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ED physicians group ousted, sues — power struggle with CEO blamed

Here are tips that can ensure a good working relationship

Haywood Emergency Physicians, which had managed the ED at Haywood Regional Medical Center in Clyde, NC, since 1991, was ousted by a unanimous vote of the hospital's board in late December 2006 and replaced by the corporate physicians staffing firm Phoenix Physicians following a heated contract dispute. The termination occurred a full 18 months before the Haywood contract was slated to expire.

"I think the main issue was really a story about command and control [by the hospital CEO]," says **Mark Jaben**, MD, who had been the associate ED director at Haywood Regional for 15 years. Most of the particulars cited in negotiations and/or the local press "were smoke screens," he asserts.

The hospital board "felt Phoenix would be more cooperative in hospital initiatives aimed at improving wait time, moving patients through different departments more smoothly, and working with a new digital medical records system," according to the *Smoky Mountain News*.[1]

ED managers who are part of groups such as Haywood Emergency Physicians are all too familiar with the potential tenuousness of their relationship with hospital administration, but experts assert that such a termination should never come as a surprise and usually can be avoided if the ED managers take certain steps.

"Medicine is an art, a science, *and* a business," says **Gregory L. Henry**, MD, FACEP, risk management consultant at Emergency Physicians Medical Group, Ann Arbor, MI. "The day you forget that is the day you are no longer a great doctor."

Executive Summary

Serious contract problems with administration should never come as a surprise. The ED manager who is part of a physicians group should communicate regularly with key audiences within the hospital, and keep an ear to the ground for potential issues.

- Have routine meetings with senior administration, and work to gain a seat on the hospital's executive committee.
- Participate in community activities with hospital leadership, including family activities.
- Work to develop a professional working relationship with the nurse manager.

IN THIS ISSUE

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The day you and your group have to pull a contract out of a drawer "is the day you've lost," Henry continues. "The day the contract has to be enforced, you're screwed."

Winning a lawsuit is no way to endear oneself to a hospital, he says. "Let's say the hospital loses a million dollars; these guys are still out," says Henry.

If you find yourself being defensive, you have waited too long, adds **Josh Rubin**, MD, FACEP, president of the Western Region for Emergency Medicine Physicians, a privately held physician-owned group, based in Roseville, CA. "You should *always* be proactive," he says.

An issue of control

While the board had cited several reasons for the dismissal, including failure to fully implement new triage and testing protocols and failure to implement a new information technology system rapidly and efficiently, the real issue was power, Jaben says.

"The CEO felt he needed to have a level of control — that he should be able to choose ED staff and fire them at will," he explains. "We resisted; we had had a stable group and had never asked the hospital for help with recruiting."

Jaben says the group had no problem with the board having input, "but they were asking for thumbs-up, thumbs-down power and to dismiss any doc on 14 days notice with no warning."

However, argues Henry, this is not a realistic stance from a business point of view. "You are in a business; you provide a service," says Henry. "Some of these guys do not realize who their 'daddy' is; where their bread is buttered." In the case of the right to hire and fire, if he were the ED manager, "I'd say, 'That's very interesting; I'd love to have you involved. Here's how I think it could work,'" he says.

Jaben argues that medicine is different from any business in America. "Traditionally, to really provide good care takes a balance between administration and the medical staff — neither should have the upper hand on the other," he says.

But, counters Rubin, someone *does* have the upper hand. "We live in the hospital's house — it's not *our* house, it's theirs," adds Rubin. "We have to be perceived as being cooperative, although we should not be passive."

An ounce of prevention

If the ED manager takes the appropriate steps on a daily basis, this kind of crisis can be avoided, Rubin maintains.

"Your most natural allies are fellow members of the medical staff," he says. "If they are pleased with the service you provide, they will support you." These allies include the chief of staff and the medical executive committee, he says.

Have routine meetings with senior administration, and have a seat on the executive committee, Rubin advises. Your physicians should serve on various medical staff

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Sources

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- **Josh Rubin**, MD, FACEP, President, Western Region, Emergency Medicine Physicians, Roseville, CA. Phone: (916) 782-5705, ext. 2204.

committees, he adds. In addition, Rubin says, "If you have a functional partnership with the nurse manager, these kinds of outcomes are less likely to occur." If you have established these relationships, he argues, if a conflict ever arises, "they will support you, and the hospital will listen."

There are almost always warning signs, says Rubin. "If you do not see them, it's because you did not spend enough time working with the nurse manager, the medical staff, and the hospital administrator," he says. "You should almost *never* be surprised; you should know what problems exist."

Henry agrees. "If you do not know the CEO's kids' names and birthdays, if you do not know his secretary personally and stop in and say hello, you deserve what you get," he says. "After all, you are by law the retained agent in service of the hospital when they have a contract with you."

Every day he is in the hospital, says Henry, he does "administration rounds." "I show up in the office, I talk to the secretary and ask if there's anything going on that I need to know about," he explains. "Then, when I get asked about it 10 minutes later by the administrator, I can say 'I know, and I'm on it.'"

You should meet regularly with the administrator and ask what you can do to do make things better, adds Henry. "If I walk into a fine restaurant and do not like how the food tastes, nobody from the kitchen is going to come out and say, 'Eat it, it's good,'" he notes. "They say, 'What else can we give you?'"

Jaben admits that he and his group could have done a better job of building relationships. "You have to maintain relationships with your board as individuals — not just the CEO, but the board members," he says. In fact, he suggests, it might not be a bad idea for your group to have a "relationship director." "That's not what we chose to do, but it's more important now than it's ever been," he concedes.

Don't make it personal

One problem ED managers must avoid is taking these issues personally, Henry advises. "The rules of human interaction never change," asserts Henry, adding that the two most valuable days of his career were the days he took a class in negotiation techniques.

"Humans are only tuned in to one radio station: WIFM [What's In It For Me?]," he notes. "You need to understand how disagreements take place, how to get to yes, and discovering what the *real* agendas are," Henry says.

Henry and others provide mediation services for situations like these, and he says ED managers who spot a problem with management "need to call me or someone like me early on to give them a look from the outside." What is needed in such situations, he says, is someone to come in and say, "What's *really* going on here?"

Henry insists it's an integral part of the ED manager's job responsibilities to have a positive working relationship with management. "If you're not making people happy," he says, "You are not a great doctor."

Reference

1. Johnson B. Phoenix says transition smooth despite patient complaints. *Smoky Mountain News*, Jan. 3, 2007. Accessed at: www.smokymountainnews.com/issues/01_07/01_03_07/fr_phoenix_says.html. ■

What surveyors want to see for review of med orders

Broader interpretation is now allowed

Most ED managers breathed a sigh of relief after The Joint Commission approved an interim action, effective Jan. 1, 2007, that changed the requirement for pharmacy review of ED medication orders [element of performance (EP) 1 for standard 4.10 of medication management]. The new requirement allowed pharmacists to retrospectively review the orders, but just 14 weeks later, the action was suspended.

"I am extremely disappointed in the reversal of this action," says **Alisa Murchek**, RN, MS, associate director of nursing for the ED at University of Illinois at Chicago Medical Center. "This has been a huge challenge for our ED. To comply, we switched to an electronic fix, which interfaces pharmacy with the ED

Executive Summary

The Joint Commission has suspended its interim action allowing pharmacists to retrospectively review ED medication orders, but it is allowing broader interpretation of the exceptions to the requirement for prospective review.

- The medication can be processed by a nurse, and the licensed independent practitioner (LIP) will not be required to remain at the bedside while the medication is administered.
- The LIP must remain available to provide immediate intervention in the event that the patient experiences an adverse medication event.
- The LIP will be allowed to define when a clinical situation is urgent.

medication dispensing machine."

Now, when a medication is ordered electronically, the order is first verified by a pharmacist and then sent to the ED's automated medication dispensing machine. "A nurse can remove only verified medicines from the machine," says Murchek. "We have the capability to override the verification process for medications such as those needed for rapid intubation."

The problem is that the new process causes delays, Murchek says. ED physicians can't always drop what they are doing to enter a drug order on the computer terminal, and nurses are accustomed to working fast and concurrently; a physician asks for a medication, and a nurse is on the way to get it while he places the order, she says. "With this new interface, there is a three-minute delay between the time the physician orders the drug and it is verified by a pharmacist and sent to the machine," she says. "It is amazing how an extra few minutes per patient can destroy an ED's overall throughput."

McKay-Dee Hospital Center in Ogden, UT, has been attempting to comply by staffing pharmacists in the ED. However, due to a shortage of pharmacists in Utah, they have coverage for only 12 hours a day, says **Kayleen L. Paul**, RN, CEN, director of emergency, critical care, and trauma services. "It's been difficult, costly, extraordinarily frustrating, and I honestly believe that the evidence does not support a safety need for this in the ED," Paul says. "Words cannot express the enormity of this challenge to our ED."

What went wrong?

According to **Robert A. Wise**, MD, vice president of The Joint Commission's Division of Standards and Survey Methods, the interim standard was put into effect because allowing retrospective review appeared to be a good solution. "But after the field review came back, we found that some people thought it was helpful, but we now had another group that told us we just made it worse," says Wise.

That group reported that they didn't have enough pharmacists to perform retrospective reviews of all the medication orders written in the ED. "We realized that there was no quick fix we could make that was going to clearly change for the better the processes going on in the ED," says Wise. "So instead of continuing to tinker here and there, we decide to instead go through the systematic process."

The Joint Commission is developing revisions to EP 1 for Standard MM 4.10 and will conduct a field review before finalizing those changes, he says. The revision process is expected to continue throughout 2007.

What you can expect

Since the interim action was suspended, the current standard is now reinstated as written in the 2007 accreditation manual. However, that standard has two exceptions for EP 1, and surveyors will be interpreting them more liberally. **Kelly Podgorny**, RN, MS, CPHQ, The Joint Commission's project director for the Division of Standards and Survey Methods, says, "The Joint Commission will now allow a more broad interpretation of these two exceptions in the ED as we go through the process of revising the standard."

The first exception allows for a prospective review to be bypassed if a licensed independent practitioner (LIP) controls the ordering, preparation, and administration of

Sources/Resource

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The American College of Emergency Physicians, the American Academy of Emergency Medicine, and the Emergency Nurses Association jointly wrote a letter to The Joint Commission regarding standard MM 4.10. (To read the letter, go to www.ena.org/future/Issues/Joint_ltr_JCAHO_Med_Recon.pdf.)

the medication. Now the medication can be processed by a nurse, and the LIP will not be required to remain at the bedside while the medication is administered.

"That is different from our previous position and allows a little bit more room for EDs to get that medication administered," says Podgorny. However, the LIP must remain available to provide immediate intervention in the event that the patient experiences an adverse medication event. For example, if an ED doctor always is available within the department and is in immediate contact by radios carried by all staff, the requirement is met.

The second exception is for urgent situations when the resulting delay could harm the patient, including situations in which the patient experiences a change in clinical status. "What The Joint Commission will permit now, that we had not permitted previously, is to allow the LIP to define when a clinical situation is urgent. So whatever clinical situation the LIP thinks is urgent and the prospective review is not conducted, The Joint Commission surveyors will accept this decision," says Podgorny. ■

Fever kit helps ED save $300,000 in three years

Unnecessary return visits cut nearly in half

By creating inexpensive fever kits and providing them free of charge to parents of children between 3 months and 5 years of age who presented and were discharged, the ED at Presbyterian Hospital of Dallas has saved approximately $300,000 since the initial pilot program began in July 2004. In addition, notes **Mary Rowe**, RN, MSN, CEN, nurse manager of the ED, the staff saw a 42% drop in inappropriate fever return visits to the ED between July 2004 and December 2004.

Executive Summary

A fever kit is easy and inexpensive to assemble, and it's an effective strategy for reducing unnecessary ED visits.

- Be sure the kit includes a digital thermometer, a supply of children's acetaminophen, an oral syringe to measure doses, and dosing instructions (also in Spanish if needed).
- Make sure discharge instructions are not only written, but also verbal. Make sure parents understand how to use the thermometer and measure the proper dosage.
- Have clear protocols outlining who should receive the kits and for which conditions.

Discharge instructions help parents provide home care

The following are examples of fever discharge instructions provided to parents at Presbyterian Hospital of Dallas:

- **Do not bundle your child in heavy clothing or blankets.** Use light clothing and bedding to help your child stay cool.
- **Give plenty of extra fluids to prevent dehydration.** Your child should drink enough to urinate every six hours. Be observant of the number of wet diapers for infants and toddlers.
- **Use acetaminophen or ibuprofen as instructed to relieve discomfort and keep temperature down.** You may sponge or bathe your child in lukewarm water for 20 minutes. *Never* use cold water or alcohol to sponge a feverish child.
- **The use of aspirin to relieve fever or other symptoms of viral illness has been linked to Reye's syndrome.** Children should be given only nonaspirin medications (such as acetaminophen or ibuprofen) for the relief of pain or fever.
- **Check your child's temperature every four hours.** For infants, use a rectal thermometer.
- **Call your doctor if the fever has not subsided in two days. [Instructions in Spanish are available with the online version of this month's *ED Management* at www.ahcmedia.com. For assistance, call Customer Service at (800) 688-2421.]**

Parents also receive instruction on symptoms that require immediate evaluation by a physician. Examples of these symptoms include a fever longer than two days, seizures, delirium, repeated vomiting, dehydration, or difficulty breathing. ■

Before the fever kit project was initiated in 2004, 53% of parents of pediatric patients with fever had made no attempt at fever control prior to presenting to the ED, Rowe says. The percentage of parents of febrile children who made no attempt at fever control prior to presenting to the ED dropped to 11% in 2005. "These levels have stayed about the same," she reports.

"The staff were reporting a large number of bouncebacks [return visits], so we brainstormed about what we could do to educate the public," Rowe recalls. At Presbyterian, an inappropriate repeat visit for fever involves patients previously treated within 72 hours for a minor bacterial illness such as otitis media and/or upper respiratory infections.

Rowe and her staff came up with the format for the kits, which include a digital thermometer, a supply of

Sources

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children's acetaminophen, an oral syringe to measure doses, and dosing instructions in English and Spanish. When a young patient with a fever enters triage, vitals and temperature are taken. If they are febrile, they are treated in triage for fever. "Then, based on their acuity rating, they either go to fast track or the main ED," says Rowe.

Education is delivered at discharge, says **Linda Miars**, LVN, who works in fast track and who helped implement the program. "We make sure they have a thermometer at home to measure the child's temperature, and if they come in with fever but were not treated by their parent, we treat the fever with Motrin or Tylenol and recheck upon discharge," she says. The staff members also demonstrate how to take the child's temperature, Miars says. "They do not just walk out with a piece of equipment they don't know how to work."

The staff also discuss proper dosage, based on weight, and how parents should alternate acetaminophen and ibuprofen. "I often draw a clock and show them when to give each medicine," she notes. If the parents do not speak English at all, a telephone interpreter is available. In addition, bilingual fever care instructions are provided on laminated reference cards. **(An example of the instructions can be found in the box on p. 77.)**

Parents who don't speak English present a special challenge, says Miars. "They think fever is a sickness, as opposed to a symptom, so when they come in and say the child had a fever yesterday, they gave the child Motrin, and it came back, it's a challenge to explain the difference to them," she says. The parents do not want to appear to be uneducated or unable to take care of their kids, Miars says. They greatly appreciate the bilingual cards, says Miars, noting, "I tell them to put it on the fridge."

Calculating the savings

According to Rowe, most of the families who come in for inappropriate repeat febrile illness are uninsured and depart from the ED with an average bill of about $350 ($300 when the program began), which they cannot afford to pay. Each kit costs $2.21 to put together, and the cost is paid by the hospital's community outreach center. For the first six months, 327 kits were given out. Rowe estimated that cost savings for the hospital, in terms of care that wouldn't be reimbursed, was $54,732, which equates to a little more than $100,000 per year. Rowe asserts the savings have continued at that pace each year.

Rowe has had no problem keeping the program alive. "It has just become part of our culture," she says. Any ED could do what she has done, Rowe says. "Even if they had to pay for it themselves, it would be worth it," she says.

Miars expresses her admiration for the program. "If anything, it's not used enough," she says. "I'd like to see it used by every nurse at every opportunity — not just in fast track." ■

'Boarded' patients prefer halls on inpatient floors

Proximity of specialists puts them more at ease

Harried ED managers who are trying their best to get patients upstairs apparently have some strong allies in this battle: The patients themselves.

In a new study of emergency patient preferences for boarding locations, just published online by *Annals of Emergency Medicine,*[1] admitted patients said they prefer to board out of the emergency department and in inpatient hallways by a margin of three to two.

"I was actually surprised that even more patients more didn't prefer inpatient hallways over the ED," says lead author **Jesse Pines**, MD, MBA, MSCE, an

Executive Summary

If you can board patients upstairs rather than in your ED, not only will you free space in your department, but you will be giving patients what they want, based on the results of a recent study. Because this change involves other units, buy-in must be obtained from administration.
- You can make a case with administration based not only on improved safety and care, but also on patient satisfaction.
- Initial costs for boarding patients in inpatient halls will be higher because additional staff will be needed, but these can be offset by reducing the number of patients who leave without being seen.
- Spreading care over several units will relieve the pressure on ED nurses.

attending ED physician in the Hospital of the University of Pennsylvania in Philadelphia. The percentage in the study was 59%. "The main reason for putting them upstairs is that it locates them closer to inpatient providers, unclogs the ED so they can see new patients, and unburdens ED nurses from having to care for these patients."

The study, conducted over a four-week period, surveyed 431 admitted patients. During the study period, the median weekly ED boarding time ranged from 8½ hours to just over 12 hours.

The percentage of patients who preferred inpatient hallways also seemed low to **Peter Viccellio**, MD, FACEP, vice chairman of the Department of Emergency Medicine, School of Medicine, and clinical director of the Emergency Department at Stonybrook (NY) University Hospital. "Our bed coordinator personally interviewed our patients, and 95% said they preferred being upstairs," he reports. **(For more on Stonybrook's initiative, see "Use protocol to send inpatient holds upstairs," *ED Management,* April 2003, p. 43.)**

Boarding vs. holding

Viccellio suggests the difference in responses could be due to the status of the patients in Philadelphia and Stonybrook.

"In the study, Penn is not boarding the patients but holding them [in the ED]," he explains. "When the patients were asked their preference, they were asked to compare what they were experiencing at the time with something they had not yet experienced."

At Stonybrook, the survey took place *after* patients started boarding upstairs in 2001, he says. "People were worried about the impact on patient satisfaction, so the bed coordinator collected responses from several hundred patients," Viccellio explains.

What else did the surveys show? "Patients preferred [being boarded upstairs], and they got better care: The nurse/patient ratios are better, it's a more peaceful and quiet environment, and nurse and physician specialists are there," Viccellio says. In short, he notes, patients simply get more attention.

An 'institutional thing'

Viccellio has a short list of issues he considers unequivocal. Among them are the following: The ED *must* continue to function as patient loads increase. "We must get boarded, admitted patients out of the ED," he says. "Second, patients prefer to go upstairs, and they get better care."

The challenge of handling increasing patient loads is not solely an ED issue, Viccellio says. "It's an institutional thing," he says. "It makes the institution ask how we can best take care of *all* our patients — not just the ones who are lucky enough to show up in time for a bed."

The idea of moving boarded ED patients upstairs flowed from the decision that it was unsafe to continue to accumulate patients in the ED, Viccellio says. "Let's say you have 10 units, all identical, all full," he poses. "Now, you have 20 extra patients: Do you send them all to one unit?"

Change is hard

As Viccellio's experience shows, getting such a change in place can be a challenge. "I had been part of a group trying to improve inpatient processes, but in spite of well-intentioned efforts, nothing seemed to change," he recalls. "I kept suggesting it, but everyone knew it was 'against the rules.'"

However, when he researched health department regulations, Viccellio discovered there were no such rules. He even got the state's health department to write a letter to all area hospitals saying that — and adding that boarded patients should be spread out among departments. This cleared the way for change.

"In order to make this change, you would have to go to hospital administration, because it would require a change in policy, Pines says. How do you make the case? "In addition to the care benefits, this is where patients would rather be; so if we are going to use the patient-centered model of health care going forward, these kinds of questions should be asked, and we should go along with where they want to be," he explains.

In terms of cost, he concedes, it could appear to the administration to be more costly because you have to staff the beds upstairs. "You can overcome

Sources

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that objection in terms of overall reimbursement," he says. "In addition, uncrowding the ED can only improve revenue by reducing the percentage of patients who leave without being seen and by providing better service for existing patients by moving them more quickly through the system."

Viccellio confirms this last point. "We don't go on diversion," he notes. "Some studies say for every patient you board, you add 15 minutes, but our data show we add only one minute."

Reference

1. Garson C, Hollander JE, Rhodes KV, et al. Emergency department patient preferences for boarding locations when hospitals are at full capacity. *Ann Emerg Med* (Corrected Proof), 11 May 2007. (In press) DOI: 10.1016/j.annemergmed.2007.03.016. ■

Social workers cut nonemergent visits 45%

Registration times slashed, elopement rate cut

By locating a social worker in a hospital ED to help members overcome barriers to primary care, Horizon NJ Health, a West Trenton, NJ-based managed care organization, was able to decrease ED visits by 45% among its members who had a face-to-face conversation with the social worker. The 12-month pilot program at Newark Beth Israel Medical Center, a large facility (86,000 annual ED visits) in West Orange, NJ, was deemed so successful that Horizon NJ Health has maintained it for three years and has expanded it by adding social workers to five more EDs.

Having a social worker in the ED is not all that unusual; in fact, the department already had a social worker, says **Thomas Michalowski**, MBA, RN, director of patient care for the Beth Israel ED, What was different about this one was the role she played.

"We had a social worker that meets with victims of domestic violence, child abuse, and assault, counsels the homeless, and so forth," he explains. This social worker, however, only meets with patients enrolled in the Horizon NJ Health plan. "If they require follow-up care, rather than coming back here, she hooks them up with an appropriate physician in the network to get the care they need," Michalowski adds.

The statistics compared ED visits by members enrolled in the Medicaid managed care plan with Horizon NJ Health, explains **Pamela Persichilli**, RNC, manager of clinical services and utilization management for Horizon NJ Health. The health plan embarked on the pilot project after a data analysis showed that a large number of members were using the ED for primary care purposes, such as treatment for sore throats and earaches, Persichilli says. "When somebody comes in with a minor ailment, such as a sore throat, they tie up the staff and take up the bed for someone who needs to be seen urgently," she says.

Executive Summary

Having a social worker in your ED to identify patients who are seeking primary care can significantly limit return nonemergent visits. ED staff who have interfaced with a social worker find it doesn't interfere with their normal work flow.

- Invite the social workers to staff meetings before they begin working in your department to familiarize staff with what the social workers will do.
- Make sure the social workers are well versed in EMTALA so they do not turn patients away from the ED.
- If the social worker does not approach the patient until treatment is completed, smooth flow in the department is ensured.

Social workers check census

The social workers keep tabs on the ED census, so they can identify any Horizon NJ members who present to the department. After the members are treated, the social worker asks to talk with them and conducts a brief assessment to determine the barriers that kept the members from seeking care from a primary care physician.

The social workers update telephone numbers, addresses, and family members to contact in case of an emergency. They have a wireless computer and cell phones, which give them the tools they need to access the member's coverage and to find out and, if necessary, to change the primary care physician to whom the member was assigned at enrollment.

The social workers see all members who were discharged from the ED and who don't refuse the interaction. "We don't interfere with the hospital's operation or the treatment team," says Persichilli. "We are absolutely respectful of EMTALA and don't interfere with the patient being seen; we don't turn anybody away from the emergency department."

Michalowski agrees the social workers have been unobtrusive. "The program was designed not to affect flow; [Horizon NJ Health] didn't want to be perceived as interfering," he says. "We deliver our care, and she goes up to the patients after that."

There really was no need for the staff to adapt to the presence of the social worker, he continues. "I invited the social worker here to several staff meetings before

Sources

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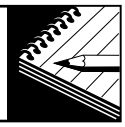
the program started to let folks know what she'd be doing," he notes. "Sometimes a staff member will call her if they notice they have one of their patients, but normally the social worker just goes through our census."

Before implementing the program with any hospital, Horizon NJ Health conducts a claims analysis to identify the times during the day when the most members visit the ED. "The social workers staff the EDs during the times when there are the most visits among our members," Persichilli says.

For instance, peak hours for member visits are 11 a.m. to 7 p.m. at one hospital, but are 2 p.m. to 10 p.m. for another hospital in another part of the state. The social workers are off during the days of the week when the volume tends to be lowest. Many work on Saturday and Sunday because those are some of the busiest days in the ED.

The program does not affect the ED budget at all, notes Michalowski, as the social workers are paid by the health plan. "We just set her up with a small office area," he says. "The program is offered more as a benefit for their members; it cuts down the numbers of their patients who come to a busy ED and get caught in the system, and hooks them up with a physician rather than seeking primary care in the ED." ■

GUEST COLUMN



Discharging the homeless — Crisis in 'La-La Land'

[Editor's note: M. Steven Lipton, JD, is an attorney with the San Francisco law firm Davis Wright Tremaine. This is the first of a two-part series on the growing crisis of "dumping" homeless patients in Los Angeles. The second installment will appear in our August 2007 issue Lipton can be contacted at (415) 276-6500.]

An adult patient arrives at the ED in the middle of the night with a presenting complaint of head trauma of unknown origin, and associated pain and dizziness. The patient is examined by the emergency physician, given a head scan and treatment, monitored for several hours, and is ready for discharge with instructions for a follow-up physician visit within 24 hours.

Routine? Perhaps, except for one problem: The patient is homeless.

For many years, hospitals have faced the problem of dealing with homeless patients who frequently are not aligned with shelters or other residential facilities, have little or no access to health care services other than hospital EDs, and often are unable to understand their discharge instructions or provide the self-care necessary for post-hospital recuperation. In many communities, there are no resources for the homeless and little willingness by local politicians to fund homeless services. Many hospitals try to align homeless patients with shelters or other local resources, but these efforts are often futile or rejected by the homeless.

What does the law say?

For EDs, the laws on patient discharge requirements are sparse. The Medicare conditions for discharge plans clearly apply to inpatients and expressly do not apply to emergency patients.[1] However, EDs are subject to the Medicare conditions for preparing a discharge summary, although the summary is not required to be given to the patient.[2] Under the EMTALA Interpretive Guidelines, emergency patients who are discharged (as opposed to transferred or admitted) must receive a plan for appropriate follow-up, including information necessary to prevent a relapse or worsening of their medical conditions.[3] State laws vary, but often do not address discharge planning for emergency patients.

During the past 18 months, hospital discharges of homeless patients in Los Angeles have resulted in investigations and enforcement actions initiated or threatened by the Los Angeles city attorney. Video cameras have captured patients delivered to Skid Row shelters and missions, some of whom were clad in hospital gowns. Pictures (including videos) of these patients have been published by the media and posted on the Internet. Several celebrated cases have been the subject of local and national news stories, with a feature piece by

Anderson Cooper on *60 Minutes* that was aired on May 20, 2007.

What did the investigation cover?

In December 2005, the city attorney asked several Los Angeles area hospitals to provide voluntarily information on their discharge practices. The letter alerted the hospitals of possible action for their discharge practices involving homeless patients. The specific focus of the letter involved the transport of homeless patients to Skid Row, later characterized by the city attorney as the "one of most dangerous places, not only in L.A., but in the state and the country . . ."[4]

The primary focus of the investigation has been three issues:

• Are hospitals obtaining the consent of homeless patients (especially patients with limited capacity) who are transported to Skid Row? Specifically, are hospitals placing homeless patients in taxis, vans, or ambulances and directing the transport to Skid Rows without the knowledge and consent of the patients?

• What are the clinical conditions and medical needs of homeless patients, especially those transported to homeless shelters without prior notice?

• Why are homeless patients transported long distances (e.g., up to 30 miles) to Skid Row?

Although several cases of alleged "homeless dumping" have been widely publicized, the city attorney has indicated that as many as 55 cases are under investigation,[5] although it is unclear how many cases are being actively pursued.

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The lawsuit is filed

In November 2006, the city attorney filed criminal and civil changes against a Kaiser hospital in Los Angeles for the practice of homeless dumping.[6] The Kaiser complaint alleged that the hospital discharged a homeless woman who was found "wandering in a daze along the dangerous streets of Skid Row wearing little more than a hospital gown, sweatshirt, and socks."[6] Additional facts included that the patient was "rushed into a taxi" and dropped in front of a Skid Row mission that was unfamiliar to her and without any plan for post-hospital care.

The complaint characterized described homeless dumping as including the following elements:

• discharging homeless patients without proper clothing, sometimes no more than a hospital gown;

• discharging homeless patients on a gurney or wheelchair, with intravenous or other equipment attached to the patient;

• discharging homeless patients prematurely;

• arranging for homeless patients to be transported considerable distances, often up to 30 miles, notwithstanding the availability of a closer shelter; and

• transporting homeless patients to Skid Row without first checking to determine the availability of shelter beds or services necessary for the patients.

The Kaiser complaint included criminal counts of false imprisonment and dependent adult endangerment, and civil complaints of unlawful and unfair business practices, including failure to follow state law on discharge planning. For the alleged violations, the complaint sought to stop the Kaiser hospital from engaging in homeless dumping activities that violate applicable law, as well as obtaining fines, costs, and other relief as permitted by law.

The investigations and litigation all point to continued pressure on hospitals for handling the discharge of homeless patients. In Part II of this saga, we will explore legislative action addressing homeless discharges as well as the outcome of the Kaiser complaint.

References

1. 42 CFR 482.43; *Medicare State Operations Manual,* Appendix A, Tag A0349 (§482.43).

2. 42 CFR 482.24.

3. *Medicare State Operations Manual*, Appendix V, Tag A407).

4. "ABC News," Nov. 16, 2006, citing a story from The Associated Press.

5. Senate Health and Welfare Committee Analysis (SB 275; 2007 Legislative Session); March 28, 2007.

6. *People v. Kaiser Foundation Hospitals,* Case No. BC362039; filed Nov. 15, 2006 (Kaiser complaint). ■

COMING IN FUTURE MONTHS

■ CDC guidelines for 'opt-out' HIV testing prove successful

■ EDs participate in drill simulating intruders in local high school

■ Can cell phones be kept in operation during a disaster?

■ Whiteboards prove effective for collaboration, communication

CNE/CME instructions

Physicians and nurses participate in this continuing medical education/continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the articles. Participants should select what they believe to be the correct answers and then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/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. ■

CNE/CME *questions*

19. According to Gregory L. Henry, MD, FACEP, if the hospital administration makes a contract demand you believe is grossly unfair, the most appropriate response is to:

A. hire an attorney.
B. see if there's a way to give them what they want that also is acceptable to you.
C. refuse to negotiate further unless they drop the demand.
D. accept whatever they offer.

20. According to Mary Rowe, RN, MSN, CEN, a fever kit should include:

A. a digital thermometer.
B. acetaminophen elixir.
C. an oral syringe to measure doses.
D. All of the above

21. According to Jesse Pines, MD, MBA, MSCE, while boarding patients in upstairs hallways — rather than in the ED — will require additional

expenses, those costs eventually will be offset by:

A. reducing the number of patients who leave without being seen.
B. achieving higher levels of patient satisfaction.
C. having more patients come to the facility.
D. staff adapting to the additional duties.

22. According to Thomas Michalowski, MBA, RN, his staff sometimes will assist the social worker provided to the department by Horizon NJ Health by:

A. sharing patients' medical history.
B. notifying her if one of their members is a patient.
C. conducting research to see if a patient has a primary care physician.
D. checking if the patient is returning for a previous condition.

23. According to Alisa Murchek, RN, MS, complying with The Joint Commission's latest ruling on review of ED medication orders has added how long a delay between the time the physician orders the drug and it is verified by a pharmacist and sent to the ED's automated medication dispensing machine?

A. One minute
B. Two minutes
C. Three minutes
D. Four minutes

24. According to M. Steven Lipton, investigations into "dumping" homeless patients in Los Angeles are focusing on:

A. Whether hospitals are obtaining consent of the patients who are transported to Skid Row.
B. The clinical conditions and medical needs of the patients.
C. Why homeless patients are being transported long distances to Skid Row.
D. All of the above

CNE/CME answers

19. B; 20. D; 21. A; 22. B; 23. C; 24. D.

Fiebre

Su nino tiene una fiebre (temperatura sobre los 100 grados F o 37.8 grados C). Las fiebres ligeras no son daninas; sin embargo, temperaturas sobre los 104 grados F o 40 grados C, pueden causar deshidratacion e intranquilidad en el nino. Aqui hay varios puntos muy utiles, que pueden ayudar en hacer que su nino se sienta mas comodo, y mantener la fiebre baja:

- No arrope o envuelva al nino en ropas o cobijas gruesas. Use ropas y coberturas ligeras, para qu el nino se mantenga fresco.
- El nino debe tomar bastantes liquidos (agua, bebidas gaseosas, helados), para prevenir la deshidratacion, y para promover que orine por lo menos cada 6 horas.
- Use acetaminofen (Tylenol, Panadol, Liquiprin), o ibuprofen, cada 4 horas, para aliviar el malestar, y mantener la temperatura baja.
- Chequee la temperatura de su nino cada cuatro horas. Use un termometro rectal en los bebes. Asegurese de sacudir el termometro, para bajar la temperatura antes de usarlo, y de lavarlo con agua fresca y jabon para limpiarlo.
- Si usted no logra controlar la fiebre con las medidas recomendadas, lave al nino con una esponja o banelo en agua tibia por 20 minutos. Nunca use agua fria para banar un nino con fiebre. Por favor llame a su doctor si la fiebre no baja en dos dias. Su nino debe ser cheqeado por un doctor immediatamente si el o ella tiene cualquiera de estas sintomas: convulsions, delirio, vomito repetido, deshidratacion, o dificultad para respirar.
- El uso de aspirina para aliviar la fiebre u otros sintomas de enfermedad viral ha sido asociado con el desarollamiento del syndroma de reye. Para aliviar el dolor o la fiebre en los ninos, es importante que se les de los medicamentos que no contienen aspirina, como el acetaminophen (Tylenol) o el ibuprofen.

Source: Presbyterian Hospital of Dallas.