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DECEMBER 2003
VOL. 15, NO. 12 • (pages 133-144)

Want to drastically cut LWBS numbers? Try ice packs and adding a fast track

Comfort and quick care can reduce risk of EMTALA violations

Somewhere deep in an ED manager's mind, maybe when you're feeling cynical at 3 a.m., the patients who left without being seen (LWBS) might seem like a blessing. After all, your ED is too busy, and they probably didn't need emergency care in the first place.

Then you snap to your senses and realize that high LWBS numbers are a reflection on the overall quality of care in your ED and, at the very least, reflect poorly on customer service and satisfaction. But is there anything you can do, or are LWBS patients just inevitable in today's overcrowded, understaffed EDs?

There always will be some LWBS patients, but you can keep that number to a minimum with strategies aimed at the specific reasons patients get up and walk out the door. Uncertainty about the waiting time and lack of comfort items, such as ice packs, are major contributors,[1] says **Annie T. Sadosty**, MD, an attending physician in the department of emergency medicine at Mayo Clinic in Rochester, MN, and assistant professor at Mayo Medical School. Sadosty recently studied the reasons patients leave the ED.

The first step in addressing LWBS patients is to acknowledge that it's an important issue, she says. ED managers should care how many people walk out for several reasons, Sadosty explains.

With growing populations being turned away from office doors and other EDs closing, the EDs that exist become the safety net for people who can't find access

Executive Summary

Your ED's left-without-being-seen (LWBS) rate is a direct reflection of quality of care and customer service, plus a high rate can put you at risk of charges that you are violating the Emergency Medical Treatment and Labor Act. Some simple strategies can help, but faster throughput is the ultimate solution.

- Handing out ice packs and other comfort items will help people wait longer.
- Announcing waiting times might help, but it can backfire.
- A dedicated minor emergency unit can reduce LWBS rates dramatically. One facility cut the rate from 14% to 2%.

to primary care," she points out.

"If we aren't able to see these people who have nowhere else to turn, it's an unraveling of the safety net," she says.

LWBS rates are a quality marker in many ways, Sadosty states. "Cynics would say that people who leave aren't sick, but there are very good data to the contrary," she says.[2]

The notion that they will self-triage, and if they're sick enough, they will wait, does not hold true, Sadosty continues. "They have other pressing concerns, such as family who depend on them, that force them to leave anyway," she says.

LWBS patients also represent potential lost revenue, since many of them may be paying patients. And there is the potential for a poor public image. People who leave are going to talk to a lot of friends and family about their experiences.

There also is the risk of an Emergency Medical Treatment and Labor Act (EMTALA) violation, says **Matthew Rice**, MD, JD, senior vice president and chief medical officer for Northwest Emergency Physicians in Seattle. He also is chair of the medical/legal committee for the American College of Emergency Physicians (ACEP) in Irving, TX. The federal Centers for Medicare & Medicaid Services (CMS) in Washington, DC, has investigated and cited some hospitals for using long ED delays as a way to discourage some patients from seeking care.

Although not common, such cases make ED managers concerned that they could be cited, Rice says. "If a patient leaves and has a bad outcome, there is a potential for an EMTALA violation," he says. "There is a risk, even if it's not a huge risk. CMS does not seem to find it acceptable that we're getting busier and busier and there may be times when people have to wait."

It is most likely that CMS would require some evidence that the ED was purposefully using long waiting times to discourage undesirable patients, but Rice also says that it might not be hard to prove an EMTALA violation in an individual case. If the patient waited for hours, finally gave up and left, then died on the sidewalk a few blocks away, it would not be hard to argue that the ED staff mismanaged his triage and should have seen him earlier, Rice says.

"And of course, medical malpractice attorneys would be interested in picking up on a case where a person waited three hours and left and suggest that better care could have been provided, that it was, in fact, negligent," he says.

Research on the LWBS problem has identified some strategies that work and some that should work even though they haven't been extensively studied yet, adds Sadosty. Most of them boil down to identifying what would keep patients just a little bit more comfortable and satisfied during a long wait in the ED — the small difference between them staying in their seats or walking out in a huff.

Here are some of the strategies you can employ to lower your LWBS rate:

• Hand out analgesia and comfort items.

Sadosty's study revealed that patients would be more likely to wait if they were given temporary analgesia

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

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Statement of financial disclosure: To reveal any potential bias in this publication, and in accordance with the Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Auer (editorial advisory board member) discloses that she has no conflicts of interest; Dr. Bukata (advisory board member) is president of the Center for Medical Education and is the developer of EDITS software; Dr. Joseph discloses that he is a stockholder in AMC Registry. Dr. Mayer (advisory board member) is a stockholder in Emergency Physicians of Northern Virginia Ltd. and Patient Care and ED Survival Skills Ltd.; Dr. Yeh (advisory board member) serves as a consultant to Dynamics Resource Group, a spokeswoman for Medic Alert, and a member of the board of directors for Vital Solutions and MassPRO.

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such as Tylenol and comfort items such as ice packs and temporary bandages for lacerations. Since Sadosty published her results, the Mayo ED staff have made a stronger effort to use this technique.

The triage nurses now are very attentive to the person's needs and obtain ice packs on a regular basis, she says. "They're also on the lookout more for the patient whose needs aren't so obvious, like the person with a migraine who might need analgesia and a quiet place to wait," she says. "It's always a fair question to ask how practical that is in a busy ED, but it doesn't take much time to get someone an ice pack."

As in any ED, their practices change with the volume. "Some of the things we can do when we're not so busy we can't always do during a rush of patients," Sadosty says.

• **Announce waiting times.**

This strategy has been recommended by some ED experts as a way to keep patients better informed and willing to wait. However, the Mayo ED doesn't announce waiting times because it can backfire, she says.

"If you tell them it's going to be 20 minutes and then a bus crashes and you're deluged with a rollover accident, your 20-minute estimate becomes six hours," she says. "It's hard to really and truly provide an accurate estimate, and there is tremendous possibility for dissatisfaction if your estimate turns out to be way off."

• **Entertainment for children.**

A long wait can be unbearable for a parent with fussy children, so anything that keeps the kids entertained will delay that moment when Mom or Dad just can't take it anymore and storms out. Showing children's movies on one of the televisions is a good idea, as are toys such as coloring books and reading material, she says.

• **Fast track patients to improve flow through.**

The LWBS population is intimately related to ED waiting times, Sadosty says. If you can increase your throughput, your LWBS rates presumably are going to be less. "So much of the research related to increasing throughput time can be extrapolated to LWBS rates as well," she says. "Address one problem, and you're bound to improve the other also."

Fast tracking certain patients can have a tremendous impact on wait times and LWBS, Sadosty says. The Mayo ED doesn't fast track because it is a high-acuity ED and Mayo has a separate urgent care center, but Sadosty says other hospitals have shown good results with the strategy.

The ED at Onslow Memorial Hospital in Jacksonville, NC, has dramatically reduced its LWBS rate by implementing a fast-track strategy. **Pat Stark**, RN, BSN, nurse manager for the ED, says the ED treats about 37,000 patients a year. When the hospital opened its minor emergency care unit (MECU) in May 2001, the LWBS rate was 14%, or about 180 patients per month.

Now the ED's LWBS rate is down to a steady 2%

Fast track keeps everyone moving through your ED

The fast track in the ED at Onslow Memorial Hospital in Jacksonville, NC, is designed to keep everyone in the ED moving, not just those seen in the minor emergency care unit (MECU), says **Pat Stark**, RN, BSN, nurse manager for the ED. When those with relatively minor needs are funneled out of the regular ED system, they receive faster care, and so does everyone else in the ED.

The MECU is an eight-bed unit, staffed with two nurse practitioners and three licensed personnel, that is adjacent to the normal ED at Onslow. The unit is open from 11 a.m. to 11 p.m., but its success and the ever-growing number of ED patients has the hospital considering longer hours.

All patients enter through the main ED and are triaged normally, but those with the lowest priority triage are sent to the MECU instead of waiting at the end of the line in the main ED. The MECU patients immediately are sent to the MECU, which has its own waiting area. "We didn't want patients from the two services arguing about who was there first and why the minor injury is getting faster care," Stark says. "The MECU typically sees things like sore throats and flu; but on some days, we might step it up to the next level and send over patients with minor lacerations that aren't bleeding."

Most of the nurse practitioners can suture minor wounds in the MECU. If the patient needs to see a physician, the patient can be taken back to the other side or the physician can come to the MECU.

When the ED is short staffed, the nurse practitioners may be pulled from the MECU to help out. The MECU is proving to be more successful and more helpful in relieving the main ED's overcrowding than the off-site urgent care center that the hospital formerly had.

The left-without-being-seen rates have plummeted from 14% to 2%, but the number of patients coming to the ED keeps rising, Stark says. That increase may be one unintended result of the MECU, she adds.

"A potential downside is that you encourage people to come to the ED with nonemergency needs. It's amazing how word gets around in the community," Stark says. "I've heard patients say they came here instead of another hospital because we move faster," she states. ■

Sources

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per month. The LWBS rate varies considerably nationally, but one study found that it ranges from 2.4% in private hospitals to 7.3% in public hospitals.[3]

The MECU was a major reason for the drop, but Stark says other initiatives also contributed. Stark and the other managers in the ED put much more emphasis on LWBS overall and started holding individual staffers accountable for their role in patients walking out. **(For details on the Onslow program, see article, p. 135.)**

Knowing nothing would change if staff didn't consider LWBS a real problem, Stark and the other ED managers explained the ramifications of high LWBS numbers. And then they told staff that they would be required to improve their customer service as a means of reducing those numbers.

ED staff were required to watch instructional videotapes on improving customer service, and Stark instituted a zero-tolerance policy for disrespect to patients. Then she carefully started assessing the LWBS numbers by posting goals in the ED for that month and keeping staff abreast of how well they were doing — as a team and individually. "We provided the triage nurses with a breakdown of how they were doing, and we posted the overall numbers so they could compare themselves to everyone else," she says.

The process was competitive, she says. "We ended up with some nurses running after patients in the parking lot, yelling, 'Come back inside! We'll see you!'" Stark adds.

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Are more lumbar punctures needed after CT scan?

Far too many emergency physicians are complacent about the use of lumbar punctures following a negative computed tomography (CT) scan to rule out subarachnoid hemorrhage in a patient with high-risk headache ("worst ever" or "thunderclap" headache), some experts say. Best practice guidelines clearly call for a lumbar puncture in such cases,[1,2] but many physicians risk a catastrophic result and a malpractice suit by foregoing the procedure, they say.

Subarachnoid hemorrhage occurs in about one in 10,000 people, says **Jonathan Edlow**, MD, assistant professor of medicine at Beth Israel Deaconess Medical Center in Boston.

Edlow says the research is crystal clear on the need for a lumbar puncture after a negative CT scan in a patient with high-risk headache, also defined as a headache of abrupt onset achieving maximal intensity within 10 to 30 seconds.

His own research confirms what others have suggested: A negative CT scan is insufficient to rule out subarachnoid hemorrhage and a lumbar puncture is the gold standard.[1] Yet other research also shows that 78.4% of "rule out subarachnoid hemorrhage" patients with a negative CT scan do not undergo a lumbar puncture.[3]

So why the big disconnect? Edlow says one reason is that physicians are misinformed about the need for a lumbar puncture and the accuracy of CT scans. Add to that the fact that lumbar punctures can be difficult, time-consuming, and unpleasant for the patient, and soon you have a physician who decides the CT scan is sufficient to rule out subarachnoid hemorrhage.

Most patients being worked up for subarachnoid hemorrhage, in fact, don't have subarachnoid hemorrhage, so the number of cases that any physician diagnoses by lumbar puncture is very small, Edlow says. "They don't see it happen that often, and so they sort of devalue the lumbar puncture," he says.

Edlow says physicians are providing substandard care by not doing enough lumbar punctures. "We miss subarachnoid hemorrhages because we're not doing spinal taps," he says. "It may not be an enormous number of cases, but it's a significant number."

Part of the problem lies in basic human nature, Edlow says. Physicians don't want to perform the lumbar puncture for a number of reasons, and the patient can be very

Sources

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resistant because of the pain, so it is easy for both to rationalize a decision to forgo the lumbar puncture.

Both may rely too much on the CT scan for a definitive diagnosis, says **Robert Solomon**, MD, FACEP, assistant professor of medicine at the West Virginia School of Osteopathic Medicine in Lewisburg and faculty member at the Ohio Valley Medical Center in Wheeling, WV.

"Patients think of CT scanning as high tech, state of the art, and they're inclined to think that if anything bad is causing their symptoms, the CT scan will find it. And it's easy for physicians who should know better to fall into the same trap," Solomon says.

Physicians look at papers that say the sensitivity for CT scanning for subarachnoid hemorrhage is well into the 90s, and when the CT scan comes back negative, they think they're done, he says.

"What they fail to appreciate is that though the sensitivity is in the 90s overall, it's not in the 90s for those for whom the diagnosis is most challenging," Solomon adds.

The CT scan will find the subarachnoid hemorrhage in the most obvious cases, but not necessarily in the patient with a smaller bleed and less dramatic symptoms, he explains.

Those are the patients most in need of a follow-up lumbar puncture, but physicians can convince themselves that the less dramatic presentation means it is safe to stop after a negative CT scan, Solomon says.

Pain management, ironically, also can get in the way of performing a lumbar puncture, Edlow and Solomon say.

Physicians often have treated the patients for pain before they go to the CT, and by the time they get back, they're feeling better, Edlow says. However, the improvement with pain medication does not distinguish a subarachnoid hemorrhage from other causes of headache, he emphasizes.

"We properly treat these patients for pain, then we improperly conclude that because they're feeling better, it can't be a subarachnoid hemorrhage," Edlow says.

If clinical standards aren't enough of a motivator, perhaps fear of a malpractice suit is. Edlow and Solomon say failure to perform a lumbar puncture can lead directly to a malpractice suit if the patient, in fact, has a bleed. Edlow says he has consulted on a number of such malpractice cases, and Solomon says he frequently warns fellow physicians about the risk.

Sometimes, of course, the patient simply refuses to undergo the spinal tap no matter how much the physician recommends it.

That decision can't be held against the doctor, Solomon says, but there are ways to reduce that number of refusals. Emergency physicians can help patients accept the lumbar puncture by telling them up front that the CT scan helps diagnose the bleeding suspected in the patient's brain but it can miss.

Explain to the patient that you already know you will need to do a lumbar puncture if the CT scan is negative; thus, the patient doesn't go to the CT thinking it is a definitive diagnosis and then think the lumbar puncture is overkill.

Some patients still will resist after a negative CT, no matter what you tell them beforehand, Solomon says.

"Sometimes, I tell them that meningitis is one possible explanation, even though it actually is far down the differential, because they understand that meningitis is serious and they start wondering about that," he says. "It gets them to take seriously the idea that the CT may not have found everything."

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Tool ensures follow-up for traumatized children

Survey predicts post-traumatic stress disorder

A child comes in for an injury in a traffic accident in which others were hurt and killed. The ED clinicians take care of the physical injuries, and the patient is discharged. Still, the staff members feel uneasy about the impact of the accident on the child's mental health.

"One thing we hear from nurses is that they see kids all the time they worry about, thinking the kid is likely to have trouble down the road," says **Nancy Kassam-Adams**, MD, associate director for behavior research at TraumaLink, a pediatric trauma research center based at Children's Hospital.

Identifying problems before child goes home

When the child goes home, the nurse has no way to help, she says. However, a newly developed simple screening tool gives staff a means to identify children and parents who suffer post-traumatic stress disorder (PTSD), according to clinicians at the Children's Hospital of Philadelphia.

"The nurses tell us that the screening tool gives them a way to provide some sort of follow-up to those kids they worry about," she adds. "It can provide a kind of closure for the ED staff."

While only about one in six children develop PTSD from injuries, the effects for those children can be serious, Kassam-Adams points out.

The Screening Tool for Early Predictors of PTSD (STEPP) should help ensure that the parents and kids who screen positive would receive a visit or a follow-up call from a social worker, she explains.

EDs also could include an extra sentence in the discharge instructions that the parents take back to their primary care doctor. This could be a short note suggesting that the child and parents be watched for signs of PTSD because they tested positive on the screening tool, Kassam-Adams says.

ED staff skeptical: Is it easy to use?

Current field research shows the tool is practical for use in the ED, which allays some initial fears that it might be a good idea on paper but not so easy to use in a real ED, says one of the developers.

When physicians developed the tool, the published report was met with some interest but also skepticism by ED staff, Kassam-Adams says.

Simple questions used in screening kids for PTSD

The Screening Tool for Early Predictors of PTSD (STEPP) is the first method available for emergency physicians to quickly and effectively assess the risk of post-traumatic stress disorder (PTSD), says **Nancy Kassam-Adams**, MD, associate director for behavior research at TraumaLink, a pediatric trauma research center based at Children's Hospital in Philadelphia.

Emergency physicians can use the STEPP to help determine who should be referred for psychological evaluation and intervention so that families can avoid PTSD, she says.

Kassam-Adams and her colleagues found that severity of injury is not necessarily a predictor of PTSD. Instead, a combination of event-related factors, early physiological reactions such as heart rate, and early psychological responses serves to predict future development of PTSD.

STEPP was developed in a population of children who had traffic-related injuries and their parents. The STEPP method includes four yes/no questions asked of the parent, four yes/no questions asked of the child, and four items easily obtained from medical records. Kassam-Adams says these are the 12 questions included on the screening tool:

- **For the parent:**
  1. Did you see the incident (accident) in which your child got hurt?
  2. Were you with your child in an ambulance or helicopter on the way to the hospital?
  3. When your child was hurt (or when you first heard it had happened), did you feel really helpless, like you wanted to make it stop happening, but you couldn't?
  4. Does your child have any behavior problems or problems paying attention?
- **For the child:**
  5. Was anyone else hurt or killed (when you got hurt)?
  6. Was there a time when you didn't know where your parents were?
  7. When you got hurt, or right afterward, did you feel really afraid?
  8. When you got hurt, or right afterward, did you think you might die?
- **From the medical record:**
  9. Is there a suspected extremity fracture?
  10. Was the pulse rate at ED triage > 104/minute if the child is younger than 12 years or > 97/minute if the child is 12 years or older?
  11. Is the child 12 years or older?
  12. Is the child a girl?

To assess the results, Kassam-Adams says the provider scores one point for each yes answer and zero points for a no answer. Parents' likelihood of suffering PTSD is scored by adding up the yes answers on questions 1, 2, 3, 4, 9, and 11. A score of 3 or more yes answers is a positive result.

A child's assessment is based on questions 5, 6, 7, 8, 9, 10, and 12. A score of 4 or more yes answers is a positive result. ■

She says many ED staff thought it sounded like a nice idea, but they weren't so sure it could be implemented effectively without creating an unwelcome burden.

After publication of the STEPP tool, Kassam-Adams and her colleagues went on to test the idea in the ED at Children's Hospital.

"I can tell you that the process of using the tool was very acceptable to nurses and parents," she says. "This confirmed that using the STEPP tool is something you can add to your ED without creating much of a ripple."

In the second-phase research aimed at assessing feasibility, Kassam-Adams says 70 nurses administered the STEPP screen to about 300 patients and their parents older than six months in the ED.

When the child is registered, the staff identify those who meet two criteria: The injury was accidental, and the child is between 8 and 17 years old. (The tool was developed for children in that age range because research supported the ability to predict PTSD in them but not necessarily younger children.) Those patient charts are flagged so that the nurse knows to use the STEPP screen, and a one-page form with the 12 questions is added to the chart.

One of the nurses who used the tool in the ED says it only takes about two minutes. **(For information on how to use the screening tool, see box, p. 138.)** **Christine Macaulay**, RN, MSN, emergency department project coordinator and chair of the hospital's unit-based research committee, says the STEPP tool was welcomed by the nurses as a way to fulfill their obligation to educate the patient and family.

"This is something the typical ED could use without it being a real burden," she says. "It helps with flagging these patients who may have a problem later on because it is an education tool for the more novice staff, and it gives them a real quick format for doing it. Anything that quickens the job will be welcome in the ED."

Results prompt referral to social workers

To create the screening tool, the researchers had 171 families complete a 50-question risk factor survey at the initial treatment and complete a three-month follow-up assessment.[1]

The STEPP questions were derived from the combination of responses from participants that most often predicted persistent post-traumatic stress at three months.

The initial study results suggested that the STEPP tool is an effective screen for PTSD, Kassam-Adams says.

Of children who screened positive, 25% went on to present with PTSD. Of children who screened negative, only 5% developed PTSD. Of parents who screened positive, 27% developed PTSD symptoms compared to only 1% of parents who screened negative, she states.

The screening tool can help ED staff determine when a referral to psychological care is warranted and when they should recommend that the parents watch for symptoms of PTSD in the child, she says.

However, Kassam-Adams and her colleagues are not suggesting ED staff take on a mental health role in addition to everything else they already do, she says. Instead, it triggers the next step in the care process after patients leave your ED, she says.

"You can send some basic messages that can have a tremendous impact on the patient and the parents months later," Kassam-Adams says.

She offers this example of the kind of message ED staff can provide: "It's OK to be upset about this accident for a while, but things will get better. If your child is still very upset six months from now and afraid to cross the street, you might want to seek some counseling. And if you find that you're still worried all the time and overprotective, there is help available."

Why not just recommend counseling for the most severely injured children and their parents? Kassam-Adams says that approach would ensure that those most likely to suffer PTSD get help, but it would miss many who have less severe injuries but are nonetheless at high risk because of other factors.

"This is empirically based triaging rather than just common-sense triaging or relying on your gut instinct," she adds.

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EMTALA Q & A

[Editor's note: This column is part of an ongoing series that addresses readers' questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Greg Freeman, Editor, ED Management, *3185 Bywater Trail, Roswell, GA 30075. Telephone: (770) 998-8455. E-mail: Free6060@bellsouth.net.]*

Question: What does the final EMTALA rule say about taking time to consult with the patient's personal physician? I've heard that the rule says something about how you can't inappropriately delay treatment to make that call. So what's an "inappropriate delay?"

Answer: EMTALA always has allowed emergency physicians to contact a patient's private physician for more information, but the recently released final rules make it even easier.

The change is one more refinement that makes EMTALA a bit less burdensome and difficult, says **Charlotte Yeh**, MD, FACEP, Centers for Medicare & Medicaid Services (CMS) regional administrator in Boston and an emergency physician.

Other changes in the final rule eased the obligation of hospitals to provide EMTALA screenings and care for anyone who shows up near the hospital property, and hospitals were given more flexibility to devise physician on-call schedules, she explains. **(For more on the final EMTALA rule, see *EDM*, October 2003, p. 109.)**

Most of the changes in the final rule were intended to clarify confusing points that had surfaced in the first years of EMTALA compliance, Yeh says.

The CMS intended the same improvement when it reworded the part regarding personal physician contacts.

"People weren't sure if you could use a physician assistant or nurse practitioner for the communication between the private physician and the emergency department," Yeh says. "The final rule makes it clear that you can."

CMS officials never really had any problem with nonphysician emergency staff contacting the private physician, she says, but the language originally specified that only physicians could make the call. The final rule specifies that "an emergency physician is not precluded from contacting the patient's physician at any time to seek advice or information regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient, as long as this consultation does not inappropriately delay required screening services or stabilizing treatment."

It goes on to say that "the prior authorization policies apply equally to hospital services, physician services, and nonphysician practitioner services," and "nonphysician practitioners [physician assistants and nurse practitioners], should be permitted to initiate such contacts. . . ."

An inappropriate delay is not defined specifically, but Yeh says the rule is clear that this provision is intended for the emergency physician to obtain information necessary to provide the best care for the patient. The emergency physician is expected to use his or her professional judgment in determining whether a delay for contacting the personal physician is justified by the need for more information about the patient.

Beyond that, an ED can only get in trouble by somehow tying the phone call to an inquiry about the patient's ability to pay, she says. Section 1867(h) of the act specifically prohibits a delay in providing required screening or stabilization services to inquire about the individual's payment method or insurance status. ■

Source

For more information, contact:

- **Charlotte Yeh**, MD, FACEP, Regional Administrator, Centers for Medicare & Medicaid Services, Boston Regional Office, JFK Federal Building, Room 2325, Boston, MA 02203.

CDC: Heart problems not linked to smallpox vaccine

The nation's efforts to vaccinate ED staff and other frontline health care providers against smallpox hit a serious bump when some people developed serious heart problems after the vaccination, but the concerns were unwarranted, states the Centers for Disease Control and Prevention (CDC) in Atlanta.

Three deaths and 13 other serious heart problems occurred following vaccination with the New York City Board of Health (NYCBOH) strain of the smallpox virus, according to the CDC's *Morbidity and Mortality Weekly Report* on Oct. 3, 2003.

When those heart problems were first revealed, the CDC recommended that individuals with potential heart disease forego smallpox vaccination.

There was no clear evidence that the heart problems were associated with the vaccine, however, and the latest information from the CDC indicates there is no connection.

To determine if the vaccine caused heart problems, the New York City Department of Health and Mental Hygiene studied a 1947 vaccination campaign during which more than 6 million residents were vaccinated with the same NYCBOH strain. The researchers compared New York City death certificates filed after the vaccination period in 1947 to those filed in the same periods in 1946 and 1948.

They found no evidence during this earlier period that smallpox vaccination caused heart problems. ■

SARS plan offers tools, but could be hard to use

ED managers are no longer on their own when it comes to figuring out how to respond to prepare and respond to a resurgence of severe acute respiratory syndrome (SARS) — but they're not home free just yet.

The Centers for Disease Control and Prevention (CDC) recently released a draft version of its plan for what you should do, and though you're likely to find useful tools and strategies, some may be difficult to implement.

ED managers probably will welcome the advice, but they may be less thrilled when they realize how much it costs to follow some of the guidelines, says **Brian F. Keaton**, MD, FACEP, attending physician in department of emergency medicine at Summa Health System, in Akron, OH, and secretary treasure of the American College of Emergency Physicians in Washington, DC.

He urges ED managers to study the many tools and resources provided in the plan and incorporate them in their SARS response plans when possible.

But Keaton also notes that the CDC's plan represents a "best possible response" that requires money and resources to implement. While he has no disagreement with the CDC plan, he doesn't think every ED will be able to implement it fully.

"While I'm happy to get the specific guidance, I'd also like to get some of the resources that I'll need to do these things in my ED," he says.

"You're looking at some pretty substantial resource demands for something that might happen, as opposed to spending that money on things that happen every day. Those are the realities we face when we look at implementing these plans," Keaton adds.

Health officials caution that SARS may return with this year's flu season, and it may be difficult to distinguish from the common malady.

Keaton and other experts say emergency physicians and department managers should pay attention to public health trends because they will determine how much diagnosing SARS should be a concern in your own ED. **(For more on SARS and ED preparations, see *ED Management*, September 2003, p. 97.)**

Algorithms for screening potential SARS

Keaton says some of the specific guidance in the CDC's SARS plan may help alleviate the uncertainty about how to screen for SARS. In particular, ED managers and physicians may find useful the CDC's two algorithms for evaluation and management of patients with radiographic evidence of pneumonia — one to use when there is no evidence of SARS activity worldwide, and one to use when SARS has been reported. **(For one of the algorithms, see p. 142. To download the entire CDC plan free of charge, go to www.cdc.gov/ncidod/sars/sarsprepplan.htm.)**

The plan outlines the concepts and strategies that the CDC says should guide the U.S. response in the event of a SARS outbreak. It provides specific guidance to ED managers and also describes many of the activities needed at the federal, state, and local levels to prepare for and respond rapidly and decisively to a re-emergence of SARS.

Hospitals, state, and local health departments and other public health providers will have an opportunity to comment on the draft before it becomes final, but the CDC suggests that much of its content can be used immediately.

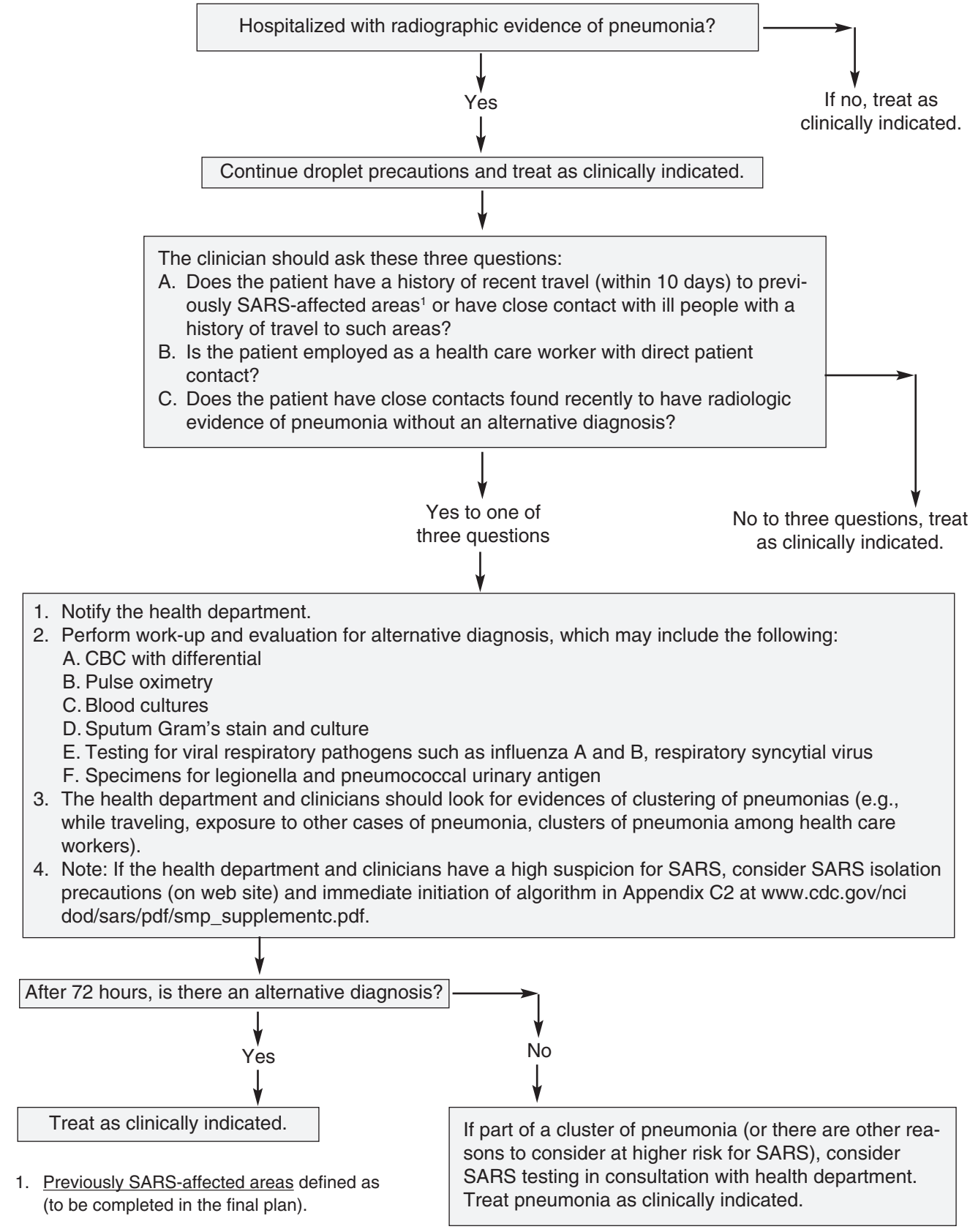
"The CDC guidelines are good ideas," Keaton points out. "They provide a huge service to EDs in that they give us an organized structure and specific strategies to follow." ■

Source

For more information, contact:

- **Brian F. Keaton**, MD, Secretary Treasurer, American College of Emergency Physicians, 2121 K St., Suite 325, Washington, DC 20037. Telephone: (800) 320-0610.

Evaluation and Management of Patients Hospitalized with Radiographic Evidence of Pneumonia, in the Absence of Known SARS Activity Worldwide



1. Previously SARS-affected areas defined as (to be completed in the final plan).

Source: Centers for Disease Control and Prevention, Atlanta.

CE/CME *questions*

13. How did the ED at Onslow Memorial Hospital keep nurses aware of its left-without-being-seen rates?
    A. By telling individual nurses during performance reviews
    B. By posting rates in the ED
    C. By periodic announcements on the hospital's public address system
    D. By including the rates in the hospital's annual report
14. Who staffs the fast-track unit in the ED at Onslow Memorial Hospital?
    A. Physicians
    B. Registered nurses
    C. Physician assistants and volunteers
    D. Nurse practitioners and licensed personnel
15. According to the research regarding computed tomography (CT) scans to rule out subarachnoid hemorrhage, what should happen when the scan shows no hemorrhage and no alternative diagnosis?
    A. No more testing is necessary.
    B. A more sensitive CT scan should be obtained.
    C. The patient should be observed for 72 hours.
    D. The patient should undergo a lumbar puncture.
16. With the Screening Tool for Early Predictors of PTSD (STEPP) tool after traumatic injury, what percentage of children who screened positive actually developed post-traumatic stress disorder (PTSD)?
    A 5%
    B. 25%
    C. 55%
    D. 75%
17. About how long does it take to use the STEPP screening tool for PTSD?
    A. 2 minutes
    B. 4 minutes
    C. 8 minutes
    D. 16 minutes
18. According to the final EMTALA rule, who is allowed to contact the patient's primary care physician for information that may be useful in assessing and treating the patient?
    A. No one
    B. Only a nurse
    C. Only a physician
    D. Any qualified medical personnel

Answer Key: 13. B; 14. D; 15. D; 16. B; 17. A; 18. D

SARS audio program updates guidelines

Leading epidemiologists say a global return of severe acute respiratory syndrome (SARS) — which wreaked havoc on the health care systems that had to deal with it — is almost inevitable. The current overriding concern is that SARS will resurface as a seasonal illness along with influenza and other respiratory infections. Indeed, it would be a surprising development if the emerging coronavirus did not return, said **Julie Gerberding**, MD, MPH, director of the Centers for Disease Control and Prevention (CDC).

"As an infectious disease expert, I can say in my experience, I've never seen a pathogen emerge and go away on its own," she said. "I think we have to expect that somewhere, some time, this coronavirus is going to rear its ugly head again; and that's the whole purpose of all this preparedness effort."

What would happen *today* if a patient with suspect or probable SARS showed up at your ED? To help you prepare for the threat, Thomson American Health Consultants offers the upcoming audio conference: **The Resurgence of SARS: Why Your Hospital May Not Be as Prepared as You Think**, Dec. 9, 2:30-3:30 ET. Let our experts help you answer that and many other critical questions with practical tips and solutions to detect first cases and protect other patients and health care workers.

Our speakers include **Allison McGeer**, MD, director of infection control at Mount Sinai and Princess Margaret Hospitals in Toronto. A veteran epidemiologist, McGeer dealt firsthand with SARS patients and occupationally infected workers during the prolonged outbreak in Toronto. Hear the lessons learned by someone who has dealt with this novel emerging pathogen on the front lines.

If SARS returns, hospital EDs certainly will be on those front lines. To provide valuable guidance and critical insight in that setting, **Susan E. Shapiro**, PhD, RN, MSN, CEN, will outline valuable tips and procedures, in addition to addressing and clarifying recently updated CDC recommendations for SARS. Shapiro is a postdoctoral fellow in risk assessment and intervention research with individuals and families at Oregon Health and Science University School of Nursing in Portland. A career ED nurse and nurse manager before

COMING IN FUTURE MONTHS

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- Cross-training staff — methods that work

recently completing a doctoral program, Shapiro is the Emergency Nurses Association's representative to the CDC's SARS task force.

Educate your entire staff for one low fee including 1 hour of CE, CME, or critical care credits for all attendees. You may invite as many participants as you wish to listen for the low fee of $249. Information on obtaining audio conference instructions and continuing education forms will be in the confirmation notice, which will be mailed upon receipt of registration. Your fee also includes access to a 48-hour replay following the conference and a CD recording of the program.

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CE/CME objectives

- Discuss and apply new information about various approaches to ED management. (See *"Want to drastically cut LWBS numbers? Try ice packs and adding a fast track"* and *"Fast track keeps everyone moving through your ED"* in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *"EMTALA Q&A."*)
- Share acquired knowledge of these developments and advances with employees. (See *"Are more lumbar punctures needed after CT scan?"* and *"SARS plan offers tools, but could be hard to use."*)
- Implement managerial procedures suggested by your peers in the publication. (See *"Tool ensures follow-up for traumatized children"* and *"Simple questions used in screening kids for PTSD."*) ■

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

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