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Emergency care in some states 'in critical condition,' warns ACEP's report

Publication identifies barriers to improvement in key areas

The national emergency health care system is in serious condition, with many states in a critical condition.

This warning jumps off the page from the first-ever "National Report Card on the State of Emergency Medicine," just released by the Dallas-based American College of Emergency Physicians (ACEP). The report covered all 50 states and the District of Columbia.

This main "headline" surprises no one intimately involved with emergency medicine. What may be particularly disappointing, however, is the fact that not a single state received a grade of A, and the vast majority received a C. **(See list by state, p. 15.)** The national average grade was a C-.

The ACEP Report Card scores each state in four main categories: access to emergency care, quality and patient safety, public health and injury prevention, and medical liability environment. It then assigns an overall state grade of A, B, C, D, or F. The report was compiled from data collected by health-related groups such as the American Medical Association and the American Hospital Association, federal agencies, and state governments. **(For highlights, see box on p. 15. For information on how to obtain a copy of the report card, see the resource box, p. 15.)**

For ED managers, however, it is only by digging beyond the overall grades that

Executive Summary

A new report from the American College of Emergency Physicians gives a letter grade for each state. However, a close look at the statistics behind that grade can give you insight into your own department's performance.

- The national average grade was a C-. Not a single state received a grade of A, and most received a C.
- Study the breakdowns provided for each of the four major categories, and share your findings with your staff.
- Some of your ED's problems, such as overcrowding or difficulty with call panels, are likely occurring statewide and should be addressed with legislators.
- The findings can help you identify key issues to bring to the attention of policy-makers.

IN THIS ISSUE

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they will find the most valuable information, according to those most familiar with the report. For example, a state may have a high overall ranking compared with the other 51 states, yet lag woefully behind in one particular area. It is only by studying the numbers behind the grades that they will learn — or confirm — the greatest threats to quality emergency care in their state, they say.

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"Each state should be looking at where they scored well and where they scored poorly, and maybe the reasons for doing so in each specific area, and use that to learn where they need to improve," says **Bruce Bonano**, MD, an attending emergency physician at Bayshore Hospital in Holmdale, NJ. "Or, more importantly, give it to their legislators in order to help improve the emergency medical system."

It's about the system, not the staff

This report is not an indictment of the personnel that staff EDs, but how the system of emergency care in the state is lagging or forging ahead in providing better service, say industry sources.

Another issue in the report is that there are many forces at work impacting emergency care that have very little to do with how well or how poorly ED managers and their staffs perform. "This is an effort to try to get our arms around some very large problems, most of which extend beyond our direct control," says **Wes Field**, MD, FACEP, a member of the emergency medicine clinical faculty at the University of California Irvine, past chairman of the board of California Emergency Physicians, based in Emeryville, CA, and a member of ACEP's Report Card Task Force. "It's an attempt to start to control quality at a level beyond emergency department care."

This report is a "road map for change," asserts **Roneet Lev**, MD, FACEP, director of operations for the ED at Scripps Mercy Hospital in San Diego, past president of Cal-ACEP, which is the California chapter of ACEP, and chairperson of the Emergency Medicine Oversight Commission, which oversees the 20 EDs in San Diego County.

The report has four categories, but under each there are more specifics, notes Lev. "So, you should take any state you are interested in and go specifically down the rows to see what you're good at and what you need to fix," she suggests. Emergency leaders who are not familiar with the details may not be able to give policy-makers effective guidance for solutions.

It's only by this "drilling down" process that you will truly understand what's impacting your ED, she continues. "California's overall grade is a B, but we know we have tremendous problems in our state," Lev notes. While California has good protection under medical liability, where it received an A+, and public health, because of laws regulating seatbelts and child restraints, it ranked 51st in EDs per million and 50th in nurses per population in access of care, she says.

"People can't get in to see us, because we are 46th in hospital beds per patient," Lev says. "So, if you do not have EDs, nurses, or hospital beds, no matter how

Report Card's Top 20

Ranking	State	Grade
1	California	B
2	Massachusetts	B
3	Connecticut	B
4	District of Columbia	B
5	South Carolina	B-
6	Michigan	B-
7	Pennsylvania	B-
8	Maine	B-
9	Rhode Island	B-
10	Maryland	B-
11	Ohio	C+
12	New Jersey	C+
13	Georgia	C+
14	Missouri	C+
15	New York	C+
16	Delaware	C+
17	West Virginia	C+
18	Alaska	C+
19	Iowa	C+
20	Minnesota	C+

Source: American College of Emergency Physicians (ACEP), Dallas.

good your providers are, you don't have access."

The impact of outside forces on the ED is perhaps the most dramatic revelation of the report, and it is one the authors hope will spur action on several levels.

"I think what the report reflects is that there are still unacceptable levels of variation from state to state in terms of quality of care," says Field. Money is part of the reason, "but I think it's really more complicated," he says.

A good example is the part of the report card about the medical liability environment, he says. "There are states where docs in any specialty can't get affordable coverage and have almost no willingness to participate in backup panels."

This issue is in the realm of health care policy-makers, he says. "We hope to inspire state legislatures and governors to recognize they have serious issues they need to address, and as much as possible, be a launching point for ad hoc groups or task forces to try to attack some of these problems," Field says. ED physicians should join these groups, he adds.

Lev recognizes that while most ED managers will find at least some of the statistics disturbing, not all of them will pick up the torch of protest and then march down to their state legislatures. For those not so inclined, she says, there still is much of value to be derived from the report.

Find the page for your state, Lev suggests. "Then, I would go and read the details offered in the little boxes," she says. "Chances are whatever problems you're seeing, all the rest of the EDs in your state are seeing."

It also can help explain a "poor" performance on the part of your ED, Lev continues. "A big thing managers have shoved down their throats is throughput," she notes.

It would help in California, for example, to know they are the 51st state in the number of RNs, Lev says. "We are understaffed and have few EDs, which would help explain why our Press Ganey [patient satisfaction] scores are down."

Such statistics "give us legitimacy and quantifies our concerns," she says. "It also helps explains things to patients when your ED is absolutely full."

Should ED managers share the report with their staff? "Absolutely," Lev answers. "This Friday, I have my commission meeting and I plan to share it. This is something nurses and physicians like to know."

This first report card is just the beginning, adds Field. "In future, we want to get close to ED managers with more compelling data."

The temptation they tried to avoid was doing original research, Field says. "As future report cards are developed, we will try to drill down on practice management issues, and critical issues that surround crowding," he says.

For example, he says, the whole issue of overcrowding and boarding is still unchartered territory, he says. The Joint Commission on Accreditation of Healthcare Organizations is just beginning to understand this is a

Sources/Resource

For more information on the national report card, contact:

- **Bruce Bonano**, MD, Attending Emergency Physician, Bayshore Hospital, Holmdale, NJ. Phone: (732) 739-5924.
- **Wes Field**, MD, FACEP, Emergency Medicine Clinical Faculty, University of California Irvine. Phone: (949) 452-3569.
- **Roneet Lev**, MD, FACEP, Director of Operations, Emergency Department, Scripps Mercy Hospital, San Diego. Phone: (619) 203-7190. E-mail: roneet@cox.net.

For a free interactive version of the ACEP national report card, go to www.acep.org/webportal. Move your cursor to "Check the Grades" and click on the "go" arrow. For a free hard copy, contact: American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038-2522. Phone: (800) 798-1822.

problem and just starting to ask hospitals to address it, he says. "But to make a lot of headway, you have to at least compel hospitals to report data on the amount of time EDs are saturated and overcrowded, and whether diversion is an issue," Field says. "Just to get everybody to look at same issues would be a step up." ■

Pick a CPOE that's right for your ED and hospital

Run detailed case studies

(Editors' note: This is the second in a two-part series on computerized physician order entry [CPOE]. In this month's article, we tell you how to compare different systems, and we cover other key steps in the decision-making process. In last month's issue, we told you how to plan for such a system.)

If you're in the market for a CPOE, it's important to play with a number of systems before making your choice to determine which is most user friendly and which is the best fit for your ED, advises **Brian F. Keaton**, MD, FACEP, attending physician/emergency medicine informatics director at Summa Health System, Akron, OH, and president-elect of the American College of Emergency Physicians (ACEP).

What's more, the CPOE system also must be compatible with your hospitalwide system, he says. "The ED is so tightly linked to the enterprise that it's foolish to do a CPOE program *not* tightly linked to it," he says. "I can't imagine there is a hospital that is *not* looking at CPOE, so you need to be part of that enterprise process."

Think about what such a system does: It gives information to the lab about what studies need to be done, to radiology, and even to ancillary services such as dietary, Keaton says. "Ultimately, the orders you create in the ED have to be translated into their language and become part of the hospital's electronic record, so you need to be playing in that game," he says.

The big part of searching for the right system "is to sit down and play with it," Keaton suggests. "It's wonderful to have someone come in and give you a demo."

Use scenarios specific to your ED, employees

Keaton's staff sat down with its 10 most common patient care scenarios and developed detailed cases that were scripted out. "Then, we'd sit down and go through those cases with each of the systems that came in," he says. First, they would read the case to the manufacturer's representative and watch how they progressed and how long the process took.

"We would make the manufacturer's representative do the tasks that were required of their system to accomplish the tasks dictated by the scenario," he explains. "For example, we timed and counted the number of mouse clicks and typing necessary to register a patient, order a [complete blood count], view an X-ray, find an old dictated operative note, and so forth."

There are clear differences in the way manufacturers handle data entry needs, especially with repetitive tasks, notes Keaton. "Another instructive point was watching the restrictions placed on work flow by the system," he says. "For example, were orders batched or executed in the order they were placed?"

Then, the system was tested on someone from the department who was reasonably adept, Keaton recalls. "Next, we took someone who knew nothing, which showed us the beginning of the learning curve. We also had the learning curve for the average person and used the teacher as an example of 'as good as it could get.'"

If the vendor has a system that would be compatible with the common patient care scenarios and the existing hospital electronics, the vendor should be able to rapidly educate several ED employees on effective use of the system, say emergency medicine sources. They note that using your ED staff to demonstrate the product to the decision makers is much more effective than having the vendor staff perform that task.

As for whether to incorporate an ED module into a hospitalwide system or purchase an all-inclusive ED

Executive Summary

Purchasing a computerized physician order entry system is too important to be taken lightly. Follow a detailed checklist to determine the best choice.

- Be sure the system you choose is compatible with your hospitalwide system.
- Run through your 10 most common patient scenarios with each candidate system.
- Look closely at the ways the different products handle data entry.

Source

For more information on computerized order entry, contact:

- **Brian F. Keaton**, MD, FACEP, Attending Physician/Emergency Medicine Informatics Director, Summa Health System, 525 E. Market St., Akron, OH 44310. E-mail: bfkeaton@earthlink.net.

system, Keaton concedes that it's very tempting to buy the latter. However, he cautions, it's still useful to go to ACEP meetings or similar industry gatherings and experiment with the different systems side by side. "Then, you really have to take the vendor you pick, put them together with the enterprise vendor, and make sure the ED system interfaces well with them," he cautions. "Otherwise, it could cost you $20,000 to $30,000 to build an interface." ■

Guideline compliance improves pneumonia care

Safely send patients home

A study conducted by investigators from the University of Pittsburgh School of Medicine and the Pittsburgh Veterans Affairs Healthcare System showed that more intense implementation strategies for care of pneumonia patients than typically found in most EDs safely increased the proportion of low-risk patients who were successfully treated as outpatients.[1]

"Our goal was to get not-so-sick patients discharged to home," explains lead author **Donald M. Yealy**, MD, professor and vice chair of emergency medicine at the University of Pittsburgh.

All of the EDs agreed to follow uniform practice guidelines, which were based on expert consensus of national experts in pneumonia care. They were then randomly divided into three groups:

• In the low-intensity sites, practitioners also were asked to voluntarily develop quality improvement strategies for pneumonia care and received supportive literature.

• Moderate-intensity sites received the supportive literature and reminders and were mandated to develop quality improvement strategies for pneumonia care. Additionally, the moderate-intensity sites received on-site educational training sessions, which reinforced practice guidelines and offered in-depth training in pneumonia assessment.

• High-intensity sites received all low-intensity and moderate-intensity strategies and received real-time reminders, medical provider audits and feedback, and participated in site-specific ongoing quality improvement activities.

The low-intensity group represents the kind of practices that are commonly employed in EDs, notes Yealy. "Moderate-intensity would be very much like what happens when an outside regulatory body asks you to comply with certain standards," he explains. "High intensity is when there is an outside regulatory body, and folks inside the ED are really putting in special efforts."

According to the study, low-risk patients in moderate intensity (61%) and high intensity (61.9%) were significantly more likely to be treated as outpatients compared with those in the low-intensity (37.5%) group.

Executive Summary

Expanding your standard practices can change staff behavior in the treatment of patients, as demonstrated by study of pneumonia care in 32 EDs.

- Repeat important information more often than you normally do.
- When staff do not follow procedure, take them aside and discuss the situation.
- Share mistakes with the rest of the staff, without identifying the one who made the error.

Manager, staff, have greater interaction

Another benefit of participation in the study was greater interaction between the ED manager and his staff, which led to better compliance with guidelines, according to **Richard Heath**, MD, FACEP, medical director of emergency services at University of Pittsburgh Medical Center (UPMC) Braddock, whose ED was one of the high-intensity groups.

He says, "We did see improvement in the measured items: getting blood cultures before antibiotics, getting antibiotics within eight hours of admission, and so forth."

Heath's ED was one of 32 in Connecticut and southwestern Pennsylvania that participated in the yearlong, multicenter randomized trial. It involved more than 3,200 patients, all of whom were diagnosed with pneumonia but who posed varying risks of adverse outcomes from the disease.

Expanding standard practice

What changes did the ED at UPMC Braddock make as part of the study? "There was a lot more feedback to the physicians — mostly from me," says Heath. "The normal process would just be announcing that we are going to do a particular thing a particular way, and I would do that at regular department meetings. Sometimes, I would repeat it at two or three consecutive meetings."

For the study, in addition to his normal practice, Heath would repeat the most important information nearly every month, he says. This information would include the importance of getting a pulse oximetry reading on anyone with pneumonia, obtaining blood

Sources

For more information on treating pneumonia patients in the ED, contact:

- **Richard Heath**, MD, FACEP, Medical Director, Emergency Services, University of Pittsburgh Medical Center Braddock, 400 Holland Ave., Braddock, PA 15104-1599. Phone: (412) 636-5388.
- **Donald M. Yealy**, MD, Vice Chair, Emergency Medicine, University of Pittsburgh Medical Center; Professor, University of Pittsburgh School of Medicine. Phone: (412) 647-8295.

cultures early — before antibiotics were started, and getting antibiotics on board early. This sometimes involves what Heath calls "empiric treatment."

"You may give [antibiotics] to someone you suspect has pneumonia before you even know it," he says. "Once you make the diagnosis, if it has not been given, you give it right away."

When people did not receive care in the appropriate fashion, "I would take that particular chart not only to that physician, but to others on the staff — de-identified — and say, 'Look, we really need to do this in the timed fashion,'" Heath says. "And I'd say to the doc, 'Here's what we're trying to get to. Let's look at why we didn't.'"

A little reverse psychology helped with compliance, says Heath. "Most line docs do not want to hear from the director all time, so they modified their behavior on their own — which led to them doing the desired behavior," he observes.

Anticipating CMS

Many of the guidelines seemed to anticipate the core measures recently set out by the Centers for Medicare & Medicaid Services, "so we're generally continuing the same functions — with an even greater need to do empiric antibiotics," Heath says. **(For more information, see "JCAHO and CMS align performance measures," *ED Accreditation Update,* November 2004, p. 4.)** The hospital has picked up the chart review process and is using it throughout the facility, he adds.

What global messages did the study have for ED managers? "It takes effort to change physician and nursing behavior, but with that effort, you *can* change behavior and get more adherence to protocols," says Yealy.

Reference

1. Yealy DM, Auble TE, Stone RA, et al. Effect of increasing the intensity of implementing pneumonia guidelines. *Ann Intern Med* 2005; 143:881-894. ■

'Psych ED' helps speed throughput time by 9%

Improvement seen despite increase in patient volume

A new, separate area for psych patients within the ED has helped Forsyth Medical Center in Greensboro, NC, cut its average throughput time by 9% — from 201 minutes to 189 minutes for all patients, according to department's manager. This reduction was accomplished while the department was facing a growing influx of psych patients, she notes.

The area, part of a new $18 million ED opened in October 2004, is staffed by one psychiatric nurse each shift, with 24/7 coverage, as well as by one or more members of the "access" staff: mental health workers, human service clinicians, social workers, or advanced degree psychiatric services providers. Access staffing varies with patient volume.

In designing the new department, "we had to evaluate what population was coming into the ED," recalls **Robin Voss**, RN, MHA, director of emergency and trauma services. Not only was the department starting to see a significant increase in psych patients coming to the ED, but it was taking a fairly lengthy time to determine the type of care they would need, notes Voss, who was in charge of the redesign effort.

The change couldn't have been soon enough, notes **Jo Haubenreiser**, executive director for post-acute services. "In the first 10 months of 2005, we saw 4,088 psych patients, while for the same period in the previous year it had been 3,766," she reports.

Prior to the change, the behavioral health department had behavioral health clinicians working in the ED along with staff handling these patients, notes Haubenreiser.

"We pulled in all the key stakeholders, including psych people, to determine what would help most with throughput," Voss shares. "In the old department, we

Executive Summary

Adequate staffing, proper location, and design of psychiatric ED services area are critical to successful implementation. One ED cut average throughput time by 9%.

- Have mental health workers available to determine the level of care each patient needs.
- Have your psych area set apart from the main ED to avoid excessive noise and confusion.
- Have a minimal amount of equipment in the rooms so that patients cannot harm themselves.

Sources

For more information on psychiatric EDs, contact:
- **Robin Voss**, RN, MHA, Director, Emergency and Trauma Services, and **Jo Haubenreiser**, Executive Director, Post-Acute Services, Forsyth Medical Center, 3333 Silas Creek Parkway, Winston-Salem, NC 27103. Phone: (336) 718-7000.

just put these patients in the midst of everything else. We decided we wanted a new area out of the hubbub."

Triage unchanged

These patients come in the main entrance and go through triage like any other patient, says Voss. "They see a triage nurse, they're asked the same questions as anyone else," she notes. Then, they are brought back to have their emergency medical screening exam.

"If they are determined to have a psych issue [typically the patient self-identifies] as well as a medical issue, they must be admitted as a regular emergency department patient," Voss explains. "If they are determined not have a medical emergency, then the access process gets started."

That means that the access staff is contacted to initiate a process to determine what level of care the patient needs. "What we do is see they are placed at the right level of care — such as being admitted to the psych unit or triaged down to the psych outpatient unit — and not just filling beds in the hospital," explains Haubenreiser.

Patients who did not have an emergency medical condition, but whose emergency condition was psychiatric, are moved back to the ED behavioral health area, which is adjacent to the main ED, says Voss. The area, which is located in one corner of the large, rectangle-shaped department, includes a sitting area with a television where patients who are acting out can sit while they de-escalate.

The rooms have hardly any equipment, so the patients can't find items that they can use to hurt themselves, Voss says. "The bathrooms are set up the same way, and the patients can't lock themselves in," she adds. "The whole area is monitored on closed-circuit TV in the security surveillance room." Bathrooms are not monitored, to allow the patients privacy, Voss says. However, she has no privacy concerns about the other cameras in the area, "because it's obvious they are there."

Cross-training eases burden

The cost to the hospital of the additional ED staff is minimized through cross-training the psych nurses in minor emergency care, says Voss.

"If they do not have patients in their area they could float to the other area to help out," she explains. "Or, they can go to the psych floor and help in behavioral health."

What's more, ED staff also are trained to expand their traditional roles. There is very extensive crisis prevention training given to the ED staff to effectively manage behavioral inappropriateness, Haubenreiser notes. For example, they've been very successful in calming down overly excited individuals, she reports.

No added cost for ED

In reality, having a separate area represented no additional cost to the ED, Voss says. "We were going to have the rooms and these patients either way," she notes, "So it's more a matter of what's best for the patients."

The critical benefit of the new arrangement, says Voss, is that the ED nurse can focus primarily on triage, while the psych nurse cares for the mental health and well-being of psych patients.

Theoretically, says Voss, any ED could do what hers has done, as long as they have enough space available to create a separate area. "Clearly, it's a much more ideal situation when your hospital has an inpatient unit, because that's where the psych staff can come from," adds Haubenreiser. "But you could also use specially trained master's-level social workers from the hospital to handle the process." ■

Quality, equipment hold keys to infection control

Watch staff members wash their hands

While developing and maintaining effective infection control procedures involves a large range of issues in the ED, many of them fall within two major areas: quality control and equipment/facilities. And

Executive Summary

EDs that are the most successful at infection control are the ones that look for new ways to improve on proven strategies and techniques.
- Follow and observe staff during hand-washing, and make them repeat steps that were omitted or performed improperly.
- Increase the percentage of isolation rooms in your department to help improve surge capacity.
- Have all cleaning supplies readily at hand to improve flow.

while the basics are familiar to experienced ED managers, two facilities have devised some unique strategies for going the extra mile to protect patients and staff from infectious disease.

At Gaston Memorial Hospital in Charlotte, NC, for example, **Michelle Dickerson**, RN, the manager of the ED, has devised a new method for eliminating a lack of consistency in hand washing. As a result, compliance rates in her ED have gone from 92% to 100% in the past year.

"At every staff meeting, we review our compliance with our educational audits, so the staff hears how we are doing with hand washing, environment of care compliance, and so on."

"We observe a certain number of staff members and their techniques to make sure they are doing things in the right sequence and at the right times," she says. About 10 people per month are observed at random, out of a total of 120.

As a rule, hand washing is expected before and after seeing every patient, she says. "As the staff member is washing, when an auditor sees an issue they will stop them, and make them go back and do it right," says Dickerson. She and another RN act as auditors.

Speaking of audits, Dickerson has gained even greater control over staff infection control activities and equipment with the hiring of a clinical quality analyst — an RN with ED experience — who monitors or audits performance and makes recommendations for improvement.

"She has worked on the reorganization of supplies, which includes supplies of staff to use for infected patients, making sure the supplies are there so staff does not need to cut corners when they are in a rush," says Dickerson.

They also have looked at the organization of patient care rooms. "We want the positioning of supplies to be the same in every single room, in order to organize the chaos," she says.

ED design assists in process

At Emory Healthcare in Atlanta, the EDs are given a head start in infection control simply by virtue of their design, explains **Marilyn Margolis**, RN, MN, director of nursing for emergency services.

"In terms of our physical plant, we have a higher percentage of our rooms that are isolation rooms, with better air exchange," she says. "Our psych room also has isolation capabilities."

At the Emory Crawford Long Hospital ED, which is part of the Emory system in Atlanta, about 40% of the rooms are isolation rooms, which was part of the plan when the newer ED facility was built. "At Emory University Hospital, we did an expansion of the ED and made *all* the rooms isolation rooms," Margolis shares.

The large percentage of isolation rooms proved helpful in dealing with the flu last year, she reports.

The ED followed the Centers for Disease Control guidelines, Margolis adds. "Every person who was triaged who had a cough or [other flulike] symptom got masked and was asked to wash their hands," says Margolis, adding the ED has hand gel outside every ED room and waiting room. "We also have backup areas to separate out if there is a pandemic," she says.

After the patients were triaged, if they fit the criteria for flu, they were sent to an isolation room. "Everyone who was immunosuppressed went into isolation, too, so they would not be subjected to the flu," adds Margolis. "One of our triage guidelines is to keep people who are immunosuppressed out of the waiting room."

Little changes, big difference

Sometimes small changes can go a long way in ED infection control. For example, staff at Gaston used to use spray bottles of cleaning solutions from housekeeping to wipe down stretchers. "Now, we use saniwipes — Clorox-based pop-ups — which are real strong, so when the staff needs to change over stretchers, they don't have to run around the room looking for a bottle and wipes. In a crisis, they don't have to wait on housekeeping," notes Dickerson.

And at Emory, new signs have gone up this year in the waiting rooms. Their main message: "We welcome you — but not with the flu."

"Something that can be a big issue if you have pandemic flu is to triage patients who need to stay home," explains Margolis. She says her facilities use the Severity Index Risk Classifications included in the Department of Health and Human Services' "Pandemic

Sources/Resource

For more information on infection control, contact:

- **Michelle Dickerson**, RN, ED Manager, Gaston Memorial Hospital, Charlotte, NC. Phone: (704) 834-2440.
- **Marilyn Margolis**, RN, MN, Director of Nursing, Emergency Services, Emory Healthcare, Atlanta. Phone: (404) 712-4567.

To download a free copy of the Department of Health and Human Services' "Pandemic Influenza Plan," go to: www.hhs.gov/pandemicflu/plan.

Influenza Plan" to help determine which patients should go home, which should be admitted, and which should go to a clinic. **(For information on how to access plan, see resource box, this page.)**

Reinforcement of staff education also is critical, adds Dickerson. "At every staff meeting we review our compliance with our educational audits, so the staff hears how we are doing with hand washing, environment of care compliance, and so on," she notes. ■

Implants will aid care of unconscious patients

Chips provide history plus meds

The next generation in patient identification and electronic medical information is now unfolding in a growing group of EDs across the country. The ED managers who are using it are convinced it will prove invaluable in the not-too-distant future.

The technology, called VeriMed, involves an implantable radiofrequency identification (RFID) chip the size of a grain of rice, which is injected into the patient's triceps area. It contains an identification number that allows access to relevant medical information held in an external database. **(For more on RFID, see "New tracking system improves patient flow," *ED Management,* August 2005, p. 91.)**

VeriMed, manufactured by Delray Beach, FL-based VeriChip, received Food and Drug Administration approval as a Class II Medical Device just a year ago, but already more than 70 facilities have signed up for the technology. Only two facilities have complete systems running: Hackensack (NJ) University Hospital and CareGroup Health Systems/Beth Israel Deaconess Medical Center in Boston. According to those facilities, the potential benefits are numerous.

"Many patients come to EDs with an altered mental status: They are confused, shocked, demented, wandering from home, or too upset or have too complicated a history to give you one, and you can end this confusion right up front," says **Joseph Feldman**, MD, chairman of the emergency trauma department at Hackensack.

Emergency care providers often have to "fly blind," says **John Halamka**, MD, an emergency physician who is now the chief information officer (CIO) at Harvard Medical School in Boston and Beth Israel. When a patient comes in unconscious, he could have anything from a barbiturate overdose to a diabetic coma, he says.

"Beyond the initial set of resuscitation measures, wouldn't it be great to know if this patient has a seizure history?" Halamka says. "Obviously, we'd be able to provide a much higher quality level of care if we did not have to go on such a big fishing expedition."

Halamka, who is an avid ice climber, had himself implanted in December 2004.

Getting patients on board

Since being implanted is totally voluntary, the chip passes all the rigor of the Health Insurance Portability & Accountability Act (HIPAA), Feldman asserts. "The only thing on the chip is your ID number — *not* your medical record."

Still, the two facilities are going about patient 'solicitation' in different ways, with Hackensack being more proactive. "We've done physician focus groups, met with primary care providers in the county and with ED directors and chairmen in collaborative meetings on a monthly basis, and VeriChip made a pitch to spread the word in each of the hospitals," says Feldman.

Executive Summary

Use of implantable chips can make a big difference in care of patients with altered mental status.

- With unconscious patients, staff can wave a reader over their arm to get information about their medical history and current medications.
- Since the chip has an identification number, but not medical records themselves, federal privacy laws are not violated.
- Technology is relatively inexpensive and can be borne by insurance carriers.

Sources/Resource

For more information on implantable radiofrequency identification (RFID) chips, contact:

- **John Halamka**, MD, Chief Information Officer, Harvard Medical School and CareGroup Health Systems/Beth Israel Deaconess Medical Center, Boston. Phone: (617) 754-8002. Fax: (617) 754-8006. E-mail: jhalamka@caregroup.harvard.edu.
- **Joseph Feldman**, MD, Chairman, Emergency Trauma Department, Hackensack University Medical Center, 30 Prospect Ave., Hackensack, NJ 07601. Phone: (201) 996-3192.

For additional information on the VeriMed chip, contact:

- **VeriChip**, 1690 S. Congress Ave., Suite 200, Delray Beach, FL 33445. Phone: (800) 970-2447.

It's starting out slowly, he reports. "We've chipped only about 30 patients so far." Because Hackensack was a development test site, all patients were chipped free of charge.

In addition, Feldman says, Horizon Blue Cross/ Blue Shield of New Jersey is involved in the pilot program with Hackensack and VeriChip to evaluate this technology for the subscribers of their program. "They are giving us critical patient information that can be shared during an emergency," he explains. "They will look at this technology and evaluate its efficiency and familiarize themselves with it, to see how they can incorporate it into future programs."

Halamka is letting the patients come to him. "We're not recruiting," he says. "If patients come in with it, we want to be able to support them." He estimates that about a dozen patients are implanted in the Boston area.

"This is a personal choice between patient and physician," he says. "As CIO, I believe there is value in investing in the technology, and as an ice climber, I thought it would be a good idea if I'm found at the bottom of a cliff that someone can scan me and know my medical history."

In fact, during the staff training sessions last March, Halamka served as the "patient."

A simple process

The scanners (readers) used by hospitals cost $300, while the chip and injector kits cost about $200 each.

The process itself is quite simple: A scanner is placed 6 inches from the patient's arm. If it shows the presence of a chip, the provider goes to a web site, types in the identifier, and reads whatever information the patient has elected to put on the site, such as current medications, allergies, blood type, and emergency contact information. "It's a truly personal health record," Halamka explains.

Both facilities developed special protocols for dealing with implanted patients. "Once a patient comes in with an altered mental status or is delirious, they are automatically scanned at the direction of the nurse or physician," Feldman summarizes.

His ED has computers on wheels available so that the provider can access either the VeriChip internet site (which requires a double password) or the Hackensack intranet to get to patient information.

"Our ultimate vision is to have a hyperlink to people's discharge summaries, lab results, and so forth, but it will take a lot of work to get past the potential legal issues," Feldman shares. He adds that future versions of chips might be able to detect body temperature, blood glucose levels, and the like. ■

FY '06 budget may have bad news for EDs

If the current federal budget package is approved by the House of Representatives without significant changes, it could lead to decreased revenue for EDs, says **Molly Collins Offner**, MHSA, senior associate director of public policy in the Washington, DC, office of the American Hospital Association.

One of the potentially troublesome provisions concerns regulating the rate out-of-network hospitals and their EDs are paid by Medicaid managed care plans, with the effective date pushed back to fiscal year 2007.

"Many states have moved to Medicaid managed care for large chunks of their populations," Offner explains. "Typically, the state will contract with managed care companies, and they go out and find providers to be part of the network. Federal law says that they have to pay out-of-network care by the plan."

Access issues prompted change

This change was proposed because of access issues, she explains. The provision was put in to ensure these recipients could seek emergency services out of network and not have to pay for them. Under the new provision, Offner adds, "this would go up a notch, because it would require how these out-of-network hospitals are paid."

Nothing before directed the state or the plan on payment level, she says. "This would tie the payment level to the fee-for-service level for payment outside of managed care, and fee-for-service is a fairly low payment."

If the provision goes through as proposed, the impact on EDs will vary, Offner says. "A lot of states already handle things this way, but there is a handful where it's an open, negotiated process," she says. "If it's currently negotiated in your state, your ED will lose revenue."

Source

For more information, contact:

- **Molly Collins Offner**, MHSA, Senior Associate Director, Public Policy, American Hospital Association, 325 Seventh St. N.W., Washington, DC 20004. Phone: (202) 638-1100.

A second potentially negative provision also deals with Medicaid. "In this section, they've granted states a fair amount of flexibility in how they set benefit packages for certain populations and charging premiums and copays that are new, and one package has to do with the ED," says Offner. The rationale is if you pay a copayment for nonemergent care in the ED, you may wait or go to a doctor the next day, she says. "We've argued against this provision because research has shown it delays care and results in bad debt for the most part," Offner says. "You just can't collect it."

Offner: Fairly complicated process

The new provision sets up a fairly complicated process, she continues. "The Medicaid patient goes through a screening, and if it's determined it is a nonemergency, the ED staff has to inform the patient they will be subject to a copay," Offner says. "They also have to work with the patient to find a referral and help with that process."

AHA officials argue that's a huge burden of time and effort, she says.

"The argument we get back is you get paid for that, but we don't think that will happen," she asserts. "What the states will likely do is look to that payment rate, see that a copayment is available, and you might actually see a drop in that payment rate over time."

The bill is awaiting final Senate approval. ■

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. ■

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COMING IN FUTURE MONTHS

- ■ Does EMTALA require EDs to provide narcotics for patients with chronic pain syndromes?
- ■ Is your ED secure from theft of patients' records?
- ■ 'Timeout room' helps staff recharge their batteries
- ■ Pediatric ED boosts satisfaction scores from 43% to 97% in two years

CE/CME *questions*

25. According to Roneet Lev, MD, FACEP, ED managers can use the results from the new national report card to:
A. explain some of the difficulties their department may be experiencing.
B. identify key issues that should be brought to the attention of policy-makers.
C. educate staff about some of the major challenges facing EDs in the state.
D. All of the above

26. According to Brian F. Keaton, MD, FACEP, the best way to learn about a CPOE system is to:
A. have a manufacturer's representative provide a demonstration at your facility.
B. ask other EDs that have used the system.
C. see them at industry expositions.
D. ask your information technology manager for their recommendation.

27. According to according to Richard Heath, MD, FACEP, one of the things he does *not* do when a physician strays from the recommended guidelines for pneumonia treatment is to:
A. take the chart to the physician.
B. share the physician's identity only with the other physicians.
C. take the chart with names unidentified to the staff.
D. speak to the physician personally about the proper procedure.

28. According to Robin Voss, RN, MHA, her facility's psychiatric ED has access staff that include:
A. human service clinicians.
B. social workers.
C. advanced-degree psychiatric services providers.
D. All of the above

29. According to Marilyn Margolis, RN, MN, what percentage of the ED rooms at Emory University Hospital's ED are isolation rooms?
A. 100%
B. 95%
C. 90%
D. 85%

30. VeriMed, an implantable radiofrequency identification (RFID) chip the size of a grain of rice, is implanted in the patient's right:
A. bicep.
B. quadracep.
C. tricep.
D. buttock.

Answers: 25. D; 26. A; 27. B; 28. D; 29. A; 30. C.

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Prepare for emergency management committee meeting as part of Joint Commission survey

Using a disaster tracer, surveyors will ask staff about their roles

Beginning this year, the Joint Commission on Accreditation of Healthcare Organization has added an emergency management committee meeting and a disaster tracer. The tracer will be conducted mostly as a tabletop exercise, with additional questions for your staff about their roles. While these steps will be taken only for all hospitals with more than 200 beds, many of the disaster planning exercises are helpful for facilities of every size, sources say.

"We're digging in deeper to make sure not only that plans are in place, but to see that they're working and that there's substance behind what's presented to us as to how they would work," says **Jerry Gervais**, CHFM, CHSP, engineer in the Standards Interpretation Group at the Joint Commission. No new standards have been added, but the Joint Commission will be evaluating disaster plans differently at the survey, he emphasizes.

John L. Hick, MD, medical director for emergency preparedness at Hennepin County Medical Center in Minneapolis says, "For those who have surveys upcoming, this is a wake-up call." This evaluation will be a priority, Hick emphasizes. "The Joint Commission used to not get into detail [with disaster plans]" he says. "That's not the case anymore."

Consider these suggestions for your disaster planning:

• Be prepared to explore your disaster planning as a tabletop exercise.

The emergency plan will be the last item on the agenda at the environment of care (EOC) review, Gervais says. The plan will be reviewed in the hospital's incident command center, and the full incident command team will attend, he says.

A mock disaster exercise will be conducted over 1½ hours without using any outside hospital staff, Gervais says. The disaster will be chosen from one of the top three potential disasters identified by the hospital's hazard vulnerability analysis, he says. The exercise will begin with the surveyors describing a disaster scenario.

"With most emergencies, you'll get some preliminary information" but not a lot of detail, Gervais says. The situation will escalate as more information comes available about the number of victims. "We'll ask what would they do internally," he says. "We're trying to assess that and, most importantly, how they would work together as a team to address issues."

Depending on how the exercise is progressing, it can be escalated or slowed down, he says. "If it's going well, we'll throw some more detail in to require them to dig deeper," Gervais says. "If it's going poorly, we tend to slow down to see how things work."

At Maimonides Medical Center in Brooklyn, NY, the Emergency Management Committee (EMC) is reviewing the new Joint Commission publication "Surge Hospitals: Providing Safe Care in Emergencies" to be as thorough and compliant as possible with the recommendations, says **Carl Ramsay,** MD, medical director of the department of emergency medicine. **(See**

Executive Summary

Accreditation surveys for larger hospitals will include an emergency management committee meeting and a disaster tracer.

- The plan will be reviewed in the hospital's incident command center, and the full incident command team will attend, he says.
- Staff will be asked about their roles in a disaster.
- All hospitals should have a plan for responding to biological and chemical disasters.
- Don't rely on drills alone; also use training.

information about publication in resource box, this page.) Hospitals and communities must be prepared to establish temporary care facilities when a major disaster or disaster cripples the hospitals and forces patients and staff to evacuate. "That is a tall task and will be a significant challenge for most EMCs to undertake," Ramsay says.

• Your staff must be prepared to be questioned.

When that mock disaster session concludes, surveyors will go out into the operating areas of the hospital and question staff, Gervais says. Staff will be asked about what the surveyors were told during the mock disaster in terms of job responsibilities and supply availability. "We want to know if you're walking your talk," Gervais says.

A mock disaster victim will be traced through the facility, he says. Hennepin County already has experienced this step at their recent survey, Hick says. The mock mass casualty incident involved a 60,000-seat domed stadium across the street from the hospital, he says. The victim was traced from the ED to surgery to intensive care, and even members of the housekeeping staff were questioned along the way, Hick says. "It was very across the board," he says.

Staff members were asked what their roles would be in the hypothetical disaster. "The surveyors didn't want to talk to people on committees — just people who happened to be working that day," Hick says. In the ED, surveyors questioned the charge nurse about specifics including the location of disaster equipment, such as radios, and asked how the emergency nursing department would operate, he says.

• Have a backup ED person. Ensure that as part of your planning, you have a backup person in the ED responsible for disaster response, Gervais says.

"Emergencies aren't ever scheduled, and you must be able to handle them 24/7, 365 days a year," he says. "Have more than one layer, in case someone is out of commission."

• Have public safety contact information.

Be prepared to give surveyors the name of the public safety contact persons, including those who work for the fire and police departments, and tell them how you would contact those people, Gervais says. This step is especially critical in an external disaster, he says. "You need formality in what for many places has been informal," Gervais says.

• Regardless of your size, have a plan for responding to biological and chemical disasters.

Gervais has seen many EDs scrambling to develop disaster plans for biological and chemical events. "Many aren't prepared that well right now," he says.

Even rural hospitals need a plan, which can be as simple as transferring patients to larger facilities with more capabilities, Gervais says. All ED managers should keep in mind that there are more than 600 accidents every year involving chemicals, and those accidents can occur anywhere, he emphasizes. Also, epidemics can spread to any location, Gervais says.

"We're warning hospitals to be prepared for what they would do if those types of patients presented: a biological epidemic, whether it be avian flu, SARS [severe acute respiratory syndrome], a terrorist attack releasing smallpox, etc.," Gervais says. "All are biological threats, and the hospital needs specific measures and plans to deal with that in its preplanning." **(For more information, see "Make decontamination part of all-hazards plan," *ED Management,* November 2005, p. 127.)**

All ED managers should keep in mind that there are more than 600 accidents every year involving chemicals, and those accidents can occur anywhere.

• Your staff must be trained, not just drilled.

Traditionally, EDs rely on drills to educate staff, Hick says. Drills are not training, he emphasizes. Training is providing education that health care workers need to accomplish the task, Hick says. A drill is when you show confidence in training previously delivered, he says. EDs have to provide training, and then test that training with drills, Hick says. "I think that's the biggest problem" that hospitals have with their disaster preparation, he says.

For example, during a chemical event, ED managers need to be able to draw on hospital resources and staff and integrate with community resources for additional decontamination support, Hick says. Specifically, many hospitals are weak in their training for chemical decontamination, he says. "There's been a lot of equipment purchased, but there is a deficit in training for people

Source/Resource

For more information on preparing for accreditation surveys, contact:

- **Carl Ramsay**, MD, Medical Director, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. E-mail: CRamsay@maimonidesmed.org.

"**Surge Hospitals: Providing Safe Care in Emergencies**" includes case studies on temporary health care facilities established after Hurricanes Katrina and Rita. A free copy is available at www.jcaho.org/about+us/public+policy+initiatives/surge_hospital.htm.

who are supposed to be operating that equipment."

• Use drills to help your disaster planning evolve.

Disaster planning is always on the mind of **Dan Hanfling**, MD, FACEP, director of emergency management and disaster medicine at Inova Health System in Falls Church, VA. Inova is located eight miles from the Pentagon, and two inhalation anthrax cases were diagnosed in the hospital's ED. "We seem to be living here at the crossroads of disaster," Hanfling says.

The facility conducts two drills a year, then makes improvements based on the measurements and assessments of how well they've done, he says. In other words, disaster planning is not occurring in a vacuum, Hanfling says. "It's happening in real time, and you're forever learning and making improvement as your health system and community develops, and as threats change," he says. "In that regard, it's a living, breathing process, not just an item on a shelf to be dusted every so often." ■

Form reconciles meds, but doctor buy-in difficult

To meet the National Patient Safety Goal to reconcile medications across the continuum of care, one ED is finding success with a medication reconciliation form that it developed.

The National Patient Safety Goal requires hospitals to implement a process for documenting a list of the patient's current medications upon the patient's admission and with the involvement of the patient. This process includes comparing medications the hospital provides to those on the list.

The ED manager at Providence Saint Joseph Medical Center in Burbank, CA, developed a form that includes sections for drug name, dose, route, frequency, reason, and last dose. **(This form is available on-line. See resource box, p. 4.)**

Executive Summary

One ED has developed a medication reconciliation form to meet the National Patient Safety Goal of reconciling medications across the continuum of care.

- The form does require additional staff time to complete.
- Staff and physicians need training so they understand the importance of meeting the safety goal.
- Physicians may resist giving orders on previously prescribed meds and may see the form as redundant.

For nursing home patients who bring in a list of their medications, the staff members confirm that all areas of the form are documented on the patient's form, then they add a note that says "see attached sheet."

The form is used in the ED and for inpatients being boarded in the ED. The ED is developing a policy to use the form for reconciling medications for those inpatients boarded in the ED, says **Carol Rozner,** RN, MICN, BSN, ED manager. In the comments section, nurses can write additional information such as a patient not taking his or her medications regularly. Also in that section, nurses write the medications, and physicians mark them as continue, delete, or hold. The form also is used hospitalwide for inpatients when the hospital's computer system is down.

Story highlights form's importance

To help obtain staff buy-in for the form, Rozner shared the story of one staff member's mother. A physician ordered thyroid medication, but a decimal was placed incorrectly. "The form would have helped if the doctor at the time of discharge reconciled all medications and looked to see that was not a therapeutic dose," Rozner says. The mother was on the wrong dose for more than a year until she was hospitalized again, she says. The mistake was caught when the patient was readmitted, she says.

Another benefit is that physicians can ensure that there aren't any interactions between medications, she says. In the past, they might have looked at medications in terms of safety during pregnancy, or whether they were safe for a certain age child, Rozner says. "Now we look at all medications to make sure it's safe for them to take," including medications that are prescribed as part of the patient's discharge.

The form has been well received by floor nurses receiving patients from the ED, she says.

Training staff to use form

Implementing the form in the ED required a one-hour training course. "We held an update class this fall, and every person, including techs in the ED, came," Rozner says.

Additionally, staff members were required to complete a 10-minute self-study module on the computer. The module includes a copy of the form and explains the sections that nurses complete. "It explains the National Patient Safety Goal and why it's necessary," she says. "It's not just busy work; it's important."

Using the form took some adjustment by the staff. "It's cumbersome for the staff," Rozner says. "We

Source/Resource

For more information on the medication reconciliation form, contact:

- **Carol Rozner**, RN, MICN, BSN, ED Manager, Providence St. Joseph Medical Center, Burbank, CA. E-mail: Carol.Rozner@providence.org.

If you want to access the medication reconciliation chart and you're accessing your on-line account for the first time, go to www.ahcpub.com. Click on the "Activate Your Subscription" tab in the left-hand column. Then follow the easy steps under "Account Activation." **If you already have an on-line subscription**, to go www.ahcpub.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose 'ED Management,' and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006" and then select the February 2006 issue. For assistance, call Customer Service at (800) 688-2421.

didn't used to have to ask all those questions, but those are all elements that are required," by the National Patient Safety Goal.

Some of the physicians still are disgruntled. They have raised objections because they aren't the patients' primary care physicians and they don't know what medications that physician actually ordered, Rozner says.

'Very time-consuming'

While one physician describes the form as a "great idea," he says that operationally it creates tremendous problems in the ED. "It's very time-consuming, and the ED physician doesn't need that information on most patients," says **Philip Schwarzman**, MD, FACEP, medical director of the ED at Providence St. Joseph.

Previously, ED nurses would list medications without the dosages. "If the ED doctor needed more, he or she could get it," Schwarzman says. Currently, a patient may come in who is on 10 or 15 medicines, some of which are "trivial," he says.

One solution may be to narrow the focus of the form to patients who will be admitted, Schwarzman says. "Most of our patients that come in get discharged," he says. "Maybe only half get a prescription." He questions the need for such a form for patients who have not be taking medications but are given a prescription. "There is redundancy," he says.

Another potential snag with the form is that physicians have to remember to sign the form, he says. "From my experience, most of us are not signing the form," he says. "We're too busy, and nurses aren't reminding us."

There is a need for more physician compliance, Rozner acknowledges. The managers are performing ongoing audits to determine compliance, she says.

Resources address unannounced surveys

To prepare for the new unannounced survey process, the Joint Commission on Accreditation of Healthcare Organizations is offering several new resources on its web site. Those resources include a computerized graphic presentation, questions and answers, and a video presentation.

To access these resources, go to www.jcaho.org/accredited%2Borganizations/unannounced.htm. ■

HOME MEDICATIONS
(Prescriptions, OTC, herbals, patches, eye drops, and supplements)

Drug Name	Dose	Route	Freq.	Reason	Last Dose	Comments
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	
	☐ Unk.	☐ By mouth ☐ Other	☐ Unk.	☐ Unk.	☐ Unk.	

NURSE SIGNATURE / TITLE

DATE

Based on the above medication list you provided, I recommend you:

☐ Continue the above medications as directed by your physician.

☐ Make the following changes to the above medications:

____

____

☐ Add the following medications:

Drug Name	Dose	Route	Frequency	Reason	Next Dose

PHYSICIAN SIGNATURE

X M.D.

DATE

Providence | Saint Joseph Medical Center

501 South Buena Vista Street • Burbank, CA 91505-4866

MEDICATION RECONCILIATION

DISTRIBUTION: ORIGINAL – Medical Record
CANARY – Patient
PINK – Department

Pilot 11/05

Patient Name (Last, First, M.I.):________________

M.D. Name: ________________

Medical Record No:________________

Admit Date: ________________