

MISSION CRITICAL MOVING OUTSIDE THE WALLS OF THE EMERGENCY DEPARTMENT

Health care in the United States is delivered through a fragmented and complex system than can be difficult to navigate in the best of times. While the purpose of the emergency department (ED) is treat and stabilize in instances of acute episodic care, in reality the ED does a lot more than treat and release patients. The Follow-Up Office at Stony Brook Medical Center is an example of how one ED is collaborating with the local community to improve the health of its citizens.

A decrease in the number of health care facilities combined with an increase in the number of Americans without health insurance and an aging population have contributed to a significant increase in the number of people receiving health care through the emergency department (ED). The Medical College of Georgia is using telemedicine to keep nursing homes residents from visiting the ED unnecessarily.

In recent years, there has been a major push to better integrate the efforts of the wide variety of federal agencies that do similar work, the Emergency Care Coordination Center was established to examine and explore ways to regionalize the delivery of emergency care.

BEST PRACTICES: EMERGENCY DEPARTMENT FOLLOW-UP OFFICE

The emergency department (ED) is most commonly associated with acute illness and traumatic injury — heart attacks, car accidents, gunshot wounds, even anaphylactic shock — but the reality is that many visits to the ED are triggered by symptoms that stem from grave but undetected conditions. That, and the transient nature of ED patients, creates special challenges for health care.

“Due to the nature of the ED, patients are most often unknown to staff, and yet the physician is expected to examine, diagnose and treat potentially serious conditions and injuries in a timely manner without the ability to determine if the treatment was effective or the diagnosis correct,” observes Judy Specht, R.N., of Stony Brook University Medical Center in New York. “Patient satisfaction with the ED is directly related to wait time and the speed and ease of discharge, but diagnostic testing performed in the ED often provides results hours or days after the patient has left the facility. So providing professional aftercare services is essential.”

The importance of carefully reviewing and documenting the diagnostics administered to ED patients is why

Stony Brook University Medical Center has a designated team whose sole job is to manage communications with patients and their providers after they have been discharged from the ED.

Housed in the Follow-Up Office, a highly specialized team of RNs and clerks inform patients about diagnostic tests completed after discharge, communicate with primary care and other community providers, and field calls from patients who have questions or concerns after leaving the hospital. Established in a trailer outside the hospital nearly 20 years ago, the office now occupies its own space and has expanded its caseload from roughly 90 to 300 patient chart reviews per day. Staffed by two full-time registered nurses, two part-time registered nurses, and three clerks, the Follow-Up Office is open seven days a week, 365 days per year, for 10 hours per day. Salaries are paid by the Department of Emergency Medicine, which also purchases all supplies and equipment.

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Creating A Safety Net

Specht, who runs the Follow-Up Office, characterizes the program as “a safety net that diverts all aftercare issues away from the ED staff.” The tasks of the Follow-Up Office staff fall into one of two categories: calling patients to alert them to medical conditions identified by tests and scans and handling in-coming patient inquiries covering a wide range of issues, from concerns about wound care to requests for proof of their ED visit to satisfy a employer.

Having a designated team to deal with these calls is beneficial for two reasons, Specht says. First, it relieves physicians and other ED clinicians of the burden of phone calls and paperwork. Second, it provides a back-up set of eyes to review the patients’ medical charts to make sure the ED staff did not fail to record any symptoms or diagnostic results during the visit. Often, she notes, a test ordered to address one symptom will flag another, sometimes more serious, condition. The Follow-Up Office staff cross-reference the diagnostic results with the patient chart to look for things that may have fallen through the cracks.

“If something’s not written in the chart,” says Specht, “I’m going to assume no one discussed it with the patient.”

For maximum efficiency, the RNs handle specific tasks and delegate others to the clerks. RNs review every lab result and radiology report to identify abnormal findings not documented on the chart, in which case the patient must be called at home and informed. Work sheets are created to follow every result to completion, and 50-60 patient follow-up calls are made daily. A progress note is created for the purposes of patient education and becomes part of the permanent medical record.

Communicating with Patients

“There is an enormous amount of time spent on patient education when a patient must be informed of an incidental finding on a CAT scan or a positive culture,” Specht notes, saying patients might be told, for example, they have a lung nodule, Lyme Disease, or they are infected with an organism resistant to the antibiotic they were given in the ED.

If the nurse is unable to contact the patient after two attempts and the finding requires non-urgent intervention, a letter is sent to the home. If the finding requires a treatment that should not be delayed, a letter is sent via UPS. Or, if it is urgent the patient return to the ED and the patient cannot be contacted by phone, the police are sent to the home.

In addition, every patient who walks out prior to discharge, leaves without being seen, or leaves against medical advice is contacted to determine why they left and to make sure that they have the resources that they need.

“We are often able to convince patients who remain symptomatic to return,” Specht says. “If their needs are financial, we can provide contact with the financial aid department; if they’re social, with our clinical social worker. If they have no primary medical doctor or dentist, we can share clinic numbers with them and may even negotiate an appointment. An effort is made in all cases to determine if safety is an issue. Victims service referrals can be initiated if there is an issue associated with domestic violence. Tracking the reason for a patient leaving without being

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seen and addressing those issues has decreased our walkout rate significantly. We now generally have only about a 1% rate."

The Follow-Up Office also handles daily and episodic reports to the Department of Health, which mandates the reporting of events such as animal bites, Lyme Disease, pesticide ingestion, certain burns, sexually transmitted diseases, possible rabies exposures, diagnostic clusters (i.e. food borne illnesses), and evidence of pandemic viruses.

"The DOH calls daily to log how many patients are encountered each day," a practice that started after 9/11, Specht says. "Requiring ED physicians to monitor and report these findings would prevent them from providing essential care to patients and thus all reporting has been assumed by our program."

Clerks conduct basic telephone screening, provide non-clinical information to patients, and maintain records of each chart processed through the office. The bulk of their workload entails faxing all ED reports to each patient's primary care physician. The Follow-Up Office has a computerized fax for ED forms and has installed the names and fax numbers of almost all the physicians in the county. Clerks often have to send information to other counties or states, which then requires a call to the physician's office to obtain fax numbers. In addition, the test results are manually faxed, and the office is currently working on a system to allow computerized faxing of labs as well.

Finally, if the office staff need advice or counsel from a physician to address a patient problem, the main ED attending or pediatric ED attending physicians are available for consultation.

According to Specht, the office has changed considerably over time. In addition to a far larger caseload — resulting from a stark uptick in ED volume — all ED charts are now scanned as the patient is discharged and all forms can be immediately accessed via ED Sanchart, eliminating the need for staff to search for a paper chart.

Improving the Quality of Care

The Follow-Up Office is now seen as an important source of clinical expertise. All new RN staff members must spend a day in the office to learn about different types of concerns patients may encounter after discharge. In addition, all third-year ED residents spend 10 days in the Follow-Up Office. During this time, residents actually make some of the patient calls and spend time listening to concerns.

Specht, who has presented the Follow-Up Office on two occasions to the Emergency Nurses Association Scientific Assembly, has not identified a single comparable program in the country. According to Specht, similar offices do exist in other EDs, however their scope of work and resources is not as comprehensive as theirs.

Specht cautions hospitals to consider the costs and resources involved before launching a similar program, but she says the requirements are minimal. Staff are the greatest expense, and the requisite equipment is limited to phones, fax machines, computers and space. Specht also says, "it's critical to use only very experienced nurses with ED experience who are able to address a

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wide variety of patient concerns. Employees, both clerical and professional, need to possess knowledge and skills regarding patient education and must have a reassuring phone demeanor."

Specht says the Follow-Up Office has been well received by community physicians, who have been overwhelmingly positive in polls, as well as by patients, who express relief that the process for sharing information is simple and requires no cost or effort. Continuity of care is promoted. ED staff, she says, "has experienced relief from the numerous phone requests for guidance, information, clinical concerns, and requests to have information faxed to primary care physicians. In addition, ED staff have expressed relief that a second check may reduce the potential for liability."

Finally, notes Specht, "because we are the only department in the medical center that has the ability and charge to review every patient contact and all results, there have been many opportunities to initiate research and system change."

Judy Specht, R.N., Stony Brook University Medical Center, Stony Brook, New York

INNOVATIONS: USING TELEMEDICINE TO LINK NURSING HOMES TO THE EMERGENCY DEPARTMENT

The nation's health care system could greatly alleviate burdens on emergency departments by abandoning the old school of thought that it's necessary to touch someone to make a medical decision. According to emergency medicine expert Bruce Janiak, "most of the information comes from the medical history, and a little from symptoms and tests."

This insight, which gave birth to a relationship between the Medical College of Georgia in Augusta and the Georgia Partnership for Telehealth, an innovative new telemedicine program, has outfitted 10 nursing homes with the equipment necessary for emergency medical consults. Janiak, a professor of emergency medicine at the school, believes the use of these consults can reduce the number of nursing home residents sent to the ED unnecessarily while saving the health care system time and money.

Identifying the Problem

"Typically, a patient in a nursing home will develop what the staff feels is a possible medical emergency — manifested by heart rate or oxygen changes, a fever, or other symptoms — and he or she will call the nursing home physician on call, who will most often suggest the patient be sent to the local ED," Janiak says. "An ambulance takes the patient to the ED where they are evaluated, and in roughly four out of ten cases the patient is discharged, and an ambulance takes them back to the nursing home. During this episode of care, roughly \$2,500 is spent on transportation and ED costs.

"Nationwide, we're seeing several hundred thousand needless transports from nursing homes to local EDs for care that is not needed," Janiak adds. "We could make better decisions about whether those trips are necessary by having an emergency physician evaluate those patients via telemedicine prior to transport."

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Using Telemedicine in the ED

Janiak joined the Medical College of Georgia after the Georgia Partnership for Telehealth had already supplied five nursing homes with telemedical equipment for the purposes of primary care consults, and he expanded the program to include acute condition consults and an additional five facilities. Each nursing home has one room outfitted with a telemedicine transmitting unit comprised of a PC, a camera and a dial-in network through a T1 line, which provides "an excellent image and is reliable," Janiak says. If a nursing home resident develops an acute condition, a member of the nursing home staff can call the communications center at the Medical College of Georgia, which will in turn contact the emergency physician on duty to relay the request for a consult.

If an emergency physician is available to do a consult, says Janiak, "they can go over to the unit in the emergency department and do a visual consult and ask questions. There is equipment that allows us to look in the ears, listen to the chest, and look at the skin with a magnifying lens. The emergency physician then determines what, if any, treatment is needed or whether a trip to the ED is warranted.

The Centers for Medicare & Medicaid Services does not pay for teleconsults conducted in what it deems urban areas so the Medical College cannot partner with nursing homes in its vicinity. The Medical College of Georgia is 200 miles from the furthest nursing home in the program and 40 miles from the closest. , Janiak says. As a result, the Medical College ED sends the nursing home residents to the closest ED and does not make a profit from their admission. It receives payment for the consult alone.

The benefits of the program, says Janiak, are that the EDs near the nursing homes are not tied up with avoidable visits, and elderly patients do not needlessly undergo the stress of transport to and from the hospital. In addition, it is important to consider the substantial costs associated with transport and treatment.

In the year since the program has been established, says Janiak, 20 teleconsults have been conducted resulting in only 10 admissions to the ED. Given that the 10 nursing homes in the program send roughly 300-500 patients to the ED annually, Janiak says the potential to save time and resources is great if nursing home staff can be persuaded to use teleconsults more frequently. Often they forget to remind the nursing home physician that a teleconsult with the ED is available, he says. And some of the residents' primary care physicians request it not be used, he adds, because of lingering skepticism in the health care arena vis-à-vis telemedicine.

Making the Business Case

"The biggest thing an ED needs when starting this type of telemedical consult arrangement is an advocate who is willing to make it work and who is constantly encouraging people to use the technology," says Janiak. "Funding and equipment by themselves do nothing."

It will also be more widely adopted if the ED can identify organizations that will realize a profit by using telemedical consults. The costs are not negligible: each PC is roughly \$20,000, the cost of leasing a T1 line is about \$400 per month, and annual operating costs are roughly \$48,000, but any number of organizations could benefit from the arrangement, says Janiak. And there are also ways to reduce those costs. Janiak says he was recently successful in persuading the GA

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Partnership to abandon T1 lines for the Internet. The resulting cost savings “will be dramatic,” he says.

Janiak plans to publish a study on the Medical College’s use of emergency telemedicine consults in nursing homes when the number of interactions increases to the point they can yield statistically significant data. He is currently gathering data on the number of times the system is used, how many times an ED visit is not recommended by the emergency physician conducting the consultation, and what the outcome was for those denied a visit. He will compare that to the number of patients transported to the ED when the system was not used and analyze why it wasn’t used.

Meanwhile, Janiak says there is ample anecdotal evidence that telemedicine consults are tremendously beneficial to patients.

“We have had requests for psychiatric consults for acute mental status changes in nursing home patients,” he says. “It typically takes a nursing home weeks to bring a physician in to provide this type of consult, and we’ve been able to do it within a couple of hours.”

Moreover, he says, “every nursing home nurse I’ve talked to is thrilled about the fact that their patients are not being abandoned in the corner of an ED for a few hours waiting for a ride back to the nursing home. And they are thrilled that their patients have not had to leave unnecessarily an environment where they are mentally comfortable.”

Bruce Janiak, MD, FACEP, FAAP, Professor of Emergency Medicine, Medical College of Georgia, Athens, Georgia

PERSPECTIVES: TRIAGING THE EMERGENCY CARE SYSTEM

In recent years, there has been a major push to better integrate the efforts of the wide variety of federal agencies that do similar work, bringing together the many different offices and organizations that have been created to coordinate national defense, intelligence, financial oversight and yes, even emergency care.

In 2006, a report from the Institute of Medicine (IOM) recommended a federal lead office be created to focus and coordinate federal efforts relating to the emergency care system. As a result of this, then-President Bush signed the Homeland Security Presidential Directive #21 dealing with public health and medical preparedness which created the Emergency Care Coordination Center (ECCC), an office in the Department of Health and Human Services. The directive deals in large part with developing and improving public health, as well as increasing our nation’s capacity to handle a medical disaster. Developing and maintaining our nation’s emergency care system is a critical part of ensuring we are prepared for any response efforts to a disaster or crisis.

“Many fail to realize that the emergency care system permeates many different aspects of the federal government – including the Departments of Defense, Transportation, Veterans’ Affairs, Homeland Security, and Health and Human Services,” said Michael T. Handrigan, MD, FACEP, director of the ECCC in Washington, D.C. “While each of these organizations have programs that involve or engage the emergency care system in some way, previously there had been no federal agency primarily concerned with coordinating the issues affecting the emergency care system.”

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Coordinating the Nation's Emergency Care

Since its inception the ECCC has been focused on laying the groundwork for a manageable, 21st century national emergency care system. Working with stakeholders and policymakers Dr. Handrigan and his team have partnered with the National Quality Forum (NQF) to explore a framework for developing and endorsing quality care measures in the emergency care system.

"Part of the IOM's report suggested the need for a regionalized approach for the emergency care system as well as a stronger system of accountability, which means having the right metrics to accurately and objectively determine how things are functioning in different emergency departments. "Through our work with the NQF, we are developing metrics we hope will fill this role, and will help us foster the sort of regional, measurable and accountable emergency care systems that everyone agrees we so desperately need."

Dr. Handrigan also says that the area in which the ECCC should be able to make the biggest impact is by creating and fostering awareness in the federal government of the need to align programs that deal with the emergency care system. "If we bring our federal partners together so they can more effectively collaborate, we can have a meaningful effect on the state of emergency care in America," said Dr. Handrigan.

The ECCC also is working to create awareness within the greater health care community regarding the role and function of the emergency care system.

"Our nation's emergency care system serves as the point of entry into the health care system for a large number of people," said Dr. Handrigan. "Those who are not directly involved may not appreciate the immense burden we place on the system everyday – as well as the absolutely critical role we expect it to play in the wake of a crisis or disaster."

Dr. Handrigan acknowledges that the ECCC cannot tackle every issue confronting emergency care, and says the challenge is to find areas where they can feasibly make changes and improvements, while ensuring their work is as meaningful as possible.

"Some might view the ECCC's role as refocusing the federal government on emergency care system issues, but I prefer to think of it as providing the federal government with an opportunity to find focus. We are not going to be taking over the jobs of any of our federal partners," said Dr. Handrigan. "Rather, in a post-Affordable Care Act world, it is critical for our government to be able to identify opportunities to collaborate, leverage, and align the myriad of organizations and agencies who work with and around emergency care, in order to create a federal agenda for the entire emergency care system."

This, it would seem, is the ECCC's mission, and while they have more work to do, they seem to be off to a very good start. While their challenges are daunting, the opportunities they have to strengthen our nation's emergency care system are great.

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FOCUS ON URGENT MATTERS LEARNING NETWORK II: GOOD SAMARITAN HOSPITAL MEDICAL CENTER

Hospital Metrics
Location: Suffolk County, NY
Number of Beds: 437
Affiliations: Mount Sinai Hospital and Mount Sinai School of Medicine
Ownership: Non-Profit, Catholic Health Services of Long Island
Number of Emergency Department Visits Annually: Approximately 100,000

Good Samaritan Hospital is a high-volume, Level-II trauma center, with both an adult and pediatric emergency department (ED). Patient flow has always been a concern for this busy community hospital that seen significant growth in volume in recent years. "For Good Samaritan, participation in Urgent Matters Learning Network II provided a great opportunity to gain access to the collective brain trust of other hospitals working through patient flow issues," said Susan Dries, RN, Vice President Quality/Care Management, Good Samaritan Hospital Medical Center.

"In addition to a large ED and the ability to leverage a state of the art electronic medical record, Good Samaritan also had a hard working staff that was open to change and innovation", noted Adhi Sharma, MD, FACMT, FACEP, Chairman Emergency Medicine, and Co-Project Director of Urgent Matters.

Since starting work on the Urgent Matters Project, the Good Samaritan team has seen enormous success with their chosen change strategy of improving the time to treatment for 'MidTrack' patients. Recognizing the relatively high morbidity levels of non-urgent or mid acuity patients returning to the ED after leaving without being seen on a previous visit, the hospital chose to focus on a solution to this problem. The innovation is similar to Fast Track – patients with select chief complaints within emergency severity index (ESI) level 3 triage category are evaluated by a dedicated team and the diagnostic work-up is begun immediately upon arrival. The strategy so far has been a successful as left-without-being rates for ESI level 3 patients has decreased from 7% to 4%. Left-without-being rates for the entire ED have decreased from 2.4% to 1.7% since the addition of MidTrack.

"The data collection, status updates, and required reports kept the project moving forward," said Sharma when asked about the benefits of being involved in Urgent Matters LNII. He also explained that the team benefited greatly from the opportunity to share information, experience, and skills with others working on the same issues.

The benefit of the Urgent Matters LN II initiative to Good Samaritan lies not only in the specific improvement strategies and measures that the hospitals will produce, but also in the way participation in project like this changes the hospital culture. "The opportunity to utilize flex-space in the development and implementation of the project was critical," said Sharma. "The way that we were able to re-purpose existing space and provide the resources and staff

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necessary to create MidTrack speaks volumes about the adaptability and innovative nature of our ED and its staff," explained Sharma.

The support from senior hospital administration was vital in the development and implementation of the project. Cooperation from top officials also gave the project increased importance and encouraged buy-in from staff across the ED. "As a result of Good Samaritan's participation in the Urgent Matters project, there has been a greater awareness of crowding as a hospital-wide issue, not just an ED problem," says Dries.

Dries noted that when forming their Urgent Matters LNII team they wanted to establish a core group of people encompassing many different aspects of patient flow across the ED. The hospital's LNII team included ED nurses and physicians, as well as representatives from security, and the information technology departments.

The hospital hopes this project will have larger implications for future ED redesign at hospitals everywhere. "The ideas of flex-space and MidTrack are hardwired into our hospital's modernization project," noted Sharma. With the dedicated space and staff the hospital will be able to increase the hours of operation for the MidTrack and open up treatment to all ESI 3 patients.