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From New Orleans to Houston: The New City of Brotherly Love

by Michael F. Boyle, MD, FACEP, Medical Director, Memorial Hermann Memorial City Hospital

On August 29, 2005, Hurricane Katrina struck New Orleans. This category four storm with winds exceeding 150 mph and storm surges of greater than 30 feet devastated the Gulf Coast region. New Orleans – known for its jazz, Mardi Gras, and the French Quarter – is a city with a population of approximately 500,000. The economy survives on tourism, conventions, petroleum refining, and shipping. In the days preceding the storm, the city and surrounding area had a voluntary evacuation order. Many residents traveled north and west. Interstate 10, which leads directly through Louisiana to Houston, Texas, became the major evacuation route west. Residents unable or unwilling to evacuate because of desire, financial hardship, or illness were sheltered at the Superdome and Convention Center. At the time, these shelters were felt storm-worthy as had been the case for many previous storms. About 500 miles to the west, the city of Houston became host to a multitude of out-of-town visitors fleeing New Orleans, numbering more than 250,000. This evacuation was thought temporary, and the majority of hotels along Interstate 10 away from the storm area became filled with these evacuees.

During the peak of the storm, significant components of the Superdome roofing structure were damaged. As New Orleans is below sea level (twenty feet in many areas), the city is fortified by protective levees. Two of these

levees ruptured, allowing water to fill up “the bowl” of the city. The city actually survived the storm quite well; the levee ruptures caused a significant component of the flooding. Those residents unable to respond to the evacuation orders, or ignoring them, were now in major distress.

President Bush had allocated FEMA funds prior to the storm’s occurrence. Local and state agencies had the responsibility for initial search, rescue, and evacuation. Due to the extent of the storm, local authorities quickly became overwhelmed. Flooding from the levees, loss of all power, loss of a clean water source, and breach of the sewage system further complicated the situation, as well as contamination of multiple water sources from local refineries damaged during the storm surge. After three to four days, shelters quickly ran out of food, water, and sanitation facilities.

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From The Top: Stormy Weather

by Robert M. Williams, MD, DrPH, FACEP
Chairman, ECI Board of Directors

The year 2005 was a challenging, yet successful one for ECI. In September, we launched the very exciting Mistake-Free Medicine® program, highlighted by ECI President Dr. James M. Johnson's speech at the Annual Meeting on the genesis of human errors. This highly innovative program is the focus of everyone at ECI. By reducing errors, we can improve services to all of our clients – including our most important clients, the patients we serve.

A number of new clients joined the ECI family in 2005, including: West Suburban Medical Center of Chicago, Illinois; Huntsville Memorial Hospital of Huntsville, Texas; St. Joseph Outpatient Center - Urgent Care of Wauwatosa, Wisconsin; St. Joseph's Regional Medical Center of Paterson, New Jersey; and Christian Hospital Northeast of Saint Louis, Missouri and Northwest HealthCare of Florissant, Missouri - both of BJC HealthCare. **We**



Dr. Robert M. Williams

are proud to be partnered with these outstanding facilities, and we will strive to deliver high quality emergency care to the surrounding communities that they serve.

But there was also a lot of stormy weather last year. The devastating hurricane season of 2005 affected everyone in the United States, from those directly hit by the storms to the millions who felt the economic impact through higher gasoline prices. Most experts anticipate that Katrina will be the

costliest natural disaster in U.S. history, with damages expected to exceed \$100 billion. Over one million people were displaced – a humanitarian crisis of epic proportions in our homeland.

Emergency medicine was thrust into the limelight with so many people left homeless, sick, and in need of immediate medical care. Heroic actions taken by disaster response teams, hospitals, and emergency department staff were essential to the welfare of thousands of refugees. As illustrated in Dr. Michael F. Boyle's article on the "From New Orleans to Houston: The New City of Brotherly Love" (page 1), the majority of refugees from Katrina were transported to Texas, with over 230,000 persons being sheltered throughout the state by Labor Day. The response of the Memorial Hermann System was immediate and extensive. Life Flight helicopters transported critically ill and injured adult and pediatric patients from Ochsner and Charity Hospitals in New Orleans to Memorial Hermann Hospital and Memorial Hermann Children's Hospital. Thousands of hurricane victims were treated throughout the System's twelve hospitals. Truckloads of supplies were provided to an emergency clinic set up at the George R. Brown Convention Center where hundreds of medical professionals from the Memorial Hermann System volunteered. The System also responded to the threat of Hurricane Rita; fortunately, Rita veered to the north and east, sparing the immediate Houston area from severe damage.

Throughout the catastrophic hurricane season and its aftermath, our partner hospitals in the Memorial Hermann System remained steadfast

in their commitment to the health and well-being of the residents of Houston, as well as their neighbors along the Gulf Coast.

The 2005 hurricane season had a direct impact on ECI as well, as manifested by the turn-out of partner physicians and representatives at the ECI Annual Meeting, held September 22-24, 2005, in Traverse City, Michigan. Many individuals from Texas were unable to attend due to impending Hurricane Rita. A few weeks later, Hurricane Wilma came perilously close to our billing company, Apollo Information Services, Inc., in Fort Myers, Florida.

It has been ECI's custom to host its Annual Meeting in the fall in Traverse City, and in recent years, a number of our meetings were disrupted by storms, including Hurricane Isabel in Richmond, Virginia, in 2003. Because of these disruptions, the ECI Executive Committee made the decision to move this year's **ECI Annual Meeting to May 24-26, 2006**. Please mark your calendars for this important event. The meeting immediately precedes the Memorial Day weekend, and attendees will have an opportunity of perhaps extending their stay in beautiful Northern Michigan for a few extra days to enjoy the Memorial Day festivities. In any event, we anticipate a very exciting meeting!

National politics were also very stormy in 2005. The continuing war in Iraq and the massive hurricanes placed enormous strain on the resources of the United States. The politics were complicated by the generally acknowledged poor response of the Department of Homeland Security and the Federal Emergency Management Agency (FEMA) to the acute needs of

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Stepping Up To The Plate – With The Help Of The ECI QualChart System®

by Peter T. Mellis, MD

Medical Director, CJW Medical Center Pediatric Emergency Department, Richmond, Virginia

As part of the ECI Initiative on Mistake-Free Medicine®, Inside ECI will from time to time include a feature to share the success of various educational and quality measures utilized by ECI-affiliated physicians that reduce errors and improve patient care. This article was written by Peter T. Mellis, MD, Medical Director at CJW Medical Center Pediatric Emergency Department (ED) in Richmond, Virginia. He serves as a member of the ECI QualChart® Committee, is board-certified in Pediatrics and Pediatric Emergency Medicine, and serves as Pediatric Advanced Life Support Affiliate Faculty and an Associate Clinical Professor of Pediatrics for Virginia Commonwealth University.

It started off a slow shift. I had gone to check my mailbox, as there were no new patients ready to be seen. I immediately got a “stat” overhead page to return to the Pediatric ED.

The patient was an ill-appearing, lethargic adolescent male. He had been sent by car from his primary physician’s office with a CBC result; a platelet count of 43,000 was circled. The nursing staff had placed him on cardiac and pulse oximetry monitors, started oxygen, and obtained IV access. Vital signs were pulse 130, respirations 24, temperature 39°C and blood pressure 84/50. After ensuring airway patency and respiratory effort, I ordered a liter bolus of normal saline, paired blood cultures, blood count, chemistries, coags, and repeat vital signs.

I stepped out of the room to interview the family and select a QualChart®. As is my practice, I chose the adult “Febrile Illness” QualChart® because the patient was over 12 years of age. There were no other symptoms apart from fever and lethargy. His father told me he had also been seen by a physician in another state several days previously and was told he had a “viral illness.” He had no significant past medical history, specifically including Sickle Cell Disease or other immune deficiency. I completed the Risk Factor section and asked about travel history, expecting another nega-

tive, but learned he had just returned from Africa! Peripheral smear for malaria was ordered.

The patient had no response to the bolus. I had also pulled the “Management Form: Septic Shock” from The ECI QualChart System®, thinking “it might help.” A second normal saline bolus was ordered, and there on the Management Form was the prompt for a second IV line for drugs, which I ordered. The patient was becoming more lethargic and was still hypotensive, so I chose to intubate him using rapid sequence anesthesia. Good chest rise and fall, equal breath sounds. An Airway Procedure Note was integrated into the Management Form, including place for drugs used and ETT size formula for pediatric patients.

Time for dopamine @ 20 mcg/kg/min – no response, still hypotensive. Another liter of normal saline – no response, still hypotensive. Time for an old PALS trick – wide-open dopamine bolus followed by titration to target blood pressure. Bingo! Systolic pressure above 100, titrated back to 20 mcg/kg/min with sustained systolic normotension. Rocephin® 2 grams IV given. NG/foley placed by nursing staff. Patient is fully reassessed and is well oxygenated with good peripheral perfusion. All find a place on the QualChart® Management Form and Order Sheet.

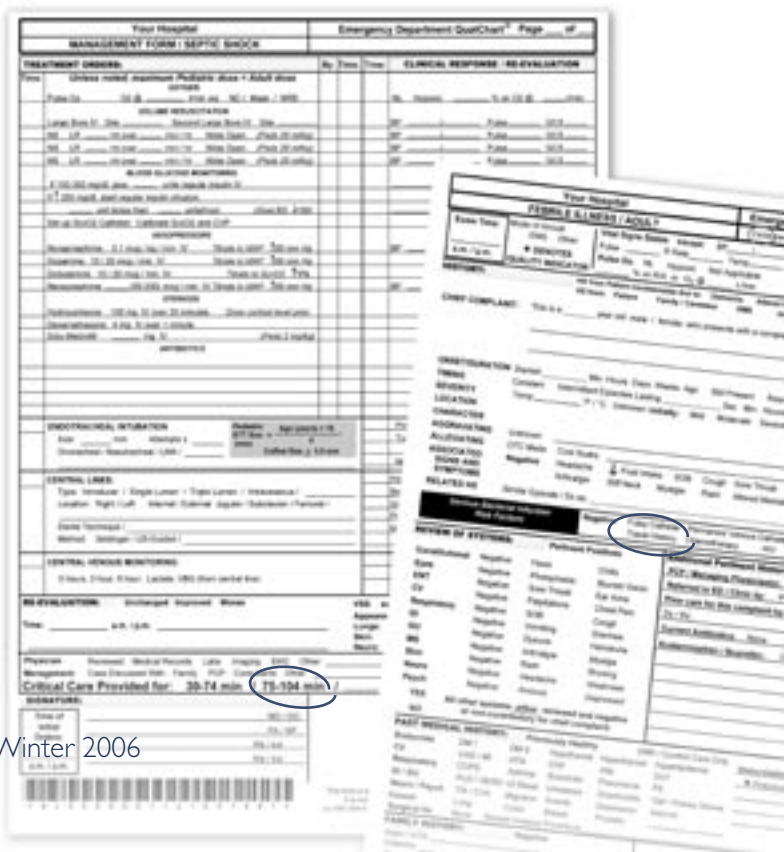
Time to call the PICU. The pediatric intensivist accepts,

and, amazingly, a bed is ready. While advising the family of the patient’s status, I am interrupted by the nursing staff – the peripheral smear is positive for Plasmodium falciparum, the most common species of malaria.

My diagnosis is septic shock due to malaria. He is only the third, and by far the sickest, patient I have seen with malaria. The patient is stabilized and the ED nurses are clamoring to transport him to the PICU. I insist on my customary final review of the QualChart® before disposition and notice “Critical Care Provided For” at the bottom of the Management Form with convenient choices of ranges of times from which to choose. My Regional Director will be pleased....



Dr. Peter T. Mellis



Physician and Physician Extender Survey Results: Physician Satisfaction Continues to Rise in 2005

by Scott T. Caldie
ECI Vice President, Staffing Operations

ECI recently received the results of its bi-annual survey of physician partners and physician extenders. A report of the tabulations follows:

A total of 179 physicians and 57 physician extenders completed the ECI August 2005 survey questionnaires – 24 more participants than those completing the 2003 survey. This equates to a 25% and 30% participation rate, respectfully. The questionnaire was administered and the data was tabulated by Industrial Relations International, Inc., (IRI) of Richardson, Texas.

There were 42 positively phrased questions in the survey, 11 of which were IRI core questions that are asked on all surveys conducted by IRI countrywide. The overall favorability on the core questions for physicians was 77, five points above the national norm for professional employees and a four-point increase over the 2003 ECI survey.

All 42 survey questions scored a 70, one point above the previous survey given in 2003. Physician extenders also scored higher than national norms on the core questions, with a score of 78, while the overall favorability was a 75, the same as in 2003.



Scott T. Caldie

What did the physicians say were ECI's best attributes? According to IRI, they are as follows:

- **Professional, friendly employees.** 95% said they enjoyed working with the ECI staff.
- **Strong administrative support for physicians.** Approximately 82% were satisfied with their physician management support and all ECI administrative departments received marks of 83% or higher.
- **Honesty, integrity of leadership.** Overall, 78% answered positively. More than 95% of the physicians who have been with ECI more than 10 years believe that ECI honors the value of integrity.
- **Stability of company.** More than 90% of those who have been with ECI for more than one year responded positively to the statement, "I believe ECI honors the value – corporate growth and stability."

- **Scheduling flexibility.** Of the respondents, 88% said they were treated fairly regarding the scheduling of their shifts and 83% said they were satisfied with ECI's Scheduling Department.

Physician extenders also commented on their views of ECI's best attributes:

- **Benefits.** Of the 10 "benefit" questions given to full-time extenders, the range of agreement answers was 71% to 100%, with 83% being the average.
- **Working conditions.** Of the respondents, 87% thought the physical working conditions at their facility were good.
- **The physicians.** Overall, 88% liked working with the physician staff and over 90% were satisfied with their Medical Director. Furthermore, 94% said that their medical department leader knew his/her job well.
- **Strong leadership.** High marks (see above) for medical leadership were observed.
- **Stable organization.** Only 6% of the respondents disagreed with the question about ECI honoring the value of growth and stability.

Identifying challenges:

Both physicians and extenders indicated that ECI's biggest challenges are in wages and compensation, recruitment and retention, and The ECI QualChart System®.

Comparing all other surveys conducted by IRI to ECI's survey, the physicians scored ECI higher than IRI national norms on the following core statements:

- The Medical Director (boss) is fair in his/her dealings with me.
- My facility has good physical working conditions.
- The emergency department Medical Director knows his/her job well.
- I receive enough information about what's going on at ECI (home office).
- Rules and policies of the partnership practice are consistently applied.
- I know where I stand with regard to performance.
- I feel that my position/job is secure.

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- Considering my responsibilities and my geographic location, my compensation is fair. [The compensation question is an interesting one. Many workers nationwide, professional and otherwise, feel they should be paid more. While many physicians felt that it is an area where significant challenges exist, many thought that under current conditions (the national economy, government regulations, etc.) they were being treated fairly.]

The survey showed that the longer the physician affiliation with ECI, the more likely a positive agreement with a statement. Physicians who have partnered with one of ECI's LLPs for less than one year gave a 76% overall agreement rating. One- to five-year affiliated physician partners were slightly higher at 77%, while 6- to 10-year affiliates moved up one more percentage point to 78%. The ECI QualChart System® satisfaction question had the highest increase in agreement from one "length of service" demographic group to the next. It rose from 67% agreement with physicians who have been with ECI less than one year to a 94% agreement rate for those who have been with ECI longer than 10 years.

Comparing 2003 and 2005 results:

The highest increase in physician satisfaction (as judged by the agreement answers to the statements) was with ECI's accounting department (payroll), which jumped from an 87% agreement percentage to a 97%. Other notable increases in agreement answers were as follows:

- Satisfaction in ECI's malpractice insurance program, (which increased 8%).
- QualCharts® are an excellent system for documenting patient visits, (which increased 7%).
- ECI honors the value of quality, (which increased by 7%).
- The value of growth and stability, (which increased by 6%).

The physician's agreement percentage slipped downward in 2005 as compared to the 2003 survey in (1) scheduling fairness, (2) satisfaction with the 401(k) savings/tax deferral plan, and with (3) statements regarding their compensation. While there were many com-

ments made about the challenges facing recruitment and retention, the percentage of agreement to statements in those categories remained identical from survey year 2003 to 2005.

The highest increase in physician extender satisfaction (as judged by the agreement answers to the statements) was with their satisfaction with the working conditions at their facilities, which rose 14%. Other increases were in the following:

- Receiving enough information about what's going on at ECI, (which rose 10%).
- Satisfied with the effectiveness of the Medical Director, (up 10%).
- ECI listens to and appreciates my thoughts and views, (which rose 10%).
- Satisfaction with QualCharts®, (which rose 8%).
- Feeling that position/job is secure, (rising 5%).

There is a high level of satisfaction with payroll, scheduling, and credentialing.

In statements relating to recruiting, communications between their department and the hospital medical staff, and the value of corporate growth and stability, physician extenders were less agreeable according to the 2005 respondents, when compared to the 2003 survey.

The 2005 survey was the third Physician Survey conducted by ECI of its physician partners. In the first survey year of 2001, the overall satisfaction was measured at 62%. In 2003 it went up to 69% and in 2005 it crept up to 70%.

The compensation satisfaction results remained relatively unchanged, while satisfaction with ECI's medical malpractice program has increased dramatically from 63% in 2001 to 73% in 2003, and to the current level of satisfaction of 82% in 2005.



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Stormy Weather, continued

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so many people left without medical care and the basic necessities of life. The shocking conditions displayed on national news networks will remain in the public consciousness – and conscience – for many years to come.

There is great irony in public health policy. Most people who viewed the devastating scenes in the aftermath of the hurricanes were appalled that the most wealthy nation on earth did not respond in a coordinated and timely manner to the most basic of needs of its afflicted citizens – food, water, shelter, and medical care. Yet, literally in the midst of these natural disasters, policymakers in Washington have pursued vigorous cost-cutting plans that will have enormous impact on the Medicaid and perhaps Medicare programs. Medicaid is being targeted because it has become the largest government health care program. Since 1998, Medicaid inflation has outpaced revenue growth in state budgets according to the Kaiser

Commission on Medicaid and the Uninsured. The program serves about 53 million people and pays for nearly half of all nursing home care in the United States. It pays for health care costs of one in four U.S. children and more than forty percent of the cost of caring for children in hospitals. At a time when more and more Americans are without health insurance, huge cutbacks in Medicaid will compound the misery of the most unfortunate of our citizens. These cutbacks in federal programs, and the ever-increasing number of Americans without health insurance, will place greater strain on the nation's safety net – hospital emergency departments.

The year 2006 promises to be another interesting and challenging one. Emergency medicine is at the forefront of so many of today's and tomorrow's issues and concerns – whether it's stormy weather or stormy politics. As Dr. Johnson is fond of saying, "One of the great things about working with ECI is that it is never boring." Stay tuned.

Survey Results: continued

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This is a fairly large increase in popularity and it shows that physician partners are appreciative of the solid finances and a lower than national average in the number of claims.

Physicians were only 71% satisfied with working with the ECI staff in 2001, while now the satisfaction rating is over 90%!

In another interesting category, only 53% of those surveyed in 2001 agreed that there was good communication between the ED physician and hospital medical staff at their facility. That number has jumped to more than an 80% agreement/satisfaction level in the 2005 survey.

The ECI Executive Committee and the Regional Medical Directors take the Physician and Physician Extender survey very seriously. Comments with suggestions for improvements were most appreciated. We will work on improving those areas where a negative pattern was seen in the answers given to the questions. It is our goal to keep ECI a premier management company where the interests of the individual provider are taken into consideration in all aspects of our business.

One interesting comment from physicians that needed additional study was the question regarding status; namely, do the physician partners wish to remain as a "self-employed" partner or do they wish to make a change to the employed status? As shown above, 74.5% of the 247 respondents to a separate survey letter desire to remain as self-employed partners.

ECI COMPLIANCE HOTLINE

As part of the ECI Compliance Plan, employees, contracted health care providers, service providers, and others may discuss any coding, billing, and/or reimbursement issues, or report any violations of the law or of the Compliance Policy by calling the ECI COMPLIANCE HOTLINE.

(800)632-3496, FOLLOWED BY #, FOLLOWED BY 3106

The ECI COMPLIANCE HOTLINE is confidential and reporting concerns or violations is encouraged. Reporters need not fear reprisal. This hotline is the direct VOICE MAIL to the Chief Financial Officer who is the most knowledgeable individual in the organization on coding, billing, and/or reimbursement issues. The Chief Financial Officer has full authority to deal with any issues that may arise.

From New Orleans to Houston: The New City of Brotherly Love, continued

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Access to the flooded areas of New Orleans could only be gained by boat and air. Realizing the city was unfit for living, and with shelters like the Superdome rapidly deteriorating, city leaders made the decision to completely evacuate New Orleans.

On September 3, 2005, Mayor Bill White and the city of Houston opened its doors with eleven evacuation buses (to be followed by many more) rolling into the Astrodome parking lot. Preparations had been initiated to set up a major evacuation shelter. These evacuees, however, had just lived through a major storm, were dehydrated, out of medication, out of food, and had slept little. Initially, they were triaged by local EMS and Medical Control physicians from the Houston Fire Department. Due to significant volume/illnesses, this option became overwhelmed rapidly. The Harris County Hospital district quickly designed an on-site medical command center. Evacuees underwent initial triage and referral to the on-site clinics, which included critical care, general medicine, pediatrics, psychiatry, dental, and ob/gyn. Further, the shelter sites had corporate (volunteer) sponsored lab, pharmacy (outpatient), and radiology services.

The Astrodome, Reliant Center, and George R. Brown Convention Center were set up as the primary shelters. Each shelter was developed to be self-contained (including medical care) with approximately 27,000 people housed at these sites.

The living situation provided for the

most basic needs. Temporary showers were erected. Clothing donations came from across the nation to be sorted by local volunteers. There were donations of toys for the children. Meals were provided three times a day. Each person/family was provided a designated living area that included cots and/or inflatable mattresses with bedding materials. Very tight and visible security was essential, and a curfew was developed after 11:00 p.m. This reduced issues with late night alcohol use and disruption.

“You will never look at America the same way. You will never look at your family the same way. You will never look at your home the same way. And I promise, it will forever change the way you practice medicine.”

Dr. Hemant H. Vankawala

Creature comforts were soon added, including playrooms, laundry rooms, free donated clothing, and shoes. Movies, church services, job information, and disaster relief registration from FEMA and the Social Security administration were all available on-site.

From around Houston, people came to give whatever they could. They opened their houses and their wallets, and provided their time – all to help fellow Americans. I am proud to say that many of our ECI-affiliated partners/employees assumed these roles. We should all be proud to live in this

country where we continue to lend a hand to others in need. Houston made its mark and should be coined, “The New City of Brotherly Love.”

As a final thought, we will continue to read stories of heroism, grief, pain, and death resulting from this disaster. For those of you receiving ACEP news, I refer you



Dr. Michael F. Boyle

to a published email from Hemant H. Vankawala, MD, (ACEP News, Vol. 24(10): October 2005, page 7). He was part of the DMAT response team to the New Orleans airport and provided care for more than 30,000 evacuees from the disaster area. Most came with nothing and had recently lost their homes and their livelihoods. Many lost their lives at the airport.

After several overwhelming days of caring for these distraught, homeless, and sometimes dying patients, Dr. Vankawala provided reflections via email: “You will never look at America the same way. You will never look at your family the same way. You will never look at your home the same way. And I promise, it will forever change the way you practice medicine.”

With this reflection, please hug your spouses, love your children, appreciate your life, and say prayers of thanks for your good health and fortunate circumstances.

Chest Pain: An Emergency Physician's Approach

by Mark Mitchell, DO, FACP, ECI Regional Director
Chair, Department of Emergency Medicine, St. Joseph Regional Medical Center, Milwaukee, Wisconsin

It's a busy day in the emergency department (ED) and the triage nurse tells you a 53-year-old male has just arrived complaining of "chest discomfort." You know that chest pain or discomfort can indicate many different medical problems. Because you know that more than 5.3 million patients with chest pain present annually to the ED,¹ you immediately begin to consider all possibilities. These range from those not medically serious to those potentially lethal. Being trained to "rule out the worst," you immediately consider that the patient is having an acute myocardial infarction (AMI, heart attack). After all, he is a middle-aged male and this puts him at risk.

Following established protocol, you immediately place the patient in a room, and many activities begin to occur. The cardiac monitor is attached, oxygen is given, an electrocardiogram (ECG) is performed, and an intravenous line (IV) is started. If possible, the nurse draws blood for testing at the same time the IV is established to eliminate the need for a second "stick."

This gentleman, who thought there was nothing seriously wrong with him and who was coerced by his wife to come to the ED, reluctantly finds himself as the center of attention. You read the ECG and there is no evidence of a heart attack. What do you do next?

This is where the art of medicine comes into play. A physical exam and a careful history must be obtained to elicit the key factors that will assist you in narrowing your differential diagnosis. What is the nature of the discomfort? Is the pain sharp or dull? Was it a sudden onset or has the patient

CHEST PAIN - DIFFERENTIAL DIAGNOSIS	
SERIOUS CONDITIONS	LESS SERIOUS CONDITIONS
Acute Coronary Syndrome	Musculoskeletal Chest Pain
Acute Myocardial Infarction	Gastroesophageal Reflux
Unstable Angina	Hiatal Hernia
Esophageal Rupture	Pericarditis
Pulmonary Embolism	Pulmonary Infections
Thoracic Aortic Dissection	Bronchitis
Spontaneous Pneumothorax	Pneumonia

experienced these symptoms before? Was there radiation of the pain? If so, was it to the arm, neck, or back? Was there any event that seemed to precipitate the chest pain?

Despite an increased awareness on the part of emergency physicians and high admission rates to exclude an AMI, the rate of missed myocardial infarction continues to be about 2% to 5%.² In emergency medicine, missed myocardial infarctions account for approximately 10% of all malpractice cases and about 25% of all dollars paid in malpractice claims.

Currently, no medical tool exists that can accurately and specifically determine that a patient is not experiencing symptoms from coronary artery disease.

Over the years, medicine has made tremendous advances; we could not have imagined the number of disease states that we currently can diagnose, treat, and even cure. However, in an ED, where decisions must be made quickly, we are often still in a quandary when presented with a patient exhibiting chest pain.

Many patients with chest pain are eventually admitted to the hospital for additional evaluation. Often this testing provides time for observation as well as diagnostic testing that is not readily available in the ED. However, fewer than 25% of patients admitted to the hospital for chest pain are ultimately diagnosed with a cardiac etiology for their initial presentation.³ This low rate of diagnosis leads to a large portion of health care dollars being spent for what is often discovered to be a noncritical situation.

Currently, the emergency physician must rely on the ECG and cardiac markers to assist in the evaluation of the patient with chest pain. The ECG, a readily available tool, may be normal or nondiagnostic even in a patient with an AMI. Therefore, patients with a strong history of potential cardiac disease cannot be ruled out based upon a single ECG reading. Cardiac markers such as creatine kinase-MB (CK-MB) and troponin supplement the ECG. When myocardium (cardiac muscle) is damaged, enzymes are released into the bloodstream, and, therefore, elevated

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cardiac markers indicate cardiac injury.

When damage occurs to the myocardium, it takes upwards of six hours before an elevation occurs in the cardiac markers. Even though the public has been educated to seek medical care immediately when experiencing chest pain, many do not. In those who have experienced chest pain for a while prior to presentation and have a normal or nondiagnostic ECG, the rapid acquisition of cardiac markers is essential. Conversely, patients may also present early in the course of their cardiac event and prior to a measurable increase in the cardiac markers. Therefore, while a positive result assists in prompt diagnosis of a cardiac event, a single negative result will not rule out disease, and, therefore, cardiac marker testing may need to be repeated in a serial manner.

When a patient experiences chest pain from an AMI, time is of the essence. Immediately following an AMI, the damaged portion of the myocardium is going without a supply of blood and, consequently, without oxygen. The longer the cardiac muscle goes without regaining blood flow, the more irreversible the damage that occurs. It is vital to make an accurate diagnosis as soon as possible. Therefore, the emergency physician must have access to all the diagnostic tools and results as soon as possible. With the advent of smaller, faster, and more reliable laboratory instruments, the goal is to have results of the cardiac markers within 30 minutes of presentation and an ECG within 10 minutes. It is only with this level of efficiency that the emergency physician

can rapidly evaluate the patient with a potential AMI. As an ED physician, I have found that in a busy ED, a dedicated staff can best accomplish this speed, along with the availability of point-of-care testing (POCT). Every minute it takes a specimen to be transported and the resultant delay in obtaining results leads to an increase in morbidity and potential mortality for the patient.

We still do not have a perfect tool or test to evaluate patients that present with chest pain, but we do have better access to diagnostic tools, and more diagnostic tools are available than ever before. To provide the best care, all the technology that is currently available should be readily accessible to the emergency physician. In many institutions, the patient is best served by having all the necessary staff and equipment right in the emergency department. Emergency personnel must understand the urgency in rapidly evaluating these patients to save cardiac muscle and, ultimately, lives.

I am fortunate to work at a hospital administered by personnel who recognize the tenuous environment of the emergency department and which has allocated the resources required to operate at maximum efficiency. We have a dedicated laboratory within the ED that is able to perform POCT. Our staff is committed to the rapid evaluation and treatment of patients that present with chest pain, as is evident by our door-to-acquisition-of-ECG average of seven minutes. We are also able to obtain the results of cardiac

markers within approximately 16 minutes after the specimen is placed on the laboratory testing instrument. With the dedication of all personnel to the chest pain patient, we have seen marked improvement in the treatment of these special and complicated patients. This leads to earlier stratification of these patients as well as the prompt initiation of appropriate treatment for those with documented cardiac disease.

This article originally appeared in Dade Behring's RESOURCE magazine, North American Edition, for the clinical laboratory (3rd quarter, 2005). It is reprinted with permission from Dade Behring, Inc.

¹ Mitka. Experts promote adoption of chest pain guidelines by Emergency Departments. *JAMA* 2005; 294:164-165.

² Pope JH, et al. Missed diagnoses of acute cardiac ischemia in the emergency department. *N Engl J Med* 2000; 342:1163.

³ Rouan GW, Lee TH, Cook EF, et al. Clinical characteristics of patients with acute myocardial infarction and nonspecific electrocardiograms. *Clin Res* 1987; 35:360A.

Dr. Mark Mitchell

ECI Around The Country

ED Nurse Manager Honored as Leader In Enid, Oklahoma

St. Mary's Regional Medical Center in Enid, Oklahoma, recently announced the winner of the hospital's 2005 Leadership Award at the annual leadership retreat. **Yolanda Romanos**, RN, BSN, Emergency Services Nurse Manager, was selected to receive this award, which is presented to a member of St. Mary's management team who best exemplifies high standards in service excellence and leadership responsibilities.

Romanos is responsible for the management of the emergency department (ED) and supervises the nursing and ancillary personnel involved in rendering patient care service. She oversees the Transitional Unit and monitors its nursing staff involved in patient care. Romanos also collaborates with the Dialysis Service and monitors all its activities.

Romanos has worked at St. Mary's as a staff nurse and in the ED for 26 years, the last two of those have been in the management position.

In response to receiving this coveted award, Romanos says, "I have always strived for excellence in everything that I do. When I started this position within the department, I was uncertain as to how much improvement and change for the better I could accomplish. This award reassures me that I have an important impact on my staff as well as the hospital. The staff has been wonderful and my position has been very rewarding."

Romanos says she is most proud of raising two successful daughters. "I have two wonderful daughters; one is a junior at Oklahoma State University and my oldest daughter is looking into a career in business management," she said. "I

am also proud of being a St. Mary's ER nurse for 26 years. I have had excellent support and patience from my daughters and my life-long partner, Alonzo. Also, the entire staff of St. Mary's Regional Medical Center, as well as the physicians involved, are top-notch."

Call for Nominations:
ECI/Apollo Meritorious Awards 2006
Emergency Consultants, Inc. (ECI), has a long-standing reputation for recognizing exemplary service from employees and physicians, but it wasn't until 2004 that a formal annual award was established. Since then, time has been set aside at the ECI Annual Meeting to honor those who have distinguished themselves among their peers and who exemplify the tenets set out in the ECI Mission and Values Statement: Integrity, Quality, a Dedication to Corporate Growth and Stability, and People.

The Meritorious Awards of Distinction will again be presented to a Physician Partner of the Year, a Mid-Level Provider of the Year, an ECI Employee of the Year, and an Apollo Employee of the Year. With the recent change in the dates of the ECI Annual Meeting, now scheduled for May 24-26, 2006, in Traverse City, Michigan, the nomination deadline has been moved to April 1, 2006.

"The success of ECI and Apollo as one of the nation's top emergency medicine staffing, management, and billing companies can be directly attributed to the core values that have guided the companies since they began," said James M. Johnson, MD, ECI President and CEO. "It is imperative that we recognize these individuals who share

our beliefs in personal and professional integrity, high quality service, the highest levels of patient care, and a commitment to a positive and productive work environment for everyone."

To qualify for this honor, nominees must have been employees or physician partners prior to April 2, 2005, and must be affiliated at the time the awards are given. Past winners of the Meritorious Award of Distinction are ineligible. Nominations will be accepted from physicians, hospital staff members, and ECI and Apollo employees. Nomination forms may be obtained by contacting Cherie Meredith, ECI Marketing Coordinator (cmeredith@eci-med.com), and should be submitted to the following for review:

ECI Employees:

Cristal Guinan-Wittman
(cguinan@eci-med.com)
Director of Human Resources
Emergency Consultants, Inc.
4075 Copper Ridge Drive
Traverse City, MI 49684

Apollo Employees:

John Mantica (jmantica@eci-med.com)
Director of Human Resources
Apollo Information Services, Inc.
4350 Fowler St., #15
Fort Myers, FL 33901

Physicians and Mid-Level Providers:

Scott Caldie (scaldie@eci-med.com)
Vice President of Staffing Operations
Emergency Consultants, Inc.
4075 Copper Ridge Drive
Traverse City, MI 49684

Final determination of award winners will be made by Dr. James M. Johnson, ECI President and CEO, and the ECI Executive Committee. Winners will receive an inscribed Waterford crystal vase, as well as a \$500 monetary gift.

Congratulations

The following physicians, nurse practitioners, and physician assistants were recently board-certified or re-certified. ECI congratulates you on your achievement.

James D. Arnold, PA-C – NCCPA
Shirley J. Baker, PA-C – NCCPA
Fletcher Kathleen Bennett-Gayle, PA-C – NCCPA
Robert Leo Black, MD – ABEM
Shawn Michael Blair, PA-C – NCCPA
Scott D. Brown, PA-C – NCCPA
Kim M. Carnazzola, MD – ABFP
Tania U. Celia, RN, MSN, APN-C, NP-C – AANP
Mark Andrew Coates, PA-C – NCCPA
Patrick Michael Fitzwater, PA-C – ER AAPS
Linda J. Fraser, MD – ABFP
Kelly A. Gaba, PA-C – NCCPA
Louis Hiottis, MD – ABIM
Keri A. Hodgins, CFNP – ANCC/FNP
Jessica L. Hoff, PA-C – NCCPA
Katia V. Ilieva, MD – ABFP
Chad S. Kessler, MD – ABIM
Elizabeth A. Marlin, MD – ABFP
Francis P. Martin, MD – ABFP
Teresa D. Martin, PA-C – NCCPA
Daniel S. McPartlin, PA-C – NCCPA
Mark A. Mitchell, DO, FACOEP – AOBEM
Cynthia S. Mohny, PA-C – NCCPA
John D. Mucha, PA-C – NCCPA
James Edward Nahlik, MD – ABFP
Thomas Tirona Nasser, RN, MSN, ENP – ANCC/ENP
Kalpana M. Nayak, MD – ABFP
Elaine M. Noble, PA-C – NCCPA
David A. Poggemeier, MD – ABFP
Todd J. Reiman, MD – BCEM
David A. Rios, PA-C – NCCPA
Joyce A. Robinson, PA-C – NCCPA
William C. Shelby, PAC – NCCPA
Stephen T. Smith, MD – ABFP
Laura L. Snyder, DC, PA-C – NCCPA
Kelly T. Spiers, PA-C – NCCPA
Mark A. Stefaniuk, MD – ABFP
Jeannine Marie Wallace, PA-C – NCCPA
Lisa M. Warack, PA-C – NCCPA
Karla L. Whitcomb, PA-C – NCCPA
Bonnie S. Yoder, MSN, RNCS, FNP – ANCC

ECI Around The Country

National Medical Staff Services Week Celebrated at ECI

During National Medical Staff Services Awareness Week, November 6-12, 2005, ECI Credentialists were applauded for their hard work and commitment.

In 2005 alone, this group has accomplished the following:

- Successfully supported multiple start-ups, working under extreme deadlines and conditions to secure privileges;
- Secured 496 privileges for our practitioners by working closely with MSOs and CVOs
- Completed follow-up for clients' files, as well as ECI's files, as necessary, to exceed their goal of reducing missing and expired credentials to 1.48%;
- Completed a record 14,280 verifications;
- Exceeded their goal of reducing verification to less than 5.25 days;
- Exceeded their goal of complete verifications to better than 96.74%; and,
- Demonstrated leadership, creativity, open-mindedness, and flexibility while seeking new ways to improve ECI's processes.

“While the numbers are impressive, the most remarkable achievements in the department are realized through teamwork,” said **Pamela L. Gilbert**, CPCS, ECI Director of Credentials. “In addition to their tremendous daily tasks of monitoring and verifying credentials for more than 1,000 ECI-affiliated providers, they are studying to become certified by CPCS, a nationally recognized certification for credential specialists. I am proud to work with this outstanding group of professionals.”



ECI Credential Specialists (front row, from left): Jeanne Durga; Suzie Lautner; Lori Rodes; (back row, from left) Pam Gilbert; Laura Kroupa; Erin Norton; Heather Davis; Sharon Weber; Debbie Schichtel. (Not pictured: Erin Luca; Sarah Stephan)

W D I S I N I

All INSIDE ECI readers are invited to submit story ideas, photographs, or news items. Please contact **Cherie Meredith**, ECI Marketing Coordinator, at (800) 632-3496, extension 3134, or mail your items to the address which follows:

Mailing address: Emergency Consultants, Inc.
4075 Copper Ridge Drive
Traverse City, MI 49684-4796

Phone numbers:
National (800) 253-1795
Local (231) 946-8970
Fax (231) 946-1730

Internet:
Editorial submissions: cmeredith@eci-med.com
General information: www.eci-med.com

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