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# Emergency department managers warned of 'catastrophic' crowding due to elderly

*Study says total number of visits could double in 10-year period*

The number of patients between the ages of 65 and 74 who visit the nation's EDs annually is likely to double from 6.4 million in 2003 to 11.7 million by 2013, according to a new study published in the *Annals of Emergency Medicine*.[1] This growth, the authors warn, could lead to catastrophic overcrowding.

While the actual numbers may come as a surprise to ED managers and other emergency medicine experts, the trend does not. "There is definitely an increase in ED visits, and the fastest segment is the elderly population," says **David Seaberg**, MD, FACEP, dean and professor of emergency medicine at the University of Tennessee College of Medicine and an ED physician at Erlanger Hospital, both in Chattanooga. "As the population lives longer, people develop more problems and need more care, and the fact is that Medicare patients have a difficult time getting in to see primary doctors, who do not want to take new Medicare patients into their practices."

For several years, the complexity of Medicare-aged patients coming into EDs, and the varieties of complaints, has been increasing, says **Susan M. Nedza**, MD, MBA, FACEP, chief medical officer of Region V for the Centers for Medicare & Medicaid Services in Chicago. "The ACEP [American College of Emergency Medicine] geriatric section has recognized this for years and projected this wave

## Executive Summary

While a new study indicates there may be twice as many elderly patients visiting your ED in 2013 as there were in 2003, there are steps to minimize the amount of time they spend in your department.

- Develop a list of outpatient links to home health agencies, visiting nurse organizations, care centers, nursing homes, and assisted living facilities.
- Negotiate a reimbursement arrangement that provides an incentive for administration to help move your patients upstairs more quickly.
- Make sure your staff are aware of the unique presentations seen in the elderly. This will help speed diagnosis and care.

## IN THIS ISSUE



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would be coming."

This increase should be an alarm bell, says **Mary Pat McKay**, MD, MPH, one of the article's authors and director of the Center for Injury Prevention and Control at The George Washington University Medical Center in Washington, DC. "It's an opportunity in 2008 to do something prospectively — or else wait until the pandemic flu in 2013 when all these old folks come to the EDs and we have no surge capacity," McKay says. Such an event, she warns, "could be worse than the pandemic flu in 1918."

## Addressing capacity issue

While recognizing that overcrowding is a complex issue, McKay says a large part of the solution lies in disposition: getting patients — especially admitted ones — out of the ED.

"The average stay of this population is longer, and the percentage of the elderly we admit is about to grow exponentially," she observes.

What is the answer? "Just moving people to floors upstairs is not it," says McKay. "We need to understand how many ED beds we need in the hospital *community*, because we are not going to prevent them from coming to the ED." Short of that, she says, managers need to start planning now for different ways to move them out of the ED. "The 'newest' way may be the oldest: build more beds and staff them," McKay says.

That approach may not be best, however, counters **Kenneth Iserson**, MD, MBA, an ED physician at the University of Arizona Medical Center and professor of emergency medicine at the University of Arizona School of Medicine, both in Tucson. Instead, Iserson suggests, ED managers should look for more alternative sites for such patients, or they should look for easier access to other facilities once they have been evaluated in the ED. "Part of the answer is to get more social workers and case managers to help out," he says. Then, change the laws — "for example, those that say elderly patients have to be admitted a certain length of time before you can put them in a nursing home," Iserson says. "This ties up beds unnecessarily."

Develop some outpatient links to home health agencies, visiting nurse organizations, care centers, nursing homes, and assisted living facilities, says **Robert Fitzgerald**, MD, FACEP, an attending physician in the ED at Boswell Hospital in Sun City, AZ. Boswell also lectures at Harvard University in Cambridge, MA, on designing the ED for the elderly patient. **(For more on how to design a geriatric wing or a geriatric ED, see the story, p. 15.)** "We will also have to get better at asking whether the patient *truly* needs an inpatient bed, or if there is a better or safer location for them," Fitzgerald says.

## Improving, speeding treatment

At the same time ED managers are looking for additional facilities outside of their hospital, they must work on limiting the amount of time elderly patients stay in their department, say McKay and

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other observers.

"The key is decreasing the time from when I decide the patient needs to be admitted to when they go upstairs," she says. "When they stay 12, 24, or 36 hours, that's a huge problem."

In one hospital where McKay worked, the amount of time such patients could stay in the ED was negotiated, and there was a limit of four hours put on how long the patient could stay in the ED before being moved upstairs. Once you were past that deadline, the facility fee for the DRG was attributed back into the ED, she explains. "That may be a way to emphasize the importance of this issue."

When you speak to hospital administrators, McKay adds, money talks. "When you say the ED group is losing money because you are not moving patients upstairs and that you [the administrators] need to be paying for that, it provides an incentive to get the patient out of the ED," she asserts.

Making sure your staff understand what to look for in elderly patients also can decrease the time they spend in your department, adds Fitzgerald. "Make sure everyone has the clinical knowledge to appreciate what is going on," he advises. Elderly patients in general will show up with atypical presentations of common complaints, Fitzgerald says. "For example, with acute coronary syndrome, instead of the proverbial elephant standing on their chest, they could be experiencing nausea or delirium," he suggests. "Or, they may have same common disease and not come in with the typical story you hear."

Speeding the diagnosis and eliminating certain possibilities immediately is especially important with elderly patients, Fitzgerald continues. "Geriatric patients demand what most EDs can't give you, which is time," he says. "It may take five minutes just to undress them or perhaps they have dementia or they can't hear you."

An ED nurse or physician simply doesn't have hours to spend taking a history, Fitzgerald says. "In sexual assault cases, for example, we have special nurses — a crisis team — to do that," notes Fitzgerald, suggesting a possible solution with elderly patients. "We will have to modify our personnel in the EDs, and that may well require more than what the typical ED provides," he says. "If you can't figure that out and you have to keep them in the department longer, it will literally break the bank."

Finances, more than anything else "will push us to change dramatically the way we take care of this patient group," Fitzgerald says.

Nedza agrees. ED managers need to look at their capacity for providing the kind of services these patients require, she says. "They may have higher levels of acuity, longer stays in the ED, more testing, and need more resources for evaluation," Nedza says. These demands have staffing ramifications as well as risk ramifications, she says. "Leaving a 70-year-old in the waiting room is different than leaving a 40-year-old there," Nedza says.

### *Reference*

1. Roberts DC, McKay MP, Shaffer A. Increasing rates of emergency department visits for elderly patients in the United States, 1993 to 2003. *Ann Emerg Med* 2007; Dec 5 [Epub ahead of print]. Web: www.biomedcentral.com/1471-227X/7/1. ■

# Customize design, staffing for geriatric ED or wing

When you're planning a geriatric ED or looking to transform part of your department into a geriatric wing, there are several design and staffing considerations the ED manager must take into account, advises **Robert Fitzgerald**, MD, FACEP, an attending physician in the ED at Boswell Hospital in Sun City, AZ. Fitzgerald also lectures at Harvard University in Cambridge, MA, on the topic of designing the ED for the elderly patient.

"You've got to consider the kind of environment that would be more comfortable and more conducive

to better care, given the visual and hearing limitations of the elderly," he says. "The typical ED is noisy, chaotic, and brightly lit, which does not work well for most patients — especially the oldest of the old."

These issues can be addressed by having private rooms with individual controls over lighting, temperature, and acoustics, Fitzgerald says. "In a typical ED when you're lying on a gurney and you can hear everyone else's conversation, a lot of the elderly will not understand a word you're saying," he notes.

### *Issues with lighting*

Lighting can be a big issue in ways you might not typically think about, says Fitzgerald. "If you are a typical ED doc or nurse and are backlit, for a lot of elderly patients that really blanks out your face," he says. "In an ideal geriatric ED, you should have the ability to have indirect lighting and a rheostat to adjust it."

The elderly do not do well on the typical 2-inch gurney pad, Fitzgerald says. "After 45 minutes, they overcome capillary refill, so you are working on skin breakdown at minute 46," he explains. Fitzgerald says he uses 5½-inch mattresses "which have become more of a standard now because, frankly, the younger patients do not like the thinner mattresses, either." Beds, he adds, should be able to be lowered down to 14 inches so the older patients will not require step stools.

"I'm also a big believer in eye-to-eye contact," Fitzgerald says. "We have moving barstools with joysticks so you can look directly in the patient's eyes, rather than standing over someone and looking down on them." In addition, he shares, at South Shore Hospital in Weymouth, MA, "We designed part of the ED with nonskid linoleum, which made it easier to evaluate the gait of older patients."

In reality, says Fitzgerald, "Most of these changes are things you might want to do for your younger adult patients as well. After all, who wouldn't want private rooms with less harsh lighting?"

When it comes to staffing, he says, a geriatric ED requires that you develop a geriatric team to treat the patients. "This should include a doctor, a nurse, a social worker or case manager, and ideally a midlevel provider like a geriatric physician's assistant," Fitzgerald advises. "They will have the time to spend on things doctors or nurses may not — for example, screening patients for depression or to determine if they have an altered mental status rather than a stroke." These fine distinctions are universally missed in most EDs, Fitzgerald asserts, "and such patients often get admitted for a couple of days." ■

# Having a patient advocate dedicated to the ED

*Manager creates new position, then fills it herself*

Good ED managers are adept at identifying problems in their department and coming up with innovative solutions, but how many of those solutions involve a title and position change for the managers themselves? That's exactly what happened at St. Mary's Hospital in Tucson, AZ, where **Cassandra Pundt**, RN, CEN, who had been the ED nurse manager for 10 years, created and then filled the new position of ED patient representative.

Patient advocates, or representatives, are common at many hospitals, but few EDs are fortunate enough to have one exclusively devoted to *their* patients and families. Why did Pundt believe this was so important, and how did she sell it to management?

"With all of the challenges emergency services face — with increased volume of patients, more and more patients coming in to use the ED as primary care, and our population of 'boomers' booming — we've see increased utilization of services and, along with that, more challenges for throughput," Pundt says. "As a manager, you must deal with everything regarding patient and family complaints and quality of care issues, and you have your hands in so many pots, it's difficult to keep up with it all."

Inpatient services had nurse/advocates covering all nursing units, but Pundt thought the ED needed its own to enhance the timeliness of responding to patient and family complaints, quality issues, and customer service training.

## Executive Summary

The ED at St. Mary's Hospital in Tucson, AZ, has its own departmental patient advocate. This new staff position saves a lot of time for the rest of the team members. Here are some of the functions a patient advocate can perform in your ED:

- proactively prevent problems and satisfy delivery of care needs in a timelier manner to avoid complaints;
- train the ED staff in customer service and communication techniques;
- communicate with outside clinics to support uninsured or underinsured patients who don't have primary care physicians.

## Sources/Resource

For more information on creating a patient advocate for the ED, contact:

- **Diane Foster**, RN, BSN, Director of Emergency Services, St. Mary's Hospital, Tucson, AZ. Phone: (520) 872-6001.
- **Cassandra Pundt**, RN, CEN, ED Patient Advocate, St. Mary's Hospital, Tucson, AZ. Phone: (520) 349-9817.

**For more information on patient satisfaction surveys**, contact: NRC Picker, Lincoln, NE. Phone: (800) 388-4264. Web: nrcpicker.com.

**Diane Foster**, RN, BSN, director of emergency services, agrees. "I think the nature of what we are dealing with here is unique, particularly because of the vast variety of patient population we are dealing with in one environment," she says. "You really have to be physically in the department and a part of that whole team to understand what is needed." In addition, she says, the department's goal is to be proactive; to prevent problems and satisfy delivery of care needs the first time, rather than having to go back afterward and deal with complaints.

### *Selling the idea*

It was really not that difficult to convince administration to create the position, Pundt confesses. "I wrote the job description and presented it to my director in nursing leadership, and the position was approved in August of 2006," she recalls.

The fact that there were others to fill her position as nurse manager made the transition a bit easier. "In terms of replacing me as manager, I had two assistant managers — one who was on days and one on nights," she explains. "We took the nursing director I had [Foster] and dedicated her time to just emergency services, and the other departments took up that slack." The ED, she says, now has a director, a patient representative, and two co-managers.

Why did Pundt decide to fill the position herself? "I'm getting ready to retire in a couple of years and wanted to transition into something less stressful than management," she explains. "Also I thought that getting back into really close touch with the patients and families would be rewarding, which it has been."

Her job is multifaceted. For example, in addition to interacting with patients and their families, she trains the staff in customer service and communication techniques, such as how to professionally communicate with patients and family members, and how to deal with difficult individuals. "I also work with some of our outside clinics that support our uninsured or underinsured patients who do not have a primary care physician," Pundt adds. "I refer patients like that on a daily basis."

Of course, she also spends a lot of time addressing patient and family concerns. Documentation and investigation, she adds, takes a lot of time. "Sometimes an issue will take the form of a grievance, which requires a committee to meet and review the complaint; sometimes it may go to quality or maybe back to the director for associate counseling or physician counseling," she says.

While Pundt works during the daytime, she is virtually on call 24/7. "She has a cell phone and is always available, and sometimes a lot can be done by phone," says Foster. **(Communication is a key to Pundt's success. See the story, below.)**

### *Pleased with results*

Pundt and Foster are pleased with how the new position has worked out.

Foster says, "I think it's been extremely successful. We've seen improvement in patient satisfaction scores."

While the department, which is surveyed by Lincoln, NE-based National Resource Corp. (NRC) Picker, is "not yet in the top 10%," Foster says that in the category of overall patient experience, "we are performing better than the comparison group we benchmark against." **(For contact information for NRC Picker, see resource box, above left.)** Pundt says, "We've also seen improvement in several dimensions of care, like physical comfort, respect for patient preferences, and access and coordination of care."

Picker also keeps Pundt informed on a regular basis. "I receive alerts from them if comments come back on the survey, and then I follow up with those patients," she says. "I may then discover a quality-of-care issue, in which case I refer it to the quality manager or risk manager for review, and I always keep my director informed." ■

# Communication is critical for patient advocate in ED

A proactive communications effort, before and after the creating of the new ED patient representative position at St. Mary's Hospital in Tucson, AZ, has helped smooth the transition for ED staff, patients, and

families, says **Cassandra Pundt**, RN, CEN. Pundt had been the ED nurse manager for 10 years when she created and filled the new position.

"I met with the staff at staff meetings and also with the physicians, did a presentation on new my role and how to access me," Pundt recalls. "I also gave out business cards, which included my cell phone number."

In addition, since she also trained the staff in how to deal with difficult individuals, "I made it clear that if they have an issue with a patient or a family complaint, they are supposed to first try to resolve it themselves," she says. "If they feel they were not successful, they can then either go to the charge nurse or access me if I am on campus."

As for patients and their families, they are all given an emergency center fact sheet when they enter the department, which is in English and Spanish. "It tells them that if they have a complaint or a problem, to contact me, and it includes my telephone number," says Pundt. ■

# Award-winning ED treats its patients like family

*Staff provide nonmedical services to its 'customers'*

The ED at Martha's Vineyard Hospital in Oak Bluffs, MA, has consistently achieved extraordinarily high customer satisfaction ratings while operating in a unique environment. For example, being a resort destination, its patient population swings from an off-season low of about 15,000 to an in-season high of more than 100,000, which has a significant effect on it ability to maintain high levels of patient satisfaction due to issues such as staffing and space. More than 30% of its annual 14,000 ED visits occur during July and August.

On the other hand, say its leaders, the "family" atmosphere of its small-town locale easily translates into the ED, where the staff often know the patients personally.

"One of the things that strikes me most about this department is that people here try very hard to treat the patient the way they would like to be treated; maybe that is part and parcel of being a very small community," says **Timothy Tsai**, MD, director of the ED. "A lot of people who work in the hospital have grown up here and have a strong sense of connection with friends and neighbors."

Tsai notes that in previous jobs, "I could go a year without seeing a patient on the street. Here, I see friends, neighbors, and kids in the department, and there are automatic predisposing factors to wanting to provide good care."

Martha's Vineyard is one of 12 departments to receive the prestigious Summit Award in 2007 from the patient satisfaction firm Press Ganey Associates. Award winners must score in the 95th percentile or higher for three consecutive years.

## Executive Summary

Patients appreciate ED staff who make extra efforts to ensure their needs are met. One way to ensure this level of service is to treat all patients as if they were friends or family. Here are some strategies you can use:

- Encourage staff, when possible, to call a cab for discharged patients to make sure they have transportation home.
- If you hire temporary staff on a seasonal basis, make an effort to hire the same staff each time, to ensure familiarity with the patient population.
- Communicate results of patient satisfaction surveys — the good *and* the bad — with your staff on a regular basis.

### Going the extra mile

As a small, critical access hospital, Martha's Vineyard must often transfer trauma patients to Boston on the mainland, notes president and CEO **Tim Walsh**. Here is where the staff often will go the extra mile for patients, he says.

"We try to eliminate the worries that patients and families might normally have about these transfers," he explains. "For example, we might call the ferry and have it held to wait for them, which only can be done by a hospital." The staff, he adds, often will set up the ferry rides and arrange the tickets for the family so they can immediately leave the hospital and drive to meet it. They are given preprinted directions to the ferry and to the appropriate hospital in Boston.

"If it's needed, the staff will print out directions from MapQuest," adds Tsai. "We also call cabs to take people home after they are discharged."

### Tourists get same treatment

It might not seem that surprising to see friends and neighbors get such special treatment, but the same caring and courtesy are also extended to the tourists who make up most of the island population a few months

## Sources

For more information on dealing improving patient satisfaction, contact:

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- **Tim Walsh**, CEO, Martha's Vineyard Hospital, Oak Bluffs, MA. Phone: (508) 693-0410, ext. 487.

out of each year. This change in patient population took much more planning, not only in arranging for additional staff, but in selecting the right staff and in keeping that staff together year after year.

"This is quite a busy, metropolitan place for three months in the summer," notes Walsh, who says the hospital has to rent 30-35 houses for the extra ED staff. "Tim has done a great job of lining up the same contingent of physicians."

"During the [summer] season, we add 12 hours a day of physician coverage and more than double the nursing staff from eight to eighteen," says Tsai. "We also open up a fast-track area."

He says the department benefits from the fact that people like to come to the area in the summer. "We try to bring the same staff back because it creates a strong esprit de corps, and it contributes to quality of care," he says. Having a "revolving door of strangers" does not lend itself to consistency, Tsai says. "People who come back summer after summer have a commitment to the patients and to the department," he says.

In terms of selecting summer staff, Tsai is cognizant of the type of staff he already has. "The people we invite back are quality people," he says. "There are also intangibles like chemistry and a sense of teamwork."

### *Reinforcing the message*

Despite the built-in tendency to treat patients and families like family, Tsai says he takes care to reinforce the need to stress patient satisfaction in his department. "I believe in positive reinforcement," he emphasizes.

All Press Ganey surveys at the facility are reviewed carefully by senior management and passed on to department managers. "We get a lot of good feedback, but all of the survey results are posted on a regular basis, every six months," says Tsai. "I go over the results and highlight the areas we need to pay attention to."

Negative feedback, he continues, is given equal play. "I circle it on the form and post it along with the positive stuff. We will discuss the results at meetings with the nursing staff, but our staff is small enough and we know each other well enough that it's possible for nurses and physicians to talk about the results and think about ways to improve together." ■

# Are curtained dividers a setup for a lawsuit?

Caring for patients with little privacy other than thin curtains in a crowded emergency department seems to fly in the face of the requirements of the Health Insurance Portability and Accountability Act (HIPAA). But what are the actual liability risks of this practice?

A patient cannot bring a lawsuit directly under HIPAA, because the federal statute does not provide for a private right of action. "Because of this, even if the person believes that the provider has violated HIPAA, the person would still need to bring the claim under state law," says **Helen Oscislawski**, JD, a health care attorney at the Lawrenceville, NJ, office of Fox Rothschild, who has substantial experience with HIPAA compliance.

### *Complaints go to HHS*

Under HIPAA, patients are able to submit their complaints alleging that a violation has occurred to the U. S. Department of Health and Human Services (HHS) Office of Civil Rights. Otherwise, the patient would need to look to state law to see if there is an actionable complaint, since standards vary by state as to what is "actionable" and what is not. "I have yet to hear of a case where overheard comments through dividers amounted to a breach of duty, but that is not to say that such a case has never been filed or may never be filed," Oscislawski says.

In fact, there have been a recent smattering of cases with plaintiffs bringing lawsuits based on state law claims for negligence, and they have successfully argued that the failure to adhere to a HIPAA standard is evidence that the provider breached its duty to keep a patient's information confidential, she says. "This makes proving negligence a lot easier," Oscislawski says.

**Jeffrey Freeman**, MD, clinical assistant professor of the Department of Emergency Medicine at University of Michigan Health System in Ann Arbor, says, "Although curtains may present a visual barrier, and we all know that this is no more guaranteed than the typical hospital

gown, they provide minimal barrier to sound."

In fact, the perception that there is a barrier may increase the likelihood of conversations or private information being overheard, adds Freeman. Patients may be reluctant to provide medical information or undergo physical examinations, and physicians may be reluctant to be complete due to privacy concerns, he adds. In addition, privacy curtains often are used in areas that otherwise would not be considered rooms, including hallways and alcoves.

There have been a few, limited studies on the effects of privacy barriers in the emergency department, notes Freeman.[1-3] "These studies confirm that patients feel their conversations are overheard when privacy curtains are the barriers between patients," Freeman says. A small percentage of patients withhold medical information or refuse part of the physical examination because of privacy concerns, according to the research.

"Although patients often perceive that their privacy is being respected with curtains, we know in fact that occasional oversights occur and personal information and privacy is not ensured," says Freeman. "This is more likely to occur in larger or crowded institutions, where chaos and larger numbers of staff, trainees, and visitors increase the chance of privacy blunders." For example, in large, busy EDs, it is not unusual for patients to be boarded next to nursing and physician stations behind curtains. "Although this may improve supervision of patients, it also virtually ensures that conversations can be overheard," says Freeman.

Although Freeman says he is not aware of specific legal suits that have arisen directly from these issues, he points to the potential for state civil penalties for breaches of privacy, administrative sanctions from licensing boards, and federal penalties for violation of HIPAA. "These could include monetary and criminal penalties," says Freeman. "Poor patient satisfaction with privacy and confidentiality also may increase the likelihood of action if medical negligence also is perceived."

## Take 'reasonable' steps

Under HIPAA, "incidental disclosures," such as those that occur when two patients are in adjacent rooms or cubicles, do not automatically amount to a privacy violation. "However, if reasonable steps could have been taken to minimize the chances of the incidental disclosure from occurring, then the ED group or hospital may be at a greater risk that they could be subjected to lawsuit if the wrong set of facts were to unfold," Oscislawski says.

An example of "bad facts" would be an ED patient told of a new positive test for a sexually transmitted disease (STD) while another patient, or person visiting another patient, happens to overhear the information and also happens to know the patient's spouse well. "If that information is then communicated back to the spouse by the person who 'incidentally' overheard the STD diagnosis, you can imagine how that situation can go from bad to much worse for the patient as a result of his or her privacy not being adequately protected," says Oscislawski. "These kinds of facts set the ED up for potential lawsuits."

For a typical ED, what would be considered "reasonable steps" to prevent patients from overhearing protected health information (PHI)? "Almost anything that the provider can implement as an attempt to minimize incidental disclosures is fair game," says Oscislawski. "Room dividers are tough. Absent major construction, there is not a lot you can really do to diminish this without significantly interrupting the ED workflow."

The guidance from the Department of Health and Human Services on HIPAA is that physical safeguards to protect PHI must be "reasonable" and "appropriate," she notes. "The guidance also specifically says that the HIPAA privacy rule does not require private rooms nor soundproofing of rooms," she says.

Curtained room dividers in an ED would be considered "reasonable and appropriate," Oscislawski says. In addition, if the department is not too busy, the triage nurse may consider putting patients at the farthest point in the ED away from each other, until that becomes impossible due to capacity being filled up. "However, the reality is, as we know, EDs are generally maxed out, overcrowded, and do not have this luxury," Oscislawski says. "Thus, the only other answer would be to put up more solid barriers. Yet, this is not mandatory if it is not cost-effective for the hospital."

Consider using thicker curtains, Plexiglas or similar auditory barriers, or sliding glass doors that improve auditory barriers while allowing visual oversight, suggests Freeman. "Specific rooms may be designated for private conversations or examination, moving patients in and out temporarily as needed," he adds.

## HIV status is higher risk

As for what EDs could possibly be sued for, any situation is a potential risk because people have individual thresholds for what they are willing to consider a privacy breach, Oscislawski says. "That said, I would think that cases where there is sensitive information being discussed, like an STD, drug test results, HIV status, and communicable diseases, tend to have a higher risk because of the potential implication to that patient if such highly sensitive information were to be overheard by the wrong person," she adds.

## Sources

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**Sheila M. Sokolowski**, JD, a health care attorney with Fulbright & Jaworski in Austin, TX, says, "Generally, an individual would have to sustain some sort of harm in order to sue, but it is not clear what harm might be sustained from simply another overhearing private information."

On the other hand, in Texas and several other states, HIV test results have greater protection than other types of health information, she notes. "So if HIV status is what is at issue in Texas, there is no need to show harm to recover an award from a person who unlawfully disclosed that information, though if harm is shown, actual damages could also be awarded," Sokolowski says. "As for disclosures of other types of health care information, the individual might be able to maintain an action for defamation, but truth is a complete defense to defamation."

If ED nurses or physicians speak too loudly when there is a lack of privacy, this generally would be considered an incidental disclosure, Oscislawski says. "However, as noted above, under HIPAA ED physicians and other staff must take reasonable precautions to minimize such incidental disclosures," Oscislawski says "Therefore, staff should be reminded not to yell and to be careful in particular when highly sensitive information is involved."

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3. Moskop JC, Marco CA, Larkin GL, et al. From Hippocrates to HIPAA: Privacy and confidentiality in emergency medicine — Part II: Challenges in the emergency department. *Ann Emerg Med* 2005; 45:60-67. ■


# Interview questions are dangerous territory

Whether you are interviewing emergency medicine physicians, midlevel providers, or technicians in your ED, certain questions or remarks can get you into legal trouble. What should you avoid saying during the hiring process?

Any comments about a person's race, national origin, religion, age, family, military or marital status, or disability are off-limits, says **John W. Robinson IV**, JD, a shareholder in the employee litigation department in the Tampa, FL, office of Fowler White.

Avoid any attempts at humor involving these topics, which are "protected categories" under the law, he advises. "In fact, the joke will be on the interviewer," Robinson says.

One interviewer commented negatively about how "everyone from Miami is Cuban. Little did the interviewer know that this highly qualified female interviewee, with an Anglo married name, was the daughter of a prominent businessman from Cuba and turned down the job offer," he says. "So, you never know."

### You can ask these questions

You can, and probably should, ask questions about past job performance, licenses, skills, experience, abilities, education, and dependability, says Robinson. Questions may include: Why did the applicant leave his or her last job? Does the applicant have dependable transportation? Can the applicant work all shifts, overtime, and on-call?

"These are all job fitness issues, not family or disability issues," says Robinson. "Rarely do you need to know why someone is unfit for the job. You just need to know whether the applicant is minimally fit for the job and, ideally, whether he or she is the best fit for the job."

By the same token, you do not need to take an applicant's word that the applicant can perform under pressure and reliably. "You usually have a probation period

and reference checks to help figure out those issues," says Robinson.

There are far fewer claims of illegal failures to hire vs. illegal discharges, adds Robinson. "One reason is the unsuccessful applicant rarely knows who got the job," he says. "If the applicant does know who got the job, and that may happen in the emergency department community in a town, be prepared to document that you hired the objectively best-qualified candidate."

Gratuitous questions or statements about gender, race, religion, age, disabilities, or national origin can backfire with an unsuccessful applicant, says Robinson. "Nobody blames herself when she does not get a job. She is looking for other reasons," says Robinson. "If the interviewer plants the seed of suspicion that the 'real' reason was a discriminatory reason, look out."

## Don't ask 'creative' questions

Interviewees generally do not intend to focus on protected characteristics. **Katrina Campbell**, JD, general counsel at Brightline Compliance, a Washington, DC, firm specializing in workplace issues, says, "Often, they resort to seemingly harmless jokes and small talk to fill in dead space during the interview or to try to establish rapport with the candidate."

However, inappropriate comments can lead to Equal Employment Opportunity Commission (EEOC) charges and litigation by rejected candidates, she warns.

When trying to create a rapport, be careful to avoid "creative" questions or remarks that could lead you down an inappropriate path, advises Campbell. For example, interviewers should not joke or comment about their own age or the age of the population by saying, "There are a lot of gray hairs around here," or, "It's like a college campus here."

Candidates may take these statements as signs that they will not fit in, or if they are not hired later, may conclude it had something to do with their age, says Campbell.

In addition, questions that seem to relate to protected categories can be risky. For example, questions about whether a person has children and how old they are may indicate to a candidate that the interviewer questions the candidate's ability to work certain hours. Instead, ask direct questions about the candidate's ability to work the specified schedule, to travel, if necessary; to working overtime; and other job requirements. For example, an interviewer can say: "Working in the emergency department requires that you work different shifts, including overnight shifts. Can you meet this job requirement?"

### Sources

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Family status can be a protected category in certain states and localities, and it is a protected category under the new EEOC guidelines on discrimination against caregivers, adds Campbell. Lawsuits generally claim illegal discrimination under Title VII of the Civil Rights Act of 1964 and similar state laws, and they also may be brought under the Pregnancy Discrimination Act, Americans with Disabilities Act of 1990, and the Age Discrimination in Employment Act of 1967.

To avoid problems, give everyone involved in the interviewing process training on appropriate interviewing and hiring behaviors, recommends Campbell. Options include online training, with interactive scenarios about interviews and hiring decisions, or in-person training using slides and written scenarios in a training room or off-site conference room. "When you run a 24-hour operation, scheduling for in-person training can be difficult," acknowledges Campbell. "However, this option is low-tech and can be good for small groups." ■

# ACEP, AIUM publish ultrasound guideline

The American Institute of Ultrasound in Medicine (AIUM) in Laurel, MD, and the American College of Emergency Physicians (ACEP) in Irving, TX, have jointly published the *Guideline for the Performance of the FAST* (*Focused Assessment with Sonography for Trauma*) *Examination.*

According to the organizations, The FAST examination is a proven and useful procedure for the evaluation of the injured patient immediately during resuscitation to detect large abnormal fluid collections or other collections that need immediate treatment. Before its use, more invasive procedures, including surgery, were required to evaluate trauma patients. Use of the FAST examination to evaluate trauma patients is growing in hospital emergency departments, pre-hospital situations, military locations, and disaster areas.

AIUM and ACEP joined forces to create a guideline that will provide assistance to emergency medical practitioners and promote high-quality ultrasound examinations. FAST includes indications for performing the examination, qualifications and responsibilities of the performing physician, specifications for individual examinations, documentation requirements, equipment specifications, quality control, and safety standards.

The FAST examination is widely accepted as the standard of care for the initial assessment and treatment in trauma centers. It is now taught to more than 95% of emergency medicine residents and included in *Advanced Trauma Life Support*, a training program for doctors in the management of acute trauma cases.

"The FAST guideline reinforces ACEP's ultrasound imaging criteria," said **Vivek Tayal**, MD, FACEP, chair of the ACEP Section of Emergency Ultrasound and member of the AIUM, in a prepared statement. "In addition, the FAST examination, an emergency department-focused, bedside ultrasound examination, gains further national and international prominence by its formal acceptance by AIUM, a national, multispecialty organization."

Copies of *Guideline for the Performance of the FAST Examination* are available by going to www.aium.org. On the left side of the page, click "Practice Guidelines." On the next page, click the pull-down menu, and then click on "FAST." ■

## 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. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

## 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*

25. According to Mary Pat McKay, MD, MPH, one ED she worked at negotiated an arrangement with the facility that said if an elderly patient was in the ED for more than four hours:

A. They would be found a bed no matter what it took.
B. Transfer to another facility could be sought.
C. The facility fee for the DRG would be credited to the ED.
D. They would be boarded in an upstairs hallway.

26. According to Robert Fitzgerald, MD, FACEP, the following accommodations for patients should be made in a geriatric ED:

A. All patients should have private rooms.
B. There should be individual controls for lighting.
C. Gurney mattresses should be more than 5 inches thick.
D. All of the above

## *COMING IN FUTURE MONTHS*

- ED saves man who falls from a 47-story building
- Pediatric ED cuts time to triage evaluation in half
- CMS issues several new updates to EMTALA guidelines
- Delayed transfer to the ICU increases LOS and mortality

27. According to Cassandra Pundt, RN, CEN, which of the following is *not* among her job responsibilities?
A. Reprimanding ED staff members who have spoken with patients or family members in an unprofessional manner.
B. Customer service training.
C. Handling family complaints.
D. Researching potential quality issues.

28. According to The Joint Commission, noncompliance rates for both National Patient Safety Goals 8a and 8b (medication reconciliation) are:
A. Between 1% and 10%.
B. Between 11% and 20%.
C. Between 21% and 30%.
D. Between 31% and 40%.

29. According to Jerod M. Loeb, PhD, executive vice president for quality measurement and research at The Joint Commission, which of the following new outpatient measures does *not* apply to the ED?
A. Aspirin on arrival.
B. Appropriate selection of prophylactic antibiotic.
C. Median time to EKG.
D. Median time to transfer to another facility for acute coronary intervention.

30. The ED staff at Martha's Vineyard Hospital often go out of their way to help patients and families, which has won them an award for patient satisfaction. These service extras include:
A. Using MapQuest to help them find directions to transfer hospitals.
B. Calling a cab for patients who have been discharged.
C. Having the ferry delayed to accommodate family members.
D. All of the above





## CNE/CME answers

**25. C; 26. D; 27. A; 28. B; 29. B; 30. D.**

ED ACCREDITATION UPDATE

*Covering Compliance with Joint Commission Standards*

# Joint Commission adds outpatient measures, 5 will have a direct impact on ED managers

The Joint Commission has added an initial set of seven hospital outpatient measures to its current complement of core measure sets that may be used to satisfy ORYX performance measurement requirements. ORYX is the Joint Commission initiative that integrates outcomes and other performance measurement data into the accreditation process.

The hospital outpatient measures are in the calendar year 2008 final rule for the outpatient prospective payment system (OPPS) from the Centers for Medicare & Medicaid Services (CMS). The OPPS rule requires that data collection for these measures begin in April 2008.

"We initially developed a set of 10 measures, seven of which CMS decided were 'ready for prime time,'" explains **Jerod M. Loeb**, PhD, executive vice president for quality measurement and research at The Joint Commission. Of the seven measures, he says, these five will directly affect the ED:

- median time to fibrinolysis;
- fibrinolytic therapy received within 30 minutes of hospital arrival;
- median time to transfer to another facility for acute coronary intervention;
- aspirin on arrival;
- median time to EKG.

"These measures really focus in on systems and processes [that must be] in place to rapidly triage and treat patients with chest pain," Loeb continues. "The ED manager has to have evidence-based practices in place that ensure with a fair degree of accuracy that the diagnosis will be made in timely manner and that appropriate processes are in place to provide therapy quickly."

**Millie Perich**, Joint Commission associate project director over OPPS measures, AMI, and heart failure, says, "The goal is to get that patient seen immediately, have a process in place that ensures they get the EKG and aspirin quickly, and if they require acute coronary intervention like a bypass and you can't provide that care, that the patient is carried out in a timely manner, because 'minutes are muscle.'"

All of these require careful preplanning, adds Loeb. "It can also involve interplay between the ED and the EMTs, because they may do the EKG en route," he says. "The system, processes, and staffing

## Executive Summary

The new outpatient performance measures added by The Joint Commission carry implications for reimbursement, accreditations, and new business (as they will be publicly reported), and they also provide ED managers with new opportunities to justify additional resources. To optimize your responses:

- Actively monitor your department data to identify opportunities to improve processes.
- A standardized approach (i.e., protocols, order sets) will go long way toward ensuring optimal performance.
- You may be able to justify additional equipment by demonstrating that it is needed to meet Joint Commission requirements for timely service.

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must be in place."

These measures are really intended to help organizations measure current performance so they can identify opportunities for improvement, notes **Linda Hanold**, The Joint Commission's director of the Department of Quality Measurement. "If you track your rates over time, you can look for those opportunities," Hanold says.

## Money is the new element

The current move by The Joint Commission is "not revolutionary," notes **Dennis Beck**, MD, FACEP, CEO of Denver-based Beacon Medical Services, an emergency medicine practice management company, and chair of the American College of Emergency Physicians' (ACEP) quality and performance committee.

"The fact is that actually the aspirin and empiric antibiotic were there before [as core measures] and other programs measured time to fibrinolysis and time to EKG, so the fact that CMS has now implemented this does not come as a big surprise," he says. "But now, there's a financial stake tied to it through the pay for performance movement."

He explains that CMS will be requiring hospitals to report on performance levels for these measures, or face a 2% 'market basket' reduction in reimbursement. "Margins are slim enough that they obviously have to participate and report," he adds.

ED physicians should be well prepared for this change, he says. Some of the measures, such as aspirin on arrival, already were part of the Physician Quality Reporting Initiative (PQRI), a voluntary program instituted by CMS in July 2007, he says. "Antibiotic selection is also tied into PQRI, so those two are already being reported on," he says. "There are now 199 different PQRI measures, of which a limited number are appropriate for ED physicians, but ED docs are eligible for a 1.5% bonus based on all their Medicare allowables."

In addition, notes Beck, "ACEP has challenged us to educate the members as to what the measures are and how to document them."

## 'System' measures

Some of the newer measures, such as median time to EKG and transfer for acute coronary intervention, as well as the two that apply to fibrinolysis, are system measures, Beck says.

"Some others can be attributed directly to doctors, but these are dependent upon the interaction of the ED doc, ED staffing as well as hospital staffing, and protocols and processes you put in place to meet these benchmarks," he says.

While nurse managers will be expected to be accountable for reporting on these measures and department performance, they, like the physicians, will not be operating in a vacuum. "This will require cooperation between nurses and doctors, and in some cases collaboration with the rest of the hospital — or even other hospitals," notes Beck. "For example, with the time to transfer, you would typically have transfer agreements already in place." This might involve having a single number to call or a single facility for whom you are part of their referral system, he says.

ED managers should actively monitor their own data, Beck says. "For example, with aspirin on admission, which is typically done by protocol, review the data abstraction and reporting, and if it's not what it should be, you've got to identify where the 'lesion' is," he advises. "For example, protocols may be in place but they are not getting implemented, or perhaps you do not have the proper protocols in place."

Much of your success will be dictated by whether you have a standardized approach, says Beck. "For example, when a patient comes in with chest pain, everyone should know that an EKG ought to get done within 10 minutes," he observes. "Or if it is a STEMI [ST-segment elevation myocardial infarction] MI, and your facility does fibrinolysis, it should be started within 30 minutes."

## Create leverage

Oftentimes, says Loeb, Joint Commission and CMS requirements such as those can create valuable leverage, enabling the ED manager to get the additional resources the department needs.

"We are looking at reimbursement, accreditation, and ultimately public reporting of these data," he notes. "So, for example, you could justify the need for

### Sources

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another EKG in the ED because one machine for seven rooms is not enough to ensure the timeliness required by The Joint Commission."

Or, he adds, you might obtain approval for additional discussions with tertiary facilities in your catchment area because you don't have a catheterization lab and there are not a sufficient number of transfer facilities lined up in advance. "These requirements provide the ED manager with leverage — and its leverage to do the right thing," Loeb says.

These seven measures are just the initial set, Loeb says. More will be added in the years ahead. "It was the expectation of Congress that the original measures would be increased in 2009, so CMS needs to figure out how they wish to do that," he explains. "There are more coming, but we don't yet know how many more, which measures, and which clinical areas will be involved." ■

# Meds reconciliation summit promises more clarification

Since the implementation of National Patient Safety Goals (NPSGs) dealing with medication reconciliation in 2005, The Joint Commission has received a steady stream of feedback from the medical community. Emergency medicine experts and organizations, in particular, have complained that the goals were unclear and made compliance difficult. In response to this feedback, The Joint Commission convened a one-day summit on Sept. 27, 2007, to address the issue. According to The Joint Commission, compliance rates reveal that compliance with two goals has proven to be difficult for many health care organizations:

- comparing the patient's current medications to those ordered while under the care of the health care organization (Goal 8a);
- communicating the patient's medications to the next provider of service and giving the medications list to the patient at discharge (Goal 8b).

## Executive Summary

The Joint Commission has responded to feedback concerning medication reconciliation with a summit designed to hear complaints from medical organizations and to come up with a list of possible modifications to its guidelines. Here are some areas where relief may be on the way:

- While survey consistency has improved, and The Joint Commission has specifically stressed medication reconciliation at its most recent surveyor training session.
- The Joint Commission is considering amending its requirement for medication reconciliation to be done for all patients under all conditions.
- The Joint Commission also will address potential changes in the information that must be included in the medication reconciliation list.

## *Compliance is 'complicated'*

Noncompliance rates for these requirements — 18.9% for Goal 8a and 14.2% for Goal 8b for 2006 — remain much higher than desired.

"Fairly soon after implementation, it became evident this was going to be difficult for institutions; it entails a variety of organizational system and process changes," notes **Peter B. Angood**, MD, The Joint Commission's vice president and chief patient safety officer. "Our regular field monitoring feedback showed pretty quickly how complicated [compliance] was, so we went ahead with convening the summit to bring together by invitation a wide variety of professional organizations and experts with a particular interest and focus on this issue to solicit further feedback, input, and suggestions."

According to The Joint Commission, the consensus of the summit was that while medication reconciliation improves patient safety, more guidance on implementation is required. Additionally, NPSG 8a needs clarification, particularly in regard to the information that should be included on a medication list, the appropriate times and settings for taking medication information (as well as information about allergies, etc.), and how to handle temporary changes to a medication list.

## *Skepticism remains*

Not all of the organizations accepted these conclusions at face value. For example, **Denise King,** RN, MSN, CEN, newly elected president of the Emergency Nurses Association, was not ready to accept even the initial premise of safety.

"We need to look at that," says King, who is a senior consultant with Blue Jay Consulting of Orlando, FL, where she fulfills interim ED leadership assignments. "There are individuals out there who are convinced [medication reconciliation] does *not* improve safety and could actually lead to unsafe situations in some cases." For example, she suggests, a

## Sources

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- **Denise King**, RN, MSN, CEN, President, The Emergency Nurses Association. Phone: (360) 330-8935.

patient who comes into the hospital environment does not always know what they are taking, in what dosages, or why they are taking it.

"We may have an incomplete or inaccurate list, but this is nevertheless sent out by the hospital later as accurate," she says. "We do not want to work under the assumption it will improve safety." In fact, King says, The Joint Commission could consider not even having a medication reconciliation requirement.

Having been in ED nursing for 20 years, King says that every hospital ED already did medication reconciliation to some degree anyway. "We always asked patients what they were taking when they came in, so this is not a completely new concept," she says. "What we're struggling with is the depth and degree of what The Joint Commission wants."

Angood recognizes the complexity of obtaining an admission list of patients' meds as "one of the recurring themes" of the summit. "Related to that is the question of whether or not obtaining a full and complete list is necessary for *all* encounters, regardless of acuity of setting or the appropriateness of the patient, and whether it should be required for everyone," he says.

### Consistency sought

King would like to see more consistency in accreditation. "There's been a lot of inconsistency in how the goal is surveyed," she asserts. "I have seen some surveyors who will hold you to the letter of the standard, while others will not do it so strictly."

In the current environment, she continues, when one facility gets surveyed, that information spreads to other facilities. "That becomes the new 'word on the street," she says. "So, when another survey is handled differently, that leads to inconsistencies."

Angood agrees, to a point. "Inconsistency between surveys has been a recognized issue for us," he concedes. "We do our best to make sure there is fairly good consistency, but it will never be perfect."

Nevertheless, he insists, the degree of consistency has improved a lot in the last few years. In fact, at press time, he was planning to participate in a meeting with surveyors. "We will be discussing all of the National Patient Safety Goals tomorrow morning, but you can be sure medication reconciliation will get a lot of attention," Angood shares. **(How and when will The Joint Commission formally respond to the summit feedback? See story, below. For more on this topic, see "The Joint Commission says the goal for medication reconciliation is unchanged, *ED Accreditation Update,* August 2007 p. 1.)** ■

# Joint Commission follow-up is under way

After receiving input from several medical organizations and other interested parties during a Sept. 25, 2007, summit on medication reconciliation, The Joint Commission is digesting that feedback and crafting a response.

"What we do following these summits is create a summary document to make sure we have captured the essence [of the feedback] and distribute it to the attendees to make sure we have their input described accurately," explains **Peter Angood**, MD, vice president and chief patient safety officer at The Joint Commission. At press time, that process was scheduled to be completed by the end of January, according to Angood.

"Then, with all the feedback and suggestions we will make our own suggested changes to refine and clarify the document," he says.

This phase, Angood explains, is part of The Joint Commission's annual field review of potential National Patient Safety Goals, which is conducted via Internet-based surveys. "Following input from the field review, we will review the responses, further refine them, and then show them to our Sentinel Event Advisory Group," says Angood. "Then, we will come out with our new goals." Those goals usually are published by early summer.

If ED managers are interested in staying on top of these developments, "I would encourage them in February to go to The Joint Commission web site, www.jointcommission.org, and participate in the National Patient Safety Goal field review, which will still be open," says Angood. He says that information on participation usually is provided in a banner at the top of the home page. ■