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The monthly update on Emergency Department Management

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IN THIS ISSUE

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EDs finish last in national quality report — steady decline noted

Statistics are seen as a reflection of lack in customer service

In an unsavory distinction, the lead author of the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ) has singled out the nation's EDs as the worst performers in its *2005 National Healthcare Quality Report.* **(To obtain report, see resource box, p. 27.)** While overall quality of care for all Americans across 44 core measures in the report improved at a rate of 2.8%, there was a 10% *deterioration* in the percentage of people who go to the ED and leave before they are treated.

This is "our worst performing measure and it has been getting worse for a number of years," notes **Dwight McNeill**, PhD, lead author on the National Healthcare Quality Report and an AHRQ expert in quality measurement and improvement.

This sad statistic comes as no surprise for ED managers, one of whom called it "a catastrophic failure of customer service." **Pat Scanlon**, RN, ED manager at Northside Hospital in Atlanta, says, "This is always a concern for everyone, because this is the population that decides, for one reason or another, that they want leave — whether they have waited too long or were unhappy with their interaction with staff."

If you have a high percentage of patients who leave without being seen [LWBS], "it could be a service indicator — that you don't give care," adds **Kathy Hendershot**, RN, ED clinical director at Methodist Hospital in Indianapolis. "It certainly has a financial impact, but there is also a medical/legal risk surrounding people presenting and not being able to get them seen and having them walk away."

Executive Summary

If you have more than 2% of your patients leaving without being seen, try these strategies to get your numbers down:

- Quick triage and bedside registration will get your patients into a room much more quickly.
- Have patient relationship advocates explain to patients why they are waiting and reassure them that they will be seen.
- Monitor your statistics on a monthly basis so you can quickly identify and address serious problems.

Besides the fact that the thought of acutely ill patients getting up and leaving "keeps me up at night," says Hendershot. "There's always a legal risk that if they present and then walk away before they have a medical screening, you can get into an EMTALA [Emergency Medical Treatment and Labor Act] situation."

It may be difficult to find one common national benchmark for an acceptable LWBS percentage, but most ED experts agree that when you start hitting 3% or 4%, you are losing too many potential patients.

The Oakbrook, IL-based University HealthSystem Consortium (www.uhc.edu) says 1% is good benchmark, "but emergency medicine has to start somewhere," says Hendershot. She has seen statistics for the national average that range up from 4%. "Four percent of a 20,000-visit department is significant; however, 4% of a 100,000 volume is not as bad," Hendershot explains.

Her ED sees 100,000 patients annually, and in 2004-2005, her department's LWBS rate was 2.2%. "This year, I would think we will get close to 2%," Hendershot says. Eventually, she'd like to have the rate reach 1%, she adds.

Deb Richey, MPA, director of emergency services at Parkview Hospital, Fort Wayne, IN, estimates that most EDs are in the 2%-5% range. "We generally range around 1%," she reports.

Through regular contact with the American College for Emergency Physicians (ACEP), Scanlon has concluded that ED managers should strive to have their LWBS rate lower than 1.5%. "We usually hit between 1.5% and 2%," she says. "We're not serving our community if people are walking out."

Strategies that work

The good news is that there *are* proven strategies for getting those LWBS numbers down.

"When we very first started looking at this [eight to 10 years ago], our LWBS rate was more in the 2%-3% range," Richey recalls. "We determined that on average people were waiting 45 minutes in the lobby to get back to a room because of the front-end process."

Her ED began a bedside registration process, as well as quick triage. "We use a five-level triage, and the nurses only gather enough information to determine the appropriate level for the patient," Richey explains. This process usually involves chief complaint and history, to rule out a chronic illness; vitals usually are taken at the bedside.

"We do a more extensive triage if needed — for example, if the patient has chest pain and requires monitoring — but we don't use extensive triage assessments if all rooms are full," she reports says. "This has cut 45 minutes from our overall length of stay."

Hendershot says she knows you can decrease LWBS rates if you expedite the time to physician. "If you get them to the doc quick enough, they are not going to leave," she says. "We've done several things in the last few years, including a fast-track, dedicated area for low acuity patients; having bedside registration; and 'quick-reg.'"

This quick registration is a two-step process,

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The AHRQ *2005 National Healthcare Quality Report* is available free on-line at www.qualitytools.ahrq.gov. Scroll down to "Quality Tools News" and click on "2005 National Healthcare Quality Report." Also, you can obtain a free copy by calling (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov.

Hendershot explains. "You come into the department, and we just ask your name, date of birth, and if you've been here before. If you have, we click the mouse, and we already have your record." That may have been the biggest change her ED has made in terms of cutting door-to-doc times, she adds.

At Northside Hospital, "the other thing we've done that's new this year is a dedicated triage staff that does a rapid triage assessment," says Scanlon. This system involves having a physician at triage between 1 p.m. and 9 p.m., the busiest times in the ED. Only a year ago, she notes, LWBS for her ED was at 3.3%.

Abbreviated triage helps LWBS rate

Northside's ED uses several processes to keep LWBS low, says Scanlon. "We have abbreviated triage, so at least we know the acuity of the patient that's waiting," she says, noting that in most cases it's sufficient to determine if the patient is really sick and needs to get to the back or if they can wait.

"If they have to wait," Scanlon explains, "We have patient relationship advocates come down to see them." These representatives try to give the patients a better idea of how much time they might wait to be seen, she says. They try not give an exact time but provide general comments such as, "It should be soon," she says. "Without any kind of guideline, the patients get frustrated."

Her ED has standard guidelines for specific complaints and will initiate them at triage. "Patients really appreciate that," says Scanlon. "They feel like at least you are starting them on another path; it makes them feel you are doing something."

Northside also uses a "pull-through" triage. "If there are open beds in the back and a patient comes in with a big group, say six at once, we won't have them queue up, but will rather pull them to the back and triage them there," Scanlon explains.

Constant monitoring critical

Another important strategy in keeping LWBS low is to remain constantly vigilant, Richey says.

"It's very important to watch it on a monthly basis," she says. For example, during a time when the census was going up and LWBS was going up, Richey calculated their average revenue per visit. "When I told the administrator the hospital was losing this much revenue, I was able to get a $50,000 budget increase to add rooms to the ED," she says.

Finally, Hendershot recommends, it would be valuable for all EDs to agree on a common definition of LWBS, to make benchmarking more accurate. "The definition we use is, 'A patient presents to your hospital to be seen and leaves prior to a medical screening exam,'" she shares. ■

Identity theft poses new threat for ED managers

Private information of staff and patients is at risk

At Southern Regional Medical Center in Riverdale, GA, the credit cards of one of the emergency nurses was stolen while she was at work, and the thieves used them all day. They knew nurses work long shifts and that if they removed the cards early in the day, they would have all day — and perhaps the night as well — to shop.

Kaiser Permanente South Bay Medical Center in Redondo Beach, CA, has sent letters to 25,000 members warning that two contract employees stole personal information from emergency and surgery patients' records and ran up thousands of dollars in charges on fake credit cards.

Theft — petty or not — is alive and well in the ED. With identity theft becoming a more common threat throughout society, ED managers are standing up and taking notice.

"I think petty theft in the ED has always been an issue," says **Gregory Henry**, MD, FACEP, risk management consultant at Emergency Physicians

Executive Summary

Recent incidents show EDs are vulnerable to identity theft. You can "harden" your ED against both low- and high-tech theft with a number of simple actions.

- Install a coded entry system to your staff lounge, and have staff lockers located within this secured area.
- Educate staff about the need to keep small instruments and prescription pads out of plain view.
- Add cover flaps to your computer screens, and individualize monitors to minimize access to private information.

Medical Group in Ann Arbor, MI. "That's why you need secured places for staff's possessions: purses, doctors' bags, and so forth."

Henry says the incident at Southern Regional is not unusual. It's more common, however, for items such as prescription pads to be stolen. "That's why they are never left in rooms or on the tops of desks," he says. "We had one guy who had stolen scrip pads and was selling blank scrips for $10 apiece."

Protecting staff property

Many EDs provide staff with lockers for personal belongings, and combination locks are placed on them for extra security. Those measures may not be sufficient, however, Henry says.

"Lockers may do the job inside the staff room [with secured access], but lockers that others have access to *won't* do it," he warns.

First, have limited access to staff areas, Henry advises. "We have a separate staff room with a door code on it," he shares. "You have to push the buttons for a three-digit code to gain access into the lounge, and that seems to solve a lot of problems."

At Montefiore Medical Center in the Bronx, NY, a similar system is in place.

"We have a common room which requires a key code to get in," says **Alice "Bonnie" Corbett**, RN, administrative nurse manager of the ED. All of the lockers are together, Corbett says. The lunch table is there, so staff members are in and out all day, she says. For that reason, they have a "double" system: a key code to get into the room, and individual locks on the lockers.

Beyond those types of measures, ED managers should seek to minimize loose items and wandering individuals, Henry says. "In general, anything small enough to go in a pocket, like medical instruments, should not be left in the room," he says. "Even the staff lounge should be spartan, he says. "If it can sprout legs, it will," he says.

As for visitors and well-wishers, "you should make sure they are either in a room with the patient or in the waiting room," he says. "Free-floating people in general are bad."

Safeguard computer information

While the information technology department may have overall responsibility for securing computer data, there are steps ED managers can take within their department to keep private information private, says Henry.

"The computer has actually allowed great theft," he says. That's why the Health Insurance Portability and Accountability Act (HIPAA) says screens need to be blank after a number of seconds, Henry says. You also should have a flap or a cover on computers in your department, he adds.

Corbett agrees. "A hospital staff member here designed an actual flap with heavy rubber that goes over the computer screen," she says. "We also have individual computers for each physician, so you can see if someone [other than the designated individual] is sitting at it. And if they get up, they put the flap over the screen."

ED managers also must guard the paper printouts from computers, adds Henry. "When medical records are done, they should be put in locked boxes so they can be shredded," he advises.

The dangers of leaving computers unprotected are many, Henry says. For example, consider departments that use computerized physician order entry (CPOE) for prescriptions, he says. "A sophisticated patient could push the right set of codes and get whatever drugs they wanted off that," Henry says.

Patient privacy is a serious concern, of course. AIDS, for example, has a designated ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) code, notes Henry. "That could be used for extortion," he says. "Armed with that information, an extortionist could target a ritzy area, call everyone who has AIDS, and threaten to make the information public unless they are paid off." ■

Sources

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EDIS helps shrink door-to-doc times

Being able to track patients speeds upfront process

Executive Summary

Optimal use of an ED information system not only can dramatically improve length of stay, but also will help demonstrate to management the value of the investment.

- Access to patient information helps the charge nurse get beds assigned in advance.
- Patient tracking alerts staff to possible logjams that can be addressed in real time.
- Nurse charting captures the necessary data to calculate your return on investment.

The ED at MetroHealth Hospital in Grand Rapids, MI, has achieved a door-to-doc time of 19 minutes with the help of an information system.

In addition, average length of stay (LOS) for discharged patients has dropped from 2.18 hours to 1.86 hours, and inpatient LOS is down to 3.55 hours from 3.98 hours with the ED Information System (EDIS) from Medhost of Addison, TX, according to **Helen Berghoef**, RN, MSN, the director of ambulatory services/ED at MetroHealth.

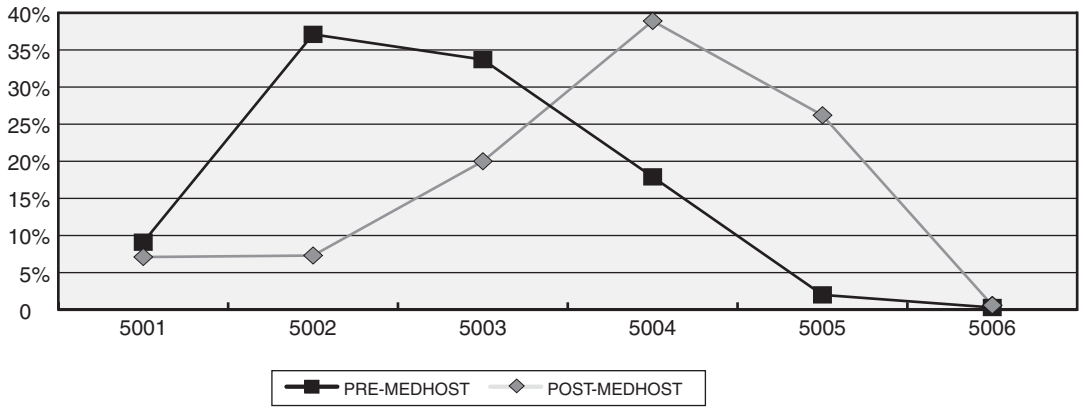
"The Medhost system has had a dramatic impact on all three of those [numbers]," she reports. "I might not go so far as to say we couldn't have done it without it, but it certainly has been an invaluable tool."

In 2001, MetroHealth went live with the patient tracking component of the system, which also has discharge instructions and prescription writing. In 2003, the ED added a second component: nurse charting. This module has the ability to capture charges based on what the nurses are documenting. "Without a doubt, our goal was to be able to know what was going on with our patients all the time, in real time, and be able to look at the data retrospectively and quickly, without lengthy manual data collection," says Berghoef.

The system has helped their upfront process, notes Berghoef. When a patient comes to triage and is seen by the nurse or greeter, their information is immediately entered into the EDIS.

"Because the triage nurse has access to all that is going on in that department — and so does the charge nurse — the charge nurse already has the next patient assigned to a bed, so the triage nurse can finish up

Facility Coding Enhancing Revenue



MetroHealth Hospital's pre-Medhost electronic charge capture case mix was about 2.2. Post-Medhost implementation increased case mix to about 3.6.

	Projected	Actual
Per Visit Increase in Gross Revenue	$167	$165
Per Visit Increase in Net Revenue	$60	$50

$10 difference attributed to analysis — projected. Analysis done using selected payer groups. Actual was done on all outpatient visits.

Source: MetroHealth Hospital, Grand Rapids, MI.

Sources

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triage and get the patient right back to a room," says Berghoef. "They don't have to make phone a call and talk to the charge nurse — which takes time."

In addition, Berghoef has put a registration person in triage. "Some say bedside registration is the be-all and end-all," she observes, "But we've found with this approach, we can do it all [triage *and* registration] in four minutes and not have to find another person to do registration. Plus, it's very customer-friendly."

Managing the care process

The EDIS also has led to better management of the care process in the ED itself, says Berghoef. "Because all staff has access to what's happening with all patients — including physicians — they can tell at a glance when there are delays with lab work or with getting a patient to X-ray," she notes. "Even our physicians will get involved in making things happen and keeping them rolling."

This emphasis affects the process up front as well, she emphasizes. "What you do in the back has a big impact, because if you keep things moving you are preventing bottlenecks, so you can keep these patients up front moving back," she explains. "If you have bottlenecks in the back, the impact goes to the front."

Another facet of the system that helps speed processes is its touchscreen technology, notes **Craig Herrod**, CEO of Medhost. "You can use a mouse and a keyboard, and the nurse at triage will often do that, but the bulk of the rest of the clinicians use the touch screen," he says.

A significant investment

How much does a software system like this cost? "Depending on the size of the hospital, you are typically talking anywhere from $350,000 to $600,000," Herrod says.

How can an ED manager cost/justify such an investment to administration? Herrod says the answer is the return on investment. "The ED managers get to talk with a bunch of customers who have hard numbers to share about what they are getting for their returns," he says.

Berghoef says, "If you consider that our return on investment was an incremental $50 per patient net, it would be pretty easy to cost justify this for a small or a large ED." **(See the chart on p. 29.)**

Still, such an important investment requires a lot of homework. Herrod says, "The best way, first and foremost, is to immediately talk to some user groups on the web, as well as each company's customers about their decision. Then, you should definitely include the IT people at the hospital, because they need to help drive the decision." It's also important that you get an administrative "champion," he says. If the hospital is spending more than $10,000, it will be in the capital budget, Herrod points out. "Finally, create opportunities for vendors to come to your department so your staff can get their hands on the system," he says. ■

Hospital's primary care center relieves ED logjam

New policy complies with EMTALA?

Is it an extremely creative solution to one of emergency medicine's most nagging problems, or a violation of the Emergency Medical Treatment and Labor Act (EMTALA)? We may never know the complete answer unless the issue winds up in court someday, but for now, Flagler Hospital in St. Augustine, FL, is successfully easing the pressure on its ED by directing some patients to a county-funded primary care center just down the hall.

Flagler had opened a new ED, and the first winter season brought a change to their caseload, reports **Jennifer Arguilla**, RN, BSN, MBA/HCM, LNC, director of Flagler's Emergency Center Care. "We saw a dramatic increase in self-pays, which is difficult for a single, not-for-profit hospital," she says. "We looked at the majority

Executive Summary

An in-house "transfer" must meet certain requirements in order to be in compliance with Emergency Medical Treatment and Labor Act (EMTALA).

- Have an emergency physician in charge of the receiving primary care facility.
- Have strict criteria concerning which patients will be allowed to leave the ED.
- Having physician conduct an appropriate medical screening is necessary.

of our patients and what they came in for, and what part of the ED they used most."

Arguilla found that most of the patients were fast-track cases of nonepisodic, nonacute care.

Hoping to reduce $28 million a year in unpaid bills, St. Johns County's only hospital made a policy change in early January to direct some ED patients to the county center. "We were trying to find ways we could buffer the business we have," Arguilla explains.

The hospital started the county-run primary care center two years ago, reports **Peter Bacon**, a hospital spokesman. "Its purpose is to provide a primary care doctor for people who don't have one or who don't have insurance," he says.

These patients present to the ED with a cold or a headache, and they need to see a physician, Bacon says. "What we initiated in January is designed to direct them to the more appropriate, long-range wellness care they really need."

How the system works

Under this new arrangement, when a patient signs in, the triage nurse follows normal ED protocols and does her initial assessment. Then, she calls the physician at the primary care center and does a person-to-person referral, says Arguilla. "After that, they either send the patient over, or the doctor says they need more labs," she says. "Also, if the patient is in the clinic and the physician finds something, they will send them back to the main facility."

The physician at the primary care center is trained in emergency medicine and family practice, notes Arguilla. "He works under the same physician group that has our ED," she says. "So, we are still doing appropriate medical screening by an actual physician."

Since the program was begun only recently, there is not a lot of data available on its effectiveness. "We're averaging at least five patients [transferred] a day," says Arguilla. "It's mainly impacting my fast-track population. but it cuts everyone's wait time, so everybody's happy."

There's another benefit for the patients: "People who come here and don't have a physician now have a home," says Arguilla. "And, since we're hooked up with the county, we have social workers, prescription assistance programs, and so forth." She doesn't see why other facilities couldn't do what Flagler has done, but notes that "we are the only hospital serving this county; that's why we have full county support."

What would EMTALA say?

Naturally, Flagler ran the plan by its general counsel and received a green light in terms of EMTALA. "We made sure our bylaws did not violate EMTALA," says Arguilla. "My comfort level is that we are using an emergency physician. I wouldn't be comfortable otherwise."

But for **Alan Steinberg**, Esq., an attorney with the law firm of Horty Springer in Pittsburgh, the situation is not that black and white. "If a patient presents and receives a true screening exam, and it is not an emergency medical condition, then EMTALA is done," he says. "The patients certainly are getting screened and seen by a physician."

However, he adds, "in a really strict review, there may be a problem, because under EMTALA you have to treat all the people presenting with symptoms the same way. If you send one patient over [to the county center] and keep another in the ED, are you making a distinction?"

In other words, he says, on the one hand Flagler may be compliant because both patients are being screened by a physician, but because some patients leave the ED *before* screening, there could be a problem. "It is a well thought-through plan, and its intent is good," he summarizes, "but you would need to [demonstrate] rigorous compliance language if there were ever legal questions raised." ■

Sources

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ED quadruples patient satisfaction rankings

How can one keep numbers that high?

In the third quarter of 2001, the ED at Methodist Medical Center of Illinois, Peoria, ranked in the 17th percentile in patient satisfaction surveys by Press Ganey Associates in South Bend, IN. By the end of 2003, that number had risen incredibly to the 95th percentile.

That happy ending, however, is not quite the entire story. "We've become victims of our own success,"

Executive Summary

Staffing changes, vigilant monitoring can lead to dramatic improvements in patient satisfaction. One ED boosted its rankings from the 17th percentile to the 95th percentile.

- Having a physician in triage keeps patients with minor complaints out of the ED.
- Meet with your staff on a regular basis to review performance and identify problems.
- As volume increases, flexible staffing can help maintain satisfaction gains.

notes **Elsburgh Clarke**, MD, chairman of the department. You see, the boost in patient satisfaction mirrored a similar growth in caseload for the ED, which now sees 55,000 patients a year instead of the 37,000 it was seeing a few years ago. This increase has made the maintenance of a 95% patient satisfaction rate impossible, Clarke says; still, the ED's rankings consistently remain in the mid-80s.

When the downward trend in patient satisfaction rates became apparent, Clarke and **James Sowards**, MD, the medical director, were charged with the task of getting patient turnaround to 30 minutes, which, it was felt, would bring the satisfaction numbers up.

"As we all know, length of wait is one of the main determinants [of patient satisfaction], so I had to devise a process and procedure so that, no matter what a patient came in with, they could be seen in a timely fashion," recalls Sowards.

That timeliness can't happen with standard triage, he says. By moving the physician out to the patient, not only do they not have to see minor complaints in ED beds, but the patient is taken care of just as quickly, he says. If they triaged patients in standard fashion, someone with a toothache could wait four to five hours, Sowards explains. He says this new system "is a win for the ED and for the patient who comes in with a nonurgent complaint — and that represents a large portion of our patients."

Clarke says they have a physician out front from 9 a.m. to 5 p.m. and from 5 p.m. to 1 a.m. They also have a fast-track service that is open during those same hours, he says. These practices continue, he notes.

Stats closely monitored

During the turnaround process, the ED managers kept a close eye on satisfaction performance.

"We get weekly updates on Press Ganey scores, and we post them in the department so everyone can see how we are doing," Clarke explains. Survey comments were shared with staff at least twice a week.

Patient satisfaction became a topic in the monthly physician meetings. Also at the physicians' meetings, the individual scores were posted.

"When you have peer pressure like that, you don't want to be in a lower percentile," he notes. "If a physician is under percentile for several months, we will have a separate meeting with them." The nurses, he adds, only see a graph that represents the performance of the entire department.

Sowards says another factor in improvement has been a financial incentive. "Doctors are paid on a base salary and an incentive bonus, which is partly based on customer satisfaction," he explains. "While 90% of your salary is set, 10% is at risk for productivity, customer satisfaction, and coding."

The challenge of growth

Since the department volume hit 55,000 patients a year, the satisfaction scores have typically ranged between 83% and 85% — still far above their low baseline, but lower than their 95% target, says Clarke.

"The community knows this is just a better place to come, and it's put a lot of stress on the system," he says. "We're trying to get back" to 95%.

Clarke identifies several possible remedies. "We need a bigger ED and more people working, but that will not happen anytime soon," he says. However, he adds, "the nursing staff has basically bought into [the satisfaction goal] and knows we basically have to be fluid with staffing as volume shifts and changes on a daily basis." The nursing staff is at its maximum, he says, "but we've made changes in our schedule, and they have to accommodate those changes to help us out."

Sowards says they've adjusted their hours to meet the increased volume. "And we do have an on-call system if it gets even crazier, to bring in extra people and de-compress," he says. "We do whatever it takes to get the volume out of here." ■

Sources

For more information on boosting patient satisfaction rates, contact:

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EMTALA Q & A

Can PAs provide on-call patient care?

[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: Imagine the following situation: John Smith presents to the ED of Community Hospital. Hugo Brown, MD, in the ED performs a medical screening examination and determines that Smith has an emergency medical condition. Brown decides care should be provided by the on-call surgeon, Gina House, MD. After describing the situation to her, House says: "This is an excellent situation for my physician assistant [PA] to come in and provide the care." Does EMTALA allow for the PA to help provide on-call care for patient Smith? In place of House? What should the ED physician do?

Answer: For the longest time, the answers from the Centers for Medicare & Medicaid Services (CMS) to these questions were "no," "no," and "tell the on-call physician that his or her PA cannot provide EMTALA-required, on-call services," says **Alan Steinberg**, Esq., of the Pittsburgh law firm Horty Springer. Now, he says, to a limited degree, based upon what appears to be CMS' desire to be more flexible with EMTALA and call, CMS is allowing a PA to provide such care. And that approach is quite new for CMS, Steinberg says.

CMS officials' long-held position was rooted in the EMTALA statute itself, Steinberg explains. The statute states that physicians must provide the on-call services. Because of this assertion, CMS officials thought they were bound to the limited statutory language itself, i.e., "physicians." However, says Steinberg, in the preamble to the 2003 EMTALA regulations, CMS officials took a rather striking new position concerning the use of nonphysician practitioners in on-call services: "We agree that there may be circumstances in which a physician assistant may be the appropriate practitioner to respond to a call from an emergency department or other hospital department that is providing screening or stabilization mandated by EMTALA. However, any decision as to whether to respond in person or direct the physician assistant to respond should be made by the responsible on-call physician, based on the individual's medical needs and the capabilities of the hospital, and would, of course, be appropriate only if it is consistent with applicable State scope of practice laws and hospital bylaws, rules, and regulations."[1]

CMS provided similar information in the revised EMTALA interpretive guidelines released in May 2004,[2] notes Steinberg. In addition, in the guidelines, CMS expanded the list of available nonphysician practitioners to include "physician assistant, nurse practitioner, orthopedic tech."

This new language is broad enough to capture two possible situations involving call and nonphysician practitioners, Steinberg says. The first is when the PA cares for and prepares the patient with full anticipation that the on-call physician will be in to complete the care. The second situation is when the PA provides all of the on-call care needed, if appropriate.

Each hospital's board of directors should approve the use of nonphysician practitioners who can provide such on-call services, and the particular category or categories of such practitioners, Steinberg advises. Of course, he adds, the nonphysician practitioner can provide care only within the limit of his or her state licensing rules and hospital scope of practice. Written protocols also may be worth developing, he says.

It is Steinberg's understanding from the language of the preamble and the guidelines that the on-call physician must be contacted in every instance so that the physician can decide, based upon the actual patient situation and circumstances, whether the physician or nonphysician practitioner should respond to the call. This contact means that there cannot be a standing order by which the surgeon's PA is to be called directly for situations "1 through 10," without first contacting the on-call physician, he says.

Steinberg emphasizes that all hospitals, medical staff leadership, and physicians need to be thoughtful and careful in their use of nonphysician practitioners in on-call services. If CMS officials think that physicians and

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Source

For more information on the Emergency Medical Treatment and Labor act, contact:

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hospitals are abusing this new, measured approach, it would not be a surprise if CMS reverted to its prior policy position, he warns. The new position actually is not cited in the newly revised regulations, he points out. The position is stated in the preamble and in the guidelines, both of which are simply guidance materials that do not bind CMS. The guidelines can be unilaterally changed at any time by CMS.

Steinberg adds this final thought: The guidelines make it clear that it is the medical screening examiner on-site who determines whether the on-call physician must come to the hospital. As stated in the guidelines: "A determination as to whether the on call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on call physician must come to the emergency department."[2]

While this quotation concerns physicians, CMS has made it clear in the past that it sees the on-site screening practitioner, whomever that might be, as the person who determines whether the physician must come to the hospital to provide on-call services, Steinberg says. Accordingly, the hospital's on-site screening practitioner would have the ultimate authority as to whether the physician has to come in or whether a nonphysician practitioner would be sufficient, he says.

References

1. 68 *Fed Reg* 53,222 (Sept. 9, 2003). Codified at 42 *Code of Federal Regulations* Parts 413, 482, and 489.
2. U.S. Department of Health and Human Services. *Medicare, Medicaid State Operations Manual,* Appendix V, Interpretative Guidelines and Investigative Procedures for Responsibilities of Medicare Participating Hospitals in Emergency Cases. Washington, DC; 2004. ■

NEWS BRIEFS

ACEP proposes plan to increase ED capacity

David C. Seaberg, MD, a board member of the American College of Emergency Physicians (ACEP), has proposed a 10-point plan to increase capacity, alleviate overcrowding, and improve surge capacity in the nation's emergency departments (ED).

Among other proposals, the plan suggests changing the way hospitals are funded to allow for inpatient and intensive care unit surge capacity; requiring hospitals severely affected by a natural or other disaster to postpone elective admissions until the crisis abates, while compensating them for lost revenue; and providing federal and state funding to compensate hospitals and EDs for the unreimbursed costs of meeting their critical public health and safety net roles. His plan was part of Feb. 8 testimony before a House Committee on Homeland Security hearing on pandemic flu preparedness.

"Without sufficient warning, emergency physicians and nurses would be unprepared to place arriving avian flu patients in isolation until it was too late," Seaberg told the hearing, titled "Protecting the Homeland: Fighting Pandemic Flu From the Front Lines." "Since most hospitals only have one isolation unit, there would be no way to isolate the next avian flu patient seeking emergency care," he said.

(Editor's note: To access the entire 10-point plan, go to www.acep.org. Under "Breaking News, click: "ACEP Presents 10-Point Plan for Avoiding Mass Casualties in Pandemic Flu, Other Disasters.") ■

CDC recommends free flu vaccines for staff

The Centers for Disease Control and Prevention (CDC) has released new guidance aimed at increasing flu vaccination among health care workers.

Developed by two CDC advisory committees, the guidance recommends facilities offer flu vaccine annually in the workplace to all eligible personnel at no cost; use reminders, education and other proven strategies to improve vaccination coverage; and obtain a signed form from staff who decline vaccination for nonmedical reasons to help in monitoring and addressing barriers to

vaccination. The guidance also recommends using flu vaccination coverage rates as one measure of a patient safety quality program. The CDC has recommended that all health care workers be vaccinated annually against the flu since 1984, but only about 40% do. ▼

Certification offered in disaster medicine

The American Board of Physician Specialties (ABPS) in Atlanta has established the American Board of Disaster Medicine, making available for the first time a board certification in disaster medicine. The board will be accepting applications from physicians of various specialties, including emergency medicine, starting May 1, 2006, and plans to administer the first examination this fall.

The need for such a certification was underscored by the recent hurricane disasters, notes **Maurice Ramirez**, MD, chairman of the new board. "There is a hesitance on the part of staff physicians to volunteer when a disaster is headed their way because they are afraid they will be pressed into duties they are not familiar with," he explains. "One cardiovascular surgeon was pressed into urgent care and fast-track services in the wake of Rita and had to totally rely on a physician's assistant," he says. "He said he would never be back."

David McCann, MD, a member of the board, says over the past two years, the board has amassed a core body of knowledge and skill sets the applicants will have to demonstrate. "How they get that training will be up to them, but they must be board-certified already in one of the specialties of medicine: emergency medicine, family medicine, surgery, pediatrics, pathology, and so forth," he says. "Disasters require a multispecialty approach."

The required skill sets will include basic and advanced disaster life support or Disaster Medical Assistance Team (DMAT)-equivalent training, says Ramirez. Also, CME requirements in disaster should include communication, planning, interaction with other agencies, psychology of refugees, refugee status and care, public health, all weapons of mass destruction, and natural disasters, he notes. "These will be prerequisites for the certification test," he says. "Without this knowledge base, you won't be able to pass our exam."

[Editor's note: For more information on the American Board of Disaster Medicine, contact: The American Board of Physician Specialties, 2296 Henderson Mill Road, Suite 206, Atlanta, GA 30345. Phone: (770) 939-8555. Fax: (770) 939-8559.] ■

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CE/CME *questions*

31. According to Deb Richey, MPA, director of emergency services at Parkview Hospital, ED managers should review their department's leave without being seen (LWBS) statistics:
A. once a month.
B. quarterly.
C. twice a year.
D. once a year.

32. According to Gregory Henry, MD, FACEP, risk management consultant with Emergency Physicians Medical Group, the items most vulnerable to theft in the ED are those that:
A. are not labeled with the owner's identity.
B. can fit inside of a pocket.
C. are considered valuable.
D. are left in the staff lounge.

33. According to Helen Berghoef, RN, MSN, an ED information system can provide a return on investment as high as:
A. $20 per patient.
B. $30 per patient.
C. $40 per patient.
D. $50 per patient.

34. According to Jennifer Arguilla, RN, BSN, MBA/HCM, LNC, being able to transfer patients to a primary care center down the hall does *not* change:
A. where the screening physician is located.
B. where fast-track patients are treated.
C. the protocols followed by the triage nurse.
D. the patient load in the ED.

35. According to Elsburgh Clarke, MD, and James Sowards, MD, which of these strategies was a key to dramatic improvements in patient satisfaction?
A. Having a physician in triage.
B. Reviewing patient satisfaction ratings during staff meetings.
C. Offering financial incentives to physicians for improvements in patient satisfaction.
D. All of the above

36. According to Alan Steinberg, Esq., the Centers for Medicare & Medicaid Services says that any decision as to whether the on-call physician should respond in person to a call from an ED or direct the physician assistant (PA) to respond should be made by:
A. the ED manager.
B. the on-call physician.
C. the PA.
D. the medical director.

Answers: 31. A; 32. B; 33. D; 34. C; 35. D; 36. B.

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

CE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Explain** developments in the regulatory arena and how they apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■