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A More Effective Approach for Managing Behavioral Health Emergencies

By Dorothy Brooks

Some EDs struggle with boarding problems driven by many patients presenting with behavioral health issues. These patients might wait in the ED for hours or even days before they are connected with appropriate care, tying up precious resources and leaving everyone frustrated.

Often, law enforcement officers and EMS crews are dispatched to the scenes of behavioral health emergencies. EMS might transport these patients to the ED. Others might be taken to jail. But in recent years, stakeholders in Dallas have looked closer at these scenarios. At a time when resources are stretched thin, hospital staff, police officers, and communities all are asking questions.

Innovators from multiple entities have fashioned a new approach to the way behavioral health emergencies are handled. The collaborative effort is producing results in terms of accelerating appropriate care to patients while also diverting significant case volumes away from EDs and the criminal justice system.

The impetus emerged several years ago when Dallas-based Meadows Mental Health Policy Institute (MMHPI) approached Dallas Fire-Rescue to gauge interest in supporting a novel initiative aimed at providing better service, preserving scarce resources, and potentially producing better outcomes. **S. Marshal Isaacs**, MD, is medical director for Dallas Fire-Rescue and an emergency physician at Parkland Hospital. Isaacs was familiar with a program in Colorado Springs called the Community Response Team that was addressing mental health emergencies by pairing a community paramedic with a mental health peace officer, a licensed mental health practitioner, and a Crisis Call Diversion Program. He thought something similar might be a good fit in Dallas.

"I suggested to the [MMHPI] that they consider working with us to develop a grant to support the development of what became known as a RIGHT [Rapid Integrated Group Healthcare Team] Care team in a grant-funded pilot project," Isaacs recalls.

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Under the RIGHT proposal, appropriate patients would be paired with a Dallas police officer, a Dallas Fire-Rescue paramedic, and a behavioral health clinician from Parkland Hospital.

"It took some time to develop that, but, ultimately, we launched one RIGHT Care team that was available to respond to behavioral health emergency calls in the part of Dallas that historically had the highest volume of those calls," Isaacs reports.

During the pilot phase, investigators determined the team could collaborate safely and effectively while also producing data to show this integrated team could deliver outcomes collaborators were looking for: better outcomes for behavioral health patients and less reliance on EMS, EDs, and law enforcement.

"In addition, behavioral health patients would no longer have to go to jail for minor civil disturbances that could now be viewed as behavioral health issues rather than criminal issues," Isaacs adds.

Instead, many of these patients could be treated in place by the RIGHT Care team or directed to appropriate behavioral health resources in the community. In the first 18 months of operation, a RIGHT Care team responded to more than 4,000 calls in Dallas's south central police district, diverting about 900 patients from the ED and close to 500 patients from jail. In addition, arrests were made in fewer than 2% of cases.

Armed with results from the pilot project, in 2018 Dallas officials funded the program and expanded the partnership to include the North Texas Behavioral Health Authority. The goal was to eventually form 10 RIGHT Care teams that could respond to behavioral health emergencies throughout the city.

As of the end of 2021, there were seven teams, one for each of seven police districts, operating 7 a.m. to 11 p.m., according to **Kurtis Young**, MSSW, LCSW, director of social work at Parkland Hospital.

In terms of volume, Young says RIGHT Care teams respond to anywhere from 850 to 1,000 mental health calls every month. "In [November 2021], that amounted to about 54% of all mental health calls that happened during the times when RIGHT Care teams were operating," he says. "The goal is to respond to 90% to 95% of these calls."

There is a wide range of circumstances RIGHT Care teams encounter. For example, the issue may be as simple as a patient needing a refill on his medication or a report that someone is acting strangely on a street corner and may need assistance. At the other end of the spectrum, RIGHT Care teams encounter patients who are suicidal, in withdrawal, or are struggling with other urgent mental healthcare needs. "We might have as much information as a name, date of birth, and a whole history of hospital [utilization], or we might have absolutely no data," Young says.

If patients already are working with a mental health provider or a case worker, RIGHT Care team members can contact the relevant individual while they are on scene and obtain guidance on how to proceed. Team members also can help reconnect patients with care that may have lapsed.

When no provider or medical information are available, the RIGHT Care program has established agreements with outpatient mental health providers so patients can be seen that day.

"RIGHT Care gets preference. If we need to bring someone into an outpatient behavioral health center for an assessment by a psychiatrist about medicine adjustments or to get put on medication, [the team] can get it done that day," Young says. "We will take [the patient] there, and we can even bring them back home when they are done."

How do 911 dispatchers know when to send a RIGHT Care team to the scene of a call as opposed to a traditional ambulance or law enforcement response? Parkland has placed behavioral health clinicians in the 911 call center to guide dispatchers when they receive what appears to be a mental health emergency call. Young acknowledges that discerning what is going on in some cases can be difficult.

"Someone might say that their husband is acting crazy, but what does that actually mean?" Young offers. "Does it mean that [he] has an actual mental illness, or does it mean there is a domestic dispute?"

In such cases, the dispatcher typically will patch the behavioral health clinician into the call so he or she can learn what is going on. "It is hard to get [the decision] correct 100% of the time," Young admits. "Sometimes, we have to reclassify [the calls]."

Dispatchers tend to become better at managing mental health calls with more experience; regardless of the learning curve, the skills the behavioral health clinicians bring to the call center are essential. "Some of this stuff takes years of experience in working with the mental health population to really understand what is happening, what these diagnoses need, and how everything connects," Young says. "Bringing in professionals who understand the complexity of the mental health system ... and how to get people to the right level of care is really important."

In fact, for some low-acuity cases, there might be no need for any EMS or law enforcement response; the patient may only need to be referred to appropriate resources. Isaacs notes this type of response is one of the enhancements the RIGHT Care program has brought to the 911 process.

If there are any concerns regarding safety or property at the time of the 911 call, the dispatcher will send a Dallas police unit to the scene first to check for any threats. Then, once the scene is deemed safe, a RIGHT Care team will respond. At this point, the police officer who arrived on the scene as part of the RIGHT Care team takes charge of team safety while the paramedic assesses the patient.

The assessment consists of a basic clinical algorithm that requires the paramedic to check mental status and vital signs, along with any signs of trauma or other potential life threats. Paramedics will take a blood glucose reading when appropriate. "If the patient meets all those algorithm parameters, then [the paramedic] turns the patient over to the behavioral health clinician who will have access to pre-existing behavioral health records, if they exist," Isaacs says.

If the patient is known to the system, the clinician can determine what medications the patient has been prescribed and the outpatient treatment plan. However, if there are no such records, the behavioral health clinician will develop a treatment plan, which may involve a simple referral to outpatient resources. The team also may transport the patient to a community behavioral health clinic or hospital. If, during the paramedic's assessment, a patient records a persistently elevated heart rate, complains of chest pain, or exhibits any other medical concerns requiring urgent attention, the paramedic will request an ambulance to transport the patient to an appropriate ED.

Young says there were some early struggles to ensure patients who had been assessed by a RIGHT Care team received a warm handoff when they arrived in the ED. "Now, [ED providers] know what RIGHT Care is, they know that RIGHT Care has already assessed these patients, and they know what the RIGHT Care team thought," Young says.

One of the keys to the successful implementation was the fact each partnering organization had a strong stake in making progress in this area. "Parkland had to buy in, but we have the busiest ED in the country. Anything we can do to prevent someone from coming to our ED [who does not require that level of care] is a positive thing, especially when it is not an immediate emergency," Young says.

With all the focus in recent years on criminal justice and police reform, the Dallas Police Department recognized a need for improvement, too.

"They had buy in to change how they were handling mental health phone calls, and they talked pretty openly about that," Young says. "[Police] knew they could get better, so they [embraced] the program."

Similarly, Dallas Fire-Rescue was seeing a lot of cost related to unnecessary ambulance transports to hospitals involving patients with psychosocial or mental health issues.

Despite broad recognition of the need for change, that does not mean putting all the pieces together is easy. "When you are combining practitioners from different organizations and cultures, there are always challenges involved with

getting those individuals to learn how to work closely together," Isaacs shares.

Further, Young stresses just grouping a behavioral health clinician, a police officer, and a paramedic is only the start.

"You've got to have buy-in from your outpatient providers or from your behavioral health authority," Young says. "You [need] a place to take people other than the ED or jail. You find out who is on your team and what the motivation is, and then use that motivation to really build a coalition."

A good bit of this burden, at least from an organizational standpoint, falls on **Tabitha Castillo**, MPA, the RIGHT Care program manager. She works for the Dallas Office of Integrated Public Safety Solutions, the entity that oversees programs addressing public safety in nontraditional ways.

"I am responsible for program operations, policy planning, training, staffing, equipment needs, and collaboration with other internal city departments and external community partners," she explains. "One challenge has been to merge, coordinate, and create policies from differing organizations to provide working protocols for a productive and effective team. Each organization works and communicates differently than the others."

Castillo says continuous communication through weekly leadership meetings, team supervisor meetings, training meetings, and constant evaluation and operations reviews is the key to effective collaboration. "Although the creation of a multidisciplinary team has challenges, the benefits have not only increased efficiencies for each organization but have [also] resulted in a higher level of compassionate care for the clients we serve," she says. *(Editor's Note: For more statistics and information about RIGHT Care, please visit: https://bit.ly/3Ag6Gkn.)* ■

Palliative Care Guidelines Call for Equipping Frontline Providers to Meet Growing Need

By Dorothy Brooks

As the U.S. population ages, there is a growing need for clinicians skilled in primary palliative care. Such skills include the ability to assess for need, engage in advance care planning discussions, and provide appropriate care for symptom management that aligns with patients' wishes. Considering the volume of patients who access care through EDs annually, experts note emergency clinicians often are in a position to provide primary palliative care to those with serious or life-threatening conditions.

While some clinicians are more comfortable in this role than others, until recently there has been a dearth of information on best practices for providing primary palliative care in this setting. To help bridge this gap, an ED palliative care expert panel has developed recommendations that cover how to screen and assess for palliative care needs, manage such care needs, conduct goals-of-care discussions, develop good processes for palliative care or hospice consults, and facilitate transitions of care, all with the unique characteristics and needs of the ED in mind.[1]

Anthony J. Loffredo, MD, lead author of the guidelines, says he recognized early in his career many ED patients presented with unmet palliative care needs in part because clinicians were so overwhelmed with other duties. "I also recognized in myself that if I wanted to help address these needs, I needed a guide and more training," says Loffredo, director of emergency department palliative care at Cedars-Sinai Medical Center in Los Angeles. "Standards of care were being put forth by experts in the field, but the idea of merging palliative care and emergency medicine was still in its infancy."

Over the past two decades, the number of emergency clinicians who are double-boarded in palliative care and emergency medicine has grown, but not enough to meet the needs of the aging population.

"Meeting the palliative care needs of our patients now and in the foreseeable future will require the provision of primary palliative care by frontline ED clinicians," Loffredo offers.

Interestingly, as a frontline emergency clinician, Loffredo is quick to agree EDs are overwhelmed, and that administrators and policymakers must be careful about asking emergency clinicians to handle more. "At the same time, sometimes doing better can mean doing less, such as less inappropriate critical care when that care is not concordant with the patient's goals," Loffredo suggests. "I will also admit that changing ingrained habits is often not easy. A humble and dispassionate long-range view can really help."

Loffredo adds EDs do not have to implement every recommendation or improvement all at once; they can start small. "Maybe think about how [you] might have the most impact with the least amount of effort," he says.

Sangeeta Lamba, MD, MS-HPEd, co-author of the guidelines, echoes many of these sentiments, but also says palliative care is not really separate from emergency care.

"Many so-called palliative care-related practices, such as controlling symptoms effectively, communicating effectively, and aligning care to the patient's values, are also core to good quality ED care," explains Lamba, vice chancellor for diversity and inclusion at Rutgers Biomedical and Health Sciences. "Primary palliative care skills are really our skill set in the ED; we do this all the time, 24/7. Therefore, integrating these best practices and defining aspects of primary ED palliative care for all ED clinicians is just good, overall patient care."

Lamba admits there are unique challenges for EDs. Most notably, there are the time constraints and the demands for making major intervention decisions regarding life support — sometimes made with limited information and in rapidly evolving, often-unclear and unstable clinical scenarios. "Often, the patients we see are there in the ED from sudden, unexpected, often-disabling, or catastrophic events that has family totally unprepared and in shock," Lamba observes. "The practice of palliative care in the ED is also uniquely nuanced in order to meet the needs of our patients."

For example, while there are several screening tools that can be used to assess palliative care needs, Loffredo, Lamba, and colleagues used what they refer to as the surprise question for assessment purposes. Clinicians ask themselves whether they would be surprised if the patient they are treating died within the next year.

"[We] like the surprise question because it is effective, easy to use, and easy to implement," Loffredo says. "You can adjust the time frame based upon the palliative care needs that you or your organization may want to address."

At Cedars-Sinai, Loffredo notes he and colleagues decided to focus on the needs of critically ill patients. Clinicians might ask themselves whether they would be surprised if the patient they are treating died during this hospitalization.

"If we would not be surprised, then we could focus on code status, determining the burden tolerance of critical care interventions, and the patient's minimal acceptable quality of life," Loffredo notes. "This can be difficult in the ED if the issues have never been addressed."

For cases with an expanded timeline, perhaps a year or longer, a tiered approach might be appropriate. Here, the clinician could ask the patient about a healthcare proxy or surrogate decision-maker, make a referral to palliative care, or suggest further discussions with family or providers.

According to the guideline authors, part of the assessment process involves engaging in a goals-of-care discussion with patients who present with palliative care needs. Some emergency practitioners might be uncomfortable with these discussions, but Loffredo notes many of his colleagues are excellent at conducting these conversations. Those who lack the skills needed to manage this task effectively can improve with appropriate training. "Luckily, communication skills can be learned just like the skills that we've all learned to do emergency procedures," Loffredo says. "The conversations also sometimes can be quite straightforward."

For instance, Loffredo notes he often asks patients in the ED if they have ever talked to anyone about their preferences for care if they become seriously ill. It is an easy way to start a goals-of-care conversation. Other providers can pick up where a conversation in the ED leaves off.

"Patients and families just need more time to think about the issues," Loffredo says. "It is totally appropriate in the ED to just introduce certain topics, such as a healthcare proxy."

If there are no proxies, clinicians might suggest patients think about who knows them well and would express appropriate care preferences in the event a serious illness strips them of decisional capacity.

Palliative care providers are trying to make serious illness communication skills a part of resident training. "I am also participating in a serious illness communication skills initiative at my own institution," Loffredo says. "That initiative currently is centered on physicians, but will hopefully be expanded to other healthcare professionals soon."

Lamba says EDs can diminish the barriers to providing effective primary palliative care. "Using and embedding structures within other routine practices of the ED are more likely to be effective than adding on tasks that will require added time or staff," she says. "For example, [embedding] screening for palliative care-eligible patients within triage processes and [implementing] automatic electronic triggers that pull up advance directives and help flag for [palliative care] consult reminders may work best since they are tools to assist the provider."

Loffredo advises clinicians to consult with each other to identify opportunities for improvement. "Find those with energy for this topic and brainstorm," he says. "Where is there potential for significant impact with a relatively simple solution?"

Identify a metric or set a goal, define the interventions, and set a schedule for reporting performance. "Frontline providers [can provide] key information to guide this whole process, and it gets the clinicians engaged," Loffredo says. "Engaging the right stakeholders, such as upper-level leadership, is also critical and can help provide resources, such as administrative support."

The new guidelines should offer emergency leaders some ideas on how to move forward while also helping them "establish a reasonable standard of primary palliative care," according to the authors.

However, the authors also expressed hope this effort is just a starting point, that national benchmarks, policies, and research specifically aimed at the provision of palliative care in the emergency setting will follow. ■

REFERENCE

1. Loffredo AJ, Chan GF, Wang DH, et al. United States best practice guidelines for primary palliative care in the emergency department. *Ann Emerg Med* 2021;78:658-669.

Researchers to Test Groundbreaking Treatment for Intracerebral Hemorrhage-Type Strokes

By Dorothy Brooks

Clot-busting drugs can be used to treat patients with ischemic strokes, but there are no good pharmacological alternatives for patients with intracerebral hemorrhages (ICH). This is a concerning treatment gap because ICH-type stroke outcomes can be dire.

However, the creators of a new trial are testing whether a drug already used in other applications can offer benefits to patients with ICH strokes. Recombinant factor VIIa (rFVIIa) is a protein the body makes to stop bleeding related to blood vessel injuries. Researchers hypothesize it might improve outcomes for ICH patients. If the results are positive, frontline providers might be able to add an important therapeutic tool to help ICH-type stroke patients.

The authors of rFVIIa for Acute Hemorrhagic Stroke Administered at Earliest Time (FASTEST) are looking for sites that want to participate in this potentially groundbreaking research.

"There is no scientifically proven treatment for acute ICH, the most devastating of all stroke subtypes," explains **Joseph Broderick**, MD, principal investigator and director of the University of Cincinnati Gardner Neuroscience Institute in Cincinnati. "Two potential approaches include stopping the bleeding or removing blood surgically. Surgical removal has not been demonstrated to clearly change outcomes, at least in the way it has been done so thus far."

Broderick notes to be successful, rFVIIa will have to be administered to patients quickly, within two hours of brain bleeding onset. With this narrow treatment window in mind, Broderick and colleagues are aiming to compare ICH patients who receive rFVIIa to ICH patients who receive placebo.

To pull this off, investigators will use exception from informed consent (EFIC). "If we have a legal representative available, we get consent. If we can't find someone initially, we can enroll the patient and pursue consent vigorously as soon as someone is identified [who can provide consent]," Broderick explains. *(More background from the FDA on EFIC is available online at this link: https://bit.ly/32fnqLX.)*

This is the first trial that will take advantage of mobile stroke units (MSU) to accelerate the administration of a new treatment, according to **James Grotta**, MD, FAAN, another FASTEST co-principal investigator. "There will be 15 mobile stroke units that will be incorporated into this trial in both the U.S. and Germany," says Grotta, director of stroke research at the Clinical Institute for Research and Innovation at Memorial Hermann-Texas Medical Center.

Grotta notes EDs will serve as FASTEST sites, too. "So long as the patient can be treated within two hours, it doesn't matter whether they are in an MSU or the ED," adds Grotta, founder and director of the Houston Mobile Stroke Unit Consortium.

There are risks to consider when using rFVIIa. Mainly, these concern

the medication's actions at the site of any vessel injury in any part of the body. For instance, Broderick notes cardiac arteries could have damaged vessel walls.

At this point, Broderick stresses rFVIIa should not be used for ICH patients except as part of a clinical trial. "Until we know it clearly benefits patients, it should not be used in clinical practice," he says.

FASTEST investigators are enrolling patients, although the COVID-19 pandemic has slowed the process significantly. At press time, four study sites were up and running, with the goal of engaging 100 sites globally.

"They should be sites that have a good volume of ICH, have research experience involving acute stroke patients, and sites that are committed to very rapid treatment of stroke patients," Broderick says. *(Editor's Note: For more information about FASTEST, please visit this link online: https://bit.ly/3rqKvE4.)* ■

Dangerously Understaffed EDs Can Legally Expose Hospital

By Stacey Kusterbeck

Widespread staffing shortages caused by ongoing COVID-19 outbreaks, staff resignations without replacements, and staff callouts are wreaking havoc at many EDs. Short-staffing is reaching dangerous levels at some EDs, enough to cause the areas to shut down altogether.[1-3] The problem also could legally expose the hospital.

"Even before the pandemic, ED staffing levels relative to the patient census were routinely an issue in emergency medicine cases," reports **Joshua E. Gajer**, JD, a partner at Philadelphia-based White and Williams.

Gajer has seen ED staffing levels become a central focus in two types of malpractice cases. Most commonly, it is a case alleging delayed diagnosis. "Plaintiffs' lawyers criticize the amount of time it took for the patient to be seen by a doctor," Gajer says.

Operating minus just one triage nurse or emergency physician (EP) can extend wait times, and electronic medical records make it easy to show the precise time frame between arrival and evaluation. Understaffing allegations also arise in ED observation cases. In those lawsuits, attorneys criticize the lack of available staff to closely monitor the patient. "For years, plaintiffs' attorneys have argued that a hospital is liable, as an institution, for not employing sufficient numbers of qualified staff to triage and/or monitor patients," Gajer notes.

In the cases Gajer has seen, understaffing allegations are especially effective if bad outcomes happened during overnight shifts. Those EDs were not unexpectedly short-staffed due to an emergent issue. "Rather, plaintiffs argue that the hospital's normal staffing plan was insufficient from the outset," Gajer explains.

To prevail, plaintiff attorneys must establish an applicable "standard of care" with respect to the minimum number of providers needed to safely render care in any given ED, along with a breach of that standard by the hospital. Plaintiffs also must establish a causal link between the alleged staffing breach and the patient's outcome. For example, the attorney would have to show that because of understaffing, it took an EP too long to diagnose a time-sensitive condition.

The necessary proof of causation differs state to state, adding to the complexity of these cases. In some states, plaintiffs only need to prove the lack of personnel was a substantial factor in causing the adverse outcome. "In other states with a higher causation standard, the plaintiff would have to prove that, but for the staffing shortage, the bad outcome would not have occurred," Gajer reports.

Plaintiff attorneys will study the patient census in the ED and the staff members assigned to the area during the shift in question. Importantly, these records can be used to determine the hospital's average patient-to-provider ratio. "There is no set ratio that is considered adequate," Gajer says.

Rather, plaintiffs would need expert testimony to support the claim that a particular level of staffing fell below the minimum standard of care. "A hospital may have an excuse or justification for the staffing ratio. But the question of whether the hospital acted reasonably, and consistent with the standard of care, will likely be left to the jury to decide at trial," Gajer says.

Hospitals may note other area hospitals also experienced staffing shortages. "But this is unlikely to provide a complete legal defense.

Ultimately, it will be an issue for determination by the jury," Gajer says.

EP defendants accused of negligent care are going to resent bearing blame for understaffing. "ED providers need to be careful in their depositions not to pass responsibility to the hospital for understaffing or otherwise providing inadequate resources," Gajer cautions.

Such testimony would bolster a direct claim against the hospital. It also is highly unlikely to benefit the EP defendant. "Unless the provider actually believes that he or she provided care that was so delayed that it fell below the minimum standard, the provider would be better served simply testifying to the facts of the treatment, including the related timing," Gajer explains.

Gajer says ED providers are better served by testifying honestly about staffing levels and the ED's capacity while avoiding opinions on how these factors affected their ability to provide adequate care.

"If the ED provider is unable or unwilling to do so, this could create a conflict of interest in the representation of the provider and the hospital, requiring the retention of separate counsel for the provider and the hospital," Gajer notes.

In ED malpractice litigation, understaffing allegations are one way to bring the "deep pocket" hospital into the claim. "If a plaintiff can 'add on' to their potential theories of negligence against the hospital defendant, they will do so. It is inevitable that the hospital will always be a target defendant if things go awry," says **Heather A. Tereshko**, JD, principal at Philadelphia-based Post & Schell.

As understaffing has been an ongoing crisis for several years, it is expected to be a frequent allegation in future litigation. "It is simply another theory of negligence that plaintiffs may allege against a hospital defendant," Tereshko says. "We have not seen these cases yet, but expect to see them in the next year or so."

Assuming plaintiffs can prove understaffing resulted in bad care, causation remains a daunting hurdle. "The question remains whether the understaffing was the cause of the patient's injury," Tereshko explains.

If the patient waited hours for a chest X-ray because the ED was understaffed, the plaintiff's experts can argue the patient's impending myocardial infarction or pneumonia complications could have been prevented. Defense experts can admit the ED was understaffed, but counter that the delayed chest X-ray did not cause the bad outcome. In that kind of case, a hospital cannot escape liability by taking the position that other EDs were understaffed, too.

"Ultimately, the hospital is responsible for providing emergency medicine treatment that complies with community standards of care," Tereshko says. ■

REFERENCES

1. UH Lake Health. Emergency department at UH Madison Health Center temporarily closed. Dec. 31, 2021. https://bit.ly/3nEf9sF
2. George J. Crozer Health temporarily suspends some services because of COVID-19 surge, staffing shortage. *Philadelphia Business Journal*. Jan. 10, 2022. https://bit.ly/33U6P0U
3. Otterman S, Goldstein J. More patients, fewer workers: Omicron pushes New York hospitals to brink. *The New York Times*. Jan. 7, 2022. https://nyti.ms/3tCcO5b

Many Patients Worried Health Plan Will Not Cover ED Visit

By Stacey Kusterbeck

Of 2,200 adults asked about concerns regarding an ED visit, 48% said they were "very concerned" about the cost of the visit, according to a survey conducted by the American College of Emergency Physicians.[1] About the same percentage (47%) were "very concerned" their health insurance might refuse to cover the visit. For providers, there is no easy answer. "The provider won't know what services the patient needs prior to evaluation, and won't know if the patient is insured, has a copay, or [pays a] deductible," says **Patricia S. Hofstra**, JD, a partner in the Chicago office at Duane Morris.

Well-meaning staff may tell patients, "You should be admitted as an inpatient, but your insurance won't pay for your admission."

"But if the patient refuses admission because of fears of being responsible for the bill, and it leads to a bad outcome, it could be legally problematic for the ED," Hofstra warns.

It also would be an EMTALA problem if the patient was discharged before he or she was stabilized. "The provider should not initiate any discussion with the patient regarding

payment for ED services," Hofstra says.

If patients ask about it, Hofstra says that providers should document the patient was the one who initiated the discussion, the patient was told the hospital will work on the financial component of the visit after evaluation and stabilization, and the patient was told treatment will be provided to evaluate and stabilize, regardless of ability to pay. "The ED's EMTALA policy should state that the patient will be evaluated and stabilized prior to requesting payment (or payment information) from the patient," Hofstra offers.

Patients who express worries about the cost of the visit should be encouraged to stay until they are evaluated and stabilized. Some patients still insist they are leaving. In those cases, Hofstra says providers should ask the patient to sign a form stating they are leaving against medical advice before evaluation and stabilization and before requesting financial information.

"The signed form could be helpful in defending a malpractice claim as well as an EMTALA action," Hofstra says.

It makes sense for EDs to be clear on this message: Patients have a right to emergency medical treatment regardless of financial status. "We now need to layer this with obligations arising under the No Surprises Act," says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA.

The No Surprises Act requires providers to tell patients about their right to receive pricing information up front (i.e., a good faith estimate of the estimated charges for all expected services). Part of this estimate must include the estimated price of services rendered by all providers involved in the care continuum, regardless of whether those providers are part of the same system or practice. Also, these estimates must include discounts that are available, before services are scheduled.

It is somewhat unclear how all these particulars would apply in the ED, where care is unexpected. "Since the No Surprises Act is new, we will have to see how it plays out," Malone says.

The No Surprises Act requires all health plans to pay for emergency services in the ED regardless of network participation. "But a patient might still receive treatment for non-emergency services in an ED," Malone notes.

Emergency medical screening exams, stabilizing treatment, and appropriate transfers are requirements under EMTALA. None of that should be delayed by the process of gathering price estimates. "Responding to patient inquiries regarding costs of ED services, insurance coverage, or network participation has been a bit of a tricky area in the context of EMTALA compliance," Malone says.

The EMTALA statute does not prohibit EDs from providing information on the cost of the visit, or whether the hospital is in network with the patient's plan. "But we have to remember that the focus of EMTALA is ensuring access to emergency medical treatment, regardless of a patient's ability to pay for it," Malone says.

Answering tricky questions about the cost of the visit cannot interfere with the provision of care. "The sticking point is that EMTALA clearly provides that neither examination nor treatment can be delayed to respond to those questions," Malone says.

That has not changed in many years, despite rising out-of-pocket costs for ED patients. In 1999, CMS issued a Special Advisory Bulletin to clarify recommendations on appropriate communications on payment issues in the context of EMTALA.[2] "Although this Special Advisory Bulletin is more than two decades old, it still provides good guidance regarding how to respond to patient questions regarding payment issues," Malone says.

EMTALA regulations were amended in 2003 to permit reasonable registration procedures (including addressing questions about insurance).[3] Those questions can be answered before the medical screening exam is completed, provided that does not delay treatment in any way.

According to Malone, there are several ways EDs can avoid EMTALA violations. Do not post signs, or otherwise communicate to patients in any way, the hospital has created policies regarding prepayment fees for emergency services (including copayments or deductibles). Never allow a request for payment from the patient or the patient's representative to delay the hospital from fulfilling its EMTALA obligations. If patients ask about the cost of the visit, respond with this: "We will obtain the information you are requesting as soon as possible. But you have a right to emergency treatment under the law, and we need to address your medical condition without delay."

Additionally, train staff to carefully document discussions with patients regarding billing or payment questions. Ensure staff members understand patients are never implicitly discouraged from seeking emergency care in the ED (e.g., by stating another ED is in network with their health plan, noting there are shorter wait times at another ED). "Patients, not staff, should initiate discussions regarding payment for services," Malone says. ■

REFERENCES

1. American College of Emergency Physicians. Public opinion on the value of emergency physicians. August 2021. https://bit.ly/3FIQxFl
2. Bonner S. Update on EMTALA and managed care: HCFA issues special advisory bulletin. *ED Management*. March 1, 1999. https://bit.ly/3Kssaz0
3. Lipton MS, Hayward LR. Summary of final changes to EMTALA regulations. *J Med Pract Manage* 2003; 19:121-126.

Uncertainty Over Health Plan Coverage Affects EDs

By Stacey Kusterbeck

Patients are right to worry about out-of-pocket costs or whether their health plan will cover the visit. *ED Management* (EDM) spoke with Critical Care Medicine Associates President **Rade Vukmir**, MD, JD, FCCP, FACEP, FACHE, about what this means for EDs and about the current state of reimbursement for ED visits. *(Editor's Note: This transcript has been lightly edited for length and clarity.)*

EDM: What are concerns with how health plans reimburse for ED visits? Are some insurers denying payment for these visits unfairly?

Vukmir: If you look at the federal governmental payors, they have a fairly explicit statement regarding an emergency. A lot of their language, through CMS, really has to do with life- and limb-threatening emergencies. Public information sites, such as HealthCare.gov, define an emergency medical condition as that which a reasonable person would seek immediate care to avoid harm.[1]

EMTALA uses language that is a lot broader. The EMTALA language has historically spoken about the obligation to care for any patient with serious impairment to bodily function or serious dysfunction of any bodily organ. Various federal government resources offer wide-ranging definitions of what constitutes an emergency condition that requires ED evaluation and care. There is often a little bit of a quandary for patients to understand what care resources to use for what conditions. But in terms of how health plans are reimbursing for ED visits, it has been relatively quiet now for years. With the Affordable Care Act, the "prudent layperson" standard was sort of codified. Previous to that, there was case law that described a prudent layperson standard. The other legal premise is the "reasonable person" scenario: What would a reasonable person think if someone came to an ED with abdominal pain and fever? Maybe it did not turn out to be appendicitis; in the ED, we don't get the benefit of hindsight.

So what upset the apple cart? First, a couple of private insurers presented plans to not pay for visits where it turns out retrospectively not to be an emergency.[2,3] *(Editor's Note: One of the insurers clarified there will be no imminent changes to its coverage criteria for emergency services.[4])*

From the ED perspective, we basically take care of everybody. I cannot remember a time where someone has said, "That isn't an emergency, so you have to go somewhere else." That just doesn't happen in EDs. As we all recognize, during peak COVID-related emergency time periods, systematic triage, medical screening, and redirection may be necessary and appropriate. There is the perception that some populations tend to use the ED more frequently, including for primary care issues. They tend to be people who are more disadvantaged, with less access to primary care. But we are America's safety net. We don't ever suggest to the patient that somehow we wouldn't care for them.

EDs provide a lot of care that is poorly reimbursed, with the gap between care expenditures and insurer prospective payment systems. Factoring in the programmed governmental payer rate and uninsured care component provided, these reimbursement rates are at a low point. COVID hit, and made everything exponentially worse in regards to resource availability, healthcare provider staffing, and nursing staffing.

At the end of the day, there are hospitals and provider groups that are struggling financially, often in rural or inner city areas. Due in part to issues with extraordinary resource needs, health plans are cutting reimbursement rates and attempting to deny payment for ED visits based on retrospective care outcome. Those are the people who need that care resource most.

EDM: How will the No Surprises Act will affect reimbursement for ED visits?

Vukmir: Until now, there was precarious balance of contractual patient network care obligations, balance billing prohibitions, and in/out of network payment mandates. The No Surprises Act provides statutory protection from large, unexpected bills, typically for out-of-network

emergency care. Although well-intended, this then puts the burden of substantiating care with the providers to resolve with the insurers. The unintended consequence is that providers may not be adequately reimbursed to cover care costs. Instead of patients complaining to the hospital about the bill or to the insurer about the coverage, the burden is now shifted to the providers and insurers to resolve reimbursement discrepancies. Failure to amicably resolve [the problem] forces affected parties — providers, facilities, and insurers — to enter a dispute resolution and arbitration process.

[Emergency department billing practices] were largely settled. Now, it's disrupted again. Patients and providers don't know what to do. Ultimately, it has complicated things. To add this burden at this point in time, when the systems are COVID-stressed to their breaking point, it's just not proper.

The act sounds good on paper. But is the law or its consequences funded? This is where EMTALA got into trouble. EMTALA literally changed everything in emergency medicine, and it was an unfunded mandate. We are likely at the same point again. If as a society we say, "We will use the ED to take care of everybody," then you need to provide funding for that. If we say, "We only have the ED for emergencies," that's an approach as well. But we have to have care resources for the patients somewhere else. In the ED, we are still taking care of patients the way we have always done for anyone who comes in the door, whether it's a simple complaint or a complicated complaint. We show up every day and work as hard as we can. But it's gotten harder. The waits are now extraordinary. The systems are breaking.

EDM: What if patients are concerned about the cost of the visit? How should providers respond?

Vukmir: EDs try to be good stewards of the resources, to do things smarter, better, and more financially sound, for everybody. If the patient says, "I don't know if this is covered," we tell them, "Your health is the important thing now." But, importantly, we don't minimize the patient's concerns about cost, because there are real financial repercussions.

As always, we first provide definitive screening, treatment, and stabilization. We then try to use registration, financial [assistance], or case management resources to try to assist. They may visit with the patient to help them navigate the insurance part and give guidance ... to help you navigate a complicated insurance process.

We also might have discussions about whether to do a test. A patient might actually request a different treatment pathway, or want to avoid the admission if possible. We will choose the safest course. But there is sometimes an alternative treatment plan, if that's what the patient prefers. I usually ask the patient what they would like to do. What is your opinion about this testing strategy? Were you planning on going home?

Patients do bear some responsibility to know about their insurance — coverage, network status, and potential payment responsibilities. But if we can assist them somehow in navigating the system, whether through financial navigators, case management, or registration, and help the patient during a time of stress, we are happy to do so. This team approach is all part of the care process. ■

REFERENCES

1. HealthCare.gov. Emergency medical condition. https://bit.ly/3FFBGv9
2. Chou SC, Gondi S, Baker O, et al. Analysis of a commercial insurance policy to deny coverage for emergency department visits with non-emergent diagnoses. *JAMA Netw Open* 2018;1:e183731.
3. Abelson R. Outcry forces UnitedHealthcare to delay plan to deny coverage for some ER visits. *The New York Times*. June 10, 2021. https://nyti.ms/3FBpR9m
4. American Hospital Association Special Bulletin. UnitedHealthcare clarifies no immediate changes to coverage criteria for emergency-level care. Dec. 31, 2021. https://bit.ly/3GKqdMj

EDs See More High-Risk Patients with Ventricular Assist Devices

By Stacey Kusterbeck

ED patients with ventricular assist devices (VADs) present some unique care challenges and also some legal risks. "ED providers are seeing an increasing number of these patients, and we expect that number will continue to increase," says **Jonathan B. Edelson**, MD, an attending physician with the division of cardiology at Children's Hospital of Philadelphia.

More patients are discharged from the hospital with VADs for two reasons: A limited supply of organs available for transplant, and improvements in mechanical circulatory support.

"The care model of patients with end-stage heart failure is changing," Edelson notes. "However, there were very little data describing the interaction between these patients and the ED."

It was unclear how often patients with VADs were visiting the ED, why they visited, or how the situation concluded. Edelson and colleagues analyzed 44,042 VAD-related ED visits, using the Nationwide Emergency Department Sample database.[1] They found VAD-related ED visits increased sixteenfold from 2010-2017. Nearly three-quarters of these visits led to hospital admission.

One in 40 of the visits resulted in death (either in the ED or during hospital admission). More than half the visits were attributed to cardiac problems, bleeding, or infection. Almost one in 10 visits were because of stroke or a device complication.

To reduce risks for patients with VADs, Edelson says that providers can develop a familiarity with VADs (i.e., how they work, what complications need to be evaluated, and how to do so). Ensure systems are put in place for providers to care for these patients in an expeditious and effective way. Finally, remember that these are high-risk patients. "Understanding how to identify those patients at the highest risk of poor outcomes is critical," Edelson says.

To help in this process, Edelson and colleagues developed and validated a risk score that assigns ED patients with VADs to one of three groups.[2]

"We hope this proves to be a useful tool for emergency department providers," Edelson offers. ■

REFERENCES

1. Edelson JB, Edwards JJ, Katcoff H, et al. An increasing burden of disease: Emergency department visits among patients with ventricular assist devices from 2010 to 2017. *J Am Heart Assoc* 2021;10:e018035.
2. Edelson JB, Edwards JJ, Katcoff H, et al. Novel risk model to predict emergency department associated mortality for patients supported with a ventricular assist device: The emergency department-ventricular assist device risk score. *J Am Heart Assoc* 2022;11:e020942.

Abnormal Vitals Linked to Unanticipated Death After ED Discharge

By Stacey Kusterbeck

More than half of 129 patients who died unexpectedly after they were discharged from EDs exhibited abnormal vital signs at the time.[1] Each patient had presented to an urban academic ED between 2014 and 2017, and died within seven days after they went home.

"The findings should perk up the ears of ED providers and remind them to take a second look at if discharge is safe, or if rapid follow-up or admission should be considered," says **Richard Hoang**, MD, the study's lead author and an EP and trauma team leader at Sunnybrook Health Sciences Centre in Toronto.

Pneumonia was the most common cause of death. Recurrent themes among the patients included multiple

COMING IN FUTURE MONTHS

- Treating opioid use disorder
- Boarding pediatric psychiatric patients
- ED-based rapid testing for COVID-19
- Who evaluated: PA or NP?

complaints or comorbidities, acute progression of chronic disease, and a history of recurrent falls.

Other common factors included patients with multiple ED visits, patients who had been admitted recently, or patients for whom no repeat vital signs were recorded. ED providers failed to admit high-risk elderly patients, missed diagnoses, and failed to consider infectious etiology.

"Hopefully, this encourages clinicians to consider repeating vital signs prior to discharg[ing] their patients," Hoang says. ■

REFERENCE

1. Hoang R, Sampsel K, Willmore A, et al. Remember that patient you saw last week: Characteristics and frequency of patients experiencing anticipated and unanticipated death following ED discharge. *CJEM* 2021;23:767-771.

Family Violence Implicated in Injury-Related ED Visits

By Stacey Kusterbeck

Most ED visits for intentional, interpersonal violence-related injuries to youth ages 10 to 15 years resulted from family violence (as opposed to peer violence), according to a recent analysis.[1]

Of 2,780 ED visits for injury by youth ages 10 to 15 years, 819 of these presented with intentional violence-related injuries. Researchers chose to look at this age group in particular because most previous research involved older teens, says **Leticia Manning Ryan**, MD, MPH, the study's lead author and division chief of pediatric emergency medicine and medical director of injury prevention at Johns Hopkins Children's Center.

Peer violence-related injuries comprised 19.2% of the injuries, but 54.7% involved family violence. This reflected instances of both child maltreatment and physical fighting. More than half of violence-related injuries happened at home. Ryan and colleagues also found more involvement of alcohol, drugs, and weapons in violent events during the COVID-19 pandemic. "Social work consults may be needed to further evaluate the safety of the child's home environment. ED providers must also consider involving child protective services," Ryan says.

ED-based efforts to screen and intervene "can be critical to preventing future violence," Ryan says. The study's findings show this is important not only for family and peer violence, but also for contributory factors — mainly, access to alcohol, drugs, and weapons.

"In addition to obtaining thorough patient and family interviews, the use of standardized instruments to screen for these factors can help identify youth at risk, and link them to appropriate interventions and care," Ryan says.

EPs are deemed mandatory reporters under the federal Child Abuse Prevention and Treatment Act. "This indicates a legal requirement to report any suspicion of child abuse to the relevant authorities," Ryan notes.

Generally, healthcare providers are legally obligated to report suspicion of abuse and neglect "in a timely manner and in good faith," says **Amy Evans**, JD, executive vice president of business development and liability claims division at Intercare Insurance Services in Bellevue, WA.

State laws vary as to the particulars. "It is important that providers know the specific legal obligations where they practice," Evans says. In some states, simply notifying the hospital is not enough to comply with reporting requirements. If EPs fail to make required reports or knowingly make an untimely report, warns Evans, "they could face criminal, civil, and/or licensure actions."

All states provide reporters with immunity against criminal prosecution and some form of protection against civil liability, provided there is "good faith" basis to suspect abuse. "With that framework in mind, it is important for ED health professionals to remember that the public policy is one that supports their assessment if child abuse is suspected," says **Anna Berent**, JD, MBA, senior director of claims at MCIC Vermont in New York.

Berent says worried or angry ED providers should remember their institutions, along with federal and state legislation, are behind them. "This helps stave off the panic and charged emotions that typically accompany cases where child abuse is suspected."

It is best for ED documentation to be as objective as possible. "Mandatory reporters are required to include facts and circumstances in their reports," Berent says.

Examples of good documentation: Quotes with statements from caregivers that EPs deemed

suspicious, and detailed observations of the child's injuries or general appearance.

If providers learn violence was perpetrated by a caregiver, or if the caregiver put the child in an unsafe situation, "then, in addition to the potential need for a police report, a child protective services report is necessary," according to **Genevieve Santillanes**, MD, an associate professor of clinical emergency medicine at Keck School of Medicine at USC. "If the patient is going to be discharged, the team must ensure that the child or teen is being discharged to a safe situation."

• EDs must assess if the perpetrator will continue to be in the home or will otherwise have access to the child.

"For example, if the child was injured by a non-custodial parent, ask if the child can be kept away from that parent until child protective services completes their assessment," Santillanes suggests.

Likewise, if the child was injured by an adult sibling or a parent's partner, EDs should determine if that person will be in the household once the child returns.

• Any agreed-upon safety measures (e.g., the adult sibling will not be allowed in the house) should be documented in the medical record.

"Even if the perpetrator is arrested, they might be released from custody quickly. A plan to ensure the youth's safety is critical," Santillanes says.

Child protective services' planned response should be documented. For instance, the chart should specify the time frame (i.e., is the response going to be immediate, or will it happen within a certain number of days), whether child protective services will respond to the home, or if they would like the patient held in the ED. "Ultimately, for in-home violence, if the patient is medically ready for discharge, child protective services will determine if the child can return to the home," Santillanes says.

ED staff can advocate for an alternate plan if they believe this is unsafe. "These discussions should be clearly documented in the medical record," Santillanes adds.

• ED providers should speak to the child or teen alone to determine if they feel safe in their home and if there have been other incidents of violence perpetrated by the same individual or others.

"This risk assessment should be documented," Santillanes says. "Any other incidents of violence by a family or household member must also be reported to the appropriate authorities."

• Screening for trafficking and sex work should be considered in teens presenting with a violence-related injury.

For teens injured by an intimate partner, the age of the partner should be ascertained. "Unfortunately, a number of teens experience trafficking and other exploitative situations," Santillanes laments. ■

REFERENCE

1. Ryan LM, Irvin N, Miller M, et al. Characteristics of pediatric emergency department visits for youth 10-15 years old with injuries due to interpersonal violence. *Int J Inj Contr Saf Promot* 2021;1:1-6.

Missed STEMI Time Frames Will Complicate ED Malpractice Defense

By Stacey Kusterbeck

In lawsuits alleging negligent care of ST-elevation myocardial infarction (STEMI) patients, all kinds of specific recommended time frames — to physician, to treatment, to cath lab — become the central focus. From a medicolegal standpoint, "there is little debate about the standards of care when faced with STEMI," says **Eric Weitz**, JD, a Philadelphia-based medical malpractice attorney.

The American College of Cardiology Foundation, in conjunction with the American Heart Association Task Force on Practice Guidelines, promulgated a robust series of guidelines on the management of patients with a wide variety of cardiac conditions.[1] "Emergency departments are hard pressed to ignore these standards, since the American College of Emergency Physicians and others collaborated with and signed on to these guidelines," Weitz asserts.

The firm sees many cases in which an ED provider seeks a cardiology consult, which either is delayed, or intervention is delayed due to issues outside the department. "As the service responsible for the care, can the ED provider simply watch a patient deteriorate because the cardiology service is delayed in responding?" Weitz asks. During litigation, the question becomes: What more should the ED provider have done? "The factors that are important in determining if the ED provider should have done more are fact-sensitive," Weitz says.

There are other questions to consider: What do the 12-lead ECGs reveal? Are cardiac enzymes concerning? Are there continuing symptoms? Is transfer to a higher level of care possible? "If the patient is at low risk of imminent harm, then a delay is likely not malpractice," Weitz says.

However, the ED provider's failure to escalate the situation if the cardiology service is too slow in responding to an imminent condition likely violates not only the hospital's policies, but also the legal standard of care. Weitz says documentation of calls and responses from the cardiology service, and acknowledgement of risk stratification based on the guidelines can be key pieces in subsequent litigation. "The classic scenario seems to be when an at-risk patient comes in with STEMI late on a Friday," Weitz observes. As the initial test results arrive, cardiology typically is consulted. Sometimes, the cardiologist decides to wait to see the patient until the next morning. Once this plan is implemented, EDs often become complacent and do not react to changing symptoms. "Or, EDs try to treat symptoms rather than acknowledge the imminent heart attack that continues to declare itself," Weitz says.

Failure to follow or meet clear standards of care for STEMI "can lead to significant morbidity and mortality, as well as high malpractice payouts," says **Adam Hennessey**, DO, medical director/chair of emergency medicine at Roxborough Memorial Hospital in Philadelphia and Lower Bucks Hospital in Bristol, PA. The American Heart Association has set a 90-minute door-to-balloon time goal. "Obviously, the shorter the better," Hennessey says.

Hospital policies may set shorter goals, which can complicate the situation for EP defendants. "The emergency physician may be held to both the national standard as well as their institutional standard," Hennessey explains.

If the provider's institution is not an interventional center, and the ED cannot promptly send a patient to an interventional facility, then the ED provider likely will be held to the STEMI thrombolytic standard. In that case, Hennessey warns, "failure to meet this standard could open the physician up to significant liability."

Regardless of whether a patient is an interventional or a thrombolytic candidate, the ED provider should clearly document their discussions with cardiologist consultants. To avoid unfortunate outcomes, obtain immediate ECGs on chest pain patients, and obtain prompt cardiology consultation. If the ED provider is named in STEMI litigation, the biggest issue probably will be the timing of the ECG. "If the patient hasn't had an ECG, and somebody ultimately has a STEMI, there's a huge legal issue. That would be the No. 1 legal issue that everybody should be aware of, the door-to-ECG time," says **Kendall McKenzie**, MD, chair of the department of emergency medicine at University of Mississippi Medical Center. The risk of not ordering an ECG immediately "is higher than we would like. EDs across the board are having staffing issues," McKenzie adds.

EDs need broad inclusion criteria for obtaining an ECG and immediately review it to determine whether a STEMI exists. Not everyone experiencing a STEMI arrives with crushing chest pain radiating down the left arm. "You have to have a heightened index of suspicion for a lot of patients. That, at times, is challenging," McKenzie says. "But it's indefensible not to have the ECG when somebody ultimately has a STEMI."

Guidelines drive home the urgency of early ECG (within 10 minutes of arrival to the ED). "Guidelines don't necessarily set the standard of care," McKenzie notes. "But the drive to get that door-to-ECG within 10 minutes is so pervasive that I think that is the standard of care."

Sometimes, the ECG happened within 10 minutes, and the patient does not initially meet STEMI criteria. Yet the patient continues to report ongoing chest pain, but no one repeats the ECG. "The ideal way to take care of a STEMI is inside a cath lab, and there are time frames associated with that," McKenzie says.

If the hospital operates a cath lab on site, door-to-cath lab in less than or equal to 90 minutes is the standard. If the patient has to be transferred, door-to-cath in less than 120 minutes is the benchmark. If the ED cannot hit either mark, then staff must consider giving fibrinolytics if the patient meets criteria. "That is probably more of an issue if the patient is being transferred a great distance or there is going to be a delay in transfer. That is a real problem today, more than it has been in the past," McKenzie says.

As ambulance patient offload times increase, it decreases the number of ambulances available to transport patients from hospital A to hospital B. "There is pretty solid evidence that the quicker you cycle a patient through the process of getting to the cath lab, and getting vessels opened back up, that outcomes are impacted by this," McKenzie says. "This is one of those front-end processes that sets the stage for the rest of the patient's course in the hospital." ■

REFERENCE

1. Gulati M, Levy PD, Mukherjee D, et al. 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR guideline for the evaluation and diagnosis of chest pain. *Circulation* 2021;144:e368-e454.

CME/CE QUESTIONS

1. **In the first 18 months of operation, a Rapid Integrated Group Healthcare Team responded to more than 4,000 calls in the south central police district of Dallas. How many patients did the team divert from EDs?**

   a. 250
   b. 500
   c. 775
   d. 900

2. **While there are several screening tools that can be used to assess palliative care needs, the authors of new guidelines on the provision of primary palliative care in the ED use:**

   a. basic triage skills.
   b. the surprise question.
   c. medical history 101.
   d. the emergency clinician's toolbox.

3. **Which is true regarding allegations of understaffing at EDs?**

   a. Plaintiff lawyers need expert testimony to support the claim that a particular level of staffing fell below the minimum standard of care.
   b. Plaintiff attorneys struggle to identify the precise time frame between arrival and evaluation.
   c. Understaffing allegations are much harder to prove if bad outcomes happened during overnight shifts.
   d. Plaintiff attorneys no longer need to establish a causal link between the alleged staffing breach and the patient's outcome.

4. **Which is true regarding EMTALA obligations?**

   a. ED providers are obligated to inform patients up front if health plans refuse to cover a necessary admission.
   b. Patients can be discharged before they are stabilized if the ED is out of network.
   c. ED providers should initiate discussions about payment with patients.
   d. ED providers should inform patients the hospital will work with the patient on the financial component of the ED visit only after the patient is evaluated and stabilized.

5. **Which was a recurrent theme among ED patients who died unexpectedly after they were discharged?**

   a. Patients who had not visited the ED in the prior 12 months.
   b. Patients who had not been hospitalized recently.
   c. Patients who recorded multiple repeat vital signs.
   d. Patients who experienced acute progression of chronic disease.

6. **Which is true regarding pediatric ED visits involving violence-related injuries?**

   a. Peer violence was involved in most cases.
   b. Few injuries involved family violence.
   c. Most of the injuries happened at school.
   d. There was more involvement of alcohol, drugs, and weapons in violent events during the pandemic.