



Management

The monthly update on Emergency Department Management

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Number of geriatric patients grows: You must prepare for distinct challenges

Diagnoses are less straightforward — protocols must be targeted

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- **2004 Salary Survey Report**
- **ED Accreditation Update:** New infection control standard takes effect Jan. 1; tips for complying with environment of care standards; JCAHO and CMS align quality measures

A 73-year-old woman who lives at home with her husband presented at the ED with progressive weakness and difficulty walking. Her chief complaint: “My legs just feel weak.” After an extensive work-up, including a CAT scan, there were no clear answers, and she was admitted for further evaluation.

“I could have come up with an easy answer and sent her home, but she would have had difficulty getting around the house,” the ED physician explains.

A neurologist saw her post-admission. She was given an MRI, and a neurological disease that only showed up with that test — a nonspecific demyelinating disease — was diagnosed.

This case typifies the challenges presented by geriatric patients, says the physician who handled this case: **Steve Meldon**, MD, associate professor at Case Western Reserve University in the department of emergency medicine and attending physician at MetroHealth Medical Center, both in Cleveland.

“Their symptoms are much less obvious,” he observes. And as his example demonstrates, admission decisions may be complicated by the situation at home.

The special challenges presented by this population, combined with the steady graying of America, are making the emergency medical profession sit up and take notice. The Washington, DC-based American College of Emergency Physicians (ACEP) made the geriatric population one of the major foci of its Scientific Assembly this October. (See chart, p. 123, for impact on EDs.)

J. Brian Hancock, MD, president of ACEP, says, “As the number of visits by

Executive Summary

With the elder population steadily growing, it’s time to reassess how your department treats patients beyond age 65.

- Symptoms are less obvious in geriatrics, so more testing often is required.
- Social situation and daily life activity skills are as important as the patient’s medical condition.
- Expand your definition of “pain” to include discomfort, anxiety, and depression.

NOVEMBER 2004

VOL. 16, NO. 11 • (pages 121-132)

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older people to overcrowded emergency departments increases, emergency physicians have been focusing greater attention on their special care needs and leading research on improving diagnosis and treatment of geriatric diseases.”

About four years ago, **Scott T. Wilber, MD**, FACEP, assistant professor of emergency medicine at Northeastern Ohio University College of Medicine in

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

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Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.
Subscription rates: U.S.A., one year (12 issues), \$479. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are \$78 each. (GST registration number R128870672.)
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This CME activity is intended for emergency physicians and other clinicians. It is in effect for 36 months from the date of the publication.

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This publication does not receive commercial support.

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Rootstown, and associate director of the Emergency Medicine Research Center at Summa Health System in Akron, was practicing in an all-adult hospital.

“What drove this issue home for me was the realization that these were the toughest patients to take care of, and took the most time,” Wilber says. Since then, he has focused on researching the geriatric population, and recently he authored an extensive chapter on geriatric emergency medicine in the American Geriatric Society's (AGS's) publication, “*New Frontiers in Geriatric Research: An Agenda for Surgical and Related Medical Specialties*.” (The publication is available, at no cost, in its entirety on the AGS web site: www.frycomm.com/ags/rasp.)

With geriatric patients, you cannot focus just on what is *medically* wrong, but you also must consider their social situation at home, how well they are able to care for themselves, and indeed, whether they are cognitively able to provide you with a good history, Wilber says.

ED managers will face an increasing number of these patients in the next 25-30 years, notes **Lowell Gerson, PhD**, professor of epidemiology at Northeastern Ohio University College of Medicine.

“Older patients use the ED in proportion to their numbers in the population, and the fastest growing segment of the population is people over 65,” he says. “In 25-30 years, there will be more people over 65 than we have pediatric patients today. They will be the biggest ED user group.” (**Will this trend lead to the development of geriatric EDs, similar to the pediatric EDs? See story, p. 124.**)

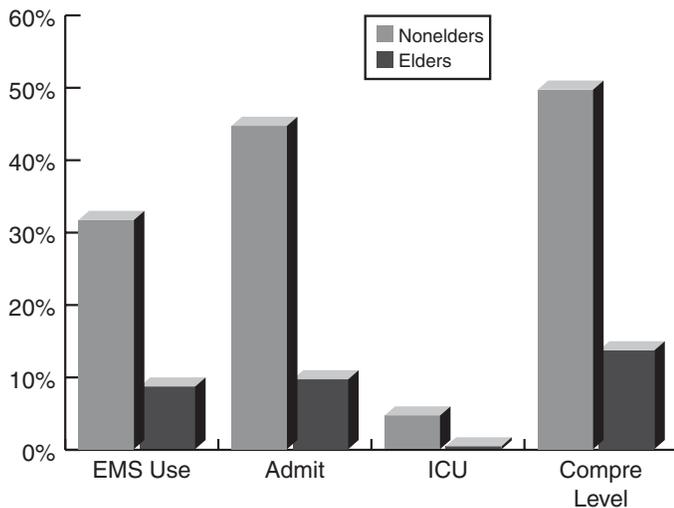
There are several conditions that, when seen in geriatric patients, call for different protocols than would be followed with younger patients, Wilber says.

One is abdominal pain, he observes. In younger patients, its treatment often is a lot more straightforward, Wilber says. “Even if I cannot say exactly what's wrong, if they're not too sick, you can tell them to go home,” he says. “An older person could come in confused, have tenderness in the abdomen, and you may have to take many extra steps to find out what's wrong.”

Those steps, he says, could include more testing. “Lots of times a CT scan is ordered, where in a younger person, the pain is often where it should be in order for you to make an accurate diagnosis and determine whether to go to surgery,” Wilber notes. In addition, he says, there is a tendency to want to have more time to observe the older patient, and that extra time often results in admission.

Injuries present another challenge in geriatric patients, Wilber says. “In younger patients, you take care of them and that's that,” he observes. In older patients, a lot of times, an injury would prevent them from functioning at

Geriatric Patients Impact on ED Time and Costs



Source: Singal BM, Hedges JR, Rousseau EW, et al. Geriatric patient emergency visits. Part I: Comparisons of visits by geriatric and younger patients. *Ann Emerg Med* 1992; 21:802-807.

home, Wilber points out. “Then, you must ask if they have the necessary social support, if they are able to dress themselves, to walk, or to feed themselves,” he says. “If they don’t end up being admitted, that may lead to repeat emergency visits.”

If caregivers are in their late 70s or 80s, says Melton, you must determine if they can care for the patient at home. “In addition, the patients may have mild dementia, or not be able to lift themselves up to bathe,” he notes.

Pain treatment is another area that is significantly different when dealing with geriatric patients, says **James A. Espinosa**, MD, FACEP, FAAFP, chairman and medical director of the ED at Overlook Hospital in Summit, NJ, and founding co-chair of ACEP’s new Geriatric Emergency Section.

Espinosa says that working with John Gregory, a cardiologist involved in bioethics and palliative care, he learned of the World Health Organization’s (WHO) concept of total pain. “Its definition is really about total discomfort; not only that physical sensation we call pain, but to be anxious at the end of life, to be terrified, to be dehydrated, to have bouts of nausea, to have terrible diarrhea, overwhelming depression, to be air-hungry, to be separated from your loved ones,” he says. This approach, says Espinosa, leads the ED physician to seek to relieve patient *discomfort* of all sorts. **(Look for more on this new concept of pain in the December issue of *ED Management*.)**

Geriatric patients have the potential to adversely affect patient flow, notes Meldon.

“The model for the ER is what is the chief complaint, then a quick differential, and then take care of the complaint — but not with *this* patient,” he observes.

“You need to do a functional assessment.” Bearing that in mind, Meldon offers several suggestions for maintaining optimal flow. “You may want to send the patient to admission sooner,” he advises. One strategy he used while on staff at the Cleveland Clinic was a nurse practitioner model for screening patients. “They could address questions such as whether they could fix their own meals, if they needed help with transportation, and so on,” he explains. The reasoning behind the strategy was that most patients were in the ED for two or three hours anyway, so there was some built-in time if you had the personnel to do this screening, and it would not delay discharge.

“It can also be a rapid way to get referrals for a geriatric assessment, and that would be very helpful,” he adds. “You *need* to work with your geriatricians.” Also try to develop a brief screening tool for this population to assess problems that are not obvious, by asking questions such as whether the patient feels sad, suggests Meldon.

One such tool, called the TRST (Triage Risk Screening Tool), was developed by Meldon himself. **(See recommended reading, p. 124.)**

A more formal abbreviated mental status exam also may be required if the patient has trouble with his or her memory or seems confused, he says. “If one suspects depression, a good follow-up to a single question

Sources

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[such as] depression is the Geriatric Depression Scale — short form,” he notes. **(For more information, see recommended reading, at right.)**

There is much your ED can do to make the environment more geriatric-friendly, says Wilber. “You should have discharge instructions in 14-point type or larger,” he suggests, “And try not to have the area be too cold.” Often such patients require assistance in going to the bathroom, so be sure to have volunteers and/or bedside commodes available, Wilber says. Remember, too, that hospital chairs may be more comfortable for these patients than standard gurneys, because of the back problems common in geriatric patients.

Finally, “make sure they don’t accidentally get too much fluid,” he warns. A younger person can filter out the fluid, he notes, but an older patient with heart failure or kidney disease could wind up with pulmonary edema. Use intravenous clamps that can’t be accidentally opened, he advises.

Caring properly for your geriatric patients can be good business as well as good medicine, Wilber asserts. “This will be a good customer base to have. They are

covered by insurance and/or Medicare, so from a management standpoint, they are good people to focus on.”

Recommended reading

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Are geriatric EDs the wave of the future?

Eventually, hospitals will develop geriatric EDs, just as many now have pediatric EDs, predicts **Lowell Gerson**, PhD, professor of epidemiology at Northeastern Ohio University College of Medicine in Rootstown.

“If you look at the parallels — i.e., kids present differently than adults and have tremendous dependency needs — there are a lot of similarities,” Gerson says.

Additionally, there will be more geriatric patients in the long-term future than pediatric patients, he adds.

While agreeing with much of what Gerson says, **James A. Espinosa**, MD, FACEP, FAAFP, chairman and medical director of the emergency department at Overlook Hospital in Summit, NJ, is not convinced his ultimate prediction will come to pass.

“Geriatrics are not just older adults; their physiology is different,” he observes. “There are simply not enough geriatricians [as opposed to pediatricians, for example] to run all of those departments. What will happen is that they will teach all of us how to work with geriatrics.”

Nonetheless, there are many steps between the current reality and Gerson’s vision, and Espinosa is taking several of them right now. Overlook soon will be moving to a new building, and the ED there will have a geriatric wing.

The new ED will have several beds in an area

in which the clocks will have different faces, he explains. Patients will have a two- or three-step stool to help them get onto a bigger bed that’s a little softer than normal, and the décor will have more soothing colors, Espinosa says. The area will have less ambient noise, he explains.

“It’s not a geriatric ED per se, but just as we’ve made a commitment to kids, just the presence of geriatric beds and protocols for things like pneumonia, for example, means we are adjusting to the geriatric population,” Espinosa says.

These changes address what Gerson calls the “micro environment” required by geriatric patients. “If you go to a pediatric ED, the decorations are suitable for children,” he observes. “What affects older people? One is temperature, two is a lack of anything to orient themselves — i.e., clocks,” Gerson says. “They get concerned if they don’t know what’s going on.”

Espinosa agrees. “These patients *do* have special needs,” he says. They have special needs for protection, Espinosa says. “Just as there is pediatric abuse, there is elder abuse.” However, he adds, it’s also important that the patients’ families be involved in their care. “You need to respect family and caregivers as part of the world of that patient,” Espinosa explains.

Despite the many parallels between pediatrics and geriatrics, he asserts that doesn’t mean the future inevitably will lead to specialized EDs for geriatric patients. “In the pediatric world, there were pediatric specialties and subspecialties,” Espinosa adds, underscoring why pediatric EDs have been possible — and why geriatric EDs may not be. ■

Rapid-cycle testing cuts bed turnaround by 85%

Change in notification process critical to success

[Editor's note: A new report from the Urgent Matters Learning Network, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, identifies best practices from 10 hospitals selected as participants in an initiative to help hospitals eliminate ED crowding. Each participating hospital developed and implemented strategies to improve patient flow through the ED and to reduce overcrowding. (See resource box, below, for information on how to obtain the report.) EDM looks behind the results to the strategies and methods that achieved them. With this issue, we begin a series of articles (also see story, p. 126) that will examine just what made these programs special and successful.]

Would you believe it was possible to slash the average time it takes to clean and turn around beds from 164 minutes to 24 minutes? Well, get ready to become a believer, because that's exactly what the ED at the University Hospital in San Antonio did. And that's just one of several successes achieved through rapid-cycle testing, the focus of its participation in the Urgent Matters Learning Network.

In rapid-cycle testing, you first assess your current status, then implement a quick change and track it for three or four days, explains **David Hnatow**, MD, FACEP, FAAEN, medical director of the University Hospital emergency center and chief of emergency medicine at the South Texas Poison Center, both in San Antonio. "Then you ask, 'Did it work, or do we need to further change the process?'" he says.

Hnatow met with an inpatient team three times a week and asked them to come up with process improvement ideas that could be tried. Potential candidates were

Source/Resource

For more information on rapid-cycle testing, contact:

- **David Hnatow**, MD, FACEP, FAAEN, Medical Director, Emergency Center, University Hospital, San Antonio, TX; Chief of Emergency Medicine, South Texas Poison Center, San Antonio. Phone: (210) 358-2078. E-mail: hnatow@uthsca.edu.
- The report, *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, can be found at www.urgentmatters.org. A link to the report is found under "Latest News."

Executive Summary

You can use rapid-cycle testing to try out new approaches to overcrowding much more frequently than with more traditional process improvement strategies.

- Improving bed turnaround notification can yield dramatic improvements.
- Telling staff they have to try a new process only for three days makes it easier to gain buy-in.
- Look for old policies that are no longer needed, yet continue to keep your staff bogged down.

identified through Excel spreadsheets created by hospital staff, which were used to track different processes.

"Without the ability to track metric data, it's hard to see your problems," Hnatow explains.

One of the first projects undertaken was the bed cleaning turnaround time, because, as Hnatow notes, "Our average was 164 minutes, and we were told the benchmark was 40 minutes." The notification process was not adequate, it was determined, so with the housekeeping supervisor's enthusiastic support, "Christmas in July" was established. It consisted of a jar with green and red labels; a red label placed in the jar by ED staff let housekeeping know there was a dirty bed; housekeeping put a green label in the jar when the bed was clean.

"We ran this for three or four days and got it down to 60 minutes," Hnatow says. "When you have 40-60 discharges a day that adds up."

Improvement has continued, and today the average is down to 24 minutes.

"Housekeeping was our first success; it came early in the project, and that got people's attention," he adds.

With the rapid-cycle testing approach, Hnatow and his staff were able to test out 52 approaches in one year. Naturally, not all were successful, but staff were willing to at least give them a try.

"The thing about rapid-cycle testing is, if you know you're only going to have to try it for three days, most people will say 'OK,'" he notes. "Just make sure you have pre-testing data and test data, so you can compare results."

Here are a few of the more beneficial changes achieved through this approach:

- **Changing the policy that required nurses to remove bed linens.** "This was to avoid needlesticks for housekeeping, but we had had a needleless system for years, so we no longer needed that policy," says Hnatow.

- **Establishing a discharge lounge.** A sign was put in every room saying, "We will try to discharge you early in the day."

"We have a number of indigent patients who have trouble getting transportation," he explains. "If they are

stable, we now take them down to the lobby to our discharge lounge, which is supervised by a nurse, and it's amazing how fast people can get transportation."

- **Putting a physician assistant out front in triage.**

Now, patients with minor problems are seen right at the door.

The project, which started in May 2003, still is going today, Hnatow adds, even though it officially ended in April 2004. "The project is now becoming the facility's quality improvement model," he says. "We recently had a [Joint Commission on Accreditation of Healthcare Organizations] site visit, and they were very impressed with what we had done." ■

Care management unit has broad LOS impact

Short stay, telemetry admissions, costs decreased

A new report from the Urgent Matters Learning Network titled *Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments*, describes the experiences of 10 hospitals selected for an initiative to help hospitals eliminate ED overcrowding. Of the 10, four received a special \$250,000 grant for "demonstrator projects." One such project, an innovative care unit at Grady Health System in Atlanta, yielded this impressive roster of results:

- Decreased number of short stay admissions.

During the period of the grant, the care management unit (CMU) cared for 1,147 patients, which is 1,147 hospital admissions diverted.

- Decreased number of admissions to telemetry beds requested from an average of 11 per day (before the CMU opened) to an average of four per day at the end of the grant period.

- Decreased congestive heart failure (CHF) costs. Actual costs per patient ranged from \$616.28 to \$1,061.62, with a total savings of \$3,600 on average.

- Decreased relapse rate. (The final numbers are being determined.)

"We went back and looked at what we thought were some causative factors [of overcrowding]," recalls **Leon L. Haley Jr., MD, MHSA**, deputy senior vice president of medical affairs, chief of emergency medicine, and vice chairman of clinical affairs for Grady Health System, and associate professor in the department of emergency medicine at Emory University, both in Atlanta. "One of the major impacts for us was patient bed availability," he continues.

Grady conducted a two-month study beginning in August 2002 to obtain a representative sample of

Executive Summary

A care management unit can dramatically increase bed availability.

- Consulting with internal medicine and the financial department can help identify key sources of bottlenecks.
- Creative use of existing beds can make space available for a new unit.
- Case managers can arrange primary care physician follow-up and track ongoing patient compliance after discharge.

volume in patients, the number of patients admitted, and how many patients were in the waiting room. "In the evening hours, especially 6 p.m. to midnight, it was not unusual for us to have 120 active patients in the ED and 25 to 35 admitted, so about 30% of ED capacity was being taken up by inpatients," Haley explains. "That's a big deal for us."

Haley and his Urgent Matters team got together with the internal medicine service, as well as with the financial department, and asked them if addressing any particular condition(s) could make a difference in improving throughput. The finance department assisted with this analysis by assessing the admitted patients within the hospital that were identified as having a stay of less than 48 hours, months before the opening of the CMU.

The findings showed that three diagnoses stood out as potential candidates for the CMU (chest pain, asthma, and CHF). Hyperglycemia was identified as an additional candidate because patients with diabetes made frequent return visits to the ED.

"They were chosen because they tend to get bottled up in admissions," notes Haley. For example, most patients with chest pain or CHF were admitted to telemetry beds. Hyperglycemic patients generally went home, but they spent a lot of time in the ED first, as did the asthma patients. "They also tend to make repeat visits," Haley adds.

Haley identified the existing seven-bed chest pain center that was attached to the ED, so he proposed augmenting it to transform it into a CMU.

"At that time, I was the director of inpatient case management, and I knew we had all these case managers upstairs, so I suggested we bring them downstairs," Haley says.

The patients in the four identified categories were then sent to the new CMU. Funded by the grant, the new unit was open 24 hours a day, seven days per week. Additionally, the CMU had dedicated case managers seven days a week, 20 hours a day and was staffed by a nurse and a clinic assistant.

The case managers were responsible for patient and

Source

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family disease education, getting the patients the proper meds, arranging for very specific primary care follow up, and follow-up with every patient.

“Our case managers were allowed to schedule primary care follow-up directly out of the unit to their primary care physicians’ [PCPs] schedules,” says Haley. “This included our downtown clinic, as well as a neighborhood center.” The care manager could ask the patient, for example, “How is next Tuesday at 2 o’clock with Dr. Jones?” and the patients knew when they walked out the door that they would be seeing him, Haley notes.

“They also worked with cardiology to set up outpatient stress tests,” he adds. “All of these targeted follow-up appointments were within 48-72 hours.”

The case manager usually would call the next day, but definitely before their follow-up PCP appointment, then a week later, and after 30, 60, and 90 days. They would ask the patients how they were feeling and whether they were following up as they were supposed to.

In the seven- to eight-month-long pilot program, about 1,500 patients went through the new unit. “The vast majority went home,” says Haley. “Perhaps 15% got admitted; but if they did, it was to a lower acuity bed.” Chest pain patients did not have to go to telemetry unless they were very ill.

The average length of stay (LOS) in the CMU was about 13-14 hours, Haley notes. Under the old model, these patients would have been admitted. “The way to think of it is, those patients who went into the care management unit are a group that no longer would be adding an additional six hours to LOS, by going to an inpatient bed and then later being discharged,” he observes.

In other words, in the past, patients with chest pain or CHF were admitted almost all of the time.

“They basically sat in the [emergency care center] five or six hours before they got to a bed, and then were here maybe 24-36 hours,” Haley explains.

“By putting in the care management unit, chest pain patients went there and had a total stay of about 16 hours — but 85% of the group went home, as opposed to being admitted,” he adds. ■

Focus on process slashes average cycle time by 37%

Staff overcome instinct to blame personnel levels

It may seem logical to blame your overcrowding problems on understaffing, but as the ED staff at the 302-bed North Shore University Hospital at Forest Hills in Queens, NY, found out, that may not always lead you to the root of your problems. Learning that lesson, and finding the *real* cause of their problems, enabled them to slash their average cycle time from 187 minutes to 118 minutes.

At the outset of a Six Sigma project to address the issue of excessive patient wait times in the ED, “Everyone involved stated that the ED was understaffed,” recalls **Kevin G. Tuttle**, MBB, MHA, the Six Sigma Master Black Belt who oversaw the project on-site. (Six Sigma Master Black Belts are quality leaders responsible for Six Sigma strategy, training, mentoring, deployment, and results.)

“The [Six Sigma] team also thought staffing was a major issue with the project,” Tuttle says.

Tuttle and North Shore partnered with GE Healthcare, a \$14 billion unit of General Electric Co., “so that GE could train North Shore in the Six Sigma methodology,” he says. GE Healthcare offers services to address productivity and better enable health care providers to diagnose, treat, and manage patients with conditions such as cancer, Alzheimer’s, and cardiovascular diseases. North Shore partnered with the Sam Ramon, CA, office of GE Healthcare.

Tuttle, who is with the Center for Learning and Innovation at the hospital’s parent organization, Long Island Jewish (LIJ) Health System in Lake Success, NY, demonstrated to them that more nurses, physicians, and registrars were not the answer. “We started to measure the data, and what we saw was there were gaps in the process that had *nothing* to do with staff,” he recalls. “We could have had 14 more ED people, but the process

Executive Summary

Don’t assume you know the cause of your overcrowding. Examine the data first.

- Six Sigma approach helps staff keep their eyes on the process and ultimately leads to the root cause of your problem.
- Adding more staff may not improve your overcrowding problems at all.
- Breaking down the process into smaller buckets makes it easier to problem solve.

Sources

For more on the North Shore Six Sigma project, contact:

- **Eric Carter**, Performance Solutions, GE Healthcare, San Ramon, CA. Phone: (860) 663-3655. E-mail: eric.carter@med.ge.com.
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was broken and not where it should be.”

The Six Sigma team included the assistant director of the ED, Jim Halfpenny, DO, who, in Tuttle’s words, was “our lifeline to the clinical staff.” The team, which also included two staff nurses and the ED charge nurse, broke down the process into several steps, or buckets:

- **Arrival to triage.** When patients came through the door, they filled in a form with their name and chief complaint. A time clock was stamped.
- **Triage to registration.** The nurse took the triage slip, saw the patient, then time-stamped the triage form in the upper right hand corner.
- **Arrival to seen by physician.** The patient then went to the registration booth. When registration was complete, the form was time-stamped once again.
- **Seen by MD to discharge.** After registration, the patient and chart went to the physician. When the chart went to the back, it also was time-stamped.
- **Arrival to discharge.**

All of the time clocks were synchronized with the ED computer system. “That’s basically how we measured the whole process,” says Tuttle. This required purchasing three additional time clocks at a cost of less than \$500, he notes.

After completing a measurement system analysis, the data were reviewed by the team. A primary issue that surfaced was how the registrar was working and the batching of charts by the registration staff. When they were busy, the registration staff gathered three or four before bringing them back. In addition, which physician was on duty seemed to be a major cause of variation in the process. Here were some solutions:

- Time-stamping was used to reduce the delay problem caused by batching. “By time-stamping the charts, you could easily identify which registrar was batching charts,” Tuttle explains.
- Registrars were retrained on how to use laptops for bedside registration, because they had not been using them. Backup printers were installed directly in the ED so they would be available whenever needed.
- Before, when patients were triaged, the triage

nurse would complete a seven-page assessment form. “We reasoned, why can’t they just fill out the top form?” he continues. (The form basically notes the complaint and records vitals.) The triage form was incorporated into the nursing assessment form, Tuttle explains, and the triage nurse was instructed to complete the triage section of the form only — not the entire nursing assessment.

- During triage, the nurses also would draw blood. Now, a threshold has been established by the charge nurse and ED physicians: If there are more than seven patients waiting to be seen, there are no blood draws; the patient is triaged and brought right to the back of the ED.

- The shortened triage form was an effective solution to a common ED problem, notes **Eric Carter**, a Six Sigma Master Black Belt and a consultant with performance solutions at GE. “A lot of hospitals ask 60 questions or more, which delays the process,” he notes. “What they came up with is good solution and would make a difference in other EDs as well.”

- Scripts for standardizing patient communication (to be used by the registrars) were developed and addressed questions such as how long they might wait. “This not only reduced cycle time, but increased satisfaction,” says Tuttle.

- Discharge instructions sheets, which used to be written on the charts, now are entered electronically into a database and printed as needed. “Thus, they are always legible, and patients don’t have many questions,” he points out.

Another key lesson learned is the value of having someone like Halfpenny on the team. “Given their preconceived notions, getting physician and nurse buy-in was critical,” Carter notes. “For that, you need to have the people closest to the process itself on your team.”

Finally, he advises, let your team find its own solutions. “I always have some good solutions in the back of my head,” Carter concedes, “But you must let the team [members] figure it out for themselves. They will not let their own idea fail.” ■

To speed up admissions, address ‘virtual capacity’

As the ED staff at Lehigh Valley Hospital in Allentown, PA, have learned, it’s how you respond to benchmarking data that determines success. For example, to speed up admissions, it was necessary to address virtual capacity issues.

This, in turn, required cooperation by the entire hospital, says **Michael Weinstock**, MD, FACEP, chairman

Sources

For information on getting patients admitted faster, contact:

- **Richard MacKenzie**, MD, FACEP, Vice Chairman, Department of Emergency Medicine, Lehigh Valley Hospital, Cedar Crest and I-78, P.O. Box 689, Allentown, PA 18105-1556. Phone: (610) 402-8128. E-mail: Richard.mackenzie@lvh.com.
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of the department of emergency medicine.

“You can improve all the ED processes you want, but if there is no buy-in from the organization where the beds are, you will go nowhere,” he asserts. “Regardless of how many benchmarks you do, [you won’t succeed] until you eliminate the virtual capacity problems that exist in the organization.”

By ‘virtual capacity,’ Weinstock is referring to arcane processes that make inpatient beds unavailable for occupancy — not just in the ED. “In some places, it takes 3.5 hours to clean a bed; in this hospital, it takes 30 minutes,” he declares.

While these improvements were initiated by the ED, middle and upper hospital management supported the ED with assistance and resources, Weinstock notes.

“This included the time and focus of middle management and upper management that were brought to the table and provided us with staff from organizational development and from all areas of the hospital that impacted length of stay and patient care,” he explains,

“Three years ago, we recognized the [capacity] problem and tried to address it with specific changes in the ED, but we were unsuccessful,” adds **Richard MacKenzie**, MD, FACEP, vice chairman of the department of emergency medicine at Lehigh Valley. “That spurred us to get involved with the hospital network in terms of bed capacity.”

Every hospital has a supply and demand curve, he explains. “Our demand for hospital beds peaks at around 10 a.m., but capacity, prior to all our work, peaked at around 5 p.m., so we had a supply-demand mismatch.”

What was required was moving the capacity curve earlier in the day, which was dependent on hospital-wide changes. “In the past, we would routinely go on diversion many afternoons because we were told by bed management there were no beds, and we would not get any,” MacKenzie recalls. “But there really *was* capacity, just not enough staff to clean the beds and no priority [on making them available]. When you remove those barriers, you move the patients better.”

The hospital responded with two express admit units. One is for the office-based medical staff members who have a direct admission and for whom there will be potential bed availability in two hours. That patient can then go to the express admit unit and be worked up in accordance with the physician’s orders; and when a bed becomes available, the patient can go upstairs.

The second express admit unit specifically is for the ED patient who is admitted and awaiting bed placement. These patients can be moved to the ED express admit unit, making that bed available in the ED, and that patient then will be moved upstairs, MacKenzie explains. In the past, he notes, if a doctor called and wanted to admit a patient at 9 a.m., they would hold a medical-surgical bed and the patient might not arrive until 5 p.m. “Now, when the patient arrives, we start looking for a bed,” says MacKenzie.

In addition, it was discovered that the hospital’s 40-bed pre-surgical area was packed at 7-10 a.m., but emptied out at noon, so “40 beds were just sitting there until 6 a.m.,” he adds. “Now, at 2 p.m., these beds are used to relieve the backlog in the ED, and we are using *no* additional space resources.” ■

AHRQ guide helps with vaccine, drug dispensing

A new planning guide funded by the Agency for Healthcare Research and Quality (AHRQ) is designed to help communities make sure they have needed drugs and vaccines in the event of a natural epidemic or bioterrorist attack.

The guide, *Community-Based Mass Prophylaxis: A Planning Guide for Public Health Preparedness*, complements the Strategic National Stockpile guidebook prepared by the Centers for Disease Control and Prevention (CDC), which includes a chapter on dispensing medications and vaccines. It was developed by researchers in the Department of Public Health at Weill Medical College of Cornell University and New York-Presbyterian Hospital, led by Nathaniel Hupert, MD, MPH.

The guide does the following:

- provides a framework for understanding the

Source

For more information on the new guide, contact:

- **Anthony Joseph**, MD, FACEP, AMC Registry Inc. Columbus, OH. Phone: (614) 457-9190, ext. 14. E-mail: amc_tjoseph@compuserve.com.

components of epidemic outbreak response (surveillance, stockpiling, distribution, dispensing, and follow-up care) and the planning and conduct of dispensing operations using specially designated dispensing clinics;

- applies these concepts to develop model pill-dispensing and vaccination clinics run on the Bioterrorism and Epidemic Outbreak Model (BERM), a computer staffing model that can be customized to meet local community needs;

- discusses implementation of a command and control framework for dispensing clinics based on the CDC's National Incident Management System.

“We need such a plan for both natural — and human-perpetrated — disasters,” says **Anthony Joseph**, MD, FACEP, president and CEO of AMC Registry, a health care process improvement company in Columbus, OH. “Vaccination works, and it is relatively simple — with some side effects to consider. Antibiotics work as well.” (Industry sources say that while for some diseases, vaccination is an appropriate and relatively simple intervention, for others only antibiotics are available).

“It only makes sense that the emergency physician assume a central role in this work,” notes Joseph, adding that the activity of planning ahead, educating, and drilling is much needed, and that he endorses the new AHRQ guide. “It also makes sense that health care and public health professionals plan ahead, vaccinate where appropriate, and prepare programs to

administer antibiotics, should *they* be the appropriate form of treatment, *before* the disaster hits,” he advises.

Community-Based Mass Prophylaxis: A Planning Guide for Public Health Preparedness can be accessed free at www.ahrq.gov/research/cbmprophyl/cbmpro.htm. If you are interested in printed copies, one copy per organization is available free (with no shipping or mailing costs) by contacting AHRQ's Publications Clearinghouse at (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov. ■

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From hurricanes and tornadoes to wildfires and floods, natural disasters can strike at anytime, anywhere. Does your facility have a disaster plan? How realistic is it? And do you know where to go for help if you need it?

To make sure your facility has the appropriate disaster plan in place, join Thomson American Health Consultants on Tuesday, Nov. 16, from 2:30-3:30 p.m. ET for **If Disaster Strikes, Is Your Healthcare Facility Prepared?** — a timely audio conference designed to address the essential needs and requirements of hospital disaster plans.

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Corrections

In the August 2004 issue, *ED Management* should have said that Emergency and Acute Care Medical Corp. (EA) fee-for-service programs compensate participating physician specialists with negotiated payments for services rendered, and the payments are hospital-specific, productivity-based, and per-relative value unit (RVU). Also, regarding prearranged transfer agreements among the EA hospitals, EA entered contracts in September 2004 with Santa Clara County hospitals to create regional call panels.

In our October 2004 issue, correct spelling of the Cleveland hospital is Rainbow Babies and Children's Hospital. The range of salaries for child life specialists should be the upper \$20,000s to the lower \$30,000s.

EDM regrets the errors. ■

COMING IN FUTURE MONTHS

■ A new paradigm for pain management protocols

■ Urgent Matters success story: Fighting overcrowding

■ Flu vaccine limited: Implications for ED managers?

■ Are EDs providing colorblind medical care?

CE/CME questions

United States Postal Service
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1. Publication Title
ED Management

2. Publication No.
 1 0 4 4 - 9 1 6 7

3. Filing Date
 10/01/04

4. Issue Frequency
 Monthly

5. Number of Issues Published Annually
 12

6. Annual Subscription Price
 \$479.00

7. Complete Mailing Address of Known Office of Publication (Not Printer) (Street, city, county, state, and ZIP+4)
 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305

Contact Person
 Robin Salet
 Telephone
 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer)
 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Blank)

Publisher (Name and Complete Mailing Address)
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Editor (Name and Complete Mailing Address)
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 Has Not Changed During Preceding 12 Months
 Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)

PS Form 3526, September 1998 See instructions on Reverse

13. Publication Name
 ED Management

14. Issue Date for Circulation Data Below
 September 2004

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies (Net Press Run)	1268	1447
(1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. (Include advertiser's proof and exchange copies)	917	943
b. Paid and/or Requested Circulation		
(2) Paid In-County Subscriptions (include advertiser's proof and exchange copies)	5	5
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	3	5
(4) Other Classes Mailed Through the USPS	19	29
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))	944	982
d. Free Distribution by Mail (Samples, Complimentary and Other Free)		
(1) Outside-County as Stated on Form 3541	28	29
(2) In-County as Stated on Form 3541	2	2
(3) Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail (Carriers or Other Means)	29	25
f. Total Free Distribution (Sum of 15d and 15e)	59	56
g. Total Distribution (Sum of 15c and 15f)	1003	1038
h. Copies Not Distributed	265	409
i. Total (Sum of 15g and h)	1268	1447
Percent Paid and/or Requested Circulation (15c divided by 15i times 100)	94	95

16. Publication of Statement of Ownership
 Publication required. Will be printed in the November 2004 issue of this publication. Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner
 Signature: *Brenda L. Mooney* Date: 9/27/04

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PS Form 3526, September 1999 (Reverse)

- According to Scott T. Wilber, MD, FACEP, assistant professor of emergency medicine at Northeastern Ohio University College of Medicine, what will make your ED more patient-friendly for geriatrics:
 - Using hospital chairs instead of gurneys
 - Using 14-point type or larger on your discharge instructions
 - Have volunteers or bedside commodes available for patient toileting needs.
 - All of the above
- According to James A. Espinosa, MD, FACEP, FAAFP, medical director of the ED at Overlook Hospital, a comprehensive approach to pain when treating geriatric patients should encompass:
 - Depression
 - Dehydration
 - Air-hunger
 - All of the above
- According to David Hnatow, MD, FACEP, FAAEN, medical director of the University Hospital emergency center and chief of emergency medicine at the South Texas Poison Center, rapid-cycle testing enabled his ED staff to try out new strategies:
 - Twice a week
 - Once a week
 - Twice a month
 - Once a month
- In the new Care Management Unit at Grady Health System, case managers are responsible for:
 - Patient and family disease education
 - Scheduling follow-up visits with PCPs
 - Getting the patient proper medications
 - All of the above
- Which strategy was *not* implemented in the Six Sigma program to reduce overcrowding at North Shore University Hospital at Forest Hills?
 - Standardizing patient communications with scripts
 - Training registrars on laptops for bedside registration
 - Adding more ED staff
 - Time stamping to reduce delays caused by batching
- According to Michael Weinstock, MD, FACEP, chairman of the department of emergency medicine at Lehigh Valley Hospital, no benchmarking effort will be entirely successful unless you:
 - Focus entirely on best practices.
 - Institute changes at the organizational level.
 - Use more than one benchmarking source.
 - Seek to identify and solve problems.

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CE/CME objectives

- Implement managerial procedures suggested by your peers in the publication. (See *Rapid-cycle testing cuts bed turnaround by 85%* and *Care management unit has broad LOS impact*.)
- Discuss and apply new information about various approaches to ED management. (See *Number of geriatric patients grows: You must prepare for distinct challenges* and *To speed up admissions, address 'virtual capacity'*.)
- Share acquired knowledge of these developments and advances with employees. (See *Focus on process slashes average cycle time by 37%*.)
- Explain developments in the regulatory arena and how they apply to the ED setting. ■

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 answers

7. D 8. D 9. B 10. D 11. C 12. B

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ED

ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Are you ready for an influx of SARS patients?

By Jan. 1, you must comply with new Joint Commission standard

If several patients with severe acute respiratory syndrome (SARS) started coming into your ED, would you be prepared to separate them? Could you triage to alternative off-site areas, if needed?

As of Jan. 1, 2005, you'd better be prepared. A new infection control standard requires that EDs and other departments of the hospital be prepared to respond to an influx or the risk of an influx of infectious patients, according to the Joint Commission on Accreditation of Healthcare Organizations. (See standard, p. 2.)

The biggest changes for EDs? "Probably deciding on the capacity that they want to prepare for, and how they are going to prepare for that in a setting where their ED is likely to be full and the hospital will be full," says **Thomas Terndrup, MD**, professor and chair of the department of emergency medicine at the University of Alabama, Birmingham School of Medicine.

"It's a challenge we all face: preparing and exercising toward the notion of improving their response capability for an infectious disease outbreak, especially a respiratory infection that is transmissible," such as SARS, he explains.

EDs always have faced the challenge of an influx of patients, says **Nancy Kupka, DNSc, MPH, RN**, project director of the Division of Standards and Survey Methods at the Joint Commission.

"This challenge is compounded now by the nature of disease, rather than a massive influx of trauma patients from a building explosion, for example," she says. "It may be unknown how it's transmitted."

The ED will have to work with infection control and other departments of the hospital to have a concrete plan to meet the standard, sources say.

At University of California, San Francisco (UCSF) Medical Center, hospital disaster committees are developing protocols and obtaining supplies and equipment for handling an influx of infectious patients, says **Jinhee Nguyen, RN, MS, CEN**, clinical nurse specialist in the ED and assistant clinical professor at UCSF School of Nursing.

In addition, they are working with the materials services department to obtain ample backup supplies of protective gear and equipment, Nguyen says.

ID, contain, mobilize resources, and treat

The ED will play a crucial role in identification, containment, mobilization of resources, and treatment during an influx of infectious patients, she points out.

How can you plan your response? First read

Executive Summary

Under a new accreditation standard, EDs and all departments must be prepared to handle an influx, or the risk of an influx, of infectious patients.

- Collaborate with your infection control committee, disaster management committee, local board of health, and other providers to develop protocols and policies.
- Hold disaster drills in which you must handle infectious patients.
- ED staff, particularly the triage nurses, need training in early recognition of presenting symptoms of infectious diseases.

through all of the infection control standards and ensure you are in compliance, Kupka suggests.

Secondly, consider networking outside of your own hospital system with other providers and your local board of health, she notes. "We don't require it, but they network to say, 'We're all in this together; let's set up lines of communication,'" Kupka says.

Work with your local emergency management agency to identify a plan in which patients would be distributed to a variety of facilities in a logical process so that no one facility is completely overwhelmed, Terndrup says.

Also, ED managers need to ensure they are part of the communication loop to submit information about infectious diseases to the proper agencies, Kupka says. "It could be a grand influx of patients, but it could be one patient with a serious illness," adds Kupka, pointing to the small number of monkeypox cases in 2003.

The Centers for Disease Control and Prevention and county public health departments have set up processes for faxing out information about unusual cases in communities, she explains. "One of the challenges is to make sure that the ED works with the infrastructure of bigger organizations to make sure they're apprised of information," Kupka says.

Are your staff ready? Find out!

Training and drilling your staff is a critical part of complying with this standard, sources say.

Train the ED staff and the rest of the medical staff on how to handle an influx of infectious patients, Nguyen says. **(For information you can use for training about SARS, see *ED Management*, May 2003, p. 49.)**

"Emergency department staff, particularly the triage nurses, would need further training in early recognition of presenting symptoms of infectious diseases, which could potentially lead to mass casualties," she adds. **(See "Triage Screening for SARS," *EDM*, May 2003, insert.)**

Every facility should prepare for at least a handful of patients it could isolate and manage, Terndrup says.

In annual exercises, consider incorporating an outbreak of a respiratory pathogen that can be transmitted person to person, he adds.

"The challenge is to identify the person early; isolate the expired particles from that person's respiratory apparatus, mouth, and nose by putting a mask on him or her; and then putting the person in a room with a closed door, preferably with

New Infection Control Standard

Standard IC.6.10

As part of emergency management activities, the organization prepares to respond to an influx or the risk of an influx of infectious patients.

Rationale

The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver care, treatment, or services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period.

Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.

This planned response may include a broad range of options including the temporary halting of services and/or admissions, delaying transfer or discharge, limiting visitors within an organization, or fully activating the organization's emergency management plan. The actual response depends upon issues such as the extent to which the community is affected by the spread of the infection, the types of services offered, and the organization's capabilities. The concepts included in these standards are supported by standards found elsewhere in the manual including standard EC.4.10.

Elements of Performance for IC.6.10

- B 1.** The organization plans its response to an influx or risk of an influx of infectious patients.
- B 2.** The organization has a plan for managing an ongoing influx of potentially infectious patients over an extended period.
- B 3.** The organization does the following:
 - determines how it will keep abreast of current information about the emergence of epidemics or new infections, which may result in the organization activating its response;
 - determines how it will disseminate critical information to staff and other key practitioners;
 - identifies resources in the community (through local, state, and/or federal public health systems) for obtaining additional information.

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

air-handling capability — either filtering or laminar flow,” he says.

Once people are confirmed as having an infectious disease, they need to be transported to an area of the hospital that previously has been identified as being able to hold a number of patients reflective of their overall facility capacity, says Terndrup. For example, the average hospital might want to be capable of identifying and grouping 25 patients, he suggests.

UCSF has conducted disaster drills involving influx of infectious patients, which tested the ED’s protocols, readiness, and effectiveness, Nguyen says.

“This is an evolving and ongoing process for our department and the hospital,” she points out.

The University of Alabama at Birmingham Health System held a disaster exercise in August that included mock patients assumed to have smallpox, Terndrup says.

“We learned from that,” he adds. For example, staff needed to know where to get a N-95 mask, Terndrup says. Additionally, staff learned how to handle droplet precautions and how to submit samples for confirmations of smallpox to the CDC, he notes. They also learned how to safely transport and group patients, Terndrup says.

There’s nothing like a practice session, he says. “You can have all the policies you want, but it shows operationally what you need to do to be ready,” Terndrup explains. “You can’t prepare sitting in your office writing a policy.” ■

Ensure compliance with environment of care

As census grows, so do potential problems

As EDs have grown and become overcrowded, environment of care issues also have grown, particularly security concerns, says **Dean Samet**, associate director/senior engineer of accreditation operations/Standards Interpretation Group at the Joint Commission.

“In recent years, there have been a number of incidents where the gang-related activities or domestic problems are brought right into the ED,” he says.

Review logistics and make adjustments

To comply with environment of care standards, assess your logistics and past history of incidents, and make adjustments as needed, Samet advises.

You may want to consult with law enforcement personnel, he says.

Also, obtain input from your peers at other facilities, particular ones in heavily populated areas that are more likely to encounter such problems, Samet says.

The Joint Commission is looking at security for patients, security for employees, and security for visitors, says **Eileen Whalen**, MHA, RN, vice president of emergency, trauma, and perioperative services at University Medical Center in Tucson, AZ.

You should have panic alarms in the triage rooms and any other room where a staff member is locked in or closed in, Whalen says. Also, verify that your panic alarms are working, she advises.

Another problem with overcrowding is lack of privacy with hallway beds, Whalen points out. Also, expect surveyors to ask how you ensure privacy in rooms that simply have a curtain pulled, she says.

“Your staff members need to have scripted responses to a site reviewer: ‘We speak in a modulated tone. If we have something we need to talk to the family about something that’s very confidential, we step out into the greeting rooms,’ or the nurse manager’s office, social worker’s office, or wherever it may be,” Whalen says.

Consider her other tips for compliance with environment of care standards:

Sources

For more information on meeting the new infection control standard, contact:

- **Jinhee Nguyen**, RN, MS, CEN, Clinical Nurse Specialist, Emergency Department, University of California, San Francisco (UCSF) Medical Center; Assistant Clinical Professor, UCSF School of Nursing, Phone: (415) 353-1444. Pager: (415) 719-7583.
- **Joint Commission on Accreditation of Healthcare Organizations**, Standard Interpretation Group. Phone: (630) 792-5900. Web: www.jcaho.org. Click on “Standards FAQs — Ask a Question” and “Go to the Standards Online Question Submission Form.”
- **Thomas Terndrup**, MD, Professor and Chair, Department of Emergency Medicine, University of Alabama at Birmingham, 619 19th St. S., Birmingham, AL 35249-7013. Fax: (205) 975-4662. E-mail: tterndrup@uabmc.edu.

- **Emergency preparedness.**

- Have an inclusive bioterrorism plan that addresses various emergencies and explains all staff members' involvement.

- Conduct drills, and document the drills if that is the responsibility of the ED manager. Document when the drills were, who was available, and how you coordinated it with others.

- Ensure that your bioterrorism plans follows the methodology of the Hospital Emergency Incident Command System (HEICS), which is a generic crisis management plan expressly for comprehensive medical facilities. Explain how your bioterrorism plan is implemented with community resources and how other hospitals are involved.

- **Environmental hazards.**

- Don't have intravenous setups or open syringes in patient rooms.

- Don't have open needles, even if it's a need-less system.

- Secure all knives (including any kept around simply for cutting up birthday cakes).

- **Signage.**

- Drive around as if you were a patient, and see if you can find the ED.

- Ensure that the signs have the same language as your license. For example, if your license says you are a basic "emergency/trauma center," that wording should be on the signs.

- Publish the signs in every language you serve in your community.

- **Access.**

- Ensure staff and physicians don't impede access by parking in the ED patient parking lot.

- Ensure patients, and family members escorting patients with dementia-related diseases, can easily access the ED.

- **Lighting/aesthetics.**

- Inspect the hospital grounds at night.

- Perform a deep cleaning if you haven't done so recently.

- Walk through your department with your environmental service staff and engineering staff. Determine what lighting works, and ensure all areas are well-lit.

- **Contamination.**

- Ensure dirty and clean items are separated into the correct designated utility rooms.

- Educate your nurses to discard material down a sink only if there isn't a patient in the room.

- **Patient flow.**

- Obtain knowledge and educate your staff

about your experiences with diversion, your process to prevent it, and your policies and procedures.

- Be prepared to explain how you work with your emergency medical services (EMS) community. Surveyors may pull aside EMS staff to obtain their input.

- Ensure your charge nurse knows your turnaround times and diversion data.

- "If you've been on diversion in the 24 hours prior to [the survey], you'd sure as heck better know why," Whalen adds. ■

JCAHO and CMS align performance measures

The Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare & Medicaid Services (CMS) have been working to align their common national hospital performance in the areas of acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention.

Previously, these common measures were referred to as the Joint Commission's ORYX Core Measures and CMS' Seventh Scope of Work Quality of Care Measures.

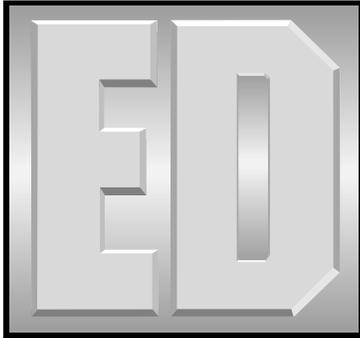
Now, both groups will refer to them as Hospital Quality Measures. The *Specifications Manual for National Hospital Quality Measures*, version 1.0 (2005), a single common quality measures manual for hospitals, is effective with discharges beginning Jan. 1, 2005.

The specification manual can be found on the Joint Commission web site at www.jcaho.org/pms/core+measures/aligned_manual.htm.

The manual contains documentation on the identical measures, as well as measures and operational processes (for example, data transmission) unique to each agency.

For example the acute myocardial infarction (AMI) section of the manual contains the common identical measures as well as two CMS test measures and the Joint Commission AMI mortality measure.

The *Specifications Manual for National Implementation of Hospital Core Measures (2004)* is posted on the Joint Commission web site, and this manual is in effect for hospital discharges through Dec. 31, 2004. ■



Management

The monthly update on Emergency Department Management

Incentives are a growing trend in emergency department pay, link seen to pay for performance

Physicians and nurse managers in emergency medicine stand a better chance of boosting their income through incentive packages, as opposed to straight salary increases, according to industry observers. And if you *did* receive a significant salary boost in the past year, chances are you're an ED nurse manager — not a physician manager.

"The biggest trend I'm seeing is incentive income," says **Barbara Katz**, who heads a Tampa, FL-based emergency medicine consulting firm specializing in ED physicians that bears her name.

In general, more administrative teams are giving incentives to nurse directors with bonus structures tied to performance targets, adds **Diana S. Contino**, RN, MBA, CEN, CCRN, a consultant

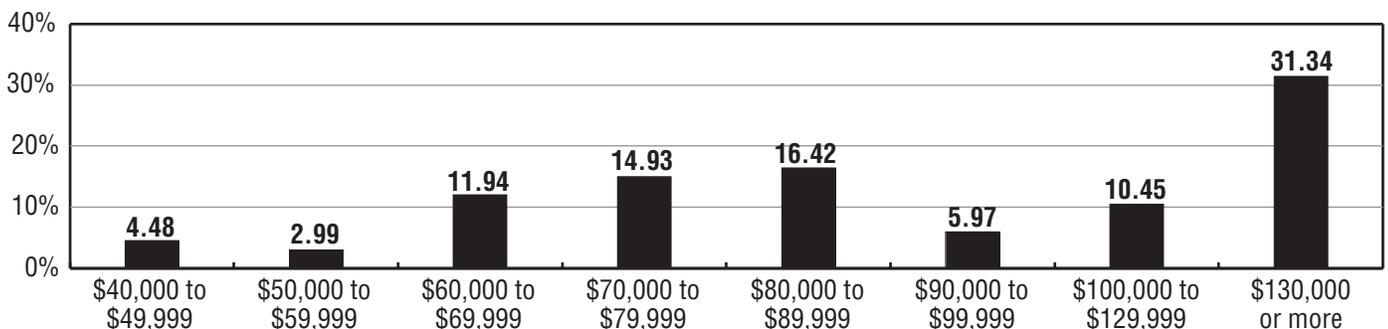
with MedAmerica, an Oakland, CA-based medical practice support company for emergency services, and owner of Emergency Management Systems, a Laguna Niguel, CA-based consulting firm that specializes in staffing issues.

Where can such incentive structures be found? "It really depends on hospital leadership and if they subscribe to the pay-for-performance concept," Contino notes.

"Some facilities are increasing director incentives if they reach their goals and targets for such items as budget, staffing productivity, and supply expenses," she explains.

However, Katz adds, "You can have an incentive structure in any environment — even in academics." Structures for emergency physician

What is Your Annual Gross Income From Your Primary Health Position?



managers vary widely, she says, but in general, they are based on finding ways to increase the income into the department.

Incentives and disincentives

Incentives for relative value units (RVUs), or the amount of billing, is the most common denominator for incentive programs, Katz points out, adding that hospitals are a bit behind groups when it comes to incentives for directors or managers.

“The big national groups can sometimes pay very high administrative stipends and create different kinds of incentives — not always based on clinical billing,” she explains. “They could be based on an increased census over the past year, or quality assurance.”

Many packages also involve disincentives, she notes. “If you have a doc seeing 4.5 patients per hour but not doing the documentation properly, that can impact the incentive.”

At many large hospitals, says Katz, department directors may receive an administrative stipend on top of their clinical annual salary; in most of those cases, if there is an incentive program in place for physicians, they would not take part in that.

However, she adds, “This doesn’t rule out the possibility of a smaller hospital with lower volume, say 15,000-18,000, where the director is putting in as much clinical time as the rest of the staff; in which case, they would probably have the opportunity to take part in an incentive program.”

Here is one model for an incentive package, offered by Katz: “Let’s say you’re in Tampa, and you’re earning \$90 an hour,” she poses.

“Incentives are based on a formula of 50% billing, 15% citizenship — monthly meetings,

getting involved with committees — 15% could be based on documentation, how well and how quickly the charts are done. Then, the last 20% could be director’s discretion: Do you ‘play well with others?’ Are there complaints from patients, family, nurses?” she asks.

The incentive bonus might then be set up so that each bonus point represents “X” dollars an hour — higher or lower, Katz explains.

For nurse managers, incentives and pay for performance structure vary from organization to organization, says Contino. Some are a straight percentage of the amount the department is under budget, she says.

“Others are structured as a total pool of money, say \$10,000, and the director receives 20% for turnover rates at less than 5%, 20% for meeting budget, 20% for filling all positions, 20% for achieving departmental operational goals, and 20% for a successful accreditation survey,” she notes.

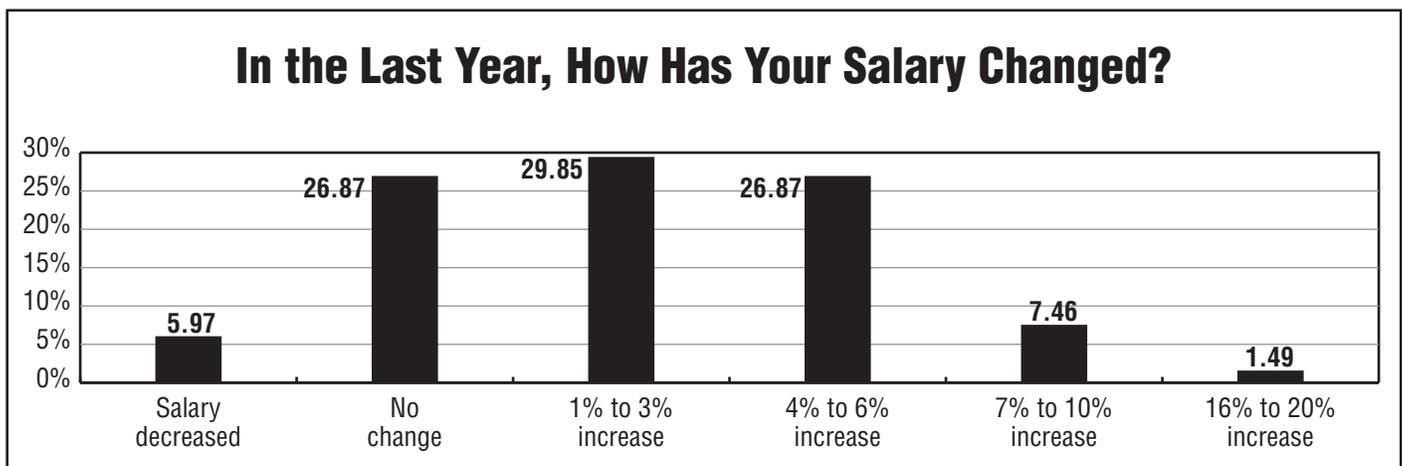
“Others are just based upon meeting your budget targets, and the director receives the total pool of money set aside for bonuses.”

Who received pay raises?

Most ED physician and nurse managers did receive an increase in the past year, although huge raises were rare. According to the *ED Management 2004 Salary Survey*, nearly two-thirds of the respondents (65.67%) received salary increases.

Of that total, 26.87% of the respondents had increases of between 4% and 6%, and 29.85% had increases of between 1% and 3%. Another 26.87% reported no change in their salary. (See chart, below.)

The survey was mailed in July to 1,108



subscribers. There were 67 responses, for a response rate of 6.5%.

Nearly one-third of respondents (31.43%) reported gross income of \$130,000 or more. The second largest grouping was the \$80,000-\$89,999 range (16.42%), followed by \$70,000-\$79,999 (14.93%).

Still, for ED physician managers, “salaries are *not* going up,” Katz asserts. The malpractice crisis has decimated the industry, she says.

“You wake up one morning, and your premium has increased 800% overnight; but that money is *not* going to come from the hospital.” Increasingly, Katz adds, hospitals are starting to regard malpractice premiums as part of their total physician compensation — “and this includes department managers,” she asserts.

Disparities seen in wages

There is a big disparity in physician manager salaries from state to state, but apparently no rhyme or reason, Katz says. “A physician in Maine will earn half what the same guy in the same ED in Texas is earning, and some of highest cost-of-living locations have the lowest salaries,” she says.

The highest dollars are to be earned in Texas and Louisiana, Katz notes. In Odessa, TX, for example, an ED physician can earn three times as much as one on the Oregon coast — for example, \$400,000 vs. \$140,000.

Also near the top of the salary ladder are parts of the Midwest, northern Illinois, parts of Indiana, Minnesota, and Wisconsin, then small pockets in Kansas, she explains.

“Then, parts of the Southeast are scrambling to catch up, with South Carolina being one of the highest in the region,” Katz continues “The Northeast is really working very hard to get their bucks up because they are one of the most expensive places to live, and they are climbing close to the Southeast.”

And what about California, which is known for its high cost of living? “That depends,” she explains. “It’s a huge HMO state, so it depends on the process for earning income, whether a group offers partnership potential, and so on.” If you are a director of a group, as opposed to a hospital, you will make more money, Katz adds, noting that some small groups also rotate directorship.

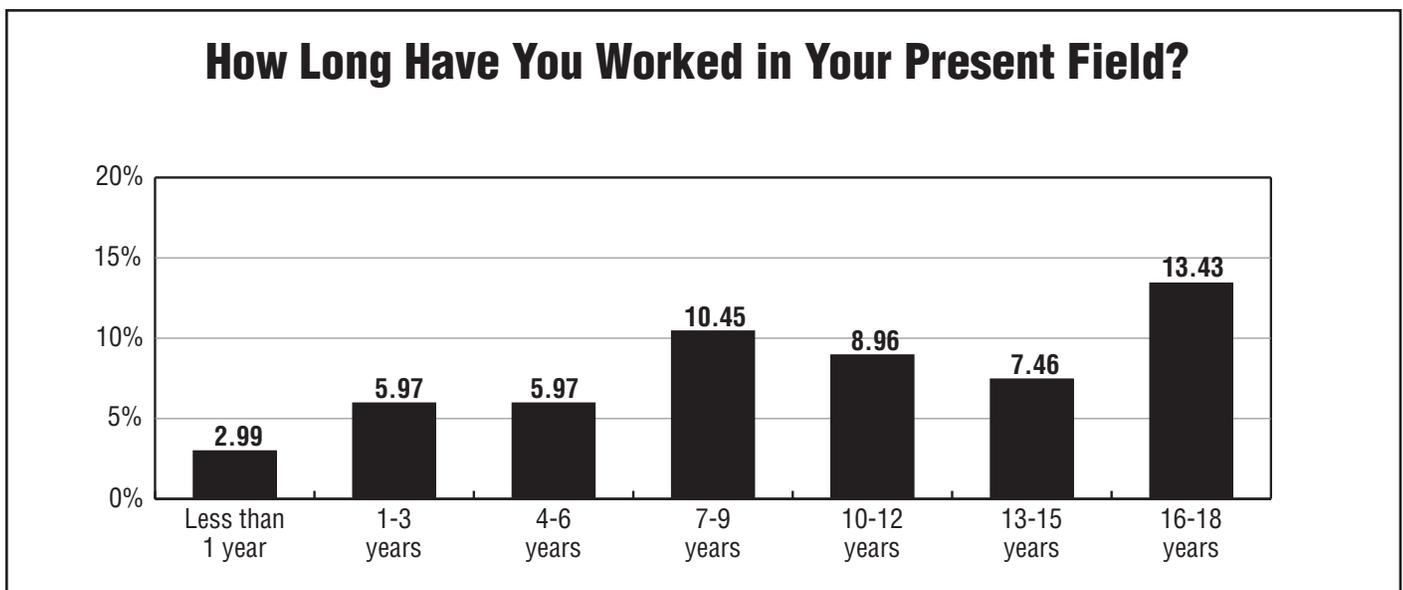
Location sometimes can draw recruits to areas where compensation is lower, “but they still can’t underpay,” she asserts.

Katz adds that she doesn’t see salaries for emergency physician managers improving anytime soon. “I do not see anything major in terms of increases in the next five to 10 years unless we are able to stabilize malpractice issues,” she says.

Experience alone not enough

Experience alone may not be enough to earn the bigger bucks, note observers, and as the EDM Salary Survey shows, having years of experience does not necessarily set you apart from the competition.

Nearly 30% of the survey respondents have worked in the field for 10 or more years, and 13.43% have worked in the field for 16-18 years. Another 10.45% have been in the profession for seven to nine years. (See chart, below.)



But industry organizations such as the Emergency Nurses Association (ENA) are seeking to help nurse directors complement their years of experience with management-specific skills, which in turn, they hope, will increase their value in the marketplace.

“Traditionally, nurse directors are promoted because they are wonderful clinicians,” says Contino.

But nurses receive very little financial management education, says Contino, and she points specifically to revenue cycle management, data accuracy as it relates to front-end processes (registration), back-end processes (insurance verification and point of service collection), middle-clinical documentation, and chargemaster management and departmental budgeting.

“For those places that have management incentives and bonus plans, the more nurse directors know and can do, the higher the bonus structures are,” she says.

Many of these topics are covered in a new nurse manager training course, called “Key Concepts in Emergency Department Management,” launched this year by ENA. “In 2004, the faculty taught over 350 emergency nurse directors, managers, and charge nurses,” says Contino, who is part of that faculty.

Because the margins in health care have decreased, it is increasingly more important for nurse directors to be able to evaluate and change the fiscal management of their departments, Contino notes.

“Directors who are able to manage supplies and human resources, and assure their processes are positively impacting the revenue cycle, have a tendency to be promoted, to receive raises, and to achieve success in their organizations,” she says.

More health care organizations are investing in nurse director education and training as well, Contino continues.

“The increased training is not only an investment in the individual, but also in the organization,” she notes. “The more the nurse leaders know about finance and operations, the more they are able to meet and achieve financial and operational targets.”

Changing management structure

Another trend Contino sees for nurse directors is a change in the management structure of the ED, especially EDs with more than 30,000 visits per year.

They are allowing the ED to have one nurse director and supporting assistant managers, clerical support, and dedicated charge nurses, she notes.

“The ED is the window of the hospital, and the staff admit and discharge exponentially more patients than the inpatient units,” Contino says.

“EDs are also faced with challenges of high burnout among staff, recruiting challenges, and rapidly changing volumes that often require the leadership team to assist in the department.”

On a positive notes, those departments, the EDM Salary Survey reports, steadily are increasing in staff size.

Of those who responded to the survey, 58.21% said the number of employees in their departments had increased, and another 28.36% said that number had not changed at all. Only 13.43% said the number of employees in their department had decreased. (See chart, below.)

In light of this reality, Contino adds, “It is critical that this department receive adequate leadership support.”

Not all EDs are seeing a shift in management structure, she says.

“On the flip side, small rural sites — or those faced with significant financial losses — will assign multiple department responsibility to one director,” Contino notes. “Pay and responsibility are often dependent upon the fiscal success of the organizations.” ■

In The Past Year, How Has the Number of Employees in Your Department Changed?

