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Inside

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Ready to answer ORYX data questions? Here's what Joint Commission will ask

Fail to report for 2 quarters, receive automatic type I recommendation

In the near future, you'll be answering surveyors' questions about ORYX, so you need to prepare by collecting data, analyzing the results, and using them to compare your ED with those in other facilities, says **Stuart Shikora**, MD, FACEP, a surveyor with the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and an ED physician at Mount Diablo Medical Center in Concord, CA.

Your hospital already should have chosen six measures to report for the ORYX program, which integrates performance measurement into the Joint Commission's accreditation process. If the indicator involves the ED, you may be asked in-depth questions about the collected data.

"[The measures] are supposed to reflect the scope of practice and important issues at that institution," says Shikora. Many of the measures affect the ED, he adds. Those measures include intrahospital mortality of trauma patients with systolic blood pressure of less than 70 within two hours of ED arrival who did not undergo a laparotomy or thoracotomy, explains **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting

Executive Summary

The Joint Commission on Accreditation of Healthcare Organizations' ORYX program integrates performance measurement into the accreditation process.

- Your hospital already should have chosen six measures to report for the ORYX program, and those measures may affect the ED.
- Surveyors will want to see comparison charts, so your ED can be measured against other facilities, and control charts with internal data.
- Automatic type I recommendations result if institutions fail to report data they said they would report for two quarters in a row.
- Your control charts may have findings that are statistically, but not clinically, significant.

firm in Marblehead, MA, specializing in regulatory compliance. Another indicator is trauma patients undergoing selected neurosurgical procedures: time from ED arrival to procedure, she says.

If your hospital chooses indicators that affect the ED, it can be a boon for your department. Being involved with ORYX measures can demonstrate the ED's value to the hospital, Shikora emphasizes.

"Not all EDs are liked by the other departments," he says. "With ORYX, you can do something that might lead to better patient care and demonstrate improvement for the hospital."

The Joint Commission now has more than a year's worth of data on ORYX measures for hospitals, so surveyors might ask you to explain how those data have been collected, analyzed, and used for comparison, Catalano notes.

The data that have been sent to the Joint Commission are reviewed by surveyors and discussed during the performance improvement and leadership interviews during surveys, explains Catalano. "Also, if the data were truly bad, the Joint Commission could send surveyors to the facility, unannounced, to find out what was being done to rectify the identified problem," she says.

If any of the performance measures chosen by your hospital involve the ED, you'll need to answer questions about them during your next Joint Commission survey, says Shikora. **(For a list of ORYX indicators and performance measures, see pp. 41-42.)**

The following are some questions Joint Commission surveyors will ask:

• **Did you collect data in a systematic way over 12 or more months? Are you continuing to collect data on the same measures, or have you switched to other issues?**

At this time, surveyors are not scoring the quality of the data, and they won't make judgments that you did the right or wrong thing, says Shikora. "At this point, the goal of the surveyors is to see that there is some data collection, and if data quality is an issue, that the health care organization is doing something to correct the problem, as well as how the data is being analyzed and used by the organization," he says.

• **Was appropriate statistical methodology used?**

Surveyors will want to see that you are using statistical methods and that your decisions regarding quality improvement are data-driven, says Shikora. "They will want to know if you recognized a trend, and were there performance outliers? Did you adjust the way you collect data, and did you change the way you care for patients?"

• **Do you have comparison charts?**

Your selected performance measurement system for ORYX is required to provide you with comparison feedback information quarterly. Surveyors will want to see how you used those comparison feedback data charts and any supporting data, says Shikora. "Comparison charts allow an organization to compare itself to other institutions looking at similar measures," he explains. "For example, do you have more patients who left without being seen than a comparable hospital?" **(See sample of a Joint Commission comparison chart, p. 39.)**

The facilities also need to be comparable in size and scope of services. "A 1,000-bed hospital with broad spectrum of services may not accurately be compared with a 100-bed hospital with a narrow scope of services," says Shikora.

The ED should provide data that have been compiled by the quality improvement department or the contracted ORYX analysis service, he notes.

• **Do you have control charts?**

These are charts representing internally acquired data. **(See sample of control chart, p. 39.)** Surveyors will get much of this ORYX information before they arrive on the scene, he says.

"They will have a list of measures, the data your organization has submitted, and the Joint Commission's statistical analysis," he says. "They will know if there has been a lapse in reporting, which you should be able to explain."

However, surveyors won't know what decisions you've made based on the data and analysis. "That's for your teams to present at the survey," Shikora explains.

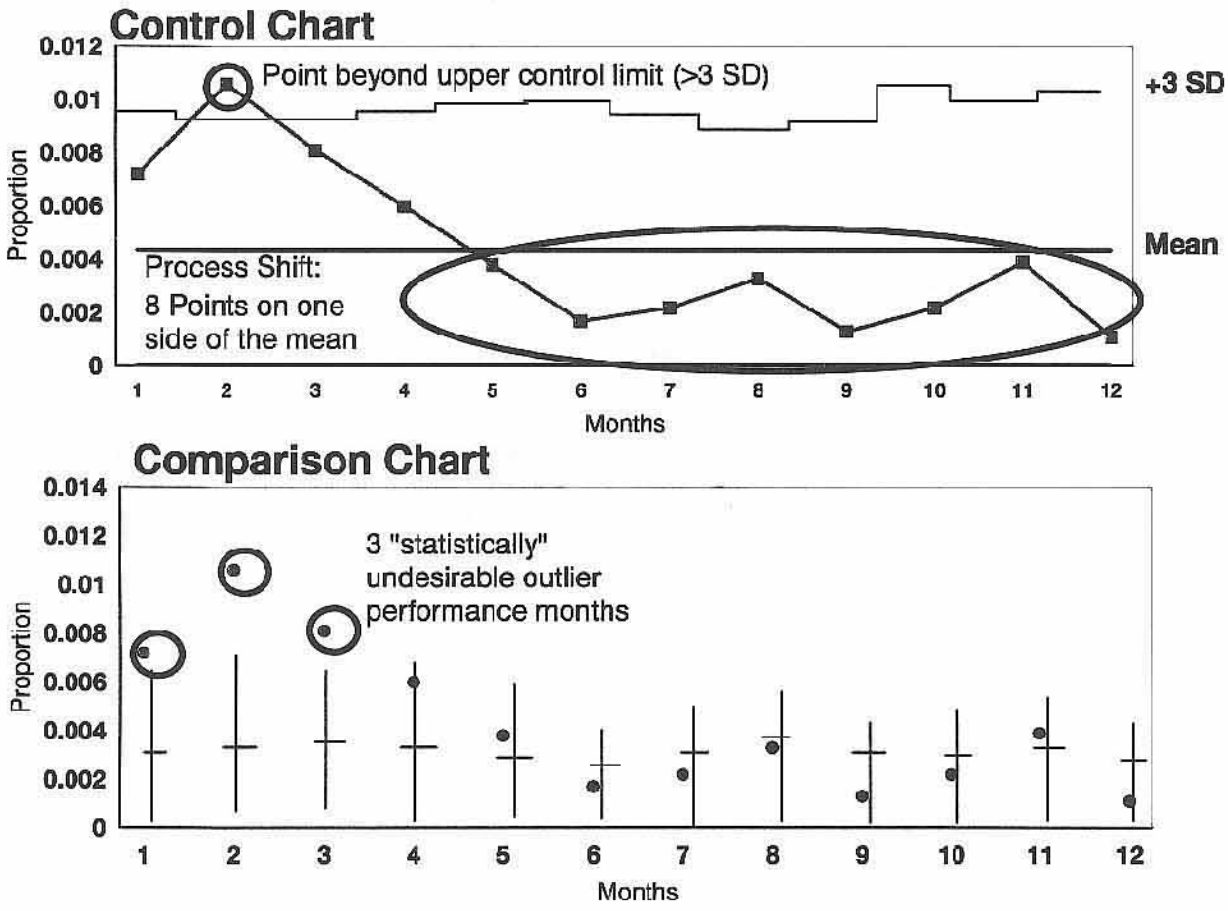
The reporting is a new development for the Joint Commission, he says. "It used to be that surveyors had no idea what the facility was doing until they showed up and listened to your performance improvement presentation."

(Continued on page 40)

COMING IN FUTURE MONTHS

- Update on restraint regulations
- Screen for alcohol and drug addiction
- Reduce conflict with floor nurses
- Results of ED administrator survey

Sample ORYX Control and Comparison Charts



- **Control chart:** This hospital's average monthly sample size was 1,200 X-rays preliminary interpreted by nonradiologists.
- **Control chart interpretation:** The second month's data point (measure rate) in the control chart lies beyond the upper control limit indicating variation due to a special cause (high rate of incorrect X-ray interpretations). The last eight months indicate a process shift or change in the measure's rate and is also indicative of special cause variation. But this time the special cause is a good thing, as the organization's observed rate has decreased.
- **Comparison chart:** The comparison group involved more than 400 hospitals and an average of 400,000 for the monthly sample size.
- **Comparison chart interpretation:** The dot is the health care organization's (HCO) observed rate for the month, and the center hash mark is the HCO's expected rate (based on comparison group's mean rate). The vertical bar is the 99% expected range based on the 99% confidence interval for the HCO's observed rate.
- **Comparison chart interpretation:** The first three months show that this organization's performance was statistically an outlier, and furthermore, it was an outlier on the undesirable side of the expected range. Outlier performance means, statistically speaking, that the organization's performance is very different from that of its peers (comparison group).
- **Risk adjustment:** This measure is not risk-adjusted, as it is felt a patient's severity/level of illness factors would generally not influence whether an X-ray was correctly or incorrectly interpreted. The skill of the interpreter is more in question here. Furthermore, it is felt that a patient has the same expectation of quality from a large urban hospital as from a small rural hospital for X-ray discrepancy issues — in that the customer wants the X-ray film interpreted the right way the first time.

Source: Joint Commission on Accreditation of Healthcare Organizations. *Benchmark* 2000; Vol. 2. In press. Reprinted with permission.

Sources

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- **Stuart Shikora**, MD, FACEP, Mount Diablo Medical Center, Department of Emergency Medicine, 2540 East St., Concord, CA 94520. Telephone: (925) 258-0013 or (800) 838-6140. Fax: (925) 258-0014. E-mail: sshikora@jcaho.org.

But as of this year, surveyors will be receiving the ORYX data several weeks in advance, Shikora says. "This will give the surveyors an idea of what the hospital is looking at, what its measures are, and whether data has been reported regularly."

• Have you reported data according to schedule?

An automatic type I recommendation results if an institution fails to report data for any measure for two quarters in a row, Shikora warns.

• Can you explain the data reported?

If an ED measure was chosen by the hospital, you probably will be asked to explain the data that were reported, he says, noting that the ED may be asked following questions about reported data:

— Why was the measure chosen?
— What did you learn by studying it?
— Can you explain the data that were generated?
— Who analyzed the data, and how were they trained?
— What were the results?
— What trends were identified?
— To whom were the data reported?
— What improvements were made in the system of patient care based on the data and its analysis?

(See list of additional possible surveyor questions, p. 41.)

At the physician leadership meeting, ED physicians might be asked to describe their involvement in performance improvement activities, notes Shikora, "so they need to be familiar with the concept of control and comparison charts and ORYX data. They also need to demonstrate they were involved in the choice of the measures from the hospital. If an ED measure was chosen, explain why it was chosen and how it was analyzed."

• Do you understand the difference between clinical significance and statistical significance?

"There are many findings on control charts that are statistically significant, but not clinically significant," he explains. "You may look at a control chart and say, 'the ED data was beyond the expected range for a month,' but it might not be clinically significant."

For example, patient returns to the ED within 48 hours might be much higher one month, but there might be extenuating factors. "Those patients may have been asked to come back to the ED because they had wound checks and the outpatient clinic was closed for renovations," Shikora says. However, a good measure likely would exclude patients returning to the ED for a scheduled visit, he adds.

Surveyors are attuned to this, he stresses. "They are looking for quality improvement activities just as before, only now they will be looking for a systematic, statistical approach to data collection, analysis, and decision making. They know there is a difference between statistical and clinical significance, so do not be worried about showing data to surveyors."

Still, ED staff who compile ORYX data need to interpret them and explain whether items are clinically significant, he notes. Everyone is afraid to be a performance outlier, he points out: "The ED needs to know that having an outlier performance is not necessarily bad. It may mean you did exceptionally good work."

However, when core measures are being used (as early as 2002 or 2003), the information gleaned from performance measures may be considered more rigorously by surveyors in scoring standards, says Catalano. "In the future with core measures, when data is recovered and analyzed by the Joint Commission, if something is noted that may be detrimental to patient care, the Joint Commission may perform an impromptu visit to the facility and analyze their process." ■

Time frame for ORYX: Know these deadlines

Your hospital already should have selected six noncore-measure indicators from the ORYX program, which requires you to measure performance indicators regularly and report data on an ongoing basis. ORYX, an initiative of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, will require your ED to compare its outcomes with those of other facilities.

"At present, the Joint Commission has capped the noncore measures at six indicators," says **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co. in Marblehead, MA. "That means that facilities are currently collecting data that is transmitted to Joint Commission on six indicators."

Most facilities chose to measure areas in which they already were performing well, notes Catalano. Because of this, the Joint Commission has switched

Possible ORYX questions from the surveyors

Suppose the ORYX data you collect show more returns to the ED for further treatment than your ED previously experienced. According to **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, surveyors may ask these questions:

- Are the data statistically accurate?
- Has the ED begun tracking the returns on an ongoing basis?
- What are the reasons for the returns?
- If medical treatment is at issue, has the problem been presented to the ED committee?
- What actions have been taken?
- Do you have flowcharts, diagrams, or control charts to demonstrate how returns were tracked?
- Are the outcomes better now? ■

to standardized sets of performance measures, or "core" measures, to replace the indicators, she says. "Most facilities chose indicators that made them look good in the eyes of the Joint Commission. The core measures are very specific and will allow for consistent comparisons."

Here's an explanation of future ORYX requirements:

- Each facility will be required to selected two core measure sets from the five focus areas by Sept. 1, 2000. "Once hospitals begin collecting data on the two core measure sets, they will no longer have to collect data on noncore-measure requirements," says Catalano.
- Hospitals must begin collecting those core measure data by Jan. 1, 2002. When the core measures begin in 2002, they will take the place of the other ORYX indicators. "For a period of time, I would suspect that the surveyors would use the ORYX indicator data during survey because there would not be enough data on core measures," she notes.
- The core measures must be chosen by September 2001 and implemented by January 2002.
- The core measures are acute myocardial infarction (AMI), heart failure, community-acquired pneumonia, pregnancy and related conditions, and surgical procedures and complications. The first four of those may relate to the ED, says Catalano.
- The two core measure sets chosen will have specific measures. AMI will have eight measures, heart failure will have five, community-acquired pneumonia seven, pregnancy and related conditions four, and surgical procedures and complications two. ■

Joint Commission lists ORYX indicators

5 focus areas announced

Here is a listing of the core ORYX performance measures from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations in the five focus areas:

1. **Acute myocardial infarction (AMI).**

— Smoking cessation advice/counseling: AMI patients with a history of smoking who are given smoking cessation advice or counseling during hospitalization.

— Aspirin at arrival: AMI patients who are given aspirin within 24 hours of arrival or within 24 hours prior to arrival at the hospital.

— Reperfusion therapy — time from arrival to initiation; timely reperfusion (opening blocked arteries) of eligible AMI patients; time from arrival to initiation of thrombolysis medication administration or primary percutaneous transluminal coronary angioplasty procedure.

— Aspirin at discharge: AMI patients who are prescribed aspirin at discharge from the hospital.

— Beta blocker at arrival: AMI patients who receive beta blocker medication within the first 24 hours of arrival to the hospital.

— Left-ventricular ejection fraction (LVEF).

— Less than 40% prescribed angiotensin-converting enzyme inhibitor (ACEI) at discharge: AMI patients with low left-ventricular ejection fraction (index of how well the heart functions) who are prescribed an ACEI medication at discharge from the hospital.

— Beta blocker at discharge: AMI patients who are ideal candidates for beta blocker medication and who are given a prescription for beta blockers at discharge.

— Intrahospital mortality: Patients with a primary diagnosis of AMI who die during hospitalization.

2. **Heart failure.**

— Patients with atrial fibrillation (irregular heartbeat) prescribed warfarin at discharge: Heart failure patients with atrial fibrillation who are given a prescription for oral anticoagulation therapy (warfarin) at discharge from the hospital.

— Diet/weight/medication management instructions at discharge: Heart failure patients who receive patient education (as documented on their written

discharge instructions) regarding all of the following: all discharge medications, weight monitoring, diet, activity level, follow-up appointment, and steps to take if symptoms worsen.

— Assessment of left-ventricular function: Heart failure patients not admitted on ACEIs or angiotensin receptor blocking agent medications who have LVEF evaluated before or during admission.

— LVEF.

— Less than 40% prescribed ACEI at discharge: Patients with low LVEF who are prescribed an ACEI medication at discharge.

— Smoking cessation advice/counseling: Heart failure patients with a history of smoking who are given smoking cessation advice or counseling during hospitalization.

3. **Community-acquired pneumonia.**

— Pneumonia screen or pneumococcal vaccination: Patients 65 or older who are screened for or given pneumococcal vaccination during hospitalization.

— Smoking cessation advice/counseling: Pneumonia patients with a history of smoking who are given smoking cessation advice or counseling during hospitalization, or pediatric caregivers who are given advice or counseling about effects of secondhand smoke.

— Oxygenation assessment: Patients who receive oxygenation assessment (to determine amount of oxygen in blood) within 24 hours of hospital arrival.

— Blood cultures: Of patients who have blood cultures collected, those who had them drawn prior to first dose of antibiotic administration in the hospital.

— Antibiotic timing: time (in hours) from initial presentation at hospital to first dose of antibiotics.

— Empiric antibiotic regimen nonintensive care unit: For pneumonia patients not admitted to an ICU, the antibiotic given is consistent with current consensus guidelines [such as the New York City-based American Thoracic Society, the Alexandria, VA-based Infectious Disease Society of America, and the Atlanta-based Centers for Disease Control and Prevention (CDC)].

— Empiric antibiotic regimen ICU: For pneumonia patients admitted to an ICU, the antibiotic given is consistent with current consensus guidelines (such as the American Thoracic Society, Infectious Disease Society of America, and the CDC).

4. **Surgical procedures and complications.**

— Surgical site infection within 30 days (for selected surgical procedures).

— Timing of prophylactic administration of antibiotic: when patients were given prophylactic (preventive) intravenous antibiotic administration for selected surgical procedures.

5. **Pregnancy and related conditions.**

— Vaginal birth after cesarean rate.

— Third- or fourth-degree laceration.

— Neonatal mortality: Infants who die within 28 days of birth. ■

Examples of data that EDs will collect

Here is a list of proposed core ORYX measures for which the ED would collect data, according to the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations:

❑ For the acute myocardial infarction (AMI) patient, was aspirin received within 24 hours of arrival or within 24 hours prior to arrival?

❑ For the AMI patient, was there timely reperfusion of eligible AMI patients? Measure time from arrival to initiation of thrombolysis medication administration or primary percutaneous transluminal coronary angioplasty procedure.

❑ For the AMI patient, was a beta-blocker medication received within the first 24 hours of arrival at the hospital?

❑ For the community-acquired pneumonia (CAP) patient, was oxygenation assessment received within 24 hours of arrival at the hospital?

❑ For the CAP patient who had blood cultures collected, were they drawn prior to the first dose of antibiotic administration in the hospital?

❑ For the CAP patient, what was the time in hours from initial presentation at the hospital to first dose of antibiotics?

❑ For the CAP patient admitted to an intensive care unit, was the antibiotic given consistent with current consensus guidelines?

❑ For the CAP patient not admitted to an ICU, was the antibiotic given consistent with current consensus guidelines? ■

Point/Counterpoint

A union for ED physicians is not the solution

By **Todd Taylor**, MD, FACEP
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[Editor's note: The Chicago-based American Medical Association has formed a union-like organization for employed physicians. ***(For details, see* ED Management*, October 1999, p. 117.)*** *In this issue,* ED Management *presents opposing viewpoints on this controversial issue from two ED physicians.]*

Traditionally, a major difference between "professionals" and "laborers" has been the professionals' personal commitment to those they serve and their commitment to continuing their education beyond their formal training years. Professionals have traditionally looked to societies to support these organizational and educational commitments, while laborers have relied on unions to forward their goals. It has also been true that laborers traditionally have been employees, while professionals were independent contractors or self-employed.

Emergency medicine, more than any other medical specialty, has broken with those traditions. The number of emergency physicians who are employed has increased dramatically in recent years due in part to Internal Revenue Service and Medicare regulations. It would follow, then, that the recent American Medical Association formation of a physician union would have the most potential for emergency medicine. As we embark on this venture, it is imperative that we carefully consider the consequences of such a transition. Here are some potential consequences:

• **Loss of autonomy.**

Much of the business of emergency medicine will be abdicated to business people and, in some circumstances, labor leaders who clearly have different objectives than physician professionals do. If you think managed care bean counters are bad, these guys have to be worse.

• **Public perception.**

Positive public perception of physicians increased significantly from 1997 to 1999, according to recent polls (Harris Poll as reported in *USA Today* April 28, 1999). Medicine (increase of 28% in 1997 to 38% in 1999) is third from the top after the military (55% in 1999) and the Supreme Court (42% in 1999) in the minds of adults expressing a "great deal of confidence" in those in charge. Even more significant in the polls was that "union labor" (15% in 1999) ranked second to the bottom after Congress (12% in 1999) in the degree of confidence. Clearly, becoming a union will do little for public perception of physicians.

• **Dissension among physicians.**

Union activity tends to promote single-mindedness and compliance among members. This is more easily done when union members are less competitive and less independent-thinking (more sheep-like). Organizing physicians is more like trying to herd cats. The principles necessary to form and be an effective union will likely run contrary to physicians' basic mentality and values. Unions have much more potential to divide than unite physician members.

• **Discouragement of efficiency and productivity.**

One of my more memorable impressions of unions is that union members who are more productive than the norm are encouraged to slow down so they won't show up other union members. Increased productively is generally discouraged so you don't work yourself out of a job.

Unions' insistence on better work environments through shorter hours, more help, and fewer expectations may be contrary to many physicians' fundamental principles. Despite promises to not negatively impact patient care, physicians will be required to follow the "union line" at work. It may mean they must leave patients unserved or underserved to justify the need for a better work environment.

• **Strike!**

Anyone who believes a physicians union strike will never be an option clearly does not understand the basic principle of unions. Unions in other critical American services — for example, air traffic controllers, airline pilots/flight attendants, truckers, and rail line workers — still strike. Only an obscure federal law has allowed the president to intervene in those situations in the past.

Barry Liebowitz, MD, a New York pediatrician and president of the Oakland, CA-based Union of American Physicians and Dentists with approximately 5,000 members, said, "Strikes may be essential. Sometimes it is far better to strike than to allow a patient to go into a substandard facility. In other words, there are reasonable strikes" (*American Medical News* 1999; 42:1).

In my opinion, the current physician union movement is either grandstanding in an attempt to get the

federal government to implement antitrust reform, or it is a desperate move by physicians frustrated with the current health care environment. Neither is a good enough reason to throw away centuries of tradition among physician professionals.

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Labor organization is a boon for physicians

By **Mark Bair**, MD, FACEP
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In June 1999, the American Medical Association (AMA) created Physicians for Responsible Negotiation (PRN) in response to a demand by its House of Delegates for help. PRN was created to empower today's physicians in their challenging medical, social, and economic practice environment. Although PRN was created by the AMA, it functions separately by design. PRN functions as a labor organization under the National Labor Relations Board (NLRB) and National Labor Relations Act (NLRA), which require PRN to be an independent organization. PRN is the only labor organization created specifically for physicians.

Today's environment in medicine has become more complicated than ever before. In many circumstances, physicians have tried to find help in working with employers, insurance companies, hospitals, and patients. Federal law is restrictive to physicians when it comes to discussing and negotiating as a group. PRN was developed to add another possible tool for physicians.

In response to physicians' needs for assistance, many organizations have developed programs and information. A physician or group of physicians with a particular circumstance or question can access those programs locally or nationally. State organizations have various committees that deal with reimbursement, resident issues, young physician contracting, and financial information for physicians. Those organizations are available at both the state medical associations and specialty societies. Various states also have developed programs for physicians.

At the national level, the AMA has developed programs to deal with contracting and advocacy. The Private Sector Advocacy Group (PSA) of the AMA has positioned itself to provide a response that includes the full scope of AMA resources. The PSA group will pursue strategies that address marketplace issues that impact physicians in any mode of practice. The PSA group has been involved across the country in trying to improve the quality of physician practice. Its activities include creating and passing national legislation, engaging the Federal Trade Commission to amend restrictive clauses, support state legislative attempts, engage health care organizations, and disseminate tools to assist physicians in their practice. AMA members can access the PSA group on the Web at www.ama-assn.org.

PRN was created to add to the arsenal available to physicians to achieve their goals in their practice environment. PRN is directed and restricted by the NLRB and NLRA. This means PRN can represent employed physicians only when asked to assist. In December 1999, the NLRB passed down a ruling that residents are considered employees. This increases the number of physicians who can be represented by more than 90,000 residents. Once physicians initiate contact with PRN, they must then petition the NLRB for permission to represent that group of physicians in a negotiation.

In January 2000, PRN officials were asked to represent their first official organization, The Wellness Plan physicians from Detroit. The Wellness Plan is a mixed-model HMO developed for underserved areas of Detroit. The 42 staff physicians have become the victims of downsizing, contract renegotiations, and practice changes. Those physicians now are going to be represented by PRN. The physicians want to make sure they are still active participants in providing care to the underserved to whom they have dedicated their lives.

PRN, developed as a tool for physicians, is limited in its scope by the NLRB and NLRA. PRN has the ability to help physicians in an employed contract situation to improve their practice environment. Physicians should remember that many tools are available. PRN has its own Web site at www.4prn.com. Any physician who would like more information about the organization, its programs, or the qualifying membership rules should contact PRN. Today's physicians must be the designers of their own future. If we don't do it, someone else will.

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Here are 5 ways to celebrate EMS Week

By celebrating Emergency Medical Services (EMS) Week, your ED can improve rapport with paramedics and realize other benefits, says **John A. Brennan**, MD, FAAP, FACEP, chair of the EMS committee of the Dallas-based American College of Emergency Physicians and director of EMS and pediatric emergency medicine at Saint Barnabas Health Care System in Livingston, NJ.

"The closer your relationship is with the group, the better your patient care will be," Brennan says. "Find ways to recognize them for a very important contribution and say to them, 'You make a difference.'"

EMS Week will be celebrated May 14 to 20. Your participation sends a message that you feel emergency medical services are a vital link in the continuum of health care, says Brennan. "Even if it's 20 degrees outside and 2 a.m. and they have to transport a patient down four flights of stairs, they do it."

EMS Week recognizes those who provide care seven days a week, 24 hours a day, and often go beyond their physical capabilities in unsafe conditions, he says. "It has been clearly shown that when the EMS system works well, there is an improvement in morbidity and mortality."

Last year, EDs celebrated EMS week in a variety of ways, including local paramedics and EMTs visiting grade schools to educate children about cardiopulmonary resuscitation, hosting events honoring paramedics who saved lives, having ambulance and equipment displays so children and adults can see emergency equipment firsthand, and holding health fairs and demonstrating a "mock" disaster, Brennan notes.

Those activities benefit the ED directly because emergency medicine is being promoted and patients can learn about what to do in an emergency, he says. Here are some ways your ED can participate, according to the American College of Emergency Physicians:

❑ **Invite paramedics, dispatchers, emergency physicians, nurses, emergency medical technicians, firefighters, and others to participate in your event.**

In addition to recognizing the services of EMS providers, you give the public the opportunity to learn about the EMS system. Consider holding a "Meet the Lifesavers" open house or an "EMS Awareness" fair.

❑ **Ask organizations, local businesses, or other area EMS systems to sponsor your event.**

Combining resources is a great way to host an EMS Week event and attract new audiences. Local businesses often are eager to help by sponsoring equipment displays, offering door prizes, providing free blood pressure clinics, or running articles in their employee newsletters and ads in local newspapers. You can ask retail businesses to run banners in their ads or distribute circulars during EMS Week.

❑ **Target groups such as parents, local businesses, or seniors to join your celebration.**

Think about the concerns and interests of specific audiences and how best to reach them. Many participants look at EMS Week as an opportunity to offer special programs to their communities or to provide services such as free safety inspections, glucose screenings, and medical identification programs that allow health care providers to identify patients with special needs. Distribute educational fact sheets on topics such as emergency etiquette, summer safety for children, or strokes. **(See sample EMS fact sheet on emergency etiquette and strokes, inserted in this issue.)**

❑ **Pitch your events to local media.**

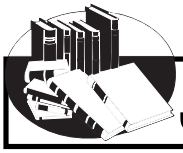
Contact news directors at your local newspapers and television stations far ahead of time and ask them to run public service announcements on your upcoming EMS Week activities. Invite them to provide coverage of your open house, fair, or carnival. Ask them to assign reporters to participate in an ambulance ride-along and/or write a feature on "A Day in the Life of a Lifesaver." Also, contact the editorial departments about running editorials on your EMS Week activities.

❑ **Target activities to your unique regional needs.**

By looking for your community's areas of greatest need, you'll give your EMS Week activities more focus and stronger impact. For example, if you live in a rural area, farm safety might be a local concern. Arizona might address forest fire prevention, and Michigan might offer a class in boating safety. Last year, an EMS organization in California put together an earthquake preparedness kit. ■

Sources

- **John A. Brennan**, MD, FAAP, FACEP, Saint Barnabas Medical Center, Emergency Department, Old Short Hills Road, Livingston, NJ 07039. Telephone: (973) 322-8400. Fax: (973) 328-5807. E-mail: jkmmpp@aol.com.
- **The American College of Emergency Physicians** (ACEP) offers a planning kit with materials to assist with local promotions. The kits include clip art, logos, an Emergency Medical Services Week poster, statistics, and a specialty item catalog. To order a free packet, call ACEP's Customer Service Department at (800) 798-1822, extension 6. For more than 15 packets, payment for postage is required.



JOURNAL REVIEWS

Mayer BWM, Smith FB, King CA, et al. **Factors associated with victimization of personnel in emergency departments.** *J Emerg Nurs* 1999; 25:361-366.

The incidence of physical assault among ED staff was reported to be 42% during 1998 and 72% during the respondents' careers, according to this study. The study examined incidents of ED personnel victimization in Central Florida and characteristics of the patient/perpetrator, the personnel victimized, and the ED environment.

A survey of 226 ED personnel collected data anonymously, with questions about violence in the ED. Respondents reported avoiding identification on duty, underreporting, post-victimization staff turnover, dissatisfaction with security, and the desire for every security provision listed.

These are all indicators of fear and stress, note the researchers.

Other findings include:

• In rating overall satisfaction with security, 57% indicated they were "dissatisfied" or "extremely dissatisfied."

• Alcohol use was associated with violent incidents.

• Verbal abuse was significantly higher on the day shift.

• The most desired environmental variable was 24-hour security attendants.

• More than a fourth of the subjects reported that they had completed no coursework or had no continuing education in violence prevention.

• 38% of respondents indicated there was no effect of victimization on job performance.

Women were significantly more likely to avoid identification in the ED area through practices such as turning their name tags over, despite a trend of using only first names on name tags.

The goals of reducing the fears and victimization of ED personnel should become a priority within the health care system, say the researchers. They recommend open communication between ED staff and managers about violence concerns, protocols, databases for better reporting, education, problem solving, and policy development for prevention, intervention, and post-victimization follow-up. ▼

Lerner EB, Billittier AJ, Sikora J, et al. **Use of a geographic information system to determine appropriate means of trauma patient transport.** *Acad Emerg Med* 1999; 6:1,127-1,133.

Inappropriate choice of transport mode is linked with increased out-of-hospital time, according to this research from the Center for Transportation Injury Research in Buffalo, NY. Minimizing out-of-hospital time is considered to be an important factor for trauma patient survival.

The study found that a geographical information system and historical transport data can be used to create a map that identifies locations (zones) from which either ambulance or helicopter transport will result in shorter out-of-hospital times. A review of 6,185 patient transports at a trauma center was conducted over three years. Patients transported by helicopter from locations within the outer air zone arrived at the trauma center 13 minutes sooner than those transported by ground ambulance. Patients transported by ambulance

from locations within the inner ground zone arrived at the trauma center 36 minutes sooner than those transported by helicopter.

It appears that an "inappropriate" choice of transport mode was associated with significant delays in patient arrival at the trauma center.

Planners from other systems of emergency medical services might choose to perform similar evaluations of their regions, note the researchers. "Alternatively, they may generically apply distance and topographic principles learned from this and future studies to create trauma triage and helicopter utilization guidelines for their systems," they suggest. ▼

Abrunzo T, Gerardi M, Dietrich A, et al. **The role of emergency physicians in the care of the child at school.** *Ann Emerg Med* 2000; 35:155-161.

ED physicians may contribute significantly to the health of children in the school setting, according to this research by the school health task force of the American College of Physicians' pediatric emergency medicine committee in Dallas.

Because school health emergencies are so common, the expertise of emergency physicians is needed, the researchers argue. ED physicians have an important role in ensuring the proper treatment of these emergency medical problems, they say. Physicians need to be involved in the development and organization of systems for prevention, initial stabilization, management, and follow-up of injuries, the researchers add.

Address these 6 issues

ED physicians should meet with administrators at the local school district level to address the following issues, the researchers recommend:

• assist in creating, modifying, or supporting a school-based emergency plan or system;

• inform and educate school personnel of the community's emergency medical services system;

• advocate and assist with school personnel training in first aid and cardiopulmonary resuscitation;

• encourage injury prevention and regularly reviewed accident reporting systems and ensure input from emergency medical caretakers in the education and training of school-based health personnel;

• ensure availability of emergency medicine consultants for establishing triage systems, developing guidelines, ensuring immediacy of referrals, and creating standing orders as deemed necessary for a local population;

• assist schools in disaster planning.

Physicians should become involved in children's health by making presentations at schools and involving the school health community in hospital-based, ED-sponsored educational presentations, the researchers suggest.

Specific areas of assistance to school districts might include development and promulgation of an emergency data set for students by outlining identification data, caretaker contact information, primary care physician information, significant past illnesses, allergies, medications, insurance data, and consent, they recommend. ■

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CE objectives

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

1. Discuss and apply new information about various approaches to ED Management. (See *Journal Reviews* in this issue.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Are you ready to answer questions about ORYX data? Here's what Joint Commission surveyors want to know* and *Labor organization is a boon for physicians.)*
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.

Web site rates latest ED research

Site: Weekly Web Review in Emergency Medicine
Date started: February 1997
Address: www.wwrem.com

Want the latest research that affects your ED? Log on to the Weekly Web Review in Emergency Medicine site, which contains reviews of studies relevant to emergency medicine, such as new guidelines for myocardial infarction.

"I started the site because I saw the Web as a logical tool to shorten the time between when medical literature is published and when it becomes general knowledge," says **Leon M. Gussow**, MD, ABMT, medical editor of the Web site. In addition, as more medical information becomes available on the Web, each discussion will be linked and cross-referenced to other relevant on-line material, he says. "Finally, by reviewing articles critically, we might contribute to shortening the life span of erroneous or poorly supported information."

Articles from a wide range of journals are reviewed, including *The New England Journal of Medicine, Journal of the American Medical Association, The Lancet, Journal of Trauma, Critical Care Medicine, Circulation, Annals of Emergency Medicine, American Journal of Emergency Medicine, Journal of Emergency Medicine,* and *Academic Emergency Medicine*.

"I write the weekly copy, and a Webmaster uploads the material and updates the site," Gussow explains.

"In many cases, we can link to the full text of the article on the Web site of the original journal." Each article is critically discussed and rated on the basis of one to five stars. "That makes it easy to determine which articles are worth searching out and reading in detail." If there is Web access in the ED itself, the clinician can easily search out and print relevant abstracts and gain access to other resources on the Web, he adds. ■