

THE EMERGENCY HOTLINE



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The ESS "Emergency Hotline" provides physicians and hospital administrators quarterly updates on issues relevant to emergency medicine.

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Emergency Department Updates

By Peter Way, MD

As all of you now know, ESS has been staffing a few more specialty hospitals in the last few months. The reason for surgical specialty hospital ER staffing is that in the past two years, the Texas Department of Health and Human Resources has been enforcing the requirement that specialty hospitals operate with the same ER standards as all other hospitals. As Medicare and Joint Commission surveys begin to target these specialty hospitals and their ERs, the rules have become more strict. Here are some updates.

Stringent time logs are now required to prove the presence of 24/7 ER physician coverage. ER physicians are expected by the regulatory agencies to remain on the hospital campus until relieved or coverage arranged for special circumstances (ambulance ride with a pregnant patient, etc), just as in any hospital.

In emergent changes of

inpatient condition, the ER Physician in a specialist hospital is required to act emergently as a hospitalist or ER physician to stabilize that patient's condition. EMTALA laws no longer apply to inpatients, and you cannot legally convert a patient from an inpatient to ER patient status, though you may treat the patient in the ER as an ER physician. In these cases a memorandum of transfer, consent to transfer, and acceptance from the receiving physician and hospital must still be obtained. Obviously there is not much real difference despite the laws. If you do act as a hospitalist, please make sure to fill in a hospitalist timesheet, and fax it to HCC or ESS to be paid.

Many of these specialty hospitals are planning to treat more pediatric patients in the future, so we should all be planning to take PALS in the near future to remain on staff. As always, please

make sure your BLS, ACLS, and ATLS are up to date. Luckily, most of these courses are now available online.

Please note that T-Sheets now require an extra sheet for chest pains, syncope, MIs, and CVAs. All ERs, radiology departments, and inpatients are now also required to provide the patient and their PCPs a drug reconciliation form. This form requires an exclusive document with all drugs, dosages, intervals, and new changes of a patient's medications. The hospital is required to provide a copy to the patient and the PCP. As an ER physician, it is your duty to make sure this form is completed prior to discharge.

Changes are rapidly being legislated and implemented. Real challenges await all of us. Despite our opinions and perceptions, the reality of changes is certain. I know that we can see the rewards of new changes if we comprehend and comply with them.

Let's Go Over It Again

By Leigh Dillard, MD

What makes a good/great ER physician? I have written about this subject before and have seen the landscape change. I am attempting to share with you what I hear from administrators, ER nurses, and patients when they complain about ER physicians. Of course, in the medical field one rarely hears compliments, so I have to speak in terms of the negatives I hear.

I know our ESS physicians are overall exceptional. I know this because of the limited number of complaints I receive about you. Our physicians' malpractice track record is extremely low considering the sheer number of patient contacts you are involved

in.

The intangibles you may or may not have are what make your reputation in the ER business. I thought it would be good to go over these again in our newsletter. Patients and their families want you to care about them and their welfare. How do you convey this air of caring in the face of never ending streams of patients? Several things seem to work well over and over.

1. Give your undivided, unhurried, attention to listening to their story. This includes eye contact and a concerned facial expression. Ask a few questions to clarify the history and listen intently to their response. If

you are good you can do this in 3 minutes and get all the information you need and have the patient feel as though you have spent a long time with them.

2. Touch the patient. Placing your hands on them for the expected examination confirms to them that you are thorough in your search for the diagnosis of their malady.

3. Explain your findings and your treatment decisions. Make this short and sweet and in laymen terms. Answer a question or two that they may have, and then have the nurse finish up.

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Rethinking ER Wait Time Equation

By Ron Weiss

“Patients are often unaware of what makes an emergency department so busy, often leading to patient frustration during long waiting sessions.”

One of the more common complaints filed in patient satisfaction surveys revolves around waiting times. Patients are often unaware of what makes an emergency department so busy, often leading to patient frustration during long waiting sessions. Patients spent an average of 4 hours and 5 minutes in ER waiting rooms across the US last year, up five minutes from 2006, according to a report by Press Ganey Associates. While some of this time is part of triage, this is still time spent in the hospital.

The frustration that patients feel while waiting has a major effect on their overall satisfaction with the hospital. Physicians and administrators are being held accountable more and more each year for patient satisfaction scores. So, what can your hospital do to alleviate a bulk of the waiting time?

One hospital that has attempted to revolutionize patient flow and has shortened patient wait times is Avera McKennan in Sioux Falls, SD. South Dakota happens to be the state with the shortest wait times last year (see map). The hospital just built a new ER with efficiency in mind. Before planning the renovation, the hospital's administration

interviewed ER medical staff to get suggestions and videotaped staff and patients (with consent) to identify where the lag times were. Then, they designed the ER with changes in mind:

1. Triage Improvements: The hospital condensed the questions that triage nurses ask, made the route patients travel within the department more direct, and started requiring triage nurses to assign patients to their next nurse — rather than waiting for somebody else to do it at the next stop.

2. The Next Step: After triage, patients see a nurse and doctor at the same time, rather than the old method of nurse first, doctor second. If the nurse is not ready, the doctor can treat the patient without waiting. For common ailments, the hospital follows set protocols if a doctor is delayed. For instance, patients with likely fractures get X-rays while they wait.

3. Universal Rooms: These are equipped with bedside supplies that allow the hospital to care for 85% of problems patients arrive with at the ER. Other supplies can be rolled to patients on carts. The idea is to keep patients from having to move unnecessarily, and to prevent employees from getting

in each others' way on the floor.

4. Bedside Paperwork: Registration functions such as getting patients' addresses and payment information take place at the bedside, after care has been started.

5. Admission Analysis: The hospital did a thorough review of where patients go after the ER. Each department is prepared for the average amount of daily admissions so that beds are available to get patients out of the ER as quickly as that clinical decision is made.

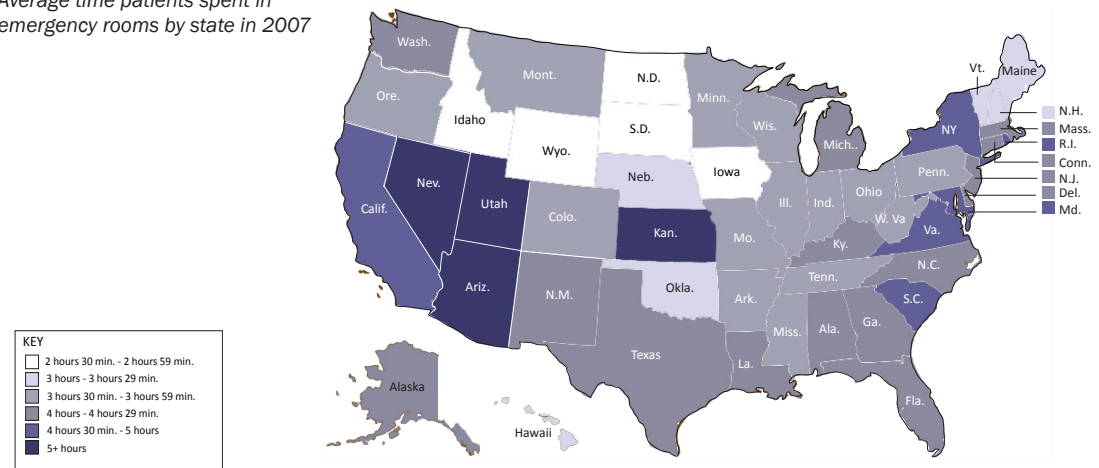
The hospital cut its average times in the ER by about 20 minutes since early 2005. Last month, the figure was just shy of the 2-hour mark, which beats all the states' averages.

Many of these processes are easy to implement institutionally. For the most part, they don't require investments in new equipment or staff. By simply allocating resources in an efficient way, ER's can drastically improve the patient's experience by reducing the time patients wait.

Is your hospital doing anything unique to improve ER wait times? If so, send to me at ron@emergencystaffingsolutions.com for publication in the next news letter.

Waiting Game

Average time patients spent in emergency rooms by state in 2007



source: Press Ganey Associates

Rat Trouble in the Oil Patch

By Leigh Dillard, MD

The rising price of oil and gas has dramatically increased the number of drilling rigs operating in the oil patch. I thought I would alert you to include in your history taking whether or not the patient works in the drilling industry. A large work force is currently located on land based drilling rigs. This is important to ER physicians because of the unique work-related problems these laborers present emergency rooms with.

The typical roughneck works 7 days on and 7 days off. During the 7 days on they live in mobile trailers with other workers. Men are not known for their housekeeping skills and the living quarters are usually less than hygienic. There are dirty plates, crumbs from food, open partially filled drink containers, and other things lying around. These things draw rats. Rats have feces, urine, and fleas that are all sources of disease in humans. Rat borne diseases are showing up in these

workers in the ER setting.

Please be on the lookout for diseases such as Hanta virus, Leptospirosis, Salmonellosis, and Rickettsial diseases. I have treated both Hanta virus and Leptospirosis from this type exposure in the last 6 months.

Be alert for the young, and typically healthy, male roughneck presenting to the ER with a febrile "flu like" illness with a history of temperatures in the 103 to 105 degree range. Their WBC may be normal. They may have associated jaundice, azotemia, uremia, rhabdomyolysis, dehydration, and pulmonary infiltrates and are usually much sicker than they appear. The cases I treated ended up on ventilators and hemodialysis before they recovered.

Hanta virus, Leptospirosis, and Rickettsial diseases can be diagnosed by serology if ordered.

I am sure you are all seeing increasing numbers of skin and

soft tissue infections. These are also occupational diseases for the roughneck. Skin abscesses (carbuncles) are best treated by I&D, iodoform gauze packing, and appropriate antibiotics with close follow up. Trimethoprim/Sulfamethoxazole plus Rifampin is an effective regimen usually, if accompanied by I&D. First generation cephalosporins (Keflex) are generally ineffective.

There are traumatic risks on the oil rig also. A frequent injury is a smashed distal phalanx with nail disruption, cuticle laceration, and distal phalanx fracture. Burns and other lacerations are also common. Occasionally the trauma is severe. Please be prepared for these instances and react accordingly.

In the meantime, ESS will try to negotiate good pay for you so you can pay for your gasoline to get to work.

"A large work force is currently located on land based drilling rigs. This is important to ER physicians because of the unique work-related problems these laborers present emergency rooms with."

Post TURP Hyponatremic Syndromes

An Urgent and Timely Review

By Peter Way, MD

As I began reviewing recent ESS charts, I began to realize that very few of us are aware of Post TURP Hyponatremic Syndrome. This is a diagnosis we cannot afford to miss or ignore. We will continue to face this syndrome more often as surgical hospitals begin to do more of them in the push to diagnose early prostate cancer.

Since three months ago, ESS physicians have treated three cases of it in the Dallas/Fort Worth area, usually without realizing it. It is different from the usual post-obstructive diuresis, UTI, or hemorrhage. Most internists think of SIADH, IVF overload, diuretics, CHF, renal failure, and Addison's Disease when confronted with post-TURP Hyponatremia, but in 5-10% of patients, it is actually PTHS (Post-TURP Hyponatremia Syndrome).

PTHS occurs because of absorption of bladder irrigation solution during and post TURP

and underlying medical problems. As mentioned, it occurs in 5-10% of post TURP patients.

Symptoms include confusion, HA, dyspnea, bradycardia, nausea predominately. Also agitation, temporary muscle tremors, HTN, lethargy, visual changes are reported. Signs include rales and occasionally wheezes, bradycardia, respiratory distress, slowing of papillary responses. EKG shows bradycardia widened QRS, elevated ST segments, and inverted T-Waves mimicking MI or PE. Lab studies often reveal hyponatremia and high ammonia levels. CXR reveals fluid overload.

Pre-surgical risk factors of PTHS include MI, pre-surgical hyponatremia, COPD, CHF, anemia, and hepatic disease.

Diagnosis consists mainly of ruling out emergent syndromes such as SIADH, CHF, renal disease, diuretics, fluid overload and Addison's Disease. If necessary,

rule out coronary artery disease and pulmonary embolus. Then consider PTHS. PTHS is treated with oxygen, cardiac monitoring, IV Lasix if blood pressure is sufficiently high, and Hypertonic IVF (3% Na) until a sodium level of 125 is reached, and frequent laboratory monitoring. Patients with chronic hyponatremia or the very elderly should be slowly brought to normal sodium to prevent catastrophic pontine demyelination syndromes.

Newer research suggests that post-TURP COX 2 inhibitor therapy may be able to prophylactically treat PTHS, but this treatment has not yet been endorsed by the FDA nor is it considered a standard of care.

I hope this brief, but timely and important review will provide you with another tool to treat the growing number of post-TURP patients that we are being asked to evaluate and treat.

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Story ideas or comments?

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Let's Go Over It Again

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4. Avoid confrontational behavior. Avoid long lectures about their shortcomings as human beings or lifestyles. "You need to stop that smoking," sounds much better than "you are killing yourself, what do you expect me to do about it?"

5. Treat the patients you see just as you would like your family member or yourself treated in a similar situation.

This all sounds so simple and actually it is just that simple. The patients and their families pick up immediately when you are rude, condescending, angry, frustrated, passive-aggressive, short, curt, cold, uncompassionate, or robotic. You can be the world's greatest physician in diagnosis and treatment and it won't matter. All the patients and their families will remember is your attitude. If the outcome is bad you have just set yourself up for revenge in the

form of a legal action. Patients will rarely sue a physician they like.

Several things are important to hospital administrative personnel:

1. The timely completion of the medical record of the ER visit is paramount. Delayed charting throws everything off schedule from coding to billing to collections for your service.

2. Your attitude sets the mood of all who work the shifts with you. The patients and families pick up on this tension and feed off it.

3. Compliance with hospital procedures of the particular hospital you are working for can seem annoying. Remember that is how they do it there and your job approval will be much better if you adhere to the requests of each hospital.

4. Your skills in critical situations should be sharp and allow you to take charge of the situation. If you

find yourself taking a back seat to EMS, nursing, respiratory therapy, etc., then you probably need to refresh some of your skills. You should be the leader (captain of the ship) with good skills. Inspire confidence in every situation.

5. Turn around time is measured in every hospital we serve. Some of our physicians need to see why they take so long in comparison to their peers in completing the encounter. When you waste time making a final diagnosis and treatment plan, you increase the waiting time of the next patient and those to follow. Lengthy "toning up" treatments in the ER take up examination beds. Contract hospitals would rather these patients be admitted to observation or acute care status.

Overall, keep up the good work. ESS appreciates your cooperation and efforts to make us look good.

The Problem of Drug Seekers

By Peter Way, MD

No matter which ER I work in, I inevitably see the same chronic migraine and backache patient over and over every week. They always promise to see the pain specialist tomorrow, if they could just get a shot to get them through today.

Often they are loud, making threats, and acting dramatically. They are allergic to all non-narcotics, non-urgent, and speak insultingly about you and other doctors.

If you give them medications they always lose them or just want a refill. They will invariably file a complaint about you. If you think about them too much, you will probably be very unhappy. What can you do?

I think we should first look at the facts. First, most of these patients truly believe they feel physical pain, or know that they are addicted, but do not know a way out. Most are more than willing to discuss your concern of addiction, provided you have another suggestion other than just referral. Only a small number actually hoard or sell their drugs. Usually the Medical Board will not investigate you for refusing narcotics to a chronic pain patient as long as you offer them some non-narcotic alternative and follow-up, but will investigate if they get

too much medication or become addicted.

A small number of drug seekers will file complaints to the administration, and your fate will largely be determined by the Medical Director or Chief of Staff. Usually I will defend you, provided that the chart is complete, the diagnosis is reasonable, you addressed the issue in the chart, adequate labs and X-Rays were ordered, and no overt and recurring insults were uttered. The most important issue I find which leads to a bad outcome is demeaning or insulting comments, and missing a true medical emergency because no labs or X-Rays were ordered.

Usually if I know the patient well, and am convinced no new or emergent condition exists, I will politely, but firmly offer only non-narcotic medications and physical therapy with specialist referral. I will firmly bite my lip if any nasty comments begin to well up, and simply state that I will not provide narcotic treatments. Then I will answer a few pertinent questions. This is followed by good documentation. If I have any doubts or suspect any change, I will run laboratory and X-Ray data and usually a urine drug screen to avoid

any catastrophic errors. If I think the patient is truly experiencing pain, even a small exacerbation of a chronic problem, I am obligated to consider a one time pain treatment or document why I did not. First time encounters with a pain patient should always be approached with the goal of finding any emergent problem with laboratory and radiologic studies, and treating the pain. Any other approach reeks of Malpractice.

I frequently find it helpful to obtain an old chart, call the patient's PCP, or run a urine drug screen if the patient begins to act ugly. If they refuse any studies, I make sure they sign an AMA form. I also document all pertinent thoughts, and make sure I do not say anything derogatory or unnecessary to the patient. Then I consult the nurses to determine if they are of like mind, or if they have any suggestions or differences. If things truly get nasty, I will confer with the on-call physician for consultation and agreement or admission and follow-up help.

When all is done, I tell myself I did all that was expected, and all I could. I try to forget the encounter and look forward to helping other patients.