Abstracts of the 19th Annual Meeting of the Society for Academic Emergency Medicine

Editor's note: The following 216 abstracts will be presented at the Annual Meeting of the Society for Academic Emergency Medicine in San Diego, May 22-25. Presenters' names are printed in italics; where presenter is not indicated, none was specified by the authors.

Poster Presentations

1 'Frequent Fliers' — A Protocol for the Management of Frequent Visitors to a Community Hospital Emergency Department

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Most emergency departments have patients who present frequently, account for a substantial number of repeat visits, and often have either minor complaints or major demands. Encounters with such "regulars" may be difficult, frustrating, and time-consuming for the emergency physician. We present a method for management of patients with frequent ED visits, or "frequent fliers." The steps for implementing the program include patient identification, establishment of a confidential file, ensuring the diagnosis, arrangement of follow-up and continuity of care, periodic file review and update, and staff education. The majority of patients have a history of one or more of the following: chronic pain syndrome, borderline personality, psychiatric disorder, chronic medical problems, drug-seeking behavior, drug abuse, or alcoholism. Patients with frequent ED visits for acute medical problems, such as sickle cell disease, chronic obstructive pulmonary disease, or positive HIV antibody, are also included. The names of all frequent fliers are kept on a computerized list that is updated every two months. Each patient has a confidential file, available only to the emergency physician, that contains copies of the records from previous ED visits along with a transcribed summary of ED diagnoses, treatment, and aftercare plans. Information concerning medical, social, psychological, and legal intervention is also included. The files are maintained by one interested physician who, when available in the ED, evaluates and treats these patients. The physician also reviews previous hospital records, communicates with the patients' previous and current physicians, formulates patient care plans, identifies a continuity of care physician, confers with families, and, where indicated, involves legal authorities (such as the narcotics bureau or child protective services). Emergency physicians, nurses, counsellors, and social workers must be knowledgeable of the system and present a unified and consistent approach to the patient. We have used the frequent flier program over the past four years, decreasing the number of patients with more than 30 visits per year from 30 patients in 1984 to two in 1987.

2 Radiograph Ordering: Agreement Between the Triage Nurse and Physician in a Pediatric Emergency Department

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Techniques to reduce patient waiting time are of importance in busy emergency departments. We hypothesized that the triage nurse in a busy pediatric ED could accurately order radiographs, thus reducing patient waiting time. All patients registering at the ED of the Children's Hospital of Eastern Ontario in a one-week period were entered into the study. A study form was attached to each chart at registration. It was removed and completed by the triage nurse prior to the physician seeing the chart. The triage nurse documented whether they would send the patient for a radiograph if allowed to. If a radiograph would have been ordered, documentation was done as to the function deficit, swelling, deformity, and specific radiograph desired. The radiographs that were actually ordered by the physicians were subsequently obtained. Data were analyzed for agreement beyond chance (kappa), sensitivity, specificity, and positive (PPV) and negative predictive values. Radiographs ordered by the emergency physician were used as the gold standard.

Radiograph ordering: Triage nurse versus physician

	No.	Sensitivity	PPV	Kappa
All radiographs	212	.73	.74	.65
Ankle	16	.85	.91	.87
Knee	17	.88	.78	.83
Finger	18	.67	100	.79
Wrist	12	.67	.80	.72
Chest	24	.21	.50	.28
Abdomen	12	.17	.50	.24

Triage nurses showed good agreement with physicians in the ordering of extremity radiographs.

3 Emergency Department Medical Record Quality — Measured by Implicit and Explicit Methods in an Academic Setting

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Controversy still exists in the field of quality of care assessment as to the correlation between the adequacy of the medical record and patient outcomes. Studies disagree as to the quality of care rendered, based on retrospective chart audit, depending on whether implicit (subjective) or explicit (objective) criteria are used. This study was conducted at the end of an academic year (March to June 1988) at a major, 330-bed urban teaching affiliate of the University of Massachusetts Medical School whose Level II emergency department, staffed by 24-hour attending physicians, housestaff (emergency medicine and internal medicine), and nurse practitioners, evaluates more than 30,000 patients annually. The study compared the congruency between an explicit and an implicit criteria approach vis-`a-vis two common and potentially serious patient complaints — chest pain and abdominal pain. ED records of randomly selected patients (13 to 89 years old) who presented with complaints of chest pain (142) and abdominal pain (159) and were subsequently discharged comprised the study population. Records were graded by different nonblinded departmental attending physicians, as part of our departmental QA program, unaware of the study design or intent, as to the presence in the medical records of specific historical and examination elements (objective), ancillary laboratory/radiographic use, and overall adequacy of the history and examination (subjective). Physicians did not self grade. A 10% subset of the study sample demonstrated an interobserver positive correlation of 0.84. A positive correlation ($r \approx 0.81$, abdominal pain; $r = 0.78$, chest pain), independent of the provider or either clinical condition, existed between the explicit score and the subjective score. There were significant differences between and among attending physicians, nurse practitioners, and all housestaff levels as to their medical record "quality," but overall, attending physicians scored higher than housestaff and nurse practitioners when compared by the explicit approach. There were fewer but still significant differences in their grading when assessed by the subjective approach.

4 A Dictated and Transcribed Medical Record Can Be Cost Effective

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A dictated and transcribed emergency department record provides an improved medical/legal/billing document with a more professional appearance. A major concern has been raised regarding the cost of that transcribed medical record. Our ED had an experience with a computerized and dictated medical record for a two-year period. The Dictaphone® data bank and transcriptionists were located in the ED. The record was transcribed onto an IBM®-AT computer using MultiMate® software with fixed headings. The