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The monthly update on Emergency Department Management

**Is there a 'mystery shopper' in your ED:
Mystery shoppers can uncover ED
weaknesses. 'Patients' present
unannounced, report findings140**



Management

The monthly update on Emergency Department Management



Celebrities in the ED: Managers often face both ethical and operational challenges

Famous don't deserve better care, but adjustments may be necessary

Despite their efforts to maintain a perfect image in the press, celebrities have many of the same experiences as your everyday patients. They get sick and injured, and they go to the hospital. Often, that involves a trip to the ED. On Sept. 16, for example, movie star Lindsay Lohan was taken to the ED at St. Vincent's Hospital in New York City after she broke her wrist. On Sept. 27, Dallas Cowboys football star Terrell Owens was taken to the ED at Baylor University Medical Center in Dallas after an adverse reaction to prescription meds.

Incidents like these, of course, can happen anywhere, and one day a celebrity might present in your ED. What would you do if Lindsay Lohan suddenly was *your* patient? Should she be required to wait the same amount of time as a "normal" patient if the injury was not life-threatening? How would you handle the press?

Do board members, donors deserve VIP care?

ED managers with extensive experience note that such situations raise delicate ethical issues. In fact, they add, other types of VIPs such as hospital board members or large donor celebrities might be treated differently than Lohan or Owens. Celebrities might be treated differently, for example, not because they are "special," but because they have the same right to privacy as any patient. On the other hand, a large donor might be hard to ignore if "special" treatment could mean

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Executive Summary

To prevent a celebrity's visit from disrupting your department, plan ahead to preserve their privacy and confidentiality — and recognize that they are *not* just like every other patient.

- Have secluded spaces available where they can wait to be seen while preserving their anonymity.
- Offer to have them registered under an alias, or sign them in as John or Jane Doe.
- Be aware that giving a wealthy VIP or large donor a positive experience can mean millions to your ED.

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millions of dollars to your facility.

“When you’re talking about a VIP or a high-profile patient, you start to tread on treacherous ethical grounds,” says **Joel Geiderman, MD**, chair of the Department of Emergency Medicine at Cedars-Sinai Medical Center in Los Angeles. “Nobody deserves more or better or faster care.” But while ethically you cannot do that, he continues, “you *can* give different care under an ethical framework if it’s in the best

interests of the patient and doesn’t harm another patient.”

There are definitely differences between celebrities and VIPs, adds **David Goldwag, DO, FACEP**, the medical director of the ED at Westchester Medical Center in Valhalla, NY. “With a large donor, that’s part of deal,” he says. “They *do* get special treatment.”

If a VIP has a good interaction with your ED, he continues, that can mean millions of dollars in donations that will help you take care of many other people. “They might not wait 12 hours, and I don’t think anyone is really happy with that,” Goldwag notes. “I’d rather not pander to people with millions of dollars, but if they bring more money to my department, those are the decisions we make.”

Celebrities, on the other hand, are a random event, he says. “It depends on how sick they are, how much of an entourage they have, and so forth,” Goldwag says.

If they are not very sick, Goldwag continues, “the idea is to get them through quickly — not because they deserve it, but to limit the disruption and to preserve the environment of your department.” **(For more details on patient encounters involving celebrities, see the story on p. 135.)**

Treating the famous

As an ED manager, you sometimes will receive advance warning that a celebrity is on the way to your facility, says Geiderman. “Sometimes their ‘machine’ — the people around them — will notify the hospital in advance, but sometimes they just show up unannounced,” he says.

“When they just come in as a normal patient and you recognize them, that’s the easiest,” says Goldwag. “They act like a normal patient, you treat them like a normal patient, and it can be a very nice interaction.” The most difficult cases, he says, are the celebrities with an entourage.

What do you do in a case like that? Let’s assume you receive notification that a well-known personality is coming or is in your waiting room, says Geiderman. “My feeling is they should be separated from the main waiting room — not because they should be seen sooner, but because they have a right to privacy and confidentiality,” he says.

The Cedars-Sinai ED has some secluded areas — such as their bereavement area, or the room used by police to write up reports — that can be used in these situations, says Geiderman. “Separate care may not be *better* care,” he insists. “That is not the goal; nobody should ever jump line in terms of someone needing to

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be seen sooner.” In other words, if their condition allows, the celebrity can continue to wait in the secluded area.

You also should seek to maintain confidentiality when it comes to registration, Geiderman continues. “Try to register those people by initials,” he advises. “If they are ‘big’ enough, you may want to ask if they have an alias they commonly use, or if they want one.” Another alternative, he suggests, is simply to register them as John or Jane Doe.

Depending on the identity of the celebrity or the VIP, security also can be an important concern, says Goldwag. “My whole career as a director I’ve been in departments that are prime locations for high-level government officials,” he says. “A lot of security and extra precautions must be in place should they need to come.”

Depending on the size and magnitude of the celebrity, you may need to notify security, adds Geiderman. This becomes a particularly significant issue when the paparazzi show up, he says.

“There are informants — particularly in L.A. — who get paid off to tell paparazzi when celebrities are going to the hospital,” he shares. “You may need extra security and in some cases you may need to have your perimeter secured. These people can be aggressive.”

To keep communications secure, Geiderman continues, notify your PR department *before* they start getting phone calls. “Any calls that come to you should be referred to PR,” he says.

Create a formal policy?

While Geiderman and Goldwag have had extensive experience dealing with celebrities and other VIPs, neither has a formal policy in place for their EDs. It’s not, they say, because it doesn’t make sense.

“I don’t know that I’ve ever seen one,” says Goldwag. “It’s something that might be hard to police.”

Nevertheless, he emphasizes, “everyone has to understand the reason for having a VIP plan, and everyone has to agree with it.” You don’t want to find out in ‘real time’ that someone has a big problem with how these people are treated, he explains. “You should discuss it theoretically as a department first, so problems do not come up later,” he suggests.

“I’ve thought a lot about this,” Geiderman adds. “We don’t really have a formal policy, but maybe one should be created.”

Whatever your preferred process, he continues, it should be very transparent. “It’s a good idea for people in charge of the ED to have thought about it, and perhaps they should consider a formal policy,” he concludes. ■

Consider assigning senior treatment team

When a celebrity presents at Cedars-Sinai Medical Center in Los Angeles, the managers prefer to assign a specific treatment team to limit the number of people who have contact with the patient.

“Depending on where the celebrity ranks in the ‘firmament,’ you may want to consider more senior people,” says **Joel Geiderman**, MD, chair of the Department of Emergency Medicine at Cedars-Sinai.

This approach accomplishes several things, Geiderman says. The patient may feel more comfortable, the nurses may feel more comfortable, and the encounter is likely to feel more normal. “Some people may consider this pulling rank, but in my department I go in and introduce myself as the department chair,” he says. “Everyone has a duty to maintain the privacy and confidentiality of this patient, and I think it’s implied that this duty is even higher in my case.”

A recent encounter, he continues, helped validate this approach. A well-known actress brought her little boy in with a minor head injury. She was requesting that her son have a CT [computed tomography] scan. “I went in and introduced myself, and after examining the boy, I asked her, ‘How married are you to having this CT?’” Geiderman recalls. “She said she was not married to it at all.”

Geiderman proceeded to tell her that if it was his child, he would not have the scan done. “It was important in a sense to acknowledge who she was, but not to make any bones about it, and then tell her what I thought what my best medical judgment was,” he explains. “You can fall all over these celebrities and do more testing than you need, so it’s important to establish that comfort level so you can be honest with them.” ■

Sources

For more information on treating celebrities and other VIPs in the ED, contact:

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- **David Goldwag**, DO, FACEP, Medical Director, Emergency Department, Westchester Medical Center, Valhalla, NY 10595. Phone: (914) 493-7000.

Temblor drives ED staff, patients into outdoor tent

Disaster call tree ensures adequate staffing

While weather-related disasters such as hurricanes or tornadoes can present some tough challenges for an ED manager, you generally have at least a few hours to prepare for the possibility of severe weather. But when an earthquake hit Hawaii at about 7:10 a.m. on Oct. 15, there was no warning at all for **Kathy Kotecki**, RN, the charge nurse who was running the ED at Kona Community Hospital in Kealahou, HI.

"I started to feel things shake, but this happens frequently," Kotecki recalls. "I thought it would just stop, but it lasted for what seemed like a couple of minutes." The lights went out, and the backup generator did not come on right away, she says.

'We had to stay open'

While the hospital stayed dark for a couple of minutes, it suffered minor structural damage such as fallen ceiling tiles and damage to an operating room. However, much of the damage in the ED was limited to overturned equipment and items thrown off shelves into hallways. Nevertheless, the decision was made to evacuate the hospital. Kotecki, however, remained to treat any new patients who might need help.

"Med/surg evacuated, the OR was closed, OB was evacuated, but we had to stay open because we needed to treat people who just walked in," Kotecki explains. "There was no way we could turn them away."

Immediately after the initial shaking stopped, Kotecki told the rest of the staff to get out of the ED and into the parking lot.

"This was the strongest quake I'd felt in my life,"

she says. "We're on the basement level, and since the hospital is a three-story building, I was thinking we could get crushed."

The three ED patients, who already were in gurneys, were brought outside, along with portable equipment such as cardiac monitors. Then they started their disaster call tree. "One of the unit secretaries called everyone and asked additional staff to come in," says Kotecki. About 90% of the total staff — 20 RNs and six physicians — showed up. "Maintenance showed up and put up a tent." (The "tent" was actually a vinyl dome typically used for chemical disasters. It can cover five gurneys in a row, plus supplies.)

Lynn Guillermo, RN, a staff nurse that day, notes that other departments pitched in. "Central supply brought carts outside, so we had all the equipment we needed for IV supplies, bandages, and so forth," she recalls. The dietary department helped by bringing water and ice for the patients, she adds.

There was no central source of electricity in the tent for more serious patients who were on monitors, notes Kotecki, so they eventually had to be treated inside. "The battery life was not long enough," explains Guillermo.

"I stayed in the ED because we still had people walking in, and we assumed we'd have traumas coming in pretty soon," she says. "Luckily, that did not happen." Instead, what she saw were "Mostly abdominal pains, chest pains, some anxiety chest pains — in other words, 'regular' ED patients," Kotecki says.

Ten people were admitted to the Kona ED with earthquake-related injuries, none of which were life-threatening. "Some of them came straight to the tent, but some went into the ED and were triaged first," says Guillermo, who notes that she had as many as six or seven patients outside at one time.

By about 2 p.m., all of the tent patients had been discharged, and the ED stopped using the tent. "Everybody was eventually discharged, except for a chest pain patient who ended up being flown out to Oahu," says Guillermo.

Not a one-day event

Things were not nearly back to normal the next day, recalls **Lori Cannon-Salis**, RN, a staff nurse who worked as the ED supervisor on Oct. 16.

"Only 10% of the hospital was operational," she notes. "The emergency patients had been relocated back to the ED, and we did continue to get some lacerations or minor injuries."

The changes in the rest of the hospital affected the ED, she continues. "The entire second floor was shut down, and they relocated the OB unit and the med/surg unit to the ICU, which has only nine beds," notes Salis.

(Continued on page 138)

Executive Summary

Just because some disasters come without warning does not mean you shouldn't have an adequate response once it occurs.

- Be sure your disaster plan is in good order, and that you have a procedure in place for ensuring additional staff is available.
- If there is a threat to the structural integrity of your building, evacuate patients as quickly as possible. Ask maintenance and central supply to help with alternative facilities and portable equipment.
- Be prepared to function in less-than-ideal conditions for several days after the event.

HICS is updated for consistency with NIMS

The California Emergency Medical Services Authority has released an updated version of the Hospital Incident Command System (HICS), an incident management system to help hospitals improve their emergency planning and response capabilities. Formerly known as the Hospital Emergency Incident Command System (HEICS), HICS consists of a guidebook and planning and training tools developed by a national panel of experts with support from the American Hospital Association (AHA) and its American Society for Healthcare Engineering.

The update is designed to be consistent with the new implementation activities for hospitals and health care systems released on Sept. 12, 2006, by the National Incident Management System (NIMS) Integration Center of the Federal Emergency Management Agency (FEMA), notes **Roslyne Schulman**, AHA senior associate director of policy development. There are 17 elements in the new activities that hospitals should integrate into their current emergency management planning, according to NIMS. (See list, right.) These elements will assist hospitals in ensuring they are NIMS compliant.

"If you look at what was formerly the organizational chart, we now have an ICS [Incident Command System] team chart to be consistent under NIMS," notes Schulman. "It shows how the team should be organized." Also, some of the titles are somewhat different, she says. (A side-by-side comparison is offered in an appendix to the HICS system. It can be found at www.emsa.ca.gov/hics/hics.asp.)

The other improvement in HICS, says Schulman, is that it is intended to be "flexible and scalable" by organizations. "One of the things we heard from small rural facilities when HICS III came out is that it was huge; and if you are a small hospital, it was hard to put into place," she says. "Now, it is intended for different sized organizations and different types of events."

In fact, Schulman adds, the HICs web site also contains a number of scenario-based planning guidances. "Scenarios have been developed for anything from a hurricane to a nuclear detonation," she explains. "HICs has taken each scenario and designed a set of planning and response guidances around them." For hospitals, HICS also has developed guidance and scenarios for internal disasters such as hostage situations or floods, Schulman adds.

These updates, she continues, should be of major importance to ED managers, as "they would be part of the operational arm of any type of response." The external scenarios, for events such as biological disease outbreaks and pandemic influenza, should be of

particular interest, she adds.

There also may be a financial impact for noncompliance, Schulman adds. "In the last couple of years, NIMS has issued some guidance for state and local agencies, which are required to be in compliance. Hospitals that receive federal preparedness funds are also required to comply, and we strongly urge others to do likewise," she says. For example, she points out, the Health Resources and Services Administration (HRSA) grants guidance include the NIMS health elements, and over the next two years facilities receiving those grants are expected to come into compliance.

[Editor's note: For more information on the Hospital Incident Command System, contact Schulman at (202) 638-1100. To download a copy of the Hospital Incident Command System free of charge, go to www.emsa.ca.gov/dms2/dms2.asp. Scroll down to the heading "Hospital Emergency Management Topics" and click on "HICS: Hospital Incident Command System."] ■

New National Incident Management System (NIMS) Activities

- Adoption of NIMS at all organizational levels
- Manage incidents in accordance with the Incident Command System
- Multi-agency coordination
- Public information system
- NIMS implementation activities tracking done annually as part of Emergency Management Program (EMP)
- Develop and implement system to coordinate preparedness funding
- Revise and update plant to incorporate NIMS
- Participate in and promote mutual aid agreements with private sector and governmental and nongovernmental agencies
- Hospital personnel in a leadership role should complete:
 - Independent Study (IS) 700
 - IS 800
 - ICS (Incident Command System) 100 and 200
- Incorporate NIMS into all trainings and exercises
- Participate in all-hazard exercise program involving multiple partners
- Incorporate corrective actions into plans and procedures
- Maintain inventory of response assets
- Resource acquisition according to relevant national standards and guidance to achieve interoperability
- Apply standard and consistent terminology

Source: National Incident Management System (NIMS) Integration Center, Washington, DC.

Sources

For more information on ED operations following an earthquake, contact:

- **Lori Cannon-Salis**, RN, **Lynn Guillermo**, RN, **Kathy Kotecki**, RN, Emergency Department, Kona Community Hospital, 79-1019 Haukapila St., Kealahou, HI 96750. Phone: (808) 322-9311.

“At one point, we had laboring patients in the ED until we could get them upstairs.”

Because other departments still were closed, “We [the ED] had to troubleshoot transferring patients off-island from other departments,” she recalls. “We actually got a C-130 [airplane] to get our patients off.”

There also was added pressure on the ED because of their location, adds Kotecki. “There were no other hospitals available, except on the other side of the island,” she says. “It was very scary.” **(In other disaster news, the Hospital Incident Command System has been updated. See the story, p. 137.)** ■

QI project slashes mislabeling rates

Computer re-education a key to turnaround

The ED at Boston Medical Center has reduced major mislabeling events from 47% (23/49) to 14% (4/29) in a year, thanks to a quality improvement project that kept the ED informed weekly when errors occurred. The initiative was an important one, notes **Karen Quillen**, MD, medical director of the blood bank, Department of Pathology and Laboratory Medicine, who oversaw the hospitalwide project, because acute hemolysis, primarily the result of ABO (the main blood types) incompatibility, is an important cause of transfusion-related mortality and morbidity.

Quillen targeted blood group inconsistencies. “I would get blood group results based on a sample, but when I compared it to the patient’s historic record, some had different blood types two months or two years ago,” she says. “We *know* your blood type cannot change, so one of those times it was wrong.”

All mislabeled specimens received by the transfusion service for a type and screen were recorded and classified into minor and major mislabeling categories. The major mislabeling events were tracked by origin of the specimen, and the areas with a high proportion of major mislabeling were given feedback within one

week of the events.

“We collected all relevant data, and only when we looked at it after a year did patterns emerge,” notes Quillen. “We did not *focus* on the ED, but they do a lot of labeling, and from the prior data analysis we could tell where the high problem areas were.”

Having a large number of mislabeling errors originate in the ED can be a serious problem, Quillen adds. ED samples sent to the blood bank don’t always request transfusions. “Sometimes it’s a ‘just-in-case’ situation when they’re doing a work-up,” she says. “But if they do order a transfusion, and we don’t pick [the mislabeling] up, it could potentially be disastrous.”

Identifying the causes

Linda Fisher, MSN, director of emergency nursing, received weekly e-mails from Quillen noting all major mislabeling events.

“She let me know each time an error occurred so I could speak with the individual nurses,” Fisher recalls. She would approach the nurses and, in a nonaccusatory fashion, retrace process steps to see what had gone wrong. “This was simply observation of practice,” she explains.

This was what ultimately uncovered some common problems in the department. “Initially [speaking with the nurses] was the only intervention, but we soon realized the mislabeling had become an issue when we went to electronic documentation and order entry,” Fisher notes.

That problem was not with the system itself (ibex PulseCheck, from Chicago-based Pangaea Information Technologies) but with the way the nurses were using it, she says. After a number of discussions with the nurses, it became clear that the way the nurses were entering the information was a major cause of the errors.

The most frequent error involved nurses hitting the “enter” key after each specimen was drawn, instead of after all specimens were drawn from that one patient. Problems arose when more than one nurse was on a computer simultaneously. “If I hit ‘enter’ after one

Executive Summary

You can achieve dramatic patient safety improvements by focusing on specific processes. One ED reduced major mislabeling events from 47% to 14%.

- Receive weekly updates on errors that occur so you can review them with staff while their memories are fresh.
- By looking at data from departmentwide processes, you can more readily identify common causes of errors.
- When discussing errors with staff, always take a nonaccusatory approach.

Sources

For more information on quality improvement in blood labeling, contact:

- **Linda Fisher**, MSN, Director of Emergency Nursing, or **Karen Quillen**, MD, Department of Laboratory Medicine, Boston Medical Center, One Boston Medical Center Place, Boston. Phone: (617) 638-8000.

specimen for Mr. Jones, and another nurse hit 'enter' after one specimen for Mr. Brown, and a third did the same after drawing one specimen for Mr. Smith, the labels could get interspersed (at the printer), and that was the main cause of errors," Fisher explains.

Solving the problem

Fisher took several steps to eliminate these errors. "First, we talked to the nurses and explained they should not hit 'enter' until they were completely done with the patient," she says. "This way they would have all their Patient Smiths and Patient Joneses together."

As a fail-safe measure, she asked the information technology staff to alter the system so that whenever the 'enter' key was hit, a blank label would be printed. "This acts as a 'stop sign' for the nurse," she explains. "She now knows she has all the labels she can have for Mr. Smith."

Of course, the nurses often will draw extra blood early in the encounter 'just in case' more tests are needed later, in order to avoid an additional needle stick. "We are a safety net facility, so some of the patients are a very difficult draw," Fisher explains. "If the nurses have drawn an extra tube of blood, they have to manually label that for later."

The nurses are grateful that these errors have been eliminated, Fisher says. "After all, if the lab called and told them, 'This can't be Mr. Smith's blood. You have to re-draw,' they then had to re-draw the patient and explain why," she says. ■

Caffeine abuse may be missed in the ED

Warning signs: Chest pain, palpitations in teens

Caffeine abuse may be an emerging problem among young people, according to research summarized in a poster presented in October at the annual American

College of Emergency Medicine Scientific Assembly.

The average age of those who had abused caffeine was 21. "Young people taking caffeine either to stay awake or for a feeling of euphoria may actually end up in the emergency department more often than we think," asserts **Danielle McCarthy**, MD, an emergency medicine resident at Northwestern University's Feinberg School of Medicine in Chicago, who along with her colleagues compiled the data from calls into the Illinois Poison Center, also in Chicago.

The study looked retrospectively at 265 caffeine abuse cases at the poison center over a three-year period (Jan. 1, 2002 to Dec. 31, 2004). Of the 265 cases, 12% (31) ended up in an area ED.

Caffeine alone was abused in 186 of the cases (68%) and abused with other pharmaceutical products in 81 (29%) of the cases. Of all the variables examined, it was use of other pharmaceutical products along with the caffeine abuse that was associated significantly with hospitalization. Of the 31 patients who were hospitalized, 20 of them (65%) required admission to the intensive care unit.

Their findings "absolutely ring true," says **Daniel E Brooks**, MD, chief of the Division of Medical Toxicology, Department of Emergency Medicine at Presbyterian Hospital, University of Pittsburgh Medical Center. "We have one of the busiest medical toxicology departments in the country, and this does not surprise me," Brooks says.

There's a propensity in humans to alter their sensoria, he continues, and students will use drugs that are readily available, such as caffeine.

Missing the symptoms?

Despite the fact that caffeine abuse may be more common than suspected, it can be misdiagnosed easily if the ED is not looking for it. "Young people being hospitalized for chest pains and heart palpitations are rarely asked if they've taken caffeine supplements

Executive Summary

ED managers should be aware of the tendency of young people to abuse caffeine and other nonprescription drugs. Experts say they end up in the ED more often than we think.

- Be sure to ask young patients with chest pain or heart palpitations whether they have taken any caffeine supplements.
- Be aware that most caffeine abusers also are abusing other pharmaceuticals such as dexamethorphan.
- Symptoms of caffeine abuse can include insomnia, tremors, sweating, nausea, vomiting, diarrhea, and neurological symptoms.

Sources

For more information on diagnosing caffeine abuse in the ED, contact:

- **Daniel E. Brooks, MD**, Chief, Division of Medical Toxicology, Department of Emergency Medicine, Presbyterian Hospital, University of Pittsburgh Medical Center, Pittsburgh. Phone: (412) 647-2345.
- **Danielle McCarthy, MD**, Northwestern University, Feinberg School of Medicine, 303 E. Chicago Ave., Chicago, IL 60611-3008. Phone: (312) 503-8649.

because everyone perceives them to be safe,” notes McCarthy.

That perception may be far from the truth, however, warns McCarthy, noting that not only is caffeine a drug, but its overuse is potentially harmful — especially when mixed with other pharmaceuticals for euphoria.

Brooks concurs. “Of the people presenting in the ED, the majority of these folks were also abusing other pharmaceuticals,” he notes. “For example, dexamethorphan is even much more important and prevalent.”

Of course, if you miss the caffeine abuse diagnosis, you can’t properly treat the patient, Brooks continues. “That is one of the arts of emergency medicine: recognizing that some young kid who comes in with palpitations may basically be suffering from sympathomimetic toxicity.” Dexamethorphan, he notes, is “weak PCP. Caffeine is similar to ecstasy, amphetamines, and cocaine; they all ‘rev’ you up.”

“If you don’t ask the right questions, you may think the patient is having a panic attack or a heart attack, when all they have is an adverse drug affect — which obviously would be treated differently,” says Brooks. “When ED docs see people with these symptoms, they should ask them about any over-the-counter drugs they may have taken, and if they want, specifically about caffeine.”

Brooks agree that a lot of ED staff do not ask specifically about abusing caffeine, but it’s more important to ask, “have you been taking *any* meds — including over-the-counter drugs?” he advises. “Kids use what they can easily have access to.”

McCarthy adds that other symptoms of caffeine abuse can include insomnia, palpitations, tremors, sweating, nausea, vomiting, diarrhea, chest pains, and neurologic symptoms.

More research needed

McCarthy says more research is needed to understand the long-term effects of caffeine abuse, and emphasizes there are no data to suggest that caffeine

in doses associated with coffee and tea drinking poses any health problems.

The study did not define caffeine abuse. People self-reported the abuse to the poison center. Still, she warns, “There is a trend in the pro-drug culture toward promoting legal alternatives to illegal drugs, and it can be very harmful.”

Brooks shares her concern. “The people who present in the ED are probably the tip of iceberg of folks who abuse drugs,” he observes. “When they abuse caffeine and show up, they may be self-selecting as folks who are either very naïve or doing the caffeine in an inappropriate setting” outside of the coffee or colas they drink.

While calling this research a very good study, Brooks says that more than providing answers, it serves as food for thought for ED managers. “What would be great would be a follow-up on the abuser and how they came to show up in the ED,” he suggests. “For example, was this a call for help, or did their RA [resident advisor in a college dormitory] bring them in?” ■

‘Mystery shoppers’ can uncover ED weaknesses

‘Patients’ present unannounced, report findings

The next patient you see in your ED may be a “mystery shopper” — and you won’t even know it. Companies, such as Devon Hill Associates in San Diego, are being retained by hospital CEOs to have individuals come to their facilities to be “treated” and to report back on their findings. The findings then are shared with the different departments in the hospital, with an eye toward improving patient safety and satisfaction.

While the individual patient/mystery shopper will not be known, the ED manager probably will not be

Executive Summary

One veteran “mystery shopper” has uncovered several common ED practices that can hurt patient satisfaction. You can learn from her observations to improve your ED’s customer service:

- Be sure to let all of your patients know how long they might expect to wait before seeing a doctor.
- Wash your hands where the patient can see you, so they can be confident you are practicing good hygiene.
- Clearly explain all forms and discharge instructions to help ensure patient compliance.

totally blindsided. “If I’m doing it, I insist they tell the entire hospital that mystery shopping will take place as part of their quality improvement or patient satisfaction plans,” says **Barbara Gerber**, MPH, CHE, a former hospital administrator who is founder and president of 10-year-old Devon Hill. “Usually, all department managers will know.” However, she adds, the ED manager would not know the “when” or the “who” of the visit.

Gerber says a project solely involved the ED would cost between \$7,000 and \$10,000 and involve three to five mystery shoppers. “It’s better with five,” she asserts. There are a few other companies that provide similar services, she adds, including Dee Peterson & Associates in Houston, and Perception Strategies in Indianapolis.

Bruce G. Jones, DO, medical director of the ED at Doctors Hospital in Columbus, OH, says, “As an ED director, I think this is a good thing. Anything that can provide valuable information to improve your process or the physical plant or interactions with patients is a valuable thing in your management role.”

Jones says there have been mystery shoppers in his department. As a physician, Jones reacts a bit differently to what he calls the “dishonesty” of the scenario. “As an ED doc, I may have seen one and not known it, and clinically thought it was really a patient,” he shares.

Gerber concedes that is a valid concern. “It always comes up in the ED. People ask why they should take care of three people who are not real patients when it takes time away from treating some very sick patients,” she says. “While that’s valid, the CEO will respond that out of thousands of visits a year, 70% to 80% may not be real emergencies; and if the ED can’t take care of three patients out of the 15,000-20,000 nonemergent patients they might see, then they *really* have a problem.”

How it works

Gerber, who says she has posed as an ED patient many times, says her company creates a variety of scenarios. She would not, however, provide much detail.

“A lot depends on the area we are in, but in general we use scenarios where the illness or condition is such that no one will be able to pick the fact that we are not real patients,” she says.

Some pseudoconditions are minor, while others are more major, she continues. “We are able to do this because we have a number of mystery shoppers who have conditions that might make it necessary to go through certain processes or procedures,” Gerber explains.

There are certain issues that show up often in

Sources

For more information on mystery shoppers in the ED, contact:

- **Barbara Gerber**, President, Devon Hill Associates, San Diego, CA. Phone: (858) 456-7800. E-mail: Barbara@devonhillassociates.com.
- **Bruce G. Jones**, DO, Medical Director, Emergency Department, Doctors Hospital, Columbus, OH. Phone: (614) 544-1810.

EDs, says Gerber. “We frequently find a lack of good communication — not letting people know how long they might expect to wait,” she notes. “People are left alone in rooms with no communication for 40 or 50 minutes.”

Gerber says she often has been handed a form and not been told what it was that she was supposed to be signing. “A lot of that happens with a busy ED, and staff forgets they really need to communicate,” she asserts.

Discharge instructions are another area where EDs commonly fall short, she continues. “Instead of having them explained in a manner the patient understands, the provider is gone very quickly, and the patient leaves not knowing what they are supposed to do,” she asserts.

Gerber has also observed a lot of little things that she would correct. For example, patients often are not offered a pillow, asked which gurney position they prefer, or asked whether they want the TV turned on. “These things would make them feel they mean something to the caregiver,” she notes.

EDs take note

Several EDs visited by Gerber or her staff have made important improvements following the visit. “Some EDs have developed systems where someone on the staff makes rounds on patients every 15-20 minutes — or they might have a patient advocate or volunteer responsible for making those visits,” she shares.

Her mystery shoppers frequently uncover safety issues, such as staff not wearing gloves or not washing or sanitizing their hands in front of the patients. “Maybe they do it between patients, but the perception is that it is *not* happening,” she explains. “When it has been brought to their attention, some EDs have had sanitizers installed in the rooms so the process is now more obvious.”

While Jones says he has not yet received any feedback from mystery shopper visits, he prefers to take a broader, more process-oriented approach. “We track productivity per doc every hour of every day, as well as a lot of other measures,” he says. ■

Final 2007 OPPS rule has some good news for EDs

Payments higher, 5-level E&M model adopted

The Centers for Medicare & Medicaid Services' (CMS) final rule for Medicare payment for hospital outpatient services in calendar year 2007 contains several new wrinkles that will benefit EDs, say observers. Among them is a significant boost in ambulatory payment classification (APC) rates.

"The APC rates went up considerably once you get past Level I," says **Barbara Marone**, federal affairs director for the American College of Emergency Physicians (ACEP) in Washington, DC. "The high end of ED rates is up to about \$325, as opposed to \$236 in 2006."

This increase is the result of CMS' decision to pay for five levels of services — instead of the current three levels — for evaluation and management (E&M) services performed in EDs and clinics — a move long advocated by groups such as ACEP and the American Hospital Association (AHA). **Michael A. Ross**, MD, FACEP, director of the Emergency Observation Unit at William Beaumont Hospital in Royal Oak, MI, helped negotiate the APC rate for observation with CMS. "This better captures the work performed in the ED," Ross says. Marone adds, "If you combine levels II and III and average them, you are also way above the mid-level for last year. We're just not exactly sure how CMS actually cross-walked the five CPT [Current Procedure Terminology] codes into the APC codes."

Overall, the new rule includes a 3.4% market basket update to Medicare payment rates for services paid under the hospital outpatient prospective payment system (OPPS) for 2007, as dictated by statute. However, after taking into account other factors that affect the level of payments, CMS estimates that hospitals will receive an overall average increase of 3%.

New rules for DEDs

The final rule also creates five new HCPCS (Healthcare Common Procedure Coding System) codes to describe hospital emergency visits provided in part-time dedicated emergency departments (DEDs) that are subject to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) but do not meet the more prescriptive requirements consistent with the CPT definition of an emergency department.

The new codes would enable CMS to gather data to determine the relative resource costs of the services

provided in these entities, as distinct from emergent care furnished in a facility that is accessible 24 hours per day, seven days per week. While gathering hospital cost data, CMS will pay for the new DED visit codes at the payment levels set for clinic visits.

"We are pleased with CMS deciding to just limit the new G codes," which are the temporary codes for data collection purposes, says Marone, noting that "we do not want the payment system to encourage a proliferation of less than 24/7 emergency facilities."

The G codes will be a financial burden for some hospitals, however. Marone gives the hypothetical example of a downtown hospital with a full-service ED that also has a suburban facility with no night shift. "Most hospitals have been billing them together," she notes. "Financially, they will take a big hit since ED payments have been pulled away from clinic payments, and the less than 24/7 facilities being paid at the clinic rate will make a pretty big difference."

Nevertheless, she emphasizes, "Despite the fact that some of our members work in these facilities, we are glad to see that the 'status quo' EDs will not have to go through burdensome changes." In the original proposed rule, there would have been new CPT coding for both types of facilities.

Change made to CAHs

The final rule also revises the critical access hospital (CAH) conditions of participation to allow CAHs to include a registered nurse that is on site as one of the qualified medical personnel available to perform an emergency medical screening. For this provision to apply, the nature of the patient's request for medical care must be within the scope of practice of a registered nurse as defined in applicable state laws. This revision conforms to the changes made to EMTALA regulations in 2003 and will align the emergency medical screening requirements in CAHs with those applicable to acute care hospitals.

Sources

For more information on the 2007 hospital final payment rule, contact:

- **Barbara Marone**, Federal Affairs Director, American College of Emergency Physicians, 2121 K Street N.W., Suite 325, Washington, DC 20037-1801. Phone: (202) 728-0610.
- **Michael A. Ross**, MD, FACEP, Director, Emergency Observation Unit, William Beaumont Hospital, 3601 W. Thirteen Mile Road, Royal Oak, MI 48073-6769. Phone: (248) 898-3080.

“We’re OK with that, given it is in line with the state’s scope of work for nurses,” says Marone. “There are probably those in our membership who are a bit concerned, but staffing is what it is, and you have to have somebody be that dedicated person.”

Observation underpaid?

One area where CMS falls short is in payment for observation services, notes Ross.

“It is good to see that CMS is providing fair hospital compensation for the observation of three conditions [chest pain, asthma, and congestive heart failure],” he says. “However, it would be much better to see them expand the list of conditions eligible for observation, as has been recommended by their own observation subcommittee.”

For those three conditions — and *only* these three — CMS offers separate APC payment for observation over and above the basic payment for the ED, which covers only use of space and nurses’ time. The APC payment for observation of those conditions is \$442.16.

Ross notes that the recommendation to remove the current restrictions on medical conditions that are eligible for separate clinical decision unit (CDU) payment also was made in the 2006 Institute of Medicine Report, “Future of emergency care services: Hospital-based emergency care: At the breaking point.” (See **coverage of that report in the July 2006 issue of ED Management.**) “I don’t know what else it takes for CMS to see the light on this issue,” he concludes. ■

Have clinical staff wear locator badges

At Swedish Medical Center’s ED in Seattle, clinical staff wear locator badges (Versus; Traverse City, MI) that identify where specific individuals are located, via a light above the patient rooms and on a tracking view of a computer.

If a patient is calling for his or her nurse, or if a doctor is looking for another physician, they are easily located. A call can be placed to the patient’s room, for example, to determine if someone else needs to respond or that a nurse already has responded, says **Judy Street**, RN, manager of emergency services. “This helps us avoid the ‘hunt’ process we all experience that is both time-consuming and frustrating,” she says.

Four tracking boards are in the ED, but even if nurses are away from the tracking board, they can locate someone by looking above the patient rooms. “In addition, if a patient’s light is flashing and the staff indicator light is on above the room or in the room, then there is no duplication of staff responding,” says Street. *[Editor’s note: Staff locator badges manufactured by Versus integrate with SimplexGrinnell’s 500 Nurse Call System. The cost of the badges is approximately \$60 per badge, but require hard-wired cable infrastructure along with computer hardware and software for a complete system. For more information, contact Barry Reimer, Electronic System Sales, SimplexGrinnell, 9520 10th Ave. S., Suite 100, Seattle, WA. 98108. Phone: (206) 291-1400, ext. 1441. E-mail: breimer@tycoint.com.]* ■

CE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. 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. ■

CE/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. ■

CE/CME answers

13. B; 14. D; 15. C; 16. A; 17. D; 18. C.

COMING IN FUTURE MONTHS

■ Care management: A new strategy to boost revenues

■ Web-based system displays current capacity for area EDs

■ Multivariable testing helps EDs weed out bad ideas

■ New EM residency being prepared at medical center

CE/CME questions

13. According to Joel Geiderman, MD, which of the following should *not* be done for a celebrity being treated in your ED?
- A. Making a secluded waiting room available.
 - B. Giving them better care than you give other patients.
 - C. Offering to register them under an alias.
 - D. Providing them with extra security.
14. According to Kathy Kotecki, RN, if an earthquake hits your area, you should:
- A. Get as many patients as possible outside the hospital.
 - B. Activate your telephone tree to bring in more staff.
 - C. Enlist the aid of maintenance and supply departments to make portable equipment available.
 - D. All of the above
15. According to Linda Fisher, MSN, a quality improvement project to reduce blood labeling errors included a number of key components except the following:
- A. Weekly review of cases where errors were made.
 - B. Re-educating staff on proper use of the computer system.
 - C. Reprimanding nurses for their serious errors.
 - D. Working with the information technology department to make the system less error-prone.
16. According to Danielle McCarthy, MD, caffeine abuse is potentially harmful, especially when:
- A. Caffeine is taken in conjunction with other over-the-counter drugs.
 - B. The patient is experiencing chest pains and heart palpitations.
 - C. The patient has more than eight cups of coffee a day.
 - D. The patient did not self-report, but was brought to the hospital by someone else.
17. According to Barbara Gerber, MPH, CHE, common customer service errors in the ED include the following:
- A. Not explaining discharge instructions adequately.
 - B. Inadequate hand washing techniques.
 - C. Letting the patient know how long a wait they should expect.
 - D. All of the above
18. According to Barbara Marone, the final 2007 hospital outpatient payment rule states that instead of paying for three levels of ED service, the Medicare system now will pay for:
- A. Two levels
 - B. Four levels
 - C. Five levels
 - D. Six levels

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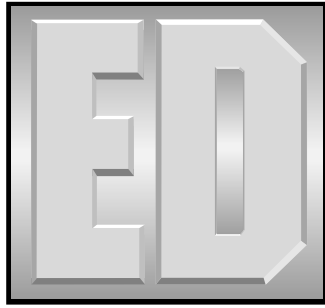
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