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The monthly update on Emergency Department Management

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## IN THIS ISSUE



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- **2005 *EDM* Reader Survey**

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# Quick turnover of physician groups raises red flags for ED managers

*Strong communication, planning can help ensure group continuity*

That was quick . . . In late November 2004, Methodist Hospital in St. Louis Park, MN, replaced its existing emergency physician staffing group, Emergency Physicians Professional Association (EPPA), with EmCare, a Dallas-based corporation providing services to more than 300 hospitals in 37 states. On Jan. 20, 2005 — a mere 61 days later — Methodist announced it was re-establishing its relationship with EPPA.

The short but event-filled reign of EmCare involved problems with inadequate staffing, according to Methodist in a press release announcing the EPPA re-hiring, and a lawsuit against Methodist. The lawsuit was brought by the Milwaukee-based American Academy of Emergency Medicine (AAEM), which claimed corporate entities such as EmCare violate state law. **(See story, p. 39.)**

The reasons for the initial dismissal of EPPA are less clear, with the parties directly involved reluctant to talk now that EPPA is back on board. However, sources have told *ED Management* that Methodist was seeking to move to an all-employee staffing model.

As for why EPPA was brought back, "My understanding is the most compelling reason cited by the hospital for reentering negotiations with the original group was that after the original group left, insufficient numbers of board-certified emergency physicians were credentialed to provide for the needs of the emergency department," notes **Robert E. Suter**, DO, MHA, FACEP, current president of the Irving, TX-based American College of Emergency Physicians (ACEP).

Regardless, the implications for ED managers extend far beyond one hospital in

## Executive Summary

With proper planning and awareness, impact of contract changes can be minimized.

- Make sure goals and objectives are understood clearly by you and your physicians' group.
- Recognize transitions always are stressful; be on guard for staff morale problems.
- Avoid midwinter staff turnover, and give new staff at least six months' advance notice before their move.

Minnesota. For one thing, observers note a growing trend toward providing physician services with larger corporate entities such as EmCare. The use of all contracted services, especially physician services, has implications for ED managers and ED medical directors. The short stay of EmCare also points to the potential volatility of changing groups, which can affect not only job security and morale, but quality of care as well — if adequate staffing is not maintained.

ED management experts agree that contract service failures, such as the one in Minnesota, can be avoided if physician and nurse managers maintain clear communication.

"I'd have to say the biggest issue in changing contracts from a nurse director's perspective is clearly the lack of communication. The hospital and the physicians were not in agreement on the overall goals and objective, or the goals were unrealistic," says **Diana S. Contino**, RN, MBA, a consultant for MedAmerica, a Laguna Hills, CA-based emergency physician management company. "To a physician's group, the hospital is a customer, and if they really pay attention to what the hospital needs and wants for the patients, they have a better chance for longevity," she explains.

Suter agrees. "If you are in an existing [contract] situation, the best strategy is prevention," he advises. "Maintain a good dialogue with the hospital, and make sure the members of your physician group participate to the extent that your group is indispensable to the overall success of the hospital." **(ACEP has a document available on how small groups can get and retain contracts. See the resource box, p. 39, for information.)**

## Transitions are never easy

From the point of view of the physician or nurse managing an ED, continuity of staffing almost always is preferable, Suter says. "These transitions are always difficult, always stressful," he notes. "It's not an experience you want to go through."

From Contino's perspective as a former nurse director, all of this can be averted if the nurse director/hospital executive team and the medical director have open and honest communication and work effectively as a team, she says. "If you agree on the performance criteria the hospital has chosen, and if you work together, oftentimes, you do not end up with unplanned loss of contract issues," Contino says.

More and more, she adds, nurse directors are gaining a voice in the contract process. "CEOs, COOs, and vice presidents trust the input and suggestions of a results-oriented and effective department director," Contino asserts.

It's important to do all you can to maintain continuity; changes made in an atmosphere of divided loyalties can have a lasting impact on an ED, Suter explains.

The people who stay may not be very happy about the fact that the contract turned over, he notes. "For example, the nursing staff may be mad at the new group because their favorite doctor's not there anymore," Suter

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## Source/Resource

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For a free copy of the American College of Emergency Physicians (ACEP's) *Obtaining, Maintaining and Retaining an Emergency Department Contract*, go to ACEP's web site: www.acep.org. In the "search" box, type "obtaining, maintaining contracts." Then click on the link, "Obtaining, Maintaining, and Retaining an Emergency Department Contract."

says. These changes are so difficult that they should never be entered into lightly, he says. "You should try work to through your problems and work with the group that you have."

The reality, of course, is that, ultimately, it is the hospital administration's decision; the ED manager, however, must deal with the consequences. "If the hospital is very clearly moving in a certain direction, try to work with this as much as possible," Suter advises. "You could try to convince the hospital [administrators] that this is not what they really want to do; but if you can't, then at least shake out any goals you see as incompatible [with optimal ED operations.]"

Another element of which you should be keenly aware, he says, is the time of year the turnover is occurring. "It's never as easy to staff an ED with physicians as you think it will be, especially if you have short lead time, and *especially* in winter," he notes. "The reality is there are not many emergency physicians who tend to move in the middle of the school year."

If your hospital has made an absolute determination to turn its ED physician contract over, "you want to do it in July and make sure whoever is going to staff your ED has at least six months to move," Suter asserts. "Most people they bring in will be straight out of residency, and there's a good chance they have kids [who] they do not want to take out of school."

In other words, he concludes, "*you* should choose precisely when your contract will turn over."

Suter's advice to nurse managers or staff ED managers? "Make your CEO aware of [the importance of timing]," he says. "Get on your knees and beg them not to do it in the winter." ■

# Physician-owned group or corporation: Pros, cons

The turnover of ED physician contracts at Methodist Hospital in St. Louis Park, MN, has brought into focus some of the major issues evolving in the competition between smaller, physician-owned ED groups and the larger corporate entities, such as EmCare, of Dallas; Team Health of Knoxville, TN; and Sterling Healthcare of Durham, NC. While some of those issues are philosophical, others are legal and may have significant implications for ED managers. And while those legal issues were, in this case, specific to Minnesota, the Milwaukee-based American Academy of Emergency Medicine (AAEM) asserts they also apply in many other states.

"Our belief is that EmCare, as a corporate entity, cannot legally own ED contracts in the state of Minnesota," says **Robert McNamara**, MD, FAAEM, professor and chairman of the department of emergency medicine at Temple University School of Medicine in Philadelphia.

McNamara, a past chairman of AAEM, was the association's point person in a legal battle with Methodist Hospital over its replacement of local group Emergency Physicians Professional Association with EmCare.

This prohibition exists in Minnesota through case law, he says. "In Tennessee, Texas, and in other states, there is fairly strong supporting evidence for the prohibition of the practice of corporate medicine," McNamara explains. "It creates a conflict between business interests and patients' interests."

"If someone could actually show me a specific case, I'd love to see it," responds **Stephen Dresnick**, MD, CEO of Sterling Healthcare. "It's a specious argument; and frankly, it does not hold water." In states where there are prohibitions against corporations such as Sterling, the ownership control is held by professional corporations, and Dresnick's group provides management services, he adds.

Be that as it may, the Minnesota case was not an isolated challenge by AAEM, McNamara notes. "One of the AAEM's political agendas is to challenge the prohibited corporate practice of medicine," he says.

Such challenges could have a significant impact on the ED physicians employed by such entities, continues McNamara. "We informed the Minnesota physicians in a big meeting held in November 2004 that there were prohibitions on this and that physicians could be placing their licenses at risk by aiding and abetting [EmCare], and it could be viewed as a fee-splitting arrangement," he says.

McNamara advises all ED physicians against joining

## Source/Resource

For more on ED physician group options, contact:

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- **Lynn Massingale**, MD, FACEP, Chairman, CEO, Team Health, 1900 Winston Road, Knoxville, TN 37919. Phone: (800) 818-1498.
- **Robert McNamara**, MD, FAAEM, Professor, Chairman, Department of Emergency Medicine, Temple University School of Medicine, Philadelphia. Phone: (215) 707-5030.

For more information about AAEM's legal concerns concerning corporate ED entities, go to the AAEM Web site at www.aaem.org. Scroll down to "Breaking News" and click on "AAEM Files Suit against Methodist Hospital" and "The Corporate Practice of Medicine in Minnesota."

such groups: "If you're looking to join such a group, according to everything we know about the practice of corporate medicine, you are putting yourself in danger." He suggests a visit to the AAEM web site for more information. **(See resource box, above.)**

People are free to choose any model they want, Dresnick replies. "About 2,500 physicians work with us; and by and large, they are very happy," he says. "We can buy malpractice insurance at a significantly lower rate than a [smaller] group, we can provide billing at lower rate, and we have a lot more experience in negotiating hospital contracts."

Every emergency medicine practice model has its strengths and weaknesses, adds **Lynn Massingale**, MD, FACEP, chairman and CEO of Team Health in Knoxville, TN, which provides clinical outsourcing to more than 450 hospitals. "Physicians should research all alternatives when looking for a job to determine which one best meets their needs." In addition to some of the advantages noted by Dresnick, Massingale says, Team Health offers tail insurance — which many small groups can't offer — and free CME through the Team Health Institute for Education and Patient Safety.

There's another advantage for ED physicians who join corporate entities, Dresnick adds. "Physicians who work for us actually tend to make more money than they would if they were out on their own," he claims. "Just because you have an ownership interest in a small, democratic group doesn't mean that's where you'll make the most money."

While not involved in the legal actions in Minnesota, the Irving, TX-based American College of Emergency Physicians (ACEP) takes a strong philosophical stance on the issue.

**Robert E. Suter**, DO, MHA, FACEP, president of ACEP, says, "To the extent that ACEP is concerned about how these things affect patients and emergency physicians, as well as how they impact the whole nursing staff, we feel very strongly the best situation is when you have an emergency physician's group at the hospital that is controlled by the emergency physicians *at* that hospital and works in partnership with the hospital nurse and administrative staff to create the best environment for the patient."

While admittedly not the only possible model, "historically, the best way to go is to work with a group that is democratic in structure and in which the physicians have a vested ownership interest," Suter says. (In the corporate groups, the physicians are employees.) "In a survey of our members, this model was felt to be the best by 80% of our respondents." He acknowledges, however, that 14% of ACEP members do prefer to practice as corporate or hospital employees or subcontractors.

There are a substantial number of emergency physicians employed by hospitals — maybe 30%, notes McNamara. The rest are in groups, he says.

At Team Health, the average tenure of the emergency physicians exceeds nine years, Massingale says. "A recent anonymous survey of our emergency physicians indicates that 94% say they would recommend Team Health to a colleague, and 98% are either very satisfied or satisfied with their career in emergency medicine," he notes.

Whatever their merit or legal status, one thing is clear: There are a growing number of corporate groups. In fact, McNamara says, it is part of their nature as a corporation to grow. "They need to expand their market share," he explains. "They advertise in *Modern Healthcare;* they go to meetings of administrators and purchase exhibit booths."

Over the last 10 years, there has been a consolidation into two or three major players, McNamara says. "If you include the smaller regional corporations, I'd say up to half the EDs in the country now have some form of that model," he adds. ■

# ED screening changes put pressure on competitors

*Nonurgent cases may look for treatment elsewhere*

When Ocala (FL) Regional Medical Center announced a new screening initiative that would involve counseling nonurgent patients to seek alternative care, a funny thing happened: Local competitors "Monroe Regional and Timber Ridge became involved

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Counseling patients about other options for nonurgent care can help ease the pressure on your ED.

- This process has the potential to decompress your ED by as much as 40%.
- Implementing post-screening counseling will put pressure on your competitors to follow suit.
- If the patient does not have an emergency condition, seek confirmation of payer source before treatment.

when they heard about our initiative, because they felt they would then be inundated by patients who were not having their treatment here," notes **Susan Atkin**, RN, ED director.

The irony is that the initiative being promoted by her hospital's parent firm, Nashville, TN-based Hospital Corp. of America (HCA), was itself the result of competitive forces in Houston.

"We got into it mainly because of *our* competitors," says **Timothy Seay**, MD, regional medical director for Greater Houston Emergency Physicians, a group of doctors who staff 12 hospitals in Houston and Corpus Christi, TX — all but one of which are HCA hospitals. "The screened patients coming out of their EDs were coming to ours."

Seay is unfamiliar with how the other hospitals screen their patients, but notes that "our goal is not to get them to another ED, but to an appropriate place. Another ED is a complete waste of time," he says.

The HCA screening process works like this: Every patient is triaged using the five-level Emergency Severity Index (ESI) system, originally developed by the late Richard Wuerz, MD, in the department of emergency medicine at Brigham and Women's Hospital in Boston. (*Editor's note: The American Academy of Emergency Physicians and the Emergency Nurses Association support the adoption of "a reliable, valid five-level triage scale,"*[1] *of which the ESI is one.)* In a five-level system, Level 1 is the most critical, and Level 5 is the least urgent.

"If the patient has no emergency medical condition, they are advised that they will need to speak to a patient financial counselor prior to care," Atkin explains. "They will determine a payer source for the patient or request a base rate payment for the self-insured patient."

Once a source of payment is determined, the care will continue. "But if the patient decides not to pay, and we determine there is no medical emergency, they are given a resource packet, which provides names and locations of the Department of Health, walk-in clinics, and local community health services for their follow-up care," he says. "Or, they could be referred to their own [primary care provider]."

This process sounds familiar to Seay, and it should; it was his group that communicated the HCA initiative to Ocala Regional and West Marion Community, the two HCA facilities in Ocala. The Houston HCA facilities have been using this process since April 2004.

"We don't charge on the physician side [for the screening]," Seay notes. "If they decide to stay, we send them a regular bill." The base rate referred to by Atkin is a hospital charge, which can vary from facility to facility, he explains. In Houston, a typical charge is $150, he says. The other special feature in the Houston system is that, in recognition of the large Hispanic population in that city, all resources also are in Spanish.

At Ocala Regional, the new process brought an additional challenge: They had been using a three-tiered triage system. While the five-level ESI system is not part of the new initiative, "all HCA hospitals are changing over to it," Seay notes.

In Ocala, the need to convert to a five-level triage scale meant a delay in implementation; in fact, the competitors already are running their new systems, while Ocala Regional is not.

"We needed to redevelop our triage form," Atkin notes. "Then, we needed to educate our staff on that five-level system. We sent about 90% of them to 'Triage First,' a two-day class sponsored by HCA."

It was necessary "to refresh our staff about the importance of triage — to discern initially which patients are critically ill and need immediate help, who can wait a little while, and those who are not urgent," she notes.

The hospital is waiting for a "go live" order from the administration, Atkin adds.

In Houston, the process has been in place for nearly a year, and it seems to be working well, Seay says.

"We set out to decompress the wait room and get people to go to the appropriate place for care," he adds. "There were no financial goals."

How does decompression work? "For every 10 people we have in the waiting room, our statistics show that seven will have insurance, and six of those seven will stay," Seay notes. "That means [under the new system] four will leave; so instead of a waiting room with 10 patients, you have six."

## Sources

For more on post-screening counseling, contact:

- **Susan Atkin**, RN, ED Director, Ocala Regional Medical Center, 1431 S.W. First Ave., P.O. Box 2200, Ocala, FL 34478. Phone: (352) 401-1000. Fax: (352) 401-1198.
- **Timothy Seay**, MD, Regional Medical Director, Greater Houston Emergency Physicians. Phone: (281) 784-1500, ext. 222. Fax: (281) 784-1522. E-mail: Tim.Seay@HCAHealthcare.com.

They have decompressed the waiting room by 40%, and in turn, the rest of the ED has been decompressed, Seay notes. "The fast-track area has gone from chaotic to manageable, and we have thoroughly educated the population and changed acuity mix as well."

The system is reinforced with an override option, he says. It works like this: A patient arrives and is triaged by the RN to Level 4 or 5. The patient is put in the medical screening exam room, and a provider — a doctor, a physician assistant, or a nurse practitioner — sees them. "If the provider wants to do a test to see if an emergency exists, or if they do not think the patient should see a finance counselor before the completed ED visit, then they override the triage RN's assessment of nonurgent," Seay explains. "This happens 20% of the time for us. We allow up to 30%."

Physician compensation includes incentive pay, some of which is tied to proper use of the override option, he continues. So, for example, if a physician exceeds the 30% ceiling, it could cost them "at most, a few thousand dollars a year," Seay says.

The overridden patients then become traditional ED patients. "It is the clinical judgment of the examining provider, with the only rule being that there is substantial clinical certainty that no one goes to financial screening who could be sick," he adds. "If a test has to be done, then the patient is reclassified as potentially sick and is overridden, and seen like a traditional patient. Most of this is transparent to patients."

### Reference

1. Emergency Nurses Association. Board of Directors meeting, Sept. 16, 2003. Formal statement regarding the joint Emergency Nurses Association/American College of Emergency Physicians Joint Five-Level Triage Task Force. Web: www.ena.org/about/position/default.asp. ■

# ED managers: Know your EMTALA guidelines

The screening/counseling initiative employed by HCA facilities in Houston and Ocala, FL, appears to be in compliance with the Emergency Medical Treatment and Labor Act (EMTALA), says one expert. However, he notes that there are many aspects of the act that apply to these processes, and it's crucial that ED managers understand what they are and how they can affect the design of such initiatives.

According to EMTALA, you can have the medical screening exam (MSE) done by a physician or by a qualified medical practitioner (QMP), notes **Alan Steinberg**, Esq., a partner with the Pittsburgh-based law firm of Horty, Springer & Mattern. *(Editor's note: According to EMTALA, QMPs are individuals who are "properly credentialed and have appropriate education and experience to perform [MSEs]."*)

"The rules require that the board of the hospital has approved that category, such as PAs [physician assistants]," Steinberg says. "It also depends on what the state says PAs can and can't do, which is covered in the licensing rules." In the case of Ocala Regional Hospital, for example, the MSEs will be done by a physician, a PA, or a nurse practitioner.

There is no problem with dividing triage into five levels, he continues. "The only consideration is that you not have patients who are Level 5 unfairly sitting around," he adds. "At one point, CMS [the Centers for Medicare & Medicaid Services] had gotten concerned that folks who weren't urgent were being made to wait around for too long in the waiting room, and you could get cited for that."

Once the screener has determined there is not an emergency situation, EMTALA is done, Steinberg observes. "Then regular rules for appropriate care and treatment apply," he concludes. ■

### Source

For more information about EMTALA, contact:

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# Use of e-mail raises many HIPAA concerns for EDs

*All e-communications must be encrypted.*

While the transmission of electronic information has become an integral part of our daily business and personal lives, for health care providers, including ED managers, it carries with it a special set of obligations and responsibilities.

"Under HIPAA [Health Insurance Portability and Accountability Act of 1996], health care providers are authorized to transmit electronically under certain circumstances, like billing, but it has to be encrypted, and it should only be accessible to people authorized to use it, so there have to be passwords to protect the information from hackers," explains **Catherine Marco**, MD, FACEP, clinical professor of surgery at the Medical

## Executive Summary

Learn which types of electronic communications are most secure and who is permitted to see them to avoid regulatory violations.

- Use of common commercial e-mail services will not offer the necessary protection required by the Health Insurance Portability and Accountability Act of 1996.
- ED managers should be familiar with guidelines, especially electronically protected health information.
- Follow-up e-mails to primary care providers are only appropriate if your line and the recipient's line are encrypted.

College of Ohio in Toledo, attending physician at St. Vincent Mercy Medical Center, also in Toledo, and immediate past chair of the American College of Emergency Physicians' Ethics Committee.

Marco and other experts say that HIPAA applies to e-mail, even though the act does not specifically address it. "HIPAA is a very general guideline, and it does not specifically say you can or cannot use e-mail, but it *does* address the use of electronically protected health information," she notes. This is an important concept, Marco says.

"Electronically protected health information refers to any specific information by which you might be able to identify a specific patient, called 'identifiers,'" she says.

The term refers to information through which anyone might be able to find out who a patient is: the name, address, Social Security number, images that include the patient's face, zip code, etc. "If you are over 90, your age is also protected because someone might be able to figure out who the patient is," Marco adds.

Because of a potential lack of privacy, ED managers would be ill-advised to communicate directly with patients via e-mail, say observers.

"I like to think of e-mails as postcards; you don't know where they will be forwarded," says **Kathleen Clem**, MD, FACEP, associate professor and chief of the division of emergency medicine in the department of surgery at Duke University Medical Center in Durham, NC. "We do not communicate directly with patients by e-mail, except if they are an employee in our system. If I receive an e-mail, I'm on the phone to that patient, and I then respond in ['snail mail'] writing."

At the ED at Doctors West Hospital in Columbus, OH, the staff have discussed using e-mail for ED follow-up, "but because of HIPAA, we're not doing it," says **Peter Bell**, DO, FACOEP, FACEP, attending physician in the ED and assistant dean for academic affairs at Ohio University in Athens.

"Because an e-mail is discoverable, we felt there might be liabilities," he says.

Routine e-mails are not encrypted and would not be considered protected, Marco notes. "It's not appropriate for me, or *any* provider, to use a commercial e-mail provider [i.e., AOL, Yahoo!] for protected health information," she says.

Under carefully defined circumstances, however, ED managers and staff can communicate with each other, and even with other health care providers. "EDs e-mail each other all the time, but not using protected health information," Marco explains. For example, they do not identify a specific patient, she says. "However, if all the security safeguards HIPAA dictates can be met, you can use a hospital server," Marco adds.

In other words, she explains, if she ascertained that her hospital's e-mail was secure and that a patient's primary care provider (PCP) also had a secure line, "I might actually be able to e-mail someone's PCP and say, 'I saw Mrs. Jones today, and she had X condition. Could you follow up?'" Marco says.

At Doctors West Hospital, medical records are password protected and each doctor and nurse can access them through the internal computer system, Bell says. "Also, we send out notices, such as, 'Patient Y as been in the ED for the fifth time using a false ID, or they have OD'd for the third time; please be aware the family doctor wants to be notified when they come in.'"

## Sources/Resource

For more information about compliance with electronic privacy regulations, contact:

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- For more information on HIPAA and electronic communications, go to www.cms.gov. On the left-hand side of the page, click "HIPAA," then "HIPAA Administrative Simplification."

However, his ED does not, at present, e-mail the PCPs. "Now, we dictate charts, and hard copies are sent out by snail mail," he says. "We have talked about faxing, because it *is* considered protected. The next move would be to do encrypted or encoded e-mail."

Every additional precaution you take helps ensure the privacy of e-mail. For example, Marco suggests, "never put a patient's name in the subject line, because those are easier to [steal]."

Even within the secure e-mails themselves, her staff members try not to use the patient's name, she says. "But we use the medical record number because we have to," she adds. However, she notes, HIPAA mandates that such communications must be only between people directly involved in the patient's care.

In summary, Marco says she would *not* consider e-mail an appropriate way of contacting patients about their health care. "Other providers are OK, as long as you know the transmission is secure: password protected *and* encrypted," she says. ■

# Do EDs need a policy for e-communications?

While your facility, no doubt, has a HIPAA-compliance policy, which, among other things, covers electronic communications, it might be a good idea to craft one that is specific to your ED, experts say.

"It may be appropriate to have separate policies for the hospital and the ED, because there are certain issues appropriate to the ED that might not be appropriate to other departments," advises **Catherine Marco**, MD, FACEP, clinical professor of surgery at the Medical College of Ohio in Toledo, attending physician at St. Vincent Mercy Medical Center, also in Toledo, and immediate past chair of the American College of Emergency Physicians' Ethics Committee.

One example, Marco notes, is transmission of patient information to the primary care provider. It happens all the time, she says. "You see a patient at midnight, and you do not want to wake up Dr. Jones," Marco adds. "How do you get the information to him so he'll have it first thing in the morning?"

At her facility, fax lines are used, because they are considered secure under HIPAA. "The time may come when the security of e-mail is better," she adds. "Right now, I just would never trust every physician in Toledo to have a secure e-mail line."

**Kathleen Clem**, MD, FACEP, associate professor and chief for the division of emergency medicine in the department of surgery at Duke University Medical Center in Durham, NC, says it's important enough for ED managers to write their department's own policy.

"You don't necessarily need to have a specific policy *just* for e-mail, but a more specific HIPAA policy for the ED is a good idea," Clem says.

What should such a policy include? "It should cover all of the patient identifiers **[see related story, p. 42]**, the basics of what HIPAA is, and the types of communication covered," Clem adds. Her facility offers online training for all staff, which is updated every year with a computerized graphics presentation and a quiz. "It includes the basics of what HIPAA is, the ways we communicate internally, and the types of communication possible under HIPAA," she explains.

Duke's e-mail policy also includes the use of a disclaimer with all e-mails. "If your e-mail is discovered or accidentally sent to the wrong place or server, it's something that protects you legally," she explains.

For reasons of confidentiality, she was unable to share the specific contents of Duke's disclaimer.

"I would say that before you do your own, check with your hospital's legal services to help you create it," Clem advises. ■

# An increase in obesity takes a toll on EDs

*Trend affects staff preparation and equipment costs*

The national rise in obesity is significantly affecting the nation's EDs. In fact, a recent nationwide survey of Irving, TX-based VHA hospitals showed 90% of the respondents said they had treated obese patients who were first seen in the EDs. The increase in ED obese patients not only requires adjustments by ED managers and their staffs in terms of treatment, but it also translates into higher costs for specialized equipment such as larger beds, wheelchairs, and blood pressure cuffs.

## Executive Summary

Make sure you have the necessary equipment, and train your staff to treat obese patients with respect.

- Consider the acquisition and addition of oversized beds, wheelchairs, and blood pressure cuffs.
- Renovations of doorways and commodes may be necessary to accommodate larger patients.
- Sensitivity training can help improve satisfaction levels among obese patients.

The survey was conducted by Novation, an Irving-based firm that offers management consulting and supply chain services to hospitals and other health care facilities, including members and affiliates of VHA, a national health care alliance. It queried 584 directors of materials management and directors of surgical services across the country to determine the influence that treating severely obese patients (more than 100 pounds overweight) had on hospitals in 2004.

The numbers also reflect a broach spectrum of patients, says **Sandy Wise**, RN, MBA, senior director of medical and surgical services at Novation. "These are not patients coming to the hospital for bariatric surgery, but patients who are being seen for other medical conditions," she explains.

William Beaumont Hospital in Royal Oak, MI, has seen rising numbers, but they are not alone, says **Val Gokenbach**, DM, RN, CAN, chief nurse and executive administrative director at the hospital. "The issue, first of all, is sheer volume," she says. "This is a national crisis.

"People who do not manage their weight are going to see an increase in cancers, cardiac disease, and injury potential," Gokenbach adds. "They have fractures from falling, an increase in diabetes, and pulmonary problems," she says.

Even obese patients who present to the ED for other reasons present special problems, Wise adds. "It can be people who come to the ED for a car accident," she notes. "The reason that EDs are seeing more obese patients is mainly due to the fact that more people are obese."

It is the transport and comfort of such patients, rather than their specific care, which should be treated differently in the ED, Gokenbach notes. "From the perspective of care, the medical protocols probably would be the same, because you are treating symptoms," she explains.

However, she notes, with an increase in the percentage of obese individuals in the population has come an increase in bariatric surgery, which can lead to post-surgery visits to the ED, Gokenbach says. "As with any surgery, bariatric surgery can have complications," she adds. "And the more surgeries you do, the more complications you will have."

Post-op patients can present with adhesions or with abdominal pain that may, in fact, be related to healing, she explains. "There are also nutritional changes post-op, and some patients present with electrolyte imbalances," Gokenbach observes.

However, the number of bariatric surgery patients who return for ED treatment may not be as high as some would expect, says **Patricia Flanagan**, RN, emergency room clinical nurse specialist at Massachusetts General Hospital in Boston. "We do not see a lot of returning bariatric patients, because they are usually direct admits," she declares. "When we do, we make sure to have the appropriate equipment."

Some of that equipment is not actually in the ED, she notes. "We link into the inpatient side for [oversized] beds, but we do have appropriate-sized blood pressure cuffs in the department," Flanagan adds.

ED managers also must be aware of the emotional needs of these patients. Wise, for example, recommends staff sensitivity training. "Many obese patients have related how they have been humiliated by overhearing staff talk about things like 'big-boy beds,'" she explains. "This is a satisfaction issue, but also good, ethical nursing care."

Depending on how your ED responds to the growing number of ED patients, the costs can be considerable. "The beds can be $1,000 more," Gokenbach says. "They can be expensive, but we have purchased increased numbers, and we're getting ready to purchase lift equipment."

Renovations are another consideration, says Wise. Normal doorways do not accommodate oversized beds or wheelchairs, she notes. "Also, if you are obese and come into an ED and you need to go to the bathroom, you can't sit on a wall-mounted commode," Wise says. "EDs will have to make some adjustments."

In the Novation survey, the mean cost of renovations made to accommodate obese patients was $22,000, compared with $15,250 in 2003. "That can range from a whole new bariatric room to trading out a few toilets,"

## Sources/Resource

For more on handling obese patients, contact:

- **Patricia Flanagan**, RN, Emergency Room Clinical Nurse Specialist, Massachusetts General Hospital, 100 Charles St., Boston, MA 02114. Phone: (617) 724-4932.
- **Val Gokenbach**, DM, RN, CAN, Chief Nurse, Executive Administrative Director, William Beaumont Hospital, 3601 W. Thirteen Mile Road, Royal Oak, MI 48073. Phone: (248) 898-1995.
- **Sandy Wise**, RN, MBA, Senior Director of Medical and Surgical Services, Novation, 125 E. John Carpenter Freeway, Suite 1400, Irving, TX 75602-2325. Phone: (972) 581-5000. Web: www.novationco.com.
- For a free complete copy of the survey, go to www.novationco.com and click on the link on the right-hand side under "News" that says, 'Novation Surveys VHA Members Regarding Bariatric Supplies.' When the story appears, scroll to the bottom and click the link that reads, "2004 Obese Patients Care Survey Market Research Report."

Wise says. Mean costs for obesity-related equipment equipment were up 13%.

The bottom line is that your staff and your equipment must be up to the task, Wise says. "If you have a patient coming in for bariatric surgery, you are geared up; but with an ED, you could have a 600-pound person involved in an accident, and you do not know when they will present," she notes. "You should always be prepared with a larger wheelchair, stretcher, and lift, so you're ready for these patients."

Flanagan agrees. "More often than not, we are notified by the fire department or EMS that they are bringing in a patient of size, so we have a heads-up and are ready with a bed in the bay for the patient," she says. ■

# EMTALA Q & A

*[Editor's note: This column addresses readers' questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Steve Lewis, Editor,* ED Management*, 215 Tawneywood Way, Alpharetta, GA 30022. Phone: (770) 442-9805. Fax: (770) 664-8557. E-mail: steve@wordmaninc.com.]*

**Question:** Does EMTALA apply to a patient who presents to the ED with a scheduled appointment? From time to time, patients arrive at a hospital dedicated emergency department with scheduled appointments. These patients may be presenting to a typical ED for an after-hours diagnostic test ordered by their personal physician or to the labor and delivery department for a prenatal stress tests. Are these patients covered by EMTALA, or is there some exception to EMTALA that applies to these types of patients?

**Answer:** The EMTALA law requires that a hospital must perform a medical screening examination (MSE) if a patient presents to a dedicated emergency department requesting or in need of an examination or treatment for a medical condition. There are no exceptions under the EMTALA law to the medical screening requirement, notes **M. Steven Lipton**, JD, an attorney with Davis Wright Tremaine in San Francisco who specializes in EMTALA.

However, the Centers for Medicare & Medicaid Services (CMS) stated last year in its official EMTALA *Interpretive Guidelines* that hospitals may be "exempt" from EMTALA in some instances. The guidelines cite two examples: First, the guidelines suggest there "may" be an exemption from the medical screening obligation for an individual who presents to a dedicated emergency department with orders from his/her physician for a nonemergency test. The guidelines suggest EMTALA may not necessarily apply if the purpose of the visit is to collect evidence and not to analyze the test results.

The guidelines then go on state that ". . . a hospital may be exempted from its EMTALA obligations to screen individuals presenting to its dedicated emergency department if the individual has a previously scheduled appointment."

These statements from CMS are intended to help hospitals define which patients are covered by EMTALA. However, the conventional legal wisdom of "exemptions" — or as they often called, "loopholes" — to a general statutory rule such as the medical screening obligation is that they usually are adopted by statute or regulation so as to have the force of law, Lipton notes.

Secondly, he says, exemptions usually are read very narrowly to avoid defeating the purpose of the statute, or in other words, having the exception "swallow" the rule.

In this case, the exemptions suggested in the guidelines were not adopted by statute or regulation, Lipton notes. They are the interpretation of EMTALA by CMS that are intended as guidance to its regional offices and surveyors who enforce EMTALA.

In addition, it is important to note the language of the guidance: Hospitals *may* be exempt from EMTALA, he explains. The use of "may" suggests these types of patient visits will be examined on a case-by-case basis, thereby leaving hospitals and physicians guessing as to whether their actions are covered or are not covered by EMTALA, Lipton points out.

To complicate matters, Lipton adds, the statement suggesting that scheduled appointments in the dedicated emergency department may be exempt from EMTALA is all that CMS says about the issue.

What can we make of a possible exemption from EMTALA for scheduled appointments? Does it apply only to the example in the guidelines, namely patients referred to a dedicated emergency department by their personal physicians for diagnostic tests? Does the exemption apply to other types of patients who present to the dedicated emergency department with same-day (or maybe same hour) dedicated emergency department appointments? Could the exemption possibly apply to patients presenting with chest pains or other ailments who are sent to a dedicated emergency department by their physicians who arrange to see them in the dedicated emergency department at a prescribed time?

At best, it is difficult to decipher the coded messages in the guidelines, Lipton concedes. It may be argued that a patient who presents to a dedicated emergency department with a scheduled appointment for a diagnostic test on orders of a staff physician is not covered by

## Source

For more information about EMTALA, contact:
- **M. Steven Lipton**, JD, Davis Wright Tremaine, Suite 600, One Embarcadero Center, San Francisco, CA 94111-3611. Phone: (415) 276-6500.

EMTALA if the patient does not request or appear to need examination or treatment for a medical condition, and the only services rendered by the dedicated emergency department staff are the performance of the diagnostic test and the reporting of the results to the patient's referring physician, he says. This "exemption" could also apply to pre-scheduled stress tests rendered to women presenting to labor and delivery as part of their ongoing prenatal care, says Lipton. However, according to CMS, patients presenting for pharmaceutical services (such as infusion therapy, injections, or prescription refills) "generally" are covered by EMTALA, he says.

If there is an EMTALA exemption, these examples admittedly do not stretch the limits of the exemption very far, Lipton adds. In addition, the courts may decide that there are no exemptions to EMTALA and, therefore, hold a hospital liable for an EMTALA violation if a patient later claims there was a lack of a medical screening when he or she came to the dedicated emergency department with a prearranged appointment, he says. Therefore, hospitals and physicians may be proceeding at their peril if they use scheduled appointments in the dedicated emergency department to avoid the EMTALA obligations, he concludes. ■



## CE/CME *questions*

1. According to Diana S. Contino, RN, MBA, a consultant for MedAmerica, the biggest issue in changing ED contracts is:
   A A shortage of available ED physicians
   B. Lack of communication
   C. The hospital's desire to change to an all-employee staff model
   D. Change of personnel within the group

2. According to Timothy Seay, MD, regional medical director for Greater Houston Emergency Physicians, an ED physician can override a nonurgent medical screening exam (MSE) assessment if the patient is designated a triage level:
   A. Five
   B. Four or five
   C. Four
   D. Three or four

3. According to Alan Steinberg, Esq., partner with Horty, Springer & Mattern, EMTALA guidelines allow the following health care professionals to conduct MSEs:
   A. Physicians
   B. Physician assistants
   C. Nurse practitioners
   D. All of the above

4. According to Catherine Marco, MD, FACEP, clinical professor of surgery at the Medical College of Ohio, the following are considered patient identifiers under HIPAA:
   A. Social Security number
   B. Age, if the patient is older than 90
   C. Zip code
   D. All of the above

5. According to Val Gokenbach, DM, RN, CAN, chief nurse and executive administrative director for William Beaumont Hospital, oversized beds that can accommodate obese patients cost how much more than typical beds?
   A. $1,000
   B. $1,500
   C. $1,750
   D. $2,000

## *COMING IN FUTURE MONTHS*

■ ED 'treats' patient dummies to improve quality of care

■ Detailed documentation is key to successful process improvement project

■ On-call specialist follow-ups: What are EMTALA's requirements?

■ Researchers say psychiatric disorders are underdiagnosed in EDs

6. According to M. Steven Lipton, JD, Davis Wright Tremaine, hospitals and physicians that use scheduled appointments in the dedicated emergency department to avoid the obligations under the Emergency Medical Treatment and Labor Act (EMTALA):
   A. Are in clear violation of EMTALA
   B. Are well within EMTALA guidelines
   C. Proceed at their own peril
   D. Can back up their decisions based on existing case law

## CE/CME objectives

- Implement managerial procedures suggested by your peers in the publication. (See *ED screening changes put pressure on competitors*, in this issue.)
- Discuss and apply new information about various approaches to ED management. (See *Quick turnover of physician groups raises red flags for ED managers* and *Do EDs need a policy for e-communications?)*
- Share acquired knowledge of these developments and advances with employees. (See *An increase in obesity takes a toll on EDs.)*
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *ED managers: Know your EMTALA guidelines* and *EMTALA Q&A.)* ■

## CE/CME answers

**1. B 2. B 3. D 4. D 5. A 6. C**

## CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■