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The Abaris Group

The TAG Line

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Practical Guidelines for Improving ED Physician Productivity

Part 2 of 2-part Series

By James J. Augustine, M.D., FACEP

James J. Augustine, M.D., FACEP, is an emergency physician from Atlanta and serves on the Clinical Faculty in the Department of Emergency Medicine at Emory University. A consultant with The Abaris Group, he serves as Medical Director for the Atlanta Fire Department, which includes operations at Atlanta Hartsfield Jackson International Airport.

In the second of a two-part series, Dr. Augustine offers physicians some advice on improving their productivity in the ED.

In the last *The TAG Line* issue, Dr. Augustine described steps 1 and 2. Step 1, organize yourself and your work, detailed the importance of taking care of yourself as well as your daily tasks. Step 2, organize the ED to work effectively, listed the changes you can make to make your environment work for you and your staff. In the next three steps, Dr. Augustine continues to share his experiences and the helpful details you can incorporate into your everyday life that can make a difference in the ED.

Step 3: Improve Your Documentation

- WRITE NEATLY. Nothing slows you down or causes medical errors more than bad writing.
- Hire a scribe.
- Have the ED nurses carry a few charts with them, go see a block of patients, and have them do the order entry. You can go back and do documentation later.
- Use templates (one or two page maximum) to do your "clerking work" like Chief Complaint, Major HPI, Family, Social Hx, Review of Systems, most of the Physical Exam, and the results of diagnostic tests. Dictate the important part of the history and physical examination, key labs, medical decision-making, and disposition.
- Organize the discharge instructions the way you like them. That means you can write them yourself, have the nurse scribe them, use written templates, or electronic versions. Make sure they cover all the necessary bases for the patient.
- When you dictate, memorize

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Air Medical Ambulance Under Microscope

An Air-Evac helicopter was transporting a 71-year-old Texas man who was involved in an automobile accident while visiting relatives in Arkansas on Feb. 21, 2005. Shortly after takeoff, the helicopter experienced a malfunction and dropped 400 feet, killing the patient and critically injuring the three crew members on board.

The incident in Arkansas is one of the fatal crashes this year involving air medical helicopters. The crashes have probed federal regulators to investigate the cause as well as the benefits of medical helicopters.

Air medical helicopters were the target of a recent *Wall Street Journal* article (March 3, 2005). According to the article, air ambulance observers speculate on the

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Practical Guidelines for Improving ED Physician Productivity, *continued*

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"macros" in your head. Most of these you will learn from the older, good ED physicians in your group.

Step 4: Work Effectively with the Hospital's Medical Staff

- Know their referral patterns.
- Know when they want to be called on for their patients or new referrals.
- Anticipate phone calls needing to consult with attendings or residents.
- It will always be good practice to call medical staff before 5 p.m. on weekdays, before 11 p.m., or after 7 a.m. Individual medical staff members may have their own work schedule, but these are great numbers for the vast majority of the medical staff.
- Know your transfer hospitals and what patients are always going to be transferred out.

Step 5: Best Practices at the End of the Shift

- Know your best "end of shift management." Most physicians should not batch charts for dictations at the end of the shift. A few can do that well. Know where you do it best.
- As part of the end of shift management, don't turnover patients unless it is an extremely easy disposition. This is a dangerous risk management practice. If you have to leave the ED, have any important information on turnover patients called to you on your cell phone to complete the patient interaction safely and without burdening your partner.
- Get the family and patient to the bedside as rapidly as possible and talk to all of them at the same time. This gives you the whole story and lets everyone understand the expectations upfront. At disposition time, have everyone at the bedside so you can provide information in one setting.
- Negotiate pain medicine yourself. Don't expect the nurse to do it. Doing the negotiations before you leave the bedside allows you to automatically check for allergies to that medicine.
- When you are seeing patients who have medical backgrounds, ask them "What do you think is wrong? What do you want me to check for? What treatments do you want/need/expect?" In my opinion, there is no easier group to deal with, but many ED staff members treat other nurses, doctors, and paramedics who are patients with disrespect and generate very bad interactions.
- If you have any doubt, ask the patient to return for a recheck or call you back, especially on weekends and holidays.
- Address any service complaints immediately. Apologize, explain and resolve. It will not help to ignore complaints.

Update—Nurse Staffing Ratios

The nurse staffing issue has been an almost daily topic in the newspapers throughout California. The nurse-patient ratios signed into law by former Gov. Gray Davis in 1999 was challenged late last year when current Gov. Schwarzenegger postponed the new ratios for California hospitals' medical/surgical units and emergency rooms.

Gov. Schwarzenegger's order maintained the 1-to-6 ratio of nurses to patients, citing a severe nursing shortage and hospital closures as the reason for his emergency decision. Gov. Schwarzenegger delayed the law until January 2008.

Then in December, the California Nurses Association sued Gov. Schwarzenegger to enforce the 1-to-5 ratio that went into effect January 2004.

Recently, Sacramento County Superior Court Judge Judy Holzer Hersher tentatively ruled that Gov. Schwarzenegger had no authority to suspend the law. Judge Hersher stated that there was no evidence to support the administration's use of emergency rule-making. (*San Francisco Chronicle*) On March 15, Judge Hersher signed the order requiring hospitals to comply with the 1-to-5 ratio.

Following Judge Hersher's final order, Gov. Schwarzenegger announced that his office will use $13 million in federal funds to recruit and train more nurses to address the state's shortage. (*Sacramento Bee*)

Part Two
Revisiting California ED Nursing Ratios
May 4, 2005
10:00 a.m. – 11:30 a.m. PST

Join our expert panel for a 90-minute highly interactive Webinar, and learn the latest on the California nurse ratio law and the steps being taken by some EDs to respond to the law.

Learn effective strategies on:

- ED flow & decompression strategies
- Modeling demand & staffing
- Meeting peak demand needs
- Using alternative triage systems to meet the standards (e.g., Rapid Medical Evaluation)
- Maintaining compliance with the ratios & other regulations

You'll also:

- Hear from EDs & how they are approaching the issues with best practice strategies
- Hear a roundtable discussion of other CA hospitals on their compliance efforts
- Participate in an online Q & A session
- Participate in online automatic polling surveys

Scheduled to Participate:

Pankaj Patel, MD, FACEP, Chief, Emergency Dept., Kaiser Permanente – Sacramento, Roseville
Mark A. Alderdice, MD, CHW/West Bay Regional Director, California Emergency Physicians
Barb Payne, RN, BSN, MHA, Director, Emergency Services, Northridge Hospital Medical Center
Sara Small, Director, Access Care Services, Northridge Hospital Medical Center
Mike Williams, MPA/HSA, President, The Abaris Group
Other California EDs to be added

Additional details about the series can be found at **www.abarisgroup.com** or by emailing **webinars@abarisgroup.com**.

Study Reviews Cardiac Survival Rates in Major U.S. Cities

Sudden cardiac arrest is one of the major killers in the U.S., claiming the lives of 225,000 people each year (National Center for Early Defibrillation). But the immediate reaction of bystanders and treatment of an automatic external defibrillator (AED) can decrease the chances of death during the critical first six minutes.

The national cardiac arrest survival rate average is estimated at 6 to 10 percent. According to the National Center for Early Defibrillation (NCED), fewer than 5 percent of cardiac arrest victims survive in most communities. In contrast, survival rates range from 30 to 50 percent in communities with strong response systems.

In a recent study conducted by *USA TODAY*, 50 major U.S. cities are compared on the state of their emergency medical responses. An 18-month investigation found that most city EMS systems are fragmented and slow, resulting in a loss of about 1,000 lives a year that could be saved.

The report found that Seattle leads the country in saving 45 percent of its cardiac arrest victims; Boston follows closely with a 40 percent survival rate.

A bystander's reaction is important to the survival rate of a person falling to cardiac arrest. According to *USA TODAY*, the victim's chance of survival triples when a bystander performs cardiopulmonary resuscitation (CPR). Seattle firefighters train about 18,000 citizens in CPR a year, and has one of the highest "bystander CPR" rates in the nation (44 percent).

Administering CPR on a victim is critical until the arrival of an AED.

In actual situations featured in *USA TODAY*, Boston bystanders, including a hotel security guard and a business security representative, react to sudden victims by administering CPR until EMS members arrive.

Boston's support for its EMS has been the foundation for the city's improvement in survival rates. Citizens' commitments to learning the fundamentals of CPR and the Mayor's determination to strengthen its EMS system have been critical for the city's turnaround.

To review the *USA TODAY* study, *Six Minutes to Live or Die*, visit www.usatoday.com. You can find additional information at the NCED Web site, www.early-defib.org.

Summit to Train Bystanders

Save a Life Foundation (SALF) is hosting its 2005 Bridge the Gap Summit on April 28 in Illinois. A member of the U.S. Homeland Security's Citizen Corp., SALF will address the nation's need for bystander intervention during an emergency by incorporating pre-EMS training throughout the community.

The 2005 Bridge the Gap Summit will encompass the entire spectrum of natural and accidental disasters as well as terrorist actions. First responders and bystanders will be linked together in attempts to reduce the nation's social, economic and environmental upsets of disasters.

According to SALF, a person who goes into cardiac arrest has only four to six minutes before suffering brain damage or death. Half of the 2.5 million people who die each year of illness or injury could have been saved if bystanders had administered prompt basic life-supporting first aid prior to EMS arrival.

The Summit will bring together federal, state and local emergency experts, including Dr. Henry Heimlich (father of the Heimlich Maneuver), U.S. Fire Administrator David Paulison, and Illinois State Senate President Emil Jones.

The Bridge the Gap Summit is taking place on April 28 in Rosemont, Illinois, at the Donald E. Stephens Center. For more details and contact information, please visit the Bridge the Gap Summit Web site at www.salf.org/events/summit.

What is an Automatic External Defibrillator (AED)?

Early defibrillation is a critical determinant of surviving cardiac arrest. The advancements of automatic external defibrillators (AEDs) has placed these life-saving devices in businesses, schools and vehicles, increasing the chances of saving a life. AEDs are portable devices (about the size of a laptop) that read heart rhythms and deliver a shock if one is needed. AEDs now have visual and audio prompts to guide users.

According to an report by Frost & Sullivan, sales of defibrillators rose 35 percent in 2001 as companies bought 22,742 of the life-saving devices (*USA TODAY*, Feb. 25, 2005).

The combination of bystander CPR with the immediate administration of defibrillation is critical to surviving a sudden cardiac arrest.

The American Heart Association developed Chain of Survival in 1990, four links which must be initiated as soon as a person falls to sudden cardiac arrest: 1) early access; 2) early CPR; 3) early defibrillation; and 4) early advanced care. For information and to learn more, visit the Chain of Survival Web site at www.chainofsurvival.com.

Air Medical Ambulance Under Microscope, *continued*

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value of medical air transports, saying that the helicopters save few lives and can cost as much as 5 to 10 times more than ground ambulances; from $5,000 to $10,000 a trip.

According to the Association of Air Medical Services, the majority of air transports occur not from accident scenes but from hospitals. Doctors at smaller hospitals will assess and stabilize the patients before sending them to larger medical or trauma centers for further care.

Clayton Shatney, a Stanford University trauma surgeon, conducted a study of 947 patients flown to Santa Clara Valley Medical Center between 1990 and 2001. He found that 23 percent of the patients possibly benefited from the air transport.

In contrast, air transport volume is rising at an estimated 5 percent each year and the industry fleet has doubled since 1997, according to Tom Judge, president of the Association of Air Medical Services. (*Wall Street Journal*)

The discussion continues in both rural and urban areas where the benefits of utilizing air medical transport are weighed by stakeholders. Little debate exists on the importance of providing air transport in rural areas when patients need to travel quickly to a nearby hospital or trauma center.

On the other hand, Shatney concludes in his study that helicopter use is excessive in metropolitan areas where ground ambulances can transport patients at faster rates for a fraction of the cost. Shatney recommends implementing new criteria for helicopter deployment in urban areas.

The Federal Aviation Administration (FAA) proposed steps to improve flight safety, and the National Transportation Safety Board has been examining medical helicopter safety and plans to issue recommendations.

Visit the FAA at www.faa.gov and the National Transportation Board at www.ntsb.gov for updates and more information on the proposed recommendations.

Abaris—

Q: At The Abaris Group, we are often asked the question—what does "Abaris" mean? Well readers, we'd like to explain ourselves to you.

A: Abaris was a priest of the Greek god Apollo. With the help of Apollo, Abaris fled Scythia (in the Caucasus) to Greece to avoid a plague. Apollo gave Abaris a golden arrow ("dart of Abaris") which cured disease, told the future, and made its possessor invisible and able to fly. Abaris flew throughout the world curing diseases and telling the future until he passed the arrow to Pythagoras.

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ED Patients Meet Screening Before MD

Skyrocketing costs in America's EDs are forcing hospital administrators to develop more creative and efficient methods to see patients while staying financially afloat. A growing trend across the nation is to screen-out walk-in patients by assessing whether the patient exhibits a minor complaint that can be treated in nearby clinics instead of the ED.

The University of California-Davis Medical Center is one of the institutions establishing a policy in its ED to screen-out patients. The medical center will soon screen people who do not need emergency medical services and direct them to nearby community clinics rather than being treated in the ED. (*Sacramento Bee*)

Similarly, physicians at the University of Texas Medical Branch (UTMB) in Galveston are using new screening procedures to decide who needs treatment in its busy ED and trauma center. According to a *Houston Chronicle* article (Feb. 19, 2005), UTMB officials hope to reduce the average number of patients treated in the ED each day from 200 to 180 with the new screening measures.

The screening process at UTMB includes interviewing people about their medical problems shortly after arriving at the ED. Those with minor ailments will be told that they do not need emergency care and will be transferred to staff who can recommend alternate care. (*Houston Chronicle*)

The University of Colorado Health Science Center in Denver has been screening its patients since 2002. As UTMB has been doing and UC Davis plans to follow, the University of Colorado refers its patients to federally-funded local clinics for care. Although the initial change at the University of Colorado raised complaints from patients, the result was shorter waiting times in the ED and increase in efficiency.

Critics of the screening process worry that it will overlook seriously ill patients that need additional examinations beyond a quick review.

"Consistency is the key to complying (with EMTALA)," said Robert Derlet, a UC Davis physician who devised the screening methods. "You have to have strict medical standards that you apply to every single patient the same way." (*Sacramento Bee*)

The need for healthcare—emergency and non-emergency—is not being supplied at the same level of its demand. Oftentimes, the uninsured are not aware of the available community resources that offer low- to no-cost medical services. The examples seen at UTMB and the University of Colorado are reflections of the promising adjustments that are positively affecting the numbers in ED waiting rooms.

The Abaris Group continues

Webinar Series on Improving ED and Trauma Services

The Abaris Group is conducting a Webinar series throughout the year designed to assist emergency, trauma and other healthcare providers with effective strategies to use in the hospital and out-of-hospital environments. Led by experts in the field, the Webinars will provide participants with tools and tactics to use in the everyday healthcare setting.

Webinar Series Timeline

Revisiting California ED Nursing Ratios
May 4, 2005

Implementing New Product Lines in the ED
July 12, 2005

Enhancing Medical Staff Coverage for the ED and Trauma Center
September 7, 2005

Developing New ED Revenue
November 2, 2005

For more details and to register, visit www.abarisgroup.com. Educate your entire staff for one low cost. Pay only **$295** per site for one Webinar or learn about our special discounts when you register for two or more Webinars.

If you've missed our previous Webinars, visit www.abarisgroup.com to purchase a recorded version on CD.

News Briefs

Kaiser Permanente reports a 56 percent increase in net income from FY 2003 to 2004. The Oakland-based HMO increased its membership by 20,000 to 8.23 million members in 2004. (*San Francisco Chronicle*)

Winchester Medical Center in Virginia has become the 14th trauma-care center in the state's emergency care system. (*Richmond Times-Dispatch*)

A report released by New York University's Center for Catastrophe Preparedness and Response (CCPR) found that emergency responders are not getting adequate training and are not outfitted with the proper equipment to respond to terrorist attacks. The report, *Emergency Medical Services: The Forgotten First Responder*, can be found at CCPR's Web site, www.nyu.edu/ccpr/.

Florida state legislators have introduced SB 2434 (titled Driver Responsibility) and HB 1455 (titled Florida Driver Responsibility Law) to increase penalties on motor vehicle infractions. The additional funds generated from infractions (driving under the influence, driving without insurance or driving without a valid driver's license) will go to Florida's 21 trauma centers.

CMS recently announced the development of a technical advisory group that will review regulations affecting hospital and physician responsibilities under EMTALA. The group will help CMS develop rules to protect individual rights while minimizing unnecessary burdens on healthcare providers. The group will meet twice a year.

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Innovative Solutions for the Emergency Care Field

About Us

The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

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