AMERICAN HEALTH CONSULTANTS®

ED Management®

The monthly update on Emergency Department Management

Vol. 11, No. 7

Inside

July 1999

Is your ED overcrowded? Reduce risks with these aggressive tactics

Delays caused by overcrowding may present significant liability

Overcrowding may be a way of life in many EDs these days, but that doesn't mean ED managers have to live with it. You can—and should—take action to ease the burden on your staff and patients, **Gregory Henry,** MD, FACEP, and other experts contacted by *ED Management* say.

All agree that overcrowding is potentially dangerous. The inherent delays can lead to poor outcomes and increased liability risks. Yet the problem doesn't have to be overwhelming. In fact, it should be viewed as a challenge, says Henry, vice president of risk management at Emergency Physicians Medical Group in Ann Arbor, MI. "I don't know any other industry that would complain about having too much business," he says. "If you went to a restaurant and wanted a table for eight instead of four, they would accommodate you. This is a numbers game, and people coming to us only adds to the power of emergency medicine."

The causes are varied. In large EDs, overcrowding is a consistent and dangerous problem, says **Robert Hockberger,** MD, FACEP, chair of the department of emergency medicine at Harbor-UCLA Medical Center in Torrance, CA. "As a large, public teaching hospital in Los Angeles, we have an ED that provides all levels of care, including follow-up care. Since it can often take weeks or months for patients to be seen in a clinic, patients choose to come to the ED, and we are always overcrowded," he reports.

Overcrowding often results from sick patients being housed in the ED for hours [while] waiting to be admitted because there are not enough inpatient beds for them, notes Hockberger. "Also, many of our patients just want access to care when the doctor's offices and clinics aren't open," he says. "The EMTALA federal guidelines basically preclude us from turning anyone away."

Other scenarios can result in an overwhelmed ED, such as local hospitals going out of business. "We've had a couple of large HMOs go out of business, and those patients who temporarily don't have a physician tend to use the ED instead," says **Sue Dill Calloway,** BA, BSN, RN, MSN, JD, director of risk management at Ohio Hospital Association in Columbus, OH. "We are also experiencing a significant nursing shortage, which is starting to create a problem."

During a recent flu epidemic, Columbus EDs reported record delays and overcrowding. "Like many other states, you couldn't pick up a newspaper with-

out reading how bad it was," says Dill. "Some hospitals were reporting eight-hour delays. We had three times the usual amount of patients coming in the door, which presented major liability risks."

Another factor is that the typical ED patient has become more complex, partly due to the "greying" of Americans, with a higher percentage of patients older than age 50. "It takes a lot longer to work up an 82-year-old patient who is dizzy than a 12-year-old who cut his finger," Henry notes.

Also, admitted patients are receiving their first hours of intensive care in the ED, and patients are being treated in the ED with more intensive treatments and sophisticated interventions, which prolong ED stays, Henry says. "There is a push to have more patients seen and discharged as opposed to admitted. That is changing the scope and dynamics of emergency medicine and increasing delays."

Often, long delays are unnecessary, Henry asserts. "You need senior people who can make clinical decisions promptly. Care delayed is care denied. Some patients need to be admitted before the work-up is done," he says. "When it comes to this issue, people tend to do a lot more whining than creative thinking."

Rather than whine, Henry offers the following creative ideas to help ED managers cope with overcrowding:

Switch to disaster mode. "We need to call disaster mode more often," argues Henry. "A disaster isn't just a train wreck or an airplane crash. It's any time your resources are overwhelmed, whenever you can't handle the patients in front of you. At those times when you need to deal with greater volumes, you need some reserve capacity so more personnel are thrown at the problem."

Increase pace of work. "Too often, there is a mindset on the part of doctors and nurses, particularly in city or county hospitals, of saying, 'This is all I do, I do this much and not any more: When the ED is overcrowded, that attitude is unacceptable," Henry says.

The physician mindset has to change in overcrowded situations, he says. "We have three speeds for working. We have the usual and customary speed, which includes banter and some interactive time. Then we have what I call the 'hustle mode,' when we're moving from bed to bed and have very little fun time. The last one is 'warp speed,' in which you're doing only what is necessary to get people moving in the system."

When confronted with a glut of patients, staff must increase their pace accordingly, Henry stresses. "If 22 people are brought in by ambulance, you need to decide in a minute what you are doing with each patient," he says. "You need to practice [at different speeds] depending on how badly you're overwhelmed."

In most cases, ED clinicians are not flexible enough, he says. "A lot of physicians have no ability to alter their speed of seeing patients, which is wrong. Every other profession does it. Restaurants have slow and busy nights, and so does the ED."

Have physicians do triage. "Doctor triage is not an unreasonable proposition in big hospitals," Henry suggests. "That way, the patient gets [all of his or her labs] going before they are seen in the back. [The physician in this position] can do lots of things, so when the patient actually shows up back [in the treatment room], all the work is done."

Create a holding area for patients. At Mount Carmel Medical Center in Columbus, OH, a holding area was created to reduce delays caused by overcrowding. "As soon as we decided a patient would be admitted, we take the patient to a holding area so beds [in the ED] would be open sooner," Dill recalls. "Now if I have a patient and find out they're being admitted, I make arrangements to have the history and physical done [after that happens]. Now instead of having six beds tied up for an hour [by patients waiting to be admitted], we put those six patients in the holding area."

Hire a float nurse. At Mount Carmel Medical Center, a float nurse facilitates treatment and discharge of ED patients. "Otherwise, the patient might sit there for 10 minutes waiting for his or her discharge instructions because the nurse was starting an IV or transporting a patient," says Dill.

Document overcrowded status on charts. "When you are backed up, I think it's perfectly appropriate to dictate right on the chart 'we are in a delayed or disaster mode.' You can't pretend you are giving out care you're not providing," Henry suggests. "Instead,

COMING IN FUTURE MONTHS

- Teach staff about low-cost alternatives
- Dual staffing in the ED
- Update on patient bill of rights
- Ensure staff are properly vaccinated

state up front, 'we are in an overcrowded, overloaded situation.'"

Doing this can reduce legal risks later, says Henry. "In court, everything is played out as if you saw one person at a time and had all the time in the world," he explains. "We need to demonstrate that's not how we do business. Nobody in court trials mentions the other 28 patients you saw that shift."

Enlist the help of other departments. The ED should get help from other departments as needed, says Henry. "There are people upstairs who are not overwhelmed. We tend to think of ourselves as lone cowboys, but we're not. Frequently, long delays occur because you can't get patients up to the floors," he notes.

Often other departments aren't supportive of emergency medicine, Henry argues. "Lab and x-ray need to be truly supportive to us, and not keep to themselves," he says. "They function without regard to patient wait time and outcome, which is ridiculous."

When your ED is overwhelmed, other departments, including admitting services, need to station staff in the ED to help out, Henry says. "We need to get bodies out before we get new ones in. Because it's dispositioning the patients, not seeing the patients, that holds things up."

Use observation units. "We are not utilizing observation medicine techniques to the greatest degree," says Henry. "There ought to be units where patients can be admitted directly that have nothing to do with floor services. That way, proper observation services can be done by the ED physician, and then we can get the patient out the door."

There should be standard work-up protocols on those patients, so they never have to go upstairs, says Henry. "The trend is toward having less and less inpatient beds and more rapid decision treatment centers, where we work up complex diseases and get patients out the door."

Start labs while patients wait. Even if delays are increased because of overcrowding, labs can be started while patients wait, Henry suggests. "Patients believe their wait time ends when they get started in the process, so sometimes that can be speeded up [by starting labs while they wait]."

Inform patients of expected wait times. At Harbor-UCLA, a sign is posted stating "No patients are denied care. All patients are seen in order of their medical acuity. Currently, patients without life or limb threatening problems will need to wait 'X' hours."

At triage, patients are informed of the approximate wait time. "There have been studies showing that patients are more likely to wait that long, and be satisfied, if in fact you are honest with them up front," says Hockberger. "We tell them 'we're not going to turn you away, and we would rather not refer you for an appointment for tomorrow. If you get sicker while you're waiting, please give us an opportunity to look at you again. And if you decide to leave, please come back to the triage nurse so we can make sure you're OK."'

Get buy-in from administrators. "Explain that the faster you [see] patients, the less chance there is that patients will sign out AMA (against medical advice), and you will recoup a lot more revenues," says Dill. "We were fortunate we had an administration which understood that patients are our customers and were willing to invest in reducing delays." ■

Reduce risks of patients who leave the ED

There are two distinct groups of patients that need to be tracked: those who leave against medical advice (AMA) who have already been assessed and choose to leave, and those who leave without being seen (LWBS). "Both groups present significant liability risks," says **Robert Hockberger,** MD, FACEP, chair of the department of emergency medicine at Harbor-UCLA Medical Center in Torrance, CA.

LWBS patients sign in, register, have a chart generated, sit in the waiting room, and after a certain amount of time they choose to leave. "They have never given us the opportunity to assess them," says Hockberger.

For these patients, the approach has been to shorten waiting times by referring less acute patients elsewhere, which makes it less likely they will leave, Hockberger says. "However, between 10 and 20 patients still end up leaving each day without being seen," he reports.

Ways to lower your liability

Document thoroughly. "If the patient is not going to stay, we have them fill out forms to document that we've done the right thing," says Hockberger. "We've come up with a satisfactory Plan B. For example, if we thought they needed to be admitted for IV antibiotics, we tell them, 'OK, we understand you don't want to do that, but we are going to send you to a referral center and we will call to check on you in 24 hours.'"

Know the five-part legal test for AMA patients. "If you follow this and patients leave AMA, you will basically never lose a case [should one go to court]," says **Gregory Henry,** MD, FACEP, vice president of risk management at Emergency Physicians Medical Group in Ann Arbor, MI. The process is as follows:

1. The patient must be of sound mind and have the capacity to make the decision to leave.
2. The patient must be of mature years, considered an adult or emancipated minor.
3. The patient must be told what you are thinking and given a potential diagnosis in a language he or she can understand.
4. The patient must be given alternatives.
5. Involve family or friends to take responsibility for the patient when the patient leaves or help you to convince the patient to stay.

Signing an AMA form is only part of the process, says Henry. "ED physicians always make the mistake of having someone sign a piece of paper, but they don't go through the legal process. If you fulfill all [of the steps in] the process, you're in good shape," he stresses.

Track number of AMAs. "We track the number of people on day-to-day basis who LWBS. Of those, the number we call back runs about 10 a day, although it varies from five to 30," says Hockberger. "We use that number as one parameter of our overall efficiency."

Convey risks to the patient. You need to clearly explain to AMA patients what would happen if they don't stay in language they can understand. "Explain, 'You could have permanent tissue damage because we are not going to reperfuse your heart,'" says **Sue Dill Calloway,** BA, BSN, RN, MSN, JD, director of risk management at Ohio Hospital Association in Columbus, OH. "Write right on the form, 'The patient has been informed that a risk of leaving is death.'"

When documenting, use the exact words you say to the patient, says Dill. "The most important thing is not

Use UCC to address overcrowding in ED

To address overcrowding, Harbor-UCLA Medical Center in Torrance, CA, built an urgent care center (UCC) that triages 18,000 patients a year from the ED. Patients with conditions not requiring immediate medical attention are triaged to a UCC. In the ED, traditional triage is followed by a secondary medical screening exam, to identify patients who can be seen at a later appointment or the following day at the UCC, **Robert Hockberger,** MD, FACEP, chair of the department of emergency medicine explains.

The UCC is open from 9 a.m. to 5 p.m. Monday through Saturday. "A lot of our patients come in after hours. So when patients come to the ED, we triage them into one of five levels of care: level one is critical, two is emergent, three is urgent, four is non urgent, and five is chronic," Hockberger explains.

In addition to triaging out patients who don't require immediate care in the ED, the system ensures that uninsured patients who have no other options for care don't fall through the cracks, reports Hockberger. "Many of these patients are working during the day at low paying jobs or have to take care of young children or older people at home, and their schedule may not be able to correspond with hours that the clinics are open," he says.

"[The UCC] is one way we have been able to unload our lower acuity patients, who come to us primarily because they have no other options," says Hockberger.

Patients identified for the UCC

Patients who receive a rating of 4 or 5 based on the nursing assessment are offered the option of waiting to be seen in the ED or of being scheduled for a specific appointment in the UCC. "If a patient comes in early in the morning, we usually assign them for an appointment that day, but we do send some people home to come back the following day," says Hockberger.

Initially, [the referral system was tested] on a trial basis. "If we found that a substantial amount of patients wouldn't take the referrals, we probably would have had to hire the extra staff [to keep the UCC open longer]. But enough people do take the referrals, so this system has worked for us so far," Hockberger notes. "We thought it was the more appropriate way to go, than to hire additional staff to keep the UCC open until midnight."

A system was implemented to avoid violating EMTALA requirements, Hockberger notes. "We put together a committee of physicians and nurses and developed guidelines to perform a medical screening exam at triage, which is done in greater depth than our usual triage. This was adopted by our medical committee as policy," he explains.

If patients choose to take the appointment, the triage nurse performs the medical screening exam. "If that confirms they are a low-risk patient, we schedule the appointment. But if it comes up with something more than the superficial triage exam did, we elevate the patient to a higher level and see them as soon as we can get to them," Hockberger says.

An ongoing QI process ensures follow-up with patients that come back the following day. "If they don't come back, the nurse calls them to find out why didn't keep the original appointment, and encourages them to make a second appointment," Hockberger says. JCAHO surveyors recently found the system acceptable, he adds. ■

only to tell them they've been informed of the risks but also what the risks are specifically," she notes.

Patients can still sue you, but their case will not be strong if they have been fully informed of the risks, Dill explains. "You can't restrain them and force them to have treatment, and if 50 patients walk in the door at once, there is no physical way you can treat all of them without delay," she says. "If you tell them what the risks are, the law says they have the right to refuse any treatment. It just has to be an educated refusal."

Mention insurance coverage. "Most states permit you to tell the patient that their insurance company won't pay if they sign out AMA. So you can say to a patient, 'You might want to check with your insurance company to make sure they'll pay if you leave against medical advice,'" recommends Dill. "However, a couple of states, including Texas, actually have a law that prohibits you from doing that, so you need to know your state laws."

Monitor patterns related to AMAs. AMAs should be tracked by shifts and individual practitioners. "You need to identify patterns. It may be that a specific physician is responsible," says Dill. "When we looked at our data, we found that one particular physician was linked to a high number of AMAs, and the hospital eventually used that data to terminate her."

Bar graphs can be used to track patterns and give you insight into why patients are leaving AMA. "You should track where the patient left in the process: for example, did they leave before they came back, or were they in the middle of getting t-PA for a stroke?" recommends Dill.

Determine wait times of AMAs. It is a JCAHO and HCFA standard to record the date and time patients arrived, which can help you track how long AMA patients waited before leaving. "You should also be documenting the time they left," Dill recommends. "It's important, because if an AMA patient waits 15 minutes, it is not significant, but if the patient was waiting six hours, you have a problem."

Post a sign explaining that seriously ill patients are seen first and not in the order they arrive. This can reduce liability risks, says Dill. "However, a malpractice suit could still be successful if they can show you are chronically understaffed, with a pattern of short staffing," she notes. "The plaintiff's attorney could argue you were inadequately staffed, and knew it was a problem, which led to a poor outcome."

Give AMA/LWBS patients referrals for return visits. At Harbor-UCLA, The attending physician on the night shift reviews the charts of LWBS patients. "They call to request that the patient returns to the ED to be seen. We automatically give those patients a triage rating one level higher, from a scale of 1 to 5, because we don't want people to go without care," says Hockberger.

Some patients decide not to take the referral. "The most common scenario is when a patient working in a low paying labor job with no medical insurance comes to the ED in the evening. It doesn't make sense for them to return the next day because they have to work. So sometimes these people will wait four or six hours and just leave."

Generally, those patients don't pose significant risks because they usually come in with chronic conditions, says Hockberger. "If someone came in with a rash they've had for three months, we wouldn't do anything about that," he explains. "But if a patient came in complaining of about chest pain, we would routinely get that person to come back in."

Another example of a patient who would be called back and raised a triage level is someone with an urgent, abdominal pain with suspected appendicitis, says Hockberger. "They haven't been here long enough to determine whether they have gastritis or appendicitis. They never got a medical screening exam, because we told them to wait, we got backed up, and they chose not to wait," he explains. "That's why we decided to be very cautious and bump them up a level."

If the patient is going to leave, a medical screening exam is performed. "That way we can make some judgment at that point. The triage nurse contacts the attending physician, and says, we have a patient with stomach pain who has been waiting for four hours. They're now saying they're going to go home, what do you want me to do?" says Hockberger.

Usually the physician will raise the patient's triage acuity rating one level higher. "But we try to do that off to the side in a separate room, because we don't want our patients to learn that if they complain and threaten to leave, they will automatically be given a higher priority." ■

Onsite visits identify ED-specific issues

Onsite visits by risk-management personnel can reduce liability risks for your facility and/or individual practice, says **Craig Self,** MBA, director of practice operations for Premier Health Care Services, based in Dayton, OH. "Through this process, we reduce risk exposure for our physicians and, in turn, for our hospital clients," he says.

There are eight components to the group's risk-management program:

Section 1: Physicians and physician assistants attend a nationally sponsored risk management course.

Section 2: A biannual, high-risk topic seminar is held for all ED physicians in the organization. Category 1 CME activities include [learning about] actual clinical cases from the group's practice, which are presented by the attending physician involved and then compared to similar cases in the court system. Past topics have included chest pain, sepsis, abdominal pain, and trauma.

Section 3: A incident reporting system is utilized at the ED sites and reviewed by the medical director in cooperation with the hospital's risk manager.

Section 4: Occurrence screening is coordinated to allow high-risk areas to be periodically screened to make sure the "system" is working properly. This has included areas such as equipment failure and treatment/procedure complications.

Section 5: Our credentialing department coordinates efforts with the hospitals and monitors licenses and the national practitioners' database.

Section 6: A comprehensive customer service and complaint management program complemented the risk management program. Collection of data from the EDs is annually assessed and trends noted. The customer service training program provides on-site presentations to physicians.

Section 7: On-site ED evaluation tours are conducted to uncover potential risk management issues.

Section 8: The group's documentation improvement initiative is coordinated by a physician led task force and reviewed locally by medical directors.

On-site ED evaluation visits result in reduced risks, with more than 40 areas targeted, Self reports. Key areas include: x-ray and EKG overreads, patient care policy and procedures, staff responsibilities, EMTALA [requirements] , treatment times, discharge instructions, quality improvement projects, and specialist coverage.

Site visits are divided into two components: an interview session and a review of documents section. "During the interview period, we discuss operational issues that, based on previous experiences, may provide some exposure for the physicians or our hospital clients," says Self. Pertinent issues are discussed with the medical director, ED manager, hospital risk manager, and other administrators.

Some of the topics discussed include credentialing, informed consent, EMTALA, documentation, patient satisfaction, and safety/security. "Rather than reviewing specific cases from the past or present experience of that particular ED, we focus more on current trends and 'best practices' which will reduce the medicolegal risks for that ED and hospital," says **Thomas Syzek,** MD, FACEP, the group's associate director for risk management.

The document review process includes double-checking credentials in employee files and reviewing charts for select high-risk patients, the hospital's mission statement, disaster plans, and departmental policy and procedure manuals.

Several patterns have been identified from the onsite visits. "Although a Level-1 trauma center and an ED that sees 6000 patients per year each have different exposure areas, we have identified some common themes," Self notes. These include immediate availability of dictations, informed consent, medication mishaps, documentation, telephone advice, and discharge instruction consistency.

Many variables affect the cost of malpractice insurance, including past claims experience (i.e., number, frequency, and severity of claims and suits brought against the group), location (this accounts for regional differences in claim frequency and severity, as well as any state laws limiting or controlling malpractice lawsuits), size of group, census and acuity of patients seen, type and amount of insurance coverage, amount of deductible and any self-insurance, and a whether or not there is a comprehensive risk management program, says Syzek.

This corporate-wide approach is less than two years old and significant statistics or trends are not yet available, says Self. "However, since we developed this in cooperation with our malpractice carrier, they have recognized our efforts and our current average cost per patient is well below the national average. Based on level of service, our cost ranges from $2 to $3 per patient," he reports.

Reducing legal risks with onsite assessments cut costs of malpractice insurance, says Syzek. "Claims, suits, and settlements are costly, so our ED groups pay out lower premiums," he says. "Detailed risk management assessments in the ED will result in cost containment. It's a collaborative effort between the hospital administration and the ED staff to reduce risk, reduce cost, and increase patient satisfaction," says Syzek.

The site assessments improve patient care and reduce risk and liability for the hospital, says Self. "By evaluating areas we have discussed, departments can focus on minimizing their exposure," he stresses. "Including risk management education as an important component to a continuing education program for the entire ED staff is also important."

A team approach is crucial, Self emphasizes. "We are also planning to start a 'Risk Management Topics' newsletter and quarterly mailing to our physicians

regarding key issues, recent publications, or generalized information that would be of benefit," he says. "This can be done at any ED with input from the physicians, nurses, and hospital legal counsel."

After the site visit, a report addresses areas of strength and weakness for each ED.

"Some typical questions posed to an ED manager are 'How do you handle x-ray overreads, EKG overreads, and positive lab results that come back after the patient has left?'" says Sizek. "If you have missed a fracture and do not have a process for that, it may result in poor patient outcomes and increased liability," he explains.

High-risk areas are identified, such as chest pain, missed fractures, pediatric fever, foreign bodies in wounds, and ectopic pregnancies. "We target these areas and look for processes to address these risks, and reduce the number of lawsuits," says Sizek. "We have the lowest suit rates of any group in the country. As a result, we are able to negotiate very competitive rates with our insurance carriers." ■

Educate on-call consultants about EMTALA

On-call physicians are currently the largest single source of EMTALA citations in the country, reports **Stephen Frew,** a Rockford, IL-based health care attorney. "The level of citations are heavy and the focus of the regulators regarding on-call consultants is broad for many hospitals."

Violations have increased in large part due to the ignorance of consultants about EMTALA, notes Frew. "Historically the consultants view EMTALA as being entirely an ED problem, and did not understand that it also applied to them," he says. Also, there is a greater awareness by receiving hospitals about requirements to report violations, which has increased the number of citations.

Consultants may be ignorant of EMTALA requirements. "Personally, I am repeatedly surprised at how oblivious our colleagues can be on these issues," says **Larry Mellick,** MD, FAAP, FACEP, chair and professor of emergency medicine at the Medical College of Georgia in Augusta. "For some reason it isn't on their radar screens, and when they are made aware of the requirements they are absolutely incredulous that there is such a law."

Here are responsibilities of on-call consultants under EMTALA:

- They must participate in the call system if required by the hospital.
- They must be capable of being contacted and making a response to the hospital. There is no fixed rule on response time, but it's generally 30 minutes for a stat response, and 60-90 minutes for a routine response.
- They must respond to the hospital to provide care, rather than having patients sent to their office.
- They have a responsibility to accept all patients within their privileges.
- If the ED physician declares a need for the consultant's presence, he or she is required to respond. The consultant may not substitute admission of the patient for coming to the ED. They must respond within the time period before making the decision to admit the patient.

In HCFA's region 9, which includes the state of California, more than half of EMTALA alleged violations involve on-call physicians. "A lot of on-call consultants still don't realize their obligations under EMTALA," stresses **Larry Bedard,** MD, FACEP, director of emergency services at Doctors Medical Center in San Pablo and Pinole, CA. "I think most ED physicians understand the law better than the on-call consultants. We need to educate the medical staff about what their responsibilities are."

Consultants may be required in the ED for the following reasons:

Prolonged care is required. "Most ED physicians are well trained in plastic surgery techniques for repair of wounds. However, they don't have the time in a busy ED to do complex wound repairs," says Mellick. "The consultant may have special skills that are also owned by the ED physician. However, the ED physician doesn't have the time, or the family wants the 'specialist' to repair the wound."

Special skills or training are required. The ED physician can make the diagnosis of appendicitis as well as the surgeon, notes Mellick. "However, the ED physician can't take the patient to surgery. The ED physician is not asking for cognitive for intellectual guidance. The consultant has a special skill or training not owned by the ED physician," he explains.

Special information is required. Consultants may be needed to address the needs of a complicated patient with multiple, complex disease processes. "An example would be an HIV patient with TB," Mellick says. "An infectious disease consultant may be contacted for advice concerning the latest therapy guidelines."

Legal requirements for on-call consultants

EMTALA is very specific that the scope of on-call consultants must include all areas of physician practice that are rendered by the hospital on an active basis, says Frew. "That doesn't mean it's limited to the active medi-

cal staff category. What it means is that any medical services currently available to the public at that institution must be backed by on-call personnel," he explains.

Recently, HCFA held a Kansas City hospital responsible for a turndown of a transfer by a non on-call courtesy staff physician because the hospital had no on-call psychiatric staff to cover its psychiatric services. "At the time, they had no active psychiatric staff, so they were faced with a choice of covering it with general medicine on call, closing the unit, or hiring staff," says Frew. "This particular hospital elected to temporarily cover with internal medicine and has commenced hiring hospital-employed psychiatrists," he reports.

Another recent case involved a hospital that had acute dialysis available only on a scheduled basis. "They were cited for not having an on-call list for transferring a patient who needed acute dialysis. That meant that they did not have on-call capability, so that hospital chose to close its dialysis service," Frew explains.

Most violations involve hospitals that don't have consultants from all specialties on the call list, or don't include subspecialty calls, says Frew. "They are the ones running into the most trouble on the basis of an inadequate list," he explains.

ED staff seen as troublemakers

EMTALA may cause a rift between you and the medical staff. "In many instances, the ED physicians have been viewed as troublemakers for bringing this up, by disturbing the usual and customary practice that's gone on in the community," Frew explains. "The consultants want to shoot the messengers."

This misdirected anger may cause problems for your ED group. "If you alienate the medical staff, they may encourage administration get rid of your ED group and go to the competition. The ED group may be considered a contract and [seen as] dispensable, which can cause political tension between you and the medical staff," says **Charlotte Yeh,** MD, FACEP, medical director for Medicare Policy at National Heritage Insurance Company in Hingham, MA.

As a result, ED physicians are often reluctant to make waves. "Then when a violation occurs, the ED group is 'scapegoated' as the reason it occurs. So being quiet has an equal potential of costing them their jobs," says Frew.

Consultants may give no credence to the ED, because they are not private attendings. "I encounter that philosophy in a number of hospitals, which requires a cultural change," Frew says.

On-call consultants may not believe EMTALA applies to them. "They may believe that it's just an ED thing, or don't believe they can be forced to take a call. But if the hospital sets a call list and is a Medicare provider, their choice is to comply with EMTALA measures or not practice at the hospital," says Frew. "In a Phoenix hospital, virtually every plastic surgeon has withdrawn their privileges at regional hospitals because [of the increased responsibility for liability]." **(See related story on pg. 81.)** ■

Ways to manage conflicts

Be a leader. "You have two choices," says Frew. "You can either take an assertive leadership role, or sit back and hope the consultants don't do something you are scapegoated for."

It comes down to a tricky balance between asserting leadership and avoiding problems with consultants. "We have seen ED physicians fired over insisting on proper standards, and there is some litigation going on now with that issue," says Frew. "Some of these physicians had made extensive records to administration, which had gone ignored."

Ask consultants to do inservicing. EMTALA actually provides an incentive to medical staff to work closely with the ED staff, notes Frew. "This is because the ED physician's decision is the controlling one, not the consultant's," he stresses. "Therefore, it places a high premium on the on-call staff for getting along with and assisting the ED staff. If they think they are being called too quickly about a pediatric sniffle, then it's to the pediatrician's advantage to do inservicing with ED staff."

Act as information distributors about EMTALA. Distribute information to critical members of the medical staff, such as the hospital's chief of surgery or chief of staff, Frew recommends. "Be diplomatic by circulating third-party sources, so that you won't be viewed as an advocate," he says.

Identify a few medical staff opinion leaders. Educate the leaders about both the law and the implications for the hospital. "You need to have allies on the medical staff," says Frew. "Then let those allies carry the message through."

Typically, the medical staff's initial reaction is negative. "It will create controversy," Frew predicts. "It doesn't produce an instant interest in taking corrective action. It produces the attitude 'that can't possibly be right.' But [after that], the medical staff will probably bring in outside speakers to explain it to them."

Distribute information before you confront consultants about violations. "After [the information is distributed], when faced with a case, you can then stand your ground and say, 'no, we can't transfer this patient, you've got to come in,'" says Frew. "Since they already have the information, you can refer them to it."

Know exceptions. There are situations where the on-call physician doesn't need to come to the ED, says Yeh. "If the patient meets the definition of stable, they can be sent to the physician's office," she explains. "If the physician has special equipment in the office, it may be appropriate to send the patient to the physician's office. There is increasing capability at the offices, whereas certain services could previously only be done in the hospital."

Do data collection. Document every instance when consultants have refused to come in, or have ordered that the patient be transferred after asking about their financial situation, Frew recommends. "Bring that list of specific instances to administration. That doesn't always work, but at least you have done your job by alerting them," he says.

One ED physician sent administration a stack of data about on-call responses, where admissions in critical condition weren't seen until four to 18 hours later, says Frew. "He brought all the data to administrators, and they told him 'we don't see a problem,'" he reports.

Still, make sure everything is in writing. "You need to do this, because when the day comes that HCFA investigators show up and discover these violations,

Fewer physicians willing to take call

A California task force demonstrated more than half of hospitals have a serious problem with on-call physicians, reports **Larry Bedard,** MD, FACEP, director of emergency services at Doctors Medical Center in San Pablo and Pinole, CA. "In California, more than 40% of neurosurgeons are being asked to be paid for standing by, with some physicians getting paid up to $2,000 a day," he says.

Many hospitals are unable to afford these fees, and therefore, are experiencing shortages of physicians willing to take 'call.' "This has changed the whole dynamics of being on call," stresses Bedard.

There is also a disturbing trend of physicians trying to shirk their on-call responsibilities because of expanding responsibilities under EMTALA. "You can empathize with their desire to have an effective practice, on the other hand, the hospital can't eliminate a requirement that's put there by federal law," says **Stephen Frew,** a Rockford, IL-based health care attorney and consultant.

There are multiple reasons for this problem, says **Charlotte Yeh,** MD, FACEP, medical director for Medicare Policy at National Heritage Insurance Company in Hingham, MA. "The changes in reimbursement and recognition of specialty care is making it much harder," she explains. "Physicians have to be more productive during the daytime, so it's much harder to come in at night. There is the risk of no reimbursement even if the patient is insured, if it's the wrong network."

The potential for receiving stiff penalities for EMTALA violations is discouraging physicians from taking call, says Yeh. "For years, the on-call service was considered voluntary and part of the good will of physicians," she explains. "Now that you attach liabilities to that, it changes the whole character of the on-call system."

EDs typically used to be sources for physicians [who were on call] to build practices, but that has changed. "As you have more salaried physicians, the need to be responsive to the ED and build a practice is diminishing," Yeh notes.

Managed care exacerbates the problem, says Bedard. "We did a survey in our state and were surprised to find how many physicians relate this problem to managed care," he reports. "A plan may decide to pare the list of participating physicians so it doesn't renew the physician's contract. But the next time the physician's on call, the MCO's family practitioner asks them to take care of their patient's broken hip. Physicians have been abused by managed care plans, which then use EMTALA to force them to take call."

MCOs often do not reimburse consultants fairly. "Many payors have arbitrarily refused to provide payment for services required by EMTALA," Frew reports. "These folks are getting stiffed on their money on a routine basis."

No law forces a physician to be on call, but once consultant agrees to be on call, he or she has to respond in a timely basis, says Bedard. "According to JCAHO requirements, that usually means within 30 minutes by phone," he notes.

The on-call physician issue needs to be brought to the general public's attention, Bedard urges. "It may take a bad situation for this to become public. Unfortunately, a patient will probably have to pay dearly before this issue comes to light nationally, he says.

There needs to be a legislative solution to the problem, argues Bedard. "Patient advocate groups are getting more concerned with this issue as more adverse outcomes and problems occur," he says.

One potential solution is putting premium tax on managed care plans to pay the standby costs, based on their market share, to appropriately reimburse on-call physicians," Bedard suggests. Meanwhile, increasing numbers of physicians are likely to refuse to take call, he predicts. ■

you don't want to be held responsible for not doing what administration insisted on," says Frew. "I know of physicians who have left hospitals because their certainty that their personal EMTALA liability was going to be serious threat to their livelihood if they didn't leave."

Come to an understanding in advance. When you can, working it out prospectively is far better, says Yeh. "You do not want to do your education and challenges in the heat of the moment at 2 a.m. Engage the leadership of medical staff, and clearly delineate the responsibility of on-call physicians with respect to EMTALA [during down time]. Make sure they understand the types of cases it is appropriate for them to respond to in the ED," says Yeh.

Work with MCOs. "Your efforts may include working with third-party payors to make sure they understand the responsibility of on-call physicians, and therefore reimburse them if they respond appropriately," says Yeh.

Know documentation requirements for transfer. "If the ED is going to send a patient to a physician's office, that patient must meet the definition of stable. Or if they are not stable, then the ED staff must fulfill the transfer requirements showing that the benefits outweigh the risks," says Yeh.

Don't feel overwhelmed by the requirements for transfer. "When people get uptight about paperwork, I point out that it's a part of good medical practice," says Yeh. "When would you ever send a patient for care to somebody's office without calling the physician, making sure he or she will accept the patient, and sending along the medical records? Those are the essence of the transfer requirements."

Protect yourself when violations occur

An ED physician can be held personally liable for making improper EMTALA decisions, warns **Stephen Frew,** a Rockford, IL-based health care attorney and consultant. Physicians can be individually fined by HCFA for up to $50,000 per incident. "That is not covered by insurance, it is out of pocket," he stresses.

"The Office of the Inspector General has dramatically increased citations of individual physicians for EMTALA violations, which parallels their overall gearing up on patient transfer issues," says Frew. ED nurses are not individually liable, but the hospital can be liable for a nurse's actions as well, he notes.

There are other consequences for individual clinicians who violate EMTALA, says Frew. "These matters are reported to state licensing boards, and have resulted in actions against individuals," he reports. "Internally, it may also result in discipline, which could effect employment."

The law provides 'whistle blower' protection for ED physicians who act appropriately in response to violations, notes **Larry Bedard,** MD, FACEP, director of emergency services at Doctors Medical Center in San Pablo and Pinole, CA. "If you do not get an on-call physician to respond, work it through formal hospital policies and procedures. So if the surgeon doesn't respond, my next call will be to the chief of surgery, and the next call is to the chief of staff of the hospital," he says.

If you can't get the consultant to respond, you are required by law to report the name and address of that physician, Bedard stresses. "If you do this, the law protects you and you are absolved from responsibility. The responsibility falls back on that physician and the hospital. It's illegal for a hospital or another physician to retaliate against you," he says.

If you inform the physician of your obligation to report, they may decide to come to the ED, notes Bedard. "Say, 'The law requires me to report you, but I would rather you just came in and took care of my patient,'" he recommends. "I've done that half a dozen times. Every time I've informed a physician of that, they are surprised and generally promptly come into the hospital and take care of the patient."

Address the situation immediately, Bedard advises. "If you've got a physician who doesn't return calls while you are in the midst of the crisis, I think that needs to be referred to your QA committee. You should also file an incident report," he says.

Document the situation thoroughly. "Document that you have a consultant who is not calling you back. You need to document on medical records that the phone call was made and you didn't get a timely response," Bedard urges. "For example, write on the chart that the consultant later told you that his answering service didn't call him, or his beeper battery ran out."

When HCFA investigators review records, he or she will assume consultants were asked to come in. "If all it says is 'the physician was called,' they presume that was called to come in. If it doesn't say there was a phone consultation, they will assume he or she was asked to come in and failed to," says Frew.

Follow the hospital's chain of command. "After 30 or 45 minutes of waiting, call the chief of surgery and tell them, 'Dr. Smith does this all the time and you know it. If the response [from the chief of surgery] is 'don't bother me with this,' then your next call should be to hospital administration," says Bedard." ■

Be aggressive when necessary. "Take advantage of teachable moments," Bedard stresses. "Tell the consultant, 'If you absolutely refuse to come in, I will transfer the patient to a major medical center. But I need to inform you that I am required to report you, so give me your address because I have to put that on the form. And by the way, they can take you off Medicare for five years and give you a $50,000 fine, which is not covered by your malpractice insurance."

The law clearly says that the consultant must respond based on your clinical judgment, Bedard emphasizes. "The consultant at home may say, 'From what you describe, they sound stable,' but if there is any doubt in your mind, your response should be, 'Examine the patient yourself and then help me with the decision.'"

Err on the side of caution, Bedard advises. "My advice is, if you are caught between a rock and hard place and have a patient that needs a specialist, always do what is in the best interest of the patient." ■

Could you respond to these EMTALA scenarios?

Here are several common scenarios involving EMTALA violations and on-call consultants, with tips for managing each:

1. The consultant asks you to send the patient to his or her office. "The physician contacts the consultant, and they say, 'That's no big deal, send them to the office tomorrow,'" says **Stephen Frew,** a Rockford, IL-based health care attorney and consultant. "Sending the patient to the office for continued evaluation or acute definitive care is expressly forbidden. That triggers a violation and all three parties—the hospital, ED physician, and on-call physician—are in trouble," says Frew.

Other problems may be associated with this office referral request. "It is not uncommon for the patient to arrive in this setting only to be told that they cannot be treated unless they are able to pay a substantial part of the bill up front." notes **Larry Mellick,** MD, FAAP, FACEP, chair and professor of emergency medicine at the Medical College of Georgia in Augusta. This is an EMTALA violation because payment cannot be discussed before the patient receives a medical screening exam.

2. The consultant says he or she will come to the ED when they're done with office hours. That may mean he or she won't arrive for eight hours, which is unacceptable, says Frew. "HCFA requires that the medical staff bylaws include a definition of specific response times in numbers, which is typically 30 minutes, not general statements like 'reasonable length of time.'"

So if the on-call consultant responds in anything beyond that time frame, it's considered failure to respond in a timely fashion. "That will result in a citation against the hospital and the on-call physician," says Frew.

3. The consultant responds, "Admit the patient and I'll come over and see them later." "Once the request has been made to come in, the consultant has to come in within a reasonably accepted time frame," says Frew. "Often they may defer it late in the day, or the following day, which will result in problems."

A Missouri hospital was cited for a violation when the on-call physician didn't come in, despite repeated calls about an admitted patient having increasing pain, Frew reports. "Several hours later, the patient died of peritonitis, and it was determined that the consultant failed to respond in a timely fashion."

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to ED Management®, P.O. Box 740059, Atlanta, GA 30374-9815.

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Hours of operation:
8:30 a.m. - 4:30 p.m.

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4. The on-call asks about the means or source of payment, and then declines. "This situation can pop up sporadically in a residency training setting and seems to be part of the ongoing educational process for consultants," says Mellick. This is one of the most common educational opportunities for introducing EMTALA obligations to consultants, he adds.

5. The consultant is reluctant to see a former patient who has become dissociated from the consultant's practice. This scenario is a common question brought up by medical staff members, says Frew. "They consultant may become upset when they are required to see that patient. The consultant may arrange for somebody else to cover that patient, but if you can't do that, it is the consultant's responsibility [to see the patient] under EMTALA," he stresses

6. You call the on-call consultant's office, and the secretary says they're too busy to come to the phone, and they don't get the message for an extended period. "HCFA requires that the nursing staff [in the ED] log the time of the call and the physician's response," says Frew. "So time is running on that physician even though he or she isn't potentially aware of it. This comes down to an office management issue for those physicians."

7. The on-call physician asks for tests to be done and reviewed by internal medicine before they come to the ED. "Turfing off responsibility is not allowed. The consultant can't say, 'if internal medicine doesn't find anything, then I'll come in.' They still have to respond within the time period," says Frew.

8. After hearing a description of the patient's condition, the consultant says the patient is too severe for them, and needs to be transferred to another facility. "That came into play in a recent citation," says Frew. "HCFA determined that the only reason the consultant felt that way, was because it was 2 in the morning. They looked at the physicians other activities and concluded that he handled other equally serious cases without transferring the patient." ■

Readers are invited

Readers are invited to submit questions or comments on material seen in or relevant to ED Management. Send your questions to: Reader Questions, ED Management c/o American Health Consultants, P.O. Box 740059, Atlanta, GA 30374. Or, you can reach the editors and customer service personnel via the Internet by sending mail to: suzanne.zunic@medec.com. You can also visit our home page at http://www.ahcpub.com. We look forward to hearing from you. ■

CE objectives

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

1. Discuss and apply new information about various approaches to ED management.
2. Explain developments in the regulatory arena and how they apply to the ED setting.
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by one's peers.