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IN THIS ISSUE

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Proposed OPPS changes for 2008 may threaten observation units

Pay-for-observation services would disappear under 'wholesale' packaging

For years now, the annual changes proposed in the outpatient prospective payment system (OPPS) rules by the Centers for Medicare & Medicaid Services (CMS) have been changes of degree, not kind. Payments have shifted a few dollars here and a few percentage points there, criticisms have been raised and addressed, providers have adjusted, and the process was repeated the following year.

This year, however, CMS appears to be making a major philosophical shift. In its 2008 proposed rule, it has expressed the intention "to view a service, in some cases, as not just the diagnostic or treatment modality identified by one individual HCPCS code but as the totality of care provided in a hospital outpatient encounter that would be reported with two or more HCPCS codes for component services." **(See resource box, p. 99.)** In other words, under the proposal several services for which hospitals are receiving separate payments would no longer be treated in that manner. This change could pose a significant threat to the creation of new observation units and the continued existence of those already in operation, say emergency medicine observers.

Under the proposal, payment for these services would be bundled into the associated ambulatory payment classification (APC) under the following categories:

- observation services;
- guidance services;
- image processing services;
- intraoperative services;

Executive Summary

If you have an observation unit in your facility or your hospital is considering one, here are some things you should do in response to the proposed outpatient prospective payment rule for 2008:

- Understand your payer mix and the difference your unit has made in charges and length of stay, so you can make a strong case to management.
- Study the literature that shows observation units are a best practice.
- Make your opinion known in public venues where comments are called for.

- imaging supervision and interpretation services;
- diagnostic radiopharmaceuticals;
- contrast media.

How big a threat?

"Observation medicine has been a tremendous capacity builder, because when these patients are taken upstairs, you typically double and triple the length of stay," notes **Michael J. Williams**, MPH, HSA, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. "For emergency care, this one wholesale packaged approach will deter some hospitals from staying in the [observation unit] business and some others who are not in it from getting in."

The American College of Emergency Physicians (ACEP) has been urging CMS for years to *expand* observation care and the number diagnoses and conditions that would be allowed for separate payment, says **Barbara Marone**, federal affairs director at ACEP in Washington, DC. "This proposal is basically bundling all observation now," she says. 'We don't think it's a good thing."

It "flies in the face" of their own APC technical advisory committee and the recommendations of the Institute of Medicine (IOM) in its report last year, Marone says. "And given ED crowding, we could end up sending people home prematurely or admitting them as inpatients when we could have had them in observation," she says. **(For more on the IOM report, see the special report, "Institute of Medicine to overwhelmed ED managers: 'You're not alone,'" on p. 73 of the July 2006 issue of *ED Management*.)**

Michael A. Ross, MD, FACEP, director of observation medicine in the Department of Emergency Medicine at Emory University School of Medicine in Atlanta, and a newly appointed member of CMS' APC advisory panel, admits to being "shocked" by the proposal, but is not ready to predict dire consequences for observation services. "It's not clear this would be a disincentive for having a separate unit," he asserts. "I could come up with a strong argument on either side."

On the one hand, says Ross, if the hospital is not paid separately for the observation services, "it still makes sense to follow best practices, such as a dedicated ED observation unit." On the other hand, he concedes, "the lack of separate payment for the use of an observation bed could gives the impression that it is an unfunded service, and shouldn't be supported."

One of the key variables affecting the economic impact of the proposed new rule, adds Marone, is case mix. "When you estimate the payment for a high-level emergency visit on the facility side vs. what was paid on the observation side, you lose at least $100," she says. "But since this proposal is budget-neutral; what comes out goes into other areas, so there will be winners and losers on the hospital side."

A call to action

Williams says the potential threat posed by the proposal is serious enough that ED managers should take

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Editor: Steve Lewis (steve@wordmaninc.com).
Senior Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: Coles McKagen, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Senior Managing Editor: Joy Daughtery Dickinson, (229) 551-9195, (joy.dickinson@ahcmedia.com).
Senior Production Editor: Nancy McCreary.

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (229) 551-9195.

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action. "Remember, these changes are just *proposed*, and CMS has done some major reversals in the past," he says. "It's time to testify, if need be, and those who have observation units should be aghast and respond to a call for action." **(For information on how to comment on the proposal and the deadline for submissions, see resource box, below.)**

There is "lots of science" that demonstrate the cost-effectiveness of observation units, as well as the quality and bed capacity improvements that occur as a result of having such units, Williams says. "ED managers should be educated about what having an observation unit does and does not mean," he advises. "If you have a program that supports itself, do *not* let administration overreact [to the proposal] and shut it down."

You should know what your payer mix is and be aware of other important facts such as charges and lengths of stay for rule-out myocardial infarction, for example, before and after having an observation unit, Williams says. "If you can break these numbers out and defend them, you'll have a better chance," he says.

"I strongly encourage people to respond based on how they feel about this," adds Ross. "The IOM report authors, for example, felt strongly that observation should not be restricted by condition and that there should be fair and separate payment of observation services."

Another area of growing importance in the OPPS involves quality measures. Hospitals must submit data on 10 such measures in order to receive the full OPPS payment update for services furnished in 2009, and of more immediate concern is the fact that these measures will become effective with outpatient services provided as of Jan. 1, 2008. Those measures include five that are directly related to the ED:

- ED transfer [acute myocardial infarction (AMI)] — aspirin at arrival;
- ED transfer (AMI) — median time to fibrinolysis;
- ED transfer (AMI) — fibrinolytic therapy received within 30 minutes of arrival;
- ED transfer (AMI) — median time to electrocardiogram;
- ED transfer (AMI) — median time to transfer for primary percutaneous coronary interventions.

"This would definitely affect the ED, and they are currently being called for at the National Quality Forum as well," notes Marone. "ED managers have to know what these quality measures are, and I would assume they also need to educate their staff." It's important, she adds, for ED managers to revisit their processes and make sure they meet these quality measures.

Williams says, "We now have more definition to quality indicators, and ED managers definitely need to be familiar with the quality measures." It's important that the ED is being included in these measures, he says, "But it will make it that much more important in the future to have an EMR [electronic medical record] to figure out the reporting, because you will not be able to do this by hand."

CMS also is seeking comment on 30 additional quality measures that are under consideration for reporting in future years. They include ECG performed for patients with syncope — percentage of patients ages 18 to 60 years with an ED discharge of syncope who had an ECG performed. ■

Sources/Resource

For more information on the proposed rule, contact:

- **Barbara Marone**, Federal Affairs Director, American College of Emergency Physicians, 2121 K St. N.W., Suite 325, Washington, DC 20037-1801. Phone: (202) 728-0610.
- **Michael A. Ross**, MD, FACEP, Director of Observation Medicine, Department of Emergency Medicine, Emory University School of Medicine, Atlanta.
- **Michael J. Williams**, MPH, HAS, President, The Abaris Group, 700 Ygnacio Valley Road, Suite 270, Walnut Creek, CA 94596. Phone: (925) 933-0911. Fax: (925) 946-0911. E-mail: theabaris@aol.com.

A copy of the proposed 2008 OPPS rule can be found at: www.cms.hhs.gov/HospitalOutpatientPPS/downloads/cms1392p.pdf. Comments on the proposed rule will be accepted until Sept. 14, 2007. You may submit comments electronically at www.cms.hhs.gov/eRulemaking. Click on "submit electronic comments on CMS regulations with an open comment period."

Solid plan, 'gut instinct' are disaster response keys

Bridge collapses, ED manager makes judgment call

When a bridge that links Minneapolis and St. Paul, MN, collapsed early in the evening on Aug. 1, it touched off a series of events and tragedies that unfolded rapidly amid much confusion and conflicting media reports. Fortunately for the 24 patients brought to the ED at nearby Hennepin County Medical Center in Minneapolis, there was anything but chaos and confusion among the staff.

In fact, says **John L. Hick**, MD, medical director

Executive Summary

Even with the most intricate disaster response plan, not all contingencies will be accounted for. In the case of the Minnesota bridge collapse, one ED manager had to rely on his experience and judgment to determine exactly when to implement the plan.

- Don't wait until you are sure your ED will be overwhelmed with new patients to begin preparing for that eventuality. Assess your resources, and have additional help lined up.
- If you do not have insufficient data to definitively state there is a disaster, err on the side of caution and initiate disaster response.
- Make sure your plan has a well thought-out strategy for making additional beds available.

for emergency preparedness at Hennepin County, "Within hours afterward, we had resumed pretty normal operations at the hospital."

This efficient response was due to effective planning and quick thinking on the part of **William Heegaard**, MD, MPH, assistant chief of emergency medicine. Heegaard was the senior staffer present when the disaster occurred, and it was his decision to call a Code Orange (the hospital's highest-level emergency) earlier than some ED managers might have.

"We initially got a quick report from one of the paramedics who had had contact with the police, who told us a bridge had perhaps gone down," he recalls. "I was running a critical case at the time, so I just asked them to keep me abreast of the situation."

A few minutes later, the control center for the Hennepin ambulances informed the ED they had sent multiple rigs to the scene, so Heegaard knew it was more than just a small event. "However, there was no way to assess how many patients to expect," he adds.

Stepped-up readiness

At this point, it was about 6:20 p.m. (The bridge collapsed at 6:07.) While Heegaard did not officially call a disaster, "we contacted the charge nurses, started to ask about resources available, and got a status report of the ED at that point," he says.

He started reviewing what to if it became necessary to clear the ED for an influx of victims. He contacted the chief of emergency medicine and told him to turn on his TV. "I also called the on-call surgeon, alerted him, and asked him to make sure to have a couple of extra people he could call if need be," says Heegaard.

Shortly thereafter, after speaking with ambulance personnel and people on the scene, "it became obvious this was an event that could potentially overcome all our resources," says Heegaard. While the information still was relatively sketchy, with no idea of how many victims might be on their way, "I had a gut feeling that calling a disaster response was the right thing to do," he explains. "After all, we could always call it off." The time was about 6:30 p.m.

From that point on, says Heegaard, there was "a massive, impressive response." Team Center A — the

Disaster communications need to be improved

While ED the staff at Hennepin County Medical Center in Minneapolis responded quickly and efficiently following the collapse of an interstate bridge, **John L. Hick**, MD, medical director for emergency preparedness, already has set in motion actions to remedy the few shortcomings that were noted.

"The single biggest challenge was on the communications end," he says, echoing a common theme in disaster response evaluations. "The switchboard was jammed, and as a consequence, our internal phone system prioritized internal calls over external calls."

That's normally a good thing, he concedes, but all the lines in the ED are "ring-down" lines, so when someone picked up a phone, there would be another caller that had been rolled over from a busy phone line.

Hick says he is looking into adding some lines in the ED that are not "ring-down" lines. How was this problem overcome during the response to the bridge collapse? "We used runners to pass messages back and forth between the ED and the hospital command post," says Hick. The runners, appointed by the command post, included radiology technicians. "Also, when they saw that CT scanners would soon be ready for the next person, they passed on that information as well," he says.

Hick also is about to purchase a two-way, "push-to-talk" 900 MHz radio system for the hospital, something that was planned before the disaster. "We had radios for the ED, but we did not have a system that works for most of the hospital," he explains. "Now we will have a radio near each CT scanner and in each OR." ■

Sources

For more information on disaster response, contact:

- **William Heegaard**, MD, MPH, Assistant Chief of Emergency Medicine, Hennepin County Medical Center, 701 Park Ave. S., Minneapolis, MN 55415. Phone: (612) 873-3961.
- **John L. Hick**, MD, Medical Director, Emergency Preparedness, Hennepin County Medical Center, 701 Park Ave. S., Minneapolis, MN 55415. Phone: (612) 873-3020. Fax: (612) 904-4241. E-mail: john.hick@co.hennepin.mn.us.

ED's main area for the sickest people — was cleared out, as the patients were immediately admitted or moved into Team Centers B or C. As for the patients who had been in those areas for lower acuity, "we discharged the people we felt comfortable with, and admitted a few," says Heegaard. The Express Care area was cleared. In the "special care" area, reserved for intoxicated patients and prisoners, the patients were discharged, and it became the triage staging area.

"At that point, we also elected to divert any non-trauma critical patients and communicated to those on the scene that we would take all critical patients," says Heegaard. "We had cleared out about 25 beds for them and had 10 fully staffed ORs up and running within an hour."

The ED had a relatively quick rush of six seriously injured patients, he recalls. "I initially managed those patients and pulled faculty from Teams B and C into the critical care area," Heegaard says. He knew he had to manage the patients with his current staff for about 10 minutes. Soon, another faculty member who had heard about the disaster drove in to work. A page went out to all staff, and "pretty quickly, we had three faculty and accompanying residents to manage the critical care area," says Heegaard.

Faculty soon replaced residents managing Teams B and C. There also were several faculty members, nurses, and physicians assistants available to manage patients who were not critical. There were 14 cubicles available by then in the Team A area.

Of the 24 patients received by the Hennepin ED, six were critical (one eventually died), 10 were serious (primarily spinal and other blunt-force injuries), and eight were treated and released in less than 24 hours. "We were really lucky that we did not have that many 'criticals,'" says Hick. "We had very rapid and impressive staff and facility response." **(Even with a disaster response as impressive as this, there are lessons to be learned. See the story, p. 100.)** ■

'PIT' more than triples ED's satisfaction rates

Averages for LOS and LWBS more than cut in half

How would you like to boost your patient satisfaction scores from the 30th percentile to the 96th percentile with a single new strategy in your ED? If that's not enough, how about a 44% reduction in your LWOT (left without treatment) rate and a 42-minute decrease in your average length of stay (LOS) for all patients?

Those impressive performances were turned in by the ED at Parma (OH) Community General Hospital between Jan. 1, 2007, and March 10, 2007, as the result of a pilot test for its new Physician in Triage (PIT) program.

The traditional LWOT rate in the ED had been 4.8% prior to the PIT program. Following implementation, it dropped to 2.7%. The average LOS before the program was 293 minutes. Following implementation, it was 251 minutes.

"We started toying with the idea [of a physician in triage] in the fall of 2006," recalls **Jesse DiRando**, MD, FACEP, director of emergency services. In fact, he adds, it had been tried earlier, but it didn't work well without much cooperation from the hospital. "We had a substantial administration change and new nurse management, who liked the idea and was committed to it as well," he explains.

They spent about two months putting the project together; obtained buy-in from administration, nurses, and physicians; and implemented the plan on a half-time basis to see if they were actually getting improvements. "Out premise was the following: Could we improve satisfaction, accuracy of triage, proper diagnosis, and proper lab and radiology studies at the front end by

Executive Summary

One ED boosted its patient satisfaction rate from the 30th percentile to the 96th percentile, just by placing a physician in triage. Here are some tips for implementing this process, which also will have a significant impact on your bottom line.

- Create a triage team that includes a physician, nurses, and an ED tech.
- Perform quick registration. Order tests while patient is still in triage.
- If your ED has a fast-track area, send low-acuity patients there to be seen by a physician or PA.

Sources

For more information on physicians in triage, contact:

- **Jesse DiRando**, MD, FACEP, Director, Emergency Services, Parma (OH) Community General Hospital/ Emergency Medicine Physicians of Cuyahoga. Phone: (440) 743-4020. E-mail: JDiRando@emp.com.
- **Carl Schikowski**, MD, Parma (OH) Community General Hospital. Phone: (440) 743-4020.

having a physician there — the highest-trained person in care of the patient seeing them *first?*" DiRando explains.

A parallel process

The traditional triage process is a serial process, DiRando says. The patient presents, then evaluation begins by nursing or clerical staff. Next, they are sent to the ED or fast-track facility or waiting room, with no orders. The physician then evaluates the patient, arrives at a diagnosis and orders treatment; the orders are executed, studies returned, the patient is re-evaluated by the physician, and final disposition is determined.

"In the PIT model, we created a team that handles evaluation and treatment while we simultaneously register the patient," says DiRando. The team includes one triage physician, two RNs or LPNs — one medic can be substituted for a nurse, but never two — one ED tech, and one float tech. In this "parallel processing," the patient walks in the door, comes to the triage window, and is greeted by the registrar, who takes only the name and a minimum amount of information to "quick-reg" them in order to obtain a medical record number. Then they go into the triage room, where the doctor and nurse conduct triage simultaneously. "If we know labs will be required, the tech immediately draws blood right then," adds DiRando. The doctor enters orders for lab or radiology studies and determines where the patient will go next. Low-acuity patients go to fast-track, where they are seen by a physician assistant (PA) who collaborates with the triage doctor. Higher-acuity cases are sent to the main ED, where they are seen by ED physicians.

Cost-free pilot

The three-month pilot program was a cost-free method of demonstrating the success of this approach to staff and administration. "We started out with half-days of traditional staff and the other half PIT, to allow a basis of comparison," says DiRando, adding the schedules were rotated on different days to ensure an accurate comparison.

As with most new processes, everyone was skeptical at first, says **Carl Schikowski**, MD, an ED "physician champion" for the new program. "However, after a couple of weeks of seeing how it works, they were all pretty much on board," he says.

The improvement in patient satisfaction is the one that "sold everybody," says DiRando. The patient satisfaction scores were provided by Press Ganey of South Bend, IN. "In addition, we have been able to discharge 8% of the patients seen by PIT, and they never entered the ED," DiRando says. **(A great deal of effort was spent on obtaining staff buy-in. See story, below.)**

DiRando says the staff have evolved "from resistance to acceptance, and now to commitment and reliance on the new process." By the end of the pilot period, on the days they were not using PIT, "they got upset and angry they weren't doing it," he says.

Now, the ED is going to PIT full-time, and some additional costs will be incurred. The additional cost was the hiring of a PA to fill a shift, DiRando says. "But recaptured revenue from the decreased LWOT rate more than paid for the additional required staff," he says.

The program has exceeded expectations, says Schikowski. "It's an unbelievable relief knowing that every appropriate test had been ordered, and in a lot of instances, they're done by the time you pick up the chart," he says. "It's a huge timesaver." ■

'Sense of urgency' helps sell staff

One of the keys to getting staff onboard with the new Physician in Triage (PIT) program in the ED at Parma (OH) Community General Hospital was creating a sense of urgency, says **Dawn Beljin**, RN, director of emergency services.

Jesse DiRando, MD, FACEP, and Beljin held meetings at which they let staff members know the patient satisfaction scores were in the 30th percentile, as well as the rates for patients who left without treatment (LWOT) — 4.8% — and length of stay (LOS) — 293 minutes. "We said, 'Look, this where we're at, this is what's happening, and by implementing doc in triage, we will improve all of these numbers — and also help throughput,'" Beljin says.

This sense of urgency "gained their buy-in," she says. Obtaining staff buy-in was accompanied by a philosophy of open communication. "We used e-mail, rounding, and additional staff meetings to explain why we were committed to the process," Beljin says.

Source

For more information on gaining staff buy-in, contact:
- **Dawn Beljin**, RN, Director of Emergency Services, Parma (OH) Community General Hospital. Phone: (440) 743-4611.

To prepare the nursing staff for the pilot program, she first met with all the charge nurses. "We looked at the process and the environment, discussed what supplies would be needed up front in order for them to do their jobs," Beljin explains. "Then, we flowcharted the process from beginning to end."

Throughout the process, "We listened to them," she says. "We asked what was going well, and what was not going so well, and whether they needed anything they didn't have."

Adjustments had to be made along the way, Beljin reports. "We were ordering exams up front in the triage area, and all of a sudden we realized radiology did not know where these patients were," she recalls. "I talked with the director of radiology and gained her support." Now, Beljin says, radiology comes over to get patients from the waiting room and returns them there after their tests are performed. ■

Anticoagulation therapy is safety goal for 2008

Growing number are taking these drugs

One of the new National Patient Safety Goals recently published by The Joint Commission addresses a situation emergency medicine experts say is becoming increasingly common: Patients on anticoagulation medication. Goal 3E for 2008 states: *"Reduce the likelihood of patient harm associated with the use of anticoagulation therapy."*

"There are a large number of people now presenting to the ED who are on these medications," says **James J. Augustine**, MD FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH. "These medications come in a number of versions in three big classes, ranging from aspirin — including the baby aspirin many people take prophylactically every day — to Coumadin [warfarin] to heparin," Augustine says. "A lot of people we see now are on them, and anyone at risk for coagulation in the heart, lung, or brain can be put on them."

The potential for patient harm is significant, notes **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission. "The types of medications used [to reduce coagulation risk] place the patient at risk for underdosing as well as overdosing," he explains. "Underdosing creates a situation where the disease is not adequately managed, while overdosing creates increased risk for bleeding and other various complications."

Accordingly, it is important for these medications to be maintained in a therapeutic range, both for inpatients and outpatients, he says. "This goal does not replace existing clinical guidelines developed by other professional societies, but focuses rather on trying to ensure there are adequate processes and systems in place to make sure the patient is identified and followed, the staff is educated appropriately, and any adverse outcomes are evaluated on a regular basis," Angood explains.

Modifying approaches

Because of the increased number of patients who may present while taking such a medication, "we have to modify our diagnostic approaches and be very careful in administering other medicines that prolong the effects of Coumadin," warns Augustine. "The patient can have significant harm from that medication overlap."

For example, ED staff may think they are doing the patients a favor by putting them on certain antibiotics, he says. "We may be resolving some infection problem, but when they are back at home, there could be at significant risk for a bleed in the head," Augustine says.

Accordingly, "this raises a big concern in regards to medication reconciliation," he says. Furthermore, the large number of people older than age 40 taking one baby aspirin a day "makes them susceptible to bleeding, and when we do a diagnostic work-up, we have to remember that," Augustine advises.

A classic example of a problem involved with patients on anticoagulation therapy would be patients on warfarin falling and striking their head, he says. "They could have a slow bleed, and be worsening over the hours — either at home or waiting in the ED," Augustine says. "You have to know how to avoid potential safety problems related to their care; you also have to know when the right window exists to find the bleed on the CT scan."

Angood agrees and outlines several strategies members of The Joint Commission staff think should be in place in this area. "[Anticoagulation therapy] processes should be defined and [the issue] established as a distinct management program, with recognition of different types of therapies," he says. "The ways they are

Sources/Resource

For more information on anticoagulation therapy, contact:

- **Peter Angood**, MD, Vice President and Chief Patient Safety Officer, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000.
- **James J. Augustine**, MD, FACEP, Director of Clinical Operations, Emergency Medicine Physicians, 4535 Dressler Road, Canton, OH 44718. Phone: (330) 493-4443. E-mail: JAugustine@emp.com.

Go to www.jointcommission.org/npsg for the specific National Patient Safety Goals for each of The Joint Commission's accreditation and certification programs.

administered — oral, IV, and so forth — should involve protocol-driven strategies with well-established laboratory parameters for therapeutic range, and policies for testing and management." There also should be education programs for staff and patients, he says.

Augustine, who recently attended a Joint Commission technical advisory committee meeting on the new National Patient Safety Goals, summarizes the agency's expectations thus: "They are looking for expert care of patients on anticoagulants — both in the hospital and when they leave the hospital to go home," he says. **(For more on patient safety goals, see the resource box, above.)** ■

Patient navigators show the way to faster flow

Phone liaison position expands to different ED areas

The ED at Lutheran Medical Center (LMC) in Brooklyn, NY, has reduced its average door-to-doc time from more than two hours to 30 minutes in just 18 months, with the nearly simultaneous implementation of six major initiatives. The most innovative of all of the initiatives was the creation of a "patient navigator" position, originally conceived as a link between primary care physicians and ED physicians and nurses. The position later was expanded to include bed management and riding herd on test results and virtually any activity that could hinder patient flow.

"Our CEO and I had done this previously at another hospital, where the individuals were called communication nurses," says **Claudia Caine**, LMC's chief operating officer. The three full-time navigators at LMC are physician assistants. They cover two consecutive shifts each day, while a third backup navigator works in the quick care area, which was created as another one of the six initiatives.

The other four initiatives are:

- **electronic medical records and bedside registration;**
- **ED huddle/inpatient huddle.** Representatives from every discipline and patient unit meet in the ED at 11 a.m. each day to plan the day's strategy with Caine;
- **ED diplomat program.** Senior staff members complete hourly rounds. They speak to patients and family members to ensure that they are comfortable and receiving all the services they need in a timely fashion;
- **ED greeter.** A staff member meets and greets every patient who walks into the ED.

Navigating the ED

To perform their initial role, the patient navigators were provided with a separate telephone line. The primary care physicians, and some nursing homes, were given the direct numbers. "We tried not to give it out to too many people," says Caine.

Initially, this was done to ensure that private docs who sent in emergencies knew they would not lose their patients in a "black hole," explains **Bonnie Simmons**, DO, FACEP, chair of emergency medicine and medical director of pre-hospital care. Because ED physicians often didn't have enough time to interact with the primary care physicians and provide them with the updates they needed, "the navigators could be a liaison for them," she says.

This service was valuable not only to the primary care physicians, but for the ED physicians as well, notes Caine. "This may have been the single most important thing we've done for our doctors," she says.

Executive Summary

Nurses or physician assistants designated as patient navigators can ease the burden on the rest of the staff, improve relations with outside physicians, and improve patient flow in your ED.

- Provide them with separate phone numbers that primary care physicians can call to check on the condition of referred patients.
- Make them an integral part of your bed flow team, and have them serve as liaisons to admitting.
- Navigators also can be used to check with radiology when test results appear to be delayed.

Sources

For more information on patient navigators, contact:
- **Claudia Caine**, Chief Operating Officer, Lutheran Medical Center, Brooklyn, NY. Phone: (212) 861-5122.
- **Helen Costello**, RN, Nurse Manager, Emergency Department; **Bonnie Simmons**, DO, FACEP, Chair of Emergency Medicine, Medical Director of Pre-Hospital Care, Lutheran Medical Center, Brooklyn, NY. Phone: (718) 630-8383.

"Even as visits went way up, they felt they had a sense of control."

And go up they did, from about 137 patients a day to 167, which was part of the reason the position expanded. The other impetus came from the aforementioned 11 a.m. bed huddles. "The huddles existed before I came here, but we were not getting dramatic results," says Caine, who decided to attend every huddle personally. "The purpose of a bed huddle is to *support* the ED," she notes, and that just wasn't happening.

"I started to go at first just to watch, but I'm told things became different," says Caine. "The staff started to be much more aggressive about things like putting patients in the hallways upstairs." New ideas were instituted in a rapid-cycle fashion; after a few days, they would be discussed and evaluated in the huddle.

One of those ideas involved having the navigators attend the huddle. They still worked their central phone number, says **Helen Costello**, RN, the ED nurse manager. "But as we expanded our bed flow teams and the 11 a.m. huddle, and our bosses embraced the overcrowding issue, they started going to the huddle, she says. They would find out which beds were to become available and make sure admitting knew the ED's exact needs," Costello says. "Now, as soon as a bed is available, admitting calls *them*, they go to the nurse that has that patient, and puts the information on the tracking board." They also help expedite the transfer, close out the chart, or sometimes bring the patient upstairs, she adds.

If lab tests take too long, Costello says, the navigators will interface with radiology to get the results as quickly as possible. They also will help with family problems, such as long waiting times or ordering snacks.

The position clearly has become more formalized. "They start the day by looking at a printout of the tracking board and make rounds of all three ED areas [waiting room, quick care, and acute care]," Costello says. "They make sure all dispositions make sense, and if not, they will go to the doctors."

This position has morphed into a *real* navigator role, Simmons says. "It's expanded to anything and everything that has to do with patient flow and helping *all* our physicians and nurses with communication and moving patients through the system," she says. "I don't know how we ever lived without them." ■

New staff and a team approach boost morale

Patient satisfaction numbers also climb higher

New staff physicians, a reduced workload, and a team approach to department endeavors have not only improved morale in the ED at Samaritan Hospital in Troy, NY, but they also boosted patient satisfaction scores from between the 70th and 80th percentiles into the 90s.

The new physician contract started three years ago, says **Orion Colfer**, MD, FACEP, medical director of emergency services and a member of Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH. "Many members of the previous group stayed with us through the transition, but over the last three years, most have left for a variety of reasons," he says.

Thus, he says, he faced the dual challenges of hiring physicians to fill the staff and building an ED team. "The nursing and support staff were really a strong and cohesive team already and survived the transition," Colfer recalls. "I spent two years recruiting aggressively and added seven full-time physicians over the last 2½ years." This, he says, transformed the ED from a department that had too few doctors to one that has "more than enough."

The department sees about 40,000 patients a year,

Executive Summary

Your staff's work environment can have a significant impact on how they view their jobs and how they deal with patients. Here are some strategies for improving this all-important area of ED management:
- When possible, increase the number of physicians in your staff while keeping the total number of hours worked constant.
- Invite nurses to social gatherings to meet new physicians, to help engender a sense of teamwork.
- Showing flexibility when nursing staff requests personal time off will be rewarded by an enthusiastic response when you need additional coverage.

Sources

For more information on creating teamwork in your ED staff, contact:

- **Orion Colfer**, MD, FACEP, Medical Director of Emergency Services; **Judy Quinn**, RN, Emergency Department Nursing Director, Samaritan Hospital, 2215 Burdett Ave., Troy, NY 12180. Phone: (618) 271-5045.

reports Colfer. "We went from six doctors working 200 hours each to 11 working 120 hours each, which eliminated what was a completely overstressed working environment," he says. "We found that we became much nicer people to work with and be around, while at the same time adding efficiency to the department."

Judy Quinn, RN, the ED nursing director, agrees. "We've been doing employee opinion surveys for seven or eight years; and historically, we've had high scores, but each time we've done them [since Colfer arrived], it has improved," she says. The department scores "above four" on a scale of one to five, Quinn reports.

Teamwork pays

Since there already was "a cohesive nurse team with little turnover" when Colfer arrived, Quinn wanted to increase the Press Ganey patient satisfaction scores. "I had done all I could do with the nurses, but I needed someone to work with the physicians," she says.

The team approach "took off very quickly with the infusion of [new physicians] and Orion's philosophy," Quinn notes.

Colfer has taken an aggressive approach to creating a unified team front. "For example, whenever we added a doctor to our group, we had catered events at our homes, to which 15 or 20 nurses were invited," he says. The purpose of the invitations was "to tear down doctor/nurse barriers and make the ED staff a team," he says.

This approach dovetailed nicely with what Quinn already had been doing with the nursing staff. "You need to value the people who work for you," says Quinn, who has been in the department for 19 years. "For example, we give them time off when there is something special they need to do with their family," she says. While Quinn doesn't personally handle the scheduling, "I have created an environment in which people are not made to feel bad about [asking for time off] or feel pressured to find their own coverage," she says. The result of this approach "is that when I need to fill sick call, there is no problem, because the nurses know I will be there when they need *me,*" Quinn says.

Creating this type of environment takes time, she emphasizes. "It's not a 'light-switch' event," she says. "It takes a couple of years."

Creating a cohesive team also pays off when new initiatives are implemented, says Colfer. "We are in the ninth day of an entirely new patient evaluation process, Physician in Triage [PIT]," he notes. "I have been extraordinarily blown away by how the group has come together." **[This initiative is modeled after a successful PIT program developed in the ED at Parma (OH) Community General Hospital. For more information on this program, please see "'PIT' more than triples ED's satisfaction rates" on p. 101 of this issue.]**

Like Quinn, Colfer notes this is an attitude that takes time to develop. "I couldn't imagine trying to do this at the beginning of the process — before we developed a relationship of trusting each other," he says. *[Editor's note: Do you have an idea for boosting staff morale that you'd like to share? Contact Steve Lewis, editor at (770) 442-9805 or via e-mail: steve@wordmaninc.com.]* ■

$25 million available for preparedness grants

The U.S. Department of Health and Human Services (HHS) is making $25 million for hospitals and other health care facilities via a competitive emergency care grant program that will focus on hospital surge capacity, emergency care system capability, and community and hospital preparedness for public health emergencies.

According to HHS, grants will be awarded for projects that will:

- develop plans for strengthening public health emergency medical management, and the provision of emergency care and treatment capabilities;
- help integrate public and private emergency care system capabilities with public health and other first responder systems through periodic preparedness and response capabilities via drills and exercises; and integrate public health (including private sector organizations), medical donations, and volunteers;
- improve the efficiency, effectiveness, and expandability of emergency care systems and overall preparedness and response capabilities in hospitals, other health care facilities, and trauma and emergency medical service systems, with respect to public health emergencies.

Grant applications may be filed online at www.grants.gov and must be received no later than 5 p.m. EST on Sept. 7, 2007. ■

Vermont EDs acessing records of patients' meds

Obtain history, even at first visit

Two Vermont EDs have initiated a health information technology project that will enable their physicians and nurses to obtain accurate medication lists for patients within seconds — even if the patient has never visited the hospital before.

Rutland Regional Medical Center and Northeastern Vermont Regional Hospital in St. Johnsbury are the first two hospitals in Vermont to implement the new electronic medication history service in their EDs. The service will be rolled out to other hospitals in the state over the next year.

The medication history service is offered by Montpelier-based Vermont Information Technology Leaders (VITL), a not-for-profit, public-private partnership. GE Healthcare, of South Burlington, VT, developed the service for VITL and provides maintenance and support for the hospitals.

Data from prescriptions filled at pharmacies are being provided by pharmacy benefit managers (PBMs), including RESTAT in West Bend, WI, and MedMetrics in Worcester, MA, the PBMs for Blue Cross Blue Shield of Vermont and Vermont Medicaid, respectively. Playing a central role in the project is RxHub of St. Paul, MN, which electronically routes up-to-date patient-specific medication history and pharmacy benefit information to caregivers at every point of care.

Patients arriving at the EDs are asked for permission to access their electronic medication history. Almost all choose to opt in.

State officials claim that the medication history service developed in Vermont is considered the most effective in the country because of its high level of data availability. Medication data are available on 75% of the patients visiting the ED, due to the cooperation of major payers, including Blue Cross Blue Shield of Vermont, MVP Healthcare, and the Vermont Medicaid program.

VITL and GE Healthcare say they will be work together to develop and implement other standards-based health information technology projects. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. **The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

For information on the CNE/CME program, contact customer service at (800) 688-2421 or customer service@ahcmedia.com. ■

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*

31. Under the proposed 2008 outpatient prospective payment system rule, which of the following quality measures will become effective with outpatient services provided as of Jan. 1, 2008?

A. ED transfer [acute myocardial infarction (AMI)] — Median time to ECG.
B. ED transfer (AMI) — Median time to fibrinolysis.
C. ED transfer (AMI) — Aspirin at arrival.
D. All of the above

32. According to William Heegaard, MD, MPH, when an interstate bridge collapsed nearby, he asked his charge to assess ED resources:

A. After paging all ED staff that were not working and determining who was available to report.

COMING IN FUTURE MONTHS

- Is there racial bias in the care your ED patients receive?
- Report says hospital workers keep mum about verbal abuse
- Hospital web site updates urgent care wait times every 30 minutes
- 'Medical tourists': What to do when they present in your ED

B. Before he initiated the disaster response.
C. After he called a Code Orange.
D. When he was so directed by the chief of emergency medicine.

33. According to James J. Augustine, MD FACEP, which of the following is *not* part of an appropriate approach to treating patients on anticoagulants?
A. Avoid use of all antibiotics.
B. Keep accurate medication reconciliation records.
C. Be careful of potential patient harm due to medication overlap.
D. Include aspirin in your list of anticoagulants.

34. According to Jesse DiRando, MD, FACEP, which of the following is *not* an example of a parallel process in triage?
A. The doctor and nurse conduct triage simultaneously.
B. Treatment and registration occur at the same time.
C. Evaluated patients are sent to the ED, the waiting room, or fast-track, but with no orders.
D. If labs are required, blood is drawn immediately.

35. According to Helen Costello, RN, the patient navigators in her department help ease the workload of the rest of the staff by:
A. Communicating directly with primary care physicians.
B. Participating in bed huddles.
C. Checking up on overdue test results.
D. All of the above

36. According to Orion Colfer, MD, FACEP, when new doctors joined the department, he would engender a feeling of teamwork by:
A. Sending out a mass e-mail.
B. Inviting a number of nurses to a catered affair at a private home.
C. Introducing them at staff meetings.
D. Provide them with name tags to wear on their first day of work.

CNE/CME answers

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