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The monthly update on Emergency Department Management

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Avoid construction nightmares by taking charge of the process and setting rules

Some disruption inevitable, but careful planning can make it bearable

Sooner or later, your emergency department will be the site of some type of construction project, whether it is a full-scale renovation or a relatively small repair job. If you think your ED is hectic now, just imagine a bunch of construction workers tearing out walls with sledgehammers and sawing lumber while your physicians and staff try to continue with patient care.

That's what the staff encountered most days when Pocono Medical Center in East Stroudsburg, PA, renovated its 18-bed ED into a 36-bed department two years ago. **Pete Favini**, MD, medical director at Pocono, says the yearlong experience was a real challenge for everyone working in the ED.

"It is said that surgery is like working on a car with the engine running," Favini says. "Working in an emergency department under renovation is like working on that car while it is racing at full speed."

Not a pretty thought? Some of that scenario always is going to be unpleasant, but it doesn't have to be a complete nightmare, says **Jon Huddy**, managing principal of FreemanWhite, a firm in Charlotte, NC, that specializes in health care facility design. Huddy has overseen many ED construction projects, and he says there are specific ways to keep the disruption to a minimum.

Favini agrees and says planning and ingenuity are necessary if you are going to make the best out of a construction project. You might have to come up with novel ways to work around the disruption, but he says you can make the experience a positive one in the end.

Executive Summary

A construction crew in your ED guarantees some level of disruption, but you can keep your department functioning well by hiring contractors familiar with health care settings and establishing ground rules up front.

- The ED manager must be firm about patient safety and unnecessary disruptions.
- You can reasonably expect contractors and their crews to behave appropriately in your ED.
- Don't stop construction work unless necessary, or you may incur costly penalties.

"At one point, we were working out of two separate areas because of the construction, and our ED staff communicated by walkie-talkies," Favini continues. "Renovation and construction are great opportunities for process change for ED management and a wonderful pickup for staff morale once you get finished."

Most likely, your hospital's facilities department will be in charge of finding the contractor and working directly with that company. Thus, it is important for you to convey all of your concerns to the facilities department and establish good communication, Huddy adds.

Start early if you want to keep your ED running during the construction, he explains. When the architect and engineers are putting together a plan, they must incorporate phases of construction and come up with alternatives to normal operating conditions, such as temporary entrances for ambulances and other patients. Don't wait until all those plans have been made to get involved, Huddy says.

Once construction starts, make sure you understand who is in charge of the construction. For starters, it's not just a single construction company. There may be one company that your hospital contracted with, but that company then hires other subcontractors to do specific jobs. This arrangement matters when you're trying to maintain control of the department.

"If you want construction halted because you have a trauma, it's not as easy as turning to the first guy you see hammering nails in the wall and telling him to stop everything," Huddy continues. "That guy may be a subcontractor with no authority at all. You need to know who is in charge of the job site and deal directly with that person." Planning can make all the difference, he says. For instance, make sure there is specific language in the contract that allows the ED manager to temporarily halt construction. The contract should specify that you can, within reason, halt all work for short periods.

"If that language is not in the contract, every time you stop work, they can say you have caused them a delay and charge the hospital extra money over and above the contract," Huddy explains. "And you can give them excuses for falling behind schedule."

Savvy contractors will charge more for a contract that allows you to stop work temporarily, but he adds that is a fair exchange and better than paying penalties.

One potential problem with construction projects is having so many nonhealth care personnel in your ED. With the facilities department and the contractor, you should establish what is acceptable behavior by the construction crews. Can they play music while they work? What type of clothing is acceptable? Can they curse? Construction workers these days don't all fit the boorish stereotype, but many also aren't used to working in a clean environment such as your ED.

"You have to be careful if you get a contractor who hasn't done work in a health care setting before," Huddy says. "If they're used to working in a half-finished office building with no one else around, you might not be happy with how they act in your ED."

But is it reasonable to think that you can control the behavior of construction workers? Absolutely, says **Bob Buckner**, head of the construction department at FreemanWhite. Don't just assume that you have to put

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up with a loud, rowdy crew until the work is done.

"Our contracts usually require acceptable dress that prohibits shorts, T-shirts with offensive language, and working shirtless," he says. "We also specify things like the hospital being a smoke-free campus, the use of embarrassing language, or harassment. It's entirely reasonable to expect a certain level of decorum from the contractor, and if they can't meet that standard, you're dealing with the wrong contractor."

You also should specify how you expect the construction crews to leave your ED when they go home for the day. Some mess is to be expected, but you can require that certain areas be cleaned, tools put away, and no hazards be left behind. (Infection control will be involved with the construction planning as well and will have their own requirements, such as sealing off areas with plastic film.) "It will be a tough experience, but you can have very high expectations of the people who will be working there," Huddy says.

Though you must exercise control, you shouldn't look at the construction crew as an invading army, he stresses. To the contrary, he encourages the ED manager to introduce the crews to the ED staff and develop some rapport. You're going to be working side by side for a while, so things will go more smoothly if you know each other's names.

"You can have a lunch with the contractors before they start so that everyone knows the name of the guy who's hammering on the wall," Huddy says. "It sounds kind of hokey to have a big picnic with name tags and all, but it really does help."

Patients tend to take construction in stride, he adds, but staff can be a different matter because it interferes with their daily surroundings and lasts a long time.

Tips for surviving work projects in your ED

Jon Huddy, managing principal of FreemanWhite, a Charlotte, NC-based firm that specializes in health care facility design, offers these tips for surviving construction in your ED:

✔ **Understand what is coming tomorrow, next week, and next month.**

What walls will be coming down? What type of work will be done, and what type of noise should you expect? When and where will the entrances be moved? Will signage be changed in time?

Communicate these plans to staff so they can anticipate changes and not be confused when they show up for work. Remember to inform the night shift, who often are overlooked.

✔ **Always ask how the next phase will affect your patient care spaces.**

Your patient care spaces may fluctuate greatly. One week you may have 35 spaces when they open a new wing, but then it will drop down to 22 spaces when they take over another wing.

✔ **Plan for compromise, but avoid surprises.**

Some compromise is necessary when the construction crews must do something that is disruptive. If tearing down a wall in your exam area is going to throw your department into chaos, you can work with the contractor to do it when you expect your census to be the lowest, maybe during the overnight shift. But it has to be done sometime, so be prepared to compromise.

"What you don't want is a surprise," Huddy points out. "You don't want the contractor to show up one morning when you've got dozens of patients and start knocking down your wall. Communication is everything."

✔ **Inform the emergency medical services (EMS) providers in your community.**

EMS providers must know when your ED will change entrances and where to go. No one wants to see an ambulance driving around the campus looking for the temporary entrance to your ED. Make sure the signage is clear and updated regularly.

✔ **Avoid stopping the construction work unless absolutely necessary.**

The ED manager should have the ability to stop all construction work, or a particular part of it, but should do so only as a last resort. Only call a work stoppage if you believe the construction is going to negatively affect patient care, patient safety, or staff safety. You also should be specific on what work must be stopped and for how long. For the contractor, there is a huge difference in asking that there be no jackhammer use for the next hour vs. no one working in a certain area for the rest of the day. One can result in reassigning a worker for a while, and the other can result in a dozen workers being sent home for the day.

✔ **Make sure all significant communication goes through the key contacts.**

Key contacts probably will be the ED manager (or the hospital's other designee from the facilities department) and the construction supervisor. Avoid having staff hand out instructions, such as work stoppages, to individual construction workers. Encourage staff to be friendly but emphasize that staff and physicians should not give direct orders.

✔ **Provide orientation for the construction crews.**

Show them around so that they know the critical areas of your ED, such as trauma rooms and hallways with a lot of traffic. Point out entrances where ambulance crews will bring in patients and explain those areas need to be kept free of hindrances at all times and that there should never be an extension cord across the hallway. ■

Sources

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Huddy says he has seen success with letting the ED team get involved with some of the demolition during the project.

"Letting a nurse or physician take a few swings with a sledgehammer can be a fun way to establish camaraderie and participation in the project, as opposed to just feeling that the contractors are in the way all the time," he states. ■

Increase capacity with chest pain accreditation

If you already are working to optimize the care of cardiac patients in your ED, seeking accreditation as a chest pain center can be a good way to draw attention to your efforts, improve capacity, and make sure you maintain those standards over time. And if you're not yet focusing on how you can improve in this area, accreditation could be one more reason to get started.

That's the advice from an ED manager who is seeking chest pain accreditation for six additional EDs at Florida Hospital in Orlando, after receiving the state's first accreditation as a chest pain center in one of the EDs. The hospital has seven campuses in the area.

Florida Hospital's first ED was accredited as a chest pain center by the Society of Chest Pain Centers and Providers (SCPCP) in Columbus, OH, which began offering accreditation in 2003.

Florida Hospital's seven EDs treat more than 18,000 patients with chest pain annually and have been working for years to improve cardiac care, according to **Jackie Mueller**, RN, MSHS, administrative director of emergency services and flight medicine.

Some of the improvements have included shorter times between arrival in the ED and the patient's electrocardiogram (EKG) and faster transfers for angioplasty and other treatment. Chest pain patients are transferred to the cath lab within 30 minutes, when necessary. Patients needing angioplasty are transferred within 15 minutes. All of the clinical improvements were based on best practices in cardiology from the Dallas-based American Heart Association and current literature, Mueller says.

"The primary goal was to improve patient care, but there also is a tremendous benefit to the capacity for the ED because we've developed a continuum of care with places appropriate for the patient, such as a chest pain observation unit," she says. "Once we've made some very quick decisions about a patient, we're able to move them out of the ED in a timely manner to continue the flow of patients through the ED."

With the focus on improved care of chest pain patients, the ED is able to turn over beds for those patients faster, and staff are excited about providing the best treatment possible. **(For more on how Florida Hospital optimizes treatment for chest pain, see article, p. 17.)**

That's all well and good, but an ED could pursue the same goals without accreditation, right? That's true, Mueller says, but accreditation provides the recognition that the ED staff deserve and helps get the most public relations benefit out of the improved care.

"Staff appreciate hearing that not only is all this hard work paying off in better quality care, better capacity, and better relationships with the department of cardiology, but they're also being recognized for what they're doing," she explains. "There are lots of good reasons to take the steps to improve cardiac care, and then accreditation is icing on the cake."

The hospital's marketing department is making use of the new accreditation by pointing to it as a mark of excellence that sets the hospital apart from others in the state, Mueller points out.

Actually obtaining the accreditation was not difficult, she says. Most of the work involved compiling information for the visit, such as education plans and how the hospital's care plan includes working with emergency medical services.

"They came in for a one-day site visit and reviewed what we do, visited the different areas, and went through some information with us," Mueller adds. "It wasn't much of a burden. All the hard work is in the clinical processes that make you eligible for accreditation."

The SCPCP requires a hospital to meet specific criteria for accreditation, such as integrating the ED with the local EMS and ensuring prompt transfers out of the ED. To start preparing for chest pain accreditation, the hospital can purchase a kit that includes a manual, application, self-evaluation, and other materials for $150.

When the hospital is ready for a site visit to seek accreditation, the fee is $15,000. **(For more on the**

Code STEMI moves heart patients quickly from ED

One part of the special cardiac care program that helped Florida Hospital in Orlando receive accreditation as a chest pain center is the "Code STEMI" program. Code STEMI stands for "segment elevation myocardial infarction" and results in the patient being transported quickly from the ED to the catheterization lab.

The code was part of the improvements in cardiac care that recently gained the hospital accreditation from the Society of Chest Pain Centers and Providers (SCPCP) in Columbus, OH.

Code STEMI is a new alert system that immediately notifies the hospital's specially trained cardiac team when a patient is experiencing an acute heart attack, says **Danielle Johnson**, RN, BSBM, administrative director of cardiovascular services. She says the code works much like the better known "code blue" and is activated in the same way.

Calling a Code STEMI alerts the Florida Hospital ED, the emergency medical services team, the air ambulance crew, catheterization lab, and interventional cardiologists, says **Jackie Mueller**, RN, MSHS, administrative director of emergency services and flight medicine. When a patient arrives at any of Florida Hospital's seven locations with chest pain, the Code STEMI system helps fast-track patients who meet certain criteria.

"Our goal is to perform an electrocardiogram [EKG] within just a few minutes of their arrival," she points out.

A physician on the Code STEMI team immediately reads the EKG to determine whether the patient is experiencing an acute heart attack. If indicated, he or she immediately notifies a cardiologist.

"A lot of our efforts to improve chest pain care focus on getting the patient out of the ED to the best care available, without any unnecessary delays," Mueller says. "The code helps us do that." ■

Sources

For more on chest pain accreditation, contact:

- **Robert Weisenburger Lipetz**, Executive Director, Society of Chest Pain Centers and Providers, 4900 Reed Road, Suite 209, Columbus, OH 43220-3164. Phone: (614) 326-1264. Web: www.scpcp.org.
- **Jackie Mueller**, RN, MSHS, Administrative Director of Emergency Services and Flight Medicine, Florida Hospital, 601 E. Rollins St., Orlando, FL 32803.

accreditation program, see source box, below left.)

About 30 chest pain centers have been accredited so far, and another 30 or so should be accredited by May 2004, one year after the program was announced, says **Robert Weisenburger Lipetz**, executive director of the SCPCP. "The number of accredited facilities is greatly exceeding expectations," he says. "It's looking like the market is embracing this idea."

Much of the accreditation criteria focus on process improvement systems, Lipetz adds. The SCPCP also requires a collaborative effort between many hospital departments, most notably the emergency and cardiology departments, he explains. The accreditation criteria are intended to keep the hospital focused on providing the best cardiac care possible even as clinical guidelines change. "We're not talking about a form that you fill out and throw in a drawer until the inspectors come by again," Lipetz says. "If you meet our criteria, you will have a system of protocols, policies, people interactions, and everything the hospital will need to keep moving forward and creating better outcomes."

While accreditation as a chest pain center requires a hospitalwide effort, the ED manager always will be a key player, if not leading the charge, Mueller explains. Nearly all chest pain patients enter the hospital through the ED, she notes, and the quality of care in the ED can affect everything that happens afterward.

Mueller and the rest of the ED team worked collaboratively with physician groups and the cardiology department to improve quality of care. "Being able to quickly identify the patients needing cardiac care and have a process for moving those patients — that's where the ED manager is going to be working the hardest and getting the biggest benefit," she adds. ■

Headache, abdominal pain pose liability risk

(Editor's note: This is the second of a three-part series covering the top five issues that lead to malpractice claims in the ED and how you can address them. The January 2004 issue of ED Management *addressed chest pain, and this month's installment involves headache and abdominal pain. Next month, the last installment will address head injury and stroke.)*

Though it is impossible to eliminate the malpractice risk in the ED, you can greatly reduce the risk by better addressing headache and abdominal pain, said **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of

emergency medicine at New York Hospital Medical Center of Queens in Flushing.

Sixsmith's insight comes from 25 years as an expert witness and malpractice consultant, in addition to her years in the ED. She spoke on the topic at the recent meeting of the American Society for Healthcare Risk Management in Nashville, TN, along with **Andrew S. Kaufman**, JD, a partner with Kaufman Borgeest & Ryan in New York City, a prominent law firm defending health care malpractice claims.

The patient presenting with a terrible headache is a clinical challenge and a huge liability risk, Sixsmith explained. Does the patient have only a routine headache or a subarachnoid hemorrhage that could kill suddenly? The temptation is great to assume that the patient only has a normal headache, but that assumption could have terrible consequences, not only for the patient but also in terms of your liability.

Likewise, the patient with abdominal pain could have bad case of gas or an aortic dissection. The huge difference in outcomes, and the limited time and background available to the ED physician, creates a tremendous liability risk, Kaufman said.

"ED physicians are at a distinct disadvantage," he explained. "They're expected to catch every case of aortic dissection without overreacting and practicing too much defensive medicine every time someone says they have a stomachache. We're asking a lot of them."

A CT scan and lumbar puncture (LP) often are necessary to properly diagnose the cause of headache, but Sixsmith said ED physicians often perform only the CT scan and don't proceed on to the LP when the CT is negative. That's a big mistake clinically and in terms of risk management, she added.

"If the patient needs a particular procedure, you can't say he doesn't need it because it's difficult. Either he needs it or he doesn't," she continued. "A

Headache case illustrates the risks of poor ED care

To explain how EDs often leave themselves open for liability when treating headaches, **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing, tells a story, based on a real incident, in which everything went wrong.

Sixsmith told this story at the recent meeting of the American Society for Healthcare Risk Management in Nashville, TN:

A 25-year-old mother of two presented at the ED with a two-day history of fever, headache, and confusion. A resident and attending examined the woman, and when there were no focal findings on the neurological exam, their differential diagnosis was encephalitis and meningitis. They decided to do a lumbar puncture (LP), which a resident attempted three times with no success.

With no active supervision of the LP by the attending ED physician, the two physicians decided the patient didn't really need an LP after all because the resident was having too much difficulty doing it. She left with a diagnosis of reaction to amoxicillin. The next day, her husband called the family doctor and told him that he thought his wife was having a nervous breakdown. The family doctor referred the wife to the local outpatient psychiatric facility. The psychiatrist there spent five minutes with her, felt strongly she had an organic process, not a psychiatric one, and referred her back to the ED.

In the ED, the differential again was encephalitis, but also acute depressive psychosis. The plan was to do a computed tomography (CT) and an LP. But then there was a shift change. The oncoming physician, without examining the patient, decided she was really a psychiatric problem and requested a psychiatric consult. No psychiatrist was available at 3 a.m., so the patient was discharged and told to return in the morning. That day, the patient had a grand mal seizure and was hospitalized, in a coma, from which she gradually improved over several weeks. The diagnosis was herpes encephalitis. The patient ended up with residual cognitive deficits and sued for malpractice.

So what went wrong in that case? Just about everything, Sixsmith said. These are some of the lessons:

- The standard of care for new onset headache is a careful history and a complete and documented neurological exam.
- A CT scan and LP should be done sooner rather than later; and in many cases, a neurological consult is helpful.
- Unsupervised care provided by residents often results in mistakes. "When the resident could not do the LP, there was no reason for the attending not to step in or for an alternative, more expert provider to do the LP," she explained. "Deciding that the LP was no longer necessary defies logic."
- Regarding the second ED visit, Sixsmith advised you should always "look twice as hard to find the cause of the patient's symptoms on the second visit."
- It is equally important that the off-going and incoming doctor are crystal clear about what the plan is about the patient, "so that the second doctor doesn't cavalierly dismiss a patient whom he or she didn't initially evaluate," she added. ■

Sources

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standard policy in the ED should be 'If you think of it, do it.'" **(For more advice on treating patients complaining of headache, see article, p. 18.)**

Sixsmith said that, from her experience in working with ED lawsuits, abdominal pain is the most frequent condition leading to malpractice suits.

It is difficult to diagnose because the symptoms often are nonspecific. She explained that incorrectly diagnosed ischemic bowel, perforated viscous, and appendicitis often lead to prolonged hospitalization, significant complications, infertility, and not infrequently, death.

"The ED provider is well-advised to pay attention to the abdominal exam and do it well," she added. "Patients with tenderness usually have pathology; but not infrequently, they will have completely normal blood tests and plain X-rays."

CT scans have completely changed the management of abdominal pain, Sixsmith said. The standard is no longer "admit and observe" or "discharge and hope," she explained. "A CT is now the standard of care for abdominal pain, and I will stake my professional reputation on it," she said. "It's no longer just observation. Make sure your institution makes it easy for ED docs to get a CT scan."

Because surgeons are regarded as the experts in evaluating abdominal pain, it is difficult to defend *not* calling in a surgical consult, Sixsmith noted. Many abdominal conditions present atypically, especially in elderly patients, she said, so this common complaint must prompt a thorough examination.

All patients complaining of abdominal pain should undergo a rectal exam, Sixsmith added, and a normal blood test does not rule out an abnormal process. Heed other red flags, such as low blood pressure, fever, or tachycardia.

She also cautioned that, more so than many others, abdominal pain is a condition in which the patient's personal behavior can get in the way of a proper diagnosis.

Sixsmith recounted an elderly patient in her own ED who complained of severe epigastric pain but was uncooperative and kept insisting he only needed an enema. He eventually received an enema and was discharged soon after with a diagnosis of abdominal pain. The patient returned to the ED hours later and was diagnosed with a perforated peptic ulcer. The patient died after several weeks of postoperative complications. Sixsmith said the patient's unpleasant attitude may have gotten in the way of a good diagnosis on the first visit.

"Don't let a patient's behavior, insurance status, substance abuse, hairstyle, or personality affect your diagnosis," she advised. "Stick to what you know are the right steps toward a diagnosis." ■

A billing analyst can find $300,000 for your ED

A dedicated billing analyst for your ED can generate hundreds of thousands of dollars that goes straight to the bottom line instead of just flying out the window, say two managers who have added about $300,000 a year. And that's a *net* increase in revenue after accounting for contractual discounts and reimbursement levels, and after subtracting the salary of the billing analyst.

The ED at Carondelet St. Mary's Hospital in Tucson, AZ, has had a billing analyst in place since 1996, and she has greatly improved the financial status of the department, says **Cassie Pundt**, RN, clinical manager of emergency services. "I know that we're capturing tons and tons of revenue that otherwise would have been missed," she adds.

The other billing departments and coders don't look at things as closely as they do, so many items are overlooked, Pundt says. "Other hospitals use their own billing departments and train people specially for ED charts, but we have a dedicated person for just reviewing ED charts within our own department," she explains.

The difference all comes down to the degree of expertise and how much the analyst can focus exclusively on ED charts, she says. Having one person who is experienced in the ED and can focus entirely on its charts yields far more revenue than just urging staff in the hospital's billing department to look more carefully at the ED charts, Pundt continues.

The St. Mary's ED billing analyst reviews all charts before they leave the ED and looks for missing documentation or errors that might result in reduced reimbursement. If anything is missing, she can go directly to the appropriate nurse. If the nurse has miscoded the acuity level, the analyst can study the care provided and has the authority to raise the acuity level when appropriate.

Sources

For more on billing analysts, contact:

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The St. Mary's billing analyst program was started by **Maggie McClellan**, RN, MBA, now director of emergency critical care services at sister hospital Carondelet St. Joseph's Hospital in Tucson.

She recalls that her ED in 1995 routinely was losing out on money it was rightly due.

"Every day I would get a pile of either lost charges or inability to charge from our charging department because of inappropriate documentation or lack of charge slip being sent to that department," she says. "I had an employee who was on light duty, and I was looking for something for her to do. So I had her start checking records before they left the department to see how we could capture charges better."

That modest effort started paying off, so McClellan put more effort into it. The St. Mary's ED developed a process for using bar codes based on charges, and then the billing analyst used those bar codes and a thorough catalog of procedures to check charts for the necessary documentation. Within a couple of months, McClellan realized that the ED was recouping more money than it was spending on the billing analyst.

After a year of success with the effort, McClellan proposed to the hospital that it create a permanent position for an ED billing analyst. Once she showed hospital leaders the numbers from the past year, they couldn't say yes fast enough.

Over that first year, the St. Mary's ED billing analyst identified more than $1 million of charges that would have been lost, McClellan says. After applying the hospital's standard contractual discounts and other factors that reduce the actual reimbursement level, the ED actually received about $400,000 in additional revenue for the year. The billing analyst made about $12 an hour, so with her salary and benefits deducted from that sum the hospital was left with about $300,000 per year in new revenue.

"That's held steady for a while now," she says. "It's clear that you can recover far more than you pay for the billing analyst. It's kind of a no-brainer when you look at the numbers."

When she moved to the St. Joseph's ED across town, McClellan instituted the same program and is seeing the same results. Experience in the ED is important to making the billing analyst effective, so she looked for someone who had been there long enough to know the staff and intricacies of how the department worked.

McClellan also wanted someone who could be extremely focused and "willing to be very nitpicky and thorough when reviewing the charts." She found a clerk who had been there for 15 years and moved her to the new billing analyst position. McClellan says you can expect to pay between $12 and $17 per hour for a dedicated ED billing analyst.

St. Joseph's considered providing a bonus program to the analyst tied to the amount of revenue she generated from chart reviews but ultimately decided against it. Such a bonus program could encourage the analyst to be too liberal in assessing charts and lead the hospital into fraudulent charges. Instead, the analyst participates in a bonus program open to other employees but not tied directly to the amount of revenue she generates.

The St. Joseph's ED sees more than 60,000 patients a year, and the billing analyst must review each of their charts before it leaves the department.

"She's busy but stays pretty well current," McClellan explains. "Mondays are bad because she has to do charts from the whole weekend. She has three days to do the reviews and usually makes it."

Aside from the increased revenue, McClellan points out one benefit of the billing analysis: She gets to see exactly how well individual staff members are documenting patient care. "It does allow us to do focused reviews from a staffing standpoint to see who is appropriately documenting and who isn't," she says. "The nurse manager will speak to the billing analyst and see who isn't documenting appropriately and then speak to them or provide additional training." ■

Coding study shows wide variance, undercoding

More than a year after implementation of the Medicare outpatient prospective payment system (OPPS), there are "unexpected variances" in the assignment of evaluation and management (E&M) codes on claims from EDs, suggesting many are undercoded or overcoded and may risk compliance charges.

E&M codes reflect the extent of clinical staff involvement with a patient and define payments ranging from $63 to $408 for the medical component of a hospital-based outpatient visit. Undercoding can result in lower

levels of reimbursement, but overcoding can be a compliance problem requiring immediate intervention and correction.

Overcoding can result in substantial monetary penalties, sometimes three times the value of the disputed charge, according to the Department of Health and Human Services. Substantial overcoding also can lead to compliance charges that could bring more penalties, civil charges, and expulsion from the Medicare system.

A recent study by American Hospital Directory in Louisville, KY, used hospital OPPS claims to define normal Medicare payment levels and distributions of patients among various levels of E&M codes for calendar year 2002.

Data for some hospitals indicate that there may be systematic undercoding or overcoding of ED encounters, says **Paul Shoemaker**, president of American Hospital Directory. The company provides the operating details of virtually every hospital in the United States as a free online service, plus other services for a fee.

The E&M study shows, for example, that there were eight hospitals with more than 90% of their patients classified to APC 610, the lowest E&M level.

While there could be operational reasons for such a low intensity, Shoemaker says, a hospital falling outside normal ranges should make certain that valid reasons exist. If patients routinely are being classified to the lowest APC regardless of actual circumstances, a hospital would be underreimbursed.

Conversely, there were 19 hospitals with fewer than 2% of their patients classified to APC 610. Shoemaker says it is difficult to define a normal percentage for that APC because of variations in patient populations and levels of care, but anything on the extremes should be questioned.

"Again, it is important to understand the reasons," he says. "If patients are being erroneously classified to a higher range, there could be a compliance problem related to overreimbursement."

Shoemaker says the findings of this study should be useful in helping a hospital to determine whether its E&M coding is within expected ranges.

A free copy of the complete study can be retrieved from the American Hospital Directory web site at www.ahd.com/EMstudy040108.pdf. ■

Source

For more on ED coding, contact:

- **Paul Shoemaker**, President, American Hospital Directory, 4350 Brownsboro Road, Suite 110, Louisville, KY 40207. E-mail: inbox@ahd.com. Phone: (800) 894-8418.

Medicare issues rule on smallpox damages

The Department of Health and Human Services (HHS) has announced an interim final rule to identify and compensate ED staff and others injured as a result of receiving a smallpox vaccine. The interim rule for the new Smallpox Vaccine Injury Compensation Program describes eligibility criteria, the process for requesting benefits and receiving payments, and other necessary policies and procedures.

Funded at $42 million, the program provides financial and medical benefits to eligible members of an HHS-approved smallpox emergency response plan who sustain certain medical injuries caused by a smallpox vaccine. In addition, nonvaccinated individuals injured after coming into contact with vaccinated members of an emergency response plan — or with a person with whom the vaccinated person had contact — may be eligible for program benefits. The program also provides benefits to survivors of eligible individuals whose death resulted from a covered injury.

While some ED managers welcome the compensation plan, it might not alleviate the difficulty of convincing staff to be vaccinated, says **Val Gokenbach**, RN, MBA, CAN, director of emergency services and observation at William Beaumont Hospital in Royal Oak, MI. "Although I agree with the need for the compensation program, it has not changed the minds or increased the willingness of the staff to become vaccinated," she explains. "Without an imminent threat, the risks of the vaccine still seem to outweigh the perceived benefits."

To file a claim, and to find forms and information, go to: www.hrsa.gov/smallpoxinjury. ■

ACEP endorses rules for avoiding wrong sites

The American College of Emergency Physicians (ACEP) in Irving, TX, has joined more than 40 organizations endorsing a new universal protocol to standardize pre-surgery procedures for verifying the correct patient, the correct procedure, and the correct surgical site. The protocol focuses attention on marking the surgical site, involving the patient in the marking process, and at least in the operating room, taking a final time-out to double-check information among all members of the surgical team.

The protocol was developed by the Joint Commission

on Accreditation of Healthcare Organizations with several organizations that also have been addressing the problem in recent years. Joint Commission president **Dennis S. O'Leary**, MD, reports that despite years of intense focus on the problem of wrong-site surgery, the organization continues to receive five to eight new reports of wrong-site surgery every month.

The Joint Commission's new national patient safety goals, which became effective Jan. 1, 2003, include a goal to eliminate wrong-site surgery.

The universal protocol officially will become effective on July 1, 2004, for all Joint Commission-accredited hospitals, ambulatory care surgery centers, and office-based surgery sites. Compliance may require substantial changes in policy and procedure at some hospitals, says O'Leary. Though much of the protocol already has been in place as part of the patient safety goals, he explains.that recent unannounced Joint Commission site visits revealed 36% of accredited organizations are not marking the operative site.

How much the universal protocol applies to ED procedures may require some judgment, but O'Leary points out it is not exclusively for use in the surgery department. Procedures can be performed on the wrong person or wrong site in the ED, he says, and the right procedure can be performed on the wrong person.

Source

For more information on wrong-site surgery, contact:

- **Linda Groah**, RN, Chief Nurse Executive and Director of Hospital Operations, Kaiser Foundation Hospital, 2425 Geary Blvd., San Francisco, CA 94115. Phone: (415) 929-4000.

While the Joint Commission's protocol leaves room for deciding how many of the steps apply to specific procedures in the ED, O'Leary adds the Joint Commission expects all health care providers to adhere to the spirit of the protocol: Whenever possible, take time to pause and confirm with others and through documentation that you are about to perform the correct procedure. And when possible, mark the operative site ahead of time.

Kaiser Foundation Hospital in San Francisco has adopted the universal protocol with enthusiasm, and that adoption includes the ED, says **Linda Groah**, RN, chief nurse executive and director of hospital operations.

"I know of a case where a chest tube was put into the wrong side of a patient's chest in the ED," she says. "This is an example of how there are opportunities to implement this universal protocol in the emergency room. There is great value in pausing to confirm that you're doing the right thing on the right patient." ■

EMTALA Q & A

Question: We have a hospital 25 miles away that can provide a higher level of critical care for trauma then what we can provide. We recently signed an agreement with them that allows our community-owned ambulance (basic life support) team to call them to dispatch their paramedic squad for an intercept for trauma situations that the ambulance crew feels we cannot handle at our local hospital. Even though the ambulance is community-owned and housed downtown, all the dispatching comes from the hospital. In these situations, the crew call us back and let us know that they are arranging an intercept and will not be bringing the patient to our hospital even if we are closer than the higher level of care. Are we triggering an EMTALA violation? Is there something more we can do to protect ourselves in this arrangement?

Answer: You're not violating EMTALA, explains **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. The reason is that the law does not apply to community-owned ambulances. According to the regulations promulgated by the Centers for Medicare & Medicaid Services (CMS), EMTALA applies only to ambulance services that are owned and operated by a hospital. In the arrangement you describe, the methods of transportation or where the community-owned ambulance chooses to transports patients is not governed by EMTALA.

"Furthermore, you are transporting the patient to the appropriate facility, which is simply good medicine," he adds. "Also, you are taking patients to a higher level of care according to established protocols and not moving patients based on economic or other nonmedically indicated considerations." Health care providers sometimes think that EMTALA applies to emergency medical services systems and ambulances, Bitterman says. Some of this confusion may have arisen since CMS's final EMTALA rule talks about how hospital-owned ambulances must comply with EMTALA.

If in your scenario, the transport unit was a hospital-owned and operated ambulance, CMS would say the patient had come to the hospital's ED and EMTALA applied to that encounter. However, CMS would deem you in compliance with the law because you were operating the ambulance according to established community protocols. "CMS is essentially granting you a safe harbor if you're operating in good faith under community

protocols and those protocols are based on medical indications, not insurance status, doctor-patient relationships, managed care contracts, or other discriminatory reasons," Bitterman says.

As for whether there is anything else to be done to protect your system in this arrangement, he advises keeping good documentation. Demonstrate that you're moving patients according to protocol to provide the best medical care possible under the circumstances and are appropriately utilizing the resources in the community to benefit the patients.

"Also, use physician telemetry or backup to help you decide where to go in tough situations, because undoubtedly difficult scenarios will arise in the field," he says. ■

CE/CME *questions*

For information on the CE/CME program, call customer service at (800) 688-2421.

25. According to Jackie Mueller, administrative director of emergency services and flight medicine at Florida Hospital, what is the goal for transferring patients to the cath lab when necessary?
    A. 15 minutes
    B. 30 minutes
    C. 45 minutes
    D. 1 hour

26. According to Jon Huddy, managing principal of FreemanWhite, a firm in Charlotte, NC, what is true of the construction crews that work in the ED?
    A. You cannot expect them to behave differently than any other construction crews.
    B. You should expect them to behave appropriately and in a more dignified way than they might in other settings, but you must specify the proper behavior up front.
    C. The behavior of the crews will vary from one project to another, and you cannot have much impact.
    D. All construction crews will behave appropriately in your ED, whether you specify that proper behavior up front or not.

27. According to Diane M. Sixsmith, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens, what is the role of CT scans in diagnosing abdominal pain?
    A. CT scans are no longer necessary.
    B. CT scans can be useful but only in limited circumstances.
    C. CT scans can be misleading and should not be employed for abdominal pain.
    D. CT scans are the standard of care for diagnosing abdominal pain in the ED.

28. According to Sixsmith, when is it OK to abandon attempts at a lumbar puncture (LP) to diagnose severe headache?
    A. After three attempts, if performed by a resident
    B. After six attempts, if performed by an attending physician
    C. After three attempts if the CT scan is negative
    D. Never. The LP should be performed if indicated, no matter how difficult.

COMING IN FUTURE MONTHS

- Tracking habitual drug seekers
- Avoiding liability with head injury, stroke
- 'Gridlock page' helps clear crowded ED
- EMTALA for helicopter stopovers?

29. According to those at Carondelet St. Mary's Hospital, how much can you expect to pay an in-house billing analyst per hour?
    A. $9 to $12
    B. $12 to $17
    C. $15 to $18
    D. $17 to $20

30. According to Robert A. Bitterman, MD, JD, FACEP, director of risk management and managed care in the department of emergency medicine at Carolinas Medical Center, when does EMTALA apply to *community-owned* ambulances?
    A. Never
    B. Only when the community has no other ambulances
    C. Only when the ambulance is diverted from a hospital
    D. Always

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. ■

CE/CME objectives

- Discuss and apply new information about various approaches to ED management. (See *"Avoid construction nightmares by taking charge of the process and setting rules"* 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 *"Increase capacity with chest pain accreditation")*
- Implement managerial procedures suggested by your peers in the publication. (See *"Headache, abdominal pain pose liability risk," "Headache case illustrates the risks of poor ED care,"* and *"A billing analyst can find $300,000 for your ED.")* ■

CE/CME answers

25. B 26. B 27. D 28. D 29. B 30. A

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Disease-specific certification links EDs to continuum of care, may reduce return visits by the chronically ill

Educating patients to manage chronic illnesses can reduce number of future visits

Your ED is geared toward delivering acute care to sick or injured patients, but hospitals that aspire to earning disease-specific care (DSC) certification are requiring their EDs to take a fresh look at how they treat patients with chronic illnesses.

"It's a very different thought for the ED to look at a patient who is acutely ill, and to think of the care that they are receiving here as part of a chronic treatment program," says **Joyce Masterton,** RN, MS, AEC, who coordinates the asthma outreach program for the ED at Central DuPage Health in Winfield, IL.

The Joint Commission on Accreditation of Healthcare Organizations began accepting applications in 2002 from organizations that wanted additional recognition for the disease management and chronic care services they provide. The DSC certification is awarded to an organization's chronic disease management program specifically, but hospitals that have attained the certification say ED buy-in to the process is critical, because it often is the portal to the chronic disease program.

Training ED staff to look at the patient's chronic illness, and not just at the acute exacerbation (asthma attack, etc.) currently at hand, has been a challenge, Masterton says.

"It's a completely different way to think," she says. "Our whole theme has been to change practice patterns in all settings, so we provide education in the ED, and do [primary care] office site training, all to train how to manage the patient more aggressively and effectively. It's a good continuum-of-care process."

After more than 15 years of trying to get respiratory therapists assigned to the ED, Central DuPage piloted a program, Masterton says.

"For 16 hours of coverage, seven days a week, therapists from the respiratory department are housed in the ED," she explains. But there is not always a respiratory emergency in the ED, so these ED respiratory therapists are also trained to take lab samples, conduct electrocardiograms, and help alleviate the regular workload in the ED during their shifts. ED management wrote the therapists' job description so that the ED could get as much benefit from the arrangement as possible.

The ED staff receive two hours' training each year in the basics of asthma, Masterton says, and she has drawn up an asthma template for all hospital departments, including the ED.

"It's like a puzzle, and if any of the pieces are missing, if you do inservice with all departments or staff but miss one group, then the whole program goes down, she adds.

Melissa Zolecki, RN, asthma project liaison in the ED at Central DuPage, says having respiratory therapists in the ED, where they can do telephone follow-up on asthma patients the day after they're seen in the ED, "has made our continuity of care so much better."

According to Zolecki, one tool created by the ED staff that has been an important asset to the asthma program is a flowsheet on which is recorded exactly how much asthma education a patient received during his or her visit. That lets the therapists know, when they make follow-up calls, how much additional contact the patient needs with the asthma education program.

Sources

For more information on disease-specific care certification, contact:

- **Maureen Potter,** RN, MSN, Executive Director, Disease-Specific Care Certification, Joint Commission on Accreditation of Health Care Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5291. E-mail: potterm@jcaho.org.
- **Joyce Masterton,** RN, MS, AEC, Asthma Outreach Program Coordinator, Central DuPage Health Systems, 25 N. Winfield Road, Winfield, IL 60190. Telephone: (630) 933-6202. E-mail: joyce_masterton@cdh.org.
- **Melissa Zolecki,** RN, Asthma Project Liaison, Emergency Department, Central DuPage Health Systems, 25 N. Winfiled Road, Winfield, IL 60190. E-mailL melissa_zolecki@cdh.org.

At Central DuPage, when an asthma patient comes in, he or she is treated for the asthma attack that prompted the visit and also receives asthma education, all the equipment (nebulizer or peak expiratory flow meter) needed, and a referral into the hospital's asthma management program. The next day, a respiratory therapist follows up with the patient to encourage him or her to enter or maintain an asthma management program rather than waiting until the next attack and returning to the ED.

While providing more than acute care might take a bit more of the ED staff's time, the payoff in the long run is that that patient might not return time after time for the more expensive ED care.

Masterton points out that the ultimate payoff for Central DuPage's disease-specific program shows in the drop in pediatric admissions for asthma exacerbations. "We're able to keep many more patients out of the hospital and out of [return visits to] the ED, so of course that has made the lives of the ED staff easier," she says.

"The ED is the most expensive place [to receive treatment], and when the patients are treated acutely, they feel better and they think they're better, so they aren't encouraged to think of it as a chronic disease," Masterton continues. "Education in the ED, in addition to the acute care, encourages them to think of it in terms of ongoing treatment."

Currently, the Joint Commission awards DSC for more than 40 chronic conditions. About a dozen organizations have been certified since the program began. The areas of specialty in which organizations have received certification so far are congestive heart failure, chronic obstructive pulmonary disease, asthma, wound care, diabetes, and women's health. Another 48 organizations are nearing completion of their certification process, according to **Maureen Connors Potter,** RN, MSN, executive director of the Joint Commission's DSC program.

The Joint Commission and the Dallas-based American Stroke Association worked together to draft the recently announced advanced DSC certification program to evaluate stroke care provided by hospitals. Because stroke is an acute event that is a leading cause of serious, long-term disability in the United States, the ED can play an important role in educating these patients about managing their conditions, Potter explains. There are an estimated 4.7 million stroke survivors in the United States today.

DSC certification is independent of an organization's accreditation by the Joint Commission. It is voluntary, and organizations that are not accredited by the Joint Commission also may apply.

Hospitals applying for DSC certification in stroke, for example, must identify clinical practice guidelines, performance measures; describe its stroke team and patient education program; offer relevant marketing materials; describe the mission statement and the hospital's ethics statement; and supplies demographic information. The ED's role in the application process, Potter adds, would be to have written protocols to demonstrate compliance with the Brain Attack Coalition's (www.stroke-site.org) recommendations for stroke care.

Once an organization applies for certification and provides an overview of its program, goals and objectives, and clinical practice guidelines, the Joint Commission conducts an on-site review, usually within 45 days of receiving the request for certification. Based upon surveyors' findings, certification is granted or denied within 45 days after the site visit. Denial or granting of certification does not affect an organization's accreditation, but receipt of certification often is used by organizations in their survey process for accreditation.

A hospital not already accredited by the Joint Commission can expect to pay a $9,000 base fee to participate in the DSC certification process, while already-accredited organizations receive a 25% discount on that fee. Once certification is awarded, there is a $6,750 cost for the first year and $1,125 for the periodic performance review the second year. ■

Joint Commission warns of abbreviations to avoid

Compliance urged by end of 2004

Emphasizing the importance it places on eliminating easily misinterpreted abbreviations and acronyms from written orders and medical records, the Joint Commission on Accreditation of Healthcare Organizations has amended patient safety goals to urge hospitals to achieve 100% compliance by the end of this year.

Standardization of abbreviations and symbols that are used, and elimination of ones that are easily misunderstood or confused, has been a goal of the Joint Commission's for some time. **(See *ED Accreditation Update*, November 2003, p. 2.)**

The Joint Commission in November issued a minimum list of nine abbreviations and symbols it deems dangerous, and as of Jan. 1, required those abbreviations to be included on all accredited organizations' "do not use" list.

The abbreviations to be eliminated are: U (for units); IU (for international units); QD and QOD (for once daily and every other day); and MS, MSO_4, and $MgSO_4$. In the cases of those abbreviations, the dosage, drug, or instruction should be written out and not abbreviated. Also to be eliminated are trailing zeros (as in 2.0 mg) and failure to use leading zeros (use 0.2 mg instead of .2 mg).

For this year, hospitals will be surveyed and scored only on all handwritten, patient-specific documentation (not just orders). After the end of 2004, surveyors will look for compliance in all documentation media.

Through the end of 2004, organizations that have not achieved 100% compliance will be recorded as "in compliance" if the use of any of the items on the hospital's list is sporadic, or occurs fewer than 10% of the times the intended term is abbreviated or used in open and closed medical records reviewed; if, when a prohibited symbol or abbreviation is used in an order, there is written evidence of confirmation of the intended meaning before the order was carried out; and the organization has implemented a plan for continued improvement to achieve 100% compliance by the end of 2004. ■

Accreditation Q & A

Q. In light of changes to the survey process made last year, what does my ED need to provide to surveyors to demonstrate compliance with staffing effectiveness standards?

A. Good news: This is a change to the survey process that is unlikely to create any new work for emergency department staff, according to **Mark Forstneger,** spokesman for the Joint Commission on Accreditation of Healthcare Organizations.

"The ED is considered an outpatient setting, and hospital-based ambulatory areas do not have to collect indicators," he says.

The current list of indicators relates to inpatient populations, according to the Joint Commission. Research and field review now is being conducted to identify appropriate indicators for other populations, but no indicators have yet been identified for ambulatory patients.

(Submit questions or suggestions for this column to Joy Daughtery Dickinson, Senior Managing Editor. E-mail: joy.dickinson@thomson.com.) ■

More core performance data required in 2004

Measures for MI among those needing ED data

As of Jan. 1, your accredited hospital was required to collect and report data on one additional core measure set as part of an expansion of the Joint Commission on Accreditation of Healthcare Organization's ORYX initiative.

Emergency departments are unlikely to notice dramatic change in terms of time spent collecting data, some ED managers say.

"We don't actually do that [collect data] ourselves; our QI [quality improvement] department does," says **Rich Lowery**, director of emergency services at Euclid Hospital, Euclid, OH. And the ED at Good Samaritan Hospital in Dayton, OH, benefits from a computer tracking system that

Quick Fact

A medical student has no legal status as a provider of health care services. Therefore, a history and physical taken by a medical student would not fulfill Joint Commission requirements that the history and physical entered into the record must be performed, documented, and authenticated by a licensed practitioner or by a qualified delegate such as a physician's assistant or nurse practitioner.

gathers core performance data, says **Barbette Spitler**, RN, nurse manager. But both say any time new data is required from the ED, there is some increase in demand on ED staff.

But the Joint Commission is studying new core measures that would involve ED participation in collecting data — such as for pediatric asthma, expected to be introduced in 2005 — and even core measures that specifically focus on the ED, according to **Sharon L. Sprenger**, RHIA, CPHQ, MPA, project director for the Joint Commission's Division of Research.

"This year, the only new core measure being introduced will be on surgical infection control, and that will have no impact at all on the ED," she adds. But ones on the horizon — pediatric asthma and pain management, for example — likely will draw on EDs for data.

The Joint Commission estimates that hospitals spend anywhere from 12 to 15 work hours per month, total, per set of measures.

The ORYX initiative was introduced as a pilot program in 1999 as a means of collecting data on standardized, or core, performance measures.

Core measures compare a hospital's performance against national quality goals and Joint Commission core measures. In July 2002, accredited hospitals began reporting data in four areas identified by the Joint Commission: acute myocardial infarction, heart failure, community-acquired pneumonia, and pregnancy and related conditions.

Each core measure set has from four to nine components aimed at documenting arrival, treatment, length of stay, and discharge/mortality. **(See "Joint Commission Lists ORYX Indicators" and "Examples of Data EDs Will Collect," in *ED Management*, April 2000, pp. 41 and 42.)**

Before Jan. 1, 2004, most hospitals were required to report data on two of those four core measure sets (which two depended upon the health care services the hospital provides), but now are required to report on a third.

Four new core measure sets are being developed and are expected to be introduced during the next two to three years.

Starting this year, core measure data are being used by the Joint Commission in focusing on-site survey evaluation activities. Data will be posted on the Joint Commission web site (www.jcaho.org) in late 2004. ■

Delayed treatment causes most sentinel events in ED

Delay in treatment remains the most common cause of sentinel events in EDs, accounting for more than half of all sentinel events originating in EDs since the Joint Commission on Accreditation of Healthcare Organizations began tracking the events in 1995.

In order of frequency, the top five most common sentinel events in EDs were: delay in treatment (50 cases, 51.5% of the total); medication error (12, 12.4%); suicide (9, 9.3%); restraint-related events (4, 4.1%); and assault, rape, or homicide (3, 3.1%).

Figures for hospitalwide sentinel events indicate that, counting sentinel events from all departments, delay in treatment accounted for 5% of all sentinel events in hospitals as of mid-December 2003, when the figures were released by the Joint Commission. Hospitalwide, postoperative complications are the most common sentinel events.

Communication remains the predominant root cause of delay in treatment sentinel events, accounting for nearly 85% of delays in treatment, reporting hospitals told the Joint Commission.

Other root causes of delayed treatment, in order of predominance, included patient assessment (75%), continuum of care (62%), availability of information (42%), competency/credentialing (29%), orientation and training (29%), staffing levels (25%), specialist availability (16%), and ED overcrowding (16%). Agencies reported more than one root cause for most sentinel events. ■

A supplement to answer your accreditation questions

In response to reader interest, *ED Management* is pleased to offer this periodic supplement that will give you greater coverage of topics pertaining to the Joint Commission and its impact on the emergency department. This value-added supplement makes your subscription to *ED Management* even more essential.

Reader feedback is welcome, and questions for the Q & A on the Joint Commission may be directed to Joy Daughtery Dickinson, Senior Managing Editor, at joy.dickinson@thomson.com.