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The monthly update on Emergency Department Management

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Reimbursement cuts, payment delays threaten ED bottom lines

Seemingly arbitrary payer reductions are announced without warning

On May 1, 2006, Medical Mutual of Ohio (MMO), one of the state's largest insurers, instituted an immediate reimbursement rate cut of 50% for all physicians, including ED doctors. In the same year, TennCare, created in 1994 to replace Tennessee's original Medicaid program, disenrolled more than 100,000 people as a cost-saving measure.

These are just two of the higher-profile moves that have taken place recently that threaten the economic well-being of EDs and the ability of ED managers to attract and retain talented physicians. Insurance companies are exerting unusual influence in abruptly and arbitrarily reducing payments or delaying them, industry sources say. They are announcing that they won't pay for certain services, such as observation, X-rays, or EKGs, or they are bundling the charges with evaluation and management (E&M) services.

"I've heard numbers [for reimbursement cuts] ranging from 10%-20% to the 50% MMO announced," says **Ron Stunz**, MD, medical director of Healthcare Business Resources in Bala Cynwyd, PA, which provides ED management services to hospitals. "I have also seen, in my experience as a managing physician in a fee-for-service practice, periodic and recurrent delays in reimbursement that are inexplicable" based on any business consideration, he says.

Executive Summary

The best way to limit the damage to your department from arbitrary insurance reimbursement reductions and delays is to be proactive. Learn all you can about the appeals process and be on guard for subtle signs that the insurer's payment procedures may have changed without any formal announcement.

- When negotiating a contract, be sure to have a billing and coding expert accompany you.
- Regularly compare your volume statistics with your revenues to spot sudden substantial discrepancies.
- If you suspect a change in reimbursement procedures, conduct a random audit of at least 100 charts.

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— Evaluation form for CE/CME subscribers

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While Medicare always pays for EKGs, many private payers will deny or bundle the charges, adds **Dave Packo**, MD, president of Emergency Medicine Physicians (EMP), a Canton, OH-based provider of emergency medical services that is fighting the MMO increases. Packo also is a practicing emergency physician.

Packo reports a new wrinkle he has just personally experienced. "We recently had a hospital that signed a new insurance contract for their employees, introducing HSAs [health savings accounts] of $3,500 for each person, but the payer said they wanted us to sign on to a 50% reduction in fee schedule," he says.

Packo says EMP is still trying to negotiate a better arrangement. "No doubt in the long run we will take a big hit if we want the contract," he concedes. "We've been told if we not do agree quickly, they will find another group that will."

The bottom line is that all EDs and physician groups are under a lot of pressure from the expense and revenue side, Packo says. "We have a lot of payers who are either cutting rates, bundling certain CPT codes, or denying particular payments like EKGs or after-hours care."

Implications are serious

Moves like these can have serious implications for ED managers, experts agree. TeamHealth, a Knoxville, TN-based provider of ED administrative and staffing services, serves more than 50 EDs in the state of Tennessee. TeamHealth is fighting the TennCare changes, notes **Ron Matthews**, senior vice president of operations and managed care. Reportedly, TeamHealth has taken action against MMO, according to sources. "TennCare has been very slow to react, and they plan to go live in April," Matthews says.

Because ED physicians in Tennessee will not be able to work for less than they are making now, the proposed changes will "exacerbate things in the ED," he says. If primary care providers cease participating in the TennCare program, the ED will be the only place many of these individuals in rural areas can visit to receive medical care. "They will be even busier, for fewer dollars," he says.

These kinds of developments clearly have implications for staffing, says Stunz. "How many hundreds of thousands of dollars in reimbursement have to be lost before it means the ED has lost its ability to hire physicians or PAs?" he asks.

Stunz adds, tongue very much in cheek: "I'm not aware of Ohio reducing its malpractice insurance [to compensate for the MMO cuts]." ED doctors and departments, he notes, face a number of fixed expenses. "EDs may have to cut redundancy of staffing to compensate," he predicts.

For the ED manager, the impact of all of these trends is interwoven, says Packo. "For example, some cuts may not impact directly on the hospital, but you could still have a group of unhappy physicians," he says.

Of course, there always is the option of terminating a contract, as EMP may have to do with MMO. "We're

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still negotiating, but this affects the ED manager because when you terminate a contract, they either need to make cuts in the practice or cut the hours they work, and this affects patient care," Packo explains. "You can't change even one thing in this process without it having an impact [on another area]."

Know appeals process

Before you reach a point as dramatic as terminating a contract, there are other steps that can be taken against onerous reimbursement cuts — although success is far from guaranteed, say observers.

What's important when you sign a contract with a carrier is that you really need to know how their appeals process works, says Stunz. "However, the reviewers may not be 100% objective," he says. There still is a "bounty hunter" mentality among reviewers in that they are compensated in some way based on what they find, Stunz notes. "However, while they are incentivized to 'find' something, what they find may not be in line with the industry-accepted coding policy," he says.

You do have a right to challenge, but the problem Packo finds is that the reviewers tend to be blinded to any opinion other than their own. The insurance companies may say they are using a nonbiased auditor, "but sometimes that auditor is on their payroll — or, the appeal is sent to their medical director, who invariably agrees with them," he says.

First of all, you need to know how the appeals process works, who does it, and what the mechanism is for dispute resolution, Stunz says. "In other words, if you are not happy with the outcome, what option is left to you?" he says. "Many ED managers just don't bother to get down to that level of granularity."

Catch things early

There are perhaps greater opportunities to prevent an onerous financial outcome by catching small problems before they become big ones, say the experts. Stunz says his general advice when first negotiating a contract "is to have someone with you at the table from the coding and billing side who has some experience with multiple payers and has some idea of what should and should not be in it."

Clearly, keeping a close eye on cash collections is important, Matthews advises. "With any payer where you see a specific trend, you need to go in and review claims," he says. "Do your own sampling."

How many charts should you review? Stunz says, "I wouldn't look at less than a couple of hundred charts if I felt there was an issue, but [when you don't necessarily suspect something] a sampling of 100 charts or less might unveil a potentially irregular increase."

Regularly compare your volume stats with your revenues, so you can spot sudden substantial discrepancies, Stunz suggests. "Except for regular seasonal changes [for example, there are traditionally delays in reimbursement in January and February] — assuming your volume is constant — if there is suddenly a drop in revenue, that's a potential red flag that there is a delay on the part of the payer," he says.

If you are concerned about reimbursement for procedures, "you should track payments yourself or have your billing company track procedural codes to make sure you are being separately reimbursed [for each procedure]," Stunz advises.

He also recommends that you check the Internet and emergency medicine listservs to learn about coding issues that already may have been adjudicated. One site he particularly recommends is EMED-L@ itssrv1.ucsf.edu, a list for hospital-based emergency medicine practitioners provided by the University of California at San Francisco medical center. **(To subscribe, send an e-mail to: listserv@itssrv1.ucsf. edu. Put SUBSCRIBE EMED-L in the message line. For more information you can contact the list owner at: emed-l-request@itssrv1.ucsf.edu.)** ■

Palliative program yields triage changes in the ED

Turnaround accomplished in just six months

If your hospital doesn't have a palliative care program yet, it soon will, and that may mean changes in the way you triage your patients.

The 2007 American Hospital Association *Annual Survey of Hospitals,* which included data analysis from the New York City-based Center to Advance Palliative Care (CAPC), shows that 1,240 hospitals now provide palliative care programs. What's more, 50% of all facilities with more than 75 beds have a program, and 70% of those with more than 250 beds have a program, CAPC says. According to CAPC, the total in 2000 was 632.

While the advent of such a program may mean changes for your ED, it can be a win-win for your department and the new program. The Mount Carmel Health System in Columbus, OH, initiated its program in 1997, and not only has the program proved successful, but it has helped speed throughput in the ED. When there is a palliative care bed available, it usually takes 30 minutes from door to transfer, vs. 90-140

Executive Summary

Ensuring a smooth transition when your hospital adds a palliative care program can help improve throughput in your department while enhancing patient care and flow throughout for the facility. Here are some key steps for you to take:

- Develop and/or obtain from the palliative care department a set of triage triggers for palliative care admission and palliative care consults.
- Communicate the triggers to your staff. Post the triggers prominently, and publicly recognize physicians who are using them on a regular basis.
- Make sure ancillary department staff such as social workers and chaplains are available for lengthy consultations with family members.

minutes for an admitted telemetry or ICU patient, says **Loren Leidheiser**, DO, chairman of the Department of Emergency Medicine at Mount Carmel's St. Anne's Hospital in Westerville, OH.

It was not time-consuming to make the adjustment, he adds. "It was almost a relief," he explains, because now there was another alternative for moving patients out of the department.

Filling needs

The St. Anne's ED sees about 73,000 patients a year, while the hospital is relatively small — about 185 beds, notes Leidheiser. "While we see 1,000 pediatric patients a month and we are not a major trauma center, we do see a lot of patients in their 60s, 70s, and 80s," he says. "We also have a cancer center, so this provided a patient population that included people with chronic illnesses that raised more management issues than cure issues."

The ED had to move admitted patients out, the program had to provide needed services, and the administration was seeking new ways to get patients into the hospital, Leidheiser summarizes.

To begin the process, Leidheiser invited the leaders of the new program to come to one of his department's bi-weekly meetings for nurse and physician leaders. They then pushed out the information to the rest of the department.

"The big issue was communication, since we write our own orders in the ED," says Leidheiser. "This allows us to control throughput better, but with the new palliative care program, there were additional things to consider when admitting patients."

The palliative care program provided the ED with indications for direct admits and for palliative care consults. The palliative medicine service developed a list of triggers, says **Sharol Herr**, RN, MSEd, CHPN, a nurse clinician with Mount Carmel Palliative Medicine Services. **[The complete list of triggers is available with the online version of *ED Management*. If you already have an online subscription, go to www.ahcmedia.com. Select the tab labeled "Subscriber Direct Connect to Online Newsletters. Please select an archive." Choose "ED Management," and then click "Sign on" from the left-hand column to log in. Once you're signed in, select "2006," and then select the March 2007 issue. For assistance, call customer service at (800) 688-2421.]**

The triggers were shared with the entire ED staff via e-mail. Leidheiser says, "That was the springboard, but the true piece that led to success was the palliative care people sent progress e-mails that I would forward. They would identify doctors who were using the program really well, and I would send out congratulations, which would serve as an ongoing reminder."

Mount Carmel keeps a supply of palliative service admission orders in the ED so they were handy, Herr says, "and they have the list of triggers posted by every documentation computer in the ED." Now, they are able to look in a template and determine whether a patient is appropriate for palliative care, notes Leidheiser. For example, if a patient comes in with an abdominal or pulmonary mass that is a brand-new diagnosis, "we immediately use palliative care services and do not lose the 36 hours it takes for an internist to admit the patient, and then consider a consult after those 36 hours," he says.

Education critical

Staff education is critical to the success of a transition such as this one, Leidheiser emphasizes. "You can put in all the triggers you want, but education is huge," he says. "Your staff has to understand what kind of care the program will be giving and how the patient will benefit from it."

In fact, adds Herr, the entire ED staff had to be educated because the medical staff informed her they did

Sources

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- **Loren Leidheiser**, DO, Chairman, Department of Emergency Medicine, St. Anne's Hospital, Westerville, OH. Phone: (614) 898-5550.

not have the time, for example, to sit down with the family and discuss the program in depth. A resource team of chaplains, social workers, and case managers can initiate the palliative care process by informing the ED clinical staff when a family has told them they only want palliative care for their loved one, she says.

"We developed a resource team to have those difficult discussions with families in the ED about advanced care planning and establishing goals of care," Herr says. The hospital has several chaplains on staff, including some whose primary unit assignments are the ED, she says. They are on call 24/7. In addition, there is a caseworker or a social worker in the ED at all times. ■

Executive Summary

Adding a pharmacist to your ED staff can improve cost efficiency, reduce the time it takes to have drugs available for patients, and aid in compliance with accreditation standards for medication review.

- Standardized treatment for common diseases and conditions helps ensure that drugs will be readily available at all times.
- On-staff pharmacist will review medications prospectively and retrospectively, helping your department comply with requirements from The Joint Commission.
- Pharmacist's recommendations on product standardization will enable you to consolidate your drug supplies.

Pharmacist in ED slashes medication errors by 50%

Turnaround accomplished in just six months

By placing a pharmacist within the department to review medications being given to patients, the ED at Huntington Hospital in Pasadena, CA, has achieved more than a 50% reduction in errors in six months.

The clinical pharmacist, **Jill Hara**, PharmD, approached the director of the pharmacy department at Huntington with the idea about two years ago. "I was coming out of a specialty training program for ED pharmacists," she reports. The proposal had several objectives: to help the ED comply with The Joint Commission requirements for review of medication, to monitor contrast administration within radiology, to improve medication safety, and to increase communication between the pharmacy and the ED.

Jeanette Abundis, RN, MN, the ED's clinical director, was supportive — which was essential because the ED pays Hara's salary. "I thought it would be of benefit since a lot of our medical management oversight of meds was occurring based on the practitioner's history with a product," Abundis notes. "They may not have been considering more recent meds or meds that were more effective, more cost-efficient, and with fewer side effects."

In addition, she says, Hara's presence has allowed the ED to streamline and control practice patterns and to create more consistency in how certain diagnoses are treated, based on her recommendations. "Physicians regularly recommend antibiotics or pain control meds, but it helps when you have a pharmacist on board to look at other drugs and potential interactions, as well as past meds, because she knows the literature and [the latest information on] drug-drug interaction," Abundis explains.

Two-level review

On a daily basis Hara reviews all orders, prospectively and retrospectively. "I'll look at any medications given on previous shifts, and of course as they are being ordered," says Hara, who works Monday through Thursday from 7 a.m. until 5:30 p.m. They established those hours because there is a large administrative component to the position, she explains. "I can't impact all shifts, but by the revamping of protocols and improvement in medication safety in the daytime hours, where I can be most efficient, I can impact the department as a whole," Hara says.

Hara also is available for any drug-related questions ED physicians or nurses may have. "Lots of times, if I'm not on, they will save questions for me," she says. "I had someone come to me the other day and ask me if I thought what they had done earlier was the best possible treatment."

Abundis says that Hara's role in standardizing the products used and implementing more consistent dosing has helped regulate practice patterns. "It's very beneficial from an administrative standpoint and very cost-effective, because if you standardize practice and products instead of offering 20 different versions of one type of drug, you can consolidate it down to five," she says. "Jill will tell you at what dose a drug is most effective, which of two equivalent drugs costs less, and what we should and shouldn't stock." In addition, she notes, the medications that are needed are always readily available for conditions with standardized treatment, such as community-associated pneumonia.

Sources

For more information on adding a pharmacist to your ED staff, contact:

- **Jeanette Abundis**, RN, MN, Clinical Director; **Jill Hara**, PharmD, Clinical Pharmacist, Emergency Department, Huntington Hospital, Pasadena, CA. Phone: (626) 397-5000.

The ED staff were excited to have Hara on board, Abundis recalls. "Before, if they had questions they either had to call the pharmacy, go online, or refer to the PDR [*Physician's Drug Reference*]," she notes. "A live body is much more readily available." Hara made herself even more accessible with a cell phone and trauma pager.

Having Hara in the ED also saved the staff time, says Abundis. "Previously, if we did not have a particular drug, we would have to put in a requisition and wait for the pharmacy to send it, which meant a treatment delay of up to half an hour," says Abundis, pointing out that some intravenous medications, for example, have to be mixed. "If you standardize, you can increase your inventory and make sure common treatment meds are readily available in Pyxis," she explains.

Hara's position also helps limit liability, Abundis asserts. "Considering that the environment of practicing medicine in the ED is very litigious, this is one way to control your risk," she says. In an evaluation of pediatric high-risk medication orders in the six months prior to and subsequent to Hara's hiring, 22 errors in miscalculation or reconstitution of the amount administered were found prior to her hiring, while only nine were found in the six months after she came on board.

"I highly recommend this approach for EDs," says Abundis. "In fact, we are pushing for 24-hour coverage." To make more department-based pharmacists available, the hospital is establishing a specialty residency program, she says. ■

ED's 'PALs' help put focus back on patients

Overcoming staff distractions from technology

At Parkview Medical Center in Pueblo, CO, the introduction of an electronic medical record (EMR) in 2004 was a mixed blessing, at best, for the ED. Patient flow was slowed dramatically, and patient complaints rose because the staff seemed to be paying more attention to the computer than to the human beings they were treating.

While the temptation was strong to simply stop using the technology, **Mike Archuleta**, RN, MSN, CCRN, director of emergency services, found an even better solution. He established a group of Physician Assistant Liaisons (PALs), second- and third-year nursing school interns, who were paired with each emergency physician to handle the data-entering functions.

"A red flag went up when we saw our LWOC [left without care] rate, which had been 0.8%, went up to 2.5%," Archuleta recalls. "The waiting room was backed up, and our customer service scores, which had been in the high 80s, dropped to the mid-80s." Pueblo uses surveys from Avatar International, of Lake Mary, FL. Prior to the change, Parkview had been designated a "Five-Star" facility by Avatar.

In addition, he says, ED length of stay, which had been averaging three hours, "was getting over four hours, and we had a lot more stays going six hours or longer."

Are such changes a natural offshoot of switching to EMRs? "They can be," Archuleta says. "A lot of EDs went through EMRs and then switched back to paper."

Since the EMR was a hospitalwide initiative, Archuleta looked for a way to attack the problems without getting rid of the EMR.

"When I started getting complaints that nurses and doctors were talking to the computer and not to patients, I brought it up at our regular Monday [staff] meeting to talk about possible improvements," he says. The other issue was that physicians were not keeping up with order entry at the bedside, Archuleta says. "Some physician orders were still being put on paper, and there was a lot of inconsistency," he says.

Initially, Archuleta suggested having a unit clerk or

Executive Summary

If your department's new electronic medical record is slowing down your patient flow and hindering staff communication, provide your physicians with interns from a local nursing school to handle the electronic charting and other documentation. Your ED will benefit from:

- improved patient satisfaction scores, reduced left-without-being-seen (LWBS) rates, and faster throughput;
- improved communication between physicians and nurses;
- a steady supply of future nurses who are well versed in ED practices and the preferences of staff physicians.

secretary work with the physicians or using some of the emergency medical technicians (EMTs) and paramedics to perform order entry, start an IV, or perform an EKG. A pilot program was started. "But they weren't quite the right match," he concedes. "They were unfamiliar, for example, with the names of life-sustaining meds such as antibiotics."

Archuleta then hit upon a solution: nursing students. "I thought, why not use the interns?" he says. The hospital already had established nurse intern programs, run in conjunction with Colorado State University-Pueblo and Pueblo Community College. They already had knowledge of pharmacology, assessment, and medical terminology, Archuleta says.

The program was then piloted using the students, and it was "a dramatic success," he says. **Brittney Romero**, RN, a former PAL who is now a nurse in the ED, says, "We would do orders, assist the doctors with some of the procedures, do the charting, and enter labs. You would enter the room with the docs and sometimes explain to the patients what was going to happen."

An all-around win

Archuleta says the program was a benefit not only to the patients, but to the ED staff and the PALs as well. "The PALs had a 100% pass rate [on their nursing boards], and some eventually became nurses in the hospital," he notes. This also helped meet his desire to only use experienced nurses in the ED, he adds.

"The PALs learn the practices and preferences of the ED physicians, which helped establish good relationships between the nurses and the medical staff, where in the past there had been some friction," Archuleta says. "They really got to know one another." The interns also became much more informed nurses, learning about the flow of the ED and what doctors' orders could be anticipated, he says.

He believes the program also helped improve relationships among existing staff. "There had been a little controversy among the nursing staff about docs not sharing enough information with them, but we have a lot of nurses who also worked as PALs, and that helped close that gap," Archuleta says.

As for the program's impact on the ED, the LWOC rate was back down below 1% after less than six months. "Our customer service score has climbed up again," Archuleta adds. He says the scores now are between the 88th and 90th percentile, which puts Parkview among the top two Avatar-rated EDs for departments of comparable size.

The PAL program also is paying off in ED performance measures, he says. "On average, ED patients are being seen 15 minutes faster than they were before the program was introduced, and length of stay has crept back down to numbers seen previous to EMR implementation," Archuleta says. "Throughput has dramatically improved, with physicians seeing 0.5 patients more per hour, increasing to an average of 2.5 patients per hour since PAL was put into place with nursing interns."

In short, he concludes, "This is one of the best things we've ever done." ■

Sources

For more information on Physician Assistant Liaisons (PALs), contact:

- **Mike Archuleta**, RN, MSN, CCRN, Director of Emergency Services; **Brittney Romero**, RN, Emergency Department, Parkview Medical Center, Pueblo, CO. Phone: (719) 584-4917.

ED uses 'Virtual ICU' to improve patient care

Resuscitation continues as docs, nurses help others

A program that provides "critical care without walls," originally intended solely to support the intensive care units (ICUs) at Christiana Healthcare in Wilmington, DE, has been adapted to support the care of critically ill patients in two of the system's EDs. The staff assert that the program, called eICU for electronic ICU, has enhanced quality of care and speeded the resuscitation process.

The program, provided by VISICU of Baltimore, includes the eCareMobile unit, staffed by intensivist physicians and nurses and two mobile cameras inside the ED. **(For more information on VISICU, see resource box, p. 32.)** "I believe we are the first ED in the country to use eICU," says **Marc Zubrow**, MD, FACP, FCCP, FCCM, medical director of eCare and director of critical care medicine for the health system.

When this program was created, it was not designed for an ED setting, says **Karen Toulson**, RN, MSN, CEN, nurse manager of the ED at Christiana Hospital, Wilmington. "But we felt it had merit, and we have found it really does," Toulson says.

The program was implemented in November 2005. The ED staff use the program to implement therapies such as early goal-directed sepsis care, tight blood glucose control, and normalized blood pressures in neurology patients while the patient still is in the department.

Executive Summary

The use of remote monitoring and patient consultation can ease the caseload burden of your staff, improve the flow of resuscitative therapies, and help relieve the pressure on other departments in the hospital.

- You can use technology and additional off-site staff to monitor progress of sepsis care, glucose control, and blood pressures.
- Off-site intensivists also can serve as back-up by responding to staff requests to review steps they have taken in patient care.
- Patients who otherwise would have been admitted into the intensive care unit may be resuscitated and discharged directly from the ED.

The approximate $2.5 million program is funded through the information systems budget.

Intensivist care needed

One of the reasons such a program was needed is that it was difficult providing intensivist coverage for two hospitals: Christiana and Wilmington Hospital, Zubrow recalls. (Full-time intensivist coverage is one of the requirements of The Leapfrog Group, of Washington, DC, which publicly reports on the safety performance of hospitals.)

"We were boarding critical care patients in the ED all the time, and it was clear we needed to improve our continuity of care," Zubrow says. While the ED docs did a great job evaluating and handling initial resuscitation, he says, they were very busy. "Sepsis resuscitation, for example, takes about four to six hours, and they have to move on to the next patient," Zubrow says.

The mobile unit is located right across the street from Christiana. "The critical care nurse sits at a table with a bank of computers, getting patients' real-time physiological data," explains **Anita Witzke**, RN, CCRN, the operations nurse manager of the eCare virtual ICU. "They can pick up changes in condition earlier than ED nurses, who may be too busy to pick up on them."

Zubrow recalls: "I had an 18-year-old female asthmatic patient one night. She was intubated and stable on the ventilator, but I was watching her through the camera and saw her ventilator flows were getting better." He was able to wean the patient and extubate her, he says, and she was discharged from the ED 12 hours later and "never saw an ICU."

The critical care nurses, who staff the virtual ICU 24/7, all have at least five years of critical care experience, Witzke notes. The board-certified intensivists are scheduled from 7 p.m. to 7 a.m., seven days a week.

Staff are pleased

Toulson says the ED staff "can't live without" the eICU, although it was not that way at first. "The nurses were at first a little hesitant to see the benefits, but we marketed it well with the ED staff and showed what the benefits were," she notes. "Now, they call the eICU staff on their own and say, 'I see this — do you?' or, 'Can you double-check this drip?'"

There was some staff training involved, she recalls. "They were basically taught how the system worked," says Toulson. "The nurses learned what the cameras did and also learned a computer program they can [access] and see what the e-staff sees: trends of vital signs, lab results, and so forth."

Zubrow says the ED has realized most of the anticipated benefits of the program. "There used to be a gap in care between initial resuscitation and when the patients got to the ICU, and we're trying to make that gap go away," he says. "These patients may still stay in the ED as long as they previously did, but they are further along in care." A percentage of those patients now have their conditions downgraded sufficiently so that when beds open, they can go to a regular hospital bed instead of the ICU, he says.

There is also some hard data that show the eICU has helped improve patient safety. Witzke says that as part of the patient safety initiative, there are intravenous medication rounds designed to prevent errors. "In the first six months, we prevented 34 major medication errors," she says. ■

Sources/Resource

For more information on using a virtual intensive care unit to boost ED performance, contact:

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For more information on the eICU, contact:

- **VISICU**, Baltimore, MD. Phone: (410) 276-1960. Fax: (410) 276-1970. Web: www.VISICU.com.

'Plain talk' is best when dealing with disasters

Communication breakdown can overturn response plan

This past summer, when strong storms knocked out power in the St. Louis area, the incident command group at BJC Healthcare called the local emergency management agency (EMA) to tell them they had lost power at several of their 13 hospitals and were operating on emergency generators. The EMA representative, not having a medical background, thought everything was fine, and it wasn't until a later follow-up call that it became clear help was needed.

"When we called them, they had no idea we meant that if we did not get the power on soon we probably would have to evacuate our ICUs because we lost suction and chillers," explains **Debbie Mays**, MS, the director of emergency preparedness.

This episode underscores just how far we still have to go in the area of disaster communications. As ED managers may be aware, as of fiscal year 2006, the National Incident Management System (NIMS) has required the use of plain language, rather than 10-codes, for disasters and exercises that involve several agencies, jurisdictions, or disciplines. However, say the experts, this plain language will not be enough to ensure clear communications during a disaster. While everyone now will be using plain language, that doesn't mean they will be using the same language.

Even though you think you are using plain language, communication between EDs and local EMAs can be problematic if you are talking to a non-medical person, notes **J. William Jermyn**, DO, FACEP, EMS medical director of the Missouri Department of Health and Senior Services in Jefferson City. Jermyn says he has seen problems arise in communication between EDs and local agencies on more than one occasion. "Once, when the local EOC [Emergency Operations Center] had been activated, several ED personnel who were requesting both manpower and equipment did not understand that they were being asked what their current needs were, rather than what they anticipated

Executive Summary

Communicating in a clear manner with local agencies during a disaster is critical to making sure your department gets what it wants, when it wants it. Here are some tips to ensure smoother communication:

- Tell the agency exactly what you need for the short term — for example, six to 12 hours.
- When describing your situation, include details about how it is affecting the ability of your department to function properly.
- Participate in tabletop exercises and other emergency management drills so you can begin to establish an understanding with the people to whom you will talk.

Is relief on the way for disaster management 'Babel'?

The move to abolish 10-codes from intradiscipline communications, which gained impetus in the wake of huge communication problems during 9/11 and Hurricane Katrina, may just be the first step in a move by the federal government to make clearer communications possible, says **Bruce Clements**, MPH, director of the Missouri Center for Emergency Response and Terrorism (CERT) in Jefferson City.

"There is an effort through the NIMS [National Incident Management System] Integration Center to try to create standard definitions that everyone can use as a baseline to agree on," Clements says. "They are working with the Department of Health and Human Services to standardize language in public health and medical locations."

Things get tricky when you use medical terminology, he explains. "When we looked at [what happened during] Katrina, even if someone requested 'a fire truck,' there are dozens of different types, so broad definitions like that are not helpful," he says.

It comes down to developing a common language, or a standardized typing of resources, Clements says. "So, for example, if I say I need 10 ED nurses, how 'ED nurse' is defined would be the same here as it is in other states," he says. "They aren't just looking to simplify terms so everyone will understand them, but to use agreed-upon definitions so you will know what it means when you hear it during a disaster."

The formal process, called the National Mutual Aid and Resource Management Initiative, will send out its definitions for peer review when they have been completed, says Clements. To stay abreast of those developments, the best public health resource will be the Association of State and Territorial Health Organizations at web site www.astho.org, he says. You also can monitor the NIMS Integration Center web site (www.fema.gov/emergency/nims/index.shtm) or contact your professional organizations. ■

their needs to be over the next 72 hours," he says. "They were giving projections, vs. what they needed to get through the next six to 12 hours."

Thus, he continues, using plain language is not enough. "You need to clarify the time frame and respond exactly to what it is you are being asked," he advises. "Most of all, when you are making requests during a disaster, don't ask for what you think you may need in a day or two, but what you need right now."

Make requests specific

The manner in which you ask is just as important as what you are asking for, adds **Bruce Clements**, MPH, director of the Missouri Center for Emergency Response and Terrorism (CERT), also in Jefferson City. "During our recent ice storms, one hospital said they would like a DMAT [Disaster Medical Assistance Team], but when we asked a few additional questions, it turns out what they really needed was additional nursing support."

Your requests must be specific, he continues. "If you say you need doctors, I might send you some podiatrists, when what you really need are emergency physicians or trauma specialists," Clements notes.

A prime consideration for the ED manager talking with a local agency is to know who is on the other end of the line, says Jermyn.

"It very well may not be another health care professional; therefore, using a health care language perspective, as many ED managers may do, may not serve you well," he says. For example, an ASAP request to someone in the ED might mean five minutes or less, "whereas in public health, it might mean anywhere from one to three days," Jermyn says.

If you're talking with a nonmedical person within the EMA, "you may need to repeat yourself and ask them to read back to you what they heard," he says.

Mays agrees. "Once you get to the appropriate EOC, don't speak in clinical terms; use very plain layman's language," she says. "You may be talking to a firefighter, a public health official, or someone else who may have no experience in the hospital," Mays says. So, for example, if you are having a staffing issue, be very plain and specific, she emphasizes. "Say something like, 'We have a 40% no-show, and we can't provide adequate care,'" she advises.

Is there a way to prepare in advance for such potentially difficult communications? It would be very helpful to meet with them ahead of time, suggests Jermyn. "Having met and sat across the table, even if it is just done in a couple of tabletop exercises, could be very helpful in your efforts to improve communications," he says.

Communication during a disaster is especially challenging, Jermyn concedes, because you may be dealing with individuals from a number of different areas. "If I had to condense it all into one point, it would be to sit down and participate in those EM [emergency management] exercises," Jermyn emphasizes. Through those exercises, you develop respect and perspective for what your counterparts need, and vice versa, he says. "You begin to have that dialogue and get to know those people," Jermyn says. **(Help may be on the way: Federal agencies are hard at work on common disaster terms. See story on p. 33.)** ■

New emergency funds won't 'trickle down'?

The amount of funds allocated for emergency preparedness in President Bush's newly presented fiscal year 2007 budget may look good on paper, but as

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a practical matter, they won't be much help to individual hospitals, says one expert.

"The real question is, how much of the budget actually trickles down to the individual hospital?" poses **Andrew I. Bern**, MD, FACEP, founder and past chair of the disaster medical section of the American College of Emergency Physicians.

$8,300 per hospital

Bern points out that the budget includes $414 million for the Hospital Preparedness Cooperative Grant program, which provides funds to support disaster preparedness drills. He further notes that the American Hospital Association estimates there are 5,000 hospitals in the United States, which means about $8,300 per hospital under the grant program. However, he observes, when the state of Ohio studied the financial outlays of a communitywide drill in 1984, they found that the coordinating hospital spent $100,000 and participating hospitals spent $50,000 each.

"When you do the math and spread it out, [the money] is just not going to reach everybody, and the states are completely on their own in terms of paying the bills," says Bern, despite the fact that The Joint Commission requires at least one annual communitywide drill.

In Israel, he notes, "they literally train as much as once per month per hospital, and they also have unannounced drills."

To handle the added space demands of a disaster, 20% of licensed bed capacity in that country is available for surge capacity. "They can literally empty out 20% of their hospitals at any given time," he notes. "This country does not have anything like that." ■

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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 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 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 *questions*

30. According to Ron Stunz, MD, when conducting a random audit of your charts, you should review a minimum of how many charts?
A. 75
B. 100
C. 125
D. 150

31. According to Sharol Herr, RN, MSEd, CHPN, the ED resource team supports the palliative care program by:
A. initiating the palliative care process by contacting ED physicians.
B. discussing advanced care planning with the family.
C. establishing goals of care.
D. All of the above

32. According to Jill Hara, PharmD, having a pharmacist in the ED offers the following benefits:
A. Prospective and retrospective review of medications.
B. Help in compliance with medication reconciliation guidelines from The Joint Commission.
C. Consolidation of drug supplies.
D. All of the above

33. According to Mike Archuleta, RN, MSN, CCRN, director of emergency services at Parkview Medical Center, the PALs program has enabled his clinical staff to see patients how much faster on the average?
A. Five minutes
B. 10 minutes
C. 15 minutes
D. 20 minutes

34. Which of the following ED activities at Christiana Healthcare are not supported by the remote intensivists in the eICU (electronic intensive care unit) program?
A. Surgical procedures
B. Sepsis care
C. Blood pressure control
D. Blood glucose control

35. According to J. William Jermyn, DO, FACEP, when requesting aid during a disaster, notify the local emergency management agency what you will need:
A. during the next 6-12 hours.
B. during the next 24 hours.
C. during the next 48 hours.
D. during the next 72 hours.

CE/CME answers

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

Mount Carmel Health System Palliative Care Service

Indicators:

Consideration for Direct Admission to Acute Palliative Care Unit

Or

Palliative Consultation initiated from ED

ED Patient to be admitted to hospital presents with at least one of following:
Patient transferring from SNF
DNR (CC or CC Arrest) status established or requested
Patient actively dying in pain and discomfort
Patient currently enrolled in a community hospice
Previously discharged from Mount Carmel Acute Palliative Care Unit
Multiple admissions to the hospital (2 or more within 6 months) with same symptoms
Patient with advanced disease with frequent infections
Nutritional complications with an Albumin of less than 2.5 mg/dl
Primarily bed bound
Advanced disease with enteral feeding in place
Sudden acute event such as CVA
Patient with advanced disease being admitted for Pegtube/trach placement
Disease Triggers: Malignant Neoplasm esp. Lung Cancer; Aspiration Pneumonia, COPD, HF, Septicemia, Bone Mets, Renal Failure, Hemorrhagic Stroke

Source: Mount Carmel Health System, Columbus, OH. Reprinted with permission.