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60 Minutes is Calling...

and News Helicopters are Overhead!

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Such frenzied messages are the stuff of sleepless nights for hospital administrators. But, in spite of administrators' best efforts, these calls are a given hazard of the business, and this was indeed the call received several years ago by a startled Los Angeles hospital CEO.

As now seen in the rear-view mirror, the call was proceeded by an unfortunate series of events that started with a paraplegic homeless person presenting at the hospital's Emergency Department. Scrolling through the 24-hours following the patient's arrival at the ED, a series of triage, evaluation, discharge, and transportation glitches led to the media frenzy upon receiving surveillance camera views of the patient, still in his hospital gown, dragging himself in a Skid Row street gutter.

This was followed by expensive litigation posturing during which time the local media was pleased to revisit the event with each new filing. After a year, the fire was substantially doused by settlements of lawsuits brought by the City and the patient.

The effects, however, are still felt anytime a "patient dumping" (or, in the less incendiary terminology, "homeless discharge") case hits the press and reference is invariably made to this case, although the hospital staff chafes with the knowledge that for each problematic discharge, thousands are handled with care and utmost professionalism with the best result possible under the circumstances.

Disasters Happen

Disaster preparedness has been seminar fodder for some years. Hospitals have in place procedures for a variety of natural and man-made events, but not every event can be anticipated and protocols may prove ineffective if not properly stated and owned at all levels by those who may touch the problem.

Such was the case with this homeless discharge event. The hospital substantially followed its procedures, the principal bad actor being a contracted third party. But after-the-fact finger pointing may not rectify serious harm. A costly lesson is that finding avoidable error can prevent, as in this case, millions of lost dollars and largely undeserved negative press.

Find the Error and Eliminate It

Hospitals have been adopting procedures to assist generally in error reduction, in some cases taking lessons from other industries.

Error reduction methodologies, whether Six Sigma, Toyota Production or another, can empower staff, shine bright lights on improvement needs, and stop impending disaster in its tracks, assisting the development of best practices.

Also assisting the cause is the new found voice to admit errors swiftly, publicly, and appropriately celebrate them as learning opportunities.

So, Before Sixty Minutes Calls

The stars can line up in unfortunate ways at any place in a facility, but

consider this actual case study of a homeless person presenting at an ED under circumstances that may sound familiar to you:

- An often frenetic level of activity in the ED
- An ED staff with a close knowledge of EMTALA requirements, but perhaps this knowledge is at the expense of failure to train in other areas because of limited training time
- A homeless patient presenting with the possibility of significant substance abuse and mental health issues
- ED staff pressure on throughput and admissions
- For some EDs, significant language and cultural barriers

Although this may appear to be an issue for larger metropolitan facilities, any facility having homeless people presenting at the ED cannot ignore the significant potential for problems that may arise should there be error in any step of the process in dealing with this special needs population.

Lessons Learned

It starts with the template hospital administrators have preached elsewhere in error reduction:

- Well-stated and frequently-updated **protocols**
- Continuous live and e-module **training**
- **Reassessments** from all who touch the issues

Other lessons learned include:

- Do not ignore ever-changing state and local laws on this subject, which may exact fines or criminalize certain actions
- ED training must go beyond EMTALA requirements
- Be mindful of the mental health issue – more jurisdictions are looking at possible exclusion zones for places where the mentally ill may not, under any circumstances, be transported, which of course places added burden on the psychosocial evaluation by the attending physician and social worker
- Get to know the capabilities and offerings of local social service agencies

Staff Protocols

These should include:

- Full-time and on-call social service staff (at a time of reductions in staff at many hospitals, a fairly modest move such as extending social service availability until 10 p.m. can greatly assist with reducing overnight admissions for homeless per-

sons presenting in what is typically a spike between the hours of 7 pm and 10 pm, and provide the homeless with better service)

- Overall compliance responsibility with one person, perhaps a case manager
- Initial and periodic training, including shelter and service location, referral sources, cognitive intactness assessment, and post-discharge problems

Evaluation Protocols

These should include:

- Entering the patient name in a homeless person log maintained in the ED
- Documenting personal belongings and providing clothing, if inadequate
- Assessing and documenting mental or psychosocial status with participation by the treating physician and social worker, including cognitive intactment and ability to understand a discharge plan, to care for self, access shelter and medical care, determine current sleeping place, identify support systems, and evaluate orientation to person, time, and place
- Continuous pre-discharge mental assessment and treatment referral as appropriate

Discharge and Transportation Protocols

These should include:

- Applying for Medicaid, mental health services, and other financial assistance
- Transfer, if medically appropriate and legally permissible
- The patient leaves with the correct DME for ambulatory assistance
- Assisting with outpatient referral
- Transportation expense approval by a supervisor and the patient's written consent to be transported
- Knowing the choices of facilities to assist with patient requests and verify a shelter meets the patient's needs
- Faxing or e-mailing information to the receiving shelter before transport, with proper identification of information required by the receiving facility
- Reviewing security and transportation contractor agreements regarding hospital policy compliance, including training
- Checking the ED waiting area for discharge compliance and re-engagement with social services, as needed

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