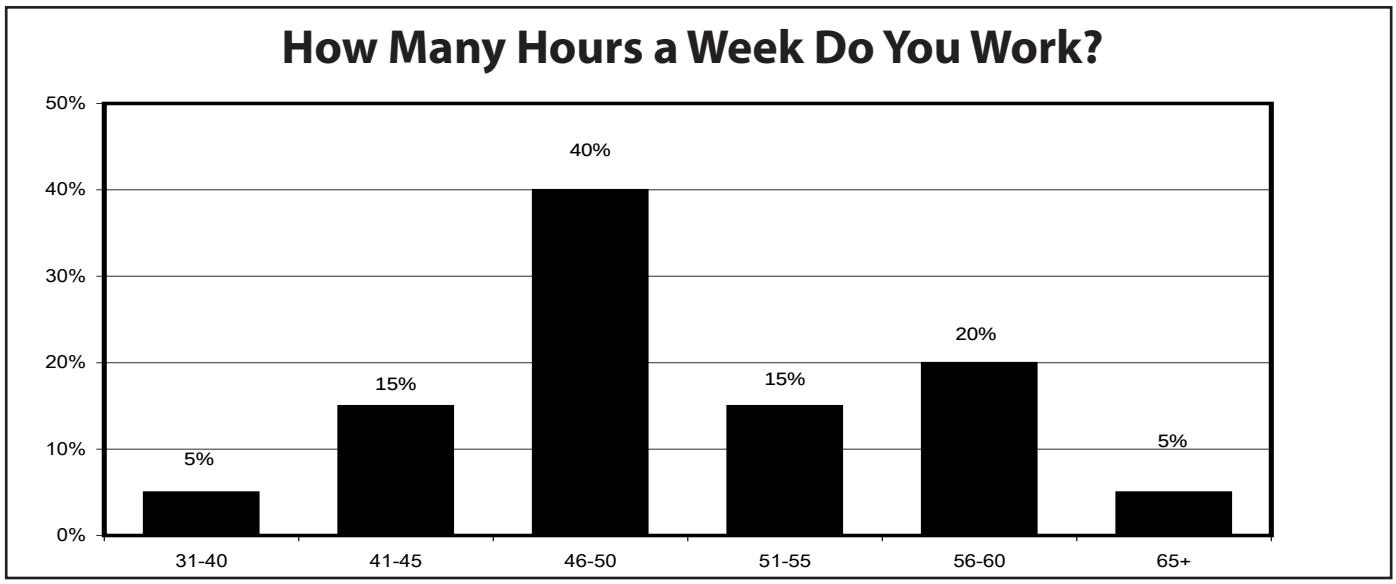
As Contino's comments indicate, managers seeking the higher salaries are expected to take on greater responsibility. But, notes Bishop, this is a two-way street.

"On the high end of the spectrum are medical directors and people taking on more responsibilities for both their groups and the hospital," he says, "So the hospital administrators have to come along and say if we want this doctor/manager/administrator/medical director to go to more hospital meetings, meet more with staff, and do less clinically, we have to pay them something because they are not able to see as many patients."

That lost income is often not replaced dollar for dollar, however, Bishop observes. "You are not going to be paid the same for going to staff meetings as one might be able to generate taking care of trauma patients, for instance," he says. Still, hospitals are requiring more of their physician medical directors. "They are looking at more quality assurance, quality improvement efforts, more time working with their group on such things as patient satisfaction and more integration of what's happening within the medical staff as well as within their own staff within the ED," says Bishop.

While they are willing to lay out more money for ED managers, "hospitals are looking for more bang for the buck," echoes Williams. "Long ago it was acceptable for an ED manager to staff the department, keep track of complaints, and manage the challenges of shifts." Now, he says, there are much stronger and more complex expectations in areas such as throughput and customer satisfaction, which do not always have simple answers. "It takes a person who is more system-oriented, actually, a management engineer," he says. "Most hospitals don't have them, so every department head has to be one."

His local ED manager has a master's degree



in informatics, says Williams. "You need those skills, or you need to have a valuable partner who does," he notes.

This need is no less true of nurse managers, Williams adds. "There are increased demands to improve customer satisfaction, but no clear roadmap on how to get there," says Williams. "It takes a nurse manager who can not only look at overall scores but sub-scores, and determine what needs to be done." For example, he notes, it could involve daily rounding to see where the bottlenecks are and identifying the most common patient complaints.

Clinical care in the ED also is changing, Williams says. "We have brand-new cardiac resuscitation protocols that didn't exist before and pressure to improve survival rates," he notes. "Test ordering is coming under more scrutiny. CT scans, once thought to be necessary, are now a source of concern as to whether EDs order too many of them." It takes a fairly self-sufficient manager to not just manage shifts and take care of the department, but to also manage these protocols and make them successful, he says.

On top of that, as the survey shows, ED managers are being asked to do more when often they have less help. While 57.9% of survey respondents said the number of employees in their department increased in the last year, 42.1% reported their staff had either decreased or not changed at all.

The trend of nurses leaving hospital positions to enter different fields is still significant, especially in the information technology sector, says Contino.

"Several of my colleagues have gone to work for professional services/consulting firms and vendors to assist with implementing electronic medical records and other technologies," she notes. "ED nurse directors/managers are also central to the healthcare reform initiatives including meaningful use, so there is increased pressure to leverage information technology and analytics to manage populations."

This situation is a two-edged sword, Contino notes. "In the short term, it contributes to hospital personnel turnover," she says. "In the long run, if those individuals re-enter hospital employment, they bring a vast array of experiences and expertise into work environments in desperate need of these skills."

Labor statistics report the projected growth is in physician offices, nursing care facilities, and home health, Contino says. Hospitals are expected to be in last place, with growth about 17%, she says. New graduates are struggling to find jobs, and in some communities, 40% to 50% are not employed two to three months after graduating. However, she notes, "the survey indicates the majority of ED managers have 25 years-plus in the industry, and 60% are between the ages of 51 and 65, which indicates they are among the group planning to retire in the next five to 10 years, so overall the long range outlook for nurses is very positive."

Because of high unemployment rates, her clients are not experiencing high vacancy rates, she says, but many organizations still have similar turnover rates. "In some organizations it ranges between 10%-15%, and among male nurses, turnover is reported as significantly higher," Contino reports. *(See the chart on p. 2.)*

All in all, Contino says, there is an excellent outlook for job opportunities once the economy stabilizes. "In fact, if, as the survey indicates, the majority of ED managers have 25 years-plus in the industry, that group will be among the group that retires, so we have to start finding ways of effectively grooming people for managerial positions," says Contino. ■

FOLEY CATHETER PROJECT

Avoiding Unnecessary Foley Catheter Placement in the Emergency Department

Goal:

- **Decrease placement of unnecessary Foley catheters**

Background:

- 80% of hospital-acquired UTIs are from a Foley catheter
- Half of Foleys placed do not have a valid reason

Acceptable Indications for Foley Placement:

- Urinary flow obstruction (prostatic hypertrophy, hematuria with clots, urethral stricture, trauma to area involved)
- Neurogenic bladder, including paraplegia/quadriplegia (if no straight catheterization is done)
- Urologic study or procedure
- Stage 3 or 4 decubitus ulcer with incontinence
- Hospice/ comfort care/ palliative care
- Severe hypoxia, requiring ≥ 6 l/min O2 (or 40% FIO2)
- Emergency surgery
- Acute hip fracture
- Intubated patients
- Unconscious patients
- Acute mental status changes with confusion or agitation
- Urine output monitoring, if being admitted to ICU
- Chronic indwelling UC from nursing home
- Pelvic Ultrasound (if emergently needed or patient unable to drink)

Non-Indications for Foley Placement:

- Incontinence
- Morbid obesity
- Dementia or chronic confusion
- Patient's request
- Nursing convenience
- Urine specimen collection

Avoid Placement of Unnecessary Foley Catheters

Always Use Sterile Technique when Placing Foley Catheters!

Source: St. John Providence Health System, Warren, MI

ST JOHN PROVIDENCE HEALTH SYSTEM

Emergency Department Patient Care Plan

	DEPARTMENT	An "X" in this box means you need tests from this department or completion of registration	Circle One of the Below Levels of Care				Staff Please Initial
			Level 3	Level 4	Level 5		
	Complete Registration Process						
	Laboratory Studies						
	X-Ray Studies						
	Please remain in the: "Emergency Department Patients Requiring Lab and X-ray" area before and after your studies have been completed. **A staff member will call you back to the Emergency Department once results have arrived**						

Thank you for seeking your care at Enumclaw Regional Hospital !

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