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Measles patient ordered into isolation, but remains in the ED for 12 hours

'Hypervigilance,' clearly defined process can help avoid such incidents

This was the stuff of an ED manager's nightmare: A 36-year-old woman with measles, thought to be the source of an eventual outbreak of measles in February 2008, was kept in the ED of Northwest Medical Center in Tucson, AZ, for more than 12 hours *after* a physician had ordered that she be placed in isolation. To add insult to injury, she had presented to the same ED a day earlier complaining of flu-like symptoms. She was misdiagnosed, given an antibiotic and discharged.

A state investigation subsequently showed that no isolation precautions were taken at either visit, and the hospital was fined $1,000 for waiting too long to isolate the patient.

The hospital has worked with the state to develop a correction plan, and now has an action plan in place, says spokeswoman **Kim Chimene**, although she would not provide any details.

Experts say there are several steps ED managers can take to ensure that isolation orders are followed. "There needs to be some clear delineation of responsibility once [isolation is] ordered," says **Matt Keadey**, MD, the medical director of the ED at Emory University Hospital in Atlanta. "You need to have a process set up, and there needs to be some semblance of early identification; if not, you'll end up with those patients out there [in the waiting room] with everyone else." **(For more on process changes that can reduce the likelihood of such an event, see the**

Salary survey moves to January — Coding column begins in this issue

The *ED Management* Salary Survey Report will run in the January 2009 issue. Don't miss out on this valuable resource for determining what others in your field are being paid and what your salary should be! In this issue, look on **p. 125** for a new feature: *ED Coding Update.* Stay updated on coding quirks and changes that can mean increased reimbursement for your department!

IN THIS ISSUE

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story on p. 123.)

James G. Adams, MD, chair of emergency medicine at Northwestern Memorial Hospital in Chicago, agrees. "You need to have hypervigilance, knowing that anything can take an interesting twist," he says. For example, Adams notes, measles initially might resemble a viral infection. "This one *was* recognized by the doctor, but hypervigilance means that *everybody* should be alert and aware," Adams says. Sometimes, he says, even the department secretary might recognize something odd or "off" that is not being recognized by the staff. "I've had circumstances where a secretary pointed out that a person looked 'different,'" he recalls. "That prompted me to look at them, and it turned out they had just had a stroke in the waiting room."

Keadey takes a similar approach. "It's the responsibility of everyone," he says. "What this scenario sounds like is they were waiting on an isolation bed upstairs, but the doctor may not have communicated this to his or her own staff."

Information can be communicated electronically, Keadey says, "but if it's critical, face to face and voice to voice is by far the best way to do it." If a doctor wants to isolate a patient, he says, "I would say tell the individual nurse responsible for caring for the person, and then the charge nurse if you do not get the response you need." If necessary, Keadey adds, you could even take it to a person on a higher level.

Your infection control professional also is a key member of the team, says Keadey. "They are not only valuable for developing protocols for identifying patients with infectious diseases, but if there is any uncertainty about whether to isolate a patient, they can be an invaluable resource," he says.

Create a culture of ED teamwork

One of the most effective ways for identifying and responding quickly to an infectious patient is to create a culture of teamwork, Adams says.

"You must have an atmosphere of welcoming everyone's input — avoid an authority gradient, where staff members are reluctant to address those who 'outrank' them," he says. He likens the situation in the ED to

Executive Summary

Having isolation protocols in place is not always a guarantee they will be followed, as illustrated by an outbreak of measles at Northwest Medical Center in Tucson, AZ. Here are some tips for helping to ensure a smooth transition from the isolation order to placing the patient in an isolation bed:

- Have an action plan in place that outlines the steps to be taken once the isolation order is given.
- Clearly delineate who is responsible for taking which specific actions.
- Empower everyone in the department with the ability to notice and point out anything that seems out of the ordinary.

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flying a ship to the Moon. "If anybody notices something wrong, they'd better bring it up, or it could have bad consequences."

In terms of the isolation order that wasn't followed, "how do these orders get communicated from team to team?" he asks. "Was the order ignored because it was too much trouble, or was the effort needed to get the patient isolated too tough?

Communication, and high recognition of everyone on the front lines, can keep problems such as these from escalating, Adams argues. Meetings will not work, he says. "It's a day-to-day culture," Adams says." If secretaries have a concern, they should be listened to and made to feel they are an important part of the team," he says. "If they feel respected, their performance will go up," Adams says.

At Adams' ED, "we will entertain any comment about anything," he says. "We all have to pitch in." Creating this "ultimate teamwork" takes a lot of on-unit positive communication, Adams says. "Congratulate someone if they pick up an error," he advises. "Don't blame them." ■

Revisit your process for infectious diseases

Recently, a patient at Northwest Medical Center in Tucson, AZ, was diagnosed with measles and ordered into isolation by her physician, but remained unisolated in the ED for more than 12 hours. One way to avoid such mistakes, say the experts, is to hone all of your infection control processes.

"For example, everyone who comes in with a cough, a sneeze, or flu-like symptoms, they should get a mask," advises **James G. Adams**, MD, chair of emergency medicine at Northwestern Memorial Hospital in Chicago. "It may be infectious or it may be allergies, but this way the intake nurse will not have to make a complicated judgment, but automated responses to improve safety."

Matt Keadey, MD, the medical director of the ED at Emory University Hospital in Atlanta, agrees. "You can approach it in a manner similar to what was done with SARS [severe acute respiratory syndrome]," he suggests. "Develop a set of criteria for the initial presentation of people you think might need to be isolated — like fever and rash, a cough, and travel to certain parts of world."

The most important thing is to determine the appropriate level of isolation based on your concerns, he says. Every ED clinician also should understand what each level of isolation requires in terms of protective equipment and process. Does the patient need a mask? What about visitors? Who is required to wear gowns into the room?

How do you communicate those concerns to your staff? The tracking board is often the most useful place for notifying staff, as well as signage at the entrance to the room. "We have EMR [electronic medical record] here, so I do a lot our requests electronically, but however you communicate, there has to be a good process set up, and it needs to be followed all the time without ambiguity," says Keadey.

The doctor and the nurse are responsible for seeing that the order is followed, Keadey says. "It's a team, like in any ED," he notes. ■

Experienced coders help ED create excellence

Consider increasing compensation

(Editor's note: This is the third in a three-part series on innovative approaches to documentation that can significantly enhance your department's revenues without making any changes in patient flow and throughput processes. This article discusses the use of experienced coders and improved documentation. In the previous two articles, we discussed effective documentation tools, proper staffing to optimize their use, and incentive programs for improved documentation.)

It might seem like common sense, but it doesn't happen enough. One of the keys to achieving excellence in ED billing and coding is enlisting the help of coders with specific experience in this area.

"EDs should use certified coders who are experienced [in ED coding], and who keep up with their profession and national education," says **Sandy Steele**, CPC, man-

Executive Summary

Some ED managers have found that using certified coders, giving them incentives to perform at a high level, and educating their staff about improved documentation can improve their bottom line by hundreds of thousands of dollars. Here are some lessons they have learned:

- Certified coders can have specific expertise in emergency medicine, which is invaluable for appropriate coding and billing.
- Most coders will be compensated with a percentage of what they collect. Offering a higher percentage ultimately will result in a healthier bottom line.
- There is maximum value if the certified coder participates in an ongoing educational program with the staff about documentation best practices.

ager of coding and billing for Midwest Emergency Services, a billing, coding, and practice management company in Fraser, MI. Steele explains that all of her company's coders are certified professional coders (CPCs), and many hold a special certification in ED coding. In addition, they are all required to attend a seminar once a year that provides information specific to ED coding. The important issue for EDs is that they use certified coders, this being personnel that have passed an extensive test and are required to maintain their coding education, she adds.

Robert B. Takla, MD, MBA, FACEP, medical director and chair, Department of Emergency Medicine, St. John Hospital and Medical Center, Detroit, agrees. "We will only use coders and billers that are certified" and have experience in ED coding, he says. His department's administrators selected coders and billers based on their reputation and because all of them are certified."

Takla says there is no substitute for ED experience. "I have worked with billing companies that try to be all-inclusive rather than specializing, and I saw a big difference," he asserts. "Those coders and billers need expertise in emergency medicine."

In the end, Takla says, you don't really pay any more for that expertise. In fact, it can *save* you money. For example, while he now works with Midwest, he says that every firm he has worked with was paid a percentage of what they collected.

Takla says he has found that companies that are paid a higher percentage will tend to perform at a higher level. "If I offer you 9% [of what you collect], and the going rate is 10%-12%, it's possible I'm not going to get as good work from you," he advises.

Midwest works with his facility on a "tiered system," which pays a certain percentage up to a designated level, and then a higher percentage after that point. Collections went up an average of $10-$15 per chart, says Takla, adding, "I'd much rather pay them a higher percentage and collect more." The firm he worked with previously did not charge as high a percentage, Takla says, "but I'm much happier now."

Coding staff don't work in a vacuum

Even if you have the finest coders available working for your ED, there is a limit to what they can accomplish if your staff has not been trained to be productive as possible, Takla says.

"Let's say somebody comes in who has sustained a trauma in a motorcycle accident and has leg pain," he suggests. "When you select 'leg pain' as a chief complaint, and the doctor focuses around the extremities, that give us limited information for coding."

In actuality, he notes, that physician is performing a head-to-toe assessment. "The correct chief complaint and template is 'trauma complaint,'" Takla says.

Without the proper documentation, the coder will be limited, Steele says. "They will not actually be able to code for all the services the doctor provided," she says. Complete documentation by the physician and nursing staff will determine the most appropriate facility code, Steele says.

By working with Midwest and Steele, says Takla, his staff learned about opportunities they were missing. "She gave us relatively short-term feedback," he says. "She was able to say, for example, 'You missed an opportunity here because you only included three or four body parts, and the most I could [bill for] was Level III, when I could have done a Level V.'"

Steele explains that she does "backward coding." "I

Sources

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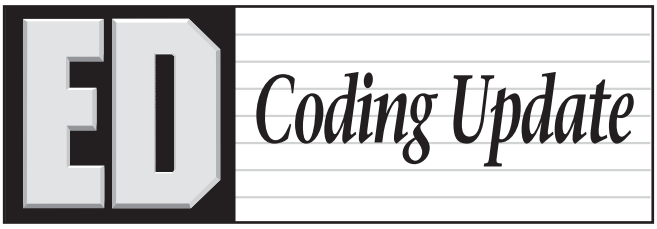
first look at all the doctor did, and from that I determine the level of care that he provided," she says. If the documentation requirements were not met for that level of care, Steele finds the doctor deficient in coding in that area, and reviews those deficiencies with them. ■



Coding for critical care: Timing is everything

[Editor's note: With this issue, we begin a quarterly column on coding in the ED by ***Caral Edelberg****, president of Edelberg Compliance Associates. If there are coding issues you would like to see addressed in this column, contact: Caral Edelberg, CPC, CCS-P, CHC, Edelberg Compliance Associates, Baton Rouge, LA. Phone: (225) 454-0154. EFAX Number: (225) 612-6904.]*

Documentation and billing for ED critical care continue to present a challenge for hospitals. The rules are based somewhat on Current Procedural Terminology (CPT), but with a twist added by the Centers for Medicare & Medicaid Services (CMS). The rules differ enough from the professional rules to create a challenge for ED providers and coding professionals. Becoming conversant with the various impacts that time has on different CPT codes will go a long way toward overcoming that challenge.

As of Jan. 1, 2007, hospital critical care services have been paid at two levels, depending on whether there was also trauma activation. Hospitals receive one payment rate for critical care without trauma activation, and they receive an additional payment when critical care is associated with trauma activation and billed accordingly. When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical Care, Evaluation and Management (E&M) of the Critically Ill or Critically Injured Patient; First 30-74 Minutes. If critical care time is documented longer than 74 minutes, 99292 Critical Care would be billed for each additional 30 minutes of critical care. If trauma activation occurs under the circumstances described by the National Uniform Billing Committee (NUBC) guidelines that would permit reporting a charge, the hospital also may bill one unit of trauma activation code G0390, which describes trauma activation associated with hospital critical care services.

Time, intensity, and content of the service form the foundation of critical care, which is often considered the sixth E&M level. Critical care is defined as a critical illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Key to understanding appropriate billing of critical care is an understanding of how a routine E&M service makes the jump to critical care. As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an ED visit, at a level consistent with their own internal guidelines. Critical care requires decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to, central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

The time spent managing the critical patient is the key factor. For the hospital to bill the facility component of this service, documentation must support a minimum of 30 minutes of critical care service to the patient. *Medicare Pub 100-94 MCP (Medicare Claims Processing), Transmittal 1139*, Dec. 22, 2006, has stated this 30-minute minimum has always applied under the outpatient prospective payment system (OPPS) and will continue to apply. CMS says under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or injured patient.

If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can be counted only once. Thus, to ensure this service is coded correctly, documentation clearly must state the start and stop times spent with the patient by each health care provider, so that coding professionals can accurately count individual and group provider times accurately. Although time in excess of 74 minutes can be billed, the 2008 ambulatory payment classification (APC) payment for 99291 Critical Care includes payment for additional time billed with the 99292 code, so don't expect the extra payment — although at some point in the future when CMS has an opportunity to review all of the critical care utilization data, it's possible the agency might assign a separate payment to this charge.

Often, critical patients require life-saving interventions in the ED. One of the most frequent is cardiopulmonary resuscitation (CPR). The levels of critical care are deter-

mined by time. When CPT code 92950 is reported, the time required to perform CPR is not included in critical care, according to the Correct Coding Initiatives (CCI) edits. CPR CPT 92950 is payable under APC 0094 as a type S procedure. CPR and any additional procedures provided by ED staff or consultants supported by ED staff are separately billable by the hospital as long as the time spent performing these procedures is removed from the time used to determine critical care. ■

EMTALA Q & A

New on-call options: CMS rejects EMTALA expansion

[Editor's note: This column addresses readers' questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Steve Lewis, Editor, ED Management, *Atlanta. Phone: (770) 442-9805. Fax: (770) 664-8557. E-mail: steve@wordmaninc.com.]*

Question: On July 31, 2008, the Centers for Medicare & Medicaid Services (CMS) released final regulations for the inpatient prospective payment program system (IPPS) for fiscal year 2009. Among the new rules, CMS adopted new options for setting up community on-call plans, but it rejected its own proposal to expand the EMTALA obligations of accepting hospitals. What does this mean for ED managers?

Answer: In 2007, the EMTALA Technical Advisory Group (EMTALA TAG) recommended to CMS that hospitals should be able to participate in communitywide call arrangements to improve the coverage of specialty services and ease the call burden on individual hospitals. In the new rules, CMS adopted guidelines for hospitals to meet their on-call obligations through the voluntary use of community call plans, explains **M. Steven Lipton**, JD, an attorney with Davis Wright Tremaine in San Francisco.

The community plan concept involves two or more participating hospitals that adopt a plan for coordinating call coverage in a designated geographic area, Lipton says. For example, a three-hospital plan could include designation for each facility to provide 10 days of coverage in one or more specialties in a particular month, with specialty call rotating between the facilities. As noted by CMS, if a patient presents to a participating hospital when it is not providing coverage, the hospital, after medical screening and treatment within its capacity, could transfer the patient to the hospital that has designated specialty coverage, Lipton says.

The new regulations require that the hospitals adopt formal written plan that includes all of the following elements:

- a clear delineation of on-call responsibilities for each hospital participating in the plan;
- a description of the geographic area covered by the plan;
- the signature of an appropriate representative of each participating hospital;
- assurances that local and regional EMS system protocols include information on the community call arrangements;
- a statement reaffirming the obligation of each participating hospital to meet its EMTALA obligations for medical screening and stabilizing treatment with its capacity, and to comply with the EMTALA transfer requirements;
- an annual assessment of the plan by the participating hospitals.

In the preamble to the final rules, Lipton observes, commenters expressed concerns with antitrust liability for multihospital call arrangements. In response, CMS suggested that hospitals should direct their concerns to the Department of Justice. Hospitals that are considering community call arrangements should therefore consult with antitrust counsel for guidance on structuring the plan.

Accepting hospital obligations — inpatients

Under the EMTALA statute, Lipton explains, a hospital that has the capacity to provide specialized facilities or services (i.e., a higher level of care) must accept an appropriate transfer of an emergency patient who has an unstabilized emergency medical condition if the transferring facility does not have the capability or capacity to stabilize the patient's condition at the time of the transfer. In 2003, he notes, CMS adopted regulations providing that EMTALA did not apply to an individual after admission to a hospital as an inpatient, even if boarded in the ED while waiting for a bed.

In the draft rules earlier this year, CMS proposed to expand the accepting hospital obligation to include the transfer of an inpatient admitted to the sending hospital from the emergency department with an unstabilized condition if the condition had not been stabilized during the inpatient stay, Lipton says. CMS also requested comments on whether the proposed change should be expanded to other inpatients. The proposed change also

Source

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was recommended by the EMTALA TAG, but by the margin of a single vote. **(For more on those CMS regulations, see "Medicare's shifting of call panels could be good news for ED managers," *ED Management,* August 2008, p 85.)**

In the final rules, however, CMS rejected its own proposal. According to Lipton, CMS noted the submission of numerous comments opposing the proposal that questioned the legality and need for the proposal, the adverse impact on tertiary facilities and the emergency system, the administrative burden on hospitals to comply with the rule, the inconsistency of the CMS position, and the split decision of the EMTALA TAG. CMS ultimately concluded the following: "After consideration of the comments, we believe that finalizing the policy as proposed may negatively impact patient care, due to an increase in inappropriate transfers which could be detrimental to the physical and psychological health and well-being of patients. We are concerned that finalizing our proposed rule would further burden the emergency service system and may force hospitals providing emergency care to limit their services or close, reducing access to emergency care."

In addition to reversing course, CMS modified the accepting hospital obligation to state expressly that it does not apply to the transfer of an emergency patient who has been admitted to another hospital as an inpatient, Lipton says. The new language, he hopes, lays to rest any ambiguity as to the scope of the EMTALA obligation for the accepting hospital as it relates to inpatients. ■

When can staff divulge patient's HIV status?

Is there a duty to warn others?

A man with chest pain tells your ED physician that he uses cocaine and is HIV-positive, then asks the physician not to tell his girlfriend who is about to enter the room. What is the most likely basis for a lawsuit: Disclosure of the patient's status, or if the physician doesn't tell and his partner gets infected?

A patient's status as HIV-positive is protected by federal and state law, says **Erin McAlpin Eiselein**, a health care attorney with Davis Graham & Stubbs in Denver. Your staff may disclose this confidential and protected health information only if there is an exception to the federal or state law, says Eiselein.

However, in light of the California Supreme Court's 1974 decision in *Tarasoff v. Regents of the University of California,*[1] involving a patient who killed a specific individual after informing his psychologist that he intended to do so, physicians also have an obligation to warn a party in clear or imminent danger. "The intersection between the physician/patient privilege and the physician's duty to warn raises a number of legal and ethical considerations," says Eiselein. "If an ED physician encounters this situation, he or she should immediately contact the hospital's legal counsel, as controlling laws vary widely by state."

Many states allow, but do not require, notification to third parties, while a few states require the notification. "In those states, the disclosure would be permissible," says Eiselein. Michigan, for example, has enacted a statute requiring physicians to notify the contacts of an HIV-positive patient, if this disclosure is necessary to prevent further transmission of HIV. "The ED physician can also discharge this duty by notifying a local health officer," adds Eiselein.

However, the Michigan statute is unusual. In the vast majority of states, such notification isn't mandated and might not be allowed at all. "State statutes are all very different," says Eiselein. "Some allow disclosure to spouses. Others allow disclosure to sexual partners but not needle-sharing partners, and others permit disclosure to anyone who may have been exposed to the virus."

In states in which notification is permitted, the ED physician will have to make a decision as to whether to notify a contact directly, or make a report to the local health agency, based upon the particular state law involved and the set of facts presented, says Eiselein. She cautions that physicians who are statutorily authorized to notify a third party about a possible exposure to HIV should take care to strictly comply with such laws. "In many cases, this means providing the contact's name to a local health agency so that the agency can conduct the notification," says Eiselein. "Any questions about such a notification should be brought to the immediate attention of legal counsel."

If you divulge a patient's HIV status, the patient could sue you for breach of physician-patient privilege, breach of confidential physician-patient relationship, invasion of privacy, and intentional or negligent infliction of emotional distress. If you fail to disclose this information, however, a third party could sue you

for failure to warn, or intentional or negligent infliction of emotional distress.

There also may be claims for breach of a particular statute imposing a duty of confidentiality on HIV-related information. For example, a New York appellate court held that a plaintiff could seek punitive damages from a physician for breach of the physician's duty of confidentiality and violation of a New York law prohibiting disclosure of HIV-related information.[2] "The failure-to-warn cases will be most successful in states such as Michigan, that have placed an affirmative duty on the physician to notify a sexual partner or a local health organization of the patient's status as HIV-positive," says Eiselein.

Physicians have been sued for disclosing HIV status in violation of a confidentiality statute, *and* failing to warn a third party about possible HIV infection.[3,4]

The American Medical Association's policy on HIV testing states that "Physicians must honor their obligation to promote the public's health by working to prevent HIV-positive individuals from infecting third parties within the constraints of the law. If an HIV-positive individual poses a significant threat of infecting an identifiable third party, the physician should: a) notify the public health authorities, if required by law; b) attempt to persuade the infected patient to cease endangering the third party; and c) if permitted by state law, notify the endangered third party without revealing the identity of the source person."

"Another idea is to inform the patient about the criminal liability he or she will face for willful or even negligent exposure," says Eiselein.

The majority of states have some type of statute criminalizing unprotected sexual activity of a person who is HIV-positive. "Some states even criminalize a person's failure to notify a sexual partner of his or her status as HIV-positive," says Eiselein.

Otherwise, says Eiselein, ED physicians generally are legally able to divulge a patient's medical information only when the patient consents or there is a court order compelling such disclosure. "Other than those two categories, the exceptions are very limited, and again, are heavily state law dependent," she says.

In addition, there are many state laws expressly prohibiting disclosure of a patient's status as HIV-positive. "This is an additional layer of patient confidentiality protection," says Eiselein. **(For information on warning patients about specific risks, see story, above right. For information on HIPAA, see story, right.)**

References

1. *Tarasoff v. Regents of the Univ. of Cal.,* 118 Cal. Rptr. 129 (Cal. 1974) (Tarasoff I), modified by *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976) (Tarasoff II).
2. *Doe v. Roe,* 190 A.D.2d 463 (N.Y. App. Div. 1993)
3. *Urbaniak v. Newton,* 226 Cal. App. 3d 1128 (Cal. App. 1991)
4. *N.O.L. v. District of Columbia,* 674 A.2d 498, (D.C. App. 1996). ■

Warn patients of specific risks

ED physicians should *not* disclose a patient's HIV status, except when there is a legal mandate to do so and even in this case, this is preferably done through a third party, such as a public health official, advises **Matthew Rice**, MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

When there is a person at specific risk of harm, then an exception might be considered, he says. "But this would be a highly unusual case," says Rice. If your patient is aware of their HIV-positive status, but indicates that he or she is going to continue to have unprotected sexual contacts with a specific person without appropriate protections, then there is a specific risk to a specific person and, thus, a potential duty for the ED physician to take action to protect this individual.

Even if this is not the case, however, clinicians should clearly document instructing the HIV-positive patient to avoid risky behaviors that could infect others, such as sharing needles and exchange of bodily fluids. Also, it should be documented that you have explicitly informed them about ways to prevent exchanges of bodily fluids. "I would be specific about this, so there is no doubt the patient has been warned of what to be careful about," adds Rice. ■

What if HIPAA conflicts with your state's law?

Disclosure isn't always prohibited

According to **Jill M. Steinberg**, a health care attorney with Baker Donelson in Memphis, TN, the Health Insurance Portability and Accountability Act (HIPAA) would prevent an ED physician from discussing a patient's HIV status with any other person, even if that person could be potentially exposed to an infectious disease.

Instead, the ED physician should do what he or she can to obtain permission from the patient to disclose

the information, and/or make a strong recommendation to the patient himself to disclose his HIV status. "The physician should also document in the patient's record that he was counseled to avoid unprotected intercourse, stop using drugs, and warn all of his sex partners of their potential exposure," she says.

It is unlikely that a successful lawsuit could be maintained against the emergency physician for failure to tell a patient's girlfriend of his HIV status even if she becomes infected, since HIPAA prevents the disclosure, says Steinberg. "Without permission or a health care power of attorney, there are very few, if any, scenarios wherein an ED physician or nurse would be legally able to divulge patient information unless the patient is incompetent or comatose," says Steinberg.

There appears to be no private right of action for a HIPAA violation. Patients complaining of violations are required to file their grievance with the Office of Civil Rights. However, suits may be filed by patients alleging a breach of confidentiality based upon state law rights of privacy.

Laws may conflict

There may be situations in which state law and federal law are in conflict, such as states that require the physician to notify a sexual partner or local health organization of the patient's status as HIV-positive. "Failure to notify may put the physician in violation of state law. But notifying a nonpatient of the patient's status would be in violation of federal law," says Steinberg.

However, ED physicians likely will not violate HIPAA by complying with a state statute that permits or requires reporting known contacts of a HIV-positive individual to a public health agency. "Such reporting probably would fall under the HIPAA exception for public health activities, so those state laws would not be contrary to HIPAA," says **Erin McAlpin Eiselein**, a health care attorney with Davis Graham & Stubbs in Denver.

Eiselein adds that there is a "good argument" that an ED physician notifying a contact or a local health agency about a possible HIV infection would not violate HIPAA for the reason that there is an exception for disclosures to avert a serious threat to health or safety. Steinberg points to a Wisconsin case that found that an emergency medical technician invaded the privacy of an overdose patient when she told the patient's co-worker about the overdose.[1] In a Michigan case involving a pharmacy employee who loudly blurted out a patient's HIV status in a crowded waiting room, the court of appeals upheld a jury verdict of $100,000 for slander, invasion of privacy, intentional infliction of emotional distress, and violation of a Michigan statute that protects the confidentiality of HIV results.[2]

Before HIPAA, physicians had been sued for failure to disclose to third parties in limited instances, notes Steinberg. A physician was successfully sued in a case involving the failure to warn family members of the possibility that they also had been exposed to Rocky Mountain spotted fever when a relative had died of the disease.[3] "With HIPAA now in effect, these lawsuits probably not be successful if filed today," says Steinberg.

References

1. Sink L. Jurors decide patient privacy was invaded. *Milwaukee Journal Sentinel,* May 9, 2002.
2. *Doe v. American Medical Pharmacies, Inc.* (unpublished), 2002 WL 857766 (Mich. App.).
3. *Bradshaw v. Daniel*, 854 S.W.2d 865 (Tenn. 1993). ■

Patients accessing records: Liability for the ED staff?

Don't act like you have something to hide

A growing number of hospitals are allowing patients to view their own medical records electronically. Does this increase liability risks for emergency staff?

Probably not, says **Helen Oscislawski**, JD, a health care attorney at the Lawrenceville, NJ, office of Fox Rothschild. "If the patient already believes that there is malpractice involved, it shouldn't really make a difference," she says. "If the patient does bring a med-mal lawsuit, records will be subpoenaed anyway."

Patients already have a legal right to access their medical information under federal law and under certain states' laws, Oscislawski notes. In addition, most ED patients do not have the medical or nursing training that would allow them to conclude, based on the medical record, that a provider was negligent or caused them injury, says **Chris DeMeo**, JD, a health care attorney at McGlinchey Stafford in Houston.

"Being open with patients in this regard may actually limit potential claims," he says. Refusing to show the patient the medical record or being defensive about the situation invariably leads to the impression that the health care provider is trying to hide something, which increases the feelings of suspicion and resentment that often fuel lawsuits, DeMeo says. In addition, a patient's impressions of negligence and proximate cause are usually inadmissible, he adds.

"Being defensive about allowing the patient to see the record would reflect poorly on the provider, whereas being transparent and addressing any concerns the patient

has would give the record a certain reliability because the patient has had a chance to review it," he says.

ED nurses and physicians should be made aware of the possibility that patients may access their records, Oscislawski suggests.

"There should be some discussion as to how things should be written in an objective matter," she says. "It shouldn't impact clinical judgment or what is recorded, but clinicians should be mindful that patients are going to be reading this."

Because the medical record is a means of memorializing the care received by the patient, it should be accurate and explain what was done and why, as clearly as time and circumstances allow, says DeMeo. "The medical record may be the only or best evidence for the defense two or more years after the encounter," he says. "So it should be something that, as much as possible, can stand on its own."

If litigation occurs, a physician will be judged by how they treated the patient, as a patient and as a person, adds DeMeo. "Reports by the patient that they were not allowed to see their record or that their concerns were not taken seriously will undermine the defense," he says. **(For information on what to do if the patient disagrees with the record, see below.)** ■

"A patient who sees that a 'GI,' 'CVS,' or 'Integ' assessment is left blank may be left with the wrong impression that these systems were not examined by the physician," he says.

This misconception is exacerbated by the fact that many patients may not know what a gastrointestinal, cardiovascular, or skin assessment entails, and thus they might not realize that they actually received them, says DeMeo. To address this, the ED physician should comply strictly with guidelines for filling out the forms, which typically require a backslash or other mark indicating that the system was reviewed but was negative, or a check mark in a box that states systems were reviewed but were negative except as documented, he says. Similarly, a narrative note may seem terse to a patient if several systems are not mentioned because they were reviewed but deemed normal or otherwise noncontributory.

Again, DeMeo recommends a simple notation that the systems were assessed but were negative except as set out in the record. "This will assist the physician in explaining to the patient that an assessment was done even if the results are not written out in the record," he says.

In addition, allowing the patient to review the medical record while the ED physician is available to answer any questions reduces the risk of confusion, adds DeMeo. ■

When the patient disagrees with the ED record

What should be done if the ED patient disagrees with what is documented or perceives that the record is incomplete?

These situations might raise questions in the patient's mind, says **Chris DeMeo**, JD, a health care attorney at McGlinchey Stafford in Houston. Many EDs, for example, use electronic template charting, which can be confusing to someone who doesn't use it on a regular basis. The form might have entry points for numerous system reviews, many of which are noncontributory to the patient's presenting complaint and/or are normal on assessment. Some ED physicians might get into the habit of simply leaving these data points blank, even though they were assessed, because they are not pertinent to the reason the patient is in the ED, says DeMeo.

OIG says no problem with patient gift cards

Important notice regarding frequent ED practice

If you want to give patients gift cards as a way to say "sorry" for that long wait in the ED — or anything else that left them unhappy — feel free. The government says you're not violating any prohibitions on improper remuneration.

The Office of Inspector General in the Department of Health and Human Services recently issued an advisory opinion in response to a specific query from a health system that wanted to issue the gift cards, but it wants to make sure the plan would not violate any rules before issuing an opinion that would have broad application. The OIG opinion technically only applies to that unnamed health system, but such opinions

COMING IN FUTURE MONTHS

- ED wins patient satisfaction award with 'holistic' approach
- Tracking system saving money after only five months
- Boston 'experiment': Stopping diversions does not increase wait times
- Urgent care center transformed into freestanding ED

generally are regarded as a broadly applicable clarification of how the OIG would interpret similar situations.

The health system proposed offering $10 gift cards to patients who were left dissatisfied by service shortfalls, such as a delay of more than 30 minutes. The gift cards could be used at local retailers but could not be redeemed for cash or health care services. The health system also planned to track the cards to make sure that no patient received more than $50 in gift cards in one year.

The OIG opinion states that the plan "would not constitute prohibited remuneration" under the anti-kickback statute, which makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. Providing gift cards to patients could violate the statute, but the specific plan proposed by the health system is sufficiently limited to avoid that conclusion, the opinion states.

"In these circumstances, we conclude that the gift cards in the proposed arrangement will be nominal in value and will not constitute cash or cash equivalents for purposes of our enforcement," the OIG wrote. For the full OIG opinion, go to oig.hhs.gov/fraud/docs/advisory opinions/2008/AdvOpn08-07.pdf. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **March** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

7. According to James G. Adams, MD, which of the following members of the ED team should be empowered to report changes in a patient's condition?
A. Technicians.
B. Nurses.
C. Secretaries.
D. All of the above

8. According to Robert B. Takla, MD, FACEP, when he retained certified coders and paid them a higher percentage of the collections than he had the previous coding firm:
A. Collections per chart decreased.
B. Collections per chart increased.
C. Collections per chart remained the same.
D. Collections became erratic, making month-to-month comparisons difficult.

9 According to M. Steven Lipton, JD, CMS' final regulations for the Medicare inpatient prospective payment program for fiscal year 2009 states that the community call panel concept involves:
A. Two or more participating hospitals.
B. Three or more participating hospitals.
C. Four or more participating hospitals.
D. Five or more participating hospitals.

10. According to Caral Edelberg, CPC, CCS-P, CHC, oif evaluation of the critically ill or critically injure patient is documented over 74 minutes:
A. No additional 99292 Critical Care may be billed.
B. 99292 Critical Care would be billed for each additional 15 minutes of care.
C. 99292 Critical Care would be billed for each additional 30 minutes of care.
D. 99292 Critical Care would be billed for each additional 45 minutes of care.

11. According to David Ross, DO, which of the following strategies will help boost staff influenza immunization rates?
A. Making immunization readily accessible by placing stations throughout the facility.
B. Offering immunizations free of charge.
C. Allowing staff to receive immunizations beyond the designated end of the program.
D. All of the above

12. According to Kevin Hickey, MSA, which of the following would not qualify as a "direct impact" standard under the new simplified scoring process?
A. A National Patient Safety Goal.
B. Standards for planning and evaluation.
C. The Universal Protocol.
D. Standards covering drugs that look and sound alike.

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CNE/CME answers

7. D; 8. B; 9. A; 10. C; 11. D; 12. B.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

The Joint Commission challenges facilities to improve staff flu immunization rates

Joint Commission Resources (JCR) has launched a "Flu Vaccination Challenge" to underscore the responsibility that hospitals have to help keep their employees and patients healthy this flu season and to increase flu vaccination rates among health care workers.

JCR notes that the Centers for Disease Control and Prevention (CDC) statistics for the 2005-06 flu season show that only 42% of surveyed health care workers received a flu vaccination. The "Flu Vaccination Challenge," which began Sept. 1, 2008, continues until May 2009.

Hospitals that achieve a vaccination rate of 43% or more will be recognized for their dedication to helping keep their employees healthy and helping to protect their patients. "This program is a great complement to existing [Joint Commission] standards," says **Louise Kuhny**, RN, MPH, MBA, CIC, senior associate director of standards interpretation for The Joint Commission. "It should serve as a challenge to all hospitals to try to make patient safety a priority by decreasing the spread of influenza. If you increase the immunization rate of health care workers, the infection is less likely to spread to patients." **(To learn about best practices that help get compliance rates up, see the story on p. 2.)**

Kuhny says The Joint Commission has not yet determined what form the recognition will take, "but there will be some sort of ability for the facilities to have public recognition."

Some emergency medicine experts, however, believe the goal of a 42% immunization rate is too modest, given the fact that some facilities have achieve rates of 95% and higher. "I was disappointed with 43%," says **David Ross**, DO, an emergency physician at Penrose Hospital in Colorado Springs, CO, and a spokesman for the American College of Emergency Physicians. However, Kuhny counters by saying, "That's a national *average.* There are some organizations that do significantly better, but those that already do well will be recognized and able to broadcast that fact to their communities and able to share their successes with those who may be struggling."

Kuhny notes that on the flu challenge web site, where hospitals can register for the challenge, there are recommendations for best practices. *(Editor's note: Go to www.fluvaccinationchallenge.com. Click on "Resources," then "NFID Best Practices.")*

Know 5 expectations

The Joint Commission's influenza standard (IC.4.15) also offers guidance for ED managers and hospital leaders looking to improve their staff vaccination rates. The standard has five Elements of Performance (EPs), says Kuhny. The expectations are:

- Hospitals should have a vaccination program for all staff.
- Hospitals should educate staff and physicians not only on the importance of vaccination, but how influenza spreads and the negative implications of that spread.
- Hospitals should measure vaccination rates every year.
- Hospitals should know why people are refusing to be vaccinated.
- Hospitals should take action the next season to improve upon those rates.

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Further guidance, says Kuhny, is available through a list of best-practice tips on the CDC web site (www.cdc.gov/flu/professionals/vaccination/vax-summary.htm). "We have taken a subset of those best practices and added them to our standard as a footnote," she says.

Kuhny says The Joint Commission "is in full implementation of year two of the [influenza] standard, which fits in perfectly with the challenge; it's kind of a built-in process improvement project." ■

Convenience, accessibility boost vaccination rates

One way to get your staff flu vaccination rates higher is to make it as easy as possible for them to obtain a vaccination, says **David Ross**, DO, an emergency physician at Penrose Hospital in Colorado Springs, CO. Ross says his hospital's staff vaccination rate has risen from 63% to 73% in the past year.

"We have made immunization very accessible, and we offer it at no charge," he says. Each flu season, vaccination stations are set up within the hospital, and for a period of days or weeks, the vaccinations are offered at set hours, with an effort to hit all three shifts. "There are stations in the ED," notes Ross. "And even if you are not there during the designated period, you can come in and tell one of the nurses, 'I didn't get mine last week. Can I get it now?' and they will go to the Pyxis, because we always have some vaccine there."

The facility also has a strong awareness campaign, Ross continues. "Every year our newsletter will make an announcement, and we also communicate by e-mail and at our monthly meetings as the flu season starts," he says. "The nurse manager will also announce it to her staff and provide them with times and schedules, and we do the same with our own contracted ED group."

Perhaps the biggest impact is from a strategy, introduced last year, involved asking staff who declined a vaccination why they had done so. Ross says in many cases they had been vaccinated elsewhere, which allowed the hospital to count them as having been vaccinated.

It's critical to educate your staff about the importance of immunization, says Ross. "The key is to get across to anyone who does not understand that immunization is more likely to keep you healthy and avoid some potentially debilitating flu cases and lost wages," he notes.

Louise Kuhny, RN, MPH, MBA, CIC, senior associate director of standards interpretation for The Joint Commission, says the approaches Ross outlines are considered best practices for improving staff vaccination rates. "Making it convenient and easy to be immunized is important, because health care workers are so busy," she notes. "There is also growing recognition of the importance of a signed declination. It's good to know why people are refusing to be immunized."

(Editor's note: You can download a copy of a declination form free of charge at: www.immunize.org/catg.d/p4068.htm.) ■

Mandatory immunizations: Do they make any sense?

In light of the importance of having health care workers immunized against influenza, some facilities have instituted mandatory vaccination programs. For a few years, Virginia Mason Medical Center in Seattle stood alone with a mandatory influenza vaccination policy that enabled the hospital to vaccinate 98% of its employees, but other hospitals have quietly moved toward mandatory vaccination in an effort to reach the highest levels of coverage.

Yet several experts question that approach. "First of all, it is not currently recommended by the [Centers for Disease Control and Prevention], and our standards are based on scientific guidelines," says **Louise Kuhny**, RN, MPH, MBA, CIC, senior associate director, standards interpretation, for The Joint Commission. "We have no guidelines on which to base or recommend that practice."

David Ross, DO, an emergency physician at Penrose Hospital in Colorado Springs, CO, says, "I think immunization rates can be raised without a mandatory system, and I don't favor that approach. People should be able to opt out." He says his hospital allows staff to opt out.

Ross adds that if he had knowledge that an epidemic was a certainty and that morbidity and mortality rates were going to be substantial, it might be a different story, "but in our current environment, we are better off not trying to force it on people," he says. Not only is it "draconian" in nature, Ross says, but there could be a liability issue if staff members who have been immunized subsequently develop vague symptoms such as a numbness and tingling in their legs, and decide to sue.

Ken Braxton, JD, a health care attorney and partner in the Dallas law firm of Stewart Stimmel, says, "I agree with him; there's always a potential for that. Every hospital has to weigh the risks vs. the benefits, the potential side effects vs. having all your employees have flu shots." One of the key considerations, he adds, is the level of risk for flu infection in a given locale. ■

Newly OK'd test detects seasonal, novel flu viruses

The Food and Drug Administration has approved a new test to diagnose human flu infections, including the avian flu virus (H5N1), which scientists fear could cause a pandemic.

The device uses genetic material from a patient's nose or throat to detect flu virus and differentiate between seasonal and novel influenza. Results can be available within four hours, and the system can test multiple samples at once. The test, called the Human Influenza Virus Real-Time RT-PCR Detection and Characterization Panel, was developed by the Centers for Disease Control and Prevention (CDC) and will be available to CDC-qualified laboratories for diagnosing influenza this fall. *(Editor's note: For more information, go to news.yahoo.com/s/afp/20081001/pl_afp/ushealthfludetection.)* ■

New scoring process: 'quality, not quantity'

The Joint Commission has released a statement that effective Jan. 1, 2009, there will be new simplified scoring and decision processes for all accreditation and certification programs that "better reflect an organization's performance regarding compliance with Joint Commission standards and elements of performance [EPs]."

"We've tried to eliminate some of layers of complexity," explains **Kevin Hickey**, MSA, director of survey scheduling and support. At press time, The Joint Commission had not finalized all of the elements of this new process, but perhaps the most significant for ED managers and hospital leaders was the "last piece," which he expected to be resolved in October.

That piece involves what The Joint Commission calls its accreditation "threshold." At present, that threshold is based on the total number of findings reported by the surveyor. "Once they have determined certain standards to be noncompliant, we count those up," Hickey explains. "In the current model, we have pre-established thresholds; and based on the volume [of noncompliance to standards], we issue either conditional accreditation or preliminary denial."

The current model, he continues, requires accreditation decisions based solely on the quantity of the findings, no matter whether the violations are critical to patient safety or not. "What we are proposing is rather than focusing on the total count, we want the focus to be on the standards we find have a direct impact on the quality of care and patient safety," Hickey explains. **(For addition details on the new scoring process, see story, p. below.)**

So, for example, more weight would be given to most of the National Patient Safety Goals. Also covered, says Hickey, would be a new standard, PC.03.01.01, EP 6, covering appropriate monitors of physiological status for patients under sedation; the new standard for response to pain assessment, PC.01.02.07 EP 1; and the requirement for emergency medicines to be readily accessible, MM.03.01.03, EP 2.

"The balance of the standards, such as those covering planning and evaluation, will be labeled as having 'indirect impact,'" Hickey continues. "They are important, but many are not a critical issue with the patient today."

In The Joint Commission's program governing hospitals, Hickey says, about 20% of the EPs have been given this label. "The focus in the future would be more on the direct impact group, where noncompliance has the potential to have immediate impact on quality of care and patient safety," says Hickey, adding that the new rankings will be included in the 2009 accreditation manual, to be posted online until hard copies can be distributed.

Emergency medicine experts are pleased with the new approach. "It's always good news for ED managers and hospital leaders when the accrediting and standards bodies value quality over quantity," says **James J. Augustine**, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group based in Canton, OH. "I support that philosophy." ■

Joint Commission to use new scoring process

A new simplified scoring process that The Joint Commission will use for all accreditation and certification programs as of Jan. 1, 2009, was created in conjunction with The Joint Commission's Standards Improvement Initiative (SII). The goals of SII are to:

- enhance clarity and objectivity of standards and EPs (Elements of Performance);
- tailor standards language to the characteristics of each program;
- refine scoring and decision processes;
- enhance manuals for ease of use.

"We wanted make sure our new scoring model

would work in parallel with SII," explains **Kevin Hickey**, MSA, director of survey scheduling and support. "Since [standards] language was being modified, we elected to use the same time period to [revise the scoring process] from top to bottom."

Scoring changes being made for 2009 include:

• Bulleted lists of expectations have been minimized.

• Compliance problems previously cited as supplemental findings will be cited as requirements for improvement.

• EPs will be divided into two scoring categories: A and C. Scoring Category B will be eliminated.

— Category A EPs: Usually related to structural requirements (for example, policies or plans) that exist or do not exist, and are scored 0 or 2. They also may be related to a Medicare Condition of Participation (CoP) that must always be fully compliant.

— Category C EPs: Scored based on the number of times an organization does not meet a particular EP. They are scored 2 if there are one or no occurrences of noncompliance; they are scored 1 if there are two occurrences of noncompliance; and they are scored 0 if there are three or more occurrences of noncompliance.

• All findings of less-than-full compliance require resolution through an Evidence of Standards Compliance (ESC) submission. The timeline for completing the ESC submission will depend on the criticality of findings and immediacy of risk.

• If one or more Direct Impact (on quality of care and patient safety) EPs under a standard are found to be partially or insufficiently compliant, then all EPs under that standard that have been found to be partially or insufficiently compliant must be addressed in an ESC submission within 45 days.

• If no Direct Impact EPs under a standard are found to be partially or insufficiently compliant, then all EPs under that standard that have been found to be partially or insufficiently compliant must be addressed in an ESC submission within 60 days.

The three-point EP scoring scale will be retained, in which a 2 equals satisfactory compliance, a 1 equals partial compliance, and a zero equals insufficient compliance. ■

Urgent care group, Joint Commission form alliance

The Joint Commission and the Urgent Care Association of America (UCAOA) have formed a partnership to provide quality oversight for urgent care clinics.

Both organizations provide accreditation for urgent care clinics, but in the new alliance, the UCAOA will discontinue its accreditation program and focus its support on services available under The Joint Commission's Ambulatory Care Accreditation Program. The collaboration will include development of quality standards specific to urgent care, targeted for introduction in 2010.

Earlier this year, UCAOA joined The Joint Commission's Ambulatory Professional and Technical Advisory Committee to provide input on standards and other issues. There are an estimated 8,000 urgent care centers in the United States. ■

Sentinel Event Alert targets anticoagulants

The Joint Commission has issued a *Sentinel Event Alert* on "Preventing errors relating to commonly used anticoagulants."

The anticoagulants cited most frequently in medication error reports are unfractionated heparin, warfarin, and enoxaparin, classified as low molecular weight heparin (LMWH), says The Joint Commission.

The *Alert* says patients under consideration for receiving anticoagulant drugs must be carefully screened for contraindications and drug interactions. While receiving anticoagulants, patients must be monitored closely to ensure effectiveness and to prevent side effects or overdosing. Heparin and warfarin in particular have narrow therapeutic ranges and a high potential for complications, so there is a greater risk of patient harm, notes the alert.

Health care organizations that dispense or administer anticoagulant medications can prevent errors relating to anticoagulants by implementing specific risk reduction strategies, the *Alert* notes. Since the management of anticoagulants is interdisciplinary, any risk strategies should be implemented by all staff who manage anticoagulants, which can include physicians, nurses, pharmacists, dietitians, and case managers, it points out. The *Alert* adds that guidelines issued by organizations such as the Institute for Healthcare Improvement emphasize improving staff communication and access to information, implementing close pharmacy oversight and involvement, and enhancing patient education.

You can access the entire *Alert* at www.jointcommission.org. Under "Sentinel Event," click on "Sentinel Event Alert." Under "Index of Issues," click on "Issue 41 — Preventing errors relating to commonly used anticoagulants." ■