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The monthly update on Emergency Department Management

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IN THIS ISSUE

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Lawsuit over lack of call coverage raises new concerns about liability

Experts recommend a 'better-safe-than-sorry' approach

It probably was inevitable, given the call coverage crisis in this country. Now that it has happened, emergency medicine experts are sitting up and taking notice: A hospital is being sued over the failure to provide adequate specialist coverage for an ED patient.

Mary Stone, 52, recently was taken to the ED at Jupiter Medical Center in Palm Beach County, FL, after suffering a stroke. It took 11 hours to find a neurosurgeon, and it was at Shands University of Florida Hospital in Gainesville, 260 miles away. Stone was transferred and had surgery, but died 10 days later. Her husband has a lawsuit pending against Jupiter Medical Center and is claiming his wife would be alive had a neurosurgeon operated sooner.

While the defendant in this case is the hospital, such cases could represent a new, but limited, area of liability for ED managers. "The hospital is responsible for providing on-call coverage," notes **Michael Frank**, MD, JD, general counsel for Emergency Medicine Physicians, a physicians' group based in Canton, OH. Frank adds, however, that in those situations in which the ED manager is responsible for call coverage, that information could come out in discovery.

"Since the ED manager is an employee of the hospital, there's not much benefit to naming them, since it's the hospital that has the deep pockets," Frank adds. "But if the ED manager is tasked with the responsibility of filling the on-call coverage list and a specialist is available but the manager failed to obtain their services, the

Executive Summary

Regarding poor call coverage, take every step possible to minimize your potential exposure to litigation. Here are some strategies:

- Have policies and procedures for addressing the needs of patients for times when coverage is not available.
- Make sure potential patients and families are clear on the services your ED does and does not offer.
- Be sure to have transfer relationships set up with facilities that provide the services your ED cannot.

hospital would have some complaint about the performance of the ED manager."

Anyone can sue

There could, Frank concedes, be more similar cases in the future.

"There's a 'colorable theory' plaintiffs use that says the defendant has an obligation to foresee the problems that are likely to be happening and should, therefore, take reasonable steps to be staffed and equipped to deal with those problems," he explains. "If there is a shortage of subspecialists but the hospital had not bothered to sign up a neurosurgeon for on-call duty, in theory they may be negligent."

In addition, says Frank, delays in call coverage might expose the ED manager to problems with governmental agencies. For example, he says, while the Emergency Medical Treatment and Labor Act (EMTALA) doesn't require that you have someone on call for every conceivable medical condition, an ED manager who doesn't have a particular specialist on call might run afoul of Centers for Medicare & Medicaid Services (CMS) regulations.

"Nothing requires a hospital to have every specialty covered," says Frank. "In the final rules, CMS clarified the fact that a hospital only has to have on-call specialties that fit the needs of the patients and medical staffs."

However, he adds, when CMS officials clarified the rules, they said that you *do* have to have in place policies and procedures for addressing the needs of patients when that coverage is not available. "When you do not have such policies and procedures in place and there are delays in treatment because of that, then you *will* have some liability to CMS," says Frank.

Managers must prepare

Because of the possibility of such a case arising, ED managers should take care that they are as well protected as possible, say experts.

"In a case like [the one in Florida], if you don't practice neurosurgery in that hospital, you should be immune," notes **Paul Kivela**, an attending physician at Queen of the Valley Hospital, Napa, CA, and past president of the California chapter of the American College of Emergency Physicians. "If you do practice limited neurosurgery, the issue is, are you putting yourself out there [to the public] to provide those services?"

ED managers should check to ensure neurosurgeons on staff are properly credentialed. If your neurosurgeons do not have the ability to do a procedure, Kivela advises, document it. He adds that in protecting themselves and their departments, ED managers should think "outside the box." For example, he suggests, "Post on the outside of your ED what services you do and do not have available."

Gregory L. Henry, MD, FACEP, risk management consultant for the Emergency Physicians Medical Group, Ann Arbor, MI, agrees that intimate knowledge of your department's capabilities is critical. "It's not enough to have a call list. You need to know exactly what it will do," he advises. Some surgeons, for example, will not handle

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burn cases, he notes, and those patients are better off being sent to a burn unit.

If your ED faces such a situation — for example, an orthopedist who will not treat children younger than 12 — Henry says you should state that fact to the family up front. "Say, 'This is why we have to transfer your child,'" he suggests. Don't pretend that you can treat them, Henry says. "You do not need the orthopod's OK to send the case," he says. "Just do it."

In fact, Henry reports, he saw a child just recently who had an elbow fracture. "Our orthopod didn't do kids who were that age, so we sent the patient to Children's Hospital at the University of Michigan," he says. That was the intelligent thing to do, Henry says. "It's better to have the patient cared for by people who provide that specialized care all the time," he says.

Kivela agrees. "EDs in most states classify themselves, for example, as a trauma center or not," he notes. In California, for instance, there are three designations: comprehensive, full-service, and standby, Kivela says. "If you are a standby facility, you really shouldn't guarantee anything more than a doc or maybe a nurse to triage the patient," he says.

In addition, cautions Henry, *never* promise to the patient or family what will be done at the other center. "Do not say you are sending the patient for an operation; say you are sending them for evaluation," Henry recommends. "The condition of the patient may change, or the other facility may do a new or different procedure."

What's more, he says, never guarantee an outcome. "Don't say, 'If we send them there they'll be fine,'" Henry warns.

To avoid any confusion at such times, says Henry, ED managers should have all of their transfer agreements in good order. "The worst thing you can be doing is going shopping," he says. "If you have a neurologist or a neuro-radiologist on staff, you need to know if they are available that day; there can't be any questions of 'maybe.'"

In addition, to avoid EMTALA violations, you must know who's on call, how to reach them and, if you can't, what your next steps should be, says Henry. "You should *never* be in a quandary about what to do with a particular case," he says. Have the essential disposition "airtight," Henry advises. "This should be true of any thing your hospital does not supply," he adds.

There's hope on the horizon in this area, says Kivela. "One of the things we argued for in California, unsuccessfully, is the possibility of having regional referral networks," he says. "But that's what's coming in the future." ■

Is OPPS rule as good as it looks for EDs?

Experts divided about benefits

At first glance, the proposed outpatient prospective payment system (OPPS) rule for Medicare payment for hospital and outpatient services in calendar year 2007 is great news for ED managers. The Centers for Medicare & Medicaid Services (CMS) has expanded the number of levels for emergency visit ambulatory payment classification (APC) assignments from three to five, a change that emergency medicine advocates have been requesting for several years. What's more, the highest-level payment for an ED visit in calendar year 2007 will be $332.14, compared with $237.17 in 2006.

The three levels for ED visits in 2006 — low level, midlevel, and high level — have respective APC median payments of $76.43, $133.98, and $237.17. This year,

Executive Summary

The proposed payment rule for hospital outpatient services could significantly enhance your department's revenues in the coming year. Familiarizing yourself with the new service levels can help point out strategies that will help boost your Medicare reimbursement.

- The new Level 5 ambulatory payment classification (APC) will pay nearly $100 more than this year's highest level, so determine the percentage of your patients that fall within that category to estimate your potential reimbursement gains.
- Offer fast track services or place physicians in triage to reduce the number of low-acuity patients that come into your ED. Market appropriate use of your ED to limit the number of patients who come to your department seeking primary care services.

the proposed APC for level 1, 2, 3, 4, and 5, respectively, are $51.41, $84.79, $133.98, $214.88, and $332.14. These payments would be effective Jan. 1, 2007.

But the news may not be as positive as it first appears, warns **Frederick C. Blum**, MD, FACEP, FAAP, president of the Dallas-based American College of Emergency Physicians. "We've been working very hard to try and get our visit levels coded and valued properly and [the proposed new rule] reflects that, but what we've already seen is that it is going to be counterbalanced by the budget neutrality adjustment," he says. "In other words, if CMS does this, it would add significant dollars to the system, so this adjustment will take back a significant amount from that."

The actual impact on reimbursement will depend on the method used, Blum says. "They could either do it through a conversion factor or through an adjustment of work RVUs [relative value units]," he notes.

A conversion factor, which would simply reduce reimbursements by a fixed percentage across the board, would be less onerous for ED managers, Blum explains. "Because emergency medicine has the highest percentage of work to total RVUs — 73% — using that method would have a disproportionate effect on us, so we've been suggesting that using a conversion factor would be the most appropriate," he says. Blum notes that the conversion factor is a methodology CMS has used before to make these sorts of adjustments.

EDs still win?

Despite the potential offset, EDs still will be among the winners when the smoke has cleared, insists **Michael J. Williams**, MPH, HAS, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services.

"While each hospital has a different mix, anywhere from 5% to 15% of your Medicare patients would be Level 5 patients," he says. "This is a big deal."

How big? In an ED with 40,000 visits per year, if 10% of the patients were Level 5 patients that would mean approximately a $100 differential for 4,000 patients, or a revenue increase of $400,000 per year.

Even with the budget neutrality adjustment, Williams says, "I think EDs will still win." While the vast majority of the 420 ED-related APC codes are for procedures, and not visits, hospitals typically underbill for procedures, he says, "so if you get more bang for your buck out of your visit codes, you will come out better."

In addition, note observers, ED managers may want to increase their efforts to get the lowest-paying codes out of their EDs by offering fast tracks, marketing appropriate use of the ED, and so forth. "I think that's totally appropriate," says Williams. "There's already been a major trend across the country where EDs put docs at triage."

Williams says on the average, 30% of the patients who present at triage are sent out of the ED "and don't even get to the back of the department," and that that percentage is likely to increase. "If you have the capacity to move sicker patients through faster, you could add your capacity to see a larger percentage of the sicker patients," Williams says.

Another double-whammy

But Blum counters that ED managers may, in fact, be in store for another double-whammy. "The other side of the formula, the sustainable growth rate, is fixed," notes Blum, explaining that there are another five or six years of cuts scheduled, the end result of which would be a drop of 26% in Medicare reimbursement for all physicians.

While this change in physician reimbursement does not directly address hospital ED reimbursement, there could be an impact on EDs, Blum says. "It actually has a multiplying bad effect on emergency medicine because as you cut Medicare reimbursement, primary care providers are less likely to enroll Medicare patients in their practice, so they are likely to come more often to the ED," he predicts. **(Editor's note: These updates can be found on-line in the "Hospital Outpatient Regulation and Notices" section at: www.cms.hhs.gov/HospitalOutpatientPPS. For information on how to comment on the proposed rule, see resource box, below.)** ■

Sources/Resource

For more information on the proposed outpatient payment rule for 2007, contact:

- **Frederick C. Blum**, MD, FACEP, FAAP, President, American College of Emergency Physicians, Dallas, TX. E-mail: fblum@acep.org.
- **Michael J. Williams**, MPH, HAS, President, The Abaris Group, 700 Ygnacio Valley Road, Suite 270, Walnut Creek, CA 94596. Phone: (925) 933-0911. Fax: (925) 946-0911. E-mail: theabaris@aol.com.

To comment on the proposed rule, comments must be received by Oct. 10, 2006. Please refer to file code CMS-1506-P. You may submit electronic comments at www.cms.hhs. gov/eRulemaking. Attachments should be in Microsoft Word (preferable), WordPerfect, or Excel. Or you may mail written comments (one original and two copies) to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1506-P, P.O. Box 8011, Baltimore, MD 21244-1850.

EKG at triage slashes door-to-aspirin time

Chest pain process not without snags

The ED staff at Contra Costa Regional Medical Center (CCRMC) in Martinez, CA, has slashed its time to aspirin for chest pain patients from 67 minutes to about eight minutes by completely revamping its triage process.

In the past, the patient would be seen by a nurse, says **Steven Tremain**, MD, CCRMC's director of system redesign and senior medical director. "They would describe their pain, the nurse would look at our set of criteria, and if they looked like a cardiac case, they would be admitted to a high-profile bed in the ED where the whole rule-out MI [myocardial infarction] process would be started," Tremain says. "We redid the process so that every patient gets an EKG [electrocardiogram] right in triage, and if not contraindicated, they all get aspirin."

The change started in late 2005, when CCRMC began participating in the Boston-based Institute for Healthcare Improvement's (IHI) "100,000 Lives" campaign, a nationwide quality improvement initiative. **(See resource box, p. 102.)** "Even before IHI, we had been concerned with our triage delays in getting patients with chest pain evaluated, and specifically, we had always fought a battle about prioritizing seemingly low-acuity chest pain vs. high-acuity chest pain," says **David Goldstein**, chief of staff for the ED." They had a lot of difficulty creating reasonable expectations for the nurses who were doing triage, so they ended up with very unpredictable and nurse-dependent information, Goldstein says.

Tremain adds, "What we learned is that it's very hard to predict which chest pain is [myocardial infarction] and which is not."

Executive Summary

Giving all chest pain patients an electrocardiogram (EKG) in triage can significantly improve treatment times and quality of care and it eliminates the need to prioritize patients and takes undue pressure off the nurses, ED managers say.

- Triage delays in chest pain evaluation are eliminated by giving all patients the same treatment.
- Time to first aspirin at one hospital was slashed from 67 minutes to eight minutes.
- Asking nurses to differentiate patients on the basis of an interview and a set of vitals is unrealistic, managers say.

When the hospital joined the IHI campaign, administrators decided to take another look at this issue, says Goldstein.

Dissecting the process

The ED staff began by "taking apart" the triage process, Goldstein recalls.

"We realized we had unrealistic expectations of nurses at triage to differentiate chest pain patients that we [the physicians] ourselves had trouble differentiating when we saw them," he says. "We realized we were putting the cart before the horse, and that a uniform practice would be better than attempting to get nurses to do something that probably was not even possible: differentiating very sick people vs. those who were not so sick."

Goldstein had a gurney placed in the triage area, and every patient who presented with chest pain received an EKG and an aspirin at time of triage, unless they were allergic to aspirin. "All EKGs were then reviewed immediately by an ED physician," adds Goldstein. The rest, as they say, is history.

Goldstein concedes there are some downsides to the new protocol. "It has actually lengthened the triage process when you include all these chest pain patients, because we do a lot of EKGs on patients who previously might not have gotten one or been made a high priority," he notes. Getting an EKG probably takes only three to four minutes, says Goldstein, but it also requires more personnel. "You've got to pull a nurse or a medical assistant from the ED to do it; but since we would have done those an hour later anyway, our only real limitation is space," he says.

"In addition, we don't know yet whether we are making a difference in terms of thrombolytic [clot-buster] timing," says Goldstein. "Our assumption is that it will, but we have not seen enough cases yet to do a study." He believes, however, that the new process is making a difference there as well, "and we know that should improve outcomes."

As with any such process change, Goldstein says, the biggest barrier is to change physician practice. "In fact, the biggest challenge that still remains for us are the physicians," he says. "They are resistant to the idea that patients they perceive as having low acuity chest pain get a higher-acuity evaluation and are maintained as such."

CCRMC uses a five-level triage system. Chest pain patients are classified as Triage I until the EKG is studied and the ED physician is certain they do not need thrombolytics. "But we still maintain them at a Level 2 until they are seen by a physician," says Goldstein, although he asserts they still are brought back for treatment much

Sources/Resource

For more information on using EKG in triage for chest pain patients, contact:

- **David Goldstein**, MD, Chief, Emergency Department, Contra Costa Regional Medical Center, Martinez, CA. Phone: (925) 370-5973.
- **Steven Tremain**, MD, Director of System Redesign and Senior Medical Director, Contra Costa Regional Medical Center, Martinez, CA. Phone: (925) 370-5100.

For more information about the "100,000 Lives" campaign, go to the web site, www.ihi.org/ihi and click on the "100,000 Lives" logo.

more quickly on a consistent basis than they otherwise might have been.

How does he handle the negative feedback from physicians? "You re-explain to them every time you do an EKG why it is you are doing it," he says. "When we can show our time to thrombolytics has significantly improved, that will be the proof of the pudding — that we have brought about a big quality change." ■

Positive feedback spurs process improvements

Time to first antibiotic for pneumonia drops

The traditional approach to process improvement — where errors are identified and then corrections sought — just doesn't work in the ED, argues **John Whitcomb**, MD, ED director at Aurora Sinai Medical Center in Milwaukee.

"When you ask what went wrong, the way you ask the question can lead you down the wrong path," Whitcomb asserts. "If you're giving your people a 'traffic ticket' — for example, asking why it took three hours to get an antibiotic to a patient — the message you're sending is, 'You failed. Your patient fell out.'"

That approach makes staff feel angry and hurt, and it also leads them to feel their manager is irrelevant, he says. "I recommend identifying the part of the bell curve that's two standard deviations *above* the mean (a standard deviation is sometimes referred to as the 'mean of the mean') — that defines excellence — and then reward it," Whitcomb recommends. "When I wash the dishes, for example, my wife gives me a kiss. That's pretty simple stuff, but it moves whole mountains."

Whitcomb and his staff clearly have moved mountains at Aurora Sinai. When they began a process improvement project in community-acquired pneumonia (CAP), it sometimes took patients as long as 12 hours to receive their first dose of antibiotics. The standard set by the Centers for Medicare & Medicaid Services [CMS] is four hours. "Our fastest time from door to antibiotic last month was 23 minutes," Whitcomb reports. "The month before, it was seven minutes."

The initiative coincided with a decision made in the ED to address pneumonia care. This initiative was part of a demonstration project being jointly sponsored by CMS and Premier, a Charlotte, NC-based health care performance improvement alliance owned by more than 200 not-for-profit hospitals and health care systems. "People were getting antibiotics at 12 hours — *upstairs*," Whitcomb recalls. "Once we started, we embarked on a relentless journey of looking monthly at every single pneumonia for the previous month."

As easy as 1, 2, 3

While the process was relentless, it was nevertheless always positive. Whitcomb employs a three-step process in his approach:

• **Step One: Identify excellence.** "That was easy; CMS has done that for you," he says. "They give you a whole list of procedures for pneumonia, with all sorts of minute details." **(See resource box, p. 103, for more information on pneumonia procedures.)**

• **Step Two: Make sure everyone in the department *knows* it's excellent.** Whitcomb posts the processes on the department bulletin board. "Talk about it, get that pathway up there — make it easy and convenient," he recommends.

• **Step Three: Start a process for rewards.** "We all want to be acknowledged," says Whitcomb. "Tell the world. Put my name on the bulletin board, and let everyone know I was perfect. But most of all let *me* know!"

Whitcomb created a "wall of fame" in the ED, says **Ann Staroszczyk**, RN, MS, director of quality at

Executive Summary

Motivate your staff to strive for excellence by clearly establishing optimal standards of care and then rewarding and recognizing your top performers.

- Identify "excellence," using standards such as core measures from the Centers for Medicare & Medicaid Services.
- Post pathways on the department bulletin board to make sure all your staff members are aware of what they are striving for.
- Reward those who achieve excellence with creative gifts, and publicly recognize them within the department.

Sources/Resource

For more information on improving performance in community-acquired pneumonia, contact:

- **Ann Staroszczyk**, RN, MS, Director of Quality, Aurora Sinai Medical Center, 945 N. 12th St., Milwaukee, WI 53233. Phone: (414) 219-5517.
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For more information on the Centers for Medicare & Medicaid Services (CMS)/Premier demonstration project and CMS guidelines for community-acquired pneumonia, go to the CMS web site, www.cms.hhs.gov. In the search box, type "pneumonia." When the next page opens, click on the following link: "Community-Acquires Pneumonia Premier Hospital Quality Incentive."

Aurora Sinai. That wall included the names of people who were top performers in following recommended procedures. "He gave a lot of positive feedback to staff who performed well," Staroszczyk says. She notes that Whitcomb also would commend those staffers in writing.

Process improvement in pneumonia was a regular topic at monthly departmental meetings. Once a month they would give something small, such as a package of 10 M&Ms, to top performers at the meeting, says Whitcomb. "I'd stand up and say, 'Dr. X got the best pneumonia this month, but it was not just him — it was Nurse Jones, Secretary Smith, and X-Ray Tech Lewindowsky.'"

All of those names would go up on the 'Wall of Fame,' and they'd all get packages of M&Ms. "You do this every month, and what starts happening? People start using their imaginations cohesively as a team so they can get the reward and be named 'the smartest people in the department' for that month," says Whitcomb.

Keep it light

It is important to inject a certain amount of humor into the program, adds Whitcomb. "The reward needs be of such 'serious' intent that you can laugh about it; you need to have a little bit of playfulness involved," he explains. "You also need to keep it under $10 so they don't have to pay taxes."

Even when he has to notify staff members that they've been less than perfect, he continues to emphasize the positive. "I craft a letter something like this: 'Dear Dr. Whitcomb: Thank you for the care you are providing your patients. It was perfect on the following five measures, and it would have been completely perfect if you had given antibiotics within four hours,'" he relates. "*That's* how you craft feedback notes."

This approach "has led to a dramatic paradigm shift in behavior," Whitcomb says. Now, when the radio goes off, and the emergency medical services staff report a high fever and shortness of breath, "the nurse says, 'I'll go hang the rocephin;' the doctor says, 'I'll call X-ray; the secretary says, 'I'll call registration,'" says Whitcomb. "When the patient is wheeled into the ED, the portable X-ray is already there." ■

Increasing ICU bed capacity cuts diversions

Study: As diversions drop, hospital revenues rise

A new study published on-line in the *Annals of Emergency Medicine* finds that ambulance diversions can result in significant revenue losses for emergency departments and that increasing bed capacity in hospitals can decrease diversion and increase monthly net revenues.[1] Using data collected between Jan.1, 2002, and Dec. 31, 2004, at the Oregon Health and Science University Hospital, Portland, the researchers determined that:

• Every hour of ambulance diversion costs the hospital approximately $1,100 in revenues.

• When the intensive care unit beds were increased from 47 to 67 and ambulance diversion decreased, the hospital gained approximately $175,000 per month in additional revenues generated by ambulance patients.

• Those additional revenues reflected a 10% increase in the hospital's ED revenues.

Oregon Health and Science is a 400-bed, acute care teaching hospital with a Level 1 trauma center in an urban area, which treats approximately 43,000

Executive Summary

A new study demonstrates a real dollar cost to diversions, which can give ED managers added ammunition when lobbying administration for increased bed capacity hospitalwide. Here are some strategies you can use:

- Point out the demonstrated link between increased bed capacity in the intensive care unit and reduced diversions.
- Emphasize the fact that when patients are boarded, staff morale is negatively affected.
- Because your ED may represent 30% of your hospital's volume, note the connection between improved flow and patient satisfaction.

emergency patients each year. "We took advantage of a natural experiment," explains **Chris Richards**, MD, chief of acute care and a co-author of the article, who notes that prior to the research, there had been numerous discussions about having trouble getting ED patients up to beds in the hospital.

"We were active in various meetings making this known to administration," Richards adds, but he concedes that surgery needs were probably a more critical factor. "High-margin services always are," he says. "When we have trouble getting our patients admitted, it's not perceived as a high-margin problem, but when cardiac surgeons can't operate because patients don't have beds, that are another story."

Thus, when a new cardiac intensive care unit (ICU) opened in the hospital, it was an opportunity to show the cost of diversions to the ED and to the hospital as a whole. "We tried to figure out the economics of the situation," Richards says.

This was an empirical simulation, adds **K. John McConnell**, PhD, lead author, an assistant professor of emergency medicine at Oregon Health and Science University (OHSU) and an economist in the OHSU Center for Policy & Research in Emergency Medicine. "We had two years' data, and we could see what patients were coming in and what the revenues were," he says.

Calculating the economics

The researchers used three sources of data: A radio frequency identification (RFID) patient tracking system, hospital financial data, and a log of ambulance diversion times and types. Ambulance diversion and revenues were analyzed hour by hour and also in eight-hour blocks of time.

"The hour-by-hour calculation was to develop something that made sense to the ED manager or hospital manager: What would it cost if we were on divert for an hour?" McConnell explains. "For the eight-hour blocks, we wanted to see if there were certain times of the day when diversions were particularly costly. So, for example, going on divert on Friday night is more costly than on Tuesday morning."

With the addition of the new ICU beds, total diversion decreased from an average of 307 hours a month to 114. "We were able take those figures and simulate what revenues would have been if we were not on divert and what the cost of an hour of diversion was," McConnell explains.

As impressive as the numbers are, other ED experts have calculated even higher costs per one hour of diversion — as high as $5,400 — by looking at emergency medical services (EMS) patients only during the busy hours of the day and by asserting that diversion doesn't get used in the middle of the night. However, Richards disagrees with that approach.

"When I first hashed over the data, I thought the numbers were low, but they are *real,*" he insists. "You *have* to calculate the middle of the night, as well as the fact that some of these patients are uninsured."

Whichever way the numbers were calculated, the additional beds in the ICU had a clear impact on the ED staff, says Richards.

"One of the things that some ED managers know — and some perhaps don't — is that staff morale for practitioners is severely impacted by having to hold on to these patients for an extended period of time," he notes. "As the boarding times went down, we saw an impact on staff morale, which was positive."

There also are patient safety issues involved, he continues. "I am *not* an ICU doc; they are better at it and should take care of those patients," Richard asserts. Finally, he says, patients are more satisfied when flow is smoother. "And when you can get someone straight to a bed and they are less stressed, the providers are also happier," Richards says.

Based on the findings of the study, McConnell says ED managers should lobby for addition ICU beds in their facilities. "But it's a complex issue," he warns. "The total impact on hospital revenues is small — less than 1% — so fighting an effective battle to reduce diversions means you need to show the effects on patient satisfaction and outcomes."

Diversion is not a revenue neutral area, Richards adds. "Since the ED is 30% of your volume, if you bring in more revenue and increase customer satisfaction, they *have* to think about it," he says.

Reference

1. McConnell KJ, Richards CF, Daya M, et al. Ambulance diversion and lost hospital revenues. *Ann Emerg Med* DOI: 10.1016/j.annemergmed.2006.05.001. ■

EMTALA Q & A

Applying EMTALA to behavioral emergencies

Question: The police present at a busy ED seeking medical clearance for an individual they are holding

with a suspected behavioral emergency. The hospital does not offer psychiatric services. The police do not want to wait around for several hours for medical clearance, so they leave the hospital (which is not authorized to hold the patient involuntarily). The emergency physician confirms that the patient is medically stable but has a behavioral emergency condition. The physician calls for a crisis team to write a new hold and assist in arranging placement at a local referral center; however, the crisis team cannot arrive for hours (perhaps many hours). The police consider the transfer to be the responsibility of the hospital. The hospital calls the referral center, but the center does not want to accept the transfer unless the patient is on a hold — that is, legal authority to detain a psych patient involuntarily for a limited period of time. (This refusal may be an EMTALA violation, but this is not much help at the moment of crisis.) Compounding the problem is that the local ambulance company will not accept the transfer of an individual with a behavioral emergency in the absence of a hold because the patient may exercise his/her right to refuse the transfer during transport. And, the patient wants to go home. How should we handle this situation?

Answer: The above scenario, a scene now played out all too often in EDs, illustrates some of the incongruities between EMTALA and patients with behavioral emergencies, says **M. Steven Lipton**, an attorney with the San Francisco law firm Davis Wright. Since the early days of EMTALA, he notes, the Centers for Medicare & Medicaid Services (CMS) has taken the position that hospitals are not relieved of their EMTALA obligations to screen, treat, or arrange for an appropriate transfer of emergent patients because of prearranged referral centers. As stated in the *EMTALA Interpretive Guidelines*:

"Hospitals are prohibited from discharging individuals who have not been screened or who have an emergency medical condition to nonhospital facilities for purposes of compliance with state law. The existence of a state law is not a defense to an EMTALA violation for failure to provide an [medical screening exam] or failure to stabilize an [emergency medication condition] . . ."

But that's the easy part, says Lipton. The hard part, he says, is making EMTALA work for behavioral emergency patients. Unlike most patients with medical emergencies, many hospitals do not offer psychiatric services or have psychiatrists or other behavioral clinicians on their medical staff. In addition, he notes, many states and local authorities have established laws on the detention, evaluation, and treatment of individuals who are a danger to themselves or others. Many of those laws fail to consider the EMTALA obligations in their application, such as:

• **Behavioral screening.** CMS has long taken the position that hospital emergency departments must provide a behavioral screening examination based on the presenting complaint, signs, and symptoms of a psychiatric patient. The documentation should include an assessment by the emergency physician (or other qualified medical person working under hospital policies) of suicidal or homicide risk, orientation, and other behavioral signs that indicate a danger to self or others.

In locations where local agencies provide psychiatric crisis or evaluation teams, hospitals may use these to meet the hospital's obligation to provide further evaluation and treatment for patients with emergency conditions. However, warns Lipton, the use of crisis teams does not absolve the hospital from its obligation to conduct a screening, and monitor, assess, and treat (when indicated) an individual with a behavioral emergency until his or her departure from the hospital.

• **Behavioral patient transfers.** Hospitals may transfer behavioral emergency patients to referral centers, but only in accordance with EMTALA standards for an appropriate transfer if the patient's behavioral emergency is not stabilized, says Lipton. As noted in the *EMTALA Interpretive Guidelines,* a "sending hospital's appropriate transfer of an individual in accordance with communitywide protocols in instances where it cannot provide stabilizing treatment would be deemed to indicate compliance with . . ." EMTALA.

• **Behavioral patient stabilization.** Another problem, says Lipton, is determining whether a behavioral emergency condition is stabilized. The *EMTALA Interpretive Guidelines* provide that psychiatric patients are "considered stable when they are protected and prevented from injuring or harming him/herself or others." However, the guidelines also warn clinicians that the use of restraints for purposes of transferring a behavioral patient may only temporarily stabilize the emergency, and therefore practitioners "should use great care when determining if the medical condition is not fact stable" after administering restraints.

COMING IN FUTURE MONTHS

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CMS unveils planned changes to EMTALA

In its final inpatient prospective payment system (PPS) regulations for fiscal year 2007, the Centers for Medicare & Medicaid Services (CMS) has included some "modest" changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations, says **M. Steven Lipton**, an attorney with Davis Wright in San Francisco. They are as follows:

• **Determination of labor.** Under the current regulations, a physician must certify a determination of "false labor," even if a nonphysician (such as a certified nurse midwife) has made the finding within the scope of his or her license. Changes to the regulation have been requested since its enactment in 1994, and the EMTALA Technical Advisory Group recently made a formal recommendation that CMS modify the rule to meet industry standards.

"At long last, CMS has revised the 'false labor' provisions to expand the scope of who may certify the presence of 'false labor,'" says Lipton. "The revised rule will state that a woman experiencing contractions is in 'true labor' unless a physician, certified nurse midwife or another qualified medical person acting within his/her scope of practice (and the medical staff bylaws and state law) certifies, after a reasonable time of observation, the woman is in false labor."

• **Accepting hospital obligations.** Under the current regulations, a Medicare-participating hospital with a specialized capability must accept, within its capacity, an appropriate transfer under EMTALA from a requesting hospital. CMS has interpreted the 'accepting hospital obligation' to include all hospitals, including those that do not provide a dedicated ED, notes Lipton. "The EMTALA Technical Advisory Group recently ratified the CMS interpretation and recommended that all hospitals with specialized capabilities that do not have a dedicated emergency department have the same obligation to accept transfers as hospitals with dedicated emergency departments," he says. "In response, CMS has amended the regulations to state specifically that hospitals without dedicated emergency departments are subject to the 'accepting hospital obligation.'"

Regional referral centers. The final revision to the EMTALA guidelines is a clarification that the reference to "regional referral centers" means rural hospitals that are classified under 42 *CFR* Section 412.96 as rural referral centers (as opposed to all rural facilities located in rural areas).

The regulations are effective Oct. 1, 2006. ■

• **Psychiatric holds.** Many states have enacted legislation permitting designated clinicians and law enforcement officers to hold a psychiatric patient in custody pending evaluation and treatment at a referral center. Unfortunately, says Lipton, EMTALA does not authorize involuntary treatment for a patient who has capacity to refuse treatment, while state law may permit involuntary detention, transfer, and limited types of treatment for certain behavioral patients.

Some hospitals, Lipton notes, have been cited for EMTALA violations for failing to make an appropriate transfer when peace officers or crisis teams, having custody of behavioral patients under a legal hold, transport behavioral patients from an ED to a referral center. In addition, he says, the EMTALA rules permitting patients to refuse further evaluation, treatment, or transfer do not specifically address the rights of behavioral patients under state law holds, or worse, patients who dangerous to self or others who are not under a legal hold.

There is help on the way, says Lipton, noting that the EMTALA Technical Advisory Group (TAG), charged with giving input to CMS on EMTALA standards, is considering the application of EMTALA to behavioral patients. He hopes the TAG will propose more thoughtful guidance and direction as to how behavioral emergency patients should be treated under EMTALA. ■

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 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. ■

EMTALA Today: The Courts, Compliance, and Implementation

A new sourcebook that helps you take a critical view of your EMTALA compliance program

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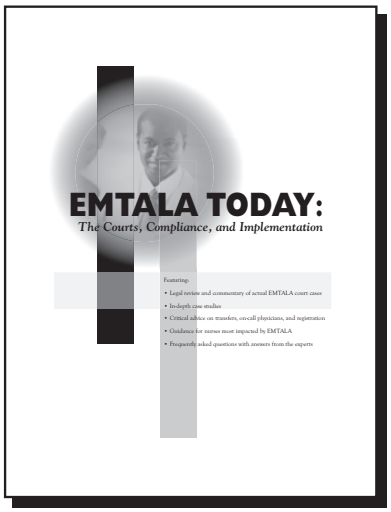

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CE/CME *questions*

31. According to Gregory L. Henry, MD, FACEP which of the following strategies can help limit an ED manager's liability for call coverage?
A. Knowing exactly which services your specialists will provide.
B. Avoid promising that specific procedures will be done at another facility.
C. Avoid guaranteeing an outcome to patients or their families.
D. All of the above

32. According to David Goldstein, one disadvantage of giving every chest pain patient an electrocardiogram at triage is:
A. some patients who receive the test would otherwise not have gotten one.
B. nurses cannot handle the extra work.
C. it is extremely expensive.
D. it doesn't reduce time to thrombolytics.

33. According to John Whitcomb, MD, the following strategy will help motivate your staff during a process improvement initiative:
A. Identifying excellence.
B. Communicating to your staff what constitutes excellence.
C. Rewarding top performers.
D. All of the above

34. According to Michael J. Williams, MPH, HAS, new Level 5 APC code for emergency services might apply to as many as ___ of an ED's total patient visits.
A. 5%
B. 10%
C. 15%
D. 20%

35. K. John McConnell, PhD, recommended that all of the following arguments in favor of increasing bed capacity for the intensive care unit be made to administration except:
A. patient satisfaction will increase.
B. more patients will choose the hospital for treatment.
C. outcomes will improve.
D. revenues will increase.

36. According to M. Steven Lipton, which of behavioral treatments are specifically addressed by EMTALA?
A. State hold laws.
B. Patients who are dangerous to self or others but not under a legal hold.
C. Involuntary treatment for patients who have the capacity to refuse treatment.
D. Transfers allowed under state law.

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. ■

CE/CME answers

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