



A newsletter for affiliated physicians,  
clients and co-workers

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**“It’s Part of the Deal”**

By James M. Johnson, MD  
ECI President and CEO

**F**orty-one million people! Fourteen percent of our population! That’s the number of citizens in this country without health insurance. This group is also twice as likely to visit an emergency room than average. For most, it may be the only time they see a doctor and 90% don’t pay or can’t pay. Emergency physicians attend over 20 million of these patients yearly. Our group alone sees nearly a quarter of a million such patients. But, that’s okay. It’s “part of the deal for us,” and I’ll tell you why.

After World War II, President Harry Truman was pushing hard for universal health coverage for all citizens as an extension of Social Security. American doctors hated the idea of government intervention in medicine. They fought vigorously against the concept and won. To quote the AMA in 1946, “National health insurance legislation would overturn the traditional predominately private system of medical care, gradually destroy private initiatives and freedoms, reduce physicians to the status of government employees and eventually dictate medical decision.” While national health insurance didn’t happen in the U.S., it did happen in Britain in 1946 with its National Health Service and the above AMA quote was prophetic for the fate of that service.

Compared to the British, American doctors enjoy much higher social status, income levels, and freedom of medical practice. Moreover, I believe our medical care is the finest in the world. Indeed, even for patients without resources, their basic medical needs are being met through the charity of hospitals, organizations and doctors such as ourselves.

So as a physician, I’m grateful to those rough, independent doctors of the 1940s and 1950s who fought for, and won, our professional freedom. It wasn’t all about the money as they provided a lot more free care than we can imagine in those days. All patients now covered by Medicare and Medicaid were basically “freebies” prior to 1965. But as they told me, “that was just part of the deal.” Sure, things have changed a lot since those days, but there’s still nothing in the world like being a doctor in America.



James M. Johnson MD  
ECI President and CEO

# ED/X: A Vital Tool in Improving Patient Satisfaction

By Linda J. Nordeman, MD, FACEP  
Medical Director, St. John's Hospital, Springfield, Illinois

Last fall, the emergency department staff at St. John's Hospital initiated a campaign with the single-minded focus of improving patient satisfaction within the department. An essential tool used in obtaining and maintaining our campaign has been ECI's program entitled, ***ED/X: Ten Simple Ways to Improve Patient Satisfaction.***

Concentrating our focus was the first step. We recognized that our greatest opportunity to achieve improvement was to concentrate our efforts in three specific categories. We chose to emphasize: 1) informing patients about their treatment plans, 2) informing patients about delays, and 3) controlling pain.

Step two was a thorough understanding of the survey tool. We reviewed the Press Ganey survey and identified those questions that specifically addressed our chosen focus for improvement: Are doctors and nurses informative about treatment? Is the information provided to family and friends adequate? Are tests explained adequately?

Are patients informed about delays? How well was the patient's pain controlled?

Enthusiasm was the real strategy

for success. Our success was ultimately dependent upon the entire ED staff's investment in the process. We shared our goals and engaged the staff in developing a strategy. Both our chosen focus, which was to demonstrate improvement on the Press Ganey survey, and our prior survey results were presented at nursing and physician staff meetings.

The *ED/X* program was used as an impetus for discussion. We looked at ways to change our behavior and our patients' perceptions. The *ED/X* modules are ideal for this purpose. Each module addresses an individual issue or behavior, and we discovered that each module contained very practical information that deserved reinforcing. The staff requested a written copy of many of the suggestions provided in the modules, particularly alternative methods of communicating, both verbal and nonverbal. A transcript of the modules was obtained which made this task much easier. We used several of these suggestions as scripts.

We also initiated a 411 campaign. Expanding on the "Explaining Procedures" and "Explaining Delays" modules, we undertook a "give them the 411" program. The nurses wore "411" buttons, reinforcing our commitment to keeping patients and families informed.

Measuring the results provided credibility for our efforts. There was uniform improvement in our Press Ganey scores the quarter following these initiatives. Responses to the questions listed above were tracked and graphed.

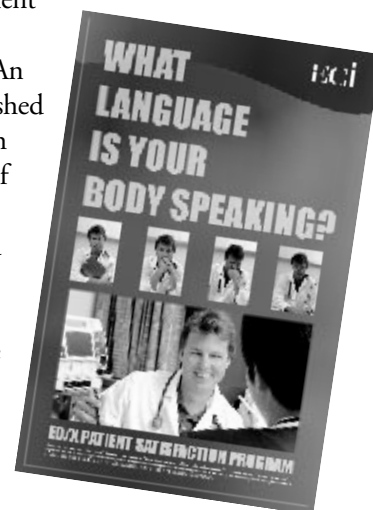
We provided rewards to the staff for a job well done. T-shirts bearing the logos "BettER" and "KindER" were

designed and purchased by the physicians as gifts for ED staff to thank them for their tremendous efforts in making our department

a better and kinder ER. An article published in the March 2004 issue of ECI's *Nexus* documented our success. When the *Nexus* article was shared with our hospital administration, we

received even greater recognition. Now, our task is to maintain the results. Borrowing an idea from ECI's Regional Director Dr. Jim McCorry, we have displayed the *ED/X* posters in the staff lounge. Adjacent to each poster are actual survey responses, thank you letters, and staff recognition notes that correspond to the appropriate poster. Every individual specifically identified by a patient is recognized as part of the display. The staff (not management) develops and maintains the theme-based display and we continue to track and post the survey responses. This kind of *personal* feedback is most rewarding.

Now, several months later, we are "re-viewing" the *ED/X* modules to reinforce our new ways of interacting with patients. Newly developed quizzes for each *ED/X* module have been modified to focus on our areas of concentration. These are used as a fun challenge to reinforce the *ED/X* program message.



Linda J. Nordeman, MD, FACEP, Medical Director  
St. John's Hospital  
Springfield, Illinois

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# Continuing Education Requirements for Board Members

By Harvey Calcutt, Director  
ECI Board of Directors

The literature about being a good board director stresses the need for ongoing involvement and continuing education in the business. The more informed you are, the more you participate in the processes of the business. The decisions you help make have the consequence of making the business better. Each board member has a unique background and experience, some outside the emergency medicine field, and thus can provide insight and perspective to look at problems differently, to “see the forest for the trees.”

ECI generously offers its board members the opportunity to participate at various levels of the organization. It also affords the opportunity to independently meet executives, management, and staff within the organization as well as outside it. These opportunities provide a board member with the foundation to better assess and provide guidance in meeting ECI’s strategic and operational goals. The board’s overall goal is to make ECI a long-term, successful company.

It also helps to participate in the business throughout the year, as this allows directors to reflect on the critical issues facing the company, such as ECI’s worsening payer mix and lower patient reimbursement. Without staying informed about the issues and participating in the process, it is difficult for directors to retain their independence, which is essential in

meeting their responsibilities on the board.

Throughout 2003, I attended a wide range of ECI related business functions. You might call them my board member’s Continuing Education Requirements.

- Attended the Annual Emergency Medicine Symposium in Franklin, PA, organized and presented by ECI Regional Director, Dr. Rade Vukmir.
- Met with Bayhealth Medical Center executives in Dover, Delaware, along with Regional Director Dr. Tom Zguris and ECI President Dr. James Johnson.
- Participated in the February, May and September Regional Director meetings of ECI.
- Visited several emergency departments, met local emergency physicians, and received a better education of the daily working issues and hospital environment.
- Participated in several Apollo Information Services, Inc. quarterly meetings that covered operational issues and compliance matters of ECI’s billing company.
- Observed an Executive Committee meeting of ECI, and participated in the board meetings of National Guardian Risk Retention Group and ECI-Reinsurance.

- Attended the ECI’s Medical Directors’ Management Course in the spring of 2003 and also ECI’s Annual Meeting in September, where I was able to meet with hospital CEOs and other executives, hearing their concerns about critical issues.

In addition to these activities, I reviewed surveys, financial statements and operating plan documents that were provided to me, such as the strategic 2004 to 2006 Technology Plan for ECI and Apollo Information Services. From these I was better able to grasp ECI’s operating challenges from managing appropriate staffing levels, to improving internal productivity, to recruiting and retaining qualified physicians. These are ongoing issues that ECI’s board and management continue to address.

ECI encourages its board members to understand the business, the ever-changing regulations, and its critical choices. ECI solicits the perspective of its board members when making its long-term choices. It is good management to make use of directors, and in the end it is good business for everyone.



Harvey Calcutt, Director  
ECI Board of Directors

# Quality AND Productivity: What More Could You Want?

By John D. Hayden, DO, FACOEP  
ECI Regional Director / Chair, QualChart® Committee

Would an opportunity to enhance quality while doubling production interest most business persons? Does that concept interest you? That opportunity is precisely ECI's goal/aspiration upon release of the latest version of The ECI QualChart System® – QC2004.05 – later this month.

How can a documentation system aspire to such lofty claims, many sane folks might ask? And here, of course, comes the "fine print." But, bear with us, please, as this "fine print" is eminently above board and, we think, logical.

In our business of emergency medicine the maxim is, "if you didn't document it, you didn't do it." Therefore, excellence in patient care can only be demonstrated through excellence in documentation. Striving for this excellence has always been the paramount goal of The ECI QualChart System.® Furthermore, it stands to reason that doubling documentation of *certain common emergency department (ED) events* would also double the legitimate coding of same. Thus, we theoretically substantiate the introductory statement at the onset of this article.

Okay, that's a pretty brief synopsis. Thank you for reading this far. From here on we promise only the "straight" stuff with more detail, as we focus on three segments of the overall documentation requirements for all providers:

- Procedure Notes
- Critical Care
- Enhanced Quality Management / Risk Management (QM/RM)

Let's look at QM/RM first because that is where it all begins. Significant progress was achieved via customer response and a continuing quest for improvement through four major revisions since 2002. However, two areas the QualChart® Committee believed could

benefit from further design improvement were:

- Documentation of specific History and Physical elements of *certain high risk patient complaints*

- Documentation of patient re-evaluation and patient status on discharge

The former was readily attained via our regular editing procedures. The latter goal required a new approach, as the QualChart® Committee concluded that we should incorporate this initiative into the re-design of the QualChart® Order Sheet project, on the drawing board since mid-2003.

The **Order Sheet** is a crucial document. It is the sole component of the documentation system that must clearly and efficiently communicate information between all ED personnel on a real time basis. It has to be good.

One common area of concern of the System's current Order Sheet comes from end-users who want a less structured format. They suggest, "it is too busy," and/or, "we need more room to write additional orders." Conversely, we have received just as many comments suggesting that the inclusion of specific additional order entries would ease documentation needs. So, we face the task of resolving concerns registered from totally opposite ends of the documentation spectrum.

The most reasonable approach to begin resolution of these disparate viewpoints was to create one or more specific Order Sheets for each body system AND manage the content variability of these new Order Sheets to maintain a uniform format and appearance.

ECI's Executive Committee and Regional Directors have endorsed this concept, and we, respectfully, present it to you.

## **PROPOSAL:** **Complaint-Specific Order Sheets (CSOSs)**

### **Process:**

- Define Chief Complaint areas that warrant specific Order Sheets. Not surprisingly, this worked out roughly parallel to our existing body system index

- Remove all general Order Sheet entries that did not pertain to a specific Chief Complaint area

- Add occasional specific orders that may not have been included previously

- Draft appropriate routine medication and treatment orders for each Chief Complaint area

- Insert Procedure Note templates (revised from current Procedure Notes section) where (or when) pertinent

- Design specific re-assessment criteria for each area of Chief Complaint

- Cross reference one specific CSOS for each existing QualChart®, so the correct CSOS prints automatically with the appropriate QualChart®.

**Result:** QualChart® 2004.05 will feature approximately 20 adult and pediatric Complaint-Specific Order Sheets. We hope you find them helpful.

Developing the CSOSs was a valuable experience. The process convinced us that Order Sheets can definitely enhance our documentary quest for excellence. However, they cannot by themselves address all our Critical Care documentation concerns. Therefore, QualChart® 2004.05 will introduce a new documentation format, entitled Critical Care Management Forms.

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# Congratulations

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

Antonio B. Martins, MD - ABEM

Anwer M. Hussain, DO - AOBEM

Brian J. Hoberman, MD - ABEM

Cynthia S. Mohney, PA-C - NCCPA

Darcy M. Clawson, PA-C - NCCPA

David W. Andrews, MS, PA-C - NCCPA

Dominic I. Asika, MD - ABEM

Elizabeth K. Denniss, NP - ANCC

Emma Morris, RN, MS, FNP - ANCC/FNP

Harparminder S. Chadha, MD, FACEP  
ABEM

Helene Connolly, MD, FACEP - ABEM

Joanne E. Lapetina, MD - ABIM

Joyce M. Mitchell-Savinsky, MD - ABEM

Karla L. Whitcomb, PA-C - NCCPA

Kenneth C. Ramey, PA-C - NCCPA

Kevin Prince, ENP - ANCC/FNP

Manuel V. Sarroca, MD - ABEM

Martin R. Artman, MD - ABEM

Mary E. Horrigan, MD - ABEM

Melani B. De Silva, MD - AB Pediatrics

Michael F. Boyle, MD, FACEP - ABEM

Michael R. Cantu, MD - ABEM

Phillip R. Tatnall, MD - ABFP

Robert Stephen Venable, MD, FAAFP,  
FACEP - ABEM

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## PROPOSAL: Critical Care Management Forms

### Process:

- Select Cardiopulmonary Management Form (CPMF) prototype
- Include nearly all standard therapeutic measures and medications routinely used in treatment of seriously ill patients with chief complaints of Chest Pain, Shortness of Breath, or Dysrhythmia
- Note that the CSOS should be utilized initially with the CPMF added when indicated. We have provided clear suggestions/indicators as to when it is appropriate to forward continuing patient care documentation from the CSOS to the CPMF.

**Result:** We think this will work. We believe you will agree after using it a time or two. Please keep in mind that the goal is to aid us in providing the best possible care and documentation for our sickest patients by enabling providers to circle preprinted entries rather than writing them. This can only help you and your ED staff, especially in the wake of the new JCAHO requirements restricting use of unacceptable abbreviations.

The CPMF will serve as our prototype. After we have resolved any “kinks” it may contain, we anticipate introducing Management Forms addressing additional Critical Care areas, such as DKA, Sepsis, Really Sick Kids, and Trauma.

Ergo, system-wide adoption of these improved documentation tools cannot miss in augmenting the quality of our documentation. It will surely enhance communication between providers, RNs, and ED support personnel.

We sincerely expect these forms to make your job easier. We also expect use of these Critical Care Management Forms will increase our rate of coding for Critical Care Services. We further look forward to an even more significant increase in the number of CPT Procedural Codes assigned by Apollo. (*Note: A significant but unquantified number of procedures you currently perform for your patients cannot be billed due to incomplete documentation.*)

The QualChart® Committee is willing to bet a year’s worth of work that, together, we can double production of the previously less than optimally captured CPT codes of various Procedures and Critical Care. We hope to commission audits through Apollo in an attempt to quantify the effect of these changes. We anticipate reporting our results in a future issue of *Inside ECI*.

We hope and believe you will find these new documentation tools to your liking. As always, we encourage your thoughts and written comments. Please contact us any time via email at [qc@eci-med.com](mailto:qc@eci-med.com) or voice mail at (800) 253-5358, extension 64.

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# Head, Hands, and Heart

by Thomas C. Zguris, MD, MBA, FACEP  
ECI Regional Director

I coached my sons' hockey team for seven years. We enjoyed considerable success with five consecutive undefeated seasons. I would certainly like to credit that success to my coaching ability, but, in fact, it was not my coaching at all. It was my ability to recruit excellent players.

Each year, tryouts were held and hundreds of hopefuls would fill the arena. They were put through a series of drills designed to show off their skills. I evaluated each player based on three attributes: *Head*, *Hands*, and *Heart*. *Head*, of course, addressed how smart they were. It's said that a good hockey player is always where the puck is, but a great hockey player is always where the puck will be. *Hands* assessed how technically capable players were at skating, stick handling, passing, and shooting. *Heart* measured spirit, how driven the player was, how much fire he possessed.

A true champion has all three attributes in large doses. Over seven years and hundreds of players, I never saw a true champion. Some came close with healthy combinations of the three, most had one or two, and some poor souls possessed little or none. By choosing players based on this system, I was able to recruit a consistently winning team.



I always placed the greatest premium on *Heart*. These players were the guys who were

always eager and would find a way to accomplish their task, no matter what it took. Sometimes, they were not smart enough, or technically capable enough, to realize that they didn't have the natural ability to succeed, even while they were succeeding as a matter of the *Heart*.

A little over one year ago, both of my parents passed away. As I sorted through their belongings, I was forced to confront my past. As an only child, what they left was a virtual scrapbook of my life. Every greeting card, every Cub Scout project, every report card (good and bad) was all mine. I couldn't help but reflect inwardly and take a true measure of myself.

Strangely enough, I began for the first time to look at myself in terms of *Head*, *Hands*, and *Heart*. It was enlightening, humbling, and liberating – all at the same time.

It became quickly apparent (no help from the report cards) that of the three attributes, *Head* was not my strong suit. As I was finishing my undergraduate degree, my counselor asked what my plans were. When I told him that I was going to be a doctor, his incredulous response was, "No, really, what are you planning to do?" I scratched and clawed my way through the halls of medicine for the next four years. Afterwards I entered a surgical residency, where my *Hands* were put to the test. Not so subtle comments like, "You are a klutz," or "Try your other left hand," made it apparent that hands were not going to carry me. So what was left was my *Heart*. So far, it

has never failed me. I have always been able to hang in there and do what was needed of me.

Several years ago, my family visited Africa, and while in Egypt we cruised the Nile. As we made our way through the Valley of the Kings, we lightheartedly discussed what role we might have played in the ancient times. This was an empire filled with gods, pharaohs, kings, servants, and slaves.

On the shore of the Nile, I found my answer. The Nile means life to Egypt. Just a few hundred yards off the shoreline is the harsh Sahara Desert. The fertile area adjacent to the river is kept that way by irrigation. This irrigation is accomplished by tying a donkey to a wheel and having the animal walk in circles, turning the wheel and scooping small buckets of water from the Nile that feed the irrigation ditches. Handlers keep the donkey moving, blindfolding the animal so it doesn't realize that it is walking in circles. The handlers give the donkey a crack with the whip and off it goes, non-stop, providing the lifeblood to the otherwise completely arid region. If the blindfold is removed, the donkey stops. There it was. There was my purpose: set on a course, to steadily complete my task. If they ever remove the blindfold, I will probably get a tattoo, hop on a Harley, and head off to Cabo. But for now I use the one attribute that I possess, my *Heart*, to do my best.

As I began to look at myself in these terms, I couldn't help but look at others in the same way. My family, friends, colleagues, and co-workers all suddenly became clearer as I regarded

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## ECI: Around the Country

Giggles and laughter were coming from emergency departments throughout the country as the recent ECI teambuilding exercise “Laughter is the Best Medicine” was unveiled. Judging from the smiles on the faces of those pictured here, there are more good times to come. Winners in the network-wide program were: 1) Jeanne Cox, RT, shown with Joe Behrman, ED Nurse Manager (center) and Premal M. Joshipura, MD, FAAEM, Medical Director of the Condell Acute Care Centers in Buffalo Grove, Gurnee, Round Lake Beach and Vernon Hills, Illinois, 2) Eric Herrin, RN, shown with Lisa Mathis, RN, MSN CS, FNP-C, ED Nurse Manager (left) and William R. Elliot, MD, Medical Director of the Emergency Department at Satilla Regional Medical Center in Georgia, and 3) Dan Zimage, RN, shown with Dawn Spar, RN, ED Nurse Manager (third from right), Michelle Amos, RN (second from right), Mary Speicher, Patient Care Assistant (far right), and Mark L. Grimes, MD, Medical Director (far left) at Samaritan Hospital in Ohio.



### Management Course Brings 18 Directors to TC

At ECI's annual Management Course, held April 22-24 in Traverse City, Michigan, 18 Medical and Assistant Medical Directors from ECI-affiliated hospital emergency departments and clinics joined ECI Regional Directors and staff for a two-day orientation and education session. Speakers included Drs. James M. Johnson and Robert M. Williams, ECI's founders, and Mark Burnheimer, ECI legal counsel and president of ECI's captive insurance company, National Guardian Risk Retention Group.

Presentations covered ECI Qual-Chart® System updates, educational offerings, an overview of Apollo Information Systems (ECI's coding and billing company), quality management, marketing materials and patient satisfaction training. Other sessions included an overview of the ECI Vital Signs report, EMTALA updates, practice management processes, and conflict resolution.

## Head, Hands, and Heart

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them according to their “*Head, Hands and Heart*,” and better understood what their strengths and limitations were. I even found that while interviewing physicians, I began measuring them in these terms. Try it. You will quickly be able to determine your strengths as well as those of others.

Finally, a few words of advice. If

your prize possession is your *Heart*, treat it well, and entrust it to those who will take care of it. For twenty-one years I have entrusted mine to my wife, Diane, and have committed it to the only company I have ever worked for, ECI. Both have taken very good care of my heart. Secondly, if you are technically gifted, this will carry you



a long way. This is the attribute that is most visible and most admired by others. Lastly, if you're blessed with a big brain, be patient with the rest of us. Remember, even if you see the finish line well ahead of the pack, life is not always a race. Go easy on those who are not so blessed, particularly if one happens to be interviewing you.

# EMERGENCY INSIDE



All INSIDE ECI readers are invited to submit story ideas, photographs or news items. Please contact **Debra Meints**, ECI Marketing Coordinator; at (800) 253-5358, extension 3134, or mail your items to the address which follows:

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