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Are you losing staff to military call-ups? ED managers share their key strategies

Staffing losses 'could quickly reach crisis proportions'

If your ED already is experiencing high vacancy rates for nursing staff, decreased morale, and increased patient volume, try this on for size: What if you suddenly lost several nurses, technicians, and physicians without notice for an undetermined period of time?

This is the scenario many EDs may face in the coming months as a result of losing staff due to military call-ups.

"This is a huge issue, and it's going to get even worse," says **Robin Gilbert**, RN, BSN, CEN, manager of the ED at Memorial Hospital in North Conway, NH. "For rural EDs, even having one nurse mobilized could have a tremendous impact."

The ED's medical director has just reported for active duty, she notes.

"We are already struggling trying to fill open shifts," Gilbert says. "In the middle of a nursing shortage, the ability to rely on traveling or agency nurses is greatly diminished."

At Methodist Hospital in Indianapolis, two ED nurses have been activated full time and are not expected back for one year; three others are called in on a temporary basis for two to six weeks; and another nurse is awaiting orders, reports **Kathy Hendershot**, RN, MSN, CS, director of clinical operations for the emergency medicine and trauma center.

"The nurses themselves are unsure as to how long they will be off our schedule," Hendershot says.

Generally, an ED could suffer the loss of up to 10% of their personnel and survive

Executive Summary

Many EDs are losing staff due to military call-ups, and the problem is expected to worsen in the coming months.

- Use flexible staffing including short shifts.
- Develop a pool of volunteer ED physicians willing to work per diem.
- Plan for solutions in advance with administrators.

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- Military/Nonmilitary-Related Obligation Pay and Leave policy
- Emergency Department Full Capacity Protocol

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on volunteerism for the first month, but after that, it would quickly become problematic, says **Michael L. Carius**, MD, FACEP, chairman of Norwalk (CT) Hospital's department of emergency medicine. "This could quickly reach crisis proportions," Carius says. **(See related story on how military call-ups impact your smallpox vaccination policy, p. 40.)**

Use these survival strategies for military call-ups:

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Editor: Staci Kusterbeck.
Vice President/Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: Valerie Loner, (404) 262-5475, (valerie.loner@ahcpub.com).
Senior Managing Editor: Joy Daughtery Dickinson, (229) 377-8044, (joy.dickinson@ahcpub.com).
Senior Production Editor: Ann Duncan.

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (229) 377-8044.

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- **Use flexible scheduling.**

Add short four-hour shifts to satisfy peak demands, Carius suggests. "The bottom line is to have sufficient personnel to handle the load during peak times, such as early evenings or midafternoons," he says. "These or other times may represent predictable surges."

- **Create networks of part-time ED physicians.**

Develop a list of individuals willing to work additional shifts at your ED should the need arise, Carius suggests.

Four physicians from local EDs work in Carius' department occasionally, he reports. This provides a buffer for any potential staffing shortfalls, such as unexpected illnesses and injuries, and staff being called to active duty from the reserves, he explains.

The per-diem physicians also cover the ED's monthly staff meetings, which results in nearly 100% participation, and cover additional open shifts each month, says Carius.

Each per-diem physician ends up working about one shift a month, says Carius. "The minimum number to have is probably two for a group the size of ours [12 full-time ED physicians], but four is much more comfortable and doable," he says.

- **Address unique needs that occur when managers are called up.**

While having to replace nursing staff is a daunting challenge, it is even more difficult to cover managers should they be called up, says **Denise King**, RN, MSN, ED nurse manager at St. Joseph Hospital, Orange, CA, who is a reservist.

If any managers are reservists, you should develop a contingency plan now, King says. "It would be unwise to wait until the call-up occurs," she says.

Maintaining smooth operation of the ED

The goal is to support the manager's military service with minimal disruption to the ED, King says. "With a lack of leadership, things can get ugly very quickly," she says. If King is called up, the ED director and four clinical coordinators would take on more administrative responsibilities, she says.

King recommends the following:

— holding a meeting to discuss ideas for a smooth transition;

— assigning a manager from another unit as a resource and backup;

— training a staff person to take on the role.

"This may entail having a charge nurse stepping up and filling in for the nurse manager, in which case, the manager should begin orienting and working with the identified replacement," King says.

- **Discuss plans with administrators in advance.**

Discuss backup plans for staffing with administrators now, Carius advises.

"We all manage these situations on a daily and weekly basis, but when they become prolonged, then we have some real problems," he says. "That is why early conversations are extremely important."

- **Find out which staff may be called.**

After the Sept. 11, 2001, terrorist attacks, Hendershot found that her ED was suddenly short-staffed when several members of the Federal Emergency Management Agency's (FEMA's) search and rescue team were deployed to New York.

"We were not ready for such sudden vacancies over such a long time," she says. "I looked for ways to mitigate the circumstances if it happened again. I could not afford any more holes in my staffing plan."

Here are some of the steps she took:

— conducted an informal survey to find out how many ED staff could possibly be activated;

— monitored patient census carefully to keep a close watch on staffing needs;

— communicated with staff about the need to ask for overtime or deny requests for vacations and educational time off.

"I explain the military leave policy and what it may mean to us, and review our mission to deliver great care," Hendershot says. "I am willing to look at anything they can come up with that will get the job done and minimize the hardships." **(See Military/Nonmilitary-Related Obligation Pay and Leave policy, enclosed in this issue.)**

For example, she says that the ED may change the length of shifts for a short time to accommodate the needs of older nursing staff.

Address reservists' concerns

You also will need to address concerns of reservists about what will happen to their jobs, Hendershot says.

The facility's policy is that they return to a similar job within the institution at a comparable rate from the time they left, she explains.

"It does not guarantee them the same position in my ED with the same shift," she says. "I personally will hold their position and promise a return to their previous status. I do not do this for any other leave of absence."

- **Contact staffing agencies in advance.**

The biggest problem with military call-ups is the loss of staff with almost no notice, explains **Camilla Jones**, RN, BBA, director of emergency and transfer services at Lewis-Gale Medical Center in Salem, VA.

"Our ED has had one person to date deployed to active military duty with only two days notice, and we have another employee who also may be deployed," she reports.

Contact staffing agencies now to prepare for this possibility, Jones recommends. "You need to establish relationships and agreements in advance if a sudden loss of manpower is expected," she says.

- **Use more per diems and part-timers.**

Broaden your pool of supplemental staff in advance, recommends Carius. "We have a ready supply, most of whom are more than willing to work additional hours," he says.

At Methodist's ED, an incentive package was created to encourage nurses to take a temporary assignment with the ED, to avoid having to hire traveling nurses, Hendershot reports.

Nurses who worked two shifts each week were offered a third shift at time and a half, she says. "If three part-timers agree to do that, you can fill in a full time slot," she explains.

Other incentives include a $25 bonus for every additional four hours worked, Hendershot adds.

"This [incentive package] can be helpful in quickly filling a vacant spot with very little orientation to environment or culture of your ED," she says. "If all else fails, our educators, managers, and I are expected to don the uniform and provide the care." ■

Sources

For more information about the impact of military call-ups on staffing in the ED, contact:

- **Michael L. Carius**, MD, FACEP, Norwalk Hospital, Maple Street, Norwalk, CT 06856. Telephone: (203) 852-2281. Fax: (203) 855-3705. E-mail: michael.carius@norwalkhealth.org.
- **Robin Gilbert**, RN, BSN, CEN, Manager, Emergency Department, The Memorial Hospital, 3073 White Mountain Highway, North Conway, NH 03860. Telephone: (603) 356-5461. E-mail: rgilbert@tmhf.org.
- **Kathy Hendershot**, RN, MSN, CS, Director of Clinical Operations, Emergency Medicine and Trauma Center, Methodist Hospital, 1-65 at 21st Street, P.O. Box 1367, Indianapolis, IN 46206-1367. Telephone: (317) 962-8939. Fax: (317) 962-2306. E-mail: KHendershot@clarian.org.
- **Camilla L. Jones**, RN, Director of Emergency and Transfer Services, Lewis-Gale Medical Center, 1900 Electric Road, Salem, VA 24153. Telephone: (540) 776-4850. Fax: (540) 776-4849. E-mail: cami.jones@hcahealthcare.com.
- **Denise King**, RN, MSN, Nurse Manager, Emergency Department, St. Joseph Hospital, 1100 W. Stewart Drive, Orange, CA 92868. Telephone: (714) 771-8000, ext. 7983. Fax: (714) 744-8527. E-mail: DKING@sjo.stjoe.org.

Address risks of staff who get smallpox vaccine

Even if your ED staff are not being vaccinated for smallpox, you'll need to address transmission risks if reservists receive the vaccine due to military call-ups.

"The reservist and military issue is why everyone needs a policy," says **Robert E. Suter**, DO, FACEP, senior consultant at Texas Emergency Physicians in Dallas. "You cannot simply hide and avoid the issues surrounding the vaccination program. They can come to you regardless." **(For more information on smallpox, see "Don't miss smallpox/plague outbreaks: Adapt strategies to track bioterrorism," *ED Management,* January 2002, p. 1.)**

There are three items that are essential to consider:

- **Survey staff about their vaccination status.**

At Inova Health System in Fairfax, VA, nurse managers regularly inquire as to whether staff have been vaccinated as part of the military vaccination campaign, reports **Dan Hanfling**, MD, FACEP, director of emergency management and disaster medicine.

"Those who have are being asked to report this to their supervisors, and to undergo evaluation of their bandage covering prior to participating in their health care-related activities," he says. The bandage is being evaluated for proper placement and integrity, he says. "We are assuming the vaccine recipient will be responsible for following the progress of their own vaccine reaction, and [they] will be asked to notify their physician of any unexpected findings," adds Hanfling.

- **Remind staff to ask if patients have been vaccinated.**

"We are emphasizing to our ED staff that any patients who present with fever and rash, either localized or generalized, should be asked if they or a close contact have recently been vaccinated with the smallpox vaccine," Hanfling says.

Vaccinia virus, which causes rash, fever, and head and body aches, can be spread from the vaccination site by touching the site before it has healed or by touching contaminated bandages or clothing, according to the Atlanta-based Centers for Disease Control and Prevention (CDC) guidelines.

- **Address risks of transmission.**

Because some ED staff will be vaccinated from other sources regardless of your policy, you'll need to address this problem even if your ED staff weren't vaccinated at your facility, Suter says. "The best defense is to give leave to those who are vaccinated until they are noninfectious," he says. If this is not possible, Suter says the following are recommended:

- Wear a gauze bandage covered with a semipermeable dressing as an additional barrier.
- Wear long sleeves over the dressing site.
- Give assignments which minimize patient care duties to those who are still potential transmitters.

The key recommendation is to wash hands, especially after touching the vaccination site or bandages, clothing or anything else that might have come in contact with the vaccination site, Hanfling says.

Review and implement CDC guidelines to avoid transmission to patients, staff, and visitors at increased risk, advises **Bettina Stopford**, RN, a member of the Des Plaines, IL-based Emergency Nurses Association Disaster Planning Workgroup. (The guidelines can be accessed at no charge at www.bt.cdc.gov/agent/smallpox. Click on "ACIP Recommendations: Smallpox Vaccine in a Pre-Event Vaccination Program.")

Encourage staff who receive the vaccine to work with their hospital infection control professional to prevent any transmission, Stopford says.

According to the CDC guidelines, newly vaccinated staff can safely care for patients, Hanfling says. "With [more than] 300,000 vaccine recipients to date in the U.S., there have been no reported transmissions of vaccinia from vaccine recipient to patients," he says.

"The Israeli vaccination experience also did not demonstrate any cases of vaccinia amongst hospitalized patients," he says.

However, a California adult recently became infected with the same virus used in the military's smallpox vaccination program. The patient had been in close contact with someone who was recently inoculated, although it is unclear exactly how the virus was transmitted.

"While this is not known to be a case of transmission from a health care worker, it reminds us all that it can happen," Suter says. Health care workers will be expected to exercise caution and diligence to prevent transmission, he emphasizes. "Those who don't can expect the legal community to be a step away from filing a lawsuit," Suter says.

Executive Summary

You'll need a policy to reduce risks of inadvertent transmission of the smallpox virus to address staff participation in the military's vaccination program.

- Vaccinated staff must wash hands, especially after touching the vaccination site or bandages.
- Implement Centers for Disease Control and Prevention guidelines to avoid transmission to staff, patients, and visitors.
- Have newly vaccinated staff avoid contact with immunocompromised patients if possible.

Sources

For more information on reducing risks of inadvertent transmission of the smallpox vaccine, contact:

- **Dan Hanfling,** MD, FACEP, Director, Emergency Management and Disaster Medicine, Inova Health System, 3300 Gallows Road, Falls Church, VA 22042. Telephone: (703) 698-3002. Fax: (703) 698-2893. E-mail: dan.hanfling@inova.com.
- **Bettina Stopford**, RN, Senior Program Analyst, SAIC, Homeland Security Group, 8301 Greensboro Drive, MS E-1-6, McLean, VA 22102. Telephone: (703) 676-6348. E-mail: stopfordb@saic.com.
- **Robert E. Suter**, DO, FACEP, Senior Consultant, Texas Emergency Physicians, 5926 Saint Marks Circle, Dallas, TX 57230-4048. Telephone: (214) 739-2776. Fax: (214) 739-0658. E-mail: TexEPs@aol.com.

To avoid this scenario, promote basic infection control practices such as good hand washing and appropriate site coverage to reduce the likelihood of such transmission, Hanfling advises. "We are also working with our staff to avoid the situation whereby a known immune-compromised patient is cared for by a recently vaccinated health care worker," he says.

Many ED patients may have immunocompromised status that you are unaware of, he acknowledges.

"Whenever possible, we are going to avoid patient care contact with those most obviously immunocompromised, such as those with neutropenia or recently transplanted, as an added precaution," Hanfling says. ■

5 ways to comply with HIPAA oral privacy regs

When an orthopedic resident was paged repeatedly to assess a patient with an open fracture of the forearm, he failed to respond. The resident was paged multiple times and took more than an hour to get to the ED. When he finally arrived, instead of apologizing for his delay, he began to loudly explain to the patient and his family that he was unaware of the urgency of the situation, recalls **Peter Alan Bell**, DO, FACOEP, FACEP, professor of emergency medicine at Ohio University College of Osteopathic Medicine in Columbus.

"In a loud and clear voice, he criticized the staff's treatment and questioned their competency," Bell says.

Furthermore, the resident loudly discussed the extent of the injury, treatment, and potential complications, he adds.

"His residency program director and I discussed this," he says. "Needless to say, his behavior was not condoned, and he received counseling."

This is a potential violation of the Health Insurance Portability and Accountability Act's (HIPAA's) oral privacy requirements, which go into effect April 14, 2003. **(To obtain the regulations, see resource box, p. 42.)**

Penalties are severe, with civil penalties of up to $25,000 for each requirement violated, and criminal penalties of up to $50,000 and one year in prison for obtaining or disclosing protected health information.[1,2]

Consider another example of a potential HIPAA violation: When a thoracic-vascular surgeon suspected an aortic aneurism in an 89-year-old man, he discussed the plan of care, the risks, and the probability of success in full earshot of other patients.

"He was loud enough for patients at a half dozen beds to hear, plus the staff at the adjacent nursing station," Bell says.

When asked why he was speaking so loud, he replied that this was a risky operation and he wanted witnesses. "I suggested he lower his voice," he says.

The patient and his three children all had good hearing, he says. "The nurse would serve as his witness on the surgical consent form, and he could list the risks on the form for the patient to sign," Bell says. "If he was really concerned, he should ask the children to sign as well."

Don't ignore oral privacy

You may wrongly believe that it's impossible to give patients oral privacy in the hectic ED environment, says **David Sykes,** PhD, vice president and lead consultant for HIPAA compliance for Acentech, a Cambridge, MA-based consulting firm specializing in noise control. "ED managers often assume that it's too expensive a problem to solve, and therefore, they ignore it," Sykes says.

That's a mistake, he says. "It's in the patient's best interest and your best interest to fix this," Sykes says.

Here are effective ways to comply with HIPAA

Executive Summary

ED managers should use cost-effective and simple strategies to comply with Health Insurance Portability and Accountability Act requirements for oral privacy.

- Consider using cubicles or screens to block sound, and perform triage in a room next to the waiting area.
- Limit the number of visitors per patient, and require badges.
- Install white noise machines, sound-absorbent curtains, and ceiling tiles with a higher noise-reduction rating.

Sources/Resources

For more information about compliance with oral privacy regulations, contact:

- **Peter Alan Bell**, DO, FACOEP, FACEP, Professor of Emergency Medicine, Ohio University College of Osteopathic Medicine, 1087 Dennison Ave., Columbus OH 43201. Telephone: (614) 297-4207. Fax: (614) 298-2638. E-mail: bell@exchange.oucom.ohiou.edu.
- **David Sykes**, PhD, Vice President, Acentech, 33 Moulton St., Cambridge, MA 02138. Telephone: (617) 868-8866. Fax: (617) 499-8074. E-mail: david.sykes @remington-group.com.

- A guidance document for compliance with HIPAA's Medical Privacy — National Standards to Protect the Privacy of Personal Health Information regulations is available, titled *Office of Civil Rights Guidance Explaining Significant Aspects of the Privacy Rule — Dec. 4, 2002.* The document can be accessed free at www.hhs.gov/ocr/ hipaa/ privacy.html. The final rule was published in the Feb. 20, 2003, *Federal Register*, and can be downloaded at no charge at http://www.cms.hhs.gov. Click on "HIPAA," "HIPAA Administrative Simplification," and scroll down to "HIPAA Security Standards Final Rule Published."
- The Sonet Acoustic Privacy System includes a sound generator and two sound-masking emitters that can be placed on the wall, desk, or ceiling. Each sound generator can be expanded to cover a wide range of office and waiting room sizes. A variety of units ranging in cost from $144.95 to $999.95 can be ordered at web site store.yahoo.com/earplugstore. Click on "HIPAA Products and Information," "Sonic Acoustic Privacy System."
- The Oasis System is a miniature, ceiling-mounted acoustical privacy system for health care facilities. The Oasis Master Control unit costs $375 each. For more information, contact Ergonomic Resources, 412 Long Cove Court, Allen, TX 75002. Telephone: (877) 474-3746 or (972) 678-2190. Fax: (972) 678-2192. E-mail: sales@ ergo-2000.com. Additional information about sound masking products compliant with privacy regulations is available on the company's web site (www.ergo-2000. com). Click on "White Noise/Soundmasking."
- Noise-reducing and sound-masking ceiling systems are available from Armstrong World Industries. A selection can be viewed on the company's web site (www.armstrong. com.) Click on "Commercial Ceilings," and under "Browse ceilings by . . . " click on "Performance Attribute," "Acoustics." For more information, contact Armstrong World Industries, Attention: BPO Customer Service Center, P.O. Box 3210, Lancaster, PA 17604. Telephone: (877) 276-7876.
- Sound Curtains are sound-absorbent barriers that can be installed with ceiling- or floor-mounted hardware. For more information, contact: Unger Technologies, 15370 Herriman Blvd., Noblesville, IN 46060. Telephone: (888) 213-4711. Fax: (317) 774-1911. E-mail: info@eNoise Control.com. Web: www.enoisecontrol.com.
- A variety of sound control curtains, ceilings, and wall panels are available from Acoustical Surfaces, including portable enclosures and screens. For more information, contact: Acoustical Surfaces, 123 Columbia Court N., Suite 201, Chaska, MN 55318. Telephone: (952) 448-5300. Fax: (952) 448-2613. E-mail: sales@acoustical surfaces.com. Web: www.acousticalsurfaces.com.

requirements for oral privacy:

1. Encourage staff to be discreet.

Bell says, "I believe that we all could do a better job lowering our voices or stepping away from the bedside or main flow of people to discuss cases."

2. Consider simple design changes.

Remodeling the ED is *not* a HIPAA requirement, Bell stresses. "However, it certainly seems prudent that we take into consideration simple changes that would enhance confidentiality," he says.

Bell gives these examples to improve oral privacy:

- using cubicles or screens in open areas;
- doing triage in a room adjacent to the waiting area;
- using physician dictation cubicles to replace open desk areas that allow dictations to be overheard;
- placing clear plastic screens by nursing stations and desks.

3. Limit access of visitors.

Visitors pose the greatest risk of breach of confidentiality, but limiting access is not that difficult, Bell says. "Locked EDs are now the standard," he adds. "Defining how many visitors are allowed per patient and use of a visitors badge system can control flow."

Security personnel can help by ensuring that a visitor's badge matches the patient they are visiting, and if not, asking visitors to leave, Bell points out.

4. Ask staff to put themselves in the patient's shoes.

It helps to remind staff to consider the issue of privacy from the ED patient's perspective, he says.

"Patients put on a gown, lay down on a gurney, and subject themselves to a full work-up/evaluation," he says. "Add inadequate pain control, and the picture is almost complete."

Consider the embarrassment of having the details of whatever brought you to the ED broadcast to others, he says. "It's not a pleasant feeling," Bell says.

5. Use sound-blocking tools to mask noise.

The following are effective and inexpensive solutions to block conversation in the ED waiting room, treatment areas, and hallways, says Sykes. (To obtain

information about these tools and products, he recommends accessing www.google.com and doing a search using key words 'HIPAA sound masking.")
• Use portable "white noise" machines. "You can buy very useful, HIPAA-compliant sound-masking devices for as little as $100 that will take care of a waiting room, and they can simply be plugged into a wall," says Sykes. **(See resource box for a list of manufacturers, p. 42.)**
• Switch to ceiling tiles with a higher noise-reduction rating.
• Use sound-absorbent curtains or cubicle panels between beds. **(For more information, see resource box, p. 42.)**

If you put a panel between two beds, you can prevent a patient from hearing a doctor talk to another patient in the next bed, Sykes says.

References

1. 45 CFR §160.306 and §160.312 (2000) for Civil Enforcement.
2. 42 USC 1320d-6 (HIPAA Sec. 1177) for Criminal Enforcement. ■

ED Benchmarking Success

Use protocol to send inpatient holds upstairs

It was a typical scenario: The ED at Stonybrook (NY) University Medical Center was holding 15 or 20 admitted patients waiting for an inpatient bed to become available. This was a common occurrence, but **Peter Viccellio**, MD, FACEP, vice chairman of the department of emergency medicine for the school of medicine at State University of New York at Stony Brook, was fed up.

"We had a longstanding history with the New York State health department, so I called a senior person," Viccellio says. "I asked in frustration why it's against health codes to hold patients upstairs in hallways, but it's OK for us to hold them in the ED," he says.

Viccellio was surprised to learn that no such distinction is made. "It's a myth that has been perpetuated in hospitals for many years, but there is no specific code against holding patients upstairs," he says.

Executive Summary

A "full capacity" protocol requires that admitted patients being held in the ED are moved upstairs when the ED is at full capacity.
- Length of stay for admitted patients is reduced.
- Morale of ED nurses is improved.
- Inpatients receive better care when moved upstairs.

Viccellio asked the official to put this in writing. "They wrote a series of letters saying that holding patients upstairs is encouraged and that boarding of inpatients in the ED is unacceptable," he says. **(The letters can be viewed at www.viccellio.com/overcrowding.htm. Click on "Page 1," and "Page 2.")**

As a result, Viccellio began lobbying to have admitted patients being held in the ED instead sent upstairs. "It became clear that this was obviously in the patient's best interest," he says. "Patients deserve the expertise of the inpatient physician and inpatient nurse."

A "full capacity protocol" was developed that requires patients to be held upstairs, often in the hallway, when the ED is at full capacity. "When we have to see newly arriving patients in our hallway, it is time for patients to be moved upstairs," says Viccellio. **(See Emergency Department Full Capacity Protocol, enclosed in this issue.)**

Holding inpatients is outdated

The practice of holding inpatients in the ED came about as a result of lack of clout for EDs in general, says Viccellio. "This practice went on for so long that a new generation of physicians, nurses, and administrators believe that this is the way things are supposed to happen," he adds. "It makes absolutely no sense whatsoever. It never did and never will."

Building a unit adjacent to the ED for overflow admissions is not a real solution, says Viccellio. "You still have the same problem, because there is no inpatient physician and nurse," he explains.

Here are benefits of the full capacity protocol:
- **Patients are given better care.**

ED patients are seen more quickly as a result of the protocol, Viccellio says.

"Our driving concern was giving people appropriate medical care," he says. "To force critically ill people to stay in the waiting room for hours so that the hospital can store all the admitted patients in the ED doesn't make sense."

However, the ED still holds inpatients for specialty units such as critical care and respiratory patients, notes Viccellio.

Sources

For more information on this topic, contact:

- **Cheryl A. Barraco**, RN, MS, Nurse Manager, Emergency Department, Stony Brook University Hospital, Stony Brook, NY 11794-7400. Telephone: (631) 444-8028. Fax: (631) 444-6271. E-mail: cbarraco@notes.cc.sunysb.edu
- **Carolyn Santora**, RN, MS, Associate Director, Critical Care Nursing, Stony Brook University Hospital, Stony Brook, NY 11794-7715. Telephone: (631) 444-2922. Fax: (631) 444-6298. E-mail: csantora@notes.cc.sunysb.edu.
- **Peter Viccellio**, MD, FACEP, Vice Chairman, Department of Emergency Medicine, School of Medicine, State University of New York at Stony Brook, UH L4-515, SUNY 7400, Stony Brook, NY 11794-7400. Telephone: (631) 444-3880. Fax: (631) 444-3919. E-mail: aviccellio@epo.som.sunysb.edu.

"The problem that continues to plague us is that the protocol only applies to people we would put in our own hallways," he says. "Other patients still remain in the ED because there is no bed for them upstairs. But even given that limitation, the ability to move patients upstairs has a profound affect on diminishing the time patients wait for a doctor."

The full capacity protocol puts the focus on what is best for the patient, as opposed to the competing interests of individual departments, says **Carolyn Santora**, RN, MS, the facility's associate director of critical care nursing.

Admitted patients are better served being held on the unit where inpatient nurses can provide appropriate care, says **Cheryl A. Barraco**, RN, MS, nurse manager of the ED.

"For example, if cardiac patients are being held in the hallway on the floor instead of the ED, even though they are not in a room, they are still being cared for by inpatient nurses," she says.

- **Beds may become available immediately.**

There are times that departments are overloaded, and there aren't any beds, Viccellio acknowledges. "But oftentimes, when patients are moved upstairs to the hallway, a bed magically becomes available," he says.

This behavior is rampant throughout the hospital industry, Viccellio says. "The bed may become available at 1:00, but it doesn't get reported until the change of shift," he says.

Trying to get patients discharged early and nurses to report an available bed is fighting a losing battle, says Viccellio. "There is no incentive for them to rush or get patients upstairs," he says. "Once the problem is put in their lap, then they act to solve that problem."

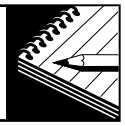
- **Length of stay is reduced.**

The facility did a study which found that the average length of stay for admitted patients held in the ED was 6.2 days, as compared with 5.4 days for the patients moved upstairs, Viccellio reports. "Most hospital administrators would love to get that much of a reduction in length of stay," he says.

- **Morale of ED nursing staff improves.**

The full capacity protocol improved morale because ED nurses are freed to care for their own patients, says Barraco. "We aren't dividing our time between taking care of admitted and ED patients, so we can concentrate on our specialty, which is the care of ED patients," she says. ■

GUEST COLUMN



New strategies assist billing under APCs

By **Caral Edelberg**, CPC, CCS-P
President/CEO
Medical Management Resources/Team Health
Jacksonville, FL

[Editor's Note: This is the first part of a two-part series on improving ED reimbursement under ambulatory payment classifications. This month, we cover nursing assessment criteria, ED chargemasters, billing for evaluation and management services (E/M) services, and observation services. Next month, we'll cover staff physicians, supplies and medications, local medical review policies, and proper use of modifiers. Edelberg can be reached at Medical Management Resources/TeamHealth, 8001 Belfort Parkway, Suite 200, Jacksonville, FL 32256. Telephone: (904) 725-4889. Fax: (904) 724-1948. E-mail: Caral_Edelberg@teamhealth.com.]

As the complexities of outpatient billing increase under the ambulatory payment classification (APC) payment system, EDs are becoming more and more vulnerable to the pressures of shrinking dollars resulting from financial losses that are preventable.

The list of the critical components of this system grows longer with each Centers for Medicare & Medicaid Services (CMS) memorandum that is published. However, unlike in years past, when the hospital business office had the major responsibility for

ensuring payment, ED administrators must be actively involved in coordinating and monitoring this system that has a major affect on ED revenues.

Use these four strategies to effectively improve your billing under APCs:

- **Review your nursing assessment criteria.**

The element of APCs getting the most attention is Medicare's desire to standardize the criteria that define facility nursing assessment levels for ED and clinic services. EDs are responsible for developing internal definitions and coding guidelines to identify the tiered levels of resource consumption of services provided to ED patients.

As ongoing analysis of hospital billing patterns for ED services continues at the national level, CMS encourages recommendations from hospitals and other interested parties in an effort to develop and implement a national standard for nursing assessment levels by 2004. CMS data currently indicate that hospitals are identifying the majority of nursing assessment levels and ED resources at the low to mid range, and ED physician distribution data indicate a mid- to high-range distribution of resources and acuity.

If CMS seeks to develop national criteria to reflect this low- to mid-level resource consumption, many EDs can expect to see a significant drop in ED revenues for evaluation and management (E/M) services.

Managers at each hospital need to review the entire process for developing, coding, and monitoring the E/M coding system to ensure that it accurately reflects the resources of the ED for each patient.

- **Maintain complete, up-to-date ED chargemaster.**

The ED chargemaster is a unique listing of all of the services and products that may be performed or provided to ED patients. ED services are performed by medical staff consultants as well as the ED physicians. The medications and supplies maintained in the ED that are disbursed to ED patents also must be identified for billing purposes.

This menu of services requires that a complex chargemaster be developed and routinely reviewed for accuracy. Generally, more than 450 procedures are performed in the ED by ED staff or other members of the medical staff. These procedures must be coded through the chargemaster in order to migrate over to the UB-92 billing form.

Procedures not listed on the ED chargemaster are not likely to go through the review and fee assignment process in time to be billed. Thus, many procedures and services never make it through the billing process. Some hospitals, due to staffing shortages, feel that maintaining procedures on a chargemaster that may be performed only a limited number of times a year is not a wise use of staff resources.

It takes time to research the codes and descriptions, determine their appropriate fee, assign the internal "charge" code, and enter them into the hospital computer system accurately. However, significant revenue for the hospital is related to those high-end procedures, whether or not they are performed on a frequent basis. Thus, they must be maintained in the chargemaster if they can be performed in the ED.

- **Bill for E/M services in addition to surgical procedures.**

Hospitals are instructed to bill for procedures performed in the ED as well as separately identifiable E/M services also performed in conjunction with the ED visit. The controversy surrounding the billing of both of these services at the same visit centers on how E/M services are differentiated from other cognitive services associated with the preoperative and intraoperative services directly related to the procedure.

In two significant communications outlining billing requirements for E/M and surgical procedures performed at the same visit, CMS provides detailed instructions and clarifications to hospitals.

Both *CMS Transmittal A-01-80,* dated June 29, 2001, and *Program Memorandum Transmittal A-00-40,* dated July 21, 2000, include examples for separately identifying these services. (To access the memorandums, go to www.cms.gov/manuals. Under "Program Memoranda," click on the year of publication and scroll down for the correct document.)

In addition, in both of these documents CMS outlines the requirement for appending the modifier -25 to the E/M level to designate it as a separately identifiable and payable service, without which the payment for the ED E/M level is denied.

- **Ensure adequate documentation for observation services.**

Rules for billing of observation services continue to undergo revisions by Medicare. Currently, observation services are paid for three conditions, additionally requiring the performance of certain diagnostic tests and listing of allowable ICD-9-CM diagnosis codes.

A new twist to the observation dilemma recently was added when Medicare added codes to identify patients that circumvent the ED work-up and are directly admitted to observation. This class of observation also is restricted to certain clinical conditions, diagnostic tests, and diagnosis codes.

All require that specific documentation address certain elements of the observation process, the patient's condition, and discharge. Without meeting these requirements, observation billing may be vulnerable to audits and recoup of payment. This already has occurred, and it promises to emerge as a future audit risk. ■

EMTALA Q & A

[Editor's Note: This column is part of an ongoing series that will address reader questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Staci Kusterbeck, Editor, ED Management*, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: StaciKusterbeck@aol.com.]*

Question: Is it necessary to send a nurse on a transfer of a stable myocardial infarction patient to another facility for cardiac catheterization/percutaneous transluminal coronary recanalization who recently has received thrombolytics? Or is a paramedic sufficient?

Answer: The answer to the question of paramedic vs. nurse on a transfer revolves around skill levels, says **John D. Lipson**, MD, MBA, principal of Columbus, IN-based Medical Staff Support Services, which assists medical staff leaders and administrators with EMTALA compliance.

If the paramedics are skilled at cardiac rhythm interpretation, have communications with medical command, and are trained to give appropriate medication, then paramedic transport is appropriate, he says. However, if the patient's condition is more complex — for instance, if the patient is being titrated on an antiarrhythmia medication — then a cardiac nurse would be appropriate, Lipson says.

"It is therefore important that the ED physician know the skills, talents, training, and protocols of the paramedics, so the physician can make an informed decision as to the most appropriate personnel for transport," he explains.

The transfer requirements of EMTALA demand that adequate equipment and personnel suitable for the condition of the patient be utilized, according to **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"I question how 'stable' a patient is who has recently received thrombolytics," he says. The potential of dysrhythmias, blood pressure lability, bleeding complications, and recurrence of thrombosis makes these patients inherently "unstable" for at least eight to 12 hours after the treatment, Lawrence explains.

"While some paramedics may be up to the task, I think the more prudent course would be for a critical care nurse to accompany the patient," he says.

"Their training is far more comprehensive than a paramedic's," Lawrence adds. ■

Sources

For more information about the Emergency Medical Treatment and Labor Act, contact:

- **Jonathan D. Lawrence**, MD, JD, FACEP, Emergency Department, St. Mary Medical Center, 1050 Linden Ave., Long Beach, CA 30813. Telephone: (562) 491-9090. E-mail: jdl28@cornell.edu.
- **John D. Lipson**, MD, MBA, Medical Staff Support Services, 6043 Chinkapin Drive, Columbus, IN 47201. Telephone: (812) 342-2658. E-mail: lipsonj@medstaff.net. Web: www.medstaff.net.

MRIs found to be faster at detecting heart attacks

Managing chest pain is a challenge for every ED, fraught with risks of missed diagnosis, adverse outcomes, and potential lawsuits.

As an ED manager, you should take note of a new study reporting that magnetic resonance imaging (MRI) technology can detect heart attacks faster than other methods in ED patients with chest pain.[1]

The study, conducted by the Bethesda, MD-based National Institutes of Health (NIH), says that more patients with a heart attack or major blockage would be able to receive treatment to reduce permanent damage if they were given an MRI.

The researchers compared the MRI results with three standard diagnostic tests: an electrocardiogram (ECG), a blood enzyme test, and the Thrombolysis in Myocardial Infarction risk score, which assesses the risk of complications or death in patients with chest pain.

MRI detected all of the patients' heart attacks, including three in patients who had normal ECGs. In addition, MRI detected more patients with unstable angina than the other tests.

The study shows that better strategies are needed for chest pain patients when the initial ECG and troponin level do not make the diagnosis, says **Andrew Arai**, MD, an NIH investigator and one of the study's authors. "Detecting the patient with a myocardial infarction despite normal ECG is relatively easy by MRI," he says.

Patients with a minimally abnormal ECG but MI in process, and patients with unstable angina, may be more accurately diagnosed with an MRI scan, Arai says. With MRI, you can detect patients with unstable angina, he

Source

For more information on the study, contact:

- **Andrew Arai**, MD, Investigator, National Heart, Lung and Blood Institute, National Institutes of Health, Department of Health and Human Services, 10 Center Drive, Bethesda, MD 20892-1061. E-mail: AraiA@NHLBI.NIH.GOV.

adds. "Cardiac enzymes theoretically should always miss the patient with no infarction," Arai says. "The ECG is not sensitive or specific enough to accurately diagnose these patients."

Use of MRI could fundamentally change the approach to patients who are not immediately diagnosed by simpler tests on presentation, says Arai. "ED managers and physicians need to help participate in developing reasonable new strategies for diagnosis of patients with chest pain," he says.

Currently, physicians rely heavily on the ECG, which may show nonspecific changes, so many patients end up being admitted to "rule out" MI. "Many of these patients do not need hospitalization. So an MRI might reduce some fraction of 'rule out MI' hospitalizations," Arai says.

Reference

1. Kwong RY, Schussheim AE, Rekhraj S, et al. Detecting acute coronary syndrome in the emergency department with cardiac magnetic resonance imaging. *Circulation* 2003; 107: 531-537. ■

CE/CME instructions

Physicians and nurses participate in this CE/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 this semester's activity with the September 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. ■

CE/CME *questions*

1. Which is an effective strategy to handle staffing shortages caused by military call-ups, according to Michael L. Carius, MD, FACEP, chairman of Norwalk Hospital's department of emergency medicine?
   A. Broaden the pool of supplemental staff in advance.
   B. Rely solely on traveler nurses.
   C. Offer 12-hour shifts only.
   D. Avoid use of per-diem physicians.

2. Which of the following is true regarding compliance with oral privacy requirements of Health Insurance Portability and Accountability Act, according to Peter Alan Bell, DO, FACOEP, FACEP, professor of emergency medicine at Ohio University College of Osteopathic Medicine?
   A. A complete redesign of the ED is necessary.
   B. A significant investment of capital resources is needed.
   C. The triage area is excluded from compliance requirements.
   D. Simple changes such as cubicles and lowering voices are effective.

3. Which is a result of the "full capacity" protocol used for admitted patients being held in the ED at Stonybrook University Medical Center?
   A. Nurse vacancy rates increased.
   B. Liability risks increased.
   C. Length of stay decreased.
   D. Patient satisfaction scores decreased.

4. Which is accurate about ED reimbursement under APCs, according to Caral Edelberg, CPC, CCS-P, president/CEO of Medical Management Resources/Team Health?
   A. Facility nursing assessment levels will not be standardized.
   B. Medications and supplies do not have to be identified on the ED chargemaster.
   C. Maintaining an up-to-date ED chargemaster is a poor use of staff resources.
   D. You may bill for procedures performed in the ED as well as separately identifiable E/M services.

COMING IN FUTURE MONTHS

- ■ Bar-coding technology for medications
- ■ Improve morale with a nursing committee
- ■ Update on chest pain centers
- ■ Novel solutions to improve patient flow

5. To comply with the Emergency Medical Treatment and Labor Act, which is true regarding accompaniment of a patient being transferred after receiving thrombolytics?
   A. A paramedic must transport the patient.
   B. It depends on the patient's condition and the skill level of personnel.
   C. If the patient is considered stable, a nurse is not required.
   D. A paramedic is not permitted to transport the patient in any circumstance.

6. Which is true about diagnosing chest pain patients in the ED, according to a study published in *Circulation*?
   A. Magnetic resonance imaging (MRI) technology can detect only unstable angina.
   B. Electrocardiograms should be given only to myocardial infarction patients.
   C. A blood enzyme test detected more patients with unstable angina.
   D. Patients with unstable angina may be more accurately diagnosed with an MRI scan.

Answer Key: 1. A; 2. D; 3. C; 4. D; 5. B; 6. D

CE/CME objectives

• Discuss and apply new information about various approaches to ED management. (See "*MRIs found to be faster at detecting heart attacks*," and "*Use protocol to send inpatient holds upstairs*," in this issue.)

• Explain developments in the regulatory arena and how they apply to the ED setting. (See "*New strategies assist billing under APCs*," and *EMTALA Q&A*.)

• Share acquired knowledge of these developments and advances with employees. (See "*5 ways to comply with HIPAA oral privacy regs*.")

• Implement managerial procedures suggested by your peers in the publication. (See "*Are you losing staff to military call-ups? ED managers share their key strategies."*) ■

ADMINISTRATIVE POLICIES & PROCEDURES

MANUAL CODE: TX:0052

RE-REVIEW DATE: (Assigned by Policy Review Committee)

SUBJECT: Emergency Department Full Capacity Protocol
RESPONSIBLE DEPARTMENT, DIVISION, OR COMMITTEE: Medical Director's Office
EFFECTIVE DATE ORIGINAL POLICY: _____
EFFECTIVE DATE REVISED POLICY: 02/22/2001
SUPERSEDES POLICY NUMBER: _____
LAST REVIEW DATE: _____ DATED: _____

SUBJECT: Emergency Department (ED) Full Capacity Protocol (In-House Hall Bed Placement)

SCOPE: ED, Admitting Department, Physicians, Nursing Department, Administrative Personnel, Acute Care Units as listed: 19 North, 19 South, 16 South, 15 North, 15 South, MRN, 5L Ortho, 5L Cardiac (ICRs are excluded).

PURPOSE: To facilitate the admission of adult patients held in the ED awaiting Acute Unit Bed Assignment.

POLICY: When an adult patient requires admission to an Acute Care Unit from the ED and that area cannot accommodate that patient because of lack of sufficient beds, the patient will be admitted to the next most appropriate bed. In the event appropriate hospital bed utilization has been maximized, and the number of admitted patients holding in the ED has prohibited the evaluation and treatment of incoming patients to the ED in a timely fashion, the admitted ED patients already awaiting in-house acute care bed assignments will be admitted to acute care unit hall beds.

The Bed Utilization Coordinator will facilitate this policy. When unavailable during the day, the ADN on call to the Nursing Staffing Office in collaboration with the Staffing Coordinator will assume responsibility and assign hall beds in conjunction with the Bed Control Supervisor. On nights and weekends, the ADN on duty shall serve this role.

The placement of patients to hall beds will be implemented by the Bed Utilization Coordinator only after the ED Attending Physician, the Charge Nurse, and the Bed Utilization Coordinator have declared the need to implement the ED Full Capacity Protocol and approval to do so has been granted by the Medical Director of University Hospital, the Chief Operating Officer, or the Chief Executive Officer, or their designees. The decision of patient placement by the Bed Utilization Coordinator after discussion with the ED Attending physician (if indicated) shall be binding.

If hall bed placement has been maximized (two per unit) and the ED is still at Full Capacity, the Chief Executive Officer, Chief Operating Officer, and the Medical Director will be notified and make decisions on implementation regarding deferral of elective and urgent cases and ED Diversion.

FORMS: None

POLICY CROSS-REFERENCES: Commissioner of Health Memo on ED Overcrowding dated Dec. 11, 2000.

DEFINITIONS: ED Full Capacity Protocol identifies "full capacity" when 100% of the main department is occupied with patients and admitted (ED) patients have been awaiting in-house placement for two hours.
ALL UNOCCUPIED ACUTE FLOOR BEDS SHOULD BE UTILIZED BEFORE HALL BEDS ARE USED, WHERE NURSE COMPETENCY PERMITS SUCH PLACEMENT.

A. Patient Priorities for Hall Bed Placement:
1. Nontelemetry patients with little or no comorbidity will be first considered for hall bed placement.
2. Nontelemetry patients with minimal to moderate risk factor comorbidity will be the second patient population to be considered for hall beds
3. Patients admitted on or for telemetry monitoring with little or no comorbidity and with minimal index of suspicion for a cardiac event will be the last patient population to be considered for hall bed placement.
4. For adults ages 18, 19, and 20, they can be considered for a Pediatric Unit if a bed is available.

Telemetry patients will be assigned to hall beds only after approval of the ED Attending Physician and it has been confirmed that the receiving in-house unit has a telemetry box and a central monitoring slot. Telemetry C patients in the ED may be assigned to 16S or non-16S hall beds except that arrhythmia patients and patients who already have ruled-in for MI may not go to 5L.

B. Exceptions:
1. Patients on Acute Units will not be moved to hall beds in order to make room for patients admitted from the ED.
2. Patients being transferred out of Intermediate Care or the Intensive Care Unit (ICU) beds will not be placed in hall beds.
3. If hall bed utilization has been maximized and the ICU is full, and there is one or more ICU patients waiting in the ED, the next available floor bed will go to an ICU patient transferring out of ICU (not to a hall bed patient).
4. Any "exception" to the above will be with the individual approval of the Medical Director or designee.

PROCEDURE

A. Hall Patient Placement During Weekday Shift:
1. The ED Attending Physician, Charge Nurse, and the Bed Utilization Coordinator will declare full capacity.
2. The Bed Utilization Coordinator will request approval to implement the ED Full Capacity Protocol from the Chief Executive Officer, the Chief Operating Officer, or the Medical Director.
3. Once approval is granted, the Bed Utilization Coordinator will notify the Directors of Patient Care of the need to implement the ED Full Capacity Protocol.
4. Nursing Staffing Office will notify the respective units that the ED Full Capacity Protocol is in effect and of the need to prepare for hall bed patients.
5. Patients admitted to hallways on inpatient units will be placed as much as possible according to service. Each unit will receive one hall bed patient. After all applicable units have received one patient, a second hall patient may be assigned. No unit will have more than two hall bed patients.
6. Patients admitted to hallways on inpatient units will be prioritized over the ED for admission to the first available bed on any unit where nursing competencies meet patient needs. Hallway patients need not be admitted to the unit on which they are boarding.

B. Procedure on the Off-shifts:
1. The ED Attending Physician and Charge Nurse will notify the ADN on duty that ED Full Capacity is being invoked.
2. The ADN will request approval to implement the ED Full Capacity Protocol from the Chief Executive Officer, the Chief Operating Officer, or the Medical Director.
3. The Nursing Staff Office will notify all Medical, Surgical, and Cardiac Units that the ED is on Full Capacity Protocol and to expect hall bed patients.
4. The ADN will notify the Bed Control Supervisor to begin placing hall bed patients on the designated acute floors and will intervene for any placement.

C. Hall Bed Exclusions**:**

Admitted ED patients that will not be placed in hall beds:
1. Patient requiring the Intermediate Care Unit or the ICU will not be placed in hall beds.
2. Vented patients will not be placed in hall beds.
3. Patients requiring isolation or negative pressure room placement will not be placed in hall beds.
4. Patients requiring minimal oxygen (less than 4 L via nasal cannula) will arrive to the unit hall bed assigned with a full tank of O_2. (Any equipment exchange will be prearranged prior to transporting the patient.)
5. Patients who require suctioning are poor candidates for hall bed placement.

D. Procedure for Discontinuation:
1. All unit hall bed placements have been maximized (two per unit).
2. The ED no longer needs hall bed placements.
3. ED Attending, Charge Nurse, and Bed Utilization Coordinator agree to stand down from the Protocol.
4. The Bed Utilization Coordinator/designee will notify the Nursing Staffing Office. The Nursing Staffing Office will notify all units.

Source: Stony Brook (NY) University Hospital & Medical Center.

Military/Nonmilitary-Related Obligation Pay and Leave

I. Purpose

This policy presents the organization's obligations in complying with The Uniformed Services Employment and Reemployment Rights Act (USERRA) and stipulates compensation parameters for nonworking time granted due to certain military training and service obligations.

II. Scope

All full-time, part-time, and supplemental status employees with regularly scheduled hours are covered by this policy. Supplemental status employees with an FTE status of zero and temporary status employees are excluded.

III. Definitions

- **Discretionary Leave/Nonmilitary** Service (more than 30 calendar days): Personal leave referenced under the *Discretionary Leave of Absence* policy (HR-106), which is an inactive status associated with absence from work without pay by reason of nonmilitary service in excess of thirty (30) calendar days not to exceed 12 months.
- **Military Leave of Absence (MLOA):** An inactive status associated with absence from work without pay by reason of military service in excess of 30 calendar days not to exceed five cumulative years.
- **Military-Related Obligation:** Any training or service time associated with the Uniformed Services.
- **Nonmilitary-Related Obligation:** Any service time required by the Federal Emergency Management Agency (FEMA) or the State Emergency Management Agency (SEMA).
- **Uniformed Services:** Refers to the armed forces (Army, Navy, Marine Corps, Air Force, and Coast Guard); the Army and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commission corps of the Public Health Service, and any other category of people designated by the president in time of war or national emergency.
- **Uniformed Services Employment and Reemployment Rights Act (USERRA):** refers to USERRA, signed into law in October 1994, which prohibits discrimination against people because of their service in the Armed Forces Reserve, the National Guard, or other uniformed services. USERRA prohibits an employer from denying any benefit of employment and protects the rights of veterans, reservists, National Guard members, and certain other members of the uniformed services to reclaim their civilian employment after being absent due to military training or service.

IV. Policy Statements

A. USERRA protections do not make any distinctions based upon the category of military training or service or the timing, frequency, duration, or nature of the service. People absent from employment by reason of service in the uniformed services are protected by USERRA.

B. Any employee who requests a military leave status to perform service in the uniformed services, voluntarily or involuntarily, is entitled to return to his/her job if the following eligibility criteria under USERRA are met:

1. Gave advance written or verbal notice of the service unless circumstances made giving advance notice impossible, unreasonable, or was precluded by military necessity.
2. Has not exceeded a cumulative length of uniformed service of five years.
3. Submits a timely application for reemployment by specified guidelines that vary based on the length of military service.
4. Has separated from military service under honorable conditions (this applies to all types of service).

C. Military-Related Obligations (less than 30 calendar days):

1. Any employee serving in the armed forces Reserve, the National Guard, or other uniformed service (i.e., retired personnel of the naval, air, or ground forces) are entitled to leave for military-related obligations.

2. The organization will pay an employee for no more than 15 days in any calendar year for these obligations. Payment for all scheduled workdays that fall within this period will be the difference between the employee's base rate of pay, including associated differentials (excluding overtime), and the pay received for the military obligation that was performed on what would have been a regularly scheduled workday.
This provision applies to any military-related obligation for which the employee has military orders, but normally does not apply to regularly scheduled weekend military-related obligations. Military pay for weekend military-related obligations is applicable if the employee has a regular work schedule that includes Saturdays and/or Sundays, is scheduled to work the weekend, and is also ordered by the military.

3. Military service time should be designated with the appropriate code in Timeline, and the employee must provide proof (i.e., military check or pay stub) to the payroll department of the amount earned during the military-related obligation before a paycheck will be issued.

4. Upon request from an employee, management may approve paid time off (PTO) to be taken in waiver of the 15 days in any calendar year stipulation. Any absences requested and approved in excess of 15 calendar days should not exceed 30 calendar days. Managers may use discretion in approving the time off without pay. Under both circumstances benefits continue to accrue.

5. Any time requested in excess of 30 calendar days would fall under a formal military leave of absence.

D. MLOA (more than 30 calendar days):

1. MLOA is an inactive status associated with absence from work in excess of 30 calendar days, without pay, granted to employees who perform service, either voluntarily or involuntarily, in the uniformed services.

2. A leave of absence for training and service may not exceed five cumulative years.

3. Periodic and Special Reserve National Guard training, most National Guard service during time of state or national emergency, initial enlistments lasting more than five years, and involuntary active duty extensions and recalls are not subject to the five year limitation.

4. When an employee enters the uniformed services for extended active duty beyond 30 calendar days, the following apply if the employee is benefits eligible:

a. coverage up to the date active military duty commences;

b. may elect to continue medical and dental coverage for up to 18 months and pay not more than 100% of the full premium;

c. may elect to convert any employee or dependent life insurance to an individual policy through the carrier.

5. Upon return from MLOA, an employee must report to work or submit an application for reemployment by certain specified deadlines that vary based upon the length of military service. Failure to apply in a timely manner may impact entitlement to full reemployment benefits.

6. Upon re-employment, the employee will be reinstated into the position, which was vacated or one of similar status and pay, subject to the same adjustments in pay and benefits that would have been received had the employee remained in the position provided. If the position was eliminated under the *Restructuring/Staff Reduction* policy, the employee will be subject to the options outlined under policy.

7. Upon reemployment, health plan coverage and employer pension contributions will resume without delay.

E. Nonmilitary-Related Obligation (less than 30 calendar days):

1. Any employee serving in a nonmilitary capacity who is formally mobilized by a sanctioned (i.e., presidential order) initiative through FEMA or SEMA will be approved for time off for a nonmilitary-related obligation.

2. The organization will pay an employee for no more than 15 days in any calendar year for these obligations. Payment for all scheduled workdays that fall within this period will be the difference between the employee's base rate of pay, including associated differentials (excluding overtime), and pay received for the sanctioned nonmilitary-related obligation that was performed on what would have been a regularly scheduled workday.

3. Nonmilitary service time should be designated with the appropriate code in Timeline, and the employee must provide proof (i.e., nonmilitary check or pay stub) to the payroll department of the amount earned during the nonmilitary-related obligation before a paycheck will be issued.

4. Upon request from an employee, management may approve PTO to be taken in waiver of the 15 days in any calendar year stipulation. Any absences requested and approved in excess of 15 calendar days should not exceed 30 calendar days. Managers may use discretion in approving the time off without pay. Under both circumstances benefits continue to accrue.

F. Nonmilitary-Related Obligation (more than 30 calendar days). Any time requested and approved by management for a nonmilitary-related obligation more than 30 calendar days would fall under the *Discretionary Leave of Absence* policy. Although current policy does not list a nonmilitary-related obligation as a reason, absences of this nature would be considered for personal reasons. The employee would be subject to return to work under the condition the leave was granted.

V. Responsibility

The department director is responsible for consistent application of this policy within a department. The director of employee relations/human resources information systems (HRIS) is responsible for consistent application of this policy throughout the organization.

VI. Exceptions

Exceptions to this policy require authorization by the director of employee relations/HRIS prior to any action being taken.

VII. Cross-Reference

Discretionary Leave of Absence policy; Restructuring/Staff Reduction policy

VIII. Procedure

A. Employees must give advance verbal or written (preferably written) notice of service unless circumstances make giving advance notice impossible, unreasonable, or was precluded by an emergency nonmilitary or military necessity. Written notification is retained by department management and used for time record coding in Timeline.

B. The organization will pay an employee for 15 days in any calendar year for military or nonmilitary-related obligations. Payment will be the difference between the employee's base rate of pay, including associated differentials (excluding overtime), and the pay received for the military or sanctioned nonmilitary-related obligation that was performed on what would have been a regularly scheduled workday.

C. Military and nonmilitary-related obligations should be designated with the appropriate code in Timeline, and the employee must provide proof (i.e., military or nonmilitary check or pay stub) to the payroll department before a paycheck will be issued.

D. Upon request from an employee, management may approve PTO to be taken in waiver of the 15 paid days in any calendar year stipulation. Any absences requested and approved in excess of 15 calendar days should not exceed 30 calendar days. Managers may use discretion in approving the time off without pay up to the 30-day limit. Under both circumstances, benefits continue to accrue.

E. Any time requested in excess of 30 calendar days for a military-related obligation should be designated as a Military Leave of Absence. Job restoration conditions would be subject to those established under USERRA.

F. A nonmilitary-related absence should be designated as a Discretionary Leave of Absence for personal reasons. Employees would be subject to the job restoration conditions established when the leave was granted.

G. Upon return from a military or nonmilitary-related obligation less than 30 calendar days, the employee is subject to the following return to work deadlines:

1. One to 30 calendar days: The employee must return at the beginning of the next regularly scheduled shift on the first full day after release from service, taking into account safe travel home plus an eight-hour rest period.
2. Being absent from work to take a military fitness-for-service examination requires reporting back to work by the beginning of the first regularly scheduled shift that would fall eight hours after returning home.

H. An employee must complete a Request for Military Leave of Absence (RMLOA) form for any absence of 31 calendar days or more, unless precluded by military necessity. RMLOA requests must be granted.

1. Department management is responsible for reviewing the benefit information and return from leave procedures with the employee. Department management provides the employee with a Clearance Checklist form and instructs the employee to proceed through the clearance process.

2. Department management forwards a copy of the approved form to HRIS.

I. Upon return from military service in excess of 31 calendar days, the employee submits an application for reemployment by the following specified deadlines that vary based upon the length of military service:

1. 31 to 180 calendar days: The employee must submit an application for reemployment within 14 calendar days of release from military service. Application may be written or oral, as long as it clearly conveys the person is a returning service member seeking reemployment. If it is impossible for the employee to submit timely, an exception to the 14 calendar days would be to apply for re-employment the next full calendar day after it becomes possible to submit an application.

2. 181 calendar days or more: The employee must make application for reemployment within 90 calendar days after completing the period of military service.

J. Any employee who is hospitalized or convalescing from an illness or injury incurred or aggravated during a military-related obligation must report to the employer and submit an application for re-employment at the end of the necessary recovery period. The employee must apply for return to work within two years unless circumstances make it unreasonable or impossible to do so.

K. Upon completion of a military-related obligation (more than 30 calendar days), the employee is reinstated into the position which was vacated, or one of similar status and pay, subject to the same adjustments in pay and benefits that would have been received had the employee remained in the position, provided the employee is honorably discharged. If the employee's position was not held, Employment Services works with the employee for placement into a position of similar status and pay. If the position was eliminated under the *Restructuring/Staff Reduction* policy, the employee is subject to the options outlined under policy.

L. The employee must successfully complete a health assessment with Employee Occupational Health Services prior to returning to work if the leave period exceeds 30 calendar days.

M. Depending upon the reemployment process and return to work status, the appropriate documentation (i.e., employee data change) is completed by either department management or Employment Services.

Source: Methodist Hospital, Indianapolis.