What are others doing to comply with the new Health Insurance Portability and Accountability Act (HIPAA)?

Answer:
Congress proposed legislation in 1996 to make health insurance portable (as employees moved from job to job). HIPAA actually has 6 parts. Most hospitals are currently focusing on the aspects of electronic data transaction (implementation effective October 2002) and security and privacy (implementation effective April 2003). These areas require new restrictions on users and protection for personal, private health information.

Some applications for nursing to consider include the following:

- Do not give away your personal computer password. Change your password regularly.
- No patient information should be sent by external E-mail unless you know your system is secured against unauthorized access.
- Fax machines must be in a secured location, such as inside a work station.
- Do not send patient information by fax unless your machine is equipped to detect whether the number you dialed matches the number on the cover sheet.
- A compact disk that includes patient information must be “ruined” (eg, by running a nail over it) before it is placed in the trash.
- All patient paperwork must be kept in a secured area and shredded before being discarded.
- Patient monitors must not be visible from a public area.
- All employees should be required to sign a specific confidentiality agreement with strict enforcement. If blatant offenses are not reprimanded, an improper practice will become commonplace.
Be aware that as of August 14, 2002, the final Rule acknowledges that uses or disclosures that are incidental to an otherwise permitted use or disclosure may occur. Such incidental uses or disclosures are not considered a violation of the Rule provided that the covered entity has met the reasonable safeguards and minimum necessary requirements. For example, if these requirements are met, physicians’ offices may use waiting room sign-in sheets, hospitals may keep patient charts at the bedside, physicians can talk to patients in semiprivate rooms, and physicians can confer at nurses’ stations without fear of violating the Rule if they are overheard by a passerby. The emphasis is on meeting the reasonable safeguards and minimum requirements.

Although the focus of HIPAA is patient confidentiality, many organizations consider these safeguards just as important for their employees’ information. For instance, some institutions are no longer posting the unit’s work schedule (with phone numbers) in a common area or having a secretary ask employees for the reason they are calling in sick. We have developed an HIPAA Risk Assessment/Impact Analysis tool to evaluate your needs. Contact us if you would like a copy of this tool or our assistance.

Additional information can be obtained from the following Web sites: http://www.hipaadvisory.com/ or http://insideenps.ins.com/sales/hipaa/.

—Chrysmarie Suby, RN, ANP, Co-owner/Senior Consultant, Labor Management Institute, Bloomington, Minn; (952)835-2866; E-mail: c.suby@labormanagementinstitute.com and John Washburn, Senior Business Consultant, Lucent Technologies, Minneapolis, Minn, and VP Professional Services, AcuStaf Development Corporation; E-mail: john.washburn@acustaf.com

**FAQS FOR ADMITTED PATIENTS**

**How are other emergency departments using faxed reports, instead of a verbal report, on an admitted patient going to the floor unit?**

**Answer:**

When we initially started our program more than a year ago, we held meetings for the nurses from the floor units and the emergency department. After the process began, we followed up with trouble-shooting meetings to review issues (eg, poor penmanship and broken fax machines).

Our form is satisfactorily meeting everyone’s concerns (Figure 1). With the faxed form, the floor unit nurse always has a reliable report, and the faxed report is used as the start of the inpatient kardex. In addition, the Medical Records Committee has decided to make it part of the patient’s permanent record because it provides a useful synopsis of the patient’s ED stay.

We do not fax a report on our patients going to the ICU. The conditions of those patients are too complicated, and the ICU nurses seem to be more readily available to take report.

Since starting to use faxed reports, our ED length of stay for admitted patients has decreased by an average of 45 minutes. We wonder now how we ever got by without it!

—Darin Roark, RN, BSN, Manager, Emergency and Intensive Care Services, Oak Park Hospital, Oak, Park, Ill; E-mail: Darin_Roark@rush.edu

**ASSESSING NEW HIRE COMPETENCIES**

It seems like the new nurses we have hired recently are not “up to speed.” Have others noticed this problem?

**Answer 1:**

Much of today’s emphasis is necessarily on recruitment. We emphasize a more important aspect: Are your new hires competent to safely care for today’s sicker patients?

Competency involves technical skills, interpersonal relations skills, and critical thinking. We assess both interpersonal relations and critical thinking but focus on critical thinking because of its significance for patient safety.

The Performance Based Development System (PBDS) includes a video of scenarios with adult patients and other critical thinking exercises. New registered nurse/licensed practical nurse (RN/LPN) graduates do an acute care assessment. Experienced RNs/LPNs complete an ICU, acute care, obstetrics, neonatal ICU, perioperative, or mental health assessment based on their prior experience.

The assessment measures 4 critical thinking components of clinical judgment:

- Can the employee recognize the patient’s problem?
- Can the employee safely and effectively manage the problem within his or her scope of practice?
- Does the employee have a relative sense of urgency?
Oak Park Hospital
The Spirit of People Who Care™
SPONSORED BY THE WHEATON FRANCISCAN SYSTEM
© RUSH | RUSH SYSTEM FOR HEALTH

Faxed Admission Report
**CONFIDENTIAL**

| Time Sent: ________ | Room # ________ | Nurse: ________ |

| Patient Name: ____________________ | Sex: M F | Age: ________ | Diagnosis: ____________________ |

| Report By: ____________________ | ER RN Time: ________ | Allergies: ____________________ |

| Admitting MD: ____________________ | Consulting MD: ____________________ | Code Status: ____________________ |

| Admitting Complaint: ____________________ |

| Pertinent Past History: ____________________ |

| Home: ____________________ |

| Meds: ____________________ |

---

**Assessment on Arrival:**

| Cardiac: ________ | WNL: ________ | BP: ________ | P: ________ | R: ________ | T: ________ | Pulse Ox: ________ |

| Neuro: ________ | WNL: ________ | Confused? ________ | Oriented? ________ |

| Resp: ________ | WNL: ________ | Left Lung Sounds: ________ | Right Lung Sounds: ________ |

| GI: ________ | WNL: ________ | Bowel Sounds: ________ | NG? ________ |


| Ext: ________ | WNL: ________ | Pulses: ________ | Misc: ________ |

---

**Treatment in ED:**

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| IV Site#1 | Rate: ________ | Size: ________ | Solution: ____________________ | Amt. Infused: ________ |

| IV Site #2 | Rate: ________ | Size: ________ | Solution: ____________________ | Amt. Infused: ________ |

| IV Site #3 | Rate: ________ | Size: ________ | Solution: ____________________ | Amt. Infused: ________ |

**Meds Given in ED:**

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**Condition Now:**

---


| Pertinent Lab Results: WBC: ________ | HGB: ________ | HCT: ________ | CKMB: ________ | Troponin: ________ |


**Pertinent X-Rays:**

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**Receiving RN Signature: ________ Date: ________

FIGURE 1
Oak Park Hospital Faxed Admission Report. Used with permission.
• Does the employee know why he or she is doing the actions indicated? In other words, does the employee do the right thing for the right reason?

For example, 1 day after surgery, a trauma patient exhibits clinical symptoms of diaphoresis, change in skin color, severe shortness of breath, and right-sided chest pain. An arterial blood gas value shows respiratory alkalosis. The RN is expected to identify these signs and symptoms as a pulmonary embolus or pneumothorax, manage the patient with oxygen and breath sound assessment, and immediately call the physician. Anticipation of medical orders is also expected of inexperienced RNs. PBDS findings are that 75% of inexperienced nurses (ie, those with less than 1 year of experience) and 25% of experienced staff manage the hyperventilation/alkalosis aspect with a paper bag only!

Performance Management Services, Inc has the only objective database of new-hire competency assessment in the United States. Valid and reliable benchmark statistics have been established from our clients' collective data:

• Experienced ED RNs have an 85% acceptable initial critical thinking assessment. Experienced nurses, in general, have an acceptable initial assessment at 60% to 65%. ED RNs, however, may not have equally acceptable interpersonal skills that are assessed with other competence components.

• Inexperienced RNs have a 25% to 30% initial acceptable entry-level assessment, with the range from 12% to 60%. There is no difference between the educational preparation (ADN, BSN, diploma) and no difference if there was previous health care experience, such as being an LPN or assistive personnel. Acceptable results for new RNs have been declining each year from 43% in 1995/96 to 26% in 2001.

• In general, RNs have the greatest limitations in recognition and management of patients with renal and neurologic problems.

PBDS provides strategies to client hospitals to help employees to develop critical thinking skills. We also recommend clinical practice, not more classroom time. These persons know content; they need help applying it.

We also recommend that traveling nurses not be remediated but rather be sent back to the traveler agency, because they are receiving a premium rate based on an assumption that they are competent.

A unit-specific reassessment is done in 4 to 6 weeks for experienced nurses and 10 to 12 weeks for inexperienced nurses. Sixty percent to 70% of those who are reassessed improve to an acceptable assessment, with a higher percent of improvement in the inexperienced nurses' group. The benchmark for a health care system is that 85% of new employees eventually reach an acceptable assessment result.

Some persons argue that those with unacceptable results “are doing fine” on the job. In our experience, this is true, at best, for only 5% to 7% of persons who have difficulty with simulation testing.

Health care organizations often assume that all experienced nurses are competent and a one-size-fits-all orientation works. Obviously, on the basis of our findings, this assumption is not true.

The advantage of using a reliable and valid assessment is that you know who needs how much orientation. The 85% of ED nurses with acceptable assessments need only learn “how we do it here.” Those who do not meet expectations need a tailored remedial plan.

PBDS assessments can also be used to identify accomplished LPNs or assistive personnel who have potential to go on and obtain more advanced nursing education. They should be encouraged to attend educational programs and be provided with tuition support.

On the other hand, an organization needs to acknowledge that some persons are not able to meet expectations by the end of the traditional probation period, and it must make decisions about continued employment accordingly.

Our recommendation is that persons who cannot meet standards, both clinical and assessment, “have their future freed up” (aka, be let go). They are “walking time bombs” who will consume extraordinary resources and supervision until they are competent, if ever. One hospital kept its 15 employees who did not pass the reassessment. In a 6-month period, 2 of those employees were involved in a sentinel event.¹

—Dorothy del Bueno, EdD, RN, Senior Consultant, Performance Management Services, Inc, Tustin, Calif; (714)731-3414

REFERENCE

**MANAGERS FORUM/Zimmermann**

**Answer 2:**
We use the PBDS assessment throughout our health system to assess the competency of all the nurses we hire. To date, we have found that fewer than 40% of the new graduates initially can meet our clinical competency requirements. Although they may have the theoretic knowledge, they often cannot apply that knowledge in a clinical situation. For example, a patient was admitted with chest pain to rule out a myocardial infarction. He complained that his arm “felt funny” and that he was warm; the new graduate nurse responded by turning down the temperature in the room. Although she could, when asked, recite the signs and symptoms of a myocardial infarction perfectly, she failed to see those same symptoms in her patient.

In an attempt to raise the scores of our new graduates, we recently developed a new program, in conjunction with the University of Pittsburgh, called the Clinical Scholars Program. Senior students are assigned to an experienced staff nurse for an intensive clinical practicum of 32 hours per week; the students follow the same schedule and assignment as their mentor.

We assess the students’ competency with PBDS prior to beginning the program, and the mentor is given a detailed description of the student’s learning needs. Typically the mentors are our level 3 or 4 nurses. Thus far the program has been well received. The students are exposed to “real life” situations with support; the nurses are “freed up” to do some of the more demanding aspects of the job.

—Gail A. Wolf, RN, DNS, FAAN, Senior Vice President and Chief Nursing Officer, UPMC Health System, Pittsburgh, Pa; E-mail: wolfga@msx.upmc.edu

**INTERNAL AGENCY** NURSE COMPETENCIES

I find it difficult to ensure that the competencies documentation is met with ED float pool nurses. How are others handling that situation?

**Answer 1:**
Our Nursing Resource Center (aka centralized “float pool”) took over the educational needs for this category of staff. We developed different booklets/sheets for each type of employee (RN, LPN, nursing assistant). All new employees are provided with an initial organizational orientation booklet that includes generic information, such as the hospital’s mission.

The nurses’ booklet also includes nursing service standards and skills verification. The unit manager, preceptor, and orientee all sign off after the skills are demonstrated. The completed document is processed through the Nursing Resource Center and stored in the Nursing Staff Development Office.

A second unit-specific orientation booklet is provided to nurses. Developed by Nursing Staff Development, it includes content related to the specific patient population, including age-specific competencies and pain management. It is distributed through, and returned to, the Central Nursing Office within 48 hours or 2 shifts.

A third form regarding environmental issues is given to all employees, including topics such as the fire hydrant locations and universal precautions.

This system works well for us. It may sound burdensome, but we have almost 100% ongoing completion. When planning for a Joint Commission for Accreditation of Healthcare Organizations visit, that feels great.

—Connie J. Rigdon, MSN, RN, Director of Flexible Resources & Systems, University of Wisconsin Hospital & Clinics, Madison, Wis; E-mail: cj.rigdon@hop.wisc.edu

**Answer 2:**
I used to believe that the “float” nurses could pick up the necessary competency education on the unit. Instead, they were the ones who were covering the staff nurses who attended the unit’s inservice offerings.

I now have a mandatory annual paid competency day for all “float” nurses. I add 2 enticements for attendance: free lunch and a staff meeting.

Those who miss this day are responsible for coming in on their own time to attend a comparable unit’s competency education. If they have not done that by the deadline, they cannot be scheduled to work until this deficiency is met.

These float competency days now have almost 100% attendance.

—Sandra J. Greenland, RN, Manager, Nursing Floats, Evanston Northwestern Healthcare, Highland Park Hospital, Highland Park, Ill; E-mail: sgreenland@enh.org
HOSPITAL-WIDE UNIFORM CRASH CARTS?

At my workplace, consideration is being given to changing to a uniform crash cart that would be used throughout the hospital. What has been the experience of others in this regard?

Answer 1:
We have had generic adult and pediatric crash carts for years in our facility. Central Supply replaces the cart after each use. Using generic carts is especially helpful when we respond to a code in another department because we know what is available and where it is located.

One area has been allowed to have a different cart. However, the code team gets frustrated when trying to use that unique cart. As a result, the responding team has started to bring along a regular generic cart with them to that area.

Because of some building changes, the hospital is currently changing its system to include 3 carts: adult, pediatric (30 days to 12 years with Broselow multicolored drawers), and neonatal (newborn to 30 days).

—Bev Beard, RN, Staff Nurse, Emergency Department, Providence Everett Medical Center, Everett, Wash; E-mail: angelbev@juno.com

Answer 2:
We use 2 generic crash carts (for adults and pediatric patients) throughout the hospital. The generic crash carts are restocked by Pharmacy and Central Supply. We stock a special cart in the emergency department for additional supplies that we like to use. This second cart is maintained by the ED staff.

—Robert G. Flade, RN, BS, MSN student, Clinical Manager-3rd Shift, Emergency Department, New Britain General Hospital, New Britain, Conn; E-mail: RGFlade@nbgh.org

Answer 3:
We approach this issue in a variety of ways.

• Separate pediatric crash cart. This secured cart is restocked by the emergency department. Every Wednesday we reopen it, check inventory, and then resecure it. This responsibility is rotated by shift during the month so that all of the staff are familiar with the contents of the cart.

• Uniform adult crash carts for conscious sedation or codes outside the emergency department. These 2 locked carts are located in our lower acuity area and our orthopedic room. They are restocked by Central Supply but are rarely used.

• Critical rooms unique carts. Each of our 4 critical rooms has an identical code-capable set-up of a central monitor, defibrillation/pacing unit, and code drug modules. This module is a separate divided tray, with the code medications and inventory sheet, secured with cellophane. It does not contain controlled drugs. The included inventory slip is completed with the patient information to aid in billing. Carts in these areas are not secured and function to house ED-specific supplies. It takes less than 5 minutes for nurses to check their rooms for these key supplies before taking report. We decided to use this system because so many patients present in an unstable condition and require these supplies. It is more efficient to stock the rooms than to continuously restock and lock a crash cart.

• Major tray cart. One locked cart is checked by RNs. It contains all major trays, such as chest tube insertion, central line insertion, and cut-down. Use of this cart has significantly reduced the “Where is it?” questions and improved the likelihood that the equipment is there when you need it.

—Brenda Brennan, RN, MS, ED Clinical Specialist, Washington Hospital, Fremont, Calif; E-mail: brendabrennan@hotmail.com

PREVENTING DRUG ERRORS

The Institute of Medicine report regarding medication errors was alarming. What are others doing to help prevent drug errors?

Answer 1:
The Institute for Safe Medication Practices (http://www.ismp.org) agrees with the Institute of Medicine findings that bad systems as a whole, not people, are behind medical errors. We focus on modifying processes.

One area of focus is “high-alert” medications, that is, a small number of medications that have a high risk of causing injury or death if they are misused. Examples include adrenergic agonists, intravenous digoxin, intravenous...
heparin, insulin, thrombolytics, opiates, intravenous calcium, intravenous potassium, or lidocaine/local anesthetics in large vials.

Some of the key concepts we recommend to safeguard these high alert medications include the following:

- **Simplify**—reduce steps and number of options
- **Differentiate** items (appearance, location, color, touch, etc)
- **Standardize** communication and dosing methods
- **Redundancy** (check systems, back-ups)

Another key emphasis is standardizing order communication. Toward that end, we recommend the following:

- Eliminate verbal orders except in extreme emergencies or sterile situations (repeat back the order).
- Use both generic and brand names.
- Do not abbreviate drug names.
- Do not refer to drugs by class name, such as “blockers.”
- Never prescribe by volume, number of vials, or amps.
- When calculating mg/kg, double check with another person.
- Abbreviate subcutaneous as “subcut,” not “sq” or “sc.”

Practitioners are now held to an unattainable standard of perfection. We know human errors are inevitable. Performance improvement in medication administration requires changing the system to make it more difficult to err. As Albert Einstein said, “Insanity is doing the same things the same way and expecting a different result.”

—Hedy Cohen, BSN, RN, Vice President, Institute of Safe Medication Practices, Huntington Valley, Pa; E-mail: hcohen@ismp.org

**Answer 2:**
Our hospital’s Pharmacy Director requested an on-site visit from the Institute for Safe Medication Practices. The purpose was to solicit suggestions on how we could improve our medication administration process. Some of their recommendations we have instituted include the following:

- **Reference books.** Throw out any drug reference books older than 1 year. They are no longer valid.
- **Verbal medication orders.** No verbal orders are accepted anywhere in the hospital except in absolute, extreme emergencies. (At this time phone orders are still accepted.)

- **Double-checking medications.** Medications that are at high risk for error must now have another RN or a medication LPN verify and sign at the bedside (not at the area where the medication is stored and removed). This way there is verification not only of the medication but of the administration route. This procedure is applied to the drugs decided on by a committee of pharmacy, nursing, and risk management based on literature and industry/facility statistics. These drugs are heparin/low molecular weight heparin (subcutaneous and intravenous), epinephrine, insulin, and thrombolytics. Anecdotally, I have noticed that one common potential error is not clarifying whether the ordered epinephrine is to be given subcutaneously or intravenously.

- **Allergies.** Anyone with an allergy (even if the patient only says, “I am not sure but I might be allergic to.....”) receives an obvious, obnoxious green arm-band. The band does not list specific drugs but serves as a visual cue to check the medical record.

- **Unsecured paralytics.** The position of the Institute for Safe Medication Practices is that only the emergency department, operating room, and ICU should have “loose” paralytic agents available. All other units have those drugs available in a secured intubation kit. However, the Institute’s concern made me reconsider our ED practice, and we also have removed our “loose paralytics.”

- **No-fault medication error reporting system, including “near misses.”** We have seen an increase in the number of reports made. We believe this is probably because there was underreporting, especially of “near misses,” under the previous system. The improved reporting has provided information regarding processes contributing to errors. The nursing staff is committed to improving processes where patient safety is a concern. We believe knowledge is power and we are glad to have these (probably) more accurate statistics to drive our decisions.

—Patricia Scott, RN, BSN, CEN, Emergency Department Nurse Leader, Martin Memorial Health Systems, Stuart, Fla; E-mail: pscott@mmhs-fla.org
Answer 3:
In Australia, we have always had many of the “newer” recommendations in place. It is standard to:

- never transcribe anything.
- have all intramuscular, intravenous, and subcutaneous medications double-checked by another RN. (In many hospitals, it is also a blanket requirement that all pediatric oral medications be checked.)
- allow only RNs who are permanent staff in high-acuity areas to administer intravenous medications routinely in those high-acuity areas (ie, emergency department, ICU, critical care unit). This includes even intravenous antibiotics.
- allow only RNs to administer medications. (There is a movement for our enrolled nurses [EN], similar to your LPNs, to be permitted to give oral medications in nursing homes.)

Although some persons may believe these methods are inconvenient or time-consuming, they have proved to be valuable safeguards against medication errors. Most medication errors that I know of or have read about are the result of the system not being followed correctly. It only takes a minute or 2 to get things checked.

—Toni McCallum, RN, Accident and Emergency Certificate, Clinical Nurse, Emergency Department, Wyong Hospital, NSW, Australia; Past President ENA NSW; E-mail: ToniMcCallum@bigpond.com.au

FMLA—Notification

My employee has a chronic attendance problem. When should I offer the Family Medical Leave Absence (FMLA) option?

Answer:
Under the FMLA law, employees are entitled to take up to 12 weeks unpaid absence during any 12-month period. One of the acceptable reasons is that the employee “is unable to work because of a serious health condition.”

One of the 10 top problems with FMLA, according to the Bureau of Labor and Wage, is a failure of the employer to properly notify the employees of their FMLA rights. Four types of notices need to be in place: a poster, handbook information, written notice, and a process to handle employee inquiries.

Human Resources often handles many of these aspects. However, many managers include mentioning (and documenting) the FMLA option as part of all corrective counseling done for attendance problems. This practice prevents an employee from saying that he or she was not informed about his or her FMLA rights and attempting to seek a retroactive FMLA leave or taking a leave without 30 days’ prior notice.

If the employee chooses to use an FMLA option, I recommend that you ask for a medical certification even though the law does not require its use. When employees take a paid leave, they are not required to provide information about the reason. Employees taking an unpaid FMLA leave, however, are required to do so.

A complete set of Regulation 825 can be obtained at www.dol.gov.

—Michael Corcoran, MS, BS, Labor Law Consultant, Corcoran & Associates, Wyoming, Pa; (570)333-4062; E-mail: mikcorco@epix.net

VIDEO MONITORING OF PSYCHIATRIC PATIENTS

How do others handle video monitoring of psychiatric patients?

Answer:
It is not considered acceptable to have routine video monitoring on every patient with a psychiatric history. We use our video monitoring capacity for continuous patient observation only for 1 of 2 legitimate reasons:

- When patients are in seclusion
- When currently cooperative patients are not in seclusion (eg, the door is not locked) but are considered a risk for suicide/homicide or escape

These patients require continuous monitoring, and video monitoring gives us an alternative option to having someone with them in the room or observing them through a window. Although patients do not need to give permission to be monitored under these circumstances, they must be informed they are being monitored for their safety.

—Nina M. Fielden, MSN, RN, CEN, ED Clinical Nurse Specialist, Cleveland Clinic Foundation, Cleveland, Ohio; E-mail: fielden@ccf.org
CONTROLLING E-MAIL

At times I feel like my E-mail is controlling me rather than the other way around. Do you have any suggestions for how to deal with this problem?

Answer 1:

A series of conventions, rules, and procedures have evolved around E-mail that can make it highly unproductive. We each need to change how we use this relatively new medium.

From my productivity research, some suggestions I offer include the following:

- **Choose a permanent E-mail address.** Have one job-related E-mail address and one at home that stays with you for life for all other matters. Limit the use of your work E-mail address to job-related interactions; that way the incoming mail (and spam) is already partially sorted.

- **Check your E-mail at only selected times in the day.** One chief executive officer checks her E-mail first thing in the morning, once during lunch, and then again before going home. It is wise to turn off the notifying chime or icon.

- **Sort your incoming messages.** For instance, one person sorts messages by chronologic order. When she had received several messages from the same sender, she opens the most recent one first and usually can pick up the gist of the earlier messages.

- **Use the FLAG method to handle each E-mail message only once.** Decide whether to:
  - **F**ile. Create files such as “to be done,” “upcoming events,” or project names and move the message into the appropriate file.
  - **L**et someone else do it. Forward and delegate the message to someone else.
  - **A**ction. Write a response, make a phone call, or write it in your schedule.
  - **G**arbage. Delete it. If you are afraid that you might need to keep something “just in case,” put it into a file labeled “delete later.” Then purge this file periodically.

- **Do not feel compelled to answer your E-mail immediately.** People will learn to call you for truly urgent needs if you do not always respond to E-mail messages right away.

- **Practice the rule of three.** If an E-mail thread has gone back and forth 3 times, it is probably time to pick up the phone.

- **Say “no” to newsletters.** An E-mail newsletter is rarely your best source of information; you can find it elsewhere and it just gives you additional E-mail glut to deal with.

- **Ignore jokes.** People today feel less connected, so they send jokes as a way of staying in touch. Instead, find other ways to recapture a sense of community. Have a pizza lunch or meaningful staff meetings. Besides, do you want to be viewed by your boss as someone who contributes to E-mail glut?

- **Avoid the free stuff.** Nothing is ever free: 25% of conventional television is advertising. The Internet is developing its own version of a business model. Do you really want to be besieged by unwanted Web pages and spam?

- **Create an automatic expiration date for old E-mails.** Usually 6 months to a year is a good time frame. When was the last time you referred to a year-old E-mail message?

- **Force yourself to take time off from E-mail.** Designate at least 1 day a week that you will not use E-mail. And that resolve should include your vacation time!

It is not always easy to change, but be bold. Start with at least one thing: checking E-mail less often, limiting the use of the “cc” button, or getting off a distribution list. Your time is worth it! 

—Mark Ellwood, Productivity Consultant and Author; President, Pace Productivity, Inc, Toronto, Ontario, Canada; E-mail: mark@GetMoreDone.com; (416)762-3453

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1. Ellwood M. Cut the glut of E-mail. Toronto: Pace Productivity; 2002.

Answer 2:

Estimates are that the average white-collar worker wastes an average of 3 hours a week just sorting through junk mail. Dr David Greenfield of the Center for Internet Studies in
West Hartford, Conn, believes that at least 6% of the 100 million American users are what he would classify as compulsive E-mail checkers.

The evidence is intriguing. One study found that 42% of American E-mail users check E-mail on vacation and nearly 1 in 4 look for messages every weekend.

Begin with realizing you may have a problem. Use some of the suggestions to limit your “addiction” to E-mail use.1

—Chris Taylor, Writer, Time Magazine, New York; E-mail: cdt@well.com

REFERENCE

Answer 3:
Junk E-mail, or spam, can waste your time. Estimates are that spam has increased 5-fold in just the past year and will continue to increase at this rate.1 It can also be fraudulent: up to 15% of online scams come directly via E-mail.2

The best way to deal with it is to delete it before you see it. Most E-mail programs have a feature called Rules (in Outlook, it is under the Tools menu). It is designed to filter incoming junk mail straight into your deleted folder. Trying filtering out all E-mail with 3 exclamation points (!!!), dollar signs ($$$), X’s (XXX), or the word “nude” in the subject line.

For more information about E-mail fraud, check the National Consumers League (NCL) Web site, www.fraud.org.2

—Lev Grossman, Writer, Time Magazine, New York; E-mail: lev@timeinc.net

REFERENCE

COMMUNICATING IMPORTANT NEWS TO STAFF

I often feel inadequate in communicating key information to staff so it will be well received. Do you have any tips to help me?

Answer:
How you deliver your information will determine how your staff hear it. If it involves change, slow your speech down. Speaking too fast can lead people to think you are covering up other details.

With important information, the content should be:
• Only what is necessary
• Realistic, as it relates to their everyday practice
• Presented in an orderly fashion, with a brief overview about the “why”

In addition, be prepared with an action plan to implement the information when necessary. An excellent resource is Teamwork from Start to Finish by Frank Rees (Jossey-Bass, Inc, 1997).

—Shelley Cohen, RN, BS, CEN, Educator and Consultant, Health Resources Unlimited, Springfield, Tenn; E-mail: educate@hru.net; http://www.hru.net

PHYSICAL THERAPIST IN THE EMERGENCY DEPARTMENT

Does anyone use physical therapists in the emergency department?

Answer:
We have one part-time (20 hours/week) dedicated ED physical therapist whose position is under the physical therapy department. Some responsibilities of the physical therapist include the following:

• Gait training with assistive devices, such as crutch walking
• Application of modalities (heat/cold, ultrasound, electrical stimulation, massage) for spasm relief, range-of-motion programs, etc. (This treatment is commonly needed by persons with pain after a motor vehicle crash.)
• Patient education (eg, teaching range of motion to prevent shoulder adhesive capsulitis in someone who has sustained a wrist fracture)
• Assisting the continuity of care for admitted patients’ rehabilitation

A separate charge is made on the overall ED visit bill for these services. The program has worked very well for us for more than a year. Patients now receive interventions and access follow-up rehabilitation services sooner.

—Jean A. Proehl, RN, MN, CEN, CCRN, Emergency Clinical Nurse Specialist; E-mail: jean.proehl@hitchcock.org and Dierdre L. Muller, PT, Dartmouth-Hitchcock Medical Center, Lebanon, NH
COPYRIGHTING YOUR PERSONAL WORK

I developed a new form on my own time. How do I copyright it?

Answer:

Some persons believe that once you create a piece of writing, you need to mail it to yourself or mark it with a copyright symbol to unofficially “register” the copyright and prevent someone from stealing it. However, this practice began, it is unnecessary under the current US copyright law.

The law protects your work as soon as you create it or when it is fixed on a copy. On its Web site (http://lcweb.loc.gov/copyright), the US Copyright Office notes that “Copies are material objects from which a work can be read or visual perceived either directly or with the aid of a machine or device, such as books, manuscripts, sheet music, film, videotape, or microfilm.”

Simply save your initial notes and drafts. If the authorship is ever contested in court, these documents will assist you in claiming initial ownership. Official copyright registration occurs upon publication of your work.1

However, from a practical standpoint, you still could be a victim of “innocent infringement.” Someone who in good faith thought your work was in public domain because there was no notice can copy it and not be held liable for damages. To prevent this from happening, place an appropriate notice, such as the word “copyright,” its abbreviation, or the © symbol with the copyright owner’s name and year when the work was first published.2

—Elfrieda Abbe, Editor, The Writer Magazine, Waukesha, Wis

REFERENCES


DOUBLE BILLING

I continue to hear that billing Medicare for both an ED nursing level and for the procedures performed in the ED is double billing. I do not want my hospital to be accused of fraud. What are we supposed to do?

Answer:

Emergency departments are required by Medicare to bill for the nursing level and additional procedures performed during the ED visit. However, differentiating portions of the routine assessment from components of the procedure “package” requires an understanding of coding rules.

Under the APC payment system, emergency departments are required to identify the ED nursing level by assigning one of the ED Evaluation and Management (E/M) codes, including critical care, with the CPT/HCPCS codes 99281-99291. The content of each assessment level is to be determined by each hospital individually as long as it is tiered to reflect distribution of acuity and resources. Each hospital will be held to the content for each level and assigned code as they have developed it.

Procedures performed in the emergency department by ED staff, ED physicians, and hospital staff physicians also must be identified with their appropriate CPT/HCPCS code. Because APCs bundle the value of supplies, medications, and other associated resource costs into the procedure, identifying each separately performed procedure also ensures payment for its associated resources and is required by Medicare.

Much of the information on billing for ED nursing levels and ED procedures is found in Centers for Medicare and Medicaid Services (CMS) Transmittal A-00-49 and A-00-40 July 20, 2000, A-01-80 June 29, 2001, available at www.CMS.gov. Although these transmittals focus primarily on the modifier -25, which is necessary for payment of the assessment level when billed with certain other procedures, it provides excellent guidance on billing assessment levels with procedures.

There does seem to be a universal misconception of what services are included in the assessment level and what services are included in the procedure. CMS-1206-Proposed Rule allows for counting of separately paid services (intravenous lines, radiographs, EKGs, laboratory tests, etc) as “interventions” or “staff time” in determining a level of service. CMS believes that the level of service for an emergency visit should be determined by resource consumption that is not otherwise payable. As illustrated by current data, the distribution of paid emergency and clinic visit codes under the Outpatient Prospective Payment System, well over 50% of the visits, are considered multiple procedure claims. This means that services (diagnostic and procedural) were billed in addition to the visit. These services include services billed outside the ED revenue center as well as ED services.
When developing the facility assessment level, resource consumption for visits should reflect one or more of the following services that are distinct from other procedures or services that are performed at the same visit but may be required to diagnose the problem, arrange for treatment, and support the overall ED course:

- Number and type of staff interventions (including registration, triage, actual clinical nursing time managing the patient, ordering tests, etc)
- Staff time (all nonphysician ED staff including non-clinical personnel)
- Clinical examples of resource utilization at each level
- Patient acuity (this is not necessarily the diagnosis, but the presenting problem that indicates the level of care to be considered and helps to establish the medical necessity for the course of treatment in the emergency department)
- ED course

Components included in the resource cost for procedures include services directly related to the procedure but, unlike physician packaging for procedures, does not include the postoperative services. Facility payment for diagnostic and/or therapeutic procedures includes services directly related to the procedure such as taking the patient’s blood pressure or temperature, asking the patient how he/she feels, and getting the consent form signed, as outlined in CMS Transmittal A-00-40. In addition, any costs incurred to furnish use of an operating room suite, procedure or treatment room; anesthesia, medical and surgical supplies, and equipment; surgical dressings, supplies, and equipment for administering and monitoring anesthesia or sedation; and various incidental services such as routine venipuncture are also included as outlined in the final rule published in the April 7, 2000, Federal Register.

The “surgical package” definition that is applied to physician performance of surgical procedures is somewhat different from the policies governing the facility and adds to the confusion about what is included in each component. The physician procedure “package” includes the operation per se, any local infiltration, digital block, or topical anesthesia; writing orders; evaluating the patient postanesthesia; and follow-up care. (Billing under the hospital guidelines, however, excludes the postoperative period from the procedure package and alters the procedure package for certain procedures.) One additional departure from the physician procedure guidelines is the facility policy that allows unbundling of procedures commonly packaged in the physician critical care package. Thus, different rules apply for facility and physician coding of critical care.

As CMS continues to develop its own nationally uniform nursing assessment criteria, you can expect to see a more objective clarification of what is included in the “package” for the evaluation and management assessment and what is included in the “package” for diagnostic and therapeutic procedures. In the interim, complex coding rules that define what services are “bundled” into procedures, what services qualify for the E/M component as defined by hospital facility assessment criteria, and what modifiers are necessary to designate certain services as separate and significant to facilitate payment vary according to the procedure and/or service, so consult with your coding specialist for detailed information and stay tuned for developments later this year.¹

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REFERENCE