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The monthly update on Emergency Department Management

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EMTALA reg eases overall burden, but on-call physician issues still unclear

Rule is clearer, scope narrowed to true emergency units

It's finally here, and it's mostly good news. The government recently released the final rule of the Emergency Medical Treatment and Labor Act (EMTALA), and the 262 pages offer many long-awaited clarifications that mean you no longer have to worry so much about issues such as when you must deliver emergency care within 250 yards of your hospital.

But don't throw out your EMTALA policies just yet. There still is plenty of bite left in the rule, and the final rule won't wipe away all your EMTALA-related frustration. The question of on-call physicians, for instance, still is difficult, and the final rule may have just made it worse.

Tom Scully, administrator of the Centers for Medicare & Medicaid Services (CMS), announced the new rule by saying that it "carries out EMTALA in a common-sense and effective way . . . ," and many ED professionals are sure to agree. **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care in the department of emergency medicine at Carolinas Medical Center in Charlotte, NC, says CMS achieved its goal of making EMTALA clearer and less burdensome, with some notable exceptions.

"They did it without jeopardizing the safety of individuals seeking emergency care," he says. "There's still plenty to get confused about, but part of that is due to

Audio conference clarifies final EMTALA regulations, provides valuable information

The final version of the recently proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) takes effect Nov. 10.

To provide you with critical information on the updated regulations from the Centers for Medicare & Medicaid Services, Thomson American Health Consultants offers **New EMTALA Regulations: Are They Too Good to Be True?** — an audio conference on Tuesday, Oct. 21, from 2:30-3:30 p.m., EST.

(Continued on page 118)

the discrepancy between what they say and how they enforce it. They can say all these things in the rule, but if the regional offices don't enforce it that way, we've still got problems."

The rule essentially limits the application of EMTALA to "what you and I think of as real emergency departments," Bitterman says. **(For more details on how an emergency department is defined, see story, p. 111.)**

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The new definitions in the rule have the effect of clarifying the vexing "250-yard rule" that many ED managers interpreted to mean they were obligated to provide care to anyone who showed up within 250 yards of the hospital campus. That led to many debates over exactly where the campus borders lay and how to measure the 250 yards, not to mention how the ED staff was going to leave and provide care. Bitterman says ED managers misinterpreted that rule in the past and created unnecessary policies and procedures, including how to respond when a person needs emergency care on a public street near the hospital.

The final rule makes it clear that such a scenario would not trigger EMTALA, he says. "If it's not hospital property, but it's within 250 yards of the ED, that doesn't count," he says. "It never did, really, but people thought it did. Now CMS is making clear that it definitely does not count."

That interpretation is seconded by **Charlotte Yeh**, MD, FACEP, CMS regional administrator in Boston and an emergency physician. CMS officials never applied the 250-yard rule to nonhospital property, even though health care professionals often interpreted it that way, Yeh says. The final rule makes clear that EMTALA applies only to dedicated emergency services, other hospital departments, parking lots and driveways, or other hospital property within 250 yards, she says.

"The outpatient regulations that came out in 2000 talked about a 250-yard rule, and it wasn't clear," Yeh says. "It appeared that everything in that 250 yards counted as hospital property, whether the hospital had ownership or any relationship to it at all. But this is clarifying that 250 yards to say what counts and doesn't count."

Thus, if you've been worried that you risk an EMTALA violation if you don't respond to a person

Executive Summary

The government's final Emergency Medical Treatment and Labor Act (EMTALA) rule clarifies and simplifies many issues that have frustrated ED managers, but there still are significant areas of concern.

- The rule clearly defines what facilities are covered by EMTALA, essentially restricting it to only true emergency departments.
- ED staff are not expected to render aid beyond hospital property.
- Physicians and hospitals have more flexibility in devising specialist on-call schedules.
- EDs may encounter more difficulty finding specialists, and those with physicians on call may be flooded with transfers.

injured on the street within 250 yards of your hospital, you can relax.

"If the person is across the street in the boutiques and shops, even within 250 yards, you have no legal duty whatsoever because that's not hospital property," Bitterman says.

In the not-so-good-news department, CMS declined to tell hospitals and physicians how to resolve their disputes about how to maintain an adequate on-call list of specialists for emergency care. That could turn into a real problem for EDs and patients, says **George Molzen**, MD, president of the American College of Emergency Physicians in Irving, TX. The omission creates uncertainty that could potentially increase the shortage of on-call medical specialists, and it could multiply the number of patients transferred to other hospitals in search of a specialist, Molzen says.

"Under the new rule, hospitals may not have to provide on-call medical specialists, such as neurosurgeons, orthopedists, and plastic surgeons, around the clock for emergency patients," he says.

Hospitals also can allow specialists to opt out of being on-call to the ED, Molzen says. "This means that patients in need of specialty care may need to be transferred to other hospitals," he says. "But the question is where? We already have a shortage of on-call specialists because of the medical liability crisis. This rule could exacerbate an already difficult situation."

The new rule potentially could leave only a few hospitals with medical specialists, which means those hospitals may be flooded with emergency patients, Molzen says. It could result in conflicts between hospitals over who will provide specialty care and result in delayed care or more transfers of patients, intensifying the ambulance diversion problem.

Bitterman says CMS gave hospitals and physicians maximum flexibility in determining how to handle the on-call list, "but to me, that's just maximum uncertainty. Hospitals won't know if they're in compliance unless they're reviewed and the government says they don't like it."

Though the final rule responds to many concerns by ED managers, it would be a mistake to think the CMS is bowing to pressure and weakening the law, Yeh says. "No one should look at this as a wholesale change or weakening of EMTALA," she says. "It's just really a much better balance and assurance that patients will get the necessary care without being overly burdensome to hospitals. This makes it more manageable."

For instance, Yeh says the final rule means that a mammography clinic does not have to duplicate —

Highlights of the final rule include definition of ED

The Baltimore-based Centers for Medicare & Medicaid Services (CMS) lists these highlights of the final Emergency Medical Treatment and Labor Act (EMTALA) rule:

- The new rule changes the definition of emergency department to mean any department or facility of the hospital, whether situated on or off the main hospital campus, that: 1) is licensed by the state as an emergency room or emergency department; 2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or 3) during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.
- CMS clarified the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff on-call lists. Under the revised regulations, hospitals will have discretion to develop their on-call lists in a way that best meets the needs of their communities. In keeping with traditional practices of community call, CMS says physicians will be permitted to be on call simultaneously at more than one hospital, and to schedule elective surgery or other medical procedures during on-call times.
- The rule confirms that hospital-owned ambulances may comply with citywide and local community protocols for responding to medical emergencies and thus be used more efficiently for the benefit of their communities.
- Hospital departments that are off-campus now can provide the most effective way of caring for emergency patients without requiring that the patient be moved to the main campus, when this would not be best for the patient.
- The final rule clarifies that EMTALA does not apply to individuals who come to off-campus outpatient clinics that don't routinely provide emergency services or to those who have begun to receive scheduled, nonemergency outpatient services at the main campus — for example, routine laboratory tests. Other regulations and state licensing laws already cover the hospital's obligations to patients in such circumstances.
- The rule clarifies that EMTALA does not apply after a patient has been seen, screened, and admitted for inpatient hospital services, unless the admission is made in bad faith to avoid the EMTALA requirements. This provision was adopted to conform to the decisions of five circuits of the United States Courts of Appeals. ■

Sources

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even in theory — the services provided by the ED because it does not meet the new definition of an emergency department. CMS intended to eliminate the unnecessary policies and preparations that some nonemergency facilities took just to avoid a possible EMTALA violation.

The final rule clears up one misunderstanding related to patients who came to the hospital for outpatient care such as lab tests, she explains. Because they were in the hospital, some people interpreted EMTALA to mean there was an obligation to provide screening — a burden, but one that some thought necessary.

"The answer is no. If you're coming in for a nonemergency medical condition, EMTALA does not apply and you can just go on to your rehab appointment," Yeh says. If you develop an emergency on your way to the appointment or need emergency help, then EMTALA applies, she says. "But if you're being treated in rehab and develop chest pains, then the other hospital outpatient conditions of participation apply, and you don't have to apply EMTALA," Yeh adds.

So what does an ED manager need to do in response to the new rule? Reassess where EMTALA applies in your facility, Bitterman advises. "Address that, so you can undo a lot of those ridiculous policies you had in place before. And also, the rule says you need to have a policy in place for when patients come to those facilities that are not considered emergency departments but they have an emergency condition. That's just common sense." **(For more information, see article, p. 118.)** ■

Blackout creates influx of patients, generator woes

Few traumas, more car wrecks and vent patients

When the lights go out, brace yourself for a surge in patients even if things seem relatively peaceful. That was the lesson learned during the blackout that recently crippled the northeastern United States.

Though the crisis ended peacefully, without the feared violence in the streets, most EDs in the New York City area reported a fourfold increase in ED visits, says **Monica Mahaffey**, spokeswoman for the Rensselaer-based Healthcare Association of New York State.

When the New York City-based Greater New York Hospital Association queried member hospitals about how they were coping with the blackout, ED volume was always a major concern, says spokeswoman **Mary Johnson.**

"We don't have hard data yet, but the majority said they were definitely seeing an increase in volume," she says. "The answers ranged from 'bursting at the seams' to '30% above normal,' to 'very busy, but we're handling it.'"

Here are some of the lessons you can learn from their experiences:

• People will need your electrical power and medications.

A lot of people came to plug in their ventilators because they had no power at home, Mahaffey says. Mothers came in for baby formula because they were afraid theirs had spoiled, and diabetics came in for food, she says. "Then they saw a lot of people who were trapped in subway cars and the usual people who tripped in the dark and had minor fractures," Mahaffey says.

One hospital turned one of its ED waiting areas into a holding area for ventilator patients and others who just needed to plug in their electrical devices to the hospital's power, she says.

Some people came to the ED just for a cool drink of water, and some nursing homes had to transfer patients to hospitals when their own backup generators failed or were unable to support air conditioning. Heat-related illnesses also sent many people to the ED for help. Some patients came to the ED when they couldn't obtain their prescription medications from closed pharmacies.

• Prepare for an increase in car accidents and food poisonings.

JoAnne Tarantelli, executive director of the New York chapter of the Irving, TX-based American College of Emergency Physicians, confirms that "there definitely was increased volume" at area EDs, including some car accidents that happened when the traffic lights went dark.

In the days after the blackout, Tarantelli and others heard stories that there were increased incidents of

food poisoning, from people eating food that should have been destroyed. "People started showing up with flulike symptoms that turned out to be food poisoning," Tarantelli says. "So there was increased ED volume both during the blackout and after."

When the blackout happened, EDs first saw patients from motor vehicle accidents start to roll in, then the elderly who couldn't handle the heat, and then those whose nebulizers or oxygen wouldn't work without power at home, Tarantelli says. During the evening, the volume increased at a steady pace, she says.

• Prepare to be without your utilities.

Some facilities had difficulty getting their generators on line and were saved only by the fact that power was restored within hours to some parts of the community. Before it was known how long the crisis would last, others realized that their fuel supply for the generator might not last as long as they needed it.

Most hospitals in the New York area revamped their emergency plans after 9/11, and the blackout put many of those contingencies to the test, Johnson notes. Most found that their plans were sufficient, but some hospitals struggled with a lack of water and sewage services.

One such hospital was Lockport (NY) Memorial Hospital, where **Susan Wendler,** director of development and community relations, says the ED had to go on diversion for a short time.

The power went off about 5 p.m. and returned about 8:45 p.m. The hospital's generator provided backup power without difficulty, but the city of Lockport was unable to provide water pressure.

"That was the most serious thing for us to deal with. We couldn't use toilets and had to limit our overall water use to preserve our emergency supply of water," she says. "We had to divert our emergency department for a very short time while we were refilling the water supply to our radiology X-ray processor."

Wendler says her ED learned to stock more flashlights, fans, and waterless hand sanitizers.

• Use extra staffing and volunteers.

ED volume was up at Lockport, just like it was everywhere else, but medical staff from other departments pitched in to help with suturing and similar tasks. Staffing was made easier by the timing of the blackout, which was in the afternoon before the day shift had gone home. Volunteers also helped manage the influx of patients in the ED.

"We had people who came to the hospital to use the facilities, like going to the bathroom or just cooling off," she says. "They didn't really need ED care, but the ED was the point of entry for most of those."

• Stay aware of potential violence.

St. Barnabas Hospital in Bronx, NY, initiated its emergency plans because it is in a heavily populated area. As darkness fell, the ED staff braced for looting and other violence in the streets and prepared for a surge in injured patients. But those patients never showed up.

The ED staff stayed in close contact with the local police precinct, but much of their news about the blackout came from ambulance crews. When an ambulance came in, the ED staff peppered the crew with questions about what they had seen out on the streets and how bad the situation was. In turn, the patients coming to the community asked the same questions of the ED staff.

• People will come for encouragement.

Mahaffey says the type of patient coming to the ED that night was different from what ED managers usually see. In many cases, they just needed reassurance, she says.

"We found out that communities look upon their hospitals not only for medical care but also for comfort, shelter, and solace," Mahaffey says. "When disasters happen, a lot of people run to the emergency room."

The ED will always be a focus of activity in a situation such as a blackout, says **Jerry Balentine**, DO, medical director at St. Barnabas.

"It's the entry point for the hospital, especially when people are scared and there is an unusual situation," he says. "People looked to the ED for help, and we learned that we have to be ready to give that kind of assistance. It's a different type of demand on the ED from what we practice for in a disaster drill that focuses on large number of injuries and trauma." ■

Sources

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Support grows for more family access in ED

Staffing shortage is biggest hurdle

Very few hospitals have policies that allow family access during resuscitation and other treatment in the ED, even though research has shown that the public overwhelmingly desires it and a growing number of emergency physicians and nurses support the idea. **(See list of studies, below.)** The holdup is that allowing more family access requires the involvement of trained staff members, and hardly any facilities have staff to spare these days.

But advocates of family access say that requirement doesn't have to be an absolute roadblock to doing what they refer to as "the right thing." Some creativity and flexibility can improve family access even in a short-staffed ED, they say.

Only 5% of U.S. hospitals have written policies permitting such access during CPR or invasive procedures, according to a new survey cosponsored by the Emergency Nurses Association (ENA) in Des Plaines, IL, and the American Association of Critical Care Nurses (AACN) in Aliso Viejo, CA. About a quarter of responding nurses say family presence still is prohibited for resuscitation and invasive procedures, despite urging of professional organizations to allow access, says **Dorrie Fontaine**, RN, DNSc, FAAN, president-elect of AACN and associate dean for academic programs at the University of California at San Francisco School of Nursing.

The ENA has encouraged more family access for almost 10 years, but EDs have been slow to adopt the practice, says **Kathy Robinson**, RN, president of ENA and emergency medical services program manager for the Pennsylvania Department of Health. There is growing interest, she says, but still much room for improvement.

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"A decade of research shows that the presence of family members during invasive emergency procedures can be helpful to families, health care providers and the patients themselves," Robinson says. **(See box, below left.)** "Yet despite growing support for family presence during emergency procedures, too many physicians and other health care practitioners resist adopting this practice."

Fontaine sees more willingness among clinicians to accommodate families in the ED. The trend is part of a larger change in health care and consistent with other efforts to allow families in treatment areas, she says. It used to be much more common for physicians to resist the idea of family access with claims that family members would get in the way and impede proper treatment.

That argument still is cited by some, but not nearly as much as before, she says.

"Only few years ago obstetricians were saying 'Over my dead body will the father or anyone else be in there while I'm delivering a baby,'" she says. "Now there's nowhere in the country where you don't have fathers in there helping deliver and right in the middle of everything that is happening. People are more comfortable with the overall idea of family presence."

So why do so few EDs have a policy and allow family access? The same reason you can't do a lot of things that otherwise sound like a good idea: short staffing. The American College of Emergency Physicians doesn't have a formal stance on the issue, but **Stephen Epstein**, MD, MPP, spokesman for ACEP and clinical operations director at Beth Israel Deaconess Medical Center in Boston, says he generally favors allowing more family access. However, Epstein says he understands why so few EDs can make it happen. Like most EDs, his is chronically short-staffed and can't spare a nurse to escort the family in the ED treatment areas.

Resources are restricted, and ED managers can't do all they would like to do, Epstein says. Many physicians agree that it's a great idea, if they have the nursing staff, he says. "But when the ED is already maxed out with patients and too few staff, the patient is our

first responsibility, and this becomes something they would like to do but just isn't a priority," Epstein says.

Staffing is such a significant issue because it is imperative that you provide a trained escort for the family members. Even the strongest advocates of family access agree that you can't simply let the family come in and watch. A trained escort, preferably a nurse, should be at the family members' side making sure they don't interfere with treatment, helping them understand what is happening, and watching for any physical reactions such as fainting. **(For tips on allowing family access, see box, below.)**

For that reason, many ED managers nix the idea entirely when they're already dealing with a nursing shortage. But Epstein and Fontaine say that's a mistake to automatically assume you can't provide more family access. They suggest two strategies that might work for you:

Strategy 1: Use someone other than a nurse as the family escort.

An ED nurse is by far the best choice for this job, but someone else might suffice. Fontaine suggests that a social worker or clergy might escort the family, and Epstein says an emergency medical technician or even a lab tech might work. In any case, the person should be trained specifically in how to escort families in ED treatment areas.

There is a limit to how flexible you can be, however. Epstein notes that hospital volunteers probably are not sufficiently trained and experienced for this type of work.

Strategy 2: Allow family access when you can, but accept that you can't sometimes.

Family access does not have to be all or nothing, he says. If you don't have the staff to do it all the time, establish a policy that you will allow family access as much as you can. That may not be a perfect solution, but it is far better than not even trying to allow family access because you are short-staffed.

"You can develop a policy that says when the ED is not too busy and you have appropriate staff, you should allow family access," Epstein says.

"The policy is key because, otherwise, you'll have family kept out of the room even on a slow night, just because there's no policy guiding people to say it's OK," he adds. ■

Physician support, formal policy key for family access

Flexibility is the key word when developing a policy on family access, says **Stephen Epstein**, MD, MPP, spokesman for the American College of Emergency Physicians and clinical operations director at Beth Israel Deaconess Medical Center in Boston. Understanding the family's needs is important, but they must be balanced with patient safety.

Epstein offers these additional tips:

- **Obtain physician support when developing a policy.** Be prepared for some physicians to resist the idea, mostly because they fear the family members may be upset by what they see or because the family might interfere with treatment. Emergency physicians don't want to be distracted from the patient, so you will have to reassure them that those fears very rarely materialize. Show them the research that proves it. **(See selected references, p. 114.)**
- **Consider practical matters such as the room size.** No matter how good an idea it is to allow family access, you may face insurmountable obstacles. If your trauma bay is tiny and crowded, it's not a good idea to introduce a family member and escort.
- **Maintain patient's privacy.** Having family members stand in the hall and look through an open doorway is not a good solution. That exposes the patient to anyone else who happens to walk by.
- **Allow personal touching if possible but not at the risk of patient safety.** It's important that the family member be able to hold the patient's hand, and you should allow that touching as much as is practical. But in a resuscitation, for instance, there's too much activity going on, and you should have the family stand back. The patient's treatment needs come first.
- **Have the family escort help decide what the family wants to see.** Not every family member will be willing or able to watch. What they can and can't tolerate will vary greatly from one individual to the next. But the research suggests that most family members can tolerate very graphic efforts and still want to be present.
- **Make sure the escort is ready to take family members out if they are disruptive in any way.** The family should not interfere with treatment, either physically or by talking critically to the staff. If family members can't be calmed, the escort should take them out.
- **Establish that the physician running the resuscitation has the final say about family presence.** The patient's care comes first, so the physician must have veto power over the family presence. But that is why it is important to work closely with the physicians when developing the policy, so that they understand the need for family presence and don't automatically say no in the heat of the moment. ■

Flowcharts are basis for symptom-based tools

Health care providers have access to plenty of flowcharts and algorithms designed to guide the treatment of patients with particular diagnoses, but many of them aren't designed for use in the ED. What good is a flowchart for pneumonia if you don't know what's wrong with the patient yet?

To address that problem, the ED team at Overlook Hospital in Summit, NJ, has developed what it calls "flow-gorithms" for commonly seen illnesses. The difference between the flow-gorithms and the other tools commonly available is that the flow-gorithms are symptom-based rather than diagnosis-based, says **Patricia Gabriel**, RN, BSN, CEN, nurse manager of the ED. "All of the things we look at in terms of pathways and patient management are all diagnosis-driven," she says. "That doesn't help us from an ED perspective because patients don't come in with labels that say, 'I have pneumonia.'"

The flow-gorithm is a symptom-driven tool that guides the entire ED team — physicians, nurses, and others — to a proper diagnosis and ensures that the best testing and treatment are provided along the way.

The flow-gorithm is fairly simple in design and easy to use, Gabriel says. It looks much like a typical flowchart that leads the user from one step to the next, depending on the patient's symptoms, she says. The triage nurse usually is the first to use the flow-gorithm and matches the patient's symptoms to those listed at the top of the flow-gorithm. For example, if the patient reports fever, cough, shortness of breath, and increased sputum, that fits the pneumonia flow-gorithm, and the triage nurse will attach a copy to his or her chart. When patients come in by ambulance, they bypass the triage nurse and go directly to an exam room. In that case, the nurse responsible for that room initiates the flow-gorithm. **(See the sample flow-gorithm, p. 117.)**

The flow-gorithm give specifics as to whether the patient should be triaged as emergent or urgent, and lists other steps and questions for others. Some steps have spaces to initial and indicate the time that an action was taken. At several points, the results of the examination may lead the clinician out of the decision tree by indicating that the patient does not have pneumonia and should be treated accordingly.

"It lets you work through the symptoms and processes without always having to have physician input up front," she says. "Then if the physician says the X-ray shows pneumonia, we use the flow-gorithm to tell them what blood work needs to be done and which of the antibiotic groups they can pick from."

The first flow-gorithm, for pneumonia, was developed about four months ago, and then the team developed one specifically for geriatric pneumonia. A flow-gorithm for chest pain was developed more recently, and the team plans to develop one for potential stroke patients.

Pneumonia was a good place to start because its symptoms are clearly defined and straightforward, Gabriel says. The ED team also wanted to improve the way it treated patients presenting with suspected pneumonia. "We have a strict time frame to give them antibiotics — just four hours from presentation," Gabriel says. "On a busy day in the ED if a middle-aged person comes in with cough and fever, and the pulse oximetry was all right, they were not going to be high on the list for acuity. If you don't get the chest X-ray done right away, the clock is ticking, and you're not going to get the antibiotics to them in four hours if it does turn out to be pneumonia."

The team also found that elderly patients often slipped through the system and didn't get antibiotics in time because their pneumonia presented with very different symptoms than the average patient.

"If you fell in the 18 to 65 range, almost 100% of the time you got your antibiotics within four hours," she says. "If you were in the 65 to 85 range, maybe 65% of the time you got your antibiotics within four hours. If you were 85, forget it. You didn't get your antibiotics for a while because you didn't present with symptoms that we recognized as pneumonia."

So the flow-gorithm for geriatric pneumonia includes "change in normal activity tolerance" as a symptom that should trigger the use of the flow-gorithm. "If the patient presents with that, that automatically moves them up on the list and we order a chest X-ray," Gabriel says.

The flow-gorithms are based on commonly accepted practice guidelines, but they also are tailor-made to the needs of the Overlook Hospital ED staff. For instance, the flow-gorithm for chest pain addresses a common problem that the staff encountered concerning how much aspirin to administer. No one could ever remember whether to count the patient's daily aspirin dose or aspirin administered by the paramedics when figuring the dosage. "So it says right on there to give aspirin unless they got a certain amount from the paramedics," Gabriel says. "And it says to give the aspirin even if they took their normal maintenance aspirin." ■

Source

For more information, contact:

- **Patricia Gabriel**, ED Nurse Manager, Overlook Hospital, 99 Beauvoir Ave., Summit, NJ 08043. Telephone: (908) 522-2000.

Source: Overlook Hospital, Summit, NJ.

Audio conference

(Continued from cover page)

While the new rule clarifies many points and is intended to reduce the compliance burden for hospitals and physicians, it's only good news if you implement it correctly. You still could face violations, hefty fines, confusion, and misinterpretation.

Find out the answers to the following questions:

- How do you provide emergency treatment during a national emergency?
- How does EMTALA apply to inpatients, including those admitted through the ED?
- What should be the procedure regarding on-call lists?
- What's the new rule regarding hospital-owned ambulances?
- How are off-campus clinics affected?

Ensure that you and your staff are prepared with straightforward advice from a panel of EMTALA experts.

The program will be presented by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine in Peoria; and **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care, department of emergency medicine, Carolinas Medical Center in Charlotte, NC.

Our expert advice will help you steer clear of potential pitfalls.

Rule could affect access to specialists

"The new rule could aggravate an existing problem," Bitterman told *The New York Times*. "Specialists are not accepting on-call duties as frequently as we would like. As a result, hospital emergency departments lack coverage for various specialties like neurosurgery, orthopedics, and ophthalmology. The new rule could make it more difficult for patients to get timely access to those specialists."

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $249, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit.

The conference package also includes handouts, additional reading, a free 48-hour replay of the live conference, and a CD recording of the program.

For more information or to register, call Thomson American Health Consultants' customer service department at (800) 688-2421 or (404) 262-5476. E-mail: customerservice@ahcpub.com. When ordering, reference effort code: **83941**. ■

Sign up for update on EMTALA revisions

You and your facility waited more than a year for the final revisions to the Emergency Medical Treatment and Labor Act (EMTALA), but are they really good news?

Emergency department managers and practitioners, hospital administrators, risk managers, and others must quickly digest this complex regulation and determine how the changes will affect patient care. The revised regulation takes effect Nov. 10.

EMTALA: The Essential Guide to Compliance from Thomson American Health Consultants, publisher of *ED Management, Emergency Medicine Reports, ED Nursing, ED Legal Letter,* and *Hospital Risk Management,* explains how the changes to EMTALA will affect emergency departments and off-campus clinics. In-depth articles, at-a-glance tables, and Q&As on real-life situations are presented, and key differences between the "old" EMTALA and the new changes are succinctly explained.

Here are some of the vital questions you *must* be able to answer to avoid violations and hefty fines:

- Do the revisions mean hospitals are less likely to be sued under EMTALA?
- How does EMTALA apply during a disaster?
- What are the new requirements for maintaining on-call lists?
- How does EMTALA apply to inpatients admitted through the ED?
- What are the rules concerning off-campus clinics?

EMTALA: The Essential Guide to Compliance draws on the knowledge and experience of physicians, nurses, ED managers, medicolegal experts, and risk managers to cover the EMTALA topics and questions that are most important to you, your staff, and your facility.

The publication is edited by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine, Peoria, and reviewed by **Kay Ball**, RN, MSA, CNOR, FAAN, perioperative CE/CME consultant/educator, K&D Medical, Lewis Center, OH.

EMTALA: The Essential Guide to Compliance also provides 18 AMA Category I CME credits and 18 nursing contact hours. Order your copy today for the special price of $249! Call (800) 688-2421 to receive this valuable guide to the new EMTALA. ■

EDs need plan to contact smallpox-vaccinated staff

A new report from the Institute of Medicine of the National Academies in Washington, DC, urges EDs to create systems in which staff vaccinated for smallpox can be called up quickly in the event of an outbreak. The committee that wrote the report also recommended that the Centers for Disease Control and Prevention in Atlanta support the creation of registries of health care workers and others who have been vaccinated.

ED preparations for a smallpox outbreak should focus "as much on the availability of a good response plan and the ability to quickly coordinate responders as it does on the number of responders who have been vaccinated in advance," says committee chair **Brian Strom**, MD, chair and professor of biostatistics and epidemiology, and of medicine and pharmacology at the University of Pennsylvania School of Medicine in Philadelphia.

The committee urges state and federal authorities to consider including former military service members and reservists who have received the vaccine. Their assistance could help keep health and emergency systems from being overwhelmed in the event of an attack, the report says.

For a copy of *Review of the Centers for Disease Control and Prevention's Smallpox Vaccination Program Implementation: Letter Report #4*, go to: www.nap.edu. Enter the title in the "search title" box. ■

CE/CME instructions

Physicians and nurses participate in this CE/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 each semester's activity, you must complete the evaluation form and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME *questions*

1. According to the final EMTALA rule, does EMTALA apply to a facility that "during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis?"
   A. Yes, by definition
   B. No
   C. Only if the facility actually calls itself an "emergency department"
   D. Only if the facility is physically connected to the hospital campus

2. What does the final EMTALA rule say about physicians serving on the hospital's on-call list?
   A. Hospitals can require physicians to serve, but only if they pay for the service.
   B. Hospitals are prohibited from paying physicians to serve on call.
   C. Physicians are required under EMTALA to take call at the hospital's discretion.
   D. The rule gives wide discretion to the hospital and physicians to work out on-call issues but does not offer specific instructions.

3. According to Monica Mahaffey, spokeswoman for the Healthcare Association of New York State, most hospital EDs in the New York City area experienced how much of an increase in patient volume during the blackout?
   A. None
   B. Double
   C. Triple
   D. Fourfold

4. Who is the best choice for escorting family members if they are allowed to witness a patient resuscitation in the ED?
   A. Nurse
   B. Physician
   C. Hospital volunteer
   D. Security guard

5. What was the primary reason that the ED team at Overlook Hospital in Summit, NJ, developed what they call "flow-gorithms"?

COMING IN FUTURE MONTHS

■ Preparing for sudden volume surges

■ Improving children's waiting areas

■ EMTALA risk: Watch what you say to EMS personnel

■ Billing analyst helps improve ED bottom line

A. Staff could use a tool that is symptom-driven.
B. Staff could use a tool that is diagnosis-driven.
C. No clinical pathways were available for treating pneumonia.
D. No clinical pathways were available for chest pain.

6. Who uses the flow-gorithms at Overlook Hospital?
A. Only physicians
B. Only nurses, but not the triage nurse
C. Only the triage nurse
D. All clinical ED staff

Answer Key: 1. A; 2. D; 3. D; 4. A; 5. A; 6. D

CE/CME objectives

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

- Discuss and apply new information about various approaches to ED management. (See *"EMTALA reg eases overall burden, but on-call physician issues still unclear"* in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *"Highlights of the final rule include definition of ED."*)
- Share acquired knowledge of these developments and advances with employees. (See *"Blackout creates influx of patients, generator woes"* and *"Support grows for more family access in ED."*)
- Implement managerial procedures suggested by your peers in the publication. (See *"Flow-charts basis for symptom-based tools"* and *"Physician support, formal policy key to allow family access."*) ■