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Desperate to stop the flow of red ink, Level I trauma center will deny transfers

Facility asserts other hospitals can care for lower-level trauma patients

Caught between the proverbial rock and a hard place, the University of Mississippi Medical Center (UMC) in Jackson has taken drastic action and announced that on a case-by-case basis, it may decide not to accept future transfers from facilities it believes have the resources to care for those patients themselves. But in so doing, UMC may have put itself in danger of violating the Emergency Medical Treatment & Labor Act (EMTALA), says one expert.

While perhaps being one of the more dramatic responses to a growing trend, the medical center's decision is not all that surprising. UMC experienced a $20 million increase in the amount of indigent or uncompensated care from fiscal 2003 to 2004 — from $48 million to $68 million.

"We have, like everyone else, been monitoring our financial situation and seen dramatic increases in costs of uncompensated care," says **Dan Jones**, MD, UMC vice chancellor. UMC performed an analysis of the reasons for that dramatic increase and found that roughly two-thirds were related to trauma. "We further found that essentially all that growth in trauma uncompensated care was in lower-level trauma cases," Jones says.

Michael Frank, MD, JD, general counsel for Emergency Medicine Physicians (EMP), a physicians group based in Canton, OH, says, "There's definitely a trend for hospitals to try to find ways to deal with shrinking reimbursement and growing acuity, and everyone has to find ways to make ends meet." He adds, however, that he is unaware of other facilities taking this specific action.

Executive Summary

Despite financial hardship, the Emergency Medical Treatment & Labor Act (EMTALA) may place severe limitations on solutions available to overcrowded EDs.

- It is not up to the receiving hospital to determine capabilities of the transferring facility.
- If you suspect an improper transfer request, accept the transfer *and then* file a complaint with the Centers for Medicare & Medicaid Services.
- Whistle-blower laws protect ED managers if they refuse or complain about orders that violate EMTALA.

UMC will tell other hospitals that it will not accept the transfer of some lower-level trauma patients. "We are the state's only Level I trauma center, but we saw we could not sustain our current course and started talking publicly about other centers' ability to handle lower-level trauma cases," recalls Jones. "Everyone has a need and a desire to move patients on to another place, but we simply had to put the notice out that we can't financially sustain this increased growth in uncompensated trauma care."

Did UMC decide upon this course of action after learning that other facilities were doing the same thing? Jones says no. "We did it based on what our judgment was here," he notes. "There are, however, other large trauma centers nationally that are looking at how they accept transferred trauma patients."

Beware of EMTALA

That may be so, but Frank contends that UMC's new policy may violate the spirit — if not the letter — of EMTALA.

"One of EMTALA's provisions requires hospitals that have 'specialized units' to accept the transfer of unstable patients who need further evaluation or stabilizing treatment, and to refuse to accept those patients would constitute reverse dumping," he notes.

Even though the actual law refers only to specialized units and even gives examples (e.g., regional trauma centers, burn units, and neonatal intensive care units), the Centers for Medicare & Medicaid Services (CMS) and the associated regulators and investigators generally have decided to interpret this law to mean that any hospital that has a facility for caring for patients that the transferring facility does not have is under the obligation to receive transfer — and to refuse would be reverse dumping, Frank explains.

"It is not [literally] supported by the statute, but it is by practice," he says.

What's more, Frank adds, it doesn't take much for your facility to be deemed to have a specialized unit. "It could be as simple as, 'We have a bed open in our telemetry unit, and you don't,'" he explains.

In addition, Frank notes, it isn't up to the hospital being asked to accept a transfer to decide that the hospital seeking transfer is fully capable of treating the patient in question. "That judgment is not up to the receiving hospital," he asserts. "Obviously, a transferring hospital is not going to call up and say, 'We could take care of this patient, but we're not going to.' But Mississippi is saying they're going to second-guess the transferring hospital and basically tell them, 'We say you *can* take care of this patient, so we won't.'"

Such a decision, however, "is pre-emptive and could land the receiving hospital in a lot of trouble if it turns out afterward that the transferring hospital, in fact, could *not* take care of that patient," Frank asserts.

If a receiving hospital decides there is a problem with a hospital transfer request, the proper course of action is to contact CMS and complain — in which case, there would be an investigation after the fact, he explains.

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Jones, having consulted with his own counsel, is confident that UMC's actions fit within the guidelines of EMTALA. The term "refuse to treat" is never something you will hear out of any administrator, he declares.

"We do make decisions on a case-by-case basis; and if we have limited beds available, we may say, 'Not now,' in terms of a request for transfer in a situation where patients are being managed at the time of the call and the facility has the resources to care for that patient," Jones says. "We certainly aren't going to refuse to care for people who need it and can't get it other places."

As for Frank's observation that it's not up to the receiving hospital to determine the transferring facility's ability to care for a patient, Jones contends he has that concern covered as well. "There are simple questions that are easy to ask and answer, like, 'Is there a neurosurgeon available on your staff?'" he offers. "We've been very careful that we do not get crossed with any EMTALA guidelines."

ED managers, beware

As more and more facilities desperately seek solutions to this problem, Frank advises ED managers to be aware of their rights — and the potential legal exposure they may face under EMTALA. "ED managers are the ones being put on the hot seat; they generally will be giving the receiving calls," he notes.

While under EMTALA, there is no private right of action due to actions of individual physicians. "It is very common for suing attorneys to name physicians for violation of EMTALA; the first thing your defense attorney needs to do is get it stricken," Frank advises.

However, he adds, physicians who *do* violate EMTALA can be subject to monetary fines as high as $50,000 for each violation and/or exclusion from government programs such as Medicare.

The good news is that you have every right to refuse a request from upper management that violates EMTALA. "There are whistle-blower and compliance protections, so under EMTALA a physician can't be penalized for refusing to violate EMTALA or complaining about a violation," Frank adds. ■

New report highlights crisis with on-call panels

Will recommendations solve complex problem?

"The patchwork of call panel arrangements is unwieldy, expensive, and may compromise the quality of care for patients in the emergency department." This dramatic finding is part of a new report that outlines the seriousness of the call panel situation in California, often considered to be a state that precedes the rest of the country, and offers recommendations to remedy the situation.

The report was funded by the Oakland-based California HealthCare Foundation (CHCF) and produced by The Performance Alliance of Anaheim, CA, in collaboration with the University of Southern California Center for Health Financing, Policy and Management in Los Angeles.

Their findings come as no surprise to ED physicians, who have been wrestling with the problem for years. "I read the CHCF report, and it simply reaffirms other reports," says **Paul Kivela**, MD, MBA, FACEP, president of the California Chapter of the American College of Emergency Physicians (CAL/ACEP), an attending physician at Queen of the Valley hospital in Napa, and co-author of his own study of the on-call coverage situation in California. **(See resource box, p. 29.)**

The situation in California may be a bit extreme compared to other areas of the country, but experts warn it's only a matter of time before they are faced with similar crises. "It's unfortunate, but inevitable; California is where it all starts — here, or Florida, or New York," says **Wesley Curry**, MD, FACEP, CEO of California Emergency Physicians (CEP) Medical Group, an Emeryville, CA-based partnership of physicians that provides emergency physician services in about 51 EDs.

In other states where Medicaid reimbursement is more appropriate, they will be shielded from it for a longer period of time, but nobody is immune to this

Executive Summary

To solve the challenge of filling call panels, money, turf, and lifestyle issues of physicians must be addressed.
- Use of hospitalists and physician assistants can help provide coverage for internal medicine cases.
- Competitive contracting could create a critical mass of available on-call physicians.
- Paying physicians to be on call makes sense, but adequate funding must be provided.

problem, Curry emphasizes. "Unfortunately, we may just be five to 10 years ahead of other areas," he says.

Kivela agrees. "In many cases, California is the bellwether. I've talked to people out of state where call panel coverage is not yet such an issue, but they are aware it is headed in that direction," he explains.

The challenge seems to be finding solutions, sources say. The CHCF report offers a combination of possibilities, including:

- taking legislative action, such as payment standards for on-call physicians;
- introducing regional competitive contracting for on-call coverage;
- instituting mandatory on-call duty for hospital medical staffs;
- creating physician compensation incentives such as tier-based stipends or productivity-based guarantees;
- restructuring the delivery of on-call services through use of hospitalists or physician assistants;
- establishing transfer agreements among hospitals.

Kivela remains unconvinced that anyone has found the silver bullet. "We tried an initiative this year, but it failed," he says. **(See story, at right.)** "There are numerous other solutions being proposed, although I believe they are only partial fixes."

Some merit seen

Partial though they may be, the solutions offered by CHCF have merit, Curry notes. For example, he says, regional competitive contracting for on-call coverage "actually has promise." Essentially, this solution would involve putting together a group of physicians responsible for coverage in multiple hospitals, Curry adds.

"You could potentially get a critical mass of physicians," he says. "It's not likely they would be called to the same hospital at the same time."

However, Curry notes, because hospitals are basically in competition with each other, some may not be interested in such an arrangement. "Also, there is the issue of sharing of availability [on-call] fees," he adds. "There are hospitals that pay north of $5 million a year to arrange that."

Payment standards for on-call physicians seems to make the most sense, Curry says. "Paying physicians to be on call, or some mechanism where they get paid a fair amount for what service they provide, is a good idea," he continues, but adds that funding such payments in California is a problem. "The [state's] Maddy Emergency Medical Services [EMS] fund does pay for uncompensated care, but it's nearly bankrupt in every county by July," Curry. continues.

Restructuring the delivery of on-call services through use of hospitalists or physician assistants is another solid proposal, he says. "We have already used hospitalists here, and it's been very successful," Curry points out. "That's definitely a solution people should look at — but that only [solves the problem] on the internal medicine side." **(For more stories on hospitalists, see "Want to improve quality of care and ease the burdens on your physicians?"** ***ED Management,*** **May 2004, p. 49, and "Hospitalist use increases: What is the benefit for EDs?" p. 51.)**

California ED doctors ante up to boost on-call coverage

Just how serious is the on-call panel coverage situation in California? Serious enough that this fall, the state's emergency physicians put up nearly $2 million of their own money in support of a ballot initiative that would have added $600 million a year to pay for uncompensated emergency care. The initiative did not pass.

"This is *exactly* an indication of how serious it is," says **Paul Kivela**, MD, MBA, FACEP, president of the California Chapter of the American College of Emergency Physicians (CAL/ACEP) and an attending physician at Queen of the Valley hospital in Napa, CA. The funding for the initiative fell on providers, he says. "The total was about $3.5 million to $4 million, and we raised close to $1.8 million among the emergency physicians," Kivela explains.

CAL/ACEP launched the initiative because, "We tried to find other ways to solve this problem, but it kept snowballing," he adds. So, the organization asked every emergency physician in California to donate $500 a year for two consecutive years to support the effort.

"About 50% of them gave, and some gave a lot more than $500," Kivela continues.

He contends the initiative, along with other recent events in California, will spur more people to try to come up with a solution. "This is more than an imminent crisis; we're there right now," Kivela asserts. "The past election has been a big wake-up call; outgoing Gov. Grey Davis signed a bill requiring all mid-sized and large employers to offer insurance to their employees, but it was narrowly defeated."

Nor has he given up on his own efforts. "We failed because the proposed source of our funding was a surcharge on phones," Kivela observes. "We did not receive appropriate counsel on the reaches of the phone company." Will CAL/ACEP try again? "If that's what it takes, we will try to do it again," he adds. ■

Sources/Resource

For more information on the call panel crisis, contact:

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- **Paul Kivela**, MD, MBA, FACEP, President, CAL/ACEP, Attending Physician, Queen of the Valley Hospital, 1370 Trancas No. 336, Napa, CA 94558. Phone: (707) 207-0477. E-mail: pkivela@myifp.com.

For a copy of *On-Call Physicians at California Emergency Departments: Problems and Potential Solutions,* go to the California HealthCare Foundation web site (www.chcf.org) and click on "Emergency Departments' Unstable On-Call System Examined." Or contact:

- **California HealthCare Foundation**, 476 Ninth St., Oakland, CA 94607. Phone: (510) 238-1040. Fax: (510) 238-1388.

One definite nonstarter, he says, is mandatory on-call duty. "I think it will backfire," he predicts. "Orthopedic surgeons, for example, will stop working in hospitals, as they have in Florida and in other states."

The key to developing effective solutions is to remember the main causes of the problem, observers say.

"It still boils down to money, turf, and, in many cases, lifestyle," Curry asserts. "People are less willing to respond to being an on-call physician when they perceive significant costs for liability coverage, a lack of reimbursement, and also the intrusion into the usual schedules of their office practices." That's why, for example, the hospitalist solution makes sense; they have no outside office hours to interrupt.

"You must determine whose problem this is," he continues. "Hospitals do not want to feel like they have a bunch of physicians on payroll, but the physicians do not want to feel they are doing this work for free, because it only benefits the hospital." This continues to be the primary sticking point, Curry says. "So more hospitals are paying physicians to be available," he says.

One thing is clear, says Kivela; something has got to be done soon. "EDs in California are closing; we've lost six in the L.A. area in the last 14 months, and since the summer, it's been escalating to nearly one a month," he says. "This creates domino effect, because the facilities adjacent to the ones that are closed will not be able to provide the on-call coverage needed." **(For another look at potential call panel solutions, see "Situation critical for call panels: Is there a cure?" *EDM,* August 2004, p. 92.)**

Suggested reading

• Rudkin SE, Oman J, Langdorf MI, Hill M, et al. The state of ED on-call coverage in California. *Am J Emerg Med* 2004; 22:575-581. ■

To ease overcrowding, delay elective surgeries

Crazy idea or valuable strategy?

No one is claiming it's a cure-all for ED overcrowding, but a number of facilities have turned to postponing elective surgeries that required admissions as an important part of a multifaceted plan to ease the burden on their harried ED staff. And when they do, many give the ED manager a key role in the decision-making process.

It's important for ED managers to be in the decision loop, because they often will be the ones that give the most accurate information about the need for a hospital response, experts say.

Just this winter, two hospitals in Utica, NY — Faxton-St. Lukes Healthcare and St. Elizabeth Medical Center — announced that they had reduced the number of elective surgeries that were scheduled, and would evaluate, on a day-to-day basis, what further elective surgeries might need to be postponed to help move patients who need to be hospitalized more efficiently through their EDs.

But this is a strategy that has been used on an as-needed basis for several years at other facilities, such as Southeastern Ohio Regional Medical Center in Cambridge, and Latter Day Saints (LDS) Hospital, the flagship facility for Intermountain Health Care, in Salt Lake City. In both cases, the ED manager has been instrumental in the new processes.

"A couple of winters ago, we were full to the gills," recalls **Mark Slabinski**, MD, FACEP, FAAEM, director of emergency services at Southeastern Ohio. "Our ED works very well and almost never holds patients,

Executive Summary

Make sure you are in the loop when decisions about postponing surgeries are made.

- The ED managers often have the most accurate information available concerning likely demand for beds.
- Try to be part of the drafting process for any new policies.
- A response plan that does not include ED input is likely to suffer a breakdown.

but in that winter, out of our 15 beds, six were holding; and it was then up to us to figure out what to do." In response, Slabinski sat down with a hospital vice president, and together they crafted a policy for postponing elective surgeries that required admission. Their recommendations have been formally incorporated into the hospital's diversion policy. **(See policy, below.)**

"In 2002, our hospital hired a new CEO at the same time that our inpatient census was growing beyond our capacity, and we were frequently on diversion status," says **Mike Gibbons**, RN, BSN, the nurse manager of the LDS Hospital ED. The CEO implemented a daily administrative huddle. "When beds were tight, decisions were made as to how to limit admissions or increase discharges," he says. "As the ED manager, I provided input as to how long we could reasonably 'hold' patients without placing the hospital on divert," Gibbons adds. **(For more on the value of the administrative huddle, see story, p. 31.)**

While the plan at LDS was devised by upper management, at Southeastern Ohio, it had to be sold.

"We had to get administration's attention," Slabinski notes. "After crafting the basic policy, we got together with the medical and surgical chairs and figured out what made the most sense."

Selling administration was not really a problem, he says. "The harder sell sometimes is the primary care docs, who are used to doing something a certain way. But if you have administration's backing, then that's how it is, and they understand," Slabinski observes.

Diversion Policy (Excerpt)

IMPLEMENTATION

The decision to divert patients is a serious one and needs to be made as collaboration between the emergency department physician on duty, the nursing supervisor, and administration. When available, the chief of staff, the vice president of medical affairs, the medical and surgical department heads, the emergency department director, and the emergency department nurse manager also should be consulted in this decision. Time is of the essence in making this decision; therefore, no unreasonable delays in contacting all personnel should be allowed to delay implementation.

Patient diversion (both EMS and direct admissions) should occur only after the hospital has exhausted all internal mechanisms to avert a diversion, including recruitment of additional staff, utilization of alternative units, delays in elective admissions, etc.

Diversion must be temporary. All hospital personnel need to be notified and make every effort to cooperate during a diversion crisis so that the system may return to normal operation as quickly as possible. It will be the responsibility of the vice president of medical affairs, the vice president of nursing affairs, the chief of staff, and the medical/surgical department heads (or designates of the above) to ensure diversion procedures are followed.

PROCEDURE

1. Identify situations in which a hospital's resources are not available. This identification ideally will occur well in advance of a possible need to divert to prepare alternative arrangements.
2. Diversion only is considered after exhausting all possibilities as outlined in our "bed/telemetry management" policy, e.g., open flex unit; expansion of beds to the post-anesthesia care unit or ambulatory surgery, delaying elective admissions or surgeries, etc.
3. The clinical nurse coordinator (CNC) or nurse director will assign an associate to pull the diversion call list and to immediately telephone all emergency medical service squads and administrative staff listed on the call list the need for diversion. Document date and time diversion initiated.
4. The CNC or bed manager will assign an associate to telephone surrounding hospitals our diversion status and acquire a list of their available beds if needed. A courtesy call also will be made to local nursing homes and to the Appalachian Behavioral Center.
5. Physician offices will be notified of diversion status through the medical staff office. Direct admissions to the hospital will not be accepted during diversion unless those patients either have arrangements made for their transfer by the admitting physician or a bed is available for that category of admission (i.e., telemetry not required, maternity, etc.)
6. The vice president of medical affairs and the surgery department head will evaluate the need to cancel or delay elective surgeries that may take a bed space away from another patient requiring an acute care admission.
7. There will be an ongoing evaluation of bed availability and staffing resources. Diversion will end as soon as possible. The decision again should be a collaborative effort.

Source: Southeastern Ohio Regional Medical Center, Cambridge. Reprinted with permission.

Sources

For more on postponing elective surgeries, contact:

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Attention: ED manager now in the huddle . . .

An "administrative huddle" at Latter Day Saints (LDS) Hospital in Salt Lake City has been tremendously helpful in determining when to postpone elective surgeries, but it has had a much broader impact on patient flow in the ED and the hospital as a whole.

In 2002, the hospital instituted daily administrative huddles. "The huddle reviews events and patient-flow information from the previous day," explains **Mike Gibbons**, RN, BSN, the ED nurse manager. "The nursing supervisor reviews census data, and the group evaluates the day's planned admissions to verify that enough beds are available."

The huddle attendees include the nursing supervisor, the ED manager, the surgery manager, and the administrative directors for cardiovascular, neuromusculoskeletal, women's and newborn, trauma, and surgery services.

Daily ED involvement in these huddles is very significant; otherwise, they get overlooked, Gibbons adds. "Typically, the ED is the last place people think of as part of the hospital," he says.

"This helps us be part of the mix, and for other departments to understand that a large percentage of their admissions come from us." If the ED is not taking into account when the hospital is full, says Gibbons, "something will break somewhere."

The administrative huddle idea has caught on so well at LDS that is has expanded to a charge nurse huddle, which takes place at 4 a.m. and 11 a.m. daily, to discuss critical staffing needs. "This huddle provides the ED charge nurses with information about bed availability times and staffing issues on various floors and ICUs," says Gibbons. "This information is then used by the ED charge nurses to better manage their resources — knowing, for example, that they may need to hold several patients until the usual afternoon discharges are completed on the acute care floors." ■

At LDS, it's simply a matter of the plan playing out. "It's totally based on the census on the surgical floors," Gibbons explains. "If all the surgical floors are full, we look at which floors will be the next to go. Then, if we run out of room, it's time to cancel surgeries [that require admission]."

At that point, the OR manager and catheterization lab manager consult with the house supervisor prior to beginning elective cases that required admission.

"When it reaches that point, they call me, see how many patients we have in the department, and of those, how many we think will end up upstairs," Gibbons points out.

The managers attempt to review that information every couple of hours, he says. "If OR cases need to be admitted, they won't let anesthesia start until they are sure there's a bed for that person," he explains.

While LDS has not postponed or cancelled a large number of surgeries, the strategy has been used several times over the past few years, Gibbons says. "We've used it maybe five days in all," he adds.

It's a great tool to analyze resources, Gibbons says. "When the hospital is that full, this process helps," he says. "Plastics cases, gastric bypasses, and such can certainly be delayed or postponed."

Of one thing, Slabinski is certain: "The ED absolutely should be involved [in decision making]," he asserts. "We admit 60% to 65% of the patients who come through our doors, so it's silly not to include us at the table."

Gibbons agrees, and he notes that ED statistics are vital to the decision-making process. "Part of the huddle is knowing, for example, that you will typically get 30 patients from the ED [every day] based on averages, and a certain percentage of those will typically go up to elective surgeries," he says. ■

'Predicting the future' helps cut LOS by 50%

Bed turnover time slashed from hours to minutes

ED managers may not possess a crystal ball, but the ability to predict future events is nonetheless critical to their success, notes **Bonnie Coalt**, RN, MS, director of nursing at Miami Valley Hospital in Dayton, OH.

"The role of ED managers is to be able to predict by hour of the day their walk-in patient arrivals, their ambulance patient arrivals — by hour of the day and by day of the week — and also to be able to predict

Executive Summary

Being able to predict demand is critical to achieving proper staffing levels and optimal patient flow.

- No need to invest in fancy software; a basic Excel program can perform the functions you require.
- If you don't integrate your data with the rest of the hospital, you actually may make things worse.

the admissions, by hour of the day, that generate out of the ED," she asserts.

The ability to forecast such statistics, part of a comprehensive strategic improvement initiative at Miami Valley, has helped cut length of stay (LOS) nearly in half and helped slash bed turnover time from several hours to just a few minutes. Forecasting is, in fact, the key to fulfilling any number of management responsibilities, says Coalt. "No. 1, it's important so you can do staffing appropriately," she says. "It's also tremendously helpful in improving patient flow."

In 2002, when the initiative began, the ED diverted 2,010 hours. By 2003, it was able to reduce that to 860 hours; and in 2004, the department was able to maintain at 792 hours — with higher volume.

Coalt recognizes that many people perceive the ED as highly *unpredictable,* but says that when you look at trends over a long period of time, they are quite predictable — even by a statistician's standards. Once you have studied these trends, you will know your future demand, including the demand for scheduled surgeries, elective inpatients, as well as for patients who initially come in for outpatient treatment but end up as inpatients. Subsequently, you will be able to predict peak demand times for all of those areas, she notes.

"You will then be in a better position to compete for resources, and for available, appropriate beds," Coalt explains.

This statement brings up one more key aspect of the predictive process: The recognition that the ED does not operate in a vacuum. "It is essential that the ED integrates [its own analysis] with the analysis of the whole hospital's demand," says **Diane Pleiman**, CNMT, RTN, MBA, director of financial operations, patient placement, and staffing. "[Integration] is probably one of the greatest things ED managers need to know."

Learning to 'Excel'

Miami Valley began its own experience with predictive modeling this past fall, using a standard Microsoft Excel program.

"We entered the data in Excel, and then created pivot tables [also an Excel function] to sort the data by hour of day, day of week, and so forth," Pleiman explains.

The ED has five clinical stations in the ED, and it could pull data from those computers to identify the highest acuity station, as well as fast-track data, Coalt adds. "We pulled data out of our computer system, as well as our charge system. That's how we knew what acuity level the patients were," she says.

"We had to collect the data in order to be able to make observations and validate that some 'lean process' changes would work," Pleiman notes. *(Editor's note: "Lean process" is a Six Sigma term that basically refers to an organization becoming quicker and more agile.)* "We were also able to predict 'takt time,'" she continues. *(Editor's note: "Takt time" is another Six Sigma term, a German word indicating the time it takes to complete an individual activity, such as triage.)*

"We were able to predict the number of patients we would have to discharge out of the department in order to accommodate incoming patients, based on average length of stay, and how much we would have to reduce the LOS in order to meet that takt time," Pleiman says.

Integrating, implementing

At first, the ED predicted its own demand and workload figures. Next, it integrated the numbers with those of the entire hospital.

"Without that integration, folks would think the ED *does* live in a vacuum," she adds. "And we would have gotten into *more* trouble in rerouting and diverts if we only looked at our own piece of the puzzle."

After examining the data, a number of changes were implemented. Among the most effective: changes in transportation staff. "We were able to zero in on the bottleneck point, which required more staffing," Coalt explains. "We did not change [the number of] RNs, but we did for clerical support and patient care technicians that do transport out of the ED."

Sources

For more information on predictive skills in the ED, contact:

- **Bonnie Coalt**, RN, MS, Director, Nursing, Miami Valley Hospital, One Wyoming St., Dayton, OH 45409-2793. Phone: (937) 208-6196.
- **Diane Pleiman**, CNMT, RTN, MBA, Director, Financial Operations, Patient Placement and Staffing, Miami Valley Hospital, One Wyoming St., Dayton, OH 45409-2793. Phone: (937) 208-6196.

A total of 21 peak-level staffing level changes were made, and in six months, the LOS (from the time it is determined to admit a patient until that person is in an inpatient bed) was cut from more than three hours to an average of 1.7 hours.

A new interactive voice response telephone system for notifying staff when a patient is transferred out of a room has helped cut bed turnaround time from five to six hours to a few minutes.

When a staff member picks up the phone, he or she hears a series of computer-generated prompts; using these prompts that person can instantly notify the entire staff of the bed availability. New standard operating procedures also were created, to decrease variation when staff personnel changed.

"Through these initiatives, we have raised awareness for the entire institution," Pleiman concludes. ■

Most ED patients feel safe, but many fear errors

Misdiagnosis, medication errors are top concerns

A new study published in the journal *Academic Emergency Medicine* contains good news and bad news for ED managers. The good news: In a survey of 767 patients from 12 EDs, most individuals surveyed (88%) believed their safety from medical errors had been good, very good, or excellent.

However, 38% of them reported experiencing at least one specific error-related concern, with the most common concerns being misdiagnosis (22% of all patients), physician error (16%), and medication error (16%).[1]

"I was pleased to see the majority of patients actually did feel they were not at high risk for medical errors; it's actually a greater number than I would have guessed," explains **Linda Laskowski Jones**, RN, MS, APRN, BC, CCRN, CEN, director of trauma, emergency, and aeromedical services at Christiana Hospital in the Christiana Care Health System in Newark, DE.

While most patients believe hospitals are doing a good job managing these concerns, ED managers need to recognize that medical errors are real issues to patients, says **Thomas E. Burroughs**, PhD, associate professor at St. Louis University Center for Outcomes Research and lead author of the study.

"Emergency department personnel need to recognize that during the course of care, patients experience concerns about specific impending medical errors — some of which may be associated with actual errors," he notes.

Executive Summary

Involving your patients in the care process can help ease their fears and promote safety.

- In a culture of safety, ED managers must be accountable for keeping patients well informed.
- Easing patient safety concerns can contribute to higher levels of satisfaction and more return visits.
- Even worries about *potential* errors can affect the likelihood a patient will recommend your facility.

Sources

For more information on reducing ED patients' concerns, contact:

- **Thomas E. Burroughs**, PhD, St. Louis University Center for Outcomes Research, Salus Center, Second Floor, 3545 Lafayette Ave., St. Louis, MO 63104. Fax: (314) 977-1101. E-mail: burroute@slu.edu.
- **Linda Laskowski Jones**, RN, MS, APRN, BC, CCRN, CEN, Director, Trauma, Emergency, and Aeromedical Services, Christiana Hospital, Christiana Care Health System, Newark, DE. Phone: (302) 733-1835. E-mail: LJones@Christianacare.org.

Involvement eases concerns

There are several strategies ED managers can adopt to ease these concerns, and the most important one is to involve patients more directly in their own care, Laskowski Jones says.

"The first and foremost thing is to stress to your staff that they have to keep the patient informed — to make them part of the team," she asserts.

"If they know their plan of care, and something does not go according to that plan, either they or a family member can raise a concern." For example, Laskowski Jones notes, patients can offer an additional check on whether they are being given the proper medications or having the right part of their body X-rayed.

"In a culture of safety, the manager must hold staff accountable for keeping patients informed," she says. "That's key."

Burroughs agrees. "By directly involving patients in their own care, and encouraging them to inform their providers of any signs of errors, the level of safety can be elevated for all emergency department patients," he says.

As part of the safety culture, the ED staff at Christiana Hospital also pay close attention the Joint Commission

on Accreditation of Healthcare Organizations' 2005 National Patient Safety Goals, Laskowski Jones points out.

"The nurse manager can audit the compliance of staff, whether self-reported or directly, and in instances that need follow-up, look at work-flow processes and individual employee behavior to address issues that need to be corrected," she advises.

While Laskowski Jones hasn't done it yet, she adds that it probably would be a good idea to have the goals written out and given to the patients.

"You could say, 'These are important safety goals, and we are committed to them,'" she offers. "It would be a nice, innovative approach, and whenever you build patients into the care process, they will feel more comfortable."

And patients who feel comfortable can mean dollars in your pocket, says Burroughs. "The occurrence of a single error-related concern — not necessarily an *actual* error — was enough to have a significant impact on a patient's willingness to recommend and return to the facility for future care," he observes.

Reference

1. Burroughs, et al. Patient concerns about medical errors in emergency departments. *Acad Emerg Med* 2005; 12:57-64. ■

JCAHO's abbreviation requirements adjusted

The Joint Commission on Accreditation of Healthcare Organizations has issued its final modifications to the National Patient Safety Goal 2b, which address its 2005 requirements for standardizing medical abbreviations and symbols.

The requirements now apply to pre-printed forms as well as handwritten documentation, but apply only to orders and medication-related documents.

Source

For information about the abbreviation requirements, contact:

- **Darlene Christiansen**, Director, Standards Interpretation/Office of Quality Monitoring, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5273. E-mail: dchristiansen@jcaho.org.

The "prohibited abbreviations" requirement under the communication goal (2b) has changed in the following ways:

- It now applies to ALL orders and ALL medication-related documentation that are handwritten, utilize free text entry, or employ pre-printed forms.
- The minimum expected level of compliance for handwritten documentation and free text entry is 90%.
- The minimum expected level of compliance for pre-printed forms is 100%.
- Clarification of an order prior to implementation is expected but does not eliminate that occurrence from being counted. Similarly, after-the-fact correction of the order by the clinician does not eliminate that occurrence from being counted.
- Surveyors will count occurrences of "do-not-use abbreviations."
- One occurrence equals one or more "slips" per clinician per record.
- Three occurrences equal a Requirement for Improvement (Revised 1/21/05).
- There is no "partial compliance" for National Patient Safety Goals.
- This requirement will not be surveyed in electronic documentation or computerized order entry in 2005 (New 12/20/04).

"Monitoring of implementation by ED management is important to ensure effective implementation," says **Darlene A. Christiansen**, director of standards interpretation in the Joint Commission's Office of Quality Monitoring.

"[Unless otherwise specified,] surveyors will look for 100% compliance," she notes. ■

It's not over: Prepare for a strange flu season

This year is a wild card, and anything still could happen. First, we had a dangerous shortage of influenza vaccine, followed by many high-risk people who couldn't get or decided to forgo immunization.

Fortunately, this has been a mild flu season — so far. But February and March are the historical peak months for influenza activity, and the large numbers of high-risk unprotected people make this a potential recipe for disaster.

Influenza vaccine shortages and delays are a recurring problem, and at some point, we inevitably will face another influenza pandemic.

Are you and your facility prepared if we run out

of luck? Do you know where to turn for guidance and help? Do you know how to prevent the spread of this infectious disease? Or how to handle major staff shortages due to record absenteeism?

Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what could happen this flu season — or the next flu season.

Hospital Influenza Crisis Management provides the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients.

This sourcebook addresses the real threat of a potential pandemic and the proposed response and preparedness efforts that should be taken in case of such an event.

Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for health care worker vaccination and the efficacy of and criteria for using the live attenuated influenza vaccine.

Hospital Influenza Crisis Management will offer readers continuing education credits.

For information or to reserve your copy at the price of $199, call (800) 688-2421. Please reference code **64462**. ■

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

CE/CME *questions*

This concludes the CE/CME semester. See instruction box, below left.

31. According to the Emergency Medical Treatment & Labor Act, which of the following qualify as "specialized units?"
    A. Regional trauma centers
    B. Burn units
    C. Neonatal intensive care units
    D. All of the above

32. According to Wesley Curry, MD, FACEP, CEO of California Emergency Physicians Medical Group, which of the following call panel solutions proposed by the California HealthCare Foundation is a "nonstarter?"
    A. Regional competitive contracting
    B. Mandatory on-call duty for hospital medical staffs
    C. Creating physician compensation incentives
    D. Transfer agreements among hospitals

33. To finalize his plan for postponing elective surgeries, Mark Slabinski, MD, FACEP, FAAEM, director of emergency services at Southeastern Ohio Regional Medical Center, had to bring the following people on board:
    A. Chairman of medical services
    B. Chairman of surgery
    C. Administration
    D. All of the above

34. The administrative huddle at LDS Hospital in Salt Lake City includes the following departmental representatives:
    A. The cardiovascular services administrative director
    B. The surgery manager
    C. The ED manager
    D. All of the above

35. Which of the following is *not* a responsibility of the ED manager, according to Bonnie Coalt, RN, MS, director of nursing at Miami Valley Hospital?
    A. Predicting walk-in patient arrivals
    B. Predicting ambulance patient arrivals
    C. Predicting which elective surgeries will be cancelled
    D. Predicting admissions that generate out of the ED

COMING IN FUTURE MONTHS

■ The growing challenge — and cost — of treating obese patients

■ Withdrawal of emergency specialists blamed in patient deaths

■ Staggered staffing plan addresses patient census challenges

■ Computer-aided dispatch system crashes: How can EDs respond?

36. According to a study by Thomas E. Burroughs, PhD, associate professor at St. Louis University Center for Outcomes Research, the following percentage of ED patients report experiencing at least one specific error-related concern:
    A. 18%
    B. 22%
    C. 28%
    D. 38%

CE/CME objectives

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

- Implement managerial procedures suggested by your peers in the publication. (See *To ease overcrowding, delay elective surgeries.)*
- Discuss and apply new information about various approaches to ED management. (See *Desperate to stop the flow of red ink, Level I trauma center will deny transfers* and *New report highlights crisis with on-call panels.*)
- Share acquired knowledge of these developments and advances with employees. (See *'Predicting the future' helps cut LOS by 50%* and *Most ED patients feel safe, but many fear errors.*)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *JCAHO's abbreviations requirements adjusted.)* ■

CE/CME answers

31. D 32. B 33. A 34. D 35. C 36. D

BINDERS AVAILABLE

ED MANAGEMENT has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **ahc.binders@thomson.com**. Please be sure to include the name of the newsletter, the subscriber number, and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcpub.com/online.html.**

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