



Management

The monthly update on Emergency Department Management



CMS wants to double list of conditions for which it will not pay a higher rate

Focus is on hospital-acquired conditions not present on admission

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In a move that has generated great concern in the ED community, the Centers for Medicare & Medicaid Services (CMS) is proposing to more than double the list of hospital-acquired conditions (HACs) for which it will no longer pay hospitals at a higher rate for the resulting increased costs of care. Those conditions are:

- surgical-site infections after total knee replacement, laparoscopic gastric bypass and gastroenterostomy, or ligation and stripping of varicose veins;
 - Legionnaires' disease;
 - diabetic ketoacidosis, nonketotic hyperosmolar coma, diabetic coma, or hypoglycemic coma;
 - iatrogenic pneumothorax;
 - delirium;
 - ventilator-associated pneumonia;
 - deep-vein thrombosis or pulmonary embolism;
 - *Staphylococcus aureus* septicemia;
 - disease associated with *Clostridium difficile* (*C-difficile*).
- These would be added to the eight HACs currently in force:
- object left in the patient following surgery;
 - air embolism;

Executive Summary

The Centers for Medicare & Medicaid Services is proposing to no longer pay at the higher reimbursement rate for several hospital-acquired conditions that were not documented as present on admission. This change requires even greater vigilance on the part of ED staffs.

- Special care should be taken with the elderly, particularly those transferred from nursing homes, to detect conditions such as incipient pressure sores.
- To avoid a penalty, carefully document conditions that are present on admission.
- Placing catheters will require greater scrutiny, and additional steps may avoid infections.

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- blood incompatibility;
- catheter-associated urinary tract infections (UTI);
- pressure ulcers;
- vascular catheter-associated infections;
- surgical-site infections;
- falls in trauma.

The new rule would become effective Oct. 1, 2008. The final rule will be issued at the beginning of August.

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Editorial Questions

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Emergency medicine experts argue that many of these conditions are not totally preventable (i.e., UTIs) and therefore would unfairly penalize the hospital for what might credibly be called appropriate care. They also foresee an onerous documentation burden and fear that some hospitals might pressure EDs to not admit older patients with multiple comorbidities, lest one or more of those conditions might develop further after admission.

What's more, the proposed rule is part of a bigger picture that surrounds a move toward "nonpay for non-performance." In addition to CMS, the National Quality Forum has compiled its own list of what it calls "never events," or events that should be preventable. Several hospitals have indicated that they will no longer charge patients when some or all of these events occur, and leading insurance companies are following suit. Some states, such as Massachusetts, are even proposing to link accreditation to how well hospitals avoid these events.

"Right now, CMS is purporting to be more of a value-based purchaser, so instead of paying based on volume they say they will pay for quality," says **Dennis Beck**, MD, FACEP, president and CEO, Beacon Medical Services, an Aurora, CO-based practice management firm that provides coding and billing services for emergency physician groups. "My question is, are we really rewarding quality, or figuring out ways to reduce payment?"

The momentum, however, may be irreversible. "WellPoint, Anthem [Health], they're all jumping into this, and hospitals are saying there are certain never events they ought not to charge for," says Beck, who also chairs the quality and performance committee of the American College of Emergency Physicians.

However, it's important to keep things in perspective, says **Charlotte S. Yeh**, MD, FACEP, CMS regional administrator in Boston. "Remember the big picture: If you look at Medicare, we spend over \$1 billion a day on health care; and in 10 years, one out of every five dollars [in the budget] will be spent on health care. With that, people are asking that we get what we pay for."

Yeh cites studies indicating that Medicare patients only get 65% of the recommended care. CMS is part of a much larger national movement to spend health care dollars wisely and get good quality of care, she says. "Every ED manager and doctor I know deeply care about providing quality care," Yeh says.

What's missing, she contends, are incentives to have systems in place to really facilitate that type of care. "This is a pretty major step Medicare has taken, but we know through research that some of these complications are preventable," says Yeh.

She emphasizes that CMS is only talking about not paying for these complications; the basic care still will be reimbursed. As for preventing these "preventable"

events, Yeh says, “I don’t think any one of us would say that is not our goal.” (For more on how CMS views these requirements, see the story, below right.)

Is CMS reasonable?

For Beck, the issue is not whether quality is important, but whether what CMS is requiring makes medical sense.

“My question is: Is this something that is reasonably preventable?” he asks. “Take pulmonary embolism, for example. What actions by a doctor would be likely to prevent this?”

Jedd Roe, MD, MBA, FACEP, chairman of emergency medicine at William Beaumont Hospital in Royal Oak, MI, says, “UTIs and Foley catheters concern me a lot. We will probably be scrutinized more than we have in the past for when we place the catheter, and a lot of times we can’t do it right away.” One of the key considerations, he points out, is whether the purpose of the catheter is therapeutic or diagnostic.

There are going to be challenges that occur at the direct care level in the ED, Yeh concedes, “but the challenge to the ED is to do what it can to mitigate those challenges.” All providers need to be working toward the goal that no patient has UTIs or pressure sores, which is a real challenge with patients transferred from nursing homes, “because nobody wants these complications,” she says.

In many of these situations, Yeh says, preventing complications is “difficult but not impossible.” For example, she notes, many say that ventilator-associated pneumonia is unavoidable in some cases, “but there are some hospitals that have gotten them down to zero.”

Unintended consequences

Roe is concerned that by seeking to avoid this lost revenue, some EDs may fall victim to unintended consequences.

“If you place a Foley catheter in your ED, you may feel obligated to give a dose of ciprofloxacin at the same time to reduce the likelihood of infection, but you then risk an antimicrobial situation where you would have more *C-difficile* [which also carries a financial penalty], prolonged lengths of stay, and so forth,” he says. “The ED is left to try and come up with systems and plans to address these unintended consequences, so the impact is not just from an operational standpoint but from the aspect of clinical care as well.”

Such options also may force hospitals to conduct financial analyses to see what treatment regimen is “best for the money,” Roe says.

Beck agrees. “These measures will require EDs to

Sources

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- **Charlotte S. Yeh**, MD, FACEP, Regional Administrator, Centers for Medicare & Medicaid Services, Boston. Phone: (617) 565-1188.

change how they practice medicine,” he says. For example, he asks, would the fear of financial penalty due to vascular catheter associated infections “dissuade someone from putting in a central line or putting it in under emergent conditions but not having the time to put in full barrier protection?”

Roe also is concerned the new measures will require more documentation. “With decubitus ulcers and UTIs, we will have to document the existing conditions well, and that will put a lot more pressure on docs and nurses,” he says.

Beck says, “These measures do create an onus or burden to document what’s present on admission, but it’s not clear from the regulation that it is the ED’s responsibility. It could be done by the admitting physician or hospitalist.”

And what about the fear that EDs will be pressured to not admit certain patients? Pressure not to admit is a legitimate concern, says Beck. On the other hand, Roe says, “I’m not so sure, though it may be there to a small degree. Many of these people are nursing home patients, and they often have a bunch of other things they need to be admitted for.” ■

CMS looks to drive quality improvement

A leading official from the Centers for Medicare & Medicaid Services (CMS) in Boston says that the impetus behind its list of hospital-acquired conditions for which it will no longer pay the “bump-up” in the complexity rate is a desire to improve quality of care.

Source

For more information on how the Centers for Medicare & Medicaid Services views regulations concerning hospital-acquired conditions, contact:

- **William Kassler**, MD, MPH, Chief Medical Officer, New England Region, Centers for Medicare & Medicaid Services, Boston. Phone: (617) 565-1319.

Some of the fears expressed by ED experts may be unfounded, he says.

“We are trying to incentivize things that are done routinely or should be done anyway, but we’re not introducing another layer of bureaucracy into this,” says **William Kassler**, MD, MPH, chief medical officer for the New England region of CMS.

Kassler offers the example of pressure ulcers. “The ED doc more than likely will have to look at patients from nursing homes to see if they have ulcers, but that’s not documentation. It is quality of care,” he says. “Having patients who come into the ED in a wheelchair from a nursing home examined for pressure ulcers is good care, and the documentation is no more onerous than any other

Pandemic strikes — Who receives no treatment?

Journal recs raise ethical concerns

ED managers are well aware of the need for triage protocols during a disaster and have incorporated them into their disaster response plans. However, plans vary among facilities and within regions. In an attempt to standardize, the American College of Chest Physicians (ACCP) convened a task force representing leading universities, medical groups, the military, and government agencies.

Their recommendations, which were published in the May *Chest*,¹ have raised ethical concerns among some practitioners and medical organizations. They include the following list of patients who should not be treated during a disaster:

- patients older than 85 years of age;
- seriously hurt trauma victims;
- severely burned patients;
- patients with severe dementia;
- patients with a severe chronic disease

“This sounds like a very, very naive approach, the recommendations of people who have never had to do

aspect of notes.”

What’s more, he says, in the case of patients such as these, the hospital likely will not suffer financially, even if such conditions are discovered after admission. “We’ve done our analysis, and most of the patients who would fall under these conditions are likely to earn [the additional payment] for other conditions,” Kassler notes. “If they have multiple problems and comorbidities, there is an overwhelming likelihood they will get some payment for a different reason, so we think this is far more about stimulating quality than it is about saving money.”

While conceding that these rules likely will drive differences in ED behavior, Kassler says CMS will be reasonable. “If someone has a fracture and is in pain, do you have to stop treating the pain to do a box-checking exercise? That’s not what we’re talking about,” he says.

In the case of infection in the ED, he says, the required documentation will be part of the work-up. “The clinical work necessary to take care of a patient with fever is sufficient for documentation,” he says. “If you do not know if a patient has a urinary tract infection you do a history, an exam, and lab tests, the diagnostic work-up is routine care, and documentation is routine.” The coder ultimately will need to sum up the case, he explains, and “put present on admission” or not. ■

critical triage of many, many people,” asserts **Kenneth V. Iserson**, MD, MBA, professor of emergency medicine at The University of Arizona, Tucson, and director of the Arizona Bioethics Program. The university, with the University of New Mexico and New Mexico State University, has created the Critical Response and Emergency Systems Training (CREST) program through a cooperative agreement with the U.S. Office of the

Executive Summary

A task force formed by the American College of Chest Physicians has listed certain patients who should receive no treatment during a disaster. However, some ED experts believe such decisions should be made on an individual basis. Here are some of their suggestions for triage decisions during a disaster:

- Avoid general categories of patients, such as the elderly, listed by the task force and instead consider the physical condition of the patient.
- Be prepared to adapt your triage response, based on the type of disaster that has occurred.
- Use a sliding scale for your triage decisions, based on the seriousness of the event.

Assistant Secretary of Preparedness and Response. **(CREST has an instructional video available online, narrated by Iserson. See the resource box, right.)**

“Our videos talk about the real way to do it,” says Iserson. “You train people who are going to do the triage and follow general guidelines, but every case or group of cases will be specific.”

One of the problems with such broad guidelines, says Iserson, is that there always are exceptions, and some, he argues, should not even be included.

“Extensive third-degree burns, give me a break!” he says. “In any really extensive triage situation where there are multiple casualties, the extensive third-degree burns are way on the bottom of the list.”

As for the very elderly, he continues, the key issue is not their age but whether they are survivable. “I’ve seen 85-year-olds who are much more active than 40-year-olds,” Iserson points out.

In addition, he says, the nature of the disaster also might dictate the triage response. “From flu, to war, to hurricanes, the situation varies, the responses of people vary, and the resources available vary with the situation and change over time,” he explains. “Your cadre of triage officers has to be flexible.”

The pandemic guidelines at the University of Utah Hospital, Salt Lake City, use a sliding scale for triage, reports **Colleen Connelly**, RN, BSN, emergency preparedness manager. They use a modified Sequential Organ Failure Assessment (SOFA) score, she says, “And the scale slides depending on the level of pandemic. The list of patients that don’t receive a ventilator or who are turned away [from active treatment] to palliative care are more clearly done in our plan.”

Nonetheless, says Connelly, she recognizes the need for such guidelines. “I’ve been working with my hospital and my state [on disaster preparedness] for several years, so I know that when we talk about projecting the number of people who will be ill or require a ventilator, just in my county alone, it’s something like five times the number we have *in the entire state*,” she says.

So when Connelly considers those statistics along with federal projections that there will be a 40% decrease in the health care work force during a mass casualty disaster, “Then [the *Chest* plan] makes more sense to me. If I have a 68- or 70-year-old person with 90% full thickness burns and a 16-year-old in the same condition, who gets the ventilator? Who gets care?”

When all possible beds are filled, all alternative sites are overwhelmed, and when staffing is unavailable, “that’s when that piece of the triage guidelines gets initiated, and I regard that as a good thing,” she says. Making such decisions is very difficult, “and it’s hard to put them all on the health care provider,” she says.

Still, Connelly says, Iserson is correct to point out

Sources/Resource

For more information on triage during a disaster, contact:

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- **Kenneth V. Iserson**, MD, MBA, Professor of Emergency Medicine, Director, Arizona Bioethics Program, The University of Arizona, Tucson. Phone: (520) 626-2398. Fax: (520) 626-2480.

To view a copy of the Critical Response and Emergency Systems Training (CREST) video, go to www.crestaznm.org/crest/ecs/main/home.html?homeid=uberlink. Then, go to: “Looking for The Most Difficult Healthcare Decisions video? Click here.”

that each case must be considered individually. For elderly patients, for example, considerations should include more than age, such as whether they can perform activities of daily living, whether they have family to assist with care after discharge, and so on. “It’s not just a case of whether they are old,” she says.

The other side of the coin, however, is that the urge to “save everybody” must be tempered with a dose of realism. “A pandemic, for example, is so big that we owe it to our health care providers to at least be able to give them *some* guidelines,” Connelly says. “It’s not fair not to talk about it just because it makes someone uncomfortable.”

Reference

1. Devereaux AV, Dichter JR, Christian MD, et al. Definitive care for the critically ill during a disaster: A framework for allocation of scarce resources in mass critical care: From a task force for mass critical care summit meeting. Chicago; Jan. 26-27, 2007. *Chest* 2008; 51S-66S. DOI 10.1378/chest.07-2693. ■

Pediatric ED seeks to touch all the bases

Advanced courses prepare staff

The “child-friendly” environment of the pediatric ED at Medical University of South Carolina (MUSC) Children’s Hospital in Charleston is a dead giveaway as to the kind of patients the department sees.

Executive Summary

The pediatric ED at Medical University of South Carolina (MUSC) Children's Hospital in Charleston has made an extensive effort to have the staff and the design of the department ensure optimal comfort and care for their young patients. These strategies include:

- having child-life specialists, who help put the children at ease during frightening procedures;
- equipping every room with a TV, VCR, and DVD player to help keep the children occupied and to reduce stress;
- insisting that all physician and nursing staff complete advanced courses in caring for pediatric patients.

All rooms are private, each decorated to follow a different theme, such as animals, fish, or boats. Every room also is equipped with a TV, VCR, and DVD player. Another unique aspect of the department is the presence of child life specialists, who are on hand to help ease the fears of the young patients and make them feel more comfortable.

But that's just one aspect of a staff geared toward this patient population. All staff members have received specific advanced training that helped prepare them to recognize and cater to the specific medical needs of children.

"We are designated as a Level I trauma center, and that includes both adult and pediatric patients," explains **Melanie Ann Stroud**, RN, the trauma coordinator. "The official term is an adult trauma center with pediatric consideration."

The ED nurses care just for children, adds **Debbie Browning**, RN, MSN, nurse manager for the pediatric ED. "There is no back and forth between the two [adult and pediatric] EDs," she says, "and all our physicians are board-certified attendings in pediatric emergency medicine."

The department's physicians are trained in advanced trauma life support, which is a fairly intense course, says Stroud. The nurses are trained in the Trauma Nurse Core Course (TNCC).

"We also do additional training with our nurses in relation to pediatrics," she says. For example, they are certified in pediatric advanced life support (PALS).

In addition, all the RNs take the Emergency Nursing Provider Course (ENPC) "which teaches them to recognize sick children," says Browning. "It is very specialized in the unique care of children up to age 18."

Stroud says, "Children are very unique patients in that they have anatomical differences, there are certainly more

emotional family concerns, they will react differently to traumatic situations, and they have a high incidence of post-traumatic stress syndrome [PTSS]," she says. "Children are very resilient and heal faster in terms of injury, but some studies show they do suffer from PTSS."

For these cases, the child-life therapists and full-time social service worker are of great value, says Stroud. "They identify families and patients who might not be able to react well to injury or other issues — like a parent who was killed in the same accident — and can get them into proper treatment after discharge," she explains.

The child-life specialists, who are available during the busiest hours (11 a.m. to 11 p.m. or 1 a.m. to 1 p.m.) seven days a week, are "master's-prepared, with strong backgrounds in child growth and development," says Browning. So, for example, if a child is about to have an IV started or any other procedure that seems threatening or frightening, the specialist will prepare the child in terms they will understand, explain to them how they can participate and help, and actively involve the parents. "So instead of having to hold a child down, the parents can support them while we start the IV," Browning explains. These "comfort holds" involve the parent helping to hold an arm or snuggle the child on their lap. "It makes the procedure a whole lot less threatening," Browning says.

The department also has respiratory therapists who are capable of managing a child's airway. "They are smaller in a child," Stroud explains. There is a pediatric surgeon on staff, who can perform procedures in the ED or determine that the child needs to go to the OR, and a pediatric intensivist in the pediatric ICU who can care for children in a trauma bay or help out in the ED.

Improving safety

Browning is convinced that the care in the pediatric ED is superior to the care children receive in a 'non-specialized' ED.

"It is safer and better, very much so," she says. "We

Sources

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Growing doesn't have to mean slowing

Although the volume in the pediatric ED at Medical University of South Carolina Children's Hospital in Charleston has increased 67% in the past four years, its length of stay (2.5 hours) has not increased at all. How has the department managed to keep things moving so smoothly despite this rapid growth?

"The first thing we did was to take over part of the adult bronchoscopy lab after they closed," says **Debbie Browning**, RN, MSN, the nurse manager. When the lab closes late in the afternoon, all "quick-care" patients are sent to the four-bed area. The lab is available during peak hours: from 6 p.m.-10 p.m. Monday through Friday, and from 4 p.m.-10 p.m. on weekends.

In addition, nurse practitioners have been added to the caregiver mix. "Every day from 11 a.m. to 11 p.m. — our busiest hours — we have both an NP and a physician," says Browning.

The department also has implemented bedside registration and triage. "As long as we have a bed, the patients walk [or are carried] straight to the back," Browning says.

Another change that Browning calls a "big help" was a shift to point-of-care testing around the clock. This change includes urine/pregnancy testing, respiratory syncytial virus testing, rapid flu testing, and rapid strep testing. "In the past, it could take up to two hours to turn around these tests in the lab," Browning says. "Now we have results in seven minutes." ■

have a group of nurses who know what a sick and well child looks like, who can make those triage decisions, go back and reassess if their condition changes, and have a strong desire to be there and care for children." In many EDs where adult and pediatric care are combined, "you will find that some nurses are not comfortable with or like caring for children," she says.

Shortly after the department opened, says Browning, an ED operations committee was established to look at throughput and related outcomes. The committee consists of representatives from nursing, physicians, respiratory therapy, child-life, and registration, plus additional departments on occasion as needed. Although the department's volume has increased 67% in the past four years, the length of stay "is right at 2.5 hours, right where we started," she reports. **(For information on how the hospital has accomplished this feat, see story, above.)** ■

CA-MRSA shown to be an emerging problem

Not as deadly as 'cousin,' but still merits vigilance

In the wake of a series of media warnings about the deadly health care-associated methicillin-resistant *Staphylococcus aureus* (MRSA) comes a new study in *Annals of Emergency Medicine* that outlines the emergence of its "cousin," community-associated MRSA (CA-MRSA).¹ While the researchers note that CA-MRSA is very rarely fatal, they nonetheless declare that it merits the attention of ED managers.

The researchers, using merged National Hospital Ambulatory Medical Care Survey data from 1993-2005, identified ED visits with diagnoses of numerous skin infections. An abscess, for example, can be indicative of CA-MRSA. They found the following:

- "Infections of interest" were diagnosed in 3.4 million visits in 2005, vs. 1.2 million visits in 1993.
- As a proportion of all ED visits, such infections were diagnosed in 2.98% of ED patients in 2005, vs. 1.35% in 1993.
- When antibiotics were prescribed, those typically active against CA-MRSA were used increasingly during the study period, being used rarely in 1993 but rising to 28% in 2005.

How serious a threat is CA-MRSA? "You've got to remember we're talking about two different things: One is nosocomial, or hospital-acquired, the other is community-acquired [CA]," says **Daniel J. Pallin**, MD, MPH, lead author of the study. Pallin is director of clinical research at Brigham and Women's Hospital (BWH) in Boston, an attending ED physician at BWH

Executive Summary

With the significant increase in the incidents of community-acquired methicillin-resistant *S. aureus* (CA-MRSA), it's important for ED managers to be conversant not only in hospital-acquired MRSA, but also this less lethal version. Here are some recommendations:

- The appropriate treatment for an abscess, the most common manifestation of CA-MRSA, is surgery.
- If an antibiotic is deemed necessary, the most effective against CA-MRSA is trimethoprim/sulfamethoxazole.
- You may wish to culture all abscesses to determine the precise nature of the bacterium.

ACEP: MRSA caused pneumonia deaths

A high number of cases of pneumonia caused by staph infections resulted in death among young, otherwise healthy patients during the 2006-2007 flu season, with more than three-quarters caused by methicillin-resistant *S. aureus* (MRSA), according to a new report available online in the *Annals of Emergency Medicine*.¹

“Staph-caused pneumonia in the nonhospitalized population is rare to begin with, especially in otherwise healthy, young people, but the amount caused by MRSA was particularly striking,” the lead author of the study, **Alexander J. Kallen**, MD, epidemic intelligence service officer with the Clinical and Environmental Microbiology Branch of the Centers for Disease Control and Prevention in Atlanta, said in a prepared statement. “More than three-quarters (79%) of the staph-caused pneumonia patients were infected with MRSA.”

To download a copy of the article free of charge, go to www.annemergmed.com and scroll down to “Featured Articles.”

Reference

1. Kallen AJ, Brunkard J, Moore Z, et al. *Staphylococcus aureus* community-acquired pneumonia during the 2006 to 2007 influenza season. *Ann Emerg Med* 2008. DOI: 10.1016/j.annemergmed.2008.04.027. ■

and Children’s Hospital, also in Boston, and an assistant professor of medicine and pediatrics at Harvard Medical School in Cambridge, MA.

When a patient is hospitalized and exposed to nosocomial MRSA, “this is often associated with serious bloodborne infections and is quite dangerous,” he says. “It is also well documented to be spread in hospitals, particularly by clinicians’ hands.”

CA-MRSA, by contrast, often is contracted outside the hospital, and the vast majority of cases are skin infections, typically abscesses. “While these community-associated infections are certainly painful and unsightly, they are very rarely fatal or life-threatening,” says Pallin. Still, he observes, “The rate of these infections among ED patients has gone up considerably, and we are probably seeing an epidemic.”

David A. Talan, MD, chairman of the Department of Emergency Medicine, Olive View-UCLA Medical Center, Sylmar, CA, and professor of medicine at the David Geffen School of Medicine at the University of California Los Angeles, wrote an editorial on Pallin’s study in the same issue of *Annals*. “Community-associated MRSA is not a deadly superbug,” he wrote.

He added, however, that the study’s findings were “. . . compelling, and suggest that community-associated MRSA has resulted in a significantly increased burden of disease and that additional attention and resources should be directed to monitor, prevent, and control this emerging problem.”

In light of the significant increase in CA-MRSA, “when patients come in with skin infections, you have to be aware of the possibility the bacteria causing those infections are resistant to the usual antibiotics,” says Pallin.

There are two broad categories of infection: purulent and nonpurulent. The former, characterized by an abscess, is most likely these days to be caused by CA-MRSA, he notes. “The treatment is surgery,” Pallin says.

However, when the abscess is surrounded by redness and hard, painful skin, then an antibiotic that is effective against MRSA also may be needed. “There are several, but probably the best is Bactrim [trimethoprim/sulfamethoxazole],” he says.

Other skin conditions such as folliculitis are sometimes not treated by surgery, but should be treated with agents effective against MRSA, Pallin continues. “For nonpurulent [non-puss] conditions, we don’t know what antibiotics should be used,” says Pallin. “Some physicians have started to use Bactrim, but others give cephalexin for conditions like cellulitis.”

ED managers also should be aware that “it is not completely clear these bacteria [hospital-acquired and CA-MRSA] will continue to live in different environments,” Pallin warns.

If the separation of these two disappears completely, he says, “We will see people who have not been in the hospital have a MRSA infection and not necessarily respond to what we expect them to,” Pallin says. For example, hospital-acquired MRSA often is not sensitive to trimethoprim/sulfamethoxazole.

The two are not always easily distinguishable, says Pallin. “If you have a dialysis patient, you assume it’s hospital-acquired, and if it’s a high school wrestler with an abscess, you assume it’s CA-MRSA, but the only way to tell for sure is to wait for culture results,” he says.

There is a difference of opinion concerning when to do a culture, Pallin says. “When you talk about abscesses, some say there’s already enough information out there to think they are probably caused by MRSA; that these patients don’t need antibiotics anyway, so why bother to culture; or if they do need antibiotics, you give them Bactrim. So again, why bother to culture?” he says. “Others, including me, feel we are in a time of historical change, and my feeling is that all abscesses should be cultured.”

These cultures are very inexpensive and very specific, Pallin notes. “If the patient does not get better

after an operation, we can look at the labs and then know exactly what bacterium caused the problem and choose antibiotics appropriately,” he explains.

Reference

1. Pallin DJ, Egan DJ, Pelletier AJ, et al. Increased U.S. emergency department visits for skin and soft-tissue infections, and changes in antibiotic choices, during the emergence of community-associated methicillin-resistant *Staphylococcus aureus*. *Ann Emerg Med* 2008; 51:291-298. ■

Alcohol screening can reduce readmissions

Free ENA tool kit introduced in 360 EDs

On April 10, 2008, 360 nurses in EDs nationwide began using the Screening, Brief Intervention and Referral to Treatment (SBIRT) program, an alcohol screening and intervention tool kit provided free by the Emergency Nurses Association (ENA).

The tool has been piloted for more than two years in several EDs and has shown impressive results. **(For ordering information, see resource box, p. 82.)** For example, a three-month follow-up in the five EDs that participated showed the following:

- Of the ED patients who received the intervention, 97.3% had no return ED visits, compared with 88.6% of those who received usual care.
- The patients in the intervention group had a 10%+ reduction in alcohol consumption compared to the control group.

“I think the program is effective because it tells you how to quantify drinking in terms of who is at risk and needs to be referred for additional treatment, and it is gender- and age-specific,” explains **Patricia Kunz Howard**, PhD, RN, CEN, operations manager, emergency and trauma services at the University of Kentucky Chandler Medical Center in Lexington.

The program begins with a brief survey that helps define at-risk or problem drinking. “If you drink this amount [accounting for age and gender], you have a problem. If it’s negative, you don’t have to do the intervention,” says Howard, who helped develop the tool kit.

For patients who screen positive, there is a “brief, negotiated session with targeted information,” during which the patient comes up with a rate of drinking that might represent a reasonable reduction, she says. The patient is provided with advice on how to meet that goal.

The basic components of the program were in place in 2005, when Howard put out a call for sites to do the

Executive Summary

A pilot program named the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program has shown that it is effective and practical to implement in a hectic ED. Here are some reasons to consider such an alcohol intervention in your ED:

- You virtually can eliminate return visits due to alcohol-related injuries.
- Regular use of this intervention can make your staff more adept at discussing this sensitive topic with patients.
- It generally takes five to seven minutes to conduct the screening, so it will not significantly tie up your staff.

screenings. “We wanted to see if ED nurses could do it within the constraints of a busy ED,” she explains.

That turned out not to be a problem. “We were already asking ED patients about alcohol use. This just helped quantify our results,” Howard explains. “These screenings are easy to do, and the whole process takes between five and seven minutes.”

Based on those findings, Howard was asked to do an outcomes study to determine if using SBIRT in the ED would decrease the likelihood the patient would come back to the ED with an injury related to alcohol. “We saw that basically it does improve the likelihood the patient will reduce drinking, and it dramatically reduced repeat visits, so I was asked to develop the tool kit,” she says.

The kit makes it much easier to understand SBIRT and to train the ED staff, says **Wendy St. John**, RN, assistant trauma nurse coordinator at Wishard Health Services in Indianapolis. St. John has been using the SBIRT process since 2005.

“The tool kit that ENA had just released is free, and it has an informational video to pass out to help train the ED staff,” she says. “We had to bring medical professionals and other experts here to help with our training.”

The kit also includes case studies that demonstrate different possible scenarios, St. John says.

St. John, who has personally conducted the trauma interventions at her facility, warns ED managers that even though she thinks the program is “fantastic,” she has seen a wide range of reactions from patients.

“I’ve actually seen rage from patients in a major state of denial,” she says. “Even if I just provided them with their alcohol level, they would become argumentative and refuse to believe that was the true level.”

Other patients, while appreciative, would listen politely but “would probably not make a change in their lives,” says St. John. However, there were those with

Resource

To obtain a free copy of the ENA's SBIRT Tool Kit, go to www.ena.org/ipinstitute/SBIRT/default.asp.

whom she might spend as much as an hour in conversation about what got them into alcohol abuse, and they would re-evaluate the choices they needed to make in their lives. "I think the more you do these, the more comfortable you feel discussing with patients the fact that they might not be in a place in their lives to make any sort of change," says St. John. "In any event, you want to prevent getting in an argument when they are in that state."

Despite these occasional frustrations, the efficacy of the program cannot be denied. It can clearly reduce injuries and future health problems, Howard says. "Not every patient will want to change, but for a lot of people, recognizing what is at risk is a real eye-opener," she says.

SBIRT is good for ED patients, says St. John. "One of our roles as an ED nurse is to help prevent future injury," she says. St. John also is convinced the time it takes to provide the intervention is time well spent. "As long as we don't have some other ED patient in deep crisis we can and should use that time to really prevent further injury," she says. ■

Matching nurses, skill sets spells ED success

Triage staffed by nurses with experience, interest

Although EDstat, a new eight-bed area that was added to the ED at Reston (VA) Hospital Center about a year ago, is only open from 11 a.m. to 11 p.m.,

Executive Summary

In an area such as the EDstat at Reston (VA) Hospital Center, where patients with minor conditions are treated, it's important to match the skills of your staff with the requirements of such a specialized area.

- The nurses must have excellent assessment skills.
- The ability to work quickly and display exceptional technical skills also is a must.
- When putting the staff together, consider those who work well as a team.

it has helped to improve the performance of the *entire* ED. For example, in early spring 2007, before the new area opened, the percentage of patients who left the ED before treatment ranged from 2%-2.5% (statistics were measured monthly). Today, that has been reduced to 0.3%-0.4%.

In addition, time from arrival to triage was 18.59 minutes before EDstat, and 5.17 minutes after implementation. Door-to-doc time was 56.89 minutes prior to EDstat, and 34.07 minutes following implementation.

These results come as no surprise to **Sherry Hawkins**, RN, quality improvement coordinator for the ED. They've increased the number of beds from 22 to 30, Hawkins says. "We see everyone immediately, and treatment is started quickly," Hawkins says. "They get right to that bed. It's almost like an assembly line."

While the ED leaders credit much of the improvement to the superior processes the EDstat has brought, they also point to the staff as a key component of its success. That staff, they point out, not only possessed a specific set of skills that were needed, but they also actively expressed the desire to work in the new section. Although the department still has a triage area, the triage nurse's primary job is now to do a rapid-fire sorting of patients, immediately placing them on a bed in the EDstat area or the main ED. Patients with conditions that quickly can be cared for, such as minor lacerations, orthopedic injuries, and uncomplicated respiratory and gastrointestinal complaints, are sent to the EDstat area.

As the EDstat plan was taking shape, the managers of the ED recognized that nurses would require a very specific skill set to be qualified to work there. It's an area that requires a significant amount of focus and attention, says **Kendra Cline**, MSN, assistant director of the ED and ED educator. "You have to have excellent assessment skills so the patients can move quickly," she says.

This is the *raison d'être* of the EDstat. Any patient that presents and does not need immediate intervention can be rapidly triaged and taken there. The triage process involves chief complaint, a very brief history, the reason the patient came to the ED, "and what they look like, just enough information to know what their acuity level might be," Hawkins says.

When you are able to put more experienced nurses, who are a little quicker, there, the process works better," she says. "A lot of it also has to do with organizational skills, as far as determining who needs to be seen and what needs to be done next."

Cline says, "They also have to be adept at determining which patients need to be moved to the main ED, to free up beds in EDstat. Their technical skills need to be pretty superb, too, to get things, [such as starting IVs,] done quickly and efficiently."

Although there is a technician to handle splints and

other basic services, “there is only one tech and two nurses, and they have to all be very proficient and also work well as a team,” says Cline. The EDstat also includes a physician.

In fact, says Cline, the ability to work well as a team “may even be more important than their technical ability.”

How did ED management evaluate that ability? “It’s based on knowing your employees,” she says. “If they function well together, it’s something you see in their day-to-day practice. In fact, some people requested to go to the EDstat and work there together.”

Wanting to work in the EDstat was another important consideration in the selection process, says Cline. Initially, the concept was piloted by Cline, Hawkins, and Teresa Kreider, MSN, RN, the ED director, says Cline. “We did it over a three-day weekend just to see how well we could make it work,” she says. Next, they piloted the concept for six weeks using staff who told them they were interested in working within that environment, Cline says. “We are blessed to have experienced nurses, and there were quite a few who could do it.” ■

NYC jury rejects rectal exam lawsuit

A New York City jury has decided that a hospital did nothing wrong when it tried to examine the rectum of a construction worker who had been hit on the head by a falling wooden beam. The man had sued the hospital and claimed that he was examined against his will after being sedated and restrained. **(For more details, see “Can you force treatment on a patient? New York lawsuit addresses key issues,” *ED Management*, May 2008, p. 50.)**

The jury deliberated for about an hour, according to a report by The Associated Press.¹ The state Supreme Court jury found the hospital and its ED medical staff were not liable and awarded nothing to 38-year-old Brian Persaud, who had sued New York-Presbyterian Hospital for unspecified damages. Persaud’s lawyer, **Gerard Marrone, JD**, of New York City, said Persaud might appeal.

Reference

1. The Associated Press. Don’t touch me there: NY Jury rejects rectal exam lawsuit. April 22, 2008. Accessed at abcnews.go.com/Health/wireStory?id=4699791. ■

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 with the **September** 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. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME questions

19. According to Jedd Roe, MD, MBA, FACEP, which of the following adjustments will ED managers and their staffs have to make in order to meet the new CMS regulations regarding hospital-acquired conditions?
 - A. Be on guard for pressure sores in nursing home transfer patients.
 - B. Carefully document all conditions that are present on admission.
 - C. Take additional steps to avoid urinary tract infections.
 - D. All of the above
20. According to Colleen Connelly, RN, BSN, the Sequential Organ Failure Assessment using a sliding scale for triage based on:

COMING IN FUTURE MONTHS

■ Helicopter crashes on hospital roof; ED jumps into action

■ New protein speeds, improves diagnosis of failing kidneys

■ ED collaborative beats national averages for MI response time

■ Is ‘Google Health’ sharing patient records at your hospital?

■ New strains indicate bird flu pandemic is more likely

- A. the age of the patient.
 B. the level of a pandemic.
 C. the severity of the injury.
 D. the type of disaster.
21. According to Debbie Browning, RN, MSN, the “comfort hold” requires an _____ in the care team.
 A. an ED technician
 B. a physician’s assistant
 C. a parent
 D. a nurse practitioner
22. According to Daniel J. Pallin, MD, MPH, the most effective drug for CA-MRSA is:
 A. Bactrim.
 B. ciproflaxin.
 C. cephalixin.
 D. vincristine.
23. According to Wendy St. John, RN, when a patient is adamant and in denial about their drinking problem, you should:
 A. sit there and say nothing.
 B. try to show them the error of their ways.
 C. avoid getting into an argument.
 D. call for assistance.
24. According to Kendra Cline, MSN, a nurse who works in the EDstat area must have:
 A. the ability to work well as part of a team.
 B. the ability to perform procedures quickly and efficiently.
 C. the judgment to determine which patients should be moved to the main ED.
 D. All of the above

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CNE/CME answers

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