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The monthly update on Emergency Department Management

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IN THIS ISSUE

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Organizations join forces against Joint Commission medication rules

Overburdened EDs differ from other hospital departments, they argue

On May 30, 2006, the American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM), and the Emergency Nurses Association (ENA) did something they had never done before: They wrote a letter in concert to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) expressing their concerns about an issue affecting emergency medicine practitioners. The issue was the Joint Commission's new standard (MM 4.10), which requires pharmacist review of orders prior to administration, and National Patient Safety Goal (NPSG) No. 8: "Accurately and completely reconcile medications across the continuum of care." Both went into effect in January 2006.

"It is my understanding that the Joint Commission wants every medication given to patients in the ED to be reviewed by a pharmacist unless the urgency of giving is such [that it is not practical]," says **Richard Bukata**, MD, medical director of The Center for Medical Education in Creamery, PA. In terms of NPSG No. 8, a staff member, such as a nurse, is required to write down every medication the patient is taking, he says. **(For the Joint Commission's interpretation of what compliance to MM 4.10 and NPSG No. 8 entails, see the story on p 88.)**

"They want the ED to do this on everyone who may get a drug," says Bukata. "We would be disproportionately burdened." In addition, he says, medication administration in the ED should not require first-dose review by a pharmacist "since ED physicians are licensed independent practitioners, so we are already meeting the standard."

Executive Summary

Leading emergency medicine organizations debate new standards on prescription review and medication reconciliation with the Joint Commission on Accreditation of Healthcare Organizations.

- Every medication given to patients in the ED must be reviewed by a pharmacist unless there is an urgent need to give the drug.
- All patients who present to the ED must have a full reconciliation of all of their medications.
- If the patient or family members cannot complete medication reconciliation, their primary care physician or pharmacy must be contacted.

(A complete list of the ACEP/AAEM/ENA objections and their joint recommendations for alternatives are listed in the sidebar on p. 87.)

Tom Scaletta, MD, FAAEM, president of AAEM, says, "We are not trying to play a game. We think this is a losing hand." He says the ED is a unique environment, in that you have the patients, the doctors, and the nurses all together during the duration of treatment.

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"It's not like a medical ward where the doc walks in and out, and the nurse is not sure what he wrote or said," Scaletta continues. "You have two professionals there with the patient and family, who generally know what the patient is allergic to, what they can tolerate, and so forth."

Denise King, RN, MS, CEN, 2006 secretary/treasurer of the ENA and point person on the joint ACEP/AAEM/ENA task force for medication standards, agrees. "The Joint Commission had very little data documenting that there was indeed a problem with ED physicians ordering wrong doses and so forth," she says. "In fact, there is *no* data to support that this drastic action is needed."

Bukata says, "I've reviewed the literature and basically concluded using data from the [U.S. Pharmacopeia and National Formulary] that one in 10,000 ED patients *may* be harmed by a meds-related misadventure."

But such statistics can be deceiving, responds **Robert Wise**, MD, the Joint Commission's vice president, Division of Standards and Survey Methods. "It's very difficult to figure out how many problems of medication administration occur, because once you give the meds the patients often leave," he says. "Many pharmacists would disagree with their assertions."

However, he adds, Scaletta brings up important points that in certain situations, if there were not other exceptions, providers could inadvertently make things worse. "In the ED, [the potential safety benefits] need to be clearly worth the increased problem of access this may involve," Wise says.

Standards not practical

While sharing the Joint Commission's concerns for patient safety, the three organizations say the new standards do not reflect the reality of life in the ED.

Scaletta says, "No system is perfect, but adding a third professional also slows things down. The recommendation means the doctor would write the order, the nurse would go to the pharmacy, get it approved, and then unlock the Pyxis drawer to get the drug and give it to the patient."

These additional steps are unnecessary, he asserts, because the ED "uses a pretty finite group" of medications with which the staff is very familiar. "When we do use something unusual, it's often because we discussed it with a specialist — and we may actually get it from the pharmacy because it's not in our Pyxis — so the pharmacy *is* involved," Scaletta notes. "And if it's something super-dangerous, like tPA [tissue plasminogen activator], protocols are in place, so we have taken precautions we think are adequate."

King says, "When you consider the meds we routinely administer, there are so many that have low risk.

Having a pharmacist review the order every time you give Tylenol is ridiculous." In addition, she notes, many hospitals do not have 24/7 pharmacy coverage. "Where do you get the [review] people?" she poses.

In terms of medication reconciliation, King says the task force asked the Joint Commission for clarification. The comment that came back was that it is their expectation that every patient who presents would have full reconciliation of all meds, and if the patient couldn't provide the information, the ED should contact the patient's pharmacy or family physician to complete it, she reports. "When you consider the volume of patients who come in to the ED, I question the benefit it would provide," King says.

In addition, she says, during the assessment the patient is routinely asked if they are allergic to any drugs. "We *do* make an effort to determine such issues, and these are documented on the ED record," says King. "We really feel this does not help achieve our ultimate goal of efficient, safe, quality patient care in the ED."

Bukata thinks the Joint Commission has gone overboard. "This patient safety business is consuming everyone," he asserts. "I think it's an important issue, but personally it does not in any way rival the importance of providing patients with solid, evidence-based medicine."

Wise disagrees. "It may be accurate that they give only one or two doses of meds in the ED, and they usually have few side effects, but the patient is coming to the ED for all kinds reasons that *may* have to do with the side effects of what the patient is already on," he says.

" . . . These two requirements mandated by the JCAHO are unprecedented in their impact on the day-to-day operation of hospitals and, in particular, their EDs . . ."

— ACEP/AAEM/ENA letter to the Joint Commission, May 30, 2006

At present, the organizations are involved in an ongoing dialogue with the Joint Commission. They already have had one conference call, and a second was scheduled for late July.

King says JCAHO has received multiple inquiries from organizations around the country, asking how these standards would look in the ED. "They want to know if it applies there, and how JCAHO will be surveying," she explains. "It's caused a lot of anxiety."

Because of the volume of complaints, says King, a workgroup has been assembled to review the requirements and try to determine what needs to be done. In addition to the three emergency organizations, the workgroup includes representatives from the areas of pharmacy, radiology, and hospital administration, she says.

Scalettta says, "We're not sure we're going to be able to change things, but we think they are listening. We'll see what happens."

In the meantime, what advice does he have for ED managers? "If you are going to push back against this, you should do it under the representation of your professional organizations," he advises.

Often, Scalletta adds, hospitals will use as consultants individuals who formerly worked with the Joint Commission. They can advise ED managers as to what will and will not be acceptable when you are not sure if you will be in compliance. ■

Sources

For more information on the medication reconciliation standard and National Patient Safety Goal No. 8, contact:

- **Richard Bukata**, MD, Medical Director, The Center for Medical Education, P.O. Box 600, Creamery, PA 19340.
- **Denise King**, RN, MS, CEN, 2006 Secretary/Treasurer, Emergency Nurses Association, 915 Lee St., Des Plaines, IL 60016-6569. Phone: (951) 688-2211, ext. 2430.
- **Tom Scaletta**, MD, FAAEM, President, American Academy of Emergency Medicine, 555 E. Wells St., Suite 1100, Milwaukee, WI 53202-3823. Phone: (630) 527-5025.
- **Robert Wise**, MD, Vice President, Division of Standards and Survey Methods, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000.

ACEP, AAEM, ENA outline their objections

In a May 30, 2006, letter under the letterheads of all three organizations, the American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM), and the Emergency Nurses Association (ENA) voiced their objections to National Patient Safety Goal No. 8 from the Joint Commission on Accreditation of Healthcare Organizations. That goal calls for "accurate and complete" reconciliation of medications across the continuum of care. In the letter, they specifically enumerated their objections to "the compilation of a drug list for essentially each ED patient and the dissemination of that list to either the admitting physician or the primary care physician if the patient is discharged" as follows:

• EDs would be disproportionately burdened with this task because of the large number of patients seen

in the ED compared to other areas of the hospital.

• For the vast majority of patients, the compilation of a comprehensive medication list will not be germane to the patient's visit in the ED.

• Most medications administered in the ED are given on a one- or two-time basis and, as such, drug interactions with prior medications are highly unlikely.

• ED medications are fundamentally not danger-prone drugs (mostly pain medications, antibiotics, and gastrointestinal medications) and those that are (thrombolytics, blood, etc.) are administered using tight protocols.

• Primary care physicians are the appropriate physicians to determine all of the drugs that their patients are taking, and they are in the best position to modify medications based on their knowledge of the patient.

In the letter, the organizations also stated their objections to standard MM 4.10, which requires pharmacist review of orders prior to administration. They conclude their letter with the following alternative recommendations:

• Medication administration in the ED not require first-dose review by a pharmacist because a licensed independent practitioner (the emergency physician who ordered the drug based on his/her assessment of the patient) is in attendance. They support that a pharmacist be readily available (by phone or otherwise) for consultation should it be sought by emergency physicians and nurses.

• Reconciliation of medication lists should be limited to patients admitted to the hospital and conducted by inpatient personnel. ■

Source

For more information on compliance with National Patient Safety Goal No. 8 and the medication reconciliation standard (MM 4.10), contact:

- **Mary McNeily**, Associate Director of Standards Interpretation, Standards Interpretation Group, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5900.

Here's how JCAHO defines compliance

Since there are no guarantees as to when — or if — the objections of emergency medicine groups to standard MM 4.10 from the Joint Commission on Accreditation of Healthcare Organizations will result in any modifications, it's critical for ED managers to know exactly what the Joint Commission is looking for when it comes to compliance with the standard.

Mary McNeily, associate director of standards interpretation, offers the following clarification: "MM 4.10 . . . requires that before dispensing, removal from floor stock, or removal from an automated storage and distribution device, a pharmacist reviews all prescription or medication orders unless an LIP [licensed independent practitioner] controls the ordering, preparation, and administration of the medication, or in urgent situations, when the resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status (for example, new onset of nausea). The standards regarding pharmacist review of medication orders . . . apply whether the patient is located in the emergency department, PACU [post-anesthesia care unit], or elsewhere."

There are two exceptions, she notes, which are *not* based on the location of the patient: circumstances in which the LIP maintains control of the medication or when the circumstances are urgent or emergent, and harm would come to the patient by waiting for a pharmacist to review the medication.

The purpose of the exception when physicians control the dispensing and administration is to allow physicians to accept full responsibility for the dispensing, preparation, and administration of medications under circumstances in which delay could harm the patient, McNeily explains. Physician control means that a physician (or other licensed independent practitioner) performs the function directly or is physically present at the bedside to direct the activity.

The precise definition of LIP control has been a subject of much discussion, McNeily notes, and the current interpretation is that "the LIP must remain with the patient, at the bedside, during the administration of the medication."

However, she says, many organizations have exempted areas such as EDs, PACUs, intensive care units (ICUs), neonatal ICUs, and labor and delivery departments from the requirements of MM.4.10 for pharmacist review, based on the LIP being present in the ED or other area. "This practice is *not* in compliance with the standards," McNeily says. The LIP must actually be performing the function or at the bedside to direct if for the LIP exemption to be applicable."

Tom Scaletta, MD, FAAEM, president of the American Academy of Emergency Medicine, asserts that the Joint Commission has left a small "escape hatch" in its standards. "They said that time-sensitive meds are not covered," he says. "You could expand your interpretation and say that *all* meds in the ED — even a tetanus shot — are time-sensitive. It really

depends on how aggressive you want to be with that interpretation."

McNeily disagrees. "Many organizations have classified entire units as exempt from pharmacist review based on urgency," she says. "This practice is not in compliance with the standards." The exemption for urgency, she explains, must be applied to each individual circumstance in which the classification of urgency is based on a judgment that waiting for pharmacist review would result in harm to the patient. ■

JCAHO establishes new infection control standard

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has approved an infection control standard that requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers, and licensed independent practitioners with close patient contact. The standard will be effective Jan. 1, 2007, for the critical access hospital and hospital programs.

The Joint Commission developed the standard in response to recommendations by the Centers for Disease Control and Prevention (CDC) making the reduction of influenza transmission from health care professionals to patients a top priority in the United States. While the CDC has urged annual influenza vaccination for health care workers since 1981, a *Morbidity and Mortality Weekly Report*[1] published by the CDC earlier this year calls for stronger steps to increase influenza vaccination of health care workers. Despite the recommendations, health care-associated transmission of influenza has been documented among many patient populations in a variety of clinical settings, and infections have been linked epidemiologically to unvaccinated health care workers. Typically, fewer than 40% of health care workers are immunized each year, according to the CDC.

The new Joint Commission standard requires organizations to:

- establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- provide access to influenza vaccinations on-site;
- educate staff and licensed independent practitioners about: flu vaccination; nonvaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission, and potential impact of influenza;
- annually evaluate vaccination rates and reasons for nonparticipation in the organization's immunization program;
- implement enhancements to the program to increase participation. (The entire standard is published on pages 10 and 11 of the June 2006 edition of the Joint Commission's publication *"Perspectives,"* which is distributed to administrators at all accredited facilities.)

EDs feel impact

The standard is directed at health care organizations in general. However, "while the ED is not directly targeted, obviously a lot of patients with influenza present at the ED, so hopefully this will be an important patient safety and employee safety initiative," says **Louise Kuhny**, RN, MPH, CIC, associate director of standards interpretation for the Joint Commission.

Of the five elements of performance outlined above, perhaps the greatest challenge for EDs is providing access to vaccinations. "The ED is located far away from other departments, and if vaccinations are not convenient, people will not get them," notes Kuhny, who says the literature indicates that simply increasing the distance to the vaccination point decreases the rate of participation. "One of the recommendations from the CDC is to use proven strategies like mobile carts," she says. "They also recommend providing access during all shifts."

Education is very important, adds Kuhny, because "there are still a lot of myths out there about vaccination." One of the biggest, she says, is that "people — even health care workers — think they can get the flu from the vaccine, and that's not possible." Another myth that Kuhny says even some health care workers believe is that women who are pregnant should not get the flu shot. "In fact, the opposite is true: It's *recommended* during pregnancy," she responds.

Buy-in by leaders can strengthen the education process, Kuhny continues. "Some facilities even post pictures of leaders who get the vaccine," she shares.

Finally, she says, the elements dealing with annual evaluation and enhancing your program offer the opportunity for a "built-in" performance improvement project. "Every year you can look at why you've not

Source

For more information on the influenza vaccination standard, contact:

- **Louise Kuhny**, RN, MPH, CIC, Associate Director, Standards Interpretation, Joint Commission on the Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5900.

been able to achieve your goal, and based on what you find, you can develop the needed enhancements," she concludes.

Reference

1. Centers for Disease Control and Prevention. Influenza vaccination of health-care personnel: Recommendation of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2006; 55:1. ■

Computers aid EDs in violence screening

Staff, patients discuss sensitive issue

Computer screening may increase the odds that a woman at risk for domestic violence will talk to a health care professional in the ED, according to a recent article in the *Archives of Internal Medicine.*[1] The article's authors say that such screenings help ease the discomfort that patients and ED staff members feel when discussing such matters.

"Women are willing to speak to health care providers, but they need to be *asked,*" says **Karin V. Rhodes**, MD, lead author of the article, director of healthcare policy research in the Department of Emergency Medicine at the University of Pennsylvania and an emergency physician at the Hospital of the University of Pennsylvania, both in Philadelphia. "They are reluctant to initiate the conversation, but if they are asked in the context of discussing physical and emotional health issues, they are more likely to tell their story — especially if they are asked in a confidential, concerned, and nonjudgmental fashion."

The study was conducted in two EDs: the University of Chicago Hospital ED (where Rhodes worked at the time), an academic urban center, and Lutheran General Hospital, which is in the suburbs. A total of 903 women who visited the EDs between June 2001 and December 2002 participated in the study and were randomly selected to complete the computer-based risk assessment or receive the usual care. Those who participated took the screening alone in a private room off the ED waiting room.

Executive Summary

You may never get 100% of domestic violence victims to confide in you, but with the proper tools and approach, you can increase the number of victims and at-risk patients your ED identifies.

- Incorporate computer-based risk assessment as part of a screening involving of general physical and emotional health issues.
- Be sure to have your screening conducted in private area where no one but the patients can see their answers.
- Ask your follow-up questions in a confidential, concerned, and nonjudgmental fashion.

Sources/Resource

For more information on screening for domestic violence in the ED, contact:

- **Karin V. Rhodes**, MD, Hospital of the University of Pennsylvania, 3400 Spruce St., Philadelphia, PA 19104. Phone: (215) 421-1036.
- **Sam Shartar**, RN, CEN, Nurse Manager, Emergency Department, Emory University Hospital, Atlanta. E-mail: samuel.shartar@emoryhealthcare.org.

For more information about a triage screening program that can include questions about domestic violence, contact:

- **Cerner Corp**., 2800 Rockcreek Parkway, Kansas City, MO. Phone: (816) 221-1024. Fax: (816) 474-1742. Web: www.cerner.com.

Similar results

The urban center saw mostly African American patients, while the suburban ED saw mainly Caucasian, upper middle-class patients. "Interestingly enough, although the two EDs were quite different, the rates were not that dissimilar," says Rhodes. "We found that 26% of the surveyed patients at the urban ED and 21% of those in the suburban ED indicated they were at risk for domestic violence."

The study is interesting in terms of the impact of a confidential domestic violence screening, says **Sam Shartar**, RN, CEN, ED nurse manager at Emory University Hospital in Atlanta. "I think the authors correctly note that it does overcome some reluctance," Shartar says.

Shartar says his ED's triage, as well as that of Emory Crawford Long Hospital, uses screening questions from an electronic medical record (Cerner Corp., Kansas City, MO. **See resource box, above.)**

If an ED staffer is suspicious there may have been violence involved in a patient's injury, they can include the screening question, "Have you been hit, kicked, or abused in any way?" The provider then can manually direct a special icon to appear on the system's tracking

Sample Domestic Violence Screening Questions

Current emotional abuse:
- Does your partner try to control your life?
- Does your partner keep you away from family and friends?
- Does your partner insult you and put you down?
- Are you afraid to disagree with your partner?

Current physical abuse:
- Has your partner ever physically hurt you?
- If yes, is that a current partner within the last year?
- Have you ever been made to have sex when you didn't want to? Has that happened with your current partner?

Potential abuse:
- Do you feel threatened by a current or former partner?

[Editor's note: The screening program is supported by the National Family Violence Prevention Fund, the Chicago Community Trust, and the Agency for Healthcare Research and Quality. The program, National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings, *can be edited and modified. It can be downloaded free of charge from the Family Violence Prevention Fund's (FVPF) web site at endabuse.org/programs/display.php3?DocID=206. The one-page chart that recommends practice by setting (and which has the ED as a highlighted setting) is on p. 33. The FVPF's National Health Resource Center on Domestic Violence includes an additional list of materials at fvpfstore.stores.yahoo.net/healpractool.html. You can view a "screen to end abuse" video at: fvpfstore.stores.yahoo.net/trainingvideos.htm, and view safety cards at: fvpfstore.stores.yahoo.net/safetycards1.html. Copies of the video or safety cards are also free of charge.]* ■

board to identify the patient as being at risk.

"When we see the icon, we do a social services consult," says Shartar. "If appropriate, we will contact law enforcement."

Lowering the threshold

Rhodes says computer screening "lowers the threshold" for providers as well "when it functions as your doctor/patient communication source." In the study she conducted, the questions were asked in the context of an overall assessment: physical, lifestyle, and emotional.

"We told the patients that all of these things influenced their health, and that the doctor would see a copy of report," Rhodes says. "The fact they were willing to disclose such information means they want to share it, and if the doctor gets a copy of the report that indicates a risk factor, this gives them an opening to discuss the topic." **(These questions not only show whether domestic abuse has occurred, but also if the patient is *at risk* of potential abuse. See a sampling of the questions, at left.)**

What can ED managers take from the study? "I think that as we move more and more to an EMR [electronic medical record] that allows patients to confidentially self-disclose sensitive risk factors such as domestic violence and depression, the providers will be more likely to address the issue if the patient discloses it, and they can then focus on assessing risk and referring the patient," says Rhodes.

It might be even better to flag those charts for the social workers, she says. "The ED is a busy setting, and you are still going to miss some patients," Rhodes says. ED managers need to set up a system that prevents such people from falling through the cracks, she says.

"This should be easier to do as we set up EMRs," Rhodes notes. "You should include a screening for domestic violence for both men and women."

Confidentiality remains critical, Rhodes emphasizes. "If the patient comes in with a partner, any screening should be done in a way not to alert the partner that this person might be telling," she advises. "You can do it during bedside registration — when all patients go back by themselves — or you can give the patient a [computerized] tablet."

Reference

1. Rhodes KV, Drum M, Anliker E, et al. Lowering the threshold for discussions of domestic violence: A randomized controlled trial of computer screening. *Arch Intern Med* 2006; 166:1,107-1,114. ■

Shortage of specialists worsens, ACEP says

75% of ED directors report inadequate coverage

Almost three-quarters of ED medical directors responding to a survey reported inadequate on-call specialist coverage, compared with two-thirds in 2004, according to a new report released by the American College of Emergency Physicians (ACEP).

The new survey was conducted from August 2005

Executive Summary

Despite discouraging statistics, there are strategies that may help ensure coverage by specialty physicians.

- Specialty physician management companies, which guarantee payment to the physicians, have been successful in some regions.
- In some areas, "traumatologist" and "surgicalist" groups are being formed, which follow the hospitalist model for ensuring coverage.
- Coordinate with emergency medical services citywide to deliver certain types of patients to certain types of hospitals.

to November 2005. It was released by ACEP with researchers from Johns Hopkins University and funded by a grant from the Robert Wood Johnson Foundation. The top five shortages were among the specialties of orthopedics; plastic surgery; neurosurgery; ear, nose, and throat; and hand surgery. A total of 73% of ED directors reported problems with inadequate specialist coverage, compared with 67% in the 2004 survey.

"There are several factors involved," says **Angela Gardner**, MD, FACEP, a board member of ACEP and a professor of emergency medicine at the University of Texas Medical Branch in Galveston. The most recent problem occurred with interpretation of Emergency Medical Treatment and Labor Act (EMTALA) guidelines, Gardner says. "EMTALA had previously been interpreted to mean that hospitals had an obligation to provide on-call physicians," she says. "But CMS [the Centers for Medicare & Medicaid Services] clarified that interpretation, saying they never meant the hospitals had to provide on-call physicians — just that they had to provide information about who was on call and when."

This clarification specifically allowed for physicians to be on call at more than one facility, Gardner explains. Thus, if there is only one ear, nose, and throat physician in town, he or she is not required to be on-call 24/7 at a given facility, she says.

In addition, she says, there simply aren't enough specialists available to answer the calls. "Especially in big cities, in order to cover call obligations, groups were assigning one person to answer *all* calls," Gardner notes. "That one person may be in surgery for four or five hours; meanwhile, new patients are waiting in the ED, not getting admitted, and things back up."

Not all ED managers believe things will get better. "I have only bad news," laments **Todd B. Taylor**, MD, FACEP, who co-authored a paper on the topic in *Annals of Emergency Medicine*[1] and is a board member of ACEP.

In Taylor's article, three strategies were recommended:

- Pay physicians by stipend.
- Implement fee-for-service programs.
- Establish regional calls panels.

But, says Taylor, none of these has truly been successful. "As it turns out, if you don't address the liability issue, almost nothing else matters," he says. "It comes to the point where almost no amount of money is enough."

Taylor compares on-call specialists to bomb technicians. "How much will they take to defuse a bomb if you do not give them protection?" he poses. "You can give money and incentives, but one of two things happens: One, it's not enough because of the risk; or two, the hospitals don't have enough money."

Gardner agrees. "I've seen a number of strategies used across the country," she says. "But one that has *not* been very successful is having the hospital pay people to take calls. It doesn't solve the problem because physicians are still reluctant to come in, and it causes resentment among other members of the medical staff."

Try this strategy

One strategy that has worked fairly well, Gardner says, is the on-call specialty physician management company model, which guarantees payment to the physicians. She points to Emergency and Acute Care Medical Corp. in Rancho Santa Fe, CA, as an example of this model. **(For more on such companies and the call panel issue, see "Situation critical for call panels: Is there a cure?" *ED Management,* August 2004, p. 92.)** "Unfortunately, they are not big enough yet to solve the problem across the nation, and there have not been a lot of companies getting on the bandwagon." says Gardner.

A new concept is evolving which is similar to the hospitalist model, she adds. "We're beginning to hear about people who have formed 'traumatologist' or 'surgicalist' groups — specialists whose only job is to provide acute care," says Gardner. This could be an answer, she says. "It certainly has worked for internists to get their call covered with hospitalists."

One solution that could work on a citywide basis is to coordinate emergency medical services to deliver certain types of patients to certain types of hospitals, Gardner says. "Trauma patients would be directed to trauma centers, cardiac patients to cardiac facilities, and so on," she explains. Another possibility that sounds good is a regionally directed ER call, Gardner adds. "If the region is large enough, you could designate a person to be on call for a certain region for everyone," she says. "If you had a regional on-call list, a patient could be transferred to the on-call person at another facility."

Despite these potential solutions, Gardner admits that "it will get worse before it gets better." Taylor is even less sanguine. In Arizona, the governor vetoed a

Sources

For more information on ED call panel strategies, contact:

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- **Todd B. Taylor,** MD, FACEP, Board of Directors, American College of Emergency Physicians, 2714 Westwood Ave., Nashville, TN 37212-5218. Phone: (480) 731-4665. E-mail: ttaylor@acep.org.

bill that Taylor had worked on for years. The bill would have raised the burden of proof from "a preponderance of evidence" to "clear and convincing evidence" for civil claims against physicians and other health care providers who render emergency services required under EMTALA or following a disaster.

Taylor says he chose to leave clinical medicine and Arizona. "I've had it," he says. "And I'm not alone; four other emergency physicians I know are doing this in the wake of the veto."

Reference

1. Johnson LA, Taylor TB, Lev R. The emergency department on-call backup crisis: Finding remedies for a serious public health problem. *Ann Emerg Med* May 2001; 37:495-499. ■

Field hospital model aids New Orleans ED

Pre-Katrina strategies fall short, only 2 EDs open

You might think that with the population of New Orleans greatly reduced following the devastation of Hurricane Katrina, the city's EDs would find the going a bit easier. However, with only two EDs up and running, the exact opposite is true — and it's taken all the creativity at the disposal of their ED managers to stay on top of things.

At Touro Infirmary, a nonprofit community-based facility, the ED team at first benefited from governmental assistance that included a field hospital model, and once that help departed, the ED manager adopted that model herself to get through a challenging Mardi Gras season.

"We are a 17-bed ED with three overflow beds," relates **Helen Ruiz**, RN, director of outpatient services, who was the ED director from spring 2004 until June 2006. "Before the storm, Charity Hospital [which has not yet reopened its ED] took all the major trauma cases."

Touro has a fast-track system, created about three years ago, which operates as a separate department. Prior to the storm, annual volume was 25,000 patients for both departments.

DMAT is invaluable

Following Katrina, Touro had to close Aug. 29, 2005, and was evacuated Sept. 1, Ruiz says. "We were on the roof for 48 hours before the choppers came," Ruiz recalls. "We reopened as the first hospital in Orleans Parish on Sept. 28, after a dress rehearsal on the 27th."

This opening was accomplished, she relates, "with the major help of a huge DMAT team [Disaster Medical Assistance Team] and the 82nd Airborne." The 82nd Airborne arrived before the hospital reopened, asked what they needed, and within 24 hours had provided potable water, electricity, hand washing stations, and medical supplies.

The DMAT team stayed until December 2005. "They would see 100 patients a day in their own tent, which included an ICU," Ruiz recalls. "Because of that, all we would get into the ED was about 35 patients a day."

The size of the DMAT team gradually was reduced, and in January 2006, Touro was on its own. "Our volume was almost exactly what it was pre-storm, and we ramped up quickly, but our ancillaries [dietary, housekeeping, maintenance] were still weak," says Ruiz. This weakness was due to the fact there were few places for them to live or eat, so many employees had not returned to the area, she says.

Some the ED team reverted to "the old ways," in Ruiz' words. "We had clinical people doing stuff that

Executive Summary

Unusual circumstances, dramatically increased patient demand, and staffing shortages call for creative remedies. Here are a few strategies ED managers might consider in such circumstances:

- If there are ancillary service shortages, ask clinical staff members to perform nonclinical duties, such as cleaning beds.
- If neighboring facilities have closed, seek out their staff members to help offset your own shortages.
- Set up triage tents outside your facility to keep the demand inside at a more manageable level.

was nonclinical." The few ancillaries they did have made the ED a priority, she says, "but we had nurses cleaning beds."

Many people, including patients, ate military Meals Ready to Eat. "We used paper 'everything' so we did not have to have dishwashers," Ruiz adds.

The department was given portable hand washing stations and disposable sheets. "It was almost like field medicine," Ruiz observes. "You just improvised."

Then came Mardi Gras (Feb. 28), when ED volume typically doubles. That's when her experience with DMAT came in handy, says Ruiz. "We set up two huge tents in the streets for triage, with 15 army cots and a draw station," she recalls. "We were able to keep volume inside the hospital normal, since most of what we do during Mardi Gras — intoxication, sprained ankles, lacerations — we did from the tents."

With eight area hospitals closed, Ruiz was able to pull ED nurses from those facilities. "We had applications waiting," she says.

Second ED opens

Meanwhile, on Feb. 14 — just two weeks before Mardi Gras — the ED at Tulane University Hospital and Clinic opened. With such a short lead time, things did not go quite as well.

"We were overwhelmed with patients as opposed to before, with the closing of the other facilities," says **Bryan Dean**, RN, clinical manager of the ED. "Not only that, we're seeing much more high-acuity patients." One of the problems is that before the storm Tulane had a fast-track area [in the ED] but because the hospital still is under construction, another unit farther away — abdominal transplant — is being used for fast track.

"We've redesigned the ED better to facilitate flow, but we're so inundated we can't handle it all," says Dean. "We've made triage larger. All our equipment is new and approved and easier to use, and has been put in areas that are more user-friendly."

Tulane also has increased security and initiated a medical screening room instead of urgent care. "We've added a clinic-type treatment room to try to facilitate minor care," he says. "We can rotate 10-20 patients a day, but to run that room requires more staffing than we have."

The good news for Dean was that, thanks to outside help, things actually got *better* during Mardi Gras. "The city's population was lower, even though there was a large influx of visitors," he says. "The federal government sent in two detachments of DMAT units, and the one from North Carolina brought a portable hospital."

The DMAT saw 50-60 patients a day. "Once Mardi Gras ended, however, the DMAT was gone, the portable hospital was gone," Dean laments. "We're just kind of hanging in there, hoping for some state or federal aid." ■

Sources

For more information on ED surge capacity strategies, contact:

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- **Helen Ruiz**, RN, Director of Outpatient Services, Touro Infirmary, 1401 Foucher St., New Orleans, LA 70115. Phone: (504) 897-8521.

EMTALA Q & A

Privilege resignations: ED manager's dilemma

[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: How should ED managers respond to requests from physicians to resign limited clinical privileges?

Answer: More and more, medical staff leaders are receiving requests from physicians to selectively resign limited clinical privileges, says **Susan Lapenta**, JD, of Horty Springer in Pittsburgh. For example, Lapenta notes, the orthopedic surgeon on staff might want to resign general orthopedic surgery privileges and focus instead on hips and knees or hands. The neurosurgeon on staff might want to resign all privileges pertaining to the head and focus his practice on spines. Or, the general surgeon might want to limit her practice to breast surgery.

These requests, while all reasonable from an individual physician perspective, are also likely to increase

Source

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

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the on-call burden of other physicians in the specialty and/or have a negative impact on the hospital's ability to satisfy its obligation under EMTALA to have a reasonable on-call schedule, says Lapenta. Therefore, she says, before granting these requests decision makers should consider the effect of the selective resignation of privileges on the other physicians who are sharing call responsibilities and the hospital's obligation under EMTALA.

Subspecialty call schedule?

In some instances, there might be a need for a subspecialty call schedule that could be filled by the physician(s) who want to resign general privileges, Lapenta says. In other situations, there might be more than enough physicians in the specialty that the selective resignation of privileges by some would not create an unreasonable call burden on other physicians. In either situation, granting the request to resign limited privileges, after consideration of the issues and input from the department, would make sense, Lapenta says.

Absent either one of these situations, however, medical staff leaders could decide not to allow the resignation of privileges within the core or specialty, Lapenta asserts. Instead, she suggests, the expectation and requirement could be that physicians must maintain a basic level of competency within their specialty and thus may be required to retain their privileges and fulfill on-call responsibilities within the specialty.

Of course, that requirement does not mean that an on-call physician must treat every patient who presents to the ED, notes Lapenta. For instance, she suggests, if after examining a patient, the on-call physician decided that the patient required expertise beyond that possessed by the physician, the physician could ask another member of the medical staff to assume care for the patient. If no one else was available, the patient could be transferred to another facility, with the help of the on-call physician.

To help manage these requests, Lapenta recommends that medical staffs include language in their bylaws to address the resignation of limited privileges. The bylaws should lay out the process that will be followed when such a request is received and the factors that will be considered in deciding whether to grant the request, she says. The bylaws also should make it clear that a request to resign privileges is not effective on submission, but rather requires review by the Medical Executive Committee and final action by the Board of Directors, Lapenta adds. ■

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. ■

CE/CME objectives

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

COMING IN FUTURE MONTHS

■ Rapid response teams: Small hospitals transfer floor patients back to ED

■ Study shines new light on preventable deaths in the ED

■ ED completely revamps its chest pain triage protocols

■ Tiered triage: Nurses battle LWBS by informing patients of their level of urgency

CE/CME *questions*

25. Which of the following are part of the requirements of the Joint Commission on Accreditation of Health-care Organizations' new standard (MM 4.10) or National Patient Safety Goal (NPSG) No. 8?

A. Pharmacists review of orders prior to administration.
B. Accurate and complete reconciliation of all patient medications.
C. Contact with primary care physician or pharmacy if the patient or family members cannot complete medication reconciliation.
D. All of the above

26. According to Mary McNeily, which of the following is an acceptable exception to standard MM 4.10?

A. Circumstances in which the licensed independent practitioner (LIP) maintains control of the medication.
B. Whenever medications are given in the ED, since the LIP is present.
C. Whenever the patient is in the ED, since all ED care is "urgent" care.
D. Whenever a pharmacist is available for consultation.

27. According to research in two EDs by Karin V. Rhodes, MD, computerized screenings resulted in the following percentage of patients sharing information about domestic violence:

A. 0%-10%
B. 10%-20%
C. 20%-30%
D. 30%-40%

28. According to Todd Taylor, MD, FACEP, the most intractable problem facing ED managers seeking specialists to serve on call panels is:

A. Insufficient stipends.
B. Liability costs.
C. Lack of regional call panels.
D. Poor fee-for-service programs.

29. According to Helen Ruiz, RN, the following strategy can help improve patient flow when understaffed EDs experience a heavier than normal influx of patients following a disaster:

A. Having clinical staff performing nonclinical functions.
B. Setting up triage tents outside your facility to control flow inside the building.
C. Hiring out-of-work nurses from closed facilities.
D. All of the above

30. According to Susan Lapenta, JD, granting a specialist's request to resign limited privileges would make sense:

A. If the physician feels they are more competent in certain areas of their specialty than in others.
B. If the physician wishes to limit their practice to specific areas of the body.
C. There are enough other physicians available in that specialty.
D. The physician claims they do not have the time to honor all call requests.

CE/CME answers

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

ED ACCREDITATION UPDATE

Covering Compliance with Joint Commission Standards

Is your department prepared to make changes to your emergency management exercises?

Surveyors will expect communitywide focus

As of July 1, 2006, hospitals are required to improve the planning and evaluation of emergency management exercises under revised standard EC 4.20. This change is being made to help ensure that providers are conducting emergency management exercises, formerly called drills, rigorously and thoroughly, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Officials with the agency believe there have been missed opportunities by ED managers and others to identify and improve weaknesses.

When it comes to emergency management exercises, the ED is "home base," says **Jerry Gervais**, CHFM, CHSP, engineer with the Joint Commission. "So they're right at the heart of the matter, right at the point of sword in receiving victims, whether it's an internal or external disaster," he says.

Compliance with the revised standard will be challenging for EDs, says **Marianne Klaas**, RN, MN, director of accreditation and safety at Swedish Medical Center in Seattle. "There is a temptation to knee-jerk national events and expect hospitals to turn their emergency management plans around on a dime, when in fact, these are issues we have been grappling with for a long time and in many cases, need local and regional government support and financial support," she says.

Exercises must be based on the hospital's hazard vulnerability analysis, Gervais says. Other changes to the elements of performance for EC 4.20 include:

• **Hospitals are required to designate a formal observer, internal or external, to critique the exercise.** That person can't have any other responsibilities during the exercise, Gervais emphasizes. "The key is that whoever it is, that person needs to be intimate with that organization's emergency management plan," he says.

St Joseph's Hospital of Atlanta experience evaluators through its participation in two drills with the Metropolitan Atlanta Rapid Transit Authority (MARTA), which hired a company, Alexandria, VA-based Community Research Associates that puts on large-scale emergency exercises. "It's a really good opportunity for them to see how you perform, and also to give you some ideas about where you can improve or things you can work on," says **Joe Nedley**, RRT, coordinator for emergency preparedness and director of respiratory therapy at St. Joseph's. In the MARTA exercises, the hospital and other participants learned that there were opportunities to improve communication, which is "always an issue," he says.

Under the revised standard, administrators, clinical staff, and specifically physicians must be involved in giving input for the critique, Gervais says.

• **Strengths and weakness identified in the critique must be shared with all levels of the organization.**

In the past, post-exercise reports often went to

Executive Summary

Hospitals are required to improve the planning and evaluation of emergency management exercises under revised standard EC 4.20.

- You must use a formal observer to critique the exercises. Physicians and other staff should give input for the critique, and results must be shared with staff participants at all levels.
- Future drills must incorporate lessons learned from the critique.
- The focus will be on communitywide coordination and communication, rather than individual facilities.

administration and committees, but the results weren't often communicated beyond those groups, Gervais says. "Employees participated but never get any information back as far as how we did overall, what worked well and didn't," he says.

• The facility modifies its emergency management plan in response to critiques.

"People were identifying issues, but they were not modifying their plans to alter them to expand on what they've learned," Gervais says. When the critique indicates opportunities for improvement, those opportunities need to be tied into future exercises, he says. You must test and retest to validate changes, he adds.

Klaas says, "It's a good idea to close the loop on improvements, but the timing and methodology will need to be explored." Gervais acknowledges that not every issue applies to every disaster, but notes that many needed improvements will be universal regardless of the specific scenario.

• Facilities will be judged on how effectively they communicate within the hospital and with groups outside the hospitals such as the local government, police, and fire department.

The focus will be much more on community drills and community activities, Nedley says. "So from the ED standpoint, I think this is kind of a more complex version than what we've had in the past," he says. "I think we're seeing an evolution away from emergency management activities at an individual facility and moving more toward community."

Lesson from Hurricane Katrina

One of the most powerful lessons that came out of the Hurricane Katrina disaster response was that when you have complete failure of your infrastructure and the scope of the disaster exceeds what the hospital can handle by itself, you need to be able to formally communicate and integrate with the community, Gervais says.

Consider the example of a bioterrorism situation that require inoculation of citizens, Gervais says. "The last thing you want is thousands of people showing up at your ED trying to get an inoculation of Cipro," he says. You may want to designate a civic center, company warehouse, or airport hanger for such an event, he says. "Each community needs to be creative in their own context," Gervais adds. "No matter your size, even the larger hospitals are not prepared to deal with that kind of response."

Swedish Medical Center focused on integration with its community by obtaining input for its hazard vulnerability analysis, Klaas says. "We have always had a very close working relationship with our public health emergency operations center [EOC], King County EOC, and various Homeland Security committees [for the state]," she says. "We also get together with key businesses surrounding our hospital campuses in order to incorporate possible risks into our overall planning."

Key members of the hospital's Safety Team and Hospital Emergency Incident Command System (HEICS) are completing training requirements from the Department of Homeland for Security for Incident Command Systems courses and National Incident Management Services courses. "This will enable us the theoretical knowledge to link our HEICS with community incident command structures and support a unified incident command system," Klaas says.

Swedish Medical puts hospital representative on key local, regional, and state committees for the National Disaster Medical Systems program to ensure coordination of drill requests, so they aren't inundated with requests to participate from various leaders.

Staff must 'walk and talk' roles

To successfully met the revised standard, staff must be able to "walk and talk" their roles as defined by the hospital incident command system and understand they are obligated to carry out the expectations of their hospitals, Gervais says. "It starts with solid communication to the staff as to what expectations are, followed with education for them to carry out responsibilities," he says.

Exercises are an opportunity to make an assessment of your staff's ability and preparedness to do that, he says. "Hopefully, by the time JCAHO comes through on its triennial cycle, we will validate what's already in place," Gervais says.

(For information on another new requirement from the Joint Commission regarding emergency management drills, see story, p. 3.) ■

Sources

For more information on the revised standard, contact:

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- **Joe Nedley**, RRT, Coordinator for Emergency Preparedness, Director of Respiratory Therapy, St Joseph's Hospital of Atlanta. E-mail: jnedley@sjha.org.

New focuses: Resources and patient management

What will you do if you only have a helicopter?

To meet the revised standard for emergency management exercises from the Joint Commission on Accreditation of Healthcare Organizations, hospitals must determine how they are going to allocate resources that may be in short supply in an emergency situation.

Resources include responders, equipment, and supplies, both ones you have and ones you need, says **Jerry Gervais**, CHFM, CHSP, engineer with the Joint Commission. In the Hurricane Katrina response, transportation was an issue by itself, he emphasizes.

"For a period of time, the only way in or out was helicopter," Gervais points out.

Another critical element is to test your patient management system, he says. After Katrina, 200 people who had been triaged disappeared, Gervais says. "It was documented they were entered into the process as they departed facilities in New Orleans, but they never were accounted for where they ended up."

When hospitals have to integrate their tracking systems with other facilities on a broad scale, the patient tracking system broke down, he says. EDs need to focus on the intake side of patient tracking, Gervais suggests. "If they didn't identify patients on the way in, there's not much hope of success tracking them on the way out, if that's what it comes to," he says.

The Washington State Hospital Association tackles this issue and others by gathering emergency managers monthly to discuss, plan, and collaborate on individual plans and community response and recovery, says **Marianne Klaas**, RN, MN, director of accreditation and safety at Swedish Medical Center in Seattle. "We approach solicitation for [Health Resources and Services Administration] funding as a collaborative — not competing against each other, but working together on a defined plan to ensure appropriate resources and training," she says.

While they need to enhance their sharing of key roles and contact information, they currently rely on a hospital web site to gather and communicate this information, Klaas says. "We are always looking to improve patient tracking internally as well as with external resources when loved ones are searching for family or friends," she says. ■

JCAHO changes standards for credentials in a disaster

You have 72 hours to verify primary source

Standards have been added and revised in the accreditation manuals for the Joint Commission on Accreditation of Healthcare Organizations to address the verification of credentials and assignment of responsibilities for volunteers who are *not* licensed independent practitioners during disasters, as well as licensed independent practitioners.

The principle additional burden placed on ED physician leadership relates to the task of quality oversight of emergently credentialed volunteer practitioners, says **Timothy Seay**, MD, regional medical director of Greater Houston (TX) Emergency Physicians. "The credentialing process for these volunteers is not onerous for the hospital, requiring proof of licensure and a picture ID, followed up within 72 hours some primary source verification, much or all of which is available online in most states," he says. "There is even a provision for the inability to complete primary source verification in the event that the disaster is of sufficient import to preclude it [HR.1.25.B.6]."

Obviously, you have to attend to patients first, says **John Herringer**, RN, MS, associate director of the Standards Interpretation Group. The Joint Commission's expectation is that you would complete the task within 72 hours unless the communication systems are completely down, he says. "Then you have to document that it's out."

Reason for the revision

The new and revised standards are applicable to the hospital, critical access hospital, and ambulatory care programs. Hospital standard MS.4.110 already included an abbreviated process for privileging licensed independent practitioners when the facility's emergency management plan is activated and the organization cannot handle the immediate needs of its patients. Because there was not a similar process in the critical access hospital's manual and the ambulatory care manual, standard HR.4.35 was added. Among other requirements, standards HR.1.25, MS.4.110 and HR.4.35 establish that, even in a disaster, two parts of the usual process for determining qualifications and competence must be maintained: verification of licensure, certification, or registration; and oversight of the care, treatment, and services provided.

All of the changes were effective July 1, 2006. ■

Joint Commission offers free audioconferences

The Joint Commission on Accreditation of Healthcare Organizations is conducting free monthly one-hour audio conferences with Joint Commission president Dennis S. O'Leary, MD. The dates and topics for upcoming audioconferences are:

• **Aug. 24:** The Joint Commission's Public Policy Initiative on the Development of a National Performance Measurement Strategy;

• **Sept. 27:** Efforts to Enhance the Value of Hospital Accreditation;

• **Nov. 1:** Using Elements of the Accreditation Process as a Performance Improvement Tool.

All audioconferences begin at 2 p.m. EST. Information will be sent to accredited hospitals via listserv within two weeks before each call. A playback of each audioconference is available for up to two weeks following each.

Written transcripts of the audioconferences are posted on the "Jayco" extranet site and the Joint Commission web site (www.jointcommission.org/Accreditation Programs/Hospitals/data_policies.htm). Transcripts of previous audio conferences include:

• **June 28, 2006:** Enhancing Access to and Utility of Data Available to the Public through Quality Check;

• **May 31, 2006:** Joint Commission Performance Measurement Requirements;

• **April 27, 2006:** The Joint Commission's Potential Receipt and Use of Case-Identifiable Data;

• **March 23, 2006: Data Policy Decisions.**

For more information, contact Cathy Barry-Ipema, chief communications officer, at cipema@jcaho.org. ■

IOM report recommends Joint Commission action

The Institute of Medicine's (IOM's) three-year "Future of Emergency Care" project, recently completed, includes recommendations for the Joint Commission on Accreditation of Healthcare Organizations. **(For more information on the IOM report, see the special issue of *ED Management,* July 2006, p. 73, p. 76, p. 77, p. 79, and p. 80.)**

Specifically, the report titled *Hospital-Based Emergency Care: At the Breaking Point,* recommends that the Joint Commission should put into place strong standards about ED crowding, boarding, and diversion. In particular, the practices of boarding and ambulance diversion should be eliminated except in the most extreme circumstances, such as a community mass-casualty event.

In a prepared statement, the Joint Commission said it supports this call to build an emergency care system that can adequately serve ED patients. "Our nation's health care system currently provides only a patchwork of emergency care," said **Dennis S. O'Leary**, MD, president of the Joint Commission. "Fixing hospital-based emergency care, including overburdened emergency departments, ultimately means fixing much of what ails our health system."

The Joint Commission is ready to work with stakeholders to address the issues surrounding hospital-based emergency care, the statement says. The agency has taken a number of significant steps, including the 2005 standard on managing patient flow, according to the statement. **(For more information on the 2005 standard, see the following stories in *ED Accreditation Update:* November 2005, "Hospital addresses ED overcrowding, sees treatment times and walkout rates drop," p. 1, and "ED cuts throughput from 3.2 to 2.3 hours, p. 4; May 2005, "Managers at recently surveyed EDs warn: Surveyors target overcrowding standard," p. 1; August 2004, "EDs must offer inpatient level of care to admitted patients, new Joint Commission standard says," p. 1.)**

"This standard places the accountability for managing patient flow with hospital leaders, who must provide the resources — both financial and human — to manage this critical patient safety issue," O'Leary said. "But public policy-makers must eventually come to grips with the broader issues that are adversely affecting emergency care capacity in this country."

Additionally, the Joint Commission supports the development of national performance measures to evaluate the effectiveness, efficiency, and quality of emergency services, the agency said. ■

JCAHO revises standard on organ procurement

Beginning Jan. 1, 2007, hospitals will be required to develop a policy regarding organ donation after cardiac death, based on the revised organ procurement and donation standard (LD.3.110).

The revision reflects recommendations from the Organ Donation Collaborative Leadership Coordinating Council and the Association of Organ Procurement Organizations (AOPO). **(For more on organ donation, see "Do your staff know how to handle organ donations?" *ED Management,* August 2005, p. 89.)** ■