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The monthly update on Emergency Department Management

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IN THIS ISSUE

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OCTOBER 2006
VOL. 18, NO. 10 • (pages 109-120)

Approval of nonprescription sale of Plan B muddies ethical waters

Requests for morning-after pill may drop, potential moral conflicts remain

The recent federal approval of nonprescription sales of the emergency contraceptive Plan B (Barr Laboratories; Woodcliffe Lake, NJ) to women and men ages 18 and older may have quieted what was a brewing controversy in emergency medicine. However, the ethical issues that gave rise to the debate still are very much in play, ED experts say.

The issue came to the forefront most when, on July 22, an ED doctor at Good Samaritan Hospital in Pennsylvania cited his Mennonite beliefs and refused to prescribe a morning-after pill for a rape victim. The incident touched off a national debate on emergency contraception.

Despite the recent federal approval, however, "The underlying ethical principal is still open for discussion," asserts **Mark Debard**, MD, an emergency physician at The Ohio State University Medical Center in Columbus, who wrote much of information used in sexual assault protocols in his state's EDs.

While emergency medicine experts note that the vast majority of rape victims are older than age 18, they agree this does not make the issue moot. Some states, for example, are moving to make access to the pill in pharmacies more difficult.

John Banja, PhD, a medical ethicist in the Center for Ethics at Emory University in Atlanta, poses these scenarios: A patient is in a rural area and can't get emergency contraception at the hospital. Or, the pharmacy closest to a patient won't provide the pill.

Banja notes that the state of Georgia legislature has passed a law that allows pharmacists to refuse to prescribe the pill without fear of prosecution. "The assumption of widespread availability may not be correct," he says. "Just because it is approved does not necessarily mean women will be able to get the drug."

Executive Summary

The best way to minimize conflicts and confusion over ethical and religious issues is to understand provider and patients' rights and have a solid plan in place, say ED experts.

- Make sure you know what your providers are and are not willing to do.
- Staff members who refuse care still are obligated to inform patients how they can receive it.
- Have other physicians or nurses available to provide care when such situations arise.

As part of their preparation for dealing with staff who object to prescribing the pill because they are opposed to abortion, Banja says it's critical to understand exactly how Plan B works.

"For pregnancy to occur, of course, three things must happen: The woman's ovaries have to secrete an egg into the fallopian tube; the male sperm has to fertilize the egg in the fallopian tube; and the fertilized egg has to implant into the lining of the uterus," Banja summarizes. "The morning-after pill can work in one of three ways: It can stop ovulation from happening; it can stop the fertilization from happening or, it can prevent the fertilized egg from implanting."

Generally, fertilization will not occur within the first 24 hours of unprotected sex, Banja says. Thus, in most rape victims in the ED, the Plan B pill is going to prevent ovulation or fertilization, he says. "To the extent it does that, we are not talking about abortion," he asserts.

Still, Banja concedes, there will be ED staff members who reject that rationale, or who are opposed to any form of contraception, so in an ethical issue still would exist.

Finding a balance

For the ED manager, the challenge is to find a balance between the rights of the provider to refuse certain forms of treatment (which are substantial) and the rights of the patient to receive what they consider to be necessary care.

"We have a long-standing tradition of allowing physicians a great deal of autonomy in what they are allowed to do [or not do] within the rule of law," says Debard. "There is no question that doctors with ethical and religious scruples about not performing certain acts are not required to perform them." Thus, he says, in the case of the Pennsylvania physician, "there's no question he acted within proper professional ethics." Still, Debard counters, "Just because he was within his ethical rights does not mean he doesn't have other ethical obligations."

Those obligations always have existed, he says. "To the point where even when doctors did not want to prescribe birth control pills because it was against their religion, they were traditionally required to provide information about others who *would* — in other words, how the patients might obtain that prescription," Debard says.

So, how does this translate into ED operations? "To my knowledge, such a protocol or policy rarely exists in the ED — but it probably *should,"* Debard says. "Such a policy would acknowledge the rights of the physician not to prescribe the drug, but it also should acknowledge the patient's rights to information on how to obtain that prescription."

Finding alternatives

The approval of over-the-counter sale of Plan B has not changed the policy in the ED at Emory University Hospital in Atlanta, says **Matthew T. Keadey**, MD, medical director.

ED Management® (ISSN 1044-9167) is published monthly by AHC Media, LLC, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

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This activity is intended for emergency physicians, ED nurses, and other clinicians. It is in effect for 24 months from the date of the publication.

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ED managers face many ethical issues

While the Plan B controversy has dominated emergency medicine news lately, there are several other ethical issues that arise in the ED from time to time and can create conflicts for ED physicians and nurses.

Blood for a Jehovah's Witness is a classic issue, says **Matthew T. Keadey**, MD, medical director of the ED at Emory University Hospital in Atlanta. "It's challenging to be able work with the patient as well as the physician to see what the potential options would be, but as long as the patient is an adult and understands the risks and benefits, it's their right to make any decision they want," he explains.

Children, Keadey adds, are another story. "You usually need to get the hospital ethics committee involved, and often if it's deemed a danger to the child, most states have a statute that allows you to take temporary guardianship of the child for 72 hours until a magistrate can come down with ruling," he explains.

Here are other ethical issues you may encounter in your ED:

• Abortion.

Keadey says there are cases where ED staff need to perform an abortion to save the life of the mother. "If you are the only practitioner at the time, there needs to be a policy or protocol that says how [a practitioner who refuses to perform an abortion] should be handled," he says. If a member of the team has a religious problem, Keadey adds, the ED manager must be able to shift staff around.

• Female Muslims having pelvic exams done by a male.

"If it were a religious request, I would make an extra effort to fulfill the request within the limits of continuing to provide the same level of care to all my other patients," says **Mark Debard**, MD, an emergency physician at The Ohio State University Medical Center in Columbus. "I would not, however, go to the length of trying to find someone not on duty to perform the exam. The patient can then make their choice (about whether to have the exam performed by a male)."

• Coin rubbing (Vietnamese custom).

Coin rubbing involves a cultural belief that when you heat a coin and rub it across the afflicted parts of a person's body, it has a healing effect, Banja says. "When they present to an ED physician, if they see burn marks on a child they might suspect parental abuse, so you need to be aware of this practice," he says.

This is a Southeast Asian custom that is easily recognized by experienced emergency physicians, says Debard. "It is harmless and [minor burn marks] should be ignored," he says.

• Do-not-resuscitate (DNR) order.

The DNR is "perhaps the most common and difficult ethical issue with which we deal," says Debard. All states have specific laws on the subject, and it is essential that the emergency physician be familiar with their own state's laws and that they follow them scrupulously, he advises. ■

First of all, he notes, rape victims younger than 18 represent a "small volume" for his ED. "It's often a date-rape incident, and alcohol-related, involving campus freshmen," he notes.

"Our position in general has been that we will provide post-exposure prophylaxis to anyone who requests it," he says. If someone in his group does not feel comfortable providing that care, "usually the staff will call me, and I will be happy to call the prescription in for the patients."

Have a backup plan

While it is admittedly difficult to delve into someone's religious belief, it is nevertheless important to know how your staff feel about these issues, says Keadey. "If there is somebody who feels, for whatever reason, uncomfortable about caring for this problem, you need to have some sort of backup plan to facilitate the care of the patient," he notes.

Banja agrees — to a point. "To the extent that the emergency room physician would routinely have written a prescription for a birth control pill, it should make no difference," he says. "On the other hand, suppose he is even against contraception — now, what do we do?"

Banja notes that while there is great political

Sources

For more information on ethical issues in the ED, contact:

- **John Banja**, PhD, Medical Ethicist, Center for Ethics, Emory University, Atlanta. Phone: (404) 712-4804. E-mail: jbanja@emory.edu.
- **Mark Debard**, MD, Emergency Physician, The Ohio State University Medical Center, Columbus, OH. E-mail: mldebard @cs.com.
- **Matthew T. Keadey**, MD, Medical Director, Emergency Department, Emory University Hospital, Atlanta. Phone: (404) 712-0448.

controversy in the United States about abortion, "women do have the absolute legal right to an abortion during their first trimester, and to the extent that the hospitals are licensed facilities and have to obey the law to maintain that license, they have to respect the rights of the patient."

However, says Banja, the ED manager should respect the conscience of the physician and allow him not to prescribe the pill. "But if I am the ED director, I will have another doctor available to fill it," he says. He "absolutely" recommends making this action part of the ED's policies and procedures.

Even in cases involving younger victims, there are ways for the victims younger than age 17 to ask for Plan B, says Debard. Most states have laws that allow for the examination and care of a minor with regard to sexually transmitted diseases and pregnancy, he says. "If a sexual assault has occurred, this approach can certainly be conceived of under those circumstances," he says, "But in general, I would do it in association with the parents being present."

While the physician still would have the right to refuse care, "I think it would be a very small minority," says Debard. Even then, he says, "There would be an ethical obligation to educate the patient and their parents about where they could get the pill."

(Editor's note: This is just one of many ethical issues that can arise in the ED. See more on this topic, p. 111. For more on emergency contraception, see "Do sexual assault victims receive adequate care? If not, you risk fines, violations," *ED Management,* June 2002, p. 61.) ■

EDs pool resources to weather flood

Staffs combine to meet patient needs during crisis

Three hospital EDs in Binghamton, NY, overcame late June floodwaters that caused one of them to close by sharing staff and other resources to enable the remaining two to function with increased caseloads until operations returned to normal.

It had rained for about a week. Water was covering cars and the first level of many homes when "on the 27th, we received notification that if it continued to rain that day and night it would put us at a dangerous level," recalls **Maria Berry**, BSN, CEN, director of emergency services at Lourdes Hospital.

Following preset disaster policies, a command center was set up, each department called in extra personnel, and supplies and staff were assessed. "Initially, we just evacuated the ground floor, which includes the lab, the cafeteria, supplies and purchasing, social services, radiology, and oncology," she reports. "The ED sits on the main floor, which is the upper level, so we knew we would be safe."

Executive Summary

When disaster strikes your community, creativity can go a long way toward keeping your ED up and running, but cooperating with neighboring facilities can double your available resources in a hurry.

- Contact all unscheduled staff members and request that they accept additional shifts during the crisis.
- If nearby facilities are shut down, contact their manager to ascertain availability of their staff and supplies.
- Seek additional staffing help from local residency programs.

The power plant sits on the ground floor. When it started to take flood, the hospital went to auxiliary power. However, when water overcame the plant, the decision was made to evacuate the hospital — even before the loss of auxiliary power. **(The Joint Commission on the Accreditation of Healthcare Organizations has just issued a *Sentinel Event Alert* on the loss of electrical power. See the story on p. 113.)**

Although the hospital evacuation began at 10:30 a.m., the Lourdes ED remained open. "We were on generator, although we had no air conditioning," says Berry. "We kept accepting patients and had probably six extra nurses and two extra PAs [physician assistants] and physicians." At that hour, the ED normally has one doctor, one PA, and five nurses, but the night shift remained on duty.

By 1:30 p.m., the Lourdes ED stopped accepting ambulances and began transferring their patients to the EDs at Wilson Regional Medical Center and Binghamton General Hospital, which had remained open.

Seeking extra staff

Meanwhile, the other EDs were facing a staffing crisis. "This couldn't have come at a worse time," says **Stephen Gomez**, MD, FACEP, medical director of the EDs at Wilson Regional and Binghamton General. "That week was the first week after two physicians had left on vacation. In fact, every physician who was not scheduled to work was out of town."

Once he heard Lourdes had closed, "I went in and tried to get a read on how bad things would be," he recalls. Gomez coordinated with his administration to ascertain the availability of additional personnel outside the ED, as well as a place to put their overflow

Sources

For more information on dealing with disasters, contact:

- **Maria Berry**, BSN, CEN, Director of Emergency Services, Lourdes Hospital, Binghamton, NY. Phone: (607) 798-5111.
- **Stephen Gomez**, MD, FACEP, Emergency Department Medical Director, Wilson Regional Medical Center, Binghamton General Hospital, Binghamton, NY. Phone: (607) 763-6412.

ED patients.

He called every one of his staff members who was in town and already scheduled to work and let them know what was happening, and he told them that they needed to be on standby in case extra staff were needed. "Everyone who was in town readily agreed," says Gomez.

Despite the fact that some staffers had flooded homes and children affected by closed schools, they continued to work. With so many flooded roads, some staffers had to take alternative routes.

Once he knew for sure his EDs would be getting more patients, Gomez started calling his staff and assigned them to the two EDs. "Wilson was where we handle trauma and cardiac cases, so they got the bulk of our additional patients," he says. "Then, I started making contact with Maria Berry to check on the availability of their practitioners."

Berry sent basically everyone who scheduled to work the regular shift to the two open hospitals, "and we continued to do that for the next 12 days," she says. In addition, she says, Lourdes sent intravenous pumps, beds, stretchers, and monitors. The items were transported by the National Guard and local fire departments, says Berry. Wilson Regional and Binghamton General also sent trucks to pick up equipment. Fortunately, the road between the hospitals was completely clear of floodwaters.

Once the Lourdes staff arrived, the ED nurses were paired up with staff nurses, met the other staff and managers, and went through orientation. "Within a short period of time, they got full access to our computer system and the meds administration system," says Gomez.

The additional staff were more than welcome. In one day, the volume at the two remaining EDs went up 60%. Gomez found additional help as well. "We have a teaching program of internal medicine and family practice at Wilson Memorial, and some senior residents and attendings came in and helped out during times of really peak volume," he says. "The key really was to assign them to areas in which they were comfortable, which was not too difficult, as most of those cases were medical cases, not trauma cases."

To help accommodate the additional patient demand, Gomez had the gastrointestinal lab turned into an overflow area, staffed by nurses, for several patients who were waiting for test results. Stretchers were brought in for those patients. "That worked out well," says Gomez. ■

JCAHO issues *Alert* for power failures

The 2001 floods in Houston. The 2003 blackout in the Northeast. Hurricanes in the Southeast.

These disasters showed how severely clinical operations can be affected in health care organizations that lose their electrical power, and they have led the Joint Commission on the Accreditation of Healthcare Organizations to issue a *Sentinel Event Alert.* The *Alert* urges health care organizations to pay special attention to how emergency power systems can fail and recommends specific steps to keep patients safe in a disaster or other event that knocks out the organization's electrical power.

To reduce risks to patients created by power failures, the Joint Commission recommends that health care organizations take the following specific steps:

- Match the critical equipment and systems needed in an extended emergency against the equipment and systems actually on the emergency power system.
- Inventory emergency power systems and the loads they serve.
- Provide training for and test those who operate and maintain the emergency power supply system.
- Ensure that generator fuel is available and usable.
- Ensure that the organization management and clinical leaders know how long emergency power will be available and what locations within the facility will and will not have emergency power in the event of an electrical outage.
- Establish contingency plans for doctors and other caregivers to follow during losses of electrical power.

Joseph Cappiello, the Joint Commission's vice president of accreditation field operations, says he first witnessed how electric power failure can affect patient care and safety during Tropical Storm Alison in Houston in 2001. "Memorial Hermann was impacted to the point

Resource

You can access *Sentinel Event Alert* Issue 37, Sept. 6, 2006, on the Internet by going to: www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_37.htm.

where they had to evacuate without power," he recalls. "They had to carry people down the stairs strapped to backboards in the dark, carrying flashlights, and I think transported 30-40 ventilator-dependent patients."

For EDs, he notes, loss of power means loss of lights, loss of ventilators, and lack of power for portable X-rays and ultrasound machines. "In addition, you have to work in a chaotic environment when the lights go out, and the amount of calls and visits go up dramatically," Cappiello says.

Be proactive

Because their departments can be affected so severely, ED managers must take a proactive stance in seeing that the Joint Commission's recommendations are followed in their facilities, says Cappiello.

One specific area of concentration should be the recommendation of matching critical systems and equipment, he says. When the Northeast was hit with a blackout several years ago, he says, it was assumed that critical equipment such as ventilators were hooked up to the backup system, but often they weren't. ED managers should review the backup system, identify critical equipment, and make sure all of it is in the backup power plan, he advises.

"The ED manager need not do that in isolation, however," he adds. "This is an issue they should bring up at meetings of the emergency preparedness committee, and take the initiative to recommend this is checked once a year."

Contingency plans also are critical, he continues. For example, notes Cappiello, many hospitals have boxes of flashlights available for use during power outages, but that may not be the best way to go. "It's not an easy thing to provide patient care with one hand, or start an IV, while holding a flashlight," he notes. "The ED manager should think about other emergency lighting — something like headband lamps or miner lamps — and have them available." ■

Hospital planning ahead for bird flu pandemic

ED plays critical role in developing response plan

The staff at the University of Utah Hospital, Salt Lake City, is taking a proactive approach to the possibility of an avian flu or other influenza pandemic, and the ED is playing an integral role in the development of the response plan.

Executive Summary

In preparing your department's response to a pandemic, it's best to plot out worst-case scenarios. Once the scenarios have been created, explore all possible solutions to equipment and staffing shortages.

- Since existing capacity will be insufficient, identify in advance alternative sites for treating victims.
- Stay abreast of new equipment developments, such as multiple ventilators, that may help deal with the added volume of immune compromised patients.
- Recognize that the level of care will be reduced, and adjust your emergency preparedness protocols accordingly.

"I think the ED is one of most important elements [in creating a plan]," says **Colleen Connelly**, RN, BSN, emergency preparedness manager. "They have a better understanding of triage, but beyond that, they have a better feel for telling people who need help that they have to wait; that's a skill that no one else in the hospital has clearly defined."

In any emergency response, triage capability is clearly paramount, she says. "It's not like this would occur within 24 hours; it will be a slow buildup," she predicts. "And we will depend on the ED to help us identify those initial patients coming in, making sure we have effective use of personal protective equipment and that we separate the infected patients from the rest of the people in the hospital."

Because of those skills, she says, the ED is intimately involved in the development of triage protocols, which must be specifically crafted for pandemic response. "For example, we will not have enough ventilators, so who gets them?" Connelly says.

Accordingly, she says, **Gerald Doyle**, MD, an ED physician and assistant professor in the Division of Emergency Medicine at the University of Utah, is part of the emergency preparedness policy group that makes decisions for areas such as triage, ventilator use, and antiviral distribution.

Worst-case scenarios

Doyle's approach is to look at worst-case scenarios such as lack of resources. "There is not one of those problems we can solve ideally, but if we adapt to them and put together a good plan, we can maximize our chances of success," he explains.

So, for example, while the Centers for Disease Control and Prevention (CDC) has statistics available from the 1918 avian flu pandemic, Doyle notes that their value is limited due to changes in medicine and

Sources/Resources

For more information on emergency planning for a pandemic flu outbreak, contact:

- **Colleen Connelly**, RN, BSN, Emergency Preparedness Manager, University of Utah Hospital, Salt Lake City. Phone: (801) 585-3134. E-mail: colleen.connelly@hsc.utah.edu.
- **Gerald Doyle**, MD, Assistant Professor, Division Emergency Medicine, University of Utah, Salt Lake City. Phone: (801) 581-2730. E-mail: gerald.doyle@hsc.utah.edu.

For more information about the Centers for Medicare & Medicaid Services (CMS) scoring system for community-acquired pneumonia, go to the CMS web site: www.cms.hhs.gov. In the search box, type "CAP + scoring." Then, click on "HQI Composite Ranking Index Calculation."

For more information on disaster ventilators, contact: Vortran Technology, 3941 J St., No. 354, Sacramento, CA 95819. Phone: (800) 434-4034. Web: www.vortran.com/vortran.html.

the advent of air travel, which, of course, enables a more rapid spread of the disease. "I don't think we have a handle on what we're dealing with, which makes it harder to plan," he says. "Also, more people are walking around with immunodeficiency and diabetes, making the playing field vastly different."

These changes, in turn, will affect triage protocols. "We expect those individuals to be sicker and more subject to lung disease, for example, so we're looking at incorporating those factors into our triage protocols," Doyle says. For example, he notes, the group is considering the use of community-acquired pneumonia (CAP) scoring systems developed by organizations such as the Centers for Medicare & Medicaid Services. **(See resource box, above.)**

Many patients on 1 ventilator?

Doyle says he also is looking at new developments in academic medicine that may enable placing several patients on a single ventilator, as outlined in an article just published on-line in *Academic Emergency Medicine.*[1] The reality is that with shrinking bed capacity and fewer ICU beds, we do not expect we will have enough ventilators to go around," he says.

ED staff members are not comfortable with the concept of having several patients attached to a single ventilator, Doyle says. "We've been taught for so long that you have to isolate people to prevent the spread of infections that this is a pretty amazing proposal," he concedes, "But it may be something we need to do."

Others, such as Vortran Technology in Sacramento, CA, are designing simple, relatively inexpensive disaster ventilators. **(See resource box, left.)** "But this speaks to an overarching concern of mine: What will the standard of care be?" Doyle says.

As much as it bothers him, Doyle says that it may be necessary to accept that lower standard of care when developing a realistic disaster preparedness plan. "To deal with a pandemic outbreak, there very well may have to be a decrement in the level of care people get," he admits.

For example, he points out; the CDC says that anywhere from 10% to 40% of the health care work force will not show up for work during a pandemic. "With a strenuous burden on the nursing staff already due to shortages, people will have to start looking at ways to get around that — and keeping people cared for may need some major adjustments," Doyle suggests.

What might some of those adjustments be? "At some point, we may have to largely focus around just comfort measures," he predicts. "People may not have all their linens changed as frequently, and more self-care may be required in terms of bathing and so forth."

But that's not the worst of the scenarios Doyle envisions. "It may get to the point where we won't get things we rely heavily on that are provided by contractors, such as liquid oxygen," he says. "If their trucks don't arrive, we may have to ration it."

This also could happen with drugs, he says. "If we need Tamiflu and it's just not out there, we may need to ration it or limit the dosages," he says.

Reference

1. Neyman G and Babcock Irvine C. A single ventilator for multiple simulated patients to meet disaster surge. *Acad Emerg Med* published Aug. 2, 2006, as doi:10.1197/j.aem.2006.05.009. ■

Satisfaction turnaround requires persistence

ED staff ride 'roller coaster' before earning award

The ED staff at Saint Francis Medical Center in Cape Girardeau, MO, is justifiably proud of the Compass Award it recently received from Press Ganey Associates of South Bend, IN, for raising their patient satisfaction scores from the 36th percentile to the 96th. But they'll also be the first to tell you it wasn't easy.

The ED started using Press Ganey in late 1998 for external benchmarks, reports **Marilyn Curtis**, MSA,

Executive Summary

The key to improving patient satisfaction scores and maintaining those improvements lies not only in devising a successful strategy, but in ensuring that your staff consistently follow the new procedures.

- Institute simple changes, such as stools in exam rooms, to ensure closer physician-patient contact.
- Post satisfaction scores in the department to make the staff aware of how they are performing.
- Use focus groups and outside experts to generate new ideas for you to implement with your staff.

vice president of professional services. "As we started that process, our scores really bounced around," she says. "They could be as high as the 80s or as low as the 50s."

In fact, even some dramatic initial successes proved to be short-lived. Thanks to improved "scripting," which required staff to tell the patient their names, explain what they were doing, and ask upon leaving if the patient needed anything else, scores initially went straight up. "In February 2002, we hit the 97th percentile," notes Curtis. "We got so excited that we took out a full-page ad in the local paper and gave each employee a gift certificate."

However, she adds, they were soon to realize they did not have consistent focus. In fact, says **Marcia Abernathy**, RN, director of emergency services, "In August 2003, our score was in the 36th percentile."

Turning it around

To turn the scores around again and to ensure consistency, a service excellence committee was established that included ED medical staff, floor nurses, and registration and medical records staff. Their goals included the following:

- Determine scripting effectiveness.
- Determine customer perceptions of the staff.
- Determine customer understanding of emergency/trauma services.
- Obtain input on improved changes.
- Determine patient perceptions at all levels of the emergency process.
- Determine initial and final customer impressions.

The scripting was reintroduced to help ensure consistency, Curtis says. The team started tracking weekly satisfaction scores, posted them in the department, and compared each quarter's scores with those of the previous quarter. In November 2003, the ED went to 10-hour shifts for physicians. They had been 12 hours. "We had a couple of physicians who just did not seem to be able to meet customer service expectations, so we also made a couple of changeovers" in staff, she notes.

Gainsharing program included score

Another key motivator was the hospital's gainsharing program, which actually went into effect in late 2000 but later was modified for the ED. Your department had to exceed your budgeted gross margin, she says. "To even be eligible, your Press Ganey [score] had to hit the 70th percentile, and not until you hit the 90th would you be eligible for all the gainshare dollars," Curtis explains. This past year, staff members who did not take any sick days (another component of the formula) could have earned $5,500.

In April 2004, several key leaders, including the staff RN, the hospital executive team, and the ED's assistant manager, attended an ED service excellence workshop by Quint Studer of the Gulf Breeze, FL-based Studer Group, an executive coaching firm. "We really ended up using three components to help us go forward: the ideas from the workshop, our own internal service excellence committee, as well as several focus groups we held with employees of the medical center who had been patients or whose family members had been patients in the ED," says Curtis.

Actions still are being implemented. They include:

- scripts for staff to remind patients to complete their satisfaction surveys;
- altered doorway structures to keep cold air from entering the emergency waiting area;
- waiting time posters comparing the amount of time waiting at Saint Francis to the national standard in emergency situations;
- posters reinforcing the fact that patients are not in a typical doctor's office by focusing on trauma prevention and the urgent nature of injuries stated on the posters;
- patient care cards thanking patients for their business, asking them to complete a forthcoming survey, and explaining that Saint Francis strives to provide the best care possible;
- follow-up telephone calls to check on patient progress after discharge and remind them to complete the satisfaction survey.

Sources

For more information on improving patient satisfaction, contact:

- **Marcia Abernathy**, RN, Director of Emergency Services, or **Marilyn Curtis**, MSA, Vice President of Professional Services, Saint Francis Medical Center, 211 Saint Francis Drive, Cape Girardeau, MO. Phone: (573) 339-1265.

• additions to waiting and care areas, such as stools for physicians so they can sit and speak with patients eye to eye, boards for physicians to write their names on so patients can easily identify their caregivers, etc.

The stool had a significant impact, Abernathy says. "It removes the perception you are just breezing in and out," she says. "A lot of the staff used to just stand at the door and were not even aware they were doing it." **(Working with your staff on these projects can be a challenge. See the story, below.)** ■

Help your ED staff get over culture shock

Patient satisfaction improvement projects can be a significant challenge for an ED manager, says **Marcia Abernathy**, RN, director of emergency services at Saint Francis Medical Center in Cape Girardeau, MO.

"I think the basic temperament and type of individual who works in the emergency setting is not really your 'fluffy' person," she says. "They are very intent on the clinical aspects of the care."

In other words, Abernathy says, ED staff take great pride in their quality of clinical care, but are sometimes not as focused on their interpersonal relationships. How did she overcome this challenge?

"You have to have credibility with your staff, and since I had been on the clinical side myself and had fallen into the same trap, I had it," she says. "I told them that we may be meeting the expectation of every patient that they will be getting good care, but we needed to go a step further and give the patient a feeling of comfort and safety as well."

This meant "really forcing the staff" to put themselves in the position of the patient, says Abernathy. She reinforced that message at staff meetings. "I had to be there and watch provider-patient interactions, and when I got specific feedback from the patients, I shared it," she says.

Abernathy also listened to what her staff had to say. "They initially did not like the idea of a script," she recalls. "They said, 'If you want us to have our care be more personalized, then let us use the same basic content to get the main points across, but allow us to make it sound like us.'" Abernathy agreed.

Who calls discharged patients?

Another area where Abernathy bowed to reality involved the daily follow-up calls to discharged patients. The ED nurses handled these calls themselves initially. "Many times the nurse was actually calling their own patient and actually got feedback," she recalls. However, when the census went up, Abernathy realized that task was no longer possible. "Ultimately, we had to acquire an assistant ED manager for evening shifts, and now that's the first thing they do," she says. ■

Will new e-facility help fight ED overcrowding?

New site can positively effect LWBS, satisfaction

A newly opened telemedicine primary care facility in Peachtree City, GA, called Health-e-Station, will help curtail the severe overcrowding problems facing area EDs, according to its founder. What's more, he asserts, by keeping nonemergent patients out of EDs, it also will reduce the number of patients who leave without ever being seen and will significantly improve average wait times and patient satisfaction.

The first Health-e-Station in the nation (more are planned soon in Georgia), located in a shopping mall, is next to a 24-hour Kroger pharmacy. When the patient arrives, he or she is registered into the facility's computerized system by a medical assistant using a touch screen. "That information is immediately available to a physician who is in another location," explains **Andy Agwunobi**, MD, MBA, founder of Health-e-Station. Agwunobi also is a pediatrician, executive vice president and chief operating officer of St. Joseph Health System in Orange, CA, and immediate past president and CEO of Grady Health System in Atlanta.

"When the patient is taken into the examining room, the physician is already up on the plasma screen and welcomes and talks to the patient," he says.

Executive Summary

The use of telemedicine to diagnose patients before they come to the ED may benefit the operation of your ED, as well as the emergency medicine system in general. Potential advantages include the following:

- By identifying nonemergent cases, it can help reduce overcrowding.
- Since nonemergent patients have the longest wait times, it may reduce rates for patients who leave without being seen and boost satisfaction.
- It can help avoid unnecessary transfers to and from the ED.

Several Health-e-Station physicians are located in a separate facility from which they treat the current patients and will treat patients at future Health-e-Station locations.

The Health-e-Station equipment enables the physician to remotely examine the patient's ears, eyes, throat, and skin.

'Same truth to both sides'

While asserting this new concept will help ease ED overcrowding, Agwunobi, who himself has overseen EDs, acknowledges "there is some truth to both sides," noting a recent study from the American College of Emergency Medicine that asserts patients with minor ailments do not cause ED overcrowding. **(See story, p. 119.)** "Yes, there are certainly people in the EDs who are real emergencies, but if you look at the recent [Institutes of Medicine] report on emergency medicine, there is also agreement that some portion of those patients are nonemergent, and some studies have shown that up to 30% of visits to the ED are for nonemergent conditions." **(For more on the IOM report on emergency medicine, see the special report in the July 2006 issue of *ED Management.)***

Agwunobi goes on to say the actual percentage may be unknown and that the numbers will vary from facility to facility. "One thing we know for sure: When nonemergencies come in, they will wait longer — and rightly so. It is not unusual to wait all night and still not end up not being seen."

Accordingly, he says, facilities like his will have an impact on the patients who leave without being seen (LWBS) and on patient satisfaction, "Because the people who do need to be in the ED will be seen faster."

Sources/Resource

For more information on telemedicine's impact on the ED, contact:

- **Andy Agwunobi**, MD, MBA, Executive Vice President and Chief Operating Officer, St. Joseph Health System, Orange, CA. Phone: (714) 721-4067.
- **Michael Bishop**, MD, CEO, Unity Physician Group, Bloomington, IN. Phone: (812) 322-0151. E-mail: mbishop@unitypg.com.
- **Bruce Janiak**, MD, FACEP, FAAP, Professor of Emergency Medicine, Medical College of Georgia, Augusta. Phone: (678) 852-1639.

For more information on Health-e-Station, go to: www.healthestation.com.

Some ED experts disagree, however. "While I'm not necessarily opposed to the concept, if the goal is to relieve crowding in the ED it will not help," asserts **Michael Bishop**, MD, CEO of Unity Physician Group, a Bloomington, IN-based emergency medicine urgent care physician group. "It has nothing to do with the 10%-20% of patients who present with nonemergent problems, because in general those patients are there not just because of a lack of access to a primary care provider, but for other social reasons — they don't have money, insurance, or transportation."

Those types of issues do not go away because a patient is talking to a TV screen instead of having a doctor physically there, he says. "If you don't have to pay [in an ED], nothing's cheaper," Bishop says.

Although he says that Health-e-Station's charges seem fairly reasonable, Agwunobi says they can go as high as $60 for the most complex visit.

Bruce Janiak, MD, FACEP, FAAP, professor of emergency medicine and an emergency physician at the Medical College of Georgia, Augusta, comes down somewhere in the middle. "Will it alleviate overcrowding? I'm not sure," he says. "It has to have some kind of positive effect, but it may take business away from doctors' offices as much as it will EDs."

What is the impact?

In terms of helping with LWBS rates and patient satisfaction, Janiak says Agwunobi "is right on the mark." How many patients it can effect is unclear, he concedes, "But we do know that time of throughput relates to satisfaction, and waiting for nonemergent care takes longer," Janiak says. What isn't known, he continues, is what percent of people are unwilling to wait three hours or more, rather than pay $30 or $40.

His summary of the technology? "Overall, I really encourage experimentation," he says.

Still, says Janiak, this may not be the most cost-effective application of telemedicine for EDs. "We know from studies that a lot of patients are sent from nursing homes to EDs because of a changing or perceived change in condition, and that at least half of them go back — which is another transport," he notes.

The latest study on cost, which is several years old, indicated each transport cost about $1,500, says Janiak.

"If you put up telemedicine in the nursing home and had an emergency physician talk to the people there about the patient, 50% of transports could be eliminated," he asserts. "You are talking about savings of tens of thousands of dollars a year, vs. the cost of a [personal computer]." ■

Study: Minor ailments don't cause ED overcrowding

Culprit: Delays for sicker patients

Patients who come to EDs with minor conditions do not contribute significantly to delays and overcrowding, despite widely held beliefs to the contrary, according to a new study published on-line by the *Annals of Emergency Medicine.*[1]

"Our research shows that caring for patients with minor ailments [or low-complexity patients] does not lead to longer delays or slower care for other, sicker patients," said **Michael Schull**, MD, an emergency physician at the Institute for Clinical Evaluation Services in Toronto, and the article's lead author, in a prepared statement from the American College of Emergency Physicians. "We already know that it is delays in the care of sicker patients, especially those who require hospital admission, that lead to worsened crowding. Therefore, our study suggests that low-complexity patients are not a key contributor to overcrowding."

10 minor ailments equal 5.4 minutes

Over a one-year period (April 2002 to March 2003), Schull and his team studied 4.1 million patient visits at 110 emergency departments in Ontario hospitals. They found that every 10 patients with minor ailments arriving in any eight-hour period added only 5.4 minutes on average to the length of stay and 2.1 minutes on average to the time spent waiting to see the doctor for patients with more serious medical problems.

The study suggests that reducing the number of low-complexity patients in EDs would do little to reduce ED delays for sicker patients and, hence, do little to reduce crowding. One likely explanation is that most patients with minor ailments or injuries are not usually placed in the treatment spaces used for sicker patients. In addition, the resources they require are generally simple and readily available, and staff allocates time to these patients in lower priority than they do for sicker patients.

However, **Thomas Granchi**, MD, medical director of Ben Taub General Hospital Emergency Center in Texas' Harris County, told the Houston Chronicle that Schull's findings are "counterintuitive" and do not affect physicians' "assumptions or current knowledge."[2] He added that the study compares "apples and oranges," as the United States and Canadian health systems differ.

References

1. Schull MJ, Kiss A, Szalai JP. The effect of low-complexity patients on emergency department waiting times. *Ann Emerg Med* Aug. 25, 2006. DOI: 10.1016/j.annemergmed.2006.06.027.
2. Ackerman T. "Study casts doubt on policy to help ERs." *Houston Chronicle,* Aug. 23, 2006, Section B, p. 1. ■

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. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

COMING IN FUTURE MONTHS

- ED goes on divert one hour in two years
- Study: Follow-up care for suicidal patients
- ED slashes door-to-doc time from six hours to less than two
- More EDs allowing families to view resuscitation efforts

CE/CME *questions*

1. According to Mark Debard, MD, policies that protect the ethical rights of physicians and patients:
A. are common in most EDs.
B. are unnecessary.
C. are rare, but should be instituted in all EDs.
D. are required by law.

2. According to Colleen Connelly, RN, BSN, during a communitywide disaster response, the ED is responsible for:
A. identifying initial patients coming into the ED.
B. ensuring effective use of personal protective equipment.
C. separating infected patients from the rest of the patient population.
D. All of the above

3. According to Marcia Abernathy, RN, the best approach to scripted communications with patients is to:
A. make them mandatory.
B. allow staff to personalize them, while maintaining the basic content.
C. make them voluntary.
D. not have them at all.

4. According to Stephen Gomez, MD, FACEP, what is the appropriate use of residents and attendings in the ED during a disaster?
A. They should be used for medical cases, but not for trauma.
B. They never should be used.
C. They should be used only as a last resort.
D. They should be used whenever needed.

5. According to Michael Bishop, MD, what percentage of ED patients present with nonemergent problems?
A. 0%-10%
B. 10%-20%
C. 20%-30%
D. 30%-40%

6. According to the Joint Commission on the Accreditation of Healthcare Organizations, which of the following steps should be taken to reduce risks to patients created by power failures?
A. Match the critical equipment and systems needed in an extended emergency against the equipment and systems actually on the emergency power system.
B. Establish contingency plans for doctors and other caregivers to follow during losses of electrical power.
C. Ensure that the organization management and clinical leaders know how long emergency power will be available and what locations within the facility will and will not have emergency power in the event of an electrical outage.
D. All of the above

CE/CME answers

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